# Governor's Racial and Ethnic Health Task Force

# FINAL REPORT

Submitted to:

Governor John A. Kitzhaber, M.D.

*November 2000*


**Governor's Racial and Ethnic Health Task Force**

Department of Human Services
Oregon Health Division
Office of Multicultural Health

Department of Administrative Services
Office for Oregon Health Plan Policy & Research

## SPECIAL DEDICATION

*On October 30, 2000, the Task Force on Racial and Ethnic Health voted to dedicate their report to the memory of Josiah Hill, III, a community leader and activist who left this world too soon but whose life made a big difference for Oregon. His tireless work to end health disparities served as an inspiration to the people he touched with his healing hands, and a heart filled with compassion and courage. His spirit lives on.*

*May his legacy continue in the hearts and minds of Oregonians who work to end racial and ethnic health disparities. He helped us realize that Oregon may be that special place where his dream to end health disparities has become more than a dream and will be achieved.*

*"Power is not in who or what you know, it is in what you do with your passion."*

*~ Author Unknown*

## SPECIAL THANKS

*Special thanks go out to the following people for their hard work and contributions to help complete this report on racial and ethnic health:*

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*Brown-Kline & Associates*

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# INTRODUCTION

The Task Force on Racial and Ethnic Health is pleased to present its report for consideration in the 2001-03 budget and legislative process. This report reflects the leadership of Governor John Kitzhaber and the commitment of racial and ethnic community members throughout Oregon to a shared mission of ending health disparities. Racial and ethnic communities in Oregon are disproportionately impacted by health concerns that are not adequately addressed by the current health systems in Oregon or nationally.

The Task Force recognizes that this as an opportunity to proactively remedy persistent and emerging health disparities, and to reconstitute a collective approach – public, private, medical and community together – to the health and well-being of ALL Oregonians. Together, we must strive for quality, affordable and culturally competent health services for every member of every community in Oregon.

There are reasons to be hopeful. Oregon is a leader in many areas of health and health care. The Oregon Health Plan has lowered the percent of Oregonians without health insurance from 18 percent in 1994 to 10 percent in 2000. Oregon is a leader and innovator in moving toward universal access. In spite of this progress, one out of ten Oregonians, or, more than 300,000 people, are still without health insurance coverage – more than 85,000 are children. Eighteen percent of the total uninsured population is made up of people of color, despite there being only nine percent of the total state population.

In addition, the incidence of many chronic diseases, lead poisoning in children and alcohol or drug abuse continue to escalate in communities of color. For example, diabetes is at least two times more common in the African American, American Indian, Hispanic, Asian and Pacific Islander communities, and people of color are also more likely than whites to have undiagnosed diabetes. This points to the need for making quality outreach, education and treatment available, accessible and culturally appropriate for all racial and ethnic communities.

The Governor's and Legislature's responses to the findings of the Task Force will begin to solidify a role for state government in ending health disparities in Oregon. The challenge is significant and will require partnerships that go beyond current efforts. The solutions will involve finding new resources, redirecting existing programs and services, or establishing new policy directions. The ultimate goal is for all Oregonians to live in a state where equity in health programs is a basic and important human right that works effectively to end health disparities.

## BACKGROUND

The Racial and Ethnic Health Task Force is the result of several years' committed work by a group of dedicated people. The motivation for creating the Task Force was the recognition that persistent and significant health problems weaken Oregon's racial and ethnic communities much more than these same problems affect the population as a whole. Over the course of the 1990s, it had become evident that government health programs were not satisfactorily addressing many of these health problems plaguing Oregon's racial and ethnic communities. Despite ongoing efforts in several State agencies (notably the Oregon Health Division - OHD and Oregon Medical Assistance Programs - OMAP) to improve responsiveness, and despite improvements in some areas, there was continuing dissatisfaction with the slow improvement in critical health outcome measures.

Beginning in 1997, Carla Freeman (a health researcher, past/present member of the African American Health Coalition and longtime advocate for better programs targeting health issues for communities of color) began raising this issue with leaders and advocates committed to improving the health of Oregon's racial and ethnic communities. In numerous settings, including meetings with the Governor's Office, key Legislators, and community representatives, she argued for stronger and more structured efforts to address these debilitating disparities. At a planning retreat for the Oregon Health Council that summer, she suggested that a commission modeled on the Ohio Minority Health Commission be created in this state. In 1998, a workgroup was formed to evaluate the feasibility of establishing such a commission or task force in Oregon.

The workgroup was co-chaired by State Senator Avel Gordly and Mark Gibson, the Governor's Senior Advisor on Health, Human Services and Labor. Other members included, State Senator Susan Castillo, State Representative JoAnn Bowman, Carla Freeman, Barbara Taylor, Ruth Ascher, and state program representatives including Elinor Hall and Suganya Sockalingam of OHD, and advocates representing the concerns and interests of the following racial and ethnic communities: African American, American Indian/Alaska Native, Asian/Pacific American, Hispanic/Latino.

Over the following year, the workgroup further investigated the Ohio Minority Health Commission and other standing bodies designed to improve health outcomes for racial and ethnic communities in other states. Closer to home, the workgroup also began a study of State programs addressing health issues for communities of color and identified the need for a more thorough inventory of these programs and of the funds allocated to them. In the discussions that followed these investigations, three important points became clear. First, there is

a wide range of relevant issues that might benefit to some extent from additional attention and resources. Second, the greatest net benefit would most likely result from concentrated efforts focused on a small number of high priority issues. Third, each year or two, findings and recommendations should be reported to the Governor and Legislature, and a new set of high priority issues should be selected for the next round.

The workgroup identified two basic criteria for selecting these high priority issues: a.) each issue must substantially and persistently undermine the well-being of one or more racial or ethnic communities; b.) the issue must not already be receiving heightened attention and increased funding. The workgroup further realized that once the first set of priority issues had been identified and addressed, a second set would be identified, and so on. This iterative process could then continue to address ongoing and emerging issues of importance to racial and ethnic communities, and therefore of importance to Oregon as a whole. The proposed commission would set new priorities based on the best available information on health disparities and their effects on racial and ethnic communities. On this basis, six critical health issues (see below) were selected as the first to be addressed.

The work group also considered the composition of the commission it would propose. To maximize effectiveness, it would be important to include representation from the executive and legislative branches of state government, from local government health officials, from providers of health care, and of course from the various communities themselves. Only with all bases covered could the work group expect substantial improvement in health outcomes related to the six priority issues.

In early 1999, the concepts developed by the workgroup were written into Executive Order NO. EO-99-07. This Executive Order both created the Racial and Ethnic Health Task Force and identified its role and responsibilities as well as its first year's priorities. These six priorities for 1999/2000 are:

1. Adequate access to treatment for Oregonians with physical and mental health coverage, with adequate access being defined as medically appropriate care provided when necessary by culturally competent providers in a suitable setting;
2. HIV/AIDS
3. Diabetes
4. Asthma
5. Lead poisoning
6. Alcohol and drug abuse

Executive Order NO. EO-99-07 also set the Task Force membership at 21, and specified that it would include representation as follows: six members from the

Legislative Assembly; one member each from the Commission on Asian Affairs, the Commission on Black Affairs, the Commission on Hispanic Affairs, the Legislative Committee on Indian Services, the Oregon Medical Association, the Conference of Local Health Officials, the Oregon Association of Hospitals and Health Systems, and the Governor's Office; and seven additional members representing racial and ethnic communities. The Governor's Office then worked with leadership from the work group that had designed the Task Force to select and appoint the 21 members (attached to this report as page i – ii).

The Task Force began meeting in the summer of 1999, and set to work immediately on gathering information and hearing testimony from State officials and community representatives. At the Multicultural Health Conference held in April 2000, the Task Force conducted a series of round-table discussions on the six priority issues listed above. These discussions were facilitated to encourage free expression by all participants, and were open to all who attended the Conference. As had been hoped, participation was inclusive of all communities represented at the Conference, and discussion was sophisticated and on point.

In July 2000, a design team was convened to identify findings and possible recommendations for the report from the Task Force to the Governor and Legislature. The design team had both plenary sessions and targeted work groups on each of the six priority issues. The first plenary session reviewed the work of the Task Force to that point, including its meetings and the round table discussions at the Multicultural Health Conference. The six work groups, with each group addressing one of the six priority issues, followed this plenary. Each work group included presentations from experts on the priority issue in question, as well as candid discussion by Task Force members, community advocates, staff from community-based programs, and state and county officials responsible for programs addressing the issue. During this discussion, a scribe made note of findings and possible recommendations.

The design team meeting concluded with a plenary session during which a representative of each of the six work groups presented findings and possible recommendations. When candidate recommendations from all work groups had been posted on the walls of the meeting room, participants prioritized the recommendations by distributing 20 "vote dots" according to the importance they attached to the various recommendations that had proposed by the work groups.

Following the design team meeting, Task Force staff tabulated the results of the priority setting exercise and developed a matrix arraying the recommendations according to those results. The recommendations in this matrix represent the remedies to health disparities underlying the six issues identified in Executive Order-99-07. The presentation, explanation, and implementation of these recommendations are the purpose of this report to the Governor and Legislature.

## RECOMMENDATION OVERVIEW

It is clear that Oregon is well positioned to begin the process of closing the health disparities gaps that continue to impact racial and ethnic communities in Oregon. This report represents a major step along the path. Success will depend on state government, communities and policy makers acting as a catalyst for change. The recommendations address the need for change on three different fronts; making better use of existing resources, changing policy directions and finding new resources to address important issues.

In the process of developing recommendations in the six priority areas, it was clear that several "cross-cutting" issues were seen as overarching issues. As a result, the report has two sections. The first section is a set of recommendations relating to the "cross-cutting" issues. The second section represents recommendations in each of the six priority areas assigned to the Task Force in the Executive Order.

The matrix used to present the Task Force Recommendations is intended to provide complete information and serve as a summary of several months of work and interactions with community, providers and policy makers. Additional information on the meetings and presentations that led to this report are included in the Appendix. The following is an explanation of the information contained on the matrix:

**First Column: "Action Items"**

These initiatives or action items are being recommended by the Task Force for the Governor's consideration. The format has been designed to present a menu of choices for follow-up action by Governor Kitzhaber. It is envisioned that the Governor will select his priorities from the Action Items offered as recommendations. Once selected for implementation, the State agency, department or division designated as the “lead” (see "Responsible" description below) will develop an implementation plan.

**Second Set of Columns: "Policy - Budget - Legislation"**

Each “Action Item” has been marked to designate whether the full implementation of the concept will require state government to: make policy changes; introduce new legislation or finance with new budget resources.

**Third Column: "Responsible"**

The first agency, department or division listed in this column and designated as "lead" is identified as the one responsible for facilitating development of the recommended action if approved by the Governor. This box also lists any other state departments, divisions, or offices needing to be involved in the planning and implementation process. The listing does not include other government agencies, private sector or community partners at this point. However, they will be added if the initiative is selected for further concept development.

## Recommendations on Overarching Issues

This section consolidates recommendations that cut across several priority areas. These solutions address two or more of the priority areas in this report but do not replace the recommendations detailed in the sections that follow.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| **I. Data** | | | |
| **A.** The availability of sufficient data on racial and ethnic communities is key to positioning the state to compete for new sources of funding and determine a level of priority in decision-making processes. The Governor's Office is requested to charge the Department of Human Services with the responsibility to form a Racial & Ethnic Health Data Group that includes state and local government and community partners. The Data Group shall reflect the racial and ethnic diversity of the state. Additional funding will enable the Oregon Health Division to conduct enhanced data collection utilizing culturally appropriate methods. The focus shall be on collecting data that will support the State's efforts to eliminate health disparities in Oregon. | X | X | X | Oregon Health Plan Policy & Research (lead agency), Dept of Human Services, Oregon Health Division, Oregon Medical Assistance Program, Oregon Progress Board |
| **II. Establishing Deliverables for Eliminating Racial and Ethnic Health Disparities** | | | |
| **A.** The State of Oregon must adopt a common set of expectations and deliverables for State departments, local government agencies and private and public sector contractors to meet when state funds are being utilized. These expectations can best be developed by a work group led by the Department of Human Services in cooperation with the Racial and Ethnic Health Task Force. At a minimum, the standards shall address: access to services, language interpretation, diversity in planning and decision-making, training, workforce diversity (hiring, retention, cultural support systems for people of color and strategies for developing future workers). | X | X | X | Dept of Human Services (lead department), Dept of Administrative Services, Oregon Health Plan Policy & Research, Oregon Progress Board |

## III. The Changing Face of State Government

**A.** Diversity will be fully embraced by organizations when the make-up of the workforce at all levels and decision-making groups reflect the communities and individuals being served by state and local government. In order to achieve this goal, State government must make sure there is a pipeline for future talent that includes people of color and bi-lingual workers. In addition, state government must implement retention practices reflect this priority and provide support systems to ensure the success of people of color in the workplace. All decision-making and advisory bodies must reflect the many aspects of diversity that are representative of Oregon. The Governor must hold state departments and divisions accountable for progress in this area.

## IV. Meeting the Needs of Under-served Communities in Oregon

**A.** People of color are over-represented in the populations faced with the greatest barriers to good health. The needs of migrant seasonal farm workers (documented and undocumented), new immigrants, individuals and families who are homeless, individuals served by the adult and juvenile criminal justice system, the dependent elderly, and people with physical and mental disabilities are often discriminated against as well as under-served by state systems. It is recommended that the Department of Human Services develop an inventory of programs on an annual basis with activity reports that describe activities specifically relating to the involvement and outcomes for people of color and other under-served populations.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | | | Governor's Affirmative Action Office (lead office) Dept of Administrative Services, Dept of Human Services, Oregon Health Division, Oregon University System, Dept of Community Colleges & Workforce Development, Oregon Health Sciences University |
| X | | | Dept of Human Services (lead department), Dept of Administrative Services, Dept of Employment, Oregon Health Division, Mental Health & Developmental Disability Services Division, Senior & Disabled Services Division, Vocational Rehabilitation Division, Office of Alcohol & Drug Abuse Programs, Dept of Corrections, Oregon Youth Authority, Adult & Family Services Division, Services to Children & Families Division |

## V. Office of Multicultural Health

The Office of Multicultural Health must be adequately funded, staffed and organizationally positioned to lead the State of Oregon's agenda to eliminate racial and ethnic health disparities. The Office must report to the Governor and have responsibility for overseeing the implementation of the adopted recommendations of the Racial and Ethnic Health Task Force and serving as a resource for programs serving racial and ethnic communities at the state, local and community levels.

**A.** Create a quasi-governmental Office of Multicultural Health that reports to the Governor. The office must have; a full staff; access to state resources and office space funded through the state; and provide on-going private, state and federal grant funding through a not-for-profit foundation staffed by an experienced grant writer.

**B.** The office will be accountable to a newly appointed Board of Directors, comprised of the directors of the State's cultural affairs offices, bipartisan representation from both houses of the legislature, the administrator of the Oregon Health division and representatives from the private sector. The Office of Multicultural Health will be granted authority to implement the work of the Racial and Ethnic Health Task Force.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| | X | X | Governor's Office (lead agency), Racial and Ethnic Health Task Force, Dept of Human Services |
| X | X | X | Governor's Office (lead agency), Racial and Ethnic Health Task Force, Dept of Human Services |

**Issue Area (1):**

*Access to treatment for Oregonians with physical and mental health coverage, with adequate access being defined as medically appropriate care provided when necessary by culturally competent sensitive in a suitable setting.*

**I. Goal Statement:** Improve the availability of culturally relevant health and mental health services to persons from diverse racial and ethnic backgrounds. Provide persons with Limited English Proficiency with access to health care by ensuring certification and standards of interpreting and translation services. (Include all languages).

**Action Items:**

**A.** Establish an Interpreter and Translator Task Force. Establish policies and procedures that will effectively enable limited English speaking persons access to interpreter services. Establish a forum that will include representation from a broad spectrum of groups who are affected by interpreter services. Ensure that consumers of interpreter services are included in developing policies and practices that will assist the community at large.

**B.** Develop a set of common standards for interpreter services and assist in the implementation of standards for state departments. Establish policies and procedures that will ensure that the August 2000 "Guidance Memorandum" from the Office of Civil Rights and the 1978 Patients Bill of Rights of the American Hospital Association is upheld at a statewide level (including public and private sectors) for limited English speaking patients.

**C.** Establish funding sources for appropriate oversight of interpreter services statewide. The state oversight would include development and oversight of examinations, qualifications, curriculum, competency policies and consumer reports. Funding sources should be established to assist public and private sectors in qualified interpreting and translating services.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | | | Dept of Human Services (lead department), Mental Health & Developmental Disability Services Division, Oregon Health Division, Senior & Disabled Services Division, Oregon Medical Assistance Program, Insurance Pool Governing Board, Office of Alcohol & Drug Abuse Programs |
| X | X | X | Dept of Human Services (lead department), Mental Health & Developmental Disability Services Division, Oregon Health Division, Senior & Disabled Services Division, Oregon Medical Assistance Program, Insurance Pool Governing Board, Office of Alcohol & Drug Abuse Programs, Dept of Administrative Services, Dept of Consumer & Business Services, Dept of Corrections, Oregon Youth Authority, Dept of Justice |
| X | X | X | Department of Human Services (lead department), OHD-Office of Multicultural Health |

**II. Goal Statement:** Develop and implement a common plan and expectations related to culturally competent services that apply to all DHS divisions and programs and their contractors at the local level. Improve access to culturally relevant health and mental health services to persons from diverse racial and ethnic backgrounds.

