MOVING TO INSTITUTIONAL EQUITY

A Tool to Address Racial Equity
for Public Health Practitioners

NATIONAL ASSOCIATION OF
CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

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Foreword

Over the years, the National Association of Chronic Disease Directors (NACDD) Health Equity Council (HEC) has addressed many difficult issues in our ongoing effort to achieve health equity. We have tried to move systematically through the widely acknowledged "*social determinants of health*" by highlighting them one at a time. This gives our membership the ability to recognize opportunities to view some of their current work through a health equity lens and apply the lens where they hadn't before. In turn, we have given workshops, created literature or tools and hosted webinars to address various aspects of the social determinants including cultural competency, neighborhood segregation, access to healthy foods and food deserts, and high school drop-out rates. We believe the time is right to have one of the most difficult conversations about the most insidious barrier to equity in the social determinants; institutional racism. This is an extremely difficult and uncomfortable discussion. We know institutional racism exists and we know that it contributes to health disparities and health inequities in our country. Because it is such an uncomfortable conversation and we are not sure where to start or stop — we delay. Over the years the HEC has asked its membership how they think the issue might be best addressed. The prevailing response is that we know institutional racism exists, but the question remains how do we identify it in our work and how do we constructively change each (and all) of the separate expressions of it to create a new reality called **institutional racial equity**.

In response to these challenges, the Institutional Equity Committee, a subgroup of the HEC, has created a tool to help identify biased practices and policies. These do not reflect individual fault or bad intent; rather, they reflect practice and comfort of a systemic status quo. The intent of this tool is to shed light and NOT blame or shame. In order to fully understand how entrenched institutional racism is in our society, we have to know some of the dark truths in U.S. history. We must acknowledge the many points in history when foundations were laid that helped create and continue to perpetuate institutional racism. Once we understand the historical context we become better equipped to recognize opportunities to move toward **institutional racial equity**.

Is your organization ready?

Creating an environment of **institutional racial equity** is an ongoing and sometimes difficult process requiring cooperation on many levels. Organizations may have their own individual starting point in this process. We believe several factors should be considered before implementing this tool. Below is a checklist to help you determine if your organization is ready to take the next step toward achieving **institutional racial equity**.

- You have begun to have the conversations about health equity and root causes of health inequities.
- You are clear, as an organization, about why you are making this effort.
- The leadership of your organization is committed to this work.
- Your organization is prepared to invest the time required.
- Staff and leadership are prepared to engage in difficult discussions that may surface while exploring issues of social inequity.
- Leadership is prepared to address this likelihood and will respond.
- You are committed to take action.

Historical Context for the Legacy of Racial Inequity

Senator Jacob Merritt Howard was an abolitionist and one of the authors of the 14th Amendment. He made these conciliatory comments—considered reprehensible by current standards, to his colleagues in 1866:

"For weal and for woe, the destiny of the colored race in this country is wrapped up with our own; they are to remain in our midst, and here spend their years and here bury their fathers and finally repose themselves. We may regret it. It may be not entirely compatible with our taste that they should live in our midst. We cannot help it. Our forefathers introduced them, and their destiny is to continue among us; and the practical question which now presents itself to us is as to the best mode of getting along with them."[1]

The Senator's statement urges tolerance for the irreversible presence of Blacks as opposed to demanding equality for the freed slaves. Senator Howard's apprehension about Blacks in White America resounds throughout contemporary policies and decisions where so-called equality is determined by the impact that will be experienced by White America rather than the potential impact or benefit that will be experienced by society as a whole. There is no consideration of benefits if we were ALL afforded the same opportunity for equality in both life and health.[2]

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1 Encyclopedia of the American Constitution 761 (Leonard W. Levy, Kenneth L. Karst & Dennis J. Mahoney, eds 1986
2 Race, Racism and American Law, Fifth Edition, Aspen Publishers page 13

Post-Civil War Reconstruction laws weakened the Black vote and impeded Black Americans' participation in government policy making.[3] Eventually, this resulted in laws and policies that supported, among other things racial segregation in public places, housing and education. These policies worsened the significant social factors that we currently identify as *social determinants of health*. They have roots in our political, economic and social past and are the legacy that plagues our present. Please note: As a visual resource to the **Institutional Racial Equity Tool,** we have included a section on geospatial mapping that shows how some discriminatory laws and policies were used to create pockets of poverty, sub-par education, substandard housing and ultimately poor health.

