

Findings and Recommendations

Committee Membership Workgroup

OREGON HEALTH POLICY BOARD

October 2021

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HEALTH POLICY AND ANALYTICS

Office of Health Policy

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EXECUTIVE SUMMARY

This report of findings and recommendations should be considered as another step along a journey of organizational transformation, with proposed implementation steps that are necessary, but still insufficient, to achieving diversity, inclusion, and equity. The Oregon Health Authority (OHA) goal of eliminating health inequities by 2030 requires actions far beyond diversifying Oregon Health Policy Board (OHPB) Committee membership recruitment and retention, and includes:

- OHA staff recruitment and retention (including OHA Equity Action Leadership Team work),
- community engagement and relationship building more broadly,
- examining Committee practices to get to the broader goals of equity, not just diversity and inclusion, and
- other OHA efforts to address health inequities.

OHA and the OHPB Committees will need to continue to develop and implement additional policies, procedures, and practices to support the ambitious goal of eliminating health inequities throughout the state.

Background about Committee Membership Workgroup and this Project

At the September 2020 OHPB meeting, OHA staff presented a proposed roster of new members for a Board Committee for approval. The roster was not approved because the OHPB felt that it did not sufficiently represent the diverse communities that OHA serves. The OHPB asked OHA staff to examine and reconsider its Committee recruitment and diversity efforts.

Accordingly, in December 2020, this Committee Membership Workgroup was chartered¹ to identify and provide recommendations to overcome the structural and procedural barriers that limit the recruitment and retention of diverse committee members. This work has been grounded in alignment with OHA's definition of health equity, the Oregon Public Health Association's (OPHA) definition of diversity, as well as the following principles for policymaking:

- Empowering community leaders to co-create policies that impact their communities;
- Addressing clinical and social conditions, as well as the historical and contemporary injustices, which harm health;
- Respecting diverse cultures, populations, histories, and health practices by being inclusive, accessible, and developing action steps to address barriers to health; and
- Consideration of the diversity of Oregon's communities by ensuring representation on OHA Boards, Councils, and Committees.

¹ See Appendix A for the charter

The OHPB Committee Membership Workgroup was specifically charged with:

1. Informing and developing a process for ensuring diverse and equity-focused Committee membership.
2. Providing guidance on best practices for Committee recruitment and retention.
3. Providing recommendations for systemic changes that will support diverse and equity-focused Committee membership.

This report of findings and recommendations was presented to OHPB at its October 5 meeting.

OHA and OHPB Definition of Health Equity

(Updated April 2021)

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

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

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

Root Cause Analysis and Gap Analysis

- The common perception or statement that “Oregon is not a very diverse state” is more a myth than fact; school enrollment trends show that racial and ethnic diversity will continue to increase
- Oregonians served by OHA, and impacted by OHA policies, especially through the Oregon Health Plan (Medicaid), are racially and ethnically diverse
- Structural racism, exclusion, and discrimination in educational and employment opportunities have resulted in the under-representation of individuals from Tribal communities and communities of color in health professions, including significant under-representation of Blacks, Latinos, and American Indians/Alaska Natives among physicians, nurses, social workers, and dentists licensed to practice in Oregon
- Other structural exclusions have created barriers for individuals with disabilities, individuals who speak languages in addition to English, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals from accessing and utilizing health care, and from opportunities as health professionals
- A significant number of geographic areas throughout Oregon have persistent shortages of primary care, mental health, and dental providers, which exacerbate challenges for diverse representation

- There is a need for Committee members with subject matter expertise about diversity and health equity, including:
 - “Lived experience” based on self-reported racial and ethnic identity, or other identity
 - “Cross-cultural experience” based on living among, working with, or learning about communities and populations different from one’s racial or ethnic identity or other identity
 - This information is not currently requested and tracked for committee members

External Community, Health Care, and Public Health Partner Input

External community, health care, and public health partners shared their experiences of engagement with OHPB Committees and other government advisory groups.

- External community and health care partners are generally aware of, and very supportive of OHA’s prioritization of health equity, and eager to partner with OHA to recruit more diverse OHPB Committee members
- However, community partners (compared to health care partners) were generally less aware of OHPB Committees and their work
- Moreover, community partners noted other priorities and limited organizational capacity to participate on government committees and advisory groups

These external partners made the following recommendations:

- Engage in authentic, ongoing community engagement even before recruitment for OHPB Committees
- Support recruitment of diverse OHPB members with improved information and coordination
- Collect and report comprehensive, disaggregated, and granular demographic data about OHPB Committee members and applicants
- Intentionally support retention of diverse OHPB Committee members
- Consider system changes to support OHPB Committee diversity and work on health equity
- Ensure that OHPB Committee meetings are safe, welcoming, and inclusive
- Ensure that OHPB Committee meetings are accessible
- Implement more inclusive practices for OHPB Committee meetings, including improving public comment and decision-making practices
- Support OHA staff and OHPB Committees with training and other tools

OHPB and OHA Sponsor and OHA Staff Input

- OHA staff are committed to increasing the diversity of OHPB Committee members, and recognize the importance of this work
- Internal staff support standardized data collection about Committee applicants and members, and raised the need for diversity beyond racial and ethnic diversity
- OHA staff generally understand this goal of increasing OHPB member diversity as an individual responsibility, specific to the OHPB Committee they are supporting or working most closely with

- OHA staff are aware that successful recruitment requires ongoing community engagement but need more support for effective community engagement
- Internal interviewees highlighted the need to engage, support, and retain diverse Committee members
- While OHA staff would like to increase accessibility of OHPB Committee meetings, there are questions about support and resources for implementation
- OHA staff had recommendations about improving the public comment process during OHPB Committee meetings
- Some internal interviewees recognize the need for work beyond OHPB Committee member diversity, and are anxious to advance inclusion and equity within Committee policies, procedures, and practices

Findings

- A. Diversity is necessary, but not sufficient, for inclusion and equity
- B. While OHA is committed to many dimensions of diversity, the recognition of structural racism calls for a prioritized focus on racial and ethnic diversity
- C. Current OHPB Committee member recruitment processes are not always coordinated and consistent, nor specifically designed to advance health equity
- D. Current demographic data about OHPB Committee members and applicants are not comprehensive, standardized, or complete
- E. There are significant barriers for partners from diverse, under-represented, and excluded communities and populations to serve on OHPB Committees
- F. There are no systematic supports for retention of OHPB Committee members

Recommendations

- A. All OHPB Committees should **engage** diverse, under-represented, and excluded **communities**
 1. Identify populations and communities most impacted by Committee decisions and policies
 2. Engage and listen to diverse, under-represented, and excluded communities and populations
- B. **Support recruitment and retention** of more diverse OHPB Committee members
 1. Coordinate recruitment across OHPB Committees
 2. Standardize collection and reporting of demographic and sector data about Committee members and applicants
 3. Support retention of diverse Committee members
 4. Recommend changes to authorizing statutes and charters to increase Committee member diversity
- C. **Implement** more **inclusive** OHPB Committee **meeting practices**
 1. Ensure access to all OHPB Committee meetings
 2. Highlight public comments and other community partner input
 3. Practice inclusive decision making
- D. **Implement** OHPB Committee **work on equity**
 1. Provide training to OHA Committee staff and Committee chairs and members about diversity, inclusion, and equity
 2. Identify and use equity tools
 3. Use an equity analysis as part of every decision and policy

Achieving the OHA goal of equity and eliminating health inequities requires transformational change. Increasing the diversity of OHPB Committee members to better reflect the diversity of Oregonians, populations and communities who have been under-represented and excluded, and the lived experiences of Oregonians most impacted by OHA and OHPB policies will not, in and of itself, achieve equity. These findings and recommendations are an additional step in that journey towards that transformational change by OHA and the OHPB Committees.

BACKGROUND ON INCREASING OREGON HEALTH POLICY BOARD COMMITTEE MEMBER DIVERSITY

Oregon Governor Kate Brown recently wrote the following to all state government employees:²

Every state employee has a higher calling to public service, and now is the exact time to reevaluate and reexamine how to serve everyone in the state to the very best of our abilities.

Over the past year, our most vital needs – health, safety, education, housing, and economic security – have been challenged to the core. Because of systemic racism, racial disparities impact every part of our culture and economy, and the effects of our current struggles are more severe for communities of color and Tribal communities. As Oregon continues to recover from the historic year of a global pandemic, worst-in-a-century wildfires, unprecedented ice storms, and racial reckoning across our nation, we must put racial equity at the forefront of all of our recovery efforts and strategies. Racism is insidious, and racist policies and practices have undergirded the nature of our economy. Getting at these deep roots requires specific attention to ensure we are being proactive to embed anti-racism in all that we do and to minimize the negative, disproportionate outcomes experienced by communities of color.

There is a wide spectrum of understanding about what anti-racism really is. We, as state employees, must do the work of unlearning our internal bias and actively changing the way institutions work. That means acknowledging the history, the root cause, learning, growing, and making a concerted effort to upset and uproot racism wherever it exists.

As state employees, counteracting racial injustice is our job.

Background about Committee Membership Workgroup and This Project³

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² State of Oregon Diversity, Equity, and Inclusion Plan: A Roadmap to Racial Equity and Belonging, August 2021, https://www.oregon.gov/das/Docs/DEI_Action_Plan_2021.pdf

³ At the end of April 2021, an independent contractor was contracted as the project lead to provide support to the Workgroup, conduct external community and health care partner interviews, develop root cause and gap analyses, identify resources and references to support this work, and prepare this report of findings and recommendations.

Accordingly, in December 2020, this Committee Membership Workgroup was chartered⁴ to identify and provide recommendations to overcome the structural and procedural barriers that limit the recruitment and retention of diverse committee members. This work has been grounded in alignment with OHA's definition of health equity, the Oregon Public Health Association's (OPHA) definition of diversity, as well as the following principles for policymaking:

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⁴ See Appendix A for charter

In particular, the OHPB and OHA Sponsors called out the following framing for this work in the charter:

Committee Membership Workgroup Charter: Current Reality

OHPB and its committees are important decision-making and advisory bodies that need more member representation in the following areas:

- Expertise in equity, diversity and inclusion;
- Representation from communities experiencing health inequities;
- [Members who] Can contribute the unique knowledge of lived experiences from underrepresented communities; and
- Allies with the willingness to learn and take meaningful action to break down barriers to achieving health equity.

These challenges are perpetuated due to structural and legislative barriers, historic and contemporary inequities and biases, unclear and inaccessible processes, and an inadequate level of dedicated time and resources for committee member recruitment and capacity building with under-voiced communities.

Without more diverse representation in policy development, policies have the potential to exacerbate discrimination. When we design programs and provide services that improve health for people of color, immigrants, refugees, people with limited English proficiency, and LGBTQ+ communities, all age groups and people with disabilities, everyone benefits.

An educational webinar about this project was presented on July 13, 2021,⁵ and draft findings and recommendations were presented to the OHPB at its August 3 meeting.⁶ This report of findings and recommendations responds to the Workgroup charge and was presented to OHPB at its October 5 meeting.⁷

OHA Strategic Goal of Eliminating Health Inequities

The Oregon Health Authority (OHA) has adopted a strategic goal of eliminating health inequities by the year 2030. Moreover, one of OHA's core values is health equity:⁸

We address the clinical and social conditions, as well as the historical and contemporary injustices, which undermine health, so everyone can reach their full

⁵ Presentation slides: https://www.oregon.gov/oha/OHPB/MtgDocs/Committee%20Membership%20Webinar%20Slides_updated.pdf; video recording: <https://www.youtube.com/watch?v=wKyQmzI9ZM4>

⁶ Draft findings and recommendations: <https://www.oregon.gov/oha/OHPB/MtgDocs/2.0%20Draft%20Findings%20and%20Recommendations%20Report.pdf>; presentation slides: <https://www.oregon.gov/oha/OHPB/MtgDocs/2.1%20Committee%20Membership%20Project.pdf>; video recording: <https://www.youtube.com/watch?v=Maxvf03g7Sg>

⁷ Draft final findings and recommendations: <https://www.oregon.gov/oha/OHPB/MtgDocs/5.0%20Committee%20Membership%20Workgroup%20Findings%20and%20Recommendations%20Draft%20Final%20Report.pdf>; presentation slides: <https://www.oregon.gov/oha/OHPB/MtgDocs/5.1%20Committee%20Membership%20Report%20Presentation.pdf>; video recording: <https://www.youtube.com/watch?v=kk1CQbfCJ5w>

⁸ <https://www.oregon.gov/oha/Documents/OHA-Core-Values.pdf>

health potential. We respect diverse cultures, populations, histories, and health practices. We consider the diversity of Oregon’s communities as we make decisions about how policy and practice are developed, and how resources are distributed. We ensure our workforce is diverse and inclusive because a workforce and leadership reflecting all Oregonians is best able to achieve these outcomes.

The draft Oregon Health Authority Equity Advancement Plan for 2021-2023 states:⁹

The Oregon Health Authority (OHA) is a state government agency with a single overarching strategic goal: eliminate health inequities in Oregon by 2030. Hundreds of people throughout the state have helped develop the strategic plan. The plan primarily focuses on communities experiencing health inequities and the health care system that has failed to serve them.... To achieve the strategic plan goal, OHA must become an anti-racist organization....

During the 2021–2023 biennium, OHA will focus on the following equity advancement strategies:

- Continue strategic planning efforts. Anti-racism is a core component of the strategic plan. OHA is facilitating ongoing anti-racism education and practice with its Executive Leadership Team and the “Group of 70” who are informing and developing the strategic plan. A key focus during the 2021–2023 biennium will be to expand anti-racist education and practices more broadly across the agency. It will also be important for OHA to identify and take action on workforce-focused initiatives tied to advancing the strategic plan goal.
- Develop an Equity Action Plan. Informed by the Equity Advancement Leadership Team, other key stakeholders and an agencywide equity-readiness assessment, the agency will develop and implement an Equity Action Plan. The plan will serve as a roadmap for OHA-specific priorities and initiatives to improve workforce equity and inclusion. The Equity Action Plan will align with and operationalize the OHA Strategic Plan. As part of OHA’s Equity Advancement Plan submitted every biennium to the Governor’s Office, the agency will report on priorities and progress from the Equity Action Plan.
- Integrate equity, inclusion, anti-racism and accessibility into existing systems and processes. One critical example of an action the agency can take immediately is to assess external and internal agency policies for equity-related consequences and impacts.

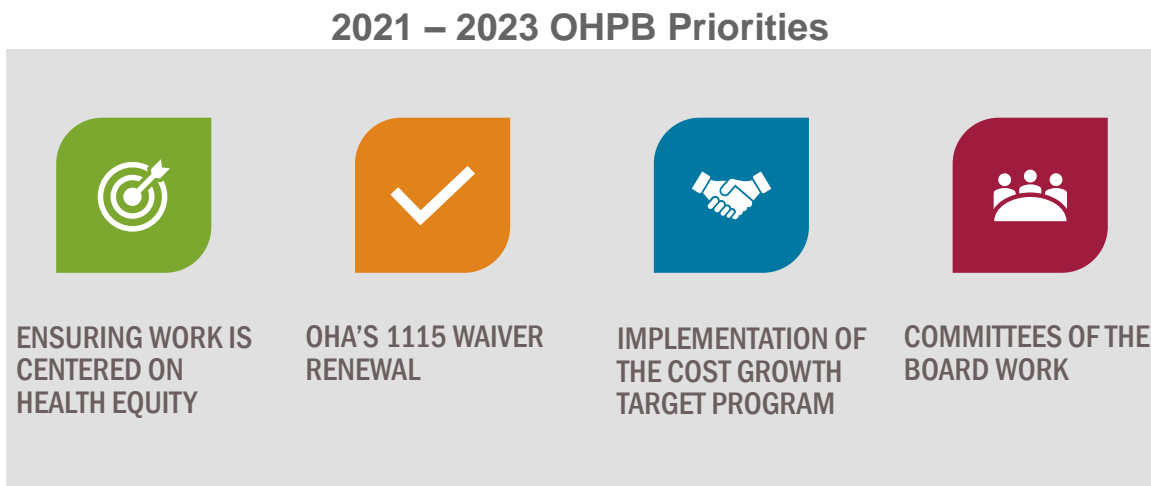
OHA is responsible for many of the state’s major health programs, policies, and purchasing, including the Medicaid program known as the Oregon Health Plan (OHP), the Oregon State Hospital, public health, behavioral health, and the Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB).

⁹ <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9813.pdf>

OHA’s nine divisions each have a vital role in achieving that strategic goal. OHA’s Division of Equity and Inclusion works with diverse communities to eliminate health gaps and promote optimal health in Oregon. Other divisions’ roles contribute to the goal as well. For example, the Health Policy and Analytics Division recently updated its mission statement to “reimagine and transform the health system to achieve health equity”.

OHPB and its Committees

OHA is overseen by the OHPB, a nine-member citizen board that develops and guides implementation of health care policy, and is committed to providing access to quality, affordable health care for all Oregonians and improving population health.¹⁰ The OHPB has significant influence in establishing regulatory guidance, payment policies and incentives, performance measures and accountability, and other policies for Oregon’s health system through its own actions and actions by its Committees. The OHPB has prioritized centering health equity as one of its four strategic priorities:

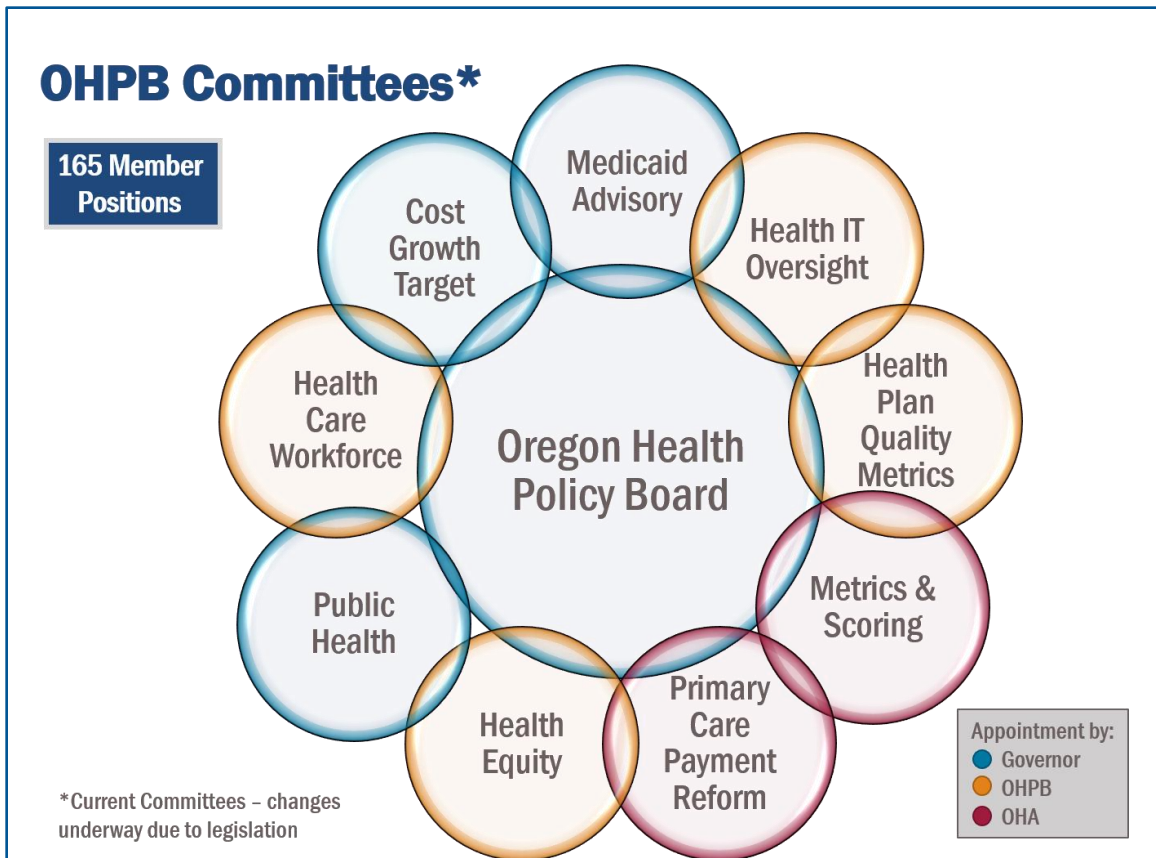


At the beginning of 2021, there were nine Committees of the OHPB with a total of 165 member seats (including the OHPB):¹¹

- Health Care Workforce Committee (HCWF)
- Health Equity Committee (HEC)
- Health Information Technology Oversight Council (HITOC)
- Health Plan Quality Measures Committee (HPQMC)
- Medicaid Advisory Committee (MAC)
- Metrics and Scoring Committee (MSC)
- Primary Care Payment Reform Collaborative (PCPRC)
- Public Health Advisory Board (PHAB)
- Sustainable Health Care Cost Growth Target Implementation Committee (CGT)

¹⁰ <https://www.oregon.gov/oha/OHPB/Pages/index.aspx>

¹¹ New committees will be added as a result of bills enacted in the 2021 legislative session, as well as changes to at least one current committee charter. The Health Insurance Marketplace Advisory Committee will move under the OHPB later this year, there will be a new Behavioral Health Metrics and Incentives Committee, and the Cost Growth Target Committee will be re-established.



The analyses of OHPB Committees in this report are based on these nine Committees. Each OHPB Committee has a liaison from the OHPB, who brings issues and decisions from the Committees to the OHPB, and issues and decisions from the OHPB back to the Committees.

The OHPB and its Committees are staffed and supported by a number of OHA Divisions, including the Health Policy and Analytics Division, Public Health Division, and Division of Equity & Inclusion. Several committees are already engaging in health equity focused work, including:

- Health Equity Framework (HCWF and PCPRC)
- Health Equity Assessment of CCO Metrics (MSC)
- Health Equity Policy & Procedure (PHAB)

OHPB Committees Have Many Requirements for Membership

Some OHPB Committees were established by the Oregon Legislature, others by OHA, and some by OHPB. Each of the Committees has different requirements for Committee membership. For example, the PHAB must have Committee member seats from public health directors from specifically named counties. Some Committees are required to have one or more member seats for coordinated care organizations (CCOs), providers, hospitals, and consumers/Medicaid beneficiaries. Several of the Committees have member seats to be

named by a specific organization such as the Oregon Health Leadership Council, Oregon Educators Benefit Board (OEBB), or Oregon Public Employee Benefit Board (PEBB).

There are six OHPB Committees with statutorily specified “seats” (naming a sector or external partner to be represented): most have a mix of seats that are specified and those that are generally call for subject matter expertise. HPQMC is the exception – it has 15 total seats and each is specifically designated, so there is no opportunity to identify members who have a combination of backgrounds and roles that may fit multiple “hats” (for example, a health provider that works in primary care). See Appendix C for more information about statutory and charter requirements.

Statutorily Designated Membership “Seats” (by category)	Number
Hospitals, Health Systems & Providers	11
Insurers & CCOs	11
State Agencies (some are non-voting)	10
Public Health	9
Consumers	7
Health Care Analysis	5
Advisory Bodies (including OHPB)	1
Federally Recognized Tribes	1
Centers for Medicare & Medicaid Services	1
Other Sectors (Behavioral Health, Members At Large)	8
Total	64

The current OHPB Committees with statutorily specified seats are:

- CGT
- HPQMC
- MAC
- MSC
- PCPRC
- PHAB

The OHPB and three of its nine committees do not have specific designations for seats in statute.¹² Rather the statutory or chartered requirements for these bodies describe a collective expertise required of their membership to accomplish their respective charges. These committees include:

- HCWF
- HEC
- HITOC

¹² The Health Equity Committee was established by the OHPB in 2017 and its charter has not been codified in Oregon Laws or Administrative Rules.

Tribal member participation on committees is managed by OHA's Tribal Affairs Office. OHA considers the Tribes as sovereign nations and accordingly, Oregon maintains a government-to-government relationship with the Tribal governments through the OHA Tribal Consultation policy.¹³

In addition, several of the Committees have requirements for specific expertise and experience about the following issues:

- aging population
- broad range of health professions
- consumer advocacy
- economically disadvantaged populations
- finance
- health care and the operation of a small business
- health care financing
- health outcomes and measures
- health care quality measures
- health care research
- health disparities
- health economics
- health education
- health equity
- health equity in operational settings
- health information technology
- health workforce
- immigrant and refugee populations
- LGBT populations
- linguistically diverse populations
- management of a company that offers health insurance to its employees
- Medicaid
- mental health
- mental health and addiction services
- organized labor
- payment reform
- people with disabilities
- public health
- quality measurement
- racially and ethnically diverse populations
- rural communities
- social determinants of health

¹³ https://www.oregon.gov/oha/documents/Tribal_Consultation_and_UIHP_Confer_Policy.pdf

There are Many Related Boards, Commissions, and Other Policy Bodies Related to Health Care and Public Health and to Diverse Populations and Communities

However, there are an estimated 200 total health care and public health Boards, Commissions, Councils, Committees, Advisory Groups, and Work Groups staffed by OHA (see examples on the following page).

