Hello, everyone. Good afternoon and thank you for joining us today for our webinar, Expanding the Public Health Workforce: Understanding Health Disparities of Oregonians with Intellectual and Developmental Disabilities Using Medicaid Claims Data.

My name is Reanna McMillan. I use she/her pronouns, and I am the Education and Training Coordinator here at OHSU's University Center for Excellence in Developmental Disabilities, called the UCEDD. I'll be your moderator for today's session. Larissa Yoshino will be helping with logistics for this training.

For any technical issues, please contact her at yoshino@ohsu.edu or direct message her on Zoom.

We are so glad that you could join us for this important discussion.

Our focus today will be on understanding the health disparities faced by Oregonians with intellectual and developmental disabilities and how we can use Medicaid claims data to address these challenges. We want to note that this webinar is being recorded and will be available after the webinar on our website along with copies of the slides.

Before we dive into our presentation, I'd like to take a moment to introduce our presenters. First, we have Rhonda Eppelsheimer, MSW, LCSW, who is the UCEDD co-Director and an Associate Professor of Pediatrics. Rhonda's focus for this project is to ensure that the public health workforce has the information and support they need to ensure people with disabilities can live healthy lives and that the gap for health disparities is closed.

Next, we have Rachel Benson, MSW. She is a social worker and the Assistant Director at the UCEDD. Rachel brings a rich background in case management, maternal health, addiction, and disability, and is passionate about addressing health disparities. We are looking forward to a thoughtful and engaging presentation.

Good afternoon, everyone. This webinar is brought to you by the University Center for Excellence in Developmental Disabilities Institute on Development and Disability at Oregon Health and Science University. The presenters have no disclosures to offer.

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How to listen to Spanish interpretation. In your webinar controls, click on interpretation. Then select Spanish as your language. If you'd prefer to hear only the interpreted language, you can click mute original audio.

We also have live ASL interpretation. Thank you to our Spanish interpreters, Paula and Carolina, and our ASL interpreters, McKay and Amanda.

At the end of the webinar, we'll have some time for questions. If you have a question, just click the Q&A button at the bottom of your screen. This will open up a panel where you can type your question and send it to the host. We'll do our best to group questions together to cover a theme and get to as many as we can.

Let's take a quick look at today's agenda. Our speakers will start by giving an overview of the project, covering goals in the big picture to give a solid understanding of what we're trying to achieve.

Next, they will take you through the different phases of the project, including the data analysis, some of the data limitations, and the key findings and recommendations that came out of it.

Then, we'll review the website, including the report created by the Center for Health Systems Effectiveness Research (CHSE) at OHSU, along with the Accessible Language Report. We'll share some important insights, especially focused on making sure our content is accessible to everyone.

After that, we'll do a live demo of the data dashboard, showing off some of the coolest features.

Then we'll wrap up with the next steps. As I mentioned at the end of the session, we will have some time for questions. Rhonda will now get us started by providing an introduction to the project.

So as an introduction, it's a shared value in our DD network to promote the health and well-being of all Oregonians. The OHSU UCEDD, The Oregon Council on Developmental Disabilities, were both awarded these grants from the Administration for Community Living to carry out this project.

The project is grounded in the DD Act of 2000 area of health emphasis where it states: "Health-related activities support future advocacy and capacity building that lead to systemic change. The ultimate goal is to ensure that individuals with developmental disabilities have access to and use of coordinated health, dental, mental health, and other human and social services, including prevention activities in their communities."

So existing research has indicated that individuals with intellectual and developmental disability, or IDD going forward, fare worse on a broad range of health indicators than those without IDD. For example, individuals with IDD can experience higher rates of complex health conditions, poorly managed chronic and secondary conditions Lower rates of health screenings, reduced or preventative care, and undetected vision and hearing loss. Additionally, there are challenges associated with accessing state level data about the health and health disparities experienced by people with intellectual and developmental disabilities.

