2025-2029

# Community Health Improvement Plan

## Stronger Together: Collaborative Solutions for Community Health

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# Letter from Health Share + Trillium

Health Share of Oregon (Health Share) and Trillium Community Health Plan (Trillium) are pleased to present our 2025-2029 Community Health Improvement Plan (CHP).

Our role as the Community Advisory Council, Board, and Leadership is to provide vision and guidance that enable Health Share and Trillium to achieve our respective missions – to support a healthy community for all. We are proud to continue lifting the strength and health of our communities, one person at a time.

This is the first time Health Share and Trillium are working together on a shared CHP. We are honored to have this opportunity to work together with our regional partners to support our members and the larger community. We have listened to voices in our community and looked at important data to guide this plan. This CHP will be our foundation for the activities and investments we want to make to improve the health of our community for the next five years.

As you read through this plan, please remember that we have only just begun. Putting the plan into action is the most important part of this process. We will do this with our regional partners and community.

Yours in Community,

**Mindy Stadtlander**, Chief Executive Officer
Health Share of Oregon

**Sarah K. Brewer**, President & CEO
Trillium Community Health Plan

# List of Acronyms and Terms

Some of the most used terms in this plan are defined below. For a full glossary of acronyms, please refer to Appendix A.

**CAC** – Health Share and Trillium each have a Community Advisory Council (CAC). Each CAC includes Oregon Health Plan members and community partners who help think of innovative ideas that focus on health equity.

**CCO** – A Coordinated Care Organization (CCO) is a network of health care providers that work together to serve people who receive health care coverage from the Oregon Health Plan (OHP).

**CHA** – A Community Health Needs Assessment (CHA) is a process used to look at the health needs of a specific community or group. This CHP focuses on needs identified in the 2022 CHA for Clackamas, Multnomah, and Washington counties. "CHA" is sometimes referred to as "CHNA."

**CHP** – Community Health Improvement Plans (CHPs) present priorities, goals, and strategies for improving health.

**Community health** – Community health means protecting and improving the health of people in specific geographic areas. These can be neighborhoods, cities, or regions. We look at the needs of that community and work on ways to help. The goal of community health is to promote healthy living and prevent disease. It also means trying to reduce health disparities in groups of people.

**Goals** – Goals refer to what we're trying to get done in the long-term.

**HCWC** – The Healthy Columbia Willamette Collaborative (HCWC) is a partnership of 12 organizations in Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington.

**Members** – Members are the people who receive health care services from a Coordinated Care Organization (CCO). Members are also referred to as people who are on the Oregon Health Plan or OHP.

**Metrics** – Metrics are things we want to measure to track our progress. They also help us look at how effective these ideas are over time.

**OHP** – The Oregon Health Plan (OHP) is Oregon's Medicaid program, providing health care coverage to members who are eligible based on income, family size, and other factors.

**Priority Area** – A health priority area means a specific area that we are focusing on to improve the overall health of a community.

**SDOH** - Social Determinants of Health, also called Social Drivers of Health[a], are the social factors that affect health. They are the conditions in which people are born, live, learn, work, play, worship, and age. These conditions may include one's housing and neighborhood, income, access to and quality of education, and access to food.

**Strategy** – A CHP strategy is something we do to try to reach a specific goal or outcome.

**THW** – Traditional Health Workers (THWs) are trusted people from communities who may share social and economic connections with health plan members. They also might have similar life experiences. THWs may provide a bridge between people in a community and the health systems that serve them.

# About This Community Health Improvement Plan

## This plan will help move our communities closer to health equity in the next five years.

This 2025 Community Health Improvement Plan (CHP) presents ways to improve health in Clackamas, Multnomah, and Washington counties. This region includes the city of Portland, the largest city in Oregon with over 635,000 people. It also includes many other surrounding cities for a total population of over 1.8 million. Health Share and Trillium together serve over 527,000 members. This is about 30% of the regional population.

In this CHP, Health Share and Trillium are responding to the needs identified in the 2022 Healthy Columbia Willamette Collaborative (HCWC) Community Health Needs Assessment (CHA). Health Share and Trillium also listened to the community in 2024 and engaged with tribes to hear their ideas. This plan lines up with Oregon's 2020-2024 State Health Improvement Plan as well as the community health improvement plans for Clackamas, Multnomah, and Washington counties.

## Collective Impact: Making a Difference For All

Improving community health and equity requires a broad and collective effort. Health Share and Trillium have taken a collective impact[b] approach in this CHP. The CHP points out goals, priorities, and strategies that each Coordinated Care Organization (CCO) will work on over the next five years. However, recognizing that everybody relies on a shared network of resources, services, and supports, the CHP also represents ideas shared by many partners in the region.

The Healthy Columbia Willamette Collaborative (HCWC) is a partnership of 12 organizations in Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington. The HCWC provides a structure for Health Share and Trillium to work with local hospitals and local public health departments on shared community health goals. All of these groups look at how to align priority areas with needed resources, including funding.

Both Health Share and Trillium have partnerships with tribes that are recognized by the federal government. These include the Confederated Tribes of Warm Springs, The Confederated Tribes of Siletz Indians, and The Confederated Tribes of Grand Ronde. These tribes contributed to this CHP by participating on CCO Community Advisory Councils.

Health Share and Trillium each have Community Advisory Councils (CACs) and both CACs helped develop this CHP. The CACs include Oregon Health Plan (OHP) members, and this helps make sure that many community voices are heard.

Other key collaborators and contributors to this CHP are listed in Appendix B.

Health Share and Trillium are committed to achieving health equity and improving health for our members through transparency, innovation, and collaboration with partners. We will engage with communities and our members throughout this five-year CHP. We hope that this CHP leads to more partnerships and investments in our region to create positive change for our communities.

# Guiding Values and Principles

In 2019, as part of the development of Health Share's first CHP, Health Share's Community Advisory Council created a set of five Guiding Values and Principles. Health Share's current CAC members reconfirmed them in 2024. Health Share and Trillium prioritize the following Guiding Values and Principles in this CHP:

- We are **grounded** in health equity, trauma-informed care, and social determinants of health.[c]
- We are **strategic** by including upstream and downstream efforts so that we address the social determinants of health upstream while impacting clinical improvements downstream.
- We are **aligned** with our local public health departments and health system partners to maximize impact.
- We are **strengths-based** to lift up the assets and resiliency of the communities we serve.
- We are **adaptive** and **emergent** in this CHP 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[d] and institutional white dominance[e], 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.

Inequitable access to resources serves 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.

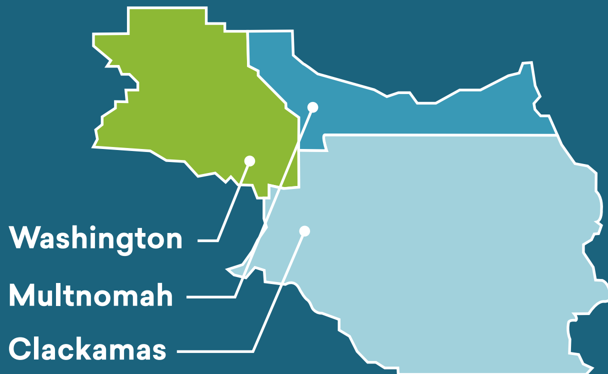
Though racism and oppression are embedded in the foundation of this country, Oregon has a unique history of racialized policies and practices that have perpetuated generational and lasting health impacts experienced by communities of color. It is only when we acknowledge the harm caused by these policies 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.

Health Share and Trillium are committed to leading with health equity. Our health equity statements guide this CHP. You can find these statements in Appendix C.

