For there is another kind of violence, slower but just as deadly, destructive as the shot or the bomb in the night. This is the violence of institutions; indifference and inaction and slow decay. This is the violence that afflicts the poor, that poisons relations between men because their skin has different colors. This is a slow destruction of a child by hunger, and schools without books and homes without heat in the winter.

Robert Kennedy, April 5, 1968

Achieving Oregon's Promise – an equitable opportunity for every child, family, and community to succeed

Executive Roundtable for Healthcare and Education

Overall Concept

Achieving Oregon's Promise through:

- Addressing the conditions of poverty, injustice and systemic racism, alarmingly exacerbated by the Pandemic, that undermine success and lead to structural social inequities and health disparities and;
- Empowering and investing upstream in those most impacted by co-creating whole-person, community-based, culturally-specific integrated supports and services for children, families, communities, and our workforce by;
- Creating partnership between health, education and social service sectors, in collaboration with local community leadership and;
- Building and testing scalable, trauma-informed model systems with an asset-based approach to create conditions where all children, families and communities are afforded an equitable opportunity to succeed.

Executive Summary

Introduction

In 2019 Healthcare and Education leaders in the Portland metropolitan area got together to explore collaborative, innovative approaches to meeting the needs of the children and families we collectively serve. Initially designed as a table where the relationship between schools, payors, providers and the Coordinated Care Organization can be aligned, the COVID pandemic altered the immediate focus. We had early successes in working to improve dental care for children, collective education to align education priorities to CCO quality metrics, and a successful public campaign to support and recognize the work of educators during the pandemic. However, the pandemic significantly increased the level of stress on families, many of which were already struggling, and highlighted a collective recognition of the gaps in the behavioral healthcare system to serve Oregon's children. With a renewed focus on these issues at all levels of Government we pivoted our work to designing a long-term solution.

Our approach is not to create a new program, but a system redesign with children at the center. Recognizing that children exist in an ecosystem that includes their family and their community, our goal is to use a child-centered, family focused approach to ensure every child has an equitable opportunity to succeed. There are over 45,000 children born each year in Oregon, and we cannot afford to lose one.

Problem Statement

There is a strong correlation between the level of traumatic stress in childhood (Adverse Childhood Experiences – "ACEs") and poor physical, mental and behavioral outcomes later in life – including behavioral and learning problems, risky behavior, school failure, the early adult onset of chronic disease, mental illness, and subsequent involvement in the social support system and often in the criminal justice system, and early death.

The pandemic, one of the most traumatic events of our time, and the trauma of the Oregon wildfires have alarmingly exacerbated these existing challenges faced by our children, families and communities. A public recognition of the past and present systems of injustice and inequity highlighted in the wake of George Floyd's murder added additional Trauma to many of our children.

The Centers for Disease Control and Prevention reported that the number of mental health–related emergency department visits increased 24% among children aged five to 11 years and 31% among adolescents aged 12 to 17 years from January to October 2020, compared with the same period in 2019.

Our children and youth are in crisis coming out of the pandemic, which has highlighted problems that have been building for years. On top of these challenges the Oregon wildfires also traumatized many already experiencing the impacts of poverty and systemic racism across our state.

Proposed Solution

We are committed to successfully interrupt these existing realities by redesigning our system of supports and services to create a different future for our children. Children are resilient and a strengths-based rather than a deficit-based approach is critical to achieving our goal. Ensuring that every child has an equitable opportunity to succeed, involves breaking the generational cycle driven by the social, economic and health consequences of the ACEs. Breaking the generational cycle of the ACEs requires having in place an integrated, aligned and collaborative delivery system that can effectively and efficiently deliver treatments, supports, interventions, and other promotion / prevention strategies, universally, to every child and family in a way that is ethnically, culturally and linguistically appropriate.

A strong sense of common purpose, of shared mission is the one essential ingredient necessary to build community – and it is community that gives us the adhesiveness that holds us together and allows us to act in concert for the common good. Fortunately, we don't need to reinvent the wheel here. In many cases, we are doing the right things, but often not in a systematic and coordinated way that is aligned around a *clear*, common objective that puts children and their families at the center of our work and elevates their success above any individual program, agency, organization or institution.

We are committed to establish Child Success Delivery System Demonstration Models where the central partners will operate within a new shared governance compact which, in turn, will interface with all the agencies, programs, community-based organizations, foundations, institutions and service providers. The Demonstration Models will require additional funding even though many of the supports and services already exist.

Next Steps

The Executive Roundtable for Health and Education is proposing to initially stand up at least four scalable Child Success Delivery System Demonstration Models that seek to break the generational cycle of ACEs by addressing the sources of trauma and adverse experience, from the first thousand days of life, through the age of 5, with a warm hand off to our system of public education. It is important that each of these "pilot" Demonstration Models be built with a sense of "local ownership," and acknowledge and build upon current or past work happening in that region. During the first 1000 days most of the investments will be focused on health and social factors and, as the child grows older, more of the investment will move toward education. Throughout the cycle, the healthcare system must be an integral part of the work to support the effort.

We are confident funding will not be a barrier to enact such a compelling initiative – and it is imperative that we act on this now – our children can't wait!

Background and Current Landscape

The Executive Roundtable for Healthcare and Education

The Executive Roundtable for Healthcare and Education was co-convened by Eric Hunter, President and CEO of CareOregon and Bob Stewart, Superintendent, Gladstone Schools. [See Appendix for list of members] The overarching goal was to "explore collaborative, innovative approaches to meeting the *needs of the children and families* we collectively serve."

In his opening remarks at the first meeting on February 19, 2020, Eric Hunter expressed his commitment to "getting something done." This sentiment was echoed by Bob Stewart, who assured participants that there *would* be a product at the end of the discussions: "We don't know what that is yet, but these meetings are not just about getting together to chat."

