



APPENDIX B

State Agency Presentation Matrix

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

Updated: July 12, 2000

State Agency	Questions #1: <i>Describe current agency programs & activities that support the priorities of the Task Force.</i>	Question #2: <i>Give an overview of the current and proposed biennial budget items that relate to Task Force priorities.</i>	Question #3: <i>Describe gaps and unmet needs your agency would like to address.</i>
<p>Department of Consumer & Business Services</p> <p><i>Insurance Pool Governing Board / Office of Medical Insurance Programs</i></p>	<p><u>Current Programs / Efforts</u></p> <ul style="list-style-type: none"> • Oregon Medical Insurance Pool (OMIP) and the Family Health Insurance Assistance Program (FHIAP), in many ways mirror the private insurance industry • OMIP & FHIAP support the work of the task force indirectly through access to health benefit coverage • Have targeted areas with high concentrations of minority populations and high rates of uninsurance for the first training sessions. • In April 1998, went to Hillsboro, NE Portland, and Woodburn, Hermiston, Medford, Klamath Falls, and Pendleton – this effort was to get people onto the program’s reservation list • This effort to reach racial and ethnic groups have worked to a degree • Have marketing materials in Spanish (reservation cards, posters, and table tents) that are free to stakeholders and community partners • Application and member handbook in Spanish • Have bilingual Spanish-speaking staff at the administrative offices 	<p><u>Budget / Funding</u></p> <p><i>OMIP</i></p> <ul style="list-style-type: none"> • OMIP is funded primarily through member premiums and through an assessment made on the insurance carriers and self-insured entities doing business in the State. • The program can absorb increases in enrollment due to enhanced outreach and marketing efforts to minority populations. <p><i>FHIAP</i></p> <ul style="list-style-type: none"> • FHIAP is funded by the tobacco tax passed by voters in November 1996. • Declining tobacco tax revenues will continue to put pressure on the program’s budget. • Also has a Legislatively Adopted Budget (LAB) that is \$3 million less than what the Governor requested in his budget for 1999-2001. <p><i>Overall</i></p> <ul style="list-style-type: none"> • Can serve between 5,250-5,350 people during current biennium 	<p><u>Gaps / Unmet Needs</u></p> <ul style="list-style-type: none"> • The uninsurance rate for racial/ethnic groups still considerably higher than that if the general Oregon population • Growing size of the FHIAP reservation list indicate an interest in the program, but there are budget limitations • There is a need to market importance of offering health insurance to small minority businesses • Have no contractual or statutory authority to demand that specific providers (clinics, doctors, hospitals, etc.) who serve racial/ethnic minorities be included on provider panels • Private insurance industry tends to lag behind government programs in its ability to offer information in languages other than English

	<ul style="list-style-type: none"> • Have ability to connect to translation services by phone when needed • FHIAP’s Agent Referral program allows potential applicants or members to request the services of a specially trained insurance agent to help them with both the FHIAP application and with selecting and purchasing a health insurance plan • 16 different languages are spoken by various agents in the Agent Referral Program <p><u>Additional Information:</u></p> <ul style="list-style-type: none"> • Since the March 28 meeting, FHIAP has experienced some major administrative changes • Starting June 15, 2000, the Insurance Pool Governing Board will begin taking over the operational functions of FHIAP from the Third Party Administrator. This phase will occur in phases over the next several months, and will be completed by December 1, 2000. • In process of designing data systems which will be used to administer the program, and many of the concerns of the Task Force have been incorporated into its design. After the new system has been in place for several months, we should be able to give the Task Force reliable and up-to-date data on the racial/ethnic makeup of the people on the reservation list and those who are members of the program. • Since the FHIAP program is now releasing a limited number of applications on a regular basis, it is appropriate for us to examine our marketing efforts to all targeted populations, including racial and ethnic minorities. Cheri Tebeau-Harrell is on a job rotation with the Insurance Pool Governing Board. She will help us to make stronger connections within the different racial/ethnic communities so that 	<p>Proposed Budget</p> <ul style="list-style-type: none"> • Intend to ask for additional funding during the 2001-2003 biennium 	
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	<p>we can develop communications and marketing strategies that will be meaningful to those communities.</p>		
