OREGON'S
COORDINATED CARE ORGANIZATIONS
ADVANCING HEALTH EQUITY

January 2019

Ignatius Bau
Technical Assistance Consultant
Oregon Health Authority Transformation Center

TABLE OF CONTENTS

PAGE

Acknowledgements
Thanks to Adrienne Mullock, Tom Cogswell, Alissa Robbins, Anona Gund, and Chris DeMars from the Oregon Health Authority (OHA) Transformation Center for their continuing support of this work on health equity. Thanks also to Anastasia Sofranac, Kweku Wilson, Mavel Morales, Emily Wang, Maria Elena Castro, and Leann Johnson from the OHA Office of Equity & Inclusion; Frank Wei-Tung Wu from the OHA Office of Health Analytics; and Innovator Agents Joell Archibald, Estela Gomez, Bevin Hansell, Cyndi Kallstrom, Belle Shephard, and Dustin Zimmerman for their continued collaboration and support.

Prepared by:
Ignatius Bau
1067 Market Street Suite 3007
San Francisco, CA 94103
ignatius.bau@gmail.com

January 2019

SECTION 1: BACKGROUND ON OREGON'S COORDINATED CARE ORGANIZATIONS (CCOs) AND HEALTH EQUITY

Since 2012, Oregon's Coordinated Care Organizations (CCOs) have integrated activities to advance health equity as part of the state's innovative model of health system and payment transformation. These activities were reviewed as part of tailored technical assistance made available to the CCOs by the Oregon Health Authority's (OHA) Transformation Center in 2016-2017.[1]

During that time, the CCOs were obligated to identify and pursue opportunities to advance health equity in several ways. Three of the eight Transformation Plan Areas in their contracts with OHA required CCOs to meet the cultural and linguistic needs of their diverse members, and to reduce racial and ethnic disparities. These obligations included:

- assuring that communications, outreach, and member engagement are tailored to cultural, health literacy, and linguistic needs,
- assuring that the culturally diverse needs of members are met (cultural competence training, provider composition reflects member diversity, Certified Traditional Health Workers and Traditional Health Workers composition reflects member diversity), and
- developing a quality improvement plan focused on eliminating racial, ethnic, and linguistic disparities in access, quality of care, experience of care, and outcomes.

This imperative to advance health equity is reinforced by health care quality performance measurement data that continue to reflect the avoidable disparities in access, utilization, and outcomes among racial and ethnic minorities, individuals who speak primary

[1] Oregon Health Authority Transformation Center, Opportunities for Oregon's Coordinated Care Organizations to Advance Health Equity (2017), https://www.oregon.gov/oha/HPA/dsi-tc/Documents/CCO-Opportunities-to-Advance-Health-Equity.pdf

languages other than English, and individuals with disabilities. These data have highlighted the continuing disparities experienced by Oregon's diverse CCO members:

- Hispanic/Latina women are less likely to have timely prenatal care
- American Indian children are less likely to receive developmental screening
- Hawaiian/Pacific Islander children are less likely to receive immunizations
- Children with disabilities, and American Indian and Hawaiian/Pacific Islander children, are less likely to receive dental sealants
- Adolescents of color and from households speaking languages other than English are less likely to receive adolescent well-care
- Latinos/Hispanics are less likely to receive colorectal cancer screening
- American Indians have the highest rates of smoking
- Asian Americans are less likely to receive screening for alcohol and substance misuse
- Asian American women at risk for unintended pregnancy are less likely to have effective contraception use, and
- American Indians, African Americans/Blacks, and individuals with disabilities have higher rates of utilization of emergency departments.[2]

In June 2017, CCOs participated in the OHA Transformation Center's annual Innovation Café, which included a focus on health equity, and a presentation summarizing some of the best practices and learning from the technical assistance that had been provided to the CCOs on health equity.[3] For example, many CCOs were improving the information they provided about language assistance services available, translating member communications into Spanish and other languages, and reviewing member communications for appropriate health literacy and appropriateness for members with disability. CCOs also were providing training to staff and providers on cultural competency, health literacy, adverse childhood events (ACEs)/trauma-informed care, and the culture of poverty. Some were reviewing the cultural competency policies of providers. Many were supporting the training and use of community health workers (CHWs), other Traditional Health Workers (THWs), and health care interpreters. A few were reviewing their own staff hiring policies to improve the diversity of their own workforce. Finally, CCOs were beginning to designate staff or create staff work groups on health equity; analyzing quality data stratified by member demographic characteristics; implementing specific interventions to reduce disparities; reviewing member reports on experiences of care, complaints, grievances, and appeals from diverse members; and participating in regional health equity coalitions.

Overall, the following are key strategies used by the CCOs to advance health equity:

- Create a CCO-wide plan to advance health equity
- Use each CCO's own data to identify and prioritize disparities
- Partner with diverse members and communities served

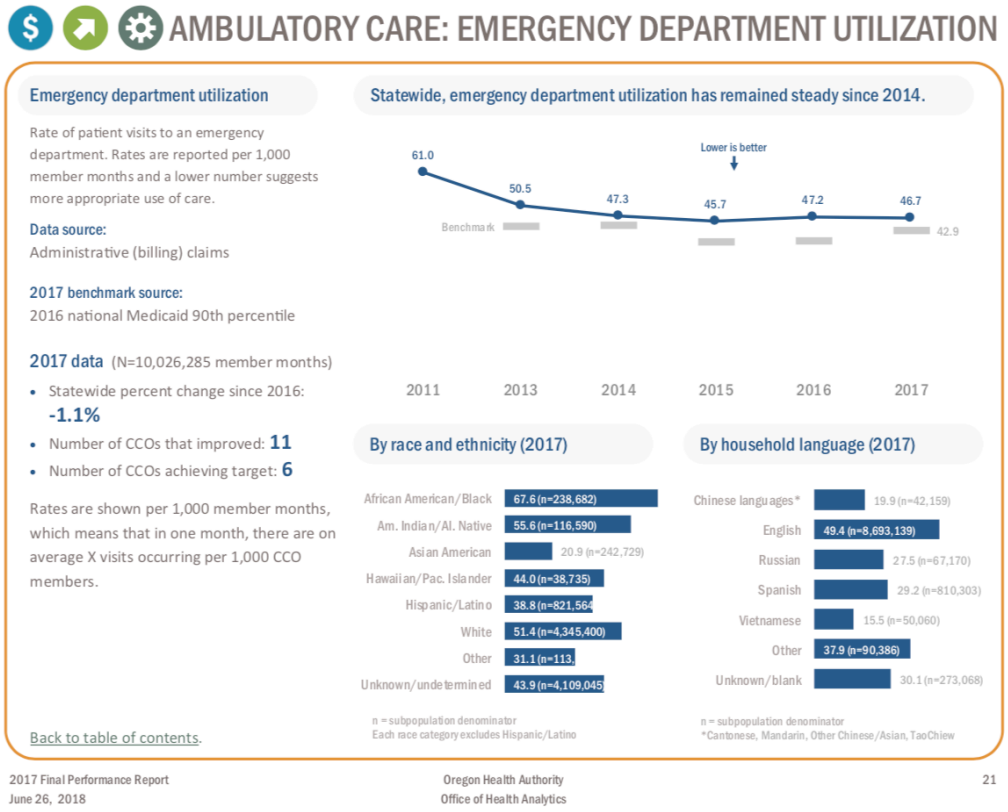
---

[2] Oregon's Health System Transformation CCO Metrics 2015 Mid-Year Update (January 2016), https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2015-Mid-Year-Report.pdf; Oregon's Health System Transformation: CCO Metrics 2015 Final Report (June 2016), https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2015-Final-Report.pdf; and Oregon's Health System Transformation: CCO Metrics 2016 Mid-Year Report (January 2017), https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2016-Mid-Year-Report.pdf

[3] https://www.oregon.gov/oha/HPA/dsi-tc/Pages/2017-innovation-cafe.aspx

- Engage clinics and providers
- Build and sustain a diverse workforce
- Integrate equity into health system transformation
- Be accountable for advancing health equity.

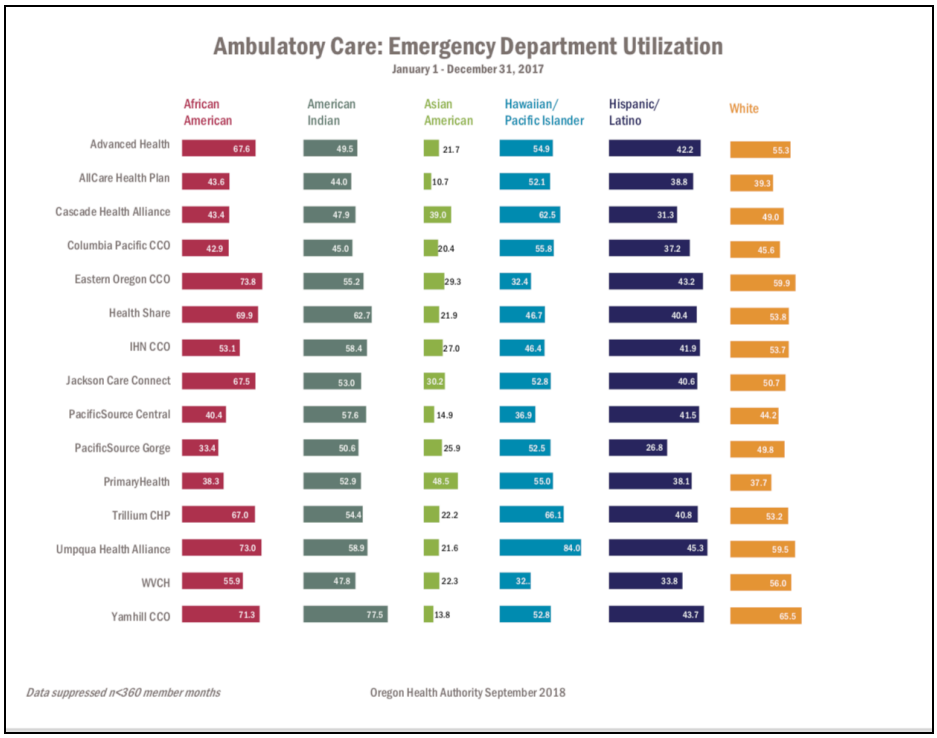
Despite these important activities to advance health equity, the most recent health care quality measurement data reported by the CCOs still reflect the persistence of continuing disparities among CCO members by race, ethnicity, language, sex, and disability status.[4] For example, while the rate of emergency department utilization has decreased statewide, utilization is still higher for African Americans, American Indians, and individuals with disabilities.

