In 2012, Oregon is arguably the nation’s most active area for transforming healthcare delivery. In addition to strong Oregon health equity advocates pushing for better care for underserved populations, such as a surging Latino population, migrant workers and rural residents, Gov. John Kitzhaber, a physician himself, is leading an overhaul of the healthcare system. If he’s successful, it could reduce spending by more than $3 billion over the next five years, according to Health Management Associates, an independent consulting firm.

Relying on community-based coordinated care organizations (CCOs), the overhaul plan primarily targets some 600,000 people who receive Medicaid benefits under the Oregon health plan. Eventually, however, the reforms could include state employees, school employees, and even people outside government.

“Healthcare equity was very clearly represented in the authorizing legislation for this new system,” says Tricia Tillman, director of the Office of Equity and Inclusion (OEI), part of the Oregon Health Authority (OHA). “It’s a critical opportunity to get health equity on the map.” Elements of the Affordable Care Act such as expanded insurance coverage, focus on quality improvement, increasing workforce diversity, and expanding the role of the Office of Minority Health will reduce health disparities and promote health equity. Indeed, one cannot have health reform without addressing health equity.

**New era of coordinated care**

In testimony before the Oregon Health Policy Board, which oversees the Oregon Health Authority, Gov. Kitzhaber said, “Coordinated care organizations give local health systems the tools they need to shift the focus from the emergency room and acute care to prevention, early intervention, and chronic disease management.”

Currently, Oregon Health Plan clients must navigate 16 managed care organizations, 10 mental health organizations, and eight dental care groups. These healthcare providers then bill Medicaid for each visit or procedure. Under the new system, community-based collaborations between hospitals, clinics, and doctors will provide care. Each of these CCOs will have a single point of accountability for health outcomes and one budget that grows at a fixed rate. The focus on community-based prevention has implications for reducing health disparities.

Although the legislature approved the CCO system in 2011, lawmakers this year have had to debate and approve key aspects of the plan’s implementation, including issues surrounding budget, administrative control, oversight, and consumer protection.
“It may take three to five years to see health reform’s return on investment, but we think it will improve health equity and reduce high-cost hospitalizations,” says Mary Anne Harmer, director of health disparity efforts for Regence Blue Cross Blue Shield of Oregon.

“Much will depend on who will sit on the governing boards of the CCOs,” adds Liz Baxter, executive director of We Can Do Better, a Portland health education organization. “It is very important that the boards include community leaders who can give voice to the kinds of health concerns that CCOs need to address in local areas, such as AIDS or the special problems facing the elderly, residents in rural areas that lack services, or people with disabilities.” Baxter recognizes an important point: in a time of major healthcare change, health equity must be considered as new structures are put into place, otherwise disparities will remain and become part of the new system.

Baxter is also the board chair of the new Oregon health insurance exchange, which she says has a clear mandate to reduce health disparities in the state. Also created by 2011 legislation, the exchange will operate as a central clearinghouse for more affordable health insurance coverage. Beginning in 2014, the exchange is expected to deliver coverage to some 350,000 Oregonians, including individuals, families, and small business employees. Depending on income, policyholders will qualify for subsidies and tax credits on the premiums they pay.

“Prevention is the wave of the future,” says Harmer of Blue Cross Blue Shield, one of the carriers expected to participate. “Providing insurance coverage to a wider audience will expand access to cancer screening and other preventive measures, and we know that a greater percentage of minority groups in particular have not had the screenings they need.”

Similarly, Oregon is trying to enroll more children in the Healthy Kids program, which offers no- or low-cost health coverage for uninsured children under age 18, including preventive checkups, vision and dental care, and prescriptions. Since the Healthy Kids program launched in 2009, OHA has worked with local healthcare agencies and community groups to enroll about 90,000. However, Baxter notes that children of undocumented families don’t qualify and the legislature in 2011 cut $6.7 million from the program’s outreach component.

Focus on community

Even before CCOs, there was ample evidence in Oregon that grassroots efforts make good economic sense in the drive to reduce health disparities.

OHA’s Office of Equity and Inclusion has spearheaded several initiatives ranging from funding regional coalitions on health equity issues to encouraging the development of a network of health care interpreters and community health workers.
To showcase the factors important to decision makers—including economic considerations—OEI is launching a new training initiative that brings community leaders together with health policy and health systems leaders.

From a cost-benefit standpoint, OEI Director Tillman says that healthcare interpreters can be hugely helpful because they can prevent medical mistakes and misdiagnoses that can drive up costs and prompt lawsuits. She envisions community health workers, who represent diverse cultural groups, playing a key role in promoting health equity and assisting individuals and families in the emerging CCO structure.

As members of community care teams that work with the managed care organizations treating the state’s Medicaid population, healthcare interpreters serve an essential function. As primary points of contact for families, they steer families to the appropriate medical services, reducing reliance on costly ER and hospital visits. What does this new brand of healthcare worker deliver in cost savings? A recent Oregonian story cited the case of one woman suffering chronic abdominal pains who visited the ER 95 times in 2011 and had 16 hospital stays. The cost: $250,000. Healthcare interpreters also counsel their clients on nutrition, exercise, proper use of medications, and even help them solve housing and transportation needs.

