Public Health Advisory Board
Health equity resources
September 2016

The City of Portland, Parks and Recreation. Affirmation of Equity Statement.

Multnomah County Health Department (2012). Equity and Empowerment Lens.

Oregon Health Authority, Office of Equity and Inclusion. Health Equity and Inclusion Program Strategies.

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Oregon Health Authority, Office of Equity and Inclusion. Health Equity Policy Committee Charter.

Parks & Recreation
Healthy Parks, Healthy Portland

Phone: 503-823-PLAY (7529) Fax: 503-823-6007 1120 SW Fifth Ave., Suite 1302, Portland, OR 97204

Affirmation of Equity Statement

We recognize that race, socio-economic status, and where you live in Portland are all factors in each resident's ability to access park facilities and services. The more we are able to diminish the barriers of these factors the further we will be in achieving our vision of equity.

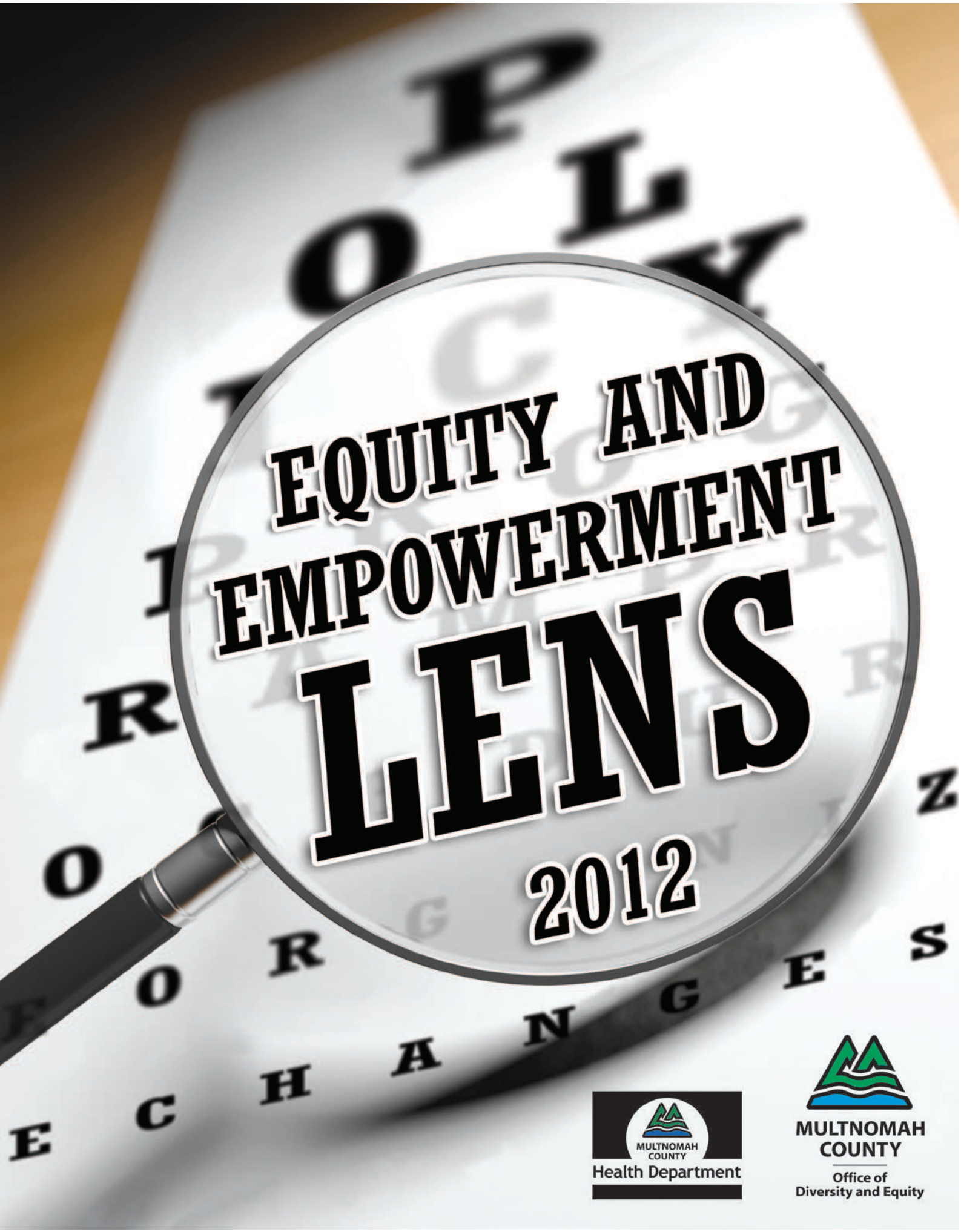
We look at equity through a conceptual framework inclusive of Race, Geography (the community in which one lives), Socio-economic Status and Disability. Equity is both the means to creating and sustaining healthy communities and an end that benefits us all. It requires the intentional examination of systemic policies and practices that, even if they have the appearance of fairness, may, in effect, serve to marginalize some and perpetuate disparities. An understanding of historic implications of systemic racism together with the active investment in strategies, practices and programs over time is essential to the advancement of our equity goals.

We believe that Portland Parks and Recreation staff should be encouraged and empowered to view the promotion of equity as a core principle in their respective roles. This commitment can be honored and advanced by the Bureau of Parks and Recreation continuing to focus on the following areas.

Hiring staff that exceeds the broad diversity of the populations of Portland that have been historically underrepresented on Parks staff
Hiring reflects diversity through recruitment, retention, and advancement within the Bureau
Directing resources and programs to underserved populations
Collaborating with underserved populations to design services and create innovative culturally appropriate strategies and partnerships to reach these populations.
Working within City systems and processes to contract minority businesses.
Strengthening and enhancing the organizational culture of openness, transparency with a goal of continual learning.
We also are a contributor to the vision and work of equity within Portland Parks & Recreation. As a board we will be leaders in reflecting the demographics of the shifting population of Portland. This commitment can be advanced by:

Recruiting and retaining board members that reflect the diversity of Portland including geographic representation.
Sharing the presentation guidelines to assure that all presentations at Parks Board meetings include discussions of equity issues.
Vision of Parks 2020 frames the work of the Portland Parks Board and the
Bureau of Parks and Recreation. Eleven years into the work of 2020, the Parks Board recognizes that to achieve the objectives set forth we must diligently apply an equity lens to better frame our work and more fully achieve our important community goals.

We believe that we have a shared fate—as individuals within a community and communities within society.



MULTNOMAH COUNTY
Health Department

MULTNOMAH COUNTY
Office of Diversity and Equity

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Ben Duncan, *Former Policy Analyst, HEI and Environmental Health, MCHD and Current Program Manager, HEI, MCHD*
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Pamela Zaragoza, *Office Assistant Senior, Rockwood Community Health Clinic, MCHD*

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Multnomah County's Office of Diversity and Equity
Lillian Shirley, *Director, Multnomah County Health Department*
Tricia Tillman, *Administrator, Office of Equity and Inclusion, Oregon Health Authority, and former HEI Program Manager, MCHD*

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**Have authored or co-authored components of this document (Concept Papers, Introduction, Lens versions)*

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Jeff Cogen, Multnomah County Chair

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October 30, 2012

Dear Colleagues,

These are adverse and challenging times we live in. But while we are all struggling, we know that for some members of our community these adversities and challenges are disproportionate and glaring. Multnomah County faces enormous inequities that are well-documented. Communities of color, immigrants, and refugees are bearing the weight of disparity in poverty, educational attainment, chronic health conditions and mortality. A recent analysis of neighborhood poverty and mortality within Multnomah County shows that residents of high poverty neighborhoods are more likely to die of cancer or heart disease, and have an overall life expectancy that is more than five years shorter than residents of low poverty neighborhoods. During times of economic and social adversity the challenge of inequity in our community must be met with priority and innovative leadership.

We must play a role within our communities, shaping the organizational conditions, the context and environment, and the methods by which we develop policy decisions to yield positive community outcomes. As Chair, social responsibility is one of my top priorities.

The Equity and Empowerment Lens, which has a racial justice focus, embodies social responsibility as a quality improvement process and tool. The Lens reflects upon and evaluates the effectiveness of a policy, program or practice in regards to the fair and just distribution of resources and representation. The Multnomah County Health Department has been a tremendous leader in this work. We are learning great things as we begin the process of integrating and institutionalizing the Lens county-wide.

The inequities in our community are unjust, systemic in nature, and avoidable. We all have the power to change this. As elected officials, directors, managers and supervisors, we have the power to create the conditions within our organizations to identify and eliminate barriers to equity. By holding a laser-like focus to our policies and operations with values like inclusion, social, and racial justice leading the way, we can change the way we do our business to promote more equitable conditions and opportunities for our employees and the entire community.

I urge you to join us in these efforts to make systemic, sustainable change in improving all of our communities.

Sincerely,

Jeff Cogen
Multnomah County Chair

Health Department
MULTNOMAH COUNTY OREGON
Office of the Director

426 SW Stark Street, 8th Floor, Portland, Oregon 97204
(503) 988-3674 phone (503) 988-4117 fax

October 30, 2012

Dear Colleagues,

We know that our community members succeed when they have the opportunity to make the choices that allow them to work, play, live and thrive in a healthy environment.

Unfortunately, we also know that for no other reason than where you happen to be born within our larger community or what race or ethnicity your parents are, your life may be shorter, your health may be worse, and you may not have the opportunities to further your education or access stable housing for your family. These unfair circumstances have been created, over time, by the policies and investment decisions that our community has chosen to make, and we recognize the importance of focusing our energies on undoing this legacy of unfair and unequal distribution of opportunities and resources for health.

At the Health Department, guided by conversations with our community, we feel a strong ethical obligation to ask more refined questions to help us guide our work and change the way we do business. To this end we have developed an Equity Impact Review Tool, which has now come to be known as the Equity and Empowerment Lens (E&E Lens) (racial justice focus). The purpose of the Lens is clear: to improve the quality of services and policy-making within the walls of our organizations and for the communities we serve by reflecting, analyzing, and integrating key Lens questions based on inclusion and justice.

This work takes stepping into an unknown space, a space that makes us vulnerable. Answering the Lens questions and institutionalizing clear, systemically-based recommendations based on equity and empowerment requires us to be brave, courageous, and persistent in our efforts. Focusing specifically on racial justice is essential for the health of all of our communities, because racial and ethnic inequities are the most prevalent and pronounced according to our data.

This year, the MCHD documented in its Report Card on Racial and Ethnic Health Disparities that although some progress has been made, there are still areas of great inequity across health indicators.

In the African American community, high priority inequities we must address are: teen births, diabetes mortality, gonorrhea and Chlamydia incidence, and homicide. In the Native American community, we must address inequities in HIV disease mortality and teen birth rates. In the Latino community, we must focus on examining and improving our teen birth rates, Chlamydia incidence, and prenatal care within the first trimester.[1]

All social policy is health policy. When we take an active role to improve our community's living and working conditions, as well as the decision-making that shapes resource investment and policy, the health of our entire community will improve. I look forward to moving forward this critical and courageous work with you.

Sincerely,

Lillian Shirley

Public Health
Prevent. Promote. Protect.

[1] Multnomah County Report Card on Racial and Ethnic Health Disparities, 2011.

INTRODUCTION

Institutionalizing equity and racial justice within our organizations requires that we recognize how our policies, procedures, and practices can perpetuate forms of oppression that are both hidden and overt, and both old and new. Once we see and truly understand the inequities that exist in our society, we must take active steps to dismantle structures that do not promote the well being of all people, and reconstruct institutions that embody principles of equity and racial justice. Doing this work requires an integration of both heart and mind, along with an unwavering commitment to success for all people. We must continuously strive toward a common vision of equity. To that end, we open the Equity & Empowerment Lens (E & E Lens) with the Northwest Health Foundation's *Case for Equity*, a foundational statement for understanding what equity means in content, process, and outcome.

> **The NWHF Case for Equity**
> *We have a shared fate––as individuals within a community and communities within society. All communities need the ability to shape their own present and future. Equity is both the means to healthy communities and an end that benefits us all. Equity requires the intentional examination of systemic policies and practices that, even if they have the appearance of fairness, may, in effect, serve to marginalize some and perpetuate disparities. Working toward equity requires an understanding of historical contexts and the active investment in social structures over time to ensure that all communities can experience their vision for health.* (Northwest Health Foundation)

Value-added of applying the Lens: Why do it as an organization?
Using the Lens will significantly increase the capacity of your organization to identify and eliminate the root causes of racial and ethnic inequities. It will provide . . .

- An eye on **quality improvement** with an internal and external focus;
- An **increased awareness** of individual and organizational roles in achieving equity and racial justice;
- A **more accurate assessment of client needs** and understanding of how to improve satisfaction and service delivery;
- **New opportunities** to influence operational processes and decisions;
- Increased ability to explain what you do and the **value of your services** to clients and community members;

- A stronger integration of budgeting and workforce development with future program needs based on data and community partner input;
- Increased contribution to positive social and economic impact on the community
- Increased organizational capacity in:
  - strategic planning
  - capacity building with partners
  - performance measurement
  - data collection and analysis
  - process improvement

PREFACE

In the United States, communities of color, immigrants, and refugees currently comprise approximately one-third of the nation's population. By 2042, demographers project these same populations will be the majority of US residents and by 2050, they will constitute 54% of the nation's population (Park, 2009). As our diversity grows, it is essential to develop and maintain a focus on the success and wellness of all people, and to be aware of where and why some populations experience better life outcomes than others. While the NWHF Case For Equity emphasizes a moral concern for the well being of our communities, a 2012 report by Policy Link also highlights the economic rationale for system transformation, stating that "equity is the superior growth model" (p. 1). The report reiterates that "equity is no longer a moral imperative – it is also an economic one" (p. 2) and insists that institutions and government must prioritize equity in policy and decision-making in order for lasting economic growth to occur.

This Lens recognizes both the economic and moral imperatives of this work and seeks to help institutions address both. As an initiative emerging from the Multnomah County Health Department (MCHD) and now expanding throughout Multnomah County, we draw upon extensive research on health inequities to frame the Equity and Empowerment Lens (E &E Lens) for other sectors. Health inequities are defined as the unjust, unfair, and systemic differences in populations' health outcomes. According to the National Association of City and County Health Officials (NACCHO), "health inequities result from an unequal structuring of life chances, based on growing social and economic inequality," (Hofrichter, 2010, p.3).

Across the nation, communities of color, immigrants, and refugees experience the greatest inequities in health and other population outcomes. A series of recent reports released by the Coalition of Communities of Color (2012a, 2012b, 2011, 2010), an organization that provides accurate data, needs assessments, and policy advocacy for communities of color, indicate that Multnomah County mirrors the national trend. Inequities are avoidable, unfair, and unjust differences in any and all population outcomes across the social determinants (such as educational achievement, housing status, and transportation access), not just across measurable health indicators. Within this document equity and health equity are both used,

and are desired outcomes of this work. (When reading the Lens, you may want to substitute your area of work for 'health' if it is different – for instance 'community justice' or 'educational' or 'hiring' inequities).

In order to improve overall population health and success, while eliminating the unequal structuring of life chances, we must address the social, structural, economic, environmental, and political factors that lead to such inequities. As we plan for the upcoming changes in our nation's demographics, we must be ready to more deeply understand and mitigate the inequities within all sectors. The Lens aims to empower decision-makers with the tools to recognize and address the social and institutional policies, procedures and practices that perpetuate differential outcomes for populations.

Research clearly indicates that the bulk of racial and ethnic health inequities are the result of cumulative past and current social structures and policies that are unequal, rather than poor decision-making by individuals or genetics (R. Hofrichter, personal communication, Spring 2011). Social divisions in society experienced as racism, class oppression, and gender inequity are in fact the root causes of inequities. This alone compels government and decision-makers at all levels to play a more active role in developing and implementing solutions. Viable and sustainable solutions to systemic and deeply entrenched inequities require policy makers to critically analyze past, current, and future policies and make investments to create a more equitable society. In order to achieve equity and racial justice, solutions must also integrate empowering strategies and social justice approaches that challenge the unequal structuring of assets, opportunities, and access (R. Hofrichter, personal communication, Spring 2011). (See Concept Papers on *Empowerment Theory and Practice and Hierarchy and Root Causes*)

THE EQUITY AND EMPOWERMENT LENS

The E & E Lens encompasses the array of inequities that exist in and across multiple sectors beyond public health, such as education, housing, etc. However, to provide a clear context about the inception of the tool we included a review of the steps taken specifically within the Multnomah County Health Department to launch the initiative both internally and within the Office of Diversity & Equity for the County.

Background and History

In 2008, the Multnomah County Health Department (MCHD) released the MCHD Report Card on Racial and Ethnic Disparities (Bhat & Vance, 2008). This report summarized the inequities experienced by communities of color, immigrants, and refugees across 17 indicators and highlighted the need for deeper, systemic, and community-led change towards equity, broadly, and specifically, around racial justice. Combined with existing culturally specific efforts and advocacy, the MCHD launched the Health Equity Initiative (HEI) in March of 2008, with extensive community and employee conversations about inequities, their impacts on health,

and possible solutions. The Health Department was a pilot site for developing and utilizing an equity lens and continues to be a pilot for this work across the County.

Consistent with other equity initiatives within Health Departments around the country, the MCHD used the documentary series Unnatural Causes (Adelman & Smith, 2008) as a starting point for the community and employee conversations. During these sessions, diverse groups of community residents and county staff identified a set of community priorities for action. One of these priorities was the need for the County as a whole to include an equity analysis and evaluation system within existing decision-making and planning processes. The Board of County Commissioners approved the plan to develop and implement a tool that could be widely used throughout the county to more intentionally examine and address root causes of inequities. The combined efforts of county staff, policy makers, and community members resulted in the newly revised Equity and Empowerment Lens (E&E Lens) that specifically highlights the importance of integrating racial justice principles and practices.

The Lens outlined in this document draws upon the successful work of our regional partners (City of Seattle and King County, WA), and an evaluation of the 2009, 2010 pilot initiatives implemented by the MCHD. Our local pilots focused on the opening of a new clinic in the Rockwood area and budget development for critical services during a year of significant cuts. In addition to the pilot results, key sources of feedback and guidance include: community of color leaders; political leadership spanning the Portland-Metro area; county staff, including Managers of Color; local research and analysis such as the Coalition of Communities of Color report on racial inequities (2010); the State of Black Oregon report (2010); State of Equity Report (2011).

Moving Forward

With the initial pilots and revision of the Lens complete, the focus has now shifted to dissemination, integrating the Lens into organizational learning processes, and institutionalization. To support this initiative, in 2011, the Multnomah County Chair created a new position within the Office of Diversity and Equity (ODE) to institutionalize and integrate the Lens County-wide. This work fits with the mission of the Office of Diversity and Equity to hold *"Multnomah County accountable to ensure access, equity, and inclusion with its services, policies, practices, and procedures."* The Health Equity Initiative within the Health Department will continue with its mission to eliminate the root causes of social injustices that lead to racial and ethnic health inequities, and will utilize this new version of the Lens.

Over the next two years, the Equity and Empowerment Initiative plans to train county leaders on the use of the Lens across all departments. To make the Lens as effective as possible and to institutionalize its use, county leaders are working to establish this strategy a significant policy. Using the Lens, the Office of Diversity and Equity will convene key stakeholders to help further prioritize and institutionalize improved County investments, services, and resource allocation

in regards to communities of color, immigrants, and refugees. Everyone in our community has a role in eliminating inequities and their root causes.

At its core, the Lens is a quality improvement tool, and as such, ongoing evaluation, revisions and improvements will be made to the Lens as it is used. While the Lens itself will continuously evolve, its goal and purpose will always remain the same: to serve as a tool and set of processes to analyze, influence, and improve decision-making to support equity and empowerment within our community and across all sectors.

What is the Equity and Empowerment Lens?

A Lens leads us to think about issues in a new way; it can bring an idea into focus, or alternately, expand it outward and upward. In this particular case, this Lens does both, by asking us to focus in on how equity and racial justice relate to a particular issue at hand, and then how that issue also exists in relation to a much larger system of factors. The concepts of equity and empowerment are not new per se; many cultures have been focusing on balance, sustainability, relationship, and honest analyses of cause and effect for thousands of years.

What is newer and innovative about this effort is the more focused application of the Lens in organizational development, focusing on resource allocation, decision-making, and meaningful engagement. Grounded in the above values, the Equity and Empowerment Lens (E & E Lens) is a set of nine questions, accompanying educational materials, and tools designed to provide information needed for discussion, planning and decision-making that will lead to more equitable policies and programs. The Lens' questions, values, and principles seek to uncover patterns of inequities, separate symptoms from actual causes of such inequities, and maintain the visibility of impacts on communities of color, immigrants, and refugees.

As a quality improvement tool this set of questions and processes are designed to help integrate a focus on equity at the individual, organizational, and community levels. The Lens alone is not the solution, and using the Lens is not an exact science. Working toward similar goals across jurisdictions, building organizational capacity, meaningfully integrating community voice, and strengthening structures of accountability within our workplaces are just a few other key strategies necessary to eliminate inequities.

Guided by current research, the Lens pays particular attention to inequities experienced by communities or color, immigrants, and refugees with its racial justice focus. Universal models that employ a 'one size fits all' approach can often neglect to consider and address the needs of those with less political, economic, and social power. (See Concept Paper on *Hierarchy and Root Causes*) According to race and poverty scholar, john a. powell, it is critical to support targeted strategies and outcomes in order to meet overall goals of eliminating inequities. This approach, called targeted universalism, takes into account that overarching, 'universal' programs and

policies do not often target structurally disadvantaged groups when distributing benefits or burdens (powell, 2010).

Transformative change processes speak to both the heart and the mind, communicating in ways that are inspiring and motivational as well as efficient, concise, and grounded in research. The tone and structure of the Lens embodies this concept, incorporating the voices, ways of being, and approach of multiple paradigms.

To further help guide your transformational change process, the Lens employs a holistic and culturally responsive framework that includes reference to the key areas that influence equity. Research indicates that equity and inequity are driven by a set of interrelated factors. Examining these interconnections between people, place, process and power is an accessible way to deeply understand your organization's impact on communities. We briefly define each key concept area below and use this framework to organize the Lens questions.

- **Connection to People:**
  People refers to individuals, groups, communities, or populations. Within the Lens we ask you to consider multiple cultural ways of being, and how organizations can integrate diverse paradigms into practice. (See Concept Papers on *Relational Worldview, Empowerment Theory and Practice and Positive Mental Health and Equity*)

- **Connection to Place:**
  Place refers to a locale, defined as a particular region, center of population, or location (Merriam Webster online). Tuan (1977) goes a bit deeper saying that place is a space with meaning attached: "Places are centers of felt value" (p.4). We deliberately expand our notion of place beyond geography to include a more holistic perspective held by a diversity of cultures that additionally defines place as a locale comprised of social relationship and meaning. (See Concept Papers on *Relational Worldview, Sustainability, Climate Health, and Equity and Social Determinants of Health and Inequity***)**

- **Connection to Process and Power:**
  A process is a series of actions or steps. Connecting to process in the Lens means continually refining engagement and relationship-building methods in order to be more inclusive, respectful, and aware that within equity work how we do something is just as important as what is being done and why.

  Power exists in relationship to one another, and is exercised within social relationships within families, institutions, and communities. The Lens asks you to consider that relationships are constantly changing, and therefore the balance of power can also change. (See Concept Papers on *Hierarchy and Root Causes, Relational Worldview, Lens as a Quality Improvement Tool and Process and Empowerment Theory and Practice*)

Although the primary audience for the Lens is Multnomah County staff and leadership, we believe in its applicability in any sector. We hope the Lens serves as a resource for our partners working on the social determinants. (See Concept Paper on *Social Determinants of Health and Inequity*) Lastly, true to the practice of empowerment, we are especially moved by the possibility of the Lens becoming a resource for policy advocacy efforts led by our community leaders working with populations most affected by inequities. (See Concept Paper on *Empowerment Theory and Practice*)

What does it mean to apply the Lens fully?

The Lens is not designed to be a static checklist of criteria or actions. Applying the Lens fully requires strongly prioritizing the time, budget, and energy needed to create a supportive learning environment and authentic, sustainable change. It also requires a transformative shift in how we think, what we do, and why we make specific decisions. This transformed mindset embodies patience, practices deep listening, and values flexibility.

The first step to a Lens application is to identify social inequities within our organizations and the communities we serve. Next we must understand what role our policies, procedures and practices play in the presence of these inequities. Thirdly, the process embraces the notion of cultural humility, and dedicates time and space to hold reflective and often challenging discussions. Learning from the lived experiences of people from different backgrounds is a key component of understanding and addressing root causes. The next step is to engage in authentic and collaborative strategic planning about how to initiate and sustain the transformation required to uproot inequities. Finally, tracking progress and celebrating the real changes that emerge from this work will further strengthen the organizational commitment to equity and racial justice.

The process we use to answer the questions is just as important as the answers to the questions. For example, when we create the space to collaborate with those most affected by specific inequities, we address the historic denial of access to institutional participation and power. Lack of voice and participation is a root cause and negative indicator of specific outcomes. (See Concept Paper on *Empowerment Theory and Practice*) john powell also shares that "more than just asking people what they think, we need to understand the processes behind how they think" (powell, 2010). See the Lens Overview and the *Organizational Readiness Summary* sections for more information on how to build capacity and prepare for an application.

What do I do with the results?

The Lens must lead to action in order for real, sustained change to occur. When creating actions and solutions (which the Lens itself will walk you through), distinguish between short-term 'wins' and structural changes that will generate long-term, ongoing 'wins'. Truly integrate and systematize recommended processes and actions that result from Lens applications. Compile responses and any action plans on a regular basis, identify trends, assess potential

recommendations, and take action in order to reach full implementation. Throughout the process, it is also critical to over-communicate results back to staff and community stakeholders in order to recognize, share, and celebrate successes.

Limitations, Barriers and Opportunities for Lens Application

The Lens is not intended to overcome all problems related to inequities. It is intended to guide you through the process of recognizing inequities, the conditions under which they thrive, and the possible solutions and environments that would mitigate negative effects and enhance positive results. This is not easy. Organizational and individual resistance often surface when we ask people to transform old structures and paradigms. Remember that such resistance is often present in transformational change efforts that call for new language, the understanding of initially new and complex models, and the need to honestly examine personal biases. Keep moving forward. Embarking upon a process to address institutional inequities requires patience, determination, and focus, guided by a clear vision of what true equity means within your organization and for your constituents.

The Lens seeks to unearth and shed light upon oppressive policies, processes, and systems in place organizationally, as well as provide ways for individuals to continue to personally transform by questioning the assumptions and paradigms that guide our decision-making. Given the nature of this work, it is important to recognize the barriers and obstacles that will arise as people begin to talk about and assess equity racial justice in our communities. Community of color leaders support the naming of racism in its many forms in order to correctly target and eliminate root causes of inequities (Curry-Stevens & Cross-Hemmer, 2010). Anticipate the barriers that may arise. Be ready to persevere and continue guiding your team through the discomfort. While challenging and often uncomfortable, these conversations are critical to addressing our historical inequities and moving this work forward.

There is growing momentum locally and nationally around the importance of understanding social determinants, and the impact of inequities and racial injustices on communities. Current social conditions compel us to find the space, funding, and support for Lens' implementation and institutionalization across sectors. In addition, current economic conditions are forcing organizations to make major changes to services and policies. We must be intentional and strategic about our response to these existing conditions and the needs of all of our communities. Now is the time to take action.

DEFINITIONS

There are a number of different definitions that are currently in use for the key terms we have listed below. While we acknowledge these variations, we feel that it is important to share the definitions we have employed in developing the Lens to ensure a common understanding of some of the key concepts as we move forward. As such, we offer the following definitions:

CLASS – Class is relative status according to income, wealth, power and/or position (Class Matters). Class relations extend beyond income, and reflect the entire structure of society.

CLASSISM - "Classism is differential treatment based on social class or perceived social class. Classism is the systematic oppression of subordinated class groups to advantage and strengthen the dominant class groups. It's the systematic assignment of characteristics of worth and ability based on social class" (Class Action).

COMMUNITY CAPACITY - Community capacity focuses on 10 areas: active participation, leadership, rich support networks, skills and resources, critical reflection, sense of community, understanding of history, articulation of values, and access to power. Community capacity-building operationalizes the concept of empowerment (Wallerstein, 2002).

COMMUNITIES OF COLOR - Communities of color are identity-based communities that hold a primary racial identity that describes shared racial characteristics among community members. The term aims to define a characteristic of the community that its members share (such as being African American) that supports self-definition by community members, and that typically denotes a shared history and current/historic experiences of racism. An older term for communities of color is that of "minority communities" which is increasingly inaccurate given that people of color are majority identities on a global level. That term has also been rejected for its potential to infer any inferior characteristics. The community may or may not also be a geographic community. Given that race is a socially-defined construct, the definitions of these communities are dynamic and evolve across time. At present, in Multnomah County, the Coalition of Communities of Color defines communities of color to include Native Americans, Latinos, Asian and Pacific Islanders, African Americans, Africans, Middle Eastern, and Slavic communities (Coalition of Communities of Color).

CULTURAL PROFICIENCY (RESPONSIVENESS) – Cultural proficiency (responsiveness) is a transformational approach and an inside-out perspective on change, involving making the commitment to lifelong learning for the purpose of being increasingly effective in serving and integrating the needs of cultural and ethnic groups. Employees and leaders who embody cultural proficiency (Lindsey, Randall, Graham, Westphal, & Jew, 2008):

- recognize and value professional development;

- hold a value for social justice; and
- advocate for students and community groups as part of their professional responsibility.

DISABILISM – According to Emerson (2010), "disablism is discrimination based on disability" (p. 683). Barnes, Colin, and Mercer (2004) extend the definition by identifying that "one who is disabled can be subject to social oppression. Disablism functions alongside sexism, racism, ageism, and homophobia in society" (p.4).

DISABILITY - The Americans with Disabilities Act (ADA), an individual with a disability is a person who: (1) has a physical or mental impairment that substantially limits one or more major life activities; OR (2) has a record of such an impairment; OR (3) is regarded as having such an impairment. In line with a social justice perspective, the focus of this definition should not be on the individual with an impairment, but on how society excludes people living with disabilities from meaningful participation, employment opportunities, and access to resources to thrive (U.S. Department of Justice).

DISCRIMINATION - Unequal or different treatment of an individual in any personnel action on the basis of race, color, sex, age, religion, national origin, political affiliation, marital status, sexual orientation, gender identify, source of income, familial status, or physical or mental disability or other protected status in accordance with applicable law (Multnomah County).

EQUITY – Equity is an ideal and a goal, not a process. It ensures that everyone has the resources to succeed.

ETHNICITY – While related to race, ethnicity refers not to physical characteristics but to social traits that are shared by a human population. Some of the social traits often used for ethnic classification include: nationality; tribe; religious faith; shared language; and shared culture and/or traditions. Unlike race, ethnicity is not usually externally assigned by others. The term ethnicity focuses more upon a group's connection to a perceived shared past and culture (Cavalli-Sforza, Monozzi, & Piazza, 1996).

GENDER – Refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for masculine and feminine (World Health Organization). Sex is biological and refers to physical attributes such as sex chromosomes, gonads, sex hormones, internal reproductive structures, and external genitalia. At birth, it is used to identify individuals as male or female. Gender on the other hand is far more complicated. Along with one's physical traits, it is the complex interrelationship between those traits and one's internal sense of self as male, female, both or neither as well as one's outward presentations and behaviors related to that perception. Therefore, gender is a construct that exists on a spectrum, rather than two static choices (Gender Spectrum).

GENDER INEQUITY - Like race, gender is a social construct. Traditions, laws, roles, and behaviors, and most importantly gender relations of power greatly affect access to necessary resources, the ability to meaningfully participate politically, the ability to achieve one's full potential economically, and the prominence of discriminatory acts. The inequities themselves can place many people who identify as women in positions leading to violence and exploitation (Hofrichter, 2010). One's perceived gender can also be tied to violence and other oppressions because gender expression is often tied to a stereotype of one's sexual orientation.

HEALTH – The "state of complete physical, mental and social well-being, not merely the absence of disease or infirmity" (World Health Organization, 1948).

HEALTH EQUITY – All persons have access to the resources and power they need to attain their full health potential.

HEALTH INEQUITIES – Systemic, avoidable, unfair and unjust differences in health status and mortality rates, as well as in the distribution of disease and illness across population groups (Hofrichter, 2010).

HIERARCHY - Hierarchy is the categorization of a group of people according to ability or economic, social, or professional status. Hierarchies can have positive and negative attributes. The negative effects of hierarchy manifest when there is an established dominant group that tends to enjoy a disproportionate share of assets, resources, and other areas of positive social value (Pratto, Sidanius & Levin, 2006).: The ability or official authority to decide what is best for others, the ability to decide who will have access to resources, and the capacity to exercise control over others (Leaven, 2003; Visions, Inc.).

MEANINGFUL INVOLVEMENT – (1) potentially affected community residents and communities most affected by inequities have appropriate and culturally responsive opportunities to participate in decisions about a proposed activity that will affect their environment and/or health; (2) the public's contribution can influence the agency's or jurisdiction's decision; (3) the concerns of all participants involved will be considered in the decision-making process (and measures will be taken to document how they were or were not considered); and (4) the decision makers seek out and facilitate the involvement of those potentially affected and communities most affected by inequities (Environmental Protection Agency).

OPPRESSION – Young (2011) refers to oppression as "the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms-- in short, the normal processes of everyday life" (p.41). She continues, to emphasize that oppression "also refers to systemic constraints on

groups that are not necessarily the result of the intentions of a tyrant. Oppression in this sense is structural, rather in that the result of a few people's choices or policies" (p.41).

POSITIVE MENTAL HEALTH - Positive mental health is a resource and a pathway to obtain what one needs to thrive, meaningfully participate, and engage. Positive mental health is promoted by making sure people have the material resources they need, have a sense of control over their lives, and have the ability to participate in important decision-making in community governance. (See Concept Paper *Positive Mental Health and Equity*)

QUALITY IMPROVEMENT - "Continuous and ongoing effort to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community" (Riley, Moran, Corso, Beitsch, Bialek, Cofsky, 2010).

ROOT CAUSES – The underlying factors leading to inequities, including, but not limited to:

- inequities in living and working conditions;
- unjust decision-making;
- disempowering engagement processes; and
- racism, classism, and other forms of discrimination (sexism, ageism, homophobia, disabilism, etc.)

POPULAR EDUCATION – "A philosophy and methodology that seeks to bring about more just and equitable social, political, and economic relations by creating settings in which people who have historically lacked power can discover and expand their knowledge and use it to eliminate societal inequities" (Wiggins, 2011, p.38).

RACE – A race is a human population that is believed to be distinct in some way from other humans based on real or imagined physical differences, and at its core, race is a social construct. Racial classifications are rooted in the idea of biological classification of humans according to morphological features such as skin color or facial characteristics. An individual is usually externally classified (meaning someone else makes the classification) into a racial group rather than the individual choosing where they belong as part of their identity (Cavalli-Sforza, Menozzi, Piazza, 1996).

RACISM – Conduct, words, practices or policies which advantage or disadvantage people because of their culture, ethnic origin or color. Racism is just as damaging in obvious forms as it is in less obvious and subtle forms, and is still called racism whether intentional or unintentional (Lopes & Thomas, 2006).

- **INSTITUTIONAL RACISM** – "The network of institutional structures, policies, and practices that create advantages for White people and discrimination, oppression and disadvantage for racialized people" (Lopes & Thomas, 2006, p.270).

- **SYSTEMIC RACISM** – "The conscious or unconscious policies, procedures, and practices that exclude, marginalize, and exploit racialized people. Systemic racism is supported by institutional power and by powerful (often unexamined) ideas which make racism look normal and justified. Systemic racism allows individuals to practice racism in organizations, unchecked by effective complaints procedures, performance appraisals, and promotions which require equity competencies" (Lopes & Thomas, p.270).

SEXUAL ORIENTATION - The deep-seated direction of one's sexual (erotic) attraction. It is on a continuum and not a set of absolute categories. Sometimes referred to as affection, orientation or sexuality. Sexual orientation evolves through a multistage developmental process, and may change over time (UC Berkeley Gender Equity Resource Center).

- **LGBTIQ** - Lesbian, Gay, Bisexual, Transgender, Intersex, Queer.

