Patient-Centered Primary Care Home Program Health Equity Initiative Community Feedback Summary and Next Steps

December 2021

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Overview

High-quality primary care is foundational to a health system, yet very few people receive what is defined as "high-quality primary care": "The provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."[1] A recent study by the Commonwealth Fund found a key feature distinguishing high-income countries with top-performing health care systems from the United States is their investment in primary care to ensure that high-value services are equitably available in all communities to all people.[2]

The COVID-19 pandemic highlighted that the current primary care system does not meet the needs of all people living in Oregon. In December 2020, the Oregon Health Authority's (OHA) Health Policy and Analytics (HPA) division leadership initiated a process to ensure that the Patient-Centered Primary Care Home (PCPCH) program supports a primary care system that addresses community-identified needs, especially the needs of those who experience systemic racism, barriers in accessing care, and health inequities. The PCPCH program staff enthusiastically embraced this directive, calling it the PCPCH Program Health Equity Initiative ("the Initiative").

The Initiative supports OHA's goal of eliminating health inequities by 2030 and is guided by the agency's definition of health equity:

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*
>
> *Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*
>
> - *The equitable distribution or redistribution of resources and power; and*
> - *Recognizing, reconciling and rectifying historical and contemporary injustices.*

The PCPCH program convened a Primary Care Health Equity (PCHE) workgroup comprised of OHA staff from across divisions to assist the PCPCH program in gathering and synthesizing

[1] National Academies of Sciences, Engineering, and Medicine 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.
[2] Eric C. Schneider et al., Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01dv-h208.

community input about primary care. The PCHE workgroup convened five times from February through July 2021. (See Appendix A for list of members.)

This report describes how the PCPCH program gathered community input, a summary of the findings, and the next steps in the Initiative.

Community feedback methodology

Document analysis

PCPCH program staff began gathering community input through an analysis of reports, needs assessments and surveys to identity feedback that has already been shared with OHA and to reduce potential "listening fatigue" among community partners. PCPCH program staff and PCHE workgroup members identified 19 documents to be analyzed for community feedback about primary care, including the OHA Strategic Plan Community Input Report, the Immigrant & Refugee Community Organization Needs Assessment, and Coalition of Communities of Color reports (see Appendix B for a list of all documents). PCPCH program staff recorded findings in a document analysis template intended to capture specific feedback about primary care from distinct communities. Staff completed over 41 analysis templates since some documents included feedback from multiple communities.

Listening sessions

Upon completion of the document analysis, the PCPCH program collaborated with staff in the Primary Care Office (PCO) to conduct listening sessions with over 25 organizations and primary care practices statewide in order to collect feedback that may not have been represented in the documents analyzed. Participating organizations included the Urban League of Portland, Asian Pacific American Network of Oregon, Basic Rights Oregon, Yakima Valley Farm Workers Clinic, Central City Concern, and Winding Waters Medical Clinic, among others. Please see Appendix C for a list of participating organizations. The format, time, and duration of each listening session was based on the organization's preference. Some listening sessions occurred during a scheduled meeting with many attendees while other listening sessions were one-on-one interviews.

The PCPCH program and PCO used five open-ended questions to guide the listening sessions in advance of each meeting. See Appendix D for a list of questions. Findings were recorded from staff notes from each listening session. Prior to the listening sessions, PCPCH program and PCO staff participated in a constructivist listening training from the Cross-Cultural Health Care Program,[3] which provides training and consulting expertise to help with culturally competent communication and practices in health care.

Data analysis on health disparities

PCPCH program staff conducted an analysis of data reports and dashboards published by OHA and other public sources to evaluate specific populations in Oregon that experience

[3] https://xculture.org/

significant health disparities in select measures of health behaviors, current health status, access to primary care, quality of primary care, and health outcomes (see Appendix E).

The analysis highlighted 14 demographic groups in Oregon that experience health-related disparities based on the identities and communities identified in the OHA health equity definition. Many of the groups were targeted in the document analysis and/or listening sessions. The remaining three groups (people who identify as White/Caucasian, self-identified males, and people who are either uneducated or low-income), while not directly targeted, may have been represented in the more general feedback gathered about primary care.

