Focused Equity Investments

Oregon is requesting a federal investment to support closing health equity gaps for Oregon Health Plan (OHP) members across the state. While Oregon's commitment to slowing statewide health care cost growth has saved significant federal funds across markets and improved quality, the health outcomes have varied based on race and ethnicity. Moreover, improvements have not adequately addressed health inequities resulting from long-standing systemic racism and oppression. Accordingly, as part of our federal-state partnership, Oregon requests CMS provide an upfront federal investment in community-driven initiatives focused on eliminating health inequities among OHP members. Oregon anticipates that community-driven investments will improve the health of those most harmed by health inequities,[1] as well as address upstream social determinants of health. Both of these improvements will result in downstream cost savings for the state and federal government.

Oregon further requests that coordinated care organization (CCO) spending to address health inequities be counted as medical claims or quality improvement expenses within the value-based global budget for purposes of rate setting, budgeting, and the medical loss ratio (MLR). This request was directed by the Oregon State Legislature (HB 3353)[2] in July 2021. (See *Value-based Global Budget* concept paper for further information on this request.)

1. A new federal investment focused on improving health equity, including investments to build infrastructure to support health equity interventions; support community-led health equity interventions and statewide initiatives; grant community-led collaboratives resources to invest in health equity.

In order to implement this federal investment, **Oregon requests the following spending authorities:**

2. Expenditure authority to draw down federal match on Medicaid funds spent to address Social Determinants of Health (SDOH) for OHP members experiencing specified life transitions or disruptions as described in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper.
3. Authority to count CCO investments in health equity required by HB 3353 and as described in the in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper as medical claims or quality improvement spending for purposes of CCO rate setting.

For full proposed strategies, please see page 8.

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[1] Populations and communities who have been most harmed by historic and contemporary injustices and health inequities include but are not limited to Tribal Nations and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.

[2] https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3353/Enrolled

Problem and background

Health inequity

It is widely accepted that health is largely determined not by the medical care people receive but by social determinants of health, including factors such as built environment and housing, access to healthy food and green spaces, job opportunities and income.[3] People of color and those living with fewer financial resources are more likely to be exposed to unsafe neighborhoods, substandard housing, lack of transportation, the criminal justice system, and low-quality schools, which means they are more likely to experience worse health outcomes, and shorter lifespans.

Oregon's health equity definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Despite increased access to health coverage and care throughout Oregon, health inequities persist because systems and institutions have been created to benefit a select group of people over time. Health inequities are traceable to inequitable access to power, resources, opportunities and decision-making resulting from long-standing, generations-old racism and oppression, social injustice, bigotry, bias, discrimination and colonization. Communities of color and Tribal communities have experienced chronic underinvestment, resulting in increasingly damaging social determinants of health and worse health outcomes than their white counterparts. These inequities also result in financial burden. An estimated 31% of medical care expenditures result from health inequities caused by systemic racism and oppression.[4] The 2018 Oregon State Health Assessment[5] found the following inequities regarding social determinants of health:

Poverty and food insecurity

- Almost all racial and ethnic groups in Oregon experience higher levels of poverty than in the United States as a whole, particularly people who identify as African American.
- Oregon ranks 44th in the country in food insecurity. Food insecurity is highest in rural communities, communities of color, households with children, and among renters.

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[3] Magnan, S. (2017). Social Determinants of Health 101 for Health Care: Five Plus Five. National Academy of Medicine. Available at: https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/
[4] https://journals.sagepub.com/doi/pdf/10.2190/HS.41.2.c
[5] https://www.oregon.gov/oha/PH/ABOUT/Documents/sha/state-health-assessment-full-report.pdf

Housing and homelessness

- One-third of all African American households spend more than 50% of their income on housing costs, compared to 17% of all households in the state.
- Just 32% of African American people in Oregon's most populous county owned homes in 2010, compared to 60% of white people in the county.
- With the exception of people who identify as Asian, people of color experience homelessness at a disproportionate rate compared to their white counterparts.

Incarceration

- In Oregon, people of color are more likely to be incarcerated than white people:
  - African Americans are 4.6 times more likely
  - Native Americans are 1.8 times more likely
  - Latino/a/x people are 1.4 times more likely

COVID-19

The COVID-19 pandemic underscores the persistence of health inequity in Oregon and serves as a wake-up call to the severity of the gaps.

- Hispanic Oregonians comprise only 12% of the population but represent more than 18% of COVID-19 cases. [6]
- Black Oregonians are 3.1 times more likely to have a COVID-19 associated hospitalization than their white counterparts. [6]

Legislatively required health equity investments

In July 2021, the Oregon Legislature passed HB 3353 (see Appendix A), which requires CCOs to:

- spend at least 3% of their global budget on programs and services that improve health equity, *and*
- be more accountable to community.

