Response to the State of Equity Report Phase 1

Acronyms:

AMH – Addictions and Mental Health	JOBS – Jobs, Opportunity and Basic Skills	PHD – Public Health Division
CCD – Child Care Division	MCH – Maternal and Child Health	RH – Reproductive Health
CCOs – Community Care Organizations	OEI – Office of Equity and Inclusion	SNAP – Supplemental Nutrition Assistance Program
DHS – Department of Human Services	OHA – Oregon Health Authority	TANF – Temporary Assistance for Needy Families
DMAP – Division of Medical Assistance Programs	OHPR – Oregon Health Policy and Research	VR – Vocational Rehabilitation

The Phase 1 of the State of Equity Report demonstrated a significant pattern of inequities impacting the African American community in Oregon. As a result, as both agencies were producing Phase 2 of the report, OHA and DHS conducted a community listening session with the African American community on April 30, 2012 to follow up on the findings of the first phase. Six months later, both agencies followed up on the community feedback with written comments and a second in-person dialogue. The following is the written update provided to the African American community at the State of Equity Report Community Response on November 26, 2012.

These community dialogues will continue to occur regularly, engage additional communities and incorporate the updated findings of each phase of the State of Equity Report. The purpose of the community conversations is to listen to, engage, and inform the Oregon's diverse community about the departmental responses to promote equity in access, services, and outcomes.

Oregon Health Authority Response

Division of Medical Assistance Programs

1. **What is/are the health or human service disparity/ies that you are working to address?**

   DMAP's Key Performance Measure: PQI (Preventive Quality Indicator) measures hospitalizations for 12 conditions (nine chronic, three acute) called ambulatory care sensitive conditions, for which timely and effective outpatient care can help prevent or reduce the risk of hospitalization. Four of the chronic measures are related to diabetes. The others are: asthma, hypertension, congestive heart failure, chest pain related to coronary heart disease, and COPD (chronic obstructive pulmonary disease). This measure shows that there may be less access to primary and preventive care for African Americans and Native Americans than the other groups.

2. **What are some of your take-aways from the April 30 event?**

   The main take-aways centered on the importance of promotion and engagement within the community, to address the need for preventive and integrated care in helping to reduce health disparities. We heard good ideas and feedback such as ensuring health literacy and culturally competent training and care, the importance of community health workers needing to be from the community, importance of focusing early on high-risk families, and the need for member engagement and empowerment in the health care setting.

3. **Who have you engaged since the April 30 event and what did this engagement look like?**

Since the last event, DMAP has focused on launching CCOs as a major part of Health Care Transformation in Oregon. This effort included public input opportunities with the CCO applicants at the local level. DMAP looks forward to opportunities for more engagement (see below) as CCOs begin serving members across the state. CCOs were designed to be community-based organizations and are required to provide culturally and linguistically appropriate services.

DMAP has submitted a state plan amendment and drafted a rule to provide doula services following guidance from the House Bill 3311 Implementation Committee. A doula is a certified professional who provides personal, non-medical support to women and families throughout a woman's pregnancy, childbirth and postpartum experience. The committee recommends doulas as an overall strategy to improve birth outcomes funded by both Medicaid and private insurance. The state plan amendment and draft rule emphasize access to doula services for women from racially and ethnically diverse backgrounds and women who speak limited to no English.

4. What are you doing to incorporate community feedback or other community-input factors into your work?

Community concerns were included in the development of CCOs and included in their request for approval process, contract, implementation planning, and required transformation plan.

The CCOs must prepare a transformation plan that:

- assures communications, outreach, member engagement, and services are tailored to cultural, health literacy, and linguisitic needs,
- ensures that the culturally diverse needs of members are met (cultural competence training, provider composition reflects member diversity, non-traditional health care workers composition reflects member diversity), and
- includes developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

5. Have you identified any goals and objectives for achieving health equity for African Americans based on community feedback? If so, what are they? Where are they in development (draft, being vetted, final)?

There is an extensive accountability component in place for CCOs through performance measures. A core focus area is the reduction of disparities. In order to assess disparities most measures are required to be broken out by race and ethnicity. Measure areas are

- Optimal diabetes care: diabetic patients meeting goals for blood sugar, cholesterol and blood pressure levels;
- Controlling high blood pressure: hypertensive patients meeting goals for blood pressure;
- Colorectal cancer screening;
- Prenatal care initiated in first trimester or within six weeks of enrollment;
- Reducing elective deliveries before 39 weeks;
- Patient experience with health care;
- Developmental screening by 36 months old; and
- Adolescent well care visits.

These are directly related to the health disparities we identified and that were brought up at the last event.

6. **If your division is headed in a new direction, either due to internal systems change (i.e./health systems transformation, public health re-design) and/or due to community feedback, please explain what that looks like, why it is happening and what review processes you have used to ensure equity for African Americans.**

   OHA certified 15 CCOs as part of Health System Transformation. CCOs are set up so that anyone who provides a member care – doctor, nurse, or counselor – will coordinate that care to better focus on prevention and improving member and community health. Most Oregon Heath Plan members are now receiving their physical, mental and eventually dental health services through CCOs. The development of CCOs is a system change in response to state and federal legislation. Community feedback informed the enabling state legislation, as well as OHA's requirements for CCOs. Community feedback continues to be a critical part of CCO development as CCOs draft and implement their community assessment (see 7 below) and transformation plans.