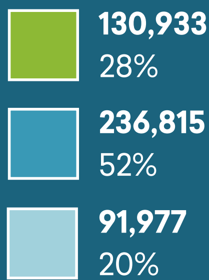
# 2024 CCO Member Demographics[f]

## Members by County



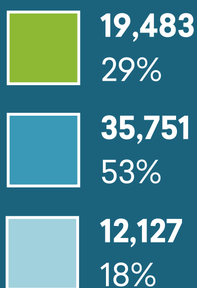

### Health Share

459,725 total



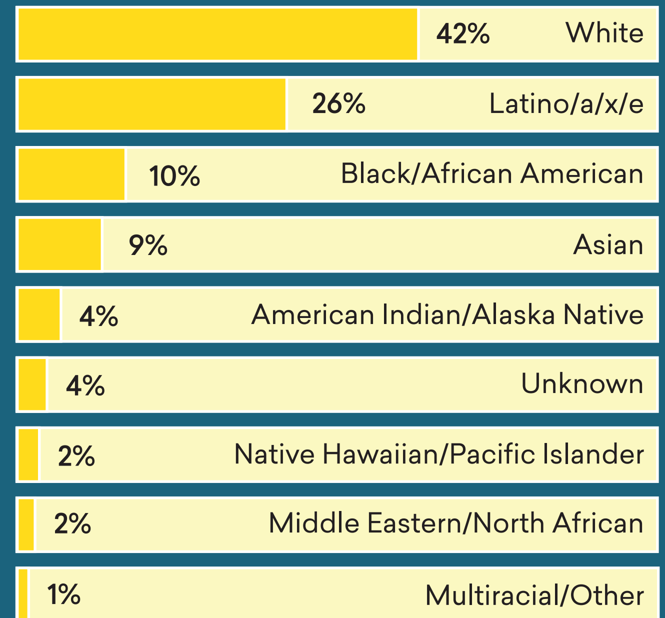
### Trillium

67,361 total

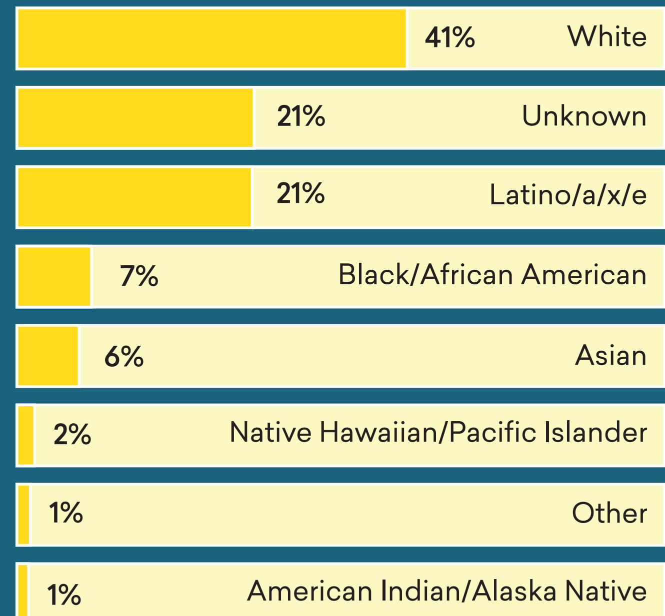


## Race/Ethnicity[1]

### Health Share




### Trillium

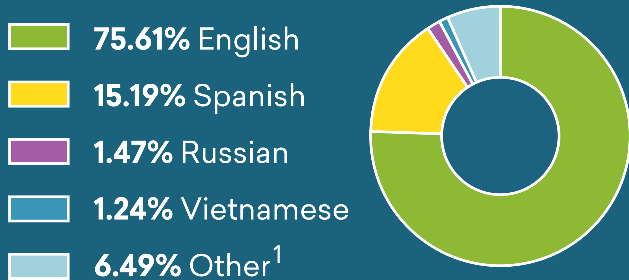



1 Race/ethnicity data comes from OHP applications. However, some members prefer not to share data, are unsure of their racial/ethnic identity, or do not identify with the listed options. Thus, the racial/ethnic categories "Unknown" and "Other" represent people who are unaccounted for in the other categories. For more information, see oregon.gov/oha/ei/pages/reald.aspx.

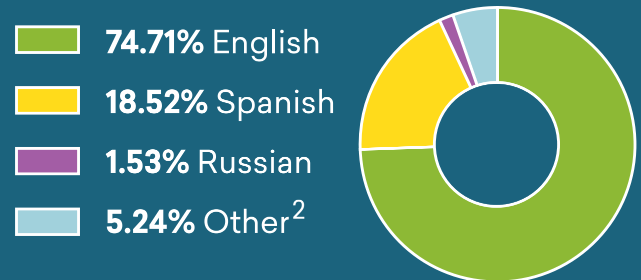
# 2024 CCO Member Demographics

## Preferred Language

### Health Share




### Trillium




## Gender

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. We are working with the Oregon Health Authority to get better representation in this data.

### Health Share

### Trillium

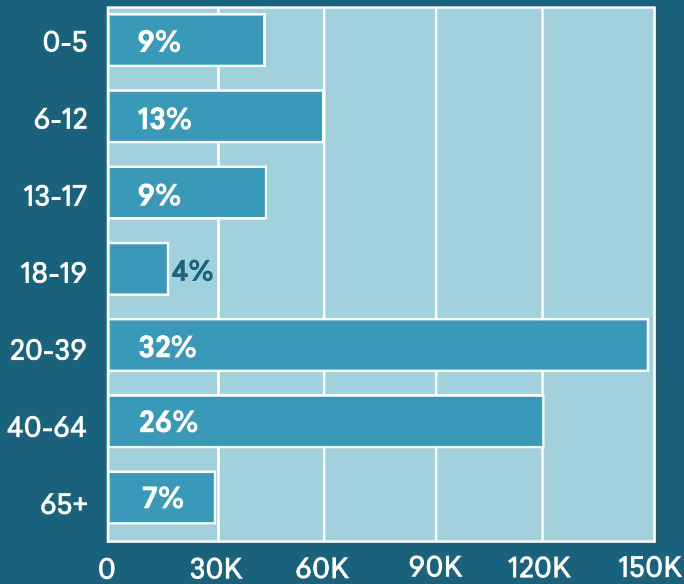
1 There are 199 other languages spoken by 6.49% of Health Share members.

2 There are 80 other languages spoken by 5.24% of Trillium members.

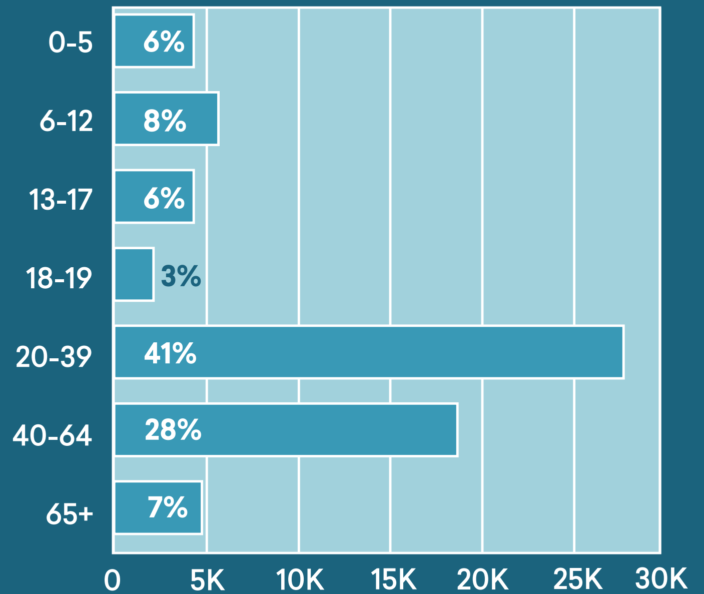
# 2024 CCO Member Demographics

## Age

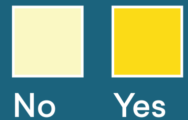
### Health Share




### Trillium




## People Living With Identified Disabilites[g]




### Health Share

### Trillium

# Community Engagement for the CHP

1. **May 2024**
   Community Engagement
   Propose CHP Priority Areas

2. **June-July 2024**
   Community Engagement
   Develop CHP Goals and Strategies

3. **August 2024**
   Identify Metrics
   Leadership and partners offer feedback on Goals, Strategies, and Metrics

4. **September-October 2024**
   Final CAC and Board of Directors Approval of Goals, Strategies, and Metrics

5. **January-March 2025**
   Present CHP to community
   Health Share and Trillium begin CHP implementation with partners

6. **2025**
   First of five annual Community Health Events

Most of the CHP process took place in 2024. Past assessments of community health needs and prior relationships with the community helped this process.