The COVID-19 pandemic derailed the initial strategy and created unanticipated costs and disruptions in both health care and education. The work of the Executive Roundtable for Healthcare and Education is now focused on investments that can be made given the influx of resources from the American Rescue Plan Act.

American Rescue Plan Act of 2021 (ARPA)

The state of Oregon is now looking at a huge infusion of revenue from the American Rescue Plan Act (H.R.1319 - American Rescue Plan Act of 2021, signed into law by President Biden on March 11, 2021) that will arrive over the next few months, including over $4 billion for state and local government.

The ARPA package[1] intends to address the ongoing impact of the COVID-19 pandemic on individuals and families, on the economy, public health, and state and local governments. Funding provisions in ARPA offer support for direct COVID-19 response (e.g., vaccinations, testing, treatment, prevention) and recovery (e.g., nutrition assistance, school and child care program funding, mental health services), as well as broader economic, social, and scientific investments (e.g., small business assistance, scientific research, and capital projects). [A detailed summary of ARPA provisions is included in the Appendix].

Over the next few months, Oregon expects to see an infusion of over $4 billion from the ARPA for state and local governments. The Oregon Health Authority (OHA) intends to use a portion of its funds from the ARPA to meet the strategic goal of "ending health inequities in our state by 2030." To help achieve this goal, "OHA and community partners co-created the State Health Improvement Plan, which identified the following priorities:

- Institutional bias
- Adversity, trauma and toxic stress
- Behavioral health
- Economic drivers of health
- Access to equitable preventive healthcare

[1] https://www.congress.gov/bill/117th-congress/house-bill/1319/text

While all of these investments make sense, most of them are going into *existing* structures and delivery systems. And many of them will be *one-time* investments. To meet the goal of "ending health inequities in our state by 2030," however, we must effectively address the socioeconomic inequities that drive them, including systemic racism. These are *root causes,* and addressing them requires an integrated, collaborative delivery model that can sustain investments in a given child and their family over an 8 to 10-year period.

Goal

Our goal is to ensure every child has an equitable opportunity to succeed.

We want to reach a point where ZIP Code, ethnicity, race or language are no longer indicators of future success (or lack thereof). The seeds that undermine successful children are planted very early, even before birth. These are the same root causes that lead to the health disparities and socioeconomic inequality that continue to plague our state and our nation.

Children's Contextual Ecosystem

Children exist in an ecosystem that includes their family and their community. This means that to meet our goal, we must focus not only on the child, but also on the environment in which the child lives.[2]

The World Health Organization defines *health* as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." If we could write a prescription for America that would surely be it. And if we could fill that prescription by spending more money on the U.S. health care system, we would already be there. Yet, fifty years of evidence tells us that the promise of health care for all Americans is not the same as a healthy America. In 1968 the U.S. was spending 6.2% of its GDP on health care. Today we are spending almost 18%, yet life expectancy has declined three years in a row, driven largely by inequality and economic hardship, particularly in working class America.

Although not apparent at the moment people need access to medical care, our health care system plays a relatively minor role when we look at those factors that have the greatest impact on lifetime health status. Far more important are the "social determinants of health: healthy pregnancies, affordable housing, good nutrition, safe communities, education and living wage jobs. These are the pillars of family stability, success – and of health.

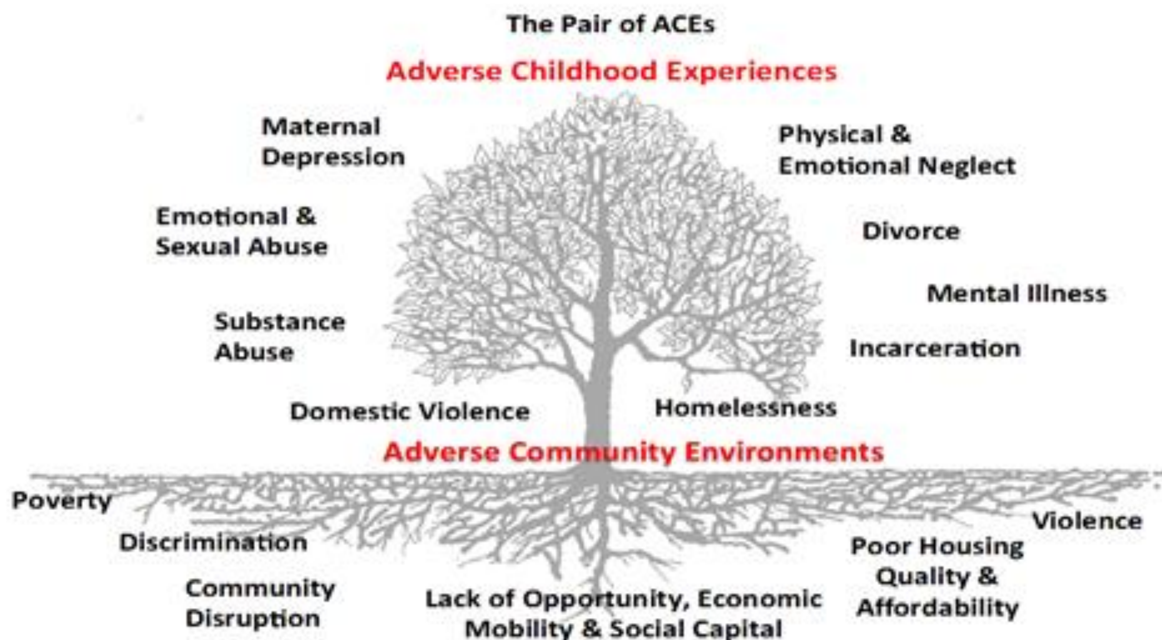
One of the most powerful social determinants of health, one that dramatically undermines the opportunity for a child to succeed, is growing up in a family under stress—and two of the most significant factors that lead to stress and family dysfunction are systemic racism and poverty.