Each of these Boards, Commissions, Councils, Committees, Advisory Groups, and Work Groups have their own membership requirements, and are likely to be recruiting from a similar pool of potential members who are interested and available to serve on a health policy-related Oregon state government Board or Committee.¹⁴

From an external partner or community perspective, serving on an OHPB Committee may not be the highest or most strategic priority in advancing the interests of that partner or community. Just as a more systematic and wholistic approach to OHPB Committee member recruitment is recommended, it also is important to consider how diverse external partners and communities are interacting with multiple OHA and other Oregon Boards and Committees, and what may or may not be priorities for their finite organizational and network capacities.

Boards and Commissions focused on diverse communities and populations (which are not staffed by OHA) but work on priority issues for those diverse communities and populations, including health care and health policy issues:

- Racial Justice Council
- Commission for the Blind
- Commission for Women
- Commission on Asian and Pacific Islanders
- Commission on Black Affairs
- Commission on Hispanic Affairs
- Oregon Council on Developmental Disabilities
- Oregon State Rehabilitation Council
- State Independent Living Council
- Youth Development Council

There are both advantages and disadvantages to having OHPB Committee members who have served on other OHPB, OHA, or Oregon Boards and Committees. While prior Board or Committee experience is invaluable, cycling the same individuals through Boards and Committees also concentrates power and decision-making influence and may perpetuate other inequities. However, a more systematic and wholistic approach to OHPB Committee membership recruitment would make these considerations more transparent.

¹⁴ There are other boards that might be recruiting from the similar pool of potential members such as the Oregon Health Sciences University and the State Accident Insurance Fund.

Committees, Boards, Commissions Convened by OHA's Health Policy & Analytics Division

(not including OHPB or its Committees)

Delivery Systems Innovation

Advisory Committee on Physician Credentialing Information

Health Evidence Review Commission

Mental Health Clinical Advisory Group

Pain Management Commission

Palliative Care Advisory Council

Pharmacy and Therapeutics Committee

Primary Care Payment Reform Collaborative

Quality and Health Outcomes Committee

Health Analytics

All Payer All Claims (APAC) Technical Advisory Group

APAC Payment Arrangement File Workgroup

Metrics Technical Advisory Group

Office of Health Information Technology

Health Information Technology Advisory Group

Public Benefit Plans

Public Employees Benefit Board

Oregon Educators Benefit Board

Health Care and Public Health-related Boards and Commissions Appointed by the Governor

(which are not all staffed by OHA):

Alcohol and Drug Policy Commission

Board of Direct Entry Midwifery

Home Care Commission

Long Term Care Advisory Committee

Medicaid Long Term Care Quality and

Reimbursement Advisory Council

Nurse Staffing Advisory Board

Nursing Home Administrators Board

Oregon Board of Dentistry

Oregon Board of Licensed Professional Counselors and Therapists

Oregon Board of Naturopathic Medicine

Oregon Board of Psychology

Oregon Medical Board

Oregon Patient Safety Commission

Oregon State Board of Nursing

Oregon State Hospital Advisory Board

State Board of Licensed Social Workers

State Board of Pharmacy

Demographic and Sector Data Collection from OHPB Committee Members and Applicants

OHA staff currently collect racial and ethnic and other demographic data about OHPB Committee members and applicants. However, data collected by staff or otherwise furnished by applicants varies. Committees established in statute that require Oregon Senate confirmation complete a comprehensive questionnaire that collects these data; other Committees are not required to ask these questions.

- All Committees collect some information about sector and subject matter expertise but do not necessarily use the same definitions or categories
- While OHA staff have collected the most comprehensive data on OHPB Committee members for race and ethnicity and for geography, data are not uniformly collected
- Moreover, most Committees do not disaggregate Native Hawaiian and Pacific Islander as a distinct category from Asian
- Not all Committees have collected data on language, disability, gender identity, and sexual orientation; no Committees have collected age data
- Only one Committee (the Health Equity Committee) collects data about applicant/members' expertise in equity, diversity, and inclusion, and about lived experience

See Appendix D for data on current OHPB Committee member demographics and preliminary analysis on sector representation. Some key takeaways from this analysis:

- Payers and providers together currently make up over 40% of OHPB Committee members
- Consumer, Tribal and community groups have very low representation when compared to other sectors
- There is a potential disproportionate concentration of influence and power, with several organizations having multiple members on different Committees

ROOT CAUSE ANALYSIS¹⁵ AND GAP ANALYSIS

Racial and Ethnic and Other Demographic Diversity of Oregonians

The most recent U.S. Census data from 2019 show that approximately 30% of Oregonians identify as members of Tribal communities and communities of color (including Hispanics or Latinos of Any Race, and excluding individuals identifying as White or Some Other Race).¹⁶ See Appendix E for details of the data referenced in this section.

If nearly one in three Oregonians identifies as members of Tribal communities and communities of color, then the common perception or statement that “Oregon is not a very diverse state” is more a myth than fact. That racial and ethnic diversity will continue to increase, as demonstrated by data about the race and ethnicity of children enrolled in Oregon public schools in 2020-2021, showing nearly 40% of the students being members of Tribal communities and communities of color.¹⁷

Part of the imperative for increased racial and ethnic diversity among OHPB Committee members is that Oregonians served by OHA, and impacted by OHA policies, especially through the Oregon Health Plan (Medicaid), are racially and ethnically diverse.¹⁸

Oregonians are demographic diverse in other ways. For example, English is not the primary language for over 15 percent of Oregonians aged 5 years and older, or nearly 621,000 Oregonians, who speak languages in addition to English.¹⁹ Of those Oregonians whose primary language is other than English, about 33 percent, or over 204,000 Oregonians, speak English less than “very well”, defined as being “limited English proficient”, and are likely to need language assistance services.²⁰

Nearly 15 percent of Oregonians are individuals with disabilities, or over 614,000 Oregonians.²¹ While 5 percent of Oregonians ages 18 and younger report a disability, nearly 34 percent of Oregonians ages 65 and older report a disability. Other measures of disability

¹⁵ <https://www.solvingdisparities.org/tools/roadmap/diagnosing-the-disparity>

¹⁶ American Community Survey, 1-Year Estimate, 2019 for Race Alone or in Combination, and for Hispanic or Latino Ethnicity, <https://data.census.gov/cedsci/table?q=0400000US41&tid=ACSDP1Y2019.DP05&hidePreview=true&moe=false> [the American Community Survey 1-Year estimate provides the most current data while the 5-year estimate has a larger sample size that will have more stratified and granular data on smaller populations: <https://www.census.gov/programs-surveys/acs/guidance/estimates.html>]

¹⁷ Oregon Department of Education, Fall Student Membership Report <https://www.oregon.gov/ode/reports-and-data/students/Pages/Student-Enrollment-Reports.aspx>

¹⁸ Note that this OHA data report uses “Caucasian” instead of “White” and combines the “Asian” with the “Native Hawaiian and Pacific Islander” categories, which are inconsistent with both federal and Oregon guidelines for race and ethnicity data categories.

¹⁹ This term is used rather than “individuals with limited English proficiency”, which is a term used in civil rights law to prohibit discrimination based on national origin, including primary language.

²⁰ American Community Survey, 2019 One-Year Estimate (Table S1601), <https://data.census.gov/cedsci/table?q=&text=S1601&q=0400000US41&tid=ACSST1Y2019.S1601>

²¹ American Community Survey, 2019 1-Year Estimates (Table DP02), <https://data.census.gov/cedsci/table?text=DP02&q=0400000US41&tid=ACSDP1Y2019.DP02>

report that nearly 26 percent of Oregonians have a disability.²² It should be emphasized that there is a wide range of disabilities, and that the health care and other needs of individuals with disabilities are very diverse, including whether one has multiple disabilities.²³ Whether one was born with a disability, or recently developed a disability also makes a difference in how much that disability has impacted that individual's access to and experience of health care, and to life opportunities. Individuals with intellectual and developmental disabilities experience additional stigma and exclusion.²⁴

In addition, it is estimated that 5.6 percent of Oregonians are lesbian, gay, bisexual, transgender, and queer (LGBTQ+), which is the highest percentage for any of the 50 states.²⁵ An estimated 11 percent of LGBTQ+ individuals in Oregon are uninsured, which is a higher rate than the overall population.

Impact of Structural Racism and Other Structural Inequities in Health Care, including Under-Representation in the Health Professions

Despite the best intentions and efforts of OHA staff, recruitment of OHPB Committee members must be understood in the context of racism, and the current racial and other systemic inequities in health care, and in Oregon's social, economic, and political environments.²⁶

Structural racism, exclusion, and discrimination in educational and employment opportunities have resulted in the under-representation of individuals from Tribal communities and communities of color in the health professions.²⁷ For example, the latest OHA report on the racial and ethnic diversity of Oregon's health professions shows significant under-representation of Blacks, Latinos, and American Indian/Alaska Natives among physicians, nurses, social workers, and dentists licensed to practice in Oregon.²⁸

Individuals who speak primary languages in addition to English also are disadvantaged by the U.S. education system, including a health professions education and training system, that is

²² Behavioral Risk Factor Surveillance System, 2016,

<https://www.oregon.gov/oha/PH/BirthDeathCertificates/Surveys/AdultBehaviorRisk/brfssresults/Documents/2016/disability16.pdf>

²³ Western Oregon University Regional Resource Center on Deafness, Community-Based Needs Assessment of Oregon's Deaf and Hard of Hearing Communities, 2016, <https://wou.edu/rrcd/files/2016/07/DHS-Interagency-Agreement-151333-Final-Report-with-Exec-Summary.pdf>

²⁴ Pelleboer-Gunnink HA, van Oorsouw WMWJ., van Weeghel J, Embregts PJCM. Stigma research in the field of intellectual disabilities: A scoping review on the perspective of care providers. *Intl J Developmental Disabilities*/ 2021;67(3):168–187

²⁵ University of California Los Angeles School of Law Williams Institute, <https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=41#density>

²⁶ Bailey ZD, Krieger N, Agenor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: Evidence and interventions. *Lancet*. 2017;389(10077):1453-1463; Gee GC, Ford CL. Structural racism and health inequities: Old issues, new directions. *Du Bois Rev*. 2011;8(1):115-132; Jee-Lyn Garcia J, Sharif MZ. Black Lives Matter: A commentary on racism and public health. *Am J Public Health*. 2015;105(8):e27-30; the Governor's Diversity, Equity, and Inclusion Plan includes a timeline of some of the history of Oregon and federal policies that have perpetuated racial inequities: State of Oregon Diversity, Equity, and Inclusion Plan: A Roadmap to Racial Equity and Belonging, August 2021, https://www.oregon.gov/das/Docs/DEI_Action_Plan_2021.pdf

²⁷ See history of structural racism and other systemic exclusion in American Medical Association, Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021, <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf> (Appendices 3-9, pages 71-77)

²⁸ <https://www.oregon.gov/oha/HPA/HP-HCW/Documents/2021-Health-Care-Workforce-Needs-Assessment.pdf>; Oregon health professions by occupation and county, 2015, <https://sharedsystems.dhs.oha.state.or.us/DHSForms/Served/le8120.pdf>

conducted entirely in English, and does not recognize nor incentivize health care providers who speak languages in addition to English as an asset. While there is increasing recognition for the need to provide language access to patients who speak other languages, there are still significant systemic gaps in the availability of certified and qualified health care interpreters in all languages and all settings of care. At least for OHP members, OHA has begun to take first steps in measuring and holding CCOs accountable for ensuring language access.²⁹

Individuals who speak primary languages in addition to English are often immigrants or refugees, which also raises complex issues of structural inequities related to one's immigration status. There is a long history of racially exclusionary immigration laws, most notably the 1882 Chinese Exclusion Act, which remains as one of the few racially exclusionary laws that was upheld as constitutional by the U.S. Supreme Court. It has been noted that immigration status should be understood as a social determinant of health,³⁰ and it is notable that immigration status is still the primary barrier to accessing health insurance in Oregon.³¹ From 1996 until just last year, many Oregonians from the Freely Associated States in the Pacific were excluded from Medicaid despite Compact of Free Association (COFA) treaties that ensured continued access to federally-funded health care.³² Moreover, there are many individuals with Deferred Action for Childhood Arrivals (DACA) status who have been able to pursue their dreams of becoming health professionals, but those careers could be cut short if that temporary protection from deportation is eliminated.³³

There are still physical and social barriers for individuals with disabilities,³⁴ including significant barriers to becoming physicians and other health care providers.³⁵ There is still a pervasive lack of attention in health professions education and training, and practice, to the health of individuals with disabilities.³⁶ While Oregon has begun to collect demographic data about OHP members that includes disability,³⁷ current federal standards for demographic data collection in

²⁹ <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/meaningful-language-access.aspx>

³⁰ Castañeda HS, Holes M, Madrigal DS, DeTrinidad Young ME, Beyeler N, Quesada J. Immigration as a social determinant of health. *Ann Rev Public Health*. 2015;36(1):375–392; National Academies of Sciences, Engineering, and Medicine, Immigration as a social determinant of health: Proceedings of a workshop. 2018, <https://www.nationalacademies.org/our-work/immigration-as-a-social-determinant-of-health---a-workshop>

³¹ <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/6.1-Waiver-Concept-Draft.pdf>

³² <https://www.oregon.gov/oha/HSD/OHP/Tools/COFA-Member-Fact-Sheet.pdf>; COFA citizens are from the Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau.

³³ Rojas Martinez D. I'm an emergency medicine physician and a DACA recipient; without immigration reform, thousands of people like me face uncertain times. *Association of American Medical Colleges Insights*, September 14, 2021, <https://www.aamc.org/news-insights/i-m-emergency-medicine-physician-and-daca-recipient-without-immigration-reform-thousands-people-me>

³⁴ U.S. Surgeon General, A Call to Action To Improve the Health and Wellness of Persons with Disabilities, 2005, <http://www.ncbi.nlm.nih.gov/books/NBK44667/pdf/TOC.pdf>; Iezzoni LI. Eliminating health and health care disparities among the growing population of people with disabilities. *Health Affairs*. 2011;30(10):1947-1954

³⁵ Meeks LM, Herzer K, Jain NR. Removing barriers and facilitating access: Increasing the number of physicians with disabilities. *Acad Med*. 2018;93(4):540-543; Meeks LM, Case B, Stergiopoulos E, Evans BK, Petersen KH. Structural barriers to student disability disclosure in US-allopathic medical schools. *J Med Educ Curric Dev*. 2021; doi: 10.1177/23821205211018696

³⁶ Iezzoni LI, Rao SR, Resselam J, Bolcic-Jankovic D, Agaronnick ND, Donelan K, Lagu T, Campbell EG. Physicians' perceptions of people with disability and their health care. *Health Affairs*. 2021;(40(2):297-306

³⁷ <https://www.oregon.gov/oha/OEI/Pages/REALD.aspx>; these REALD standards have also been required for reporting COVID-19 testing, cases, and vaccinations, <https://www.oregon.gov/oha/OEI/Pages/REALD-COVID19.aspx>

electronic health records,³⁸ or for electronic health data information sharing,³⁹ do not include any data about disabilities.

As recently as the 1970s, one's sexual orientation or gender identity was classified as a disease⁴⁰ and there were no protections for discrimination against LGBTQ+ individuals in education, employment, housing, and other aspects of daily life.⁴¹ Sexual activity among same-sex couples was only decriminalized nationally in 2003, marriage equality has only been available nationwide since 2015, and nationwide protections against employment discrimination based on sexual orientation or gender identity were only established last year.⁴² It was only after the enactment of the Affordable Care Act that discrimination in health care based on gender identity was prohibited, but this protection was actively opposed by some health care providers, including litigating against its implementation and persuading the U.S. Department of Health and Human Services (HHS) to amend the policy in 2020;⁴³ the current HHS has restored the original 2016 policy.⁴⁴ Oregon did not implement trans-inclusive and affirming health care for OHP members until 2014.⁴⁵

Meanwhile, threats to physical safety, discrimination, exclusion, and lack of respect by health care providers against LGBTQ+ individuals are still widespread, especially against transgender individuals.⁴⁶ There are still efforts to "change" or "convert" one's sexual orientation or gender identity that are practiced as legitimate medical or mental health therapies.⁴⁷ While there has been significant progress in awareness about LGBTQ+ health,⁴⁸ the progress is uneven. There is still significant under-representation, discrimination, and exclusion against LGBTQ+

³⁸ U.S. Department of Health and Human Services Office of National Coordinator for Health Information Technology, 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications; Final Rule, 80 Fed. Reg. 62602-62759 (October 16, 2015)

<https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25597.pdf>

³⁹ Office of National Coordinator for Health Information Technology, Core Data for Interoperability, <https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v2>

⁴⁰ American Psychological Association, Sexual Orientation and Homosexuality, <https://www.apa.org/topics/lgbtq/orientation>

⁴¹ American Psychological Association, History of Lesbian, Gay, Bisexual, and Transgender Social Movements, <https://www.apa.org/pi/lgbt/resources/history>

⁴² U.S. Equal Employment Opportunity Commission, Protections Against Employment Discrimination Based on Sexual Orientation or Gender Identity, <https://www.eeoc.gov/laws/guidance/protections-against-employment-discrimination-based-sexual-orientation-or-gender>

⁴³ Keith K. HHS strips gender identity, sex stereotyping, language access protections from ACA anti-discrimination rule, Health Affairs Blog, June 13, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200613.671888/full/>

⁴⁴ Keith K. HHS will enforce section 1557 to protect LGBTQ people from discrimination, Health Affairs Blog, May 11, 2021, <https://www.healthaffairs.org/doi/10.1377/hblog20210511.619811/full/>

⁴⁵ <https://www.oregon.gov/oha/HPA/DSI-HERC/FactSheets/Gender-dysphoria.pdf>

⁴⁶ Human Rights Watch, Anti-LGBT Discrimination in US Health Care, 2018;, <https://www.hrw.org/report/2018/07/23/you-dont-want-second-best/anti-lgbt-discrimination-us-health-care#>; National Center for Transgender Equality, U.S. Transgender Survey, 2016, <https://transequality.org/issues/us-trans-survey>; Lambda Legal, When Health Care Isn't Caring: Survey on Discrimination Against LGBT People and People Living with HIV, 2010, <https://www.lambdalegal.org/publications/when-health-care-isnt-caring>

⁴⁷ American Medical Association, Conversion Therapy Issue Brief, <https://www.ama-assn.org/system/files/2019-12/conversion-therapy-issue-brief.pdf>

⁴⁸ American Medical Association, Advocating for the LGBTQ Community, <https://www.ama-assn.org/delivering-care/population-care/advocating-lgbtq-community>

physicians and health care providers.⁴⁹ The only hospitals and clinics in Oregon who participated in the 2020 Human Rights Campaign Healthcare Equality Index are from either the Portland metro area or Central Oregon,⁵⁰ so that outside these areas, LGBTQ+ Oregonians may not be assured of receiving inclusive and affirming care.

Only in this most recent 2021 legislative session has the Oregon Legislature established requirements for OHA and the Oregon Department of Human Services to collect and analyze demographic data about sexual orientation and gender identity.⁵¹

Finally, the federal Health Resources and Services Administration (HRSA) reports that a significant number of geographic areas throughout Oregon have persistent shortages of primary care, mental health, and dental providers, exacerbating challenges for representation of providers from those geographic areas.⁵² See Appendix E for the most recent maps showing these shortages.

Root Causes for Lack of Racial and Ethnic Diversity and Other Diversity among OHPB Committee Members

In summary, it is not surprising that the current racial and ethnic and other demographic composition of OHPB Committee membership has significant gaps among groups that have faced barriers because of “systemic racism, oppression, discrimination and bias”, including “Black, Indigenous, people of color, and American Indian/Alaska Native people (BIPOC-AI/NA), people with low incomes, people who identify as lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+), people with disabilities, and people living in rural areas of the state.”⁵³ The OHPB Committee Membership Workgroup charter recognizes: “These challenges are perpetuated due to structural and legislative barriers, historic and contemporary inequities and biases, unclear and inaccessible processes, and an inadequate level of dedicated time and resources for committee member recruitment and capacity building with under-voiced communities.”

There are additional root causes for the continued lack of representation from other diverse populations and communities on OHPB Committees, including the systematic inequities, discrimination, and exclusion experienced by individuals who speak languages in addition to English, individuals with disabilities, and LGBTQ+ individuals. The lack of legal protections against discrimination, physical and social barriers for individuals with disabilities, and stigma and social exclusion around issues of language access, immigration, disability, sexual orientation, and gender identity compound these historical and contemporary inequities.

⁴⁹ Samuels EA, Boatright DH, Wong AH, Cramer LD, Desai MM, Solotke MT, Latimore D, Gross CP. *Association between sexual orientation, mistreatment, and burnout among US medical students.* JAMA Netw Open. 2021;4(2):e2036136; Eliason MJ, Dibble SL, Robertson PA. *Lesbian, gay, bisexual, and transgender (LGBT) physicians' experiences in the workplace.* J Homosex. 2011;58(10):1355-1371

⁵⁰ Human Rights Campaign, *Healthcare Equality Index, 2020*, <https://www.hrc.org/resources/healthcare-equality-index>

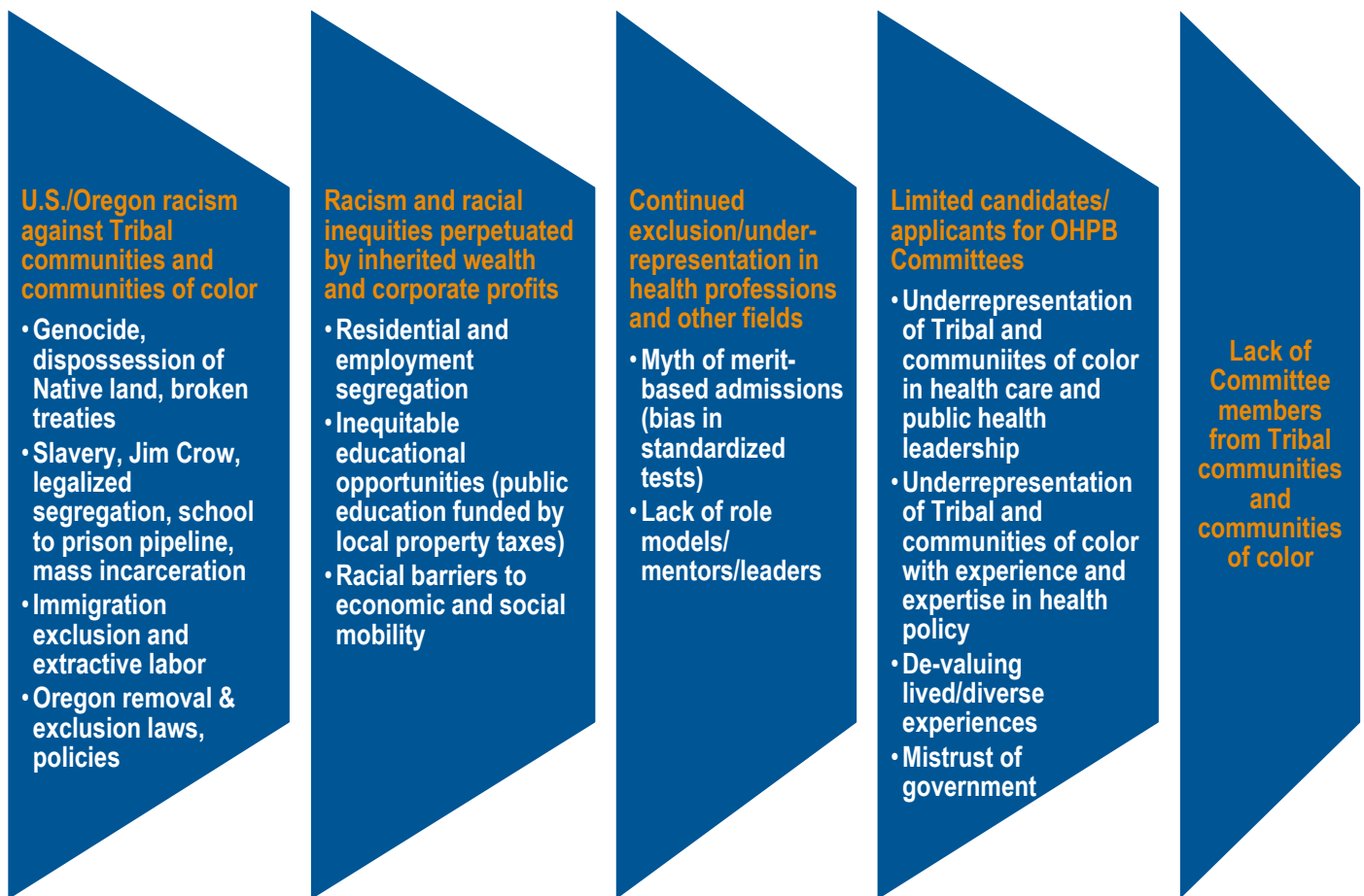
⁵¹ Oregon House Bill 3159 (2021)

⁵² <https://www.oregon.gov/oha/HPA/HP-PCO/Pages/Maps.aspx>

⁵³ *Healthier Together Oregon: 2020-2024 State Health Improvement Plan, 2020*, <https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/2020-2024/Healthier-Together-Oregon-full-plan.pdf>

Ongoing efforts by health care providers to “change” or “convert” one’s sexual orientation or gender identity is just one indication of how the health care system and health care providers can continue to perpetuate these inequities, and actually do harm.

