Conference Call Number: 1-888-808-6929
Public Participant Code: 915042#

Oregon Health Policy Board

DRAFT AGENDA

October 1, 2019
Portland State Office Building
800 NE Oregon St. Room 177, Portland, OR 97232

#	Time	Item	Presenter	Purpose
1	8:30	OHPB Welcome, Minutes Approval	Carla McKelvey, OHPB Chair	Welcome & Possible Vote
2	8:40	OHPB Liaison Updates	Carla McKelvey, OHPB Chair & Board Members	Information & Discussion
3	9:00	OHA Report	Patrick Allen, OHA Director	Informational
4	9:10	CCO 2.0	Jeremy Vandehey, OHA Health Policy & Analytics (HPA) Director	Information & Discussion
5	9:20	OHPB Policy Priority Area	Trilby de Jung, OHA HPA Deputy Director	Information & Discussion
6	9:50	Break		
7	10:00	Public Testimony	Carla McKelvey, OHPB Chair	Information & Discussion
8	10:10	Workforce Incentive Program	Marc Overbeck, OHA Primary Care Office Director Joe Sullivan, OHA Health Care Workforce Jeff Clark, Health Care Workforce Committee Chair Curt Stilp, Health Care Workforce Committee Vice-Chair	Information, Discussion & Possible Vote
9	11:10	Defining Health Equity	Leann Johnson, OHA Office of Equity & Inclusion Director Carly Hood, Health Equity Committee Co-Chair Micheal Anderson-Nathe, Health Equity Committee Co-Chair	Information & Discussion
10	12:00	Adjourn		

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Next meeting:
November 5, 2019
Portland State Office Building, Rm. 177
800 NE Oregon St. Portland, OR 97232
8:30 a.m. to 12:00 p.m.

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Oregon Health Policy Board
DRAFT September 2, 2019
Portland State Office Building
800 NE Oregon St, Room 177, Portland, OR 97232
8:30 a.m. to 12:00 p.m.

Item
OHPB video and audio recording To listen to audio of the OHPB meeting in its entirety click here.
Welcome and Call to Order, Chair Carla McKelvey **Present**: Board members present: Chair Carla McKelvey, Vice-Chair David Bangsberg, John Santa, Rosenda Shippentower (Phone), Kirsten Isaacson, Brenda Johnson All Board members present voted to approve the minutes for August.
OHA Report, Patrick Allen OHA Director Allen recognized Chair McKelvey for her long service as a Board member and as the current Chair. Vice-Chair Bangsberg read a letter from the Governor recognizing her work and presented her with a plaque.
Advanced Health CCO: CEO Ben Messner, Medical Director Kent Sharmen Advanced Health shared a video presentation focused on OHP and CAC members. Ben Messner and Kent Sharmen of Advanced Health shared details regarding Advanced Health's structure and delivery system. He discussed the nature of the CCOs ownership structure emanating from the community. Dr. Sharmen discussed motivations for working in the south coast and provided more information about primary care recruitment and retention. He discussed integration and the move to a new electronic health record. Ben talked about the value of coordinated decision making in support of the CCO. The Board discussed interoperability among local health systems and how interoperability supports CCO model design as well as how health information technology will push deeper interoperability. The Board discussed VBP changes that are occurring and how more VBP is likely the future as well as the spread of Comprehensive Primary Care Plus (CPC+) in the local area. Kent shared that almost 100% of local primary care providers are engaged in CPC+. The Board discussed Advanced Health's CCO incentive measure performance and possible improvements.
Public Testimony Robert Bandon testified about his support for SB 770 as a supporter of Healthcare for All Oregon.
Coquille Indian Tribe: Community Health Center Administrator Kelle Little and Tribal Councilor Kippy Robbins Julie Johnson, the OHA Tribal Affairs Director introduced the Tribal presenters and shared some demographic statistics. Coquelle Vice-Chair and Clinic Administrator shared information about the Tribe's story including their priorities and clinic details. The Board discussed Tribal forced moves to Siletz, housing, communications and new construction the Tribe is engaged in.

They discussed challenges around EHR connectivity, access to specialty services, housing and provider recruitment.

Confederated Tribe of Coos, Lower Umpqua & Siuslaw: Tribal Councilor Iliana Montiel and Tribal Director of Health Services Vicki Faciane

Vicki & Illiana shared a brief history of the Confederated Tribes of Coos Lower Umpqua & Siuslaw Indians. They noted expanding services for oral health, family support and behavioral health services. Vicki discussed specific health policy issues, including addressing disparities like diabetes and funding for nutrient and healthy food programs as well as Medicaid expansion. Vicki shared the value of Dental Therapists in the Tribal Dental clinic as a result of OHA sponsored dental pilot-projects as well as the availability of dental specialists. She shared a gap in services around Tribal clinics being allowed to make direct referrals to CCO specialists. She shared concerns with separation of family members from Tribal Dental clinic services. The Board discussed concerns with eligibility requirements for Tribal family members not being able to join Tribal members for services. Rosenda noted the problem is similar across Tribes.

Coos Bay: Integrated Care: Eric Gleason, Health Promotion Director Coos Health & Wellness PHIT (Physical Health Integration Team) Program & Courtney DuMond, Community Wellness Liaison Waterfall Community Health

Eric described the need and approach PHIT utilizes. David asked that the Transformation Center be involved in spreading best practices and that the Board have a CCO leadership focused meeting. Eric described the need to link the program to primary care and the program's design around integrated health.

Courtney shared information regarding Waterfall clinic programs and partnerships as well as assessment tools and barrier feedback. She noted specific programs focused on dental hygiene, equitable patient outcomes and veggie RX. She noted the clinic's focus on the social determinants of health. The Board discussed how SDOH services are captured in EHRs. Brenda asked OHA staff for more information regarding how screening tools and SDOH services are captured in data, she asked that the Board consider the issue as an agenda item. The Board discussed how the data is collected and concerns with this information being part of a medical record. Trilby shared information about a potential health information exchange being developed with the Oregon Health Leadership Council which could consider data such as this. Carla asked about billing and Courtney relayed that they aren't currently billing, she also shared information about EPICs tool to identify SDOH needs.

Adjourn

Next meeting:
November 5, 2019
Portland State Office Building, Rm. 177
800 NE Oregon St, Room 1D, Portland, OR 97232
8:30 a.m. to 12:00 p.m.

OHPB Committee Digest

PUBLIC HEALTH ADVISORY BOARD, METRICS & SCORING COMMITTEE, HEALTH PLAN QUALITY METRICS COMMITTEE, HEALTH INFORMATION TECHNOLOGY OVERSIGHT COUNCIL, HEALTHCARE WORKFORCE COMMITTEE, HEALTH EQUITY COMMITTEE, PRIMARY CARE COLLABORATIVE, MEDICAID ADVISORY COMMITTEE, MEASURING SUCCESS COMMITTEE

Public Health Advisory Board

In September, the Public Health Advisory Board (PHAB) reviewed funding distribution plans for local and Tribal public health authorities as part of the 2019-21 legislative investment in public health modernization. PHAB reviewed statutes pertaining to the transfer of local public health authority to the Oregon Health Authority and discussed how the Oregon Health Authority is currently providing public health services in Wallowa County.

PHAB also discussed the 100-Year Oregon Water Vision, a plan to steward water resources to ensure clean and abundant water for Oregonians, the economy and the environment.

PHAB had an initial discussion about priorities for the public health system for the biennium, which will support strategic planning and the development of the 2020 PHAB work plan later this fall.

COMMITTEE WEB SITE: https://www.oregon.gov/oha/ph/About/Pages/ophab.aspx
STAFF POC: Cara Biddlecom, cara.m.biddlecom@state.or.us

Primary Care Payment Reform Collaborative

In September, The Evaluation and Implementation workgroups convened for a joint meeting to review the PCPRC workplan and key components of moving toward infrastructure implementation. Since there is significant overlap in the work of these group workgroups, a joint workgroup meeting was essential in obtaining feedback on the Collaborative workplan, especially as it relates to the activities that fall under these two workgroups. The workplan will be presented to the full collaborative in October.

The workgroups will continue to convene monthly except during the month the full Collaborative convenes. The next Primary Care Payment Reform Collaborative meeting will take place on October 8th, 2019, from 9am to Noon in Portland.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx.
COMMITTEE POC: Susan El-Mansy, SUSAN.A.EL-MANSY@dhsoha.state.or.us

Healthcare Workforce Committee

The Healthcare Workforce Committee met on September 11. Key Items included:

OHPB Updates:
Brenda Johnson shared about the previous two Board meetings. She spoke about the on-site visits the Board held in Coos County. These brought reflections by employers on the value from the Health Care Provider Incentive Program and the J-1 Visa Waiver Program in support of their ability to recruit and retain health professionals. It was noted that the Committee will be presenting to the Board at the Board's October meeting.

Primary Care Office Updates:
Marc Overbeck orally shared about the effects of the federal Auto-Facility HPSA score adjustments. He presented a screen showing changes made to score for primary (physical) care, oral health and mental health HPSAs. Members were able to see the number of decreased scores as well as facilities where scores remained the same or were increased. Marc's reminder is that the decreased HPSA scores are largely due to improvements in the health professional-to-population ratios, as well as some modest decreases in poverty in certain communities.

CCO 2.0:
Ralph Magrish and Jackie Fabrick presented a high-level summary and timetable for the work being done to develop rules and contracts under CCO 2.0. They received and answered questions from committee members. Committee members also reminded OHA staff of several of the policy pronouncements from the committee in years past regarding maximizing the contribution of existing health professionals.

Behavioral Health Workforce Implementation Plan:
Jackie Fabrick shared updates regarding legislative committee and executive branch efforts to develop plans for the BH workforce. Jackie plans to work closely with a workgroup from the Workforce Committee to help follow up on the Farley Center recommendations to expand the BH workforce.