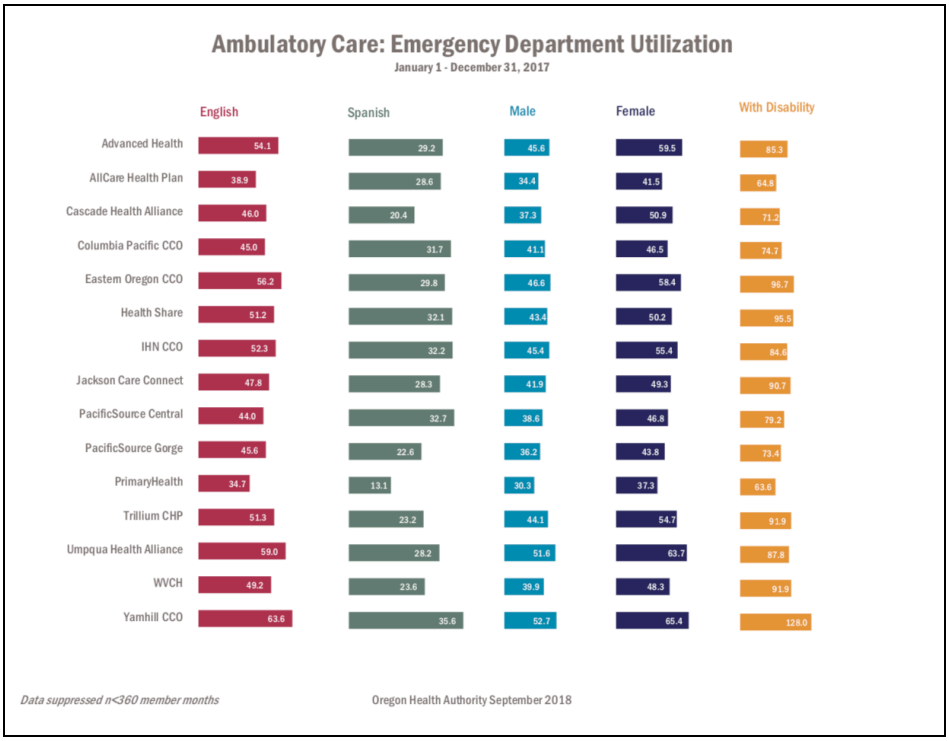


While there are variations among the CCOs, higher rates among African Americans, American Indians, and individuals with disabilities are found across all the CCOs.[5]

[4] Oregon Health Authority, Oregon Health System Transformation: CCO Metrics 2017 Final Report (June 2018), https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/2017-CCO-Metrics-Report.pdf

[5] The OHA Office of Health Analytics and OHA Transformation Center has extracted CCO-level data for seven incentive measures, disaggregated by race, ethnicity, language, sex, and disability status of their respective members: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/10-24-18%20HE%20Charts-Combined.pdf





Similarly, disparities in effective contraceptive use among adult women at risk of unintended pregnancy persist for Asian, and Native Hawaiian and Pacific Islander women, and for Russian- and Vietnamese-speaking women.[6]

[6] The data on Russian- and Vietnamese-speaking women should be considered with caution because of the high proportion of missing data in the language variable.

EFFECTIVE CONTRACEPTIVE USE AMONG ADULT WOMEN AT RISK OF UNINTENDED PREGNANCY

Effective contraceptive use

Percentage of adult women (ages 18-50) with evidence of one of the most effective or moderately effective contraceptive methods during the measurement year: IUD, implant, contraception injection, contraceptive pills, sterilization, patch, ring, or diaphragm.

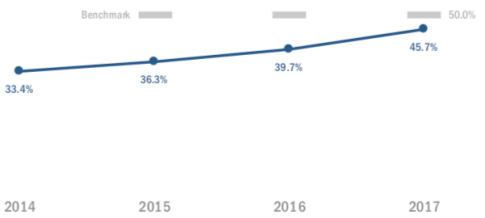
Data source:
Administrative (billing) claims

2017 benchmark source:
Metrics and Scoring Committee consensus

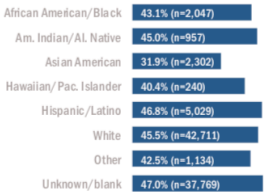
2017 data (N=92,189)

- Statewide change since 2016: **+15.1%**
- Number of CCOs that improved: **all 16**
- Number of CCOs achieving target: **all 16**

Statewide, effective contraceptive use among adult women continues to increase.

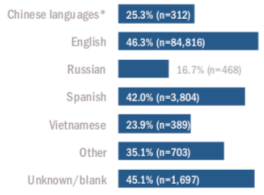


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

Back to table of contents.

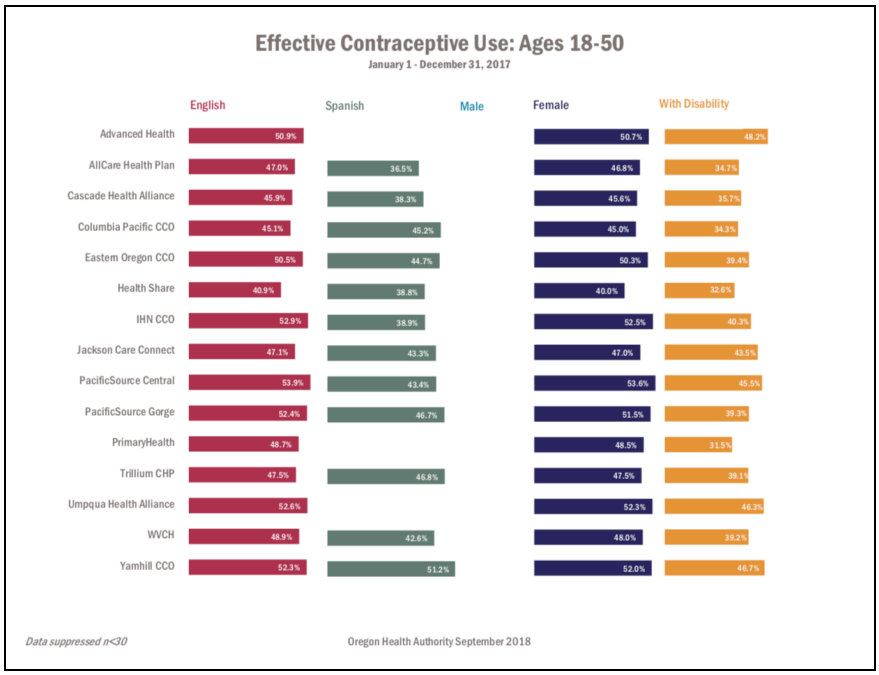
Effective Contraceptive Use: Ages 18-50

January 1 - December 31, 2017

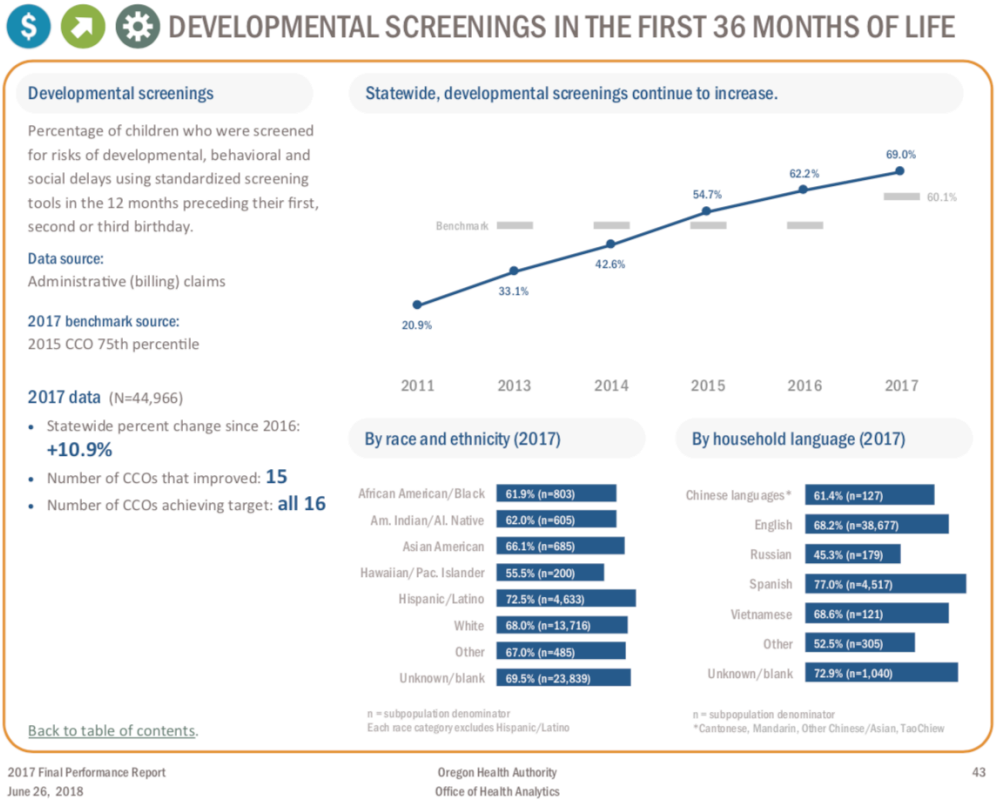
	African American	American Indian	Asian American	Hawaiian/ Pacific Islander	Hispanic/ Latino	White
Advanced Health					45.5%	50.6%
AllCare Health Plan		43.5%			50.0%	46.5%
Cascade Health Alliance					50.0%	45.0%
Columbia Pacific CCO					49.2%	45.2%
Eastern Oregon CCO		50.8%			41.7%	50.9%
Health Share	42.6%	38.3%	30.8%	36.4%	43.9%	38.8%
IHN CCO	61.9%	50.9%	35.7%		45.8%	52.3%
Jackson Care Connect		40.0%			52.7%	45.4%
PacificSource Central		42.0%	31.3%		51.7%	53.4%
PacificSource Gorge					45.7%	49.5%
PrimaryHealth						48.3%
Trillium CHP	45.2%	55.9%	33.9%		49.1%	46.9%
Umpqua Health Alliance					44.7%	51.9%
WVCH	30.3%	45.1%	35.5%		48.5%	46.7%
Yamhill CCO					53.2%	50.7%

