

# Oregon Regional Health Equity Coalitions Evaluation Report, 2016

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## Executive Summary

Regional Health Equity Coalitions (RHEC) are community-driven, cross-sectorial groups organized regionally to identify solutions that increase health equity. Through the use of the RHEC model, the coalitions build on the inherent strengths of their local communities to meaningfully involve them in identifying sustainable, long-term, policy, system and environmental solutions to increase health equity for underserved and underrepresented populations experiencing health disparities.

The Oregon Health Authority's (OHA) Office of Equity and Inclusion (OEI) supports six Regional Health Equity Coalitions to serve diverse communities spanning 11 Oregon counties and the Warm Springs Tribe. The RHECs collect data on an ongoing basis in order to measure their progress on short-term and intermediate outcomes that have theoretical and/or empirical links to health equity to evaluate where and how they are making progress towards meeting the large overarching goal of health equity for all. Specifically, data are collected on successes related to: increased and authentic community engagement, strengthened organizational capacity, system change, social norm and environment change, and policy change. The following information is based on evaluation data collected through site visits conducted winter of 2016.

The work of the RHECs covers a wide range of underserved communities and they have the ability to reach 68% of Oregon's total population<sup>1</sup>, including 77% of OHP's racially diverse communities and 55% of OHP's Hispanic population<sup>2</sup>. This includes people of color, immigrants, refugees, migrant and seasonal farmworkers, low-income populations, individuals with disabilities, and LGBTQ communities in both rural and urban areas.

RHEC membership comprises a diverse set of stakeholders, representing many communities and sectors including but not limited to: behavioral health, chronic disease prevention, city and county governments, community-based organizations, coordinated care organizations (CCOs), corrections/law enforcement, disability communities, education, employment, environmental, faith-based, healthcare, higher education, local business, policymakers, public health, public housing, tobacco prevention, and transportation. Through RHEC membership, the coalitions engaged over 1,400 individuals from more than 250 organizations across Oregon in 2016. In the last 6 months of 2015 alone, RHECs were able to impact 21 sectors, and reach more than 600 organizations and over 12,000 individuals. All of this work builds the foundation for empowering communities to sustainably improve health equity across Oregon.

Disparities that communities in the RHEC regions face greatly impact many systems, namely, the health, education, housing, employment and transportation systems. The Regional Health Equity Coalitions have made great strides in a relatively short period of time to begin addressing several social determinants of health that have persisted for generations. Ultimately, the coalitions are improving the overall state of health equity in Oregon, making this work a nominal investment for substantial, long-term improvements among the state's most vulnerable populations.

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<sup>1</sup> US Census. American Community Survey (ACS), 2014 estimates.

