VACCINE EQUITY COMMITTEE (VEC):

ENSURING ALL OREGONIANS HAVE ACCESS TO COVID-19 VACCINE

This internal document serves to capture best practices and lessons learned through 1.5 years of practicing a culturally-centered strategy for COVID-19 vaccine distribution to racial, ethnic, and underserved communities.

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COVID-19 VACCINE INEQUITY AND THE EMERGENCE OF VACCINE DESERTS

The COVID-19 pandemic has had a disproportionate impact on underserved communities. Inequities within the health care system that existed long before COVID-19 have amplified these disparities. CDC data shows racial and ethnic minority groups are at greater risk of contracting COVID-19, experiencing more severe illness, and dying from its effects.

By early 2021, OHSU launched mass vaccination sites, bringing life-saving vaccine to thousands of Oregonians who had the means, access, and language to reach these locations. As related vaccination data was reported, areas of low vaccination rates began to emerge. Racial, ethnic, linguistic, and other minority groups in concentrated "vaccine deserts" were being left behind,

exposed and vulnerable to the virus. Underlying conditions, more common in these groups, put members at risk for more severe COVID-19 symptoms. Additionally, members of these communities often work in fields labeled "essential", thereby increasing their exposure.

The OHSU Vaccine Equity Committee (VEC) was formed with the purpose of increasing vaccination rates and vaccine education among diverse racial and ethnic communities within the state of Oregon. During the pandemic, these communities are being vaccinated, tested, and boosted at disproportionately low rates compared to the white population. Multiple barriers and health inequities persist, such as access, information, language, transportation, work hours, technology, immigration status, past medical mistreatment, discrimination, and overall exclusion to services.

This paper serves to capture the best practices of the VEC, as well as lessons learned through experience. Among other sources, it draws from the documented VEC Charge; repeated interviews with VEC subcommittee leads Kat Phillips, Jenny Lee Berry, Leslie Garcia, and Mariana Phipps; input from the VEC Recommendation & Requests subcommittee members; a September 2021 VEC draft white paper by Leslie Garcia; multiple documented resources from committee members; and it leans heavily on a recorded April 2022 National Minority Health Month lecture by Dr. Donn Spight.

GENESIS OF THE VACCINE EQUITY COMMITTEE (VEC)

In February 2021, Dr. John Hunter reached out to Doctors Donn Spight and Derick Du Vivier with a request to co-lead an effort to address inequities in vaccine access. More than 20 OHSU members or affiliates with high levels of expertise in the areas of operations, community relations, vaccine education, culture, communication, and medical specialties joined the committee to devise and support a strategy for improving vaccine equity. Importantly, this capable group represents a cross-section of the larger diverse community. Of the VEC members (see Appendix A), 70% bring perspectives based on lived experience as a member of a racial, ethnic, or linguistic group. Integrating these voices in the initial stages of strategic planning produced an authentic and passionate vision for health equity and culturally-specific outreach efforts.

Executive leaders provided support, influence, and assistance in removing obstacles to success. Providers and leaders across missions joined the OHSU Vaccine Equity Committee (VEC) weekly meetings. In no particular order, the members of the committee include:

Donn Spight	Derick Du Vivier	Abby Tibbs	Kevin O'Boyle	Leslie Garcia
Jenny Lee Berry	John Cockerham	Mariana Phipps	Kat Phillips	Eric Herman
Leda Garside	Michael Harrison	Sulma Flores	Katrina McPherson	Connie Amos
Neil Edillo	Megan Pugmire	Zhenya Abbruzzese	Christopher Evans	Banning Hendriks
Stephanie Shriver	Brian Park	Aluko Hope	Caroline Saxe	Kurt Freeman
Allison Empey	Lisa Huynh	T Timbreza	Apoorva Somayazulu	David Robinson
Robert Trachtenberg	Hayes Bakken			

The operation of the VEC involves focused subcommittees that manage the process from identification of an underserved community to the administration of vaccines to members of that community, including:

- Community Requests and Recommendations
- Communications
- Workforce
- Operations

The subcommittees of the VEC work together on specific community-based efforts to ensure access to vaccines for underserved communities. Strategies are in place to support homebound patients, mobile van events, community-based clinics, and specific group-tailored events.

VEC CHARGE

The charge of the VEC, as outlined in a Vaccine Equity Committee (VEC) document (see Appendix B), defines the purpose, scope, and function of the committee:

> *"OHSU's Vaccine Equity Committee (VEC) provides expertise, outreach, advocacy and action to increase vaccination rates and vaccine education among diverse communities historically underserved within the state of Oregon. To ensure every Oregonian has access to COVID-19 vaccine regardless of race, ethnicity, language, mobility, zip code, education level, occupation, technology access, socioeconomic or immigration status."*

The summarized functions of the VEC charge are:

1. Provide oversight and coordination for external, ad hoc vaccine operations.
2. Guide all vaccine processes for accountability, cultural humility, education, advocacy, and outreach.
3. Be the destination for external requests to OHSU for community-focused vaccination events.
4. Administer vaccine doses from OHSU's OHA allocation within a targeted community-based equity strategy.
5. Maintain a dedicated operational team with assigned support units necessary to execute parallel strategy for:
    1) Homebound patients
    2) Targeted mobile van events
    3) Recurring vaccination events in community locations
    4) Specific group tailored events at OHSU controlled sites
6. Schedule mobile van events within the logistical constraints of existing calendar commitments.
7. Oversee the creation and specific deployment of a racially, ethnically, and linguistically diverse, compensated workforce.
8. Create solutions for identified structural barriers that prevent access to vaccines in underserved communities.
9. Apply for and manage grant funds specifically targeted at underserved groups.
10. Utilize respectful, culturally appropriate and identity-affirming language in all COVID-19-related communications that allows everyone to feel recognized.

Experience and influence enable members of the VEC to remove barriers to progress, allowing quick decision-making and execution within a rapidly changing environment. Expertise and empowerment, combined with a shared passion for equity, helped to create a culturally responsive approach to reaching underserved communities with an opportunity for vaccination.

As vaccine availability changed, the VEC adjusted its strategy and influenced internal stakeholders to reach additional underserved groups, continually modifying it to accommodate changes in COVID-19 health guidelines and vaccine hesitancy within the population.

The successful makeup of the VEC includes:

- Diverse representation
- Multi-disciplinary makeup with expertise in the field
- Passion for equity coupled with experience and expertise in the fields of diversity, equity, and inclusion

- Executive support
- Empowerment to remove internal barriers
- Collaborative and democratic processes

LEADERSHIP SUPPORT

Executive leaders who serve as advisors to the Vaccine Equity Committee (VEC) provided crucial and prominent support throughout the design and implementation of VEC strategies. The tactics used by the VEC to rapidly bring vaccine into communities were unlike standard clinical practice; the trust and support of executive leaders to remove obstacles in this new landscape proved critical to the success of the VEC program.

Examples of leadership insight, guidance, and advocacy to remove barriers include:

- **Escalations to address staffing shortages** and establishing partnerships to recruit advanced providers. This included pushing messaging throughout distribution groups to promote VEC work and generate interest in clinic volunteerism.
- **Ensuring compliance to operational guidelines** and sharing information related to clinical delegation protocols, including standardization, best practices, and compliance.
- **Providing timely access to updates** in a fast-changing environment, including Emergency Use Authorization.
- **Securing extra COVID-19 test kits**, originally not earmarked for community-based care. Executives influenced OHA to allocate test kits for community clinics.
- **Offering funds and financing support** from the OHSU Marketing budget for culture-specific radio advertising to promote education and awareness of clinics occurring in the community.
- **Advocating for safety protocols.** Mobile vaccination sites introduced security risks and safety concerns. Leadership continued to promote the value of community-based clinics and advocate for safety protocols to keep VEC operations running securely.
- **Reducing/revising demographic information.** Oregon state law requires the collection of REALD data (Racial, Ethnic, Language, Disability, and other factors), which includes detailed questions that slow the vaccination registration lines. For efficiency and to help establish and build trust with the community, OHSU leaders advocated to reduce this data down to the minimal amount of information necessary (including country of origin and basic race and ethnicity questions of self-identity).
- **Advocating for continuity and continuation of COVID-19 community clinics**.

