

Community Engagement In Oregon

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Community engagement, also called community development, is the process of working with groups of people related by location or interest on issues that affect their well-being.¹⁻³ Although community engagement efforts have historically focused on marginalized groups such as the elderly⁴ or racial and ethnic minorities,⁵ more recently engagement activities have started targeting people with disabilities.⁶ The Oregon Office on Disability and Health (OODH) has been practicing community engagement activities since 1999 and has used community engagement to identify and resolve access barriers in seven areas: housing, transportation, education, employment, accessing public places, recreation, and healthcare, with more recent community engagement efforts focusing on healthcare access in rural communities in Oregon.

The Community Engagement Initiative (CEI) was developed by OODH, a program of the Center on Community Accessibility at Oregon Health & Science University (OHSU). The CEI process engages representatives and members of the disability community, as well as members of the community infrastructure to work together to improve access to the community for people with disabilities. CEI activities consist of three primary steps and several supporting activities which are further described in the Community Action Guide.³ The primary components of CEI are 1) a town hall meeting for individuals with disabilities and their families that gives individuals an opportunity to discuss barriers to community participation; 2) a meeting with representatives from the communities' infrastructure, such as government officials, city planners, and transportation and service providers; and 3) a mobilization process whereby communities are empowered to include disability perspectives in ongoing community decision-making.

People with Disabilities in Oregon

Data from the 2005 American Community Survey (ACS) indicate that 16% of the Oregon population five years and older have a disability.⁷ Among Oregonians 18 years and older, 24% have a disability, compared to 20% nationally, according to 2005 Behavioral Risk Factor Surveillance System (BRFSS) data.⁸ Among Oregonians 65 years and older, 37% have a disability. Across age groups, 26% of women and 22% of men have a disability. Disability is more common in some race/ethnicity groups, particularly American Indian (38%) and Black (30%). Among adults with disabilities, 87% are non-Hispanic White, 4% are Hispanic or Latino/a, 1% are Black, 1% are Asian, and 6% are American Indian. Income is also strongly related to disability: 44% of Oregonians with incomes less than \$15,000 have a disability, compared to 15% percent of people with incomes \$50,000 or higher.⁹ Clearly, disability is an issue of significant concern in Oregon.

Health Status of People with Disabilities in Oregon

Proportionally, disability is more prevalent in some rural locations than in the more densely populated parts of the state (see Oregon map in Appendix B). Living in a rural area or being of minority race/ethnicity place people at greater risk for poor health. Rural Oregonians with disabilities are more likely to have unmet health care needs than those living in urban areas.¹⁰ Of Oregon adults with disabilities, 40% describe their health as fair or poor, compared to 8% of people without disabilities.⁹ People with disabilities are more likely to smoke than people without disabilities¹¹ and women with disabilities are less likely to receive breast and cervical cancer screening as often as recommended.¹² The current obesity epidemic also has a heavy impact on Oregon. Twenty-one percent of the non-disabled adult population is obese, but 35% of adults with disabilities are obese.⁹ Obesity increases risk for additional health problems (e.g., heart disease, diabetes) and medical costs.

Health Insurance Type

The 2004 NOD/Harris reported that nationally 18% of people with disabilities had unmet health care needs over the previous year compared with 7% of people without disabilities.¹³ These differences are not directly attributable to insurance coverage, since people with disabilities are as likely to have insurance as the general population nationally.¹³ People in Oregon's Medicaid population with mobility or cognition disabilities have a higher risk of developing smoking related cancers than the general population and of being diagnosed at a later stage for cancers for which screening and early diagnosis is the control strategy, resulting in more costly treatments, longer hospitalization, and greater risk of death.¹⁴

Community Engagement Findings

A recent population-based survey of Oregonians with disabilities found that of seven community participation domains (public places, transportation, employment, education, housing, recreation, and healthcare), healthcare was identified as the most important area for being an independent and active community member.¹⁵ Participants in a 2006 Community Town Hall Meeting in Ontario, OR (population: 11,125)¹⁶ also cited access to local healthcare services as a primary concern that limited their community participation. Additionally, those participants who were covered by the Oregon state Medicaid plan administered through the Division of Medical Assistance Programs (DMAP) reported increased access barriers to healthcare.

For example, participants living in Ontario who were covered by Medicaid found that they could not obtain specialist services in the larger city of Boise, ID (population: 193,161)¹⁷ even though Boise is only a one hour drive from Ontario. These same participants reported that specialist services covered by DMAP could be found if they saw Oregon providers, but oftentimes these services were only available in the more populated cities of Bend or Portland, which required traveling at least four hours by car.

Summary

Disability is more prevalent in rural Oregonians and rural Oregonians also have more unmet healthcare needs than their counterparts who live in urban areas. The availability of specialist services are also limited in rural areas of the state, adding to the access barriers they face. This highlights the need to increase access to healthcare services in rural areas of the state to meet the needs of Oregonians with disabilities.

Further examination of Medicaid reimbursement in Boise specialist offices (i.e., neurologists) found that in many instances the lack of access was a function of Medicaid reimbursement paying less than private insurance and as a result, specialists limited the number of all Medicaid recipients they treated, regardless of state.¹⁸ Even though DMAP does not currently cover healthcare services in other states (like Boise, ID services for Ontario, OR residents), the systemic access barriers to specialty healthcare experienced by Oregonians with disabilities on state Medicaid plans may stem from the differences between public vs. private insurance coverage, rather than the differential reimbursement rates between the Oregon and Idaho state Medicaid plans.

Policy Recommendations

Increase the Oregon DMAP reimbursement rates so that they are more competitive with private insurance reimbursement rates. This would help to ensure that rural residents in towns such as Ontario, OR have the option of obtaining needed specialist healthcare wherever it is available (which may sometimes be in a neighboring state).

Identify and provide incentives for Boise specialists to serve Oregon patients on Medicaid experiencing other economically-based access problems. This would then make it more attractive for Boise specialists to treat Ontario residents with disabilities who are on Medicaid.

Increase the Oregon DMAP coverage for in-state travel needed to obtain specialist services that are not offered in rural areas or covered in other states. This would place less of an economic burden on Medicaid patients living in rural areas who need in-state specialty services in urban areas and help offset the overall low Medicare reimbursement rates.

Establish a task force comprised of DMAP representatives, administrators of the Idaho Medicaid Program, Boise specialists, other healthcare providers, and rural residents with disabilities residing in eastern Oregon. This task force will explore options for increasing rural access to specialty healthcare services for Oregon Medicaid recipients with disabilities.

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