## 2022 Community Health Needs Assessment

The Healthy Columbia Willamette Collaborative (HCWC) released the most recent Community Health Needs Assessment (CHA) in 2022. The purpose of the CHA is to hear directly from community about how they experience health and what their greatest health needs and assets are. This important community assessment then guides health care organizations and public health departments in the region to plan for future programs.

The CHA includes information on health disparities. These differences in health can be defined by race, ethnicity, language, disability, age, gender, sexual orientation, and other factors.

Key findings from the 2022 CHA, as well as past CHAs, can be found on Health Share's website.

## Community Engagement for the Community Health Improvement Plan

Health Share and Trillium held many activities to engage the community. Some of the main things that community members want:

- Housing and housing support services
- More services for mental and behavioral health treatment
- Culturally specific services to make access to care more equitable
- More support from Traditional Health Workers (THWs)

The CHA from 2022 and community engagement in 2024 set the foundation for this CHP, which aims to address identified health disparities. All community engagement activities conducted specifically for the 2025 CHP are described in Appendix D.

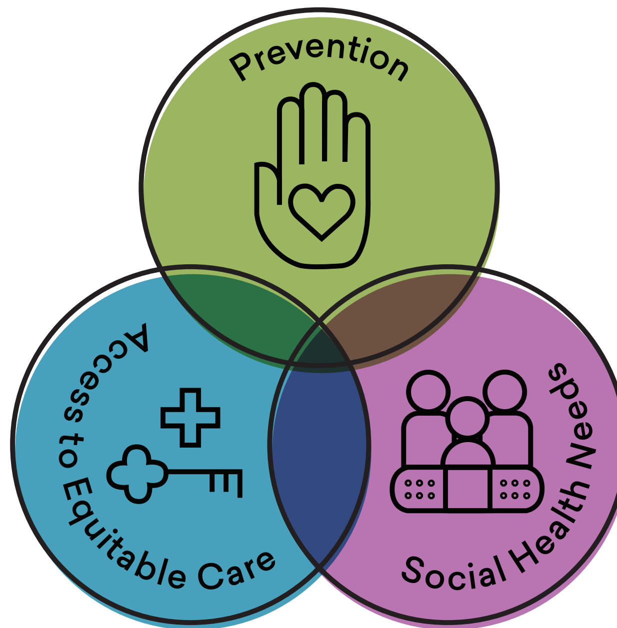
# Three Priority Areas

Health Share, Trillium, and their respective CACs identified the following three strategic priorities. We are committed to achieving health equity with our members and the broader community, spanning all ages. This is a theme for all three priority areas.

| | |
|---|---|
| **Access to Equitable Care** | **GOAL:** Members are able to access the health care system, connect to care easily and locally, and get their physical and behavioral health needs met. The workforce is equipped to support access to equitable health care. |
| **Prevention** | **GOAL:** Community partnerships, efforts, and investments are aligned to support prevention across all ages.<br><br>*This ranges from ensuring supports for children to have a healthy start, to providing adults with substance use disorders access to effective, person-centered treatment wherever they seek care in our region.* |
| **Social Health Needs** | **GOAL:** Partnerships are established to address social determinants of health in the member population. Social Health benefit (called Health-Related Social Needs, or HRSN[h]) is implemented. |

## Priorities are All Connected

In this plan, CHP strategies fall in these three distinct priorities. However, access to care, prevention, and social health needs are deeply interconnected. We must look at them as a whole to get better health outcomes. For example, individuals must have reliable transportation and stable housing to access health care services. This includes preventive care like screenings and vaccinations. Without addressing social health needs, such as food security or affordable housing, many people may be unable to get to preventive visits. They might not be able to manage chronic conditions well. This can lead to more severe health issues in the future. This shows that improving one priority area often strengthens the others. It points to the need for integrated approaches to improve community health.




## Alignment With Regional and State Priorities

Health Share's and Trillium's priorities and strategies in this CHP align with some of the priorities and strategies in the community health improvement plans for Clackamas, Multnomah, and Washington counties. Health Share's and Trillium's work will complement the county plans. They will do this 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. Also, some of this CHP's priorities and strategies align with those in the most recent State Health Improvement Plan (SHP), called Healthier Together Oregon.

## Strategies and Metrics

Based on the three interconnected priorities, Health Share and Trillium developed strategies for the next five years. The strategies outlined in this plan are evidence-based practices aligned with OHP covered benefits and long-standing best practices to promote health outcomes including culturally and linguistically accessible services (CLAS), Traditional Health Workers, healthy literacy, SDOH and the collaborative care model. The metrics outlined in the plan align with CCO quality and performance measures.

While Health Share and Trillium share the same priorities and strategies, each CCO has their own set of metrics to measure progress which align with their unique services and initiatives. Health Share's and Trillium's initial sets of metrics are included in Appendix E and F. Metrics will continue to be developed over the next five years as conditions, data, and priorities change.

Find CHP strategies in the following sections.

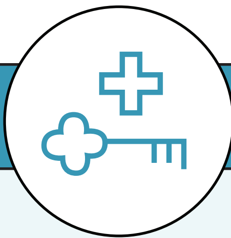
## Community Vital Signs

Some strategies and goals are bigger than one group can pursue alone. Health Share and Trillium will continue to develop "Community Vital Signs" to monitor the health and well-being of the region as we implement the CHP.

Some things to know about Community Vital Signs:

- They measure structural social determinants of health in the region. They might include income levels, education, housing conditions, access to health care, employment rates, kindergarten readiness, food access, and neighborhood safety.
- They might also measure the quality of CCO services. High-quality CCO services can mean that:
  - health care workers match the cultures and languages of members,
  - health care services match the health care needs of members,
  - services are trauma-informed, and
  - members are aware of their health benefits and use them when they need them.
- In some cases they measure processes rather than outcomes. For example, CCOs alone can't solve houselessness in the region. But CCOs can help lighten the harms of being houseless for some people. They can bring health care and social health resources to houseless communities. Thus, a Community Vital Sign for measuring progress could be the presence of mobile clinics that provide health care services in houseless communities.

Health Share and Trillium will work with community partners to develop Community Vital Signs for the region over the next five years.



## Priority 1: Access to Equitable Care*,[i]

| | |
|---|---|
| **GOAL** | Members are able to access the health care system, connect to care easily and locally, and get their physical and behavioral health needs met. The workforce is equipped to support access to equitable health care. |
| **STRATEGY 1** | Increase Workforce for CLAS (Culturally + Linguistically Accessible Services)[j, k] |
| **STRATEGY 2** | Support sustainability for community-based[1] Traditional Health Workers (THWs)[l] |
| **STRATEGY 3** | Invest in basic health literacy through intentional, culturally specific, and sustainable community education[m] |

** All strategies align with recommendations in the 2022 CHA.*

Prioritizing access to equitable care means that every person, no matter their background or circumstance, can easily get the health care they need to lead healthy lives. Equitable access is crucial because it directly affects the health of individuals and benefits the entire community. Health Share and Trillium aim to close the gaps in health care services. This can help reduce health disparities, promote early interventions before health problems get worse, and support overall wellness.

We want our members to equitably access a wide range of health care services. This ranges from physical and behavioral health to mental and social health. One example is to make sure health care providers understand the cultural, linguistic, and social needs of patients. This may mean offering services that are physically accessible, located within the community, and delivered by providers who share similar cultural backgrounds or speak the same language.

Health Share and Trillium will continue to build their Traditional Health Worker (THW) programs. THWs help bridge gaps between care that happens in clinics and social services.

By offering educational materials and outreach that align with cultures, languages, and lived experiences of the communities we serve, Health Share and Trillium are also helping to boost health literacy among members. Basic health literacy means that members will understand how to make health decisions and navigate health care systems.

