Central Oregon Diversity Equity and Inclusion (CODEI) Committee

April 6, 2022; 8:30am – 10:00am

Join by computer: https://us02web.zoom.us/j/87938002036?pwd=eHNkbl1nTFREa0JweW5qdIjSTVkJUT09
Join by phone: 1-253-215-8782 or 1-669-900-6833
Meeting ID: 879 3800 2036
Passcode: 061565

8:30 am - 8:50 am Welcome, Guiding Principles, Introductions
• Current Events and Relationship Building
  o Critical Race Theory:
    o From PBS: https://www.youtube.com/watch?v=_gdxrkwpPKc
    o From NowThis News featuring Ibram X. Kendi: https://www.youtube.com/watch?v=miVlHcdjaWM

8:50 am - 9:15 am RHIP Workgroup and Equity Update

9:15 am - 10:50 am CODEI Action Plan
• Update on Community DEIJ Learning Survey
• CODEI Charter and Participation Practices Equity Review
• Participation Check-ins and Invites

12:40 pm - 12:45 pm Closing

Links to Shared Documents
COHC Webpage:
https://cohealthcouncil.org/

Shared Google Drive: (holds all the document(s) above, and many others)
https://drive.google.com/drive/folders/1Y3-hzNmUV9aZ5rxh9iORVtA4jPp87U2N?usp=sharing

Next Meeting – May 4, 2022
Land Acknowledgement

We recognize and acknowledge the indigenous land of which we live, work, learn, play, and grow. This is the land of the Warm Springs, Wasco, Northern Paiute, Tenino, Klamath, Molalla, and Yahooskin. We acknowledge them as the past, present, and future caretakers of this land. It is on their traditional land where we partner to improve the health and well-being of Central Oregonians. We aspire to be good guests honoring the concept in the Warm Springs culture: “This land is for you to know and live upon and pass on to the children.”
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.
Regional Health Improvement Plan (RHIP) Workgroup Update

CODEI
April 6, 2022

Structured Problem Solving

Upstream Prevention: Promotion of Individual Well-Being

Background: Why are we talking about this?
- Roe v. Wade
- ACEs Study
- Evolving birth control options
- Tech Advancement and Screen Time
- No Child Left Behind
- National Traumas (9/11, school shootings)
- Anti-Vax (Vaccine) Movement

Current Condition: What happens right now?
- In Central Oregon, early literacy had a decreasing trend from 2016 to 2018

Goal Statement: Where do we want to be in 4 years?
- All communities in Central Oregon have equitable access and opportunities to health, education, healthy relationships, community support, and experiences necessary to thrive at every stage of life.

Analysis: What’s keeping us from getting there?
- Unbalanced distribution of resources across the region
- Ineffective ending of misinformation in the group usually
- Insufficient communication among entities
- Unbalanced bias creating isolation (connection vs. alienation)
- Generational impact of foundational instability

Strategic Direction: What are we going to try?
- Transforming care coordination across health systems
- Cultivating equity and inclusion in our communities
- Operationalizing DEI practices
- Broadening education to improve health outcomes
- Advocating for policies that improve health outcomes

Focused Implementation: What are our specific actions? (who, what, when, where?)

Follow-Up: What’s working? What have we learned?

Future State Measures

Improving Kinder Readiness and 3rd Grade Reading
Community Grant Opportunity
Awarded 7.2021
Full region. Focus on priority populations

Increase proportion of pregnancies that are intended
Media Campaign Promoting Intended Pregnancies
Awarded 1.2022
Full region. Focus on 18-24yo, under resourced, specific identities and their partners

Increase two-year-old immunization rates
Central Oregon Immunization Quality Improvement Coordinator
Awarded 2.2022
Clinics and public health

Create a regional measure for Resilience and Belonging
Create a regional measure for Resilience and Belonging
Awarded 12.2021
Full region. Representative sampling.
Inclusion and Equity Strategic Directions

- Empowering All People Through Inclusive And Collaborative Partnerships
- Improving Coordination and Access to Culturally Responsive Behavioral Health Care
- Partnering With Underserved Communities For Equitable Decision-Making
- Formalizing Diverse and Welcoming Approaches
- Operationalizing Organizational DEI Practices
- Cultivating Equity and Inclusion in Our Communities

Diversity, Equity, and Inclusion Investment Design

“Which specific populations of people are prioritized? Which data sources support this?”

“What are some recommended partnerships that you want the applicant to consider?”

“Which specific geographic region(s) are prioritized?” (e.g. rural)
Diversity, Equity, and Inclusion
Grant Application

REALD Data Collection
Please select any data your organization collects around Race, Ethnicity, Language, Disability (REALD).