Moreover, many Oregonians have multiple and intersecting identities and so these inequities are compounded and cumulative for many individuals who self-identify as both members of Tribal communities and communities of color, and as a person with a disability, or who speaks a primary language in addition to English, and/or identifies as an individual with a diverse sexual or gender identity.



Some have noted and cautioned that just focusing on numerical diversity can result in tokenism and have the additional unintended consequence of perpetuating a false narrative about diversity that does not address the root causes and systemic barriers to the lack of diversity. OHA staff and OHPB Committees have a responsibility to educate themselves about these root causes and systemic barriers, in order to understand and overcome the barriers to increased engagement and participation from individuals and communities that have experienced these inequities, discrimination, and exclusion.

Accordingly, achieving an increase in the racial and ethnic and other diversity of OHPB Committee membership will not result from increasing one-time, short-term, transactional recruitment, selection, and retention activities that focus on a small percentage of overall Committee membership. OHPB Committees and OHA staff will continue to struggle to find applicants for specific Committee member vacancies and will be at risk of missing the “forest for the trees” if focused solely on numerical diversity.

It is unrealistic to expect that each Committee lead staff will have the knowledge and working relationships with the broad universe of diverse community, health care, and public health partners who can assist in recruitment activities. For example, while many Committee staff have had some interactions and working relationships with the OHA-supported Regional Health Equity Coalitions (RHECs), not all staff have working relationships with all the RHECs.

The OHPB Committee Membership Workgroup charter recognized that Committee member diversity is only one step in a broader strategy that advances health equity: “Without more diverse representation in policy development, policies have the potential to exacerbate discrimination. When we design programs and provide services that improve health for people of color, immigrants, refugees, people with limited English proficiency, and LGBTQ+ communities, all age groups and people with disabilities, everyone benefits.”

The project has gathered feedback and recommendations from community, health care, and public health partners, as well as from OHPB and OHA sponsors and OHA staff about how to increase OHPB Committee member diversity, and to begin to implement other strategies to increase inclusion of communities who have been under-represented, discriminated against, and excluded from health care systems and health policymaking in OHPB Committee meetings. Finally, resources and recommendations for supporting OHPB Committee work on more explicitly advancing equity are included.

Recognizing Lived Experiences and Cross-Cultural Experiences as Subject Matter Expertise

There is an important distinction between any individual’s self-reported identity (across multiple dimensions of diversity) and whether that individual can “represent” a diverse population or community. While one’s identity provides “lived experience” about a population or community, it should not be automatically assumed that the individual should or can “represent” that population or community. While one may self-report a particular identity, one may not have much experience living or working in that community or with that population to be able to share about the needs, strengths, priorities, and aspirations of that community or population.⁵⁴

⁵⁴ This is also an issue of accountability; OHPB Committee members that are employed by a health care or public health organization and using paid time to serve on the Committee are more likely to represent their employer/sector first and foremost, rather than the community or population of their racial and ethnic identity. In other words, an Asian American physician from a large hospital and health system that serves on an OHPB Committee using paid time is more likely to participate from a perspective of a physician, or of the hospital that she works at, rather than as a “representative” of the Asian American community in Oregon. On the other hand, that Asian American physician could be active in the Asian American community through her volunteer work on the board of an Asian American community-based organization, or with a faith-based organization in the Asian American community and would be able to share perspectives informed by those lived experiences.

On the other hand, individuals may have experiences in and/or working with diverse populations and communities (other than their self-reported identity) that enable them to be informed and knowledgeable about those populations and communities, i.e., to be subject matter experts. Such experiences could be as a family member, caregiver, work experience, volunteer experience, learning and regularly speaking a language other than English, or living in a racially and ethnically diverse neighborhood or in a country other than the United States. This report will use the term “lived experience” to refer to one’s life experience based on self-reported identity, and “cross-cultural experience” to refer to one’s experience with populations and communities different than their self-reported identity – but both as subject matter expertise.

In other words, simply collecting and using self-reported demographic information about OHPB Committee members and applicants is an incomplete, and even potentially misleading, way to understand diversity. Additional questions about both one’s lived experiences based on self-reported identity and one’s cross-cultural experiences are needed to understand whether a Committee member brings diverse perspectives and voices, and subject matter expertise, to the Committee. Such questions are not currently asked and would need to be standardized across all OHPB Committees.

Understanding lived experiences and cross-cultural experiences is much more qualitative and nuanced and cannot be easily reduced to a “check-box” or any simplistic categorization. If this work authentically honors the value that members from diverse identities, backgrounds, and experiences bring to OHPB Committees, then there needs to be a willingness to think and act differently about what “subject matter expertise” is important to the work of the Committees, and how such expertise is essential to achieving the OHA and OHPB goals of achieving health equity.

Finally, some note a tension between racial and ethnic and other demographic diversity and needing what has been called “technical expertise” to effectively serve on an OHPB Committee. Health policy work can be very technical and complex, requiring understanding of federal and state policies, laws, health care delivery and payment systems, and other subject matter expertise. Some OHPB Committees are focused on specific issues of health care quality measurement, health information technology, and health care workforce that also are considered more specialized knowledge and expertise. Some individuals have subject matter expertise on more than one subject.

The perspectives of consumers, who are most impacted by the policies being considered by OHPB, is often not fully considered or given sufficient weight in developing and adopting those policies. However, as OHA and the OHPB continue to prioritize health equity, lived and cross-cultural experiences about health equity generally, and racial equity specifically, should be considered subject matter expertise that are essential for every OHPB Committee. In other words, it may become as important, or even more important, for OHPB Committees to have Committee members with subject matter expertise - lived and cross-cultural experiences about diverse populations and communities - as having subject matter expertise about quality measurement, health information technology, or health care workforce issues.

EXTERNAL COMMUNITY AND HEALTH CARE PARTNER INPUT

During late May to mid-July, twenty external community, health care, and public health partners were interviewed about their experiences with OHPB Committees and their perspectives and recommendations about how best to increase the racial and ethnic diversity of those Committees. During late August to mid-September, an additional eight community, health care, and public health partners were interviewed to obtain additional community-based perspectives about how OHPB Committees might address other elements of diversity (language, disability, sexual orientation and gender identity, age, etc.) See Appendix B for the list of external community, health care, and public health partners interviewed. (As shorthand, “health care partners” will include both health care and public health partners in the remainder of this report.)

External community and health care partners were identified by both the project consultant and by the Committee Membership Workgroup members, OHA and OHPB sponsors, and OHPB Committee lead staff. The most recent quarterly update about the work of the nine OHPB Committees was shared with the external partner prior to the interviews.⁵⁵ All interviews with external partners were conducted by videoconference or phone by the project consultant using open-ended questions. Interviews were adapted based on the external partner experience with OHPB Committees. For example, if an external partner did not have specific experience with OHPB Committees, questions about diversity and inclusion on any boards or community advisory groups were asked. To encourage more direct and honest responses, external partners were advised that their responses and statements would not be directly attributed to any individual.

The general themes and recommendations from these external community and health care partner interviews are summarized below.

External community and health care partners are generally aware of, and very supportive of OHA’s prioritization of health equity, and eager to partner with OHA to recruit more diverse OHPB Committee members

- Universally, external partners were aware, and very supportive, of OHA’s prioritization of health equity
- None were surprised about OHA’s effort to increase the diversity of the OHPB Committees
- At least two health care partners noted that diversity was more of a priority and of interest among their younger, more diverse members so there was also an internal business case to prioritize diversity as an issue for its future members and leaders, to help the organization grow [and remain relevant]

⁵⁵https://www.oregon.gov/oha/OHPB/MtgDocs/1.1%20Committee%20Digest_2021.Q1_updated.pdf and https://www.oregon.gov/oha/OHPB/MtgDocs/1.1%20Committee%20Digest_2021.Q2.pdf

- A few health care partners voiced concerns about the appropriate balance between increasing diversity and continuing to identify individuals with the specific expertise and experience to serve on OHPB Committees, especially the more content-specific Committees such as HPQMC and HITOC
- Several partners affirmed a first prioritization of racial and ethnic diversity and one suggested that OHA not try to “boil the ocean” and address all the dimensions of diversity at once
- Several health care partners noted that OHA needed to ask more explicitly for their assistance in recruiting diverse OHPB members, especially asking organizational leaders to identify rising and emerging diverse leaders within their organizations, systems, and networks
- A number of health care partners shared about their efforts to address diversity, inclusion, and equity within their own organizations, including increasing the diversity of participants in their own leadership development programs, who are ideal candidates for OHPB Committee member recruitment
- One health care partner noted that if OHA continues to ask about diversity, it results in external organizations thinking about diversity more, “which makes us a better organization” as well
- One health care partner suggested more personal touches to support recruitment, such as a letter from the Governor asking for specific assistance in recruiting more diverse Committee members to help reach her priority goals related to health equity
- One external partner noted that “if it was easy to diversify, we would have done it, but it’s NOT easy”

However, community partners (compared to health care partners) were generally less aware of OHPB Committees and their work

- Many community partners were not familiar with the OHPB Committees; and several community partners noted that this was the first contact they had with any OHA staff or consultant about the work of the Committees
- Several external partners representing diverse populations or communities, or who themselves are members of Tribal communities and communities of color, reported that, except for ongoing working relationships with the Division of Equity & Inclusion, they had never been contacted about collaborating on OHA work
- Several community partners referenced increased contact and engagement with OHA during COVID-19, including more regular communication, and funding to their community-based organization for community outreach, education, and engagement
- When asked about participation in any health policy-related boards or committees, several community partners referred to their participation on their local/regional Coordinated Care Organization (CCO) Community Advisory Council (CAC); these community partners generally reported inclusive experiences when participating on these CCO CACs
- Many community partners working with Tribal communities and communities of color and other diverse communities were appreciative of being consulted about this issue of OHPB Committee member diversity but asked how the information and perspectives they shared would be used, and whether it would result in any specific actions or changes

Moreover, community partners noted other priorities and limited organizational capacity to participate on government committees and advisory groups

- One community partner noted that OHPB Committees may not be the only, or even the highest priority, for recruiting members from their organization, association, or constituency
- One community partner stated, “whenever some asks me about serving on another committee or advisory group, I run the other direction” [because I already have too much work and serve on too many committees]; another community partner shared that she already is on three volunteer boards and can’t join others, and that it is not always clear what the benefit to her or her community would be from joining another board or committee; one community partner noted is already serving on seven advisory committees, in addition to having two jobs; another community partner noted that many Tribal communities and communities of color-based organizations are “tapped out”
- One community partner responded that it would be difficult to find community members or community representatives to sit on every OHPB or OHA Committee; there might be some Committees such as the Health Equity Committee or Medicaid Advisory Committee that might be of more interest to community members
- Another community partner working with Tribal communities and communities of color wondered whether it was a current priority to work with these governmental processes when there is so much community-level work happening making economic, social, political changes
- Several community partners suggested that OHA could be doing more to financially and directly support community-based organizations (CBOs) working in Tribal communities and communities of color, and immigrant and refugee, and LGBTQ communities, noting the dramatic increase in direct contracts with these culturally specific CBOs for COVID-19 related work; at least one community partner noted that this recent OHA funding has enabled their organization to think more about the future, about how to be more engaged with OHA
- Several community partners discussed the need for financial support for capacity-building and leadership development to increase their capacity to be engaged with OHA and with policy work; however, at least one community partner expressed concern that this might create expectations for there to be compensation for all volunteer boards and committees, which many non-profit community-based organizations would not be able to provide
- Several community partners noted that the Regional Health Equity Coalitions (RHECs) already are supported by OHA but now receive constant requests for engagement that they don’t have the capacity to respond to without additional financial, staffing, and other support⁵⁶

⁵⁶ Senate Bill 70 (2021) will expand OHA support for the RHECs

- Several community partners noted the importance of working with the OHA Office of Tribal Affairs and Tribal councils in seeking any representation from Oregon’s nine federally recognized tribes and communities; these partners also emphasized that unless an individual is designated by the Tribe/Tribal council, they are not authorized to “represent” the Tribe or Tribal communities, and that one Tribal representative may not “represent” all nine tribes and all Tribal communities; finally, community partners noted the many American Indians/ Alaska Natives residing in Oregon who are not members of the nine federally Tribes in Oregon - or other federally recognized Tribes - who generally don’t have any representation in these state government policy advisory groups
- Community partners also noted that the OHA Office of Tribal Affairs and other OHA offices are charged with sharing information with the nine tribes and with many key partners; these are important bi-directional communications channels for the OHPB Committees
- LGBTQ+ community partners referred to existing forums where LGBTQ+ communities and their allies already come together, including a monthly LGBTQ+ roundtable convened by the Q Center and a statewide Oregon Transgender Healthcare Coalition (that worked with OHA to implement trans-inclusive health care policies for OHP members in 2015); these are forums where OHA could go to learn about LGBTQ+ community priorities
- A community partner working with immigrants and refugees referred to the informal networks in every immigrant and refugee community, whether a church or faith-based organization; or the homes where families gather for birthdays, weddings, funerals; or social media networks on WhatsApp [and WeChat and other apps]; this partner wondered whether OHA had compiled basic demographic profiles of these communities as a first step in recognizing and understanding them
- At least one community partner noted the difference between staff of community-based organizations who serve and work with diverse communities and populations representing those communities and populations on these Committees, and inviting directly impacted community members to serve on these Committees
- A community-based partner noted that in communities of color, when impact and real change happens, that success will be shared with others in the community, which will engage others to get involved as well

Overcoming challenges to diversity from rural areas

- Almost all interviewees noted the additional challenges of identifying potential diverse Committee members from rural areas; one person called geographic diversity the “low hanging fruit” when discussing diversity
- Several interviewees noted that racial and ethnic diversity does exist in rural areas, especially noting Native Americans in rural areas and the fast population growth among the Latinx community, but that such recruitment often require extra steps that take more time
- One LGBTQ+ community-based partner commented that with virtual meetings during COVID-19, they had been able to strengthen and build more working relationships with community members in rural areas

- Many interviewees highlighted the multiple challenges of recruitment from and participation by individuals in general from rural areas, including need for support from employers to pay for the time spent on Committee work, including the travel time; and understanding that consistent and reliable broadband is not always available for videoconferencing; and that some cannot afford the technology
- One person noted that travel and other support needed to be planned for and included in Committee budgets

Community and health care partners also made specific recommendations about OHPB Committee membership and meetings that are the basis for the recommendations included in this report.

External Partner Recommendation Themes:

- Engage in authentic, ongoing community engagement even before recruitment for OHPB Committees
- Support recruitment of diverse OHPB members with improved information and coordination
- Collect and report comprehensive, disaggregated, and granular demographic data about OHPB Committee members and applicants
- Intentionally support retention of diverse OHPB Committee members
- Consider system changes to support OHPB Committee diversity and work on health equity
- Ensure that OHPB Committee meetings are safe, welcoming, and inclusive
- Ensure that OHPB Committee meetings are accessible
- Implement more inclusive practices for OHPB Committee meetings, including improving public comment and decision-making practices
- Support OHA staff and OHPB Committees with training and other tools

Engage in authentic, ongoing community engagement even before recruitment for OHPB Committees

- Several community partners suggested processes for diverse communities to share *their* priorities and issues with OHA and OHPB Committees rather than the Committees setting the agenda and seeking feedback on what has already been prioritized
- A community partner noted that if OHA and its Committees want to engage the community, then OHA and its Committees have to go out to where communities are, not expect community members to come to Portland to attend a Committee meeting; another partner noted that OHA staff need training and preparation how to listen and respond appropriately in these community settings, which may make them uncomfortable and defensive
- One partner noted that there are many ways to obtain feedback and input from diverse groups in addition to diverse Committee members, and noted the more inclusive processes used by OHA to develop the state health improvement plan and some of the shortcomings in the recent community engagement activities related to the Medicaid Section 1115 waiver

- One community partner noted that town halls and community conversations are effective ways to get input and feedback on specific issues that OHPB Committees are working on, e.g., cultural competency training for the health workforce, or quality measures
- One community partner noted that many only have one to three contacts with diverse communities and feel that they have engaged those communities; this community partner strongly encouraged going deeper within each diverse community and having a continuous curiosity to learn proactively who is doing work in each community

Support recruitment of diverse OHPB members with improved information and coordination

- One health care partner noted, “there are a LOT of committees” related to health care and health
- More than one partner asked whether there was an accessible, user-friendly description of all the OHPB and other OHA Committees
- Several community partners noted that it would be helpful in recruitment to have clear understandings of the obligations and responsibilities of prospective Committee members, e.g., how many meetings, how many hours of work to review materials and prepare for meetings, etc.
- One health care partner noted that any orientation, training, or other support that OHA staff could provide about the work of the Committees would be invaluable in explaining the work of the Committees when recruiting for diverse members
- At least one community partner commented that even the quarterly Committee update was “intimidating” and would be difficult to understand for many community partners, especially OHP members and consumers
- One community partner who currently serves on an OHA committee shared the challenges in recruiting a successor to represent that community, noting that many Committee staff do not have lists of contacts or community members to recruit from
- Numerous health care partners reported that the most common way to find out about a Committee member vacancy or recruitment was through a mass e-mail
- One health care partner noted that if the process is mainly person to person, each person has insular networks, and the result will be mainly White nominees/ applicants
- One health care partner specifically requested a continuously updated spreadsheet with all the upcoming Committee member vacancies clearly listed
- At least two health care partners described their own organizational efforts to track upcoming Committee member vacancies to plan their recruitment activities
- One health care partner suggested that there are multiple other channels for notices about Committee member vacancies, including the weekly Friday provider newsletter, COVID-19 updates, and social media
- Several health care partners reported receiving specific requests from OHA Committee lead staff for recommendations for vacant Committee member seats, but often at the last minute, as short as a week before decisions about the Committee member seat were to be made

- One health care partner called the recruitment process “hunting and pecking” by OHA staff, noting that it was unrealistic to expect that individual OHA staff had access to the breadth and depth of external organization networks
- One health care partner suggesting more coordination with the Governor’s office, which receives many more applicants for the Governor’s appointments to Boards and Commissions, as well as recruitment for Committees for related departments

Collect and report comprehensive, disaggregated, and granular demographic data about OHPB Committee members and applicants

- Community partners were supportive of collecting and reporting demographic data about Committee applicants and members, and were supportive of using the same demographic questions and categories used for OHP members and other health care consumers
- Community partners wanted disaggregated and granular data about race, ethnicity, disability, sexual orientation, and gender identity; several noted that without disaggregation, smaller populations and communities will be overlooked; for example the needs of individuals who are deaf-blind are often overlooked if not specifically identified among those who are deaf and hard of hearing; similarly, the needs of transgender, queer/questioning, intersex, asexual, and two-spirited individuals are often overlooked among the LGBTQ+ community⁵⁷
- Community partners working with disability communities and LGBTQ+ communities noted the broad diversity within those communities
- One community partner felt that open-ended questions worked best and noted that if specific populations are not named, they are made invisible
- One LGBTQ+ community partner noted that there had been an OHA Committee that included community partners that developed questions to ask about sexual orientation and gender identity
- Several partners recommended that there should be an explanation of collecting and reporting such demographic data was important, and one specifically recommended that there should be an option to decline to answer
- Several community-based partners also emphasized the importance of lived experiences and the need to ask specific questions about lived experiences with diverse communities and populations

Intentionally support retention of diverse OHPB Committee members

- At least one partner working with communities of color noted that the processes of OHPB Committees are very White and based on dominant culture, with strong power dynamics; one community partner noted that even the vocabulary and process of “on-boarding” can be experienced as assimilation into a dominant culture, where Committee norms and processes are already in place

⁵⁷ Portland Art Museum, Powerful Self: LGBTQIA2S+ Lives Today, <https://portlandartmuseum.org/learn/programs-tours/object-stories/powerful-self-lgbtqia2s-lives-today/>

- Several partners cautioned that since racial micro-aggressions and macro-aggressions are still part of the organizational cultures of OHA and OHPB Committees, it makes the work on diversity even more challenging; it feels tokenizing
- One community partner noted that it is part of White supremacy culture to prioritize urgency, efficiency, and completion of tasks; diversity and inclusion prioritizes human connections and relationship-building
- Several partners expressed concerns about tokenizing or being tokenized as the single “diverse” member, the only member from communities of color, or the only trans member and that the goal should be to increase diversity beyond having just one member represent diverse communities and populations; one community partner observed that when a collective voice is lifted up, it is more powerful
- One community partner highlighted on the importance of board and committee members getting to know each other as individuals, to know who is in the space together
- A number of community partners suggested Committee meeting processes and agreements that could create more inclusive meetings, including check-ins and ice-breakers so that Committee members get to know each other as persons and are more trauma-informed, including acknowledging the ongoing historical, community, family, and individual trauma, challenges, and resilience members bring to the Committee
- One community partner said that diversity is more than inviting people to seats at the proverbial table but that one has to make sure everyone has the tools – the place settings, the utensils, etc. to participate; and that sometimes the table [and menu] have to be re-set or modified to be inclusive of everyone
- Other community partners recommended Committee processes where those who tend to speak a lot or dominate the discussion “step back”; proactively inviting/facilitating those who tend to speak less or later to “step up”, such as going around and inviting those who haven’t spoken to either speak or to affirmatively pass from speaking; using tools like a single passed microphone or talking stick so that only one person is speaking at a time and everyone pays attention to that speaker; using anonymous and group feedback tools such as jam boards, virtual chalkboards, etc. so that everyone has the opportunity to participate when there isn’t enough time to everyone to take turns speaking; ensuring that everyone is respectful of the limited time available; no one speaking too long; allowing flexibility in the agenda so that those who want to speak to certain items can do so earlier in the agenda; rotating chairs/discussion facilitators to allow for different meeting facilitation styles
- One community partner emphasized that it was *not* the responsibility of individuals from diverse backgrounds to educate other Committee members about diversity and equity, but it was everyone’s responsibility to become educated about these issues, and to understand their privilege
- One community partner highlighted the strengths and resilience that community members bring, if what is unique about them is celebrated
- Several community partners observed that calling out the dynamics of power and privilege often makes Committee members who are White uncomfortable and defensive; and that more needs to be done by Committees to make these opportunities for learning and growth rather than focused on maintaining the comfort of the Committee members who are White

- At least one community partner questioned whether there was any common understanding whether individuals were representing themselves or their employers when serving on Committees, and whether there was any expectation or support for Committee members to seek feedback and input about Committee business from other organizations and constituents if that member was supposed to be representing a particular sector, profession, etc.
- One health care partner proactively convened other constituents to provide feedback and input for the individual from their organization serving on the Committee to bring to the Committee
- Several health care partners shared how they continued to provide support to individuals that they had recommended and supported for Committee membership by checking in with them, answering their questions

Consider system changes to support OHPB Committee diversity and work on health equity

- Several partners questioned the degree of OHA’s commitment to made systems changes that would support increased OHPB Committee diversity, and were pleasantly surprised to learn that potential changes to Committee charters and authorizing statutes would be considered
- Several internal interviewees noted power dynamics within Committees based on profession, privilege, and wealth
- One partner asked whether there were term limits for all the Committees and noted that some had been serving for a long time, and might not be the best champions for health equity

Ensure that OHPB Committee meetings are safe, welcoming, and inclusive

- Several community partners highlighted the importance of acknowledging the past, the history of governmental inequities, discrimination, and exclusion, as OHA reaches out to engage communities that have experienced inequities
- One community partner noted that when communications with diverse communities are done poorly or inadequately, it creates more distrust and harm; it’s often not about “re-building trust” when there has never been trust established
- One community partner noted that trust has to be earned, and the first step in building relationships is being open to listening to the stories and experiences of others
- One community partner asked whether the OHPB Committees would be comfortable spaces for diverse community members
- One community partner pointedly noted that board and committee members from diverse backgrounds need to feel protected and valued
- One partner noted that racial or ethnic groups who are not used to participating “will remain hidden and won’t be on the radar screen” of OHA
- LGBTQ+ community partners emphasized the need for “psychological safety” for LGBTQ+ community members to show up at a government meeting

- Similarly, a health care partner that works with youth emphasized that if youth are to be involved, then there must be “safe space” for youth to participate, rather than being put down or ignored for not having “adult skills”; another community partner observed that many youth are eager to learn about public health and community service, and how to improve their communities
- A community partner who works with immigrants and refugees noted that many community members are from countries where there were many reasons to distrust colonial and failed governments; a first necessary step to building trust is to explain what OHA has done for immigrants and refugees and for their communities, and how OHA will listen to them
- One community partner suggested land acknowledgments, developed with local Tribal and indigenous communities, as a way of recognizing historic and contemporary inequities
- At least one community partner emphasized that these Committee processes create harm [and perpetuate trauma, exclusion, and discrimination] for those already marginalized when there isn’t respect or inclusion, or when issues are raised but there is only “circular dialogue” and lots of “yes, but…” responses; another community partner commented that when individuals from diverse communities share their experiences and perspectives, it just gets “lost in the void” without any follow-up, and then they are asked to repeat that sharing; another community partner experienced these types of processes as frustration, anger, and sadness

