Engaging Oregonians in Identifying Health Equity Policy Priorities:
a Modified Policy Delphi Approach

2014

Oregon Health Authority

Office of Equity & Inclusion

Principal author
Emily Wang, M.P.H.

Contributors
Erica DeJong and Rachel Gilmer

Community analysis conducted by:
Liz Baxter, M.P.H.; Ann Curry-Stevens, Ph.D.; Brandy Ethridge, Ph.D., M.P.A.;
Rachel Gilmer; Sandra Hernandes, Ph.D.; Junghee Lee, Ph.D.;
Candace Lewis-Laietmark, M.P.H. candidate; Margaret Sarna, M.P.H. candidate;
Charniece Tisdale, M.P.H.; and Emily Wang, M.P.H.

The Office of Equity and Inclusion would like to honor and thank the many statewide community stakeholders and partners who helped us learn more deeply about diverse community experiences and ideas for advancing health equity in Oregon. This includes members of the:

- Health Equity Policy Committee
- Regional Health Equity Coalitions
  - » Let's Talk Diversity
  - » Linn Benton Health Equity Alliance
  - » Oregon Health Equity Alliance (formerly HOPE Coalition)
- Northeast Oregon Network
- Oregon Action
- The Next Door, Inc.
- Policy Delphi Process-Community Analysis Team (members listed in Appendix A)
  - » Special thanks to Junghee Lee, Brandy Ethridge and Liz Baxter for their major contributions to the analysis and organization of the community forum and survey results, and to Dayna Morrison for suggesting the Delphi process idea.
- Policy Platform Development Panel (members listed in Appendix B)

Their involvement strengthened our ability to hear from and understand intergenerational voices representing a wide range of racially, ethnically, culturally, socially and geographically diverse communities from across this beautiful state.

TABLE OF CONTENTS

Executive summary **6**

Engaging Oregonians in Identifying Health Equity Policy Priorities: a Modified Policy Delphi Approach **12**

- **Instituting health equity at the Oregon Health Authority** **12**
- **Oregon's growing diversity** **12**
- **Building upon Oregon's strengths in health leadership and community engagement** **17**
  - Health leadership 17
  - Community engagement at the Office of Equity and Inclusion 18
- **Methods** **19**
  - Phase 1 — Community policy forums 19
  - Phase 2 — Modified Policy Delphi process 20
- **Results** **24**
  - Demographic make-up of Policy Platform Development Panel 24
  - Section 1: General policy areas ranked by importance 27
  - Section 2: Top policy priorities overall 28
  - Section 3: Top policy priorities overall, by subpopulations 29
  - Section 4: Top OEI policy priorities 57
- **Criteria for OHA-OEI leadership or supportive partner role** **59**
- **Next steps** **60**
  - Strength-based social determinants of health environmental scan 60
- **Conclusion** **61**

Appendices **62**

- **Appendix A. Community Analysis Team** **63**
- **Appendix B. Policy Platform Development Panel** **64**
- **Appendix C. Select sample findings from survey rounds** **66**
  - Round Two: List of Community Policy Items 66
  - Round Two: Assessing Level of Importance for Policy Items 70
  - Round Three: Assessing Level of Support for Policy Items 82

References **84**

Engaging Oregonians in Identifying Health Equity Policy Priorities: a Modified Policy Delphi Approach

EXECUTIVE SUMMARY

Instituting health equity at the Oregon Health Authority

In 2009, the Oregon Legislature created the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB), its governing body, to address the issues of cost, quality and access to health care. The board developed the Action Plan for Health, a comprehensive health reform plan for Oregon. The plan addresses the legislative mandate to achieve the Triple Aim of better health, better care and lower costs. It encourages innovative actions among stakeholders including the legislature, health policy leaders, consumers, businesses and health care providers. One of the foundational strategies of the Action Plan is to improve health equity.

Building upon Oregon's strengths in health leadership and community engagement

Through health systems transformation efforts, Oregon is moving "upstream" to a more preventive approach by expanding efforts outside of health care settings.

In 2011, the Office of Equity and Inclusion (OEI) conducted a strategic planning process focused on advancing health equity throughout Oregon. This process emphasized the need for continued community engagement among Oregon's diverse communities, the Oregon Health Authority (OHA), and the state's health promoting systems. The goal is to support dynamic, strength-based and trust-building relationships.

Advised by its Health Equity Policy Committee (HEPC), OEI developed a multi-phase community engagement process to inform its health equity policy platform (policy priorities) for the next several years.

Phase 1 — Community policy forums

In spring 2012, OEI began implementation of phase 1 by partnering with its Regional Health Equity Coalition partners and other community-based statewide organizations to engage diverse populations through eight health equity strength-based community forums. Eight were conducted in English, and two were done in Spanish.

Phase 2 — Modified Policy Delphi process

For phase 2, HEPC recommended OEI use a Policy Delphi process (Rayens & Hahn, 2000). This is a structured group process during which a series of surveys are presented to a panel of community experts recruited for their knowledge, experience and interest in the subject area (Turoff 2002). For OEI's purpose, the survey's subject area was health inequities.

Primary objectives

Unlike conventional surveying methodology, the Policy Delphi is a "forum for ideas," which welcomes opposing viewpoints. Primary objectives of OEI's survey process were to:

- Ensure that all suggested policy options were considered; and
- Examine and estimate the acceptability (level of importance and support among panelists) of particular policy options.

Community Analysis Team

The Community Analysis Team (CAT) was the monitoring group steering the Policy Delphi process. Specifically, the CAT developed the surveys, reviewed and analyzed the quantitative and qualitative survey data, and guided the process. This multidisciplinary team was racially, ethnically and culturally diverse. Team members had knowledge and expertise in health equity (see Appendix A).

Policy Platform Development Panel

The recruitment process for the Policy Platform Development Panel involved an application in which respondents:

- Answered a series of demographic questions;
- Specified their leadership capacity within their community; and
- Described their interest in process participation.

OEI received 180 applications for 50 openings on the panel. OEI sought to reflect Oregon's growing diversity among the final panelists, which included representatives of communities experiencing health inequities (see Appendix B).

Three rounds of surveys

Panelists received incentives to complete three intensive rounds of the Policy Delphi survey. The CAT collected and analyzed qualitative and quantitative data in rounds one and two. Data from the early rounds informed the content of subsequent survey rounds and panelists' responses.

Results

Policy areas related to social determinants of health are highlighted in red below.

General policy areas ranked by importance

Refer to Table 6 for full rankings.

1.) Access to health care;

2.) Affordable and safe housing and neighborhoods;

3.) Employment opportunities;

4.) Education opportunities.

Top policy priorities — overall

Refer to Table 7 for full rankings.

1.) Ensure access to health, dental and mental health services for all individuals.

2.) Pay a living wage.

3.) Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services.

4.) Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers.

Top policy priorities — OEI (supported by 80% or more of the panel)

Note that some rankings are tied. Refer to Table 17 for full rankings.

1.) Ensure access to health, dental and mental health services for all individuals.

2.) Ensure more granular data on communities of color and other disadvantaged or underrepresented communities.

2.) Ensure coordinated care organization (CCO) community health assessments track inequities and work with community to identify policies for eliminating them.

2.) Update school curriculum to incorporate racial, social and economic justice; students develop skills and attitudes to build an inclusive society and end damaging biases and stereotypes of "others" and support cultural identity development.

Criteria for OHA-OEI leadership or supportive partner role

The Policy Delphi Community Analysis Team (CAT), Health Equity Policy Committee and OEI developed criteria for determining whether OHA-OEI should play a leadership or supportive partner role in advancing top community priorities (see Table 18).

Criteria are aligned with OHA, OEI and HEPC mission, purpose and Lean government practice. Survey results respond to two criteria assessing levels of **importance** and **support** among panelists. These attributes characterize a Policy Delphi survey process.

Next steps

OEI and its community partners have already begun to move forward some of the more conventional health policy items that received 80% or more support from panelists (i.e., collecting more granular data, informing CCO community health assessments, advancing cultural competency training opportunities for health care professionals, etc.).

However, moving the social determinants of health priorities forward (i.e., school curriculum, employment protection, increase in number of minority and bilingual teachers and personnel reflective of student body, etc.) will require unconventional, interdisciplinary, intersectoral and cross-government partnerships during an opportune time of health systems transformation. Partnerships between public health and other sectors can lead to more holistic and integrative policies and programs. Partnerships can also leverage resources, political will and relationships to advance health equity.

OEI will conduct a strength-based social determinants of health environmental scan specific to top-ranked general policy areas identified by the Policy Platform Development Panel (see Table 6) with leaders in affordable and safe housing and neighborhoods, employment, and education. They will help assess potential partnership opportunities.

Conclusion

OEI's mission is to engage and align diverse community voices and the Oregon Health Authority to assure the elimination of avoidable health gaps and promote optimal health in Oregon. To this end, OEI partners with community members to create policy agendas and ensure that OEI's policy platforms are informed by lived experience and community wisdom (Office of Equity and Inclusion 2011-2012 Annual Report).

Informed by results of the Policy Delphi survey, the strength-based social determinants of health environmental scan provides an opportunity for a broad range of diverse community stakeholders to respond during health systems transformation.

This work helps OHA develop a strategic response to social determinants of health. These results open the door to partnerships that align with OHA's upstream actions. This new direction will enable OHA to maximize limited resources for meaningful community impact by tackling root causes of health inequities.

It may be more appropriate for other government agencies, tribes, health institutions and/or community partners to lead on specific policy priorities. Even in cases where OHA does not lead, it can provide strong, influential support to help strengthen, accelerate and advance health equity priorities for all Oregonians.

ENGAGING OREGONIANS IN IDENTIFYING HEALTH EQUITY POLICY PRIORITIES: A MODIFIED POLICY DELPHI APPROACH

Instituting health equity at the Oregon Health Authority

In 2009, the Oregon Legislature created the Oregon Health Authority (OHA) and the Oregon Health Policy Board (OHPB), its governing body, to address the issues of cost, quality and access to health care. OHA is responsible for most state health services and implementation of health care reform (health systems transformation). OHPB developed the Action Plan for Health to:

- Create a comprehensive health reform plan for Oregon;
- Address the legislative mandate to achieve the Triple Aim of better health, better care and lower costs; and
- Encourage innovative actions among stakeholders including the legislature, health policy leaders, consumers, businesses and health care providers.

One of the action plan's key strategies is to improve health equity. The U.S. Department of Health and Human Services' Healthy People 2020 initiative defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." Making health equity a centerpiece of the action plan provides evidence of OHA's commitment to advancing health equity for all Oregonians.

Oregon's growing diversity

The growth of the state's and nation's diversity makes advancing health equity within health systems transformation more critical. In Oregon, the non-White population increased from 16% in 2000 to 22% in 2010. Oregon's racial and ethnic populations are growing at a faster rate than the nation, with one in five (21.5%), or 800,000 Oregonians identified as people of color (see Figure 1).

Within Oregon's low-income population, the changing demographics are even more apparent with nearly 40% of Oregon Health Plan clients identifying as non-White (see Table 1). In 2010, at least 137 languages were spoken in Oregon. This makes Oregon one of the 15 most language-diverse states in the nation (see Figure 2).

Figure 1: Oregon's population change by county

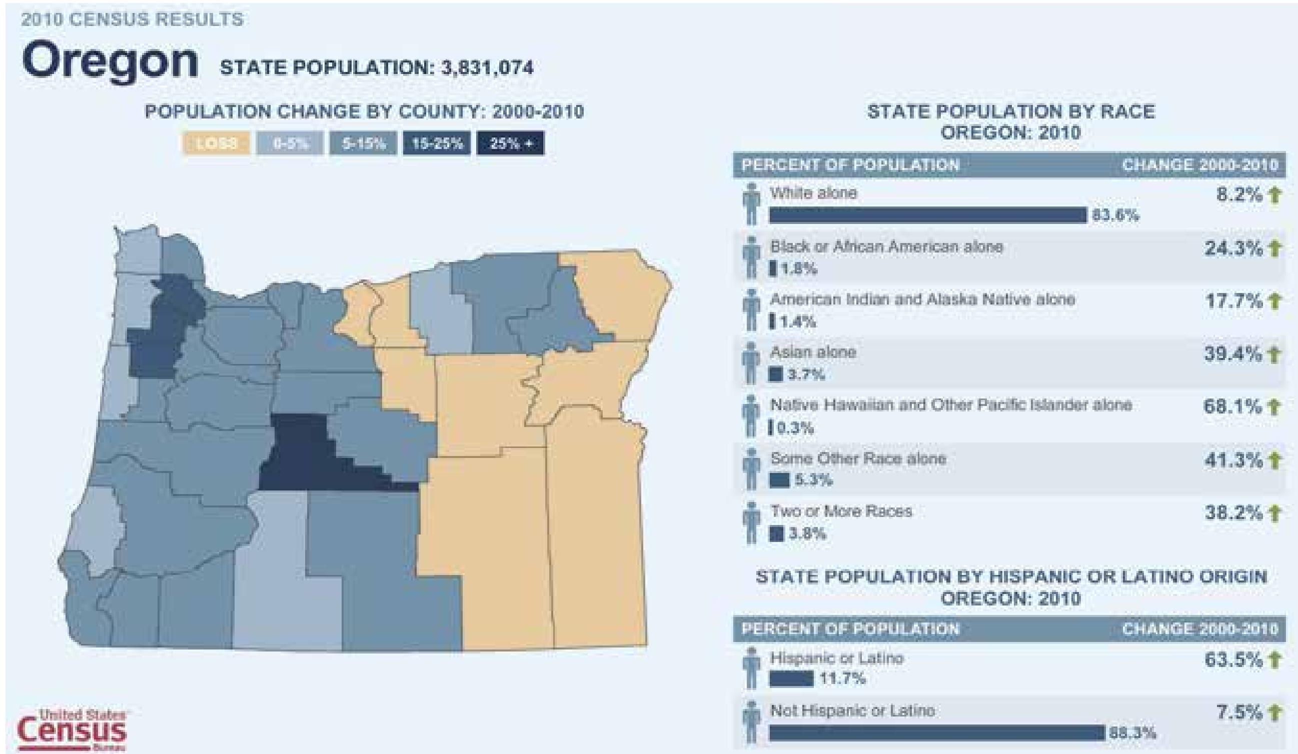


Table 1: August 2014 distribution of age, race/ethnicity and gender among Medicaid clients

Nearly 40% of Oregon Health Plan enrollees are people of color

	Race									Gender			
Age group	African American	American Indian or Alaska Native	Asian or Pacific Islanders	White	Hispanic	Other/ unknown	Data missing	Total	% of Medicaid	Female	% female	Male	% male
<1	732	296	670	12839	5943	3846	1882	26208	2	12739	49	13468	51
01-5	4175	1691	3630	65101	35379	11296	4142	125414	12	61124	49	64290	51
06-12	5782	2711	4869	82318	51853	12774	4724	165031	16	80371	49	84659	51
13-18	4610	2333	3931	63479	34733	8305	4253	121644	11	59796	49	61848	51
19-21	1737	830	1385	25765	10561	2543	2712	45533	4	25382	56	20151	44
22-35	7166	3343	5231	130457	37235	13494	20726	217652	21	128426	59	89226	41
36-50	5279	2613	5058	105985	29316	9213	12872	170336	16	92569	54	77767	46
51-64	4092	2120	3546	91438	16102	5333	14961	137592	13	73701	54	63891	46
65+	1301	630	5141	37806	4632	1167	240	50917	5	33620	66	17297	34
Total	34874	16567	33461	615188	225754	67971	66512	1060327		567728		492597	
% Of Medicaid	3.29	1.56	3.16	58.02	21.29	6.41	6.27			53.54		46.46	

Gender by race/ ethnicity	African American	American Indian or Alaska Native	Asian or Pacific Islanders	White	Hispanic	Other/ unknown	Data missing	Total
Female % female	17871 51.24	9173 55.37	18701 55.89	333939 54.28	119666 53.01	36604 53.85	31774 47.77	567728 53.54
Male % male	17003 48.76	7394 44.63	14760 44.11	281249 45.72	106088 46.99	31367 46.15	34736 52.23	492597 46.46

Notes:

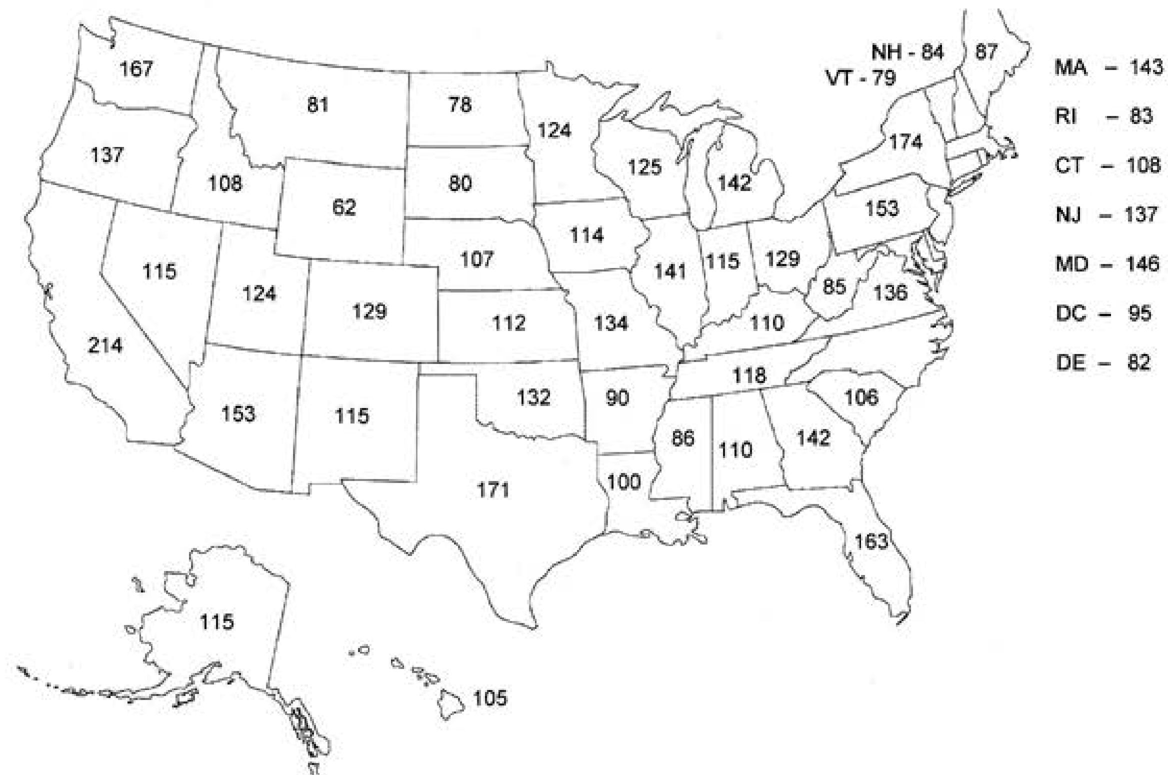
Population includes: Standard benefits and recipients eligible under the classes: QB, QS, NP, CW, and BC, #2131, Version 1

Datasource: OHA/DHS DSSURS warehouse; 15OM database; August 2014

Prepared by: Oregon Health Authority, Office of Equity and Inclusion and Office of Health Analytics, Oct. 1, 2014

Figure 2: Number of languages spoken, by state

Reproduced with permission from the U.S. English Foundation, www.usefoundation.org



State	Languages	State	Languages
California	214	Nevada	115
New York	174	New Mexico	115
Texas	171	Iowa	114
Washington	167	Kansas	112
Florida	163	Alabama	110
Pennsylvania	153	Kentucky	110
Arizona	153	Idaho	108
Maryland	146	Connecticut	108
Massachusetts	143	Nebraska	107
Michigan	142	South Carolina	106
Georgia	142	Hawaii	105
Illinois	141	Louisiana	100
New Jersey	137	District of Columbia	95
North Carolina	137	Arkansas	90
Oregon	137	Maine	87
Virginia	136	Mississippi	86
Missouri	134	West Virginia	85
Oklahoma	132	New Hampshire	84
Colorado	129	Rhode Island	83
Ohio	129	Delaware	82
Wisconsin	125	Montana	81
Minnesota	124	South Dakota	80
Utah	124	Vermont	79
Tennessee	118	North Dakota	78
Alaska	115	Wyoming	62
Indiana	115		

This rapid growth presents a major challenge and opportunity for the state's health and health care systems. Populations of color and other culturally and socially diverse populations currently experience health inequities. Some examples include:

- American Indians and Alaska Natives are twice as likely to smoke as adults overall (Kaiser Family Foundation, 2012).
- The age-adjusted African American prevalence of diabetes is three times higher than for Whites (Oregon Behavioral Risk Factor Surveillance System Oversample, 2010–2011).
- Latinos experience obesity at a higher rate than the general population (30.9% vs. 24.1% respectively) (State of Oregon, Public Health Division, 2012).
- Low-income Asian and Pacific Islanders are least likely of all racial and ethnic groups to initiate prenatal care in the first three months of pregnancy (State of Oregon, Office of Multicultural Health and Services, 2011).
- Pacific Islanders experience the lowest 2-year-old immunization rates among Oregon's race and ethnicity groups (State of Oregon, Office of Equity and Inclusion, 2013).
- Thirty-five percent of minority women have no regular care provider compared to 18% of White women (State of Oregon, Oregon's Action Plan for Health, 2010).
- Lesbians, gays and bisexuals (LGB) are less likely to have medical insurance than heterosexual adults (State of Oregon, Public Health Division, 2012).

We now understand these inequities do not arise by chance. They result from historical injustice and institutional racism experienced across various social determinants of health (e.g., education, employment, housing, environment, land use). These determinants lead to health outcome differences (World Health Organization).

Policies that reproduce inequities and a lack of policies that specifically address the needs and experiences of culturally and socially diverse communities maintain these social structures. Therefore, incorporating social determinants of health into government policymaking will help more effectively tackle the root causes of health inequities (see Table 2).

Table 2. Policy implications of the social determinants of health ("Closing the Health Equity Gap: Policy Options and Opportunities for Action," World Health Organization, 2013)

Health policy implications	Broader policy implications
• Disease prevention and control actions will leave many of the most vulnerable groups without better health prospects unless the **root causes** of ill health are also tackled. • The health sector has an important role in addressing these root causes in its services and by advocating for change and taking **intersectoral action.**	• Actions in all areas of government policy affect health — from the urban environment to trade policy. • The health implications of policy decisions need to be taken into account in order to maximize opportunities for health benefits and to avoid the adverse consequences of government actions. • Unemployment and employment that is temporary or informal can lead to increased risk of poor health and reduced life expectancy.

Building upon Oregon's strengths in health leadership and community engagement

Health leadership

Oregon continues to lead the nation in health and health care delivery solutions. The state increasingly focuses on advancing health equity. OHA's and its Office of Equity and Inclusion's (OEI) leadership efforts include:

- Leading expansion of national health care interpreter oral certification exams from Spanish to five additional languages: Russian, Mandarin, Cantonese, Korean and Vietnamese.
- Implementing qualified/certified health care interpreter requirements.
- Integrating traditional health workers (community health workers, doulas, peer support/wellness specialists and patient navigators) into health care delivery teams.
- Collecting data at a granular level of race; ethnicity; preferred written, spoken or signed language; and disability status.
- Supporting cultural competency continuing education for health care professionals.

OHA is also a national leader in health system transformation through its coordinated care organization (CCO) model. Oregon is one of six states awarded a State Innovation Model (SIM) grant by the Center for Medicare and Medicaid Innovation to test creative health improvement approaches.

The SIM grant's newly established Transformation Center (TC) will work with OEI to support and foster innovative strategies for health equity and for elimination of avoidable health gaps in health and health care outcomes in order to achieve the state's Triple Aim goals:

- Improve the lifelong health of all Oregonians;
- Increase the quality, reliability and availability of care for all Oregonians;
- Lower or contain the cost of care so it is affordable for everyone.

These health systems transformation efforts are moving Oregon "upstream" to a more preventive approach by expanding efforts outside of health care settings. Health systems are now integrating traditional health workers (non-clinical work force), qualified/ certified health care interpreters who provide language services, early learning professionals, and those delivering long-term care services and supports. This will also help OHA improve its ability to address social determinants of health, which are the root causes of health inequities.

Community engagement at the Office of Equity and Inclusion

In 2011, OEI began a strategic planning process focused on advancing health equity statewide. Informed by diverse community engagement efforts, the office refined its role in working with health systems to advance health equity in Oregon. This process emphasized the need for continued community engagement among Oregon's diverse communities, the Oregon Health Authority (OHA), and the state's health promoting systems. The goal is to support dynamic, strength-based and trust-building relationships by:

- Identifying and engaging critical strategic and statewide constituencies to assist with policy and organizational development priorities;
- Including community in "co-creation" of policy, data, research and cost-benefit analyses;
- Facilitating investment in the capacity of Oregon's diverse communities to promote community and regional solutions to avoidable health gaps;
- Increasing health equity and diversity development leadership among community leaders/influencers; and
- Connecting OHA to diverse community members to improve policy and to develop staff diversity and cultural competency.

Juventud FACETA in Eugene, Oregon, engaged Latino youth to complete the Policy Delphi survey.

Community engagement is important for increasing the overall performance and accountability of health systems (World Health Organization, 2013). The quality and inclusivity of engagement between institutions and the communities they serve largely determine whether policies and programs reflect the interests of all residents.

It is essential to engage communities experiencing health inequities in identifying the policies they believe will make the most meaningful impact on their health outcomes. Understanding inequities is important, but understanding what creates optimal conditions for health and wellness is arguably just as important (City of Minneapolis, 2010). Solutions for achieving health equity are not limited to professional "experts" and individuals with formal education, training or extensive work or research experience in a particular subject. Wisdom from communities with lived experience of health inequities will lead to more effective and sustainable solutions. These communities have intimate knowledge of their strengths and what works best to support their health.

Institutions can earn and keep the community's trust and partnership through continually engaging and following through with meaningful actions to achieve health equity for all Oregonians.

OEI sought to design a policy development process to capitalize on diverse community ideas that address health inequities. The results would inform OEI's strategic decisions

and actions involving OHA policies and programs, other state and local government efforts, legislative initiatives and coalition building activities. The Health Equity Policy Committee (HEPC) — a group of culturally, socially and professionally diverse policy advisors — helped OEI develop and implement an unprecedented multi-phase community engagement process.

This report describes this unique community engagement process used to gather community ideas for health equity policy priorities. It also shares results and next steps to advance Oregon's top policy priorities for the next several years.

Methods

In spring 2012, OEI began a multi-phase community engagement process to identify health equity policy priorities for the next several years.

Phase 1 — Community policy forums

In the first phase, OEI partnered with its Regional Health Equity Coalitions (RHECs) and other community-based organizations statewide to engage diverse populations through eight health equity community forums. These forums incorporate strength-based elements of a multicultural storytelling community engagement process certified by National Association of County and City Health Officials in 2011. The forums asked communities to explore:

- How they define health?
- What community strengths and challenges exist in achieving health?
- What policy and programmatic solutions should be implemented to advance health equity in their region?

Forums were held in the following areas. Six forums were conducted in English and two were conducted in Spanish:

- Portland metro area;
- Corvallis and Albany (English and Spanish);
- Confederated Tribes of Warm Springs and Jefferson County;
- Medford;
- Hood River (English and Spanish);
- La Grande.

Phase 2 — Modified Policy Delphi process

In the second phase, HEPC recommended that OEI use a Policy Delphi process (Rayens & Hahn, 2000). A series of surveys are presented to a panel of community experts recruited for their knowledge, experience and interest in the subject area (Turoff 2002). For OEI's purpose, the subject area for the survey was health inequities.

Community experts remain anonymous to one another as they respond to the surveys. This prevents those with authority, personality or reputation from dominating others.

Primary objectives

Unlike conventional surveying methodology, the Policy Delphi is a "forum for ideas." It's a decision analysis tool that, contrary to its precursor (a consensus-building Delphi method), welcomes opposing viewpoints. Primary objectives of OEI's survey process were to:

- Ensure that all suggested policy options were considered; and
- Examine and estimate the acceptability (level of importance and support among panelists) of particular policy options.

The Policy Delphi methodology was modified to increase the diversity of perspectives among the survey monitoring group and fit the fast-paced needs of OHA decision-makers during a peak health systems transformation time. It also responded to limited state government and volunteer resources to conduct this work. This modification resulted in:

- Increasing the size of the monitoring group to include interdisciplinary and culturally diverse perspectives;
- Shortening the timeline of the survey;
- Limiting the number of survey rounds;
- Focusing the survey on prioritizing community ideas (by level of importance) and estimating the acceptability (by level of support) among the panelists of proposed ideas;
- Strengthening co-ownership of the process and its results by diverse community stakeholder groups.

This modified Policy Delphi process may make it more accessible to others interested in replicating the process.

Key components

In December 2012, OEI fulfilled two key components of the modified Policy Delphi process:

- Community Analysis Team (survey monitoring group);
- Policy Platform Development Panel (panel of community experts/survey respondents).

Community Analysis Team

The Community Analysis Team (CAT) was the monitoring group steering the Policy Delphi process. Specifically, the CAT developed the surveys, reviewed and analyzed the quantitative and qualitative survey data, and guided the process. It was an interdisciplinary as well as racially, ethnically and culturally diverse team. Members had knowledge and expertise in health equity, and included:

- Representatives of HEPC and OEI with undergraduate to Ph.D. degrees in adult education, Africana studies, American culture, community health education, education, gerontology, human ecology, multicultural education, policy administration, psychology, public health, social work, and sociology;
- A Centers for Disease Control and Prevention masters in public health level fellow;
- Portland State University (PSU) social work faculty; and
- PSU public health graduate students.

Members were Liz Baxter, Ann Curry-Stevens, Brandy Ethridge, Rachel Gilmer, Sandra Hernandes, Junghee Lee, Candice Lewis-Laietmark, Margaret Sarna, Charniece Tisdale and Emily Wang. (See Appendix A.)

Policy Platform Development Panel

The recruitment process for the Policy Platform Development Panel involved an application in which respondents answered a series of demographic questions, specified their leadership capacity within their community, and described their interest for participating in the process. OEI received 180 applications for 50 openings on the panel.

OEI sought to reflect Oregon's growing diversity among the final panelists, which included representatives of communities experiencing health inequities Panelists represented racially, ethnically and linguistically diverse populations, LGBTQ populations, seniors, people with disabilities, rural communities, economically disadvantaged, and other specific subpopulations. OEI invited:

- "Grass tops" leaders who have a strong background in advocacy and public policy;
- "Grass roots" leaders whose lived experience makes them leaders in their community; and
- Health equity experts.

This diversity allowed OEI to gain a deeper understanding of health equity priorities from diverse subpopulation perspectives statewide. (See Appendix B.)

Respondents were each offered $100 Fred Meyer gift cards as an incentive to complete all three rounds of lengthy surveys electronically within a short timeframe of less than two months.

Three rounds of surveys

Panelists were asked to complete three rounds of the Policy Delphi survey. This was an iterative survey process; the CAT collected and analyzed quantitative and qualitative data in rounds one and two. The results informed the content of subsequent survey rounds as well as panelists' responses.

Round one survey

In the first round survey, panelists responded to community ideas for health equity policy priorities collected through eight statewide community forums. The CAT categorized more than 50 policy priorities into 13 main policy areas:

- Access to health care;
- Affordable and safe housing and neighborhoods;
- Employment opportunities;
- Education opportunities;
- Health reform funding/payments;
- Access to healthy foods;
- Health education and prevention;
- Community engagement with government and health institutions;
- Transportation;
- Access to physical activity and recreation;
- Driver's licenses;
- Data and metrics;
- Regulation.

Panelists could also recommend more policy priorities they believed would positively affect their community.

