Oregon

Theodore R. Kulongoski, Governor

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June 2, 2008

The Honorable Peter Courtney, Co-Chair
The Honorable Jeff Merkley, Co-Chair
State Emergency Board
900 Court St, NE
Salem, OR 97301-4048

Re: DHS Policy Note on Health Care Disparities

Dear Co-Chairpersons:

NATURE OF REPORT

This report (including Appendix A) is submitted in response to the following policy note contained in HB 5031 passed in the 2007 Legislative session:

> The Department of Human Services (DHS) is directed to report to the Emergency Board by June 30, 2008 on its efforts to reduce health care disparities among the variety of racial and ethnic populations served by the Oregon Health Plan (OHP). The report should include a discussion of the ways the Office of Multicultural Health within the Public Health Division has collaborated with the Division of Medical Assistance Programs to develop and implement strategies to achieve this goal. As an introduction, the report should discuss the costs of health care disparities and the benefits of reducing those disparities.

AGENCY ACTION

The report shows that health care disparities exist between individuals on the OHP and Oregon citizens, as indicated by a 2007 Consumer Assessment of Health Plans and Systems (CAHPS) survey. As expected, OHP clients reported a lower rate of health status than Oregon citizens in each of the ethnic categories surveyed. Living in poverty is a strong risk factor for poor health. In

addition, the report shows health care disparities exist between racial and ethnic populations.

Chronic health conditions, such as asthma and diabetes are more prevalent among people on the OHP than the rest of the states' population. However, among the ethnic groups, there is no consistent pattern showing that one ethnic group/race has a higher or lower rate than the others for all conditions measured.

As shown in Appendix A of the report, the Department of Human Services, through its various offices and divisions, is promoting health awareness and access to health services by:

- Providing materials and messages, in multiple languages, that encourage and inform people on how to improve and maintain their health.
- Developing and participating in projects and initiatives across the Department focusing on the health care needs of ethnic groups.
- Participating in joint workgroups focused on improving health care.
- Designing performance measures that can be broken out by race and ethnicity, for example Table 8 of the report, Rate of Ambulatory Care Sensitive Inpatient Claims.
- Attending health fairs and community events.
- Participating in advisory committees.

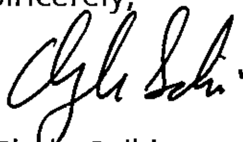
ACTION REQUESTED

The Department requests Emergency Board acceptance of the attached report.

LEGISLATION AFFECTED

The attached report is a Policy Note to House Bill 5031.

Sincerely,



Clyde Saiki,
Deputy Director of Operations

cc: John Britton, Legislative Fiscal Office
Sheila Baker, Legislative Fiscal Office
Eric Moore, Department of Administrative Services
Lynn Read, Department of Human Services

Oregon Department of Human Services'

Efforts to Reduce Racial and Ethnic Health Care Disparities

Compiled by the
Division of Medical Assistance Programs
and the
Public Health Division

May 23, 2008

Introduction

This report was produced at the direction of the 74th Oregon Legislative Assembly. It describes the Oregon Department of Human Services' efforts to reduce health care disparities among the variety of racial and ethnic populations served by the Oregon Health Plan.

More particularly, this report describes ways the Office of Multicultural Health within the Public Health Division has collaborated with the Division of Medical Assistance Programs to develop and implement strategies to achieve the goal of reducing disparities. Both entities are within the Department of Human Services. This report reflects a collaborative effort spanning the agency as a whole.

The report begins with a discussion of the disease burden experienced by different racial and ethnic communities in the state, in general and within the Oregon Health Plan. This will provide a basis for estimating costs associated with these conditions and then describing the benefits of further reductions.

> *"U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services."*
>
> *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* March 20, 2002, Institute of Medicine.

In Oregon, the Governor's Task Force on Health Care Disparities undertook efforts to collect information and assess state efforts. Its report identified areas for review.

These documents, along with the latest national information on health care disparities, guide the frame work for this report.

A 2005 report by the Colorado Department of Public Health and Environment, Office of Health Disparities estimated the annual cost of health care disparities for diabetes and obesity was over $120,000,000 for their population of 4.6 million.

Burden of Health Care Disparities

The following tables describe how different racial and ethnic communities in Oregon fare in comparison to those on the Oregon Health Plan. Because Medicaid determines eligibility based on low-income, one might expect the Medicaid-eligible population to be less healthy than the general population.

Oregonians who are African American, American Indian/Alaska Native, or Latino are less likely to report that their health status is "good" to "excellent" than are Whites. There may be several reasons for this. One important factor is the higher incidence of several chronic diseases among people of color.

In addition, living in poverty is a strong risk factor for poor health. Although a different data source, the table below shows all Oregon Health Plan clients' race/ethnicity groups are below the overall population for reported health status of "good" to "excellent." Latinos/Hispanics are most likely to report their health status as "good" to "excellent" and "American Indians/Alaska Natives" are least likely to report their health status as "good" to "excellent." There may be other factors such as Latinos/Hispanics on OHP are a younger population group and younger people tend to be healthier. Also, as the next tables show, Latinos/Hispanics on OHP, are less likely to smoke and less likely to have asthma than other groups on OHP.

Table 1: Comparison of health status Oregon vs Oregon Health Plan (OHP)

Reported Health Status: Good to excellent		
Race and Ethnicity	**Oregon**[1]	**OHP**[2]
African Americans	75%*	63%
American Indians and Alaska Natives	69%*	45%
Asians and Pacific Islanders	90%	62%
Latinos/Hispanics	71%*	66%
Whites	86%	55%

[1] Statistically significant difference, compared with Whites - Behavioral Risk Factors Surveillance Survey (BRFSS) 2004-2005 oversample)*

[2] Data are not comparable between Consumer Assessment of Health Plans and Systems (CAHPS) Survey and BRFSS as they are weighted to different population distributions and assess race/ethnicity using different methods.