   To support CCOs, OHA is establishing a Center for Health System Transformation. The center will serve as the state's hub, or integrator, for health system innovation and improvement. It will engage CCOs, state agencies, and stakeholders through a **Learning Collaborative** that will cover a range of health system transformation topics. The Center will also serve as a bridge to communities that have been historically under-represented in health program and policy development, and provide support to validate whether CCO's Community Health Improvement Plans are effective in addressing health disparities.

   OHA will monitor access, quality performance and outcome metrics to ensure that CCOs are meeting their health equity goals. Intensified learning collaborative involvement may be used as an intervention if a CCO is found to be underperforming on access or quality performance and outcome metrics.

   Non-Traditional Health Workers are another important part of Health Care Transformation. Several new types of health workers will be emphasized including community health workers, peer wellness specialists, personal health navigators and doulas. Non-Traditional Health Workers are defined as individuals who share ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves. As part of their core roles and responsibilities, Non-Traditional Health Workers:

   - Provide health culturally appropriate education and information to the individual member;
   - Advocate for the individual patient and community health needs;
   - Build individual and community capacity to advocate for health and meet health care needs; and
   - Assist community members to receive the care they need.

   Non-Traditional Health Workers will need to be recruited, trained and certified. Opportunities will exist for the African American community (and other communities) to participate in workforce development through the recruitment, training and certification processes.

7. **What are further opportunities for African Americans to engage in your work?**

   Much of the Agency's health system transformation work is guided by policy boards and advisory committees that offer public engagement opportunities on an ongoing basis. Some board members are appointed and terms rotate so new membership opportunities exist at different times, providing opportunity for community members and leaders to submit their names for consideration to fill vacant positions. The Oregon Health Policy Board holds a monthly meeting that is open to the public and reserves time on the agenda for public input and/or testimony. Other committees and advisory boards offer similar opportunities. Information about committees and boards is available online at: www.health.oregon.gov.

CCOs are required to demonstrate how they will carry out health improvement strategies to eliminate health disparities and improve the health and well-being of all members. To do this they must partner with local public health and culturally, linguistically, and demographically diverse community partners to address the causes of health disparities, providing local opportunities to engage directly with CCOs and their partners.

A CCO Community Advisory Council will oversee the CCO's community health assessment and adopt an annual community health improvement plan. The activities, services and responsibilities defined in the plan may include development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities; health policy; system design; outcome and quality improvement; integration of service delivery; and workforce development. OHA will partner with CCOs to provide guidance about their health assessment and implementation plans.

Addictions and Mental Health

1. **What is/are the health or human service disparity/ies that you are working to address?**

   The 2011 data shows statewide Substance Use Disorder (SUD) treatment completion rates for African Americans is 29.2%. The health disparities we are working to improve are access, service engagement, and treatment completion outcomes. Forty-two percent of African American Oregonians (41,401 of 98,479) reside in Multnomah County. In 2011, 1,314 African Americans admitted into SUD treatment, but only 343 (26.1%) completed.

2. **What are some of your take-aways from the April 30 event?**

   The African American community expressed its frustration with the repeated listening groups hosted by state divisions that have not resulted in measurable change over the years. African Americans are tired of having the same conversations coupled without response. The community wants to be part of the CCO conversations. African Americans want to take care of their community, make sure that outcomes are improved, and work towards eliminating health disparities. African Americans want to participate in policy level governance, however there are communication barriers that must be acknowledged and addressed.

3. **Who have you engaged since the April 30 event and what did this engagement look like?**

   AMH partnered with the Urban League of Portland, OHSU Avel Gordly Center for Healing, Addictions Counseling Certification Board of Oregon, African American Recovery Counseling Association, and Care Oregon to plan the African American Treatment Summit held at the Miracles Club September 2012. The project's goals:
   - Collect meaningful directives for the care of African Americans;
   - Increase awareness of current treatment outcomes;
   - Provide a historical context of the undercurrent of health equity issues; and
   - Development of recommendations for the expansion of a culturally competent addictions and mental health infrastructure.

   AMH introduced Oregon's Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant project officer to African American providers and agencies in Portland. The Miracles Club, OEI, and Project Network were the sites visited. The Block Grant project officer collected health equity improvement directives for the Center for Substance Abuse Treatment (CSAT).

AMH met with peer support specialist and consumers at Miracles Club to collect feedback and input on our Block Grant performance indicators.

4. **What are you doing to incorporate community feedback or other community-input factors into your work?**

   Our Alcohol and Drug Policy & Program Development Specialists utilized survey results from the African American Treatment Summit to determine next steps. This information assisted us in engaging African American Community members in workgroups that address AMH Integrated Support Services Rules, the CCO Rules Advisory process, and our Peer Delivered Services Workgroups. AMH brought African American community members to the 2012 State Systems Development Conference/ Behavioral Health Block Grant Conference in Baltimore, Maryland.

