Health Care Workforce Committee

Charter and Committee Operations

2024-25

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SECTION 1: Introduction

I. Authority and Committee Charge

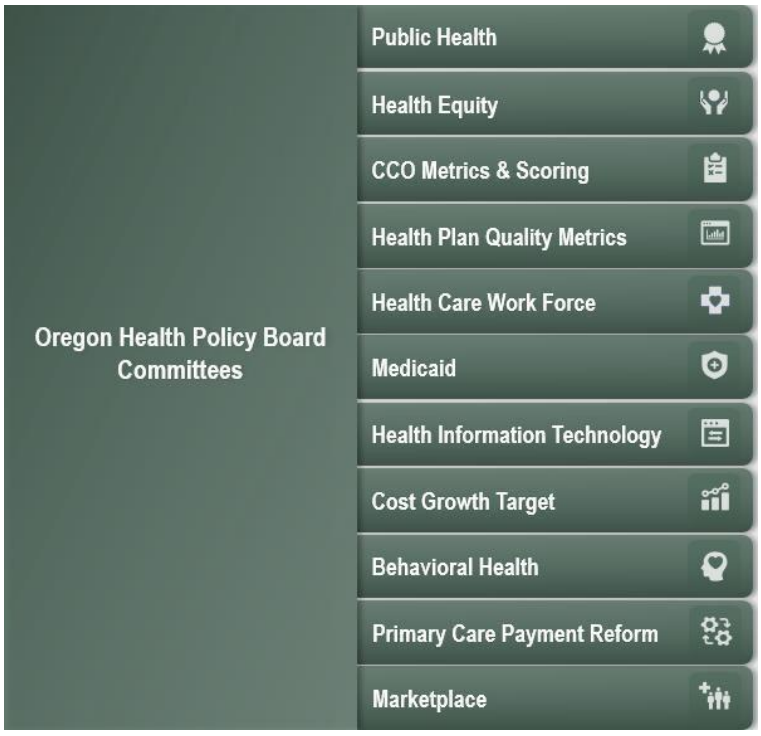
The Health Care Workforce Committee (HCWF or Committee) was established by House Bill 2009, Section 7 (3)(a), and is found in Oregon Revised Statutes (ORS) 413.017(3). This charter defines the Committee's objectives, responsibilities and scope of activities. The Committee will be guided by the Quadruple Aim of improving population health, improving the individual's experience of care, reducing per capita costs, and improving the work-life of health care professionals. The Committee is also guided by the Oregon Health Authority (OHA) goal of eliminating health inequities by 2030.

As identified in statute, the Committee "shall coordinate efforts to recruit and educate health care professionals and retain a quality workforce to meet the demand that will be created by the expansion in health care coverage, system transformations and an increasingly diverse population." Additionally, given the strategic focus of the Oregon Health Policy Board (OHPB or Board), the Committee shall be mindful of how the health care professional workforce plays a role in improving health equity and in reducing health disparities in making recommendations and in its deliberations.

II. Committee Organizational Location and Relationship

At the beginning of 2023, OHPB included 11 committees, which report to OHPB and also engage with and support each other (Figure 1). OHPB and its committees are staffed and supported by several OHA divisions, including Health Policy and Analytics Division (HPA), Public Health Division, Equity & Inclusion Division, and Behavioral Health Division.

Figure 1. Visual representation of OHPB and its 11 committee



HCWF is staffed and supported by OHA's HPA Division, primarily through the Clinical Supports, Integration and Workforce (CSIW) Unit.

HCWF is charged, in collaboration with other OHPB committees, with reporting and making recommendations regarding the diversity, wellness, and development and retention of the health care workforce. The Committee's responsibilities include:

- Review and guide development of two statutorily mandated biennial reports: evaluation of health care provider incentive programs and Health Care Workforce Needs Assessment.
- Review the health care workforce diversity profile and supply report released every two years.
- Review and make recommendations to OHPB on the distribution of money in the Health Care Provider Incentive Fund and provide periodic updates.

III. Health Equity Definition

In 2019, OHA adopted health equity as one of its core values and committed to its strategic goal of eliminating health inequities by 2030 (Figure 2).

Figure 2. OHA/OHPB Health Equity Definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:

- **The equitable distribution or redistribution of resources and power; and**
- **Recognizing, reconciling and rectifying historical and contemporary injustices.**

IV. Tribal Sovereignty and Health Equity Statement

HCWF recognizes that the Nine Federally Recognized Tribes of Oregon are sovereign nations. In accordance with our government-to-government relationship and the federal trust responsibility, HCWF and OHA Committee staff acknowledge the five essential components of health equity for American Indians and Alaska Natives as defined by the National Indian Health Board[1]:

1. Resilience Through Culture
2. Tribal Sovereignty
3. Strong Tribal Institutions
4. Tribal Representation in State and Federal Governance

[1] A Path to Health Equity, 2022 Inter-Tribal World Cafe, National Indian Health Board Tribal Health Equity Summit

5. Federal Trust Responsibility

V. Committee Health Equity Framework

In October 2021, the Committee adopted a Health Equity Framework approved by OHPB.[2] The Framework's development followed Committee members and OHA staff participating in listening sessions with nearly 30 organizations representing people from communities across the state, including those who have experienced health inequities. HCWF meetings begin with the Committee Chair reminding members to listen to and participate in discussion from the following Guiding Questions (Figure 3), which are a key component of the Health Equity Framework:

Figure 3. Guiding Questions Related to Advancing Health Equity

How do Oregon's health care workforce development efforts advance opportunities for people from communities experiencing health inequities?

1. Who are the racial/ethnic communities and communities that are experiencing health inequities? What is the potential impact of the resource allocation to these communities?
2. Do OHA programs ignore or worsen existing health inequities or produce unintended consequences? What is the impact of intentionally recognizing the health inequity and making investments to improve it?
3. How have we intentionally involved community representatives affected by the resource allocation? How do we validate our assessment in questions 1 and 2? How do we align and leverage public and private resources to maximize impact?
4. How should we modify or enhance strategies to ensure recipient and community needs are met?
5. How are we collecting REALD and SOGI data (race/ethnicity, language, and disability and sexual orientation and gender identity data) in OHA awards and matching recipient demographics with communities served?
6. How are we resourcing and/or influencing system partners to ensure programs optimize equity?

