The Roundtable of Population Health Improvement presents

SHIFTING THE NATION'S HEALTH INVESTMENT TO SUPPORT LONG, HEALTHY LIVES FOR ALL

NATIONAL ACADEMIES *Sciences Engineering Medicine*

ATTENDEE PACKET
MARCH 2023

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NATIONAL ACADEMIES Sciences Engineering Medicine

ROUNDTABLE ON POPULATION HEALTH IMPROVEMENT

Shifting the nation's health investments to support long, healthy lives for all: A (participatory) symposium

March 6-7, 2023

National Academy of Sciences Building, Room 125 |2101 Constitution Avenue, NW, Washington DC

Live webcast

DRAFT AGENDA

Two milestone Institute of Medicine reports highlighted the nation's health disadvantage compared to peer nations, and the policies and investments that shape it. This event, marking a decade since the reports' release, will:

- Frame the conversation about our national predicament (shorter lives, poorer health, profound inequities) and its systemic causes (e.g., income inequality and poverty, inadequate social supports and social spending on the earlier part of the life course) and make the case for a different future being possible.
- Showcase glimpses of what is possible, the existing and emerging solutions
- Provide a forum for participants to share their ideas/strategies
- Equip all participants with at least one new strategy to support or implement in their specific practice/setting…

Monday, March 6

9:00 AM ET

Welcome and Introduction
Ray Baxter, *Roundtable Co-Chair,* Chair-elect, Blue Shield of California Foundation Board; secretary, CDC Foundation Board

Facilitated audience participation: James and Kristen Whitfield, Be Culture; Fisher Qua, Back Loop

9:25 AM

Keynote session: Anchoring in Curiosity
Tiffany Manuel, President and CEO, The Case Made
Dave Chokshi, Clinical Professor of Medicine and Public Health, NYU Langone Health
Anita Chandra, Vice President and Director, Social and Economic Well-Being, RAND
Facilitated audience participation

10:35 AM **A Bridge from Curiosity to Solutions**
Hilary Heishman, *Planning Committee Chair,* Senior Program Officer, Robert Wood Johnson Foundation

10:45 AM **BREAK**

11:00 AM **Showcasing what is possible (4 stations)**
(1) **Aparna Mathur,** Senior Fellow, Harvard Kennedy School
(2) **Lindsay Morgan Tracy,** Innovator-in-Chief for the Department of Social & Health Services, **Jennifer Bereskin,** Steering Committee for the Governor's Poverty Reduction Work Group, **Lori Pfingst,** Senior Director in the Washington State Department of Social and Health Services, Washington State
(3) **Sue Polis,** Director of Health and Well-Being, National League of Cities
(4) **Dorianne Mason,** Director of Health Equity, Reproductive Rights and Health, National Women's Law Center

12:30 PM **BREAK**

1:30 PM **Showcasing what is possible**
Anita Chandra, Vice President and Director, Social and Economic Well-Being, RAND
Robert Kaplan, Adjunct Professor, School of Medicine, Stanford University
Mac McCullough, Associate Professor of Public Health, Boise State University
Facilitated audience participation

2:15 PM **Revisiting two landmark NASEM reports**[1]
Atul Grover, Executive Director, Research and Action Institute, Association of American Medical Colleges
Marthe Gold, Professor Emeritus, Department of Community Health and Social Medicine, City University of New York
Steven Teutsch, Senior Fellow, Leonard D. Schaffer Center for Policy and Economics, UCLA
Steven Woolf, Director Emeritus and Senior Advisor, Center on Society and Health, Virginia Commonwealth University
Facilitated audience participation

3:00 PM **BREAK**

[1] *For the Public's Health: Investing in a Healthier Future* (2012) recommended that the Secretary of HHS set 2030 targets for life expectancy and health care spending that are more in line with peer nations. *US Health in International Perspective: Shorter Lives, Poorer Health* (2013) recommended (1) that the philanthropy and advocacy communities organize a comprehensive media and outreach campaign to inform the general public about the US health disadvantage and to stimulate a national discussion about its implications for the nation; and (2) that the NIH or other appropriate entity commission a review of the available evidence on the effects of policies on the areas of US health disadvantage and how policies have varied over time across high income countries, and extent to which policy differences may explain cross-national health differences.

3:15 PM **The Path Forward, or Amplifying Signs of a Movement**
Tiffany Manuel, President and CEO, The Case Made
Somava Saha, Executive Lead, WE (Well-Being and Equity) in the World
Tyler Norris, Visiting Scholar, Federal Reserve Bank of New York
Martha Sanchez, Director of Health Policy and Advocacy, Young Invincibles
Facilitated audience participation

4:30 PM **Adjourn First Day**

Tuesday, March 7

8:30 AM **The Path Forward, or Amplifying Signs of a Movement**
Tiffany Manuel, President and CEO, The Case Made
Somava Saha, Executive Lead, WE (Well-Being and Equity) in the World
Tyler Norris, Visiting Scholar, Federal Reserve Bank of New York
Martha Sanchez, Director of Health Policy and Advocacy, Young Invincibles
Audience participation

10:00 AM **BREAK**

10:15 AM **The Path Forward, Continued**

11:30 AM **Closing Remarks and Audience Reflections**
Ray Baxter, *Roundtable Co-Chair,* Secretary, CDC Foundation Board, Trustee, Blue Shield of California Foundation

12:00 PM **Adjourn**

This event was planned by the following experts: Hilary Heishman (Chair), Robert Wood Johnson Foundation, Marcella Alsan, Harvard University; Anita Chandra, RAND; Atul Grover, AAMC; Dora Hughes, CMS; Tiffany Manuel, The Case Made; Mac McCullough, Boise State University; Bobby Milstein, ReThink Health; Kara Odom Walker, Nemours; Tyler Norris, Federal Reserve Bank of New York.

Note: The planning committee's role is limited to planning the event. A proceedings based on the event will be prepared by an independent rapporteur.

Follow the conversation #pophealthrt @NASEM_Health
Roundtable web page: https://nas.edu/pophealthrt

NATIONAL ACADEMIES Sciences Engineering Medicine

HEALTH AND MEDICINE DIVISION | Board on Population Health and Public Health Practice

Roundtable on Population Health Improvement

Vision, Mission, and Roster

Vision | A thriving, healthful, and equitable society

Mission | In recognition that health and quality of life for all are shaped by interdependent historical and contemporary social, political, economic, environmental, genetic, behavioral, and health care factors, the Roundtable on Population Health Improvement exists to provoke and catalyze urgently needed multi-sector community engaged collaborative action.

Members

Raymond Baxter, Ph.D. (co-chair)
Chair-Elect, Blue Shield of California Foundation Board
Secretary, CDC Foundation Board
San Francisco, CA

Ana V. Diez Roux, MD, PhD, MPH (co-chair)
Dana and David Dornsife Dean and Distinguished University Professor of Epidemiology
Dornsife School of Public Health
Drexel University
Philadelphia, PA

Philip M. Alberti, Ph.D.
Senior Director, Health Equity Research and Policy
Association of American Medical Colleges
Washington, DC

Debbie I. Chang, M.P.H.
President and CEO
Blue Shield of California Foundation
San Francisco, CA

Marc N. Gourevitch, M.D., M.P.H.
Professor and Chair
Department of Population Health
NYU Langone Health
New York, NY

Meg Guerin-Calvert, M.P.A.
Senior Managing Director and President, Center for Healthcare Economics and Policy
FTI Consulting
Washington, DC

Hilary Heishman, M.P.H.
Senior Program Officer
Robert Wood Johnson Foundation
Princeton, NJ

Dora Hughes, M.D., M.P.H.
Senior Advisor, Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
U. S. Department of Health and Human Services
Washington, DC

Sheri Johnson, Ph.D.
Director, Population Health Institute
Professor (CHS), Department of Population Health Sciences
School of Medicine and Public Health
University of Wisconsin-Madison
Madison, WI

Robert M. Kaplan, Ph.D.
Professor
Center for Advanced Study in the Behavioral Sciences
Stanford University
Stanford, CA

Milton Little, M.A.
President
United Way of Greater Atlanta
Atlanta, GA

Monica Valdes Lupi, J.D., M.P.J.
Managing Director
Health Program
Kresge Foundation
Troy, MI

Bobby Milstein, Ph.D., M.P.H.
Director
ReThink Health
Morristown, NJ

José T. Montero, M.D., MHCDS
Director, Office of Recipients Support and Coordination
National Center for STLT Public Health Infrastructure and Workforce
Centers for Disease Control and Prevention
Atlanta, GA

Willie (Billy) Oglesby, Ph.D.
Dean
College of Population Health
Jefferson University
Philadelphia, PA

Jason Purnell, Ph.D.
President
James S. McDonnell Foundation
Associate Professor
Brown School
Washington University in Saint Louis
Saint Louis, MO

Kosali Simon, Ph.D.
Herman B. Wells Endowed Professor
Associate Vice Provost for Health Sciences
Paul H. O'Neill School of Public and Environmental Affairs
Indiana University
Bloomington, IN

Kara Odom Walker, M.D., M.P.H, M.S.H.S.
Senior Vice President and
Chief Population Health Officer
Nemours
Washington, DC

Terry Williams, M.B.A., Dip. Econ.
Executive Vice President & Chief, Population, Corporate, & Government Affairs Officer
Atrium Health
Winston-Salem, NC

Hanh Cao Yu, Ph.D.
Chief Learning Officer
The California Endowment
Oakland, CA

Shifting The Nation's Health Investments To Support Long, Healthy Lives For All

A Symposium

Biosketches of Speakers, Moderators, and Planning Committee Members

*denotes planning committee member, †denotes roundtable member

Marcella Alsan*

Marcella Alsan, M.P.H., M.D., Ph.D. is a Professor of Public Policy at Harvard Kennedy School. Prior to returning to Harvard, she was on faculty at Stanford. She is an applied microeconomist studying health inequality. Some of her recent papers include "Does Diversity Matter for Health: Experimental Evidence from Oakland" and "Tuskegee and the Health of Black Men" – published in the American Economic Review and The Quarterly Journal of Economics, respectively. These papers have been cited in the New York Times and other major media outlets and findings have been presented to the Association of American Medical Colleges and the Centers for Disease Control and Prevention. She is currently on the Board of Editors for Science Magazine, Co-Editor of the Journal of Health Economics and Co-Chair of the Health Care Delivery Initiative of Poverty Action Lab based out of MIT. She is the co-recipient of the 2019 Arrow Award for Best Paper in Health Economics.

Dr. Alsan received a B.A. from Harvard University, a Master's in public health from Harvard School of Public Health, a M.D. from Loyola University, and a Ph.D. in Economics from Harvard University. Dr. Alsan trained at Brigham and Women's Hospital Hiatt Global Health Equity Residency Fellowship – then combined the Ph.D. with an Infectious Disease Fellowship at Massachusetts General Hospital.

Ray Baxter†

Raymond Baxter, Ph.D., currently serves as the co-chair of the Population Health Roundtable of the National Academies of Science, Engineering and Medicine; a Trustee of the Blue Shield of California Foundation; and a member of the Board of Directors of the CDC Foundation. Dr. Baxter most recently was CEO of the Blue Shield of California Foundation. He currently serves on the advisory boards to the Deans of the UC Berkeley School of Public Health and the UCSF School of Nursing.

For 15 years, Dr. Baxter was Kaiser Permanente's national senior vice president for community benefit, research and health policy. There he built the largest community benefit program in the US, investing over $2 billion annually in community health. He led Kaiser Permanente's signature national health improvement partnerships, including the Weight of the Nation, the Convergence Partnership and the Partnership for a Healthier America. Dr. Baxter also established Kaiser Permanente's Center for Effectiveness and Safety Research and built out its national genomics research bank, served as President of KP International, and chaired Kaiser Permanente's field-leading environmental stewardship work. He was a founding sponsor of the KP School of Medicine.

Previously he headed the San Francisco Department of Public Health, the New York City Health and Hospitals Corporation, and The Lewin Group. Dr. Baxter holds a doctorate from Princeton University. In 2001 the University of California, Berkeley, School of Public Health honored him as a Public Health Hero for his service in the AIDS epidemic in San Francisco. In 2006 he received the CDC Foundation Hero Award for addressing the health consequences of Hurricane Katrina in the Gulf Coast. In 2016, the San Francisco Business Times recognized his philanthropic contributions with its first Legacy Award.

Jennifer Bereskin

Snohomish Tribe of Indians | Youngest Daughter of The SeaMonster Man | Qawalangin Tribe of Unalaska - Unangan

Jennifer Bereskin has lived experiences with childhood poverty, domestic violence, systemic racism, and chronic homelessness. She is the mother to a special needs child who gives her strength. Jennifer's advocacy journey includes Indigenous and sovereign inherent rights, environmental protections, eliminating multi-generational poverty, housing justice, and dismantling domestic violent extremism through anti-racial and anti-discriminatory policy reform in Washington state. She has served on the Steering Committee for Governor Jay Inslee's Poverty Reduction Work Group for 5 years and is a staunch advocate for systems change that result in economic, racial, environmental and social justice.

Jennifer is graduating winter 2023 from Northwest Indian College with a Bachelor of Arts degree in Native Studies Leadership. The next step in her educational career will be attending law school to obtain a Juris Doctorate in Tribal Law and Indian Policy. "It's essential that I lead with traditional and cultural values of my ancestors. I am taught to walk softly on Mother Earth and reminded that my actions in this lifetime will impact the seven generations forward and I am grateful for all my relations."

Anita Chandra*

Anita Chandra, Dr.P.H., is the vice president and director of RAND Social and Economic Well-Being and a senior policy researcher at the RAND Corporation. The division manages RAND's Center to Advance Racial Equity Policy as well as other Centers on climate, housing, drug policy, policing, and civil justice. She leads studies on civic well-being and community planning; disaster response and resilience; public health emergency preparedness; health and health equity; child health and development, and effects of military deployment on families.

Throughout her career, Dr. Chandra has engaged government and nongovernmental partners to consider cross-sector solutions for improving community well-being and to build more robust systems, implementation, and evaluation capacity. This work has taken many forms, including engaging with federal and local government agencies on building systems for emergency preparedness and resilience both in the United States and globally; partnering with private sector organizations to develop the science base around child systems; and collaborating with city governments and foundations to modernize data systems and measure environmental sustainability, well-being, and civic transformation. Chandra has also partnered with community organizations to conduct broad-scale health and environmental needs assessments, to examine the integration of health and human service systems, and to determine how to integrate equity and address the needs of historically marginalized populations in human service systems. These projects have occurred in partnership with businesses, foundations, and other community organizations.

Chandra earned a Dr.P.H. in population and family health sciences from the Johns Hopkins Bloomberg School of Public Health.

Dave Chokshi

Dave A. Chokshi, M.D., M.Sc., FACP was the 43rd Commissioner at the New York City Department of Health and Mental Hygiene, one of the leading health agencies in the world. He led the City's response to the COVID-19 pandemic, including its historic campaign to vaccinate over 6 million New Yorkers, saving tens of thousands of lives. Dr. Chokshi architected treatment strategies, navigated school and economic reopenings, and served as principal public spokesperson. Under his tenure, the Health Department's budget grew to its highest-ever level, reflecting investment in signature initiatives such as the Public Health Corps, Pandemic Response Institute, and New Family Home Visiting program. In 2021, the Department also stewarded the launch of the nation's first publicly-authorized overdose prevention centers—as well as a landmark Board of Health resolution on racism as a public health crisis.

From 2014-2020, Dr. Chokshi served in leadership roles at NYC Health + Hospitals (H+H), including as its inaugural Chief Population Health Officer, where he built an award-winning team dedicated to transforming the largest public health care system in the country. He was also Chief Executive Officer of the H+H Accountable Care Organization (ACO), one of the few ACOs in the nation to achieve high quality and cost performance for nine consecutive years. He has been a practicing primary care internist at Bellevue Hospital since 2014. He is also Clinical Professor of Population Health at NYU and a Senior Scholar at the CUNY School of Public Health and Health Policy.

Marthe Gold

Marthe R. Gold, M.D., M.P.H., is the Logan Professor Emerita in the Department of Community Health and Social Medicine at the City University of New York School of Medicine (CUNYSOM). A graduate of the Tufts University School of Medicine and the Columbia School of Public Health, Dr. Gold has been a primary care provider in urban and rural underserved settings. She served as Senior Policy Adviser in the Office of the Assistant Secretary for Health in the U.S. Department of Health and Human Services from 1990–1996 where her focus was on the economics and outcomes of clinical prevention and public health programs. She directed the work of the Panel on Cost-Effectiveness in Health and Medicine, an expert panel whose 1996 report remains an influential guide to cost-effectiveness methodology for academic and policy uses. As Department Chair at the CUNYSOM she oversaw initiatives to advance population health training for students who are underrepresented in medical careers. An ongoing focus of her work is the use of democratic deliberation for gaining public input in service to guiding challenging policy decisions at micro and macro policy levels.

She currently serves as an advisor to the Institute for Clinical and Economic Review, America's Health Rankings, and NIH's Fairness Dialogues Advisory Group. A member of the National Academy of Medicine, Dr. Gold served as chair of its Committee on Public Health Strategies to Improve Health (reports published 2010–2012). She was a founding member of the Roundtable on Population Health Improvement and is a member of its Health Expenditure Collaborative.

Atul Grover*

Atul Grover, M.D., Ph.D., FACP, FCCP is the inaugural Executive Director of the AAMC Research and Action Institute. The Institute brings together experts from the nation's academic medical centers and other leaders in policy to tackle complex health policy issues, bring nonpartisan analysis to policy, and develop straightforward solutions to improve health.

Dr. Grover is an internal medicine physician, health services researcher, and nationally recognized expert in health policy. Dr. Grover joined the AAMC as associate director for the Center for Workforce Studies in 2005, where he managed research activity and directed externally funded workforce studies. He became a director of government relations and health care affairs in 2007, and served as the association's chief public policy officer from 2011-2016. From 2016-2020 he served as executive vice president, providing strategic leadership in the areas of medical education, academic affairs, health care affairs, scientific affairs, learning and leadership programming, diversity and inclusion, public policy, and communications. Previously, Dr. Grover held positions in health care finance and applied economics consulting as well as in the U.S. Public Health Service, Health Resources and Service Administration National Center for Health Workforce Analysis.

Dr. Grover earned his Doctor of Medicine degree from George Washington University (GWU) School of Medicine and his Ph.D. in health and public policy from Johns Hopkins University Bloomberg School of Public Health. Dr. Grover holds faculty appointments at GWU School of Medicine, and JHU Bloomberg School of Public Health.

Hilary Heishman†*

Hilary Heishman, M.P.H., joined the Robert Wood Johnson Foundation (RWJF) in 2011 and spent her first two years supporting regional health care system transformation through initiatives like Aligning Forces for Quality. As a senior program officer, she has expertise in a variety of topics, with special attention to improving and connecting systems that enable people to be healthy. She embraces the aspect of her role that she describes as "finding connections among projects that RWJF supports."

Heishman's background in local public health, community health planning, and health care system improvement enable her to take a broad, multifaceted approach to program development. She has developed programs related to building communities' capacities to improve health, helping health care organizations address patients' social circumstances and play a strong role in improving community health, improving the use of health data and information systems, identifying health care payment methods that support community health, and helping people learning from one another in networks. For example, she is a senior program officer for grants that support Health Leads, Data Across Sectors for Health, Payment Reform for Population Health, and 100 Million Healthier Lives.

Previously, Heishman was a prevention specialist with the Centers for Disease Control and Prevention (CDC). While on

field assignment, she coordinated the development of a Community Health Improvement Plan in Manchester, N.H. At CDC headquarters in Atlanta, Ga., she supported the Influenza Epidemiology and Prevention Branch during the spread of the 2009 H1N1 influenza. She also worked with CDC's Healthy Community Design Program to promote and evaluate Health Impact Assessments (HIA) and with CDC's WHO Collaborating Center for Reproductive Health to improve birth outcomes in hospitals in Kabul, Afghanistan.

Heishman received a bachelor's degree in Biology from the University of Virginia and a Master of Public Health in Community Oriented Public Health Practice from the University of Washington, Seattle.

Dora Hughes†*

Dora Hughes, M.D., M.P.H., is Associate Research Professor of Health Policy & Management at the Milken Institute School of Public Health at The George Washington University, where her work focuses on the intersection of clinical and community health, social determinants of health, health equity, healthcare quality and workforce. Previously, Dr. Hughes was a Senior Policy Advisor at Sidley Austin, where she advised on regulatory and legislative matters in the life science industry. Prior to that, she served for nearly four years in the Obama Administration as Counselor for Science & Public Health to Secretary Kathleen Sebelius at HHS. Her areas of responsibility included implementation of public health and FDA-related provisions of the ACA, as well as signature legislation for tobacco, Alzheimer's and FDA reform. She served in leadership roles for several White House initiatives, including the Childhood Obesity Task Force, President's Food Safety Working Group, Committee on STEM Education and Let's Move. Dr. Hughes began her career in health policy as Senior Program Officer at the Commonwealth Fund, and subsequently as Deputy Director for the HELP Committee under Senator Edward M. Kennedy. She then served as the Health Policy Advisor to former Senator Barack Obama.

Dr. Hughes received a B.S. from Washington University, M.D. from Vanderbilt and M.P.H. from Harvard. She completed internal medicine residency at Brigham & Women's Hospital.

Robert (Bob) Kaplan†

Robert M. Kaplan, Ph.D., is currently a faculty member at the Stanford School of Medicine Clinical Excellence Research Center (CERC). He previously served as Chief Science Officer at the US Agency for Health Care Research and Quality (AHRQ) and as Associate Director of the National Institutes of Health, where he led the behavioral and social sciences programs. He is also a Distinguished Research Professor of Health Policy and Management at UCLA, where he previously led the UCLA/RAND AHRQ health services training program and the UCLA/RAND CDC Prevention Research Center.

He was Chair of the Department of Health Services from 2004 to 2009. From 1997 to 2004 he was Professor and Chair of the Department of Family and Preventive Medicine, at the University of California, San Diego. He is a past President of five different national or international professional organizations and has served as Editor-In-Chief for Health Psychology and for the Annals of Behavioral Medicine. His 20 books and over 580 articles or chapters have been cited more than 70,000 times (H-index>116) and Google scholar includes him in the list of the most cited authors in science. In 2019 Kaplan took on a new role as an opinion editorialist, contributing op ed pieces on about a monthly basis. His work has appeared in The Wall Street Journal, USA Today, the Los Angeles Times, the Boston Globe, The San Jose Mercury News, The San Francisco Chronicle, STAT News (Boston Globe Media), RealClear Politics, MedPage, Health Affairs, The Hill, and a variety of other newspapers. Dr. Kaplan was elected to the National Academy of Medicine in 2005.

Tiffany Manuel*

Tiffany Manuel, Ph.D. is President and CEO of TheCaseMade, an organization dedicated to helping leaders powerfully and intentionally make the case for systems change. She also serves as the Executive Director of the Redress Movement – a movement to build public will around redressing the effects of racial segregation in our nation today. In these capacities, Dr. Manuel works with hundreds of passionate social changemakers, innovators and adaptive leaders around the United States who are building better, stronger communities that are diverse, equitable and inclusive. By aligning their community stakeholders around the kind of deep systems changes that can improve population outcomes, these leaders are able to grow their impact, scale their programs, and harness the investments they need to improve their communities.

Dr. Manuel has degrees from University of Chicago, Purdue University, and the University of Massachusetts Boston.

She's written extensively on public will building on equity issues. She sits on the board of several national organizations (KaBoom!, Rebuilding Together and Shelterforce) and has served on the External Advisory Committee for the Culture of Health Evaluation with the Robert Wood Johnson Foundation and on the Advisory Committee for the City Health Dashboard.

Dorianne Mason

Ms. Mason has worked for over a decade on issues related to women's health across the lifespan, and currently leads the National Women's Law Center legal, research, policy, and public education efforts on health equity. Throughout her career, she's partnered with state and federal lawmakers, regulators, and officials; community members; health care providers; consumer advocates; researchers; and other health experts to effect change.

Ms. Mason is an expert in coverage and access to health care, having worked in depth on implementation of the Affordable Care Act (ACA) in New Mexico, and issues related to culturally responsive outreach and care for Black, Latinx, Native and Asian-American communities across the country. Ms. Mason has experience examining and evaluating services important to women with multiple marginalized identities and identifying violations and other barriers to coverage. She has worked with state and federal advocates and regulators and also provided direct representation to address problems and ensure equitable access to care. Ms. Mason has spoken to thousands of people at conferences and meetings about the intersection of equity, health and justice.

As part of her work at the National Women's Law Center, Ms. Mason identifies and prioritizes the needs and voices of underserved populations, in particular women who are low-income, women of color, and those facing multiple, intersecting forms of discrimination.

Ms. Mason currently serves on the Women's Committee for the Institute for Medicaid Innovation and is a Sargent Shriver National Center of Poverty Law Racial Justice Fellow.

Aparna Mathur

Aparna Mathur is a Senior Research Manager in Economics at Amazon. In this role, she tracks and conducts research to help identify labor and employment related challenges faced by Amazon's domestic and global workforce, with a view to informing best policy. She is also a Senior Fellow at Harvard Kennedy School's Mossavar-Rahmani Center where she is researching safety net issues, and a Visiting Fellow at FREOPP.

Prior to Amazon, she spent a year as a Senior Economist at the Council of Economic Advisers. She joined the Council as part of the COVID-19 response task force at the peak of the crisis in April 2020 and worked with epidemiologists on the health aspects of the crisis, while also tracking the economic downturn that came with the lockdowns. Prior to joining CEA, she was a resident scholar in economic policy studies at the American Enterprise Institute. At AEI, she directed the AEI-Brookings Project on Paid Family and Medical Leave, building bipartisan momentum on paid leave, for which she was recognized in the Politico 50 list for 2017. Her academic research has focused on income inequality and mobility, tax policy, labor markets and small businesses. She has published in several top scholarly journals including the Journal of Public Economics, the National Tax Journal and the Journal of Health Economics, testified several times before Congress and published numerous articles in the popular press on issues of policy relevance, including on her own blog at Forbes. Her work has been cited in leading news magazines such as the Economist, the New York Times, the Wall Street Journal and the Washington Post. She has regularly provided commentary on prominent radio and television shows such as NPR's Marketplace and the Diane Rehm Show, as well as CNBC and C-SPAN.

She has been an adjunct professor at Georgetown University's McCourt School of Public Policy. She received her Ph.D. in economics from the University of Maryland, College Park in 2005, and is currently serving on the University of Maryland Economics Leadership Council. She is also on the Board of the National Academy of Social Insurance, Simply Green and the National Economists Club.

Mac McCullough*

Mac McCullough, Ph.D., M.P.H., is associate professor and director of public health agency partnerships at Boise State University School of Public and Population Health. McCullough came to Boise State in 2022 from Arizona, where he served in a dual role as associate professor at Arizona State University (ASU) and health economist at the Maricopa County Department of Public Health. Dr. McCullough's research centers on public health practice and finance. He

created a national data source to measure public health and social service spending and uses these data to explore how spending can influence health factors and outcomes.

Dr. McCullough was a '40 Under 40 in Public Health' honoree by the deBeaumont Foundation and an elected member of the Arizona Public Health Association Board of Directors. At ASU he won educator of the year (2019, 2022) and translational science (2021) awards. He was deputy director of the RWJF-funded National Safety Net Advancement Center (2015-20) and chair of AcademyHealth Public Health Systems Research group (2017-19).

McCullough received his Ph.D. in health policy and management from UCLA, M.P.H. from the University of Minnesota, and B.S. from Georgetown University. Prior to academia he worked at the National Academy of Sciences and the U.S. Department of State.

Bobby Milstein†*

Bobby Milstein, Ph.D., M.P.H., is a director of ReThink Health for the Fannie E. Rippel Foundation and a visiting scientist at the MIT Sloan School of Management. With an educational background that combines cultural anthropology, behavioral science, and systems science, Dr. Milstein concentrates on challenges that involve large-scale institutional change and the need to align multiple lines of action. He led the development of the ReThink Health Dynamics model and a suite of regionally-configured simulations that are used by leaders across the country to explore the likely health and economic consequences of policy scenarios.

From 1991 to 2011, Dr. Milstein worked at the Centers for Disease Control and Prevention, where he founded the Syndemics Prevention Network, chaired the agency's Behavioral and Social Science Working Group, and was coordinator for a wide range of new initiatives. He was the principal architect of the CDC's framework for program evaluation and published a monograph entitled Hygeia's Constellation: Navigating Health Futures in a Dynamic and Democratic World, recommended as "required reading for all health professionals."

Dr. Milstein has led several award-winning teams that bring greater structure, evidence, and creativity to the challenge of health system change. He is a cofounder (with Patty Mabry) of the NIH Institute on Systems Science and Health, and a codeveloper of several other widely used health policy simulation models including HealthBound and the Prevention Impacts Simulation Model. He has received CDC's Honor Award for Excellence in Innovation, the Applied Systems Thinking Prize from ASysT Institute, as well as Article of the Year awards from AcademyHealth and the Society for Public Health Education.

Dr. Milstein holds a B.A. in cultural anthropology from the University of Michigan, an M.P.H. from Emory University, and a Ph.D. in interdisciplinary arts and sciences with a specialization in public health science from Union Institutes and University.

Tyler Norris*

Tyler Norris, MDiv., is a social entrepreneur and trusted advisor to philanthropies and partnerships working to improve the well-being of people and place. For over four decades, he has shaped health and development initiatives in hundreds of communities in the U.S. and around the world and built over a dozen business and social ventures.

Tyler serves as Board Chair of Naropa University; co-Chair of the CEO Alliance for Mental Health; and as a board member for Mindful Philanthropy, the National Academies of Sciences' Child Well Being Forum, Build Healthy Places Network, and the Global Flourishing Study. He was recently named as Visiting Fellow of the Federal Reserve Bank of New York. Until recently, Tyler served as founding CEO of Well Being Trust for its first 5½ years was an impact philanthropy with a mission to advance mental, social and spiritual health of the United States. Previously, Tyler led Total Health at Kaiser Permanente.

Tyler is a graduate of Harvard Business School's Executive Leadership Program, earned a Master of Divinity (MDiv.) from Naropa University, and has a bachelor's degree in World Political Economy from Colorado College. He lives and serves in the communities of the Wood River Valley of Idaho and Oakland, California.

Kara Odom Walker†*

Kara Odom Walker, M.D., M.P.H., M.S.H.S., is Senior Vice President and Chief Population Health Officer (CPHO) for Nemours Children's Health System. She leads Nemours National Office of Policy and Prevention, as well as all aspects of Population Health Strategy, Research, Innovation and Implementation. Dr. Walker and her team are responsible for the

development and implementation of national and state-specific advocacy strategies to help achieve outcomes tied to health and value while also leading Nemours's policy agenda. She is based in Washington, D.C., and reports to Nemours President and Chief Executive Officer, R. Lawrence Moss, MD.

A highly accomplished executive, physician and scientist, Dr. Walker is a visionary leader who has focused her career on transforming health care delivery to ensure that the system is designed to create a healthier population. She has led efforts to focus on addressing critical social determinants that impact health while eliminating unnecessary medical tests and procedures. Her philosophy and vast experience are a tremendous asset to Nemours' goal of redefining health in children and transforming payment for medical care to ensure the healthiest generation of children.

Dr. Walker has been recognized for her leadership by Harvard Business School's Program for Leadership Development, the American Medical Association and the National Medical Association. A respected leader, innovator and clinician, she was elected to the National Academy of Medicine (NAM) in 2018. Election to the NAM is considered one of the highest honors in the fields of health and medicine, recognizing individuals who have demonstrated outstanding professional achievement.

Dr. Walker completed her family and community medicine residency at the University of California San Francisco, graduated with a Master's of Public Health from Johns Hopkins School of Public Health and Master's of Health Services Research from the University of California, Los Angeles, School of Public Health, where she also completed her fellowship in the Robert Wood Johnson Clinical Scholars program.

Lori Pfingst

Lori Pfingst, Ph.D., is a national expert on child and family well-being, currently leading Washington state's nationally recognized economic justice and inclusion efforts as a Senior Director in the Washington State Department of Social and Health Services (DSHS).

A research scientist and lifelong advocate for social and economic justice, Dr. Pfingst's body of work has spanned a broad range of issues, including poverty, income inequality, labor markets, early learning, human services, criminology, and epidemiology. She is a published author and storyteller, using the power of data paired with community voice to foster long-term, systems-level change for children, families, and communities.

Dr. Pfingst is a recipient of the Aspen Institute's prestigious Ascend Fellowship, an American Public Human Services Association Racial Equity Champion, and a recent nominee for the Governor's Distinguished Manager Award. Prior to joining DSHS, Dr. Pfingst served in leadership roles at the Washington State Budget & Policy Center, Public Health-Seattle & King County, and the Evans School of Public Affairs at the University of Washington.

