Central Oregon Health Council

Central Oregon Diversity Equity and Inclusion (CODEI) Committee

Agenda: July 27, 2020; 1:00 – 3:30pm

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

1:00pm - 1:10pm	Introductions and introductory exercise – Renee Wirth/Ignatius Bau • Please come prepared with 4 blank sheets of paper and a large marker or crayon!
1:10pm - 1:55pm	Report back and discussion of Intercultural Development Inventory (IDI) profiles – Brenda Comini
1:55pm - 2:25pm	Sharing about lessons learned and health equity work from DELTA program participants – Ignatius Bau, Miguel Angel Herrada, Liliana Cabrera, Kat Mastrangelo
2:25pm - 2:55pm	Questions and discussion about DELTA program lessons learned
2:55pm - 3:25pm	Discussion of CODEI Action Plan – Ignatius Bau
3:25pm - 3:30pm	Feedback on learning session – Gwen Jones

Next Meeting – August 24, 2020; 11:15-12:45; Virtual Meeting

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.

Background

"Health disparities" are differences between specific population groups in the incidence, prevalence, mortality or burden of disease and illnesses. Reporting on health disparities typically illustrates how some population groups have higher rates of certain diseases and conditions than other groups. For instance, it has long been documented that African American and some Latino ethnic groups have higher infant mortality rates than white populations.

The term "*health equity"* broadens the disparities concept by asking, "Why are some populations at greater risk of illnesses and preventable deaths than others?" This question leads to a deeper analysis and exploration of the causative factors that contribute to disparities. In the case of infant mortality, where African Americans suffer twice the rate of infant deaths than whites, the answer is often not because of a need to increase clinical encounters, but because of the neighborhood in which the mother lived, the foods she ate, her quality of health prior to pregnancy, her levels of support, and her access to transportation, neighborhood conditions, and culturally appropriate providers. Of course, community-centered, affordable, quality health care is also essential, but is not the only lens through which this type of complex problem should be examined.

To deepen our understanding of health equity, we must first understand the concept of "*equity"* – just and fair inclusion so all can participate and prosper.

[1] *"Health equity"* focuses on the root causes or social determinants of health. It requires broadening our definition of "health" to mean one's overall quality of life, an analysis of socioeconomic factors, including education, income and wealth inequality, and a willingness to address racial and social inequality. These are the factors that impact a person's overall quality of life and life expectancy. When health is measured not just by a lack of diseases and illness, but by access to opportunities, we see that some populations have greater access to opportunities than others.

In its seminal report on health disparities, *Reducing Health Disparities Through a Focus on Communities*,[2] PolicyLink created a framework identifying four primary factors in communities that impact health either directly or indirectly. They form the social and political determinants of health:

1. **Economic environment**: degree of poverty; employment with living wages and good benefits; neighborhood economic conditions; home ownership; small business ownership; presence of quality commercial and retail services and investments.
2. **Social Environment**: ability to have strong social networks and support systems; civic engagement; community cohesion; cultural values and affiliations; perceptions of the neighborhood.
3. **Physical environment**: quality of the built environment and infrastructure; environmental quality (degree of toxins and pollution); public safety; quality, affordable housing; parks and recreation; geographic access to opportunities.
4. **Services**: quality, affordable health services; community and public support services, including good schools; reliable transit; access to healthy and affordable foods; banking and financial services; police and fire protection; quality schools and child care services; consistent sanitation.