2 Health Care Workforce Committee, Health Equity Framework, 2021, Health Equity Framework Full Report.

SECTION 2: Strategic Framework, Vision, Mission and Scope of Work

VI. Strategic Framework, Vision and Mission

In May 2023, the Committee adopted a Strategic Framework (Figure 4 on page 8). The Committee developed the framework as a next step to Oregon's Health Care Workforce Needs Assessment 2023 report. The Committee aimed to propose actionable policy solutions to create a culturally and linguistically responsive health care workforce in Oregon.

The Committee's process to develop the framework began by reviewing and prioritizing assessment's recommendations. The Committee identified eight priority recommendations and grouped them into three broad areas of workforce diversity, wellness and resiliency, and development and retention. Following the framework's adoption, the Committee organized subcommittees to examine data and best practices in the three areas, and to create strategy papers. These papers, which were approved by the Committee in December 2023, are intended to move forward the framework's vision and priorities.

The framework's vision, mission, and links to the strategy papers are provided below.

o Vision

A robust, diverse, and resilient health care workforce that provides culturally and linguistically responsive care, eliminates health inequities, and meets the local health care needs of everyone in Oregon.

o Mission

Provide guidance on policy and practice to inspire, support and sustain the Oregon health care workforce.

o Strategy papers

- Background and summary
- Workforce diversity
- Workforce wellness and resiliency
- Workforce development and retention

The Committee recognized the urgency to address all three framework goals to have a diverse, well, and resilient health care workforce that supports Oregonians to be healthy. This will require ongoing action by government and non-governmental entities to ensure that progress is made towards achieving the framework's strategies and goals.

Health Care Workforce Committee Strategic Framework

Vision:

A robust, diverse, and resilient health care workforce that provides culturally and linguistically responsive care, eliminates health inequities, and meets the local health care needs of everyone in Oregon.

Mission:

Provide guidance on policy and practice to inspire, support, and sustain the Oregon health care workforce.

Oregon Health Authority

Diversity Strategies

- Make workplaces more welcoming for diverse health care professionals.
- Reduce barriers to entry and advancement for people of color, Tribal members, individuals with disabilities, and people from other diverse backgrounds and identities in the workforce.
- Increase investments in health care professionals who will provide culturally and linguistically responsive, person- centered health care.

Wellness & Resiliency Strategies

- Sustain a positive health care workplace culture and environment and reduce workplace burdens.
- Collect data which identifies the current challenges and priorities of health care professionals, and support workforce well-being strategies that are informed by findings.

Workforce Development & Retention Strategies

- Address workforce recruitment and retention factors such as geography, housing cost and supply, opportunities for partners/spouses and families, and quality of K-12 education.
- Ensure adequate numbers of faculty and clinical training placements for health care professionals at every level.
- Invest in reliable and new strategies to enhance training opportunities for people who provide and support physical, oral, and behavioral health care for everyone in Oregon.

VII. Committee Scope and Deliverables

1. Scope

The Committee works collaboratively with OHA, OHPB, the Nine Federally Recognized Tribes of Oregon, community-based organizations, and other partners to provide analysis, guidance and recommendations on policy development, funding, and implementation of programs regarding the health care workforce, using an equity-focused approach and framework.

Related activities include, but are not limited to:

- Provide input or guidance on agency and Committee policies being considered by OHPB and OHA.
- Assist HPA and other parts of OHA as requested with developing rules chapters to inform health equity-related workforce policy.
- Provide input into OHA legislative concepts.
- Assist with agency and legislative policy development, gap identification, and impact evaluation.
- Provide recommendations to OHPB on legislatively mandated reports and funding.
- Obtain input and advice on a regular basis from across the health care sector, from outsiders as well as insiders.

2. Deliverables

The Committee will deliver the following products to OHPB:

a. Draft biennial Oregon Health Workforce Committee Needs Assessment as required by House Bill 3261 (2017).
b. Draft biennial Evaluation of Health Care Provider Incentive Programs in Oregon as required by House Bill 3261 (2017).
c. Draft biennial Health Care Workforce Diversity Profile.
d. Other items as requested by OHPB.

VIII. Review, Reporting and Evaluation

The Committee will conduct a review of its work every two years. The evaluation will review the vision and mission of the Committee, and deliverables presented to OHPB, identifying how actions aligned with the Committee's scope of work's focus areas from its Strategic Framework (workforce diversity, wellness and resiliency, and development and retention); and how the Committee used its Health Equity Framework to consider and conduct its work.

The evaluation will be conducted by a workgroup of Committee members, supported by OHA staff, and preferably will include community partners participating in this review as well. The evaluation will be reviewed by the Committee. The evaluation will be based on qualitative data collected from interviews and group discussions with members; a survey or other tool may also be used to collect quantitative outcome data. Other national reports may be considered for measuring outcomes and a format for evaluation.

The Committee may use the following structural, process and workforce system outcome measures to determine its effectiveness:

1. Structural Measures
1.1 Committee membership that is inclusive of and gives voice to the diverse perspectives and experiences of Oregonians.
1.2 Meetings of sufficient duration, attendance, and frequency to accomplish committee mission and statutory requirements.

2. Process Measures
2.1 Number/percent of committee deliverables completed on time.
2.2 Number/percent of committee recommendations implemented by relevant organizations (Oregon Legislature, OHA, Coordinated Care Organizations [CCOs], health care systems, education institutions).

3. Workforce System Measures
A. Workforce Diversity: A workforce that is reflective of the demographics of the community it serves.
3.A.1. Number/percent of health care professionals by REALD (race, ethnicity, language, disability) in Oregon (baseline).
3.A.2 Number/percent of health care professionals by REALD (end of the measurement period).
3.A.3 Number/percent of health care professionals who provide care in a language other than English.
3.A.4 Ratio of health care professionals trained to provide culturally and linguistically competent care to percentage of non-English speakers in each county.

3. Workforce System Measures (continued)
B. Workforce Wellness: Improvements in reported job satisfaction and decreases in burnout among health care workers.
3.B.1. Number/percent of health care professionals (and allied health care professionals) who report needing support with burnout as part of their weekly tasks.
3.B.2. Number/percent of clinics with a workforce wellness program for staff.
C. Workforce Development: Oregon is developing and expanding its workforce.
3.C.1 Number of education programs for licensed and certified health care professionals.
3.C.2 Number of newly trained licensed and certified health care professionals.
3.C.3 Number of health care professionals who relocated to Oregon to practice within past year.
3.C.4 Full-Time Equivalent (FTE)/population ratio (by county/area).
3.C.5 Number of telehealth health care professionals a) inside Oregon; b) outside Oregon providing services to patients in Oregon.
3.C.6 Medicaid FTE by profession.
D. Workforce Retention: Oregon and health care employers are retaining its health care workforce.
3.D.1 Retention at 1 year/5 years: (a) at same employer and (b) in Oregon's workforce.

