



Together in Health

**2019-2023 Community
Health Improvement Plan**



health

share

Health Share of Oregon

“We have the answers to solve health disparities – they are carried in our stories, our land, and our DNA. Only when this knowledge is incorporated and valued will we begin to achieve health equity.”

URBAN INDIAN HEALTH INSTITUTE



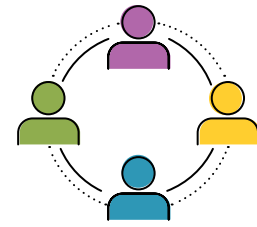
As the Community Advisory Council (CAC) for Health Share of Oregon, we present our Community Health Improvement Plan (CHP) of 2019-2024.

This CHP is a thoughtful, intentional response to the needs identified in our 2018-2020 Community Health Needs Assessment (CHNA) of the same name: *Together in Health*. It prioritizes the needs that were elevated by the community and our members. This plan will move our communities closer to health equity in the next five years.

We, the CAC, are representatives of your communities (and OHP members) and are tasked to ensure OHP members' and community voices are centered in all of Health Share's planning, operations, and initiatives. We identify, advise, and recommend promising and culturally responsive best practices, strategic initiatives, and investments that promote health and wellness for tri-county communities. We work collaboratively with Health Share's Board of Directors to ensure this plan directs strategic planning and drives investments into our communities that support health.

The CAC and Health Share are committed to achieving health equity for our members through transparency, innovation, and collaboration with partners and communities. We are also committed to remaining engaged with communities and our members throughout the life cycle of this five-year CHP.

Our hope is that this CHP leads to even more partnerships, alignments, and investments throughout our region, creating positive impacts for our communities.



**“We asked,
you spoke, we
listened, we’re
still listening”**

**ABIGAIL LAWRENCE,
COMMUNITY ADVISORY
COUNCIL MEMBER, HEALTH
SHARE OF OREGON**

Guiding Values and Principles

Early in the process, Health Share's Community Advisory Council held a retreat where we shared our hopes and dreams for this Community Health Improvement Plan. It all started with a simple question: "What are your hopes for the CHP?" The responses formed the following guiding values and principles.



Grounded in health equity, trauma-informed care, and social determinants of health.



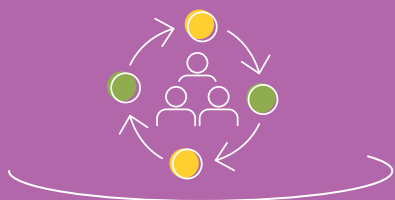
Strategic by including upstream and downstream efforts so that we address the social determinants of health upstream while impacting clinical improvements downstream.



Aligned with our local public health departments and health system partners to maximize impact.



Strengths-based in order to lift up the assets and resiliency of the communities we serve.



Adaptive and emergent in that it should be designed to respond to what we know, while also holding space to adapt to new information from communities throughout the duration of the plan.

Racism is pervasive throughout society, with visible and invisible consequences creating tangible impacts on the lives of many individuals and communities.

Structural racism and institutional white dominance, as evidenced in the disparate outcomes of all social determinants of health, are foundational to the distribution of and access to resources, including health care. According to the World Health Organization, the social determinants of health are “conditions in which people are born, grow, live, work and age,” and they include factors such as education, employment, housing, food access, and environmental exposure.

Inequitable access to resources serve to privilege the dominant culture while demonstrating an increase in long-term impacts of stress, notable disparities in educational attainment and employment, infant mortality, maternal health, and poverty rates – all clear indicators of a community’s health. Research and data demonstrate the clear relationship between structural racism and the social determinants of health, which has been foundational to extreme inequities in health outcomes.

Though racism and oppression are embedded in the foundation of this country, Oregon has a unique history of racialized policies and practices that have perpetuated generational and lasting health impacts experienced by communities of color. It is only when we acknowledge the harm caused by these policies and practices, and actively create inclusive systems with communities of color that share power and center the expertise of the community, that we can begin to interrupt institutional white dominance.

