STATE OF EQUITY REPORT

Phase 2

Oregon Health Authority and
Department of Human Services

September 2013

Oregon Health Authority | Office of Equity & Inclusion | DHS Oregon Department of Human Services

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DIRECTOR'S LETTER

Dear reader,

The Department of Human Services (DHS) and the Oregon Health Authority (OHA) publish and update the State of Equity Report on an ongoing basis. The purpose of the report is to document both the inequities experienced by racially and ethnically diverse populations in the delivery of health and human services programs, and Oregon's progress in alleviating those inequities. The goal is to use this information to guide our actions to ensure all Oregonians enjoy the highest level of health and well-being.

The Phase 1 Report, completed in 2011, offers a better understanding as to why disparities exist, how we can improve relationships with diverse communities and what policy and program solutions should be implemented to improve outcomes. Using data in the report, we can focus our efforts within disproportionately affected communities. Having inclusive conversations and interactions with local communities moves us toward accountable actions in our delivery of health and human services.

In Phase 2 of the State of Equity Report, each DHS and OHA division selected meaningful indicators by race and ethnicity to inform their programs and policies. Ongoing measurement of these indicators will provide us with specific direction in four areas:

1. **The need for services and programs**: We must recognize and mitigate disproportionate levels of need experienced by some communities, while meeting the unique needs of each client we serve.
2. **Access to those services and programs**: the ability of our clients to receive services through any point of contact, free of barriers.
3. **Quality of customer service**: providing a consistently high quality of assistance with respect and consideration for each individual's cultural strengths and personal needs.
4. **Outcomes**: having deliberate, strategic, and intentional actions focused on achieving the best possible outcomes for our clients and communities at every level of service.

Keeping these four points as our guiding compass, we will use them to address current inequities that have arisen through historical factors. With these shared goals, DHS and OHA reaffirm our commitment to take intentional, practical steps toward equity. We recognize that longstanding disparities will not be eliminated overnight, but their elimination is attainable through meaningful action.

As Dr. Martin Luther King observed, "The arc of the moral universe is long, but it bends toward justice." The State of Equity Report reflects this aspiration toward justice. Even as we document the present inequities, we aspire to a future state where our work results in equity, and we invite your continued partnership to achieve our aim of an equitable state for *all* Oregonians.

Sincerely,

Bruce Goldberg, M.D.
Director
Oregon Health Authority

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Director
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CONTRIBUTORS

PROJECT TEAM

The Office of Equity and Inclusion (OEI) and Program Design and Evaluation Services (PDES) have collaborated to produce this report. OEI serves as a leader and catalyst in helping the Oregon Health Authority to promote equitable health and human services. PDES is an applied research and evaluation unit within the Oregon Public Health Division and Multnomah County Health Department.

OEI provided both direction and oversight for the State of Equity Report. PDES led the effort to convene division representatives from DHS and OHA to form the Race, Ethnicity and Language (REAL) Data Leadership Group. The REAL data leadership group facilitated selection of indicators, calculated indicators, provided interpretations for the results, and reviewed the report. PDES compiled and summarized the data.

ACKNOWLEDGEMENTS

We appreciate the invaluable input from the OEI Community Advisory Council and Health Equity Policy Committee on this report. We also thank the following individuals within DHS and OHA for taking time from their already busy schedules to help gather information for the report:

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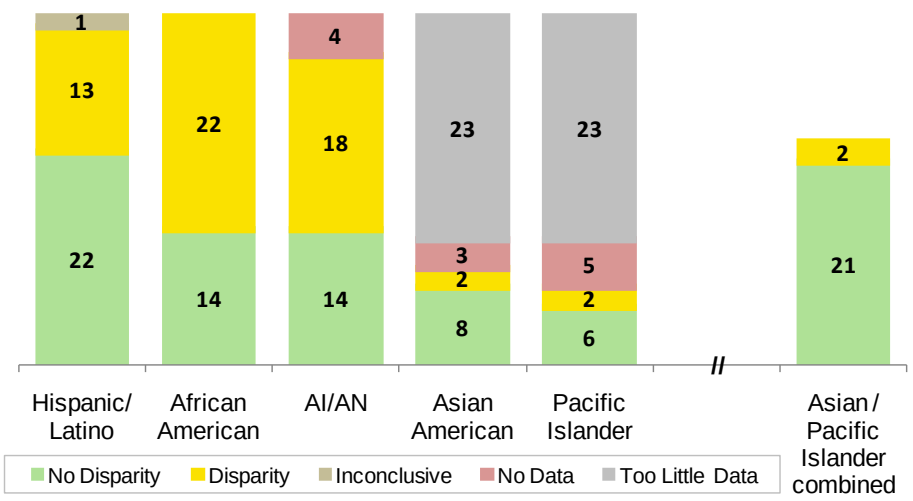
EXECUTIVE SUMMARY

BACKGROUND AND PURPOSE

The purpose of the State of Equity Report is to describe the need for DHS and OHA services and programs, access to those services and programs, customer service quality, and related outcomes by race and ethnicity. Information in the report is intended to be used for policy and program development and as a baseline by which to measure future progress.

The objectives of the Phase 1 State of Equity Report[1] (published June 2011) were to assess the availability and quality of data on DHS and OHA Key Performance Measures (KPMs) by race and ethnicity, and the feasibility of compiling information by race and ethnicity across DHS and OHA. In Phase 1, we found most KPMs could be calculated by race and ethnicity and results provided some useful information on disparities, but the picture was incomplete.

For the Phase 2 State of Equity Report, each DHS and OHA division or office was to choose, calculate, and report the three to five most meaningful indicators related to need for services and programs, access to those services and programs, quality of customer service, and/or related outcomes by race and ethnicity to inform their programs and policies.



Note on the calculation of Asian / Pacific Islander combined: There were too few observations for 23 measures to report for Asian and Pacific Islander separately. For these measures, they are combined.

SUMMARY OF RESULTS

The indicators chosen for Phase 2 appear to be well chosen in that most (30 of 36) demonstrate disparities by race/ethnicity, thus highlighting the need to track these measures over time. The considerable variability in the type of indicators chosen across DHS and OHA divisions and offices make it difficult to make overall summary statements about the results. Nevertheless, having these results together in one report highlights several important findings:

- Consistent with Phase 1, this report demonstrates a distinct pattern of disparities among African Americans and American Indians / Alaska Natives.
- The patterns for the other racial and ethnic groups are less consistent, but the findings still reveal some important areas for further exploration: 13 disparities were identified for Latinos, two for Asian Americans, and two for Pacific Islanders. Among the 23 indicators that combined Asian Americans and Pacific Islanders, two disparities were identified.
- In several cases, some groups seem to be experiencing better outcomes than non-Latino Whites. Asian Americans and Latinos appear to have overall better outcomes in a few categories. However, the findings for Asian Americans should be interpreted with caution due to the diversity of communities represented in the category and the likelihood that disparities experienced by some subpopulations are masked.

[1] Available at: www.oregon.gov/oha/oei/soe/index.shtml

Disparities at a Glance

Indicator	Page	Hispanic /Latino	African American	AI/AN	Asian American	Pacific Islander
Aging & People with Disabilities & Developmental Disabilities						
*Distribution of APD and DD clients served compared to the adult population of Oregon**	16	▲	●	●	●	●
*APD staffing levels compared to SPD clients served**	17	●	●	●	●	●
*Distribution of APD clients among 3 long-term care settings (In-Home/CBF/Nursing)**	18	●	▲	▲	▲	▲
*Distribution of clients among those in Developmental Disability residential settings (In-Home/Out-of-Home)**	19	▲	●	▲	▲	**N/A**
Child Welfare						
Ratio of foster care entrants to general child population of Oregon	22	●	▲	▲	● ‖	
Ratio of foster care exits to general child population of Oregon	22	●	▲	▲	● ‖	
Self-Sufficiency						
Ratio of children entering foster care who had received TANF within the prior 60 days to all children and youth receiving TANF	25	●	●	▲	**N/A**	**N/A**
Ratio of children entering foster care who had received TANF within the prior 60 days to all children and youth entering foster care	25	●	▲	●	**N/A**	**N/A**
Vocational Rehabilitation						
Vocational Rehabilitation clients who achieved desired employment outcomes, compared to non-Latino Whites	28	■	▲	**N/A**	**N/A**	**N/A**
Addictions and Mental Health						
Percentage of engaged clients who complete alcohol and other drug treatment (AOD) abuse treatment and are not abusing AOD compared to non-Latino Whites	33	●	▲	▲	●	●
*Percentage of adults receiving mental health services on Medicaid dollars who report improved functional outcomes as a result of those services compared to Whites**	34	●	●	●	●	**N/A**
Oregon State Hospital forensic Psychiatric Security Review Board (PSRB) commitments compared to the adult population in community mental health services and to the general adult population of Oregon	35	▲	▲	●	●	

LEGEND

● No Disparity	▲ Disparity	■ Inconclusive	**N/A** Data Not Available	‖ Appears to be doing better than the comparison group	* Hispanic / Latino ethnicity included in all race categories for this indicator	** This indicator is age adjusted

Indicator	Page	Hispanic /Latino	African American	AI/AN	Asian American	Pacific Islander
Division of Medical Assistance Programs						
Utilization rate of preventive services for children birth through 10 years old covered by the Oregon Health Plan, compared to non-Latino Whites	38	○ ‖	○	△	○ ‖	○
Utilization rate of preventive services for youth and adults 11 years old and older covered by the Oregon Health Plan, compared to non-Latino Whites	38	○	○	○	○	○
Rate of ambulatory care sensitive condition hospitalizations (Preventive Quality Indicators) of Oregon Health Plan clients, compared to non-Latino Whites	39	○ ‖	△	△	○ ‖	○
Office for Oregon Health Policy and Research						
Percentage of Oregonians ages 0-18 who do not have health insurance, compared to non-Latino Whites	43	○	○	○	○	
Percentage of Oregonians ages 19-64 who do not have health insurance, compared to non-Latino Whites	43	△	○	△	○	
Diversity of health care workforce in select fields versus Oregon adult population	44	△	○	○	○ ‖	
Public Health Division						
Rate of domestic violence before or during pregnancy, compared to non-Latino Whites	47	○	△	△	○	
First trimester initiation of prenatal care, compared to non-Latino Whites	48	△	△	△	○	
Low birth weight births, compared to non-Latino Whites	49	○	△	○	○	
*Immunization rates for 2-year olds, compared to non-Latino Whites**	50	○ ‖	○	○	○ ‖	△
Teen pregnancy rate per 1,000 15 to 17 year-old females, compared to non-Latino Whites	52	△	△	△	○ ‖	
Rate of new HIV/AIDS diagnosis per 100,000 cases, compared to non-Latino Whites	53	△	△	○	○	
*Cigarette smoking among adults, compared to non-Latino Whites***	54	○ ‖	△	△	○ ‖	
*Obesity among adults, compared to non-Latino Whites***	56	△	△	△	○	

LEGEND

○ No Disparity	△ Disparity	□ Inconclusive	**N/A** Data Not Available	‖ Appears to be doing better than the comparison group	* Hispanic / Latino ethnicity included in all race categories for this indicator	** This indicator is age adjusted

Indicator	Page	Hispanic/ Latino	African American	AI/AN	Asian American	Pacific Islander
Public Health Division cont.						
*High blood pressure prevalence among adults, compared to non-Latino Whites***	57	○ ‖	△	○	○	
Female breast cancer stage at diagnosis for age 50+, compared to non-Latino Whites	58	△	△	△	○	
*Years of potential life lost before age 75 per 100,000, compared to non-Latino Whites***	59	○ ‖	△	△	○ ‖	
*5-year average homicide rate per 100,000, compared to non-Latino Whites***	61	△	△	△	○	
Office of Private Health Partnerships						
*Approval rate for initial FHIAP applications, compared to non-Latino Whites**	64	△	△	**N/A**	○	
*Primary reasons for denying FHIAP applications, compared to non-Latino Whites**	65	○	○	○	○	
*FHIAP redetermination application approval rate, compared to non-Latino Whites**	65	○	△	**N/A**	○	
*Rates at which FHIAP applications are pended, compared to non-Latino Whites**	66	△	○	○	△	
*OMIP/FMIP applications approval rate, compared to non-Latino Whites**	68	○	○	**N/A**	○	
*Average number of enrollment days for terminated members, compared to non-Latino Whites**	68	○	△	△	△	

LEGEND

○ No Disparity	△ Disparity	□ Inconclusive	**N/A** Data Not Available	‖ Appears to be doing better than the comparison group	* Hispanic / Latino ethnicity included in all race categories for this indicator	** This indicator is age adjusted

NEXT STEPS

In this second phase of the State of Equity Report, DHS and OHA divisions, offices and programs chose, calculated, and reported on the most meaningful indicators related to need for and access to services and programs, quality of customer service, and related outcomes by race and ethnicity to inform their programs and policies. Moving away from KPMs to self-selected indicators has resulted in a keener understanding of a more glaring pattern of disparities in health and human services in Oregon. During Phase 2, staff from DHS and OHA and community partners mentioned interest in better understanding the need for and access to services and programs. Given this, in Phase 3, the DHS and OHA Race, Ethnicity and Language (REAL) Data Leadership Group will continue to work with divisions, offices and programs to update the indicators in this report, as well as adding indicators related to need and access. The identification of racial and ethnic disparities, especially in the areas of need for and access to services and programs, will help divisions identify unmet needs and may be useful to secure additional funding to meet those needs.

In addition, the progress attained due to the Phase 1 findings will continue to advance. DHS and OHA will continue to work on implementation of a policy to standardize the collection of race, ethnicity, and language data,[2] and to engage communities in understanding and directing the State of Equity work. This collaborative effort will inform the development of Phase 3 of the State of Equity Report, as well as informing other equity-focused data analytics efforts.

Using this comprehensive approach, DHS and OHA continue to make important advancements toward having sufficient data available on communities of color to support the state in obtaining appropriate funding, determining level of priority in decision making processes, and eliminating health and human services disparities in Oregon.

[2] Available at: www.oregon.gov/oha/oei/Documents/REAL_Data_Collection_Policy.pdf

BACKGROUND AND PURPOSE

In 2000, the Governor's Racial and Ethnic Health Task Force identified having data on communities of color as key to positioning the state to compete for new sources of funding and for identifying priorities in decision-making processes (*Governor's Racial and Ethnic Health Task Force, Final Report*. November 2000).[3]

The Task Force requested that DHS form a Racial and Ethnic Health Data Group that would include state and local government and community partners. The goals for the group were to include conducting enhanced data collection utilizing culturally appropriate methods, and focusing on the collection of data that would support the State's efforts to eliminate health and human services disparities in Oregon. Ten years later, DHS still had neither a Racial and Ethnic Health Data Group nor an organizational culture that supported enterprise-wide analysis of data by race and ethnicity.

In 2011, in an effort to build such capacity within DHS and the emergent OHA, the Office of Equity and Inclusion (OEI) began working on the State of Equity Report. The overall purpose of the report is to describe, whenever possible, the need for DHS and OHA services and programs, access to those services and programs, customer service quality, and related outcomes by race and ethnicity in Oregon. Information in the report is intended to be used for policy and program development and as a baseline by which to measure future progress. The intended audiences for the report include OEI, the OEI Community Advisory Council, community advocates, community partners, DHS and OHA leaders and managers, and policy makers. The State of Equity Report is to be updated and expanded upon in phases over time.

The objectives of Phase 1 of the State of Equity Report[4] (published June 2011) were to assess the availability and quality of data on DHS and OHA Key Performance Measures (KPMs) by race and ethnicity, and the feasibility of compiling information by race and ethnicity across DHS and OHA. KPMs are measures that provide a barometer of how well the agency is using available resources to accomplish mission-critical business and serve clients. They are, depending on the division, related to service need, access, quality, or related outcomes. KPMs were used as a starting place for the report because they are routinely calculated, publicly vetted, reported to the Legislature, and were few enough in number (42) to make compiling by race and ethnicity feasible.

In Phase 1, we found most KPMs could be calculated by race and ethnicity and results provided some useful information on disparities, but the picture was incomplete. Indeed, divisions and offices reported having many other indicators besides KPMs that could be analyzed by race and ethnicity and might more meaningfully highlight disparities to inform programs and policies.

The findings from Phase 1 informed a new approach for the State of Equity Report. For Phase 2, each DHS and OHA division or office was to choose, calculate, and report the three to five most meaningful indicators related to need for services and programs, access to those services and programs, quality of customer service, and/or related outcomes by race and ethnicity to inform their programs and policies. The DHS and OHA Race, Ethnicity and Language (REAL) Data Leadership Group helped guide this work by advising on the selection of indicators, analyses, and interpretation of results. This group was formed to support the State of Equity Report and related work, and has representation from each division and office.

This document represents a summary of Phase 2 methods, findings, conclusions, and next steps.

[3] Available at: www.oregon.gov/oha/oei/Documents/2000_RE_Health_TF.pdf

[4] Available at: www.oregon.gov/oha/oei/Pages/soe.aspx

PHASE 2 METHODS

In this section, we describe the methods for selecting, analyzing and reporting of the indicators for Phase 2.

SELECTION OF PHASE 2 INDICATORS

Each division or office used the following 11 guidelines to choose three to five meaningful indicators.

1. **An Indicator of Need, Access, Quality or Outcomes**
   The indicators were to be related to one or more of the following:
   - Need for services and programs (e.g., percentage of families eligible for TANF; prevalence of adult cigarette smoking);
   - Access to those services and programs (e.g., percentage of children without health insurance);
   - Quality of customer service (e.g., length of time between application for services and program enrollment);
   - Outcomes of those services and programs (e.g., family stability; effectiveness of substance abuse treatment).

2. **Raising Awareness of Disparities**
   Divisions and offices were to choose the most meaningful indicators for assessing racial and ethnic disparities related to their services or programs. In choosing the indicators, we encouraged divisions and offices to consider which indicators might most clearly raise awareness of racial and ethnic disparities and might be the most impactful in driving programmatic or policy changes related to equity.

3. **Scope of Influence**
   Ideally, the indicators were to be under the direct influence of DHS and OHA. However, these indicators were not necessarily performance indicators. If there was an issue that was important to track by race and ethnicity, but there were not sufficient services or programs to address the issue, the division or office could have selected a related indicator to highlight the need for services or programs in that area. For example, the Public Health Division may have chosen to track the percentage of people who are obese by race and ethnicity, even without a comprehensive obesity program.

4. **Interpretation**
   The indicators were to be easy to interpret.

5. **Represent Breadth of Division or Office**
   The indicators for a given division or office were to represent different dimensions of the division's service and program areas, thus avoiding duplication and providing a broad overview of services and programs. For example, the Public Health Division was encouraged to choose indicators from multiple public health issues, rather than focusing on one issue such as tobacco use.

6. **Ability to Calculate**
   Divisions or offices were to choose indicators that they could calculate by race and ethnicity. However, if potentially important indicators of equity could not be calculated by race and ethnicity, divisions or offices were encouraged to let us know so we could support the development of a plan to be able to calculate them by race and ethnicity, if feasible. Gaps in available data and analytic resources can be points of advocacy.

7. **Representativeness of Indicator**
   Divisions or offices were to choose indicators that had at least 50 clients (or survey respondents) in the denominator within each racial and ethnic group.[5] For some indicators, that may have required combining data across multiple years. If there were still fewer than 50 clients within racial or ethnic groups for service quality or outcome indicators, we suggested divisions and offices consider choosing indicators related to need or access because those indicators may be based on a larger number of people.

8. **The Long View – Calculating and Reporting Annually**
   Divisions and offices were instructed that they must be able to report the indicators over time. We anticipated requesting these data annually. We recognize that some programs calculate indicators by race and ethnicity using data that are obtained only every few years or using multiple years of data combined. Reporting the same estimate for a few years in a row was acceptable as a starting place, and could highlight the need to obtain more data.

9. **Quality of Data**
   We did not set any other thresholds for the quality of data on race and ethnicity for divisions and offices when choosing their indicators. We viewed this as a starting place for calculating key indicators of racial and ethnic disparities, and gaining knowledge about limitations of these data (e.g., 15% of clients were missing racial and ethnic data) as an important step in improving data quality.

10. **The Number of Indicators**
    A division or office could have included more than three to five indicators.

11. **Key Performance Measures**
    A division or office could have chosen KPMs as their indicators.

RACIAL AND ETHNIC CATEGORIES

Recognizing the inherent limitations of racial and ethnic categories to adequately represent the complexity of racial and ethnic identity, but with the goal of providing meaningful data on DHS and OHA clients and the public, we requested each division or office calculate their meaningful indicators by race and ethnicity as feasible. We asked that divisions report racial and ethnic data to us in a way that was consistent with OMB guidelines[6] and similar to the Department of Education standards[7] and those used in studies of disparities (see CDC Health Disparities and Inequalities Report, U.S., 2011). Specifically, we requested indicators be calculated by the following racial and ethnic categories:

- Hispanic/Latino;
- Non-Latino Black or African American;
- Non-Latino American Indian / Alaska Native (AI/AN);
- Non-Latino Asian American;
- Non-Latino Native Hawaiian / Pacific Islander (NH/PI);
- Non-Latino White.

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[5] For the purposes of these guidelines, we are defining the racial/ethnic groups as Hispanic/Latino, non-Latino Black/African American, non-Latino American Indian / Alaska Native, non-Latino Asian, non-Latino Pacific Islander, non-Latino White, non-Latino Multiracial (if primary race not available), non-Latino Other, and Unknown/Missing. It is acceptable to combine non-Latino Asian and non-Latino Pacific Islander, if needed, but keeping these racial/ethnic groups separate is strongly preferred.

[6] Available at: www.whitehouse.gov/omb/fedreg_1997standards

[7] Available at: http://nces.ed.gov/statprog/2002/std1_5.asp

We asked divisions and offices to combine race and ethnicity data in order to create mutually exclusive categories, thus allowing for comparisons to be made more easily across racial and ethnic groups. Combining race and ethnicity may also reduce the amount of missing race data as Latinos in Oregon often do not identify with listed race categories and select "other" for race.

Other racial and ethnic categories used included:

- Non-Latino Multiracial;
- Non-Latino other;
- Unknown/missing.

Some DHS and OHA data systems do not collect primary race or preferred race. For indicators based on data from those systems we asked divisions and offices to use the category of "Multiracial," which would include all persons who identify more than one race; if someone identifies as "African American" and "White" they would be included in the "Multiracial" category, not in the "African American" or "White" categories.
The "other" category was for individuals who identified with a race that was not listed and the "unknown/missing" category for individuals where race and ethnicity information was not collected.

Not all divisions and offices could use these categories. Variations are noted in the division and office findings, and in Appendix III.

DEFINITION OF DISPARITY

For each indicator provided, we asked that divisions and offices indicate whether or not there was a disparity needing further investigation, using the definitions in Table 1 below. The definitions are broad because they were written to be able to match the broad variability across DHS and OHA indicators.

Guidelines for Identification of Disparities

No Disparity	The comparisons suggest little or no disparity for any community of color.
Disparity	The comparisons suggest at least one community of color is experiencing a disparity. Further analysis of both possible reasons for these disparities and remedial interventions are needed. Disparities could be influenced by many factors, such as co-morbidities, poverty, education, social exclusion, and lack of social support, so we caution the reader to not view these disparities as the result of a single cause.

Note: Table and text adapted from "*Multnomah County Health Department: Report Card on Racial and Ethnic Health Disparities*, March 2008."

In order to apply the disparity definitions to their racial and ethnic data, divisions and offices were asked to use the non-Latino White population, when available, as the comparison group because they are less likely to experience discrimination based on race. However, some divisions and offices chose to use a different population as the comparison group. The text of each division or office indicator specifies the comparison group used to identify disparities in the data.

In general, divisions and offices used one of two methods to identify disparities in communities of color. Either they used statistical testing (such as non-overlapping confidence intervals) to determine if there were disparities among groups, or they based their interpretation on whether or not the differences appeared to be meaningful, such as there being at least 5 percentage points between a community of color and non-Latino Whites.

INTERPRETATION OF FINDINGS

One of the key developments of the Phase 2 State of Equity Report is in approaching the development of context for understanding and interpreting the disparity data. The REAL Data Leadership Group developed a list of what type of information should be included when interpreting each indicator, specifically:

- Why the indicator is important;
- Whether the findings identify disparities;
- Possible reasons why disparities are present;
- What the division or office is doing to address disparities; and
- Areas for further investigation.

PHASE 2 FINDINGS

In the following section, we present the findings of the selected Phase 2 indicators. Results are grouped by agency, with DHS findings presented first followed by the findings for OHA.

Within each agency section, findings are organized by the division or office that selected, analyzed and interpreted the indictor. Divisions and offices organized the discussion of their findings as follows:

1) Description of the agency, division, program, or office
2) Explanation of the clients they serve
3) Information about the indicators selected, including how they defined a meaningful difference in results by race and ethnicity
4) Description of the findings includes whether racial and ethnic disparities were identified as well as:
    a. Why the indicators are important
    b. What the findings mean
        i. How to interpret the findings
        ii. Whether the findings are new
        iii. Possible reasons why disparities are present
    c. Next steps
        i. What the division or office is doing to address disparities
        ii. Areas for further investigation and/or additional indicators to explore related to findings

Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity or where one or more communities of color is experiencing better results than the comparison group, by a green circle. For all indicators, each racial category excludes Latinos unless otherwise indicated.

The following additional information is given in the Appendices:

- Appendix I includes technical notes about the racial and ethnic categories used in the analyses, along with information explaining confidence intervals, sample sizes, and data suppression rules.
- Appendix II includes the DHS and OHA organizational charts and the respective agency vision, mission, and goals.
- Appendix III includes tables that present more detailed results on the indicators calculated by race and ethnicity, including confidence intervals and sample sizes.

About the Agency

The Department of Human Services (DHS) is Oregon's principal agency for helping Oregonians achieve well-being and independence through opportunities that protect, empower, respect choice and preserve dignity, especially for those who are least able to help themselves.

About 87 percent of the DHS budget is spent directly in Oregon communities by providing direct services to more than 1 million Oregonians each year. These services provide a key safety net for those in our society who are most vulnerable or who are at a difficult place in their lives. During 2010 DHS provided:

- Food benefits helping 1,016,065 people buy food and avoid hunger with foods such as fruits, vegetables, and whole grains needed for good health.
- Helped 762,863 low-income Oregonians with medical coverage through an eligibility determination process.
- Helped stabilize 51,456 low-income families with cash assistance through the Temporary Assistance for Needy Families federal program (TANF).
- Helped more than 36,645 seniors and people with physical disabilities with activities of daily living.
- Adult and child protective services kept 11,600 children and 20,000 adults safe.
- Adoption services found permanent, safe homes for 556 children.
- Domestic violence services helped 8,920 victims address safety concerns.

We present the Phase 2 results by the five key program areas in DHS: Aging and People with Disabilities & Developmental Disabilities; Child Welfare; Self Sufficiency; and Vocational Rehabilitation.[8]

For more information on DHS, visit: www.oregon.gov/DHS/aboutdhs.

[8] When work began on the Phase 2 State of Equity Report, DHS was organized into two divisions: 'Children, Adults and Families' (CAF) and 'Seniors and People with Disabilities' (SPD). Both CAF and SPD selected three to five meaningful indictors to analyze, interpret and track by race and ethnicity for the State of Equity Report. Subsequent to the selection and analysis of the selected indicators, DHS reorganized its divisions into the five key program areas of Aging and People with Disabilities, Child Welfare, Developmental Disabilities, Self Sufficiency and Vocational Rehabilitation. As a result, many of the DHS key program areas present fewer than the prescribed three to five meaningful indicators.

AGING AND PEOPLE WITH DISABILITIES AND DEVELOPMENTAL DISABILITIES PROGRAMS

About the Programs

The Aging and People with Disabilities (APD) and Developmental Disabilities (DD) programs assist Oregonians to become independent, healthy and safe by helping seniors and individuals with disabilities of all ages achieve well-being through opportunities for community living, employment, family support, and services that promote independence, choice and dignity.

Clients

The APD program serves seniors and people with disabilities. Services include determination of eligibility, case management, Older Americans Act services, direct financial support and long-term services and supports. Long-term services and supports are provided in the individual's home, in community-based facilities such as adult foster homes, residential care facilities and assisted living facilities, as well as in nursing facilities. Approximately 28,000 seniors and individuals with physical disabilities access long-term services and supports.[9]

The DD program provides supports and services to 19,870 children and adults with developmental disabilities who meet eligibility criteria for services. Individuals who are eligible and their families can access services to provide the support to be able to live with as much independence as possible. Services and supports may include information and referral, case management or hourly services, and supports that provide 24-hour care. The DD program operates five waiver programs (three of which are children's model waivers) and serves individuals in a variety of in-home and out-of-home settings.[10] Across those waiver services, approximately 8,100 individuals are receiving services within their own home, apartment or family's home; approximately 5,800 individuals are receiving out-of-home services. Also, approximately 4,000 additional people are enrolled in non-waivered family support services, which are also provided in-home.