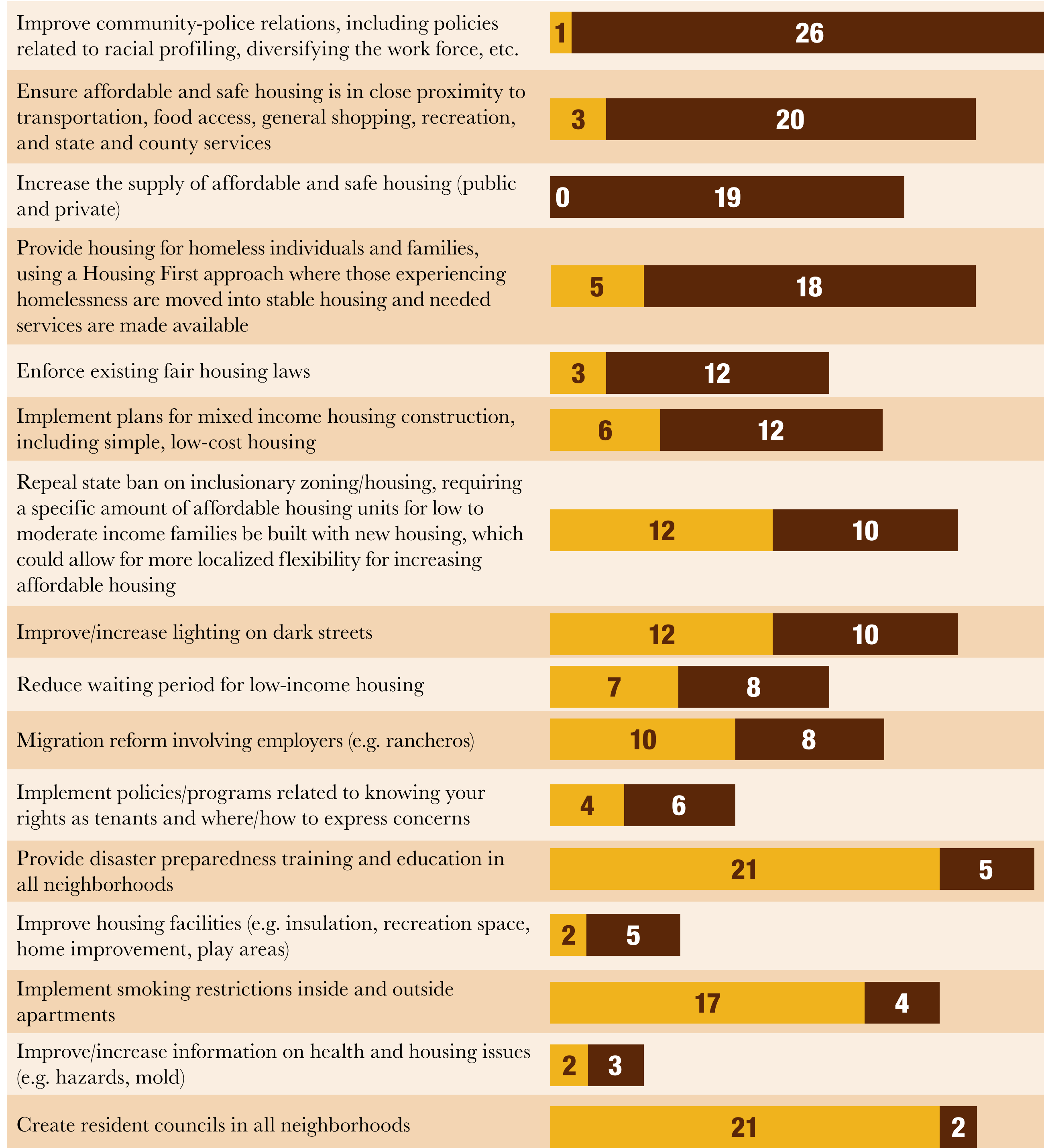
The result was 67 policy recommendations. They were then asked to rate and rank the importance of each of the main policy areas, as well as the individual policy priorities within each of the areas on a scale of 1 to 5, with 1 being "most critical" and 5 being "least important." Panelists also provided a written description of what health means to them and their community, which was not always consistent with health professionals' more conventional disease-oriented definitions.

Round two survey

In the second round survey, panelists reviewed the results of the first round survey and rated (1-10) the importance of the 13 main policy areas, as well as the individual policy priorities. They were then asked to identify their top four and bottom three policy priorities within each issue area. By reviewing the results of the previous survey, respondents saw how other panelists rated the individual priorities. This information was considered in their final survey responses (see Table 3).

Table 3. Sample results: Affordable and safe housing and neighborhoods priority area

Delphi round two survey of 42 panelists: 13 issue area bar charts (March 6, 2013 data)



Issue	Total # for least important	Total # for most critical
Improve community-police relations, including policies related to racial profiling, diversifying the work force, etc.	1	26
Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services	3	20
Increase the supply of affordable and safe housing (public and private)	0	19
Provide housing for homeless individuals and families, using a Housing First approach where those experiencing homelessness are moved into stable housing and needed services are made available	5	18
Enforce existing fair housing laws	3	12
Implement plans for mixed income housing construction, including simple, low-cost housing	6	12
Repeal state ban on inclusionary zoning/housing, requiring a specific amount of affordable housing units for low to moderate income families be built with new housing, which could allow for more localized flexibility for increasing affordable housing	12	10
Improve/increase lighting on dark streets	12	10
Reduce waiting period for low-income housing	7	8
Migration reform involving employers (e.g. rancheros)	10	8
Implement policies/programs related to knowing your rights as tenants and where/how to express concerns	4	6
Provide disaster preparedness training and education in all neighborhoods	21	5
Improve housing facilities (e.g. insulation, recreation space, home improvement, play areas)	2	5
Implement smoking restrictions inside and outside apartments	17	4
Improve/increase information on health and housing issues (e.g. hazards, mold)	2	3
Create resident councils in all neighborhoods	21	2

Total # for least important | Total # for most critical

Round three survey

In the third round, panelists reviewed the results of the round two survey and then ranked the policy areas and policy priorities from "most important" to "least important." Additional questions, including those characteristic of a Policy Delphi process, were also included in the round three survey (see Table 4).

Their answers helped assess panelists' willingness and ability to support and/or invest resources into advancing the identified policy priorities. The answers also helped OEI understand what efforts currently exist. Panelists were also asked whether specific policy priorities should be included in OEI's final policy platform and could suggest specific changes needed for them to support the policy for OEI's platform.

Table 4: Additional round three survey questions

1)	Is your organization and constituency base currently working to advance this priority?
2)	If no, is this a priority you or your organization would be willing to work on and put resources towards?
3)	From your perspective, are there currently funding opportunities available to support advancing this priority?
4)	Should this item be included in OEI's final policy platform?
5)	If you selected "no," please specify why. If you selected "yes, with changes," what changes should be made?

Results

Demographic make-up of Policy Platform Development Panel

Fifty-one of 180 applicants were invited to participate on the Policy Platform Development Panel. Forty-three completed the first survey round; 42 completed the second round; and 41 completed the third round. Of the 41 panelists who completed all three surveys:

- Eleven identified as Hispanic;
- Eleven identified as Asian;
- Eight identified as Black, African, Caribbean or African American;
- Five identified as White;
- Four identified as American Indian or Alaska Native; and
- Two identified as Native Hawaiian or Pacific Islander.

Additionally,

- Nine panelists described themselves as immigrants;
- Seven described themselves as a person living with a disability: and
- Nine panelists identified as LGBTQ, including two individuals who identified as transgender.

OEI also sought diversity in age, preferred spoken language, work condition and insurance coverage among the final panelists (see Table 5).

Note: Because this is not a conventional polling survey, standard survey and analysis practices may not apply without further examination.

Table 5. Round three Policy Delphi survey panelist select demographics (n = 41, 100%)

Demographic	Number of panelists (%)	Demographic	Number of panelists (%)
Work condition		**Insurance**	
Nonprofit	27 (65.9%)	**Private**	23 (56.1%)
Government	7 (17.1%)	Employment-based	16 (39.0%)
Small business	3 (7.3%)	Individually purchased	3 (7.3%)
Corporate	1 (2.4%)	Student insurance	4 (9.8%)
Academic	6 (14.6%)	**Public**	5 (12.2%)
Self-employed	6 (14.6%)	OHP	2 (4.9%)
Not working	1 (2.4%)	Medicare	2 (4.9%)
Retired	1 (2.4%)	Military	1 (2.4%)
Student	10 (24.4%)	**Uninsured**	3 (7.3%)
Age (years)		**Language spoken**	
18-24	1 (2.4%)	English only	28 (68.3%)
25-34	7 (17.1%)	Spanish	8 (19.8%)
35-44	8 (19.5%)	Chuukese	1 (2.4%)
45-54	6 (14.6%)	Khmer	1 (2.4%)
55-64	10 (24.4%)	Hmong	1 (2.4%)
65+	3 (7.3%)	Lao	1 (2.4%)
		Tagalog	1 (2.4%)

Demographic	Number of panelists (%)	Demographic	Number of panelists (%)
Race/ethnicity		**Region**	
American Indian	4 (7.8%)	Metropolitan area	33 (80.5%)
Asian	11 (26.8%)	Metropolitan area with high commuting	3 (7.3%)
Black	8 (19.5%)	Micropolitan area	3 (7.3%)
Hispanic	11 (26.8%)	Rural	2 (2.4%)
Pacific Islander	2 (4.9%)		
White	5 (12.2%)		
Immigration status		**County**	
Immigrant	9 (22.0%)	Multnomah	23 (51.6%)
Refugee	1 (2.4%)	Washington	6 (14.6%)
LGBTQ	9 (22.0%)	Lane	4 (9.8%)
Disability	7 (17.1%)	Clackamas	2 (4.9%)
Gender		Benton	1 (2.4%)
Female	24 (58.5%)	Jefferson	1 (2.4%)
Male	15 (36.6%)	Marion	1 (2.4%)
Transgender	2 (4.9%)	Thurston, WA	1 (2.4%)
		Union	1 (2.4%)
		Wasco	1 (2.4%)

Notes:

1.) Work condition included multiple responses.

2.) Due to missing values, total panelist number differs by categories.

3.) Race/ethnicity: Self-identified race/ethnicity is included. If multi-race/ethnicity is reported, primary race/ethnicity is chosen.

4.) One panelist who reported that s/he was born in a foreign country is included as being an immigrant.

5.) Rural Urban Commuting Area (RUCA) codes including metropolitan area core: primary flow within an urbanized area (UA); metropolitan area high commuting: primary flow 30% or more to a UA; micropolitan area core: primary flow within an urban cluster (UC) of 10,000 through 49,999 (large UC).

Section 1: General policy areas ranked by importance

Panelists ranked by importance 13 general policy areas that reflected participant recommendations from eight statewide community policy forums (see Table 6).

Policy items related to social determinants of health are highlighted in red throughout this report.

Table 6. General policy areas ranked by importance

Overall ranking	Policy area
1	Access to health care
2	Affordable and safe housing and neighborhoods
3	Employment opportunities
4	Education opportunities
5	Health reform funding/payments
6	Access to healthy foods
7	Health education and prevention
8	Community engagement with government and health institutions
9	Transportation
10	Access to physical activity and recreation
11	Driver's licenses
12	Data and metrics
13	Regulation

Section 2: Top policy priorities overall

Data were quantitatively analyzed for the panel as a whole (see Table 5) and for each of the demographic subpopulations (see tables 8 through 16). Of the top 10 overall policy priorities, many related to the social determinants of health, rather than more conventional disease-oriented health topics. These include:

- Pay a living wage;
- Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services;
- Ensure affordable access to healthy foods;
- Advisory councils and oversight committees should reflect the communities they serve and have decision-making power;
- Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs;
- Increase funding for schools.

Policy items related to social determinants of health are highlighted in red throughout this report.

Table 7. Top 10 overall policy priorities

Group	Rank	Sub-policy items
All	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	4	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	5	Ensure affordable access to healthy foods
	6	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	7	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	8	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	9	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	10	Increase funding for schools

Section 3: Top policy priorities overall, by subpopulations

Race/ethnicity

The top 10 policy priorities by racial/ethnic subpopulations represented a wide range of topics, including:

- Safe and affordable housing;
- Adequate transportation;
- Implementing the Dream Act; and
- Updating school curriculum to incorporate racial, social and economic justice, with additional social determinants of health.

Although there were some similarities, rankings varied across subpopulations. For example:

- Although "advisory councils and oversight committees should reflect the communities they serve and have decision-making power" was ranked by the panel overall as a top 10 policy priority, in the race/ethnicity subpopulation analysis, only the Hispanic and Pacific Islander panelists ranked it within their top 10.
- The American Indian sub-group ranked "implementation of the Dream Act and other related immigration reform policies" as a number two policy priority, while the Black/African American subpopulation ranked "remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs" as their number two policy priority.
- African American panelists uniquely ranked "lower costs for public transit" in their top 10, while Asians were the only group with "improve community-police relations, including policies related to racial profiling, diversifying the work force, etc." in their top 10 (see Table 8).

Please note that some subpopulations have more respondents than others.

Table 8. Top 10 policy priorities ranking by race/ethnicity (n = 41, 100%)

Race/ethnicity	Rank	Policy priorities
American Indian	1	Ensure access to health, dental and mental health services for all individuals
	2	Implementation of the Dream Act and other related immigration reform policies
	3	Update school curriculum to incorporate racial, social and economic justice

Race/ethnicity	Rank	Policy priorities
American Indian	4	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	5	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	6	Pay a living wage
	7	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	8	Ensure that public transportation routes and frequencies are adequate in rural, suburban and low-income communities
	9	Require diversity on boards, commissions and in hiring reflective of populations being served
	10	Ensure affordable access to healthy foods

Race/ethnicity	Rank	Policy priorities
Asian	1	Ensure access to health, dental and mental health services for all individuals
	2	Ensure affordable access to healthy foods
	3	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	4	Increase funding for schools
	5	Ensure local, healthy foods in all government programs, including school lunches
	6	Improve and ensure safe, accessible neighborhood infrastructure
	7	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	8	Ensure more granular data on communities of color and other disadvantaged or underrepresented communities
	9	Improve community-police relations, including policies related to racial profiling, diversifying the work force, etc.
	10	Fund sports programs for youth at risk of criminal involvement

Race/ethnicity	Rank	Policy priorities
Black, African American	1	Ensure access to health, dental and mental health services for all individuals
	2	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	3	Pay a living wage
	4	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	5	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	6	Ensure affordable access to healthy foods
	7	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	8	Lower costs for public transportation
	9	Improve and ensure safe, accessible neighborhood infrastructure
	10	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
Race/ethnicity	**Rank**	**Policy priorities**
Hispanic	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	4	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
	5	Implementation of the Dream Act and other related immigration reform policies
	6	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services

Race/ethnicity	Rank	Policy priorities
Hispanic	7	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	8	Immigration reform to ensure housing supplied by employers for migrant and seasonal farmworkers is safe, affordable and adequate
	9	Ensure affordable access to healthy foods
	10	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
Race/ethnicity	**Rank**	**Policy priorities**
Pacific Islander	1	Ensure access to health, dental and mental health services for all individuals
	2	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
	3	Implement plans for mixed-income housing construction, including simple, low-cost housing
	4	Update school curriculum to incorporate racial, social and economic justice
	5	Increase the supply of affordable and safe housing (public and private)
	6	Provide more creative and engaging education methods (including radio/TV) to help underserved populations
	7	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	8	Reduce waiting period for low-income housing
	9	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	10	Implementation of the Dream Act and other related immigration reform policies

Race/ethnicity	Rank	Policy priorities
White	1	Ensure access to health, dental and mental health services for all individuals
	2	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	3	Pay a living wage
	4	Expand supports for minority-owned businesses to succeed, including shared resources, mentoring, technical assistance and health coverage
	5	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	6	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	7	Increase funding for schools
	8	Hold CCOs accountable for reducing health disparities in their area by implementing economic/financial penalties if they fail to achieve reductions
	9	Require all clinics and hospitals to collect data on the languages spoken by clients
	10	Implement plans for mixed-income housing construction, including simple, low-cost housing

Immigration status

In regards to policy priorities specific to immigration status:

- "Ensure access to health, dental and mental health services for all individuals" appeared as the number one policy priority for both immigrant and non-immigrant populations.
- Furthermore, immigrants (N=9) ranked "advisory councils and oversight committees should reflect the communities they serve and have decision-making power," "increase farm-to-school and farm-to-market programs," and "improve and ensure safe, accessible neighborhood infrastructure," among their top 10 policy priorities, while non-immigrants identified "ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services" within their top three policy priorities (see Table 9).

