Organizational Assessment for Racial Equity

The Maternal and Child Health Section engaged in an organizational assessment for racial equity during the summer of 2016. With initial guidance from the Coalition of Communities of Color (www.coalitioncommunitiescolor.org), a team of 11 MCH staff members gathered for a total of 9 hours to complete "The Tool for Organizational Self-Assessment Related to Racial Equity"[1].

MCH Racial Equity Assessment Team included: Nurit Fischler, Benjamin Hazelton, Michelle Leon-Henry, Sarah Kowalski, Stefanie Krupp, Julie McFarlane, Maria Ness, Kalii Nettleton, Kerry Norton, Lari Peterson, and Vivian Siu. Wendy Morgan and Liz Stuart facilitated the assessment process.

This assessment is a snapshot in time and takes an honest look at where MCH is **right now** in terms of racial equity**.** Past initiatives and projects are not included here, unless they are consistent and ongoing. The MCH Racial Equity Assessment Team looked at the following domains:

1. Organizational Commitment, Leadership & Governance
2. Racial Equity Policies & Implementation Practices
3. Organizational Climate, Culture & Communications
4. Service-Based Equity
5. Workforce Composition & Quality
6. Community Collaboration
7. Resource Allocation & Contracting Practices
8. Data, Metrics & Continuous Quality Improvement

The report is broken down into these 8 areas, with each specific area color coded:

- **Red**: This is not happening within the MCH Section.
- **Yellow:** There is some evidence of this happening, although not institutionalized or consistent.
- **Green:** This is consistently happening in MCH.

Each statement has a short narrative describing where MCH lands in that area. Where applicable, "recent changes and shifts" are also included. These indicate things that MCH has been working on, but may not be reflected elsewhere in the Assessment.

Next Steps: The findings of this assessment will be presented to the MCH section so that all sections members can engage with the issues and help to design the next steps. This report will be used by the MCH Equity Workgroup to identify areas of racial equity work for 2017. All MCH staff members are encouraged to join the work group. The committee will prioritize domain areas, and create action plans for each area. It is not expected that all eight domains will be included in the first phase of action plans. However, it is expected that every staff member in the MCH Section will take part in the strategies that are identified to improve racial equity internally among our staff, in our work, and in our collaborations with external partners.

[1] Coalition of Communities of Color; All Hands Raised (2014). Tool For Organizational Assessment Related to Racial Equity. Retrieved from: http://www.coalitioncommunitiescolor.org/research-data-tools/cccorgassessment

1. Organizational Commitment, Leadership & Governance

1.1	**Maternal and Child Health has not made a public commitment to racial equity.**

The MCH Section has a Health Equity Workgroup that has been in place since February 2014. Although we have made some progress internally, we have not made a **public** commitment to racial equity.

Recent changes and shifts that have been made include:

- Commitment of MCH Section Management to make equity a priority.
- Culturally and Linguistically Appropriate Services (CLAS) is a state Title V priority area.
- Financial commitment to tribes through Title V grant funding.

1.2	**Maternal and Child Health has an internal equity committee responsible for addressing racial equity.**

The MCH Section has a Health Equity Workgroup that has been in place since February 2014. This group meets twice per month, and membership has varied from inception until now. At the time of this assessment, 6 people were on the committee. General demographics as determined by self-identification: 5 white, 1 person of color; 4 identify as LGBT; 5 women, 1 man; none identify as having a physical/mental disability.

Recent changes and shifts that have been made include:

- Since the assessment, the workgroup has grown to 11 members, including two additional women of color, one manager and two administrative staff.

1.3	**Maternal and Child Health does not consistently allocate resources for equity initiatives, make racial justice a standing agenda item, nor ensure that people of color are part of decision-making.**

The MCH Section has made recent efforts to allocate resources to equity initiatives, including undergoing an Organizational Assessment for Racial Equity and including equity projects under Title V grant priorities.

Recent changes and shifts that have been made include:

- Regarding decision-making, MCH has made efforts around hiring practices, including diversifying hiring panels to include people of color in all panels. We also diversified panels to include a wide variety of staff classifications.

2. Racial Equity Policies and Implementation Practices

2.1	**Maternal and Child Health does not have a written policy for racial equity.**

MCH does not have a written policy for racial equity, nor do we have a plan in place to create a policy.

Recent changes and shifts that have been made include:

- The Assessment for Racial Equity is one step towards creating the policy/planning for racial equity.

3. Organizational Climate, Culture & Communications

3.1	**Maternal and Child Health does not have a welcoming physical space that takes into account diverse staff and stakeholders.**

The MCH office is a very typical, westernized government office setting. Our office is set up primarily in cubicles, with gray walls without a lot of natural light. Although aisles and doorways are ADA compliant for mobility, our signage and general navigation is not clear. Our reception area is often unstaffed, so there is no immediate welcome to our office, and deliveries are often left in this area (sometimes for days). Staff feel limited in how they are allowed to decorate their cubes, and public art and displays are not always representative of diverse populations.

OHA/DAS policies that impact individual expression in the workplace are 50.010.01: Discrimination and Harassment Free Workplace and 50.010.03: Maintaining a Professional Workplace.

3.2	**Maternal and Child Health section meetings are improving in the areas of supporting equity and inclusion, and valuing diverse ways of speaking, thinking, debating, reflecting and making decisions.**

The MCH Section meeting structure has changed to encourage shared facilitation from various staff members. This structure has increased opportunities for small group discussions and feedback in writing. The MCH culture generally respects everyone's input and opinions, although it tends to often be the same people who always speak up.