We can start addressing disparities in health outcomes, in part, through changing how we invest and prioritize the distribution of resources, sharing power in decision-making and collaborative efforts, making intentional efforts to create policies and infrastructure that dismantle structural racism, and creating systems that uplift marginalized and oppressed communities. This is why we have prioritized addressing racial equity and social determinants of health in our CHP – we believe that we all have the right to live long and healthy lives and envision a healthier community for all.

Overview

In response to health needs identified in Health Share's 2018-2020 CHNA, the CAC identified five strategic priorities:



Supportive Housing

Supportive housing is a key social determinant of health that often underlies individual and community health disparities.



Food Access

The ability to access fresh, affordable, and culturally relevant foods is a foundation for healthy growth and development throughout the lifespan. Food access deepens connection to the environment and increases social connectivity access; healthy food access is one signifier of a community's health.



Social Connection

Research demonstrates social connectivity is among the most important predictors of health and well-being.



Access to Care

Culturally responsive, accessible, and high-quality care that includes access to primary care, mental health, behavioral health, and oral health can help people live longer, healthier lives.



Chronic Conditions

Approaching chronic conditions with an ethno-racial analysis will help us take action and focus attention on how health differs within communities of color, which are often most impacted by health disparities.

Priorities

Social Determinants of Health

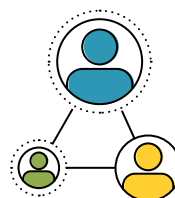
Clinical and System-Level

1 Supportive Housing — 2 Food Access — 3 Social Connection — 4 Access to Care — 5 Chronic Conditions



The CAC engaged community members in Clackamas, Multnomah, and Washington counties to help refine the priorities and identify potential strategies.

Health Share will work on priorities in stages throughout the complete CHP cycle, with the first year focusing on Supportive Housing and Access to Care. Health Share has developed strategies, metrics, and goals to accomplish both of these priorities, which are described in the companion document, *Connecting Care*. In future years Health Share will engage communities to develop strategies, metrics, and goals for the other three priorities. Each year, Health Share will publish an update describing priorities for the next year and report progress from the past year.



Alignment

Health Share's priorities align with the priorities identified in the community health improvement plans for Clackamas, Multnomah and Washington counties. Health Share's work will complement the county plans through intentional investments, collaboration, and by placing a strong focus on groups in the region that experience the greatest disparities in health and health care.



History and Evolution

Health Share's CAC released its second Community Health Needs Assessment in 2018. Both quantitative and qualitative feedback informed it, encapsulating the overall health of Clackamas, Multnomah, and Washington counties.

That feedback and data set the foundation for this report. Key findings from the CHNA can be found online: www.healthshareoregon.org/commitment-to-health/health-for-all.

This report is our roadmap for how Health Share can best meet the needs of the community and contribute to whole-person care and well-being. It is based on extensive community feedback and engagement, prioritizes the strengths and needs of the community, and helps us achieve our mission!

This is Health Share’s second CHP; some of the noted differences from the first one are:



**“Inequity Kills,
Equity Heals”**

**SOCIAL MEDICINE
CONSORTIUM**

1. A focus on the social determinants of health.

Health Share recognizes that health is more than just an absence of disease and that it is shaped by the conditions in which we live, work and play. Toward that end, Health Share is committing to investing resources to address the social determinants of health in our community.

2. An acknowledgement on the impacts of racism on health and health outcomes.

As outlined on page 4 of this CHP, racism is a factor in our community that has disastrous consequences on the health of many of our members. Not only is racism morally reprehensible, it is emotionally and physically killing our communities. We all deserve better, and it will take deliberate actions from all of us to end it.

3. A commitment to invest. Health Share’s Council and Board are committed to investing resources to realize the priorities within this report.