<p>Department of Human Services</p> <p><i>Mental Health & Development Disability Services Division</i></p>	<p><u>Current Programs/Efforts</u></p> <ul style="list-style-type: none"> • Office of Mental Health Services' Planning and Management Advisory Council has membership representing Hispanic, African American and Native American communities • Collects info on racial/ethnic characteristics of all persons served in outpatient and inpatient programs. In FY 1994-95 through FY 97-98, report showed an increase of mental health services received by: Asians → 11.7%, African Americans → 11.8%, Hispanics → 17.6%, & Native Am. → 10.4% • Oregon Health Plan Mental Health Organizations report in 1999: Asians, African Americans, and Native Americans are served in approx. the same proportion as they are represented in the Medicaid-enrolled population of which they are a part of • 1999 Office Mental Health Services survey determined that there were 6 community mental health programs who were offering targeted programs for racial/ethnic groups: Malheur Co. (serving 152 Hispanics); Multnomah Co. (with 6 different programs serving a total of 869 Hispanic, Vietnamese, Laotian, Cambodian, Mien, Russian, Chinese, and African Americans); Polk Co. (serving 25 Hispanics); Umatilla Co. (serving 172 Hispanics); Washington Co. (serving 200 Hispanics); and Confederated Tribes of Warm Springs (serving 388 Native Americans) • Involved in statewide trainings with cultural competency component for: Office of Mental 	<p><u>Funding / Budget</u></p> <ul style="list-style-type: none"> • Will continue to take an integrated approach to budget development, but will remain close to monitoring of contracts which require culturally competent services to members of racial/ethnic groups • Legislative concept: to amend the Local Mental Health Act to make state funds available to any federally recognized tribe wanting to offer community-based mental health services • Oregon Federal Block Grant Application targeted an increase in the number of Hispanic children, youth, and adults served in the public mental health system • DHS Dual Diagnosis Task Force contains a series of recommendations related to a finding of insufficient services which are culturally relevant for persons who have co-occurring disorders. The first of these recommendations is to transmit the report to the Racial and Ethnic Health Task Force and to request feedback and consultation. The two state offices are proceeding with an implementation plan for each of the recommendations in this section of the final report. • Identified cultural competence as a major training topic in our Office of 	<p><u>Gaps / Unmet Needs</u></p> <ul style="list-style-type: none"> • Continue efforts to improve the availability of culturally relevant mental health services to persons from diverse racial and ethnic groups • Assure the development of specialized programs for persons who require identifiable cultural approaches in the most acceptable settings

	<p>Health Services Successful Community Living Conference; DHS Diversity Conference; Oregon Office on Disability and Health Conference; National Association for Rural Mental Health 26th Annual Conference; and Oregon Rural Health Conference</p> <ul style="list-style-type: none"> • Organized and co-sponsored training for all mental health training staff in 1999-2001 biennium • Represented Division at the African American Hlth Coalition's Wellness Village • In past years, represented Division at the Multicultural Health Conference • Hiring more bilingual staff • Training staff to be more culturally competent • Increase the number of Hispanics to utilize services <p><u>Additional Information:</u></p> <ul style="list-style-type: none"> • In 1998-1999, 14.33% of all people served in one of the state hospitals were people of color: AAPI → 23 people; African American → 83 people; Latino → 54 people; Native American → 28 people; Unknown → 7 people; White → 1166 people • Community mental health services are provided in partnership and cooperation with 32 county-based community mental health programs. For the Oregon Health Plan, community managed care mental health services are also provided through 12 mental health organizations. • Working on developing a table, which would illustrate the enrollment of persons of color in each community mental health program. • Requesting info on cultural competency status from each community mental health program as a part of the 2001-2003 biennial implementation plans. • Will be actively engaging racial/ethnic health 	<p>Mental Health Services Training Plan 1999-2001. A major two-day conference on mental health and cultural competency is being planned for the Spring of 2001.</p>	<p><u>Additional Information:</u></p> <ul style="list-style-type: none"> • Plan to promote an increase in the number of mental health professionals of color. The DHS Dual Diagnosis Task Force report makes recommendations in this area which the Office of Mental Health Services and the Office of Alcohol and Drug Abuse Programs are now developing specific plans to implement • Will also be continuing its discussion with leadership in higher education training programs to promote the issues regarding increasing the number of mental health professionals of color. • Federal funds were used in the late 1980's under the Human Resource Development Grant administered through the National Institute of Mental Health. The Division worked collaboratively with OHSU and PSU to develop stipends for students of color specializing in studies related to mental
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	<p>advocates in the promotion and delivery of the Spring 2001 major conference on cultural competence in mental health programs.</p>		<p>health services. Unfortunately, funding for that program was eliminated in the early 1990's and no targeted resources have been available since.</p> <ul style="list-style-type: none"> • <u>Example:</u> increased outreach to members of racial and ethnic groups in high schools, community colleges and other colleges is one area of need. • Persons from the Hispanic community are underserved in many Oregon programs for a variety of reasons: lack of bilingual / bicultural staff; programs serving these communities not well-publicized; many programs which are available need to adapt themselves more to the cultural needs of Hispanic persons and cultures. The Division plans to make this a special focus of MHO reviews in the next 12 months.