For more information on APD, visit: www.oregon.gov/dhs/spwpd/Pages/about_us.aspx.

For more information on DD, visit: www.oregon.gov/dhs/DD/Pages/about_us.aspx.

About the Indicators

The indicators chosen by APD and DD to examine service equity by race and ethnicity are:

1. Number of APD and DD clients served compared to the overall adult population of Oregon
2. APD staffing levels compared to clients served
3. Distribution of APD clients in specific long-term care settings
4. Utilization of different service settings for people with developmental disabilities

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[9] "Overview, Seniors and People with Disabilities," presented to the Joint Ways and Means Subcommittee on Human Services, February 24, 2011.

[10] In-home services are defined as those that are provided in the individual's own home or apartment or the individual's family home. Out-of-home services are defined as those that are contracted to a licensed or certified provider (group home and foster care).

Indicators one and two examine the race and ethnicity of individuals served by APD and DD as compared to the overall Oregon adult population and to the APD workforce, respectively.

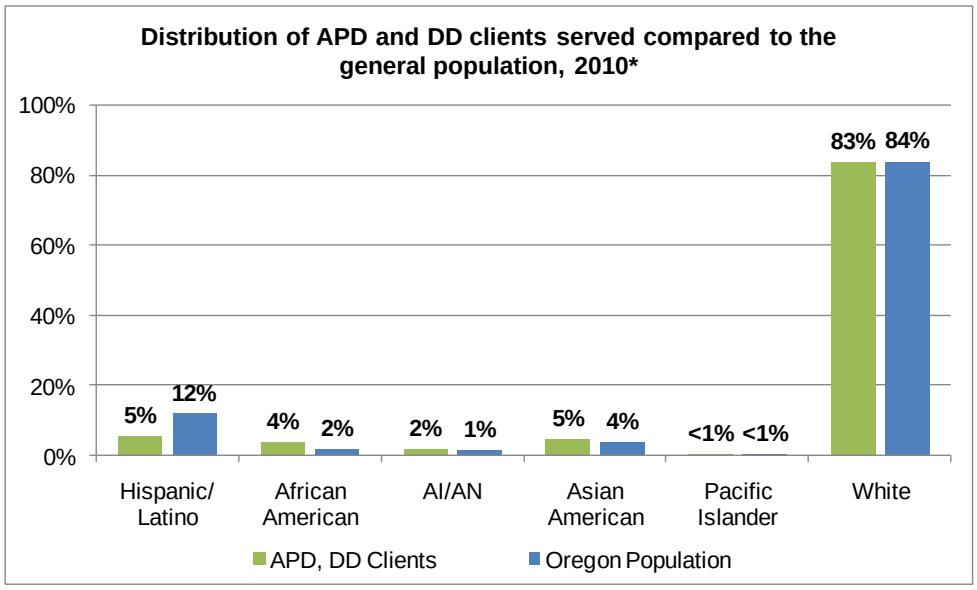
Indicator three examines the racial and ethnic distribution of seniors and individuals with disabilities served in each of the three APD long-term care settings. The final indicator looks at the racial and ethnic distribution of children and adults with developmental disabilities who receive services in-home versus out-of-home.

For all indicators a 5 percentage point or greater difference between communities of color and non-Latino Whites is considered a meaningful difference.

Findings

Findings for the APD and DD indicators are presented below. Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity by a green circle. For all indicators, each race category excludes Latinos unless otherwise indicated.

1. Number of APD and DD clients served compared to the adult population of Oregon:* The proportion of APD and DD Latino clients is smaller than their proportion of the general population.



Why This Indicator is Important

This indicator attempts to illuminate how access to APD and DD services is experienced by communities of color across the state and to pinpoint potential areas for improvement.

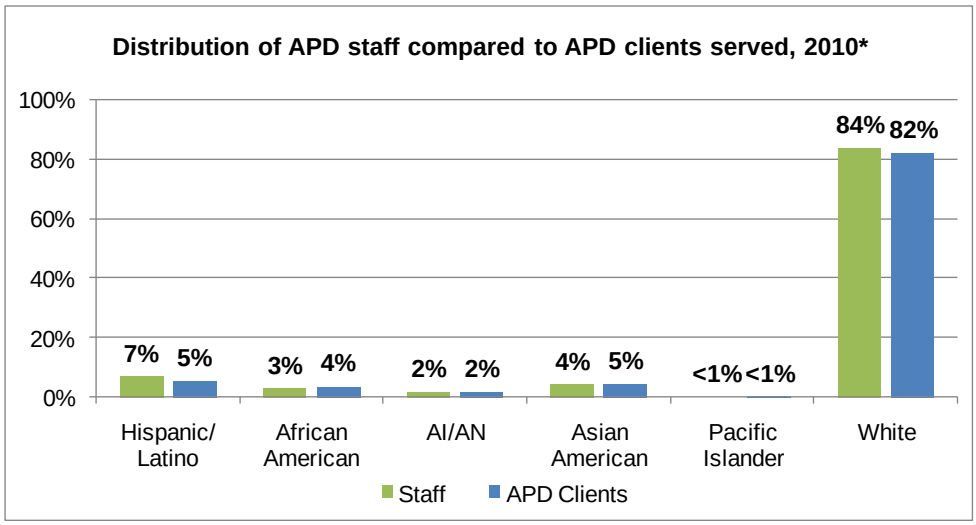
What These Findings Mean

To compare the racial and ethnic composition of individuals served by the APD and DD programs to the overall Oregon adult population, the number of individuals accessing services is compared to the 2010 Oregon Census data report of persons over the age of 18.

A comparison of the race and ethnicity of individuals served and the racial and ethnic composition of the state of Oregon reveals that there is a disparity in how self-identified Latino individuals are accessing services. The Oregon Census reports that 11.8 percent of the Oregon population is Latino. When compared with individuals served by APD and DD programs, only 5.5 percent of clients are Latino, a difference of more than 6 percent. This finding suggests Latinos may potentially be underserved by APD services for seniors and people with physical disabilities. Factors that may contribute to this difference are explored under Next Steps below. Also, the data show that the proportions of African Americans, American Indians / Alaska Natives, and Asian Americans served by APD and DD programs are greater than their respective proportions of the overall population; this did not meet the threshold of a meaningful difference at this time, but will be monitored and analyzed in future reporting.

* Hispanic/Latinos included in all race categories for this indicator.

2. APD staffing levels compared to clients served:* Little or no difference between the racial and ethnic distribution of APD staff compared to APD and DD clients.



Why This Indicator is Important

This indicator attempts to illuminate how access to APD and DD services is experienced by communities of color across the state and to pinpoint potential areas for improvement.

What These Findings Mean

The racial and ethnic composition of individuals accessing APD and DD services was compared to the racial and ethnic composition of APD employees. To do this, the population of individuals accessing services was compared to APD staffing data provided by the Department of Human Services, Human Resources Department. These findings suggest the racial and ethnic distribution of APD staff is representative of the clients served. Important to note is that staffing data do not include individuals employed in local DD entities – Community Developmental Disabilities Programs (CDDPs) and DD Brokerages – but APD offices determine eligibility for medical and other programs for individuals served by local DD entities.

Next Steps

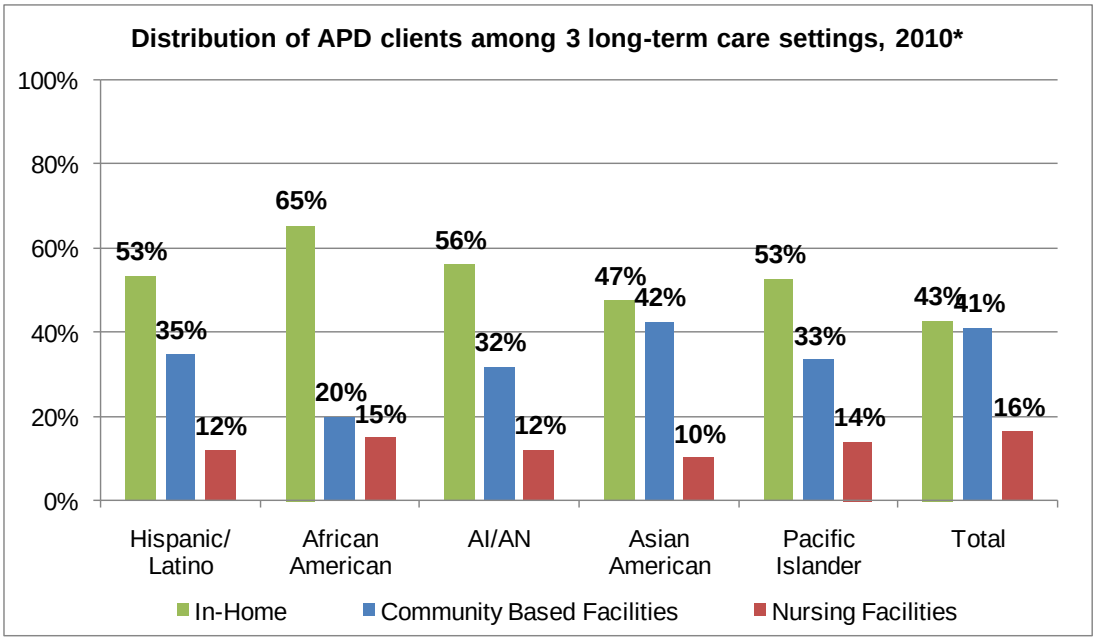
The cause for the identified difference in how Latinos are accessing services is not fully understood, however, answers to questions such as the following may shed light on potential contributors:

- Is there a shortage of culturally and linguistically competent services and outreach to Latino communities?
- How large a role does the younger age distribution of the Latino community play in the identified disparities? Age is an important component of eligibility for APD services, but a closer examination of individuals with physical disabilities and developmental disabilities under the age of 65 would show if this disparity persists.
- What percentage of Latino individuals do not have documentation for citizenship or legal residency, yet are still counted in census figures? Lack of legal documentation would prevent someone from being able to access public services.
- Are there cultural considerations that reduce the need for public services, such as the prevalence of strong family, community and intergenerational supports in Latino communities?
- Do social determinants of health create lower quality of life expectations for someone of Latino origin?

A key piece of data that will also be useful in future research is to introduce greater data granularity so that experiences can be described at the county level as well as the state level.

* Hispanic/Latinos included in all race categories for this indicator.

3. Distribution of APD clients in specific long-term care settings:* Compared to long-term care service population as a whole, there are differences in where African Americans, American Indians / Alaska Natives, Asian Americans, and Pacific Islanders are choosing to receive care.[11]



Why This Indicator is Important

This is a significant indicator for service equity because APD policy is to provide seniors and individuals with physical disabilities a choice of setting when accessing long-term services and supports. Service setting choice is a basic right of individuals eligible for Medicaid funded long-term care. With some exceptions, an equivalent level of service can be provided in nursing facility, community-based facility[12] or in-home service settings.

What These Findings Mean

The above graph shows that 43 percent of the total long-term care service population receives care in an in-home service setting, 41 percent of the total population resides in a community-based facility, and 16 percent reside in a nursing facility. When comparing service setting preferences of the total service population to specific communities of color, some striking differences are revealed:

- In-home services - *high utilization*: Compared to the total service population, Latinos are nearly 11 percentage points more likely to receive services in-home, African Americans 22 percentage points more likely, American Indians / Alaska Natives 13 percentage points more likely, and Pacific Islanders 10 percentage points more likely.
- Community-based facilities - *low utilization*: Compared to the total service population, Latinos are 6 percentage points less likely to receive services in community-based facilities, African Americans 21 percentage points less likely, American Indians / Alaska Natives 9 percentage points less likely, and Pacific Islanders 8 percentage points less likely.
- Nursing facilities - *low utilization*: Compared to the total service population, Asian Americans are 6 percentage points less likely to reside in nursing facilities.

The findings support that overall, the long-term care service population prefers to receive care in less restrictive settings; however there is a striking difference in the high utilization of in-home services in communities of color versus a trend of under-utilization of community-based facilities.

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* Hispanic/Latinos included in all race categories for this indicator.

[11] While the comparison group chosen is the total population, it should be noted that the percentages for non-Hispanic Whites vary by less than 1.5% of the percentages for the total population.

[12] Community-based facilities include adult foster homes, assisted living facilities, residential care facilities and specialized living facilities.

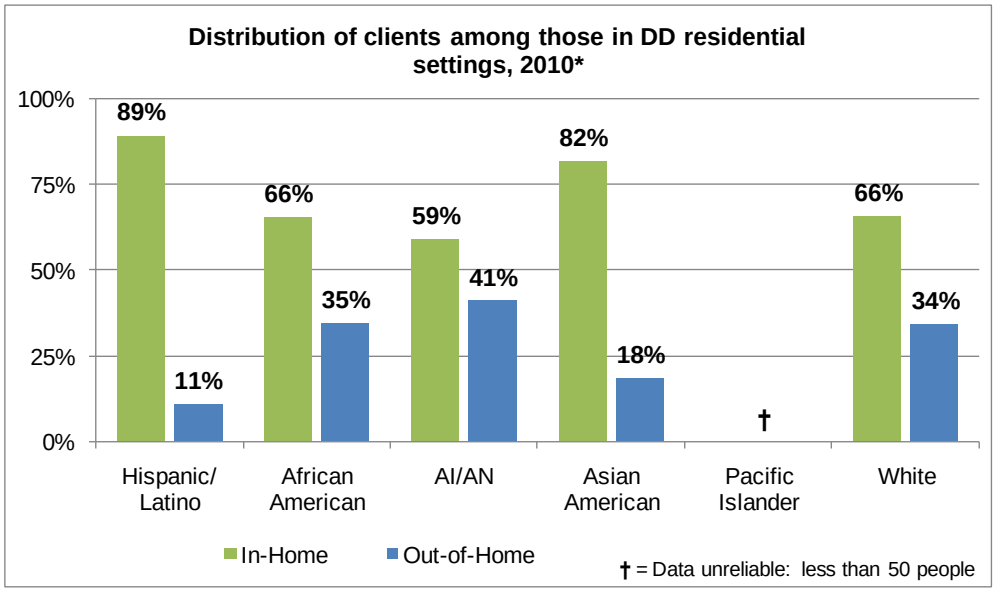
Next Steps

As APD policy is to provide seniors and individuals with physical disabilities a choice of setting when accessing long term services and supports, and a higher utilization of in-home services is not necessarily a disparity, several of the following questions may need exploration:

- What role does cultural isolation play in determining client choice of service setting?
- Are there cultural considerations that reduce the desire to reside within a community-based care facility?
- Are there family, community or intergenerational supports that may make access to in-home services more prevalent than community-based services?
- What percentage of Medicaid-eligible individuals in community-based facilities start out as private pay? This is an important economic consideration as someone who does not have sufficient funds to start as a private pay resident in a community-based setting may not have an opportunity to move into a community-based facility as a current Medicaid client.

4. Access to Service Settings for People with Developmental Disabilities:* Compared to Whites, there are differences in how Latinos, American Indians / Alaska Natives, and Asian Americans utilize these services.

Why This Indicator is Important



This indicator attempts to shed light on how utilization of the different types of service settings is experienced by communities of color across the state and to identify potential areas of improvement. A primary value of the DD program area is to ensure people with developmental disabilities have choice and access to their most preferred service setting, be it an in-home or an out-of-home service. DD does not discriminate between in-home and out-of-home services; the individual, his or her family/guardian, or support team determine which service is most desirable for the person accessing supports. However, utilization of out-of-home waivered services is capped and the portal through which an individual can access those services is limited.[13] It should be noted, however, that national data indicates that more than half of all individuals with developmental disabilities are now living at home with their families.[14]

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* Hispanic/Latinos included in all race categories for this indicator.

[13] OAR 411-320-0090 (4) (j-l). Available at: www.dhs.state.or.us/policy/spd/rules/411_320.pdf

[14] www.nasddds.org/pdf/2011AnnualReport.pdf

What These Findings Mean

The percentage of Whites and African Americans utilizing in-home and out-of-home services is fairly equal. By contrast, Latinos and Asian Americans utilize in-home services more often than Whites and African Americans, while American Indians / Alaska Natives utilize in-home services less than Whites and African Americans; the converse is true for out-home-services in each racial and ethnic group.

The cause for this disparity is not fully understood, however, answering questions similar to the following may shed light on potential contributors:

- Are Latinos and Asian Americans more likely to use specific types of in-home services compared to others? If so, what are the drivers?
- Are there factors contributing to American Indians / Alaska Natives utilizing out-of-home verses in-home services at a higher ratio than other racial and ethnic groups?
- What is the utilization threshold for out-of-home services? At what point do we consider utilization as "over-utilization?"
- Are there cultural and economic considerations that affect whether out-of-home or in-home services are utilized?
- What is the demographic breakdown of the ODDS out-of-home provider community? Does greater emphasis need to be given to the diversification of the provider base? If so, would more self-identified Asian Americans and Latinos utilize out-of-home services?
- Is there a shortage of culturally and linguistically competent services and outreach in Latino and Asian American communities?
- Is there a demand for out-of-home services that is going unmet?

Next Steps

DD is making more bi-lingual forms available for public use via paper and electronic format (Application for DD services, family support forms, etc.). However, ODDS needs to look at other materials utilized by racial and ethnic groups for translation into native languages.
Additional steps may help answer some of the questions posed above:

- To date, DD has not done a detailed analysis comparing how different racial and ethnic groups utilize in-home and out-of-home services. This data serves as a starting point to do so;
- Analysis of multi-year data to evaluate trends within the race and ethnicity categories;
- Gather demographic information about out-of-home provider bases;
- Survey service participants to glean why a particular service was chosen instead of another;
- Evaluate what forms of media would improve access to information for service participants;
- Use race and ethnicity data in the development of Employment First policies that ensure equal access to vocational services.

CHILD WELFARE

Clients

Child Safety Services

The Child Protective Services (CPS) Program is the part of DHS, Child Welfare that responds to allegations of child abuse and neglect. The child abuse reporting law, codified in Oregon Revised Statute (ORS) 419B.005 to 419B.050, provides the definition of child abuse as well as the department's authority to investigate child abuse. Each report of child abuse is handled by a CPS-trained worker who makes an initial determination whether a report meets the statutory definition of child abuse. If the information constitutes a report of abuse or neglect and the alleged perpetrator is a legal parent of the child, lives in the child's home, or has access to the child, then a CPS-trained worker is assigned to conduct a comprehensive safety assessment. In situations when children are identified as unsafe, a plan must be developed to manage their safety. If a child's safety cannot be managed in-home, then it may be necessary to develop a plan where the child is placed in foster care, which may include placement with a relative. The purpose of protective social services is to prevent further abuse, safeguard and enhance the welfare of abused children, and preserve family life when consistent with the protection of the child by stabilizing the family and improving parental protective capacity.

Permanency for children who have been removed from their homes by Child Protective Services

Foster care services provide temporary care for children removed from their homes for reasons of abuse or neglect. While children are in foster care, their parents, DHS, and other agencies work toward safely reuniting the family. Adoption Services permanently place children with other families when they cannot return to their parents.

About the Indicators

In order to examine equitable provision of DHS services and related outcomes by race and ethnicity in its Child Welfare Program the following meaningful indicators were chosen:

1. Ratio of foster care entrants to general child population;
2. Ratio of foster care exits to general child population.

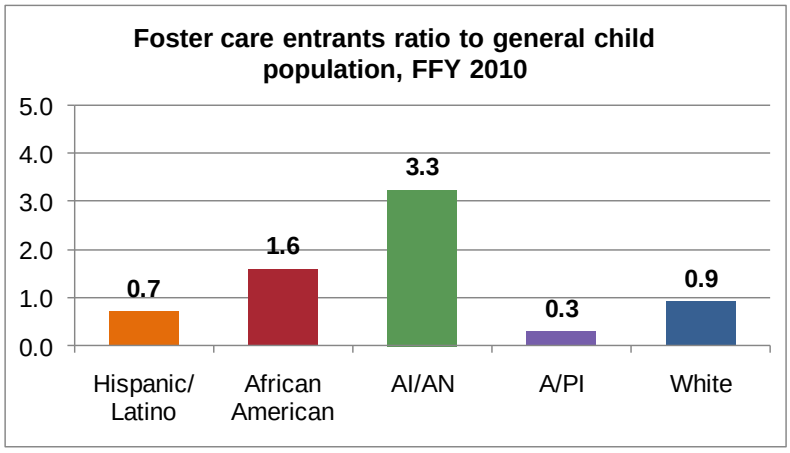
These two indicators track the frequency of children entering and exiting the Oregon foster care system by race and ethnicity.

A 0.5 difference in the ratios between communities of color and non-Latino Whites is considered a meaningful difference in the indicators.

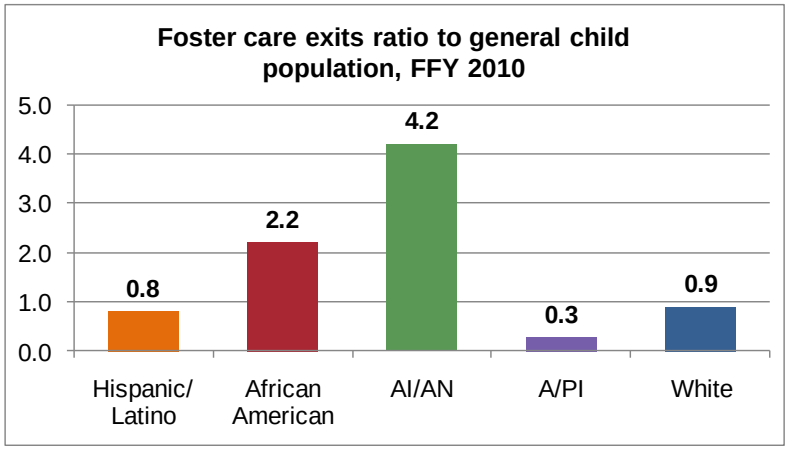
Findings

Findings for the DHS Child Welfare indicators related to foster care entrants and exits are presented below. Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity by a green circle. For all indicators, each race category excludes Latinos unless otherwise indicated.

1. Ratio of foster care entrants to general child population of Oregon: Compared to non-Latino Whites, the ratio is higher for African Americans and American Indians / Alaska Natives, and lower for Asian Americans / Pacific Islanders.



2. Ratio of foster care exits to general child population of Oregon: Compared to non-Latino Whites, the ratio is higher for African Americans and American Indians / Alaska Natives, and lower for Asian Americans / Pacific Islanders.



What these findings mean

Foster children range in age from birth to 20, and come from many different backgrounds and types of families. However, they are all children who cannot remain safely at home due to abuse or neglect. In federal fiscal year (FFY) 2010, 4,736 children entered foster care while only 4,213 children exited care during that same period, resulting in a net increase in the total number of children in care during that reporting period.[15]

During that same FFY 2010 reporting period, the findings above demonstrate that American Indian / Alaska Native children were 3.3 times more likely to enter foster care than would be expected based on their representation in the general population, and that African American children were 1.6 times more likely. However, American Indian / Alaska Native and African American children were over-represented among children exiting foster care as well; in fact, they appeared even more likely to exit foster care than enter foster care, so their overall representation in the foster care population would decline over time if this trend continues.

As Oregon moves to address over-representation in the foster care system, necessary and desired outcomes include equitably providing child safety alternatives to foster care where circumstances allow, and sustaining higher proportions of African American and American Indian / Alaska Native youth safely exiting foster care to permanency.

[15] Available at: www.oregon.gov/dhs/abuse/publications/children/2010-cw-data-book.pdf, page 15.

Oregon's over-representation of American Indian / Alaska Native and African American children in foster care resembles that in other states. Although there is national awareness about the issue, common strategies to address it have not been identified. Oregon has begun efforts to work on it, with high-level support from the Governor, the courts, and legislative leaders. In 2009, Governor Kulongoski created the Child Welfare Equity Task Force, which charged leaders from across the state with submitting an initial report and recommendations to significantly reduce and eventually eliminate racial disproportionality in the child welfare system. The Task Force's final report was issued in March 2011.[16]

In recent years, Child Welfare has partnered with the Oregon Commission on Children and Families, Oregon Courts, Casey Family Programs, and numerous community stakeholders to develop strategies and goals to safely reduce the overall number of children in foster care and to eliminate the over-representation of American Indian / Alaska Native and African American children in foster care. There is still work to do, but we are seeing some progress when comparing 2010 to 2009: the over-representation of American Indian / Alaska Native children served in foster care declined by almost 21 percent, and the number of African American children entering foster care declined by 8 percent (data not shown).

Next Steps

During the 2011 legislative session, DHS supported a bill to further the efforts to create equity in the child welfare system. If it had passed, the bill would have, among other things, directed DHS to provide a racial impact statement to the Legislature for bills impacting child welfare clients in Oregon. This would have helped alert legislators to unintended consequences when proposed legislation could affect racial or ethnic populations receiving child welfare services.

DHS is currently working toward implementing a Differential Response (DR) system for its child safety programs. Some of the stated goals of the DR system are to keep children safely at home, provide stronger placement prevention and family reunification services, safely reduce the number of African American and American Indian / Alaska Native children in foster care, and strengthen partnerships between child welfare and community based organizations. This system change is consistent with recent legislative changes that require DHS and county partners to collaborate to identify and implement programs that provide an array of services with the stated goal of helping children remain safely with their families and, when that is not possible, to experience the shortest stay in foster care that is safely possible.

[16] Available at: www.oregon.gov/dhs/children/docs/tf-report.pdf

SELF SUFFICIENCY

Clients

The Self-Sufficiency programs serve clients at or below 185 percent of the federal poverty level. Self-Sufficiency administers the following programs: Temporary Assistance for Needy Families (TANF), Employment Related Day Care (ERDC), Supplemental Nutrition Assistance Program (SNAP), and determines eligibility for companion medical programs.

TANF services include supports to meet immediate needs and child abuse prevention through its Family Support and Connections (FS&C) program. FS&C provides supports to prevent children in at-risk TANF families from entering the child welfare system by providing voluntary contract services to families. These short-term interventions are provided by contractors and include home visits, strengths- and needs-based family assessments, advocacy, and outcome-based case planning.

TANF services also include Temporary Assistance to Domestic Violence Survivors (TA-DVS). TA-DVS provides temporary financial assistance and support services to families with children to flee and stay free from domestic violence. TA-DVS is used to help domestic violence survivors address their safety concerns and to stabilize their living situations, thus reducing the likelihood of survivors returning to an abuser. These services maintain the safety of these vulnerable children and their parents, and can prevent sometimes life-threatening situations.

About the Indicators

In order to examine equitable provision of DHS services and related outcomes by race and ethnicity in the Self-Sufficiency Program area the following indicators were chosen:

1. Ratio of children entering foster care who had received TANF within the prior 60 days to all children and youth *receiving TANF;*[17]
2. Ratio of children entering foster care who had received TANF within the prior 60 days to all children and youth *entering foster care.*

These indicators track the movements of children from low-income families who enter foster care while receiving TANF or who enter foster care within 60 days after their TANF cases close. These indicators are intended to measure the overall effectiveness of the TANF program in stabilizing families by reducing the number of children who enter foster care.