For the purpose of these measures, health care professional is inclusive of Traditional Health Workers (THWs), health care interpreters, doctors, nurses, primary care providers, behavioral health providers, oral health providers, and other workforces required for culturally and linguistically responsive health care.

Data sources that may be used to measure impact include but are not limited to:

- OHA Health Care Workforce Reporting Program, Occupational Supply Report, Workforce Diversity Profile, and other data collected
- Traditional Health Worker (THW) and Health Care Interpreter data from Equity and Inclusion Division and other sources
- Certified health care workforce data from Mental Health and Addiction Certification Board (MHACBO) and other sources
- Oregon Employment Department Labor Market Information
- All Payer All Claims Reporting Program data (APAC)
- Portland State University (PSU) Population Research Center demographic data
- Provider Retention and Information System Management (PRISM)

Results of the evaluation will be shared with OHPB. This report will analyze successes and gaps in Committee work in its specific focus areas and identify opportunities for improvement for each upcoming period.

SECTION 3: Committee Membership, Organization and Support

IX. Committee Membership

1. Composition

There is no mandatory maximum or minimum number of members, nor are there specific organizations or constituencies mandated to be included. Oregon law stipulates:

> The Health Care Workforce Committee shall include individuals who have the collective expertise, knowledge and experience in a broad range of health professions, health care education and health care workforce development initiatives.
>
> (ORS 413.017(3)(a))

While the statute sets no requirements, OHPB's adoption of the definition of health equity, as well as the commitment to include the voices of consumers affected by the performance of the health care system suggest the following priorities for Committee composition:

a. The preferred range of membership shall be no less than 15 and no more than 23 members.
b. Members shall include individuals representing:
    i. Health care employers.
    ii. Health care education institutions and programs.
    iii. Substantial health care, social service or health equity experience,
    iv. Health care professionals who have lived experience and/or cross-cultural experience in culturally responsive and specific care.
    v. THWs, health care interpreters, doctors, nurses, primary care providers, behavioral health providers, oral health providers, and other workforces required for culturally and linguistically responsive health care.
    vi. Consumers of health care.
    vii. Students in health care education programs.
    viii. Others with a commitment to advancing workforce development, retention, wellness, and diversity.
c. OHA staff shall make additional efforts to identify individuals who are experienced and skilled in the review, analysis and development of health equity policy, results-proven implementation, and social determinants of health in its recruitment efforts.

2. Recruitment

Applications shall be solicited on an annual basis from a diverse group of individuals with lived experience and/or cross-cultural experience. Selection shall be made to ensure the Committee is representative of communities experiencing health inequities, including but not limited to, racially and ethnically diverse populations, linguistically diverse populations, immigrant and refugee populations, LGBTQIA2S+ populations, youth and aging populations, people with

disabilities, rural communities, and economically disadvantaged populations. Individuals with experience in education and training of health care professionals and from the health care professional workforce.

The recommendation of members for appointment shall prioritize lived experience and cross-cultural experience (see Appendix: Definitions section starting on page 26), and other expertise in health care and health equity generally, and racial equity specifically. We recognize that lived and cross-cultural experience can help OHPB, Committee and OHA staff better understand and advance health equity.

3. Appointment

While recruitment and screening are conducted by OHA staff and Committee representatives, appointment to the HCWF is the purview of the OHPB.

4. Term lengths

Terms will be three years, with terms finishing at the end of a calendar year, or until such time as t OHPB appoints a replacement. Additionally, terms will be grouped to ensure continuity. A member may serve up to two full consecutive terms. A member completing two terms may remain on the Committee for an additional year to serve as Immediate Past Chair during that period.

5. Reappointment

A former member is eligible to seek reappointment to the Committee by the Board after leaving the Committee, following an absence of at least one year.

6. Resignations and vacancies

If a member finds it necessary to resign from the Committee, then the member is encouraged to remain until a replacement can be selected and to provide as much notice as possible. Members are also encouraged to recommend candidates who may be interested in serving on the HCWF Committee. Members who plan to resign from HCWF shall submit a formal resignation letter to the Chair and Lead Staff for the committee. OHA shall strive to conduct interviews with Committee members within a short period of their departure, whether it be from resignation or completion of their term of service, to advance continued diversity of committee membership, effectiveness and quality of operations.

7. Attendance

Members should attend at least 75% of Committee meetings per year. Committee members who are unable to attend meetings consistently will be asked to reconsider their membership.

8. Removal

The Committee leadership may decide to remove a member should there be extraordinary circumstances happening, such as abusive behavior.

9. Replacements

Replacement members will be appointed to the remainder of the resigning member's term and are eligible for reappointment at the discretion of OHPB. OHPB may appoint a replacement for any member who misses more than two consecutive, unexcused absences or a total of 25% of the meetings per year. OHPB and OHA will also consider extenuating circumstances on a case-by-case basis. The Chair of the Committee is the official authorized to determine whether an absence may be excused.

10. Public officials

In 1974, voters approved a statewide ballot measure to create the Oregon Government Ethics Commission (Commission). The measure established laws that are contained in Chapter 244 of the Oregon Revised Statutes (ORS). When the Commission was established, it was given jurisdiction to implement and enforce the provisions in ORS Chapter 244 related to the conduct of public officials. In addition, the Commission has jurisdiction for ORS 171.725 to 171.785 and 171.992, related to lobbying regulations, and ORS 192.660 and 192.685, the executive session provisions of Oregon Public Meetings law.

The provisions in Oregon Government Ethics law restrict some choices, decisions or actions of a public official. The restrictions placed on public officials are different than those placed on private citizens because service in a public office is a public trust and the provisions in ORS Chapter 244 were enacted to provide one safeguard for that trust. Public officials must know that they are held personally responsible for complying with the provisions in Oregon Government Ethics law. This means that each public official must make a personal judgment in deciding such matters as the use of official position for financial gain, what gifts are appropriate to accept, when to disclose the nature of conflicts of interest, and the employment of relatives or household members.

