

# Regional Health Equity Coalitions: Equitable Governance Structures 2018

## Purpose of this Document

This document outlines the various governance structures of the Regional Health Equity Coalitions (RHECs). Each coalition's organizational structure, decision making processes, and stakeholders engaged all impact the success of their work. This information is presented to offer ideas around various governance models that others may want to consider in the future. Each coalition's structure is unique and are ever-changing. Ideally governance structures are responsive to the needs of the coalitions based on the issues faced within each region, the body of work related to those issues, existing capacity, and timeline to be achieved. Suggestions for best practices and lessons learned are also provided.

## Background Info

Regional Health Equity Coalitions (RHECs) are autonomous, community-driven, cross-sectoral groups. The RHEC model works by building on the inherent strengths of local communities to meaningfully involve them in identifying sustainable, long-term, policy, system and environmental solutions to increase health equity for communities of color, and those living at the intersection of race/ethnicity and other marginalized identities.

In 2011, the Oregon Health Authority's (OHA) Office of Equity and Inclusion (OEI) established the Regional Health Equity Coalition Program and provided funding to support local, community-driven, culturally-specific activities to reduce disparities and address social determinants of health. With funding, coalitions select the region and populations to focus their work on. Each RHEC conducts community needs assessments to identify priority areas to concentrate their efforts, and ultimately inform their strategic plans. Both strategic plans and contract deliverables (i.e. meaningful community engagement, strengthening organizational capacity, social norm and environment change, and policy and system change) help provide guidance on annual work plans.

## The RHEC Model

The RHEC model supports regional, community-driven, culturally specific, cross-sector strategies aimed at reducing local health disparities and promoting equity. Coalitions build on the inherent strengths of their communities. Additionally, coalitions utilize a policy, systems and environment (PSE) framework to craft and implement sustainable, long-term solutions to eliminate health inequities and address the social determinants of health. The basis for the RHEC model is a theoretical framework that increased and authentic community engagement, strengthened organizational capacity, and social norm and environment change are the foundation for policy and system change.

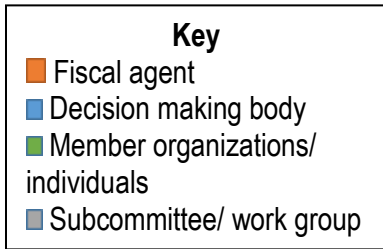
## Current RHECs

The four RHECs serve populations in nine Oregon counties. The work of the RHECs covers a wide range of underserved communities in urban, rural and frontier regions with communities of color as a leading priority. Current coalitions are below:

- Linn Benton Health Equity Alliance (LBHEA): Linn & Benton Counties; received OEI funding since 2011
- Mid-Columbia Health Equity Advocates (MCHEA): Hood River & Wasco Counties; received OEI funding since 2014
- Oregon Health Equity Alliance (OHEA): Multnomah, Washington & Clackamas Counties; received OEI funding since 2011
- SO Health-E (Southern Oregon Health Equity Coalition): Jackson & Josephine Counties; received OEI funding since 2014

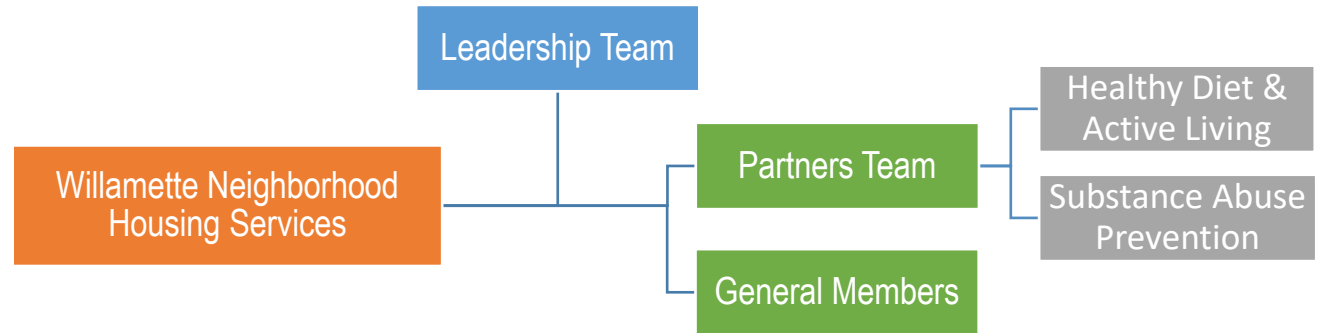
# Regional Health Equity Coalitions: Equitable Governance Structures 2018

