Central Oregon Health Council

Central Oregon Diversity Equity and Inclusion (CODEI) Committee

Agenda: June 22, 2020; 11:15 – 12:45pm

Virtual Meeting
Join by computer: https://zoom.us/j/307489003
Join by phone: +1 669 900 6833; Meeting ID: 307 489 003

11:15-11:25	Introductions, Land Acknowledgement and Guiding Principles
11:25-11:40	Current Events Discussion • Reading: Stolen Breaths from the New England Journal of Medicine https://www.nejm.org/doi/pdf/10.1056/NEJMp2021072?articleTools=true
11:40-12:20	CODEI Workplan
12:20-12:40	Advocacy Letter Draft • Focused Conversation
12:40-12:45	Next Steps, General Information and Closing

Next Meeting – July 27, 2020; 1-3:30 Learning Session; Virtual

As the *Central Oregon Diversity, Inclusion and Equity Committee* we collectively and individually practice and believe in:

- Solidarity
    - We move toward action in solidarity with our neighbors to actively and positively impact our agencies and communities.

- Humility
    - We carry the burden of history and a better future together, responsible to each other and ourselves for the space and energy we give and take.

- Curiosity
    - The direction we seek is bigger than any one of ourselves or agencies. We actively work to see a broader perspective, gain deeper insight, self-reflect and work towards equitable representation of diverse identities.

- Courage
    - This is courageous work. We choose to lean into the discomfort we experience knowing we grow in understanding and relationships.

- Transformation
    - Our lived experiences and need for safety are as true and diverse as we are. It is through invitation, curiosity, and listening that we reach our greatest shared understanding and commitment to transformative action.

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Stolen Breaths

Rachel R. Hardeman, Ph.D., M.P.H., Eduardo M. Medina, M.D., M.P.H., and Rhea W. Boyd, M.D., M.P.H.

In Minnesota, where black Americans account for 6% of the population but 14% of Covid-19 cases and 33% of Covid-19 deaths, George Floyd died at the hands of police.

"Please — I can't *breathe*."

He was a black man detained on suspicion of forgery, an alleged offense that was never litigated or even charged, but for which he received an extrajudicial death sentence.

"Please — I can't *breathe*."

He was only 46 years old.

"Please — I can't *breathe*."

And he was loved.

But despite onlookers' pleas and his own calls of distress, with his face against the pavement, three officers on his back, and a knee in his neck, he was murdered.

"Please — I can't *breathe*."

While trained officers and paramedics stood by, and a horrified community witnessed, Floyd was denied the basic rights of due process and the basic dignity of life support.

"Please — I can't *breathe*."

In the wake of his public execution, uprisings have ignited in cities throughout the United States and the world, many of them led by young black people. Despite potential risks of exposure to Covid-19, demonstrators are laying bare the deep pain that persists for black people fighting to live under the crushing weight of injustice that has long been at our necks. The words "I can't breathe" hang heavy in the air. But they are so much more than a rallying cry. They are indictments.

"Please — I can't *breathe*."

The truth is black people cannot breathe because police violence is a major cause of premature death, of stolen lives and stolen breaths in America. And it is a particularly deadly exposure for black Americans.

"Please — I can't *breathe*."

The truth is black people cannot breathe because as many mourn George Floyd, we also mourn Breonna Taylor and Tony McDade, and the nearly 1000 people who are killed by police each year, an outsized proportion of whom are black.

"Please — I can't *breathe*."

The truth is black people cannot breathe because we are preemptively grieving the 1 in 1000 black men and boys who will be killed by police.[1]

"Please — I can't *breathe*."

We are holding our children closer and tighter because we know black girls will be presumed to be older, less innocent, and less in need of protection than white girls as early as 5 years old,[2] and black boys by 10 years old. We know the risks that may meet them when they leave our sides, and we hide our silent devastation when we prepare them for those risks — risks that no amount of guidance may deter.

"Please — I can't *breathe*."