Putting trust in VEC strategies that moved definitively away from standard care to an unproven model of community care was a risk for OHSU as an established institution of excellence. Through repeated successes, enabled by the support of executive leadership, the VEC administered thousands of vaccine doses to members of underserved groups, established trusted partnerships with over 150 communities, and secured the position of a trusted partner within Multnomah, Clackamas, and Washington Counties. In doing so, the Vaccine Equity Committee (VEC) also gained and retained the confidence and support of OHSU executive leadership.

ALLOCATING VEC RESOURCES

Advocacy and support from OHSU executive leaders was instrumental in allocating resources for VEC work, including people, vehicles, and call centers.

Staff

Staff was allocated and funded for VEC-specific work. Although initially all VEC members were drawn to the committee in a volunteer capacity, by fall of 2021, three staff (Donn Spight, Kat Phillips, Christopher Evans) were partially allocated to

support VEC direction. A full-time employee (FTE) role was later created for Kat Phillips as Director of Health Operations. VEC members met weekly and included support from executive leaders, providers, and leaders across missions.

Vans

Three mobile health units (vans) were put in place for vaccine distribution. These vehicles, given on grant from Oregon Health Authority (OHA) were outfitted and customized to offer vaccines and other medical supplies to members of underserved communities. Originally to provide COVID-19 testing, the vans' purpose pivoted to vaccine distribution once COVID-19 vaccines became widely available. The vans are now fully owned and operated by OHSU.

COVID-19 Connected Care Center (C4)

The OHSU-sponsored toll-free call line for COVID-19 information and appointments is staffed with nurses and providers who act as a public resource for people seeking information about COVID-19 symptoms, testing, treatment, and vaccination access. The call center was launched in April 2020 with the help of a grant from the Andrew and Corey Morris-Singer Foundation, and with guidance from colleagues across OHSU. Interpretation is available for a number of languages; however, the quantity of calls from Spanish-speaking and Russian-speaking communities led to the development of an IZO-contracted call center to support members of these communities with full in-language experience, without the use of interpreters (see *Communication* section). Leslie Garcia (Cultural Competency & Institutional Responsibility) led this initiative with Jenny Lee Berry (Manager of Community Relations) and solicited the support of Ambulatory Services led by Debbie Lambert. Effort included working with providers to set up the line, train call center staff, provide timely information to the call center in either Spanish or Russian, testing and optimization cycles.

WORKFORCE AND OPERATIONS

The Workforce Subcommittee, managed by Kat Phillips, organizes a strategy for delivering a culturally-specific workforce for each event. In addition to weekly meetings, during periods of high volume, this involves ongoing discussions to specifically recruit workers from a pool of 1400 registered students, employees, and volunteers who identify as racially, linguistically, or culturally diverse, or as an ally to these groups.

Recruiting a Diverse Workforce

Once the leadership of the VEC was established, the VEC broadcasted various Calls to Action in effort to recruit a broader workforce to staff VEC clinics. Messages to the OHSU community specifically invited those individuals who represent culturally, racially, ethnically, and linguistically diverse communities from among OHSU faculty, staff, students, residents, researchers, clinicians, and others. Approximately 1400 employees, students, OHSU volunteers, and faculty answered the call and completed the form to indicate their interest in serving at a vaccination site.

The registration form included fields identifying the volunteer's race, ethnicity, and spoken language. By filtering the database, the VEC could identify and reach out to volunteers to staff specific community-based vaccination sites with workers who align with that community.

In the event of staffing shortages, additional recruitment emails, escalation to executives, or other outreach methods to encourage team members to support the clinic were employed.

It was a goal of the VEC to staff each community event with volunteers who represent the cultural, linguistic, and ethnic makeup of the community. However, it is vital not to overburden individuals who, because of their cultural or ethnic connection to an underserved community, are continuously asked to help solve the disparities of their own community; a burden sometimes referred to as a "race tax" or "minority tax", defined as extra financially uncompensated duties and

responsibilities that minorities are asked to perform to increase diversity at their institutions. To ensure equity, volunteers that staffed the VEC's community clinics were compensated at their base rate of pay, plus overtime when appropriate.

Volunteer Management System

The Smartsheets platform was utilized by means of a Diverse Community Vaccination Site Interest Form to gather personal contact information of volunteers, as well as their language, racial or ethnic identity, clinical and volunteer experience, and availability.

OHSU's Information Technology Group (ITG), specifically T. Timbreza, built Smartsheets and widgets that provide collection, access, and reporting functions for volunteer scheduling at both mass vaccination sites and community clinics. Although not an allocated resource in terms of VEC funding, T. Timbreza became a dedicated internal Smartsheet development and support resource.

Scheduling

When recruited, workers receive access to work shifts at community-based clinics for which they can sign up or cancel, if necessary. An overview of the volunteer schedule for each site is reflected in a Smartsheet accessible to the VEC committee.

Once a volunteer is registered for a shift, they receive an automated email built into the Smartsheet that contains culturally-specific information about the site (such as dress code), as well as logistical information, including where to park, where to check in, who to contact, and how to cancel.

A smartsheet form listing all volunteers by shift is used by VEC clinic staff for on-site registration and check-in of volunteers.

Training

The confirmation email volunteers receive also includes a link to online training for vaccinators and training/tips for CV19 Epic access (electronic medical information system), where each clinic has a unique Epic log in. OHSU was given permission by OHA to certify non-clinical, non-licensed staff to access Epic.

Those volunteers administering vaccines must complete a certification process and vaccinator training. Prior to registering as a vaccine administrator, volunteers must also complete required Compass modules and an in-person assessment to demonstrate competency. This vaccinator training module was created by OHSU Occupational Health though the leadership of Andrea Dayot, Director of Occupational Health. The provisioning of non-clinical OHSU members to administrate vaccines was used for all mass vaccination sites including Portland Airport, Oregon Convention Center, Expo Center, Hillsboro Stadium, and community sites.

On-site training is provided for each event, including a single-sheet cultural information reference and site flow. Once volunteers show up to stations, Medical Assistants (MAs) dedicated as leads provide an overview of the greeting and registration process, including how to input and update patient chart information in the Epic environment.

Compensation

An unclassified compensation model was put in place through HR for all mass and community clinic sites. Medical Assistants (MAs) dedicated as leads at mass and community-based clinics are compensated at a rate that reflects this role.

The VEC arranged for vaccination events to be paid experiences for those who sign up to help. Community clinic volunteers are compensated for their service at their regular OHSU pay rate. The UKG Kronos tool is used for volunteer scheduling and timekeeping, where hourly and salaried volunteers are given instructions on how to remotely sign in or scan their badges to start and end their shifts.

At conclusion of each vaccination clinic, the volunteer roster, including rates and differentials captured in the Smartsheet, is sent to payroll for processing.

Temporary Hires

Pathways to quickly hire external temporary employees were designed with OHSU Human Resources. The Workforce Subcommittee overcame challenges stemming from the slow OHSU hiring process to truncate the background check process and ensure an employee could be hired within the timespan of a week. This allows the VEC to quickly leverage community health care workers for vaccine clinics, even if only used as trusted greeters.

Pharmacy Partners

Pharmacy is an integral partner to the VEC clinics and works with the VEC to flex and meet demands. In addition to greeters, registration volunteers, and medical staff, a pharmacist is on site at all VEC community clinics. Although medical assistants (MAs) can be trained to draw up doses of COVID-19 vaccine, due to the newness of the vaccine and frequent changes related to dose amounts, it is best practice to employ pharmacists for this task. Neil Edillo served as the Pharmacy Lead for the VEC.

Flexibility within the process allows for MAs to courier vaccines from the OHSU pharmacy to VEC clinic sites. In driving the mobile health van, MAs can transport pharmacy supplies through the scope of their license and certification. Processes put in place by the VEC allow the MAs to convene at the OHSU campus, pick up supplies allocated for the VEC, put them in the van, and drive them to the clinic site. At the conclusion of the event, the pharmacist on site accounts for any leftover supplies, and the MAs courier the doses back to OHSU.