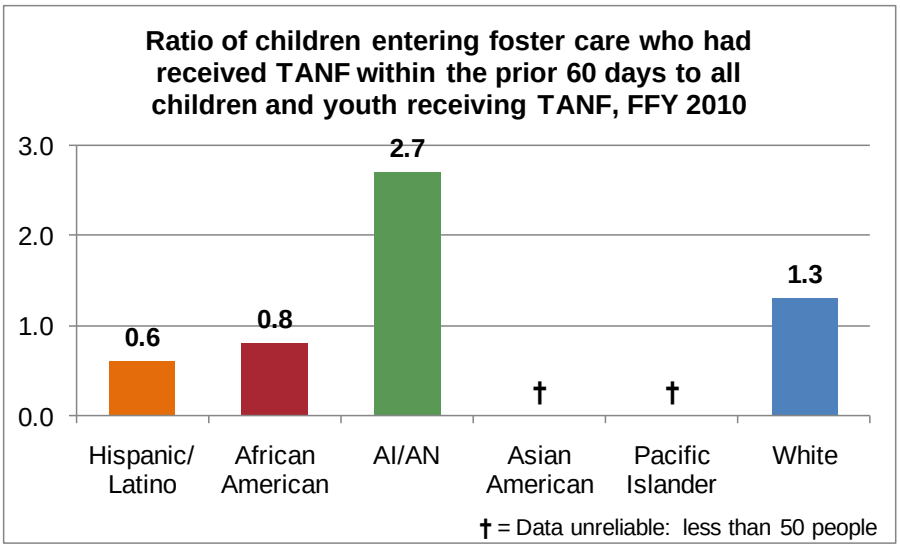
To understand any differences in family stabilization by race and ethnicity, disproportionality ratios have been calculated. The ratios measure whether those transitioning from TANF to foster care are representative of (a) all children and youth on TANF and (b) all children and youth entering foster care. A disproportionality ratio greater than 1 indicates that a group is over-represented while a ratio less than 1 indicates a group is underrepresented. As with the disproportionality ratios included in the Child Welfare section above, a 0.5 difference in the ratios between communities of color and non-Latino Whites is considered a meaningful difference in the indicators.

[17] Note that this does not answer the question of whether there are racial inequities in who receives TANF. As discussed below, we will work to explore this issue and address any inequities found.

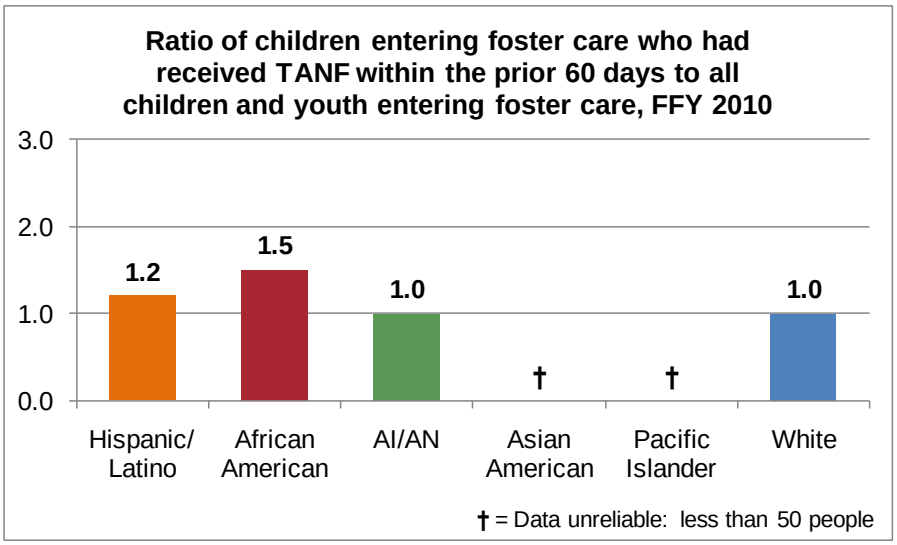
Findings

Findings for the DHS Self Sufficiency indicators are presented below. Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity by a green circle. Each race category excludes Latinos unless otherwise indicated.

1. Ratio of children entering foster care who had received TANF within the prior 60 days to all children and youth receiving TANF:[18] Compared to non-Latino Whites, the rate is higher for American Indians / Alaska Natives.[19]



2. Ratio of children entering foster care who had received TANF within the prior 60 days to all children and youth entering foster care: Compared to non-Latino Whites, the rate is higher for African Americans.



What These Findings Mean

TANF provides family-stabilizing supports in the form of cash assistance, job search and training services, and referrals for alcohol and drug abuse treatment when needed. The assistance with substance abuse issues and economic stabilization these services can provide may decrease family stressors that can lead to negative child outcomes, including the need for child welfare involvement. Further, those who take part in the FS&C program receive additional, contracted family-stabilizing supports designed to address risk factors related to child abuse and the need for child welfare intervention.

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[18] Note that the comparison with all children on TANF uses data from two different systems. The race for children transitioning to foster care comes from the child welfare system, which identifies a primary race for multiracial children. The data for all children on TANF is from the TANF system, which does not identify a primary race, but includes a designation of multiracial. Since there is no comparison in the Child Welfare data, multiracial children have been excluded from the calculation for the first indicator. Note that fewer than 2.7 percent of all children on TANF identify as multiracial; therefore, any impact on the ratios is likely minimal.

[19] The charts display disproportionality ratios, which differ from what was included in the preliminary report. These ratios are more accurate measures of racial inequity and will be used moving forward. They allow us to move beyond an analysis of the number who transition from TANF to foster care (as in the previous report) to an understanding of whether these movements are in line with the rates in which different races/ethnicities enter foster care overall, and the racial make-up of children receiving TANF.

In FFY 2010, 2.3 percent of children receiving TANF transitioned to foster care within 60 days of receiving TANF; however, 36.3 percent of all foster care entrants during this period had received TANF within the prior 60 days. The proportion of foster care entrants who were recent TANF recipients was fairly stable from 2004-2007, but has been increasing since 2008. The increase is likely due to a combination of factors, including the marked growth in the TANF caseload as a result of the recession, which occurred during a time when the number of children entering foster care overall had only modest changes. While only a small fraction of children receiving TANF are abused or neglected and enter foster care, the marked increase in the TANF caseload means a greater number of these children may be identified. The indicators above track whether the racial breakdown of those children who transition into foster care from TANF align with the racial breakdown of all children receiving TANF and all children entering foster care.

Based on the racial or ethnic identity of all children and youth receiving TANF, the proportion of Native American children who crossed over from TANF to foster care is 2.7 times greater than would be expected. However, as shown in the second chart, the proportion of Native American children who enter foster care from TANF is ***not*** out of proportion when compared to the racial or ethnic identity of all children entering foster care. This discrepancy is likely due to the fact that Native American children in general are disproportionately likely to enter foster care. As noted above, the Child Welfare Program is committed to and making strides in reducing overrepresentation of Native American children in foster care (see Child Welfare section for more information).

The second chart shows that the proportion of African American children who crossed over from TANF to foster care is 1.5 times greater than expected when compared to the racial breakdown of all children entering foster care. The Self-Sufficiency Program will research to better understand the crossover to Child Welfare Programs and the opportunities to address the disparity between programs.

Next Steps

During the 2011 legislative session, DHS supported a bill to further the efforts to create equity in the child welfare system. If it had passed, the bill would have, among other things, directed DHS to provide a racial impact statement to the Legislature for bills impacting child welfare clients in Oregon. This would have helped alert legislators to unintended consequences when proposed legislation could affect racial or ethnic populations receiving child welfare services.

DHS is currently working toward implementing a Differential Response (DR) system for its child safety programs. Some of the stated goals of the DR system are to keep children safely at home, provide stronger preventive and family reunification services, safely reduce the number of African American and Native American children in foster care, and strengthen partnerships between child welfare and community-based organizations. This system change is consistent with recent legislative changes that require DHS and county partners to implement programs to provide family preservation and reunification services, with the stated goal of helping children remain safely with their families.

In addition to the measures above, the Self-Sufficiency Program plans to explore other areas of the program in which there may be inequities. Identification of these areas will allow the program to better understand the impacts and plan its services to address disparities where appropriate. Areas of exploration include:

- Comparing the racial makeup of the state population in poverty to those on TANF to ensure equal access to the services provided by the program;
- Identifying any racial/ethnic differences in job placement rates among TANF recipients;
- Analysis of the role of the recession on TANF receipt by different ethnic groups. Has the recession disproportionately impacted certain ethnic groups in Oregon? If so, how has this impacted the TANF caseload? This may also impact crossover from TANF to foster care;
- Identifying any racial/ethnic differences in the types of providers (center-based, enhanced services) ERDC recipients are able to access;

- Looking at racial/ethnic differences in SNAP participation rates among those eligible for the program;
- Identifying any racial/ethnic differences in TA-DVS service provision;
- Analysis of the TANF service levels of parents of children transitioning from TANF to foster care to understand any impacts JOBS program reductions may have on this measure. This will likely be coupled with an analysis of TANF service level by race/ethnicity.

VOCATIONAL REHABILITATION

Clients

Employment services delivered through the Office of Vocational Rehabilitation Services (OVRS) serves individuals with disabilities. Individuals are eligible if they meet the following three requirements:

- The individual has a physical or mental impairment;
- The impairment constitutes a substantial impediment to employment; and
- The individual requires vocational rehabilitation services to prepare for, secure, retain or regain employment consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.

About the Indicator

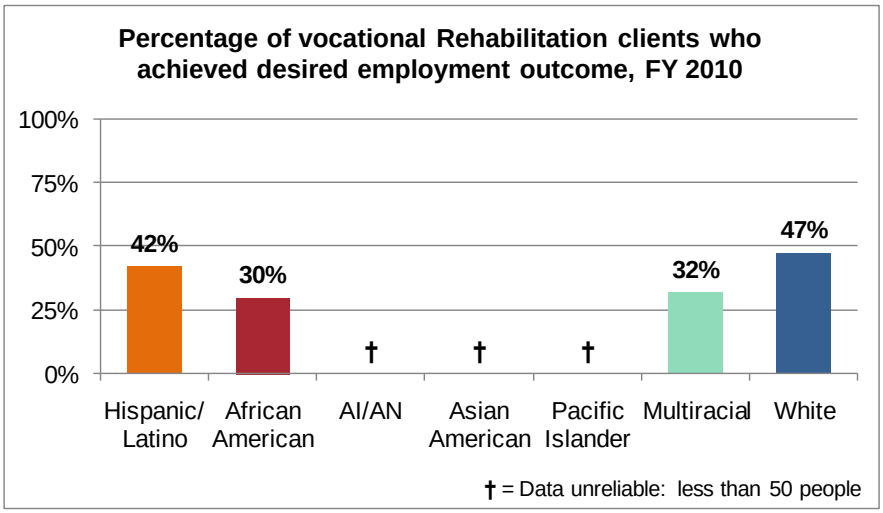
In order to examine equitable provision of DHS services and related outcomes by race and ethnicity across its Vocational Rehabilitation Program area the following meaningful indicator was chosen:

1. Employment outcomes for Vocational Rehabilitation clients.

This indicator relates to employment outcomes for DHS OVRS clients. The measure is used by the Federal Rehabilitation Services Administration to evaluate the ability of OVRS to provide employment services. A 5 percentage point difference between communities of color and non-Latino Whites is considered a meaningful difference.

Findings

Findings for the DHS Vocational Rehabilitation indicator are presented below. Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity by a green circle. Each race category excludes Latinos unless otherwise indicated.



1. Percentage of Vocational Rehabilitation clients who achieved desired employment outcome: Compared to non-Latino Whites, the percentage is lower for Latinos, African Americans and those identifying with more than one race.

What These Findings Mean

The indicator represents the percentage of clients who obtain their desired employment goals and are thus determined rehabilitated. Generally, after clients are determined eligible, the client and the counselor jointly develop a plan of services that are deemed necessary for the client to obtain a rehabilitation designation. Currently, roughly

50 percent of the clients determined eligible enter a plan. Clients are determined rehabilitated and their plan closed if the following criteria are met:

- The client has achieved the employment outcome as described in the client's Individualized Plan for Employment (IPE)[20] and the outcome is consistent with the client's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.
- The client has maintained the employment outcome for an appropriate period of time, but not less than 90 days, necessary to ensure the stability of the employment outcome, and the client no longer needs vocational rehabilitation services.

In order to focus efforts to increase desired employment outcomes, the number of additional clients OVRS would need to rehabilitate in order to achieve employment parity was examined.

Parity Table				
Race/Ethnicity	Closed from Plan (#)	Rehabilitated (#)	Rehabilitated (%)	Additional rehabilitations needed (#)
Hispanic/Latino	170	71	42%	9.5
African American	92	28	30%	15.6
Multiracial	69	22	32%	10.7
White	2156	1021	47%	-

Due to a relatively small number of clients served from communities of color, the number of additional clients that OVRS would need to rehabilitate in order to achieve parity with non-Latino Whites may only be a few individuals. The three populations with identified employment disparities (Latinos, African Americans and multiracial) would be the obvious place to focus efforts, but potential difficulties with this approach were examined.

The multiracial group would be difficult to target as it represents a multitude of different racial and ethnic groups and its composition changes over time. For example, one year the multiracial group may represent clients who identified themselves as Asian American and American Indian / Alaska Native while another year it may be composed of clients who identify themselves as Hawaiian and American Indian / Alaska Native. In addition, OVRS often has clients who identify themselves as being in a different ethnic or racial group each time they apply to the program.

For Latinos, when trends are examined, it is important to note that 2010 appears to represent an anomaly in terms of the percent rehabilitated. With the exception of 2010, Latinos have had a higher percent rehabilitated than non-Latino Whites over the past several years (data not shown).

Given the anomalies in the employment data for Latinos and the difficulty in targeting multiracial clients, OVRS believes that any initial efforts to achieve employment parity should focus on African American clients. African Americans are a population needing a substantial additional number of rehabilitated clients to achieve parity with non-Latino Whites. Also, the disparity between African American and non-Latino White OVRS clients has been consistent over the past several years.

Next Steps

The identified disparities in Vocational Rehabilitation employment data are a new finding. This measure deals less with need and access to OVRS services, but rather deals with the performance of the program in assisting clients from communities of color obtain employment.

[20] IPE is a plan designed to achieve a specific employment outcome that is selected by the individual consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

Obtaining successful employment outcomes is influenced by a number of factors, including disability. For instance, African Americans served by the North Portland OVRS branch who had either drug and alcohol or adult probation as an identifier were more successful (22 percent) in obtaining employment than all other clients with those identifiers.

OVRS will continue to monitor employment outcomes in communities of color and identify strategies to improve success in these populations.

About the Agency

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

OHA will transform the health care system in Oregon by:

- Improving the lifelong health of Oregonians;
- Increasing the quality, reliability, and availability of care for all Oregonians;
- Lowering or containing the cost of care so it is affordable to everyone.

OHA includes most of the state's health care programs, including the Public Health Division, the Oregon Health Plan, Healthy Kids, employee benefits and public-private partnerships. This gives the state greater purchasing and market power to begin tackling issues with costs, quality, lack of preventive care and health care access.

OHA is working to fundamentally improve how health care is delivered and paid for, but because poor health is only partially due to lack of medical care, OHA will also be working to reduce health disparities and to broaden the state's focus on prevention.

Bruce Goldberg, M.D., was originally appointed by Governor Ted Kulongoski to lead the formation of OHA. In February 2011, he was appointed Director of OHA by Governor John Kitzhaber.

For more information about OHA, visit: www.oregon.gov/OHA/about_us.shtml.

ADDICTIONS AND MENTAL HEALTH DIVISION

About the Division

The Addictions and Mental Health Division (AMH) assists Oregonians in being independent, healthy, and safe by preventing and reducing the negative effects of alcohol, other drugs, gambling addiction, and mental health disorders. AMH promotes recovery through culturally appropriate, evidence-based best practices that treat addictions, pathological gambling, mental illness, and emotional disorders.

Clients

Based on an analysis completed in preparation of 2013-15 budget requests, AMH serves approximately 24 percent of individuals who need addiction services and approximately 41 percent of individuals who need mental health services. An unknown percentage of individuals may receive services through private insurance or other funding mechanisms. The services AMH administers are funded through state General Funds, federal block grants, beer and wine taxes, and Medicaid dollars.

For more information on AMH, visit: www.oregon.gov/OHA/mentalhealth/about_us.shtml.

About the Indicators

AMH chose the following indicators to examine by race and ethnicity:

1. Percentage of clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD;
2. Percentage of adults receiving mental health services on Medicaid dollars who report improved functional outcomes as a result of those services;
3. Oregon State Hospital forensic Psychiatric Security Review Board (PSRB) commitments compared to the adult population in community mental health services and to the general adult population of Oregon.

The first indicator relates to AMH clients receiving mental health services. The source of the data is a survey of adult clients receiving Medicaid-funded mental health services. The survey is designed to track performance across outpatient and residential services in the community. The results are summarized by several performance domains and by Medicaid-managed care plans to assist them with performance improvement plans.

The second measure relates to AMH clients receiving mental health services and is a key performance measure of functional outcomes as rated by clients. Functional outcomes refer to a summary of quality of life indicators such as housing, employment, and relationships, which are outcomes supported by AMH.

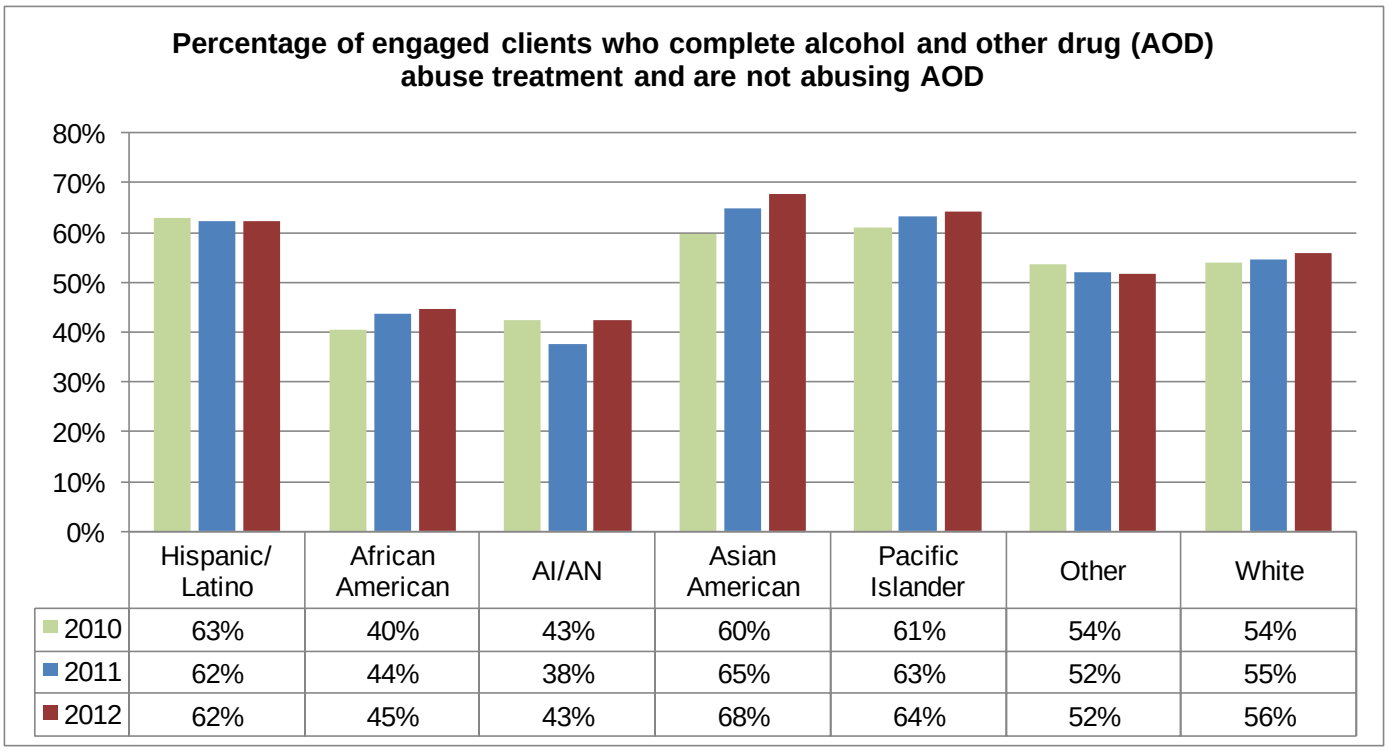
The third measure is a reflection of access to care in the community. The measure represents disproportionate admissions across race and ethnicity by the Oregon State Hospital. Commitments represent involuntary treatment in most cases and have sometimes been attributed to the lack of access to appropriate services in the community.

The definition of a meaningful difference varies by measure and is discussed in the findings.

Findings

Findings for the three AMH indicators are presented below. Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity by a green circle. For all indicators, each race category excludes Latinos unless otherwise noted.

1. Percentage of engaged clients who complete alcohol and other drug treatment (AOD) abuse treatment and are not abusing AOD: Compared to non-Latino Whites, African Americans and American Indians / Alaska Natives have a lower percentage.

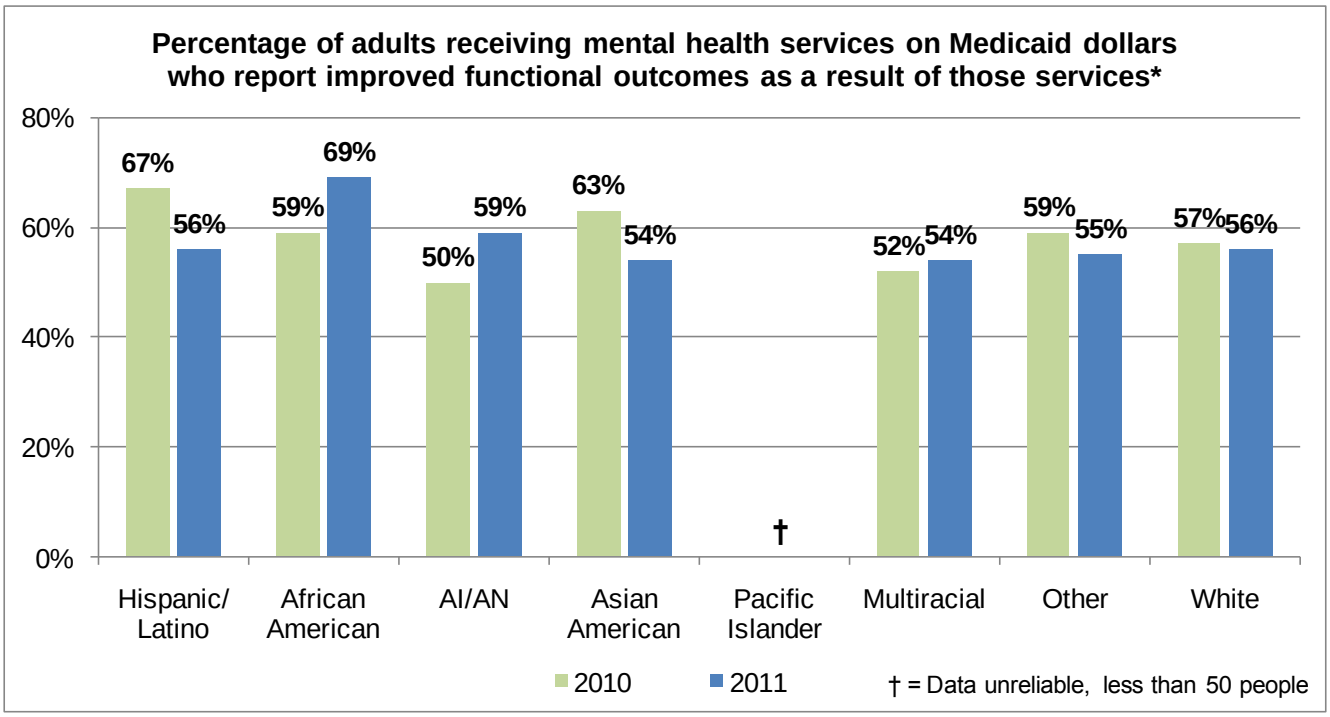


	Hispanic/ Latino	African American	AI/AN	Asian American	Pacific Islander	Other	White
2010	63%	40%	43%	60%	61%	54%	54%
2011	62%	44%	38%	65%	63%	52%	55%
2012	62%	45%	43%	68%	64%	52%	56%

What These Findings Mean

There has been little change in outcomes since the 2009 data were revealed in the State of Equity Report Phase I. The measure suggests disparities between the African American and American Indian / Alaska Native communities compared to non-Latino Whites. There is more than a 10 percentage point difference between both African Americans and American Indians / Alaska Natives compared to non-Latino Whites, and this pattern is consistent from 2010 to 2012. Disparities could be influenced by access to education, employment, housing, and social support.

2. Percentage of adults receiving mental health services on Medicaid dollars who report improved functional outcomes as a result of those services:* Compared to Whites, there are no significant differences among any communities of color.



What These Findings Mean

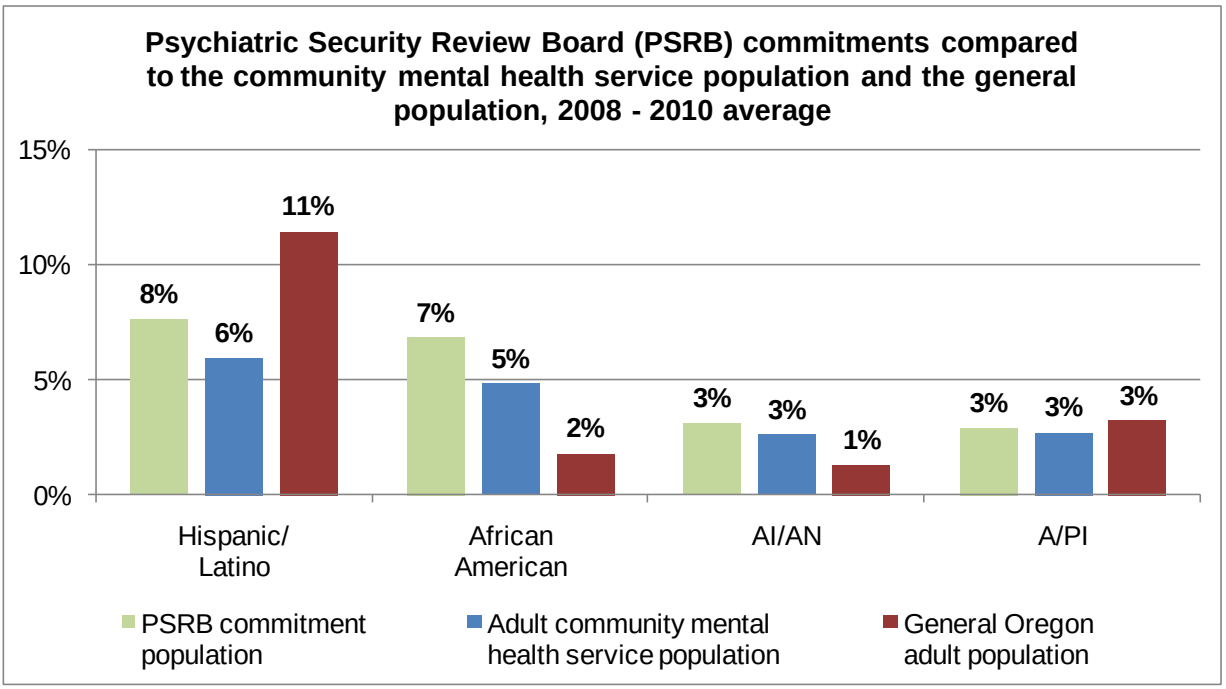
For this indicator, improvement in functional outcomes was chosen as the performance domain to compare across racial and ethnic groups. Functional outcomes are a composite of outcomes such as improved housing, employment, and relationships with family and friends. In 2010 and 2011, there are no statistically significant differences between communities of color and Whites* in improved functional outcomes.

There was a significant increase in survey participation for 2010-2011 compared to earlier years. Of the 13,519 individuals who received the survey, 3,400 (25 percent) returned them. Of those, 1,296 were non-White and 22 percent or 282 of the non-Whites responded.

Between 2010 and 2011, African Americans showed increases in the functioning domain. A full report of this and other measures is available at:
www.oregon.gov/oha/amh/data/2012/or-mhsip-survey4adults2011.pdf.

* Each race category includes Hispanic/Latino for this indicator.

3. Oregon State Hospital forensic Psychiatric Security Review Board (PSRB) commitments compared to the adult population in community mental health services and to the general adult population of Oregon: Compared to the proportion of the general adult population, African Americans are over-represented and Latinos are under-represented for this type of commitment.



What These Findings Mean

The population proportion by state hospital commitment type is based on the population's average daily population (ADP).[21] The other two columns represent the proportion of people served in the general adult community mental health service population and in the general Oregon adult population, respectively by race and ethnicity.

Latino populations were under-represented in PSRB state hospital commitments. However, this difference was only in comparison to the general adult population of Oregon, as Latinos are also under-represented in the general adult community mental health service population. As described earlier, the root cause associated with these difference is likely much more complicated than there being an "access issue" for Latinos needing state hospital level of care. While AMH obviously wants state hospital services to be available for all individuals who need it, the general emphasis is on providing services at the least restrictive level and providing resources in the community to better support recovery.