Health Care Provider Incentive Program:
The Committee discussed OHA staff recommendations on use of the Health Care Provider Incentive Fund for the 2019-21 biennium. After considerable discussion a memo was approved to be brought to the Board, along with a presentation to the Board in October by committee leadership and OHA staff.

Health Equity:
The Committee heard from Maria Castro regarding efforts of the Health Equity Committee of the Board.
The Committee will meet next on November 6.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/HP-HCW/Pages/index.aspx
COMMITTEE POC: MARC OVERBECK, Marc.Overbeck@dhsoha.state.or.us

Health Plan Quality Metrics Committee

At the September 12 meeting the Committee discussed the Oregon Health Policy Board (OHPB) guidance letter to HPQMC with Trilby De Jung, OHA HPA Deputy Director, and John Santa, the OHPB liaison to the Committee. The Committee discussed the guidance and had a conversation about expectations and intent. The Committee asked about health plan measurement versus provider measurement as well as how CCO incentive measures and PEBB/OEBB measures might interplay and inform with a voluntary core. Trilby shared news about specific TA that will be available to the Committee from Michael Bailit of Bailit Health to help meet the Board's charge, including around criteria development for transformational measures.
The Committee also noted issues related to data stratification, provider burden, opportunities to align with CPC+ and Value-Based Purchasing while discussing the guidance.

The committee elected a new Chair, Jon Collins, OHA HSD Deputy Director, and Vice-Chair, Melinda Muller, Clinical Vice-President for Care Transformation at Legacy Health

The next meeting is October 10th, 2019 from 1:00pm – 3:30pm.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx
COMMITTEE POC: Kristin Tehrani, Kristin.Tehrani@dhsoha.state.or.us

Metrics & Scoring Committee

At its 20 September meeting the Metrics & Scoring Committee reviewed the letter from the Oregon Health Policy Board to the Health Plan Quality Metrics Committee. The Committee heard about CCO Transformation Quality Strategies from the Oregon Health Authority's Quality Improvement Director and finalized all benchmarks and improvement target floors for 2020. Final benchmarks for the program can be found here: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

At its 18 October meeting the Committee will hear an update on the evidence-based measure being developed on obesity; discuss the quality pool under CCO 2.0; and, make decisions regarding continuous enrollment and the 2020 immunization measures.

The Committee chairs will also address the Oregon Health Policy Board in November, to discuss Committee decisions regarding the 2020 measure set.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx
COMMITTEE POC: Sara Kleinschmit, SARA.KLEINSCHMIT@dhsoha.state.or.us

Health Information Technology Oversight Council

The Health Information Technology Oversight Council (HITOC) will be meeting on October 3, 2019. HITOC will hear updates on the Oregon Health IT Program, conduct chair/vice-chair elections, and discuss plans for committee leadership development. HITOC will also cover the following in-depth topics:

Health Equity and Health IT
Leann Johnson from OHA's Office of Equity and Inclusion will present on health equity. HITOC members will also explore the connection between health equity and health IT and examine opportunities to promote health equity through health IT.

2020 Strategic Plan Revision
HITOC will begin its work on the planned revision of its Strategic Plan for Health IT and Health Information Exchange. HITOC's current strategic plan runs from 2017-2020, and HITOC will spend significant time in 2020 engaging with partners and stakeholders and developing a revised strategic plan to present to OHPB in late 2020. This session will focus on reflecting on the expiring strategic plan and planning the revision work.

2020 HITOC Work Plan and OHPB Report
HITOC will reflect on its 2019 work plan progress and begin planning its 2020 work. HITOC will also begin discussing its report to OHPB about its 2019 activities, the current state of health IT in Oregon, and planned 2020 activities.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/OHIT-HITOC/
Committee POC: Francie Nevill, Francie.j.nevill@dhsoha.state.or.us

Medicaid Advisory Committee

The Medicaid Advisory Committee met September 25th to hear an update on the Public Charge Rule and learn about how Oregon is preparing for the chilling effect the Rule is expected to have on immigrant children and families. Last December, the Committee joined OHA and other State agencies in submitting a formal response to the Department of Human Services opposing the proposed rule.

The MAC also heard an overview of the May 2018 report Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon's CCO Model (given the many new members who were not on the committee during the report's development) and learned about new requirements and expectations around social determinants of health and equity in CCO 2.0.

At the MAC's next meeting, October 23rd, they will review and finalize a work plan for the next 12-18 months.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx
COMMITTEE POC: Milena Malone milena.malone@state.or.us

Health Equity Committee DRAFT

An essential part of the Health Equity Committee Charter is to work in close collaboration with other OHPB committees. The rest of this year will see presentations from staff from the Healthcare Workforce Committee, Metrics and Scoring, Health Plan Quality Metrics, OHITOC, Public Health Advisory Board, Medicaid Advisory Board, and the Oregon Health Policy Board. The purpose of these presentations is to find areas of alignment and or potential opportunities for collaboration.

Metrics and Scoring Committee Presentation
Sara Kleinschmidt, OHA Policy Advisor and lead staff for the Metrics and Scoring gave an overview of the committee, current committee work and there were questions about member composition and how the member and community should be represented and how consideration needs to be given to power dynamics when the community is brought to committees like this one. Metric and Scoring staff are working with OEI on upcoming recruitment opportunities to address that community representation need. The presentation also presented an opportunity for dialogue on how both committees can collaborate.

Healthcare Workforce Committee Presentation
Marc Overbeck, Primary Care Office Director, is the lead staff for the Healthcare Workforce Committee. The HCWFC is one of two initial OHPB Committees, codified in 2009 (ORS 413.017)
The committee's charter states that the role of the HCWFC is to coordinate efforts in Oregon to recruit and educate health care professionals and retain a quality workforce to meet the demand created by the expansion in health care coverage, system transformation, and an increasingly diverse population.
Marc provided an overview of the committee, its composition, current State workforce picture and shared some of the committee's charter deliverables that include:
• Biennial Healthcare Workforce Needs Assessment, required by HB 3261 (2017) by December 2020
• Biennial profile of Oregon's current healthcare workforce, including a demographic and geographic profile, focused on race, ethnicity, and languages spoken. By January 2021

Marc shared that there is a potential of collaboration with the HEC. He invited HEC members to consider serving on specific subcommittee's or as an ex-officio and non-voting member that could serve at HCWFC. He extended an invitation to HEC members to attend the HCWFC meetings, and he will encourage HCWFC members to participate at HEC meetings.

Co-chair Elections
HEC will hold Co-Chair elections at their November 14th meeting. Potential Co-Chairs can nominate themselves or nominate another HEC member. HEC members nominated by others must accept the nomination and complete the required materials as outlined below.

As part of the selection process, the Committee asks that all members interested in this committee leadership role complete the following requirements to be considered.

All HEC members that wish to be considered as a potential candidate for co-chair will send an email to committee staff (Maria) expressing their interest no later than October 25th by noon with responses to the "Co-Chair Interest Form." In the form, candidates should also answer the following questions:
• In 250 words or less what unique contribution you will make as HEC Co-chair.
• Identify 2 - 3 goals that you would like to see the committee achieve in the coming year.

Health Equity Definition
Work to refine the health equity definition has continued. Staff presented an overview of the work taking place to develop a framework to the health equity definition developed by HEC. This work will be shared with the OHPB at their October meeting. HEC members will send their additions and comments to the health equity definition framework no later than Tuesday, September 17th.

Health Equity Plan Guidance Document Review
HEC members had the opportunity to review and provide feedback to a draft of the Health Equity Guidance Documents that aims to support CCOs on fulfilling one of the CCO 2.0 Contract requirements. HEC would like to see on the document some guidance to CCOs on how to present the health equity plan to the community and, the addition of essential stakeholders such as the Regional Health Equity Coalitions or other grassroots organizations when Regional Health Equity Coalitions are not available.

Other feedback included, to consider moving a timeline for the plan submission process to the beginning of the document for clarity; adding contact points where CCOs and OHA can check in once plans are submitted and, adding tools such as an organizational equity audit. HEC members can submit comments until Tuesday, September 17th, 2019.

Next HEC meeting: Thursday, October 10th, 2019 at noon at OHA Transformation Conference Room (Five Oak Building)

COMMITTEE WEB SITE: https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx
STAFF POC: Maria Elena Castro maria.castro@state.or.us

Measuring Success Committee

The Measuring Success Committee of the Early Learning Council met on May 1. The committee completed its process of reviewing the proposed early learning system measures by mapping them across seven identified developmental domains, five sectors, and nine objectives of early learning system strategic plan, *Raise Up Oregon*. The committee determined that the proposed measures adequately covered the intended areas.