**Action Items:**

| | POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|---|
| **A.** | X | X | | Dept of Human Services (lead department), Mental Health & Developmental Disability Services Division, Oregon Health Division, Senior & Disabled Services Division, Oregon Medical Assistance Program, Adult & Family Services, Services to Children & Families, Office of Alcohol & Drug Abuse Programs |
| **B.** | X | X | | Dept of Human Services (lead department) |
| **C.** | X | X | | Dept of Human Services (lead department), OHD-Office of Multicultural Health |
| **D.** | X | X | | Dept of Human Services (lead department) |
| **E.** | X | X | | Dept of Human Services (lead department) |

**III.** **Goal Statement:** Increase the representation of people of color and bi-lingual/bi-cultural staff trained in health care, medicine and health policy. Consistently include individuals who represent diverse perspectives and backgrounds in the policy and decision-making bodies created by state government.

**Action Items:**

**A.** Submit quarterly DHS reports on efforts to meet affirmative action goals to the Governor's Task Force on Racial and Ethnic Health.

**B.** Develop partnerships with higher education to recruit and train bilingual/bicultural and people of color in health fields. Encourage state departments and divisions to participate in school-to-work programs that expose students of color to health-related careers. Provide resources to ensure the retention and skill development of existing employees.

**C.** Utilize lay workers to provide health services and provide appropriate training and oversight.

**D.** Develop partnerships with professional licensing boards and organizations to increase diversity in professions where people of color and bi-lingual/bi-cultural individuals are under-represented. Introduce legislation to require health licensing boards to increase the representation of people of color and bilingual licensees and report bi-annually to the Legislature.

**E.** Direct state department directors and division administrators to ensure, when appointing a policy-making and/or advisory body, that the appointments reflect the population that is being served.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | | | Dept of Human Services (lead department) |
| X | | | Oregon University System (lead department), Dept of Community Colleges & Workforce Development, Dept of Administrative Services, Oregon Health Sciences University, Oregon Student Assistance Program, Scholarship Commission |
| X | | | OHD-Office of Multicultural Health (lead division), Oregon Health-related Licensing Boards, |
| X | X | | Governor's Affirmative Action Office (lead office), Oregon Health-related Licensing Boards |
| X | | | Dept of Administrative Services (lead agency), Oregon Health Plan Policy & Research |

**IV. Goal Statement:** Improve the availability of relevant health data regarding people of color in the state.

**Action Items:**

| | POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|---|
| **A.** Develop a plan and secure funding to increase collection of health-related data for people of color and other under-represented populations. Funding is needed to implement new techniques for collecting data that are culturally sensitive and more effective. (Refer to page 7, item I.A.) | X | X | X | Dept of Human Services (lead department), Oregon Health Division, Oregon Health Plan Policy & Research, Oregon Progress Board |
| **B.** Develop and adopt a common set of definitions and agreement on how data will be collected and made available to other departments, divisions, community organizations and the public. | X | | | Oregon Progress Board (lead agency) Oregon Health Division, Dept of Human Services, Oregon Health Plan Policy & Research |
| **C.** Involve communities of color in planning and administering quantitative and qualitative methods of data collection. The Task Force and community partners shall be involved in prioritizing data needs to support the work of the Governor's Task Force. | X | | | Dept of Human Services (lead department), Oregon Health Division, Oregon Health Plan Policy & Research, Oregon Progress Board |

**V. Goal Statement:** Address resource, access and financial barriers that prevent quality health care. Reduce the high rate of uninsured and under-insured among racial and ethnic populations.

**Action Items:**

| | POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|---|
| **A.** | | X | | Dept of Human Services (lead department), Oregon Health Division, Oregon Health Plan Policy & Research |
| **B.** | X | X | | Dept of Human Services (lead department), Oregon Health Division, Insurance Pool Governing Board |
| **C.** | X | X | | Oregon Health Division (lead division), Oregon Health Plan Policy & Research, Dept of Human Services, Oregon Medical Assistance Program, Office of Rural Health |
| **D.** | X | X | X | *Pacific University (lead agency)*[1] |

[1] Non-State Partner

**VI.** **Goal Statement:** Support and provide technical assistance for community advocacy groups in order to assist with health education activities and advocacy.

**Action Items:**

**A.** Provide education on emerging health-related issues like long-term care needs and involve community voices in the planning of new programs and services.

**B.** Develop new outreach strategies to reach communities of color and involve community members in community health promotion for the individual, family members, work place and community. Develop partnerships between private and public sector partners to implement a community specific wellness movement. (Refer to page 7, item II.A.)

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | | Dept of Human Services (lead department), Oregon Health Division, Oregon Medical Assistance Program, Senior & Disabled Services Division |
| X | | | Oregon Health Division (lead division), Senior and Disabled Services Division |

**Issue Area (2):**

*Alcohol, Tobacco and Other Drug Abuse Prevention and Treatment*

**I. Goal Statement:** The needs and voices of communities of color should be represented at every stage of the fight against alcohol, tobacco and other drug abuse.

**Action Items:**

**A.** Change norms in communities of color toward the importance of prevention and treatment of substance abuse and mental health treatment through community education and outreach.

**B.** Close information gaps by collecting quantitative and qualitative data on alcohol and drug use and abuse in communities of color. (Refer to page 7, item I.A.)

**C.** Require state divisions to involve more people of color in the provision and administration of prevention services and treatment to communities of color through contractual provisions between DHS and counties.

**D.** Develop model processes and shared standards among DHS divisions that are based on community needs in order to implement culturally appropriate services. Areas to include: male role models of color, language interpretation services, sign language, treatment modalities for addressing alcohol and substance abuse issues.

**E.** Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | | Office of Alcohol & Drug Abuse Programs (lead division), Senior & Disabled Service Division |
| X | X | | Office of Alcohol & Drug Abuse Programs (lead division), Oregon Health Plan Policy & Research, Oregon Medical Assistance Program, Oregon Progress Board |
| X | | | Office of Alcohol & Drug Abuse Programs (lead division) |
| X | X | X | Dept of Human Services (lead department), Office of Alcohol & Drug Abuse Programs, Senior & Disabled Services Division, Mental Health & Developmental Disability Services Division |
| X | | | Dept of Human Services (lead department), Office of Alcohol & Drug Abuse Programs |

**II.** **Goal Statement:** Take steps to prevent alcohol, tobacco and other drug abuse from beginning and intervene early and effectively in cases of substance abuse.

**Action Items:**

**A.** Advocate for changes in business and advertising practices that target people of color. For example, explore methods to get the liquor industry to fund advertising to discourage underage drinking in communities of color.

**B.** Through contractual provisions between DHS and counties, add prevention dollars to alcohol, tobacco and other drug services in communities of color. Conduct community outreach to inform community members about the availability of treatment and prevention resources. Implement "drug free" housing programs and utilize mentors as a prevention strategy.

**C.** Educate medical providers to identify alcohol, tobacco and other drug abuse as a health issue of importance to racial and ethnic communities and make culturally appropriate referrals. DHS shall require any contract between the department and health plan organizations and managed care organizations to educate their medical providers to be culturally sensitive and make sure they subcontract with providers that represent communities of color.

**D.** Target community programs to address youth perceptions of alcohol, tobacco and other drugs, and integrate substance abuse education with youth violence initiatives.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | X | Office of Alcohol & Drug Abuse Programs (lead division), Oregon Housing and Community Services, Oregon Liquor Control Commission, *Grocers Association*[1] |
| X | X | X | Office of Alcohol & Drug Abuse Programs (lead division), Oregon Liquor Control Commission |
| X | | X | Office of Alcohol & Drug Abuse Programs (lead division), Oregon University System, Dept of Community Colleges & Workforce Development, *Oregon Medical Association*[2] |
| X | X | | Office of Alcohol & Drug Abuse Programs (lead division), Oregon Youth Authority |

[1] Non-State Partner
[2] Non-State Partner

**III.** **Goal Statement:** Ensure that substance abuse treatment services adequately serve the needs of racial and ethnic communities.

**Action Items:**

| | POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|---|
| **A.** Expand the availability of quality residential services for communities of color in community-based, minority-operated settings. Address the gaps in residential treatment facilities that compromise the care of adults with older children, seniors and youth. | X | X | | Office of Alcohol & Drug Abuse Programs (lead division) |
| **B.** Require treatment facilities to address the needs of families of individuals with alcohol and/or drug problems as a part of the treatment plan. Provide family counseling, drug-free housing and other support services. | X | | | Office of Alcohol & Drug Abuse Programs (lead division), Mental Health & Developmental Disability Services Division |
| **C.** Require that treatment dollars are used in the most effective manner and evaluated to meet community needs based on appropriate, identified outcomes. Identify best practices and fund treatment programs that provide the most effective and culturally specific services. | X | | | Office of Alcohol & Drug Abuse Programs (lead division) |
| **D.** Provide treatment for alcohol and drug abusers before they enter the adult and/or juvenile justice systems to avoid using the correctional facilities as treatment programs. | X | | | Office of Alcohol & Drug Abuse Programs (lead division), Dept of Corrections, Oregon Youth Authority, Oregon Medical Assistance Program, Insurance Pool Governing Board |
| **E.** Address the discontinuity in insurance coverage and health care that follows incarceration for many released prisoners. | X | | | Dept of Corrections (lead department), Oregon Youth Authority, Office of Alcohol & Drug Abuse Programs, DCBS-Insurance Pool, Oregon Medical Assistance Program |

**Issue Area (3):**

*Reduce the disproportionate impact of asthma on communities of color*

**I. Goal Statement:** Improve coordination of asthma control efforts to improve outcomes for communities of color in Oregon.

**Action Items:**

**A.** Require that the Statewide Asthma Network is well represented by diverse community representatives and interests. Create a linkage between the Network and the Governor's Task Force on Racial and Ethnic Health and the Office of Multicultural Health.

**B.** Establish agreements with the Oregon Medical Association, Oregon Academy of Pediatrics, and other professional associations to cooperate with the activities of the Governor's Task Force on Racial and Ethnic Health on asthma outreach, education and treatment.

**C.** Require that the Oregon Asthma Program involve communities of color to reduce the burden of asthma in racial and ethnic communities. Utilize culturally specific strategies to obtain input from racial and ethnic communities, include making meetings accessible through their location, language interpretation, and facilitation.

**D.** Increase resources for asthma prevention and care. Explore new and sustainable resources to increase services in communities of color, including asthma education, asthma clinics, and asthma management resources.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | | | OHD-Asthma Program (lead division), Office of Multicultural Health |
| X | | | Oregon Health Division (lead division), Office of Multicultural Health |
| X | | | OHD-Asthma Program (lead division) |
| X | X | X | Dept of Human Services (lead department), Dept of Motor Vehicles, OHD-Tobacco Program, Oregon Medical Assistance Program |

**Action Items:**

**E.** Acquire funding to support statewide and local public health surveillance for use in the development of appropriate interventions, evaluation, and new data resources. Refer to page 7, item I.A.)

**F.** Research and implement national and local programs/initiatives that mobilize individual and community support for lifestyle changes that can prevent asthma attacks. Identify best practices and involve and support racial and ethnic communities in creating programs to meet their needs in a culturally relevant manner.

**G.** Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | X | OHD-Asthma Program (lead division), OHD-Vital Statistics (BRFSS) |
| | X | | Oregon Health Division (lead division) |
| X | | | Dept. of Human Service (lead department), Oregon Health Division |

**II.** **Goal Statement:** Conduct asthma education and outreach in communities of color.

**Action Items:**

**A.** Develop and implement a targeted outreach and education effort to reach communities of color. Partner with the public and private sectors to increase outreach and leverage new resources. Develop strong and effective community partnerships with childcare providers, employers, schools, medical providers, faith organizations and business community members to support asthma education, treatment, and prevention.

**B.** Provide culturally relevant early detection and "living with asthma" classes. Involve racial and ethnic communities, health care providers, partner associations and private sector resources to provide information and possible subsidies for the purchase of peak flow meters, other treatments, and tools for self-management and education.

**C.** Utilize national and local education efforts targeted at every age group and designed to teach the community about the triggers of asthma. Address topics such as indoor and outdoor air quality, second-hand smoke, dust mites, roaches, and pesticides as triggers. Educate communities of color concerning the behavioral and psychological aspects of asthma to enable individuals to live well with the disease.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | | OHD-Asthma Program (lead division), Oregon Youth Authority, Dept of Education |
| X | X | | OHD-Asthma Program (lead division) |
| X | X | | OHD-Asthma Program (lead division), Dept of Environmental Quality, OHD-Tobacco Program, OHD-0ccupational Health |

**Issue Area (4):**

*Reduce the disproportionate impact of diabetes on racial and ethnic communities.*

**I. Goal Statement:** Initiate and support targeted health awareness and prevention campaigns and increase screening to identify undiagnosed cases of diabetes with the support and involvement of impacted communities.

**Action Items:**

**A.** Utilize national and local education efforts targeted at every age group and designed to teach the community about the warning signs. Educate communities about diabetes risk factors, symptoms, positive and negative outcomes and encourage early screening and treatment.

**B.** Research and implement national and local programs / initiatives that mobilize individual and community support for lifestyle changes that can delay or prevent the onset of diabetes. Focus efforts on diet, exercise and elimination of smoking at a community level. Identify best practices, and involve and support racial and ethnic communities in creating programs to meet their needs in a culturally relevant manner.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | | OHD-Diabetes Program (lead division), Dept of Education, Oregon Youth Authority, Dept of Corrections, Senior & Disabled Services Division, Oregon Medical Assistance Program |
| X | | | OHD-Diabetes Program (lead division), |

**II.** **Goal Statement:** Coordinate health care providers and organizations to deliver effective, holistic and culturally relevant treatment to diabetes patients and their families/support network.

**Action Items:**

**A.** Require that the health care system make timely and appropriate referrals to specialists for diabetes management especially in the early stages of the disease. Provide information to communities on treatment options and how to access the best care available.

**B.** Increase the number of diabetes educators of color and bilingual educators available to serve communities by providing educational grants, scholarships, and low interest loans. Recruit Certified Diabetes Educators (CDE's) from other states and provide incentives to relocate.

**C.** Fund new and existing programs to teach culturally relevant self-management skills to people with diabetes.

**D.** Provide psychological and psychiatric support for individuals diagnosed with diabetes. Educate medical providers to listen to diabetes patients' questions and needs, make referrals to service providers and teach patients to articulate their needs to providers.

**E.** Develop strong and effective community partnerships among divisions, organizations, people living with diabetes, service organizations, community media, public departments and schools, grassroots organizations, insurers, pharmaceutical companies, faith organizations, business community and funding organizations to support diabetes education and outreach efforts.

**F.** Utilize physicians and insurers to provide information to patients about accessing resources available in the community.

**G.** Track diagnosed patients and provide continuing care by providing information and access. Inform them of "best practices", education and tools in the community.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | X | Oregon Health Plan Policy & Research (lead agency), Oregon Medical Assistance Program |
| X | X | X | Oregon Health Division (lead division), Oregon Medical Assistance Program, Oregon University System, Dept of Community Colleges & Workforce Development |
| X | X | | OHD-Diabetes Program (lead division) |
| X | X | | Mental Health & Developmental Disability Services Division (lead division) |
| X | X | | OHD-Diabetes Program (lead division), Senior and Disabled Services Division, Dept of Corrections, OR Youth Authority, Oregon Medical Assistance Program, Insurance Pool Governing Board |
| X | | | Oregon Medical Assistance Program (lead division), Insurance Pool Governing Board, *Oregon Medical Association*[1] |
| X | X | X | Oregon Medical Assistance Program (lead division), Insurance Pool Governing Board |

[1] Non-State Partner

**III.** **Goal Statement:** Improve data collection measures on racial and ethnic communities on the prevalence of diagnosed and undiagnosed people with diabetes as well as barriers to screening and care.

**Action Items:**

**A.** Collect improved data on all ethnic/racial populations using model methods for data collection. Current data is especially lacking in Asian/Pacific Islander and Russian populations. Refer to page 7, item I.A.)

**B.** Identify and reduce barriers to self-management and treatment faced by racial and ethnic populations living with diabetes including the problems caused by the increased financial burdens of people living with diabetes. Quantify results of improved self-management and better access to care.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | | OHD-Diabetes Program (lead division), OHD-Vital Statistics, Oregon Progress Board |
| X | X | | OHD-Diabetes Program (lead division), Oregon Medical Assistance Program, Senior & Disabled Services Division, Oregon Progress Board |

**IV.** **Goal Statement:** Introduce, improve and or strengthen existing legislation and budgets that will improve diabetes prevention and treatment for racial and ethnic communities.

**Action Items:**

**A.** Research and adopt "best practices" developed nationwide to use in developing new programs, legislation, and budgets for communities of color. Conduct reviews, and share information with community based programs on "state of the art" programs that have been successful in other parts of the country.

**B.** Introduce and/or support legislation to provide funding and insurance reimbursement for diabetes education taught by certified diabetes educators or qualified health professionals with training on diabetes education. Increase the use of lay health educators to provide services. Negotiate the addition of an associate-level CDE lay-educator class.