So during the pandemic, the Oregon DD network struggled to access specific data about the experiences of health of people with IDD related to COVID-19. This funding spurred a conversation between the UCEDD and DD Council Executive Directors to begin to develop solutions for accessing state level health data.

The goal of the project was to provide data on current health disparities in Oregon that will allow disability advocates, policymakers, legislators, and most importantly, the public health workforce, to identify and work towards ending health disparities affecting Oregonians with IDD.

Our proposed aims specific to this project were identifying health disparities in Oregon adults with IDD using Oregon all pair all claims data and diagnostic codes specific to the IDD population, create a public-facing dashboard presenting health outcome data disaggregated by IDD status, and then complete an environmental scan that maps out current data sets and data sharing agreements of health outcomes information about the Oregon IDD population. And then develop policy recommendations for addressing health disparities experienced by people with IDD in Oregon based on the findings.

Making this data available through dissemination to the public health entities is a key step to help gain a clear focus on areas that need resources, strategic planning, and policy guidance in order to address and close the disparities gap. We'll go to the next slide.

Key partners and community input are listed on this slide. It certainly took a strong collaboration for this effort of two years, a little more than that actually, without which this project would not have been possible. There was significant engagement from our community partners and advocates on this project.

Our DD Council provided additional funding and with the self-advocacy Coalition and UCEDD Advisory Board who provided input on the domains and measures and the recommendation refinement.

The OHSU Center for Health Systems Effectiveness, or CHSE, conducted the analysis of Medicaid claims data, the environmental scan for additional data sets and access requirements, and develop the initial policy and research recommendations. They partnered with Oregon REALD team through the Oregon Health Authority to ensure we were capturing more accurate race and ethnicity data. And Rachel's going to give a few more details about REALD later in the presentation.

The staff at Disability Rights Oregon was instrumental in refining and contextualizing the recommendations. The Oregon Clinical and Translational Research Institute worked with our UCEDD team to develop the interactive public-facing dashboard. And finally, the Oregon LEND, which is a Leadership Education in Neurodevelopmental and Related Disabilities. Their health administration team and trainees developed the plain language report that we'll share later.

The project had two phases. Phase one included the analysis, preparation and implementation and the analysis report. And then phase two included the dashboard development, the plain language report, and the website development.

Rachel's going to share now a little bit about phase one of the project.

Thanks, Rhonda. Yeah, I'm going to share a bit about the collaboration that we had with the Center for Health Systems Effectiveness Research, or CHSE, here at OHSU. Their mission is focused on providing the analysis, evidence, and expertise needed to create a better and more sustainable health care system. And they have a lot of experience analyzing Medicaid claims data from states like Oregon, Washington, Colorado, and Idaho. And we contracted with them to focus on goals we developed and together we created a clear scope of work to accomplish them.

Rhonda, a little bit earlier mentioned the overall proposed aims for this project. And now I'm going to share the scope of work that we developed with CHSE based on these aims. First, we wanted to assess health care disparities between adult Oregon Medicaid members with and without IDD. Next, based on our findings from the data analysis, we wanted to provide research and policy recommendations based on those findings. And lastly, we wanted an environmental scan to map out existing data sets and data sharing agreements related to health outcomes for the Oregon IDD population.

And this was important to really help us understand what data is already available, how it could potentially be linked to ultimately improve our understanding of health care disparities. I'm just going to go over a bit of the data analysis that CHSE did.

The data that was used. Adult Medicaid claims data was used from 2022 for this specific study. And you might be wondering why this specific data set was chosen. And the main reason is that accessing all payer all claims data, which would include all health insurance data, took longer than the timeline of this grant would allow because of data use agreement. So, there was a shift to using Medicaid data only since this was the best option within our timeframe.

The claims data used included diagnosis and procedure codes to identify individuals with IDD and help create outcome measures. People with IDD were identified using diagnostic codes that were developed in early research, earlier research and publications. And that was specifically for recognizing individuals with IDD and Medicaid claims data.

