



**THE STATE OF
HEALTH IN
ALL POLICIES**

Executive Summary

Using a Health in All Policies (HiAP) approach provides a framework for diverse partners from multiple sectors to work together to define common goals, engage key stakeholders in problem solving, and identify opportunities to create healthier policies and communities.



State health agencies (SHAs) are well-positioned to lead efforts to embed health considerations into policymaking across sectors, and increased coordination and collaboration between SHAs can lead to improved government efficiency, shared goals across sectors, and better infrastructure to support local and regional agencies. As more SHAs create HiAP programs, they are developing new HiAP models and activities along the way.

Since 2011, the Association of State and Territorial Health Officials (ASTHO) has communicated with many states that have started formal or informal HiAP efforts. SHAs have had early successes building relationships for cross-sectoral collaboration to raise awareness about health, but they continue to contend with questions about what specific activities constitute HiAP, what roles non-governmental stakeholders play in state HiAP efforts, and how HiAP initiatives measure their impact. This report aims to document the current state of HiAP practices in SHAs and provide some initial answers to these outstanding questions.

Between July and October 2016, ASTHO's HiAP team interviewed representatives from nine states (California, Connecticut, Massachusetts, Minnesota, North Carolina, Oklahoma, Oregon, Tennessee, and Vermont) to discuss their HiAP initiatives. For each case study, background information, drivers behind starting and maintaining the HiAP work, partnerships, challenges, keys to success, and impacts are included. In addition, the report summarizes, at a higher level, themes that emerged from the collection of case studies.

Through case study interviews and previous work around HiAP, ASTHO found that HiAP can encompass a variety of SHA activities. Interviews revealed some discrete activities, including formal and informal mandates, participation in task forces, white papers, and education about HiAP through trainings and other venues. States also reported a range of other activities that were less concretely defined, like capitalizing on emerging opportunities. Health impact assessments (HIAs) were used in nearly every state interviewed to demonstrate HiAP concepts, raise awareness, and build capacity. Based on the themes and reflections above, ASTHO identified the following opportunities to move health agencies' HiAP work forward in the future.

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Background and Introduction



ASTHO DEFINES HEALTH IN ALL POLICIES AS

“a collaborative approach for integrating and articulating health considerations into policymaking and programming across sectors and levels of government with the goal of improving the health of all communities and people.”¹

Health in All Policies (HiAP) is a promising approach for improving health and equity for all, following a growing awareness that the factors that create health lie outside the scope of traditional public health or health-care activities. HiAP provides a framework for diverse partners from multiple sectors to work together to define common goals, engage key stakeholders in problem solving, and identify opportunities to create healthier policies and communities.

Although HiAP did not surface as a discrete concept until the World Health Organization (WHO) published the **Adelaide Statement on Health in All Policies** in 2010, cross-sectoral collaboration to improve health dates back to the 19th century, when public health pioneers linked living conditions to disease. In the last few decades, several key WHO publications began to expand the concept of health beyond physical health and healthcare, promote collaboration across sectors, and call attention to social and environmental factors that shape health outcomes. The history of HiAP around the world and its emergence in the United States has been well-documented in other recent reports.^{2,3} In 2010, California became the first state to mandate a statewide HiAP task force.

Health impact assessment (HIA), a semi-structured method of providing information to decisionmakers about the health impacts of projects and policies, has emerged as one promising way to achieve HiAP. In the United States, a close look at early successes with HIA provides useful information about potential practices for HiAP. For example, an evaluation of HIAs completed between 2011-2014 found that HIAs with clear recommendations for decisionmakers, adequate stakeholder engagement, compelling messages, and several methods of disseminating information were more likely to have an impact on policy outcomes than HIAs without these traits.⁴

In the absence of a full HIA, there are many activities that fall under the scope of HiAP that can have profound impacts on health. HIA practitioners have started to adapt the six steps of HIA—screening, scoping, assessment, recommendations, reporting, monitoring, and evaluation—and apply them to contexts where full HIAs may not fit.⁵ This may include activities like writing a comment letter on a public project proposal, integrating health into comprehensive plans, or creating health-based standards for new housing developments.

at State Health Agencies

Although the HIA field has produced valuable lessons for making discrete policies healthier, HiAP is distinct in that it aims for consideration of health across all government agencies in an integrated, systematic way. State health agencies (SHAs) are well-positioned to lead efforts to embed health considerations into policymaking across sectors. Increased coordination and collaboration between state agencies can lead to improved government efficiency, shared goals across sectors, and better infrastructure to support local and regional agencies.

In 2010, California became the first state to have a formal mandate for HiAP. Through an executive order, the governor created the Health in All Policies Task Force, which brings together more than 20 state agencies to identify health-promoting opportunities. By 2012, several other states had started to implement HiAP approaches. That year, ASTHO convened a HiAP advisory group composed of SHA leadership and national experts to identify promising practices and create a model framework for HiAP work in state agencies.⁶ ASTHO's resulting report, **Health in All Policies: A Framework for State Health Leadership**, was published in 2016 and describes the challenges and strategies unique to SHAs. This includes the foundational resources needed for HiAP (relationships, informational resources, personnel resources, funding resources, and legal resources) and a range of informational, consultative, engaging, and collaborative activities that SHAs can use to spur new efforts. ASTHO's HiAP framework also includes a list of potential short-term, intermediate, and long-term outcomes that states can use as goals for their HiAP programs.

As more SHAs create HiAP programs, they are developing new HiAP models and activities. Since 2011, ASTHO has communicated with many states that have started formal or informal HiAP efforts. SHAs have had early successes building relationships for cross-sectoral collaboration to raise awareness about health, but they continue to contend with questions about what specific activities constitute HiAP, what roles non-governmental stakeholders play in state HiAP efforts, and how HiAP initiatives measure their impact. This report aims to document the current state of HiAP practice in SHAs and provide some initial answers to these outstanding questions.

and Health Equity

Health equity has been defined as “achieving the conditions in which all people have the opportunity to attain their highest possible level of health.”⁷ The opportunity for a healthy life is shaped by many social, economic, and environmental factors, sometimes called health determinants. Over the last few decades, we have learned that certain populations experience unjust and avoidable differences in health determinants like income, education, or housing, and these differences contribute to poorer health.

Because good health for all cannot be achieved without a close look at the root causes of inequities, prioritizing health equity has become central to many public health initiatives. ASTHO's **2016 President's Challenge** focused on advancing health equity and optimal health for all. ASTHO's then-president and former Minnesota Department of Health Commissioner, Edward Ehlinger, invited SHAs to join him in promoting health equity through the Triple Aim of Health Equity: implementing a HiAP approach with health equity as the goal, strengthening the capacity of communities to create their own healthy futures, and expanding our understanding of what creates health.⁸

The Triple Aim of Health Equity helps define the relationship between health equity and HiAP, and provides guidance to SHAs about policy and program efforts that will reduce inequities in their states. According to this concept, HiAP can be thought of as an approach necessary for achieving the larger goal of health equity since public health stakeholders know that addressing the root causes of health inequities requires working with partners outside of the public health sector to create health-promoting policies and programs.

The states interviewed for this report all approached their health equity work differently. Some created a statewide HiAP initiative and then applied the concept of equity in complementary program areas (e.g., equitable transportation planning). Others created a statewide strategic plan for health equity and used HiAP principles and practices to implement it. These approaches are described in more detail below. In all of the states, health equity was mentioned as a crucial part of their larger HiAP initiatives, which reflects a national trend to prioritize health equity in public health initiatives.

Methods



Since 2012, thanks to support from CDC's National Center for Environmental Health/Agency for Toxic Substances and Disease Registry, ASTHO has worked to educate and empower SHA leadership to promote HiAP. A major piece of this work has been providing resources and technical assistance on implementing HiAP, including connecting states for peer-to-peer support and information sharing. ASTHO developed this report to provide HiAP examples from a cross-section of states. This report describes the "state of HiAP" across SHAs using information gathered from formal interviews with nine states about promising practices and recommendations for the future.

Through its ongoing work, ASTHO became aware of HiAP initiatives in a number of states, and chose nine of those for case study interviews: California (CA), Connecticut (CT), Massachusetts (MA), Minnesota (MN), North Carolina (NC), Oklahoma (OK), Oregon (OR), Tennessee (TN), and Vermont (VT). It is important to note that these are not the only states with ongoing HiAP work, and it is likely that there are SHAs with initiatives that ASTHO was unaware of at the time of these interviews.

ASTHO's HiAP team interviewed representatives from all nine states between July and October 2016. ASTHO identified interviewees by reaching out to contacts in each state and asking which staff were the most knowledgeable about HiAP efforts. The team conducted three interviews (CT, MA, and OR) with groups of staff from different departments within the SHA, and conducted the remaining interviews with one SHA representative. Interviewees varied in their roles and responsibilities within their SHAs, but the majority were departmental or program leaders from equity, policy and planning, environmental health, or chronic disease units. ASTHO conducted the MN and OK interviews with the deputy directors of the SHAs.

ASTHO used feedback from key stakeholders to develop a list of 21 interview questions (see Appendix A). The questions helped ASTHO learn how and why states became involved in formal HiAP efforts, and to understand the efforts drivers, impacts, and challenges. The questions centered on the themes of leadership, stakeholder engagement, awareness of HiAP, resources needed, and program impacts. The interviewers recorded and transcribed the interviews and supplemented details with information supplied via email.

ASTHO used information from the interviews to develop state HiAP case studies and conduct an analysis to identify similarities and differences across states. (Full case studies for each state can be found in Appendix B.) The analysis used information from interviewees to identify key activities in each state, common themes, successes and challenges, and outcomes.

This paper aims to provide insights into current HiAP practices at SHAs. However, there are a few notes to make regarding information collection. The interviewers encountered some methodological challenges that made it difficult to obtain complete information from all states and fully compare SHA efforts. In some interviews, interviewees commented that it can be unclear which SHA activities "counted" as HiAP. One example of this is HIA. Although most states interviewed had conducted HIAs, not all discussed HIAs as a significant HiAP activity. Similarly, some states discussed informal cross-sectoral collaborations, while others have formal HiAP mandates. In addition, although there may have been informal cross-sectoral collaboratives in states with formal mandates, the interviewees didn't focus on them. In many states, significant HiAP work is happening at the local level with support from the SHA, but not all interviewees were familiar with the details of such work.

Another challenge was that it can be difficult for one person to be aware of all of a SHA's HiAP efforts. Further, each interviewee's perspective is shaped by his or her position and role in the agency. (For example, high-level leadership may have greater awareness of the relationships and policy decisions driving a HiAP initiative than program staff.) Generally, the group interviews yielded richer information about multiple efforts in different departments than the solo interviews. In several states, HiAP initiatives predated an interviewee's tenure, making questions about the original drivers of the program difficult to answer.

Despite these challenges, the interviews revealed that many of the SHAs are doing remarkably similar work and have complementary recommendations for building successful programs. A brief summary of each state's HiAP initiative is presented in this report, followed by the analysis of similarities in activities and themes across states.

A woman and a young girl are running on a dirt path in a forest. The woman is on the left, wearing a white tank top and dark blue leggings. The girl is on the right, wearing a white t-shirt and dark blue leggings. They are both smiling and appear to be enjoying their run. The background is filled with tall trees and green foliage.

State Health in All Policies Initiatives





HEALTH IN ALL POLICIES IN CALIFORNIA:

The First Formal Mandate

In 2010, California’s governor created the Health in All Policies Task Force (HiAP Task Force) through an executive order, making it the first state with a formal mandate for cross-agency collaboration to improve health. The HiAP Task Force convenes representatives from 22 diverse state agencies to create a shared vision of a healthy and equitable community, define common goals, explore the root causes of health, implement HiAP policies and programs, and engage stakeholders. Now in its eighth year, the HiAP Task Force has successfully integrated health and equity into state policies and programs and garnered increased leadership support for continuing the initiative. In a recent survey, partner agencies indicated that the task force helped them identify mutually beneficial goals, build relationships and trust, and facilitate sustained interagency collaboration. The California Department of Public Health, the Public Health Institute, and several foundation partners provide resources to support seven positions to staff the work of the task force.

QUICK FACTS

California’s Health in All Policies Approach

YEAR STARTED	2010
INITIATED BY	Governor
OTHER STATE AGENCIES INVOLVED	22 state agencies, departments, and offices
OTHER PARTNERS	California Strategic Growth Council (within the Governor’s Office), local government agencies, community groups
INITIAL FUNDING	None initially; later, the California Endowment
FORMAL OR INFORMAL PARTNERSHIP?	Formal
DRIVEN BY STAFF OR LEADERSHIP?	Both
COMMUNITY ENGAGEMENT IS...	Both informal and formal, as a part of Strategic Growth Council governance process and with assistance from community partner organizations
HEALTH EQUITY IS...	A central theme in the work



HEALTH IN ALL POLICIES IN CONNECTICUT:

Embedding Health Equity

The Connecticut Department of Public Health (CTDPH) has led several parallel HiAP-like efforts for many years, including building cross-sectoral partnerships to promote healthy homes, conducting HIAs, and engaging more than 300 diverse local government and community partners to create the Connecticut State Health Improvement Plan (SHIP). In 2015, a grant from ASTHO allowed CTDPH to create a coordinated, statewide strategic plan to promote health equity through HiAP approaches. CTDPH has already seen some early positive impacts from its work: it has implemented a health equity impact review process for all public health-related bills introduced in the state legislature, created resources to improve communication about health equity, and empowered local leadership to become health equity champions. CTDPH's health equity strategic plan is staffed by existing leadership, program coordinators, and technical experts in CTDPH's Office of Health Equity and Environmental Health Section.

