

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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