American Heart Association.
CEO Roundtable

Driving Health Equity in the Workplace

TABLE OF CONTENTS

FOREWORD

As we reckon with structural inequities throughout society and their disproportionate impact on the health of our employees and communities, CEOs across America are examining their own business policies, procedures and programs.

Many workplace cultures and policies were built without regard to equity. As a result, employees may face limited opportunities based on their race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors.

As business leaders, we must do better. That is why the American Heart Association CEO Roundtable – a leadership collaborative of nearly 50 CEOs dedicated to improving employee and community health – is delivering a roadmap and resources for organizations to dismantle practices and policies that contribute to health inequity.

This work is designed to help employers eliminate inequities at work and consider contributing factors within their communities – ultimately with the aim of reducing health disparities nationwide.

We invite other executive leaders to join us in critically reviewing our own organizations to identify and eliminate structural racism, discrimination and biases.

We hope these guiding principles and actionable strategies will further empower employers to champion equitable health for the nation's workforce and their families.

Nancy Brown
CEO, American Heart Association

Alex Gorsky
Chairman and CEO
Johnson & Johnson

Brian Moynihan
Chairman and CEO
Bank of America

ACKNOWLEDGEMENTS

We are grateful to the AHA CEO Roundtable members for their support and commitment to driving health equity in the workplace:

CEO ROUNDTABLE LEADERSHIP

Nancy Brown
CEO
American Heart Association

Alex Gorsky
Chairman and CEO
Johnson & Johnson
CEO Roundtable Co-Chairman

Brian Moynihan
Chairman and CEO
Bank of America
CEO Roundtable Co-Chairman

We wish to thank the following people who contributed to this report:

WRITING GROUP

Keshia M. Pollack Porter, Ph.D.
(Chairperson) Professor, Vice Dean for Faculty, Johns Hopkins Bloomberg School of Public Health

Lydia Campbell, M.D.
Vice President, Chief Medical Officer, IBM

April Carson, Ph.D., M.S.P.H.
Professor, Associate Dean of Diversity, Equity, and Inclusion, University of Alabama, Birmingham

Edward Chang, B.S.
Managing Director, TDW+Co.

Luther Clark, M.D.
Deputy Chief Patient Officer & Global Director, Scientific, Medical, and Patient Perspective, Merck

Maria Dee, M.B.A.
Executive Director, Workforce Wellbeing, Kaiser Permanente

Jeff Harris, M.D., M.P.H., M.B.A.
Professor and Chair, Department of Health Systems and Population Health, University of Washington

Bob Lockett, M.B.A.
Chief Diversity and Talent Officer, ADP

Octavio Martinez, M.D., M.P.H., M.B.A.
Director, Hogg Foundation for Mental Health; SVP Diversity and Community Engagement, University of Texas at Austin; White House COVID-19 Health Equity Task Force

John McFarland
VP News, Content, and Editorial, American Heart Association

Drew Mills, M.P.H.
Health Programs Analyst, American Heart Association

Brendon Perkins, B.S.
SVP Global Compensation and Benefits, Nielsen

Laurent Tao, M.D., M.P.H.
Editor-in-Chief, MCG (Part of the Hearst Health Network)

Scott White, M.S.
VP Total Rewards, Levi Strauss & Co.

Eduardo Sanchez, M.D., M.P.H., FAHA
Chief Medical Officer for Prevention

EXTERNAL REVIEWERS

American Medical Association

Business Roundtable

NAACP

National Organization on Disability

U.S. Hispanic Chamber of Commerce

AMERICAN HEART ASSOCIATION STAFF

Webb Bierbrier
Director of Communications

Kristi Durazo
Director of Health Equity Strategies, Office of Health Equity

Gerald E. Johnson II
EVP Health Equity, Chief Diversity Officer

Lisa Langas
Program Director, CEO Roundtable

Jennifer Pratt, MBA, APR
Senior Communications Manager, Office of the CEO

Karen Robb
Senior Manager, Customer and Marketing Research

EXECUTIVE SUMMARY

Inequity, discrimination and bias have no place in the workplace. Yet, they remain. And these problems have been proven to take a heavy toll on the health and well-being of employees, organizations and their communities.

Significant improvement in the health of employees is expected when workplaces focus on equity. Conversely, stressors from discriminatory practices are threats to employees' emotional, psychological and physical health. Many employers are taking action to eliminate health inequities and will continue to do so. However, progress must be made on a broader scale to truly achieve health equity.

This report is designed to provide leaders a compilation of policies and practices that promote health equity and eliminate inequitable policies and practices. Whether an organization's journey to advance health equity is well underway or just beginning, we hope this report will spark change and lead to thoughtful conversations and partnerships among business leaders that can truly have an impact. Our aim is to help end historical structures and workplace cultures that advertently – or inadvertently – treat people inequitably based on race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors.

The American Heart Associations' CEO Roundtable, a leadership collaborative of nearly 50 CEOs, sponsored this report based on scientific evidence, market research, and best practices and examples from leading organizations.

Working toward health equity is the right thing to do for all organizations. Equity benefits employee health and productivity, reduces health care costs for employees and employers, and is a moral and business imperative. The health of the entire nation will improve if employers commit to actions that eliminate inequities.

GUIDING PRINCIPLES

1. Practice intentional inclusion at all levels of the organization, including but not limited to shared decision-making, ensuring participation and listening to perspectives of individuals from historically excluded populations.
2. Adopt policies, practices and programs that address the historical legacies of structural inequities and how current systems, practices and norms may perpetuate inequity. Explore and acknowledge the organization's role in these histories and systems.
3. Eliminate structural racism and bias to promote health equity and improve employee health and well-being.
4. Commit to practicing allyship, modeled and supported by leadership, to promote health equity.
5. Adopt a common language guide promoting dignity and culturally sensitive use of language.
6. Create a plan for assessing the impact of organizational change on health equity.
7. Be accountable for having a true impact on advancing health equity. Intent is not enough.

INTERNAL ACTIONABLE STRATEGIES

1. Review and revise hiring, retention and recruitment practices to eliminate policies that may favor one group of people or disadvantage others.
2. Include equity in evaluation of employees, managers and leadership.
3. Offer comprehensive, understandable and affordable health care coverage for all employees.
4. Ensure leadership is composed of people from diverse backgrounds and representative of your workforce and community.
5. Support employee financial well-being through education, employee benefits and other strategies.
6. Adopt anti-racism principles and implement anti-racism policies.
7. Promote employee health literacy and employee benefits literacy.
8. Offer paid family and medical leave.
9. Ensure pay equity and provide a living wage.
10. Promote use of employee assistance programs.
11. Ensure employees have a voice in organizational decision-making.
12. Offer diversity, equity and inclusion training to employees.
13. Review contracts to maximize hiring of historically underrepresented businesses and ensure supplier commitment to equity and equitable practices.
14. Advocate for culturally and linguistically effective training for all employees, providers and vendors.
15. Review organizational communications for cultural appropriateness, diverse representation and accessibility.

EXTERNAL ACTIONABLE STRATEGIES

Employers can focus their advocacy efforts in the name of equity through these actions.

1. Advocate for comprehensive, understandable and affordable health insurance coverage for all.
2. Advocate for affordable housing.
3. Advocate for high-quality, accessible and affordable early care and education for children.
4. Advocate for culturally and linguistically appropriate services in the health system.
5. Advocate for increased support of public health infrastructure.

MARKET RESEARCH HIGHLIGHTS:

(Based on a survey of 1,203 employed U.S. adults conducted from May 4-13, 2021)

- There are significant variations in health equity perceptions across race, ethnicities and other demographic groups.
- Many respondents felt societal effects of health inequities, but most reported a mostly positive work environment where they can be their true selves.
- Comprehensive benefit plans contribute to health equity.
- The workplace is regarded as a place that values diversity and inclusion.
- There was a noticeable disconnect between white respondents and Black, Asian and Hispanic respondents, suggesting an opportunity to review and improve organizational practices, practice allyship and increase understanding of health challenges.

For additional insights, refer to the Resource section on the *Driving Health Equity in the Workplace* website.

CONCLUSION

Achieving health equity is the right thing to do for all organizations. Equity benefits employee health in many ways, and it increases productivity and reduces health care costs for both employees and employers.

These benefits can be multiplied far beyond an organization's offices. Equity also improves the health of employees' families and their communities. The health of the entire nation will improve if more employers commit to actions that eliminate inequities.

OVERVIEW

Health equity is a state that would exist if everyone had a just opportunity to be healthy. Absence of health equity limits opportunities for optimal health and well-being based on race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors.

Structural inequities lead to startling contrasts in health among different people. The death rate from heart disease is significantly higher among Black people (206 per 100,000) than white people (166 per 100,000).[1] Black, Hispanic and Asian people,[2] and members of the LGBTQ community,[3] also generally have higher rates of cardiovascular risk factors such as hypertension, diabetes and obesity. The life expectancy for white people (78 years) is about 6 years longer than it is for Black people (72 years).[4] And reductions in life expectancy, largely due to COVID-19, have disproportionately affected people of color.[4] Adults with disabilities are 1.5 times more likely to die prematurely from any cause than adults without a disability. And people in rural areas have less access to and lower quality of health care than people in urban and suburban areas.[5,6]

Health inequities are rooted in historical and present-day policies and systems that may favor one group over others. These structural inequities take their toll on people's health through social, economic, political, cultural and physical factors. Simply put, health is deeply connected to where people live, work, learn, play and pray. Health is also shaped by a wider set of economic, social and political forces that influence the allocation of power and resources.[7] Inequities in these environments lead to poorer health and well-being.

The impact of inequities in the workplace is significant, considering the amount of time spent working. On average, full-time employees spend roughly half of their waking hours at work.[8] Even though many employees work remotely due to the COVID-19 pandemic, they report working longer hours,[9] feeling increased stress and higher rates of poor mental health.[10] Health inequities can adversely affect workplace performance, whether in-person or remote. Having a healthy workforce reduces absenteeism, presenteeism and health care costs, and improves productivity.[11]

Research shows that promoting health equity can benefit employee health and productivity,[12] and reduce health care costs. Employers can make a great difference in their organizations and communities by addressing factors within and outside of the workplace.

This body of work is a resource for leaders who are seeking to learn more about achieving health equity and dismantling inequities that affect the health and well-being of their employees.

It is intended to generate thoughts and conversation and spark action. Whether employers are just beginning their journey to advance health equity or are already well on their way, the guiding principles and strategies shared here offer evidence-based ways to promote equity and work toward eliminating health disparities.

BUSINESS FRAMEWORK

WHAT ARE THE BENEFITS OF PROMOTING HEALTH EQUITY IN THE WORKPLACE?

U.S. employers pay, on average, 82% of health care costs for employees and 70% of costs for families.[13] **Yet, even with broad coverage and advancements in medical care, a health gap remains, with many employees facing disadvantages that limit their opportunities for optimal health.** Opportunities to be healthy depend largely on living and working conditions, often referred to as social determinants of health.[14] Employees who live in health-promoting environments and have access to necessary resources and services when needed can focus on the things that matter most – spending time with family and friends, maintaining physical and mental health, and personal and professional development. For employers, understanding, embracing and promoting health equity are moral and socially responsible actions – and they are imperative for business success.

A healthy and engaged workforce collaborates well, allowing employees to focus on solutions for clients and business objectives. This positively impacts an organization's bottom line, boosting its brand and attracting more talent, clients and investors.[15]

A 2019 study published in the American Journal of Health Promotion suggests organizations that foster health and safety of employees outperform the Standard and Poor's 500.[16]

Advancing policies and practices that promote health equity, diversity and inclusion are paramount in bolstering corporate growth and performance. While many organizations refer to diversity, equity and inclusion as one office or entity, it's important to understand these terms individually. This report focuses primarily on health equity in the workplace – that is, working toward a state where everyone has a just opportunity to be healthy. Diversity and inclusion among staff are crucial but not synonymous with equity; ensuring diversity and inclusion is one of many ways to work toward equity. Intentional effort must be made to foster a workplace culture that provides equitable opportunities for employees.

WHAT IS THE EMPLOYER'S ROLE? WHAT ARE THE DIRECT AND INDIRECT COSTS TO EMPLOYERS?

Achieving health equity requires societal action to remove barriers to health and increase opportunities to be healthy for everyone, focusing particularly on people who face the greatest social obstacles and have worse health. While employers cannot control all causes of health inequity, they play a key role in removing barriers for employees to access critical health care services. Discussions about health equity should begin from a common perspective and belief that health inequities are indeed remediable and that removing them benefits all stakeholders, immediately and in the longer term. Employers should work in collaboration with other employers, government entities and community health organizations to create strategies

that eliminate health inequities based on race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors.

Employers are uniquely positioned to leverage their collective purchasing power and influence to drive policies and practices that ensure equity – and dispel practices rooted in structural racism, social injustice and disenfranchisement.

Employers should adopt a holistic view of the general health status of employees and the impact their work environment has on their health. That includes a clear understanding of the availability of preventive health services, mental and well-being programs, benefits and financial wellness support – and whether employees consider their workplace to be safe and positive. Further, employers should be conscious of how their policies, programs and practices may inadvertently contribute to inequity, and how they might be changed to promote an inclusive, equitable workplace environment.