Equity*
How does this project meet the characteristic needs of communities experiencing health disparities based on geography, age, sex, race, ethnicity, national origin, language, culture, disabilities, immigration status, faith, gender identity, and/or sexual orientation?

Share the specific approaches you are using.

Equity (Continued)
Please explain how the people served by the project are involved in the planning and carrying out of the project.

---

Diversity, Equity, and Inclusion
Grant Review

* 5. Diversity, Equity and Inclusion
- The project includes strategies to meet the characteristic needs of the people being served
- The people served by this project are involved in the planning and carrying out the project.
- This project will serve at least 50% people from communities experiencing health disparities based on geography, age, sex, race, ethnicity, national origin, language, culture, disabilities, immigration status, faith, gender identity and sexual orientation.

- It is clear through data, lived experience, expert advice or other ways that the project is needed.
- The project includes multi-cultural measurement such as:
  - testimonials, diary accounts, story telling
  - ways that capture more than words such as photographs, videos, sound recordings
  - open-ended surveys, focus groups, case studies, unstructured interviews
Behavioral Health: Increase Access and Coordination

Background: Why are we talking about this?

<table>
<thead>
<tr>
<th>Period</th>
<th>Events/Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990s</td>
<td>Mill Closures / Timber Industry Decline</td>
</tr>
<tr>
<td></td>
<td>US Wars impact on Veterans</td>
</tr>
<tr>
<td></td>
<td>Housing shortage</td>
</tr>
<tr>
<td></td>
<td>Tech Advancement &amp; Screen Time</td>
</tr>
</tbody>
</table>

Current Condition: What’s happening right now?

- Approximately 1 in 4 adults over 55 in Central Oregon reported a diagnosis of depression
- Percentage of students who reported feeling sad or hopeless has been generally trending upward
- 64% of individuals who died by suicide visited their primary care provider within one year prior to their death

Current State Metrics:
1. Availability of behavioral health providers is less in the rural areas of the region
2. No way to measure timeliness and engagement with specialty behavioral health when referred by primary care
3. No standardize screening processes for appropriate levels of follow-up care across services

Goal Statement: Where do we want to be in 4 years?

Aim/Goal
Increase equitable access to skilled and coordinated care between specialty behavioral health and the larger health system, including primary care, while decreasing barriers to ensure an effective and timely response.

Future State Metrics - By December 2023:
1. Increase availability of behavioral health providers in marginalized areas of the region
2. Increase timeliness and engagement when referred from primary care to specialty behavioral health
3. Standardize screening processes for appropriate levels of follow-up care across services

Analysis: What’s keeping us from getting there?

- Care is culturally inappropriate and unresponsive
- Behavioral Health Careers are undervalued, underappreciated and not at parity with medical health
- Siloed communication and coordination across systems and agencies
- Behavioral Health Conditions are viewed as a character weakness
- Systemic undervaluing & underfunding of Behavioral Health
- Disjointed systems do not address whole person care

Strategic Direction: What are we going to try?

- A. Strengthening and Expanding the Behavioral Health Workforce
- B. Improving Coordination and Access to Culturally Responsive Behavioral Health Care
- C. Normalizing and Destigmatizing Mental Health Across the Lifespan
- D. Advocating and Lobbying for Behavioral Health Funding at Parity with Physical Health

Focused Implementation: What are our specific actions? (who, what, when, where?)

<table>
<thead>
<tr>
<th>Future State Measure</th>
<th>What</th>
<th>When Start</th>
<th>Who/How</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Create a community-driven behavioral health workforce development pipeline to serve rural areas</td>
<td>RFP Process Open</td>
<td>RFP</td>
</tr>
<tr>
<td>2</td>
<td>Identify, create or adapt regional measure for timeliness and engagement and integrate into payer models</td>
<td>2021 - 2024</td>
<td>Consultant, Creach Consulting Group, LLC.</td>
</tr>
<tr>
<td>3</td>
<td>Develop a method to standardize screening processes to assure clients receive the appropriate level of care and follow-up</td>
<td>In Draft.</td>
<td>Consultant RFP Estimated release March 2022</td>
</tr>
</tbody>
</table>

Follow-Up: What’s working? What have we learned?

{ insert }
Promote Enhanced Physical Health Across Communities

Background: Why are we talking about this?

