



CITY OF MILWAUKEE
HEALTH DEPARTMENT

2020 ANTI-RACISM PLAN

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WHAT IS GOING ON IN PEOPLE'S LIVES?

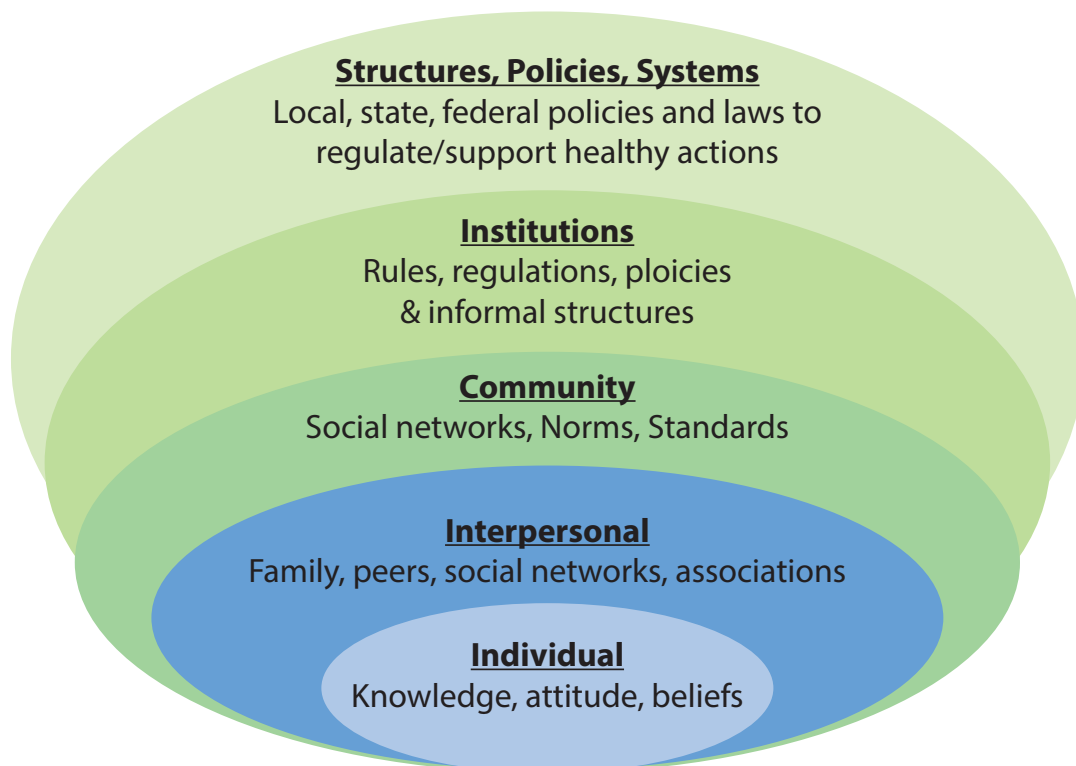
The relationship between socioeconomic determinants of health (the conditions that contribute to health, e.g. economic stability; neighborhood and built environment; education, etc.) and health outcomes is one of the most robust and well-documented findings in social science (Marmot & Wilkinson, 2006). The social determinants of health demonstrate that not all communities have equal opportunity for health and wellness. The majority of the diversity for the State of Wisconsin is concentrated in the Southeastern region that includes Milwaukee proper. Across our lifecycles, there are multiple times and ways in which we are primed to look around us — for advice, for products, for a hand — before we make a decision that affects our well-being. Some of the structural determinants include systems of healthcare, education, economics, social and community context.

Social networks. The individual has direct contact and can easily be influenced by i.e. family and peers.

Living and Working Conditions. Living and working conditions are indicators of health. The major indicators of health include education, employment status, educational attainment, rental occupancy, car ownership, home ownership, median income and female headed-households.

Macro-level Conditions and Policies. Macro-level conditions and policies are broad social, economic, cultural, health and environmental conditions and policies at global, national, state and local levels.

