May 2017

# Developing Equity Leadership through Training and Action (DELTA)

## Evaluation Report of the DELTA Cohorts, 2014–2016

Oregon Health Authority

Office of Equity & Inclusion

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# What makes health care so complex?

*"The ... thing that I think is most complex and most interesting is the health equity issue. What we are capable of if we gave everyone in this country access to the care that the people with means and resources get, we'd have a great health care system. But health care is so complicated by other social determinants that prevent people from getting care. It's about education, housing, transportation. Many other issues. You can't solve the problems in health care without looking outside at how people live and addressing the issues.*

*– Andy Slavitt, former administrator of the Centers for Medicare & Medicaid Services, April 19, 2017 interview with TCJewfolk.com*

Trainer Emily Wang and 2014 cohort member Michael Anderson-Nathe

2015 DELTA graduation speaker State Representative Tina Kotek

2016 DELTA cohort graduates

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# Background

In February 2013, the Centers for Medicare & Medicaid Innovation (CMMI) awarded the Oregon Health Authority (OHA) a State Innovation Model (SIM) grant of $45 million over three years. The grant supported states taking innovative approaches to improving health and lowering costs across the health care system, including Medicaid, Medicare and the private sector. Oregon was one of six states to receive the grant to reduce costs, improve quality and expand coordinated care, all of which align with Oregon's triple aim of creating a health system that:

- Improves the lifelong health of all Oregonians
- Increases the quality, reliability and availability of care for all Oregonians and
- Lowers or contains cost of care so it is affordable for everyone.

This grant focused on targeted activities and initiatives within OHA to support extension of the health system transformation beyond Medicaid. The grant supported Oregon's ongoing health system transformation by strengthening, supporting and expanding the coordinated care model for Medicaid and other payers, and facilitating partnerships to reduce inequities that drive up costs.

OHA's Office of Equity and Inclusion (OEI) Division received a portion of the grant to facilitate the Developing Equity Leadership through Training and Action (DELTA) program. DELTA is a nine-month leadership learning collaborative designed to build and strengthen the capacity of Oregon's public health and health systems' leaders to promote health equity. The DELTA program was based on a pilot conducted prior to this grant in 2013 in which 18 participants engaged in a six-month statewide, comprehensive health equity and inclusion leadership training. The evaluation of the pilot program provided recommendations that informed the development of the current program.

# Description of DELTA

Cohorts of approximately 20–25 individuals included community leaders, policy makers, health care providers, and coordinated care organization (CCO) administrators and clinicians. Cohort members received:

- Nine full-day trainings over the course of several months that combined lectures, large and small group discussions and exercises focused on developing and institutionalizing health equity policies and practices within organizational structures
- Individual consulting to advance health equity within their organizations as well as at the policy and legislative level and
- Assistance identifying concrete actions to advance health equity.

Participant organizations across the state often hosted the sessions onsite. Travel to various parts of the state enabled statewide representation within each cohort and, thus, contributed to the program's success.

The curriculum varied only slightly from year to year and included the following topics:

- Using a health equity lens in policy, program, budget and planning
- Diversity and inclusion return on investment
- Community engagement
- Collecting and analyzing data for equity and inclusion
- Developing health equity and inclusion metrics
- Diversifying the health care workforce
- Best practices for language access
- Exploring implicit bias, power and privilege
- Community-specific cultural considerations in service delivery
- Implementing equity as a health leader

**The objectives of the DELTA program are to:**

- **Build the capacity and commitment of Oregon's health leaders to decrease inequities and eliminate health disparities**
- **Develop collaborative approaches and partnerships to promote health equity across Oregon's health systems**
- **Inspire leaders to act individually and collectively as proactive change agents to address significant challenges and barriers to achieving optimal health.**

DELTA participants and their organizations could expect the following outcomes:

- Establishment of strong linkages and partnerships among local community leaders, health systems, policy leaders, community resources and community organizations
- Creation of additional resources and a support system in developing health equity, diversity and inclusion strategies, policies and legislation
- Improved data collection and coordinated policies resulting in reduced cost for health care services
- Increased knowledge of resources about equity and inclusion best practices
- Increased ability of policy and systems leaders to communicate and promote organizational health equity policy, diversity and inclusion concepts
- Integration and institutionalization of health equity and inclusive workforce strategies into planning, policies, programs and practices.

# Evaluation

The Office of Equity and Inclusion Division is responsible for implementing the DELTA program. OEI contracted with Program Design and Evaluation Services (PDES) to conduct the evaluation. PDES is a research and evaluation unit within both the Multnomah County Health Department and Oregon Health Authority. OEI completed four DELTA programs over the course of the SIM grant period. PDES evaluated all four. This report will refer to each by their cohort years: 2014, 2015, 2016 and the small pilot in Central/Eastern Oregon referred to as the mini-cohort.

The evaluation had four goals:

1) To assess the skills and knowledge participants gained from the program in understanding systems change solutions for all people experiencing health inequities in Oregon.

2) To evaluate participants' progress on their DELTA projects and the level of implementation of health equity concepts within their organization.

3) To determine the overall impact of the program on participating organizations.

4) To identify ways to improve quality of the program.

## Methods

The evaluation used a mixed-methods approach to address process, formative, impact and outcome evaluation measures. This report combines findings from several data sources using three different data collection methods:

- Online pre-program organizational assessment survey
- Individual pen and paper session evaluation surveys
- Online post-program outcome survey
- Qualitative key informant phone interviews with a sample of participants from each cohort
- Focus group with participants of Eastern/Central Oregon pilot mini-cohort and
- Process data, including attendance records and applications, provided by the program.

PDES collected data at multiple time points throughout the program, including:

- Online pre-program organizational assessment survey: Prior to the program, all participants completed this survey, sent via Survey Gizmo. It included questions covering organizational and participant characteristics over a variety of domains, such as organization type; community engagement; ability to collect, analyze and use race and ethnicity data; language access; existence of strategic plans for health equity, diversity and workforce development; and funding for diversity and inclusion activities.
- Session evaluation surveys: During the program, cohort members were encouraged to complete session evaluations after each meeting. Participants evaluated each session on the training delivery and effectiveness as well as the value of the information to their job. Participants also rated themselves on their level of engagement, understanding of content and skills development.
- Online post-program outcome survey: Upon completion of the program, participants received an electronic follow-up survey through Survey Gizmo. Questions covered level of implementation or activity for incorporating health equity concepts, CLAS standards, attitudes and behaviors related to health equity, value of the cohort, and resource and technical assistance requests.
- Qualitative key informant phone interviews: Small samples of each cohort participated in in-depth semi-structured interviews six months after program completion. PDES assessed participant satisfaction, progress in implementing health equity concepts within their organization, connection between program and personal experience, sustainability and general feedback.
- Focus group: The Eastern/Central Oregon cohort (mini-cohort) differed from the other statewide cohort trainings in size (10 participants), schedule (condensed to four months), and region/location (focus on rural issues in east/central Oregon). Rather than sampling and interviewing participants six months after the training, PDES conducted a focus group at the last session. The focus group provided immediate feedback to the program for planning purposes.
- Process data: The DELTA program coordinator provided additional process data as needed.

This report highlights the key results from all of the above data collection tools and methods.

# Limitations

These results are based on multiple sources of data that provide an overall picture of the DELTA program. However, there are some limitations to the data.