**C.** Generate state and local government funding to match federal funds for addressing diabetes and related complications. Seek potential funding, in-kind support, marketing resources and partnership opportunities with foundations and other public and private sector organizations.

**D.** Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | X | OHD-Office of Multicultural Health (lead division), OHD-Diabetes Program |
| | X | X | Dept of Human Services (lead department), Dept of Consumer & Business Services, Dept of Community Colleges & Workforce Development |
| | X | | OHD-Office of Multicultural Health (lead division), OHD-Diabetes Program |
| X | | | Dept of Human Services (lead department), Oregon Health Division |

**Issue Area (5):**

*HIV/AIDS*

**I. Goal Statement:** Ensure that the needs of racial and ethnic communities are accounted for in the allocation of resources for HIV/AIDS prevention and treatment.

**Action Items:**

**A.** Fund capacity-building infrastructure needs of community-based organizations, as identified by those institutions, in order to empower those organizations to diversify funding streams to serve communities of color. Implement a system that allows for more opportunities for directly funding community-based organizations. Develop a solid infrastructure for board development, successful grant applications and stabilized financial systems and staffing.

**B.** Require representation for people of color on HIV prevention and services planning committees and advisory groups at the state and local levels. Require that the involvement of new members is meaningful and inclusive of individuals from many backgrounds, interests and perspectives. Require that the needs of people of color from rural areas and non-English speaking communities are not overlooked in statewide planning efforts.

**C.** Fund improved qualitative and quantitative HIV data collection for communities of color. Include people of color from racial and ethnic communities in the outreach efforts, and the analysis of the findings of both qualitative and quantitative data collection. Require data sharing between the Oregon Health Division and Oregon Medical Assistance Program.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | | OHD-HIV/STD/TB Program (lead division), OHD-Office of Multicultural Health |
| X | | | OHD-HIV/STD/TB Program (lead division), OHD-Office of Multicultural Health, OHD-Community Partnerships |
| X | X | X | OHD-HIV/STD/TB Program (lead division), OHD-Vital Statistics, OHD-Office of Multicultural Health, Oregon Medical Assistance Program, Oregon Progress Board |

| | POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|---|
| **D.** Review and report to the Task Force on the new guidelines for HIV case managers issued in July 2000 for consistency and impact on communities of color. The new guidelines must help to assure that communities of color receive adequate resource levels, staffing, and services that meet the needs of individual racial and ethnic communities. | X | | | OHD-HIV/STD/TB Program (lead division), OHD-Office of Multicultural Health, Dept of Human Services |
| **E.** HIV prevention and treatment activities must reflect community needs. | X | X | | OHD-HIV/STD/TB Program (lead division) |
| **F.** Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment. | X | | | Dept of Human Service (lead department), Oregon Health Division |

**II.** **Goal Statement:** Ensure that people of color living with HIV/AIDS are able to access culturally competent and affordable care.

**Action Items:**

| | | | | |
|---|---|---|---|---|
| **A.** Provide incentives to physicians who treat HIV patients in rural and under-served areas. There is a barrier in finding culturally competent clinicians willing to accept patients and administer treatments. Clinicians serving HIV patients are difficult to find in rural areas. | X | X | | Oregon Medical Assistance Program (lead division), Insurance Pool Governing Board, Office of Rural Health |
| **B.** Establish cultural and linguistic competency as a requirement for HIV/AIDS educators and service providers. | X | X | X | OHD-HIV/STD/TB Program (lead division), OHD-Office of Multicultural Health, Oregon Medical Assistance Program |
| **C.** Fund the Needle Exchange Program as a prevention strategy for high-risk HIV populations. | X | X | X | Oregon Health Division (lead division) |

**III.** **Goal Statement:** Expand efforts to educate and involve the community outside of the current HIV/AIDS system to the need for prevention, education and improvement of treatment services.

**Action Items:**

**A.** Maximize the benefit from mandated HIV education programs by holding state and local education departments accountable for increasing the quality and quantity of educational programs in schools.

**B.** Involve the public and private sector departments and employers in creating programs to return HIV positive individuals to the workforce. Model programs exist (e.g. Welfare-to-Work, Better People Program) to serve as examples. Explore the need for legislative changes to ensure employee rights to adequate insurance coverage and employment rights.

**C.** Establish cooperative agreements between the Oregon Health Division, Oregon Medical Assistance Program, managed care plans and community partners on prevention efforts at the individual and community level.

**D.** Assure access to education and screening in communities of color.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | | Dept of Education (lead department), OHD-HIV/STD/TB Program, Oregon University System, Dept of Community Colleges & Workforce Development, Oregon Youth Authority, Dept of Corrections |
| X | X | | Dept of Human Services (lead department), Vocational Rehabilitation Division, Oregon Health Division, Oregon Medical Assistance Program, Adult and Family Services, Dept of Corrections |
| X | | | OHD-HIV/STD/TB Program (lead division), Oregon Medical Assistance Program, Insurance Pool Governing Board |
| X | X | | OHD-HIV/STD/TB Program (lead division) |

**Issue Area (6):**

*Lead Poisoning*

**I. Goal Statement:** To prevent lead exposure to children from racial and ethnic communities, and to assure access to screening for those children who are potentially at risk for exposure.

**Action Items:**

**A.** Develop new funding streams to support lead poisoning prevention efforts. Create new partnerships with State divisions and organizations in the public and private sector. Explore legislative changes that would generate new revenue through collecting fees on certain types of real estate transactions to fund prevention efforts such as repainting older, high-risk houses.

**B.** Assure that funding for Local Health Departments (LHD's) is sufficient for funded collaborations/contracts with community-based organizations that are organized to serve racial and ethnic communities. Fund health promoters through LHD's. Fund community-based organizations to build infrastructure and capacity to provide culturally appropriate lead poisoning prevention and education services. Assure that community-based organizations can pay a living wage in order to recruit and retain qualified employees.

**C.** Work with Oregon Health Division's Lead Program and the Office of Multicultural Health to develop assurances with the Conference of Local Health Officials (CHLO) to assure that testing and investigation services are culturally and linguistically competent.

**D.** Convene a subcommittee of the Task Force to review the findings of the OHP Pilot Lead Screening Project among children living in high-risk communities. The subcommittee shall make recommendations based on the report regarding future screening protocols for OHP Children. The recommendations shall also take into consideration the HCFA and CDC guidelines for lead testing of children.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | X | OHD-Lead Program (lead division) |
| X | X | X | Oregon Health Division (lead division) |
| X | | | OHD-Lead Program (lead division), OHD-Office of Multicultural Health |
| X | | X | OHD-Lead Program (lead division), Oregon Medical Assistance Program |

**II.** **Goal Statement:** Improve the information available on the scope and impact of lead poisoning on communities of color in Oregon.

**Action Items:**

**A.** Fund studies of the prevalence of lead paint in pre-1978 housing throughout the state. The Multnomah County studies provide a framework for conducting other studies.

**B.** Monitor lead screening data and utilize information in reviewing current policies and making changes as necessary in the policies of DHS and other state departments and divisions (i.e. Oregon Housing and Community Services Department).

**C.** Fund testing for uninsured/underinsured children, follow-up investigation and mitigation education for any child with elevated blood lead levels, and referral to care when indicated.

**D.** Utilize strategies that assure efficient service delivery to populations at risk for lead poisoning by integrating blood-lead screening services into community immunization clinics, health fairs, and community-based testing clinics. Use health promoters who come from the community in order for them to outreach to communities of color that naturally congregate in places such as churches, Migrant Head Start clinics, etc.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| | X | | Oregon Health Division (lead division), Oregon Housing & Community Services |
| X | | | OHD-Lead Program (lead division), Oregon Housing & Community Services |
| X | X | | Oregon Health Division (lead division) |
| | X | | Oregon Health Division (lead division) |

**III.** **Goal Statement:** Increase targeted outreach and education strategies through the use of traditional and non-traditional activities to prevent lead poisoning.

**Action Items:**

| | POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|---|
| **A.** | X | | | OHD-Lead Program (lead division), Dept of Education, Dept of Human Services |
| **B.** | X | | | OHD-Lead Program (lead division) |
| **C.** | X | X | | OHD-Lead Program (lead division), Dept of Consumer & Business Development |

**IV. Goals Statement:** Fund development of rural and urban models for comprehensive pilot intervention programs in targeted geographic areas (e.g. large neighborhoods or small communities) where the prevalence of older housing and poverty indicate potential risk to children from racial and ethnic communities.

**Action Items:**

**A.** Provide funding to develop the capacity for community involvement in the development of the prevention efforts and include resources for full process and outcome evaluation. For example: structure components to include an intensive community awareness/mobilization strategy; household risk assessment; on-site testing; referral to care as needed; education and tools necessary for household lead exposure reduction (e.g. CLEARCorp Resident Intervention Model); referral to low-income lead remediation programs; follow-up with parents/guardians. Move or expand the pilot interventions into additional areas at risk if the program is successful.

**B.** Work directly with Tribes and urban Indian programs to develop culturally appropriate models for prevention and treatment.

| POLICY | BUDGET | LEGISLATIVE | RESPONSIBLE |
|---|---|---|---|
| X | X | | OHD-Lead Program (lead division) |
| X | | | Dept of Human Services (lead department), Oregon Health Division |

# APPENDICES

# APPENDIX A

## Governor's Racial & Ethnic Health Task Force Executive Order – 99 – 07

**EXECUTIVE ORDER NO. EO - 99 - 07**

RACIAL AND ETHNIC HEALTH TASK FORCE

This Executive Order creates the Racial and Ethnic Health Task Force to review, analyze, and recommend changes as needed in State of Oregon Agencies, including but not limited to the Department of Human Resources and other state programs with the goal of improving the individual and community health status for people of color and ethnic populations.

The Task Force created by this Order shall be comprised of concerned individuals from effected racial and ethnic communities, as well as representatives from both private and non-profit organizations and state agencies who are dedicated to working toward improvement in the health status of Oregon's racial and ethnic populations.

The Task Force will report annually to the Governor and Legislative Assembly on the performance of those state agencies whose programs address racial and ethnic health issues.

The Task Force will generally advise and assist state agencies in meeting the goals and objectives established by the Governor.

It is essential that we as a state achieve this goal for the economic, health, and social costs attributed to poor health status of racial and ethnic communities are substantial, and inflict a needless toll upon these communities and our state as a whole.

In early 1998 a group of concerned citizens gathered to form the Racial and Ethnic Health Work Group (Group) to study issues regarding racial and ethnic health issues. The Group developed a plan of action which identified the following three goals:

* develop legislation establishing an entity to oversee racial and ethnic health issues affecting Oregonians;

* recommend increased funding for the Oregon Health Division's Office of Multicultural Health;

* create a task force to provide assistance and advice on monitoring and ensuring accountability for state activities related to prioritized racial and ethnic health issues identified in this Order for the 1999-2001 biennium.

**WHEREAS** the Oregon Benchmarks track the progress on infant mortality, prenatal services, and the numbers of adults and children lacking health coverage;

**WHEREAS** the Oregon Progress Board issued an update on Oregon minorities in January 1998 indicating improvement in selected health benchmarks but Oregon minorities continue to lag behind the state as a whole in areas such as infant mortality, prenatal services, and people lacking health coverage;

**WHEREAS** it has been determined that access to health care by racial and ethnic minorities is inadequate to address the chronic health issues these communities face;

**WHEREAS** it has also been determined that health coverage can best be defined as medically appropriate care provided when needed by culturally competent providers;

**WHEREAS** it has been determined that people of color and people with native languages other than English experience extreme difficulty accessing health services;

**WHEREAS** improving health status in all communities requires effective programs of prevention, protection, education and health promotion;

**WHEREAS** six critical health priorities have been identified for increased efforts during the 1999-2001 Biennium;

**THEREBY IT IS HEREBY ORDERED AND DIRECTED:**

1. The Racial and Ethnic Task Force is hereby created. The membership of the Task Force shall be no greater than 21, comprised as follows:

    a: Six members of the Legislative Assembly with interest and expertise in the subject of racial and ethnic health. Three of these members shall be members of racial or ethnic groups.

    b: One representative from each of the following agencies and organizations, as nominated by the executive authority of the organization or agency.

        i) the Commission on Asian Affairs;
        ii) the Commission on Black Affairs;
        iii) the Commission on Hispanic Affairs;
        iv) the Legislative Committee on Indian Services;
        v) the Oregon Medical Association;
        vi) the Conference of Local Health Officials;

vii) the Oregon Association of Hospitals and Health Systems;
viii) the Governor's Office.

Organizations are encouraged to nominate persons who are knowledgeable about public health issues and persons who have a specific knowledge about one or more of the six priority areas that shall constitute the focus of the Task Force during the 1999-2001 biennium.

c: Seven additional members appointed by the Governor who are members of racial or ethnic groups.

2. The members of the Task Force shall choose two members as co-chairs. The co-chairs shall establish an agenda for the Task Force, facilitate communication among members of the Task Force, and generally provide leadership and direction for the Task Force.

3. The following state agencies shall provide support to the Task Force:

a: the Oregon Health Division;
b: the Office of Alcohol and Drug Abuse Programs;
c: the Office of Medical Assistance Programs;
d: the Mental Health Division;
e: Senior and Disabled Services Division;
f: the Office for Oregon Health Plan Policy and Research;
g: the Oregon Medical Insurance Program;
h: the Insurance Pool Governing Board.

The directors of these state agencies, and other state agencies with authority and activities affecting the health status of racial and ethnic communities as identified by the Oregon Health Council and the Oregon Health Division, shall cooperate by providing information as needed and available, and by meeting with and reporting to the Task Force as requested.

4. The Task Force shall carry out the following activities:

a: review and recommend revisions to the goals, strategies, and outcome measurements of prevention and treatment programs

related to the racial and ethnic health issues identified in this Executive Order;

b: review and recommend revisions to the implementation plans for programs related to the priority racial and ethnic health issues identified by this Executive Order and the accompanying budgets;

c: review the overall effectiveness of such programs and advise the appropriate agencies of any recommended changes including redirection of resources as indicated;

d: Make an annual report to the Governor detailing its findings and recommendations.

5. In carrying out these activities during the 1999-2001 biennium, the Task Force shall focus upon the following priorities:

a: adequate access to treatment for Oregonians with physical and mental health coverage, with adequate access being defined as medically appropriate care provided when necessary by culturally competent providers in a suitable setting;

b: HIV/AIDS

c: diabetes;

d: asthma;

e: lead poisoning;

f: alcohol and drug abuse.

6. While other issues also disproportionately effect racial and ethnic communities, these priority areas were identified for the extreme consequences they visit upon children and families throughout racial and ethnic populations, as well as the need for concerted collaboration toward improving outcomes in the treatment of these conditions. In prioritizing these conditions, the Group assumed continued and funding levels and

service efforts for existing programs and activities in areas which also aim to provide increased access to services relating to racial and ethnic health. The Task Force shall establish priorities for future bienniums.

7. Meetings of the Task Force shall be coordinated and staffed by the Office for Oregon Health Plan Policy and Research in collaboration with the Oregon Health Division Office of Multicultural Health. The Task Force shall meet at least once per quarter, and may hold additional meetings as deemed necessary by the chairs.

8. This Order expires four years from the date of its issuance unless explicitly extended by the Governor.

Done at Salem, Oregon, this 10th day of March, 1999.