The Issues: Systematic and Unjust Distribution of Opportunity Impacts Health

The degree to which some communities have greater access to these basic factors than other communities is a result of systemic and unjust distribution of opportunities. Quite simply, it is a demonstration of social injustice – policies that legalized racial and residential segregation and exacerbated inequality in education and housing – and this injustice forms the basic foundation of health inequities. In its groundbreaking publication, *Unequal Treatment, Confronting Racial and Ethnic Disparities in Healthcare,* The Institute of Medicine of the National Academies documented differences in diagnosis and treatment based on race, finding that "disparities can be traced to many factors, including historic patterns of legalized segregation and discrimination."[3] In some communities, there is an eight to twelve year difference in life expectancy between African Americans in low-income neighborhoods and wealthier whites in more affluent areas. This discrepancy can be attributed to resource disparities: in the same poor communities, there are check cashing stores and no financial institutions. There are "convenience" stores with an abundance of alcohol but limited numbers of grocery stores offering healthy food choices, and far too many fast-food restaurants. There are strong academic institutions in the wealthier areas and poorly performing schools in the lower-income neighborhoods. These are the types of structural inequities that create barriers to health and demonstrate an urgent need for a paradigm shift from simply charting differences in health outcomes to advancing *health equity* – dismantling the systems and structures that continue to breed our country's health disparities. Further, healthcare systems, many with historic practices of treating patients unfairly based on race, income, or ethnicity, must be changed in order to have healthier individual, family, and community outcomes.

The policies and systems that created and expanded our nation's racial divides in employment, wealth, education, and housing are at the core of our country's high levels of health inequities. Even today, policies can exacerbate racial divides. As a result, we must apply a racial equity lens and assess the potential impact of any proposed policy on each of the factors that form the social determinants of health.

A Key Opportunity for Action: Place-Based Approaches

Place-based approaches are those strategies that are informed by the environments where people live, work, attend school, and spend time. There is a direct relationship between the quality of these places and health outcomes. Good individual and family health must begin with good community health and equal access to health-promoting opportunities. Having a "place-based" approach in diagnosing the problem and in identifying strategies is vital – this means that we must look at each community separately to identify the factors that influence health outcomes in that place. The need to explore how community conditions impact health is important for several reasons. Chief among them is to ensure that meaningful solutions are not just focused on the individual or on simply increasing access to healthcare, but on crafting holistic solutions with overall wellness at the center, taking into account the need for environmental changes. Effective place-based solutions also increase attention on prevention efforts, identify multi-sector partners and community members, and change policies and systems. Ultimately, the goal is to explore ways the environment affects health and initiate strategies that impacts choices, behaviors and outcomes. For example, while a concerned provider may create a treatment plan for his or her overweight patient that involves eating five servings of fresh fruits and

vegetables daily and walking a mile every few days, if there are not places to purchase these healthy foods or if the neighborhood is too unsafe to walk, the person may be seen as noncompliant without understanding the limitations of the family's environment. Personal responsibility is important, but choices are dependent on the community context. In its report, *Why Place and Race Matter*, PolicyLink offers a framework to understand how community factors affect health and provides a series of case studies demonstrating how communities have tackled complex neighborhood change. [4]

At its core, health inequity is rooted in systemic racial and economic inequality. And racism itself is one of the ways health inequities can manifest, both in terms of institutional racism influencing social determinants (as noted in *Unequal Treatment*, cited above), and in terms of individual racism: the personal experience of being treated unfairly. The cumulative effect of feeling devalued and less-than-equal over the life course can result in emotional trauma, but also contributes to physiological illnesses. Studies have shown the direct health effects of continuous stress on the body.[5] Many of these health conditions are preventable and demonstrate how health inequities are a result of broader systems of neglect and injustice.

While it may seem like an overwhelming task to tackle huge systemic problems like poverty and racism, incremental changes matter and can make a difference. Left unchanged, our country will continue to lag behind in significant health indicators such as obesity, life expectancy, infant mortality, academic achievement,[6] and economic growth, and we will all suffer the effects. As the United States experiences a significant demographic shift, where it is projected that the country will be predominantly people of color by 2042,[7] we must commit to changing patterns and moving the needle on these complex problems so that the health and wellness of *all* of our nation's residents is our top priority.