- First, for self-administered surveys with less than 100% response rates, the data may not reflect the non-respondents' view, opinions or experiences.
- Second, the quantitative data are presented as averages or percentages; therefore, the individual responses may vary in range.
- Third, the responses for each of the surveys represent a specific point in time of that particular survey.
- Finally, qualitative interviews were conducted with a sample selected by OEI. While there was an attempt to reach a variety of respondents, their responses may not represent all DELTA participants.

# DELTA demographics

## Who participated?

DELTA participants applied to be part of the program beginning in 2014. OEI scored their applications based on a potential participant's:

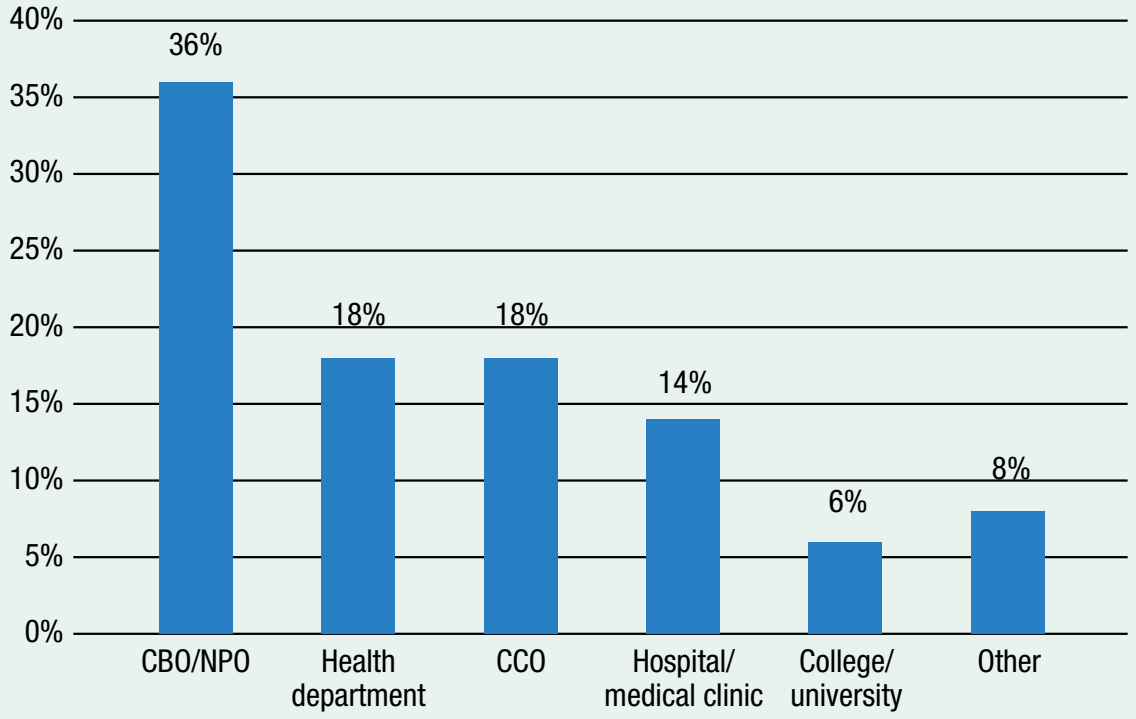
- Interest in the program
- Ability to share the information gleaned from DELTA
- Capacity to influence change within their organization
- An informal organizational needs assessment
- Cohort member diversity (with an effort to create a racially diverse, multi-regional and multi-sectoral group) and
- Merits of a project the applicant was either currently working on or proposed to work on during the DELTA program.

The DELTA Advisory Group — composed of stakeholders, OEI staff, health equity leaders, trainers and past participants — scored the applications and attempted to choose a diverse cohort with the capacity to effect change. Cohorts were limited in size from 20–25 members (the mini-cohort had 10) to allow for the deep, personal discussions that contributed to the experience.

A total of 83 people completed the DELTA program in the four different cohorts (23 in 2014, 25 in 2015, 25 in 2016 and 10 in the mini-cohort). One or two participants from each of the 2014, 2015 and 2016 cohorts did not complete the program. For the most part, the reasons for discontinuing were a change in employment that no longer applied to the training, personal/family reasons or moving from Oregon.

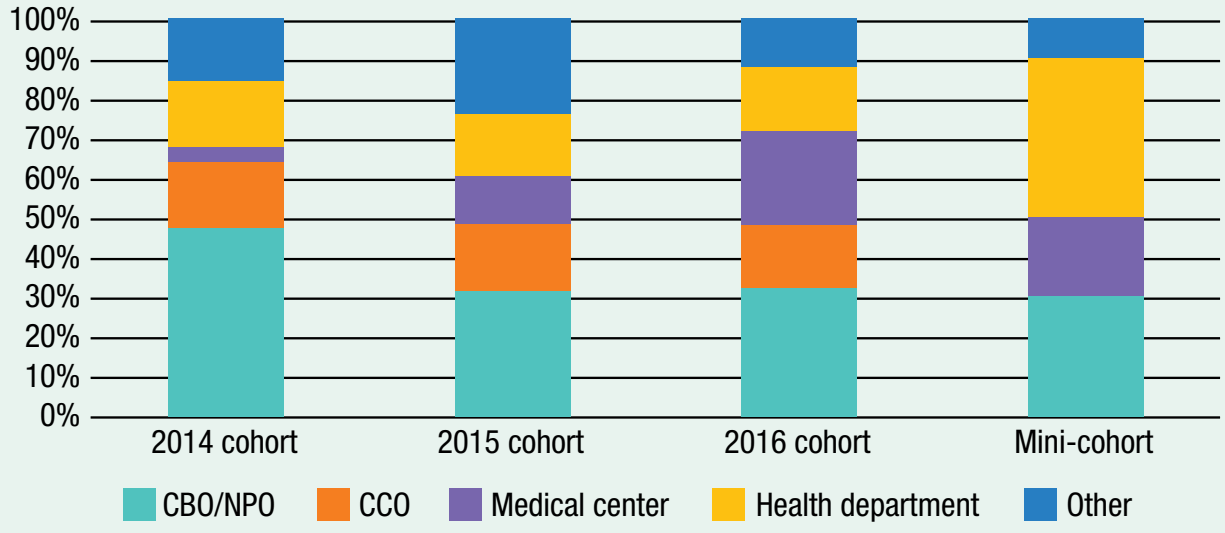
The majority of the participants represented community-based organizations (CBOs) or nonprofit organizations (NPOs) (36%), followed by health departments (state or local) (18%); coordinated care organizations (18%), which were specifically recruited for the purpose of this health systems transformation grant; hospitals, medical centers or clinics (14%); or colleges or universities (6%). The "other" category (8%) represents tribal organizations, local government (not health), private industry or business and undefined.