QUICK FACTS

Connecticut's Health in All Policies Approach

YEAR STARTED	2015 (health agency-wide; years earlier for individual programs)
INITIATED BY	Health department (Office of Health Equity and Environmental Health Section)
OTHER STATE AGENCIES INVOLVED	All state agencies involved in the SHIP
OTHER PARTNERS	CommonHealth ACTION, Health Resources in Action, and state and local nonprofits
INITIAL FUNDING	ASTHO grant
FORMAL OR INFORMAL PARTNERSHIP?	Both
DRIVEN BY STAFF OR LEADERSHIP?	Both
COMMUNITY ENGAGEMENT IS...	Achieved with organizations representing communities engaged through SHIP process (engaging community members happens at the individual program level)
HEALTH EQUITY IS...	The main driver for this project



HEALTH IN ALL POLICIES IN MASSACHUSETTS:

Growing Healthy Communities Locally

In 2004, the Massachusetts Department of Public Health (MADPH) began applying the strategic framework it had used in its successful tobacco prevention work to chronic disease more broadly. This brought policy, systems, and environmental (PSE) change and community engagement approaches to pressing public health issues such as obesity, and helped MADPH develop strong relationships with partners outside of public health, including land use and transportation agency staff and community advocates.

In 2009, high level conversations between agencies, along with ongoing advocacy from community stakeholders, eventually led Massachusetts to create the Healthy Transportation Compact, the nation's first state-level mandate to include health considerations in transportation planning. At the same time, local and regional officials around the state were starting to build partnerships with local smart growth initiatives. Also in 2009, MADPH launched Mass in Motion (MiM), a state-wide public-private partnership to address overweight/obesity and chronic disease through increasing healthy eating and active living in local communities. MADPH has a parallel effort to build partnerships with state and regional agencies that distribute state resources and guide local work, including land use and transportation, energy, environment, and housing agencies, through HIAs and other HiAP tools and approaches. Further, MADPH has conducted numerous HIAs in built environment, transportation, housing, and community development.

QUICK FACTS

Massachusetts' Health in All Policies Approach

YEAR STARTED 2009

INITIATED BY Health department, public health advocates, and private foundations

OTHER STATE AGENCIES INVOLVED The Departments of Transportation, Planning and Land Use, Energy Resources, Environmental Protection, and Housing and Community Development

OTHER PARTNERS Public health advocates, regional planning agencies, Health Resources in Action, and the Massachusetts Public Health Association

INITIAL FUNDING Private state foundations and state resources

FORMAL OR INFORMAL PARTNERSHIP? Both

DRIVEN BY STAFF OR LEADERSHIP? Both

COMMUNITY ENGAGEMENT IS... Embedded in MiM and through HIA activities

HEALTH EQUITY IS... Central to public health work

Partnerships to Promote Equity

Recognizing that health for all was not possible without addressing social and environmental factors, leadership at the Minnesota Department of Health (MDH) made a commitment to finding new ways to talk about what truly creates and maintains health, and to promote a shared responsibility for health and health equity among the agency’s many state, local, and community partners. The Healthy Minnesota Partnership (HMP), a group convened by the SHA and tasked with completing Minnesota’s state health assessment and SHIP, started by framing the assessment around the conditions that create health (also known as social determinants of health) and health equity instead of “the usual” health outcomes of disease and injury. Through this process, HMP members and participants developed a shared understanding of these concepts.

After the SHA was successful in bringing partners together around this broader view of health, the follow-up action plan (**Healthy Minnesota 2020: Statewide Health Improvement Framework**) focused on building capacity across the state to change the conversation about what creates health and to implement cross-sectoral policy change approaches to health. Now, MDH is utilizing a number of tools to move HiAP forward, including HIA.

In recent years, MDH has produced several papers that review the evidence linking health to social and economic factors like income, paid leave and sick time, and incarceration justice. One of these papers focused entirely on a strategic vision for statewide health equity and secured the commitment of all state agencies to partner with MDH to work toward this vision. State leadership has also asked MDH staff to review its internal policies, programs, and budgets for structural inequities. MDH continues to work alongside community partners to prioritize issues and identify opportunities for policy change.



QUICK FACTS

Minnesota’s Health in All Policies Approach

YEAR STARTED	2010
INITIATED BY	Health department
OTHER STATE AGENCIES INVOLVED	The Departments of Transportation, Human Services, Public Safety, Corrections, and Education; the Minnesota Housing Finance Agency; and state councils of color
OTHER PARTNERS	Community-based organizations, advocacy and community organizing groups, state business collaborative, tribal governments, educational institutions, health plans, and provider organizations
INITIAL FUNDING	None
FORMAL OR INFORMAL PARTNERSHIP?	Informal
DRIVEN BY STAFF OR LEADERSHIP?	Both
COMMUNITY ENGAGEMENT IS...	The foundation of this initiative
HEALTH EQUITY IS...	The goal for using a HiAP approach



HEALTH IN ALL POLICIES IN NORTH CAROLINA:

Sustaining Partnerships and Programs

In 2006, the North Carolina Department of Health and Human Services (NCDHHS) formed the Healthy Environments Collaborative (HEC) without a formal mandate or funding. The HEC brings together the state health, transportation, commerce, and cultural and natural resource agencies to define common goals and look for opportunities for collaboration. Since the collaborative's inception, the agencies have been working to align their efforts at the state and local level through dozens of projects and policies.

In 2009, three years after HEC began meeting, it received a CDC **Communities Putting Prevention to Work** grant, which allowed the group to accelerate its progress by creating a strategic plan that identified data, research, and comprehensive planning as priorities for state agencies. As a result of this work, HEC has provided grants to municipalities around the state to advance active transportation through changes in the physical environment; updated local comprehensive plans to include health; promoted a local **Complete Streets** policy; and raised awareness with other agencies and the public about the links between health, transportation, built and natural environments, and the economy. HEC is supported by agency program-level staff, and the meetings provide a convenient way for agency leadership to stay involved in North Carolina's HiAP efforts.

QUICK FACTS
North Carolina's Health in All Policies Approach

YEAR STARTED	2006
INITIATED BY	Health department
OTHER STATE AGENCIES INVOLVED	Departments of Transportation, Environmental Quality, and Commerce
OTHER PARTNERS	University of North Carolina Chapel Hill and local government agencies
INITIAL FUNDING	None initially; then the CDC Communities Putting Prevention to Work Component II Grant in 2009
FORMAL OR INFORMAL PARTNERSHIP?	Informal
DRIVEN BY STAFF OR LEADERSHIP?	Staff
COMMUNITY ENGAGEMENT IS...	At local level through partner programs
HEALTH EQUITY IS...	Always part of conversation, but not the main driver

Leading with Health Impact Assessments

Following growing national awareness of HiAP, the Oklahoma State Department of Health (OSDH) leadership embraced the opportunity to integrate HiAP principles and practices into the statewide Oklahoma Health Improvement Plan (OHIP) revision in 2015. OHIP’s existing governance structure, inclusion of diverse partners, and existing relationships provided a strong foundation for HiAP. As a result, obesity, the flagship issue of the OHIP, includes a multisectoral approach.

Soon after in 2015, OSDH accelerated its HiAP progress through participation in the **Aspen Institute’s TeamWork: Leadership for Healthy States** program, convening state leadership and tribal partners to conduct an HIA on the health

impacts of summer learning programs for elementary school children. The HIA informed state, local, and tribal policymakers about funding summer learning programs and built strong relationships between the health and education agencies.

Participation in the Oklahoma Works governing council, a statewide, multiagency partnership to build state workforce capacity and increase access to jobs, also provided an opportunity for OSDH to share the HIA and additional information about the links between health, education, and employment with workforce stakeholders. As a result, Key Economic Networks, the local community coalitions that implement Oklahoma Works, now have participation from local HIA and HiAP practitioners. In the future, OSDH plans to build on its past successes through Health 360, a comprehensive, statewide HiAP initiative that will identify priority health issues, use state data to examine the magnitudes of the problems, and identify evidence-based best practice solutions and available state assets.



QUICK FACTS

Oklahoma’s Health in All Policies Approach

YEAR STARTED	2013
INITIATED BY	Health department
OTHER STATE AGENCIES INVOLVED	Departments of Education, Labor, Commerce, and Corrections, and the Health Care Authority
OTHER PARTNERS	HIA experts and local community economic and health coalitions
INITIAL FUNDING	Aspen Institute
FORMAL OR INFORMAL PARTNERSHIP?	Both
DRIVEN BY STAFF OR LEADERSHIP?	Leadership
COMMUNITY ENGAGEMENT IS...	Not currently a part of activities
HEALTH EQUITY IS...	Not a driver, but embedded in the work

Formal Partnerships by Sector

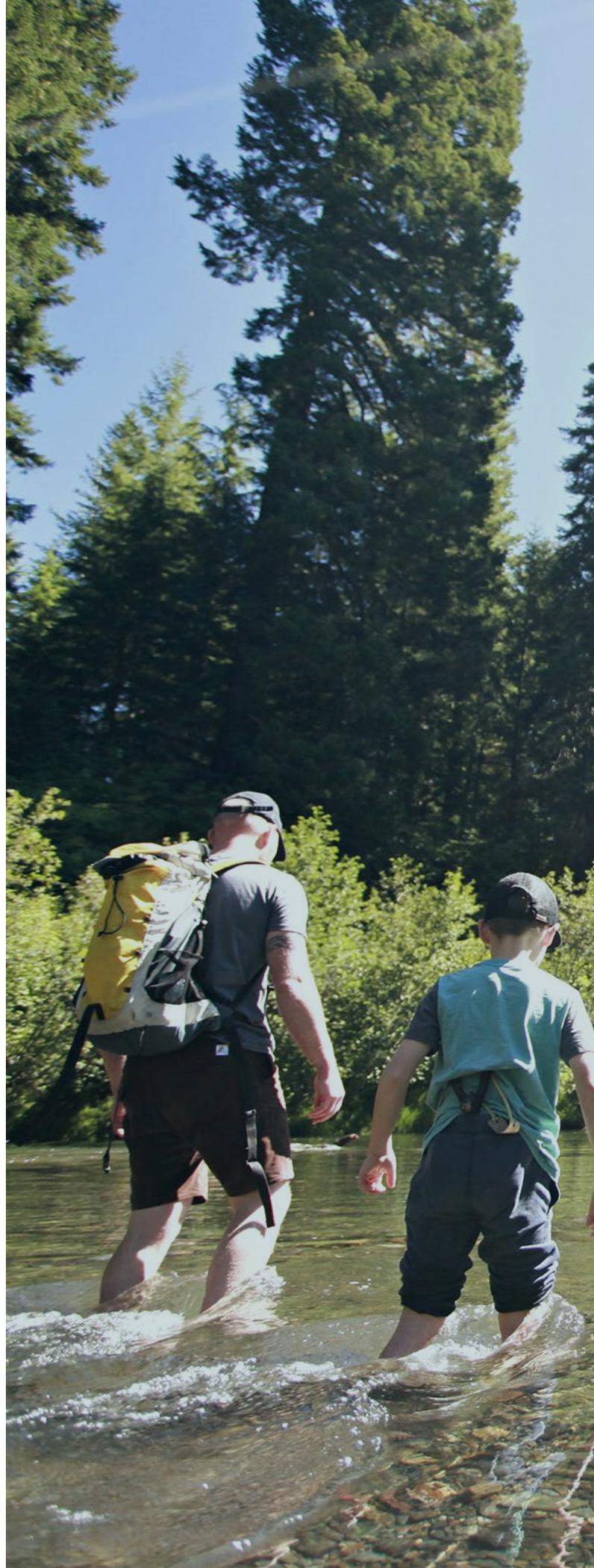
The Oregon Health Authority’s Public Health Division (OPHD) started learning about cross-sectoral approaches to health many years ago, including healthy community design, HIAs, and investing in local initiatives to build capacity in these approaches. While the formal partnerships are newer, this has been a sustained, intentional, and long-term effort. HiAP efforts complemented an existing commitment from the governor and state health official to address the social determinants of health and equity.

As HiAP approaches increased across OPHD centers, the SHA coordinated and aligned efforts through existing cross-cutting initiatives like the **OPHD Strategic Plan** and **Public Health Modernization initiative**, which both name HiAP approaches to promoting health and equity. Additionally, in at least three discrete topic areas—education, transportation, and environment—OPHD developed formal partnerships with other state agencies. Through these partnerships, OPHD has shared goals, strategies, and performance measures with several other agencies, health agency leadership serves on several non-health sector advisory committees, and grant opportunities issued by the state transportation and environment agencies include health components. OPHD staff have initiated programs that support the growth of HiAP through federal grants, and staff support has been sustained without funding by integrating HiAP into ongoing work.