/S/_____
John A. Kitzhaber, M.D.
GOVERNOR

ATTEST:

/S/_____
Phil Keisling
SECRETARY OF STATE

# APPENDIX B

## State Agency Presentation Matrix

**Racial and Ethnic Health Task Force**
***State Agency Presentation / Informational Summary***

*Updated: July 12, 2000*

| **State Agency** | **Questions #1:**<br>*Describe current agency programs & activities that support the priorities of the Task Force.* | **Question #2:**<br>*Give an overview of the current and proposed biennial budget items that relate to Task Force priorities.* | **Question #3:**<br>*Describe gaps and unmet needs your agency would like to address.* |
|---|---|---|---|
| Department of Consumer & Business Services<br><br>***Insurance Pool Governing Board /***<br><br>***Office of Medical Insurance Programs*** | **Current Programs / Efforts**<br><br>• Oregon Medical Insurance Pool (OMIP) and the Family Health Insurance Assistance Program (FHIAP), in many ways mirror the private insurance industry<br>• OMIP & FHIAP support the work of the task force indirectly through access to health benefit coverage<br>• Have targeted areas with high concentrations of minority populations and high rates of uninsurance for the first training sessions.<br>• In April 1998, went to Hillsboro, NE Portland, and Woodburn, Hermiston, Medford, Klamath Falls, and Pendleton – this effort was to get people onto the program's reservation list<br>• This effort to reach racial and ethnic groups have worked to a degree<br>• Have marketing materials in Spanish (reservation cards, posters, and table tents) that are free to stakeholders and community partners<br>• Application and member handbook in Spanish<br>• Have bilingual Spanish-speaking staff at the administrative offices | **Budget / Funding**<br><br>***OMIP***<br>• OMIP is funded primarily through member premiums and through an assessment made on the insurance carriers and self-insured entities doing business in the State.<br>• The program can absorb increases in enrollment due to enhanced outreach and marketing efforts to minority populations.<br><br>***FHIAP***<br>• FHIAP is funded by the tobacco tax passed by voters in November 1996.<br>• Declining tobacco tax revenues will continue to put pressure on the program's budget.<br>• Also has a Legislatively Adopted Budget (LAB) that is **$3 million less** than what the Governor requested in his budget for 1999-2001.<br><br>***Overall***<br>• Can serve between 5,250-5,350 people during current biennium | **Gaps / Unmet Needs**<br><br>• The uninsurance rate for racial/ethnic groups still considerably higher than that if the general Oregon population<br>• Growing size of the FHIAP reservation list indicate an interest in the program, but there are budget limitations<br>• There is a need to market importance of offering health insurance to small minority businesses<br>• Have no contractual or statutory authority to demand that specific providers (clinics, doctors, hospitals, etc.) who serve racial/ethnic minorities be included on provider panels<br>• Private insurance industry tends to lag behind government programs in its ability to offer information in languages other than English |

| | | | |
|---|---|---|---|
| | • Have ability to connect to translation services by phone when needed<br><br>• FHIAP's Agent Referral program allows potential applicants or members to request the services of a specially trained insurance agent to help them with both the FHIAP application and with selecting and purchasing a health insurance plan<br>• 16 different languages are spoken by various agents in the Agent Referral Program<br><br><u>*Additional Information:*</u><br>• Since the March 28 meeting, FHIAP has experienced some major administrative changes<br>• Starting June 15, 2000, the Insurance Pool Governing Board will begin taking over the operational functions of FHIAP from the Third Party Administrator. This phase will occur in phases over the next several months, and will be completed by December 1, 2000.<br>• In process of designing data systems which will be used to administer the program, and many of the concerns of the Task Force have been incorporated into its design. After the new system has been in place for several months, we should be able to give the Task Force reliable and up-to-date data on the racial/ethnic makeup of the people on the reservation list and those who are members of the program.<br>• Since the FHIAP program is now releasing a limited number of applications on a regular basis, it is appropriate for us to examine our marketing efforts to all targeted populations, including racial and ethnic minorities. Cheri Tebeau-Harrell is on a job rotation with the Insurance Pool Governing Board. She will help us to make stronger connections within the different racial/ethnic communities so that | ***Proposed Budget***<br>• Intend to ask for additional funding during the 2001-2003 biennium | |

| | | | |
|---|---|---|---|
| | we can develop communications and marketing strategies that will be meaningful to those communities. | | |
| Department of Human Services<br><br>***Mental Health & Development Disability Services Division*** | **<u>Current Programs/Efforts</u>**<br><br>• Office of Mental Health Services' Planning and Management Advisory Council has membership representing Hispanic, African American and Native American communities<br>• Collects info on racial/ethnic characteristics of all persons served in outpatient and inpatient programs. In FY 1994-95 through FY 97-98, report showed an increase of mental health services received by: Asians → 11.7%, African Americans →11.8%, Hispanics → 17.6%, & Native Am. → 10.4%<br>• Oregon Health Plan Mental Health Organizations report in 1999: Asians, African Americans, and Native Americans are served in approx. the same proportion as they are represented in the Medicaid-enrolled population of which they are a part of<br>• 1999 Office Mental Health Services survey determined that there were 6 community mental health programs who were offering targeted programs for racial/ethnic groups: Malheur Co. (serving 152 Hispanics); Multnomah Co. (with 6 different programs serving a total of 869 Hispanic, Vietnamese, Laotian, Cambodian, Mien, Russian, Chinese, and African Americans); Polk Co. (serving 25 Hispanics); Umatilla Co. (serving 172 Hispanics); Washington Co. (serving 200 Hispanics); and Confederated Tribes of Warm Springs (serving 388 Native Americans)<br>• Involved in statewide trainings with cultural competency component for: Office of Mental | **<u>Funding / Budget</u>**<br><br>• Will continue to take an integrated approach to budget development, but will remain close to monitoring of contracts which require culturally competent services to members of racial/ethnic groups<br>• Legislative concept: to amend the Local Mental Health Act to make state funds available to any federally recognized tribe wanting to offer community-based mental health services<br>• Oregon Federal Block Grant Application targeted an increase in the number of Hispanic children, youth, and adults served in the public mental health system<br>• DHS Dual Diagnosis Task Force contains a series of recommendations related to a finding of insufficient services which are culturally relevant for persons who have co-occurring disorders. The first of these recommendations is to transmit the report to the Racial and Ethnic Health Task Force and to request feedback and consultation. The two state offices are proceeding with an implementation plan for each of the recommendations in this section of the final report.<br>• Identified cultural competence as a major training topic in our Office of | **<u>Gaps / Unmet Needs</u>**<br><br>• Continue efforts to improve the availability of culturally relevant mental health services to persons from diverse racial and ethnic groups<br>• Assure the development of specialized programs for persons who require identifiable cultural approaches in the most acceptable settings |

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| | Health Services Successful Community Living Conference; DHS Diversity Conference; Oregon Office on Disability and Health Conference; National Association for Rural Mental Health 26th Annual Conference; and Oregon Rural Health Conference<br>• Organized and co-sponsored training for all mental health training staff in 1999-2001 biennium<br>• Represented Division at the African American Hlth Coalition's Wellness Village<br>• In past years, represented Division at the Multicultural Health Conference<br>• Hiring more bilingual staff<br>• Training staff to be more culturally competent<br>• Increase the number of Hispanics to utilize services<br><br>*Additional Information:*<br>• In 1998-1999, 14.33% of all people served in one of the state hospitals were people of color: AAPI → 23 people; African American → 83 people; Latino → 54 people; Native American → 28 people; Unknown → 7 people; White → 1166 people<br>• Community mental health services are provided in partnership and cooperation with 32 county-based community mental health programs. For the Oregon Health Plan, community managed care mental health services are also provided through 12 mental health organizations.<br>• Working on developing a table, which would illustrate the enrollment of persons of color in each community mental health program.<br>• Requesting info on cultural competency status from each community mental health program as a part of the 2001-2003 biennial implementation plans.<br>• Will be actively engaging racial/ethnic health | Mental Health Services Training Plan 1999-2001. A major two-day conference on mental health and cultural competency is being planned for the Spring of 2001. | *Additional Information:*<br>• Plan to promote an increase in the number of mental health professionals of color. The DHS Dual Diagnosis Task Force report makes recommendations in this area which the Office of Mental Health Services and the Office of Alcohol and Drug Abuse Programs are now developing specific plans to implement<br>• Will also be continuing its discussion with leadership in higher education training programs to promote the issues regarding increasing the number of mental health professionals of color.<br>• Federal funds were used in the late 1980's under the Human Resource Development Grant administered through the National Institute of Mental Health. The Division worked collaboratively with OHSU and PSU to develop stipends for students of color specializing in studies related to mental |

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| | advocates in the promotion and delivery of the Spring 2001 major conference on cultural competence in mental health programs. | | health services. Unfortunately, funding for that program was eliminated in the early 1990's and no targeted resources have been available since.<br>• Example: increased outreach to members of racial and ethnic groups in high schools, community colleges and other colleges is one area of need.<br>• Persons from the Hispanic community are underserved in many Oregon programs for a variety of reasons: lack of bilingual / bicultural staff; programs serving these communities not well-publicized; many programs which are available need to adapt themselves more to the cultural needs of Hispanic persons and cultures. The Division plans to make this a special focus of MHO reviews in the next 12 months. |
| Department of Human Services<br><br>***Office of Alcohol and Drug Abuse Programs (OADAP)*** | **Current Programs/Efforts**<br><br>• Beer and Wine Tax<br>• OARs 415-510-090<br>• Certified Intensive Residential Treatment<br>• Residential Treatment<br>• Outpatient Treatment<br>• DUII Programs<br>• Or. State Incentive Cooperation Agreement<br>• Oregon Together! Communities That Care<br>• Integrated effort with Addiction Certification Board of Oregon<br>• Collaborated efforts with Portland Community College<br>• Entry Level Certification Program<br>• OADAP Annual Treatment Conference<br>• Support development of African American training/advocacy consortium<br>• Review NARA's proposal for Native American Internship program<br>• Working with Chemeketa Community College and Mid Valley Behavioral Care | **Funding / Budget**<br><br>***Current Budget***<br>• Treatment programs with ethnic/minority focus: currently funds outpatient, residential and DUII programs for minority populations in 17 counties, approx. $1 million not including fee for service payments for DUII and OHP clients.<br>• SICA Tribal dollars: $50,000 annually to nine recognized tribes and 36 counties in Oregon for alcohol and drug prevention planning.<br>• Prevention Programs with Ethnic/Minority Focus: Oregon Together Communities receive between $5,000 – $10,000 to implement prevention programs. | **Gaps / Unmet Needs**<br><br>• Availability of programs for racial/ethic minorities<br>• Research-based and culturally competent treatment approaches<br>• Recruiting and retaining qualified professionals and leaders into the workforce<br>• Raising awareness about alcohol and drug issues in minority communities; appropriate materials for education |

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| | Network to develop Latino scholarship programs and develop plan<br>• PCC minority scholarships<br>• CCC plans for Latino scholarships and CEU gambling course<br>• MHCC CEU's in Dual Diagnosis<br>• OHD cross training focus HIV/Hepatitis C<br>• SCF and other DHS Divisions cross training on confidentiality and best practices, shared values, and case management<br>• DHS Training Project<br><br>*Additional Information:*<br>• 39 programs throughout the state have received certification to provide services to people of color. These include 26 programs for Hispanics, 7 for African Americans, and 6 for Native Americans. These programs demonstrate that they meet the following: 1) staff is qualified to work with the target populations including possession of bilingual skills when appropriate; 2) program must provide language appropriate when written; 3) program must establish an advisory committee that is representative of the target population; 4) the office environment must be appropriate to the target population. ODAP requires counselors to complete a 4-day course on cultural competency in order to receive Entry Level Counseling Program (ELCP) certificates. | ***Proposed Budget***<br>• Continue current funding<br>• Consider more workforce development by funding: college tuition, mentoring projects, clinical supervision at various agencies<br>• Continue treatment and prevention services expansion .<br><br>*Additional Information:*<br>• Spending $10 million in regard to racial/ethnic communities: **Treatment Enhancements** → $6.25 million; **Safe, Drug-Free Housing** → $2 million; **Community Prevention** → $1 million; **Training & Accountability** → $0.75 million<br>• As part of the county/tribal grants process, OADAP awarded approx. $800,000 for programs aimed at ethnic minority populations<br>• As part of a community grants process, OADAP awarded to three counties (Washington, Lane, and Marion) and the Cow Creek Tribe to develop and implement multicultural parent training programs. | |

| Department of Human Services<br><br>***Office of Medical Assistance Programs (OMAP)*** | **Current Programs / Efforts**<br><br>***Adequate Access:***<br>• Rule requirements for culturally competent services OAR 410-141-0220 (7)(b-d)<br>• Qualified interpreter services<br>• Site review of plans by evaluation & analysis unit<br>• 101 agreements with county health departments, hospitals, FQHCs, etc for outreach services (providing OHP applications and info about OHP)<br>• Developed a draft "external diversity plan"<br><br>***HIV/AIDS:***<br>• OHD tracks prevalence through their surveillance system – OMAP has plans to study the proportion of HIV/AIDS pop. Covered by OHP and their demographics to assess program improvements needed<br><br>***Diabetes:***<br>• Participation in the Oregon Diabetes Coalition (ODC)<br>• Working with OHD to identify clients w/ diabetes, utilization of care & episodes of care<br>• Will use HEDIS measures on diabetes and will analyze finding by ethnic/racial group<br>• Site reviews of managed care plans include review of policies, procedures, and description of processes to promote care for those with chronic conditions<br>• Participant in a newly formed diabetes chronic disease project with DHS | **Budget / Funding**<br><br>**Total Amount Budgeted 1999-2001**<br><br>***HIV/ AIDS:***<br>• Amount budgeted per member per month = $0.39<br>• *African American members* = **$152,889**<br>• *Asian members* = **$95,573**<br>• *Hispanic members* = **$402,149**<br>• *Native American members* = **$66,506**<br><br>***Diabetes:***<br>• Amounts budgeted per member per month = $14.71<br>• *African American members* = **$5,743,009**<br>• *Asian members* = **$3,590,042**<br>• *Hispanic members* = **$15,106,065**<br>• *Native American members* = **$2,498,204** | **Gaps / Unmet Needs**<br><br>***Adequate Access:***<br>• Involvement of community groups to help identify medical providers that exist within the community that are competent and sensitive to cultural differences.<br>• Incentives for providers that provide culturally competent translation services<br>• With OHD, OMA, ODA, etc to help recruit providers from diverse backgrounds w/ a focus on cultural competency<br><br>***HIV/AIDS:***<br>• Studies of how to improve the linkages between OHD and OMAP related to data from OHD and claims from OMAP<br>• Prevention programs in coordination with OHD, managed care plans, and community partners<br><br>***Diabetes:***<br>• Completion of ed. Materials to include a focus on ethnic/racial groups<br>• Completion of study (Medicaid Assessment) using HEDIS measures that will analyze findings by ethnic/racial groups |
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| | ***Asthma:***<br>• OMAP support OHD's successful application for a grant to study asthma w/ a commitment to provide access to claim and utilization reports<br>• OHD hired staff and is in the process of identifying clients receiving asthma related services and will use claims and utilization reports from OMAP to identify gaps in service<br>• Asthma report will include ethnic/racial groups' assessments<br><br>***Lead:***<br>• OMAP involved with Multnomah County pilot (Mar99-Sept00)<br>• Mandatory lead testing for children under age 6 in 21 zip codes in Multnomah County<br>• Testing in physicians' offices and community clinics and labs<br>• Each of the managed care plans has appointed a "lead screening contact" person<br>• Mandatory screening for OHP children in the state<br>• Educational materials made available and widely distributed<br>• Study to identify frequency and prevalence of elevated lead levels and demographic assessment of high-risk population<br>• OMAP claims data will be matched with OHD lab results<br>• Data will be used to establish protocols for future lead prevention programs within the state<br>• Interim report due June 2000 w/ a report to Medical Directors in April and July 2000<br>• Final report in early 2001 | ***Asthma:***<br>• Amount budgeted per member per month = $0.99<br>• *African American members* = **$386,990**<br>• *Asian members* = **$241,913**<br>• *Hispanic members* = **$1,017,916**<br>• *Native American members* = **$168,340**<br><br>***Prevention (e.g. Lead):***<br>• Amounted budget per member per month = $1.27<br>• *African American members* = **$494,060**<br>• *Asian members* = **$308,844**<br>• *Hispanic members* = **$1,299,545**<br>• *Native American members* = $**214,915** | ***Asthma:***<br>• Newly started program – finding expected within the next 6-9 months.<br><br>***Lead:***<br>• Need to develop a process that addresses statewide issues<br>• Getting children from NE Portland neighborhood to doctor's offices<br>• Data collection efforts have not been as smooth as originally hoped<br>• Matching children between systems is time consuming and problematic<br>• Making parents and caretakers aware of importance of lead testing |

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| | ***Alcohol and Drug*** | ***Chemical Dependency*** *(does not include acute detox):*<br>• Total OHP 1999-2001 Budget = **$39,155,859**<br>• *African American* (4.46%) = **$1,746,351**<br>• *Asian* (2.93%) = **$1,147,267**<br>• *Hispanic* (11.73%) = **$4,592,982**<br>• *Native American* (1.94%) = **$759,624** | ***Alcohol and Drug*** |
| Department of Human Services<br><br>***Oregon Health Division (OHD)*** | **<u>Current Programs / Efforts</u>**<br><br>***DIABETES***<br>• Increase the receipt of preventive services to all people with diabetes<br>• Establish community-based educational programs for preventing complication of wellness programs for people with diabetes<br>• Reduce disparities in high risk populations<br><br><u>Priorities for FY 2000-2001:</u><br>• In partnership with communities of color, design and conduct an assessment of: receipt of preventive services; financial and practical barriers to access to care; community capacity to develop population-based interventions<br>• Create a clearinghouse of patient education and training resources to increase cultural competence among diabetes educators and either health care professionals<br>• Leverage resources within Oregon Diabetes Coalition to improve the quality of life for people with diabetes in high-risk populations | **<u>Budget / Funding</u>**<br><br>***DIABETES***<br>• There is no State general funds for diabetes<br>• Oregon receives $720,00/yr from Centers for Disease Control (CDC), Division of Diabetes Translation<br>• Grant Cycle: 3 or 4 year cooperative agreement<br>• Proportion allocated to Multicultural Activities = 15%<br>• Estimated direct and indirect costs of diabetes in Oregon in 1996 = $1.4 billion | **<u>Gaps / Unmet Needs</u>**<br><br>***DIABETES***<br>• Collecting and using data for evaluation<br>• Costs<br>• Methods<br>• Creating awareness that diabetes is serious, common, and costly<br>• Creating awareness among high-risk populations that diabetes can be controlled through preventive health care about modifiable risk factors (e.g. diet and physical activity) |