In comparison with general adult community mental health service population, African Americans were over-represented among the PSRB state hospital commitments. This over-representation is also found in the general adult community mental health service population, but it is not as high. It should also be noted that Native Americans tended to be over-represented in the state hospital populations. However, the percentages associated with this group are small compared to the other groups discussed.

These findings require statistical testing to assess whether these findings might have been due to chance. AMH needs to explore possible differences; what might appear to be differences may be easily attributed to

[21] Proportion based on average daily population (ADP) for this commitment type is used and represents an average across three years, 2008-2010. It is calculated by taking the total days of service and dividing it by the total days of the three years.

other factors, including criminal justice prevalence, which is outside AMH's immediate control but will require additional information sharing and collaboration.

Next Steps

The Addictions and Mental Health Division (AMH) supports equity in health care for individuals receiving services through the public health and behavioral health systems. AMH supports health care equity through the following efforts of the Health Equity Workgroup (HEW):

1. As part of the Oregon Health Authority (OHA), AMH-HEW tracks and reports data for the State of Equity Report prepared by the Office of Equity and Inclusion;
2. Regular children's mental health system reports to the legislature that provide comprehensive service utilization;
3. Block grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) supports the community behavioral health services with reporting requirements regarding services to required and specialty populations and is monitored, reviewed, and evaluated by the AMH Planning and Advisory Council (AMHPAC) for the allocation and adequacy of behavioral health services. The block grant serves as the state's plan for behavioral health services;
4. HEW will assist the Division of Medical Assistance Programs and the Office of Equity and Inclusion in evaluating and monitoring transformational components for the Community Care Organizations (CCOs) in the area of reducing health disparities, specifically as it relates to behavioral health services. Additional resources will be assigned to support the workgroup's activities.

In promotion of the goal to eliminate health disparities among required and specialty populations identified in the block grant, the AMH Health Equity Workgroup is addressing the following areas of work:

- Provide support and technical assistance to Biennial Implementation Plan "guides" in their review of county and tribal plans and outcome data.
- Provide AMH measures to the Office of Equity and Inclusion for Phase 3 of the State of Equity Report reflecting behavioral health services regarding the need for services, access to services and programs, customer service quality, and related outcomes by race, ethnicity and language.
- Provide technical assistance and support to the group responding to the Secretary of State Audit of the Children's Mental Health System.
- Provide technical assistance and support to the AMH Planning and Advisory Council (AMHPAC).
- Provide technical assistance in the development of policies, procedures and rules related to health equity.
- Support technical assistance to CCO Innovator for individuals receiving cultural-behavioral health services.
- Provide training for minority communities in meaningful engagement in the governance process. HEW provided this training at the 2012 African American Treatment Summit where findings for African Americans receiving behavioral health services were shared.

DIVISION OF MEDICAL ASSISTANCE PROGRAMS

About the Division

The Division of Medical Assistance Programs (DMAP) oversees the Oregon Health Plan (OHP), which is a public and private partnership that ensures universal access to a basic level of health care for Oregonians. The division also includes provisions for oversight, research and analysis to achieve the best use of health care funding.

Clients

DMAP health care services assist Oregon individuals and families in becoming more independent, healthy and safe. OHP serves low-income, vulnerable children and adults who are eligible for Medicaid or CHIP (Children Health Insurance Program). Eligibility depends on a combination of criteria including age, family income, pregnancy, disability, and foster child status. DMAP collaborates with partners and stakeholders to provide access and deliver affordable health care to more than 650,000 Oregonians. Health care services reach about one in four Oregon children, and pay for more than 40 percent of Oregon births.

For more information on DMAP, visit www.oregon.gov/OHA/healthplan/index.shtml.

About the Indicators

The indicators chosen by DMAP to examine by race and ethnicity are their three KPMs[22] related to the provision of preventive services:

1. Preventive services for OHP children: Utilization rate of preventive services for children birth through 10 years old covered by OHP;
2. Preventive services for OHP youth and adults: Utilization rate of preventive services for youth and adults 11 years old and older covered by OHP;
3. Rate of ambulatory care sensitive condition hospitalizations (Prevention Quality Indicators) of OHP clients 18 years old and older.

Indicators one and two directly assess the rate of preventive services provided to OHP clients.[23] Meaningful differences in these two indicators are defined by a difference of 0.5 or more in the rates between communities of color and non-Latino Whites.

The third indicator is a national Prevention Quality Indicator (PQI)[24] that measures hospitalizations for 12 conditions (nine chronic, three acute) called ambulatory care sensitive conditions, where timely and effective ambulatory care (usually primary care) can help prevent or reduce the risk of hospitalization. Meaningful differences in the PQI indicator are defined by a difference of 350 or more in the rates between communities of color and non-Latino Whites.

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[22] Part of OHP data and reports, found here: www.oregon.gov/OHA/healthplan/data_pubs/main.shtml.

[23] As assessed using Lines 3 and 4 of OHP Prioritized List of Health Services. See: www.oregon.gov/OHA/OHPR/HSC/Pages/HSC_reports.shtml.

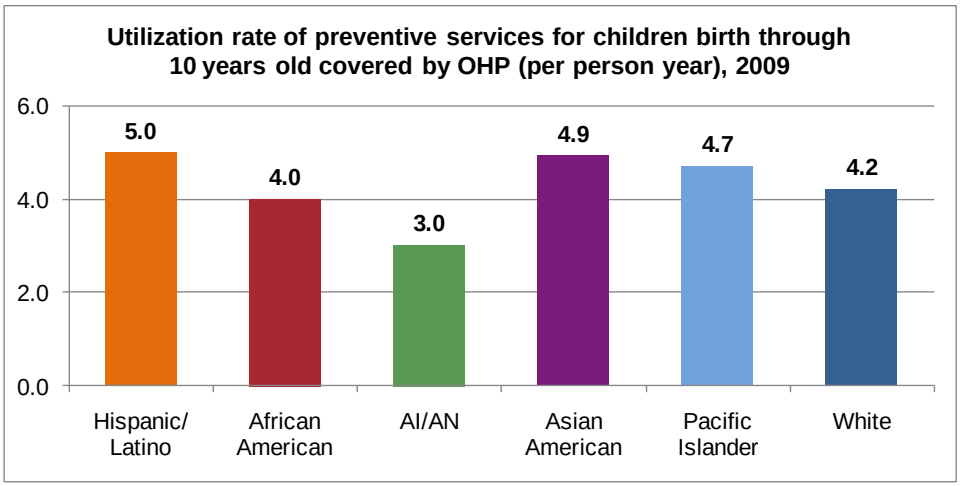
[24] www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx.

Findings

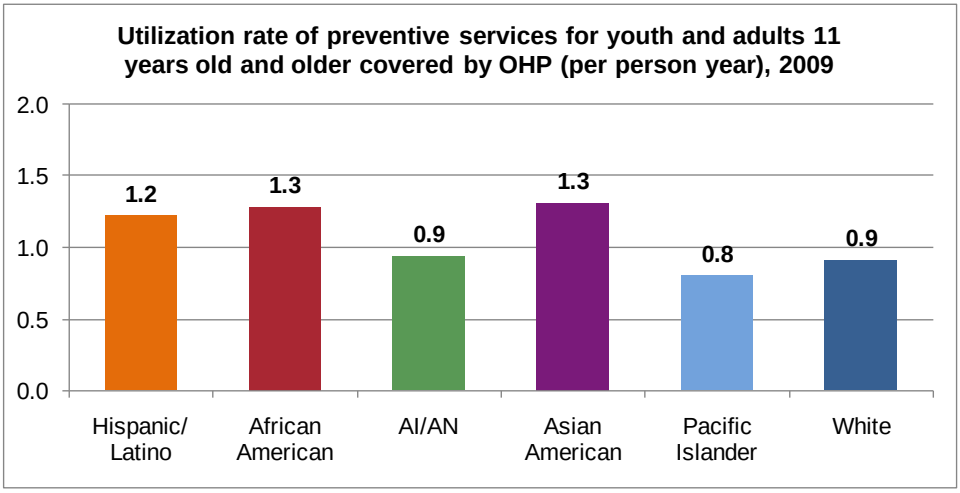
Findings for the DMAP indicators related to provision of preventive services are presented below. Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity by a green circle. For all indicators, each race category excludes Latinos unless otherwise indicated.

Provision of Preventive Services

1. Utilization rate of preventive services for children birth through 10 years old covered by the Oregon Health Plan per person year:[25] High rate is favorable. Compared to non-Latino Whites, the rate is lower for American Indians / Alaska Natives and higher for Latinos and Asian Americans.

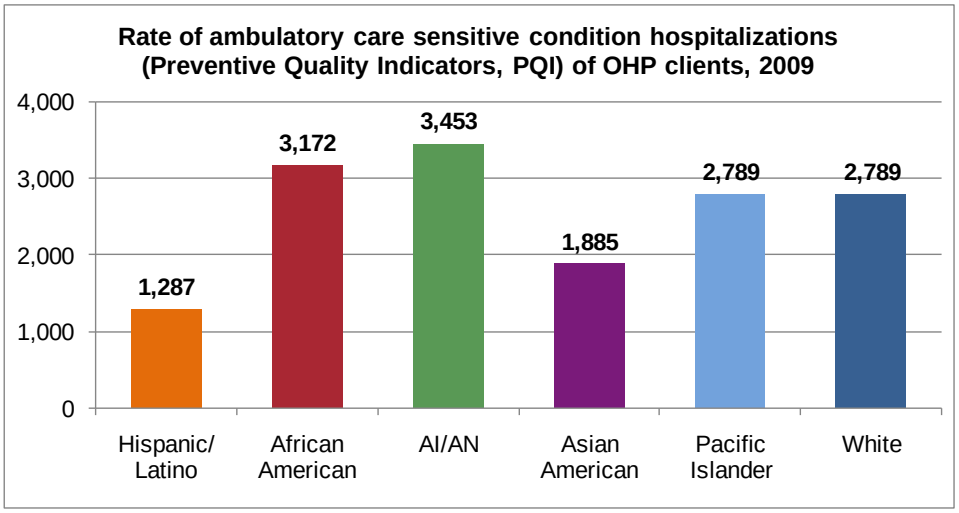


2. Utilization rate of preventive services for youth and adults 11 years old and older covered by the Oregon Health Plan per person year:[25] High rate is favorable. Little or no difference between non-Latino Whites and communities of color.



[25] Person Year: One person year equals any combination of Oregon Health Plan members and their enrollment that sums to 12 months (i.e. one member enrolled for 12 months; two members, one enrolled 3 months, one enrolled 9 months). A person year is used as many clients are not enrolled in OHP for all twelve months of the calendar year.

3. Rate of ambulatory care sensitive condition hospitalizations (Preventive Quality Indicators, PQI) of Oregon Health Plan clients per 100,000 person years:[25] Low rate is favorable. Compared to non-Latino Whites, the rate is higher for African Americans and American Indians / Alaska Natives and lower for Latinos and Asian Americans.



Why These Indicators are Important

A cornerstone of OHP is to increase access to preventive health services, thereby reducing unnecessary and more expensive health care in the hospital or emergency room setting.

What These Findings Mean

A higher rate is more favorable for the two utilization-related indicators, while a lower rate is more favorable for the PQI indicator. The rates for the two utilization indicators signify the number of preventive services provided to OHP clients while the rate for the PQI indicator signifies the number of hospitalizations for ambulatory care sensitive (ACS) conditions where timely and effective preventive and primary care can reduce the risk of hospitalization. Lower rates of preventive service utilization or higher rates of ACS hospitalizations may indicate issues with access to preventive services or access to primary care. However, sometimes ACS hospitalizations occur despite adequate use of primary and preventive care, especially among older or sicker patients.

The two indicators in which disparities have been identified follow the same pattern: Latinos having the most favorable rates followed by Asian Americans, Pacific Islanders, non-Latino Whites, African Americans, and American Indians / Alaska Natives, in that order.

In addition we have observed there is a correlation between a population's smoking prevalence and PQI rates. Specifically, Latinos, Asian Americans and Pacific Islanders have favorable (low) smoking rates and also have favorable (low) PQI rates. American Indians / Alaska Natives, African Americans, and non-Latino Whites have unfavorable (high) smoking rates and also have unfavorable (high) PQI rates. This is not surprising as many of the chronic conditions that make up the PQI measure are greatly impacted by the effects of long-term smoking and aging.

The positive findings for OHP Latino clients may be due to several factors. Latinos as a whole are much younger than other populations in Oregon. PQI rates are greatly affected by the age of the population as older adults as a group tend to be sicker than younger adults.[26] Also, it is known that less acculturated Latinos have healthier eating behaviors than many other groups.[27] In addition, many OHP Latino clients receive their health care through Federally Qualified Health Centers and Rural Health Centers that are experienced in providing culturally competent services. Another possible reason why Latinos appear to have more favorable outcomes is that the Mexican health care system emphasizes preventive health care;

[26] U.S. Department of Health and Human Services – Healthcare Cost and Utilization Project (HCUP). Available at: https://healthmeasures.aspe.hhs.gov/measure/3a.

[27] Culturally Effective Toolkit, p.9. Available at: http://public.health.oregon.gov/preventionwellness/oralhealth/firsttooth/documents/culturallyeffectivetoolkit.pdf

OHP Latino clients with heritage ties to Mexico may be more familiar than other OHP clients with the concept that regular preventive visits are necessary and important. In fact, Latino children in Oregon as a group have the highest immunization rates. The high child immunization rate may be due to an emphasis on preventive care among Latinos in addition to the fact that immunization records can be used as an identification document in Mexico.

The interplay of several factors may explain why African American and American Indian / Alaska Native children on OHP have less favorable rates for utilization of preventive services. Within OHP, a higher proportion of African American and American Indian / Alaska Native children are in foster care or disabled. Children in foster care experience more movement and disruption in their lives and so may be less likely to receive as many preventive visits as children not in foster care. In addition, children who are disabled may be receiving problem-focused health care but not preventive services at as high a rate as children who are not disabled. The factor that influences both of these is that the proportion of African American and American Indian / Alaska Native children is much smaller than non-Latino White children and so the two factors mentioned above have more influence in lowering their rates of receiving preventive services. This needs to be researched further.

The high (less favorable) PQI rates for American Indians / Alaska Natives may be associated with a greater proportion of adult American Indians / Alaska Natives rating their overall health as “fair” or “poor” than any of the other groups.[28] So within OHP, American Indians / Alaska Natives as a group report that they have a higher burden of illness than the other groups report.

The high (less favorable) PQI rates for African Americans compared to other groups may be associated with a greater proportion reporting that their usual source of medical care was a hospital-based clinic or a hospital emergency room as opposed to a private doctor’s office or clinic.[29] This may indicate that African Americans on OHP have less adequate sources of primary care services than other groups on OHP. For both OHP clients and for the overall population, studies show people who live closer to emergency departments are more likely to use them and more likely to be admitted to the hospital.

All OHP clients — regardless of their race and ethnicity — are low-income, and low-income persons are less likely to be familiar with the concept of seeking health care services when they are not sick. For example, nationwide low-income populations, including those on Medicaid, consistently have more unfavorable (higher) PQI rates compared to the population as a whole.[29] To increase rates of preventive and well care health services received by OHP clients, this barrier must be overcome.

Next Steps

Within DMAP, the measurement of racial, ethnic and linguistic variations within health care quality measures is recognized as a necessity. DMAP has always and continues to provide translation and interpreter services. In the past, DMAP and its contracted health care plans have had grants that funded special projects to reduce health care disparities.

As part of state health care reform, OHA’s contracts with the new health care organizations will require a focus on identifying and reducing health care disparities. Specifically, the laws that govern the new Coordinated Care Organizations (CCOs) emphasize providing culturally and linguistically appropriate health care services, as well as community advisory committees that represent the populations served.

DMAP plans to continue measuring PQI – hospitalizations for ambulatory care sensitive conditions – of OHP clients as a KPM as it is a nationally recognized measure. However, DMAP is planning to drop the two ‘utilization of preventive services’ measures as they are unique to OHP and so there are no comparative rates. To compensate for this loss, DMAP plans to add three similar Healthcare Effectiveness Data and

[28] CAHPS Survey 2011.

[29] OHP High Risk Health Status Survey, 2004.

Information Set (HEDIS®) measures. HEDIS® measures are a widely used health care industry standard. The following HEDIS® measures will be calculated by race and ethnicity:

- Adolescent Well Care Visits – The percentage of members 12 to 21 years of age who had at least one comprehensive well care visit in the measurement year.
- Well Child Visits in Third, Fourth, Fifth, & Sixth Years of Life – The percentage of members 3 to 6 years of age who received one or more well child visits in the measurement year.
- Well Child Visits in the First 15 Months of Life – The percentage of members who turned 15 months old during the measurement year and who had well child visits during their first 15 months of life.

Other important indicators DMAP plans to examine by race and ethnicity are smoking rates, cancer screenings, diabetes, and asthma care. In addition, most of the measures required of the CCOs will be assessed by race and ethnicity.

OFFICE FOR OREGON HEALTH POLICY AND RESEARCH

About the Office

The Office for Oregon Health Policy and Research (OHPR) conducts impartial policy analysis, research, and evaluation, and provides technical assistance to support health reform planning and implementation in Oregon.

For more information about OHPR, visit www.oregon.gov/OHA/OHPR/about_us.shtml.

Clients

OHPR clients are policymakers, including the Oregon Health Policy Board, the Oregon Health Authority (OHA), the Governor, and the Legislature.

About the Indicators

OHPR compiles and analyzes technical and statistical information about Oregon's health care system in order to:

- Support policy formation and evaluation;
- Evaluate OHA programs; and
- Provide data to support health system and program planning.

OHPR chose the following indicators to examine by race and ethnicity:

1. Percent of Oregonians ages 0-18 who do not have health insurance;
2. Percent of Oregonians ages 19-64 who do not have health insurance;
3. Diversity of health care workforce in select fields compared to the diversity of the Oregon population.

The first two indicators relate to health insurance. These indicators provide measures of access to health care, and help to identify needs, barriers, and changes regarding health care coverage in Oregon. The source of the data is the 2010 American Community Survey (ACS) Public Use Microdata Sample.[30] The method of determining a meaningful difference in the health insurance related indicators is non-overlapping 95 percent confidence intervals.

The third indicator provides a gauge of access to health professionals and the overall diversity of the health care workforce. The indicator compares the diversity of the health care workforce for physicians, dentists, and nurses from the Oregon Healthcare Workforce Database with that of the Oregon population. A meaningful difference in this indicator is defined as workforce database results that deviate by more than 1 percentage point from Oregon's racial and ethnic demographics provided by the U.S. Census.

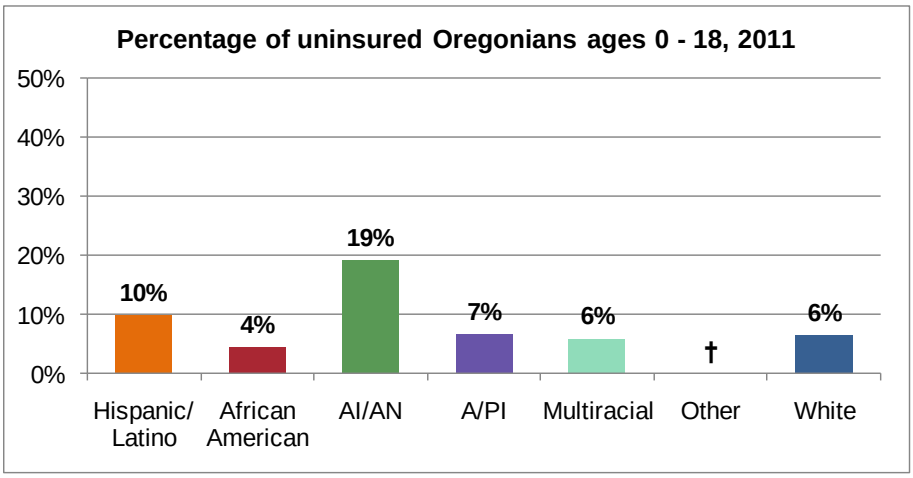
[30] The Office for Health Policy and Research provides further health insurance statistics from the ACS and other sources on their health insurance coverage web page, available at www.oregon.gov/OHA/OHPR/RSCH/Insurance_Data.shtml. ACS PUMS data provided by the University of Minnesota's Integrated Public Use Microdata Series: Version 5.0, Steven Ruggles, Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Analysis excludes Oregonians in the military on active duty and those living in group quarters.

Findings

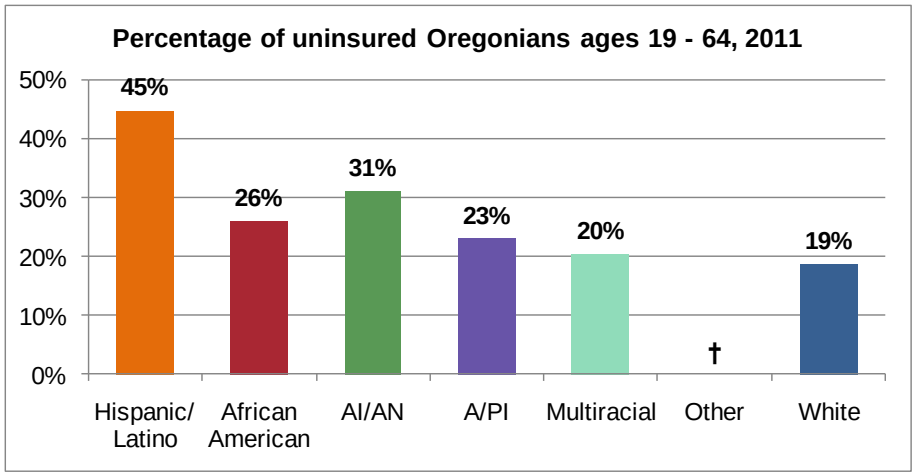
Findings for the two indicators related to health insurance are presented first followed by the findings for the indicator related to health care workforce diversity. Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity by a green circle. For all indicators, each race category excludes Latinos unless otherwise indicated.

Health Insurance[31]

1. Percent of Oregonians ages 0-18 who do not have health insurance in 2011: Evidence is insufficient to demonstrate a statistical difference in the percentage of uninsurance among Hispanic/Latino, African Americans, American Indians / Alaska Natives, Asian Americans / Pacific Islanders, and multiracial individuals compared to non-Latino Whites.



2. Percent of Oregonians ages 19-64 who do not have health insurance in 2011: Compared to non-Latino Whites, the percentage of uninsurance is higher for Latinos and American Indians / Alaska Natives. Evidence is insufficient to demonstrate a statistical difference in the percentage of uninsurance among African American, Asian Americans / Pacific Islanders and multiracial individuals compared to non-Latino Whites.



What These Findings Mean

Health insurance coverage is primarily obtained through employment. However, the availability of this benefit is not distributed evenly across the employment continuum. Employees who are full-time, have higher incomes, higher educational attainment, along with those employed at larger firms are more likely to receive employer-sponsored health insurance as a benefit. Since 1999-2000, the trend has been that fewer employees have access to employer sponsored health insurance. Furthermore, employees who do have access to health insurance through their job have increasingly declined coverage due to increasing

[31] Data on health insurance taken from the American Community Survey (ACS), an ongoing statistical survey that samples a small percentage of the population every year. For American Indian / Alaska Native respondents, those with Indian Health Services (IHS) and no other source of health insurance are classified as uninsured. IHS is not considered health insurance because it does not have a defined benefit plan.

premium share costs. Low and moderate income families have been most affected by these trends.[32] For Oregon's children and adults 65 and over the greater availability of health insurance through the public programs of Medicaid, Medicare, and the Children's Health Insurance Program (CHIP) is seen in lower uninsurance rates.

In 2011 many of Oregon's communities of color lack health insurance at rates greater than non-Latino Whites. Differences in uninsurance rates between non-Latino Whites and communities of color varied by age. Among working age adults (19 to 64), significant differences were identified in the American Indian / Alaska Native and Latino populations when compared to non-Latino Whites.

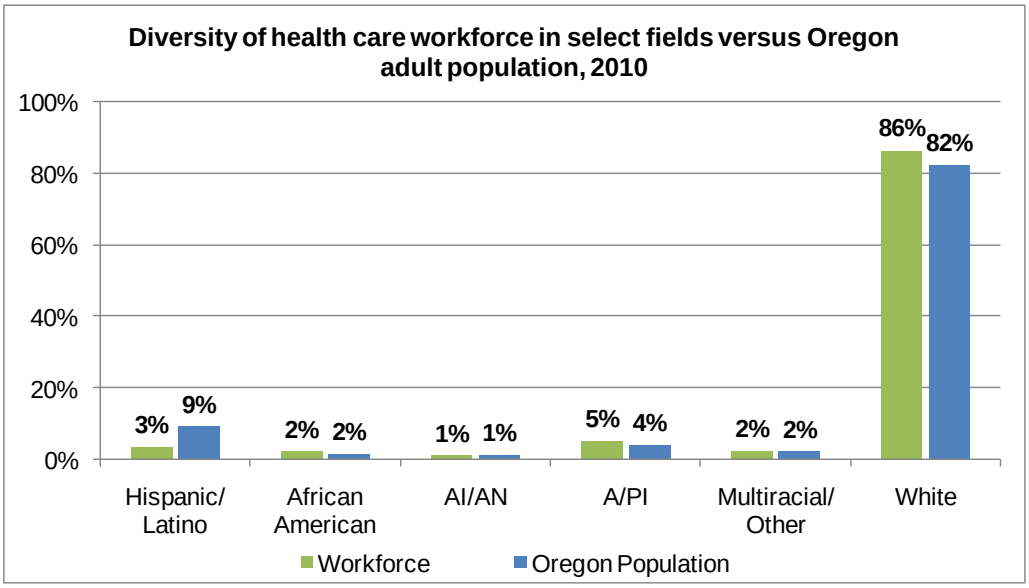
Among Latino Oregonians we find the greatest percentage point difference in health uninsurance between youth and adults:10 percent versus 45 percent. Oregon had roughly 135,000 Latinos, of all ages, without health insurance coverage in 2011. Oregon's Latino uninsurance rate of 29 percent (all ages) ranks near the middle of all states at 24th worst (highest uninsured) in the nation.[33]

Next Steps

OHPR is engaged in a variety of activities to address access issues for the uninsured. This includes evaluation activities to understand how Oregonians receive health care, and what issues and barriers are faced in obtaining care. OHPR is carrying out additional investigations around utilization of primary care services and health outcomes over time to formulate future initiatives.

Health Care Workforce Diversity

3. Diversity of health care workforce[34] in select fields compared to the diversity of Oregon population: Latino Oregonians have a lower representation in the health care workforce than in Oregon's adult population. Asian Americans / Pacific Islanders and non-Latino Whites have higher representation in the health care workforce than in Oregon's adult population.



[32] State Health Access Data Assistance Center (SHADAC). "State-Level Trends in Employer-Sponsored Health Insurance: A State-By-State Analysis," June 2011, Robert Wood Johnson Foundation. Available at: www.rwjf.org/coverage/product.jsp?id=72528 (accessed May 17, 2012).

[33] Rankings based on OHPR analysis of 2011 ACS PUMS data excluding confidence intervals.

[34] Workforce data includes a large percentage of missing data, 13.9 percent overall and nearly 40 percent in the physician's dataset.

Why This Indicator is Important

This measure demonstrates in a very general manner the ability of clinics and health care providers within Oregon to deliver culturally appropriate care for their clients. However, this measure does not capture many efforts by health care providers to ensure access to effective care regardless of an individual's cultural or linguistic background. Examples of such efforts include the provision of health care interpreters and navigators, staff training, and community outreach. Disparities in the representation of racial and ethnic groups among health care workers may be attributable to many factors including income, education, recruitment and retention by health care professional training programs as well as by employers, differences in data collection methods, or demographic factors such as age.

What These Findings Mean

Latino Oregonians make up a much smaller share of the health care workforce than their share of the general population. In contrast, non-Latino Whites and Asian American / Pacific Islander Oregonians are more prevalent in health care occupations than among the general population.

The indicator measures the racial and ethnic composition of Oregon's health care workforce to that of the state's adult population. Using 2010 workforce data collected for physicians, physician assistants, dentists, dental hygienists, and nurses, OHPR explored the overall workforce composition to that of Oregon's general population (age 18 and over) from the 2010 Census.

A number of data limitations exist for this indicator, making a direct comparison of workforce representation to overall population representation difficult. Limitations include differences in how race and ethnicity data are collected, such as the absence of multiracial and Pacific Islander categories for some health care licensing data. Additionally, limitations include a large rate of missing data (14 percent overall but nearly 40 percent in the physicians' dataset) and the lack of separate ethnicity and race variables in the nurses' dataset.