SOCIAL DETERMINANTS - The social determinants are the conditions and circumstances in which people are born, grow, live, work and age, and are key factors in how populations experience equity or inequity. Examples include: housing, transportation, education, dignity and respect, social supports/networks, health care, race/ethnicity, wealth and income development, and public safety, to name a few. (See Concept Paper *Social Determinants of Health and Inequity*)

SUSTAINABILITY - Sustainability means meeting the needs of the present without compromising the ability of future generations to sustain their own needs. Sustainability is often tied to three distinct goals:

- To live in a way that is environmentally sustainable or viable over the long term;
- To live in a way that is economically sustainable, maintaining living standards over the long-term; and
- To live in a way that is socially sustainable, now and in the future (Dillard, J., Dujon, V. & King, M. C., 2009, p.2).

LENS OVERVIEW

How to Think About the Lens

In an effort to create a "user friendly" tool that serves as a practical guide for leaders to initiate systemic change, each section will begin with a brief narration that outlines key environmental, emotional, relational, and social factors to consider when moving through components of the Lens. Equity work calls for a fundamentally different approach to organizational change and thus compels us to be extraordinarily focused and intentional. We cannot undo the inequities present within the existing system using the very strategies we are critiquing and have been critiquing when applying a Lens to our work. Integrating equity and empowerment at all levels of an organization takes time, committed resources, an innovative and supportive environment, and the ability to maintain a sense of urgency while simultaneously practicing patience.

The Lens leads the participant(s) through the following stages:

- **Assess** your current organizational capacity for equity work.
- **Describe** current direction and strategies.
- **Identify** inequities and injustices in the current issue.
- **Reflect upon and understand** your strengths and challenges.
- **Enhance what is leading** to equity and empowerment.
- **Eliminate strategies** and root causes leading to inequities and injustices.
- **Celebrate** successes and improvements.

To assist the user with an intentional, thoughtful application of the Lens that support the above stages, we have included the following components:

1. An *Organizational Readiness Summary* to help determine organizational capacity;
2. Three versions of the Lens questions (one general, one on Resource Allocation, one on Policy and Decision-making);
3. A *Moving Into Action Guide* focusing on how to build effective recommendations;
4. An *Evaluation Summary*; and
5. A set of Concept Papers to help frame the foundational assumptions of the different versions of the Lens questions.

Depending on your organization goals, institutional capacity, and current resource allocation to equity work, each of these sections could serve as a portal into the Lens. Start where it makes sense for you as an individual or as a team. Based on our pilot findings, we urge the you to apply the Lens with a team, of key

voices at the table, including a technical expert on equity and related Best Practices, someone well-versed in data, an evaluator, diverse representation from all levels of your organization, and most importantly, community members most affected by inequities.

Prepping for the Application of the Lens

If you have read the introduction, considered how to think about the Lens, and are ready to envision what implementation could look like within your organization, now is the time to prepare yourself and your team for engagement!

Remember that as a leader you must create the emotional and physical space for your team to engage in deep, reflective conversation, and feel comfortable describing beliefs and experiences that might challenge institutional norms and reveal inequitable polices and practices. The work can be challenging because it inherently questions the flow of resources, the dynamics of power, and the inclusiveness our engagement processes. Specifically, the Lens requires users to examine the impact of existing hierarchies, facilitator style, language, and relationships between team members. The Equity & Empowerment Lens emerges from a deep connection to and understanding of the intersections between people, place, processes, and power. The following suggestions for how to navigate through the Lens as an individual and/or a team reflect a consensus between leaders of the initiative and community contributors.

Going through the Lens as an individual?

- Think about why you are interested in the Equity & Empowerment Lens and identify what you hope to accomplish by engaging with the tool.
- Make a personal and doable commitment to the process and your own professional practice.
- Read through the *Concept Papers* to increase your capacity to engage in equity work.
- Think about your own assumptions, experiences, and biases around equity and racial justice within your current and previous positions.
- Incorporate recommedations into your practice, including a regular review of your own biases and how these affect decision-making.
- Share your process and learning with colleagues and friends to increase their capacity. Suggest that your team utilize the *Concept Papers* one or two at a time as a reading and learning activity during staff meetings.
- Review and reflect upon the workforce characteristics in the *Organizational Readiness Summary*.What characteristics do you already possess? Which ones need strengthening? Talk to other staff members/managers about how to best obtain training to build your capacity.
- Begin with the *Lens At A Glance*. If you would like to ask questions that address deeper root causes, try the Resource Allocation or *Policy and Decision-making* versions.

Going through the Lens as a team? Whether as a small group or larger team, this is the preferred method of Lens application to ensure organizational transformation and institutionalization:

- Think about why you are interested in the Equity & Empowerment Lens for the organization and identify what you hope to accomplish by engaging with the tool.
- Make an organizational commitment to the process and to create visible shifts in practice.
- Identify the current organizational mindset around equity issues, and think about what shifts need to occur in order to effectively utilize the Lens.
- Consider the organizational and workforce characteristics present in the *Organizational Readiness Summary*.
  - Identify which characteristics need more support and strengthening and which ones are already in place.
  - Integrate strategies to enhance characteristics that are weaker, and sustain the ones already in place.
- As mentioned in the introduction, ensure inclusion of a diverse representation of voices at the table for your team analysis, paying particular attention to the representation of communities of color, immigrants and refugees. If your team is mostly homogenous in terms of race, class, and gender, explore ways to engage communities most affected by inequities.
- Begin with the **Lens At A Glance**. If you would like to ask questions that address deeper root causes, try the Resource Allocation or Policy and Decision-making versions.
- Regardless of the time you have to apply the Lens, strive to include a data person at the table, and those who directly impact decisions and policy, and team members at the gound level

Components of the Lens

This section outlines the purpose, materials, and suggested use for each component of the Equity & Empowerment Lens. We have also included recommendations for how to effectively engage your staff and/or additional stakeholders in the process, with special attention given to creating an environment conducive for doing transformative work.

Organizational Readiness Summary (page 25)

Institutionalizating, policies, procedures, and practices requires a laser-like focus on continuously assessing and building organizational capacity. To take root, equity work must extend beyond any one leader and infiltrate the system. This section highlights research-based organizational and individual characteristics that enable an institution to effectively move towards equity and racial justice. If you are implementing strategies to increase organizational readiness, you are doing the work of equity and racial justice. This section is two-fold; it can both help you assess your organizational level of readiness to implement the Lens, and also help you identify strategies that would increase your level of readiness.

Lens Versions (start on page 28)

We recognize that organizations have varying levels of institutional readiness for change. To that end, we have included several versions of the Lens to accommodate existing resource levels, in the hope that as organizations begin the process they will increase their investment and work toward comprehensive institutionalization. If you want more information on the background for or suggestions about how to answer one of the questions, notice the attached icons (this resource is specific to the Lens At A Glance version - each icon will point to one of the related Concept Papers). While the Lens questions are a solid starting point, you/your team should feel free to devise a more nuanced inquiry directly applicable to your issue areas.

Equity & Empowerment Lens – Lens At A Glance: We urge all Lens users to start here. This is the basic version for application at all levels of capacity. This version calls for an equity analysis based on race/ethnicity, class, and gender categories (paying particular attention to communities of color, immigrants, and refugees), and includes the primary questions to use in all applications based on social justice and empowerment. The nine questions are organized around their connection to people, place, processes, and power and provide a foundation on which to build equity within your organization. We urge the user to examine all axes of difference, including income level, ability, age, and orientation in relation to the above-mentioned categories. The **Lens At A Glance Worksheet** (page31) immediately follows, providing promting questions, additional information on the Lens At A Glance and space to write.

Specific versions:

- **Resource Allocation Lens:** For working in the areas of budget, grants allocation, purchasing, contracting or human resources, and to delve deeper into institutionalizing equity and racial justice.
- **Policy and Decision-Making Lens:** For working with a specific policy or decision (new or existing), and to delve deeper into institutionalizing equity and racial justice.

Moving Into Action Guide (page 43)

Intentional and thoughtful review, discussion, and analysis of existing policies, procedures and practices within your organization will lay the groundwork, but to move the vision of equity forward we must also be willing to take action. The *Moving Into Action Guide* has three components:

1. Moving Into Action Introduction;
2. Sample Action Plan; and
3. Blank Action Plan.

This section provides a brief introduction into the types of resources to have on hand, and a step-by-step process to create a recommendation with an achievable action plan. Start where you can, and utilize other team members' support to increase the rigor of your action plans over time. From our pilots we learned that the *Moving Into Action* phase requires adequate

time for thoughtful deliberation before finalizing and implementing an action plan and an appropriate accountability structure for evaluation.

Evaluation Summary (page 51)

In this section we discuss the role of evaluation in the successful application of the Lens and institutionalization of recommendations, highlighting the need to include an evaluator and a data person at the beginning of a Lens application process. This version of the E & E Lens does not include specific samples or detailed evaluation methods, but instead provides an overview of how and why to integrate evaluation into this work. We also emphasize the importance of building accountability methods into your action planning, and share a few examples of how best to do this within an organizational setting.

Concept Papers (start on page 56)

The E & E Lens draws upon the expertise of multiple disciplines and academic and community voices. To help the user understand the underlying theoretical framework of the Lens we have included a *Concept Paper* on eight different topics instrumental to pursuing equity work. Writers have designed the concept papers to increase user knowledge and capacity to understand the Lens questions and structure. Contributing authors also incorporated feedback and research provided by key experts in the field (see list of contributors in the Acknowledgments section). Each concept paper can be used as stand-alone educational material, and all papers are structured according to the following format:

1. Connection to the Lens
2. Background and Basics
3. Recommendations for Implementation (according to paper topic)
4. Individual Reflection Questions

The Concept Papers serve as grounding and context-building materials and we urge you to engage your staff in reading and discussing them either as part of the Lens application or simply to strengthen your organization's capacity around equity (for example, you could read one paper together and answer the "Individual Reflection Questions" together as staff). If implemented as a Best Practice, such activities reflect empowerment theory and intentionally engage staff most affected by inequities. (See Concept Paper on *Empowerment Theory and Practice*).

Additional Educational Resource Available

NOTE: While the Lens itself has valuable tools to initiate the process of critical inquiry into equity, we also encourage you to consider completing the accessible and well-researched online course 'Roots of Health Inequity', developed by lead policy advisers and researchers at the National Association for City and County Health Officials (NACCHO). Sign up (it is free, and not singularly for public health employees), and take the course at your own pace. This tool is another strategy to build capacity and readiness to embark upon this work. After completing the online course participants will be able to: (1) explore social processes that produce inequities

in the distribution of disease and illness in communities, and (2) strategize more effective ways to act upon the root causes of health inequities.

How to Use Your Lens Results (Lens at a Glance Assessment, Action Plan)

COMPILE your thoughts, responses, and notes for ongoing review and analysis.

DOCUMENT trends in your thinking, program practices, and institutional policies that relate to equity. *Investigate* and assess any resulting suggestions or recommended areas of change.

CELEBRATE programs, strategies, policies, and practices that successfully incorporate equity and racial justice. Recognize staff who implemented successful strategies and programs related to equity and racial justice.

SHARE your discoveries with community stakeholders (including opportunities, challenges, barriers, and recommendations), especially to communities most affected by inequities, paying particular attention to racial and ethnic communities.

DIALOGUE with internal staff, external partners, and communities most affected by inequities. Make recommended changes based on employee and community feedback.

CREATE processes and policies that institutionalize the recommendations into current and future planning.

ORGANIZATIONAL READINESS SUMMARY

The current economic and social climate often obligates organizations to operate in response to what is deemed the most urgent. We serve people and communities with immediate needs. However, achieving equity and social justice also requires a deep, and parallel focus on developing systems and implementing strategies that address and eliminate root causes. Organizations have dual roles – to serve the immediate needs of communities, while also striving toward collective empowerment and equity. To achieve this end, we must constantly assess our capacity to do equity work and intentionally create the supportive, reflective environments within which to do this work well.

The Bay Area Regional Health Inequities Initiative (BARHII) has completed seminal work in the area of organizational assessment and readiness to tackle inequities. This collaborative effort of 11 local health departments in the San Francisco area developed a toolkit that helps public health leaders identify the skills, practices, and infrastructure needed to address health equity, and also provides steps for departments to build their organizational capacity to eliminate negative policies.

The purpose of this section in our Lens document is to:

- share highlights from BARHII's work, which integrated promising practices and well-researched literature from the organizational development and public health sectors; and
- urge managers, leaders, and staff to build their group and individual capacity around these characteristics and competencies as part of a comprehensive equity and racial justice strategy.

Whether an organization is far along in this work, or just beginning the journey, utilizing these key principles and practices will build the capacity to successfully institutionalize equity and de-institutionalize inequitable and oppressive policies and practices.

BARHII's organizational self-assessment is based on the following research-based items that we have turned into a reflective tool for you to begin examining your organization's readiness to do equity work. Remember that the characteristics and competences outlined are applicable to multiple sectors, and we are simply using the BARHII work as specific example to guide you through a process of organizational analysis. As you review the self-reflection and apply it to your organization, insert your particular social area or sector where 'health' appears and insert equity/racial justice where 'health equity' appears. Additionally, the

comments in italics speak specifically to capacities that increase the ability to decrease root causes of racial and ethnic inequities.

Organizational Readiness Reflection*

Directions: Fill in the blanks with the number that best describes where your organization is in relation to the organizational characteristics and workforce competencies listed below.

Then tally up the majority of your responses and look at the attached 'Sample Scoring Guide' at the bottom to figure out how best to utilize the Lens and accompanying materials.

Haven't started work in this area yet	Plans exist to use in planning and implementation	This is in place and we have evidence of its use	This is part of our routine, and we model it for others
(1)	**(2)**	**(3)**	**(4)**

We have augmented this model from BARHII's with racial justice strategies indicated by italics.

Organizational Characteristics:

1._____ Institutional commitment to addressing [health – insert what is relevant to your organization] inequities (*eliminating racial and ethnic inequities*)

2._____ Hiring to address [health – insert relevant area] inequities, prioritizing the hiring of employees who best represent communities of color, immigrants, and refugees

3._____ Structure that supports true community partnerships (*empowering and more fluid than hierarchical*)

4._____ Supporting staff to address [health] inequities (*racial and ethnic inequities*)

5._____ Transparent and inclusive *culturally-responsive communication*

6._____ Institutional support for innovation

7._____ Creative use of categorical funds (*supporting programs/policies vital to or disproportionately needed by, particular disadvantaged racial/ethnic communities*)

8._____ Community-accessible [and driven] data and planning (*data should also incorporate community narrative and experience*)

9._____ Streamlined administrative processes

Workforce Competencies:

1._____ Knowledge of [public health – insert your area] framework (e.g., Ten Essential Services, public policy development, advocacy, data)

2._____ Understanding of the social, environmental, and structural determinants of health (*SDOH – and the connection between their presence or absence which reflects the success/health of communities of color, immigrants, and refugees*)

3._____ Knowledge of affected community (*can be built by building of authentic relationships with communities, analysis of community-driven data, etc.*)

4._____ Leadership (courageous, consistent around applying Lens, *understanding of power and privilege)Collaboration skills (developed partnership-building skills interculturally, with dignity and respect, and across classes)*

6._____ Community organizing skills *(build community organizing skills based on the principles and practices espoused by communities of color, immigrants, and refugees)*

7._____ Problem-solving abilities

8._____ *Cultural responsiveness and humility*

Reflecting on Organizational Readiness:

This tool is meant to deepen your awareness of and thinking about the essential characteristics and workforce competencies required to do high quality equity work.

- If you notice that your organization is tending toward the one and two range, a good start to Lens application might be to read the concept papers and facilitate a conversation among your staff or partners about the topics and accompanying questions.
- If you notice your organization is tending toward the three and four range, you might be ready for a more thorough Lens application.

At any of the levels of readiness organizations can use the questions during trainings, and conversations about budget or decision-making. Start using them. As with anything, the term readiness is relative, and this reflective tool is simply a guide to help you determine how best to utilize the Lens as a resource. The following questions are additional considerations as you examine your organization's readiness and begin planning your way forward.

After completing the Organizational Readiness Reflection ask yourself:

- ✔ What is already working well?
- ✔ What can be improved?
- ✔ What is missing?
- ✔ How can your organization improve upon celebrating its accomplishments?
- ✔ How are you arriving at the answers in relation to the above questions? What kinds of data are your currently using? What other data do you need?

LENS AT A GLANCE

Ready to Use the Lens

Now that you have reviewed the background, history, theoretical framework, and organizational readiness summary of the Equity & Empowerment Lens (E & E Lens) you are ready to begin using the components we have laid out to more thoughtfully examine your organization. Below you will find a simple reminder about the underlying concepts present in the actual Lens questions, and tips for maximizing your use of the tool.

At its core, the Lens guides the participant to:

You are here

- ➡ ***Assess*** *your current organizational capacity for equity work.*
- ➡ ***Describe*** *current direction and strategies.*
- ➡ ***Identify*** *inequities and injustices in the current issue.*
- ❑ **Reflect upon and understand** your strengths and challenges.
- ❑ **Enhance what is leading** to equity and empowerment.
- ❑ **Eliminate strategies** and root causes leading to inequities and injustices.
- ❑ **Celebrate** successes and improvements.

What are the foundational concepts and theories guiding these questions?

This basic version of the Lens is based on the foundational assumptions found in the Concept Papers (see pages 56 to 99). Essentially, the Lens asks questions in the areas of ***People, Place, Processes, and Power***, and seeks to identify underlying patterns, barriers, and opportunities leading to equity and racial justice. (See *Introduction* for more information on connection to People, Place, Processes, and Power).

What are some guiding tips to complete this assessment?

Before beginning, make a personal and organizational commitment to a specific Lens aplication process. If you plan to fully apply the Lens, ensure that you have allocated appropriate resources, staffing, and time to move from analysis into meaningful action. If you intend to utilize the Lens to examine a particular institutional dilemma, make sure that you are prepared to shift your decisions in alignment with your reflection and discoveries. If you are interested in using elements of the Lens (e.g. *Concept Papers*) to promote organizational readiness and capacity building, be transparent with your staff about the ultimate goal being application at a broader level. The following suggestions will help guide your work at any initial capacity.

Creating the Space, Setting the Tone

- Arrange to host the Lens application session in a comfortable, private location with limited distractions and space for people to think, brainstorm, and discuss in a variety of ways (e.g. large group, small group, pairs, flip chart, individual notes, etc.)
- In advance, think about who should be in the room in order to meet the goal of representation from communities most affected by inequities. Provide reasonable notice about the day and time for the session to demonstrate the value you place on their presence and to increase the likelihood of their participation.
- Be intentional with time and goals for each session; if you intend to move through the whole Lens in one session, ensure ample time for completion to alleviate the loss of momentum if the conversation has to stop mid-stream because of time limitations.
- When introducing the Lens, explain the broad goals of the initiative and the specific goals of its application in your setting so your team understands the context and what they can expect of the process and outcomes.

Moving Through the Lens

- Moving through the process as a team? Consider breaking down the Lens questions in manageable chunks over a few meetings, and utilize meaningful engagement methods as a way to integrate active listening, diverse viewpoints, challenging conversations, thoughtful communication, and collective wisdom around data-sharing and recommendation creation.
- Strive to have the analysis completed by people who bring different racial and economic perspectives to the table, including communities who identify as people of color and as Caucasian. Diverse perspectives will lead to more robust solutions and bring about a more equitable analysis.
- Racism, class oppression, and gender inequity are often three major drivers of inequities. Think across these three lines in your answers to questions about who is being affected, how, and why, paying particular attention to communities of color, immigrants, and refugees.
- The *Concept Papers* are referenced by icon to questions below as a resource. Look back at the *Concept Papers* for more information, and / or over a longer period of time, commit to reading through them to build overall capacity.
- Some of your answers might be 'I don't know,' or 'we have low capacity in this area.' Honest and accurate answers will help you better determine where to start in terms of creating upcoming actions.
- If possible, engage an equity expert and someone well-versed in data as part of this analysis to ensure adherence to equity and racial justice principles and provide more relevant information for your discussion.

Equity and Empowerment Lens Questions

Basic Intro Questions

1. **Describe the policy/decision/program/practice/etc. used for this Lens application.**
   a. Are social justice and racial justice clearly stated in the vision, mission, and goals?
   b. Who does this intend to serve, and who is actually served?
   c. How is this funded, and what are the limitations?

2. **What data or evidence guides the policy/decision/program/practice/etc.?**
   (See Evaluation Summary chapter, p. 51)
   a. How does your organization currently **utilize** existing data to inform your practice?
   b. How does your organization make data available for employees and community members to easily access and understand?

Connection to People

3. **Describe the groups that will be most affected by and concerned with this policy/decision/program/practice/etc.?**

4. **What are the benefits and burdens that communities experience with the policy/decision/program/practice/etc.?**
   a. What factors may be producing and perpetuating these positive and negative effects on communities?

Connection to Place

5. **There are three main areas of sustainability and equity (environmental, economic, and social justice) What impacts do communities of color, immigrants, and refugees experience in these areas?**

6. **How are public resources and investments distributed geographically (such as funding, housing, education, transportation)?**
   a. What trends do you see in how resources are flowing in and out of certain areas?

Connection to Process and Power

7. **What barriers do you and your staff encounter in making changes directly related to equity and racial justice? (i.e., obligational political, institutional racism, emotional, legal, programmatic, managerial, financial, internal biases)**

8. **How does your organization engage the community in planning, decision-making, and evaluation?**
   a. What policies, processes and social relationships meaningfully and intentionally *include* communities most affected by inequities?
   b. What policies, processes and social relationships contribute to the *exclusion* of communities most affected by inequities?
      b.i. For policies and processes that exclude, what actions or strategies could build inclusion?

9. **How does the policy, decision, program, practice build community capacity and power in communities most affected by inequities?**

LENS AT A GLANCE WORKSHEET

This worksheet provides a few guiding prompts, resources, and space to answer the questions within *Lens At A Glance*. During sessions with teams, this format has been helpful for individuals to jot down notes, or for a note-taker to cut and paste into Word to record the conversation and analysis.

Consider also using the *Concept Papers* as a resource for more thoroughly addressing the questions. Notice the icons that indicate which *Concept Paper* relates to the question. To know which icon is linked to which *Concept Paper*, refer back to the *Table of Contents*.

Before you begin completing the worksheet, read through the *Lens At A Glance* for guidance on how complete this assessment stage.

Before completing the Moving Into Action Guide, reflect upon the notes you have taken on this worksheet and consider the topics in the Concept Papers.

WORKSHEET

Basic Intro Questions

1. Describe the policy/decision/program/practice used for this Lens application.

a. Are social justice and racial justice clearly stated in the vision, mission, and goals? (*See Appendix 3: Organizational Checklist for Racial Justice, section on Racial Justice Policy and Plan for ideas*)

_____
_____
_____
_____

b. Who does this intend to serve, and who is actually served?

_____
_____
_____
_____

c. How is this funded, and what are the limitations?

_____
_____
_____
_____

2. What data or evidence guides the policy/decision/program/practice/etc.?

a. How does your organization currently utilize existing data to inform your practice?

- Share all demographic data, maps, qualitative experience, reports, etc., used to guide your work.

_____
_____
_____
_____

- What is the data telling you about inequities experienced in our communities? Pay particular attention to inequities experienced by communities of color, immigrants, and refugees.

_____
_____
_____
_____

- Did you use reports/data that were based on community priorities and culturally-specific feedback (paying particular attention to reports on communities of color, immigrants, and refugees)? If so, how?

  A few examples include: State of Black Oregon Report, Coalition of Communities of Color Reports, State of Equity Report (from State Office of Equity and Inclusion), Multnomah County's Report Cards on Racial and Ethnic Health Disparities, Racial Equity Strategy Guide, visionPDX, etc.

_____

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_____

b. How does your organization make data available for employees and community members to easily access and understand?
   - Is your data transparent and available to employees and community members in a way that is easily understood, available, and interactive? If not, how can you begin to make it so?

_____

_____

_____

_____

Connection to People

(Write answers for #3 and #4 in the table below as guided)

3. **Describe the groups that will be most affected by and concerned with this policy/decision/program/practice/etc.**
   Insert your answers in Column 1 below: Consider populations within racial/ethnic, income development, gender, and ability groupings, as well as geography.
   - Pay particular attention to the effects on communities of color, immigrants, and refugees.
   - Consider impacts to staff as well.

_____

_____

_____

_____

4. What are the benefits and burdens that communities experience with the current policy/decision/program/practice/etc.?

Insert your answers in Columns 2 and 3 below: Potential Positive and Negative Impacts.
Consider the impact to:

- The various sectors (physical, mental, spiritual, contextual)
- The overall distribution of resources
- Meaningful involvement in decision-making processes, which not only includes access, but the ability to influence the outcome based upon participation

a. What factors may be producing and perpetuating these negative and positive effects on communities?
Insert your answers in Column 4 (table).
Time is needed to answer this question, and the first response is not always the most thorough. Possible root factors or causes can initially be things like 'lack of funding,' or 'the ending of a program.' However, continue to ask 'why' after you get your first answer. Why is there lack of funding? Why is a program ending? Incorporate deeper possible reasons like: biases, lack of awareness based on prioritization of other values, any of the –isms, the five faces of oppression, etc. You will also find there might be some overlap between this question and Question #7.

_____

_____

_____

_____

Table: Connection to People

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4
Demographics (Group affected – be as specific as possible) *Note: this includes an internal analysis, too: are staff affected?*	**Differential Impacts** (Positive - benefit)	**Differential Impacts** (Negative - burden)	**Root causes for benefits and burdens** (mention the benefit/burden the root cause or oppression links to)
Etc.			

Connection to Place

5. In the three main areas of sustainability and equity (environmental, economic, and social justice): What are the impacts in these areas experienced by communities most affected by inequities?

Pay particular attention to communities of color, immigrants, and refugees.

- Environmental Justice: Environmental impacts in areas such as access to nature, restoration of natural systems, preservation/increase of green space, air quality improvements, active transportation options? How are cultures and populations who have been historically connected to land and water included in decision-making around the particular policy/program/etc.? *See Appendix 2 for the main principles of Environmental Justice.*

_____

_____

_____

_____

- Economic Justice: Economic impacts in areas such as workforce development/training opportunities, Minority Women Emerging Small Businesses (MWESB), contracting/purchasing, support of regional economy, greater opportunities for income development, etc.

  Helpful prompts for contracting/purchasing/MWESB areas:

  Taken from Question #1 in the Resource Allocation Version of the Lens:

  Consider all suppliers of goods and services that the organization purchases.

  - Does your budget process have supplier diversity goals? (e.g. racial and ethnic, gender, small/large business suppliers.)
  - What goals promote diversity outside of the organization in addition to internally?
  - How does the proposed action support MWESB (Minority, Women, and Emerging Small Businesses)?
    - Building capacity for MWESB contractors? Examples include: technical assistance, educative online materials, etc.
    - Tracking who the contractors currently are (especially in areas that don't require bids, and do not already have MWESB in their language)?

_____

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_____

_____

- Social Justice: Social impacts in areas such as health, education, housing, public outreach and education, community capacity-building, access to decision-making.
  (See Concept Papers on Social Determinants of Health and Inequity, Empowerment Theory and Practice)

_____
_____
_____
_____

6. **How are public resources and investments distributed geographically (such as funding, housing, education, transportation)?** *What is the flow of resources across different geographic regions? What patterns might exist between the flow of resources (past, current, future), displacement of populations, or any forms of marginalization?*

_____
_____
_____
_____

Connection to Process and Power

7. **What barriers do you and your staff encounter in making changes directly related to equity and racial justice?**
   Examples include: obligational (federal/state/grant requirements), institutional racism in structure/policy, political, emotional, personal biases manifesting in the workplace, financial, programmatic, managerial, legal, anything around the hierarchical structure of the organization).

_____
_____
_____
_____

8. **How does your organization engage the community in planning, decision-making, and evaluation?**
   Think about people internal as well as external to your organization, across position class and position within the communities. Pay particular attention to communities of color, immigrants, and refugees.

_____
_____
_____
_____

a. What policies, processes and social relationships meaningfully and intentionally include communities most affected by inequities?

_____
_____
_____
_____

b. What policies, processes and social relationships contribute to the exclusion of communities most affected by inequities?

_____
_____
_____
_____

- For policies and processes that exclude, what actions or strategies could build inclusion?

_____
_____
_____
_____

9. How does the policy, decision, program, practice build community capacity and power in communities most affected by inequities?

Community capacity focus areas: active participation, leadership, rich support networks, skills and resources, critical reflection, sense of community, understanding of history, articulation of values, and access to power.

_____
_____
_____
_____

With this analysis, you are now ready to Move Into Action!

Resource Allocation Questions
(Budget, Human Resources, Grants, Purchasing, Contracting)

Identifying and eliminating the root causes that lead to inequities is the heart of our Lens work. Providing support, technical assistance, and a toolkit to engage institutions in deep, reflection conversation, planning, and action to promote transformational change is the goal of this initiative. We know that all organizations follow a set of guiding practices to allocate resources, create policy, and make decisions. We also know that existing processes are often inequitable. For this reason, we have included two additional Lens versions that build upon the nine questions in the *Lens At A Glance* to more specifically address critical root cause areas in organizational structure and practice: resource allocation, and policy and decision-making.

Before starting this *Resource Allocation* version, please review the *Lens At A Glance*, paying particular attention to the section about barriers to success (Question #7). Identifying barriers and constraints is exceptionally important when assessing decisions in the areas of resource allocation, as many of the decisions are dependent upon external factors such as federal mandates, grant requirements, and personnel rules and regulations.

The four areas we focus on for this version are budget, funding (new or existing), purchasing, and human resources.

- **Budget:** How are we prioritizing funding? What are our true priorities and how are they reflected in the numbers?
- **Funding (new or existing):** Regarding grant funding, how are we using the grant money for addressing equity and racial justice? What are the plans for ongoing sustainability? What limitations exist around funding?
- **Purchasing:** Includes any expenditures on supplies, services (contracting), and other supportive resources for programming.
- **Human resources*:** Includes hiring, demotions, firing, retention, talent development.

* The area of human resources requires more in-depth analysis and application. This version includes just a few questions to provide an overview of the intersection between human resources and equity/racial justice. For more information, see the Employment Systems, Complaints Processes, and Management sections of Appendix 3, the Organizational Racial Equity Checklist.

Questions

1. Consider all suppliers of goods and services that the organization purchases.
   - Does your budget process have supplier diversity goals? (e.g. racial and ethnic, gender, small/large business suppliers.)
   - What goals promote diversity outside of the organization in addition to internally?
   - How does the proposed action support Minority, Women, and Emerging Small Businesses (MWESB)?
     - By building capacity for MWESB contractors? Examples include: technical assistance, educative online materials, etc.
     - by tracking who the contractors currently are (especially in areas that don't require bids, and do not already have MWESB in their language)?

2. How does your budget prioritize programs and strategies that build community capacity, specifically in communities most affected by inequities?

3. Often programs and practices funded by a single source of funding are more easily eliminated during budget cuts. How are you developing multiple funding streams for programs that address equity and racial justice?

4. As part of the budget process, do documents and presentations clearly state a commitment to equity and racial justice, including any guiding principles and values?

5. In the creation of your budget, how are you engaging various levels of staff (paying particular attention to communities of color, immigrants, and refugees) in frequent, proactive, ways to identify yearly budget priorities?

6. How have you or how can you innovatively engage communities of color, immigrants, and refugees who are not staff in your budget process?

7. For specific budget proposals (Keleher, 2009):
   - Will the budget proposal reduce, limit, or eliminate programs that are vital to or disproportionately needed by, particular disadvantaged racial/ethnic communities?
   - Will the proposal increase, expand, or create programs that are vital to or disproportionately needed by particular disadvantaged racial/ ethnic communities?
   - Will there be adequate provisions to ensure success and fairness, including sufficient public participation by stakeholders in development, implementation, and evaluation?
   - What modifications in the proposal are needed to maximize racial justice and inclusion?

8. Regarding human resources (Lopes & Thomas, 2006):
   - What are your hiring practices? How do they incorporate multiple strategies?
   - How do job announcements/postings state the organization's desire for candidates from equity-seeking groups (paying particular attention to communities of color, immigrants, and refugees)?
   - How do job qualifications acknowledge the value of experiences in working with communities of color, immigrants, and refugees, knowledge of anti-racism/anti-oppression frameworks, the ability to work within racially diverse teams, and the capacity to work in languages other than English?

Policy and Decision-making Questions

Identifying and eliminating the root causes that lead to inequities is the heart of our Lens work. Our goal is to providing support, tactical assistance, and a toolkit to engage institutions in deep, reflective conversation, planning, and action to promote transformational change. We know that all organizations follow a set of guiding practices to allocate resources, create policy, and make decisions. We also know that existing processes are often inequitable. For this reason, we have included two additional Lens versions that build upon the nine questions in the *Lens At A Glance* to more specifically address critical root cause areas in organizational structure and practice: resource allocation, and policy and decision-making.

Policies and decisions within organizations can be spoken or unspoken, formal or informal. We must understand the impact of policies on all stakeholders, and take measures to enhance positive and decrease negative outcomes that occur as a result. Before starting this *Policy and Decision-making* Version, please review the *Lens At A Glance*, paying particular attention to the section about barriers to success (Question #7). Identifying barriers and constraints is essential when assessing decisions in the areas of resource allocation, as many are dependent on external factors such as federal mandates, grant requirements, and personnel rules and regulations.

Questions

1. Who does the policy or decision benefit? Community members? The organization? Both?
   - If the answer is one or the other, how can your organization incorporate the needs of both?

2. What forces are restraining your decision or policy? What are your supportive or driving forces?
   - Specifically, what community support exists for or in opposition to the proposal? Why? (City of Seattle, Racial and Social Justice Initiative, Budget Policy Filter)

3. How does your organization use data that reports specifically on inequities?
   - Pay particular attention to data on the experiences and outcomes for communities of color, immigrants, and refugees.

4. How does the policy or decision explicitly acknowledge the value of equity and racial justice to the organization?

5. How are you integrating diverse perspectives, even when you do not agree with them?

6. How does the policy/decision perpetuate or help to dismantle historical, legal, or political oppressions set in the past?
   - General examples of oppression include exploitation, marginalization, powerlessness, cultural imperialism, and violence (See Concept Paper on *Hierarchy and Root Causes*).
   - Specific examples include policies that perpetuate redlining, exclusion of native voice in land use decisions, impacts of gentrification, inequitable homeownership and rental laws, exclusion of communities most affected by inequities in decision-making, etc.

7. How does the policy or decision anticipate and address influence or differential power within the organization? (Lopes and Thomas, p.243)
   - For example, performance reviews could include an appraisal of a manager's or supervisor's ability to provide employees from diverse backgrounds with ongoing support and necessary resources to perform well in their jobs, in addition to being monitored for basic performance.

CREATING AN ACTION PLAN

The Equity & Empowerment Lens (E & E Lens) is intended to be a catalyst for organizational change to promote equity and racial justice within multiple sectors. An action-oriented mindset, accompanied by a deep, reflective approach is essential to create sustainable and equitable policies, procedures, and practices within your organization. While this document contains resources and helpful tips to support development of an action plan that reflects your analysis and reflection, remember that the collective passion of your team's commitment to lasting change is the most powerful tool to maximize during this phase. Actions toward equity can range from subtle and internal (e.g. utilizing racial justice definition in organizational documents) to visible and public (e.g. organizational policy to prioritize contracts with minority-owned businesses). Whether subtle or visible, every step is important and should be recognized as part of the process.

At its core, the Lens guides the participant to:

- ✔ **Assess** your current organizational capacity for equity work .
- ✔ **Describe** current direction and strategies.
- ✔ **Identify** inequities and injustices in the current issue.

You are here

- ➡ ***Reflect upon and understand*** *your strengths and challenges.*
- ➡ ***Enhance what is leading*** *to equity and empowerment.*
- ➡ ***Eliminate strategies*** *and root causes leading to inequities and injustices.*

- ❑ **Celebrate** *successes and improvements.*

Resources needed for this section:

- Copy of your answers from any and all of the lenses; Appendix 1 on page 108: Menu of Outcomes for Advocacy and Policy Work;
- Appendix 3 on page 113: Organizational Checklist for Racial Justice;
- Appendix 4 on page 118: Empowerment Assessment Tool; and
- Any Concept Papers that might support your recommendations.

A high quality action plan requires organizations to dedicate time and space to thoroughly review comments of the action plan and will help you integrate intentionally the perspectives of multiple staff members'. These two steps develop accurate timelines, identify appropriate leads, and select meaningful

evaluative measures. Additionally, we discovered during our pilot with the Health Department that it was vital to have a technical expert on equity and/or racial justice present available during these conversations to provide research, information, and a focus on strategies to eliminate the root causes of inequities.