Levels of Influence in the Social Ecological Model



The Milwaukee Health Department (MHD) has a unique role in responding to needs at the community level. We have direct links to community partners, stakeholders, and residents. We have connections to data and research. MHD can better develop and support community-academic research partnerships, translate health interventions for dissemination for community leaders, and directly teach and create policy to better impact community health.

Demographic Overview of County/City Milwaukee, WI

- Population: 946k/ 592k -- 3926/sq. mi.
- Gender: 52% female 48% male (same)
- Age in years: <18, 24/26%, >65, 14/10%
- Race/ethnicity
 - o White 51/45%, Black 27/39%, Latinx 15/19%, Asian 5/4%
- Disability 9/10%
- Uninsured 8/11%
- Poverty 19/27%
- Median income \$49/40k, 2014-2018

According to the 2018 United Way ALICE Report for Milwaukee County Demographics

- Milwaukee has a population: 948,201
- Number of Households: 384,201
- Median Household Income: \$49,636 (state average: \$60,773)
- Unemployment Rate: 4.5% (state average: 3.2%)
- ALICE Households: 26.0% (state average: 23.0%)
- Households in Poverty: 18.0% (state 11.0%)

TIME FRAME	Organizational Infrastructure and workforce capacity	Internal practices and process	Policy and legislative change	Community alliance building
MHD VISION	Capacity-building and Leadership Development	Targeted Resource Development and Financial Innovation	Equitable Policies & Systems	Coordinated Social Action
FIRST YEAR GOALS	Build innovative institutional capacity	Ensuring access to essential resources	Foster political will and empowerment	Inclusive information exchange
	Draw upon best practices of social enterprise movement	Increase social cohesion	Take social action to next level	Expanding social networks
		Build health community infrastructures	Change rules	Vibrant and bi-directional information exchange
		Change rules	Platform for joint action	Community change projects by community leadership and diverse stakeholders
			Level playing field	

A FRAMEWORK FOR IMPROVING HEALTH OUTCOME FOR CHILDREN AND ADULTS

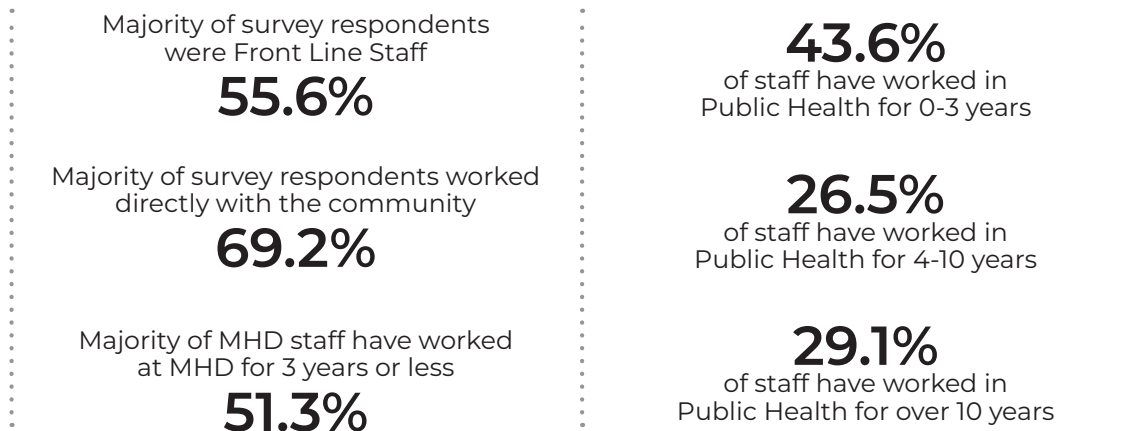
Racism and other forms of discrimination; living in poverty; low educational attainment; poor access to public transit; little to no quality, affordable childcare; an incarcerated family member; or the inability to obtain affordable housing in a safe neighborhood are all examples of social conditions that increase stress levels in adults and children. However, because these are not one-time events, but actual living conditions, they lead to chronic stress (also referred to as “toxic stress”) (astho.org/Health-Equity/Documents/Foundational-Practices-for-Health-Equity). Because the social, political, and economic consequences are very real, together compound its bodily effects also known as weathering. The concept of the “weathering hypothesis,” is whereby the body exhibits consequences of and responses to chronic exposure to social, economic and political exclusion arising from racial discrimination (societyandhealth.wordpress.com/tag/weathering-hypothesis). Hence, systematic racism are public policies, institutional practices, cultural representations, etc. that perpetuate inequities across racial groups.

