ORANGE COUNTY ADVOCACY FOR PEOPLE WITH DISABILITIES COLLECTIVE

HEALTH EQUITY PLAN

The Equity in OC (EiOC) Initiative was a limited-term project funded by the Centers for Disease Control and Prevention (CDC) under the National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities (CDC-RFA-OT21-2103). The initiative concluded in May 2024. This document and any associated EiOC branding were developed as part of that grant-funded effort.

EQUITY IN OC

An Initiative of OC health CARE AGENCY

CONTENTS

The plan is divided into the following sections:

INTRODUCTION

The Orange County Health Care Agency (HCA) Office of Population Health and Equity (OPHE) received nearly $23 million in grant funding from the Centers for Disease Control and Prevention (CDC) national initiative to address COVID-19 health disparities among populations at high-risk and underserved, including racial and ethnic minority populations and rural communities (CDC-RFA-OT21-2103).

The long-term strategies of this two-year **Equity in OC Initiative** will:

- Expand existing and/or develop new mitigation and prevention resources.
- Increase or improve data collection, reporting, and infrastructure.
- Build, leverage, and expand the capacity and infrastructure of local health departments.
- Mobilize partners and collaborators to advance health equity and address social determinants of health.

As a part of EiOC, seven Population Health Equity Collectives were created:

- Asian American, Native Hawaiian, and Pacific Islander community
- Black or African American community
- Individuals with disabilities
- Latino, Hispanic, Chicano, or Latin American community
- Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community
- Older adult community
- South Asian, Middle Eastern, North African (SAMENA)

The overarching goals of these Collectives are to:

- Address health inequities and improve social determinants of health through collaboration, partnership, and inclusion of lived experiences and authentic voices.
- Overcome inequitable access to opportunities, resources, and support services for targeted and prioritized populations in Orange County.
- Build and support cohesive and sustainable Collectives in Orange County and to address systemic health inequities facing prioritized impacted communities.
- Provide venues for community voice in identifying and determining solutions and priorities in addressing health inequities of the Collective.

PURPOSE OF THIS PLAN

The purpose of the Health Equity Plan (HEP) is to support the creation of practical, meaningful, and sustainable improvements in the health and well-being of communities in Orange County. The HEP for each community will guide the vision, including unique strategies and calls-to-action that will help to propel the community toward health equity.

PRINCIPLES OF EQUITY

For the Individuals with Disabilities community in Orange County, we, the members of the Orange County Advocacy for People with Disabilities Collective (OCAPDC), are operating under the common shared understanding of what will lead to health equity for our community.

Key areas of focus:

- Access to disability services within the county
- Access to healthcare services
- Access to behavioral health services
- Insurance coverage
- Education/health literacy
- Housing
- Access to affordable childcare and/or after-school care
- Employment

These principles of equity for the Collective were co-created over a two-day summit held in August of 2022. During this two-day summit, members of the Collective discussed structure, governance, and priorities.

COLLECTIVE MEMBERSHIP

OCAPDC is made up of nine (**9**) partner organizations focusing on addressing health disparities among individuals with disabilities mainly residing in the cities listed below:

- Anaheim, Huntington Beach
- Buena Park
- Costa Mesa
- Fountain Valley
- Fullerton, Westminster
- Garden Grove
- Irvine
- Midway City
- Mission Viejo
- Orange, Newport Beach
- Santa Ana
- Tustin

Leaders and members from each partner organization bring their unique skills, talents and experiences. They contribute their expertise for the benefit of our shared vision and mission. By leveraging the collective knowledge, lived experience, and expertise of community members, new and exciting ideas are generated that an individual or a single coalition could not have thought of alone. Rules and regulations that govern the collective's internal operations are outlined in the collectives Bylaws.

Table 1 below lists our key partners and stakeholders, also referenced in the Bylaws section.