To support the intent of this directive, under this 1115(a) demonstration waiver renewal OHA will propose that CCOs allocate at least 1/3 of these funds (at least 33% of the 3%) to be directly administered by new community investment collaboratives. Importantly, this proposal was co-created with Oregon Regional Health Equity Coalitions (RHECs) through a unique community-driven process, as described below. Further, the legislation requires OHA to seek CMS approval that 3% of the CCO value-based global budgets be directed to improving health inequities, and that such spending be counted as medical and quality improvement expenditures for the purposes of rate setting (for more, please see *Value-based Global Budget* concept paper).

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[6] OHA Weekly COVID-19 Report, September 29, 2021.
https://www.oregon.gov/oha/covid19/Documents/DataReports/Weekly-Data-COVID-19-Report.pdf

Community voice in CCO decision-making

A core element of Oregon's CCO model has been to build community voice into CCO decision-making, which Oregon hopes to expand through community-led partnerships that will focus on populations and communities who have been most harmed by historic and contemporary injustices and health inequities.

> *"And who better to say what's needed in the community* ***than the community?"***
>
> *-OHA Strategic Plan community input*

Regional health equity coalitions

In 2011, RHECs came to OHA with a proposal for the 1115(a) demonstration waiver renewal, and subsequently worked closely with the Oregon legislature to inform the design of HB 3353. Subsequently, OHA and RHEC leadership worked closely together to build out the intent of HB 3353 and increase accountability to community by emphasizing community role in identifying inequities and making investment decisions to address inequities.

RHECs, which reach anywhere from 300-500 organizations, are leaders in empowering diverse groups to become involved in developing unique, culturally responsive and sustainable solutions to pervasive issues of inequity that impact the health and wellbeing of people in Oregon. A key part of their work includes helping diverse communities build their capacity to work with decision-makers, CCOs, and other health systems to address systemic inequities at the policy, system and environment change level that are barriers to communities achieving their full health potential.

The OHA/RHEC workgroup met 12 times between May and July 2021 to develop strategies to develop a model for shifting power and resources to community. Recognizing that the process can be as important as the outcome, the work involved relationship and trust building, particularly to build increased trust between community organizations and government, naming some of the values we hold in conducting work together through developing group agreements, sharing needs to successfully accomplish the work together, clarifying roles and scope of work, and agreeing on guiding principles to ensure the model was designed to achieve health equity goals, including investment in racial, cultural, and underserved communities.

Community advisory councils

Since 2012, statute has required each CCO to convene and operate a community advisory council (CAC) to oversee the CCO's community health assessment (CHA) and community health improvement plan (CHP) and to ensure that the health care needs of consumers and community are addressed. At least half of each CAC's membership must be CCO members.

CCOs are also financially encouraged to partner with local, culturally specific organizations and community entities, such as Oregon's Regional Health Equity Coalition (RHECs) (see Appendix A). Under its most recent CCO procurement, Oregon took steps to strengthen CACs' advisory roles and increase community representation and diversity on CACs. However, CACs remain advisory committees to the CCOs, with varying influence on decision-making.

Community investment collaboratives

Now, Oregon will request federal investment in community-led collaboratives that direct health equity investments. Oregon has already laid groundwork to support this strategy: HB 3353 intends to enable communities to direct a portion of Medicaid funds to address health care and social factors that most contribute to health inequities.

In accordance with this legislation, Oregon, in close partnership with the community RHECs, designed a pilot program to create and resource new community investment collaboratives (CICs). These community-led partnerships will focus on populations and communities who have been most harmed by historic and contemporary injustices and health inequities, including but not limited to Oregon's nine federally-recognized tribes and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations, and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.

While addressing root causes of health inequity caused by white supremacy is a relatively new venture for the health care system, RHECs and community-based organizations (CBOs), including social service organizations and culturally specific organizations, have long been mitigating inequities and addressing social determinants of health. As CCOs continue to expand their work to address OHP members' social needs, health equity and community social determinants of health, it is critical that Oregon supports historically underserved CBOs as strong partners and leaders in that effort.

Federal savings

Oregon has been working to contain health care costs in Medicaid and across other markets. Under its 2012 and 2017 demonstration renewals, Oregon committed to reducing the per member per month (PMPM) Medicaid spending growth rate by two percentage points from a projected national average of 5.4% to 3.4%. To date, Oregon has succeeded in meeting this commitment, and containing costs remains a top priority for the state. Oregon has met this target through its innovative health system reform model, CCOs, which are incentivized to maintain high-quality care delivery while slowing the rate of cost growth.