## What type of organization do you work for? Total (combined cohorts)

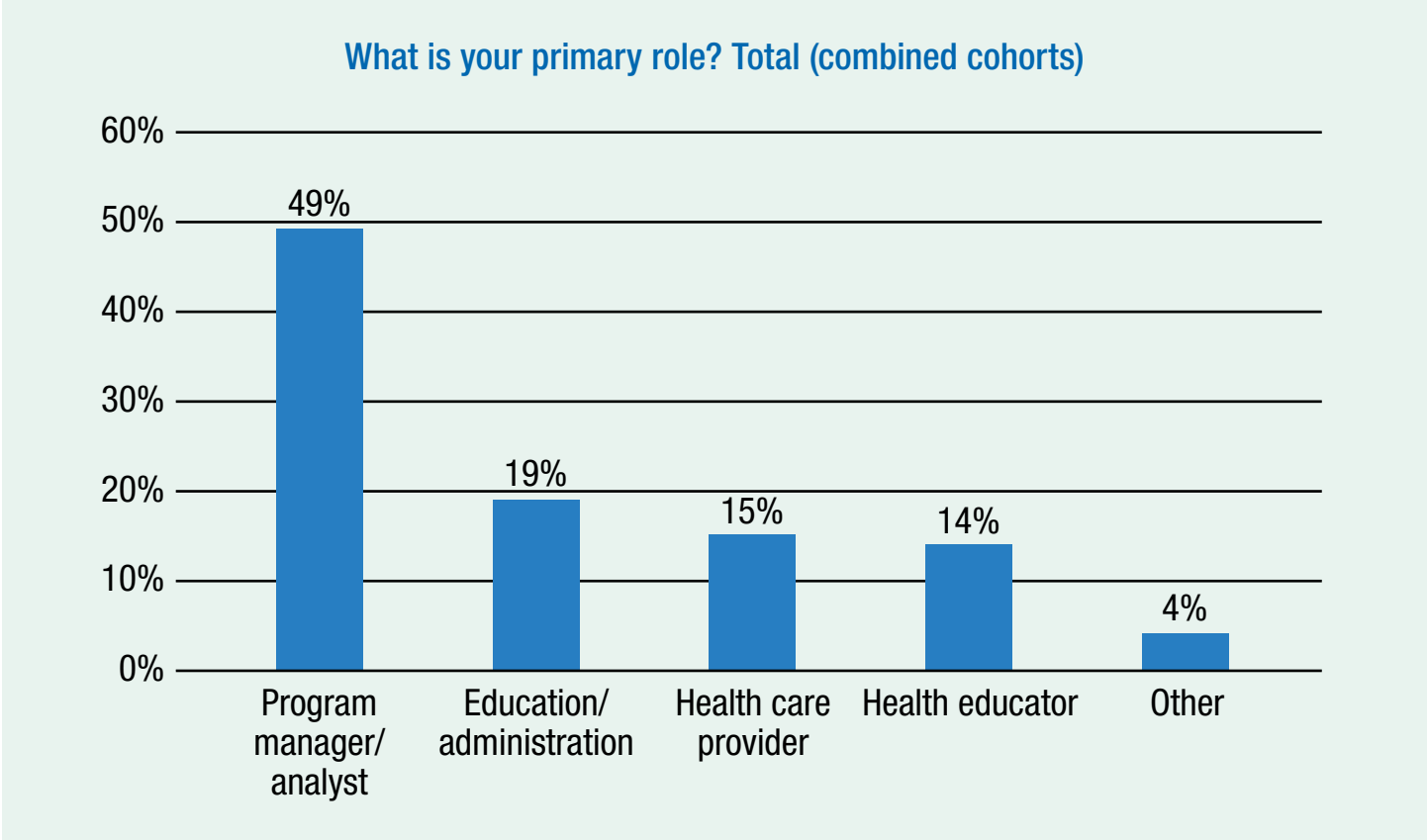



The chart below (by cohort) represents the type of organization participants worked for, separated by cohort. In this chart, the "other" category represents participants in the following types of organizations: (n=5), local government (not health) (n=4), private business (n=1), tribal organization (n=1).

## What type of organization do you work for? (by cohort)



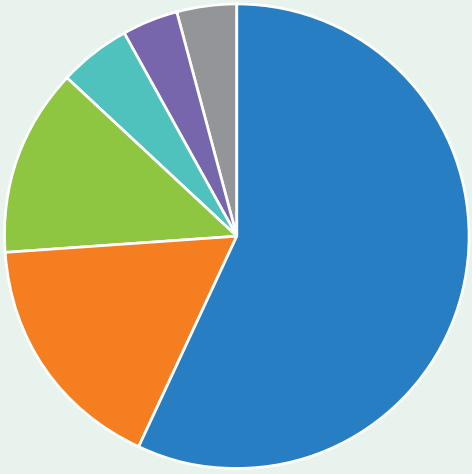
Almost half (49%) of the participants were program managers or analysts, followed by executive directors or administrators (19%), health care providers (15%), or health educator/trainers (14%). Once DELTA offered continuing medical education (CME) hours, starting in the 2015 cohort, the level of provider participation increased. Almost three-quarters (72%) of the participants had been in their current position for three years or less.



More than half the participants (57%) identified as Caucasian, 17% as Hispanic or Latino, 13% as Black or African American, 5% as Asian, 4% as Native American and the remaining 4% were unknown or did not identify. Comparatively, the 2015 census data for race and ethnicity **overall in the state of Oregon** shows 77% Caucasian, 4% Asian, 2% Black/African American, 2% Native American and 13% Hispanic/Latino. This demonstrates the DELTA program successfully recruited diverse cohorts.

### What is your primary race or ethnic identity?

- More than half the participants (57%) identified as Caucasian
- 17% identified as Hispanic or Latino
- 13% identified as Black or African American,
- 5% as Asian
- 4% as Native American and
- The remaining 4% were unknown or did not identify.



All seven regions of Oregon were represented among the four cohorts with the greatest (48%) being from the Portland Metropolitan area. Several participants working on statewide issues (i.e., state government, statewide nonprofits) work in Portland, thus pushing the Portland Metro percentage even higher.

| Region | |
|---|---|
| Portland Metropolitan | 48% |
| Central Oregon | 8% |
| Mt. Hood and Columbia River Gorge | 7% |
| Southern Oregon | 11% |
| Willamette Valley | 17% |
| Coastal | 2% |
| Eastern Oregon | 5% |

# Pre-program organizational assessment

PDES used the pre-program organizational assessment to determine organizational and participant characteristics of the cohort members over a variety of domains. Participants received the assessment through Survey Gizmo one month before they began DELTA. This information described the cohort and helped tailor the curriculum. The questions on the 2014 cohort pre-program assessment are not comparable to the survey used for the 2015, 2016 and mini-cohort, so data presented are from the latter three surveys (N=59). The 2014 pre-session organizational assessment only asked about the general policies, programs or plans and did not follow up with the specific elements within each topic. For example, it asked if participants had a plan for community partner engagement, but did not follow up with the eight specific elements listed below in Table 1.

## Policies, plans and programs

Respondents noted where their organization was on the spectrum of addressing several key equity and inclusion elements by indicating whether they had a plan, were developing one or had intentions to do so. Importantly, the questions did not ask if respondents' organizations were implementing a plan, only whether a plan existed.

The following tables list the responses. PDES removed the "unsure" responses from the denominator, which means the total number of responses differs for each element. In addition, there was no "not applicable" response category, which may mean that the "not intending to do this" responses included those organizations for which the policy, plan or program did not apply.

## Community partner engagement

At the time of the pre-program assessment, at least half of the respondents indicated their organizations had most of the main components of community engagement with three exceptions:

- 21% had a plan for analyzing survey results by race, ethnicity and language data categories and 23% were not intending to do so.
- 19% had a plan for a board or governing body that represented the communities they served and 57% were not intending to do so.
- 47% had a plan for an advisory group representative of the communities they served and 29% were not intending to do so.