CULTURAL HUMILITY AS A FOUNDATION

Recognition and respect for culture are central to the work of the Vaccine Equity Committee (VEC). For every outreach project, this is carried authentically into planning through the lived experience of VEC members, as well as through acknowledgment of unconscious bias and practice of cultural humility. This way of interacting with other VEC members, and in outreach to a community, is the strength and resulting success of the VEC.

The basis of cultural humility is to enter an interaction by recognizing one is there to learn, regardless of what one may already feel one knows about the culture. Remove assumptions, withhold judgment, keep an open mind and an open expression. Cultural Humility is put into practice by humbly exercising the "5 R's":

- Reflection
- Respect
- Regard
- Relevance
- Resilience

Source: Leslie Garcia, Associate Dean of Diversity and Inclusion, School of Medicine, Unconscious Bias and Cultural Humility. Adapted from the work of Dr. Ansari, Loyola University Medical Center

Training in the concepts of unconscious bias and cultural humility heightens awareness to create culturally-sensitive interactions. At the vaccine site, one-page information sheets for OHSU workers and volunteers provide a ready resource, so that those who are the first interaction with community members (welcoming, directing to parking, registering) are following a template to apply cultural humility in every interaction. Clinical staff and community navigators also received cultural training provided by Leslie Garcia.

With cultural humility as a foundation, collaboration within the VEC and careful consulting with representatives of the communities it serves builds specialized awareness. The resulting partnerships with underserved communities (approximately 150 VEC vaccine clinics in the first 14 months of operation) and the growing trust communities began to have in OHSU, speak to the effectiveness of this culturally-centered strategy.

Leslie Garcia and Jenny Lee Berry implemented many clinical changes to ensure each space was culturally competent from language, signage, communication, customer service, and other elements to ensure the VEC offered a bilingual, bicultural, and culturally humble environment. Led by Leslie Garcia, cultural humility was the cornerstone of the work the team conducted prior to opening a community clinic. To meet the needs of a specific community, each clinic looked different depending on the group it was designed to serve.

COMMUNITY ENGAGEMENT

Defining Communities

To define targeted communities, the VEC utilizes Area Deprivation Index datasets, Medicaid population and disparity metrics, and Oregon Health Authority (OHA) state and county data to highlight low-vaccination zip codes. This data, combined with known historical inequities within the health care system, and the combined lived experience of VEC members, guide the committee to areas of greatest need.

Non-cultural considerations for moving forward with a location include:

- Does the community partner have good outreach mechanisms to ensure its members are aware of the vaccine opportunity?
- Are there other vaccine options or outlets in the vicinity that could introduce redundancy and diminish turnout?

In the beginning phases of vaccine rollout, the VEC initiated contact with communities in need of vaccine. Through the work of the VEC, OHSU's reputation grew in underserved communities to that of a trusted partner. This resulted in a shift from a push strategy to a pull operation, where community-based organizations self-identify and reach out to OHSU to request vaccine services through a Community Request Form Smartsheet.

Weekly meetings of the VEC Recommendations & Requests Subcommittee, chaired by Jenny Lee Berry, serve as a forum to review, discuss, and vote on community-based clinic requests. This racially, ethnically, and linguistically diverse group deliberates and approves clinics within a collaborative and democratic process guided by data, lived experience, and the assessed potential to reach a meaningful number of prospective patients.

The community-based vaccine clinic request process of obtaining, viewing, reviewing, assessing, and dispositioning vaccine clinic requests is managed by through Smartsheets. Dashboard filters allow the committee to isolate new requests, and views allow customized displays by category or calendar.

As part of community outreach efforts led by Jenny Lee Berry, Community COVID Information Communication was provided via email to current or prospective community-based organization partners with a frequency of 1-2 times per week. The messages contain current vaccine distribution status and a curated list of news and information.

Establishing Trust

Once a community group is identified as needing support, the VEC works to establish a partnership of trust between OHSU and the identified community. Difficulty with access to transportation may exist for individuals within an underserved group, as well as reluctancy to travel to unknown locations. Due to experiencing discrimination within the system, individuals in underserved communities may experience hesitancy, or even fear, when faced with the need for health care. Insurance may also limit individuals' confidence if they perceive that it is required to access services. Additionally, language can be a barrier if interpretation or bilingual services are not provided.

It is the mission of the VEC to ensure that members of a community not only have comfortable physical and linguistic access to the vaccination site, but that they have trust and confidence in its purpose. This involves looking at non-traditional health settings that may yield a higher level of familiarity and reassurance, such as schools, churches or temples, markets, and community centers. It includes removing barriers to access, including physical barriers, such as ensuring access to those with mobility challenges, and providing non-standard hours of operation; and eliminating barriers that might induce trauma, such as removing solicitation of social security numbers and citizenship papers, police presence, or requesting Army National Guard members work outside of uniform. Clear and precise communication of clinic location in the spoken language also removes a common barrier to access.

Canvassing, outreach, and site visits to form a relationship, answer questions, and establish trust with a targeted community are critical to identifying and forming a plan to remove or overcome obstacles. These efforts can flush out additional barriers to vaccine access including computer and mobile literacy and Wi-Fi access, language and translation needs, lack of (or hesitation to present) personal identification, as well as the influence of vaccine misinformation.

The outcome of this partnership is a pathway toward reaching the community in the most effective and efficient way possible with culturally-centered activities around education, advocacy, and outreach. The experience and empowerment of the VEC members enable quick decision-making and execution of strategy within a rapidly changing environment.

Although many relationships with communities the VEC served were preexisting through the personal, professional, and cultural connections of its members, the VEC emphasized practices to build trust, including:

- Meeting with community leaders to establish a relationship.
- Identifying causes of hesitancy in the community or among its individual members.
- Implementing various forms of communication and outreach.
- Providing translation and use culturally-appropriate language.
- Removing obstacles to increase awareness and attendance.
- Ensuring volunteers and providers reflect and/or are part of the communities.
- Creating a welcoming environment.

Beyond providing the service of vaccine distribution, the VEC builds trust through a genuine partnership with the community. As an example, when possible, the VEC sources food from local community establishments to feed OHSU workers and volunteers, allowing OHSU to not only bring COVID-19 vaccines to the community but to also inject funds into the local economy.

OUTREACH AND PARTNERSHIPS

Collaboration with Health Systems and Local Government

OHSU was a key partner to local government, providing vaccine delivery services for Oregon Health Authority (OHA) and county health departments, specifically Multnomah, Washington, and Clackamas. Michael Harrison served as the lead for Government Relations on the VEC.

The shared goal of vaccinating as many people as possible brought new levels of collaboration for community relations. In addition to partnering with local government and leaders of underserved communities, OHSU worked side-by-side with Kaiser Permanente, Legacy Health, and Providence healthcare systems as part of the All4Oregon collaboration to coordinate vaccine supply and other resources. Regular meetings served as forums to share information and foster collaboration, thereby reducing duplication of effort and increasing the combined reach of vaccination efforts.

Canvassing

As vaccine interest began to decline in spring 2021, the Vaccine Equity Committee (VEC) emphasized canvassing efforts as a way of reaching members of specific communities. To staff a vaccination clinic, it is important to generate enough patient interest to justify the time, effort, and expense of hosting an event. Once a clinic site was identified, OHSU's VEC members and volunteers walked the streets surrounding the venue one to two days prior, posting flyers in businesses and talking to the general public and local businesses to inform potential patients of the upcoming clinic.

When available, it was possible to engage people in conversation by offering a COVID-19 test kit, which may open an avenue to share about the upcoming vaccination opportunity. The goal is to communicate science-based information in a way that will reach members of the community, while informing members that there will be doctors and medical providers on site to answer their questions. Aligning canvassing efforts with community events, such as food box distribution at a nearby school, is a way to

reach a larger concentration of potential patients. In many cases, these opportunities happened by chance and through intuition.

