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# Joint ELC/OHPB Subcommittee Recommendations

## *Towards Collective Impact*

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**Prepared for:**

The Early Learning Council (ELC) and Oregon Health Policy Board (OHPB)

**Prepared by:**

Members of the Joint ELC/OHPB Subcommittee

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- Tina Edlund, Chief of Policy, Oregon Health Authority

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**Acknowledgements:**

The Joint Subcommittee thanks Jennifer Gilbert and Richelle Borden for their assistance with the Joint Subcommittee and contributions during the preparation of this report.

## Executive Summary

Under Governor Kitzhaber's leadership, Oregon has initiated simultaneous transformation of its health, education and human service systems. The opportunity to align these reform efforts will dramatically influence our ability to meet desired short and long-term outcomes and position Oregon for success in the global economy of the 21<sup>st</sup> century.

Based on the charge from the Oregon Health Policy Board and Early Learning Council, the goal of the Joint ELC/OHPB Subcommittee ("Joint Subcommittee") was to develop strategies, a policy framework and a timeline to ensure alignment and/or integration between health and early learning system transformation. After seven meetings and review of existing research, we make the following recommendations to achieve our desired outcomes. Our recommendations are based on a collective impact approach, whereby no single entity has the resources or authority to bring about the necessary change. It requires a systematic approach including disciplined and integrated relationships across health, early learning and human services that drive progress toward shared outcomes. The structure of this report and our recommendations reflect the five conditions of collective success as described by the authors of Collective Impact (Kania & Kramer, 2011): common agenda, shared measurement systems, mutually reinforcing activities, continuous communication and backbone support organizations.

The Joint Subcommittee imparts a sense of urgency to address the foundations of health and education outcomes and to meet the needs of Oregon's children. Many of the proposed recommendations can be implemented immediately. Where a step-wise approach is needed, a four year implementation timeline has been proposed.

Summary of straw proposal recommendations:

- *Adopt this collective impact framework to guide the joint work of the Early Learning Council and Oregon Health Policy Board.*
- *Designate kindergarten readiness as the common agenda for the Oregon Health Policy Board and Early Learning Council with a focus on equity.*
- *Adopt kindergarten readiness as a shared outcome with the included implementation timeline.*
- *Establish shared incentives linked to joint outcomes.*
- *Adopt the Child and Family Well-being measurement strategy and identify a technical advisory committee to support implementation.*
- *Identify additional resources to ensure capacity for cross-system learning and health information exchange dedicated to care coordination.*
- *Adopt and implement a statewide system of developmental screening including identified core components.*
- *Renew the Joint ELC/OHPB Subcommittee Charter with new deliverables focused on a shared measurement strategy, care coordination, information exchange and shared incentives.*
- *Designate the Transformation Center as the backbone structure for fostering shared learning and alignment at the local level.*
- *Implement shared communication strategies that facilitate local, cross-system learning between health and education.*

## Introduction

Science tells us that meeting the developmental needs of young children is as much about building a strong foundation for lifelong physical and mental health as it is about enhancing readiness to succeed in school. (Center on the Developing Child at Harvard University, 2010)

The preconception, prenatal and early childhood periods are critical for long-term health and education outcomes (Shonkoff & Phillips, 2000). An extensive body of scientific evidence shows that the most common diseases in adults (hypertension, diabetes, cardiovascular disease and stroke) are linked to negative experiences during sensitive periods in brain and other organ development, such as stress and poor nutrition (Felitti et al., 1998; Barker, 2004). Physical and mental health problems in childhood are associated with poor adult health and also impact human capital development and long-term socioeconomic status (Delaney & Smith, 2012). Health outcomes are influenced by factors well beyond medical care, including genetic endowment, social circumstances, environmental conditions and behavioral choices (Robert Wood Johnson Foundation Commission to Build a Healthier America, 2009).

High quality, early learning environments are essential for lifelong health and education outcomes. Home visiting programs for pregnant women, infants and young children have been shown to improve school performance, employment rates, and reductions in welfare use among participants (the PEW Center on the States, 2010). Two longitudinal, preschool studies- the High/Scope Perry and Abecedarian studies- have shown significant, long-term impacts from high quality early learning programs for socioeconomically at risk children. Outcomes from these programs were broad and sustained, including: reductions in special education, crime and need for welfare, as well as increases in employment and income (Knudsen, Heckman, Cameron & Shonkoff, 2006). Researchers for the High/Scope Perry program have estimated a public return on investment of \$12.90 for every dollar spent on the program (Schweinart et al., 2005).

Finally, nurturing and stable relationships are crucial for ensuring optimal health and development. “A child’s environment of relationships can affect lifelong outcomes in emotional health, regulation of stress response systems, immune system competence and the early establishment of health-related behaviors” (Center on the Developing Child at Harvard University, 2010). The absence of these solid relationships and exposure to adverse childhood experiences (ACEs) are correlated with both academic failure and chronic disease (Felitti et al., 1998).

Long-term outcomes, such as those sought by Oregon’s health and education system reform, are reliant on secure attachments between children and the adults in their lives, early health, early learning, and the investments we choose to make during the most sensitive and optimally receptive periods. As stated by Gabriella Conti and James Heckman (2011), “The evidence is quite clear: Early health and early childhood development from birth to age 5 is a form of preventive health and economic investment that drives achievement and economic returns.”

### **The Joint Subcommittee**

With knowledge of the evidence linking health and early learning, the Joint Subcommittee was chartered by the Oregon Health Policy Board (OHPB) and Early Learning Council (ELC) to develop strategies, a policy framework and a timeline to ensure alignment between health care and early learning system transformation. Specifically, the Joint Subcommittee was charged with the following deliverables: a strawperson proposal for alignment and/or integration of health and early learning

policy and service delivery, a proposal and timeline for establishing kindergarten readiness as a shared outcome, and a proposed system of screening across health and early learning. The Joint Subcommittee was convened in December 2012 and has met a total of seven times.

