Health Equity Recommendations for CCO Implementation Proposal

Section/ Page #	Recommended Language/Concept (Includes HB 3650 language, if any)
Governance and organizational relationships /p10 Governing Board OHPB recommends that, as part of the certification process, a CCO should articulate:	**We recommend adding the following legislative justification language:** **Sec 2(2)** The Oregon Health Authority shall seek input from groups and individuals who are **part of underserved communities, including ethnically diverse populations**, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management. **We recommend adding the following language:** • How the governing board makeup reflects underserved communities, including ethnically diverse populations.
Patient Rights & Responsibilities, Engagement, & Choice/p 13	**We recommend adding the following language:** • Ensure equal patient access regardless of language, disability, culture through: staffing and training protocols (i.e. career path development to increase culturally-based providers, provider/staff workforce training on cultural and linguistic competency, and health literacy, etc.) • Assess consumer satisfaction and share clear grievance procedures translated and offered through multimedia approaches •Ensure that providers are not working in isolation from underserved communities to develop best practices for culturally appropriate care and service delivery

Delivery System: Access, patient-centered primary care homes, care coordination and provider network requirements /p 13-16	**We recommend adding the following legislative justification language:** **Sec 4(1)(f)** Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are **accessible to families, diverse communities and underserved populations.** **Sec 4(k)(G)** Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization: **Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members**. **Sec 20(4)** 'Community health worker' means an individual who: (c) **To the extent practicable, shares ethnicity, language,** socioeconomic status and life experiences with the residents of the community where the worker serves; (d) Assists members of the community to improve their health and **increases the capacity of the community to meet the healthcare needs of its residents and achieve wellness**; (e) **Provides health education and information that is culturally appropriate** to the individuals being served; **Sec 69(4)**'Community health worker' means an individual who: (c) **To the extent practicable, shares ethnicity, language,** socioeconomic status and life experiences with the residents of the community where the worker serves; (d) Assists members of the community to improve their health and **increases the capacity of the community to meet the healthcare needs of its residents and achieve wellness**;

	We recommend adding the following language: • CCOs must specifically address how they will support clients moving off of coverage and into Health Insurance Exchange (HIE) **Throughout CCO Implementation Proposal, We recommend replacing "certified health interpreters" with "qualified or certified health interpreters" language**
Health Equity and Eliminating Health Disparities /p 17	**We recommend adding the following legislative justification language:** **Sec 19(1)(L)** The authority shall: Implement policies and programs to expand the **skilled, diverse workforce** as described in ORS 414.018 (4) **Sec30(1)(a)** Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including: (a) **Demographics, including race and ethnicity.** (f) **Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education.** **We recommend adding the following language:** • OHA Office of Equity and Inclusion will serve as an additional resource to CCOs to ensure equal patient access regardless of language, disability, culture and improvement of health equity outcomes by connecting CCOs with technical assistance, especially as needs involve provider/staff workforce training on cultural and linguistic competency, health literacy, and career path development to increase culturally-based providers.

	• CCOs will be required to demonstrate the elimination of health disparities by submitting quality improvement plans with performance-based results for addressing health equity outcomes and documentation for services (i.e. Certified Health Care Interpreters) • CCOs need to describe processes they will be utilizing to collect community wisdom and experience with health care [& health], with links to implementation • CCOs falling behind on expectations will be required to put together a specific health equity improvement plan and adopt benchmarks and measures. • OHA will develop a system of incentives/disincentives for those that meet/fail to meet standard of care expectations related to health equity
Health Information Technology /p 18	**We recommend adding the following legislative justification language from HB2009C:** **Sec1201 (1)** The Administrator of the Office for Oregon Health Policy and Research shall establish and maintain a program that requires reporting entities to report health care data for the following purposes: (i) Evaluating health disparities, including but not limited to disparities related to race and ethnicity. (2) The Administrator of the Office for Oregon Health Policy and Research shall prescribe by rule standards that are consistent with standards adopted by the Accredited Standards Committee X12 of the American National Standards Institute, the Centers for Medicare and Medicaid Services and the National Council for Prescription Drug Programs that: (b) Establish the types of data to be reported under this section, including but not limited to: (C) Data related to race, ethnicity and primary language collected in a manner consistent with established national standards. (4) The Administrator of the Office for Oregon Health Policy and Research