The disparity analysis also highlighted gaps in available data, as several of the demographic groups identified were not included in statewide health assessments or comparisons. Efforts to improve the collection and quality of available data are needed in order to fully understand and reduce the health-related inequities that Oregonians experience.

"You need to understand the culture; understand the traumas, and where the people are coming from. So, I would love to have something like that where it's required like, certain people are required to go to some kind of training"

Communities represented

The document analysis, listening sessions and data analysis included feedback from people throughout the state who identified with one or more of the following broadly defined communities:

- Hispanic and Latino/a/x
- Native Hawaiian and Pacific Islander
- American Indian and Alaska Native
- Black and African American
- Slavic and Russian
- Middle Eastern and North African
- Asian
- LGBTQIA+
- People with Disabilities
- Adolescents
- Pregnant People
- Women
- Parents/Guardians of Children with Special Health Care Needs
- People experiencing houselessness
- People with a severe and persistent mental illness
- Older adults
- Linguistic minorities
- Rural and frontier populations

Community feedback results: What we heard

Lack of culturally responsive care

Culturally responsive care can be defined as, "an extension of patient centered-care that includes paying particular attention to social and cultural factors in managing medical encounters with patients from very different social and cultural backgrounds."[4] In nearly every listening session people described how culturally responsive care was not provided in primary care.

Insufficient language interpretation services

- No interpreters for certain languages or dialects available
- Incorrect interpretation or interpretation errors by interpreters
    - *"We need translators and interpreters who really know our language and community. Oftentimes, I see translations that are done by someone who does not understand the grammar. The same for interpreters – they are/say they are trained, but when they interact with the doctors, you can tell that they either did not learn much or forgot".*
- Some people prefer a family member to interpret but this not always allowed by clinic
- Lack of in-person interpreters (which is preferred over phone interpreters)
- Lack of full-time employment opportunities create structural wage inequalities that impact retention of interpreters

Lack of understanding about how a person's culture, priorities, identity, and/or social circumstances guides decision-making

- Differences in how a person approaches behavioral health
    - *"I went to a clinic and they scanned me. Later told me I was depressed. I did not think I was sick. I was told I was sick. I only thought I missed my family."*
    - *"There is a lot of stigma around mental health in the Asian community. You can't really use the term 'mental health' so we use different language."*
- A woman would prefer to only be treated by a female provider and clinical staff
- A person's priorities are not considered when making recommendations or prescribing health behaviors. For instance, a patient experiencing food insecurity may prioritize access to food instead of decreasing their cholesterol

People do not feel acknowledged by primary care providers and staff

- Dismissal of traditional healing practices (herbal products, tai chi, acupuncture, etc.)
- Omission of chosen name and/or pronouns on clinic documents

[4] Carteret, Marsha (2011) Culturally Responsive Care. http://www.dimensionsofculture.com/2010/10/576/

- Referrals to community resources are not culturally specific to the patient. For instance, a patient may be referred to a diabetes education class taught in English when the patient's preferred language is Spanish

Patient education, self-management tools and documents are not culturally specific

- Documents are only in English and/or do not address a patient's culture

Health literacy

Health literacy is the degree to which individuals can find, understand, and use information and services to inform health-related decisions and actions for themselves and others. In listening sessions and the document review, people described how low levels of health literacy was a barrier in primary care.

- Written documents are difficult to understand (such as intake forms, after visit summary, patient education materials, billing statements)
- Provider speaks in medical terminology or vocabulary that is difficult to understand for patients and/or provider speaks slowly which feels patronizing to the patient
    - *"They'll use big words like "mastoid." No, just say tell me this part right here on my neck. Or they really, sometimes they will talk so slow. Like dumb it down."*
- Health insurance is difficult to navigate; this includes challenges with applying for insurance, understanding what services are covered by insurance, and where to call with questions.

An inadequate and underequipped health care workforce

During the listening sessions people described the negative impact of Oregon's inadequate and under-equipped workforce on their experience in primary care and the health care system.