1 All THWs are based in the community, regardless of their employer.

Community Health Workers (CHWs) are a type of Traditional Health Workers. In 2024 Trillium funded Greater New Hope Charities to train 75 members of the Black, Indigenous, and People of Color (BIPOC) community to be CHWs at no cost to them. The project aims to increase and improve the culturally specific CHW workforce and provide better job opportunities for members of the BIPOC community. Trainees shared their feedback about the experience:

> "I felt seen and heard. I like that I was able to meet people from different cultures and was able to obtain information I didn't know about to help me learn further."

> "I liked that we were a mixed group of various BIPOC communities and we could relate to each other."

## Doulas are one of the six types of THWs (see Appendix A)

Health Share is collaborating with Black Futures for Perinatal Health to support their initiatives in the Momnibus bill[1] submitted to Representative Lisa Reynolds. We are also supporting the Black Futures for Perinatal Health to increase the Black and African American Doulas workforce. We are providing technical assistance to the group as they work towards establishing a Black Birthing Center to provide holistic, culturally specific services to our community.

1 The Momnibus Bill in Oregon is part of a broader effort to address maternal health disparities and improve outcomes, particularly for communities of color. Modeled after the federal Black Maternal Health Momnibus Act, the Oregon Momnibus focuses on funding and strategies to reduce maternal mortality and improve health equity for mothers and babies.

| Priority 2: Prevention[*, n] | |
|---|---|
| **GOAL** | Community partnerships, efforts, and investments are aligned to support prevention across all ages. This ranges from ensuring supports for children to have a healthy start, to providing adults with substance use disorders access to effective, person-centered treatment wherever they seek care in our region. |
| **STRATEGY 1** | Support trauma-informed, equity-centered, prevention-focused physical and behavioral/mental health services, clinics, and community centers[o, p] |
| **STRATEGY 2** | Increase community awareness and system coordination for a collaborative network of behavioral health services[q, r] |
| **STRATEGY 3** | Upstream Prevention: Address policies, systems, and environments that impact health |

** All strategies align with recommendations in the 2022 CHA.*

Prevention promotes health education and activities where people live, work, learn, play, and gather. This helps people maintain good health. It also helps watch for signs of illness or keep illnesses from getting worse. Prevention can include getting screened for skin cancer, obtaining healthy food, accessing tools to stay safe during extreme weather, seeking support for keeping diabetes in check, or taking babies to receive their scheduled vaccines. Health Share and Trillium prioritize prevention for children and youth by offering social emotional health screenings and services to members, a training series for providers, and Family Connects Oregon[1] newborn nurse home visits. Emerging work in this CHP includes developing relationships with school-based health centers and implementation of the new CCO Quality Metric for Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services in 2025.

Prevention in a community means that healthy behaviors recommended by a nurse, doctor or doula are then supported by a teacher, imam, or worksite boss. And when an organization or community finds a prevention solution that works, they can work to make it more widespread. This can be done through policy, funding, and programs.

1 Family Connects Oregon is Oregon's universally-offered public health nurse home visiting program. Family Connects Oregon builds on Oregon's current home visiting programs and will offer home visiting to all families with newborns. It is a voluntary, opt-in program.

The prevention practices of behavioral health are in greater demand than ever. One example is harm reduction.[1] Harm reduction approaches may include providing clean needles or administering Narcan for a fentanyl overdose. Harm reduction can also include education, support services, and connections to health care to empower individuals to make healthier choices over time. It is rooted in compassion and respect for people's autonomy. It recognizes that the dignity held by every person is crucial to effective health care, inside and outside of every care facility.

## Ecosystem Analysis

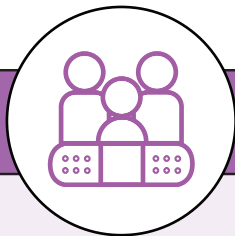
There is a perfect storm of intersecting crises including substance use disorder, psychosis, and housing insecurity happening in our region. Health Share is conducting an analysis to understand the size, scope, and scale of the substance use disorders and severe behavioral health challenges members and broader community. This **ecosystem analysis** has spurred Health Share and partners to identify and expand models of care for this population. Exploring opportunities to align efforts between housing and health care sectors in service to this population is important work that lies ahead.

## Peer Support Training for Supporting Youth with Substance Use Disorders

Health Share and Trillium are partnering together to enhance the culturally specific behavioral health workforce through investment in youth support (peer support) training. This initiative is geared toward helping with the initiation and engagement of treatment for youth with substance use disorders.

The graduates of this program will earn their Peer Support Specialist certifications and have the opportunity to participate in a culturally specific peer support job fair. This will empower them to continue their journey as Peer Support Specialists within our network.

1 Harm reduction is a public health approach that focuses on minimizing the negative consequences associated with risky behaviors, such as substance use, without necessarily requiring people to stop those behaviors entirely. It recognizes that some people may not be ready or able to stop, so it emphasizes practical strategies to improve their health and safety. For more information, see harmreduction.org and samhsa.gov/find-help/harm-reduction/framework.



| Priority 3: Social Health Needs*, [s] | |
|---|---|
| **GOAL** | Partnerships are established to address social determinants of health in member population. Social Health benefit (HRSN) is implemented. |
| **STRATEGY 1** | Deliver Health-Related Social Needs (HRSN) benefits (housing supports, nutrition supports, climate supports, and outreach and engagement)[t, u] |
| **STRATEGY 2** | Identify and address the social needs of members, including food insecurity, housing insecurity, and transportation needs[v] |
| **STRATEGY 3** | Invest in equity-centered and community-informed solutions for improving outcomes for justice-system involved people |

**All strategies align with recommendations in the 2022 CHA.*

Prioritizing social health needs means looking beyond the care that happens in a clinic. Trillium and Health Share want to look at the social and economic factors that affect overall health. Social health needs are things like access to housing, food, transportation, and employment. These are often referred to as social determinants of health (SDOH). These are the conditions in which people are born, grow, live, work, and age. They are important in shaping physical, mental, and behavioral health. When social health needs are not met, it is difficult for people to maintain their well-being. It's also hard to get preventive health services, which can lead to long-term health disparities.

Health Share and Trillium are supporting efforts like the THW program, which helps connect individuals to social health services. Both CCOs also offer housing, nutrition, and climate supports for members who are facing certain life challenges. Connect Oregon[w] is another resource that connects people to their social needs.

Health Share and Trillium aim to create a health care system that is more holistic and supportive. They want to not only treat illnesses but also help people achieve long-term health through social and economic stability.

## Offering Food to the Community

In 2024, Trillium identified zip codes in Multnomah County with high rates of food insecurity, and partnered with a local church to develop a food pantry. For the last year, this food pantry has offered food boxes to the community. The food boxes are tailored to household sizes, diets, and cultural food preferences. They are provided to members of the community who walk in, drive up, or prefer home delivery. This partnership has started to meet the food needs of people living in communities that surround it. Part of its success is Trillium's partnership with a long standing, trusted community organization.

## Food as Prevention

A local partner of Health Share's, East County Community Health (ECCH; initiative of Rockwood Community Development Corporation), has been hosting a Free Food Pantry every third Tuesday of the month since 2021. In 2024, ECCH received funding from CareOregon to continue the Free Food Pantry and nutrition classes, called "Healthy Recipe." The goal of these classes was to provide tools for improving community health through learning how to cook traditional, culturally specific foods. They have provided Mexican, African, and a variety of Asian cooking classes. With the help of Oregon State University (OSU), the classes have included nutrition education and have shared tools for preventing and identifying possible signs of diabetes, hypertension, and other diseases. ECCH has found fun and creative ways to cook and dine in the community together, and the classes have become a trusted space for friends and neighbors to gather and learn.

# Next Steps: Implementing and Tracking Progress of this Plan

This Community Health Plan is a framework to guide Health Share and Trillium to address the evolving health needs of the members and communities we serve. The CHP unites both Coordinated Care Organizations under the same priorities—strengthening access to equitable care, enhancing prevention strategies, and addressing social health needs. While Health Share and Trillium share the same vision, each CCO will implement our own interventions over the next five years. Each CCO will measure progress using metrics tailored to our specific focus areas based on member data, needs, and experiences.

By working in parallel, Health Share and Trillium are committed to creating a healthier future for all, where community health is improved through targeted interventions, collaboration, and data-driven decision-making.