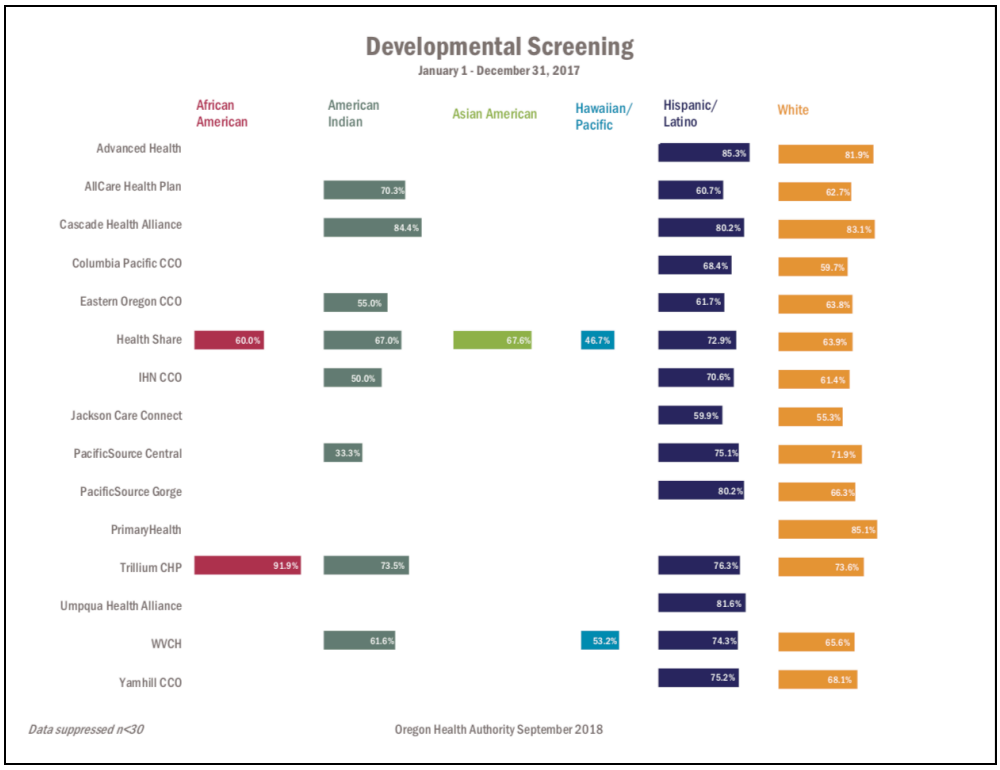
Data suppressed n<30

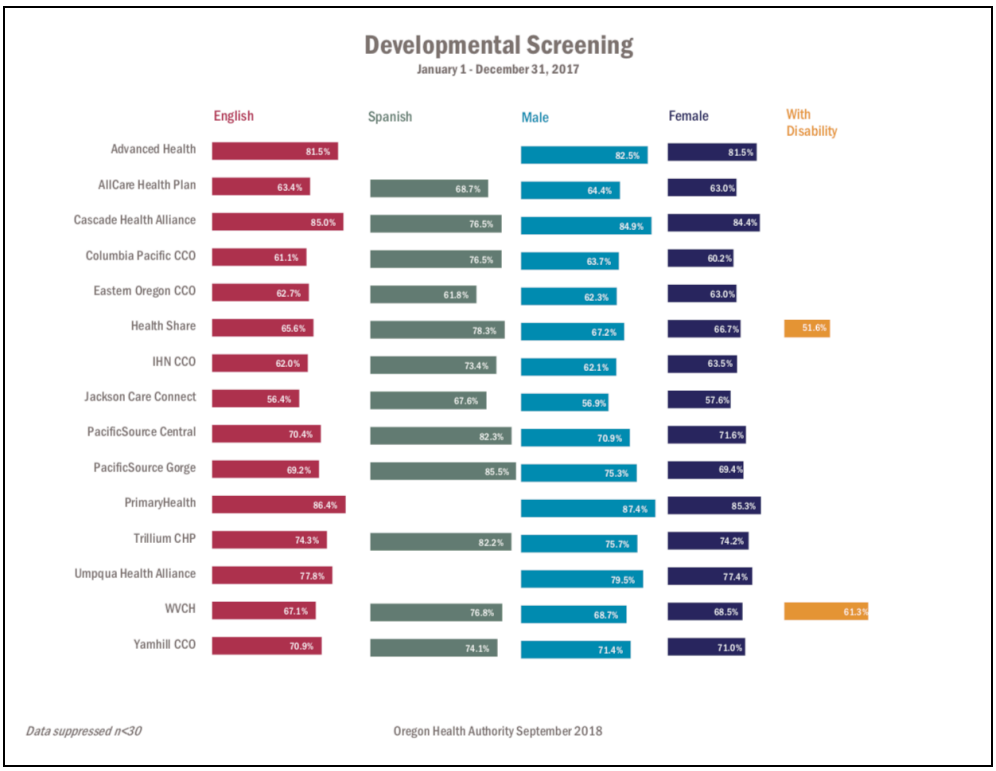
Oregon Health Authority September 2018



Moreover, disparities in developmental screening in the first 36 months of life also persist among Native Hawaiian and Pacific Islander infants, and among Russian-speaking families.







These data highlight the continuing relevance and importance for the CCOs to address and advance health equity.

SECTION 2: CURRENT CCO ACTIVITIES TO ADVANCE HEALTH EQUITY

In 2018, instead of continuing to report progress on Transformation Plans, CCOs have prepared Transformation and Quality Strategy Reports, first submitted in March 2018, with progress reports submitted in September 2018.[7] A guidance document from the OHA Transformation Center, "Using a Health Equity Lens in the Transformation and Quality Strategy", suggests ways in which CCOs could focus on health equity in each of the Transformation and Quality Strategy components.[8] In their Transformation and Quality Strategy Reports and progress reports, the CCOs have continued to report numerous activities that advance health equity.

Creating plans to advance health equity

An increasing number of CCOs have created formal plans to advance health equity. For example, in 2017, the leadership of *Columbia Pacific CCO* conducted an organization-wide equity self-assessment to determine priorities at the organizational and departmental levels for equity, diversity, and inclusion. The self-assessment resulted in a comprehensive 2018 equity strategic plan and the development of an equity lens that will provide a framework for activities and programs to be implemented by *Columbia Pacific CCO*; the equity lens includes policies on workforce and volunteer diversity, minority/women/small business contracting, and partnerships with community-based organizations, including those serving limited English proficient and other diverse populations. *InterCommunity Health Network CCO* worked with its Delivery System Transformation leadership to develop and adopt a five-year health equity strategic plan. As an Early Learning Hub, *Yamhill Community Care Organization* conducted an organizational racial equity assessment in 2016, and then developed and adopted a health equity plan in 2017. *PacificSource* worked across its lines of business to develop a company-wide health equity strategic plan in 2017. *AllCare CCO* has a health equity strategic work plan. *Health Share of Oregon* has a health equity plan. *Trillium Community Health Plan* has an equity quality improvement plan. These formal health equity plans promote transparency and accountability, and allow CCOs and their stakeholders to monitor and evaluate progress on advancing health equity.

Designating staff positions and staff working groups focused on health equity

A number of CCOs have designated staff positions and staff working groups and committees focused on health equity. *PacificSource* has a Health Equity and Diversity Strategist. *Health Share of Oregon* has a Chief Equity and Engagement Officer and three Health Equity Strategists; it also has a Disparities Analytics and Reporting Team. *Trillium Community Health Plan* has a Health Equity Officer and a Diversity and Health Equity Committee that meets monthly.

AllCare CCO has a Health Equity and Inclusivity Action Team. *InterCommunity Health Network CCO* has a Health Equity Workgroup. *Yamhill Community Care Organization* has an Equity Committee. *Jackson Care Connect* has an Equity, Diversity, and Inclusion Committee, and has been working including equity, diversity, and inclusion questions in all hiring interviews. These designated staff positions and staff working groups support accountability within each CCO for advancing health equity.

[7] https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx
[8] https://www.oregon.gov/oha/HPA/dsi-tc/Documents/TQS-Health-Equity-Lens-Guidance.pdf

PacificSource Central Oregon also has increased its outreach and recruiting of bilingual and bicultural employees from regional educational institutions, and moved its customer service functions in-house, resulting in hiring additional bilingual, bicultural staff.

Providing staff, board, and stakeholder training on health equity and related topics
Many CCOs continue to provide staff training on health equity and related topics. During 2017, *Columbia Pacific CCO* board members and senior leadership members underwent training to advance their personal and leadership capabilities to using principles of equity, cultural responsiveness, and diversity. In 2017, *AllCare CCO* sponsored company-wide mandatory training in health equity, with 100% of its 210 employees trained; topics included implicit bias, health literacy, and cultural agility; external organizations and companies also requested the training. The trainings led to the formation of a Health Equity and Inclusivity Action Team and Health Equity Champions at the CCO. In 2018, four one-hour trainings will be provided by *AllCare CCO* on cultural agility, health literacy, creating an affirming setting for non-binary people, and implicit bias. *Yamhill Community Care Organization* conducted an all-staff training in September with a focus on equity and the social determinants of health. *Health Share of Oregon* provides mandatory quarterly training on health equity for its staff and monthly lunch and learns; topics have included power and privilege, racism, health equity and social determinants of health, implicit bias, transgender competency, understanding poverty. *Eastern Oregon CCO* provides a workforce diversity and cultural competency training (both online and on-site options) for all its staff.

Cascade Health Alliance provides annual trainings for its staff and providers/clinics on obtaining care that recognizes their experiences, cultural diversity, and other unique needs. *PacificSource Central Oregon* provides new employee training on health equity and is developing online resources for providers about diversity. *Jackson Care Connect* provides training and hosts staff brown bag lunches on equity, diversity, and inclusion; and its board of directors, led by its governance committee, is building awareness of equity, diversity, and inclusion among the board. *Trillium Community Health Plan*'s quarterly lunch and learns about diversity and lived experience are open to all its staff and contractors.

Advanced Health has provided training on Neuroscience, Epigenetics, Adverse Childhood Events (ACEs), and Resilience (NEAR); 12 individuals have completed an ACEs Master Training; and in November 2017, a steering committee and a metrics committee were seated to provide a cross-sector community infrastructure to guide the Self-Healing Communities Initiative and produce a comprehensive implementation and measurement plan for Coos and Curry counties. *Advanced Health* also has provided trainings on the culture of poverty, health literacy, and the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. *PrimaryHealth* provides three hours of ACEs training to all its employees; promotes education regarding the impact of ACEs and the use of this science in creating a trauma-informed approach throughout the community through Southern Oregon Success (SORS) and the Grants Pass District 7 Schools. *Yamhill Community Care Organization* also co-sponsors training on trauma-informed care for its community providers and partners.

Using member demographic data to identify and prioritize disparities
All CCOs have access to and are able to regularly monitor their own CCO-level member data in terms of enrollment, and in terms of performance on reported quality measures

stratified by demographic factors (sex, race, ethnicity, language, disability status). Several CCOs have begun to report and share the stratified data with their providers. For example, *Eastern Oregon CCO* disseminates monthly progress reports on claims-based quality measures to its providers that contain information about the race, ethnicity, and language of members served (e.g., 13% identified a language other than English). *Advanced Health* has race, ethnicity, language, and zip code filters in its quality measure dashboards. *Jackson Care Connect* and *Columbia Pacific CCO* have disaggregated CCO metrics data in their provider dashboards by race, ethnicity, and language. *Yamhill Community Care Organization* is refining its provider dashboards to include disaggregated data by age, sex, race, ethnicity, language, and disability (e.g., Hispanics were the only racial or ethnic group meeting targets for colorectal cancer screening). *AllCare CCO* has identified a disparity on emergency department utilization among its Native American members and is developing strategies to engage the Native American population and to introduce Native American wellness programs among its providers; it will be developing a disparities report at the provider level for all its alternative payment model (APM) measures.