Next Steps

OHPR continues to work with the Health Care Workforce Committee to coordinate efforts in Oregon to recruit and educate health care professionals and retain a quality workforce to meet the demand created by the expansion in health care coverage, system transformation and an increasingly diverse population.

OHPR is also working on improving the quality and comparability of the workforce data. Improvements include adding additional health care licensing board data to the race and ethnicity workforce database and promoting the adoption of consistent racial and ethnic formats in workforce data collection.

PUBLIC HEALTH DIVISION

About the Division

The mission of the Public Health Division (PHD) is to protect and promote the health of all the people of Oregon. PHD works to protect individuals and communities against the spread of disease, injuries, and environmental hazards while promoting and encouraging healthy behaviors. PHD responds to disasters, assists communities in recovery and is dedicated to ensuring the quality and accessibility of the State's health services and resources.

Clients

PHD provides an array of services with the common purpose of improving and protecting the health of all Oregonians. That goal is achieved through an emphasis on prevention and early intervention.

For more information on PHD, visit http://public.health.oregon.gov/PHD/Pages/about_us.aspx.

About the Indicators

The indicators chosen by PHD to examine by race and ethnicity are:

1. Domestic violence before and during pregnancy;
2. First trimester initiation of prenatal care;
3. Low birth weight;
4. Immunization rates for 2-year olds;
5. Teen pregnancy rate (per 1,000, 15 - 17 year old females);
6. Rate of new HIV/AIDS diagnosis (cases per 100,000);
7. Percentage of adults who smoke;[**]
8. Percentage of adults who are obese;[**]
9. Percentage of adults who have high blood pressure;[**]
10. Female breast cancer stage at diagnosis for age 50+;
11. Years of potential life lost before age 75 per 100,000;[**]
12. Homicides.

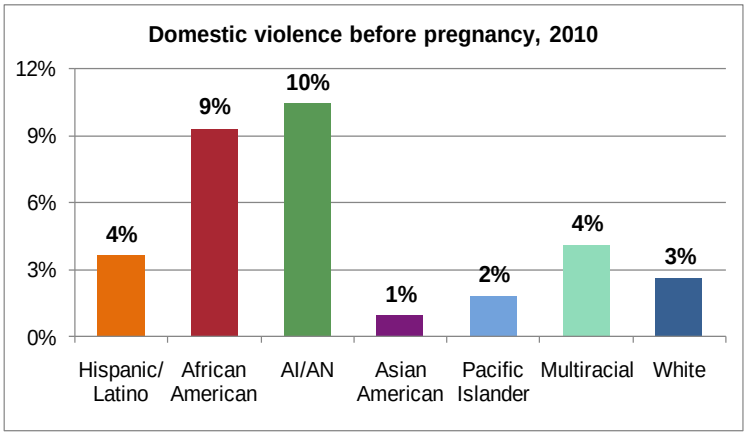
For all indicators, a meaningful difference was defined by non-overlapping 95 percent confidence interval between communities of color and non-Latino Whites, unless otherwise indicated.

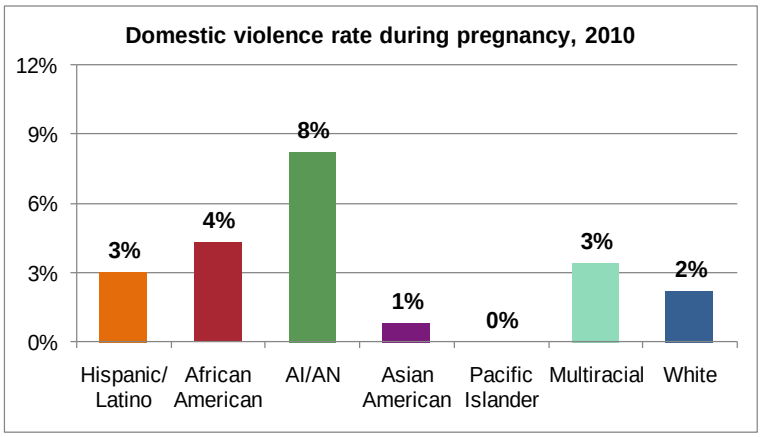
[**] Age-adjusted indicator: Adjusts for differences in the age distribution of populations. Allows for comparisons between populations with less chance that potential differences are due to one population, on average, being older or younger than another.

Findings

Findings for the PHD indicators are presented below. Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity by a green circle. For all indicators, each race category excludes Latinos unless otherwise indicated.

1. Domestic violence before[35] and during pregnancy: Compared to non-Latino Whites, the percentage of African American and American Indian / Alaska Native women who report abuse before pregnancy is higher.





Why This Indicator is Important

Violence is widely recognized as a public health concern and thought to play a key role in women's health before, during and after pregnancy. Violence is a leading cause of injury and disability and increases the risk of other poor health outcomes such as post-traumatic stress disorder (PTSD), depression, anxiety, and substance abuse.[36]

What These Findings Mean

This indicator is the percentage of women surveyed who reported physical abuse by a partner before and during pregnancy. National data indicates that intimate partner and sexual violence disproportionately affects American Indian / Alaska Native women across their life spans.[37] While the data for domestic violence during pregnancy are not statistically significant, they are notable in identifying problems and disparities.

Next Steps

Preventing violence involves comprehensive and multidisciplinary efforts to address the complex underlying contributors to violence and builds on assets in youth, families, and communities. To decrease the disparities that exist, the demographics of the perpetrator should be considered because it is the behavior of the perpetrator (rather than the victim) that needs to change.

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[35] "Before pregnancy" is defined as within 12 months prior to becoming pregnant.

[36] Feletti, Vincent J. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*. Volume 14, Issue 4, Pages 245-258 (May 1998).

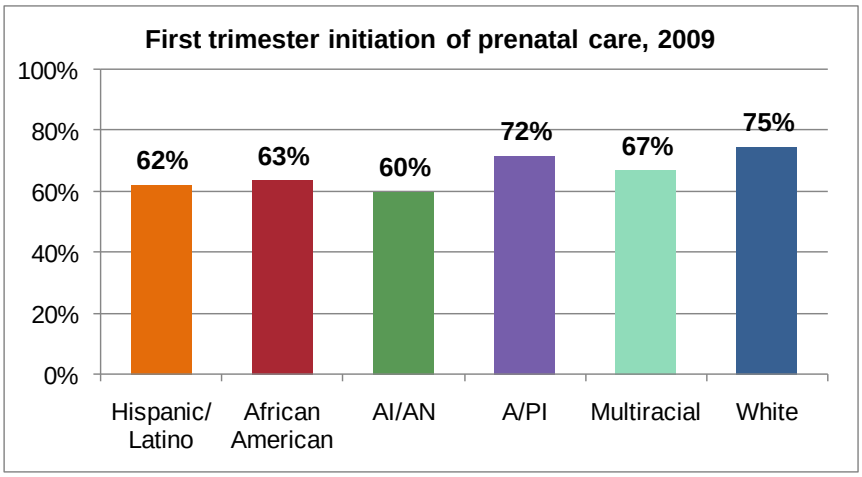
[37] www.cdc.gov/ViolencePrevention/pdf/NISVS_Executive_Summary-a.pdf

PHD's major initiatives that address domestic and sexual violence in Oregon include:

1. Rape Prevention Education Program – A CDC grant changing social norms among young men to prevent them from accepting that violence is an option. The focus of one of the seven funded sites in Oregon is working with American Indian / Alaska Native young men.
2. Title V Priority – Domestic and sexual violence are identified in a statewide Title V needs assessment as a priority during the next five years.[38] Most of these efforts will focus on training health and social service providers to screen clients for domestic violence and refer them on for services.
3. Oregon Domestic Violence Fatality Review Team – Recently convened by PHD, the team is using a national model of bringing together a group of state and local leaders and community members to review domestic violence homicide cases with the purpose of improving response and the safety net system for victims. The Team has a permanent position for a tribal representative.
4. Department of Justice grant – Partnering with the Department of Justice to help pregnant and parenting teens and women who are victims of intimate partner violence and who have entered the Child Welfare, Self-Sufficiency and/or county public health systems.

Further analyses of the data on domestic violence before and during pregnancy by race and ethnicity are planned. Of interest is to determine if abuse increases during pregnancy. In order to perform these analyses, multiple years of data may need to be combined due to a small number of survey respondents for many communities of color.

2. First Trimester Initiation of Prenatal Care (as a percent of live births): Compared to non-Latino Whites, the percentage is lower for Latinos, African Americans, American Indians / Alaska Natives, and those identifying as multiracial.



Why This Indicator is Important

Prenatal care offers opportunities to screen for pregnancy complications, manage chronic conditions, and provide education and referral to social and nutritional services – all of which can help promote positive birth outcomes. Inadequate prenatal care, including late initiation of care, infrequent prenatal visits, or no care at all, is associated with poor infant outcomes.

What These Findings Mean

This indicator is the percentage of women who have had a live birth who began prenatal care in the first trimester of pregnancy (first three months of pregnancy). This data is drawn from birth certificates which only record live births. Women give a variety of reasons for not accessing early prenatal care. Women may not feel that early care is important, may not know they are pregnant, or may be experiencing barriers such as lack of insurance coverage, inability to get an appointment or unreliable transportation.

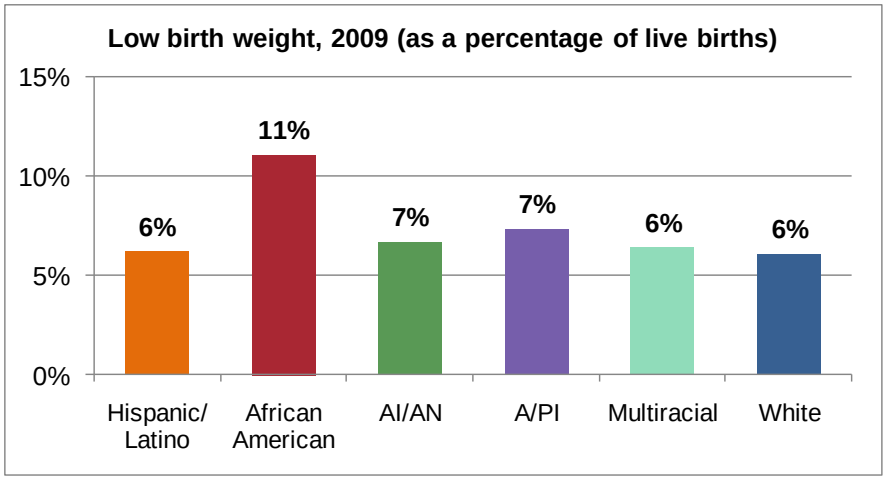
Next Steps

38 http://public.health.oregon.gov/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Pages/mch_needsassessment.aspx

PHD has been working for many years to increase the ease with which women can initiate prenatal care in the first trimester of pregnancy.

- Oregon Mothers Care[39] is a program devoted to improving early access to prenatal care for all Oregon women. It streamlines state and local systems for prenatal care, including oral health care, and links pregnant women to health insurance benefits as well as prenatal care providers.
- PHD has worked with local health departments, the Division of Medical Assistance Programs (DMAP), and the Latino Health Coalition to help more Oregon counties implement the Prenatal Expansion Project which provides Medicaid coverage (including prenatal care coverage) for undocumented pregnant women.
- PHD will continue to advocate for policy changes to promote early access to Medicaid and prenatal care for pregnant women, including presumptive eligibility.
- PHD will work with Oregon's new CCOs to improve access to and quality of prenatal care.[40]

3. Low birth weight: Compared to non-Latino Whites, African Americans have more low birth weight infants.



Why This Indicator is Important

Weight at birth is closely associated with gestational age, and is an important predictor of infant well-being and survival. The lower the birth weight, the greater the risk of long-term morbidity and early death. Low birth weight infants are more likely to suffer from long-term disabilities such as cerebral palsy, blindness or other chronic conditions. Risk factors associated with low birth weight include: cigarette smoking; multiple births; maternal age extremes; short inter-pregnancy interval, and poor nutrition.

What These Findings Mean

This indicator is the percentage of all live births that are less than 2,500 grams (5.5 pounds). The primary cause of low birth weight is preterm birth (being born before 37 weeks gestation). Despite decades of work to address racial disparities in birth outcomes, in Oregon, as in the United States, African American women continue to experience higher rates than Whites of both low birth weight and preterm births.

Next Steps

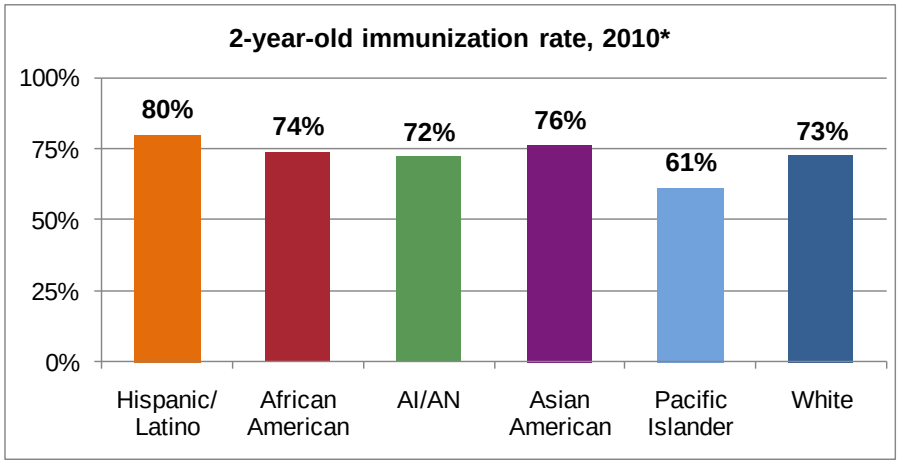
A comprehensive approach to improving birth outcomes (including low birth weight births) follows a life course approach, acknowledging and accounting for the interplay of biological, behavioral, psychological, social, economic and environmental influences on one's health across the course of their life. The Oregon PHD works with local public health departments and other partners around the state to promote healthy birth outcomes using a multiple-strategy approach. These strategies include:

[39] http://public.health.oregon.gov/HealthyPeopleFamilies/Women/Pregnancy/OregonMothersCare/Pages/index.aspx

[40] https://cco.health.oregon.gov/Pages/Home.aspx

- Home visiting programs that work to address the behavioral, social, economic and nutritional factors that can negatively affect births;
- Efforts to raise awareness about the importance of preconception health among the public and providers;
- Perinatal health equity work includes support for culturally specific programs such as the Healthy Birth Initiative and peer breastfeeding counselors; policy initiatives such as HB3311 exploring options for expanded use of Doulas in Oregon's Medicaid program; and targeted public health promotion and outreach to populations most at risk for poor birth outcomes;
- WIC, the Supplemental Nutrition Program for Women Infants and Children, and other programs work towards environments and public policies that increase access to healthy foods;
- Providing training to home visitors in the 5As prenatal smoking cessation counseling intervention;
- Promoting efforts to ensure quality maternity services including decreasing early elective deliveries;
- Public health surveillance activities including Vital Statistics birth data, the PRAMS (Pregnancy Risk Assessment Monitoring System) and PRAMS 2 surveys of postpartum women. Oregon PRAMS oversamples racial and ethnic groups other than White in an effort to better understand and appropriately work to address disparities.

4. Immunization rates for 2-year-olds:[41] Compared to Whites,* Pacific Islanders have a lower immunization rate, and Latinos and Asian Americans have a higher immunization rate.



Why This Indicator is Important

The entire population is largely protected from vaccine preventable disease as a result of high vaccination coverage levels among children 0-2 years of age. A topic of concern to public health is whether individual communities of color are less likely to receive vaccinations or are at greater risk of vaccine preventable diseases. Also, as the receipt of recommended vaccinations in early childhood is a proxy for measuring the quality of well-child care, differences in immunization rates by race and ethnicity are one indicator of potential differences in care given to vulnerable populations. Understanding differences in vaccination rates between racial and ethnic groups helps to inform how immunization program activities should be directed and whether special attention needs to be paid to particular groups.

All children in Oregon are served by the Oregon Immunization Program. Children who meet the requirements of the Vaccines for Children (VFC) program (uninsured, Medicaid-enrolled, and American Indians / Alaska Natives) are eligible to receive vaccines at no cost from ages 0 through 18 years of age. These VFC vaccines are distributed through the Oregon Immunization Program to more than 569 VFC-enrolled providers throughout the state, and have resulted in eliminating vaccination access barriers related to lack of insurance or cost of vaccines. The Oregon Immunization Program also works closely with the

[41] Rates reported for the 4:3:1:3:3:1 immunization series which include 4 doses of DTaP, 3 doses of IPV, 1 doses of MMR, 3 doses of Hib, 3 doses of HepB, and 1 dose of Varicella.

* Hispanic/Latinos included in all race categories for this indicator.

provider community to give updated vaccination recommendations, guidance on vaccine storage and handling, assistance with reporting to the ALERT Immunization Information System (IIS),[42] and to help address community issues such as parental vaccine hesitancy.

What These Findings Mean

In comparison to Whites, the vaccination rates observed among Latinos, African Americans, and Asian Americans are slightly higher. The rate among the small birth population of Pacific Islanders is lower and only slightly lower for American Indians / Alaska Natives. The narrow range of results in Oregon is a measure of success in bridging potential disparities in care by race and ethnicity for young children.

The availability of no-cost or low-cost vaccines through county health departments and VFC providers, as well as the role of the Oregon Health Plan in promoting vaccinations among its enrollees, help to sustain high immunization rates among populations who may otherwise have access issues for medical care.

This report represents the first time the Immunization Program has reported a rate specific to the Native Hawaiian / Pacific Islander population; this population was previously grouped with the Asian American population and lower rates would have been masked by the higher rates associated with the much larger Asian American population. The Pacific Islander population represents the smallest race group, including only 310 children, which is why the confidence interval[43] is much wider than for each of the other race groups.

Nevertheless, a lower immunization rate for Pacific Islanders was found, so this is a population that will receive increased attention from the immunization program. The ability to assess rates among each race group, stratified by Latino ethnicity, will be an important next step in how immunization data are collected and reported. As the immunization program transitions to collecting data on race and ethnicity in separate questions, there will be greater capacity to examine the rates by race and ethnicity with more granularity.

Next Steps

On an annual basis, we use data from our ALERT IIS to assess vaccination coverage levels among different racial and ethnic groups, as well as by geographic area. Specific efforts to address disparities in coverage involve working with providers and key members of different communities by race and ethnicity.

Present data collection on race and ethnicity, as reported on birth certificates, does not provide a reliable basis for tracking immunizations beyond the traditional racial and ethnic groups. For example, individuals of Eastern European heritage cannot be identified using current racial and ethnic data. Use of other data, such as records of languages spoken at home, may be needed to further assess ethnic acceptance of vaccination. However, as Vital Records modifies the way race and ethnicity data are collected, ALERT IIS will be able to analyze disparities with more detail and accuracy. The lower rates associated with Pacific Islanders also needs to be further researched.

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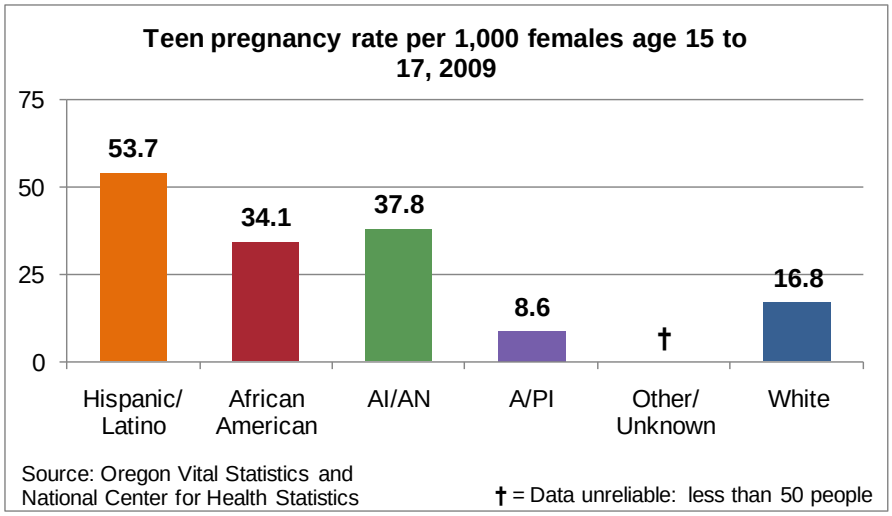
[42] www.immalert.org/AboutALERT.aspx

[43] CI: 55.9 % - 66.7%.

5. Teen pregnancy rate per 1,000 females age 15 to 17: Compared to non-Latino Whites, the rate is higher among Latinos, African Americans, and American Indians/ Alaska Natives.



Why This Indicator is Important

Monitoring the teen pregnancy rate aligns with the Oregon Youth Sexual Health Plan.[44] Eliminating sexual health disparities and reducing rates of unintended teen pregnancy are two of the five overarching goals of the plan.

The Youth Sexual Health Program works with statewide and county partners to address all issues of youth sexual health, including teen pregnancy. PHD supports the provision of reproductive health care services to teens through the School-Based Health Center (SBHC) Program and the Family Planning Program.

SBHCs are required to provide developmentally appropriate reproductive health services to their clients. Whether or not SBHCs provide birth-control services on-site is a local decision. SBHCs that do not provide all reproductive health services that youth are entitled to by state law must refer students to community providers. In 2009-2010, 26 of 55 SBHCs reported dispensing some form of birth control on-site. SBHC Certification Standards state that all students in the school are eligible for services if they have obtained the necessary consent. Students shall not be denied access to services based on insurance status, ability to pay, race, color, national origin, religion, immigration status, sexual orientation, handicap or gender.

All persons of reproductive age can receive medical and/or counseling services related to contraception, sterilization, infertility treatment or related reproductive health care (i.e., annual exams, STI/STD testing and treatment) at a Title X[45] clinic, regardless of their ability to pay, citizenship status, or residence. Clients with annual income at or below 100 percent of the federal poverty level (FPL) are seen free of charge. Fees are based on a sliding fee scale for clients with annual incomes between 101 and 250 percent FPL. All income is self-declared. Minors 18 and under may report their own income. Services included under Title X include a broad range of family planning/reproductive health services.

Oregon's Family Planning Medicaid Waiver, called Oregon **Contraceptive**Care, or CCare**,** has more restrictive eligibility criteria. Persons must be of reproductive age, a resident of Oregon, U.S. citizen or lawful permanent resident for five years or more, with an annual income at or below 250 percent FPL. Teens under 20 may qualify on their own income. Services included under CCare are narrower than Title X, encompassing services related to contraceptive management. STD testing is allowed if conducted within the context of a routine family planning visit.

What These Findings Mean

Disparities in teen pregnancy exist because of differences in sexual behavior among groups. The most recent year Oregon Healthy Teens data were reported by race and ethnicity was 2006. In 2006, non-Latino

[44] www.oregon.gov/DHS/children/teens/tpp/yhsp-021109.pdf?ga=t

[45] The Title X Family Planning program [“Population Research and Voluntary Family Planning Programs” (Public Law 91-572)], was enacted in 1970 as Title X of the Public Health Service Act. Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. The Title X program is designed to provide access to contraceptive services, supplies and information to all who want and need them. By law, priority is given to persons from low-income families.

White 11th-graders were less likely to have had intercourse than African American or Latino 11th-graders. Among those who have had intercourse, non-Latino White 11th-graders were more likely to have used some method of birth control at last intercourse than African American or Latino 11th-graders.[46]

Obstacles in accessing medically accurate reproductive health information and comprehensive services, and lack of access to economic and educational opportunities and social supports may be root causes of the disparities in teen pregnancy.

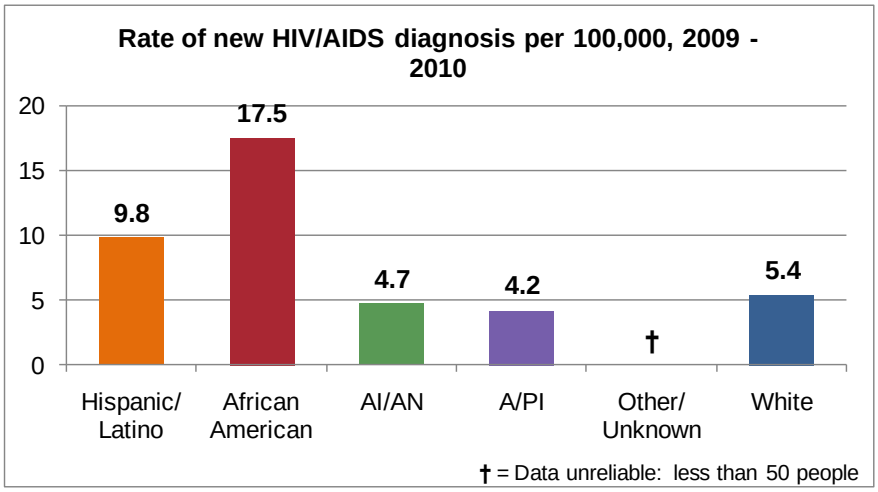
These disparities have been identified previously. However, the National Center for Health Statistics Data Brief #46, State Disparities in Teenage Birth Rates in the United States (October 2010), emphasized the need to address Oregon's disparities in teen pregnancy rates. This report showed that though our overall teen birth rate is significantly lower than the national rate, our Latino teen birth rate is significantly higher than the national rate.

Next Steps

PHD is dedicating prevention funding to reduce teen pregnancy among Latino youth through implementation of Cuidate, a Latino-specific, evidence-based teen pregnancy and sexually-transmitted infections prevention program. PHD is currently selecting counties where Cuidate programming will be provided to a minimum of 750 youth annually, beginning January 2012.

Looking at the relationship between teen pregnancy rates and other social, economic and educational factors is important to better understand and address the root causes of the disparities.

6. Rate of new HIV/ AIDS diagnosis (cases per 100,000): Compared to non-Latino Whites, the rate is higher among Latinos and African Americans.



Why This Indicator is Important

Differences in HIV occurrence by race and ethnicity are important because they reflect that minority groups are more likely than Whites to become infected with HIV and to bear the burden of lifelong disease. In addition, identifying potential differences in these rates can help us identify weaknesses in our strategies to prevent new HIV infections and suggest alternatives.

The programs related to this indicator include HIV Disease Surveillance, HIV Prevention, and HIV Care and Treatment. All of these programs are funded by federal cooperative agreements. All serve people at risk for new HIV infection and people already infected with HIV. The Care and Treatment Program assists people with HIV with disease management and provides financial assistance for purchase of medications and medical insurance premiums. People are eligible if they are HIV-infected and fall below income and wealth thresholds. About two-fifths of people with HIV infection in Oregon receive some benefits from the Care and Treatment Programs. All Oregonians are served by HIV Prevention and HIV Disease Surveillance because

46 http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2006/11/Pages/06DataResults11th.aspx

these programs support efforts to track the occurrence and burden of disease and to prevent new infections.

What These Findings Mean

The measure indicates the number of new HIV infections identified and reported to Oregon's Public Health Division for the years indicated. These are reported as the number of new infections identified per 100,000 residents in Oregon for the indicated years. Ideally, these rates will decrease over time, indicating fewer new infections.

These disparities by race and ethnicity have been identified previously and this means that African Americans and Latinos have a higher likelihood of becoming infected. Actually, the differences in rates of new infections between African Americans and non-Latino Whites are less in Oregon than in most of the U.S. The CDC reported that the rate of new HIV diagnoses were more than six times higher among African Americans relative to Whites in 2010.

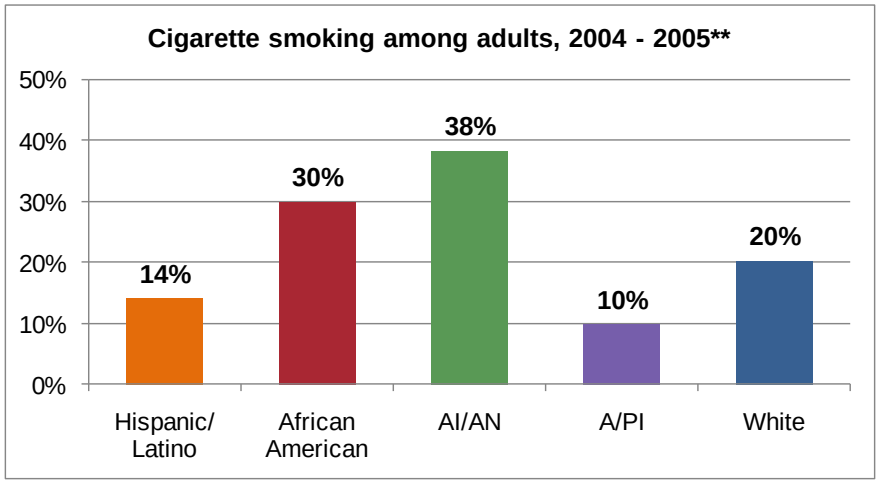
Racial and ethnic disparities in the distribution of infectious diseases are common in the U.S. These differences are probably not attributable to a single factor but rather result from a complex combination of historical and current differences by race and ethnicity in educational achievement, income and wealth, cultural assimilation, incarceration, higher rates of disease in sexual networks, and differences in sexual norms. Ideally, we want to see new HIV infections decline among all groups.