<table>
<thead>
<tr>
<th>Decade</th>
<th>Event/note</th>
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</thead>
<tbody>
<tr>
<td>1990s</td>
<td>Rise in obesity rates</td>
</tr>
<tr>
<td></td>
<td>Increased sugar consumption</td>
</tr>
<tr>
<td>2000s</td>
<td>Decrease in recess time at school</td>
</tr>
<tr>
<td></td>
<td>Increasing Aging Population</td>
</tr>
<tr>
<td></td>
<td>Tech Advancement &amp; Screen Time</td>
</tr>
<tr>
<td></td>
<td>Vaping / E-cigarettes</td>
</tr>
</tbody>
</table>

Physical health is influenced by genes and biology, health behaviors, social environment, physical environment, and health services. Enhancing physical health throughout our communities improves quality of life and reduces the burden of healthcare and other costs to personal and public health. Access to healthcare is a challenge for residents in rural areas.

Current Condition: What’s happening right now?

- Current rates of cardiovascular disease: Crook 9.7%, Deschutes 4.8%, Jefferson 5.7%
- Current rates of diabetes: Crook 10.6%, Deschutes 5.9%, Jefferson 20.4%
- Current adult obesity rates: Crook 31.5%, Deschutes 21.4%, Jefferson 42.2%
- Fewer than 30% of 11th graders report 60 minutes or more of physical activity in 7 days
- Fewer than 25% of 11th graders report getting 5 or more servings of fruits and vegetables per day
- Adults who currently smoke: Crook 29.3%, Deschutes 17.3%, Jefferson 12.7%
- Adults reporting high blood pressure: Crook 48.8%, Deschutes 24.8%, Jefferson 16.9%
- New cases of syphilis have been steadily increasing in the entire region since 2012
- Percentage of Medicaid members who receive both annual wellness visit and preventive dental visit:
  - Crook 17.8%, Deschutes 20.75%, Jefferson 19.3%

See RHIP for Full Current State Metrics

Goal Statement: Where do we want to be in 4 years?

**Aim/Goal**
Equitably and measurably support all Central Oregonians to prevent disease by improving health behaviors and reducing risk factors that contribute to premature death and diminish quality of life.

**Future State Metrics** - By December 2023:
1. Decrease asthma, cancer, cardiovascular disease, and diabetes rates
2. Decrease obesity rates in adults
3. Increase fruit/vegetable consumption and physical activity in youth
4. Decrease risk factors for cardio-pulmonary and/or preventable disease
5. Decrease sexually transmitted infections
6. Increase individuals receiving both an annual wellness visit and preventative dental visit

Analysis: What’s keeping us from getting there?

- Inequitable measurement and approaches to weight and health management
- Rrigidity of time, funding/payment, availability of service and receiving service
- Disparate funding and deceptive marketing
- Siloed systems prevent coordination of care
- Power dynamics adversely affect and create an underrepresentation in policy creation
- Trauma without resilience skills negatively impacts health
- Resource inequality exacerbates health disparity
- Individual and collective health beliefs impact health literacy efforts
- Restrictive and inequitable built environment impacts health

Strategic Direction: What are we going to try?

- Reducing financial barriers to health
- Ensuring access and coordination of health services
- Improving health & wellness communication, education & delivery
- Partnering with underserved communities for equitable decision making
- Ensuring policies that promote health and an equitable built environment

Focused Implementation: What are our specific actions? (who, what, when, where?)

- Investing in programs that reduce barriers to youth fruit and vegetable consumption and physical activity.
- Increasing coordination between oral health and primary care

Follow-Up: What’s working? What have we learned?

(insert)
## Address Poverty and Enhance Self-Sufficiency

### Background: Why are we talking about this?

- **1990s**: Mill Closures / Timber Industry Decline
  - The Great Recession
  - Decreasing safety net – “War on Poor”
  - Local workforce displacement
  - Widening Opportunity Gap

- **2000s**: Population Growth in Central Oregon

Central Oregon has grown rapidly over the past two decades. Individual communities face different economic and social challenges associated with this development, including increased unemployment, lack of affordable housing, and income inequality. There is significant evidence linking poverty to health disparities and poor outcomes.

### Current Condition: What’s happening right now?

- 9-17% of residents in Central Oregon lived in poverty between 2013 and 2017
- Almost 50% of the region’s renters are considered to be cost burdened
- Almost 25% of the civilian labor force in Warm Springs is experiencing unemployment

**Current State Metrics:**

1. 2018 Central Oregon graduation rates were significantly lower among economically disadvantaged students
2. Food Insecurity by County: Crook 15%, Deschutes 13%, Jefferson 13%
3. Income constrained households: Crook 29%, Deschutes 26%, Jefferson 34%
4. Housing and transportation costs combined as a percent of income: Crook 67%, Deschutes 58%, Jefferson 58%

### Goal Statement: Where do we want to be in 4 years?

**Aim/Goal**

- Individuals and families in Central Oregon experiencing poverty are provided equitable access and connected to appropriate resources that help them overcome obstacles to self-sufficiency and address health-related challenges.

