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Health Share of Oregon

May 7, 2019

Health Share of Oregon Comments on OHP Equity Data

Members of the House Committee on Health Care:

I am the Chief Equity and Engagement Officer for Health Share of Oregon. I am not just an executive at a CCO, but I am also the son of a Vietnamese immigrant woman and member of the LGBTQ community. As a queer person of color, I have seen first-hand, the impacts of health disparities on my family and communities. This is why I have dedicated my career to eliminating them. I also serve as Co-Chair of the Oregon Health Policy Board's Health Equity Committee, but I am here today as a representative of Health Share.

Health Share is the Coordinated Care Organization serving the approximately 315,000 Oregon Health Plan members in Clackamas, Multnomah, and Washington Counties. We are a 501(c)3 non-profit organization that was founded and continues to be governed by a collaborative of the counties, health plans, hospitals, health systems, and social service agencies serving OHP members in our community.

One of Health Share's values is that **we believe health equity is achievable and requires deliberate action on our part**. We have acted on this value by:

- Creating a C-Suite position and a team of staff devoted to health equity
- Convening multiple committees of our partners to identify disparities, intervene to address them, and evaluate those interventions, and
- Disaggregating all of our performance metrics by race, ethnicity, language, and other demographic characteristics to ensure that when we are improving health and health care for our members, we are doing so for ALL of our members, not just a majority of them

Unfortunately, the data available to us is limited to the official demographic data provided to us by the Oregon Health Authority, which assigns members to us. The OHA's data automatically overwrites our data when new files are uploaded to our system, so we depend on accurate and complete data from OHA.

We have noticed a trend in the last couple years of a declining proportion of members' race and ethnicity data being included in the file. Currently, the data we receive from the OHA lists race and ethnicity as "unknown" for just under 45% of our population. It is difficult to develop an adequate picture of race and ethnicity based health outcomes when **45% of the race and ethnicity data is missing**.

We have been able to supplement the data with historically reported race and ethnicity data that bring that number down to 25% unknown, but that remains inadequate. If those data were reported historically but are not now, then that means something has changed about the way the data are collected. Ever since we noticed this trend, we have been asking OHA to look into what has changed that has dramatically increased the number of members for whom race and ethnicity are not reported. We would like to reiterate this request and implore the OHA to take steps to reverse the trend.

At the same time as race and ethnicity data collection is declining, OHA has reduced the number of members whose preferred language is unknown to almost zero. We applaud OHA for this work.

When we have adequate demographic data, we can act on it to address disparities. For example, in 2016, when we learned through data analysis that non-English speaking members had lower participation rates in developmental screenings—because counting cheerios is not a culturally relevant activity for many non-English speaking communities—we worked with community partners to develop culturally relevant, transcreated ages and stages questionnaires (ASQs). Today, our Spanish, Vietnamese, and Somali speaking populations outperform English speakers on the developmental screening metric. We ended 2017 a full seven points above the benchmark for developmental screenings, advancing our five-year trend of continuous improvement on this measure. **We were only able to act on this disparity because we could identify it in the data.**

Without adequate race and ethnicity data from OHA, we will not be able to fully achieve our mission of partnering with communities to achieve ongoing transformation, health equity, and the best possible health for each individual. We hope to partner with the OHA to support a concerted effort to increase collection of race and ethnicity data.

Respectfully submitted by Michael Anderson-Nathe, Chief Equity and Engagement Officer.

For more information, please contact Ashlen Strong, Director, Public Policy & Communications: ashlen@healthshareoregon.org, 703-350-5611.