In the beginning of the canvassing effort, VEC members generated flyers from home printers or ordered prints from local suppliers. VEC members Leslie Garcia, Jenny Lee Berry, Mariana Phipps, and other volunteers took to the streets in pairs to personally contact as many members of the community as possible. It was a meaningful, but unsustainable effort. After various regional meetings with other health systems and county colleagues, OHA hired a team through New Grounds Strategies to continue the canvassing effort on a larger scale.

Incentives

During periods of waning vaccine interest, and in areas of vaccine hesitancy, the VEC joined incentive efforts by offering food boxes, library books, Portland Blazers swag, or grocery gift cards to patients receiving COVID-19 vaccine. In many cases, this additional support helped solidify a strong partnership with the community. It also highlighted the risks of injecting monetary incentives into areas of socioeconomic need. Some patients were willing to put their own health at risk by furtively subjecting themselves to multiple doses of vaccine, solely to obtain multiple $100 grocery gift cards. In their pursuit of gift cards, or when confronted about their attempt to obtain multiple cards, patients became verbally abusive and potentially dangerous to OHSU staff and volunteers.

Learnings regarding the use of monetary incentives:

- Can distract from the goal of safe distribution of vaccine
- May produce unwanted or dangerous situations
- Should be used sparingly or without promotion
- Could convey the wrong message of “paying to get vaccinated”

Transportation

Lyft transportation network provided $3000 worth of $50 ride credits over four non-consecutive quarters to assist community members in getting to vaccination sites. This generous grant was not fully utilized prior to community health navigators coming on board since the VEC didn’t have a mechanism to allocate the credits in a meaningful way. Before the community health navigator team was employed, the Lyft credits were given to the C4 line as a best way to reach individuals who may benefit from transportation to their vaccination appointment.

STRATEGY AND TACTICS FOR SPECIFIC POPULATIONS

Once an underserved community is identified, efforts are made to understand specific needs of the group. Members of the Request and Recommendation Subcommittee reach out to community leaders requesting information about its population. This information is used to provide community resources, linguistic support, and a community-centered environment for the vaccination clinic.

In specific groups, such as the houseless and justice-involved communities, concerted effort is necessary to identify and reach patients in these environments. In all cases, community engagement efforts included specific tactics to effectively and respectfully reach specific populations and to tailor an approach that meets the needs of each community.

Black and African American Communities

One of the first underserved populations that emerged from review of Oregon mass vaccination site data was that of the Black and African-American community, which helped trigger the community-based response of the Vaccine Equity Committee (VEC).

In partnership with the Black and African American community, OHSU VEC members Kat Phillips and Donn Spight participate in the Black COVID-19 Strategy Meeting, convening every 3rd Wednesday of the month. This meeting is a listening session of community-based Black and African American leaders, including participation from Oregon Health Authority (OHA), Oregon counties, and health system partners. The meeting serves as a forum to discuss happenings within the Black and African American community and to identify specific zip codes that are lagging behind in vaccination rates. From this data, OHSU VEC can identify specific areas to target with community-based outreach and vaccination clinics.

Strategies used to reach the Black and African American communities include placement of Black physicians and medical professionals into trusted community centers with the goal of dispelling myths and conspiracy theories, and to provide straight-forward information to community members.

To initiate its relationship with the Black and African American community, respected OHSU VEC members, Dr. Evans and Dr. Spight delivered messages to the congregation of Emmanuel Temple Full Gospel Pentecostal Church, a predominantly Black and African American Christian community. This outreach resulted in the vaccination of approximately 1100 patients and served as the catalyst for OHSU's relationship with the Black community.

When staffing vaccine clinics, the VEC took efforts to ensure its workers reflect the community they are serving. Placing Black and African American medical teams or physician leads on site serves to build trust with the community, which helps build momentum toward reaching additional Black and African American communities.

Slavic and Russian-Speaking Communities.

Representing one of the largest minority groups in Oregon, the Slavic community, despite being largely white, suffers from health disparities often seen in non-white ethnic communities. Chronic vaccine hesitancy, including seasonal flu and standard childhood vaccines, contribute to the low COVID-19 vaccination rate.

To reach this community, the VEC enlisted Russian-speaking physicians in the Portland area to engage with faith leaders in hosting community-centered education events. Drawing on this community's respect for OHSU as a healthcare provider of excellence, the VEC engaged with faith leaders and members of the congregation to hold conversations in culturally-specific settings. Rather than access to vaccine clinics, the focus was on overcoming vaccine hesitancy in the community.

OHSU's VEC submitted a specific Slavic community engagement proposal (prepared by Dr. Donn Spight of OHSU and Zhenya Abbruzzese of Adventist Health Portland) and request for OHA funding. The resulting grant was tied to Slavic health outreach, including a media campaign through Russian-speaking radio that was led by Zhenya Abbruzzese.

Specific steps to reach this community included engagement with the community to establish trust; conducting listening sessions for the purpose of creating culturally-specific content; partnering with Russian-speaking clinicians, who members of the community inherently trust over "American" doctors; engaging with Adventist Health's Slavic Navigation program, which was designed to address the Portland Slavic population; partnering with the Slavic Community Center NW; and finally, leveraging OHSU's respected reputation for excellence.

A Russian-speaking call center to provide COVID-19 information and vaccine scheduling assistance was put into place through a contract with IZO System in September of 2021.

Spanish-Speaking Communities

One of the largest communities the VEC was able to reach with its efforts was that of the Spanish-speaking community, which includes diverse groups across indigenous peoples, farm workers, front-line workers, undocumented families, and others. Oregon Health Authority (OHA) budgeted for a media campaign to support Spanish-speaking audiences through video and social media. In early 2022, OHSU proposed internally to create a radio campaign led by Leslie Garcia, Mariana Phipps, and Leda Garside, to fill in where OHA's strategy was not covering. The VEC's radio campaign aired ads to promote OHSU clinics on stations with predominantly Spanish-speaking audiences.

Community engagement efforts resulted in clinics that were designed to meet the needs of the community, including non-standard hours of operation, accommodations for children and families, elimination of many personal identification requirements, and positioning Spanish-speaking volunteers throughout the vaccine clinic. Vaccine information sessions were conducted in Spanish for community forums, schools, and other centers.

A Spanish-speaking call center to provide COVID-19 information and vaccine scheduling assistance was put into place through a contract with IZO System in September of 2021 to increase direct service for individuals who don't have a computer, Wi-Fi, or who cannot access a computer during the workday.

LGBTQIA+ Community

All VEC clinics are led with cultural humility, with special care for communities who have low trust in the health care system due to experienced trauma. In initial phases of community-based work, the VEC assisted Quest Center for Integrative Health to work with LGBTQIA+ communities, then provided clinics in working partnership with the Clackamas, Multnomah, and Washington Counties. In addition, the OHSU Partnership Project works with HIV/AIDS patients, as well as trans, and LGBTQIA+ communities, whose members may experience challenges in navigating the health care system.

Through training, VEC leaders ensured that employees and volunteers staffed at LGBTQIA+ clinics were culturally aligned to the sensitivities of the community to avoid asking gender-based questions that may induce or revive distress.

In supporting the Sweethearts of Portland trans and drag community, the VEC provided a daytime vaccine clinic in a popular venue outside of business hours. The Sweethearts of Portland leaders produced their own flyer and OHSU VEC provided vaccination services for community members who were willing to receive COVID-19 vaccine.

Patients with Disabilities

Completing clinic site consultations served to identify limitations of the site and ensure accessibility. VEC member Dr. Kurt Freeman provided accessibility training to VEC staff and volunteers and supplied language throughout VEC's communication strategies to ensure wording was inclusive of patients with disabilities.

Homebound and Medicaid Patients

Homebound patients have mobility limitations that make it difficult or impossible to reach a vaccination site. The VEC included in its scope the identification of OHSU patients who fall in this category. Dr. Brian Park worked with data analysts to obtain patient panels. Once homebound patients were identified, Connie Amos established connections with OHSU

partners, Hillsboro Medical and Adventist Health, to provide home health services where medical staff is sent to the home to vaccinate the patient and other members of the household.