**Future State Metrics** - By December 2023:

1. Increase high school graduation rates among economically disadvantaged students
2. Decrease food insecurity
3. Decrease percent of income constrained households
4. Decrease housing and transportation costs as a percent of income

### Analysis: What’s keeping us from getting there?

- Demand exceeds supply for range of housing needs required
- Disjointed Systems
- Funding/Educational system is designed not to meet the needs of historically marginalized students
- Inactive response to Awareness, Barriers and Cultural Sensitivity
- Transportation can be inaccessible due to distance/economic
- Inequity of resources for income constrained families
- Scarcity culture promotes exclusionary programming
- Historical classism and racist structures undervalue and constrain people
- Complex & excessive restrictions to access safety nets

### Strategic Direction: What are we going to try?

- Strengthening Foundation of Individual and Community Health
- Empowering All People and Communities Through Inclusive and Collaborative Partnerships
- Connecting People and Establishing Pathways to Enhance Community Resources
- Boosting Advocacy to Address Systemic Factors Contributing to Poverty

### Focused Implementation: What are our specific actions? (who, what, when, where?)

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
<th>Status</th>
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<tbody>
<tr>
<td>02/21</td>
<td>Invest in programs to increase HS Grad Rates</td>
<td>Funded</td>
</tr>
<tr>
<td>02/22</td>
<td>Invest in regional ALICE Listening Sessions</td>
<td>Funded</td>
</tr>
<tr>
<td>02/22</td>
<td>Invest in programs to decrease Food Insecurity</td>
<td>Funded</td>
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### Follow-Up: What’s working? What have we learned?

(insert)
Stable Housing and Supports

**Background: Why are we talking about this?**

<table>
<thead>
<tr>
<th>1990s</th>
<th>Mill Closures / Timber Industry Decline</th>
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<tbody>
<tr>
<td></td>
<td>Federal Housing Policy</td>
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<tr>
<td></td>
<td>Housing shortage</td>
</tr>
<tr>
<td></td>
<td>The Great Recession</td>
</tr>
<tr>
<td>2000s</td>
<td>Population Growth in Central Oregon</td>
</tr>
<tr>
<td></td>
<td>Housing shortage</td>
</tr>
<tr>
<td></td>
<td>Wage Vs. Housing Costs</td>
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<tr>
<td></td>
<td>Single Income Households</td>
</tr>
</tbody>
</table>

Stable, healthy housing is a basic need. Insecure housing and an unhealthy living environment impact both physical and behavioral health conditions. By spending much of their income on housing, individuals and families must cut corners on other living expenses such as food, transportation, and medications, which can also significantly influence their health outcomes and overall well-being.

**Current Condition: What’s happening right now?**

- In 2017, 18% of Central Oregonians paid more than half of their income for rent and mortgage
- In Central Oregon, minority households experience more housing challenges than their white counterparts
- Central Oregon has a critical shortage of supportive housing units to meet the needs of people with disabilities, with co-occurring mental health or substance use disorders, and/or extended history of homelessness

**Current State Metrics:**
1. In 2017, 18% of Central Oregon households were severely rent or mortgage burdened
2. In 2018, only 30% of Housing Choice Voucher holders were able to find and lease a housing unit
3. No system to determine an accurate number of those experiencing homelessness exists in Central Oregon

**Goal Statement: Where do we want to be in 4 years?**

**Aim/Goal**

Central Oregonians experiencing homelessness and those most at-risk of homelessness will have increased and equitable access to housing and supports that offer opportunities for stability and increased individual well-being.

**Future State Metrics - By December 2023:**
1. Decrease severely rent and mortgage-burdened households
2. Increase Housing Choice Voucher holders able to find and lease a unit
3. Accurately capture Central Oregonians experiencing homelessness

**Analysis: What’s keeping us from getting there?**

- Inaccurate and accurate assumptions reduce acceptance of diverse housing
- Housing cost & supply outweigh wealth & income
- Uncoordinated common advocacy goals, problems & efforts
- Inconsistent disjointed & inaccurate systems of data collection
- Housing is considered a commodity not a human necessity
- Prohibitive income & background requirements

**Strategic Direction: What are we going to try?**

Creating and increasing housing resources and opportunities
Developing and implementing advocacy strategies for housing policies and zoning
Aligning efforts across systems to address the housing crisis and homelessness
Educating the public to increase understanding and de-stigmatize housing needs