Most importantly, remember that transformational equity work calls for a new way of organizational being; one that takes a step back to examine root causes, looks closely to recognize intersectionality between elements of the issue, and seeks to embrace multiple perspectives. Once you have considered each of these things, you have set the stage for an effective and transformative action planning session. The following steps will guide you further:

Step 1:

- **Create the space** where you (and your team) can quietly and thoroughly reflect and discuss your Lens application. Whether at a particular meeting, or in between meetings, encourage moments of silent reflection and stillness, providing space for the surfacing of images and feelings, both positive and challenging in nature. Engaging emotions taps into unique reservoirs of creativity and resolve. Case Clinic models that utilize these principles have been effective methods for meaningful and successful group analyses (Presencing Institute).

- **Review the answers** in your *Organizational Readiness Summary*, Lens assessment(s), and any other data relevant this work.

Step 2:

- Based on what you have reviewed, **brainstorm a list of potential actions** that build upon existing strengths and/or mitigate challenges. To assist your process:
  - Think about root causes related to the issue, examine the challenges and barriers that you face, and highlight specific strengths you bring to the work.
    - Be sure to focus on where and how institutional racism and personal biases manifest in order to identify racial injustices that need addressing.

  - Renew your responses to the *Organizational Readiness Summary*. If you scored mostly 1's and 2's, look at strategies that focus on Shifting Social Norms (Outcome Area 1) and Strengthened Organizational Capacity (Outcome Area 2). If you are further along, and answered mostly 3's and 4's, look to institutionalize and begin shifting policies, considering strategies that focus on Improving Policy (Outcome Area 5).

  - Use the Appendices 1, 3, or 4 (Menu of Outcomes for Advocacy & Policy Work, Organizational Checklist Racial Justice or the Empowerment Assessment Tool).

- Include a wide range of strategies that speak to the internal (e.g. human resources, strategic planning) and external (e.g. community partnership building and service provision changes).

Step 3:

- **Organize the brainstormed list** of recommendations or strategies along the six outcome areas. (See Concept Paper on *Six Outcome Areas for Advocacy & Policy Work* and refer to Appendix 1). A filled-out list might have two to three strategies or recommendations under each outcome area.
  - Example: Developing and implementing an organization wide training on racial justice would be under the **Strengthened Organizational Capacity** outcome area.

- **Select one action (strategy)** that has political will behind it, addresses root causes, and can have far reaching benefits. The remaining strategies can be done over time.

Now you're ready to complete your action plan!

Step 4:

- **Review the <u>Sample Action Plan</u>** to familiarize yourself with the tool.
  - Notice how each outcome area intersects to support the main action and outcome area you selected.
  - As you begin thinking about the prioritized strategy for your action plan, imagine that it is like one root of the tree, and if you implement only that action without other supportive roots, the tree will fall.
  - Create a draft list of the additional outcome areas that will provide supportive roots to your selected strategy, and find a supporting action or two under each that will maximize the impact of your main action. Use the Sample Action Plan examples as a guide:
    - **Main Action:** Equity Lens trainings for all departmental management and staff (under the outcome area Strengthened Organizational Capacity).
    - **Supporting Actions:**
      - Equity and empowerment message development (under the outcome area Shift in Social Norms).
      - Revision of HR policy to include mandatory Equity Lens training (under the outcome area Improved Policy)
      - Partnership development with leaders, staff, union (under outcome area Strengthened Alliances)

Step 5:

- **Complete every column of the Moving into Action Plan** with your specific action in mind.
  - For every column, **reflect upon the intersectionality** between the action you have chosen and the six outcome areas; you will see overlap and alignment. Opportunities for innovative practice often emerge from this synchrony.
  - In the economic and environmental justice column, consider the following: contracting equity, supplier diversity, prioritizing Minority Women Emerging Small Business (MWESB), environmental impact. (See Appendix 2, page 112 on the principles of Environmental Justice)
  - In the accountability and institutionalization row consider how to sustain the recommendation or action beyond the presence of any one leader, staff member, or employee. (See upcoming Evaluation Summary for further information)
    - How can this work become part of the institutional policies, practices, planning methods, and programs of your organization?
    - How can you improve the sharing and celebrating of accomplishments in the areas highlighted by the E&E Lens?

Congratulations! You have completed your first Equity & Empowerment Lens Action Plan to build equity and racial justice within your organization. Now you are ready to **take action** and **communicate your results to leadership, staff and constituents**.

EQUITY AND EMPOWERMENT LENS: SAMPLE ACTION PLAN

MAIN RECOMMENDATION/ACTION: Equity & Empowerment Lens trainings for all departmental management and staff.
RELATED OUTCOME CATEGORY: Strengthened Organizational Capacity

1. Review the Menu of Outcomes for Advocacy and Policy work (See Appendix 1), choose the one that best links to your action, and insert your recommendation/ action in the space provided.

2. In order for your main action to be successful and sustainable, it is critical to conduct work in the other five outcome areas as a wrap-around strategy. Fill out the various columns as they relate to your main action /recommendation above, checking in with leadership, staff, and community members to complete columns accurately. See tips in Moving Into Action Guide for further information. Create a similar table electronically for more space.

	Shift in Social Norms	Strengthened Organizational Capacity	Strengthened Alliances	Strengthened Base of Support	Improved Policies	Changes In Impact
Actions / Recommendations	Message development (in line with equity, empowerment)	Equity Lens training for all departmental management/staff.	Partnership development with leaders, staff, union.		Revise HR policy to include mandatory Lens training and introduction for new staff.	Depend on department: Decreased in equities in X area, greater success and wellness for all populations.
Smaller Outcomes	Changes in awareness of the importance of equity/racial justice to work.	Increased use of Lens in decision-making	Increased number of partnerships. Increased level of collaboration. Increased level of input and participation by multiple levels of staff into training and policy.		Policy development Policy adoption	
Timeline	January, 2012	Develop and implement by February 2012.	Ongoing, January 2012.		By December, 2012	

	Shift in Social Norms	Strengthened Organizational Capacity	Strengthened Alliances	Strengthened Base of Support	Improved Policies	Changes In Impact
Lead for Action	Communications	Lead Supervisor X	HR Lead X, HR Staff		HR Lead X, Lens staff, Department Leadership	
Evaluation Method / Evaluation Lead	Survey of all staff. Lead: Manager X.	Evaluative onsite surveys for staff to complete each time the Lens is utilized. Lead: Contracted state evaluator	At three and six months, by survey, gauge level of collaboration nd participation. Separate focus groups/surveys on provision of input into policy.		Was the policy developed? By whom, and when?	
Economic and Environmental Justice Considerations	Go with paperless messaging.	How can we better support MWESB contractors in our trainer search?				
Accountability and Institutionalization	Bring evaluation results to the leadership team.	Bring evaluation results to the leadership team.			Include in administrative rules. Translate the learning outcomes from the training into performance review measurements for department. Regular evaluations of policy outcomes brought to small quality team.	Ensure these changes are a part of our strategic plan.

EQUITY AND EMPOWERMENT LENS ACTION PLAN TEMPLATE

MAIN RECOMMENDATION/ACTION: _____

RELATED OUTCOME CATEGORY: _____

1. Review the Menu of Outcomes for Advocacy and Policy work (See Appendix 1), choose the one that best links to your action, and insert your recommendation/ action in the space provided.

2. In order for your main action to be successful and sustainable, it is critical to conduct work in the other five outcome areas as a wrap-around strategy. Fill out the various columns as they relate to your main action /recommendation above, checking in with leadership, staff, and community members to complete columns accurately. See tips in Moving Into Action Guide for further information. Create a similar table electronically for more space.

	Shift in Social Norms	Strengthened Organizational Capacity	Strengthened Alliances	Strengthened Base of Support	Improved Policies	Changes In Impact
Actions / Recommendations		Insert from above (under Main Rec/ Action)				
Smaller Outcomes						
Timeline						

Lead for Action						
Evaluation Method / Evaluation Lead						
Economic and Environmental Justice Considerations						
Accountability and Institutionalization						

EVALUATION SUMMARY

At its core, the Lens guides the participant to:

- ✔ **Assess** your current organizational capacity for equity work .
- ✔ **Describe** current direction and strategies.
- ✔ **Identify** inequities and injustices in the current issue.
- ✔ **Reflect upon and understand** your strengths and challenges.
- ✔ **Enhance what is leading** to equity and empowerment.
- ✔ **Eliminate strategies** and root causes leading to inequities and injustices.

You are here ➡ ***Celebrate*** *successes and improvements.*

The Equity & Empowerment Lens (E & E Lens) is not only meant to inspire deep, reflective, intentional thinking and planning, but also to generate significant quality improvement within organizations to address historic and present inequities. Integrating evaluation and building accountability during Lens processes are at the core of institutionalizing the policies, programs, and practices that further equity and racial justice. Meaningful evaluation helps organizations define success and improve quality by bringing a critical focus to the identification of outcomes, appropriate and relevant strategies to achieve those outcomes, and maps to visualize how various factors (such as program elements and strategies) intersect and lead to the change outcomes. By thoughtfully applying the Lens, organizations can examine existing evaluation structures and determine how to better assess the impact of services on multiple populations.

The purpose of this section is to review the roles of evaluation and accountability in a successful Lens application, while providing some helpful tips and things to consider when developing your evaluation strategy. Remember that all evaluation processes aim to address the following key questions:

- Where are we going? What are our goals?
- How do we know if we're getting there?
- How do we know when we've gotten there?
- How are we celebrating what we're doing well?

Helpful Tips to Evaluation:

Prioritize developing an evaluation plan. Evaluation as an afterthought is not as meaningful or helpful as one that was intentionally and thoughtfully designed. Often organizations do not recognize the critical importance of sound evaluation mechanisms to ongoing quality improvement and informed decision-making.

(See Concept Paper on *The Lens as a Quality Improvement Tool*). When creating an evaluation plan include multiple perspectives early in the process to help better define success, identify a plan to achieve it, and prioritize the steps requiree to institutionalize equitable processes and policies.

Utilize multiple methods of data collection. Effective evaluation requires creativity and a commitment to identifying the strengths and weaknesses of your work from multiple perspectives. Using surveys to collect comprehensive qualitative data can help you discern your organization's progress from the macro level*. Focus groups and one-one on interviews can help delve deeper into the lived experiences of the people (in the areas of Physical, Mental, Spiritual, and Contextual Health, for example) affected by your work and provide additional details not gleaned from surveys. (See Concept Paper on *Relational Worldview*). A thorough equity review requires that you gather as much information as possible, and specifically integrate input from communities most affected by inequities.

Use evaluation at every stage of the Lens application. Making an organizational commitment to formative assessments throughout the stages of the process will familiarize your team with the process of ongoing evaluation for improvement, increase the credibility of your Lens application, and help the organization grow by sharing what is working.

As you begin your Lens Application, consider:
(See *Organizational Readiness Summary*. Some of these questions support Organizational and Workforce Characteristics necessary to successfully apply a Lens)

- When applying the Lens, how do we know the answers to the questions are true?
- What kinds of data (qualitative, quantitative, and based in community priorities) are you using?
- How do you define success, and on what paradigms is that success based? What kinds of questions can you ask to gauge the cultural responsiveness of evaluators at the table?
- Do you have a team member or colleague within your department or on staff who knows data well? If not, how can you partner with evaluators within your department or externally to support your Lens application?
- How is your team utilizing engaging, culturally responsive methods of selecting and collecting relevant data to your issue?
- How can you consistently communicate evaluation results, highlighting what is working/accomplishments as well as challenge areas?

As you begin Moving Into Action, consider:

- What is the plan of action, including clear roles, timeline, and outcomes?
- How can tie the recommendations/actions to the six outcome areas for advocacy and policy from the start? (See Appendix 1)

*Acknowledge survey fatique in your development and planning if using surveys.

Here are a few evaluative questions specific to the Equity and Empowerment Lens (racial justice focus):

- How are you incorporating communities of color, immigrants and refugees (community members and employees) in the creation of your evaluative methods and processes? This particular question is key to applying the Lens to evaluation practices.
- How does your organization evaluate the impact of program priorities, processes, and strategies on racial and ethnic communities? How regularly? If you do not, why not?
- Does your organization change programming based upon evaluations, feedback and suggestions? Are these changes required? If so, how do these changes occur? If not, why?
- How does the program measure progress internally (such as organizational processes, policies, and workforce development) and externally (such as outcomes affecting clients, participants and community members) in relation to racial justice?
- How does your organization celebrate accomplishments, what is working, and changes made?

Examples from the Field:

Including real-time evaluation: During the 2009 Equity & Empowerment Pilot with three Health Department managers, equity lens staff and facilitators learned how to capitalize upon the availability of real-time information to enhance the Lens itself. Combining session assessments with the end-of-pilot evaluation, Lens developers were able to improve the training structure, update Lens versions to incorporate new ideas and strategies, and develop a higher quality application process. As a result, all participants were building their own capacity while contributing to the overall efficacy of the Lens for other users.

For example, after an initial Lens application meeting with one of the program managers and their staff, the evaluator asked Lens discussion facilitators to assess the meeting and identify what additional resources they needed to improve their impact. The evaluation interview and survey revealed a need for more extensive training around how to facilitate difficult conversations, identify clearer roles for participants during the meeting, and clarify specific Lens questions. Having access to this information during the Lens application was critical to achieving positive outcomes for the pilot because facilitators were able to integrate observations and suggestions into the follow-up meetings and activities.

Now that you have reviewed the value of ongoing evaluation within the Lens application, here are a few key questions, methods, and considerations that will help you integrate evaluation and accountability through each stage of the process.

Building accountability to equity: Within Multnomah County Health Department, supportive, flexible, and interactive accountability systems are most effective. In its ideal form the accountability system should be a body to which programs are responsible for reporting progress, and which would provide supportive technical assistance on how to most effectively

roll out implementation. In Multnomah County's Health Department, a group called the Diversity and Quality Team (DQT) serves this function. Members of the group come from all areas of the department, and include a representative from the department's leadership team. The DQT's mission is to monitor, measure, and make decisions on health department policies, programs and initiatives, and support the development of an increasingly culturally competent health department workforce. Recently, the DQT has taken a stronger evaluation and accountability role in the Lens processes and outcomes. DQT now strives to be the body within the health department that focuses on:

- Assessing Lens usage within the department and how and where this occurs;
- Gauging what training and extra resources are needed for successful applications of the Lens;
- Providing technical assistance to those applying the Lens; and
- Tracking and monitoring progress on action plans/recommendations coming out of Lens applications.

DQT is one example of how to build accountability for institutionalizing equity and racial justice into an organization's policies and practices. Here are a few questions to consider in building accountability and institutionalizing equity- and empowerment-based recommendations:

- To whom do Lens application leads report their progress and make requests for resources? How can you begin to document lessons learned from the recommendations or actions that come from utilizing the Equity and Empowerment Lens?
- How can your organization create a quality assurance body or team within your department or organization that can serve as the central location for evaluation and technical assistance needed after staff and managers create action plans.
  - A few key questions to ask within this group: did the group or person applying the Lens do what they said they were going to do? If so, what difference did this make? What were the outcomes? (See the example of DQT above)

The role of accountability in evaluation

At its core the Equity & Empowerment Lens (E & E Lens) compels organizations to address institutional inequities that lead to differential outcomes for populations. Accountability is therefore a central component and a necessary committed strategy of an authentic Lens application. Accountability speaks to what processes, policies, or leadership are in place to ensure that program plans, evaluation recommendations, and actions leading to the identification and elimination of root causes of inequities are actually implemented within the organization. (See Concept Paper on *Hierarchy and Root Causes*). Recognizing that institutions utilize different accountability systems, the Lens seeks to emphasize the importance of addressing accountability within the application process, rather than dictating the type of system required.

The marriage of evaluation and accountability to the Lens application will strengthen the institutionalization of any organizational changes initiated by this analysis. Embedding these

structures within performance reviews, strategic planning sessions, organizational capacity building initiatives, and other institutional processes will enhance existing processes and improve your institution's ability to articulate how outcomes address inequities.

CONCEPT PAPER #1

SOCIAL DETERMINANTS OF HEALTH AND INEQUITY

"There must exist a paradigm, a practical model for social change that includes an understanding of ways to transform consciousness that are linked to efforts to transform structures." - Bell Hooks

Connection to the Lens

At its inception, the Equity and Empowerment Lens (E & E Lens) was envisioned as a tool to help leaders and organizations examine the conditions under which equity grows or diminishes and take action to rectify the inequities that result from policies, procedures, and practices that benefit some while disadvantaging others. Understanding the social determinants of health is key to an effective Lens application process. In our day-to-day work, it may not be immediately apparent how various social determinants intersect with our programs and policies. A few Lens questions prompt us to think beyond conventional boundaries and institutional silos by asking us to consider developing new and innovative partnerships or strengthening current relationships with nonprofits and community partners. An example might include a health clinic developing a partnership with a nearby high school to tackle high rates of teen pregnancy, or a housing agency partnering with an economic justice organization to promote just and sustainable employment for its clients.

Background and Basics

The vision of the Multnomah County Health Department is "healthy people in healthy communities." But what is a healthy community? What conditions create healthy communities? Community members and those who work in communities have always understood that people who have peace, shelter, employment, access to education, and other basic needs tend to be healthier. Now, a large and expanding body of literature documents the health impacts of environmental, social, political, educational, and economic conditions, which together are referred to as the social determinants of health (SDOH). By improving each condition, and by working cross-sector on joint actions and goals, we can improve the livability of the community as a whole. When livability is improved for all, the community becomes healthier and we move a step closer to achieving health equity.

(Important note: for the purpose of this document, "health" is synonymous with positive outcomes in any sector.)

What are Social Determinants of Health?

According to the World Health Organization (WHO), social determinants of health are the conditions in which people are born, grow, live, work and age, the health care system being one of several. The social determinants are largely responsible for inequities, which are unfair, avoidable, and systemic differences in population outcomes. The social conditions (referred to as social determinants) resulting in inequities are shaped by (1) the distribution of money and other resources, and (2) the presence of fair/just decision-making processes leading to meaningful engagement of communities most affected by inequities. These social determinants are greatly influenced by policy choices at local, national, and global levels.

A report issued by the Robert Wood Johnson Foundation (2010) provides a compelling explanation of why we must pay close attention to these factors:

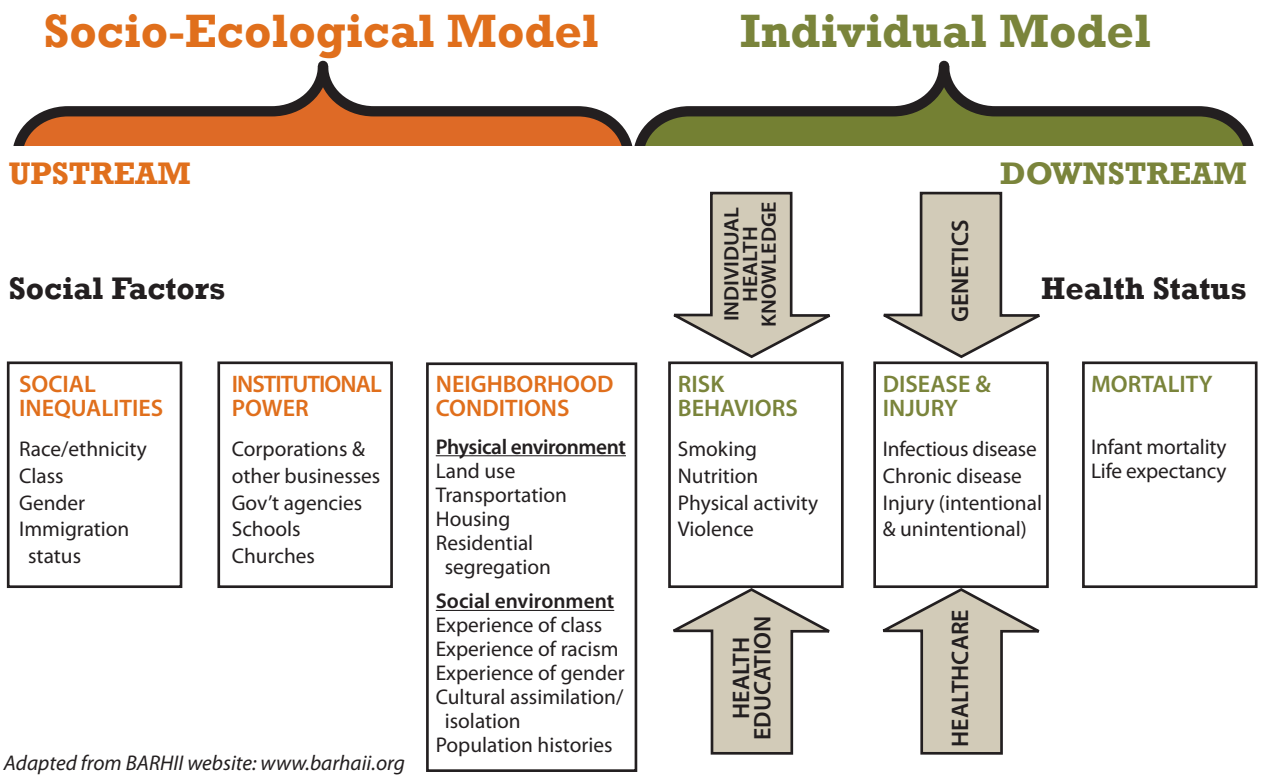
> *America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on Earth. Yet on some of the most important indicators . . . we're not even in the top 25. . . It's time for America to lead again on health, and that means taking three steps. The first is to ensure that everyone can afford to see a doctor when they're sick. The second is to build preventative care . . . into every health care plan and make it available to people who otherwise won't go or can't go in for it. . . The third is to stop thinking of health as something we get at the doctor's office but instead as something that starts in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and in the water we drink. The more you see the problem of health this way, the more opportunities you have to improve it.*

Taking these words to heart, we have adapted the following graphic from Bay Area Regional Health Inequities Initiative (BARHII) to depict how external, social factors (such as housing, institutional power, and racism, to name a few) and individual-related factors (in this example, risk behaviors, disease, and injury) work together to bring about positive or negative population health. Until recently, we have tended to focus on solutions and strategies that only target individual behaviors, as seen in the "risk behaviors" and "disease and injury" categories. However, in order to significantly improve outcomes at the population level and ultimately to eliminate root causes of inequities, we must recognize the external factors that also contribute to inequities experienced by populations and communities. These include neighborhood conditions, education, the role of institutional power in upholding unjust structures, processes, and decision-making, and how and why root causes exist in the first place. (see Concept Paper on *Hierachy and Root Causes*)

The socio-ecological model also connects health status to sustainability, climate health and equity (see Concept Paper on *Sustainability, Climate Health and Equity*), by examining how our social and economic sustainability exists within the resources and limitations of environmental sustainability. What affects our natural environment (clean air, food, and water) will greatly affect our social and economic environment. For instance, food shortages that result from increasing number of droughts due the climate change can result in higher prices in the markets, making it harder for low-income populations to access healthy, nutritious food.

SOCIAL DETERMINANTS FRAMEWORK

The following graphic illustrates another way to visualize the continuum of upstream, midstream, and downstream actions needed to eliminate the root causes of inequities, with a few sample strategies provided.



Adapted from BARHII website: www.barhaii.org

Below we describe a number of social determinants that contribute to inequities. Following each is a brief, non-exhaustive list of questions to help frame each factor and suggest how to apply the principles of equity and empowerment within each area. You will notice that we have included questions about staff and organizational development in addition to questions about community members and clients. To make transformative change, it is important to work both internally and externally.

Socioeconomic Status

- Can families in the neighborhood afford basic needs? If not, how could this affect the conditions you/your organization are tracking (health indicators, educational benchmarks, homeownership, etc.)?
- How do your organizational processes exclude people based on socioeconomic status? What can you/your organization do to identify and eliminate barriers to just and fair decision-making and planning processes?

Wealth and Income Development

- Are economically sustainable jobs available for all communities, specifically communities of color, immigrants, and refugees? How can they prepare for better access to these jobs?
- Are green jobs available to all communities, specifically communities of color, immigrants, and refugees? How can they prepare for an access these jobs?
- How does your organization prioritize economic justice, in such area as workforce development, contracting and providing greater opportunities for income development for all?

Education

- Are all community members with whom you work able to obtain high quality education as children, as adults, and as elders? If not, why?
- What organizational, local, state, and federal policies, processes, and procedures assist communities in obtaining high quality education? What gaps still exist?
- How can you, your colleagues, and your organization help ensure that schools and places of learning provide culturally responsive education?

Housing

- Can people of color, immigrants and refugees, and people living on low-income find housing in safe neighborhoods?
- How do policies protect (or not protect) renters from health hazards such as lead exposure and mold?
- What opportunities for quality home ownership exist for any population regardless of race/ethnicity and income?

Early Childhood Development

- Where do young children have the chance to learn and play in a safe environment? Where do they not, and why?
- How do children experience the negative effects of racial and other inequities in the community? According to what indicators?
- How can you / your organization support or sponsor community-capacity building efforts within the area of early childhood that are culturally specific and culturally responsive?

Transportation

- Do all people in the neighborhood have adequate access to public transportation?
- What transportation challenges do people face based upon income inequities? How do these challenges affect access to health care?
- How can current and new modes of public transportation better incorporate the voices of communities of color, immigrants, and refugees?

Access to Health Care

- Who has access to health services in the community? Who does not have access? Why or why not? What can be done to increase coverage for all residents to ensure health as a human right?
- How are health care organizations providing culturally responsive treatment and prevention services?
- How do health care organizations build capacity in communities to serve their own health needs?

Physical Environment/Land Use

- Is the physical environment safe for children?
- How do empty lots/abandoned areas in the neighborhood pose a threat to safety?

- Where geographically are certain populations more exposed to environmental toxins and pollution than others? What can be done to reduce such toxins and pollutants?
- What aspects of your program or project contribute to environmental pollution (transfer of resources and supplies, location in areas not conducive to public transit and multimodal forms of transport, etc.)? How can you mediate the negative impacts.

Respect and Dignity

- How does your organization demostrate respect for community members and promote deeper respect throughout the larger community?
- How do you know the community members with whom you work feel that they are respected in your organization and in the larger community?
- How does your organization demonstrate respect and value for staff who identify as members of communities most affected by inequities (paying particular attention to communities of color, immigrants, and refugees)
- How do you know they feel respected and valued in your department or organization?
- What policies, procedures, and practices in your organization protect the cultural values and ways of being that people from different communities bring?

Empowerment

- What barriers do empowerment exist in your organization or community?
- What strategies do you currently use to overpower staff and communities you work with?
- How do community members participate actively, as a community, in the broader society? Which community members participate, and why?
- What social and economic conditions change as a result of community action?
- How does your organization build community capacity to have agency over their lives?

Social Support/Social Networks

- How do community members provide support for their families and communities?
- How do high levels of stress affect community abilities to support each other?
- What robust, culturally specific networks support community members to lead healthy and fulfilling lives? How do these networks influence larger systems?

Public safety

- Do all neighborhoods have safe streets, yards, and buildings? Why or why not?
- How do unsafe neighborhoods negatively impact the overall health and success of community members you serve or staff working in your organization?
- Are children and teens exposed to violence in the neighborhoods? What are the demographics across income, race / ethnicity, age, gender, etc., of these children and teens?
- How do community members, most affected by inequities, relate to public safety officials?

Food Access, Safety and Security

- Do all communities have access to healthy and culturally specific food choices?

- What grocery stores exist in the neighborhood? Do communities of color, immigrants, and refugees have access to culturally specific stores and markets in their neighborhoods?
- Where is the distribution of local farmers markets? Of stores selling mostly processed and unhealthy foods? How does that correlate to the demographics in the area?

Access to Culturally-Responsive Activities and Services

- How can your organization actively value cultural heritage and integrate diverse cultural paradigms into organizational planning and decision-making?
- What safe places exist where culturally focused activities can take place?
- How are elders encouraged to pass on the knowledge and stories that are part of their heritage to the children of the community?

Race and Ethnicity

- What organizational processes exclude people based on racial and ethnic background? What might be some of the barriers to inclusion and meaningful engagement for these populations?
- Where is participation and involvement of communities of color, immigrants, and refugees working in your systems? How can your organization strengthen these processes?
- In regards to the other social determinants, how is your organization (1) tracking data based on race and ethnicity demographics; (2) making that data accessible to employees and staff; and (3) making decisions based upon that data.
- Where is our organization promoting culturally responsive policies and structures?

Recommendations for Lens Implementation and Application from an Social Determinant of Health Perspective

- Develop partnerships with programs doing equity work within other social sectors than the one(s) you work with currently. When working with individuals one-on-one or in small groups, it is sometimes challenging to consider how to integrate issues such as educational success, income development, and transportation. Perhaps your organization can develop a partnership with an organization working on one of these issues. Consider organizing a public forum highlighting the issue you are working with (for instance, overrepresentation in the community justice system), and integrate leaders from education or health who are also partnering with your organization.

- Ensure that messaging to people you serve is holistic and recognizes both the social and the individual influence on positive community outcomes. Population health clearly depends on both social and individual factors. Reflect on the messages you send to the people you serve. Is too much emphasis placed on the role of the individual in population health? Is it the other way around? Strive to communicate a balance and implement solutions accordingly.

- Prioritize and fund programs and partnership-building efforts that support cross-jurisdictional approaches. Organizations often prioritize direct services and individually based efforts to the detriment of successful partnership-building and collaborative strategies to eliminate duplication, share best practices and social technologies, and serve families and individuals in more holistic ways.

Individual Reflection Questions

- Think about your own experience and assets within housing, education, and other social determinants of health. How have such experiences and assets influenced the level of power you have or don't have in your organization or community?

- As you meet with community members you are working with or serve, consider how challenges or opportunities in other social determinant areas you are not directly working with might impact their situation. For instance, if you are working on improving library access for various communities you serve, what other social determinant areas (income/wealth development, education, transportation, etc.) could affect people's access? How does this knowledge move you to provide services differently or collaborate with external partners differently?

HIERARCHY AND ROOT CAUSES

"For every effect there is a root cause. Find and address the root cause rather than try to fix the effect, as there is no end to the latter." - James Baldwin

Connection to the Lens

The Equity & Empowerment Lens (E & E Lens) embodies principles of social and racial justice. According to Krieger (2001) this framing "explicitly analyzes who benefits from - and who is harmed by - economic exploitation, oppression, discrimination, inequality and degradation of natural resources" (p.55). In order to eliminate the root causes of inequity, organizations must identify and eliminate oppression and discrimination in policies, practices, processes, structures, and relationships between colleagues, and between their structures and community members. Values and beliefs shape discrimination; the decision to create a more just society is, at heart, a choice about values. Values that support social justice and equity include honesty, inclusion, innovation, solidarity and humility. Using this Lens will help your organization address root causes, and specifically, how they relate to racial and ethnic inequities, how they contribute to maintaining the unjust effects of hierarchy, and how best to level the playing field for all residents of Multnomah County.

In line with national equity efforts that define the three main drivers of inequities – racism, class oppression, and gender inequity – the general version of the Lens (see *Lens At A Glance, page 28*) will focus specifically on how to identify policies, procedures, and practices that contribute to institutional racism, classism, and sexism. Below we will briefly review the definition and role of hierarchy in maintaining systems of oppression and reinforcing existing root causes.

Background and Basics

Hierarchy is the categorization of a group of people according to ability or economic, social, or professional status. The negative effects of hierarchy manifest when there is an established dominant group that tends to enjoy a disproportionate share of assets, resources, and other areas of positive social value (Pratto, Sidanius & Levin, 2006). (See Concept Paper *on Social Determinants of Health and Health Inequity for more information*). As a population in terms

of race/ethnicity, Whites/Caucasians comprise the dominant culture and possess the most direct access to the power and resources of society. As a result, the paradigms present in our institutions often reflect and empower the normative cultural values of the dominant group, and simultaneously disempower non-dominant groups who may not share these normative characteristics. Denying the value of non-dominant characteristics reinforces hierarchy. The consequence of hierarchy is an inequitable distribution of access to the resources necessary to thrive and meaningful inclusion and participation of all community members (Burke & Eichler, 2006).

Wallerstein argues that being powerless, or lacking "control over one's destiny," is a core social determinant of health and success (as cited in Symes, 1988).

> Living in an environment of physical and social disadvantage - being poor, low in the hierarchy, under poor working conditions or being unemployed, subject to discrimination, living in a neighborhood of concentrated disadvantage, lacking social capital, and at relative inequity to others - is a major risk factor for poor health (p.73).

Root causes of inequities stem from institutionalized practices shaped by dominant culture values, attitudes, and beliefs. These values and beliefs influence perspectives about the nature of problems and solutions, thus directly affecting decision-making and planning. Therefore, it is vital to integrate non-dominant culture perspectives to ensure more robust policy and decision-making processes based on equity and empowerment (Burke & Eichler, 2006). In order to achieve consistent, fair, and just decision-making, it is vital to focus on shifting cultural norms and strengthening organizational capacity to embody the values of inclusion, fairness, honesty, and empowerment within organizations. (See Concept Paper on *Empowerment Theory and Practice* for more information).

The labels that we place on people – black, white, poor, rich, gay, straight, old, young, disabled, etc. – can prevent people from being valued fairly and from receiving equal treatment. Treating someone differently, unfairly, and unjustly because of their actual or perceived identity is an "ism." The "isms" can be broadly defined as conduct, words or practices which advantage or disadvantage people because of their relationship to dominant culture (Burke and Eichler, 2006). The practice is just as damaging in less obvious and subtle forms as it is in obvious forms, and is still called an "ism" whether it is intentional or unintentional (DeAngelis, 2009). Some of the most common "isms" are racism, classism, sexism, ageism, heterosexism and disablism.

The E & E Lens is designed to help organizations identify and eliminate root causes, including institutional racism (also known as structural racism or systemic racism). Institutional racism is "the network of institutional structures, policies, and practices that create advantages for White people and discrimination, oppression, and disadvantage for racialized people [communities of color, immigrants, and refugees]" (Lopes and Thomas, 2006, p.270). Such racial discrimination

can occur by governments, corporations, religions, educational institutions or other large organizations with the power to influence the lives of many individuals. The following research studies highlight the racist impact of practices, whether directly or indirectly driven by institutional policies. In a 2004 study, researchers Bertrand and Mullainathan discovered widespread discrimination in the workplace against job applicants whose names were perceived as "sounding black." These applicants were 50% less likely than candidates perceived as having "white-sounding names" to receive callbacks for interviews. In another study, a sociologist at Princeton University sent matched pairs of applicants to apply for jobs in Milwaukee and New York City, and found that black applicants received callbacks or job offers at half the rate of equally qualified whites (Bonikowski, Pager, & Western, 2009). In both examples, the negative influence of hierarchy manifests in the categorization of job applicants who were perceived to be a member of a non-dominant group. The result was decreased employment opportunities for this group and thus the perpetuation of inequities.

As organizations work to identify and eliminate policies and practices that support racism, classism, disablism and other forms of discrimination, it is also vital to identify factors that contribute to keeping them in place. Not only does hierarchy play a significant role in the perpetuation of racist policies and practices in organizations, but the experience being a member of a non-dominant group can also decrease positive mental health (See Concept Paper on *Positive Mental Health & Equity*). In a surprising learning, researchers in the famous Whitehall Study discovered that social standing within an institution was connected to health risk factors. While the researchers had originally assumed that executives at the top of the hierarchy experienced increased health risks as a result of high stress, what they discovered instead was the opposite. With each employment grade level decrease, the risk factors increased. Sir Michael Marmot, who was featured in the health equity PBS documentary series Unnatural Causes, and has done extensive research on the influence of social standing on health outcomes, described the results more specifically in an interview for the film:

> The higher the grade, the better the health. The lower the grade, the higher the mortality rate and the shorter the life expectancy, in this remarkably graded phenomenon. So if you were second from the top, you had worse health than if you were at the top; if you were third from the top, you had worse than if you were second from the top – all the way from top to bottom (Unnatural Causes, p.2).

Not only did this study reveal the negative health effects of social stratification, but also established hierarchy as a critical determinant and root cause. Although none of the participants lived in poverty (another potential health risk factor), simply experiencing lower levels of social and professional status within a workplace hierarchy significantly impacted health outcomes. Marmot explained that people at lower levels of the hierarchy experienced less autonomy, control and empowerment, also associated with decreased health. These findings align with research reviewed for the Concept Paper on *Empowerment Theory and Practice* and

a comprehensive study of major world economies that revealed societies with higher rates of homicide, infant mortality, obesity, teen pregnancy, depression and incarceration also tend to have greater social inequality (Hofrichter, 2006).