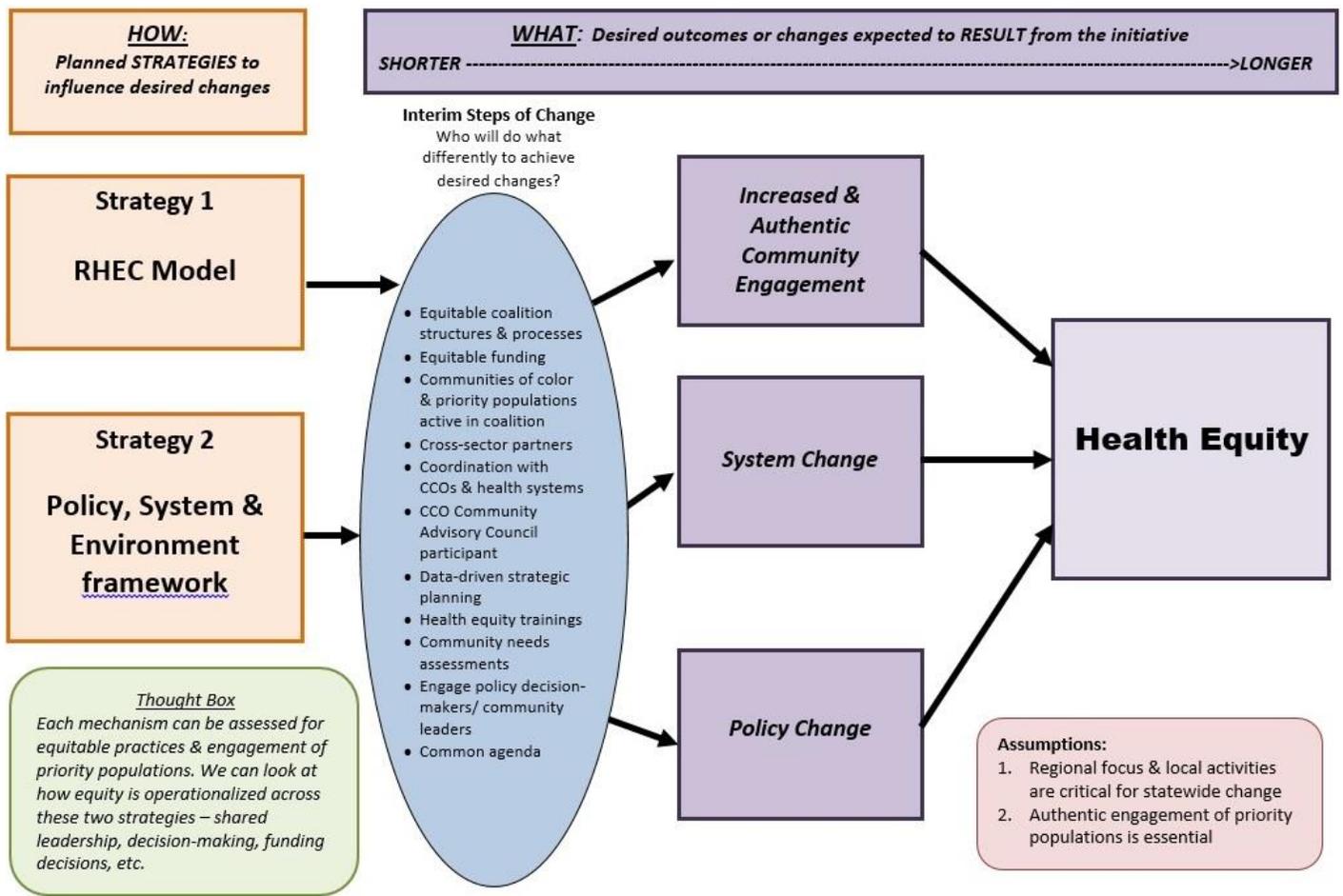
<sup>2</sup> Oregon Health Authority, Office of Health Analytics. Oregon Health Plan (OHP) Demographics, January 2016.

## Background

In July 2011, the Oregon Health Authority (OHA) established the Regional Health Equity Coalition (RHEC) program to support local, community-driven, culturally-specific activities to reduce disparities and address social determinants of health. Three RHECs were funded through the Office of Equity and Inclusion (OEI) and the Public Health Division’s Health Promotion and Chronic Disease Prevention Section (HPCDP) by leveraging funds from the DHHS Office of Minority Health and the Northwest Health Foundation. In 2014, three additional RHECs were funded through the Centers for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) grant.

The RHEC model supports regional, community-driven, culturally-specific, cross-sectorial strategies aimed at reducing local health disparities and promoting equity. Coalitions build on the inherent strengths of their communities and utilize a policy, systems and environment (PSE) framework to craft and implement sustainable, long-term solutions to eliminate health inequities and address the social determinants of health. Below is the RHEC strategy map (Figure 1).

**Figure 1: RHEC Strategy Map**



Because the RHEC initiative is addressing health equity issues across multiple sectors and continuously engaging new partners, evaluation efforts used a Developmental Evaluation (DE) approach. The DE framework is informed by systems thinking and dynamic realities in complex environments, and offers a structure that is supportive of adaptive management and continuous development.

## Community Context

There are currently six Regional Health Equity Coalitions, serving a diverse group of Oregonians in multiple regions of the state (Table 1), spanning 11 Oregon counties and the Warm Springs Tribe. The majority (5 out of 6) coalitions’ regions cover mostly rural<sup>3</sup> areas. All RHECs have high proportions of diverse, underserved communities that are often considered “difficult to reach” or even “invisible” populations.