Health Share and Trillium will:

1. Work with their respective CACs to develop a detailed plan to implement CHP priorities and strategies.
2. Maintain ongoing engagement with the CACs for guidance and accountability on CHP implementation.
3. Expand existing relationships with early learning and school-based programs to develop future strategies that support capacity and referral pathways for members.
4. Align community-based funding projects with CHP priorities and strategies.
5. Use data collection and analysis, as well as relationships with partners, to monitor evolving community needs and steer the CHP towards meaningful community change.
6. Host community conversations and connect with other community councils to learn about local efforts and identify opportunities to partner with organizations working to address the same health priorities.
7. Collect data, stories, and information to support annual progress reports to be submitted to the Oregon Health Authority.
8. Continue to develop, refine, and monitor metrics and Community Vital Signs related to the CHP.

# Appendices

# Appendix A: Glossary of Acronyms and Terms

**AI/AN** - AI/AN stands for American Indian and Alaska Native. It refers to Indigenous peoples in the United States, including tribes, villages, and communities with distinct cultures, histories, and traditions.

**Baseline data** - The initial measurement of an data point, prior to the start of intervention. Used to compare with future data to measure if an intervention is effective.

**BIPOC** - BIPOC stands for Black, Indigenous, and People of Color. It is a term used to highlight and acknowledge the unique experiences, histories, and challenges faced by these groups, especially regarding racism and systemic inequities.

**CAC** – Health Share and Trillium each have a Community Advisory Council (CAC). Each CAC includes Oregon Health Plan members and community partners who help think of innovative ideas that focus on health equity.

**CCO** – A Coordinated Care Organization (CCO) is a network of health care providers that work together to serve people who receive health care coverage from the Oregon Health Plan (OHP).

**CHA** – A Community Health Needs Assessment (CHA) is a process used to look at the health needs of a specific community or group. This CHP focuses on needs identified in the 2022 CHA for Clackamas, Multnomah, and Washington counties. "CHA" is sometimes referred to as "CHNA."

**CHP** – Community Health Improvement Plans (CHPs) present priorities, goals, and strategies for improving health. (Plan that is based on an assessment, the CHA, and is used to identify priority issues, develop strategies for action, and guide the work of the CAC and its community partners to improve population health.)

**CLAS** – Culturally and linguistically appropriate/accessible services.

**Collective Impact** - A collaborative approach used to address complex social issues through the coordinated efforts of multiple organizations and sectors. It involves a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems level change. Visit Collective Impact Forum for more information.

**Community health** – Community health means protecting and improving the health of people in specific geographic areas. These can be neighborhoods, cities, or regions. We look at the needs of that community and work on ways to help. The goal of community health is to promote healthy living and prevent disease. It also means trying to reduce health disparities in groups of people.

**Community Vital Signs** – Community Vital Signs are data that show the social and environmental conditions in neighborhoods where people live, such as access to food, transportation, housing, and income levels.

**Evidence Based Practices** – The application of an intervention that is backed by extensive and best available research in an area of practice.

**Family Connects Oregon** – Family Connects Oregon is Oregon's universally-offered public health nurse home visiting program. Family Connects Oregon builds on Oregon's current home visiting programs and will offer home visiting to all families with newborns. It is a voluntary, opt-in program.

**Goals** – Goals refer to what we're trying to get done in the long-term.

**Harm Reduction** – A public health approach that focuses on minimizing the negative consequences associated with risky behaviors, such as substance use, without necessarily requiring people to stop those behaviors entirely. It recognizes that some people may not be ready or able to stop, so it emphasizes practical strategies to improve their health and safety. For more information, see National Harm Reduction Coalition and Substance Abuse and Mental Health Services Administration.

**HCWC** – The Healthy Columbia Willamette Collaborative (HCWC) is a partnership of 12 organizations in Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington.

**HRSN** – Health-related social needs (HRSNs) refer to social determinants of health including stable housing, food security, access to transportation, and utilities like heating and cooling. Oregon Health Plan (OHP) is rolling out programs under Medicaid to address these needs. OHP and CCOs are providing supports like rent assistance, air conditioners for heat protection, and nutrition benefits to those who qualify. These initiatives aim to bridge the gap between health care and social determinants of health by supporting basic needs.

**Indicator** – A measure or data that describe community conditions currently and over time (e.g., poverty rate, homelessness rate). In this CHP, the terms "metric" and "indicator" are used interchangeably.

**Intervention** – An action with the purpose of changing an outcome.

**Members** – Members are the people who receive health care services from a Coordinated Care Organization (CCO). Members are also referred to as people who are on the Oregon Health Plan or OHP.

**Metrics** – Metrics are things we want to measure to track our progress. They also help us look at how effective these ideas are over time. In this CHP, the terms “metric” and “indicator” are used interchangeably.

**Objectives** – The process steps to meet the goals and how the CHP partners plan to achieve them.

**OHA** – Oregon Health Authority is an agency that includes most of the state’s health care programs, including Public Health and the Oregon Health Plan. The agency’s mission is to ensure all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care.

**OHP** – Oregon Health Plan is Oregon’s Medicaid program.

**OSU** – Oregon State University.

**Outcomes** – The desired effect on the community, what the measure of success will be.

**Priority Area** – A health priority area means a specific area that we are focusing on to improve the overall health of a community.

**REALD** - Race, Ethnicity, and Language, Disability is a new type of demographic information that is collected by health care providers. Collecting this information helps to identify health inequities for populations within Oregon. Having this data allows the Oregon Health Authority (OHA) to better understand different populations and move toward the goal of ending health inequities by 2030. Collection of REALD became required by law in 2022. Visit OHA’s REALD & SOGI page for more information.

**SDOH** - Social Determinants of Health, also called Social Drivers of Health, are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect health. These conditions may include housing, income, access to food and safe communities. For more information, see US Centers for Disease Control and Prevention and Healthy People 2030.

**SOGI** - Sexual Orientation, Gender Identity is a new type of demographic information that is collected by health care providers. Collecting this information helps to identify health inequities for populations within Oregon. Having this data allows the Oregon Health Authority (OHA) to better understand different populations and move toward the goal of ending health inequities by 2030. Visit OHA’s REALD & SOGI page for more information.

**State Health Improvement Plan** - The 2020-2024 State Health Improvement Plan (SHIP), called Healthier Together Oregon, is a strategic roadmap to address key public health priorities across the state.

**Strategy** – A CHP strategy is something we do to try to reach a specific goal or outcome.

**Target** – End goal or aim of interventions.

**THW** – Traditional Health Workers (THWs) are trusted people from communities who may share social and economic connections with health plan members. They also might have similar life experiences. THWs may provide a bridge between people in a community and the health systems that serve them. There are five types of THWs licensed in Oregon:

- **Doulas** are trained birth companions. They provide support to pregnant people and families during pregnancy, birth and beyond.
- **Peer support specialists (PSS)** and **Certified Recovery Mentors (CRM)** give support services to people who are or have been in mental health or substance use treatment.
- **Peer wellness specialists** have personal experience with psychiatric conditions plus intensive training. They're part of a home health team that combines mental health with primary care.
- **Personal health navigators** provide tools to help patients make the best health care choices.
- **Community health workers** are public health workers who are trusted members of a community and have a close understanding of it.
- **Tribal Traditional Health Workers** facilitate the delivery of culturally responsive care to Tribal community members, including using Tribal-based practices.

Visit Care Oregon's THW page for more information.

# Appendix B: Key Contributors to the CHP

We want to thank **Celia Harris, MPH**, for her tremendous leadership and support in facilitating the development of our shared CHP, community engagement, and data analysis.

We also want to thank **Christine Lee Kan**, Health Share's Community Health Manager, and **Sheri M. Lilli**, Trillium's Tri-County Community Outreach and Engagement Manager, for leading on behalf of the two CCOs to develop this plan, and for their ongoing work in facilitating its implementation.