Table 9. Top 10 policy priorities ranking by immigration status (n = 41, 100%)

Immigration status	Rank	Policy priorities
Immigrant	1	Ensure access to health, dental and mental health services for all individuals
	2	Immigration reform to ensure housing supplied by employers for migrant and seasonal farmworkers is safe, affordable and adequate
	3	Require diversity on boards, commissions and in hiring reflective of populations being served
	4	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	5	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
	6	Ensure affordable access to healthy foods
	7	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	8	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	9	Increase farm-to-school and farm-to-market programs
	10	Improve and ensure safe, accessible neighborhood infrastructure
Immigration status	**Rank**	**Policy priorities**
Non-immigrant	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	4	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers

Immigration status	Rank	Policy priorities
Non-immigrant	5	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	6	Ensure affordable access to healthy foods
	7	Increase funding for schools
	8	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	9	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	10	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them

Spoken language

Policy priorities were also analyzed by panelists' preferred spoken languages. Primary languages included English (68.3%) and Spanish (19.8%). Chuukese, Khmer, Hmong, Lao and Tagalog languages were spoken at a much lower rate (2.4% each).

Policy priorities held among these language groups included priorities related to institutional practices, such as advisory committees, employment pipeline programs, and hiring processes being reflective of populations being served. Access to physical activity facilities, physical education, and improvement of public communal spaces and neighborhood infrastructure were also commonly identified.

Some differences include:

- Hmong- and Lao-speaking panelists ranked "ensure local, healthy foods in all government programs, including school lunches" in their top three policy priorities while the Tagalog speaker identified "improve community-police relations, including policies related to racial profiling, diversifying the work force, etc." as a number one priority.
- For the Chuukese speaker, "update school curriculum to incorporate racial, social and economic justice" and "provide more creative and engaging education methods (including radio/TV) to help underserved populations" appeared within the top three policy priorities.

For more information, please see Table 10.

Note: Findings from these groups require additional analysis given the small and varied numbers of panelists per group. Please use caution when interpreting results. This is not a conventional polling survey.

Table 10. Top 10 policy priorities ranking by language spoken (n = 41, 100%)

Language	Rank	Policy priorities
English only	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	4	Ensure affordable access to healthy foods
	5	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	6	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	7	Increase funding for schools
	8	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	9	Improve and ensure safe, accessible neighborhood infrastructure
	10	Increase the supply of affordable and safe housing (public and private)
Language	**Rank**	**Policy priorities**
Spanish	1	Ensure access to health, dental and mental health services for all individuals
	2	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
	3	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	4	Implementation of the Dream Act and other related immigration reform policies
	5	Pay a living wage
	6	Immigration reform to ensure housing supplied by employers for migrant and seasonal farmworkers is safe, affordable and adequate
	7	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them

Language	Rank	Policy priorities
Spanish	8	Require diversity on boards, commissions and in hiring reflective of populations being served
	9	Provide low-cost and free access to exercise and recreation facilities through efforts such as public-private partnerships with gyms and other services
	10	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
Language	**Rank**	**Policy priorities**
Chuukese	1	Ensure access to health, dental and mental health services for all individuals
	2	Update school curriculum to incorporate racial, social and economic justice
	3	Provide more creative and engaging education methods (including radio/TV) to help underserved populations
	4	Reduce waiting period for low-income housing
	5	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	6	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
	7	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	8	Increase the availability of culturally and geographically specific physical activity and recreation
	9	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	10	Keep going back to communities for feedback
Language	**Rank**	**Policy priorities**
Khmer	1	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
	2	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	3	Expand supports for minority-owned businesses to succeed, including shared resources, mentoring, technical assistance and health coverage

Language	Rank	Policy priorities
Khmer	4	Increase number of minority and bilingual teachers and personnel reflective of student body; ensure cultural competency among work force
	5	Increase funding for schools
	6	Require all clinics and hospitals to collect data on the languages spoken by clients
	7	Ensure more granular data on communities of color and other disadvantaged or underrepresented communities
	8	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	9	Reduce waiting period for low-income housing
	10	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
Language	**Rank**	**Policy priorities**
Hmong	1	Ensure access to health, dental and mental health services for all individuals
	2	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	3	Ensure local, healthy foods in all government programs, including school lunches
	4	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	5	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	6	More health and wellness education materials and methods in plain language, especially for those with limited literacy and education levels
	7	Implementation of the Dream Act and other related immigration reform policies

Language	Rank	Policy priorities
Hmong	8	Increase and/or improve job preparation and future job skills (including for health careers) in middle school, high school and community colleges
	9	Increase the availability of culturally and geographically specific physical activity and recreation
	10	Ensure that public transportation routes and frequencies are adequate in rural, suburban and low-income communities
Language	**Rank**	**Policy priorities**
Lao	1	Ensure access to health, dental and mental health services for all individuals
	2	Ensure local, healthy foods in all government programs, including school lunches
	3	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	4	Ensure affordable access to healthy foods
	5	Increase farm-to-school and farm-to-market programs
	6	Fund sports programs for youth at risk of criminal involvement
	7	Ensure that WIC and SNAP are being accepted as payment and promoted for every farmers' market
	8	Improve community access to public spaces
	9	Improve and ensure safe, accessible neighborhood infrastructure
	10	Improve/increase the availability of physical education (PE) classes for all children in grades K–12
Language	**Rank**	**Policy priorities**
Tagalog	1	Improve community-police relations, including policies related to racial profiling, diversifying the work force, etc.
	2	Require diversity on boards, commissions and in hiring reflective of populations being served
	3	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	4	Increase funding for schools
	5	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers

Language	Rank	Policy priorities
Tagalog	6	Ensure access to health, dental and mental health services for all individuals
	7	Repeal state ban on inclusionary zoning/housing
	8	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	9	Ensure more granular data on communities of color and other disadvantaged or underrepresented communities
	10	Increase bus routes, shuttles, and frequency on weekends and 24-hour access [to public transportation]

Sexual orientation

Panelists who identified as lesbian, gay, bisexual, transgender or queer (LGBTQ) (N=9) ranked top 10 priorities similar to that of non-LGBTQ panelists, including:

- Pay a living wage:
- Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services; and
- Ensure affordable access to healthy foods.

LGBTQ panelists ranked "implementation of the Dream Act and other related immigration reform policies" and "increase and/or improve job preparation and future job skills (including for health careers) in middle school, high school and community colleges" within the top 10 policy priorities.

However, those who identified as non-LGBTQ included "increase the supply of affordable and safe housing" and "remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs" in the top 10. Please see Table 11 for additional information.

Table 11. Top 10 policy priorities ranking by sexual orientation (n = 41, 100%)

Sexual orientation	Rank	Policy priorities
LGBTQ	1	Ensure access to health, dental and mental health services for all individuals
	2	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	3	Pay a living wage

Sexual orientation	Rank	Policy priorities
LGBTQ	4	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	5	Implementation of the Dream Act and other related immigration reform policies
	6	Increase and/or improve job preparation and future job skills (including for health careers) in middle school, high school and community colleges
	7	Ensure that public transportation routes and frequencies are adequate in rural, suburban and low-income communities
	8	Ensure local, healthy foods in all government programs, including school lunches
	9	Ensure affordable access to healthy foods
	10	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
Sexual orientation	**Rank**	**Policy priorities**
Non-LGBTQ	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	4	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	5	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	6	Ensure affordable access to healthy foods
	7	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	8	Increase the supply of affordable and safe housing (public and private)

Sexual orientation	Rank	Policy priorities
Non-LGBTQ	9	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	10	Update school curriculum to incorporate racial, social and economic justice

Age

The top 10 policy priorities were analyzed for the following age groups: 18–24, 25–44, 45–64 and 65+. The results demonstrate some intergenerational agreement. For example:

- "Ensure access to health, dental and mental health services for all individuals" was ranked as a number one priority for all age groups.
- Similarly, "pay a living wage" was a top 10 priority for all age groups except 65+.
- Panelists ages 18–24 ranked "address gentrification issues surrounding access to public transportation for displaced populations" and "promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon" within their top 10 policy priorities.
- Additionally, panelists ages 25–44 ranked "lower costs for public transportation" among their top 10, while it did not rank as highly for other groups.
- "Improving community-police relations, including policies related to racial profiling, diversifying the work force, etc." was a top priority for panelists ages 45–64.
- Panelists ages 65+ ranked "increase and/or improve job preparation and future job skills (including for health careers) in middle school, high school and community colleges" and "expand supports for minority-owned businesses to succeed, including shared resources, mentoring, technical assistance and health coverage" as top priorities. Other age groups did not rank these as top priorities.

Table 12. Top 10 policy priorities ranking by age (n = 41, 100%)

Group	Rank	Sub-policy items
All	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services

Group	Rank	Sub-policy items
All	4	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	5	Ensure affordable access to healthy foods
	6	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	7	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	8	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	9	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	10	Increase funding for schools
Group	**Rank**	**Sub-policy items**
Age: 18–24	1	Ensure access to health, dental and mental health services for all individuals
	2	Implement plans for mixed-income housing construction, including simple, low-cost housing
	3	Increase the supply of affordable and safe housing (public and private)
	4	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	5	Implementation of the Dream Act and other related immigration reform policies
	6	Pay a living wage
	7	Require all employers to pay sick leave
	8	Increase bus routes, shuttles, and frequency on weekends and 24-hour access [to public transportation]
	9	Address gentrification issues surrounding access to public transportation for displaced populations
	10	Promote change, including removing citizenship and legal residency requirements, to obtain driver’s license in Oregon

Group	Rank	Sub-policy items
Age: 25–44	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Increase funding for schools
	4	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	5	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	6	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	7	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	8	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	9	Lower costs for public transportation
	10	Ensure affordable access to healthy foods
Group	**Rank**	**Sub-policy items**
Age: 45–64	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	4	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	5	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	6	Ensure affordable access to healthy foods
	7	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them

Group	Rank	Sub-policy items
Age: 45–64	8	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	9	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	10	Improve community-police relations, including policies related to racial profiling, diversifying the work force, etc.
Group	**Rank**	**Sub-policy items**
Age: 65+	1	Ensure access to health, dental and mental health services for all individuals
	2	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	4	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	5	Ensure affordable access to healthy foods
	6	Increase and/or improve job preparation and future job skills (including for health careers) in middle school, high school and community colleges
	7	Expand supports for minority-owned businesses to succeed, including shared resources, mentoring, technical assistance and health coverage
	8	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	9	Improve and ensure safe, accessible neighborhood infrastructure
	10	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs

Disability status

Seven panelists identified as persons with a disability (17.1%).

- Among persons with disabilities "provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers" and "ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services" ranked among the top three policy priorities.
- The White and disability subpopulations were the only two that ranked "hold CCOs accountable for reducing health disparities in their area by implementing economic/financial penalties if they fail to achieve reductions" in their top 10.
- Additionally, two of the priorities within the disability subpopulation were immigration-related: "implementation of the Dream Act and other immigration reform policies" and "promote change, including removing citizenship and legal residency requirements, to obtain drivers licenses in Oregon."

Table 13. Top 10 policy priorities ranking by disability status (n = 41, 100%)

Disability status	Rank	Policy priorities
Disability	1	Ensure access to health, dental and mental health services for all individuals
	2	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	4	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	5	Pay a living wage
	6	Implementation of the Dream Act and other related immigration reform policies
	7	Hold CCOs accountable for reducing health disparities in their area by implementing economic/financial penalties if they fail to achieve reductions

Disability status	Rank	Policy priorities
Disability	8	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	9	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
	10	Ensure affordable access to healthy foods
Disability status	**Rank**	**Policy priorities**
Non-Disability	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	4	Ensure affordable access to healthy foods
	5	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	6	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	7	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	8	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	9	Increase funding for schools
	10	Update school curriculum to incorporate racial, social and economic justice

Gender

Top policy priorities were also analyzed by gender. Of the 41 panelists, 58.8% (N=24) identified as female, 36.6% (N=15) identified as male, and 4.9% (N=2) identified as transgender.

- Again, "ensure access to health, dental and mental health services for all individuals" is ranked as a number one policy priority for all three gender groups.
- Each group also ranked "pay a living wage" and "ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services" within their top 10 priorities.
- "Implementation of the Dream Act and other related immigration reform policies" ranked within the top three priorities for transgendered panelists, while it did not rank in the top 10 for either female or male panelists. Females ranked "advisory councils and oversight committees should reflect the communities they serve and have decision-making power" within their top 10 (#2), while males ranked "lower costs for public transportation" in their top 10 policy priorities (#7).
- Additionally, transgender was the only subpopulation of the three that ranked "more health and wellness education materials and methods in plain language, especially for those with limited literacy and education levels" within their top 10.

Table 14. Top 10 policy priorities ranking by gender (n = 41, 100%)

Gender	Rank	Policy priorities
Female	1	Ensure access to health, dental and mental health services for all individuals
	2	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	3	Pay a living wage
	4	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	5	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	6	Update school curriculum to incorporate racial, social and economic justice
	7	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers

Gender	Rank	Policy priorities
Female	8	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
	9	Ensure affordable access to healthy foods
	10	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
Gender	**Rank**	**Policy priorities**
Male	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	4	Ensure affordable access to healthy foods
	5	Improve and ensure safe, accessible neighborhood infrastructure
	6	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	7	Lower costs for public transportation
	8	Increase the supply of affordable and safe housing (public and private)
	9	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	10	Increase funding for schools
Gender	**Rank**	**Policy priorities**
Transgender	1	Ensure access to health, dental and mental health services for all individuals
	2	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	3	Implementation of the Dream Act and other related immigration reform policies
	4	Ensure that public transportation routes and frequencies are adequate in rural, suburban and low-income communities

Gender	Rank	Policy priorities
Transgender	5	Ensure local, healthy foods in all government programs, including school lunches
	6	Pay a living wage
	7	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	8	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	9	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	10	More health and wellness education materials and methods in plain language, especially for those with limited literacy and education levels

Health insurance status

Policy priorities were also examined through health insurance status. Twenty-three panelists had private insurance, five had public insurance and three panelists were uninsured.

- Each group ranked "ensure access to health, dental and mental health services for all individuals" as the number one policy priority.
- For panelists with public insurance and those who were uninsured "ensure affordable access to healthy foods" was ranked within the top three policy priorities.
- "Update school curriculum to incorporate racial, social and economic justice" also made the top 10 for both those with public insurance and those who were uninsured. However, this did not hold true for privately insured panelists.
- Private and uninsured panelists identified "require ongoing training on cultural competency, linguistic appropriateness, and trauma and torture impacts for health care workers" in the top 10 at #6 and #3, respectively.
- Those with private insurance ranked "ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them," and "advisory councils and oversight committees should reflect the communities they serve and have decision-making power," in their top policy priorities (see Table 15). However, these did not make the top 10 for publicly funded or uninsured panelists.

- Instead, panelists with public insurance ranked “identify, ban, and inform communities (including employees) of harmful chemicals” and “increase scholarships and discounts for local public and private schools, community colleges, and four-year colleges and universities” within their top 10.
- The uninsured also prioritized “provide more creative and engaging education methods (including radio/TV) to help underserved populations” and “fund sports programs for youth at risk of criminal involvement” within their top 10.