Thus far, we have only referred to discrimination as it relates to the Black experience; however, other races have been the victims of racial discrimination as well. Other races that are easily identifiable as non-white—Native Americans, Chinese, Japanese, Mexicans and other Spanish and French speaking people have had experiences similar to the Black experience. Therefore, the purpose of this tool is to identify and eliminate institutional racism wherever it exists and to create pathways toward implementing and practicing **institutional racial equity**. This tool will not solve all problems related to race and racism. There are still laws on the books that allow for subjective interpretation and that continue to perpetuate bias and institutional racism. We also have to contend with people's personal beliefs about the inferiority of individuals who don't share a common ancestry. However, it is important we understand that history, policy and law have helped to create the circumstances that we live with today. We can't change history, but moving forward, we can create policies and laws to protect people from discrimination and provide them with an equal opportunity to live and thrive. This tool is a small step in the process of identifying inequities and creating new pathways to remedy them.

The creators of this tool have presented an example of a process that can be examined through an equity lens. The example speaks to diversity and focuses on hiring practices that may unintentionally, eliminate qualified candidates and discourage diversity in the workplace. We understand that diversity alone will not create the equity we seek; it must become part of a much bigger process. It will also require training, regular monitoring and a relatively large (paradigm) shift in our culture. However, with diversification comes perspectives from many different life experiences. It gives voice to people who may not have had the opportunity to influence a process before. It's time for upstream efforts to educate and advocate for **institutional racial equity** and converge with those who create downstream impacts. Ownership, respect and trust will prevail when a convergence is recognized. With a new perspective, there is also opportunity to influence policies and procedures in our organizations and eventually in our society.

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3 Race, Racism and American Law, Fifth Edition, Aspen Publishers page 63

Geospatial Mapping: A tool that Exposes the Legacy of Racism

Geo-mapping provides a visual representation of a geographic location layered with identified data points that, when pooled together—often over time, give a dramatic socio-economic picture about the location.

Committee members that created this tool wanted to find a way to provide an illustration of institutionalizing racism. Members agreed that geospatial mapping is a tool that could be used to expose the legacy of racism. This tool helps demonstrate the results of laws and policies implemented many decades ago that still affect us today.

Geo-mapping has been especially important in racial and health equity forums because it offers concrete data that expose how social and economic laws and practices have led collectively and over time to the oppression and detriment of certain groups, while maintaining or improving the status and opportunity of a privileged group.

In addition to the past perspective they provide, geo-maps are guides to seeing existing problems which in turn help to identify new benchmarks for achieving more equitable goals in the future. Today's built environment is not a natural landscape; rather, it is influenced deeply by the development of specific long-term policies and practices. For example, zoning and land use practices, redlining and investment practices, "urban renewal," public housing and federal highway policies, explicit racial discrimination and intimidation practices all led to segregation and limited opportunities to thrive. Below are examples of federal, state and local policies that have helped shape our current landscape. We also have some maps of Ohio that demonstrate the results of these policies and how residents have been affected.