<p>Department of Human Services</p> <p><i>Office of Alcohol and Drug Abuse Programs (OADAP)</i></p>	<p><u>Current Programs/Efforts</u></p> <ul style="list-style-type: none"> • Beer and Wine Tax • OARs 415-510-090 • Certified Intensive Residential Treatment • Residential Treatment • Outpatient Treatment • DUII Programs • Or. State Incentive Cooperation Agreement • Oregon Together! Communities That Care • Integrated effort with Addiction Certification Board of Oregon • Collaborated efforts with Portland Community College • Entry Level Certification Program • OADAP Annual Treatment Conference • Support development of African American training/advocacy consortium • Review NARA's proposal for Native American Internship program • Working with Chemeketa Community College and Mid Valley Behavioral Care 	<p><u>Funding / Budget</u></p> <p><u>Current Budget</u></p> <ul style="list-style-type: none"> • <u>Treatment programs with ethnic/minority focus:</u> currently funds outpatient, residential and DUII programs for minority populations in 17 counties, approx. \$1 million not including fee for service payments for DUII and OHP clients. • <u>SICA Tribal dollars:</u> \$50,000 annually to nine recognized tribes and 36 counties in Oregon for alcohol and drug prevention planning. • <u>Prevention Programs with Ethnic/Minority Focus:</u> Oregon Together Communities receive between \$5,000 – \$10,000 to implement prevention programs. 	<p><u>Gaps / Unmet Needs</u></p> <ul style="list-style-type: none"> • Availability of programs for racial/ethnic minorities • Research-based and culturally competent treatment approaches • Recruiting and retaining qualified professionals and leaders into the workforce • Raising awareness about alcohol and drug issues in minority communities; appropriate materials for education

	<p>Network to develop Latino scholarship programs and develop plan</p> <ul style="list-style-type: none"> • PCC minority scholarships • CCC plans for Latino scholarships and CEU gambling course • MHCC CEU's in Dual Diagnosis • OHD cross training focus HIV/Hepatitis C • SCF and other DHS Divisions cross training on confidentiality and best practices, shared values, and case management • DHS Training Project <p><u>Additional Information:</u></p> <ul style="list-style-type: none"> • 39 programs throughout the state have received certification to provide services to people of color. These include 26 programs for Hispanics, 7 for African Americans, and 6 for Native Americans. These programs demonstrate that they meet the following: 1) staff is qualified to work with the target populations including possession of bilingual skills when appropriate; 2) program must provide language appropriate when written; 3) program must establish an advisory committee that is representative of the target population; 4) the office environment must be appropriate to the target population. ODAP requires counselors to complete a 4-day course on cultural competency in order to receive Entry Level Counseling Program (ELCP) certificates. 	<p><i>Proposed Budget</i></p> <ul style="list-style-type: none"> • Continue current funding • Consider more workforce development by funding: college tuition, mentoring projects, clinical supervision at various agencies • Continue treatment and prevention services expansion . <p><u>Additional Information:</u></p> <ul style="list-style-type: none"> • Spending \$10 million in regard to racial/ethnic communities: Treatment Enhancements → \$6.25 million; Safe, Drug-Free Housing → \$2 million; Community Prevention → \$1 million; Training & Accountability → \$0.75 million • As part of the county/tribal grants process, OADAP awarded approx. \$800,000 for programs aimed at ethnic minority populations • As part of a community grants process, OADAP awarded to three counties (Washington, Lane, and Marion) and the Cow Creek Tribe to develop and implement multicultural parent training programs. 	