The Joint Subcommittee identified the following set of principles which have guided our work:

- *As shared as possible* (community culture and change; accountability; outcomes; coordination)
- *As simple as possible* (family experience; build on existing resources; common forms)
- *As straightforward as possible* (clear communication; family-centered; customer-driven)
- *As soon as possible* (urgency to address transformation opportunities, improve outcomes)

The Joint Subcommittee previously identified a set of initial recommendations to align early learning and health system transformation. The following is a summary of these recommendations already adopted by the Oregon Health Policy Board (3/5/13) and the Early Learning Council (3/14/13):

- *Joint Needs Assessment:* CCOs and Early Learning Hubs jointly develop a community needs assessment and community improvement plan.
- *Care Coordination/Case Management:* CCOs and Hubs identify best approaches to provide joint care coordination/case management for targeted children and families.
- *Cross Governance:* establish cross governance between CCOs and Early Learning Hubs.
- *Developmental Screening:* develop a statewide measure that accounts for developmental screening occurrences across early learning and health systems. The Early Learning Council adopts the Ages and Stages Questionnaire (ASQ) as the statewide general developmental screening tool for the early learning system.
- *Transformation Supports:* the Transformation Center serves as a resource for building alignment between health and early learning at the local level.

### **Concurrent System Transformation**

Investments in early learning remain critical to meet the state's "40/40/20" educational goals: that 40 percent of adult Oregonians have earned a bachelor's degree or higher, that 40 percent have earned an associate's degree or post-secondary credential, and that the remaining 20 percent or less have earned a high school diploma or its equivalent by 2025. During the 2013 legislative session, critical steps were taken to ensure that children enter kindergarten ready to learn, including: 1) the creation of the Early Learning Division within the Department of Education and 2) the ELC charge to establish up to 16 Early Learning Hubs across the state during the next biennium. Early Learning Hubs are coordinating bodies that pull together resources for children and families in defined service areas while focused on achieving outcomes. They must work with all sectors that touch early childhood to produce desired outcomes, including health care, early childhood educators, human and social services, K-12 school districts, and the private sector.

Concurrently, health system transformation continues to move forward to meet the goals of the Triple Aim: Better Health, Better Care, and Lower Costs. Fifteen Coordinated Care Organizations (CCOs) have been established since 2012; certification of one additional CCO as well as dental care integration is underway. With approval from the Center for Medicare and Medicaid Services (CMS), a final agreement for the Oregon Healthy Authority's (OHA) Accountability Plan has been achieved, including the establishment of 17 incentive metrics and an overall Measurement Strategy. Quarterly progress towards defined benchmarks will be shared publicly. OHA has approved the CCOs' first transformation plans and community improvement plans are expected by July 2014. Recently created within OHA, the Transformation Center will support CCOs and the adoption of the coordinated care model through

technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices among CCOs and other health plans and payers.

### **Strawperson Proposal and Recommendations**

#### **Collective Impact**

As described by Kania & Kramer (2011), large-scale social change comes from better cross-sector coordination rather than isolated interventions of individual organizations or agencies:

Collective impact is the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem... It requires a systemic approach to social impact that focuses on relationships between organizations and the progress toward shared objectives. (p. 36, 39)

The collective impact concept recognizes that no single entity or organization has sufficient power or resources to solve complex social problems alone. Ultimately, Oregon's achievements towards optimal health and early learning will be realized through local efforts across Oregon that address the unique needs of each community. Collective impact at the local level can serve as a helpful tool towards shared success across multiple community partners. However, in order to reduce unnecessary barriers and provide optimal support to local communities, state agencies must also break down existing silos and work collectively towards shared goals.

#### **Recommendation 1:**

**Adopt this collective impact framework to guide the joint work of the Early Learning Council and Oregon Health Policy Board.**

#### **Common Agenda**

According to Kania & Kramer (2011), collective impact requires that all participants have a shared vision for change, one that includes "a common understanding of the problem and a joint approach to solving it through agreed upon actions" (p 39). To optimize outcomes amidst health, human services and education reform, these systems must identify a common agenda. The ultimate goal of Oregon's broad transformation efforts is to position Oregon for success in the global economy of the 21<sup>st</sup> century and to ensure prosperity for all. For purposes of this collective impact initiative, however, the Joint Subcommittee has defined **Kindergarten Readiness** as the immediate common agenda.

What is kindergarten readiness? Kindergarten readiness means that a child enters school ready to succeed. It encompasses core areas of child development including social/emotional, physical, cognitive, and language development. Some of the most essential components of kindergarten readiness include: optimal health, a safe and nurturing environment, an eagerness to learn, the ability to follow direction, to work well with others, to recognize numbers and letters and to hold a pencil or crayon.

Kindergarten readiness is reliant on the critical role and responsibility of parents as their child's most important and life-long teachers. Kindergarten readiness is also a community issue that requires involvement of health, human service, and education supports for success. Finally, kindergarten readiness requires that communities are ready to support the needs of every child, including children with developmental delay, disability or other health care needs.

While pursuing a kindergarten readiness agenda in Oregon, attention to equity is paramount. The Oregon Education Investment Board (OEIB) and ELC recently adopted the *Equity Lens* (OEIB, 2013) which

calls attention to the education achievement gap between communities of color, immigrants, migrants, and low income rural students compared to more affluent students. Similarly, these populations experience persistent and increasing disparities in health status (Health Affairs, 2013). To meet the goals of health and education system transformation, starting with kindergarten readiness, we must explicitly identify and address disparities to reverse these trends.