Redlining is a uniquely American phenomenon whereby large swaths of inner city neighborhoods were deemed unsafe for home mortgage investments. Redlining was initiated and sanctioned by national and state administrative agencies and documented in a series of maps that were not available for public review and appraisal; they were however, shared with strategically placed bankers and elites in the real estate industry. Redlining represents the disinvestment of home mortgage loans and was widespread in all American central cities. Redlines were literally drawn around neighborhoods where mortgage loans could or could not be made. It was almost exclusively the result of lending discrimination towards non-Whites. The practice of redlining was used by several national and state agencies including the Federal Home Loan Bank, through its subsidiary Home Owners Loan Corporation (HOLC), and the Federal Housing Administration. This coordinated disinvestment played a crucial role in the decline of many cities and significantly contributed to population losses, changes to the racial make-up of populations and the deterioration of (inner) cities. Coincidentally, and perhaps an unintended consequences, these practices are long lasting and have far reaching consequences on our health, health disparities and health inequities.

A NUMBER OF FEDERAL POLICIES WOULD RADICALLY RESHAPE URBAN AMERICA

The Build Out of Suburbia

- The FHA and the creation of the standard mortgage 1934
- The GI Bill 1944
- Federal Highway Act 1953
- Infrastructure Subsidizes for New Suburbs

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The Demolition of Urban Areas

- Urban Renewal 1949
- High rise public housing
- Berman v Parker (1954): Justification of using eminent domain for blight removal
- Federal Highway Act 1953
- Dismantling of street car systems


freeway construction in 1962

The two maps below demonstrate the dramatic impact of inequitable and unjust policies and practices on neighborhoods and the individuals who inhabit them. The first map exhibits an area of Boston, Massachusetts historically subjected to redlining practices. This is physically illustrated by the red colored section of the map, which corresponds to a Grade D security rating. There are 4 security ratings ranging from A to D, A representing the most desirable areas and lowest risk for banks and mortgage lenders and D representing the least desirable areas with the highest risk for granting loans. Lenders often refused to lend in neighborhoods deemed Grade D by HOLC.

REDLINING: 1930'S TO 1970

- The FHA explicitly practiced a policy of "redlining" when determining which neighborhoods to approve mortgages in. Redlining is the practice of denying or limiting financial services to certain neighborhoods based on racial or ethnic composition without regard to the residents' qualifications or creditworthiness. The term "redlining" refers to the practice of using a red line on a map to delineate the area where financial institutions would not invest.

- The Fair Housing Center of Greater Boston
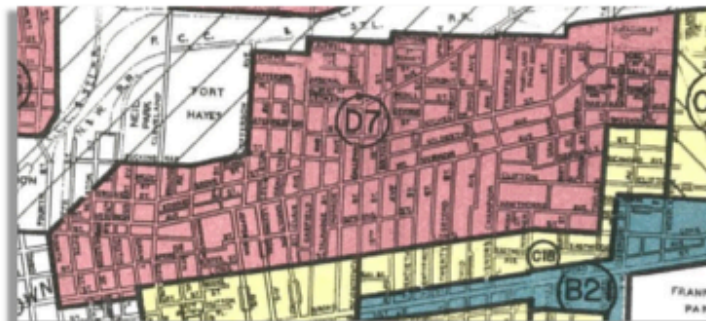
KIRWAN INSTITUTE
for the Study of Race and Ethnicity

This American Life, Nov 22, 2013
· "House Rules" (listen to 20:17-25:00)