5. **Have you identified any goals and objectives for achieving health equity for African Americans based on community feedback? If so, what are they? Where are they in development (draft, being vetted, final)?**

   - Addictions and mental health treatment that meets the cultural needs of African Americans needs to be established in areas where the population resides and those services need to be guided by African American administrators and providers
   - Integrated Services and Supports Rules (ISSR) pertaining to Cultural Competency service delivery needs leadership support in changing to recognize current needs of the community
   - Health equity must be elevated within AMH in order to successfully impact subpopulations

6. **If your division is headed in a new direction, either due to internal systems change (i.e./health systems transformation, public health re-design) and/or due to community feedback, please explain what that looks like, why it is happening and what review processes you have used to ensure equity for African Americans.**

   AMH System Change is the restructuring of how we conduct business with local mental health authorities to provide addictions and mental health services to Oregonians. Moving from a payment structure based on service elements to a global budget will give our county partners more flexibility in the services they provide and more control over local resources. AMH leadership reached out to the African American community for inclusion on the System Change Design Advisory Committee and the Implementation Advisory Committee.

7. **What are further opportunities for African Americans to engage in your work?**

   The AMH Planning and Management Advisory Council (AMHPAC) provides comment on the Mental Health Block Grant. The Council has recently restructured to integrate with addictions, prevention, problem gambling, and peer delivered services. Applications for the new Council have been sent out to community members who have expressed interest.

   The AMH Health Equity Workgroup suggests that AMHPAC be held in diverse geographical locations within the state to promote cross cultural engagement at the sub-committee structure level of the Council.

   AMH is committed to assembling workgroups that represent Oregon's communities. The process of inviting and offering the capacity for dialogue will require commitment from the community to change, to participate, and the capacity to bring the dialogue complete with feedback loops to the community.

Whenever possible, AMH will offer to bring the discussion to the community in their setting; AMH is aware that the road goes both ways and meetings do not always need to be in Salem.

Oregon Health Policy and Research

1. **What is/are the health or human service disparity/ies that you are working to address?**

   African Americans experience disparities in safety net clinic use.

2. **Key message from the April and subsequent action: New measures & strategies to improve access**

   OHPR's existing key performance measure that tracks by race and ethnicity the percentage of uninsured individuals accessing safety net clinics is not necessarily informative in that it is unclear how to interpret findings. OHA must develop more useful measures to address disparities in access to health care.

   Since the April 30 event, the Office of Health Analytics has worked to identify alternative measures of disparities in access to health care that can be implemented using existing data sources. The November 26 meeting will provide an initial opportunity to gather community feedback on the measures that have been identified.

   In addition, OHPR and Health Analytics have made progress on several initiatives to improve access to high-quality affordable health care and reduce health disparities including implementation of patient-centered primary care homes and the development of measures of coordinated care organizations' progress towards eliminating disparities in access to health services and the quality of the health care delivery system.

3. **Opportunities for community input and feedback**

   Community stakeholders may apply to participate on volunteer workgroups and committees of the Oregon Health Policy Board and OHA — many of which are staffed by OHPR and the Office of Health Analytics — or may provide public comment to these groups. A listing of Oregon Health Policy Board workgroups can be found here: www.oregon.gov/oha/pages/ccw.aspx

   A public comment period for a proposed benchmark set of health metrics under the Oregon Health Plan in 2014 closed on November 19th. The Health Evidence Review Commission frequently issues calls for public comment on the evidence-based clinical guidelines or guidance for insurance coverage that the Commission is responsible for producing.

   OHA's Office of Health Analytics primarily provides research and data analysis to inform policymaking and program management. Interested stakeholders are invited to review reports and publications at the websites below:
   www.oregon.gov/oha/OHPR/RSCH/Pages/index.aspx
   www.oregon.gov/oha/pages/data/index.aspx
   Feedback on this work is always welcomed and can be provided in a variety of ways including individual meetings with staff (please see contact information below) or public comments before the Oregon Health Policy Board, which guides this work.

   OHA is actively recruiting a community representative to serve on the Privacy & Security Advisory Board of its All Payer All Claims database. This board reviews research applications requesting

access to the All Payer All Claims database in order to ensure that the risk to individuals from disclosing data has been minimized and that the potential benefits of proposed research outweigh potential risks. Interested individuals may express interest by emailing apac.admin@state.or.us.

Public Health Division: Maternal and Childhood Health

1. **What is/are the health or human service disparity/ies that you are working to address?**

African Americans experience disparities in teen pregnancy, intended pregnancy rate, early prenatal care.

Health inequities in all three measures (teen pregnancy, unintended pregnancy and late initiation of prenatal care) are related to a variety of underlying factors including:

- The social determinants of health (conditions in which people are born, grow, live and work) such as poverty, racism, low engagement with school, and stressful life circumstances;
- Health and mental health issues which can begin in childhood and adolescence and impact women's health throughout their lives; and
- Low utilization/access to preventive health services (which may not be structured to meet the individual, family, or community's needs).

2. **Take-aways from the April Community Forum**

Issues which community participants in the forum raised as central to impacting the MCH and RH measures were:

- Racism;
- History of negative experiences with the health care system;
- Lack of a family-centered approach to services, particularly around male involvement;
- The need to better engage and educate youth (both teens and pre-teens); and
- The need to have African American professionals as mentors for youth.