## Table 1: Pre-program assessment of community partner engagement

| My organization … | Has a plan | Is developing a plan | Intends to develop a plan | Does not intend to do this |
|---|---|---|---|---|
| Engages community members in health assessment/health improvement plans (N=55) | 53% | 15% | 20% | 13% |
| Adapts to new communities and changes within populations we serve (N=50) | 62% | 22% | 12% | 4% |
| Engages community partners in policy and planning activities (N=58) | 69% | 12% | 14% | 5% |
| Analyzes survey results by race, ethnicity, language and disability to inform policies and practices (N=48) | 21% | 31% | 25% | 23% |
| Has formal partnerships with CBOs that represent communities served (N=57) | 75% | 7% | 5% | 12% |
| Creates opportunities for shared ownership with communities served (N=58) | 59% | 17% | 17% | 7% |
| Has a board or governing body representative of diverse communities served (N=54) | 19% | 13% | 11% | 57% |
| Has advisory group representative of diverse communities served (N=51) | 47% | 14% | 10% | 29% |

# Race, ethnicity, language and disability (REaL D) data collection

Approximately one-half or more of the respondents indicated their organizations had most of the elements related to race, ethnicity, language and disability data collection with a few exceptions in areas they sought to improve:

- 25% had a plan to use data to design culturally specific programs.
- 33% had a protocol to share data with communities they served, and 43% indicated their organization was not intending to do so.
- 43% had a plan to use data to distribute grant funding to address health disparities, and 32% of the organizations were not intending to do so.

### Table 2: Pre-program assessment of REaL D data collection

| My organization … | Has a plan | Is developing a plan | Intends to develop a plan | Does not intend to do this |
|---|---|---|---|---|
| Can collect, analyze and interpret disaggregated REAL D data (N=55) | 69% | 15% | 9% | 7% |
| Uses data to tailor plans, policies and programs (N=57) | 49% | 29% | 16% | 5% |
| Uses data to design culturally specific programs (N=56) | 25% | 29% | 30% | 16% |
| Uses data to seek targeted grant funding (N=48) | 73% | 10% | 6% | 10% |
| Uses data to distribute grant funding to address health disparities (N=47) | 43% | 15% | 11% | 32% |
| Uses data to develop materials and resources in other languages (N=54) | 57% | 11% | 9% | 22% |
| Has protocols to share data with communities (N=49) | 33% | 12% | 12% | 43% |
| Shares data with communities (N=52) | 54% | 19% | 8% | 19% |

## Language access

Before beginning the DELTA program, approximately three-quarters of the respondents' organizations employed or contracted with interpreters (79%) and provided publications and materials in different languages (73%). The remaining elements contributing to improved language access were not as well represented. Only 35% had building signage, 35% used media outlets to reach their diverse audiences, 24% provided recordings or videos of important information in other languages, and 19% had a multilingual and accessible website. For those organizations with bilingual employees, only 43% provided salary differentials for employees required to use their additional language for work.

### Table 3: Pre-program assessment of language access

| My organization … | Has a plan | Is developing a plan | Intends to develop a plan | Does not intend to do this |
|---|---|---|---|---|
| Has building signage in various languages (N=55) | 35% | 4% | 2% | 60% |
| Employs or contracts with bilingual interpreters (N=52) | 79% | 4% | 4% | 14% |
| Uses media outlets to reach diverse audiences (N=40) | 35% | 8% | 13% | 45% |
| Provides publications and materials in different languages (N=55) | 73% | 0% | 4% | 24% |
| Has a multilingual and accessible website (N=54) | 19% | 11% | 7% | 63% |
| Has recordings/videos of important messages in other languages (N=51) | 24% | 4% | 10% | 63% |

## Resources for equity, diversity and inclusion work

Of the organizations that were accepted into the DELTA program and that had an office or program focused on equity (44%), more than half (61%) of them had two or fewer full-time employees (FTE) dedicated to equity and inclusion, while the remainder had three or more FTE with the most being one organization with 16 FTE.

### Table 4: Pre-program assessment of resources for equity, diversity and inclusion work

| My organization … | Has a plan | Is developing a plan | Intends to develop a plan | Does not intend to do this |
|---|---|---|---|---|
| Has an office or program focused on equity (N=55) | 44% | 15% | 15% | 27% |
| Has a diversity and inclusion plan (N=49) | 20% | 43% | 14% | 22% |
| Has dedicated funds for equity activities (N=24) | 38% | 21% | 13% | 29% |
| Has sought grants for equity work (N=38) | 42% | 16% | 8% | 34% |
| Provides grants to community partners that focus on health equity activities (N=49) | 29% | 10% | 14% | 47% |

# Health literacy

For the most part, the organizations typically did not include the components of health literacy. Many respondents were either not intending to do it or were unsure whether their organization even had some of the elements:

- 50% were unsure whether their organization used health literacy universal precaution approaches
- 34% did not know if their organization used funds to improve health literacy access and
- 34% were unsure whether their organization used the teach-back method.

## Table 5: Pre-program assessment of health literacy

| My organization … | Has a plan | Is developing a plan | Intends to develop a plan | Does not intend to do this |
|---|---|---|---|---|
| Uses universal precaution (1) approaches (N=34) | 29% | 12% | 15% | 44% |
| Distributes easy to understand media content (N=55) | 62% | 16% | 6% | 16% |
| Integrates health literacy/plain language in all published materials (N=50) | 50% | 16% | 6% | 28% |
| Has dedicated staff for health literacy work (N=51) | 29% | 4% | 2% | 65% |
| Directs funds to improve health literacy access (N=41) | 22% | 5% | 5% | 68% |
| Includes populations served in design, implementation and testing of health info and services (N=47) | 38% | 15% | 15% | 32% |
| Uses Teach Back method to confirm client understanding (N=40) | 20% | 8% | 10% | 63% |
| Provides client support for navigating system (N=53) | 72% | 6% | 0% | 23% |

# Workforce development

In the pre-program assessment, the organizations did not sufficiently represent the elements for developing a diverse workforce. Very few had plans or were in the process of developing plans for most of the elements. Fifty-three percent were not intending to develop a plan for helping staff navigate across cultural differences; 50% were not intending to assess staff cultural competency; 47% were not intending to develop a plan to have staff representative of the communities served.

## Table 6: Pre-program assessment of workforce development

| My organization … | Has a plan | Is developing a plan | Intends to develop a plan | Does not intend to do this |
|---|---|---|---|---|
| Has staff representative of the communities we serve (N=51) | 26% | 16% | 12% | 47% |
| Utilizes diversity recruitment practices (N=36) | 25% | 25% | 14% | 36% |
| Has systems to support a diverse workforce (N=40) | 10% | 23% | 23% | 45% |
| Assesses staff for cultural proficiency (N=48) | 13% | 21% | 17% | 50% |
| Performs staff development activities for navigating across cultural differences (N=47) | 11% | 15% | 21% | 53% |
| Reflects how organizational culture supports diversity and inclusion (N=49) | 14% | 31% | 27% | 29% |
| Requires non-management staff to have cultural competency training (N=51) | 43% | 12% | 12% | 33% |
| Utilizes pro-diversity initiatives to reduce social isolation (N=41) | 20% | 12% | 15% | 54% |
| Conducts regular reviews of compensation programs to ensure equity and non-discrimination (N=29) | 38% | 3% | 10% | 48% |
| Recruits at diverse colleges/universities (N=38) | 21% | 0% | 8% | 71% |
| Offers internships to diverse students (N=40) | 53% | 0% | 8% | 40% |

# Civil rights

Approximately three-quarters of the respondents' organizations had a process for addressing employee (79%) and client (72%) civil rights. Slightly more than half had a plan to assess equitable access and distribution of their programs (56%) and accessibility of programs and services for people with disabilities (54%).