2007 CAHPS data are a survey of continuously enrolled Medicaid clients, of which a large proportion are women who are pregnant or may have recently given birth. CAHPS data also lets respondents "select all that apply" and categories are not mutually exclusive. Data are weighted by race. Tests of significance were not calculated.

The next two tables below show the prevalence of the chronic health care conditions of asthma and diabetes by race group in the state and in OHP. Caution should be heeded when directly comparing rates. The general population rates are from 2004-05 survey data in which the survey question was "Have you ever been told by a doctor, nurse or other health professional that you had asthma (or diabetes)? The OHP rates are based on clients enrolled in 2005-06 and then looks at actual medical claims over a ten year period in the Medicaid database for asthma and diabetes diagnoses (must have either two diagnoses of the disease or one diagnosis and one pharmacy dispensing related to the disease). Though different, both methods cast a wide net of disease prevalence.In the overall Oregon population, asthma is significantly more common among American Indians/Alaska Natives than it is among most other groups. Though not statistically significant due to small sample size, African American rates are also greater than Whites. The prevalence of asthma among Latinos/Hispanics and Asians and Pacific Islanders is significantly lower than it is among Whites.

Among OHP clients enrolled for at least six months, American Indians/Alaska Natives have the highest rate of asthma. African Americans and Whites have the next highest rates, and Asian/Pacific Islanders and Hispanics have the lowest rates.

Table 2: Asthma Prevalence in Adults - Oregon vs OHP by race/ethnicity.

Percentage with Asthma		
Race and Ethnicity	**Oregon[1]**	**OHP[2]**
African Americans	16%	17%
American Indians and Alaska Natives	15%*	24%
Asians and Pacific Islanders	6%*	13%
Latinos/Hispanics	5%*	12%
Whites	10%	19%

[1] Statistically significant difference, compared with Whites - Behavioral Risk Factors Surveillance Survey (BRFSS) 2004-2005 oversample)*

[2] OHP data sources are eligibility, enrollment, and medical claim and encounter tables of the MMIS/DSSURS database. Clients enrolled 2005-06. Service dates for claims and encounters are from 7/1/1997 through 12/31/2006. Tests of significance were not calculated.

The table below shows the prevalence of diabetes among different racial/ethnic communities in the state and among Oregon Health Plan clients.

In the general population, among Latino, American Indian/Alaska Native, and African American Oregonians, diabetes is significantly more common than it is among Whites. This is at least in part due to the higher rates of obesity, which increases the risk of diabetes, in these communities (see Table 3, below). Asian/Pacific Islander Oregonians, on the other hand, have lower rates of obesity than do Oregonians in general.

Among OHP clients enrolled for at least six months, diabetes rates are high, 16% and above, for all races. Prevalence of diabetes is related to living in poverty and greater age. Economically disadvantaged Oregonians are 1.5 times more likely to have diabetes. The high rate of diabetes among Asian/Pacific Islanders on OHP may possibly be that they are older as a group than other groups on OHP.

Table 3: Diabetes Prevalence in Adults Oregon vs OHP by race/ethnicity

Percentage with Diabetes		
Race and Ethnicity	Oregon[1]	OHP[2]
African Americans	13%*	16%
American Indians and Alaska Natives	12%*	19%
Asians and Pacific Islanders	7%	22%
Latinos/Hispanics	10%*	18%
Whites	6%	16%

[1] Statistically significant difference, compared with Whites - Behavioral Risk Factors Surveillance Survey (BRFSS) 2004-2005 oversample)*

[2] OHP data sources are eligibility, enrollment, and medical claim and encounter tables of the MMIS/DSSURS database. Clients enrolled 2005-06. Service dates for claims and encounters are from 7/1/1997 through 12/31/2006. Tests of significance were not calculated.

The table below shows the prevalence of obesity among different race groups in the state. At this time, rates of obesity prevalence for the overall OHP population are not available.

Table 4: Obesity, Adults Oregon by race/ethnicity.

Prevalence of Obesity	
Race and Ethnicity	Oregon[1]
African Americans	29%
American Indians and Alaska Natives	30%*
Asians and Pacific Islanders	15%*
Latinos/Hispanics	31%*
Whites	24%

1 Statistically significant difference, compared with Whites - Behavioral Risk Factors Surveillance Survey (BRFSS) 2004-2005 oversample)*

Having diabetes increases a person's risk of heart disease (Table 5). The higher rates of smoking and diabetes among African Americans and American Indians/Alaska Natives are consistent with the significantly higher rates of

heart attack reported within these communities (below). Rates of heart attack prevalence for the OHP populations can be made available in a future analysis.

Table 5: Heart Attack, Adults - Oregon by race/ethnicity.

Reported Heart Attack	
Race and Ethnicity	**Oregon[1]**
African Americans	8%*
American Indians and Alaska Natives	10%*
Asians and Pacific Islanders	2%
Latinos/Hispanics	3%
Whites	4%

*1 * Statistically significant difference, compared with Whites – Behavioral Risk Factors Surveillance Survey (BRFSS) 2004-2005 oversample)*

As shown in Table 6, below, smoking rates among African American and American Indian/Alaska Native Oregonians are significantly higher than they are for the general population, while rates for Latino and Asian/Pacific Islander Oregonians are significantly lower.

Living in poverty and using tobacco are known to be positively correlated. Among OHP clients enrolled for at least six months, African Americans, American Indians/Alaska Natives, and Whites have the highest smoking rates. Asian/Pacific Islanders and Hispanics have the lowest smoking rates and are statistically significantly lower than Whites.

Table 6: Smoking prevalence in Adults Oregon vs OHP by race/ethnicity.