## Linn Benton Health Equity Alliance (LBHEA)



**Info at a Glance**

First Year of OEI Funding: 2011  
 Member Organizations: 44 (14 grantees, 30 other stakeholders)  
 Individual Members: 80  
 Steering Committee: 9 orgs & their reps  
 Number of Staff: 4  
 OEI-paid FTE: 0.65/ Total FTE: 1.5



LBHEA provides capacity building mini-grants (up to \$3,000) to bring diverse voices to the table and to allow smaller organizations to regularly attend meetings/events. In addition, sponsorship awards (up to \$2,000) as well as policy and systems change grants (up to \$15,000) are offered to partner agencies.

### Leadership Team

There are 7-11 members who represent communities of interest and other local stakeholders. They are expected to regularly attend meetings every other month in person, and via conference call as needed. The Leadership Team is charged with the authority to make key decisions for LBHEA. In order to hold a vote, a quorum consisting of three-fourths of the Leadership Team must be present. Those who are unable to attend when a vote is taken have the option to send a proxy in their place. Voting by consensus by preferred, but majority rule is considered when needed, and if the topic is sensitive, members submit votes anonymously.

### Partners Team

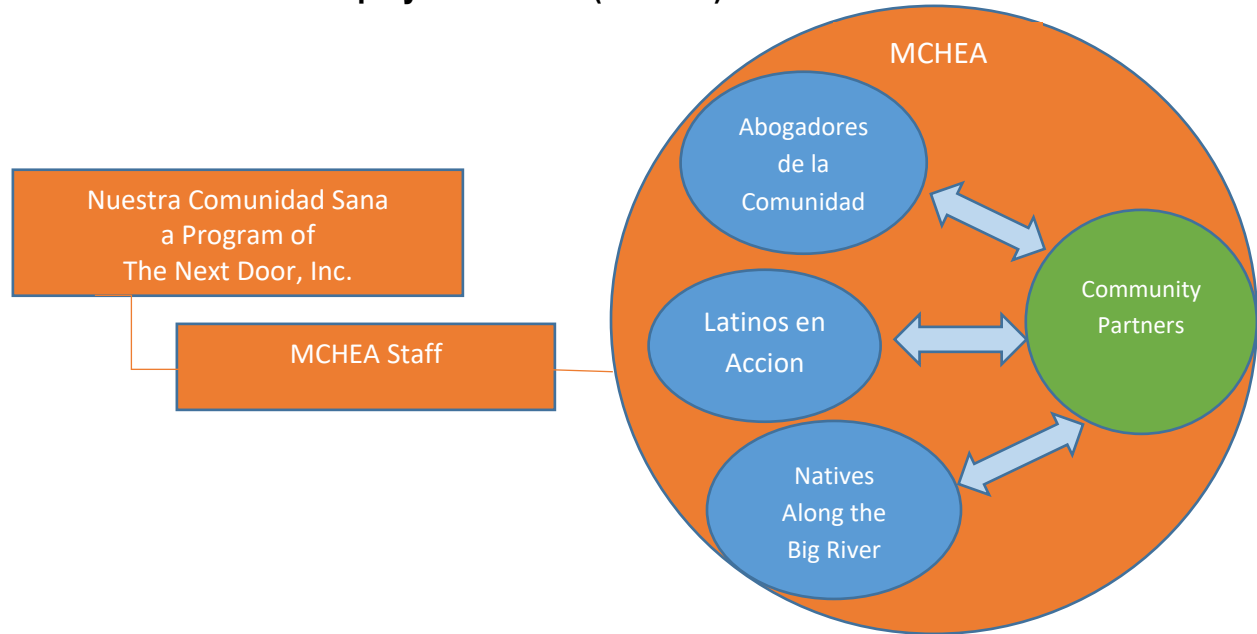
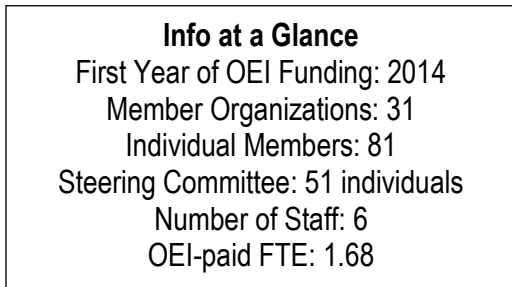
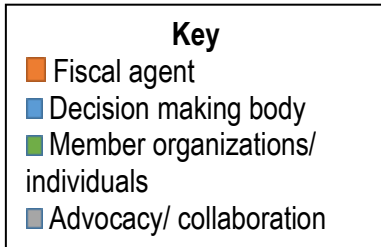
All organizations and/or individuals who receive grants from the LBHEA are considered de-facto Partner Team members. Organizations that receive sponsorships are not mandated to attend Partner Team meetings. Partner Team members are expected to regularly attend meetings which take place 6-8 times over the course of the year, as well as quarterly coalition meetings. Two individuals in the team serve as the co-chairs.