In 2021, Oregon expanded this model, applying a statewide sustainable health care cost growth target to all markets. This target caps annual per-capita health care cost growth across the state to 3.4% for 2021-2025 and 3.0% for 2026-2030. Oregon projects significant savings across markets. Oregon could save $19 billion in Medicaid, Medicare, and commercial health care costs over the next 7 years, as shown in Figure 1.

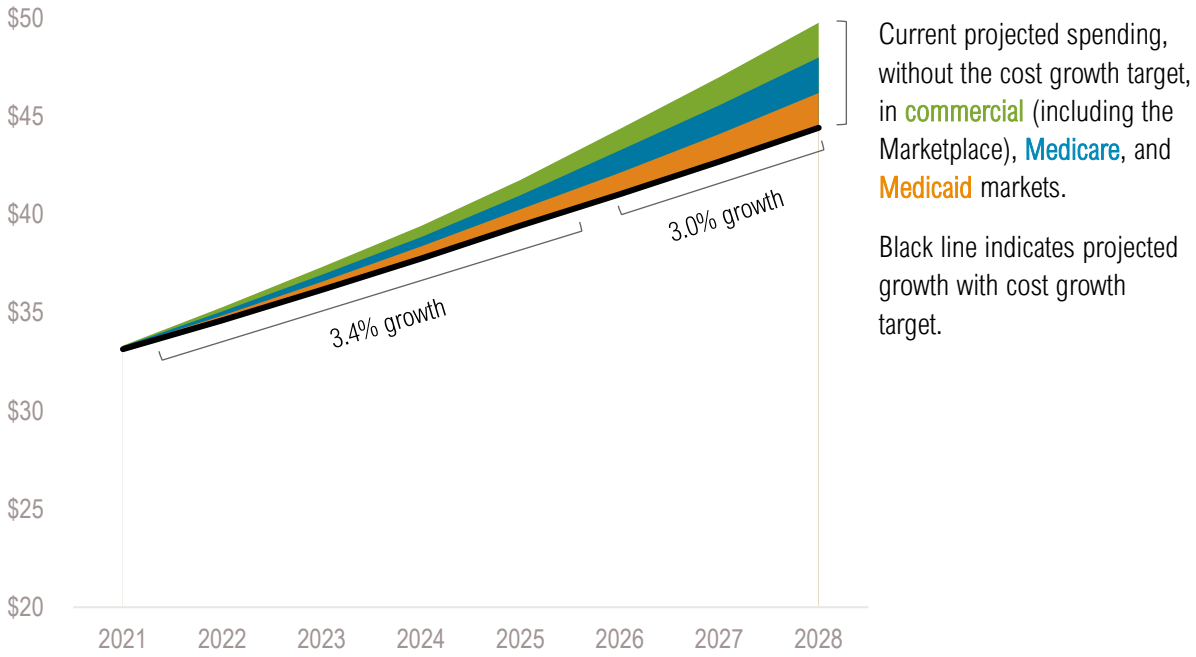
By lowering spending for qualified health plans, this sustainable health care cost growth program may result in lower premiums for commercial carriers, including those in the Marketplace, leading to additional federal savings on Advance Premium Tax Credits.

Finally, Oregon has a relatively high proportion of Medicare enrollees in Medicare Advantage plans – 47% in Oregon as compared to 38% nationally. Because the new spending cap applies to all markets, the federal government can expect to see additional savings among Medicare Advantage plans accruing to the federal government.

Figure 1

Oregon's Cost Growth Target could save $19 billion in Medicaid, Medicare, and commercial health care costs over the next 7 years.[7]

Dollar figures are in billions



Proposed strategies

For Oregon to begin to rectify historical and contemporary injustices that are the root cause of health inequities, we must make new and focused investments outside health care facility walls. These investments must also shift the decision-making power and resources to direct these investments to the communities most harmed by social injustices.

With CMS support, Oregon can increase investments in health equity and support strong models of community governance across the state. Oregon anticipates these investments will improve upstream social determinants of health, resulting in improved health outcomes for those most harmed by systemic racism and social injustice, as well as downstream cost savings for the state and federal government.

Oregon requests new federal investment focused on improving health equity, including funding to:

1. build infrastructure to support health equity interventions
2. support community-led health equity interventions and statewide initiatives
3. grant community-led collaboratives resources to invest in health equity.

In order to implement this federal investment, Oregon requests the following spending authorities:

[7] Data source: CMS National Health Care Expenditures

a. Expenditure authority to draw down federal match on Medicaid funds spent to address Social Determinants of Health (SDOH) for OHP members experiencing specified life transitions or disruptions as described in the in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper.
b. Authority to count CCO investments in health equity required by HB 3353 and as described in the in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper as medical claims or quality improvement spending for purposes of CCO rate setting.