Some CCOs are taking a closer look at other data, especially results of member experience surveys, and complaint, grievance, and appeals data, to identify any potential disparities. For example, in 2017, *AllCare CCO* surveyed members who have providers participating in its APMs about feeling treated differently because of insurance type; race; gender; age; being lesbian, gay, bisexual, transgender, queer; disability; language; or other status; 1,980 responses have been collected so far, with the feeling of being treated differently being most often reported because of insurance type or disability. *Eastern Oregon CCO* analyzed its Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data, identifying lower scores from Spanish-speaking and English-speaking members; the CCO is now developing quality improvement projects focused on improving access to care for its members who are Hispanic women and children.

Health Share of Oregon analyzed its grievances and appeals by race and ethnicity and by language**,** which showed over-representation of grievances among White and African American members, and among English- and Arabic-speaking members. There also was overrepresentation of English- and Arabic-speakers in appeals, and of White and African American members in hearings. Accordingly, *Health Share of Oregon* has established a performance improvement goal to increase engagement of non-English speaking and of racial and ethnic minority members in pursuing their grievance, appeal, and hearing rights.

Trillium Community Health Plan is analyzing its utilization of its community health workers (CHWs)(Member Connections Representatives) by race, ethnicity, and preferred language to determine if there are disparities.

<u>Integrating equity into health system transformation and quality improvement</u>
A number of CCOs reported explicitly integrating equity and disparities reduction into their health system transformation and quality improvement activities. For example, *InterCommunity Health Network CCO* is screening for social determinants of health and ACEs in its pediatric patient-centered primary care homes, with referrals to CHWs and social workers. *PrimaryHealth* is identifying language translation needs, as well as examining social determinants of health such as homelessness, as part of its Maternal Medical Home and maternal case management services. *Willamette Valley Community*

Health is offering parenting education, resources, and support services in Spanish, and distributing a Spanish-language children's book promoting immunizations. *Yamhill Community Care Organization* provides its Diabetes Prevention Program in Spanish.

Engaging clinics and providers

As noted above, one way that COCs are continuing to engage their clinics and providers on health equity is by sharing and reviewing quality data stratified by member demographics such as race, ethnicity, and language. For example, provider dashboards disaggregated by race, ethnicity, and language and equity are discussed at *Columbia Pacific CCO*'s Clinical Advisory Panel meetings.

Each year, *Trillium Community Health Plan* assesses its providers using a cultural and linguistic competence survey; to date, there have been 50 responses to this year's survey. *Eastern Oregon CCO* surveyed its providers about cultural and linguistic capabilities and facility accommodations for people with physical disabilities and, as of June 2018, has received responses from 43% of its providers (with a goal of a 75% response rate by January 2019). *PacificSource Central Oregon* and *PacificSource Columbia Gorge* are including discussion about the CLAS standards in their provider visits, and assessing each provider's perception of patient panel's diversity, readiness to support their patients' linguistic and culturally-specific needs, and knowledge about options for accessing interpreter services. *Willamette Valley Community Health* is developing an audit to assess the Spanish language proficiency of its providers. *InterCommunity Health Network CCO* is developing a plan to collect information about the race and ethnicity of its providers (physicians, physician assistants, nurses, traditional health workers (THWs), etc.).

Another common way to engage clinics and providers (and other CCO stakeholders) is to offer training on health equity and related topics. *AllCare CCO* offers its health equity training to its providers, with 81 participants completing the training; the CCO also developed a LGBTQ health training for primary care providers. *Eastern Oregon CCO* provides a cultural competency training for its behavioral health providers through Greater Oregon Behavioral Health, Inc. (GOBHI)(topics include working in an inclusive environment, implicit bias, and cultural competence) and developed a training on transgender health through Moda Health; the CCO also is developing a cultural competency training for its delegated dental care organizations and providers. *Willamette Valley Community Health*'s behavioral health delegate, Mid-Valley Behavioral Care Network, provided training on cultural competency to its staff. *Umpqua Health Alliance* provides training on ACEs and trauma-informed care for its primary care providers and local educators, and has collaborated with the Ford Family Foundation on a project on Trauma Informed Care with the Early Learning Hub in Roseburg.

Ensuring language access and effective communications with members

The CCOs also continue to monitor and seek to implement improvements to their language access and effective communications with members who speak languages in addition to English, members with disabilities who need assistive or adaptive communications assistance, and members with lower health literacy. For example, *PrimaryHealth* conducts an in-language welcome call for new members; if the member is hearing impaired, the TTY line is used; during the welcome call, primary care provider (PCP) options are discussed so that the language needs can be aligned with providers who speak that language whenever possible; all members requiring language assistance are notified of translation options and their right to translation services if the PCP they

choose does not speak their preferred language[9]; new member materials will be sent in the preferred language; if member materials are not available in the language needed, translation services will be offered regarding member materials. The CCO will generate quarterly reports to identify the number of members in each language category and when a threshold of 50 households with a specific language need is exceeded, vital member materials (such as member handbooks) will be translated into that language. *Cascade Health Alliance* also makes outreach calls to new members, including collecting and changing information about primary spoken and written language, and identifying any linguistic or cultural barriers.

Eastern Oregon CCO uses the Patient Education Materials Assessment Tool and the Cultural Sensitivity Health Literacy Guidelines to assess all its member communications and its website, and provides customer service in sign language, Spanish, Somali, Arabic, and other languages. *InterCommunity Health Network CCO* provides its member materials in multiple languages and at a 6th grade literacy level. *PacificSource Columbia Gorge* and *PacificSource Central Oregon* are updating their provider FAQ about interpreter services, and support the annual Legacy Health Literacy Conference. *Willamette Valley Community Health* uses health literacy guidelines of a 6th grade reading level and a12-point font for its member materials. *AllCare CCO* added preferred language cards to its member packets, added instructions to its provider manual about how to access a telephonic or in-person interpreter, and added a health equity measure to its APM, with a "pass" if the practice has a qualified or certified medical interpreter.

Several CCOs continue to support health care interpreters, through funding and partnerships with health care interpreter training programs. *AllCare CCO* supported trainings for 39 additional Spanish language interpreters, has had one staff member become a health care interpreter trainer (and began training of 20 new health care interpreters), and became a testing site for the national Certification Commission for Healthcare Interpreters. *PacificSource Columbia Gorge* has provided funding for health care interpreter training.

A number of CCOs reported innovative methods to evaluate and improve the accessibility and effectiveness of their language access services. For example, *Eastern Oregon CCO* has conducted "secret shopper" surveys of its community mental health providers about access for Spanish speakers by calling contracted providers speaking only in Spanish, and asking about access to services. In 2017, only six out of sixteen (37.5%) providers were able to access and use telephonic interpretation services during these calls; in 2018, this rate had improved to ten of the sixteen providers randomly called (62.5%). The CCO also will conduct a gap analysis to identify the percentage of members who have identified a primary language other than English, compared to the percentage of members who have utilized its telephonic interpretation services and the percentage of members who have utilized interpreter services at medical office visits. *Willamette Valley Community Health*'s behavioral health delegate, Mid-Valley Behavioral Care Network, conducts quarterly audits of verify that Spanish-speaking members are provided a gateway to services in Spanish from an initial call; in Quarter 2, 78% of those audited answered the call in Spanish or connected to Spanish-speaking staff, compared

[9] Presumably, the services available are both oral "interpretation" services and written "translation" of any printed materials. National Council on Interpreting in Health Care, FAQs – Translators and Interpreters, at: https://www.ncihc.org/faq-for-translators-and-interpreters

to 66% in Quarter 1. *Columbia Pacific CCO* is conducting a review of 200 medical charts (half completed to date) to determine if members are being offered and provided meaningful language access; results will be shared with its Clinical Advisory Panel, Board of Directors, and primary care learning collaborative (PC3) for discussion and action planning, and to establish a goal of 50% improvement in the percentage of members being offered an interpreter. Both *Columbia Pacific CCO* and *Jackson Care Connect* have Language Access Improvement Committees that are conducting a language accessibility assessment and developing a value-stream map of member language access experience. *Yamhill Community Care Organization* is analyzing the ratios of the number members assigned to its network providers by primary languages to determine the current state of language services within the network.

One of the reporting requirements for the Transformation and Quality Strategy Reports was attaching a copy of how each CCO notified their members about their rights and responsibilities under the Oregon Health Plan. By comparing these notices, it is apparent that there are wide variations in length, comprehensiveness, literacy level, and whether the notice specifically addresses issues of language access, literacy, and equity. For example, *Eastern Oregon CCO*'s notice of member rights and responsibilities include the following member rights:

+ right to receive culturally and linguistically appropriate services and supports, in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations
+ right to receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including by not limited to the use of certified or qualified health care Interpreters, and advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate a services and participate in processes affecting the member's care and services
+ right to receive certified or qualified health care interpreter services free of charge

Umpqua Health Alliance's notice of member rights and responsibilities include member rights to:
- to receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters, and advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.
+ to receive culturally and linguistically appropriate services and supports, in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations.
+ to receive oversight, care coordination and transition and planning management from UHA to ensure culturally and linguistically appropriate community-based care is provided

in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care

And *Umpqua Health Alliance* notifies its members that it is required to:
+ make certified or Qualified Health Care Interpreter Services available free of charge to each potential member and member. This applies to all non-English languages, not just those that Oregon Health Authority (OHA) identifies as prevalent. UHA shall notify its members and potential members that oral interpretation is also available free of charge for any language and that written information is available in prevalent non-English languages in service area(s).…UHA shall notify its members how to access oral interpretation and written translation services.
+ require, and cause its participating providers to require, that members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language and ability to understand.
+ ensure members are aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A, and that a member has a right to report a complaint of discrimination by contacting UHA, OHA, the Oregon Bureau of Labor and Industries or the federal Office of Civil Rights.

Cascade Health Alliance's notice of member rights and responsibilities includes:
+ right to have a language interpreter or a sign language interpreter available free of charge if requested
+ right to receive written materials translated in a language that you can understand
+ right to receive written materials explained in a manner that is understandable to you
+ responsibility to request an interpreter at least one day before the appointment

It might be useful for OHA to request and share similar member-facing notices and documents from the CCOs (e.g. complaint, grievance, and appeals forms), so that there could be identification of best practices, and more standardization across the CCOs.