Until recently, Oregon lacked a uniform way to assess kindergarten readiness. Starting this fall, every Oregon child entering publicly-funded kindergarten will receive a composite assessment of kindergarten readiness using three validated and standardized tools: the Child Behavior Rating Scale (CBRS) and easy CBM Literacy and Math measures. This statewide kindergarten readiness assessment is completed by kindergarten teachers during the first six weeks of school. Results of this assessment will offer a snapshot of Oregon's children upon entry to kindergarten that allows 1) "a look forward" so that teachers and schools can tailor their instruction to the individual needs of children, and 2) "a look back" to assess whether community supports and services are meeting the needs of children and families.

### **Recommendation 2:**

**Jointly adopt kindergarten readiness as a common agenda for the Oregon Health Policy Board and Early Learning Council. Apply the OEIB Equity Lens to this joint work.**

### **Shared Measurement System**

*Shared Measurement Strategy: Oregon's Child and Family Well-being*

In alignment with the collective impact approach, the Joint Committee recommends the adoption of a statewide, coordinated approach to measuring child and family well-being that transcends state agencies and traditional silos. The measures will be used to drive cross-sector strategic planning, mutually reinforcing actions, and policy decisions. This measurement approach will also provide local-level data to communities to help inform priorities and improvement plans. This measurement strategy will explicitly focus attention on identifying disparities in outcomes based on age, race, ethnicity, language, and geography and calls for uniform data collection on each of these parameters. The Joint Subcommittee has prioritized a set of measure categories and associated topic areas. With the support of a technical advisory committee and public input process, the Joint Subcommittee will adopt specific measures for each of these topic areas. To implement the measurement strategy, the Joint Subcommittee recommends:

- Appointment of a technical advisory committee (to include, at minimum, representation from the Metrics & Scoring Committee, CCOs, Hubs, governmental and tribal public health systems, and other state or local health, human services and education entities)
- Creation of a public, Oregon dashboard for shared child and family measures
- Adoption of a regular reporting timeline for measures
- Development of a state-level strategic plan driven by measures
- Use of the measurement strategy to design and assess quality improvement activities

The Joint Subcommittee recommends a combination of process and outcome measures to support the developmental progress towards achieving kindergarten readiness (see example dashboard below).

### **Recommendations 3:**

**Adopt the Child and Family Well-being measurement strategy and identify a technical advisory committee to support implementation in 2014.**

*Example: Child and Family Well-being Dashboard*

Family Stability

- Adverse childhood experiences (ACEs)
- Housing and food security
- Child maltreatment
- Domestic Violence
- Poverty
- Employment

Education

- Quality Childcare
- School Readiness
- 3<sup>rd</sup> Grade Math
- Absenteeism
- High School Graduation
- College Graduation

Prevention

- Screening , follow-up
- Immunization
- Unintentional injury
- Pregnancy intendedness
- Physical activity

Health Care and Access

- Insurance status
- Patient experience of care
- Mental health
- Preventive visits (prenatal, well child, adolescents)
- Alcohol and drug treatment