Lack of diverse providers, administrative staff and leadership

- Very few people of color working as providers, clinical staff, front office receptionists, and leadership in primary care
    - *"There is no one who looks like me at my clinic or understands me."*
- Lack of providers and clinical staff who understand LGBTQIA+ health care needs
- Systemic racism in the workplace and the need to create a welcoming clinical practice and community environments to retain staff of color or with other lived experiences once they are hired

Shortage of behavioral health and oral health providers

- Overall, there is a significant shortage of behavioral health providers in Oregon, especially in rural areas
- Shortage of Black, Indigenous, People of Color (BIPOC) behavioral health providers which impacts access to care

    - *"When a therapist gets too popular, they stop taking patients with Medicaid and then there is no BIPOC therapists to see patients who don't have private insurance."*
- Oral health services are difficult to access for many people due to a variety of barriers such as provider shortages and few providers accepting patients with Medicaid

Underutilization of Traditional Health Workers

Many people described how Traditional Health Workers (THW) and Community Health Workers (CHW) bridge gaps in trust, culture, and language between primary care and underserved populations. Increasing their utilization in primary care was a prominent recommendation. However, it was also noted that CHWs face the same structural barriers as the patients they work with, and therefore need support, adequate training and compensation to be successful.

The primary care workforce is not trained to provide culturally responsive and trauma-informed care

At almost every listening session people said providers, clinical staff and administrative staff would benefit from trainings on culturally responsive care, trauma-informed care, and anti-racism.

- *"Trainings should be developed by queer and trans people who can talk about their lived experience."*

"You need to understand the culture; understand the traumas, and where the people are coming from. So, I would love to have something like that where it's required like, certain people are required to go to some kind of training."

Cost of care

The cost of medical care is still a barrier for many people living in Oregon. Listening session participants specifically mentioned the following cost-related barriers:

- Premiums, co-pays, deductibles, and other out-of-pocket costs
- The cost of specialists, medication or other care referred by provider that is not covered by insurance
- Lack of health insurance either because of unaffordable premiums or ineligibility for Medicaid so any health care services are out-of-pocket expenses

Distrust of the health care system and health care providers

Listening session participants described distrust of health providers and the health care system. Some reasons cited for distrust include discrimination, historical trauma, microaggression, fear that providers would judge them for their health concerns and/or make assumptions about them, being re-traumatized when meeting with a provider (particularly for immigrants and refugees) and insufficient time spent with the providers to build a relationship.

Adolescents were concerned providers would share information about sexual activity or drug use with their parents/guardians.

- *"If you want to get pregnant, that's kind of frowned upon. Me and my significant other, we want a big family."*
- *"The history of this shows that these records (electronic health records) have been used against people of color, migrant workers and immigrants may also be too fearful of the record keeping to even use programs with mandatory record keeping."*
- *"Providers assume because I am Black that I have high blood pressure."*

A health system that perpetuates inequities and racism

Although the focus on these listening sessions was to obtain feedback specifically about primary care, the impact of social determinants of health and social determinants of equity on health disparities is important to acknowledge. People in Oregon who experience health disparities struggle with affordable housing, lack of access to transportation, lack of childcare/early childhood education, police violence, fear of deportation due to immigration status, access to healthy food that is affordable and culturally appropriate, and many other health-related social needs that are outside the direct, immediate influence of primary care.

Further, people living in Oregon interact with primary care within the constructs of a health system that perpetuate inequities and racism. Listening session participants often described system-level barriers that impacted their ability to access high quality primary care or to provide care to their patients. This section summarizes listening session participant feedback about system level challenges that impact equity.