The truth is black people can-

not breathe because the legacies of segregation and white flight, practices of gentrification and environmental racism, and local zoning ordinances combine to confine us in residential areas where we are disproportionately exposed to toxins and pollutants. As a result, black populations have higher rates of asthma and cancer. And recent data suggest that chronic exposures to particulate matter in the air may contribute to a risk of death from Covid-19 as much as 15% higher for black Americans than that faced by white Americans.[3]

"Please — I can't *breathe*."

The truth is black people cannot breathe because we are currently battling at least two public health emergencies, and that is a conservative estimate. One of every 1850 black Americans have lost their lives in this global fight against a novel virus that could have harmed anyone (https://apmresearchlab.org). And yet — because of racism and the ways humans use it to hoard resources and power for some, while depriving others — it has killed an enormous number of black people.

"Please — I can't *breathe*."

And black people are three times as likely to be killed by police as white people (https://mappingpoliceviolence.org). Both these realities are acutely threatening black lives right now. But prevailing gaps in maternal and infant mortality have long threatened our survival beginning before we are even born.

"Please — I can't *breathe*."

In the face of literal gasps, as black communities bear the physical burdens of centuries of injustice, toxic exposures, racism, and white supremacist violence, too many either do not know what our communities endure or are aware but choose not to act. Too many "leaders" wonder how we got here and what we can do to move forward, as if the answers have not been ever-present.

We got here, as the sociologist Ruha Benjamin expertly notes, because "Racism is productive" (https://belonging.berkeley.edu/video-ruha-benjamin). We got here because we live in a country established by indigenous dispossession and genocide. Because slavery and the racial ordering of humans and goods it established constructed a political economy predicated on devaluing black labor, demeaning black bodies, and denying black humanity. We got here because stolen lives and stolen breaths are profitable and we work in systems that continue to reap the gains.

"Please — I can't *breathe*."

Any solution to racial health inequities must be rooted in the material conditions in which those inequities thrive. Therefore, we must insist that for the health of the black community and, in turn, the health of the nation, we address the social, economic, political, legal, educational, and health care systems that maintain structural racism. Because as the Covid-19 pandemic so expeditiously illustrated, all policy is health policy.

We expect the deployment of these solutions to meet the urgency of this moment and the dire needs it has evidenced. We have confidence that these changes can be made rapidly, given the agility with which health care systems have reorganized in the face of Covid-19 — many establishing new practice patterns, payment models, and delivery mechanisms. The response to the pandemic has made at least one thing clear: systemic change can in fact happen overnight.

Although there is much to do, we recommend that health care systems engage, at the very least, in five practices to dismantle structural racism and improve the health and well-being of the black community and the country.

Divest from racial health inequities. Racial health inequities are not signs of a system malfunction: they are the by-product of health care systems functioning as intended. For example, the U.S. health insurance market enables a tiered and sometimes racially segregated health care delivery structure to provide different quality of care to different patient populations. This business model results in gaps in access to care between racial and ethnic groups and devastating disparities like those seen in maternal mortality. Universal single-payer health care holds the promise of removing insurance as a barrier to equitable care.

Desegregate the health care workforce. The health care workforce is predominantly white at essentially every level, from student and staff to CEO. This lack of diversity must be understood as a form of racial exclusion[4] that affects the economic mobility and thus the health of nonwhite groups. For example, health care systems are often the economic engines and largest employers in their communities. Extending employment opportunities to those communities can extend the employer-based insurance pool, raise the median wage, support the local tax base, and counter the gentrification and residential segregation that often surrounds major medical centers — each of which improves population health.

Make "mastering the health effects

of structural racism" a professional medical competency. In 2016, we asked individual clinicians to "learn, understand and accept America's racist roots."[5] In 2020, it is clear that clinicians need to master learning the ways in which structural racism affects health. We believe that medical schools and training programs should equip every clinician, in every role, to address racism. And licensing, accreditation, and qualifying procedures should test this knowledge as an essential professional competency.