These codes include a variety of conditions. For example, autism, cerebral palsy. In the report on page 41, there's a list of all the international classification of disease, or ICD codes that are used for identifying IDD for this study. And for those of you not familiar with ICD codes, they're used by doctors, hospitals, and healthcare providers around the world to track, diagnose, and categorize disease, conditions, and other health-related issues.

For data linking, to make the race and ethnicity information even more accurate, the data from Race, Ethnicity, Language and Disability, called REALD, from the Oregon Health Authority repository was linked. Doing this helped ensure that the data CHSE was working with was as complete and precise as possible.

For study population and comparison group. For the study itself, Medicaid members aged 18 to 64 with IDD were compared to carefully match groups of people without IDD. Toe comparison group was selected using a well-established research method where each individual in the main group is paired one to one with someone in the comparison group who closely matches them in terms of age, race, gender and where they live, either rural or urban areas. This matching process helps make sure the difference between the two groups are more likely because of having or not having IDD than other factors. We also wanted to mention in this study members who live in institutional care were included as well. Overall, 2,066 adults in Oregon with IDD were compared to the same number of adults in Oregon without IDD.

And then about exclusions. People who weren't continuously enrolled in Medicaid for at least 12 months in 2022 were excluded. And members who were eligible for both Medicaid and Medicare were also excluded.

By using these methods, CHSE aimed to create a clear, reliable comparison group that would help us better understand health disparities between the two groups.

All right. So just a little more about data analysis. For analysis type, CHSE performed a cross-sectional analysis. To think of it simply, it's a cross-sectional analysis like taking a snapshot of a group of people at a specific point in time. And this helped them see how health care was used across different groups during 2022.

And for subgroups, the data was broken into several subgroups to get a better sense of how different factors might affect the outcomes. Age was grouped as 18 to 29, 30 to 39, 40 to 49, and 50 to 64.

For sex, the data was split by male and female.

For race and ethnicity, the groups focused on were non-Latina white, non-Latino black, Latino, and then other multiple races, and unknown, missing, or declined.

For geography, CHSE looked at whether people lived in rural or urban areas.

By dividing into these subgroups, a clearer picture was provided on how things like age or where someone lives could affect health outcomes for people with IDD, versus those without.

And then to go into methods. For calculating means and percentages. For both the IDD group and the non-IDD group, either the average or percentage values for each measure was reviewed.

And statistical significance. To figure out if the differences between the groups were meaningful, T-tests were run with a 5% significance level. In simpler terms, this means results were only considered statistically significant if there were less than a 5% possibility that the difference happened by random chance.

And then last here, for suppressed results. Results for groups with fewer than 10 members were suppressed to ensure that the data reflects more significant trends and it isn't skewed by small sample sizes. And this approach to help maintain the accuracy and reliability of the results.

And I'll pass it back to Rhonda.

Let's take a moment and review the domains and measures used for the analysis. Again, I cannot emphasize enough how strong involvement from community partners and self-advocates was critical here. They were instrumental in the decision making for the domains analyzed. CHSE generated a list of domains and measures that we took to our community partners who discussed and prioritized what was most important to them.

We presented the options in meetings, and members of the Oregon DD Council, the OHSU Community Partners Council, and the Oregon Self-Advocacy Coalition Health Care

Committee discussed and voted on the six domains listed on the slide to be used for this initial analysis. So, they decided on mental health care, substance use, hospital stays and emergency department visits, diabetes, dental care, and cancer screenings.

And then under each of the six domains, CHSE helped us determine which measures to analyze. 17 measures were identified. The parenthesized number after the domain on the slide indicates how many measures were analyzed under each of the domains. A full listing of the measures under each domain can be accessed in the full report on page 14. Next slide.

We're going to talk about data limitations now. And as with all data analysis, there are potential limitations. We approached this analysis as a place to start in terms of how we can use data to improve the health of people with IDD.