QUICK FACTS

Oregon’s Health in All Policies Approach

YEAR STARTED	2012
INITIATED BY	Health department
OTHER STATE AGENCIES INVOLVED	Departments of Environmental Quality, Transportation, and Education
OTHER PARTNERS	Community groups
INITIAL FUNDING	None
FORMAL OR INFORMAL PARTNERSHIP?	Both
DRIVEN BY STAFF OR LEADERSHIP?	Both
COMMUNITY ENGAGEMENT IS...	Part of individual program or policy efforts
HEALTH EQUITY IS...	A driver of this work





HEALTH IN ALL POLICIES IN TENNESSEE:

Improving Government Efficiency

After years of local successes linking health and transportation in Nashville and other localities, in 2016 the Tennessee state health official wanted to create a formal space for HiAP to improve efficiency in government and improve health. As a result, the Tennessee Department of Health created a position in the newly formed Office of Primary Prevention to focus on HiAP and lead the formation of the Tennessee Livability Collaborative (TLC). TLC's mission is to "improve the prosperity, quality of life, and health of Tennesseans through collaboration between state departments in the areas of policy, funding, and programming." TLC accomplishes this by bringing together diverse state agency partners and identifying opportunities for collaboration.

TLC is modeled after the North Carolina Healthy Environments Collaborative, a successful cross-sectoral initiative now in its twelfth year. Although TLC is still new, it has already established partnerships with nine state agencies, including the Tennessee Departments of Education, Economic and Community Development, and Transportation, and has already generated several ideas for projects and policies that would benefit all partners.

QUICK FACTS

Tennessee's Health in All Policies Approach

YEAR STARTED	2016
INITIATED BY	Health department
OTHER STATE AGENCIES INVOLVED	Departments of Education, Economic and Community Development, Tourism, Transportation, Environment and Conservation, Housing and Urban Development, and Agriculture, along with the Arts Commission and Higher Education Commission
OTHER PARTNERS	University of North Carolina at Chapel Hill
INITIAL FUNDING	State general funds
FORMAL OR INFORMAL PARTNERSHIP?	Informal
DRIVEN BY STAFF OR LEADERSHIP?	Both
COMMUNITY ENGAGEMENT IS...	Not currently established, but there are plans in place to initiate it
HEALTH EQUITY IS...	A driver for this initiative



QUICK FACTS

Vermont's Health in All Policies Approach

YEAR STARTED	2011
INITIATED BY	Health department
OTHER STATE AGENCIES INVOLVED	Nine agencies in the Vermont Health in All Policies Task Force
OTHER PARTNERS	District health offices and the Vermont Public Health Association
INITIAL FUNDING	None
FORMAL OR INFORMAL PARTNERSHIP?	Both
DRIVEN BY STAFF OR LEADERSHIP?	Leadership
COMMUNITY ENGAGEMENT IS...	Established at the program level statewide, but is not part of the Vermont Health in All Policies Task Force
HEALTH EQUITY IS...	Not a driver of the executive order, but a shared value of Vermonters and was adopted as a core value by the task force

HEALTH IN ALL POLICIES IN VERMONT:

Embracing Shared Values

In recent years, the increased interest in sustainability prompted Vermont's state government agencies to explore cross-sectoral policy solutions at the intersections of natural places, healthy people, and vibrant local economies. The Vermont Department of Health has been promoting cross-sectoral solutions to health issues at the local level for years, with training and projects aimed at public health, transportation, and regional planning collaboration related to healthy community design, HIA, and implementation of complete streets policies.

In 2011, the Vermont legislature passed **Act 48**, which requires the state to create a plan to institute an HIA process for state and local agencies. In 2015, the

governor signed an executive order creating the Health in All Policies Task Force, composed of nine state agencies, to develop a shared accountability for health. The task force members are appointed by the governor and charged with reporting annually on their programs, policies, and budgets that impact health; identifying gaps and opportunities; and finding solutions to address gaps. Vermont is now the only state that has a mandate for both HIA and HiAP.

The task force, now in its third year, has developed a charter and vision that explicitly focuses on improving health and equity. All nine agencies have also adopted healthy local food procurement policies and guidelines when using state funds or facilities, an attempt to have an early policy success. The task force has maintained group stability and engagement through a recent administration change and is now focused on developing a dashboard to track investments, policies, and programs across sectors that improve health.

Themes



ASTHO compiled and systematically reviewed information from interviews and email correspondence to find common themes across states.

THE THEMES NATURALLY SPLIT INTO FOUR MAIN CATEGORIES:

descriptions of activities

keys to success

challenges

impacts

Interviewee perspectives about these topics are presented below, followed by reflections and recommendations. The states associated with each theme are noted in order to explain the state programs' unique and common features, not to compare their merits. These lists are also based on the interviews, and thus reflect the viewpoints of the interviewees.



Activities

This section explores activities that comprise the nine states' HiAP initiatives. Understanding what HiAP initiatives look like in different states provides the basis for understanding these activities' impacts and successes. The ASTHO Framework's spectrum of engagement for implementation activities (adapted from the Policy Consensus Initiative), provides a useful model for HiAP.^{9,10} It suggests that HiAP activities fall on a spectrum from informational to consultative to engaging to collaborative, with the earliest stages being informational and the latter being authentic partnerships. If the goal of HiAP is shared goals and decisionmaking with other sectors, the degree to which a SHA forms meaningful partnerships with external stakeholders will significantly influence its success. Thus, conceptualizing activities on a spectrum that prioritizes external partnerships is key to success in HiAP. Most states had a range of reported activities that fell into different categories, but it is interesting to note that all states reported at least one collaborative activity.

INFORMATIONAL ACTIVITIES

Coordinating Existing Health in All Policies Efforts:

More than half of the states (CT, MA, OR, TN, and VT) described their roles in HiAP as coordinators of existing HiAP activities or parallel efforts (sometimes, in addition to starting new HiAP initiatives). This is significant because it demonstrates that HiAP-like efforts have existed long before the concept of HiAP. Coordinating existing cross-sectoral activities under a HiAP scope can often take significant time and resources, but is an important component of HiAP work.

Health Agency Strategic Plans:

Four states (CT, MN, OK, and OR) mentioned, at some point, they had had an opportunity to write HiAP or health equity into their state mandates, departmental missions, or agency strategic plans, and that this helped advance their HiAP initiatives.

CONSULTATIVE ACTIVITIES

Multi-Agency Task Forces:

Six of the nine states (CA, CT, MA, MN, OK, and OR) mentioned participation in multi-agency task forces outside of public health as part of their HiAP activities.

Health Equity and the ASTHO President's Challenge:

Two states (CT and MN) said that they used the ASTHO President's Challenge on Health Equity to advance HiAP. Through a grant from ASTHO, Connecticut created an agencywide health equity strategic plan, and implemented a process for reviewing all proposed state legislation for health equity impacts. Minnesota's involvement with ASTHO's President's Challenge on health equity was described previously in this report. In addition to the Triple Aim for Health Equity model, Minnesota wrote a health equity white paper for partners and stakeholders to use. Five states (CT, MA, MN, OR, and TN) said that health equity was a driver for their work, but all states said that health equity is central to their conversations on HiAP.

ENGAGING ACTIVITIES

Health in All Policies through the State Health Improvement Plan¹:

Three states (CT, MN, and OK) emphasized that their SHIP process provided significant opportunities to advance HiAP through collaboration and identifying specific projects. Through the SHIP process of defining health priorities and evidence-based actions, states were able to raise awareness with non-health agencies about their links to health and encourage a shared responsibility to meet health-based performance benchmarks. In Minnesota, the state framed its SHIP

around the social determinants of health to raise awareness about the connections between health and various topics and engage communities and policy-makers to use state data and information for action.

White Papers:

Minnesota was the only state to mention the use of white papers as a major HiAP activity. The SHA published a series of white papers linking health with other factors (e.g., income and incarceration justice) with the goal of using the papers to engage other agencies and community partners to look for opportunities for policy change together.

COLLABORATIVE ACTIVITIES

Health Impact Assessments:

The most commonly cited HiAP activity was the use of HIAs to increase awareness of health in other sectors and improve cross-sectoral collaboration. Six of the nine states (CT, MA, MN, OK, OR, and VT) mentioned that HIAs helped to inspire broader HiAP approaches. HIA work included conducting statewide HIAs and supporting local HIAs through training, technical assistance, and funding. Interestingly, although HIA programs operate independently from the HiAP initiatives in most states due to different funding streams and because HIA requires staff with specialized technical skills, HIA was nonetheless seen as a crucial first step towards HiAP. Before the concept of HiAP became widely known, HIAs demonstrated the concept of HiAP, built relationships with other sectors, and provided a framework for engaging with non-governmental partners. In Oklahoma, an HIA was successfully used to demonstrate HiAP at the state level.

Formal Mandates for Health in All Policies:

Formal mandates for HiAP took a variety of forms. In Massachusetts, the Healthy Transportation Compact is a law passed in 2009 that formalizes a partnership between the health and transportation agencies. The California Executive Order that created the HiAP Task Force places oversight under the purview of the cabinet-level Strategic Growth Council, and a similar Executive Order in Vermont was the result of conversations between the governor and the health commissioner. Oregon was unique in that its formal partnerships occurred in the form of memoranda of understanding or shared programs between the SHA and three other agencies (transportation, environment, and education). Connecticut's formal mandate was internal, requiring the SHA to review proposed legislation for health equity impact. In most of these states, informal HiAP activities took place in parallel with the formal mandates, but only three states said that the informal and formal efforts were coordinated as part of a larger HiAP program.

¹ Many states create SHIPs to guide planning and implementation of statewide strategies to improve population health. SHIPs typically delineate roles for both the public health sector and other partners, and provide information about statewide health status, policy priorities, and resources. For more information, see the ASTHO's [Developing a State Health Improvement Plan: Guidance and Resources](#).

Informal Collaboratives:

Informal collaboratives were generally described as groups of staff working in state and local agencies from many sectors, and sometimes non-governmental partners, who met periodically to look for opportunities to partner. In the early stages, collaboratives tended to focus on creating strategic plans or defining goals. More well-established groups looked for specific opportunities to integrate health into other sectors, for example, by requiring health metrics in local transportation projects or creating health-focused positions in partner agencies. HiAP initiatives in four states (MN, NC, OK, and TN) focused on a more informal collaborative network composed of more than two agencies. Of those states, Minnesota and North Carolina said that the informal nature of their HiAP work was key to its success. They noted they found this structure preferable to a state-mandated initiative because the flexibility in governance process, outcomes, and goals has helped, rather than hindered, their growth.

Capitalizing on New Opportunities:

Five states (CA, CT, MN, OR, and TN) mentioned that they have the flexibility and resources to be opportunistic about new partnerships or activities with other agencies or programs as they arise (i.e., they are always looking for ways to integrate health into policies and programs), even if this is outside the scope of their regular activities. Interviewees felt that having the ability to pursue partnerships this way has had the biggest impact on public health of all of their HiAP strategies. For example, two states identified the opportunity to write health into state transportation grant requirements through a conversation with a partner. Although the activity was not in a formal work plan, it quickly had a large positive impact on health.

Supporting Local Initiatives:

At least four states (NC, MA, OR, and VT) said that they have done significant work building statewide networks led by local health departments and community partners to implement healthy community design projects and policies. These networks are often longstanding partnerships between the SHA's chronic disease unit and local health departments being funded to work on environmental and policy approaches to tobacco and obesity. Through these programs and grants, local partners across these states have been conducting HiAP-like activities for years, and provided the infrastructure and receptiveness to new HiAP activities. An additional three states (CA, MN, and OK) mentioned that local networks around the state had implemented significant HiAP-like projects and policies, although this work wasn't necessarily coordinated with the SHA's activities.

Keys to Success

This section summarizes responses about the main drivers for starting HiAP initiatives, or the interviewees' perspectives on what made their efforts successful. The themes are listed in the order of the most to least commonly reported.

Framing:

All states mentioned a "frame" that resonated with partners and policymakers alike in their states and helped them to move HiAP forward. In North Carolina and Massachusetts, this frame was obesity; in Connecticut, Oregon, and Minnesota, it was health equity. Oklahoma's focus was on the links between education and jobs, or a healthy workforce. Vermont's focus was on preserving healthy, vibrant, sustainable towns. Tennessee was focused on return on investment and government efficiency, and California framed its initiative around the goals of the California Strategic Growth Council—"sustainable communities emphasizing strong economies, social equity and environmental stewardship." Oregon also mentioned that although health equity was central to conversations, the frame could change depending on the partner agency it was working with. For example, when Oregon's SHA worked with the transportation agency, it focused on emergency services.

Strong Leadership:

Eight out of nine states explicitly named the leadership of their health commissioners and/or deputy health commissioners as a main driver for their involvement with HiAP. This included support for both HiAP and health equity, and a willingness to champion the approaches with other decisionmakers and peers. In some cases, strong leadership directly resulted in adding HiAP or health equity in SHA strategic plans. In other states, this leadership was the main driver for a formal mandate. When asked what inspired their leaders to become HiAP champions, interviewees frequently cited the important role of national organizations (APHA, ASTHO, and NACCHO) in cultivating SHA leadership on HiAP and health equity and providing support and resources to promote ideas and implement programs. Three of the states said that the evidence alone about what causes health (social determinants) directly inspired their health commissioners to provide leadership on the issue.