Type of Partner Organizations	Name(s) of Partner Organizations
Academic Institutions	**Cancer Programs** • University of California, Irvine (UCI) Center for Autism & Neurodevelopmental Disorders • University of Southern California Keck's School of Medicine • University of Southern California - Los Angeles (USC)
Council, Community Group or Coalition	• State Council on Developmental Disabilities • Children and Families Coalition of Orange County • Dayle McIntosh Center
Healthcare Providers	Children's Hospital of Orange County (CHOC)
Individual Community Members	Individuals with intellectual/developmental disabilities and their families.
Nongovernmental Organizations	• Beyond Blindness • Children's Cause Orange County • YMCA of Orange County • Quality Connection Living Services • Regional Center of Orange County • Illumination Institute
Schools/School Districts	• Garden Grove Unified School District • Anaheim Union High School
Other (Charities)	**Cancer Kinship** Cancer kinship charity guides cancer patients through treatment and after their treatments, helping them regain control of their lives and well-being.

Together, with our stakeholders and partners, we empower individuals with intellectual and/or developmental disabilities as well as their families and support networks with the tools necessary to improve their health and well-being and address health disparities in their own communities. So far, we have reached an estimated 300 individuals with disabilities in Orange County through advocacy efforts, health literacy training, and other culturally-responsive strategies.

Membership Requirements

The OCAPDC current membership was developed to ensure representation from diverse communities. Current members are primarily made up of organizations that work with children and/or adults with intellectual/developmental disabilities. Other stipulations for membership are as follows:

- Full members of the OCAPDC will be non-profit entities with at least one program that targets a disability population. These members will pay a flat fee of $550 annually to participate in the Collaborative.

- Governmental entities that serve individuals with intellectual/developmental disabilities will be invited to be Advisory Members of the OCAPDC. Governmental members will have a voice, but not a vote, in the Collaborative.
- Individual community members will be self-nominated or nominated by a member organization. Two Individuals will serve two-year terms with no more than two consecutive terms. Individuals will be interviewed by OCAPDC staff and voted in by current members. A two-thirds majority is required for membership approval.

PROCESS AND DATA

Process for Identifying Health Equity Goals and Focus Areas

Since its inception, the OCAPDC has sought to develop a deeper understanding of the issues affecting individuals with disabilities in Orange County. We value stories and shared lived experiences of individuals affected by disability because it is the most authentic way to learn first-hand about barriers to accessing healthcare and social services in their own communities. We also conduct focus group sessions, structured and semi-structured key informant interviews to gather qualitative information about the community's experience. In addition, we conduct in-house surveys and review population- level secondary data collected by organizations such as the Regional Center of Orange County (RCOC) to better understand community needs. The process is described in more detail in the quantitative data section below.

This process allows us to learn more about our community members and identify their social needs and other non-medical determinants of health such as, how much money someone makes, where they live, work, and play, how easy it is to access healthy food, and the level of community support they have. For example, we learned that people with unmet social needs are less likely to access the health care and social services they need, even when the services are available. This information serves as the starting point for addressing social needs among people with lived experience of disability and guides long-term efforts toward improving the health and well-being of Orange County residents affected by disabilities.

Quantitative Data

OCAPDC reviews population-health data from government and non-profit organizations to better understand the scale of health inequities among individuals with disabilities to determine where and how to prioritize interventions and how to properly target outreach to demographic groups with most need.

For this grant funding period, we reviewed data from the following local and national sources:

- RCOC
- CalOptima
- California Department of Education
- Social Security Administration
- The Census Bureau
- Equity in OC's Population Overview

We ultimately decided to use RCOC as our main data source for this grant because RCOC data is well formatted and is more complete (no gaps between years or age groups), allowing for more expedient analysis. RCOC data is also more targeted toward individuals with disabilities than other data sources that we identified.