[2] Early Relational Health: Community Level Strategies for Supporting the Psychosocial Health of Infants, Toddlers, and Caregivers - Gary Willis | Center for the Study of Social Policy (cssp.org)

Understanding Adverse Experiences — The "Pair of ACEs"[3]

We know that there is a strong correlation between the level of traumatic stress in childhood and poor physical, mental and behavioral outcomes later in life – including behavioral and learning problems, risky behavior, school failure, the early adult onset of chronic disease, mental illness, and subsequent involvement in the social support system and often in the criminal justice system, and early death.

Traumatic stress in children results from two sets of adverse experiences: Adverse Childhood Experiences and Adverse Community Environments – the pair of "ACEs." Adverse childhood experiences include a parent with a mental health condition and/or substance use disorder, physical or emotional neglect, physical, verbal or sexual abuse, domestic violence and loss of a parent through divorce, abandonment or incarceration. These Adverse Childhood Experiences, in turn, are often the result of Adverse Community Experiences, which include systemic racism, poverty, food and housing insecurity, lack of economic opportunity and upward mobility, and communities that are not safe.

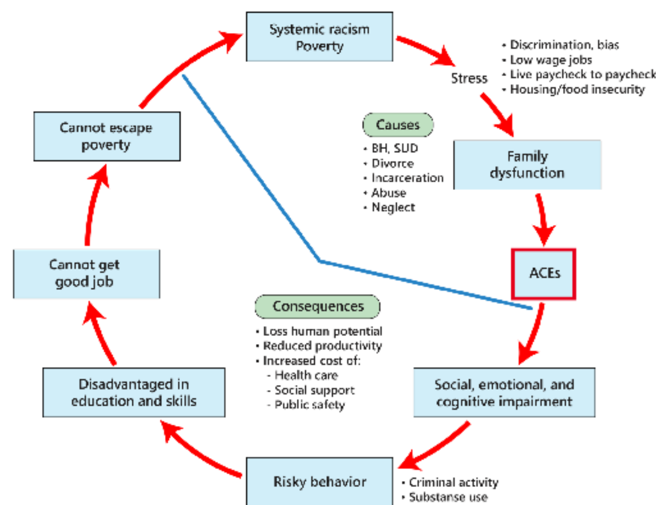


Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

It is now also recognized by the field of epigenetics that chronic stress during pregnancy can alter genetic expression in the unborn child. These prenatal experiences create templates for how the child will process experiences in the future – increasing the risk of emotional problems, behavioral disorders and learning disabilities – *thus passing the factors that can undermine childhood success from generation to generation.* This is particularly true for Black Americans and Indigenous Americans, and other communities of color, who have experienced the chronic stress of systemic racism, discrimination and racial bias for centuries.

[3] https://www.cdc.gov/violenceprevention/aces/fastfact.html

Generational Cycle of ACES



Breaking the Cycle and Building Community Resilience

In every child who is born, under no matter what circumstances, and of no matter what parents, the potentiality of the human race is born again."
— James Agee

Ensuring that every child has an equitable opportunity to succeed, involves breaking the generational cycle driven by the social, economic and health consequences of the ACEs. To do so, we must change the life arc of risk factors in children by focusing our efforts as far upstream as possible – ideally even before conception, but at a minimum during pregnancy – where we can gain the greatest leverage and best long-term outcomes.

A Waypoint Analogy

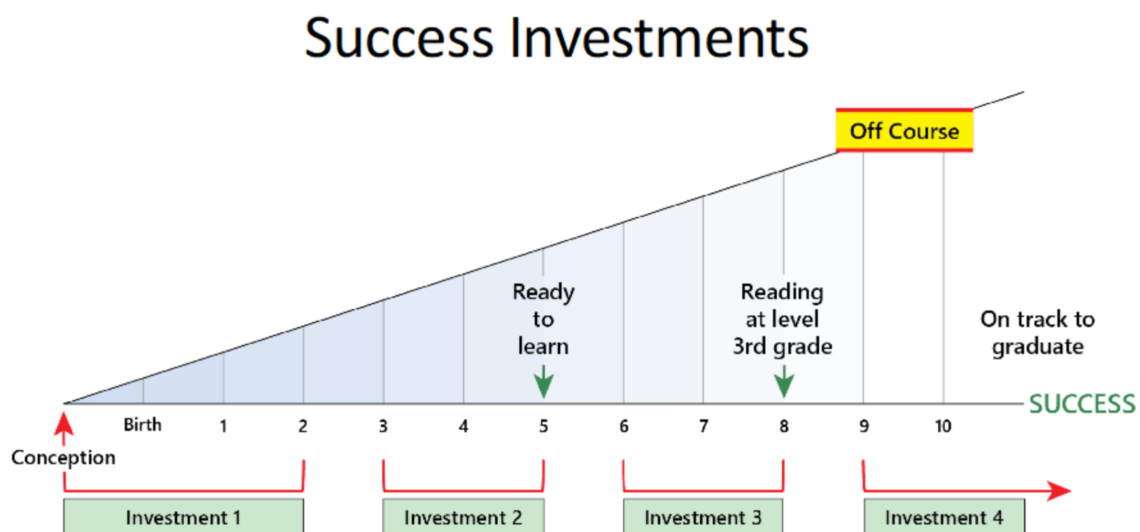
Airplanes on long trips are constantly being taken off course by cross winds, weather and other factors. Any long flight has a series "way points" to guide the necessary course corrections required to arrive at the destination. Suppose an airplane takes off from Portland on a flight to New York City and the flight is a few degrees off course when it clears the runway at PDX. Without a correction in the flight plan, the plane will end up somewhere north of Montreal, Canada. Once the error in trajectory is discovered, it is much easier to make the course adjustment at a way point over Boise, Idaho than over Chicago. And at some point, the course correction becomes so extreme that it becomes nearly impossible to reach the original destination.