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<p>Department of Human Services</p> <p><i>Office of Medical Assistance Programs (OMAP)</i></p>	<p><u>Current Programs / Efforts</u></p> <p><i>Adequate Access:</i></p> <ul style="list-style-type: none"> • Rule requirements for culturally competent services OAR 410-141-0220 (7)(b-d) • Qualified interpreter services • Site review of plans by evaluation & analysis unit • 101 agreements with county health departments, hospitals, FQHCs, etc for outreach services (providing OHP applications and info about OHP) • Developed a draft “external diversity plan” <p><i>HIV/AIDS:</i></p> <ul style="list-style-type: none"> • OHD tracks prevalence through their surveillance system – OMAP has plans to study the proportion of HIV/AIDS pop. Covered by OHP and their demographics to assess program improvements needed <p><i>Diabetes:</i></p> <ul style="list-style-type: none"> • Participation in the Oregon Diabetes Coalition (ODC) • Working with OHD to identify clients w/ diabetes, utilization of care & episodes of care • Will use HEDIS measures on diabetes and will analyze finding by ethnic/racial group • Site reviews of managed care plans include review of policies, procedures, and description of processes to promote care for those with chronic conditions • Participant in a newly formed diabetes chronic disease project with DHS 	<p><u>Budget / Funding</u></p> <p>Total Amount Budgeted 1999-2001</p> <p><i>HIV/ AIDS:</i></p> <ul style="list-style-type: none"> • Amount budgeted per member per month = \$0.39 • <i>African American members</i> = \$152,889 • <i>Asian members</i> = \$95,573 • <i>Hispanic members</i> = \$402,149 • <i>Native American members</i> = \$66,506 <p><i>Diabetes:</i></p> <ul style="list-style-type: none"> • Amounts budgeted per member per month = \$14.71 • <i>African American members</i> = \$5,743,009 • <i>Asian members</i> = \$3,590,042 • <i>Hispanic members</i> = \$15,106,065 • <i>Native American members</i> = \$2,498,204 	<p><u>Gaps / Unmet Needs</u></p> <p><i>Adequate Access:</i></p> <ul style="list-style-type: none"> • Involvement of community groups to help identify medical providers that exist within the community that are competent and sensitive to cultural differences. • Incentives for providers that provide culturally competent translation services • With OHD, OMA, ODA, etc to help recruit providers from diverse backgrounds w/ a focus on cultural competency <p><i>HIV/AIDS:</i></p> <ul style="list-style-type: none"> • Studies of how to improve the linkages between OHD and OMAP related to data from OHD and claims from OMAP • Prevention programs in coordination with OHD, managed care plans, and community partners <p><i>Diabetes:</i></p> <ul style="list-style-type: none"> • Completion of ed. Materials to include a focus on ethnic/racial groups • Completion of study (Medicaid Assessment) using HEDIS measures that will analyze findings by ethnic/racial groups
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	<p>Asthma:</p> <ul style="list-style-type: none"> • OMAP support OHD’s successful application for a grant to study asthma w/ a commitment to provide access to claim and utilization reports • OHD hired staff and is in the process of identifying clients receiving asthma related services and will use claims and utilization reports from OMAP to identify gaps in service • Asthma report will include ethnic/racial groups’ assessments <p>Lead:</p> <ul style="list-style-type: none"> • OMAP involved with Multnomah County pilot (Mar99-Sept00) • Mandatory lead testing for children under age 6 in 21 zip codes in Multnomah County • Testing in physicians’ offices and community clinics and labs • Each of the managed care plans has appointed a “lead screening contact” person • Mandatory screening for OHP children in the state • Educational materials made available and widely distributed • Study to identify frequency and prevalence of elevated lead levels and demographic assessment of high-risk population • OMAP claims data will be matched with OHD lab results • Data will be used to establish protocols for future lead prevention programs within the state • Interim report due June 2000 w/ a report to Medical Directors in April and July 2000 • Final report in early 2001 	<p>Asthma:</p> <ul