1. Invest federal funds toward infrastructure to support health equity interventions

a. Build capacity for community-led health equity investments

Oregon requests federal investment to support capacity-building among community investment collaboratives (CICs) and enhance their ability to direct and manage large-scale investments.

While Oregon expects CICs to leverage existing organizations and efforts in many communities, the reality is that CBOs are chronically under-resourced when compared with health care organizations. Other states and communities have found it essential to provide capacity building funding and resources to CBOs to partner with health care organizations.[9]

> *"The people who are already doing the work and have been doing the work for so long…* ***There doesn't need to be a new strategic plan.*** *I think it needs to bring everybody to the table who already has plans going on and be like, "Okay, how can we uplift y'all who are already doing the work?"* ***I think the work that OHA can do as an institution is advocate for the organizations who are already doing the work.****"*
>
> *-OHA Strategic Plan community input*

b. Resource statewide infrastructure to support community-led health equity investments

In addition to directing federal investment toward CICs, Oregon requests federal funds for statewide infrastructure to support the CIC program and for cross-sector communication more broadly. Federal investment for CICs could include, for example, technical assistance to support the CIC grant process or support for collaboration across CICs with similar interventions. While CICs coordinate local interventions, there will also be a need for statewide systems that support communities in addressing health inequities outside of the CIC program.

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[9] Recent 1115(a) demonstration waivers in several other states, such as North Carolina and Massachusetts, have included capacity-building/infrastructure funding for community-based and/or social service organizations partnering with health care. A case study of community-based organizations participating in New York's DSRIP program identified "building capacity" as a key need to "level the playing field" between CBOs and health care organizations. *See* Achieving Health Equity and Wellness for Medicaid Populations: A Case Study of Community-Based Organization (CBO) Engagement in the Delivery System Reform Incentive Payment (DSRIP) Program, https://academyhealth.org/sites/default/files/achieving_health_equity_medicaid_cbos_april2019.pdf

2. Invest federal funds in community-led health equity interventions and statewide initiatives

a. CCOs investment in community-managed funds to count as medical and quality improvement expenditures

Once CICs have developed sufficient infrastructure to assume financial responsibility, they will manage CCOs' community funds (per HB 3353). As discussed in the *Value-based Global Budgets* concept paper, Oregon's CCOs currently have the flexibility in their budgets to spend on health equity and social determinants of health, including through health-related services (HRS) and the Supporting Health for All through REinvestment: the SHARE Initiative.[10] However, spending on HRS remains low (0.7% on average), considering the potential impact investments in health-related social needs could have on health outcomes. As mentioned in the background, HB 3353 requires OHA to seek approval from CMS that 3% of the CCO value-based global budgets directed to improving health inequities and counted as medical and quality improvement expenditures.

3. Grant community-led collaboratives resources to invest in health equity

a. Oregon requests additional federal investment to support health equity investment (HEI) grants—funds made available directly to CICs through a process managed by the state.

Ideally, the grant process would not be competitive, limited to a small number of awards, or prescriptive about which topics to address. HEI grants would allow qualifying CICs to further invest in addressing health inequities that impact local Medicaid members and their families.

HEI grant proposals will identify the population served and planned investments, both of which must be informed first by available community-based and empirical evidence as well as local community health assessments/community health improvement plans.[11] Examples of proposed HEIs could include expanding availability of housing supports and services; enhancing green space and making improvements in the built environment; increasing access to social and mental health supports; dismantling structural racism, such as efforts to expand a culturally and linguistically responsive work force; and/or affordable childcare. Further, depending on a community's needs, HEIs may focus interventions on a specific population, such as children and families, especially from priority populations. By allowing CICs to invest in the range of supports they know are of highest priority, HEI grants will facilitate community agency and resilience. (See Appendix A for details about HB 3353, CICs and HEI grants.)