MILWAUKEE GOVERNMENT ALLIANCE ON RACIAL EQUITY (GARE) WORK GROUP

The MHD Government Alliance on Racial Equity (GARE) group created the Health Equity Survey in order to (1) learn from staff experience dealing with inequities; (2) hear what concepts interest staff so that MHD can develop trainings tailored to staff needs; and (3) use staff knowledge and experiences to better gauge how MHD can integrate the concept of health equity into daily work to deliver the best services to the residents of Milwaukee. By identifying strengths and areas for improvement in these three areas, the MHD can better assess overall capacity for addressing the root causes of health inequities from the perspectives of staff.

The survey was based on the BARHII survey, with elements specifically chosen by GARE group members. The electronic survey was issued by the MHD HR department, and responses were recorded from January 23, 2020 to February 24, 2020. One hundred and seventeen total MHD staff responded to the survey.

BRIEF DATA SUMMARY





Please select the categories that you think are the most important environmental, social, economic conditions that impact health for residents of the City of Milwaukee. These categories are known as the social determinants of health. These are not mutually exclusive numbers, they are “check all that apply.”

CATEGORY	FREQUENCY	PERCENTAGE
Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.	95	81.2%
Education – low education levels are linked with poor health, more stress and lower self-confidence.	98	83.8%
Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions.	86	73.5%
Social support networks – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.	79	67.5%
Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behavior and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life’s stresses and challenges all affect health.	37	31.6%
Health services - access and use of services that prevent and treat disease influences health	81	69.2%
Gender - Men and women suffer from different types of diseases at different ages.	34	29.1%

A recent publication in the American Journal of Public Health reviewed the state of the US Governmental Public Health Workforce from 2014 - 2017 (doi.org/10.2105/AJPH.2019.305011). The findings of this workforce review suggests there are inherent challenges of developing a public health workforce to meet population health needs. These challenges are often complex and nuanced. Collectively, studies over the past 10 years have summarized workforce changes resulting from recession-related budget cuts, identified education and training deficiencies, and projected workforce turnover.

The lack of investment in public health is a primary barrier for addressing governmental public health workforce changes. One way that MHD Leadership can focus on developing comprehensive strategies that address workforce size and composition, training, recruitment and retention, effectiveness, and expected competencies in public health practice is by improving our onboarding processes.

MHD strongly believes an independent equality or human rights body can aid in monitoring and assist in addressing issues regarding race, class, gender, sexual identity and power. MHD will work with The City of Milwaukee Equal Rights Commission to ensure accountability and technical assistance for the implementation of this Anti-Racism Plan.

MHD honors the language and conceptual framework put forth by the CommunityWise Resource Center, Anti-Racist Organization Change: Resources & Tools for Nonprofits (coco-net.org/an-anti-racist-organizational-change-tool-for-nonprofits). Like the CommunityWise Resource Center, MHD recognizes that race is a social construct, the MHD describes people as a “racialized person” or “racialized group” instead of the more outdated and inaccurate terms “racial minority;” “visible minority;” “person of color” or “non-White”.

In alignment with CommunityWise, we decided to approach our anti-racist organizational change project as an emergent process. There was a lot we needed to learn and a lot of people we needed to listen to. Because of this, our end result was not predictable when we started. You don’t know exactly how an emergent process will unfold. You also don’t know the specific outcomes that will help move anti-racism forward. When a process is emergent, expectations and outcomes change along the way.

DIVERGENT / CONVERGENT *(as defined by CommunityWise)*

An emergent process follows a pattern of divergent and convergent phases. The divergent phase is where we discover insight into a problem, and define the area to focus on. The convergent phase is when we come together to work on potential solutions.