## Table 7: Pre-program assessment of civil rights

| My organization … | Has a plan | Is developing a plan | Intends to develop a plan | Does not intend to do this |
|---|---|---|---|---|
| Assesses accessibility of programs and services for people with disabilities (N=46) | 54% | 9% | 15% | 22% |
| Assesses for equitable access and distribution of all programs (N=45) | 56% | 7% | 18% | 20% |
| Has a clear process for addressing client civil rights (N=42) | 72% | 5% | 2% | 21% |
| Has a clear process for addressing employee civil rights (N=47) | 79% | 2% | 0% | 19% |

# Individual session evaluations

The individual session (day-long classroom-based meeting times/trainings once per month) evaluations contributed to the program's quality improvement and measured improvement in participant knowledge and confidence in their ability to do the work. PDES modified the training process, protocol or curriculum based on the individual sessions' evaluation results. Participants evaluated each session on the training delivery and effectiveness of that day, as well as the value and relevance of the information to their job. Participants also rated themselves on their level of engagement, understanding of content and skills development.

Using the same five-point scale as above, participants rated their own level of understanding pre- and post-session. These additional statements indicated a shift in knowledge, awareness and confidence in the session topic with the post-session scores averaging between *strong* and *very strong*. See tables 8–15.

**Overall, participants demonstrated a general satisfaction with the training sessions as well as increased knowledge, awareness and skills for addressing health equity issues related both personally and within their organizations.**

The following tables report means. They suggest a trend of increased knowledge and confidence. For the most part, the pre-test scores demonstrate participants were more comfortable in the general and conceptual topics, such as evaluation or community engagement, than in the more specific, skills-based ones such as best practices for demographic data collection. Therefore, it is not surprising the change between pre- and post-test scores was greater for the more specific topics. In addition, we only asked participants whether they had specific ideas or recommendations for their organization after the training session; therefore, N/As are only listed in the pre-session score.

## Table 8: Evaluation of orientation, history of inequities in Oregon and cohort building session (N=65)

| Scale: 1 = poor, 3 = average, 5 = very strong | MEAN (average score) | |
|---|---|---|
| | Pre | Post |
| **I understand the purpose, goals and objectives of the DELTA program.** | 3.4 | 4.4 |
| **I understand the social determinants of health and inequities in Oregon.** | 3.5 | 4.2 |
| **I feel acquainted with other cohort members and understand their motivation for participating in this program.** | N/A | 4.0 |
| **I share a common vision and project potential for the cohort and DELTA program experiences.** | N/A | 4.0 |

## Table 9: Evaluation of demographic data and health equity measures session (N=54)

| Scale: 1 = poor, 3 = average, 5 = very strong | MEAN (average score) | |
|---|---|---|
| | Pre | Post |
| **I understand how the collection and use of demographic data can identify health disparities and advance health equity.** | 3.6 | 4.6 |
| **I am knowledgeable about best practices, standards and requirements for demographic data collection.** | 2.9 | 4.4 |
| **I have specific ideas and recommendations for improving demographic data collection at my organization.** | N/A | 4.2 |
| **I have specific ideas for integrating health equity measures into my organization.** | N/A | 4.3 |

## Table 10: Evaluation of diversity in recruitment, hiring and retention session (N=62)

| Scale: 1 = poor, 3 = average, 5 = very strong | MEAN (average score) | |
|---|---|---|
| | Pre | Post |
| **I understand strategies to outreach, recruit, hire and retain a diverse workforce.** | 3.1 | 4.0 |
| **I am knowledgeable about best practices, standards and requirements to address implicit bias.** | 2.9 | 4.1 |
| **I have specific ideas and recommendations for improving diverse hiring, recruitment and retention at my organization.** | N/A | 4.1 |
| **I have specific ideas for reducing implicit bias in my work.** | N/A | 3.8 |

## Table 11: Evaluation of literacy, language and culture session (N=66)

| Scale: 1 = poor, 3 = average, 5 = very strong | MEAN (average score) | |
|---|---|---|
| | Pre | Post |
| **I am knowledgeable about messaging strategies to communicate effectively across literacy levels.** | 3.0 | 4.2 |
| **I am knowledgeable about addressing language access barriers to services.** | 3.0 | 4.2 |
| **I have specific ideas for assessing and revising materials in my work.** | N/A | 4.4 |

## Table 12: Evaluation of equity and empowerment planning session (not included in the mini-cohort) (N=44)

| Scale: 1 = poor, 3 = average, 5 = very strong | MEAN (average score) | |
|---|---|---|
| | Pre | Post |
| **I am familiar with the process of creating a strategic plan/road map to reduce health disparities from an organizational perspective.** | 2.8 | 4.0 |
| **I am knowledgeable about best practices in evaluating for impact equity.** | 3.0 | 4.1 |

## Table 13: Evaluation of community engagement session (N=53)

| Scale: 1 = poor, 3 = average, 5 = very strong | MEAN (average score) | |
|---|---|---|
| | Pre | Post |
| **I am familiar with levels of true community engagement.** | 3.2 | 4.4 |

## Table 14: Evaluation of privilege session (See Ns below)

| Scale: 1 = poor, 3 = average, 5 = very strong | MEAN (average score) | |
|---|---|---|
| | Pre | Post |
| **I am aware of many categories and dimensions of privilege. (2015/2016 cohorts only, N=34)** | 3.6 | 4.5 |
| **I am knowledgeable about addressing individual and systemic impact of power. (2015/2016 cohorts only, N=34)** | 3.1 | 4.0 |
| **I recognize the dynamics of oppression and how they are perpetuated at a personal level, as well as within my organization/institutional level. (2014 cohort only, N=14)** | 3.0 | 4.2 |
| **I am knowledgeable about resources, processes and practices related to power. (mini-cohort only, N=9)** | 3.1 | 4.7 |

## Table 15: Evaluation of addressing health equity with intentionality session (N=57)

| Scale: 1 = poor, 3 = average, 5 = very strong | MEAN (average score) | |
|---|---|---|
| | Pre | Post |
| **I am confident I can approach health equity in my organization and the communities we serve with intentionality.** | 3.3 | 4.2 |

In addition to the above statements, participants were asked after every session:

- What they learned that was important to themselves and/or their work and
- If they learned skills or tools that could be immediately applied to their work.

There was quite a bit of overlap in the open-ended responses to these two questions so we merged the responses to better understand the overall impact of each training. Most respondents indicated they had learned something or acquired tools or resources they could immediately implement at their workplace, or with their colleagues or organizational partners. In addition to general praise, most of the responses listed at least one or more tools or resources they felt were relevant to their work.

***DELTA cohort member reflections:***

*Community Engagement is extremely important to CCOs. It is one of our primary focus issues. I will be using a great deal of the information in my work.*

*I appreciated trainers' pragmatic and real world approach. Really refreshing — I'm thinking about how to apply this to "built environment" discussion about SDOH (social determinants of health).*

*That working for health equity is not just the right thing to do — it will improve my organization!*

*I think it's particularly valuable to better understand the performance measures/metrics that OHA/CCOs are accountable for — I think my organization is in a position to align with some of these priority areas.*

*Continued collaboration with community partners is imperative to improve health equity and achieve the "Triple Aim."*

# Outcomes and organizational assessments

We assessed outcomes using three tools: a post-program outcome survey, project application of Office of Minority Health's Culturally and Linguistically Appropriate Standards (CLAS) and implementation, and key informant interviews.