style="list-style-type: none"> • Amount budgeted per member per month = \$0.99 • <i>African American members</i> = \$386,990 • <i>Asian members</i> = \$241,913 • <i>Hispanic members</i> = \$1,017,916 • <i>Native American members</i> = \$168,340 <p>Prevention (e.g. Lead):</p> <ul style="list-style-type: none"> • Amount budgeted per member per month = \$1.27 • <i>African American members</i> = \$494,060 • <i>Asian members</i> = \$308,844 • <i>Hispanic members</i> = \$1,299,545 • <i>Native American members</i> = \$214,915 	<p>Asthma:</p> <ul style="list-style-type: none"> • Newly started program – finding expected within the next 6-9 months. <p>Lead:</p> <ul style="list-style-type: none"> • Need to develop a process that addresses statewide issues • Getting children from NE Portland neighborhood to doctor’s offices • Data collection efforts have not been as smooth as originally hoped • Matching children between systems is time consuming and problematic • Making parents and caretakers aware of importance of lead testing
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	<i>Alcohol and Drug</i>	<p><i>Chemical Dependency (does not include acute detox):</i></p> <ul style="list-style-type: none"> • Total OHP 1999-2001 Budget = \$39,155,859 • African American (4.46%) = \$1,746,351 • Asian (2.93%) = \$1,147,267 • Hispanic (11.73%) = \$4,592,982 • Native American (1.94%) = \$759,624 	<i>Alcohol and Drug</i>
<p>Department of Human Services</p> <p><i>Oregon Health Division (OHD)</i></p>	<p><u>Current Programs / Efforts</u></p> <p>DIABETES</p> <ul style="list-style-type: none"> • Increase the receipt of preventive services to all people with diabetes • Establish community-based educational programs for preventing complication of wellness programs for people with diabetes • Reduce disparities in high risk populations <p><u>Priorities for FY 2000-2001:</u></p> <ul style="list-style-type: none"> • In partnership with communities of color, design and conduct an assessment of: receipt of preventive services; financial and practical barriers to access to care; community capacity to develop population-based interventions • Create a clearinghouse of patient education and training resources to increase cultural competence among diabetes educators and either health care professionals • Leverage resources within Oregon Diabetes Coalition to improve the quality of life for people with diabetes in high-risk populations 	<p><u>Budget / Funding</u></p> <p>DIABETES</p> <ul style="list-style-type: none"> • There is no State general funds for diabetes • Oregon receives \$720,00/yr from Centers for Disease Control (CDC), Division of Diabetes Translation • Grant Cycle: 3 or 4 year cooperative agreement • Proportion allocated to Multicultural Activities = 15% • Estimated direct and indirect costs of diabetes in Oregon in 1996 = \$1.4 billion 	<p><u>Gaps / Unmet Needs</u></p> <p>DIABETES</p> <ul style="list-style-type: none"> • Collecting and using data for evaluation • Costs • Methods • Creating awareness that diabetes is serious, common, and costly • Creating awareness among high-risk populations that diabetes can be controlled through preventive health care about modifiable risk factors (e.g. diet and physical activity)

	<p>LEAD POISONING <u>Partnerships:</u></p> <ul style="list-style-type: none"> County Health Departments: on-site investigations, supplemented by OHD; Multnomah County screening program, community education and limited lead paint removal (Water Bureau) Physicians for Social Responsibility (PSR): free screening for children in NE Portland, OHD attained grant to support lab tests Urban League, Coalition of Black Men: community education, outreach <p>ASTHMA</p> <ul style="list-style-type: none"> Oregon Asthma Program This program started at OHD in January 2000 Capacity building Focused on improving care / removing triggers Goals: Build system to describe and monitor prevalence and asthma care; develop state-wide coalition and plan Multiple partners: managed care, community groups, OMAP, clinicians Planned special outreach to communities of color: faith communities, Native American governments, Environmental justice groups <p>HIV</p> <ul style="list-style-type: none"> HIV/AIDS monitoring Prevention: testing and risk reduction counseling; community