Sue Pechilio Polis

Sue Pechilio Polis directs the health and well-being portfolio for National League of Cities as part of the Institute for Youth, Education and Families. The portfolio includes the conceptualization, development and implementation of Cities of Opportunity, a multi-year effort to engage mayors and city leaders in comprehensively addressing social determinants of health (SDOH) through policy and systems change. With expertise in health policy, Sue's work spans the connection to housing, economic opportunity, mental health and substance use disorders, obesity, trauma, and local systems alignment, and data for well-being. Prior to the National League of Cities, Mrs. Polis led the development and management of the Trust for America's Health (TFAH) external relations and strategic partnership efforts in support of the organization's public policy goals. Her focus included multi-sector alignment in community health improvement, as well as workplace wellness and substance use disorders.

Prior to joining TFAH, Mrs. Polis worked at AARP on health and financial security-related issues with an emphasis on advancing policy to address the needs of vulnerable 50+ populations. Her focus areas included health care workforce, retirement savings, consumer protection, and low-income programs such as the Supplemental Nutrition Assistance Program (SNAP) and the Low-Income Heating and Energy Assistance Program (LIHEAP). Mrs. Polis was the first National Director of Advocacy for the American Heart Association. Mrs. Polis background also includes consulting on health, environmental and tobacco-related issues campaigns.

S. Fisher Qua

S. Fisher Qua is a practitioner at Back Loop Consulting. He is based in northern New Mexico. His primary areas of focus

and involvement professionally have been in education (postsecondary, though with an increasing familiarity in K-12), community health & vitality, and supporting scientific research organizations. He is very committed to developing participatory approaches to working with complex problems that tap into more of each person's intelligence, imagination, and creativity.

Somava Saha

Somava Saha, M.D., M.S., currently serves as Founder and Executive Lead of Well-being and Equity in the World (WE in the World), as well as Executive Lead of the Well Being In the Nation (WIN) Network, which work together to advance inter-generational well-being and equity. Over the last five years, as Vice President at the Institute for Healthcare Improvement, Dr. Saha founded and led the 100 Million Healthier Lives (100MLives) initiative, which brought together 1850+ partners in 30+ countries reaching more than 500 million people to improve health, wellbeing and equity. She and her team at WE in the World continue to advance and scale the frameworks, tools, and outcomes from this initiative as a core implementation partner in 100MLives.

Previously, Dr. Saha served as Vice President of Patient Centered Medical Home Development at Cambridge Health Alliance, where she co-led a transformation that improved health outcomes for a safety net population above the national 90th percentile, improved joy and meaning of work for the workforce, and reduced medical expense by 10%. She served as the founding Medical Director of the CHA Revere Family Health Center and the Whidden Hospitalist Service, leading to substantial improvements in access, experience, quality and cost for safety net patients.

In 2012, Dr. Saha was recognized as one of ten inaugural Robert Wood Johnson Foundation Young Leaders for her contributions to improving the health of the nation. She has consulted with leaders from across the world, including Guyana, Sweden, the United Kingdom, Singapore, Australia, Tunisia, Denmark and Brazil. She has appeared on a panel with the Dalai Lama, keynoted conferences around the world, and had her work featured on Sanjay Gupta, the Katie Couric Show, PBS and CNN. In 2016 she was elected as a Leading Causes of Life Global Fellow.

Martha Sanchez

Martha Sanchez serves as the Health Policy and Advocacy Director at Young Invincibles. Martha is a proud first generation immigrant from El Salvador, raised in Washington D.C. and Maryland. Prior to joining YI, she served as a health legislative assistant for U.S. Senator Chris Van Hollen (D-MD) where she helped introduce federal legislation to streamline the health care enrollment process, and focused on legislation to support youth with chronic conditions such as Sickle Cell Disease. Previously, Martha worked for five years in the U.S. House of Representatives, first serving as a caseworker in the district office of Congressman Jamie Raskin (D-MD), and then as a legislative assistant handling his Rules Committee, health, education, labor, and transportation portfolios.

Martha's early advocacy career started in the immigrant rights space, where she advocated in support of higher education and economic opportunities, as well as a pathway to citizenship, for undocumented immigrants. In her junior year of college, Martha was fortunate to participate in YI's first class of YI Scholars. It was through this fellowship that she focused on the intersection of immigration and health care access, and delved into the disparities and inequities present in the U.S. health care system.

Martha is a graduate of American University, where she majored in Interdisciplinary Studies: Communications, Legal Institutions, Economics, and Government. She enjoys Latin dancing, art, and exploring new restaurants.

Steven Teutsch

Steven Teutsch, M.D., M.P.H., is an adjunct professor at the UCLA Fielding School of Public Health; Senior Fellow at the Public Health Institute; and Senior Fellow at the Leonard D. Schaeffer Center for Health Policy and Economics at the University of Southern California.

Until 2014 he was the Chief Science Officer, Los Angeles County Public Health where he continued his work on evidence-based public health and policy. Dr. Teutsch had been in Outcomes Research and Management program at Merck since October 1997 where he was responsible for scientific leadership in developing evidence-based clinical management programs, conducting outcomes research studies, and improving outcomes measurement to enhance quality of care. Prior to joining Merck Teutsch was Director of the Division of Prevention Research and Analytic Methods (DPRAM) at CDC where he was responsible for assessing the effectiveness, safety, and the cost-effectiveness of disease and injury

prevention strategies. DPRAM developed comparable methodology for studies of the effectiveness and economic impact of prevention programs, provided training in these methods, developed CDC's capacity for conducting necessary studies, and provided technical assistance for conducting economic and decision analysis. The Division also evaluated the impact of interventions in urban areas, developed the Guide to Community Preventive Services, and provided support for CDC's analytic methods.

Dr. Teutsch received his undergraduate degree in biochemical sciences at Harvard University, an M.P.H. in epidemiology from the University of North Carolina School of Public Health, and his M.D. from Duke University School of Medicine. He completed his residency training in internal medicine at Pennsylvania State University, Hershey. He was certified by the American Board of Internal Medicine in 1977, the American Board of Preventive Medicine in 1995, and is a Fellow of the American College of Physicians and American College of Preventive Medicine.

Lindsay Morgan Tracy

Lindsay Morgan Tracy is the Innovator-in-Chief for the Department of Social & Health Services in Washington State working on the Blueprint for an Equitable Future: The 10-Year Plan to Dismantle Poverty in Washington State (www.dismantlepovertyinwa.com).

She is a staunch advocate of shifting organizational structures from transactional to transformational with an emphasis on continuous learning and stories. Tracy has expertise in systemic tracking, building capacity and building a culture of program improvement for better qualitative and quantitative outcome measures.

Tracy entered the workforce as a civics high school teacher. Following her teaching career, she moved into collegiate administration. During her tenure at the university, she became a commissioner within the Colorado Governor's Commission on Community Service (now Serve Colorado), a commissioner on the Denver Mayor's Office of Strategic Partnerships and became a founding board member for the Foundation for the Prevention of School Violence.

James Whitfield, Kristen Whitfield

James Whitfield and Kristen Whitfield are Co-Founders of Be Culture. The two work collaboratively on planning and design of workshops, trainings, and keynotes. They co-facilitate round-table discussions, executive coaching, and strategy sessions.

James employs a decidedly multi-disciplinary approach resulting from broad-based experience as an executive in business, non-profit, and government, including having been appointed by the White House to oversee the U.S. Department of Health and Human Services. In his dual role as the Regional Director for the Pacific Northwest and a Deputy in the Office of the Secretary, he split his time between Seattle and D.C and managing staff across the nation. As the lead for community engagement for the Washington Health Foundation, James conducted community town hall meetings in each of the state's 39 counties to develop a Values Map of the state in preparation for developing a roadmap to health that provided coordination for businesses, non-profits, the health care sector, and community leaders to improve the health of the people of the state of Washington.

James has also held positions on numerous local, statewide, and national boards of directors – including the founding board for Leadership Eastside where he subsequently served as CEO for approximately ten years and helped develop a Master's Degree in Executive and Civic Leadership. He has received numerous accolades for his public speaking, training, and civic engagement work.

Kristen is a former small business owner and sales lead. She has experience in business development and customer service in both wholesale and retail environments. In addition to providing project oversight, logistics, and operations management for Be Culture, Kristen specializes in designing retreats and interactive participant experiences.

Kristen and James met as students at the University of Iowa. Since then, James has studied health care policy at Harvard; has delivered a TEDx talk called, "Defining Equity. Pursuing Unity." and is co-founder of Nourishing Networks, a local all-volunteer anti-hunger movement. Together, Kristen and James have served as marriage counselors and are the proud parents of two adult children who are making their own amazing impacts in the world.

They are currently co-authoring a book about the Be Culture framework and process.

Steven Woolf

Steven Woolf, M.D., M.P.H., is a senior fellow at American Progress and professor of family medicine and population

health at Virginia Commonwealth University School of Medicine, where he was the founding director of the Center on Society and Health and now holds the C. Kenneth and Dianne Wright Distinguished Chair in Population Health and Health Equity. Dr. Woolf has edited three books and published more than 200 articles in a career that has focused on raising public awareness about the social, economic, and environmental conditions that shape health and produce inequities. He works to address these issues through outreach to policymakers and the public, including testimony before Congress, consulting, media outreach, and speaking engagements.

Dr. Woolf received his M.D. from Emory University and underwent residency training in family medicine at Virginia Commonwealth University. He is also a clinical epidemiologist and underwent training in preventive medicine and public health at Johns Hopkins University, where he received his M.P.H. He is board certified in family medicine and in preventive medicine and public health. Dr. Woolf began his career as a health services researcher, with a focus on evidence-based guidelines. He served on the U.S. Preventive Services Task Force and was elected to the Institute of Medicine in 2001.

The Paradox of U.S. Health Care and the Price We Pay to Live Shorter, Less Healthy Lives

Ayshia Coletrane[1]

[1] Staff-prepared background synthesis for March 2023 symposium, Shifting the Nation's Health Investments to Support Long, Healthy Lives for All (https://www.nationalacademies.org/event/03-06-2023/shifting-the-nations-health-investments-to-support-long-healthy-lives-for-all-a-symposium)

A Decade in Review: Health Care in the United States

In 2012, the National Academies' Institute of Medicine (IOM) released the report, *For the Public's Health: Investing in a Healthier Future,* which declared the U.S. health care financing system to be terribly misaligned. According to the report, the nation's poor health and "costly medical care consumption reflect a failure of the nation's health system as a whole—medical care, governmental public health, and other actors—to support strategies that advance population health." (IOM, 2012: 20). The report showed that such failure is indicative of inefficiencies, inflexibilities, and insufficiencies in both funding and infrastructure. "The United States gets the health outcomes that it chooses to pay for," the report noted; therefore, the problem with the U.S. health system (broadly defined by the report as the medical care system and public health agencies) lies in its failure to invest wisely and consistently, and reliably in the drivers of population health (IOM, 2012: 48). In this, the report called for less pouring of resources into individualized treatment of disease and greater emphasis on population-based prevention, public health infrastructure, research and development, and policy approaches.

The 2013 IOM report, *U.S. Health in International Perspective: Shorter Lives, Poorer Health*, expanded on the troubling state of population health in the United States. It centered on the "U.S. health disadvantage" displayed by the American population through shorter lives; higher prevalence, severity, and mortality rates of disease; and poorer well-being when compared to other high-income nations (IOM & NRC, 2013: 21). In a cross-national assessment of health and well-being among high-income countries, research revealed that the United States consistently fared worse than its peers across multiple measures of health such as life expectancy, chronic disease burden, risky behavior, and mental health. Poor health outcomes were also observed along the life course, from childhood to adolescence and well into adulthood (IOM & NRC, 2013:87-88). In presenting the nation's shortcomings on a global scale, the report not only identified the "U.S. health disadvantage" but also noted that it was growing; if left unaddressed, the U.S. would continue to fall far behind its peers.

A decade later in 2023, the U.S. has little to show for progress on the key metrics of spending and health despite the National Academies reports' recommendations to bolster population health. The nation therefore remains where it stood ten years ago as its poor health outcomes, the underfunding of public health, and the ever-increasing cost of U.S. health care come into consideration yet again. In assessing the current landscape of population health in the United States, it is evident that the high price this country pays for health does not to improve its outcomes in lost lives and poor health.

It Was The Best of Times, It Was The Worst of Times

Today, the United States continues to rank far below other high-income countries across measures in health outcomes as well as in health care affordability, administrative efficiency, access, and equity (Schneider et al., 2021). At the same time, it pours more money into its health care system than any other nation in the world (Gunja et al., 2023). Most recent data from 2021

reveals that the U.S. spent $4.3 trillion on health care, accounting for 18.3% of its gross domestic product (GDP) (CMS, 2023). Thus, with all its money, the U.S. has largely failed to preserve and improve the health of its people as it presents the poorest health outcomes when compared to international high-income peers (Gunja et al., 2023).

Health Outcomes and Quality of Life

The United States presents the some of the highest mortality rates, worst health outcomes, and poorest health system performance among all OECD countries.[2] Considering mortality, the U.S. has the lowest life expectancy at birth, falling three years below the OECD average (Gunja et al., 2023). Moreover, life expectancy in the U.S. worsens as the country has yet to rebound from the effects of the COVID-19 pandemic unlike most of its peers (Gunja et al., 2023). Additionally, the country ranks highest in annual preventable deaths, and preventable mortality continues to increase at a rate unlike any other OECD country (Gunja et al., 2023). Infant mortality and maternal mortality also remain the highest among OECD nations (Gunja et al., 2023). Furthermore, when infant and maternal mortality are stratified by state, states with the highest rates trail behind middle-income countries like Thailand, Ukraine, or Sri Lanka (CDC, 2022b; The World Bank, 2020).

In addition to high mortality rates, the United States presents the highest obesity prevalence, chronic disease burden, depression rates, and number of deaths by suicide among OECD nations (Gunja et al., 2023). Amidst these health challenges, the U.S. remains the only high-income country that does not guarantee health coverage, with 8.6 percent of its population uninsured (Gunja et al., 2023). Somehow the nation manages to spend nearly twice as much as the average OECD country on health care, and overall, rank last in health care system performance (Gunja et al., 2023; Schneider et al., 2021). Ultimately, these statistics, combined with rising income inequality and decreasing social progress over the past decade, uncover a declining quality of life in the United States (Haynie, 2020; Semega & Kollar, 2022).

A Country of Paradox

Perhaps it is a symptom of American exceptionalism to believe that this system, veiled by wealth, modern technology, and leading experts, is better than others. Indeed, the United States excels in many ways: it is the wealthiest nation by GDP, with five of the world's top ten hospitals, some of the best health care technologies and innovations, and the majority of Nobel prize winners in physiology and medicine. However, with poorly managed health care; widening social, economic, and racial disparities; underfunded communities; a self-interested culture; and ultimately, a less healthy and happy people – the paradox of the U.S. health care system comes into view.

[2] The Organization for Economic Co-operation and Development (OECD) is an international organization with 38 member countries that promote economic growth, development, and sustainability. The majority of OECD membership includes high-income nations. https://www.oecd.org/about/

The Curious Case of the U.S. Health Care System

Despite all its health care spending, America's return on investment is a negative one. If this was any other business, one would expect this capitalist-centric society to immediately redirect its investments or redesign its business plan. Nevertheless, the U.S. has yet to restructure its traditional health care system, thus remaining trapped in a paradox where it spends more money on health care but produces worse health outcomes.

Medical Care Spending

To be fair, the traditional U.S. health care system comes with layers of great complexity, which makes its case an altogether curious one. Due to the nation's history and culture, health care in the United States is not organized under a single, unified system (Malâtre-Lansac, 2019). Rather, it is fragmented across local, state, federal, and private sector levels, which involve multiple stakeholders who possess competing interests. Moreover, when factors such as geography, politics, or power dynamics are considered, communication, consistency, and shared understanding become increasingly difficult and less attainable. In addition, unchecked drug and medical device prices, administrative and advertising costs, and medical billing propel health care spending to an even greater degree (Malâtre-Lansac, 2019). Overall, between the lack of cohesion and financial restraint, sits a lack of accountability. The system's players are too focused on the "bottom line" to streamline coordination or establish greater control (Berwick, 2023; Malâtre-Lansac, 2019). This fixation on profitability, in turn, leads to a "willingness to tolerate large gaps in income, total wealth, educational quality, and housing" in the U.S., which produce "unintended health consequences;" in this, the United States' spirit for entrepreneurism eclipses its desire for egalitarianism (Schroeder, 2007).

Social Spending

The U.S. health care system not only displays a lack of accountability within itself, but to those it claims to serve. While the United States exceeds the OECD average on social spending and remains comparable to many of its peers, it invests less overall in its populations and communities (OECD, 2023; Papanicolas et al., 2019). When social spending is broken down, money is found to be primarily allocated to elderly populations in the form of pensions, home health, and residential services (Tikkanen & Schneider, 2020). The country's spending on social services like early childhood education or parental leave is about one-third that of other countries (Cabrera et al., 2022; Tikkanen & Schneider, 2020). Furthermore, the U.S. spends approximately one-quarter the amount on unemployment benefits compared to these same countries (Tikkanen & Schneider, 2020). When spending on social services is considered in this way, it becomes clear that the nation falls short in investing in its children, youth, and working age adults, thus failing to impact an entire generation of people during the majority of their lives.

Ultimately, the United States' failure to invest in its people is rooted in the very culture of the nation. Like entrepreneurism, values such as independence, hard work, and self-

determination are the driving force behind so much of what America does. Some proof of this is found in the fruitless debate for universal health coverage or the fight against Medicaid expansion, where challengers to these ideas suggest that health care is something to be earned (Malâtre-Lansac, 2019). In this nation, it seems that leaders can only agree to invest in the health care system at the point where people directly encounter it.

Health Disparities

When America invests in health care it fails to do so for everyone, everywhere, at every time. Health disparities exist overwhelmingly within communities of color through every stage of life – from birth to death, leading the U.S. to rank last in health equity among all OECD peer nations (Schneider et al., 2021). Starting at birth, U.S. infant mortality rates are not only the highest among OECD nations but are even greater when stratified by race and ethnicity. People of color – specifically Hispanic, Native American, Pacific Islander, and Black citizens – experience higher infant mortality rates than White citizens (CDC, 2022a). Moreover, these rates, specifically those for Black Americans, persist even when controlling for socioeconomic status (Geronimus et al., 2006). This curious case of its own suggests that additional elements are at play like systemic racial discrimination and exclusion – or "weathering" – which deteriorates the health of mothers and their children over generations, leading to higher maternal mortality, higher infant mortality, and shorter life expectancy at birth (Geronimus, 1992; Geronimus et al., 2006; Hill et al., 2022a; Hill et al., 2022b).

In addition, multiple chronic diseases disproportionately affect people of color, including diabetes, obesity, stroke, heart disease, and cancer – all of which are leading contributors to death in the U.S. (Thorpe et al., 2017). A complex interplay of social, environmental, economic, and cultural determinants of health create structural inequities, which then give way to health inequities (NASEM, 2017: 100). Structural inequities in education, income, employment status, insurance coverage, housing, neighborhood environment, among other aspects of society present major barriers to health care access for minorities.

When people of color do encounter the health care system, they are traditionally neglected and ignored. Research repeatedly shows that institutional bias and discrimination are fundamental drivers behind racial differences in diagnosis, prognosis, and treatment (Tong & Artiga, 2021). People of color experience more negative patient-provider interactions, along with disparities in pain management and empathy. Additionally, minorities, especially Black and Hispanic patients, are more likely to report experiences of providers refusing to believe them, to provide treatment, or to issue pain medication (Ndugga & Artiga, 2021; Tong & Artiga, 2021). This systemic racism therefore perpetuates a cycle of marginalization in which certain populations live less healthy lives, birth less healthy children, and suffer disproportionately from premature death.

Lessons from COVID-19

When the COVID-19 pandemic hit the United States in March 2020, the United States was neither coordinated, nor prepared, nor efficient in its response. The American response – or lack thereof – led to hospitalizations and deaths, burnout and mental health crises, and protests and riots. Fundamentally, each of these consequences revealed the same brokenness within the U.S. public health system identified by the IOM report, *For the Public's Health*, a decade ago.

The nation had to learn that short-term funding does not address long-standing systemic weakness (Trust for America's Health, 2022). Funding for public health and emergency preparedness drastically decreased over the past few decades, where essential national programs provided by the Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services faced a one-fifth and two-thirds reduction in funding since FY 2002, respectively (Trust for America's Health, 2022). Two decades later, chronic underfunding in this area showed. In its immediate allocation of resources to these programs during the pandemic, the U.S. paid a great price for temporary solutions that could not fully address major deficits in its public health and health care system such as providing basic public health services, replacing old data systems, and strengthening the health care workforce (Trust for America's Health, 2022).

Although U.S. health care spending increased by 9.7 percent in 2020, reaching $4.1 trillion, only 5.4 percent of money targeted public health and prevention, and states were largely left to depend on their own financing and resources (Alfonso et al., 2021; Trust for America's Health, 2022). Thus, rather than mitigating its problems, the U.S. highlighted them. Health disparities grew as low-income and communities of color disproportionately suffered from higher COVID-19 incidence, hospitalization, and mortality rates. In addition, the country's fragmented public health infrastructure struggled to meet demands for greater technology modernization and interoperability, better surveillance and reporting, improved national health security, and more coordinated management. Moreover, hospitalizations, death, and tragedy overwhelmed the health care workforce, resulting in a second pandemic of burnout and an exodus of approximately 20 percent of health care workers in just two years (Levine, 2021). Furthermore, excess mortality in the U.S. ranked the highest of other high-income countries, increasing by 22.9 percent between March 2021 and January 2021 (Woolf et al., 2021). These deaths were only in part explained by COVID-19, exacerbated by poor socioeconomic conditions, systemic racism, weak health care policy, unhealthy physical and social environments, and deficiencies in U.S. health care (Woolf, 2022). Today, three years later, these areas continue to be some of the greatest challenges for U.S. health care and public health systems.

The Price We Pay

Essentially, the problems stemming from the U.S. health care system are rooted in the fact that the nation does not invest in its people and communities, it simply funds them. And when it does, there are conditions and limitations. Investment—particularly a well-balanced

portfolio of investment—requires preparation, education, time, commitment, accountability, partnership, and a sense of care (IOM, 2012: 14). Investment runs deep like the problems the U.S. health care system faces. As it currently stands, the U.S. health care system is failing the American people and desperately needs to be reimagined. The nation must shift its priorities in health care away from the focus on treatment of individuals, maximization of profits, and fulfillment of personal priorities, and toward the investment in populations, promotion of health, and empowerment of communities. Research has shown that, to do so, the U.S. must disrupt its current institutions, habits, and beliefs to promote progress. Indeed, this may be an expensive and challenging undertaking, but it is an investment that, ultimately, will build stability, sustainability, and wealth in health, life, and dollars for the nation.

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Background Material for March 6-7 Symposium

An Attempt to "Map" Key Contours of the Issues that Informed Planning

THE PREDICAMENT (as highlighted by the 2012 and 2013 IOM reports):

- Shorter lives, poorer health, inequities
- Uncontrolled health care cost growth
- Imbalanced investments
- Uninformed & disengaged public

Who's bearing the costs and consequences?

(1) Costs to/spending by: Public sector/Government at all levels spending on health care

Harms to the public sector: Impact on other social spending (opportunity costs)– especially felt at state & local levels; wasteful, inefficient[i]

(2) Costs to/spending by: Businesses/Employers (Private payers)

Harms to business/private sector: Impact on profits (and indirectly, on pay?); lower competitiveness; wasteful and inefficient

(3) Costs to/spending by: Individuals and families

Harms to individuals/families: Impact on household income & economic stability, medical bankruptcy;[ii] avoided/delayed care and worse outcomes; imbalance in public sector spending also means underinvestment in the vital conditions for health and well-being

(4) Costs to the nation as a whole: Poor return on investment, in part because other investments are needed along with health care

Broad harms from the health care status quo and resulting from society's relationship with health care

- Health care workers not paid living wage, burned out
- Land use/community development if hospital worsens gentrification
- Wealth building outside the community through corporate purchasing, hiring practices

Other harms related to the status quo

- By its nature and existing incentives, health care spending drives societal priorities
- Like military-industrial complex, it drives agenda and dialogue, inaccurately shapes public perception
- Blinds internal and external decision-makers to other possible futures

FUTURE GOAL: All people living long healthy lives in thriving communities.

- Public awareness of and support for what creates health
- Policies to invest in the seven vital conditions for health and well-being[iii]
- High quality, accessible, affordable care for all
- A strong public health system

SOLUTIONS: HOW DO WE GO FROM THE CURRENT PREDICAMENT TO THE FUTURE GOAL?

- Identify, scale, and spread what works (solutions that include evidence-based policies, diversifying investments [in the vital conditions, public health infrastructure], in addition to controlling health care cost growth)
- Change/reframe the narrative, make the case.
- Other ideas?

Solutions in the public sector, at different levels of government (see also Resources & Readings for a sampling of references):

- (Mixed success) change expectations for quality, ROI, value-based payment, some attention to and support for furthering health equity and addressing health-related social needs.
- (some promising signs) several states setting targets for controlling cost growth
    - Washington, Oregon, Nevada, New Jersey, Connecticut, Rhode Island, Delaware, California, Massachusetts[iv]
    - Similar efforts in Maryland (all payer model) and Pennsylvania
- more balanced investment in SDOH (i.e., the seven vital conditions for health and well-being) and public health infrastructure, includes:
    - Federal:
        - Child tax credit[v]
        - The ACA
        - Medicaid expansion
        - CDC Eviction Moratorium
        - Other examples
    - State:
        - New Mexico child care in the state constitution
        - Massachusetts Fair Share tax (4% over first $1 million in income) to support education and transportation programs
        - Washington state Poverty Reduction initiative
        - SEED For Oklahoma Children (529 college savings account for all; privately funded and evaluated with Washington University in St. Louis, partnership with state)
        - And many more
    - Local:
        - Guaranteed income experiments (26 pilots around the US, 4 more coming)

        - Magnolia Mothers' Trust (oldest running experiment, since 2018, now in its 4th cohort of giving $1000 to Black mothers for 12 months with no conditions; evaluation[vi])
    - Cities of Opportunity (National League of Cities) – 5 cities ("helps bring communities together through four key entry points (Action Cohort, Mayors' Institute, Learning Labs and Solutions Forums) to find common ground and drive transformational change toward equity, well-being and life expectancy")
    - Project Room Key to rapidly shelter unhoused people during the pandemic, and translating temporary pandemic housing into permanent housing[vii]
    - And many more

Solutions in the private sector:

- change payer expectations for quality, ROI, value-based care
- promising examples (e.g., MA hotel workers union & GM arrangement with Henry Ford HS[viii])

Solution demanded by public payers:

- improve quality/value, reduce/regulate administrative cost
- financial health system never events (debt collection, not paying a living wage to health sector workers, etc.)

Solution(s):

- embrace health anchor mission.
- invest in people and communities

Solution(s)

- a national dialogue shaped by new frames and narratives
- more evidence-based policymaking and resource allocation

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[i] See IOM. 2013. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America National Academies of Sciences, Engineering, and Medicine. Washington, DC: The National Academies Press. https://doi.org/10.17226/13444; see also Brookings Institution. 2020. A Dozen Facts about the Economics of the US Health Care System. https://www.brookings.edu/research/a-dozen-facts-about-the-economics-of-the-u-s-health-care-system/; and McCullough JC, Zimmerman FJ, Fielding JE, Teutsch SM. A health dividend for America: the opportunity cost of excess medical expenditures. Am J Prev Med. 2012 Dec;43(6):650-4. doi: 10.1016/j.amepre.2012.08.013. PMID: 23159261.

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[iv] See for example: https://www.commonwealthfund.org/sites/default/files/2022-02/Hwang_health_care_cost_growth_strategy_01_target.pdf

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[vi] https://springboardto.org/wp-content/uploads/2022/08/MMT-Evaluation-Full-Report-2021-22-website.pdf

[vii] https://homelessness.acgov.org/roomkey.page

[viii] A hotel workers union in Boston (Local 26) that pushed back on Partners Healthcare's upcharging (2-3X other academic health systems) by dropping them from their provider list, see

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Shifting the Nation's Health Investments To Support Long, Healthy Lives for All

A Symposium

Readings and Resources

Contents

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>
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Estimates of excess deaths in 2020–21 only begin to capture the devastating health impact of the COVID-19 pandemic in the US. More deaths will occur, and a larger number of Americans will experience disease complications as delays in accessing care and increasing socioeconomic precarity take their toll. No other high-income country experienced as high a death rate during the pandemic. For decades Americans have experienced poorer health outcomes than people in peer countries because of deficiencies in the health care system, adverse socioeconomic conditions, unhealthy physical and social environments, systemic racism, and policies that jeopardize health. The pandemic exposed problems in each of these areas and highlighted the power of policymakers, including those in state government, to alter health outcomes.

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NLC NATIONAL LEAGUE OF CITIES

CITIES STRONG TOGETHER

How U.S. Cities are Making Real Progress Toward Health Equity

Here are a few examples of how—with support from the National League of Cities' Cities of Opportunity initiative—city leaders, communities and their partners are making tangible and significant progress toward improving the social and economic conditions that impact health equity.

It Begins with Alignment: Roanoke, Va. and Missoula, Mont.

For more than a decade, city leaders in Roanoke, Va., have been concerned about a glaring health disparity among its residents—and aware of the irony surrounding it.

"If you were to stand looking out a sixth-floor window of our city's major hospital, you'd see the two neighborhoods with the lowest life expectancies," says Roanoke City Manager Bob Cowell.

Roanoke is not alone in this disparity. In several other U.S. cities, neighborhoods with the poorest health outcomes are also right next to the city's major health corridors.

In Roanoke's case, one neighborhood, the historic and once thriving Black community of Northwest, can point to the ravages of urban renewal and the decades-old policy of redlining as the start of its decline and the city's disinvestment in the area. The other neighborhood, Southeast, consists predominantly of low-income white residents negatively impacted by the loss of manufacturing jobs. "Two different root causes," notes Cowell, "same outcome: shortened lives."

Addressing low life-expectancy topped the Roanoke city team's agenda when members began participating in the Cities of Opportunity pilot program in 2018. The team, composed of Cowell, other senior city leaders and leaders from The United Way and the local hospital system, knew this effort would require engaging the city's anchor institutions.

But first they needed to take an important—and necessary—step, one that virtually every city engaging in equity work must take: making people aware of health inequities and their root causes.

For Roanoke, that meant extensive community discussions. "We were updating the city's comprehensive plan at the same time we joined CoO," says Cowell, "so we incorporated 'health' and 'equity' directly into the plan. As a result, all of our public discussions about the plan included discussions of equity related to health." Simultaneously, community conversations were taking place, particularly in Northwest, focused on racism's historic role in shaping the city. In primarily white Southeast, where socioeconomic status and poverty were primary factors, similar discussions took place.

"It was an interesting dynamic," says Cowell. "But we worked our way through it. And as a result, the community not only has more awareness, but a common language about race-based inequities as well as socioeconomic-based inequities."

In Missoula, Mont., a city very different in size, culture and demographics than Roanoke—Missoula's population is 92% white—the same step toward aligning learning and language was also necessary before making progress in advancing health equity.

As the Missoula team was keenly aware, lack of diversity does not mean that a community has escaped the impact of institutionalized and historic roots of health inequities. Having conducted a community health assessment that documented how Missoula's low-income communities and communities of color were not receiving the same opportunities for good health outcomes as the broader population, the city's team—comprised of city staff as well as representatives from the public school district, local university, the county and the primary public health providers—entered the 2021 CoO cohort with a clear commitment to addressing those health disparities.

Still, alignment around this commitment was critical. "What I really appreciated about the CoO experience is that the team was able to coalesce around a common language, mission and vision," says Donna Gaukler, Missoula Parks and Recreation Director.

For the Missoula team—as with each team participating in the CoO initiative—this required a degree of introspection. "We're doing work that is outside of our lived experience," notes Gaukler, who is white. "So, we needed to pause and better understand how we've received advantages because systems were set up for us to have access. That helped us get clear on our end goals, our vision, who we are really trying to serve—and to create the roadmap to get there."

In the year following participation in the CoO initiative, Missoula city leaders see evidence of increased awareness and knowledge throughout the community:

- In 2021, both the city and county passed resolutions committing to a "Just, Equitable, Diverse and Inclusive" (JEDI) Missoula.
- The CoO team was expanded into a Community JEDI Network, a broad, community-driven group of government and non-governmental agencies, nonprofits, businesses, community experts and more.
- The JEDI Network's 2022 community summit is the city's first ever, extending the alignment created in the CoO cohort to the broader community.

And within the city infrastructure, Gaukler notes the "lowering of silos," made possible by creating strategic implementation teams focused on both equity and climate impact and adopting a JEDI lens across them all. "Instead of the typical team composition—department heads, managers, directors—our teams consist of city employees of every classification, from almost every department, coming together to ask broad questions such as 'How does engagement now look different?' and 'What does procurement look like today, and how should it look tomorrow?'"