<u>Building and sustaining a diverse workforce, including community health workers and other traditional health workers</u>
One of the elements of the CCO model is to encourage the use of community health workers (CHWs) and other traditional health workers (THWs). Many CCOs are supporting CHWs and THWs in a number of ways. *Advanced Health* advocated for and established CHW training at Southwest Oregon Community College and funded the tuition for community partners who wished to have employees receive training; all 20 available slots in the first cohort were filled, with plans to provide coordination and financial support to subsequent cohorts. *Eastern Oregon CCO* has invested funding in the development of an OHA-certified CHW training program for its region at Oregon State University, which includes training new CHW's and providing continuing education courses to existing CHWs; in 2016-2017, this program trained 30 new CHWs.; in 2017-2018, 14 additional CHWs were trained. *Umpqua Health Alliance* supports CHW training at Umpqua Community College. *PacificSource Columbia Gorge* supports CHW training, certification, and community of practice groups, and ongoing CHW services through its Bridges to Health project.

Eastern Oregon CCO has developed a CHW billing and payment policy to help ensure a sustainable revenue source for its provider partners who employ CHWs; reimbursable services include face-to-face time spent with members to address social determinants of health, such as assistance navigating community resources and obtaining assistance

with food or housing; nearly 1,200 claims for CHW services were paid from June 2017-May 2018. *Yamhill Community Care Organization* has three paid CHWs, working with homeless and agricultural worker populations. *Primary Health* has two CHWs on its staff. *Willamette Valley Community Health* has been supporting THWs working in Marion and Polk counties through the Fostering Hope Initiative.

Health Share of Oregon has funded infrastructure development at the Oregon Community Health Worker Association (ORCHWA); ORCHWA will identify and customize a health information tracking system to capture the efforts and outcomes of CHWs, identify sustainable payment mechanisms for CHWs; enable health systems to reliably contract for community-based CHW services; and enhance professional and workforce development efforts for CHWs.

Health Share of Oregon also is in the preliminary phase of investment in the doula workforce, with the objective of increasing access for its members to community-based doulas of color; the CCO will identify promising practices for community-based doulas of color to engage with clinical maternity care teams, and will invest in workforce development and curriculum development; Health Share of Oregon has identified BirthingWay as the contractor to develop the curriculum.

<u>Partnering with diverse members and communities served</u>
Another important way for CCOs to advance health equity is to partner with their diverse members and communities served. For example, *Willamette Valley Community Health* has been conducting outreach to and developing deeper engagement with Latino, Russian, and Cambodian communities, and is working on outreach to Pacific Islander communities. *AllCare CCO* conducted listening sessions in Spanish to learn about potential reasons for higher utilization of the emergency department among Spanish-speaking members. *Columbia Pacific CCO* is engaging in a participatory action process to collect narratives on service user voice and member perspectives on community vitality and perception of an ideal future related to social determinants of health and health care system needs.

While all CCOs have Community Advisory Councils (CACs),*Trillium Community Health Plan* engaged its Community Advisory Council (CAC) and its Rural Advisory Council to develop recommendations to improve no-show rates; among the recommendations presented to the board of directors in June 2018 were ensuring communications in the member's primary language and in "layman's terms", no higher than a 5th grade comprehension level, training for provider front-line staff in cultural competency and socioeconomic sensitivity, and hiring more bilingual/bicultural provider staff.

Many of the CCOs are in the process of updating their Community Health Assessments (CHAs), which will inform and help establish priorities for their Community Health Improvement Plans. As part of these CHA processes, several CCOs are specifically reaching out to and engaging diverse community partners and stakeholders. For example, *Eastern Oregon CCO* has conducted community focus groups in Spanish and *Umpqua Health Alliance* has prioritized Latino/Spanish-speaking members and members with disabilities for its focus groups. *PrimaryHealth* plans to conduct a listening session with Native Americans and *Advanced Health* has continued its engagement with the Confederated Tribes of Coos, Lower Umpqua, and Siuslaw as part of its CHA.
In addition, health equity is emerging as a priority for the Community Health Improvement Plans being developed by *Advanced Health* for Curry and Coos counties.

Supporting regional health equity coalitions

CCOs also continue to support their respective regional health equity coalitions. *Jackson Care Connect*, *AllCare CCO*, and *Primary Health* continue to support the work of the Southern Oregon Health Equity Coalition (SO Health-E) in Jackson and Josephine counties. *Trilllium Community Health Plan* is an active partner in the Lane Equity Coalition. The Linn-Benton Health Equity Alliance continues to be an active partner with the *InterCommunity Health Network CCO*.

Willamette Valley Community Health has been active in developing a regional health equity coalition for Marion and Polk counties and *Cascade Health Alliance* has been supporting the development of a health equity coalition in Klamath county. *Advanced Health* continues to explore the feasibility of establishing a regional health equity coalition in Coos and Curry counties.

SECTION 3: HEALTH EQUITY WORKSHOP

In 2018, the OHA Transformation Center began planning for a one-day health equity workshop for the CCOs. In July, the Transformation Center engaged one of its technical assistance consultants, Ignatius Bau,[10] to review the CCO Transformation and Quality Strategy Reports to identify examples that might be presented at the workshop (see Section 2). All the Innovator Agents for the CCOs were then consulted for additional details and updates about the health equity activities identified from the reports. The Innovator Agents also recommended individuals from the CCOs that they work with to serve on a planning committee for the workshop. OHA Transformation Center staff and Office of Equity & Inclusion staff also were consulted for ideas for the workshop and candidates for the planning committee.

The OHA Transformation Center staff and consultant then reached out to potential members of the planning committee, inviting them to serve. The members of the planning committee were:

- Carla Munns, *Willamette Valley Community Health*
- Denise Johnson, *CareOregon*
- Jennifer Johnstun, *PrimaryHealth*
- Jovita Castillo, *Jackson Care Connect*
- Lucy Zammarelli, *Trillium Community Health Plan*
- Miao Zhao, *InterCommunity Health Network CCO*
- Miguel Angel Herrada, *PacificSource Central Oregon*
- Stick Crosby, *AllCare CCO*
- Suzanne Cross, *PacificSource Columbia Gorge*

Innovator Agent Belle Shepherd and Anastasia Sofranac from the OHA Office of Equity & Inclusion also participated on the planning committee. A peer-based approach was used to plan, and ultimately, implement the workshop. The planning committee met by conference call two times and worked in teams to plan each of the six breakout sessions, refining the potential topics for breakout sessions that had been identified by the consultant (see descriptions of breakout sessions below). Planning committee members reached out to suggested contacts at CCOs, and developed presentations and materials for each of the breakout sessions. The sessions were to be designed to be interactive, with exercises and discussion time for session participants. There was an intentional effort to ensure that every CCO had the opportunity to make a presentation at the workshop. Ultimately, staff or partners from fourteen of the fifteen CCOs were presenters at the six breakout sessions. The planning committee also provided input and feedback on ideas for opening and closing general sessions.

The Innovator Agents worked with their respective CCOs to identify invitees to the workshop and Transformation Center staff followed up with a registration and confirmation process. CCOs were responsible for supporting any needed travel expenses for their participants. The final agenda, presentation materials, handouts, and a list of participants are posted on the OHA Transformation Center website.[11] Each of the fifteen CCOs had participants at the workshop.

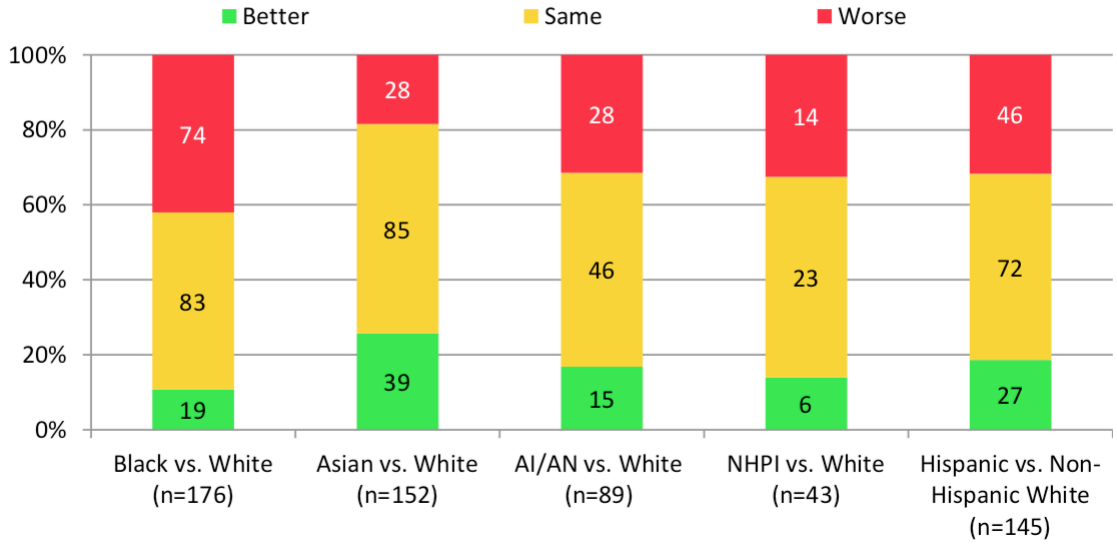
[10] https://www.oregon.gov/oha/HPA/dsi-tc/Pages/TA-Bank-Consultant-Bios.aspx?View=%7bB507F7BD-7BFC-4948-9C53-4FF433C832A1%7d&SelectedID=3
[11] https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CCOs-Advancing-Health-Equity-Workshop.aspx

Opening General Session

OHA Transformation Center Director Chris DeMars and OHA Office of Equity & Inclusion Director Leann Johnson welcomed the participants and highlighted the importance of addressing equity as part of the work that CCOs are doing.

Health equity consultant Ignatius Bau then presented an overview of federal and national developments on advancing health equity. While some progress does continue to be made, racial and ethnic and other disparities persist nationally, as documented by the annual National Healthcare Quality and Disparities Report: according to the 2018 report, performance on quality measures reported was worse for African Americans on 42 percent of measures, worse for Native Hawaiians and Pacific Islander on 33 percent of measures, worse for Hispanics on 32 percent of measures, worse for American Indians on 31 percent of measures, and worse for Asian Americans on 18 percent of measures.[12]

Figure 19. Number and percentage of quality measures for which members of selected groups experienced better, same, or worse quality of care compared with reference group (White) in 2014-2016



The U.S. Department of Health and Human Services continues work on both moving health care payment from volume to value, and addressing health equity. The continuing activities and resources provided by the Centers for Medicare & Medicaid Services (CMS) are particularly noteworthy.[13] CMS' Office of Minority Health has an especially important role since CMS' Center for Medicare & Medicaid Innovation is expected to

[12] Agency for Healthcare Research and Quality, National Healthcare Quality and Disparities Report (2018), https://www.ahrq.gov/research/findings/nhqrdr/nhqdr17/index.html

[13] For example, CMS Office of Minority Health, Building an Organizational Response to Health Disparities, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf; CMS Office of Minority Health, Disparities Impact Statement, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement.pdf; CMS Office of Minority Health, Guide to Developing a Language Access Plan, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf; CMS Office of Minority Health, A Practical Guide to Implementing the CLAS Standards (2016), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf

continue to create opportunities for health system transformation and payment reform, both through state initiatives and directly with health care providers.