Capacity Building:

All states said that highly motivated and skilled staff were crucial to keeping initiatives going with limited resources and leadership changes. The skills most cited as being important for HiAP were technical expertise, relationship building and collaboration, and communication and facilitation skills. Four states (CT, NC, OK, and TN) said that they used external facilitators or technical assistance providers to help them plan and implement initiatives. These neutral third parties were from universities or public health institutes, and all states that used neutral third parties agreed that this assistance was crucial to the successes of their projects.

Community Engagement:

Six states (CT, MA, MN, NC, OR, and VT) said that their communities are engaged in HiAP work at the local level. According to interviewees, this was by far the most common way for state agencies to bring non-governmental partners into the HiAP process. Four states (CA, CT, MA, and MN) said that community groups' involvement in state HiAP initiatives was integral to keeping the health agencies accountable to their missions. These states have engaged community partners through a formal governance process to ensure community involvement, either as part of their HiAP initiatives or through another mechanism, like the SHIP.

Sustained Infrastructure:

Five of the nine states (CA, NC, OR, TN, and VT) said that they were intentional about structuring their HiAP initiatives to insulate them from staff turnover and changes in administration. Indeed, the fear of SHA programs disappearing with changes in leadership was common in all states. One state mentioned that having long tenured staff who eventually rise to leadership positions within the SHA has shielded them from the instability of administration changes.

History of Collaboration:

Five states (CT, MN, NC, TN, and VT) said that a long history of cross-sectoral partnerships helped their partners understand and accept HiAP. However, although all states mentioned that they look for collaborative opportunities with partners, only two states (MN and TN) said that they encourage their partners to have ownership over the projects that result from HiAP collaborative efforts so the responsibility does not fall entirely on the SHA.

Connecting with National Organizations:

Three states (CT, OK, and VT) said that information about HiAP from national organizations (APHA, ASTHO, and NACCHO) was helpful in educating their partners and/or leadership about the concept. However, only two states said that they used the ASTHO HiAP Framework to guide their programs. The other states felt that they were generally too far along in the process for the framework to be useful, but that it would be useful to states newer to HiAP.

Challenges

States interviewed were asked specifically about challenges to implementing HiAP programs. The responses below reflect common challenges in public health—funding, lack of information, and the return on investment for prevention. Understanding HiAP is also an initial hurdle common to most SHA efforts.

Funding and Resources:

Lack of funding and resources was consistently cited as the biggest barrier to implementing HiAP initiatives. Five states (CT, MA, MN, NC, and OK) used parts of small grants awarded to similar programs to support their initial HiAP initiatives. North Carolina and Minnesota used CDC funding for policy, systems, and environmental change in local communities. Connecticut used a health equity grant from ASTHO. Massachusetts received funding for HIA, and Oklahoma participated in the Aspen Institute's TeamWork program. Other states mentioned that they had previously received grants for related work like HIA, but that it was not directly funding their current HiAP initiatives. Many states mentioned that they were concerned about continued funding for their HiAP initiatives, either because grants were going to expire or because general funding for positions was uncertain. Similarly, almost all states mentioned that they were concerned about having staff capacity to maintain work once HiAP initiatives were fully implemented.

Understanding HiAP:

Four states (CA, CT, OK, and TN) mentioned that the theoretical nature of HiAP can be difficult for partner agencies to understand without practical examples, and that this has been a barrier to work. According to the interviewees, using successful HIAs as examples of cross-sectoral partnerships has been helpful, but the process takes time.

Health Data and Information:

Two states (CA and MA) mentioned that partner agencies have a higher expectation for data and information than the health agency can provide. When HiAP moves from the theoretical phase to implementation, interviewees said, partners expect that public health can quantify health issues or impacts, but this is an area where public health generally lags behind other fields.

Investments in Distant Outcomes:

Two states (MA and OR) discussed how it is hard for partners to commit to making investments in long-term health outcomes that cannot yield immediate results. This is particularly difficult when making decisions about funding HiAP versus funding healthcare services that would have immediate positive impacts.

Impacts

Interviewees were asked a number of questions about what impacts their HiAP initiatives have had to date. As with the activities mentioned above, this information is derived primarily from the interviews conducted in 2016, so there may be additional impacts of HiAP initiatives that were not captured here.

Health in Other Agency Mission:

Eight states (CA, MA, MN, NC, OK, OR, TN, and VT) reported that as a result of their HiAP work, health has been integrated into the mission or work.

Raising Awareness:

Seven states (CA, CT, MA, MN, OK, OR, and VT) noted that their HiAP initiatives have been successful in raising awareness about the social determinants of health, health equity, or HiAP.

Shared Metrics:

Five states (CA, CT, OR, TN, and VT) said that they either currently have or aspire to have shared metrics across agencies or a shared agency dashboard that tracks health outcomes.

Health in Other Agency Work:

Five states (CA, MA, NC, OK, and OR) reported that, as a result of their HiAP work, health has been integrated into the plans and/or policies of other state agencies.

Supporting Local Networks:

Five states (CA, MA, NC, OK, and TN) reported that HiAP efforts have grown the capacity of local networks to participate in policy and program change.

Conducting Trainings:

In five states (CA, CT, MA, OK, and VT), the SHA has conducted new trainings in HIA or HiAP.

Funding for Health in All Policies Staff:

In four states (CA, OR, TN, and VT), new staff positions have been created or existing staff positions have been refocused on HiAP.

Health in Local Plans:

Four states (MA, MN, NC, and VT) reported that, as a result of their HiAP and associated work, health has been integrated into the plans and/or policies of local agencies.

Creating Resources:

Four states (CT, MA, MN, and VT) reported that their SHAs have created HiAP resources.

Health in All Policies Required by Mandate:

Three states (CA, MA, and VT) reported having a state mandate that requires HiAP.

Public-Private Partnerships:

Three states (CA, MA, and TN) have public-private partnerships that support HiAP or related work.

Routine Monitoring of Policies for Health and Equity Impacts:

One state (CT) has implemented a health equity impact review process for all proposed state legislation.

New Programs:

One state (CA) began an initiative as a direct result of the SHA's HiAP work: California's department of food and agriculture created a Farm to Fork program.



Reflections



As mentioned above, HiAP can encompass a variety of activities at SHAs. Interviews revealed some discrete activities, including formal and informal mandates, participation in task forces, white papers, and education about HiAP through trainings and other venues. States also reported a range of other activities that were less concretely defined, like capitalizing on emerging opportunities and participating in task forces. While there is general agreement in the field that these relationship-building activities are necessary for HiAP, it is still unclear whether they are sufficient to create healthy public policies and programs in other sectors. In addition, states continue to have questions about what constitutes HiAP and which specific activities impact health.

Regardless of these outstanding questions, the interviewed states were able to pinpoint activities that were successful in starting HiAP initiatives. HIAs were used in nearly every state interviewed to demonstrate HiAP concepts, raise awareness, and build capacity. The only other factor common to success in nearly every state was strong leadership from the health commissioner in promoting HiAP. The commissioner's support was important in all state models, regardless of activities or approach.

Two main models of state-level HiAP initiatives emerged during these interviews:

FORMAL MANDATE APPROACH

The formal mandate approach, taken by states like California, Vermont, and Massachusetts, involves an executive order or law requiring collaboration between state government agencies for health. Formal mandates have been successful in bringing together high-level leadership from multiple agencies to comprehensively review the impacts of their programs and policies on health. These mandates have raised the profile of public health, led to greater government efficiency, and allowed agencies to reflect on the impacts of their current activities. In Vermont, the formal approach was offered and approved after years of “informal” collaboration. Their messaging was that the task force would provide a stable structure to ensure future systematic integration that was not dependent on personal connections or politics.

However, the formal mandate approach also has some drawbacks. Often, because of their structure or governance process, formal mandates primarily include government agency representatives in discussions and decisionmaking, allowing little input from community partners. Although all states interviewed recognized the value of community participation in HiAP, very few had mechanisms in place for authentic community engagement at the state level. Change within agencies can also be slow, resulting in a lack of tangible short-term outcomes.

INFORMAL COLLABORATIVE APPROACH

The second model for HiAP initiatives is the informal collaborative. States like Tennessee, Minnesota, and North Carolina have used this model. Informal collaboratives bring together diverse partners around issues or processes (like the SHIP) to identify emerging opportunities. Often, these collaboratives are staff-driven (as opposed to leadership-driven), focused on concrete outcomes and projects, and engaged with external partners and community members.

Informal collaboratives have the benefit of being flexible and responsive when new opportunities emerge, which can lead to quick, visible outcomes. For example, the North Carolina HEC works with program staff in the state transportation agency to tailor grant programs for health. This doesn't require extensive discussions with leadership or policy change, so it can be implemented right away. However, in informal collaboratives, sustainability is dependent on continued funding and

supportive leadership. This makes initiatives vulnerable to inevitable changes in administration and expiring grant funding. Many states used a combination of both informal and formal HiAP approaches driven by leadership and staff. The state interviews make it apparent that both approaches are important for long-term, impactful initiatives.

States that worked through existing networks and processes to start HiAP programs (e.g., local networks of healthy community design grantees in Massachusetts, or the SHIP process in Minnesota) were able to accelerate their progress because of the complementary nature of HiAP to other topics and approaches. Since relationship building forms the foundation for all HiAP activities, working through existing networks can lead to faster successes. Further, existing state-wide networks often present opportunities to engage community partners at the local level, which can be difficult for programs led by SHAs.

Although the interviews did not include questions about framing and messaging, all states mentioned using frames that resonated with both decision-makers and communities in their states and proved useful in moving initiatives forward. For example, Vermont's HiAP work builds on the state's efforts to preserve vibrant town centers, and California's Health in All Policies Task Force is embedded in the California Strategic Growth Council's goals of strong economies, equity, and environmental stewardship. States were intentional about finding a unique message and using it with multiple partners.

Finally, SHAs showed once again that they can accomplish much with a small investment. Although most interviewees said that they required some grant funding to jump start their HiAP programs, in many cases this support was minimal and built on existing programs and activities. Some states have staff to coordinate HiAP activities, but they often also have the responsibility of coordinating other cross-agency initiatives.



Opportunities for Action

Based on the themes and reflections above, ASTHO identified the following opportunities to move SHA HiAP work forward in the future:

The HiAP field should continue work to define HiAP and evaluate the impact of discrete HiAP activities on health outcomes.

ASTHO, funders, and national partners should continue to support the use of HIAs to demonstrate HiAP concepts and inspire further HiAP work.

ASTHO and national partners should continue to cultivate HiAP champions by providing resources and policy guidance.

ASTHO and SHAs should identify promising models and mechanisms for non-governmental partner input into state-led HiAP initiatives.

ASTHO and SHAs should explore models for informal collaboratives as a promising approach for HiAP in the absence of formal mandates.

SHAs should use HiAP principles to support and complement existing programs where possible.

SHAs should work through existing networks with similar missions related to HiAP.

SHAs should use framing that resonates with local decisionmakers and residents to promote HiAP.

SHAs should assess and build on current programs that resemble HiAP.

ASTHO and funders should continue to provide and promote investments in HiAP initiatives.



Appendices

Interview Questions

- 1**
How did your state become aware of and involved in HiAP?
- 2**
What was the main driver(s) to start a HiAP initiative in your state? What is an official policy, program, or relationship?
- 3**
What factor or factors were most responsible for having your leadership adopt a HiAP initiative in your state?
- 4**
Who were the champions that helped it get off the ground, and did their success result from the strength of their position, personality, perseverance, or some other factor?
- 5**
What or who is responsible for the momentum that has kept the initiative going and sustaining its progress?
- 6**
Is the concept of HiAP well understood and accepted in your state? Why or why not?
- 7**
What funding and/or resources were necessary to start the initiative?
- 8**
What has hindered the initiative from getting off the ground and/or growing?
- 9**
What have been the biggest challenges through this collaborative process?
- 10**
Who have been your best allies and supporters (e.g., state housing agency), and why?
- 11**
Who have been your most unexpected allies and supporters?
- 12**
What have been the biggest successes since implementation of your HiAP efforts?
- 13**
What is an ideal marker of success for your HiAP initiative? (e.g., legislation introduced multiple times)
- 14**
Did your assessment of health impacts measure direct/indirect/proxy measures for health impacts?
- 15**
What other impacts have these efforts had?
- 16**
Do you have a governance process in place that you feel is conducive to a successful initiative?
- 17**
What processes have you used, if any, for engaging non-governmental stakeholders (i.e., communities or non-government organizations) in your initiatives? How has this impacted your priorities?
- 18**
Have you had any success in any of the following since beginning your initiative?
(Adapted from ASTHO's HiAP Framework, p. 17. Available at: www.astho.org/HiAP/Framework)
- 19**
Are there other markers of success that we didn't mention?
- 20**
Was health equity a driver for this HiAP effort?
- 21**
Have you referenced ASTHO's HiAP framework? Have you done any of the activities outlined in the framework? If so, what was most useful?