VEC's role was to identify the names of patients and reach out to obtain the patient's agreement for vaccination. Since OHSU doesn't currently run a homebound program, services were provided through vendors of existing programs at OHSU's partners: Adventist Health, Hillsboro Medical, and Signature (a vendor that provides nurses to vaccinate the homebound).

Medicaid patients were also within the scope of the VEC and were identified by Dr. Katrina McPherson. Outreach efforts were put in place to connect with Medicaid patients to ensure they are scheduled for vaccination.

Houseless Patients

OHSU followed Multnomah County's approach to reaching houseless patients and contributed employee volunteers to help staff Multnomah County-organized outreach events for houseless communities. OHSU-led events included the OHSU Health Equity Fair (led by OHSU students), Parkrose Marketplace clinic, and clinics at the Mead building in Old Town (a Multnomah County facility).

Walk-in clinics and mobile health units served as the most effective way to reach houseless patients. Student-run non-profit Bridges Collaborative Care Clinic (BCCC), which includes OHSU medical students, worked to serve the houseless community through on-foot mobile vaccination support. VEC clinic volunteers could sign up to support these opportunities to assist the Multnomah County outreach team and BCCC for encampment and shelter vaccination events.

Justice-Involved Patients

The congregate setting of jails, combined with the medical resources of the county, allowed for quick vaccination of individuals who were incarcerated. However, those who were leaving the incarceration system were at risk of falling through the cracks. The OHSU Vaccine Equity Committee (VEC), in partnership with the Joint Office of Homeless Service and Multnomah County Corrections Health, set up a second-dose vaccination event on July 29, 2021 for justice-involved individuals who had received their first COVID-19 vaccine while they were in custody. At this, and a series of clinics in partnership with Multnomah County, OHSU's VEC provided first and second dose COVID-19 vaccines, vaccinators, a medical lead, and a pharmacist. The Multnomah County Mead building (a parole check-in site) was the location for the clinics and provides multiple services to houseless populations in Old Town within downtown Portland.

Although the primary purpose of these clinics was to vaccinate justice-involved patients, Multnomah County also took the opportunity to offer tents, sleeping bags, socks, water, and snacks to those in the justice-involved and houseless communities who could benefit from these items.

Drawing justice-involved patients to these clinics required significant canvassing and outreach. In many cases, volunteers were on the streets, sharing information about the clinic, and even walking patients to the Mead building or mobile clinic site to receive their vaccines. This level of outreach and support was effective in reaching patients outside of the health care system who may not have otherwise completed their vaccination series.

CULTURALLY-SPECIFIC LANGUAGE

The VEC produces multicultural communication to inform and invite racial, ethnic, and other underserved communities. Selecting the appropriate language involves carefully choosing the right words to clearly convey information, increase inclusivity, and convey respect. It may also involve translating materials into a specific dialect to meet the needs of a cultural or linguistic group.

Language

Language includes regional, cultural, or ethnic linguistics, as well as careful word choice. It incorporates the thoughtful art of using appropriate and respectful phrasing, in any language.

The VEC follows the Associate Press (AP) Style Guide (using capitalization of Black and Indigenous in a racial, ethnic, or cultural sense) and the OHSU Inclusive Language Guide in its communication.

> "The OHSU Inclusive Language Guide is intended as an evolving tool to help OHSU members learn about and use inclusive language in institutional communications, patient care, instruction and presentation around descriptors of:
>
> - Race and ethnicity
> - Immigration status
> - Gender and sexual orientation
> - Ability (including physical, mental and chronological attributes)"
>
> Source: OHSU Inclusive Language Guide (Feb 2021) co-created by Leslie Garcia and committee
> https://o2.ohsu.edu/diversity-and-inclusion/upload/OHSU-Inclusive-Language-Guide.pdf

Examples of inclusive language include the use of specific descriptors, such as "Spanish-speaking" or "Black and African American" to address these groups rather than more general terms such as Latinx or BIPOC, with which many individuals in these groups do not identify, and that can produce a feeling of being "other".

When addressing individuals, VEC members and volunteers avoid using the word "preferred" if inquiring of a patient's name or pronouns; instead, asking "What name do you use?" and "What pronouns do you use?" This practice reduces the risk of harming an individual through assumptions about gender, or by inadvertently deadnaming a member of the trans community.

The use of culturally-centered language extends beyond translation; it is a manner of consciously employing the practice of cultural humility to respectfully address an individual or a community.

Translation

Effective communication to non-English-speaking communities involves translating materials into the native language of the underserved group. Explorative site visits with community partners help define the need for translated communication. OHSU Language Services provides translation for VEC materials, where requests are submitted to Language Services via email, and turnaround time can vary from a few days to weeks. When possible, VEC members with proficiency in the translated language check translated materials for clarity and accuracy of language and of message.

The OHSU Language Services timeline doesn't always meet pace with the deployment of VEC clinics. In some cases, the rapidly changing environment and speed with which it was necessary to create and distribute materials resulted in the VEC assuming responsibility for immediate translation. Multi-lingual members of the VEC have been instrumental in providing emergency translation and verifying the accuracy of translated materials.

Despite best efforts, translation miscalculations occasionally introduce confusion. For example, a clinic that does not require an appointment for service may be referred to in American English as a 'walk-in clinic'; however, Spanish-translated material identified it as a 'walking clinic', implying one that moves around a neighborhood. Stickers, erroneously translated and given to Tagalog-speaking vaccine recipients, confusingly proclaimed "I got COVID-19!" rather than "I received a COVID-19 vaccine".

There is no clear process for translation feedback. Sometimes there is an opportunity to identify an error and change the language before communication materials are circulated, broadcasted, or posted in the community; sometimes there is not. When there is no VEC member fluent in the language of a community partner, the VEC relies on relationships within the community to check translated materials. This comes with a level of risk, as it is difficult to assess the level of expertise that an individual reviewing the material has with the written language.

Based on translation outcomes and experience in the field, the VEC provides feedback to OHSU Language Services; however, due to the use of different linguists, the message doesn't always reach the intended recipient. Inconsistencies remain related to regionalisms (for example South American versus Central and North American Spanish) and within a language (toggling between the use of 'el Covid' and 'la Covid').

Because verbal interactions are essential to establishing a trusted relationship with a partner community, forming a workforce of multi-lingual speakers is both advantageous and necessary. Informal, unstructured interaction with clients in their own language puts individuals at ease. In situations involving phone calls and virtual or face-to-face discussions, placing fluent speakers in positions that interact with non-English speaking members of the partner community reduces confusion and increases patient confidence.

Learnings:

- Include multi-lingual speakers when designing teams.
- Ensure mechanisms for rapid development and checking of translated materials.
- Develop a language access plan and a translation style guide to ensure consistency in translation.
- Improve feedback mechanisms for translated materials.

Informational Materials

To ensure it could move with speed and match communication to the community, the VEC assumed the responsibility of creating non-marketed communication materials in collaboration with the communities they were serving. Committee members work closely with specific organizations or community leaders to identify the target audience and the need for translation and specialized language. Flyers were created for the community that specified clinic dates, times, and information relevant to the clinic and to community members, such as the availability of childcare or that identification was not required.

VEC communication materials assure the target group that a vaccine event is specifically designed for them. Radio announcements, flyers, signs, call center scripts, and posters are examples of effective and culturally-specific communication. These specially-targeted materials state accessibility status, available translation or interpretation services, and they identify accommodations for children and families. Communication also emphasizes that COVID-19 is completely safe and free to all, regardless of health insurance or residency status. Signage and communication clearly identify that the site is accessible to those with mobility challenges, that families are welcome, and that no proof of citizenship or immigration status is required. Simple and direct confidence-building statements such as "No social security number required", "No ID required", "No medical insurance required", and specific vaccine brand information and dose timelines are helpful in instilling confidence.