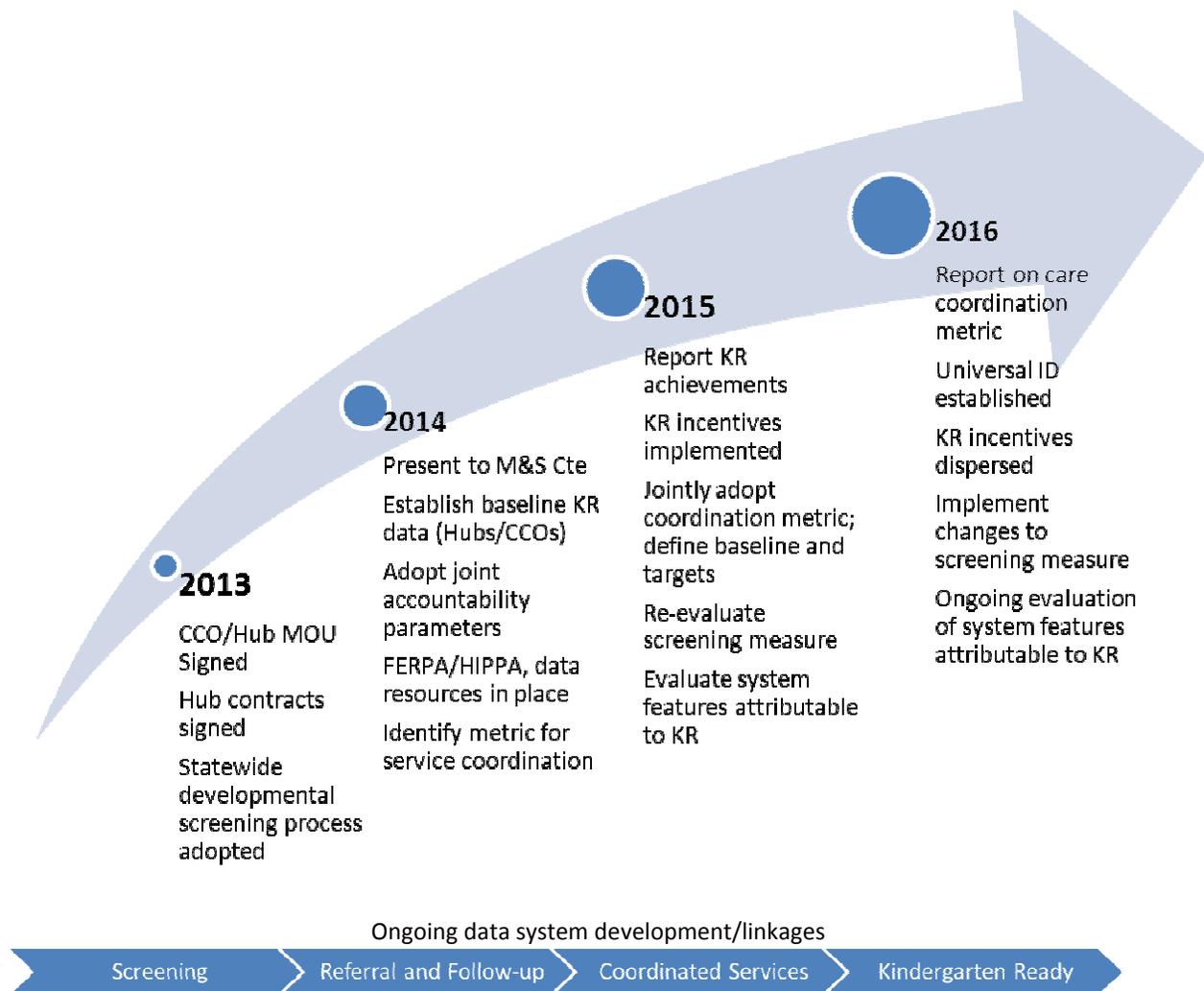
Systems of Care

- Care coordination
- Transitions of care
- Health home
- Data alignment

*Kindergarten Readiness*

The Joint Subcommittee was charged with developing a proposal and timeline for establishing kindergarten readiness as a shared outcome for health and early learning systems. In developing this proposal, the Joint Committee has considered a variety of environmental and policy factors that impact this recommendation, including: statutory role of OHA’s Metrics and Scoring Committee; capacity for information exchange, data linkage and reporting; privacy and security policies (e.g. FERPA/HIPAA); need for shared accountability and incentives; relationship of screening, coordinated services and kindergarten readiness; and differing stages of system transformation. The Joint Subcommittee recommends adoption of a four year timeline for establishing kindergarten readiness as a joint outcome, including the following implementation activities:

**Figure 1. Kindergarten Readiness as a Shared Outcome: 4 Year Proposal**



**Recommendations:**

4. Adopt kindergarten readiness as an urgent, shared outcome, including a maximum four year timeline for implementation of associated activities. The timeline shall be shortened where possible.
5. Establish shared incentives for achieving kindergarten readiness. The Joint Subcommittee shall identify an approach to shared incentives that recognizes the imbalance in financial resources across health and early learning.

**Mutually Reinforcing Activities**

It is expected that health, early learning and human service systems will each contribute unique activities and efforts towards the goal of kindergarten readiness. For optimal results, these activities must be mutually reinforcing and coordinated.

*Shared Learning*

Learning collaboratives represent a critical element for shared learning and spreading best practices. They can be employed in a collective impact approach to enhance mutually reinforcing activities towards a shared outcome. As previously agreed, the OHA and Early Learning Division will convene local leaders in health, education and human services to explore and spread opportunities for cross-system care coordination and case management for at-risk children. With initial seed funding through OHA's State Innovation Model (SIM) grant, additional opportunities to leverage these funds should be sought.

**Recommendation 6:**

**Identify resources to build capacity for cross-system learning collaboratives dedicated to care coordination, including but not limited to: funding for shared learning, Health Information Exchange and Technology (HIE/HIT), and neutral skill sets (e.g. process engineers) to move this work forward.**

*Developmental Screening*

Developmental screening, core to both health and education, is a discrete example of a mutually reinforcing activity. Developmental screening using a validated and standardized screening tool can improve the identification of children at risk for a developmental delay or disorder. Developmental screening in the first three years of life represents one of Oregon's 17 incentive measures as adopted by the Metrics & Scoring Committee. Quality pool dollars will be distributed, in part, based on a CCO's ability to improve or meet a benchmark for this measure. Likewise, screening to identify children at risk for not being kindergarten ready at school entry is a statutory requirement of the early learning system. Funding from Oregon's Race to the Top grant is being used to build resources and professional training for early learning providers related to developmental screening. Ultimately, Early Learning Hubs will be required to work with CCOs to improve the local rate of developmental screening for young children.

To ensure that screening activities are mutually reinforcing and coordinated, a statewide system of screening is recommended (see Appendix A). The necessary system components include:

1. Accountability for screening should be held jointly across health and education.
2. Shared incentives should be established.
3. Training requirements should be set for participating providers.
4. Incentives for meeting training requirements should be established (e.g. participation in QRIS, future data exchange, and reimbursement or incentive decisions).
5. Opportunities for secure information exchange should be identified and implemented.
6. Shared messaging must be delivered regarding the importance of developmental screening.
7. Health, human services and early learning providers should identify best approaches to providing care coordination/case management for identified at-risk children and their families.
8. Strategies must be identified to address the unique screening considerations for specific child populations, such as children with existing intellectual or developmental disability and those served by Child Welfare

**Recommendation 7:**

**Adopt and implement a statewide system of developmental screening including the core components listed above.**

### **Backbone Support Organization**

The identification of a backbone support organization or entity to create and manage collective impact efforts has been hailed as one of the most critical elements for success. Essential functions of the backbone organization include: providing strategic direction, facilitating dialogue between partners, managing data collection and analysis, handling communication, coordinating community outreach, and mobilizing funding (Kania & Kramer, 2011). We recommend the following backbone support structures for our collective impact strategy towards statewide kindergarten readiness:

#### *The Joint Subcommittee*

We recommend that the ELC and OHPB carry forward the Joint Subcommittee charter to provide ongoing strategic direction and governance. With education and health system transformation efforts still in their infancy, it is too early to abandon alignment efforts until they are fundamentally incorporated into daily operations. The agenda for the Joint Committee's next phase of work should include: 1) implementing the shared measurement strategy, *Oregon's Child and Family Well-being*, 2) implementing policies and spread of best practices for cross-systems care coordination, 3) executing next steps for secure information exchange across health and early learning, and 4) identifying and implementing shared incentives. Representation from the Department of Human Services remains critical to this group's work. **CCO and Hub representatives will be added to the Joint Subcommittee by 2014. Tribal representation will be included on the Advisory Committee.**

#### *The Transformation Center*

The newly developed Transformation Center within the Oregon Health Authority and associated State Innovation Model (SIM) grant funding should be leveraged to serve as a backbone structure for transformation efforts across health and early learning. The Transformation Center will support the adoption of the coordinated care model throughout the health care system through technical assistance and learning collaboratives among CCOs. Similar strategies can be implemented to foster shared learning across CCOs and Hubs and to disseminate local best practices targeted at achieving kindergarten readiness. Economies of scale can be achieved through shared resources such as staffing and communication technology. The Transformation Center can provide the vehicle through which early learning and health staff can work together to support community-level transformation efforts and the spread of best practices across local health and early learning systems.