Ensure that OHPB Committee meetings are accessible

- One community partner said simply, “people have jobs; if you want them to attend your meeting, it has to be in the evening or on weekends”
- Several partners representing Tribal communities and communities of color emphasized the need for stipends, reimbursement of travel and transportation expenses, food, and childcare to support participation of individuals who are not paid to attend OHPB meetings
- One community partner recommended that every meeting begin with the question of whether any participants had any access needs
- Several community partners commented that most government meetings are not accessible in other languages, noting how unusual it was to see ASL interpretation during OHA press conferences about COVID-19, but that there was no Spanish or other language interpretation; community-based partners also highlighted the need for interpretation and translations in languages in addition to Spanish
- A community partner noted that while there are many languages and dialects spoken by Oregonians, it is a finite number, and makes a significant difference to each community when information is translated, or interpretation is provided in their language or dialect
- One community partner shared about the capacity to get testimony from community members, including providing interpretation for languages other than English, but noted that there are many layers of information to understand, and that ongoing communication and collaboration between OHA and community partners is what is needed

- A community partner who works with individuals with disabilities highlighted the barriers to accessing and using assistive technologies, including lack of affordability and lack of available and reliable broadband service
- Several community partners highlighted the importance of access for individuals with disabilities as a matter of disability justice
- One community partner noted that captioning, ASL interpretation, and Spanish interpretation should be available at every public meeting because it should not be the obligation of those with access needs to repeatedly request access; one should be able to just show up and engage
- One community partner who works with individuals with disabilities and with seniors noted that it is important for such individuals to have support in accessing and using technology, and other personalized support to participate in meetings
- Similarly, one health care partner who works with youth noted the importance of being available to answer questions, and to provide additional background and information to youth participating in youth advisory councils and similar committees
- Many community and health care partners were supportive of more virtual meetings in the future, or at least some combination of in-person and virtual meetings; it was noted that having a speakerphone with audio challenges is very different than a well-facilitated, participatory videoconference
- One community partner noted how slow OHA was to transition from Microsoft Teams to use Zoom as a videoconference platform when Zoom was more accessible to more community members and the use of Teams created barriers to participation; another community partner noted that “Zoom is the best technology for our community”
- One community partner noted that technology such as Zoom, with captioning and spotlighting, can help individuals who are deaf and hard of hearing participate in videoconferences but that the meeting organizers need to know how to use all these features
- However, at least one community partner also noted recent low turnout and burnout from so many virtual meetings during COVID-19, and that many community members are tired, frustrated, and exhausted from constantly showing up, being vulnerable and sharing their very personal stories and experiences, and then not seeing any actions or changes in response to what they share, and no tangible benefits from their engagement
- At least one community partner asked whether returning to in-person meetings would create health risks for seniors and individuals with disabilities, and limit their participation

Implement more inclusive practices for OHPB Committee meetings, including improving public comment and decision-making practices

- Several health care partners noted that the webpage for each Committee was formatted differently, and that it was not always easy to find background materials about the Committee, including meeting agendas and meeting materials

- Another health care partner suggested that key decisions and documents, and pending issues could be highlighted on the Committee webpages; currently, one had to either know that an issue was considered at a Committee meeting on a specific date and go to the materials for that meeting, or scroll through many meetings to find a policy decision or document
- One community partner noted that the discussions at OHA meetings can sound like another language - “OHA language” - that is not understandable by community partners or community members
- Several health care partners expressed frustration with the public comment processes at Committee meetings
- Several community partners noted that decision-making processes at OHPB Committees could be more inclusive, including having good discussion facilitators; ensuring that time for discussion is not shortened because time for presentations run too long/over the time planned for on an agenda; having clearer and more transparent processes for decisions; using consensus decision-making processes, using nominal group techniques, and even weighting the votes of those from under-represented communities or impacted populations more
- More than one community-based partner commented that more inclusive processes need to be supported by awareness, training, skills-building, and practice such as how to be active listeners; one community-based partner said that while you can’t control what everyone might say, with differing levels of knowledge, everyone can continue to be educated and can put in the work to learn with humility
- A community partner suggested that safe and trusted facilitators from diverse backgrounds, or are identifiable as allies to diverse communities, help facilitate Committee meetings
- Several community partners emphasized the importance of transparency in Committee processes, including what actual decision-making power the Committee has, and how those decisions are made
- One community partner noted that unless “racial diversity” is explicitly on an agenda of a policymaker meeting, it usually is not raised or discussed
- One community partner expressed the experience of OHPB Committees as an extractive process for Committee members, with “cakes already half-baked”, with Committee members “choosing the frosting”
- One community partner asked whether there was ongoing evaluation of Committee meetings, noting how a rapid feedback form (a short post-meeting survey) can be a tool for continuous improvement
- Several community partners suggested that part of transparency, building trust, and accountability is to admit mistakes by publicly noting or posting them, and how the group is “falling forward” by making changes to address the mistake
- One community partner asked for increased accountability on diversity and equity outcomes; if goals are not being achieved, what barriers remain that are not being adequately addressed?

Support OHA staff and OHPB Committees with training and other tools

- Several partners emphasized that OHA staff have to be prepared and trained how to hear and genuinely listen to community input and feedback when it is critical or impatient about the pace of change, coming from the history of under-representation, discrimination, and exclusion that communities have experienced
- Several partners reflected that it was their experience that OHA does not have an effective way of hearing and responding to community input and feedback that is open, respectful, and responsive; for example, the OHA questions sources and credibility in ways that it doesn't with other partners
- At least two partners working with Tribal communities and communities of color noted the communities' experience of the lack of OHA support of current efforts to declare racism as a public health crisis as the most recent example of community distrust of OHA's stated efforts on diversity and equity
- At least one partner questioned whether OHA had the staff capacity to support all its Committees, and whether all these Committees were still necessary
- One community partner suggested that all OHA staff be required to spend time, e.g., a month, working in community-based organizations to learn first-hand the challenges and different perspectives of working in the community

OHPB AND OHA SPONSOR AND OHA STAFF INPUT

Beginning in April 2021, the project consultant and project staff also have had numerous discussions with OHA staff (members of the Committee Membership Workgroup, OHPB Committee lead staff, project staff, other OHA staff), the OHA executive sponsors, and individual OHPB members who are sponsors of this project.⁵⁸ See Appendix B for the list of OHPB and OHA sponsors and OHA staff consulted and interviewed. Feedback was also obtained from OHPB members after the presentation about the project at the educational webinar on July 13 and presentation of draft findings and recommendations at the August 3 OHPB meeting. Key points from these discussions and interviews are summarized here, and similar to the external partner interviews, are not attributed to any specific sponsor or staff person.

OHA staff are committed to increasing the diversity of OHPB Committee members, and recognize the importance of this work

- All internal interviewees expressed support for the goal of increasing the diversity of OHPB Committee members; however, many cautioned that this should not be just checking off demographic boxes that would result in tokenism
- One person noted that the community is demanding transformational work and systems changes from OHA, not just transactional changes; below is a working definition of transactional compared to transformative approaches:⁵⁹



⁵⁸ The conversations with OHPB members were conducted both individually and in one discussion with four Board members, in recognition of public meeting rules prohibiting meetings with a quorum of Board members without notice and the opportunity for public comment.

⁵⁹ Portland Metro Strategic Plan to Advance Racial Equity, Diversity, and Inclusion, 2017, <https://www.oregonmetro.gov/sites/default/files/2017/10/05/Strategic-plan-advance-racial-equity-diversity-inclusion-16087-20160613.pdf>

- Another person noted that for OHA, equity IS the work, and that includes shifting power from OHA to the communities it serves
- One interviewee observed that diversity of representation is not enough; the work of health equity is decolonizing over 500 years of inequities, towards the liberation of all people
- One interviewee noted that community members advocating for diversity, inclusion, equity, anti-racism, and decolonization are now bolder, and are “not fooled” by the lack of meaningful and measurable actions
- One person asked whether OHA has asked the community what it wants in terms of equity, and how the community would want these Committees structured, and to operate
- One internal interviewee noted the importance of OHPB itself as the policy-setting body for all of OHA, and how important OHPB’s leadership on and modeling of Committee diversity is for all OHA Committees
- Several OHA staff asked whether the OHPB had an “ideal composition” of the OHPB Committees that would meet the goal of Committee member diversity, i.e., what would success look like?
- Several OHA staff discussed the challenges and tensions with identifying potential Committee members that meet statutory and charter requirements for sector representation and/or subject matter expertise, as well as demographic and geographic diversity; however several interviewees noted that having technical or subject matter expertise without consumer or diverse community engagement will result in policies that “fall short”, and that lived experience needs to be valued as subject matter expertise
- One internal interviewee highlighted that there needs to be an equal voice from those who utilize health care and health services; historically, all the decisions have been made by providers and payers, without considering the expertise and solutions from consumers and community members
- At least one person cautioned that there could be some backlash to this effort and that it was important to be intentional about the most appropriate messenger(s) for announcing any changes
- Several internal interviewees wondered about an operational definition of lived experience; one suggested asking explicitly: “what [self-identified] voice(s) are you bringing to this Committee?”

Internal staff support standardized data collection about Committee applicants and members, and raised the need for diversity beyond racial and ethnic diversity

- Several interviewees commented that the demographic data categories should be based on the OHA definition of health equity; some of the terms in that definition have yet to be operationalized
- One internal interviewee wondered whether Committee members (or applicants) who are White would be less likely to answer detailed demographic questions

- A few internal interviewees felt that race, ethnicity, language, and disability (REALD) questions are not relevant for OHPB Committee members (e.g. English proficiency, the specific types of disabilities); others felt that the same questions being asked of OHP members and patients should be asked of OHPB Committee members and applicants, noting that OHA required comprehensive REALD data to be collected and reported for COVID-19 testing, cases, and vaccines, declining to make exceptions or change the demographic data categories for hospitals and other health care providers; still others did not have a strong point of view about how demographic data should be collected
- Internal staff interviewed agreed that the priority should be on increasing racial and ethnic diversity; however, several interviewees referenced the importance of geography and other dimensions of diversity
- Several internal interviewees discussed the additional challenges of recruiting and meaningfully engaging consumer members of Committees, noting that individuals who are lawyers, teachers, and professors and only nominally “consumers” can be important Committee members, but that they are not the typical users of OHA services such as OHP members, nor those directly impacted by OHA policies and decisions

OHA staff generally understand this goal of increasing OHPB member diversity as an individual responsibility, specific to the OHPB Committee they are supporting or working most closely with

- Internal interviewees had some general knowledge about other OHPB Committees that they did not directly support or work with, but there was very little specific knowledge about statutory or charter requirements for members, or about Committee member recruitment activities across all OHPB Committees
- While OHA staff have sought ad hoc assistance from other OHA staff in recruiting diverse Committee members, this has been dependent on individual initiation by Committee lead staff and their working relationships with other OHA staff; there is no structure or formal support for any coordinated recruitment activities across all the OHPB Committees
- One person cautioned against a one-size-fits-all approach and encouraged collaboration and coordination of recruitment activities, but not necessarily centralization
- Prior to this project, there was very little knowledge about how other OHA staff, including those in other OHA Divisions, recruit and retain Committee and other advisory group members with a diversity, inclusion, and equity lens; this project has identified and incorporated examples based on the successes of these other efforts

- Several OHA staff referred to recent examples of OHA recruitment of more diverse advisory groups, including the COVID-19 Vaccine Community Advisory Committee⁶⁰ and the Measure 110 Oversight and Accountability Council;⁶¹ for example the Measure 110 Oversight and Accountability Council includes about 85% individuals with lived experiences with addiction, and about 70% individuals who are from Tribal communities and communities of color
- At least one internal interviewee commented that even the application for and information about Committee membership could be more inviting and warm, and could explicitly recruit diverse individuals; even the order of a list of potential applicants makes a difference, e.g., flipping the usual lists and prioritizing lived experiences first rather than provider or other experiences
- An internal interviewee observed that there will be push-back from external partners who will always want more clinicians, providers, and payers on Committees; these health care partners will experience increased diversity as a loss, including a loss of power; it is important for these partners to understand that lived experience is another type of expertise that has value
- One internal interviewee noted that recruitment of individuals with lived experiences and from marginalized backgrounds required more one-on-one follow-up to build trust, answer questions, and provide assurances of support and inclusion
- Several internal interviewees discussed the need for improved and consistent policies for compensation for serving on Committees;⁶² and making child care available (when there is a return to in-person meetings); one recommended that such payments be simplified (hourly invoices, payments through gift cards)
- At least one person asked what the role of OHPB liaisons for each OHPB Committee now has, or should have, in supporting efforts to increase Committee diversity

OHA staff are aware that successful recruitment requires ongoing community engagement but need more support for effective community engagement

- Several internal interviewees expressed that the goal of Committee member diversity added stress and anxiety on their already overloaded work, and felt that they did not have the capacity or support to do the type of outreach to and engagement with diverse external partners that they needed and wanted to do
- Several internal interviewees strongly recommended the development and maintenance of a common database for documenting and accessing community contacts and the history of OHA staff engagement with those contacts

⁶⁰<https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/IMMUNIZATIONPARTNERSHIPS/Pages/COVID-19-Vaccine-Advisory-Committee.aspx>

⁶¹ <https://www.oregon.gov/oha/HSD/AMH/OACDocuments/OAC-Membership.pdf>; the Council sought feedback from Council members about its first meeting, which was then shared: <https://www.oregon.gov/oha/HSD/AMH/OACDocuments/Council-Feedback.pdf>

⁶² House Bill 2992 was enacted in this legislative session, authorizing compensation or per diem rates of up to \$151/day for service on state government boards and commissions for individuals with incomes below \$50,000/year, <https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2992>

- One internal interviewee noted that there was no consistency in the degree of engagement with external and community partners, which depends on the position and individual approaches of each OHA staff member
- One internal interviewee noted that from the perspective of many communities and community partners, OHA is a monolith (with some justified expectation that OHA has effective internal communication and coordination); when OHA repeatedly “engages” community partners and asks the same questions over and over, the process is extractive and only deepens inequities
- At least one internal interviewee wondered what the role of OHA staff who have roles and responsibilities for supporting community partnerships and external relations might be in supporting recruitment for more diverse OHPB members
- At least one internal interviewee asked, that given OHA’s commitment to health equity generally and to increasing OHPB Committee diversity specifically, what financial support OHA has been providing, and is willing to provide, to strengthen the capacity of organizations from Tribal communities and communities of color to participate in OHPB Committee and other OHA activities
- As part of the Committee Membership Workgroup and this project, internal staff have shared their own lists of external contacts, guides for community engagement, and analytical tools to support equity that had not been shared widely or known across OHA, e.g., the Division of Equity & Inclusion’s demographic and geographic gap analysis tool, and the MSC’s equity impact assessment of CCO incentive quality measures⁶³
- Several internal interviewees noted recent examples of proactive outreach and engagement with diverse communities, including the process to develop the State Health Improvement Plan and listening sessions being conducted by the Health Care Workforce Committee about its draft equity plan;⁶⁴ several internal interviewees encouraged going out to the community, holding townhalls, and engagement with culturally specific community-based organizations
- Several internal interviewees noted the importance of circling back and reporting back to communities what happens after community engagement, input, or feedback; how that input and feedback is documented, and how it impacts on decisions and policies, even if the community recommendations are not adopted; one commented that for many community members, providing input has felt like “screaming into the void”
- One person pointed out that community engagement is not equivalent to achieving health equity

⁶³ <https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6b.-05.2021-MS-C-Equity-Impact-Assessment-Report.pdf>

⁶⁴ HCWF Committee members received a training in constructivist listening prior to the listening sessions, <https://www.nationalequityproject.org/frameworks/constructivist-listening#:~:text=Constructivist%20listening%20is%20an%20effective,the%20speaker%2C%20not%20the%20listener.>

Internal interviewees highlighted the need to engage, support, and retain diverse Committee members

- Several interviewees noted that consumer members of Committees needed support (from OHA staff, Committee chairs, and other Committee members) to serve effectively as Committee members
- An internal interviewee commented that it was the role of OHA staff to help Committee members understand data, or to translate discussions into policies; an analogy is that while a homeowner may know what type of features they want in their house, they rely on architects, engineers, electricians, and plumbers to propose and implement the details of the design concepts; OHA data and policy analysts should be assisting Committee members in understanding data and policy
- One interviewee asked for a “power analysis” about Committee members, and whether any one sector or organization had disproportionate (over-) representation on the Committees, and therefore disproportionate power and influence on OHA policies; there is support for statutory and charter changes to focus on health equity, lived experience, and cross-cultural experiences
- One person observed that there is sometimes a perception that consumers are “biased” because they bring their personal interests in accessing and utilizing health care to discussions; however, all those who work in health care have personal and professional interests but rarely disclose or discuss what those biases are
- Another internal interviewee noted that the racially diverse (and those from lower income) members of a Committee were the ones who were less outspoken, and more often absent
- At least one person also noted how wealth can also be a barrier to equal participation; another noted how technical or policy language can be used as a way to limit discussions
- One person encouraged analysis and recommendations for who chairs these OHPB Committees as another way to advance diversity, inclusion, and equity
- Internal interviewees referred to examples when community members were able to “step into their own power” and show up in meetings and other engagements with OHA; it was noted that many are eager to learn and gain knowledge about OHA policies when access to such policymaking has been denied to them

While OHA staff would like to increase accessibility of OHPB Committee meetings, there are questions about support and resources for implementation

- There are some guidelines and resources about accessible meetings, presentations, and documents available to OHA staff on the OHA intranet⁶⁵
- While there is joint OHA-Oregon Department of Human Services policy for accessible public meetings, this is a “self-help” policy, to be implemented by each Committee; there is no centralized staffing to support such implementation

⁶⁵ For example, the Covid-19 Rapid Response Unit Accessibility Team developed guidelines for accessible presentations and documents

- It often becomes the responsibility of OHA administrative staff to implement the procedures and processes to ensure accessible meetings; there is generally no training or support for such staff to facilitate successful implementation
- There was some discussion about what specific resources and support was available to Committee lead staff at either the division level or agency-wide to provide interpretation and captioning at Committee meetings, and translations and/or alternate formats of written materials
- An internal interviewee observed that there are costs and it does take time to ensure accessible and inclusive meetings but that these should not be excuses and should be included in operational budgets
- One internal interviewee observed that prior to COVID-19 forcing videoconference meetings, it was an “insurmountable fight” to have meetings accessible by videoconference or conference call that would make them more accessible for those who did not reside where the meetings were held, i.e. Portland or Salem, as well as for those who need interpretation or other communications assistance; there are no OHA policies that require the options of videoconference or conference calls for public meetings; it is not clear whether all the videoconference meetings that have been held during COVID-19 will continue, at least as an option
- Several internal interviewees referenced more inclusive practices for meetings and OHA communications during COVID-19, including ASL interpretation, communication access real time translation (CART) captioning, and simultaneous interpretation in Spanish through Facebook Live
- Several internal interviewees recommended that ASL interpretation and CART captioning be available for all videoconference meetings;⁶⁶ however, it was noted that the Microsoft Teams platform used by OHA poses challenges to integrating such technologies, compared to other videoconference platforms such as Zoom
- Internal interviewees shared about their challenges in changing internal workflows to make captioning and ASL interpretation standard for COVID-19 related events
- A few internal interviewees noted that not all OHA meeting notices/agendas consistently include boilerplate language about accessibility;⁶⁷ and it then becomes a self-fulfilling prophecy when no one requests or uses language access processes such as interpretation because individuals who need or would use them do not know that they are available

⁶⁶ Both English and Spanish captioning were available for meetings of the COVID-19 Vaccine Community Advisory Committee: <https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINES/IMMUNIZATION/IMMUNIZATIONPARTNERSHIPS/Pages/COVID-19-Vaccine-Advisory-Committee.aspx>

⁶⁷ Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

* Sign language and spoken language interpreters

* Written materials in other languages

* Braille

* Large print

* Audio and other formats

If you need help or have questions, please contact =====

- It was noted that even with the availability and use of technology such as captioning or services such as simultaneous language interpretation, it still requires OHA staff and Committee chairpersons to be aware of how to integrate such access, e.g. slowing down when speaking, pausing for transitions from one interpreter to another, ensuring that the interpreter is spot-lighted and visible, etc.; one internal interviewee recommended at least a 30 minute “practice session” before a meeting (that includes compensation to the captioners and interpreters)

OHA staff had recommendations about improving the public comment process during OHPB Committee meetings

- One internal interviewee recommended re-examination of OHPB and Committee public comment processes to make them more accessible and meaningful, and to follow-up with individuals who comment from diverse backgrounds as potential Committee members
- It was noted that the current OHPB Committee public comment process is based on what the Oregon Legislature does (requires in-person testimony, requires pre-registration, requires comments in writing, limits speaking time to two minutes, conducts meetings in the middle of the day and only in English, with no language access) and that such a process may not be appropriate for OHPB Committees that are seeking to be more inclusive and prioritized on advancing health equity
- There was discussion among internal staff about public comment procedures and processes; on the one hand, requiring pre-registration allows prior identification of communications needs such as interpretation; on the other hand, requiring pre-registration creates an additional barrier to participation

Some internal interviewees recognize the need for work beyond OHPB Committee member diversity, and are anxious to advance inclusion and equity within Committee policies, procedures, and practices

- One internal interviewee encouraged more votes on Committee decisions to make Committee decision-making processes more transparent
- Some internal staff are frustrated by the pace of organizational change and are anxious to advance diversity, inclusion, and equity within Committee policies, procedures, and practices at a more accelerated pace
- One person wanted to see increased understanding and use of tools to implement anti-racist practices, decolonization, and indigeneity by OHA and OHPB Committees
- One person observed that the purpose of diversity is to achieve equity, and the purpose of equity is to shift power to those who have been under-represented, discriminated against, and excluded; another noted that in order to be ant-racist, one must be willing to be disruptive of racist systems and structures
- Several internal interviewees noted parallel and aligned activities to advance equity at both the divisional and agency-wide level, including efforts to increase OHA’s staff diversity

- One person noted that there is always pushback whenever there is work on diversity and equity, and that it is also a question of workforce training and skills to do this work
- Internal interviewees recognize that some of the proposed recommendations will require staffing and other resources to implement and want to see an implementation plan that outlines those needs, and how they will be met, and who will be accountable for implementation
- Other internal interviewees would like to see specific implementation timelines and measures for accountability

FINDINGS

The following findings about OHPB Committee member diversity are based on the input of internal and external interviewees.

Diversity is “honoring and including people of different backgrounds, identities and experiences collectively and as individuals. It emphasizes the need for representation of communities that are systemically underrepresented and under-resourced. These differences are strengths that maximize the state’s competitive advantage through innovation, effectiveness, and adaptability.”²⁶

Inclusion is “a state of belonging when persons of different backgrounds, experiences and identities are valued, integrated and welcomed equitably as decision makers, collaborators and colleagues. Ultimately, inclusion is the environment that organizations create to allow these differences to thrive.”

Equity “acknowledges that not all people, or all communities, are starting from the same place due to historic and current systems of oppression. Equity is the effort to provide different levels of support based on an individual’s or group’s needs in order to achieve fairness in outcomes. Equity actionably empowers communities most affected by systemic oppression and requires the redistribution of resources, power and opportunity to those communities.”