Hierarchy can have direct, insidious effects on the health and well being of our communities. As institutions we must recognize the existence of hierarchies and construct policies, practices, and procedures that mitigate the negative impacts on people. The *In Wealth and In Sickness* section of Unnatural Causes describes how society is constructed very much like a ladder. Some natural stratification occurs in society. However, we can decrease the space between the rungs by making positive changes to our structures, policies, and environments. Creating and maintaining empowering spaces that recognize, celebrate, and utilize multiple cultural ways of being is essential. Not only does this intentional practice embody the spirit of equity and inclusion, but it can also reduce the harmful results of social stratification and hierarchy.

It is also important to understand that one's place in the hierarchy shifts by time and place; we all find ourselves in different levels within hierarchies by gender, class, age, ability, religion, language, ethnic background and sexual orientation, to name just a few. We must recognize the existence of multiple and shifting identities within communities and ourselves. We must recognize that the experiences of women of color are different from those of men of color based on sexism, and are also different from the experiences of White women based on racism. Finally, we must recognize that hierarchies can exist within hierarchies. Within the gender hierarchy, some groups of men can have more dominance over other men based on income and race/ethnicity. Within the race/ethnic hierarchy, heterosexual men and women of color can be dominant over individuals who do not fall into normative definitions of sexual identity.

What keeps hierarchy in place?

The tie between hierarchy and the five faces of oppression

Hierarchy is a key characteristic of organizational structure and functioning. When hierarchical structures are oppressive, however, the gap between health and success of those at lower social status levels compared to their counterparts at higher levels is significant.

Organizations and decision-making bodies have the power to either create the opportunities or reify the constraints that can lead to population success or decline. Systemic limitations and everyday practices can inhibit the ability of individuals and groups to develop and exercise their capacities, and express their needs, thoughts, and feelings. (Young, 2011)

> In this extended structural sense oppression refers to the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms-- in short, the normal processes of everyday life. (p.41)

When applying a Lens, it is critical to become familiar with *how* people are negatively affected and oppressed within structures. Young's framework (2011) outlining the five faces of oppression is a great way for Lens participants to understand *how* populations are affected by the root causes of inequities, and how to facilitate improved systemic solutions that dismantle existing oppression and lead to greater equity and racial justice. Young states that no singular oppression is more fundamental than any other. The areas below simply function as a tool for determining how individuals and groups experience oppression, and do not comprise a full theory of oppression.

- **Exploitation:** This occurs when institutional conditions hinder the capacity of employees to develop themselves and support the development of others. When populations are being exploited, larger gaps exist between workers and employees who can accumulate more, and those who suffer from poverty, material deprivation, and a loss of control. For example, when an organization lacks focus on ensuring greater representation of communities of color in leadership roles, compared to seeing and accepting such representation only in lower levels of the organization, it contributes to exploitation. As noted by Sandra Hinson (2008), "the wage and wealth gap between the wealthy owners and managers, on the one hand, and the masses of working people, on the other, is an indication of the degree of exploitation that exists in society."

- **Marginalization:** Young (2011) suggests this form of oppression is perhaps the most dangerous. People who are marginalized are those who the system of labor cannot or will not employ. In addition to material deprivation, marginalized populations experience exclusion "from useful participation in social life" (Young, p.50) and then are often demonized and for their lack of participation. So much of society's recognized activities occur via social coordination and cooperation. Social structures and processes that exclude people from participating are unjust, and can lead to deprivation of the cultural conditions necessary to thrive. By not engaging communities most affected by inequities in planning and decision-making, and those specifically often excluded in labor (people living with disabilities, for instance), an organization exhibits marginalization.

- **Powerlessness:** Powerlessness is experienced when people in societies do not regularly and meaningfully participate in making decisions that affect their working, social, and political lives -- their daily lives. (*National Association for City and County Health Officials*) In a workplace, those who experience powerlessness have little or no autonomy around work tasks, cannot exercise their creativity or judgment fully, and overall do not command respect compared to others (Young, 2011). Structures and policies that contribute to powerlessness can further prohibit individuals from attaining higher positions and create poor working and living conditions (that can lead to decreased spiritual, mental, physical health) (See Concept Paper on *Relational Worldview*).

- **Cultural imperialism:** Cultural imperialism is the manifestation of negative hierarchy. When policies, processes, and structures value a dominant group's (the group that as a population has the most power and control over decision-making and processes affecting others) experience and culture, and establish it as the norm, cultural imperialism takes place. People who experience this form of oppression are made invisible, and labeled by stereotypes, affecting their capacity to thrive and actively participate in political and social decision-making. Organizational structures and practices that fail to recognize, hold up, and utilize a variety of perspectives (such as cyclical, relational, systemic, feminist, holistic, to name a few) in addition to dominant perspectives perpetuate cultural imperialism and oppression.

- **Violence:** Systematic violence manifests when certain groups "live with the knowledge that they must fear random, unprovoked attacks on their persons or property, which have no motive but to damage, humiliate, or destroy the person" (Young, p.61). For groups living with such fear, they share the daily knowledge with their group members that they are more susceptible to violation based solely on their group identity. While the particular acts of violence are horrible to encounter or witness; what makes this violence also a form of oppression is the social context that normalizes these acts. Organizational structures, communications, policies and practices condoning such violence (and it is critical to mention that 'violence' is comprised of both acts on the physical as well as mental and emotional) must reform via analysis, new recommendation-setting, and actual change. To combat violence, major changes in social and cultural norms, stereotypes, and policies supporting violence must happen.

Exploitation, marginalization, powerlessness, cultural imperialism, and violence manifest in different ways, visible and invisible, direct and indirect, intentional and not intentional. However, we must understand that when any of these conditions are present within our organization we are perpetuating long-standing oppression. Moving toward equity and racial justice requires that we recognize how our policies, procedures and practices play into each of these conditions and take active steps to dismantle structures that do not promote the well being of all people. Different groups and individuals within those groups can experience combinations of these five oppressions in varying ways. As Hinson (2008) states:

> Most, if not all, working people experience exploitation. Racism runs through each of these kinds of oppression, intensifying the experience of exploitation, powerlessness, cultural dominance and everyday violence. Gay men as a group experience cultural dominance [imperialism] and the threat of violence, but they may not necessarily experience other forms of oppression based on their class and occupational status. White professional women experience cultural dominance [imperialism], fear of sexual violence, and a degree of powerlessness-- especially if they constantly have to prove themselves worthy of their status. (p.85)

The Equity & Empowerment Lens (E & E Lens) asks users to take a passionate stance to promote equity and social justice. To that end, the Lens asks us to reflect deeply and honestly about who is affected by a particular policy or program, and how. (See the *Lens At A Glance, Questions #3 and 4, p.30*) Young's framework on the five faces of oppression provides a robust framework for articulating the detrimental impact of root causes as they appear in institutional structures and practices. As presented in the E & E Lens, the five faces of oppression is also a tool for organizations to initiate conversations, strategic planning, and decision-making that truly reflects a vision for equity and racial justice. Lens solutions call for immense transformation and challenge organizations to eliminate the negative impacts of hierarchy and other root causes of inequity.

Recommendations for Lens Implementation and application from an Empowerment Perspective

- **Acknowledge the existence of institutional hierarchy.** Change does not happen amidst denial. We know that the further down the hierarchy an individual or group exists the more they experience stress.
- **Make a commitment to examining how institutional hierarchy functions**, and mitigate the negative impacts.
- **Recognize when viewpoints from the dominant paradigm are privileged** and/or more readily adopted than viewpoints from non-dominant paradigms. Using a racial justice focus, integrate non-white paradigms into the work.
- **Intentionally include perspectives from multiple paradigms** in every discussion and decision-making process.
- **Adapt your structure and timeline** to integrate communities who value greater collaboration and deeper dialogue processes.
- **Examine where and how multiple areas of oppression exist in relation to the experiences of people affected (the existence of intersectionality)**. When looking at the impact of a program on racial and ethnic populations, think also about how the program is affecting women and children of color, immigrants and refugees. Ask yourself how are people who identify as LGBTIQ who are also members of communities of color, immigrant, and refugee populations being affected?
- **Engage and value the perspectives of employees** from all levels or professional classes, top to bottom.

Individual Reflections Questions

- Communities most affected by health inequities are most often from non-dominant cultures. What can you or your colleagues do to improve inclusion of non-dominant cultures' viewpoints in goal setting, implementing, and evaluating your work?
  - In relation to racial justice, how can communities of color, immigrants, and refugees be further included into all aspects of the work?

- What is your organizational structure? What hierarchies exist within that organizational structure, and how do they play out in the daily interactions between workers of different levels?

- How do you, specifically, and your organization, generally, perpetuate negative hierarchies? Think about specific examples, and explore how you could shift policies, practices, or procedures to increase the empowerment of all people.

- What types of stressors might your staff be experiencing? What can you do to mitigate the external stressors in your workplace? Are responsibilities assigned inequitably? If so, can responsibilities be redistributed to allow for more equity within your group?

CONCEPT PAPER #3

RELATIONAL WORLDVIEW

"Humankind has not woven the web of life. We are but one thread within it. Whatever we do to teh web, we do to ourselves. All things are bound together. All things connect." - Chief Seattle Duwamish

Lead Author: Terry L. Cross, MSW, ACSW, LCSW (Seneca Nation of Indians) Terry Cross is an enrolled member of the Seneca Nation of Indians and is the developer, founder, and executive director of the National Indian Child Welfare Association.

Connection to the Lens

The Equity & Empowerment Lens (E & E Lens) purposefully includes the relational worldview as a foundational model for this work because it supports the World Health Organization's holistic definition of health, and also speaks to models of population health and success deeply espoused by several communities of color in addition to Native/Indigenous populations. The four quadrants of the relational worldview, based on context, spirit, body, and mind embody the principles that guide the Lens. They speak to the collective nature of health across various sectors, and to the power of a respectful relationship between self and others, and self and surroundings. The relational attributes of this paradigm support and highlight the inclusion of both social and individual determinants of health, the significance of social supports/networks as well as respect, dignity, social determinants, and the importance of all three areas of sustainability (environmental, economic, and social).

Background and Basics

The relational worldview provides a way to help us understand the holistic scope of resources that lead to positive population health and overall outcomes. This includes the necessary mental, physical, spiritual, and contextual resources that, when considered as a whole, can lead to positive health. The model embodies key Lens values such as balance, inclusion, and empowerment. (See Concept Paper on *Empowerment Theory and Practice*). It also speaks to the intersection of the various social and individual areas (environment, economic, mental, physical, spiritual, etc.) that come together to either negatively or positively

affect population success. Additionally, the model was deliberately included to represent a worldview founded on concepts and processes supported by many communities of color.

The National Indian Child Welfare Association (NICWA) developed the relational worldview model we share here. It is a reflection of the Native thought process and concept of balance as the basis for health, whether that is an individual, family or an organization. The relational worldview does not just apply to indigenous population health, but is also a model of health in many communities of color who prioritize the importance of a balanced relationship between land, resources, people, spiritual faith, and power.

In today's society, there are two predominant worldviews - linear and relational. The linear worldview is rooted in European and mainstream American thought. It is logical, time-oriented and systematic, and has at its core the cause-and-effect relationship. In contrast, the relational worldview sees life as a harmonious relationship where health is achieved by maintaining balance between the many interrelating factors in one's circle of life.

The relational worldview, sometimes called the cyclical worldview, is a holistic model of health, grounded in indigenous teachings and realities, that has served as an exemplar and set of practices to ensure the sustainability of their populations and accompanying ecosystems for thousands of years. It is intuitive, non-time oriented and fluid. The balance and harmony in relationships between multiple variables, including spiritual forces, make up the core of the thought system. Every event is understood in relation to all other events regardless of time, space, or physical existence. Health exists only when things are in balance or harmony.

The individual relational worldview model can be best illustrated with a four-quadrant circle.

The four quadrants represent four major forces that together must come in balance. One quadrant does not exist without the other three, and all quadrants work in a symbiotic manner. These quadrants represent context, mind (mental), body, (physical), and spirit (spiritual).

- Context includes culture, community, family, peers, work, school, socioeconomic conditions, and social history.
- Mind includes our cognitive processes, such as thoughts, memories, knowledge, and emotional processes such as feelings, defenses, and self-esteem.
- Body includes all physical aspects, such as genetic inheritance, gender, and condition, as well as sleep, nutrition and substance abuse.
- Spirit includes both positive and negative learned teachings and practices as well as positive and negative metaphysical or innate forces. For the purposes of the Lens, 'spiritual' is being defined by its late Latin root, 'espiritus' or 'spirare,' meaning 'to breathe into.' Essentially, the spiritual quadrant has to do with that which brings passion, breath, or purpose into people's lives.

In the relational worldview these four quadrants are in constant flux and change. We are not the same person at 4pm that we were at 7am. Our level of sleep is different, our nutrition is different and our context is different. Thus, behavior will be different, feeling will be different and our context is likely different. The system constantly balances and re-balances itself. If we are able to stay in balance, we are said to be healthy, but sometimes balance is temporarily lost.

In the linear worldview, the person owns or is the problem. In the relational worldview, the problem is circumstantial and resides in the relationship between factors. The person is not said to have a problem but is said to be out of harmony. Once harmony is restored, the problem is gone. In the linear model, we are taught to treat the person, and in the relational worldview, we are taught to treat the balance or imbalance.

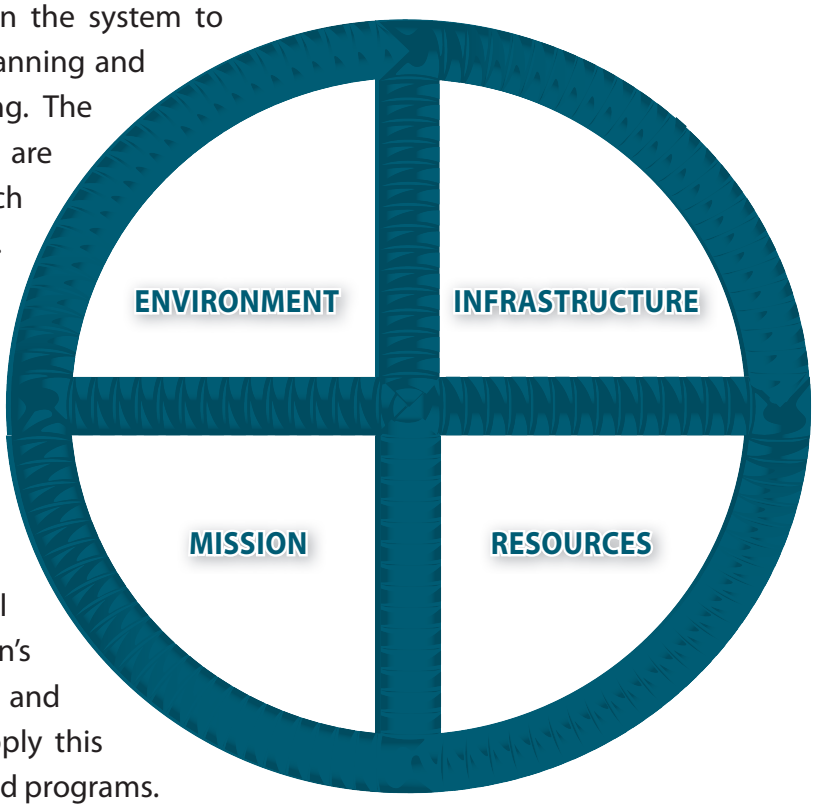
Change can occur by addressing one quadrant. However, the belief is that by attending to one, the change agent is actually opening a portal to all the others because they exist interdependently. It is the consideration of the interdependence of the relationships among all factors that give understanding. It is the constant change and interplay between various forces that accounts for resilience. We can count on the system's natural tendency to seek harmony, and we can promote resilience by contributing to the balance.

The glue that holds the four quadrants together is the presence and practice of being in respectful, inclusive relationship to one another, to an individual's and a community's purpose in life, and to the environment.

Relational Worldview Applied to Organizations

The relational worldview is a model and paradigm that we can apply to different structures, programs, and policies. The model can be applied to the individual and population perspective

depicted above, and can also be translated to the level of the organization, or a system. In this application, the 'context' applies to the 'environment' of the organization. The 'mind' applies to the infrastructure necessary in the system to do the work, such as strategic planning and culturally proficient programming. The 'body' refers to resources that are vital to get the work done, such as fiscal and human resources. And 'spirit' corresponds to the mission, purpose, and vision of an organization, or that which drives the work, and sets purposeful goals.



In addition to consciously integrating the relational worldview into our organization's work with community members and participants, it is vital to also apply this model within our departments and programs. By doing so, we adhere to the guiding principle of equity stating that in order to reach our outcomes, we must intentionally focus our equity-related efforts on both the internal and external to bring about systemic, sustained change.

Recommendations for Lens Implementation and Application from an Relational Worldview Perspective

- When addressing how a policy positively and negatively affects populations experiencing inequities, paying particular attention to communities of color, immigrants and refugees, and consider analyses of such impacts across a population's or an individual's mental, physical, spiritual, and contextual spheres.
  - **Mental:** How is the population's mental health positively or negatively affected by the policy/program/practice? (their thoughts, emotional processes, etc?) (See Concept Paper on *Positive Mental Health*)
  - **Physical:** How is their physical health affected, and by what (sleep, nutrition, ailments, genetic inheritances, sexual health, etc.)?
  - **Spiritual:** Does the population or individual feel a sense of passion and purpose in what they are doing and in how they are living their lives?

- **Context:** What contextual factors in the population's social history, economic realities, culture, work environment, educational experiences (early childhood included), etc., add to positive or negative effects on health and success? (See Concept Paper on *Social Determinants of Health*)

When creating actions/strategies, what can you include that improves relationships:

- Person to person? Person to organization?
- Person to their own talents and purpose?
- What are a few strategies that increase the sense of value or respect that people you work with (colleagues, community partners) feel in relation to working with you?
- What are a few strategies in programming that support connecting the contextual to mental, physical, or spiritual factors?
- What are key barriers to identifying areas of change and creating recommendations in a non-siloed, relational manner?

Individual Reflections Questions

- How do you identify with both the linear and relational worldview?
- How does that worldview or model manifest in what you value in relationship with colleagues, community partners, family?
- In the work you do with community members, how does including the realm of context (education, culture, family, peers, socio-economic factors) affect any recommendations for positive change or treatment?
- When looking at the health and retention of the communities of color, immigrants and refugees within your organization, how does considering the mental, spiritual, and contextual spheres have a positive effect on internal organizational processes and evaluation?

CONCEPT PAPER #4

EMPOWERMENT THEORY AND PRACTICE

An empowered organization is one in which individuals have the knowledge, skill, desire, and opportunity to personally succeed in a way that leads to collective organizational success." - Stephen Covey

Lead Author: Noelle Wiggins, EdD, MSPH, is the founder and manager of the Community Capacitation Center at the Multnomah County Health Department and Adjunct Assistant Professor of Community Health at Portland State University.

Connection to the Lens

Working in a way that promotes the empowerment of individuals, organizations and communities most affected by inequities is a practical method for achieving health equity. The Equity & Empowerment Lens (E & E Lens) itself uses and integrates empowering strategies for employees and community members leading to more diverse representation in the resulting recommendations, and most importantly, the inclusion of community voice most affected by inequities. A key resource for the Moving into Action section is the Empowerment Assessment Tool (see Appendix D) that provides concrete examples of empowering strategies to integrate into recommendations.

We can create empowering strategies simply by improving our individual interactions with one another and consciously activating an equity-based inquiry within our thinking. Ask yourself, how can we avoid hierarchy that creates oppression? (See Concept Paper on *Hierarchy and Root Causes*) How can we be more culturally humble in how we approach and partner with communities of color, immigrants, and refugees? Individual actions make up the relationships that contribute to the strength, resiliency, and effectiveness of organizations.

Background and Basics

Over the last 30 years, it has become increasingly clear that persistent variance in the health status of different communities are the result of environmental, social, and economic conditions. A number of public health researchers have proposed

that the common thread running through all these adverse social conditions is powerlessness. On average, in any relationship between two groups of people, those who have more control and power have better health, while those who have less control and power (vis à vis the other group) have worse health. If powerlessness is the root cause of health inequities, then it follows that the solution is empowerment.

The idea and practice of empowerment grew out of the work of community organizers such as Saul Alinsky, who proposed that oppressed people needed to build "power coalitions" to counter-balance the power of institutions. Although Alinsky focused mostly on governmental institutions, empowerment theory and practice applies to all types of institutions and structures. Many civil rights, international solidarity, and other transformative social movements around the world have worked to eliminate unjust power structures (see Concept Paper on *Hierarchy and Root Causes*) Similarly, much of the current equity work focuses on examining and eliminating the root causes of inequity.

The concept of empowerment entered the social sciences fields via community psychology in the 1980s. Empowerment was introduced as an alternative to the paternalistic philosophy and practice that had guided social services since the nineteenth century. Subsequently, the concept has been used within occupational and stress research and public health.

In the media and in public discourse, the term "empowerment" is often misused to refer to purely individual-level changes, or to imply that one person can "empower" another. In public health, on the other hand, empowerment is viewed as "a process of promoting participation of people, organizations, and communities towards the goal of increased individual and community control, political efficacy, improved quality of community life and social justice" (Wallerstein, 1992, p. 197-205). In public health, empowerment is something you do for yourself with your community, although outsiders to a given community can play a role in creating the environmental and institutional conditions where empowerment becomes more possible. Empowerment is both a process and an outcome.

This Lens is different from other equity lens in that it explicitly addresses the connection between equity and empowerment. Equity is an ideal, a goal. Community empowerment (to distinguish it from individual empowerment) is the vehicle for achieving equity in process and outcome (Wiggins, Johnson, Farquhar, Michael, Rios & López, 2009).

The word "empowerment" can be threatening, since it may suggest that some people will have to give up power so that others can have more. In some cases this will be true. But the concept of empowerment as used here is based on the idea that power is not a finite commodity.

There is enough to go around, as long as some people don't take too much. Ron Labonte has called empowerment a "fascinating dynamic of power given and taken all at once, a dialectical dance . . ." (Bernstein, Wallerstein, Braithwaite, Gutierrez, Labonte & Zimmerman, 1994, p.285)

How can we create conditions in our organizations that promote the empowerment of individuals and communities? One way is to begin thinking about power as something we exercise with others, rather than over others. Hierarchy serves the function of maintaining organization within our structures (See Concept Paper on *Hierarchy and Root Causes*). However, when the 'power over' orientation leads to unfair and unjust policies and practices, we need to reset and reprogram our organizations using 'power with' actions and processes. In order to actualize equity, empowerment needs to occur at three levels (individual, organization and community). If we only focus on individual empowerment (by, for example, building a client's skills to advocate for a particular issue), the outcome will be increased self-efficacy for that individual. However, when we support the empowerment of groups and communities, we move more systemically towards equity. The underlying conditions that cause health inequities won't change unless empowerment occurs at all three levels.

Practicing cultural humility and using culturally responsive communication strategies are two ways to support empowerment at the individual level. Cultural humility is vital to identifying and eliminating social injustices, and is defined as maintaining a lifelong commitment to self-reflection and openness to learning, focusing on understanding one's own assumptions and beliefs in practice (Tervalon & Murray-Garcia, 1998). Culturally responsive communication recognizes and values multiple identities, ways of being, and communication styles. One strategy to strengthen organizational empowerment is to authentically engage employees who experience inequities in the organization's decision-making processes. Organizational empowerment can be either vertical (increasing democratic processes within the organization) or horizontal (increasing the organization's empowerment through the support of other organizations). At the community level, promoting empowerment means building capacity within communities. Public agencies can do this by providing information, acting as a convener to bring community groups together with other organizations (such as universities), using and teaching empowering strategies (such as popular education), and building skills and leadership within communities (for example, by training Community Health Workers).

Recommendations for Lens Implementation and Application from an Empowerment Perspective

- When applying the Equity and Empowerment Lens (E & E Lens), it is important to "walk our talk" around empowerment. This means involving people most affected by racial/ethnic and

other inequities and using practices that promote trust and safety, so that all participants feel comfortable sharing their perspectives and opinions.

- Create conditions that promote participation by a wide range of people. This may mean reducing workloads; providing childcare, interpretation, and/or transportation; and using culturally responsive frameworks and communication styles.
- On an on-going basis, seek to determine whether or not staff and community members feel valued, respected and included in decision-making. Surveys, focus groups, and employee-supervisor meetings are just a few ways to obtain this input.
- Utilize The Empowerment Assessment Tool (Appendix 4) to help promote empowering behaviors and processess in an explicit way.

Individual Reflection Questions

- Empowerment begins in our one-on-one interactions. Thinking about our interactions with community partners, we can ask ourselves a series of questions:
  - How can I avoid hierarchy that creates oppression? (See Concept Paper on *Hierarchy and Root Causes*)
  - How can I approach and partner with communities of color, immigrants, and refugees in ways that reflect cultural humility?

- Individual actions shape relationships that contribute to the strength, resiliency, and effectiveness of organizations. Consider:
  - What are the implications of acting in a hierarchical or disempowering fashion on the quality of your partnerships?
  - Every time you sit with a co-worker, think about the implications of your interaction considering your position in the hierarchy, and what you need to do in order to avoid oppression. *Know that it is possible that the answers to your question may not match the answers of the person with whom you are interacting.*
  - Ask yourself: What barriers to empowerment exist in your organization or community, especially as they relate to the exclusion and unjust treatment of racial and ethnic communities?
  - How can you eliminate these barriers?

CONCEPT PAPER #5

THE LENS AS A QUALITY IMPROVEMENT TOOL AND PROCESS

"There are two primary choices in life: to accept conditions as they exist, or accept the responsibility for changing them." - Denis Waitley

Lead Author: Dr. Robert Johnson, MD is a Quality Manager with the Community Epidemiology Services group. He acts as Deputy Director for Community Health Services and is a retired Captain in the US Public Health Service.

Connection to the Lens

At its core, the Equity and Empowerment Lens (E & E Lens) is a reflective quality improvement tool and set of processes designed to change the way we do business, leading to improved outcomes for all members of our community and the elimination of root causes of inequities. In order to approach quality improvement in our Lens application and integrate inclusion and empowerment, we refer to 'customers' in this work as 'participants' and 'community members.' This shifts our focus from primarily business transactions involving people as consumers in relation to their providers/educators/etc., to viewing change as a relational process that occurs through the following actions:

- Supporting respectful and empowering relationships between community members and their providers, or employee to employee; and
- Analyzing and amending power structures to decrease negative effects of hierarchy and further inclusion of communities most affected by inequities.

The E & E Lens provides a space for analysis on how well a policy, program, or practice:

- Meets the needs of the community it serves (internal and external to the organization) by incorporating culturally responsive and empowering strategies;
- Makes decisions and conducts planning processes that integrate staff and community voice (paying particular attention to communities most affected by inequities); and
- Institutionalizes empowering strategies and outcomes leading to greater equity.

During the process of Lens application and analysis, we identify goals to accomplish and then further specify how to measure equity related improvements. Lastly, we plan, try, observe, and integrate the "Model for Improvement" adopted by the Health Department. The Lens, at its core, functions as a quality improvement tool because it assesses how well a program or policy addresses the root causes of inequities, identifies actions, and integrates results.

Background and Basics

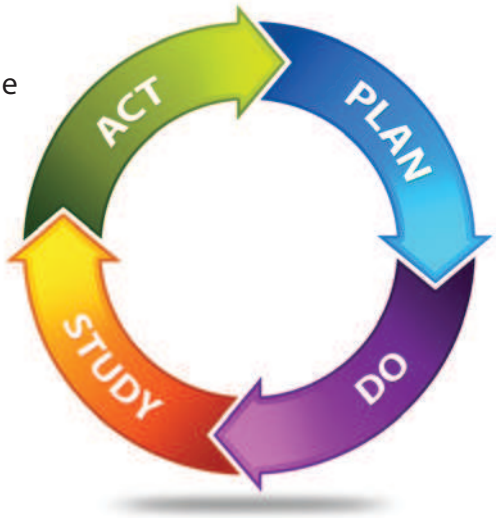
Quality improvement has its roots in the business, manufacturing and economic fields, focusing on efficiency and customer-satisfaction. Industry quality improvement efforts have a long history in the United States and around the world with icons like W. Edwards Deming, Walter Shewhart, and J.M. Juran leading the movement.

According to Deming, to comprehend the workings of a system and thus be able to improve its efficacy, we must see the system as a dynamic entity unto itself. This recognition helps us understand the interdependencies and interrelationships among all components and increases the accuracy of our predictions about the impact of changes throughout the system. Deming offered practical approaches to improving quality and productivity that shifted the focus of managers from trying to change people to instead examining and changing processes and systems. The goal of the resulting redesign was improved output and reduced cost.

The integration of quality improvement in public health has been occurring in one form or another for decades. Early efforts focused on building organizational capacity (such as staff training, leadership development, strategic planning) but in the early 1990's the focus shifted to performance measurement. Currently, organizations utilize quality improvement in a variety of ways. The "balanced scorecard" has become a tool for programs to measure their success and performance in multiple areas such as customer satisfaction, financial indicators, business processes, learning and growth. Other processes such as Value Stream Mapping and Cause and Effect diagramming have become common strategies to examine organizational practice. Future quality improvement efforts look to integrate such tools and processes to act in a more proactive and thorough manner across departmental levels (Leonard, 2010).

According to researchers in the field, quality improvement is the "Continuous and ongoing effort to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community" (Riley, Moran, Corso, Beitsch, Bialek, Cofsky, 2010, p. 6). Tying the Lens application process to quality improvement efforts has proven very successful during educational sessions on the Lens. Quality improvement presents the need for a clear focus on implementing recommendations that eliminate inequities and lead

to more successful population outcomes (health, education, transportation, etc.) and greater community satisfaction.



To make the work of quality improvement accessible and focused on basic, key components that lead to organizational learning and transformation, we must begin by repeatedly asking ourselves and colleagues key questions outlined by the Community Health Services Program Performance and Quality Improvement Workbook (2011): What are we trying to do? How well are we doing it? Could we do it better? Are we making people/communities better by doing what we are doing?

Recommendations for Lens Implementation and Application from a Quality Improvement Perspective

The Lens is only as useful and beneficial as the quality of the processes used to implement it and then institutionalize resulting recommendations/actions.

- **Be clear about roles.** The effectiveness of a Lens application depends upon the capacity of the people using it. Encourage your team (management and staff) to:
  1. apply the Lens to their own work,
  2. make resulting improvements to the work, and
  3. improve professional development according to the principles of the Lens.

- **Apply quality improvement processes to your own work and leadership strategies**. Leaders can best support system-wide change by using the tools themselves, and by creating the conditions necessary to implement equity-based recommendations and deepening professional development.

- **Share information and complete assessment in groups**. Quality improvement researchers recommend cross-organizational and cross-occupational communities of practice that share knowledge about the quality agenda (Bartunek, 2011). This calls for leaders to have a strong message about the importance of the Lens application and integration, and offer opportunities for staff to share, work through, evaluate, and disseminate information and outcomes.

Individual Reflection Questions

- What do you and other staff need in order to create a conducive environment to apply, implement and integrate the Lens?

- Where do opportunities to improve the quality of your work to identify and the root causes of inequities experienced by our communities?

- If you/your organization didn't address these inequities, how will this impact your program/policy/processes?

CONCEPT PAPER #6

SUSTAINABILITY, CLIMATE HEALTH, AND EQUITY

"The history of this country is one of struggles to achieve equity, justice and opportunity. Each generation has faced this political challenge. In this moment we are confronted with the real possibility of climate change stealing the American ideal of opportunity from not just the low-income American, not just Indigenous Peoples, not just the person-of-color in America, but all Americans (WEACT)."

Lead Author: Kari Lyons-Eubanks is a Policy Analyst for Multnomah County Environmental Health Services and focuses on ensuring that climate-related policies consider health equity and the health impacts of environmental justice programs. Tim Lynch has a BA in Political Science and serves as the Energy & Climate Coordinator of the Multnomah County Office of Sustainability. Tim draws on over ten years of sustainability and public policy experience to advance innovative climate change and energy initiatives in the community.

Connection to the Lens

The Equity & Empowerment Lens (E & E Lens) utilizes the framework of people, place, power, and process to envision and implement cross-sector solutions that will build and sustain the resources and conditions necessary for existing and future populations to thrive. Research shows that communities of color, immigrants, refugees, and people living on low-income bear the brunt of current and future climate-affected events and situations. To achieve equity in our sustainability and climate change work, we must increase the sense of control communities of color and low-income populations have within their social, economic, and political settings. Simultaneously, we must transform our institutions to create the space for meaningful community engagement in decision-making and resource allocation processes (See Concept Paper on *Empowerment Theory and Practice*). An E & E Lens application is the first step in a larger commitment to institutional transformation. In order to eliminate root causes of social injustices, organizations must identify and eliminate oppression and discrimination as they appear in policies, programs, practices, and structures.

Background and Basics

The mission of Multnomah County's Office of Sustainability is that all residents of Multnomah County have the right to a sustainable and healthy environment. Sustainable development meets the needs of the present without compromising the ability of future generations to sustain their own needs. Global trends in the environment also impact our local community. For example, according to many local climate projections our summers are likely to have hotter average temperatures and an increased number of extreme heat events than in years past. Several consecutive days of temperatures of 90 degrees Fahrenheit or higher and elevated nighttime lows in the 60s and 70s pose a risk to populations without access to air conditioning, well-insulated homes or cooling centers. Combined with the urban heat island effect – urban areas that retain heat due to a higher quantity of buildings and paved surfaces and less vegetation – that already impacts certain communities, Multnomah County's population as a whole will be at increased risk of heat related illness and mortality as the global climate changes. Communities with the fewest resources to prepare will disproportionately feel the burden of these shifts. Climate health is one of the most significant sustainability challenges and transformative issues of the 21st century (Costello, A. et al., 2009). As we see manifestations of climate change, ranging from temperature and precipitation to air quality, and increases in frequency and duration of natural hazards – we see the serious and far-reaching implications for present and future generations.

Policies and projects that have sustainability and climate change at the core of their purpose strive to (Multnomah County Office of Sustainability):

- Create a future where communities, commerce and nature thrive together in harmony.
- Use resources efficiently by recognizing the interconnections among community well being, land use, building, transportation, affordable housing, food systems, the natural environment, and public health and by adopting a holistic long term view of our investments which includes social and environmental costs.
- Ensure that ecosystem impacts and the costs of protecting the environment do not unfairly burden any one geographic or socioeconomic sector.
- Ensure healthy communities by celebrating diversity and considering the impacts of the root causes of public health in policies and programs, such as providing safe neighborhoods, advocating for a living wage, and ensuring access to education for all.
- Consider the public health co-benefits of our efforts so that we improve the health of all people while creating a healthy environment, ecosystem and economy.

Sustainability is often tied to three distinct goals:

- To live in a way that is environmentally sustainable or viable over the long term;
- To live in a way that is economically sustainable, maintaining living standards over the long-term; and

- To live in a way that is socially sustainable, now and in the future (Dillard, J., Dujon, V. & King, M. C., 2009).

The works starts with us as people and with our social processes. The economy supports the social realm, both of which depend upon the constraints of environmental resources.

Sustainability efforts are now shifting away from an exclusive focus on environmental stewardship, and towards an understanding of the deep interconnections between people, place, power, and process in relation to environmental impacts. Our social structures, institutions, and processes are greatly influenced by economic conditions, drivers, and opportunities. When environmental conditions are positive, healthy and in balance, we sustain beneficial social and economic conditions for all people.

Why is climate change such a pressing issue requiring critical transformative change? To bring home the sense of urgency, consider the following major negative health impacts:

- **Asthma, respiratory allergies, and airway diseases** will increase as people are exposed to more allergens like pollen, air pollution, and dust.
- **Cancer** will likely increase as people are exposed to more and stronger ultraviolet radiation from the sun.
- **Cardiovascular disease and stroke** will increase due to heat stress, airborne particles, and changing ecology of infectious agents connected to cardiovascular disease.
- **Heat and weather-related morbidity and mortality** will increase as extreme weather, including extremely hot days, storms, and flooding becomes more common. Effects will include heatstroke, injuries, and epidemics following weather events (e.g., cholera after flooding).
- Malnutrition and exposure to toxins will cause **impaired human development**, especially in fetuses and children.
- **Mental illness and stress-related disorders** will result from property damage and social disruption related to climate change.
- **Waterborne, vector-borne, and zoonotic** disease will increase as warmer temperatures expand the areas hospitable to these organisms (WHO, 2009).