APPENDIX B:

Case Studies





Background and Summary of Health in All Policies in California

In 2010, Gov. Arnold Schwarzenegger issued Executive Order S-04-10, which created the California Health in All Policies (HiAP) Task Force and charged it with promoting health and equity while complementing key statewide efforts to address climate change, such as Assembly Bill 32 (2006), also known as the Global Warming Solutions Act and Senate Bill 732 (2009), which established the Strategic Growth Council (SGC). These actions are due in part to the efforts of senior health department leadership over the course of several years, including the California Health and Human Services Agency Secretary and the California Department of Public Health Deputy Director, as well as promoting HiAP as a process for addressing the social determinants of health and increasing government efficiency. The governor's office saw this as an opportunity to leave a legacy of improved statewide health.

STARTING AND MAINTAINING THE INITIATIVE

The HiAP Task Force is responsible for advancing solutions that promote health and equity while simultaneously advancing SGC's goals. SGC, a legislatively-mandated cabinet-level body led by state agency secretaries, is tasked with a range of conservation, housing, infrastructure, climate, health, equity, and sustainability goals. Funding from The California Endowment, Kaiser Permanente Community Benefits, and other funders has helped sustain the work for the last seven years.

The HiAP Task Force convenes representatives from 22 state agencies to create a shared vision of a healthy and equitable community, define common goals, explore the root causes of health, implement policies and programs, and engage stakeholders. To get started, the task force collected more than 1,200 suggestions for actions that state government could take to improve health, and systematically prioritized these to create a list of 34 recommendations, which was included in their 2010 report to the SGC. Eleven recommendations were eventually selected by the task force for implementation, based upon input from public

workshops, departmental priorities, and opportunities for action. The final list focused on the following topics: active transportation; housing and indoor spaces; parks, community greening and places to be active; community safety through violence prevention; healthy food; and healthy public policy. Equity was named in the Executive Order, and is a theme throughout all HiAP Task Force projects.

Task force staff currently partner with California state agencies and community stakeholders to implement work in the topic areas described above, with a particular focus on embedding health and equity considerations into ongoing programmatic and funding work of government institutions. In a 2016 survey, most of the partner agencies agreed that the task force helped to identify mutually beneficial goals, build relationships and trust, and facilitate sustained interagency collaboration. Now in its seventh year, the task force has seen a number of successes in integrating health and equity into state policies and programs, and increased leadership support for continuing the initiative.



PARTNERSHIPS

The California Department of Public Health (CDPH), the Public Health Institute (PHI), and SGC share staffing for the HiAP Task Force. Participating agencies address topics as diverse as agriculture, food safety, education, affordable housing, transportation, land use, social services, and corrections. Agency representatives include program and managerial staff as well as executive leadership.

Community-level stakeholder input has helped the task force prioritize its work and ensure a consistent focus on equity. The task force participates in a range of stakeholder engagement activities including public workshops, informal advisory groups, and interviews with local health officers and subject matter experts.



CHALLENGES

California's state government has experienced significant state leadership changes during this project's tenure, and the task force has operated under two governors, two health agency secretaries, and three state health officers, and has seen many leadership changes at partner agencies. Its priorities have shifted in reaction to changing leadership goals, and staff have dedicated significant time to briefing and integrating new leaders on an ongoing basis. In addition, while state government values the work of the HiAP Task Force, it has been difficult to secure permanent funding for staff. In 2014, CDPH secured funding for three permanent positions, which leverages the four grant-funded PHI staff. The state government is now exploring ways to further embed the HiAP work into permanent government structures.

As HiAP relationships have deepened, partner agencies have become increasingly eager to try new approaches to promoting health and equity. While this is a success, staff have faced a challenge when it comes to measuring impact. Given the nature of social determinants of health policy-level work, health outcomes are often distal and long term. In addition, as partner departments incorporate equity and health into their work, they are increasingly turning to HiAP Task Force staff for assistance with health and equity data, scoring criteria, and measurement of impact. With growing use of a HiAP approach, consultation requests from partner agencies have exceeded the capacity of current HiAP staff, and suggest a need for additional resources, as well as opportunities to identify and replicate best practices.



KEYS TO SUCCESS

- Having an Executive Order was helpful in bringing agency leaders to the table.
- The involvement of advocacy organizations has helped the task force maintain a consistent vision between administration changes and hold government accountable.
- Despite administration changes, several HiAP Task Force staff and members have been with the initiative since the beginning, which has provided consistency in approach, vision, and leadership.



IMPACTS

- CDPH created three government-funded HiAP staff positions in 2014.
- Through a partnership with the Department of Corrections and Rehabilitation, nutrition criteria have been embedded into state purchasing guidelines for the Department of General Services, improving the nutritional content of foods served in prisons.
- A Farm to Fork office was created at the Department of Food and Agriculture, in partnership with the Department of Education and CDPH.
- Health and equity have been embedded into grant criteria, applications, and scoring by a number of agencies including Housing, Transportation, and Natural Resources.
- Health and equity are reflected in the new General Plan Guidelines (not yet released) and Regional Transportation Plan Guidelines. Both updated processes included significant health and equity stakeholder input.
- The HiAP Task Force convenes a multi-agency dialogue about the role of government in addressing equity and institutional/structural racism.
- In 2016, PHI staff moved from CDPH to the SGC, which allows them to more easily interact with Governor's Office and agency executive leadership.
- Many California communities have adopted a HiAP approach.
- CDPH developed healthy community indicators to provide data, a standardized set of statistical measures, and tools that a broad array of sectors can use for planning healthy communities and evaluating the impact of plans, projects, policy, and environmental changes on community health.ⁱⁱ

ⁱⁱ Healthy Communities Data and Indicators Project:

[https://www.cdph.ca.gov/Programs/OHE/Pages/Healthy-Communities-Data-and-Indicators-Project-\(HCI\).aspx](https://www.cdph.ca.gov/Programs/OHE/Pages/Healthy-Communities-Data-and-Indicators-Project-(HCI).aspx)



Background and Summary of Health in All Policies in Connecticut

The Connecticut Department of Public Health (CTDPH) had been leading several parallel efforts to promote health across sectors for many years before the concept of HiAP emerged and the idea coalesced into an agency-wide initiative. Some of the efforts are described below:

2009:

CTDPH forms the Environmental Health Section's Healthy Homes Initiative by combining several single-issue programs (e.g., radon and lead) into a broader, more holistic program to connect housing and health. In 2011, the Healthy Homes team identified better interagency coordination as a strategic objective, and since then has had success working with external partners and community organizations to address multifaceted issues like childhood lead poisoning. A statewide housing task force that guides the initiative's work includes the state attorney, advocates, local health departments, and code officials.

2012:

The state's Office of Multicultural Health went through a process of reexamining its mission and priorities, and was renamed the Office of Health Equity. As a result, addressing the needs of priority populations is now written into state statute.

2013:

The Connecticut Health Improvement Coalition formed to conduct Connecticut's state health assessment and state health improvement plan (SHIP). This process brought together more than 300 diverse groups to create action plans to improve health statewide. The process emphasized health equity and the social determinants of health thanks to the leadership of CTDPH Commissioner Jewel Mullen, a champion of the approach.

2013:

CTDPH participated in its first health impact assessment (HIA), working with local and national partners to examine the health impacts of the state's weatherization priorities. The HIA was successful in bringing together national nonprofits, private utility companies, and the state energy agency to discuss health, raising awareness about the HIA, and securing private funding for weatherization projects for residents statewide.

STARTING AND MAINTAINING THE INITIATIVE

In 2015, CTDPH was awarded a grant from ASTHO to implement an agency-wide strategy for ensuring health equity, which was ASTHO's **President's Challenge topic** that year. The state health commissioner was a strong advocate of equity-focused approaches to health. Thanks to this funding and supportive leadership, CTDPH was able to coordinate and prioritize the existing efforts described using health equity as a driver. The HiAP approach of cross-sectoral collaboration to address the root causes of health also helped provide a framework for improving health equity.

In addition to coordinating existing efforts, CTDPH was also able to implement some new high-impact programs to address health equity through a HiAP approach. During Connecticut's 2016 legislative session, any public health-related bills underwent an internal health equity impact review that explained the bill's impact on the social determinants of health and health equity. CTDPH has since surveyed staff about their experiences conducting these reviews, and will use the results to both improve the process in future legislative sessions and develop a staff HiAP training.

Using the 2015 ASTHO funding, CTDPH was also able to create a health equity strategic plan. Common-Health ACTION, a public health institute with expertise in HiAP and HIAs, provided technical assistance to create the plan. Some of the main goals include improving communication about health equity statewide and facilitating more standardized data collection techniques. An early positive outcome of this work was a glossary for partners to understand HiAP and health equity-related terminology.

CTDPH is measuring its progress on long-term health outcomes through a statewide dashboard, which tracks outcomes for objectives identified in the SHIP. Because the SHIP has a health equity and social determinants of health focus, the dashboard is also measuring health-influencing factors.



PARTNERSHIPS

The SHIP process has brought together a large, engaged group of traditional and non-traditional partners. Because the scope of the plan covers all aspects of health, it has been successful in coordinating efforts and providing a mechanism for partners to engage with the state health agency. It also provides the structure for a formal governance process that solicits and integrates feedback from stakeholders.

Although direct community engagement happens primarily at the programmatic level, the state health agency has a role in other activities to promote equity, like differentiating the data. However, non-profit and advocacy groups have been very involved in pushing for more systemic changes and bringing the needs of clients and communities (many of whom are outside the public health system) to the conversation. Their participation has been crucial to promoting understanding of HiAP and sustaining momentum for initiatives.

Health equity and HiAP are also beginning to gain some traction locally. One mayor of a local town has become a HiAP champion and is applying the concepts to her redevelopment work. Expertise and guidance for the initiative from the public health institute, Health Resources in Action, has also been invaluable.



CHALLENGES

Connecticut comprises 169 diverse towns with different needs and priorities. This has made finding common ground difficult at the state level. Within the state government, partner agencies tend to be supportive of general HiAP concepts but unclear about how to operationalize them. Some of the targeted trainings have helped to increase partners' understanding of the concepts, but without a formal mandate to collaborate across agencies for health like the California HiAP executive order, long-term progress will be difficult. CTDPH will also require funding to continue new initiatives like the legislative review process and to provide support for staff time in collaborating agencies.



KEYS TO SUCCESS

- The state health assessment and SHIP process were instrumental in helping public health practitioners in Connecticut understand HiAP and increase interest in these concepts. Because the SHIP includes an action plan, it has pushed public programs to think concretely about implementing HiAP-centric programs and policies.
- Staff who understand HIAs and HiAP and could communicate effectively with partners and identify specific HiAP activities to pursue were necessary to initiate and sustain this work.
- Having a health commissioner championing health equity and HiAP helped to move the initiative forward more quickly.
- Coordinating and aligning activities across the health agency was successful thanks to help from external facilitators (CommonHealth ACTION and Health Resources in Action) and because the SHIP structure was already in place.



IMPACTS

- Many CTDPH efforts, like the weatherization HIA, have successfully integrated health into discrete policies or programs.
- The SHIP process was grounded in health equity principles, and inspired an elected official to become a HiAP champion and apply the methods to a local Connecticut community.
- The HiAP initiative helped lead to the agency-wide implementation of a health equity impact review process for legislative proposals.
- The HiAP programs resulted in the creation of new resources to communicate about HiAP and health equity.
- As a result of their HiAP work, CTDPH worked with the Connecticut Public Health Association to deliver HiAP-related trainings to local communities.



Background and Summary of Health in All Policies in Massachusetts

In 2004, the Massachusetts Department of Public Health (MADPH) began applying the strategic framework it had used in its successful tobacco prevention work to chronic disease more broadly. This brought policy, systems, and environmental (PSE) change and community engagement approaches to pressing public health issues, including obesity. During the first few years of adoption, chronic disease and environmental health program staff built strong relationships with partners outside of public health, including land use and transportation agency staff and community advocates, in order to develop appropriate PSE approaches.

STARTING AND MAINTAINING THE INITIATIVE

In 2007, MADPH began to formally implement a PSE approach to addressing obesity in the state. This shift was due in part to the work of active living advocates, who had become enthusiastic about addressing obesity through changes in the built environment. Those groups set up meetings between the state's incoming health and transportation agency leadership. The incoming health commissioner understood that traditional approaches to addressing obesity were not working, and was supportive of efforts to address the social determinants of health.

These high level conversations between agencies, along with the advocacy community's continued work, led Massachusetts to include the Healthy Transportation Compact, the nation's first state-level mandate to include health considerations in transportation planning, in the 2009 transportation reform. At the same time, local and regional officials around the state were starting to build partnerships with local smart growth initiatives. Local partners invited public health staff to participate in a statewide **smart growth** conference, which helped build the foundation for new collaborative planning partnerships.