**Focused Implementation: What are our specific actions? (who, what, when, where?)**

<table>
<thead>
<tr>
<th>COIC</th>
<th>Regional Housing Council (Pilot)</th>
<th>2021-2023</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>FUSE</td>
<td>Permanent Supportive Housing</td>
<td>2021-2024</td>
<td>Region</td>
</tr>
<tr>
<td>HLC</td>
<td>Housing Case Management Infrastructure</td>
<td>2021-2024</td>
<td>Region</td>
</tr>
</tbody>
</table>

**Follow-Up: What’s working? What have we learned?**

(Insert)
Substance and Alcohol Misuse: Prevention & Treatment

Background: Why are we talking about this?

| 1980s | Social norming of alcohol increases / legalizating of brew pubs on Oregon
| 1990s | Opioids are introduced for pain treatment
| 2007  | E-cigarettes are introduced in the US
| 2016  | Marijuana is legalization in Oregon
| 2019  | Surgeon General Report on Marijuana

1 in 10 Oregonians struggle with drugs or alcohol costing the state $6 billion/year. These illnesses are common, recurrent and treatable. Research indicates that preventing substance misuse can have far reaching implications for individuals, families and our community, including impact on education, community safety, health care, employment and quality of life.

Current Condition: What’s happening right now?

- As of 2019, 19 cases of vaping related illnesses have been reported in OR, leading to 2 deaths
- Oregon has one of the highest rates of misuse of prescription opioids in the nation
- Deaths from methamphetamine overdoses in Oregon are up 400% between 2012 and 2017

Current State Metrics:
1. 37.4% of adults age 18-34 in Central Oregon reported binge drinking at least once in the past 30 days
2. 11th graders vaping or using e-cigarettes: Crook 22.6%, Deschutes 29.4%, Jefferson 16.6%
3. 7.8% of Medicaid members diagnosed with alcohol or drug dependence and who began treatment within 14 days of diagnosis, had 2 or more additional services within 30 days of initial treatment
4. Mental health / substance abuse ED visits per 1,000: Warm Springs 47, Prineville 20.1, Madras 17.2

Goal Statement: Where do we want to be in 4 years?

Aim/Goal
Create and enhance cross-sector collaborations and programming so that all Central Oregonians have equitable access to skilled, evidence-based substance and alcohol misuse prevention, intervention, treatment, and recovery services that are culturally responsive and trauma-informed.

Future State Metrics - By December 2023:
1. Decrease binge drinking among adults.
2. Decrease vaping or e-cigarette use among youth.
3. Increase additional services for alcohol or drug dependence for individuals newly diagnosed.
4. Reduce mental health/substance abuse emergency department visits in Madras, Prineville and Warm Springs.

Analysis: What’s keeping us from getting there?

- Targeted seductive marketing encourages use
- Minimization of risk & harm impact prevention & care
- Data is not easily accessible or known
- Historical investment patterns impact SUD services
- Alcohol culture dominates the local lifestyle
- Inadequate screening & guidance at all contact points
- Trauma significantly impacts well-being
- Inaccessible & inequitable housing options
- Inconsistent & ineffective health messaging
- Pervasive stigma impedes prevention & access to care

Focus Implementation: What are our specific actions? (who, what, when, where?)

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.18.21</td>
<td>Binge Drinking Regional Assessment RFP</td>
</tr>
<tr>
<td>01.06.22</td>
<td>Peer Support Specialist Funding Application hired</td>
</tr>
<tr>
<td>10.25.21</td>
<td>Peer Support Specialist Sustainability Consultant Application review</td>
</tr>
<tr>
<td>03.08.22</td>
<td>Healthy Retailing In development</td>
</tr>
<tr>
<td>03.08.22</td>
<td>Treatment referral card distribution In development</td>
</tr>
</tbody>
</table>

Follow-Up: What’s working? What have we learned?

(insert)
Upstream Prevention: Promotion of Individual Well-Being

Background: Why are we talking about this?

1973 Roe v. Wade
1990s ACEs Study
2000s Evolving birth control options
2000s Tech Advancement and Screen Time
2000s No Child Left Behind
2000s National Traumas (9/11, school shootings)
2000s Anti-Vax (Vaccine) Movement

Upstream strategies improve fundamental social and economic structures that allow people to achieve their full health potential. Discrimination and racism impact all aspects of a person’s well-being and intersect with all major systems of society. Educational status provides a significant predictor of health outcomes. Third-grade disparities exist for marginalized populations by race and economic status.

Current Condition: What’s happening right now?