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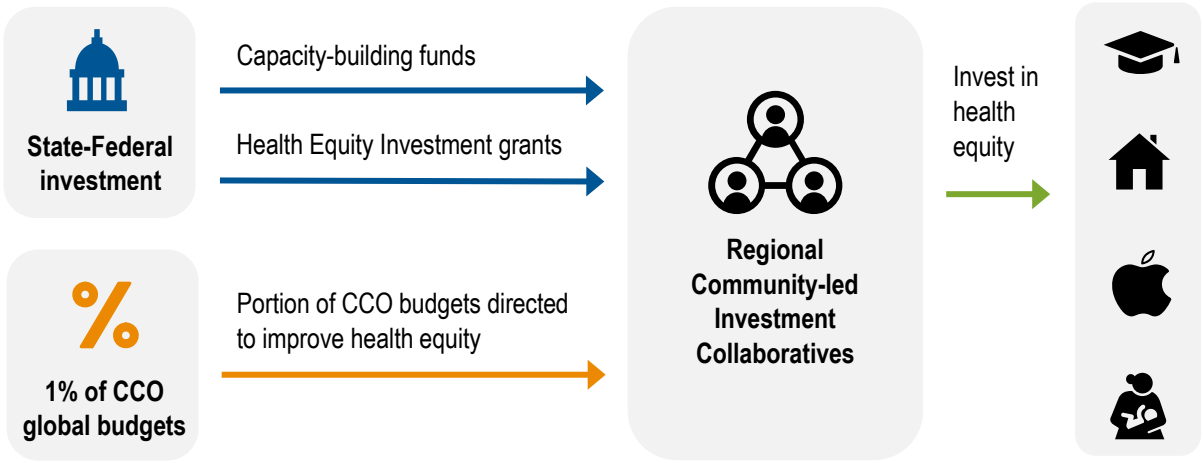
[10] The SHARE Initiative comes from a legislative requirement for coordinated care organizations to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity. For more information, visit https://www.oregon.gov/oha/HPA/dsi-tc/Pages/SHARE.aspx

[11] Including qualitative and quantitative data such as race, ethnicity, language, disability, sexual orientation, gender identity and other demographic data from the census; as well as data from community-initiated needs assessments explaining existing and emerging community needs.

Oregon's proposed model forms Community Investment Collaboratives to leverage multiple sources of funding.*



*In addition to investments from the state and CCOs, regional Community-led Investment Collaboratives could leverage other health system funds, such as hospital community benefit funding, and philanthropy for health equity investments in communities.

c. Invest in statewide health equity initiatives

In addition to investing in community-led interventions, Oregon requests investment in statewide, large-scale initiatives to address health equity. For example, as discussed in the *Improving Health Outcomes by Streamlining Life and Coverage Transitions* concept paper, Oregon seeks federal investment to modify the OHP to support members through disruptions in coverage and life transitions. The goal is address gaps in Medicaid coverage; to extend coverage for a limited time; and to provide a defined set of supportive services during transitional periods (e.g., aging out of foster care) or disruptive climate events (e.g., wildfire, heat). Given that Oregonians experiencing the transitions of focus are disproportionately from populations and communities who have been most harmed by historic and contemporary injustices and health inequities, these initiatives will be critical to advancing health equity in the state.

What these policies would mean for OHP members

OHP members who experience historical and contemporary injustices will participate in designing—or delegate other community-based organizations and advocates to design—a process for establishing Community Investment Collaboratives in the state.

The goal of this concept is that OHP members and other members of the public who come from groups that have been most harmed by historic and contemporary injustices will experience improved health as a result of community-led health equity interventions. This concept moves beyond the idea of community participation and toward community engagement in decision-making about the investment of resources. The goal is community empowerment, improved health for community members and ultimately the elimination of health inequities.

Appendix A

Oregon House Bill 3353 (2021)

To make meaningful change requires more than enhancing community decision-making and direction in the CCO model – it also requires building on ideas that have come directly *from* communities and collaborating directly *with* historically underserved communities to build a new model. To that end, the strategies behind Oregon's 1115(a) demonstration waiver renewal were co-created through a unique community-driven process.

Background

In July 2011, OHA established the Regional Health Equity Coalition (RHEC) initiative. RHECs are leaders in empowering diverse groups to become involved in developing unique, culturally appropriate and sustainable solutions to pervasive issues of inequity that impact the health and wellbeing of people in Oregon. RHECs work to identify the most pressing health equity issues in the state and find creative solutions to address root causes of barriers to health and wellness through changes to policies, systems and environments. A key part of their work includes helping racially and ethnically diverse communities build their capacity to work with decision-makers, CCOs, and other health systems to address systemic inequities at the policy, systems and environmental levels and reduce barriers to individuals and families achieving their full health potential.

Currently six RHECs reach 11 of Oregon's 36 counties and the Confederated Tribes of Warm Springs. In 2021, Oregon's legislature passed Senate Bill 70 which will resource four additional RHECs, with a goal of statewide coverage in the coming years.

RHECs approached OHA with a proposal for the 1115(a) demonstration waiver renewal and worked closely with the legislature to inform the design of HB 3353. Subsequently, OHA and RHEC leadership formed the Community Managed Funds workgroup to build out the intent of HB 3353, inform relevant content in the 1115(a) demonstration waiver renewal and increase accountability to historically oppressed communities by emphasizing a community role in identifying inequities and making investment decisions to address inequities.[12]

[12] The OHA/RHEC Community Managed Funds workgroup met 12 times between May and July to develop strategies to develop a model for shifting power and resources to community. Recognizing that the process can be as important as the outcome, the work involved relationship and trust building, particularly to build increased trust between community organizations and government, naming some of the values we hold in conducting work together through developing group agreements, sharing needs to successfully accomplish the work together, clarifying roles and scope of work, and agreeing on guiding principles to ensure the model was designed to achieve health equity goals, including investment in racial, cultural, and underserved communities.