> "In any city, you have some departments that are going to immediately lean into this while others may not as readily. But the seemingly slight change of talking about equity on a daily basis causes people to be, if nothing else, more vulnerable and sensitive in their actions. And to me, that's transformative."
>
> **— DONNA GAUKLER, Missoula, Mont.**

In Roanoke, too, Bob Cowell sees the impact of broader understandings of the root causes of health inequities—and the community's willingness to address them: from a new health clinic opening in Southeast to new investments in affordable housing and employment opportunities to a new initiative the city has labeled "Neighborhoods of Opportunity," which explores and funds citizen-driven interventions that address the social determinants of health.

Reflecting on other tangible changes, Cowell points to the way in which Roanoke has reformed its budgeting process to focus more intentionally on addressing disparities. "In the last budget round, with the assistance of ChangeLab Solutions, we engaged the neighborhoods much more directly in the discussion of how to identify the next target area to fund with our HUD Community Development funds," says Cowell. "One neighborhood came in convinced that it needed to be the next target area. But after going through the process and looking at the data, representatives from that neighborhood decided to champion another neighborhood instead, one that had a greater need. Definitely a positive outcome driven by a clear equity focus."

Addressing Systems Change: Fremont, Calif. and Las Vegas, Nev.

Most often, cities enter the Cities of Opportunity initiative focused on one of the most glaring disparities in their community. Examples from recent CoO cohorts include:

- Rochester, Minn., home to the respected Mayo Clinic and a sought-after destination for health and wellness, yet also home to BIPOC, immigrant and refugee residents who are struggling with poor health outcomes.
- Kansas City, Mo., where there is an 18-year difference in life expectancy between zip codes of majority white and Black communities.
- Tacoma, Wash., where residents who are not earning family-sustaining incomes are experiencing the poorest quality of life.

Rather than simply addressing these singular issues, the CoO initiative equips city leaders to take a broad, holistic view of how the root causes of health inequities intersect in multiple ways. Doing so enables them to lay the groundwork for real, tangible and sustainable progress for those who are most impacted by health disparities.

Take the city of Fremont, California.

The Fremont city team that participated in the 2021 CoO cohort focused specifically on residents experiencing behavioral health crises and in need of immediate intervention by police or emergency services. With CoO support and guidance, the team created a plan to ensure community-level alignment and collaboration among the city's 911 system, local emergency rooms and other entities to provide targeted responses to people with mental health issues and complex social needs. But the team hasn't stopped there.

According to Candice Rankin Mumby, management analyst for the City of Fremont and part of the CoO city team, "The biggest benefit of being in the CoO initiative was focusing on all these different entities and thinking in terms of structured systems-level change. It helped us take a step back and look at things from a higher level."

As a result, Fremont city leaders are now taking the lessons learned and applying them to other resident populations such as older adults who may lack adequate support for their health needs. "That was an a-ha moment for us," says Rankin Mumby. "Recognizing that once we had these new partnerships and structures in place, we could shift our focus to other areas where there are big equity concerns as well. It was really worth the time to put this scaffolding in place to build relationships."

City leaders from Las Vegas, Nevada, began their CoO journey in 2019, focusing on the Historic Westside, a traditionally Black and culturally significant neighborhood that was once home to the Moulin Rouge Hotel and Casino where Black entertainers including Sammy Davis, Jr., Ella Fitzgerald and Nat King Cole stayed in the late 1950s because they were barred from staying in hotels on the glitzy Strip. The neighborhood has suffered from years of segregation and disinvestment as well as literal separation from the rest of the city by highways built in the 1950s. Current city leaders are committed to revitalizing the neighborhood without dislocating current residents.

However, according to Kathi Thomas, director of Las Vegas' Office of Community Services, she and the Las Vegas CoO team knew from the start that they would take the learnings from their work in the Historic Westside to other areas of the city's policies, practices, systems and structures. And they have just done that.

"Timing is everything," notes Thomas who says she and her team were able to hit the ground running thanks to concurrent and favorable conditions, including an update to the city's master plan that required equity to be included in all policies and a unanimously-passed citywide resolution mandating the development of a Diversity, Equity and Inclusion (DEI) initiative—as well as the considerable political will of the Mayor to advance equity.

"This was the only time," recalls Thomas, "I've ever drafted a document that the mayor literally took a red pen to so that it could reflect her level of commitment."

With this laser-focus on equity in all policies, Las Vegas city leaders, partners and community members have:

- called for department-by-department work plans outlining what each can do to identify opportunities for equitable outcomes in their work, along with a data index to track progress
- hired the city's first bilingual public information officer for a community that is 30% Spanish-speaking
- segmented purchasing procedures into smaller contracts to give small- and medium-sized vendors a chance to compete, thus encouraging a greater diversity of women- and minority-owned contractors
- diversified the city attorney's staff to include women lawyers in the Civil Division (there weren't any previously) and more attorneys of color (there was one previously)
- launched training for all city employees (eventually more than 3,000) on cultural identity, cultural humility, implicit bias and creating a culture of belonging

And more.

"Across the board, there were opportunities to talk about equity and inclusion," notes Thomas. "We're certainly not going to get away from race and class if we're having meaningful discussions about equitable outcomes. But we also struggle with ageism and ableism as well as LGBTQ+ and gender identity issues. I think people were just waiting for the chance to make positive change; maybe for years they've been ready and it's like this gave them permission to be their highest, truest, most authentic selves at work."

Catalyzing Will: East Point, Ga. and San Antonio, Texas

The sentiment expressed above by Thomas—that people in the City of Las Vegas were "waiting for the chance" to make positive change—captures what many city leaders experience in the Cities of Opportunity initiative: while they come to the table with a clear sense that change in their city is necessary and with a strong will to create that change, they may lack a roadmap or a framework that will provide the chance—and the confidence—to move forward.

"We came in with a desire to do work differently, to grow differently," recalls Deana Holiday Ingraham, mayor of East Point, Ga. "And I remember going around the table, making eye contact with each person on our team and saying, 'Do *you* believe we can all do this together? Do *you* believe? Do *you* believe?' We didn't know what it would look like, but we had to have that level of commitment, that level of optimism—and be open to what the process would show us."

What the mayor and her team were so committed to was challenging and dismantling systemic inequities that have existed for decades in their community of just over 30,000. In 1912, the East Point City Council forced African American residents to live only in the most undesirable part of the city, a plot of land adjacent to fertilizer, oil and chemical plants that eventually earned the area the nickname "Stinktown." Over the years, the unhealthy practice of locating manufacturing next to residential areas spread to other areas of the city as well.

The East Point city team knew that change would need to mean more than attending to one neighborhood, or even focusing narrowly on land use, and over the course of their CoO participation they catalyzed their commitment to incorporating equity deep into city systems and policies with a comprehensive approach and plan.

As a first step, the team presented a resolution to the city council committing to an equity framework for the city and designating an equity committee. The council adopted the resolution.

SAN ANTONIO, TEXAS

Next, the City was selected to create the first City Agriculture Plan (CAP) in the region through community engagement, asset mapping and strategic planning. While developing the City Agriculture Plan, the City engaged Partnership for Southern Equity to help the City create an Equitable Growth and Inclusion Strategic Plan (EGISP), the first of its kind, and ensure authentic resident voices through listening sessions, asset mapping, surveys and a resident Equity Leaders Academy to increase community understanding of equity. Adoption of the resolution, CAP and EGISP plans, community engagement, changes to industrial zoning ordinances and more positioned East Point to be the community of focus for the up to $1.1 million grant Morehouse School of Medicine received from the US Department of Health and Human Services' Office of Minority Health to advance health equity through collaborative policy efforts, including housing, food access, and land use/environmental justice.

"The CoO initiative and NLC allowed us to springboard and be ready for all these opportunities. If we hadn't gone through the program, we wouldn't be in this position," says Mayor Holiday Ingraham. "It gave us guidance and experts to tap so we could truly walk it, not just talk it. And what's happened is we've created a climate of hope and understanding that things can be different in East Point."

> "I think there are a lot of people who want to do something different and want to grow equitably, but they don't see examples of it working. I believe that we can be a model for all things equitable, just, fair, and inclusive."
>
> **—MAYOR DEANA HOLIDAY INGRAHAM, East Point, Ga.**

When the city team from San Antonio, Texas, joined the CoO's 2021 Mayor's Institute, they did so in an enviable position, having just secured nearly $250,000 for their workforce development initiative via a sales tax approved by voters. The challenge? How to use the new funds strategically to ramp up the existing workforce program and get a number of new partners aligned.

"The mayor created a leadership task force that included our higher education institution, workforce providers, nonprofit entities, businesses—a large, diverse group that we hadn't had the opportunity

to create in our first iteration of the workforce program," recalls Victoria Shoemaker, director of external affairs in the mayor's office. "CoO provided us with space to come together and strategize how we were going to do this at a much greater scale and over a longer period of time."

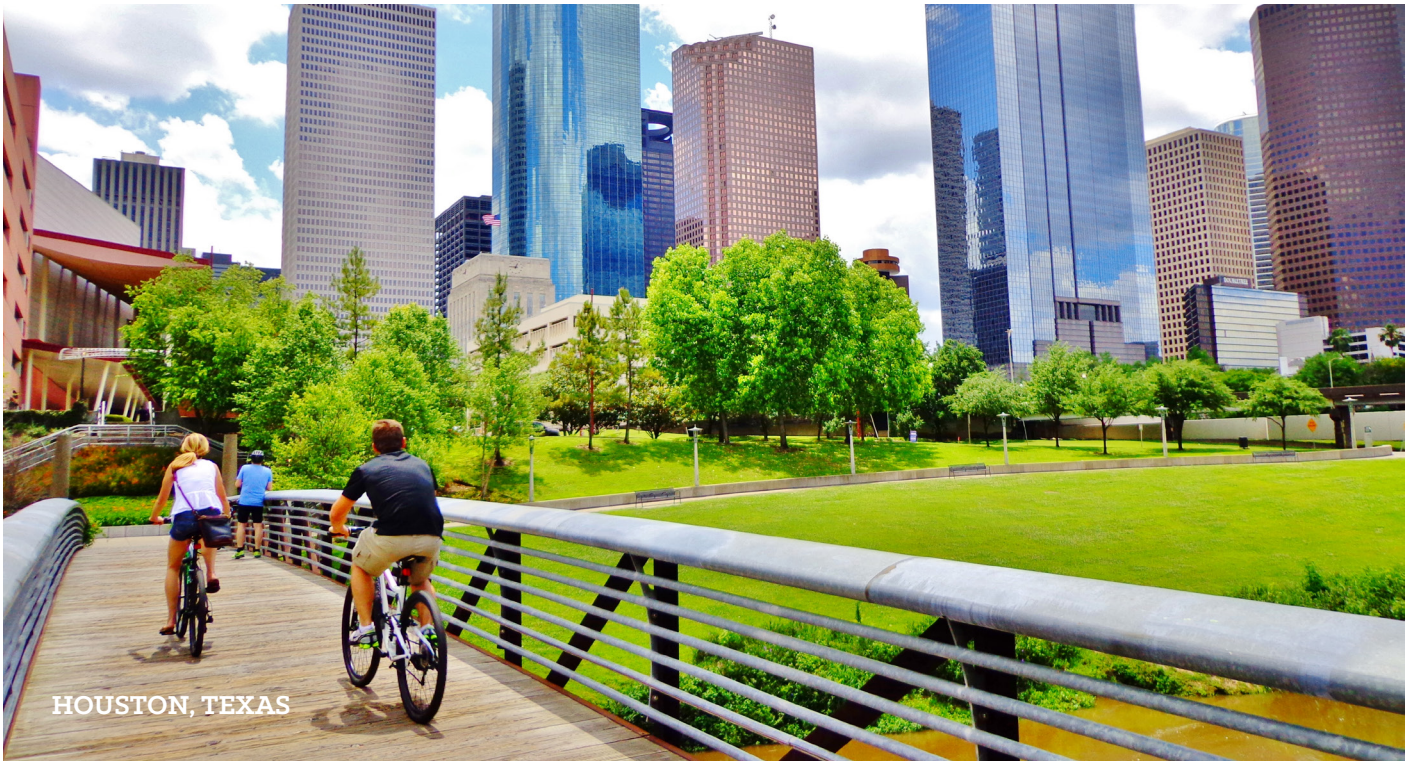
The CoO Mayor's Institute—which that year focused on the connections between job creation, economic opportunity and healthy equity—brought partners together who hadn't before sat together at the table. CoO facilitators served as neutral convenors, giving the city team the opportunity to be part of the conversations rather than having to facilitate discussions themselves. Together, the city team and partners created a shared roadmap using a human-centered design process, with health equity as the North Star.

One thing all city teams involved in CoO have in common is that their roadmaps end with the same long-term goal: health equity. Together, CoO facilitators and city teams work the roadmap, iterate it and poke at it until the entire team feels they can say, "We have a shared commitment to this result in our community, and this is how we'll get there." CoO is where cities and their partners come to do their work—and have it accelerated.

That's just what happened in San Antonio. Armed with an implementation blueprint and clear action strategies, city leaders and partners built out a workforce development initiative capable of supporting more than 400,000 participants, increased infrastructure partnerships, expanded career pathway programs, implemented a wrap-around service delivery model and developed a comprehensive intersectional data dashboard.

"The preliminary results have been great, with more than 6,000 applicants to the program getting training and skills," said Mike Ramsey, executive director of workforce development for the city. "And we have more than 200 employers at the table providing input, helping strengthen the program and committing to interviewing our program graduates. Plus, we now have a centralized data platform where data had previously been siloed. Now everyone's looking at the same scorecard and aiming toward the same goals."

The support and guidance CoO provided to the San Antonio city team is an example of CoO's principle of "meeting cities where they are"—in this case, helping them prepare to spend millions strategically.



HOUSTON, TEXAS

Shifting Focus: Houston, Texas

For Houston, San Antonio's neighbor to the east, the support provided by the Cities of Opportunity initiative is an example of another CoO principle: help city leaders redefine their view of "progress" from one that uses economic or growth measures alone to one that defines progress as "well-being for all people."

That's precisely the shift in focus the Houston team experienced as they worked together to address one of the city's most visible signs of health inequity: the impact flooding has on disinvested neighborhoods. Not only in Houston, but across the nation in cities that experience flooding, the residents most vulnerable are those living in the lowest-lying areas or neighborhoods—typically low-income or minority communities.

The city team used their CoO time to explore how centering equity could help them re-envision the city's approach to stormwater management—the policy, planning, engineering, implementation and maintenance of urban water systems. But their larger objective, as announced to the cohort by Mayor Sylvester Turner, was to use this project as a model for developing a citywide policy tool. "We are prototyping a way of thinking about ROI with a larger, more holistic set of metrics around stormwater capital investment," the mayor shared, "with the intention of creating a schema that could then be applied to all of our capital investments."

In terms of stormwater management, that meant looking differently at how decisions were made regarding hard scape and green space in the city—decisions that have historically benefitted wealthy communities.

"The first thing that needed to be worked out was what the right things to measure and prioritize were," recalls Carol Haddock, director of Houston Public Works. "What were the outcomes that would reflect what we were trying to achieve: equitable capital investment decisions driven by health equity?"

Traditionally, infrastructure decisions impacting urban water systems are made based upon a benefit/cost-ratio proposition that tends to drive projects to the wealthiest parts of a city. "We didn't want to repeat that pattern," says Haddock, "So, how could we quantify social determinants of health—particularly in terms of communities' ability to be resilient in the face of flooding? We began to include metrics such as access to transit, healthcare, schools, food and green spaces."

For Haddock and others, this shift in focus was transformative. "As somebody who's a trained engineer, the a-ha moment for me was thinking beyond 'the performance of the infrastructure' to 'human interaction with the infrastructure,'" says Haddock. "That's not what we're trained to do. But here, we were approaching it as a people solution rather than a pipe solution, asking whether we were truly meeting the needs of people, as opposed to achieving design criteria."

This was not a quick and smooth process, Haddock notes. "But the a-ha came from blending our multiple disciplines." The CoO experience provided the city team—a collection of varied stakeholders with different mandates—safe space to have difficult discussions, grounded in their shared commitment to what they wanted to accomplish. Given the time, structure and space, they were able to move forward and work together.

"CoO and NLC create a welcoming and engaging environment that allows you to throw challenges and concerns on the table and have robust discussions without worrying about being criticized for wanting to think outside the box," says Haddock. "Sometimes just having two or three people say, 'Yeah, that sounds good,' lets you feel more comfortable and willing to try."

For more information and to sign up for updates on the next City of Opportunities cohort, please contact CoO@NLC.org.

NLC NATIONAL LEAGUE OF CITIES

CITIES STRONG TOGETHER

Cities are Making Health Equity a Reality

Where you live shouldn't determine how healthy you are or how long you live. Yet in cities across the nation, from neighborhood to neighborhood, there are huge disparities in resident health, well-being and life expectancy.

These disparities exist across a broad range of dimensions—most notably race, ethnicity and socioeconomic status—but also age, gender, disability, citizenship status, and sexual identity and orientation.

The COVID-19 pandemic has only exacerbated health disparities and highlighted the fact that no U.S. city—large or small; urban, suburban or rural; red, blue or purple—is immune to them.

At the root of these disparities are social, economic and racial inequities that have, for decades, been baked into city policies, practices, systems and structures. Decisions both past and present have been made largely without key stakeholders and communities at the table.

The cumulative impact is that U.S. city residents—83% of the nation's total population—experience health inequities: unfair yet avoidable differences in their health outcomes.

City Leaders Can Drive Change

The good news is that city leaders—mayors, other elected officials and appointed administrators—are in a unique position to tackle health inequities in their cities because they can influence the very policies, practices, systems and structures in which the root causes of disparities are embedded.

But doing so can be complex and daunting for city leaders and communities for four key reasons:

1. It is difficult to find common ground. Tackling the root causes of health inequities requires building collaborations and partnerships, but this can be challenging—especially in today's divisive political and social climate. Discussions about equity necessarily raise issues related to power and privilege, gender, race and ethnicity.

2. City leaders need support. While they may have the will to address health equity and have citywide policies or resolutions in place, they often need additional capacity or skill-building.

3. Traditional approaches to addressing inequities often fall short. Traditional approaches may take a view that is too narrow, thereby missing critical intersections of root causes, or they may proceed without authentically engaging residents and communities.

4. There is no one-size-fits-all approach to addressing inequities. From a city's size and topography to its politics and economy, from its history and collective sense of identity to its appetite for change, each city must develop a vision of health equity and a plan for advancing it that is specific and meaningful to the city and its residents.

Creating Cities of Opportunity

With an understanding of the challenges city leaders face when addressing health inequities, the National League of Cities (NLC) launched the Cities of Opportunity (CoO) initiative in 2018, with support from the Robert Wood Johnson Foundation.

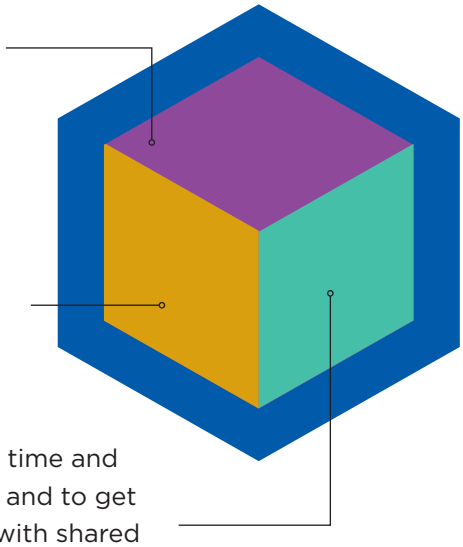
Drawing upon more than 90 years of experience helping city leaders improve resident quality of life, NLC designed the CoO initiative specifically to give city leaders the resources and support they need to ensure the well-being of all their residents.

Since its inception, the initiative has provided support and guidance to more than 50 U.S. cities. Nearly 200 city leaders and their partners have participated, from large urban areas such as Houston, Texas, mid-size metros such as Pittsburgh, Pa. and small cities such as Dubuque, Iowa.

Together, the city leaders and their partners are forming a nationwide network of peers and a supportive community of changemakers, and the changes they are driving have been nothing short of transformative.

A Process and Structure Built for Change

The transformative change that more and more city leaders are proud to claim—is due not only to CoO resources and support, but to three important features of the process itself:



- First, the CoO initiative "meets cities where they are," regardless of their current stage of equity work, their current capacity and preparedness or their most pressing issues. To that end, the CoO initiative offers city leaders multiple points of entry, from groups that work together intensively over a year's time to shorter, focused opportunities for broad discussion and idea exchange.
- Second, CoO staff "walk with cities over time," as opposed to traditional approaches from partners who may provide tools but not ongoing support and capacity building. The CoO initiative recognizes that change requires the investment of time.
- Finally, the CoO process gives city leaders and partners the space, time and structure to have important and sometimes difficult conversations and to get work done. City teams and their partners move forward together, with shared visions, values and plans.

With the support of the Cities of Opportunity initiative, city leaders, communities and their partners are making tangible and significant progress toward improving the social and economic conditions that impact health equity.

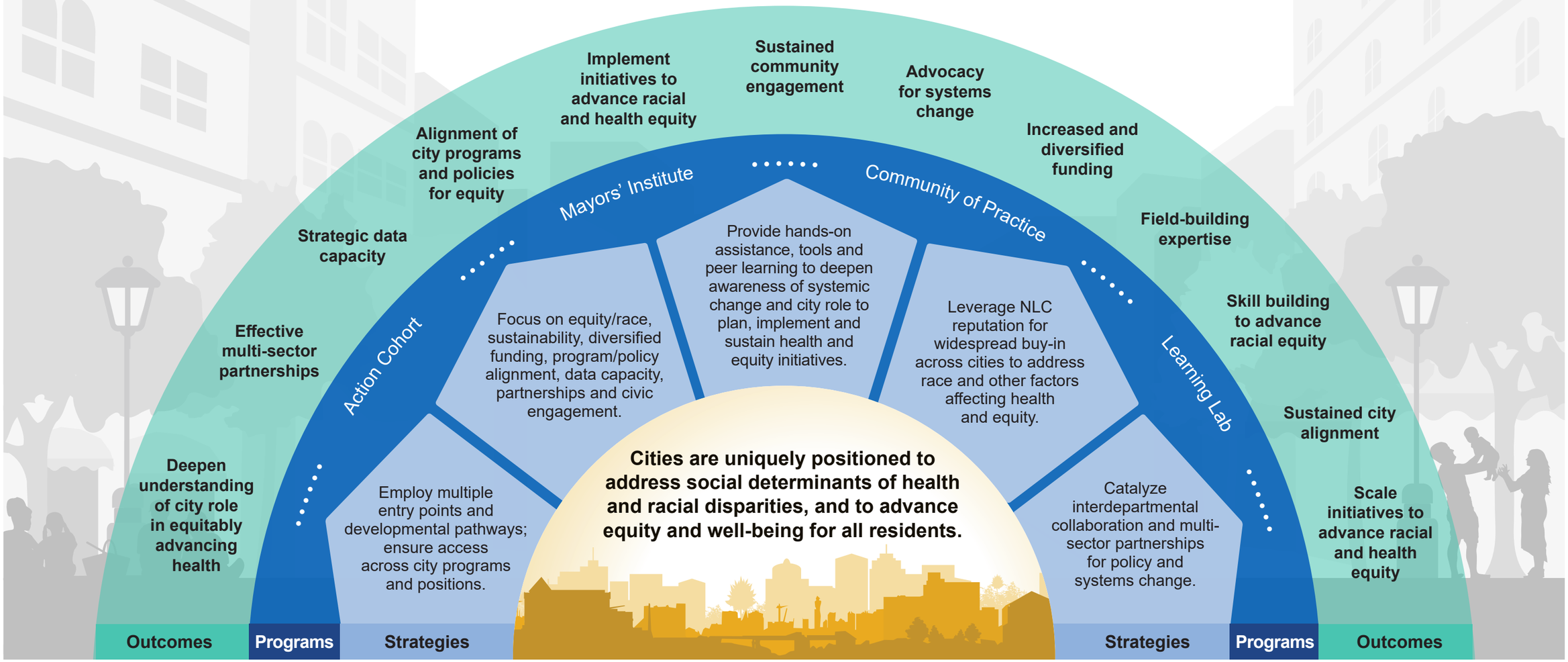
For more information and to sign up for updates on the next City of Opportunities cohort, please contact CoO@NLC.org.

NLC NATIONAL LEAGUE OF CITIES
CITIES STRONG TOGETHER

Cities of Opportunity Theory of Change

Vision

All city residents, particularly those historically excluded, have fair and equitable access to the resources and opportunities for good health and well-being, and to shape vibrant, inclusive communities.

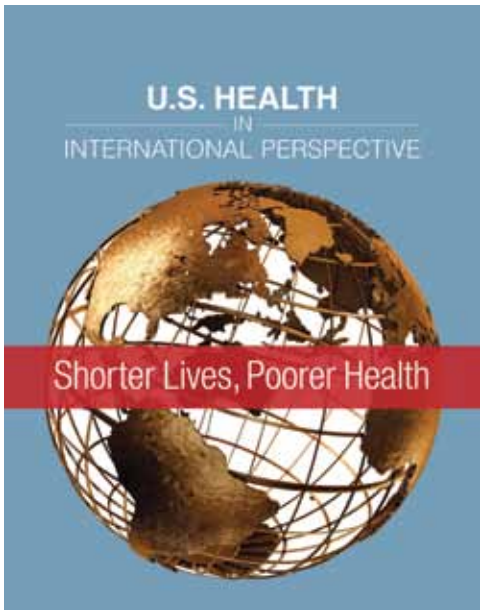


October 2021

COMMITTEE ON POPULATION
AT THE NATIONAL RESEARCH COUNCIL
www.nationalacademies.org/dbasse/cpop

REPORT BRIEF • JANUARY 2013

U.S. Health in International Perspective: Shorter Lives, Poorer Health



The United States is among the wealthiest nations in the world, but it is far from the healthiest. Although Americans' life expectancy and health have improved over the past century, these gains have lagged behind those in other high-income countries. This health disadvantage prevails even though the United States spends far more per person on health care than any other nation.

To gain a better understanding of this problem, the National Institutes of Health (NIH) asked the National Research Council and the Institute of Medicine to convene a panel of experts to investigate potential reasons for the U.S. health disadvantage and to assess its larger implications. The panel's findings are detailed in its report, *U.S. Health in International Perspective: Shorter Lives, Poorer Health.*

A PERVASIVE PATTERN OF SHORTER LIVES AND POORER HEALTH

The report examines the nature and strength of the research evidence on life expectancy and health in the United States, comparing U.S. data with statistics from 16 "peer countries" – other high-income democracies in Western Europe, as well as Canada, Australia, and Japan. The panel relied on the most current data, and it also examined historical trend data beginning in the 1970s; most statistics in the report are from the late 1990s through 2008.

The panel was struck by the gravity of its findings. **For many years, Americans have been dying at younger ages than people in almost all other high-income countries** (*see table on next page*). This disadvantage has been getting worse for three decades, especially among women. Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course – at birth, during childhood and adolescence, for young and middle-aged adults, and for older adults.

The U.S. health disadvantage spans many types of illness and injury. When compared with the average of peer countries, Americans as a group fare worse in at least nine health areas:

- infant mortality and low birth weight
- injuries and homicides
- adolescent pregnancy and sexually transmitted infections
- HIV and AIDS
- drug-related deaths
- obesity and diabetes
- heart disease
- chronic lung disease
- disability

Many of these conditions have a particularly profound effect on young people, reducing the odds that Americans will live to age 50 (*see figures on next page*). And for those who reach age 50, these conditions contribute to poorer health and greater illness later in life.

TABLE: Seventeen High-Income Countries Ranked by Life Expectancy (LE) at Birth, 2007

Males			Females		
Rank	Country	LE	Rank	Country	LE
1	Switzerland	79.33	1	Japan	85.98
2	Australia	79.27	2	France	84.43
3	Japan	79.20	3	Switzerland	84.09
4	Sweden	78.92	3	Italy	84.09
5	Italy	78.82	5	Spain	84.03
6	Canada	78.35	6	Australia	83.78
7	Norway	78.25	7	Canada	82.95
8	Netherlands	78.01	7	Sweden	82.95
9	Spain	77.62	9	Austria	82.86
10	United Kingdom	77.43	9	Finland	82.86
11	France	77.41	11	Norway	82.68
12	Austria	77.33	12	Germany	82.44
13	Germany	77.11	13	Netherlands	82.31
14	Denmark	76.13	14	Portugal	82.19
15	Portugal	75.87	15	United Kingdom	81.68
16	Finland	75.86	16	United States	80.78
17	United States	75.64	17	Denmark	80.53

The United States does enjoy a few health advantages when compared with peer countries, including lower cancer death rates and greater control of blood pressure and cholesterol levels. Americans who reach age 75 can expect to live longer than people in the peer countries. With these exceptions, however, other high-income countries outrank the United States on most measures of health.

The U.S. health disadvantage cannot be fully explained by the health disparities that exist among people who are uninsured or poor, as important as these issues are. Several studies are now suggesting that even advantaged Americans – those who are white, insured, college-educated, or upper income – are in worse health than similar individuals in other countries.

WHY ARE AMERICANS SO UNHEALTHY?

The panel's inquiry found multiple likely explanations for the U.S. health disadvantage:

- **Health systems.** Unlike its peer countries, the United States has a relatively large uninsured population and more limited access to primary care. Americans are more likely to find their health care inaccessible or unaffordable and to report lapses in the quality and safety of care outside of hospitals.
- **Health behaviors.** Although Americans are currently less likely to smoke and may drink alcohol less heavily than people in peer countries, they consume the most calories per person, have higher rates of drug abuse, are less likely to use seat belts, are involved in more traffic accidents that involve alcohol, and are more likely to use firearms in acts of violence.
- **Social and economic conditions.** Although the income of Americans is higher on average than in other countries, the United States also has higher levels of poverty (especially child poverty) and income inequality and lower rates of social mobility. Other countries are outpacing the United States in the education of young people, which also affects health. And Americans benefit less from safety net programs that can buffer the negative health effects of poverty and other social disadvantages.

Comparison of United States to average of peer countries on major causes of death before age 50.

- **Physical environments.** U.S. communities and the built environment are more likely than those in peer countries to be designed around automobiles, and this may discourage physical activity and contribute to obesity.

No single factor can fully explain the U.S. health disadvantage. Deficiencies in the health care system may worsen illnesses and increase deaths from certain diseases, but they cannot explain the nation's higher rates of traffic accidents or violence. Similarly, although individual behaviors are clearly important, they do not explain why Americans who do not smoke or are not overweight also appear to have higher rates of disease than similar groups in peer countries.

More likely, the U.S. health disadvantage has multiple causes and involves some combination of inadequate health care, unhealthy behaviors, adverse economic and social conditions, and environmental factors, as well as public policies and social values that shape those conditions.

THE COSTS OF INACTION

Without action to reverse current trends, the health of Americans will probably continue to fall behind that of people in other high-income countries. The tragedy is not that the United States is losing a contest with other countries, but that Americans are dying and suffering from illness and injury at rates that are demonstrably unnecessary. Superior health outcomes in other nations show that Americans also can enjoy better health.

The health disadvantage also has economic consequences. Shorter lives and poorer health in the United States will ultimately harm the nation's economy as health care costs rise and the workforce remains less healthy than that of other high-income countries.

NEXT STEPS

With lives and dollars at stake, the United States cannot afford to ignore this problem. One obvious solution is to intensify efforts to improve

public health by addressing the specific conditions responsible for the U.S. health disadvantage, from infant mortality and heart disease to obesity and violence. Public health leaders have already identified many promising strategies to address these problems, and the nation has adopted detailed health objectives aimed at their implementation. Although these are positive steps, addressing the U.S. health disadvantage will require not only a list of goals, but also a societal commitment of effort and resources to meet them.

Little is likely to happen until the American public is informed about this issue. Americans may know about some deficiencies in the U.S. health care system, but most might be surprised to learn that they and their children are, on average, in worse health than people in other high-income countries. Greater public knowledge may require an organized media and outreach campaign to raise awareness about the U.S. health disadvantage. One goal of this effort should be to stimulate a thoughtful national discussion about what actions the country is willing to take to achieve the health gains that other countries are enjoying.

The United States may also be able to learn from other countries. Although conditions in other countries often differ from those in the United States, strategies and approaches that have helped them achieve better health outcomes are worthy of study. The NIH or a similar entity should commission a study of policies that countries with superior health status have found useful and that might be adapted for the United States. A series of more focused studies is also needed to find explanations for the specific health disadvantages documented in the report.

To learn more about the report's findings and how the United States compares to its 16 peer countries on various specific causes of death, see http://nationalacademies.org/IntlMortalityRates

Source for table and figures: Data from the Human Mortality Database, the WHO Mortality Database, and Statistics Canada, as reported in Ho, J. Y. and S.H. Preston (2011). International Comparisons of U.S. Mortality. Unpublished data analysis for the NAS/IOM Panel on Understanding Cross-National Health Differences Among High-Income Countries. Population Studies Center, University of Pennsylvania.