Communities of color, immigrants, and refugees are already experiencing disproportionately high rates of the negative health impacts listed here. Certain groups will bear the brunt of climate change-related ill health because of their present demographic, social, or geographic

situation and their experiences of intergenerational and historical inequities. Worldwide, people living with low-incomes and communities of color will disproportionately suffer from morbidity and mortality related to extreme heat waves, dirty air, water scarcity, and urban heat island effects. They will also be disproportionately affected by higher food and electricity costs and by potential job losses and economic shifts. Low-income communities and communities of color, who already live in the most polluted areas, are the first in line for the negative impacts of climate change. Humans are particularly vulnerable, and low-income women, women of color, and immigrants will be most impacted by severe weather events, heat waves, and increases in disease rates that will characterize the Earth's changing climate (NIH, 2010).

In order to integrate equity and a racial justice lens into the work of sustainability, we must consider a few key barriers and integrate recommendations into policy, practice, and programming:

Key Barriers:

- **Not using or underutilizing existing data on disparate impacts.** We must have policies that prioritize the use of data and build the capacity of staff to effectively integrate data into their practice.
- **Lack of meaningful engagement and fair treatment** of communities most affected by racial, ethnic, and overall inequities. Given the nature of unrealistic timelines, organizational pressure, and lack of capacity to engage communities in a culturally responsive manner those most affected by inequities often feel disconnected from the process and observe decisions being made without them at the table.
- **Lack of understanding about the human right to clean air, water, land, and fair treatment**; when we acknowledge this right, integrating and compiling data on disparate impacts and engaging populations negatively affected by climate change becomes a necessary part of the process.

National sustainability and climate change work has traditionally been led by and designed for the interests and needs of the mainstream – often middle-class, white America. As a result, communities of color and low-income communities have struggled to find a place in the movement, despite a strong desire and willingness to engage meaningfully. Roger Kim of the Asian Pacific Environmental Network, in an interview from Everybody's Movement said, "[Our members] have seen huge transformation, most of it negative and polluting and the degradation of their communities back home has been quite dramatic…The lack of power and voice is the same, whether it's here in Richmond [California] or in Laos or in southern China or Beijing. The root cause is powerlessness (Park, 2009). (See Concept Paper on *Empowerment Theory and Practice* and *Hierarchy and Root Causes*)".

Various polls support the need for meaningful engagement by all communities in climate and sustainability work. For example, specifically with regard to climate change: Sixty-one percent

of African American voters, 55 percent of Latino voters, and 57 percent of all voters of color considered global warming to be "extremely serious" or "very serious" compared to 39 percent of whites and 43 percent of all voters. In order to address the urgent need recognized by the majority of communities of color, we must transform this movement into one for all people. Creating a sustainable, healthy environment requires participation from every community.

What is the solution? Grounding the climate change movement in the principles of environmental justice and equity is vital. (See Appendix 3 for the Principles of Environmental Justice on page 112). Deepening our understanding of the intersection between race, class and power dynamics will improve collaboration efforts and help us understand who benefits from resource allocation and who does not; who has a voice at the table and who does not, and why. Integrating the scientific, data driven approach to climate change and sustainability through a social and racial justice lens will engender more balanced and meaningful participation and perspectives.

Recommendations for Lens Implementation and Application from a Sustainability Perspective

The Equity & Empowerment Lens (E & E Lens) serves as a guide for organizations to critically reflect upon their policies, procedures and practices to identify and prioritize actions that will enhance equity and racial justice within their institution. When applying specific Lens questions to your climate-related or sustainability project, engaging the communities most affected by climate change and environmental concerns is an important first step. We must also take action on their recommendations, and finance the institutionalization of culturally responsive ways of practice.

Key strategies might include:

- **Build community capacity**. Strengthening outreach and providing culturally responsive education that integrates the social determinants is essential. This may mean deeper efforts in addition to sending out a flyer in multiple languages. Consider instead a more systemic approach like providing financial resources for environmental work to culturally specific organizations with established community relationships.

- **Develop mechanisms for meaningful public engagement.** This means exploring the definition of meaningful engagement and engaging key stakeholders in project development and implementation. It goes beyond public comment to public participation and voice.
- **Protect and empower vulnerable individuals and communities from economic impacts.** Review the economic implications of your project on communities of color, immigrants, and refugees and analyze the distribution of resources to determine whether these groups benefit equally from your decisions.
- **Build development capacity** and better integrate environmental justice into existing funding streams. For example, encourage creative funding strategies and partnerships that bring financial resources to community-driven organizations working directly with community leaders and participants on environmental and racial justice.

Individual Reflection Questions

- Who benefits most from the project? Who is most impacted? Who bears the most negative environmental consequences as a result of the project policy, program, or process?

- How does your program engage communities most affected by the program in an empowering way?

- How does your project integrate the community into funding decisions and planning?

- What financial resources will you provide to build capacity in communities of color, immigrant or refugee communities?

- What public health benefits or adverse health impacts may occur as it relates to this project?

- What is the impact of your project on greenhouse gas production?

- How does your work integrate principles of environmental justice? See Appendix 3.

- If your policy, decision, project involves the use of land or space, how is any prior historical or spiritual connection to the area or land and the populations who hold such connections considered in decision-making, planning, or any siting?

CONCEPT PAPER #7

POSITIVE MENTAL HEALTH AND EQUITY

Lead Author: Kari Lindahl holds a Masters Degree in Social Work and a Graduate Certificate in Sustainability from Portland State University. Ms. Lindahl led the writing on this draft during her graduate study of the connections between mental health and sustainability, which revealed a need for the public sector to place greater emphasis on the connection of positive mental health and equity.

Connection to the Lens

The connection between health, economics, and social well being is well-documented and researched. Forward-thinking, equitable, and broad policy changes can help directly counter the trends that lead to social inequities. We must initiate policy, practice, and program changes to eliminate the root causes of the socio-economic inequities that decrease positive mental health. Applying Lens questions and suggested processes to policies, decisions, resource allocation issues, programs and practices will enable your organization to make the necessary adjustments to increase equity and racial justice. This Lens specifically includes positive mental health as a major concept paper due to the clear ability of inequity to block positive mental health, and the importance of positive mental health as a key resource in supporting both individual physical and overall social health outcomes.

Background and Basics

The development of post-World War II policies directed the field of mental health towards treatment in the medical model, and away from the cultivation of positive mental health (Seligman, 2002). As we begin to understand ourselves and our communities within a relational worldview (See Concept Paper on *Relational Worldview)*, knowledge of this historic shift creates an opportunity to redirect attention to the critical importance of positive mental health. Bringing positive mental health into the picture requires understanding three main concepts.

First, mental health must be distinguished from mental illness. Positive mental health and mental illness exist on correlating but psychometrically separate axes (Keys, 2002). Curing mental illness does not necessarily lead to positive mental health. We promote and protect positive mental health by making sure people

have the material resources they need, have a sense of control over their lives, and have the ability to participate in important decision-making in community governance. The World Health Organization (WHO) recommends formally separating policies for treatment of mental illness and policies for the promotion of positive mental health (WHO, 2004).

Second, mental health is a social indicator. Cultivating positive mental health requires both social and individual level interventions (WHO, 2009). Positive mental health serves as a resource and is linked to higher overall physical health, greater longevity, increased positive social choices such as lowered criminal activity, drug use, and alcohol use, and increased productivity and job performance. Positive mental health is also a multi-directional pathway, impacting educational attainment, civic engagement, and community participation (Keys, 2002; WHO, 2009). Although the pathways are complex and multi-layered, the robust associations between positive mental health and physical health, positive health behavior choices, positive work life experiences, and positive social engagement are clear.

Finally, lack of equity is one of the key barriers to positive mental health (WHO, 2009). Positive mental health decreases, and the chances for development of mental illness increases, in a social system with high levels of inequality in social and economic resources. Status competition and insecurity is heightened across all income groups in conditions of inequality. As Layard (2005) notes about happiness, the more we are able to distribute income among populations the higher our collective levels of happiness will be. In contrast, inequality leads to lower health outcomes. Those who experience discrimination from belonging to a social group outside the dominant norm (for example discrimination against race, ethnicity, sexual orientation, age or disability) combined with distributional inequality (or poverty) also experience inequities in health, defined as systematic, unjust, and avoidable differences in health outcomes (Hofrichter, 2006).

The Commission on the Social Determinants of Health (2008) (See Concept Paper on *Social Determinants of Health and Inequity*) identifies the key factors which will reduce the impact of social stratification on health: 1) alleviating poverty, 2) empowering individual agency (or control over one's life), and 3) empowering political voice, or participation in decision-making. In addition, the World Health Organization (2009) emphasizes that addressing the gap between the rich and the poor is critical to each of these factors. Cultivating positive mental health requires that we utilize poverty alleviation strategies, incorporate empowering practices to promote health, and and create the space for authentic voice and participation in policy and decision-making. The WHO also identifies positive mental health as the primary resource for generating the solutions to address social and environmental concerns. Nurturing positive mental health in our communities is fundamental to accessing the creativity, ingenuity, and contribution of all people. Positive mental health is tightly linked to and should be as strongly considered as physical health.

The deep inequities in this realm are evident in the increased levels of mental illness and stress-related diseases experienced by communities of color. Several key federal reports, including one from the United States Surgeon General (2001), have emphasized the connection between race, culture, ethnicity and mental health inequities. The Coalition of Communities of Color (2010) report echoes the work at the federal level and more specifically highlights the need to integrate the mental health of young people of color into the work of the County and beyond. The report states that mental health stressors that can lead to mental health distress in the form of attempted suicide include "various forms of self-recrimination, self-hatred and fear and worry about the future" (p.11). While data on the mental health inequities at the local level for young people of color is not extensive, the report makes the connection between future diminished economic opportunities and decreased positive mental health for youth of color in this County, and urges all practitioners to pay strict attention to improving positive future opportunities for youth of color.

The Coalition of Communities of Color (2010) released a second report specific to the Native American/American Indian population and states that:

> We are becoming aware that the physical toll of living with racism and its daily indignities harms several essential bodily functions such as blood pressure, maternal health, hormonal balance (with high rates of the stress hormone, cortisol, understood to be pronounced among communities of color), and mental health. Nowhere is the toll of racism higher than the experience of Native American youth [in the United States] who are likely to commit suicide at levels that are 70 percent higher than among the general population (p. 73). The connection between the effects of institutional racism in the form of unfair and unjust policies and decisions affecting communities of color, immigrants, and refugees can further exacerbate social inequities experienced by these populations. According to the United States Surgeon General "racial and ethnic minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health"(2001, p.3).

Positive mental health is a resource and a pathway to obtain what one needs to thrive, meaningfully participate, and engage. Not only do physical health and positive mental health affect personal well being, but also discrimination and health inequity are tied to other social experiences that reduce the overall productivity in a community, including:

- Higher unemployment rates;
- High dropout rates;
- Greater experiences of chronic illness; and
- Experiences of racism (and other '-isms') at the individual, organizational, and community levels.

Positive mental health also links to social sustainability. If an individual and community are flourishing, and protective factors are promoting the realization of potential, then we improve

social processes and community livability. Likewise, if we enhance social sustainability, economic and environmental conditions also strengthen. The presence of positive mental health in an organization or community is a key indicator of the ability to achieve success.

Finally, positive mental health contributes to increased productivity, work satisfaction, and economic empowerment. The cost of low productivity, lawsuits around discrimination and disrespectful behavior, and overall drains of low team morale could be mitigated by more empowering behaviors and practices leading to positive mental health (See Concept Paper on *Empowerment Theory and Practice*). Empowering strategies within a community itself can build the necessary bonds to improve social cohesion, a key social determinant of positive population outcomes.

Recommendations for Lens Implementation and Application from a Positive Mental Health Perspective

Remember that positive mental health is supported by three factors:

- alleviating poverty;
- empowering individual agency (or control over one's life); and
- empowering political voice, or participation in decision-making.

Create inclusive employee decision-making processes in the workplace to focus on empowering individual agency. This brings a fuller range of skills and perspectives to problem-solving while supporting positive mental health and productivity.

Create, foster, promote, and evaluate inclusive and respectful employee-to-employee and supervisor-to-employee relations. Such positive connections are critical to success in the day-to-day within a workplace, and further positive mental health (See Concept Paper on *Hierachy and Root Causes)*.

Utilize empowering strategies. When working with community members and clients, think about how your programming or services factor in their positive mental health needs via empowering strategies such as client-led positive mental health discussions and diagnoses, and an overall integration of the cultivation of positive mental health strategies in interactions (See Concept Paper on *Empowerment Theory and Practice)*.

Incorporate community-based models of positive mental health when working with communities of color, internal and external to your organization (such as the holistic, balanced approach set forth in the *Relational Worldview* Concept Paper) in data-gathering, discussions, treatments, and/or policy changes.

Elevate the issue of positive mental health within your organization and in client and community relations, as a major resource and a pathway towards equity and empowerment.

Individual Reflection Questions

- Where do you see positive mental health occurring in your organization? What factors contribute to these examples of positive mental health?

- How can you celebrate what is working in your organization? How can you learn from and share these moments?

- How can you promote interactions leading to positive mental health with coworkers, community members, and clients?

- How can you further integrate culturally responsive actions, behaviors, and training in your work to promote positive mental health with communities of color, immigrants, and refugees?

CONCEPT PAPER #8

SIX OUTCOME AREAS FOR ADVOCACY AND POLICY WORK

Connection to the Lens

Keeping a clear vision of the six outcomes for advocacy and policy work is essential when mapping our course toward more equitable results for all communities. At its very heart, the Equity & Empowerment Lens (E & E Lens) is a tool for transformative change. Integrating the six outcomes areas into organizational conscience will enable leaders to generate more robust solutions or recommendations and connect actions to researched outcome areas that lead to equity and empowerment.

Background and Basics

By reading the Concept Papers and agreeing to apply the Lens within your work processes, you are an agent of change. Applying the Lens is a vital first step towards achieving equity and racial justice - but how will you know if the work you are doing is making a difference? This is where the importance of evaluation and accountability comes into play. (See Evaluation Summary on page 51) The Lens focuses on the following six outcome areas for advocacy and policy work (which are discussed in more length later in this section):

- Shift in Social Norms
- Strengthened Organizational Capacity
- Strengthened Alliances
- Strengthened Base of Support
- Improved Policies
- Changes in Impact

Outcomes are typically expressed as "forward progress," e.g., increases in skills or improved conditions. Clearly defining the outcome areas for equity and racial justice helps us develop a shared language and establish manageable goals and strategies directly related to the desired results. Focusing energy toward these six outcome areas will also enable us to see change at various levels (macro, mezzo, micro) within an organization and potentially open new spaces for additional equity work. Many change efforts moving towards equity and racial justice have sought to address social and environmental issues not only by direct program services, but also by looking further upstream to the conditions and policies

that underlie these concerns (See Concept Paper on *Social Determinants of Health and Equity)*. Ongoing program evaluation, including measurement of specific program outcomes, plays a significant role in the success and sustainability of transformational change.

The pathway to transformational change is not always clear when operating in a bureaucratic framework because dynamic advocacy and policy work often happens in multiple settings with multiple players, and not always in a linear fashion. In order to better understand the change process and how it operates within your organization it is important to stay attuned to shifts at each level. Once a leader or team identifies a goal, such as decreasing an inequity in juvenile detention rates experienced by youth of color, it is important to take a step back with a broader perspective to examine contributing areas and players across all levels that lead to systemic change. This could mean looking at direct service implementation (micro), hiring practices (mezzo), training of staff working with youth (mezzo), policies that determine sentencing (macro), etc.

Shift in Social Norms
Encompasses core and enduring social values, knowledge, attitudes and behaviors.

Strengthened Organizational Capacity
Addresses core capacities including staffing and leadership, organizational structure and systems, finances and strategic planning.

Strengthened Alliances
Includes the level of coordination, collaboration and mission alignment among community and system partners, including nontraditional alliances (e.g., bipartisan alliances, nontraditional allies).

Strengthened Base of Support
Composed of grassroots, leadership and institutional support for particular policy changes that includes the breadth, depth and influence of support among the general public, interest groups and opinion leaders.

Improved Policies
The stages of policy change in the public policy arena include policy development, policy proposal, demonstration of support (e.g., co-sponsorship), adoption, funding, and implementation.

Changes in Impact
The ultimate changes in social and physical lives and conditions (i.e., changes in individuals, populations and physical environments) that motivate policy change efforts.

According to the Annie E. Casey Foundation (Reisman, Gienap & Stachowiak, 2007), we can mitigate negative factors by identifying and defining the short- and intermediate-term outcomes, that is, what changes might occur along the way to longer-term change. To help navigate us toward a more equitable and empowering environment, this concept paper defines the six outcomes of advocacy and policy work and provides agents of change with a set of goals.

Clearly understanding the outcomes you seek is a critical to designing effective evaluation and to developing viable recommendations that will lead to the institutionalization of equity and empowerment principles within your organization. We advise you to think about advocacy and policy efforts in the context of multiple outcome areas. Below are concrete examples of how to tie the outcome areas to your proposed activities.

Proposed Activity or Resource	Sample Outcome Category
1. Development of a strategic plan	• Strengthened organizational capacity
2. Staff position for managing a media campaign	• Strengthened organizational capacity • Shift in social norms
3. Staff and resources for organizing coalitions in six counties	• Strengthened organizational capacity • Strengthened base of support
4. Staff, operational and evaluation costs for carrying out a demonstration pilot program	• Strengthened organizational capacity • Improved policies
5. General operations	• Strengthened organizational capacity

Recommendations for Lens Implementation and Application from a Policy and Advocacy Change Perspective

- After assessing the answers to the Lens version(s) you / your team selects, refer back to the outcomes areas to create multi-pronged, multi-faceted recommendations.
  - For instance, if your primary recommendation is to strengthen organizational capacity through hosting an E & E Lens training, how can you also shift social norms and improve existing policies to ensure institutionalization of the training and its overall success?

- Two outcome areas often missing from change practices moving towards equity an racial justice are:
  - Shift in Social Norms (speaks to the importance of leadership and changing organizational culture); and
  - Strengthened Alliances (speaks to empowerment theory and integrating meaningful community input from communities most affected by inequities).
- Consider integrating these outcome areas in your emerging recommendations and action plans.

Individual Reflection Questions

- Consider the following example. You are planning your department's next staff meeting. Based on feedback that you received, you want to give everyone the opportunity to facilitate a meeting, and will provide a brief training on how best to facilitate meetings in an empowering way. Which outcome(s) would you be achieving by doing so?

- What outcome(s) would be achieved if you invited local community leaders from a culturally-specific-serving organization to discuss shared priorities around the services/policies/programs you provide?

- How can you achieve the outcome area of 'Shift in Social Norms' through innovative messaging or advocacy efforts by you and by leadership in your day-to-day work? (See sample sub-outcomes and strategies under 'Shift in Social Norms' in Appendix 1 on page 110). What strategies or suggestions can you put forward?

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OTHER RESOURCES

The Equity and Empowerment Lens (2012) has benefited tremendously from the pioneering work of the following Lens efforts. We urge you to visit their sites, and better understand their ongoing work and resulting outcomes. We are grateful for their leadership and support.

Applied Research Center: www.arc.org/

City of Seattle, Race and Social Justice Initiative: www.seattle.gov/rsji/

Health Equity Initiative, Multnomah County Health Department: http://web.multco.us/health/health-equity-initiative

King County, Equity and Social Justice: www.kingcounty.gov/exec/equity.aspx

National Association for City and County Health Officials, Health Equity and Social Justice Workgroup: www.naccho.org/topics/justice/mission.cfm

Northwest Health Foundation: http://nwhf.org/

Policylink: www.policylink.org/site/c.lkIXLbMNJrE/b.5136441/k.BD4A/Home.htm

Portland Public Schools, Equity Initiative: www.pps.k12.or.us/departments/district-leadership/2669.htm

Portland Public Schools, Racial Equity Policy: www.pps.k12.or.us/depts/communications/docs/RESO-4459-Equity-Policy.pdf

State of Oregon, Office of Equity and Inclusion: www.oregon.gov/OHA/oei/pages/index.aspx

Urban League of Portland. Racial Equity Strategy: http://ulpdx.org/racialequitystrategyguide/

APPENDICES

APPENDIX 1

MENU OF OUTCOMES FOR ADVOCACY AND POLICY WORK

1. **SHIFT IN SOCIAL NORMS**
   Encompasses core and enduring social values, knowledge, attitudes and behaviors.

2. **STRENGTHENING ORGANIZATIONAL CAPACITY**
   Core capacities including staffing and leadership, organizational structure & systems, finances and strategic planning.

3. **STRENGTHENED ALLIANCES**
   Includes the level of coordination, collaboration and mission alignment among community and system partners, including nontraditional alliances, e.g., bipartisan alliances, non-traditional allies.

4. **STRENGTHENED BASE OF SUPPORT**
   Composed of grassroots, leadership and institutional support for particular policy changes that include the breadth, depth and influence of support among the general public, interest groups and opinion leaders.

5. **IMPROVED POLICIES**
   The stages of policy change in the public policy arena include policy development, policy proposal, demonstration of support (e.g., co-sponsorship), adoption funding and implementation.

6. **CHANGES IN IMPACT**
   The ultimate changes in social and physical lives and conditions (i.e., changes in individuals, populations and physical environments) that motivate policy change efforts.

MENU OF OUTCOMES FOR ADVOCACY AND POLICY WORK

Definition of outcomes is a crucial step of your evaluation design. We suggest that advocacy and policy efforts can be viewed in the context of one or more of these broad outcome categories. The specific element of the outcome category will be directly related to the funded strategy. Consider the following examples:

Proposed Activity or Resources	Sample Outcome Category
1. Development of a strategic plan	• Strengthened organizational capacity
2. Staff position for managing a media campaign	• Strengthened organizational capacity • Shift in social norms
3. Staff and resources for organizing coalitions in six counties	• Strengthened organizational capacity • Strengthened base of support
4. Staff, operational and evaluation costs for carrying out a demonstration pilot program	• Strengthened organizational capacity • Improved policies
5. General operations	• Strengthened organizational capacity • Specific outcome category that is applicable (e.g., Shift in social norms, strengthened base of support)

You will need to further refine these broad outcomes to determine specific outcome elements for measurement. Take, for example, a media campaign that is intended to (1) influence social norms and (2) increase the base of support. The design of this campaign, message development, media materials, media venues, campaign message, specific audiences, frequency of messages, placement of messages, duration of the campaign, formats, partnerships involved in carrying out the campaign, duration of this campaign, and any other related and supporting or enhancing strategies that occur simultaneously with the campaign are essential factors that will determine appropriate outcome selection. These specific outcomes are numerous. Some examples follow:

- Changes in awareness of an issue
- Changes in knowledge about the severity of an issue
- Changes in knowledge about what actions to take
- Changes in salience of an issue
- Changes in willingness to support an issue
- Changes in voting behavior

These types of outcomes can span many issue areas, including recycling, early learning opportunities for young children, affordable housing, access to medical insurance and many other wide-ranging issue areas.

MENU OF OUTCOMES FOR ADVOCACY AND POLICY WORK

1. SHIFT IN SOCIAL NORMS	
Examples of Outcomes	• Changes in awareness • Increased agreement on the definition of a problem (e.g., common language) • Changes in beliefs • Changes in attitudes • Changes in values • Changes in the salience of an issue • Increased alignment of campaign goal with core societal values • Changes in public behavior
Examples of Strategies	• Framing issues • Media campaign • Message development (e.g., defining the problem, framing, naming) • Development of trusted messengers and champions
Unit of Analysis (e.g., Who or What Changes?)	• Individuals in general public • Specific groups of individuals • Population groups
2. STRENGTHENED ORGANIZATIONAL CAPACITY	
Examples of Outcomes	• Improved management of organizational capacity of organizations involved with advocacy and policy work) • Improved strategic abilities of organizations involved with advocacy and policy work • Improved capacity to communicate and promote advocacy messages of organizations involved with advocacy and policy work • Improved stability of organizations involved with advocacy and policy work
Examples of Strategies	• Leadership development • Organizational capacity building • Communication skill building • Strategic planning
Unit of Analysis (e.g., Who or What Changes?)	• Advocacy organizations • Not-for profit organizations • Advocacy coalitions • Community organizers, leaders
3. STRENGTHENED ALLIANCES	
Examples of Outcomes	• Increased number of partners supporting an issue • Increased level of collaboration (e.g., coordination) • Improved alignment of partnership efforts (e.g., shared priorities, shared goals, common accountability system) • Strategic alliances with important partners (e.g., stronger or more powerful relationships and alliances) • Increased ability of coalitions working toward policy change to identify policy change process (e.g., venue of policy change, steps of policy change based on strong understanding of the issue and barriers, jurisdiction of policy change)
Examples of Strategies	• Partnership development • Coalition development • Cross-sector campaigns • Joint campaigns • Building alliances among unlikely allies
Unit of Analysis (e.g., Who or What Changes?)	• Individuals • Groups • Organizations • Institutions

MENU OF OUTCOMES FOR ADVOCACY AND POLICY WORK

4. STRENGTHENED BASE OF SUPPORT	
Examples of Outcomes	• Increased public involvement in an issue • Increased level of actions taken by champions of an issue • Increased voter registration • Changes in voting behavior • Increased breadth of partners supporting an issue (e.g., number of "unlikely allies" supporting an issue) • Increased media coverage (e.g., quantity, prioritization, extent of coverage, variety of media "beats," message echoing) • Increased awareness of campaign principles and messages among selected groups (e.g., policy makers, general public, opinion leaders) • Increased visibility of the campaign message (e.g., engagement in debate, presence of campaign message in the media) • Changes in public will
Examples of Strategies	• Community organizing • Media campaigns • Outreach • Public/grassroots engagement campaign • Voter registration campaign • Coalition development • Development of trusted messengers and champions • Policy analysis and debate • Policy impact statements
Unit of Analysis (e.g., Who or What Changes?)	• Individuals • Groups • Organizations • Institutions
5. IMPROVED POLICIES	
Examples of Outcomes	• Policy Development • Policy Adoption (e.g., ordinance, ballot measure, legislation, legally-binding agreements) • Policy Implementation (e.g., equity, adequate funding and other resources for implementing policy) • Policy Enforcement (e.g., holding the line on bedrock legislation)
Examples of Strategies	• Scientific research • Development of "white papers" • Development of policy proposals • Pilots/Demonstration programs • Educational briefings of legislators • Watchdog function
Unit of Analysis (e.g., Who or What Changes?)	• Policy planners • Administrators • Policy makers • Legislation/laws/formal policies
6. CHANGES IN IMPACT	
Examples of Outcomes	• Improved social and physical conditions (e.g., poverty, habitat diversity, health, equality, democracy)
Examples of Strategies	• Combination of direct service and systems-changing strategies
Unit of Analysis (e.g., Who or What Changes?)	• Population • Ecosystem

APPENDIX 2

WE, THE PEOPLE OF COLOR, gathered together at this multinational People of Color Environmental Leadership Summit, to begin to build a national and international movement of all peoples of color to fight the destruction and taking of our lands and communities, do hereby re-establish our spiritual interdependence to the sacredness of our Mother Earth; to respect and celebrate each of our cultures, languages and beliefs about the natural world and our roles in healing ourselves; to insure environmental justice; to promote economic alternatives which would contribute to the development of environmentally safe livelihoods; and, to secure our political, economic and cultural liberation that has been denied for over 500 years of colonization and oppression, resulting in the poisoning of our communities and land and the genocide of our peoples, do affirm and adopt these Principles of Environmental Justice:

The Principles of Environmental Justice (EJ)

1) **Environmental Justice** affirms the sacredness of Mother Earth, ecological unity and the interdependence of all species, and the right to be free from ecological destruction.

2) **Environmental Justice** demands that public policy be based on mutual respect and justice for all peoples, free from any form of discrimination or bias.

3) **Environmental Justice** mandates the right to ethical, balanced and responsible uses of land and renewable resources in the interest of a sustainable planet for humans and other living things.

4) **Environmental Justice** calls for universal protection from nuclear testing, extraction, production and disposal of toxic/hazardous wastes and poisons and nuclear testing that threaten the fundamental right to clean air, land, water, and food.

5) **Environmental Justice** affirms the fundamental right to political, economic, cultural and environmental self-determination of all peoples.

6) **Environmental Justice** demands the cessation of the production of all toxins, hazardous wastes, and radioactive materials, and that all past and current producers be held strictly accountable to the people for detoxification and the containment at the point of production.

7) **Environmental Justice** demands the right to participate as equal partners at every level of decision-making, including needs assessment, planning, implementation, enforcement and evaluation.

8) **Environmental Justice** affirms the right of all workers to a safe and healthy work environment without being forced to choose between an unsafe livelihood and unemployment. It also affirms the right of those who work at home to be free from environmental hazards.

9) **Environmental Justice** protects the right of victims of environmental injustice to receive full compensation and reparations for damages as well as quality health care.

10) **Environmental Justice** considers governmental acts of environmental injustice a violation of international law, the Universal Declaration On Human Rights, and the United Nations Convention on Genocide.

11) **Environmental Justice** must recognize a special legal and natural relationship of Native Peoples to the U.S. government through treaties, agreements, compacts, and covenants affirming sovereignty and self-determination.

12) **Environmental Justice** affirms the need for urban and rural ecological policies to clean up and rebuild our cities and rural areas in balance with nature, honoring the cultural integrity of all our communities, and provided fair access for all to the full range of resources.

13) **Environmental Justice** calls for the strict enforcement of principles of informed consent, and a halt to the testing of experimental reproductive and medical procedures and vaccinations on people of color.

14) **Environmental Justice** opposes the destructive operations of multi-national corporations.

15) **Environmental Justice** opposes military occupation, repression and exploitation of lands, peoples and cultures, and other life forms.

16) **Environmental Justice** calls for the education of present and future generations which emphasizes social and environmental issues, based on our experience and an appreciation of our diverse cultural perspectives.

17) **Environmental Justice** requires that we, as individuals, make personal and consumer choices to consume as little of Mother Earth's resources and to produce as little waste as possible; and make the conscious decision to challenge and reprioritize our lifestyles to insure the health of the natural world for present and future generations.

More info on Environmental Justice can be found online at www.ejnet.org/ej/

Delegates to the First National People of Color Environmental Leadership Summit held on October 24-27, 1991, in Washington DC, drafted and adopted 17 principles of Environmental Justice. Since then, The Principles have served as a defining document for the growing grassroots movement for environmental justice.

APPENDIX 3

Organizational Checklist for Racial Justice

Racial Justice POLICY AND PLAN	NO	WORKING ON IT	YES
Has a shared definition of racism and of anti-racism work			
Acknowledges the value of racial justice to the organization			
Links racial justice to other core values of the organization			
Has support from and specifies roles in the implementation plan for senior managers and other leaders (board members, union presidents/stewards)			
Outlines clear actions, timeframes, people responsible for each action, indicators of progress and processes for monitoring an evaluation			
Addresses all aspects of the work done by your organization			
Is integrated into all other planning in the organization			
Is understood by all employees (and volunteers)			
Has community support			
Requires annual reports on progress and setbacks to the decision-makers and governing bodies			
EMPLOYMENT SYSTEMS	**NO**	**WORKING ON IT**	**YES**
Outreach for hiring is broad and includes a variety of strategies			
Job announcement/postings make clear the organization's desire for candidates from equity seeking groups, including racialized and Native/ Indigenous groups			
Job qualifications acknowledge the value of experience in working with racialized communities, knowledge of anti-racism work, the ability to work within racially diverse teams, and the capacity to work in languages other than English			

Adapted from *Dancing on Live Embers: Challenging Racism in Organizations* by Tina Lopes & Barb Thomas, pg. 246-25 *Note: The original text used the word Aboriginal; it has been replaced by the term Native/Indigenous for our use.*

Staff on selection panels understands how to identify and challenge racial and cultural factors affecting selection			
Proportion of racialized and Native/Indigenous staff in leadership positions is consistent with their numbers in the communities served			
Proportion of racialized and Native/Indigenous staff in administrative and support positions in consistent with their numbers in the communities served			
Balanced representation of racialized and Native/Indigenous persons sit on selection panels for hirings and promotions			
Personnel policies and procedures acknowledge the organization's responsibility to meet the needs of people with diverse identities (care for dependents, religious observances, etc.)			
MANAGEMENT PRACTICES	**NO**	**WORKING ON IT**	**YES**
Supervision practices are consistent and equitable, work is allocated fairly, and decisions are based on clearly communicated criteria			
Performance appraisals are conducted regularly, and managers learn how to recognize the ways in which their biases may influence the process			
Racial justice knowledge, skills, and practices are incorporated into performance objectives and appraisals for all levels of staff			
Managers demonstrate skills in fostering racial justice work, a collegial work environment, and shared decision-making			
Managers have the capacity to discuss racism, at the individual and systemic level, and to work with staff to identify strategies for dealing with it			
Leaders make clear statements and consistently act (e.g., allocating sufficient resources, making racial justice a standing agenda item at key meetings, ensuring racialized and Native/Indigenous people are among the decision-makers) to demonstrate the importance of challenging racism in the organization			

COMPLAINTS PROCESS(ES)	NO	WORKING ON IT	YES
A clear complaint process exists for all staff, in addition to the grievance procedure for unionized staff			
Both formal and informal procedures for resolving complaints are established in order to appropriately address the range of allegations of racism that can be made; management, union stewards, and others designated to address complaints are skilled in recognizing and addressing racism			
Staff is familiar with, and are confident they can use, the complaint procedures			
Race-based problems are addressed promptly; time is taken to analyze and address the root causes of the problem			
There are examples of effective resolutions to race-based complaints			
Performance appraisals for managers include the ability to handle allegations of racism and carry out the complaint process skillfully			
The types of complaints and the frequency with which they arise are monitored and reported to the governing body of the organization			
Complaints are seen as a source of information about systemic racism that may need to be addressed by the organization			
COMMUNICATING IN THE ORGANIZATION	**NO**	**WORKING ON IT**	**YES**
All employees receive clear, relevant, and timely information about corporate discussions, decisions, and actions that affect them			
All departments (and board and committees) routinely coordinate and communicate racial justice efforts			
Publications and other communications materials appropriately reflect racialized people as valued board, staff, volunteers, service users, and community members			
All materials (publicity, educational, program, etc.) are assessed for bias and revised as necessary			
Staff and board understand the racial and cultural factors that influence communication			
Staff is able to detect and challenge bias in their own written and oral communications and in those of others			

People are supported for speaking about racism and racial justice in the workplace			
Meetings are conducted in ways that recognize and value different ways of speaking, thinking, debating, and making decisions			
Knowledge and expertise of staff and board members are recognized, used, and fairly compensated			
Knowledge and expertise of community representatives are recognized, used, and fairly compensated			
The organization uses an updated list of community media and information networks			
Communication can occur in languages appropriate to the service users or target audience			
PROGRAMS AND WORK WITH COMMUNITIES	**NO**	**WORKING ON IT**	**YES**
Major policy is developed with substantial community participation			
All policy is developed to be consistent with racial justice and other equity principles			
Mechanisms for community participation are fully utilized even when community representatives challenge the organization's leaders and its staff			
Community access to facilities includes considerations of childcare, scheduling around days and times of religious significance, a range of food and dietary restrictions, translation and interpretation requirements, and physical accessibility			
A clear plan for ensuring service equity is an integral part of the racial justice policy and implementation plan, as well as all other planning initiatives of the organization			
Staff and volunteers know where to refer clients when programs cannot meet their needs			
All aspects of service delivery have been assessed for their consistency with the racial justice policy			
Programs are evaluated in terms of their impact on racialized communities, and changed as required			
Advocacy on behalf of equity is seen as part of the organization's work			
Support is given to community groups doing advocacy work			
The organization ensures that Native/Indigenous and racialized business people benefit equitably from contracts			

EDUCATIONAL AND PROFESSIONAL DEVELOPMENT	NO	WORKING ON IT	YES
Education for all staff is a component of the racial justice policy and implementation plan			
Education and training is seen as one among many strategies to achieve equity			
All education and professional development offered by the organization incorporates racial justice and other areas of equity work			
All educators and employees responsible for planning the professional development of staff can integrate racial justice into their work; specific racial equity education is planned jointly with other education and professional development activities for staff and volunteers			
Racial justice education is designed to assist people to practice anti-racism in their daily work			
Education utilizes community expertise			
Racialized and Native/Indigenous staff, volunteers, and service users have equitable access to education and professional development opportunities			
Racialized and Native/Indigenous staff are equitably represented as educators and facilitators			
MONITORING AND ACCOUNTABILITY	**NO**	**WORKING ON IT**	**YES**
A clear structure and process exists for monitoring and evaluating progress on implementing racial justice			
The process is adequately resourced			
The structure and process are clearly communicated to staff, volunteers and community representatives			
There are clearly identified champions for the policy who take active leadership in ensuring that the racial justice plan is regularly reviewed and acted upon			
Organizational leaders periodically issue clear statements on the importance of this effort			
Regular reports are made to organizational leaders and community representatives on progress with the implementation plan			
One or two pilot programs exist in the organization, which are adequately resourced, known to staff and community representatives, and evaluated as organizational change efforts			

APPENDIX 4

EMPOWERMENT ASSESSMENT TOOL

(based on Multnomah County Health Department version)

As part of Multnomah County Health Department's Health Promotion Change Process (please see http://web.multco.us/sites/default/files/health/documents/ccc_healthpromotionframework.pdf for more information), staff developed an Empowerment Assessment Tool to help staff incorporate empowering health promotion principles into everyday practice and in an explicit way. While it is impossible to create a checklist that can determine, in every case, whether a practice is empowering or not, there are certain characteristics that empowering practices share in common. The questions presented in this tool, organized according to the five areas of the Ottawa Charter (1986), can assist staff to take empowerment into account as they design or evaluate activities, policies, or practices.