Children also have "way points" in their development that indicate whether they are on a course to success. These include certain physical, social and emotional developmental way points in the early years of life, then Kindergarten readiness, reading at level in third grade,[4] on track to graduate in the ninth grade,[5] etc. These way points represent a continuum of child development and *the earlier we intervene* in the life arc of a child who is heading off course, the more successful we will be (and the less costly both in terms of the investment involved and the avoided cost later on).

Success Investment Windows

We can identify four distinct windows (way points) for "success investments" (SI):

1. First 1000 days — conception to age 2 [normal physical, social, emotional development]
2. Age 3-5 — Preschool through Kindergarten [Kindergarten readiness/Ready to Learn]
3. Age 6-8 — Grades 1 through 3 [Reading at level in 3rd grade]
4. Age 9-13— Grades 4-8 [On track to graduate from high school]



Given the fact that stress during a woman's pregnancy can alter genetic expression, leading to problems in the emotional, behavioral and physical development of the child, the first 1,000 days is the optimal success investment window in which to start to break the cycle. This is the period of time during which the foundations of optimum health, growth, and

[4] Third grade has been identified as important to reading literacy because it is the final year children are learning to read, after which students are "reading to learn." If they are not proficient readers when they begin fourth grade, as much as half of the curriculum they will be taught will be incomprehensible.

[5] "On track" means a student has enough credits to progress to the next grade level and has been present for at least 90 percent of enrolled school days. On-track students are more than three and one-half times more likely to graduate from high school in four years than off-track students.

neurodevelopment are established. Then, investments must follow the child and his or her family through the subsequent investment windows.

The Four Key Elements of Success

Breaking the generational cycle of the ACEs, which compromises the ability of children to succeed, requires a long-term strategy built on four central elements:

1. Identifying risk factors in children's lives that can result in trauma and adverse experiences.

2. Understanding the evidence-based and community driven treatments, supports and interventions that can prevent, address or protect children from these risk factors and positively alter the life arc of the child.

3. Securing the resources necessary to sustain these treatments, supports and interventions over time.

4. Having in place an integrated, aligned and collaborative delivery system that can effectively and efficiently deliver those treatments, supports and interventions to children and families, in a way that is ethnically, culturally and linguistically appropriate.

Identifying risk factors in children / Implementing evidence-based and community driven approaches

In terms of meeting the first two challenges – identifying risk factors in children and families, and understanding those things that can help make them successful – we are fortunate that the Center for Evidence-Based Policy, which is housed at the Oregon Health & Science University, has developed a longitudinal dataset, the Oregon Child Integrated Dataset (OCID that can help guide this important work.[6]

This project has matched data on every child born in Oregon since 2000, and their known parents, with data from publicly-funded services for those children and families (such as child welfare & foster care, Medicaid services, early childhood investments (such as Head Start), K-12 information, and juvenile corrections.

This is a remarkably rich dataset, with the oldest cohort now 21 years of age. Since there are around 45,000 children born each year in Oregon, this database now includes almost 950,000 people. (By comparison, the ACE study tracked 17,000). And this is all *Oregon data*. Without going into great detail, this data provides a critical – and heretofore unavailable – picture of the

[6] This is not intended to suggest that OCID is the only resource available to us, or that there are not issues/questions about who is included, data collection methodologies and how the data would be used.

nature, prevalence and implications of chronic childhood stress and trauma. It can provide us with a "risk/success profile" that is highly predictive of future outcomes. We recognize this is not the only basis of risk assessment and we need to be careful in our assessments to not pathologize the children for whom we are focused on building resiliency. Well-meaning white people have a track record of doing just this to the detriment of children of color.

This data, coupled with a community-based, asset-focused approach, will allow us to match children and families with the treatments, supports and interventions that can prevent, address or protect children from these risk factors and positively alter the life arc of the child.

Long term, stable funding

Breaking the generational cycle of the ACEs will require securing the resources necessary to sustain evidence-informed approaches (e.g., treatments, supports, interventions, and other promotion/prevention strategies) over time. To be successful, adequate funding must last for *at least six years* (three biennia), following the child and his or her family from conception through age 5 (SI windows 1 and 2). Ideally, the investments would be maintained for ten years (five biennia), following the child and his or her family until age 6 through age 9 (SI window 3 and beginning of SI 4). Given the intense competition for limited public resources, it will be difficult to maintain funding over multiple biennia unless the goal we are pursuing is built on a solid foundation, and with such broad support across Oregon, that it can continue to move forward and be sustained regardless of changes in the executive branch or partisan changes in the make-up of the legislature.

The political challenge in making these long-term investments is that their impact will not become apparent over the course of a few years – yet to be effective, they must be sustained over several budget cycles. Furthermore, the political imperative traditionally sustains existing institutions and often discourages investing in new initiatives, even those that could make these institutions more effective.

So, a central part of the strategy needs to include building a new coalition that can elevate the importance of these investments. It also involves a community-based strategy that is culturally specific and culturally-informed. Without this, we can risk traumatizing the child and family even more.

Child Success Delivery System

Breaking the generational cycle of the ACEs requires having in place an integrated, aligned and collaborative delivery system that can effectively and efficiently deliver those treatments, supports, interventions, and other promotion/prevention strategies to children and families, in a way that is ethnically, culturally and linguistically appropriate.