Meanwhile, leading national health care stakeholders outside of the federal government also continue to address health equity, including the National Quality Forum,[14] Institute for Healthcare Improvement,[15] National Academies for Science, Engineering, and Medicine,[16] and Families USA.[17] Oregon's CCOs can utilize these resources to inform and support their own activities on advancing health equity.

Workshop participants then participated in an interactive exercise that helped them to reflect on one's privileges in the world, and how that influences our collective work on health equity, particularly with CCO members who face historic, structural, and systemic barriers to opportunities that would otherwise provide them with privileges in our society.

Workshop participants then attended two of six breakout sessions:

Session A: Health Equity Strategic Planning
At this session, *AllCare CCO*, *InterCommunity Health Network CCO*, and *Yamhill Community Care Organization* shared their experiences in developing, and now implementing, strategic plans to advance health equity.

[14] National Quality Forum, Roadmap for Promoting Health Equity and Eliminating Disparities (2017), https://www.qualityforum.org/NQFs_Roadmap_to_Health_Equity.aspx
[15] Institute for Healthcare Improvement, Pursuing Equity, http://www.ihi.org/Engage/Initiatives/Pursuing-Equity/Pages/default.aspx
[16] National Academies of Sciences, Engineering, and Medicine, Roundtable on Health Literacy, A Proposed Framework for Integration of Quality Performance Measures for Health Literacy, Cultural Competence, and Language Access Services (2018), http://nationalacademies.org/hmd/reports/2018/a-proposed-framework-for-integration-of-quality-performance-measures-proceedings.aspx
[17] Families USA, A Framework for Advancing Health Equity and Value: Policy Options for Reducing Health Inequities by Transforming Health Care Delivery and Payment Systems (2018), https://familiesusa.org/sites/default/files/product_documents/HEV_Policy-Options_Report.pdf

IHN-CCO Health Equity Strategic Plan

The Delivery System Transformation Committee (DST) of InterCommunity Health Network Coordinated Care Organization (IHN-CCO) utilizes workgroups, groups of people working towards a common agenda, to help develop and support transformational work efforts. The Health Equity Workgroup supports delivery system transformation that identifies and reduces health disparities and advances health equity.

Vision: A community where all members of IHN-CCO can meet their potential for optimum health and well-being.

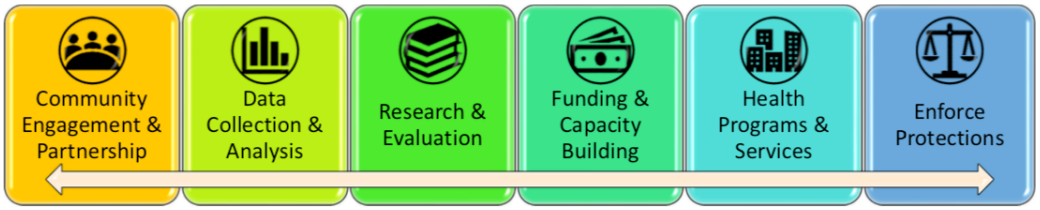
Mission

IHN-CCO meets the culturally diverse needs of members and eliminates health disparities, including promoting a diverse workforce.

Goals

Yamhill Community Care Organization

Health Equity Strategic Alignment



Action Plan for Better Health | Transformation & Quality Strategy | Community Health Improvement Plan | Quality Metrics
Quality Assessment & Performance Improvement Plan | Early Learning Strategic Plan | Performance Improvement Projects

Community Engagement & Partnership
- Health Equity Workgroup
- Community Advisory Council
- Provider and community training

Data Collection & Analysis
- REAL-D survey
- Data warehouse
- Quality metric analysis
- Disparities analysis

Research & Evaluation
- Organizational self-assessment
- Review and adopt health equity frameworks

Funding & Capacity Building
- Funding allocation for priority populations
- Align funding with policy requirement

Health Programs & Services
- Community Health Worker Hub
- Service Integration Teams
- Peer Support Network
- Early Learning
- Trauma and resiliency

Enforce Protections
- Policy Develop. Nondiscrimination Code of Conduct Communications Language Services
- Internal training and consultation

CONTACT: Emily Johnson – ejohnson@yamhillcco.org, 503-376-7428

Jenna Harms – jharms@yamhillcco.org, 503-376-7432

Given the different organizational structures among these three CCOs, the strategic planning process was different in how the strategic plan on equity was initiated, developed, approved, and now, being implemented. Among some common themes were the importance of leadership engagement, having dedicated staff with responsibility and time for the planning, conducting organizational self-assessments, accessing external resources and expertise, and setting specific goals and objectives. Each of the CCOs will be monitoring and evaluating progress on implementing these strategic plans on equity.

Session B: Using a National Framework to Engage CCO Staff and Board on Health Equity

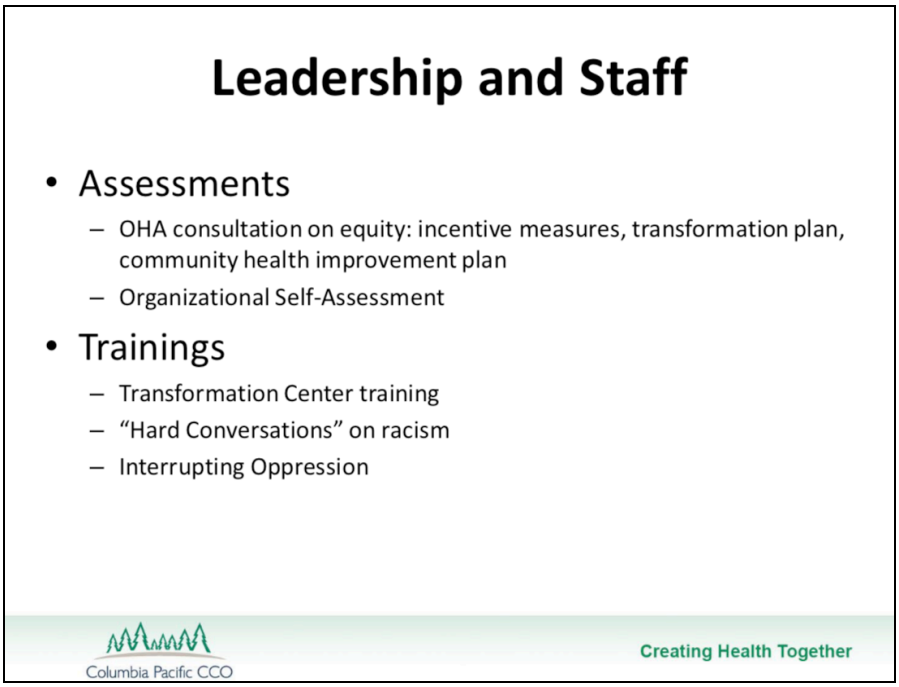
The presenters from this session used the framework of the U.S. Department of Health and Human Services Office of Minority Health's National Partnership for Action to Eliminate Health Disparities[18]as a guide for engaging CCO staff and board on health equity. The NPA framework includes:

- awareness
- leadership
- health system and life experience (communication)
- data, research, and evaluation
- cultural and linguistic competency

The leadership of *PacificSource Central Oregon* has integrated health equity into its overall organizational priorities, with engagement of its board of directors and staff, including training and education, and partnerships with community organizations.

Similarly, *Columbia Pacific CCO* has been working with both its staff and board of directors on health equity through self-assessments and trainings, culminating in an organizational equity plan:

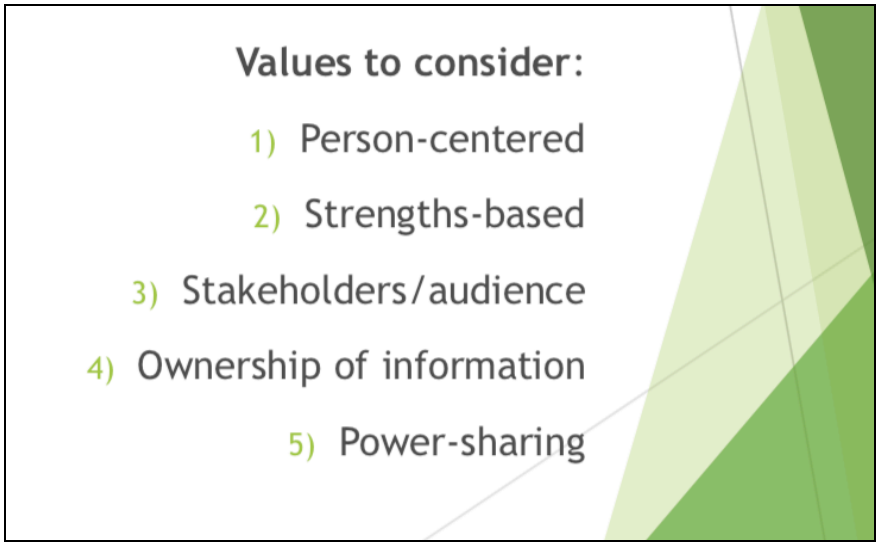
[18] U.S. Department of Health and Human Services, *National Stakeholder Strategy for Achieving Health Equity* (2011), https://minorityhealth.hhs.gov/npa/files/Plans/NSS/CompleteNSS.pdf



Columbia Pacific CCO also shared its strategies for engaging its Clinical Advisory Panel (CAP) and its Community Advisory Council (CAC) on health equity. For the CAP, there have been equity trainings for the clinics, a language access plan and toolkits to support best practices for health care interpretation, and ongoing quality monitoring that includes a quarterly review of quality measures disaggregated by member demographics. For the CAC, community narratives on health and well-being have been included in the community needs assessment, and community partnerships have been sustained with education providers and the local trauma-informed community network.

Session C: Using CCO Member Demographic Data to Inform Quality Improvement Activities to Advance Health Equity

During this session, presenters from *Health Share of Oregon* and *Willamette Valley Community Health* discussed how they understand and utilize data to advance equity. The presenters highlighted that all data are grounded in values and should be examined with an anti-bias lens. For example, was the data collected in an inclusive way? Are there alternative ways to collect data (e.g. narratives, qualitative data, information about history and context)? Do we perpetuate a deficit model when we use Whites as a comparison group?



Participants reviewed and discussed ways that data to drive action towards equity, as part of comprehensive quality improvement and health improvement strategies.