In 2009, MADPH and private partners collaborated to launch the Mass in Motion initiative (MiM), a state-wide effort to address overweight/obesity and chronic disease through increasing healthy eating and active living. MiM provides funding to local communities to reduce obesity through PSE change. Many of the communities involved are applying HiAP approaches to their work by implementing local projects that work across sectors to address the root causes of health. MADPH has also established a parallel effort to build partnerships with state and regional agencies that distribute state resources and guide local work (including land use and transportation, energy, environment, and housing agencies) through health impact assessments (HIAs) and other HiAP tools and approaches.

MiM has had many local PSE successes, which it hopes will lead to positive long-term health outcomes. Investing in MiM has given the state and private foundations the opportunity to focus on social and environmental changes, even though they may not see direct results for many years. This shift to a more holistic view of health has started to occur statewide across local communities, state agencies, foundations, and advocacy groups, and has helped maintain momentum for MiM and other HiAP initiatives.

In 2010 and 2011, MADPH was awarded grant funding from the Health Impact Project, a collaboration of the Robert Wood Johnson Foundation, and The Pew Charitable Trusts, and CDC's Healthy Community Design Initiative to conduct HIAs related to the built environment and chronic disease and support the Healthy Transportation Compact. Because MADPH had been involved in building cross-sector collaborations to advance community health initiatives for years, it already viewed HIAs as innovative HiAP decision-support tools. MADPH used its grant funding to support local projects, build additional partnerships, and provide evidence-based information to partners about health. These resources also supported the pilot HIA (**HIA of the Massachusetts Department of Transportation Grounding McGrath Study**), which is being used as the model for routinely incorporating health considerations into state level transportation planning. These efforts were designed to align and integrate with initiatives such as environmental quality programs and MiM. (Regional planning agencies have been key partners in this work, as there is no county government structure in Massachusetts.)

Building on these successes, MADPH partnered with the Metropolitan Area Planning Council and Health Resources in Action to conduct an HIA that the state housing and community development agency used to prioritize funding to local community development efforts. This HIA led to a new partnership with the

housing sector and is an example of how using HiAP tools can help health agencies build relationships with key stakeholders that have the power to influence the social determinants of health. This project also helped build relationships between community development and healthcare systems, providing the rationale for making health system investments in community development corporations.

These and other efforts continue to be explored and advanced under the leadership of MADPH's current commissioner, who has prioritized data-focused initiatives that address disparities and health determinants, which require a HiAP approach to be most effective. As an example, in January 2017, these priorities led MADPH to complete a landmark revision of the Determination of Need regulation. This program regulates the healthcare delivery system by reviewing and approving major capital expenditures, acquisitions, certain additions, and significant changes in services by hospitals, long-term care facilities, and clinics.

A unique and critical component of this program is the requirement that Determination of Need applicants include plans for addressing state-defined health priorities through community-based health initiatives. These initiatives support the principle that access alone is insufficient to reduce healthcare costs, and that healthcare systems must therefore address MADPH's goals of identifying, understanding, and tackling the underlying and common social determinants of health. The Determination of Need health priorities are thus six common social determinants of health: social environment, built environment, housing, violence and trauma, employment, and education. By implementing this requirement, MADPH will help build the capacity of healthcare systems, local health departments, and community partners to influence the policies that determine health outcomes. This will be accomplished through new standards on implementation strategies, community engagement, and partnerships that prioritize working with the organizations and agencies that influence the social determinants of health.

Another example of Massachusetts' current work is an effort focused on PSE solutions to healthy aging. Using many of the same concepts and principles from MiM, the Healthy Aging through Healthy Community Design initiative has used an "ages 8-80" approach that looks at community design features that facilitate community living for older adults while improving quality of life for individuals of all ages. This effort has led to new collaborations with the Massachusetts Executive Office of Elder Affairs and locally with councils on aging and senior centers.



PARTNERSHIPS

The changing national understanding of the root causes of chronic disease allowed public health stakeholders to try a new approach to addressing obesity in Massachusetts. The state health commissioner and active living advocates worked together to build the foundation for a HiAP approach to combatting this public health issue. In Massachusetts, advocates have been integral to elevating state and national priorities and holding public agencies accountable. As MiM grows and changes, advocates continue to play key roles in maintaining the initiative's momentum. Decisions about MiM projects are made within local coalitions, and are always informed by the community.

Staff in partner agencies, especially land use and transportation, have been natural partners for HiAP. Many have a solid understanding of how their work links to health because of their interest in smart growth, and they see the value of a public health frame when moving their policies and projects forward. MADPH recognized that these relationships and partnerships require consistent development, leading the health department to focus its 2017 annual Ounce of Prevention Conference on HiAP. At this conference, state agency partners from transportation, economic development, housing, and environmental affairs participated in a plenary panel designed to showcase opportunities for HiAP across state government.

The Massachusetts Public Health Association has also been a supportive and active partner. This group works regularly with MADPH to collaborate on larger initiatives, often increasing efficiency by aligning work and defining unique roles.

The Healthy Transportation Compact has a more formal governance process than MiM, and engages many state agencies and non-governmental partners in its work. Similarly, any HIAs completed through MADPH have an advisory committee composed of partners from inside and outside government.



CHALLENGES

Even though the social and environmental determinants of health are becoming well-understood in Massachusetts, especially at MDPH and in many of its partner agencies, public health stakeholders still encounter challenges to investment in approaches like HiAP that may not produce immediate results. For example, while some policies that address the upstream causes of health can have immediate health impacts, like addressing immediate housing related needs through supportive housing for the homeless, some strategies, such as investing in new affordable housing development, may not demonstrate health outcomes for several years. Further, regulatory programs aimed at reducing the major sources of air and noise pollution by improving environmental quality (e.g., low emission vehicle and electric vehicle programs) are not generally recognized as HiAP programs.

Limited funding and grants to implement projects continues to be a challenge, especially because federal funding for HIAs is unstable and federal priorities continue to shift. For example, CDC has dissolved its Healthy Community Design Initiative, which provided much of the funding for MDPH's HIA work.

Having accurate and timely information for partners has also been a challenge for MDPH. Although the evidence base to support HiAP approaches is generally known, granular data that links social determinant of health indicators with health outcomes is often lacking. Because of this, targeted HiAP approaches can be difficult and take significant resources. MDPH's commissioner has made this issue a key focus, and the agency is currently developing systems to address it.

Additionally, MDPH has sought to deeply understand the culture and language of its partners, which can be a challenge, as each sector has a different language and a unique set of intervention points. It can take time to learn where the opportunities are to influence decisions without derailing existing processes.



KEYS TO SUCCESS

- Health agency staff expertise in HiAP and HIA, as well as the communication, relationship building, facilitation, and technical skills to manage these large complex partnerships, has been integral to starting programs and maintaining momentum.
- The health agency has strong relationships with state and regional partners whose work influences the social determinants of health.
- Since 2007, the health agency leadership has continuously been supportive of both addressing the root causes of health and building power in communities to address local issues.
- Advocates seized the opportunity to orient state leaders to a HiAP approach, and continue to push government agencies to head these efforts.
- MiM provided a strong foundation of networks and successes upon which stakeholders could build other HiAP work.
- The national attention to the Healthy Transportation Compact helped bring attention and resources to the state.



IMPACTS

- The MiM program has been sustained for almost eight years as a public-private partnership.
- The Healthy Transportation Compact was passed, the nation's first state level law mandating collaboration between two state agencies.
- Direct and indirect health outcomes measures have been used to track progress over time for both MiM and the Healthy Transportation Compact.
- An increased general understanding of the social determinants of health in Massachusetts has allowed public health stakeholders to more easily connect with other agencies without having to continually explain their presence.
- There is continued elevation of HiAP approaches, as evidenced by the first-ever statewide HIA conference in 2016, and MDPH's 2017 Ounce of Prevention Conference, which focused on HiAP.



Background and Summary of Health in All Policies in Minnesota

Over the last decade, the evidence about what is essential for good health has revealed that advocates need to shift their focus from healthcare to social and environmental forces. Recognizing that health for all was not possible without addressing these factors, leadership at the Minnesota Department of Health (MDH) began to rethink their approach to improving Minnesotans' health. Former Minnesota Health Commissioner Ed Ehlinger and Assistant Health Commissioner Jeanne Ayers made a commitment to finding new ways to talk about what truly creates and maintains health, and to promote a shared responsibility for health and health equity among the health agency's many state, local, and community partners.

The Healthy Minnesota Partnership (HMP), a group convened by MDH and tasked with completing Minnesota's state health assessment and state health improvement plan (SHIP), provided the perfect opportunity to execute this new approach. Health department leadership worked to expand the group membership beyond public health, healthcare, and disease-focused partners to include other state agencies and community and advocacy groups. They started by framing the assessment around the conditions that create health and health equity—the social determinants of health—instead of focusing on the “usual” health outcomes of disease and injury. Through this process, HMP members and participants developed a shared understanding of these concepts.

Minnesota's state health assessment differed from other public health assessments by naming factors such as home-ownership, community safety, and incarceration justice as important to health. After the assessment successfully brought partners together around this broader view of health, the follow-up action plan (**Healthy Minnesota 2020: Statewide Health Improvement Framework**) aimed to build capacity to change the conversation about what creates health and implement cross-sectoral policy change approaches to health. The HMP process allowed MDH to begin working toward their goal of implementing HiAP with health equity as the goal.

Parallel to this HMP work, MDH's environmental health unit used funding from ASTHO and CDC to start an HIA capacity-building program. Now in its eighth year, the program has trained hundreds of Minnesotans and contributed to dozens of HIAs. Program leaders have also formed a statewide HIA collaborative and hosted an HIA conference. The HIAs have mostly focused on the built environment and land use topics, and have succeeded in bringing diverse partners together in local communities.

STARTING AND MAINTAINING THE INITIATIVE

After the success of HMP's work, MDH began to explicitly use the terms “HiAP” and “health equity” to refer to its work in order to raise awareness and illustrate these concepts in practice. However, rather than creating a discrete program to advance these concepts, the agency approached HiAP as a systems change effort where all partners play a role. It recognized that there are many opportunities to promote health and equity in complex decisionmaking processes in all sectors, and that it is limiting to focus solely on legislation or state-level policies. Instead, the agency has sought to expand the understanding of what creates health and strengthen communities' ability to create the conditions for health.

MDH is utilizing HIAs and other tools to move HiAP forward in the state. In the last few years, the agency has written several white papers that discuss the evidence linking health to social and economic factors like income, paid leave and sick time, and incarceration justice. MDH wrote these papers in response to community partner requests for more information on the issues, and partners have used the papers to advocate for healthy and equitable policies. MDH has nurtured an expectation among community partners that the agency can provide them with credible data and information on health status and the root causes of health outcomes. This has helped to build strong relationships between government and community partners around the state.

One of MDH's papers, **Advancing Health Equity in Minnesota**, which the agency presented to the state legislature in 2014, outlined a strategic vision for moving health equity forward in the state. It recommended using a HiAP approach and encouraging state agency leadership from all sectors to engage. In this report, MDH took the bold step of naming structural racism as a key factor in health inequities, which helped to strengthen the department's relationships with communities of color. Agency leadership also used the occasion of the report to require MDH staff to review their internal policies, programs, and budgets for structural inequities, and to examine their roles in promoting equity. Several health department programs have had early success making changes. MDH's newborn screening program changed a data policy that was preventing access to information about specific risk factors for African Americans. In addition, the state's tobacco program changed its grant making initiative to better serve American Indian tribes, the highest-risk population.

In 2015, Ehlinger became ASTHO's president, and chose to base the annual **ASTHO President's Challenge** on this report by asking his colleagues in other states to join him in promoting health equity nationwide. Ehlinger created the "triple aim" of health equity—to implement the HiAP approach with equity as the goal, to expand the understanding of what creates health, and to strengthen the capacity of communities to create their own healthy futures—as a decision tool for use in health agencies nationwide.

MDH continues to work alongside community partners, including HMP, to prioritize HiAP issues and identify opportunities for policy change. For each issue area, MDH and HMP will typically engage dozens of community groups and state agencies to review state data and expand the narrative around health. Community partners choose the issue areas based on community capacity and interest.



PARTNERSHIPS

Partnerships are the foundation of all HiAP efforts in Minnesota. The needs and interests of community members, nonprofit organizations, and government agency partners inform HMP's work, Minnesota's HIAs, and MDH's reports. MDH believes that this approach allows it to be flexible and responsive to state and local systems changes, promote HiAP as a shared responsibility among partners, and keep health department leadership accountable when working toward health equity.

The HMP, HiAP, and HIA processes are not formally required or defined in Minnesota statute. MDH believes that a more formal governance process might add an unnecessary administrative layer to this work and potentially prevent partners from focusing on the issues of most concern to them. In many of the efforts to promote HiAP-related legislation or other activities, MDH plays a supporting, rather than a leading role. This informal structure allows leaders from state agencies and other organizations to partner with MDH and each other, as needed, on specific health equity issues.