• In Central Oregon, early literacy had a decreasing trend from 2016 to 2018

Current State Metrics:
1. Letter recognition at kindergarten for economically disadvantaged: Crook 11.9, Deschutes 12.1, Jefferson 9.4
2. Third grade reading for underserved races: Crook 29%, Deschutes 41%, Jefferson 35.4%
3. 44.8% of pregnancies were intended in Central Oregon
4. Two-year-old up-to-date immunization rates: Crook 70%, Deschutes 69%, Jefferson 71%
5. No established baseline for a metric such as the Child/Youth/Adult Resilience Measure

Goal Statement: Where do we want to be in 4 years?

Aim/Goal
All communities in Central Oregon have equitable access and opportunities to health, education, healthy relationships, community support, and experiences necessary to thrive at every stage of life.

Future State Metrics - By December 2023:
1. Increase letter name recognition at kindergarten for economically disadvantaged and/or underserved races
2. Increase third grade reading proficiency for economically disadvantaged and/or underserved races
3. Increase proportion of pregnancies that are intended
4. Increase two-year-old immunization rates
5. Establish a resiliency measure, measure yearly and increase the number of people who feel they belong in their community

Analysis: What’s keeping us from getting there?

• Unbalanced distribution of resources across the region
• Decision-making based on misinformation and personal belief
• Systemic inequity prevents access to usable information
• Unbalanced bias creating isolation (connection vs alienation)
• Generational impact of foundational instability

Strategic Direction: What are we going to try?

• Transforming care coordination across health systems
• Cultivating equity and inclusion in our communities
• Operationalizing DEI practices
• Broadening education to improve health outcomes
• Advocating for policies that improve health outcomes

Focused Implementation: What are our specific actions? (who, what, when, where?)

<table>
<thead>
<tr>
<th>Future State Measures</th>
<th>What</th>
<th>When</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Kinder Readiness and 3rd Grade Reading</td>
<td>Community Grant Opportunity</td>
<td>Awarded 7.2021</td>
<td>Full region. Focus on priority populations</td>
</tr>
<tr>
<td>Increase proportion of pregnancies that are intended</td>
<td>Media Campaign Promoting Intended Pregnancies</td>
<td>Awarded 1.2022</td>
<td>Full region. Focus on 18-24yo, under resourced, specific identities and their partners</td>
</tr>
<tr>
<td>Increase two-year-old immunization rates</td>
<td>Central Oregon Immunization Quality Improvement Coordinator</td>
<td>Awarded 2.2022</td>
<td>Full region. Clinics and public health</td>
</tr>
<tr>
<td>Create a regional measure for Resilience and Belonging</td>
<td>Create a regional measure for Resilience and Belonging</td>
<td>Awarded 12.2021</td>
<td>Full region. Representative sampling</td>
</tr>
</tbody>
</table>

Follow-Up: What’s working? What have we learned?

{insert}
Equity tools are designed to help us fashion intentional considerations of health and racial equity into decisions. They provide a way to standardize and normalize considerations of equity in all parts of an organization’s work. Regularly using an equity tool can reduce inequities and improve the success of policies, practices, programs, and budgets. When equity tools are not integrated into planning at all levels, health and racial disparities are more likely to continue.

**Basic Questions** *(Allyship in Action)*
Ask these questions when considering an existing policy or practice AND as you build a new policy or practice.

<table>
<thead>
<tr>
<th>WHO?</th>
</tr>
</thead>
</table>
| ❖ Who is most affected (burdened or benefited) by these decisions?  
| ❖ Who is involved in the decision-making process?  
| ❖ Who is responsible and accountable to the outcome?  
| ❖ Who has or doesn’t have power and why? |

<table>
<thead>
<tr>
<th>WHAT?</th>
</tr>
</thead>
</table>
| ❖ What assumptions do I hold regarding this policy and who it affects?  
| ❖ What are the barriers to full participation in decisions and access to services? |

<table>
<thead>
<tr>
<th>WHERE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ Where are voices missing from the work and process?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHEN?</th>
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</thead>
<tbody>
<tr>
<td>❖ When designing the work, how do we maintain an intersectional approach and awareness?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHY?</th>
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</thead>
<tbody>
<tr>
<td>❖ Why do the barriers exist and how can we eliminate them?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW?</th>
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</table>
| ❖ How do we measure data, success, and failure of process and outcome?  
| ❖ How do we leave room in the process to be responsive to the dignity and unique needs of the communities we work with and serve? |

Sources:
- [https://www.health.state.mn.us/communities/practice/resources/publications/docs/1811advancingHEkeyQs.pdf](https://www.health.state.mn.us/communities/practice/resources/publications/docs/1811advancingHEkeyQs.pdf)
- [https://www.policylink.org/resources-tools/tools](https://www.policylink.org/resources-tools/tools)
- [https://hriainstitute.org/blog/78-health-equity-and-systems-change-are-you-asking-these-4-key-questions-2](https://hriainstitute.org/blog/78-health-equity-and-systems-change-are-you-asking-these-4-key-questions-2)
### Additional Questions (Questions in **bold** indicate key questions.)

