2017

# Oregon Regional Health Equity Coalitions Evaluation Report

Oregon Health Authority

Office of Equity & Inclusion

# Acknowledgments

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# Executive summary

Regional Health Equity Coalitions (RHECs) are community-driven, cross-sector groups. The RHECs work to increase health equity for underserved and underrepresented populations experiencing health disparities. The RHECs accomplish this work by building on the strengths of local communities and involving them in identifying sustainable, long-term, policy, system and environmental solutions.

The Oregon Health Authority (OHA), Office of Equity and Inclusion (OEI) supports six RHECs serving 11 Oregon counties and the Confederated Tribes of Warm Springs. The work of the RHECs covers a wide range of underserved communities. This includes people of color, immigrants, refugees, migrant and seasonal farmworkers, low-income populations, individuals with disabilities, and LGBTQ communities in rural and urban areas. Based on current geographic locations, the RHECs have the potential to impact approximately 60% of Oregon's total population.*

The RHECs collect data on an ongoing basis, to measure progress on short-term and intermediate outcomes that have theoretical and/or empirical links to health equity. In this way, they can evaluate where and how they are making progress towards meeting the large overarching goal of health equity for all. Specifically, collection of data on successes relate to five core metrics:  increased and authentic community engagement, strengthened organizational capacity, system change, social norm and environment change and policy change.

RHEC membership comprises a diverse set of stakeholders. These stakeholders include, the following sectors:  behavioral health, city and county governments, community-based organizations, coordinated care organizations, corrections/law enforcement, dental, disabilities, education, employment, environmental, faith-based, healthcare, higher education, local business, neighborhood councils, policymakers, public housing, tribal government urban planning and more. Through 141 trainings and educational events, RHECs reached 935 organizations and over 6,000 individuals across Oregon in 2016. All of this work builds the foundation to empower communities to sustain and improve health equity in the state.

* United States Census Bureau Population Division. Annual Estimates of the Resident Population by Sex, Race and Hispanic Origin, April 1, 2010–July 1, 2015. (Release June 2016)

Funding for the first three RHECs was provided in 2011. A second set of three received funding in 2014. The work of the RHECs addresses social determinants of health that have persisted for generations in sectors such as health, education, housing, employment and transportation. Ultimately, the coalitions are working to improve the overall state of health equity in Oregon. This work is a nominal investment for substantial, long-term improvements of health inequities among the state's most vulnerable and resilient populations.

# Background

In July 2011, the Oregon Health Authority (OHA) established the Regional Health Equity Coalition (RHEC) initiative to support local, community-driven, culturally specific activities to reduce health inequities and address social determinants of health in Oregon. Three RHECs received funding through the Office of Equity and Inclusion (OEI) and the Public Health Division's Health Promotion and Chronic Disease Prevention Section (HPCDP). These resources were available by leveraging U.S. Department of Health and Human Services Office of Minority Health and Northwest Health Foundation funds. In 2014, three additional RHECs received funds through the Centers for Medicare & Medicaid Innovation (the innovation center) State Innovation Model (SIM) grant.

Once funded, the coalitions selected the regions and populations they would focus their work on. Each RHEC conducted community needs assessments. These assessments were to identify priority issue areas to concentrate their efforts. Ultimately, these helped inform their strategic plans. Both the strategic plans and RHEC grant goal areas help provide guidance on coalition annual work plan activities.

The six RHECs reach 11 Oregon counties and the Confederated Tribes of Warm Springs (table 1, figure 1). The work of the coalitions covers a wide range of underserved communities. This includes people of color,[*] immigrants, refugees, migrant and seasonal farmworkers, low-income populations, individuals with disabilities, and LGBTQ[†] communities in rural and urban areas. Communities of color are a leading priority for the RHECs (See appendix 1 for population distributions). Based on current geographic location, the RHECs have the potential to impact approximately 60% of Oregon's total population.[‡]

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* People/communities of color: Members of a racial/ethnic minority communities including Black/African-Americans, Asian/Pacific Islanders, Latinos, American Indian/Alaska Natives. May include immigrants, and refugees.

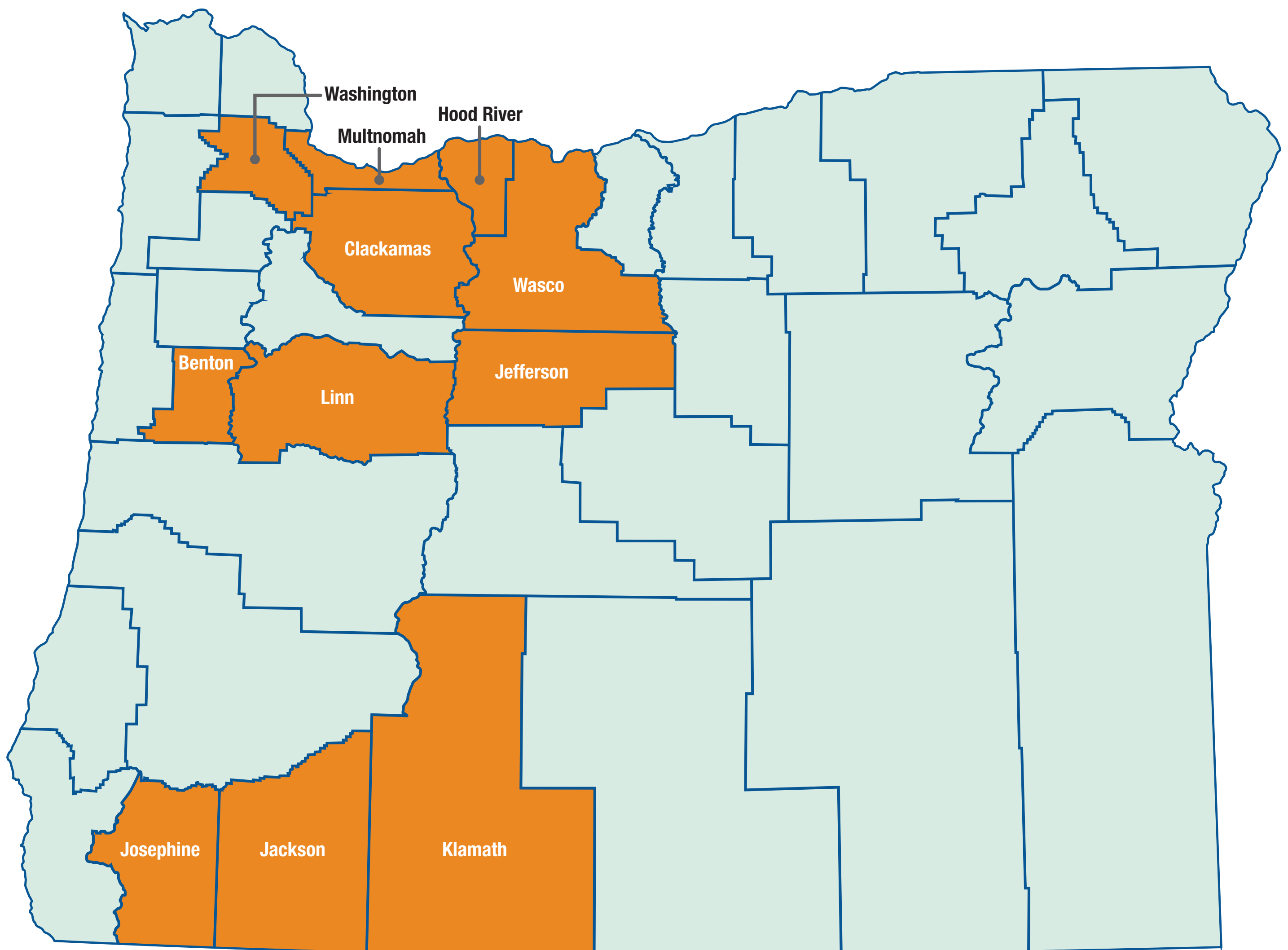
† Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)