**Health Share of Oregon Staff:**

- Health Equity and Engagement Team
- Health System Performance Team
- CCO Integration Team
- Strategic Initiatives and Communications Team
- Executive Leadership Team

**Trillium Staff:**

- Communications Team
- Community Engagement and Health Equity Team
- Executive Leadership Team
- Government Relations Team
- Network Development Team
- Population and Clinical Operations Team
- Quality Improvement Team

**Health Share of Oregon Community Advisory Council:**

- Candice Jiminez, Tribal Representative, Confederated Tribes of Warm Springs
- Hilary F.
- Natasha Davy
- Francisco Elias Molina
- Lung Wah Lazum
- Forrest Pearson, Tribal Representative, Confederated Tribes of Siletz
- Joy Mutare
- Magdalena Ramirez
- Lauren Riddle
- Yamungu Seraya
- Rachel Schutz
- Jamie Zentner

**Trillium Community Health Plan Community Advisory Council:**

Six Trillium Members
Washington County
Clackamas County
Multnomah County
Confederated Tribes of Siletz Indians
Trillium North Board of Directors Representative
Trillium members represent people experiencing health and health care disparities

**Healthy Columbia Willamette Collaborative Partners:**

CareOregon
Clackamas County Health, Housing and Human Services
Health Share of Oregon
Hillsboro Medical Center
Kaiser Permanente
Legacy Health
Multnomah County Health Department
Oregon Health and Science University
Portland Adventist Medical Center
Providence Health and Services
Trillium Community Health Plan
Washington County Public Health

**Community Partners, Councils, Boards, and Individual Contributors:**

Community based organizations who partnered towards the development of the 2022 HCWC CHA/CHNA
4D Recovery
Adelante Mujeres
Adelante Mujeres
Another Chance
Ant Farm Youth Services
Asian Health and Service Center (AHSC)
Beaverton Resource Center
Black Futures for Perinatal Health
CareOregon's Integrated Clinical Workgroup (Federally Qualified Health Centers)
Cascade AIDS Project
Central City Concern
Centro Cultural
Clackamas County Behavioral Health
Clackamas County Public Health
Coalition for Community Health Clinics
Community Partnership for Affordable Housing
Cultivate Initiatives
Early Learning Hub of Clackamas County
Early Learning Multnomah
Early Learning Washington

Estacada Community Center
Family Justice Center of Washington County
Fresh Out
Friendly House
Greater New Hope Charities
Immigrant and Refugee Community Organization (IRCO
Iraqi Society of OR
JOIN
Juntos NW
Ka 'Aha Lahui O 'Olekona Hawaiian Civic Club (KALO HCC)
Latino Network
Meals On Wheels People
Mental Health & Addictions Association of Oregon (MHAAO)
Metropolitan Family Service
Momentum Alliance
Multnomah County Health Department
NAMI Clackamas County
Northwest Portland Indian Health Board (NPIHB)
Oregon Black Brown Indigenous Advisory Committee
Oregon Community Health Workers Association (ORCHWA)
Oregon Community Partner and Outreach Program (CPOP)
Oregon Health Authority
Oregon Health Equity Alliance
Oregon Latino Health Coalition
Oregon Pacific Islander Coalition
Oregon Public Health Institute (OPHI)
Oregon Spinal Cord Injury Connection
Outside In
Portland All Nations Canoe Family
Portland Open Bible Community Pantry
Portland Street Response
Portland Street Response
Project Access NOW
Project Lemonade
Rockwood CDc - East County Community Health
Samoa Pacific Development Corporation
Slavic Community Center of NW
Somali American Council of Oregon
Washington County Public Health
System of Care Advisory and Executive Councils
Transition Projects, Inc.
Urban League of Portland
Veterans of Foreign Wars
Washington County Health and Human Services
Women First Transition and Referral Center

# Appendix C: Health Equity Statements

## Health Share Health Equity Statement

Health Share of Oregon acknowledges the inequitable health outcomes, and the deep and lasting impacts of structural and pervasive racism on marginalized populations, in particular for communities of color. As part of our continual learning and actions we seek to recognize, reconcile and rectify historical and contemporary injustices.

Recognizing that change starts with us individually, we commit to continue this equity journey. We will disrupt and dismantle systems; identify equitable distribution or redistribution of resources and power; change policies, processes, investment strategies and data sharing within our organization; and continuously center our members, collaborate with our community partners and support tribal sovereignty and culture.

## Trillium Health Equity Statement

Trillium remains committed to promoting diversity, equity, and inclusion. Guided by its health equity mission, Trillium is deliberate about fostering meaningful connections with our members, partners, and the communities it serves. By proactively addressing health disparities, Trillium aspires to be a significant force in promoting positive change and ensuring equal access to health care for all.

# Appendix D: Summaries of Community Engagement Activities

## Summary of Survey at Black, Brown, and Indigenous Conference 2024

Health Share and Trillium distributed online and paper surveys to people who attended the Black, Brown, and Indigenous Conference in May 2024 in Portland, as well as to members of the Portland All Nations Canoe Family. The survey included five questions aimed at gaining an understanding of the health priorities among respondents and the communities they represent, as well as respondents' vision of the Coordinated Care Organizations' roles as partners in supporting community health priorities. There were 113 survey responses.

In their definitions of "community health" and/or "community wellness," respondents identified themes such as unity/togetherness, a holistic definition of health, ensuring everyone has the resources they need, equity and equality, prevention of disease, and healing from trauma, addiction, and disease.

When respondents were asked to select three top health priorities out of 11 options – with the option of naming a 12th priority of their choice – as a whole, their top health priorities were **housing support** (chosen by 74%), **behavioral health** (mental health, addictions, etc.; chosen by 65%), **culturally specific services** (chosen by 50%), **financial stability** (chosen by 38%), and **food and nutrition** (chosen by 27%).

These identified health priorities are in line with the missions and objectives of the community-based organizations that survey respondents represent. When asked what their organizations do to address community health priorities, they named the following:

- housing resources and supports (35)
- culturally specific services, community outreach, and assistance navigating health care and other resources (46)
- food and nutrition resources (18)
- employment, financial stability, financial literacy, and financial support (16)
- mental health access and support (16)

As far as defining what a successful and meaningful partnership looks like between community organizations and Medicaid organizations like Health Share, the three selections that were present on the survey resonated with most respondents. **Respondents would like a partnership that includes ongoing engagement and application of community voice, is collaborative, and includes shared projects.**

The racial and ethnic groups that most survey respondents identify with are Latine/Latina/Latino, Black/African American, Indigenous/Native, and immigrant. Other communities that multiple respondents identify with include queer/LGBTQ2SIA+, Christian/religious, disabled, and women. The communities that respondents feel that they represent in their survey responses reflect these identities, with the addition of some also representing youth and children populations.

# Summary of Community Input from June Community Health Event

On June 25, 2024, Health Share and Trillium convened a community health meeting for partnering community-based organizations (CBOs) to provide input on the CHP. Over 100 CBO staff were asked a series of four questions that intended to generate feedback on their hopes for what the two CCOs can accomplish in the next five years, as well as their service population's experience of any gaps and barriers in services.

Many of the CBO staff members' responses fell into three main categories:

1. **Improve access for members receiving care.** CBO staff would like to prioritize **improving culturally specific care**, including language and translation services and culturally specific providers. They would like to **streamline bureaucracy** by reducing wait times and paperwork/online procedures. They request additional resources from CCOs – such as transportation, food, childcare, and bringing health care into homes and communities – to **address barriers to accessing care**. They would like to **expand community education** on health benefits and navigating the health care system.

2. **Improve quality of care.** CBO respondents requested that CCOs **invest more in specific services** such as mental and behavioral health treatment, chronic disease supports, vision and dental care, post-partum care, basic life skills, and emergency preparedness, among others. They had ideas for specific **program adjustments to better serve members** such as improving integrated care across specialties, extending program lengths, using flex funds more equitably, providing incentives for accessing care, and including survivors of violence and abuse in prevention and social health efforts. They feel that medical providers should provide **more trauma-informed, high-quality care** including better engagement and communication and spending more time with patients. Two comments involved **tracking equity with data** by disaggregating data to parse out which populations are accessing health care, as well as sharing data between health care and housing systems.