While adequate, sustained funding will be a challenge, the far greater challenge is that we lack an effective, integrated and collaborative community-based delivery system. The range of culturally and linguistically specific treatments, supports and interventions that may be required for a given child and his or her family might include:

- Prenatal care, health care – integrated physical/mental health and dental care
- Affordable childcare
- Quality Educational Experiences
- Mentoring
- Nutrition and health awareness
- Safe and stable housing
- Transportation
- Emotional support and mental health
- Behavior health/substance use disorder services
- Job training and employment
- Provide publicly-funded transitional jobs for families with children
- Income supports
    - Enhanced EITC
    - Enhanced child care tax credit

We have literally dozens and dozens of different agencies, programs, community-based organizations, foundations and institutions involved in providing these services and supports. In many cases, these diverse entities are dealing with only one or two of the risk factors, but not as a constellation and often not customized to the needs of a specific child and their family. And they are certainly not aligned or coordinated, they do not leverage one another and therefore are far less than the sum of their parts. Without a clear, well defined, integrated and collaborative delivery system these multiple entities can devolve into a kind of competition in which collaboration is sacrificed to a particular program or funding stream, turf issues abound, and organizational survival takes precedent over the larger purpose for which the organizations were created in the first place. We lose adhesiveness and common purpose.

Children wander through this "system" seeking services, rather than having the services follow the child and their family. Programs are fragmented, often operating in silos and there are gaps. There may or may not be coordination in the hand-offs between programs and services. While we can show positive results from various *individual* programs, we are not narrowing the opportunity gap across the population as a whole. In many cases this is a "last mile" problem—actually getting the right services to the right children and families, at the right time, in the right amount and for long enough to make a difference. As someone pointed out, "We are program rich and system poor; we are failing the community one success at a time."

The national Campaign for Grade Level Reading, which has now engaged 43 states, 344 communities and 3900 local organizations, illustrated the problem. Although this effort is showing progress in moving the needle *within* individual programs, double-digit gaps persist in every state and almost every community. Ralph Smith, the Managing Director of the organization, attributes this, in large part, to the fragmentation and duplication of efforts, the proliferation of silos and the difficulty of accessing and effectively utilizing data. That is exactly what we are facing here in Oregon.

Recommendation: Child Success Demonstration Models

Notwithstanding the billions of dollars coming our way for expanded health care coverage, housing, child care, workforce development, behavioral health, pre-K and many other worthy and long overdue investments, all of these resources are funding a siloed "delivery system" that focuses on programs, organizations, agencies and institutions, rather than on the children and families that all of these entities are ostensibly supposed to be serving. All the money in the world will not break the generational cycle of the ACEs or give each and every child a safe space in which to grow and thrive and become all that they can be – unless this massive infusion of public dollars, increasingly borrowed from future generations, is focused on the children themselves.

The missing link here is an integrated, collaborative Child Success Delivery System. The Executive Roundtable for Health and Education is proposing to stand up four scalable Demonstration Models that seek to break the generational cycle of ACEs within a defined population, by addressing the sources of trauma and adverse experience, from the first thousand days of life, through the age of 5 (investment windows 1 and 2), with a warm hand off to our system of public education.

During the first 1000 days, most of the investments will be focused on health and social factors. As the child grows older, more of the investment will move toward education.

These scalable models will seek to ensure that all children are afforded an equitable opportunity to succeed:

- By addressing the conditions of injustice and systemic racism that undermine success and that lead to structural social inequities and health disparities;
- Through a partnership between health, education and social service sectors, in collaboration with local government;
- That invests upstream in children, families, communities and our workforce;
- That empowers those most impacted to co-create needed programs and investments;
- In a trauma-informed system, and with an asset-based approach to create conditions where all children and families can excel.

Governance

These four Demonstration Models would be in the Portland metropolitan area, the Willamette Valley, Southern Oregon and Eastern Oregon. The central partners[7] would include, but not necessarily be limited to:

- A coordinated care organization
- Culturally specific, community-based organizations
- A school district
- An early learning hub
- A university or community college
- A local public health authority
- Family and community leaders

For the purposes of the Demonstration Model, the central partners would operate within a new shared governance compact which, in turn, would interface with all of the agencies, programs, community-based organizations, foundations, institutions and service providers necessary to support the child and his or her family through a "Child Success Plan" tailored to the challenges in a given family (see "Governance" in Appendix).

It is important that each of these four "pilot" Demonstration Models be built on a sense of "local ownership," and acknowledge and build upon current or past work happening in that region. That is, the model developed in Southern Oregon may not look exactly like the model in Portland or Eastern Oregon. Their goals and desired outcomes will be the same – and perhaps they are guided by a common set of operating principles around accountability, transparency and inclusiveness—but each model should evolve organically, reflecting the unique characteristics of the community in which it is formed.[8]

Defining the Population for the Demonstration Models

Since resources are limited, the initial target population might be women covered by Medicaid who are having their first child. Based on the successful implementation of the models and/or on the availability of additional resources, we can build out this population in two ways:

- Move from first born children to all births
- Move up sequentially from investment window 1 and 2 to windows 3 and 4.

[7] These "central" partners would form the basic infrastructure of each Model. Local governments are already represented in the CCO governing structure and must be engaged from the very start, as must local public health authorities. How we engage the multiple entities necessary to support the child and his or her family over time, is perhaps the thorniest and most important question we must answer.

[8] This is one of the lessons we learned from the creation of our CCOs. From the very beginning, the effort was not a top-down directive for change, but, rather, a framework for accountability, with the details to be filled in through a partnership between local providers and the community. It was this sense of local ownership and buy-in, that formed the underpinnings of the success that was to follow. I do not believe this transformational change could have happened without it. That is why the legislation which established criteria for the formation of a CCO provided only a broad framework, leaving the details to local providers and the community.