Next Steps

Laboratories and health care practitioners must report all new HIV infections to the state Public Health Division. We compile and summarize these reports for use by public health professionals, community-based organizations, academic investigators and the public for use in efforts to understand the scope and impact of HIV in Oregon and in designing strategies for reducing new infections. Our HIV Prevention Program funds efforts by local health departments to design prevention strategies that focus on new infections in members of racial and ethnic groups who are at increased risk of infection compared to non-Latino Whites.

We will continue to report data on HIV data and disease investigations by race and ethnicity. We will work with internal and community partners to compile and distribute data by race and ethnicity on the utilization and impact of programs designed to reduce new infections.

7. Percentage of adults who smoke:[**] Percentage of adults age 18+ who currently smoke cigarettes. Compared to non-Latino Whites, the percentage is higher for African Americans and American Indians / Alaska Natives, and is lower for Latinos and Asian Americans / Pacific Islanders.



Why This Indicator is Important

[**] Age-adjusted indicator: Adjusts for differences in the age distribution of populations. Allows for comparisons between populations with less chance that potential differences are due to one population, on average, being older or younger than another.

Approximately 30,000 Oregonians die each year. More than 22 percent of these deaths are linked to tobacco.

What These Findings Mean

These patterns in smoking by race and ethnicity are consistent with those seen nationally. The 1998 Surgeon General Report on tobacco use among communities of color[47] offered the following explanation for such patterns: they "are the result of complex interactions of multiple factors, such as socioeconomic status, cultural characteristics, acculturation, stress, biological elements, targeted advertising, price of tobacco products, and varying capacities of communities to mount effective tobacco control initiatives" (page 6).

Oregon Health Promotion and Chronic Disease Prevention (HPCDP) was previously aware of these findings, had disseminated these results, and used them to inform program activities. Indeed, since its inception, a major focus of HPCDP's tobacco control program has been to identify and address disparities in tobacco use.

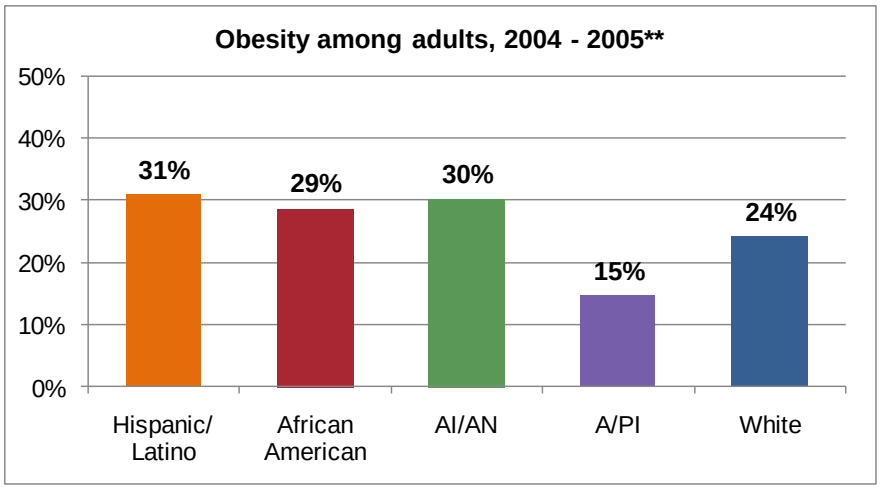
Next Steps

HPCDP is working with all county health departments and the nine federally recognized tribes in Oregon to promote effective and sustainable tobacco prevention among people with fewer financial resources and those experiencing health disparities related to tobacco. HPCDP is also working in partnership with the Office of Equity and Inclusion to build statewide public health equity capacity among community-based agencies serving populations experiencing health disparities. The purpose is to engage communities of color and people with fewer financial resources in promoting policy change to help ensure good health and mitigate negative social determinants of health. Three PHD-funded Regional Health Equity Coalitions are currently engaged in this work in Oregon.

More information is needed to supplement this basic analysis to better understand the findings. For example, an examination of smoking prevalence by socioeconomic status (SES) within each racial and ethnic group would be helpful, given that smoking is more common among persons of low SES overall. In addition, HPCDP finds reviewing published studies useful in further elucidating potential disparities in smoking prevalence. For example, despite a low smoking prevalence among Asian Americans overall, the literature from California unveils a very high smoking prevalence among men of certain Asian heritages, such as Vietnamese and Korean. We would expect to see these same types of patterns in Oregon.

[47] U.S. Department of Health and Human Services. Tobacco Use Among U.S. Racial/Ethnic Minority Groups – African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.

8. Percentage of adults who are obese:[**] Compared to non-Latino Whites, the percentage is higher for Latinos, African Americans, and American Indians / Alaska Natives, and lower for Asian Americans / Pacific Islanders.



Why This Indicator is Important

Individuals who are obese (i.e., body mass index > 30) have a 50 percent to 100 percent increased risk of premature death from all causes, compared to individuals with a healthy weight.[48] In Oregon, obesity causes about 1,500 deaths each year, making it second only to tobacco as the state's leading cause of preventable death. Obesity is also a major risk factor for chronic diseases such as diabetes, cancer, high blood pressure, high cholesterol, arthritis, heart disease and stroke. Since 1990, Oregon's obesity rates have doubled in adults. The percentage of 8th-graders who were obese increased 53 percent between 2001 and 2009, and the percentage of 11th-graders who were obese increased 55 percent. Obesity is also linked to higher health care costs, pain and suffering, and negative effects on physical ability, mobility, and other quality of life measures.

What These Findings Mean

These patterns in obesity by race and ethnicity are similar with those seen nationally. In the 2001 Surgeon General Report on obesity,[49] disparities in obesity prevalence existed in many segments of the population based on race and ethnicity, gender, age, and SES status (page 15).

Oregon Health Promotion and Chronic Disease Prevention (HPCDP) was previously aware of these findings, had disseminated these results, and used them to inform program activities.

Next Steps

Currently, HPCDP does not have funding for a program to address obesity. The Cancer, Arthritis, Asthma, Diabetes and Heart Disease/Stroke Prevention programs are funding targeted projects to slow down the obesity rate. As previously mentioned, HPCDP is working in partnership with the Office of Equity and Inclusion to build statewide public health equity capacity among community-based agencies serving populations experiencing health disparities. The purpose is to engage communities of color and people of lower socioeconomic status in promoting policy change to help ensure good health and mitigate negative social determinants of health.

More information is needed to supplement this basic analysis to better understand the findings. For example, an examination of obesity prevalence by SES within each racial and ethnic group would be

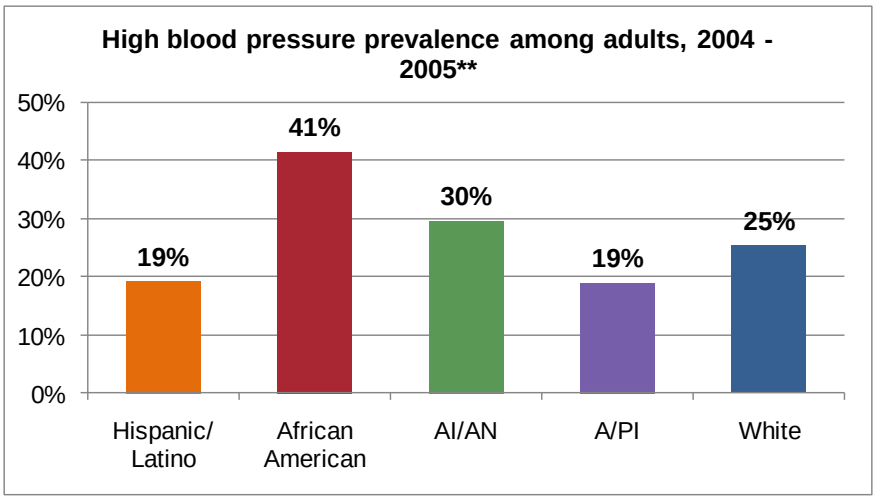
[**] Age-adjusted indicator: Adjusts for differences in the age distribution of populations. Allows for comparisons between populations with less chance that potential differences are due to one population, on average, being older or younger than another.

[48] National Institutes of Health (NIH), National Heart, Lung, and Blood Institute (NHLBI), Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults. HHS, PHS 1998.

[49] The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity is available at: www.surgeongeneral.gov/library/calls/obesity/index.html

helpful, given that obesity is more common among persons of low SES overall. It is also important to assess this indicator among youth so as to gain a clearer understanding of the onset of obesity among diverse populations.

9. Percentage of adults who have high blood pressure:[**] Compared to non-Latino Whites, the percentage is significantly higher for African Americans, and lower for Latinos.



Why This Indicator is Important

Together heart disease and stroke are the leading cause of death in Oregon. Twenty-six percent of adult Oregonians report having high blood pressure, a major risk factor for heart disease and stroke.

What These Findings Mean

Nationally, African Americans develop high blood pressure more often and at an earlier age.[50] Disparities related to diabetes, obesity and smoking – all risk factors for hypertension – likely contribute to the increased proportion of African Americans with high blood pressure. Social determinants of health such as income, education, neighborhood characteristics, access to health care, and others, are likely contributors to all of these health disparities. Note that the percentage of Latinos who have high blood pressure is comparable to Asian Americans / Pacific Islanders, but the difference when compared to Whites is only statistically significant for Latinos. This is because the smaller Asian American / Pacific Islander population in Oregon makes it more difficult to gather information from enough people of that background to get statistically significant results.

Oregon Health Promotion and Chronic Disease Prevention (HPCDP) was previously aware of these findings, had disseminated these results, and used them to inform program activities.

Next Steps

As previously mentioned, HPCDP is currently working in partnership with the Office of Equity and Inclusion to build statewide public health equity capacity among community-based agencies serving populations experiencing health disparities. The purpose is to engage communities of color and people with fewer resources in promoting policy change to help ensure good health and mitigate negative social determinants of health.

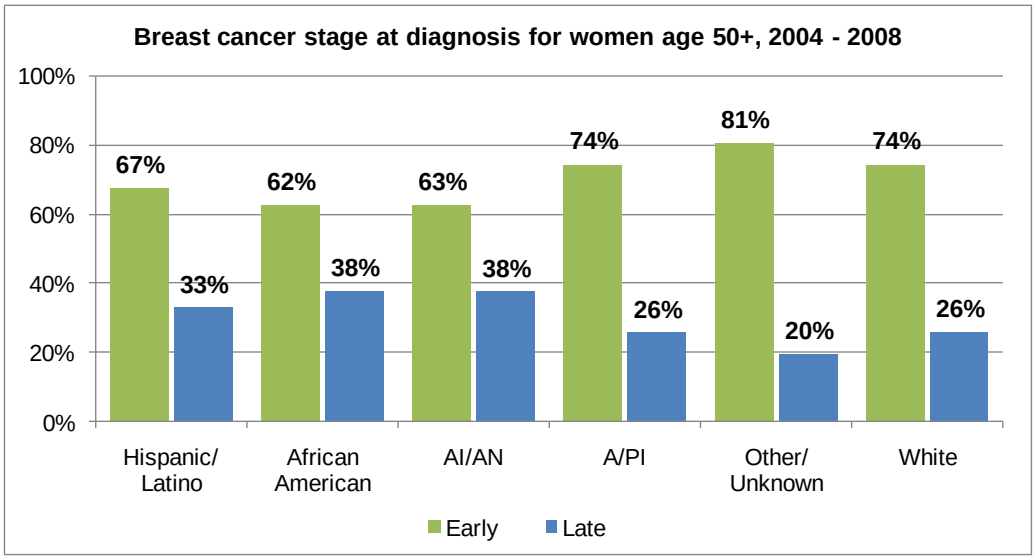
Sodium intake is a significant risk factor for hypertension. HPCDP is working with food scientists, large purchasers, the school lunch program, senior nutrition programs, the restaurant industry, and other partners to reduce the amount of sodium in the bread supply. About 77 percent of sodium comes from processed and restaurant foods. Bread products, by volume consumed, are a leading source of sodium in the U.S.

[**] Age-adjusted indicator: Adjusts for differences in the age distribution of populations. Allows for comparisons between populations with less chance that potential differences are due to one population, on average, being older or younger than another.

[50] Roger VL, Go AS, Lloyd-Jones DM, et al. Heart disease and stroke statistics-2012 update: a report from the American Heart Association. Circulation. 2012 Jan 3;125(1):e2-e220.

diet. Since bread products are still produced locally or regionally, compared to other food products, Oregon has a feasible opportunity to impact sodium reduction in one major sector of the food supply.

10. Female breast cancer by stage of diagnosis, women age 50+: Compared to non-Latina Whites, the percentage of women with late-stage breast cancer at the time of diagnosis is higher for Latinas, African Americans, and American Indians / Alaska Natives.



Why This Indicator is Important

This indicator is related to cancer stage at the time of diagnosis. Cancer stage refers to the extent to which cancer has spread or how "advanced" it is. The later the stage of breast cancer at the time of diagnosis, the more likely women are to die or suffer from disability as a result of the cancer or its treatment. Therefore, the higher the percentage of women with late-stage breast cancer at the time of diagnosis in any group, the worse the expected outcomes for that group.

What These Findings Mean

These findings include reported breast cancer cases for which information on stage at diagnosis was available. These findings should be interpreted with caution, given the small number of total and late-stage breast cancer cases in communities of color during a given year (for each group, the average total number of breast cancer cases annually ranged from 20 to 38). These small numbers of cases also make it unlikely that detected differences will be statistically significant. Although the above differences did not reach statistical significance, we consider the differences meaningful. The observed differences between racial and ethnic groups in Oregon are consistent with national data, have been consistently observed in Oregon over time, and are large enough to be meaningful. In particular, the findings are consistent with national data showing that African Americans are more likely to have late-stage breast cancer at the time of diagnosis and that late-stage diagnosis is more likely among groups with lower rates of screening mammography.[51,52]

With these limitations in mind, we find that, compared to non-Latina Whites, the percentage of women with late-stage breast cancer at the time of diagnosis is higher for African Americans, Latinas, and American Indians / Alaska Natives. No difference is identified between non-Latino Whites and Asian Americans / Pacific Islanders. Note that a substantial number of people were categorized in the "unknown" race and ethnicity category (76 average annual cases, or 3 percent), indicating that there is progress to be made in the collection and reporting of racial and ethnic data related to this indicator.

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[51] Centers for Disease Control and Prevention. Surveillance of screening-detected cancers (colon and rectum, breast, and cervix) – United States, 2004-2006. Morb Mortal Wkly Rep 2010;59, SS-9:1-25.

[52] Taplin SH, Ichikawa L, Yood MU, et al. Reason for late-stage breast cancer: Absence of screening or detection, or breakdown in follow-up? J Natl Cancer I 2004;96:1518-1527.

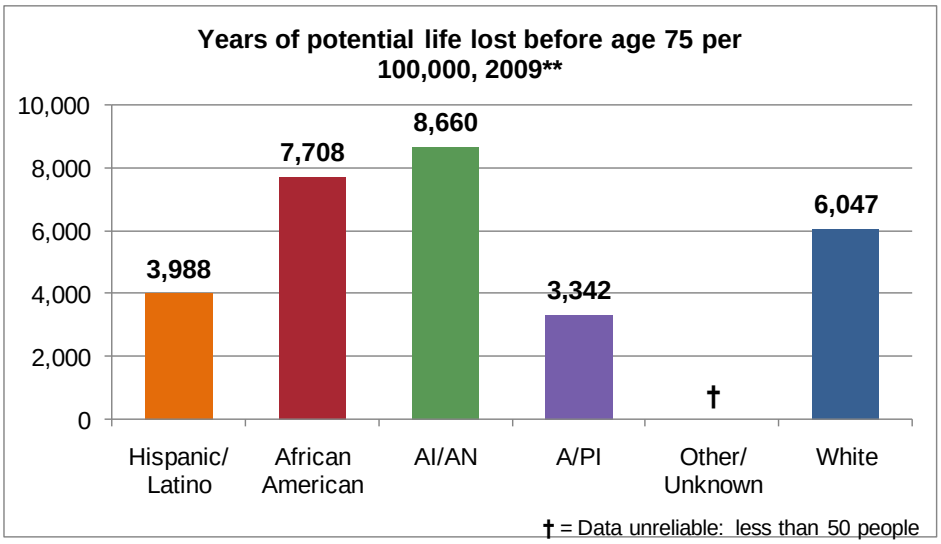
High rates of late-stage incidence of screening-amenable cancers might reflect, in part, the ineffectiveness of screening programs (e.g., not reaching enough of the population, not reaching those at highest risk, or technical problems with the screening tests), or problems with quality of follow-up for abnormal screening test results.[53] In Oregon, survey data from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that screening mammography rates among women aged 40 and above are lower among American Indians / Alaska Natives and Latinas, and higher among African Americans, compared to the non-Latino White population. Multiple factors, including individual characteristics and health behaviors, as well as provider and clinical systems factors, influence why certain populations are under-screened.

Next Steps

The Oregon Breast and Cervical Cancer Program (BCCP) seeks to address disparities by working to increase screening rates for breast and cervical cancer among low-income, uninsured or underinsured women in Oregon, and particularly among women from certain racial, ethnic, and/or cultural minority populations with disproportionately lower screening rates. The program offers reimbursement for comprehensive well-woman exams, including mammograms, to a network of primary care providers throughout the state. Women aged 40-64 living in Oregon are eligible for the program if they have an income at or below 250 percent FPL and are uninsured or underinsured. An estimated 77,000 women are eligible for the program statewide, and the BCCP receives funding to serve less than 10 percent of those eligible for the program each year. Of the women served, about 26 percent are Latina, 5 percent are Asian American, about 2 percent are African American, 1 percent are American Indian / Alaska Native, and less than 1 percent are Native Hawaiian / Pacific Islander. While limited funding is a challenge, the BCCP plans to expand targeted outreach among underserved populations.

Identifying which women do not receive recommended screening is an important step in reducing cancer mortality. For example, national screening rates are lower for women with low income, without health insurance, and without access to care, and vary by age, education, and recent immigration. Investigating the extent to which these factors influence screening mammography rates and are associated with increased rates of late-stage breast cancer at the time of diagnosis would be informative.

11. Years of potential life lost (YPLL) before age 75 years:[**] Compared to non-Latino Whites, the years of potential life lost per 100,000 people as a result of death before age 75 years is higher for African Americans and American Indians / Alaska Natives, and lower for Latinos and Asian Americans / Pacific Islanders.



Why This Indicator is Important

Years of potential life lost (YPLL) before the age of 75 years per 100,000 people gives an indication of the burden of premature death in a

[53] Henley SJ, King JB, German RR, Richardson LC, and Plescia M. Surveillance of screening-detected cancers (colon and rectum, breast, and cervix) - United States, 2004-2006, Morb Mortal Wkly Rep 2010;59(SS9):1-28.

[**] Age-adjusted indicator: Adjusts for differences in the age distribution of populations. Allows for comparisons between populations with a lesser chance that potential differences are due to one population, on average, being older or younger than another.

particular population. This information may be used to target prevention efforts to reduce the leading causes of premature death in specific populations.

What These Findings Mean

This indicator reflects both the rate of deaths before the age of 75 years in a particular population and the average age at which premature deaths occur in that population. For example, 10 years of potential life are lost for a particular population if one person per 100,000 dies at age 65 years, or if 10 people per 100,000 die at age 74 years. The larger the number of years of potential life lost before age 75 years, the higher the burden of premature death for a particular population.

Among African Americans in Oregon, premature deaths from diseases of the heart are the leading contributor to YPLL and may be related to disparities in risk factors for cardiovascular disease. For example, African Americans develop high blood pressure more often and at an earlier age than the general population. In addition, disparities related to other risk factors for cardiovascular disease, such as diabetes, obesity, and smoking, likely contribute to the increased occurrence of premature death due to cardiovascular disease among African Americans. Social determinants of health such as income, education, neighborhood characteristics, access to health care, and others, are likely contributors to all of these health disparities.

Unintentional injuries are the leading contributor to YPLL among American Indians / Alaska Natives in Oregon. In particular, preliminary 2010 data indicate that death rates from motor vehicle crashes and unintentional poisonings are higher among American Indians / Alaska Natives than they are among non-Latino Whites and other racial groups.

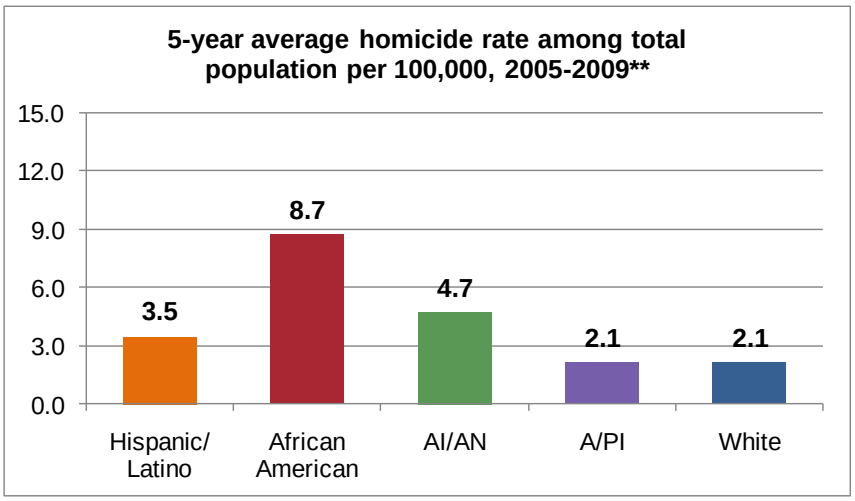
Malignant neoplasms are the second leading contributor to YPLL from premature deaths for both African Americans and American Indians / Alaska Natives in Oregon. These premature deaths may be the result of high rates of screening-amenable cancers that are detected later than they would be if appropriate screening occurred more frequently in these populations. Failure to detect screening-amenable cancers might reflect, in part, the ineffectiveness of screening programs (e.g., not reaching enough of the population, not reaching those at highest risk, or technical problems with the screening tests), or problems with quality of follow-up for abnormal screening test results.[51] Multiple factors, including individual characteristics and health behaviors, as well as provider and clinical systems factors, influence why certain populations are under-screened and may contribute to a higher premature death rate due to malignant neoplasms in those populations.

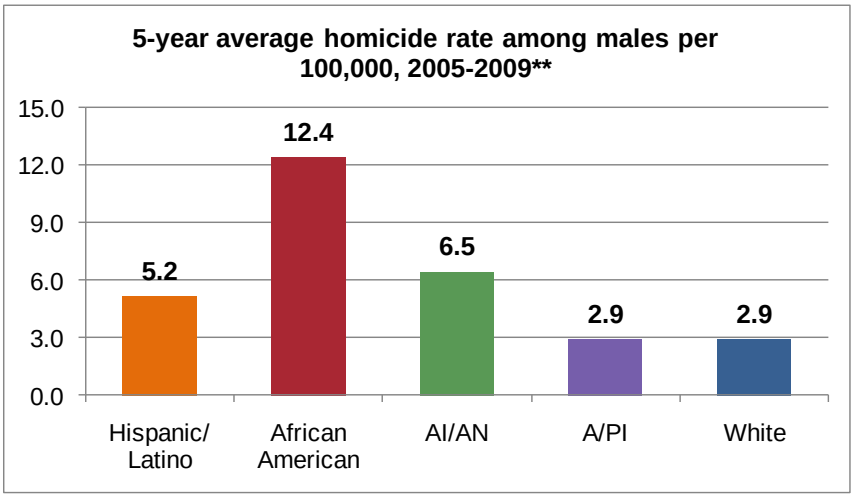
These are new findings for the Oregon Public Health Division.

Next Steps

The Oregon Public Health Division will review how these findings may be used by existing (or future) public health programs to address the identified disparities, including continued efforts to address tobacco use, hypertension, obesity, and breast cancer screening, as outlined above.

12. Five-year average homicide rate per 100,000:[**] Compared to non-Latino Whites, the five-year average homicide rate is higher for Latinos, African Americans, and American Indians / Alaska Natives.





Why This Indicator is Important

Nationally, homicide is among the top four causes of death for persons aged 1 – 40 years.[54] Homicide rates in Oregon are lower than the national average, but are still in the top five causes of death for people aged 1 – 40 years. For African Americans in Oregon, homicide is the seventh-leading cause of death overall, and the leading cause of death for those aged 15 to 34 years.

Homicide is an extreme outcome of the broader public health problem of interpersonal violence. Despite the promising decrease in certain homicide rates, primary prevention efforts against violence should be increased, particularly among young racial and ethnic minority males.

What These Findings Mean

Data for this report are from the Oregon Violent Death Reporting System (ORVDRS). Oregon is one of 18 states funded by the Centers for Disease Control and Prevention to maintain a violent death reporting system that employs the same methodology utilized by the National Violent Death Reporting System (NVDRS) for data collection and reporting.

The NVDRS is a federally-funded state-based surveillance system using death investigation records to collect data on the characteristics and circumstances surrounding violent deaths. NVDRS collects data from multiple sources and compiles them into an incident-based database. The data sources in the system include death investigation records from medical examiners or coroners, law enforcement, vital records and forensic sciences. NVDRS captures all homicides, suicides, deaths of undetermined manner, deaths resulting from legal intervention, and deaths related to unintentional firearm injury.

These data should be interpreted with some caution, given the small number of events among some racial and ethnic groups. For instance, the five-year average homicide rate for American Indian / Alaska Native

[**] Age-adjusted indicator: Adjusts for differences in the age distribution of populations. Allows for comparisons between populations with less chance that potential differences are due to one population, on average, being older or younger than another.

[54] CDC. Web-based Injury Statistics Query and Reporting System (WISQARS). Atlanta, GA: US Department of Health and Human Services, CDC, National Center for Injury Prevention and Control; 2010. Available at: www.cdc.gov/injury/wisqars/index.html

males is not statistically different than the rate for non-Latino White males. However, the higher rate for the American Indian / Alaska Native male population is thought to be meaningful, given that the rate is more than two times that for the non-Latino White male population, and the overlap between confidence intervals for the rate is minimal (see Technical Appendix).

Individual factors (e.g., employment status) and socioeconomic factors (e.g., poverty and economic inequality) play critical roles in racial and ethnic disparities in homicide.[55,56] For example, it is more likely that persons of a minority race and/or ethnicity will be unemployed or live in low socioeconomic status neighborhoods compared to those of other racial and ethnic backgrounds; both of these factors are associated with a higher homicide risk. [41,42]

Based on ORVDRS, gang violence and drug trade/use are common circumstances related to homicide among African Americans in Oregon. From 2003 to 2009, gang homicide accounted for 23 percent of homicides that occurred among African Americans. Nearly half the victims of gang homicide in Oregon during this time (n=16) were African Americans.

Next Steps

The Oregon Public Health Division will continue to monitor and report on homicide rates by race and ethnicity given the impact of homicide on communities and its connection to the broader public health problem of interpersonal violence. These findings will be used to assess how existing or future public health programs may be able to impact identified disparities in deaths due to homicide.

[55] Krueger PM, Bond Huie SA, Rogers RG, Hummer RA. Neighbourhoods and homicide mortality: an analysis of race/ethnic differences. J Epidemiol Community Health 2004;58:223–30.

[56] Logan JE, Smith GS, and Stevens MR. Homicides—United States, 1999-2007. Morb Mort Wkly Rep 2011;60:67–70.

OFFICE OF PRIVATE HEALTH PARTNERSHIPS

About the Office

The Office of Private Health Partnerships (OPHP) was created to help reduce the number of uninsured Oregonians. OPHP administers programs that work together to break down access barriers, assist with health insurance coverage costs, and educate program members, the general public, and health care professionals.