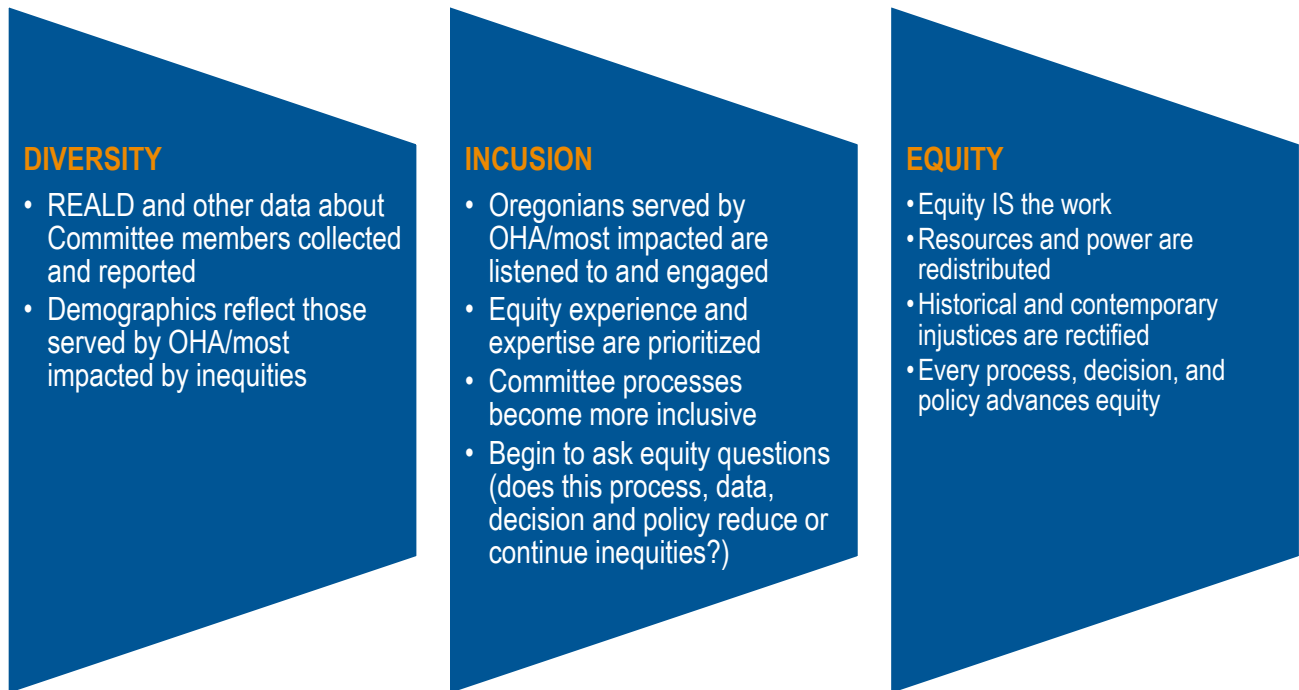
Governor’s Diversity, Equity, and Inclusion Plan, 2021, State of Oregon Diversity, Equity, and Inclusion Plan: A Roadmap to Racial Equity and Belonging, August 2021, link: https://www.oregon.gov/das/Docs/DEI_Action_Plan_2021.pdf

A. Diversity is necessary, but not sufficient, for inclusion and equity

- The charter of the Committee Membership Workgroup is to “identify and provide recommendations to the structural and procedural barriers that limit the recruitment and retention of diverse Committee members; this effort will result in Committees that better represents all Oregonians and supports OHA’s 10-year goal of eliminating health inequities by 2030”
- Increasing Committee membership diversity cannot be viewed or accomplished in isolation; Committee member diversity is not an end in itself
- The most effective strategies for increasing diversity are built on long-term, transformative relationships with diverse partners and communities;⁶⁸ such long-term relationships require time, transparency, and trust; they also require coordination and communication across OHA staff and Committees

⁶⁸ OHA Division of Equity & Inclusion, Community Engagement Strategies Checklist, https://www.oregon.gov/oha/OEI/Documents/Community%20Engagement%20Strategies%20Checklist_vOHA_FINAL.pdf

- If increasing Committee membership diversity is connected to the overall strategy for achieving the OHA goal of eliminating health inequities by 2030, then implementation has to be part of broader, and long-term, diversity, inclusion, and equity strategy that will require additional development and implementation beyond the scope of this project focused on Committee membership diversity, e.g. more work would be needed on developing and implementing inclusive and, ultimately, equitable Committee processes, practices, and decision making⁶⁹



- Ultimately, equity means redistribution of resources and power, and rectifying historical and contemporary injustices;⁷⁰ the State Health Improvement Plan states: “OHA is committed to partnerships, co-creation and co-ownership of solutions with communities disproportionately affected by health issues so they can actively participate in planning, implementing and evaluating efforts to address health issues”;⁷¹ merely diversifying Committee membership is not equivalent to redistribution of resources and power, nor rectifying historical and contemporary injustices, nor co-creation and co-ownership of policy solutions with disproportionately affected communities

⁶⁹ For example, OHA Division of Equity & Inclusion, Health Equity and Inclusion Lens for Bill Analysis, <https://www.oregon.gov/oha/OEI/Documents/Health%20Equity%20and%20Inclusion%20Lens%20for%20Bill%20Analysis%20FINAL.PDF>, and Metrics and Scoring Committee Equity Impact Assessment, <https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6b.-05.2021-MS-Committee-Equity-Impact-Assessment-Report.pdf>; there may be additional examples that operationalize OHA’s core value of transparency: “We communicate honestly and openly, and our actions are upfront and visible. We provide open access to information and meaningful opportunities to provide input and participate in our decision-making.” (emphasis added); <https://www.oregon.gov/oha/Documents/OHA-Core-Values.pdf>

⁷⁰ OHA Health Equity Definition, <https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx>

⁷¹ Healthier Together Oregon: 2020-2024 State Health Improvement Plan, 2020, <https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/2020-2024/Healthier-Together-Oregon-full-plan.pdf>

B. While OHA is committed to many dimensions of diversity, the recognition of structural racism calls for a prioritized focus on racial and ethnic diversity

- The OHA definition of health equity is broad and comprehensive; OHPB recently adopted the recommendation of the Health Equity Committee to add “age” as an additional dimension of diversity
- However, given the recognition of structural racism⁷² as foundational for many manifestations of inequities, Committee membership diversity efforts should prioritize racial and ethnic diversity
- Of course, we also recognize that individuals and communities have multiple identities and experience intersectional, compounding, and cumulative inequities; for example, the State Health Improvement Plan noted: “People at the intersection of more than one affected community, e.g., people who are Black and transgender, find these systems especially oppressive and hard to navigate”; while prioritizing racial and ethnic diversity, these efforts should also identify opportunities to address intersectional experiences of inequities

C. Current OHPB Committee member recruitment processes are not always coordinated and consistent, nor specifically designed to advance health equity

- Information about OHPB Committee member vacancies is not centrally accessible, e.g., there is no list of current or upcoming vacancies across all nine OHPB Committees
- There is no standardized information about OHPB Committee member roles and responsibilities
- Most recruitment activities for OHPB Committee members are ad hoc, focused on filling specific vacant seats on a specific Committee, which often have statutory or other requirements about prospective members for that vacancy
- Current recruitment activities often depend on group email messages (sent to long lists of recipients, with no personalization) that in turn depends on the existing contacts of the current Committee staff members; there is no centralized, updated database of contacts of key external partners, especially partners from diverse, under-represented, and excluded communities and populations
- There is no support for Committee lead staff to work together on recruitment of Committee members, or to systematically access contacts and networks of other OHA staff
- While there has been some outreach to and engagement of diverse partners to recruit OHPB Committee members, these efforts again depend on the existing contacts and working relationships of the current Committee staff members

⁷² Structural racism is defined as: “the normalization and legitimization of historical, cultural, institutional and interpersonal dynamics that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color”, Healthier Together Oregon: 2020-2024 State Health Improvement Plan, 2020, <https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/2020-2024/Healthier-Together-Oregon-full-plan.pdf>

- Ultimately, effectiveness in increasing the racial and ethnic and other diversity of OHPB Committee members will depend in part on increasing the racial and ethnic and other diversity of Committee lead staff and OHA staff as a whole; OHA has an Equity Advancement Leadership Team and is finalizing an agency-wide Equity Advancement Action Plan⁷³ that addresses OHA’s own workforce diversity challenges

D. Current demographic data about OHPB Committee members and applicants are not comprehensive, standardized, or complete

- There are no standardized definitions of demographic data categories for OHPB Committee members
- There are no standardized processes for how demographic data is collected and reported about Committee members and applicants
- There have been no data publicly reported about applicants for OHPB Committees member seats

E. There are significant barriers for partners from diverse, under-represented, and excluded communities and populations to serve on OHPB Committees

- Partners representing and from diverse, under-represented, and excluded communities and populations have finite and limited capacities to serve on OHPB Committees, other OHA Committees, and other Oregon boards and commissions
- Community partners may prioritize serving on other OHA Committees, and other Oregon boards and commissions, rather than the nine OHPB Committees
- While out-of-pocket travel expenses are generally reimbursed for OHPB Committee members, there is no compensation available for travel time for OHPB Committee members who have to travel to Committee meetings from rural and more remote parts of Oregon
- Committee members who are not supported by their employers to use paid work time to serve on OHPB Committees do not receive any stipends for their volunteer time, and may be losing money (unable to work) while serving on a Committee; of course, time invested is not only actual meeting time and travel time but time for preparation and review of Committee materials, as well as time for reviewing and responding to email and other messages from OHA staff (including scheduling), time on subcommittees and work groups, and other time as a Committee member

⁷³ <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9813.pdf>

F. There are no systematic supports for retention of OHPB Committee members

- There has not been any systematic analysis of why OHPB Committee members resign prior to the expiration of their terms, including any stratification by demographics
- There is no process for an “exit interview” with Committee members who resign, or whose terms have expired, about their experiences as a Committee member, and any lessons learned or recommendations to share with current or prospective Committee members, especially about how to increase the diversity of Committee membership
- There is no training offered to Committee lead staff or chairs of Committees about how to support or lead more participatory and inclusive Committee meetings that will result in more engaged and meaningful experiences for all Committee members, but especially for Committee members from diverse, under-represented, and excluded communities and populations

RECOMMENDATIONS

While the Committee Membership Workgroup charter was focused on increasing OHPB Committee member diversity, given community partner feedback as well as OHPB and OHA sponsor and OHA staff feedback, these recommendations include both immediate implementation activities and broader, long-term strategies on advancing diversity, inclusion, and equity. For example, many community partners emphasized that authentic community engagement - to build trust and working relationships - is needed before beginning efforts to recruit for OHPB Committee members. Moreover, OHPB and OHA sponsors and OHA staff were anxious for recommendations and guidance for addressing inclusion and equity that went beyond increasing Committee member diversity. After each recommendation, some examples of potential implementation activities are listed.

A. All OHPB Committees should engage diverse, under-represented, and excluded communities

1. Identify populations and communities most impacted by Committee decisions and policies
2. Engage and listen to diverse, under-represented, and excluded communities and populations

Identify populations and communities most impacted by Committee decisions and policies

- Use root cause and gap analyses to identify how diverse, under-represented, and excluded communities are impacted by Committee decisions and policies
- Review past Committee reports, data, policies, and other documents to highlight how the needs of diverse, under-represented, and excluded communities have been referenced and considered in Committee decisions and policies

Engage and listen to diverse, under-represented, and excluded communities and populations

- Conduct informational interviews and make site visits to learn about organizations working with diverse, under-represented, and excluded populations and communities
- Invite individuals from diverse, under-represented, and excluded populations to make presentations to the Committee about their population's or community's needs and assets, and what recommendations they would have for the Committee
- Invite individuals from diverse, under-represented, and excluded populations to serve on Committee work groups, including creating a work group specifically on identifying issues and strategies to advance health equity within the charge of that Committee
- Consider providing appropriate compensation for the time spent providing subject matter expertise about their populations and communities to Committee staff and members

If increasing OHPB Committee member diversity is just one step towards the overall goal of advancing health equity, then there are other steps that can and need to be taken before and after any activities to increase Committee member diversity. Many external and internal

interviewees recommended more continuous and coordinated engagement with community partners as essential to building trust and working relationships that would support recruitment and retention of more diverse Committee members.

The Governor's Diversity, Equity, and Inclusion Plan explains the importance of community engagement:⁷⁴

Oregonians are engaged when they are meaningfully included in discussions, decision-making, and implementation of the parts of government that affect their lives. In essence, community engagement means sharing power by proactively working with community stakeholders and building meaningful partnerships to inform decision making. To some, community engagement feels like too slow of a process to be able to meet expectations in agency-level work. However, with this plan agency directors can set their own timeline to ensure that community engagement is a high priority. Community engagement ensures that their plans are relevant, needed, and build on existing solutions, ideas, and strengths that Oregon's diverse communities have to offer. Time and again, government agencies have learned that no plans or strategies can fully succeed without engaging impacted communities.

Some of the strategies that the Governor recommends for effective community engagement:

- Strengthen proactive community engagement efforts and initiatives to foster trust and partnerships.
- Engage and center diverse community partners and local leaders across the state to be an essential part of the data-informed decision-making process.
- Build on and collaborate with the trusted network of community-based organizational partners to lead in policymaking and ensure that we proactively address policy gaps.
- Ensure policymaking bodies such as boards and commissions represent the voices of communities of color, Tribal communities, and communities representing people with disabilities.
- Engage and empower community partners and communities of color to inform policy, resource allocation and budget decisions.
- Participate in enterprise-wide efforts to build infrastructure for statewide community engagement work.
- Collaborate across agencies internally and/or with other agencies to make state government community engagement processes more efficient and less of a burden on underserved communities.

⁷⁴ State of Oregon Diversity, Equity, and Inclusion Plan: A Roadmap to Racial Equity and Belonging, August 2021, https://www.oregon.gov/das/Docs/DEI_Action_Plan_2021.pdf

OHA's Division of Equity & Inclusion has developed guidance for inclusive community engagement.⁷⁵ The guidance states:

Agencies and organizations should support community-led development of policy solutions that seek to address barriers diverse communities experience in systems for the ultimate goal of eliminating health inequities. Resources should be allocated to support active/meaningful community participation in decision making, especially from those who are underrepresented and most vulnerable. Encourage diverse community participation and remove barriers that prevent individuals from being actively involved by consulting community partners on respectful ways of engaging. It is key to be transparent about expectations of community partner involvement. These strategies shift away from telling communities what they need and facilitates communities identifying the most pressing issues and leading the development appropriate solutions.

Some of the approaches recommended include:

- Meaningful community engagement strategies begin with budget planning to ensure there are sufficient resources allocated to fully support this work. Insufficient resources and expectations that individuals volunteer their time can leave stakeholders feeling like community engagement was an afterthought, and not really valued.
- Investing in internal capacity building through training (i.e., unconscious bias, health equity, diversity and inclusion, etc.) over time supports readiness for respectful community engagement.
- If requesting that individuals provide expertise in developing strategic equity (or other organizational) plans, contributors should be supported by offering funding and resources to accomplish the task, just as any other consultant would be offered.
- Mistakes are to be expected. Acknowledge missteps and ask for feedback for future improvement.

While community engagement is not just the responsibility of OHPB Committees, it should be an essential part of the work of each of these Committees and coordinated and aligned with efforts across OHA to improve, strengthen, and maintain effective community engagement.⁷⁶

B. Support recruitment and retention of more diverse OHPB Committee members

1. Coordinate recruitment across OHPB Committees
2. Standardize collection and reporting of demographic and sector data about Committee members and applicants
3. Support retention of diverse Committee members
4. Recommend changes to authorizing statutes and charters to increase Committee member diversity

⁷⁵ OHA, Division of Equity & Inclusion, Community Engagement Strategies Checklist https://www.oregon.gov/oha/OEI/Documents/Community%20Engagement%20Strategies%20Checklist_vOHA_FI_NAL.pdf

⁷⁶ These efforts include those by the OHA External Relations Division, the Division of Equity & Inclusion, and Public Health Division.

Coordinate recruitment across OHPB Committees

- Create user-friendly descriptions of all OHPB Committees,⁷⁷ Committee member roles and responsibilities, and upcoming vacancies⁷⁸
- Create a centralized database of diverse external partners for continuous relationship-building, outreach, engagement, and recruitment accessible for all OHPB Committee (use client/customer relationship management software and best practices)
- Consider co-funding public-private partnerships with statewide philanthropic partners who have prioritized equity and are supporting leadership development and capacity-building for community-based organizations serving Oregon's diverse communities and populations, e.g., with Meyer Memorial Trust⁷⁹ and Collins Foundation,⁸⁰ to support Black, culturally-specific, immigrant and refugee, and other diverse community-based organizations
- Consider partnerships with statewide leadership programs, e.g., Women in Healthcare for recruitment
- Utilize existing OHA networks for ongoing and regular recruitment, e.g., Division of Equity & Inclusion Developing Equity Leadership through Training and Action (DELTA) program,⁸¹ CCO community advisory councils,⁸² individuals attending listening sessions/community engagement activities for 1115 waiver
- Make explicit requests to key partners (provider associations, regional health equity coalitions, etc.) for assistance in identifying and recruiting more diverse Committee members; increase OHA funding to regional health equity coalitions for the additional time and effort needed to assist with recruitment
- Committee lead staff should coordinate and share responsibilities for continuous recruitment of diverse Committee members; identify additional or new staffing resources to support this more systematic approach to recruitment
- Align or standardize Committee member application/candidate interest processes and forms to the extent possible, including collection of demographic data and questions about lived and cross-cultural experiences about health equity generally and racial equity specifically⁸³
- Include specific text in recruitment messages about OHA's prioritization of health equity and the specific recruitment of diverse members for OHPB Committees⁸⁴

⁷⁷ The OHPB has begun to compile and publish a quarterly update on OHPB Committees:

https://www.oregon.gov/oha/OHPB/MtgDocs/1.1%20Committee%20Digest_2021.Q1_updated.pdf

⁷⁸ There is a vacancies listing for Governor-appointed Boards and Commissions:

https://www.oregon.gov/gov/admin/SiteAssets/Pages/How_To_Apply/Vacancy%20List%20123121.pdf

⁷⁹ <https://mmt.org/JusticeOregonforBlackLives> and <https://mmt.org/community>

⁸⁰ <https://www.collinsfoundation.org/submission-guidelines/initiative-small-culturally-specific-organizations> and

<https://www.collinsfoundation.org/responsive-grantmaking-submission-guidelines/immigrant-refugee-funders-collaborative>

⁸¹ <https://www.oregon.gov/oha/oei/Pages/delta.aspx>

⁸² <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Community-Advisory-Councils.aspx>

⁸³ This project has developed a demographic and sector data survey that is currently being piloted by the Health Equity Committee and Cost Growth Target Committee as they recruit Committee members: <https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx>; the project will also conduct anonymous follow-up surveys with applicants for their feedback on the survey, which will then be finalized for use by all OHPB Committees for future recruitment, as well as collecting baseline data from all current OHPB Committee members. All these data will be analyzed and presented to the OHPB at its next annual retreat in February 2022.

⁸⁴ For example, see text used for recruitment for the new Behavioral Health Metrics and Incentives Committee:

<https://content.govdelivery.com/accounts/ORDHS/bulletins/2ef0ce3>

Standardize collection and reporting of demographic and sector data about Committee members and applicants

- Decide how to collect and report data about race and ethnicity of OHPB Committee members and applicants, e.g., using the definitions of race, ethnicity, language, and disability developed by OHA for patients and clients, i.e., the REALD standards⁸⁵
- Decide how to collect and report data on geographic diversity/rural status about OHPB Committee members and applicants
- Decide how to collect and report self-reported data about other dimensions of diversity about OHPB Committee members and applicants, including gender [sex],⁸⁶ gender identity, sexual orientation, and age⁸⁷
- Develop and adopt operational definitions and questions to ask of OHPB Committee members and applicants about “lived experience” and “cross-cultural experience” as areas of subject matter expertise
- Develop and adopt operational definitions and questions to ask about “lived experience” and “cross-cultural experience” specific to health equity generally, and racial equity specifically, as areas of subject matter expertise⁸⁸
- Decide whether to report demographic data about OHPB Committee members in the aggregate, or by each Committee, and what format(s) and frequency for reporting the data maximizes transparency and accountability while also addressing concerns about confidentiality; address statistical issues when members decline to respond
- Decide whether to begin to report demographic data about OHPB Committee member *applicants*, and in what formats and frequency
- Recognize that these demographic definitions are not static; build in processes to revise and update these definitions
- Develop FAQs and other materials to explain why demographic data is collected from applicants and how that data will be used and reported

⁸⁵ <https://www.oregon.gov/oha/OEII/Pages/REALD.aspx>

⁸⁶ If gender identity is included as a dimension of diversity, then “sex”, i.e., biological sex, or sex assigned at birth, should be the dimension distinct from gender identity

⁸⁷ The Governor’s executive appointment interest form asks the following demographic questions about applicants for appointment to a Board or Commission:

To better assist us in meeting our affirmative action objectives, we would appreciate information about your gender identity and background. This information is optional and is used for data collection only. Under state and federal law, this information may not be used to discriminate against you. Thank you for your participation.

Gender Identity: **LBGTQ:** **Disability:**

Race/Ethnicity (Select One): African American/Black American Indian/Alaskan Native Asian
 Caucasian/White Hispanic/Latino Native Hawaiian/Pacific Islander
 Multiracial/Multiethnic

⁸⁸ For example, the Governor’s executive appointment interest form asks these questions: “Would you briefly describe any experience, knowledge, or expertise you have with racial equity in public policy or public service?” and “If you are selected to serve, what are the opportunities you see for that board or commission to address racial equity?”

https://www.oregon.gov/gov/admin/SiteAssets/Pages/How_To_Apply/Interest%20Form.pdf

- Include regular discussions of Committee member diversity as part of Committee agendas

Support retention of diverse Committee members

- Develop and implement standardized orientation and training materials and processes for new members across all OHPB Committees⁸⁹
- Provide ongoing technical assistance and training to OHPB Committee members, including buddy-pairing/mentoring, and proactive check-ins and debriefings in between Committee meetings
- Conduct “exit interviews” with Committee members who term out or resign that includes questions about their experience on the Committee as inclusive and equitable, and their recommendations for increasing Committee diversity, including identifying potential diverse Committee members from their own networks

Recommend changes to authorizing statutes and charters to increase Committee member diversity

- Consider adding lived experience and cross-cultural experience, and other expertise in health equity generally, and racial equity specifically, as a requirement for *all* OHPB Committees
- Consider adding one or more consumer seats to *all* OHPB Committees
- Consider removing some sector requirements from authorizing statutes and charters

Note: the following recommendations go beyond recommendations to increase Committee member diversity and are recommendations for more inclusive Committee operations and practices; however, comprehensive recommendations on inclusion, and ultimately, equity need more research, analysis, consultation, and development.

C. Implement more inclusive OHPB Committee meeting practices

1. Ensure access to all OHPB Committee meetings
2. Highlight public comments and other community partner input
3. Practice inclusive decision making

Ensure access to all OHPB Committee meetings

- Rotate venues for in-person meetings, especially outside the Portland metro/tri-county area, and ensure that meeting venues are accessible and can support optimal videoconference participation
- Consider more virtual/videoconference meetings that include using chat functions, breakout groups, polling, language interpretation, close captioning, and other technologies for maximizing participation from both Committee members and the public
- Ensure public access to Committee meetings for individuals with languages other than English and for individuals with disabilities

⁸⁹ Training materials for Governor-appointed Boards and Commissions do include some content on diversity and inclusion (Module 5): <https://www.oregon.gov/das/HR/Documents/BC.pdf>

- Standardize a policy for stipends for meeting attendance by Committee members who are not able to use paid work time to attend meetings that take into consideration travel time, preparation time, and other time spent on Committee work⁹⁰
- Consider providing childcare, or reimbursement for childcare expenses, for Committee members during meetings (and any required travel time)

Although not limited to state government Committee meetings, the Governor’s Diversity, Equity, and Inclusion Plan includes recommendations for inclusive practices when communicating and engaging with diverse community members:⁹¹

- Language access and literacy: Ensure multilingual Oregonians with limited English proficiency (LEP) and English language learners have access to translated material in appropriate languages. Translate important information and guidance in a timely way. Information should be communicated clearly, in ways that are culturally and linguistically responsive to the intended community.
- Shift focus from written to spoken word and other ways of sharing information: Language access also means not always relying on the written word to convey meaning, so consider video and audio recordings for communities who cannot read or write.
- Accessibility: Ensure people with disabilities have access to information in appropriate formats (e.g., closed captioning, sign language interpretation, and/or other accommodations) that at a minimum comply with the Americans with Disabilities Act (ADA).
- Trauma-informed communications: Recognize traumas people experience due to marginalization, inequity, violence, PTSD, and other structural factors. Avoid language and messages that exacerbate these inequities.

Several interviewees noted that more inclusive meetings required intentionality, and planning by both OHA staff and the chairpersons of the OHPB Committee, and resources to support accessibility, including language interpretation and translation, and physical and communications access for individuals with disabilities. When there is a return to in-person meetings, making childcare and supporting needed transportation is also essential. While there are some OHA-wide policies and processes that provide guidance about these accessibility issues – and there were significant improvements in standardizing these processes during COVID-19 – there should be clear guidance developed for the OHPB Committees that standardize these processes and clarify issues such as budgeting for resources needed. The proposed implementation plan includes development of such guidance.

⁹⁰ OHA has a stipend policy for consumers and family members serving on Addictions and Mental Health advisory councils (\$50/meeting): <https://www.oregon.gov/oha/HSD/AMHPAC/Documents/Stipend-Policy.pdf>. However, some OHPB Committees, such as HPQMC, have statutory prohibitions on compensation for Committee members:

<https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Meeting%20Documents/2-HPQMC-statutes.pdf>.

Oregon House Bill 2992 is currently pending, which would create statutory authority for OHA to provide stipends of \$30/day for Committee members who are low-income, <https://legiscan.com/OR/text/HB2992/id/2250539>.

⁹¹ State of Oregon Diversity, Equity, and Inclusion Plan: A Roadmap to Racial Equity and Belonging, August 2021, https://www.oregon.gov/das/Docs/DEI_Action_Plan_2021.pdf

During COVID-19, all OHPB Committees were shifted from in-person meetings to virtual or videoconference meetings. While digital divide access and affordability barriers are faced by some individuals in rural areas, senior citizens, individuals who speak languages in addition to English, and individuals with disabilities, there can be supports such as subsidies for broadband service, or making local locations with more broadband service, e.g., a hospital, a community health center, CCO office, available for Committee members to go to, and participate in the videoconference from.