Screening for the Pair of ACES / Identifying Risk Factors in Children

Since the health care system sees almost all children well before they ever reach school age or interact with any other system – with the possible exception of child care – this is where the initial ACE/social determinants risk screening should be done starting, if possible, with One Key Question.[9]

If a woman is not planning to get pregnant within the next year, she is offered family planning services. If she is planning to get pregnant (or is pregnant) and her assessment reflects the kinds of stress/risk factors that can impact child development during pregnancy or the first 1,000 days, she should be referred to the integrated, collaborative Child Success Delivery System. Women who are not captured by One Key Question can be assessed at the first prenatal visit.

Following this initial screening, the woman would receive not only a home nursing visit to begin prenatal care, but also have access to a seamless continuum of care and connections to resources, which would include a visit from the school district to make an early connection with the learning community. One of the most successful quality metrics in our CCO model was the establishment of Patient Centered Primary Care Homes (PCPCH). This could be evolved into the creation of Person-Centered Primary Community Homes.

Child Success Delivery System

Building out an integrated, collaborative Child Success Delivery System will be perhaps the most challenging aspect of these Demonstration Models, because it will require that dozens of programs, organizations, agencies and institutions – and those who work in them – to subordinate their organizational, programmatic and institutional interests to serve a larger *common purpose*: the long-term success of children and families as they move across this siloed landscape. A strong sense of common purpose, of shared mission is the one essential ingredient necessary to build community – and it is community that gives us the adhesiveness that holds us together and allows us to act in concert for the common good.

Fortunately, we don't need to reinvent the wheel here. In many cases, we are doing the right things, but often not in a systematic and coordinated way that is aligned around a *clear, common objective* that puts children and their families at the center of our work and that elevates their success above any individual program, agency, organization or institution. There are lessons and experiences all around us that we can and should learn from and integrate into this effort. Several that immediately come to mind are the Gladstone Center for Children and Families, Early Head Start, 3 to PhD, and the "Early Works" at Earl Boyles Elementary School.

[9] The opportunity to provide family planning services for women who are not planning to get pregnant is important because unplanned teen pregnancies are often a risk factor contributing to the cycle of poverty. One Key Question has been endorsed by the Oregon Medical Association.

Preparing Our Workforce

Somewhere between the extraordinary things modern medicine can do to save an individual life – and the millions of people who lack access to the simple supports necessary to be healthy – must be a cadre of community workers who can connect the two by building trusted personal relationships that are ethnically, culturally and linguistically appropriate, and based on caring and compassion.

This means that the Demonstration Models need relationships with educational institutions that are training this workforce, which might include:

- Teachers
- Physicians
- Dentists
- Nurses
- Pharmacists
- Social workers
- Community health workers
- Psychologists
- Counselors
- Home health workers
- Peer support specialists

There is a significant workforce opportunity involved here. The most rapidly growing part of the workforce is in the health sector, particularly in personal care and home health aides. Nearly 90% of home care workers are women and over half of people of color. The median hourly wage is $10.11, over 25% live below the federal poverty level, and over half rely on some form of public assistance. Through our Demonstration Models, we have the opportunity to lift up, professionalize and adequately compensate this new, growing workforce. And because poverty is one of most fundamental social determinants of health, raising up the income of this workforce will further our goal of ensuring that each and every one of our children has an equal opportunity to succeed.

Furthermore, integrating teachers and student teachers into the model will both help deliver the services and supports and create practical professional preparation and *career paths for community members* using internships, apprenticeships, mentoring and professional development.

We'll be able to inspire youth to explore an array of health and education professions up close as they see and experience these professionals, and future professionals, working and learning together at each demonstration model. School age youth will be able to participate as student members in groups like Future Health Professionals of America and Future Teachers of America inspiring them to consider college and career possibilities. These models will powerfully prepare undergraduate and graduate students as future professionals in healthcare and education as they are integrated into the daily warp and weave of the communities served by each demonstration model, an environment ripe with "show, do, teach" possibilities. These

demonstration models will prepare the next generation of health and education professionals through an apprenticeship approach while they serve as role models and mentors for the youth at each site. With their extensive hands-on opportunities, those undergraduate and graduate students will be prepared to practice their craft when they graduate. This whole intern/student teacher approach significantly expands the services and supports at each site, ensuring many more caring individuals at each child and adolescent.

Securing Resources

We would ask for resources from the ARPA in two categories:

1. To fund a one year "development period" to select the four Demonstration Models and the defined populations, design and set up the governance structure and the Child Success Delivery System, including a business plan for each model. The development period would also be used to estimate the cost of providing the services for at least the first thousand days of life.

2. A set aside to fund the operation of the Demonstration Models for the second half of this biennium starting on July 1, 2022. We would seek full funding for the 2023-2025 biennium, which would take us through SI window 1 (first 1000 days) and into the beginning of SI window 2(age 3-5). By that time, we should have enough empirical data to justify full funding for the 2025-2027 biennium and to begin to scale the models.

Funding requires sequestering a *tiny percent* of the $25 billion general/lottery fund budget[10] to support these Demonstration Models over the next few biennia – an investment in human and social capital that could yield billions in savings over the years to come. Some of this investment will require new funding, but a significant portion can come from reallocating existing resources.

It may also be worthwhile to explore possibilities for additional flexible federal funding, especially for the 2023-2025 biennium. In addition, because of the broad statewide benefits that would flow from developing an effective and scalable Child Success Delivery System, we should seek funding from philanthropic organizations and the private sector as part of a public/private/civic partnership to develop and implement this model.