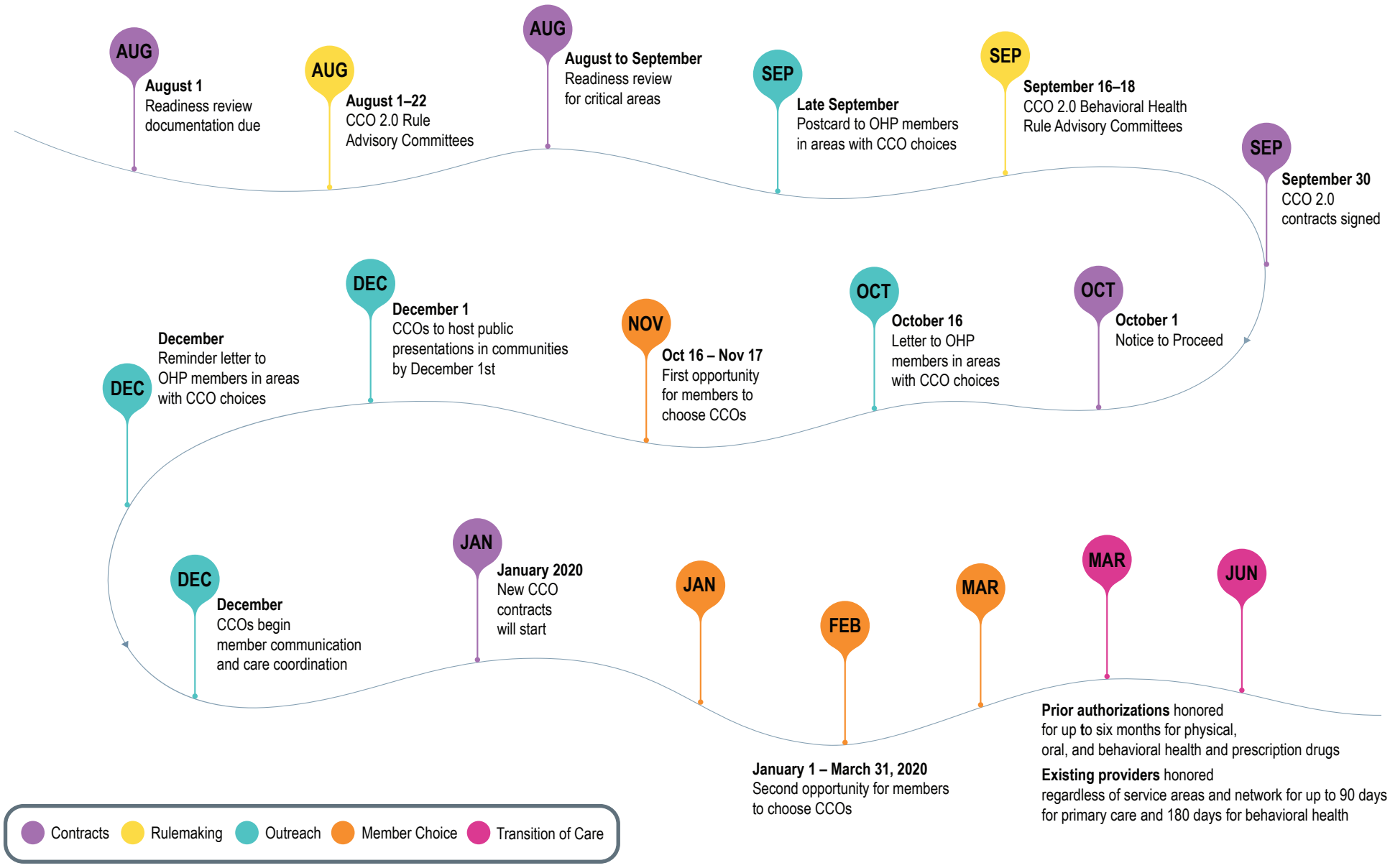
Over the course of the summer, staff will continue to document specific details of the measures and conduct a review to determine whether data can be analyzed by racial/ethnic groups. In addition, the ELD will consult with external stakeholders to conduct an equity review of the measures to determine potential bias in the measures. Further, a small workgroup will work in collaboration with OHA on the revision of the PRAMS-2 to incorporate additional early learning system items. The committee is planning on submitting the measure set to the Early Learning Council in October for consideration.

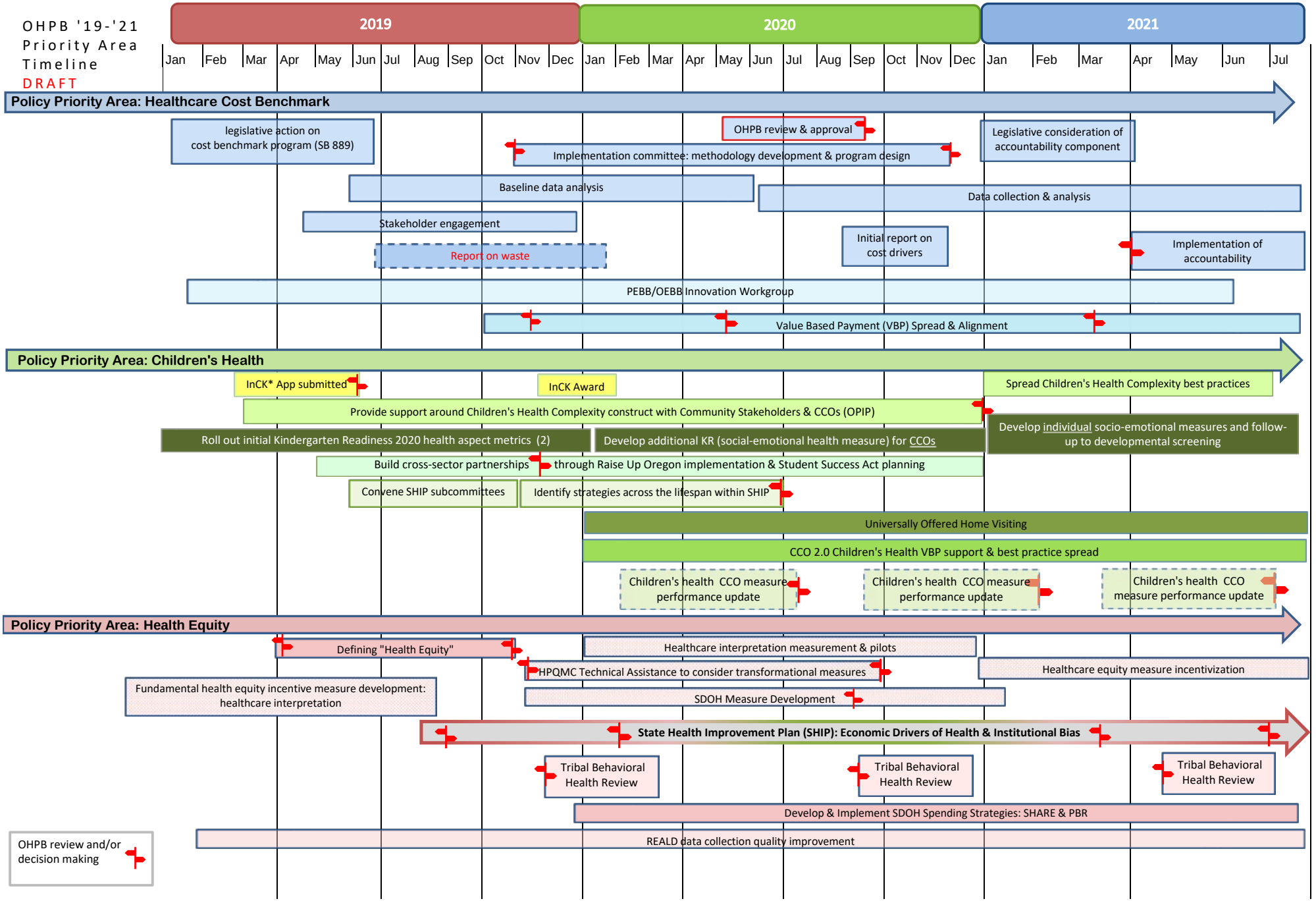
COMMITTEE WEBSITE: N/A
COMMITTEE POC: Thomas George, Thomas.George@state.or.us

CCO 2.0 Timeline

Event	Date
2016	
OHPB CCO 2.0 Listening Sessions & Initial Recommendations	July 2016 – December 2016
2017	
Decision to Delay CCO Contracts 1-year	September 2017
Evaluation of CCO 1.0	October – December 2017
2018	
Development of CCO 2.0 Goals	January – May 2018
Public Input and Direction on CCO 2.0 Goals	January – September 2018
Oregon Health Policy Board Adopts Policy Recommendations	October 15, 2018
Technical Forum on Service Areas	October 22, 2018
Technical Forum on Rates and Member Enrollment	November 19, 2018
2019	
Draft RFA Released for Public Comment	January 4, 2019
Final RFA Released	January 25, 2019
Letters of Intent Due	February 1, 2019
Questions / Requests for Clarification Due	February 4, 2019
Letters of Intent Publicly Posted	February 5, 2019
RFA Protest Period Ends	February 5, 2019
Letter of Intent to Apply – Change Requests Due	February 15, 2019
Answers to Questions / Requests for Clarification Issued	February 15, 2019
Pre-Application Conference	Announced via Addendum
Technical Assistance Forums	Announced via Addendum
Closing (Application Due)	April 22, 2019
Announcement of Applications Received	April 25, 2019
Required Applicant Conference	May 20, 2019
Notice of Intent to Award	July 9, 2019
Award Protest Period Ends	7 days after Notice of Intent to Award has been issued
Readiness Review Documentation Due	August 1, 2019
CCO 2.0 Rules Advisory Committees	August 1 – 22, 2019
2019 Rates Updated	September 15, 2019
Readiness Review and Contract Negotiations Completed	September 27, 2019
CCO 2.0 Contracts Signed	September 30, 2019
Notice to Proceed	October 1, 2019
2020 CCO Rates and Contracts Sent to CMS for Approval	Early October, 2019
1st Opportunity for Member Choice	October 16 – November 17, 2019
2020	
CCO 2.0 Contracts Effective	**January 1, 2020**
2nd Opportunity for Member Choice	January 1 – March 31, 2020
Prior authorizations honored up to six months for physical, oral, and behavioral health and prescription drugs	January 1 – June 30, 2020
Existing providers honored regardless of service areas and network for up to 90 days for primary care and 180 days for behavioral health	January 1 – June 30, 2020