3. **Oregon Public Health Division's (PHD) Approach**

Public health services in Oregon are delivered through state and local agencies as well as community organizations. The PHD is responsible for statewide planning, oversight of certain funding and programs, surveillance and dissemination of data, and providing technical assistance to local public health. Local public health agencies are responsible for most of the planning and delivery of local public health services (family planning, home visiting, etc).

PHD's contribution to this work includes a commitment to:

- Listen to community concerns: Increase our connection to the African American community in order to better hear and understand community concerns around MCH and RH.
  - MCH Program staff participates in the Healthy Birth Initiative Consortium, are partnering with the Regional Equity Coalitions, and have worked with the International Center for Traditional Childbearing on support for maternal mental health and Doulas.
  - The MCH and RH Programs will sponsor a meeting with the African American community in spring 2013 to seek community input on data interpretation and strategies to promote prenatal health and reduce unintended pregnancies.

- Ensure that community-based programs working on African American MCH and RH understand and have access to state public health resources (data, training, information about national resources and best practices, etc.).
  - Public health surveillance data (Pregnancy Risk Assessment Monitoring System (PRAMS) survey, vital statistics, Behavioral Risk Factor Surveillance System, and the Oregon Healthy Teens survey) are available and can be used by community organizations to support grant-writing, tracking of community health indicators, etc.
  - PHD will work with OEI to spread the word to community organizations about available data and resources.

- Support the development, implementation, and/or expansion of evidence-based, culturally-specific approaches to improve MCH and RH in the African American Community.
  - The Multnomah County Healthy Birth Initiative is an example of one such partnership which brings in federal dollars to provide services to improve African American birth outcomes.

- Work with local Public Health to:
  - disseminate information about the underlying causes and impact of racial and ethnic disparities in MCH and RH;
  - improve cultural competency among MCH and RH providers and services;
  - Coordinate efforts to engage with the African American community and ensure that public health strategies for improving MCH and RH are responsive and effective.

- Partner with other state agencies to identify opportunities and implement strategies to improve MCH and RH outcomes in the African American Community. For example:
  - Public Health, Healthy Start, and Early Head Start are working together to deliver evidence-based home visiting services to at-risk young mothers and families.
  - The Adolescent Health program plans to bring information from this forum to the Oregon Youth Sexual Health Partnership for incorporation into their work.

4. Opportunities for African American Community engagement in the work

- African American community leaders working with MCH and RH issues are invited to participate in a Spring 2013 work session to jointly strategize on approaches to improving prenatal and reproductive health in Oregon. (For more information contact: anna.k.stiefvater@state.or.us or 971-673-1490.)

- Multnomah County Health Department invites community and agency participation in monthly Healthy Birth Initiative's Community Consortium meetings. (For more information, please contact Tameka Brazile: tameka.brazile@multco.us or 503-988-3387, extension 22242.)

Public Health Division: Health Promotion and Chronic Disease Prevention

1. What is/are the health or human service disparity/ies that you are working to address?

African Americans experience disparities in tobacco use among adults, children, and pregnant women.

2. Feedback from the April 2012 State of Equity African American Community Response indicates that African American community members:

- Correctly perceive the disproportionate presence of tobacco advertising in their neighborhoods;
- Would like to see more and more recent data collected about their community; and
- Feel that there are critical community institutions which are not currently engaged in tobacco prevention and education efforts.

3. **The Health Promotion and Chronic Disease Prevention section has:**

- Maintained its partnership with OEI to maintain support for three regional health equity coalitions;
- Provided funding to the Healthy Oregon Partnerships for Equity (HOPE) Coalition (through our funding partnership with OEI) to educate and inform policy makers about the importance of implementing OHA's policy on collecting race, ethnic and language data; and
- Continued to invest financial resources and staff resources in collecting and analyzing racial and ethnic specific data related to tobacco use and chronic disease.

4. **The Health Promotion and Chronic Disease Prevention section will:**

- Maintain and seek to expand its partnership with OEI to maintain and expand support for regional health equity coalitions throughout Oregon;
- Continue to invest financial and staff resources in collecting and analyzing racial and ethnic data related to tobacco use and chronic disease burden; and
- Seek further ways to engage the African American community in our strategic plan implementation to assure that this community benefits from policy, system and environmental changes to improve health.

Public Health Division: HIV/STD Program

1. **What is the health or human service disparity that you are working to address?**

African Americans experience disparities in the rate of HIV infection.

2. **Take-away messages from the April 30, 2012, Forum**

- Education and public awareness messages should be tailored to the African American community.
- Community engagement in policy development and other activities is needed.
- Need to address stigma associated with HIV and sexual health.
- Priorities should have resources devoted to them.

3. **Who have you engaged since the April 30 event and what did this engagement look like?**

HIV Prevention staff actively participate in the A6 (African American AIDS Awareness Action Alliance) in support of activities to raise awareness of HIV in the African American community.
HIV Prevention Program is working with the Albina Ministerial Alliance to secure training resources from the Centers for Disease Control and Prevention (CDC) for a community health navigator pilot.