One provision, which is the cornerstone of Oregon Government Ethics law, prohibits public officials from using or attempting to use their official positions or offices to obtain a financial benefit for themselves, relatives or businesses with which they are associated if that financial benefit or opportunity for financial gain would not otherwise be available but for the position or office held.

Oregon Government Ethics law limits and restricts public officials and their relatives as to gifts they may solicit or accept. Under specific circumstances, public officials may accept certain gifts. Another provision that frequently applies to public officials when engaged in official actions is the requirement to disclose the nature of conflicts of interest.

Committee members are considered "public officials" as they have applied and were selected to a position for which you have volunteered to serve the State of Oregon.

For further information, consult Oregon Government Ethics Law - A Guide for Public Officials.

11. Conflicts of interest

Committee members are appointed, in part, because of their diverse experiences in their professional and civic lives. The Committee further recognizes that persons appointed to this body bring valued histories of service to varied populations in the state or to stakeholder groups. Each Member is reminded that by accepting membership on the Committee, they agree to serve the broader goal of recruiting, educating and retaining a quality health care workforce to serve the health care needs of every person in Oregon.

The Committee's policy is designed to ensure that voting members of the Committee identify situations that present possible conflicts of interest and to describe appropriate procedures if a possible conflict of interest arises. The Committee seeks to promote transparency and integrity of its decision-making process, aided by this policy. Questions about this policy should be

directed to the Chairperson of the Committee, OHA Director, or HPA Division (Division Director).

I. **Committee members should:**
   i. Put loyalty to the highest ethical standards above loyalty to government, persons, political party, or private enterprise.
   ii. Not make private promises that are binding upon the duties of a Committee member, because a public official has no private word that can be binding on public duty.
   iii. Expose corruption wherever discovered.
   iv. Uphold the principles described in this policy statement and stay conscious to the public's interest.

II. **Definitions of a conflict of interest.** A conflict of interest arises when a Committee member has a personal financial interest in matters that are before the Committee.

III. An **actual** conflict of interest occurs when the action taken by the Committee member would affect the financial interest of the Committee member, the Committee member's relative or a business with which the Committee member or relative is associated.

IV. A **potential** conflict of interest exists when the action taken by the Committee member could have a financial impact on that Committee member, a relative of the Committee member or a business with which the Committee member or the relative of the Committee member is associated.

V. The Committee recognizes that the standards that govern its conduct are fully set forth in ORS Chapter 244. It is therefore the policy of the Committee that all HCWF members, upon appointment, and periodically thereafter, are made aware of the requirements of this law, or subsequent versions thereof. It is the Committee's intent that the statutory requirements set forth in Oregon law are binding authority to which members must adhere, and that this Conflict of Interest Policy, or others adopted in furtherance of its purposes, be viewed and utilized as elaboration and guidance.

VI. **How Committee members identify conflict of interest situations.** Committee members are encouraged to examine prospective issues at the earliest opportunity for the potential of a conflict of interest and are reminded that compliance with the statutory requirements often require sensitivity to avoiding the appearance of impropriety. Members are to consult with the Chairperson of the Committee or Committee staff for guidance where appropriate.

VII. The following circumstances do not represent a conflict of interest:
   i. If the conflict arises only from a membership or interest held in a particular business, industry or occupation or other class that was a prerequisite for holding the Committee position.
   ii. If the financial impact of the official action would impact the Committee member, relative or business of the Committee member or relative to the same degree as other members of an identifiable group or class.
   iii. If the conflict of interest arises only from a position or membership in a

nonprofit corporation that is tax-exempt under 501(c) of the Internal Revenue Code.

VIII. **Duty to disclose**. Committee members should disclose to the Committee Chairperson as soon as the Committee member is aware of the actual or potential conflict of interest.

IX. Committee members must publicly announce the nature of the conflict of interest before participating in any official action (discussion or voting) on the issue giving rise to the conflict of interest.

i. Potential conflict of interest: Following the public announcement, the Committee member may participate in official action on the issue that gave rise to the conflict of interest.
ii. Actual conflict of interest: Following the public announcement, the Committee member must refrain from further participation in official action on the issue that gave rise to the conflict of interest.
iii. If a Committee member has an actual conflict of interest and the Committee member's vote is necessary to meet the minimum number of votes required for official action, the Committee member may vote. In this situation, the Committee member must make the required announcement and refrain from any discussion but may participate in the vote required for official action by the Committee. These circumstances are rare.

X. **Record of proceedings**. The Committee shall keep a record of disclosures of conflict of interest and the nature of the conflict in the public record.

XI. **Applicability to the Committee's workgroups.** Workgroup members should follow this policy when engaged in decision-making with the workgroup, conferring as needed with the chairperson of the Committee or the Division Director or their designee. Public employees should follow the Conflict of Interest policies of their appointing authority.

12. Compensation and House Bill 2992

House Bill 2992[3] states that any member of a state board or commission, other than a member who is employed in full-time public service, who is authorized by law to receive compensation for time spent in performance of official duties, shall receive a payment for each day or portion thereof during which the member is actually engaged in the performance of official duties. It has been interpreted by the Oregon Department of Justice that all members of state boards and commissions, including those employed in full-time public service, may receive actual and necessary travel or other expenses actually incurred in the performance of their official duties within the limits provided by law or by the Oregon Department of Administrative Services under ORS 292.210 to 292.250. The compensation to be provided is equal to the per diem paid to members of the Legislative Assembly under ORS 171.072.

House Bill 2992 defines "qualified member" as a member who is not in full-time public service

[3] https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2992

and who had an adjusted gross income in the previous tax year:

- Of less than $50,000, as reported on an income tax return other than a joint income tax return; or
- Of less than $100,000, as reported on a joint income tax return.

All members of state boards and commissions, including those employed in full-time public service, may receive actual and necessary travel or other expenses actually incurred in the performance of their official duties within the limits provided by law or by the Oregon Department of Administrative Services under ORS 292.210 to 292.250.

A member of a state board or commission may decline to accept compensation or reimbursement of expenses related to the member's service on the state board or commission.

X. Committee Organization

1. Committee officers and duties

The officers of the Committee shall be a Chair, Vice-Chair, and Immediate Past Chair, each of whom shall serve a 12-month term from the date of their election. The officers shall be elected by the Committee from among its members.