**Table 1: The RHECs in Community Context**

RHEC	Area Served and Community Composition
Klamath RHEC (KRHEC)	Klamath County: Rural and frontier areas, Confederated Klamath Tribes, Chiloquin & surrounding areas
Let’s Talk Diversity (LTD)	Jefferson County (the most diverse Oregon county per capita) and Confederated Tribes of Warm Springs: Rural, frontier and small town settings
Linn-Benton Health Equity Alliance (LBHEA)	Benton & Linn Counties: Mixture of large and small towns, and rural settings throughout
Mid-Columbia Health Equity Advocates (MCHEA)	Hood River & Wasco Counties: Small town and rural settings. High prevalence of Latinos, including monolingual and bilingual Spanish-speakers.
Oregon Health Equity Alliance (OHEA)	Multnomah, Clackamas & Washington Counties: containing 44% of the state population, mostly urban; includes some rural settings
Southern Oregon Health Equity Coalition (SO-Health-E)	Jackson & Josephine Counties: Rural and small town settings

<sup>3</sup> Oregon Office of Rural Health (2012). *Office of Rural Health (ORH) Rural/Urban Areas*, (<http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/rural-definitions/upload/orh-rural-map.png>).

Based on the coalitions’ regions and the state’s population, **the RHECs have the ability to impact approximately 68% of Oregon’s most vulnerable populations** (see Table 2).

**Table 2: Populations Served by the RHECs<sup>4</sup>**

Region	Total <sup>5</sup> population (% of state)	Populations Served as % of Region						
		African American/ Black	Asian	Pacific Islanders	American Indian/ Alaska Native	Multiple Race	White Non-Hispanic	Latino/ Hispanic <sup>6</sup>
State of Oregon	<b>3,970,239 (100%)</b>	79,405 (2%)	170,720 (4.3%)	15,881 (0.4%)	71,464 (1.8%)	158,810 (3.6%)	3,493,810 (87.9%)	516,131 (12.5%)
Klamath RHEC (KRHEC)	<b>65,455 (2%)</b>	589 (0.9%)	655 (1%)	131 (0.2%)	3,076 (4.7%)	2,618 (4%)	58,451 (89.3%)	7,789 (11.9%)
Let’s Talk Diversity <sup>7</sup> (LTD)	<b>22,192 (0.5%)</b>	133 (0.6%)	200 (0.9%)	67 (0.3%)	4,216 (19%)	732 (3.3%)	16,755 (75.5%)	4,350 (19.6%)
Linn-Benton Health Equity Alliance (LBHEA)	<b>205,672 (5%)</b>	1,851 (0.9%)	7,404 (3.6%)	617 (0.3%)	2,468 (1.2%)	6,993 (3.4%)	186,750 (90.8%)	15,837 (7.7%)
Mid-Columbia Health Equity Advocates (MCHEA)	<b>394,972 (10%)</b>	2,370 (0.6%)	3,555 (0.9%)	1,185 (0.3%)	9,874 (2.5%)	8,689 (2.2%)	368,904 (93.4%)	70,305 (17.8%)
Oregon Health Equity Alliance (OHEA)	<b>1,734,682 (44%)</b>	52,040 (3%)	123,162 (7.1%)	8,673 (0.5%)	20,816 (1.2%)	67,653 (3.9%)	1,462,337 (84.3%)	208,162 (12%)
Southern Oregon Health Equity Coalition (SO-Health-E)	<b>293,886 (7%)</b>	2,057 (0.7%)	3,527 (1.2%)	882 (0.3%)	4,408 (1.5%)	9,698 (3.3%)	273,608 (93.1%)	27,919 (9.5%)
<b>Total Reach of RHECs</b>	<b>2,716,859 (68%)</b>	59,040 (74.4%)	138,503 (81.1%)	11,555 (72.8%)	44,858 (62.8%)	96,383 (61%)	2,366,805 (67.7%)	334,362 (64.8%)

Additionally, the RHECs have the ability to impact 77% of Oregon Health Plan’s (OHP’s) racially diverse communities and 55% of OHP’s Hispanic population<sup>8</sup> (figures not included in table above).

<sup>4</sup> US Census. American Community Survey (ACS), 2014 estimates.

<sup>5</sup> Calculation of totals in this column vary due to rounding and missing data (e.g., not all respondents report race).