### General Members

Membership in LBHEA is open to any individual or organization that supports the LBHEA mission and provides, supports, or is interested in health equity in Linn and Benton Counties. The General Membership is invited to attend quarterly coalition meetings that will rotate between Linn and Benton counties, as well as other open coalition events and trainings.

# Regional Health Equity Coalitions: Equitable Governance Structures 2018

## Mid-Columbia Health Equity Advocates (MCHEA)



All members of decision making bodies vote for decision making; simple majority rules apply. Stipends are provided to active members.

**Abogados de la Comunidad** guides the health equity work in The Dalles. The group’s priorities are education, free or low cost physical activities, cultural humility, access to healthy foods and transportation.

**Latinos en Acción** leads the health equity work in Hood River. The group’s priorities are leadership development, county ID card, housing, transportation, access to healthy foods and free or low cost physical activities.

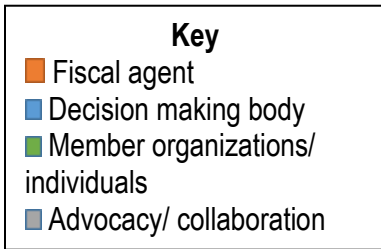
**Natives Along the Big River** guides the health equity group for the Native American Community. The group’s priorities are education, inclusion, transportation, access to medical services and community center.

**Community Partners** is made up of people from organizations who are interested in improving health equity in Hood River and Wasco counties. This group works to support the decisions made by the three leadership groups above, take messages from the leadership groups regarding priorities, concerns and solutions to their organizations and advocate for policies related to these within their organizations.

**MCHEA Staff** meet grant deliverables, help to coordinate and support the groups above. Staff also ensures that priorities, concerns and solutions of the leadership groups get communicated to the Community Partners, who can affect policy in their organizations and the broader community.

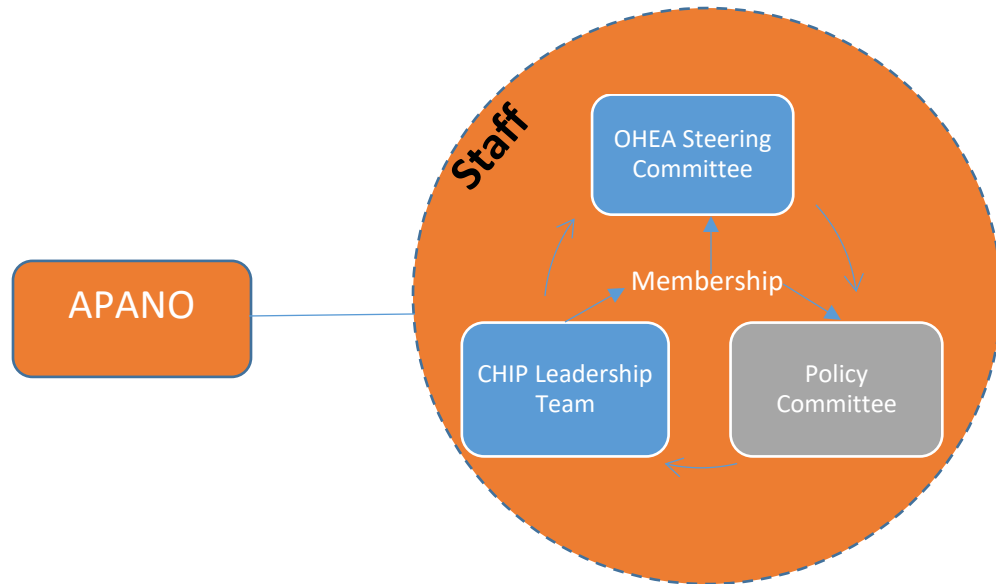
# Regional Health Equity Coalitions: Equitable Governance Structures 2018

## Oregon Health Equity Alliance (OHEA)



**Info at a Glance**

First Year of OEI Funding: 2011  
 Member Organizations: 36  
 Individual Members: 25  
 Steering Committee: 6 orgs & their reps  
 Number of Staff: 2  
 OEI-paid FTE: 1.0/ Total FTE: 3.5



### Steering Committee

This is a group of six people who provide overall direction and leadership on action items (i.e. budgets, staffing plans, new member applications, approves legislative policy platforms and member request for endorsement [with input from Policy Committee], discusses legislative agenda item suggestions from members, works with Director and staff to set quarterly meeting agendas and support Director and staff in meeting deliverables). Steering Committee members are all original founding member organizations, and are community-led with staff representing communities served. Two Co-Chairs serve for 1 term. Monthly decisions are made by consensus, with urgent decisions made by Co-Chairs. Steering Committee organizations receive sub-grant for participation.