## Post-program outcome survey

Approximately one month after the DELTA program ended, we asked participants from the 2014, 2015 and 2016 cohorts to complete an online outcome survey

### Equity, diversity and inclusion plans

The majority of respondents indicated their organization either had a plan, were developing one or intended to develop a plan related to the DELTA training's equity, diversity and inclusion concepts. Again, the questions did not specifically ask about implementation of a plan. A few respondents felt some of the concepts were not applicable to their organizations so their responses were removed from the denominator. Except for community partner engagement where all respondents intended to develop a plan if they did not already have one, all other concepts had between one and five respondents indicate they had no intention to develop a plan at all.

The concepts covered in the post-program outcome survey were more general and overarching than those asked about in the pre-program assessment. The pre-program assessment concepts were specific elements of the overarching concepts. For example, in the pre-program assessment, respondents related specific elements or activities that community partner engagement could include. However, respondents were not asked directly about community partner engagement. Therefore, the pre-program and outcome survey results are not comparable. However, **the number of organizations with no intention to develop a plan decreased from pre- to post-program assessment.** This implies that after the DELTA program, more organizations increased their plans to address these health equity concepts.

### Table 17: Utility of other resources provided during training

| Resource | Useful | Somewhat useful | NOT useful |
|---|---|---|---|
| Plain language examples and toolkit (N=49) | 84% | 16% | 0% |
| Multnomah County Equity and Empowerment Lens (2) (N=46) | 80% | 20% | 0% |
| Multicultural Storytelling Toolkit (3) (as a form of community engagement) (N=34) | 56% | 41% | 3% |
| Various articles (emailed prior to session) (N=48) | 63% | 33% | 4% |
| Implicit association tests (4) (N=46) | 61% | 26% | 13% |
| OHA Diversity Recruitment Policy(5) (N=37) | 60% | 30% | 11% |
| DELTA binder (N=31) | 55% | 36% | 10% |

## Continuing education and connection

Most of the respondents expressed interest in staying connected to DELTA alumni and continuing their education around equity through conferences (92%), special trainings or workshops (96%), and networking or social events (76% yes and 20% maybe). Those who wanted to continue the connection preferred to do so through in-person gatherings rather than conference calls or webinars.

## Shift in personal attitudes and behavior

Many respondents indicated they gained a greater awareness or improved understanding of health equity overall. Several specifically mentioned implicit bias, race and social justice affecting health care issues that must be addressed. Many respondents also mentioned the DELTA program increased their confidence when speaking on this topic and an increased commitment to working on these issues. As a result, many felt better prepared to act as "equity champions."

Some recognized that equity work requires time and planning. They view this work as impossible to fit into business as usual. It requires a comprehensive plan developed with intention.

***DELTA cohort member reflections:***

> ***I am definitely more sensitive and have noticed that I apply an equity lens to everything I do now … I feel like this training really helped me improve my equity language. I am more confident speaking about the health equity work that I do and educating others when need be.***

> ***My whole viewpoint has changed. I thought I was a fairly progressive person, but now I notice the workings of power and privilege everywhere, all the time. It's caused me to dedicate myself more to work that I feel really matters.***

*This has been rather profound for me. Having grown up with so much privilege, I now have a much, much better understanding of the issues faced by people with less privilege. I find myself seeking more information and diving deeper into this topic.*

*I have a much deeper understanding of the causes for disparity and the actual disparities that exist. I also now better understand the reasons why it is imperative to close the gap.*

## Most helpful things

When asked what one or two things from the training were most helpful, the most common responses related to the cohort itself, especially the connections with people doing this work and being able to network and learn from other cohort members. In addition, several respondents felt the materials and resources overall were invaluable. A few mentioned how nice it was to have the time to reflect on these issues in a safe, non-judgmental environment. Respondents mentioned the following specific training topics and/or tool: the health equity lens, health literacy, implicit bias, data, developing community partnerships, appropriate messaging for various audiences, and the project management and planning tools.

***DELTA cohort member reflections:***

*Opportunity to step away from daily tasks and really focus on equity issues … ability to talk and learn with people from a variety of organizations and perspectives about how they're going about this work.*

*Affirmation that equity, empowerment and engagement are essential to creating healthy communities.*

*Overall, a deeper understanding of health equity and how organizations across the state are considering and applying these concepts in their work. I can see the work my organization does intersects well with lots of different projects I heard about. I was also happy with all of the project management and planning tools we received. And again … that plain language review process is great!*

*Exposure to trainers and cohort members with a wide variety of experiences and perspectives to share – it's a wealth of knowledge, experience, and inspiration to action.*

# CLAS implementation and DELTA projects

The U.S. Department of Health and Human Services established the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to provide a framework through which organizations serve diverse communities, improve health care quality and advance health equity. These standards were used to measure how the participants' projects were implementing or addressing the equity concepts in their organizations. At least one participant's project from each cohort addressed each standard. The most projects (n=24) addressed standards 4 and 11 while four projects addressed standard 14.

## Table 18: National CLAS standards addressed by DELTA projects

| National CLAS standards | Percentage of total projects addressing standard |
|---|---|
| 1) Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. | 42% |
| 2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources. | 31% |
| 3) Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area. | 29% |
| 4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. | 44% |
| 5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. | 18% |
| 6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. | 11% |
| 7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. | 13% |
| 8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. | 27% |
| 9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations. | 40% |
| 10) Conduct ongoing assessments of the organizations' CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities. | 13% |
| 11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. | 24% |
| 12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. | 27% |

| National CLAS standards | Percentage of total projects addressing standard |
|---|---|
| 13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness. | 44% |
| 14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints. | 7% |
| 15) Communicate the organizations' progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public. | 15% |

Examples follow of how projects addressed these standards and implemented the equity concepts into their organization:

- Project example 1: A CCO health care provider started by looking at rates of colorectal cancer screening among the CCO's Latino population. This participant is now working with a three-county consortium and an internal task force to better understand all colorectal cancer screening rates by different populations and reviewing best practices to make improvements. The participant's current work includes conducting focus groups at Latino health fairs and identifying local champions to increase awareness of screening benefits. This work uncovered challenges to collecting the screening data. As a result, this process led to assessing the electronic medical records system and developing consistent processes for entering the data.
- Project example 2: A CCO administrator worked on a project to reduce emergency room (ER) usage because its ERs had one of the highest rates of unnecessary visits in the state. The CCO established a peer support model for reaching out to members with high usage rates. Once the CCO reflected the community's diversity in its peer support team, its ER usage continued to decrease.
- Project example 3: A community-based organization administrator conducted an organizational self-assessment on demographic data. As a result, the organization has improved collection of demographic data for a better understanding of its client population. Additionally, DELTA program information and tools helped an administrator facilitate a conversation with the board of directors to move from a more traditional understanding of diversity and cultural competency toward equity. This process helped inform the overall strategic direction of the organization.

# Key interviews and feedback, six months later

## Methods

We used a purposive sample design in which OEI developed an interviewee list with representation from the type of organization (i.e., CCO or CBO) and the estimated level of organizational impact (i.e., significant or lesser impact). Below are some of the characteristics we used to determine the level of impact:

- Level of health equity penetration within the organization
- Individual awareness, capacity and knowledge base
- Level of implementation/usage or skills-building with health equity tools
- Actions resulting from the training
- Increased relationship building/grown network
- Shift in attitudes and beliefs

## Findings

This section presents themes identified during analysis of the interview transcriptions. Themes represent the views of multiple individuals. Quotes that illustrate and allow the participants' voice to describe the theme are included in italics. Quotes provide good examples of the theme, but are not exhaustive. Opinions or thoughts expressed by one or two individuals are minor themes as indicated in the description.