This information will help identify and address gaps, trends and inequities that may be disproportionately affecting certain groups of employees. Business leaders can address issues in a number of ways. For example, they can promote a culture of health; ensure ease of access to more convenient health care resources (such as telemedicine); select health plan providers that offer cultural competency training to health care professionals and employees; and work with health insurance providers to offer adequate network coverage in under-resourced areas. The effectiveness of these actions can be measured by the closure of health disparity gaps, such as health care access and utilization, and health outcomes, between employee populations. As employers embrace these changes, the net effect will be an overall improvement in equity within health care.

Estimating the direct and indirect cost of health inequity for employers is challenging. **A recent analysis estimates health inequities result in about $93 billion in excess medical care costs and $42 billion in lost productivity per year. Other studies estimate the cost attributable to illness and premature death as a result of inequities to be as high as $1.2 trillion**.[17] Employers bear a significant amount of these direct health care costs, as well as costs attributable to absenteeism, presenteeism and employee turnover. Employers may face additional costs as they seek to attract and retain diverse talent and support health equity efforts, but these costs can be potentially offset by the gains made from achieving health equity through these efforts.

WHAT BARRIERS TO PROMOTING HEALTH EQUITY DO EMPLOYERS FACE?

Achieving health equity requires identifying and addressing not only overt discrimination but also unconscious and implicit bias and the discriminatory effects — intended and unintended — of current structures and policies put in place by historical injustices.

Commitment by executive leadership to make health equity an organizational priority can overcome a potential barrier that can limit the impact of diversity, equity and inclusion efforts. By not modeling strong support, leaders can undermine any progress made toward health equity.

Another perceived roadblock is funding. Skills, resources and tools are needed to collect and monitor employee health data, identify inequities and bias, address inequities and evaluate the effectiveness of these actions.

Groups of employers can collaborate to develop strategies to overcome obstacles and promote health equity across the employment and health care spectrums.

Barriers to overcome can include:

- Regulatory, privacy and legal concerns related to tracking employee health and demographic data.
- Limited ability to collect and use employee health and demographic data to develop tailored interventions to address health equity.
- Limited awareness of understanding health equity issues among workers.
- Limited ability to use data to measure health equity outcomes.
- Lack of standards for collecting and analyzing workplace health equity data.
- Limited workforce skills to enable health equity and implement programs that address social determinants of health.
- Employers must drive an agenda on equity within their own workplaces and across the employment spectrum. In addition, closing health equity gaps within our communities and across the nation will depend on employers collaborating with partners to overcome these barriers.

HEALTH EQUITY FRAMEWORK

Health equity requires addressing social determinants of health – the conditions where people live, work, learn, play and pray. These determinants often have disproportionate impact on access to power and resources based on race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors. Understanding these factors is crucial.

A strategic, holistic approach to develop a culture of health can ensure everyone has an equitable opportunity to live a healthy and productive life. This requires the conditions and resources needed to be healthy and make healthy choices. Inequities do not arise on their own. People create the systems we live in, unintentionally or intentionally. Therefore, intentional action is needed to increase opportunities to be healthy. The focus needs to be on groups of people who have been historically excluded or marginalized. Systematically focusing on people with worse health and/or fewer resources to reduce barriers and improve health can build toward health equity. Everyone's health improves in such a process because a sustained commitment to improving health will benefit all. This process should include the following guiding principles to achieving health equity.

GUIDING PRINCIPLES:

1. **Practice intentional inclusion at all levels of the organization, including but not limited to shared decision-making, ensuring participation and listening to perspectives of individuals from historically excluded populations.**

   To effect meaningful change, the voice of people who have been historically excluded or marginalized must be at the table from planning to decision-making to implementation to evaluation. Efforts to ensure these voices are welcomed and listened to must be thoughtful, deliberate and sincere. Tokenism will raise questions about the organization's sincerity and undermine the effectiveness of work to end structural inequities in the workplace and achieve health equity. This will require the intentional creation of a psychologically safe work environment – the designation of the workplace as a safe space

2. **Adopt policies, practices and programs that address the historical legacies of structural inequities and how current systems, practices and norms may perpetuate inequity. Explore and acknowledge the organization's role in these histories and systems.**

   Risk for negative health outcomes occurs through socioeconomic, political, cultural and normative interactions. Health outcomes depend on a person's position in a

hierarchical social order that is embedded in diverse networks of power relationships and effects, and in conjunction with perceived health-related deservingness, normality, credibility and assumed intelligence. Decreased or limited access to resources due to past and ongoing discrimination, fear, mistrust and lack of awareness affects the places where people live, work, learn, play and pray; with people of different racial, ethnic and other groups disproportionately impacted adversely. Meaningful changes are needed to policies, laws, systems and institutional practices to end structural inequities in the workplace and achieve health equity.

3. **Eliminate structural racism and bias to promote health equity and improve employee health and well-being.**

   Structural racism is a system in which public policies, institutional practices and cultural representations reinforce racial inequities. It has resulted in the association of power and privilege with "whiteness" and the association of powerlessness and other disadvantages with "color." It is rooted in historically intentional discrimination and discriminatory policies, practices and programs. Structural racism exerts its effects to this day through inequitable policies, practices, and programs, even when individuals do not intend to discriminate. Structural racism is a root cause of health inequities. It is embedded in our social, economic and political systems, and must be eliminated, or at least mitigated, to achieve health equity.

4. **Commit to practicing allyship, modeled and supported by leadership, to promote health equity.**

   Allyship occurs when people with power and/or privilege work in solidarity and partnership with groups who have been excluded and marginalized. This work includes changing systems, institutions and policies that undermine basic rights, access, and/or the ability to thrive. Allyship is a proactive and ongoing process of building relationships based on trust, consistency and accountability that benefits all.

5. **Adopt a common language guide promoting dignity and culturally sensitive use of language.**

   A common language guide that takes into account cultural contexts helps ensure shared understanding among employees and minimize misinterpretations and missteps. It is an important tool in creating a culture of health that is founded on the values of respect and integrity. It is critical that when the language guide is put into practice that it is honored and followed to effect a true cultural transformation. Ensuring such a guide is a "living document" will reflect evolving language as well as lessons learned through usage. Staff input on the guide will engage employees and create a continual learning experience.

6. **Create a plan for assessing the impact of organizational change on health equity.**

   It is imperative that data and metrics are collected, assessed and followed over time. Progress needs to be determined in absolute and relative terms. It is unacceptable to simply compare groups that have been marginalized or disadvantaged to an average of the general population, or to focus on overall averages alone. Employers should develop robust evaluation plans that engage employees at all levels through various channels. Plans must rely on disaggregated data for different subgroups and from a variety of sources. Evaluation must include short-term, intermediate and long-term outcome indicators.

7. **Be accountable for having a true impact on advancing health equity. Intent is not enough.**

   Accountability cannot be delegated. Eliminating structural inequities and achieving health equity require a sustained commitment to improving health for all. This commitment calls for identifying and addressing overt discrimination as well as implicit bias and the discriminatory effects of structures and policies created by historical injustices. Health equity accountability is about integrity and respect. Accountability also fosters trust and a culture of health as deeply held values. Accountability is required at all levels of the organization, especially executive leadership.

INTERNAL STRATEGIES FOR ACHIEVING HEALTH EQUITY

Employers, of course, have the greatest influence over their internal programs, policies and environments. While each organization will vary in their starting point working toward health equity, most employers have a significant opportunity to strengthen employer offerings.

This section provides a curated list of evidence-based internal strategies for employers to consider as they seek to advance health equity.

1 Review and revise hiring, retention and recruitment practices to eliminate policies that may favor one group of people or disadvantage others.

What is it?

Deliberate, equitable hiring practices ensure a diverse and inclusive staff that reflects clients and communities. Employers may need to focus on hiring from populations and communities that are underrepresented in their workforce. While sometimes considered a potential solution to unconscious bias, anonymization of the hiring process to purportedly promote equity can often ignore many of the structural factors that disadvantage people before they even apply for a position. While employers want to strip away unconscious bias and encourage inclusivity, that is only part of the solution.

Inclusivity is best achieved through intentional sourcing via broad community outreach. On a macro scale it may seem this approach introduces bias, but on a micro scale, smart recruiting can ensure a workforce truly reflects its community. Evaluation is key to ensuring equitable representation. Results can be best measured through a simple question: Is your hiring reflective of the community?

Sourcing for prospective employees is crucial. Some employers take the approach of, "If you build it, they will come." However, people from historically excluded communities may not know who you are and what you do. Good faith marketing efforts will include exposure to jobs through innovative channels.

For example, organizations can deliberately source by reaching out through community-based organizations and communication channels to a broad range of groups who have been historically excluded based on their race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors.

Organizations can amplify the value of these efforts by also focusing on careers and career pathways that increase opportunities for upward organizational and economic mobility that, in turn, can improve health equity and outcomes.

How does it impact health?

Jobs with benefits mean opportunities to access health insurance, which is strongly associated with better health outcomes.[18,19] And many organizations offer additional benefits designed to improve physical and mental health, education and incentive-based programs focused on health. For example, some organizations offer internal programs encouraging healthy lifestyles and prevention measures such as biometric health screenings or disease management programs. Evidence also shows that employment reduces the risk of depression and improves general mental health.[20]

How does it reduce inequities?

Hiring based on availability in communities means a greater diversity of people have a chance to participate in the economy with well-paying jobs. This can help reduce economic inequities that impact health and well-being. It also provides an opportunity for people to feel valued.

How can employers act?

Employers should consider implementing the following strategies to make their hiring practices more equitable:

- Establish objectives/goals for hiring to ensure that your workforce is representative of the community.
- Partner with local community organizations to source talent.
- Provide training to hiring managers to mitigate bias in recruiting and selecting diverse talent.
- Ensure oversight of the hiring funnel to ensure goals and outcomes are met and that any necessary course corrections are made.
  - This will require implementing processes for collecting and monitoring data such as race, ethnicity, sexual orientation, gender identity and people with disabilities.
- Benchmark against external hiring standards.
- Leverage employee resource groups to improve the hiring process.
- Prioritize transparency with qualitative and quantitative employee perception surveys with actionable next steps.
- Review job descriptions during hiring to ensure they emphasize the skills and competencies required by the position and not just formal education requirements.

2 Include equity in evaluation of employees, managers and leadership.

What is it?

At all levels of the organization, employers should assess employee performance fairly based on their contributions. When evaluating performance, employers should consider both WHAT the employees delivered and HOW results were achieved. Once all employees are evaluated through a standardized approach, leaders can begin to ensure evaluations are consistent and achieve the desired outcome to reward performance fairly and equitably. Like most people processes, organizations should audit their approach to ensure certain populations aren't unfairly evaluated.

How does it impact health?

Equitable evaluation leads to equitable compensation, which can benefit mental health and impart the feeling of being valued. Conversely, inequitable evaluations and their outcomes lead to stress and can be viewed as harmful microaggressions. Microaggressions – which are everyday and often-subtle verbal, nonverbal and environmental slights, snubs or insults – can be intentional or unintentional. For example, if the performance of employees of color is consistently undervalued and underestimated in performance reviews, this can lead to poor evaluations and reduced opportunity for advancement.

How does it reduce inequities?

Auditing evaluation practices may highlight inequities. These results give organizations the opportunity to challenge and change practices or evaluations that are unfair to particular groups. For example, if women are typically evaluated lower than their male counterparts, leaders would need data-based explanations about certain evaluation decisions. If the reasons are not sound, the organization should ensure evaluations are adjusted accordingly.

How can employers act?

Ensuring equitable evaluations requires intentionality, commitment, hard work and relentless analysis. An across-the-board comparison of pay, raises and promotions can make equity issues very clear. Even if you have processes and policies designed to promote equity, metrics may still reveal inequities that have been overlooked. Broad and regularly scheduled comparisons are recommended, based on gender, race, ethnicity, sexual orientation, age, ability, veteran status and other areas where inequities may exist in an organization. It is important to emphasize equity from the start of employment. For example, some organizations provide opportunities for mentorship and sponsorship, in which senior members of the organization develop a mentoring relationship with junior members and use their own influence to advocate for the advancement of the junior people. This advocacy and mentoring can promote the professional and personal development

of individuals from underrepresented groups and increase the likelihood of their advancement within the organization.[21]

If not already using one, also **consider a detailed rubric to assess employee and manager performance**. This can promote the identification of specific areas of success as well as actionable opportunities for improvement. By following a standardized rubric, employers can limit some of the unconscious bias involved in performance evaluations.[22]

Another approach is to create a "talent task force" that assesses equitable representation in leadership. This can further build literacy about unconscious bias, non-discriminatory practices, the value of diversity and other important concepts. It also can build accountability based on outcomes.

3 Offer comprehensive, understandable and affordable health care coverage for all employees.

What is it?

In 2019, over 183 million individuals (56.4% of the population) obtained health coverage through employers,[23] and many reported being satisfied with their coverage. However, not all employer-sponsored health insurance is the same, and some employees must contend with issues such as underinsurance, unaffordability, and confusing terminology, processes and payment structures.