The Empowerment Assessment Tool addresses the connection between health, positive outcomes for a community, and a broad definition of social justice, moving beyond the focus of racial/ethnic equity found within the Equity & Empowerment Lens. The tool can be used to assess whether a program or policy is likely to promote health equity across a range of axes of diversity (race/ethnicity, sexual orientation, disability status, gender, etc.) As a result, we recommend that this tool be used in concert with the Lens.

Note on usage: This tool has not yet been piloted, but can still be utilized as a guide for action planning. The reader will also notice that several of the assessment questions overlap with the Lens itself. Lastly, although health focused, the reader is invited to apply the concepts put forward by the questions to their own areas. For further information on the role of empowering strategies and environments in reaching equity, see the Concept Paper entitled *Empowerment Theory and Practice*.

Healthy Public Policy

Does/is this activity/policy/practice…

1. Result from meaningful public input in both the process of its development as well as its content (especially from communities most affected by inequities)?
2. Involve agencies and individuals outside of your organization that can create policy change?
3. Data-driven? (*Note: Data can include systematically-collected qualitative data and community wisdom.*)
4. Impact people at the population – not just individual – level?
5. Create a structural change that promotes health?
6. Change cultural and social norms?

7. Integrate evaluative measures that build accountability towards identifying and eliminating root causes of inequities?

Empowering Services

Does this activity/policy/practice…

1. Provide people with information to help them make healthy choices?
2. Encourage and support the patient/client/community member to set their own personal goals for her or his health?
3. Prioritize the establishment of a strong, trusting provider-client relationship?
4. Employ a population perspective?
5. Promote awareness of community-level impacts?
6. Provide people with actionable resources & referrals?
7. Offer people choices that will enable them to make the best decision for themselves?
8. Include an informational or educational component (rather than just a prescription)?

Personal Skills

Does this activity/policy/practice …

1. Employ interactive and empowering educational methods?
2. Begin with what the client/individual/community already knows?
3. Promote critical thinking skills?
4. Help patients/clients/community members learn how to find and access information on their own?
5. Encourage client-directed goal-setting, where the interaction is directed by the client's priorities and includes an action plan?
6. Address access & the client's ability to link to resources?
7. Monitor, analyze, evaluate, and reinforce what the client has accomplished (e.g. motivational interviewing)?
8. Increase health literacy, defined as "the cognitive and social skills which [enable] individuals to gain access to, understand and use information in ways which promote and maintain good health"? (WHO, 2000)
9. Celebrate successes?

Community Action

Does/is this activity/policy/practice …

1. Initiated by the community?
2. Focus on changing social conditions and structural inequities?
3. Address issues identified by the community, where your organization plays more of a collaborative, supporting role, rather than a lead role?

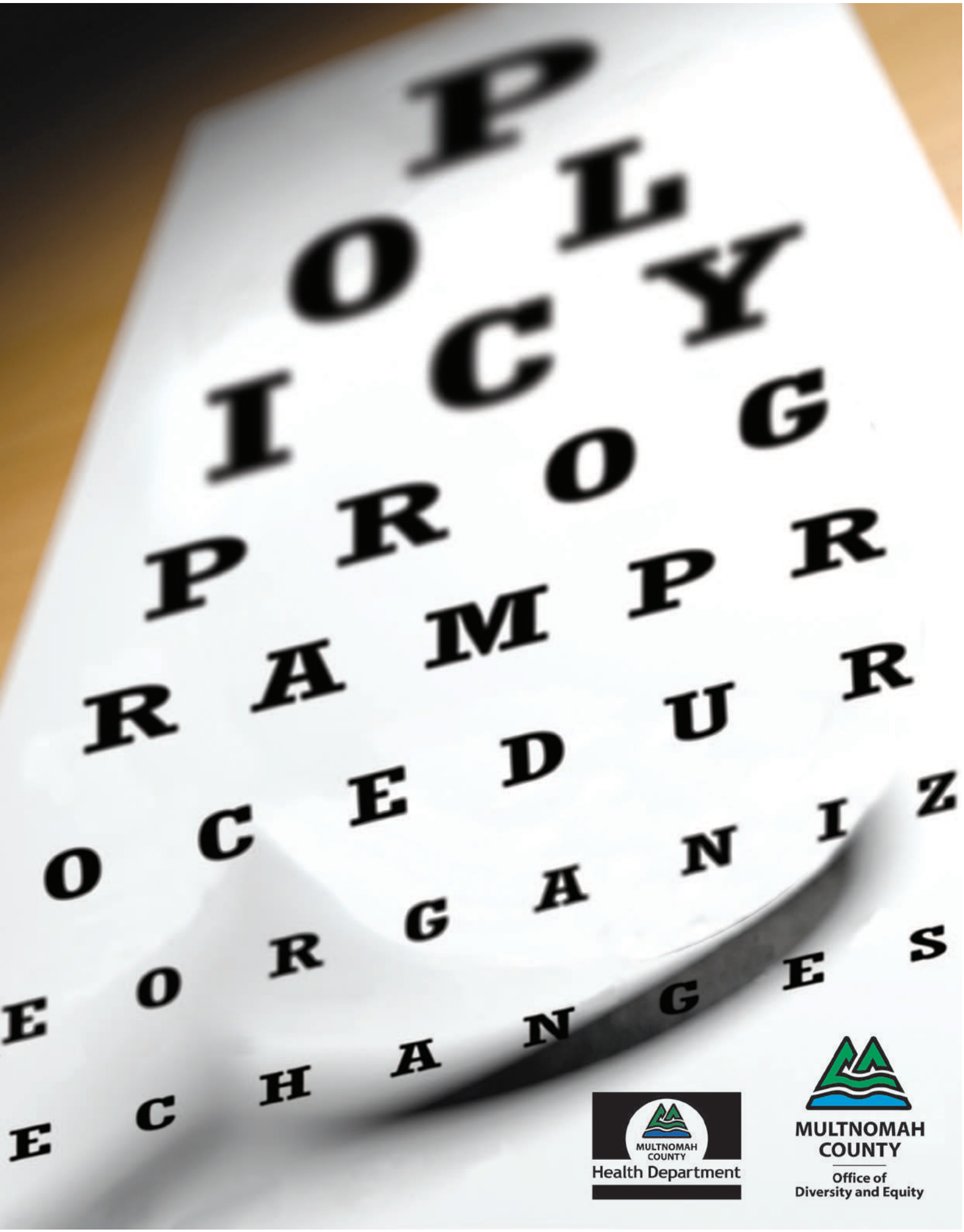
4. Explicitly focus on increasing empowerment for participants and communities?
5. Emphasize collective learning and education?
6. Create or reinforce settings in which community members can come together to identify issues and underlying causes and develop, implement, and evaluate solutions?

Supportive Environments

Does/is this activity/policy/practice …

1. Involve collaboration across the Health Department?
2. Advocate for communities and individuals experiencing health inequities?
3. Create access to services and improved living, working, and learning conditions?
4. Enhance communities' knowledge of how to be safe or avoid hazards?
5. Go beyond influencing individuals' behaviors to a focus on improving the environment in which we live, work, play, and learn?
6. Promote engagement and emphasis at community, policy, and programmatic levels?
7. Prioritize collaboration with community members?

NOTES



MULTNOMAH COUNTY
Health Department

MULTNOMAH COUNTY
Office of Diversity and Equity

HEALTH EQUITY AND INCLUSION PROGRAM STRATEGIES

"Equity and Inclusion First" *– When we design and provide programs and services that improve health for people of color, people with limited English proficiency, LGBTQ communities, and people with disabilities, all communities benefit!*

Use this tool to identify opportunities to support/enhance equity, diversity and inclusion, and reduce disparate impact in programs and services. Recommended approach:

- ❒ Review the whole document.
- ❒ Identify strategies that can be incorporated quickly or with relative ease over the next 6 months.
- ❒ Then, highlight those that you would like to work towards in the 6 months to two years.
- ❒ Finally, mark those that you'd like to set as longer term goals.

Community Engagement/Partnership

- ❒ Establish committees, councils, advisory groups or other bodies to focus on equity and/or inclusion
- ❒ Require committees, councils, advisory groups or other policy-making bodies to reflect state and/or local populations most affected by inequities (with mandated threshold or percentage requirements)
- ❒ Ensure "meaningful participation"[1] of communities experiencing health inequities
- ❒ Establish subcommittees of boards or decision making body focused on equity.
- ❒ Include a standing agenda item on equity and inclusion in meetings of the Board, task force or workgroup.
- ❒ Clearly define terminology to ensure representation of communities experiencing health inequities (including "consumers," "underserved communities," "racially, ethically and linguistically diverse communities," communities historically experiencing poor health outcomes," etc.)
- ❒ More meaningfully address inequities so that the needs of members with multiple identities are addressed (ex: low income people of color, people of color who also have disabilities)
- ❒ Create program or organization accountability to communities experiencing health inequities (example: require annual or biennial reporting on data, activities, progress on goals, service delivery, timeliness of services to reduce health inequities and promote inclusion)

Race, Ethnicity, and Language +Disability (REAL+D) Data Collection/Analysis

- ❒ Collect and report data disaggregated by race, ethnicity, language and disability (following HB2134[2] standards for data collection)

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[1] "Meaningful participation" means engaging a diverse group of stakeholders who are representative of the communities that policies and programs will impact, not only in consultative roles to provide input, but also to co-plan or lead program development efforts, have access to data and resources to make informed decisions, have decision-making authority, and participate in the analysis of data and program impact efforts.

[2] Oregon Administrative Rules 943-070-0000 to 943-070-0070

- ❒ Collect and report data on sexual orientation, non-conforming gender
- ❒ Require training for staff on best practices for collecting data from diverse communities, including maintaining confidentiality and explaining purpose
- ❒ Include affected communities in planning, data collection methods, analysis, and dissemination, and utilize culturally appropriate processes[3] to do so
- ❒ Disseminate final data to affected communities

Research and Evaluation

- ❒ Conduct health equity or other equity impact analyses on new or existing efforts
- ❒ Include diverse communities at every stage of research efforts, including planning, evaluation design, implementation, analysis, and dissemination of research results to communities affected, and utilize culturally appropriate processes to do so
- ❒ Include health equity and/or inclusion metrics or indicators in all planning, quality, intervention, and impact assessments and reports

Funding and Capacity Building for Equity and Inclusion

- ❒ Make strategic investments in and allocate specific budget line items for health equity advancements
- ❒ Require proposers to identify service populations based on racial and/or health inequities data
- ❒ Require proposers and existing contractors to submit plans and/or modifications for increasing health equity
- ❒ Include weighted criteria and scoring for health equity and inclusion elements of Requests for Grant Proposals (RFGPs) and Requests for Proposals (RFPs)
- ❒ Require proposers to include equity performance measures, including metrics and indicators that address both internal and external performance (ex: patient satisfaction, increase in diversity of staff)?[4]
- ❒ Invest in cultural competency assessment and training
- ❒ Redirect or redistribute program strategies and funding towards opportunity zones and/or geographic tracts where greater health inequities exist
- ❒ Establish meaningful funding levels for health equity activities in grant awards (to eliminate "funding for failure" amounts)
- ❒ Include communities experiencing health inequities on grant or contract review panels
- ❒ Recognize and fund culturally and linguistically appropriate community practices that promote health and protect community (include both community-identified and evidence-based or promising practices)

Health Program and Service Provision Improvements for Equity and Inclusion

- ❒ Enforce of Title VI of the Civil Rights Act[5] in program and grantee/contractor service delivery

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[3] "Culturally-appropriate processes" means tailoring processes to an individual's or community's culture and language preference, being respectful of and responsive to the beliefs, practices and needs of diverse stakeholders (adapted from ThinkCulturalHealth.org, guidance on CLAS standards)

[4] Adapted from "Multnomah County Equity and Empowerment Lens," Multnomah County, 2014.

[5] http://www.justice.gov/crt/about/cor/coord/titlevistat.php

- ❒ Ensure language access provisions (ex: provide timely interpretation, translation, alternate formats) in the service delivery
- ❒ Use only qualified/certified health care interpreters and/or ASL certified interpreters in medical settings
- ❒ Ensure that bilingual/multilingual program staff and contracted interpreters to meet bilingual proficiency standards if using their language skills in program delivery
- ❒ Require that documents are developed in plain language
- ❒ Ensure timely translation of documents necessary to maintain and protect the health of all communities
- ❒ Utilize Traditional Health Workers[6] in health promotion activities and health care service delivery
- ❒ Utilize or recognize culturally and linguistically appropriate services (including the incorporation of non-Western approaches to health promotion and health care)
- ❒ Require cultural competency training for health and service providers
- ❒ Incentivize participation to engage under-represented groups (ex: stipends for advisory bodies)
- ❒ Incentivize the incorporation of health equity policies and practices
- ❒ Provide services in "non-traditional" settings that increase access to those services
- ❒ Require programs to tie health improvement policies and strategies to social determinants of health and collaborate with other state and local cross-sector entities to address those determinants of health

Diversity, Affirmative Action, Discrimination Protections

- ❒ Increase contracting or procurement opportunities for Minority, Women and Emerging Small Businesses
- ❒ Require data collection, reporting and establishment of metrics related to employment of under-represented populations
- ❒ Require efforts to increase workforce diversity (recruitment and interviewing processes, retention strategies such as employee resource groups, professional development opportunities targeted to under-represented staff)
- ❒ Include individuals from under-represented communities on interview panels
- ❒ Incentivize or require cultural competency training for staff
- ❒ Require enhancements to ensure accessibility to meet ADA requirements (Facilities improvements, signage, materials in alternate formats, provisions for assistance animals)
- ❒ Require formal and informal complaint procedures for staff and clients to address discrimination complaints[7]

[6] Traditional Health Workers are defined as community health workers, peer wellness specialists, peer support specialists, personal health navigators and doulas.

[7] Adapted from *"Tool-for-Organizational-Self-Assessment-Related-to-Racial-Equity-2014."* Coalition of Communities of Color. http://coalitioncommunitiescolor.org/

HEALTH EQUITY AND INCLUSION LENS FOR BILL ANALYSIS

"Equity and Inclusion First" *– When we design policies and provide programs and services that improve health for people of color, people with limited English proficiency, LGBTQ communities, and people with disabilities, all communities benefit!*

Use this tool to identify opportunities to support/enhance equity, diversity and inclusion, and reduce disparate impact in legislative bills.

Community Engagement/Partnership

Is there an opportunity in the bill to:

- ❒ Mandate committees, councils, advisory groups or other bodies to focus on equity and/or inclusion?
- ❒ Require committees, councils, advisory groups or other policy-making bodies to reflect state and/or local populations most affected by inequities (with mandated threshold or percentage requirements)?
- ❒ Require "meaningful participation"[1] of communities experiencing health inequities?
- ❒ Clearly define terminology to ensure representation of communities experiencing health inequities (including "consumers," "underserved communities," "racially, ethically and linguistically diverse communities," communities historically experiencing poor health outcomes," etc.)?
- ❒ More meaningfully address inequities so that the needs of members with multiple identities are addressed (ex: low income people of color, people of color who also have disabilities)?
- ❒ Create institutional accountability to communities experiencing health inequities (example: require annual or biennial reporting on data, activities, progress on goals, service delivery, timeliness of services to reduce health inequities)?

Race, Ethnicity, and Language +Disability (REAL+D) Data Collection/Analysis

Is there an opportunity in the bill to:

- ❒ Require collection of data disaggregated by race, ethnicity, language and disability (following HB2134[2] standards for data collection)?
- ❒ Require collection of data on sexual orientation, non-conforming gender?
- ❒ Require training for staff on best practices on collecting data from diverse communities, including maintaining confidentiality and explaining purpose?

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[1] "Meaningful participation" means engaging a diverse group of stakeholders who are representative of the communities that policies will impact, not only in consultative roles to provide input, but also to co-plan or lead policy development efforts, have access to data and resources to make informed decisions, have decision-making authority, and to participate in the analysis of data and policy impact efforts.

[2] Oregon Administrative Rules 943-070-0000 to 943-070-0070

- ❒ Require the inclusion of affected communities in planning, data collection methods, analysis, and dissemination, and utilizing culturally appropriate processes[3] to do so?
- ❒ Require dissemination of final data to affected communities?

Research and Evaluation

Is there an opportunity in the bill to:

- ❒ Mandate health equity or other equity impact analyses on new or existing efforts?
- ❒ Mandate inclusion of diverse communities at every stage of research efforts, including planning, evaluation design, implementation, analysis, and dissemination of research results to communities affected, and to utilize culturally appropriate processes to do so?
- ❒ Require the inclusion of health equity and/or inclusion metrics or indicators in all planning, quality, intervention, and impact assessments and reports?

Funding and Capacity Building for Equity and Inclusion

Is there an opportunity in the bill to:

- ❒ Mandate strategic investments and resource allocation for health equity advancements?
- ❒ Require proposers to identify service populations based on racial and/or health inequities data?
- ❒ Require proposers and existing contractors to submit plans and/or modifications for increasing health equity?
- ❒ Require Requests for Grant Proposals (RFGPs) and Requests for Proposals (RFPs) to include weighted criteria and scoring for health equity efforts?
- ❒ Require proposers to include equity performance measures, including metrics and indicators that address both internal and external performance (ex: patient satisfaction, increase in diversity of staff)?[4]
- ❒ Require investments in cultural competency training?
- ❒ Require funding and resource allocation and planning to redirect or redistribute funding towards opportunity zones and/or geographic tracts where greater health inequities exist?
- ❒ Require meaningful funding levels for health equity activities in grant awards (to eliminate "funding for failure" amounts)?
- ❒ Require inclusion of communities experiencing health inequities on grant or contract review panels?
- ❒ Recognize and fund culturally and linguistically appropriate community practices that promote health and protect community (include both community-identified and evidence-based practices)?

[3] "Culturally-appropriate processes" means tailoring processes to an individual's or community's culture and language preference, being respectful of and responsive to the beliefs, practices and needs of diverse stakeholders (adapted from ThinkCulturalHealth.org, guidance on CLAS standards)

[4] Adapted from "Multnomah County Equity and Empowerment Lens," Multnomah County, 2014.

Health Program and Service Provision Improvements for Equity and Inclusion

Is there an opportunity in the bill to:

- ❒ Require enforcement of Title VI of the Civil Rights Act[5]?
- ❒ Require language access provisions (ex: provide timely interpretation, translation, alternate formats)?
- ❒ Require the use of only qualified/certified health care interpreters and/or ASL certified interpreters in medical settings?
- ❒ Require bilingual/multilingual program staff and contracted interpreters to meet bilingual proficiency standards if using their language skills in program delivery?
- ❒ Require that documents are developed in plain language?
- ❒ Require timely translation of documents necessary to maintain and protect the health of all communities?
- ❒ Require the use of Traditional Health Workers[6] in health care service delivery?
- ❒ Require programs and services to utilize or recognize culturally and linguistically appropriate services (including the incorporation of non-Western approaches to health and health care)?
- ❒ Require cultural competency training for health and service providers?
- ❒ Incentivize participation to engage under-represented groups (ex: stipends for advisory bodies)?
- ❒ Incentivize the incorporation of health equity policies and practices?
- ❒ Require the provision of services in "non-traditional" settings that increase access to those services?
- ❒ Require programs to tie health improvement policies and strategies to social determinants of health and collaborate with other state and local cross-sector entities to address those determinants of health?

Diversity, Affirmative Action, Discrimination Protections

Is there an opportunity in the bill to:

- ❒ Increase contracting or procurement opportunities for Minority, Women and Emerging Small Businesses?
- ❒ Require data collection, reporting and establishment of metrics related to employment of under-represented populations?
- ❒ Require efforts to increase workforce diversity (recruitment and interviewing processes, retention strategies such as employee resource groups, professional development opportunities targeted to under-represented staff)?
- ❒ Incentivize or require cultural competency training for staff?
- ❒ Require enhancements to ensure accessibility to meet ADA requirements? (Facilities improvements, signage, materials in alternate formats, provisions for assistance animals)?
- ❒ Require formal and informal complaint procedures for staff and clients to address discrimination complaints[7]

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[5] http://www.justice.gov/crt/about/cor/coord/titlevistat.php

[6] Traditional Health Workers are defined as community health workers, peer wellness specialists, peer support specialists, personal health navigators and doulas.

[7] Adapted from *"Tool-for-Organizational-Self-Assessment-Related-to-Racial-Equity-2014."* Coalition of Communities of Color. http://coalitioncommunitiescolor.org/

Education Investment Board:

Equity Lens

OEIB Vision Statement

To advise and support the building, implementation and investment in a unified public education system in Oregon that meets the diverse learning needs of every pre-K through postsecondary student and provides boundless opportunities that support success; ensuring a 100 percent high school graduation rate by 2025 and reaching the 40-40-20 goal.

OEIB Equity Lens: Preamble

The Oregon Educational Investment Board has a vision of educational equity and excellence for each and every child and learner in Oregon. We must ensure that sufficient resource is available to guarantee their success and we understand that the success of every child and learner in Oregon is directly tied to the prosperity of all Oregonians. The attainment of a quality education strengthens all Oregon communities and promotes prosperity, to the benefit of us all. It is through educational equity that Oregon will continue to be a wonderful place to live, and make progress towards becoming a place of economic, technologic and cultural innovation.

Oregon faces two growing opportunity gaps that threaten our economic competitiveness and our capacity to innovate. The first is the persistent achievement gap between our growing populations of communities of color, immigrants, migrants, and low income rural students with our more affluent white students. While students of color make up over 30% of our state- and are growing at an inspiriting rate- our achievement gap has continued to persist. As our diversity grows and our ability to meet the needs of these students remains stagnant or declines- we limit the opportunity of everyone in Oregon. The persistent educational disparities have cost Oregon billions of dollars in lost economic output[1] and these losses are compounded every year we choose not to properly address these inequalities.

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[1] Alliance for Excellent Education. (November 2011). *The high cost of high school dropouts: What the nation pays for inadequate high schools.* www.all4ed.org

The second achievement gap is one of growing disparity between Oregon and the rest of the United States. Our achievement in state benchmarks has remained stagnant and in some communities of color has declined while other states have begun to, or have already significantly surpassed our statewide rankings. If this trend continues, it will translate into economic decline and a loss of competitive and creative capacity for our state. We believe that one of our most critical responsibilities going forward is to implement a set of concrete criteria and policies in order to reverse this trend and deliver the best educational continuum and educational outcomes to Oregon's Children.

The primary focus of the equity lens is on race and ethnicity. While there continues to be a deep commitment to many other areas of the opportunity gap, we know that a focus on race by everyone connected to the educational milieu allows direct improvements in the other areas. We also know that race and ethnicity continue to compound disparity. We are committed to explicitly identifying disparities in education outcomes for the purpose of targeting areas for action, intervention and investment.

Beliefs:

We believe that everyone has the ability to learn and that we have an ethical responsibility and a moral responsibility to ensure an education system that provides optimal learning environments that lead students to be prepared for their individual futures.

We believe that speaking a language other than English is an asset and that our education system must celebrate and enhance this ability alongside appropriate and culturally responsive support for English as a second language.

We believe students receiving special education services are an integral part of our educational responsibility and we must welcome the opportunity to be inclusive, make appropriate accommodations, and celebrate their assets. We must directly address the over-representation of children of color in special education and the under-representation in "talented and gifted."

We believe that the students who have previously been described as "at risk," "underperforming," "under-represented," or minority actually represent Oregon's best opportunity to improve overall educational outcomes. We have many counties in rural and urban communities that already have populations of color that make up the majority. Our ability to meet the needs of this increasingly diverse population is a critical strategy for us to successfully reach our 40/40/20 goals.

We believe that intentional and proven practices must be implemented to return out of school youth to the appropriate educational setting. We recognize that this will require us to challenge and change our current educational setting to be more culturally responsive, safe, and responsive to the significant number of elementary, middle, and high school students who are currently out of school. We must make our schools safe for every learner.

We believe that ending disparities and gaps in achievement begin in the delivery of quality Early Learner programs and appropriate parent engagement and support. This is not simply an expansion of services -- it is a recognition that we need to provide services in a way that best meets the needs of our most diverse segment of the population, 0-5 year olds and their families.

We believe that resource allocation demonstrates our priorities and our values and that we demonstrate our priorities and our commitment to rural communities, communities of color, English language learners, and out of school youth in the ways we allocate resources and make educational investments.

We believe that communities, parents, teachers, and community-based organizations have unique and important solutions to improving outcomes for our students and educational systems. Our work will only be successful if we are able to truly partner with the community, engage with respect, authentically listen -- and have the courage to share decision making, control, and resources.

We believe every learner should have access to information about a broad array of career/job opportunities and apprenticeships that will show them multiple paths to employment yielding family-wage incomes, without diminishing the responsibility to ensure that each learner is prepared with the requisite skills to make choices for their future.

We believe that our community colleges and university systems have a critical role in serving our diverse populations, rural communities, English language learners and students with disabilities. Our institutions of higher education, and the P-20 system, will truly offer the best educational experience when their campus faculty, staff and students reflect this state, its growing diversity and the ability for all of these populations to be educationally successful and ultimately employed.

We believe the rich history and culture of learners is a source of pride and an asset to embrace and celebrate.

And, we believe in the importance of supporting great teaching. Research is clear that "teachers are among the most powerful influences in (student) learning."[2] An equitable education system requires providing teachers with the tools and support to meet the needs of each student.

Purpose of the OEIB Equity Lens: The purpose of the equity lens is to clearly articulate the shared goals we have for our state, the intentional investments we will make to reach our goals of an equitable educational system, and to create clear accountability structures to ensure that we are actively making progress and correcting where there is not progress. As the OEIB executes its charge to align and build a P-20 education system, an equity lens will prove useful to ensure **every** learner is adequately prepared by educators focused on equity for meaningful contributions to society. The **equity lens** will confirm the importance of recognizing institutional and systemic barriers and discriminatory practices that have limited access for many students in the Oregon education system. The equity lens emphasizes underserved students, such as out of school youth, English Language Learners, and students in some communities of color and some rural geographical locations, with a particular focus on racial equity. The result of creating a culture of equity will focus on the outcomes of academic proficiency, civic awareness, workplace literacy, and personal integrity. The system outcomes will focus on resource allocation, overall investments, hiring and professional learning.

Oregon Educational Investment Board Case for Equity:

Oregonians have a shared destiny. Individuals within a community and communities within a larger society need the ability to shape their own present and future and we believe that education is a fundamental aspect of Oregon's ability to thrive. Equity is both the means to educational success and an end that benefits us all. Equity requires the intentional examination of systemic policies and practices that, even if they have the appearance of fairness, may in effect serve to marginalize some and perpetuate disparities. Data are clear that Oregon demographics are changing to provide rich diversity in race, ethnicity, and language.[3] Working toward equity requires an understanding of historical contexts and the active investment in changing social structures and changing practice over time to ensure that all communities can reach the goal and the vision of 40/40/20.

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[2] Hattie, J. (2009), *Visible learning: A synthesis of over 800 meta-analyses relating to student achievement. P. 238.*

[3] Oregon Statewide Report Card 2011-2012. www.ode.state.or.us

ADDENDUMS

Basic Features of the Equity Lens:

Objective: By utilizing an equity lens, the OEIB aims to provide a common vocabulary and protocol for resource allocation and evaluating strategic investments.

The following questions will be considered for resource allocation and evaluating strategic investments:

1. **Who are the racial/ethnic and underserved groups affected? What is the potential impact of the resource allocation and strategic investment to these groups?**
2. **Does the decision being made ignore or worsen existing disparities or produce other unintended consequences? What is the impact on eliminating the opportunity gap?**
3. **How does the investment or resource allocation advance the 40/40/20 goal?**
4. **What are the barriers to more equitable outcomes? (e.g. mandated, political, emotional, financial, programmatic or managerial)**
5. **How have you intentionally involved stakeholders who are also members of the communities affected by the strategic investment or resource allocation? How do you validate your assessment in (1), (2) and (3)?**
6. **How will you modify or enhance your strategies to ensure each learner and communities' individual and cultural needs are met?**
7. **How are you collecting data on race, ethnicity, and native language?**
8. **What is your commitment to P-20 professional learning for equity? What resources are you allocating for training in cultural responsive instruction?**

Creating a culture of equity requires monitoring, encouragement, resources, data, and opportunity. OEIB will apply the equity lens to strategic investment proposals reviews, as well as its practices as a board.

Definitions:

Equity: in education is the notion that EACH and EVERY learner will receive the necessary resources they need individually to thrive in Oregon's schools no matter what their national origin, race, gender, sexual orientation, differently abled, first language, or other distinguishing characteristic.

Underserved students: Students whom systems have placed at risk because of their race, ethnicity, English language proficiency, socioeconomic status, gender, sexual orientation, differently abled, and geographic location. Many students are not served well in our education system because of the conscious and unconscious bias, stereotyping, and racism that is embedded within our current inequitable education system.

Achievement gap: Achievement gap refers to the observed and persistent disparity on a number of educational measures between the performance of groups of students, especially groups defined by gender, race/ethnicity, and socioeconomic status.

Race: Race is a social – not biological – construct. We understand the term "race" to mean a racial or ethnic group that is generally recognized in society and often, by government. When referring to those groups, we often use the terminology "people of color" or "communities of color" (or a name of the specific racial and/or ethnic group) and "white."

We also understand that racial and ethnic categories differ internationally, and that many of local communities are international communities. In some societies, ethnic, religious and caste groups are oppressed and racialized. These dynamics can occur even when the oppressed group is numerically in the majority.

White privilege: A term used to identify the privileges, opportunities, and gratuities offered by society to those who are white.

Embedded racial inequality: Embedded racial inequalities are also easily produced and reproduced – usually without the intention of doing so and without even a reference to race. These can be policies and practices that intentionally and unintentionally enable white privilege to be reinforced.

40-40-20: Senate Bill 253 - states that by 2025 all adult Oregonians will hold a high school diploma or equivalent, 40% of them will have an associate's degree or a meaningful postsecondary certificate, and 40% will hold a bachelor's degree or

advanced degree. 40-40-20 means representation of every student in Oregon, including students of color.

Disproportionality: Over-representation of students of color in areas that impact their access to educational attainment. This term is a statistical concept that actualizes the disparities across student groups.

Opportunity Gap: the lack of opportunity that many social groups face in our common quest for educational attainment and the shift of attention from the current overwhelming emphasis on schools in discussions of the achievement gap to more fundamental questions about social and educational opportunity.[4]

Culturally Responsive: Recognize the diverse cultural characteristics of learners as assets. Culturally responsive teaching empowers students intellectually, socially, emotionally and politically by using cultural referents to impart knowledge, skills and attitudes.[5]

[4] (The Opportunity Gap (2007). Edited by Carol DeShano da Silva, James Philip Huguley, Zenub Kakli, and Radhika Rao.

[5] Ladson-Billings, Gloria (1994). The Dreamkeepers: Successful Teachers of African American Children.

Jackson County Health Equity Assessment – Phase 1 Racial and Ethnic Disparities

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SO Health-E

HEALTH EQUITY FOR ALL

SO Health-E Regional Health Equity Coalition

Winter 2015

Prepared by Joanne Noone, PhD, RN, Oregon Health & Science University

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The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

January, 2015

Who and What is SO Health-E?

- SO Health-E is a collaboration of community stakeholders forming a regional health equity coalition in southern Oregon.
- SO Health-E is funded by the Oregon Health Authority Office of Equity and Inclusion.
- Our mission is to advance policy, systems, and environmental changes that promote equity and address social determinants of health.
- We shall prioritize health disparities for underrepresented populations including racially and ethnically diverse communities, people with disabilities, LGBT communities and low-income individuals.
- This Phase 1 Report is an assessment of health disparities related to race and ethnicity.

What are Health Inequities and Why Do They Matter?

"Health inequities are differences in health status and mortality rates across population groups that are systemic, avoidable, unfair, and unjust."

Margaret Whitehead
World Health Organization

Health equity is when all people have "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance.'"

Center for Disease Control

Social Determinants of Health

Most health inequities are due to social determinants of health. These "include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world."

Center for Disease Control

"Poverty and education are the two social determinants that have the most impact on health outcomes."

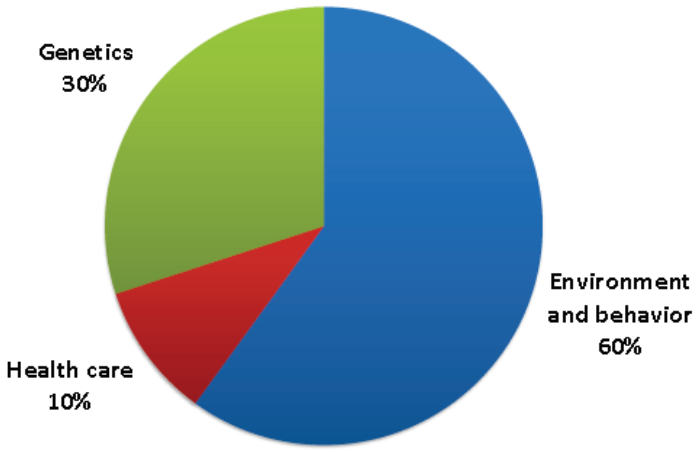
John Moenster,

Institute for People, Place and Possibility,

July 17, 2014

Determinants of Health and Their Contribution to Premature Death

The pie chart on the right represents determinants of health and their contribution to premature death. Many people think that if we just increase health care access, that alone will improve people's health. But when it comes to premature death, for example, access to health care accounts for just 10% of the impact on premature death. Changing behavior and improving the environment in which one lives, such as reducing poverty, will have the greatest impact on health.



Source: We Can Do Better, New England Journal of Medicine, September, 2007

If For No Other Reason, Consider the Economic Cost of Health Disparities

- Between 2003 and 2006, 30.6% of direct medical care expenditures for African Americans, Asians, and Hispanics were excess costs due to health inequalities;
- Eliminating health disparities for minorities would have reduced direct medical care expenditures by $229.4 billion for the years 2003-2006;
- Eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by more than one trillion dollars between 2003 and 2006.
- Between 2003 and 2006 the combined costs of health inequalities and premature death in the United States were $1.24 trillion

Source: *The Economic Burden of Health Inequities in the United States.* Joint Center for Political and Economic Studies. *(2009).*

Purpose of this Phase 1 Assessment

The purpose of the Phase 1 Health Equity Assessment is to review existing data sources and sets to identify health inequities in our community related to race and ethnicity to inform:

- Further areas for data collection
- Prioritization of health issues
- A strategic health plan

Types of Data

Over 60 national, state and local reports on health equity were reviewed and analyzed including:

- Local community assessments
- Local focus groups findings
- State data sets

2012 Jackson County Latino Parent Focus Groups on Teen Pregnancy

Preexisting state data sets were reanalyzed to provide data at county level by race and ethnicity as available.