Communication materials that reflect the community both visually and in language help OHSU connect with a community more effectively. For example, if reaching an Asian community, images in VEC vaccine clinic flyers depict multi-generational Asian

families. Although OHSU Marketing stock images can be employed, the pace of creating and updating community-specific materials is often beyond the limitations of OHSU Marketing.

The VEC works with partner communities to create brochures and other informational materials with info and pictures that market the clinic directly to the targeted population, sometimes updating flyers on the day of the clinic. When difficulties finding a photo arise, the community partner can sometimes provide a useful picture. In other cases, illustrations are used.

Due to the effectiveness and reach of broadcast media, the VEC has increased outreach on radio, especially in Spanish-speaking stations. This paid media reaches members of the community in their homes, cars, or workplaces without the need for computer or television news access.

Communication materials are specific, informative, and culturally-sensitive, including elements such as:

- Translation or interpretation services available on site
- Vaccine types (Johnson & Johnson, Moderna, Pfizer) and related dose timelines and ages
- COVID-19 vaccines are free
- No proof of social security number or citizenship required, No ID required, No medical insurance required
- Children and families are welcome
- Accessibility for varied mobility approaches
- Images that reflect the community

Overcoming Resistance

Through its communication with community partners, the VEC continuously works to overcome hesitation related to institutionalized health care.

Members of linguistic or ethnic communities may follow news sources and perspectives of their home country or absorb vaccine misinformation from various sources that lead to vaccine hesitancy. In some communities, cultural practices (such as gathering around the dying) are still being carried out, contributing to the spread. In these cases, the VEC draws on its own members who can provide insight into the cultural practices of a community they identify with, and it partners with different groups who serve those communities to provide messaging.

VEC marketing materials address frequently asked questions related to COVID-19 vaccine and also provide information related to keeping families safe and healthy. Many underserved groups are in multi-generational family environments. The roll-out of age-banded vaccine availability left seniors vaccinated, while children and young adults were not. With many adults working out of the home, this created risk within the household. In addition to the message of “Get Vaccinated”, marketing communication includes messaging on the importance of wearing a mask, immediately seeking advice for symptoms, and getting tested for the virus. This information in flyers and in clinics is translated into many languages for consistency of messaging to different communities.

Additionally, the VEC revised the minimum patient data collection in the EHR (electronic health record) to prevent trauma for communities such as LGBTQIA+ and to improve check-in efficiency at walk-in clinics.

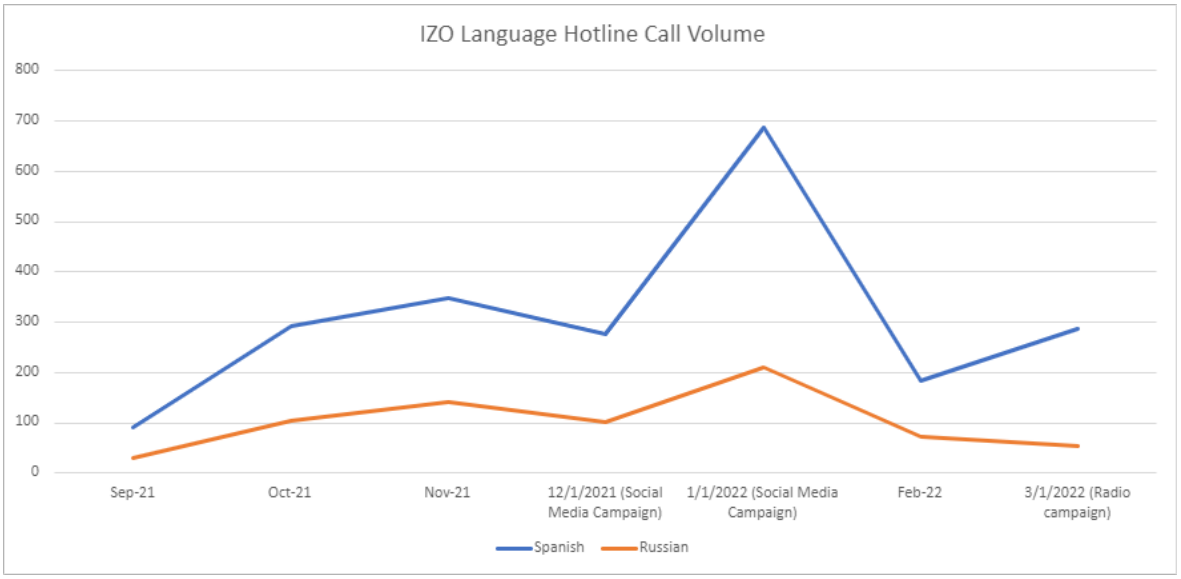
Within this culturally sensitive context, the VEC creates communication materials specific for each vaccine event that are culturally specific and that meet the individual needs of each community.

Call Center Support for Spanish and Russian Speakers

In addition to the OHSU-sponsored C4 line, supplementary call center support was established to provide Spanish and Russian-speaking communities with COVID-19 testing and vaccine information, as well as vaccine scheduling assistance. IZO System, a specialized consultancy that includes call centers in its areas of specialty, was contracted to provide OHSU with call center support with a goal of increasing COVID-19 vaccination and testing rates among Oregon Spanish-speaking and Russian-speaking populations. OHSU created an easily navigatable website and scheduling process and staffed contacts to support the OHSU-IZO relationship. Leslie Garcia, Jenny Lee Barry, Debbie Lambert and team trained call center staff and monitored the services.

IZO provided phone support and text messaging as effective tools to communicate with Spanish-speaking and Russian communities. Call center hours were determined based on time schedules convenient for the community, including weekends.

Over a period from Sept 2021 – March 2022, IZO received 2164 Spanish-speaking calls, and 718 calls to its Russian-speaking lines, and vaccination rates in these communities increased by 5%.



Source: IZO Hotline Call Volume, OHSU ITG Sharepoint

Appointment Scheduling

To ensure vaccine appointments are available to underserved communities, it is standard practice to allocate a percentage of appointments (sometimes referred to as “community slots”) for community-based appointments and clinics. These appointments do not appear as available on the main public online scheduling pages, but are held for the C4 call center, VEC scheduling page, and IZO Spanish and Russian language hotlines. If not scheduled 1-2 days prior to the event, the unused reserved appointments can be released back to public access.

The patient’s personal information required for online and walk-in appointment scheduling has also been minimized to increase efficiency and to reduce the distress for certain populations.

Funding for the scheduling work of community partners is on a case-by-case basis. In the initial phases of vaccine rollout, the only path to vaccination was through a web-based reservation system. Underserved groups commonly lack access to computers or adequate Internet service. Vaccine appointments were in such high demand, that they disappeared almost immediately after becoming available. Additionally, registration is available only in English, which further prevented access for these groups. During this time, the VEC paid a stipend to select community partners for the work of registering its own members for vaccine doses. This occurred early in the VEC phases before Spanish-speaking and Russian-speaking telephone registration lines and increased availability of vaccines were in place. The decision to fund community-based partners was evaluated individually rather than uniformly across all communities.

COMMUNICATION

Communication plans addressing both internal and external communication from the VEC were outlined in 2021 and 2022. Strategy, goals, and tactics, overseen by VEC Communications Lead, Mariana Phipps, served to regularly inform the public and recruit OHSU members and partners to support the VEC's mission and vaccination efforts.

OHSU Internal Communication

Internal communication is designed to reach all OHSU members, including providers of care, those who have expressed interest in volunteering with the VEC, and clinical staff with culturally-specific connections.

Internal channels include:

- targeted emails,
- inclusion of VEC call to actions in messages from OHSU leaders,
- postings on OHSU's intranet (O_2),
- OHSU Now stories,
- unit-specific channels such as Inside SoM and other unit-based e-newsletters, and
- emails as needed.

The purpose of the communication is to recruit a workforce to staff ongoing VEC clinics, to share information and successes with the OHSU community, and to model community-based vaccination efforts.

External Communication

External communication strategies are in place to share vaccine education with patients, health system partners, community leaders, media outlets and journalists, and a culturally-targeted public.