## Application

All respondents felt the application process was straightforward and "easy." Several mentioned the application made it clear the ideal DELTA candidate would be in a leadership role or at least in a position to implement change within that person's organization. Some mentioned the benefit of having organizational leadership sign the application to ensure awareness of the level of commitment, especially time. They did not note anything specific they would change to improve the application or its process; however, a few respondents mentioned the project proposal required for the application. Some respondents would have liked more guidance on their project. From their perspective, there was some confusion about whether the project could be something they were already working on or fit within the purview of their work, or if it should be created especially for the program. When prompted, they all felt that, in hindsight, they could have contacted OEI for more information and clarification as OEI staff were very available to answer questions.

Most respondents mentioned the application's degree of detail helped them know what they were getting into; however, when asked if the program met their expectations, all but one said the program exceeded their expectations. The one person who said the program did not meet her expectations changed her employment during the program, so she felt DELTA and its concepts were not as relevant or applicable to her new job. She reiterated several times that her new position and organization rather than the DELTA program made it less relevant.

***DELTA cohort member reflections:***

> ***I expected an intro level equity training, but I got way more than I ever expected. I think back on the things I learned in this training all the time and I still use it.***
>
> ***I don't think I completely grasped what I was getting into and by the end, I was amazed by the opportunity that was given to me.***

## Healthy equity within the organization

All of the in-depth interview respondents fall somewhere on the spectrum of having the above-mentioned characteristics of impact. The varying degrees of "success" depend on where the participant falls on the spectrum of each of the elements. The DELTA program is implemented so that the project proposed in the application and then implemented during the program enables participants to incorporate the concepts within their organization as well as within their personal life.

Those with the greatest impact or success had several organizational elements in common. They all had support from their leadership. The support varied depending on the type of organization but, in general, the organizations accepted that something must occur to move the organization forward to more fully embrace and implement the elements of health equity. Participants were encouraged by their leadership and colleagues to implement changes. One respondent described the organization's chief executive officer, who was "100% committed" to health equity, as the "chief cultural officer." Organizations had a forum or method for sharing the information gleaned from the program. Participants acted as a resource for their colleagues by sharing tools and information and, in some cases, felt obligated to educate their colleagues on the topics covered in the training.

***DELTA cohort member reflection:***

*I feel like I am this pot of knowledge that needs to be spilt and shared.*

Participants seemed to have the most impact when they started with short-term projects that were either imminent or feasible within the nine-month period. A few participants also had long-term goals, but as well but they tended to be from organizations that were farther along in addressing health equity on a broader organizational level. One respondent who had implemented several health equity projects since completing DELTA attributed it to the fact that the organization encourages innovation and values responsiveness.

However, when asked if there were barriers to implementing these changes, they all mentioned common barriers to the work: lack of time, lack of leadership vision or full understanding of health equity, and limited resources or competing priorities.

***DELTA cohort member reflections:***

*I think a lot of people loved the idea but it was always time … put that on the back burner and we'll get to it kind of thing.*

*I think there are a lot of people who should be in DELTA, but I think they're shortsighted and are only putting out fires for today and tomorrow and not looking ahead.*

*CCOs aren't connecting the dots unless they see the dollar amount associated to the equity data. So there is an expectation that the CCOs are applying the equity lens but there is no ammo or money behind it at this time … Nobody gets what it's about. It's not about throwing x amount of employees at your business and calling it good. It's about engaging the membership and getting benefits out there.*

A few respondents were not as far along the spectrum of implementing their projects. That was because either they were no longer in the same position or the organizational leadership was not as supportive. According to one respondent, it was difficult to operationalize the health equity concepts because the organizational culture was not conducive to the necessary "reflective" conversations. However, despite the obstacles, these participants were still implementing what one respondent called "equity in operations," meaning **they were finding opportunities to incorporate health equity concepts within existing projects or initiatives as well as in their day-to-day work.**

## Personal transformation

Despite the barriers and limitations within their organizations, all respondents expressed appreciation for DELTA's deeper, more personal impact. All but one mentioned having a transformative experience in the program and that it increased their awareness of the issues and **improved their confidence in their ability to lead this work.**

***DELTA cohort member reflections:***

> ***Really giving me the opportunity to view things from a different perspective. I just had never been put in those kinds of positions or even had people to talk freely about it, in a safe place.***
>
> ***It opened my eyes a lot, in a very profound way. I would look forward to every session just on my personal education and development and realized what a blessing it was to be exposed to all that.***
>
> ***It made me look at the world in a different way.***
>
> ***I think that I have privilege that I never thought about or even considered. I was always this poor person of color and realized that I'm not that poor person of color. There are some privileges that I have and I have to be conscious of those when I'm interacting with the communities I work with. That was huge. That was pivotal.***

## What makes the training worthwhile?

### *Cohort*

Overall, respondents felt the networking among cohort members as well as with the session presenters and OEI staff was invaluable. All respondents spoke highly of the cohort members, the opportunity to network and make connections with like-minded colleagues, and the support they received (and in some cases continue to receive) from the cohort. They also mentioned their appreciation for the diversity of the cohort as a learning opportunity.

***DELTA cohort member reflections:***

*One of my favorite things about the cohort is that it forces you to be in a room with people that you might not know otherwise. Different age groups, different genders, different ethnicities. I really think they get a good mixture of people who are all interested in this subject. It's a place to see the disparities that are already touching you and learn how to break them down so you can deal.*

*Having 25 professionals spend almost a year together and networking and seeing what's happening in all different parts of the state for different ethnic and minority groups is a win-win for everyone.*

*So the speakers are all wonderful and the education is great but I think the networking for me was the most profound.*

*I looked forward to going to every session because I was going to see everybody, including OEI staff. For many people of color, that relational connection is very important and I thought they did an excellent job of that.*

### *Safe environment*

In addition, respondents appreciated the safe environment and being able to discuss topics openly without fear of being judged.

***DELTA cohort member reflection:***

*And then everyone else's stories from all the different backgrounds, sharing their stories and how they view the world and how they feel they're viewed and their struggles … that was probably the best out of everything. The safe environment. People sharing from the heart and how that is encouraged. No judgement. Encouraging us to get to know each other. I have working relationships with these people now.*

### *Content*

All of the respondents felt DELTA gave them an improved and deeper understanding of health equity, the differences between equity and equality, and the factors and conditions leading to health disparities and inequities. The depth and breadth of the topics was also highly valued with one respondent acknowledging, *"You can't get that anywhere else."*

In addition to improved knowledge, respondents appreciated the acquired skills, tools and resources for addressing health equity in their organizations. Furthermore, a few respondents specifically mentioned DELTA's design and format, extending over a month period, was uniquely helpful in that it allowed participants to engage with the concepts and bring the relevance of health equity back to their work.

### *Coordinated care organizations*

A few respondents mentioned they felt that CCOs did not understand what truly goes into the quality measures around equity. Many felt that DELTA helped participants develop a common language around the topic of health equity necessary for unifying the efforts around the state. Finally, one respondent felt the training was vital for CCOs given the equity quality metrics.