PANEL ON UNDERSTANDING CROSS-NATIONAL HEALTH DIFFERENCES AMONG HIGH-INCOME COUNTRIES

STEVEN H. WOOLF (*Chair*), Department of Family Medicine, Virginia Commonwealth University; **PAULA BRAVEMAN,** School of Medicine, University of California, San Francisco; **KAARE CHRISTENSEN,** Institute of Public Health, University of Southern Denmark; **EILEEN M. CRIMMINS,** Davis School of Gerontology, University of Southern California; **ANA V. DIEZ ROUX,** School of Public Health, University of Michigan; **DEAN T. JAMISON,** Department of Global Health, University of Washington; **JOHAN P. MACKENBACH,** Department of Public Health, Erasmus University, Rotterdam, The Netherlands; **DAVID V. MCQUEEN,** Global Consultant, Atlanta, Georgia; **ALBERTO PALLONI,** Department of Sociology, University of Wisconsin-Madison; **SAMUEL H. PRESTON,** Department of Sociology, University of Pennsylvania; **LAUDAN ARON,** *Study Director.*

FOR MORE INFORMATION... This brief was prepared by the Division of Behavioral and Social Sciences and Education and the Institute of Medicine based on the report *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. The study was sponsored by the National Institutes of Health. Any opinions, findings, conclusions, or recommendations expressed in this publication are those of the authors and do not reflect those of NIH. Copies of the report are available from the National Academies Press, 500 Fifth Street, N.W., Washington, DC 20001; (800) 624-6242; http://www.nap.edu.

Poverty Reduction Work Group

Progress-to-Date on the 10-Year Plan to Reduce Poverty & Inequality

(does not include efforts at the community-level)

January 2023

DATE	WHAT	ALIGNED WITH WHAT STRATEGY
Feb. 2021	Creation of the Office of Equity - Dr. J was hired to lead the work in February 2021.	1a & 1b
June 2021	Funding for the PRWG Steering Committee (Commerce)	2b
June 2021	Equitable Economic Recovery Pilot - Funded by the Robert Wood Johnson Foundation, DSHS and community partners worked with those who stand to benefit the most from economic recovery in what the data should be and what it could look like to equitably recover (DSHS).	2c
June 2021	HEAL ACT passage - Goal is to eliminate environmental and health disparities among communities of color and low-income households. It is the first statewide law in Washington to create a coordinated state agency approach to environmental justice. (Department of Health).	2c
June 2021	Digital Equity and Broadband Access (Commerce) - Increase broadband access to underserved areas, removal of barriers across sectors to increase broadband access, etc.	2e
June 2021	Fair Start for Kids Act - Legislation that made child care more accessible and affordable for Washington families.	3f
June 2021	Working Families Tax Credit, Capital Gains Tax, and national Child Tax Credits - State and federal tax credits targeted to people with low incomes have shown to reduce economic hardship, improve physical and mental health and well-being, and support educational and	3d & 3h

	developmental outcomes for children in families that receive credits. - The 7% tax on capital gains applies to profits above $250,000 on sales of investments such as stocks and bonds. - The American Rescue Plan Act (ARPA) of 2021 expanded the Child Tax Credit (CTC) for tax year 2021 only.	
June 2021	Housing Trust Fund capital funding was awarded to organizations to build more than 3,800 low-income housing units throughout the state, over 1,900 of which will be dedicated to homeless housing. The increased allocation in 2022 for both Rapid Capital and HTF may generate another 4,000 shelter beds or affordable homes. (Commerce)	3g
June 2021	The 2021-23 operating budget proviso tasked Commerce with convening a diverse homeownership-focused workgroup to "assess perspectives on housing and lending laws, policies, and practices; facilitate discussion among interested parties; and develop budgetary, administrative policy, and legislative recommendations" with a report that was delivered to the legislature in the fall of 2022.	3g
June 2021	Continuous Medicaid Coverage for Children Under 6	4
June 2021	K-12 Education and Learning - Funding additional school counselors in elementary, middle, and high schools that have the highest proportions of students and their families experiencing poverty. - Legislators invested in our small and rural schools who have critical building system repair needs. - Legislature continues their commitment to para-educators by funding two professional learning days per year.	4
June 2021	Washington became the first state in the nation to guarantee "Right to Counsel" for renters - Ensures that the most low-income tenants have access to a lawyer during eviction proceedings.	5b
June 2021	Requiring "Just Cause" in evictions - Protects tenants from the beginning to end of their tenancies by penalizing the inclusion of unlawful lease provisions and limiting the reasons for eviction, refusal to continue, and termination.	5b
June 2021	Preventing homelessness - HB1277 provided for an additional revenue source for eviction prevention and housing stability services.	5b
June 2021	Establishing a new need standard for state programs - Standard of need will now include cell phone, Internet, and out-of-pocket costs for child care and health care as necessary items of the household budget that must be included. - WA State Self-Sufficiency Standard (University of Washington)	6b
June 2021	TANF 15% cash grant increase and elimination of 60-month time limit - Extended through June 2022 via COVID-19 relief.	6d & 6e
June 2021	Policing reform legislation (12 bills) - Improve policing, reduce use of deadly force, and ensure investigations are thorough and independent. - Use of force database, ensure police agencies notify prosecutors about officers with credibility issues, and	7a

	electronically record interrogations of juveniles & adults with felony charges. - Build programs to fund projects with communities and law enforcement. (Commerce)	
June 2021	Suspension of Medicaid during incarceration - Suspension, rather than termination, of medical assistance for persons who have been incarcerated or committed to a state hospital, regardless of the person's release date. (Health Care Authority)	7h
June 2021	Restoring voter eligibility - Restores voter eligibility for all persons convicted of a felony offense who are not in total confinement under the jurisdiction of the Department of Corrections. (DOC)	1 & 7h
June 2021	Expansion of DOC graduated reentry program - The program's aim is to improve public safety by targeting interventions and programs for incarcerated individuals' successful transition into the community. (DOC)	7i
June 2021	Automatic child support abatement upon incarceration - Concerns child support, but only with respect to standards for determination of income, abatement of child support for incarcerated obligors, modification of administrative orders, and notices of support owed. (DSHS)	7f
June 2021	Keeping Families Together Act - Protecting the rights of families responding to allegations of abuse or neglect of a child. (DCYF)	7a & 7c
June 2021	Basic Income Efforts in state - WA state feasibility study via proviso - Tacoma's GRIT pilot, Hummingbird pilot, King County pilot, Clallam County pilot	6d & 8d
July 2021	Washington increased some access to childcare subsidies for community & technical college students (WSAC)	3a-viii
Dec 2021	Executive Order 22-04 requires state agencies to develop PEAR strategic action plans - Pro-Equity, Anti-Racist (PEAR) Plan & Playbook establishes a unified vision of equity for state government, mission, values, and goals, and contains a step-by-step playbook for developing, implementing, and embedding PEAR into every government action across state government. (EQUITY)	1a
Dec 2021	Executive Order 21-05 establishes Subcabinet on Intergenerational Poverty - Governor Inslee's 2022 supplemental budget included more than $248 million in state and federal funds to improve the continuum of care in our poverty reduction programs. - The Subcabinet's immediate focus shall be on building out an integrated eligibility system for clients, developing affordable housing solutions across the spectrum of the state's housing continuum, and eliminating gaps in our benefits programs and reducing the negative consequences of benefit cliffs.	5a
Jan 2022	Community Representative Workforce Pathway Program with $7.5M (DOH) - Establish and pilot a program to build a pipeline for people who are members of the communities most impacted by COVID-19 to have an accessible pathway to public health service. This funding will also support community-led internship, mentorship, and workforce programs at community-based organizations and local health departments (funded through June 2023 unless other funding is secured).	1a & 1b

July 2022	Missing Indigenous people legislation - First in the nation policy that creates an endangered missing person advisory designation for missing Indigenous persons.	1b
Jan 2022	Creation of an informal interagency community of practice group on community engagement and compensation that meets monthly - Works to share best practices from agency efforts. - Works to ensure agencies are coordinating to reduce harm with community-based organizations and community members.	2c
July 2022	Environmental Justice Community Grants with $500k (DOH) - Grants to support community participation on the environmental Justice Council.	2c
July 2022	Digital Equity Act - Closing the digital equity divide by increasing the accessibility and affordability of telecommunications services, devices, and training. (Commerce)	2e
July 2022	Commerce implemented outreach program proviso: $10M for grants to community orgs that serve communities who have been excluded from well-being to conduct outreach and assist individuals in applying for state and federal assistance programs, including but not limited to those administered by the departments of DSHS, Commerce, DCYF.	2c
July 2022	Compensation of Lived Expertise Guidelines - Senate Bill 5793. (EQUITY) - "Communities disproportionately burdened by government decisions must have a meaningful opportunity to develop public policy," Attorney General, Bob Ferguson.	2b
July 2022	Expand and strength apprenticeships (SB 5764) - Pathways between apprenticeship programs and college so that students in apprenticeship programs are treated equally when it comes to access to tuition and grants, and successful apprenticeship graduates have a clearer pathway to earn an associate degree or four-year bachelor's degree in the future, if they choose.	3a
July 2022	Creation of the Washington program of Imagination Library (HB 2068) - The Imagination Library of Washington program provides age-appropriate, high-quality books each month to children ages birth to five at no cost to families Early exposure to books and reading has a proven impact on high achievement in literacy, learning, and strong educational outcomes. DCYF and OSPI	3a-ii
July 2022	Increasing access to behavioral health services for minors (SHB 1800) - Convene stakeholders, including families, behavioral health providers, and educators, and develop a parent portal to provide easy-to-navigate resources about behavioral health services due on Nov 1, 2024. (HCA)	3a-viii
July 2022	Extended Foster Care Stipends ($10.6M) - This critical funding will help transition foster youth to successful adulthood by supporting housing stability and securing access to essential resources like food, transportation, utilities, and more. (DCYF)	3a-v

July 2022	Bank Accounts for Foster Youth Workgroup (SB 5784) - Develop a program to provide eligible youth with the ability to establish a private self-controlled bank account with a financial institution prior to exiting dependency. (DCYF) - $775K for this effort with a minimum of $25 per month into this bank account and this program is to be fully operational by January 1, 2023.	3a-v
July 2022	Expand Fair Start for Kids Act (SB 5237) - Expand accessible, affordable child care and early childhood development programs. (DCYF) - Increase child care subsidy rates, expand access to affordable health care for staff, and support and expand access and enhanced rates for WCCC, ECEAP, and early ECEAP.	3a-vi
July 2022	The Student Emergency Assistance Grant program distributes funding to community and technical colleges to help students cover emergency expenses. (SBCTC)	3a-viii
July 2022	Expanding program for students experiencing homelessness or aging out of foster care (HB 1601) - Washington is supporting the needs of college students experiencing homelessness and those who aged out of foster care in 4-year public and 2-year public institutions with an investment that expanded the pilot to all public community & technical colleges. (WSAC)	3a-viii
July 2022	Expansion of ECEAP eligibility and work to reach ECEAP entitlement by 2026-27 and then 2030-31. (DCYF)	3c
July 2022	Update the Working Families Tax Credit (HB 1888) - The credit is intended to stimulate local economic activity, advance racial equity, and promote economic stability and well-being for working individuals and their families in Washington. (DSHS, DOR)	3d
July 2022	Expansion of home visiting slots with $2.1M (DCYF) - Made a deep, sustained and growing commitment to support a range of home visiting programs.	4
July 2022	Strengthen Apple Health access for Washingtonians - Funding to expand Apple Health for Washington residents regardless of immigration status, beginning in January 2024. - In 2022, the legislature provided funding to HCA to explore what system and procedure changes would be needed to facilitate expansion. The 2023 legislative session will determine if HCA will implement the program.	4a
July 2022	Apple Health and Homes (HB 1866) - Assists persons receiving community support services through medical assistance programs to receive supportive housing - Links health care and housing for those who need both. (Commerce)	4a
July 2022	Increasing Access to Reproductive Choice with $7.4M (DOH) - One-time grant for providers of abortion care that participate in the department's family planning and reproductive health program and which experienced drops in patient visit volume during the pandemic in order to maintain the availability of services for low-income Washingtonians.	4c
July 2022	WIC Food Security with $6.2M (DOH) - Funds to support WIC Food Insecurity, Infant Formula & e-FMNP programs.	4d

July 2022	Oral Health Equity Assessment with $170k (DOH) - Conduct an oral health equity assessment to identify unmet oral health needs and develop recommendations to advance positive oral health outcomes while reducing inequities through increased access to community water fluoridation.	4e
July 2022	Protect Washingtonians from charges for out of network health care services (HB 1688/SB 5618)	4f
July 2022	Quality housing for those living with disabilities (HB 1724) - Ensures oversight/coordination of permanent supportive housing resources.	5b
July 2022	Capital budget for affordable housing/homelessness (SB 5651)	5b
July 2022	Expansion of Recovery Residences pilot (Commerce)	5g
July 2022	Root Cause Analysis of Behavioral Health Issues in WA State with $90k (DOH) - Convene a work group to study the root causes of rising behavioral health issues in Washington communities.	5g, 5i
July 2022	Youth Suicide Prevention with $54k (DOH) - Coordination of a multi-agency approach to youth suicide prevention and intervention in support of launch of 988 Lifeline.	5g
July 2022	Children and Youth Behavioral Health Workgroup (SSB 1890) - The children and youth behavioral health work group is established to identify barriers to and opportunities for accessing behavioral health services for children and their families, and to advise the legislature on statewide behavioral health services for this population.	5g
July 2022	Expansion of School-Based Health Centers with $815k (DOH) - Expand grants to establish new school-based health centers and to add behavioral health capacity to existing school-based health centers.	5h
July 2022	Updating personal needs allowance (PNA) (SB 5745) - The PNA for clients receiving at home and community-based waiver services authorized by home and community services while living at home is increased to 300 percent of the federal benefit rate and shall not exceed the maximum personal needs allowance permissible under the federal Social Security Act.	6b
July 2022	Health & Human Services Coalition efforts - Integrated eligibility and ease of access to state system of benefits.	6c
July 2022	Care Connect Washington - Program that provides food and other necessities to people who need support while isolating at home. (Department of Health)	6d
July 2022	Transitional food assistance expansion (SB 5785) - DSHS will provide transitional food assistance to households that no longer receive Temporary Assistance for Needy Families.	6e
July 2022	Establish Pediatric Community Health Worker Program with $650k (DOH) (ESSB 5693) - Create a curriculum and provide training for community health workers in primary care clinics whose	6f

	patients are significantly comprised of pediatric patients enrolled in medical assistance under chapter 74.09 RCW, beginning January 1, 2023, in support of the health care authority's two-year grant program.	
July 2022	ABD program eligibility is expanded for victims of human trafficking (HB 1748)	6f
July 2022	Eliminating ABD/HEN Mid-Certification Review (DSHS)	6f
July 2022	Medicaid State Plan asset test removal (Health Care Authority)	6f
July 2022	Created more wraparound services for youth and young adults discharging from a publicly funded system of care (HB 1905) - Intent is to reduce homelessness. - Office of Homeless Youth (Commerce) and DCYF must develop and implement a rapid response team to support youth and young adults exiting publicly funded care system.	7d
July 2022	Washington State is one of first states in country to stop harmful and outdated practice of referring parents to child support after a child is placed into foster care	7d
July 2022	Judges can waive Legal Financial Obligations for those unable to pay for them (HB 1412) - Promotes successful community reentry and rehabilitation.	7f
July 2022	EcSA Economic Security for All pilot expansion (ESD) - Builds and tests locally developed workforce approaches to streamlining access to existing services and benefits with the goal of moving people out of poverty.	8a-i

BLUEPRINT FOR A JUST & EQUITABLE FUTURE

DISMANTLE POVERTY IN WASHINGTON

The 10-Year Plan to Dismantle Poverty in Washington

A WORD FROM THE STEERING COMMITTEE

"As people experiencing the issues addressed in this plan, we are as hopeful as we are anxious about submitting it. Trust is something that comes hard for many of us, and a plan without action is just a plan. We wholeheartedly want to believe that the time and energy we invested in this effort will result in the policy and program changes so desperately needed for our children, families, and communities, but remain concerned that politics and privilege will trump the bold steps needed for more Washingtonians to achieve the independence, self-determination, and economic success that can be shared with our children and grandchildren.

We are deeply grateful to Governor Inslee for taking a stand on poverty and inequality. For those of you with the power to now decide whether and how to act, please remember that millions of Washingtonians, just like us, will continue to struggle to keep a roof over our head, struggle to feed our children, and live without peace of mind that things will be okay. Please don't forget that we are the people behind the numbers, the lives that will benefit should you choose to act." *~ Drayton Jackson and Juanita Maestas, Co-Chairs*

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ACKNOWLEDGEMENTS

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Steering Committee Members & Staff

Penny Archer • **Marcy Bowers** • **Rebecca Boyer** • **Ceasar Carter** • **Ashley Chambers** • **Christianna Clinton** • **Liliana Cory** • **Krystina Cummins** • **Jennifer Delia** • **Claudia Franson** • **Sherri Hall** • **Monette Hearn** • **Johnathan Hemphill** • **Victoria Hilt** • **Miranda Hunter** • **Drayton Jackson** **Tracy Lang'at** • **Juanita Maestas** • **Korbett Mosesly** • **Dante Pollard** • **Shereese Rhodes** • **Amy Roark** • **Kristina Sawyckyj** • **Carla Smith** **Alina Swart** • **Omar Cuevas Vega**

Co-Leads

Drayton Jackson (Kitsap School Board) • **Diane Klontz** (Department of Commerce) • **Juanita Maestas** (Statewide Poverty Action Network) • **Tim Probst** (Employment Security Department) • **David Stillman** (Department of Social & Health Services)

Staff, Interns, & Consultants

Carol Albert (Department of Social & Health Services) • **Briana Allen** (Department of Social & Health Services) • **Marie Bruin** (Employment Security Department) • **Cecil Daniels** (Department of Commerce) • **Roxanne Garcia** (PRWG Intern) • **Jorji Knickrehm** (Department of Social & Health Services) • **Patricia Lally** (Racial Equity Works) • **Lori Pfingst** (Department of Social & Health Services) • **Babs Roberts** (Department of Social & Health Services) • **Lindsay Morgan Tracy** (Department of Social & Health Services) • **Amy Willerford** (PRWG Intern)

General Work Group Members

Amina Ahmed & Hien Kieu (Partners in Employment) • **Jim Baumgart** (Office of Governor Inslee) • **Mark Bergeson & Ami Magisos** (Student Achievement Council) • **Sarah Buhayar & Lindsay Hunsicker** (Bill & Melinda Gates Foundation) • **Luba Bezborodnikova & Nicole Rose** (Department of Children, Youth, & Families) • **Sue Birch & James Brackett** (Health Care Authority) • **Gary Chandler** (Association of Washington Businesses) • **Jim Cooper** (United Ways of Pacific Northwest) • **Senator Manka Dhingra** (Washington State Senate Democrats) • **Eu-wanda Eagans** (Goodwill Industries of the Olympic & Rainier Region) • **Colleen Echohawk** (Chief Seattle Club) • **Larry Eyer** (Community Action Partnership) • **Cheryl Fambles** (Pacific-Mountain Workforce Development Council) • **Erin Frasier** (State Board of Community & Technical Colleges) • **Nova Gattman** (Work Force Training & Education Coordinating Board) • **Claude Green** (Mentor Washington) • **Ellen Austin Hall** (Attorney General's Office) • **James Harms** (Department of Corrections) • **Lonnie Johns-Brown** (Office of the Insurance Commissioner) • **Kate Kelly** (Washington Hospitality Association) • **Haley Lowe** (Office of Superintendent of Public Instruction) • **Nickolaus Lewis** (Lummi Nation) • **Sandra Miller** (Office of the Attorney General) • **Erin Monroe** (Workforce Snohomish) • **Nam Nguyen** (Commission on Asian Pacific American Affairs) • **Daisye Orr** (Department of Health) • **Sharon Pesut** (Partners in Careers) • **Dona Ponepinto** (United Way Pierce County) • **Ed Prince** (Commission on African American Affairs) • **Michael Reichert & Josephine Tamayo Murray** (Catholic Community Services) • **Maria Sigüenza** (Commission on Hispanic Affairs) • **Neil Strege** (Washington Business Roundtable) • **Marisol Tapia Gonzales** (Puget Sound Training Center) • **Traci Underwood** (Washington State Coalition Against Domestic Violence) • **Julie Watts & Liz Olson** (Washington State Budget & Policy Center) • **Jan Wichert** (Vancouver Housing Authority) • **Christina Wong** (Northwest Harvest) • **Senator Hans Zeiger** (Senate Republicans)

Presenters & Advisors

Penny Archer (Moses Lake Food Bank) • **Laura Armstrong** (La Casa Hogar) • **Amy Bell** (Goodwill Industries of the Olympic and Rainier Region) • **Rachel Turner-Benson** (Goodwill Industries of the Olympic & Rainier Region) • **Mark Bergeson** (Washington Student

Achievement Council) • **Brian Bonlender** (Department of Commerce) • **Kelly Blucher** (Goodwill Industries of the Olympic & Rainier Region) • **Marcy Bowers** (Statewide Poverty Action Network) • **Norman Brickhouse** (Goodwill Industries of the Olympic and Rainier Region) • **Amador Castro** (Jobs for Washington Graduates) • **Colleen Chalmers** (Chief Seattle Club) • **Sarah Chaoui** (Intern, Disability Rights Washington) • **Nawiishtunmi Conner** (Chief Seattle Club) • **D'Adre Cunningham** (Washington Defender Association) • **Felice Davis** (Washington Corrections Center for Women) • **LaNesha DeBardelaben** (Northwest African-American Museum) • **Karen Dove** (Apprenticeship Pathways to Construction Careers) • **Cindy Farnsworth** (Goodwill Industries of the Olympic and Rainier Region) • **Darya Farivar** (Disability Rights Washington) • **Maria Flores** (Office of Superintendent of Public Instruction) • **Emil Floresca** (The Accelerator YMCA) • **Edel Galgon** (Intern, Disability Rights Washington) • **Leon Garnett** (Byrd Barr Place) • **Cecilia Gonzales** (La Casa Hogar) • **Kim Gunning** (Columbia Legal Services) • **Dr. Marisa Herrera** (Shoreline Community College) • **Darrell Hillaire** (Lummi Nation) • **David Hlebain** (Statewide Poverty Action Network) • **Elizabeth Hodges** (Communities in Schools) • **John Holland** (Community Services of Moses Lake) • **Rebecca Hopper** (YouthWorks participant) • **Heather Hudson** (Washington Student Achievement Council) • **Bill James** (Lummi Nation) • **Gerald James** (Lummi Nation) • **Heather Jefferson** (Lummi Nation) • **Princene Johnson** (Beacon of Washington) • **Marie Jubie** (Disability Rights Washington) • **Jeremiah "Jay" Julius** (Lummi Nation) • **Jayme Kaniss** (Goodwill Industries of the Olympic and Rainier Region) • **Tedd Kelleher** (Department of Commerce) • **Rebecca Kinley** (Lummi Nation) • **Amber Leaders** (Office of Governor Inslee) • **Dr. Terry Leas** (Moses Lake Community College) • **Portia Lee** (participant of Goodwill Industries of the Olympic & Rainier Region's Women to Work program) • **Laurie Lippold** (Partners for Our Children) • **Shannon Loew** (FIX Impact Capital) • **Victor Loo** (Asian Counselling & Referral Services) • **David Lord** (Disability Rights Washington) • **Elana Mainer** (Room One) • **Reneeka Massey-Jones** (Equity in Education Coalition) • **Brent Mayo** (Grant County Economic Development Council) • **Michael Mirra** (Tacoma Housing Authority) • **Sharonne Navas** (Equity in Education Coalition) • **Michael Nguyen** (Seattle Teacher Residency) • **Frank Ordway** (Department of Children, Youth, and Families) • **Estela Ortega** (El Centro de la Raza) • **Aija Ozolin** (Community Advocate – Reach Center graduate) • **Erika Koch Pablo** (Strategic Advisor) • **John Page** (Equity in Education Coalition) • **Dr. Robbie Paul** (Nez Perce, Washington State University) • **Chris Poulos** (Washington Re-entry Council) • **Lua Pritchard** (Asia Pacific Cultural Center) • **SL Rao** (Department of Commerce) • **Yolanda Rios** (Skill Source) • **Sara Robbins** (Solid Ground) • **Susanna Rudnitsky** (Community Services Specialist, Moses Lake) • **J Manny Santiago** (LGBTQ Commission) • **Marilyn Scott** (Upper Skagit Indian Tribe) • **Lawrence Solomon** (Lummi Nation) • **Jamie Stout** (Goodwill Industries of the Olympic & Rainier Region) • **Laura Lee Sturm** (Seattle Department of Transportation) • **Michelle Tinkler** (TACID, Pierce County) • **Silvie Valdez** (SL START) • **Gabriele Valencia** (WIOA youth participant, Family Services, Grant County) • **Deborah Wofford** (Washington Correction Center for Women) • **Kelsey Wiltfong** (former WorkFirst participant) • **Tamar Zere** (Green River College) • **Lin Zhou** (Bates Technical College)

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For Amina Ahmed and Tony Lee, who inspired so many to advocate for a just and equitable world.

INTRODUCTION

"In Washington State, more than a half-million children live in families that struggle to make ends meet. This is unacceptable anywhere, but especially in a state with so much prosperity." *~Governor Jay Inslee*

Blueprint for a Just & Equitable Future

For two years running, Washington has made national headlines for ranking as the Best State in the Nation by U.S. News & World Report.[1] Strong technology, manufacturing, and energy sectors, combined with high scores for health care, education, and opportunity, propel us to the top of the list. It is exciting many people recognize our state for what Washingtonians already know — our beautiful corner of the Pacific Northwest is indeed unique for all it has to offer.

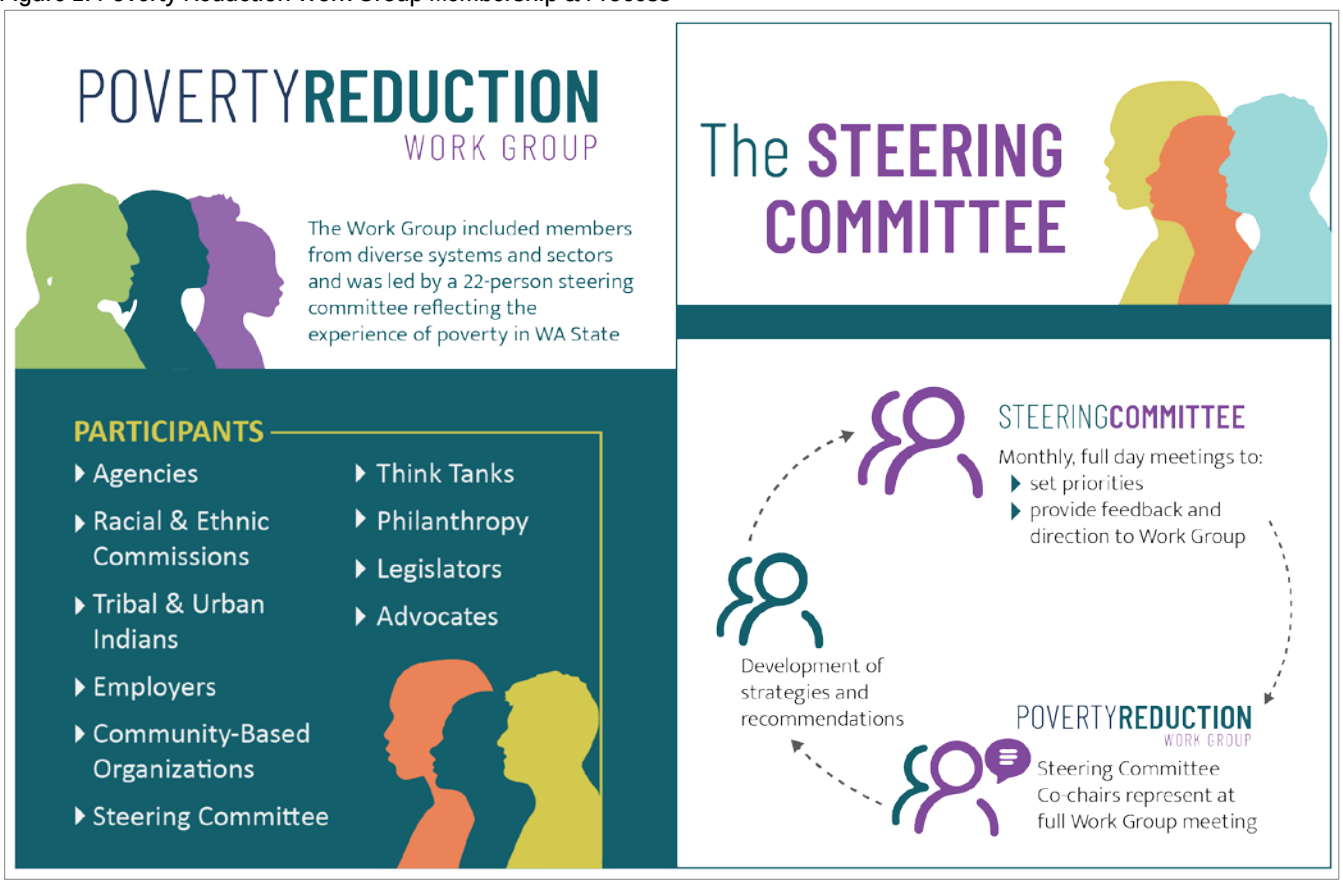
While there is much to be celebrated, data about our most precious resource — the individuals, children, families, and communities that call Washington state home — paint a more nuanced picture. **In 2019, 1.75 million Washingtonians — over 500,000 of them children — lived in a household that struggles to make ends meet; enough to fill 25 stadiums the size of Lumen Field.** Recent data show that the current economic downturn will only deepen these trends, possibly pushing poverty and inequality to their highest rates in 50 years.[2]

For at least one in four of our neighbors — likely many more due to the economic consequences of COVID-19 — the foundation needed to support them reaching their full potential is cracked, making it challenging to build for the future. Many more live on a financial fault line, with few resources to weather the life storms that can affect all of us — a sudden illness, a major car repair, or getting laid off. Before COVID-19 most were working, but finding it increasingly difficult to afford the basics in communities throughout the state. A disproportionate share of these people are Indigenous, Black, and Brown — the legacy of a social and economic system built on our history of colonialism, racism, oppression, and exclusion.

Washington state cannot reach its full potential until our residents can. That is why Governor Inslee created a Poverty Reduction Work Group (PRWG) and tasked it with creating a comprehensive 10-year plan to reduce poverty and inequality in Washington state. This 10-year Plan is the culmination of PRWG's work over the last two years, and includes recommendations that agencies, legislators, businesses, community-based organizations, and funders can all work on together to ensure social and economic opportunity and well-being exists for all Washingtonians, and that it be passed on from this generation to the next … and the next … and the next.

The goal of this strategic plan is to build a just and equitable future in which all Washingtonians have their foundational needs met, and the resources and opportunities they need to thrive.

Figure 1: Poverty Reduction Work Group Membership & Process



Governor Inslee's Poverty Reduction Work Group

Governor Inslee created the Poverty Reduction Work Group (PRWG) via directive[3] in November 2017. PRWG is co-led by the state departments of Commerce, Employment Security, and Social & Health Services, in partnership with tribal and urban Indians, state racial and ethnic commissions, employers, community-based organizations, legislators, advocates, and philanthropy. A steering committee made up of 22 people reflecting the diverse demographic and geographic experience of poverty set priorities and direction for the development of strategies and recommendations.