The map below represents historically redlined neighborhoods in Cleveland, Ohio, which have the highest rates of infant mortality. As portrayed in the map the areas with the lowest security ratings (pink and yellow) are predominantly home to the highest rates of infant mortality (the largest white circles).
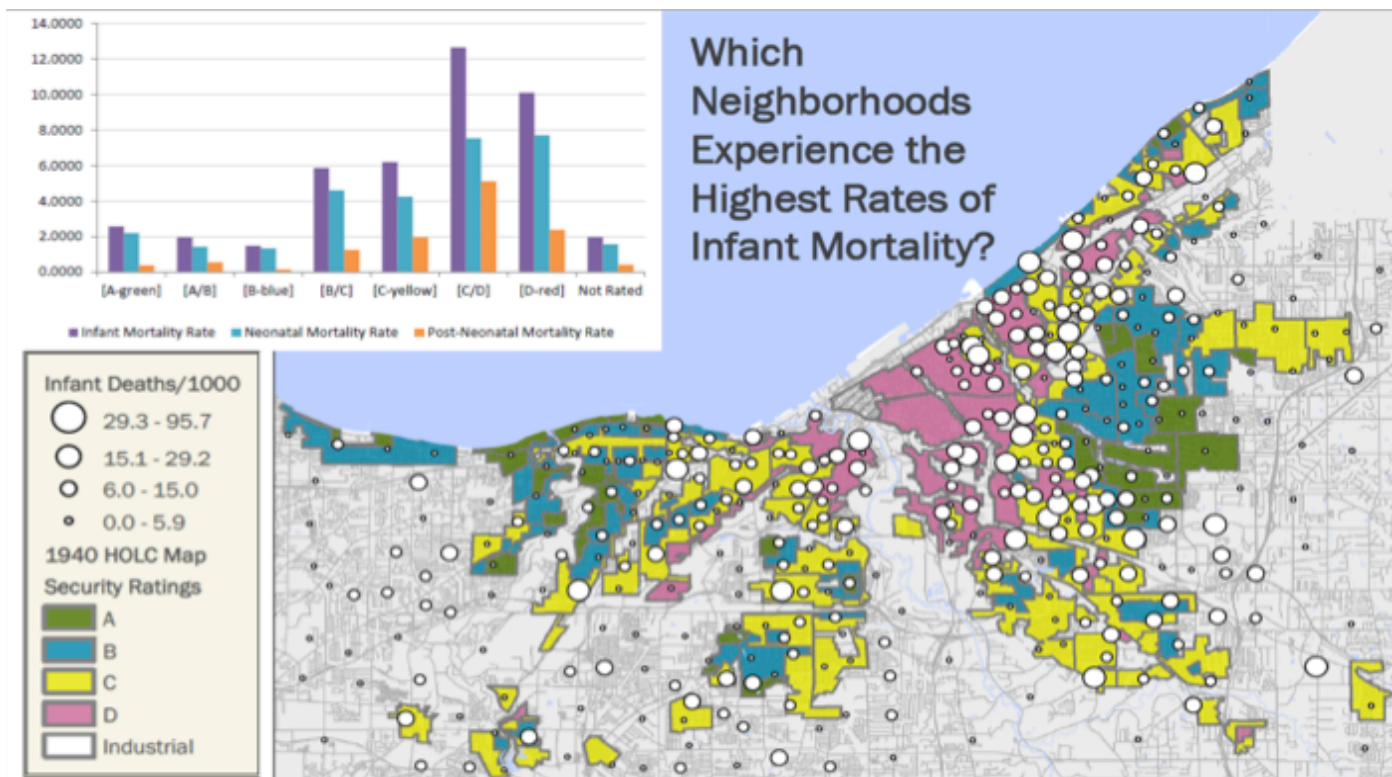
The practice of redlining has impacted disease and mortality rates. The maps show a direct relationship between the historical patterns of discrimination, health "hot spots" and community based health challenges today. Policies have played a specific role in creating health inequities in disenfranchised communities around the country. Therefore, we must consider that policy be used as one of the solutions to revitalize and improve health in these communities. The inequities demonstrated in these maps also extend to include other factors that shape our health. If we were to overlay maps to show educational attainment, access to healthy foods, income and other social determinants we would begin to see a deeper, and even more profound pattern of racism emerge.

Moving to Institutional Racial Equity:
A Tool to Address Racial Equity for Public Health Practitioners

The Public Health Case for Institutional Equity

Each year, chronic diseases are responsible for 7 out of 10 deaths among Americans, and they account for 86% of our nation's healthcare costs. Here are just a few statistics:

- Non-Hispanic blacks are 40% more likely to have high blood pressure than are non-Hispanic whites, and they are less likely/able to manage this condition.