#### ASSUMPTIONS

- What are our values that are underlying this discussion or decision?
- What is assumed to be true about the world and the role of the institution in the world?
- What is a successful outcome? For whom? Who decides what “success” is?
- What should be measured to indicate success? When should it be measured?
- Is equity a central concern? If not, why not?
- What would it look like if equity was the starting point for decision-making?
- How is opportunity defined, for whom, and who is defining it? How might opportunity be defined to include everyone?
- How is a healthy community being defined, for whom, and who is defining it?
- What is an effective, participatory, and equitable public process?
- What are the roles/responsibilities of the institution/organization/office? What are not? What should the roles/responsibilities include?

#### POLICIES

- **What are the outcomes?** Were these the intended outcomes? **What outcomes do we want?**
- Who is left out?
- Who should benefit?
- How are the benefits of the policy or policies distributed among groups, such as across racial/ethnic populations?
- How has racism (historical or otherwise) contributed to the distribution of benefits across populations?
- How are the benefits of the policy or policies distributed among places?
- How has racism contributed to the distribution of benefits across places?
- How might the benefits of the policy to populations or to places be more equitably distributed?
- What groups are burdened by this policy? Which places?
- How might the burdens on populations or on places be more equitably distributed?
- What have been the outcomes of this policy? Were these the intended outcomes?
- Does this initiative/policy maintain things the way they are now? Should it?
- Are there unintended consequences from the policy? Is there a way to correct for unintended outcomes?
- Are policies in other areas affecting the effectiveness of this policy? Where could policies be coordinated?

#### PROCESSES

- **Who is at the decision-making table and who is not?**
- Who has the power at the table?
- Who is being held accountable and to whom or what are they accountable? How will you ensure accountability, communicate, and evaluate results?
- How should the decision-making table be set, and who should set it?
- How connected are the decision makers to the communities affected? How is responsibility for making decisions shared?
- What are the criteria used to make decisions? Are these the right criteria?
- How inclusive and empowering is the decision-making process, especially for those historically excluded?
- What mechanisms are in place to ensure the decision-making process considers the long-term interests of diverse populations?
- What structures/mechanisms could ensure that experts and agency staff are “on tap” as resources versus “on top” as deciders?
- What is the implementation process? Is it reflective of stakeholder needs and values?
- How are outcomes tracked and reported? Are there ways to improve data collection and transparency?
Central Oregon Diversity and Inclusion (CODI) Workgroup Charter

Central Oregon Health Council- Central Oregon Diversity and Inclusion (CODI) Workgroup Charter

1. PURPOSE
The CODI Workgroup will serve to provide expertise, focus and actionable strategies to advance diversity, equity and inclusion in support to the goals of the Central Oregon Health Council (COHC) as articulated in the Regional Health Improvement Plan (RHIP). The workgroup is charged to:

- Create capacity to establish policy and practice that ensures cultural responsiveness and focus on reducing disparities
- Identify strategies to create safety and inclusiveness in health practice across the region
- Provide and grow leadership focus on equity, inclusion and engagement of underserved populations in decision-making
- Understand and communicate disparities in health outcomes and recommend/advocate for best/effective practice to impact change

The Triple Aim of improving health outcomes, increasing satisfaction with the health system and reducing cost will serve as guiding principles. Evaluation of effectiveness will include, but not be limited to, COHC adopted Health Impact Metrics (HIM) progress.

2. PURVIEW
The purview of the CODI Workgroup includes accountability for the positive movement of the HIMs, generating ideas and identifying areas to advance diversity, equity and inclusion in health practice (funding, aligned strategies, policy, etc.), encouraging partnerships, and community outreach. The Workgroup is not required to create or apply these initiatives itself, but strives to ensure that the gaps are filled, provide mitigation for duplication of efforts, and that barriers to HIMs improvement are removed.

3. AUTHORITY
Authority is vested to the CODI Workgroup by the COHC Board of Directors. In partnership with the Operations Council, the Workgroup has the decision-making authority to fiscally support any funded initiatives that affect diversity, equity and inclusion in health policy and practice. The Workgroup has the individual authority to make a declaration of support for any initiative.
4. COMPOSITION /GOVERNANCE

Member representatives from all impacted parties, including health and community program practitioners, representatives with lived experience and advocates for underserved populations including but not limited to race/ethnicity, limited English proficiency, populations experiencing complex health and social needs, and geographic representation will comprise the CODI Workgroup. CODI values strong partnerships with families and clients and will prioritize efforts to recruit and maintain support for members with lived experience.