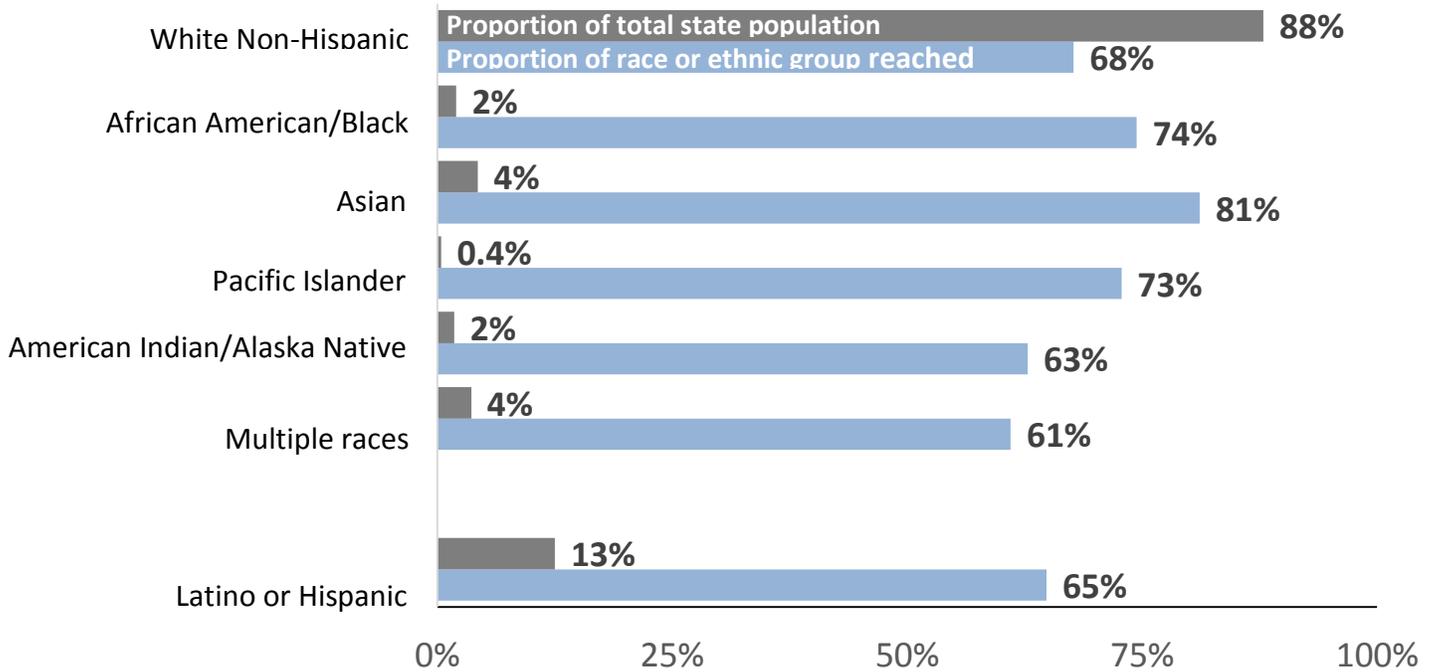
<sup>6</sup> Latino/Hispanic figures should be considered unique of the race totals since this is an ethnicity rather than race.

<sup>7</sup> LTD numbers based only on Jefferson County population, although the reservation area of the Confederated Tribes of Warm Springs reservation extends into multiple counties.

<sup>8</sup> Oregon Health Authority, Office of Health Analytics. Oregon Health Plan (OHP) Demographics, January 2016.

RHECs serve a majority of Oregonians in communities of color.

**Figure 2: Proportion of Total State Population by Race/Ethnic Group & Proportion of Race/Ethnic Group Reached by RHECs**



## Evaluation Questions and Process

The RHECs aim to promote health equity at an “upstream” level, addressing social determinants of health such as education, employment, healthcare access, housing, income inequality, and transportation, among others. Although resources to conduct a larger collective impact assessment or contribution analysis are lacking, the RHECs collect data on an ongoing basis, in order to measure their progress on short-term and intermediate outcomes that have theoretical and/or empirical links to health equity. In this way, they can see where and how they are making progress towards meeting the large overarching goal of health equity for all.

The RHEC model is based on the theoretical framework that increased and authentic community engagement and strengthened organizational capacity are the foundation for system change (with a special focus on healthcare systems and Coordinated Care Organizations), social norm and environmental change, and policy change. These things, in turn, lead to healthier, more resilient communities that experience fewer health disparities.