- The rate of diagnosed diabetes is 77% higher among non-Hispanic blacks, 66% higher among Hispanics, and 18% higher among Asians than among non-Hispanic whites.

- People living with HIV that smoke die 12 years earlier than those who don't smoke; they die sooner due to smoking-related diseases rather than from their HIV-related illness. People living with HIV smoke at a rate of 50-70% greater than the general adult population (16.8%).

- American Indians and Alaska Natives are 60% more likely to be obese than non-Hispanic Whites.

Racial and ethnic populations experience greater health disparities and poorer health outcomes related to, not only chronic disease measures, but also to social and economic indicators that impact people, and where they live, learn, work and play. It is the combination of these social and cultural factors, norms, beliefs, patterns and processes that influence the life of an individual or community. Working with communities that address risk factors for disease along with health inequities is critical if we are to have individuals and communities in good health versus the alternative of chronic disease and poor health.

Introduction and Review of the Tool

Purpose

As public health professionals working to improve health and health outcomes, we must be cognizant of delivering existing programs and health initiatives in an inclusive and equitable way. You may think this is intuitive; however, data has shown that implicit bias and the lens through which we view our populations and communities related to economic diversity are often viewed from perspectives that represent the dominant culture. As change agents, we must consider the following to ensure success of our programming efforts to improve racial equity in our institutions of service and to improve population health.

Assumptions

The tool is built on the following assumptions:

Everyday practices and policies are influenced by implicit biases (e.g., recruitment practices that limit the diversity of the applicant pool; mentors who do not reflect the diversity within entry level staff, thereby limiting promotional opportunities).

- Inequities in existing internal policies and practices can contribute to inequities at the community level.

- Many spoken and unspoken practices/policies/decision points in our work are "hiding." Our job as gatekeepers is to expose them and name them.

- There are "Choice Points" (or Decision Points) to guide in eliminating or diminishing inequity and promoting EQUITY.

- Cumulative impact of small choices can have as great an impact as big decisions.

- Focusing on equity requires that we ask different questions. Instead of…"*What individual behaviors make people obese?*" ask "*What social and environmental factors put people in environments that promote obesity?*"

- While we strive for evidence-based practices, sometimes practice-based successes are valid promising practices.

Use

The Institutional Racial Equity Review Tool will guide the user through a process to identify internal policies and practices that impact public health operations, projects, and decisions—all of these influence how **institutional racial equity** is expressed in the workplace. The Tool will help in assessing the potential impacts of institutional policies and procedures on equity.

Specifically, you will be guided to:

- Assess the potential impact on staff, communities, and populations before making decisions. Taking advantage of decision points—places in the process of planning and implementing policies or procedures where outcomes can be impacted.

- Better understand the varied and potentially disparate impacts of existing policies and new proposals as they affect people who have traditionally been overlooked.

- Build in decision-making guides that evoke consideration of equity in policy, program development, budgeting, planning and decision making giving distinct, specific and sufficient attention to key disparities/inequities.

- Systematically analyze potential impacts on identified vulnerable groups.

- Identify ways to modify proposed policies or procedures to ensure they will diminish or eliminate institutional inequities, not make them worse.

- Foster active engagement and empowerment of your stakeholders both internally and with community partners.

The Review Tool consists of a series of worksheets to be done in succession. Information from the previously completed sheet will be needed as you move forward through the tool. They are intended to focus where decisions have the potential to either negatively or positively impact priority populations. Follow the directions on each worksheet to develop and refine the proposal.

The **Institutional Racial Equity Tool** is just one example of guided strategic steps to evaluate and change current institutional policies and practices in the service of moving toward racial and **institutional racial equity**. We hope the tool will help those who use it to become more informed, expert, empathetic, and committed to racial equity in the workplace — and beyond.

Change will be incremental; however, we believe that intentional, thoughtful, progressive changes toward equity that happen in our social, economic, educational, and government institutions will lay down healthy, and hopefully permanent, blueprints toward racial equity.