Insufficient data about populations experiencing health inequities

No statewide Race, Ethnicity, and Language, Disability (REALD) and Sexual Orientation & Gender Identity (SOGI) data collection process or infrastructure to support data collection

Health system is difficult to navigate

- Lack of information about insurance or how to access health care
- Technology barriers
    - Lack of internet, cell phone and/or computer
    - Disinterest or dislike of telehealth
- Distrust of government systems by some people living in Oregon

Barriers within OHA that prevent patients from getting care

- Medications and treatments not covered by Medicaid (the Oregon Health Plan)
- Difficult referral process for specialty mental health
- Lapse in insurance coverage (Medicaid) when incarcerated individuals are released from jails
- Youth under age 18 are unable to obtain Medicaid benefits without a parent

Health care should be available outside the "clinic walls"

- Coming to a clinic in-person can be a barrier; need community-based care in settings like community service organizations, local food banks or cultural events
- Not enough primary care services for people with limited mobility and/or disabilities and older adults who live at home and in congregate care facilities

Payment models do not support the primary care health system

- Traditional fee-for-service payment model with 15-minute provider visits does not support the type of care that vulnerable populations need
- Coordinated Care Organization (CCO) incentive metric funds not being passed on to primary care practices who are doing the work with patients to help the CCO meet the metric
- Lack of adequate funding for clinic efforts to improve the quality and equity of care provided to patients (e.g., financial incentives for PCPCH model implementation sometimes limited, misaligned, or not known about).
- Some of the most underserved areas not receiving the funding they need for primary care transformation.

Next steps in the PCPCH program health equity initiative

These listening sessions, document review and data analyses provided a "starting point" for the PCPCH program staff to begin to understand the barriers and challenges with primary care among communities experiencing health inequities. The PCPCH Program has been on the forefront of primary care innovation since it was established by the Oregon legislature over a decade ago. Currently, there are over 640 primary care practices across Oregon that participate in the PCPCH program. PCPCH program staff have established relationships with primary care clinics and providers, and the program is uniquely positioned within OHA and HPA to drive health equity within primary care through program changes and direct technical assistance. In addition, staff have an opportunity to establish a vision for how the program should evolve to contribute to ensuring equitable care is available to all people in a post-pandemic world.

How the PCPCH program currently addresses health inequity

OHA has utilized the PCPCH program as a strategy to address health inequities since the program was developed over a decade ago by the legislature. Primary care practices that apply for PCPCH recognition are required to provide free interpretation services to all patients in their preferred language, encouraged to translate all written documents into languages other than English and encouraged to work closely with community partners in providing care for their patients. In 2013, the PCPCH program created a brochure explaining what can be expected at a PCPCH for providers to give to their patients. The brochure is available in 7 languages and can be downloaded directly from the PCPCH program website.

In January 2021, OHA implemented revised PCPCH standards which were based on recommendations from the PCPCH Standards Advisory Committee, health equity policy

consultant Ignatius Bau and other stakeholder feedback. The revised PCPCH program standards have a greater emphasis on health equity; notable revisions include:

- A new standard for Health-Related Social Needs/Social Determinants of Health screening and interventions;
- A new standard for alterative visit types to an in-person office visits (e.g. in-home visits, mobile vans, telehealth visits);
- The addition of the adjective 'diverse' when describing patients, families, and care givers in the PCPCH Recognition Criteria Technical Specifications and Reporting Guide (TA Guide);
- Including a Traditional Health Worker as a care team member when describing the technical specifications for specific standards in the TA Guide; and
- The addition of examples featuring diverse patients when describing how practices can meet standards in the TA Guide (e.g. preventive screenings for transgender people).

Further, the PCPCH program has identified health equity resources that are useful for primary care practices (e.g. toolkits, policies, case studies). These resources are available on the PCPCH program website and are used by PCPCH program staff when providing one-to-one technical assistance to PCPCHs.

Revise the PCPCH standards

The PCPCH standards are revised periodically in partnership with the PCPCH Standards Advisory Committee ("the committee"), a volunteer stakeholder advisory body that assists the OHA with the development and implementation of the PCPCH standards. Based on what we have learned, the PCPCH standards should be revised to focus on helping primary care practices address health inequities within their patient population that are a result of policy and structural issues like racism and discrimination.