Part 3: Using Data to Drive Action

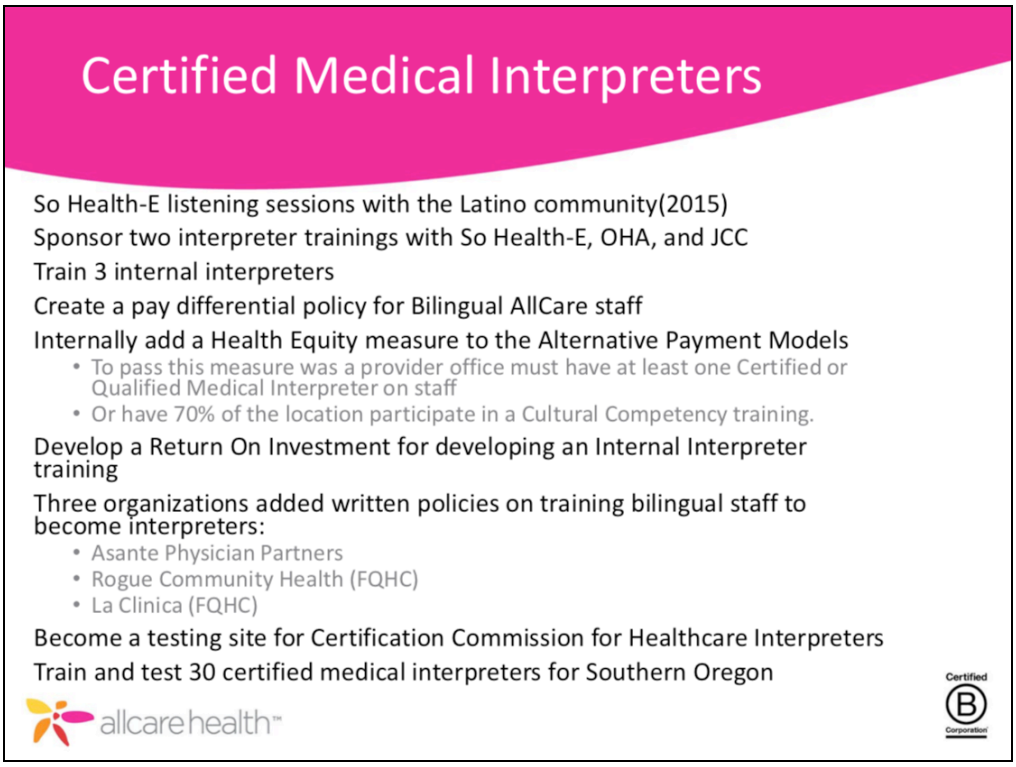
Case Study 2: Controlling STIs Using Equity Lens

Objectives	Outcomes: This Biennium	Outcomes: Beyond
Cross-Jurisdictional Sharing Model	• Policies adopted and relationships established • Marion will train Polk Co. in CD Model	Relationships, systems and sharing model is sustained and ongoing
Community buy-in for communicable disease (CD)	Develop an active CD coalition with cross-agency buy-in, Focus Groups, diverse participation, key informant interviews, identify and engage stakeholders	CD advocacy and buy-in sustains coalition beyond biennium funding
Regional Health Equity Plan	Develop a health equity action plan to establish and implement policies and systems to reduce CD control-related disparities	CD equity policies will reduce (and continue to reduce) CD control-related disparities
Educated and trained clinical network on best practices for testing and treatment of STIs	• Provide 6 provider trainings to increase knowledge of best practices • Increase adequate gonorrhea Tx in Polk Co • Maintain/improve gonorrhea Tx in Marion Co	Improved system coordination and communication
STI Control: Increase in Tx capacity, reduce incidence rates, reduce outbreaks and establish systems to control future outbreaks	• Increase gonorrhea case and contact-finding capacity in Polk Co • Improve HPV vaccine rates regionally	Lower rates of STIs in Marion & Polk Counties

Session D: Ensuring Language Access for all CCO Members

At this session, presenters from *Trillium Community Health Plan* and *AllCare CCO* presented strategies for ensuring language access for all CCO members. *Trillium Community Health Plan* regularly surveyed its providers about their number of bilingual staff, whether there are written protocols relating to the provision of interpreter services, the types of interpreter services readily available, the availability of and needs for member materials in languages other than English, and whether patient surveys are available in languages other than English.

AllCare CCO has made significant investments in supporting the training and certification of health care interpreters, dramatically increasing the number of interpreters available in its service area.

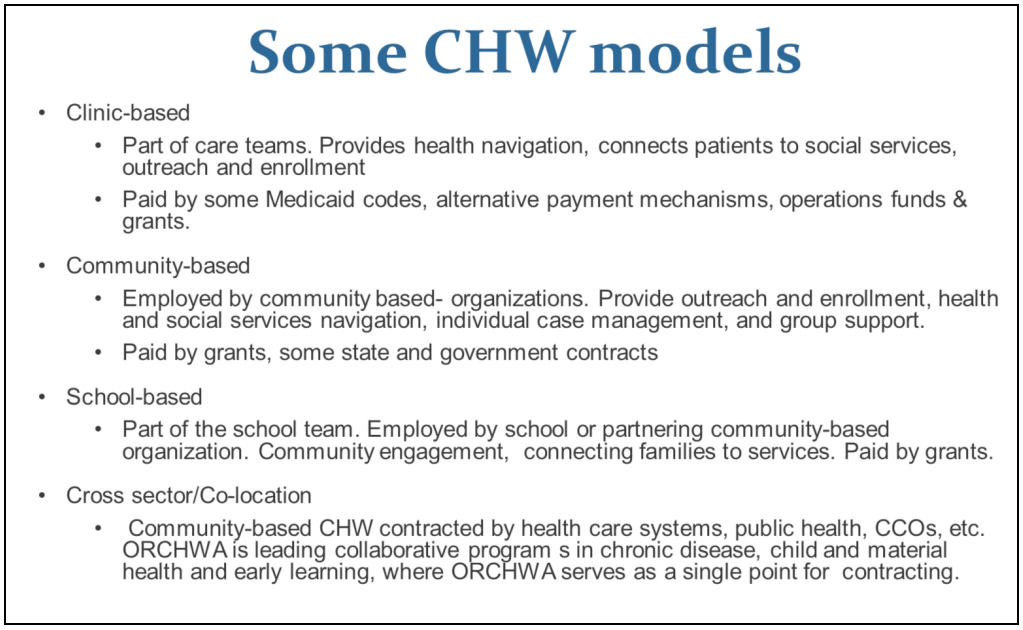


Staff from the OHA Office of Equity & Inclusion also reviewed the legal and compliance reasons for ensuring language access, and OHA's requirements for certifying trained health care interpreters and sign language interpreters. There is a wide range of health care interpreter training programs recognized by OHA. OHA also recognizes both of the national health care interpreter certification processes currently available.

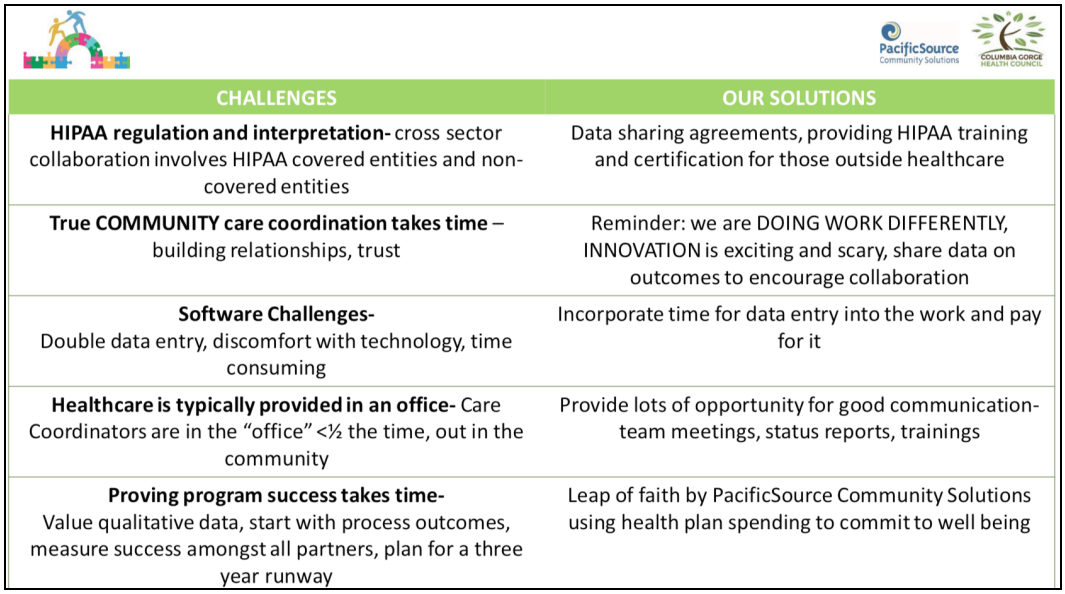
Session E: Making Community Health Workers Part of Your Community Health Strategy

This session provided an overview of the definitions, roles, and status of community health workers (CHWs) in Oregon. The director of the Oregon CHW Association referenced the American Public Health Association definition of a CHW as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served." In Oregon, CHWs are one of several types of Traditional Health Workers (THWs), which also include peer support specialists, peer

wellness specialists, personal health navigators, and doulas. There are several models how CHWs are deployed:



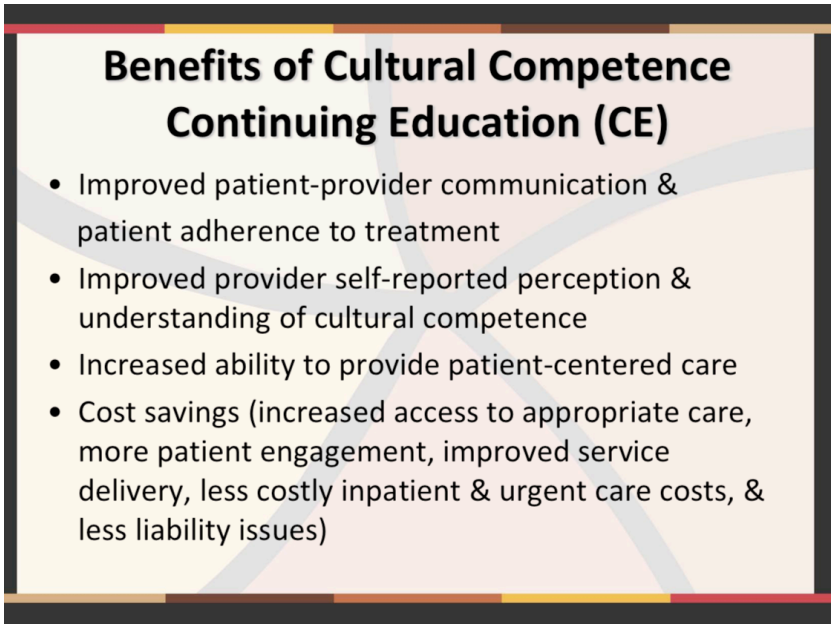
Advanced Health and *PacificSource Columbia Gorge* then shared about the development of their CHW programs at their respective CCOs, including recruitment, training, reimbursement and payment, and sustainability. *Advanced Health* has funded trainings for CHWs at Southwestern Oregon Community College and *PacificSource Columbia Gorge* has leveraged grants, and now funding from the CCO, to support Community Care Coordinators/CHWs (Bridges to Health) that can work across providers and issues to meet the needs of community members (health care, social services, education, employment, housing, food, etc.). *PacificSource Columbia Gorge* also shared some of the challenges they have faced in implementing its CHW program, and how it has addressed those challenges.