Smoking Prevalence		
Race and Ethnicity	**Oregon[1]**	**OHP[2]**
African Americans	30%*	41%
American Indians and Alaska Natives	38%*	44%
Asians and Pacific Islanders	10%*	14%*
Latinos/Hispanics	14%*	15%*
Whites	20%	41%

[1] Statistically significant difference, compared with Whites - Behavioral Risk Factors Surveillance Survey (BRFSS) 2004-2005 over sample) 2004-2005 BRFSS prevalence is age-adjusted to the year 2000 population and is weighted. Age-adjustment is used to control for differences in estimates that are due purely to populations having different age distributions. Unlike CAHPS data, race/ethnicity categories are mutually exclusive.*

*[2] *Statistically significant difference, compared with Whites. Data are not comparable between Consumer Assessment of Health Plans and Systems (CAHPS) Survey and BRFSS as they are weighted to different population distributions and assess race/ethnicity using different methods.*

2007 CAHPS data are a survey of continuously enrolled (by plan) Medicaid clients, of which a large proportion are women who are pregnant or may have recently given birth. CAHPS data also lets respondents "select all that apply" and categories are not mutually exclusive. Data are weighted by race.

The table below shows the distribution of births by different race groups in the state and in the Oregon Health Plan as well as prevalence of adequate prenatal care. According to the Vital Statistics database, in the overall population and among OHP clients, Whites have highest rate of adequate prenatal care while American Indians/Alaskan Natives have the lowest rate.

Table 7: Adequate prenatal care in Oregon vs. OHP by race/ethnicity
(*Oregon– Vista PH & Vital Statistics* - 2006).

Adequate* Prenatal Care				
Race and Ethnicity	**Oregon births**	**Oregon adequate prenatal care**	**OHP births**	**OHP adequate prenatal care**
African Americans	2.3%	65.3%	3.3%	61.5%
American Indians and Alaska Natives	1.7%	55.7%	2.4%	49.7%
Asians and Pacific Islanders	5.5%	65.8%	2.8%	51.7%
Latinos/Hispanics	20.4%	60.1%	34.4%	57.6%
Whites	69.9%	71.4%	57.0%	63.6%

****Adequate** prenatal care is a combination of Adequate and Intensive as defined by the Adequacy of Prenatal Care Utilization (APNCU) Index, also referred to as the Kotelchuck Index.*

The Public Health Division recently published the first Oregon Perinatal Data Book. The book presents information on the health status of pregnant women and infants in Oregon and includes many health indicators, prenatal care among them. Each topic is analyzed for disparities in race/ethnicity, as well as age and education where relevant. The Data book provides critical information for use in targeting perinatal health programs and interventions in Oregon to reduce health disparities. The Prenatal and Newborn Resource Guide for Oregon Families is printed in both English and Spanish and available on the Office of Family Health website.

The next table looks at Ambulatory Care Sensitive Condition Hospitalizations for OHP clients. Low rates are favorable.

Good primary care dramatically reduces the risk of hospitalization. A corner stone of the Oregon Health plan is emphasizing preventive services so that these admissions are less needed. Ambulatory Care Sensitive (ACS) conditions involve diagnoses where timely and effective ambulatory care (usually primary care) can help prevent or reduce the risk of hospitalization. There are three types of ACS conditions:

- Chronic conditions (diabetes, asthma, congestive heart failure), where effective management can often prevent more serious flare-ups that require admission.

- Acute conditions (ear/nose/throat infections, gastroenteritis, cellulitis, and so on), where early intervention can prevent more serious progression of the condition that might require hospital admission for treatment.
- Preventable illnesses (pertussis, tetanus, rheumatic fever, and so on), where immunization can prevent the onset of the disease, and any hospitalization represents a serious failure of the health care delivery system.

Higher rates of ACS hospitalizations can be an indication of a primary care access concern. These hospital admissions are not necessarily "inappropriate" in the sense of being unneeded or unwarranted. They are simply conditions where effective ambulatory care might have prevented the condition from becoming so severe that an admission was necessary. Moreover, not all individual ACS admissions are even preventable or avoidable. Situations exist where even best possible care cannot prevent serious progression of the condition ending in a hospitalization; for example, failure of treatment to be effective, especially among older and sicker patients, using the most advanced technology and methods available could still end in an admission.

The table below shows that Whites and African Americans have the highest rate of ACS inpatient claims, while, Asians/Pacific Islanders and American Indians/Alaska Natives have a slightly lower rate and Latinos/Hispanics have a much lower rate. One reason Latinos/Hispanics have a much lower rate may be that Latinos/Hispanics as a group are younger than other groups on OHP and younger people are generally healthier.

Table 8: Rate of Ambulatory Care Sensitive (ACS)[1] – Inpatient (IP) claims by race for clients on the Oregon Health Plan – 2006

Ambulatory Care Sensitive	
OHP Race and Ethnicity	**Rate of ACS inpatient claims per 10,000 member months**
African Americans	25
American Indians and Alaska Natives	22
Asians and Pacific Islanders	23
Latinos/Hispanics	10
Whites	26

[1] *See: http://www.ahrq.gov/data/safetynet/billappb.htm for exact specifications for each condition. Data were extracted from the DMAP DSSURS database:*

Note: Childhood lead screening and AIDS/HIV rates for the Oregon general population and OHP will be reported on at a future date.

> "In 1999 Congress requested the Institute of Medicine (IOM) to study health care disparities. The IOM found significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable."
>
> *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* March 20, 2002, Institute of Medicine

Highlights of efforts at reducing Disparities

> The following is by no means a comprehensive list since the core mission of the agency is to help those vulnerable populations who do not have adequate access to health care services. A more comprehensive summary is attached in Appendix A.

The Office of Multicultural Health (OMH)

The Office of Multicultural Health reaches out to racial and ethnic communities through attending community events, initiating meetings with community organizations, and participating in community health fairs and advisory committees. Through these efforts, OMH informs Public Health Division (PHD) programs about these community engagement and outreach opportunities to become more visible and involved with community efforts. Some PHD programs have attended the following events: annual African American Wellness Village, Asian Health and Service Center Community Event, and Latino Bi-national Health Week.