Equity Agenda Solutions: Making a Difference

A health equity movement is underway, in which broad sectors are working together to create solutions to the complex problem of health inequities. These solutions are grounded in strengthening communities, engaging non-health sectors, lifting up promising practices, advancing progressive policy options, and identifying research gaps that can make the case for prioritizing health equity strategies. Progress is being made. But there is still an urgent need to take action. One simple set of questions help in assessing health equity implications: 1) who benefits 2) who pays and 3) who decides?[8] These basic questions help in clarifying important power dynamics, and integrating this basic awareness allows for reflection, a beginning analysis, and humility.

Below are a few ideas that are gaining traction, including some common principles that can be promoted and strategies to be adopted in framing a health equity agenda.

1. **Policy agenda**. Lasting changes that support health require policy, system, and environmental changes. A menu of health equity policies would include: increasing access to affordable, healthy food; safe places to play and exercise; healthy school and neighborhood environments; improved academic standards and education reform; educational opportunities and jobs; improved health systems; and sufficient resources targeted to prevention.
2. **Multi-sector approach**. Making the broad changes needed to improve health inequities requires collaboration and partnerships across sectors. It requires engagement of unusual players such as businesses, planners, economists, academics, and faith-based leaders, in addition to traditional health and social service-related fields.

3. **Community engagement and leadership**. Priority populations, such as communities of color, youth, immigrants, and boys and men, are often excluded from the very conversations and decisions around the factors that most impact their health. In identifying and implementing strategies to address health inequities, and to assess their effectiveness, authentically engaging the communities most affected is essential. This engagement may include Community-Based Participatory Research, participating on advisory boards, task forces, and working groups, mobilizing community to take action, and promoting civic engagement. Seeking partnerships with community leaders to amplify their voices and valuing their feedback is critical to successful place-based solutions.
4. **Intentional focus on race and equity**. Although talking about race may not be easy, it is possible to engage in productive dialogues about issues such as how racial factors impact health, especially our shifting racial demographics. For example, many Americans may not be aware that Latinos are rapidly becoming the majority population. What are the implications of this related to health, education, and the economy? Valuing differences and increasing awareness about power, privilege, and access is important, and seeking ways to integrate race and culture into program design and delivery systems is crucial. Using skilled facilitators can be useful.
5. **Attention on prevention**. The places where people live, work, learn, play, and pray impact their health. In fact, where people live has a greater influence on how long they will live than their genetics. Allocating resources to support healthy communities is the most cost-effective pathway to reducing health inequities. Increasing awareness about the root causes of illnesses and catalyzing broad participation has been effective in changing disease patterns and advancing health equity.
6. **Affordable Care Act.** The Affordable Care Act (ACA) will increase access to quality healthcare and to information Americans need to make informed choices about their health. Shifts in the health system, including those that support practitioners and other healthcare workers to provide culturally appropriate services and approach their work with cultural humility,[9] will be needed to ensure the ACA's success. In addition to increasing access to culturally appropriate providers and affordable, quality health care, the Affordable Care Act includes provisions that support a community-centered approach to health (e.g. community benefits requirements for hospitals). Healthcare organizations can serve as anchors in the community and key partners in efforts to engage the most impacted populations in changing their communities to support their health.
7. **Changes in built environment**. Development patterns and community design significantly impact health outcomes. Sprawling developments create barriers to physical activity, and racial segregation and concentrated poverty limit access to quality food, education, and transportation. Involving health professionals in land use planning is becoming standard practice. Inserting health elements in general plans is also gaining traction.
8. **Health in all policies**. Integrating health considerations in the development, implementation, and evaluation of policies and programs is becoming more common. In some instances, formal agreements have been created to develop partnerships between health institutions and divisions such as housing, education, planning, and transportation that serve to guide processes and activities.
9. **Health Impact Assessment**. This tool, created to assess the health impact of a proposed policy or program, is widely used as an initial step in determining how the health of residents will be affected by implementing new systems, programs, or changes in the built environment.
10. **Using data to make the case.** The use of compelling data to make the case for health equity is the first step in gaining support and advocating for change. Working with public health

departments, academic researchers, and others to share data is important. Translating it in ways that are accessible to multiple audiences, including policymakers, is the next step. In an era of evidence-based approaches, capturing and analyzing data must remain an important beginning point.

