February 21, 2025

Senator Wlnsvey Campos, Co-Chair
Representative Andrea Valderrama, Co-Chair
Joint Ways and Means Human Services Sub-Committee
900 Court Street NE
State Capitol
Salem, OR 97301

SUBJECT: February 18 Subcommittee Questions

Dear Co-Chairs and Committee Members:

Please find below information requested by members of the Joint Ways and Means Human Services Sub-Committee at the February 18 meeting on Oregon Health Authority's Central Services.

1. **What are the Equity & Inclusion Division's budget and FTEs?**

   For the 2023-2025 biennium, the Equity & Inclusion Division's budget is $52.76M, with 86 positions.

2. **Regional Health Equity Coalitions (RHECs)**

   What do Regional Health Equity Coalitions (RHECs) receive grant funds for? RHECs receive grants to do coalition building that engages local community members for the purpose of identifying what the most pressing health equity issues are in their region. They are uniquely positioned to identify and develop solutions to address inequities because they are community members who have experienced directly. They do this by conducting

community needs assessments. The priorities identified by the community needs assessment then informs a 3-5 year strategic plan for each coalition. All RHECs are required to create workplans outlining what specific activities will be conducted throughout the year.

The ultimate goal is for RHECs to address health inequities in their respective regions through policy and systems change. It is important to note that they do not provide traditional health services or programming. They seek to improve laws and systems so that their impacts do not create undue harm or barriers to health for people in Oregon.

Throughout this process, RHECs receive support from OHA through training, technical assistance and ongoing consultation.

What type of entities do RHECs partner with? Membership of RHECs can include partners such as community based organizations (CBOs), state agencies (Department of Education, Transportation, Recreation, Housing Authorities, etc.), Governor's Office (Oregon Advocacy Commissioners Office, etc.), legislators and other regionally based elected officials (school board members, county commissioners, etc.), health systems (federally qualified health centers, hospitals, CCOs, etc.), local government (local public health authorities, city and county governments, etc.) labor unions, private entities (foundations, small and local businesses), and more. Partners and members of RHECs represent multiple sectors due to RHECs' focus on the social determinants of health.

Does funding go to local public health agencies (LPHAs)? Local public health authorities are welcomed partners but RHECs are not led by government entities. RHECs are supported by fiscal agents such as federally recognized Tribes in Oregon and community-based nonprofit entities, including culturally

specific organizations, social service providers, organizations that provide health care, organizations that conduct public health research, organizations that provide behavioral health treatment, private foundations, and faith-based organizations. (OAR 950-020-0010)

Are RHECs government entities or considered "state employees"? No, RHECs must be completely independent of public bodies and coordinated care organizations (CCOs) (OAR 950-020-0010). However, RHECs often partner with government and health system entities, as well as private and other community-based entities in doing this work.

In counties currently without RHECs, are there community based organizations in those locations for RHECs to work with or do they have to be established? Established entities could apply for the grant including any entity that falls into any of the following categories:

- Federally recognized Tribes in Oregon
- Community-based nonprofit entities, including culturally specific organizations, social service providers,
- Organizations that provide health care,
- Organizations that conduct public health research,
- Organizations that provide behavioral health treatment,
- Private foundations, and
- Faith-based organizations. (OAR 950-020-0010)

Are RHECs already in existence? Yes, there are 9 covering 21 counties. Please see the map that illustrates existing RHEC regions here.

Will this POP allow for expansion? Yes, the expansion is to add three new RHECs in Oregon that do not yet have RHEC representation. The POP also includes some additional funds for existing RHECs.

What are the counties that are not yet represented by RHECs? Clatsop, Columbia, Tillamook, Sherman, Gilliam, Jefferson, Wheeler, Deschutes, Crook, Klamath, Lake, Grant, Harney, Baker and Wallowa.

How are CBOs held accountable for desired outcomes? RHECs are held accountable through strict OHA contract administration practices. There are several reporting requirements outlined in RHEC grant agreements, many of which are ongoing throughout the year. For example, OHA staff conducts site visits and monthly check-ins with individual RHECs and require annual reports and updates to existing workplans.

Are any of those goals/outcomes identified ahead of contracting? Yes, as per Oregon Administrative Rule 950-020-0010, the RHEC grant agreement outlines required activities that align with the RHEC model key areas which include: 1) meaningful community engagement; 2) Building and Strengthening Organizational Capacity; 3) Creating Social Norm and Environment Change; and 4) Conducting Policy and Systems Change.