Clients

OPHP operates the Family Health Insurance Assistance Program (FHIAP), the high risk Oregon Medical Insurance Pool (OMIP), the Federal Medical Insurance Pool (FMIP), and Healthy Kids Connect (HKC). FHIAP and HKC, respectively subsidize 50 percent to 100 percent (income at or below 200 percent of FPL) and 85 percent to 90 percent (income 201 percent to 300 percent of FPL) of the member's insurance premium. HKC also provides non-subsidized coverage for children above 300 percent of FPL who enroll with select commercial carriers. OMIP/FMIP provides medical insurance coverage for individuals who are denied coverage by commercial carriers because of pre-existing conditions. Each OPHP program has its own eligibility requirements, some of which are as follows:

FHIAP:

- Income at or below 200 percent FPL;
- Uninsured during two previous months;
- Oregon resident, U.S. citizen or legal alien.

FMIP:

- Pre-existing medical condition;
- Uninsured for six months;
- Oregon resident, U.S. citizen or legal presence.

OMIP:

- Pre-existing medical condition;
- Oregon resident.

HKC:

- Income at or above 201 percent FPL (201-300 percent subsidized, 301 percent or higher not subsidized);
- Uninsured during two previous months;
- Under 19 years of age;
- Oregon resident, U.S. citizen or legal alien.

For more information on OPHP, visit: www.oregon.gov/OHA/OPHP/pages/index.aspx.

About the Indicators

The indicators chosen by OPHP to examine by race and ethnicity are:

1. Approval rate for initial FHIAP applications;
2. Reasons for FHIAP application denial;
3. Approval rate for FHIAP redetermination applications;
4. Pended rate for FHIAP applications;
5. Approval rate for OMIP/FMIP applications;
6. Average length of enrollment for terminated members.

These indicators were chosen to help inform OPHP about differences among racial and ethnic populations in access to OPHP administered medical insurance coverage or subsidies. However, the indicators provide no information about the reasons for those differences.

Application approval rates are computed only for FHIAP and OMIP/FMIP because the eligibility for HKC is determined by the Oregon Health Authority Office of Client and Community Services. OMIP/FMIP eligibility determination and enrollment data are provided by Regence Blue Cross Blue Shield of Oregon as a third-party administrator. It is also important to note that FHIAP does not require applicants to provide racial and ethnic information to be eligible for the program.

The last indicator, average length of enrollment, is based on all three OPHP programs: FHIAP, FMIP/OMIP and HKC.

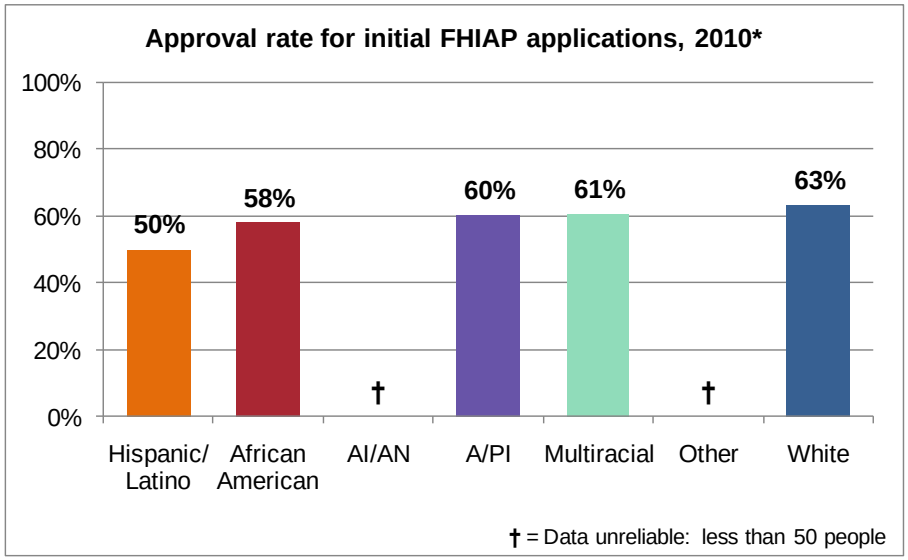
For all indicators a 5 percentage point difference between communities of color and Whites is considered a meaningful difference.

Findings

Findings for the four indicators related to FHIAP are presented first, followed by the findings related to OMIP/FMIP and average length of enrollment for all OPHP-administered programs. Indicators with an identified disparity are denoted by a yellow triangle, and those with no identified disparity by a green circle. For all indicators, each race category includes Latinos.

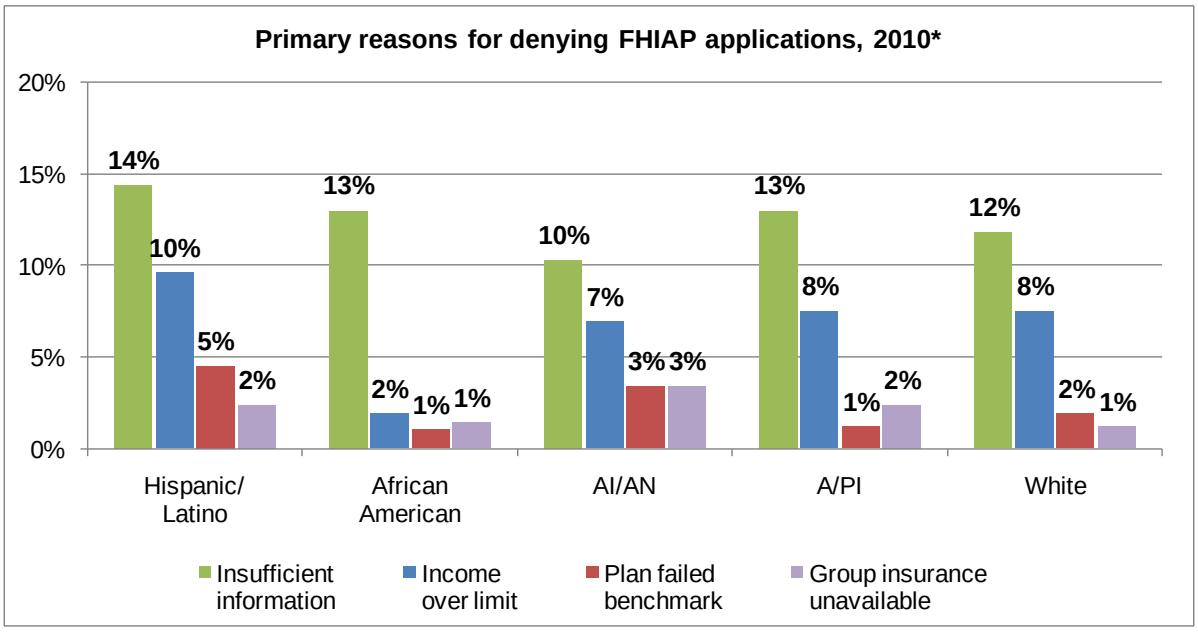
Federal Health Insurance Assistance Program (FHIAP)

1. Approval rate for initial FHIAP applications:* Compared to Whites, the rate is lower for Latinos and African Americans.



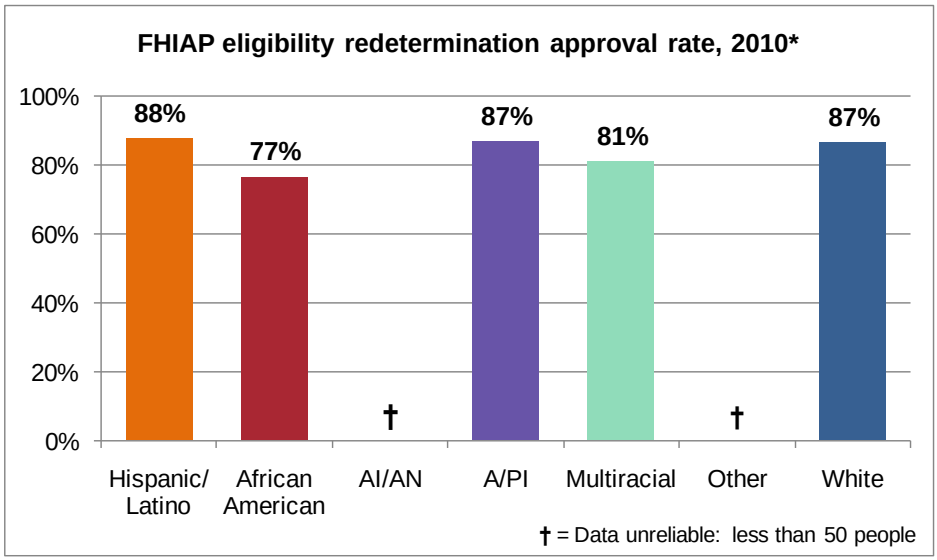
* Hispanic/Latinos included in all race categories for this indicator.

2. Reasons for denying FHIAP applications:* Little or no difference between Whites and communities of color.



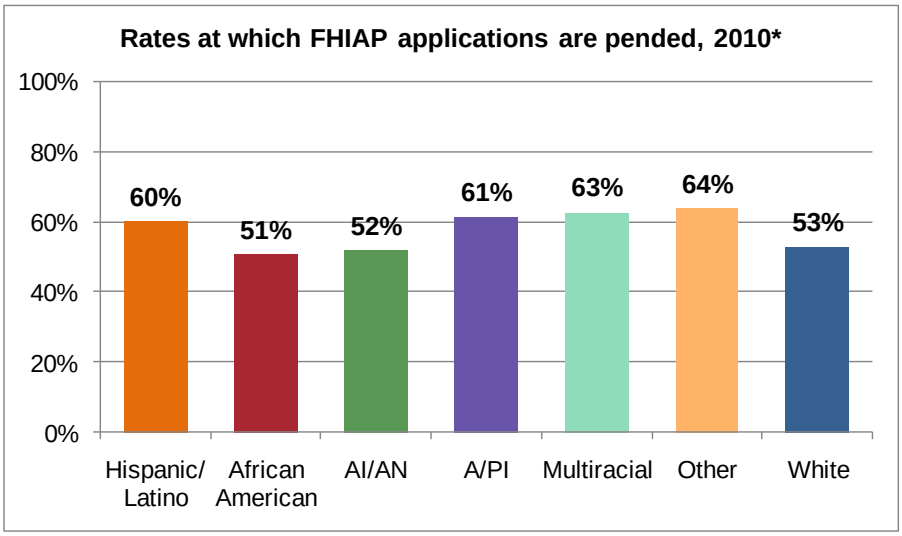
It is important to note that a FHIAP application may be denied for a single reason or multiple reasons at the same time. Since it is not always easy to choose which one is the primary reason, reasons are ranked by the number of times they are cited. Accordingly, Insufficient Information, Over Limit Income, Health Plan Not Meeting Benchmark, and Failure to Prove Group Insurance Availability are the most common reasons. The number of observations is relatively small and will not be provided due to a confidentiality constraint.

3. FHIAP: Redetermination application approval rate:* Compared to Whites, the rate is lower for African Americans and those identifying with more than one race.



* Hispanic/Latinos included in all race categories for this indicator.

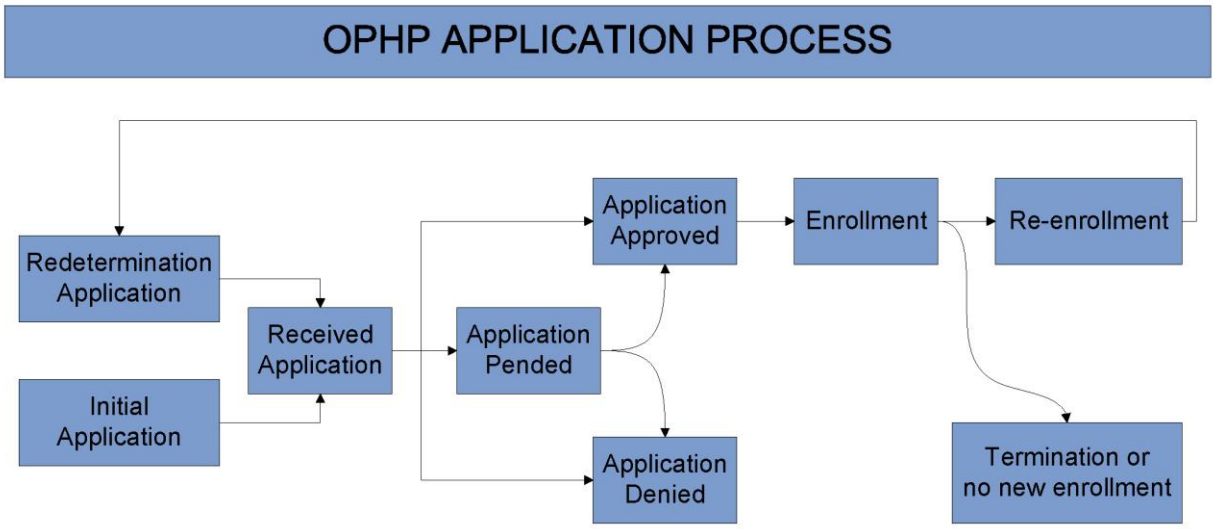
4. Rates at which FHIAP applications are pended:* Compared to Whites, the rate is higher for Latinos, Asian Americans / Pacific Islanders, those identifying with more than one race, and those identifying as "other" race.



Why These Indicators are Important

Approval of initial FHIAP applications is a critical step to access and maintain health insurance from commercial carriers or the high risk pools. For approved enrollees, FHIAP subsidizes 50 percent to 95 percent of the monthly insurance premium for adults and 100 percent of the premium for children.

What These Findings Mean



A FHIAP application is approved as a whole even though more than one person can apply in the same application. Applicants who do not meet the individual eligibility criteria can be denied even if the application as a whole was approved. Findings for the FHIAP initial application approval rates, redetermination (or reapplication) rate, FHIAP applicant denial rate, and application pended rate are based on the application as a whole. For all indicators, race and ethnicity is based on the primary applicant only, who is most often the head of the household.

* Hispanic/Latinos included in all race categories for this indicator.

The approval rates for initial FHIAP applications indicate that, compared to Whites, a smaller proportion of African Americans and Latinos were approved. When an FHIAP application is denied it is usually for more than one reason. For all populations insufficient information is the most commonly cited reason for FHIAP application denial and income exceeding the allowed limit is the second most cited reason.

The approval rates for redetermination applications indicate that, among those who were already receiving FHIAP subsidies, a disparity exists for American Indians / Alaska Natives, African Americans, those identifying with more than one race, and those identifying as “other” race in continuing to receive those subsidies.

An application is pended while FHIAP awaits additional required information or a clarification on the information provided by the applicant. OPHP has no information on why some members of these populations do not provide the information needed to avoid pending their applications. Potential reasons could include language or other culture-specific barriers, but further investigation would be needed to draw any conclusions.

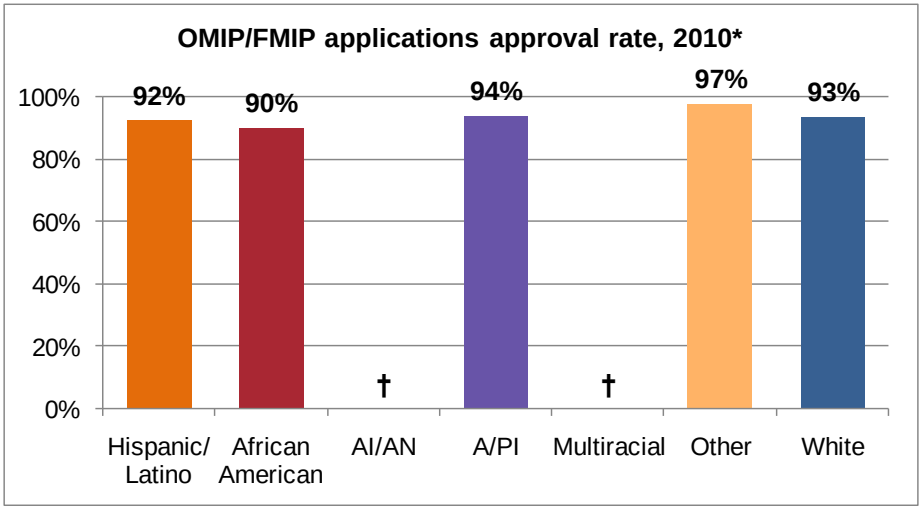
Some caution should be exercised when interpreting approval rates for both initial and redetermination FHIAP applications. OPHP has no information that explains the lower approval rates for African Americans or Latinos, and obtaining such information would require a more in-depth study that should include data from the Oregon Health Plan. Also, the disparities identified in the redetermination approval rates for those identifying with more than one race and those identifying as “other” race, although significant, are difficult to interpret because the data lack specificity. In addition, information about race and ethnicity are not required on the FHIAP application resulting in a substantial amount of missing data for initial and redetermination applications (see Technical Appendix).

Next Steps

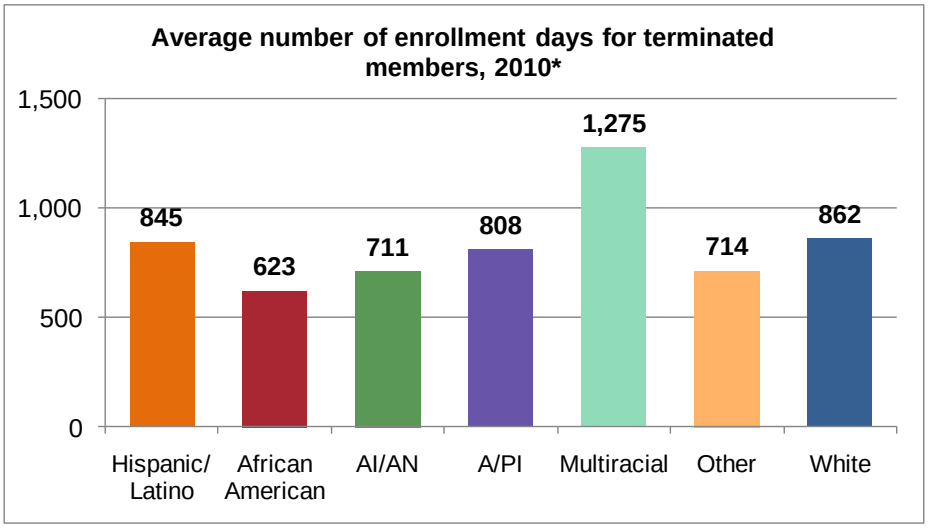
To raise awareness of administered programs, the OPHP Information, Education and Outreach Office conducts trainings and outreach activities in various regions and at community events and partners with other organizations. OPHP has FHIAP applications available in Spanish and a referral service to culturally appropriate insurance agents. OPHP staff are culturally diverse to ensure that adequate services are provided to clients. Trainings and other outreach activities are limited at this time due to budget shortfalls and organizational change that will transition some or all of OPHP’s program functions to OHA and/or Cover Oregon, also known as the Health Insurance Exchange.

Oregon and Federal Medical Insurance Pool (OMIP/FMIP) and Length of Enrollment

5. OMIP/FMIP applications approval rate:* Little or no difference between Whites and communities of color.



6. Average number of enrollment days for terminated members:* Compared to Whites, enrollment is shorter for African Americans, American Indians / Alaska Natives, Asian Americans / Pacific Islanders, and those identifying as "other" race, and longer for multiracial individuals.



What These Findings Mean

Compared to FHIAP, the approval rate for OMIP/FMIP is much higher overall. The high approval rate is likely due to the fact that eligibility is not based on income or assets, but rather the existence of particular chronic medical conditions. The primary reasons for denying high-risk pool applications are failure to provide needed information, having other coverage and member request.

For length of enrollment in OPHP-administered programs, the average number of continuous enrollment days includes members who were terminated from all three OPHP programs (FHIAP, OMIP/FMIP, and

* Hispanic/Latinos included in all race categories for this indicator.

HKC) in 2010. A member is terminated when he or she is informed in writing that enrollment in an OPHP-administered program will end on a specific date. Transfers between plans within the same program do not constitute a termination. Unlike the FHIAP indicators that used the race and ethnicity of the primary applicant, the length of enrollment indicator reflects the race and ethnicity of each covered client who was enrolled in an OPHP-administered program.

In general, it is unclear whether it is better to be enrolled in an OPHP-administered program for more or less days. For example, one client might be enrolled for a relatively brief period because a new job with good pay and affordable health insurance made continued enrollment unnecessary. Another client might lose eligibility due to higher income but not be able to afford unsubsidized insurance and become uninsured. However, to better understand the identified disparities among racial and ethnic groups, a focused investigation that spans across other agencies and programs would be needed and OPHP would caution against drawing conclusions without such data. Although a focused investigation is needed, cultural differences in areas such as language, literacy, record keeping, and sensitivity to time frames may be among the reasons for the disparities.

Next Steps

To raise awareness of administered programs, the OPHP Information, Education and Outreach Office conducts trainings and outreach activities in various regions and at community events, and partners with other organizations. Trainings and other outreach activities are limited at this time due to budget shortfalls and organizational uncertainty that will possibly transition some or all of OPHP's program functions to OHA and/or the new Health Insurance Exchange. OPHP has FHIAP applications available in Spanish and a referral service to culturally appropriate insurance agents as well as culturally diverse staff to ensure that adequate services are provided to clients.

DISCUSSION, AGENCY RESPONSE AND NEXT STEPS

In this Phase 2 of the State of Equity Report, DHS and OHA divisions and offices chose, calculated, and reported on the most meaningful indicators related to need for and access to services and programs, quality of customer service, and related outcomes by race and ethnicity to inform their programs and policies.

For this report, moving away from Key Performance Measures to leadership-identified disparities has resulted in a keener understanding of a more glaring pattern of disparities in health and human services in Oregon. The majority of indicators (30 of 36) demonstrate disparities by race and ethnicity, thus highlighting the need to track these measures over time. The considerable variability in the type of indicators chosen across programs makes it difficult to make overall summary statements about the results. Nevertheless, having these results together in one report demonstrates several important patterns:

- Consistent with Phase 1, the most disparities for both health and human services were apparent for African Americans and American Indians / Alaska Natives.
- Compared to Phase 1, nearly twice as many disparities were identified in the Latino community in Phase 2.
- Based on the Phase 2 findings, African Americans, American Indians / Alaska Natives and Latinos in Oregon face many of the same health disparities over the life course. Compared to non-Latino Whites, all three communities:
  - Are less likely to receive first trimester prenatal care;
  - Have higher rates of teen pregnancy;
  - Are more likely to be obese;
  - Are more likely to have late-stage breast cancer at the time of diagnosis; and
  - Have higher homicide rates.

Since the work for this Phase 2 Report began, significant actions to promote equity have been taken with the guidance and support of both OHA and DHS executive leadership. Examples include the formation of the Race, Ethnicity and Language (REAL) Data Leadership Workgroup that has been collaborating on this report and developed a joint DHS and OHA policy to standardize the collection of race, ethnicity and language data. Both OHA and DHS are also engaging communities to hear their feedback on the Phase 1 results.[57]

OHA Agency Response

OHA is working to achieve the Triple Aim through Health System Transformation: improve lifelong health; increase quality, reliability and availability of care; and lower or contain the cost of care. This report reveals that current health promotion, disease prevention, and access to care investments are not equally effective in achieving the Triple Aim for all Oregonians. Such disparities would be expected to impact the entire state in terms of lower productivity, lower quality of life, and lower life expectancy.[58]

[57] African American community response to the State of Equity Report Phase 1: http://www.oregon.gov/oha/oei/Documents/soe_comm_response_AA.pdf

[58] See Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2011.* Available at: www.cdc.gov/mmwr/pdf/other/su6001.pdf

OHA has taken concrete steps toward promoting health equity since the Phase 1 Report.[59] This includes the creation of a Quarterly Performance Management system that tracks mechanisms for process and outcome measures, with a focus on health equity. OHA is also investing in diversity and inclusion practices to ensure that Oregon is reflective of the state's increasing diversity. There is also significant support for the Community Care Organizations (CCOs) to build health equity and cultural competence into their Health Systems Transformation Plans.

For OHA, the findings in this report are a critical reminder that true transformation is required to assure that all staff in the agency, community partners, contractors, and stakeholders, and all phases of our work must actively align with our values of health equity.

DHS Agency Response

In response to the findings of the State of Equity Report, DHS is committed to upholding our agency objectives while remaining focused on outcomes both short-term and long-term. The need for access to quality and equitable service is at the forefront of our planning for the future state of our agency.

Disparities shown in previous findings are being used for policy and program development as a baseline for future planning. Areas such as Child Welfare and Aging and People with Disabilities have developed inclusive initiatives prioritizing culturally specific services. While findings within other agency programs show definitive disparities, it is clear further analysis is needed in order to support agency objectives moving forward. Further demographic surveying, focus groups, research and outreach are tools being utilized to keep efforts focused on the largest disparity gaps and prioritize accordingly.

DHS is actively engaging community partners with outreach and education which include:

- Budget town hall forums to gather direct feedback from local communities;
- Ongoing meetings with community leaders and stakeholders;
- Participating in the community events.

We also continue to bring an inclusive focus to our workforce by:

- Using internal initiatives such as P.A.U.S.E. (Pause, Ask Diversity, Understand, Strategize, Enact and Evaluate), taking equity to the forefront of each agency program
- Development of a Language Access policy, striving to bring equity to our delivery of services
- Participation in the statewide Diversity Conference and Diversity and Equity Committees
- Assessing and reviewing all available data related to the workforce and contracted providers serving communities to identify gaps and disparities
- Conducting recruitment and training to staff with intentional efforts toward improving culturally appropriate services

As an agency we have included "service equity" as one of our core values and have prioritized the improvement of service equity as a breakthrough initiative. We continue these engagement and education efforts to better serve our communities and clients, engage our employees and inform our partners while strategically planning for the future.

[59] Oregon Health Authority progress since Phase 1: http://www.oregon.gov/oha/oei/Documents/soe_OHA_progress.pdf

Limitations

The analyses and interpretation of the Phase 2 indicators by race and ethnicity are subject to limitations. The report focused on disparities for communities of color, yet in several instances, some communities of color seem to be experiencing better outcomes than non-Latino Whites. As noted in the Disparities at a Glance table on pages 4 – 6, Asian Americans and Latinos appear to have overall better outcomes in a few areas. Specifically, compared to non-Latino Whites, Latinos and Asian Americans in Oregon have a higher utilization rate of preventative services for children on the Oregon Health Plan; have higher immunization rates for 2-year olds; are less likely to smoke cigarettes; have lower rates of ambulatory care sensitive condition hospitalizations; and have fewer years of potential life lost before the age of 75. However, there may be disparities for some specific communities within these broad racial and ethnic categories. For example, based on data from other sources, cigarette smoking prevalence may be very high among some Asian American sub-populations, especially among males.

While DHS and OHA racial and ethnic data appear consistent with the Office of Management and Budget (OMB) guidelines, variability exists in how racial and ethnic data are collected and reported across divisions and offices. Also, the ability of these broad racial and ethnic categories to identify health and human service disparities in diverse communities is subject to limitations. For example, the racial category of "Black or African American" does not distinguish between an African American with roots in the U.S. dating back hundreds of years and a recent refugee from Africa. Due to this inherent limitation, findings on racial and ethnic disparities, or lack thereof, should be interpreted with caution. Increasing awareness of possible hidden disparities in smaller communities (Pacific Islanders, African immigrants and refugees, Eastern European immigrants and refugees) whose unique health status has been overshadowed by larger and distinct communities has created a mandate for better data and thoughtful, intentional relationships with a more diverse array of partners and individuals.

In addition, the use of non-Latino Whites as the comparison population is subject to limitation. While non-Latino Whites are less likely to experience discrimination based on race, and using this population as the reference population makes statistical sense,[60] other populations may be an equally appropriate comparison for some indicators. For example, if a community of color has a better rate than non-Latino Whites for a given indicator, using that "best" community as the comparison population could produce different findings of disparity. Likewise, when divisions and offices chose a comparison population other than non-Latino Whites to identify disparities, their findings may have differed if non-Latino Whites were instead used as the comparison population.

Finally, we caution the reader around interpreting the need for DHS and OHA services using the denominators displayed for each indicator in Appendix III. Several of the indicators are based on survey data making direct interpretation of need for or access to services impossible. For indicators based on client data, the denominators represent the number of clients served, but do not represent the number of people who may need the service. For example, only 35 American Indian / Alaska Native Oregonians applied for the Family Health Insurance Assistance Program (FHIAP) in 2010, but many more may have needed the service.