CCO 2.0 Timeline




OHPB '19-'21 Priority Area Timeline
DRAFT
2019
2020
2021
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul
Policy Priority Area: Healthcare Cost Benchmark
legislative action on cost benchmark program (SB 889)
OHPB review & approval
Implementation committee: methodology development & program design
Legislative consideration of accountability component
Baseline data analysis
Data collection & analysis
Stakeholder engagement
Initial report on cost drivers
Implementation of accountability
Report on waste
PEBB/OEBB Innovation Workgroup
Value Based Payment (VBP) Spread & Alignment
Policy Priority Area: Children's Health
InCK* App submitted
InCK Award
Spread Children's Health Complexity best practices
Provide support around Children's Health Complexity construct with Community Stakeholders & CCOs (OPIP)
Roll out initial Kindergarten Readiness 2020 health aspect metrics (2)
Develop additional KR (social-emotional health measure) for CCOs
Develop individual socio-emotional measures and follow-up to developmental screening
Build cross-sector partnerships through Raise Up Oregon implementation & Student Success Act planning
Convene SHIP subcommittees
Identify strategies across the lifespan within SHIP
Universally Offered Home Visiting
CCO 2.0 Children's Health VBP support & best practice spread
Children's health CCO measure performance update
Children's health CCO measure performance update
Children's health CCO measure performance update
Policy Priority Area: Health Equity
Defining "Health Equity"
Healthcare interpretation measurement & pilots
HPQMC Technical Assistance to consider transformational measures
Healthcare equity measure incentivization
Fundamental health equity incentive measure development: healthcare interpretation
SDOH Measure Development
State Health Improvement Plan (SHIP): Economic Drivers of Health & Institutional Bias
Tribal Behavioral Health Review
Tribal Behavioral Health Review
Tribal Behavioral Health Review
Develop & Implement SDOH Spending Strategies: SHARE & PBR
REALD data collection quality improvement
OHPB review and/or decision making

V1.1

OHPB Policy Priority Activity Dashboard DRAFT

9/25/19

Cost Growth	Children's Health	Health Equity
Legislation Crafted for Health Care Cost Growth Target (SB 889)	InCK CMS Funding Request	Defining Health Equity
Stakeholder Engagement for Target Concept	Provide TA support around Children's Health Complexity construct with Community Stakeholders & CCOs (OPIP)	Health Equity (HE) Foundational Measure Developed (Health Care Interpretation)
Initial Data Analysis & Framework Developed	Initial Kindergarten Readiness Metrics Developed	Measure of HE Piloted
Report on Waste	Convene SHIP Subcommittees	Measure of HE Selected for Incentivization
Cost Growth Target Implementation Committee & Program Design (IC) Meetings	Identify Strategies Across the Lifespan within SHIP	Accurate and Reliable Demographic Data by CCO Available
PEBB/OEBB Innovation Workgroup to Study, Identify and Analyze Cost Drivers	Build Cross- sector Partnerships Around Raise Up Oregon	Tribal BH Strategic Plan Implementation
OHPB Implementation Committee Supervision	Build Cross- sector Partnerships Around SSA	Social Determinants of Health Spending Strategies: SHARE & PBR
Recommendations for Cost Growth Target Program Implementation Approved by OHPB	Implement Universally-offered Home Visiting (early adopters)	SHIP Priority Area: Economic Drives of Health
Cost Growth Target Data Collection & Analysis	Periodic Updates on CCO Children's Health Measure Performance	HPQMC Technical Assistance to Develop Transformation Measure Criteria & Process
Initial Report on Cost Drivers Published	ONGOING WORK: Child Welfare Oversight Board. Governor's Children's Cabinet. Cover All Kids.	Social Determinants of Health Measure Developed
Leg. Consideration of Cost Target Accountability & Implementation of Accountability Mechanisms		ONGOING WORK: Monitoring, addressing and ensuring compliance with Civil Rights Title VI, Americans with Disabilities Act and Affordable Care Act Section 1557. Engaging communities statewide, most impacted by social inequities and poorer health outcomes; Providing TA to implement best practices
Align & Spread Value-Based Purchasing		
ONGOING WORK: Pharmacy-related strategies		
Current Status & Notes: Implementation Committee member recruitment has closed, the Governor's Office is considering Committee Members. The first IC meeting is November. The next PEBB/OEBB innovation workgroup meeting is October 5th.	**Current Status & Notes:** Inck awards announced Dec 2019; OHA is committed to supporting RUO and SSA cross-sector partnerships; UOHV Early Adopters are entering one year of planning.	**Current Status & Notes:** HPQMC will receive Technical Assistance to meet the Board's guidance letter from State Health and Value Strategies through Bailit Health beginning in November.

Health Care Workforce Committee Presentation

Jeff Clark, HCWF Committee Chair
Curt Stilp, HCWF Vice-Chair

Marc Overbeck, OHA Primary Care Office Director
Joe Sullivan, OHA Health Care Provider Incentive Program

Oregon Health Authority

HEALTH POLICY AND ANALYTICS DIVISION

Background on Committee

- One of two initial OHPB Committees, codified in 2009 (ORS 413.017)
  - To coordinate efforts in Oregon to recruit and educate health care professionals and retain a quality workforce to meet the demand created by the expansion in health care coverage, system transformation and an increasingly diverse population.

Oregon Health Care Workforce Committee Composition

Leadership:

Chair – Dr. Jeff Clark, ND

Vice-Chair – Curt Stilp, PA-C

Immediate Past Chair – Robyn Dreibelbis, DO

18 members, including 2 student non-voting members

Gender:

7 male, 11 female (39% male; 61% female)

Race/Ethnicity:

12 White, 2 Asian, 2 Black, 1 Hispanic, 1 Native American

(67% White, 11% Asian, 11% Black, 6% Native American, 6% Hispanic)

Geography:

Portland (7), Willamette Valley outside Portland (6), Southern Oregon (3), Central Oregon (1), NE Oregon (1)

Committee Charter Deliverables

- A report on recommended strategies to address clinician burnout rates and increase clinician and patient satisfaction. *By March 2020*
- Review and revise the 2013 Strategic Plan for Recruitment and Retention in Oregon and offer recommendations for its implementation. *By March 2020*
- Biennial Evaluation of the effectiveness of Healthcare Provider Incentives in Oregon, required by HB 3261 (2017) *by July 2020*
- Biennial Healthcare Workforce Needs Assessment, required by HB 3261 (2017) *by December 2020*
- Biennial profile of Oregon's current healthcare workforce including a demographic and geographic profile focused on race, ethnicity, and languages spoken. *By January 2021*
- A report on opportunities to increase education and training capacity of health professionals, not limited to medical training *By March 2021*
- ***Ongoing guidance to OHA and the OHPB on the deployment of resources through the new Health Care Provider Incentive fund and other incentive streams in Oregon***

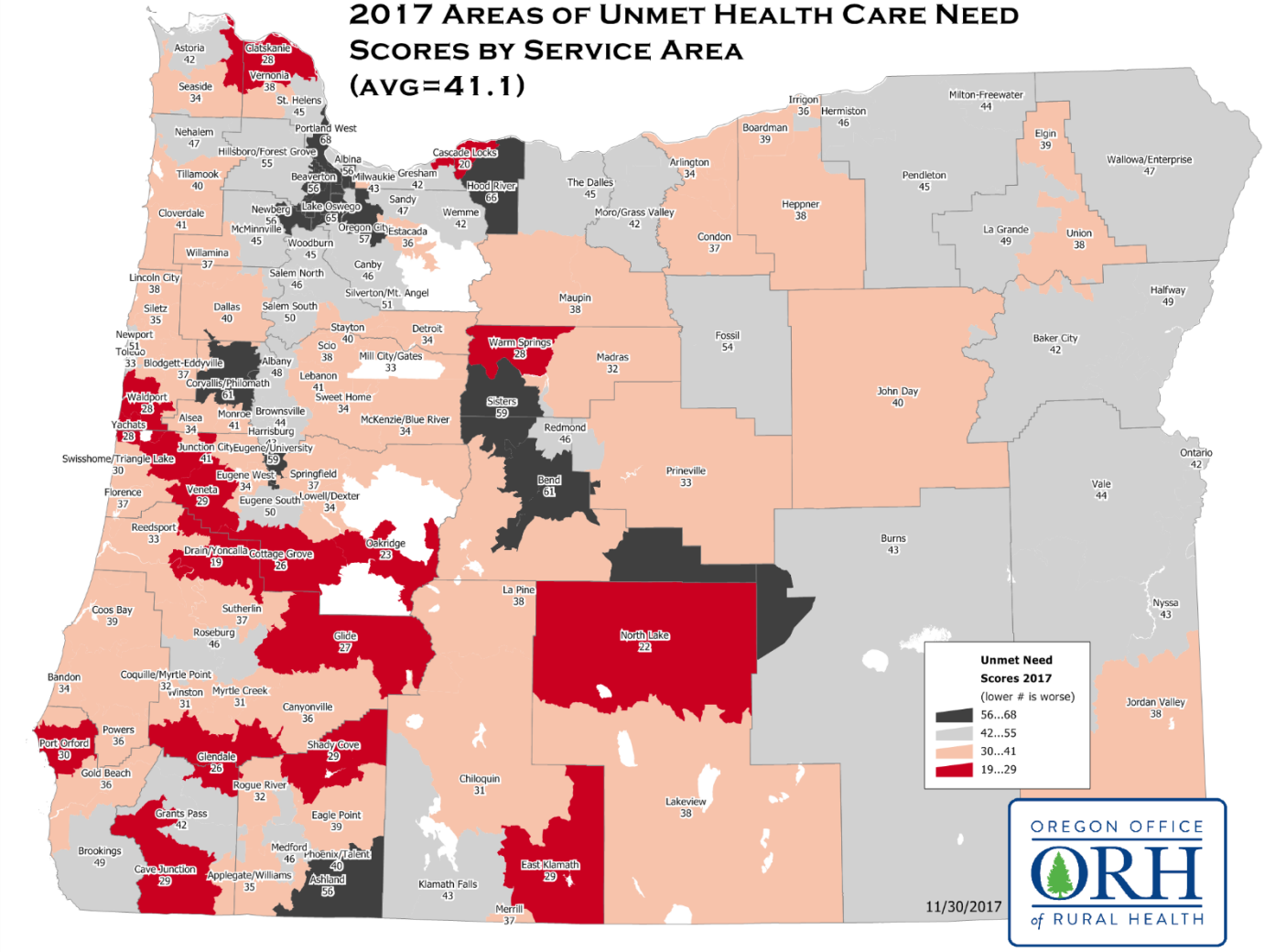
Products of the Workforce Committee

- Recommendations to Unify Student Clinical Placement Standards (2011)
- Recommendations on Traditional Health Workers (2012)
- Supply and Demand for Primary Care Report (2013)
- Recommendations on Graduate Medical Education (2014)
- Report on financial incentives for providers (2014)
  - Led to HB 3396 (2015)
- Recommendations on provider incentives, based on Lewin report (2016)
  - Led to HB 3261 (2017)

Where are we in 2019 compared with 2011?