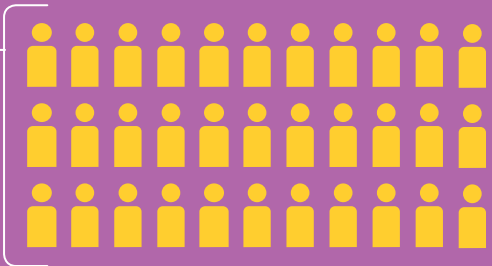
We are also committed to using this CHP to guide our strategic investments and transformation efforts, and to be accountable to the promises we are making.

4. An iterative process.

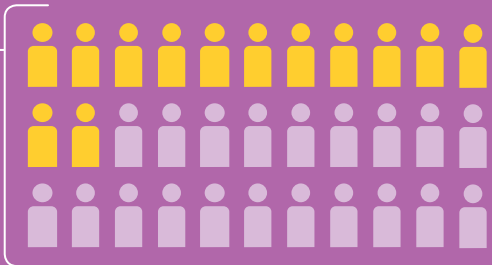
Recognizing our own limitations in our data, and collecting community input, we commit to continually listening to our community, collect more information on the needs, strengths, and priorities of our communities, and ensure efforts to elevate the most marginalized voices so we can improve on our CHP each year. We commit to providing yearly progress updates and new strategies in order to be responsive to the emerging needs of our communities.

Our Members

331,061 total members



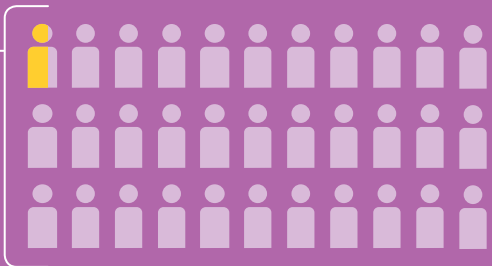
130,790 (40%) under 18



44,584 (14%) have not used services in the last 15 months

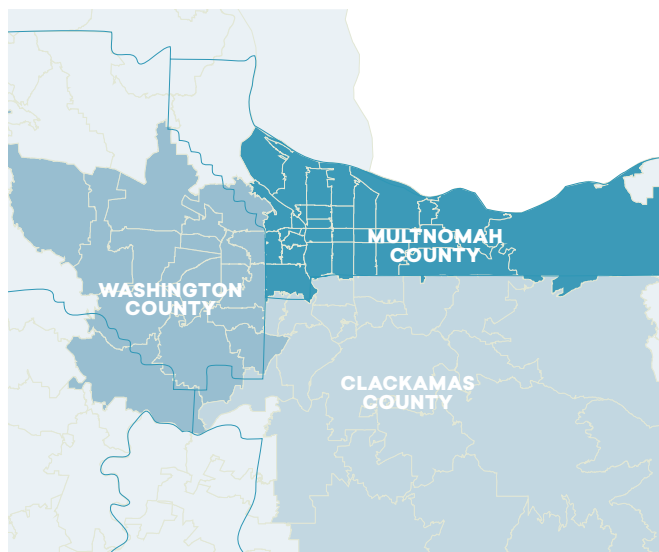


7,721 (6%) youth in foster care*



*Were in foster care at some point in their history as a Health Share member

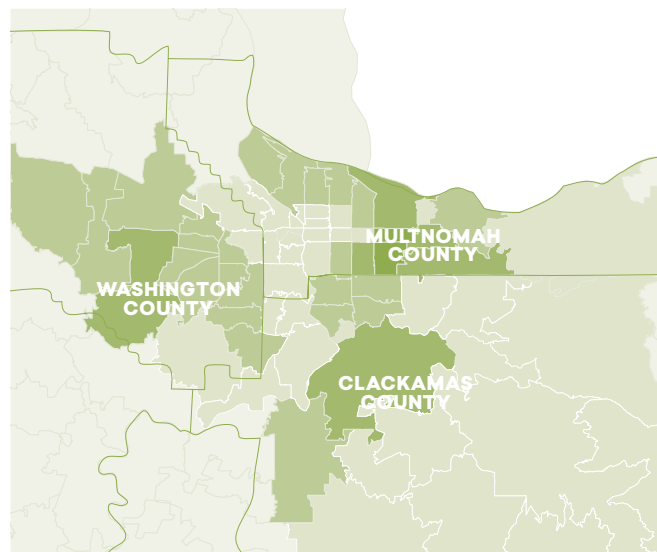
Map of current health share members June 2019