PROCESS AND PEOPLE *(as defined by CommunityWise)*

Any anti-racism process needs to center and be led by those most impacted by racism— racialized and Indigenous folks. And any organizational change process needs to involve all of the people who are necessarily part of the change— those who make it happen and are impacted by it. A strong process involves a lot of listening, learning, inquiry, and exploration. At a certain point, it became obvious that we had specific things to work on, and then we started converging and making that work happen. Emergent processes require a developmental evaluation approach and tools. These can include observation by an external evaluator, surveys, and reflection exercises that allow for continuous feedback and learning. An openness to evaluating both successes and failures, and a commitment to applying ‘lessons learned’ are essential to building accountability into the change process.

VISION, MISSION & VALUES

Vision: Living your best life, Milwaukee

Mission: Advance the health and equity of Milwaukeean through science, innovation, and leadership

Values:

- **Innovation** We believe in nurturing creativity and new ideas that challenge us to do our everyday work better.
- **Equity** We acknowledge historic and current injustices in our community and strive to cultivate an environment where everyone in our community has equal opportunity to be healthy.
- **Collaboration** We convene community members, partners, and elected officials to meet the needs of our community.
- **Courage** We take strategic risk and bold initiative to advocate for and prioritize the needs of our community.
- **Accountability** We act with transparency and integrity to advance the health of Milwaukee.
- **Quality** We continuously improve and adapt to create sustainable and positive health outcomes.

2019-2020 HIGHLIGHTS

- Government Alliance on Race and Equity (GARE)
- Leadership team complete
- Birth Outcomes Made Better (BOMB) Doula Program kick off
- Coalition on Lead Emergency (COLE) Lead Safe Kits
- Expansion of Sexual Transmitted Infections/Human Immunodeficiency Virus (STI/HIV) Clinic at Southside Health Center (SSHC)
- Electronic Health Record
- COVID-19 response

ANTI-RACISM PLAN TOWARD ACHIEVING HEALTH EQUITY

ORGANIZATIONAL INFRASTRUCTURE AND WORKFORCE CAPACITY

Department-wide initiatives

- Create annual anti-racism report

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ANTI-RACISM PLAN

Anti-racism efforts will be at the very foundation of

Capacity-building & Leadership Development

Targeted Resource Development and Financial Innovation

Equitable Policies & Systems

Coordinated Social Action

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INTERNAL PRACTICES AND PROCESSES

Department-wide initiatives

- Develop series of anti-racism town halls and listening sessions
- Develop a comprehensive mentoring pathway

Individual initiatives

- Create anti-racism section with resources and tools on website
- Partner with and support community organizations that have taken actions against racism

POLICY AND LEGISLATIVE CHANGE

Department-wide initiatives

- Develop manager guides and tool kits including template for listening sessions
- Create an anti-racist learning environment that embraces racism as a social determinant of health by enhancing curricula and racism mitigation, and fostering diversity, inclusion and equity
- Evaluate and review our efforts regularly

Individual initiatives

- With the University, provide grant funding for Ohio State research on racism as a public health crisis

COMMUNITY ALLIANCE BUILDING

Department-wide initiatives

- Conduct institutional review of all anti-discrimination policies, protocol and reporting

MHD ANTI-RACISM PLAN: CALL TO ACTION

Equity and Inclusion

- A statement documenting departmental commitment to advancing and achieving racial equity, including:
 - Roles and responsibilities at all levels of the department
 - Processes used to collect data and measure success
- A commitment to engaging key community stakeholders and using their feedback to set departmental priorities and goals
- An open-ended discussion relative to how you will use your leadership role in city government to uplift, empower, and protect black and brown lives

Diverse Workforce Demographics

- Current workforce and annual reports on new hires, promotions, and separations
- Departmental efforts to increase staff diversity and recruitment and retention efforts
- Departmental efforts to advance diversity in managerial and leadership roles
- Departmental efforts related to orientation and onboarding with a focus on racial equity and inclusion
- Managerial efforts and practices that support and expect work environments that are equitable, inclusive, and fair

Accountability

- Departmental framework for establishing policy and decision making through an equity lens
- Initiatives and strategies to provide culturally responsive service delivery
- Departmental metrics to track disparate racial impact in resident service utilization and allocation of resources
- Assessment of administrative requirements related to policies, programs, practices, fees, applications, hours of operation, licenses or fees that represent barriers to achieving equity and inclusion and plans for eliminating the aforementioned barriers
- Strategies and opportunities for engaging community stakeholders on a regular basis and for allowing on-going and continuous community feedback
- Efforts to incorporate equity goals in budget preparation and allocation

We proposed a three-step process: (1) presentation of racial equity 101 training; (2) Development of a racial equity framework within MHD (organizational values, structure, strategic plan; professional development); (3) Creation of safe spaces and a welcoming, inclusive organization.