‡ United States Census Bureau Population Division. Annual Estimates of the Resident Population by Sex, Race and Hispanic Origin, April 1, 2010-July 1, 2015. (Release June 2016)

## Table 1. RHEC regions, funding year and cohort

| RHEC | Communities served | Year funded, cohort |
|---|---|---|
| Klamath Regional Health Equity Coalition (KRHEC) | Klamath County | 2014, Cohort 2 |
| Let's Talk Diversity (LTD) | Confederated Tribes of Warm Springs and Jefferson County | 2011, Cohort 1 |
| Linn-Benton Health Equity Alliance (LBHEA) | Linn and Benton Counties | 2011, Cohort 1 |
| Mid-Columbia Health Equity Advocates (MCHEA) | Hood River and Wasco Counties | 2014, Cohort 2 |
| Oregon Health Equity Alliance (OHEA) | Multnomah, Clackamas and Washington Counties | 2011, Cohort 1 |
| Southern Oregon Health Equity (So Health-E) Coalition | Jackson and Josephine Counties | 2014, Cohort 2 |

## Figure 1. RHEC regions map



Often, the term *health equity* is used, but at times without definition or explanation. The Boston Public Health Commission has one of the most comprehensive definitions:

> Health equity means that everyone has a fair opportunity to live a long, healthy life. It implies that health should not be compromised or disadvantaged because of an individual or population group's race, ethnicity, gender, income, sexual orientation, neighborhood or other social condition. Achieving health equity requires creating fair opportunities for health and eliminating gaps in health outcomes between different social groups. It also requires that public health professionals look for solutions outside of the health care system, such as in the transportation or housing sectors, to improve the opportunities for health in communities.[§]

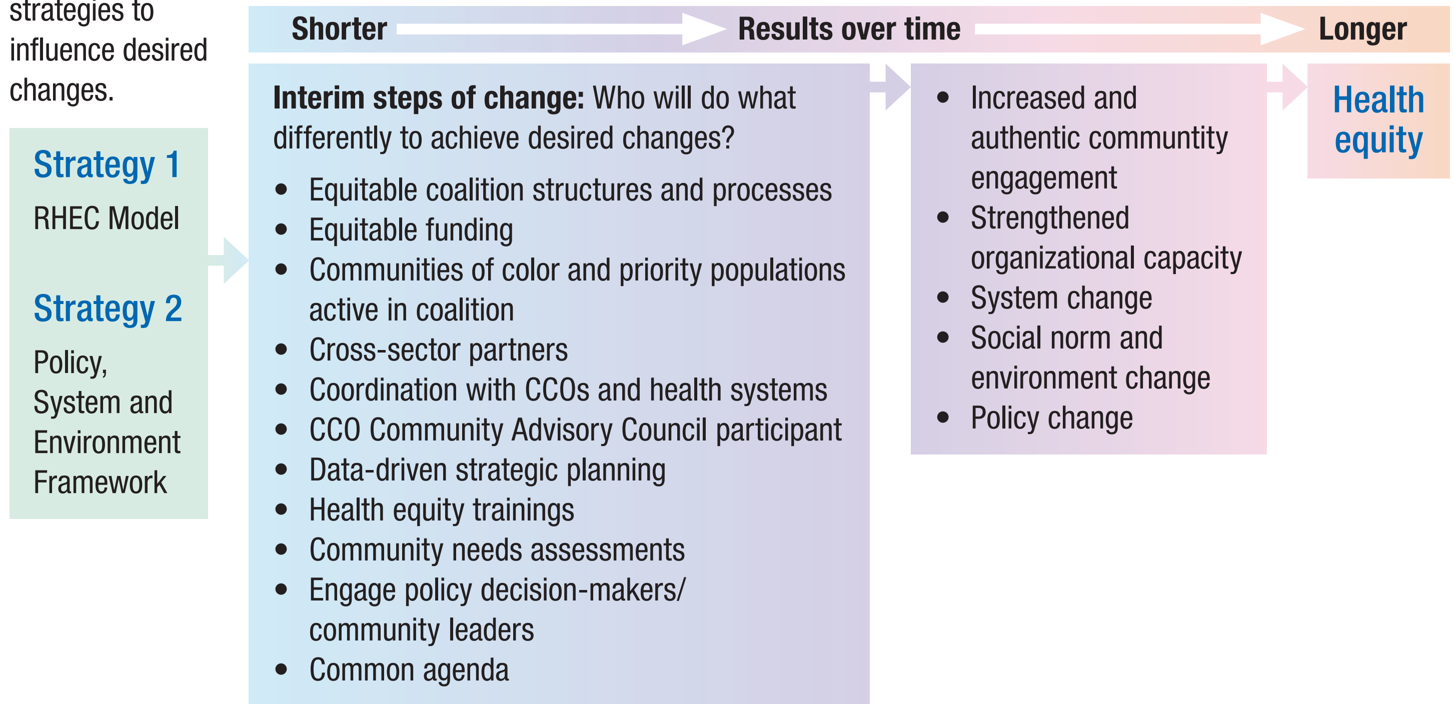
The RHEC model supports regional, community-driven, culturally specific, cross-sector strategies aimed at reducing local health disparities and promoting equity. Coalitions build on the inherent strengths of their communities. Additionally, coalitions utilize a policy, systems and environment (PSE) framework to craft and implement sustainable, long-term solutions to eliminate health inequities and address the social determinants of health. See the RHEC strategy map (figure 2).

Because the RHEC initiative is addressing health equity issues across multiple sectors and continuously engaging new partners, evaluation efforts used a Developmental Evaluation (DE) approach. Systems thinking and the realities of ever-changing social problems within complex environments informs the DE framework. This framework offers a structure that is supportive of adaptive management and continuous development.

Every six months through site visits and coalition reports evaluation data is collected. Descriptive data in this report (e.g., membership numbers, types of sectors involved) represent RHEC status between February 2016 and February 2017, unless otherwise indicated.

§ Boston Public Health Commission. http://www.bphc.org/whatwedo/health-equity-social-justice/what-is-health-equity/Pages/what-is-health-equity.aspx

### Figure 2: RHEC strategy map




**Ideas for implementation**

Each mechanism can be assessed for equitable practices and engagement of priority populations. We can look at how equity is operationalized across these two strategies.

**Assumptions:**

1. Regional focus and local activities are critical for statewide change
2. Authentic engagement of priority populations is essential
3. Champions and supportive leadership is critical

# Evaluation questions and process

The RHECs aim to promote health equity by addressing the root causes of inequities through the social determinants of health. These root causes that affect health can be related to education, employment, healthcare access, housing, income inequality, and transportation, among others. Resources to conduct a larger collective impact assessment or contribution analysis are lacking. However, the RHECs collect data on an ongoing basis to measure progress on short-term and intermediate outcomes that have theoretical and/or empirical links to health equity. In this way, they can see where and how they are making progress towards meeting the large overarching goal of health equity for all.