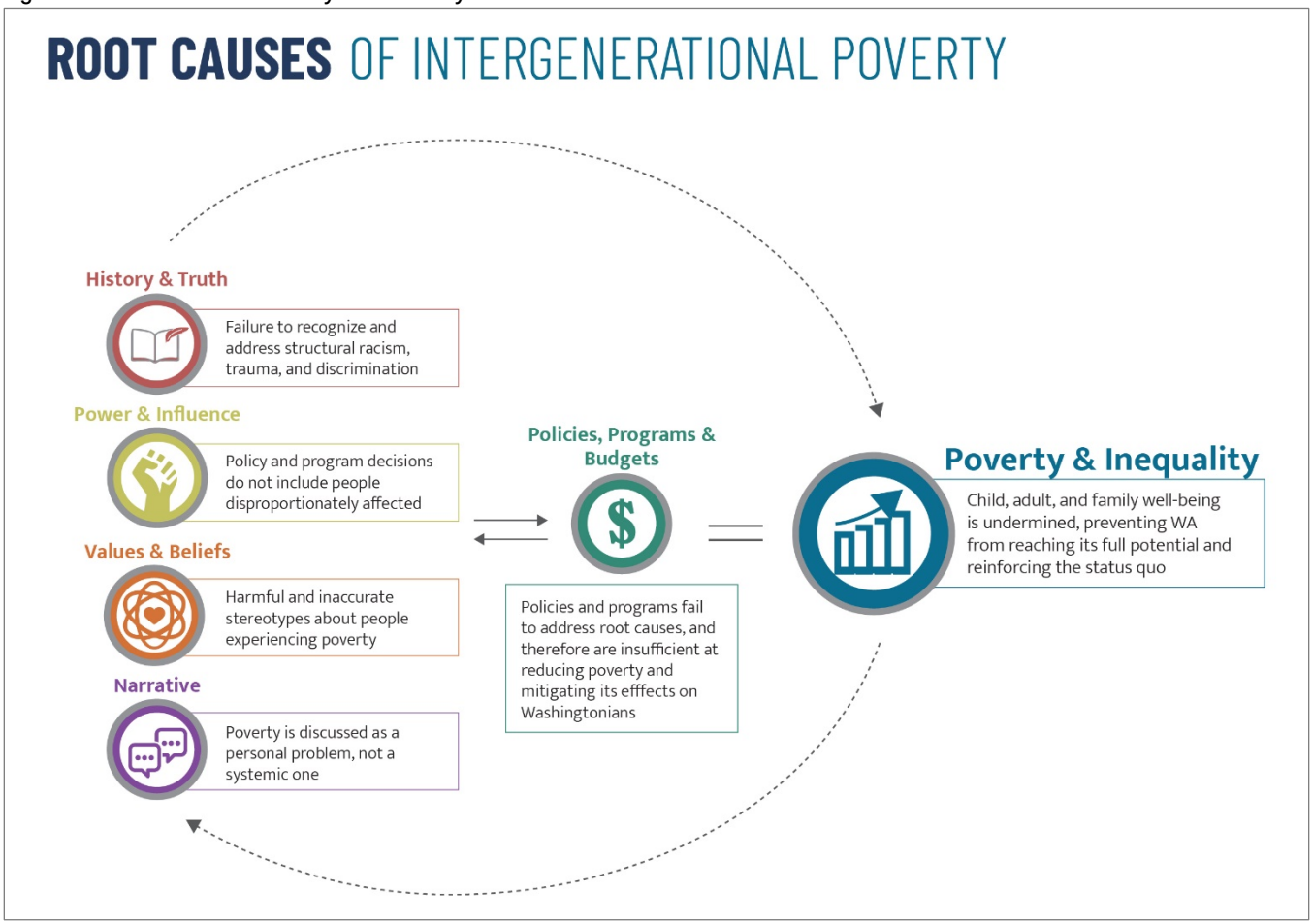
Process & Principles for Developing the Plan

The Steering Committee and general work group met monthly, but separately, with two co-chairs from the Steering Committee attending both meetings (Figure 1). Collectively, PRWG adopted the following principles to develop and prioritize recommendations in the strategic plan.

Addressing root causes AND the urgency of now. PRWG prioritized addressing the root causes of poverty in the development of the strategic plan, recognizing that past poverty reduction efforts fell short by focusing too narrowly on symptoms rather than the underlying causes (Figure 2).[4] Yet, there is also an urgent need to provide resources to the 1.75 million children, adults, and families struggling to make ends meet today. Our recommendations, therefore, address root causes and the urgency of now. In doing so, they are designed to mitigate the experience of poverty, as well as prevent it from happening altogether.

Elevating the expertise and influence of people experiencing poverty. As the foremost experts on their lives, people experiencing poverty are essential to the design of effective solutions. Through the creation of the Steering Committee, PRWG ensured people disproportionately affected by poverty had a direct say in the strategies and recommendations from which they stand to benefit (Bright Spot #1). PRWG also enlisted hundreds of experts from organizations serving people experiencing poverty, as well as communities throughout the state, to inform the 10-year Plan.

Figure 2: Root Causes of Poverty Identified by PRWG



#1: STEERING COMMITTEE

Recognizing that people experiencing poverty are the foremost experts in their lives, PRWG prioritized elevating the leadership and expertise of those most affected by poverty in the development of strategies and recommendations for the 10-year strategic plan. Toward that end, the group unanimously decided to create a Steering Committee whose role was to set priorities for the plan and provide honest and critical feedback throughout the process. Quotes from Steering-Committee members are presented throughout the report to give voice to the specific issues, themes, and solutions highlighted throughout the plan.

The 22-member Steering Committee was convened by PRWG member Statewide Poverty Action Network. Membership includes people from urban, suburban, rural, and tribal areas in Washington state, and has diverse representation from communities most affected by poverty, including: Indigenous, Black and Brown people, people with disabilities, LGBTQ, immigrants and refugees, and single parents. The steering committee held monthly, full-day meetings to determine priorities, and elected two co-chairs to represent them in the full PRWG meetings.

The Steering Committee provided the knowledge and expertise PRWG needed to develop a strategic plan that, if implemented, would actually work. They are also the heart and soul of the effort – grounding the larger group in what it means to experience poverty in Washington state, and why listening to people most affected by it is essential for us to succeed in reducing it.

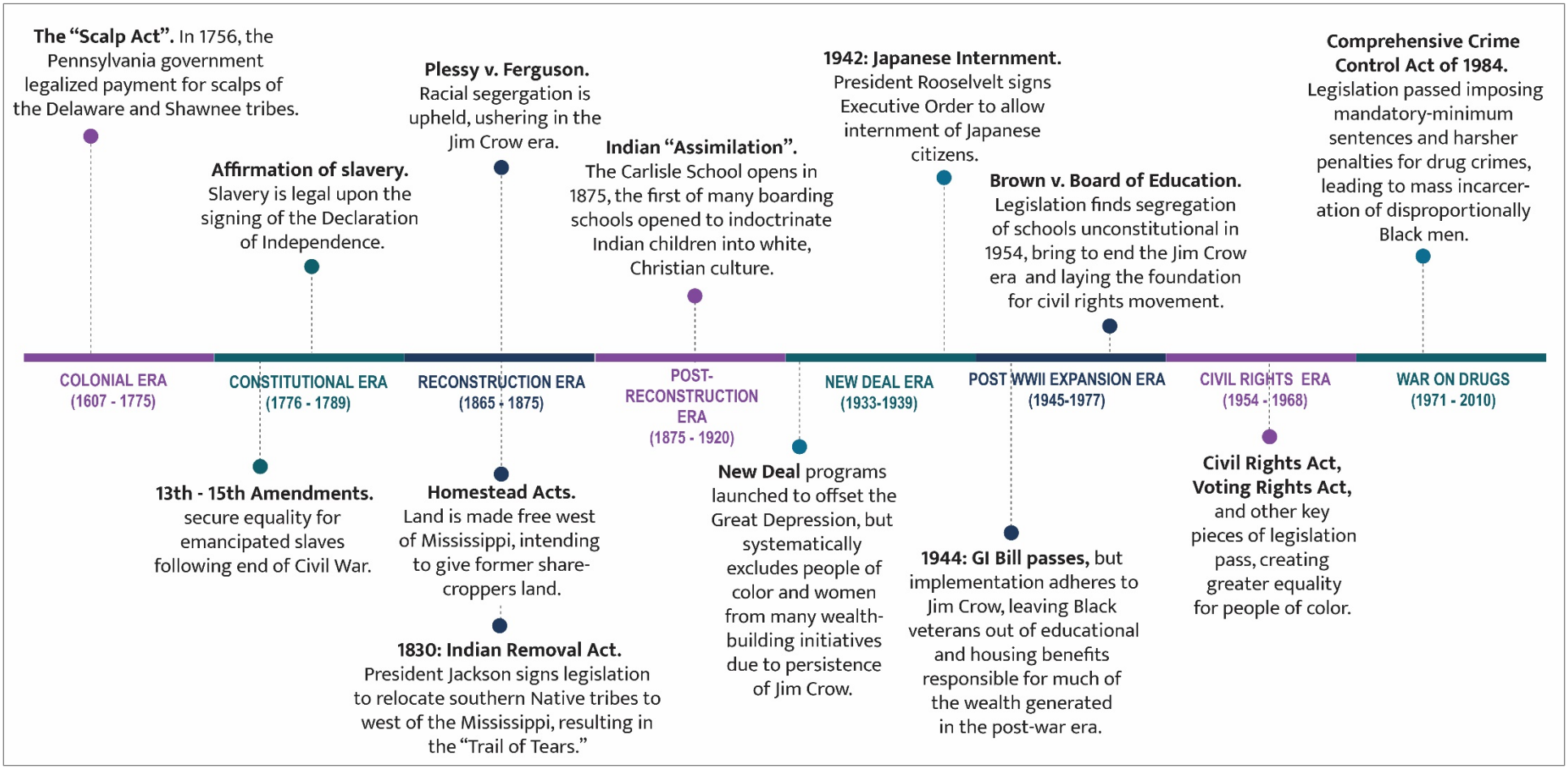
"If you truly believe that racial groups are equal, then you also believe that racial disparities must be the result of racial discrimination." *~Ibram X. Kendi, Stamped from the Beginning*

Race and social justice at the center. The experience of poverty is not shared equally. Indigenous, Black, and Brown Washingtonians, women, families with young children, youth, rural residents, immigrants and refugees, seniors, LGBTQIA+, and people with disabilities have poverty rates above the state average. Reducing poverty in a way that achieves equity for each of these groups is essential for Washington state to maximize the well-being of its residents and fully realize the talent, potential, and contributions they have to offer.

The plan centers racial equity. With poverty rates nearly double that of the state average, we cannot untangle the undue burden of poverty among Indigenous, Black, and Brown Washingtonians from the history and perpetuation of colonialism, oppression, and racism embedded throughout systems that influence the opportunities we need to succeed, such as education, employment, and housing. Indeed, throughout history policies have systematically excluded people of color from the opportunities we all need to thrive, directly affecting their disproportionate experience of poverty today (Figure 3).

Racial discrimination also overlaps with other forms of discrimination — ageism, sexism, classism, heterosexism, homophobia, xenophobia, and ableism — to deepen the experience of poverty. Understanding the intersection

Figure 3: Examples of Significant U.S. Policies Affecting Poverty Outcomes by Race and Ethnicity



Source: Adapted from Ellis, W. (2019) Community Resilience: A Dynamic Model for Public Health. Retrieved from ProQuest and Theses Database (UMI No. 13811038)

of race with all forms of inequality, and how they compound, is necessary to fully realize the potential of the 10-year Plan strategies and recommendations upon implementation.

A racial equity consultant facilitated PRWG's work with a racial equity toolkit (Appendix A) — a process designed to guide, inform, and assess how policies, programs, and practices burden or benefit people of color — to ensure strategies and recommendations address the disproportionate experience of poverty among Indigenous, Black, and Brown Washingtonians with intention.

Blending evidence, innovation, and collaboration. PRWG placed a high priority on using existing research and evidence to formulate the recommendations and, in many cases, relied on the efforts of other work groups and task forces with expertise on specific issues related to poverty. However, existing knowledge and practice has thus far failed to meaningfully reduce the demographic and geographic gaps in poverty among people of color and other groups disproportionately affected. Therefore, PRWG also prioritized innovative approaches informed by groups most affected, including and especially those recommended by Steering Committee members. We believe this approach — blending strong evidence with solutions informed by people experiencing poverty — increases the likelihood that the recommendations will succeed once implemented.

Inspiring hope and building on resilience. Current policies, programs, and practices are based upon a long legacy of shaming and punishing people in poverty, instilling a sense of fear and undermining progress. Strong and growing evidence from brain science and behavioral economics shows that children, adults, and families experiencing poverty are remarkably resilient, especially when they have a sense of hope. The recommendations contained in this plan are intentionally crafted to eliminate shame and punishment from the experience of poverty, instill hope, and leverage people's innate resiliency.

Building Momentum & Taking Action

Systemic change becomes possible when we recognize the "system" is us — people working in state and local government, non-profits, businesses, and philanthropic entities across the state all have a role to play. It simply takes a willingness to act. To stay informed about the state's poverty reduction efforts and learn how you can support the strategies and recommendations, visit www.dismantlepovertyinwa.com and sign up for updates and events.

"The opposite of poverty is not wealth — it's justice." ~ Bryan Stevenson, author, Just Mercy

A Washington Without Poverty & Injustice

The effects of economic hardship are well-documented and crystal clear: poverty causes negative outcomes for children, adults, and families[5] and costs the U.S. economy over $1 trillion annually.[6] A Washington without poverty and injustice would be substantially better off (Figure 4) — well-being would soar due to improved education, health, and employment outcomes, and rates of homelessness, child neglect, addiction, and crime would decrease. Our communities would be more vibrant, healthy, and safe, with substantial economic benefits: for every $1 spent on reducing childhood poverty, we save at least $7 in return.[7] **In Washington state, the economy would be nearly $40 billion stronger if poverty were reduced and racial disparities in income were eliminated**.[8]

Reducing poverty and inequality is not just about the economic returns — it is also about dignity, humanity, and belonging.[9] When Washingtonians have their foundational needs met and believe their lives are valued, they are more likely to thrive and fully contribute to their families, schools, communities, and jobs. Investments in economic stability, equity, and inclusion benefit all of us.

Figure 4

Visibility & Belonging: Data Trends & Limitations

To fully realize a just and equitable future in Washington state, we need to take stock of the past. Despite the narrative of a strong economy before the COVID-19 induced economic downturn, conservative estimates show nearly one in four Washingtonians — 1.75 million people, including 500,000 children — struggled to make ends meet.[10]

The burden of poverty is not equal — Indigenous, Black, and Brown people are disproportionately affected, as are rural residents, single mothers and fathers — especially those with young children — youth, seniors, people with disabilities, the LGBTQIA+ community, and immigrants and refugees. Structural racism intersects with all forms of oppression and inequality to undermine our collective well-being — when nearly a quarter of Washingtonians lack the basic building blocks of well-being, such as having enough food and a stable home, it prevents us from reaching our full potential as a state.

These outcomes are not due to chance, but rather are the product of inherently unjust and unequal policies, programs, and practices that have underwritten our economy for decades. Recent data show that the current economic downturn will only deepen these trends, possibly pushing poverty and inequality to their highest rates in 50 years.[11]

But even our best data systems are limited in the story they tell and contain significant cultural bias, reflective of the perspectives and interests of the people that created them. To address the root causes of poverty we need to disaggregate existing data to the greatest extent possible, as well as look beyond traditional data systems to tell a better story.

Decolonizing Data: The Pathway to a Better Story about Poverty & Inequality

Abigail Echohawk, Chief Research Officer for the Seattle Indian Health Board, explains how current data systems harm Indigenous people and why "decolonizing" data and storytelling is essential for making progress for all marginalized communities:[12]

> ***"When we think about data and how it's been gathered from marginalized communities, it was never gathered to help or serve us. It was primarily done to show the deficits in our communities, to show where there are gaps. And it's always done from a deficit-based framework ... what they don't talk about is the strengths of our community. Decolonizing data is about controlling our own story, and making decisions based on what is best for our people."*** *~Abigail Echohawk, Chief Research Officer, Seattle Indian Health Board*

Decolonizing data is a pathway to telling a better story about poverty and inequality. Working in partnership with communities most affected by poverty to improve data collection that is representative of their perspectives, experience, and strengths is key to dismantling myths and developing the most effective solutions. PRWG encourages policymakers and stakeholders to adopt the practice of letting people represented by data bring meaning to it to tell a better story and inform more effective solutions. In the meantime, triangulating existing data can provide some understanding of the size and extent of poverty and inequality in Washington state.

What Available Data Shows About the Burden of Poverty in Washington State

Official Poverty Measure. The official poverty level for the U.S. is based on a measure developed in 1963 during the War on Poverty and remains in wide use today to track economic hardship and determine eligibility and assistance levels for programs. In 2020, a family of three falls under the official definition of poverty if they make under $21,330 per year, no matter where they live in the continental U.S.[13] The severity of poverty is often defined as a ratio to the federal poverty level (FPL) (Table 1).

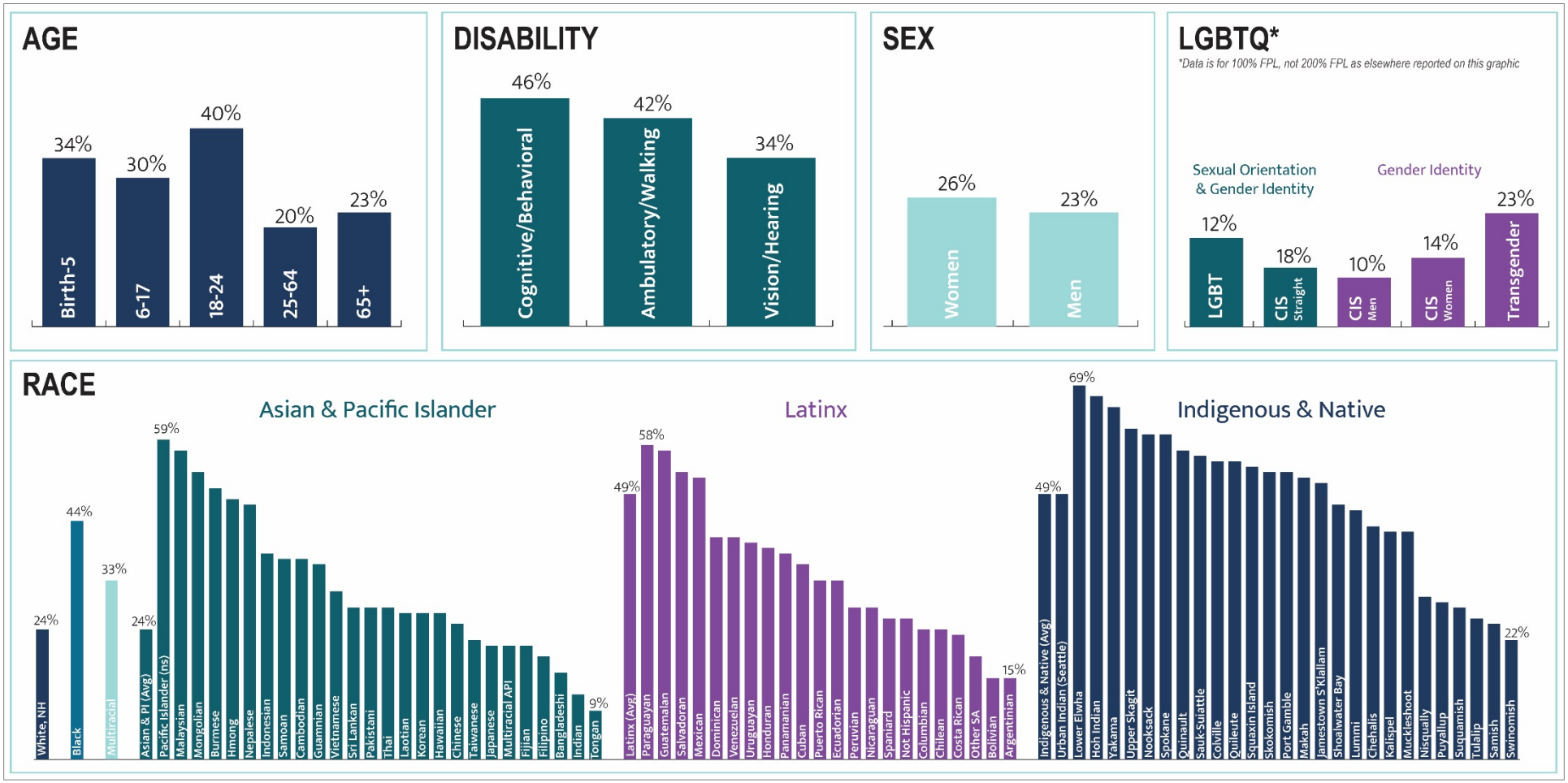
Table 1

SEVERITY	FEDERAL POVERTY LEVEL	INCOME FOR A FAMILY OF 3
Deep Poverty	0% – 49%	$0 – $10,859
Poverty	50% – 99%	$10,860 – $21,719
Low Income	100% – 200%	$21,720 – $43,440

Many researchers have increasingly criticized the official measure as outdated and insufficient at capturing the true extent of economic hardship in the U.S.[14] In recent decades, new measures have emerged to overcome limitations of the official poverty measure by estimating actual cost-of-living for basic needs — such as housing, food, child care, and transportation — for different geographies, family size, and age of children (see Cost-of-Living Measures below). These measures consistently show that it takes at least 200% FPL to meet the basic needs of most families in most communities in Washington state. Therefore, PRWG uses 200% FPL to provide a conservative estimate of the size and extent of economic hardship in Washington state.

The official measure shows that 1.75 million Washingtonians — one in four (25%) — live below 200% FPL. Disaggregating the data shows that Indigenous, Black, and Brown Washingtonians experience much higher rates than the state average (with significant variation within racial and ethnic groups), as do young children and youth, women, people with disabilities, immigrants and refugees, LGBTQIA+, and rural populations (Figure 5 and Table 2)**.**

Figure 5: Percent of People Living Below 200% of the Federal Poverty Level by Age, Race, Disability, Sex, Sexual Orientation, & Gender Identity, Washington State 2014-2018*



Source: All data retrieved from the 2014-2018 American Community Survey, with the exception of LGBTQ data, retrieved from the UCLA Williams Institute.

Table 2: Percent of People Living Below 200% by County, 2014-2018

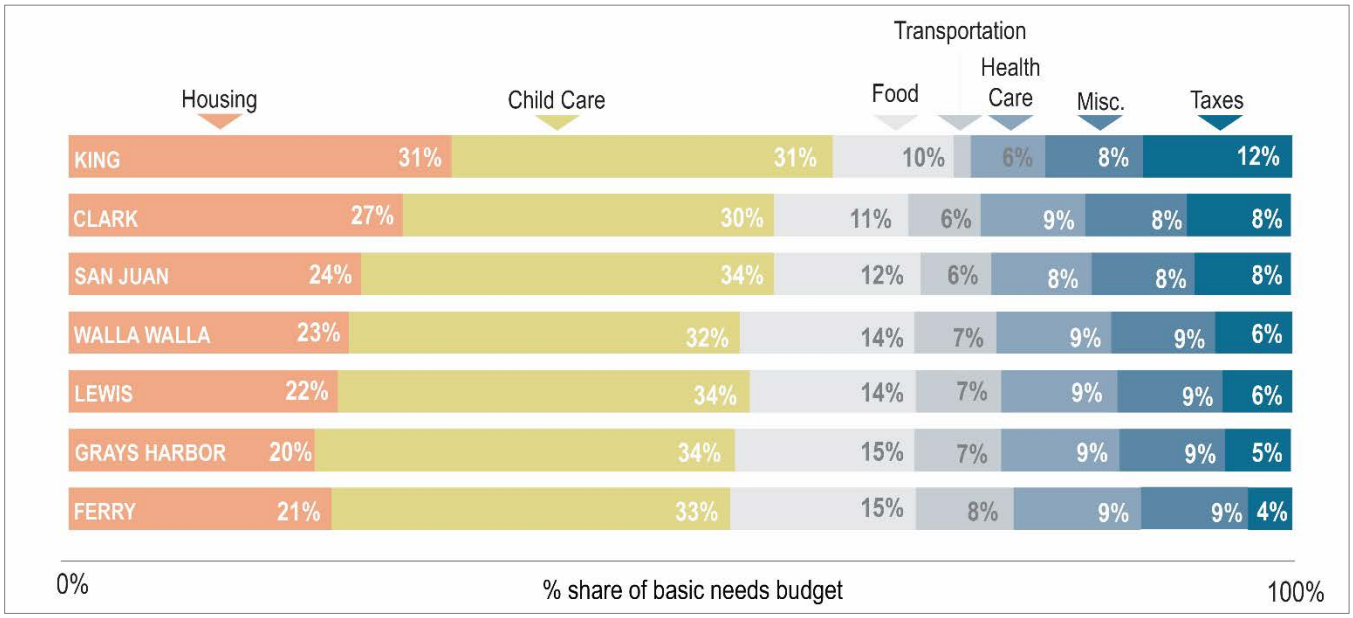
PERCENT LIVING BELOW 200% FEDERAL POVERTY BY COUNTY, WASHINGTON, 2014-2018			
Adams	50%	Lewis	34%
Asotin	35%	Lincoln	30%
Benton	28%	Mason	32%
Chelan	32%	Okanogan	45%
Clallam	34%	Pacific	37%
Clark	24%	Pend Oreille	34%
Columbia	30%	Pierce	25%
Cowlitz	34%	San Juan	25%
Douglas	33%	Skagit	27%
Ferry	41%	Skamania	27%
Franklin	37%	Snohomish	19%
Garfield	28%	Spokane	32%
Grant	42%	Stevens	34%
Grays Harbor	35%	Thurston	25%
Island	22%	Wahkiakum	25%
Jefferson	30%	Walla Walla	33%
King	19%	Whatcom	31%
Kitsap	21%	Whitman	46%
Kittitas	33%	Yakima	45%
Klickitat	38%	Washington	23%

Source: 2014-2018 American Community Survey

Cost-of-Living Measures. While using 200% FPL is a step in the right direction for how we measure the extent of economic hardship, it still suffers from the limitations inherent to the official measure, most notably: it does not reflect the modern costs incurred by families in the 21st century, and it does not adjust for geography, family structure, or age of children, all of which significantly influence what a household needs to get by.

Over the last two decades, new measures and tools have emerged to overcome the limitations of the official measure and provide a more accurate picture of the budget needed for an individual or family to meet their foundational needs. One such measure — the Self-Sufficiency Standard[15] — shows that in most places in Washington state, it takes much more than 200% FPL to make ends meet, regardless of household size (Figure 6). Housing and child care alone for families with children consumes over half of a family's budget in many communities in Washington state (Table 3).

Figure 6: Cost of a Basic Needs Budget by Expense Type, Select WA Counties 2020



Source: University of Washington Center on Women's Welfare 2020 Self-Sufficiency Standard

Table 3: Self-Sufficiency Standard by Family Type as a Ratio of the Federal Poverty Level

COUNTY	SELF-SUFFICIENCY STANDARD BY FAMILY TYPE							
	1 Adult	SSS: FPL Ratio	1 Adult + 1 Preschooler	SSS: FPL Ratio	1 Adult+ 1 Preschooler+ 1 School-Age	SSS: FPL Ratio	2 Adults + 1 Preschooler+ 1 School-Age	SSS: FPL Ratio
Benton (Kennewick-Richland)	$24,329	112%	$46,006	212%	$54,373	250%	$62,044	286%
Clark	$30,757	142%	$55,285	255%	$64,600	297%	$72,706	335%
Grays Harbor	$20,721	95%	$42,376	195%	$51,171	236%	$59,240	273%
Island	$24,973	115%	$50,830	234%	$61,448	283%	$69,762	321%
King (City of Seattle)	$36,065	166%	$69,215	319%	$82,045	378%	$86,193	397%
King (East)	$43,774	202%	$79,386	365%	$92,661	427%	$95,488	440%
King (South)	$32,506	150%	$64,925	299%	$77,145	355%	$81,902	377%
Kitsap (South)	$25,356	117%	$48,498	223%	$57,662	265%	$65,709	303%
Lewis	$21,495	99%	$43,763	201%	$52,342	241%	$60,224	277%
Pend Oreille	$19,754	91%	$36,400	168%	$45,949	212%	$53,779	248%
Pierce (West Cities)	$26,610	123%	$50,480	232%	$59,612	274%	$67,909	313%
Skagit	$25,186	116%	$51,102	235%	$61,243	282%	$69,138	318%
Snohomish	$36,791	169%	$64,053	295%	$74,590	343%	$82,658	381%
Spokane	$20,768	96%	$41,923	193%	$50,549	233%	$58,360	269%
Thurston	$25,466	117%	$47,669	219%	$56,279	159%	$64,277	296%
Whatcom	$24,517	113%	$50,727	234%	$60,985	281%	$68,941	317%
Yakima	$21,896	101%	$41,123	189%	$49,040	226%	$56,765	261%

Source: University of Washington Center on Women's Welfare 2020 Self-Sufficiency Standard

Intergenerational Poverty Measures. The duration of an individual's or family's experience with poverty may be episodic or longer-term, depending on the circumstances. Following the Great Recession in 2008, for example, many middle-class families found themselves struggling to make ends meet for the first time, but rebounded as the economy recovered. For families with a history of poverty, the experience can be harder to recover from,

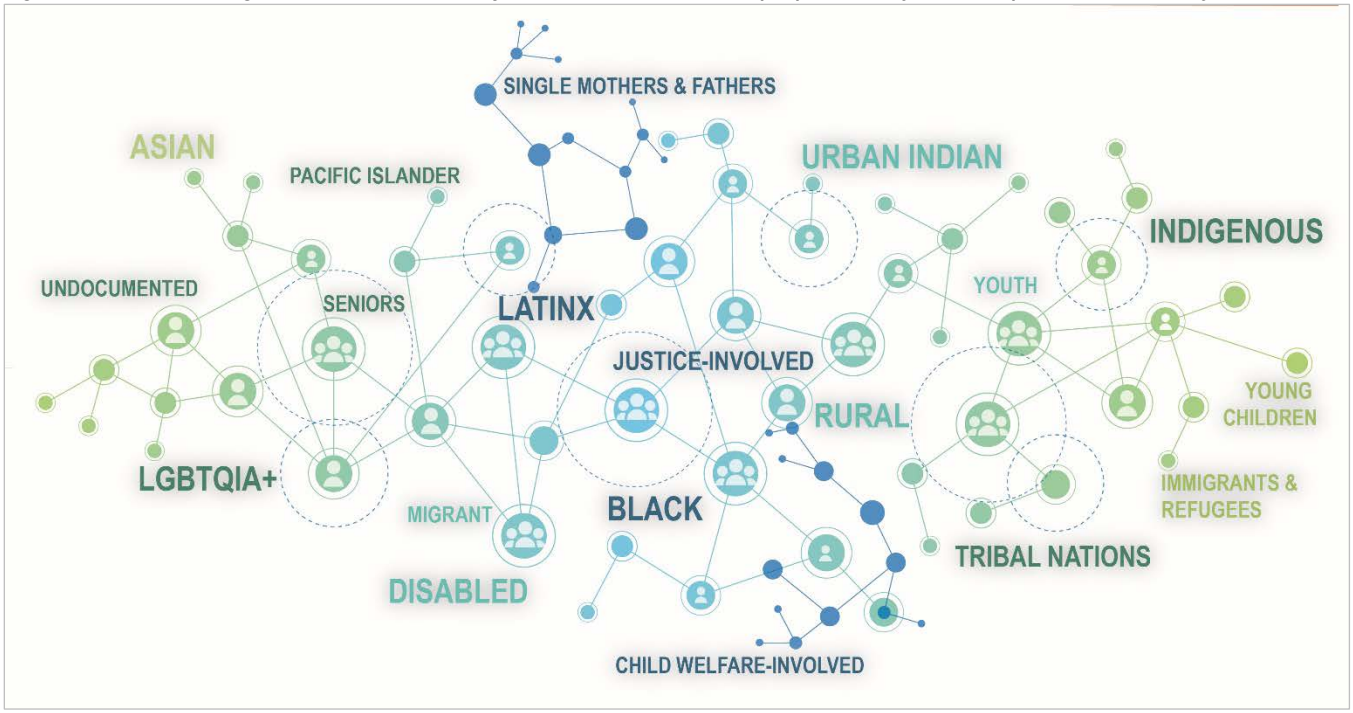
often spanning generations. Increasingly, poverty is a condition that people cycle in and out of overtime, a product of a changing economy, unstable labor market, and growing inequality.

Research shows that the experience of child poverty, even if short, can have a lifelong impact and consequences for future generations. Efforts are emerging around the country to define and measure intergenerational poverty, as well as evaluate "two-generation" or "multigenerational" policies and programs to end the cycle of poverty in families. While there is not yet a consensus on how to measure and track intergenerational poverty, estimates show that 46% of children receiving food assistance in 1997 remain on food assistance today, suggesting that rates of intergenerational poverty are likely high and that policies and programs could be more effective in reducing it.[16]

Increasing Visibility of People Disproportionately Affected in Poverty Discussions

Taken together, the above data show that poverty and inequality in Washington state is extensive, with significant intergenerational consequences, but available data is limited in the story it tells. Traditional poverty data only scratches the surface of the experience of poverty in Washington state, too often causing harm to the people it represents and those it doesn't. Most data systems are limited in their ability to show how race intersects with other identities (e.g., gender identity, sexual orientation) and circumstances (e.g., rural, single parent) to deepen the experience of poverty, and many groups disproportionately affected don't even show up in traditional data systems, rendering them invisible in discussions that have a significant impact on their lives (Figure 7).

Figure 7: Understanding How Racial & Social Injustice Contributes to Disproportionality in the Experience of Poverty is Essential



For example, the U.S. Census Bureau does not collect information on gender identity, so historical poverty rates for the LGBTQIA+ community are unavailable. Yet, recent data show that members of the LGBTQIA+ community have higher rates of poverty than their straight peers, and within the LGBTQIA+ community transgender women and men have higher rates than their cisgender peers.[17] Historical oppression and legal exclusion plays a significant role in LGBTQIA+ poverty, leading to lower education and health outcomes, higher rates of psychological distress, and barriers in obtaining adequate services.[18] For LGBTQIA+ of color, the disparities deepen.