The listening sessions with representatives from community-based organizations (CBOs) and primary care practices reinforced the importance of being led by diverse voices experiencing health inequities and engaging them in driving decision-making to rectify historical injustices. In addition, the COVID-19 pandemic has highlighted the importance of integrating primary care with public health and social services that address the social determinants of health. The PCPCH program is committed to facilitating and supporting strong partnerships among CBOs representing community perspectives, public health and social service providers, the PCPCH program, advisory committee members and the primary care practices that participate in the PCPCH program. Partnering with CBOs that have the history, cultural understanding, and trust relationships with the communities struggling with health disparities and barriers to health can help ensure that the PCPCH standards are targeted to reduce health disparities.

Convene the PCPCH standards advisory committee

To ensure the PCPCH program supports a primary care system that addresses community-identified needs, the composition of PCPCH standards advisory committee members should be expanded to include individuals experiencing health inequities, THWs, and representatives from community-based organizations. In addition, the PCPCH program is considering

convening a health equity advisory committee to provide guidance and feedback on the PCPCH standards. The health equity advisory committee may also be able to advise health care workforce programs and policies in OHA's Clinical Supports, Integration and Workforce Unit—where the PCPCH program sits—. as well. The PCPCH program plans to begin convening the PCPCH standards advisory committee within the first six months of 2022.

Possible revisions to the PCPCH standards

PCPCH program staff have already began considering possible revisions to the PCPCH standards. Staff have conducted an environmental scan of best and emerging practices in addressing health inequities in primary care settings and medical home models for ideas that could implemented in Oregon. Possible revisions identified thus far fall into three categories: revisions to existing PCPCH standards, new standards, and general changes. Below are very high-level examples of possible revisions in each category.

Revise existing PCPCH standards

There are many PCPCH standards in the current model that could be revised to incorporate components of health equity. For example, PCPCHs could be required to have a Patient and Family Advisory Council (PFAC) which is now only an optional standard. Another example is that PCPCHs could be required to include race and/or ethnicity in their risk stratification methodology for patients requiring complex care plans.

Add new PCPCH standards

New standards could be included in the PCPCH model, such as integrating traditional health workers into the PCPCH care team and PCPCH staff trainings on cultural competency, anti-racism, and trauma-informed care.

Make general changes to the PCPCH program

OHA could consider more general changes to the PCPCH standards and program, such as modifying PCPCH tier levels, verifying a primary care practice is meeting the standards before being awarded PCPCH recognition (currently PCPCH recognition is attestation-based), or having the PCPCH program staff provide robust technical assistance on health equity and related topics. Another option that could be considered is a creating a unique designation for PCPCHs that are providing culturally responsive care.

Important considerations

As OHA considers how the PCPCH program can support a primary care system that addresses the community-identified needs of those who experience systemic racism, barriers in accessing care, and health inequities, it is important to acknowledge the following:

Impact of COVID-19 on the health system

The impact of the COVID-19 pandemic on the health care system in general, and primary care specifically, will remain for years to come. Many in the healthcare workforce are experiencing trauma and burnout like never before. As one leader of a Federally Qualified Health Center (FQHC) stated during a listening session, "I would love to hire staff who look like the patients in

our clinics, but I am struggling to just find people, anyone, to fill the 20 plus open positions I have right now." Revisions to the PCPCH program standards to improve health equity should be challenging but feel attainable to struggling primary care practices.

System-level challenges

Primary care is only one component of the broader health system. Listening session participants described barriers within all levels of the health system that prevented them receiving or providing equitable care. System-level challenges that promote and sustain inequities cannot solely be addressed by primary care or the PCPCH program.

No funding to support health equity work in PCPCHs

The current Fee-For-Service payment model does not provide funds to pay for Traditional Health Workers, staff trainings on cultural competency, anti-racism and trauma-informed care, or other infrastructure changes a PCPCH may have to implement to address health disparities in their patient population. OHA should work with Coordinated Care Organizations (CCOs) and commercial health plans to find a sustainable funding model to support PCPCHs in this important health equity work to help OHA achieve the 2030 goal of eliminating health disparities.