Several organizations that support the work of government officials have observed that virtual meetings can increase inclusion of community organizations and other interested parties that have barriers to participating, or have been excluded from, in-person meetings.⁹² Currently, there is no clear guidance for OHPB Committees whether virtual meetings will continue after the COVID-19 public health emergency has ended. While there are some statutory and charter requirements for regular OHPB Committee meetings, there is no specification for how to conduct those meetings. Accordingly, it is strongly recommended that all OHPB Committees continue with a combination of virtual and in-person meetings to increase inclusion and maximize access and participation for both Committee members and members of the public. For example, an annual Committee retreat might be held in-person, but monthly meetings could continue to be virtual meetings.

OHA's Public Health Division, together with the Department of Human Services, has developed a comprehensive guide for conducting inclusive virtual meetings.⁹³ All OHPB Committees should adopt and implement this guide.

OHA staff and OHPB Committee chairpersons may need training and support to understand how to effectively implement these processes, similar to trainings that support health care providers work with health care interpreters, or trainings to support the use of videoconferencing functions such as captioning and breakout groups. The role of the Committee chairperson is especially important for establishing and modeling more inclusive meeting practices.⁹⁴

There should also be processes developed and implemented for continuous quality improvement of Committee meetings and processes. Several CCO CACs use short,

⁹² California Little Hoover Commission, The Government of Tomorrow: Online Meetings, 2021, <https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/261/Report261.pdf> and Mercatus Center, George Mason University, Crisis as Opportunity: Strategies for Integrated and Inclusive Public Engagement with Local Government, 2021, https://www.mercatus.org/system/files/labosier_-_policy_brief_-_crisis_as_opportunity_strategies_for_integrated_and_inclusive_public_engagement_with_local_government_-_v1.pdf

⁹³ OHA and ODHS, ADA Guidance for Emergency Managers and Local Public Health Authorities, 2020 (includes Guide for Facilitating Inclusive Virtual Meetings) <https://sharingsystems.dhsoha.state.or.us/DHSForms/Served/le2309.pdf>; the National Association of County and City Health Officials makes similar recommendations: National Association of County and City Health Officials, Learning Together: Creating Engaging, Accessible, and Inclusive Virtual Meetings, 2020 <https://www.naccho.org/blog/articles/learning-together-creating-engaging-accessible-and-inclusive-virtual-meetings>

⁹⁴ Institute for Local Government, Understanding the Role of Chair, https://www.ca-ilg.org/sites/main/files/file-attachments/understanding_the_role_of_chair_nov_2012_3.pdf?1396626970

immediate meeting feedback forms to collect recommendations for improving CAC meetings,⁹⁵ Such feedback forms and other methods to obtain recommendations for improving Committee meetings should be implemented across all the OHPB Committees.

Highlight public comments and other community partner input

- Examine processes for public comment at Committee meetings

Currently, most OHPB Committees only allocate a few minutes for public comment, and there are few comments made by the public, creating a cycle of potential misperception that the public comment process is not valuable or effective.

However, as OHPB Committees are charged to re-center the voices and perspectives of those most impacted by OHA policies in their work, it will be necessary to shift more time on meeting agendas to hearing from, listening to, and responding to community partners, and ultimately, to those most impacted by OHA policies. In other words, the public comment process should not be viewed as merely one required part of OHPB Committee meeting but should become the foundation for the most important task of the Committee: ensuring that the policies being discussed and recommended by the Committee are based on the priorities and recommendations of Oregonians most impacted by those policies. It becomes the work of the OHA staff and the OHPB Committees to develop and implement policies that bring in, highlight, and elevate those voices and perspectives.

For example, OHPB Committee meetings could be re-structured to include presentations, testimonies, and other sharing from impacted community partners and advocates, that would include extended public comment periods to hear from additional community members. This would require OHA staff and Committee chairpersons to work to identify appropriate community representatives and advocates that could speak about the issues, policies, and decisions to be made by that Committee. The Committee chairpersons and all Committee members would be responsible for creating safe, welcoming, and inclusive environments during the Committee meeting, need to be active listeners, and also need to be prepared with questions. The Committee should transparently discuss what specific actions they will take in response to what they heard and be accountable to specific timelines for follow-up and reporting back to the community partners. Committee minutes should reflect what was shared, and these Committee commitments to respond, follow-up, and report back.

Practice inclusive decision making

- Make more regular use of votes for Committee decision making; when there are structural imbalances on a Committee, e.g., only one “consumer” seat compared to multiple seats representing health care providers, consider weighting votes from consumer and other under-represented seats to address the imbalance until changes in statute or charters can be made

⁹⁵ CAC Handbook of Best Practices, <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CAC-Learning-Community.aspx>

- Develop and implement engagement and decision-making processes that begin to shift resources, and ultimately, power to diverse, under-represented, and excluded populations

D. Implement OHPB Committee work on equity

1. Provide training to OHA Committee staff and Committee chairs and members about diversity, inclusion, and equity
2. Identify and use equity tools
3. Use an equity analysis as part of every decision and policy

Provide training to OHA Committee staff and Committee chairs and members about diversity, inclusion, and equity

- Identify training, technical assistance, and skills-building needs of OHA Committee lead staff and OHPB Committee chairs, and develop and implement a training and technical assistance workplan
- Seek regular feedback from Committee members about the inclusiveness of Committee procedures, processes, and practices, and establish measurable and feasible milestones for continuous improvement
- Include consideration of knowledge about and working relationships with external partners from diverse, under-represented, and excluded communities and populations as an asset in recruiting and promoting Committee lead staff

Identify and use equity tools

Finally, if OHPB Committees are to succeed in advancing health equity, they must begin to apply an equity analysis to all their work. There are many tools and processes that can support an equity analysis.⁹⁶ For example, the Governor’s Diversity, Equity, and Inclusion Plan includes a racial equity assessment worksheet with questions to examine the equity impacts of budgetary and programmatic decisions.⁹⁷

Among the questions that should be asked:

- Who benefits from the program, both directly and indirectly?
- Who will be burdened from the proposal?
- How does the program increase or decrease racial equity? Does the program have potential unintended racial equity consequences? What benefits may result?

⁹⁶ Government Alliance for Racial Equity, *Racial Equity: Getting to Results*, 2017, https://www.racialequityalliance.org/wp-content/uploads/2017/09/GARE_GettingtoEquity_July2017_PUBLISH.pdf; Government Alliance for Racial Equity, *Racial Equity Action Plans*, 2016, <https://www.racialequityalliance.org/wp-content/uploads/2016/11/GARE-Racial-Equity-Action-Plans.pdf>; Government Alliance for Racial Equity, *Racial Equity Toolkit*, 2015, https://racialequityalliance.org/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf; and International City/County Management Association, *Governing for Equity: Implementing an Equity Lens in Local Government*, 2020, https://icma.org/sites/default/files/Governing%20For%20Equity%20Implementing%20an%20Equity%20Lens%20in%20Local%20Government_0.pdf; Race Forward, *Racial Equity Impact Assessment Toolkit*, 2009, https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf

⁹⁷ State of Oregon Diversity, Equity, and Inclusion Plan: A Roadmap to Racial Equity and Belonging Appendix 1, August 2021, https://www.oregon.gov/das/Docs/DEI_Action_Plan_2021.pdf

Other questions that should be asked include:

- How are we ensuring we have representation of voices across race, ethnicity, culture, color, Tribal membership, disability, gender, gender identity, marital status, national origin, age, religion, sexual orientation, socio-economic status, veteran status, and immigration status? And geographically?
- What are the ways we engage agency equity leaders and communities in decision making currently?
- Whose voices and perspectives are not at the table? Why?
- What can we do to ensure they are part of our decision-making process?
- What are the barriers that keep communities from participating in decision making?

The OHA Division of Equity & Inclusion guidance for inclusive community engagement recommends asking these questions:⁹⁸

- Are community partners leading the direction of the work, or are we plugging them into our agenda?
- Is there shared decision making with all parties impacted?
- Are community partners at the intersections (e.g., people of color with disabilities) who are most impacted by the topic or issue, present and fully participating?
- Are there more accessible ways for information be conveyed (e.g., visuals, audio presentation, role-play)?

Use an equity analysis as part of every decision and policy

The Metrics and Scoring Committee recently completed a health equity assessment of CCO incentive measures.⁹⁹ The Health Care Workforce Committee recently developed a health equity framework.¹⁰⁰ The OHA Division of Equity & Inclusion has developed an equity analysis for proposed legislation,¹⁰¹ which has begun to be implemented by OHA as a whole.¹⁰² These are examples of how OHPB Committees can use equity tools as part of their decision making and policies.

CONCLUSION

Achieving the OHA goal of equity and eliminating health inequities requires transformational change. Increasing the diversity of OHPB Committee members to better reflect the diversity of Oregonians, populations and communities who have been under-represented and excluded, and the lived experiences of Oregonians most impacted by OHA and OHPB policies will not, in and of itself, achieve equity. These findings and recommendations are an additional step in that journey towards that transformational change by OHA and the OHPB Committees.

⁹⁸ OHA, Division of Equity & Inclusion, Community Engagement Strategies Checklist

https://www.oregon.gov/oha/OEI/Documents/Community%20Engagement%20Strategies%20Checklist_vOHA_FINAL.pdf

⁹⁹ <https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/6b.-05.2021-MSC-Equity-Impact-Assessment-Report.pdf>

¹⁰⁰ <https://www.oregon.gov/oha/HPA/HP-HCW/Meeting%20Documents/4.-HCWF-Committee-Equity-Framework-Report.pdf>

¹⁰¹ OHA, Division of Equity & Inclusion, Equity and Inclusion Bill Analysis,

<https://www.oregon.gov/oha/OEI/Documents/Health%20Equity%20and%20Inclusion%20Lens%20for%20Bill%20Analysis%20FINAL.PDF>

¹⁰² <https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/OHA%202021%20Legislative%20End%20of%20Session%20Report.pdf>

APPENDIX A: OHPB COMMITTEE MEMBERSHIP WORKGROUP CHARTER

OREGON HEALTH POLICY BOARD COMMITTEE MEMBERSHIP WORKGROUP CHARTER

Approved December 2020, Updated June 2021

Current Reality

The Oregon Health Policy Board (Board) and its committees are important decision-making and advisory bodies that need more member representation in the following areas:

- Expertise in equity, diversity and inclusion;
- Representation from communities experiencing health inequities;
- Can contribute the unique knowledge of lived experiences from underrepresented communities; and
- Allies with the willingness to learn and take meaningful action to break down barriers to achieving health equity.

These challenges are perpetuated due to structural and legislative barriers, historic and contemporary inequities and biases, unclear and inaccessible processes, and an inadequate level of dedicated time and resources for committee member recruitment and capacity building with under-voiced communities.

Without more diverse representation in policy development, policies have the potential to exacerbate discrimination. When we design programs and provide services that improve health for people of color, immigrants, refugees, people with limited English proficiency, and LGBTQ+ communities, all age groups and people with disabilities, everyone benefits.

Background

At the September 2020 Oregon Health Policy Board (Board) meeting, a proposed membership roster for a committee of the Board was presented for approval. The roster was not approved because it did not sufficiently represent the diverse communities that OHA serves. The Board asked the Oregon Health Authority (OHA) to reconsider committee recruitment and diversity efforts. At this meeting, a comprehensive definition of diversity was not established nor was specific guidance for what constitutes acceptable committee diversity.

Workgroup Purpose

The OHPB Committee Membership Workgroup (“Workgroup”) is chartered to identify and provide recommendations to the structural and procedural barriers that limit the recruitment and retention of diverse committee members. This effort will result in a committee that better represents all Oregonians and supports OHAs 10-year goal of eliminating health inequities by 2030.

This work will be grounded in alignment with OHA’s Health Equity definition, the Oregon Public Health Association’s (OPHA) Diversity definition, as well as the following principles for policymaking, which include:

- Empowering community leaders to co-create policies that impact their communities;
- Addressing clinical and social conditions, as well as the historical and contemporary injustices, which harm health;
- Respecting diverse cultures, populations, histories, and health practices by being inclusive, accessible, and developing action steps to address barriers to health; and
- Consideration of the diversity of Oregon’s communities by ensuring representation on OHA boards, councils, and committees.

As Board committees continue to fill vacant positions, it is critical and timely that guidance be provided for the recruitment and retention of committee membership. Members and committee decisions should reflect the communities that may be most impacted by policy and programmatic decisions.

The OHPB Committee Diversification Workgroup is charged with:

1. Informing and developing a process for ensuring diverse and equity-focused committee membership.
2. Providing guidance on best practices for committee recruitment and retention.
3. Providing recommendations for systemic changes that will support diverse and equity-focused committee membership.

Duration

The Workgroup acknowledges adherence to traditional structural policies and procedures may not be supportive of new pathways to achieve its charge. The Workgroup aims to achieve its deliverables within six months (through April 2021) and will try to fit within predetermined structures if it does not impact the quality of the work. If initial exploratory efforts identify longer-term or ongoing needs, the timeline may be adjusted.

Deliverables

The workgroup is responsible for the following deliverables:

1. Workgroup Charter
2. Identify common working definitions
3. Workgroup Workplan
4. Root cause analysis and gap analysis
5. Legislative Recommendations (for structural, procedural, and resource changes)
6. Committee recruitment and retention - Implementation plan
7. Membership Diversity Tracker

Additional deliverables may be identified once the workgroup has begun. The workgroup is expected to serve as a resource as needed between completing initial deliverables in May and completing a transition to the longer-term structure.

Out of Scope

The workgroup is not responsible for addressing the following:

- Selection of committee membership for any committee
- Implementing legislative and policy changes (responsible staff for implementation will be identified at a future date)
- OHA committees outside of OHPB and its committees

Governance and Membership

The Workgroup will utilize a multi-team approach, with a broader workgroup to ensure coordination and content development, and two smaller teams (OHA leadership and Board sponsors) to provide guidance and decision-making authority.

OHA Executive Sponsors

Dawn Jagger (OHA Chief of Staff)
 Leann Johnson (Director, Division of Equity and Inclusion)

OHA Leadership Team

The leadership team is responsible for providing direction to the broader workgroup and reviewing and approving deliverables the workgroup is producing. The leadership team is also responsible for identifying others within their agencies or divisions that need to be involved and raising concerns or other decision points to higher level leadership where necessary.

The leadership team will meet **monthly**, and all leadership team members may also participate in the workgroup.

Agency	Division	Staff
OHA	External Relations Division	Dawn Jagger, Chief of Staff
	Division of Equity & Inclusion	Leann Johnson, Director
	Health Policy & Analytics Division	Trilby de Jung, Deputy Director
	Office of Health Information & Technology	Susan Otter, Director
OHPB	Vice-chair	Oscar Arana
	Member	Ebony Clarke
	Member	Brenda Johnson
	Member	John Santa

Workgroup Team

The broader workgroup is responsible for producing the deliverables for leadership review. The broader workgroup will meet **twice monthly**, with ad-hoc meetings as needed. Workgroup members who also participate in related groups may be tasked with providing updates to keep the work aligned. Some workgroup members may also be asked to participate in the leadership team meetings.

Agency	Division	Function	Staff
Independent Contractor		Project Lead	Ignatius Bau
OHA	Health Policy & Analytics Division	Policy and analytics staff support for OHPB committees	Susan Otter, Staff Lead Tara Chetock, Project Manager Deepti Shinde Joseph Sullivan Jeannette Taylor
	Division of Equity & Inclusion	Policy staff support for HEC; community engagement and outreach expertise	Maria Castro Danielle Droppers
	External Relations Division	Community engagement and outreach expertise	Karina Reardon

Additionally, the Workgroup may utilize the “Committees of the OHPB” staff monthly meeting for additional feedback, collaboration, and advisory functions, which includes staff from HPA, PHD, and D/OEI.

(*) Definitions

Below are working definitions of commonly used terms to create a mutual understanding among the Workgroup, sponsors, partners and stakeholders. Terms and definitions will be added and updated throughout the duration of this work. A final list of defined terms will be provided by the Workgroup (deliverable #2).

Diversity: The unique individual differences in our qualities, and characteristics that exist among us that must be respected, honored and recognized. These differences include but are not limited to: race, ethnicity, gender identity, sexual orientation, age, religion, immigration and refugee status, disability status, education, interests, family status, appearance, geography, socioeconomic status, employment status, citizenship, lived experience, relationship status, job function, linguistics, and historical and cultural awareness. OPHA centers racial diversity relative to all of its diversity, equity and inclusion efforts. The OPHA honors the diversity of professions that contribute to public health and recognizes the need for workforce diversity in

public health, health systems, healthcare and other professions essential for promoting and protecting the health of the public.

Source: Oregon Public Health Association

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

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

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

Source: Oregon Health Authority

Allies: To be defined.

Consumer Representatives: To be defined.

APPENDIX B: SOURCES FOR ENVIRONMENTAL SCAN

The following documents and materials were reviewed, and external community and health care partners and internal (OHA and OHPB) representatives consulted, as sources for the environmental scan to support the root cause analysis, gap analysis, findings, and recommendations in this report.

OHA and Oregon government documents and materials reviewed

- Reviewed Oregon Health Policy Board (OHPB) Committee member requirements, demographic data, recruitment practices, application forms, and selection processes
- Reviewed statutes and charters, and policies related to Committee member participation (meeting locations, travel, compensation, etc.)
- Reviewed OHPB discussions about Committee member diversity in September and October 2020, Committee Membership Workgroup charter, and provisional guidance for Committee membership recruitment
- Reviewed Oregon Health Authority (OHA) Health Equity Committee (HEC) definition of health equity¹⁰³ and background materials
- Reviewed application for Division of Equity & Inclusion Developing Equity Leadership through Training and Action (DELTA) program
- Reviewed demographic report template and resources for Coordinated Care Organization (CCO) Community Advisory Councils (CACs)¹⁰⁴
- Reviewed Healthier Together Oregon: 2020-2024 State Health Improvement Plan (September 2020)¹⁰⁵
- Reviewed Governor's Equity Framework in COVID-19 Response and Recovery (June 2020)¹⁰⁶
- Reviewed Governor's Diversity, Equity, and Inclusion Plan (August 2021)¹⁰⁷
- Reviewed demographic data about Oregon Health Plan (OHP) members¹⁰⁸ and health professionals licensed and practicing in Oregon¹⁰⁹
- Reviewed background information and application processes for Governor-appointed Boards and Commissions¹¹⁰

¹⁰³ <https://www.oregon.gov/oha/OEI/Pages/Health-Equity-Committee.aspx>

¹⁰⁴ <https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CAC-Learning-Community.aspx>

¹⁰⁵ Healthier Together Oregon: 2020-2024 State Health Improvement Plan, 2020, <https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/2020-2024/Healthier-Together-Oregon-full-plan.pdf>

¹⁰⁶ https://www.oregon.gov/gov/policy/Documents/EquityFrameworkCovid19_2020.pdf

¹⁰⁷ State of Oregon Diversity, Equity, and Inclusion Plan: A Roadmap to Racial Equity and Belonging, August 2021, https://www.oregon.gov/das/Docs/DEI_Action_Plan_2021.pdf

¹⁰⁸ Monthly Medicaid Population Report, CCO by Gender and Race/Ethnicity for Physical Plan Type, May 2021 (preliminary), <https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/May%202021%20Physical%20Health%20Service%20Delivery%20by%20Gender%20and%20Race-Ethnicity.pdf>

¹⁰⁹ <https://www.oregon.gov/oha/HPA/HP-HCW/Documents/2021-Health-Care-Workforce-Needs-Assessment.pdf>; Oregon Health Professions by occupation and county, 2015, <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8120.pdf>

¹¹⁰ https://www.oregon.gov/gov/admin/Pages/How_To_Apply.aspx

OHPB and OHA sponsors and staff consulted

- Had videoconferences with OHPB sponsors (videoconferences were conducted individually with OHPB members to comply with meeting quorum rules)
- Had videoconferences with OHA executive sponsors
- Had videoconference with OHA Tribal Affairs Director
- Had videoconference with OHA Division of Equity & Inclusion REALD subject matter expert
- Had videoconference with OHA Division of Equity & Inclusion Americans with Disabilities Act coordinator/civil rights investigator
- Had phone conversation with OHA Division of Equity & Inclusion DELTA program coordinator
- Had videoconference with OHA Transformation Center staff about CCO CACs
- Had videoconferences with Committee Membership Workgroup
- Had videoconferences with lead staff of Committees; had follow-up interviews or follow-up by email with lead staff of HEC, Health Care Work Force Committee (HCWF), Health Plan Quality Measures Committee (HPQMC), Metrics and Scoring Committee (MSC), Health Information Technology Oversight Council (HITOC), and Public Health Advisory Board (PHAB)
- Had videoconference with OHA staff at COVID-19 Rapid Response Unit
- Had videoconference with OHA staff for Measure 110 Implementation Committee

External community, health care, and public health partners consulted

- Interviewed staff from Regional Health Equity Coalitions (RHECs), Northwest Portland Area Indian Health Board, community-based organizations, and philanthropic partners about knowledge and experience with OHPB Committees, and recommendations for increasing Committee member diversity
 - Oregon Health Equity Alliance: Zeenia Junkeer, Director
 - Linn Benton Health Equity Alliance: Seynabou-Denise Niang, Coordinator
 - Eastern Oregon Health Equity Alliance: Roberto Gamboa, Operations Manager, and Norma Ramirez, Program Manager
 - Mid-Columbia Health Advocates: Dawn LeMieux, Program Coordinator
 - Coastal Equity and Inclusion Committee (CEIC) of Lincoln County: Rosa Coppola, Committee Chairperson
 - Confederated Tribes of Warm Springs: Jaylyn Suppah, former Community Planner
 - Northwest Portland Area Indian Health Board: Susan Steward, Deputy Director, and Nora Frank, Food Sovereignty Initiatives Director
 - Oregon Law Center: Holly Pennock, Paralegal
 - Bridges Oregon: Chad Ludwig, Executive Director
 - Basic Rights Oregon: Jo Doyle, Leadership Development Program Manager, and Seth Johnstone, Transgender Justice Lead Trainer and Organizer
 - Equi Institute: Katie Cox, Executive Director
 - Pride Northwest: Debra Porter, Executive Director
 - Olaalla Center: Beck Johnson, Director, Bravery Center
 - African Family Holistic Health Organization: Joy Mulamba, Manager

- Meyer Memorial Trust: Dahnes Medora, Building Community Portfolio Director
- Collins Foundation: Carol Cheney, Chief Executive Officer
- Interviewed staff from key health care and public health partners about knowledge and experience with OHPB Committees, and recommendations for increasing Committee member diversity
 - Oregon Health Leadership Council: Greg Van Pelt, President
 - CCO Oregon: Samantha Shepherd, Executive Director
 - Oregon Primary Care Association: Danielle Sobel, Policy & Governmental Affairs Senior Director, and Courtney Kenney, Health Equity & Policy Manager
 - Oregon Association of Hospitals and Health Systems: Sean Kolmer, Senior Vice President of Policy and Strategy; Andi Easton, Vice-President of Government Affairs; and Katie Harris, Director of Rural Health & Federal Policy
 - Oregon Council for Behavioral Health: Heather Jefferis, Executive Director
 - Oregon Office of Rural Health: Robert Duehmig, Interim Director
 - Oregon Academy of Family Physicians: Betsy Boyd-Flynn, Executive Director
 - Oregon Dental Association: Barry Taylor, Executive Director
 - Oregon Nurses Association: Deborah Riddick, Director of Governmental Relations
 - Oregon Public Health Association: Jessica Nischik-Long, Executive Director
 - Women in Healthcare, Oregon Chapter: Liberty Pertiwi, President
 - Jackson Care Connect: Michael Klein, Community Advisory Council Coordinator

External documents and materials reviewed

- Reviewed demographic data about Oregon’s population and health professionals
- Reviewed reports and resources about consumer and community engagement¹¹¹ and membership on state government health policy committees, commissions, and other advisory groups¹¹²
- Reviewed external resources for conducting inclusive meetings and implementing tools to advance health equity

¹¹¹ <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Community-Advisory-Councils.aspx>

¹¹² <https://www.cacenter.org/cac/reports>

APPENDIX C: STATUTORY AND CHARTER REQUIREMENTS FOR OHPB COMMITTEE MEMBERSHIP

Acronyms	
CCO	Coordinated Care Organization
CGT	Cost Growth Target Implementation Committee
CLHO	Coalition of Local Health Officials
CMS	Centers for Medicare & Medicaid Services
DAS	Department of Administrative Services
DCBS	Department of Consumer and Business Services
DHS	Department of Human Services
HCWF	Health Care Workforce Committee
HEC	Health Equity Committee
HITOC	Health Information Technology Oversight Council
HPQMC	Health Plan Quality Metrics Committee
LPHA	Local Public Health Authority
M&SC	Metrics & Scoring Committee
MAC	Medicaid Advisory Committee
OEBS	Oregon Educators Benefit Board
OHA	Oregon Health Authority
OHLC	Oregon Health Leadership Council
OHPB	Oregon Health Policy Board
PCPRC	Primary Care Payment Reform Collaborative
PEBB	Public Employees Benefit Board
PH	Public Health
PHAB	Public Health Advisory Board

Table 1. Appointment, Membership Maximums, and Voting Status of OHPB Committees with Designated Membership Seats

	PHAB	HPQMC	MAC	M&S	PCPRC
Statutory Reference	ORS 431.122	ORS 413.017	ORS 414.211	ORS 414.638	Sections 2 to 5, chapter 575, Oregon Laws 2015
Member Approval Body	Governor	OHPB	Governor	OHA Director	OHA staff and/or Collaborative member recommendation
Statutory Membership Maximums	17	15	15	9	None
Voting vs. Nonvoting Members	Nonvoting members are the OHPB designee; Public Health Director; State Health Officer.	All members in statute are voting members. Per HPQMC by-laws, the chair or vice chair of the Metrics and Scoring Committee and the OHPB liaison also may participate in HPQMC meetings, but not voting members of HPQMC.		All members in statute are voting members.	