Data on poverty for people with disabilities is also limited. Census data provides a cursory understanding, showing that people with disabilities have higher rates of poverty than the state average, especially among those with a behavioral or physical disability. Further breakdowns show that race exacerbates the burden of poverty among children and adults with disabilities, and over half of working-age adults with a disability are not in the work force. Severity of disability plays a role, but social exclusion and lack of workplace accommodations are key factors to address to reduce their disproportionately high rates of poverty.[19]

There are unique issues affecting any group that disproportionately experiences poverty, but race and social injustice is too often the common denominator. Greater understanding of the intersection of race with age, sex, gender, sexual orientation, immigration status, and disability is foundational to building a Washington without poverty and injustice. Data systems need to be disaggregated to the greatest extent possible and triangulated with multiple sources, and the stories of children, adults, and families most affected by poverty and injustice are data too. A just and equitable future is dependent on increasing visibility, power, and influence of people historically excluded from data and policy discussions.

STRATEGIES & RECOMMENDATIONS

"I am the light at the end of the tunnel for my family. I need someone who is truly committed to helping me succeed so I can overcome this generational curse." ~ *PRWG Steering Committee member*

Overall, eight strategic themes emerged from the work group (Figure 8), with 60 specific recommendations that broadly accomplish three objectives: (1) lay a solid foundation for building a just & equitable future; (2) mitigate the experience of poverty by maximizing the system we have; and (3) preventing the experience of poverty by building the inclusive economy we need. The strategies and recommendations are informed by existing data and research, people experiencing poverty and organizations working on their behalf, and innovations happening in communities in Washington state and throughout the country. Collectively, they serve as a blueprint for a just and equitable future in which all Washingtonians have their foundational needs met and the resources and opportunities they need to thrive.

Figure 8

STRATEGY 1. Understand structural racism, inequality and historical trauma, and take action to undo their harmful effects in state policy, programs, and practice.

The causes and consequences of poverty are experienced most profoundly among Indigenous people and people of color from all backgrounds and identities in Washington state. A large body of research draws a direct, causal relationship between structural racism, historical trauma, and the creation of policies, programs, and practices that result in inequitable outcomes.[20] Reducing poverty in Washington state, therefore, requires an approach that strategically centers race and how it intersects with other forms of inequality and injustice to lay a foundation for a just and equitable future.

Recommendation 1a. **Require state entities to collaborate with the Office of Equity (Bright Spot #2) to develop trainings on historical trauma, institutional racism, and implicit bias that are required of all public employees in systems that touch upon the lives of people experiencing poverty**. The curriculum should be developed in collaboration with Black, Indigenous, and people of color-led leaders from diverse age, gender, class, language, immigration, LGBTQIA+, and disability backgrounds throughout Washington state, and be free of charge to state partner organizations.

Recommendation 1b. **Require state entities to collaborate with the Office of Equity to develop data, processes, and tools that prioritize equity in state policies, programs, practices, and partnerships**, including:

- Developing a racial and social equity tool and process to evaluate the effects of policy, program, and funding decisions on eliminating disproportionate economic, social, and health outcomes;
- Implementing human resource practices that increase diversity among leadership and staff throughout state government, and support the career trajectories of underrepresented people and communities;
- Implementing contracting practices that increase the diversity of state vendors and partners; and
- Building representative, integrated data systems that allow for accurate, robust, and consistent analyses on the well-being of the diverse people and communities residing in Washington state.

BRIGHT SPOT

#2: OFFICE OF EQUITY

The Office of Equity Task Force was created through a proviso in the state's 2019-2021 operating budget (Engrossed Substitute House Bill 1109). The Task Force recently submitted a proposal to create the Office of Equity, which outlines the following vision and mission.

VISION: Everyone in Washington has full access to the opportunities, power, and resources they need to flourish and achieve their full potential.

MISSION: The Office of Equity will promote access to equitable opportunities and resources that reduce disparities and improve outcomes statewide across government.

Read the full proposal for the Office of Equity at:
https://healthequity.wa.gov/TheCouncilsWork/OfficeofEquityTaskForceInformation

STRATEGY 2: Make equal space for the power and influence of people and communities disproportionately affected by poverty and inequality in decision-making.

> ***"We love our children. We work hard to get by. We are smarter than we are typically given credit for. How do you design a system without the input of the people using it and expect it to work? I think the greatest opportunity we have is to build understanding about our experiences and design a system together that is based in reality and believes we can be successful."*** *~PRWG Steering Committee member*

People experiencing poverty are the foremost experts on their lives and possess considerable knowledge as users of the systems and programs intended to assist them. Incorporating the knowledge and expertise of those most affected by poverty, as well as sharing power and resources with them, is essential to the design of equitable policies, programs, and practices that build a just and equitable future.

Recommendation 2a. **Provide resources to the Office of Equity for a collaboration with Indigenous, Black, and Brown leaders and organizations to develop a formal process for truth and reconciliation.** Truth and reconciliation efforts can be a powerful way to educate people about injustice, both past and present, and accelerate healing from the effects of historical trauma and its present day impacts. The process should include, but not be limited to:

- Acknowledgement of past injustices, including decolonization of education curriculums;
- Resources and spaces to support forgiveness and healing; and
- Investment to promote the health, wealth, and well-being of Indigenous, Black, and Brown communities.

Recommendation 2b. **Establish a state entity to elevate the expertise and influence of people disproportionately affected by poverty and inequality in the implementation of the 10-year Plan.** This entity should be designed in collaboration with the PRWG Steering Committee, agencies, legislators, and other major stakeholders to ensure:

- System-wide adoption of ensuring the active participation of people most affected by poverty throughout the development, finalization, and implementation of policies, programs, and practices that affect their lives;
- An organizational structure, principles, and practice that grants sufficient authority for such a body to have influence; and
- Members receive professional development, education, and training opportunities that maximize their participation and contributions.

Recommendation 2c. **Invest state resources to increase ownership capacity in communities most affected by poverty.** Partner with communities most affected by poverty to develop ownership capacity in poor

communities by building new "capital assets" that revitalize community centers, become financial assets owned by community organizations, employ local community members, support community-centered small business enterprise, and root people to a place with an incentive to remain and build it up for generations to come. (Bright Spot #3).

Recommendation 2d. **Fund meaningful access to legal assistance and representation for children, adults, and families disproportionately affected by poverty and racially biased systems.** Such aid should be available on an individual basis and in policy and program development to ensure just and equitable access to services and the successful implementation of the 10-year Plan.

Recommendation 2e. **Make high-speed, broadband internet universally available.** The digital divide has long been a concern for people with low incomes, and has become especially acute during COVID-19. Digital equity is necessary for full engagement in education and employment, and is increasingly important to support civic participation.

#3: COMMUNITIES OF CONCERN COMMISSION

The Communities of Concern Commission is a coalition of leaders from communities of color and poor rural communities that are disproportionately affected by poverty and have yet to fully benefit from the economic growth that is so apparent in many areas of Washington State.

Community organizations strongly rooted in poor communities of color and rural communities have the cultural understanding, imagination, and vision to create capital assets that will help reduce poverty and build stronger and more sustainable communities. These capital assets should be self-determined, managed and owned by the communities they serve. The Communities of Concern Commission doing business as the Washington Community Development Authority seeks to change structural barriers by partnering with the state to build the capacity of communities to conceive, design, finance, construct and manage the types of assets that are essential to reducing poverty. Communities of Concern seeks to:

- Make immediate changes to simplify public processes and procedures and remove barriers;
- Design funding for public programs to have the greatest strategic impact on poverty by designating it for and allowing access directly by communities to be invested for long term self-sufficiency;
- Involve community members in leading the effort to identify needs and design solutions to meet those needs through the development of community growth plans and funding strategies; and
- Increase collaboration with other federal, state, and local programs to provide more access and resources (e.g., education, employment related, health) based in poor communities.

(see Appendix B for the full Briefing Paper on Communities of Concern)

STRATEGY 3: Target equitable education, income growth, and wealth-building opportunities for children, adults, and families with low incomes.

In 2019, income inequality in the U.S. reached its highest level in the 50 years since the U.S. Census began tracking data, part of a decades-long trend[21] now widening due to the COVID-19-induced economic downturn.[22] Pre COVID-19, Washington had the 11th highest income inequality in the nation.[23] High levels of income inequality contributes to poverty by: stagnating wages and income of low- and middle-income households; limiting revenue that the state can invest in policies and programs that promote widespread social and economic mobility; and compounding racial gaps in health, wealth, and well-being.[24]

Simply having a job is often not enough to make ends meet — the majority (51%) of people with incomes below 200% FPL are working or actively looking for work. Even with recent minimum wage increases, many full-time workers are still unable to afford "the basics" — housing, food, transportation, health and child care — in communities throughout Washington state, primarily due to a lack of living-wage jobs and/or not having the advanced education and skills needed for higher-paying jobs. Employers in lower-paying fields, such as food service, caregiving, and retail, are less likely to offer full-time work and employee benefits (e.g., health insurance, retirement plans), leaving an increasing number of workers with little choice but to cobble together multiple part-time "gigs" to make ends meet. Furthermore, wages for workers in lower- and median-wage jobs have been stagnant for decades, while those in higher-paying jobs have reaped the most from economic growth. [25]

Those who are not working often have a good reason. They may have a disability or illness that requires accommodation, or is so severe they are unable to work. Some may be unable to find a job that allows the family to afford the high cost of child care, or they may face other barriers — such as lack of viable public transportation or the need to care for an aging parent. Low wages, high cost of living, and unequal opportunities combine to undermine the social and economic well-being of Washingtonians.

Reducing income inequality, therefore, is a necessity for reducing poverty, as well as improving the lives of all Washingtonians and the state's economy — eliminating racial disparities in income and wealth alone, for example, would increase Washington state's Gross Domestic Product (GDP) by $38 billion annually.[26]

Washington state can achieve greater income equality in three main ways: advancing educational and vocational attainment; increasing worker incomes, compensation, and wealth-building opportunities; and making cost-of-living more affordable. Detailed recommendations in these three categories are outlined below.

ADVANCING EDUCATIONAL & VOCATIONAL ATTAINMENT

Recommendation 3a. Implement *Washington Kids for Washington Jobs* recommendations, but bolster with more intentional strategies to achieve equity. Education is a foundation of economic and workforce development, and the majority of jobs today require postsecondary education. Yet, only 57% of adults in Washington state have earned a credential beyond high school. The WK4WJ initiative estimates that there will be 740,000 job openings by 2021, the majority of which will require a post-secondary credential (including those in two- and four-year institutions, as well as through apprenticeship).[27] The effort aims to meet the state goal of increasing the share of Washington students with a credential to 70% (Table 4).

Table 4

WASHINGTON KIDS FOR WASHINGTON JOBS RECOMMENDATIONS		
Increase high-quality early learning options for low-income students.	Increase utilization of concurrent enrollment and dual-credit programs.	Invest in student wraparound supports, especially for systemically underserved populations.
Make third-grade reading the "North Star" for assessing the impacts of early learning investments and for holding the system accountable for student achievement.	Reduce financial barriers to postsecondary program enrollment.	Include students who "drop out" of the system in the P-16 longitudinal data system to better understand and address leaks in the education pipeline.
Raise achievement at low-performing schools.	Make postsecondary education more convenient for students.	Increase support for and access to workforce development programs and targeted interventions for opportunity youth (adults younger than 26 who are not working or enrolled in school).
Support Washington's 24-credit high school diploma and communicate its flexibility.	Ensure students enroll in their "best-fit" postsecondary programs.	Invest in building pathways to high-quality certificates (e.g., apprenticeships).
Maintain Washington's competency-based high school graduation requirements.	Increase transfer support for students advancing from two-year to four-year schools.	Support "HS 21+" competency-based diploma programs at Washington's two-year colleges.
Improve consistency of "High School and Beyond" plan implementation.	Continue to build and evaluate Guided Pathways at state community and technical colleges.	Expand access and availability of high-quality online programs that lead to a credential.

Source: Washington Roundtable (2018) *The Path to 70% Credential Attainment for Washington Students* available at https://www.waroundtable.com/policy-center/

WK4WJ acknowledges that the above strategies will only be accomplished by eliminating achievement gaps for systemically underserved students. PRWG supports the following additional recommendations to increase the likelihood of the WK4WJ strategies achieving equity:

Recommendation 3a-i. Increase funding to accelerate the process of naturalization for immigrants and refugees. There are nearly one million immigrants, refugees, and asylees living in Washington state.[28] Citizenship is an essential stepping stone to education and employment opportunities and drastically reduces

poverty; people born outside of the U.S. with citizenship have poverty rates 17 percentage points lower than those yet to obtain citizenship.[29]

Recommendation 3a-ii. **Strengthen literacy programs and services for children and adults across the entire education and workforce-development pipeline.** Limited English proficiency is a major barrier to education and employment for immigrants and refugees. There are currently over 250,000 people in Washington state age five and older who do not speak English well enough to navigate social, education, and employment opportunities.[30] Ensuring all children and adults have access to culturally relevant literacy programs and services will improve education and employment outcomes.

Recommendation 3a-iii. **Eliminate harsh discipline practices in schools and increase investment in culturally responsive wrap-around supports.** Practices such as suspension and expulsion disproportionately affect children that are Indigenous, Black, Brown, male, non-binary, low income, disabled, homeless, involved in the foster care system, or with a special education plan,[31] leading to their increased involvement with the homeless, child welfare, juvenile justice, and criminal justice systems. Replacing discipline with stronger social and emotional programs, behavioral health supports, and family and community engagement strategies can keep more kids in school and improve equity in graduation rates.[32]

Recommendation 3a-iv. **Increase investment in Expanded Learning Opportunities (ELO) statewide.** ELOs are high-quality youth development programs that provide innovative, hands-on learning after school and throughout the year, including summer. Research shows that quality ELO programs improve grades and attendance, and decrease juvenile crime.[33] Continued investment is needed to support a connected high-quality care continuum, birth through youth for programs that serve as a workforce support to families.

Recommendation 3a-v. **Increase investments to improve high school graduation and post-secondary enrollment of children and youth experiencing foster care and/or homelessness.**[34] Specifically:

- Align, coordinate, and monitor policy, services, resources and outcomes to ensure academic success for students experiencing foster care/homelessness statewide;
- Prioritize keeping foster children in the same school and community with consistent access to teachers, neighbors, friends, coaches, and others for critical ongoing supports for foster youth's mental and emotional health;[35] and
- Use data to inform real time, individualized education supports for students, as well as longitudinal analysis of education outcomes.

Recommendation 3a-vi. **Increase the availability of affordable child care and housing for student parents on or near college campuses.** Parental education is one of the best protections against intergenerational poverty. Yet, student parents, especially single mothers and fathers with young children, face significant obstacles to furthering their education due to a lack of affordable child care and housing options. Programs like the *Jeremiah*

Program and *Keys to Degrees*, co-locate high-quality early learning, human services, affordable housing, and peer-to-peer support systems on college campuses, and have a proven track record of reducing intergenerational poverty.[36]

Recommendation 3a-vii. **Remove residency requirements for immigrants and refugees seeking higher education.** Residency requirements for tuition and financial aid make it difficult for immigrants and refugees to pursue education that can improve their social and economic circumstances. Removing these barriers would help them to stabilize more quickly and accelerate education and career pathways.

Recommendation 3a-viii. **Improve onramps for Washington adults disconnected from the educational system to prepare for and access affordable and high quality postsecondary educational pathways.** Washington students enrolling in postsecondary education complete at rates above the national average.[37] Yet, too few Washingtonians are pursuing education beyond high school to fill employer demand for more highly educated workers. Nearly four in 10 graduating high school seniors delay or forego college enrollment, placing the state 49th on this measure,[38] and students of color have college completion rates 16 percentage points lower than the state average. One strategy for increased engagement, high school or beyond, is to connect all learners with mentors in their aspirational career field to foster success and relationship building. Engaging students and adults no longer connected to the educational system is a key strategy for improving their income, as well as ensuring employers have a competitive workforce. The Washington Student Achievement Council, representing all sectors of education, recommendations the following to improve post-secondary outcomes in Washington state:

- Leverage the Washington College Grant and increase awareness of the importance of completing financial aid applications;
- Support College Bound Scholarship students from low-income families with college readiness activities;
- Reach adults through the new statewide adult reengagement College and Career Compass initiative;
- Increase the number of low-income students enrolled in dual-credit courses (receiving college credit while in high school);
- Understand and address basic needs of college students including food and housing insecurity; and
- Continue to learn and pursue equity-focused policies and strategies to increase educational postsecondary success of students of color.

INCREASING INCOMES, COMPENSATION & WEALTH-BUILDING OPPORTUNITIES

Recommendation 3b. **Enforce stronger salary/wage transparency and fair labor practices among employers to ensure pay equity.** Women and people of color continue to make less than their white male peers, even when they have the same education and professional experience.[39]

- Collaborate with businesses and labor organizations to define and enforce wage transparency guidelines for employers in Washington state; and

- Enact stronger legal protections that allow workers to exert their rights when fair labor standards are violated.

Recommendation 3c. **Expand access to no- or low-cost financial resources and education that empower, rather than prey upon, people experiencing poverty.** A lack of access to affordable capital in low income communities and communities of color, paired with a history of bank and mortgage redlining, has led to an extreme racial wealth gap. As these disparities in wealth and income have continued, households of color are less likely to have the safety net of home equity or cash on hand to handle unexpected expenses or a loss or reduction of income. As a result, communities of color are targeted by abusive and predatory lenders, putting households of color at great risk of debt, a significant barrier to escaping poverty.

Consumers need strong protections that safeguard their crucial assets and their ability to meet their basic needs, especially in times of crisis. The financial services sector has a responsibility to address its contributions in the disparities of its outcomes and contribute to a more equitable and inclusive financial system. Specifically:

- Establish Individual Development Account programs for children and adults to encourage savings and investments in their future, like education, purchasing a home, or saving for retirement;
- Expand and subsidize financial institutions that lower the cost of banking, lending, and moving money for people with low incomes (Bright Spot #4);
- Expand protections on the payday lending industry to ensure that fringe financial services cannot take advantage of low-income consumers; and
- Regulate debt buying and debt collection practices so that the process for collecting debt is transparent to consumers. This enables people to defend themselves in the face of alleged debt adequately and allows people to meet basic needs while paying back debt.

Recommendation 3d. **Enact changes to the state tax system that lower the effective tax rate for low-income households.** Specifically:

- Offer refundable state Earned Income Tax Credits (EITC) that extend to all households, including immigrants and refugees. State EITCs can amplify the effects of the federal EITC, the most effective antipoverty policy tool in the U.S.;[40]
- Create a property tax "circuit breaker" that limits the amount of property taxes low- to moderate-income homeowners and renters pay as a share of their income; and
- Create refundable state child tax credits that support the economic stability of families with young children, from birth to age eight. Research suggests generous child tax credits are on the most powerful tools to reduce poverty.[41]

Recommendation 3e. **Work in partnership with local labor organizations and the government to modernize labor laws and the rights of workers.** Increasing the rights of workers to organize and exercise power on their

behalf has historically been an essential strategy to raise wages and reduce racial and gender disparities in earnings. Nationally, the share of workers belonging to unions is at its lowest point in history, a trend that is causally linked to stagnant wages. Workers of all ages, across all industries and occupations, strongly support the rights of workers to unionize.[42] Yet, there is widespread recognition that current laws overseeing unions are outdated given current employment conditions, and should be updated. Recent research suggests the top priorities for workers in a modernized union system are:[43]

- Stronger collective bargaining models;
- Portable health and retirement benefits; and
- Job-search assistance.

MAKING COST-OF-LIVING MORE AFFORDABLE

Recommendation 3f. Implement the Child Care Collaborative Taskforce strategies and recommendations to increase the availability of affordable, high quality early care and education. The benefits of high-quality early care and education for children are well-established, especially for children from families with low incomes. Yet, prior COVID-19, nearly half of all families in Washington found it challenging to find, afford, or keep child care, affecting their ability to work and costing employers in Washington state over $2 billion annually in employee turnover and missed work.[44] COVID-19 has exacerbated the crisis, with 20 percent of providers shutting down at least temporarily statewide and over 60 percent reporting lost revenue.[45] The industry is essential for economic recovery and growth, yet access and affordability remain out of reach for a critical mass of families.

Washington state's *Child Care Collaborative Taskforce* (CCC Taskforce) was created in 2018 to "achieve a goal of access to affordable, high-quality child care for all Washington families by 2025."[46] The recent CCC Taskforce report makes 31 recommendations within four strategies to accomplish this goal, and will complete a full strategic plan by 2025 (Table 5). PRWG supports the adoption of these recommendations and the forthcoming strategic plan, and urges the CCC Taskforce to ensure community-led definitions of quality are factored into the plan to respect the diversity of cultures, languages, and experiences of children and families in Washington state.

Table 5

CHILD CARE COLLABORATIVE TASK FORCE RECOMMENDATIONS		
Support compensating the child care workforce competitively with educators in the state's education continuum in order to provide living wages, reduce turnover and promote longevity of skilled providers in the child care workforce.	Educate employers on the business case for supporting child care and reducing barriers to participation in employer-supported child care programs.	Simplify and streamline licensing process for change of ownership of existing child care programs.
Ensure child care staff can access employment benefits and other strategies to prevent workforce burnout and support the	Develop and promote an informational web-based menu of options for employers to support employee provision of child care,	Create a graduated co-pay structure that eliminates the "cliff effect" for all state-administered child care subsidies.

well-being of child care staff. This could include access to health insurance, dental insurance, paid leave and retirement benefits.	such as what options exist, how to evaluate and access them, and available recognition or incentive programs.	
Develop a network of local substitute pools across the state to allow child care staff and providers time off to attend training, take personal or vacation time, and recover from illness.	Implement a tiered business tax incentive program to match business expenditures for provision of employee child care.	Increase eligibility for state-administered child care subsidies to support more low- and middle-income families.
Support professional development of the current and future workforce.	Provide a retail sales (and use) tax exemption or deferral for construction, renovation, and remodeling of child care facilities.	Prioritize increasing affordability of child care for families disproportionately affected by barriers and furthest from opportunity.
Foster a culture of support and mutual respect among child care licensors, regulators and providers.	Provide a point-of-sale, sales (and use) tax exemption on consumables used in providing child care.	Enable child care providers to care for children eligible for state child care subsidies by adjusting provider subsidy rate payments to cover the full cost associated with providing high-quality child care.
Support child care provider startup and expansion.	Pilot within state government a model "bring your infant to work" policy to demonstrate how other employers could scale and implement the model policy. Include alternative infant care options and other family-friendly policies for workplaces and jobs unable to consider hosting infants given workplace conditions.	Support and enable child care and related programs to implement trauma-informed, culturally responsive, and bias-reducing practices, including providing opportunities for education on implicit and explicit bias and other types of cultural competency-focused training.
Increase access to grants, loans and other funding sources to offset child care operating and capital facility costs, including but not limited to the Early Learning Facility Fund, small grants and microloans.	Invest in technical assistance for construction or renovation of child care facilities to ensure timely and efficient startup and expansion.	Incentivize provision of nonstandard-hour child care, including evening, weekend, and overnight care, to increase access to child care for those who work or attend school during nonstandard hours.
Support development of child care facilities.	Streamline licensing during child care facility development.	Incentivize provision of child care in the child's home language, and support dual language learning.
Provide state funds to leverage public-private partnerships with community development financial institutions (CDFIs) to develop child care financing options, such as loan programs.	Partner with appropriate entities and jurisdictions to limit or eliminate local construction impact fees for child care facilities.	Offer information in multiple languages to reduce language barriers in seeking and accessing child care.
Promote diverse and inclusive child care settings so children have equitable opportunities for learning that help them achieve their full potential as engaged learners.	Evaluate child care licensing standards and their impact on the development and maintenance of child care facilities.	Enable families to navigate and access child care and related programs through informational resources, technical assistance, outreach, and other supports.
		Support provision of child care in underserved geographic areas and rural areas so families may access child care in their local communities.

Source: Department of Commerce (2019) Child Care Collaborative Task Force Recommendations available at https://www.commerce.wa.gov/about-us/boards-and-commissions/child-care-collaborative-task-force/

Recommendation 3g. **Increase and preserve affordable housing for renters and owners.** Lack of affordable housing is the primary driver behind homelessness in Washington state (see Strategy 7 for recommendations to address the urgency of homelessness). There are fewer than 30 units of housing available for every 100 low-income[47] families that need one, and vacancy rates in Washington are the lowest in the country at 2%.[48]

The lack of affordable housing also prevents people with lower incomes from owning a home; the primary way families build wealth and financial security over time. This is one of the primary drivers behind the racial wealth gap, a product of discrimination in housing policy and one of the most profound examples of how the root causes of poverty intersect to influence outcomes.[49] Discriminatory practices (e.g., predatory lending) continue today, and gentrification — the process of displacement that occurs from unequal economic growth — is forcing people of color from the same neighborhood cities redlined them into. In the third quarter of 2020, the Census reported that Black households had the lowest homeownership rate at 46%, nearly 30 percentage points behind white households.[50] From past recessions and economic downturns, the homeownership gap widened between people of color and white people due to the wealth gap, thus making homeowners of color more vulnerable to loss of a home.[51]

Increasing the availability of affordable homes to rent and own will reduce homelessness and increase social and economic mobility for all Washingtonians. Also, targeting investments to communities historically excluded from wealth-building opportunities is essential for eliminating the racial wealth gap. Specifically:

- Increase the state's Housing Trust Fund to build 10,000 subsidized housing units in 2021, and an additional 90,000 subsidized units over the next decade;
- Increase state funding for weatherization and upgrades to preserve existing housing, reduce carbon emissions, and offset increased energy costs due to potential future carbon reduction initiatives; and
- Provide housing vouchers for homeownership in community land trusts[52] that build individual capital while preserving long-term affordability in a community, preventing displacement of future generations (Bright Spot #5).

Recommendation 3h. **Enact changes to the tax system that support equitable economic growth.** Enacting reforms to Washington's tax system — which taxes people with low incomes more than any other state — can provide the funding needed to invest in the income, education, and employment opportunities people need to thrive, as well as ensure more residents benefit from the state's robust economic growth. [53] The most promising policies to ensure economic growth that is more widely shared include:

- Taxes on personal and corporate wealth above a specified threshold which are used to invest in opportunities critical to social and economic mobility for all Washingtonians, such as early care and education, higher education, rural economic development, affordable housing, and workforce development; and

- Tax incentives for businesses that are accountable to specific, antipoverty outcomes[54] and promote equitable education, training, and job opportunities in rural areas, communities of color, and neighborhoods experiencing gentrification.

#4: WEALTH-BUILDING INITIATIVES

Washington's Asset-Building Coalition (ABC) is a statewide association working to promote policies and programs in Washington that assist low-and-moderate income residents build, maintain & preserve assets through investments in education, homeownership, personal savings and entrepreneurship.

Sound Outreach in Tacoma, WA – part of the Pierce County ABC – connects unemployed and underemployed individuals to job training and employment opportunities, as well as resources and tools through their partnership with Harborstone Credit Union (a not-for-profit cooperative credit union). The partnership connects people who are engaged with a Sound Outreach financial counselor to the credit union's low-cost financial products and services. Through the partnership, individuals are able to refinance loans they would otherwise not be able to – due to low credit scores, debt-to-income, or loan-to-value issues – freeing up money in their monthly budget that can be used to further advance their financial empowerment.

Also in Tacoma, WA, **Goodwill of the Olympic and Rainier Region's** (GORR) provides financial education and coaching to help neighbors in reaching their fullest potential through education, job placement, and career pathway services. GORR operates the "Key to Change" Financial Literacy course in collaboration with Key Bank to help participants gain the knowledge necessary to achieve personal financial stability and independence (including how to set financial goals, create and maintain a budget, banking basics etc.). Recently, Goodwill collaborated with Tacoma Public Utilities (TPU) and the city of Tacoma to provide "Key to Change" and one on one personalized financial coaching sessions to low income TPU customers. If they qualify, customers can receive up to $160 in credit toward their utility bill for participating in financial education at Goodwill.

#5: EL CENTRO de la RAZA & PLAZA MAESTAS

Communities of Concern Commission member and Community Action Partner, El Centro de la Raza, developed the nationally recognized, award winning Plaza Maestas in the Beacon Hill neighborhood of Seattle. El Centro de la Raza spearheaded Plaza Maestas when it learned light rail would be extended through the neighborhood, bringing opportunity for residents but also intensifying the threat of gentrification. The Plaza provides transit-oriented affordable housing for residents so they can remain in the neighborhood, prioritizes people of color- and women-owned businesses, and offers a beautiful public space for community members to celebrate and convene in.

STRATEGY 4: Strengthen health supports across the life span to promote equitable outcomes and the intergenerational well-being of whole families.

"I live with a disability and chronic illness. I have a Master's degree and am attending law school, but I live in my van because my insurance does not cover the basic medical care I need and I cannot afford rent. People ask me, 'What does 'being healthy' look like to you?' and I respond, 'Being healthy basically looks like being rich.'"

~PRWG Steering Committee member

The individual and compounding effects of racism, oppression, poverty, and historical trauma follow people throughout their lives and can affect the health and well-being of their children and grandchildren. Poverty increases the likelihood of traumatic experiences in childhood — known as Adverse Childhood Experiences (ACEs) (Table 6) — which can have a cumulative, lifelong impact on an individual's physical and mental health. ACEs can be passed down to future generations as well via "epigenetics" — the process by which behaviors and environment cause changes that affect the way genes work.[55]

The higher the number of ACEs, the greater the likelihood of developmental delays and later health problems, including heart disease, diabetes, substance abuse, depression, and early death.[56] In 2017-2018, 14% of children in Washington state experienced two or more ACEs.[57] State-level data by race and ethnicity is limited, but national data shows that Indigenous, Black, and Brown children are twice as likely to have two or more ACEs compared to their peers.

Table 6

EXAMPLES OF ADVERSE CHILDHOOD EXPERIENCES		
Somewhat often/very often hard to get by on income	Parent/guardian served time in jail	Lived with anyone mentally ill, suicidal, or depressed
Parent/guardian divorced or separated	Saw or heard violence in the home	Lived with anyone with alcohol or drug problem
Parent/guardian died	Victim/witness of neighborhood violence	Often treated or judged unfairly due to race/ethnicity

Source: CAHMI (2016) Adverse Childhood Experiences Among U.S. Children available at https://www.cahmi.org/wp-content/uploads/2018/05/aces_fact_sheet.pdf

Strategies 1-3 in the 10-year Plan would substantially reduce ACEs from occurring because they focus on equitable "upstream" policy, program, and practice changes needed to substantially reduce ACEs for all children, adults, and families in Washington state. Collectively, the recommendations in these strategies are consistent with guidance from the Centers for Disease Control and Prevention on how to both prevent ACEs and mitigate its impacts, including strengthening economic supports in families, encouraging planned pregnancies, ensuring a healthy start for children, and prioritizing early interventions.[58] Data show that children and families are remarkably resilient when the stressors related to ACEs are removed.

Until Strategies 1-3 are fully realized, however, the cumulative impact of poverty and ACEs will remain a threat to the health and well-being of Washingtonians throughout the lifespan, and are most certainly affecting a larger number of people in the wake of COVID-19. Investments in comprehensive, health supports for every age group yield intergenerational benefits — health supports for mothers and fathers with young children yield especially large returns, but investments in youth, working-age adults, and seniors improve the well-being of whole families and communities, reducing the likelihood of trauma in the future. Targeted and culturally appropriate investments aimed at closing gaps in health outcomes for people historically underserved — Indigenous, Black, and Brown Washingtonians, immigrants and refugees, homeless, rural residents, and LGBTQIA+, and people with disabilities — are also needed.

Washington state is a national leader in policies that support intergenerational health and well-being, such as Medicaid expansion, paid family and medical leave, and long-term care insurance. These strong policies can be amplified with the following recommendations.