Equity in employer-sponsored health insurance is foundational to equity in health, employment and society overall. Health insurance benefits can cover a range of important offerings that influence employees' ability to live long, healthy lives, including access to health care, disease management, mental health services, education, behavioral health care, well-being programs and on-site clinics. Coverage, access and affordability are three major lenses through which to assess the equity of employer-sponsored health insurance. Programs lacking or inequitable in any of these areas can disadvantage certain groups of employees and further exacerbate health disparities.

How does it impact health?

Health care costs have shifted over time from employers to workers through rising premiums, deductibles and cost-sharing.[24] Health insurance is becoming increasingly unaffordable for some employees. Health care costs have outpaced salaries, so many people are effectively "underinsured" (i.e., spending more than 10% of their income, excluding premiums, on health care; spending more than 5% if they earn a low income; or having a deductible exceeding 5% of their income). A study by the Commonwealth Fund found that in the first half of 2020, a quarter of adults in employer-sponsored plans were underinsured, largely due to increasingly inadequate coverage.[25] In addition, 12.5% of all adults were uninsured. That

includes many people who were employed.[26] In fact, 35% of all adults reported at least one cost-related problem obtaining necessary health care services (e.g., not filling a prescription, skipping a test or appointment, not seeking medical care when sick).[25]

Lack of affordable employer-sponsored insurance, due to uninsurance despite it being available or being underinsured, is a major issue that significantly impacts an employee's ability to receive needed care. Uninsured adults are much more likely to have no usual source of care compared to people with insurance. They also are more likely to skip or postpone care or prescription drugs, and generally are less likely to receive preventive care, receive fewer diagnostic and therapeutic services, and have higher mortality rates than insured people.[19] Limited access to care is associated with poorer health outcomes. For example, only about a quarter of people with no insurance have their high blood pressure under control (24.2%) compared to nearly half of those with private insurance (48.2%) or Medicare (53.4%).[18] Employers should strive to understand the socioeconomic realities of their employees and ensure that the health care coverage they offer can affordably address health needs.

How does it reduce inequities?

People expect their health insurance to pay reasonable costs of maintaining and restoring physical and mental health. Employer-sponsored health plans have both the power and responsibility to deliver on that promise for all plan participants, which means continually questioning and affirming equitable coverage across the entire diversity of the population.

Employers should examine coverage for unique or prevalent conditions based on gender, race, ethnicity, sexual orientation, gender identity and ability. Some rules for coverage or reimbursement belie a deeper inherent disparity. Some "uniform" approaches to classifying treatment (e.g., cosmetic, experimental, restorative) could exclude vital care for some people, such as transgender individuals.[27] Many critical medical protocols – including organ transplant eligibility, ER treatment decisions and Cesarean section risk calculations – rely to some degree on race-based formulas. For example, some blood tests provide different race-corrected results for African Americans and other people, even though there's no biology-based reason for such action.

Health care networks are required by the Affordable Care Act (ACA) to maintain access to care without an unreasonable delay. This is generally demonstrated by an adequate number of providers located within a reasonable distance for a high percentage of plan participants. But because the law fails to specify the standard of reasonableness, that determination is left to states and employer-sponsored plans. Employees may technically have access to a network, but if providers are closed to new patients, the employee has limited access to transportation or if diversity among providers does not meet the patient's needs, then access to health care is not truly adequate or equitable.

The affordability of health insurance also presents challenges to equity. For example, a $25 deductible that many senior employees (who are disproportionately white and male) could earn back relatively easily takes more than three hours to earn back at the federal minimum wage. The percentage of income that a lower-income employee spends on health care is significantly disproportionate. For employees with serious family health care issues, care can be simply unattainable, consuming much of what they earn with little leftover for basic needs such as food and housing.

Data show that Hispanic (29.7%) and Black (14.7%) people are significantly more likely to be uninsured than white people (10.5%) in the United States. Further, people with income at or near poverty levels are nearly three times as likely to be uninsured as people with higher income.[28] Of people with disabilities, 10.4% of adults do not have health insurance.[29] Lack of insurance coverage and access to affordable care is strongly related to poorer health care quality, access and outcomes.

How can employers act?

Employers can strive for equity by closely examining coverage levels, ensuring equal access and thinking past traditional definitions of affordability.

- Ensure adequate provider networks that ensure equitable access (beyond the limited definition of adequate typically set by states and employers).
- Ensure employees have access to a network of providers representative of the employee population and their needs.
- Ensure adequate coverage for mental health services by all providers.
- Endeavor to make all aspects of health care coverage reasonably affordable to all employees. For example, by adjusting monthly premiums, deductibles, out-of-pocket maximums and copayments on a sliding scale based on income.
- Ensure parity between coverage for physical and mental health, as required by the Mental Health Parity and Addiction Equity Act.[30]
- Emphasize the use of value-based services that balance clinical benefit with cost.[31]
- Ensure determinations of medical necessity are made equitably for all cross-sections of the employee population.
- Regularly evaluate employer-sponsored health coverage to ensure it is meeting the needs of the employee population in regard to affordability and coverage of services.
- Through collective action, partner with other organizations, and leverage market power to influence changes in health insurance providers such as

greater transparency, better value, and improved data collection and management.

4 Ensure leadership is composed of people from diverse backgrounds and representative of your workforce and community.

What is it?

The country's staggering health inequities have been laid bare by the COVID-19 pandemic,[32] horrifying examples of police brutality against Black people,[33] women leaving the workforce in droves[34] and medical debt. Clearly, there is hard work at hand for corporate leaders to ensure the health, well-being and diversity of their organizations.

The important topics of inequity and social change will be increasingly unavoidable for corporate leaders. The business case for diversity can no longer be viewed as mere profitability. For companies, "staying silent" is a difficult option as activists, consumers and – importantly, employees – demand action against injustice.[35] Repeated tragic events clearly tied to the nation's history of structural racism only intensify the need for leadership to understand these issues and make appropriate changes in organizational culture.

According to the Stanford Corporate Governance Research Initiative, 84% of Fortune 100 CEOs in 2020 were white, and 93% were men.[36] These rates of overrepresentation are similar in other executive and senior leadership positions, such as CFO and CHRO. Ensuring leadership is equitably composed of people from diverse backgrounds and representative of the workforce and community is critical to meeting an organization's equity goals.

Further, the opportunity for advancement to leadership positions must also be present. Being inclusive has proven not to be enough. As Harvard Business School professor Robin J. Ely and Morehouse College President David A. Thomas write: "Increasing the numbers of traditionally underrepresented people in your workforce does not automatically produce benefits. Taking an 'add diversity and stir' approach, while business continues as usual, will not spur leaps in your firm's effectiveness or financial performance."[35]

How does it impact health?

Ensuring senior leadership, and middle management, is diverse and representative of employees and the community demonstrates that employers value the capacity, perspectives and unique identities of employees from groups that have been historically marginalized. This in turn can promote good emotional, mental and physical health and reduce chronic stress among employees.[37]

Having a diverse leadership team also can ensure the specific health needs of employees from diverse backgrounds are understood and supported. This can affect how employers approach benefits design, practices and policies, as well as corporate social responsibility and community development efforts.

How does it reduce inequities?

Diverse leadership allows the voice of employees from populations that have been historically marginalized to be heard and respected. Leadership that represents the employee population ensures staff perspectives and needs are considered and met in organizational decision-making on issues such as benefits design, organizational policies and equity training.

Organizations impact employees, but also the communities where they operate. Similar to their internal influence, leaders who reflect the local community can ensure operations do not inequitably impact the local community (by championing environmental justice, for example). This also helps guide local investments to ensure equitable economic impact, such as through maximizing the hiring of historically underrepresented businesses and addressing the social needs of the community.

How can employers act?

There is no shortage of strategies to help organizations hire, maintain and equitably elevate more diverse leadership teams. These often start with the idea of building the pipeline of diverse candidates prepared to step in when an opening finally comes. Other strategies include removing bias from talent-acquisition processes and considering benefits that support the needs of underrepresented employees. These strategies are not easy to implement, but they are easy to agree on. Diversity, inclusion and equity leaders are increasingly sounding the alarm that structural inequities and racism are root issues, and these strategies may not move organizations fast enough to meet employee and consumer expectations, but they are a starting place. Like never before, CEOs need to hear and act on the explicit advice from their leaders working in diversity, inclusion and equity.

5 Support employee financial well-being through education, employee benefits and other strategies.

What is it?

Historical practices have limited the ability of some people to accrue wealth because of their race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors. One significant example is redlining, a New Deal-era government-backed policy that encouraged segregation by making it impossible

or difficult for people who were not white to buy homes. Redlining was outlawed in 1968, but the financial inequities it caused remain to this day. A survey by the Federal Reserve found that white families have 8 times the wealth of Black families, and 5 times the wealth of Hispanic/Latino families.[38] While it will require systematic efforts by society to combat this inequity, there is much employers can do internally.

How does it affect health?

Financial well-being is the single strongest predictor of lower levels of daily worry and stress for people with jobs. A Gallup study found that people who reported having enough money to do what they want to do rated their quality of life more positively. This rating was the same regardless of income level, underscoring how financial security impacts overall well-being.[39,40] Further, chronic stress, from any source, is a well-established risk factor for poor mental and physical health.[41,42]

Poor financial well-being affects an employee's ability to pay for health insurance costs, such as premiums and copays, purchase medications. It also limits people's ability to engage in health enhancing behaviors such as exercising or buying healthy foods. Disparities in access to health care (influenced by poor availability and affordability) can also result in employees from historically excluded groups not receiving the care they need to be healthy and therefore being more likely to have poorer health outcomes,[17] which can have a significant financial impact on employers and employees.[43]

How does it reduce inequities?

Financial insecurity is a top issue negatively impacting mental health, and financial wellness programs and interventions are often overlooked as strategies in addressing health equity. Moreover, the COVID-19 pandemic has magnified the issue of financial insecurity, increasing worry about the virus' impact on the economy and individuals' financial lives. It is challenging for historically excluded groups to overcome existing income and wage gaps – most notably among racial and ethnic groups that have been disproportionately harmed financially by the pandemic. By providing supportive programs and benefits, employers can ensure equitable opportunity for employees to manage their finances, save money, build wealth and ensure financial stability. For example, in addition to receiving inequitable pay, Black households are still less likely to own their homes than their white counterparts despite the banning of redlining practices; Black people are more likely to have disproportionately lower credit scores; and Black and Hispanic households are more than 6 times as likely as white households to be unbanked.[44]

How can employers act?

The financial education strategies of the past – focused on retirement and savings – are no longer enough. Programs and solutions that focus on long-term financial well-being goals help prepare for future financial health. But they don't support employees dealing with acute financial stress. Until this short-term acute financial

stress is addressed, employees cannot and will not engage in programs aimed at long-term financial health. Employers have an important role to play in providing emergency support and addressing economic empowerment for all employees.

Practices to consider include:

- *Assessment:*
  - Assess disparities that may exist in how programs are used to inform how to better market financial well-being programs.
  - Survey employees to understand the state of financial well-being of the workforce (for example, understanding their ability to cover an emergency expense).
- *Emergency support/relief:*
  - Temporary benefits (childcare grants and time-off options)
  - Emergency funding programs
- *Education:*
  - Financial coaching programs (one-on-one support)
  - Financial wellness platforms that offer personalized education, financial fitness scores/profiles, tips and tools to build knowledge and increase awareness.
  - Educational content that covers a variety of topics – budgeting and spending, credit and borrowing, saving, investing, and content specific to each employee career stage.
- *Employer benefits:*
  - Retirement plans with an opt-out design and scaled employer matching based on income.
  - Employee stock purchase plans: They are often underutilized and misunderstood but can be a large driver of wealth building.
  - Education funds (529 plans and children's savings programs): These promote participation to plan ahead and ease future financial burdens.
  - Low-interest loans to employees with payroll deduction repayments where permitted.
  - Tuition assistance upfront, rather than reimbursement, for employees seeking continued education.
- *Communication and engagement strategies:*
  - Communicating financial security not as a current state, but as a journey.
  - Use of social networks to encourage and support employees along their financial well-being journey (provides opportunity for peer support and recognition of small wins).
  - Inclusive messaging and imaging that is positive and hopeful.

6 Adopt anti-racism principles and implement anti-racism policies.

What is it?

Anti-racism refers to the "conscious decision to make frequent, consistent, intentional, equitable choices daily."[45] Leaders must adopt anti-racism principles to actualize an organization's mission, embody its values and attain equity. That means wide-ranging change, including to community engagement, employee benefits, talent recruitment and hiring at all levels, and appointment of the board of directors. A case study in adopting anti-racism, pro-equity principles occurred in the 1970s when former Atlanta Mayor Maynard Jackson required that at least 20% of business contracts be awarded to minority-owned businesses during the expansion of Hartsfield Atlanta International Airport.[46] The contract bidding and awarding process had historically blocked out minority-owned businesses, and there was initial pushback to the policy. However, the impact was clear as the policy increased contracts awarded to minority-owned businesses from 1% to over 25% within five years. The policy's impact continues in Atlanta today.[47]

How does it impact health?

Structural racism adversely affects health and well-being.[48] Well-being encompasses physical health, mental health, social relationships and the ability to meet basic needs.[49] The adoption of anti-racist principles that foster the equitable distribution of resources, access and opportunity support employee health and well-being.

How does it reduce health inequities?