Mandate and measure equitable outcomes. Just as health care systems are required to meet rigorous safety and quality performance standards for accreditation, they should be required to meet rigorous standards for addressing structural racism and achieving equity in outcomes.

Protect and serve. Health care systems must play a role in protecting and advocating for their patients. Victims of state-sanctioned brutality are also patients, who may present with injuries or disabilities or mental health impairments, and their interests must be defended. Health care systems should also be on the forefront of advocating for an end to police brutality as a cause of preventable death in the United States. They should take a clear position that the disproportionate killing of black (and indigenous and Latinx) people at the hands of police runs counter to their commitment to ensuring the health, safety, and well-being of patients.

"Please — I can't *breathe*."

Police violence, racial inequities in Covid-19, and other forms of structural racism are concurrent and compounding public health crises in the United States.

"Please — I can't *breathe*."

Postmortem evidence indicates that George Floyd tested positive for Covid-19, underscoring this reality. The choice before the health care system now is to show, not tell, that Black Lives Matter.

Because, like George Floyd, black people are loved.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on June 10, 2020, at NEJM.org.

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DOI: 10.1056/NEJMp2021072

Central Oregon Diversity, Equity and Inclusion (CODIE) Committee of the Central Oregon Health Council

Diversity, Equity and Inclusion Action Plan for 2020-2023 - last updated 2.14.20

BACKGROUND: In 2017, a gap in access to health care was identified and a partnership, Central Oregon Cares, was formed to address workforce diversity in the Central Oregon healthcare system. In 2018, the Oregon Health Authority released the Transformational Quality Standards elevating the conversation and response to address diversity, equity and inclusion within health care. PacificSource, who shares Medicaid governance with the Central Oregon Health Council (COHC), conducted a multi-stakeholder assessment about Culturally and Linguistically Appropriate Services (CLAS) Standards. In 2019, through partnership with PacificSource, the Central Oregon Health Council formed the Central Oregon Diversity, Equity and Inclusion (CODEI) team. Their charge is to address health equity throughout the region.

THE JOURNEY: The journey of CODEI is common to many diversity, equity and inclusion teams. We have experienced our starts, pauses, turns and adjustments. The questions we have sought to answer include: What does success look like? Who are we as CODIE? What is our scope? How do we do this work? Where do we start? How do we address our own biases and blind spots? How do we adjust what we do in response to our learning? How do we respond to the critical needs of those harmed by inequities? How do we impact our region? How do we partner with those already living and working in this space in our region? We continue to work through these and many other questions.

CODIE has always been open to all interested people and have met for 60- 90 minutes once a month since January 2019. As of December 2019, CODIE resides as a Committee within the COHC organizational structure. And as of October 2019, Pacific Source has provided funding support for 2019 and 2020.

THE SCOPE: Over the course of our first year's conversations, we recognized that the work of reducing and eliminating inequality in health care should begin at the individual and self-reflective level. It is only through addressing and changing our own mindsets that true evolution and change can begin. We also recognized that the Central Oregon Health Council, a 501(c)3 with the mission to improve health and well-being of all people in Central Oregon, and home to CODIE, has its own reflection and work to do to improve how we serve those who have been marginalized in our region. As the COHC non-profit does their DEI work, then they have a natural influence in the work of their Regional Health Improvement Plan workgroups, committees and board of directors. So, the work of the CODIE begins at home: first, with CODIE participants and COHC staff; second with COHC workgroups, committees and Board of Directors. As we work internally as individuals and a non-profit organization, we will naturally grow to deeper consciousness and ability to be an ally in our region.

This Action Plan is CODIE's first attempt at beginning to answer some of the questions we've been asking. We fully recognize that it is incomplete. It serves only as a first draft working plan (of many to come) to be updated and adjusted as we grow in our understanding, knowledge and will.