To help identify these resources, we might consider implementing a largely ignored provision of the legislation that created the Early Learning Division requiring the Division and the Early Learning Hubs – in collaboration with the CCOs, the business community and service providers – to develop, every two years, an "integrated children's budget." This budget would show, by program, all the money currently being spent on early childhood development and education. And while not binding, this budget could show how each program intersects with the risk factors and protective factors that we are trying to address in our Demonstration Models.

[10] One tenth of one percent of the general general/lottery fund budget for the 2021-2023 biennium is $25 million.

There are over 45,000 children born each year in Oregon, and we cannot afford to lose a single one. Yet every day that passes without an effective way to ensure that each and every one of these children truly has an equitable opportunity to succeed, some will be lost. And every time that happens, we are all diminished and we lose a little bit more of the soul of our state. It is imperative that we act on this now – our children can't wait ... and neither should we.

> *Health care and poverty are inseparable issues and no program to improve the nation's health will be effective unless we understand the conditions of injustice which underlie disease. It is illusory to think that we can cure a sickly child and ignore his need for enough food to eat.*
>
> Robert Kennedy, 1968

APPENDIX

Members of the Executive Roundtable for Healthcare and Education

Steering Committee

CareOregon - Eric C. Hunter, President/CEO
Gladstone School District - Bob Stewart, Superintendent
Clackamas Education Service District - Jada Rupley*, Superintendent
Trillium Family Services - Kim Scott, President/CEO
The Health Commons Group - Dave Ford, Principal
The Foundation for Medical Excellence - Dr. John Kitzhaber, Chair of Health Policy
Beaverton School District - Don Grotting, Superintendent
Gresham-Barlow School District - Katrisse Perera*, Superintendent
Kairos PDX - Kali Thorne-Ladd, Executive Director

Additional Roundtable Members

CareOregon - Jeremiah Rigsby, Chief of Staff
Clackamas County Department of HHHS - Rich Swift*, Director
Health Share of Oregon - James Schroeder, CEO
Health Share of Oregon - Dr. Maggie Bennington Davis, Chief Medical Officer
Kaiser Permanente - Dan Field, Executive Director of Community Health
Kaiser Permanente Northwest - Ruth Williams Brinkley*, President
OHSU - Dr. Greg Blaschke, Professor of Pediatrics
OHSU - Dr. Dana Braner, Chair Department of Pediatrics
OHSU - Pam Curtis, Director at Center of Evidence-based Policy
Oregon Department of Education - Scott Nine, Assistant Superintendent, Office of Education Innovation and Improvement
Withycombe Scotten & Associates - Dick Withycombe, Principal

Dental Subcommittee

CareOregon - Alyssa Franzen, Vice President Dental Services
Beaverton School District - Don Grotting, Superintendent
CareOregon - Jeremiah Rigsby, Chief of Staff
Clackamas Education Service District - Jada Rupley*, Superintendent
Gladstone School District - Bob Stewart, Superintendent
Health Share of Oregon - James Schroeder, CEO

Adult Wellbeing Subcommittee

CareOregon - Jill Archer, Vice President Behavioral Health
CareOregon - Eric C. Hunter, President/CEO
Clackamas County Department of HHHS - Rich Swift*, Director
Gladstone School District - Bob Stewart, Superintendent
Gresham-Barlow School District - Katrisse Perera*, Superintendent
Kairos PDX - Kali Thorne-Ladd, Executive Director
Kaiser Permanente - Dan Field, Executive Director of Community Health
Health Share of Oregon - James Schroeder, CEO
Trillium Family Services - Kim Scott, President/CEO

Adult Wellbeing: Educator Support Subcommittee

CareOregon - Jonathan Weedman, Vice President Population Health
CareOregon - Jen Echternach, Marketing Manager
Coalition of Oregon School Administrators - Craig Hawkins, Executive Director
Gladstone School District - Bob Stewart, Superintendent
Hail Creative - Tracy Forsyth, Strategy Director
Kaiser Permanente - Dan Field, Executive Director of Community Health
Kairos PDX - Kali Thorne-Ladd, Executive Director
Kaiser Permanente - Rujuta Gaonkar, Manager Community Health
Moda Health - Alethea Sabia, Director of Marketing
Oregon Education Association - Jim Fotter*, Executive Director
Oregon School Employees Association - Susan Miller, Director of Field Operations
Kaiser Permanente Educational Theatre Program in collaboration with Oregon Children's Theatre - Stephanie Cordell*, Schools Liaison and Lead Teaching Artist
Trillium Family Services - Caitlin Young, Resilience Consultant
Trillium Family Services - Kim Scott, President/CEO

Outcomes Subcommittee

CareOregon - Amit Shah, Chief Medical Officer
Clackamas Education Service District - Jada Rupley*, Superintendent
Gresham-Barlow School District - Katrisse Perera*, Superintendent
Gresham-Barlow School District - Carla Gay, Innovation and Partnerships Executive Director
Gresham-Barlow School District - Michele Cook, Executive Director of Student Support Services
The Foundation for Medical Excellence - Dr. John Kitzhaber, Chair of Health Policy
The Health Commons Group - Dave Ford, Principal
Health Share of Oregon - Dr. Maggie Bennington Davis, Chief Medical Officer
OHSU - Dr. Greg Blaschke, Professor of Pediatrics
Trillium Family Services - Kim Scott, President/CEO
Withycombe Scotten & Associates - Dick Withycombe, Principal