Table 2. OHPB Committees with Designated Membership Seats

		PHAB	HPQMC	MAC	M&S	PCPRC	Subtotal	Total
Federally Recognized Indian Tribes		1					1	1
Centers for Medicare & Medicaid Services (CMS)						1	1	1
State Agency	OHA	3	1	1			5	10
	DCBS		1			1	2	
	DHS			1			1	
	PEBB/OEBB		2				2	
Advisory Bodies (including OHPB)		1					1	1
Health Care Analysis	Health Research		1				1	5
	Health Care Measurement		1		3		4	
Insurers/CCOs	Insurers		1			1	2	11
	Coordinated Care Organization (CCO)	1	2	1	3		7	
	Health Care Org. Not a CCO	1					1	
	Self-insured					1	1	
Hospitals/Health Systems and (urban/rural) & Providers	Hospitals/Health Systems		1				1	11
	Primary care contracting and reimbursement					1	1	
	Independent Physician Association					1	1	
	Statewide organization for mental health professional who provide primary care					1	1	
	Statewide organization representing federally qualified health centers					1	1	
	Health Care Provider (including licensed and certified health professional)		2			3	5	
	Behavioral Health		1				1	
Public Health*	Local Public Health Agency	5					5	9
	Public Health	2					2	

		PHAB	HPQMC	MAC	M&S	PCPRC	Subtotal	Total
	Research/Metrics							
	Public Health Provider	1					1	
	Coalition of Local Health Officials (CHLO, nonprofit)	1					1	
Consumer Representation	Consumers			2		1	3	7
	Consumer Representatives		2	2			4	
Misc.	Behavioral Health Expertise			1			1	8
	Members At Large/General Public	1			3	3	7	
TOTAL**		17	15	8	9	15	64	64

*Three public health related positions are captured under the state agency category.

**Counts represent at least one designated seat for each category type as some committees established a cap on the total number of members representing various categories, e.g., no more than 13 members appointed by the Governor to represent nine category/representative. As a result, these numbers also do not equal committee membership caps nor do they reflect total committee membership counts.

The board and three of its nine committees do not have specific designations for seats in statute. Rather the statutory or chartered requirements for these bodies describe a collective expertise required of their membership to accomplish their respective charges. The board and those committees are summarized in Table 3.

Table 3. OHPB and Committees Without Designated Committee Seats

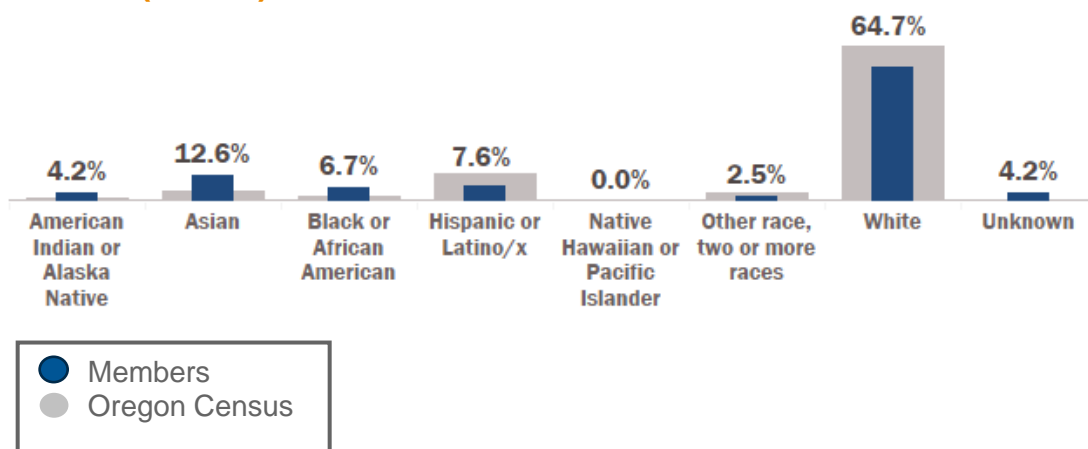
	OHPB	HCWF	HEC	HITOC
Statutory Reference	ORS 413.007	ORS 413.017	N/A	ORS 413.308
Membership Requirements	<p>(1) OHPB consists of individuals who:</p> <p>(a) Are United States citizens and residents of this state;</p> <p>(b) Have demonstrated leadership skills in their professional and civic lives;</p> <p>(c) To the greatest extent practicable, represent the various geographic, ethnic, gender, racial and economic diversity of this state; and</p> <p>(d) Collectively offer expertise, knowledge and experience in consumer advocacy, management of a company that offers health insurance to its employees, public health, finance, organized labor, health care and the operation of a small business.</p> <p>(2) No more than four members of the board may be individuals:</p> <p>(a) Whose household incomes, during the individuals' tenure on the board or during the 12-month period prior to the individuals' appointment to the board, come from health care or from a health care related field; or</p> <p>(b) Who receive health care benefits from a publicly funded state health benefit plan.</p> <p>(3) No more than four members of the board may be, during the individuals' tenure on the board or during the 12-month period prior to the individuals' appointment to the board,</p>	<p>...individuals who have the collective expertise, knowledge and experience in a broad range of health professions, health care education and health care workforce development initiatives...</p>	<p>...individuals who are experienced and skilled in the review, analysis and development of health equity policy and results-proven implementation, including but not limited to the social determinants of health. Members shall include health equity professionals or individuals who have life experience in health equity policy advocacy and policymaking processes, community members, and health equity practitioners. Applications shall be solicited from a diverse group of candidates. Selection shall be made to ensure the committee is representative of communities experiencing health disparities, including, but not limited to racially and ethnically diverse populations, linguistically diverse populations, immigrant and refugee populations, LGBT populations, the aging population, people with disabilities, rural communities, and economically disadvantaged populations as well as individuals with</p>	<p>Appoint members to the council who, collectively, have expertise, knowledge or direct experience in health care delivery, health information technology, health informatics and health care quality improvement.</p>

	OHPB	HCWF	HEC	HITOC
	employed in a health care or health care related field. (4) At least one member of the board shall have an active license to provide health care in Oregon and shall be appointed to serve in addition to the members offering the expertise, knowledge and experience described in subsection (1)(d) of this section.		experience transforming health equity in operational settings.	
Member Approval Body		OHPB	OHPB	OHPB
Membership Maximum		None	15	11-15
Voting vs. Nonvoting Members		There are currently 17 voting and 0 non-voting members. Up to two non-voting members may be included per the Committee Charter.		

APPENDIX D: DEMOGRAPHIC AND SECTOR REPRESENTATION ACROSS OHPB COMMITTEES

OHA staff presented the following analysis of the demographic data collected for OHPB and Committee members at the October 2020 OHPB Meeting. The analysis shared here is a point in time, capturing demographic data for 119 members across 8 committees (not including the Primary Care Patient Reform Collaborative). In this analysis, “Unknown” is missing or refused, and is not captured by the Census.¹¹³

Race and Ethnicity of Board and Committee Members Compared to Oregon Census (n=119)¹¹⁴

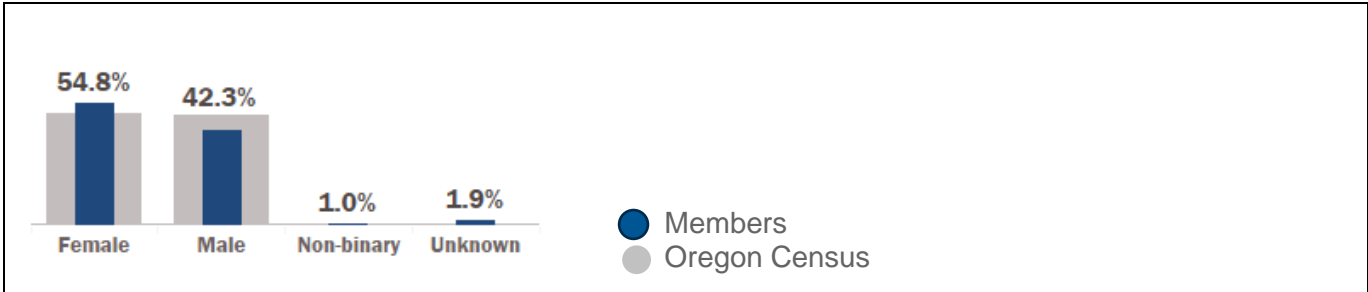


¹¹³ The Primary Care Payment Reform Collaborative is statutorily required to include representatives from specific entities. Demographic data collection has not been required. The Collaborative is committed to improving primary care payment for all Oregonians and looks forward to participating in the Board's process to collect demographic data and ensure broad representation across Board committees.

¹¹⁴ Oregon population race, ethnicity, gender, and disability from U.S. Census Bureau. QuickFacts Oregon, 2019, <https://www.census.gov/quickfacts/OR>; American Community Survey Disability Characteristics, 2019 ACS 1-Year Estimates Data Profiles (Table S1810), <https://data.census.gov/cedsci/table?q=demographic&tid=ACSDP1Y2019.DP05&hidePreview=false>; Oregon population LGBTQ+ from University of California Los Angeles School of Law Williams Institute, <https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=41#density>

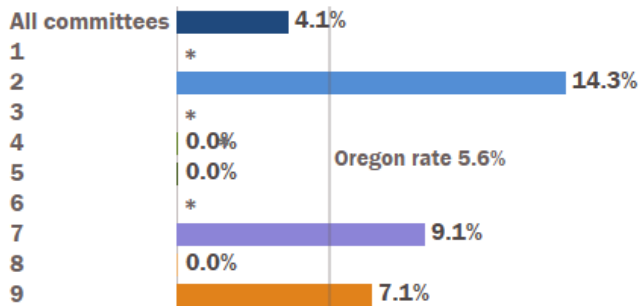
Sex, Sexual Orientation, and Gender Identity of Board and Committee Members Compared to Oregon Census (n=104)

(Unknown and non-binary are not reported by the Census).



Proportion identifying as LGBTQ+

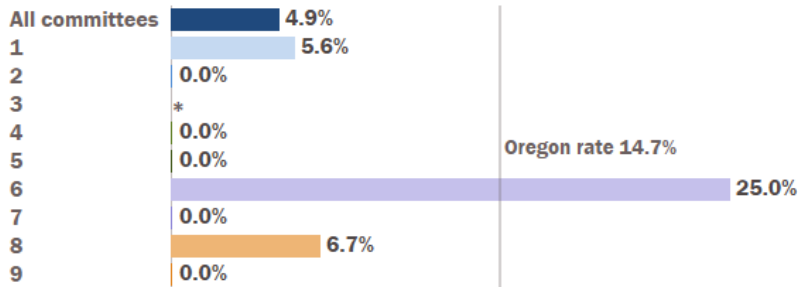
For all committees combined (top) and stratified by de-identified committees (1-9, n = 73). The number of members on each committee ranges from 7 to 18. Grey line references proportion of people identifying as LGBT in Oregon estimated from UCLA. *Data is not available for committees 1, 3, & 6.



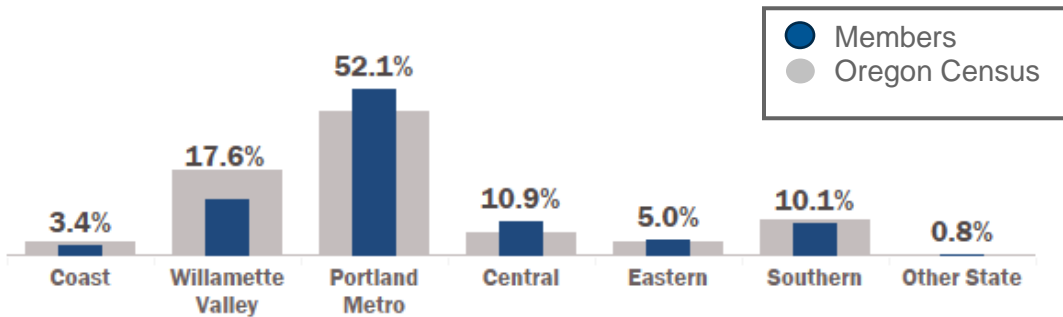
Disability Status of Board and Committee Members Compared to Oregon Census (n=103)

Proportion reporting disability

For all committees combined (top) and stratified by de-identified committees (1-9, n = 103). The number of members on each committee ranges from 7 to 18. Grey line references 2019 Oregon Census population estimates for population with disability.
 *Data is not available for committee 3.



Geography of Board and Committee Members Compared to Oregon Population (n=119)¹¹⁵



Regional Classification of Counties:

Portland Metro: Clackamas, Columbia, Hood River, Multnomah, Washington

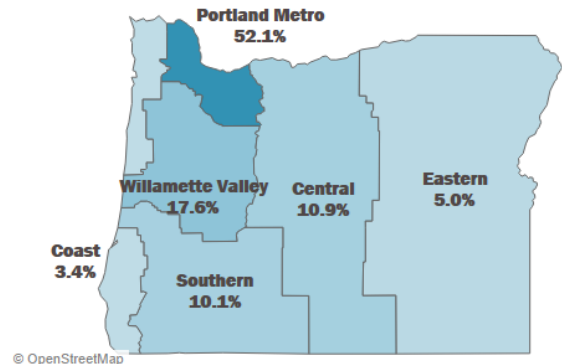
Willamette Valley: Benton, Lane, Linn, Marion, Polk, Yamhill

Coast: Clatsop, Coos, Curry, Lincoln, Tillamook

Central: Crook, Deschutes, Gilliam, Jefferson, Lake, Sherman, Wasco, Wheeler

Eastern: Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, Wallowa

Southern: Douglas, Jackson, Josephine, Klamath



¹¹⁵ Oregon population geography from Population Research Center, Portland State University, 2019, <https://www.pdx.edu/population-research/population-estimates>

Preliminary Analysis of OHPB Committee Members by Sector

In June 2021, OHA staff conducted a preliminary analysis of current Board and Committee members by sector. For the purposes of this analysis, staff assigned each Committee member to one category, although some represent multiple sectors; more work is needed to more accurately capture and reflect representation.

- Payers and providers together make up 43% of committee members
- Consumer, Tribal and other groups have very low representation when compared to other groups
- Potential over-representation: several organizations have multiple members on different committees.

Committee Members by Sector	Number	Proportion
Payer – any type	41	25%
CCO	26	16%
Commercial health insurance	12	7%
Other	3	2%
Provider - any type	29	18%
Academic/educational	20	12%
Public Health Department	12	7%
CBO & advocacy organizations	12	7%
State Agency staff or seats	11	7%
Business - private	11	7%
Association staff / seats	6	4%
Consumer	5	3%
Tribal representative/Tribal provider	3	2%
Other (social services, labor union, employer, insurance broker)	12	7%
TOTAL	162	100%

APPENDIX E: RACIAL AND ETHNIC AND OTHER DIVERSITY OF OREGON POPULATION AND HEALTH CARE PROFESSIONALS

Racial and Ethnic Diversity of Oregon's Population

The most recent U.S. Census data from 2019 show that approximately 30% of Oregonians identify as members of Tribal communities and communities of color (including Hispanics or Latinos of Any Race, and excluding individuals identifying as White or Some Other Race):¹¹⁶

	Oregon	
Label	Estimate	Percent
✓ Race alone or in combination with on...		
✓ Total population	4,217,737	4,217,737
White	3,717,165	88.1%
Black or African American	124,502	3.0%
American Indian and Alaska Nati...	129,081	3.1%
Asian	263,017	6.2%
Native Hawaiian and Other Pacifi...	35,802	0.8%
Some other race	175,072	4.2%

	Oregon	
Label	Estimate	Percent
✓ HISPANIC OR LATINO AND RACE		
✓ Total population	4,217,737	4,217,737
✓ Hispanic or Latino (of any race)	566,839	13.4%

¹¹⁶ American Community Survey, 1-Year Estimate, 2019 for Race Alone or in Combination, and for Hispanic or Latino Ethnicity, <https://data.census.gov/cedsci/table?q=0400000US41&tid=ACSDP1Y2019.DP05&hidePreview=true&moe=false> [the American Community Survey 1-Year estimate provides the most current data while the 5-year estimate has a larger sample size that will have more stratified and granular data on smaller populations: <https://www.census.gov/programs-surveys/acs/guidance/estimates.html>]

Here is the race and ethnicity of children enrolled in Oregon public schools in 2020-2021, showing nearly 40% of the students being from Tribal communities and communities of color:

Count and Calculation	American Indian / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Black / African American	Hispanic / Latino	White	Multi-Racial	Total
Total for 20-21	6,570	22,733	4,335	13,021	137,101	338,528	38,629	560,917
Percentage of Each Group in 2020-21	1.17%	4.05%	0.77%	2.32%	24.44%	60.35%	6.89%	100%
Total for 19-20	7,010	23,208	4,431	13,176	138,273	358,257	38,306	582,661
Percentage of Each Group in 2019-20	1.20%	3.98%	0.76%	2.26%	23.73%	61.49%	6.57%	100%
Percentage Change from 2019-20 to 2020-21	-6.28%	-2.05%	-2.17%	-1.18%	-0.85%	-5.51%	0.84%	-3.73%

Source: Oregon Department of Education, Fall Student Membership Report¹¹⁷

Oregon Health Plan (Medicaid) members are racially and ethnically diverse¹¹⁸



Monthly Medicaid Population Report
CCO by Gender and Race/Ethnicity for Physical Plan Type
May 2021 (Preliminary)

Count of Persons on 15th of the Month	Grand Total
Female	630,764
African American	13,620
American Indian or Alaskan Native	11,838
Asian or Pacific Islander	17,878
Caucasian	236,876
Hispanic	55,931
Other/Unknown	294,621
Male	569,663
African American	14,145
American Indian or Alaskan Native	10,428
Asian or Pacific Islander	14,266
Caucasian	209,846
Hispanic	50,400
Other/Unknown	270,578
Grand Total	1,200,427

¹¹⁷ <https://www.oregon.gov/ode/reports-and-data/students/Pages/Student-Enrollment-Reports.aspx>

¹¹⁸Note that this OHA data report uses “Caucasian” instead of “White” and combines the “Asian” with the “Native Hawaiian and Pacific Islander” categories, which are inconsistent with both federal and Oregon guidelines for race and ethnicity data categories.

Racial and Ethnic Diversity among Health Professionals

An OHA report on the racial and ethnic diversity of Oregon’s health professions shows significant under-representation of Blacks, Hispanic, and American Indian/Alaska Natives among physicians, nurses, social workers, and dentists licensed to practice in Oregon.¹¹⁹

Table 3. Race, Ethnicity, and Gender Distribution: Health Care Workforce vs. Oregon Population

Comparison to state distribution
 Similar to state Below state Above state

		Hisp/Latino	White	Black/AA	AI/AN	Asian	NH/PI	Multi-racial	Other	Fem.	Male
Oregon		12.8%	76.0%	1.8%	0.9%	4.2%	0.4%	3.7%	0.2%	50.4%	49.6%
Medical	Physicians	3.6%	77.3%	1.4%	0.1%	14.4%	0.2%	1.6%	1.4%	40.6%	59.4%
	Podiatrists	1.2%	83.0%	1.2%	0.0%	11.7%	0.6%	1.8%	0.6%	27.5%	72.5%
	Physician assistants	4.2%	87.4%	1.0%	0.3%	4.4%	0.2%	2.2%	0.4%	65.7%	34.3%
	Acupuncturists	3.2%	81.5%	0.3%	0.0%	10.5%	0.2%	3.2%	1.2%	70.3%	29.7%
Nursing	Nurse practitioners	3.8%	86.9%	1.5%	0.4%	3.9%	0.4%	2.4%	0.6%	87.9%	12.0%
	Clinical nurse specialists	0.8%	94.3%	0.0%	0.0%	2.4%	0.0%	2.4%	0.0%	95.9%	4.1%
	Cert. registered nurse anesthetists	3.9%	85.6%	0.8%	0.3%	6.4%	0.6%	2.2%	0.3%	53.9%	46.1%
	Registered nurses	4.3%	85.8%	1.0%	0.5%	4.7%	0.4%	2.9%	0.4%	87.2%	12.7%
	Licensed practical nurses	9.0%	76.3%	4.4%	0.7%	4.6%	0.6%	3.8%	0.5%	87.9%	12.1%
	Certified nursing assistants	16.6%	63.5%	6.6%	1.1%	6.6%	1.2%	3.7%	0.6%	85.3%	14.6%
Social work	Licensed clinical social workers	4.0%	88.8%	1.4%	0.5%	2.0%	0.1%	2.4%	0.8%	80.8%	19.0%
	Clinical social work associates	11.8%	74.3%	3.9%	0.4%	3.2%	0.4%	5.3%	0.7%	82.3%	16.3%
	Non-clinical social workers	5.2%	89.6%	0.7%	0.0%	2.2%	0.7%	1.5%	0.0%	86.1%	11.9%
Dentistry	Dentists	3.7%	77.5%	0.5%	0.2%	14.4%	0.3%	1.9%	1.6%	28.8%	71.2%
	Dental hygienists	4.9%	85.4%	0.3%	0.6%	4.7%	0.2%	3.0%	0.9%	97.4%	2.6%

Primary Languages Spoken by Oregonians

¹¹⁹ <https://www.oregon.gov/oha/HPA/HP-HCW/Documents/2021-Health-Care-Workforce-Needs-Assessment.pdf>; Oregon health professions by occupation and county, 2015, <https://sharedsystems.dhsosha.state.or.us/DHSForms/Served/le8120.pdf>

	Oregon		
	Total	Percent	
Label	Estimate	Margin of Error	Estimate
✓ Population 5 years and over	3,994,373	±2,367	(X)
Speak only English	3,373,446	±16,318	84.5%
Speak a language other than English	620,927	±16,138	15.5%

Label	Speak English less than "very well"		Percent speak English less than "very well"	
	Estimate	Margin of Error	Estimate	Margin of Error
Population 5 years and over	204,308	±9,257	5.1%	±0.2
Speak only English	(X)	(X)	(X)	(X)
Speak a language other than English	204,308	±9,257	32.9%	±1.4

Source: American Community Survey, 2019 One-Year Estimate (Table S1601), <https://data.census.gov/cedsci/table?q=&text=S1601&q=0400000US41&tid=ACSST1Y2019.S1601>

Oregonians with Disabilities

Label	Oregon		
	Estimate	Margin of Error	Percent
✓ DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZE...			
✓ Total Civilian Noninstitutionalized Population	4,175,002	±1,934	4,175,002
With a disability	614,059	±14,351	14.7%
✓ Under 18 years	861,852	±1,570	861,852
With a disability	43,445	±3,934	5.0%
✓ 18 to 64 years	2,556,209	±4,031	2,556,209
With a disability	306,183	±10,096	12.0%
✓ 65 years and over	756,941	±3,096	756,941
With a disability	264,431	±6,605	34.9%

Source: American Community Survey, 2019 1-Year Estimates (Table DP02), <https://data.census.gov/cedsci/table?text=DP02&q=0400000US41&tid=ACSDP1Y2019.DP02>

Oregon 2016 BRFSS
Disability

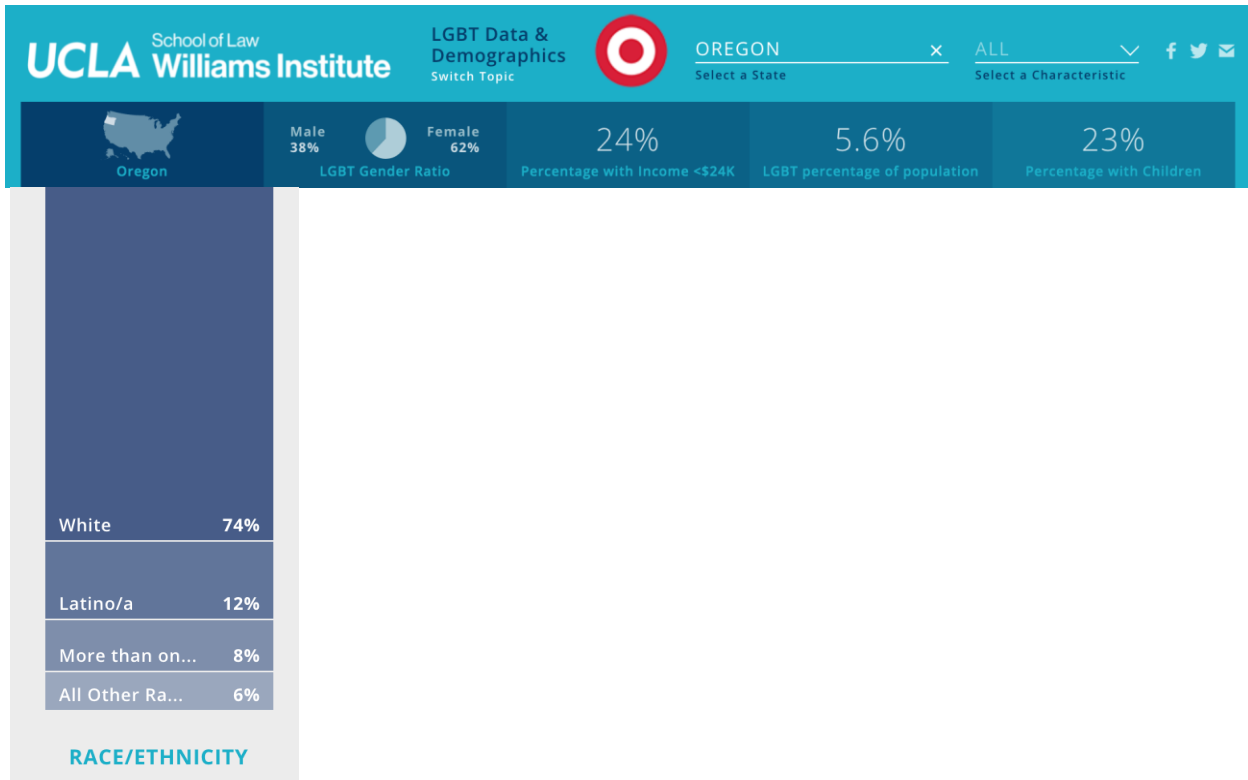
Are you limited in any way in any activities because of physical, mental, or emotional problems?