The basis for the RHEC model is a theoretical framework that increased and authentic community engagement and strengthened organizational capacity are the foundation for system change. There is a special focus on healthcare systems and coordinated care organizations (CCOs). There is also a focus on social norm and environmental change, as well as policy change. These things, in turn, lead to healthier, more resilient communities that experience fewer health disparities.

With this framework in mind, the RHECs engaged in a facilitated, collaborative process to select and prioritize three evaluation questions, five outcomes, and eight indicators to monitor progress over time. These evaluation measures align with OHA's vision, mission, and core values. Evaluation questions, outcomes and indicators are priorities for improving health equity across systems in Oregon. An outline of the questions are below.

## RHEC evaluation questions

1. How effectively have the RHECs engaged their communities, specifically communities of color and other priority populations?
    a. What processes and structures have the RHECs put into place to engage and listen to their communities?
2. How has the RHEC increased local capacity and leadership for addressing health disparities and equity?
    a. How have communities of color increased their capacity and leadership?
    b. How have funding models shifted to become more equitable?

3. How have the RHECs increased coordination across health and other social support entities to collaborate on crosscutting community wide issues?
    a. How have RHECs engaged with CCOs?
    b. What sectors and jurisdictions have actively engaged with each of the RHECs? What sectors or jurisdictions are missing in the RHEC work?

# Evaluation outcomes and indicators

| Outcome 1. Increased and authentic community engagement | |
| --- | --- |
| Indicator 1.a. | The RHEC's Steering Committee (or other leadership structure) includes a diverse set of voices and perspectives from all relevant sectors and constituencies. |
| Indicator 1.b. | Members of the target population help shape the common agenda. |
| Indicator 1.c. | People of different cultures and backgrounds feel respected and heard within the RHEC. |

| Outcome 2. Strengthened organizational capacity | |
| --- | --- |
| Indicator 2.a. | RHEC staff provides project management support, including monitoring progress toward goals and connecting partners to discuss opportunities, challenges, gaps and overlaps. |

| Outcome 3. System change | |
| --- | --- |
| Indicator 3.a. | Partners use data (both qualitative and quantitative) to inform selection of strategies and actions. |
| Indicator 3.b. | CCOs and health systems have increased knowledge and skills related to equity issues. |

| Outcome 4. Social norm and environment change | |
| --- | --- |
| Indicator 4.a. | Partners and the broader community are making the connection between health equity and other issues (e.g., housing, education, transportation). |

| Outcome 5. Policy change | |
| --- | --- |
| Indicator 5.a. | Relationships with policy developers (decision-makers/legislators) are strengthened. |

# Outcome 1: Increased and authentic community engagement

The Regional Health Equity Coalitions reach a multitude of diverse communities through meaningful and authentic community engagement. While coalitions prioritize communities of color* for their populations of focus, they also include migrant and seasonal farmworkers, people with disabilities, and LGBTQ† and low-income populations. The RHECs utilize community engagement to ensure that populations effected identify and develop priority issues and policy and system change efforts. This ensures mitigation of negative and unintended consequences by considering the full context of environmental factors that impact people's lives. Additionally, that those strategies to improve health equity are sustainable, and culturally and linguistically appropriate.

Embodying the principle of "nothing about us, without us," RHEC membership comprises a diverse set of stakeholders: in total, over 300 individuals from 157 organizations across Oregon. Currently, all of the RHEC leadership teams include representation from communities of color; five have representation from American Indian/Alaskan Native (AI/AN) communities and/or tribal representatives; and five include immigrant, migrant, and refugee community representatives. See table 2 below for more information on RHEC demographic representation in leadership and coalition membership groups.

### Table 2. RHEC communities represented in leadership and coalition membership groups

| Communities represented | Number of RHECs with representation in leadership teams | Number of RHECs with representation in leadership teams |
|---|---|---|
| AI/AN communities | 5 | 5 |
| Communities of color | 6 | 6 |
| LGBTQ communities | 3 | 5 |
| Low-income populations | 4 | 4 |
| Migrant, immigrant and refugee communities | 5 | 6 |

* Communities of Color: Members of a racial/ethnic minority communities including Black/African Americans, Asian/Pacific Islanders, Latinos, American Indian/Alaska Natives. May include immigrants, and refugees.

† Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ)

The six coalitions include representation from the following sectors: behavioral health, city and county governments, community-based organizations, CCOs, corrections/law enforcement, dental, disabilities, education, employment, environmental, faith-based, healthcare, higher education, local business, neighborhood councils, policymakers, public housing, tribal government and urban planning.

The RHECs also engage the broader communities they work in through educational events and trainings. In 2016, the RHECs conducted 141 community education and training events, reaching 935 organizations and more than 6,000 individuals.

# Examples of efforts to increase authentic community engagement

## Example 1:

One RHEC created two countywide Health Equity Assessment Reports focused on race/ethnicity, and LGBTQ issues using county and state data. Beginning in June 2015, this coalition held community conversations for people to share real life experiences related to a variety of issues. These related to educational attainment, teen pregnancy, oral health, cultural responsiveness and other issues captured in the quantitative reports. They also collected stories to guide the priority areas to be included in their strategic plan. They used a multicultural storytelling methodology to ask community members what factors contribute to health in their communities.

## Example 2:

Another coalition provides participation/capacity building mini-grants to bring diverse voices to the table. Additionally it allows smaller organizations to attend coalition events regularly. This leads to a higher level of engagement among partners that might not otherwise have the capacity to stay engaged. Two of the member organizations of this RHEC participated in a training on health and transportation with national expert, Mark Fenton. At this training, community members shared their perspectives – in Spanish – with more than 100 local policy makers and other community leaders. Equity was a central theme and community value in this meeting.

## Example 3:

One coalition identified authentic community engagement as a key strategic priority. To support and fully implement this effort the RHEC created new staff position, a community engagement advocate. This new staff person will develop a work plan specific to ensuring that community members are meaningfully engaged in their region's activities.

# Outcome 2: Strengthened organizational capacity

The coalitions provide "backbone agency" support and leadership to the 157 organizations and more than 300 individuals engaged in health equity work across Oregon. Specifically, these coalitions are able to bring diverse groups to historically underrepresented decision-making tables. The coalition staff provide project management support, including monitoring progress toward goals and connecting partners to discuss opportunities, challenges, gaps and overlaps. All of the RHECs have at least one or more core leadership teams that support the broader coalition in identifying community priorities for addressing health and health equity through policy, systems and environmental change. Leadership teams vary in size from five to 35 members, with an average of 17 members.

Governance models differ, and coalitions work from a foundation of consensus-based and democratic decision-making. Three RHECs have steering committees, one has a general leadership team, another has an advisory group, and one takes guidance from two community groups (table 2).