3. **Strengthen the capacity of Traditional Health Workers (THWs) and community health workers (CHWs) for providing high-quality care.** CBO respondents would like to **increase the capacity of and number of service providers**. One suggestion for achieving this was to improve grant accessibility and timelines. Some respondents would like more effective communication between CCOs and providers, as well as networking opportunities for CBOs. Others discussed a need for more provider trainings on specific topics. **Increasing funding for THWs and CHWs** was also raised many times, as well as **improving the billing and reimbursement system** for THWs and CHWs. Some CBO staff would like to **expand opportunities for CHWs to support their communities** such as building capacity to deliver health-related social needs (HRSNs).

There were three comments related to **reducing barriers that THWs and CHWs face**, including reducing outreach limitations and providing THW/CHW access to specialty health care centers where they can better support their clients.

4. In addition to these three main categories that most responses fell into, some CBO respondents reported a demand for **more community engagement and community building** by CCOs. There were also a few requests for CCOs to **advocate for broader systems change and legal change** that may improve member health and wellness.

# Appendix E: Health Share of Oregon Metrics

## Initial Set of Health Share CHP Metrics

| Access to Care | | | |
|---|---|---|---|
| **Indicator** | **Performance Measure(s)** | **Baseline** | **2029 Target[1]** |
| Member Utilization of Primary Care services on a yearly basis | Support trauma-informed, equity-centered, prevention-focused health services | 54.80% | 60% |
| Meaningful Language Access Rate % visits with documented interpretation services | Increase Workforce for CLAS (Culturally + Linguistically Accessible Services) | 28% | 53% |
| Number of Traditional Health Workers employed by Health Share Partners | Ensure cultural responsiveness among health care providers through increased use of THWs and trainings | 734 | 934 |
| Member Utilization of Traditional Health Workers, by type (Doulas) | Ensure cultural responsiveness among health care providers through increased use of THWs and trainings | 9% | 15% |
| **Prevention** | | | |
| **Indicator** | **Performance Measure(s)** | **Baseline** | **2029 Target** |
| Childhood Immunization Rate | Provide culturally and linguistically responsive, trauma informed, multi-tiered BH services and supports to all children and families | 60% | 67% |
| Well Child visit rate | Provide culturally and linguistically responsive, trauma informed, multi-tiered BH services and supports to all children and families | 66% | 72% |
| Adolescent immunization | Provide culturally and linguistically responsive, trauma informed, multi-tiered BH services and supports to all children and families | 38% | 41% |

1 Target is based on the information that is currently available.

| Indicator | Performance Measure(s) | Baseline | 2029 Target |
|---|---|---|---|
| Preventive Dental Visit (ages 1 to 14) rate | Provide culturally and linguistically responsive, trauma informed, multi-tiered BH services and supports to all children and families | 55.1%<br>1 to 5<br>58%<br>6 to 14 | 60.6%,<br>67.3% |
| Child Social-Emotional Health services rate | Provide culturally and linguistically responsive, trauma informed, multi-tiered BH services and supports to all children and families | 5% | 7% |
| Stipends for early childhood behavioral health workforce placement for students (focus on students of color) | Support a coordinated network of behavioral health services | 0 | 7 |
| Diabetes HBA1c poor control | Support trauma-informed, equity-centered, prevention-focused health services | 26% | <20% |
| Initiation and Engagement in Substance Use Disorder Treatment (IET) | Reduce systemic barriers to receiving BH services, such as transportaion, lanaguage and assessment | 46.1% Init<br>17 %<br>Engage | 46.1%<br>/ 18.8% |
| Number of substance-associated overdoses | Support a coordinated network of behavioral health services | 1,270 | 1,143 |

## Social Health Needs

| Indicator | Performance Measure(s) | Baseline | 2029 Target |
|---|---|---|---|
| Count of contracted network of HRSN Service Providers (CBOs) | Develop a network of CBOs to support the delivery of Health-Related Social Needs (HRSN) benefits | 15 | 30 |
| Count of People provided with HRSN Housing benefits. | Deliver HRSN benefits | TBD[1] | TBD |
| Count of eligible members provided with Climate devices | Prevent negative impact of climate | 2,405 | 12,025 |

1 TBD indicates that the target value is still under analysis and will likely be identified by the 2026 Annual Progress Report.

# Appendix F: Trillium Community Health Plan Metrics

## Priority #1: Access to Equitable Care

### Strategy 1: Increase access to CLAS (Culturally + Linguistically Accessible Services)

| Indicator | Goal | Baseline | 2029 Target |
|---|---|---|---|
| Number of visits where qualified interpreter services were provided to members when needed | Increase the percentage of visits where qualified interpreter services were provided to members when needed by 5% year over year | **14.7%** | **18.7%** |
| Healthier Oregon Program population utilization of services | Increase overall utilization of services by HOP members by 2% annually year over year | **56%** | **62%** |

### Strategy 2: Support sustainability for community-based Traditional Health Workers (THWs)

| Indicator | Goal | Baseline | 2029 Target |
|---|---|---|---|
| Number of THWs contracted with Trillium to provide services to Trillium members.* | Increase the percentage of THWs contracted as service providers with Trillium by 5% year over year | **289** | **368** |

*This indicator aligns with Healthier Together Oregon Strategy - *Workforce Development: Ensure cultural responsiveness among health care providers through increased use of THWs and trainings*

### Strategy 3: Invest in basic health literacy through intentional, culturally specific, and sustainable community education

| Indicator | Goal | Baseline | 2029 Target |
|---|---|---|---|
| Number of Trillium 101 Presentations for Community-Based Organizations | Increase the number of Trillium 101 CBO presentations by 25% year over year | **8** | **24** |

# Priority #2: Prevention

## Strategy 1: Support trauma-informed, equity-centered, prevention-focused physical and behavioral/mental health services, clinics, and/or community centers

| Indicator | Goal | Baseline | 2029 Target |
|---|---|---|---|
| Notice of Pregnancy (NOP) - Total pregnant members engaged in case management (Start Smart for Your Baby)* | Increase the NOP total pregnant members engaged in Case Management by 2.5% year over year | **40%** | **45%** |
| Number of claims billed Start Smart for Your Baby for THW services with TCHP-contracted providers | Increase the number of claims billed for THW services with TCHP contracted providers by 5% year over year | **1,372** billed claims | **1,751** billed claims |

*This indicator aligns with Healthier Together Oregon Strategy - *Healthy Families: Increase access to prenatal and postpartum care for low income and undocumented people*

## Strategy 2: Increase community awareness of and systemic readiness for a coordinated network of behavioral health services

| Indicator | Goal | Baseline | 2029 Target |
|---|---|---|---|
| Expand SUD facility-based service capacity in the Tri-County region through Trillium strategic investments | Increase the number of Trillium investments for SUD facilities to three by 2029 | **0** | **3** |

### Strategy 3: Upstream Prevention: Address policies, systems, and environments that impact health

| Indicator | Goal | Baseline | 2029 Target |
|---|---|---|---|
| Number of claims for In Lieu of Services (ILOS) benefits | Increase the number of claims for In Lieu of Services (ILOS) benefits by 5% year over year | **TBD at the end of 2024** | **Based on 2024 Baseline** |

## Priority #3: Social Health Needs

### Strategy 1: Deliver Health-Related Social Needs benefits (housing supports, nutrition supports, climate supports, and outreach + engagement)

| Indicator | Goal | Baseline | 2029 Target |
|---|---|---|---|
| HRSN Provider Network Capacity and expertise to provide adequate access to HRSN Services (Climate; Housing; Nutrition; Outreach & Engagement) | Develop and implement a methodology to establish Trillium's HRSN provider network and monitor capacity of the network | **0** | **Methodology developed** |

### Strategy 2: Identify and address the social needs of members, including food insecurity, housing insecurity and transportation needs

| Indicator | Goal | Baseline | 2029 Target |
|---|---|---|---|
| Number of community members served by Trillium-funded grants for food* | Increase the number of community members served by Trillium funded grants for food by 5% annually | **TBD at the end of 2024** | **Based on 2024 Baseline** |

* This indicator aligns with Healthier Together Oregon Strategy - *Housing and Food: Increase access to affordable, healthy and culturally appropriate foods for BIPOC-AI/AN and low-income communities*