- Clackamas County**
62,638 members | 19.4% of Health Share members
- Washington County**
87,243 members | 27% of Health Share members
- Multnomah County**
173,190 members | 53.6% of Health Share members

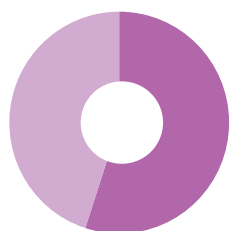
About 1 percent of Health Share members have zip codes outside of the tri-county area due to special circumstances or data entry errors.

Health Share members ages 0-17 June 2019



- 0-1,700 members**
- 1,700-3,500 members**
- 3,500-6,000 members**
- 6,000+ members**

Gender



- 53% Female**
- 47% Male**

Note: Collected data is limited to binary gender identity and inaccurately reflects members who identify as transgender, two-spirit, and otherwise outside of the gender binary.

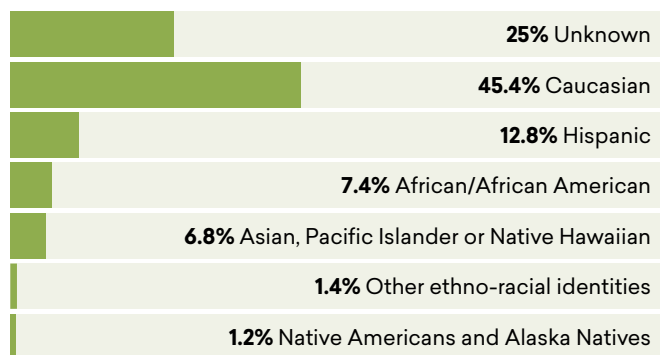
Language

16% identify a language other than English as their primary language

Our members speak over **75** different languages

The most frequently identified primary spoken languages are English, Spanish, Russian, and Vietnamese

Race/Ethnicity



Note: Health Share lacks ethno-racial identity data for approximately 25% of our members. Please note the significant change in data as it relates to the unknown data from 40% in our last CHNA report to 25%. Race/ethnicity data comes from OHP applications. All data is from Health Share claims as of June 4, 2019, unless otherwise noted.

Health Care utilization in the last 12 months

The number one reason members sought care was for routine, preventative health services

6 in 10 (62.7%) had a primary care visit

4 in 10 (38.5%) had a dental visit

1.4 in 10 (14.0%) had a behavioral health visit

On behalf of Health Share’s Board of Directors, I am pleased to provide this letter of commitment for the 2019-2024 Community Health Improvement Plan (CHP).



**“Individually, we
are one drop.
Together, we
are an ocean.”**

RYUNOSUKE SATORO

Our role as the Board is to provide vision and guidance that enable Health Share to achieve its mission—to partner with communities to achieve ongoing transformation, health equity, and the best possible health for each individual.

The Oregon Health Authority has entrusted Health Share with the care and well-being of not only our members but also our community. We deeply honor this responsibility and invest accordingly. To achieve our goals, it is imperative to recognize data which has demonstrated a need for intentional investment to marginalized and oppressed communities. Shaped by community voices, the CHP is a key component of our roadmap that will help guide our strategic initiatives to improve community health.

We acknowledge optimal and holistic health is more than the absence of disease but encompasses physical, mental, social well-being, and the social determinants of health. We are excited to take the opportunity to leverage the wisdom and expertise of our community to drive our strategic priorities through the CHP.

We are committing to invest financially in our 2019-2024 CHP to address the social determinants of health and achieving health equity.