#### **Recommendations:**

- 8. Renew the Joint Subcommittee Charter with **additional representation** and deliverables focused on a shared measurement strategy, care coordination, information exchange and shared incentives.**
- 9. Designate the Transformation Center as the backbone structure for fostering shared learning and alignment between health and early learning at the local level.**

### **Continuous Communication**

Organizational capacity and structure that promotes coordinated activities and continuous communication have begun to take shape at the state level. Oregon Health Authority representation has been included on the Early Learning Council and the Early Learning Division Cabinet. Likewise, a team of early learning focused staff are co-locating within OHA's Transformation Center to ensure alignment between health and early learning transformation efforts. This state-level coordination should be emphasized and can serve as an example of possible coordination at the local level.

Investments in communication technology are currently being explored to support CCO learning collaboratives and technical assistance within Oregon's Transformation Center. These technology

investments should be mirrored for early learning Hubs and can be used to support learning collaboratives between health and early learning at the local level.

**Recommendation 10:**

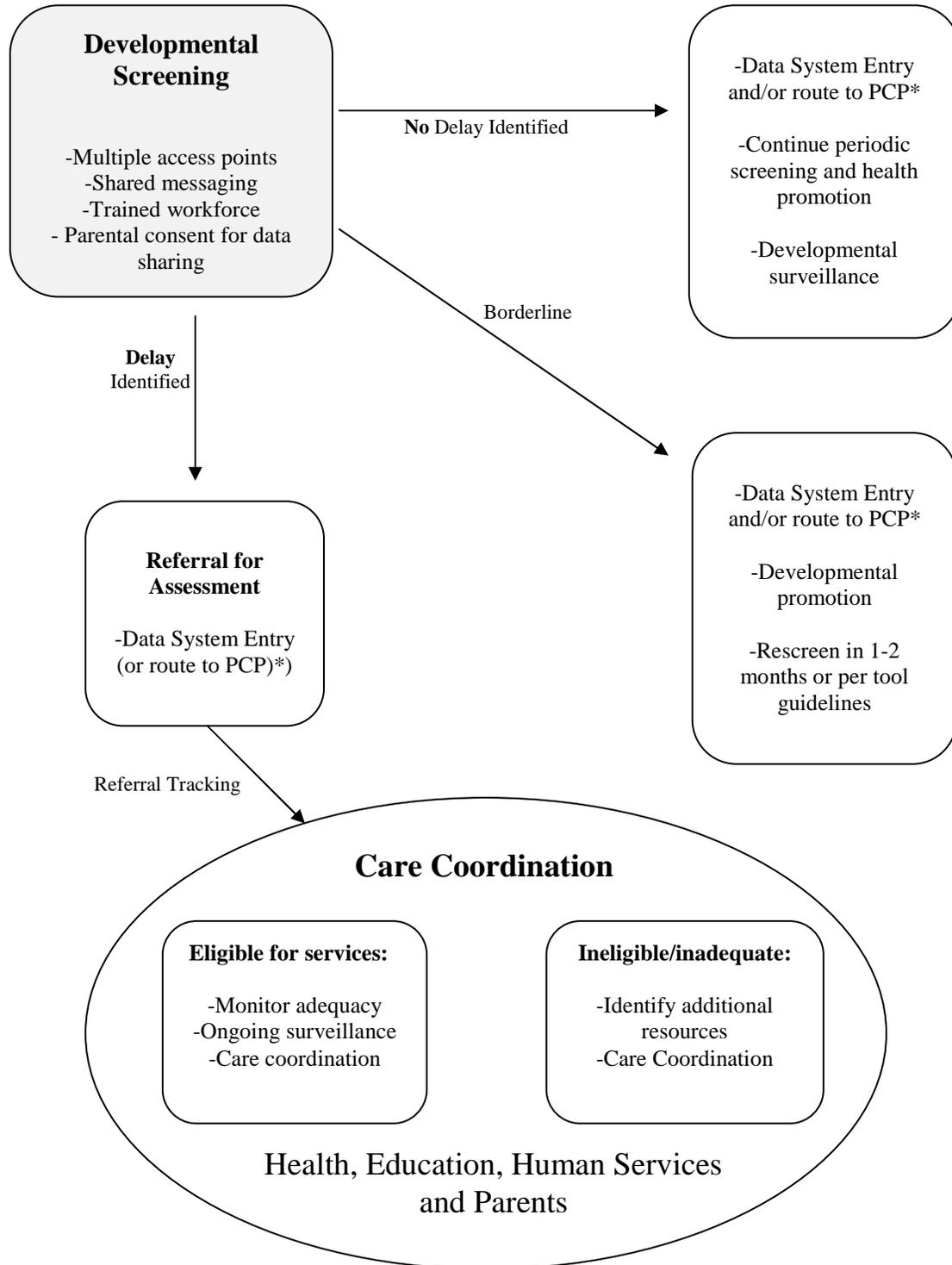
**Implement shared communication technology and strategies that facilitate local, cross-system learning between health and education.**

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**Appendix A: Statewide System of Screening**

*Example framework:*



*\*Requires appropriate release of information from parent or guardian*

## 2014 Draft Charter: Early Learning Council/Oregon Health Policy Board Joint Subcommittee

### Date Approved:

#### **AUTHORITY**

HB 2009 established the Oregon Health Policy Board (OHPB), a nine-member board appointed by the Governor and confirmed by the Senate. The Board serves as the policy-making and oversight body for the Oregon Health Authority (OHA) and is responsible for implementing the health policy reform provisions of HB 2009. Since the Board's establishment, the passage of HB 3650 (2011) and HB 1580 (2012) have provided the framework for transitioning to an integrated and coordinated health care delivery system through Coordinated Care Organizations (CCOs).