Additional external channels include:

- patient communications,
- postings on the OHSU website,
- OHSU social media,
- articles in OHSU News,
- earned media opportunities,
- radio and other media advertising,

- IZO Spanish and Russian-speaking call center lines, and
- articles, videos, and social media posts developed in collaboration with community partners.

The objective of the VEC's external communication is to provide information and education to the communities it serves, to support partners in the execution of COVID-19 campaigns, to promote vaccine clinics, and to demonstrate OHSU's commitment to population health.

FUNDING

Funding for vaccine equity efforts has been attained through FEMA, American Recovery Act, and grants specifically targeted for underserved groups Supplies such as vaccine doses are provided by the Oregon Health Authority's allocation to OHSU.

A generous 2021 grant from Cambia Health Foundation allowed OHSU's VEC to serve community groups with mobile vaccine clinics and helped to overcome barriers such as transportation, translation, navigation, as well as providing funding for volunteer time.

This partnership continued in 2022 with a second Cambia Health Foundation grant supporting pediatric and family-focused clinics, education and outreach, community-based organization partnerships, and development of materials addressing Long COVID.

Oregon Health Authority (OHA) Grants

- Slavic Population Outreach – Aug 2021

Cambia Health Foundation Grants

- #1 (2021)
- #2 (2022)

Lyft Grant

- $3000 worth of $50 ride credits over four non-consecutive quarters 2021-2022

Expanding Funding Beyond COVID-19

Initially, the VEC was solely focused on COVID-19 vaccine distribution, which was supported by federal funding. As OHSU looks to expand the work of the VEC into other health-related efforts, a pathway for funding becomes necessary. It is the VEC's recommendation that any mass health outreach effort be in partnership with localized, culturally-centered clinics. The value of this equity work must be recognized and funded by the institution to ensure ongoing success.

LOOKING TO THE FUTURE: EXPANDING VACCINE EQUITY TO HEALTH EQUITY

The acknowledgment of vaccine deserts within COVID-19 inoculation data presented an opportunity to act. It was an opening for change: To redefine strategy and create a focused, targeted, and culturally-sensitive effort, in parallel to the mass vaccination model, that directly and sensitively meets the needs of underserved communities.

Since March 2021, the Vaccine Equity Committee (VEC) has delivered over 15,000 COVID-19 vaccines. The initial phases of VEC clinic implementations provided opportunities to revise and expand the strategy to more effectively partner with underserved communities (see Appendix C). Efforts in vaccine distribution by the VEC are only the beginning of a journey towards health equity practice at OHSU.

As pandemic priorities shift, OHSU mobile and the VEC can transition and expand work from COVID-19 testing and vaccination to include other OHSU health screenings and services. This shift also presents an opportunity to transfer the knowledge and best practices of the Vaccine Equity Committee (VEC) toward a broader mission of health equity.

The culturally-sensitive strategies implemented through the VEC are transferrable to broader sections of health care to further overcome health inequities in underrepresented communities. By acknowledging and reconciling historical harm, it is possible to develop a long-term strategy to foster trust, reconciliation, and partnership with diverse communities.

The efforts of the VEC have established relationships with OHSU in communities where relationships had been non-existent or worse. Over the course of the last year, thousands of new medical record numbers have been generated through engagement with communities previously untouched by OHSU.

The initial formation of the VEC was largely volunteer-based, where members contributed to designing culturally-specific vaccine outreach in addition to their traditional roles at OHSU. Job tasks in some positions were slimmed down or reallocated, but VEC members were working at maximum capacity to carry the shared passion for vaccine equity into practice while sustaining their daily jobs. The demanding pace of the initial phases has taxed the VEC workforce.

The sustainable future of the VEC and its transition to a Health Equity Organization within the health system will depend initially on internal funding from OHSU. It will need to transition from a volunteer model to a compensated workforce model, where VEC members who work at the desk or in the field are rewarded at the same pay rate as individual members' conventional job roles. The compensated workforce model includes OHSU members and expands to include community members as workforce needs are identified. In the future, philanthropic support, grants, and fee-based services will create a broader model for financial sustainability in addition to direct funding from OHSU Healthcare.

Specific funding for broader health equity efforts is recommended for positions within the areas of:

- Leadership
- Operations
- Community Outreach & Navigation
- Clinical

By investing in staffing and resources to create partnerships outside of the pandemic setting, OHSU can be positioned to address the next health crisis, or simply be equipped to improve the lives and health of underserved communities in stable times. In this way, OHSU can ensure the enduring legacy of health equity, continue overcoming the perception of elitism, and further establish itself as an anti-racist institution.

ACKNOWLEDGEMENTS

Special thanks to Leslie Garcia, Donn Spight, Kat Philips, Jenny Lee Berry, Mariana Phipps, and members of the VEC Requests and Recommendations committee for their time and input into the content of this paper.

RESOURCES

Covid19 Community Vaccination: An OHSU Down Payment on Health Equity; National Minority Health Month Lecture, OHSU; Donn Spight, MD, FACS, FASMBS; April 29, 2022 Recorded Presentation.

Practicing Cultural Humility, training presentation, January 2022
Leslie D Garcia, MPA, Assistant Dean for DEI, SoM Dean's Office, OHSU. Some elements adapted from the work of Dr. Ansari, Loyola University Medical Center.

VEC Whitepaper Draft ("Applying Key Learnings from Initial VEC Partnerships"), Leslie Garcia, September 2021. Used in entirety.

OHSU Inclusive Language Guide, Leslie Garcia

OHSU Language Services

Community COVID-19 Vaccination Event Request

Vaccines for Houseless, Oregon Public Broadcasting, April 5, 2021

Justice-Involved Individuals Receive COVID-19 Vaccine – OHSU Now

Oregon Health Authority, Office of Equity and Inclusion

IZO Spanish and Russian Call Center Summary

Applause for the Covengers at OHSU (C4) – OHSU Now, March 18, 2022

VEC Recommendations & Requests Subcommittee Meeting, May 12, 2022. Attendees: Jenny Lee Berry, Kat Philips, Theo Latta, Brian FM Park, Sulma Flores, Stephani Shriver, Mariana Phipps, Donn Spight, Katrina McPherson, Michael Harrison, Zhenya Abbruzzese.