> "We aren't steering anything; we are following the community's lead."
>
> –Mid-Columbia Health Equity Advocate staff member

### Table 3. RHEC coalition structures and governance models

| RHEC | Leadership team structure | Other RHEC work groups |
|---|---|---|
| Klamath Regional Health Equity Coalition (KRHEC) | KRHEC and a working committee, Chiloquin First, serve the county. The seven-member KRHEC steering committee meets monthly, as do the subcommittees. KRHEC has a quarterly general assembly.<br>Chiloquin First meets monthly. | KRHEC has two work groups: transportation and health literacy. |
| Linn-Benton Health Equity Alliance (LBHEA) | LBHEA's leadership team includes 24 representatives from local community organizations, public health departments, early learning hub and the local CCO. | Occasional ad hoc subgroups form and meet based on priority areas (i.e. housing, education, access to healthcare and capacity building). |
| Let's Talk Diversity Coalition (LTDC) | Five-member board of directors; the co-facilitators are ex officio members. | Work groups form, as needed |

*Continued from previous page:*

| RHEC | Leadership team structure | Other RHEC work groups |
|---|---|---|
| Mid-Columbia Health Equity Advocates (MCHEA) | Two of the five RHEC groups comprise the leadership team: Abogadores de la Comunidad and Latinos en Acción lead the work the RHEC focuses on each year. In the spirit of Latinos en Acción and Abogadores de la Comunidad, all coalition members in attendance at respective meetings vote and simple majority rules apply. Coalition members are entitled to one vote per member. | Five groups form MCHEA:<br>**1. Abogadores de la Comunidad** (Advocates of the Community) guides health equity work in The Dalles.<br>**2. Latinos en Acción** (Latinos in Action) is the group of community leaders that guides health equity work in Hood River County.<br>**3. River People Group** focuses on the local American Indian/Alaska Native community and meets on its own with RHEC support.<br>**4. Community Partners Group** includes stakeholders from groups 1 and 2 above<br>**5. RHEC Staff members** |
| Oregon Health Equity Alliance (OHEA) | Internal group of nine people (six organizations) provide overall direction and leadership for the RHEC on action items. Committee members are all original founding members. These groups are community-led, with staff also representing communities served. Two co-chairs serve for one term. | Current work groups include the policy committee; CCO committee; Multnomah Community Health Improvement Plan (CHIP); health access/inclusion, affordability and innovation table; mental health, substance abuse, and addictions workgroup; chronic disease and other illness factors workgroup; membership; and general coalition membership group. |
| Southern Oregon Health Equity (SO-Health-E) | At the end of 2016, there were 11 people on the steering committee, and eight nominees in Jackson County. There were 14 steering committee members in Josephine County. | Current work groups include the cultural agility workgroup; data and sustainability workgroup; policy and advocacy workgroup; reproductive/ sexual health work group; and community assembly. Additional subcommittees/workgroups added, as needed. |

Each RHEC has a paid staff member working as a coordinator. Often several staff members share tasks and/or supported by in-kind dollars from sponsoring or partner agencies. A total of 23 paid staff members work on RHEC activities at the six coalitions, representing 14.6 FTE. These paid staffers receive support in their project management activities by three consultants and more than 60 volunteers.

Another way that RHECs have supported local communities of color in increasing their capacity and leadership is through participation in the Developing Equity Leadership through Training and Action (DELTA) Program,* offered through OEI. DELTA trains cohorts of approximately 25 members over the course of a nine-month period. The program is for community leaders, health care providers, CCO staff, policy makers, administrators, and local health department staff. This program focuses on advancing health equity and diversity through 40 hours of classroom training, 10 hours of individualized technical assistance, and facilitated opportunities for cross-sector partnership. Each participant submits a project prior to graduation

* Developing Equity Leadership through Training and Action (DELTA) Program http://www.oregon.gov/oha/oei/Pages/delta.aspx

designed to drive and institutionalize best practices for health equity and inclusion within their own organizations. To date, 20 RHEC members have graduated from DELTA.

# Examples of efforts to strengthen organizational capacity.

## Example 1:

One RHEC hosted an implicit bias training series in various counties in their region. The training series provided participants with strategies to minimize implicit bias in personal and professional contexts. Over 100 local professionals and community members attended workshops. Several others have expressed interest in future trainings. Opportunities to be aware of and explore one's own implicit biases means that interactions between organizations and community members can progress toward more respectful and culturally appropriate exchanges.

## Example 2:

Another coalition sponsored leadership and presentation skills workshops in partnership with their local multicultural literacy center. These events helped build capacity for approximately 30 community members. This RHEC also hosted an effective messaging training during their coalition meeting. Nearly 40 local stakeholders and community members attended the training. These activities help build the capacity needed to create a pathway for more diverse leaders in their region.

## Example 3:

A RHEC hosted a health equity training with the board of a local housing organization. The board is composed of several key decision makers in the region regarding community development. After receiving training, those decision makers are better equipped to begin considering health equity implications and impacts in the work they do.

# Outcome 3: System change

The six RHECs interface with several sectors, which impact social determinants of health. RHECs do so in an effort to identify and amend barriers people face in achieving their highest potential for health and wellbeing. The coalitions focus their system change efforts on several sectors including: behavioral health, city/county/state government agencies, CCOs, corrections or law enforcement, dental/oral health, disabilities, education, employment, environmental organizations, faith-based organizations, healthcare services, local businesses, neighborhood councils, housing, tribal government, urban planning, etc. With regard to CCOs, all six RHECs have various types of involvement with their local CCOs. This may be participating on Community Advisory Councils (CACs), providing health equity trainings to CCO staff to further health equity, or sharing local data.

## Examples of system change efforts

### Example 1:

One coalition partnered with a health equity task force of the CCO in their region to interview community members about their experiences accessing health services across three counties. They produced a 35-minute video and 25-page report, which they presented to the CCO. This resulted in an assessment of the utilization barriers of healthcare interpreter services in the region. The CCO then contracted with the RHEC to provide their medical providers with additional training around healthcare interpreter usage. Providing health care interpreter services ultimately means that patients and their families know more about their health and healthcare choices. The result is better health outcomes for individuals and cost savings for health systems.

### Example 2:

In early 2017, a coalition asked one Oregon mayor and police chief to speak to diverse immigrant and refugee community members, who may feel fearful due to recent events. For this town hall meeting, the local RHEC provided translation devices to the English speakers, for the first time. The English speakers were the mayor, the chief of police, and a few city members. The meeting was in Spanish, for the most part. Monolingual Spanish speakers in the past wore translation devices, even if they outnumbered the audience. City officials experiencing a language barrier first hand has led to continued conversations around language access, and a commitment to be more inclusive and aware of all the communities they serve.

## Example 3:

Another coalition has engaged and informed their local systems related to the social determinants of health on regional health equity issues. Activities have included:

- Presenting a briefing to their local board of county commissioners on the RHEC's community health improvement plan (CHIP) for the county.
- Developing and producing a community informed community health assessment for their local county health department.
- Providing analysis to the legislature on the benefits of community benefit programs within the health system and community based organizations.
- Providing analysis and community engagement on the Medicaid Waiver Renewal in collaboration with OHA and the Governor's office.
- Providing recommendations and analysis to the Centers for Medicare and Medicaid Services (CMS) on the state's proposal to renew the Medicaid Waiver.
- Conducting a county-specific, youth led Health Impact Assessment on raising the age of tobacco usage for youth under age 21.

## Example 4:

One of the RHECs participated in a local open house to inform a county-focused transportation plan. Participation in the meeting was to call attention to and ensure there was consideration of the needs of culturally and linguistically diverse individuals when making local public transportation decisions.

## Example 5:

One of the RHECs has seen decreases in health inequities in their region. Specifically, the areas they focused their work on, including: teen pregnancy, education, and mental health. This coalition has seen the following trends:

- Teen pregnancy rates for ages 15-17 have declined since 2008, and the gap between non-Hispanic whites and Latinas is narrowing.
- On-time graduation rates have improved for both Latinos and non-Hispanic Whites between 2013 and 2016, although there are still inequities between these groups in two of the four high schools examined.
- Fewer LGBTQ youth in 11th grade reported "poor" emotional-mental health between 2014 and 2016.