***DELTA cohort member reflection:***

> ***One major objective is the equity and equality around your CCO, both internal and external applications. I'm finding from the top down, no one really gets it … The CCOs need to sit in DELTA and get an idea of what it's all about. It's almost like they don't want to believe it's out there.***

# Summary of success

The National Partnership for Action to End Health Disparities (NPA), which was established by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health, in its report "National Health Disparities Plan and Regional Blueprints for Action"(6), draws attention to the need for a comprehensive, community-driven and sustained approach to combat health disparities. In order to achieve that goal, the NPA recommended several strategies:

- Strengthening and broadening the leadership at all levels for addressing health disparities
- Developing and supporting cultural and linguistic competence training for physicians, other health professionals and administrative workforces and
- Increasing the diversity of the health care and administrative workforces.

OEI successfully incorporated the above strategies in its overall DELTA program and curriculum as a means to address health disparities and improve health outcomes for all Oregonians. DELTA specifically focuses on racial, ethnic, limited English and marginalized populations. In fact, DELTA's three objectives include the three NPA strategies:

- Build the capacity and commitment of Oregon's health leaders to eliminate health disparities.
- Develop collaborative approaches and partnerships to promote health equity across Oregon's health systems.
- Inspire leaders to act individually and collectively as proactive change agents to address significant challenges and barriers to achieving optimal health.

Overall, the data demonstrate DELTA successfully achieved each of its three objectives. The cohorts were diverse in race and ethnicity as well as in regional and organizational characteristics. Participants demonstrated increased capacity in understanding the factors that contribute to health disparities by the positive change in knowledge and confidence for every session's topic area. Additionally, participants noted not only a change in knowledge but also receiving tools and resources that could be immediately implemented or shared. In fact, the tangible tools and resources provided was one of the program's most commonly mentioned benefits.

Prior to participating in the DELTA program, respondents to the pre-program survey indicated their organizations fell mostly within the planning stages of many health equity programs and policies. Few had actual plans in place. After the program, respondents indicated their organizations were farther along in implementation. In addition, when looking at the number of CLAS standards addressed by the participants' DELTA projects, it is clear the capacity to address health equity improved.

Although 68% of the respondents indicated they faced three common organizational barriers to developing or implementing their equity plans, participants were not only motivated but also felt supported to make the changes necessary to address equity. In fact, 96% indicated the DELTA program "very much" inspired them (and 4% were "somewhat" inspired) to address the challenges and barriers to health equity. In addition, many indicated they felt their cohort could serve as an ongoing resource and support.

Consistently, in the outcome survey and in the key informant interview, respondents mentioned three elements of the DELTA program that were particularly useful or helpful to their equity work:

- The cohort itself
- The tools and skills they acquired and
- The common language for defining and identifying health equity concepts.

Respondents valued the relationships developed within the cohort and appreciated its diversity during the program. They also viewed the relationships as a resource for future networking, assistance and support.

One of the DELTA program's primary goals is to affect change within organizations by encouraging participants to address equity both within the organization as well as among partners and people served by the organization. However, while having a participant who can affect change within the organization may appear critical to the process, the in-depth interviews revealed there are also other personal and organizational elements that are important when estimating the impact of the training. Having leadership buy-in leads to the prioritization of equity within the organization, thus providing resources such as time and money to the implementation of the concepts. Where there is less leadership buy-in, participants found their impact lacking breadth; however, they felt they gained the confidence to advocate for "equity in operations" by applying concepts to their daily work and taking smaller steps. Therefore, participants' comfort in pushing the concepts and challenging the system seemed to be more important when the organizational leadership was not as committed to equity. So, as DELTA continues to train and educate health equity change agents, so too will it continue to affect change and improve all Oregonians' lifelong health.

# Recommendations

## Recommendations for the program

Participants provided recommendations to the program in a variety of ways: on the individual session evaluations, on the outcome survey, informally to OEI staff, and during the key informant interviews. By far, the most common recommendation was to **continue the DELTA program**. OEI continues the conversation around financial support in order to maintain program continuity. Respondents praised the overall experience, the curriculum, the trainers and OEI staff. They also felt the training benefited them and their organizations and moved the work forward to improve the health of communities experiencing the greatest inequities and disparities.

For the most part, the recommendations from the session evaluations were specific to the trainings and spurred improvements or modifications over the course of the program. The other two sources of data (the outcome survey and the key informant interviews) provided a few recommendations. However, because respondents were generally satisfied with DELTA, they had little to offer in terms of improvements. Several **suggested lengthening the training;** this especially related to adding an extra half to full day to some of the sessions to allow for more relationship building among cohort members and to explore topics in greater depth. Some also recommended more than one participant attending from an organization. This would allow greater depth and breadth to the equity plans, programs and policies within the organization.

Just a few respondents suggested other ideas, such as branding the DELTA program so that upon completion, participants can, for example, be "DELTA certified"; develop some case studies that may be helpful for funding agencies to better understand the long-term impact of DELTA; and provide a letter to the executive director/CEO/senior leadership describing the benefits of participation for their employee and their organization.

# Recommendations to future cohorts

When asked about recommendations for future trainings, all of the respondents immediately answered with advice to future cohort members on how to benefit most from the training. Their words say it best:

***DELTA cohort member reflections:***

*Be ready to hear some things that you might not agree with. Be very open. Be prepared to listen. Take things in and maybe don't react. If you have a feeling about something maybe think about it and whether it resonates. Be ready to meet some amazing people. Everybody there always impressed me. Everyone I talked to I was so impressed with how super smart they were. They just always impressed me. Everybody there has the same kind of passion and goals. Get all these guys in a room together and the energy was like "whoa."*

*I would tell them to use every opportunity to network with the people that are there. Sit somewhere new all the time. Don't hang out with the same people. Talk to everyone. Get to know them. And even have in your mind 'how can I help them?' and 'how can they help me?' and 'how can we partner?' Because when you leave, I can guarantee something is going to come up and you'll want to remember who can help you with that.*

*I guess I would just emphasize the opportunity to transform at the individual level as well as the organizational level. I think people get out of it what they put into it and I just don't know if it was really talked about at that level. This is really going to push and challenge people to grow individually as much as organizationally. Be prepared for that.*

# Endnotes


1. Agency for Healthcare Research and Quality. AHRQ health literacy universal precautions toolkit [cited 2017 Aug 29]. Available from: https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html.
2. Multnomah County, Oregon. Equity and empowerment lens [cited 2017 Aug 29]. Available from: https://multco.us/diversity-equity/equity-and-empowerment-lens.
3. Minneapolis, Minnesota Health Department. Multicultural storytelling toolkit [cited 2017 Aug 29]. Available from: http://www.minneapolismn.gov/health/toolkit/multicultural https://implicit.harvard.edu/implicit/.
4. Harvard University. Project implicit. [cited 2017 Aug 29]. Available from: https://implicit.harvard.edu/implicit/.
5. Oregon Health Authority Office of Equity and Inclusion Division. Diversity recruitment policy in Affirmative Action Plan, page 49–50 [cited 2017 Sept 14]. Available from: http://www.oregon.gov/oha/OEI/Reports/OHA%202017-2019%20Affirmative%20Action%20Report.pdf.
6. U.S. Department of Health and Human Services National health disparities plan and regional blueprints for action [cited 2017 Aug 29]. Available from: https://www.minorityhealth.hhs.gov/npa/files/Plans/Toolkit/NPA_Toolkit.pdf.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OFFICE OF EQUITY AND INCLUSION DIVISION
Developing Equity Leadership through Training and Action

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