The following limitations were identified. Some health care visits might not include the IDD codes leading to undercounting. Potential missing information due to binary gender selection only in the Medicaid data set. Data analysis was for visits in 2022 and would miss people with IDD who didn't have a health care visit during that time. The study only looks at one point in time. So for now, we cannot address changes or trends over time.

And then sometimes the sample size limits prevented us from studying how different factors like race and gender together affect the outcomes.

And then I want to give a content warning here. We learned some really valuable lessons along the way from our self-advocates and feel it's important to include a content warning about sensitive data we will be sharing.

In the next part of this presentation, there is information about mental health, feeling very sad, self-harm and suicide. These are important topics, but they can be upsetting or hard to think about. Some of the results can be triggering for people who have lived through traumatic experiences.

With valuable input from our network partners and self-advocates, we implemented a best practice to include a content warning at all presentations before reviewing any of the data results.

So with that said, if you feel sad or worried or upset, you can take a break before hearing more. Talk to someone you trust about how you feel. Call a support line if you need help. And we have a text or call the 988 crisis hotline if you or anyone you know needs immediate mental health support. This number is open any time, day or night. And we'll move on and have Rachel share some of the results.

Great. Thanks, Rhonda. So let's start by looking at a few of the statistically significant differences we found. In the next few slides, we will go a little deeper into these findings. And later, we'll show you how to access all the findings through the dashboard and the full report.

So, the results indicated that in 2022, Oregonian adults with IDD, compared to adults without IDD, have more emergency room visits, higher rates of non-fatal suicide attempts and self-harm, are less likely to get cervical cancer screenings, and are more likely to be readmitted to the hospital within 30 days of being discharged.

In the next three slides, the results are from the domain of mental health. The measure reviewed in this slide is non-fatal suicide attempts and self-harm.

The results indicated that for all adults with IDD, 2.2% had a record of a non-fatal suicide attempt and self-harm compared to 0.5% of the comparison population. And this result was statistically significant. This measure again reviews non-fatal suicide attempts and self-harm.

So the results indicated that Black adults in Oregon with IDD had a three times higher risk of non-fatal suicide attempts and self-harm. These results were not statistically significant, which may reflect a small sample size. However, Black Medicaid members with IDD had the highest prevalence of non-fatal suicide attempts and self-harm for all populations studied in this report at 3.6%.

The measure that I will review in this slide are non-fatal suicide attempts and self-harm and emergency department visits for suicide ideation. The results indicated that females with IDD have higher rates of emergency department visits for suicide ideation and higher rates of non-fatal suicide attempts and self-harm, compared to females without IDD. Both of these results were statistically significant.

So these substantial mental health findings led us to have some really interesting conversations about training for mental health providers, improving communication between systems, and wanting to understand more about experiences happening within the mental health care system. And we'll discuss that further in a few slides. And back to Rhonda.

Thank you.

This result is for the domain of hospital use. The measure here was emergency department utilization. The results indicate that the number of emergency department visits was higher among Medicaid members with IDD compared to those without IDD. The difference being highly statistically significant. This is an important finding.

And then continuing with hospital use, the measure here was all cause readmission to the hospital within 30 days of an initial hospitalization. The result indicated that the number of 30-day all-cause readmissions was also much higher for Medicaid members with IDD compared to Medicaid members without IDD.

Both results led to robust discussion about hospital utilization practices, discharge planning and implementation of that planning, and cost of care. We'll discuss recommendations in a later section of this presentation related to those findings.

And Rachel?

Rhonda.

So, the results on this slide is for the domain cancer screening. And this measure here is cervical cancer screening. The results indicated that Medicaid members with IDD had a lower cervical cancer screening rate. Compared to those without IDD So 20.7% of individuals with IDD received cervical cancer screening compared to 25.9% of those without IDD. And this result is statistically significant.