4. **What will we do to incorporate community feedback or other community-input factors into our work?**

The HIV Prevention Program will hold focus groups in the African American community to develop targeted messages and to identify ways to reach the intended audiences.

5. **Have we identified any goals and objectives for achieving health equity for African Americans based on community feedback?**

   Not yet. Additional feedback is needed.

6. **What are further opportunities for African Americans to engage in HIV Prevention work?**

   Attend and/or join the HIV/Viral Hepatitis/Sexually Transmitted Infections Integrated Planning Group (IPG); partner with the HIV Prevention Program to schedule workshops, presentations or listening sessions in the community.

Healthy Kids/Oregon Health Plan

1. **What is/are the health or human service disparity/ies that you are working to address?**

   Healthy Kids continues to partner with organizations within the African American community to decrease the number of uninsured and to increase access to health care services for children in this segment of the population.

2. **What are some of your take-aways from the April 30 event?**

   The need to organize an event that provides a meaningful experience that engages individuals and families to take a more active role in their health.

3. **Who have you engaged since the April 30 event and what did this engagement look like?**

   Healthy Kids and partners are currently working on organizing a community event that promotes health literacy, community engagement, and strengthens our presence in the African American community. Our office continues providing support to the Healthy Kids African American Collaborative.

4. **What are you doing to incorporate community feedback or other community-input factors into your work?**

   A recent meeting of the African American Collaborative focused on feedback from members on what they see as the major issues (i.e. health care access) facing the African American community related to health care. This collaborative has also put together community presentations to school personnel highlighting the awareness of the assistance they can provide families and building referral networks amongst key school staff members to better ensure referrals to their agencies. Other activities include the development of marketing that best serve the African American community.

5. **Have you identified any goals and objectives for achieving health equity for African Americans based on community feedback? If so, what are they? Where are they in development (draft, being vetted, final)?**

   Healthy Kids' primary goal is to ensure that children and teenagers are insured. However, based on partners and community feedback, our office needs to educate families to learn how to use and access health care services to achieve health equity. Our office continues to work with our partners to provide additional follow-up to those enrolled.

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6. **If your division is headed in a new direction, either due to internal systems change (i.e./health systems transformation, public health re-design) and/or due to community feedback, please explain what that looks like, why it is happening and what review processes you have used to ensure equity for African Americans.**

   Healthy Kids collaborated with partners on messaging and materials to promote enrollment and health care access targeting African Americans. Healthy Kids organized the African American Collaborative meeting to allow our office to learn from partners' successes and challenges. Although, we are in our last year of funding for the outreach program; Healthy Kids has plans to create a referral system, utilizing current volunteer organizations and local DHS field offices to ensure African Americans will be enrolled.

7. **What are further opportunities for African Americans to engage in your work?**

   There are a few ways to be involved in our work. Individuals can participate in the African American Collaborative, the County Collaborative, Steering Committee, and to meet one-on-one with the Communities of Color Campaign and County Coordinators.

Department of Human Services Response

Temporary Assistance for Needy Families

1. **What is/are the health or human service disparity/ies that you are working to address?**

   Based on the last State of Equity Report, of the children placed in foster care who received TANF 60 days prior to foster care placement, more than half are African American children.
   Other issues that surfaced during the roundtable discussions had to do with:
   - Potential bias when African American children are removed from their homes and efforts needed to address the disproportionally in foster care representation;
   - The effects of budget cuts to TANF on the African American community such as lack of child care availability;
   - The need for more JOBS training programs that are culturally specific and that help African American adults learn skills to be off TANF; and
   - The need for more programs for ex-offenders and the need for DHS to work with employers to encourage hiring of people with a criminal background.

2. **What are some of your take-aways from the April 30 event?**

   One of the takeaways was the need to continue to consult with the African American community. We had representatives on the TANF Budget Note workgroup and need to continue to invite African American leaders (as well as other communities) to the table when discussing options for the TANF and JOBS program.

3. **Who have you engaged since the April 30 event and what did this engagement look like?**

   In addition to the TANF Budget Note workgroup, we know there have been efforts in the Multnomah County that Jerry Burns will describe at the Child welfare table. One of those efforts that I'm aware of is

a new JOBS contract that was revamped for July 2012 that is a coordination between five organizations which represent different communities in the Portland area including the African American community. As a result, more culturally specific services are being provided, although more resources are still needed.

4. **What are you doing to incorporate community feedback or other community-input factors into your work?**

   We have taken some of the feedback regarding JOBS and support services (which also came up in other workgroups and from DHS staff) and have added more flexibility on the issuance of JOBS support services such as child care and recommended that in the near future JOBS resources are set aside to provide specific job search and job preparation services for people with a criminal background. We also plan to advocate for resources in the JOBS program dedicated to employer engagement.

5. **Have you identified any goals and objectives for achieving health equity for African Americans based on community feedback? If so, what are they? Where are they in development (draft, being vetted, final)?**

   We've had discussions in TANF workgroups that it would be very beneficial to partner with the CCO's so that the CCO's as they help people address health concerns/prevention also have a discussion on employment to help our joint outcomes of healthy Oregonians who are also employed. This would be very beneficial to the African American community and other communities who benefit from cash assistance and JOBS services through the TANF program.