11. **Sharing stories of impact**. It is important to tell stories of impact, success, and challenges. The stories, however, must be told from the perspective and voice of those most impacted. Often this is a powerful and compelling tool that can help policymakers and funders better understand complex community problems. It can also serve to highlight community assets.
12. **Continuous assessment and refinement**. A critical element in building a health equity agenda is integrating a routine process of formal and informal evaluations. Assessing impact and monitoring progress must begin from the start. This assessment should be shared with community members as well as with program staff, funders, and researchers, an element that is often lacking.

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[1] PolicyLink. *Why Place and Race Matter: Impacting health through a Focus on Race and Place*. 2011.

[2] PolicyLink. *Reducing Health Disparities through a Focus on Communities*. 2002.

[3] Institute of Medicine, National Academy of Science. *Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care.* National Academies Press. Washington DC. 2002.

[4] PolicyLink. *Why Place and Race Matter: Impacting health through a Focus on Race and Place*. 2011.

[5] Camara Phyllis, Jones. "Levels of Racism; A Theoretic Framework and a Gardener's Tale." American Journal of Public Health. 2000.

[6] RWJF Commission to Build a Healthier America. *Time to Act: Investing in the Health of Our Children and Communities.* RWJF. 2014

[7] PolicyLink and PERE. "Summary Population Projections by Race/Ethnicity and by Major Age Groups." Census TIGER/Line, NHGIS, and ESRI. 2013.

[9] Tervalon and Murray-Garcia. "Cultural Humility versus Cultural Competence: a critical distinction in defining physician training outcomes in multicultural education." National Center for Biotechnology Information. 1998.

Resources:

Unnatural Causes: Is Inequality Making Us Sick? California Newsreel. 2008. DVD.

Thomas A., LaVeist. Race, Ethnicity, and Health: A Public Health Reader. John Wiley & Sons, Inc. 2002.

A.V., Diez-Roux. et al. "Neighborhood of Residence and Incidence of Coronary Heart Disease." *New England Journal of Medicine.* 2001.

Azevedo-Garcia and Lochner. "Residential Segregation and Health." *Neighborhoods and Health.* London: Oxford University Press. 2007.

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S. Kawachi, S.V. Subramanian, and N. Almeida-Filho. A glossary for health inequalities. *J Epidemiol Community Health.* 2002.

PolicyLink. *Healthy Food, Healthy Communities: Promising Strategies to Improve Access to Fresh, Healthy Food and Transform Communities.* 2011.

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Intercultural Development Inventory®

Group Profile Report

Introduction

Your IDI Group Profile Report provides valuable information about *the mindset/skillset toward cultural difference and commonality found within an identified group of three or more people within an educational institution*. These groups can include, for example, teaching departments, classrooms, and athletic teams. You can gain valuable insights about how your group engages cultural differences by reflecting on both past and current cross-cultural events or situations the group has been or is involved in. Your IDI Profile results can help you increase your own cultural self- and other-understanding around such differences and commonalities.

The Intercultural Development Inventory® (IDI®) is a valid and reliable assessment of intercultural competence. It has been developed and tested using rigorous cross-culturally validated psychometric protocols with over 220,000 respondents from a wide range of cultural groups and countries. In addition, the IDI has been translated into several languages using rigorous "back translation" protocols.

As you reflect on your IDI profile results, consider:

- ✓ **Have you responded to each of the statements in the IDI honestly?**

  If so, then the IDI profile will be an accurate indicator of your approach for dealing with cultural differences and commonalities.

- ✓ **Have you recently had or are currently experiencing a significant professional or personal transitional experience (e.g., moving to another country, traumatic event)?**

  If so, you may wish to reflect on how this transitional situation may impact how you make sense of cultural differences and commonalities as identified by your IDI results.