With this framework in mind, the RHECs engaged in a collaborative process where they selected and prioritized three evaluation questions, five outcomes, and eight indicators to monitor progress over time. These evaluation measures align with OHA's vision, mission, and core values. The evaluation questions, outcomes and indicators have been identified as priorities for improving health equity across systems in Oregon, and are outlined below (see page 6-7).

## **RHEC Evaluation Questions**

- 1) How effectively have the RHECs engaged their communities, specifically communities of color and other priority populations?
  - a) What processes and structures have the RHECs put into place to engage and listen to their communities?
  
- 2) How has the RHEC increased local capacity and leadership for addressing health disparities and equity?
  - a) How have communities of color increased their capacity and leadership?
  - b) How have funding models shifted to become more equitable?
  
- 3) How have the RHECs increased coordination across health and other social support entities to collaborate on cross-cutting community wide issues? (Consider 4 sectors: business, government, voluntary sector, and people who will benefit from RHEC impact)
  - a) How have RHECs engaged with Coordinated Care Organizations (CCOs)?
  - b) What sectors and jurisdictions have been engaged actively with each of the RHECs? What sectors or jurisdictions are missing in the RHEC work?

## Evaluation Outcomes & Indicators

### **Outcome 1. Increased & Authentic Community Engagement**

Indicator 1.a. The RHEC’s Steering Committee (or other leadership structure) includes a diverse set of voices and perspectives from all relevant sectors and constituencies

Indicator 1.b. Members of the target population help shape the common agenda

Indicator 1.c. People of different cultures and backgrounds feel respected and heard within the RHEC

### **Outcome 2. Strengthened Organizational Capacity**

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

### **Outcome 3. System Change**

Indicator 3.a. Partners use data (both qualitative and quantitative) to inform selection of strategies and actions

Indicator 3.b. CCOs and health systems have increased knowledge & skills related to equity issues

### **Outcome 4. Social Norm & Environment Change**

Indicator 4.a. Partners and the broader community are making the connection between health equity and other issues (e.g. housing, education, transportation)

### **Outcome 5. Policy Change**

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

## Outcome 1: Increased & Authentic Community Engagement

The Regional Health Equity Coalitions serve a multitude of diverse communities, depending on local needs, and many of their priority populations overlap (Table 3). While coalitions generally prioritize communities/people of color<sup>9</sup> for their populations of focus, they also include migrant and seasonal farmworkers, people with disabilities, LGBTQ<sup>10</sup>, and low-income populations.

**Table 3. RHEC Priority Populations**

RHEC	Latino/Hispanic	AI/AN <sup>11</sup> & Tribally Enrolled	People of color	People w/ disabilities	Low-Income	LGBTQ
KRHEC	X	X	X	X	X	X
LBHEA	X		X	X	X	X
LTD	X	X	X	X	X	X
MCHEA	X	X	X			
OHEA	X	X	X	X	X	X
SO Health-E	X		X	X	X	X

RHEC membership comprises a diverse set of stakeholders, representing many communities and sectors. In total, the RHECs engaged over 1,400 individuals from more than 250 organizations across Oregon in 2016.

Embodying the principle of “nothing about us without us,” the RHECs aim to include a diverse set of voices and perspectives from all relevant sectors and constituencies, both within the membership and at the leadership table. Currently all of the RHEC Leadership Teams include representation from communities of color, four include tribal representatives, and four include immigrant, migrant, and refugee community representatives. However, only one leadership team includes LGBTQ representation and none include people with disabilities at this time.

The six coalitions include representation from the following sectors: behavioral health, chronic disease prevention, city and county governments, community-based organizations, coordinated care organizations (CCOs), corrections/law enforcement, disabilities, education, employment, environmental, faith-based, healthcare, higher education, local business, policymakers, public health, public housing, tobacco prevention, and transportation.

The RHECs also engage the broader communities in which they work through educational events and trainings. In the last six months of 2015, the RHECs conducted more than 100 community education and training events, reaching over 600 organizations and more than 12,600 individuals.

<sup>9</sup> Communities/people of Color: Members of a racial/ethnic minority communities including Black/African Americans; Asian/Pacific Islanders; Latinos, American Indian/Alaska Natives, immigrants, and refugees.