## Strategy 3: Invest in equity-centered and community-informed solutions for improving outcomes for justice system-involved people

| Indicator | Goal | Baseline | 2029 Target |
|---|---|---|---|
| Indicator to be defined as benefits and measures for carceral benefits are developed. Measures will relate to the CCO structure of care coordination for members in carceral setting pre and post release | To be defined | **To be defined** | **To be defined** |

# Endnotes

a The word "determinants" suggests that people can't do anything to change their own health. In contrast, the word "drivers" suggests that people and communities can overcome or change some of the social factors that affect their health. For more information on Social Determinants of Health, see Social Determinants of Health | Public Health Gateway | CDC or Social Determinants of Health - Healthy People 2030 | odphp.health.gov.

b Collective Impact is a collaborative approach used to address complex social issues through the coordinated efforts of multiple organizations and sectors. It involves a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems level change. For more information, see collectiveimpactforum.org/what-is-collective-impact.

c Social Determinants of Health, also called Social Drivers of Health, are conditions in the places where people live, learn, work, and play that affect their health.

d Structural racism refers to the ways in which laws, policies, institutions, and systems work to create and maintain racial inequities. It is deeply embedded in the fabric of society and influences education, housing, health care, employment, and the justice system.

e Institutional white dominance refers to the systemic ways in which societal institutions – such as government, education, health care, and the justice system – prioritize and maintain power structures that benefit white people while disadvantaging people of color. This dominance is rooted in historical and structural inequities.

f Demographic data comes from Oregon Health Plan applications, and we acknowledge that this data has inherent limitations:

- Data are often categorized in ways that reflect dominant cultural norms and practices. Even when these norms are changing (as in the case of acknowledging multi-racial identities or a spectrum of gender identities), public databases may lag years behind how researchers and activists are reconfiguring identity groups and other classifications.
- Data has and continues to "erase" various communities in its collection, analysis, and reporting processes. This erasure is often rooted in dominant structure frameworks. Identifying health disparities requires data on health status and individual determinants of health for subgroups of the population—data that are frequently difficult to obtain. Problems include small sample sizes, missing data, and measurement errors. For more on this topic, see: Bilheimer, L. T., & Klein, R. J. (2010). Data and measurement issues in the analysis of health disparities. Health services research, 45(5 Pt 2), 1489–1507. doi.org/10.1111/j.1475-6773.2010.01143.x.

g This is the first time Health Share and Trillium are including data about people living with disabilities in a CHP.

h HRSN – Health-Related Social Needs (HRSNs) refer to social determinants of health including stable housing, food security, access to transportation, and utilities like heating and cooling. Oregon Health Plan (OHP) is rolling out programs under Medicaid to address these needs. OHP and CCOs are providing supports like rent assistance, air conditioners for heat protection, and nutrition benefits to those who qualify. These initiatives aim to bridge the gap between health care and social determinants of health by supporting basic needs.

i The following references describe the evidence base for Priority 1 strategies:

- U.S. Department of Health and Human Services. Healthy People 2030. Health Care Access and Quality - Healthy People 2030.
- Health and Human Services Department. Federal Register Published Document: 2013-23164 (78 FR 58539) (2013, September). Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.
- Oregon Health Authority Traditional Health Worker Commission (2019, October) Traditional Health Worker Toolkit 2019, Page 19.
- Guide to Community Preventive Services. Community Health Workers. Community Health Workers | The Community Guide. Page last updated June 17, 2021.
- U.S. Department of Health and Human Services. Healthy People 2030. Language and Literacy - Healthy People 2030.
- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National Action Plan to Improve Health Literacy | odphp.health.gov. Washington, DC.

j Aligns with SHP Strategy: Workforce Development: Ensure cultural responsiveness among health care providers through increased use of THWs and trainings.

k Aligns with 2022 CHA Recommendation 2 in *Access to Culturally- and Linguistically-Responsive Health Care* Priority Area: Increase workforce development pipelines for health care workers that reflect and represent the region's diverse language, ability, culture, sexual orientation, and gender.

l Aligns with 2022 CHA Recommendation 3 in *Access to Culturally- and Linguistically-Responsive Health Care* Priority Area: Expand investments in Traditional Health Workers to increase community representation in the workforce.

m Aligns with 2022 CHA Recommendation 6 in *Access to Culturally- and Linguistically-Responsive Health Care* Priority Area: Ensure adequate resources for language accessibility in services and education and invest in health literacy efforts.

n The following references describe the evidence base for Priority 2 strategies:

- Oregon Health Authority. Oregon CCO Model - Evidence Based.
- Research on Trauma Informed Care | Trauma Informed Oregon.
- Effectiveness of Trauma-Informed Care Implementation in Health Care Settings: Systematic Review of Reviews and Realist Synthesis, Ellen Goldstein, PhD, MFT, et all. March 6, 2024. doi.org/10.7812/TPP/23.127.
- County Health Rankings and Roadmaps (Last Updated Aug 1, 2024) School Based Health Centers.
- Centers for Medicare & Medicaid Services (August 14, 2023). Innovation Center: Care Coordination.
- The Community Guide (Last Updated: 2018, November). Systematic Review: Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders.

- American Psychological Association. (Last Updated: June 2022). Behavioral Health Integration Fact Sheet.
- University of Washington: AIMS Center. Evidence Base for Collaborative Care (CoCM) - AIMS Center.
- U.S. Department of Health and Human Services. Healthy People 2030. Health Policy - Healthy People 2030 Upstream Prevention.

o Aligns with SHP Strategy: Expand evidence-based and culturally responsive early childhood, home visiting programs.

p Aligns with 2022 CHA Recommendation 1 in *Access to Culturally- and Linguistically-Responsive Health Care* Priority Area: Support additional trauma-informed physical and mental health services and supports, clinics, and community centers.

q Aligns with SHP Strategy: Reduce systemic barriers to receiving behavioral health services, such as transportation, language and assessment.

r Aligns with 2022 CHA Recommendation 1 in *Access to Culturally- and Linguistically-Responsive Health Care* Priority Area: Support additional trauma-informed physical and mental health services and supports, clinics, and community centers.

s The following references describe the evidence base for Priority 3 strategies:

- Oregon Health Authority. Medicaid 1115 Waiver; 2022-2027 Medicaid 1115 Demonstration Waiver - Oregon Health Authority.
- National Association of Medicaid Directors. (April, 2024) Medicaid innovation pathway: How 1115 waivers work.
- The Community Guide. Guide to Community Preventive Services. (Last Updated May, 2024). Social Determinants of Health: Fruit and Vegetable Incentive Programs.
- The Community Guide. Guide to Community Preventive Services. (Last Updated January, 2021). Social Determinants of Health: Permanent Supportive Housing with Housing First.
- Oregon Health Authority. (2024, July) Press Release: Oregon approved to offer Medicaid coverage to people leaving carceral settings.
- National Association of Counties. (2024, August). Coordination of Care Upon Release from Incarceration: A NACo Opioid Solutions Strategy Brief. Author: Jennifer Carroll, PhD, MPH.
- The Vera Institute of Justice.
- The Sentencing Project.
- The Council of State Governments Justice Center.
- Pew Charitable Trusts | Public Safety Performance Project.

t Aligns with two SHP Strategies: Increase access to affordable, healthy and culturally appropriate foods for BIPOCAI/AN and low income communities; Use health care payment reforms to support the social needs of patients.

u Aligns with 2022 CHA Recommendation 1 in *A Neighborhood for All* Priority Area: Engage local politicians, including city councils and commissioners, as necessary advocates for creating a neighborhood where members of the community are safe, afforded access to quality housing, and afforded healthier living environments.

v Aligns with 2022 CHA Recommendation 3 in *Essential Community Services and Resources* Priority Area: Invest in addressing areas with limited grocery store options and ensure culturally-relevant and healthy food access to communities most impacted by these geographic disparities.

w Connect Oregon is a coordinated care network consisting of health care, government, nonprofit, and other organizations. Community members can access resources using Connect Oregon here: uniteus.com/networks/oregon/get-help.