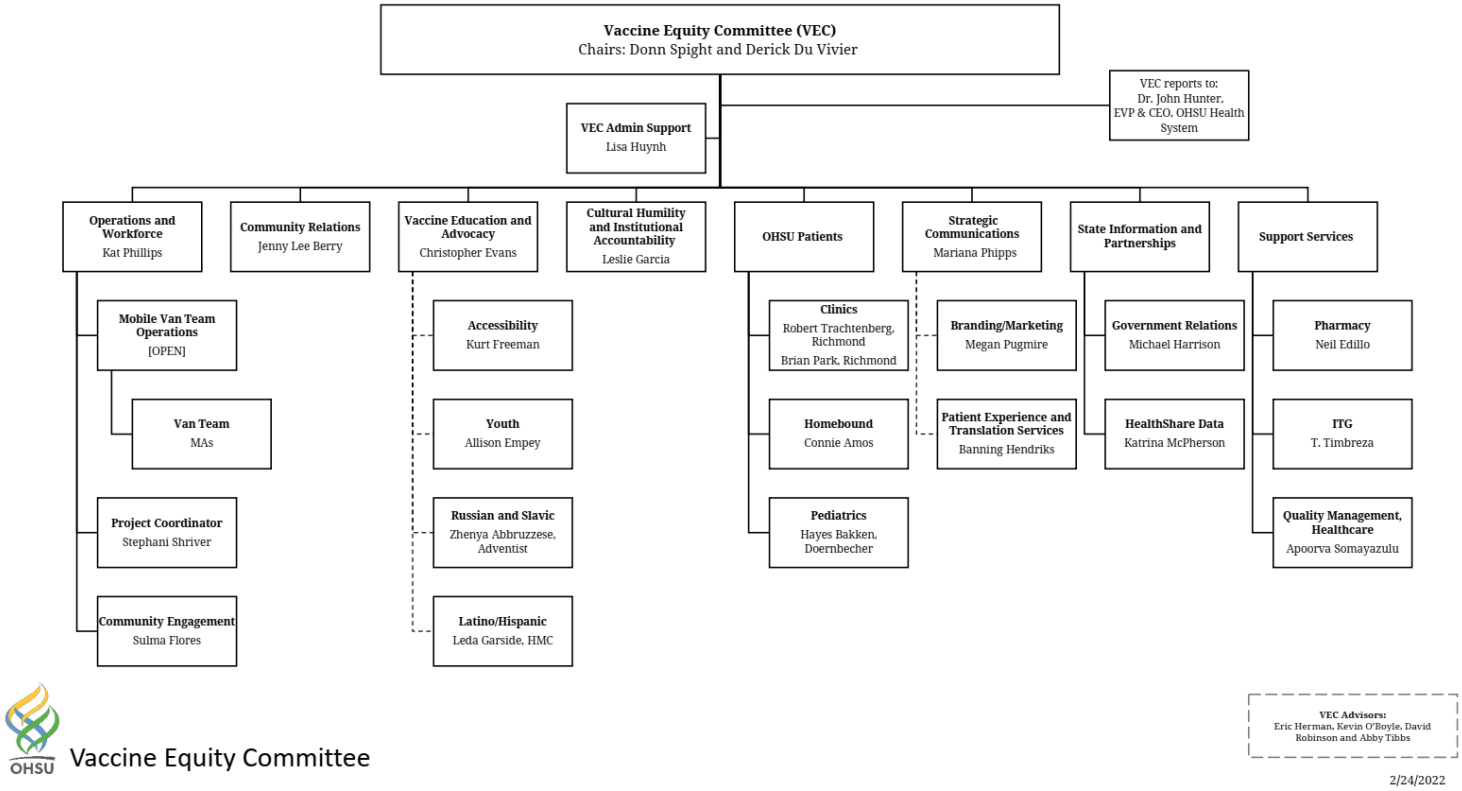
Individual VEC Subcommittee Lead Phone Interviews:

- Jenny Lee Berry, Program Manager, Community Department, CS State/Local Relations
  VEC Community Relations Manager; Lead for Community Partnerships. April 27, 2022 and July 21, 2022.
- Kat Philips, Director, Health Equity Operations, CS Center for Diversity & Inclusion,
  Lead for VEC Operations/Strategy. April 27, 2022 and July 27, 2022.
- Leslie Garcia, Associate Dean, Diversity & Inclusion, School of Medicine. May 3, 2022.
- Mariana Phipps, Sr Communications Specialist, CS Dean Administration. VEC Communications Lead. May 4, 2022 and July 21, 2022.

And additional resources, linked throughout this paper.

APPENDIX A: VACCINE EQUITY COMMITTEE ORGANIZATION CHART

VEC Organization Chart (Draft VEC Org Chart V7_2022.pdf, 2/24/2022)



APPENDIX B: VACCINE EQUITY COMMITTEE PURPOSE & CHARGE

Vaccine Equity Committee (VEC)

Purpose:

OHSU's Vaccine Equity Committee (VEC) provides expertise, outreach, advocacy and action to increase vaccination rates and vaccine education among diverse communities historically underserved within the state of Oregon. To ensure every Oregonian has access to COVID-19 vaccine regardless of race, ethnicity, language, mobility, zip code, education level, occupation, technology access, socioeconomic or immigration status.

Charge:

1. The Vaccine Equity Committee (VEC) will provide oversight and coordination for **external**, ad hoc vaccine operations. This will **include** homebound patients. This will **exclude** vaccination delivered to OHSU patients through OHSU clinics and partner FQHC's as well as existing operations at the Mass Vaccination sites.
2. The VEC will be a resource to guide all vaccine processes for accountability, cultural humility, education, advocacy, and outreach.
3. The VEC will be the destination for **external** requests to OHSU for community focused vaccination events (vaccineequity@ohsu.edu). The VEC will co-create a rubric and curate a unified, transparent events calendar of all externally facing vaccine activities for non-OHSU patients.
4. The VEC will be allocated vaccine doses from OHSU's OHA allocation to administer within a targeted community-based equity strategy. Vaccine prioritization will consider both epidemiological data and alignment with the needs of community-based partners. (Requests for specific vaccine type from communities will be reviewed independently based on authentic partnership needs.)
5. The VEC will have a dedicated operational team with assigned support units necessary to execute parallel strategy for:
    5) Homebound patients
    6) Targeted mobile van events
    7) Recurring vaccination events in community locations
    8) Specific group tailored events at Multnomah Pavilion, PDX, Hillsboro or other OHSU controlled sites
6. The VEC will have the authority/agency to schedule mobile van events within the logistical constraints of existing calendar commitments.
7. The VEC will oversee the creation and specific deployment of a racially, ethnically, and linguistically diverse, **compensated** workforce. This will start with OHSU members but expand to include community members as workforce needs are identified.
8. The VEC will have the support/authority to create solutions for identified structural barriers that prevent access to vaccine in underserved communities. (eg. Email requirement for appointment confirmation). This will include co-creation of messaging and outreach to mitigate vaccine hesitancy.
9. The VEC will apply for and manage grant funds specifically targeted for underserved groups.

APPENDIX C: KEY LEARNINGS FROM INITIAL VEC PARTNERSHIPS

The following are lessons learned regarding leadership, structural factors, institutional capacity to advance health capacity, and reconciling historical harm, as documented by Associate Dean of Diversity and Inclusion, Leslie Garcia, in September 2021 and expanded by Mariana Phipps in June 2022.

Integrate Community Leadership & Lived Experiences

- Integrate during the initial stages the voices and perspectives of racial, ethnic, and cultural linguistic membership on planning committees.
- Prioritize equity during strategic planning and visioning, to incorporate culturally- specific outreach efforts.
- Implement multicultural communication to inform and invite racial and ethnic communities.
- Build relationships and increase trust among racial, ethnic, and other diverse communities.

Address Structural Factors to Health and Health Equity

- Implement various forms of outreach, beyond website information, such as canvassing, community-based events, and partnering with community-based leaders. Community members may not have computers, Wi-Fi, and computer literacy which may create a digital divide.
- Develop translated materials in a timely manner and in multiple languages to address questions and concerns about vaccines, testing, or health information on the C4 line.
- Prioritize intentional messaging around free vaccinations, to mitigate perception among some community members that one is required to have medical insurance to obtain a vaccine
- Offer a variety of transportation vouchers to address a lack of transportation to mass sites.
- Partner with culturally specific organizations and community leaders to identify locations preferred by community members, as many individuals may be reluctant to travel to unknown locations or use public transportation.
- Offer early morning, evening, and weekend testing/vaccine events, as work schedules and the need for childcare do not always allow community to be vaccinated or tested during traditional 8-5 p.m. hours.

Enhance Institutional Capacity to Advance Health Equity

- Hire more personnel who are multi-lingual and/or multi-cultural, in order to institutionalize supporting individuals with diverse language and cultural needs. Translators should be minimized and fluent speakers/agents should be identified on services involving phone calls, virtual discussion, etc.
- Operationalize trainings and discussion for staff to support structural competency and cultural humility, to encourage these principles to be embedded in strategies from the beginning.
- Hire, identify, and elevate providers of color to deliver key messages on COVID-19, to support community members to identify with healthcare leaders, and implement multi-cultural communication.
- Develop content in the target language as opposed to translating content developed in English
- Increase and prioritize data capacity that effectively identifies racial/ethnic inequities, as data reports issued by OHSU have since shown the lack of testing and vaccine distribution to Black/African American, Hispanic/Latino, Native Americans/ etc.

Acknowledge and Reconcile Historical/Ongoing Harm by Healthcare

- Develop a long-term strategy to foster trust, reconciliation, and partnership with diverse communities of color; invest staffing, funding, and resources to community partnerships outside of the pandemic/crisis setting, so that those relationships already exist when crisis occurs.