And we had a great discussion about potential education campaigns for people with IDD regarding cervical cancer screening as a result of this finding. And now Rhonda will discuss some of the policy recommendations.

So, there are a number of ways to continue this work in partnership with the public health workforce, the DD network, advocates, in the broader community. These recommendations were developed by CHSE policy team, the UCEDD, and they include feedback and refinement from our network partners and self-advocates.

Our goal is sharing the recommendations and then working collaboratively on efforts that will influence resource allocation, policy development, research and strategic planning, to close the disparity gap that impacts the health and well-being of Oregonians with IDD.

Some of the recommendations are for measures where there was a statistically significant difference. Some are for measures where there were low numbers for both categories of people with and without IDD. And some of the recommendations are based on limited information we learned with the initial measure.

So increased support and training, that would be for health care providers on issues specific to Medicaid members with IDD, including early warning signs and available resources for mental health support. Direct support professionals to recognize mental health issues and offer support for self-care and daily living tasks.

Mental health and substance use specialists to work effectively with individuals with IDD, diagnosis and treatment, and addressing accommodation needs.

Improving system and communication coordination. Engage in partnership with the Health Authority on actions that improve communication between disability service organizations, and the mental health system. Sharing evidence-based information and promoting collaboration.

Increase the number of behavioral health providers to address the low rates of depression and substance use screenings and treatment by increasing the number of behavioral health providers available for Medicaid members with IDD. This also includes considering addressing rates reimbursements for behavioral health services to improve access for Medicaid members with IDD.

And then improve cervical cancer screening rates for people with IDD. Address screening barriers. A potential partner could be coordinating care organizations to identify and remove barriers to cervical cancer screening for people with IDD.

And then educational campaigns. Provide an accessible cancer screening guides and collaborate with cancer advocacy groups to launch educational campaigns for better awareness and participation.

The next slide.

Wonderful. So now I'm going to go over a few more policy recommendations.

For discharge planning and coordination. Reporting could be required from coordinated care organizations on outcomes related to discharge planning and core coordination for Medicaid members with IDD. And this could help provide better understanding and potentially reduce high 30-day hospital readmission rates.

Strengthening integration of data sources. So integrating data sources from various sources that identify people with IDD would help improve the detection of health disparities and enhance services for this population.

Continuing to expand the data set and reporting. So regular monitoring and reporting on health disparities for the specific population is key.

Continuously gathering this data helps identify patterns and plan interventions. It would also be valuable to expand the data set by adding children's data and eventually incorporating all pair all claims data for a more comprehensive view. This approach can help provide deeper insights into the needs of the community and guide more targeted solutions.

Using data to guide policy, research, and services practice is crucial. And it's really important to keep gathering feedback from stakeholders as recommendations are developed. This ensures that the solutions effectively address the needs of the community.

And now back to Rhonda.

So, as we look for ways to improve care and services for Medicaid members with IDD, there are a few key areas we'd like to explore further through research.

Access challenges to mental health treatment. This is a big one. Interviews with Medicaid members with IDD who have experienced non-fatal suicide attempts or self-harm and their caregivers could help us understand the factors behind these events and identify gaps between the mental health services needed and what was actually available or accessible at the time.

We also want to explore the challenges in accessing preventative depression screenings and other mental health services.

Quality in mental health care. Assess whether Medicaid members with IDD are getting the same quality of mental health assessments, diagnosis and treatments. And also look into how different living arrangements like residential settings might impact mental health needs. That could be around the type of support they're getting. Special attention in research efforts should be paid to Black Medicaid members with IDD as they experienced the most significant outcomes in this report.

Substance use disorder or SUD screening and treatment. Low engagement in said treatment among Medicaid members with IDD is also a concern. Research could explore why engagement rates are low, particularly among male Medicaid members with IDD, who were less likely to engage in SUD treatment compared to their non-IDD peers. Qualitative interviews with individuals and caregivers could help uncover gaps in SUD services, like issues with accessibility and availability, and shed light on why this population might not be engaging in treatment.