### CHIP Leadership Team (AKA Community Powered Change)

Creates Multnomah County Community Health Improvement Plan, which is a community-led action-oriented plan outlining priority community health issues and how these issues will be addressed, including strategies and measures, to ultimately improve the health of a community.

### Membership

Alliance of organizations working with and on behalf of people that face challenges or categorical exclusions to health equity. Meets quarterly and is comprised of 36 members. Members participate at quarterly membership meetings and are encouraged to attend subcommittees and workgroups as they are held. There is a sliding scale for annual membership dues for member organizations. OHEA uses a participatory process for all members and aims to obtain consensus from all members. Members can provide recommendations to the Steering Committee for decision making, and the Steering Committee makes final decisions by consensus.

# Regional Health Equity Coalitions: Equitable Governance Structures 2018

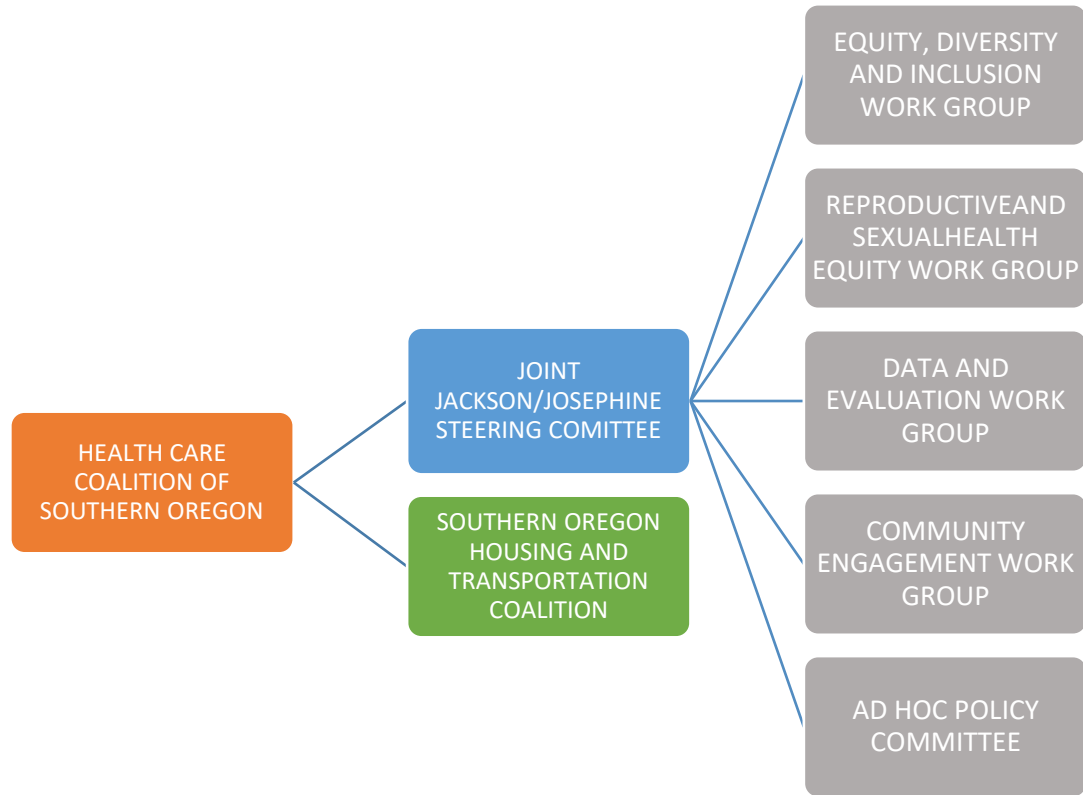
## SO Health-E (Southern Oregon Health Equity Coalition)

**Key**

- Fiscal agent
- Decision making body
- Member organizations/ individuals
- Advocacy/ collaboration

**Info at a Glance**

First Year of OEI Funding: 2014  
 Number Member Organizations: 16  
 Individual Members: 139  
 Steering Cmte: 16 orgs & 17 of their reps  
 Staff: 4  
 OEI-paid FTE: 1.6/ Total FTE: 3.1



### Steering Committee

There are 17 members of the steering committee. Decisions are made by a [“fist to five” consensus](#). When the coalition reaches an impasse, a majority vote will determine the final decision. Decision making processes codified in a coalition charter. The steering committee provides recommendations for all budgetary or large programmatic decisions to the Health Care Coalition of Southern Oregon Board.