Table 15. Top 10 policy priorities ranking by health insurance status (n = 41, 100%)

Health insurance status	Rank	Policy priorities
Private	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	4	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	5	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	6	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	7	Ensure local, healthy foods in all government programs, including school lunches
	8	Increase the supply of affordable and safe housing (public and private)
	9	Increase funding for schools
	10	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers

Health insurance status	Rank	Policy priorities
Public	1	Ensure access to health, dental and mental health services for all individuals
	2	Ensure affordable access to healthy foods
	3	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	4	Pay a living wage
	5	Identify, ban and inform communities (including employees) of harmful chemicals
	6	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	7	Provide housing for homeless individuals and families, using a Housing First approach
	8	Update school curriculum to incorporate racial, social and economic justice
	9	Increase scholarships and discounts for local public and private schools, community colleges, and four-year colleges and universities
	10	Immigration reform to ensure housing supplied by employers for migrant and seasonal farmworkers is safe, affordable and adequate
Health insurance status	**Rank**	**Policy priorities**
Uninsured	1	Ensure access to health, dental and mental health services for all individuals
	2	Ensure affordable access to healthy foods
	3	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	4	Improve community-police relations, including policies related to racial profiling, diversifying the work force, etc.
	5	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon

Health insurance status	Rank	Policy priorities
Uninsured	6	Update school curriculum to incorporate racial, social and economic justice
	7	Improve and ensure safe, accessible neighborhood infrastructure
	8	Provide more creative and engaging education methods (including radio/TV) to help underserved populations
	9	Ensure local, healthy foods in all government programs, including school lunches
	10	Fund sports programs for youth at risk of criminal involvement

Geographic region

The top policy priorities were also examined by geographic region. The panelists' place of residence/work was identified at a county level. Rural Urban Commuting Area (RUCA) codes were also determined in order to gain additional geographic information about the panelists.

RUCAs are a newer census tract-based classification scheme that uses the standard Bureau of Census urbanized area and urban cluster definitions in combination with work commuting information to characterize all of the nation's census tracts regarding their rural and urban status and relationships. (WWAMI Rural Health Research Center, University of Washington, 2005).

Forty-one panelists represented 10 counties: Multnomah 23 (56.1%), Washington 6 (12.8%), Lane 4 (9.8%), Clackamas 2 (4.9%), Benton 1 (2.4%), Jefferson 1 (2.4%), Marion 1 (2.4%), Thurston, WA 1 (2.4%), Union 1 (2.4%) and Wasco 1 (2.4%). Among the panelists:

- Thirty-three resided in a metropolitan area (primary flow within an urbanized area);
- Three lived in a metropolitan area with high commuting (with primary flow of 30% or more to an urbanized area);
- Three lived in a micropolitan area (primary flow within an urban cluster of 10,000 through 49,999);
- Two lived in a rural area (primary flow to a tract outside an urbanized area or cluster).
- Panelists who described their geographic region as metro area with high commuting ranked "promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon" and "implementation of the Dream Act and other related immigration reform policies" within their top three priorities.
- Those living within the micropolitan area ranked "immigration reform to ensure housing supplied by employers for migrant and seasonal farm workers is safe, affordable and adequate" and "require diversity on boards, commissions and in hiring reflective of populations being served" within their top three priorities.

- Housing issues were among four of the top 10 priorities for rural area panelists with "provide housing for homeless individuals and families, using a Housing First approach" (#4), "ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services" (#6), "implement plans for mixed-income housing construction, including simple, low-cost housing" (#8), and "increase the supply of affordable and safe housing (public and private)" (#9).
- Rural area panelists also uniquely ranked "ensure that WIC and SNAP are being accepted as payment and promoted for every farmers' market," "improve/increase the availability of physical education (PE) classes for all children in grades K–12," and "keep going back to communities for feedback," within their top 10.

Again, please use caution when interpreting these results. Rural representation among panelists is small. While this is not a conventional polling survey, these findings can add value to related information and/or serve as a starting point for further engagement and conversation.

Table 16. Top 10 policy priorities ranking by region (n = 41, 100%)

Region	Rank	Policy priorities
Metro area	1	Ensure access to health, dental and mental health services for all individuals
	2	Pay a living wage
	3	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	4	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
	5	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
	6	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
	7	Ensure affordable access to healthy foods

Region	Rank	Policy priorities
Metro area	8	Increase funding for schools
	9	Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs
	10	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
Region	**Rank**	**Policy priorities**
Metro area with high commuting	1	Ensure access to health, dental and mental health services for all individuals
	2	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
	3	Implementation of the Dream Act and other related immigration reform policies
	4	Ensure affordable access to healthy foods
	5	Require diversity on boards, commissions and in hiring reflective of populations being served
	6	Improve and ensure safe, accessible neighborhood infrastructure
	7	Pay a living wage
	8	Fund sports programs for youth at risk of criminal involvement
	9	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	10	Increase employment protection for those who have the least access and lowest income, including farm workers
Region	**Rank**	**Policy priorities**
Micro area	1	Ensure access to health, dental and mental health services for all individuals
	2	Immigration reform to ensure housing supplied by employers for migrant and seasonal farm workers is safe, affordable and adequate
	3	Require diversity on boards, commissions and in hiring reflective of populations being served
	4	Promote change, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon

Region	Rank	Policy priorities
Micro area	5	Increase the supply of affordable and safe housing (public and private)
	6	Incentivize system strategies that result in reduction of health disparities
	7	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power
	8	Hold CCOs accountable for reducing health disparities in their area by implementing economic/financial penalties if they fail to achieve reductions
	9	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	10	Regulate health insurance companies by defining how they must use their profits
Region	**Rank**	**Policy priorities**
Rural area	1	Ensure access to health, dental and mental health services for all individuals
	2	Ensure affordable access to healthy foods
	3	Pay a living wage
	4	Provide housing for homeless individuals and families, using a Housing First approach
	5	Ensure that WIC and SNAP are being accepted as payment and promoted for every farmers' market
	6	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services
	7	Improve/increase the availability of physical education (PE) classes for all children in grades K–12
	8	Implement plans for mixed-income housing construction, including simple, low-cost housing
	9	Increase the supply of affordable and safe housing (public and private)
	10	Keep going back to communities for feedback

Section 4: Top OEI policy priorities

Panelists indicated their top health policy priorities and recorded whether they believed OEI should include each sub-policy item in the office's final policy platform. Panelists were concerned with various aspects of health and advised OEI to include policies relating to both health care and the social determinants in their final platform.

For example, while 92% of panelists indicated that OEI should ensure that coordinated care organizations (CCOs) track and address health disparities, 92% of panelists also indicated that OEI should "update school curriculum to incorporate racial, social and economic justice, meaning students develop skills and attitudes to build an inclusive society and end damaging biases and stereotypes of "others," and support cultural identity development." Sub-policy items that received at least 80% or more support from the 41-person panel made the top OEI policy priorities list (see Table 17).

Table 17. Top OEI policy priorities (80% or more support from the panel)

Note that some rankings are tied.

Policy area		Sub-policy item
1	Access to health care	Ensure access to health, dental and mental health services for all individuals
2	Data and metrics	Ensure more granular data on communities of color and other disadvantaged or underrepresented communities
2	Data and metrics	Ensure coordinated care organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them
2	Education opportunities	Update school curriculum to incorporate racial, social and economic justice, meaning students develop skills and attitudes to build an inclusive society and end damaging biases and stereotypes of "others," and support cultural identity development
3	Data and metrics	Evaluate health providers' skills in cultural competence (such as the ability to withhold judgment), as well as the organizations' cultural competence
3	Health reform funding/payments	Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers
4	Community engagement with government and health institutions	Advisory councils and oversight committees should reflect the communities they serve and have decision-making power

Policy area		Sub-policy item
4	Education opportunities	Implementation of the Dream Act and other related immigration reform policies
4	Access to health care	Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers
5	Data and metrics	Require all clinics and hospitals to collect data on the languages spoken by clients
5	Access to healthy foods	Ensure affordable access to healthy foods
5	Driver's license	Promote changes, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon
5	Employment opportunities	Increase employment protection for those who have the least access and lowest income, including farm workers
5	Education opportunities	Increase funding for schools
5	Education opportunities	Increase number of minority and bilingual teachers and personnel reflective of student body, ensure cultural competency among work force
6	Data and metrics	Ensure data is interpreted by authentic members of the minority community to allow for better understanding of the data and the community's needs
6	Health reform funding/payments	Incentivize system strategies that result in reduction of health disparities

Criteria for OHA-OEI leadership or supportive partner role

Through a series of meetings, the Policy Delphi Community Analysis Team (CAT), Health Equity Policy Committee and OEI developed criteria to determine whether OHA-OEI should play a leadership or supportive partner role in advancing top community priorities (see Table 18).

Table 18. Criteria for OHA-OEI leadership or supportive partner role

Criteria
1. Does this help to advance health equity for all Oregonians? • Meaningful impact to culturally based communities? • Meaningful impact to place-based communities?
2. Is there a high level of importance placed on this by community stakeholders?
3. Is there a high level of support for this by community stakeholders?
4. Does this empower community members experiencing health disparities?
5. Is this appropriate for state government/OHA to address (i.e., lead or partner with county, city, local community, tribe, other)?
6. Is it achievable/feasible under conditions that can be relatively assured (i.e., costs, staff resources, political environment, other)?
7. Is there a multiplier effect, in that advancing this priority would also advance other top priorities?

Criteria are aligned with OHA's, OEI's and HEPC's mission, purpose, and Lean government practice. Survey results respond to two criteria assessing levels of importance and support among panelists, which are characteristic of a Policy Delphi survey process:

- "Is there a high level of **importance** placed on this by community stakeholders?"
- "Is there a high level of **support** for this by community stakeholders?"

Specifically, the level of importance question was answered by panelists' rating and final ranking of top 10 policy priorities overall. The level of support question was answered by the percentage of panelists who were already involved with advancing the policy priority and the percentage of panelists who believe OEI should include it on their final platform.

Community empowerment

Finally, CAT, HEPC and OEI recommended including empowerment of community members experiencing health inequities among the final criteria. As has become increasingly clear, engaging communities for health equity requires going beyond conventional models of involvement and consultation in order to empower them as agents of policy and social change (Office of Equity & Inclusion 2014).

Decisions made by staff to take a strength-based approach in conducting the initial community forums and by some panelists to meet and consult with their respective

community members before answering the survey questions (e.g., Latino youth group, rural, LGBTQ community) empowered communities experiencing health disparities to engage with their state government, some for the first time.

Ultimately, successful implementation of health equity will require the larger community to invest in health equity policy goals (which have been facilitated by the Delphi process itself). Success also depends on being infused with the community's energy (Boehm and Staples, 2004).

Providing communities with policy options that motivate their involvement and that build their power (more likely when there can be small successes along the way) correlate with successful policy achievements (Tarrow, 1998; Lee, 1997; Curry-Stevens, 2006). Community engagement and community empowerment will continue to be important elements in advancing health equity for all Oregonians.

Next steps

OEI and its community partners have already begun to move forward some of the more conventional health policy items that received 80% or more support from panelists. These items include collecting more granular data, informing CCO community health assessments, and advancing cultural competency training opportunities for health care professionals.

However, moving the social determinants of health priorities forward (i.e. school curriculum, employment protection, increase in number of minority and bilingual teachers and personnel reflective of student body, etc.) will require unconventional interdisciplinary, intersectoral, and cross-government partnerships during an opportune time of health systems transformation. Partnerships between public health and other sectors can lead to more holistic and integrative policies and programs as well as leverage resources, political will and relationships to advance health equity.

Strength-based social determinants of health environmental scan

In helping to build OHA's capacity to address social determinants of health within its policy and programs, OEI will conduct a strength-based social determinants of health environmental scan. The office will begin with a focus on the general policy areas ranked most important by the Policy Platform Development Panel: affordable and safe housing and neighborhoods, employment opportunities, and education opportunities (see Table 6).

In conducting a series of key informant interviews and group meetings with leaders in these fields, the environmental scan will help OEI identify timely opportunities where the office can lead, partner and engage with organizations to strategically and most effectively address social determinants of health and advance health equity.

Conclusion

OEI's mission is to engage and align diverse community voices and the Oregon Health Authority to assure the elimination of avoidable health gaps and promote optimal health in Oregon. To this end, OEI partners with community members to create policy agendas and ensure that OEI's policy platforms are informed by lived experience and community wisdom (Office of Equity and Inclusion 2011–2012 Annual Report).

Engagement of priority populations in decision making and policy implementation increases the chance that government policies and actions will be appropriate, acceptable and effective (World Health Organization). OEI used its multi-phase community engagement process to directly engage representatives of communities experiencing health inequities.

OEI sought diverse community ideas to advance health equity. This focused, strength-based approach will arguably lead toward more meaningful and relevant conversations and sustainable, culturally relevant, solution-based actions. Findings can build upon existing knowledge and help guide further engagement and in-depth conversations with populations of interest in order to:

- Foster trusting relationships, increased cross-cultural and interdisciplinary understanding and more complete and accurate health information for decision making;
- Build awareness of issues inside and outside of one's community;
- Strengthen interconnectedness of issues across communities;
- Empower community members experiencing health inequities; and
- Provide community leadership development opportunities as cross-sector policy actions are taken to advance health equity.

The strength-based social determinants of health environmental scan provides an opportunity for a broad range of community stakeholders to respond during an opportune time of health systems transformation.

Developing a strategic response to social determinants of health revealed by these results opens the door to partnerships that align with OHA's upstream actions. This new direction will enable OHA to maximize limited resources for meaningful community impact by tackling root causes of health inequities.

It may be more appropriate for other government agencies, tribes, health institutions and/or community partners to lead on specific policy priorities. Even in cases where OHA does not lead, it can provide strong, influential support to help strengthen, accelerate and advance health equity priorities for all Oregonians.

APPENDICES

Appendix A. Community Analysis Team

Liz Baxter, M.P.H.
Health Equity Policy Committee (HEPC) member and executive director of the Oregon Public Health Institute (OPHI)

Ann Curry-Stevens, Ph.D., M.S.W.
Associate professor at Portland State University School of Social Work and director of Center to Advance Racial Equity

Brandy L. Ethridge, Ph.D., M.P.A.
HEPC member and independent research consultant

Rachel Gilmer
Former HEPC staff and associate director of the African American Policy Forum (AAPF)

Sandra Helena Hernandes, Ph.D., M.Ed.
HEPC member, Spect-Actors Collective director, Colectivo MUJERES co-coordinator, Mujeres Unidas por la Justicia Economica y Racial artistic director, and The State of Equity forum theatre productions political educator

Junghee Lee, Ph.D.
Associate professor at the School of Social Work, Portland State University

Candace Lewis-Laietmark
Portland State University master of public health degree candidate and OEI health equity policy intern

Margaret Sarna
Portland State University master of public health degree candidate and OEI health equity policy intern

Charniece Tisdale, M.P.H.
OEI equity and inclusion training coordinator

Emily Li-wen Wang, M.P.H.
HEPC staff and OEI health equity policy analyst

Appendix B. Policy Platform Development Panel

Round 3 Policy Delphi Survey Select Demographics for Panelists That Completed All Survey Rounds (n = 41)

Demographic	Number of Panelists (%)	Demographic	Number of Panelists (%)
Work Condition		**Insurance**	
Non-profit	27 (65.9%)	**Private**	23 (56.1%)
Government	7 (17.1%)	Employment-based	16 (39.0%)
Small business	3 (7.3%)	Individually purchased	3 (7.3%)
Corporate	1 (2.4%)	Student insurance	4 (9.8%)
Academic	6 (14.6%)	**Public**	5 (12.2%)
Self employed	6 (14.6%)	OHP	2 (4.9%)
Not working	1 (2.4%)	Medicare	2 (4.9%)
Retired	1 (2.4%)	Military	1 (2.4%)
Student	10 (24.4%)	Uninsured	3 (7.3%)
Age (Years)		**Language Spoken**	
18-24	1 (2.4%)	English only	28 (68.3%)
25-34	7 (17.1%)	Spanish	8 (19.8%)
35-44	8 (19.5%)	Chuukese	1 (2.4%)
45-54	6 (14.6%)	Khmer	1 (2.4%)
55-64	10 (24.4%)	Hmong	1 (2.4%)
65+	3 (7.3%)	Lao	1 (2.4%)
		Tagalog	1 (2.4%)
Race/Ethnicity		**Region**	
American Indian	4 (7.8%)	Metropolitan area	33 (80.5%)
Asian	11 (26.8%)	Metropolitan area with high commuting	3 (7.3%)
Black	8 (19.5%)	Micropolitan area	3 (7.3%)
Hispanic	11 (26.8%)	Rural	2 (2.4%)
Pacific Islander	2 (4.9%)		
White	5 (12.2%)		

Demographic	Number of Panelists (%)	Demographic	Number of Panelists (%)
Immigration Status		**County**	
Immigrant	9 (22.0%)	Multnomah	23 (51.6%)
Refugee	1 (2.4%)	Washington	6 (14.6%)
LGBTQ	9 (22.0%)	Lane	4 (9.8%)
Disability	7 (17.1%)	Clackamas	2 (4.9%)
Gender		Benton	1 (2.4%)
Female	24 (58.5%)	Jefferson	1 (2.4%)
Male	15 (36.6%)	Marion	1 (2.4%)
Transgender	2 (4.9%)	Thurston, WA	1 (2.4%)
		Union	1 (2.4%)
		Wasco	1 (2.4%)

Thank you to ALL the Policy Platform Development Panel members who contributed their time, experience, and expertise to this process.