education; MSM intervention; IDU outreach Clinical care services: ADAP; insurance continuation (Oregon Health Plan, Oregon Medical Insurance Program) 	<p>LEAD POISONING</p> <ul style="list-style-type: none"> No State general funds support CDC grant to track poisoning = \$80,000/yr Share expertise with County and community groups – Resource for questions about lead paint removal, certify contractors OMAP/OHD Multnomah County project – Goal is to establish prevalence in area of highest risk (older housing, poverty) <p>ASTHMA</p> <ul style="list-style-type: none"> Supported entirely by competitive CDC grant \$250,00/yr for 3 years (Oregon one of only 3 states funded) No State general funds 1996 cost estimate = \$14 billion (1-3% of all health care expenditures in US) <p>HIV</p> <ul style="list-style-type: none"> HIV/AIDS monitoring = \$268,000 HIV Prevention <ul style="list-style-type: none"> CDC Cooperative = \$2.6 mil State General Funds = \$1.2 mil HIV Care ADAP = \$3.1 mil Ryan White base = \$1.6 mil 	<p>LEAD POISONING</p> <ul style="list-style-type: none"> Controversial Universal screening – testing all kinds in age group CDC Guidelines say net cost-effective when prevalence <12% Targeted screening only good in theory No treatment to repair damage Prevention is key Controversy over screening has diverted attention from prevention Dollars spent on testing may mean less for prevention Lead-containing pottery and home remedies likely to be used by communities of color – need for culturally appropriate education <p>ASTHMA</p> <ul style="list-style-type: none"> Identification of representative for Coalition from communities of color Access to proper care and medications Culturally competent teaching and promotion of self-management Addressing environmental triggers (tobacco, air pollution) <p>HIV</p> <ul style="list-style-type: none"> There is a need for culturally competent providers to deliver medical, case management, prevention counseling and support services for persons of color. A critical need for populations that are non-English speaking. Increase recruitment for people of color into graduate public health programs
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	<ul style="list-style-type: none"> • Office of Multicultural Health Community Mobilization Project <p><u>Partnerships</u></p> <ul style="list-style-type: none"> • Multicultural HIV/AIDS Alliance of Oregon Health Division (MHAAO) • Brother to Brother • Urban League of Portland • Somos Orgullo Latino • Oregon Council for Hispanic Advancement • Project Red Talon (NW Area Indian Health Board) • Proyecto Promotores (Hispanic Lay Health Promotion) collaboration with Pacific AHEC <p><u>HIV Program Priorities</u></p> <ul style="list-style-type: none"> • HIV as a chronic disease • 100% access, 0% disparities for HIV care • Accurate reporting of the entire spectrum of HIV disease • Evidence based interventions addressing the behaviors of high risk populations • Focus on local program evaluation and quality assurance <p><u>Multicultural Priorities</u></p> <ul style="list-style-type: none"> • Assure representation for persons of color • Ongoing prevention and care services needs assessment, with over-sampling in communities of color • Empower racial/ethnic CBOs in HIV prevention programs • Assure access to care for HIV-positive persons of color through enhanced care coordination • Increase cultural and linguistically proficient HIV care and prevention services through MHAAO and AETC 	<ul style="list-style-type: none"> • State General Funds = \$50,000 • AETC = \$21,000 • OMH Project = \$150,000 (for 3yr) • Medical care = \$10,000/yr/case 	
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<p>Department of Administrative Services</p> <p><i>Oregon Health Plan Policy and Research (OHPPR)</i></p>	<p><u>Current Programs / Efforts</u></p> <ul style="list-style-type: none"> Charged with supporting the efforts of the Governor and Legislator to ensure that all Oregonians have access to affordable, quality health care Staffing commissions, councils, and task forces, including the Health Services Commission, the Health Resources Commission, the Oregon Health Council, the Oversight Task Force on Mental Health Integration, the Genetic Research Advisory Committee, the Advisory Committee on Physician credentialing, and the Racial and Ethnic Health Task Force 	<p><u>Budget / Funding</u></p> <ul style="list-style-type: none"> Policy/staffing = \$1,105,970 Data/research = \$468,898 Administration = \$373,227 TOTAL: \$1,948,095 <p><u>Sources of funding:</u></p> <ul style="list-style-type: none"> General Funds = \$912,491 State Agency Transfer = \$1,652,580 Grants = \$270,075 Other = \$60,247 TOTAL: \$2,895,393 	<p><u>Gaps / Unmet Needs</u></p> <ul style="list-style-type: none"> Continue efforts to improve the availability of relevant health data about minority populations in the state