We are initially undertaking this in four phases:

1) Actions to be taken by CODIE and COHC Staff. This reflects the wise quote “To change the world, I must start with myself”.
2) Actions and practices to be taken by COHC Regional Health Improvement Plan Workgroups.
3) Actions and practices to be taken by COHC Committees and Board of Directors.
4) Actions and practices to be taken within the Central Oregon Region.

Although these are outlined as “phases”, they are not intended to mean that one phase will not happen or begin until the others are fully complete. These phases are purely for organization of thought and understanding our initial starting place. We also recognize that Diversity Equity and Inclusion work is layered, complex and evolving.

As you review this plan, we invite you to join us in this journey.

Diversity, Equity and Inclusion Action Plan for 2020-2023 - last updated 2.14.20

Goal	Strategic Objective	Action Items	Tasks
GOAL 1: To work from a shared understanding of the health care needs of the Central Oregon Community and the barriers to equitable access and outcomes	Identify internal and external disparities and opportunities	Obtain individual baseline assessment data (phase 1 - CODIE and COHC Staff)	Identify assessment tool
			COHC staff take assessment
			CODIE individuals take assessment
			Individual and collective data is generated
			Workgroup debrief with CODIE individuals
			Staff debrief with COHC staff
			Staff and CODIE consider assessment approach with workgroups
		Obtain individual baseline assessment data (phase 2 - Workgroups)	
		Obtain individual baseline assessment data (phase 3 - Committees and Board)	

		Compile existing community data on regional health disparities	
	Create a shared vocabulary around healthcare equity and access	Create a glossary of shared definitions	
		Train COHC staff on how to talk about health care equity and access	
		Train CODIE partners on how to talk about health care equity and access	
		Train workgroup individuals/partners on how to talk about health care equity and access	
		Train committees and board members on how to talk about health care equity and access	
		Learn to articulate the 'business case' for supporting DEI efforts	
	Create a shared understanding of the impacts of systems of oppression on health care access and disparities	Conduct a community needs assessment	
		Train CODIE individuals/partners and COHC staff on systems of oppression, social determinants of health and healthcare equity.	
		Train workgroup individuals/partners on systems of oppression, social determinants of health and healthcare equity.	
		Train committees BOD on systems of oppression, social determinants of health and healthcare equity.	
		Increase visibility of health disparities within COHC materials and all meetings	
		Develop and publish a meaningful DEI statement	

	Make a public commitment to addressing barriers to health equity	Increase diversity of people and communities in COHC materials to better reflect population	
		Sponsor DEI events	
GOAL 2: To develop leadership in addressing health disparities at all levels of health care systems	Expand the definition of who is considered a leader	Identify formal and informal leaders	Acknowledge power of lived experience
			Develop way to pull them into these conversations
			Develop a buddy system, provide meetings in a comfort community, evening time; make agenda item where they can share
			Remove job title from introductions, instead share passions and strengths
			Provide compensation
			Move from group conversations to 1:1 conversation
		Reframe "leadership" as partnership and influencer	
	Support all leaders in better understanding and addressing health disparities	Deploy Equity Coaches to support committees and workgroups	
		Define DEI as one of the responsibilities of the Board, Committees, workgroup members	
		Share tools and strategies with respective organizations	
GOAL 3: To develop policies and practices that prevent, address and remedy	Reduce barriers to participation	Decolonize and make more inclusive language and practices	
		Meeting location (dominate culture should carry burden of travel)	

disparities in our organizational culture and operations		Stipend, mileage, childcare to support participation	
		Provide translation for all documents, media, meetings	
		Adjust communication, meeting styles and expectations to align with non-dominate cultural norms	
	Review current policies with an equity lens	Review membership or partnership policies	Create protocol for how to look at materials
		Review voting policies	
		Review charters	
		Review funding policies	
		Review all other documents	
	Develop DEI budget line		
GOAL 4: To engage with diverse community partners and stakeholders with cultural and linguistic competency	Increase engagement by partners ans stakeholders in cultural competency and other DEI training	Develop a training plan to address needs identified in assessments	
		Hire professional trainers to deliver content	
		Mandate or incentivize participation in training	
		Reduce or eliminate barriers to participation in training	
		Embed DEI-related lessons into regular gatherings	
		Develop a forum, brown bag lunch, other types of venues to discuss DEI issues	
	Adopt cultural competency accountability measures	Create a system for receiving regular feedback from diverse populations	