HB 3353

As discussed in the *Value-Based Global Budgets* concept paper, Oregon's CCOs have the flexibility in their budgets to spend on health equity and social determinants of health, including through health-related services (HRS) and the SHARE Initiative.[13] However, spending on HRS remains low (0.7% on average), considering the potential impact investments in health-related social needs could have on health outcomes. The bill requires OHA to seek approval from CMS that 3% of the CCO value-based global budgets directed to improving health inequities are counted as medical expenditures.

Beginning in 2020, Oregon RHECs collaborated with CCOs and the legislature to develop HB 3353, legislation which subsequently passed in 2021 with nearly 90% support. Key elements of the bill include:

- At least 3% of CCOs' global budgets will be directed toward investments in health equity, social determinants of health, and a culturally responsive workforce with a focus on priority populations including, but not limited to, Oregon's nine federally-recognized tribes and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.
- Increasing accountability to communities and community-led oversight of spending.
- Adopting evaluation methods that use strengths-based approaches and qualitative data.

Implementation: Governance

Building from requirements in HB 3353, Oregon proposes to develop a two-level oversight structure for CCO health equity investments:

A **state-level oversight committee**, as required by HB 3353, will be comprised of "members who represent the regional and demographic diversity of this state based on statistical evidence compiled by the authority about medical assistance recipients and at least one representative from the nine federally recognized tribes in this state or urban Indian health programs."[14] The state-level oversight committee will be charged with developing criteria for required spending and advising on a Request for Proposals (RFP) for Community Investment Collaboratives, resolution of disputes,[15] and evaluation.

Regional Community Investment Collaboratives (CICs) will form as collaborative entities comprising representatives of diverse groups from local communities, including partners such as RHECs, culturally specific CBOs that do not replicate the damaging processes of the dominant culture in the region, CCO health councils, or other community bodies; CCOs and Community Advisory Councils; local hospitals; and local public health authorities. Each CIC will identify a lead entity, community council, and fund/reporting manager. (One entity could play multiple roles.)

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[13] Ibid. Footnote 10.
[14] Ibid. Footnote 2.
[15] Per HB 3353, the oversight committee is charged with resolving disputes between OHA and CCOs as to what qualifies as an appropriate expenditure.

CICs will be community-led and ideally leverage existing community efforts, such as RHECs and CCO health councils if these entities met criteria set by the oversight committee and OHA. To meaningfully shift power and decision-making authority, Oregon expects to establish criteria for lead entities to be representative of and serve priority populations[16] who experience the greatest health inequities. Because dominant culture agencies and organizations can perpetuate inequities due to historic and current day structural barriers, they will be considered as potential partners who can assist in supporting and championing community entity goals, but should not be considered as a lead entity for decision making. Therefore, CCOs will be expected to be partners in CICs, but CCOs and health system partners will not be eligible to be a lead entity. In the RHEC model, a similar approach has enabled RHECs to establish more equitable approaches to governance that give more voice and power to racially and ethnically diverse communities.

CICs will set sub-criteria for regional spending on health equity; ensure community-led plans are considered in criteria and investment decisions, including Community Health Improvement Plans approved by the CACs; and be responsible for investing a portion of the CCOs' 3% spending requirement in health equity initiatives in their local communities.

CICs will ideally be comprised of existing CBOs and social service organizations that are chronically underfunded compared to health care organizations. CICs will need support for administrative expenses, such as hiring and training staff, building or enhancing a community council, establishing initial agreements among lead entity and funding/reporting managers, establishing agreements with CCOs, and building the infrastructure and information technology systems needed to support community investments on an ongoing basis. As described earlier in this concept paper, CICs will have opportunities to apply for capacity-building funding. As CICs become established, they will also qualify for funding for ongoing administrative and operational expenses, focused technical assistance from OHA, and competitive "Health Equity Investments" funding to further improve health equity in their communities.