### Southern Oregon Housing and Transportation Coalition

This is a sister coalition made up of 41 members.

### Work Groups

There are 5 work groups within the coalition, and 81 work group members.

# Regional Health Equity Coalitions: Equitable Governance Structures 2018

## Lessons Learned

The following is a summary of some of the lessons learned over the years about more effective approaches to governance:

- Culturally specific organizations or those who have values related to racial equity that are in alignment with coalitions, are a better fit as a backbone organization or fiscal agent. For example, often more decision-making authority and trust is given to coalitions when values related to racial equity are the same for both groups. This may also allow more flexibility and autonomy for RHECs' to advocate for policy change.
- Government agencies as fiscal agents are not a good fit with the RHEC model due to bureaucracy, the potential for institutional racism to be manifested, and limitations in terms of advocacy.
- Decision making bodies (i.e. leadership teams or steering committees) should be representative of communities of color. Based on OEI's contract deliverables, all RHECs are required to have at least 51% representation of communities of color in their decision-making groups.
- Governance structures are best when they are fluid and responsive to the needs of the coalition.
- Some coalitions have more than one decision making body to ensure representation of specific populations of focus or geographic regions.
- Several coalitions have codified governance through a charter to ensure clarity, and continuously revise them over time. Charters often include topic area such as vision and mission, defining roles and setting expectations of membership, decision making groups, subcommittees and workgroups, decision making processes, etc.
- While all coalitions are cross-sector by nature of the RHEC model, most intentionally include dominant culture organizations and systems. This ensures that groups who often hold formal authority to make change can champion equity initiatives internally within their agencies and organizations. These groups are key to include so there are opportunities to create readiness for change through relationship building and education.
- Having at minimum, a single full-time staff person in a coordination role improves coordination, communication and ultimately supports the overall success of the coalition.
- Providing stipends to RHEC leadership members for their participation honors their work in these groups and helps support sustained engagement.

# Regional Health Equity Coalitions: Equitable Governance Structures 2018

**Table 1: Considerations for RHEC Governance Structures<sup>1</sup>**

Concepts	Operational Definition	Indicators
<b>Decision making authority</b>	Hierarchical versus decentralized (or non-hierarchical) governance	There are instances of single and multiple decision making bodies for the purpose of ensuring representation of communities, either collectively or as affinity groups (i.e. by racial/ethnic groups, or by region/geography). Most important, is ensuring appropriate and sufficient representation of diverse members within these groups (see composition below).
<b>Core Structures</b>	Relationship between backbone or fiscal agent and decision making bodies	Culturally specific backbone or fiscal agents are preferable due to the likelihood that there will be shared values and foundational understanding of racial equity. While the resources and support the backbone/fiscal agent provides the coalition is critical, ensuring the decision making bodies have the autonomy necessary to actualize their goals is key.
<b>Composition</b>	Membership of decision making bodies (i.e. leadership teams, steering committees, etc.), member organizations or partners, and general coalition membership	<ul style="list-style-type: none"> <li>-The majority of members of decision making bodies should be representative of the communities of color intended to be impacted.</li> <li>-Dominant culture agencies and organizations related to coalition priorities should be considered as potential partners/member organizations who can assist in supporting and championing coalition goals, but should not largely be in key leadership or decision-making roles.</li> <li>-Having general coalition meetings that are open to all members of the public may be considered as an ongoing mechanism for community outreach that can draw people into more engaged roles in the future. It also establishes a larger presence of accountability and expectation around racial justice.</li> </ul>
<b>Functioning</b>	The work of the coalition and the way it is performed	The core function of RHECs is to build coalition to identify most pressing equity issues, and develop policy, system and environment solutions. Coalition work can only be considered meaningful when it is truly led and representative of the communities most disproportionately impacted by health inequities. Capacity building and opportunities for many ways of engaging ensures better access to full participation.

<sup>1</sup> Adapted from Ansell, C., & Gash, A. (2007). Collaborative governance in theory and practice. *Journal of Public Administration Research and Theory*, 18(4), 543-571.