CHALLENGES

- It can be difficult for some to accept the health agency's involvement in issues that might seem to be out of its "swim lane" (e.g., why should the health department care about transportation issues?). This is also a challenge for HiAP efforts at the local level. Gradually, however, more and more sectors are realizing that identifying the health aspect of their concerns is not only important, but even strengthens their case and increases their reach in the community.
- Although identifying structural racism remains key to bringing attention to health equity and engaging a wider circle of partners, it is difficult to make racism a part of these discussions. For some individuals in positions of power, it is considered too risky to mention at all; others prefer to use more neutral language (e.g., "health disparities") to avoid the discomfort of confronting this issue head-on.
- Bureaucracies have a great capacity to resist change. Despite MDH's efforts to institutionalize health equity, there is the risk that people will adopt the language of equity, but continue with business as usual rather than fundamentally change the structure of their work.



KEYS TO SUCCESS

- Minnesota state agencies have a history of collaborating on many issues, large and small. MDH participates in and brings a health perspective to many statewide interagency efforts (e.g., regarding children's issues), and HMP members form "mini-partnerships" as needed to work on the different strategic areas identified through HMP efforts.
- MDH leadership has spearheaded state efforts to adopt a HiAP approach to health equity because it understands that the agency cannot meet its health improvement goals any other way. It has also been successful and persistent in conveying that message to partners.
- To raise awareness about the conditions that create health, MDH actively names the factors that inhibit health equity, such as structural racism.
- The department uses the HiAP approach with all of its partners.
- Rather than creating a discrete HiAP program, MDH has institutionalized the idea that health equity is everyone's responsibility.



IMPACTS

- MDH led with the conditions that create health, followed by health outcomes. This format has been used by local public health departments for community health assessments.
- HMP framed their narrative in a way that partners have used to support efforts to:
 - Increase wages through state, local, institutional, and corporate policies.
 - Establish paid leave for more workers through state, local, and corporate policies.
 - Increase active transportation through state policy.
- MDH developed white papers on income and health and paid leave and health, which HMP members and community organizations have used to advance policy change.
- MDH submitted a legislative report on advancing health equity that named structural racism as a key factor in health inequities.
- MDH secured all state agencies' commitment to partner with the department of health to advance health equity.
- MDH strengthened the practice of bringing a health equity frame to data collection.
- MDH formed and maintained an active Health Impact Assessment Collaborative.
- MDH has increased public support for HiAP approaches through development of HiAP resources.



Background and Summary of Health in All Policies in North Carolina

In 2006, the North Carolina Department of Health and Human Services (NCDHHS) formed the Healthy Environments Collaborative (HEC), which brings together the state departments of health, transportation, commerce, and environment and natural resources to define common goals and look for opportunities for collaboration. Since its inception more than a decade ago, HEC has worked to align state and local efforts through dozens of projects and policies. North Carolina has a history of successful cross-sectoral partnerships, both within and outside the health sector, which provided a welcoming context in which to form the collaborative.

STARTING AND MAINTAINING THE INITIATIVE

HEC's member agencies came together in 2006 without a formal mandate or funding. They initially focused their discussions on opportunities to promote active living at the state level and to create healthy environments for physical activity at the local level. HEC was mostly driven by agency program-level staff, but the meetings provided a convenient way for agency leadership to stay involved in these issues.

In 2009, HEC received a CDC Communities Putting Prevention to Work grant that allowed it to accelerate its progress. NCDHHS worked with researchers from the University of North Carolina at Chapel Hill to design the program to advance a HiAP approach, which included the following:

- Working with a neutral facilitator to create an HEC vision, mission, and strategic plan.
- Maintaining the focus on actions that benefitted all agencies.
- Defining three key areas of focus for state agency work—data, research, and comprehensive planning.
- Providing grants to 11 municipalities around the state to advance active transportation through changes in the physical environment, updating local comprehensive plans, and promoting Complete Streets locally.
- Obtaining commitment from the four state agencies to ensure that their existing policies were supporting active living at the local level.
- Creating a mechanism for local jurisdictions to provide feedback about barriers to active living to the state agencies.
- Raising awareness with other agencies and the public about the links between health, transportation, the built and natural environments, and the economy.



PARTNERSHIPS

Aside from NCDHHS's three key agency partners, HEC also works with local and regional planning and health agencies and the University of North Carolina at Chapel Hill. HEC has prioritized building relationships and trust within state governments, so engaging community groups occurs mostly through projects at the local level.



CHALLENGES

- Given the diversity and scope of projects that partner organizations are implementing at the local level as a result of the HEC, additional staff capacity would be helpful.
- Early on, when partners began conversations about specific areas of collaboration, determining how they could work together was a challenge. Hiring a neutral facilitator with funds from the CDC grant improved communication within the group.



KEYS TO SUCCESS

- Although the initiative originated at the staff level, leadership was able to stay involved through the HEC meetings.
- Having a dedicated staff person to coordinate the initiative helped ensure communication between partners and move activities forward.
- Having skilled and interested staff at partner agencies has been crucial to maintaining momentum for HEC's work.
- Having concrete outcomes defined early in the process helped to keep partners motivated and accountable, but over time the need for these milestones diminished. Evolving into a more informal collaborative has allowed partners to be more flexible.



IMPACTS

Although HEC has no formal benchmarks to measure its progress, it has seen several concrete successes:

- NCDHHS received funding from the state transportation department to collaborate to create and implement a statewide program called Active Routes to School. This project funds ten regional project coordinators.
- HEC has been able to integrate health into the state's 25-year comprehensive, long range planning process, as well as into local planning efforts.
- North Carolina has adopted a statewide Complete Streets policy, along with street design guidelines that support physical activity and safety.



Background and Summary of Health in All Policies in Oklahoma

The Oklahoma State Department of Health's (OSDH) leaders have actively followed national public health trends. In 2013, they obtained a copy of **Health in All Policies: A Guide for State and Local Governments** and felt that it would be helpful in operationalizing some of the state's ongoing work on the social determinants of health. This work interested both OSDH's leadership and the physical activity and nutrition program managers who had been exploring the links between the built environment and obesity for several years.

The statewide Oklahoma Health Improvement Plan (OHIP) process, which began in 2010, was a natural fit for a HiAP approach, although partners sometimes struggled to embrace the theoretical concepts without practical examples. By the time the state revised OHIP in 2015, the concept of HiAP was more broadly understood nationwide. As a result, OHIP's flagship issue, obesity, includes a multisectoral HiAP approach for addressing the issue. OHIP's existing governance structure, inclusion of diverse partners, existing relationships, and implementation plan provided a strong foundation for HiAP efforts.

STARTING AND MAINTAINING THE INITIATIVE

In 2015, OSDH had the opportunity to accelerate its HiAP progress through participation in the Aspen Institute TeamWork: Leadership for Healthy States program. TeamWork invites state policymakers to complete a project that will strengthen partnerships for health within state governments. OSDH led the TeamWork project, with technical assistance from the Aspen Institute, and convened state leadership and tribal partners to conduct a health impact assessment (HIA) on the health impacts of summer learning programs for elementary school children. The agency chose a project that could be completed in one year and could demonstrate HiAP in a tangible way. The HIA was able to inform state, local, and tribal policymakers about funding **summer learning programs** and build strong relationships between the health and education agencies.

Concurrent with the HIA project in 2015, Oklahoma's governor invited OSDH to join the Oklahoma Works governing council, a statewide multiagency partnership to build workforce capacity and increase access to jobs. At the time, the governor's priorities were criminal justice

reform, jobs, and health. Joining Oklahoma Works allowed OSDH to discuss the HIA and additional information about the links between health, education, and employment with workforce stakeholders in a variety of statewide venues. As a result of this work, Oklahoma's Key Economic Networks, the local community coalitions that implement Oklahoma Works projects across the state, now have participation from local public health practitioners who have been trained in HIAs and HiAP.

OSDH is now building on past successes to create Health 360, a comprehensive HiAP initiative that will identify priority health issues and use state data to examine the magnitude of the problem, evidence-based best practice solutions, and available state assets. The Health 360 team will also make projections about the expected outcomes and return on investment of health-focused policy and program decisions. If the state decides to make program or policy investments around a health issue, like obesity, a multisectoral team will be convened to implement solutions.



PARTNERSHIPS

In addition to the many agencies supporting the education and workforce initiatives mentioned above, OSDH has found an unexpected partner in the Federal Reserve, which has helped foster the department's involvement in new projects.

OSDH has had some success engaging community partners through local economic and health networks, but it does not yet have a formal governance process that solicits stakeholder feedback. It is the agency's hope that Health 360 will provide a mechanism for HiAP governance.



CHALLENGES

- The social and environmental determinants of health are still not well understood in Oklahoma state government, but this is changing with time. It is possible that the concept of HiAP is still seen as too theoretical, and that agency leaders need more practical examples of HiAP successes.
- Once state agencies understand HiAP and are motivated to take action, they need training and tools to build capacity for the work. The HIA conducted on K-3 summer learning programs helped partners understand the connections between health and education and built a strong relationship between agencies.
- HiAP can work efficiently when infrastructure and relationships are in place, but organizing the effort and building relationships is time consuming upfront. OSDH has moved the work forward within this limitation by prioritizing work.



KEYS TO SUCCESS

- Having a health commissioner who is a strong supporter of HiAP, a good communicator, and someone with a close relationship to the governor's office has greatly accelerated the progress of Oklahoma's HiAP work.
- Conducting an HIA to demonstrate the links between health and another sector helped illustrate HiAP principles in action and build strong relationships with another state agency.
- Since conducting an HIA is not intuitive, Aspen Institute's technical assistance and consultation from experts in the field were important to creating a high-quality and impactful HIA.
- Both the health commissioner and the deputy health commissioner were skilled at building trusting relationships, negotiating conflicts, and identifying common goals, which are the foundations of HiAP.



IMPACTS

Oklahoma is still developing Health 360, its statewide HiAP program. However, previous related efforts have had several positive impacts:

- The K-3 summer learning program HIA helped inform policymakers about HiAP and built support for HiAP approaches.
- The OHIP process has started to include HiAP in its obesity objectives.
- Through Oklahoma Works, OSDH has started a statewide dialogue about the links between education, employment, and health.



Background and Summary of Health in All Policies in Oregon

About a decade ago, staff in Oregon Health Authority’s Public Health Division (OPHD) started learning about cross-sectoral approaches to health, including healthy community design and health impact assessments (HIA). This complemented an ongoing commitment to addressing the social determinants of health.

OPHD’s Health Promotion and Chronic Disease Section was an early adopter of policy, systems, and environmental change approaches to healthy eating and active living. For many years, the section has been funding and supporting local health department-led community coalitions to create healthy communities through a variety of collaborative approaches. OPHD’s Environmental Health Section also received funding from ASTHO and CDC to start an HIA capacity building program, which provided training and resources to local health departments for HIAs. The OPHD’s HIA work helped grow the field in Oregon, leading to several new statewide HIAs.

The success of these programs and the increasing interest in cross-sectoral approaches prompted state environmental health leadership, with the support of the state public health director, to consider HiAP as a tool for increasing understanding of the social determinants of health and improving health outcomes. The director was supportive of the approach, and HiAP was included in OPHD’s 2012 Strategic Plan. The state then created a position in the public health director’s office to coordinate policy activities across the OPHD centers. In late 2013, the incoming public health director reaffirmed the department’s commitment to addressing the social determinants of health. Oregon’s current and former governors have also included both health and equity in their agendas, raising awareness and providing support for policy approaches.

For the last several years, Oregon has been working hard to improve, or modernize, the public health system at both the state and local levels by defining the foundational capabilities of the public health system and aligning activities. The public health modernization work has also been rooted in building cross-sectoral partnerships and pursuing HiAP strategies to effectively address the root causes of health inequities.

STARTING AND MAINTAINING THE INITIATIVE

OPHD’s Policy and Planning Team helps coordinate several of the agency’s HiAP efforts and grows strong partnerships with the state transportation, education, and environmental agencies, as outlined below.

- **Education:** OPHD’s partnership with the Oregon Department of Education has been in existence for many years. It focuses on school health, including health supports in educational plans, and boosting high school graduation by addressing student chronic absenteeism. Discussing education as a social determinant of health has helped the two agencies broaden the number of topics for collaboration, formalize the partnership, and sustain the work.
- **Transportation:** Many sections across the Public Health Division—including Health Security and Public Health Preparedness, Injury Prevention, Environmental Health, and Health Promotion and Chronic Disease Prevention—have been working with the Oregon Department of Transportation to bring a health lens to transportation programmatic, policy, and project decisions. Several years into the partnership, the governor required the agencies to sign a formal memorandum of understanding (MOU) that defines their roles.

- **Environmental Quality:** The partnership between OPHD and the Oregon Department of Environmental Quality has been longstanding, and has addressed both longer-term projects, like brownfields redevelopment, and more urgent needs, like the recent discovery of heavy metals in city air. The partnership has been fostered in part by public and political pressure, including the governor’s mandate for health-based environmental policies in the wake of the recent state air quality crisis. This has helped grow the partnership beyond the capacity of individual staff collaborating on projects.

With the exception of limited staffing in OPHD’s director’s office, staff time for partnerships with education, transportation, and environmental agencies has been braided together from different sources, mostly from related grant funding with flexibility. Recently, the Oregon Department of Environmental Quality provided some funding for health department staff to assist with the air quality crisis related to heavy metals.