OMH has collaborated with some PHD programs to jointly develop project work plans to reduce health disparities. The Oregon Partnership to Immunize

Children and OMH staff worked jointly with the Health Disparities workgroup to develop a Health Disparities Resource Guide. This resource has been distributed to county health clinics and other clinics that provide the Vaccines for Children (VFC) program. The goal of this project is to provide a tool for clinicians to assist in providing culturally competent services to their clients. The Behavioral Risk Factor Surveillance System (BRFSS) work group and OMH staff partnered to pilot a program that would collect a racial over sampling of health conditions. If successful, this pilot project will show that alternative data collection methods should be considered when collecting data on hard to reach populations. Preliminary findings show that this new data collection method is less costly compared to the traditional BRFSS racial/ethnic over sampling.

Coordinated information sharing and partnerships across programs and divisions are still needed. With the Office of Multicultural Health moving to the DHS Director's Office, this may be an opportunity to strategize on effective ways to coordinate, collaborate, and be accountable in program areas that are working to address racial and ethnic health disparities.

The Division of Medical Assistance Programs (DMAP)

DMAP's Medicaid Quality Strategy is being revised and will reflect disparities reduction as measures and area of focus. One of DMAP's past DHS Key Performance Measures was racial/ethnic variation of access to routine health care. A future Key Performance Measure is access to preventive services, which can be broken out by race/ethnicity.

A premise of the Oregon Health Plan (OHP) is to increase access to preventive and primary health care through routine health care visits, thereby reducing unnecessary and more expensive health care in the hospital or emergency room setting. Routine primary, preventive and specialist care are most effectively and appropriately delivered in a clinic or office rather than an emergency room.

The increased proportion of clients enrolled in managed care and having a medical home facilitates decreasing health care disparities. Another facilitator is the number of clients whose medical home is a Federally Qualified Health Center or a Rural Health Clinic, as these clinics have a high level of cultural competence.

Increased access to primary care is associated with earlier detection of disease, prevention of disease, and improved health. Accessing primary care allows diseases to be diagnosed and treated before becoming serious and debilitating. In addition, preventive screens and anticipatory guidance given as part of primary care helps to promote early treatment, healthy lifestyles and wellness.

Many of the managed care plans that contract with DMAP have Spanish speaking staff, education programs and outreach, language line services for physicians, and disease information in various languages. In addition, DMAP continues to provide an increasing number of educational materials in languages in addition to English.

DMAP provided educational videos on protecting children and other family members from second-hand smoke. The videos are in Spanish and English and were distributed to OHP's managed care plans to be used in clinic settings.

Educational materials for DMAP's Early Childhood Cavities Prevention project are produced in both Spanish and Russian. An increasing number of OHP managed care plans have a specific targeted outreach to their Spanish speaking and Russian speaking communities.

DMAP's Disease Management Program focuses on improved care for fee-for-service OHP clients who have asthma, diabetes, or congestive heart failure. These chronic diseases disproportionably affect many racial/ethnic populations. The Disease Management program annually reports clients served by race/ethnicity. As a result, educational materials have been delivered in Spanish, Russian, and Vietnamese. In addition, a Spanish speaking community-based nurse has been active in the program. All Disease Management staff has completed an immersion program for Native American cultures. In addition, all telephonic nurses are required to be trained and tested annually on cultural competency with a health care focus.

The Consumer Assessment of Health Plans survey (CAHPS) was over sampled by race/ethnicity, and results show variation in satisfaction of care and smoking rates by race/ethnicity. The Medicaid Health Risk Health Status survey was sampled in a similar way, and a separate analysis and report by

race/ethnicity was produced. In addition, DMAP and Portland State University have evaluated the Spanish language portion of the Medicaid Health Risk Health Status survey.

DMAP will continue to collaborate with community, public health, and federal partners on initiatives and projects that focus on reducing health care disparities.

Past projects of DMAP

Through the national Minority Report Card Project, DMAP and several of its contracted health plans collaborated with Oregon's African American Health Coalition to implement a REACH (Racial and Ethnic Approaches to Community Health) grant. The REACH grant funded a major campaign to reduce preventable diseases in Oregon's African American population. A major intervention targeted low-income OHP African Americans through regular mailings containing health information that promotes preventive and primary care, such as, smoking cessation, the importance of regular care for cardiovascular disease, hypertension and diabetes. An evaluation compared African Americans on OHP who received the mailings with African Americans on OHP who did not receive the mailings. The evaluation showed significant improvement in the rates of cholesterol (LDL – low-density lipoprotein) screening in African American diabetics who received the mailings. This intervention has become an example of a useful tool for eliminating health disparities for other state Medicaid programs.

DMAP facilitated and coordinated a grant application submitted by several OHP managed care plans to: "Improve Health Care Quality for Racially and Ethnically Diverse Populations in Medicaid Managed Care" sponsored by the national Center for Health Care Strategies (CHCS). The OHP managed care plans received the grant. As part of this grant, these OHP plans participated with DMAP and Portland State University in a national Best Clinical and Administrative Practices workgroup with the above focus. The specific intervention chosen by the OHP plans was reducing emergency department visits for clients with chronic diseases who do not speak English.

DMAP developed a workshop entitled "Opening Doors to Better Health Outcomes: Reducing Racial and Ethnic Health Disparities in the Oregon Health Plan." It was presented for the Statewide Quality Improvement Meeting in October 2003. The focus was to give tools and practical ideas to OHP plan

representatives, quality improvement coordinators, and health care providers for assessing health needs and improving services for disparate populations.

OMH and DMAP

The former administrator of the Office of Multicultural Health gave a presentation in October 2007 to DMAP's Quality and Performance Improvement work group entitled "Measurement and How to Connect Cultural Confidence with Quality & Performance Improvement".

In April 2008 at the same work group, the new interim administrator was introduced and participated in a discussion with DMAP's contracted managed care plans on current and future strategies for reducing racial/ethnic health disparities.