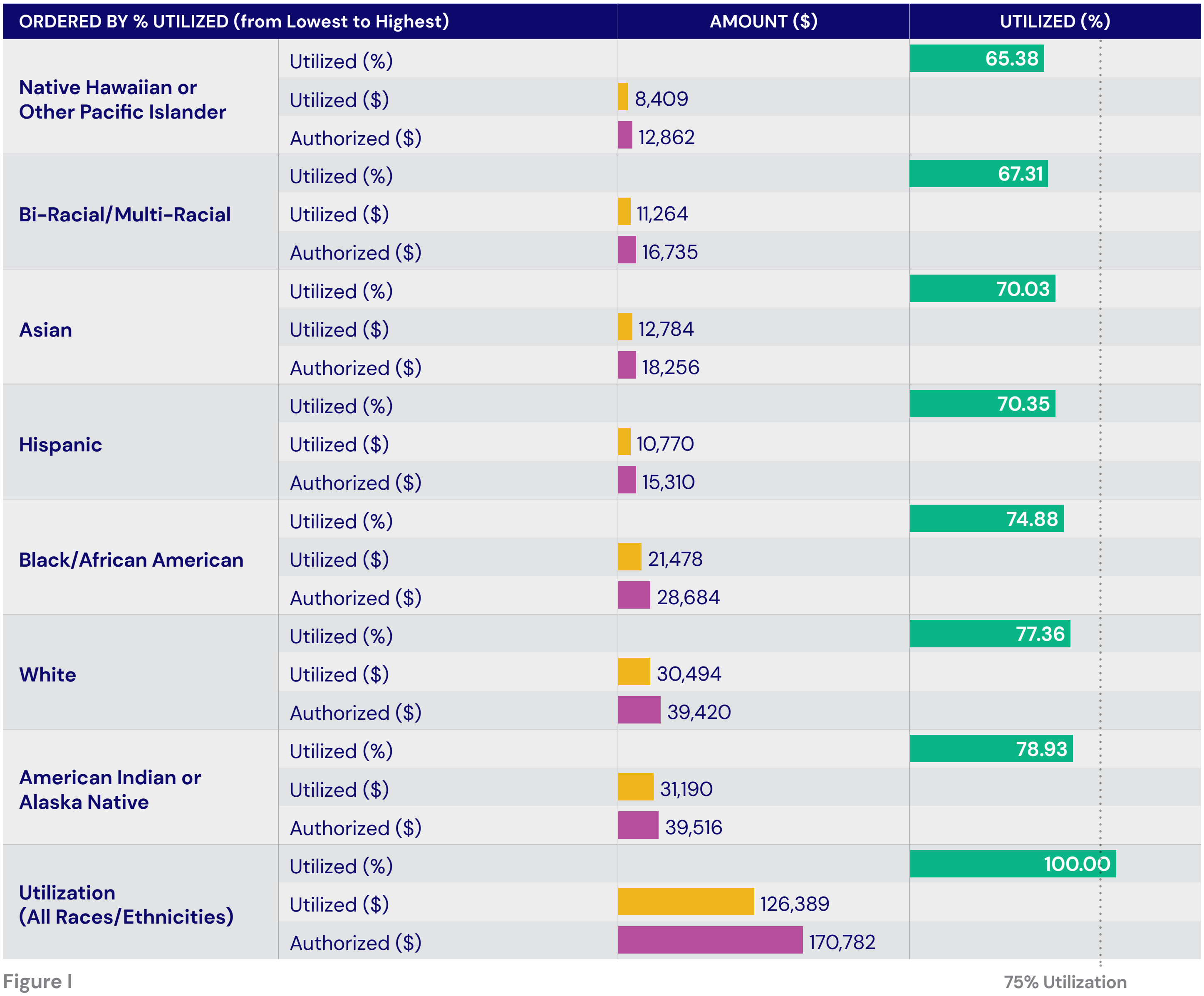
RCOC Data Analysis

Data from the RCOC (FY 2021-2022) was downloaded into Excel, inspected, formatted, and uploaded to Tableau (Version 2022.9.1) for analysis and visualization.

Findings

Findings revealed stark differences by demographic categories in the **allocation** and **utilization** of resources by individuals with disabilities in Orange County. The disparities became more apparent when we graphically displayed the data **(*Figure I-Figure III*)**.

Authorized/Utilized (Per Capita) (All Ages)