Emergency departments, visits and readmissions. First, a document review of group home policies could be conducted to see if there are protocols that might encourage emergency department visits for certain health conditions in Medicaid members with IDD. Discharge planning and accommodations for people with IDD also need to be examined with a focus on improving care to reduce hospital readmissions. Further, Medicaid claims data analysis could reveal whether Medicaid members with IDD are visiting the ED more frequently because they can't access primary care.

This data could also help us understand how ED costs compared to primary care costs. Qualitative interviews could give us valuable insight into follow-up care after ED visits and the challenges in post-visit care. I'll pass it back to Rachel.

Great. Thanks, Rhonda. For disparities in diabetes diagnosis. While treatment for diabetes doesn't seem to show disparities, timing of diagnosis might. So future research could explore what stage diabetes is in at the time of diagnosis to help gain a little more insight.

For oral health care access. Medicaid members with IDD in this particular year seem to have better access to oral health care. But we still need to understand why this is happening and if the approach used here can be applied to other areas of health care and disparities in service types.

The positive outcome in this report for oral health care does not match what we've heard from the community's experience. Research could really look at whether there are differences in the types of dental health care people with IDD receive and whether they face any barriers to access specific types of dental services.

For identification of Medicaid members with IDD. Right now, as we mentioned, Medicaid members with IDD are mostly identified using ICD codes. But this method might miss people who didn't access care or weren't diagnosed with the right codes. So, future research could explore better ways to identify people with IDD, perhaps by using self-reported data or other data sources.

And exploring the role of social determinants of health. So social determinants of health like employment, housing, food security, and access to transportation play a huge role in health outcomes. And future research could look into how these factors influence care and contribute to disparities helping to develop better strategies to improve care for Medicaid members with IDD.

So really by exploring these areas further, we can better understand the challenges this population faces and collaborate to develop targeted solutions and improve health outcomes.

All right, back to Rhonda.

Thanks. Now we're going to go to the second phase of this project and we're so excited to share this. We had a data dashboard that was developed in partnership with the Oregon Clinical and Translational Research Institute, or OCTRI. Their engineers and project team worked closely with the UCEDD to develop an interactive experience that helps bring this data to life. And this is where I really hope a lot of you will spend a good amount of time after this webinar. Rachel's going to bring up the webpage now so we can share our dissemination space.

And this is housed on The UCEDD's page, if you click the Research tab, you'll find Research and Evaluation and then you'll it'll just bring up a section that says Health Disparities Data.

There we go. If you just click Research, there we go. We got it. Okay, we're here.

And so Rachel, I'm going to have you scroll to the bottom of the page and show our audience where they can access the reports. So we have the full data analysis report, and then we have a plain language report. If you want to click through on the full language final report.

And then, I'll have you go ahead and go to the table of contents on page 3 here. And I just want to mention that this shares what you'll find in the report. There's a list of acronyms that are used throughout the report and that page is really helpful to get a clear understanding of what we're referring to.

And then the executive summary, I'd recommend starting there, gives you a full overview. Then followed by the full analysis with the data tables that start in chapter 2. And then finally, I want to draw your attention to Appendix B.

If you want to go ahead and go to that part of the report, Rachel.

And then in Appendix B, you're going to find information on all the data sets in Oregon that collect information about Oregonians with IDD. There you'll find the dataset description, access rules or restrictions, how disability is defined in the data set, and types of variables the data captures, years of data availability, limitations, and potential for linkage to other data sets. It's a really great resource for us here in Oregon.

And then I'm going to head back out of that and go to the plain language report. And this report is based on that first report, the full analysis report, but it is not a direct translation. It's a summary that explains the project and key findings in an accessible format. We wanted this information to be available for and accessible for all people.

So if you could go to the table of contents, please.

And here you can see all the components that are in the accessible report. And we're going to go ahead and have a look at the, I think we'll start with the content warning, please, on page 9.