To reduce health inequities, employers should first explore and understand the organization's history and present-day practices, procedures and policies that may disadvantage certain groups, directly or indirectly. Leaders should then identify effective strategies and adopt bold policies and courageous actions guided by anti-racist principles to support employee well-being. This is necessary to promote health equity across the organization.

How can employers act?

Anti-racism policies have typically focused on benefits such as affordable and comprehensive medical plans, culturally sensitive mental health care and paid leave. However, other policies and practices can improve health and well-being.

Examples include:

- Proactively conducting workplace climate surveys to understand employee experiences and address concerns.
- Paying a living wage.
- Supporting employee resource groups.

- Establishing mentorship, sponsorship and leadership development programs.
- Providing tuition assistance.
- Investing in local community development in historically marginalized neighborhoods.

Adopting anti-racist principles will require bold policies and courageous actions that can impact health, well-being and beyond.

7 Promote employee health literacy and employee benefits literacy.

What is it?

Health literacy is the degree to which a person can obtain, process, understand and communicate health information to make appropriate health decisions. Health literacy has been linked to behaviors, outcomes and health care costs.[50-53] However, only 12% of U.S. adults have the health literacy skills necessary to prevent or manage disease, and 36% have basic or below basic health literacy, according to a recent UnitedHealthcare Consumer Sentiment Survey.[54] In the same survey, only 9% of the U.S. population understood the four basic health insurance terms – health plan premium, health plan copayment, out-of-pocket maximum and health plan deductible.[5556]

Employers and business leaders have long recognized the human and financial cost of low health care literacy. Limited literacy skills may interfere with productivity and safety, result in poorer employee health, and increase health care costs.

Employers pay much of the high cost of insurance benefits in the U.S. However, employees share costs through premiums, co-pays and deductibles for office visits, procedures and drugs. Often employees make such payments without a full understanding of the costs and available options. Better employee models are needed for education and engagement, with a focus on understanding available options and informed decision-making that improve health and well-being outcomes.

How does it impact health?

Higher health literacy is associated with a variety of health-promoting behaviors such as being more physically active and eating healthier foods. People with adequate health literacy are also less likely to delay or forgo health care or report difficulty finding a health care provider, and they are more likely to have a usual source of care.[57] Further, people with higher health literacy are more likely to seek health-related information than people with lower health literacy, which could further exacerbate disparities in health.[58]

How does it reduce inequities?

Health literacy is directly connected to health equity. Unfortunately, the health care system is so complex that workers and their families often do not understand their health care coverage and costs. In a survey from the Kaiser Family Foundation, two-thirds of respondents said it is difficult to determine costs of medical care provided by different doctors and hospitals. Over 40% said they had difficulty understanding out-of-pocket costs.[59] Other studies have shown that limited health insurance literacy has negative impacts on seeking preventive and non-preventive services, which can result in longer-term health care inequities.[60] Black, Hispanic and Spanish-speaking people appear to have lower health care literacy than white people, which may further exacerbate health and health care inequities.[61]

Supporting efforts to increase health literacy is essential to improving employee health and wellness and achieving health equity.[62]

How can employers act?

The first step in addressing health and benefits illiteracy is understanding the extent of the issue and not assuming employees understand the basic terms and concepts of health and health care. Navigating health care and employee benefits can be complex, confusing, and intimidating. Providing a health literacy program can increase employee understanding and appreciation for the benefits provided and options available.

Considerations for employers addressing health care literacy include:

- Empower employees to engage and take charge of their health and health care.
- Provide educational programs, resources and tools that instruct employees at an appropriate health literacy level how to get the care they need, understand their benefits, and contain the costs of health care and health care plans.
- Familiarize employees with their financial responsibilities and the meanings of such terms as out-of-pocket max, deductibles, prescription co-pays, etc.
- Communicate about benefits year-round, not only during open enrollment periods.
- Provide access to benefit experts (such as health advocates) who can answer general questions as well as questions that might be uncomfortable for employees to ask the employer's HR representative.
- Employ a broad array of communication technologies for education and support, recognizing that not everyone is comfortable or familiar with all of them.

8 Offer paid family and medical leave.

What is it?

According to the American Time Use Survey, people spend roughly half of their waking lives at work.[8] Everyone should have time away from work, to rest and re-energize, spend time with friends and loved ones, tend to health needs, volunteer for causes and any number of other activities that improve well-being. **The ability to take the time needed away from work affects engagement, performance and speed of recovery from health issues.**

How does it impact health?

Robust leave policies that provide employees adequate time off to meet their needs for rest and managing personal priorities can help create a competitive advantage to attract and retain the best talent, create a healthier and happier workforce, and advance health equity. The individual and collective health benefits associated with robust leave policies are undeniable. Studies have shown access to paid family leave can have positive impacts on health outcomes such as reductions in low-birth weight, early-term babies and infant mortality; reductions in parental stress levels; and improvements in the longer-term emotional health of children.[63,64]

How does it reduce inequities?

While some organizations may feel that impacting broader societal health equity issues is too much of a challenge, they can take steps to address health equity within their own employee populations. Offering comprehensive paid leave policies is one step to improve health equity. **The ability to take paid time off from work can improve financial stability, which can have a more favorable effect on people of color and people with disabilities,[65] improve the likelihood of women returning to the workforce,[66] and support employees serving as caregivers for immediate and extended family members.**

How can employers act?

Employers should consider implementing the following strategies to promote health equity in their organizations:

- Provide enough paid time off to cover vacation, holidays, sickness and well-being.
- Provide access to robust paid family leave for men and women, driving better longer-term health outcomes and shifts in the parental expectations (e.g., more equal split of parental duties), as well as to support parental bonding and the healthy development of children.

- Ensure adherence to regulations that require employers to provide job-protected, paid caregiver leave to provide employees the flexibility to care for a sick loved one without jeopardizing financial stability.

9 Ensure pay equity and provide a living wage.

What is it?

Pay equity is fair compensation for similar work based on job duties and not extraneous factors (earnings history, negotiation skills, etc.). While pay inequities often center on current earnings, pay gaps widen over time and impact future earning potential, including merit raises and retirement contributions. Pay inequities have been well-documented for women compared with men. So much so that an "equal pay day" in March annually symbolizes the additional days women generally had to work to earn what men made the prior year.[67] This gap is so pronounced for women of color that equal pay days fall much later in the calendar: August for Black women, September for Native American women and October for Latina women.[67]

While pay inequities may affect all ranks and positions, a living wage pertains primarily to those who are the least paid in an organization. A living wage refers to sufficient income for basic living expenses, including housing, food, clothes, transportation and discretionary spending. In contrast to the federal minimum wage, which has been unchanged at $7.25 an hour since 2009, a living wage is variable and takes into account the local cost of living. To review living wages across counties in the U.S., visit the MIT Living Wage Calculator.[68] A living wage and pay equity are crucial to employee health and well-being.

How does it impact health?

There is a robust literature documenting the links between income and health; people with fewer resources face higher risk for disease, poor mental health and shorter life expectancy.[69] Pay inequities and the absence of a living wage affect financial stability, and may have indirect health impacts such as being unable to afford medical insurance or foregoing health care to avoid out-of-pocket expenses. Research has shown that when women received lower pay than men in similar occupations, depression and anxiety were more common for women than men.[70] Additionally, people with the lowest income have been shown to have higher stress levels and be more likely to have cardiovascular risk factors (e.g., high blood pressure, obesity) than those with the highest income.[71]

How does it reduce inequities?

Financial well-being is a central part of overall employee well-being. Equitable pay can help reduce disparities in employees' ability to afford necessary items such as housing, food and health insurance, as well as make it easier to take care of their families.

While often thought of in regard to the gender wage gap, pay inequity also significantly impacts people of color. For example, the relative median earnings for a white woman in 2018 was 79 cents for every dollar earned by a white man. For a Black woman, the relative median earnings was 62 cents. The number fell to 57 cents for an American Indian/Alaska Native woman and to 54 cents for a Hispanic woman.[72]

How can employers act?

Ensuring pay equity and providing a living wage are critical ways employers can advance equity and support employee well-being.

Ways employers can act include:

- Ensure the organization adopts formal written policies that commit to ensuring pay equity and providing a living wage.
- Proactively initiate systematic and regular pay equity audits to ensure sources of inequity are identified early and promptly corrected. This is important for accountability, because pay equity adjustments often occur after years of compounding inequities, and typically at the insistence of the affected employee.
- Evaluate and adjust wages regularly to ensure all employees are paid a living wage.
- Support increased living wage and pay equity policies through your organizations external advocacy efforts.
- Ensure that special skills and capacities, such as multi-lingual proficiency, are fairly compensated.

10 Promote use of employee assistance programs.

What is it?

Employee assistance programs (EAPs) have long been a source of crisis intervention. The traditional model mainly relies on a call center that's open at all times for triage of cases and some in-patient counseling sessions. For the past few decades, many EAPs have offered expanded services (nutrition, wellness, financial and legal assistance) with the ability to serve collectively in a more "life coaching"

capacity. EAPs offer confidentiality and usually are available to all employees (regardless of whether they are enrolled in the company's health insurance plan), immediate family and all who live in their household. In the EAP pricing model, employers pay for access rather than utilization, so the longstanding challenge is how to better connect employees to these services.

How does it impact health?

An effective EAP can help address the unique and often traumatic experiences endured because of race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors.[73] As mental health comes more to the forefront as a driver of overall health, the demand for EAPs will likely increase.

How does it reduce inequities?

EAPs are a particularly strong vehicle to help achieve health equity. Their easy accessibility, broad mandate to help, and strategic desire to position and differentiate themselves outside of crisis response make them ideal. By helping employees to manage and respond to challenges they face in life (such as racism, bias and discrimination), services available through EAPs can aid them in being the best version of themselves in the workplace, which can positively effect workplace outcomes.

How can employers act?

There are several ways to start leveraging your EAP for more equitable delivery of wellness and health care:

- *Simplify access to services.*
  Most employers have an array of benefits providers, each with separate contacts, which are often either hard to find or confusing when employees need them. Model the user experience of your plans and prevalent channels of employee communication to ensure the EAP is easily accessible – whether through an 800 number with interactive voice response, a portal, an app, SMS texting or however is best for employees. Also, if you have an employee relief fund, link it to the EAP or even use the EAP as a starting point for applications. These funds often are funded by employees for employees, providing limited financial help in crisis situations.
- *Segment your employee population and target messaging.*
  By understanding employees' challenges and unmet needs, employers can create tailored messaging and programs that capitalize on an EAP's capabilities. Student loan debt, for instance, is a stressor for many employees. An EAP can provide financial education and tools to help alleviate stress. Mental health in particular will be important to address due to the pandemic and its aftermath. EAPs can deliver tailored support to employees based on their unique needs.
- *Create a life-coaching intake protocol.*
  When someone reaches out to an EAP, often the presenting and underlying

issues are different. Creating a life-coaching intake process prompts a broader discussion, can help link employees to a suite of resources, and make a more impactful and lasting intervention possible.

- *Connect with employees where they are.*
  Recognize the diversity of your employee population with varied ways to connect them with the EAP and deliver services; leveraging it to help foster health equity will mean reaching many employees with more than just an email or portal posting. Telehealth services are an increasingly powerful tool for delivering care and should be invested in.
- *Make sure your EAP delivers promised services well.*
  Nothing helps drive use of a service more than people who have been positively impacted by it. The inverse is also true. Ensure that your EAP delivers quality programming that meets the needs of your employees.
- *Continuous improvement.*
  Leverage insights from employee engagement surveys to improve EAP offerings to meet the stated needs of employee.
- *Assess the diversity of the EAP's providers*

11 Ensure employees have a voice in organizational decision-making.

What is it?

Employee participation in decision-making is a key contributor to organizational performance and employee satisfaction.[74,75] Active and meaningful employee engagement helps organizations achieve their mission, execute on strategies and generate business results.

Meaningful employee engagement requires incorporation of the employee voice in every step, from planning to implementation and evaluation. This engagement promotes a healthy and safe workplace, and successful health and wellness programs. Meaningful engagement means opportunities to express ideas, perspectives and concerns, as well as influence decisions without fear of consequences. Leaders must listen to employees and act.

How does it impact health?

Effective and meaningful engagement can increase employee participation in workplace wellness activities, helps employees create and maintain healthy behaviors at home and at work, and improves overall health and wellness. Engagement also increases productivity and the ability to address normal workplace stressors.[76-79]

How does it reduce inequities?

Workers who are engaged and who perceive a sense of partnership make proud advocates, promoters and defenders of the organization. Some key purposes and organizational mechanisms for listening to the employee's voice include surveys, problem-solving groups, use of an intranet and suggestion boxes.[80] Elevating the employee voice within the organization ensures the opportunity to contribute to organizational deliberation and decision-making and demonstrates partnership, trust and respect. It is important that management demonstrates a real intention to listen, consider, respond and provide feedback regarding decisions and actions taken based on input received. Not following these actions can have the appearance of "only providing lip service." Similarly, when there are disagreements and/or dissatisfaction, management should provide a realistic hope of and process for resolution.[81] Including the employee perspective in decision-making embraces the full participation and perspectives of historically excluded individuals and promotes health equity.

How can employers act?