Next Steps: The GARE Workgroup's plans include: (1) establishment of a page for resources for members; (2) implementation of an equity-focused assessment of MHD policies, procedures, and association culture to identify areas for improvement; (3) discussion of core competencies; and (4) development of pipeline of diverse candidates for the MHD. In taking these necessary steps to identify and dismantle barriers to achieving health and racial equity, MHD could serve as a model for other City Departments to recognize racism as a public health crisis.

Organizational change is long-term work, and it is internal work. It is different from programming and it can be difficult to measure progress. There is no end point, especially with anti-racism work. Tackling structural barriers is both a process and an outcome.

ONBOARDING PROCESSES IN MHD - SUMMARY

Purpose:

To determine departmental efforts related to orientation and onboarding with a focus on racial equity and inclusion & Managerial efforts and practices that support and expect work environments that are equitable, inclusive, and fair.

Policy, Innovation & Engagement (PIE) Branch

- Review of Key Publications:
 - CHIP (MKE Elevate) – focus on Inclusive & Fair Society/Eliminate Racism
 - Blueprint for Peace
 - The Curb-Cut Effect – how some policies that are meant to make life easier for a targeted population actually benefit the community/society as a whole. Example: curb cuts were created in sidewalks to help individuals who use wheelchairs have more access within a community, but ended up helping everyone – bicyclists, parents pushing strollers, people using caddies for deliveries, etc.
 - Public Health 3.0 – eliminate silos in local public health to focus on the social determinants of health to advance health equity

Environmental Health Branch

- Cultural Competency
 - Diversity and Cultural Competency in Public Health online training
 - Managing Diversity online training
- Inspection of all Foods
 - Food inspectors' training includes training on Hispanic and Specialty Meat items and Ethnic Foods inspection
- Public Health Nurses in Home Environmental Health
 - Adverse Childhood Events training (ACEs)
 - Trauma Informed Care training

Community Health Branch

- Introduction to Public Health online training
- Trauma-informed care online training
- Ethics and boundaries training
- Adverse Childhood Events training (ACEs)
- Poverty Awareness Community Engagement (PACE) training

Recommendations

- Standardize Racial Equity and Inclusion Training across MHD
- Build on mentorship program evident within Environmental Health branch

KEY WORDS AND IDEAS

ANTI-RACISM

Anti-Racism is the active, on-going process of dismantling systems of racial inequity and creating new systems of racial equity. Anti-racism demands that this work be done at the individual, organizational/institutional, and cultural levels in order to effectively address systemic racism. Anti-racism is an approach, not an end-point, and thus provides a useful frame for an organizational change process.

ANTI-RACIST ORGANIZATIONAL CHANGE

Anti-racist organizational change is about making organizational changes in a way that intentionally addresses structural racism and creates greater diversity, inclusion, and equity.

CAUCUSING

Anti-racism acknowledges that our experiences do not occur in a neutral context. Those who identify as racialized or Indigenous experience racism differently than those who do not. Separating into groups based on this distinction—a process called “racial caucusing”—is a strategy that allows people to talk about shared experiences. The strategy is not designed to create division but to make the whole group more effective, i.e. “When the two groups come back together as a team they are better able to understand, confront, and dismantle racism within the team itself and within the institutional setting.”

HEALTH DISPARITY

A difference in health between groups of people. By itself, disparity does not address the chain of events that produces it.

HEALTH EQUITY

A fair, just distribution of the social resources and social opportunities needed to achieve well-being. An environment where everyone has a fair and just opportunity to be healthy.

HEALTH INEQUITY

Differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.



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milwaukee.gov/health