Practical Example for the Assessment Tool

The following tool is designed to help organizations and agencies address institutional racism by reexamining current policies, practices and infrastructures in order to optimize opportunities to eliminate health disparities and health inequities, and create a culture of institutional equity.

Your agency will need to hire public health professionals with: expertise in health education, experience working with culturally and socially diverse populations and, knowledge of the impact of culture, behaviors, attitudes and values of those most affected by certain chronic diseases in order to implement many of the activities outlined in the aforementioned funding requirements.

The Health Equity Council hopes the Racial Equity Impact Assessment Tool is useful to plan and implement policies that promote racial equity in public health institutions.

In the worksheets that will follow, we have already provided an example for you. Please fill in the worksheets similarly using the following question as a guide for an advanced case study.

*What strategies can be employed to ensure **institutional racial equity** in the hiring process?*

Worksheet A: Overview

Function: The purpose of Worksheet A is to assess if the policy or procedure is written and implemented in a way that is inclusive and allows for diversity.

What is the internal policy, practice, or project to assess for racial equity?	Current Status	Intended Outcome of Policy, Practice, Project Implementation	Metrics
Example 1: Assess diversity of staff in the areas of Recruiting/Hiring/ Retention/Mentoring/ Promotion Practices.	Staff does not reflect the racial and ethnic makeup of the state. Non-white staff make up most of the support and entry-level staff plus white staff are reflected at all levels (See Diversity Report).	Increase racial diversity of state department staff to fill both horizontal and vertical positions throughout the organization in order to reflect the racial and ethnic makeup of the state's population	• Use Data from the American Community Survey, https://www. census.gov/programs-surveys/ acs/. The Bureau of Labor and Statistics — and/ or check with your agency's Human Resources Department to obtain information about the # of people in protected classes for representation in the different job codes. • State Agency Affirmative Action Data (where available) — If sudden shifts in representation in hiring, disciplinary action or terminations with underrepresented groups are identified, determine patterns of bias and discrimination. • Provide opportunities and monitor hiring managers participation in professional development sessions about hiring strategies for a diverse workforce. • Baseline: racial diversity should increase by 5% annually with the goal of a 20% increase over the course of 5 years. Note: Consider adding the 5% increase to the annual objectives and/or the 20% increase as a goal in your 5 year strategic plan.

Worksheet B. Determine Decision Point(s) and Feasibility of Interventions

Function: The goal for Worksheet B is to apply the results of Worksheet A to determine if and where there are opportunities/decision points to ensure the policy or procedure is inclusive and promotes diversity.

Decision Point — a place in the process of planning and implementing policies or procedures where outcomes can be impacted.

Feasibility — capable of being accomplished.

Consider the following when determining the feasibility of a proposal:

1. Provide sufficient resources — both staff and money
2. Identify and secure internal leadership support
3. Consider external political climate
4. Ensure groups who will be impacted by the proposal have been involved throughout the process
5. Actively prepare and consider timing – what needs to happen in advance to be ready for the proposal
6. Implement a sustainable plan
7. Other — include areas that may be unique to your agency

Decision Point (Current Practice)	New Outcome (Resulting From Decision Point)	Action(s)/Change(s)	Risk	Mitigation	Feasibility
Rigid education requirements per classification level (i.e., health educators need a bachelor's degree)	A more robust pool of potential applicants that include people with appropriate years of experience but may not meet previous educational requirements.	• Review/change educational requirements on new position descriptions, where appropriate. • Change educational requirements/classification at the human resource level of the organization. • Train interview panel to choose members who understand importance of institutional equity/diversity/reasons applicants with experience who may not meet the traditional educational criteria • Require that interview questions for all applicants assess health equity and social justice aptitude of applicant. • Experience should be considered as thoroughly as those who meet the educational requirements. • Promote/market the position to outlets/organizations that serve or reach a wider range of applicants.	• Supervisors put issue on back burner • Push back and resentment from Human Resource about their current hiring practices; not aware (or resistant) that current system does not promote 'equal opportunity'; not wanting to admit or see that system can be better.	• Create Deadlines • Meet with Division Director • Meet with Division Director and Human Resource Director and bring success stories from other state health departments and how these changes may support the equity portion of the accreditation process. • Meet with each managers across the division to explain benefits of the proposed revisions • Integrate the benefits of a diverse workforce with exciting lunch and learns, and other educational activities.	Important: If strategic partnering is taking place across the department there is more likelihood of success