Resources

J. Hunsaker, E. Krause, J. Carrington, N. Hester, "Racial and Ethnic Health Disparities in Colorado 2005", Colorado Department of Public Health and Environment, Office of Health Disparities.

P. Hogan, T. Dall, and P. Nikolov, "Economic Costs of Diabetes in the U.S. in 2002," *Diabetes Care* 26 (March 2003): 917–932.

R. Y. Chen et al, "HIV Healthcare Costs Driven by CD4 Count and Medications, Not Physician Fees," Abstract H-157, 42nd Interscience Conference on Antimicrobial Agents and Chemotherapy, San Diego, Calif., September 27–30, 2002.

E. A. Finkelstein, I. C. Fiebelkorn, and G. Wang, "State-Level Estimates of Annual Medical Expenditures Attributable to Obesity," *Obesity Research* 12 (January 2004): 18–24.

PUBLIC HEALTH DISPARITY REDUCTION EFFORTS

DHS/PHD Program Responsible: Office of Community Health and Health Planning;
Office of Disease Prevention and Epidemiology/ Chronic Disease Prevention

Health Disparity Reduction Efforts: Partnership with Oregon Health Care Quality Corporation (Q-CORP)

Activities:

- Dr. Grant Higginson, Interim State Health Officer, is a Board of Director on Q-Corp.
- DMAP and DMAP's largest managed care plan, CareOregon, participates in Q-Corp's Aligning Forces for Quality Measurement & Reporting Team.
- DMAP and DMAP's largest managed care plan, CareOregon, will contribute data to be used for quality measurement.
- Support of potential new grant activity.
- Currently, Q-Corp has a Robert Wood Johnson Foundation grant (Aligning Forces for Quality) that is designed to help providers improve the quality of care; help providers measure and report performance; and help consumers demand high-quality care.
- Q-Corp is applying for an enhancement to that grant that, among other activities, would assist providers in gathering and compiling health care data by race and ethnicity. It is difficult to deal with health disparities until data is available to assess health issues across racial/ethnic population groups, and it is generally recognized there is a paucity of such data in Oregon.

DHS/PHD Program Responsible: Office of Community Health and Health Planning Health Systems Planning

Health Disparity Reduction Efforts: Migrant Worker Program

Activities:

- 1.0 FTE Migrant Health Coordinator (MHC)

- Works closely with communities across Oregon and the migrant and seasonal farmworker community to improve health through the availability of migrant health centers and community health centers that serve migrant and seasonal farmworkers.
- Currently there are 21 migrant health centers and community health clinics around the state.
- Migrant Health coordinator works at a policy level to assure that needed services are available to migrant/seasonal farmworker committee and related communities.

Health Disparity Reduction Efforts: Strengthening Safety Net Clinics

Activities:

- HSP works to strengthen all safety net clinics in Oregon from a policy, financing, and quality perspective.
- Safety Net Clinics serve a significant number of individuals who experience disparities in health status and health care.

Health Disparity Reduction Efforts: Health Professional Shortage and Medically Underserved Populations

Activities:

- HSP identifies health professional shortage and medically underserved populations and areas of the state. These designations provide the basis for eligibility for federal grants to underserved populations, the placement of National Health Service Corps clinicians, and payment methodologies which support safety net clinics in their mission to serve those who face barriers to care.

DHS/PHD Program Responsible: Office of the State Public Health Director: Community Liaison

Health Disparity Reduction Efforts: Latino/Bilingual and translation efforts

Activities:

- *Critical News Releases (CNR):* More than 80 CNRs translated since pilot began in January 2007. Templates developed for beach advisories, lifts. Translators work via interagency agreement, accuracy check team in place. Translation Coordinator(s) identified.

Appendix A

- *Public Health English-Spanish Glossary:* Began development of Glossary in fall of 2006. Produce updated version every 6 weeks; 6th edition has recently been completed. Developed process for updating glossary.
- *Public Health Spanish Display:* Created bilingual display for use with non-English speaking, bilingual audiences. Completed and scheduled for use.
- *Public Health business cards translated:* Developed process with PH Executive Assistants for translation of business cards, where appropriate. Communicated guidelines to group, who place re-orders and new orders for business cards, or help others do so. Group will use Glossary process to obtain titles and program names translated.
- *Translated public health outreach materials:* Working with Database Pilot team to include translated materials in new database. Will help better catalogue and track these materials for use with outreach activities.
- Compiled list of translated materials produced from each PHD office.

DHS/PHD Program Responsible: Office of Disease Prevention and Epidemiology: Health Promotion and Chronic Disease Prevention Program/ Tobacco Prevention & Education Program

Health Disparity Reduction Efforts: Identified Target Populations

Activities:

Populations experiencing tobacco-related disparities, identified by TPEP to date, include the economically disadvantaged, racial, ethnic, and sexual minorities, rural men (smokeless tobacco), people with disabilities, and people with mental illness or addictions.

Health Disparity Reduction Efforts: Expanded Data Analysis on Disparities

Activities:

- Over the past 5-8 years, significantly expanded data analysis.
- *Specific Population Data Reports* (available at http://oregon.gov/DHS/ph/tobacco).
- *Focus Group Report* (available at http://oregon.gov/DHS/ph/tobacco).
- DMAP shares with TPEP for analysis – Consumer Assessment of Health Plan Systems (CAHPS) survey smoking questions data. Using CAHPS survey data, TPEP plans to add a Medicaid Specific Population Data Report.