Strategies to ensure effective and meaningful employee engagement and input into decision-making include:[81,82]

- Foster a culture of inclusion, engagement and employee participation.
- Make active listening a priority.
- Follow up and provide feedback on actions taken based on input received.
- Adopt and ensure a principle of transparency.
- Develop mechanisms that encourage and enable employee input and involvement in decision-making as a way of taking innovative approaches to promote organizational excellence.
- Recognize and reward inclusion and participation.
- Involve employee resource groups in relevant organizational decision-making processes.
- Contract with an external entity that has the infrastructure to process employee feedback (confidentially) and provide real-time responses to employee concerns or suggestions.

12 Offer diversity, equity and inclusion training to employees.

What is it?

Diversity, equity, and inclusion (DEI) training can include a wide range of activities. At its core it seeks to help employees better understand the value of lifting up the voices and perspectives of people with diverse backgrounds and experiences, as well as instill organizational values such as respect, equity and belonging. Having a strong grasp of DEI concepts and practices expands cultural awareness and helps employers and employees better navigate complex workplace dynamics. It is important to note that effective training that aims to improve equity – not simply preempt lawsuits – can lead to improvements in attitudes and behaviors.[83] Conversely, ineffective, inauthentic, controlling or token efforts at DEI training can be detrimental and lead to poorer employment outcomes such as fewer women, people with disabilities and people of color in management.[84]

How does it impact health?

Effective DEI training can improve employee health by creating a great place to work for all and by reducing chronic stress caused by racism, discrimination, biases and microaggressions. It is well established that chronic stress has a significant negative impact on people's mental[85] and physical health.[42,86,87]

Further, DEI training that fosters understanding and consideration among employees of different backgrounds can support better work-life balance.[37] This can have direct, positive effects on health.[88,89] For example, DEI training can help employees be more understanding and supportive of differently-abled employees or employees with mental health disorders who may need to take time off to manage their conditions.

How does it reduce inequities?

Building staff and management skills through training, learning resources and ongoing dialogue builds cultural competency. This helps to create psychologically safe work environments, fosters belonging and respect, and helps employees learn how to apply an equity-focused lens to policies and norms to confront inequity, discrimination and biases. By challenging unconscious biases, encouraging a "speak-up environment," modeling inclusion and embracing continuous learning, equity can be increased in the workplace. Studies have demonstrated that when leaders purposefully foster speaking up, employees are more likely to contribute innovative ideas that drive the organization forward.[39] This has an even greater impact on employees in historically excluded groups who may be reluctant to speak up when they don't see themselves represented.

How can employers act?

Diversity, equity and inclusion training helps to achieve equitable career experiences in an inclusive, safe and respectful environment. This includes building a skilled and diverse workforce committed to equity, having a shared common understanding of the complexities of inequities, and applying new skills to advance equity in each person's work. Practices to consider include:

- Ensure diversity, equity, accessibility and inclusion training is supported by the necessary policies, programs, practices, structures and resources to promote employee learning.
- Implement a training program that fosters inclusion and social justice, one that includes how to disrupt bias and dismantle institutional racism to build new habits and sustainable inclusive practices.
- Deliver allyship training or workshops to empower employees and leaders to advocate for others.
- Embed leadership training for managers that builds healthy relationships and trust, increases engagement and productivity, and helps leaders model inclusion.
- Offer skill development and training opportunities for employee resource group leaders.
- Provide mentoring and sponsorship programs to accelerate employee development for the current and next generation of diverse talent.
- Regularly reinforce the training to ensure continued understanding among employees.
- Be careful in the framing to help employees understand the true value of diversity, equity and inclusion, rather than view it as remedial action.

13 Review contracts to maximize hiring of historically underrepresented businesses and ensure supplier commitment to equity and equitable practices.

What is it?

The overall makeup of an organization's vendor agreements and purchasing contracts may not be readily visible to leaders. However, reviewing these contracts and processes related to them can quickly support more equitable economic development and give supply chain access to historically underrepresented businesses such as those certified as women or minority-owned businesses and disadvantaged business enterprises.

Beyond their own efforts, employers have substantial leverage to change market practices through expectations set for vendors, suppliers and partners to spend

with diverse suppliers. Employers should review their suppliers and other partners then leverage their buying power and influence to select and/or collaborate with business partners that have a stated commitment to advancing equity.

How does it impact health?

Increased investment in historically underrepresented businesses can allow those businesses to offer more affordable and higher-quality health care coverage to their employees. It is well established that health insurance coverage is associated with improved health outcomes, increased use of health services and an increase in health-promoting behaviors.[90] And in the same way that implementing equitable practices within your own organization can improve the health of employees, holding business partners to the same high standards can ensure their employees and communities reap the same benefits. In addition to improved access to health care, reduced workplace stress and better work-life balance, for example, all help improve the health of employees and allow them to be their best, most productive selves in the workplace.

How does it reduce inequities?

Investment provides revenue opportunities for businesses owned by people from historically underrepresented groups. That, in turn, can provide benefits back to their respective communities,[91] where employees also live.

By holding suppliers and other partners accountable to the same equity and supply chain standards, those same expectations can be extended into the market. Assuming many organizations will have downline partners, the ripple effect magnifies the impact of an organization's spend to move DEI practices forward. These expectations can ensure practices such as offering a living wage, affordable, comprehensive health care coverage, and having equitable hiring practices become the norm.

How can employers act?

After reviewing supplier contracts, employers should set clear and increasing goals for the share of contracts they award to organizations that are women-owned or owned by people from historically underrepresented communities. That includes groups who are often less visible, such as business owned by members of the LGBTQ community. Ideally, those would be locally based.

Beyond that, for all vendors, suppliers and partners they do business with, employers can review diverse supplier spend to ensure alignment on their business practices through the lens of diversity, equity and inclusion. This assessment should be built in along with standard evaluations from a pricing, quality, legal and ethical standpoint.

14 Advocate for culturally and linguistically effective training for all employees, providers and vendors.

What is it?

Health care providers are increasingly aware of the cultural and linguistic differences in the general population. It is increasingly common to encounter educational programs aiming to promote cultural competence as a means of decreasing health disparities and improving the overall quality of care. These programs generally educate people on cultural differences based on race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors. However, there is now recognition that it is important to move beyond the content-oriented terms of cultural awareness and competence to the more process-oriented concepts of cultural effectiveness and humility. These terms imply an ongoing willingness to learn and reflect on one's own values and biases.[92] While culturally and linguistically effective training in the health care system is the most salient example, employers in all industries should make such training a priority in their workplaces.

How does it impact health?

Negative health care encounters can have lasting impacts on patients, and they may change behaviors and beliefs. One study found that 22% of Black patients surveyed avoided seeking health care for themselves or family members due to anticipated discrimination.[93] A similar study found 23% of Native Americans reported experiencing discrimination in clinical encounters, and 15% avoided seeking health care.[94] In the LGBTQ community, nearly 56% of sexual minority and 70% of gender minority adults report having experienced some form of discrimination from clinicians.[3] Health care avoidance can have serious consequences, including missed opportunities for preventive care, delayed diagnosis and suboptimal treatment of disease.

Language has a major impact on people's health, well-being and quality of life. According to the U.S. Census Bureau in 2013, approximately 61.6 million people spoke a language other than English at home. And 25.1 million of those people were considered to be Limited English Proficient (LEP), which is defined as anyone above the age of 5 who reports speaking English less than "very well."[95] People with limited English proficiency are less likely to have health insurance or a regular health care provider.[96] In addition, LEP has been associated with having unmet needs for medical care[97] and decreased use of health care services.[98] On the other hand, a systematic review of 33 research studies found improved outcomes when people with LEP are cared for by physicians who speak their language. Improved outcomes included quality of care, patient satisfaction with care, medical understanding and mental health.[99]

How does it reduce inequities?

Research has shown that there are significant health care disparities between underrepresented groups and majority populations, which may have implications for patient safety and outcomes.[100] Though the evidence base is relatively weak, some research studies have shown that interventions to improve cultural competency can improve provider outcomes as well as health care access and utilization outcomes.[101] As such, the U.S. Department of Health and Human Services advocates for the delivery of culturally and linguistically appropriate services to reduce health disparities and achieve health equity. The HHS's Office of Minority Health has published National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care as a blueprint for health and health care organizations to improve delivery of care to diverse populations.[102,103]

How can employers act?

Implementing culturally and linguistically effective training for all employees, providers and vendors can help to ensure that all people have equitable access to health care and are comfortable in seeking the assistance that they may need.

Practices to consider include:

- Provide education to employees on cultural effectiveness and humility, including assessment of one's own values and biases.
- Implement organizational policies and guidelines on how to optimize communications.
- Create resources in different languages that meet the needs of your employees and address and promote respect for and acceptance of various cultural beliefs.
- Make available the use interpreters.

15 Review organizational communications for cultural appropriateness, diverse representation and accessibility.

What is it?

The U.S. population is increasingly racially and ethnically diverse.[104] As the U.S. and the world continue to diversify in terms of who has a seat at the table and how people self-identify, there is a unique opportunity for communications that are representative of and respectful to employees, families, friends, colleagues and neighbors.

Communication is not only about what we read. It is also about what we see, hear, how we are represented and the stories we tell. This is why it is important to take a critical lens to all organizational communications. How are we speaking? What tone is used? Do the pictures used represent the broader population? What pronouns are used? Are we using communication methods that allow everyone to participate? All of these items will determine how people engage with, interpret and understand communications.

How does it impact health?

Inclusive communications that consider cultural appropriateness, diverse representation and accessibility can have direct and indirect impacts on people's health. Microaggressions such as inappropriate language and lack of representation in communications can adversely affect employee mental health. Further, building communications that engage a diverse workforce can lead to increased knowledge and understanding of health and other benefits offered and how to access them.

Inclusive, diverse and appropriate communications can also foster a greater sense of belonging among employees, which is associated with a number of health outcomes such as reduced risk of injury, addiction, abuse, joblessness, homelessness, incarceration, trauma, depression, disease, disability and premature death.[105]

How does it reduce inequities?

Clear and inclusive communications can help to build trust and advance health equity. Many groups that have been historically excluded don't see themselves or others like them in media and other communications. Doctors receive little training in medical school specific to the needs of communities facing increased health risks. The unfortunate result is that the LGBTQIA+ community, Black, Hispanic, Asian and Indigenous people often don't trust the health care system due to historical injustices and present-day discrimination when seeking care. This can lead to delaying important care, increases in depression and a lower likelihood to fill prescriptions.[106] While other industries may have less severe examples of poor communication, building clear, concise and inclusive communications in all organizations about benefits, how to access them and available support systems can lead to more people using these valuable benefits.

How can employers act?

Employers should critically review and improve the representativeness and cultural effectiveness of their communications, and consider implementing the following strategies:

- Work to build trust among employees from historically excluded groups, being mindful of the message, mode of messaging, messenger and perceived motive.

- Use an inclusive lens when developing communications. Make sure the visuals represent your entire workforce and community.
- Avoid pictures and videos that reinforce stereotypes based on race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors (e.g., power dynamics).
- Design simple and concise communications to increase the likelihood people will read and understand your message.
- Review communications, websites and other benefits-related documents (e.g., policies) for proper pronoun use and that it is accessible to everyone. Where possible, avoid referring to he/she and use more gender-neutral pronouns such as they.
- Demand the same from the vendor partners. They should be heavily invested in improving engagement.
- Where possible, engage employee resource groups to help develop strategy, content and oversight.

EXTERNAL STRATEGIES FOR ACHIEVING HEALTH EQUITY

The pandemic has starkly revealed the real and immediate consequences that unacceptable health inequities have on individual, community and societal health and economic well-being. Businesses have a unique role, obligation and opportunity to support a rational public dialogue shining a light on inequities and elevating the important discussion of societal investments to address structural barriers to optimal health.[107] Various recent data point to an erosion of confidence in government and elected officials – and elevation of the need and desire to see private sector leaders to take a stand.[108]

The following section identifies five external areas in which employers can focus their advocacy efforts in the name of equity.

1 Advocate for comprehensive, understandable and affordable health insurance coverage for all.

What is it?

In its implementation, the Affordable Care Act (ACA) defined comprehensive and understandable health insurance coverage as providing 10 essential health benefits.[109] These include ambulatory, emergency, hospital-based, pregnancy, mental health, rehabilitative, preventive, and pediatric care, along with prescription drugs and laboratory services.

The ACA addresses the affordability of health insurance in two major ways. First, it encourages states to expand eligibility for Medicaid health insurance to individuals and families earning less than 138% of the federal poverty level. Second, the ACA offers subsidies for purchasing health insurance to individuals and families earning up to 400% of the federal poverty level.[110] Affordability remains an issue, however. Twelve states have still not expanded Medicaid eligibility: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin and Wyoming.[111] This leaves large populations uninsured. In addition, even with subsidies, health insurance remains unaffordable for many middle-income Americans. A well-accepted standard is that health insurance should cost no more than 10% of a person's income.[112]

How does it impact health?