		Recruit COHC staff and partners who reflect the community	
		Increase and improve COHC relationship and partnership with impacted partners	
GOAL 5: To improve access to and utilization of data, research and evaluation outcomes in addressing health disparities	Apply data to future planning and decision making	Respond to individual and organizational assessment with updated Action Plan	
		Use disaggregated data in planning and decision making	
	Develop and track DEI-related metrics	Create capacity to collect and monitor data at community, zip code and census tract level	
		Collect and disaggregate data in RHA, RHIP, workgroups and funding initiatives	
		Develop a 'real time' dashboard showing progress toward outcomes, demographics, research, findings	
		Develop and track COHC organizational DEI metrics	

Dear (health care entity),

We are writing to voice our support for you (insert organization name) to increase Spanish translation of all public and internal information and to communicate that information in a way that respects and accepts cultural differences.

You may have many Spanish-speaking clients, or you may have none. It's important to know that there are over 12,000 people in Central Oregon alone (Deschutes County, Crook County, Jefferson County and The Confederated Tribes of Warm Springs) who speak Spanish. Additionally, Oregon's Latino population has grown 72% since 2000, and the Oregon Office of Economic Analysis estimates that the total state Latino population will increase by 40 percent by 2050.[1]

We know that when we provide information in our (potential) client's native language their understanding of the information is greater, they feel a greater sense of safety and belonging, and our quality of care greatly improves.

We are also called upon by Title VI, under the Civil Rights Act[2] to follow the Culturally and Linguistically Appropriate Services (CLAS) Standards[3]. The CLAS standards are 15 guidelines created in 2000 to advance health equity, improve quality, and help eliminate health care disparities.

Here in Central Oregon, we have new and long-standing partnerships built on the vision of improving health for all people. Together we are learning how to do this. We've included some stories of growth and some resources to support us in our next steps.

What is your one next step going to be?

Sincerely,

Central Oregon Health Council
Central Oregon Diversity Equity and Inclusion Committee

[1] https://oregoncf.org/Templates/media/files/reports/latinos_in_oregon_report_2016.pdf

[2] https://www.oregon.gov/oha/OEI/Documents/Memo%20from%20DOJ%20June%209,%202015.pdf

[3] https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

Here are some local stories of growth and success. We affirm their progress and acknowledge we all have more work to do:

- Pacific Source trains their translators in Plain Language (see reference below) so that information in Spanish is easy to understand and reflects language nuances.

- Mosiac Medical seeks feedback from native Spanish speakers about translations. They work to make material sound like it was written in Spanish. They provide directions to referenced information in Spanish as well.

- Deschutes County trains on all their staff on the importance of translation and how to use it. They created an easy workflow for translation requests.

- Central Oregon Pediatrics Associates (COPA) recognizes that being bilingual is different from being a qualified, certified translator. COPA staffs their clinics with certified translators.

While these are a few ways to support Spanish speaking clients, there are many more. One example is hiring certified interpreters for spoken language needs such as recorded messages, directions and instructions.

Below are a few resources with simple steps we encourage you to take:

- Share and post the Oregon Health Authority's COVID-19 Spanish-language resources: https://govstatus.egov.com/OR-OHA-COVID-19

- Implement one recommendation outlined in this physician toolkit on language access issues: https://innovations.ahrq.gov/qualitytools/addressing-language-access-issues-your-practice-toolkit-physicians-and-their-staff

- View a learning video at your next staff meeting and make one change as a team: https://thinkculturalhealth.hhs.gov/resources/

- Make your materials easier for everyone to read and understand: https://plainlanguage.gov/