# Outcome 4: Social norms and environmental change

All six RHECs are engaging their local communities around health equity through activities. Activities include the creation and dissemination of local data reports, facilitated community conversations, diversity trainings at major public and private organizations and more. Together, these activities, along with targeted projects, create environmental and social norms change.

## Examples of social norm and environmental change efforts

### Example 1:

One coalition, in conjunction with a local community college and university, launched a Juntos "together" program for Latino youth. The coalition also developed a similar program for AI/AN youth. Both are culturally specific programs designed to empower families and students to graduate high school and continue their education by providing resources, information and encouragement. This RHEC provides support for facilitation of these programs. Among the over 200 students participating in their county, there has been a 100% graduation rate.

Since its launch in 2014, the AI/AN-specific program moved from the local tribal school (starting with only two families) to the university. It is now available in 15 communities across the state. The program aligns with the university's goals to create a youth-to-college-to-employment pipeline. Current work is focusing on expanding the AI/AN-specific program to become a national model.

Because of this partnership with the university, students involved in the two culturally specific programs now benefit from a host of university resources. These resources include summer camps, admissions, tutoring, internships and mentoring. This RHEC believes that these programs have been successful because they apply a family engagement model — it is not just student-centric, like so many other programs designed to boost educational achievement. Making the introduction of the college experience to the whole family — as early as sixth grade and sometimes sooner for the youth. The program allows families to visit the local university, feel welcome, have fun and engage. Families can even learn about the college admissions process

and financial aid, which can be daunting to families experiencing the college system for the first time.

## Example 2:

One RHEC sponsored a working committee focused on a specific rural part of the county and the AI/AN community. This group developed community priorities specific to youth substance abuse prevention and positive youth development. Over the past year, adults and students working with this group have collaborated to bridge a historic gap between the AI/AN community and rural, White neighbors. After-school programs, such as open gym hours and community dances, have provided youth in the area positive after-school activities. The programs also provide opportunities for diverse community members to come together to build relationships and cross-cultural understanding. The goal is to decrease rates of crime, youth incarceration and ultimately help keep youth in school. The hope is that relationships created among diverse groups will create environmental social change to support greater cultural sensitivity and inclusion in the area.

## Example 3:

A RHEC sponsored a training focused on human resources (HR) professionals focused on embedding an equity lens into HR practice. Over 40 HR and management professionals from organizations across three counties attended the training. Building the capacity of local organizations to reflect equity improvements in their policies and procedures helps support greater workforce diversity and improvements to consumer relations.

## Example 4:

Another coalition sponsored a three-part series in partnership with their local chapter of the National Association for the Advancement of Colored People (NAACP). This event increased the capacity and reach of their partner organizations, and fostered community engagement around the issue of structural racism among community members. The event also strengthened the involvement of local stakeholders and policymakers with this population and issue.

## Example 5:

One coalition offers a four-part training series regarding equity and inclusion in the workplace. This training encourages organizations to assess how welcoming their internal policies are, and if those policies align with organizations' missions. The RHEC recently noticed that interest in equity and inclusion trainings has shifted from community members to those on behalf of organizations, agencies and their staff within their region.

This coalition provides support for a more equitable cultural lens in their local agencies and organizations, which is an ongoing need. Since their inception, this coalition has trained more than 600 participants. Over the past year, they have also provided trainings in various locations outside their region and into the eastern part of the state, including Harney County. They have been a key change agent through their facilitation of thought provoking dialogues. Talks that begin in their trainings continue long after the trainers leave.

# Outcome 5: Policy change

Policy change — at the local and state level — is one way to sustain and ensure practices that support health equity. However, policy change is a process that begins with increased community engagement and strengthened organizational capacity. All of the RHECs are moving along this continuum of readiness towards making lasting changes.

Since RHEC work began, all six coalitions have directly engaged local and state policymakers on issues of health equity through RHEC sponsored public forums, participation in meetings and committees, and public testimony.

## Examples of policy change efforts

### Example 1:

One coalition provides an excellent example of local policy engagement. Prior to this coalition's work in the community, there were no Latinos holding elected office in the region; now there are 10 Latinos on various boards throughout their region.

This process began with community engagement. For example, the superintendent asked the RHEC why more Latino parents were not involved in their kids' education. In response to the question, the coalition conducted a survey about parent barriers and solutions. A member of RHEC community leadership presented results to the school board. Following that, one of the parents was inspired to serve on the school board. She ran, won, and became the first Latina ever to hold office in the city. Since then, another RHEC member won a seat on the transportation board. This RHEC member was a write-in candidate with 427 votes in a two-week campaign. There have been many similar stories about Latino candidates stepping forward to serve and winning seats. Additionally, the local mayor has been meeting with RHEC staff to recruit community members to a Latino advisory council, and to learn more about the needs of the local Latino community. Because of these meetings, the mayor is now considering adopting a policy that addresses needs for language services.

### Example 2:

Another coalition has made incredible progress on policy change for health equity at the state level. This RHEC has developed criteria and a policy process for meaningful participation of members at every stage of the legislative process. Overall,

this RHEC has created a unified, clear and intentional policy agenda that has influenced the social determinants of health and healthcare in Oregon. The RHEC's policy committee develops, analyzes and informs local and state policy. Members receive education and training around policies and the political process to build capacity. The policy committee engages with legislative representatives, community members and leaders, and the media to provide education around health equity issues.

## Example 3:

Unsafe housing disproportionately affects families of color. Because of this, one of the coalitions drafted and advanced a property maintenance code to address the negative health impact of unsafe housing. This policy ensures that all people have safe and affordable homes.

## Example 4:

One RHEC co-sponsored three medical interpreter trainings in an area where there has historically been a shortage of qualified and certified healthcare interpreters. They also worked with their local CCO to create an alternate payment model (APM) for clinics with a medical interpreter on site.

# Policy and system change recommendations

These are the policy and system change recommendations from the RHECs based on their experiences working to promote health equity within their regions and across Oregon.

## Coordinated care organizations

As previously mentioned, most RHECs have interfaced with their local CCO and/or community advisory councils (CACs). There are many opportunities for CCOs and their CACs to strengthen partnerships with the RHECs to advance health equity in the state. The coalitions are local subject matter experts regarding community needs and concerns. The RHECs have the ability to create and inform problem-solving efforts using an equity lens. It is recommended that CCOs and CACs formalize and fortify these relationships with RHECs. These groups can do so by working together in a structured manner to engage with local communities to identify regional health equity issues. Additionally, creating a work plan together to outline activities to address identified issues.

## Healthcare

- Create a tracking mechanism that connects community benefit funds to social determinants of health and investing in care for the uninsured. Community benefit and Oregon hospitals play a critical role in caring for our communities and closing persistent health inequity gaps.
- To maximize enrollment, there should be outreach for preventative care programs to newly eligible children implemented.
- Change the state law around mandatory reporting of consensual sexual activity between minors. This law, as written, requires health providers to report all minors who are sexually active, including consensual activity. It is a barrier for youth, particularly youth of color, making them less likely to seek out and receive comprehensive reproductive health services. If this law were rewritten, requiring mandatory reporting only of sexual activity that is non-consensual, coercive, or when there is a three or more-year age difference, this would be an improvement.