Sincerely,

Marni Kuyl, RN, MS
Director, Department of Health and Human Services
Robert Wood Johnson Foundation Executive Nurse Fellow

What's Next?

The Health Share Board of Directors, CAC, staff, and partners are committed to ensuring the CHP is used as a roadmap to help guide Health Share in creating tangible responses to community needs as identified in the Community Health Needs Assessment.

Health Share strategies as outlined in the CHP will include both financial and staff resource investments, new and expanded partnerships, and continued community engagement. To ensure accountability and transparency of Health Share's investments in CHP strategies, Health Share will launch a new section on our website that allows for ongoing community input and provides evaluation and progress of CHP-related investments.

The CAC will continue to engage communities throughout the five-year CHP cycle, with a prioritized focus of engagement with communities of color and other marginalized communities. To maximize impact of CHP investments, Health Share will hold listening sessions, connect with other community councils, and engage in an environmental scan to learn about local efforts and identify opportunities to partner with organizations working to address the same health priorities. The CAC will continue to seek community advice and guidance on all CHP priorities – Access to Care, Chronic Conditions, Food Access, Social Connection, and Supportive Housing.

Achieving optimal community health requires partnership across all sectors. Health Share and its partners – hospital systems, counties, health plans, providers, and social service organizations – have collected information on local organizations and initiatives currently working on the CHP-identified priorities. By January 2020, the CAC will launch an online resource as an appendix to this report. By August 2020, the appendix will be expanded to share additional information on local efforts to address the five CHP priorities.

Glossary for CHP

Alignment: The term used to describe the process the Community Advisory Council used to compare the priorities and principles in the CHPs developed by Clackamas, Multnomah and Washington counties. The Council chose its priorities for this CHP by building on the top needs and priorities in the three counties' plans. The Council will support these shared priorities by placing added focus on the people who are most impacted by disparities.

Access to care: The ability of an individual to enter the healthcare system, find care easily and locally, pay for care, and have their health needs met.

Behavioral health: Mental health and addictive disorders such as problem gambling and/or substance use disorders.

Chronic conditions: Chronic conditions and illnesses include asthma, heart disease, diabetes, arthritis, and cancer. The burden of living with chronic disease is not the same for all communities. There is growing evidence that a person's race, ethnicity, gender, income, disability, sexual orientation, and geographic location determine the likelihood of many chronic conditions.

Community advisory councils (CACs): Groups that advise their CCO about community health issues. Council members include Medicaid members and other community representatives.

Community health improvement plans (CHPs): Five-year plans to address community health issues, needs, and priorities (from CCO 2.0).

Community health workers (CHWs): Frontline public health workers who are trusted members of and/or have a close understanding of the communities they serve.

Coordinated care organization (CCO): Community-governed organizations that bring together physical, behavioral, and dental health providers to coordinate care for people on the Oregon Health Plan. CCOs also have the flexibility to address their members' health needs outside traditional medical services. CCOs receive fixed monthly payments from the state to coordinate care and financial incentives that reward outcomes and quality. This model is designed to improve member care and reduce costs.

Disparity: Containing or made up of fundamentally different and often incongruous elements. Markedly distinct in quality or character. Disparities in relation to equity mirror social inequity and can be identified by stratified data by race, ethnicity, gender, sexual orientation, socioeconomic status, income, etc.

Health disparities: A disparity exists when there are different outcomes or circumstances for different groups. A difference in health status between social groups. Disparities in relation to equity, mirror social inequality and can be identified by stratifying data by race, ethnicity, gender, sexual orientation, socioeconomic status, income, etc. Disparities reflect social inequality.

Health equity: The ability for all to have a fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination.

Healthy Columbia Willamette Collaborative (HCWC): A unique local public-private partnership that includes 15 hospitals and four local public health agencies. HCWC helps its members bring together their resources for health improvement plans and activities to improve the health and well-being of our communities.