Andrew Riley
Ayodele Ojebode
Ben Duncan
Candice Jimenez
Caroline Cruz
Chareundi Van-Si
Chris Gray
Crystal Riley
Damarise Davis
David Komeiji
DeeAnna Garcia Dennis
Deyalo Bennette
Elizabeth Coronado-Sinclair
Ellen Mekjavich
Fabiana Wallis
Glendora Claybrooks
Harvey Rice
Jessenia Rader
John Hummel
Joseph Santos-Lyons
Joyleen Haser
Kaon-Jabbar East El
Kasey Luy
Kyle Weismann-Yee
Laura Isiordia
Lilian Ongelungel
Lisa Ladendorff
Lucy Baker
Maileen Hamto
Marcela Mendoza
Maria Pena
Mary Soots
Maurice Evans
Michael Moore
Midge Purcell
Patricia Cortez
Renee Mitchell
Rita Loop
Sonia Marquez
Selene Jaramillo
Smitty Amabilis
Thomas Aschenbrener
Valentin Sanchez
Vinay Prasad
Wayne Miya
William Donlan
Zeenia Junkeer

Appendix C. Select sample findings from survey rounds

Round Two: List of Community Policy Items

1. **Access to Health Care**
   a. Ensure access to health, dental, and mental health services for all individuals
   b. Require ongoing training on cultural competency, linguistic appropriateness, trauma and torture impacts for health care workers

2. **Access to Healthy Foods**
   a. Ensure affordable access to healthy foods
   b. Ensure that WIC and SNAP are being accepted as payment and promoted for every farmers' market
   c. Ensure local, healthy foods in all government programs, including school lunches
   d. Increase farm-to-school and farm-to-market programs

3. **Access to Physical Activity and Recreation**
   a. Provide low-cost and free access to exercise and recreation facilities through efforts such as public-private partnerships with gyms and other services
   b. Improve community access to public spaces (e.g., schools, gyms, parks, fields) for recreation, exercise, participation in team sports and other physical activities
   c. Improve and ensure safe, accessible neighborhood infrastructure (e.g., sidewalks, crosswalks, biking lanes, run/bike/walk paths) so people can walk, bike, and be active in all communities
   d. Increase the availability of culturally- and geographically-specific physical activity and recreation that are both identified and led by the local community
   e. Fund sports programs for youth at risk of criminal involvement
   f. Improve/increase the availability of physical education (PE) classes for all children in grades K-12.
   g. Increase the availability of after school programs
   h. Improve community access to school recreation activities/facilities (e.g., walking school bus program, open schools to the community)
   i. Implement mandatory physical education (PE) classes for all children in grades K-12

4. **Affordable and Safe Housing and Neighborhoods**
   a. Improve community-police relations, including policies related to racial profiling, diversifying the work force, etc.
   b. Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services

c. Increase the supply of affordable and safe housing (public and private)

d. Provide housing for homeless individuals and families, using a Housing First approach where those experiencing homelessness are moved into stable housing and needed services are made available.

e. Implement plans for mixed income housing construction, including simple, low-cost housing

f. Enforce existing fair housing laws

g. Improve/Increase lighting on dark streets

h. Repeal state ban on inclusionary zoning/housing, requiring a specific amount of affordable housing units for low to moderate income families be built with new housing, which could allow for more localized flexibility for increasing affordable housing

i. Reduce waiting period for low-income housing

j. Immigration reform to ensure housing supplied by employers for migrant and seasonal farm workers is safe, affordable, and adequate.

5. Community Engagement with Government and Health Institutions

a. Advisory councils and oversight committees should reflect the communities they serve and have decision-making power

b. Harness people's existing wisdom and empower the community to implement solutions for themselves

c. Require diversity on boards, commissions and in hiring reflective of populations being served

d. Keep going back to communities for feedback

6. Data and Metrics

a. Ensure Coordinated Care Organization (CCO) community health assessments track disparities and work with community to identify policies for eliminating them

b. Ensure more granular data on communities of color and other disadvantaged or underrepresented communities

c. Ensure data (inclusive of milestone and outcome data) is used effectively to act on problems and bring resources to communities in need.

d. Evaluate health providers' skills in cultural competence (such as the ability to withhold judgment), as well as the organizations' cultural competence.

e. Ensure data is interpreted by authentic members of the minority community to allow for better understanding of the data and the community's needs

f. Collect qualitative data along with quantitative data to describe needs and outcomes (e.g., is life better, is your health better)

g. Require all clinics and hospitals to collect data on the languages spoken by clients

7. **Education Opportunities**

   a. Implementation of the Dream Act and other related immigration reform policies

   b. Increase scholarships and discounts for local public and private schools, community colleges, and 4-year colleges and universities

   c. Increase funding for schools

   d. Increase number of minority and bilingual teachers and personnel reflective of student body, ensure cultural competency among work force

   e. Update school curriculum to incorporate racial, social and economic justice, meaning students develop skills and attitudes to build an inclusive society and end damaging biases, and stereotypes of "others," and support cultural identity development.

8. **Employment Opportunities**

   a. Pay a living wage

   b. Require all employers to pay sick leave (including family and parental leave) and adopt other policies that ensure individual and family needs are supported by their employer

   c. Remove existing barriers facing communities of color and other marginalized communities in employment and develop pipeline programs to promote opportunity and access

   d. Increase and/or improve job preparation and future job skills (including for health careers) in middle school, high school and community colleges

   e. Expand supports for minority-owned businesses to succeed, including (for example) shared resources, mentoring, technical assistance, and health coverage

   f. Increase employment protection for those who have the least access and lowest income, including farm workers

9. **Health Education and Prevention**

   a. Provide more creative and engaging education methods (including radio/TV) to help underserved populations understand how to access and utilize: insurance, health care services, chronic disease management, and treatment options.

   b. More health and wellness education materials and methods in languages that are reflective of Oregon's diverse populations

   c. More family-based, community-based health education

   d. More health and wellness education materials and methods in plain language, especially for those with limited literacy and education levels

10. **Health Reform Funding/Payments**

   a. Provide sustainable funding for health care services, including funding for community health workers, safety-net clinics and school-based health centers

b. Hold CCOs accountable for reducing health disparities in their area by implementing economic/ financial penalties if they fail to achieve reductions

c. Regulate health insurance companies by defining how they must use their profits, (e.g., excess profits must be re-directed to expanding direct care, supporting health plan members, and adequately reimbursing providers)

d. Incentivize system strategies that result in reduction of health disparities

11. **Regulation**

a. Identify, ban, and inform communities (including employees) of harmful chemicals that cause health hazards (i.e. mutagens, certain pesticides, etc.) Include prevention education for community.

b. Limit corporate marketing, especially toward youth, schools & socioeconomically challenged areas. Include prevention education for community.

c. Protect the environment, including water sources and salmon. Include prevention education for community.

12. **Driver's License**

a. Promote changes, including removing citizenship and legal residency requirements, to obtain driver's license in Oregon.

13. **Transportation**

a. Lower costs for public transportation

b. Increase bus routes, shuttles, and frequency on weekends and 24-hour access

c. Ensure that public transportation routes and frequencies are adequate in rural, suburban, and low-income communities

d. Streamline bus systems between cities

e. Increase/improve sidewalks bike lanes, and bike routes with signage

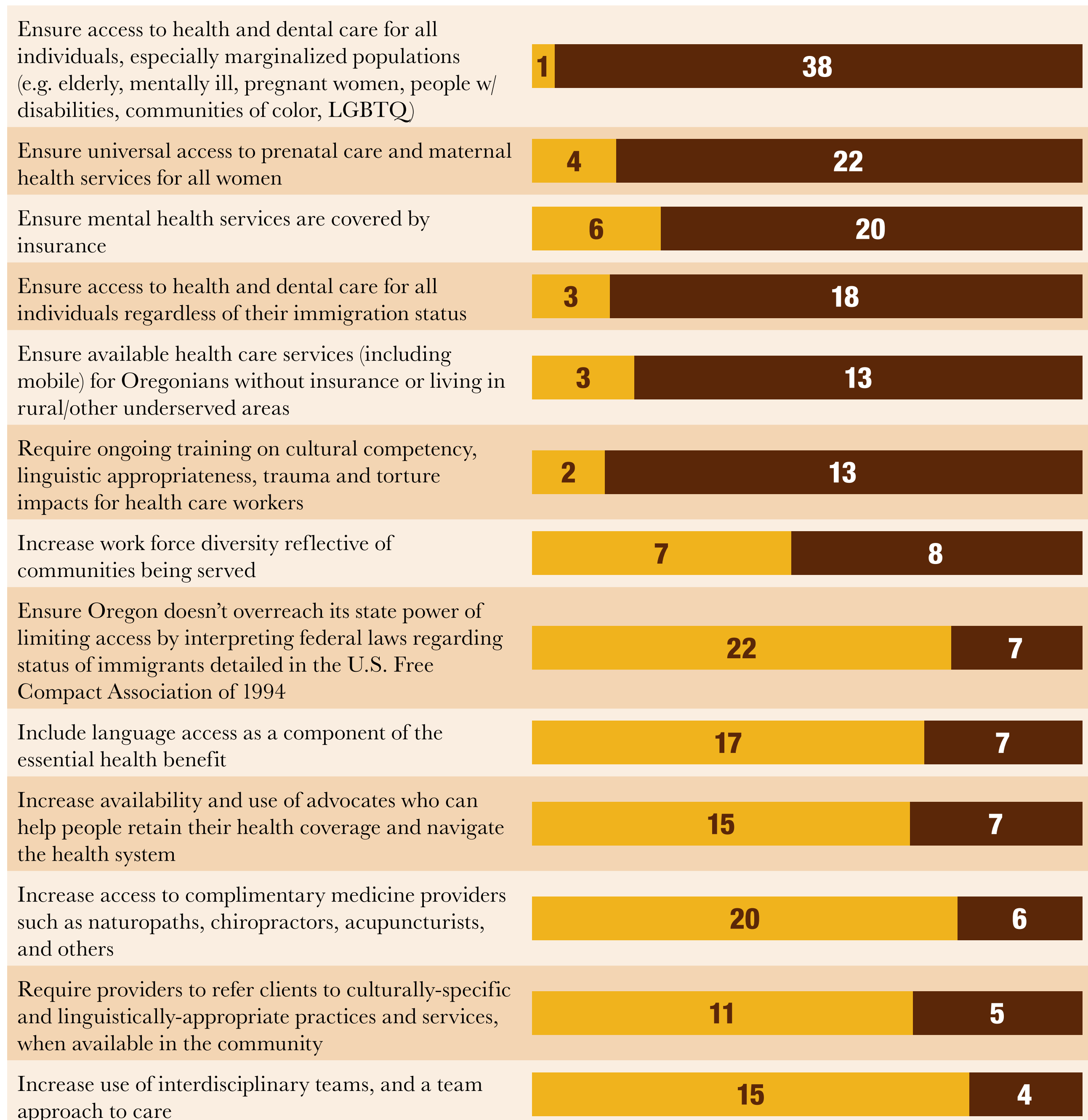
f. Address gentrification issues surrounding access to public transportation for displaced populations

g. Increase shared roads for bicycle, vehicle, and public transit use

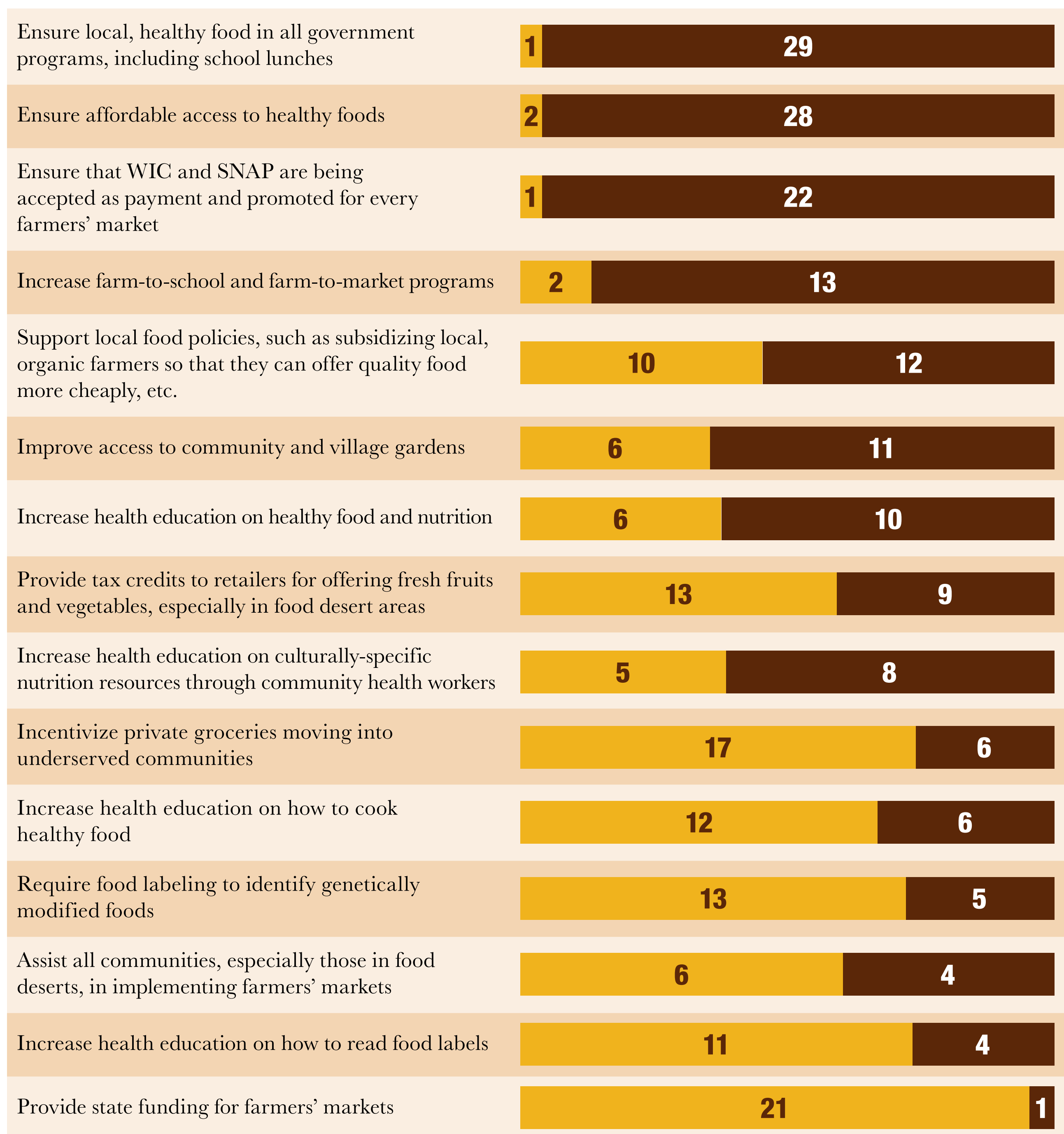
Address language barriers with public transportation use