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| | ***LEAD POISONING***<br><u>Partnerships:</u><br>• County Health Departments: on-site investigations, supplemented by OHD; Multnomah County screening program, community education and limited lead paint removal (Water Bureau)<br>• Physicians for Social Responsibility (PSR): free screening for children in NE Portland, OHD attained grant to support lab tests<br>• Urban League, Coalition of Black Men: community education, outreach<br><br>***ASTHMA***<br>• Oregon Asthma Program<br>• This program started at OHD in January 2000<br>• Capacity building<br>• Focused on improving care / removing triggers<br>• Goals: Build system to describe and monitor prevalence and asthma care; develop state-wide coalition and plan<br>• Multiple partners: managed care, community groups, OMAP, clinicians<br>• Planned special outreach to communities of color: faith communities, Native American governments, Environmental justice groups<br><br>***HIV***<br>• HIV/AIDS monitoring<br>• Prevention: testing and risk reduction counseling; community education; MSM intervention; IDU outreach<br>• Clinical care services: ADAP; insurance continuation (Oregon Health Plan, Oregon Medical Insurance Program) | ***LEAD POISONING***<br>• No State general funds support<br>• CDC grant to track poisoning = $80,000/yr<br>• Share expertise with County and community groups – Resource for questions about lead paint removal, certify contractors<br>• OMAP/OHD Multnomah County project – Goal is to establish prevalence in area of highest risk (older housing, poverty)<br><br>***ASTHMA***<br>• Supported entirely by competitive CDC grant $250,00/yr for 3 years (Oregon one of only 3 states funded)<br>• No State general funds<br>• 1996 cost estimate = $14 billion (1-3% of all health care expenditures in US)<br><br>***HIV***<br>• HIV/AIDS monitoring = $268,000<br>• HIV Prevention<br>CDC Cooperative = $2.6 mil<br>State General Funds = $1.2 mil<br>• HIV Care<br>• ADAP = $3.1 mil<br>• Ryan White base = $1.6 mil | ***LEAD POISONING***<br>• Controversial<br>• Universal screening – testing all kinds in age group<br>• CDC Guidelines say net cost-effective when prevalence <12%<br>• Targeted screening only good in theory<br>• No treatment to repair damage<br>• Prevention is key<br>• Controversy over screening has diverted attention from prevention<br>• Dollars spent on testing may mean less for prevention<br>• Lead-containing pottery and home remedies likely to be used by communities of color – need for culturally appropriate education<br><br>***ASTHMA***<br>• Identification of representative for Coalition from communities of color<br>• Access to proper care and medications<br>• Culturally competent teaching and promotion of self-management<br>• Addressing environmental triggers (tobacco, air pollution)<br><br>***HIV***<br>• There is a need for culturally competent providers to deliver medical, case management, prevention counseling and support services for persons of color.<br>• A critical need for populations that are non-English speaking.<br>• Increase recruitment for people of color into graduate public health programs |

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| | • Office of Multicultural Health Community Mobilization Project<br><br><u>Partnerships</u><br>• Multicultural HIV/AIDS Alliance of Oregon Health Division (MHAAO)<br>• Brother to Brother<br>• Urban League of Portland<br>• Somos Orgullo Latino<br>• Oregon Council for Hispanic Advancement<br>• Project Red Talon (NW Area Indian Health Board)<br>• Proyecto Promotores (Hispanic Lay Health Promotion) collaboration with Pacific AHEC<br><br><u>HIV Program Priorities</u><br>• HIV as a chronic disease<br>• 100% access, 0% disparities for HIV care<br>• Accurate reporting of the entire spectrum of HIV disease<br>• Evidence based interventions addressing the behaviors of high risk populations<br>• Focus on local program evaluation and quality assurance<br><br><u>Multicultural Priorities</u><br>• Assure representation for persons of color<br>• Ongoing prevention and care services needs assessment, with over-sampling in communities of color<br>• Empower racial/ethnic CBOs in HIV prevention programs<br>• Assure access to care for HIV-positive persons of color through enhanced care coordination<br>• Increase cultural and linguistically proficient HIV care and prevention services through MHAAO and AETC | • State General Funds = $50,000<br>• AETC = $21,000<br>• OMH Project = $150,000 (for 3yr)<br>• Medical care = $10,000/yr/case | |

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| Department of Administrative Services<br><br>***Oregon Health Plan Policy and Research (OHPPR)*** | **Current Programs / Efforts**<br>• Charged with supporting the efforts of the Governor and Legislator to ensure that all Oregonians have access to affordable, quality health care<br>• Staffing commissions, councils, and task forces, including the Health Services Commission, the Health Resources Commission, the Oregon Health Council, the Oversight Task Force on Mental Health Integration, the Genetic Research Advisory Committee, the Advisory Committee on Physician credentialing, and the Racial and Ethnic Health Task Force | **Budget / Funding**<br>• Policy/staffing = $1,105,970<br>• Data/research = $468,898<br>• Administration = $373,227<br>**TOTAL: $1,948,095**<br><br>Sources of funding:<br>• General Funds = $912,491<br>• State Agency Transfer = $1,652,580<br>• Grants = $270,075<br>• Other = $60,247<br>**TOTAL: $2,895,393** | **Gaps / Unmet Needs**<br>• Continue efforts to improve the availability of relevant health data about minority populations in the state |
| Department of Human Services<br><br>***Senior & Disabled Services Division (SDSD)*** | **Current Programs / Efforts**<br>• Access to services: transportation, information and referral, counseling, long-term care<br>• Health Maintenance Services: nutrition screening, exercise/physical fitness, wellness education, medical equipment loans, Oregon Health Plan<br>• Nutrition Services: home delivered meals, food stamps, group meals<br>• Long-term Care<br>• Eligibility for OHP, long-term care, food stamps, Qualified Medicare Beneficiary program, Medical Needy drug benefits<br>• Licensing<br>• Protective Services / Risk Intervention<br>• Cash Assistance<br>• Older Americans Act<br>• Employment Initiative | **Budget / Funding**<br>***Program Budget 1999-2001***<br>• Long-term care = $1,066.3 mil<br>• Cash Assistance = $62.8 mil<br>• Older Amer. Act = $24.6 mil<br>• Licensing = $22.4 mil<br>• Protective/Abuse Services = $16.2 mil<br>• FS, OHP, Medical Assistance = $25.2 mil<br>**TOTAL: $1,217.5 mil**<br><br>***Budget Allocation***<br>• Older Amer. Act = $22.92 mil<br>• Cash to Clients = $30.32 mil<br>• Staff, Rent, Supplies = $223.94 mil<br>• Payments to Local Care Providers = $940.33 mil<br>**TOTAL: $1,217.51 mil**<br><br>***Sources of Money 1997-1999***<br>• Client Contribution = $134.32 mil | **Gaps / Unmet Needs**<br>• A need for targeted outreach to Ethnic and Racial minority client populations to inform them about available services and resources<br>• The need for outreach to families of ethnic and racial minorities to increase awareness and knowledge of long term care needs and services and how to plan for them.<br>• Inadequate recruitment of caregivers from diverse ethnic and racial minorities groups.<br>• Lack of training in cultural sensitivity and competency for caregivers providing services to ethnic and racial minorities.<br>• There is a lack of research-based culturally competent long-term care services approaches and designs. |

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| | *Additional Information:*<br><br>• Total number of minorities on staff: **SDSD Central Office and Quality Assurance** → 17 out or 207; **SDSD Field Offices** → 54 out of 397; **Type B Contract Field Offices** → 29 out of 234.<br>• SDSD addresses cultural competence during many of its training modules, including training for eligibility workers, case managers, and protective service workers. The division also includes cultural competency as part of its training for adult foster home providers. One of the division's largest districts will pay for client-employed providers who wish to attend cultural competency training.<br>• Examples of Cultural Competency: 1) handout used during new employee orientation; 2) handout that has been used during client assessment training for case mangers; 3) handout used during training for staff who determine eligibility for food stamps.<br>• SDSD has a Tribal Liaison who works with DHS Tribal Relations Liaison. Our Tribal Liaison is responsible for networking with Oregon's Native American tribes, which includes listening to concerns and issues and providing information about the services that SDSD provides. The Liaison also facilitates access to services by working with local offices and tribes to identify and resolve problems. | • Other Funds = $47.26 mil<br>• General Funds = $365.32 mil<br>• Federal Funds = $549.41 mil<br>**TOTAL: $1,096.31 mil** | |

***** This information was provided by State Agencies at the March 28, 2000 and June 9, 2000 Racial & Ethnic Health Task Force meetings.***

# APPENDIX C

## Multicultural Health Conference 2000 Policy Roundtable Discussions
## April 11, 2000

**MULTICULTURAL HEALTH CONFERENCE 2000**
**ROUNTABLE POLICY DISCUSSION**

# ***Common Themes and Patterns of Priority Health Areas***

## ACCESS

### Issues facing the community

- *Language Diversity*. This area include unskilled providers as second language speakers, the need for an increase in the number of interpreters and consistency of payment for these services, more informational and educational materials in languages other than English, and a state certification requirement for interpreters.

- *Cultural Competency*. This area includes the need for health service providers to speak additional languages, strengthen cultural competency, and understand cultural demands of consumers and caregivers.

- *Outreach and Education*. Find better and more innovative ways to outreach and educate the community about health issues and available services.

- *Health Care System*. The need for a more proactive and user-friendly health care system including health care advocates for patients, support, recruitment, and volunteers from the community to participate in the health care system and a focus on increasing utilization not just access.

### How to Address Issues Identified

- *Partnerships*. Private healthcare institutions are developing partnerships with various cultural communities.

- *Training*. IRCO and State refugee agency created and delivering free access training for medical and legal immigrants, PCC ‘s Medical Interpreter’s Program and promoting self-care programs at Providence Hospital and other institutions.

- *Workforce Diversity*. Universities, healthcare institutions, and other agencies are increasing diversity in their workforce and encouraging minorities into the healthcare system.

- *Informational Outreach*. Religious institutions are implementing programs to increase understanding of available healthcare resources to the communities.

- *Outreach Programs*. Community and grassroots organizations including public schools are developing their own outreach programs using traditional and non-tradition methods.

**Community Resources Needed to Address Health Issues Including Community Assets and Opportunities**

- Individual assets include volunteers, long-term residents and elders who can participate in healthcare outreach efforts in the community.

- Institutional assets are religious organizations, schools, clinics, informal community networks, and community and state agencies that can provide outreach and contact within the community.

- Values within the community include non-traditional medicine, prevention programs, support and encouragement of individuals rising to serve the healthcare needs of the community, and inclusion of all people lacking access to healthcare.

**HIV/AIDS**

**Issues Facing the Community**

- *Resource Shortage and Coordination*. Lack of resources and coordination including money, housing, education, prevention, and programs.

- *Community Education*. Need for increased community education about at-risk and potential at-risk individuals within the urban and rural communities.

- *Provider Follow-up Around Education.* Need for initial and follow up education for healthcare providers outside of the HIV/AIDS system.

- *Cultural Competence*. Need for culturally competent providers/case managers and a system that provides more assistance in living with HIV/AIDS.

- *Trust and Fear*. Lack of trust and fear of the healthcare system.

**How to Address the Issues**

- *Cultural Competence Service Delivery*. Develop and deliver information to urban and rural communities in a culturally competent way.

- *Funding.* Provide more and easier funding for prevention and education programs and projects.

- *Education.* Educate peers, families, community, and providers outside of HIV/AIDS system.

- *Education and Accountability*. Maximize mandated HIV education to hold state, local, and school agencies accountable to increase education and awareness.

- *Cultural Competent Intervention.* Provide program interventions including the use of peers and ways to address environmental factors impacting people with HIV.
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**Community Resources, Asset, and Opportunities Available to Address these Issues**

- Leverage and increase funding for HIV/AIDS service delivery in rural areas, and communication around poverty.

- Utilize people in the community as resources.

- Build on best practices such as HIV Awareness Program at the State Penitentiary.

- Provide education to families, people outside the HIV Network, and to individuals at younger levels.

## ALCOHOL AND DRUGS

**Issues in the Community**

- *Language Diversity and Cultural Competence*. Lack of ESL and culturally competent educational information and providers at all levels.

- *Youth Challenge*. This area includes youth perceptions about this health problem, treatment of violence not inclusive of A&D use, lack of reliable information, and disproportionate amount of drug and alcohol advertisement in the community and toward children and youth.

- *Funding Shortage*. Dramatic cutbacks in covered medical treatment cripples diagnosis and recovery success, while chronic over/under prescription encourages abuse.

- *Prejudice and Stereotypes*. Prejudice and stereotypes among healthcare providers, institutions and the larger population inhibits access to much needed recovery care.

- *Community Education*. The lack of education on abuse for all ages and the impact of abuse within all levels of the family and community structure, from children and youth to adults.

**How to address these issues**

- *Community Education.* Need to inform a larger audience of people through advertising and educational programs, particularly around youth, violence, misperceptions, and racism.

- *Cultural Competence.* Need to increase number of culturally competent providers, and build this practice into programs and service delivery, including the use male role models of color.

- *Healthcare System*. Modify the healthcare system to be more responsive and sensitive to the needs of People of Color.

- *Target Youth.* Target programs to address youth perceptions, treatment integration of A&D and violence, and youth involvement.

**Community Resources, Assets, and Opportunities Available to Address These Issues**

- Match the advertising money: Advertisers should match the amount of money spent on pro use of ATOD with prevention dollars.

- Have agencies and the community meet children and youth at their level and be more supportive in their and their family's environment. Additionally, involve youth in developing and sharing the message about the danger of A&D use and in treatment of the health problem.

- Address the root causes of abuse: address racism and discrimination more proactively in workforce hiring, education, training, system accountability, and Including the spiritual aspect in community involvement efforts.

**DIABETES**

**Issues in the Community**

- *Community Awareness and Education.* Lack of diverse strategies to increase awareness and educate the community about this health issue.

- *Information Gap.* Need data on Asian/Pacific Islander and Russian populations using effective data gathering methods.

- *Proactive Diverse Partnering and Collaborations*. The need exists for developing, partnering, and implementing a more proactive program that would encourage screening using individuals, family members, the community, communities of faith, and organizations and institutions as champions.

- *Consumer/Physician/Provider Relationships*. Effective communication and a proactive approach among physicians and providers working with consumers are needed.

**How to Address These Issues**

- *Community Education*. Develop and implement a diverse set of strategies and activities using personal contact, community leaders, public agencies, private/community events, local media, religious faiths, and healthcare provider networks.

- *Incentives.* Provide incentives that encourage people to participate in screening and education.

- *Available Resources***.** Develop and provide a local list of available resources for consumers, families, and health care providers.

**Community Resources, Assets, and Opportunities Available to Address These Issues**

- Available outreach resources include community media and service organizations, public agencies and schools, grassroots organizations, HMOs, pharmaceutical companies, and faith organizations in the community.

- Potential service and goods providers include health clinics, grocery stores, pharmacies, specialized restaurants and other food-based activities.

- Potential funding and marketing resources include grant providers such as Meyer Memorial Trust, ADA Furse grants, etc., and partnering with other community programs.

**ASTHMA**

**Issues in the Community**

- *Employer Accommodation*. Need for employer accommodation and sensitivity for employees/dependents with asthma.

- *Education and Awareness.* Education and awareness on how to identify asthma early on and live with it.

- *Environmental Factors*. Asthmatic sensitivity is affected by indoor and outdoor air quality.

**How to Address these Issues**

- *Education*. Need for employers, schools, and businesses, education and accommodation for employees, students and others with asthma.

- *Testing and Monitoring*. Test and monitor indoor and outdoor air quality.

- *Manage Triggers.* Manage and minimize exposure to asthma triggers.

**Community Resources, Assets, and Opportunities available to address These Issues**

- Living with asthma classes and allergy clinics sponsored or put on by healthcare providers and other partner associations**.**

- Early detection educational resources on asthma for employers, caregivers, asthmatics, and parents.

- Information and tools to monitor air quality and reduce asthmatic reactions naturally.

**LEAD**

**Issues Facing the Community**

- *Motivation*. Lack of motivation to take action in the areas of screening, education, cleaning and prevention.

- *Awareness and Education.* Lack of awareness and education about the problem, impact, consequences, prevention opportunities, and community providers.

- *Screening.* Lack of screening of underrepresented populations, low income, and racial and ethnic groups who are at greater risk. Additionally, understanding the special needs required to reach these populations.

- *Resource Shortage.* Lack of resources for communities to deliver programs and services in screening, environmental testing, education and prevention, remediation and case management.

- *Limited Educational Approaches.* A shortage of effective educational approaches that will engage and increase awareness about this health issue.

- *Environmental Justice Impacts.* Challenges and addressing issues associated with land lords, enforcement of medical mandates, follow-up after testing, lab test reporting, and housing exist.

**How to Address These Issues**

- *Community Outreach.* Utilize a variety of traditional and non-traditional outreach strategies and activities including a hotline, ethnic media outlets including PSAs in (radio, television, print, door to door canvassing, churches, community centers and schools.

- *Cultural Competence Models.* Programs, service delivery, and outreach models should be culture-specific and as appropriate using community messengers.

- *Health Care Providers*. Provide awareness and education about existing health care providers including report from Physician for Social Responsibility (PSR), prevailing data, testing cost, prevalence and consequences.

- *Targeted Presentations*. Provide presentations to Oregon Medical Association, The Board of Medical Examiners, medical care organizations, and health care providers,

**Community Resources, Assets, and Opportunities Available to Address These Issues**

- Partnership and Collaborations Around Cultural Competence. Medical care organizations should promote culturally appropriate health efforts.

- Become familiar with, participate, coordinate and learn from in formal and informal organizations, networks, program and services and activities in local communities such as PSR, Environmental Justice Action Group, the Annual Lead Summit, CLEARCORP, etc.