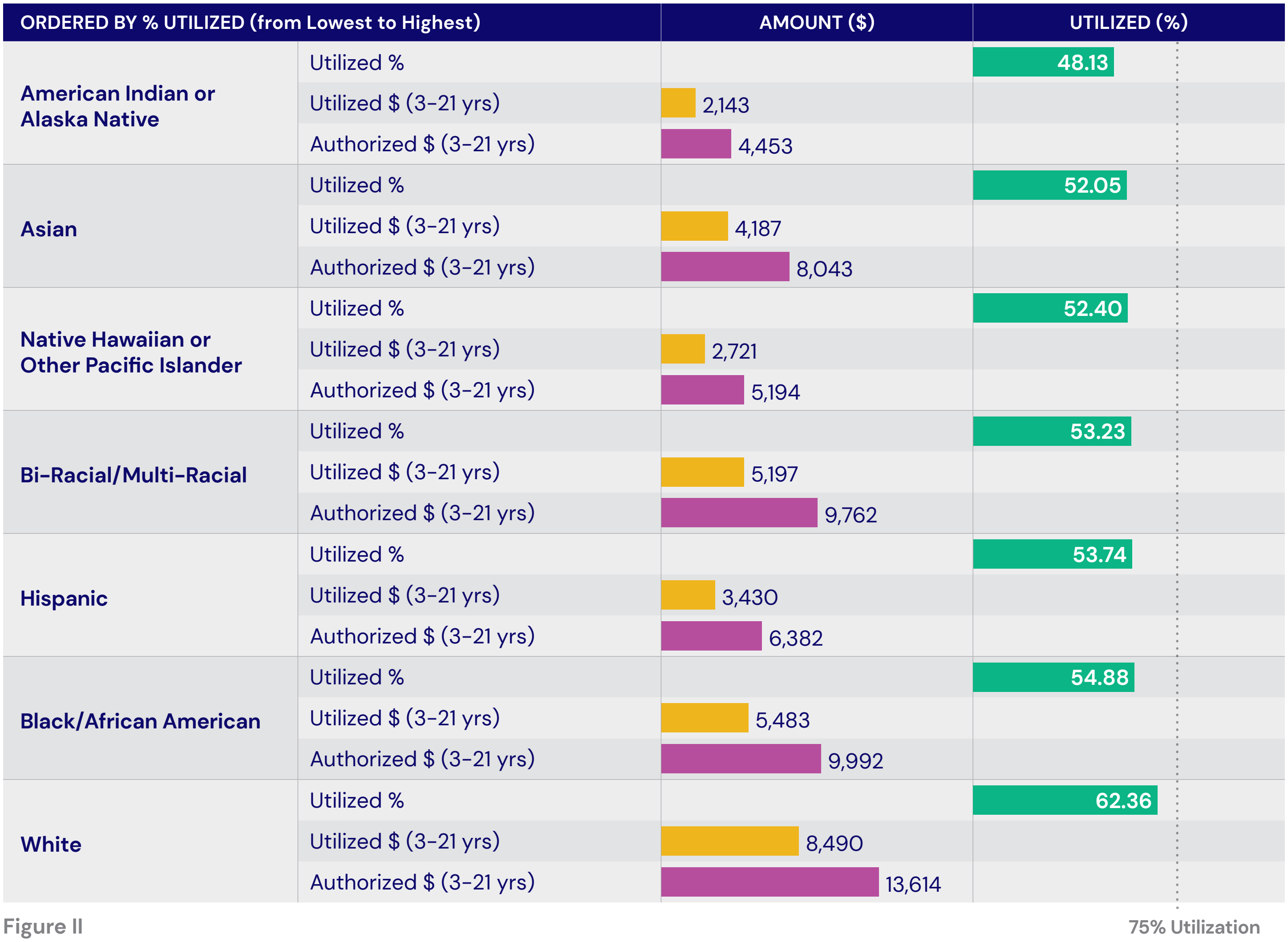


ORDERED BY % UTILIZED (from Lowest to Highest)		AMOUNT ($)	UTILIZED (%)
Native Hawaiian or Other Pacific Islander	Utilized (%)		65.38
	Utilized ($)	8,409	
	Authorized ($)	12,862	
Bi-Racial/Multi-Racial	Utilized (%)		67.31
	Utilized ($)	11,264	
	Authorized ($)	16,735	
Asian	Utilized (%)		70.03
	Utilized ($)	12,784	
	Authorized ($)	18,256	
Hispanic	Utilized (%)		70.35
	Utilized ($)	10,770	
	Authorized ($)	15,310	
Black/African American	Utilized (%)		74.88
	Utilized ($)	21,478	
	Authorized ($)	28,684	
White	Utilized (%)		77.36
	Utilized ($)	30,494	
	Authorized ($)	39,420	
American Indian or Alaska Native	Utilized (%)		78.93
	Utilized ($)	31,190	
	Authorized ($)	39,516	
Utilization (All Races/Ethnicities)	Utilized (%)		100.00
	Utilized ($)	126,389	
	Authorized ($)	170,782	

Figure I

Figure I: We found that racial/ethnic groups utilizing the least amount of funds allocated were individuals identifying as Native Hawaiians or Pacific Islanders (65.38%), followed by Biracial/Multi-racial individuals (67.31%), and Asian (70.03%). The dotted vertical line marks 75% utilization.

