



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.