Round Two: Assessing Level of Importance for Policy Items

"Access to Health Care" Issue Area Priorities

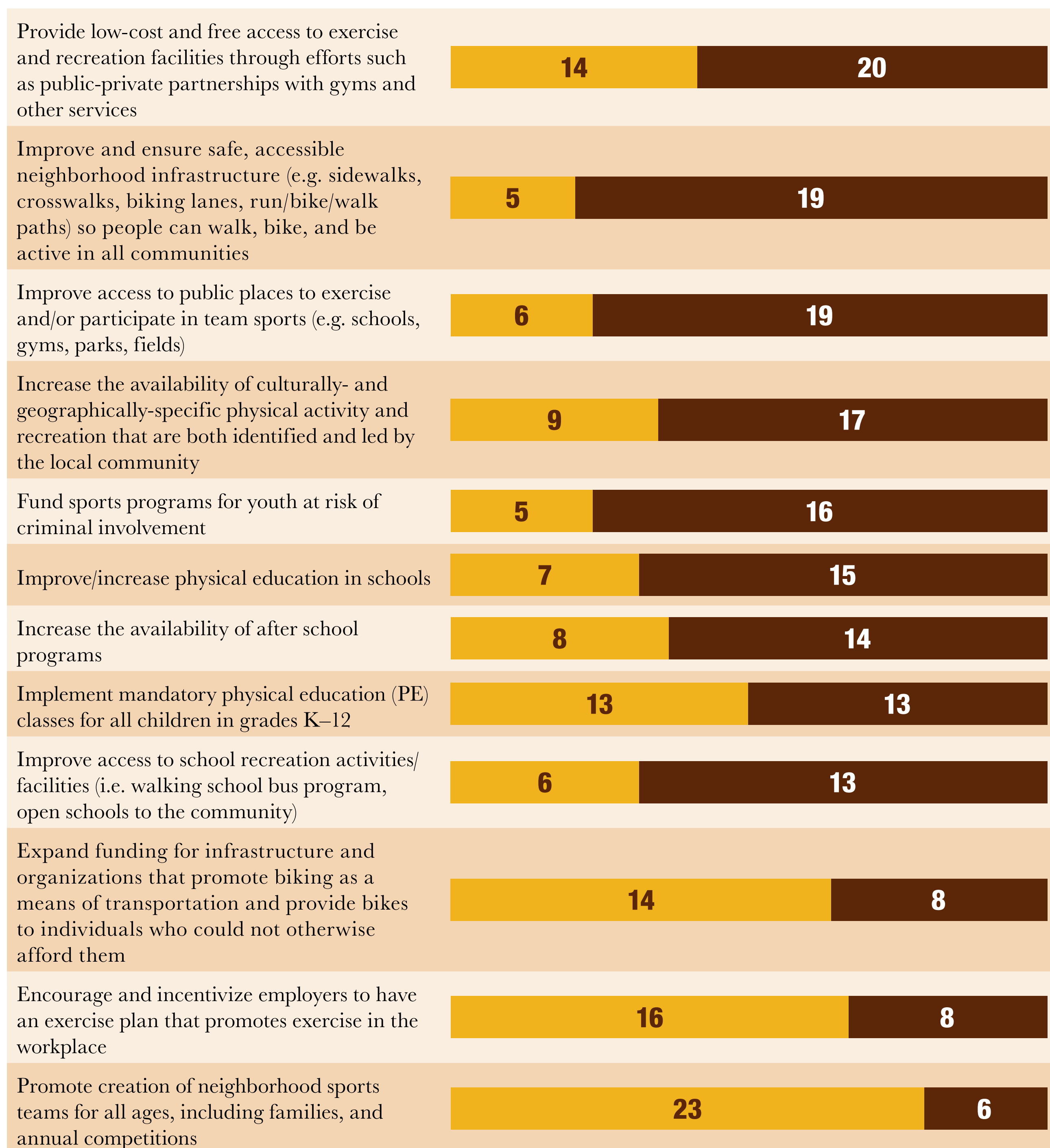


"Access to Healthy Food" Issue Area Priorities

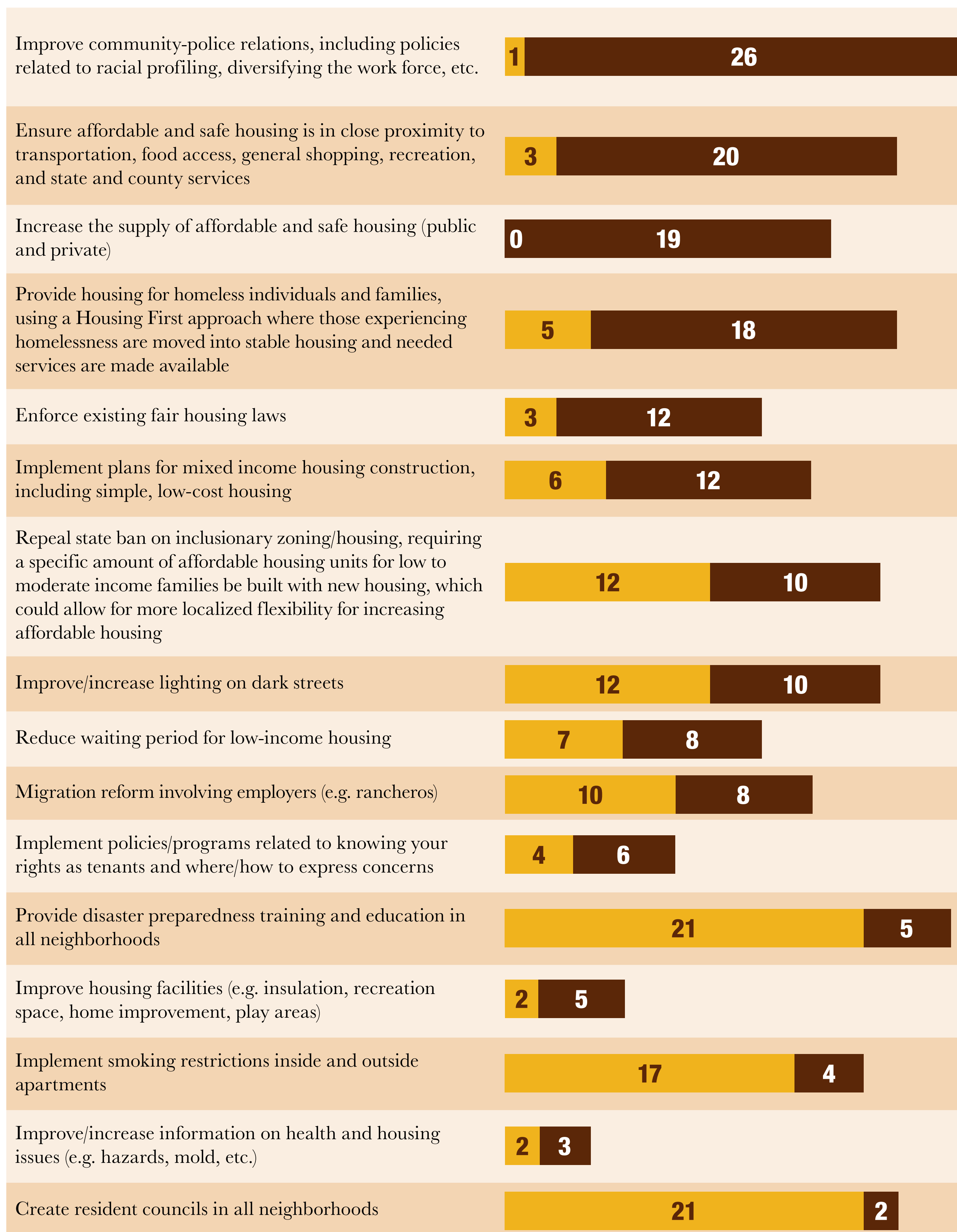


Total # for least important | Total # for most critical

"Access to Physical Activity and Recreation" Issue Area Priorities

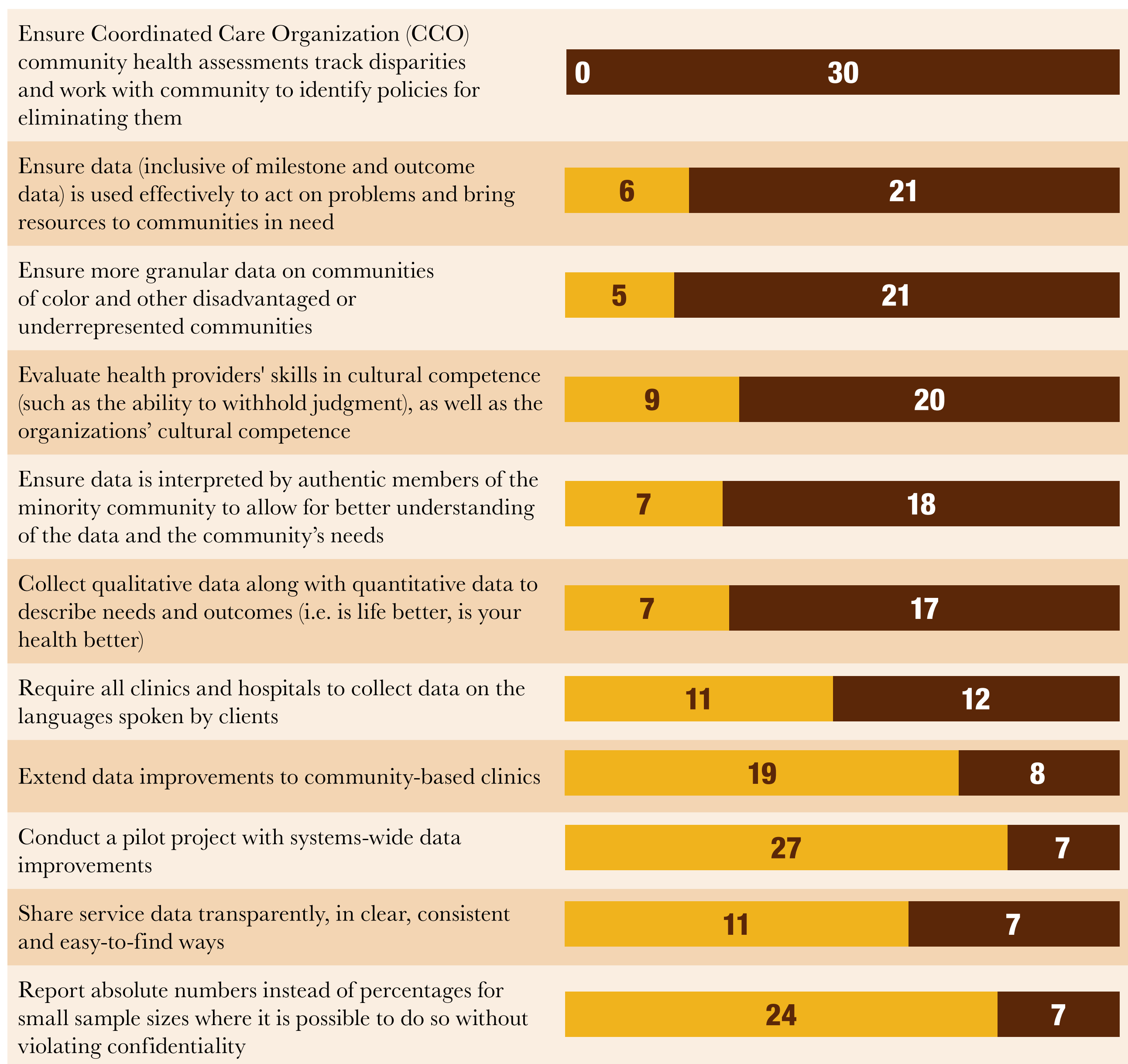


"Affordable and Safe Housing and Neighborhood" Issue Area Priorities



"Community Engagement with Government and Health Institutions" Issue Area Priorities

"Data and Metrics" Issue Area Priorities

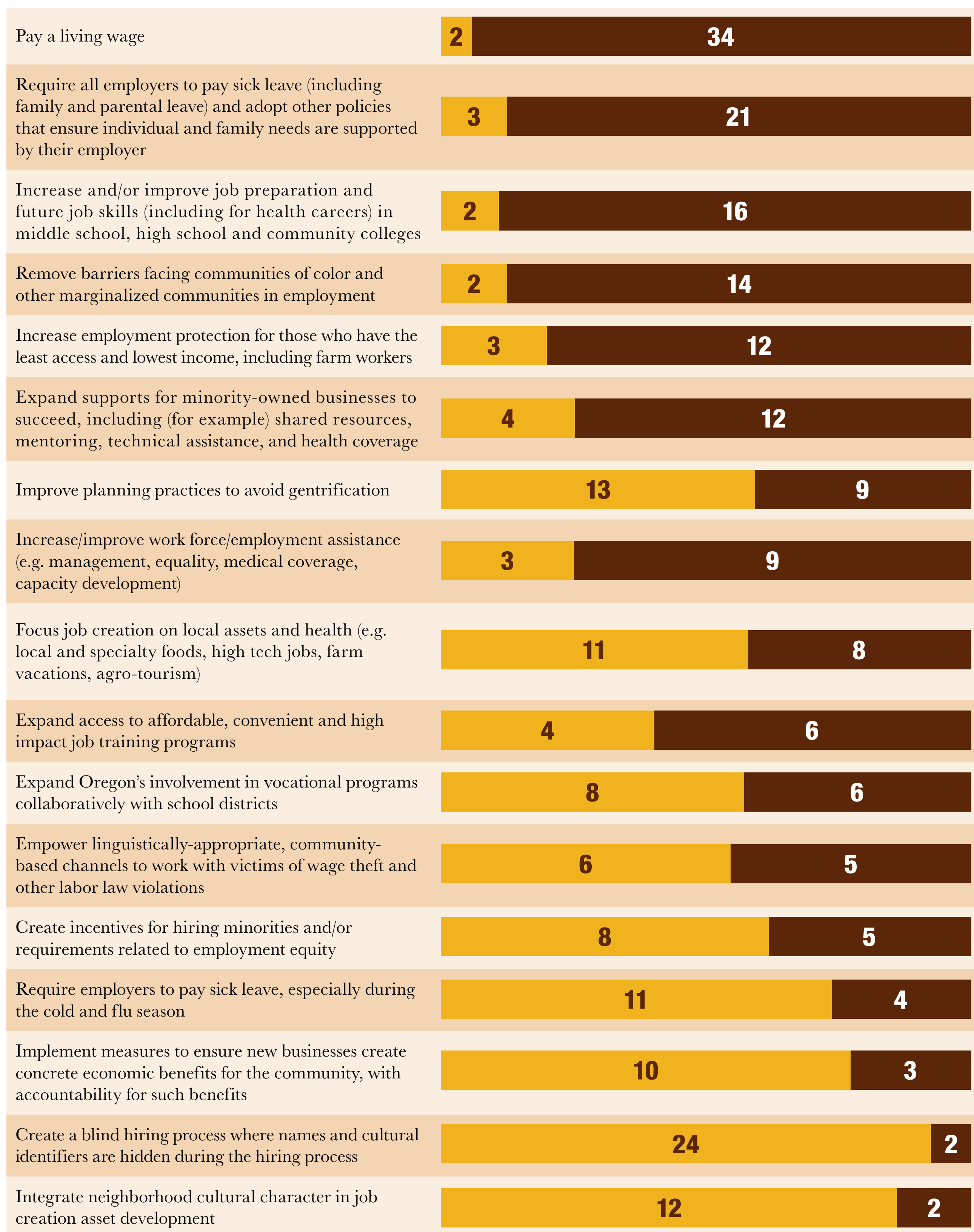


"Education Opportunities" Issue Area Priorities

Priority	Total # for least important	Total # for most critical
Implementation of the Dream Act and other related immigration reform policies	2	22
Increase funding for schools	5	17
Increase scholarships and discounts for local public and private schools, community colleges, and 4-year colleges and universities	3	16
Increase number of minority and bilingual teachers and personnel reflective of student body, ensure cultural competency among work force	2	14
Update school curriculum to incorporate racial, social, and economic justice, meaning students develop skills and attitudes to build an inclusive society and end damaging biases, and stereotypes of "others," and support cultural identity development	3	10
Ensure that teacher composition reflects the racial and linguistic composition of the community	7	9
Go beyond the Dream Act to eliminate employment barriers for undocumented residents	9	8
Mandate that schools prioritize disparities reduction rather than general academic improvements	7	8
Require curriculum about different cultures and languages in schools, involving guest speakers with direct knowledge	3	7
Require schools to report on achievements in minority education	4	7
Provide "education promotores" to reach communities not well engaged in the school system	6	6
Implement parent education program in Oregon education system from kindergarten through college	12	6
More accessible GED and English language classes at different levels (i.e. time, locations, costs)	6	6
Consult with communities to improve evaluation for school systems	6	5
Assure all school communications are available in families' first language	9	5
Require second language curriculum as early as kindergarten	8	5
Provide vocation-oriented internships and job training in occupations where racial disparities are pronounced	7	4
Adapt the student loan system to support implementation of the Dream Act	7	4
Link health education policies, inclusive of shared metrics (i.e. add health indicators to educational achievement metrics, attendance record as health marker) and health wellness education in the schools	8	4
More information in Spanish and other languages, while ensuring quality translation/interpretation	5	3
Expand availability of culturally-specific education	7	2