The Chair and Vice-Chair may be elected for more than one term. The Chair and Vice-Chair will have term limits for their roles, not to exceed two years. In the rare instances the HCWF is unsuccessful in leadership succession transitions, OHPB may extend the duration of the chair term until such a time as a new chair may be elected by the Committee.

Duties of the Chair are to:

- Preside at all meetings of the Committee.
- Coordinate meeting agendas after consultation with Committee staff.
- Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
- Be advised of all presentations or appearances of OHA staff or Committee members before Legislative or Executive committees or agencies that relate to the work of the Committee.
- Attend meetings of OHPB.

The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

Duties of the Vice-Chair are to:

- Perform all of the Chair's duties in his/her absence or inability to perform them;
- Accompany the Chair to meetings of the Board at which recommendations of the Committee are presented; and
- Perform any other duties assigned by the Chair.

Duties of the Immediate Past Chair are to:

- Serve as a resource to the Chair and Vice-Chair;
- Perform all of the Chair's and Vice-Chair's duties in their absence or inability to perform them; and
- Support Committee staff in the recruitment of new membership to the Committee.

The Committee Chair (or other leader acting in the role during a meeting) has the critical role of facilitating HCWF meetings. Facilitator is defined as "a person who plans, guides and manages a group event to meet its goals." As a facilitator, the Chair holds both power and responsibility in moving a group process along with effectiveness and efficiency and managing differences and conflicts with fairness and equity. The Chair should build awareness of how they show up in meeting spaces, including their own prejudices and biases in order to exercise their power consciously and effectively. In facilitating the Committee meetings, the Chair should take care to support each member having an opportunity to participate in discussion (vs. allowing one or a small number of members to dominate the conversation). The Chair should also ensure that meaningful alternatives to speaking publicly in meetings are available for members as ways to ensure their input into decisions and recommendations.

Actions to support anti-racist and inclusive facilitation include the following:

- Invite group participants to self-identity themselves and how they want to be addressed.
- Use clear and intentional language when addressing racial identities and disparities to avoid further marginalizing or erasing a particular community.
- Actively create space and hold space for all those from communities who have experienced racism and/or health inequities in meetings.
- Honor and uplift the lived experience, stories and expertise of those directly impacted in strategic and policy discussions.
- Welcome differences and discomfort and not be deterred by mistakes.
- Commit to continuous learning and unlearning around how to become antiracist. Continue to identify and dismantle group practices that stem from white supremacy, racial capitalism, and colonialism.

Duties of Committee members are to:

- Attend, in person or by phone/electronically, at least three-quarters of Committee meetings annually. Committee members who are unable to attend meetings consistently will be asked to reconsider their membership.
- Participate in at least one Committee workgroup or specific project per membership term. This may include attending occasional additional meetings or developing and reviewing material outside of Committee meetings.
- Advise the Committee chair and staff before representing the Committee or its views publicly.
- Advise the Committee chair and staff in advance of any inability to attend a meeting or the need to leave early.

2. Nomination and election

Committee Officers may be nominated by Committee members. Committee members shall elect Committee Officers at a committee meeting in even numbered years. Information on decision-making and voting is available in Section 4: Committee Operations on pages 23-24.

3. Standing workgroups

All standing workgroups of the HCWF will be established through the Committee Charter. Outside of specific groups called for in the Charter, the Committee may establish ad hoc, or time-limited groups for the effective implementation of its work.

4. Ad Hoc workgroups

An "ad hoc" (Latin meaning "for this") group exists to accomplish a specific, time-limited objective. They can also be called "work groups." Typically, but not exclusively, Ad Hoc work groups are formed to perform one of two functions. One is to investigate, and the other is to carry out an action that has been adopted. Work groups do not make decisions, but rather prepare recommendations that go back to the full Committee for final approval.

Organizing an "ad hoc" work group will require the committee to allocate time, expertise, and resources to the effort. An ad hoc workgroup may be established either by the Chair or by a majority vote of the full Committee to perform work on a specific project. To ensure these group are successful, when creating an ad hoc work group, the Committee shall:

- Define the scope or task,
- Specify membership,
- Provide guidance on process and product,
- Define expectations for cadence of HCWF updates on the project status.

Defining the mission or task involves conceptualizing the problem or issue and strategizing how to best address it. The HCWF under the guidance of the Chair will devote ample time to this part of planning including the number of participants, the length of time the work group will function, the deliverables and the communication channels between the work group and the full Committee. Once the task is adequately defined, HCWF Co-Chairs will solicit the participation of Committee members and/or other internal OHA and external partners if applicable. Ad hoc work group members can be self-nominated or enlisted.

Information about the Work Group (purpose, task, participants, deliverables and timeline) should be clearly outlined in the HCWF's public record/meeting summary.

XI. Committee Support

1. OHPB Liaison

The OHPB Liaison serves a key leadership role in ensuring that the HCWF is fulfilling the expectations of the Board. Committees should treat liaisons like a committee member without voting rights. Committee Chairs and OHA staff work with Board liaisons to determine a meeting schedule and cadence that meets Board liaison and committee member needs as well as inform the specific work and considerations of their respective committee. The liaison role is to listen, support and influence committees – not drive decisions and directions.

The liaison duties are defined by OHPB.[4] It is expected that the liaison will:

- Attend HCWF meetings.
- Provide updates to the Committee on OHPB Activity at meetings or otherwise, as relevant.
- Attend and participate in planning meetings with the Committee Officers and OHA staff.
- Offer feedback to the Committee Chair and members and OHA staff on the agendas, projects and implementation of a workplan.

2. Role of OHA staff

The role of OHA staff in relationship to the Committee is two-fold: a) provide logistical support and b) provide technical assistance, subject and programmatic expertise, and consultation on topics related to Committee work.

HPA staff basic functions

- Serve as informed resource persons to the Chair, Vice-Chair and OHPB Liaison(s) and Committee members.
- Assist Chair in facilitating Committee discussion and activities that address the Committee's charge as delineated in the Committee's charter, bylaws, and strategic plan.
- Work with the Chair to ensure that all Committee work is consistent with the committee's goals and objectives.