Worksheet C: Equity Plan for Priority Actions/Changes

Equity Plan for Prioritizing Actions Work Plan

Function: The goal of Worksheet C is to apply information from Worksheets A and B to identify action steps to modify the policy or procedure and implement new steps to ensure diversity and inclusion.

Project Name: Equity in Hiring (Example)

Objective: Revise the educational requirement of the Public Health Consultant (PHC) 9-11 classification from "at least possessing a Master of Public Health degree with 0 years of experience" to one of the following options:

- **Option 1**—Bachelor's degree with 3-5 years of public health experience;
- **Option 2**—Bachelor's degree in an appropriate field and two years of relevant experience; or an associate degree and four years of relevant experience.
- **Option 3**—Master's degree recommended/preferred but not required.

Activity	Person(s) Responsible	Due Date	Notes	Complete?
Assess current roles and responsibilities on PHC position descriptions to understand if any roles/responsibilities could only be completed by a person with a Master's of Public Health degree.	Jane Doe, Manager	March 2016	Position can be done by person with Bachelor degree + 5 years of experience.	Yes
Include the new education/ experience requirement on contractor position descriptions as well as the State Human Resources system.	Jane Doe, Manager John Doe, Senior Public Health Consultant	May 2016	Email Joe Elk, Human Resource Director, to set appointment to discuss education/ classification equirements.	No
Meet with State Human Resources Department to discuss the feasibility of changing the requirement for civil service positions. Bring success stories or data from other states or organizations.	Jessica Buck, Division Manager Jane Doe, Manager John Doe, Senior Public Health Consultant	June 2016	Meeting set for June 16 @ 10am.	No

Equity Crosscheck: A checklist or form based on the **R4P**[4]—a model that assesses if staff work plans addressed certain areas to reduce inequity: **R**epair historical risk; **R**emediation to reduce vulnerability and unequal consequences; **R**estructure to stop new production of risk; **R**emove racism, power imbalances, and socioeconomic status (SES) inequities; Provide culturally responsive health education, health care, and supports to help sustain healthy behaviors.

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4 Practices to Reduce Infant Mortality through Equity: A Guide for Public Health Professionals, Michigan Department of Health and Human Services, Bureau of Family, Maternal and Child Health, page 149

Equity Crosscheck

Vetting our plan with an Equity Crosscheck is the next step. Use the Crosschecks to determine the accuracy of your plan by checking it against various other sources. Answer the following questions to determine if you have accurately included equity strategies in your action plans. Next, share your plan and these crosschecks with people inside or outside of your organization who are knowledgeable when it comes to health equity, racial equity, and institutional racism and who can help you identify gaps and more strategies to round out your plan for success.

Crosscheck Question:	Answer Here:
Does our plan assess/address processes and structures in our work that exclude disparate populations? How?	
Does our plan explicitly identify and address how current policies, procedure, and/or practices disadvantage and limit access to disparate populations through institutional racism? How?	
Will institutional policies, procedures, and/or practices be reworked to minimize risk to disparate populations? How?	
Will our new plan result in culturally and linguistically responsive policies, procedures, practices and programs? How?	
How will our implementation of the new plan and activities be monitored/evaluated to assure fidelity through an equity lens?	
Who are partners, internal and/or external, who can help us plan, implement, and evaluate our fidelity through an equity lens?	
Are actions/strategies identified in our new plan reflective of some of the recommended strategies found in (resource)? Which ones?	