Authorized/Utilized (Per Capita) (Ages 3-21 Years)

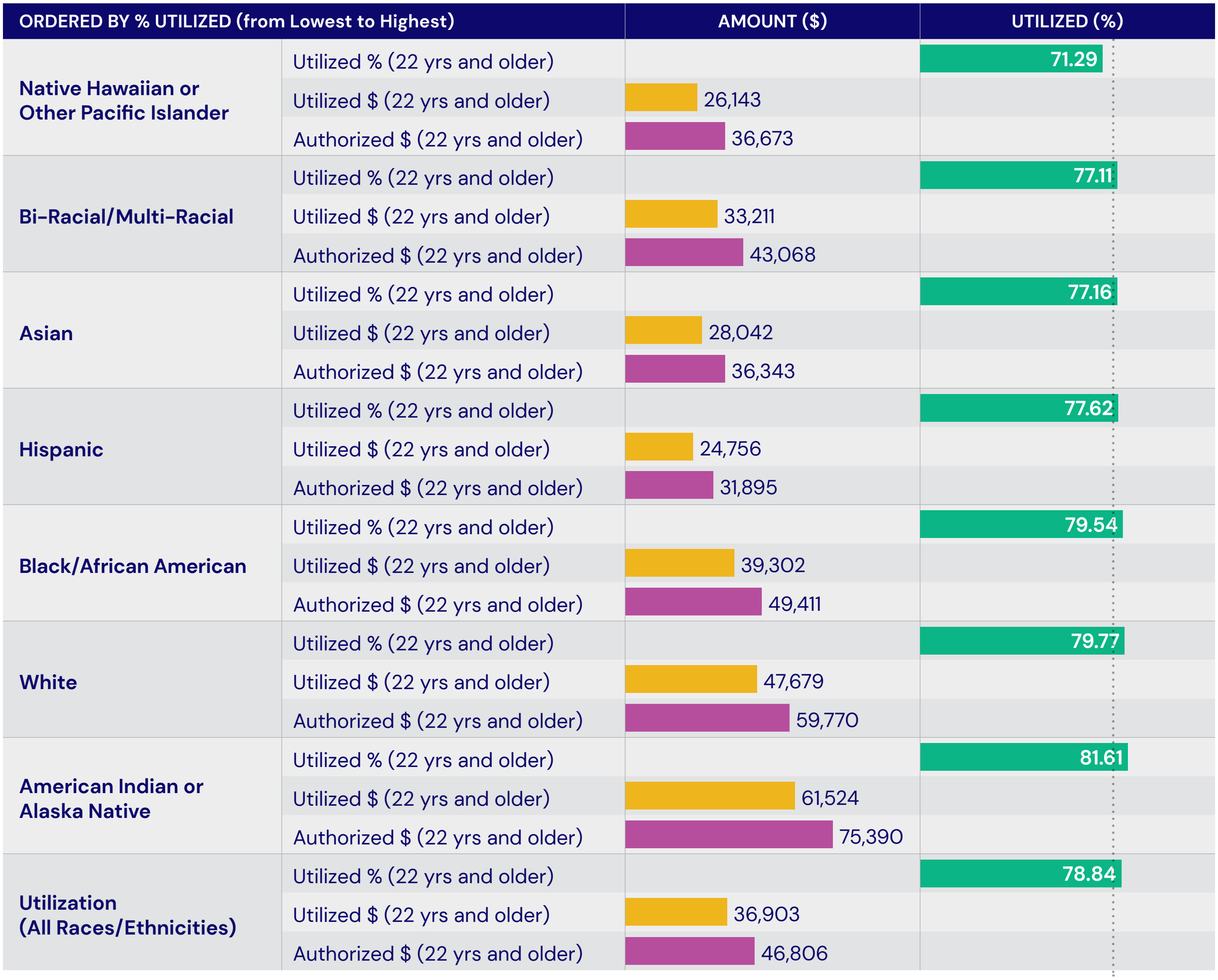


ORDERED BY % UTILIZED (from Lowest to Highest)		AMOUNT ($)	UTILIZED (%)
American Indian or Alaska Native	Utilized %		48.13
	Utilized $ (3-21 yrs)	2,143	
	Authorized $ (3-21 yrs)	4,453	
Asian	Utilized %		52.05
	Utilized $ (3-21 yrs)	4,187	
	Authorized $ (3-21 yrs)	8,043	
Native Hawaiian or Other Pacific Islander	Utilized %		52.40
	Utilized $ (3-21 yrs)	2,721	
	Authorized $ (3-21 yrs)	5,194	
Bi-Racial/Multi-Racial	Utilized %		53.23
	Utilized $ (3-21 yrs)	5,197	
	Authorized $ (3-21 yrs)	9,762	
Hispanic	Utilized %		53.74
	Utilized $ (3-21 yrs)	3,430	
	Authorized $ (3-21 yrs)	6,382	
Black/African American	Utilized %		54.88
	Utilized $ (3-21 yrs)	5,483	
	Authorized $ (3-21 yrs)	9,992	
White	Utilized %		62.36
	Utilized $ (3-21 yrs)	8,490	
	Authorized $ (3-21 yrs)	13,614	

Figure II

Figure II: When we further stratified Race/Ethnicity data by age group, we found that American-Indian or Alaskan Natives age groups 3-21 utilized the **least** amount of resources, followed by Asian at 52.05%, and Native Hawaiian/Pacific Islanders (52.4%). White identifying individuals age 3-21 were the highest users at only 62.36%.

Authorized/Utilized (Per Capita) (Age 22 and Older)



ORDERED BY % UTILIZED (from Lowest to Highest)		AMOUNT ($)	UTILIZED (%)
Native Hawaiian or Other Pacific Islander	Utilized % (22 yrs and older)		71.29
	Utilized $ (22 yrs and older)	26,143	
	Authorized $ (22 yrs and older)	36,673	
Bi-Racial/Multi-Racial	Utilized % (22 yrs and older)		77.11
	Utilized $ (22 yrs and older)	33,211	
	Authorized $ (22 yrs and older)	43,068	
Asian	Utilized % (22 yrs and older)		77.16
	Utilized $ (22 yrs and older)	28,042	