Implementation: Spending

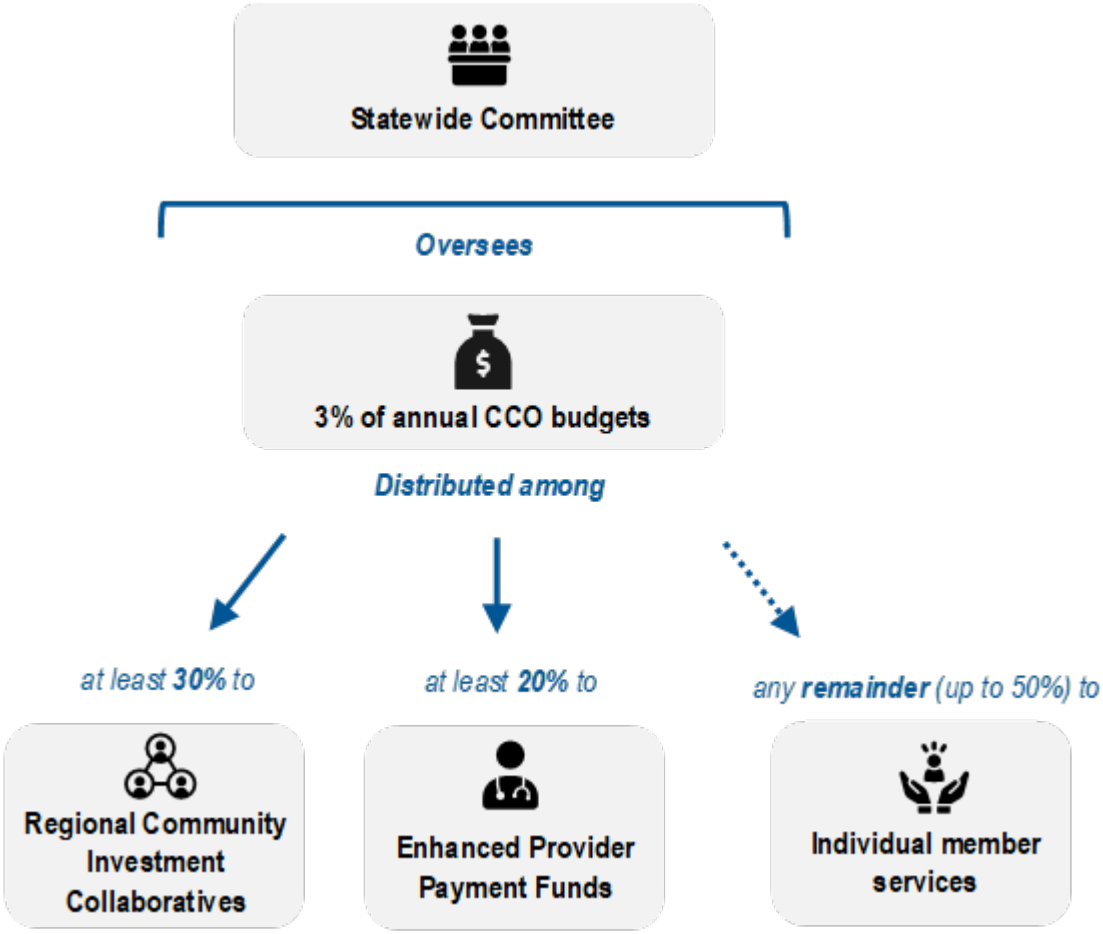
Oregon plans to establish three broader types of spending to encompass the types of expenditures outlined in HB 3353:

1. **30% of the 3%** (~1% of CCO global budgets) would be directed to programs and services to improve health equity in racial, cultural and underserved populations. These community-level investments would be directed to CICs.
2. CCOs would be required to dedicate at least **20% of the 3%** (~0.6% of global budgets) to an **enhanced provider payments fund** designated for behavioral health, culturally and linguistically

[16] Priority populations include but not limited to Oregon's nine federally-recognized tribes and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, American Indian/Alaska Native populations, and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities.

responsive services, and providers offering peer-based services (such as Traditional Health Workers).

3. **Remaining funds** under the 3% would be **flexible and responsive to community needs** and could be directed to any of the three general types of health equity funding: individual services for OHP members, additional community-level investments, or additional enhanced provider payments.



Implementation: Operations

Stage 1: The Statewide Oversight Committee prescribed by HB 3353 will develop CIC criteria and advise OHA on a request for information (RFI) process to obtain information about which community entities intend to partner in forming CICs.

The criteria will specify:

- The requirements for organizations comprising CICs, which will likely include but not be limited to: comprising representatives of diverse groups from local communities, including partners such as RHECs, culturally specific CBOs that do not replicate the damaging processes of the dominant culture in the region, CCO health councils, or other community bodies; CCOs and Community Advisory Councils; local hospitals; and local public health authorities;

- CIC lead organizations must represent, serve and be comprised of priority populations including, but not limited to, Oregon's nine federally-recognized tribes and Tribal communities; Latino/a/x, Black/African American, Asian, Pacific Islander, and American Indian/Alaska Native populations and other communities of color; people with disabilities; people with limited English proficiency; and immigrants and refugee communities;
- CICs must be able to assume fiscal responsibility (which will be supported by capacity-building grants; see below); and
- The minimum dollar amount that can be requested for both capacity-building grants and HEI grants (see below).