Appendix A

Health Disparity Reduction Efforts: Infrastructure for Addressing Disparities

Activities:

- "Eliminating Tobacco-Related Disparities" is one of TPEP's four overall goals, and one of five overall goals for the Oregon tobacco control community.
- TPEP convenes the Tobacco Disparities Advisory Council (TDAC), a diverse group of volunteers, to provide leadership and vision to the statewide tobacco control community on how we can continue efforts to reduce disparities. TDAC has two subcommittees, Data and Communications, and Cultural Competency. The Data and Communications committee are developing plans for raising awareness about disparities in Oregon by describing collaborative efforts of TPEP programs and communities experiencing disparities to address and eliminate disparities, and the policy and health outcomes accomplished. The Cultural Competency committee is working to develop guidelines for enhancing and improving the cultural competency of TPEP programs and policies.
- 1 FTE TPEP lead worker designated on disparities, and other staff (*e.g.,* program coordinators, research analysts) dedicate a portion of their time to disparities efforts.
- TPEP has targeted grants to address specific populations experiencing disparities; these grants go to all nine federally-recognized tribes in Oregon, and to five community-based agencies ("Networks") serving the African American, the Asian and Pacific Islander, Latino, urban American Indian, and LGBTQ population.
- All TPEP-funded programs (local and statewide) must address disparities in assessment, planning, coordination/engagement, and implementation (this is established via workplan development).

Health Disparity Reduction Efforts: Evaluation and Surveillance

Activities:

- TPEP has contracted with two evaluation planning contractors, NPC Research and Frank Mondeaux.
- Contractors utilize community-based, collaborative research principles in the provision of technical assistance to the Networks and Tribes:
  - ✓ Assist with program evaluation
  - ✓ Development of case studies on policy efforts (to build an evidence base on effective disparities efforts), and
  - ✓ Identify new or enhanced data systems/methodologies.

Appendix A

DHS/PHD Program Responsible: Office of Disease Prevention and Epidemiology: Health Promotion and Chronic Disease Prevention Program/Arthritis Program

Health Disparity Reduction Efforts: Oregon Arthritis Program

Activities:

- Partnered with Northwest Health Foundation on "Arthritis in Focus: Community-Based Collaborative Research to Improve Quality of Life" grant.
- Focus is on the challenges of arthritis among the Hispanic Population in a four-county area of Oregon.
- Currently in year 3 of 3.
- In 2005-06, ran the CDC's campaign "Physical Activity. The Arthritis Pain Reliever". Targeted the African American Community in NE Portland. The Campaign consisted of radio ads, newspaper ads, and brochure placements.

DHS/PHD Program Responsible: Office of Disease Prevention and Epidemiology: Health Promotion and Chronic Disease Prevention Program

Health Disparity Reduction Efforts: Oregon Diabetes Prevention and Control Program

Activities:

- Translation of diabetes resources including *Meals Made Easy for Diabetes* and the *Diabetes Care Card*, into Spanish language.
- Support for *Tomando Control de su Salud*, the Spanish version of *Living Well with Chronic Conditions.*
- Development of a diabetes resource and education guide for Latino and Asian communities in Multnomah County.
- Completion of a statewide television media campaign targeting the Spanish-speaking population; campaign message focused on diabetes prevention and management.

Health Disparity Reduction Efforts: Oregon Heart Disease and Stroke Program

Activities: *Oregon Living Well with Chronic Conditions*

- Supported by various chronic disease programs including Diabetes, Heart Disease & Stroke, Asthma, & Arthritis.

- In the process of developing two videos promoting chronic disease self-management programs, including *Living Well, Tomando Control de su Salud* and *Positive Self-Management for People with HIV/AIDS*.
- One video will be in English and focus on the benefits of all three programs, primarily through "testimonials" from program participants and leaders. This video will be used to recruit participants, demonstrate positive results to providers and funders, and used for general promotional purposes.
- Second video will be in Spanish and focused mainly on *Tomando* - using the stories of Hispanic/Latino participants and program leaders. The Spanish-language video is geared toward recruiting participants and will be shown by partners across the state in presentations, clinics, FQHCs, and other targeted outreach opportunities.
- Both videos are expected to be completed by late spring and will be provided to chronic disease self-management partners across the state at no charge.

Health Disparity Reduction Efforts: Oregon Comprehensive Cancer Control

Activities: Multi-cultural outreach activities include:

- Convened Cancer Disparities Workgroup with up to 25 participants - DMAP has joined this Workgroup as well as the Prevention and Early Detection Workgroup;
- Sponsored 5 community health representatives from racial/ethnic groups for the planning of OHSU's 2006 Cancer Disparities conference;
- Developed a list of cancer education materials in 11 languages reviewed by community partners.

Current 2008 coalition activities include:

- Participating in a project to promote breast cancer screening for women with physical disabilities in one urban and one rural community;
- Planning a spring 2008 coalition newsletter on cancer disparities;
- Hosting a "Cancer in African American Population" gathering on Saturday, June 14th, at Portland Community College;
- Coordinating a fall cancer coalition meeting on cancer disparities;
- Implementing an earned media campaign to promote colorectal cancer screening with an emphasis on rural and racial/ethnic disparities; and
- Conducting community mobilization meetings in Oregon's rural and racial ethnic communities to promote colorectal cancer screening (African American, American Indian/Alaska Native and rural communities with high mortality rates).

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DHS/PHD Program Responsible: Office of Family Health Immunization Program

Health Disparity Reduction Efforts: Identified Health Disparities in Immunizations

Activities:

- In 2005, examined birth counts by race and ethnicity on a county level, to identify possible population counts that would allow for specific rate calculations for race and ethnicity in Oregon.

  We ran state-level 431331 rates (4:3:1:3:3:1 = 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella) for race in two categories to compare against totals: African-American & Native American. Asian in total did not look different from average values, so we did not break them out. We also ran Hispanic status both for state and counties. Finally we looked at African-American vs. Caucasian in Multnomah County, as that is where the majority of African-American kids live. Otherwise not fair to compare their state total against Caucasian state total, given population distribution.

  Results:

Rates by Race:	Rates by Hispanicity:
All → 72%	Hispanic → 74%
African American →70%	Non-Hispanic → 71%
Native American → 68%	

- DMAP, utilizing a small grant from the Immunization Program, studied a large data sample of infants born on OHP to determine patterns of immunization initiation. This study resulted in a research brief published in the May 2006 "American Journal of Public Health" and several DMAP administrative process changes. One part of this study concerned the race/ethnicity of OHP infants and their initiation of immunization by three months of age.