Recommendation 4a. **Strengthen the Apple Health program by creating a state-funded assistance benefit.** Follow the lead of Massachusetts — which has the highest rate of health insurance coverage in the country, as well as the best health outcomes for children — by subsidizing all medical premiums for people with incomes below 150%, and gradually phase out for people with incomes up to 300 percent FPL. [59]

Recommendation 4b. **Ensure funding and access to culturally and linguistically appropriate health care and support services before, during, and after pregnancy.** Specifically:

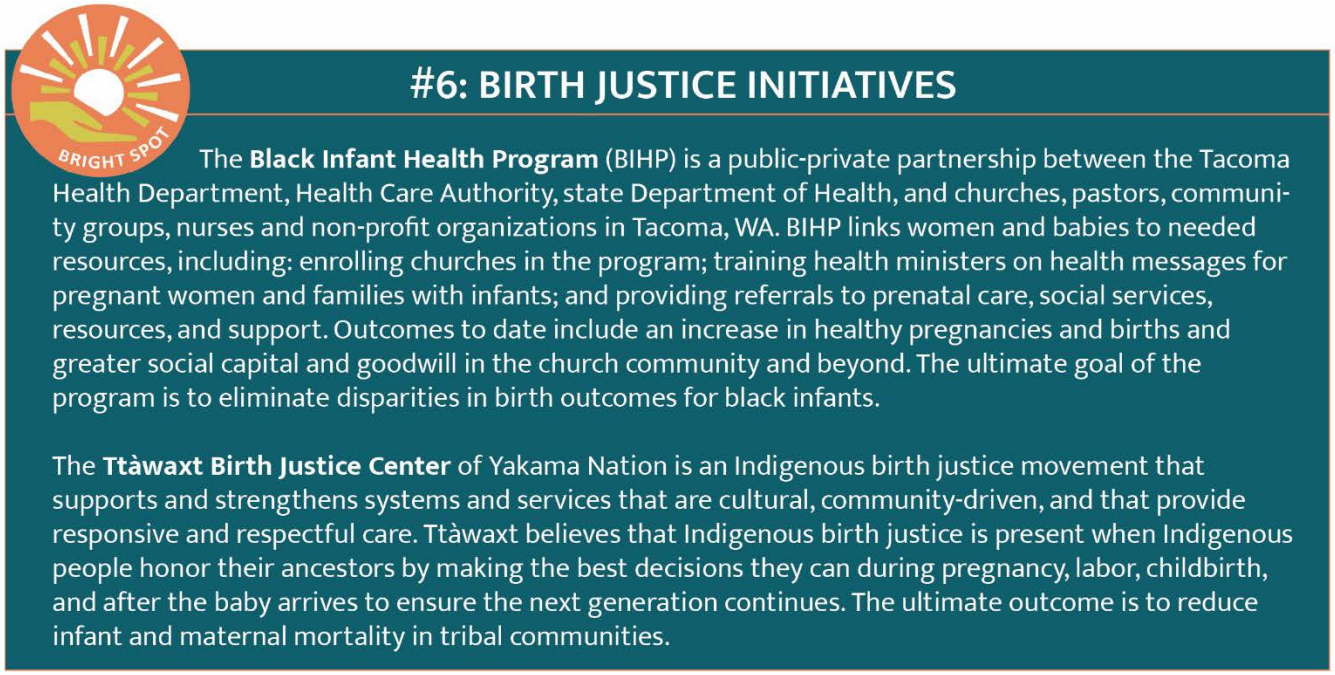
- Increase health care and support services — including pre- and postnatal care, doulas, behavioral health, screening, treatment, and monitoring — through all phases of pregnancy and the first year postpartum (Bright Spot #6).[60] The *Bree Collaborative* is one example of how care providers bundle services to provide comprehensive pre- and postnatal care while reducing disparities in infant and maternal mortality and saving taxpayer resources.[61]
- Expand home visiting so all eligible families can receive it. Home visiting programs provide physical, social, and emotional health services and referrals to expectant mothers and families with young children to optimize early childhood development. Currently, just one in four eligible families receive home visiting, leaving more than 29,000 families unserved.[62]

Recommendation 4c. **Ensure access to free and low-cost contraceptive options and family planning counseling, including long-term acting reversible contraceptives (LARCS) for people who want it.** Resources and services for quality reproductive care and contraceptives are not equally accessible to everyone statewide. The highest rate of unplanned pregnancies is among people under age 20,[63] which can worsen circumstances that may already be causing stress and increase the likelihood that a child and family will experience poverty. LARCS help people plan better for pregnancy and dramatically decrease teen pregnancy and abortion rates when made widely available (Bright Spot #7).

Recommendation 4d. **Increase funding to support the availability of culturally diverse, nutritious foods in assistance programs like Women, Infants, and Children, the Farmers Market Nutrition Program, and the Senior Farmers Market Nutrition Program.** Food is medicine, and eating nutritious foods is vital to health and well-being. Fruits and vegetables, healthy proteins, and other nutrient dense foods are often too expensive or unavailable in lower income communities. Nutrition assistance programs should be evaluated to better understand and reduce barriers for participation for underserved communities.

Recommendation 4e. **Develop, implement and evaluate health and human service programs to better meet the unique needs of LGBTQIA+ children, adults, and families.** Health and human service programs should be framed within an equity and intersectional framework (including age, gender, gender identity, race, ethnicity, culture, socio-economic status, geographic location, and ability) to ensure attention to diversity of experience within the LGBTQIA+ community.

Recommendation 4f. **Increase Medicaid funds for supported, in-home care and long-term services** so people with disabilities and aging adults can remain in environments they know and trust, as well as avoid costly residential programs.



STRATEGY 5: Address the urgent needs of people experiencing homelessness, violence, mental illness, and/or addiction.

"Never underestimate the power of giving someone a second chance."

~Resident of Washington Women's Correctional Center

People experiencing poverty often face significant obstacles that prevent them from achieving economic stability, the most common of which are homelessness, violence, mental illness, and addiction. The relationship between poverty and these conditions works in both directions — people in poverty are at heightened risk of experiencing one or more of them, and any one of these conditions can increase a person's likelihood of entering poverty.

Homelessness, violence, mental illness, and addiction had reached the point of crisis in Washington state prior to COVID-19, and are now deepening in the wake of the pandemic's economic consequences. Race and its intersection with historically marginalized identities has further threatened the safety, physical and mental health, and housing stability of Indigenous, Black, and Brown Washingtonians, LGBTQIA+, youth, and people with disabilities during COVID-19.

Homelessness, violence, mental illness, and addiction are often co-occurring and contribute to Adverse Childhood Experiences (ACEs), toxic stress, and lifelong trauma, increasing the likelihood that a child, adult, or family will experience intergenerational poverty. Unless they have close, trusting relationships to family and friends with ample resources, a child, adult, or family experiencing homelessness, violence, mental illness, and/or addiction will inevitably need financial assistance and other services to support their safety, stability, and long-term well-being.

Numerous organizations and efforts are working on the homelessness, violence, and behavioral health crises in Washington state.[64] PRWG respects the work of these existing efforts and does not wish to be duplicative, but feels it important to recognize significant strategies stemming from their work to ensure the importance of addressing the urgency of homelessness, violence, mental illness, and addiction for reducing poverty and inequality is made clear.

Recommendation 5a. Provide greater resources for consistent and timely community-led data collection and storytelling to deepen our understanding of the disproportionate impact of homelessness, violence, mental illness, and/or addiction on historically underserved Washingtonians. Data for children, adults, and families experiencing homelessness, violence, or a behavioral health issue is improving, but remains an obstacle to fully understanding the size and extent of these crises and their relationship to poverty. Investing in community-led data collections efforts — such as the Urban Indian Health Board's *Our Bodies, Our Stories Report* and the *Williams Institute* data profiles on the LGBTQIA+ community (Bright Spot #8) — are a necessity

to gain a more comprehensive and accurate understanding homelessness, violence, and behavioral health among groups most affected, and to inform the most promising solutions.

Recommendation 5b. **Adopt the "housing first" approach as the foundation to health and human service delivery and remove discriminatory barriers.** Specifically:

- Better integrate coordinated entry with health and human service programs across state agencies; and
- Reform the criminal background check process so that formerly incarcerated individuals can fully reintegrate into society after time served.

Recommendation 5c. **Increase state and local rental assistance and diversion programs that prevent children, youth, adults, and families from becoming homelessness.** Diversion programs help families obtain temporary housing outside of the homeless assistance system while connecting them to the services and resources they need to secure stable, permanent housing. Successful diversion programs improve the ability of the homeless assistance system to target shelter resources effectively and, most importantly, help families safely avoid a traumatic and stressful homeless episode.[65]

Recommendation 5d. **Increase the number of emergency, transitional, and permanent supportive housing options.** Increasing the number of affordable housing units across Washington state is the most preventive approach to the homelessness crisis, but it is a long-term strategy (see Strategy 4). To address the urgency of the current crisis, public and private partners at the state and local levels should increase investment in the availability of housing options across the spectrum of need and ensure human service supports are embedded at every stage of the process.

Recommendation 5e. **Develop stronger public-private partnerships to increase opportunities for supported education, job training, and employment.** Children, adults, and families experiencing homelessness, violence, or a behavioral health issue often require significant time to stabilize their situation, connect with support services, and heal from trauma. Embedding supportive services in education and employment settings provide a continuum of ongoing supports that can meet a wide range of needs (Bright Spot #9).[66]

Recommendation 5f. **Create a Medical-Financial Partnership model for Washington state**.[67]
Financial stress has been shown to impact health outcomes among low-income children and their families. Medical-Financial Partnerships (MFP) models are showcasing positive impacts on the social determinants of health via this cross-sector collaboration in which health care systems and financial service organizations are co-located (in the same area in the medical building) to improve health and reduce patient financial stress.[68]

Recommendation 5g. **Improve access to behavioral health prevention, treatment, and recovery support services.**[69] Expand efforts to enhance Washington state's behavioral health prevention, intervention, treatment, and recovery programs. These efforts should continue to promote solutions that reduce harm to children, adults, and families with deadly, preventable diseases such as depression, substance abuse, and addiction.

- Increase Medicaid reimbursement rates to incentivize more medical providers to accept Apple Health;
- Incentivize insurers to provide a broader range of inpatient/outpatient services, including stabilization, counselling, diversion, and respite care;
- Integrate and co-locate services across housing, social, health, education, and workforce development systems and bolster community-led programs;
- Use human-centered design and other person-centered practices to define a reimagined, modernized continuum of care across jurisdictions (see Strategy 6).

Recommendation 5h. **Improve integration of behavioral health treatment in early learning settings and K-12.** Children struggling with a behavioral health issue are not adequately or accurately screened or cared for at school, which can negatively affect their learning, social relationships, and physical well-being. However, early learning settings and schools are often trusted family-centered spaces which should be leveraged. Services can be improved by:

- Improving training for teachers and school health providers to support screening and early recognition/intervention, particularly for ACEs;
- Improving the Individual Education Plan (IEP) system to increase flexibility and minimize the removal of kids to special education classrooms or out-of-school placements;
- Increase peer counseling and mindfulness programs in schools;
- Increase educational programming to decrease cultural stigma around mental health conditions and improve access to appropriate after-school care and programming.

Recommendation 5i. **Require state entities to collaborate with civil legal aid providers and community-led programs to increase comprehensive support for children, adults, and families experiencing homelessness, violence, or a behavioral health issue.** Urgent needs involving homelessness, violence, or a behavioral health issue often include multiple emergent needs simultaneously, requiring collaboration between several systems so individuals and families may connect with appropriate services and stabilize their situation.

#8: COMMUNITY-LED DATA COLLECTION

Our Bodies, Our Stories is a series of reports produced by the Urban Indian Health Institute (Seattle, WA) that details the scope of violence against Native women and girls across the nation. Data for Indigenous people is historically lacking, inaccurate, and misleading, often leaving them invisible in public policy and program discussions. Our Bodies, Our Stories is an Indigenous-led effort to provide a baseline understanding of the sexual violence Indigenous women face, as well as document for the first time the number of Missing and Murdered Indigenous Women & Girls (MMIWG) in the country. The reports are a powerful example of why community-led data collection is needed to better understand and prioritize solutions for issues affecting the well-being of Indigenous people.

The **Williams Institute at the University of California Los Angeles** is the leading research center on sexual orientation and gender identity law and public policy. They collect data and conduct research specific to the LGBTQIA+ community to advance their well-being thtough laws, policies, and judicial decisions.

#9: SUPPORTED HOUSING & EMPLOYMENT

The **Foundational Community Supports** program provides statewide supportive housing and employment services to people with complex physical or behavioral health care needs. The primary goal of these services is to help people with a significant behavioral health need or disability obtain and maintain stable housing or competitive employment. The program is administered by Health Care Authority, and preliminary results show significant gains in housing stability, employment, and earnings for participants.

STRATEGY 6: Build an integrated human service continuum of care that addresses the holistic needs of children, adults, and families.

"As soon as I take a breath and have a second to just sit and play with my kids on the floor and not worry about how I am going to get dinner on the table tonight or how to pay the rent … the rug gets pulled out from underneath me. It's like a game of Chutes & Ladders … I climb up, just to fall back down repeatedly, and getting to the top seems dependent on a lucky roll of the dice." *~PRWG Steering Committee member*

Programs serving children, adults, and families experiencing poverty in Washington state are spread out across a multitude of agencies and sectors that work in partnership to deliver cash and food & housing assistance; health care and services; early care and education; and education, training, and employment opportunities. Feedback from people being served by these agencies overwhelmingly points to the inadequate, onerous, and fragmented nature of programs, which are like "a full-time job to navigate."[70] Too often, people fall through the cracks within and between systems, increasing their likelihood of becoming involved with other systems that can compound and perpetuate poverty, such as juvenile justice, criminal justice, child welfare, and homeless systems. Moreover, human services are in dire need of modernization to better reflect the structure and diversity of families today — emphasis on the economic inclusion of single mothers and fathers, LGBTQIA+ families, grandparent caregivers, people experiencing homelessness, people with disabilities, and child welfare- and justice-involved families is critical for a just and equitable future.

The current state of our human service systems exacerbates what brain science refers to as a "scarcity mindset."[71] People with low incomes incur significant financial, temporal, and cognitive costs[72] that tax a person's mental bandwidth to such a great extent it affects their ability to problem solve and plan.[73] Cutting these costs for people experiencing poverty by easing access to services, allowing time to "take a breath," and removing punitive measures would alleviate the toxic stress poverty can impose and better support children, adults, and families in achieving long-term economic success and well-being.

Notable examples of human service transformations exist in Colorado[74] and Tennessee[75] and are afoot in other states as well. Lessons from these efforts suggest that, at a minimum, a human service continuum of care should (Table 7):

Table 7

KEY CHARACTERISTICS OF AN INTEGRATED CONTINUUM OF CARE		
Support diversion when appropriate; address urgent needs first; empower and build resilience; customize pathways; and continue to support until a child, adult, or family is set up to thrive.	Use human-centered design and other person-centered practices to define a reimagined, modernized continuum of care across jurisdictions.	Serve the holistic needs of families by providing services to children and adults simultaneously to support healthy families.

Integrate and co-locate services across housing, social, health, education, and workforce development systems and bolster community-led programs.	Offer culturally relevant care by building a more racially and ethnically representative workforce and offering services in the preferred language of the person or family served.	Incorporate race- and trauma-informed policies, programs, and practices.[76]
Use behavioral economics and "plain talk" to communicate clear and effective information to people served.		

Recommendations for a continuum of care include:

Recommendation 6a. Develop a shared set of outcomes for individual, child, and family well-being, in partnership with communities most affected by structural racism and poverty that each agency is collectively held accountable to achieve. Selected outcomes should focus on improving multiple dimensions well-being, ensuring individuals, children, and families have the tools and resources they need to: meet their foundational needs; the dignity of having power and autonomy over their lives; and being engaged and valued in their community.[77] Baseline data for identified outcomes should be disaggregated by key demographic and geographic dimensions, which at a minimum should include: age, race, ethnicity, sex, gender, sexual orientation, LGBTQIA+, disability status, immigration status, zip code, and family type.

Recommendation 6b. Update "Standard of Need," assistance levels, and eligibility to reflect the real costs of what it takes for individuals and families to make ends meet. Specifically:

- Develop a "Standard of Need"[78] that accounts for what individuals and families need to be healthy and thrive when getting support from anti-poverty programs. The standard should account for variations in costs by geographic region, family size and composition, and age of children. The standard should be updated annually, and public benefit levels across all programs should be tied to this standard.
- Base eligibility for programs on a decent standard of living for the community in which one resides. Tools such as the *Self-Sufficiency Standard*[79] and *United Way's ALICE* (**A**sset-**L**imited, **I**ncome-**C**onstrained, **E**mployed)[80] measure adjust for geography, family size, and composition, and can be used to set targets to expand eligibility for assistance programs.

> ***"Programs do not communicate with one another. I have to tell my story 20 times, each time reliving the trauma of it. It's exhausting."*** *~PRWG Steering Committee member*

Recommendation 6c. Develop a universal intake, data sharing, and technology platform so that we can share *essential* information on people across agencies, systems, and sectors. In this intake process, clear information should be offered about what would be shared and how, giving those with safety concerns the ability to opt out. Sharing information across systems will ease the burden of sharing one's story repeatedly, save time and resources, and help break down silos across different systems. However, this may be dangerous

for some children, adults, and families — particularly survivors of domestic violence, sexual assault, or stalking — who worry about who is able to access their information with intention to cause harm.

Recommendation 6d. **Increase unconditional cash assistance.** Evidence suggests that unrestrictive cash assistance is an effective strategy for poverty reduction.[81] Furthermore, the majority of literature shows that work requirements are just as likely to increase poverty as decrease it and that employment-focused poverty reduction strategies do not result in meaningful poverty reduction.[82,83] Specifically:

- Update existing cash grants in the Temporary Assistance for Needy Families (TANF), Aged, Blind, or Disabled (ABD), and Refugee Cash Assistance (RCA) programs to align with cost-of-living and adjust annually for inflation;
- Pass through 100% of child support to children and their custodial parent for anyone on assistance while strengthening familial supports; and
- Pilot a state program that provides unrestricted cash assistance to individuals and families and evaluate its effect on key elements of well-being and return on investment compared to current programs (Bright Spot #10).

Recommendation 6e. **Smooth on-ramps and off-ramps for programs.** Individuals or families applying for assistance are often under significant stress, especially if they are experiencing homelessness, mental illness, addiction, or violence. Many programs impose immediate, onerous requirements (e.g., requiring orientation as a condition of eligibility, threat of sanction) or intake processes (identifying career goals before stably housed, etc.), which can exacerbate stress and undermine well-being. Eligibility levels vary widely across programs (Figure 9), leaving significant gaps depending on an individual's income and personal circumstances (e.g., single vs. married, disabled, with or without shelter). Similarly, assistance can abruptly end before an individual or family is ready, or if a person begins earning just $1 over a given eligibility threshold, hindering economic mobility (a.k.a. "cliff effect"). On-ramps and off-ramps can be smoothed by:

- Giving children, adults, and families time to "take a breath" by addressing urgent needs and stability before making onerous program requirements;
- Removing asset limits to qualify for public assistance programs;
- Easing harsh sanction and time limit policies in the TANF program;
- Eliminating the cash, child care, and medical "cliff effects";
- Allow for categorical eligibility when possible and appropriate; and
- Align eligibility across programs to ensure people can meet foundational needs as they work along the continuum of care.

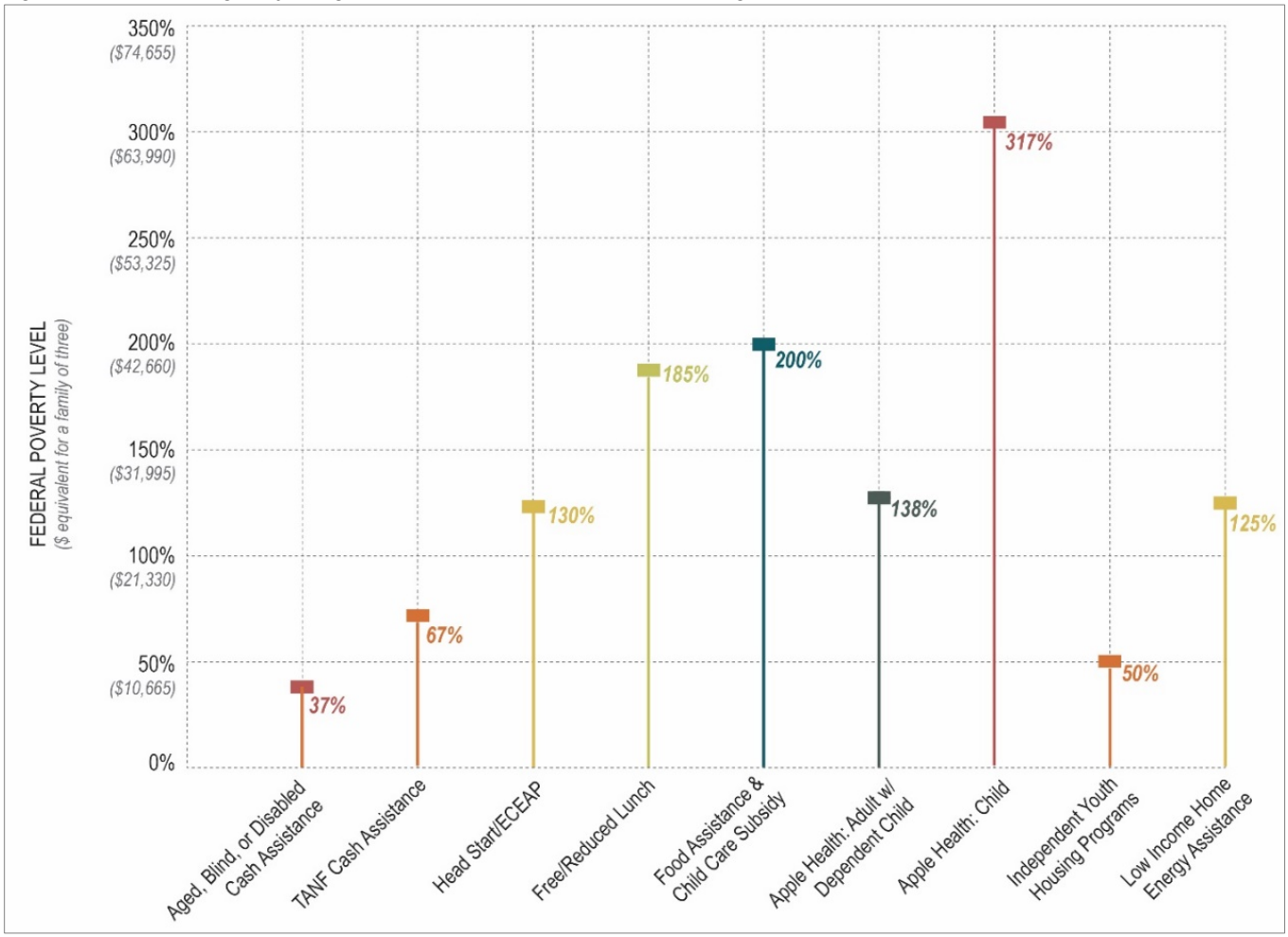
Recommendation 6f. **Revamp policies, programs, and practices to inspire hope and build resilience.** The emerging science of hope and resilience suggests that it is one of the most essential elements of well-being and success. Specifically:

- Develop and train coaching and navigator care teams to support people as they navigate state and local resources and services; and
- Invest in community-based peer-to-peer support models for individuals, children, and adults experiencing poverty.

"Most of the time I am like, what's the secret handshake? How do I navigate this to get what I need? The burden of figuring out the system is on the people being served … it's a full-time job."

~PRWG Steering Committee member

Figure 9: Maximum Eligibility Ranges Across Select Public Assistance Programs



#10: UNCONDITIONAL CASH ASSISTANCE

Providing cash assistance to children, adults, and families with no strings attached is gaining traction in the United States. Unrestricted cash assistance can alleviate the "scarcity mindset" that people in poverty experience, freeing up resources and time to plan for the future.
Research shows giving people money with no restrictions does not deter employment, and is a more effective poverty reduction tool than programs that require work to receive cash.

Many pilots are underway testing unrestricted cash assistance programs in the U.S.
One of these studies – **Baby's First Years** – will be the first study in the country to assess the impact of unrestricted cash assistance on family life and infant and toddlers' cognitive, emotional, and brain development.

STRATEGY 7: Decriminalize poverty and reduce reliance on the criminal justice, juvenile justice, and child welfare systems.

> ***People assume that just because I am poor, I must be a bad parent. It's almost as if case workers are looking for a reason to take my kids away — just because I need help, doesn't mean I don't love my kids.***
>
> *~PRWG Steering Committee member*

Families in poverty, especially deep poverty, are at greater risk of experiencing high levels of stress compared to economically stable families. This can result in a higher number of ACEs and potentially toxic levels of stress to home environments. Such conditions can negatively affect a child's health and well-being, performance in school, and their relationships, increasing their chances of becoming involved with the child welfare and juvenile justice systems when they are young, as well as the criminal justice system when they are an adult. [84]

Child and adult behaviors that are caused or exacerbated by the experience of poverty are often "criminalized" — meaning they are punishable through formal or legal action. The vast majority of child neglect cases, for example, occur in families with incomes below 50% FPL.[85] Providing more generous cash assistance and supports would help stabilize the family, but children are often placed in a foster home instead. Children from lower income backgrounds are disciplined or expelled from schools at a higher rate than their peers, when receiving social, emotional, and behavioral supports would serve them better. And people experiencing a mental illness or addiction often end up in prison instead of receiving proper behavioral health care and treatment.

Criminalizing poverty has lifelong impacts that extend to whole families and communities. Once involved in these systems, children and adults often lack the support needed to successfully exit them and face numerous barriers in acquiring the education and employment opportunities they need to achieve economic stability. As a result, child welfare- and justice-involved families have a high rate of recidivism and are at high risk of experiencing discrimination, unemployment, homelessness, and other factors that perpetuate the cycle of poverty in families. Moreover, the disproportionate burden of poverty by race, gender, immigrant status, disability, and zip code maintains systemic social and economic inequality.

Strategies 1-6 in the 10-year Plan would substantially reduce the likelihood of becoming involved with the child welfare, juvenile justice, and criminal justice systems by mitigating the experience of poverty and substantially reducing the incidence of it. In the meantime, these systems are in need of comprehensive reforms that extend beyond the scope of the 10-year Plan (e.g., ending mass incarceration), and PRWG strongly encourages Washington to look to those reform efforts for guidance. The recommendations below focus on reducing

reliance on these systems for dealing with poverty, and how to mitigate their effects on children, adults, and families once involved.

BEFORE & UPON ENTRY

Recommendation 7a. **Shift resources away from child welfare, juvenile justice, and criminal justice toward comprehensive social, economic, and health supports for children, adults, and families.**[86] Shifting resources away from these systems and investing in services that support the economic stability and health and well-being of families. Specifically:

- Redirect resources to prevention, treatment, and support services in early learning, behavioral health, and human services for whole families;
- Embrace a harm reduction approach when responding to non-violent crimes with a strong association to poverty, such as street camping, loitering, drug use, and sex work by enlisting the help of social workers and behavioral health specialists;
- Invest in equity, diversity, and inclusion training and culture change to protect the lives of people disproportionately affected by these systems (e.g., Indigenous, Black, and Brown people, LGBTQIA+, immigrants and refugees, men and boys).
- Increase law enforcement training on trauma-informed interventions and de-escalation training; and
- Rapidly engage whole families when a child or adult is at risk of becoming child welfare- or justice-involved.

Recommendation 7b. **Connect child-welfare and justice-related families to legal resources and civil legal assistance to mitigate further negative consequences of criminalization.** Specifically:

- Identify evolving civil legal needs and protections of children, youth and adults, depending on their point of involvement in the criminal and welfare systems; and
- Fund legal services programs to increase capacity to provide legal assistance and representation to incarcerated people, formerly incarcerated people and justice-related families in their ongoing civil legal needs from entry to release.

Recommendation 7c. **Keep families together as much as possible, when safe and appropriate.** Keeping children with parents, in friend and family networks, communities, and schools they feel most connected to can mitigate trauma and build resilience. Specifically:

- Raise the burden of proof for removal and placing children with relatives able to provide care instead of entering the system;
- Create clearer, culturally-informed standards for what constitutes “high quality” parenting to reduce stigma of parents with low incomes;
- Create age-appropriate opportunities for children and youth to voice their opinions and be an active participant in case decisions;

- Establish a transportation fund for students to reduce school changes for children involved with the child welfare system;
- Increase financial assistance to children and their kinship caregivers by ensuring payments are at parity with foster parents and create a child-only benefit within the Supplemental Nutrition Assistance Program; and
- Pilot school-based recruitment for foster homes so children can stay in their school systems and friendship networks.

WHILE INVOLVED

Recommendation 7d. **Provide robust, trauma-informed case management to children, adults, and families involved in child welfare, juvenile, and criminal justice systems.** Specifically:

- Increase the number of providers — including mental health professionals, case managers, and social workers — with expertise in trauma and rehabilitative care to expand high quality services for children, youth, and adults involved in these systems; and
- Create an early detection system to quickly identify children and families with a criminal justice-involved family member so they can be connected to case managers, assistance, and support services if needed.

Recommendation 7e. **Expand education, job training, and employment opportunities for children and adults while they are in the care of the juvenile and criminal justice systems.** Specifically:

- Initiate re-entry planning and case management early in an individual's sentence to address trauma, build resilience, and set long-term goals;
- Provide youth in juvenile justice settings the same school services as youth in mainstream schools, including special education services, mentoring, and career counseling;[87]
- Allow youth and adults in justice settings to obtain a meaningful post-secondary credential or degree that prepares them for re-entry; and
- Expand mentoring and apprenticeship opportunities for justice-involved youth and adults while in detention.

Recommendation 7f. **Eliminate Legal Financial Obligations (LFOs).** Strengthen and enforce LFO reform laws. Specifically:

- Limit "pay to pay" and "pay to stay" fees while individuals are incarcerated;
- Limit incentives for defendants to take two-year probation plea deals; and
- Suspend child support payment responsibilities while a non-custodial parent is incarcerated.

Recommendation 7g. **Provide adequate funding to increase the availability of safe, culturally responsive foster homes and permanent living options for children and youth involved with the child welfare system.** Specifically:

- Increase safety regulations and oversight of group and family homes that foster numerous children;
- Eliminate the practice of sending children and youth to sleep in hotels or be located out of state; and
- Provide more permanent supportive housing options for extended care youth and youth exiting the child welfare system.

UPON RELEASE & RE-ENTRY

Recommendation 7h. **Connect children, adults, and families to public assistance and support services *at least* three months before they exit a system.** Specifically:

- Allow children, youth, and adults to apply and receive public assistance before exiting a system to help them quickly stabilize upon re-entry;
- Prepare individuals for exit or re-entry through the provision of wrap-around navigation services, connection to employee mentors with lived experiences, career exploration, and advice on useful community organizations regarding access to housing, healthcare, education, and job opportunities before release; and
- Ensure compliance with the Fair Chance Housing ordinance and urge public and private housing providers to limit the use of criminal history when screening tenants so that non-violent arrests do not exclude individuals experiencing homelessness from city- and county-controlled housing placement lists.

Recommendation 7i. **Eliminate housing, education, and employment barriers, and invest in stronger, better-coordinated exit and re-entry policies, services, and programs.** Specifically:

- Reform the criminal background check system to rapidly house people with a criminal record;
- Evaluate the efficacy of the recently created Certificate of Restoration Program (CROP) for former offenders and strengthen if needed;
- Increase incentives for employers to hire and support formerly incarcerated people of color as leaders, caseworkers, and managerial staff to help people exiting the criminal justice system; and
- Strengthen K-12 school re-engagement for youth exiting the juvenile justice system.

Recommendation 7j. **Expand and strengthen post-release family and peer support services.** Specifically:

- Fund aftercare support and case managers for all youth released from residential commitment;
- Expand the number of programs that support peer-to-peer training and mentoring opportunities for children, youth, and adults exiting systems; and
- Provide public assistance and support services after exit or re-entry until individuals and families self-determine they have social and economic safety, stability, and security.

STRATEGY 8: Ensure a just and equitable transition to the future of work.

Washington state's economy is continuously undergoing significant and rapid change, especially in the wake of the COVID-19-induced downturn. Emerging technology (e.g. automation, artificial intelligence) is, and will continue, disrupting both the type of work available and the workforce needed for a thriving economy and communities. Economic downturns will continue to occur and, regardless of the cause (e.g., pandemic or cyclical), always hit people with lower incomes the hardest. Without updated policies that adapt to economic fluctuations, too many children, families, and communities are at risk of being left behind.

People experiencing poverty are especially susceptible to the changing economy and future of work. As the recent report from the *Future of Work Taskforce* (FOW Taskforce) notes, by 2025 an estimated 70% of projected job openings in Washington state will require some postsecondary education, yet some 758,000 Washingtonians under age 45 lack education beyond high school,[88] a disproportionate share of which are people of color.[89]

Moreover, the FOW Taskforce notes that full-time employment is no longer a guarantee in the emerging economy, and people will increasingly rely on a patchwork of part-time "gigs" to make ends meet. As Washingtonians continue to struggle in the wake of COVID-19, lacking a post-secondary credential should not be a prerequisite for earning a living wage and benefits. If our public assistance programs do not modernize to adapt to the future of work, many workers will experience longer periods of financial instability, "wreaking havoc" on family and community well-being. The economic disruption of the current downturn powerfully emphasizes their point.

Protecting workers and their families during the current downturn and from future disruptions in employment, while simultaneously investing in the education and skills they need for the jobs of the future, can ensure a just and equitable transition to the future of work.