We're going to show you the data sheets in just a moment, but this is the content warning that we developed with our partners and self-advocates at their recommendation. And we like to show that, again, any time before we show data.

So if you'll go to the hospital use, we're just going to show a few of these quickly.

On page 11. You'll see there's the area that was the domain and then the description of that domain and then the measures that we actually use under that domain to look at. And then you'll find a significant findings. So we pull in a visual, a graph, that shows you some of the information that was interesting or a key finding in that area.

And then we framed the research and policy recommendations in Next Steps. And really kind of looking at how we could move this forward.

So each domain has a single sheet. I'd like you to go to the Substance Use Disorder page, we'll just look at one more here.

And so substance use disorder and then the meaning again, there's the three measures that were looked at in terms of what we measured. And that information is fully revealed in the full report. And then also just a key finding around that. And then you'll see again at the bottom the recommendations are framed in the Next Steps section.

Thanks for that. I'll have you back out of that and then let's go to the middle of this web page.

We're particularly happy to have this. This is the data dashboard. It's interactive. And you can see at the top, you can choose a measure. So all 17 measures are there.

Rachel, would you pull the dropdown menu? So you can see all the measures that we looked at. And then if you'll also then do the dropdown menu for choose a category.

And those are the subcategories. So you can look at the information by subcategory as well. So, we'll click off that. And then just looking at the 30-day all-cause readmission. Is that the one we were going to do? Yeah.

You'll see the first tab is a chart. And the information when you first go to that is going to be the overall data for the comparison group. So if you roll over the red bar, you'll get the numbers that were used in this analysis and then the numbers of the non-IDD population. Consistent throughout this dashboard, red will represent the IDD population and blue the non-IDD population.

The bottom, it shows you if it was done in a people count or if it was done in a percentage, because there are some differences as we kind of go along.

Rachel, will you go up to the choose a category now, and let's look at this by age.

So this measure, by age, Rachel had gone over the breakdown beforehand and you can do a little rollover. So we look at how many, and visually it just gives you a really nice idea of where these numbers land and by age category, I think, which can be helpful in some of the planning and recommendations when it's time to take a deeper dive.

And you'll notice here members age 18 to 29, and 30 to 39 with IDD were at greater risk.

And you can... We'll have right under that measure usually a note about what this data is telling you about.

Thank you.

And then let's go to the description tab for this same measure. So we're still on 30-day all-cause readmission by age. And then looking at the description tab, it really gives you a good description of what that means. We tried to make that in as plain language as we could.

And then how it is measured, and then key findings. And really, we want to remind people this is a snapshot. It is one year of data. We hope to have the opportunity to expand this in the future. But really, right now we're just looking at 2022.

And then if you would go to the data tab next. And here we've just pulled out for people that really want to take a deeper dive in the data. The tables, the information from the tables in the full report, the full analysis.

If you see things that are colored orange in these tabs, in this data tab, you're going to note that that is where people with IDD have poorer outcomes. If you see blue in these, it'll indicate outcomes that were better for the IDD population.

Let's do one more. We're going to look at… I think we're going to look at depression.

And let's go back to the original chart there.

And so here you can see, we'll go for All first. There you go. Thank you.

And there were no statistically significant differences, but you can still see that there are differences and it will show the "n".

And let's go to the description tab. Again, a good definition of what this is measuring. And then looking at the full data from the actual thing.

So in this case, where there are not statistically significant differences we want to just be really upfront and show you that, that for this year, there were not differences for that.

And then I think we'll just take one quick minute and look at the substance use disorder. Did we do that one or? Yeah there we go.

In here, this is one of those where there wasn't statistical significantly differences, but you can see that there's a lower rate of engagement than the full IDD population.

And then let's break that down by age. And you'll see here we have data for two of the age ranges. And again, these are, this engagement is much lower for the IDD population in treatment.