(Weighted Column Percents)

		Age Groups						
		Total	18-24	25-34	35-44	45-54	55-64	65+
Yes		25.8	14.2	15.9	21.5	25.9	32.3	37.0
No		74.2	85.8	84.1	78.5	74.1	67.7	63.0
Male	Yes	23.9	13.5	15.3	20.7	22.8	29.2	36.3
	No	76.1	86.5	84.7	79.3	77.2	70.8	63.7
Female	Yes	27.6	15.1	16.7	22.2	29.0	35.2	37.6
	No	72.4	84.9	83.3	77.8	71.0	64.8	62.4

Source: Behavioral Risk Factor Surveillance System, 2016,
<https://www.oregon.gov/oha/PH/BirthDeathCertificates/Surveys/AdultBehaviorRisk/brfssresults/Documents/2016/disability16.pdf>

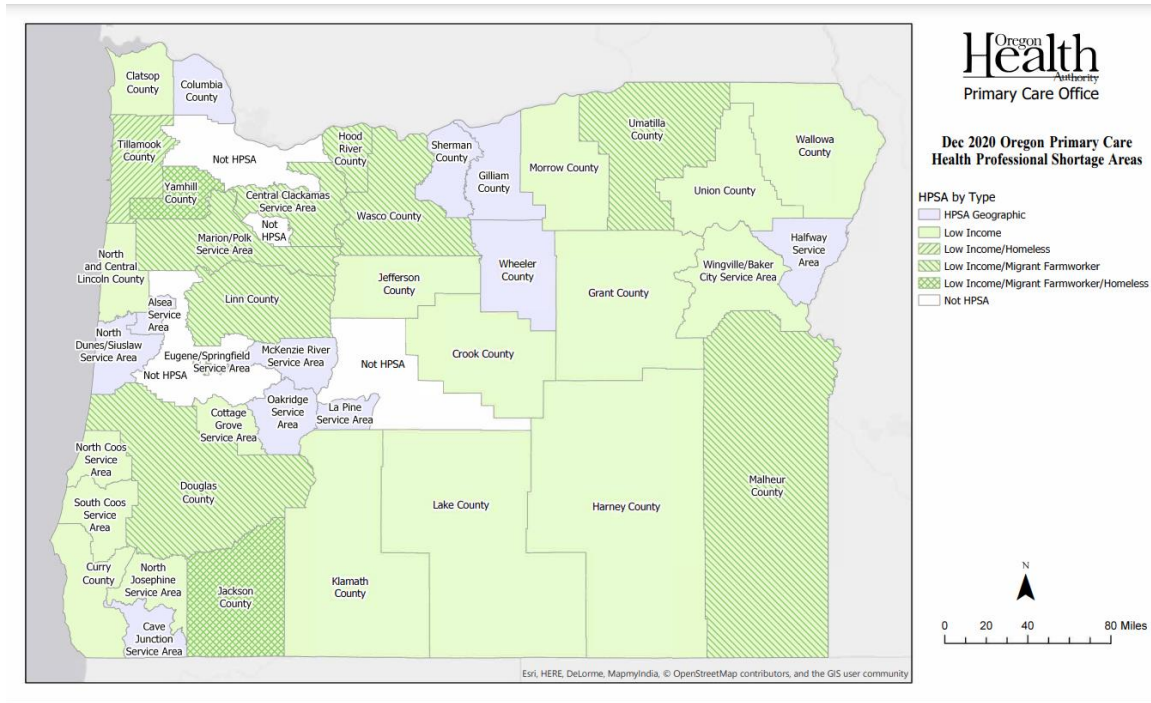
LGBTQ+ Oregonians



Source University of California Los Angeles School of Law Williams Institute:
<https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=41#density>

Regions with Health Professional Shortages

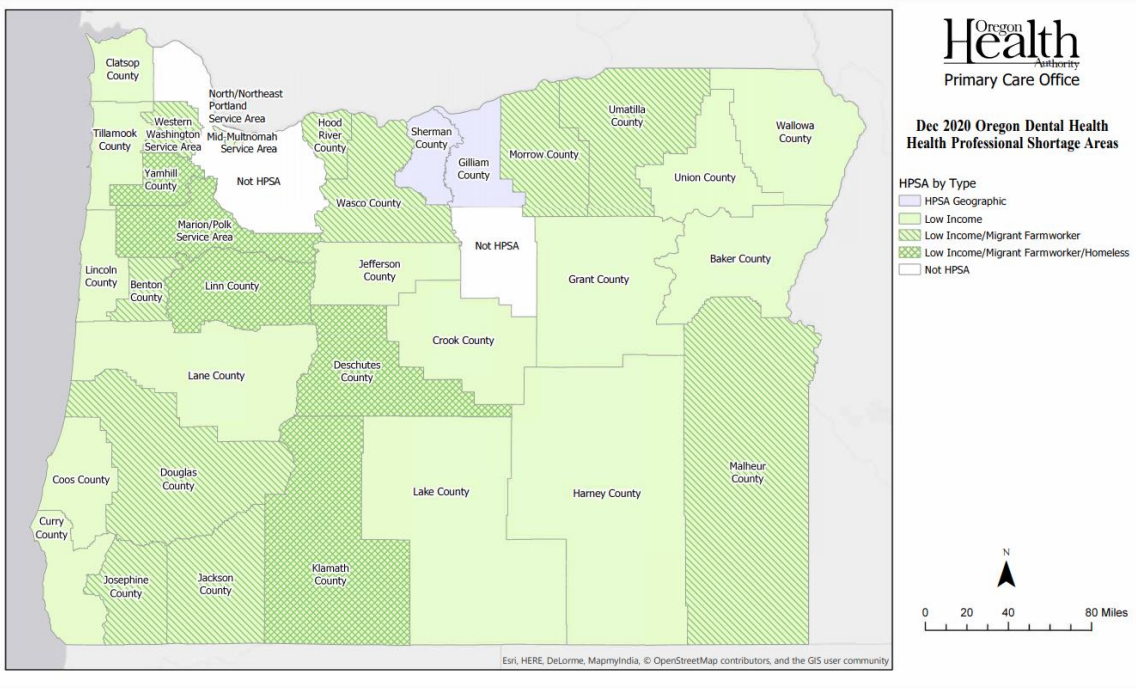
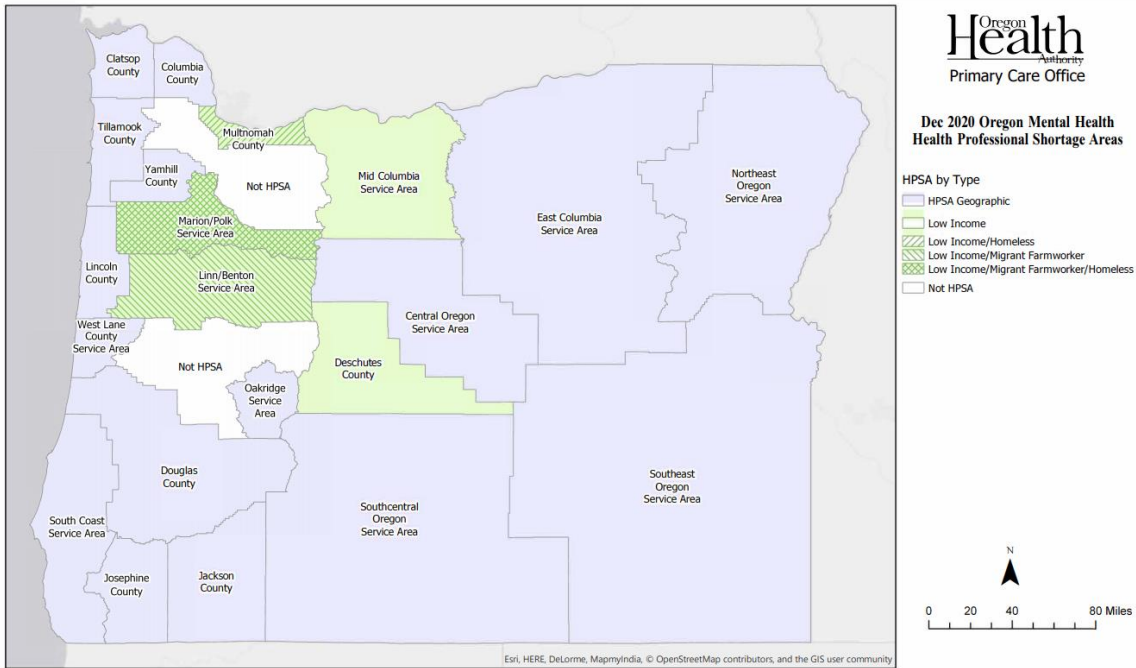
The federal Health Resources and Services Administration (HRSA) reports that a significant number of geographic areas throughout Oregon have persistent shortages of primary care,¹²⁰ mental health,¹²¹ and dental providers.¹²²



¹²⁰ <https://www.oregon.gov/oha/HPA/HP-PCO/Documents/HPSA-Primary-Type-Dec-2020.pdf>

¹²¹ <https://www.oregon.gov/oha/HPA/HP-PCO/Documents/HPSA-Mental-Type-Dec-2020.pdf>

¹²² <https://www.oregon.gov/oha/HPA/HP-PCO/Documents/HPSA-Dental-Type-Dec-2020.pdf>

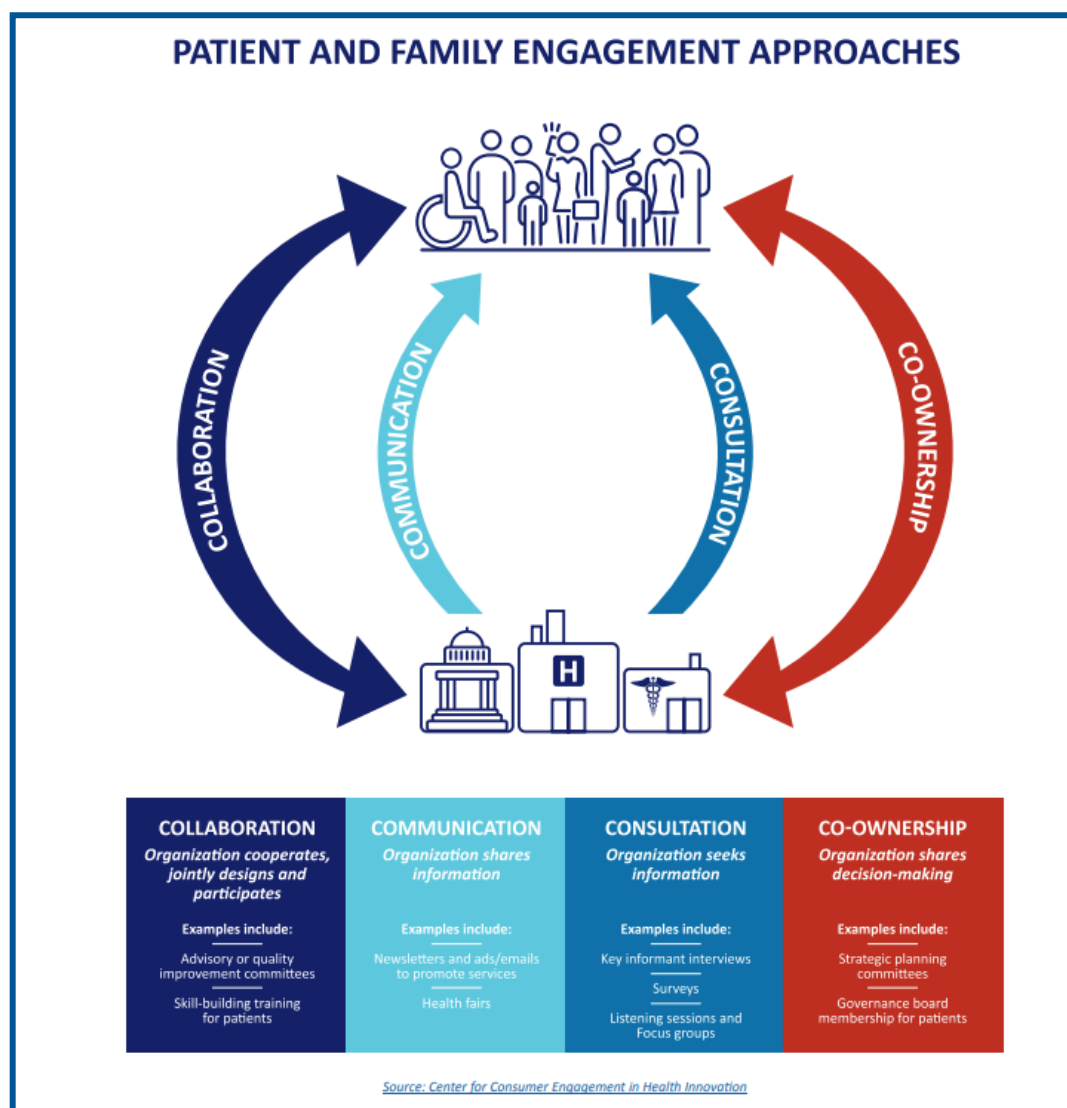


These geographic shortages compound the acuity of the lack of racial and ethnic and other demographic diversity among health professionals in Oregon.

APPENDIX F: RESOURCES ON COMMUNITY ENGAGEMENT, INCLUSIVE MEETINGS, AND EQUITY TOOLS

Resources on Community Engagement

Here is a model of levels of patient/family/consumer/community engagement that includes institutional co-ownership and shared decision-making:¹²³



¹²³ Health Care Transformation Task Force and Community Catalyst, Organizational Level Community Engagement: What It Takes, 2020, https://www.healthinnovation.org/resources/publications/body/Organizational_Level_Consumer_Engagement.pdf

Locally, the City of Portland¹²⁴ and Multnomah County¹²⁵ also have guidance for community engagement; the City of Portland guidance includes useful performance measures to evaluate progress on implementing more inclusive practices.

Multnomah County list six outcomes from more equitable community engagement:

- Shift in social norms (shift in values, beliefs, and behaviors, then “walking the talk”)
- Strengthened organizational capacity (build capacity in the areas of staffing, leadership, structure, finance, planning)
- Strengthened alliances (improve coordination, collaboration, and alignment among traditional and non-traditional system partners)
- Strengthened base of support (strengthen breadth, depth, and influence of support among public, interest groups, and opinion leaders)
- Improved policies (improvements at any and all stages of policy change from development through implementation)
- Changes in impact (improved social, emotional, physical, and environmental conditions for affected populations)

The International City/County Management Association recommends the following for inclusive community engagement:¹²⁶

- Meeting people where they are (literally and figuratively).
- Not just creating a seat at the table, but allowing others to help design the table.
- Listening to learn, improve, and understand.
- Partnering with existing established groups in the community to help with the process (faith based, language based, service based, specific agencies focused on serving populations).
- Designing multiple opportunities to engage (social media, online surveys, mailed/postcard surveys, small group meetings, videos, pop-up white boards, sticky notes, online platforms).
- With intention and integrity, invite people to lead so that staff and boards are truly reflective of the community.

And the Kirwan Institute makes these recommendations for inclusive and equitable community engagement:¹²⁷

¹²⁴ City of Portland, Community Engagement Manual, 2019, https://www.portland.gov/sites/default/files/2019-11/comm_engage_manual.pdf

¹²⁵ Multnomah County, Equity and Empowerment Lens, <https://www.multco.us/diversity-equity/equity-and-empowerment-lens>

¹²⁶ International City/County Management Association, How to Facilitate Inclusive Community Outreach and Engagement, 2021, <https://icma.org/articles/pm-magazine/how-facilitate-inclusive-community-outreach-and-engagement>

¹²⁷ Kirwan Institute, The Principles for Equitable and Inclusive Civic Engagement, 2016 <http://kirwaninstitute.osu.edu/wp-content/uploads/2016/05/ki-civic-engagement.pdf>

These six principles are necessary to create an equitable civic engagement environment best suited to bolster civic opportunity for everyone—**particularly those who are often left out.**

1 Embracing the Gifts of Diversity

2 Realizing the Role of Race, Power, and Injustice

3 Radical Hospitality: Invitation and Listening

4 Trust-Building and Commitment

5 Honoring Dissent and Embracing Protest

6 Adaptability to Community Change

Inclusive Meetings

In addition to internal OHA guidance, there are several guides available for conducting more inclusive public meetings.¹²⁸



¹²⁸ Institute for Local Government, Preparing for Successful Public Meetings: Checklist for Before, During, and After, https://www.ca-ilg.org/sites/main/files/file-attachments/meeting_preparation_checklist_.pdf?1441322558; Health Leads, Creating Inclusive Meeting Space, 2019, http://healthleadsusa.org/wp-content/uploads/2019/12/Creating-Inclusive-Meeting-Space_FINAL.pdf

Equity Tools

An equity toolkit developed by the City of Seattle recommends asking these questions about every issue, recommendation policy, and decision being considered by the City:¹²⁹

How will the policy, initiative, program, or budget issue increase or decrease racial equity? What are potential unintended consequences? What benefits may result?

What factors produce or perpetuate racial inequity related to this issue? What are ways to minimize any negative impacts (harm to communities of color, increased racial disparities, etc.) that may result? What opportunities exist for increasing racial equity?

How will you address the impacts (including unintended consequences) on racial equity? What strategies address immediate impacts? What strategies address root causes of inequity? How will you partner with stakeholders for long-term positive change? If impacts are not aligned with desired community outcomes, how will you re-align your work?

Portland Community College recommends asking the following questions to advance racial equity:¹³⁰



The "Take 5" Process Overview

We “Take 5” when we need to pause to make a decision:

1. Recognize Intersectionality:
2. Challenge the Dominant Perspective:
3. Commitment to Social Justice:
4. Value Experiential Knowledge:
5. Use an Interdisciplinary Approach:

The Communities of Color Coalition has developed a framework for decolonizing data and research by elevating the everyday knowledge and strategies of communities of color as data,

¹²⁹ City of Seattle, Racial Equity Toolkit, 2012,

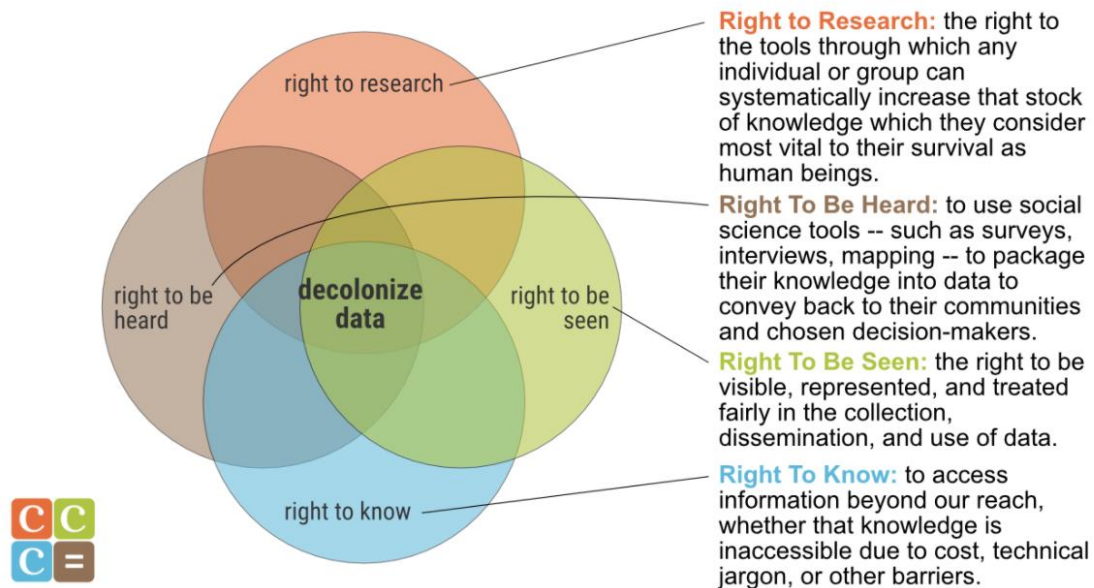
https://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit_FINAL_August2012.pdf

¹³⁰ Portland Community College, Critical Race Theory Decision Making Toolkit, 2018, <https://www.pcc.edu/wp-content/uploads/sites/159/documents/take-5-toolkit.pdf>

conducting research that defers to communities of color, and bridging the divide between community and dominant institutions through the power and uses of data from and about communities of color:¹³¹

A FRAMEWORK FOR RESEARCH & DATA JUSTICE*

Communities are experts in their own lives, possessing experiential, historical, & cultural knowledge which must be centered in any data research initiative. To that end, we believe that communities have a:



* Coalition of Communities of Color adaptation of the framework from DataCenter: Research Justice

The Black, Indigenous, and People of Color (BIPOC) Decolonizing Data Council is a strengths-based, alliance of BIPOC community advocates, leaders and change makers working on healing the lasting impacts of colonization and ending all forms of colonial violence, including racism, white supremacy, institutional neglect, scarcity and competition, and erasure.¹³² Last year, the Oregon Health & Science University (OHSU) halted the Key to Oregon research project about the impact of COVID-19 because the researchers had failed to recruit participants that were representative of the diversity of Oregonians.¹³³ OHSU recognized that continuing the study without diverse participants would have done harm by perpetuating the exclusion and overlooking of the experiences of communities of color throughout the state.

¹³¹ Communities of Color Coalition, <https://www.coalitioncommunitiescolor.org/ccr-researchdatajustice>

¹³² <https://djcpx.com/>

¹³³ Oregon Health & Science University, Key to Oregon Study Transition, August 27, 2020, <https://news.ohsu.edu/2020/08/27/key-to-oregon-study-transition-6812195>

Others have noted that decolonization demands an Indigenous framework and a centering of Indigenous land, Indigenous sovereignty, and Indigenous ways of thinking.¹³⁴ In contrast, our current dominant frameworks and thinking about data and research are based on settler colonialism, reinforcing and perpetuating power and privilege, including what is understood and valued as knowledge, expertise, and “scientific evidence”.¹³⁵ Decolonization and indigeneity reclaim the value and power of deep, historic, and contemporary community-based knowledge and experiences, including the wisdom of ancestors and elders, oral histories and story-telling, and expressions in land, objects, ceremonies, and rituals, as all essential to how we understand and act in the world. Dismantling racism and white supremacy require specific practices to undo and replace common values, assumptions, and behaviors.¹³⁶ These are potential tools that OHPB Committees and OHA staff could use to advance equity.



HEALTH POLICY AND ANALYTICS

Office of Health Policy

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¹³⁴ Racial Equity Tools, Decolonization Theory and Practice, <https://www.racialequitytools.org/resources/fundamentals/core-concepts/decolonization-theory-and-practice>; Bioneers, Indigeneity Program. <https://bioneers.org/indigeneity-program/>

¹³⁵ Okun T. White supremacy culture – still here, 2021,

https://www.dismantlingracism.org/uploads/4/3/5/7/43579015/white_supremacy_culture_-_still_here.pdf

¹³⁶ The Centre for Community Organizations, White Supremacy Culture in Organizations, 2019, <https://coco-net.org/wp-content/uploads/2019/11/Coco-WhiteSupCulture-ENG4.pdf>