IDI, LLC
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Intercultural Development Continuum

Intercultural competence is ***the capability to shift perspective and adapt behavior to cultural difference and commonality***. Intercultural competence reflects the degree to which cultural differences and commonalities in values, expectations, beliefs, and practices are effectively bridged, an inclusive environment is achieved, and specific differences that exist in your organization or institution are addressed from a "mutual adaptation" perspective.

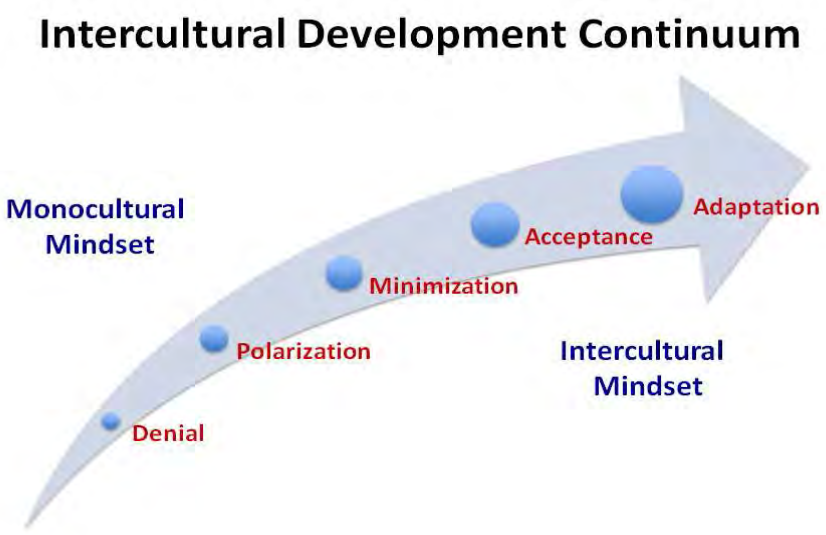
People are not alike in their capabilities to recognize and effectively respond to cultural differences and commonalities. The Intercultural Development Continuum® (IDC®) (modified from the Developmental Model of Intercultural Sensitivity originally proposed by Dr. Milton Bennett), identifies five orientations that range from the more monocultural orientations of Denial and Polarization to the transitional mindset of Minimization to the more intercultural or global mindsets of Acceptance and Adaptation. Your success in achieving your goals is better served when you can more deeply understand culturally-learned differences, recognize commonalities between yourself and others, and act on this increased insight in culturally appropriate ways that facilitate goal accomplishment among diverse individuals and groups.

Monocultural Mindset

- Makes sense of cultural differences and commonalities based on one's own cultural values and practices
- Uses broad stereotypes to identify cultural difference
- Leads to less complex perceptions and experiences of cultural difference and commonality

Intercultural/Global Mindset

- Makes sense of cultural differences and commonalities based on one's own and other culture's values and practices
- Uses cultural generalizations to recognize cultural difference
- Leads to more complex perceptions and experiences of cultural difference and commonality



Summary Orientation Descriptions

Denial	*An orientation that recognizes more observable cultural differences (e.g., food), but may not notice deeper cultural difference (e.g., conflict resolution styles) and may avoid or withdraw from such differences.*
Polarization	*A judgmental orientation that views cultural difference in terms of "us" and "them" This ranges from (1) a more uncritical view toward one's own cultural values and practices coupled with an overly critical view toward other cultural values and practices (Defense) to (2) an overly critical orientation toward one's own cultural values and practices and an uncritical view toward other cultural values and practices (Reversal).*
Minimization	*An orientation that highlights cultural commonality and universal values and principles that may also mask deeper recognition and appreciation of cultural differences.*
Acceptance	*An orientation that recognizes and appreciates patterns of cultural difference and commonality in one's own and other cultures.*
Adaptation	*An orientation that can shift cultural perspective and change behavior in culturally appropriate and authentic ways.*