Committee staff responsibilities

- Support the development of Committee work plans with timelines that will keep the Committee focused and accomplish its priorities.
- Work with the Chair and HPA leadership in developing agendas and conducting effective meetings.
- Provision of administrative and on-site support for planning, execution, and follow-up of all Committee meetings.
- Provide orientation for new and continuing Committee members each year.
- Work with the Chair, other committee members, and HPA leadership to ensure that the Committee's work is carried forth between meetings.
- Facilitate communication of Committee activities, including requests for action and/or proposed policies, to OHPB and OHA leadership, when applicable.
- Prepare agendas and distribute them before meetings.
- Keep the Committee webpage up to date, including updating meeting schedules and resources.
- Foster a culture of openness, transparency, and respect for all Committee members as equal discussion partners.
- Draft Committee reports, letters, and memos of Committees for review and approval.

[4] Oregon Health Policy Board. OHPB Liaison Assignments and Role. https://www.oregon.gov/oha/OHPB/MtgDocs/1.0%20OHPB%20Committee%20Liaison%20Assignments%20and%20Role.pdf.

SECTION 4: Committee Operations

XII. Committee Meetings, Decision-Making and Voting

1. Meeting frequency and format

- The HCWF shall meet at least six times a year. All meetings shall be open to the public.
- The HCWF and staff shall ensure that meeting venues are accessible and can support optimal video conference participation.
- Committee meetings that are virtual/videoconference meetings shall offer the use of chat functions, breakout groups, polling, language interpretation, closed captioning, and other technologies for maximizing participation from both Committee members and the public.
- The HCWF shall ensure public access to Committee meetings for individuals with languages other than English and for individuals with disabilities.
- Committee staff shall send written notice of the place, date, time, telephone/video conferencing access information, agenda of each meeting, past meeting notes and any other meeting resources to each member at least 3 business days prior to each meeting.
- The agenda for each Committee meeting will be developed in partnership by the Chair and Committee staff, with input from the HPA-CSIW and DSI Directors, and OHPB Liaison.
- The agenda may be developed through any means of communication chosen by the Chair, including electronic mail.
- The agenda shall be published on the HCWF website, with all the information necessary for the public to access the meeting such as location, telephone, videoconferencing no less than five (5) calendar days prior to the meeting. The agenda shall provide a brief description of the items of business to be transacted or discussed and the name of the presenters.
    - No item shall be added to the agenda after the agenda is posted. However, HCWF may take action on items of business not appearing on the posted agenda upon a determination by two-thirds of all voting members that an emergent need exists.
- Notice of the additional item to be considered shall be provided to each member of the HCWF as soon as is practicable after a determination of the need to consider the item is made. An update to the agenda shall also be made available on Committee's website as soon as is practicable after the decision to consider additional items at a meeting has been made.

2. Public status of committee meetings and records

Public Comments
OHPB and its committees, including HCWF, are public bodies that accept public comments related to relevant topics.

Written comment before meetings
Written public comment may be submitted by email to Committee staff prior to meetings of the Committee. Written comments submitted at least 48 hours before public meetings will be included in the meeting materials packet reviewed by members. Written comments submitted less than 48 hours prior to the meeting will be noted by staff and submitted to the chair as practicable.

Written comments should be limited to 1,000 words (PDF/Word formats). Materials provided to Committee members become public documents. Written public comments will be distributed to members. In keeping with OHPB protocol, the role of the committee with public comment is one of active listening, and generally there is not discussion of the comment at the time. A Committee member may ask for clarification, and comments may also be referred to as members choose, on topics related to agenda items.

Verbal public comments during meetings
Members of the public are provided with several ways to provide verbal comments at each Committee meeting. HCWF has allocated time for the public to participate. The public may comment on the subject/topic on that section of the agenda, or any other matter related to OHPB/HCWF/OHA priorities. Members of the public can request the opportunity to provide verbal public testimony in two ways:

- **In advance:** Verbal public comments requested at least 24 hours before the Committee meeting shall be brought to the attention of the Chair and may be noted on the agenda distributed to members.
- **During the meeting:** Members of the public will be invited to provide public comment during the time stipulated on the agenda. The public can request time in advance or come forward when the Chair so indicates. The Committee asks that the persons identify themselves to ensure their name and organization are reflected in the Committee meeting summaries.

Verbal public comments are limited to two minutes per individual share, to ensure adequate access for all those wishing to give verbal comments.

Accessibility
Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages
- Braille
- Large print
- Audio and other formats

HCWF shall ensure that committee documents are developed with a font type and size that are universally accessible.

3. Meeting documentation

A record shall be made by the Committee staff or designee of the attendance of members and actions taken by the Committee during each meeting. The draft meeting notes are considered as meeting notes only and are not official minutes unless later approved by the Committee at an open meeting. Once approved the minutes shall be posted on the web within 30 days following adoption and shall be a public record.

Language and documentation equity considerations

Equity is a guiding model for language and action in all of the HCWF's materials. These materials include public communications, presentations, meeting notes, website text, membership applications, and any other materials. The Committee is committed to ensuring that information is written such that is:

- In plain language. Oregon law requires all state agencies to prepare public communications in language that is as clear and simple as possible (ORS 183.750). House Bill 2702 specifies an additional standard for written documents.
- Culturally responsive.
- Accessible.
- Readily available in languages that represent communities in all of Oregon upon any request made.
- Use gender-inclusive language.
- Aware of ableism and how it enters the language we use when referring to people with and without disabilities.

4. Decision-making and voting

All voting actions of the Committee shall be expressed in the form of a motion and/or resolution. When a motion has been made, the Committee shall strive to reach consensus (i.e., with no Members objecting). However, if the Chair determines that a consensus is not present or cannot be reached, a vote will be called, and decisions will be made by a majority of members participating in the vote, at a meeting where a quorum is present. Before taking a vote, the Chair will ensure everyone has had an opportunity to speak who wishes to have their opinion heard.

Quorum and manner of voting

A majority of Committee Members shall constitute a quorum for the transaction of business. In the absence of a quorum, the Committee may hear presentations, discuss issues and deal with administrative matters but it may not adopt any recommendation during a meeting unless a quorum has been established first.

Meetings may be called by the Chair to take place in person, remotely, or through hybrid means.

If a Committee Member is unable to attend an in-person meeting in person, the Member may

participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting.

A Committee Member participating by such electronic means shall be considered in constituting a quorum.

Committee Members shall inform the Chair and/or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members. As a general rule, the Committee will conduct its business through discussion and consensus. In cases where consensus cannot be achieved, a vote may be used. Use of a vote and its results will be recorded in the meeting minutes and those in the minority may prepare a brief minority opinion.