Evaluation is critical

Revisions to the PCPCH standards should be evaluated to determine the impact on health disparities in populations experiencing inequities and improvements to patient care. The PCPCH program should include funding in its 2021-2023 budget for an external evaluator to develop an evaluation framework with quantitative and qualitative methodologies. A previous evaluation from 2016 by Portland State University[5] demonstrated that PCPCH program implementation reduced costs and improved care for patients. Any future program evaluation should also build on this previous work.

Conclusion

The COVID-19 pandemic has shined a spotlight on the inequities in our health system, which has been catalyst for OHA to examine how to meet the health care needs of those in our communities who face the greatest inequities. The PCPCH program has gathered very useful feedback through the listening sessions with representatives from community-based organizations and primary care practices about how to improve the PCPCH program standards. The program is ready to continue these community connections and reimagine the PCPCH program.

[5] Gelmon, et. al (2016) Implementation of Oregon's PCPCH Program: Exemplary practice and program findings. https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/PCPCH-Program-Implementation-Report-Sept2016.pdf

Appendix A: Primary Care Health Equity Workgroup Roster

OHA staff workgroup

Workgroup members:
Joe Sullivan, Health Care Provider Incentives Program Coordinator, Primary Care Office
Kate O'Donnell, School-based Health Center (SBHC) Team Lead, SBHC Program
Ruby Graven, Regional Outreach Coordinator Washington & Columbia County, Community Partners Outreach Program (CPOP)
Jon Michael McDaid, School Outreach and Engagement Coordinator, CPOP
Liliana Villanueva, Regional Outreach Coordinator – Multnomah and Clackamas Counties, CPOP
Daniel Garcia, Health Equity Advisor, Behavioral Health
Kweku Wilson, Research Analyst, Administration – Division of Equity and Inclusion
Jeanene Smith, PCPCH Clinical Advisor, PCPCH Program

PCPCH Program staff:
Neelam Gupta, Clinical Supports, Workforce and Integration Unit Director
Amy Harris, PCPCH Program Manager
Susan El-Mansy, PCPCH Program Operations and Policy Analyst
Rachel Palmer, Communications and Data Specialist
Amber Anderson, Verification Specialist Lead
Alicia Tavares, Verification Specialist
Sumeet Singh, Verification Specialist
Loralee Trocio, Improvement Specialist Lead
Suzanne Jefferson, Improvement Specialist
Kamar Haji-Mohamed, Improvement Specialist
Bernadette Lauer, Improvement Specialist

Appendix B: Documents reviewed in this analysis

Community organization published reports

Leading with Race: Research Justice in Washington County, Coalition of Communities of Color https://www.coalitioncommunitiescolor.org/leadingwithrace

Report on Latino Mental Health in Oregon, Oregon Commission on Hispanic Affairs https://www.oregon.gov/oac/Documents1/Crisis_de_Nuestro_Bienestar_-_Latino_Mental_Health_in_Oregon.pdf

IRCO 2017 Community Needs Assessment, Immigrant and Refugee Community Organization (IRCO) https://irco.org/assets/files/financials/IRCO%202017%20CNA%20Report.pdf

Peoples Plan 2017, Portland African American Leadership Forum https://static1.squarespace.com/static/5a2075ac8a02c7cbf8664919/t/5cf20d9090810000012bfd02/1559367073255/PAALF+Peoples+Plan_2017_sm+%281%29.pdf

Coos County Community Health Improvement Plan (CHIP) 2019-2022 https://www.oregon.gov/oha/HPA/dsi-tc/CCOCHIP/AdvancedHealthCoosCHIP.pdf

Community Health Improvement Plan 2019-2022 https://www.oregon.gov/oha/HPA/dsi-tc/CCOCHIP/AllCare%20ALL%20IN%20FOR%20HEALTH%20CHIP%202019.pdf

Curry County Community Health Improvement Plan (CHIP) 2019 https://www.oregon.gov/oha/HPA/dsi-tc/CCOCHIP/AllCare%20Curry%20County%20CHP%202019.pdf