Meetings are often conducted in a style typical of Western culture, with a facilitator and a timed agenda. At smaller program meetings (EHDI, for example), everyone is encouraged to contribute something to the meetings.

3.4	**Maternal and Child Health does not have a structure in place to support employees of color. There are no explicit supports for employees of color to move into positions with low diversity.**

Employee Resource Groups are currently OHA/PHD based. Within MCH, there is no formal mentoring process for new employees or employees of color. We currently have no clear pathways for people of color to move into low-diversity positions. *(Note: Most of our positions are low-diversity).*

3.5	**Maternal and Child Health does not market its equity initiatives.**

MCH currently does not have any marketing capacity for equity initiatives. We have created an Equity One Pager, but we have no set plans to market what we have come up with.

3.6	**Maternal and Child Health does not have a consistent internal culture of inclusion and equity. Maternal and Child Health does not have a process for noticing, naming and addressing racism within the agency.**

MCH has not established a culture of safety, sharing, and respect around racial issues. This has not been addressed as a section, and guidelines/agreements are not in place to support naming and addressing racism within MCH. The expectation to interrupt racism has not been clearly articulated within MCH, and no training or supports are in place to create safety around this.

4. Service-Based Equity

4.1	**Race and ethnicity data has informed Maternal and Child Health service delivery and decision-making regarding programs/initiatives.**

The MCH Section works within larger structures to identify priority communities based on data. For example, the Maternal Infant Early Childhood Home Visiting (MIECHV) Program communities were identified based on using data to identify underserved populations. Title V funding is the only source that specifically guarantees funding for communities of color (tribes who have chosen to receive the funding).

4.2	**Maternal and Child Health is actively working towards equitably serving populations of color and providing culturally appropriate services. However, our services are not regularly evaluated for quality and effectiveness.**

Culturally and Linguistically Appropriate Services (CLAS) standards are a priority for the new Title V block grant. There is funding specifically designated out for tribes who choose to participate in the Title V program. We have not explored why some tribes have not chosen to participate in Title V. We have supported local partners on culturally specific service initiatives, but this is not consistent and does not necessarily represent multiple communities of color.

4.3	**Maternal and Child Health is actively working to ensure adequate language access that aligns with community needs.**

MCH is actively focusing on appropriate literacy levels for external facing materials. We have evidence of training curricula available in Spanish and Russian. We do not consistently field test multilingual materials, and our staff is not consistently aware of or trained on using the language interpretation line.

Recent changes and shifts that have been made include:

- Presentation from Pubs/Design to explain the internal editing services available for plain language as well as translation services.

5. Workforce Composition & Quality

5.1	**MCH does not have formalized priorities related to cultural and linguistic competencies for staff and leadership.**

The MCH Section has priorities around cultural and linguistic competencies, but they are not articulated or formalized. Currently, there is only one cultural competency training class required for all Public Health Division staff.

5.2	**MCH does not have an internal structure responsible for workforce diversity.**

We do not have a dedicated position or structure for this purpose. This is influenced to some extent by Human Resources and larger organizational structures. Our internal equity workgroup has some influence here, but is not specifically responsible for this. In the last phase of hiring, we implemented some equity practices to improve equity in hiring. Currently, our internal equity workgroup is working on making these practices more standardized.

5.3	**Racial justice and cultural competency goals do not consistently inform MCH's investments in training and professional development.**

Racial justice and cultural competency goals are not consistently included in professional development plans. No key priorities have been articulated. Management has been supportive of investing in these opportunities when they have been brought to their attention. Section has been limited (from upper management) in terms of how many people it can send to diversity conferences and other development opportunities.

6. Community Collaboration

6.1	**Maternal and Child Health does not formally recognize key stakeholders from communities of color in organizational decision-making.**

The MCH section works with 4 tribal governments through Title V, but there are no other formal partnerships with communities of color. The tribes include: Cow Creek Band of Umpqua Tribe of Indians, Coquille Indian Tribe, Confederate Tribes of Warm Springs Reservation, and Klamath Tribes,

We do not formally partner with community based organizations.

6.2	**Maternal and Child Health does not consistently engage communities of color.**

The MCH section uses some popular education strategies to engage communities of color, but these are not consistent practices. We have a variety of tools and skills, but no consistent way of using them.

6.3	**Our processes and practices do not consistently include community members. Although some practices have worked to include voices from diverse communities, we have areas where we can improve.**

When MCH presents information to the public (usually on our website), it is available to anyone who seeks it out. However, the information is often exclusive related to complex language and data interpretation, as well as assuming access to the Internet.

Our surveys (i.e. needs assessments) try to be inclusive of communities of color, but they are often only available in English and sometimes Spanish. We typically reach out to local public health partners for input, which may not be inclusive of communities of color. A lot of our outreach is initiated when we need information from communities. We do not consistently engage with community stakeholders enough to demonstrate ongoing partnerships.

7. Resource Allocation & Contracting Practices

7.1	**Racial justice values do not influence MCH's investments or budget allocations.**

MCH does not require grantees or contractors to adhere to any equity practices that are not currently required by law. Our funding allocations are influenced by the funding sources, and are typically permissive rather than prescriptive (in regards to equity).

8. Data, Metrics & Continuous Quality Improvement

8.1	**Maternal and Child Health does not evaluate programs in terms of their impact on communities of color and racial equity goals.**

We do not have racial equity goals, so we are unable to evaluate them. We do surveillance, and look at benchmarks and performance measures by race/ethnicity. Surveillance data and PRAMS is used inconsistently across MCH to influence our programs and strategies. However, we believe this data is used more often by external agencies to identify program goals and interventions.