	Authorized $ (22 yrs and older)	36,343	
Hispanic	Utilized % (22 yrs and older)		77.62
	Utilized $ (22 yrs and older)	24,756	
	Authorized $ (22 yrs and older)	31,895	
Black/African American	Utilized % (22 yrs and older)		79.54
	Utilized $ (22 yrs and older)	39,302	
	Authorized $ (22 yrs and older)	49,411	
White	Utilized % (22 yrs and older)		79.77
	Utilized $ (22 yrs and older)	47,679	
	Authorized $ (22 yrs and older)	59,770	
American Indian or Alaska Native	Utilized % (22 yrs and older)		81.61
	Utilized $ (22 yrs and older)	61,524	
	Authorized $ (22 yrs and older)	75,390	
Utilization (All Races/Ethnicities)	Utilized % (22 yrs and older)		78.84
	Utilized $ (22 yrs and older)	36,903	
	Authorized $ (22 yrs and older)	46,806	

Figure III

Figure III: We then conducted similar analysis stratified by Age 22 and older. We found that although individuals age 22 and over utilized more than 75% of the resources allocated to them (unlike age 3-21), there were still obvious differences among the race/ethnicities, with Native Hawaiian/Pacific Islanders utilizing the least amount of resources (71.29%), followed by the Biracial/Multi-Racial racial/ethnic group (77.11%) and the Asian racial/ethnic group closely behind (77.16%).

Overall, these findings were consistent with anecdotal evidence from our community members with lived experience and authentic voices that individuals in the age bracket 3-21 faced the most barriers accessing health care and social services. To confirm these findings and further investigate the barriers to accessing resources, we invited several community members with lived experience of disability to participate in focus groups and key informant sessions. Recruitment was mainly done through snowball method.