6. **If your division is headed in a new direction, either due to internal systems change (i.e./health systems transformation, public health re-design) and/or due to community feedback, please explain what that looks like, why it is happening and what review processes you have used to ensure equity for African Americans.**

   The Office of Self Sufficiency and the Modernization office are planning for modernization of the eligibility and case management systems. The first programs will be SNAP and medical. TANF will follow. It would be important to have focus groups with the African American community to ensure feedback on how these systems can meet the needs of the community are captured and acted on.

7. **What are further opportunities for African Americans to engage in your work?**

   Perhaps another way we can ensure we have feedback on the planning for the TANF and JOBS programs is to have focus groups with the African American leaders and TANF customers to ensure we are meeting their needs to the best of our ability.

Childcare Subsidies

1. **What is/are the health or human service disparity/ies that you are working to address?**

   The percent of children receiving enhanced child care services.

2. **What are some of your take-aways from the April 30 event?**

   DHS needs to identify additional opportunities for outreach and education to parents, child care providers, staff and community partners. We need to engage parents and community members to share successes and failures regarding our programs and services.

DHS could improve the collection of race and ethnicity data through system upgrades to allow clients self-reporting for multiple race and ethnicities.

3. Who have you engaged since the April 30 event and what did this engagement look like?

On May 9th a meeting with Jeanne Lemieux, Director of the Child Care Resource & Referral (CCR&R) of Multnomah County, was held to discuss the Family, Friend and Neighbor (FFN) training program and other concerns reported from community members.

The Child Care Program provided an Employment Related Day Care program (ERDC) refresher class at the NE Portland branch office in May. This training included information about the FFN training program, the importance of quality child care options and special and high needs child care. District 2 in collaboration with Multnomah county CCR&R and DHS is implementing a Quality Child Care pilot including staff and parent presentations, information to parents on quality child care and activities to do with their children.

The DHS Child Care Program meets monthly with the CCR&R system and works closely with Service Employees International Union (SEIU) to address issues and make improvements to the FFN training program. Local CCR&R's are spending more time at FFN orientations to discuss the DHS background check process. At meetings with SEIU, African American providers have had an opportunity to share their concerns and provide recommendations for the FFN training program and background check process.

The Child Care Program Manager has provided some technical assistance for the Immigrant & Refugee Community Organization's (IRCO) Microenterprise grant program for Refugee Child Care Providers. A meeting of partners (DHS, CCD and CCR&R) was convened on May 9th. The program has been very successful.

The Child Care Program Manager met with staff from DHS and the Albina Head Start on May 30th. The group discussed potential areas of improvement for the DHS-Head Start full day/full year contracts. Albina has been successful with subcontracting with enhanced Family, Friends and Neighbor providers. Policy and procedure changes were implemented September 1, 2012. July and August training was provided to DHS and Head Start staff. The collaboration with Albina Head Start has been very positive. Currently, they have 66 ERDC children in contracted care.

On June 13th, an ERDC partner training for Multnomah County Developmental Disabilities Services was completed. Follow-up contact was documented with a phone call to community organizers.

4. What are you doing to incorporate community feedback or other community-input factors into your work?

The Child Care Program strives to adjust policies based on community feedback and input from partners. Example: Head Start contract changes, adjusting hours on the contract to allow more families to be eligible for slots.

5. Have you identified any goals and objectives for achieving health equity for African Americans based on community feedback?

No.

6. **If your division is headed in a new direction, either due to internal systems change (i.e./health systems transformation, public health re-design) and/or due to community feedback, please explain what that looks like, why it is happening and what review processes you have used to ensure equity for African Americans.**

   We are currently in the process of drafting a Request for Proposal for the CCR&R services and central coordinating services. We have been very thoughtful to include diversity language so proposers see that it is a priority for the services. Some examples of these include an increased focus on a) non-traditional hours, b) infant/toddler care and c) culturally diverse practices that reflect the racial and ethnic makeup of the community.

   Early Learning Initiative; Oregon Programs of Quality (OPQ) Contracted Child Care pilot Mapping was completed in July due to concerns regarding where providers were located in relationship to DHS families. There is also concern over the lack of diversity among providers. These concerns have been shared with the CCD. There will be a focus to ensure all providers are supported during the expansion of the OPQ/Tiered Quality Rating and Improvement System (TQRIS) using the Race to the Top grant. The Child Care Program Manager also had a conversation with the CCD Administrator on August 28th regarding our African American providers. It was agreed that there would need to be more support and flexibility to ensure providers had an equal opportunity to reach the higher levels of the TQRIS.