Recommendation 8a. **Adopt the recommendations detailed in the FOW Taskforce report,[90] and bolster it with more specific, intentional strategies to achieve equity for workers of color, LGBTQIA+, women, immigrants and refugees, and rural Washingtonians.** The FOW recommends 13 actions within the following five strategies (Table 8):

- Prepare for use and adoption of advancing technology in the workplace;
- Improve labor market data and credentialing transparency;
- Modernize worker support systems;
- Ensure equal access to economic development resources across Washington and
- Provide comprehensive worker upskilling and lifelong learning opportunities;

Table 8

FUTURE OF WORK TASKFORCE RECOMMENDATIONS		
Support the Workforce Board's request for additional funding for incumbent worker training.	Provide funds to establish a career and education-counseling network to support LiLA account holders and other workers who are planning for professional development and economic opportunity.	Prioritize the use of state-funded economic, workforce and community development resources to support and generate family-wage jobs, with a focus on rural vitality.
Extend the State Board for Community and Technical Colleges (SBCTC) Customized Training Program.	Perform a worker-impact audit on the selection and adoption of Artificial Intelligence (AI) and other advanced technologies within Washington State government.	Continue funding rural broadband efforts and seek out similar initiatives that may constitute best practices in other areas of the nation.
Establish a requirement for a worker-management oversight body for each awardee of state incumbent worker training funds.	Develop a methodology for assessing and evaluating advanced technology within state government.	Enlist libraries to become greater hubs for community training, credentialing, and entrepreneurship/small business development.
Add and evaluate new outcome metrics on the Job Skills and Customized Training programs.	Extend and utilize the Workforce Board's Career Bridge-Credential Engine project on credential transparency and competency-based credentialing as a learning laboratory among the higher education community.	Fund the development of accessible collaborative applied research (CAR) models that will bring two- and four-year college faculty and students together with small and midsize businesses and their workers to invent or adopt new technology or processes.
Remove the six-credit eligibility requirement from the Washington College Grant program for students co-enrolled in High School+ and I-BEST who do not have a high school diploma or equivalent.	Add a new occupation data field to Unemployment Insurance Wage Reports, provided by employers for each W-2 employee.	Reinstate a state office of employee ownership.
Fund the Lifelong Learning Accounts (LiLA) program, where employers and employees jointly fund an employee-owned educational savings account, as written in state statute (RCW 28C.18.180)	Analyze the impact of existing worker benefit and protection structures, and provide recommendations to better support workers as the nature of work changes.	

To increase the likelihood of the FOW Taskforce strategies achieving equity, PRWG recommends the following additional strategies:

Recommendation 8a-i. **Dramatically expand mentorship and career-connected learning for people of color, LGBTQIA+, refugees and immigrants, people with disabilities, and rural communities** (Bright Spot #11)**.** In the ever-changing economy, there is an even higher premium on social capital, connections to employers, and direct workplace experience. Yet, these experiences are hardest to acquire for people furthest away from opportunity. To increase mentorship and career-connected learning programs for people of color, immigrants and refugees, rural communities, and people with disabilities:

- Require mentorship from employers, community members, or other caring adults for youth and adults in career-connected learning programs;

- Create a 1:1 state-employer matching fund for programs that combine mentorship, career planning, and career-connected learning with helping people move out of poverty;
- Work in partnership with the business community to ensure appropriate supports are in place to address trauma and the wrap-around services needed for staff from low-income backgrounds to succeed in the workplace (Bright Spot #12); and
- Certify LGBTQ-owned businesses as minority-owned institutions.

Recommendation 8a-ii. **Accelerate pathways for immigrants and refugees with advanced degrees and/or training from their home country to become accredited in the U.S.** Many immigrants and refugees bring considerable education, training, and professional experience from their home countries, but face obstacles to employment in the U.S. because states fail to recognize their education and employment credentials obtained outside the U.S. Accelerating accreditation for immigrants and refugees with advanced training and degrees will increase the economic security of their families and provide Washington with the talent needed to fill shortages in high-demand occupations, such as medicine, education, science, and engineering (Bright Spot #13). Specific to medical graduates, the state can:

- Create a Limited License for International Medical Graduates (LLIMG) who have passed all the United States Medical License Examinations to practice under the supervision of a Board Certified Physician;
- Ensure Managed Care Organizations that serve Medicaid clients provide credentialing and reimburse international medical graduates who hold a LLIMG;
- Ensure 10% of Washington funded ACGME accredited residency positions are dedicated to immigrant and refugee doctors living in Washington; and
- Create a committee that oversees state funded residency positions and assures that residency programs are actively integrating immigrant and refugee doctors into our health care system.

Recommendation 8b. **Create tax structures for employers that offer full-time employment with living wages and robust benefit packages.** Specifically:

- Increase incentives to employers that hire, mentor, and train workers who are most at risk of skills becoming irrelevant in the new world of work into higher wage, in-demand jobs; and
- Increase incentives to employers that offer medical and dental insurance, long-term care, and retirement plans for all workers.

Recommendation 8c. **Protect Washingtonians from economic downturns by developing an economic "trigger" to provide countercyclical funding in human services, education, and economic and workforce development.** Economic downturns inevitably occur and planning for them can mitigate the effects on people most affected. Specifically:

- Develop a state budget protocol to prepare for economic downturns; and

- Identify policy and program changes (e.g., extending or expanding human service benefits, easing job search requirements, income supports) that can be automatically implemented in the event of a downturn.
- Target economic and workforce development resources to sustain vital industries that are especially vulnerable during downturns (e.g., food service and the arts and culture sector during COVID-19 shutdowns); and
- Ensure workers displaced as a result of economic downturns have pathways to economic stability, as well as opportunities to retool and retrain for other employment opportunities.

Recommendation 8d. **Develop and pilot a portable benefits model and a guaranteed basic income program.** In an economy that does not guarantee full-time work, benefit models must be updated to prevent worsening poverty rates and crises related to it, such as homelessness, mental illness, and addiction. Specifically:

- Develop and pilot a portable employee benefits model that stays with a worker when they switch jobs; strengthening the labor laws under 3e such that workers' boards could empower employers and workers to collaborate in system design for a portable benefits model; and
- Develop and test a guaranteed basic income program to protect people from anticipated disruptions to employment due to technological advancements.

#11: SI SE PUEDE

Connell, in southeastern Washington, is small town America at its best. But like so many rural towns, jobs have passed Connell by and over half of Connell's residents live in deep poverty or working poverty. Via Governor Inslee's Economic Security for All initiative (EcSA), four local communities are testing ways to minimize barriers, simplify intake, improve information sharing, and work as a unified team - with the singular goal of helping 895 families who are currently receiving SNAP benefits move permanently above 200% of FPL. Connell is one of those communities.

Local leaders in Connell are focusing on helping single Latina mothers move out of poverty and into secure middle class careers. Their initiative, Si Se Puede, won funding from the state's Economic Security for All Initiative, which provides local teams of community leaders, employers and service organizations resources to improve economic self-sufficiency in their region. A young woman named Jessica heard about Si Se Puede. This was personal for Jessica, who was raised by a single Latina mother in a small rural town. She moved out of poverty to become a successful young professional and teacher. Jessica joined the Si Se Puede team to help more people move up and live the American dream, like she did.

#12: MOSES LAKE RURAL ECONOMIC DEVELOPMENT

In Grant County, the average annual unemployment rate dipped from 6.3% in 2017 to 6.2% in 2018, which is the lowest percentage since 1990. In this timeframe, they added over 1,300 jobs for a 4.7% increase compared to the State's 2.5% increase for the same time period. One of the sectors seeing an increase in jobs is manufacturing and the county is working with their Economic Development Council and their Workforce Development Council to partner with K-12 schools, colleges and the business sector to create a pipeline of trained youth and adults to invest in the skills needed locally to retain talent in the region. This cross-sector partnership is boosting rural Washington's economic pipeline through innovative partnerships with public- and private-sector support.

#13: WA ACADEMY FOR INTERNATIONAL GRADUATES

Washington Academy for International Medical Graduates is working to break down the barriers that prevent Washington international medical graduates from accomplishing their professional and medical career goals. Such doctors face a steep path towards licensure and often come across many obstacles. As a result of WAIMG's efforts, in 2019 Governor Inslee signed legislation establishing a work-group to recommend strategies for international medical graduates to gain access to residency programs necessary for licensing in Washington. In doing so, the group hopes to improve the economic prospects of immigrants and refugees and also fill the large and growing doctor shortage in Washington state.

Stakeholder Engagement

PRWG conducted the majority of its work between February 2018 and February 2020, and circulated a coordinating draft just prior to COVID-19 and its economic consequences taking hold in Washington state. The timing was fortuitous — having a strategic plan to dismantle poverty grounded in race and social justice and informed by data, research, best practices, and the expertise of people experiencing poverty was well positioned to meet the moment. History shows that times of profound disruption are followed by significant social, cultural, and economic change. This time will be no different, and the timely release of the 10-year Plan outlines the strategies and recommendations we can begin implementing today to build a just and equitable future.

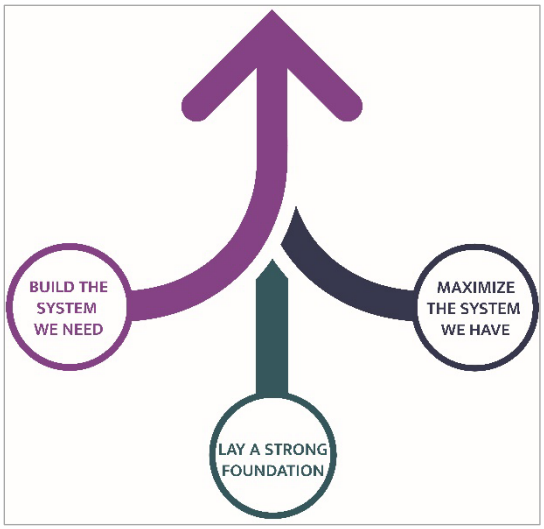
Yet, while PRWG was a large and diverse work group, members also recognized the need to gather input from an even larger group of stakeholders to ensure the 10-year Plan was robust enough to meaningfully and measurably reduce poverty and inequality, especially in the wake of COVID-19. Over 10 months, PRWG conducted over 50 briefings with the public and with organizations representing people most affected by poverty to refine the strategies and recommendations. We are deeply grateful to the hundreds of people from the following organizations for their contributions to the 10-year Plan (Figure 10) – their feedback was invaluable to the process, and the plan will remain a living, breathing document that we sincerely hope stakeholders will participate in and continue to refine in the future.

Figure 10: Organizations Contributing Feedback on the 10-year Plan Recommendations

Amara • ARC of Washington • Ballmer Group • Blacks United in Leadership & Diversity • Catholic Charities of Washington • City of Olympia • City of Olympia Economic Development Team • Coalition for Children of the Incarcerated • Community Action Agencies of WA, ID, AL and OR • Department of Commerce • Department of Commerce Tribal Resource Group • Department of Veteran Affairs • Disability Inclusion Network • Essentials for Children • Executive Council for a Greater Tacoma • Fatherhood Council • Gender Alliance of the South Sound • IF Project • Indian Policy Advisory Committee • Inland NW Business Alliance • Investing in Children Coalition • Lavender Rights Project • Legal Counsel for Youth and Children • Legal Voice • Legislative Executive WorkFirst & Poverty Reduction Oversight Taskforce • LGBTQ Chamber of Commerce • LGBTQ Commissioners of Eastern Washington • Metropolitan Development Council • Migration Policy Institute • Neighborhood House • New Life Baptist Church • NW Justice Project • Odyssey Youth • Pew Charitable Trust Pierce County AIDS Foundation • Qlaw Foundation • Rainbow Alliance & Inclusion Network • Seattle Foundation • Seattle Pride • Sexual Violence Law Center • Solid Ground • Spectrum Center of Spokane • Tacoma Pierce County Chamber of Commerce • Tacoma Pierce County Economic Development Board • The Black Collective • Thurston Strong Economic Development Council • Trans Women of Color Solidarity Network • Tri-County Refugee Planning Committee • United Way of Pierce County • United Ways of the Pacific Northwest • WA Council on Youth Homelessness • WA Low Income Housing Alliance • WA State Association of Head Start and ECEAP • WA State Board of Health • WA State Department of Social & Health Services • WA State Department of Social Health Services Division of Child Support • WA State Disability Council • WA State Health Benefits Exchange • WA State Health Disparities Council • WA State Healthcare Authority • WA State Housing Finance Commission • WA State LGBTQ Commission • WA State Pro Bono Council • Washington Anti-Poverty Advocates Group • Washington Immigrant Network • Washington Office of Refugee and Immigrant Assistance • Washington Recovery Group • Washington Workforce Association • What's Next Washington

Implementation of the 10-year Plan

There is no silver-bullet policy, program, or practice for reducing poverty and inequality. There is no one-size-fits-all solution. Systemic change becomes possible when we recognize the "system" is us — people working in state and local government, non-profits, businesses, and philanthropic entities across the state all have a role to play, and implementation of the strategies and recommendations can be organized over the next ten years as follows:



Lay a strong foundation. Take immediate action on Strategies 1 and 2 to form a foundation that centers people experiencing poverty and race and social justice in implementation.

Maximize the system we have. Address the urgency of now through stronger policy, integration, and collaboration across systems, sectors, and jurisdictions to make the most of the system we have.

Build the system we need. Begin to dismantle poverty by addressing root causes through bold systemic and cultural change.

Table 8 provides a draft guide to implementation using these categories, as well as a rough estimate of timing and anticipated costs. This guide provides initial direction, and serves as a point of departure for discussion for implementation.

We encourage any individual or organization to use the Action Toolkit to identify their unique role and contribution to building a just and equitable future in Washington state.

Table 8: Implementation Guidance for 10-year Plan

STRATEGIES/RECOMMENDATION	IMPLEMENTATION			ESTIMATED TIME TO IMPLEMENT			ESTIMATED COST RANGE*
	Maximize the System We Have	Build the System We Need	Lay a Strong Foundation	5+ Years	3-5 Years	1-2 Years	
STRATEGY 1: Understand structural racism and historical trauma, and take action to undo their harmful effects in state policy, programs, and practice.							
1a. Require state entities to collaborate with the Office of Equity to develop trainings on historical trauma, institutional racism, and implicit bias that are required of all public employees in systems that touch upon the lives of people experiencing poverty.	●			●			$
1b. Require state entities to collaborate with the Office of Equity to develop data, processes, and tools that prioritize equity in state policies, programs, practices, and partnerships.	●			●			$
STRATEGY 2: Make equal space for the power and influence of people and communities most affected by poverty and inequality in decision-making.							
2a. Provide resources to the Office of Equity for a collaboration with Indigenous, Black, and Brown leaders and organizations to develop a formal process for truth and reconciliation.	●			●			$
2b. Establish a state entity to elevate the expertise and influence of people disproportionately affected by poverty and inequality in the implementation of the 10-year Plan.	●			●			$$
2c. Invest state resources to increase ownership capacity in communities most affected by poverty.	●			●			$$$
2d. Fund meaningful access to legal assistance and representation for children, adults, and families disproportionately affected by poverty and racially biased systems.	●						$$
2e. Make high-speed, broadband internet universally available.	●						$$$$

STRATEGY 3: Target equitable education, income growth, and wealth-building opportunities for people with low incomes.									
3a. Adopt the *Washington Kids for Washington Jobs* recommendations, but bolster with more specific, intentional strategies to achieve equity.			●						$$$
3a-i. Increase funding to accelerate the process of naturalization for immigrants, refugees, and asylees.		●			●				$$
3a-ii. Strengthen literacy programs and services for children and adults across the entire education and workforce-development pipeline.		●				●			$$
3a-iii. Eliminate harsh discipline practices in schools and replace them with culturally responsive social, emotional, and engagement supports.		●				●			$$
3a-iv. Increase investment in Expanded Learning Opportunities (ELO) statewide.			●			●			$$
3a-v. Increase investments to improve high school graduation and post-secondary enrollment of children and youth experiencing foster care and/or homelessness.			●			●			$$$
3a-vi. Increase the availability of affordable child care and housing for student parents on or near college campuses.		●					●		$$$$
3a-vii. Remove residency barriers for college students with refugee status.		●			●				$
3a- viii. Increase opportunities for Washington students and adults who are disconnected from the educational system to prepare for and access affordable and high quality postsecondary educational pathways.			●			●			$$$
3b. Enforce stronger salary/wage transparency and fair labor practices among employers to ensure pay equity for women and people of color.			●		●				$$$
3c. Expand access to no- or low-cost financial resources and education that empower, rather than prey upon, people experiencing poverty.			●			●			$$
3d. Enact changes to the state tax system that lower the effective tax rate for low- and moderate-income households (bottom two quintiles).		●				●			$$$$
3e. Work in partnership with local labor organizations and the government to modernize unions and the rights of workers.		●					●		$
3f. Adopt the Child Care Collaborative Taskforce recommendations to increase the availability of affordable, high quality* early care and education.		●				●			$$$$
3g. Increase and preserve affordable housing for renters and owners.		●			●				$$$$

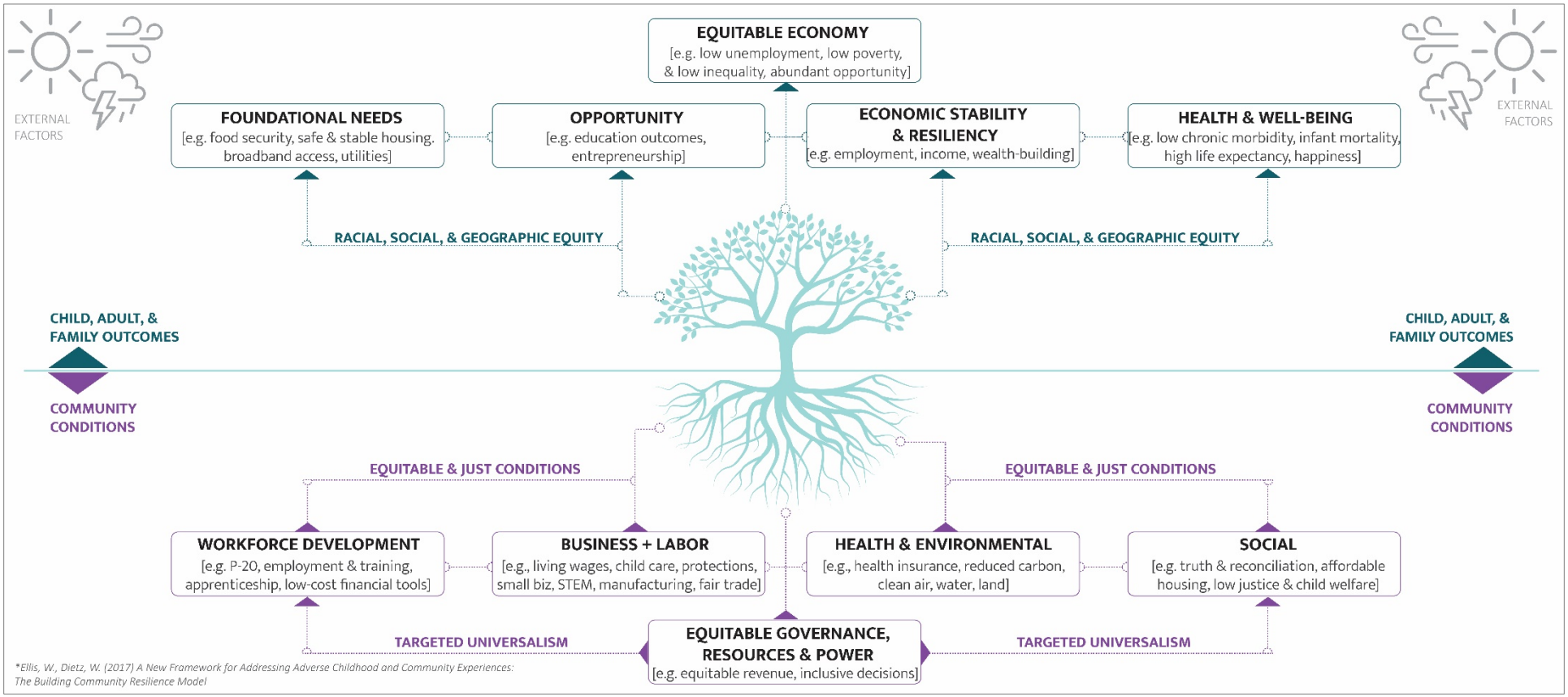
3h. Enact changes to the tax system that support equitable economic growth.		●					●		$$$$
STRATEGY 4: Strengthen health supports across the life span to promote the intergenerational well-being of families.									
4a. Strengthen the Apple Health program by creating a state-funded assistance benefit.			●			●			$$$
4b. Ensure funding and access to culturally and linguistically appropriate health care and support services before, during, and after pregnancy.			●			●			$$$$
4c. Ensure access to free and low-cost contraceptive options and family planning counseling, including long-term acting reversible contraceptives (LARCS) for people who want it.			●			●			$$$
4d. Increase funding to support the availability of culturally diverse, nutritious foods in assistance programs like Women, Infants, and Children, the Farmers Market Nutrition Program, and the Senior Farmers Market Nutrition Program.			●			●			$$$
4e. Develop, implement and evaluate health and human service programs to better meet the unique needs of LGBTQIA+ children, adults, and families.			●		●				$$$
4f. Increase Medicaid funds for supported, in-home care and caregivers so people with disabilities and aging adults can remain in environments they know and trust, as well as avoid costly residential programs.			●				●		$$$$
STRATEGY 5: Address the urgent needs of people experiencing homelessness, violence, mental illness, and/or addiction.									
5a. Provide greater resources for community-led data collection.	●				●				$$$
5b. Adopt the “housing first” approach as the foundation to health and human service delivery and remove discriminatory barriers.									
5c. Increase state and local rental assistance and diversion programs that allow children, youth, adults, and families to avoid homelessness.		●				●			$$$
5d. Increase the number of emergency, transitional, and permanent supportive housing options.			●		●				$$$$
5e. Develop stronger public-private partnerships to increase opportunities for supported education, job training, and employment.		●			●				$$$
5f. Create a Medical-Financial Partnership model for Washington state.			●			●			$$

5g. Improve access to behavioral health prevention, treatment, and recovery support services.			●			●			$$$$
5h. Improve integration of behavioral health treatment in early learning settings and K-12.		●				●			$$$$
5i. Require state entities to collaborate with civil legal aid providers and community-led programs to increase comprehensive support for children, adults, and families experiencing homelessness, violence, or a behavioral health issue.	●					□			$$
STRATEGY 6: Build an integrated human service continuum of care that addresses the holistic needs of children, adults, and families.									
6a. Develop a shared set of outcomes for individual, child, and family well-being, in partnership with communities most affected by structural racism and poverty that each agency is collectively held accountable to achieve.	●				●				$
6b. Update "Standard of Need," assistance levels, and eligibility to reflect the real costs of what it takes for individuals and families to make ends meet.		●				●			$$$$
6c. Develop a universal intake, data sharing, and technology platform so that we can share *essential* information on people across agencies, systems, and sectors.		●					●		$$$$
6d. Increase cash assistance and make it unconditional upon work.		●				●			$$$
6e. Smooth on-ramps and off-ramps for programs.			●			●			$$$$
6f. Revamp policies, programs, and practices to inspire hope and build resilience.		●				●			$$$$
STRATEGY 7: Decriminalize poverty and reduce reliance on the criminal justice, juvenile justice, and child welfare systems.									
7a. Shift resources away from child welfare, juvenile justice, and criminal justice toward comprehensive social, economic, and health supports for children, adults, and families.		●					●		$
7b. Connect child-welfare and justice-related families to legal resources and civil legal assistance to mitigate further negative consequences of criminalization.			●			●			$$$
7c. Keep families together as much as possible, when safe and appropriate.			●		●				$$$
7d. Provide robust, trauma-informed case management to children, adults, and families involved in child welfare, juvenile, and criminal justice systems.		●				●			$$$$

7e. Expand education, job training, and employment opportunities for children and adults while they are in the care of the juvenile and criminal justice systems.			●			●			$$$
7f. Eliminate Legal Financial Obligations (LFOs).		●				●			$
7g. Provide adequate funding to increase the availability of safe, culturally responsive foster homes and permanent living options for children and youth involved with the child welfare system.		●					●		$$$
7h. Connect children, adults, and families to public assistance and support services *at least* three months before they exit a system.		●			●				$$$
7i. Eliminate education and employment barriers, and invest in stronger, better-coordinated exit and re-entry policies, services, and programs.			●			●			$$
7j. Expand and strengthen post-release family and peer support services.			●			●			$$$
STRATEGY 8: Ensure a just transition to the future of work.									
8a. Adopt the recommendations detailed in the FOW Taskforce report, and bolster it with more specific, intentional strategies to achieve equity for workers of color, LGBTQIA+, women, immigrants and refugees, and rural Washingtonians.		●				●			$$$$
8a-i. Dramatically expand mentorship and career-connected learning for people of color, LGBTQIA+, refugees and immigrants, people with disabilities, and rural communities.			●		●				$$$$
8a-ii. Accelerate pathways for immigrants and refugees with advanced degrees and/or training from their home country to become accredited in the U.S.			●		●				$$
8b. Create tax structures for employers that offer full-time employment with living wages and robust benefit packages.		●					●		$$$$
8c. Protect Washingtonians from economic downturns by developing an economic "trigger" to provide countercyclical funding in human services, education, and job training.		●					●		$$
8d. Develop and pilot a portable benefits model and a guaranteed basic income program.	●						●		$$$

\$ = No/Low Cost ($0 - $1 million); $$ = Low Cost $1 million - $5 million); $$$ = Moderate Cost ($5 million - $50 million); $$$$ = High Cost ($50 million+)

Figure 11: What's in the Soil Bears the Fruit: Draft Vision for a Just & Equitable Future



Accountability for a Just & Equitable Future

Washington State is at a turning point. Without intentional investments to build an inclusive, equitable economic recovery, deeply rooted demographic and geographic inequalities that existed prior to COVID-19 will intensify and put an unprecedented number of Washingtonians at risk of poverty and its intergenerational consequences. Right now the 10-year Plan is just a plan — it will require intention and accountability among leaders from all sectors, systems, and jurisdictions to bring it to fruition.

As a start, PRWG co-lead agencies convened a group of technical experts from state entities and community organizations to develop a draft vision for what a just and equitable future looks like, and how to measure progress toward that vision. The vision (Figure 11) is based on the idea that what's in the soil bears the fruit, and if Washington state invests in just and equitable conditions in communities, equitable outcomes for all children, adults, and families will result. Economic data tools known as "triggers" can help guide the state toward this vision, but will need to be decided in collaboration with a diverse group of stakeholders, especially people most affected by poverty and the current downturn, to ensure the robust and inclusive recovery Washingtonians deserve.

CONCLUSION

Now is the time to invest in an economy underwritten by equity, in which all Washingtonians have their foundational needs met and the resources and opportunities they need to thrive. Fortunately, we have a plan to meet the moment and build a just and equitable future for all.

These recommendations were created in conjunction with the Steering Committee in an attempt to elevate the experience and influence of people experiencing poverty. Together, we blended evidence and innovation, and created trust through collaboration. We embarked on a journey that brought forward real solutions to poverty reduction and inequality in Washington State. This plan is now in your hands to make this vision a reality — a place where all Washingtonians live with dignity and have access to opportunities for reaching their fullest potential in life.

The bold solutions presented in this report will require fearless leaders willing to champion the urgency of now and a strong commitment to elevate the expertise and influence of people experiencing poverty and to center race and intersectionality in all aspects of policy development and systems change.

Through this process we built trust where it didn't exist before, with individuals who have been let down before — we cannot let them down. We hope you will join us.

APPENDIX

Appendix A – Racial Equity Toolkit

The Racial Equity Toolkit (as shown below) was created in 2008 by the Seattle Office for Civil Rights' Race and Social Justice Team. The purpose of the Toolkit is to "center race" with the goal of eliminating racial disparities and advancing racial equity. More information can be found here: http://www.seattle.gov/civilrights/programs/race-and-social-justice-initiative/racial-equity-toolkit.

Step 1. Set Outcomes
Leadership communicates key community outcomes for racial equity to guide analysis.

Step 2. Involve Stakeholders + Analyze Data
Gather information from community and staff on how the issue benefits or burdens community in terms of racial equity.

Step 3. Determine Benefit and/or Burden
Analyze issue for impacts and alignment with racial equity outcomes.

Step 4. Advance Opportunity or Minimize Harm
Develop strategies to create greater racial equity or minimize unintended consequences.

Step 5. Evaluate. Raise Awareness. Be Accountable.
Track impacts on community of color overtime. Continue to communicate with and involve stakeholders. Document unresolved issues.

Step 6. Report-Back.
Share information learned from analysis and unresolved issues with Department leadership and change team.

Washington Community Development Authority
DBA Communities of Concern Commission PDA Legislation

Who we represent: The Communities of Concern Commission is a coalition of leaders from communities of color and poor rural communities that are disproportionately affected by poverty and have yet to fully benefit from the economic growth that is so apparent in many areas of Washington State.

Our request: The Communities of Concern Commission is seeking recognition status as a statewide public development authority to work with poor communities of color and rural communities to build the capacity to meet the needs of their communities.

Rationale: Community organizations strongly rooted in poor communities of color and rural communities have the cultural understanding, imagination and vision to create capital assets that will help reduce poverty and build stronger and more sustainable communities. These capital assets would be self-determined, managed and owned by the communities they serve. The Communities of Concern Commission doing business as the Washington Community Development Authority seeks to change structural barriers by partnering with the state to build the capacity of communities to conceive, design, finance, construct and manage the types of assets that are essential to reducing poverty.

Why a statewide public development authority: Many of our communities are not geographically defined, and our members have not been included in local government planning processes. As a public development authority, the Washington Community Development Authority (WCDA) could better facilitate ongoing state investment to a dedicated fund to accelerate the creation of affordable housing and other essential facilities in the communities we represent. The WCDA would work with communities to create community growth plans to identify capital projects, and help selected capital projects. State funding would also be sought for the development of the WCDA.

Partnerships: The Washington Community Development Authority will work with the Department of Commerce to develop criteria and evaluate proposed capital projects. The WCDA will also work with Commerce and the Washington State Housing Finance Commission to identify appropriate project funding allocations.

Our Results: The 2018 Capital Budget funded the Communities of Concern at $1 million. Working with the Department of Commerce, the Commission funded ten community projects including pre-development and community planning work – Billy Frank Jr. Heritage Center (Nisqually), Equity Alliance of Washington (Seattle), Community to Community (Whatcom County), Ethiopian Community Affordable Senior Housing (Seattle), El Centro de la Raza (Seattle), Lummi Stepping Stones Emergency Repairs, Seattle Indian Services Commission, Latino Civic Alliance (south King County), Partners for Rural Washington (Methow Valley/Stevens County Fire District/Ritzville), and United Indians of All Tribes (Seattle). A report was provided to the Legislature in December 2018 of the projects' outcomes. A final report will be provided July 2020.

For further information contact:
Josephine Tamayo Murray, Vice-President for Public Policy

Catholic Community Services/Catholic Housing Services of Western Washington - (206) 328-5701

Washington Community Development Authority dba Communities of Concern Commission

Certificate of Incorporation 05/16/2017 from WA State Secretary of State: UBI# 604-127-812

Commission Board of Directors: Asian Pacific Cultural Center (Tacoma); Bethel Christian Church (Seattle); Catholic Community Services of Western WA; Catholic Housing Services of Western WA; Chief Seattle Club; Community to Community (Bellingham); El Centro de la Raza (Seattle); Ethiopian Community in Seattle; FilAm Resources for Educational Advancement for Culture & Technology (statewide); First AME Church (Seattle); Latino Civic Alliance (statewide); Lummi Stepping Stones; Native Action Network (statewide); Partners for Rural WA (statewide); SeaMar Community Health Centers (statewide); Seattle Indian Services Commission; St. Charles Parish (Burlington); Survival of American Indians Association (Nisqually); Tibetan Association of Washington (statewide), United Indians of All Tribes (Seattle); Washington Housing Equity Alliance (Seattle); and, the Washington State Catholic Conference.

Executive Committee: President-Bishop Thomas Davis (Bethel Christian Church, Seattle), Vice-President-Jesus Sanchez (SeaMar Community Health Centers), Secretary-Josephine Tamayo Murray (Catholic Community Services of Western WA), Treasurer-Claudia Kauffman (Seattle Indian Services Commission).

Loaned Executive Director: Josephine Tamayo Murray.

Fiscal Agent: SeaMar Community Health Centers.

Commission Operations:
Meetings: Monthly with Executive Committee meetings as needed.

How Decisions Are Made: By consensus of the Director organizations present at a meeting. Each Director is entitled to only one vote. Directors with more than one representative designate a voting member to cast the vote of that Director.

Board of Director Criteria: Currently, a non-profit organization serving poor communities of color and/or poor rural communities in Washington state who have an idea for a self-determined, community owned and operated capital asset.

How New Directors Are Appointed: Currently, interested organizations submit a letter of interest and description of their capital asset idea to the Executive Director who will vet the request with affiliated Commission members. If the affiliated Commission members agree, an interview with the interested organization will be scheduled. After the interview the affiliated Commission members will recommend to the Commission as a whole as to whether an interview will be scheduled between the interested organization and the whole Commission. The Commission will then determine whether the interested organization is appointed as a Director. As a public development authority, there will be no membership requirement.

How Funding Awards Are Determined: An application form has been developed that includes descriptions of the applicant organization, project/community growth plan, organization staff and board, financial statements, project team, project status and budget. The applications are reviewed and rated by an ad-hoc committee. The Executive Director recommends to the Commission the project amounts to be funded. The Commission meets with Commerce who affirms the project funding awards. As a public development authority, the Initial Board will be composed of community of color and poor rural community organizations' representatives who do not have a capital project to be funded by the PDA.

ENDNOTES

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[4] See PRWG Progress Report for data, research, and evidence identifying root causes of poverty.

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