# Language access

Sectors serving individuals who speak languages other than English should provide professionally translated materials in the languages their constituents speak. Additionally, there should be a review for fluency, clarity and plain language by a proficient contractor. Similarly, there should be free interpretation services offered by a qualified and/or certified health care interpreter* for direct health services, or a professional interpreter for other needs. Systems should steer away from using internal staff, hired for other tasks who may not have the proficiency to interpret or develop high quality materials. This can lead to embarrassing outcomes and send a public message that the organization is not equipped to serve them fully. There should be an offer of additional pay if staff have the skill set necessary to assist with language access tasks. This investment helps create an accessible, welcoming and respectful environment for clients, patients, customers and personnel served.

# Partnership investment and community engagement

Agencies and organizations should consider developing and implementing policies addressing barriers toward community involvement in the work they do. There should be resources allocated to support inviting community members to the decision-making conversation, specifically from sectors least represented and most vulnerable in local areas. Remove barriers that would prevent participation. Strategies to help support community engagement include:

- Agencies and organizations should offer funding and resources when there is a request for an expert to develop a strategic equity plan. The same as they would with any other consultant.
- Consider language access by making sure to offer professional interpretation and closed captioning.
- Have materials, documents, handouts and signage for the meetings translated.
- Ask people at meetings to limit use of jargon and acronyms. People will better understand the meeting.
- Written materials should undergo plain language assessments to support readability.
- Consider limiting use of written materials. Doing so is to be inclusive of those unable to read.
- Provide stipends for community members not affiliated or representing an agency. Anyone should be able to get a stipend, regardless of residency.

* Oregon Revised Statute (ORS) 413.552 https://www.oregonlegislature.gov/bills_laws/ors/ors413.html

- Offer care reimbursement stipends for adults and/or youth who are raising children, or who provide care for any dependent that needs supervision.
- So that travel costs to or from meetings is supported, provide transportation reimbursements or stipends.
- When scheduled during meal times, have food for meetings. This means community members will not have to incur expenses by eating away from home. It also means that it is not necessary to take time to prepare meals to take to meetings.
- Ensure meeting spaces are ADA accessible.[†]

These changes support shifting away from telling communities what they need. It is a shift toward having communities identify the most pressing issues. The community then is leading the development of culturally and linguistically appropriate solutions.

## Supporting families

- Create a paid family and medical leave insurance program for every working Oregonian.
- The Oregon Legislature should create and update an expanded definition of "family member" that reflects a broader definition of family structures and relationships.

## Tobacco

- Increase tobacco cessation programs for youth under the age of 21.

  Local organizations should join efforts to support local legislation that strengthens tobacco retail licensing requirements. This will avoid future preemptive actions from the tobacco industry. Recently, one RHEC worked in collaboration with their local county health department to advocate with their city council for stronger tobacco retail regulations. The coalition, recruited community members, parent-teacher associations, and local school board members to provide testimony – an effort that was key in passing local policies that limit tobacco sales near schools, reduce the concentration of tobacco retailers in low-income areas, and include e-cigarettes and vaporizers in the regulations language.

† Americans with Disabilities Act (ADA) https://www.ada.gov/

# Summary

By using the RHEC model, the coalitions build on the strengths of their local communities. This involves communities in meaningful ways to identify sustainable, long-term, policy, system and environmental solutions to increase health equity for underserved and underrepresented populations experiencing health disparities.

Specifically, the six RHECs have the potential to reach diverse communities in geographic areas serving 11 Oregon counties and the Confederated Tribes of Warm Springs. This is nearly 60% of Oregon's total population. The work of the coalitions covers a wide range of underserved communities. This includes people of color, immigrants, refugees, migrant and seasonal farmworkers, low-income populations, individuals with disabilities, and LGBTQ communities in rural and urban areas. The sectors impacted through RHEC work includes, but is not limited to behavioral health, city and county governments, community-based organizations, CCOs, corrections/law enforcement, dental, disabilities, education, employment, environmental, faith-based, healthcare, higher education, local business, neighborhood councils, policymakers, public housing, tribal government, and urban planning.

The coalition work highlighted in this report builds the foundation for empowering communities to improve and sustain health equity across Oregon. Provided in this report are several examples of efforts and accomplishments across the five primary outcome areas of RHEC work. These outcomes include increased authentic community engagement, strengthening organizational capacity, creating social norm and environmental change, creating system change, and effecting policy change. The examples provided also serve as potential strategies that agencies and organizations can consider when developing health equity plans.

Finally, provided in this document are policy and system change recommendations based on RHEC experiences of addressing health equity issues in Oregon. The recommendations spanned the topics of CCOs, corrections/law enforcement, healthcare, language access, partnership investments and community engagement, supporting families and tobacco.

The RHECs address health inequities across the social determinants of health that have persisted for generations. Ultimately, the coalitions are improving the overall state of health equity in Oregon. This work is a nominal investment for substantial, long-term improvements among the state's most vulnerable and resilient populations.

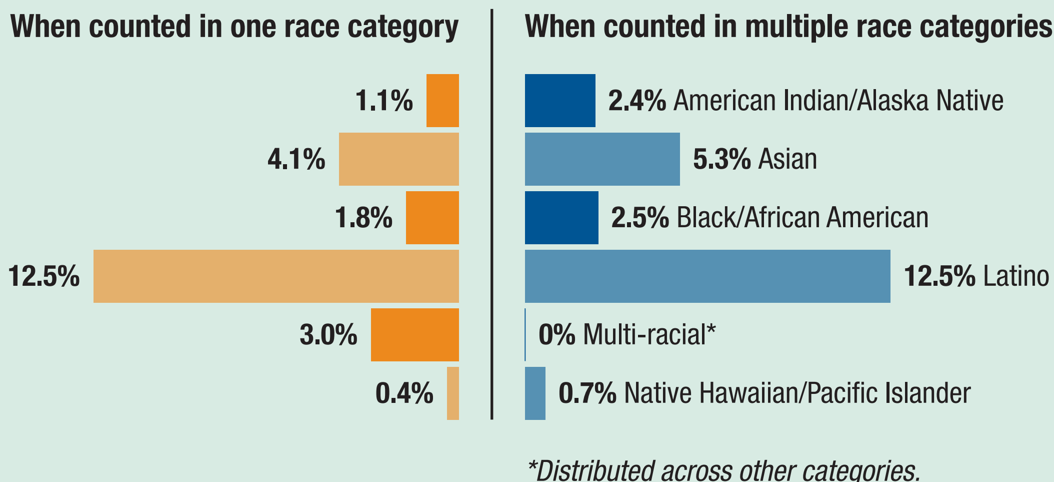
# Appendix 1

The following figures show population data for communities of color across Oregon and within each RHEC service region. The data shown is for race when counted in one category as well as when counted in multiple categories. Latino ethnicity is a separate category from race.

Presenting data in this way provides a more accurate snapshot of people's identities and lessens underrepresentation. In addition to reviewing the percentage of people with specific identities, it is also important to note the number of individuals for full context.