Houselessness: The state of lacking a residence or dwelling. There are many different groups that may be houseless using different types of programs or services and having different factors that contribute to their houselessness. People may experience houselessness for various lengths of time (short-term, long-term, or "chronic"), and some may experience multiple episodes of houselessness (moving between housing and houselessness). Those who are "doubled up" or "couch surfing" are also considered houseless if their housing arrangement is for economic reasons and is unstable. Accessible and affordable housing is the key underlying need for people in all of these situations regardless of other demographic factors.

Inclusion: The involvement and empowerment, where the inherent worth and dignity of all people are recognized.

Institutional white dominance: The ideal or assumptions that assign value, morality, goodness, and humanity to the white group while creating structural advantages and rights that people and communities of color do not have.

Racism: A system in which one race maintains supremacy over another race through a set of attitudes, behaviors, social structures, and institutional power. Racism is a “system of structured dis-equality where the goods, services, rewards, privileges, and benefits of the society are available to individuals according to their presumed membership in” particular racial groups (Barbara Love, 1994. Understanding Internalized Oppression). A person of any race can have prejudices about people of other races, but only members of the dominant social group can exhibit racism because racism is prejudice plus the institutional power to enforce it.

Social connection: The degree to which a person has and perceives a sufficient number and diversity of relationships that allow them to give and receive information, emotional support, and material aid; create a sense of belonging and value; and foster growth.

Social determinants of health (SDoH): Factors that affect health outside of the doctor’s office or hospitals, like poverty, access to housing, transportation, and neighborhood safety. Social determinants of health aren’t equally distributed in communities. Policies and structural factors like racism, sexism, age discrimination, and others mean that certain groups face more issues like poverty and lack of access to education. This results in health disparities. Health disparities are also caused by factors inside the healthcare system, like access to doctors or the availability of healthcare providers who speak your language and healthcare in rural areas.

Supportive housing: Very affordable rental housing that helps to provide stability for vulnerable people who do not have a home or are leaving institutions or hospitals. It is linked to intensive case management and voluntary, life-improving services like healthcare, workforce development, and child welfare.

Structural racism: A system in which public policies, institutional practices, cultural representation, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. Structural racism was not created by a person or institution but is an embedded element of the social, economic, and political fabric in which we all exist.

Traditional health workers (THWs): Workers who help individuals in their communities by providing physical and behavioral health services. There are five types of THWs: doulas, peer-support specialists (includes Family and Youth support specialist), peer-wellness specialists, personal health navigators, and community health workers.

Trauma: Individual trauma results from an event, series of events, or set of circumstances that a person experiences as physically or emotionally harmful or life-threatening, and that have lasting adverse effects on that person’s functioning and mental, physical, social, emotional, or spiritual well-being. Communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may experience a community-threatening event and have a harmful, long-term shared effect.

Trauma-informed care: An approach to delivering services that is based on understanding how trauma affects people. Trauma-informed care aims to make services and environments welcoming and engaging for the people receiving services as well as staff. Trauma-informed services are designed to avoid re-traumatizing individuals.

Universal design: An approach to designing an environment or product so that it can be accessed, understood, and used to the greatest extent possible by all people regardless of their age, size, ability, or disability.

“We seek equity and fairness, and a set of reforms that are entrenched in policy commitments that move the community towards a brighter future.”

COALITION OF COMMUNITIES OF COLOR & PORTLAND STATE UNIVERSITY

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Thank you to Maria Tafolla, Community Engagement Program Manager and Council's direct staff support, and facilitator of the 2019-2023 CHP from Health Share of Oregon

Health Share of Oregon Board of Directors

Health Share of Oregon Staff

Health Equity and Engagement Department

Communications Department

Community Partners, Councils, Boards, and Individual Contributors

Tri-County Community Forums Attendees

Washington County Access to Care CHP Committee

Clackamas County Public Health Advisory Committee

CareOregon Community Advisory Board

Adult Mental Health and Substance Abuse Advisory Council

Oregon Interpreter Association - Pacific NW Advisory Group

Cultural Humility & Health Equity Workgroup

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