Focus Groups and Key Informant Sessions

An estimated 30 people participated in six focus group sessions over a period of three months. Two key informants were also interviewed. In partnership with two community members with lived experience of disability, we then analyzed data from focus groups and key informant interviews to identify salient themes. The most commonly cited challenges were related to **Access, Education/Health Literacy**, and **Housing**. Other key themes are listed in table I below.

Thematic analysis further revealed that individuals with disabilities in Orange County experience pervasive health inequities based on age, gender, and immigration status. Furthermore, many of the individuals in the community are at the intersectionality of language/literacy, immigration, and race. These communities have been historically marginalized by structural barriers, racism, xenophobia, and other forms of discrimination in health care, and are still on edge over a wave of hate crimes against their communities.

Thus, it is imperative that evidence-based programs tailored to specific needs of these communities be developed and implemented. The analysis further exemplifies the need to deliver services in a manner that is linguistically and culturally concordant with that of the individuals with lived experience of disabilities.

Prioritizing Identified Needs

Following the analysis of qualitative data, we then invited 4 community members with lived experience of disability to participate in an exercise for prioritizing identified needs. (These individuals have previously worked closely with members of the Collective in conducing focus groups and implementing programs in the community).

Each key theme and associated sub-theme were rated using a scale ranging from “top need” to a “not at all a need”. Rating was done through a collaborative, rather than consultative approach. Themes that were rated as “A top need” or “An important need” **(Access to healthcare and behavioral services, *Education/Health Literacy*, and *Housing*)** were selected as our key areas of focus, the collective’s **Strategic Health Equity Action Areas**.

Key Themes

Key themes were rated as follows:

Key Themes	Associated Sub-Themes	Most Affected Demographic Group	A Top Need	An Important Need	Somewhat of a Need	Not at All a Need
Access Barriers	Access to healthcare services	Age 3-21	✓			
	Access to behavioral health services			✓		
	Access to healthcare		✓			
	Insurance coverage	All age groups and genders	✓			
	Enrollment for disability services		✓			
	Health literacy				✓	
Language Barriers	Access to interpreter services			✓		
Cultural Barriers	Access to culturally concordant services.			✓		
Transportation	Access to reliable transportation				✓	
Housing	Access to affordable housing	Age 22 and older	✓			
Childcare	Affordable childcare and/or after-school care.	Age 5-16				✓
Bias/Discrimination	Gender bias/discrimination	Women with minor children	✓			
	Mistrust of the system	Foreign-born or undocumented individuals		✓		
	Provider bias	Single women		✓		
Employment	Access to jobs that pay a living wage	Working men and women			✓	
	Fear of losing government benefits	Working men and women				
	Unpredictable work schedules	Working men and women			✓	

Table I

How the Quantitative and Qualitative Data was used to Support OCAPDC Health Equity Goals

Informed by insights from the data described in the Quantitative and Qualitative sections above, and the priorities identified in **Table I**, a consensus was reached to focus on the following specific needs:

1. Increase access to behavioral and healthcare services for families and children with intellectual and developmental disabilities. Goal: To reach 10,542 families and children with disabilities in the next two years.
2. Increase the number of individuals and families reporting (through surveys, focus groups, and/or interviews) the ability to navigate and utilize healthcare, behavioral, and social services, systems.
3. Collaborate with individuals with lived experience of disability to develop strategies for increasing utilization of Purchase of Services (PoS) for these families (POS is the money expended for provision of services from the Regional Center).

Data Infrastructure

At the same time, we will continue to strengthen our organization's data infrastructure. Specifically, we will train some of our members on how to design surveys that are tailored to the needs of non-native English-speakers, analyze data, and present findings in a way that informs intervention planning. The data insights will also help in identifying key issues, understanding the potential impacts of different strategic/policy choices, and assessing the feasibility and effectiveness of proposed interventions. Time and budget permitting, we will engage a quality consultant to help identify key indicators for monitoring our progress on the three objectives described above.