Are KPMs regarding RHECs available to the public? As part of the program's contract administration process there are several reporting requirements throughout the year where data are collected related to documenting RHEC progress. Evaluation is coalition-specific, as the work of each RHEC is customized based on the region, challenges faced, resources available, population of focus, and sector(s) impacted. If there are specific data points that are of interest, program staff could be made available to discuss what is available. RHECs are not part of OHA's agency KPMs.

Are there geographic considerations for selecting new RHECs? Yes, grants will only be offered in areas that do not yet have RHEC representation. The only exception is that geographic overlap would be allowed for existing RHEC regions and new RHECs sponsored by federally recognized Tribes in Oregon.

How are new RHECs selected? Grants are offered through a competitive solicitation process. There are criteria provided in the request for grant proposals (RFGPs) that outline how grantees are selected. Existing RHECs participate in the selection process by reviewing proposals, and scoring and selecting grantees.

What are some examples of impacts of RHEC efforts? The focus of RHECs is to create systems and policy change that can sustainably address short term and long-term positive health impacts in their communities. The RHECs serve a critical role in health systems that is not able to be served by any form of government or large provider networks. The RHECs are part of the communities who experience the health barriers and are uniquely positioned to find appropriate and sustainable solutions. They fill a gap needed to meet OHA's strategic goal to eliminate health inequity by 2030. Examples include:

- Promoted key legislative changes, including:
    - HB 4052 (2022): $2M to address structural racism.
    - HR 6 (2021): Declared racism a public health crisis.
    - SB 70 (2020): Initiated RHEC expansion.
    - Support for Equity Bills: Advocated for policies like Driver's Licenses for All, Reproductive Health Equity Act, and Ban the Box.

- Advocacy and facilitation of language access that has resulted in a larger increase of interpretation, translation and certification for bicultural and bilingual supports in Oregon.
- Responded to and met community requests for facilitated trainings across the state to improve health equity, reaching 287 organizations and 67,099 community members. These provided communities with information and tools to further health equity in their own communities.
- Emergency Response to Save Lives and Safeguard Health: RHECs have demonstrated quick action during public health crises, such as COVID-19 and wildfires, delivering essential resources such as vaccines, PPE, food, and housing support safeguarding health and saving lives, especially in rural areas.
    - For example, SO HEALTH-E distributed direct assistance through gift cards, 5,000+ masks, bottles of hand sanitizer, and 500+ Covid-19 test kits to low-income families and communities of color who experienced the greatest disparities in Jackson and Josephine counties. They also raised and distributed $1.25 million in fire relief for those most impacted by the Labor Day Fires of 2020.
    - Because of their success supporting local communities, they have also provided consultation with OHA to work toward reaching more communities across the state during these critical events.

The following graphics, taken from the OHA Regional Health Equity Coalition Evaluation Plan, illustrate the RHEC Theory of Change:

RHEC THEORY OF CHANGE

GOAL:

Eliminate health inequities across Oregon

VISION:

Create more equitable social determinants of health systems that supports all people having the opportunities needed to be healthy and well.

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RHEC THEORY OF CHANGE

INTERMEDIATE OUTCOMES

- Identification of the right issues that are most important to priority populations which leads to increased health equity, less waste from addressing the wrong issues, and minimizes unintended consequences.
- Enhanced community capacity in advocacy, legislative and local policy change, systems change, and environment change.
- Increased community participation in boards, committees, councils, and decision -making processes, demonstrating strengthened community connections.
- Broadened access to necessary financial, educational, and health resources, enabling wellness.
- Implementation of policy advocacy efforts that enhance health equity and dismantle systemic barriers.
- Improved trust and cohesion within communities, fostering a collaborative environment for health equity efforts.

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RHEC THEORY OF CHANGE

STRATEGIES

- Bridging connections between priority populations and social determinants of health systems by identifying the most important health inequities, barriers and contributing factors that create those inequities, and the development of solutions to increase health equity.
- Building and fostering ongoing relationships with communities most harmed by health inequities.
- Conducting community forums and workshops to gather input and foster dialogue on community needs and solutions.
- Advocating for policies that promote health equity and dismantle systemic and institutional barriers to health and wellness.
- Supporting and implementing community -based health programs that address local health needs and priorities.
- Strengthening community leadership and capacity for self -advocacy through community events training and technical assistance.
- Training community members in advocacy, legislative and local policy change, systems change, and environment change , health education, and program planning to enable them to lead initiatives that address systemic and institutional racism and discrimination and improve health equity.
- Creating platforms for continuous community feedback and participation in decision-making processes.
- Actively working to shift power and resources to priority populations to meaningfully address health inequities

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RHEC THEORY OF CHANGE

INPUTS, ASSUMPTIONS AND FEEDBACK MECHANISMS

INPUTS

- Funding, partnerships, community leaders' involvement, communication tools, training, and technical assistance

ASSUMPTIONS

- Increased community engagement leads to more relevant and sustainable initiatives that increase health equity.
- Communities that are actively involved in planning and implementing interventions that are meant to impact their lives are more likely to achieve better health and social outcomes.
- Effective policy advocacy leads to legislative changes that support health equity.