Health insurance increases access to health care and makes it more affordable. In its landmark 2002 report, "Care Without Coverage, Too Little, Too Late," the Institute of Medicine (now the National Academy of Medicine) reported on the consequences of lack of health insurance for working-age Americans.[113] The report presented "findings in the areas of prevention and screening, cancer, chronic illness, hospital-based care, and general health status." The main findings were that individuals "without health insurance are more likely to receive too little medical care and receive it too late; be sicker and die sooner; and receive poorer care when they are in the hospital, even for acute situations like a motor vehicle crash." Evidence since has shown that gaining health insurance can substantially reduce medical debt and improve physical and mental health.[114]As previously described, only 24.2% of persons with hypertension and no insurance have their high blood pressure controlled, compared to 48.2% of persons with hypertension who have private insurance.[18]

How does it reduce inequities?

After implementation of the ACA, lack of insurance and inequities decreased. But inequities persist. There was a large decrease in the proportion of non-elderly Americans without health insurance, from 18.2% in 2010 to 11.1% in 2020.[115] The proportions of Hispanic, Black and white Americans without health insurance were disparate in 2010: 32%, 20%, and 14%, respectively. All fell but remained disparate: 22%, 12% and 9% for Hispanic, Black and white Americans, respectively, in 2019.[115] Similarly, rates of uninsurance in the LGBTQ community decreased from 34% in 2013 to 16% in 2020.[116] Geographic disparities are also still striking. For example, 3.6% of people were uninsured in Massachusetts in 2019, while 21.4% of people in Texas were uninsured. In 2015, 10.4% of adults with disabilities were uninsured.[29]

How can employers act?

In states that have not expanded Medicaid, employers should advocate for doing so. In all states, employers should advocate for premium subsidies to make health insurance affordable for middle-income people. For example, employers can also advocate for the permanent availability of the enhanced premium tax credits (PTCs) passed as part of the American Rescue plan to make health coverage and care more affordable for millions of lower- and middle-income people.

2 Advocate for affordable housing.

What is it?

Affordable housing is generally defined as costing 30% or less of a family's income.[117] Families spending more than this are "cost-burdened" and constituted 37.1 million American households in 2019 (30.2% of households nationwide).[118] Renters are more likely than homeowners to be cost-burdened; 46% were in 2019. At the extreme, cost-burdened families and individuals can experience homelessness, and 568,000 Americans did so in 2019.[119]

How does it affect health?

Lack of affordable housing results in housing instability and forced tradeoffs that limit other health-promoting expenditures.[117] People who face housing instability are more likely to experience poor health.[117] At the extreme, those who experience chronic homelessness are more likely to be sick and to die; trauma on the street is part of the risk.[117] Those experiencing chronic homelessness face high health care expenditures resulting from use of emergency departments and hospitals.[117] Housing people who are currently homeless can both improve health and decrease health care costs.[120] For example, in an Oregon study, provision of affordable housing decreased Medicaid expenditures by 12%.[120]

Forced tradeoffs for low-income families with difficulty paying their rent or mortgage include postponing medical treatment, going without medications and not purchasing needed food.[117] In New York City, families with affordable rent were more likely than those with less affordable rent to be able to pay for health insurance, food, education expenses and save for a down payment on a home.[117]

How does it reduce inequities?

White households are more likely to have affordable housing than families of color. Among renters in 2019, 41.9% of white households were cost-burdened, as were 51.9% of Latino households and 53.7% of Black households.[118] Similarly, the home-ownership rate in 2019 for white, Asian, Latino and Black households was 73.3%, 57.3%, 46.3%, and 42.8%, respectively.[118]

Key to increasing housing affordability is increasing the supply of low-income housing. Given the rising prevalence of value-based payment for health care, the health care sector, including Medicaid programs in Oregon, New York and Massachusetts, have invested in housing stock.[117] More traditionally, banks and community-development organizations have a role to play, as does government through low-income tax credits aimed at stimulating private developers and managers,[117] and tenant-based housing voucher programs that give low-income families access to better housing and neighborhoods.[121]

Low-income employees may also have to contend with transportation issues as they seek more affordable housing outside of the city center where many jobs are

located. This introduces additional burdens and challenges they must manage that higher income employees may not.

How can employers act?

Employers can advocate for the development of low-income housing, as well as low-income tax credits for housing. They can also contribute to community-development organizations that focus on housing.

Employers can advocate for tenant-based housing voucher programs and Permanent Supportive Housing with Housing First to promote health equity for people who are experiencing homelessness and have a disabling condition.[121]

Additional strategies employers can advocate for include affordable and environmentally friendly housing renovations in historically marginalized communities as part of renewed investment strategies, as well as support for more multi-income housing plans in community redevelopment.

3 Advocate for high-quality, accessible and affordable early care and education for children.

What is it?

There are two main arrangements for early care and education (ECE), in which pre-kindergarten children (ages 3 and 4 years old) are cared for and taught by people other than their parents or other primary caregivers with whom they live.[122] One is center-based and includes child-care centers and preschools. The other is based in either the child's home (e.g., with nannies, relatives or babysitters) or a caregiver's home (e.g., regulated family child-care homes). In 2012, 60% of pre-kindergarten children attended one of these, and of those, 56% were in center-based arrangements.[122] Center-based care tends to be of higher quality, but more expensive and harder to find, particularly for infants and toddlers.[122] On the other hand, home-based childcare is often more likely to serve families of color, low-income families, families with non-traditional jobs, and immigrant families.[123]

How does it impact health?

ECE affects children's health either directly, through access to health services and exposure to infectious diseases, or indirectly, via education or by increasing parental employment and earnings.[122] ECE can increase access to health screenings, health care, improved nutrition and other health promotion.[122] But children entering ECE are also more likely to suffer respiratory infections and other infectious diseases in the short run.[124] Long-term health effects of ECE include reduced blood pressure and smoking, as well as improved self-reported health.[122]

How does it reduce inequities?

There are inequities in children's access to higher-quality center-based ECE, attended by 57% of children in households at or above poverty but only half of children below the federal poverty level.[122] Head Start and Early Head Start are large federal ECE programs that provide services primarily to children in poverty. In 2016, Head Start served 40% of these children aged 3-4, and Early Head Start served 5% of these children younger than 3. Several states and cities have also recently created or expanded public prekindergarten programs.[122] The Federal Child Care and Development Block Grant supports states in providing child-care services.[122]

Economic evidence indicates that there is a positive return on investment in early childhood education. The benefits from parents' future earnings gains alone exceed program costs. If targeted to low-income or racial and ethnic minority communities, ECE programs are likely to reduce educational achievement gaps, improve the health of these student populations, and promote health equity.[125]

How can employers act?

Employers can advocate for increases in federal, state and local financial support for ECE to increase access and quality.

Specifically, employers can advocate for center-based ECE programs to improve educational outcomes associated with long-term health as well as social- and health-related outcomes.[125]

4 Advocate for culturally and linguistically appropriate services in the health system.

What is it?

Culturally and linguistically appropriate services (CLAS) are respectful of and responsive to each person's culture and communication needs.[103] In 2013, the federal Office of Minority Health published 15 CLAS standards for health care organizations. The principal standard is to: "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."[102] The other 14 standards are in three thematic areas: governance, leadership and workforce; communication and language assistance; and engagement, continuous improvement and accountability.[102]

How does it impact health?

Improving the availability of CLAS can improve the quality of care provided.[126] The RAND Corporation has developed measures to evaluate adherence to CLAS standards in ambulatory, behavioral health, hospital and public health settings.[126]

How does it reduce inequities?

Because people of color, people with disabilities and under-resourced populations can struggle because of language, literacy, accessibility and other barriers, adherence to the CLAS standards can reduce disparities and increase health equity.[127]

How can employers act?

In purchasing health care for their employees, employers can use the RAND Corporation-developed measures to hold contracted health care organizations accountable for adherence to the CLAS standards.

5 Advocate for increased support of public health infrastructure.

What is it?

Throughout the course of the COVID-19 pandemic, the need for and value of a comprehensive and well-funded public health infrastructure has been clear. The human, social and economic impact of an underfunded system that inadequately delivers public health services has been devastating.

The Centers for Disease Control and Prevention (CDC), the nation's federal public health agency, is the largest funder of state public health services in the United States with a total budget of $7.8 billion in the 2021 fiscal year. That is a decrease of $100 million from the previous year.[128] In fact, over the decade beginning in 2012, the agency's budget has decreased by 2% after inflation while the country's population has grown by 14%.[129] Preparedness-related funding has been cut for the primary funding sources for ensuring the nation's ability to respond to public health emergencies. The Public Health Emergency Preparedness Cooperative Agreement and Hospital Preparedness Programs have been reduced by roughly 50% and 66%, respectively, after adjusting for inflation.[129] This reduction hampered the CDC's ability to meet the needs of communities during the pandemic and magnified the negative impact of COVID-19. Even before COVID-19, our nation's commitment to public health funding for infrastructure, workforce and surveillance has been inadequate to optimally address public health issues.

The 10 essential public health services have been characterized as follows:[130]

1. Assess and monitor population health status, factors that influence health, and community needs and assets.
2. Investigate, diagnose and address health problems and hazards affecting the population.
3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
4. Strengthen, support and mobilize communities and partnerships to improve health.
5. Create, champion and implement policies, plans and laws that impact health.
6. Utilize legal and regulatory actions designed to improve and protect the public's health.
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
8. Build and support a diverse and skilled public health workforce.
9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
10. Build and maintain a strong organizational infrastructure for public health.

Each of the 10 has been germane during the pandemic. The public health system must be adequately resourced to be better prepared and able to respond to the next pandemic in a manner that mitigates disparities.

How does it impact health?

Public health initiatives over the years have prevented innumerable cases of communicable and non-communicable diseases and saved countless lives. Some of the most notable achievements include tobacco control and prevention, maternal and infant health, and cardiovascular disease prevention.[131]During the 20th century, life expectancy at birth among U.S. residents increased by 62%, from 47.3 years in 1900 to 76.8 in 2000, and unprecedented improvements in population health status were observed at every stage of life. This almost 30-year increase in life expectancy is largely attributable to public health. For every 10% increase in local spending on public health, infant deaths and deaths from preventable causes such as heart disease, diabetes and cancer decrease on average between 1.1% and 6.9%.[132]

In contrast, under-resourcing of the nation's public health system contributed to the suboptimal response to the COVID-19 pandemic. As of July 2021, the pandemic has officially resulted in over 607,000 deaths, still the most reported deaths by country. There have been almost 34 million cases, of which many people still bear significant adverse long-term effects.[133] Had adequate resources been available to support surveillance, research, testing, workforce, communication, vaccination rollout and

policy recommendations, millions of cases and thousands of deaths might have been prevented.[134]

How does it reduce inequities?

Public health plays a role in limiting the spread of communicable and burden of non-communicable diseases. Due to disproportionate exposure to health risks and inequitable access to health and health care services in communities of color, poorer communities and others, the extent to which these risk factors are addressed through science-based public health measures is the extent to which inequities can be mitigated.

Black, Hispanic and Indigenous people are more likely than white people to be essential workers, live in crowded conditions, live in multigenerational or multifamily households, have jobs that cannot be done remotely, use public transportation, and live with essential workers, all of which increase a person's risk of contracting COVID-19.[137] In addition, people who are Black, Latino or American Indian/Alaska Native experience higher prevalence of hypertension, diabetes and obesity,[137] each of which contributes to a higher risk of severe or fatal COVID-19.

By supporting the public health system to adequately address communicable disease risk in the workplace, public transportation and homes – with vaccines and non-pharmacological measures – and the non-communicable disease risk by assuring access to quality care to manage obesity, hypertension and diabetes, inequities in exposure to health risk factors can be reduced and health outcomes can be improved.

How can employers act?

Employers can advocate for increased federal funding for the CDC, which provides funding and other support for state and local public health agencies. They also can advocate for increased state and local funding to adequately staff and resource health data systems and surveillance, preparedness, prevention and control of communicable and non-communicable diseases.

Employers can join public-private partnerships that leverage their internal data collection through biometric screenings, on-site health clinics, score cards and other tools to support public health efforts through the provision of aggregate data to national public health surveillance systems.

Through their on-site clinics, call centers and workforce, **employers can also bolster public health response during emergencies by contributing their resources to support treatment and response efforts.**

CONCLUSION

This American Heart Association CEO Roundtable report helps business leaders further understand workplace policies, practices and programs that lead to structural inequities, and provides solutions employers can consider to help identify and eliminate them. It is an important contribution toward ending historical structures and cultures in the workplace that advertently – or inadvertently – treat people inequitably based on race, ethnicity, gender, sexual orientation, age, ability, veteran status and other factors.

Working toward health equity benefits employee health and productivity and reduces health care costs. The expert writing group that produced Driving Health Equity in the Workplace believes working toward health equity is the right thing to do for all organizations. Undoubtedly, the health of the entire nation will improve if more employers commit to actions that eliminate inequities.

The strategies in this report are intended as a resource to help guide employers on their journey to advance health equity. For some, many of the strategies may already be in place, while others may be struggling to determine how to begin. This report should serve as a conversation starter that fosters a constructive dialogue among business leaders, employees and organizations with shared interests on ways to eliminate structural inequities and ensure every person has the opportunity for a full, healthy life.

At the foundation of this work are seven guiding principles that reflect a commitment to focusing on structural barriers to health equity, with an emphasis on inclusion, leadership and accountability. The 15 internal actionable workplace strategies include revising hiring practices, providing training on diversity equity and inclusion, and offering paid family and medical leave – strategies identified as having the greatest potential to achieve health equity.