<sup>10</sup> Lesbian, Gay, Bi-Sexual, Transgender, Queer/Questioning (LGBTQ)

<sup>11</sup> American Indian/ Alaska Native (AI/AN)

## Outcome 1: Examples from the Field

### *Example 1:*

The Southern Oregon Health Equity Coalition (SO-Health-E) has created two county-wide Health Equity Assessment Reports focused on race/ethnicity, and LGBTQ issues using county and state data. Beginning June 2015, SO Health-E held community conversations for people to share real life experiences related to educational attainment, teen pregnancy, oral health, cultural responsiveness, and other issues captured in the quantitative reports. They also collected stories to guide the priority areas to be included in their strategic plan, utilizing a multicultural storytelling methodology to ask community members what factors contribute to health in their communities.

### *Example 2:*

The Linn-Benton Health Equity Alliance (LBHEA) provides participation/capacity building mini-grants to bring diverse voices to the table and to allow smaller organizations to regularly attend coalition events. This leads to a higher level of engagement among partners that might not otherwise have the capacity to stay engaged. LBHEA member organizations, Familias Activas in Linn County and Organizacion Latinas Unidas (OLU) in Benton County, recently participated in a training on health and transportation with national expert, Mark Fenton. Both Familias Activas and OLU shared their perspectives – in Spanish – with more than 100 local policy makers and other community leaders. Equity came out as a strong community value in the meeting.

## Outcome 2: Strengthened Organizational Capacity

The RHECs provide “backbone agency” support and leadership to the more than 200 organizations and 1,000 individuals engaged in health equity work across Oregon. Specifically, RHECs are able to bring diverse groups to decision making tables where they have historically been underrepresented. Additionally, staff provide project management support, including monitoring progress toward goals and connecting partners to discuss opportunities, challenges, gaps, and overlaps. All of the RHECs have a core leadership team that supports the broader coalition in identifying community priorities for addressing health and health equity through policy, systems and environmental change. Leadership teams vary in size from 9 to 35 members.

Governance models differ, and coalitions work from a foundation of consensus-based and democratic decision making. Three RHECs have steering committees, one has a general leadership team, another has an advisory group, and one takes guidance from two community groups (Table 4).

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*“We aren’t steering anything; we are following the community’s lead.”*  
*MCHEA Staff Member*

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**Table 4. RHEC Coalition Structures and Governance Models**

RHEC	Leadership Team Structure	Other RHEC Work Groups
KRHEC	KRHEC has a Steering Committee comprised of 12 community stakeholders and the Rural Equity Coordinator. Chiloquin First is still a small group, so the whole membership meets and votes.	Two RHECs serve the geographically distant communities of Klamath Falls and Chiloquin. KRHEC has two work groups: transportation and health literacy.
LBHEA	Leadership Team that includes 24 representatives from local community organizations, public health departments, early learning hub, and the local CCO.	Occasional ad hoc subgroups form and meet based on priority areas (i.e. housing, education, access to healthcare, and capacity building).
LTD	Advisory Council comprised of 9 members that represent Latino, AI/AN, and White communities.	Work groups formed as needed
MCHEA	Two of the 5 RHEC groups comprise the leadership team: Abogados de la Comunidad and Latinos en Accion lead the work the RHEC focuses on each year. In the spirit of Latinos en Accion & Abogados de la Comunidad, all coalition members in attendance at respective meetings vote, simple majority rules apply. Coalition members are entitled to one vote per member.	5 groups form MCHCA: <ol style="list-style-type: none"> <li><b>Abogados de la Comunidad</b> (Advocates of the Community) guides health equity work in The Dalles.</li> <li><b>Latinos en Acción</b> (Latinos in Action) is the group of community leaders that guides health equity work in Hood River County.</li> <li><b>River People Group</b> focuses on the local AI/AN community and meets on its own with RHEC support.</li> <li><b>Community Partners Group</b> includes stakeholders from groups 1 &amp; 2 above</li> <li><b>RHEC Staff members</b></li> </ol>
OHEA	Internal group of 9 people (7 organizations) providing overall direction and leadership for the RHEC on action items. Committee members are all original founding members, and are community-led, with staff also representing communities served. Two Co-Chairs serve for 1 term.	Current work groups include: Policy Committee; CCO Committee; Multnomah Community Health Improvement Plan (CHIP); Health Access/Inclusion, Affordability & Innovation Table; Chronic Disease and Other Illness Factors Workgroup; and general coalition membership group.
SO-Health-E	18-person steering committee	Current work groups include: Cultural Agility Workgroup; Community & Youth Engagement Workgroup; Data & Sustainability Workgroup; Policy & Advocacy Workgroup; and Youth Empowerment Council. Additional subcommittees/workgroups added as needed.