SB 909 (2011) established the Oregon Education Investment Board (OEIB) and the Early Learning Council (ELC), a nine-member Governor-appointed committee. The Council is responsible for assisting the OEIB in overseeing a unified system of early learning services for the purpose of ensuring that children enter school ready to learn by kindergarten. HB 4165 (2012) expanded the Early Learning Council to serve as the state advisory council for the purpose of the federal Head Start Act. To fulfill this role, the Council was expanded to nineteen members. HB (2013) directs the Early Learning Council to establish up to 16 Early Learning Hubs over the biennium to serve as early learning and family resource coordinating entities.

#### **Subcommittee membership & Governance**

##### **Executive Sponsors:**

Jada Rupley, Early Learning Director  
Tina Edlund, Chief of Policy, Oregon Health Authority (OHA)

##### **Staff:**

Dana Hargunani

##### **Subcommittee Members:**

Pam Curtis, ELC  
Teri Thalsofer, ELC  
Janet Dougherty-Smith, ELC  
Mike Bonetto, OHPB  
Carla McKelvey, OHPB  
Erinn Kelley-Siel, DHS  
CCO representative  
Hub representative

#### **Scope**

The subcommittee is responsible for overseeing implementation of the Joint Subcommittee Strawperson Proposal recommendations (adopted, September 2013) that describe next steps for alignment of health and early learning system transformation. The scope of this phase of work

Revision Date:

includes: 1) implementing the shared measurement strategy, 2) implementing shared learning and spread of best practices related to care coordination, 3) executing next steps for secure information exchange across health and early learning, and 4) identifying mechanisms for shared incentives. The subcommittee will convene and oversee a technical advisory committee to support the development of the measurement strategy as outlined in the Strawperson proposal.

### **Major Deliverables**

- A detailed, shared measurement plan
- Strategies for secure information exchange across health and early learning
- Proposal for shared incentives
- Summary of best practices and implementation status for cross-systems care coordination

### **Exclusions or Boundaries**

Policy implementation will not be carried out by this subcommittee. Recommendations will be brought forth to the Oregon Health Policy Board and Early Learning Council for decision-making. Prior legislative responsibilities and/or requirements placed on the Oregon Health Policy Board or Early Learning Council are excluded from this charter.

### **Dependencies**

- Oregon Health Policy Board: health policy
- Oregon Education Investment Board: P-20 education policy
- Early Learning Council: early learning policy
- Metrics and Scoring Committee: CCO metrics
- Federal privacy policies: FERPA, HIPAA

### **Schedule**

The joint subcommittee will meet quarterly. The frequency of meetings may be altered to fit legislative timelines and/or other needs that arise. The technical advisory will meet monthly but may be altered to fit needs as that arise. The subcommittee charter will end by December 2014 or when the ELC and OHPB accept their charter as completed.

#### Deliverable Timeline:

- 12/2013- Technical advisory committee convened
- 5/2014- Update on deliverables presented
- 9/2014- Proposal/plan presented
- 12/2013- Final proposal delivered

Revision Date:

## Draft Charter: Joint ELC/OHPB Technical Advisory Committee

### Date Approved:

#### **AUTHORITY**

HB 2009 established the Oregon Health Policy Board (OHPB), a nine-member board appointed by the Governor and confirmed by the Senate. The Board serves as the policy-making and oversight body for the Oregon Health Authority (OHA) and is responsible for implementing the health policy reform provisions of HB 2009. Since the Board's establishment, the passage of HB 3650 (2011) and HB 1580 (2012) have provided the framework for transitioning to an integrated and coordinated health care delivery system through Coordinated Care Organizations (CCOs).

SB 909 (2011) established the Oregon Education Investment Board (OEIB) and the Early Learning Council (ELC), a nine-member Governor-appointed committee. The Council is responsible for assisting the OEIB in overseeing a unified system of early learning services for the purpose of ensuring that children enter school ready to learn by kindergarten. HB 4165 (2012) expanded the Early Learning Council to serve as the state advisory council for the purpose of the federal Head Start Act. To fulfill this role, the Council was expanded to nineteen members. HB (2013) directs the Early Learning Council to establish up to 16 Early Learning Hubs over the biennium to serve as early learning and family resource coordinating entities.

In December, 2012, the Oregon Health Policy Board and Early Learning Council convened a Joint ELC/OHPB Subcommittee ("Joint Subcommittee") to ensure alignment and/or integration between health care and early learning system transformation, including representation from the Department of Human Services. The Joint Subcommittee's proposal, *Towards Collective Impact*, was adopted by the Oregon Health Policy Board and Early Learning Council in September, 2013. The proposal includes the establishment of a technical advisory committee to support implementation of a shared measurement system and associated incentives.

#### **Subcommittee membership & Governance**

##### **Executive Sponsors:**

Jada Rupley, Early Learning Director  
Tina Edlund, Chief of Policy, Oregon Health Authority (OHA)

##### **Staff:**

Dana Hargunani

##### **Technical Advisory Committee Representation:**

Joint ELC/OHPB Subcommittee representative  
Metrics & Scoring Committee representative  
CCO representative  
Hub representative  
Governmental and tribal public health representative(s)  
OHA Health Analytics representative  
Education (K-12) representative(s)  
Department of Human Services representative  
Child/Family measurement expert(s)

Revision Date:

## Scope

The subcommittee is responsible for advising the Joint Subcommittee on implementation of the shared, Child and Family Measurement Strategy (Joint ELC/OHPB Proposal *Towards Collective Impact*, adopted September 2013). The scope of work includes 1) detailed recommendations, including specific measures/indicators, for the shared measurement strategy, 2) identification of mechanisms for shared incentives. The technical advisory committee will share progress and deliver final recommendations to the Joint Subcommittee by August, 2014.