In recognition of the important role employers play in driving societal change, the report also includes a handful of external actionable strategies that can be the focus of advocacy efforts to promote equity. Those strategies include calling for affordable housing and access to high-quality, accessible and affordable health care coverage for all; high-quality, accessible and affordable early care and education for all children; culturally and linguistically appropriate services in the health care system; and support for improvements in public health infrastructure. Significant progress toward achieving health equity is possible when these internal and external actions are implemented together.

The COVID-19 pandemic brought to light the disparate ways certain populations are at greater risk than others of getting sick and dying. The pandemic disproportionately impacted people of color, people from under-resourced households and communities, people who lack access to health care, and people with disabilities, among others. As a result of the pandemic and a

heightened awareness of inequities in multiple systems, public demands have grown for a more just society. Eliminating inequities is a significant step toward that goal. And organizations have unique opportunities to advance health equity for employees, their families and communities. We hope you review the strategies in this report and consider implementing them in your workplace. Join us in driving forward these strategies to ensure all people in this country can be as healthy as possible.

REFERENCES

1. Kaiser Family Foundation. Number of Heart Disease Deaths per 100,000 Population by Race/Ethnicity. *State Health Facts* 2019; https://www.kff.org/other/state-indicator/number-of-heart-disease-deaths-per-100000-population-by-raceethnicity-2/?currentTimeframe=0&selectedDistributions=white--black&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed May 7, 2021, 2021.
2. National Center for Health Statistics. *Racial and Ethnic Disparities in Heart Disease.* Health, United States Spotlight: Centers for Disaese Control and Prevention,;2019.
3. Caceres BA, Streed CG, Corliss HL, Lloyd-Jones DM, Matthews PA, Mukherjee M, Poteat T, Rosendale N, Ross LM. Assessing and Addressing Cardiovascular Health in LGBTQ Adults: A Scientific Statement From the American Heart Association. *Circulation.* 2020;142:e321-e332.
4. Arias E, Tejada-Vera B, Ahmad F, Kochanek KD. *Provisional Life Expectancy Estimates for 2020.* Centers for Disease Control and Prevention;2021.
5. Harrington RA, Califf RM, Balamurugan A, Brown N, Benjamin RM, Braund WE, Hipp J, Konig M, Sanchez E, Maddox KEJ. Call to Action: Rural Health: A Presidential Advisory From the American Heart Association and American Stroke Association. *Circulation.* 2020;141:e615-e644.
6. Simpson BW, Pollakc Porter K. How Structural Racism Harms Black Americans' Health. In. *Hopkins Bloomberg Public Health*2020.
7. World Health Organization. Social Determinants of Health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1. Accessed June 14, 2021.
8. Bureau of Labor Statistics. American Time Use Survey - 2019 Results. 2020; https://www.bls.gov/news.release/pdf/atus.pdf.
9. Maurer R. Remote Employees Are Working Longer Than Before. 2020; https://www.shrm.org/hr-today/news/hr-news/pages/remote-employees-are-working-longer-than-before.aspx#:~:text=Nearly%2070%20percent%20of%20professionals,based%20staffing%20firm%20Robert%20Half. Accessed May 11, 2021.
10. Kamal R, Panchal N, Garfield R. Both Remote and On-Site Workers are Grappling with Serious Mental Health Consequences of COVID-19. 2020; https://www.kff.org/policy-watch/both-remote-and-on-site-workers-are-grappling-with-serious-mental-health-consequences-of-covid-19/. Accessed May 11, 2021.
11. Centers for Disease Control and Prevention. Increase Productivity. 2015; https://www.cdc.gov/workplacehealthpromotion/model/control-costs/benefits/productivity.html#:~:text=In%20general%2C%20healthier%20employees%20are%20more%20productive.&text=The%20cost%20savings%20of%20providing,costs%20to%20train%20replacement%20employees. Accessed May 11, 2021, 2021.
12. Aetna. *Promoting health equity for low-wage workers: How employers can reduce health care costs, increase productivity and help employees stay healthy.* 2019.
13. Miner J. What Percent of Health Insurance is Paid by Employers? 2020; https://www.peoplekeep.com/blog/what-percent-of-health-insurance-is-paid-by-employers. Accessed April 16, 2021.
14. Healthy People 2030. Social Determinants of Health. https://health.gov/healthypeople/objectives-and-data/social-determinants-health. Accessed May 11, 2021, 2021.
15. Virgin Pulse. What is Employee Health? https://www.virginpulse.com/glossary/employee-health/. Accessed May 11, 2021.
16. Goetzel RZ, Fabius R, Roemer EC, Kent KB, Berko J, Head MA, Henke RM. The Stock Performance of American Companies Investing in a Culture of Health. *American Journal of Health Promotion.* 2019;33:439-447.
17. Ndugga N, Artiga S. Disparities in Health and Health Care: 5 Key Questions and Answers. 2021; https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/. Accessed May 11, 2021.
18. Muntner P, Hardy ST, Fine LJ, Jaeger BC, Wozniak G, Levitan EB, Colantonio LD. Trends in Blood Pressure Control Among US Adults With Hypertension, 1999-2000 to 2017-2018. *JAMA.* 2020;324:1190-1200.
19. Garfield R, Orgera K, Damico A. The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act. 2019; https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act-

how-does-lack-of-insurance-affect-access-to-care/. Accessed May 11, 2021.

20. van der Noordt M, H. I, Droomers M, Proper KI. Health effects of employment: a systematic review of prospective studies. *Occupational and environmental medicine.* 2014;71:730-736.

21. Ibarra H, von Bernut N. Want More Diverse Senior Leadership? Sponsor Junior Talent. 2020; https://hbr.org/2020/10/want-more-diverse-senior-leadership-sponsor-junior-talent. Accessed July 15, 2021.

22. Mackenzie LN, Wehner J, Correll SJ. Why Most Performance Evaluations Are Biased, and How to Fix Them. 2019; https://hbr.org/2019/01/why-most-performance-evaluations-are-biased-and-how-to-fix-them.

23. Keisler-Starkey K, Bunch NL. *Health Insurance Coverage in the United States: 2019.* United States Census Bureau;2020.

24. Collins RS, Radley CD, Baumgartner JC. *State Trends in Employer Premiums and Deductibles, 2010-2019.* The Commonwealth Fund;2020.

25. Collins SR, Gunja MZ, Aboulafia GN. *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability.* The Commonwealth Fund;2020.

26. Tolbert J, Orgera K, Damico A. Key Facts about the Uninsured Population. 2020; https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/. Accessed April 7, 2021.

27. Healthcare.Gov. Transgender health care. https://www.healthcare.gov/transgender-health-care/. Accessed July 16, 2021.

28. Cohen RA, Cha AE, Martinez ME, Terlizzi EP. *Early release of estimates from the National Health Interview Survey, 2019.* National Center for Health Statistics;2020.

29. Lauer EA, Houtenville AJ. *Annual Disability Statistics Compendium: 2016.* Durham, NH: University of New Hampshire, Institute on Disability;2017.

30. Centers for Medicare & Medicaid Services. The Mental Health Parity and Addiction Equity Act. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet. Accessed July 16, 2021.

31. NEJM Catalyst. What is Value-Based Healthcare? 2017; https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558. Accessed May 7, 2021.

32. Centers for Disease Control and Prevention. Health Equity Considerations and Racial and Ethnic Minority Groups. 2021; https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html. Accessed July 16, 2021.

33. Frimpong K. Black people are still seeking racial justice - why and what to do about it. 2020; https://www.brookings.edu/blog/how-we-rise/2020/11/12/black-people-are-still-seeking-racial-justice-why-and-what-to-do-about-it/. Accessed July 16, 2021.

34. McKinsey & Company. Seven charts that show COVID-19's impact on women's employment. 2021; https://www.mckinsey.com/featured-insights/diversity-and-inclusion/seven-charts-that-show-covid-19s-impact-on-womens-employment, July 16, 2021.

35. Ely RJ, Thomas DA. Getting Serious About Diversity: Enough Already with the Business Case. 2020; https://hbr.org/2020/11/getting-serious-about-diversity-enough-already-with-the-business-case. Accessed May 11, 2021.

36. Larcker DF, Tayan B. *Fortune 100 C-Suite Organizational Charts.* Stanford Corporate Governance Research Initiative;2020.

37. Menzies F. How does employee well-being link to diversity and inclusion? https://cultureplusconsulting.com/2018/08/17/how-does-employee-well-being-link-to-diversity-and-inclusion/. Accessed May 6, 2021.

38. Bhutta N, Chang AC, Dettling LJ, Hsu JW. *Disparities in Wealth by Race and Ethnicity in the 2019 Survey of Consumer Finances.* Board of Governors of the Federal Reserve System;2020.

39. Nembhard IM, Edmondson AC. Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior.* 2006;27:941-966.

40. Clifton J, Harter J. *Wellbeing at Work: How to Build Resilient and Thriving Teams.* Gallup Press; 2021.

41. National Institute of Mental Health. 5 Things You Should Know About Stress. https://www.nimh.nih.gov/health/publications/stress/. Accessed May 7, 2021.

42. Albert MA, Slopen N, Williams DR. Cumulative Psychological Stress and Cardiovascular Disease Risk: A Focused Review with Consideration of Black-White Disparities. *Current Cardiovascular Risk Reports.* 2013;7:318-325.

43. Integrated Benefits Institute. Poor Health Costs US Employers $575 Billion and 1.5 Billion Days of Lost Productivity Per Integrated Benefits Institute. 2020; https://www.ibiweb.org/poor-health-costs-us-employers-575-billion/.

44. Kutzbach M, Lloro A, Weinstein J, Chu K. *How America Banks: Household Use of Banking and Financial Services.* Federal Deposit Insurance Corporation;2019.

45. National Museum of African American History & Culture. Being Antiracist. https://nmaahc.si.edu/learn/talking-about-race/topics/being-antiracist. Accessed May 11, 2021.

46. Dingle DT. Maynard Jackson: The Ultimate Champion for Black Business. 2009; https://www.blackenterprise.com/maynard-jackson-the-ultimate-champion-for-black-business/. Accessed May 1, 2021.

47. Franklin. S. C. Women and minority procurement: Atlanta's Approach. 2012; https://www.intracen.org/article/Women-and-minority-procurement-Atlantas-approach/. Accessed May 11, 2021.

48. Centers for Disease Control and Prevention. Racism and Health - Science and Research. 2021; https://www.cdc.gov/healthequity/racism-disparities/research-articles.html. Accessed May 11, 2021.

49. Williams DR, Lawrence JA, Davis BA, Vu C. Understanding how discrimination can affect health. *Health Services Research.* 2019;54:1374-1388.

50. Centers for Disease Control and Prevention. What is Health Literacy? 2021; https://www.cdc.gov/healthliteracy/learn/index.html. Accessed April 12, 2021.

51. Institute of Medicine. *Health Literacy: A Prescription to End Confusion.* Washington, DC2004.

52. Dewalt DA, Berkman ND, Sheridan S, Lohr KN, Pignone MP. Literacy and health outcomes: a systematic review of the literature. *Journal of general internal medicine.* 2004;19:1228-1239.

53. Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low health literacy and health outcomes: an updated systematic review. *Annals of internal medicine.* 2011;155:97-107.

54. UnitedHealthcare. *UnitedHealthcare Consumer Sentiment Survey.* 2017.

55. Brega AG, Barnard J, Mabachi NM, Weiss BD, Dewalt DA, Brach C, Cifuentes M, Albright K, West DR. *AHRQ Health Literacy Universal Precautions Toolkit, Second Edition.* Rockville, MD: Agency for Healthcare Research and Quality;2015. 15-0023-EF.

56. Kutner M, Greenberg E, Jin Y, Paulsen C. *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy.* Washington, DC: National Center for Education Statistics;2006.

57. Levy H, Janke A. Health Literacy and Access to Care. *Journal of health communication.* 2016;21 Suppl 1:43-50.

58. Lee HY, Jin SW, Henning-Smith C, Lee J, Lee J. Role of Health Literacy in Health-Related Information-Seeking Behavior Online: Cross-sectional Study. *J Med Internet Res.* 2021;23:e14088.

59. Hamel L, Munana C, Brodie M. *Kaiser Family Foundation/LA Times Survey of Adults with Employer-Sponsored Health Insurance.* Kaiser Family Foundation;2019.

60. Tipirneni R, Politi MC, Kullgren JT, Kieffer EC, Goold SD, Scherer AM. Association Between Health Insurance Literacy and Avoidance of Health Care Services Owing to Cost. *JAMA Network Open.* 2018;1:e184796-e184796.

61. Villagra VG, Bhuva B, Coman E, Smith DO, Fifield J. Health insurance literacy: disparities by race, ethnicity, and language preference. *The American journal of managed care.* 2019;25:e71-e75.

62. Logan RA, Wong WF, Villaire M, Daus G, Parnell TA, Willis E, Paasche-Orlow MK. Health Literacy: A Necessary Element for Achieving Health Equity2015, Washington, DC.

63. Isaacs J, Healy O, Peter HE. *Paid Family Leave in the United States: Time for a New National Policy.* Washington, DC: Urban Institute;2017.