When voting on motions, resolutions, or other matters, a voice or electronic vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

The voting in the case of election of officers shall be by nomination and vote by silent ballot. A simple majority carries the vote, and the vote will be documented in meeting notes without names.

The voting on motions and resolutions shall be by voice and/or publicly recorded vote; if necessary, the Chair may request a roll call or show of hands to ensure clarity in the outcome.

Voting when there is a Recusal or Abstention

a. “Recuse” shall be defined as the act of not voting to avoid a conflict of interest.
b. “Abstain” shall be defined as the act of not voting when present and entitled to vote for any reason not indicated in subsection (a), including, but not limited to, not voting for personal reasons.
c. Abstentions and recusals by Committee members shall have the following effects on HCWF proceedings:
    a. Members who recuse themselves will not be counted toward a quorum, and their recusal may not be interpreted as support for, acquiescence in, or opposition to, any actions taken by the HCWF, unless their vote is required for a

quorum to be present in order to conduct business. In such instance the member who had recused themselves may not be allowed to speak or explain their vote.

b. Committee members who are present, but abstain, are counted toward a quorum.

All motions and resolutions shall be recorded as a matter of public record.

XIII. Communications

1. Committee communications

The OHA HPA Committee lead staff or their designee will be considered the primary point of contact for all communications. All comments and/or questions from Committee members will be directed to the Committee staff, who will keep a record of such communications and will inform the CSIW and DSI Directors and Committee Chair. The OHPB committee staff will support the HPA Committee lead staff, CSIW Director, Committee Chair and Committee staff in this function.

All comments and/or questions from the public will be directed to the Committee lead staff, CSIW Director, Committee Chair and OHA External Relations Division staff; OHPB committee staff will support these parties in this function.

2. Media

All media requests should be funneled through Committee staff to HPA leadership and OHA Government Relations and Communications officials. Individual Committee members do not represent the views of the Committee, OHPB, HPA, or OHA, but can speak to their own individual, personal, and professional perspective, including that of the organizations they are affiliated with, including the Committee. Members should seek to separate their perspective from any official position of the committee as appropriate.

3. Lobbyists

While it is expected that HCWF members will advocate for their policy positions both inside and outside of Committee spaces, HCWF members are considered public officials. As such, they must comply with all public official rules and statues, including those pertaining to state government ethics, conflicts of interest, and gifts.[5]

XIV. Amendments

OHPB may amend the Committee's charter at its discretion. The Committee may recommend changes upon the affirmative vote of a two-thirds majority of members present at any meeting of the Committee, insofar as such number represents a quorum.

[5] See Oregon Revised Statutes (ORS) Chapter 244, Government Ethics.

APPENDIX: Definitions

XV. Key Definitions and Tools

1. Ableism

Ableism is discrimination in favor of nondisabled people. Ableism is the discrimination of and social prejudice against people with disabilities based on the belief that typical abilities are superior.

2. Community engagement

Creating community partnerships through relationship and trust building facilitates the communication needed to understand how to meaningfully improve systems. **Community engagement** "often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices" (CDC, 1997, p. 9).[6]

3. Cross-cultural experience

Cross-cultural experience refers to your personal, volunteer, or professional experience with populations and communities. This experience must include an equity-centered, anti-racist, anti-oppressive, culturally appropriate and empathic approach. Cross-cultural experience is different than your self-reported identity (see the definition for lived experience). Cross cultural experience can include:

- Experiences with family members or friends,
- Working toward health equity with racially and ethnically diverse populations and communities,
- Learning another language, or
- Living in a country other than the U.S.

4. Diversity

Diversity is "honoring and including people of different backgrounds, identities and experiences collectively and as individuals. It emphasizes the need for representation of communities that are systemically underrepresented and under-resourced. These differences are strengths that maximize the state's competitive advantage through innovation, effectiveness, and adaptability (Oregon Governor's definition).[7]

5. Equity

Equity is the effort to provide different levels of support based on an individual's or group's needs in order to achieve fairness in outcomes. Equity acknowledges that not all people, or all communities, are starting from the same place due to historic and current systems of oppression. Equity empowers communities most affected by systemic oppression and requires the

[6] Community Engagement Strategies Checklist: Oregon Health Authority https://www.ohsu.edu/sites/default/files/2020-12/Community%20Engagement%20Strategies%20Checklist%20Oregon%20Health%20Authority.pdf

[7] State of Oregon. Diversity, Equity, and Inclusion Plan. https://www.oregon.gov/das/Docs/DEI_Action_Plan_2021.pdf.

redistribution of resources, power and opportunity to those communities (Oregon Governor's definition).[8]

6. Health disparities

Health disparities: Differences between the health of one population and another in measures of who gets disease, who has disease, who dies from disease and other adverse health conditions among specific population groups. If a health outcome is seen to a greater or lesser extent between populations, there is disparity.

7. Health equity

Health equity: Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, age, disability, gender, gender identity, sexual orientation, social class or the intersections among these communities or identities or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power, and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

8. Health Equity Impact Assessment (HEIA)

HEIA is a decision support tool which walks users through the steps of identifying how a program, policy or similar initiative will impact population groups in different ways. HEIA surfaces unintended potential impacts. The end goal is to maximize positive impacts and reduce negative impacts that could potentially widen health disparities between population groups—in short, more equitable delivery of the program, service, policy, etc. (MOHLTC 2019)

9. Health inequities

Health inequities: Systematic, avoidable, unjust and unfair differences in health status and mortality rates across population groups. These differences are rooted in social and economic injustice attributed to the social, economic and environmental conditions in which people live, work and play.

10. Implicit bias

Implicit bias: Associations that people unknowingly hold, also known as unconscious or hidden bias. They are expressed automatically, without awareness. These learned stereotypes and prejudices operate automatically and unconsciously when interacting with others.

11. Inclusion

Inclusion is a state of belonging when persons of different backgrounds, experiences and identities are valued, integrated and welcomed equitably as decision makers, collaborators and colleagues. Ultimately, inclusion is the environment that organizations create to allow these differences to thrive. (Oregon Governor's definition)

12. Institutional racism

Institutional racism: As the name suggests, this form of racism occurs within institutions and reinforces systems of power. It is often more difficult to name or witness because it is more

[8] Ibid.

deeply embedded in practices and policies, often presenting as a norm. Institutional racism refers to the discriminatory policies and practices of particular institutions (government, schools, workplaces, etc.) that routinely cause racially inequitable outcomes for people of color and advantages for white people. Individuals within institutions take on the power of the institution when they reinforce racial inequities. Further, institutional racism causes severe racial trauma with mental and emotional impacts that often escape those who do not experience this trauma.