*Data source of all following graphs: United States Census Bureau Population Division. Annual estimates of the resident population by sex, race, and Hispanic origin, April 1, 2010–July 1, 2014. (Release June 2015), Tables PEPSR6H and PEPSR5H*

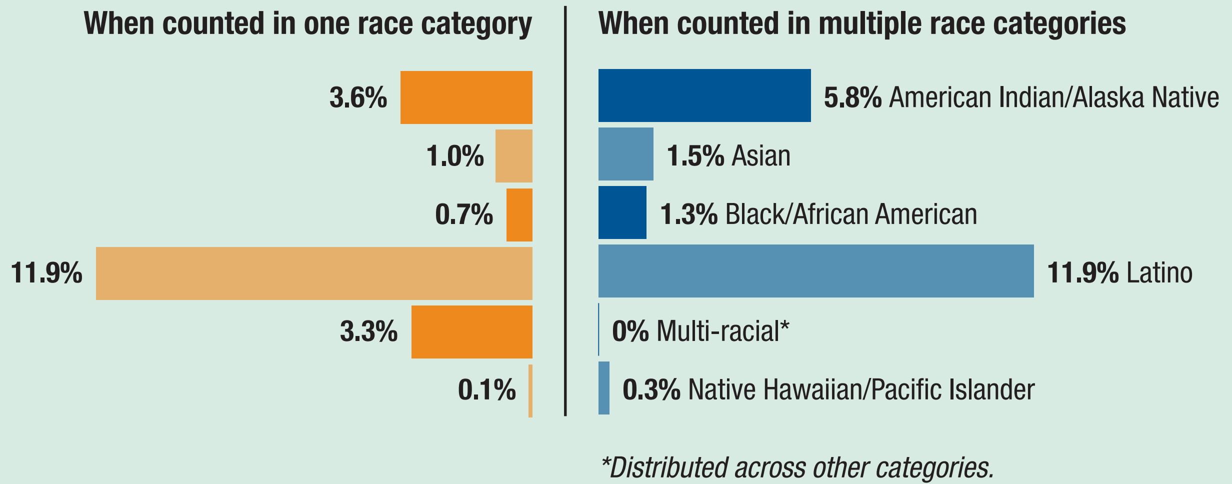
## Communities of color in Oregon




*Distributed across other categories.

NOTE: Numeric estimates for communities of color in Oregon when counted as a single race are as follows: American Indian/Alaska Native (n=66,784), Asian (n=145,009), Black/African American (n=74,414), Multi-racial (n=126,966), Native Hawaiian/Pacific Islander (n=14,649). When counted alone or in combination are as follows: American Indian/Alaska Native (n=126,075) Asian (n=190,238), Black/African American (n=104,181), Multi-racial (n/a), Native Hawaiian/Pacific Islander (n=26,936).

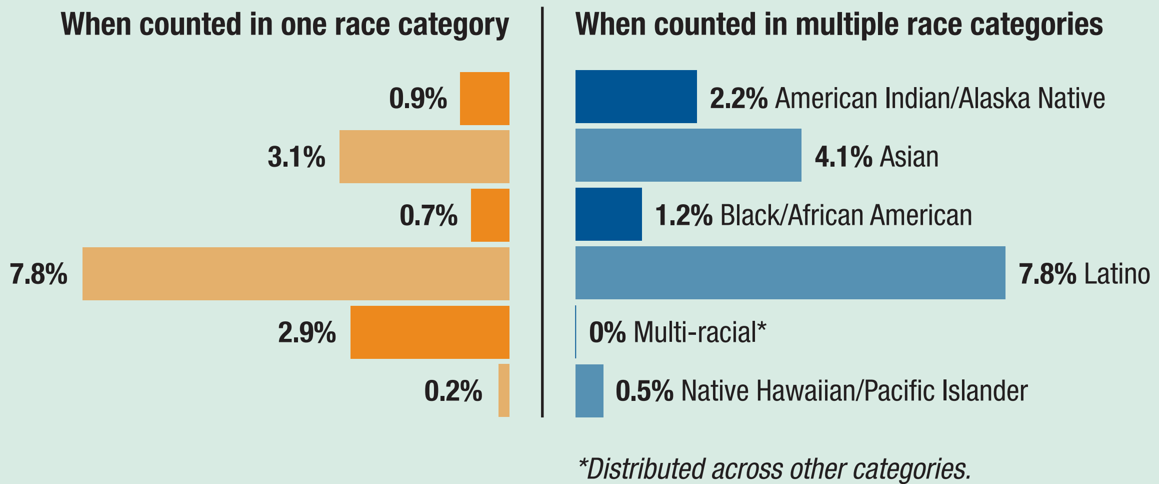
## Communities of color in Klamath County (Klamath Regional Health Equity Coalition region)




*Distributed across other categories.*

NOTE: Numeric estimates for communities of color in Klamath Regional Health Equity Coalition's service area when counted as a single race are as follows: American Indian/Alaska Native (n=2,954), Asian (n=647), Black/African American (n=474), Multi-racial (n=2,414), Native Hawaiian/Pacific Islander (n=100). When counted alone or in combination are as follows: American Indian/Alaska Native (n=4,685) Asian (n=1,033), Black/African American (n=857), Multi-racial (n/a), Native Hawaiian/Pacific Islander (n=243).

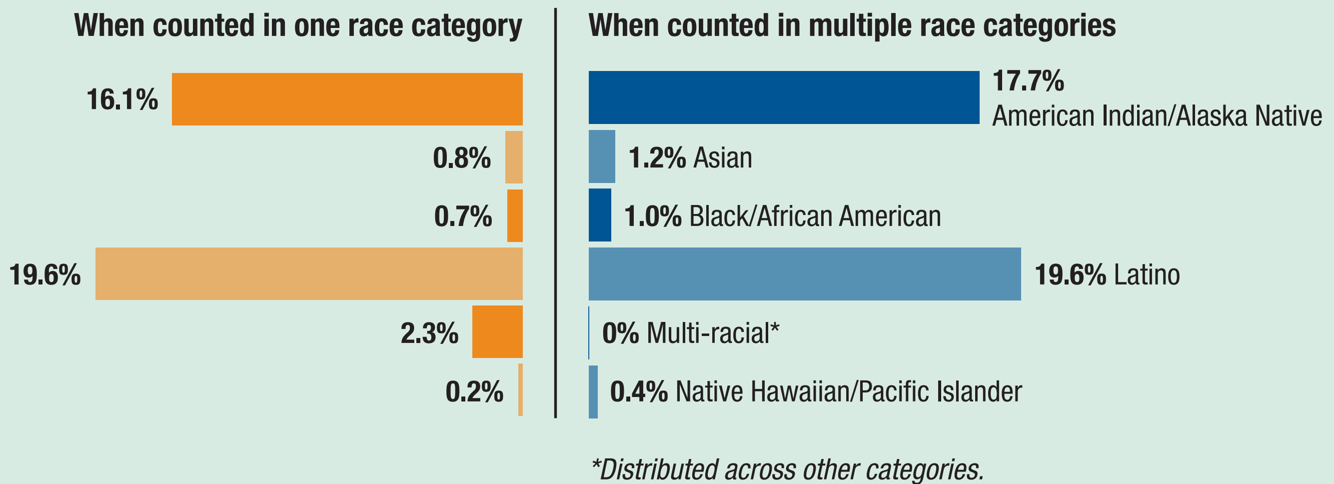
## Communities of color in Linn and Benton Counties (Linn-Benton Health Equity Alliance region)