PARTNERSHIPS

OPHD's partnerships with the transportation, education, and environmental agencies have also benefitted from community partners' involvement in coalitions. Issue-based coalitions bringing together nonprofit partners and governments around the topics of healthy kids, physical activity, and healthy eating have supported collaborative work on policy and systems change.

OPHD has been able to sustain its work, despite leadership and staff changes, for several reasons. In addition to the state public health director, there are cross-sectoral collaboration champions in the leadership of the other involved agencies. OPHD also has several staff with an interest in HiAP who have risen to leadership positions over the years, which has helped sustain HiAP efforts.



CHALLENGES

The Healthy Communities grant program that supports local health departments to promote healthy communities saw increased interest in using program funds for activities that address the social determinants of health. Although this is a positive step toward HiAP, it forced OPHD program staff to rethink their roles and the roles of other agencies. In some cases, it also created tensions with other agencies over jurisdiction for specific issues.

Relationship building and convening, the core activities of HiAP, are very important, but difficult to fund. As most of the positions at OPHD are federal grant-funded, it's difficult to build HiAP into work-plans and maintain staff time when grant funding expires. Also, partners and funders are usually hoping to see tangible outcomes, even for grants with short timelines. When outcomes are apparent, they are usually successes of the process, not changes in health status.

Communicating with partners across sectors can sometimes be difficult, especially when they equate HIAs or HiAP with existing lengthy regulatory processes, such as those required under the National Environmental Policy Act. Outside of the public health sector, there is still limited understanding of health beyond healthcare, which requires a lot of education before partners understand their work's relevance to health.



KEYS TO SUCCESS

- MOUs have been integral to both sustaining Oregon's HiAP work through staffing changes and to holding all parties accountable for formal agreements made in the MOU.
- It has been vital to capitalize on public and policymaker interest in public health issues to draw partners into a conversation about HiAP.
- Investing the time to create relationships and build trust with state partners has been extremely important for HiAP efforts.
- Having knowledgeable and passionate policy and research analysts and epidemiologists has helped maintain Oregon's initiatives through leadership transitions.



IMPACTS

- OPHD now has MOUs with the state transportation and education agencies.
- Health goals, strategies, and performance measures have been integrated into several state transportation plans, which provide a guiding framework for local jurisdictions.
- Public health staff have been appointed to high-level statewide advisory committees and governing bodies in non-health sectors.
- Health has been embedded in transportation and growth management grant opportunities in Oregon.
- OPHD has supported prioritizing the issue of student chronic absenteeism in the state because of its relationship with the education agency.
- OPHD and the state environmental agency now have a collaborative rule-making process for air permitting.
- State level HIA and HiAP efforts have supported cross-sector work in local public health departments.
- Oregon's environmental agency has integrated health data into brownfields grant applications.
- OPHD has brought health concerns into discussions about two large regional planning efforts.
- In the future, OPHD hopes to share funding, performance measures, and strategies with partner agencies.



Background and Summary of Health in All Policies in Tennessee

In recent years, collaboration between government agencies has become a common practice in Tennessee. There is a shared understanding that agencies need to work together to make a larger impact and help government investments produce better results for residents and the economy.

Tennessee's governor actively promotes the importance of a healthy workforce for a thriving economy. In 2013, the governor created a foundation that brings together diverse partners to invest in health and wellness programs with an emphasis on worksites, communities, schools, faith places, families, and individuals. The foundation has raised awareness among government leadership and communities about the importance of smoking cessation, healthy eating, and active living. Raising the profile of health with state agencies has created an opportunity for dialogue about policies that would improve health, a welcoming environment for HiAP approaches.

STARTING AND MAINTAINING THE INITIATIVE

With the support of the governor and after years of success linking health and transportation in Nashville and other localities, Tennessee Health Commissioner John Dreyzehner wanted to create a formal space for HiAP, and establish how it could be used to improve efficiency in government and improve health. At that time in 2016, there was a growing understanding within the state health agency that the top ten causes of disease are linked to decisions made primarily outside the jurisdiction of the health department, and that the Tennessee Department of Health (TDH) would need to rely on partnering with other agencies to achieve real change. In 2016, Dreyzehner made this concept a priority and created a position in the newly formed Office of Primary Prevention that will partly focus on HiAP and lead the formation of the Tennessee Livability Collaborative (TLC).

TLC's mission is to "improve the prosperity, quality of life, and health of Tennesseans through collaboration between state departments in the areas of policy, funding, and programming." The newly hired Director of the Office of Primary Prevention has responsibility for engaging members of TLC and hosting meetings where partners can identify opportunities for collaboration. The collaborative's current focus is

on new member recruitment and investment and identifying opportunities at the program and project levels for early success. One example of the latter is TDH's small grants to communities to create healthy built environment plans, which will make the communities eligible for transportation infrastructure improvement funding.

Although TLC is still a young program, it has already recruited leaders from 11 other state agencies to participate. The group's implementation plan was created thanks to technical assistance from researchers at the University of North Carolina, who also helped create North Carolina's statewide Healthy Environment Collaborative over a decade ago. TDH replicated the elements of North Carolina's program that worked particularly well, including strategic interviews with agency partners designed to draw out motivations and expectations for participation and raise awareness about the impact of the agency's work on health. TLC was also designed to target involvement from mid-level state agency leadership who have the ability to influence agency heads while simultaneously staying connected to the staff implementing the programs. TDH also hopes that this structure will help provide continuity through inevitable administrative changes.



PARTNERSHIPS

As mentioned above, the state health commissioner's support was crucial to establishing TLC. TDH also credits the technical support from North Carolina, a state with a long history of HiAP, as important to its success.

Recruiting state agencies to participate in TLC has not been difficult, and TDH is impressed by agencies' overall commitment and motivation. TLC has even had interest from some more unexpected partners: the state tourism agency wants to collaborate on promoting opportunities for physical activity statewide, and the state art agency is interested in linking its placemaking initiatives to community health.

TLC doesn't have a formal governance structure that engages non-governmental partners, but eventually their meetings will also serve as a forum for communities to propose project ideas to state agency staff in different locations around the state.



CHALLENGES

Starting a new initiative at the state agency level can be challenging when working with staff who are already overworked. TDH has had to promote HiAP as an initiative that will hopefully increase efficiency and add capacity to existing programs and initiatives in the long run, especially with state agency staff who are used to collaborating on programs regularly.

As TDH recruits more partners through interviews designed to generate ideas, it will be challenging to organize and prioritize all of the ideas, coordinate projects, and encourage other agencies to lead projects on their own. TDH will need to manage the expectation that this is a "health" initiative, and so the health department will carry out the work.

A few partners have started to move forward on securing funding and implementing ideas that have been generated by TLC. The collaborative will continue to explore what HiAP looks like on a practical level, especially with regard to funding streams, staff time, jurisdiction over work, and coordinating logistics between agencies.



KEYS TO SUCCESS

- The support from the health commissioner in prioritizing HiAP helped to create funding to staff TLC.
- Framing HiAP as a way to increase government efficiency and contribute to a healthy and productive workforce, a prosperous economy, and high quality of life resonates with Tennesseans.
- TDH has embraced the opportunity to learn from other states further along in HiAP and implement the most promising practices. The recruitment process has been particularly successful at raising awareness about health and identifying common goals.



IMPACTS

- Partnerships with several individual agencies, including education, economic and community development, and transportation, have already generated several ideas for projects and policies that would benefit all partners.
- TDH is partnering with several other agencies to provide funding for local healthy built environment plans that will make communities eligible for infrastructure improvement funding. TDH has hired seven staff to provide support for local communities in this work.
- TDH is creating health outcome measures based on the National Academy of Medicine's Vital Signs, but with a greater focus on the social and environmental determinants of health. TLC will provide input on these measures, and TDH will also work to embed health-based measures into the work of TLC agencies.



Background and Summary of Health in All Policies in Vermont

Vermont is a state with a long history of collaborative approaches to solving problems. Government agencies and community partners often work together on policies and projects to promote livability in Vermont's towns and cities. In recent years, the increased interest in sustainability has prompted Vermont's state government agencies to explore cross-sectoral policy solutions at the intersections of natural places, healthy people, and vibrant local economies. These concepts resonate with both Vermont's policymakers and community leaders, who are motivated to preserve the state's unique features and quality of life.

In the last few years, the national public health dialogue about social and environmental determinants of health and HiAP began to take shape. These concepts were a natural fit for the Vermont Department of Health (VDH), which had been promoting cross-sectoral solutions to health issues at the local level for years, especially around healthy community design and Complete Streets policies. All of VDH's district health offices have received training on both healthy community design and health impact assessments (HIAs). This has resulted in engagement of public health in town planning, local transportation plans, and HIAs of projects and policies.

When Vermont was crafting state health reform legislation in 2011, the deputy health commissioner, who was familiar with both HIAs and local community design projects, saw an opportunity to embed HIAs into the health reform legislation. As a result, **Vermont's Act 48** requires the state to create a plan to institute an HIA process for state and local agencies. Vermont is now one of just a handful of states that require the consideration of HIA through state law. Since 2011, there have been more intentional efforts in Vermont to engage planning commissions and municipalities to consider health in their plans and priorities.

STARTING AND MAINTAINING THE INITIATIVE

Building on prior investments by the health department in healthy community design and HIA, former state health commissioner, Harry Chen, collaborated with the Vermont Public Health Association to bring HIA experts to Vermont to talk to key stakeholders and the governor's cabinet about HIA and HiAP, and the opportunities to use the frameworks in the state. Due to Vermont's long history of collaborative approaches, the majority of the other state agencies represented on the cabinet, especially natural resources, education, transportation, and housing agencies, were interested in implementing HiAP in Vermont. At a governor's retreat, the concept of a HiAP task force was discussed as a mechanism to ensure sustainability for this cross-sector work.

In late 2015, the governor signed an executive order creating the **Health in All Policies Task Force** composed of nine state agencies to develop a shared accountability for health. The task force members are appointed by the governor and charged with reporting annually on their programs, policies, and budgets that impact health, identifying gaps and opportunities, and finding local or national solutions to address gaps. The health commissioner leads the task force. The task force, now in its third year, has developed a charter and vision that explicitly focuses on improving health and equity. All nine agencies have also adopted healthy local food procurement policies and guidelines when using state funds or facilities.

The task force has maintained group stability and engagement through a recent administration change and is now focused on developing a dashboard to track investments, policies, and programs across sectors that improve health. Vermont is now the only state that has a state mandate for both HIA and HiAP.

Although the task force is only a few years old, members have already developed a charter and vision that builds on existing frameworks. All nine agencies have also adopted healthy food procurement guidelines, an early policy success. Future meetings will address planning for group stability during an upcoming state administration change. The task force is optimistic that its structure will provide continuity through this turnover.

Unlike many state-level HiAP programs around the country, VDH did not receive external funding to staff this task force. VDH's director of planning and health care quality, whose position is supported in part by state general funds, is responsible for staffing the task force and leading other HiAP-related activities. VDH also has one intern and support from the Vermont Public Health Institute to help provide case studies and best practice examples to partner agencies. VDH also continues to grow its capacity for conducting HIAs at both the state and district level by investing in training and discrete projects.



PARTNERSHIPS

The agencies represented on the task force have been supportive of HiAP and are committed to the work. Because the task force is composed entirely of state government agency representatives, this particular HiAP initiative is not directly community-engaged. However, policy and program work at the various district offices is conducted in partnership with community stakeholders, especially in the project implementation phase.

VDH staff members with strong relationships with other agencies have helped to sustain momentum and activities. While the task force begins its work auditing its internal policies and budgets for health impacts, staff will continue to collaborate on projects without a formal structure.



CHALLENGES

It is too early to predict the outcome of the task force's early work. Clearly, it is a challenging task, and agencies are starting with different levels of understanding about their relevance to health. The change of administration led to a temporary slowdown as it required a second round of orientation for new leadership. VDH has been working with limited staff time to address all of these needs, and HiAP work requires a lot of time-intensive relationship building in the early stages.



KEYS TO SUCCESS

- Having a health commissioner who was a physician, a state legislator, an advocate for HiAP, and someone with the confidence and trust of his peers was been an important driving force behind this work.
- Vermont's leaders from multiple sectors and communities have shared values (vibrancy, equity, and collaboration) that align well with HiAP.
- VDH has had dedicated staff building successful cross-sectoral partnerships for years before this work was officially called HiAP.
- The initial task force members were very committed to the work and leaving a legacy regardless of changes in administration.
- Synergy with existing health reforms inherent to Vermont, including the "Culture of Health" project funded by the Robert Wood Johnson Foundation.



IMPACTS

- Vermont is unique in having a state mandate for both HIAs and its HiAP task force.
- Although it is early in the initiative, the task force will be tracking its impact with a state dashboard that reports on cross-sector shared metrics; Vermont has a strong commitment to governmental accountability and tracking outcomes within the state.
- All nine task force agencies have created an inventory of policies, programs, and budgets that impact health and identified best practices to address issues.
- The collaborative nature of this group has sparked interest in a geographic and population-specific intervention that would combine resources, data, and infrastructure from all agencies to work towards a common health equity goal.



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