- Develop and mandate policies that will deal with lead evaluation at the time of property sale, required Medicaid testing and paint stabilization.

**Common themes across all groups for each question**

**Question #1: Issues in the community?**

- Delivery of healthcare information and education in culturally competent and respectful ways.
- Need more interpreters and multi-lingual providers (across all agencies) available to reach out to ESL elements of the community. Include more informational material in multi-lingual formats.
- Prejudice and stereotypes within the community and healthcare providers around health issues and needs for people of color and youth.
- Environmental factors affecting the health of the community.
- Lack of available and affordable healthcare resources

**Question #2: How to address these issues?**

- Increased funding for healthcare, particularly for low-income populations and for specialty, high-cost treatment.
- Provide a more proactive outreach for educating people of color and particularly youth and parents, on healthcare issues, risks, and prevention.
- Encourage and support more people of color work in the healthcare system and as role models, especially men.
- Develop partnerships with public, private and religious organizations to broaden outreach of healthcare education and available services.
- Address issues around racism, prejudice and stereotypes to reduce health risks, particularly to youth.

**Question #3: What community resources are available?**

- Neighborhood, community, religious, and local public organizations are good resources to provide outreach, education and connection on healthcare with the community.
- Develop partnerships with healthcare providers assist in the outreach efforts to the community and employers, and to sponsor clinics and classes on various healthcare topics.
- Leverage healthcare mandates and existing funding to provide innovative community outreach.
- A network of existing healthcare providers and low-cost clinics is available in the community.
- Volunteers in the community are available, we need to encourage and support them.

# APPENDIX D

## Task Force Design Team Work Session Recommendations
## June 26, 2000

# *Racial & Ethnic Health Task Force*
# *Design Team Meeting*
# *June 26, 2000*

## *Recommendations and Voting Summary*

Three small work groups addressing a total of six priority areas generated lists of recommendations on which the attendees could vote. The following lists contain those recommendations, and the votes each recommendations received from those present at the final large work session. Please note that recommendations embedded in the notes of the small group sessions are not listed as part of the voting record.

## Task Force Design Team Work Session Recommendations

On June 26, 2000, the Racial and Ethnic Health Task Force convened a design team work session to address the six priority issues concerning minority communities: access to health care, alcohol and drugs, asthma, diabetes, HIV/AIDS and lead poisoning. In addition to members of the Task Force, the meeting was attended by nearly 50 others, representing government agencies, community-based organizations, health advocacy groups and medical clinics. Joan Brown-Kline, of Brown-Kline and Associates, facilitated.

Following a general information session, in which task force members and meeting participants asked questions of each other, voiced concerns and clarified issues raised in previous meetings, each attendee selected one of three work groups in which to participate. Each work group discussed two of the six core issues the task force has been charged with addressing. At the end of the small group sessions, each group posted for the plenary the recommendations it had developed to improve minority health regarding its particular health issues. Meeting participants then voted for their five favorite recommendations for each of the six health issues. Voting results may be found in brackets after each recommendation listed below. However, please note that recommendations were often embedded in the notes of the small group sessions, and were not presented uniformly for voting. The appendix contains recommendations whose absence in the body of the report represents an oversight in note-taking rather than rejection by meeting participants.

## *Access*

- Improve across-the-board performance monitoring of counties, especially on cultural competency issues. [25]
- Increase community funding for outreach to target populations to increase their access to health care services. [21]
- Expand access to complimentary care- e.g. chiropractic, naturopathic, acupuncture. [16]
- Good, accurate data is needed on all minority health issues. [16]
- Cultural competency training should be required for medical school. [13]
- Increase interpreter services and ensure provider linguistic skills. [13]
- Provide family centered services, i.e. transportation and child care. [13]
- Supply incentives for providers who accept OHP clients. [12]
- State policies governing health care funding distribution, data collection and other activities should be carefully enforced at the county level, thereby transferring accountability to the counties.[11]
- State agencies should be held accountable for state-tribal relationships. [9]

- Engage in comprehensive case management to avoid fragmentation. [8]
- Increase interpreter services. [8]
- The state should keep health plans accountable for their obligations under OHP. [7]
- Partner with higher education institutions to recruit and train bilingual/bicultural people of color in health fields. [5]
- Educate private insurers as to the rights and services provided under their coverage. [3]
- State policies setting common definitions for cultural competency and sensitivity should apply to all agencies. [3]
- Utilize private sector resources (public relations) to encourage healthful behavior. [1]
- Advisory committees to state agencies should be established to voice concerns for communities of color.
- Incentives should exist to incite providers to make services available to minority communities.

## *Alcohol and Drug Abuse*

- Fill the existing need for culturally competent, responsible and sensitive providers. [28]
- Provide more prevention and treatment services for youth. [19]
- Create a process and shared standards among agencies to implement culturally competent services. [18]
- More people of color need to be involved in the provision and administration of prevention services and resources to minority communities. [17]
- Close information gaps- quantitative and qualitative data must be collected from minority communities. [15]
- Increase awareness of and action to address programs that are not working. Shift funding dollars to more effective enterprises. [14]
- Engage in outreach to let community members know what resources are available. [10]
- Use a variety of treatment modalities for Indians to address alcohol and drug issues. [10]
- Lack of providers of color who address alcohol and drug issues. [8]
- Increase residential treatment for people with older children. [7]

- Emergency room workers should be aware of and sensitive to alcohol and drug issues. [6]
- Medical providers should identify alcohol and drug abuse as an issue. [6]
- Encourage businesses to show more sensitivity to their negative impact upon youth. Advocate changes in business and advertising practices. [5]
- Shift community norms about prevention of substance abuse and mental health treatment. [4]
- Hold liquor industries and local businesses accountable for targeting communities of color with alcohol. [3]

## *Asthma*

- Child care providers should receive information on asthma triggers. [27]
- Representatives of the Oregon Medical Association and the Oregon Academy of Pediatrics should present their current asthma-related efforts to the state legislature, and request the increased support needed for future plans. [19]
- Consistent health care and education for persons with asthma. [18]
- Given the affordability of dust covers and non-allergenic materials, their usage as prevention against asthma triggers should be encouraged and possibly subsidized. [17]
- Certify asthma, lead and diabetes educators. [12]
- Coordination [12]
    - The Asthma Network, a statewide collaboration comprised of people and organizations with an interest in reducing the burden of asthma in Oregon, should be linked to the Task Force, and this collaboration should have a liaison to the Oregon Health Division's Office of Multicultural Health.
- The Oregon Medical Association and the Oregon Academy of Pediatrics should present their perspective on asthma and lead in Oregon, what is currently being done about it and what needs to be done about it, to state legislators. [19]
- Address the behavior aspects of asthma as a health issue. [9]
- Educate workers about on-the-job asthma risks using materials translated into plain language. [9]
- Utilize resources to cover the cost of peak flow meters and other resources for treatment and education. [9]
- Address second hand smoke and dust mites as asthma triggers. [3]

- Create coalitions within communities of color. [3]
  - evening meetings
  - provide childcare and transportation.

- Determine the sustainability of funding. Will federal funds provided now be available in the future? [3]

- Reduce environmental triggers of asthma attacks. [2]

- State asthma data is needed. [2]

- Address triggers such as roaches and pesticides. [1]

- Make the Asthma Network open to community members and their input. [1]

- Education for disproportionately affected communities.

- Create a county/state list of providers.

## *Diabetes*

- Initiate a health awareness and prevention campaign for diabetes, similar to that conducted to educate women about breast self-exams. [36]

- Use a holistic model for prevention and care. [26]

- Use "best practices" to model legislation, budgets and programs for minority community health. [22]

- The Racial and Ethnic Health Task Force should assert its voice in building a budget that includes diabetes as an unmet need in the community. [10]
  - Emphasize the huge payback of diabetes prevention and care (e.g. the cost of limb amputation is far greater than routine checkups and consultations with specialists).

- Create community partnerships amongst agencies, organizations and diagnosed individuals. [7]

- Create legislation that regulates the certification standards for diabetes educators, and provides diabetes education funding. [7]

- Collect pertinent data on minority communities. [5]
  - Utilize model methods for data collection on minority communities.

- Providers and educators should emphasize linguistic and cultural competency. [5]

- State and local governments should consider matching federal funds for addressing chronic diseases. [4]

- Work with health care providers to track diagnosed patients and provide continuing care. [4]
- Work with health care purchasers to ensure that they meet the needs of people with diabetes.[2]

## *HIV/AIDS*

- Pursue cultural and linguistic competency, especially in rural areas. [34]
- Get HIV+ people "back into the world" [33]
  - provide assistance with health coverage.
  - aid transition back into workplace without losing health coverage.
  - consider modifying welfare-to-work model for HIV+ people when pursuing
  - legislative change.
  - encourage or mandate the insurance industry's reinsurance of people with HIV or
  - chronic illnesses.
- Assure adequate representation for minorities on planning committees, e.g. not one minority individual per committee. [24]
- HIV prevention and treatment activities should be focused on issues beyond CDC funding and guidelines, as CDC and state analyses may not reflect community needs. [14]
- Empower community based organizations using capacity-building funding from a diverse array of sources. [12]
- Service capabilities should be structured by ethnic group, rather than lumping plans and services for a single "minority" classification. [12]
- Data Collection – Seek funding directed to data collection for communities of color, utilizing models that work. [10]
- Obtain matching funds for project-targeted infrastructure building. [5]
- Identify and utilize more complete, comprehensive funding sources for HIV prevention and treatment. [4]
- Increase HIV screening efforts in minority communities.

# *Lead*

- Skills, training, children's enrichment and other activities must be provided after an affected individual has been screened for lead. [29]

- Establish regulations for screening [26]
  e.g. all children screened upon school entry

- Provide information, outreach, education, screening and prevention materials to minority communities. [26]

- Organize a forum for lead as a health issue, and to address the hazard as part of the health care system. [23]

- Replace Clearcorp, an under-funded program in which volunteers train community members to reduce lead risks, with new programs in education and skills building. [17]

- Search other funding streams [15]
  - National Council of State Legislators
  - Association of Oregon Counties Legislative Agendas
  - League of Oregon Cities

- Publicize the risks of lead-containing home remedies, used particularly in Asian and Latino communities. [8]

- Involve the health care community. [3]

- The private sector is not involved enough in screening efforts.[1]
  - Capitation provides a financial disincentive for private health care providers that decrease testing for lead exposure.

# APPENDIX E

## 2000 Oregon Progress Board Report

# PRESS release

**FOR RELEASE: Wednesday, July 19, 2000**

**Contact:**
**Jeff Tryens**
**Oregon Progress Board**
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**503- 510-9819**

## Report Documents Minority Progress Toward Oregon Benchmarks

SALEM – A new report from the Oregon Progress Board shows that Oregon's racial and ethnic minorities are making progress on key educational and social measures "Oregon's racial and ethnic minorities continue to improve and get closer to Oregon's benchmark goals in almost all arenas," said report author, Chuck Sigmund of Sigmund Research Associates. The report, based on data from the Oregon Population Survey as well as data collected from other state and federal sources, documents minority groups' progress concerning the state's Oregon Benchmark targets. The state report examines recent trends in eight areas, including education, health, and community for each of Oregon's minority communities: African-American, Asian-America, Native-American and Hispanic.

Not all the news is positive, however. Jeff Tryens, executive director of the Oregon Progress Board, observed that, compared to state averages, Hispanics and African-Americans actually lost ground between 1990 and 1998 in many instances. "For almost every indicator we looked at, African-Americans and Hispanics improved less rapidly than the state average, said Tryens. If this trend continues, these Oregonians will fall farther and farther behind the rest of the population."

*Education*

Eighth grade reading and math scores earned by minority students in Oregon showed mixed results between 1991 and 1998. While all groups improved, only Native-Americans improved more rapidly than the state average in both reading and math. Asian-American continued to out score all other racial and ethnic minorities in math.

"While these results are encouraging," stated Chuck Sigmund, of Sigmund Research Associates, "with the exception of Asian-Americans, none of

Oregon's minority groups currently meet the state benchmarks for meeting reading or math standards." In fact, math scores for Hispanics and African-Americans are less than half the state average.

Over seven percent of all high school students dropped out during the 1997-98 school year, compared to 5.8 percent in 1991-92. The highest dropout rate is found among Hispanics who drop out at more than twice the state average.

A record number of Oregon adults had a high school diploma and college education in 1998 and these numbers continue to grow for all groups except Native-Americans and African-Americans. In addition, all of Oregon racial and ethnic groups have higher education levels than their counterparts nationally.

*Health*

The percentage of minority mothers receiving early prenatal care grew across all minority groups from 1990 to 1998. African-American mothers experienced the most rapid increase, climbing from 61 percent in 1990 to 79 percent in 1998. The proportion of Hispanic mothers accessing early prenatal care moved up from 55 percent to 67 percent. The overall state average was 80 percent in 1998.

Hispanic adults are the least likely to have health insurance. In 1998, 22 percent of Oregon's Hispanic adults were without health care coverage, double the state's average of 11 percent. Native-Americans were also considerably more likely to be uninsured, with 18 percent of this minority group lacking health care coverage.

*Community*

Not only are African-Americans over-represented in Oregon's criminal arrest rate, the proportion of arrests attributable to African-Americans has almost doubled (from six percent to eleven percent) since 1990. In 1998, Hispanics made up six percent of the state's population, but accounted for seven percent of all arrests.

African-Americans continue to be the least likely to own their own homes in Oregon. Fifty-two percent of African-Americans in the state were homeowners in 1998, compared to 72 percent of Whites, the highest rate. Overall, the state has achieved its benchmark goal of 68 percent home ownership.

Oregon's public offices continue to be dominated by Whites. While they only make up 88 percent of the state's population, Whites comprise 98 percent of all local officials in the state. Only two percent of elected and appointed officials are Hispanic, and each of the other minority groups represents one percent or less of all officials.

Oregon's population is becoming more diverse. Hispanics are the state's fastest growing minority group. Their population increased from four percent to six percent between 1990 and 1998. During that period, Oregon's racial and ethnic minorities increased from ten percent to twelve percent of the population.

*Data*

Much of the data for this report are drawn from the *Oregon Population Survey*, a telephone survey of approximately 5,000 households conducted in even numbered years. The state agencies that fund the survey use the results to make public policy decisions. The Oregon Progress Board and the state Office of Economic Analysis jointly manage the survey, which Clearwater Research, Inc. conducted in 1998.

In addition to the *1998 Oregon Population Survey*, several state and federal data sources were used to write this report. In some cases data from different samples are compared. In each instance the different data sources are described in the endnotes.

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# OREGON UPDATE

## Oregon Minorities
## A Summary of Changes in Oregon Benchmarks
## By Race and Ethnicity 1990-1998

**Prepared by:**
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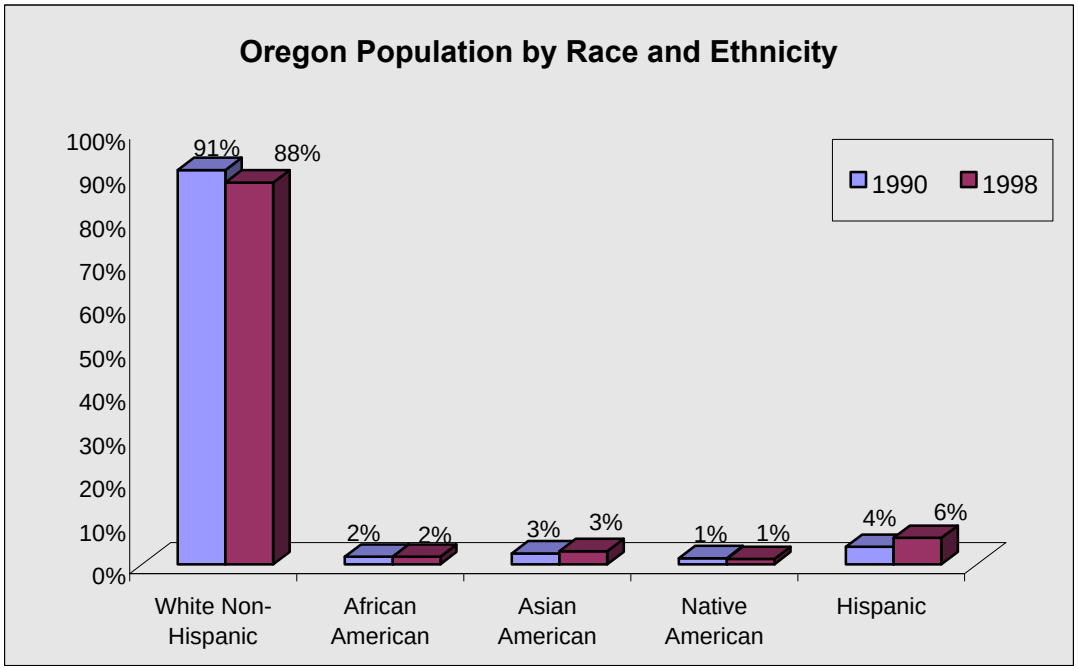
**July 2000**

**Oregon Minorities**
**A Summary of Changes in Oregon Benchmarks**
**By Race and Ethnicity 1990-1998**

The Oregon Progress Board is a ten-member citizen panel created by the Oregon Legislature and chaired by the Governor. Part of its mandate is to track progress toward societal goals represented by a set of indicators called Oregon Benchmarks. These measures provide some indication of Oregon's social, environmental and economic health and vitality. As Oregon's minority population grows, it becomes vital that solid information about how each population group is doing relative to the Benchmarks be available to policy-makers. This report provides a base of information from which comparisons can be made to develop new strategies for moving *all* Oregonians toward achieving the Benchmarks.