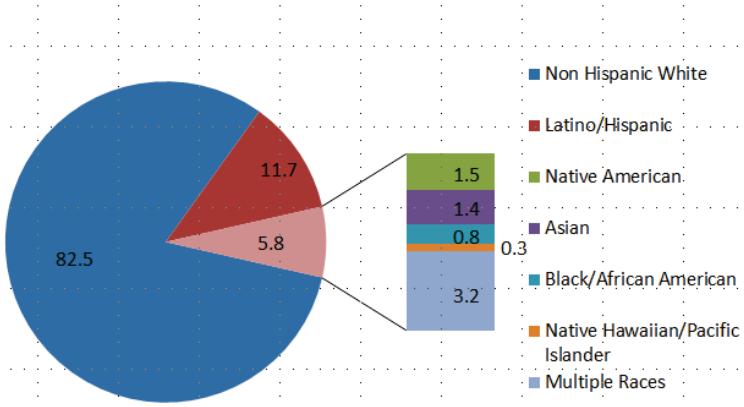
Limitations

- For certain data sets, there were not enough respondents by race and ethnicity responding from Jackson County to generate estimates
- For other data sets, data was collected years apart so multiple years of data could not be aggregated
- Some data sets do not fully report race and ethnicity
- For other data sets, the total number is so small that breakdown by race and ethnicity is meaningless
- Some data sets are a snapshot in time and trends over time need to be analyzed

Terms used in this report: Most national and state data reports comparing ethnicity use the designations Non-Hispanic White and Hispanic. In this report, we use the word "Latino" instead of "Hispanic" because of identified community preference for this term.

Trends in Jackson County Demographics - 2013

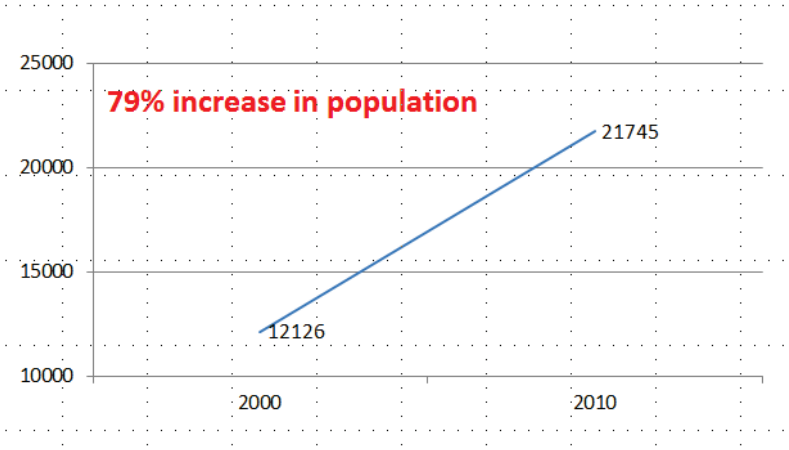
2013 US Census data estimates that about 11.7% of the Jackson County population is Latino or Hispanic. Since migrant and seasonal worker populations may not be included in census data, the number may be an underestimate.



Source: US Census Data

Latino Population Growth Jackson County 2000-2010

The Latino population grew 79% from 2000 to 2010. In 2000, census data reported 12,126 Latino residents of Jackson County. This number grew to 21,745 in 2010. As indicated above, this number may be an underestimate.



Source: US Census Data

Because of the significant numbers of Latino residents in Jackson County and the very small data sets of other race and ethnicities, the focus of this Phase 1 report is on health disparities in the Latino population in Jackson County.

Health Disparities in Jackson County Related to Race and Ethnicity

Based on available data, health disparities in the Latino population were identified in the following areas:

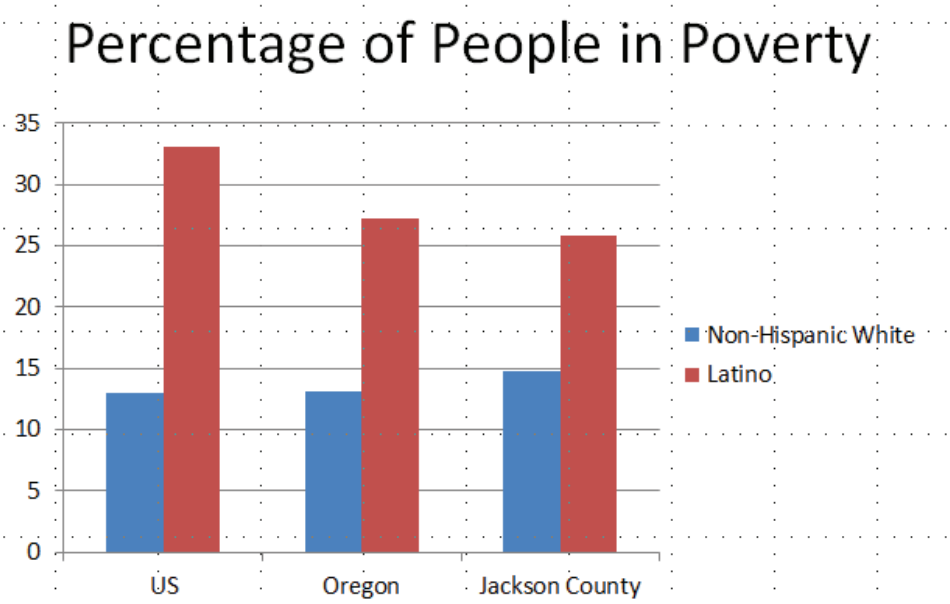
- Poverty rates
- Access to health insurance
- Education
- Child/School health
- Mental Health
- Oral Health
- Experience of discrimination
- Weight and physical activity
- Teen Pregnancy Rates
- Workforce diversity

There were certain areas where state health disparities existed but local data for Jackson County showed better outcomes and these were in the areas of:

- Late trimester prenatal care initiation
- Female breast cancer stage of diagnosis

Percentage of People in Poverty

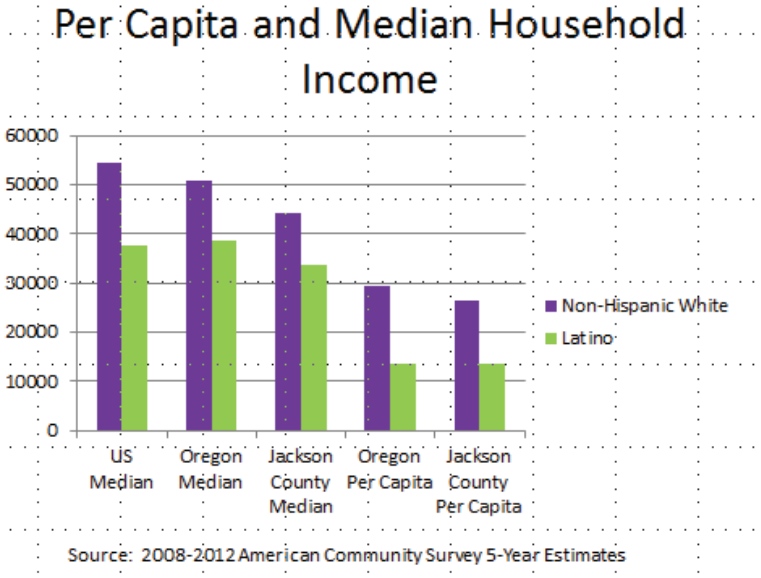
There are disparities in poverty rates and income related to race and ethnicity. These exist nationally, in the state of Oregon and locally within Jackson County. According to US Census data, 14.8% of Jackson county residents who are non-Hispanic whites lives in poverty compared to 25.8% of Latinos.



Sources: Poverty Status in the Past 12 Months, U.S. Census 2008-2012 American Community Survey 5-Year Estimates
Census Bureau's March 2012 and 2013 Current Population Survey

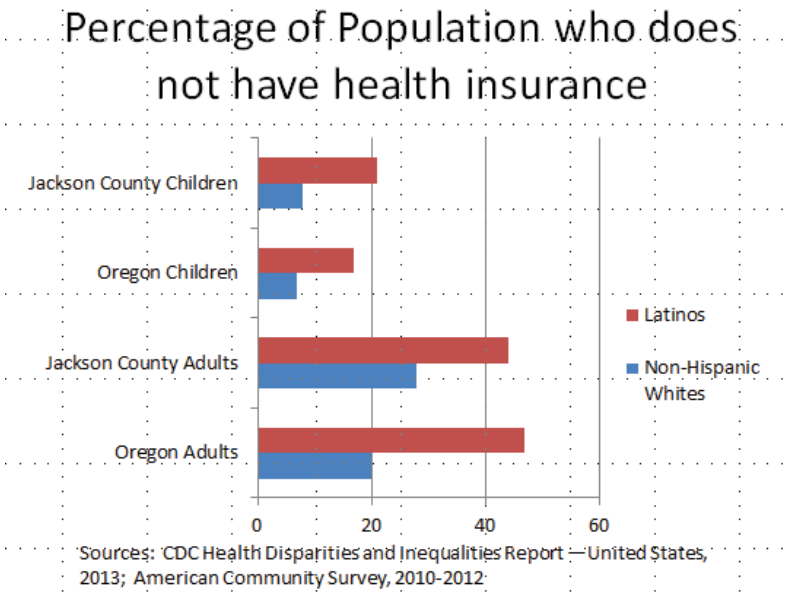
Median and per Capita Income

Disparities also exist for median and per capita income. According to US Census data 5 Year estimates for 2008-2012, median income for non-Hispanic white residents of Jackson County was $44,289 and $33,813 for Hispanic residents. Per capita income demonstrated a larger disparity at $26,379 for non-Hispanic white residents of Jackson County and $13,547 for Hispanic residents.



Access to Health Insurance

The following data from the 2010-2012 American Communities Survey was reported before recent initiatives to increase enrollment in the Oregon Health Plan. Disparities in access to health insurance exist for Jackson County Latino children and adults. Twenty-one per cent of Latino children living in Jackson County have no health insurance compared to 8% of Jackson County non-Hispanic white children. Among Jackson County adults, 44% of Hispanic adults do not have health insurance compared to 28% of non-Hispanic whites.

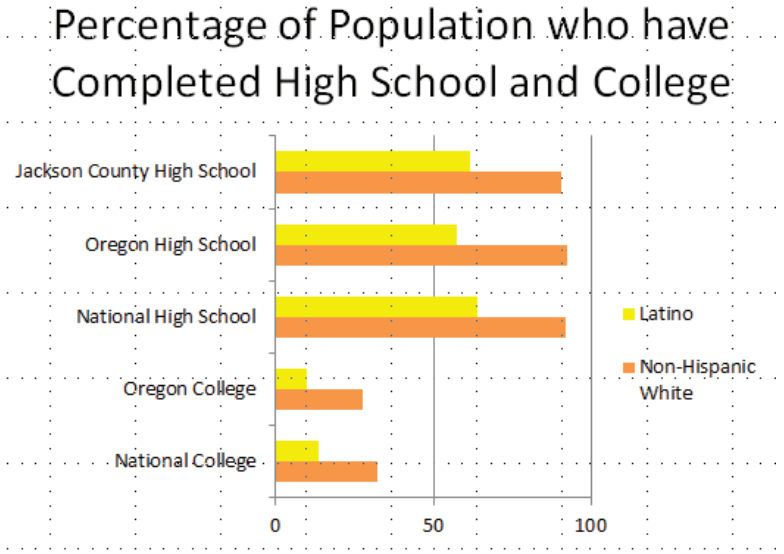


Recent data from local Coordinated Care Organizations (CCO) show enrollment data that is representative of Jackson County demographics. For example, July 2014 data for Jackson Care Connect, a local CCO, enrollment breakdown indicates that 26.3% of new child members and 12.9% of new adult members were Latino. It will be important to assess if these initiatives close the gap in health insurance access disparities.

Source: Oregon Transformation Center, 2014

Education

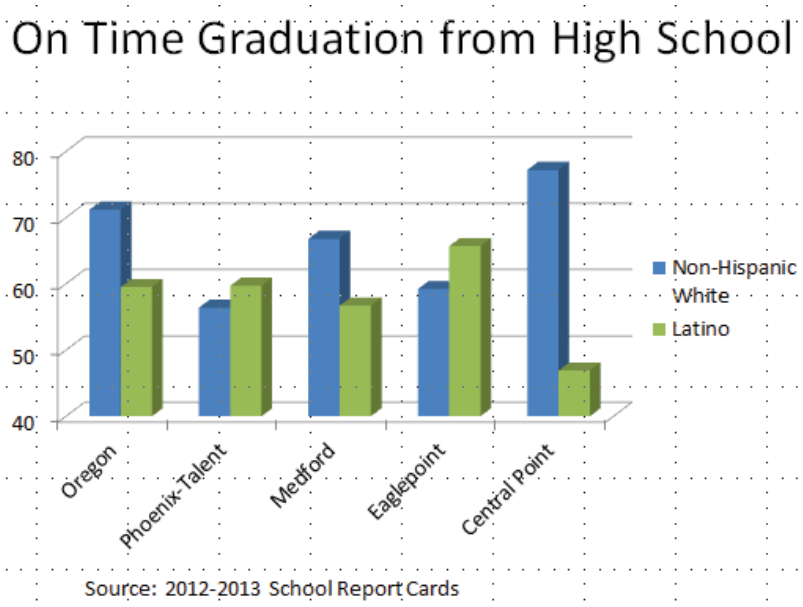
There are disparities in educational attainment for Latinos in Jackson County. For adults over age 25, non-Hispanic white residents of Jackson County have an approximately 50% higher completion rate of high school than Latino residents. Ninety per cent of non-Hispanic white residents have a high school diploma compared to 62% of Latino residents. Data is unavailable for college completion rates by race and ethnicity for Jackson County, although data trends indicate the disparity may be even greater than for high school completion rates. In Oregon, non-Hispanic whites (28%) are almost three times more likely to be college graduates than Latinos (10%).



Sources: Oregon Behavioral Risk Factor Surveillance System (BRFSS) Race Oversample 2010-2011; 2008-2012 American Community Survey 5-Year Estimates; 2012 US Census

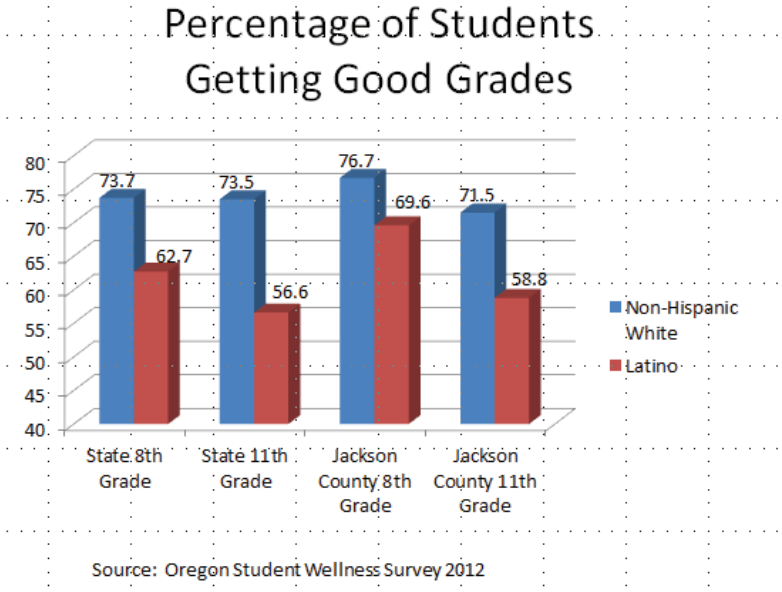
On-Time Graduation Rates

There are disparities in certain school districts, in particular Medford and Central Point school districts, in Jackson County for on-time graduation rates for Latinos based on data from 2012-2013 School reports cards. School districts, such as Phoenix-Talent and Eagle Point, have better outcomes for Latino youth. It would be important to understand what contributes to these differences.



Grades in Elementary and High School

Data from the 2012 Oregon Student Wellness Survey indicate that Latino youth are less likely to report getting good grades (As or Bs) in elementary and high school. While the difference is not wide for Jackson County 8th graders, the percentage of good grade reports drops for Latino 11th graders. This may contribute to high school completion and readiness for college.



Factors that May Impact School Success

Certain differences in students' experiences are evident in reviewing the 2012 Oregon Student Wellness Survey 2012. The following differences for 8th grade survey results and 11th grade survey results indicate that they are differences in Latino and Non-Hispanic white youth experiences with alcohol use, changing homes and schools, positive youth development and being harassed at school because of race and ethnicity and suicide attempts.

8th Grade School Health

	Oregon Non-Hispanic White	Oregon Latino	Jackson County Non-Hispanic White	Jackson County Latino
Use of Alcohol in Last 30 days	21.7%	27.1%	21.2%	30.9%
Changed homes since kindergarten	69.4%	74.5%	76.7%	84.2%
Changed school in past year	16.4%	24.2%	25.6%	30.9%
Positive youth development	61.9%	53.9%	61.4%	56%
Being harassed at school last 30 days due to race/ethnicity	9.5%	27.2%	8.7%	23.9%
Suicide attempts within last year	8.2%	11.7%	7.9%	10.9%

Positive youth development is a set of questions related to physical health, emotional/ mental health, competence, confidence, support and service. Students who answer yes to 5 of 6 questions have met the benchmark. Differences in positive youth development disappear in 11th grade respondents but differences in depression emerge.

11th Grade School Health

	Oregon Non-Hispanic White	Oregon Latino	Jackson County Non-Hispanic White	Jackson County Latino
Use of Alcohol in Last 30 days	37.5%	37.5%	37.4%	45%
Changed homes since kindergarten	70.5%	81.5%	77.6%	90.6%
Changed school in past year	11%	16%	20.3%	30%
Positive youth development*	66.8%	60.8%	62.5	64.5%
Being harassed at school in last 30 days due to race/ethnicity	6.7%	25.1%	5.3%	22.9%
Feeling sad or hopeless for at least 2 weeks in a row within last year	22.4%	26.9%	32.6%	37%
Suicide attempts within last year	6%	8.5%	6.8%	9%

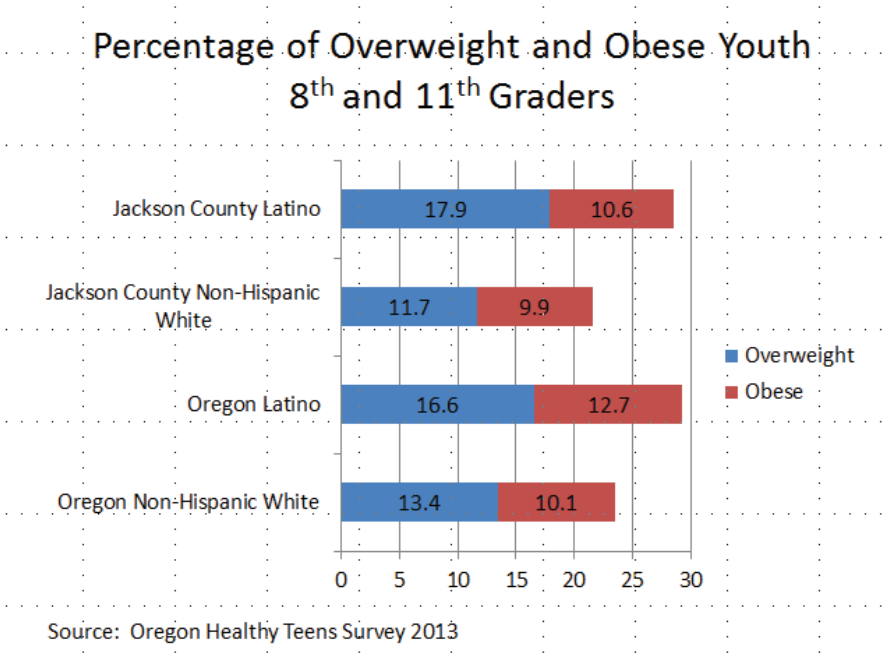
Oral Health

More than 1.6 million school days are missed in the US annually due to acute dental problems. Data from the 2012 Oregon Smile Survey of 6-9 year olds reveal that local Latino youth have oral health disparities that may impact their educational experience. Region 4 consists of Coos, Curry, Douglas, Jackson, Josephine, Klamath and Lane counties.

Oregon Smile Survey 2012	**Oregon Non-Hispanic White**	**Oregon Latino**	**Region 4 Non-Hispanic White**	**Region 4 Latino**
Cavities	47%	68%	52%	74%
Untreated decay	18%	25%	23%	32%
Rampant decay	11%	24%	21%	39%
Use of sealants	43%	37%	30.6%	26.9%
Needing urgent/ emergent dental care	17.3%	24.2%	21.7%	30.6%

Body Weight and Physical Activity

Nationally and within the state of Oregon, the Latino population is more at risk for overweight and diabetes and report less physical activity than non-Hispanic whites. In 2012 focus groups with Latino parents about teen pregnancy in Medford, White City and Talent/Phoenix, participants were also asked about other health concerns in their community. Obesity and diabetes were the top additional concerns. Data from the 2013 Healthy Teen Survey indicate Latino youth are more overweight and may be at risk for decreased physical activity and increased caloric intake than their non-Hispanic white counterparts.

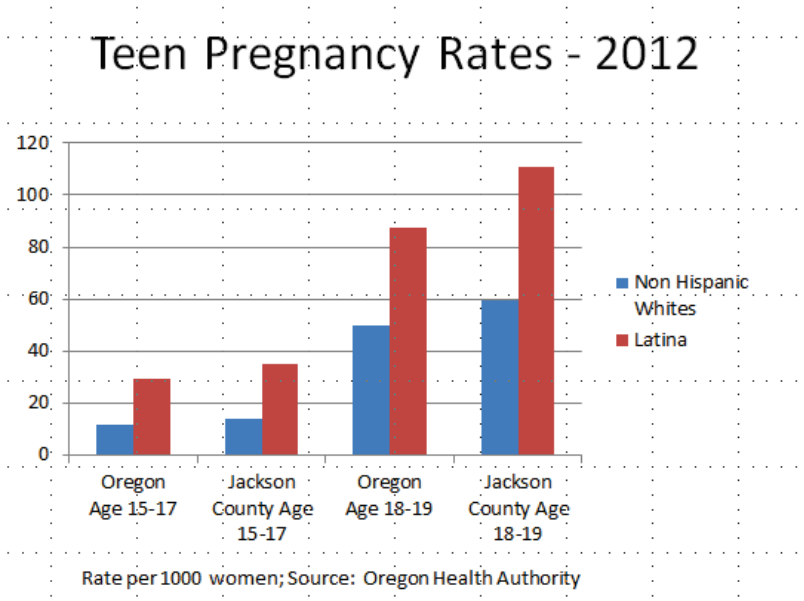


Oregon Healthy Teens Survey 2013	Oregon Non-Hispanic White	Oregon Latino	Jackson County Non-Hispanic White	Jackson County Latino
Eating out in fast food, take out, or restaurant 4 or more times in last week	15.5%	18.5%	16.8%	22.8%
Watching 2 or more hours of TV on school day	39.8%	52.4%	39.3%	51.6%
Playing video/computer games, using computer for non-school work 4 or more hours/school day	22.1%	27.7%	21.3%	30%

Teen Pregnancy

Teen pregnancy rates are declining nationally for all racial and ethnic groups. However, there is still a gap in teen pregnancy rates in Jackson County for Latina teens. Latina teens ages 15-17 have almost triple the rate of teen pregnancies compared to non-Hispanic whites, for those ages 18-19, it is almost double.

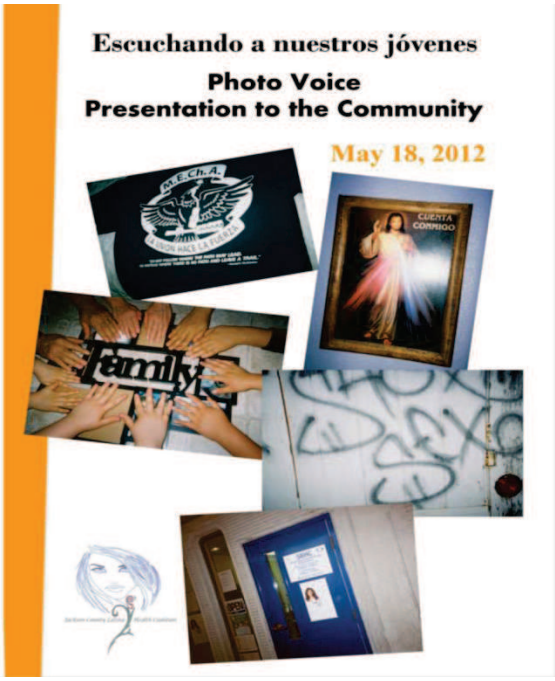
> "I thought about killing myself. After the initial shock, my aunt was happy and buying baby clothes."
>
> Teen Mother 2012
> Focus Group Participant



"I have machismo, but I cower at talking to my children about sex."
Father of Teen
2012 Focus Group Participant

Community assessments were conducted in 2012 and included focus groups with Latino parents of adolescents, Latino teen parents and a Photovoice project with Latino youth on the topic of teen pregnancy. Themes from the Photovoice project related to teen pregnancy were risks for teens, pressure, education is key, community resources and Latino values.

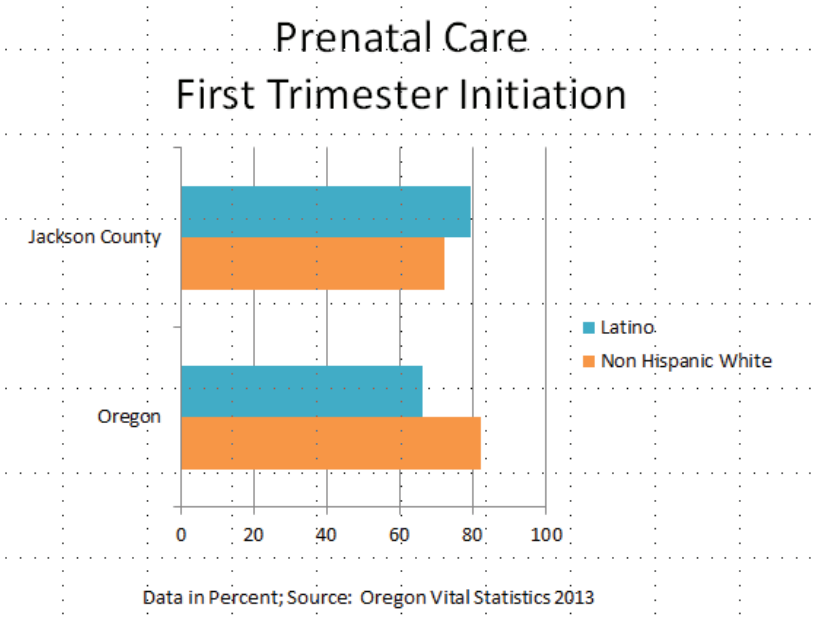
"Our parents didn't talk to us about these types of relationships. We didn't get that from our parents so now we have to break that ice barrier. This one time, it just occurred to me, in regards to this, my dad hit me; he said to me, this is something bad my dad was a very strict guy, and just by mentioning this one word, it was taken as an offense. We have to be open with our children – to prevent, for the future."
Father of Teen
2012 Focus Group Participant



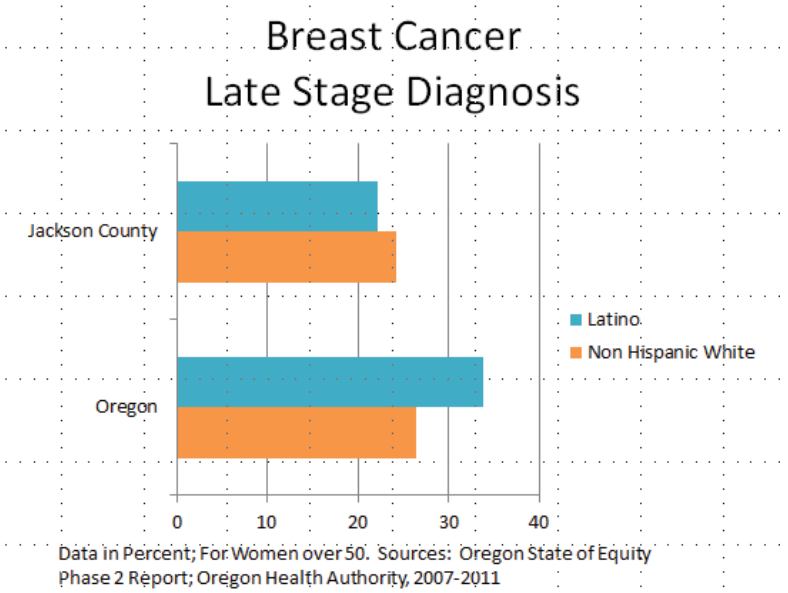
"I hid having a boyfriend – if my mom let me have a boyfriend and hang out at the house, this wouldn't have happened"
Teen Mother
2012 Focus Group Participant

Prenatal Care and Breast Cancer Diagnosis

The Oregon 2013 State of Equity Phase 2 Report identified initiation of first-trimester prenatal care and late-stage breast cancer diagnosis as health disparities for Latina women. Jackson County data revealed good news with no health disparities in these areas for Latina women.



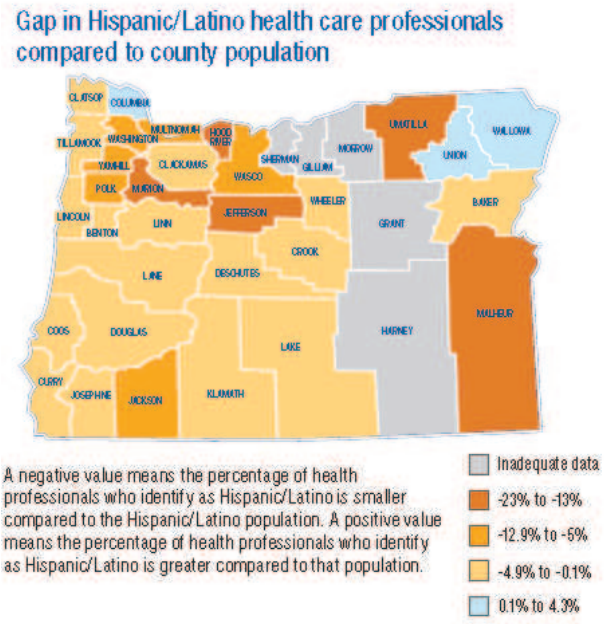
In the state of Oregon, compared to non-Hispanic whites (26.4%), the percentage of women over age 50 with late stage breast cancer at the time of diagnosis is higher for Latinas (33.8%). In Jackson County, compared to non-Hispanic whites (24.2%), the percentage of women over age 50 with late stage breast cancer at the time of diagnosis is lower for Latinas (22.2%).

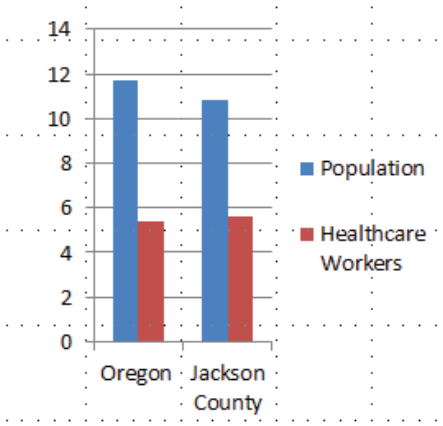


Workforce Diversity

The Oregon 2013 State of Equity Phase 2 Report identified differences in the diversity of the healthcare workforce in comparison to the Oregon adult population as a health disparity for Latinos. In a 2012-2013 report to the Oregon Health Authority from the Oregon Healthcare Workforce Committee, Jackson County was identified as a county with gaps in diversity of the healthcare workforce for Latinos.

Healthcare Workers



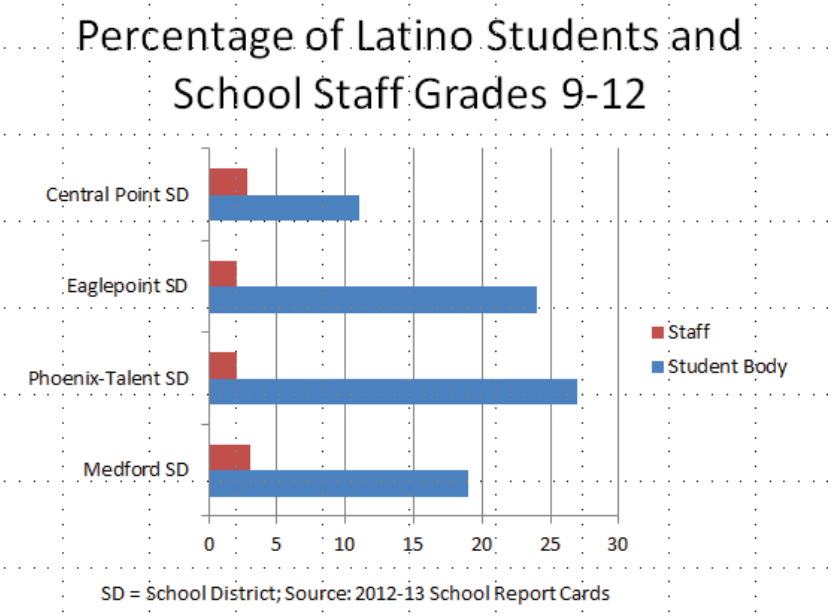


Percentage of Latino Health Care Professionals vs. Latino Population

Source: The Diversity of Oregon's Healthcare Workforce 2012—2013

School District Staff

In reviewing local school district report cards for 2012-2013, there are also gaps in composition of student body compared to school staff. Unfortunately, these school report cards do not differentiate school support staff and teachers.



SD = School District; Source: 2012-13 School Report Cards

Unknown Health Disparities in Jackson County Related to Race and Ethnicity

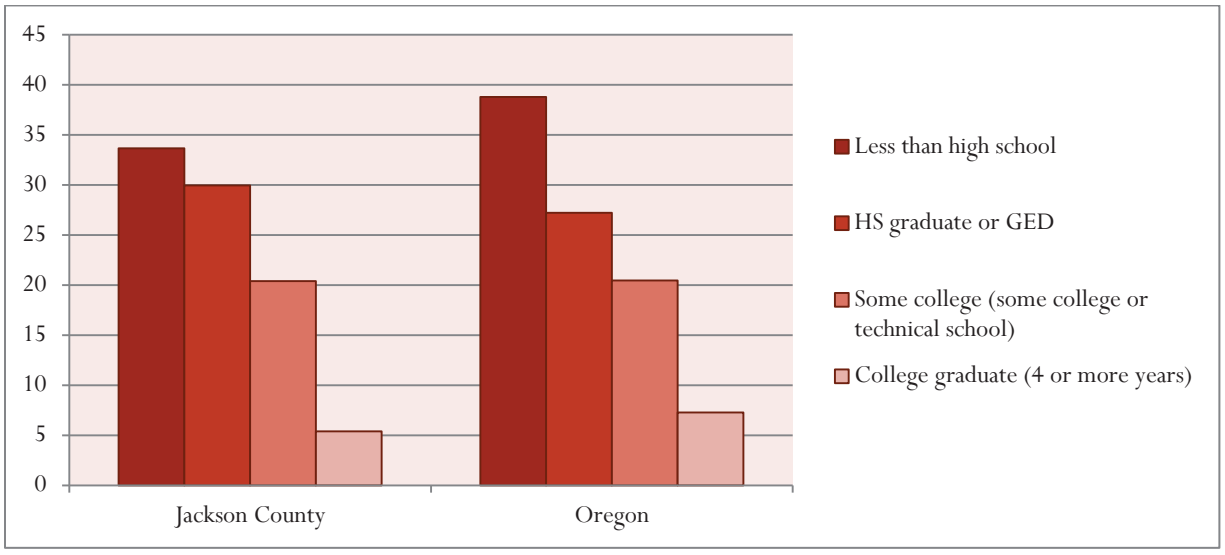
In reviewing national and state data, additional health disparities have been identified for Latinos for which Jackson County data is not available:

- HIV infection rates
- Diabetes prevalence
- Uncontrolled cholesterol
- Hypertension
- Depression in Adults
- Adult Obesity Rates
- Adult Physical activity
- Quality of life
- Colorectal screening
- Home ownership
- 5 year homicide rate
- Top concerns/Ratings of their community
- Job security
- Workers in high risk occupations

Health Disparities Related to Educational Attainment Jackson County 2015

The following charts show the disparities for four metrics gathered by the Behavioral Risk Factor Surveillance System for years 2010-2013 based on educational achievement for adults above age 25.