*Distributed across other categories.*

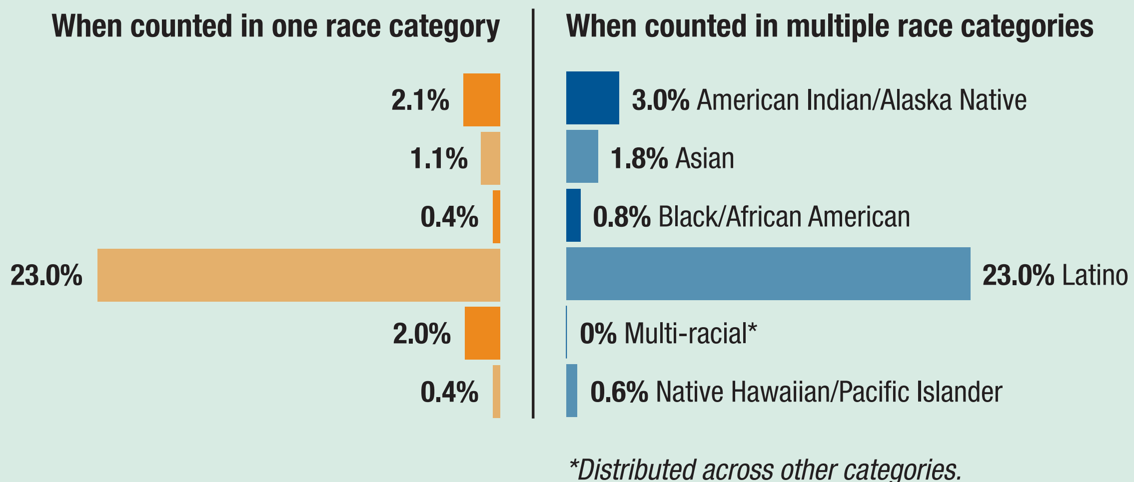
NOTE: Numeric estimates for communities of color in Linn-Benton Health Equity Alliance's service area when counted as a single race are as follows: American Indian/Alaska Native (n=2,451), Asian (n=5,677), Black/African American (n=1,486), Multi-racial (n=6,142), Native Hawaiian/Pacific Islander (n=400). When counted alone or in combination are as follows: American Indian/Alaska Native (n=5,546) Asian (n=7,797), Black/African American (n=2,501), Multi-racial (n/a), Native Hawaiian/Pacific Islander (n=1,052).

### Communities of color in Jefferson County (Let's Talk Diversity Coalition region)



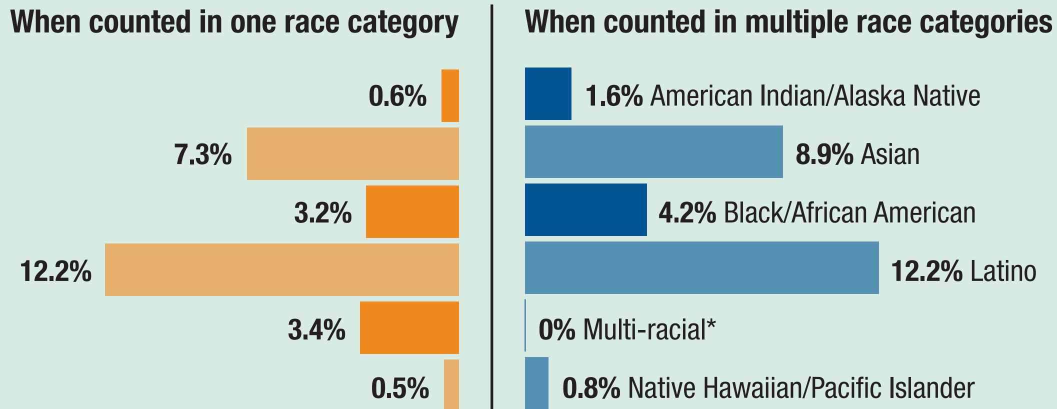

NOTE: Numeric estimates for communities of color in Let's Talk Diversity's service area when counted as a single race are as follows: American Indian/Alaska Native (n=3,928), Asian (n=102), Black/African American (n=185), Multi-racial (n=628), Native Hawaiian/Pacific Islander (n=38). When counted alone or in combination are as follows: American Indian/Alaska Native (n=4,453) Asian (n=193), Black/African American (n=260), Multi-racial (n/a), Native Hawaiian/Pacific Islander (n=95).

### Communities of color in Hood River and Wasco Counties (Mid-Columbia Health Equity Adovcates Region)




NOTE: Numeric estimates for communities of color in Mid-Columbia Health Equity Advocates' service area when counted as a single race are as follows: American Indian/Alaska Native (n=1,417), Asian (n=526), Black/African American (n=249), Multi-racial (n=628), Native Hawaiian/Pacific Islander (n=38). When counted alone or in combination are as follows: American Indian/Alaska Native (n=1,987) Asian (n=862), Black/African American (n=393), Multi-racial (n/a), Native Hawaiian/Pacific Islander (n=324).

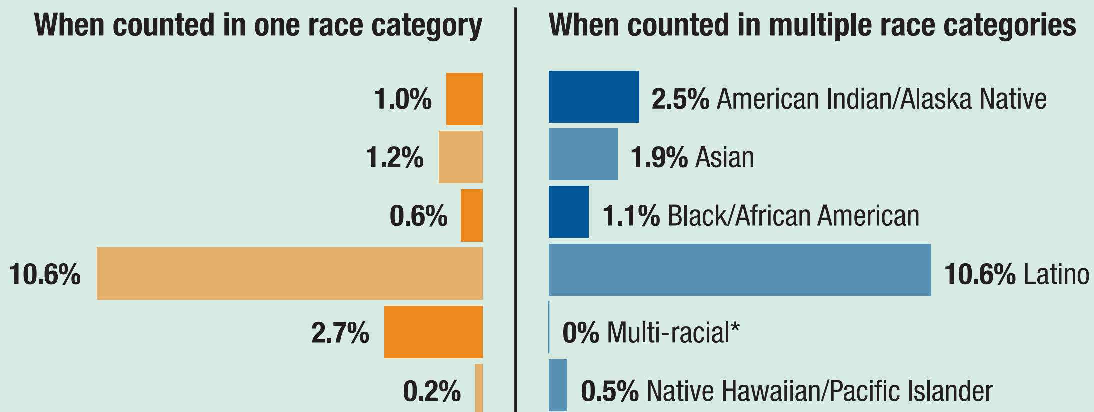
## Communities of color in Clackamas, Multnomah and Washington Counties (Oregon Health Equity Alliance region)




*Distributed across other categories.*

NOTE: Numeric estimates for communities of color in Oregon Health Equity Alliance's service area when counted as a single race are as follows: American Indian/Alaska Native (n=21,087), Asian (n=109,626), Black/African American (n=57,242), Multi-racial (n=60,655), Native Hawaiian/Pacific Islander (n=7,985). When counted alone or in combination are as follows: American Indian/Alaska Native (n=41,999) Asian (n=136,618), Black/African American (n=74,908), Multi-racial (n/a), Native Hawaiian/Pacific Islander (n=14,313).

## Communities of color in Jackson and Josephine Counties (So-Health-E region)




*Distributed across other categories.*

NOTE: Numeric estimates for communities of color in Southern Oregon Health Equity Coalition's service area when counted as a single race are as follows: American Indian/Alaska Native (n=4,183), Asian (n=3,202), Black/African American (n=1,877), Multi-racial (n=8,580), Native Hawaiian/Pacific Islander (n=805). When counted alone or in combination are as follows: American Indian/Alaska Native (n=9,345) Asian (n=5,296), Black/African American (n=3,402), Multi-racial (n/a), Native Hawaiian/Pacific Islander (n=1,644).

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