13. Intersectionality

Intersectionality: Methodology of studying and examining how various socially and culturally constructed categories (sex, gender, race, class, disability, etc.) interact on multiple and often simultaneous levels and contribute to systematic inequities. Intersectionality examines and attempts to clarify ways in which a person can simultaneously experience privilege and oppression. It is a way to see the interactive efforts of various forms of discrimination and disempowerment. Intersectionality looks at the way racism interacts with patriarchy, heterosexism, classism, xenophobia and ableism. It views the overlapping vulnerabilities created by these systems to create specific challenges. It means significant numbers of people in our communities aren't being served by social justice efforts because they do not address particular ways, they are experiencing discrimination.

14. Lived experience

Lived experience refers to one's life experience based on self-reported identity, meaning someone who has personal knowledge about the world gained through direct, first-hand involvement in everyday events such as racism, houselessness, behavioral health, etc. that might help the Committee and OHA staff better understand and advance health equity.

15. Priority populations

Populations and communities who have been most harmed by historic and contemporary injustices and health inequities include but are not limited to: communities of color, Tribal communities including the nine federally recognized tribes of Oregon and other American Indians and Alaska Natives people, immigrants, refugees, migrant and seasonal farmworkers, individuals and families with low income, people with disabilities, and LGBTQIA2S+ communities.[9]

16. Racial equity

Racial equity means closing the gaps so that race can no longer predict any person's success, which simultaneously improves outcomes for all. To achieve racial equity, we must transform our institutions and structures to create systems that provide the infrastructure for communities to thrive equally. This commitment requires a paradigm shift on our path to recovery through the intentional integration of racial equity in every decision.[10]

17. Racism

Racism: Distinct from racial prejudice, hatred or discrimination, racism involves one group having the power to carry out systematic discrimination through the institutional policies and practices of the society and by shaping the cultural beliefs and values that support those racist policies and practices.

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[9] Regional Health Equity Coalition statute: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3786e_2.pdf.

[10] State of Oregon. Diversity, Equity, and Inclusion Plan. https://www.oregon.gov/das/Docs/DEI_Action_Plan_2021.pdf.

18. Self-reported identity

Self-reported identity, such as race, ethnicity, language, disability, age, gender, gender identity, identity, sexual orientation, social class, and intersections among these identities, or other socially determined circumstances that may impact health equity and an individual's ability to reach their full health potential and well-being.

19. Structural racism

Structural racism: A system in which public policies, institutional practices, cultural representations and other norms work in various, often reinforcing ways to perpetuate racial group inequities. It is a feature of the society in which we all exist.

XVI. Acronym Definitions List

Acronyms are listed in order of appearance in the charter.

1. HCWF: Health Care Workforce Committee

HCWF coordinates efforts to recruit and educate health care professionals and retain a quality health care workforce as a committee of OHPB.

2. OHA: Oregon Health Authority

OHA is at the forefront of lowering and containing costs, improving quality and increasing access to health care in order to improve the lifelong health of Oregonians. OHA is overseen by the Oregon Health Policy Board working towards comprehensive health reform in our state.

3. OHPB: Oregon Health Policy Board

OHPB is the policy-making oversight board for OHA and its departmental divisions.

4. HPA: Health Policy and Analytics Division

HPA provides OHA with agency-wide policy development, strategic planning, and clinical leadership. HPA staffs OHPB and is also where the HCWF Committee lead staff are located.

5. CSIW: Clinical Supports, Integration, and Workforce Unit

CSIW staffs HCWF as well as housing the primary care office, the patient centered primary care home, and various state and federal incentives for providers.

6. REALD: Race, Ethnicity, Language, and Disability

REALD data provides more information about a person's self-identified racial and ethnic identity, preferred spoken and written languages, interpreter needs, English proficiency, and disability.

7. SOGI: Sexual Orientation and Gender Identity data

SOGI data is being developed to increase and standardize sexual orientation and gender identity data collection across OHA. OHA has drafted recommendations with proposed questions to use when collecting SOGI data.

8. CCO: Coordinated Care Organization

CCOs are organizations that provide Medicaid benefits for Medicaid beneficiaries in certain areas of Oregon.

9. FTE: Full-Time Equivalent

FTE is a unit of measurement that indicates the workload of an employed person in a way that makes workloads or class loads comparable across various contexts.

10. THW: Traditional Health Worker

THWs are trusted individuals from their local communities who may also share socioeconomic ties and lived life experiences with health plan members. THWs have historically provided person and community-centered care by bridging communities and the health systems that serve them, increasing the appropriate use of care by connecting people with health systems, advocating for health plan members, supporting adherence to care and treatment, and empowering individuals to be agents in improving their own health.

11. MHACBO: Mental Health and Addiction Certification Board

MHACBO certifies behavioral health professionals in Oregon through competency-based evaluation of education, experience, and exams.

12. APAC: All Payer All Claims Reporting Program

The APAC database contains administrative health care data on topics such as insurance coverage, health service cost and utilization for Oregonians who are insured through commercial insurance, Medicaid, and Medicare. APAC provides access to timely and reliable data essential to assess the cost of health care, improve quality, reduce costs and promote transparency.

13. PSU: Portland State University

PSU is Portland's public research university that combines education with creative problem-solving and collaboration across campus for maximum impact.

14. PRISM: Provider Retention and Information System Management

PRISM is a collaborative of state Primary Care Offices, Offices of Rural Health, Area Health Education Centers and other organizations have partnered to collect data to identify and document outcomes to enhance the retention of clinicians. OHA participates in PRISM.

15. LGBTQIA2S+: Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual or Agender, 2-Spirit. The plus sign identifies additional identity terms.

LGBTQIA2+ is an acronym for terms used to describe sexual orientation and gender identities, with the plus sign indicating a number of other identities and is included to keep the abbreviation brief when written out.

16. ORS: Oregon Revised Statutes

ORS contain the laws enacted by the legislature or governor, or passed by a vote of the people through the initiative process.

17. DSI: Office of Delivery System Innovation

DSI aligns medical management practices and coordinates clinical and system innovation, programs, and policies across Coordinated Care Organizations (CCOs), communities, other plans and payers, and OHA divisions.