[60] See Centers for Disease Control and Prevention, *Methodological Issues in Measuring Health Disparities*. Available at: http://stacks.cdc.gov/view/cdc/6654/

Next Steps for the State of Equity Report

During Phase 2, staff from DHS and OHA and community partners mentioned interest in better understanding the need for and access to services and programs. Given this, in Phase 3, we will work with DHS and OHA divisions to update the indicators in this report, as well as adding indicators related to need and access. The identification of racial and ethnic disparities in need for and access to services and programs will help divisions identify unmet needs and may be useful to secure additional funding to meet those needs.

DHS and OHA will continue to engage communities in understanding and directing this report. Specifically, we will expand the DHS and OHA REAL Data Leadership Workgroup to include diverse community and academic/research community representation. This collaborative effort will inform the development of Phase 3 of the State of Equity Report – as well as informing other equity-focused data analytics efforts. In addition, the REAL Data Leadership Workgroup will continue to work with others in DHS and OHA to implement the policy on the collection of race, ethnicity, and language data to improve data quality.[61]

Using this comprehensive approach, DHS and OHA continue to make important advancements toward having sufficient data available on communities of color to support the state in developing appropriate funding, determining level of priority in decision making processes, and eliminating health and human services disparities in Oregon.

[61] Available at: http://www.oregon.gov/oha/oei/Documents/REAL_Data_Collection_Policy.pdf

APPENDIX I: TECHNICAL NOTES

1. Racial and Ethnic Categories

OMB guidelines indicate that data should be collected for ethnicity (Hispanic/Latino) separately from race and that five race categories should be used. We asked divisions and offices to report these racial and ethnic data to us in a way similar to the Department of Education standards.[62] Specifically, we asked for data to be placed in the following racial and ethnic categories:

- Hispanic/Latino;
- Non-Latino Black/African American;
- Non-Latino American Indian / Alaska Native;
- Non-Latino Asian American;
- Non-Latino Pacific Islander;
- Non-Latino White;
- Non-Latino Other;
- Unknown/Missing.

These categories are mutually exclusive. For example, if a person identifies as Hispanic/Latino, they are in the "Hispanic/Latino" category and not in any other racial and ethnic categories. If a person reports more than one race, his/her race is determined by the race the person says best represents him/her ("primary race").

Multiracial category:

- Some data systems do not collect “primary race.” For those systems we have a category “multiracial,” which would include all persons who identify with more than one race. If someone identifies as “American Indian / Alaska Native” and “White,” they are in the “multiracial” category; they are not in the “American Indian / Alaska Native” or “White” categories.
- For data systems that determine primary race, the “multiracial” category is marked as “not available.”
- Data systems that combine more than one racial or ethnic category into a single value, such as Asian/Pacific Islander, are indicated by a crosshatch pattern across those categories in the Appendix III table. These are not included in the “multiracial” category.

Some divisions and offices are not able to report the data in the requested racial and ethnic categories. For example, some data systems did not allow for the creation of non-Latino race categories because information on the race and ethnicity for a given person could not be linked. Those are footnoted in Appendix III data tables.

2. Confidence Interval/Sample Size

When indicators are based on survey data, we provide a 95% confidence interval, when available, so one can get a sense of the instability (uncertainty) of the estimates. Survey data are obtained by randomly selecting a sample of people from a population, and we do not know for sure how representative any given sample is of the larger population. If we were to repeat the survey and randomly select a different sample from the same population, our survey estimates would likely be different. A bigger sample yields more

[62] http://nces.ed.gov/statprog/2002/std1_5.asp

stable survey estimates. The 95% confidence interval provides a range of values to give a sense of the stability of an estimate: there is a 95% chance that this range includes the true underlying population value. When the 95% confidence intervals were not available, we indicate the sample size the estimate is based on (n).

When the indicators are based on client, clinical or census data, we indicate the number of people the indicator is based on (N), when available, so one can get a sense of how unstable this measure might be over time. For instance, if "satisfaction" is based on 55 clients, a few clients changing their answer could have a fairly large impact on the result: e.g., 10/55 = 18% satisfied vs. 13/55 = 24% satisfied.

When the indicator is a population-based rate, denominators are the total population in Oregon so the denominators are not provided.

3. Suppression of Data

For indicators that are rates: indicators that are based on fewer than five events are suppressed because they are considered unreliable.

For other types of indicators (e.g., percentages): indicators that are based on fewer than 50 clients or survey respondents are suppressed because they are considered unreliable.

In the future, divisions and offices will avoid using indicators that are based on fewer than 50 clients or survey respondents in any one racial or ethnic category.

APPENDIX II: DHS AND OHA VISION, MISSION, GOALS AND ORGANIZATIONAL CHARTS

Department of Human Services

The Department of Human Services (DHS) is about safety, health and independence for all Oregonians. We help Oregonians in their own communities achieve well-being and independence through opportunities that protect, empower, respect choice and preserve dignity. We protect children who are abused or neglected. We serve seniors and people with disabilities. We help low-income people along the road to self-sufficiency with health coverage, job preparation, childcare and other supports.

Our services are delivered in the least restrictive setting and in partnership with communities. We are absolutely committed to ongoing innovation in the delivery of services, and we are committed to recruiting, developing and retaining dedicated employees.

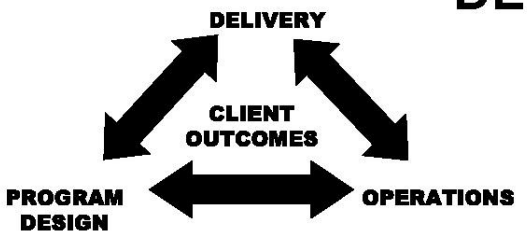
Vision
Safety, health and independence for all Oregonians.

Mission
To help Oregonians in their own communities achieve well-being and independence through opportunities that protect, empower, respect choice and preserve dignity.

Goals

- People are safe and living as independently as possible.
- People are able to support themselves and their families through stable, living-wage employment.
- Children and youth are safe, well and connected to their families, communities and cultural identities.
- Choices made by seniors and people with disabilities about their own lives are honored.
- Partners, clients and stakeholders are actively engaged in a variety of collaborative and meaningful ways.
- The department is committed to equal access, service excellence and equity for all Oregonians.

DEPARTMENT OF HUMAN SERVICES



DIRECTOR
Erinn Kelley-Siel

Community Engagement – Margaret Carter
Equity/Multi-cultural Services – Gloria Anderson
Tribal Affairs – Rick Acevado
Medical Director – Tina Kitchin

DELIVERY

- Brokerages (13)
- Community DD Programs (28)
- State Operated Care Program Homes (27)
- Local APD Offices (34)
- Area Agencies on Aging (17)
- Disability Determination
- Adoption Assistance
- Local Self Sufficiency Offices (74)
- Local Child Welfare Offices (45)
- Vocational Rehabilitation Offices (34)

PROGRAM DESIGN

Developmental Disabilities
Mike Maley (interim d)/
Trisha Baxter

District Offices (12)

Aging & People with Disabilities
Mike McCormick (d)
Trisha Baxter

Child Welfare
Lois Day/
Jerry Waybrant

District Offices (16)

Self Sufficiency
Carol Lamon (d)
Jerry Waybrant

Vocational Rehabilitation
Stephaine Taylor

OPERATIONS

Finance
Eric Moore
- Budget Center*
- Forecasting*
- Financial Services*

Human Resources
Carolyn Ross
- Human Resources Center*

Communications
Gene Evans
- Publications & Distribution*
- Forms*

Legislative Client Relations
Mickey Serice
- Legal/Rules
- Governor's Advocacy Office*

Chief Operating Officer
Jim Scherzinger

Internal Audit*

Business Intelligence
Angela Long

IT Business Supports
TBA

Licensing & Regulatory Oversight
Donna Keddy

Adult Abuse Prevention & Investigations*
Marie Cervantes

Continuous Improvement
Christy Williams
Focus on DHS

Performance Excellence*
Wes Charley

Deputy
Jeremy Emerson
Shared Services Liaison*
- Procurement*
- Imaging & Records Mgt.*
- Facilities*

Program Integrity
Chuck Hibner
- Office of Payment Accuracy & Recovery*

April, 2012

** = Shared service provided to DHS and OHA*

Oregon Health Authority

The Oregon Health Authority (OHA) is dedicated to better care, better health and lower health care costs for all Oregonians. OHA programs touch the lives of every Oregonian.

OHA and its divisions support programs to increase healthy lifestyles and improve the lifelong health of Oregonians through education, coordinated prevention, treatment and support for the management of both physical and mental health needs. With data from the many research areas of the agency, including the Office of Health Policy and Research, OHA is the leader in health care reform. OHA spearheads the effort to bring many programs and services together to provide the right care, in the right place, at the right time.

Through its Medical Assistance Programs, OHA is responsible for the physical and mental health care services provided to more than 800,000 Oregonians through the administration and management of the Oregon Health Plan, Healthy Kids, Oregon Medical Insurance Pool, Family Health Insurance Assistance Program, Public Employees' Benefit Board and Oregon Educators Benefit Board.

The Addictions and Mental Health (AMH) Division provides access to health, mental health and addiction services. Through the Oregon State Hospital, the division provides residential mental health treatment services to individuals whose care has been committed to the state through civil commitment or the Psychiatric Security Review Board.

The agency's Public Health Division protects residents and visitors to the state against safety threats from the contamination of food, drinking water and disease, as well as environmental threats. Public Health also is responsible for overseeing prevention and emergency services programs.

Working together, the programs in the Oregon Health Authority strive to achieve the agency's vision for Oregonians.

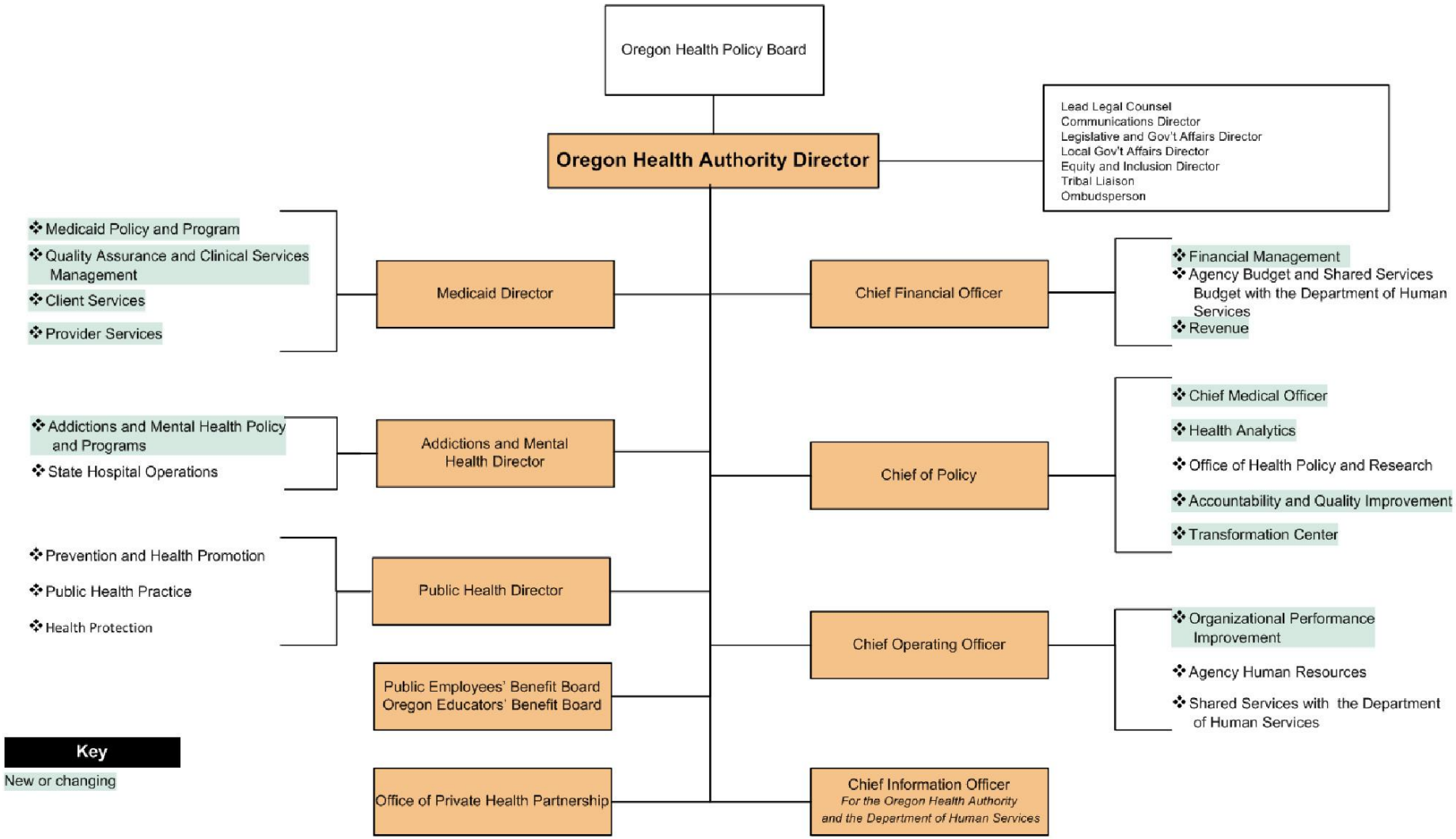
Vision
A healthy Oregon.

Mission
Helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality, affordable health care.

Goals

- Improve the lifelong health of all Oregonians.
- Increase the quality, reliability and availability of care for all Oregonians.
- Lower or contain the cost of care so it is affordable to everyone.

Oregon Health Authority



APPENDIX III: DATA TABLES

Section	Indicator		Year	Hispanic/ Latino	Non-Latino African American	Non-Latino AI/AN	Non-Latino Asian American	Non-Latino Pacific Islander	Non-Latino Multiracial	Non-Latino Other	Unknown/ Missing	Non-Latino White
APD & DD	APD & DD Clients Served (n = 138,336) Compared to the Adult General Population (N = 3,831,074)*	Clients	2010	5.5%	3.8%	1.8%	4.6%	0.2%	0.4%	Not Available	Not Available	83.5%
		Population		11.8%	1.8%	1.4%	3.7%	0.4%	3.8%			83.7%
	APD Staffing Levels (n = 2,291) Compared to Clients Served (N = 138,714)*	Staff	2010	6.9%	2.9%	1.8%	4.3%	0.0%	0.3%	Not Available	0.1%	83.7%
		Clients		5.5%	3.7%	1.7%	4.5%	0.2%	0.3%		1.7%	82.2%
	Distribution of APD Clients in Specific Long-Term Care Settings*: In-Home = 12,221, Community Based Facilities (CBF) = 11,750, Nursing Facilities = 4,690	In-Home	2010	53.4%	65.4%	56.0%	47.5%	52.6%	69.1%	Not Available	46.0%	41.2%
		CBF		34.7%	19.8%	31.9%	42.5%	33.3%	21.4%		38.7%	42.0%
		Nursing		11.9%	14.8%	12.1%	10.0%	14.0%	9.5%		15.4%	16.8%
	Distribution of Clients Among Those in Developmental Disability Residential Settings*	In Home	2010	89.3%	65.5%	59.0%	81.7%	†	54.5%	Not Available	93.2%	65.7%
		Out of Home		10.8%	34.5%	41.1%	18.4%	†	45.5%		6.8%	34.3%
				N = 1340	N = 632	N = 285	N = 387	N = 40	N = 178		N = 1966	N = 14,233
CW	Foster Care Entrants by Race Ratio to General Child Population		FFY 2010	0.7 N = 670	1.6 N = 266	3.3 N = 241	0.3 N = 70		Not Available	Not Available	Not Available	0.9 N = 3,117
	Foster Care Exits by Race Ratio to General Child Population		FFY 2010	0.8 N = 676	2.2 N = 315	4.2 N = 277	0.3 N = 56		Not Available	Not Available	Not Available	0.9 N = 2,656
SS	Ratio of children entering foster care who had received TANF within the prior 60 days to all children and youth receiving TANF		FFY 2010	0.6	0.8	2.7	†	†	Not Available	Not Available	Not Available	1.3
	Ratio of children entering foster care who had received TANF within the prior 60 days to all children and youth entering foster care		FFY 2010	1.2	1.5	1.0	†	†	Not Available	Not Available	Not Available	1.0
	Denominator data 1: Children entering foster care who had received TANF within the prior 60 days		FFY 2010	16.3%	8.3%	6.1%	†	†	Not Available	Not Available	Not Available	61.9%
	Denominator data 2: All children and youth entering foster care		FFY 2010	14.0%	5.5%	6.4%	1.5%	†	Not Available	Not Available	Not Available	64.9%
	Denominator data 3: All children and youth receiving TANF		FFY 2010	28.1%	11.0%	2.3%	1.7%	0.6%	Not Available	Not Available	Not Available	49.0%

* = Each race category includes Hispanic/Latino for this indicator
** = Age-adjusted
† = Data suppressed

Note: Values combined across two or more racial/ethnic groups are indicated by a grid pattern.

Section	Indicator		Year	Hispanic/ Latino	Non-Latino African American	Non-Latino AI/AN	Non-Latino Asian American	Non-Latino Pacific Islander	Non-Latino Multiracial	Non-Latino Other	Unknown/ Missing	Non-Latino White
OVRS	Percentage of Vocational Rehabilitation Clients Who Achieved Desired Employment Outcome (OVRS)		FFY 2010	42.0% N = 170	30.0% N = 92	† N = 47	† N = 29	† N = 19	31.9% N = 69	Not Available	Not Available	47.4% N = 2,156
AMH	Percentage of clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD		2010	63.0% N = 1,574	40.4% N = 547	42.5% N = 712	59.9% N = 154	61.2% N = 115	Not Available	53.7% N = 245	Not Available	54.1% N = 12,870
			2011	62.4% N = 1,499	43.7% N = 479	37.7% N = 595	65.0% N = 193	63.4% N = 116	Not Available	52.0% N = 255	Not Available	54.7% N = 12,455
			2012	62.4% N = 1,209	44.6% N = 416	42.5% N = 612	67.8% N = 158	64.4% N = 114	Not Available	51.7% N = 234	Not Available	55.8% N = 10,445
	Percentage of adults receiving mental health services on Medicaid dollars who report improved functional outcomes as a result of those services*		2010	67.0% N = 225	59.0% N = 176	50.0% N = 114	63.0% N = 222	† N = 11	52.0% N = 239	59.0% N = 134	Not Available	57.0% N = 2,177
			2011	56.0% N = 251	69.0% N = 87	59.0% N = 91	54.0% N = 114	† N = 14	54.0% N = 229	55.0% N = 118	Not Available	56.0% N = 2,563
	Oregon State Hospital forensic Psychiatric Security Review Board (PSRB) commitments compared to the adult population in community mental health services and to the general adult population of Oregon	PSRB	2008 - 2010	7.6%	6.8%	3.1%	2.9%		Not Available	0.0%	0.0%	79.7%
				I---------- Average Daily Population (ADP) n = 365 ----------I								
		Adult Community		5.9%	4.8%	2.6%	2.7%		Not Available	Not Available	Not Available	84.1%
				I---------- N = 73,071 ----------I								
		Adult OR. Population		11.4%	1.8%	1.3%	3.2%		Not Available	Not Available	Not Available	82.4%
				I---------- N = 2,906,711 ----------I								
DMAP	Utilization Rate of Preventive Services for Children Birth Through 10 Years Old Covered by OHP (per person year)		2009	4.98 P yrs. = 58,169	4.01 P yrs. = 7,370	3.01 P yrs. = 3,146	4.93 P yrs. = 3,298	4.70 P yrs. = 832	Not Available	Not Available	Not Available	4.21 P yrs. = 88,273
	Utilization Rate of Preventive Services for Youth and Adults 11 Years Old and Older Covered by OHP (per person year)		2009	1.22 P yrs. = 33,606	1.28 P yrs. = 12,694	0.94 P yrs. = 5,955	1.31 P yrs. = 8,940	0.80 P yrs. = 649	Not Available	Not Available	Not Available	0.91 P yrs. = 188,801
	Rate of Ambulatory Care Sensitive Condition Hospitalizations (Preventive Quality Indicators, PQI) of OHP Clients		2009	1,287 P yrs. = 15,310	3,172 P yrs. = 8,858	3,453 P yrs. = 4,159	1,885 P yrs. = 7,479	2,789 P yrs. = 430	Not Available	Not Available	Not Available	2,789 P yrs. = 154,447

* = Each race category includes Hispanic/Latino for this indicator
** = Age-adjusted
† = Data suppressed

Note: Values combined across two or more racial/ethnic groups are indicated by a grid pattern.

Section	Indicator		Year	Hispanic/ Latino	Non-Latino African American	Non-Latino AI/AN	Non-Latino Asian American	Non-Latino Pacific Islander	Non-Latino Multiracial	Non-Latino Other	Unknown/ Missing	Non-Latino White
OHPR	Percentage of Uninsured Oregonians Ages 0 - 18		2011	9.8% CI: (7.0 - 12.6)	4.4% CI: (0.5 - 8.3)	19.1% CI: (7.3 - 30.9)	6.6% CI: (3.2 - 10.0)		5.8% CI: (3.0 - 8.6)	† N = 15	Not Available	6.4% CI: (5.1 - 7.7)
OHPR	Percentage of Uninsured Oregonians Ages 19 - 64		2011	44.8% CI: (40.9 - 48.6)	26.0% CI: (18.6 - 33.4)	31.1% CI: (23.6 - 38.7)	23.1% CI: (18.9 - 27.3)		20.4% CI: (15.6 - 25.1)	† N = 27	Not Available	18.8% CI: (17.9 - 19.7)
OHPR	Diversity of Healthcare Workforce in Select Fields (n = 75,463) vs. Oregon Adult Population (N = 2,964,621)	Healthcare workforce	2010	3.4%	2.1%	0.9%	5.2%		2.2%		Not Available	86.3%
OHPR		Oregon population		9.1%	1.6%	1.1%	4.0%		2.1%		Not Available	82.1%
PHD	Rates of Domestic Violence	Before pregnancy	2010	3.6% CI: (2.2 - 5.8)	9.3% CI: (5.5 - 15.5)	10.4% CI: (5.6 - 18.2)	0.9% CI: (0.2 - 3.4)	1.8% CI: (0.3 - 11.8)	4.1% CI: (2.2 - 7.4)	Not Available	Not Available	2.6% CI: (1.4 - 4.7)
PHD		During pregnancy		3.0% CI: (1.8 - 5.2)	4.3% CI: (1.9 - 9.3)	8.2% CI: (4.1 - 15.6)	0.8% CI: (0.2 - 3.3)	0.0% Not Available	3.4% CI: (1.7 - 6.6)	Not Available	Not Available	2.2% CI: (1.2 - 4.3)
PHD	First Trimester Initiation of Prenatal Care		2009	62.3% CI: (60.8 - 63.9)	63.4% CI: (58.4 - 68.7)	60.0% CI: (54.0 - 66.5)	71.7% CI: (68.4 - 75.2)		66.8% CI: (62.2 - 71.7)	Not Available	Not Available	74.5% CI: (73.6 - 75.5)
PHD	Low Birth Weight Births		2009	6.2% CI: (5.7 - 6.7)	11.1% CI: (9.1 - 13.4)	6.7% CI: (4.8 - 9.1)	7.4% CI: (6.3 - 8.5)		6.4% CI: (5.1 - 8.0)	Not Available	Not Available	6.1% CI: (5.8 - 6.4)
PHD	Immunization rates for 2 Year Olds*		2010	80.0% CI: (79.4 - 80.6)	74.0% CI: (71.3 - 76.7)	72.0% CI: (69.7 - 74.3)	76.3% CI: (74.5 - 78.1)	61.3% CI: (55.9 - 66.7)	Not Available	Not Available	Not Available	72.5% CI: (72.0 - 73.0)
PHD	Teen Pregnancy Rate (per 1,000 15 - 17 year old females)		2009	53.7 CI: (49.5 - 58.3)	34.1 CI: (27.0 - 42.5)	37.8 CI: (27.7 - 50.4)	8.6 CI: (5.7 - 12.4)		Not Available	Not Available	Not Available	16.8 CI: (15.7 - 17.9)
PHD	Rate of New HIV/AIDS Diagnosis (per 100,000)		2009-2010	9.8 CI: (7.8 - 12.1)	17.5 CI: (9.7 - 20.8)	4.7 CI: (0.8 - 5.9)	4.2 CI: (3.8 - 11.8)		Not Available	Not Available	Not Available	5.4 CI: (4.9 - 6.1)
PHD	Cigarette Smoking Among Adults**		2004-2005	14.0% CI: (11.4 - 17.2)	29.9% CI: (22.9 - 37.9)	38.3% CI: (32.2 - 44.8)	9.8% CI: (6.9 - 13.6)		Not Available	Not Available	Not Available	20.2% CI: (19.5 - 21.0)
PHD	Obesity Among Adults**		2004-2005	30.9% CI: (27.4 - 34.6)	28.7% CI: (22.5 - 35.8)	30.3% CI: (25.5 - 35.7)	14.7% CI: (10.6 - 20.0)		Not Available	Not Available	Not Available	24.2% CI: (23.4 - 24.9)
PHD	High Blood Pressure Prevalence Among Adults**		2004-2005	19.2% CI: (15.3 - 24.0)	41.4% CI: (32.6 - 50.9)	29.5% CI: (21.6 - 37.6)	18.9% CI: (13.2 - 26.4)		Not Available	Not Available	Not Available	25.3% CI: (24.3 - 26.3)

* = Each race category includes Hispanic/Latino for this indicator
** = Age-adjusted
† = Data suppressed

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Section	Indicator		Year	Hispanic/ Latino	Non-Latino African American	Non-Latino AI/AN	Non-Latino Asian American	Non-Latino Pacific Islander	Non-Latino Multiracial	Non-Latino Other	Unknown/ Missing	Non-Latino White
PHD Cont.	Female Breast Cancer Stage at Diagnosis for Age 50+	Early	2004-2008	67.3%	62.4%	62.5%	74.3%		Not Available	Not Available	80.5%	74.2%
		Late		32.7%	37.6%	37.5%	25.7%				19.5%	25.8%
		Late Stage CI listed		CI: (19.1 - 49.3)	CI: (21.8 - 61.6)	CI: (20.7 - 59.3)	CI: (15.0 - 42.1)				CI: (12.4 - 30.1)	CI: (24.1 - 27.5)
	Years of Potential Life Lost Before Age 75 per 100,000**		2009	3,988.5 CI: (3,914.9 - 4,062.1)	7,708.4 CI: (7,495.4 - 7,921.5)	8,659.5 CI: (8,404.3 - 8,914.8)	3,341.9 CI: (3,250.1 - 3,433.8)		Not Available	Not Available	Not Available	6,046.5 CI: (6,018.8 - 6,074.2)
	5-Year Average Homicide Rate per 100,000** *(Total population)*		2005-2009	3.49 CI: (2.73 - 4.76)	8.72 CI: (6.18 - 12.61)	4.72 CI: (2.73 - 8.82)	2.14 CI: (1.27 - 3.63)		Not Available	Not Available	Not Available	2.14 CI: (1.91 - 2.39)
OPHP	Approval Rate for Initial FHIAP Applications		2010	50.0% N = 198	58.0% N = 104	† N = 35	60.2% N = 181		60.7% N = 89	† N = 46	53.8% N = 65	63.2% N = 2,826
	Primary Reasons for Denying FHIAP Applications	Insufficient information	2010	14.4%	13.0%	10.3%	13.0%		Not Available	Not Available	Not Available	11.8%
		Income over limit		9.6%	1.9%	6.9%	7.5%					7.5%
		Plan failed benchmark		4.5%	1.0%	3.4%	1.2%					1.9%
		Group insurance unavailable		2.4%	1.4%	3.4%	2.4%					1.2%
	FHIAP Eligibility Redetermination Approval Rate		2010	87.6% N = 137	76.6% N = 64	† N = 30	86.8% N = 204		81.0% N = 63	† N = 38	88.2% N = 51	86.6% N = 3,109
	Rates at Which FHIAP Applications Are Pended		2010	59.9% N = 292	50.5% N = 208	51.7% N = 87	61.3% N = 253		62.7% N = 83	63.7% N = 190	51.8% N = 764	52.7% N = 5,362
	OMIP/FMIP Applications Approval Rate		2010	92.1% N = 164	89.8% N = 59	† N = 47	93.7% N = 127		Not Available	97.3% N = 75	86.4% N = 88	93.2% N = 3,654
	Average Number of Enrollment Days for Terminated Members		2010	845 N = 185	623 N = 109	711 N = 61	808 N = 246		1,275 N = 61	714 N = 1,070	Not Available	862 N = 5,605

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