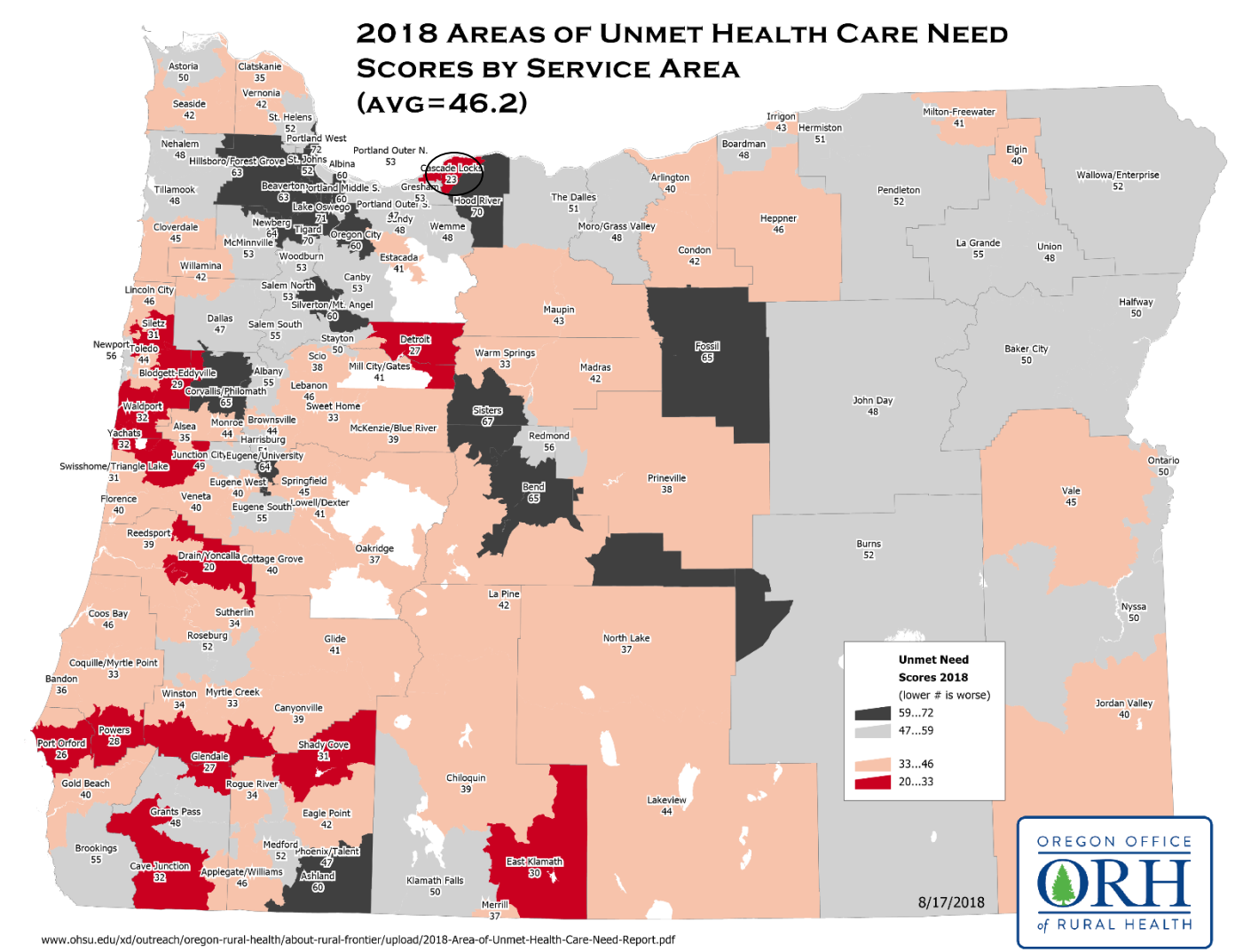
- Increased insurance coverage
- Increases in # of providers in Oregon 2010-18
- Over 700 Patient Centered Primary Care Homes (PCPCH)
- CCO 1.0 largely successful
- CCO 2.0 underway
- Changes in Unmet Need Criteria and Scores showing improved access to care
- Decreased HPSA scores reflecting stabilization of workforce and more robust workforce in some areas
- Aging provider workforce
- New methodologies for delivering care
  - Coordinated Care Model
  - Behavioral Health integration
  - Telemedicine
- Payment reform
- Federal policy uncertainty
  - Graduate Medical Education (GME) funding
  - ACA continuation/support
  - Funding for Community Health Centers/Teaching Health Centers, etc.
- More state money for and better coordination of provider incentives

Areas of Unmet Need: 2017



Oregon Health Authority

Areas of Unmet Need: 2018



www.ohsu.edu/xd/outreach/oregon-rural-health/about-rural-frontier/upload/2018-Area-of-Unmet-Health-Care-Need-Report.pdf

Oregon Office of Rural Health

Oregon Health Authority

Trending Workforce Picture

Between 2010 and 2016, the majority of health professions experienced an increase in those practicing in Oregon:

Some examples

- Occupational Therapists (+12%)
- Physical Therapists (+11%)
- Physician Assistants (+5.9%)
- Registered Nurses (+5.2%)
- Physicians (+ 3.9%)
- Dentists (+.02 %)

HOWTO Grant Program

- Funded after the 2017 legislative session, as a collaboration between OHSU and OHA.
- Purposes:
  - **Expand health professional training in Oregon**
  - **Support innovative, community-based, transformative, sustainable training initiatives**
  - **Expand current and/or develop new health professional training in a local area, which may include Graduate Medical Education**
  - **Address health disparities and social determinants of health**
  - **Support greater ethnic, racial, and linguistic diversity of the workforce**

HOWTO Grant Program

Projects funded

- Round 1
  - **Virginia Garcia Memorial Health Center**
    - Virginia Garcia Memorial Health Center Residency Program
  - **The Oregon Community Health Workers Association (ORCHWA)**
    - Community Health Workers Capacitation Collective
  - **Northeast Oregon Area Health Education Center (NEOAHEC)**
    - Increasing Psychiatric Mental Health Nurse Practitioner Workforce in Eastern Oregon
  - **George Fox University**
    - Interprofessional Primary Care Institute

HOWTO Grant Program

Projects funded

- Round 2
  - **Samaritan Pacific Communities Hospital**
    - Samaritan Pacific Communities Hospital Rural Training Track
  - **Clackamas Workforce Partnership (Diversity)**
    - Clackamas County Healthcare Workforce: Increasing Local Supply and Diversity
  - **Oregon Washington health Network (OWhN) of Pendleton, Oregon**
    - OWhN-BMCC Medical Assisting Training Program
  - **Northwest Portland Area Indian Health Board**
    - Yellowhawk/NPAIHB Behavioral Health Aide Training Center of Oregon
  - **Umpqua Community Health Center**
    - Roseburg Family Medicine Residency Program: Building Rural Oregon's Healthcare Workforce
  - **The Next Door, Inc.**
    - Valle Verde - Green Valley Mental Health Awareness Training