Each RHEC has a paid staff member working as a coordinator, and often these tasks are shared across several staff members and/or supported by in-kind dollars from sponsoring or partner agencies. A total of 27 paid staff members work on RHEC activities at the 6 coalitions, representing 9 FTE. These

paid staffers are supported in their project management/support activities by four consultants and at least 8 volunteers.

Another way that RHECs have supported local communities of color in increasing their capacity and leadership is through participation in the Developing Equity Leadership through Training and Action (DELTA) Program. DELTA trains cohorts of approximately 25 members over the course of a nine month period, and is intended for community leaders, health providers, coordinated care organization (CCO) staff, policy makers, administrators, and local health department staff. This program focuses on advancing health equity and diversity through 40 hours of classroom training, 10 hours of individualized technical assistance, and facilitated opportunities for cross-sector partnership. Each participant submits a project prior to graduation designed to drive and institutionalize best practices for health equity and inclusion within their own organizations. To date, 23% of the DELTA graduates have been RHEC members (or 14 individuals).

## Outcome 3: System Change

All six RHECs have involvement with their local Coordinated Care Organizations (CCOs), whether it is participating on Community Advisory Councils (CACs), providing health equity trainings to CCO staff to further health equity, or sharing local data.

### Outcome 3: Example from the Field

The Let's Talk Diversity (LTD) Coalition partnered with PacificSource's (the CCO in this region) Health Equity Task Force to interview community members about their experiences accessing health services across three counties and produced a 35-minute video and 25-page report. These materials were presented to PacificSource and resulted in an assessment of the barriers around utilization of healthcare interpreter services in the region. Findings from the assessment led the CCO to address identified barriers and to work with the RHEC to provide their medical providers with additional training around healthcare interpreter usage.

## Outcome 4: Social Norms & Environmental Change

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

### Outcome 4: Examples from the Field

#### *Example 1:*

The Let's Talk Diversity (LTD) Coalition, in conjunction with Central Oregon Community College and Oregon State University (OSU), launched a Juntos Program for Latino youth and developed the Papalaxsimisha Program for AI/AN youth. Both culturally-specific programs are designed to motivate and empower families and students to graduate high school and continue their education. LTD

provides support for facilitation of these programs, and of the over 200 students participating in these programs in Jefferson County, there has been a 100% graduation rate.

Since its launch in 2014, the Papalaxsimisha Program moved from Warm Springs K-8 (starting with only two families) to OSU Open University, where it is now available in 15 communities. The program aligns with OSU's goals to create a youth-to-college-to-employment pipeline; current work is focused on developing a Native Studies Program at OSU, and expanding Papalaxsimisha to become regionally and possibly even nationally-focused.

Because of LTD's partnership with OSU, Papalaxsimisha Program students now benefit from a host of University resources like summer camps, admissions, tutoring, internships, and mentoring. LTD believes Native students have been successful because Papalaxsimisha applies a family engagement model—it is not just student-centric, like so many other programs designed to boost educational achievement. In Papalaxsimisha, the whole family is introduced to the college experience, and as early as 6<sup>th</sup> grade or sooner for the youth. The program allows families to visit OSU, feel welcome, have fun, get engaged, and even learn about the college admissions process and financial aid, which can be daunting to families experiencing the college system for the first time.

#### *Example 2:*

In 2015, the Klamath Regional Health Equity Coalition (KRHEC) sponsored a second rural equity coalition in Chiloquin, where the community priorities are youth substance abuse prevention and positive youth development. Over the past several months, adults and students working with the Chiloquin First Coalition have collaborated to bridge a historic gap between the AI/AN community and rural White neighbors. After-school programs, such as open gym hours and community dances, have provided youth in Chiloquin with positive activities and opportunities to build positive relationships across diverse community members. The goal is that these efforts will aid in decreasing rates of crime, youth incarceration, and ultimately help keep youth in school. These activities are also helping to build social norms that include sobriety, cultural sensitivity, and more opportunities for positive choices for all residents, regardless of age.