System Redesign Subcommittee

Trillium Family Services - Gary Withers
Trillium Family Services - Kim Scott, President/CEO
Association of Oregon Counties - Gina Nikkel, Executive Director
CareOregon - Eric C. Hunter, President/CEO
CareOregon - David Russell, Vice President Business Development
CareOregon - Jeremiah Rigsby, Chief of Staff
The Foundation for Medical Excellence - Dr. John Kitzhaber, Chair of Health Policy
Gladstone School District - Bob Stewart, Superintendent
Gladstone School District - Lennie Bjornsen, Director of Student and Family Supports
Gresham-Barlow School District - Katrisse Perera*, Superintendent
Health Share of Oregon - Dr. Maggie Bennington Davis, Chief Medical Officer
Kairos PDX - Kali Thorne-Ladd, Executive Director
OHSU - Dr. Greg Blaschke, Professor of Pediatrics
Oregon State University - Allison Myers, Director, Oregon State University Center for Health Innovation College of Public Health and Human Sciences
Oregon State University - Javier Nieto, Dean, College of Public Health and Human Sciences
Trillium Family Services - Sai Stone, Community Engagement & Brand Manager
Trillium Family Services - John Donovan, Senior Vice President of External Affairs and Constituent Relationships
Health Share of Oregon - Peg King, Portfolio Manager, Early Life Health Partnerships
Multnomah County - Susheela Jayapal, County Commissioner

American Rescue Plan Act

Summary: American Rescue Plan Act of 2021, adapted from Congress.Gov

ARPA provides funding for:

- agriculture and nutrition programs, including the Supplemental Nutrition Assistance Program;
- schools and institutions of higher education;
- child care and programs for older Americans and their families;
- COVID-19 vaccinations, testing, treatment, and prevention;
- mental health and substance-use disorder services;
- emergency rental assistance, homeowner assistance, and other housing programs;
- payments to state, local, tribal, and territorial governments for economic relief;
- multiemployer pension plans;
- small business assistance, including specific programs for restaurants and live venues;
- programs for health care workers, transportation workers, federal employees, veterans, and other targeted populations;
- international and humanitarian responses;
- tribal government services;
- scientific research and development;
- state, territorial, and tribal capital projects that enable work, education, and health monitoring in response to COVID-19; and
- health care providers in rural areas.

The bill also includes provisions that

- extend unemployment benefits and related services;
- make up to $10,200 of 2020 unemployment compensation tax-free;
- make student loan forgiveness tax-free through 2025;
- provide a maximum recovery rebate of $1,400 per eligible individual;
- expand and otherwise modify certain tax credits, including the child tax credit and the earned income tax credit;
- provide premium assistance for certain health insurance coverage; and
- require coverage, without cost-sharing, of COVID-19 vaccines and treatment under Medicaid and the Children's Health Insurance Program (CHIP).

Governance Structure

Taking this hub and spoke approach, the central partners, operating pursuant to the governance compact, would form a nonprofit organization as the hub, and that entity would interface through separate contracts with all of the "spoke" agencies, programs, CBOs, foundations, institutions and service providers involved with the initiative in that geographic area. The common responsibilities of all parties will be spelled out in the governance compact including each "spoke" entity which shall also be subject to the governance compact. The governance compact will describe the level and type of participation and responsibility/commitment associated with each collaborator by delineating clear classifications for "central partners", "associate partners", "affiliates", and other categories that may be developed.

The governance compact will also include:

- Shared values and beliefs, including but not limited to, the grounding of the collaboration in principles of trauma informed care;
- Clear and ongoing processes for ensuring extensive community engagement, i.e. working "with" community and not "on" or "for" community, throughout the development, governance and operation of the collaboration with an equity, diversity and inclusion lens and active/measurable commitment;
- Extensive procedures for conflict and dispute avoidance, mitigation and resolution, including regular use of "presence" trauma informed principles;
- Cross institutional engagement commitments, within all legal and ethical limits, among the central partners for the selection of key leaders required to maintain the health and well-being of the collaboration, e.g. key principal(s), deans, executives, and others who are essential for the maintenance of the collaboration within each central partners organization;
- Clear performance expectations including but not limited to staff engagement, meeting attendance, financial contributions, standards of professional care, and other elements essential for the maintenance of the collaboration;
- Clear lines of reporting, communication, information sharing and responsibility among the central partners and respective spoke entities;
- A specific term of years and compact renewal process that reflect the deep commitments of all parties, including all funders;
- The creation of a governance council and select committees and ad hoc working groups including clear processes for the selection, terms and removal of individuals serving on the governance council, committees and ad hoc working groups.

Logic Model (Zero draft for discussion, operationalization)

Context and inputs	Activities	Outputs (Process Objectives)	Outcomes	Impacts		
			Short-term 1-4 years	Medium-term 5-10 years	Long-term >10 years	
Context: Structural racism, ACEs “Post-COVID-19” opportunity for recovery, renewal Inputs: Children and families Central, associate, affiliate partners Funding	Train workforce; Create support systems in model sites; Clarify outputs, outcomes, impacts ↓ One key question ↓ Nurse Home Visits ↓ Identify at-risk children/parents and connect to • Prenatal care, health care • Parenting skills • Child Care • Nutrition, housing, transportation • Emotional support • Behavior health/substance use disorder services • Job training and employment • Provide publicly-funded transitional jobs for families with children • Income supports	Workforce training outputs – Algorithm to identify child cohort Screening tools to identify child cohort Set of Child Success interventions Model governance structure and accountability structure	Increased provider knowledge about ACEs, racism, Child Success initiative Increased provider skills and confidence to assist children, families and connect to services Children have increased access to and use of Child Success interventions	Changes in X behaviors Changes in X policies Operationalize a measure on disrupting poverty cycle Measures of ACEs at individual and contextual level Some measure of family stability Healthy children – school readiness measures, CCO 2.0 healthy child measures Parents’ experience of racism, discrimination	Health and education equity – CCO 2.0 social needs screening metrics: food security, housing security, transportation, IPV, social isolation, financial strain, … residential segregation Increase community health and well-being	Zero disparity metrics: no longer see health or education disparities by race/ethnicity or income among families/children who participated in the Child Success initiative