## Population[i]

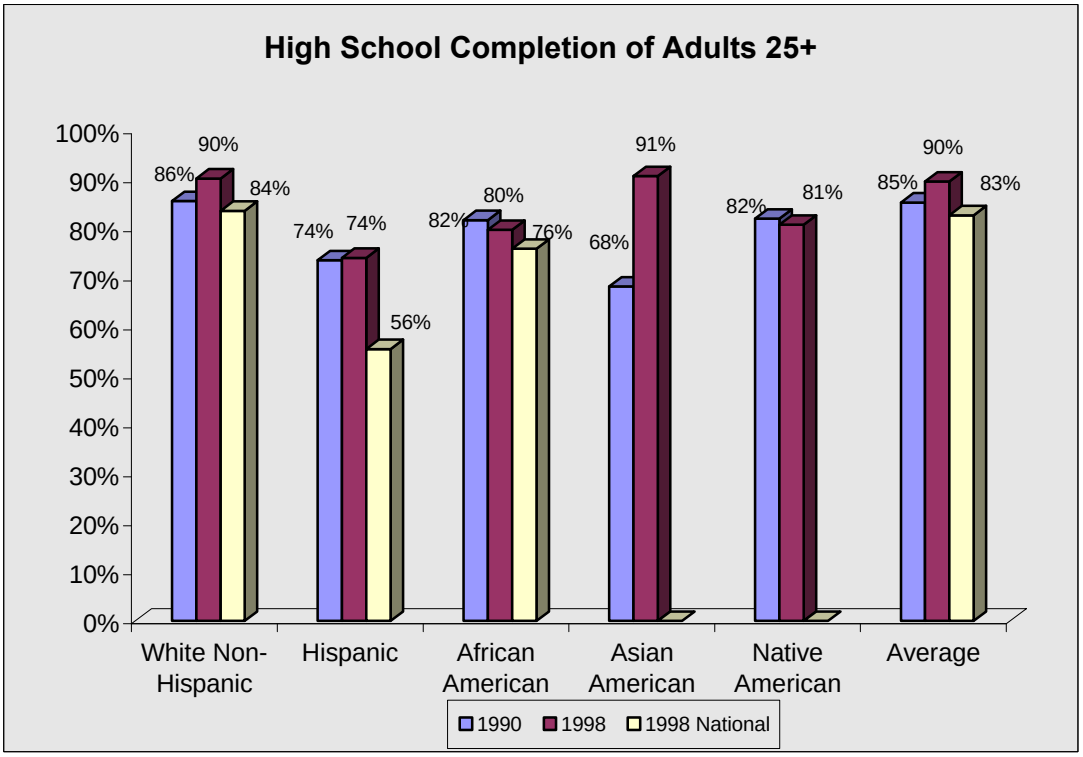
Between 1990 and 1998 Oregon's population has become significantly more multicultural. The fastest growing subset of the state's population is people of Hispanic origin. In 1990 this minority group made up four percent of the state's population, while by 1998 they accounted for more than six percent, approximately 200,000 Hispanics statewide. The proportion of Asian-Americans in the population has also increased slightly over the same period, from two and one-half percent of the state's population to three percent. There has been little or no change in the proportion of the African-American or Native-American population since 1990.



**Education**

*High School Education Levels*[ii]

In 1990, 85 percent of all adult Oregonians (aged 25+) held high school diplomas or GEDs. By 1998 that had risen to more than 90 percent. This is substantially higher then the national average of slightly more than 82 percent. While Whites, Asian-Americans and Hispanics have all shown improvement, the proportion of African-Americans and Native-Americans who have completed high school has slipped since 1990. However, all racial and ethnic groups in Oregon compare favorably with similar groups nationwide.



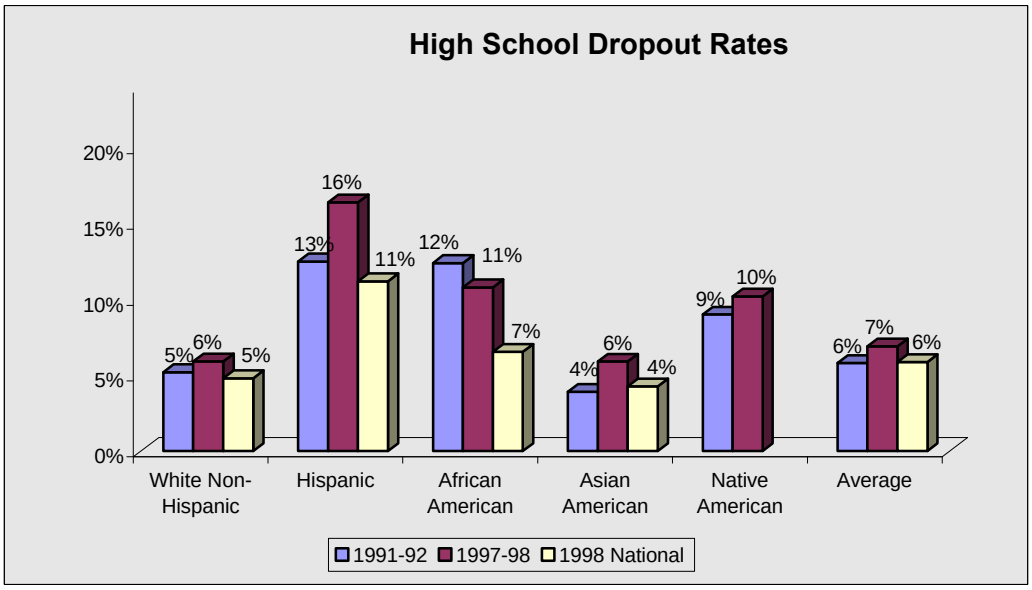

The proportion of White Oregonians with a high school diploma has increased four percent since 1990. The proportion of Asians with a high school diploma appears to have increased the most dramatically since 1990, rising from slightly less than 70 percent to around 90 percent. However, due to the small sample sizes of individuals interviewed in the surveys for these two years, these results should be used cautiously. Between 1990 and 1998 the rate of high school completion declined from 82 percent to 81 percent for Native-Americans, though this result is not statistically significant.

The Oregon Benchmark target for 2000 is 94 percent of all Oregon adults with a high school diploma or GED.

*High School Dropout Rate*[iii]

*Oregon Minorities*
Oregon Progress Board
July 2000

One area of serious concern is the number of youths dropping out of high school before completing their degrees. Many of the Oregon Benchmarks related to economic growth, social health and personal independence are directly related to an individual's educational and employment status. To the extent that students are discontinuing their education, particularly at an early stage, meeting some of the state Benchmarks becomes much more difficult. In this arena Oregon has not fared well in the past eight years.



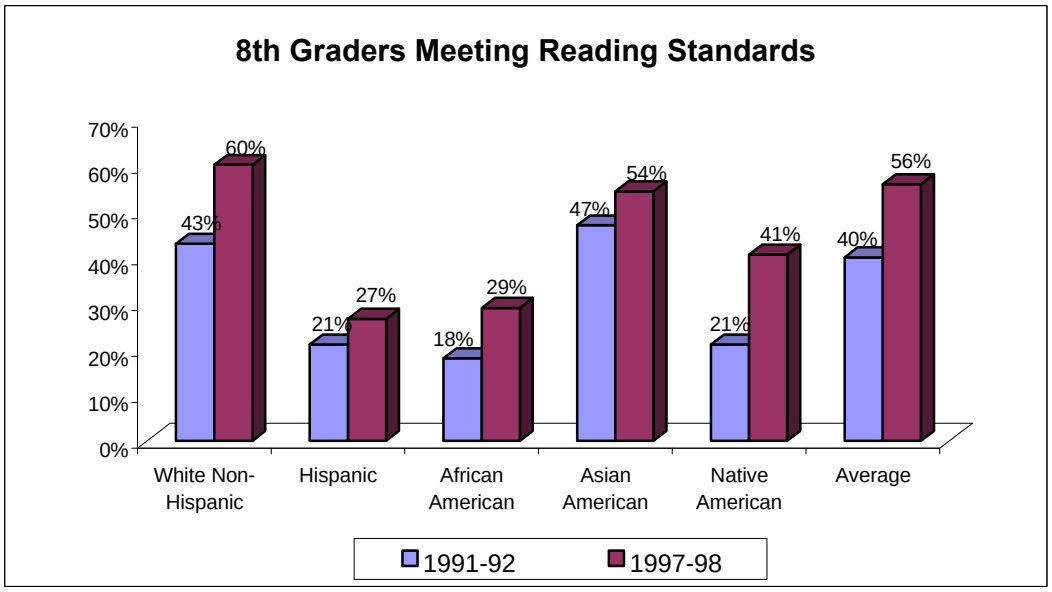

Across all racial and ethnic categories with the exception of African-Americans, high school dropout rates have increased since the 1991-92 school year, though not substantially in most cases. For the 1997-1998 school year Hispanics had a dropout rate which was three percentage points higher than in 1991-92 and Asians had a rate that was two percentage points higher than in 1991-92.

Relative to the rest of the country Oregon is not doing well either. While the state's dropout rate is similar to the national average, every minority group is experiencing higher dropout rates in Oregon than similar groups nationally. Hispanics, in particular, are lagging behind, with dropout rates nearly five percentage points higher than those nationally.

The Oregon Benchmark target for 2000 is a 5.4 percent dropout rate per class per year.

*Reading and Math Assessment Scores for 8th Graders*[iv]

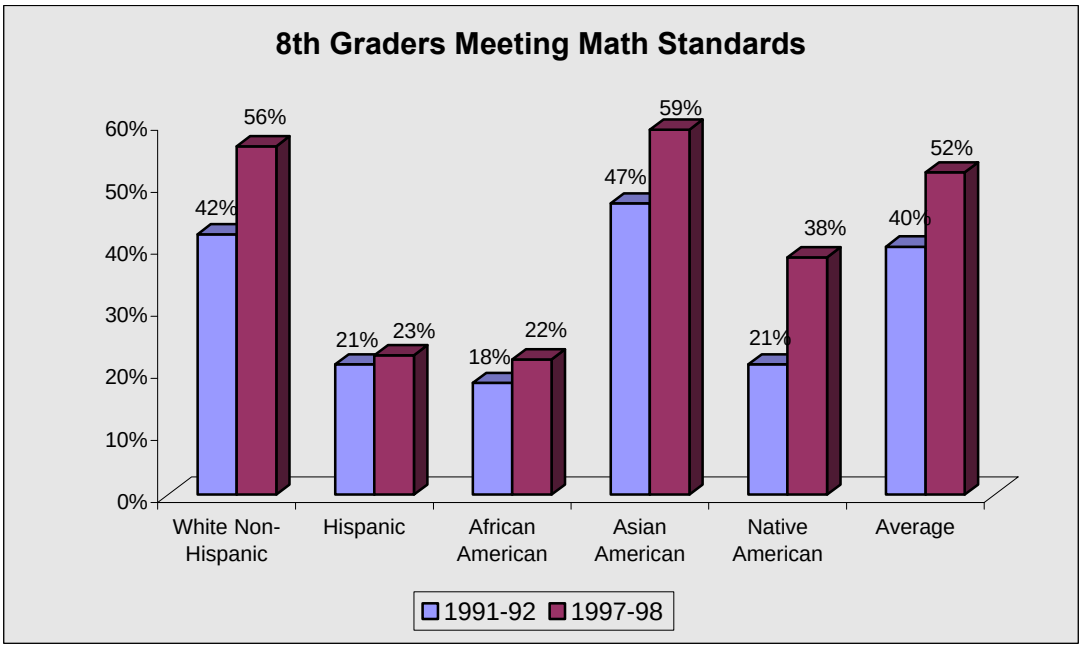
Overall the state is improving in the proportion of 8th graders who meet established reading and math standards. In 1991, the first year the standards were in place, only 40 percent of 8th graders met the reading standard. By 1998 that rate had climbed to more than 56 percent, while the improvement in math scores was slightly less dramatic, from 40 percent in 1991 to 52 percent in 1998.




All racial and ethnic groups showed strong improvements in reading standards, with the proportion of Native-Americans meeting the state standard jumping twenty percentage points, from only 21 percent to 41 percent. Hispanics still lag substantially behind the state average, but continue to improve.

The Oregon Benchmark target for 2000 is 63 percent of all eighth graders will meet the reading standard.

As with reading scores, all racial and ethnic groups improved in the area of math standards from 1991 to 1998, though the increases were less dramatic. Hispanics and African-Americans are still the least likely to meet the math standards, with only 23 and 22 percent respectively meeting the requirements; while Asians and Whites are the most likely to meet the standards.

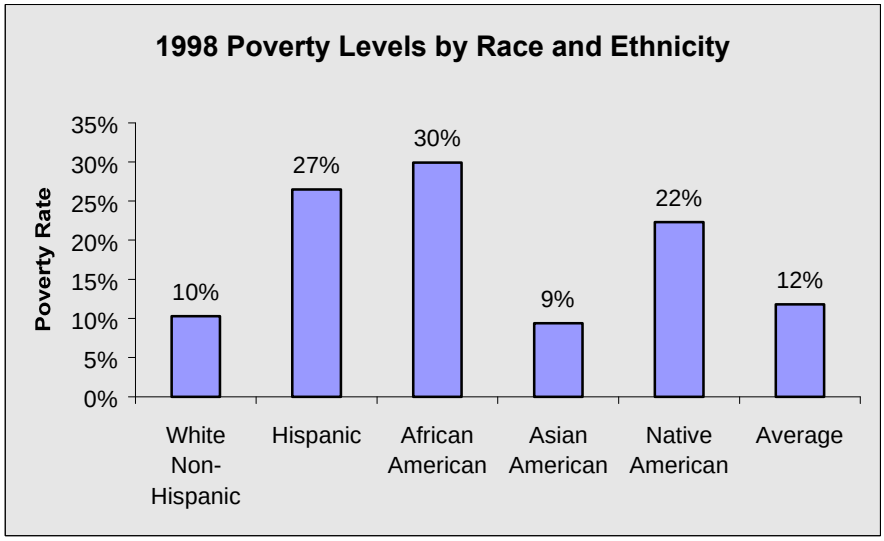



While the results regarding reading and math scores are encouraging, it should be noted that this improvement has not been continual. From 1991 to 1996 the proportion of 8th graders who met the reading and math standards grew by thirteen and nine percent, respectively. In 1997 and 1998 rates remained relatively constant.

The Oregon Benchmark target for 2000 is 59 percent of all eighth graders will meet the reading standard.

**Poverty**[v]

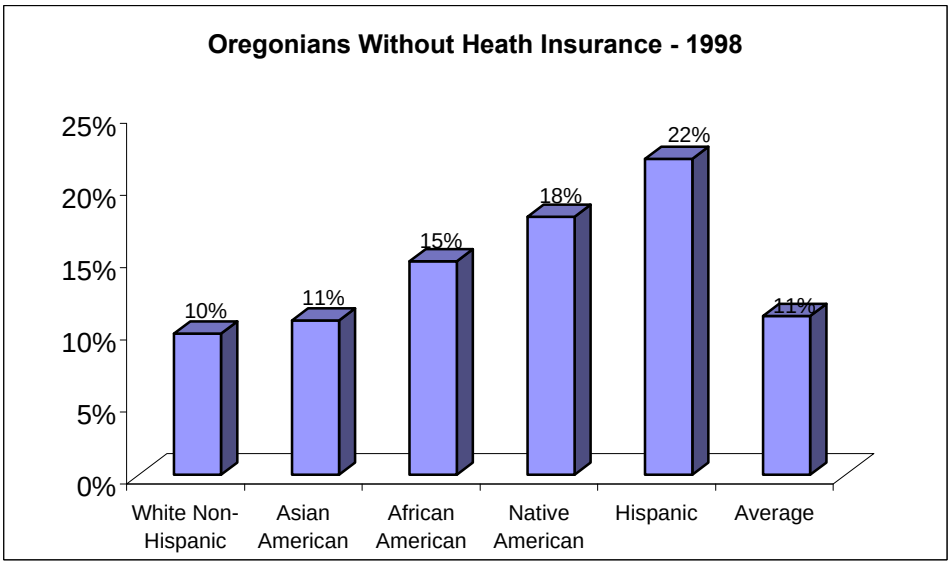
Poverty in Oregon varies dramatically by race and ethnicity. Almost one African-American in three (30 percent) was in poverty in 1998, while 27 percent of Hispanics and 22 percent of Native-Americans were below the federal poverty level. On a more positive note, only nine percent of Asian-Americans and ten percent of Whites were in poverty in 1998.




The Oregon Benchmark target for 2000 is that no more than 11 percent of all Oregonians will be in poverty.