2019-2024 Eastern Oregon Coordinated Care Organization Community Health Plan https://www.oregon.gov/oha/HPA/dsi-tc/CCOCHIP/EOCCO%20Regional%20CHP.pdf

Intercommunity Health Network CHIP 2019 https://www.oregon.gov/oha/HPA/dsi-tc/CCOCHIP/IHN%20CHP%202019.pdf

Jackson and Josephine Counties Community Health Improvement Plan 2019-2022 https://www.oregon.gov/oha/HPA/dsi-tc/CCOCHIP/JCC%20Jackson%20Josephine%20County%20CHIP%202019.pdf

OHA published reports

CCO 2.0 Community Input Report https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report-Appendix-E.PDF

Healthier Together - State Health Improvement Plan https://healthiertogetheroregon.org/about/

Healthier Together - State Health Improvement Plan Community Based Organizations survey https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/2020-2024-summary-community-feedback.pdf

OHA Strategic Plan Community Listening Sessions (no website link, but can provide report on request)

Telehealth listening session – Consumers
https://dfr.oregon.gov/help/committees-workgroups/Documents/telehealth/telehealth-consumer-session-summary.pdf

Youth Listening Session Report (no website link, but can provide report on request)

Oregon Healthy Teens Survey Report 2019
https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/Documents/2019/County/Douglas%20County%20Profile%20Report.pdf

Well-woman Care report
https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Documents/OHA8234_WW_Report_Final.pdf

Title V - Maternal, Child, and Adolescent Health Needs Assessment
https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Documents/2020%20Title%20V%20Data%20Tools%20Book%20Final.pdf

Appendix C: Organizations that participated in a listening session

Statewide and local organizations

- Asian Pacific American Network of Oregon
- Basic Rights Oregon
- Immigrant Refugee & Community Organization
- Africa House
- Project Access Now
- Self-Enhancement, Inc.
- Urban League of Portland
- Health Share of Oregon
- Consul General, Federated States of Micronesia

OHA commissions and committees

- Health Equity Committee
- Oregon Council on Health Care Interpreters, Advocacy and Legislative Committee
- Traditional Health Worker Commission
- OHA Tribal Monthly Meeting

Primary care practices and organizations

- Oregon Primary Care Association Behavioral Health Advisors
- Central City Concern
- La Clinica
- North by Northeast Community Health Center
- Older Adults provider focus group
- PRISM Health
- Wallace Medical Clinic
- Winding Waters Community Health Center
- Yakima Valley Farm Workers Clinic
- Orchid Health
- Multnomah County Health Centers

Appendix D: Questions asked during the listening sessions

To truly advance health equity in Oregon, how does primary care and the health care workforce need to change?

For the populations you serve, what would you say are the biggest barriers to accessing primary care? Are there different challenges for different groups?

What has prevented populations you serve from being able to achieve optimal health?

What advice or recommendations would you give to local primary care practices to help them better serve these populations?

Are there strategies to improve the quality and effectiveness of care that have not been funded, that need to be? What should we stop funding or start funding?

Appendix E: Sources used for data analysis on health disparities in Oregon

Oregon's State Health Assessment (2018)

State Health Assessment and Indicators – select state profiles (2017)

Oregon Health Insurance Survey (2019)

Oregon Areas of Unmet Health Care Need Report (2020)

Oregon's Health Care Workforce (2021)

Suicide & Suicide Attempts in Oregon Fact Sheet (2015)

Behavioral Risk Factor Surveillance System (2016)

Oregon Vital Statistics Annual Report (2019)

Oregon State Cancer Registry (2018)

Oregon Chronic Conditions Data Portal (2019)

Oregon Hospital Discharge Data (2019)

Oregon Disability Health Data & Statistics (2021)

Health Literacy among Individuals with Disabilities: A Health Information National Trends Survey Analysis (2019)

Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults (2017)

Oregon Census Quick Facts (2019)

Oregon Health Authority

HEALTH POLICY AND ANALYTICS
Delivery System Innovation, Patient-Centered Primary Care Home Program
Phone: 503-373-7768
Email: PCPCH@dhsoha.state.or.us