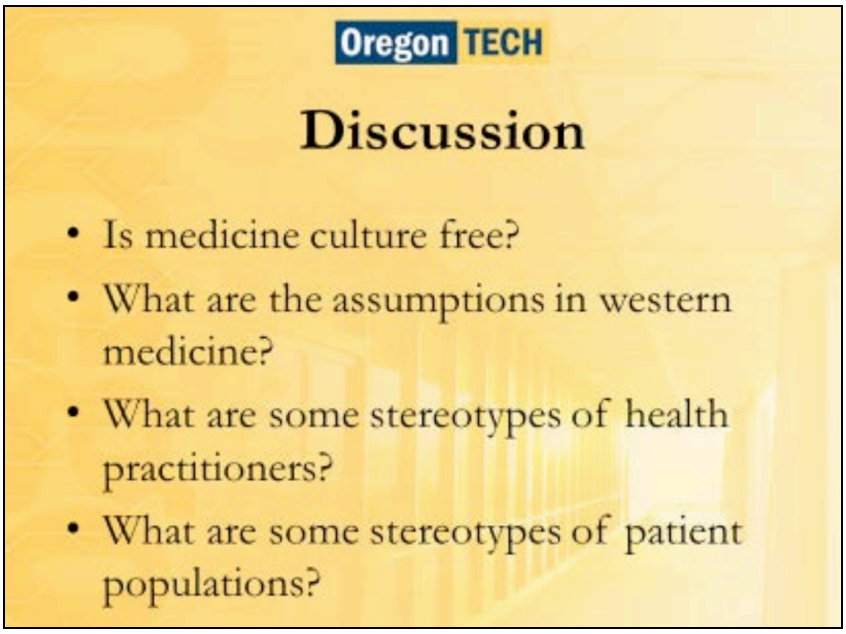
CHALLENGES	OUR SOLUTIONS
HIPAA regulation and interpretation- cross sector collaboration involves HIPAA covered entities and non-covered entities	Data sharing agreements, providing HIPAA training and certification for those outside healthcare
True COMMUNITY care coordination takes time – building relationships, trust	Reminder: we are DOING WORK DIFFERENTLY, INNOVATION is exciting and scary, share data on outcomes to encourage collaboration
Software Challenges- Double data entry, discomfort with technology, time consuming	Incorporate time for data entry into the work and pay for it
Healthcare is typically provided in an office- Care Coordinators are in the "office" <½ the time, out in the community	Provide lots of opportunity for good communication-team meetings, status reports, trainings
Proving program success takes time- Value qualitative data, start with process outcomes, measure success amongst all partners, plan for a three year runway	Leap of faith by PacificSource Community Solutions using health plan spending to commit to well being

Session F: Providing Cultural Competency Training for CCO Staff, Providers and Other Stakeholders

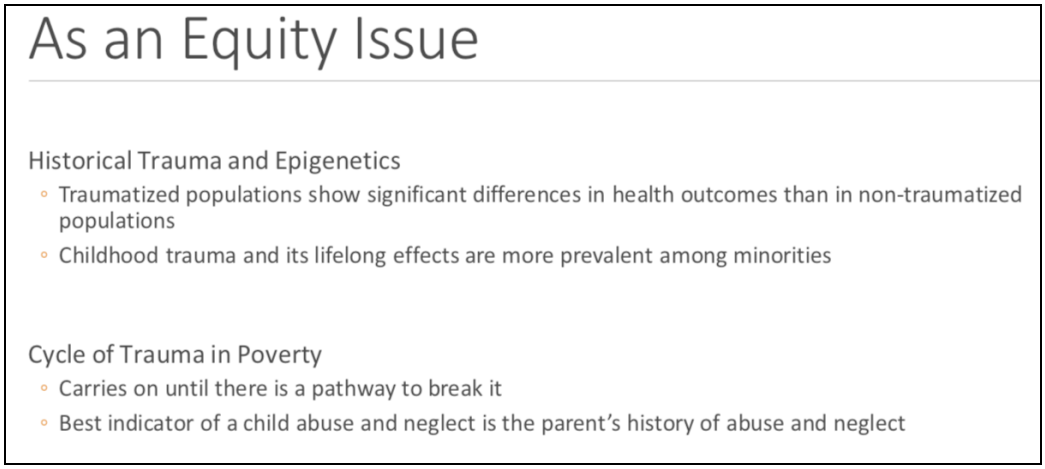
This session began with an overview of the history and development of statewide standards for evaluating, and now approving, cultural competency trainings for a wide range of health professions. OHA's Office of Equity & Inclusion manages this process, and maintains an updated list of state-certified cultural competency trainings.



Presenters from *Cascade Health Alliance* and *PrimaryHealth* then shared about the development and implementation of their cultural competency and trauma-informed care trainings for their CCO staff and other stakeholders. *Cascade Health Alliance* described some of the trainings that they have provided for its staff and providers, partnering with the Oregon Institute of Technology and the Klamath Regional Health Equity Coalition.



There is a significant relationship between trauma and equity since adverse childhood experiences (ACEs) have increased prevalence in racial and ethnic minority populations.



PrimaryHealth has partnered with two other CCOs, *AllCare CCO* and *Jackson Care Connect*, to support free trainings and events about neuroscience, epigenetics, ACEs, and resilience (NEAR science) and trauma-informed approaches for health, education, human services, workforce development, and public safety providers throughout the region. Since 2016, over 10,000 individuals have participated in these trainings in Jackson and Josephine counties. All of *PrimaryHealth*'s staff have participated in these trainings, and they have been available to all of *PrimaryHealth*'s providers and community partners.

Closing General Session

The workshop then closed with participants reflecting on what they had learned, and sharing some of the specific follow-up ideas and recommendations for changes and next steps that they would be taking back to their CCOs. Participants also completed written evaluations to provide feedback about the entire workshop as a whole and the breakout sessions that they attended.

In the written evaluations, many participants expressed appreciation for the opportunity to learn from each other and networking with others doing similar work. One said that "the most valuable part was networking with others; great blend of different variations of the same thing". Another wrote that "the variety of presenters was meaningful and helpful to see the different approaches". One said "simply getting new ideas from different people; it is helpful to get fresh perspective from other viewpoints." Another participant wrote: "I really enjoyed the opportunity to gather, share ideas, and know that there are others doing the same/similar work…that we're not alone and can learn from one another". One participant said: "This was great! More CCO only events like this. Different kind of learning."

One participant said that a breakout session had provided "valuable information/take-aways and enriched conversations" and another said that a breakout session was "awesome! all information was pertinent and very helpful". One participant wrote that the breakout session had a "good dialogue with participants". Another said that a breakout session "provided opportunity to put learnings into practice".

One participant said that a breakout session helped them to “think outside the box”. Another said that the workshop gave them the opportunity for “learning how to ask the right questions and look at things from a different perspective”.

The participants listed specific ideas and recommendations that they would be bringing back to their CCOs to advance health equity, including strategic planning, holding listening sessions, brown bag lunches, better use of data, ideas and improvements for training, and specific content resources.

SECTION 4: RECOMMENDATIONS FOR ADVANCING HEALTH EQUITY THROUGH OREGON'S CCOs

Oregon's CCOs continue to implement multiple activities and strategies to advance health equity. One of the recommendations from the 2017 report was the additional sharing of health equity best practices and resources among the CCOs, which would benefit all the CCOs and their diverse members. The October 2018 health equity workshop showcased some of the important activities and strategies that CCOs have used to advance health equity, and provided the opportunity for CCOs to learn from and motivate each other to deepen and broaden their efforts.

In summary, here are some of the steps that CCOs can take to support and sustain their efforts to advance health equity:

- Demonstrate staff and board leadership and commitment to health equity
- Develop - in partnership with members, providers, and other stakeholders - strategic plans to advance health equity, with measureable objectives
- Designate staff positions and staff work groups to be responsible for developing, implementing, and sustaining health equity activities
- Use quality performance measurement data stratified by member demographic characteristics, and data about member experiences, complaints, grievances, and appeals, to identify disparities
- Identify and implement specific quality improvement projects to reduce identified disparities
- Engage providers and Clinical Advisory Panels in implementing and supporting health equity activities and quality improvement projects
- Engage members and Community Advisory Councils in implementing and supporting health equity activities
- Implement short- and long-term strategies to diversify the CCO's own workforce and providers
- Ensure comprehensive language access for members who speak languages other than English and for members with disabilities that require communication assistance or adaptation
- Support the training and utilization of health care interpreters
- Continue to support community health workers and other traditional health workers, especially their training and financial sustainability
- Provide ongoing cultural competency and other health equity trainings to CCO staff, board, providers, and community partners
- Participate in and support regional health equity coalitions

As Oregon's CCOs continue their innovative work in transforming health systems and payment, they also have the opportunity to continue to make progress towards reducing disparities and achieving health equity for the diverse Oregon community members that they serve.

APPENDIX

CCOs Advancing Health Equity Workshop

October 24, 2018, Oregon Convention Center

Agenda

8:00 – 8:30 a.m.	**Registration and Breakfast**
8:30 – 9:30 a.m.	**Opening General Session (E145)** Chris DeMars, MPH, Director, OHA Transformation Center; Leann Johnson, MS, Director, OHA Office of Equity and Inclusion; Ignatius Bau, J.D., Health Equity Consultant; Alicia Ramirez, Program Coordinator, The Next Door Inc.; Todd Dierker, Consulting Services Project Manager, The Next Door Inc.
9:30 – 9:45 a.m.	**Networking Break**
9:45 – 11:15 a.m.	**Breakout Sessions A, B & C** Session A: Health Equity Strategic Planning (E143) Session B: Using a National Framework to Engage CCO Staff and Board on Health Equity (E144) Session C: Using Data to Advance Health Equity (E145)
11:15 – 12:15 p.m.	**Networking Lunch**
12:15 – 1:45 p.m.	**Workshop Sessions D, E & F** Session D: Ensuring Language Access for all CCO Members (E143) Session E: Making Community Health Workers Part of Your Community Health Strategy (E144) Session F: Providing Cultural Competency Training for CCO Staff, Providers and Other Stakeholders (E145)
1:45 – 2:00 p.m.	**Networking Break**
2:00 – 3:00 p.m.	**Participant Feedback and Closing General Session** Ignatius Bau, J.D., Health Equity Consultant

Source:
https://www.oregon.gov/oha/HPA/dsi-tc/Documents/HE%20Workshop%20final%20agenda.pdf