## Outcome 5: Policy Change

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

Four of the six RHECs have directly engaged local and state policymakers on issues of health equity through RHEC sponsored public forums, participation in meetings and committees, and public testimony.

## Outcome 5: Examples from the Field

### *Example 1:*

The Mid-Columbia Health Equity Advocates (MCHEA) provides an excellent example of local policy engagement. Prior to MCHEA's work in the community, there were no Latinos holding elected office in Hood River County; now there are 10 Latinos on various boards.

This process began with community engagement. For example, the superintendent asked MCHEA, "Why don't we have more Latino parents involved in their kids' education?" MCHEA conducted a survey about parent barriers and solutions, a RHEC community leadership group member presented results to the school board, and following that, one of the parents was inspired to serve on the school board. She ran, won, and became the 1<sup>st</sup> Latina to ever hold office in Hood River. Since then, another RHEC member won a seat on the transportation board as a write-in with 427 votes in a two-week campaign, and there have been many other similar stories about Latino candidates stepping forward to serve and winning seats. Additionally, Hood River Mayor Paul Blackburn has been meeting with MCHEA staff to recruit community members to the Mayor's Latino Advisory Council, and to learn more about the needs of the local Latino community. As a result of these meetings, the Mayor is now considering adopting a policy that addresses needs for language services.

### *Example 2:*

The Oregon Health Equity Alliance (OHEA) has made incredible progress on policy change for health equity at the state level. OHEA has created a process for members to participate meaningfully in the legislative process at every stage, from development and evaluation of policy, to passage of policies through committees and on the floor. Overall, OHEA has created a unified, clear, and intentional policy agenda that has influenced the social determinants of health and healthcare in Oregon. The Policy Committee develops, analyzes and informs local and state policy. Members receive education and training around policies and the political process to build capacity. The Policy Committee engages with legislative representatives, community members and leaders, and the media. Special guests are invited to inform the members.

As a result of this process, OHEA helped ensure the passage of legislation in the 2015 Legislative session including:

- **SB 454 Paid Sick Time:** This bill creates a statewide standard that allows all Oregonians to earn sick time while working.
- **HB 2002 End Profiling:** This bill: 1) prohibits law enforcement from stopping, searching or questioning persons of color, the homeless, and LGBTQ people without reasonable proof, 2) authorizes the Attorney General to collect citizen complaints, and 3) requires and track law enforcement data on stops, questioning, or searches of minority individuals.
- **HB 3025 Ban the Box:** This bill removes questions about criminal history from job applications to ease employment barriers. The bill helps create fair chances for people with previous arrests or conviction records to compete for jobs.

OHEA also co-published the "Mend the Gap" report that provides policy recommendations to address gaps and challenges to healthcare coverage for the communities they serve. The report presents data

and case studies which support OHEA's policy priorities. There was an informational presentation in the Senate and House Healthcare Committees, a rally, and media coverage around this work.

## Summary

Through the use of the RHEC model, the coalitions build on the inherent strengths of their local communities to meaningfully involve them in identifying sustainable, long-term, policy, system and environmental solutions to increase health equity for underserved and underrepresented populations experiencing health disparities.

Specifically, the six RHECs serve diverse communities in multiple regions of the state with the ability to reach 68% of Oregon's total population, including 77% of OHP's racially diverse communities and 55% of OHP's Hispanic population. This includes people of color, immigrants, refugees, migrant and seasonal farmworkers, low-income populations, individuals with disabilities, and LGBTQ communities- in both rural and urban areas. In the last 6 months of 2015 alone, RHECs were able to impact 21 sectors, and reach more than 600 organizations and over 12,000 individuals. All of this work builds the foundation for empowering communities to sustainably improve health equity across Oregon.

Disparities that communities in the RHEC regions face greatly impact many of our systems- namely, the health, education, housing, employment and transportation systems. The Regional Health Equity Coalitions have made great strides in a relatively short period of time to begin addressing several social determinants of health that have persisted for generations. Ultimately, the coalitions are improving the overall state of health equity in Oregon- making this work a nominal investment for substantial, long-term improvements among the state's most vulnerable populations.

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