Percentage of Current Smokers

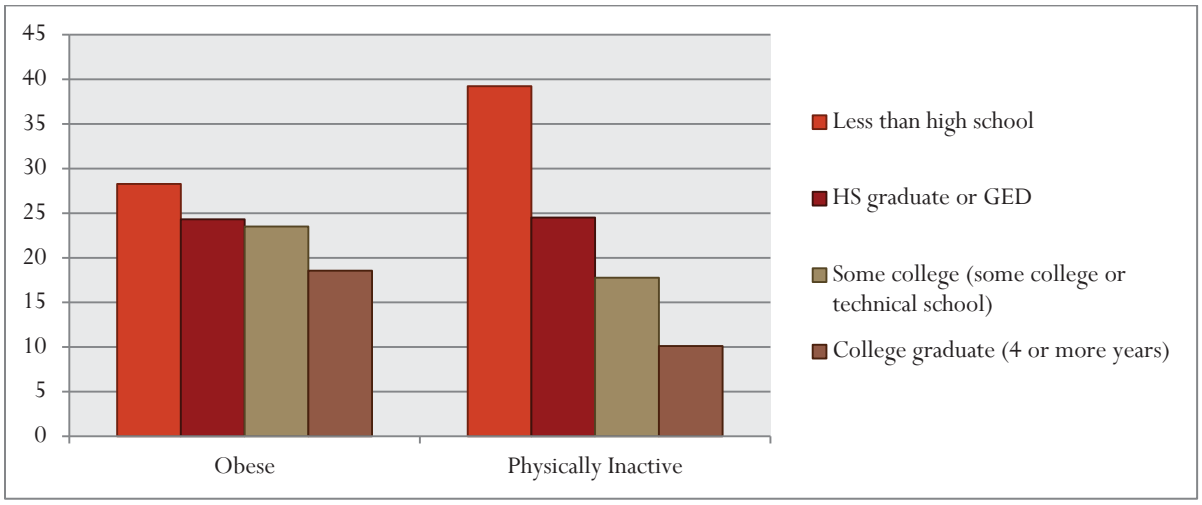


In Jackson County, almost 35% of those without a high school diploma are current smokers compared with 5% of college graduates.

SO HealthE Coalition

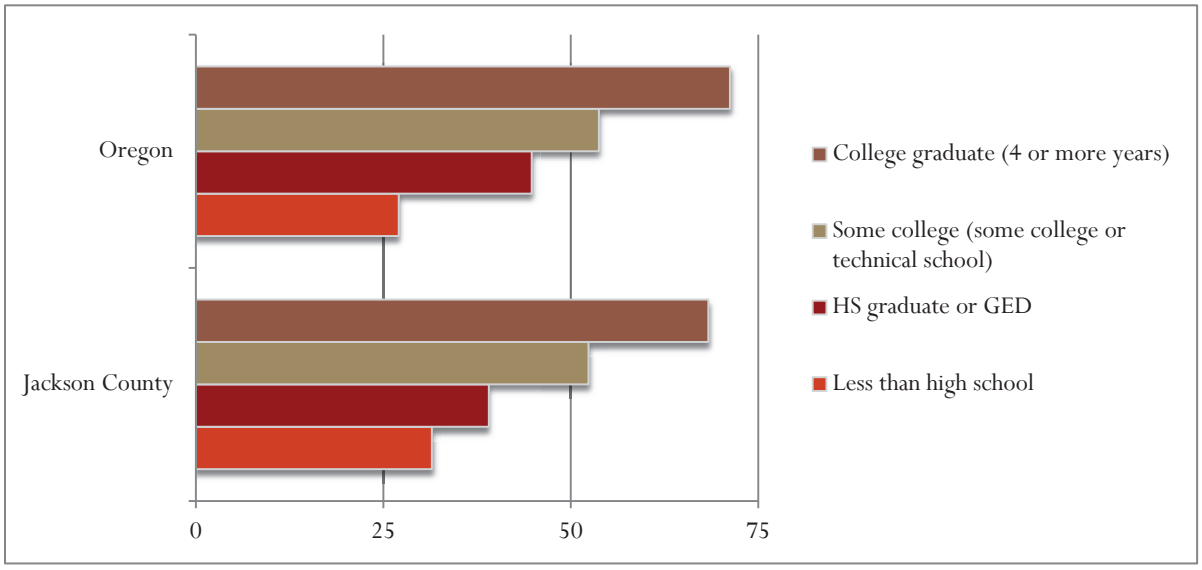
Prepared by Joanne Noone, PhD, RN
Oregon Health & Science University

Percent of People who are Obese and Physically Inactive



The prevalence of obesity in Jackson County residents who do not have a high school diploma is 28% and drops to 19% for those with a college degree. About 10% of college graduates in Jackson County report being physically inactive compared to almost 40% of those without a high school diploma.

Percent of People with Very Good or Excellent Health



About 70% of college graduates in Jackson County report very good or excellent health status compared to 32% of those without a high school diploma.

Jackson County: Lesbian, Gay, Bisexual, Transgender, Questioning Health Equity Report

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SO Health-E

HEALTH EQUITY FOR ALL

SO Health-E Regional Health Equity Coalition

Winter 2015

Prepared by Joanne Noone, PhD, RN, Oregon Health & Science University

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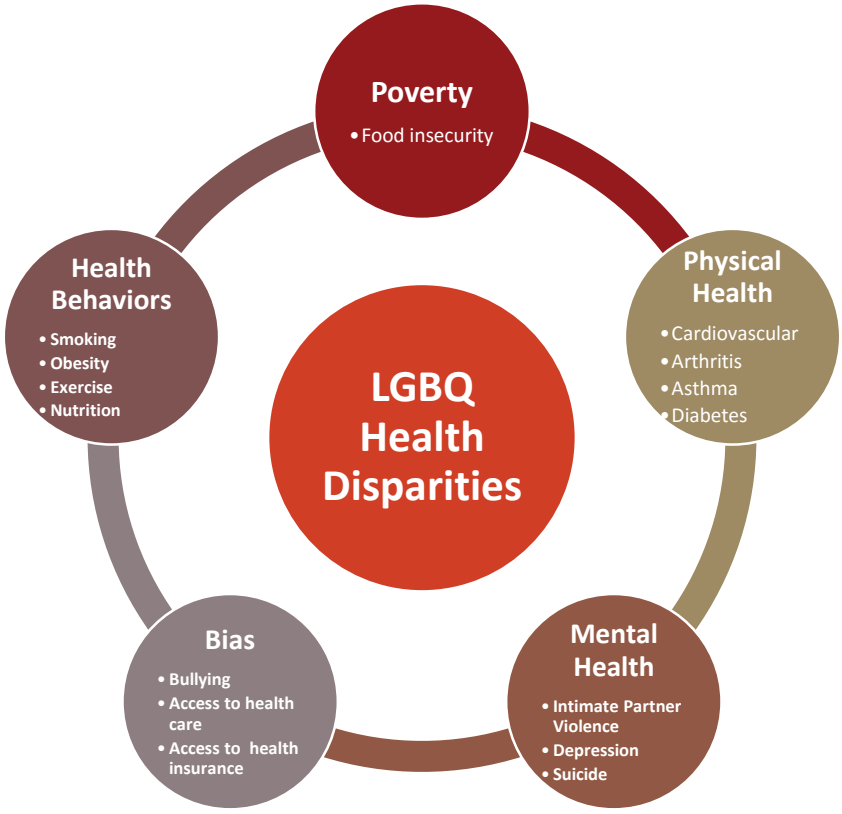
February, 2015

Introduction

According to the Center for Disease Control, people who are lesbian, gay, bisexual, transgender and those questioning or unsure of their sexual orientation (LGBTQ) experience health inequities. Sometimes these disparities are associated with the social discrimination and stigma LGBTQ people face. Within the state of Oregon, approximately 3% of the adult population is LGBTQ (Oregon Behavioral Risk Factor Surveillance Survey, 2005-2009), although a 2012 Gallup survey places estimates at closer to 5% (Gallup Daily Tracking, June-December, 2012). 8.6% of 11th graders on the 2014 Oregon Student Wellness Survey identify as LGBTQ.

Terms used in this report: The acronym LGBTQ will be used throughout this report when data includes information on all categories and is most commonly used with youth who still may be questioning or unsure of their sexual orientation. Since there is little known data in Oregon on the health of transgendered clients, the acronym LGB may be used for data limited to those subpopulations.

Known LGBQ Health Disparities in Oregon



Sources: CD Summary, Oregon Health Authority, Nov. 20, 2012 (Vol. 61, No. 21); Oregon Public Health Division State Health Profile September 2012

There are some known disparities within the state of Oregon related to lesbian, gay, and bisexual (LGB) populations – little is known related to transgendered health. In Oregon, LGB populations experience:

Poverty:

- Despite higher percentages of education, LGBQ adults are more likely to live in poverty. LGB adults are more likely to be college graduates (43% vs. 34%) than heterosexual adults, yet more LGB adults have an annual household income less than $20,000 (17% vs. 12%) and live in poverty (13% vs. 10%).
- LGB adults experience more household food insecurity (18% vs. 12%) than heterosexual adults.

Physical Health:

- More LGB adults live with arthritis, asthma, diabetes or cardiovascular disease than heterosexual adults (41% vs. 33%).
- In particular, nearly twice as many LGB adults report being diagnosed with asthma as heterosexual adults (17% vs. 9%).

Mental Health:

- Nearly twice as many LGB adults report frequent mental distress (14 or more days of poor mental health in the last 30 days) as heterosexual adults (17% vs. 9%).
- More than twice as many LGBQ youth report feeling "sad or hopeless for 2 or more weeks" in the past 12 months as their heterosexual peers (42% vs. 18%).
- One in five LGBQ youth report a suicide attempt in the last 12 months, compared with one in 25 heterosexual youth (20% vs. 4%).
- LGB adults are twice as likely to ever experience intimate partner violence as heterosexual adults (29% versus 14%).
- LGBQ youth are more than twice as likely to experience intimate partner violence within the last 12 months as their heterosexual peers (12% versus 5%).

Bias:

- Nearly 15% of LGBQ youth have missed school due to safety concerns in the last 30 days, compared to 4% of straight youth.
- LGB adults are less likely than heterosexual adults to have medical insurance (77% vs. 82%) or a usual health care provider (70% vs. 77%), and are more likely to report recent barriers to accessing healthcare due to cost (23% vs. 15%).

Health Behaviors:

- 28% of LGB adults smoke compared to 19% of heterosexual adults; and 31% of LGBT youth report smoking in the last 30 days compared to 14% of straight youth.
- LGB adults are less likely to eat five or more servings of fruits and vegetables a day.
- LGBQ youth are less likely to meet the CDC recommendations for physical activity and more likely to experience obesity.
- Lesbian and bisexual adult women are more likely to experience obesity than straight women (32% vs. 25%).

There is also some national attention towards understanding the health of LGBT elders and the impact to their health due to a lifetime of experiencing these inequities. A local survey of LGBT

elders in southern Oregon is currently underway and may help to understand local disparities for LGBT elders.

Known LGBTQ Health Disparities in Jackson County

The 2014 Student Wellness Survey provides data on health issues for 11th grade youth that can be assessed at the county level and provides information on experiences of LGBTQ youth. According to the 2014 Student Wellness Survey, 8.6% of 11th graders in Oregon identify as LGBTQ and 10.3% of Jackson County 11th graders.

Table 75: Which of the following best describes you?

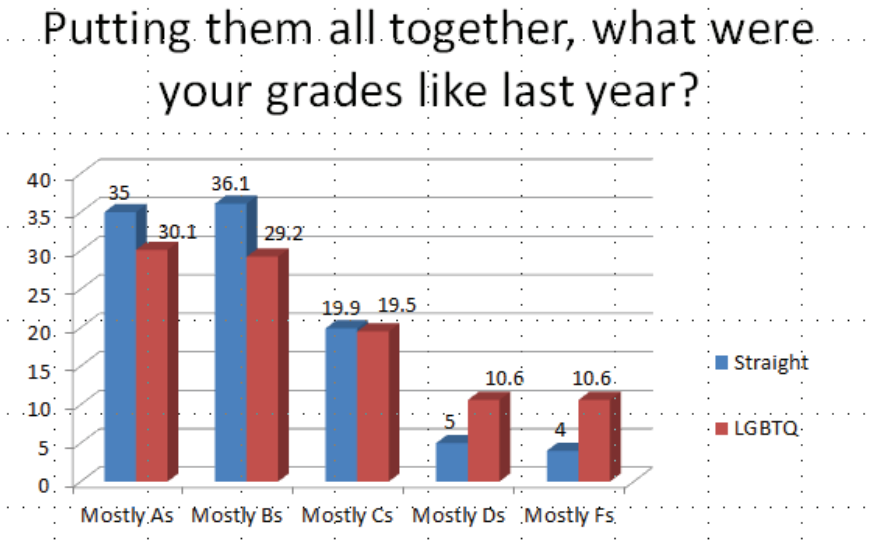
	Grade 6		Grade 8		Grade 11	
	County	State	County	State	County	State
Heterosexual (straight)	0.0	0.0	0.0	0.0	89.7	91.5
Gay or lesbian	0.0	0.0	0.0	0.0	2.1	1.2
Bisexual	0.0	0.0	0.0	0.0	5.5	4.9
I wonder/think I'm transgendered	0.0	0.0	0.0	0.0	0.2	0.5
Not sure	0.0	0.0	0.0	0.0	2.5	2.0
N of Valid	0	0	0	0	856	16,699
N of Miss	1,057	20,922	1,137	21,632	11	209

*This was not asked in grades 6 and 8

10.3% of Jackson County 11th graders reporting

School Engagement

In Jackson County, LGBTQ 11th graders were twice as likely to have poor grades (21.2%) than straight youth (9%).



Opportunities for Participation

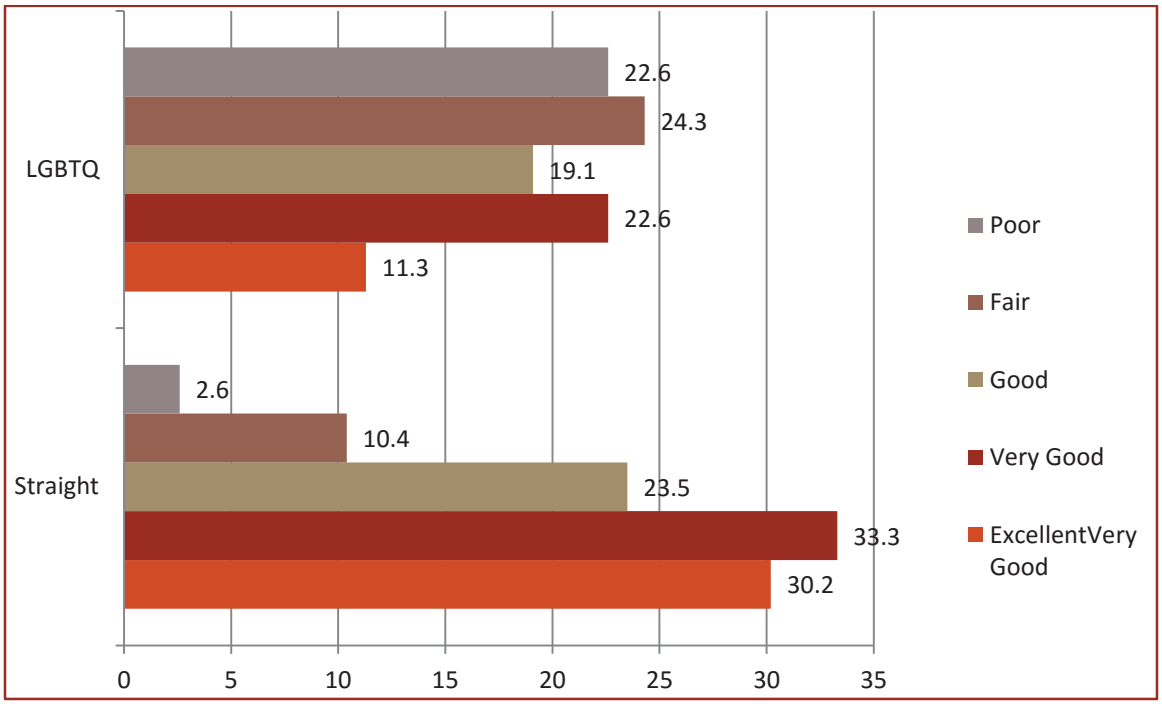
	Straight		LGBTQ	
	Agree	Disagree	Agree	Disagree
I have lots of chances to be part of class discussions and activities	92.8%	7.3%	83.4%	16.6%
There are lots of chances for students in my school to get involved in sports, clubs and other school activities outside of class	92.9%	7.1%	84.7%	15.3%

LGBTQ youth were twice as likely to feel uninvolved in class discussions and activities (16.6%) as well as after-school activities (15.3%) than straight youth (7.3 and 7.1%, respectively).

General Health

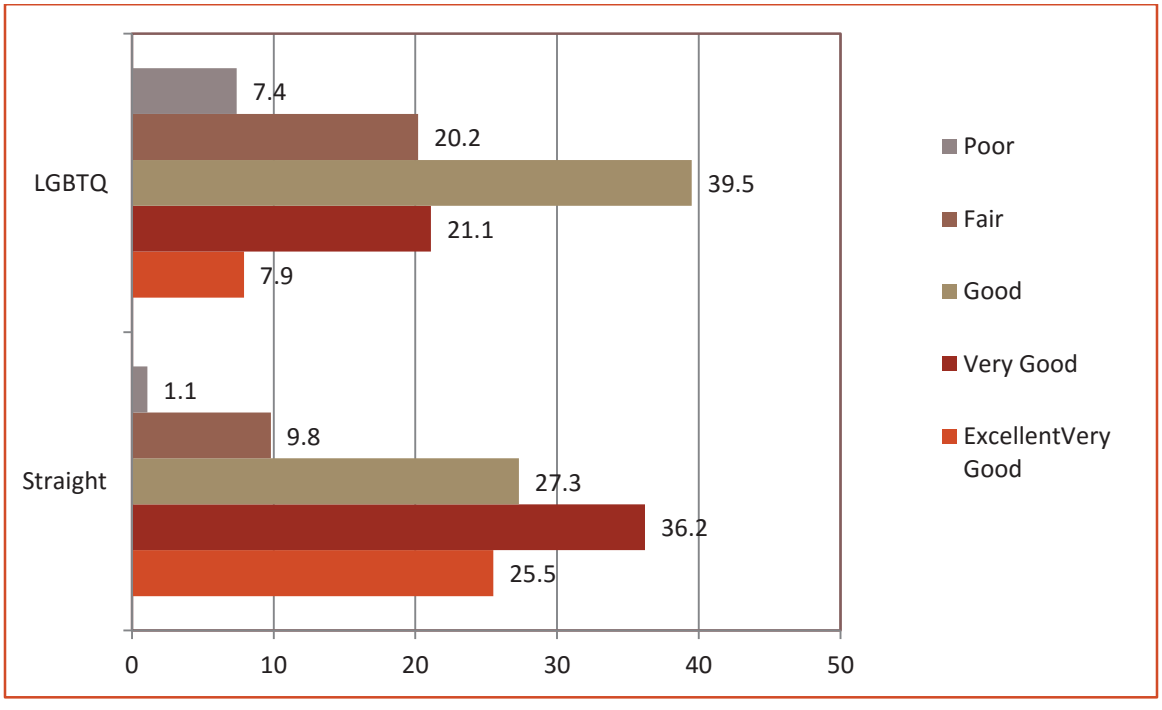
Almost four times as many LGBTQ 11th graders in Jackson County (46.9%) than straight youth (13%) reported poor or fair emotional or mental health on the 2014 Student Wellness Survey.

Would you say that in general your emotional-mental health is?



Two and a half times as many LGBTQ youth (27.6%) than straight youth (10.9%) reported poor or fair physical health.

Would you say that in general your physical health is?



Positive youth development is a set of questions related to physical health, emotional/ mental health, competence, confidence, support and service. Students who answer yes to 5 of 6 questions have met the benchmark. The Student Wellness Survey also asks a series of five questions known as the Mental Health Inventory (MHI-5). When responses for all five are considered together, the result is an estimate of the level of psychological distress that youth are experiencing. MHI-5 scores range from 5 to 30. Scores of 21 or higher are an indication that youth may be experiencing a mental health concern that requires further assessment. LGBTQ youth are less likely to have strong positive youth development and are at three times higher risk for psychological distress than their straight peers.

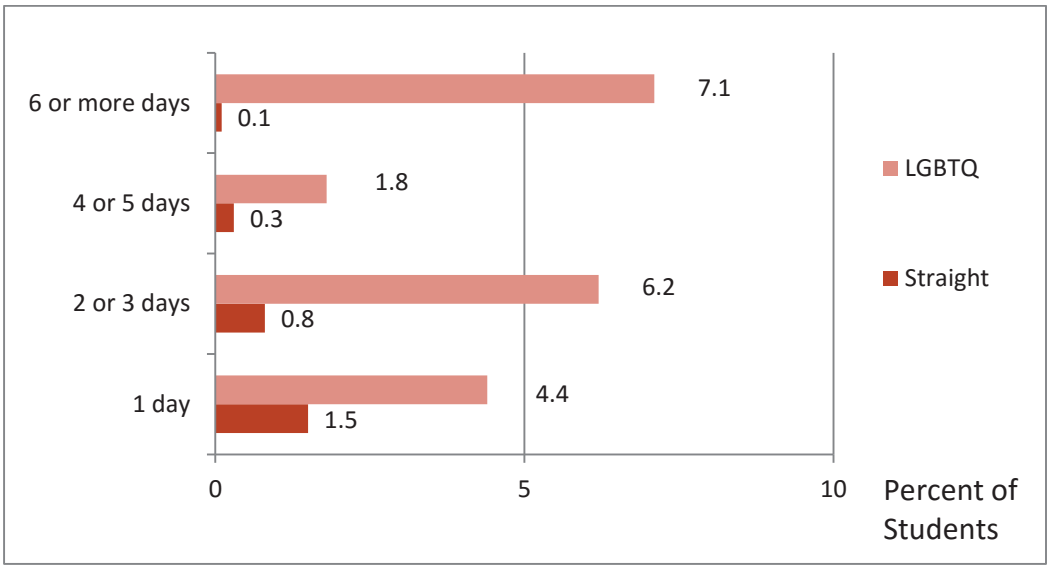
Youth Development and Psychological Distress

	Straight	LGBTQ
Strong positive youth development	69.5%	43.8%
Psychological distress - Mental Health Inventory of 21 or higher on 5 mental health questions	9.7%	30.3%

Safety

Data reported in this section includes survey results from the 2014 Student Wellness Survey for Jackson County 11th graders about verbal and physical harassment, fighting and missing school due to safety concerns. LGBTQ youth were ten times more likely to report missing school related to safety concerns than straight youth. 29.5% of LGBTQ youth reported missing at least one day of school in the past 30 days because of safety concerns compared to 2.7% of straight youth.

During the past 30 days, on how many days did you not go to school because you felt you would be unsafe at school or on your way home from school?



LTBTQ youth were twice as likely (29.8%) to be in a fight within the last year as straight youth (15.4%).

During the past 12 months, how many times were you in a physical fight?

	0 times	1 time	2-5 times	6-9 times	10 or more times
Straight	84.6%	7.5%	6.4%	0.5%	1.0%
LGBTQ	70.2%	12.3%	6.1%	2.7%	8.8%

LGBTQ youth are experiencing harassment on or traveling to school sites at a much higher rate than straight youth. For a significant number, this is occurring on a weekly basis.

In the past 30 days how many times have you been harassed at school, on a school bus or going to and from school because?

		0 times	1 time	2-3 times	4 or more times
Someone said you were LGBTQ	**Straight**	95.1%	2.1%	1.5%	1.3%
	LGBT	65.5%	12.4%	10.6%	11.5%
	Straight	82.3%	6.8%	6.4%	4.5%

Of how you look (weight, clothes, acne or other physical characteristics)	**LGBT**	62.5%	10.7%	12.5%	14.3%
Through email, social media sites, chat rooms, …texting, phone	**Straight**	85.9%	6.8%	4.6%	2.7%
	LGBT	76.8%	4.5%	3.6%	15.2%

Mental Health

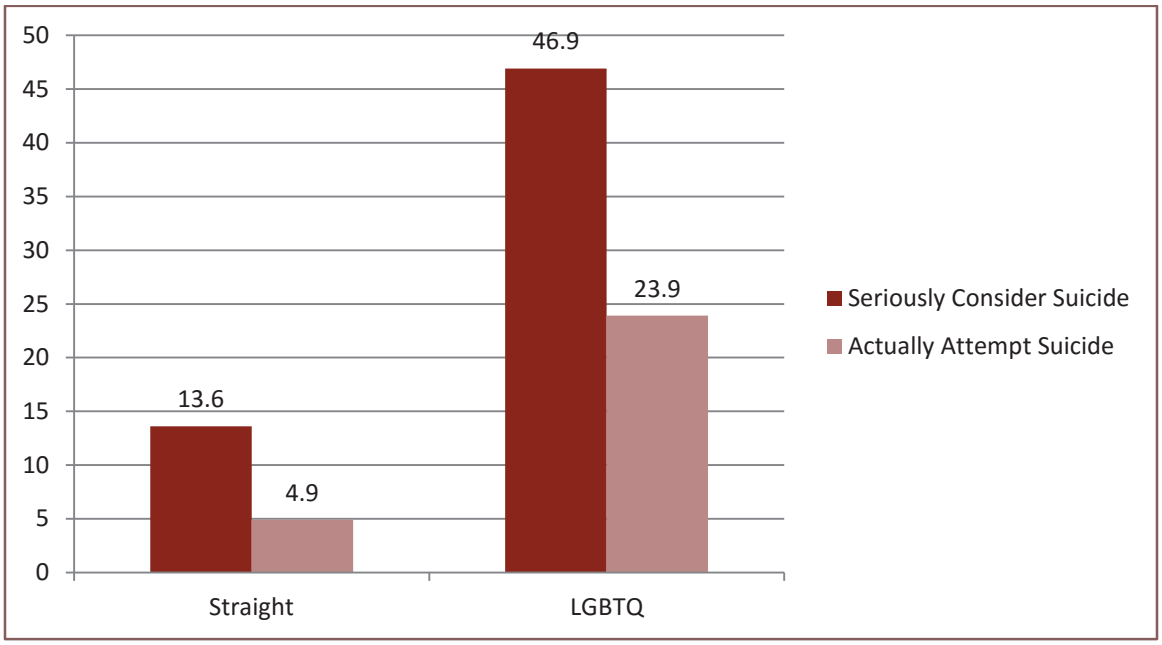
LGBTQ 11th graders in Jackson County are experiencing sadness and depression at 3-4 times that of straight youth.

In the past 30 days how much of the time, have you?

		All/most of the time	A good bit of the time	Some of the time	A little/ none of the time
Felt so down in the dumps that nothing could cheer you up	**Straight**	7.1%	7.2%	10.7%	75%
	LGBT	28.8%	9.9%	11.7%	49.5%
Been a happy person	**Straight**	57.2%	22.0%	12.4%	8.4%
	LGBT	30.6%	17.1%	19.8%	33.8%
Felt downhearted and blue	**Straight**	11.4%	13.2%	18.0%	57.3%
	LGBT	31.2%	14.7%	23.9%	30.3%

LGBTQ 11th graders in Jackson County were three and a half times more likely (46.9%) to seriously consider suicide than straight youth (13.6%) and almost five times more likely to report an actual attempt (23.9% vs 4.9%) in the last twelve months.

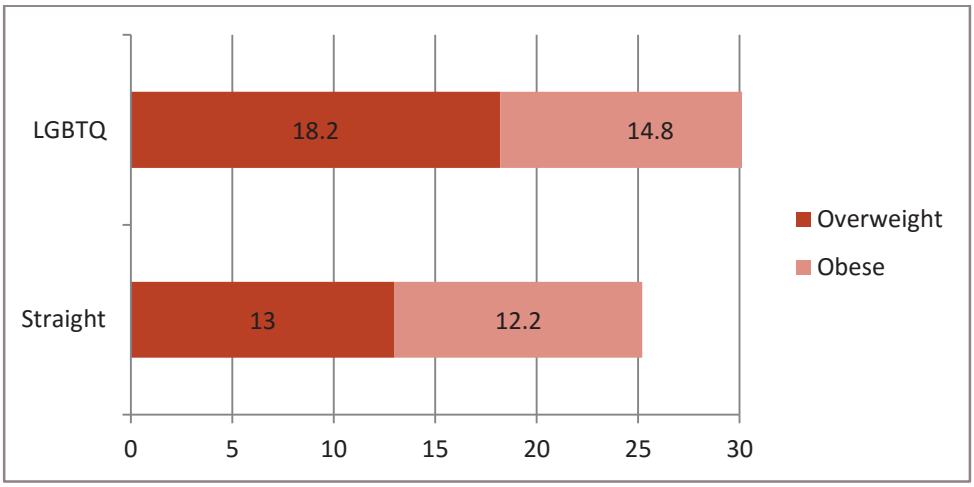
During the past 12 months, did you:



Health Behaviors

LGBTQ 11th graders in Jackson County were more likely to be overweight /obese and to smoke cigarettes. 30% of LGBTQ youth reported being overweight or obese compared with 25% of straight youth. LGBTQ youth were two and a half times more likely (24.6%) to smoke in the last 30 days than straight youth (9.8%).

Percentage of Overweight and Obese 11th Graders



In the past 30 days, on how many days did you smoke cigarettes?

	0 days	1-9 days	10-19 days	20 or more days
Straight	90.2%	5.8%	0.9%	3%

LGBT	76.4%	10%	2.7%	10.9%

2014 Safe School Act Awards – Jackson County

The Oregon Safe Schools and Communities Coalition annually rates school districts for their compliance with 2009 Oregon Safe Schools Act.

Ranking Definitions and Jackson County Rankings 2014

Ranking	Definition	Jackson County School District
Gold Star	Governance documents regarding harassment, intimidation, bullying, dating violence, and cyberbullying are substantially compliant* with current Oregon statutes and expressly reference gender identity and gender expression as protected classes.	Central Point Phoenix-Talent
Silver Star	Governance documents regarding harassment, intimidation, bullying, dating violence, and cyberbullying are substantially compliant* with current Oregon statutes.	Eagle Point
Bronze Star	Governance documents regarding harassment, intimidation, bullying, dating violence and cyberbullying need updating and/or modification to achieve substantial compliance with current Oregon statutes.	Medford Ashland

**"Substantially compliant" harassment, intimidation, bullying, and cyberbullying governance documents contain at least 80% of the statutorily required elements, including four key elements required by the Safe Schools Act and passage of Senate Bill 1555: (1) acknowledgment that interfering with the psychological well-being of a student creates a hostile educational environment; (2) a statement that bullying may be based on, but not limited to, the protected class status of a person; (3) a requirement that school employees report acts of bullying; and (4) a statement as to how the anti-bullying policy is to be publicized within the district, including, at a minimum, a statement that it will be made annually available in a handbook and readily available at each school or district office and website.*

Office of Equity and Inclusion
Health Equity Policy Committee
CHARTER

Authority

The Oregon Health Policy Board and The Oregon Health Authority's Action Plan for Health identifies improving health equity as a foundational strategy for achieving the triple aim, whose three objectives are:

- Improve the lifelong health of all Oregonians
- Increase the quality, reliability and availability of care for all Oregonians
- Lower or contain the cost of care so it is affordable for everyone

The Oregon Health Policy Board and the Oregon Health Authority have acknowledged that specific strategies need to be explored, recommended, and implemented to assure that all populations enjoy health equitably, in the Health Systems Transformation process, development of the Health Insurance Exchange and in other opportunities for policy and program development.

To this end, the Office of Equity and Inclusion establishes the Health Equity Policy Committee to encourage and increase stakeholder engagement, and proactively explore, develop, evaluate and recommend policies in order for the State to advance cross-cutting, cross-community policy improvements.

Purpose

The purpose of the Health Equity Policy Committee is to assure that policy making and program improvement processes proactively promote the elimination of health disparities and the achievement of health equity for all Oregonians.

Deliverables

Engagement

- Consult with the State's health leaders to develop policies and programs that promote health equity and eliminate health disparities
- Identify opportunities for aligning and/or coordinating community health equity efforts, including strategies and messaging
- Increase and facilitate leadership and participation of socially and culturally diverse organizations within the political process by:
    - Conducting trainings in the policy-making process
    - Facilitating relationship-building and information exchange between the State's health leaders and community organizations
    - Other identified opportunities

Policy Development and Implementation

- Identify strategic policy and quality improvement priorities to track over the 2011-13 biennium; review and update policy priorities for subsequent biennia.
- Identify, promote and monitor opportunities and activities to ensure there is sufficient focus to eliminate health disparities and promote health equity in the development and implementation of Health Systems Transformation, Public Health Accreditation and Mental Health Transformation.
- Identify and explore health equity opportunities that may be pursued through other policy and program efforts in OHA and the legislature.

Quality Improvement and Cost Reduction

- Ensure the collection, analysis, and dissemination of granular racial and ethnic health data
- Identify data initiatives that lead directly to health equity policy change

- Identify and promote policy opportunities to increase access to health care for undocumented Oregonians
- Promote cultural competency and trauma-informed care
- Promote implementation of Culturally and Linguistically Appropriate Standards (CLAS) and link CLAS standards to clinical quality measures
- Promote full implementation of Health Care Interpreter (HCI) Program
- Identify policy opportunities to promote and increase health literacy through program and service delivery
- Develop health equity business case demonstrating cost savings and return on investments
- Support efforts to diversify Oregon's health care and public health workforce.

Time Line

The Health Equity Policy Committee will meet monthly. The group is chartered to meet through June 2013. At that time, the HEPC will propose how it will function beyond that date.

Partners

The Health Equity Policy Committee will seek information from and collaborate with a wide range of state and national partners including:

1. The Oregon Health Policy Board
2. Divisions of The Oregon Health Authority
3. Health care employers and providers
4. The Oregon Health Insurance Exchange Board

The Health Equity Policy Committee will draw from national and local expertise such as:

- Individuals and organizations working with/in communities experiencing health disparities
- Publications and reports from, but not limited to:
    a. Published reports from academics, foundations and national experts on health equity and health disparities
    b. Community and faith-based organizations' publications and reports
    c. OMHS Publications and Reports
    d. National Partnership for Action to Eliminate Health Disparities

Staff Resources

The Office of Equity and Inclusion will provide staff support to committee leadership.
OEI Staff Support: Rachel Gilmer and Emily Wang

Membership:

1. Committee Membership:
   Committee membership is open to the public. The committee will welcome individuals who have varying levels of expertise and life experience in health equity policy advocacy and policy making processes. The committee will be comprised of voting and non-voting members. The eligibility process for becoming a voting member shall be determined by the steering committee. OEI staff will be non-voting members.

2. Steering Committee:
   A steering committee of 5-8 individuals, including one OEI staff member, will be charged with establishing the bylaws and operational structure of the HEPC and will help to facilitate the work of the HEPC. Initial steering committee membership will be nominated by current OEI partners and appointed by OEI staff. Thereafter, the steering committee will manage its membership with OEI staff support.

3. Committee Decision Process:
   Committee decisions will be made by voting members. Quorum is half of the voting members plus one.

4. Ensuring Committee Diversity:
   Special attention will be paid to ensure the committee and steering committee are representative of communities experiencing health disparities, including, but not limited to racially and ethnically diverse populations, linguistically diverse populations, LGBT populations, the aging population, people with disabilities, rural communities and the economically disadvantaged.

Requests for membership can be sent to Rachel.B.Gilmer@state.or.us

History

In September of 2010, The Health Equity Policy Review Committee (HEPRC) was established by the Oregon Health Policy Board (OHPB), the policy-making and oversight body for the Oregon Health Authority (OHA), to proactively evaluate all recommended policy improvements throughout the policy making process to assure they fully promote the elimination of inequities and promote health equity. The twenty-four person committee represented much of the professional, cultural and geographic diversity found in Oregon and sought to ensure the avoidance of creating or maintaining health policies that perpetuate or increase avoidable and unjust health inequities.

Over a three-month period, the HEPRC reviewed the policy plans for several of the OHPB subcommittees before they submitted their final recommendations to the OHPB. These committees included:

- The Health Care Workforce Committee
- The Health Incentives and Outcomes Committee
- Oregon Health Improvement Plan Committee
- Public Employers Health Purchasing Committee
- The Health Improvement Plan
- Health Insurance Exchange Consumer Advisory Group
- Health Information Technology Oversight Council (HITOC)

Three of the HEPRC's policy priorities were included in the policy board's Action Plan for Health, advanced through legislation and OHA administrative changes. These policies are:

- Assuring Culturally Competent Health Care through continuing education
- Assuring Granular Race and Ethnicity Data Collection
- Diversifying the health care workforce and assuring culturally competent health care through the use of Community Health Workers

The group was chartered by the OHPB through February 2011. After this time, the OHPB chose not to reinstate the committee as they felt that health equity needed to be integrated throughout all OHPB committees and policy initiatives.

The Office of Equity and Inclusion continued to convene the committee, opening up membership to the public, to create a space for advocates to coordinate efforts to advance health equity policy, including coordinating stakeholders in support of Senate Bill 97.