FEEDBACK MECHANISMS

- Regular community assessments to evaluate satisfaction and effectiveness of the engagement strategies.
- Adaptation of strategies based on community input, ensuring responsiveness to evolving community needs

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3. **How many employees do CCOs have total? How many staff at CCOs are administrative versus direct care providers? How does that compare to other states?**

   OHA does not track the number of staff employed at each CCO as each entity operates differently; some CCOs operate with in-house staffing while others leverage administrative agreements with other entities. However, OHA does require CCOs to report their administrative costs on a quarterly and annual basis. In 2023, all CCOs spent about $624 million on administrative expenses (~8%). Overall, each year CCOs are evaluated against a 85% Medical Loss Ratio (MLR), which limits their non-medical costs (administrative and profit) to 15% of their total capitation revenue. If a CCO's Medical costs (MLR) is lower than 85%, the CCO will need to invest the difference into their community.

4. **How many employees does OHA have? What is the need for increasing staff at OHA? What is the current vacancy rate at OHA?**

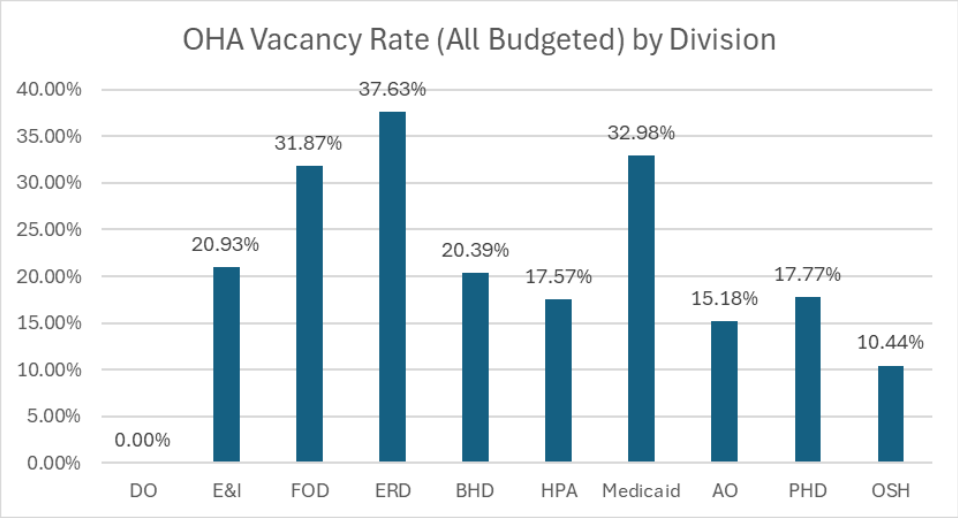
   OHA currently has 5,474 employees. The breakdown of their employment status is as follows:

   - Permanent Employees: 5,299
   - Limited Duration Employees: 145
   - Temporary Employees: 30
   - **Total: 5,474**

   The Oregon Health Authority has grown significantly over the last three biennium across all divisions. Growth has been mainly due to a combination of a number of factors including, but not limited to:

- New programs created by ballot measures/legislation/federal funding opportunities including, the Psylocibin Program, Medicaid's 1115 demonstration waiver program, Health Care Marketplace Oversight, Healthier Oregon Program, and expansion of the REALD/SOGI program.
- Expansion of staffing needs to meet compliance/staff law requirements, especially at the Oregon State Hospital.
- Expansion of existing programs, such as REALD/SOGI to include a statewide repository, expansion of the Ombuds program to manage increased call volume by Oregon Health Plan recipients, public health modernization, and the Office of Program Integrity.
- Expansion of support programs such as Human Resources and Office of Information Services as new or expanding division programs and positions required additional employee supports and technology.
- Strategic focus on behavioral health initiatives and investments to address workforce issues, county partnerships, and community infrastructure for those that needs mental health and substance use disorder services.

The current vacancy rate across OHA is 15.5 percent. Vacancy rates by division are seen in the chart below.



Please do not hesitate to reach out if there are any further questions. Thank you.

Sincerely,

Kristine M Kautz
Deputy Director for Administration