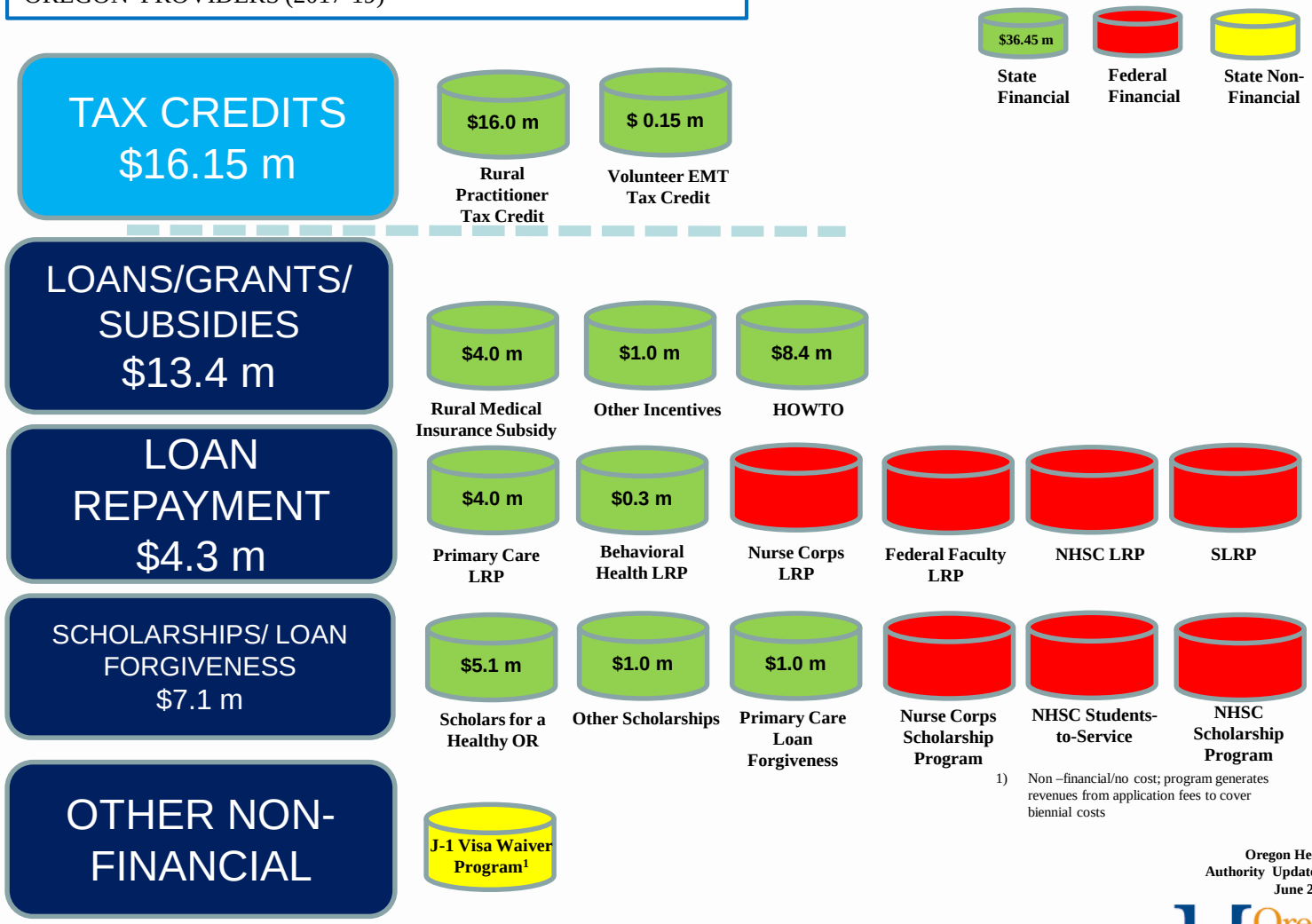
Main Focus for Today's Presentation

Board Review and Approval of Preliminary Recommendations for Use of Health Care Provider Incentive Program

Statutory Responsibility of Board:
ORS 676.467:

…the Oregon Health Policy Board shall determine the best allocation of moneys in the Health Care Provider Incentive Fund established under ORS 676.450 (Health Care Provider Incentive Fund)

STATE- AND FEDERAL FUNDED HEALTHCARE WORKFORCE PROVIDER INCENTIVES AVAILABLE TO OREGON PROVIDERS (2017-19)

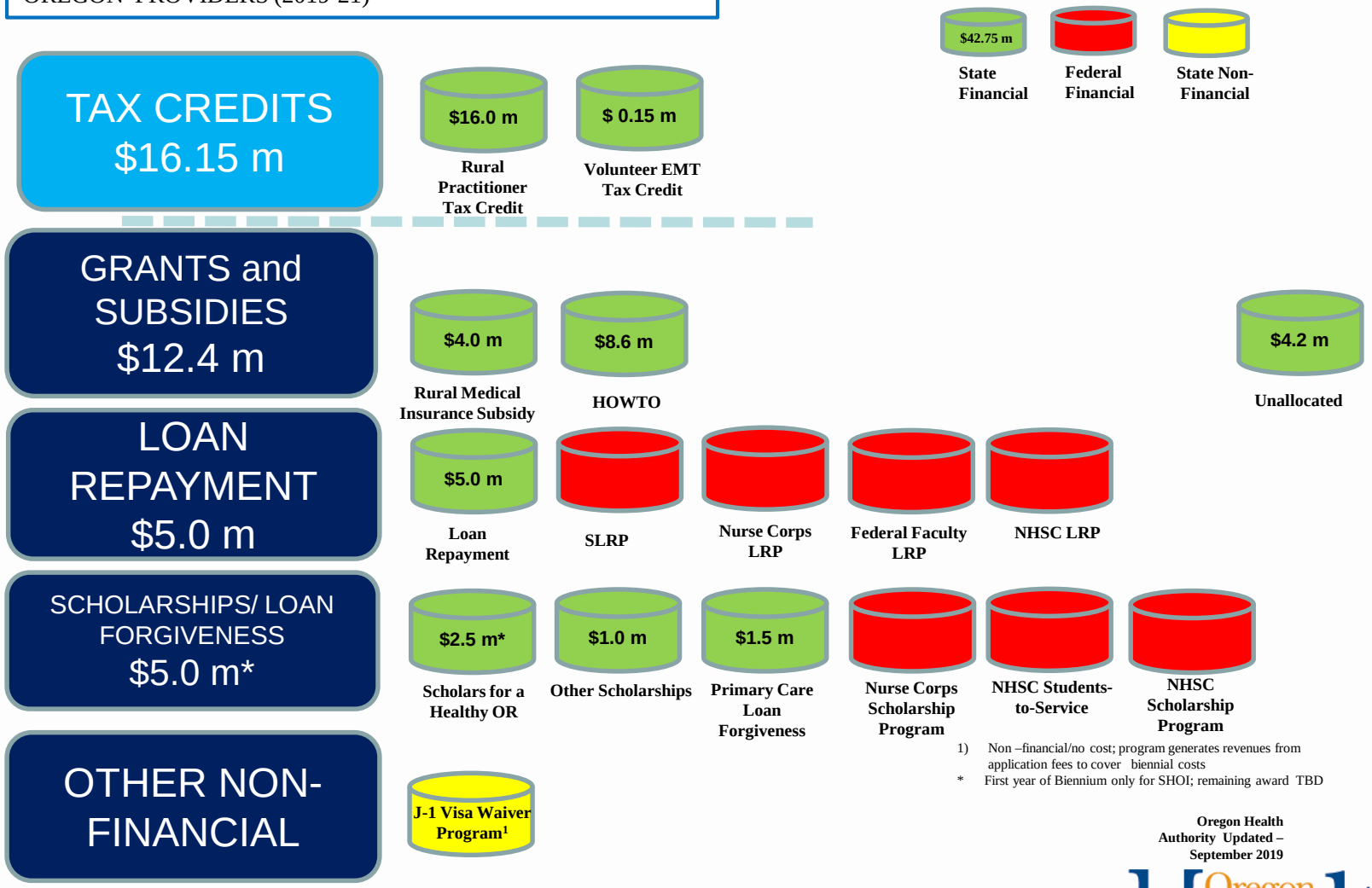


1) Non –financial/no cost; program generates revenues from application fees to cover biennial costs

Oregon Health Authority Updated – June 2019

Oregon Health Authority

PROPOSED STATE- AND FEDERAL FUNDED HEALTHCARE WORKFORCE PROVIDER INCENTIVES AVAILABLE TO OREGON PROVIDERS (2019-21)



1) Non –financial/no cost; program generates revenues from application fees to cover biennial costs

* First year of Biennium only for SHOI; remaining award TBD

Oregon Health Authority Updated – September 2019

Oregon Health Authority

Overall Recommendations for 2019-21

- Loan Repayment – Add $1 million for a total of $5 million
- Loan Forgiveness – Add $.5 million for a total of $1.5 million
- SHOI – Keep 2020 amount at $2.5 million while further discussion about logistics and effectiveness of program under discussion
- SHOI-Like – Maintain 2017-19 funding level of $1 million with 3 added schools/programs and possibly more in the future.
- Rural Insurance Subsidy – Recommend no change to $4 million funding at present, pending Administrative Rule review of provider eligibility
- Administration – No change to current $1 million cap

- Committee to return to Board in Spring 2020 with further recommendations for $4.2 million remaining balance

Loan Repayment

- 83 awards able to be made 2017-19 with $3.8 million
- 33 awards made to clinicians fluent in a language other than English
- More than 15 awards to clinicians of diverse ethnic/racial background (not White, non-Hispanic)
- Awards focused to areas where National Health Service Corps (NHSC) isn't available but have high need
- With reduced Health Professional Shortage Area (HPSA) scores in many areas and projected fewer federal awards, we want more funds available to fill in where the federal government won't.

Recommendation: Add $1 million for this incentive type

Loan Forgiveness

- 24 students offered loan forgiveness in 2017-19
- Considerable work done to expand Rural Tracks, allowing more students to experience rural clinical settings
  - 5 new programs/schools added within past 15 months

Recommendation: Add an additional $.5 million to enable more students to commit to rural practice

SHOI

- Scholars for Healthy Oregon Initiative (SHOI) established in 2013 by legislature.
  - Program enables OHSU students to receive full scholarships in exchange for commitment to practice in rural or other underserved areas

Recommendation: Make no changes to $2.5 million allocation in 2020 academic year; further discussion with OHSU taking place about the direction of funds and program parameters

“SHOI – Like” Programs

- Three schools with individual mini-SHOI programs established in 2018-19:
  - COMP-NW
  - NUNM
  - Pacific University

Recommendation: Keep level funding, and allow the programs to mature; potentially adding other institutions

Rural Insurance Subsidy

- Incentive has been around for more than 20 years
- 521 physicians and nurses participated in 2019
- Designed for those with highest medical malpractice insurance premiums and most essential services in rural Oregon:
  - Obstetrics top priority
  - Family Practice and General Practice next highest priority
  - Smaller awards also available to specialists and non-essential disciplines
- Considerable discussion regarding continuing to provide the subsidy for those in “lowest category”

Rural Insurance Subsidy

- Details on providers receiving 15% subsidy:
  - 2017: 228 (204 physicians/24 nurse practitioners)
  - 2018: 201 (181 physicians/20 nurse practitioners)
  - 2019: 168 (150 physicians/18 nurse practitioners)

Consensus in Committee to strongly rethink eligibility for this category, but Committee not able to recommend change in funding at this time.

Discussion/Questions?