## Major Deliverables

- Recommendations for a detailed shared measurement plan
- Recommendations for shared incentives

## Exclusions or Boundaries

Policy implementation will not be carried out by this subcommittee. Recommendations will be brought forth to the Joint Subcommittee. Prior legislative responsibilities and/or requirements placed on the Oregon Health Policy Board or Early Learning Council are excluded from this charter.

## Dependencies

- Oregon Health Policy Board: health policy
- Oregon Education Investment Board: P-20 education policy
- Early Learning Council: early learning policy
- Metrics and Scoring Committee: CCO metrics
- Federal privacy policies: FERPA, HIPAA

## Schedule

The joint subcommittee will meet quarterly. The frequency of meetings may be altered to fit legislative timelines and/or other needs that arise. The technical advisory will meet monthly but may be altered to fit needs as that arise. The subcommittee charter will end by December 2014 or when the ELC and OHPB accept their charter as completed.

### Deliverable Timeline:

- 12/2013- Technical advisory committee convened
- 4/2014- Update to Joint Subcommittee
- 7/2014- Update to Joint Subcommittee
- 8/2104- Final recommendations to Joint Subcommittee
- 12/2014- Final proposal delivered

Revision Date:

equity transparency community leadership accountability information data outcomes embrace diversity social justice commitment

Office of Equity and Inclusion 2011–2016

# STRATEGIC PLAN



Oregon  
**Health**  
Authority  
Office of Equity and Inclusion

 Office of  
Equity & Inclusion

## About OMHS

Since 1993, the Office of Multicultural Health and Services (OMHS) has conducted a variety of activities focused on addressing health disparities in Oregon. Initially, OMHS was located in the Oregon Public Health Division. In 2009, the Office of Multicultural Health and Services moved to the Director's Office in the Department of Human Services. At that time, the OMHS expanded its mission to encompass an agency-wide scope of health and human services.

Throughout its history, OMHS has provided consultation to programs within the Department of Human Services and the Oregon Health Authority, local health departments, higher education programs, faith- and community-based organizations, universities, ethnic media outlets, Area Health Education Centers (AHECs), health and community advocacy organizations, and others working to improve the health of all Oregonians.

The strategies OMHS has used to promote increasing awareness, skill and knowledge about how cultural and linguistic diversity affects the delivery of health and human services include:

- Policy development,
- Training and consultation, and
- Community and organizational capacity building.

In 2011, with the creation of the Oregon Health Authority, OMHS transitioned to the new agency, and a "sister office" was created in the Department of Human Services. Because the scope of the office expanded to encompass equity in all aspects of the Oregon Health Authority, and with Oregon's focus on Health Systems Transformation to achieve OHA's Triple Aim (improved health outcomes, increased access to health care, and decreased or controlled health care costs), a new strategic plan for OMHS became necessary.

This strategic plan clarifies OMHS' role relative to internal organizational development and partnership with health systems and health promoting entities to assure OHA's continued commitment to pursuing health equity.

Part of our plan includes changing our office name to be more reflective of our new vision and goals. Our new name is the **Office of Equity and Inclusion**.

We are excited about this new chapter in our history and are committed to intensifying our efforts to assure a healthy Oregon for all. We invite you to join us in achieving our goals and strategic imperatives. Indeed, we cannot do it without you.



Office of  
**Equity & Inclusion**



## Strategic Imperatives

By 2016, the Office of Equity and Inclusion will connect people, policy and programs to make substantial and measurable progress toward the achievement of our vision and mission. We will prioritize the following strategic imperatives:

### Organizational direction and capacity

Assure and sustain an organizational structure that relentlessly pursues health equity and organizational diversity within OHA and in Oregon's health promoting systems.

- Identify OHA-wide priority health equity outcomes.
- Develop and support a health equity framework, lens, training and consultation processes for improvement of policies, programs and practices.
- Develop and assure funding capacity for community-based efforts to support diversity development, cultural competence, and health equity.
- Foster a culture of outcome measurement for identifying health and health care disparities and tracking progress. Support collection and analysis of data, research, and return on investment.
- Build communications capacity to inform key stakeholders and the general public of strategies to promote equity and diversity.
- Assure OEI longevity through statutory authority and funding sustainability.

### Community engagement

Foster dynamic, strength-based, and authentic relationships among Oregon's diverse communities, the OHA, and Oregon's health promoting systems.

- Identify and engage critical strategic and statewide constituencies to assist with policy and organizational development priorities.
  - Include community in "co-creation" of policy, data, research, cost/benefit analysis.
- Facilitate investment in the capacity of Oregon's diverse communities to promote regional and community solutions to avoidable health gaps.
- Increase health equity and diversity development leadership among community leaders/influencers.
- Connect OHA to diverse community members to improve policy and to develop staff diversity and cultural competence.

## Diversity development and cultural competence

Integrate and use diversity development best practices in recruitment, hiring, retention, performance management, contracting and procurement, and leadership and employee development within OHA and in Oregon's health promoting systems.

- Promote an organizational climate that assures inclusion and equity.
- Achieve and exceed parity for people of color and people with disabilities in all job classes of OHA.
- Consult with OHA leadership to promote equitable, hiring and contracting policies and practices, and culturally competent service delivery.
- Identify and share best practices to advance culturally competent health care and public health systems.
- Utilize the Intercultural Development Inventory (IDI) and ongoing training and development for OHA leadership and staff.
- Disseminate data, research, cost/benefit analysis of the impact of diversity development and cultural competence on organizational performance.

## Health equity practice, program, and policy development and implementation

Leverage community wisdom, timely data, and research to develop and effectively communicate the rationale for investing in health equity and eliminating avoidable gaps in health outcomes.