**Health Insurance**[vi]

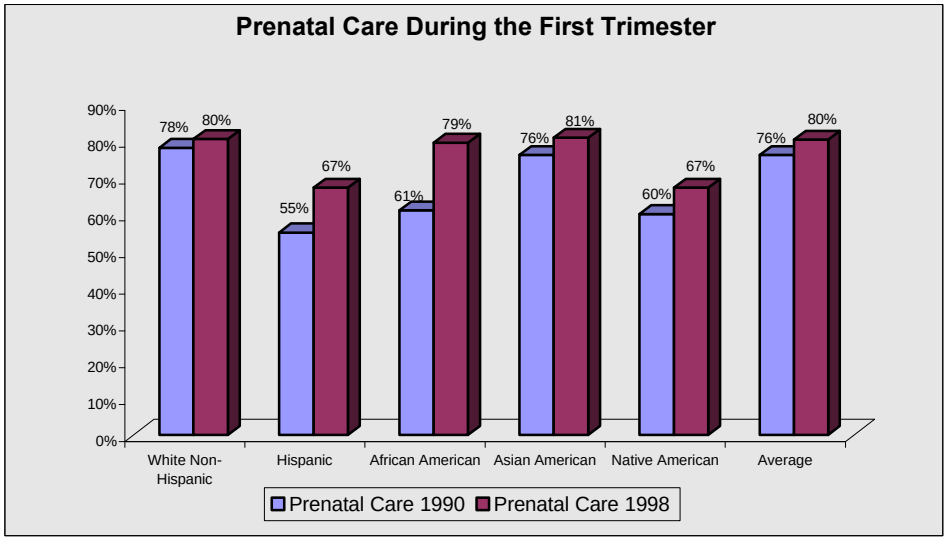
A strong economy and innovative public policies have enabled the state to make continual progress in decreasing the proportion of the state's residents who are without health insurance. In 1990, 15 percent of all Oregonians were uninsured. By 1998, this had been reduced to 11 percent. African-Americans, Native-Americans and Hispanics were uninsured at rates significantly higher than the state average, 15 percent, 18 percent and 22 percent respectively. Whites and Asian-Americans were at or near the state average.




The Oregon Benchmark target for health insurance coverage is that no more than nine percent of Oregonians are uninsured in the year 2000.

## Prenatal Care[vii]

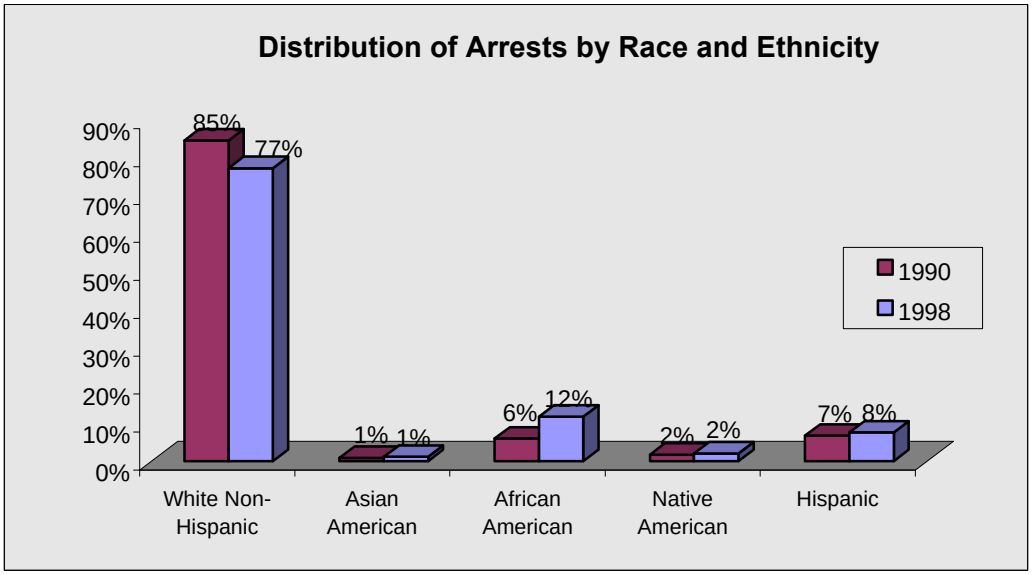
Statewide, the percentage of babies born to mothers who have received early care increased modestly, from 76 percent to 80 percent between 1990 and 1998. The percentage of African-American babies born to mothers who had received first trimester care, leapt from 61 percent to 79 percent. And the proportion of Hispanic children born to mothers who received early care rose considerably from 55 percent to 67 percent. All racial and ethnic groups saw increases in prenatal care.




The Oregon Benchmark target for 2000 is that 90 percent of all pregnant women will receive early prenatal care.

**Arrests**[viii]

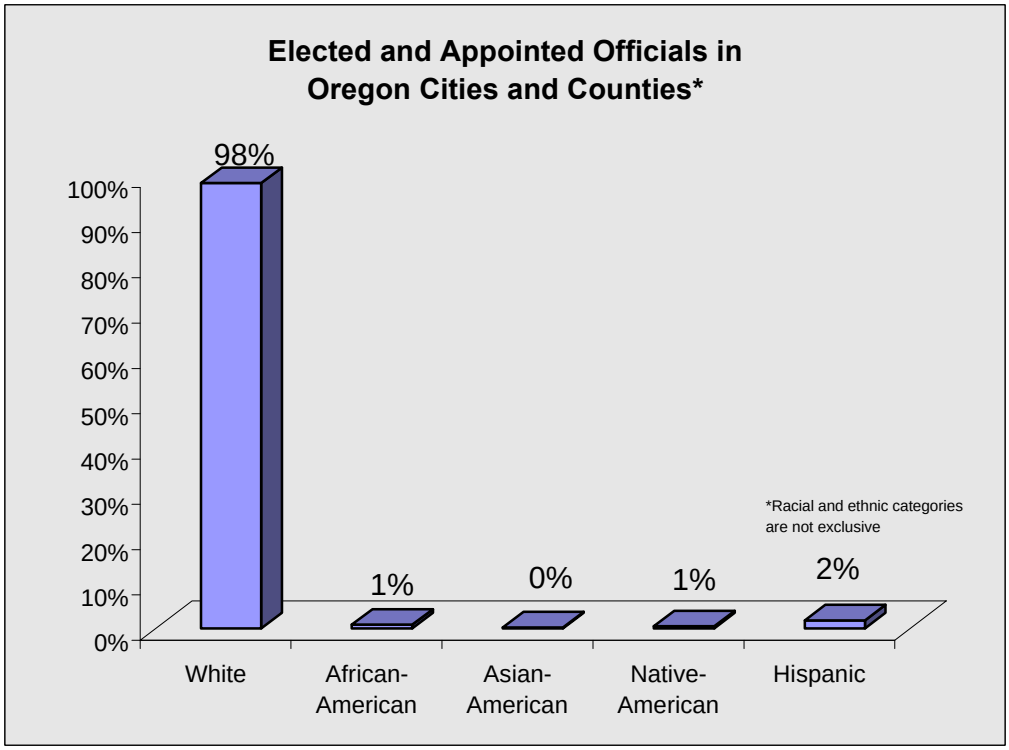
The distribution of arrests by racial and ethnic categories has changed somewhat since 1990. As a portion of all arrests, Whites decreased significantly, from 85 percent of all arrests to only 77 percent, while African-Americans increased substantially from six to twelve percent of arrests. The distribution of arrests across all other racial and ethnic groups remained relatively constant.




The Oregon Benchmarks do not contain a target for distribution of arrests.

**Local Elected and Appointed Officials**[ix]

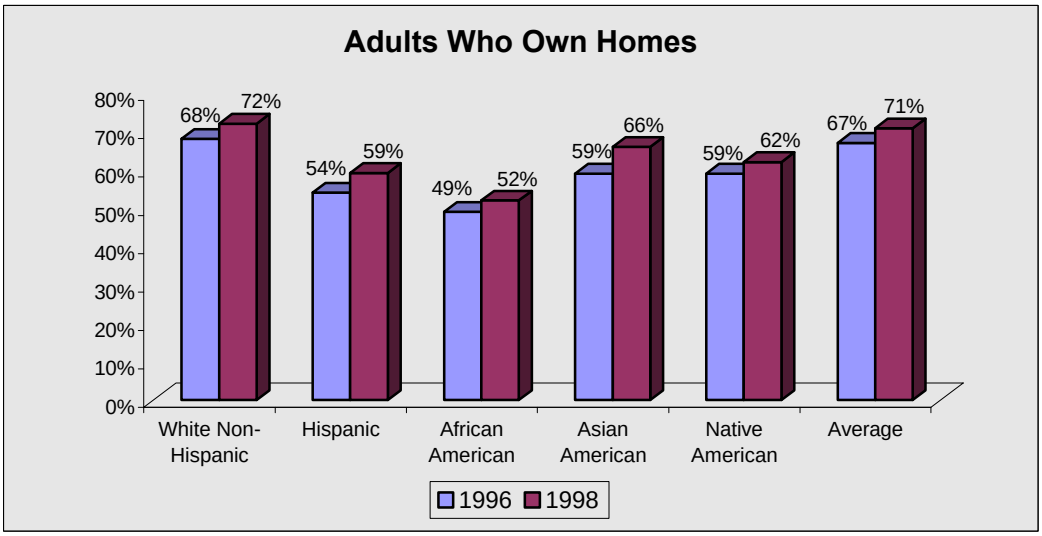
While not an official Oregon Benchmark, the Board considers this measure an important indicator of civic engagement by all sectors of society. At the city and county level, Whites make up a far larger proportion of elected and appointed officials than they represent in the state overall, accounting for 98 percent of all local-level officials.




The Oregon Benchmarks do not contain a target for distribution of local elected officials by racial and ethnic origin.

**Home Ownership**[x]

Home ownership by adults in the state continues to increase. Compared with 1996, the most comparable data available, home ownership was up four percentage points in 1998. Whites were slightly more likely than the state average, 72 percent versus 71 percent, to own their own homes, while all other groups experienced increases in home ownership. In 1996, only 54 percent of Hispanic adults owned their homes, whereas in 1998, 59 percent were homeowners. The rate for African-Americans increased from 49 percent to 52 percent over the same time period.




The Oregon Benchmark target for 2000 is that 68% of all Oregonians will own their own homes.

**Acknowledgements**

The Oregon Progress Board would like to thank all of the agencies that contributed data and staff resources to this report. Without their assistance, this work could not have been completed.

Oregon Office of Economic Analysis
Oregon Department of Education
Oregon Health Division
Office for Oregon Health Plan Policy and Research
Law Enforcement Data Systems
Portland State University Center for Population Research and Census
US Census Bureau
US Department of Education
All agencies contributing to the biennial Oregon Population Survey

**Endnotes**

[i] 1990 population data come from the 1990 Decennial Census conducted by the US Census Bureau. 1998 population estimates by race come from the US Census Bureau release September 15, 1999. Note: People of Hispanic origin can be of any race.
[ii] 1990 data compiled from the 1990 Oregon Population Survey. 1998 Oregon data come from the 1998 Oregon Population Survey. 1998 US Data come from the March 1998 Supplement to the US Current Population Survey conducted by the US Bureau of the Census.
[iii] US Data Compiled by the US Bureau of the Census. Oregon data provided by the Oregon Department of Education. URL: http://www.ode.state.or.us/stats. Figures shown represent 4-year synthetic dropout rates.
[iv] Oregon Department of Education, Assessment Initiative.
[v] 1998 Oregon Population Survey.
[vi] 1990 and 1998 Oregon Population Surveys.
[vii] Department of Human Services, Oregon Health Division, Center for Health Statistics.
[viii] Oregon State Police, Law Enforcement Data System.
[ix] Oregon Progress Board, 1999 Survey of Elected Officials.
[x] 1996 and 1998 Oregon Population Surveys.

# APPENDIX F

**Racial & Ethnic Health Disparities Paper**
**Written by Renee Witlen, Intern**
**August 2000**

# RACIAL & ETHNIC HEALTH DISPARITIES PAPER

This report reflects the work of a diverse community (i.e., Oregon) that is not willing to leave unchallenged the continuation of persistent disparities in health outcomes that threaten the well-being of racial and ethnic groups in this state. This commitment to solve a problem that hurts some but not all members of the larger community is based on an ethical position that places a high value on fairness.

In large part, the Oregon Health Plan (OHP) owes its existence to Oregonians' unwillingness to exclude a portion of the state's population from access to basic, effective health care. Over the past ten years, the OHP has expanded health coverage to hundreds of thousands who otherwise would have remained without insurance, and as a result, without reliable access to care. However, health insurance is of value when it assures access to health care, and access is of value when it leads to treatment that substantially improves health outcomes. The objective of this report is to effect change that will help to assure that Oregonians have access to health care that is effective because it accounts for the contribution of culture to health status and health outcomes. Otherwise, the relative effectiveness of resources allocated for health will not be fairly distributed across all the diverse populations that give Oregon its rich character.

In Health Care and The Ethics of Encounter: A Jewish Discussion of Social Justice, Laurie Zoloth has written on the Oregon Health Plan as a case study in the ethics of health reform. Professor Zoloth has put the core question of social justice as follows: "Who gets what and why?".[1] She goes on to suggest that in asking this question a society and its leaders can determine whether they are satisfied that the distribution of resources is fair.

Racial and ethnic minorities draw far more than their statistically fair share of undesirable health outcomes. The Racial and Ethnic Health Task Force reflects a commitment to address the bad health outcomes so destructive to minority communities. For example, in birth size, infant mortality, AIDS survival, cancer, and cardiovascular disease, being black is the single greatest risk factor.[2] The Task Force has been charged with identifying ways to correct bad health outcomes for serious diseases in minority communities. In doing so, it will increase the level of fairness in Oregon's health reform efforts.

[1] Zoloth, Laurie. Health Care and The Ethics of Encounter: A Jewish Discussion of Social Justice. University of North Carolina Press; Chapel Hill, 1999. xii.

[2] ibid., p. 265

Access to culturally competent health care has been a focal point for the Task Force as an effective means of improving health outcomes for minority communities. On this point, the work of the Task Force intersects with the structure and goals of the Oregon Health Plan (OHP). In the course of the public meetings that informed the creation of the OHP, it became clear that Oregonians were ready to formulate and implement a new vision of social justice. They wished to modify their health coverage system to provide a better answer to "who gets what and why?" Underlying the OHP is a fundamental commitment to universal access to effective health care.[3] In the context of the OHP, efforts to make health care accessible have been largely directed at removing financial barriers to care. The Task Force continues the expansion of access by addressing cultural barriers to effective care so that *everyone* can get basic health care, regardless of cultural heritage. If effective health care is unavailable to racial and ethnic communities due to cultural barriers, these barriers must be removed. In this way, racial and ethnic minority communities can be put on the same footing as other Oregonians in accessing health care, and minorities can participate fully in the benefits of the Oregon Health Plan.

It seems clear enough that lack of health coverage can severely limit access to effective care. The threat posed by cultural incompetence is not always so clear. In The Spirit Catches You and You Fall Down, Anne Fadiman describes Dr. Neil Ernst reflecting on health care given a Hmong child. Dr. Ernst speculates that, considering the family's ambivalent response to Western medicine and the linguistic barrier between hospital staff and the family, a single-medication approach would have yielded better medical results in this cultural context than the complex multi-drug regimen that is the standard of care.[4] He notes that while this course of action would not be medically ideal for all patients, in Lia's case it would likely have produced the better outcome. A culturally competent provider could have granted Lia access to the best care, clinically and culturally.

Steps taken to address cultural differences can make patients more comfortable with the health care process and so more likely to comply with the treatment plan – and more likely to get healthy. They do not constitute special or superfluous treatment. Instead, they help to ensure that culturally diverse communities have access to effective care and good health outcomes.

The governor's and the legislature's responses to the findings of the Task Force can help to change the attitudes of medical professionals who, as Fadiman explains, often believe that cultural competence is a dispensable service, rather than a fundamental element in the provision of quality health care.

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[3] ibid., p. 238

[4] Fadiman, Anne. The Spirit Catches You and You Fall Down. Farrar, Straus and Giroux; New York, 1997. 273.

Just as cultural barriers impede the delivery of care, a lack of cultural awareness may work against the creation of health policy that fully addresses minority health issues. The Task Force addresses this potential problem by introducing representative minority voices into Oregon's health policy discussions. The Task Force establishes a forum for active minority participation in health reform so that the Oregon Health Plan can effectively address the needs and values of the state's diverse population.

Policy makers and the general public have typically been more prompt in addressing the needs and interests of the poor than the particular needs of minorities. For this reason, minorities need a significant presence in health reform if their needs are to be met. The Task Force can serve to organize and amplify the voices of those who share racial and ethnic perspectives and concerns about health. If the Task Force proves effective at stimulating substantial improvements in health outcomes for racial and ethnic communities, Oregonians will take a step closer to a core policy objective of the Oregon Health Plan: fairness in the distribution of health resources.

# APPENDIX G

## Additional Resources on Data

## ADDITIONAL RESOURCES ON DATA

**Racial and Ethnic Health Task Force Briefing Book, February 2000**

Department of Human Services
Oregon Health Division, Office of Multicultural Health

Contact the Office of Multicultural Health at (503) 731-4582

**Keeping Oregonians Healthy**

Department of Human Services
Oregon Health Division, Center for Disease Prevention & Epidemiology

http://www.ohd.hr.state.or.us/hpcdp/docs/healthor.pdf

**Ethnicity Data**

Department of Human Services
Oregon Health Division, Center for Health Statistics

http://www.ohd.hr.state.or.us/chs/welcome.htm

**Healthy People 2010: Understanding and Improving Health**

U.S. Department of Health and Human Services

http://www.health.gov/healthypeople/