STRATEGIC HEALTH EQUITY ACTION AREAS

Policy and Systems Changes

Strategies to Impact Policy and Systems	Objective	Measurable Outcome	Timeline
Reduce barriers to access to healthcare, behavioral, and social (HBS) services by 25%. **Interview PLE-D who have not participated in focus group sessions (or key informant interviews) in the last six months.**	By June 2024, increase the number of members with lived experience of disability (PLE-D) reporting less barriers (or no barriers) to accessing healthcare, behavioral, or social services in Orange County (through surveys, focus groups, and/or interviews).	Number of members with lived experience of disability (PLE-D) will report a reduction in barriers to accessing HBS services in Orange County (through surveys, focus groups, and/or interviews).	By June 2024

Strategies to Impact Policy and Systems	Objective	Measurable Outcome	Timeline
Increase employment opportunities that pay a living wage. Develop and prioritize non-traditional economic models such as but not limited to worker co-ops, and community farms.	In the next six months, the number of members with lived experience of disability reporting employment in jobs that pay a living wage will increase by 10% (from a self-reported baseline of 10% in March, 2023).	Total number of living wage jobs reported (through surveys, focus groups, and/or interviews).	February 2024
Increase availability of safe, affordable housing for members with PLE-D. Provide mentoring for families to acquire alternative financial support in the form of SSI and IHSS.	By June, 2024, increase by 10% the number of available rent-controlled units in safe neighborhoods.	Decreased number of evictions (by 10%). Number of rental units setting a percentage limit on annual rent increases.	June 2024
Increasing utilization of Purchase of Services (PoS) for individuals with lived experience of disability. We will focus on age 3-21 (age group with least utilization). **Strategy:** Collaborate with individuals with lived experience of disability to develop strategies and material for increasing POS.	In 6 months, increase utilization of POS by 0.3%.	Data from will reveal a 0.3% increase in utilization for age group 3-21.	October 2024

Meaningful Partnerships, Power Building, and Power Sharing

Strategies to Build Partnerships and Power	Objective	Measurable Outcome	Timeline
Revisit the Collective's Bylaws every quarter. Each voting member will cast a vote on proposed amendments. Form a revision committee to approve/deny proposed amendments.	Review the Collective's Bylaws every four months to ensure they meet the collective's needs and that each community is equally and fairly represented. Amend as needed.	Number of times the bylaws are reviewed (per year). Number of amendments made to the Bylaws (if applicable).	June 2024
Maintain a non-hierarchical organizational structure by conducting a Stakeholder mapping/analysis with partners to increase transparency, improve communication, and secure buy-in from key players.	Perform a stakeholder analysis every six months.	Number of partners/ stakeholders with (1) High Power-High Interest (have the biggest impact on project success) and (2) High Power-Low Interest, (3) Low Power - High interest, and (4) Low Power-Low Interest.	May 2023

Infrastructure, Data, and Other Capacities

Strategies to Strengthen Infrastructure, Data or Other Capacities	Objective	Measurable Outcome	Timeline
Provide training to collective members on survey design, data analytics, dissemination, and reporting (including data visualization using Tableau software).	Provide technical assistance, training, and support for collective members to pursue funding opportunities.	Number of members trained in on survey design, data analytics, dissemination, and reporting.	October 2023 - June 2024
Create a culturally sensitive needs assessment tailored to the needs of non-native English speakers in order to better understand the needs of PWE-D in Orange County.	Utilize a data collection platform such as Qualtrics to collect needs assessment data. Leverage lived experiences, stories, and anecdotes of PWE-D to design more targeted services for the individuals we serve, both qualitative and quantitative data inform targeted interventions and advocacy, and policy changes at the local and state level.	Number of Key Performance Indicators developed through surveys. Performance on the KPIs every three months.	December 2023 - March 2024

Sustainability

To flourish in the long run, OCAPDC will collaborate with representatives from the community (PWLE-D) and key stakeholders in planning for sustainability (throughout all the stages of program design and implementation). We will implement several strategies, including, but not limited to:

- First and foremost, create a shared understanding of what sustainability means to OCAPDC and our partners/stakeholders and the role that each of the partners will play.
- Regularly review and evaluate programs to determine what is working well and what could be improved.
- Conduct on-going stakeholder analysis to determine who has high or low power to affect the Collective's projects, and who has high or low interest.
- Periodic review of strategic objectives to ensure alignment with the OCAPDC's mission and vision.
- Regularly communicate the value of our programs to community members and key stakeholders. Broadcast successes to stakeholders and communities.
- Conduct annual return on investment of the program/s.
- Develop a diverse funding portfolio, collaborative leadership, and marketing/branding strategies.