- Develop larger internal and external leadership constituency to advocate for programs and policy that promote health equity.
- Support statewide community coalitions, regional coalitions, and committees/councils to mobilize and advocate for health equity.
- Facilitate collaborative efforts to address social determinants of health.
- Develop relationships with local and national researchers to identify and disseminate promising and best practice models for achieving health equity.
- Identify and communicate the essential connection between people, policy, and programs in order to promote equitable health outcomes.
- Disseminate data, research, cost/benefit analysis on the impact of health equity policies and programs on the Triple Aim.

# Acknowledgements

OEI embarked on a planning process with the hope and expectation to move boldly and effectively into the future. The challenges OEI faces related to diversity development and health equity require strategic and global thinking, energetic curiosity, innovative leadership, candid and authentic dialogue, and a great deal of courage and hope.

We gratefully thank and acknowledge the many community stakeholders who generously shared their time, experience, knowledge and thinking in focus groups, individual interviews, and electronic surveys. Through their input and participation, they were instrumental in setting the strategic direction for OEI over the next five years.

We also thank and acknowledge our Community Advisory Council, Strategic Planning Steering Committee, Oregon Health Authority leaders, and OEI staff who were active partners in guiding the process, receiving and hearing the input, envisioning the future we want, and identifying the direction for OEI to move forward to achieve that vision.

We thank all of you who generously shared these gifts and co-created the OEI 2011-2016 Strategic Plan. The following is a list of groups and individuals who played a central role in the planning process:

## OEI Community Advisory Council

- **Heidi Allen**, Providence Center for Outcomes, Research and Evaluation
- **Dr. T. Allen Bethel**, Maranatha Church of God
- **Joe Finkbonner**, Northwest Portland Area Indian Health Board
- **Cynthia Gomez**, Latino Network
- **Mary Anne Harmer**, Regence Blue Cross Blue Shield
- **Kayse Jama**, Center for Intercultural Organizing
- **Holden Leung**, Asian Health and Service Center
- **Francisco Lopez**, CAUSA

- **David Rebanal**, Northwest Health Foundation
- **Carmen Rubio**, Latino Network

## OEI Strategic Planning Subcommittee

- **Susan Arbor**, OHA Division of Medical Assistance Programs
- **Dr. T. Allen Bethel**, Maranatha Church of God
- **Bobby Green**, OHA Local Government Affairs
- **Mary Anne Harmer**, Regence Blue Cross Blue Shield
- **Len Ray**, OHA Addictions and Mental Health Division
- **David Rebanal**, Northwest Health Foundation
- **Alissa Robbins**, OHA Communications

## Community-at-Large

- **Tim Holbert**, OHA/Multnomah County Program Design and Evaluation Services
- **Dianne Riley**, Equity Consultant
- **368 community partners and stakeholders** who provided feedback through our survey and focus groups

## OHA Leadership

- **Bruce Goldberg, M.D.**, Director, Oregon Health Authority
- **Tina Edlund**, Chief of Policy, Oregon Health Authority
- **Richard Harris**, Administrator, Addictions and Mental Health Division
- **Joan Kapowich**, Administrator, PEBB/OEBB
- **Mel Kohn**, Administrator, Public Health Division
- **Judy Mohr-Peterson**, Administrator, Division of Medical Assistance Programs
- **Jeanny Phillips**, Deputy Director, Division of Medical Assistance Programs
- **Jeanene Smith**, Administrator, Office for Health Policy and Research
- **Tom Jovick**, Administrator, Office of Private Health Partnerships

## OEI Staff

- **Alexis Asihene**, Community Engagement Coordinator
- **Felicia Bautista-Nelson**, Migrant Health Intern

- **David Cardona**, Health Care Interpreter Program Coordinator
- **Carol Cheney**, Equity Manager
- **Collaine Faddis**, Grant Developer
- **Rachel Gilmer**, Health Equity Policy Intern
- **Leann Johnson**, EEO/AA and Diversity Development Manager
- **Sabrina Kosok**, Health Equity Policy Intern
- **Janie McGee**, Diversity Development Intern
- **Christine Meadows**, EEO/AA Investigator, Diversity Unit
- **Alberto Moreno**, Migrant Health Coordinator
- **Ruth Nkemontoh**, Communications Intern
- **Carlos Richard**, Diversity Development Coordinator
- **Fabrice Saboue**, Health Care Interpreter Intern
- **Tricia Tillman**, Administrator
- **Mei Yong**, Executive Assistant

## Strategic Planning Consultants

- **Cliff Jones**, Nonprofit Association of Oregon
- **Staci Martin**, Nonprofit Association of Oregon

Office of Equity and Inclusion 2011–2016

# STRATEGIC PLAN

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This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this form in another format or language, email [rachel.b.gilmer@state.or.us](mailto:rachel.b.gilmer@state.or.us), call 971-673-1240 (voice) or 971-673-0372 (TTY), or fax 971-673-1128.



# Education Investment Board:

## Equity Lens

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### OEIB Vision Statement

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

### OEIB Equity Lens: Preamble

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

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

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

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

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

**Beliefs:**

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

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

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

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

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

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

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

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

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

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

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

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

### **Oregon Educational Investment Board Case for Equity:**

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

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

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

<sup>3</sup> Oregon Statewide Report Card 2011-2012. [www.ode.state.or.us](http://www.ode.state.or.us)

## **ADDENDUMS**

### **Basic Features of the Equity Lens:**

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

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

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

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

## Definitions:

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

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

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

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

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

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

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

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

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

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

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

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

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<sup>4</sup> (The Opportunity Gap (2007). Edited by Carol DeShano da Silva, James Philip Huguley, Zenub Kakli, and Radhika Rao.

<sup>5</sup> Ladson-Billings, Gloria (1994). *The Dreamkeepers: Successful Teachers of African American Children*.