<p>Department of Human Services</p> <p><i>Senior & Disabled Services Division (SDSD)</i></p>	<p><u>Current Programs / Efforts</u></p> <ul style="list-style-type: none"> Access to services: transportation, information and referral, counseling, long-term care Health Maintenance Services: nutrition screening, exercise/physical fitness, wellness education, medical equipment loans, Oregon Health Plan Nutrition Services: home delivered meals, food stamps, group meals Long-term Care Eligibility for OHP, long-term care, food stamps, Qualified Medicare Beneficiary program, Medical Needy drug benefits Licensing Protective Services / Risk Intervention Cash Assistance Older Americans Act Employment Initiative 	<p><u>Budget / Funding</u></p> <p><i>Program Budget 1999-2001</i></p> <ul style="list-style-type: none"> Long-term care = \$1,066.3 mil Cash Assistance = \$62.8 mil Older Amer. Act = \$24.6 mil Licensing = \$22.4 mil Protective/Abuse Services = \$16.2 mil FS, OHP, Medical Assistance = \$25.2 mil TOTAL: \$1,217.5 mil <p><i>Budget Allocation</i></p> <ul style="list-style-type: none"> Older Amer. Act = \$22.92 mil Cash to Clients = \$30.32 mil Staff, Rent, Supplies = \$223.94 mil Payments to Local Care Providers = \$940.33 mil TOTAL: \$1,217.51 mil <p><i>Sources of Money 1997-1999</i></p> <ul style="list-style-type: none"> Client Contribution = \$134.32 mil 	<p><u>Gaps / Unmet Needs</u></p> <ul style="list-style-type: none"> A need for targeted outreach to Ethnic and Racial minority client populations to inform them about available services and resources The need for outreach to families of ethnic and racial minorities to increase awareness and knowledge of long term care needs and services and how to plan for them. Inadequate recruitment of caregivers from diverse ethnic and racial minorities groups. Lack of training in cultural sensitivity and competency for caregivers providing services to ethnic and racial minorities. There is a lack of research-based culturally competent long-term care services approaches and designs.

	<p><u>Additional Information:</u></p> <ul style="list-style-type: none"> • Total number of minorities on staff: SDSD Central Office and Quality Assurance → 17 out of 207; SDSD Field Offices → 54 out of 397; Type B Contract Field Offices → 29 out of 234. • SDSD addresses cultural competence during many of its training modules, including training for eligibility workers, case managers, and protective service workers. The division also includes cultural competency as part of its training for adult foster home providers. One of the division's largest districts will pay for client-employed providers who wish to attend cultural competency training. • Examples of Cultural Competency: 1) handout used during new employee orientation; 2) handout that has been used during client assessment training for case managers; 3) handout used during training for staff who determine eligibility for food stamps. • SDSD has a Tribal Liaison who works with DHS Tribal Relations Liaison. Our Tribal Liaison is responsible for networking with Oregon's Native American tribes, which includes listening to concerns and issues and providing information about the services that SDSD provides. The Liaison also facilitates access to services by working with local offices and tribes to identify and resolve problems. 	<ul style="list-style-type: none"> • Other Funds = \$47.26 mil • General Funds = \$365.32 mil • Federal Funds = \$549.41 mil <p>TOTAL: \$1,096.31 mil</p>	
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**** This information was provided by State Agencies at the March 28, 2000 and June 9, 2000 Racial & Ethnic Health Task Force meetings.**