64. Stearns J. The effects of paid maternity leave: Evidence from Temporary Disability Insurance. *Journal of health economics.* 2015;43:85-102.

65. Mason J, Acosta PM. *Called to Care: A Racially Just Recovery Demands Paid Family and Medical Leave.* National Partnership for Women & Families;2021.

66. Society for Human Resource Management. Paid Family Leave, on the Rise, Helps Women Stay in the Workforce. 2020; https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/paid-family-leave-helps-women-stay-in-the-workforce.aspx. Accessed May 11, 2021.

67. American Association of University Women. Equal Pay Day Calendar. 2021; https://www.aauw.org/resources/article/equal-pay-day-calendar/. Accessed May 11, 2021.

68. Glasmeier AK. MIT Living Wage Calculator. 2021; https://livingwage.mit.edu/. Accessed May 11, 2021.

69. Woolf SH, Aron L, Dubay L, Simon SM, Zimmerman E, Luk KX. *How are Income and Wealth Linked to Health and Longevity?* : Urban Institute;2015.

70. Platt J, Prins S, Bates L, Keyes K. Unequal depression for equal work? How the wage gap explains gendered disparities in mood disorders. *Social science & medicine (1982).* 2016;149:1-8.

71. Khullar D, Chokshi DA. Health, Income, & Poverty: Where We Are & What Could Help. In. *Health Affairs*2018.

72. Bleiweis R. Quick Facts About the Gender Wage Gap. 2020; https://www.americanprogress.org/issues/women/reports/2020/03/24/482141/quick-facts-gender-wage-gap/. Accessed May 6, 2021.

73. Frey JJ. How Employee Assistance Programs Can Help Your Whole Company Address Racism at Work. 2020; https://hbr.org/2020/10/how-employee-assistance-programs-can-help-your-whole-company-address-racism-at-work. Accessed May 12, 2021.

74. HR Research Institute. *The State of Employee Engagement in 2019: Leverage leadership and culture to maximize engagement.* HR Research Institute;2019.

75. HR Research Institute. *The State of Employee Engagement and Experience 2020.* 2020.

76. CDC Workplace Health Resource Center. Engaging Employees in Their Health and Wellness. In: Centers for Disease Control and Prevention; 2018.

77. Centers for Disease Control and Prevention. Well-Being Concepts. 2018; https://www.cdc.gov/hrqol/wellbeing.htm. Accessed May 5, 2021.

78. Harvard Business Review Analytic Services. *The Impact of Employee Engagement on Performance.* Harvard Business Review;2013.

79. McCleary K, Goetzel RZ, Roemer EC, Berko J, Kent K, Torre H. Employer and Employee Opinions About Workplace Health Promotion (Wellness) Programs: Results of the 2015 Harris Poll Nielsen Survey. *Journal of occupational and environmental medicine.* 2017;59:256-263.

80. Miles SJ, Mangold W. Employee voice: Untapped resource or social media time bomb? *Business Horizons.* 2014;57:401-411.

81. Vance RJ. *Employee Engagement and Commitment.* SHRM Foundation;2006.

82. Gunther CE, Peddicord V, Kozlowski J, Li J, Menture D, Fabius R, Frazee SG, Nigro PJ. Building a Culture of Health and Well-Being at Merck. *Population Health Management.* 2019;22:449-456.

83. Chang EH, Milkman KL, Gromet DM, Rebele RW, Massey C, Duckworth AL, Grant AM. The mixed effects of online diversity training. *Proceedings of the National Academy of Sciences.* 2019;116:7778-7783.

84. Dobbin F, Kalev A. Why Diversity Programs Fail. 2016; https://hbr.org/2016/07/why-diversity-programs-fail. Accessed May 6, 2021.

85. Williams DR. Stress and the Mental Health of Populations of Color: Advancing Our Understanding of Race-related Stressors. *J Health Soc Behav.* 2018;59:466-485.

86. Forde AT, Sims M, Muntner P, Lewis T, Onwuka A, Moore K, Roux AVD. Discrimination and Hypertension Risk Among African Americans in the Jackson Heart Study. *Hypertension.* 2020;76:715-723.

87. Geronimus AT, Hicken M, Keene D, Bound J. "Weathering" and age patterns of allostatic load scores among blacks and whites in the United States. *Am J Public Health.* 2006;96:826-833.

88. Joyce K, Pabayo R, Critchley JA, Bambra C. Flexible working conditions and their effects on employee health and wellbeing. *Cochrane Database of Systematic Reviews.* 2010.

89. Kivimäki M, Jokela M, Nyberg ST, Singh-Manoux A, Fransson EI, Alfredsson L, Bjorner JB, Borritz M, Burr H, Casini A, et al. Long working hours and risk of coronary heart disease and stroke: a systematic review and meta-analysis of published and unpublished data for 603 838 individuals. *The Lancet.* 2015;386:1739-1746.

90. Healthy People 2020. Access to Health Services. 2021; https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services. Accessed May 5, 2021.

91. National Minority Supplier Development Council. *NMSDC Facts and Figures.* 2020.

92. Masters C, Robinson D, Faulkner S, Patterson E, McIlraith T, Ansari A. Addressing Biases in Patient Care with The 5Rs of Cultural Humility, a Clinician Coaching Tool. *Journal of general internal medicine.* 2019;34:627-630.

93. Bleich SN, Findling MG, Casey LS, Blendon RJ, Benson JM, SteelFisher GK, Sayde JM, Miller C. Discrimination in the United States: Experiences of black Americans. *Health Services Research.* 2019;54:1399-1408.

94. Findling MG, Casey LS, Fryberg SA, Hafner S, Blendon RJ, Benson JM, Sayde JM, Miller C. Discrimination in the United States: Experiences of Native Americans. *Health Services Research.* 2019;54:1431-1441.

95. United States Census Bureau. Language Use Data. 2015; https://www.census.gov/topics/population/language-use/data.html. Accessed April 30, 2021.

96. Foiles Sifuentes AM, Cornejo MR, Li NC, Castaneda-Avila MA, Tija J, Lapane KL. The Role of Limited English Proficiency and Access to Health Insurance and Health Care in the

Affordable Care Act Era. *Health Equity.* 2020;4:509-517.

97. Jang Y, Kim MT. Limited English Proficiency and Health Service Use in Asian Americans. *Journal of immigrant and minority health.* 2019;21:264-270.

98. Ohtani A, Suzuki T, Takeuchi H, Uchida H. Language Barriers and Access to Psychiatric Care: A Systematic Review. *Psychiatric services (Washington, DC).* 2015;66:798-805.

99. Diamond L, Izquierdo K, Canfield D, Matsoukas K, Gany F. A Systematic Review of the Impact of Patient-Physician Non-English Language Concordance on Quality of Care and Outcomes. *Journal of general internal medicine.* 2019;34:1591-1606.

100. Piccardi C, Detollenaere J, Vanden Bussche P, Willems S. Social disparities in patient safety in primary care: a systematic review. *International Journal for Equity in Health.* 2018;17:114.

101. Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Services Research.* 2014;14:99.

102. US Department of Health and Human Services Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.*

103. US Department of Health and Human Services Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.* 2013.

104. Krogstad JM. Reflecting a demographic shift, 109 U.S. counties have become majority nonwhite since 2000. 2019; https://www.pewresearch.org/fact-tank/2019/08/21/u-s-counties-majority-nonwhite/?utm_source=AdaptiveMailer&utm_medium=email&utm_campaign=19-08-21%20US%20Counties%20Heads%20Up&org=982&lvl=100&ite=4550&lea=1053656&ctr=0&par=1&trk=&utm_source=AdaptiveMailer&utm_medium=email&utm_campaign=19-08-21%20US%20Counties%20Heads%20Up&org=982&lvl=100&ite=4550&lea=1053656&ctr=0&par=1&trk=. Accessed May 12, 2021.

105. Minnesota Department of Health. *2017 Minnesota Statewide Health Assessment.* 2017.

106. Wells L, Gowda A. A Legacy of Mistrust: African Americans and US Healthcare System. *Proceedings of UCLA Health.* 2020;24.

107. The de Beaumont Foundation. *Seven Ways Businesses can Align with Public Health for Bold Action and Innovation.* 2021.

108. Edelman. *2021 Edelman Trust Barometer: Business and Racial Justice in America.* 2021.

109. Healthcare.Gov. What Marketplace health insurance plans cover. https://www.healthcare.gov/coverage/what-marketplace-plans-cover/. Accessed April 7, 2021.

110. Kaiser Family Foundation. Explaining Health Care Reform: Questions About Health Insurance Subsidies. 2020; https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/. Accessed April 7, 2021.

111. Kaiser Family Foundation. Status of State Medicaid Expansion Decisions: Interactive Map. 2021; https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/. Accessed April 7, 2021.

112. Aron-Dine A. *Making Health Insurance More Affordable for Middle-Income Individual Market Consumers.* Center on Budget Policy and Priorities;2019.

113. Institute of Medicine Committee on the Consequences of Uninsurance. In: *Care Without Coverage: Too Little, Too Late.* Washington (DC): National Academies Press (US)

114. Finkelstein A, Taubman S, Wright B, Bernstein M, Gruber J, Newhouse JP, Allen H, Baicker K. THE OREGON HEALTH INSURANCE EXPERIMENT: EVIDENCE FROM THE FIRST YEAR. *The quarterly journal of economics.* 2012;127:1057-1106.

115. Finegold K, Conmy A, Chu CR, Bosworth A, Sommers BD. *Trends in the U.S. Uninsured Population, 2010-2020.* Assistant Secretary for Planning and Evaluation, Office of Health Policy;2021.

116. Medina C, Mahowald L. Repealing the Affordable Care Act Would Have Devastating Impacts on LGBTQ People. 2020; https://www.americanprogress.org/issues/lgbtq-rights/news/2020/10/15/491582/repealing-affordable-care-act-devastating-impacts-lgbtq-people/. Accessed July 16, 2021.

117. Taylor L. Housing and Health: An Overview of the Literature. *Health Affairs.* 2018.

118. Joint Center for Housing Studies of Harvard University. *2020 State of the Nation's Housing.* Habitat for Humanity;2020.

119. Kilduff L, Jarosz B. How Many People in the United States Are Experiencing Homelessness? 2020; https://www.prb.org/resources/how-many-people-in-the-united-states-are-

experiencing-homelessness/. Accessed April 7, 2020.

120. Center for Outcomes Research and Education. *Health in Housing: Exploring the Intersection between Housing and Health Care.* 2016.

121. The Community Guide. Health Equity: Tenant-Based Housing Voucher Programs. 2020; https://www.thecommunityguide.org/findings/health-equity-tenant-based-housing-voucher-programs. Accessed May 11, 2021.

122. Morrissey T. The Effects Of Early Care And Education On Children's Health. *Health Affairs.* 2019.

123. Bromer J, Melvin S, Porter T, Ragonese-Barnes M. *The Shifting Supply of Regulated Family Child Care in the U.S.: A Literature Review and Conceptual Model.* Erikson;2021.

124. National Institute of Child Health, Human Development Early Child Care Research Network. Child Care and Common Communicable Illnesses in Children Aged 37 to 54 Months. *Archives of Pediatrics & Adolescent Medicine.* 2003;157:196-200.

125. The Community Guide. Health Equity: Center-Based Early Childhood Education. 2015; https://www.thecommunityguide.org/findings/promoting-health-equity-through-education-programs-and-policies-center-based-early-childhood. Accessed July 23, 2021.

126. Williams MV, Martin LT, Davis LM, May LW, Kim A. *Evaluation of the National CLAS Standards.* RAND Corporation;2018.

127. Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association.* 2008;100:1275-1285.

128. Centers for Disease Control and Prevention. FY 2021 Operating Plan. In:2021.

129. McKillop M, Lieberman DA. *The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, adn Recommendations, 2021.* Trust for America's Health;2021.

130. The de Beaumont Foundation. 10 Essential Public Health Services. 2020; https://debeaumont.org/10-essential-services/. Accessed July 14, 2021.

131. Domestic Public Health Achievements Team CDC. *Ten Great Public Health Achievements --- United States, 2001 -- 2010.* Centers for Disease Control and Prevention;2011.

132. Mays GP, Smith SA. Evidence links increases in public health spending to declines in preventable deaths. *Health Aff (Millwood).* 2011;30:1585-1593.

133. Centers for Disease Control and Prevention. COVID Data Tracker. 2021; https://covid.cdc.gov/covid-data-tracker/#datatracker-home. Accessed July 15, 2021.

134. Hsiang S, Allen D, Annan-Phan S, Bell K, Bolliger I, Chong T, Druckenmiller H, Huang LY, Hultgren A, Krasovich E, et al. The effect of large-scale anti-contagion policies on the COVID-19 pandemic. *Nature.* 2020;584:262-267.

135. QuickFacts - Flint city, Michigan. In: United States Census Bureau, ed2021.

136. Centers for Disease Control and Prevention. Lead: Information for Workers - Health Problems Caused by Lead. 2018; https://www.cdc.gov/niosh/topics/lead/health.html. Accessed July 15, 2021.

137. Lopez L, 3rd, Hart LH, 3rd, Katz MH. Racial and Ethnic Health Disparities Related to COVID-19. *Jama.* 2021;325:719-720.