  Results:

Rates by Race/ethnicity:	High Rate is Favorable
All → 83.7%	
African American →80.4%	
Native American → 81.1	
Whites → 83.1%	
Asian → 85.5%	
Hispanic → 85.8%	

Health Disparities & Education Committee:

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- Committee coordinated by Oregon Partnership to Immunize Children (OPIC) in collaboration with Office of Multicultural Health.
- The Committee's charge is to work with partners in diverse racial and ethnic communities to achieve the long-term goal of closing immunization disparities that impact racial and ethnic communities in Oregon.
- The Committee is dedicated to educating the workgroup and OPIC on health disparity concerns and cultural competency advocacy.

OPIC Health Disparities Resource Guide (2006):

- Developed an educational tool for systematically addressing health disparities and increasing childhood immunization rates.
- Resource to be used in public and private clinics, hospitals, and health professions' classrooms.
- A Multicultural Health and Health Disparities Resources page on the OPIC web pages within the DHS website.

Media Projects:

- A newly developed radio PSA promoting pertussis vaccination for infants, adolescents, and adults.
- This PSA was created in partnership with the African American Chamber of Commerce and the primary audience is African American families in the metro area.

Health Education:

- The provider services team partnered with the Asian Health and Services Center to reproduce our popular *Vaccine Preventable Flip Book* in four new languages: Korean, Chinese, Spanish, Vietnamese.
- In May, all Oregon providers will receive an HPV Vaccine Resource Kit. The kit will contain culturally appropriate resources gleaned from national and international sources, including two brochures created specifically for this project: *HPV Information for Oregon Teens* and *HPV Information for Oregon Parents.*

DHS/PHD Program Responsible: Office of Family Health; WIC Program

Activities: WIC participates in efforts to be visible in diverse communities and works to have a pulse on the multicultural community in which it serves.

- Exhibit at the Annual African American Wellness Village, NE Portland.

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- 4 Farm Direct (Farmers Market) Celebrations across the state.
- Collaborative efforts to distribute outreach materials to community agencies working with ethnic populations (SE Asian Health Center, Immigration & Refugee Community Organization, and 211/SAFENET info referral line).
- 250 printed and web materials in an alternate format.

DHS/PHD Program Responsible: Office of Family Health; Women's and Reproductive Health

Activities:

Outreach to Non-English Speaking Individuals and communities

- Translating birth control methods brochures into Spanish and Russian.
- Producing English, Spanish, Chinese, Russian, and Vietnamese versions of informational materials relating to emergency contraception for the prevention of pregnancy in victims of sexual assault.
- Making written materials on domestic violence available in low-literacy format and in a variety of languages.
- Providing every publicly-funded family planning clinic in the state with a birth control teaching kit and female pelvic model, to enable alternate modes of teaching and counseling to non-English-speaking and low-literacy clients.
- Identifying and implementing a special project to promote the use of the 1-800-SafeNet number among Spanish speakers in Oregon, and ensuring adequate bilingual staffing of the phone lines.

Outreach to minority communities, including but not limited to racial and ethnic minority communities

- Contributing materials or staff to health fairs such as the annual African American Wellness Village in Portland (sponsored by the African American Health Coalition, Inc.).
- Attending special events such as the launch of Multnomah County's African American STD Disparities Elimination Program KNOWSEXPDX website.
- Collaborating with the Department of Corrections to offer reproductive health education to inmates in all state prisons and reproductive health exams to women at the Coffee Creek Correctional Facility.
- Maintaining staff representation on the Latina Prenatal Care Coalition, the Public Health Spanish Translation Accuracy Team (STAT), and the Hispanic Health Education Task Force.

- Collaborating with the Northwest Area Indian Health Board on Fetal Alcohol Syndrome prevention and surveillance issues.

Women's Health Program

- Addresses health disparities in Oregon by sponsoring two agencies to conduct community organizing and engagement to prevent sexual violence.
- One agency works with the alternative lifestyles community and the second works with people with developmental disabilities.

Oregon Breast and Cervical Cancer Program (BCCP)

Priority populations include women living in rural areas, women of color, lesbian women, and women with disabilities. A key program goal is to eliminate health disparities through outreach targeting these populations with breast and cervical cancer early detection and prevention messages and services.

- Collaborating with the Native American Rehabilitation Association, Inc. (NARA) Indian Health Clinic to distribute cancer health education materials to urban Native Americans in the Portland area.
- Establishing strong partnerships with Salud Medical Center, Virginia Garcia Memorial Health Center, and Yakima Valley Farm Workers, agencies that provide culturally and linguistically appropriate services to Latina women. Because of this collaboration, the BCCP has been especially successful in reaching Latina women for breast and cervical cancer screening. The BCCP translated its Client Enrollment Form into Spanish.
- Given that language barriers often lead to a lack of or lesser quality of care, the BCCP provides all contracted medical providers with a mechanism to access translation services to facilitate communication with non-English speaking patients.
- The BCCP program brochure has been translated into Spanish, Vietnamese and Russian.
- The BCCP contracts with Oregon SafeNet to respond to non-English speaking callers with information and referrals to providers in over 75 languages Monday – Friday, 8 am - 8 pm.

DHS/PHD Program Responsible: Office of Family Health; Maternal and Child Health

Health Disparity Reduction Efforts: Babies First

Activities: Selected materials are translated into Russian, Vietnamese and Spanish.

Health Disparity Reduction Efforts: Child Care Health Consultation

Activities: The program has a health consultant who is a Russian speaker and is working with Russian child care providers. Evaluation tools are translated into Spanish and Russian.