OEI also supports a growing role for another type of nontraditional healthcare worker—doulas, trained professionals who provide nonmedical support to mothers during pregnancy, in childbirth, and after. In 2011, the Oregon legislature passed a bill that directs OHA to explore options for using doulas within state medical assistance programs to improve the outcomes of women who face a higher risk for poor birth outcomes. An Urban League of Portland study from 2010 found that infants born to African American women in Oregon were approximately twice as likely to die within their first year as those born to white or Latinas.

Tillman cites extensive studies by the Cochrane Collaboration, a health research organization, showing that women who receive continuous support during labor are more likely to avoid Cesarean sections and other medical interventions and feel more satisfied with their birth experiences.

Another health equity effort with a good economic track record, adds Tillman, is the Citizen/Alien-Waved Emergency Medical prenatal program, which covers medical services for pregnant women who don’t meet citizenship requirements for Oregon Health Plan coverage. Fourteen Oregon counties have implemented the program and shown that every dollar committed to the program leverages $7-$18.90 dollars in federal funds.
In the area of environmental health, county Healthy Homes programs have reduced ER visits for children with asthma by helping families identify such hazards as mold, harmful cleaning agents, and bedding that triggers allergies. The average cost of a hospital visit for asthma: $12,000.

**Laying the groundwork for equity**

Health equity proponents in Oregon acknowledge that they are in the beginning stages of demonstrating the return on investment of health disparities innovative programs. In a state where minorities make up a substantially smaller percentage of the population than most other areas of the country, many Oregon citizens and businesses are only beginning to address issues surrounding health disparities, says Harmer of Blue Cross Blue Shield.

Census figures for 2010 show that whites make up 83.6 percent of Oregon’s population versus a national average of 72.4 percent. African Americans account for just 1.8 percent of the population versus 12.6 percent nationwide. Latinos/Hispanics account for 11.7 percent compared to 16.3 percent nationwide.

However, the state’s demographics are changing rapidly. From 2000 to 2010, Oregon's Latino population surged 63 percent and its Asian population grew by 41 percent.

“About half the kindergarten children in Oregon come from minority groups,” notes Harmer. As a result, her company has stepped up its efforts to counsel its business clients on language and cultural competency issues and has created a Latino concierge to help Spanish-speaking customers navigate its services.

Blue Cross Blue Shield also has partnered with other Oregon insurance carriers to educate minority communities on such issues as childhood obesity. Other insurance company initiatives include setting up hypertension screening in barbershops in the African American community, where community-based nurses typically find evidence of hypertension in about 60 percent of visitors, who are then referred to primary care physicians for treatment.

Tillman says that a much more reliable database on health issues and ethnicity is essential to demonstrating health equity’s economic payoffs. The new all-payer all-claims database, for example, will require insurers from which the state purchases healthcare to track participants’ races and ethnicities, a key preliminary step in designing targeted programs to reduce disparities.

The state’s 2011 “State of Equity Report” helped to create a foundation for better data-gathering, Tillman says. The report looked at 31 OHA and state Department of Human Services (DHS) performance measures from a race and ethnicity standpoint. Of those measures, 20 revealed disparities. Some examples:
• **Rate of 15- to 17-year-olds per 1,000 who are pregnant:** Non-Latino Whites (18), Latinos (62), African-Americans (40), and Native Americans (44).

• **Percentage of adults who smoke cigarettes:** Non-Latino Whites (20 percent), African-Americans (30 percent), and Native Americans (38 percent).

• **Annual rate of HIV infection per 100,000 persons:** Non-Latino Whites (6), Latinos (11), and African-Americans (22).

Tillman says that the report establishes a baseline to measure future progress in health equity. Moving forward, OHA and DHS are working together to develop Phase II for the state of equity report that will provide increasingly meaningful racial and ethnic data relating to services and program. The two departments have also established a working group to develop guidelines for the standardized collection of racial and ethnic data.

Looking ahead, Tillman sees the need to do more at the state level to demonstrate the cost of health inequities, similar to how the Joint Center for Political and Economic Studies charted the economic case nationally in its 2009 report on health inequality. “We need to build on community wisdom and document, evaluate, and invest in good approaches to achieving health equity so they can rise to the level of research-based best practices,” explains Tillman, “and that requires proper funding to evaluate and replicate programs. Expertise in cost-benefit analysis has not traditionally been part of public health practice.”

**You can learn more about health equity issues in Oregon by consulting these sources:**

Oregon Health Authority
http://www.oregon.gov/OHA/

OHA Office of Equity and Inclusion

2011 State of Equity Report

Office of Multicultural Health 2009-2010 Annual Report

Coordinated Care Organizations (CCO) Implementation Proposal
Oregon Health Study: Oregon Health Insurance Experiment
http://www.nber.org/papers/w17190

2011 Oregon Racial Equity Report

Keeping Oregonians Healthy

We Can Do Better
http://www.wecandobetter.org/

Oregon Latino Health Coalition
http://oregonlatinohealthcoalition.org/