The RFI will provide information on:

- Which community entities wish to form CICs, their geographic boundaries and demographic scope;
- Which parts of the state are represented by CICs, including whether there is at least one in each CCO area and whether any of the proposed CICs overlap; and
- Whether OHA needs to conduct focused outreach to support CIC design and development. For example, if the RFI shows there are overlapping CICs, OHA may suggest CICs combine efforts, or may determine overlapping CICs is appropriate. Conversely, if the RFI indicates some CCO regions lack a CIC, OHA, in collaboration with the HB 3353 Statewide Oversight Committee, could engage in local conversations to support development of a CIC.

Stage 2: CICs may apply for a capacity-building grant, which will:

- Fund administrative work, capacity building, and technical assistance for CICs to build their CBO networks and develop internal leadership;
- Fund Community Information Exchange or other technological needs to facilitate cross-sector communication; and/or
- Provide technical assistance and resources to build CIC infrastructure to be able to accept and administer CCO funding, Health Equity Investment grants (see below), and possible funding from other sources (e.g., hospital community benefit, other government funding, or philanthropy).

Stage 3: CICs may apply for a Health Equity Investment (HEI) grant, which the CIC will use to fund community-identified strategies to address inequities.

HEI grant proposals will identify the population served and planned investments, both of which must be informed first by available community-based and empirical evidence as well as local community health assessments/community health improvement plans.[17] Examples of proposed HEIs could include enhancing green space and making improvements in the built environment; increasing access to social and mental health supports; dismantling structural racism, such as efforts to expand a culturally and

[17] Including qualitative and quantitative data such as REALD, SOGI and other demographic data from the census; as well as data from community-initiated needs assessments explaining existing and emerging community needs.

linguistically responsive work force; and expanding availability of housing and/or affordable childcare. Further, depending on a community's needs, HEIs may focus interventions on a specific population, such as children and families, especially from priority populations. By allowing CICs to invest in the range of supports they know are of highest priority, HEI grants will facilitate community agency and resilience.

For example, addressing factors related to climate change may be a priority for some Oregon communities. Climate change—a major factor in Oregon's unprecedented 2020 wildfire season and the 2021 extreme heat dome event—often disproportionately affects communities of color due to neighborhood conditions and residential segregation,[18] a disproportionate share of chronic conditions,[19] and other factors. The Oregon wildfires of 2020 decimated communities across the state, including Talent and Phoenix, which were 90% Latino/a/x. Increasing green space and other improvements to the built environment, such as climate resilient housing, can ameliorate the impact of climate change. Further, the evidence linking time outdoors with better mental health and social cohesion is substantial.[20]

Note there will be no predetermined number of HEI grants; this will depend on the number of CICs that apply and the amount of funds available. Investments will be evaluated using methods that may include practice-based or community-based evidence, with a focus on community-engaged and community-led evaluation efforts, such as community-based participatory research (CBPR), wherever possible. CBPR involves researchers and community engaging as equal partners in all steps of the research process and can be a strategy to improve data collection and interpretation while also promoting community health and addressing health inequities.[21]

You can get this document in other languages, large print, braille or a format you prefer. Contact the Community Partner Outreach Program at community.outreach@dhsoha.state.or.us or by calling 1-833-647-3678. We accept all relay calls or you can dial 711.

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18 *See e.g.* Jesdale BM, Morello-Frosch R, Cushing L. 2013. The racial/ethnic distribution of heat risk-related land cover in relation to residential segregation. Environ Health Perspect 121(7):811–817, PMID: 23694846, 10.1289/ehp.1205919. Link, Google Scholar ; Davies IP, Haugo RD, Robertson JC, Levin PS (2018) The unequal vulnerability of communities of color to wildfire. PLoS ONE 13(11): e0205825. https://doi.org/10.1371/journal.pone.0205825

[19] Daw, J. 2017. Contribution of four comorbid conditions to racial/ethnic disparities in mortality risk. **American Journal of** Preventive Medicine. 52(1) supplement 1: S95-S102. https://www.ajpmonline.org/article/S0749-3797(16)30322-1/fulltext

[20] https://willamettepartnership.org/wp-content/uploads/2014/06/HealthFramework-Final-Reduced.pdf

[21] *See e.g.* Salimi Y., Shahandeh K., Malekafzali H., Loori N., Kheiltash A., Jamshidi E., Majdzadeh R. Is Community-based Participatory Research (CBPR) Useful? A Systematic Review on Papers in a Decade. Int. J. Prev. Med. 2012;3:386–393. https://www.ahrq.gov/research/findings/factsheets/minority/cbprbrief/index.html