7. **What are further opportunities for African Americans to engage in your work?**

   - Subsidy Coordination Work Group
   - CCR&R provider training, classes and workshops
   - DHS policies are made available online
   - Rules Advisory Council meetings
   - Oregon Programs of Quality and Head Start Contracting work groups
   - Inclusive Child Care Program committees

Vocational Rehabilitation Services

1. **What is/are the health or human service disparity/ies that you are working to address**

   For over two decades, the Rehabilitation Services Administration, in the US Department of Education, has been concerned about service equity. One of the mandatory performance measures for vocational rehabilitation is a service equity measure that requires programs to serve members of minority communities in the same proportions that they exist in the community. Oregon's Vocational Rehabilitation has exceeded the Federal standard for the last decade. None the less Vocational Rehabilitation continues to look at these issues and now examines performance at the branch level. The program has identified two branches where we are working to improve outcomes. For the State of Equity Report, African Americans experience disparities in VR's indicator "Participation in Vocational Rehabilitation Services leading to employment".

2. **What are some of your take-aways from the April 30 event?**

   The April event highlighted the need to go beyond meeting or exceeding the program Federal standard. It raised the issue of examining program performance at the branch level and seeking more effective strategies in engaging the community.

3. **Who have you engaged since the April 30 event and what did this engagement look like? What are you doing to incorporate community feedback or other community-input factors into your work?**

   This event lead to a productive conversation with the Urban League regarding the nexus between health and employment which in turn informed work VR is doing on the Governor's Workgroup, Closing the Gap. This workgroup is looking at strategies and policy recommendations that will improve employment outcomes for individuals from minority communities and individuals with disabilities. A second expected outcome of the work is identifying ways that the Affordable Care Act can support employment outcomes.

4. **Have you identified any goals and objectives for achieving improved employment outcomes for African Americans based on community feedback? If so, what are they? Where are they in development (draft, being vetted, final)?**

   Vocational Rehabilitation's 2014 includes goals for increased utilization of VR services and employment outcomes for minority populations

5. **What are further opportunities for African Americans to engage in your work?**

   Vocational Rehabilitation holds annual public meetings for input in the development of the state plan. The State Rehabilitation Council holds quarterly meetings during which they receive public input.

Child Welfare

1. **What is/are the health or human service disparity/ies that you are working to address?**

   African Americans are disproportionately represented in the child welfare system.

2. **What efforts is the agency making on the local, district level to reduce disparities for African Americans?**

   New data shows that disparities are decreasing for African Americans.

   Foster Care
   The number of children in State care in the District reduced during the period of January 2010-November 2012. African American children in foster care reduced at a greater rate than other populations.
   - Population of African American children reduced by 10.1 percent, from 436 to 392.
   - The majority population fell by .01 percent, from 893 to 886.
   - Overall population reduced by 7 percent, from 1882 to 1750.
   - In 2010, African American children made up 23.2 percent of all children in substitute care in Multnomah County. In 2012, this percentage has dropped to 22.4 percent.

   Relative Foster Care
   The District increased the number of children placed with relatives during the period of 2010-2012. The increase is greater for African American children.
   - Population of African American children placed with relatives increased from 22.7 percent (99 children) to 37.0 percent (145 children).
   - The majority population increase was 19.6 percent (175 children) to 27.2 percent (241 children).

- Overall children placed with relatives increased from 21.4 percent (404 children) to 30.8 percent (539 children).

Another Planned Permanent Living Arrangement Plan (APPLA)
This is the least preferred of the Permanency Plans. The preference is a reunification and when this is not possible, adoption or guardianship, first with a relative is pursued. Between 2010 and 2012, the District reduced the number of children with APPLA plans and this improvement is greater for African American children.

- African American children on an APPLA plan reduced from 35.6 to 28.8 percent
- Children in the majority population on an APPLA plan reduced from 36.6 to 30.9 percent.
- Overall the number of children with an APPLA plan dropped from 34.0 to 28.4 percent.

Participating in projects to prevent child abuse in African American families
In partnership with the Multnomah Commission on Children Families and Communities, this pilot targets African American, American Indian and Alaskan Native families who are recipients of Self-Sufficiency benefits and at risk for child welfare intervention. 77 families have volunteered to receive culturally specific services helping with family stabilization and child safety. Specific attention is given to housing needs and barriers to employment, such as lack of education, job readiness, drug or alcohol and mental health needs.

Participating in Family Unification Program
This collaboration with the District and Home Forward and funding from Department of Housing and Urban Development provides Section 8 housing vouchers. These vouchers help families in danger of homelessness and ready for their children to return home or families that are at risk of homelessness and having their children removed. For those receiving vouchers, we work with Multnomah County's Action for Prosperity program to provide housing search and employment skill training for African American and Native American families.

In-Home Safety & Reunification Services
Statewide, DHS has changed how we support children in foster care to keeping children at home when it is safe to do so. We have expanded our provider network from four service providers to 17. This allows us more flexibility in the services we provide and the timeliness of those services. Approximately fifty percent of our funds for In-home Safety and Reunification Services are committed to agencies that focus services on families of color with 39 percent focused on African American families

Focus on the Alberta Community
Funding for one branch in our District was provided through the adoption of Senate Bill 964 with the goal to safely and equitably reduce children in foster care with an emphasis on reducing racial disproportionally for children of color. At our Alberta branch we have developed a Community Needs Assessment through focus groups with clients and others in order to prepare a service gap analysis. We have identified four areas of focus; housing and stability, visitation and parenting, family supports and community connections and innovative services for specific populations. We have also identified new populations needing assistance. This includes refugee families from Burma (Myanmar) and Somalia and members of the Muslim community. We plan to use 43 percent of our budget on culturally specific providers for African American families.