And then can you go to the race and ethnicity? And here I wanted to note that if you notice on some of these where we don't have other races identified in this data, it's because the numbers for this specific measure were too low to actually really put into the charts. So just wanted to make sure that you understood that.

And then let's look at that final category. Oh, residency first. And so you'll get an idea of if people are living in rural or urban areas.

And then... Finally, by sex. So female and male. We're really excited about this dashboard. We hope that you spend a lot of time looking at the measures, suggesting other measures that you're interested in.

And Rachel, thank you for sharing that. We'll go back to the slides now.

Thanks, Rhonda. So for next steps, we really just want to say this is a place to begin. We didn't get all of our questions answered. And as Rhonda mentioned, the research often creates more questions.

But for dissemination, we really have some work to do educating about this resource and to focus resources and other efforts based on actual disparities identified in the report.

And for expanding the data set, we'd like to continue to build this data set and expand the dashboard. And, as Rhonda said, include additional measures in the future.

And these continued partnerships are really crucial for us to inform the work and what is important to people with IDD and make sure we include their input on future measures, recommendations, and actions.

And we're going to pass it to Reanna and Larissa for some questions.

Yeah, so just as a reminder, if you have any questions, please use the Q&A feature and we'll try our best to answer any questions you have.

That's great. I think I can go ahead, actually, Larissa and tackle the questions that are in here. And it looks like one is answered.

Sure.

So, Kristen, thank you for your question. And I think that that is definitely a next step that we need to do. We really just got the analysis. You had asked, "Has there been any conversation about including providers who have a specialty in caring for those with enhanced payment rates for behavioral health services?"

I can say on another project we're working on, we're still working on providing training so providers feel confident and competent to provide this care.

And so I think definitely enhanced payment rates for behavioral services and mental health services would be another detail that we need to collaborate on, too, with providers. But what we typically hear is too much paperwork, I haven't had the training, it's not in my scope, those types of responses. I thank you for that question.

Then yes, the report is publicly available on the website we just showed you. And I think in the link, you'll find a link to the dashboard and to the reports. And we definitely would like you to be using that report and sharing it and reaching back out to us if you have questions or need more information.

And then Rumal Mahamun.

Oh, did you have something else?

Oh, I'm going to add the link is in the chat. And then also, I think we can send that out as part of the post webinar information as well.

Yeah, that'd be great. And then, thank you. The number of Medicaid patients was shared at the very beginning. And Rachel, can you pop on and give those numbers again in our comparison? It was over 2000, but I didn't...

Yeah. Yeah, the number is 2,066 overall. So, there was 2,066 individuals with IDD compared to 2,066 individuals without IDD.

Yeah, and that was for one year.

Oh, you're looking for the specific IDD diagnosis. I think that that is, and I double checked the algorithm, but I believe that that is the number. So we'll double check that and send that out in the post response. And then, yes, thank you, Kristen, for your comment. So I think that's the questions we have.

Thank you so much. I'll let you go ahead.

Oh, there was just one question that I typed an answer to earlier, but I think we covered this in the dashboard that in that data dashboard underneath the part where it has the chart, it'll tell you whether the number is a percentage or a number of people. So just little differences in those different measures the way that they were calculated.

Yeah.

Wonderful. Thank you all for joining us today for our webinar, Expanding the Public Health Workforce: Understanding Health Disparities of Oregonians with Intellectual and Developmental Disabilities Using Medicaid Claims Data. We hope you found the presentation insightful and informative.

We have placed the presenters' email addresses in the chat. If you have any follow-up questions or need more information, feel free to reach out directly.

We also have a post-webinar survey that we would like you to fill out. When you exit out of this webinar, you'll be automatically directed to the survey. And we will also send it in a follow-up email later.

Before we sign off, we just want to say thank you to everyone who helped make this webinar possible and our interpreters and of course to all of you for taking the time to join us today.

Have a great rest of your day.

Thank you.