OHA Staff Contacts:

Marc Overbeck
Director
Primary Care Office
Health Policy and Analytics Division
503-373-1791
marc.overbeck@dhsoha.state.or.us

Joe Sullivan
Health Care Provider Incentives Coordinator
Primary Care Office
Health Policy and Analytics Division
503-559-0340
joseph.a.sullivan@dhsoha.state.or.us

August 12th, 2016

To: Oregon Health Authority

Subject: HB 3396 Lewin Report

One of the requirements of House Bill 3396 passed by the Oregon Legislature in 2015 is to study and evaluate Oregon's health care workforce incentive programs, in light of current and projected health care workforce shortages. The Lewin Group was tasked to conduct an analysis of existing strategies to address these shortages and evaluate provider incentive programs to inform future funding decisions by the Oregon Legislative that ensure incentive programs are based on demonstrated effectiveness and are as cost effective as possible. The current study and recommendations will provide the Oregon Health Policy Board and the Legislature with information to help ensure Oregon is supporting programs that are both effective and cost-efficient in terms of recruiting and retaining qualified health care providers, particularly in rural and areas in high need of medical services.

We consider the incentive programs to be effective if the number of provider FTE-years in targeted areas increases as a direct result of the program. Based on this metric, we find empirical evidence that all programs increase the number of provider FTE-years above what would have been available in rural areas over the period between 2010 and 2014 without the programs. Some programs have a recruiting effect—they attract new providers into the area, some have a retention effect—they keep providers in the area longer, while some have both a recruiting effect and retention effect. More specifically, we find that:

- NHSC LRP has an important recruiting effect on primary care physicians, and an even larger effect on NPs and PAs, which makes this program an effective recruiting tool
- NHSC LRP also has a relatively minor retention effect
- The other loan repayment programs (SLRP, BHLRP and MPCLRP) are likely to have similar effects, given that they are similar in terms of award amounts and eligibility criteria
- RPTC and RMPIS have negligible recruiting effect on primary care physicians, but do have a small recruiting effect on NPs and PAs
- Instead, RPTC and RMPIS have a sizeable retention effect on all providers, which makes them efficient retention tools in rural areas
- Costs of attracting an additional FTE-year through any of the programs are lower in the case of NPs and PAs, relative to primary care physicians
- Costs of an additional primary care physician FTE-year are similar across programs, and the same is true for NPs and PAs.

We also formulate a number of recommendations that have the potential to improve the analysis and evaluation of the provider incentive programs in the future. These recommendations are aimed at increasing the programs' recruiting effect, retention effect, or both, as well as improving their cost-effectiveness. Our analysis of the key features of the current programs yields a number of insights into the features that tend to be associated with incentives that offer greater cost-effectiveness. They are centered on issues such as the:

- targeting of benefits
- budget control
- cash vs in-kind benefits
- current vs deferred benefits
- costs incurred today vs costs incurred later

We then assess the current programs through the prism of these features and provide observations on how the programs may be made more efficient and cost-effective. Also, as future efforts to enhance the effectiveness of these programs should focus on increasing the number of providers who would not serve in rural areas without incentive programs, we formulate a number of recommendations on how to achieve this objective. These include:

- Creation of a bidding mechanism allowing providers to offer more years of service in rural areas
- Increasing the value of the program "package" (for instance, by allowing for a stipend to cover moving expenses for providers who are not in rural areas)
- Relaxing job requirement as a condition for a loan repayment application
- Increasing awareness of the availability of programs, by providing a consolidated single source of information and applications across programs
- Encouraging multiple program participation
- Increasing the amount of awards
- Increasing the number of loan repayment awards
- Allowing for different award amounts by provider type

Moreover, once participating providers locate to rural areas, we propose a set of measures to increase the retention of participating providers in those areas. These recommendations include:

- Encouraging the combination of benefits
- Introducing obligation periods
- Retaining former obligors in the state
- Increasing the number of limited-funded awards

Although they are outside the scope of the incentive programs, changing clinical practices in rural centers, and boosting community support for providers may also have the beneficial effect of increasing retention of providers in rural areas.

The main conclusion of this report is that all incentive programs analyzed are successful in increasing the number of providers in rural areas in Oregon. Some programs are better recruiting tools, while other programs are better retention tools. Our program and policy recommendations are aimed at further increasing the efficacy and cost-effectiveness of programs in the future. Also, our data collection recommendations ensure that future program evaluations will have a deeper and wider scope, hence more effectively informing funding decisions by the Oregon Legislative.

Oregon Health Care Workforce Committee
Kate Brown, Governor

Oregon Health Authority

500 Summer St. NE E-20
Salem, OR 97301
Phone: (503)-947-2340
Fax: (503)-947-2341
www.oregon.gov/OHA

September 24, 2019

TO: Carla McKelvey, Chair
Oregon Health Policy Board

FROM: Health Care Workforce Committee

Re: Committee Recommendations on Health Care Provider Incentive Fund for 2019-21

Dear Carla and Board:

The Health Care Workforce Committee is pleased to submit the following preliminary recommendations for use of the Health Care Provider Incentive Fund for the 2019-21 biennium. As you know, the Board's authority of these moneys began to take shape in 2015 under HB 3396, when the legislature asked the Board for recommendations and in 2017 under HB 3261, when funds were earmarked, but the Board was given discretion to move unspent money for the final 6 months of the biennium. Beginning this year, the legislature has granted complete autonomy to the Board to direct these funds. The following is a recommendation for use of $15 million of the $19.2 million dollars allocated to the fund for this biennium.

Summary Recommendation

Budget: With $17.6 million allocated by legislature for 2019-21, plus carryover from the previous biennium, the current fund total is $19.2 million.

We recommend the following allocation of these moneys:

- Rural Insurance Subsidy: $4.0 million (no change from previous biennium)
- Loan Repayment: $5 million (an increase of $1 million from the previous biennium)
- Loan Forgiveness: $1.5 million (an increase of $.5 million from the previous biennium)
- SHOI-Like: $1 million (no change from previous biennium)
- SHOI: $2.5 million for 2020 academic year (no change from the previous year—OHA and OHSU are in discussion about program details); funding for 2021 academic year to be determined.
- Administration: $1 million (no change from previous biennium)

Further,

- Retain the remaining $4.2 million for a supplemental proposal to the Board by March 2020. This proposal will include recommendations on new incentives to be funded with remaining, unobligated funds.

Discussion of Recommendation Components

1. Rural Insurance Subsidy

This incentive, and the instrumental value of this incentive has evolved considerably in the more than 20 years since the Rural Insurance Subsidy Program was first established. At its onset, the program was seen as necessary for physicians and nurses to be able to absorb the high cost of medical malpractice insurance, which they were paying out-of-pocket in their sole-provider or group practices. With a majority of physicians and nurses now employed by organizations and not owners of their own clinics, the necessity for this incentive has decreased, since insurance is often paid by the employer.

At its September 11 meeting, the Committee discussed extensively whether the $800,000 currently spent on subsidies doctors and nurses receiving the 15% subsidy (not OB/GYN or Family Practice) is an effective support for retention. The number of providers in this category is as follows:

Figure 1. Number of providers receiving the 15% subsidy:

2017 - 228 (204 physicians/24 nurse practitioners)
2018 - 201 (181 physicians/20 nurse practitioners)
2019 - 168 (150 physicians/18 nurse practitioners)

The average subsidy to each of these providers is around $500.

No member of the committee proposed that this subsidy for these providers is having a marked, positive effect on retention. However, it was also noted that the rules for this program will be considered for revision later this fall and that providers benefitting from this have not been contracted directly to inform them of potential changes for this subsidy. The Committee therefore proposes to retain a $4 million allocation at this time, pending conversation with affected parties and a full process to review existing administrative rules.

2. Loan Repayment

Loan Repayment has long been seen as a useful tool to help redistribute the current provider workforce to areas most in need. The Lewin Report of 2017, commissioned by OHA to help make recommendations on the use of incentives in Oregon, identified this type of incentive as having the greatest combined recruitment and retention effect. In the first 18 months of the Health Care Provider Incentive Program, Loan Repayment was the most competitive incentive, with approximately 44 percent of applicants receiving awards. Many unsuccessful applicants are working in underserved areas with HPSAs below the threshold score to receive funding from the National Health Service Corps (NHSC) (18 or higher in 2020). An additional complication for next year is that Facility HPSA scores are being updated for FQHCs and Certified Rural Health Clinics during 2019—with generally lower scores resulting, making additional funding available to support the needs of clinicians throughout Oregon of the utmost importance. While many clinics were able to meet the threshold of an 18 HPSA score to get awards through the NHSC in the previous biennium, that number has decreased with the updated scores and as a result fewer clinics will be able to rely on federal resources, although need remains.

We propose to expand the pool of funds available this biennium from $4 million to $5 million. This will enable OHA to attract more applicants, while simultaneously awarding a higher percentage of those who are willing to practice in underserved areas. Keeping in mind that OHA also has the discretion of approving or denying relocation requests of those under service obligations, this tool will aid in maintaining retention at state-approved sites. While the maximum award for Loan Repayment is $105,000, in the previous biennium the average award was $57,520--evidence that awards can be well distributed among clinician types and that the funds can be used efficiently to make as many awards as possible. The total number of loan repayment awards in 2017-19 was 83; with continued awareness and interest in the program, we expect to see that number increase and fill many more workforce gaps.

3. Primary Care Loan Forgiveness

In 2017, it was believed by some stakeholders that loan forgiveness was an outdated incentive. However, since that time, the Oregon Area Health Education Center (AHEC) has expanded the number of Rural Tracks considerably and conducted so much outreach to schools that there are far more health profession students interested in serving in rural communities. At the onset of the previous biennium, only four schools offered Rural Tracks for their students. AHEC has since expanded this program to include additional schools/programs *(Figure 2)*, which will result in higher interest and higher applicant numbers, which in turn makes for a more competitive award process.

Programs already eligible to participate in PCLF:

- *Western University of Health Science: COMP-NW College of Osteopathic Medicine*
- *Pacific University PA Program*
- *OHSU School of Medicine*
- *OHSU PA Program*

Figure 2. Additional Schools/Programs added in past 15 months:

- OHSU Family Nurse Practitioner Program
- OHSU School of Dentistry
- OHSU College of Pharmacy
- OHSU School of Nursing (BSN Program La Grande)
- Pacific University College of Pharmacy

We propose an additional $500,000 be invested in this incentive, to allow as many health care profession students as possible under contract during their education and ensure they will stay in Oregon or return to Oregon upon completion of their training.