Health Disparity Reduction Efforts: Perinatal

Activities:

- In 2007, the Office of Public Health published the first Oregon Perinatal Data Book. The Data Book presents information on the health status of pregnant women and infants in Oregon including: demographics, birth outcomes, and variety of health indicators. Birth outcomes include: preterm and very preterm births, low and very low birth weight, infant mortality, neonatal mortality, and post-neonatal mortality. Health indicator topics include: pre-pregnancy vitamin use, pre-pregnancy obesity, prenatal care, tobacco and alcohol use, unintended births, postpartum depression, breastfeeding, and infant sleep position. Each topic is analyzed for disparities in race/ethnicity, as well as age and education where relevant. The Data Book provides critical information for use in targeting perinatal health programs and interventions in Oregon to reduce health disparities.
- The ORCHIDS data system, which has recently been implemented, systematically collects information on self-identified race and ethnicity and correlates that information with a needs and services delivered assessment.
- The *Prenatal and Newborn Resource Guide for Oregon Families* is printed in both English and Spanish within the same document.

Health Disparity Reduction Efforts: EHDI

Activities: The Family Resource Guide is printed in Spanish.

DHS/PHD Program Responsible: Office of Family Health; Adolescent Health & Genetics

Health Disparity Reduction Efforts: Oregon Plan to Promote Youth Sexual Health

Activities:

- Conducted two outreach forums during the development of the plan for additional community input;
- A Latino forum in Woodburn (30 youth, 12 parents) and
- An African American forum in Portland (380 participants)

Health Disparity Reduction Efforts: School-Based Health Centers (SBHCs)

Activities:

- Conducting a study of eleven to nineteen year olds who attended one of 43 Oregon school based health centers during the 2001-2002 school year.
- Examining the proportion of racial and ethnic minorities that have attended SBHCs during the described period, and assessing whether the school based health center clients over represent non-Caucasian minorities in Oregon schools.
- Among those that attend school based health centers, examining if there is an association between the frequency of visits among racial/ethnic identity.
- Examining the proportion of SBHC patients who are uninsured and may have limited access to health care services.

Health Disparity Reduction Efforts: Genetics

Activities:

- Consumer information regarding Oregon's Genetic Privacy Law is available in Spanish on the website.
- Begun translation of genetics fact sheets into other languages, beginning with Spanish. Using the Spanish translation of Diabetes fact sheet as a trial to determine its use and effectiveness in the Spanish-speaking community.
- If information about family history and genetics proves to increase assessment of risks and discussion of risk reducing behavior, will translate this and other fact sheets into Spanish, Russian, and Vietnamese at a minimum.

DHS/PHD Program Responsible: Oregon Public Health Emergency Preparedness Program

Health Disparity Reduction Efforts: Contracts with Tribes and Partners

Activities:

- Established contracts to fund public health preparedness activities with seven of the nine federally-recognized tribes and tribal confederations in Oregon (Coos, Lower Umpqua, and Siuslaw Confederated Tribes; Coquille Tribe; Confederated Tribes of Grand Ronde; Confederated Tribes of Siletz Indians; Confederated

Tribes of the Umatilla Indian Reservation; Confederated Tribes of Warm Springs; Klamath Tribes)

- The Cow Creek Band of Umpqua, and the Burns Paiute decline participation at this time.
- Established contract with the Northwest Portland Area Indian Health Board to provide technical assistance and support for a regional tribal preparedness conference.

Health Disparity Reduction Efforts: 2007 preparedness activities include:

Activities:

- Identification of a Tribal Preparedness Coordinator
- Identification of a Health Alert Network (HAN) Administrator
- Completion of two preparedness assessments (Pandemic Influenza / All-Hazards).
- Two draft emergency response plans (Pandemic Influenza / Health & Medical Annex)
- Participation in the monthly Oregon Public Health Emergency Preparedness Program conference calls
- Attendance at the annual Public Health Preparedness Coordinators conference.
- Worked extensively with tribes to include their needs and requests for antiviral purchasing and planning for pan flu.
- The Hospital Preparedness Program provided funding to the Confederated Tribes of Grand Ronde, Confederated Tribes of Siltez and the Yellowhawk Tribal Clinic to purchase computers, improve security, and increase medical surge capabilities and medical stockpiles.
- The Oregon State Public Health Laboratory – Laboratory Response Network partnered with the Warm Springs Tribal Health and Wellness Center to host a Response to Pandemic Influenza Regional Conference held at the Museum at Warm Springs.

DHS/PHD Program Responsible: Office of Multicultural Health

Health Disparity Reduction Efforts: State Partnership to improve minority health

Activities: Mini-grants up to $5000 given to racial/ethnic community-based organizations for health promotion and disease prevention efforts

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Health Disparity Reduction Efforts: Cultural competency trainings for Public Health workforce

Activities:

- OMH staff provides workshops and trainings for various internal and external organizations around cultural competency
- Provided mandatory DHS cultural competency trainings for PHD staff from September through December 2007

Health Disparity Reduction Efforts: Health Care Interpreter Program

Activities:

- Working to create Oregon's Health Care Interpreter Registry
- Program will qualify and certify health care interpreters through a series of examinations
- Registry will be used to identify qualified and certified interpreters throughout Oregon

Health Disparity Reduction Efforts: Somali Refugee Health Needs Assessment

Activities:

- Convened focus groups among Somali refugees in Washington and Multnomah counties
- Will compile and analyze findings to put into a final report
- Will conduct presentations to state and county staff regarding findings

Health Disparity Reduction Efforts: Media Project

Activities:

- Worked with PHD programs to place existing health promotion ads in *El Centinela* newspaper
- Worked with PHD programs to include health segment on *Cita con Nelly*, a local, Latino television program
- Hired a contractor to create culturally appropriate health promotion posters and brochures

Health Disparity Reduction Efforts: Consultation and Technical Assistance

Activities:

- Provide consultation and technical assistance for internal and external programs to reduce health disparities

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- Participate on internal and external advisory boards and steering committees to provide expertise on multicultural communities, program design, policy development