New members of the CODI Workgroup must be approved by the Workgroup members, and will be provided orientation on the scope, authority and activities of the Workgroup prior to approval. Members are expected to attend regularly to maximize the impact of the workgroup.

The workgroup may form ad hoc sub-workgroups or request ad hoc member representation as required to achieve specific tasks. The Workgroup will include a member(s) on any sub-workgroups in order to maintain strategic alignment and communication of improvement ideas.

The Workgroup may choose to appoint a leader but is not required to do so. The COHC staff will organize all meetings and serve as the spokesperson and liaison for the group. A COHC staff member will fulfill the duties of the leader in their absence. Support for meetings will occur through the COHC staff team.

5. RESPONSIBILITIES/DUTIES

a. Scope

Workgroup members are expected to actively engage in discussions centered on health improvement as it is impacted by issues of diversity, equity and inclusion. The Workgroup is responsible for coordination of efforts with COHC standing committees and RHIP committees and other regional efforts, identifying and declaring their support for the strategies and/or initiatives they believe will have the greatest possible impact on reducing disparities in health outcomes and championing actionable strategies to improve policy and practice in Central Oregon.

b. Objectives

The Workgroup shall develop an A3 to guide priority work and improvement progress for key areas of focus. This process will serve to identify the gaps
and brainstorm implementation pilots to improve diversity, equity and inclusion within health policy and practice in the region. The A3 will be presented to the Operations (OPS) Council on an annual basis with an update on Workgroup activities and progress.

Identified needs and proposed strategies will be coordinated with applicable RHIP Committees. If the Workgroup determines that funding is required to fill an identified gap, they will present their justification to the OPS Council. Given approval, the Workgroup will either 1) identify training or technical assistance need, organizational lead and submit through the COHC Funding request process; or, 2) if broad application, draft and disseminate a Request for Proposal (RFP), receive and review applications with the RFP Review Sub-workgroup of the Operations Council (convenes once every 6 months).

c. Communication
Meetings will be scheduled on a monthly basis. To increase access across the region, on alternate months, meetings will be facilitated through electronic meeting format. Special meetings may be called if an issue arises that requires immediate attention. Meeting agendas and supporting materials will be updated and sent to Workgroup members prior to meetings. A recording of Workgroup actions and approvals will be kept for each meeting.

d. Charter Approval and Revision
This charter must be approved by the CODI Workgroup to become active. Revisions to the charter will be approved by the Workgroup.

6. CONFIDENTIALITY
Confidentiality will be maintained during CODI Workgroup discussion and deliberations with the goal of providing a safe and inclusive venue for honest dialog.
Regional Health Improvement Plan (RHIP) Workgroup

Participation Practices

The Central Oregon Health Council’s (COHC) Regional Health Improvement Plan (RHIP) workgroups are made up of many people/partners from different parts of our communities. Every individual brings a unique and valued perspective. All of our perspectives, together, increase our ability to positively change our health and well-being. We make every effort to make sure people from every part of our many communities are present and included in our discussions, processes and decisions.

We want to help you fully understand our RHIP workgroups before participating. This will make it easier for you and for the other workgroup partners.

- If you are interested in participating in a workgroup, or are new to a workgroup, we will meet with you to educate you about the COHC, the RHIP, and the workgroup.
- Please email kelsey.seymour@cohealthcouncil.org or call 541.306.3523 to schedule a time.

All RHIP workgroups are open to the public and anyone interested in the workgroup topic. Please share your knowledge, insights and experiences in the discussions. Participating regularly gives you better understanding of the many perspectives, goals, and direction of the RHIP workgroup.

- When you participate in three monthly RHIP workgroup meetings within a 6-month period, you can vote on funding decisions. At this point, you will be called a “Voting Partner” and can vote starting at your fourth workgroup meeting.
- When you become a Voting Partner, they will need to complete the Conflict of Interest form and give it to a COHC staff person. You can find the form at _____.

Once you become a Voting Partner, your presence and absence are important to us and the community-led work the RHIP workgroup is involved in.

- If you are absent for three RHIP workgroup meetings in a row or come to four or less RHIP workgroup meetings in 12 months, you will no longer be a Voting Partner.
- If you choose to stop attending a workgroup, please tell a COHC Staff person as soon as possible. You can email your workgroup facilitator or call 541.306.3523.
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