+ Key Informant Check: Once the worksheets are complete, the work plan would be sent to 'key informants' or equity experts—those who understand health equity in the department, such as the Office of Minority Health, Health Equity Steering Committee, or staff who are exceptionally informed and understand health equity. They could serve as a check and balance to give input on the work plans if anything needs to be changed or if other equity strategies could be added.

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Definitions

Choice/Decision Points

Choice points are decision making points that influence outcomes. It is the latest moment at which a predetermined course of action is, or must be, initiated.

(Source: http://grenetwork.org/wp/wp-content/uploads/2014/04/An-Introduction-to-Racial-Equity-Assessment-Tools.pdf and http://www.businessdictionary.com/definition/decision-point.html)

Ethnicity

An *ethnic group* or *ethnicity* is a category of people who identify with each other based on common language, ancestral, social, cultural, or national experiences. Unlike most other social groups, ethnicity is primarily an inherited status.

(Source: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml)

Health Disparities

The "[statistical] difference in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States." United States Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, (Washington, DC: Department of Health and Human Services, April 2011)

(Source: http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf)

Health Equity

Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

(Source: http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_05_Section1.pdf)

Health Inequity

Health Inequities are a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair.

(Source: http://www.cdc.gov/nccdphp/dch/pdfs/health-equity-guide/Health-Equity-Guide-intro.pdf)

Health Outcomes

The changes in current or future health status of individuals or groups of persons that are attributable to previously provided medical care. Health outcomes include mortality and morbidity (e.g., following surgery), physical, mental and social functioning, costs of care, and quality of life.

(Source: http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/hcqgloss/hcqgloss.pdf)

Hiring Manager

The hiring manager is an employee who requested a new position to be filled or an employee to fill an open job. The hiring manager is the employee to whom the new employee will report when hired. The hiring manager is a key member of your employee recruitment team.

(Source: http://humanresources.about.com/od/glossaryh/g/hiring-manager.htm)

Institutionalized Racism

A structure of policies, practices and norms embedded in government and organizational systems that results in unequal access based on race to education, opportunities, power, and influence, which perpetuates an inherited disadvantage to population groups.

National Culturally and Linguistically Appropriate Services (CLAS) Standards

A comprehensive series of guidelines that inform, guide and facilitate practices related to culturally and linguistically appropriate health services.

(Source: https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf)

Priority Populations

Priority populations are groups whose members experience poorer health outcomes than the general population due to such factors as race/ethnicity, income, education, disability, age, marital status, sexual orientation and gender identify, and employment. Members of groups do not choose to be referred to as disparate, target, or vulnerable populations. Such references overlook the fact that communities have strengths and assets. Particular attention to groups that have experienced major obstacles to health associated with socio-economic disadvantages and historical and contemporary injustices.

Race

An unscientific, societally constructed taxonomy that is based on an ideology that views some human population groups as inherently superior to others on the basis of external physical characteristics or geographic origin.

(Source: http://www.ncbi.nlm.nih.gov/pubmed/8303011/)

Racism

Racism is a belief that race accounts for differences in human character or ability and that a particular race is superior to others. Discrimination or prejudice can be based on race.

(Source: http://racerelations.about.com/od/understandingrac1/a/WhatIsRacism.htm)

Redlining

Redlining is the practice of denying or limiting financial services to certain neighborhoods based on racial or ethnic composition without regard to the residents' qualifications or creditworthiness. The term "redlining" refers to the practice of using a red line on a map to delineate the area where financial institutions would not invest.

(Source: http://www.bostonfairhousing.org/timeline/1934-1968-FHA-Redlining.html)

Social Determinants of Health

Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

(Source: http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health)

Stakeholder

A stakeholder is anybody who can affect or is affected by an organization, strategy or project. They can be internal or external and they can be at senior, junior or any level within an organization.

(Source: http://www.stakeholdermap.com/stakeholder-definition.html)