4. SHOI-Like Programs

Prior to 2018, the only school with a scholarship program to encourage students to practice in rural or underserved areas was the Scholars for a Healthy Oregon Initiative (SHOI) at OHSU, established by the 2013 legislature. OHA successfully engaged Western University (COMP-NW in Lebanon) the National University of Natural Medicine (in Portland) and Pacific University PA program to establish smaller scholarship programs (SHOI-Like programs) for this purpose. These programs ensure providers return to,

or remain in, Oregon upon completion of their training and remain at a rural or underserved clinic for the same number of years we funded their education.

These new programs are just underway. While they appear to be successful (awardees have been named at each), we propose to maintain funding as it was in the past biennium and continue to support and evaluate the results of these new programs before making determinations to provide additional funds.

5. SHOI

As noted above, SHOI was established in 2013 at OHSU. OHSU and OHA are currently in discussion regarding the use of the program and whether adjustments can or should be made to better target students participating in professions that are of highest priority in Oregon's workforce. We recommend that there be no changes to the anticipated $2.5 million award to OHSU for Academic Year 2020-21. We anticipate returning to the Board in 2020 with additional information and recommendations on the most effective use of these funds.

6. Administration

OHA spent an anticipated $700,000 last biennium, with staff arriving at the beginning of 2018, which included 18 months of contract expenditures with OHSU for administration of loan repayment, loan forgiveness and collection of eligibility forms for providers using the insurance subsidy. We see no reason to propose a change right now to the maximum amount of administrative expenditures.

Health Equity Definition Presentation
DRAFT

Health Equity Committee (HEC)

Carly Hood-Ronick, HEC Co-Chair

Michael Anderson-Nathe, HEC Co-Chair

Leann Johnson, Director OHA Equity and Inclusion Division

Oregon Health Authority | Office of Equity & Inclusion

The need for a health equity definition

HEC is tasked with making recommendations to OHPB, OHA, and the broader health systems in Oregon using an equity lens (HEC Charter, 2017)

Development of an equity framework starts from a common working definition of health equity.

Consensus around a definition of health equity helps foster dialogue and bridge divides.

Lack of clarity on the definition can pose a barrier for effective engagement and action

Health Disparities v/s Health Inequities

Health Disparities

- Health disparities mean the same thing as health inequalities. They are simply differences in the presence of disease, health outcomes, or access to health care between population groups.

Health Inequities

- Health inequities are differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust. Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups.

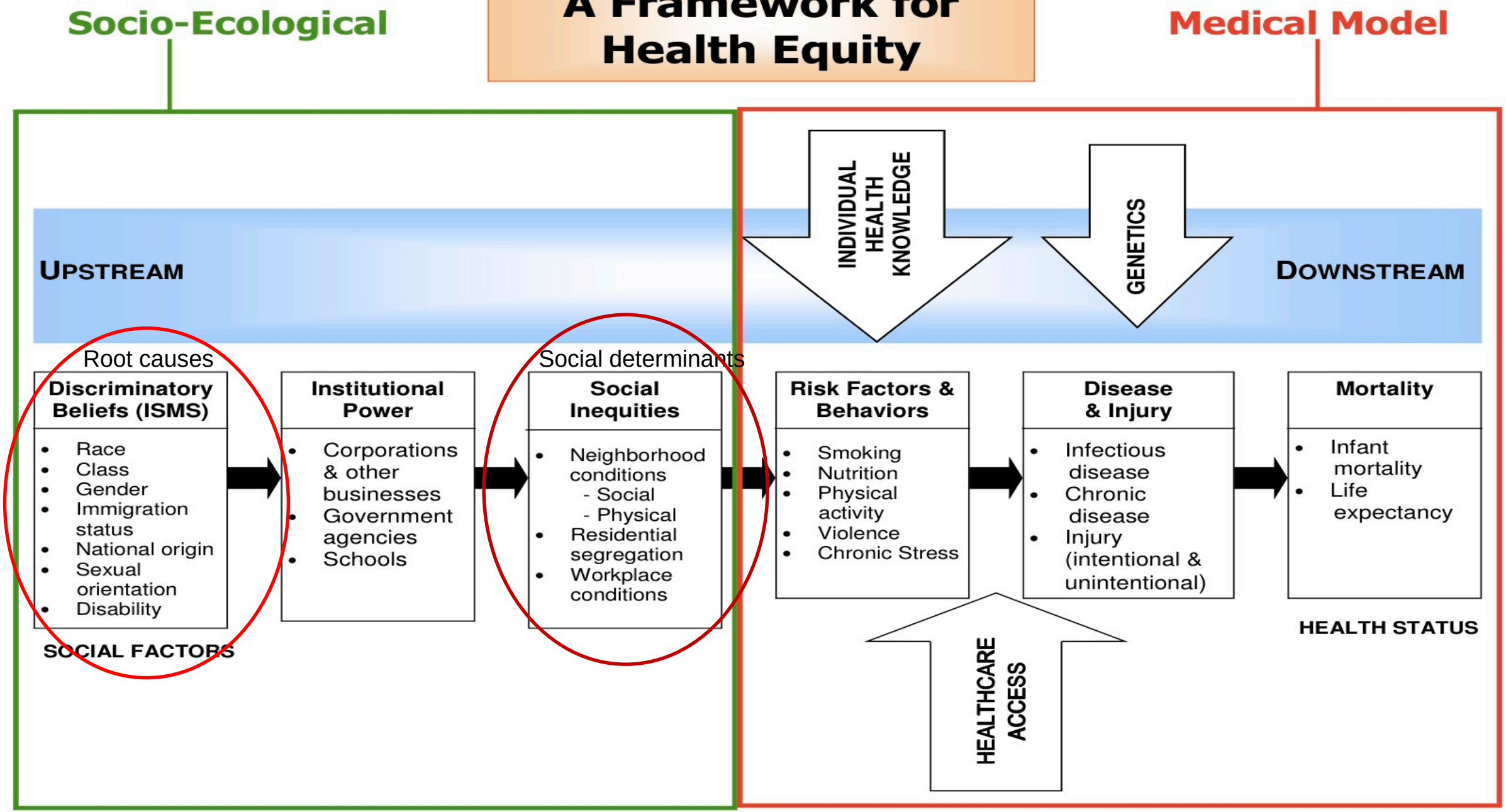
Boston Public Health Commission https://www.bphc.org/whatwedo/health-equity-social-justice/what-is-health-equity/Pages/Health-Disparities-vs.-Health-Inequities.aspx

For example

- Male babies are generally born at a heavier birth weight than female babies. This is a health disparity.
- We expect to see this difference in birth weight because it is rooted in genetics. Because this difference is unavoidable, it is considered a **health disparity**.

- Babies born to Black women are more likely to die in their first year of life than babies born to White women.
- A higher percentage of Black mothers are poor and face hardships associated with poverty that can affect their health.
- However, we find differences in the health of Black and White mothers and babies comparing Blacks and Whites with the same income.
- Research has shown links between the stress from racism experienced by Black women and negative health outcomes. **This is a health inequity** because the difference between the populations is unfair, avoidable and rooted in social injustice.

A Framework for Health Equity



FEEDBACK OVERVIEW

Health Equity Definition Feedback Period

May to July 2019

Source of Feedback	Content/Themes
Tribes	• Addition of “political relationship”
Community Advisory Councils	• Clarify meaning of terms used such as : “all sectors” • Consider geographic diversity • Consider housing status • Consider literacy level of the definition • Consider economic status
Community Based Organizations	• General sentiment definition is welcomed and gives a positive signal • Consider “Intersectionality” • Consider focus on racial equity
OHPB/Committees of the Board	• Consider using the Community Advisory Councils (CACs) as a source for feedback. • Consider engaging other OHPB subcommittees • Consider addressing geography • Address intersectionality of list of inequities and geographic isolation, community building and power differences
CCOs	• Consider literacy and readability • Definition should be accessible and understandable • Consider concern between too prescriptive and leaving areas to interpretation

Assumptions and Values

Health is broadly defined as a positive state of physical, mental, and social well-being and not merely the absence of disease.

Everyone has the right to a standard of living adequate for health, including nutrition, education, housing, medical care, and necessary social services.

Rural racial/ethnic minority populations have substantial health, access to care, and social determinants of health challenges that can be overlooked when considering aggregated population data .

Inequities in population health outcomes are primarily the result of social and political injustice, not lifestyles, behaviors, or genes

Addressing health inequities means addressing differences that are not only unnecessary and avoidable but also, unjust and unfair.

Equity must be intentionally pursued as a strategy; it will not necessarily happen as a byproduct of other development efforts.

HEC - HEALTH EQUITY DEFINITION

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

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

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

Health Equity Definition Framework

The Health Equity Committee definition framework draws attention to the concepts of fairness and justice in the distribution of resources. Furthermore, it highlights the idea that social inequities in health are avoidable through collective action and that inaction is no longer acceptable.

Identifying and implementing effective solutions to move the dial on health equity demands:

- Recognition of the role of historical and contemporary oppression and structural barriers facing Oregon communities.
- Engagement of a wide range of partners representing diverse constituencies and points of view.
- Direct involvement of affected communities as partners and leaders in change efforts.

OHPB and OHA
Opportunities to advance health equity

There are specific opportunities to build the structure and advance health equity through:

- Breaking down current silos and considering health equity in every policy and business decision.
- Adopting a shared vision for health equity.
- Aiming for greater alignment and amplification of existing efforts to advance health equity.
- Building collective capacity and infrastructure at the organization and committee level for change.
- Create and advance systems changes and policies that result in reallocation of resources and power.

Closing Comments