Total # for least important | Total # for most critical

"Employment Opportunities" Issue Area Priorities



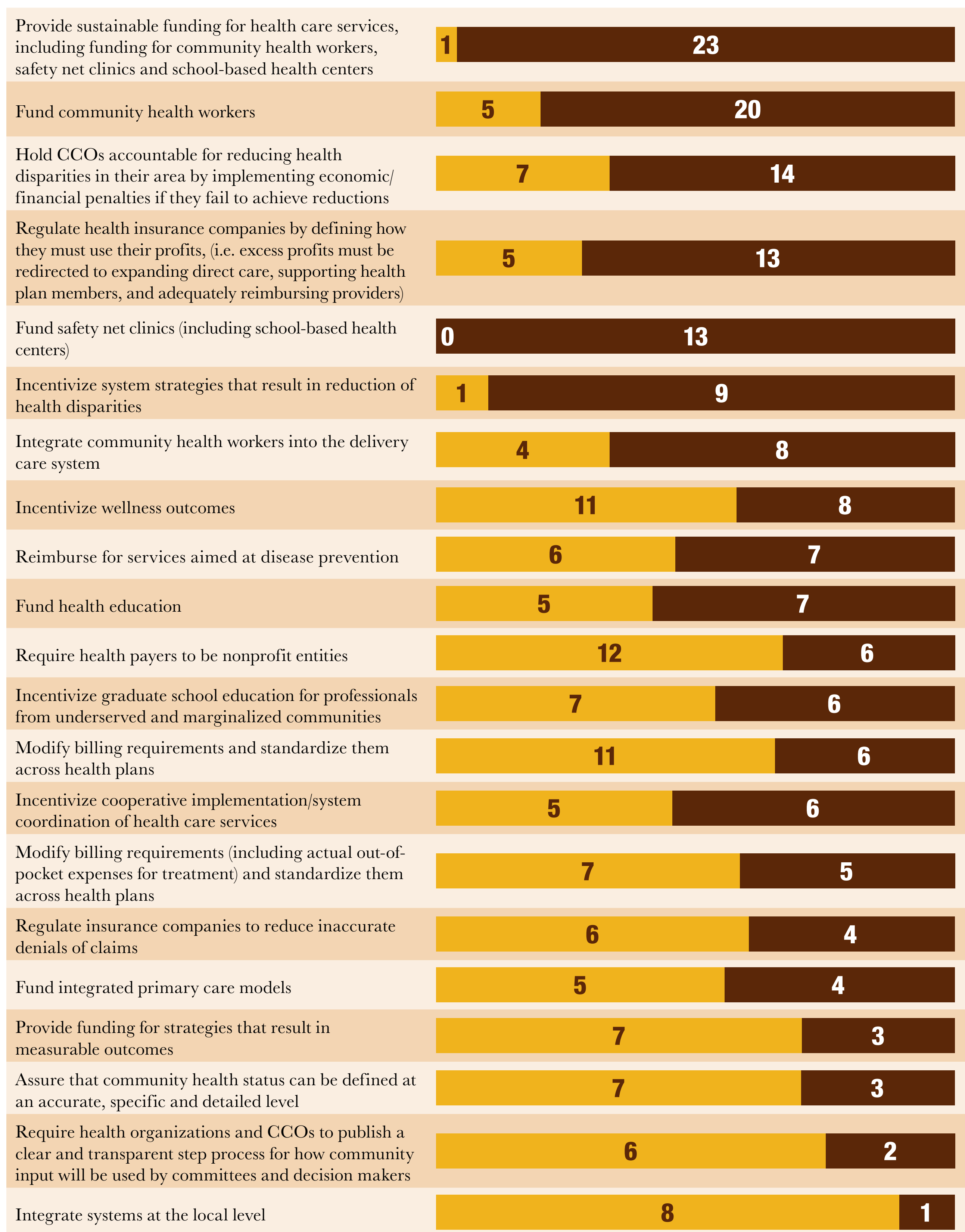
Total # for least important | Total # for most critical

"Health Education and Prevention" Issue Area Priorities

Priority	Total # for least important	Total # for most critical
Provide more education to underserved populations around access to health care and treatment options	9	30
More health and wellness education materials and methods in languages that are reflective of Oregon's diverse populations	15	23
Education needed about health care services and insurance	12	22
More family-based, community-based health education	16	22
More health and wellness education materials and methods in plain language, especially for those with limited literacy and education levels	14	21
Provide more education on chronic disease management	14	20
Provide more prevention and health education for health providers	24	15
Education needed about how to live healthier	22	15

Total # for least important | Total # for most critical

"Health Reform Funding/Payment" Issue Area Priorities



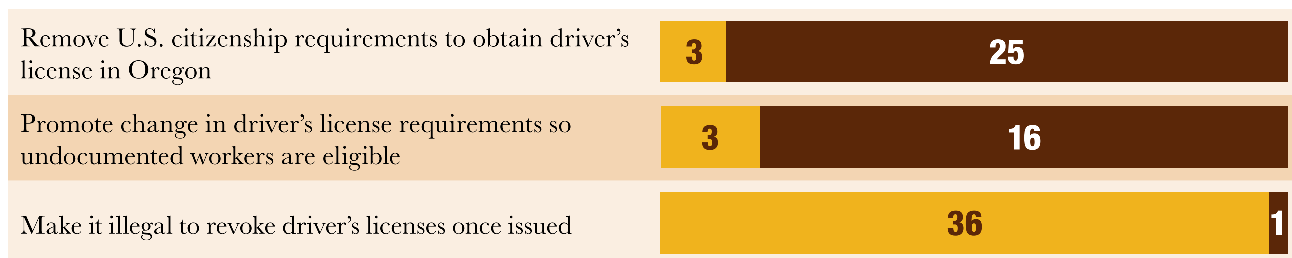
Priority	Total # for least important	Total # for most critical
Provide sustainable funding for health care services, including funding for community health workers, safety net clinics and school-based health centers	1	23
Fund community health workers	5	20
Hold CCOs accountable for reducing health disparities in their area by implementing economic/ financial penalties if they fail to achieve reductions	7	14
Regulate health insurance companies by defining how they must use their profits, (i.e. excess profits must be redirected to expanding direct care, supporting health plan members, and adequately reimbursing providers)	5	13
Fund safety net clinics (including school-based health centers)	0	13
Incentivize system strategies that result in reduction of health disparities	1	9
Integrate community health workers into the delivery care system	4	8
Incentivize wellness outcomes	11	8
Reimburse for services aimed at disease prevention	6	7
Fund health education	5	7
Require health payers to be nonprofit entities	12	6
Incentivize graduate school education for professionals from underserved and marginalized communities	7	6
Modify billing requirements and standardize them across health plans	11	6
Incentivize cooperative implementation/system coordination of health care services	5	6
Modify billing requirements (including actual out-of-pocket expenses for treatment) and standardize them across health plans	7	5
Regulate insurance companies to reduce inaccurate denials of claims	6	4
Fund integrated primary care models	5	4
Provide funding for strategies that result in measurable outcomes	7	3
Assure that community health status can be defined at an accurate, specific and detailed level	7	3
Require health organizations and CCOs to publish a clear and transparent step process for how community input will be used by committees and decision makers	6	2
Integrate systems at the local level	8	1

Total # for least important | Total # for most critical

"Regulation" Issue Area Priorities

Priority	Total # for least important	Total # for most critical
Identify, ban, and inform communities (including employees) of harmful chemicals that cause health hazards (e.g. mutagens, certain pesticides); include prevention education for community	1	37
Limit corporate marketing, especially toward youth, schools & socioeconomically challenged areas; include prevention education for community	3	30
Protect the environment, including water sources and salmon; include prevention education for community	13	17
Legalize, regulate, and tax marijuana (like alcohol), and use revenue to advance community health (i.e. preventive health education re: alcohol/tobacco, universal health care, etc.)	19	16
Limit free speech for corporations; include education for community on the billions corporations invest in marketing and consumer control	17	14
Require fluoridation of drinking water; include prevention education for community	18	14
Develop stronger regulations of sale of tobacco and alcohol; include prevention education for community	9	14
Prevent gambling addiction by limiting construction of casinos, access to Oregon Lottery, etc.; include prevention education for community	20	9
Increase regulation of tobacco retail licenses; include prevention education for community	5	9
Mandate and create a self-examination process with regard to inclusion in government and health institutions	21	8

"Driver's Licenses" Issue Area Priorities



Total # for least important | Total # for most critical

"Regulation" Issue Area Priorities

Priority	Total # for least important	Total # for most critical
Lower costs for public transportation	4	28
Increase bus routes, shuttles, and frequency on weekends and 24-hour access [to public transportation]	1	26
Ensure that public transportation routes and frequencies are adequate in rural, suburban, and low-income communities	4	17
Increase/improve sidewalks, bike lanes, and bike routes with signage	1	15
Streamline bus systems between cities	4	15
Address gentrification issues surrounding access to public transportation for displaced populations	10	14
Improve transportation options that benefit those who work night shifts	1	9
Increase shared roads for bicycle, vehicle, and public transit use	9	8
Address language barriers with public transportation use	10	7
Ensure linguistically-accessible information about driving laws, bus routes, and how to influence available bus hours	4	6
Implement ride sharing/car-pooling programs	14	6
Improve transportation options over the weekend, including weekend nights	2	4
Provide public transportation education targeted to those who are new to Oregon and/or the United States	15	4
Improve education about bus routes and the cost	13	4
Incorporate education for improving safety while using public transportation, sharing the roads, etc.	14	3
Implement shared vehicle programs (e.g. ZipCar)	20	2

Total # for least important | Total # for most critical

Round Three: Assessing Level of Support for Policy Items

Affordable and Safe Housing and Neighborhoods

Policy area	Sub-policy items	Should this sub-policy item be included in OEI's final policy platform? Please specify your reasons to select "No" or "Yes with change":			
		Yes	No	Yes, with changes	Need more information
4. Affordable and Safe Housing and Neighborhoods	Ensure affordable and safe housing is in close proximity to transportation, food access, general shopping, recreation, and state and county services	With [housing sprawl outside of town], public transportation is needed. Walkable neighborhood are good. If not walkable then, public modes of transportation could support this concept. Subsidizing taxis to provide access to 'town' from the 'hills', might be helpful. and/ or 'car pool' taxis to meet the need			More specific policy approach
	Increase the supply of affordable and safe housing (public and private)	Affordable is key here. Installing utilities or drilling for water is costly, which then affects affordability of home. Maybe the idea of increasing density in small towns could help to use available land in town to provide affordable housing. 'almost like a mini-urban development boundary' tax incentives to build higher density with multifunction building could reach a couple of the goals. Rethinking Oregon community housing authority, fee-based income, need to generate fees increases costs to developers			Seems like this could be the priority of a different entity

Policy area	Sub-policy items	Should this sub-policy item be included in OEI's final policy platform? Please specify your reasons to select "No" or "Yes with change":			
		Yes	No	Yes, with changes	Need more information
4. Affordable and Safe Housing and Neighborhoods	Provide housing for homeless individuals and families, using a Housing First approach where those experiencing homelessness are moved into stable housing and needed services are made available.		Because there are other aspects that need to first be addressed. Furthermore, there is already a lot of pre-existing housing that could essentially be changed into a mixed community.		
	Implement plans for mixed income housing construction, including simple, low-cost housing			Maintaining mixed housing without gentrification or ghettotifcation. Shifting society's view [by valuing] the individual as important at this point. The current model for economic success with maximum profit being successful, [while] devaluation of the intrinsic value of humans is diminished. As we shift from having value of money to value of community, the mixed housing idea would work well	
	Enforce existing fair housing laws			The change I suggest is the implementation of existing laws.	

REFERENCES

Boehm, A. & Staples, L.H. (2004). Empowerment: The point of view of consumers, *Families in Society,* 85(2): 270–280.

Buelo, V. & Ngo, D. (2012). *Oregon Overweight, Obesity, Physical Activity, and Nutrition Facts.* Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention Program.

City of Minneapolis, Department of Health and Family Support. (2010). *Toolkit: Multicultural Storytelling: A New Process for Community Engagement.* http://www.minneapolismn.gov/health/toolkit/multicultural.

Coalitions of Communities of Color. P*hilanthropy and Communities of Color in Oregon: from strategic investments to accessible impacts amidst growing racial and ethnic diversity.* Retrieved from: http://coalitioncommunitiescolor.org/culturally-appropriate-data-research/.

Cuhls, K. (2004). *Delphi Method.* Faunhofer Institute for Systems and Innovation Research, Germany. Retrieved from: http://www.unido.org/fileadmin/import/16959_DelphiMethod.pdf.

Curry-Stevens, A. (2006). Rooting social policy advocacy in social movements: Adapting to the demise of rationality in the policy-making process. *Canadian Review of Social Policy,* 56, 113–130.

Freire, P. (1970). *Pedagogy of the Oppressed.* New York, Continuum.

Healthy People 2020. Retrieved from: http://healthypeople.gov/2020/default.aspx.

Kaiser Family Foundation. (2012). *Oregon State Health Facts: Categories and Indicators.*

Lee, J. (1997). The empowerment group: The heart of the empowerment approach and an antidote to injustice. In J. Parry (Ed.). *From prevention to wellness through group work* (pp. 15–32). New York: Haworth Press.

O'Brien, K. & Cuevas, A. (2012 Sept). *LGBTQ Health Coalition Wellness Priorities: A CBPR Delphi Project.* Portland State University, Department of Psychology, & LGBTQ Health Coalition for the Colombia-Willamette.

State of Oregon, Office of Equity and Inclusion. *2011–2012 Annual Report.*

State of Oregon, Office of Equity and Inclusion. *2014 Health Equity Toolkit.*

State of Oregon, Public Health Division. Behavioral risk factor surveillance system oversample (2010–2011). *Age-adjusted and Unadjusted Prevalence of Chronic Conditions Among Adults, by Race and Ethnicity.* Retrieved from: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/table_2_race_oversample_2010-2011.pdf.

State of Oregon, Public Health Division. (2012 Nov 20). *CD Summary: Lesbian, Gay, Bisexual, and Transgender Health.* Retrieved from: http://healthoregon.org/cdsummary.

State of Oregon, Office of Multicultural Health and Services. (2011 June). *State of Equity Report: Phase 1.*

State of Oregon, Office of Equity and Inclusion. (2013 Sept). *State of Equity Report: Phase 2.*

State of Oregon, Office of Economic Analysis, Department of Administrative Services. (2011 November). *Oregon's Demographic Trends.* Retrieved from: http://www.oregon.gov/DAS/OEA/docs/demographic/or_pop_trend2011.pdf.

Tarrow, S. (1998). *Power in Movement: Social Movements and Contentious Politics.* Cambridge, MA: Cambridge.

Turoff, M. & Linstone, H. (2002). *The Policy Delphi.* New Jersey Institute of Technology.

U.S. English Foundation. Retrieved from: http://usefoundation.org/.

World Health Organization, Commission on the Social Determinants of Health. (2008). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.* Geneva: World Health Organization.

World Health Organization. (2013). *Closing the Health Equity Gap: Policy Options and Opportunities for Action.*

WWAMI Rural Health Research Center, University of Washington. (2005). *Rural Urban Commuting Codes.* Retrieved from: http://depts.washington.edu/uwruca/.

Engaging Oregonians in Identifying Health Equity Policy Priorities:

A Modified Policy Delphi Approach

Office of Equity & Inclusion

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact the Office of Equity and Inclusion at 971-673-1240 or 711 for TTY.

OHA 8121 (12/2014)