Improving our on-line application
Our on-line efforts are continuing to improve allowing applicants to apply for SNAP and Medical benefits from home, a library, school, etc. Applicants receive a call from a staff member shortly after submitting the application. The client does not have to come into a branch office unless they need to get a first time SNAP card and choose not to have it mailed allowing clients to receive services and benefits they need quicker.

Community Meetings

- Meet once a month with the Community Council on Family Preservation chaired by Rev. Dr. T. Allen Bethel involving faith based communities and we are working on a joint training set for December 3, 2012.
- Held several targeted discussions with the Muslim community specific to the African refugee population in order to improve our services.
- Held a meeting with community leaders to explore ways to improve services and outreach to Fathers. We are committed to furthering our conversations and plan to hold a subsequent meeting early next month.

Staff centered changes, meetings and trainings

- Standardized and restructured our services and practice across the district child welfare branches. This included; system changes at the initial investigation and assessment to target in-home placements and increased cultural specific inclusion with our service delivery.
- Now often take service providers with us to our safety assessment and initial meetings with families in order to provide immediate and direct service as quickly as possible to help families remain intact.
- Changed our practice that safety equates to removal to focusing on the philosophy of family stability through family preservation working to find a safe way to keep children at home with their families.
- Developed Family Support Specialists to assist our Child Protective Service and In-Home workers to identify and engage relatives up-front and to help match families with culturally appropriate services.
- Developed Reunification Engagement Specialists to work with staff with on-going open cases. They focus on reviewing cases to determine if a plan could be made to return the child to a parent or to engage relatives.
- In our JOBS program we have changed our contracted services offering a network of providers with performance based contracts focused on culturally responsive and specific services to families of color.
- Started joint monthly meetings with our Child Welfare and Self Sufficiency teams to improve, identify and enhance our efforts to strengthen family stabilization and preservation and to improve community relations.
- In-service cultural sensitive training covering biases, racism and how to enhance our work.
- Staff trainings review previous cases on “lessons learned”. This includes scenario discussions to talk about what team members would do to address implicit biases.
- Provided a tool kit for supervisors with cultural sensitive and cultural competency materials designed to encourage once a month small group conversations focused on race and culture.
- Our management team has completed an intense two day training focused on institutional/individual racism, prejudices, stereotypes and implicit biases called “Knowing Who You Are”. This training will be provided statewide over the next two years.

3. What efforts is the agency making on a statewide level to reduce disparities for African Americans?

The Child Welfare Program has a strategic agenda to equitably reduce the number of children in foster care by increasing the number of children who can safely be parented at home, and decreasing the length of stay for children who must enter the foster care system. When children do have to enter the foster care system, Child Welfare is focusing on increasing the number of children who are placed with relatives or other adults know to them and their family.

The department is in the process of redesigning the front door of the child welfare system, adding a tract of response for protective service workers when they first engage the family. This is called Differential Response and it will allow workers to engage the families with a goal of keeping the children safely in the home while working on the issues that brought the family to the attention of the agency. When a family is engaged in the differential track, there will be no finding of founded or unfounded, rather the family will be identified as needing services to keep their children safe. Community partners will, in certain instances, be able to accompany workers into the field and immediately initiate services for the family. When implemented, Differential Response should result in more children being able to remain safely at home while the family accesses service.

Strengthening, Preserving and Reunifying Families Programs are being implemented in 6 counties and the Alberta Branch in Multnomah County. These programs were established through legislation in 2010 and are identified by statute as the primary method of service delivery to families involved in the child welfare system. This legislation contemplates the array of services to be identified through community collaboration, which in turn, allows for the identification of culturally specific services to be included in the array. The legislature funded the implementation of these programs in 6 counties. The department has requested funding to implement in additional counties across the state.

In Home Safety and Reunification Services were redesigned to provide immediate interventions designed to keep children safely at home. We are also working on a strategy to focus our contracts with service providers to performance based. This change allows more accountability and a focus on the specialized needs of the family.

2011 State Statistics

The total number of children in foster care was reduced in 2011. The population of African American children in care was reduced. The average length of stay for a child in foster care was reduced. The number of children placed with relatives increased.

Community Engagement

Child Welfare continues the collaboration with Casey Family Programs, the Courts, and the Youth Development Council (formerly the commission on Children and Families) with a focus on safely and equitably reducing the number of children in foster care. In the last year, the number of counties engaged in this collaboration increased to 11. Each county has a mandate to engage African American leaders in their community in this collaboration.

Staff Changes

Child Welfare is currently in the process of developing a plan to provide the “Knowing Who You Are” training to all line staff and managers. This is a training focused on helping youth embrace their culture and history by addressing individual and institutional racism, prejudices, stereotypes and implicit biases. A pilot is planned in Multnomah and Washington counties in 2013 to fully train all staff with the goal to deliver the training statewide.

Trainings in neglect and chronic neglect were offered last year to help staff identify the impact of neglect on children’s brain development, and identify the difference between neglect which is a condition of poverty, and other types of abuse.