	shall adopt rules establishing requirements for reporting entities to train providers on protocols for collecting race, ethnicity and primary language data in a culturally competent manner.
Accountability **CCO Measurement and Accountability Plan/p24-26** <u>Specific areas of CCO accountability metrics</u>	**We recommend adding the following legislative justification language:** **Sec 2(3)(b)** The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including: **Progress toward eliminating health disparities**; **Sec10(2)** Quality measures. The authority shall evaluate on a regular and ongoing basis key quality measures, including health status, experience of care and patient activation, along with **key demographic variables including race and ethnicity**, for members in each coordinated care organization and for members statewide. **Sec30(1)(a)** Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including: (a) **Demographics, including race and ethnicity.** (f) **Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education.** **We recommend adding the following language:** OEI staff, partners, and/or communities representing Oregon's diversity, especially those impacted by health inequities, will bring a health equity lens to the work in the following groups:

	• Incentives & Outcomes committee • Outcomes, Quality, and Efficiency Metrics workgroup • Technical advisory group of experts from health plans and systems <u>Specific areas of CCO accountability metrics</u> OEI staff/partners will provide consultation in accountability measures for CCOs as they relate to health equity in specific areas of: access, consumer engagement, health care delivery, and quality improvement. **(See Appendix A for specific examples).**
Delivery System /p 15	**We recommend adding the following legislative justification language:** **Sec 4(k)(G)** Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization: **Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members**. **We recommend adding the following language:** •CCOs will demonstrate ability to partner with community and faith-based organizations, as made evident through letters of support of strong working relationships across communities.
Global Budget Methodology /p 20	**We recommend adding the following legislative justification language:** **Sec29(2)** The authority shall require each coordinated care organization, to the extent practicable, to offer patient centered primary care homes that meet the standards established in section 6 of this 2011 Act. The authority **may reimburse patient centered primary care homes for interpretive services provided to people in the state's medical assistance programs if interpretive services qualify for federal financial participation.** The authority shall **require patient centered primary care homes receiving**

	these reimbursements to report on quality measures described in ORS 442.210 (1)(c). **We recommend adding the following language:** The authority shall reimburse patient centered primary care homes for: • Qualified or certified health care interpreter services • Non-traditional health workers (i.e. doulas, community health workers, peer wellness specialists, and patient health navigators) OEI staff/partners will provide consultation in global budget methodology for CCOs as they relate to health equity in specific areas of: access, consumer engagement, health care delivery, and quality improvement. **(See Appendix B for specific examples).**
Blended Funding for Individuals who are Dually Eligible for Medicare and Medicaid /p 23	**We recommend adding the following language:** Federal waivers should include provisions for Medicare and Medicaid as they relate to health equity in specific areas of: access, consumer engagement, health care delivery, and quality improvement. **(See Appendix C for specific examples)**.

Appendix A: Accountability-CCO Measurement and Accountability Plan

	Outcomes, Quality, and Efficiency
Access	• # of limited English proficiency consumers • Language audit to analyze demand for and provision of linguistically competent services • Race/ethnicity data audit (based on Race, Ethnicity And Language [REAL] data standards) • # or % of comprehensive assessments for dual eligibles, by race, ethnicity and language • # and description of internal policies focused on health equity or provisions • Wait time for access to health care interpreters
Consumer Engagement	• Client/consumer representative advisory board members by race, ethnicity and language • Consumer satisfaction and grievance linked to REAL data • # of community and faith based partnerships/ subcontracts • # of contract providers who are bi or multilingual or bi-cultural
Health Care Delivery	• Providers, staff, volunteers, boards, advisory body demographics (race/ethnicity, LGBT/Homelessness) • Cultural and linguistic competence measures • Hours of cultural competence training • Hours of Community Health Worker (CHW), Health Care Interpreter (HCI), and Doula utilization

Quality Improvement	• Data sets cut by race, ethnicity, language, sexual orientation, etc.
	• Wait time for access to (HCIs)
	• Member satisfaction surveys with questions on cultural respect, linguistic access, etc.
	• Specific health outcomes across the lifespan by race, ethnicity, language, sexual orientation, housing status, etc.
	• From Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plans & systems survey:
	  o Provider communication composite
	  o Customer service composite (treated with courtesy & respect) / Cut by race, ethnicity and language

Appendix B: Global Budget Methodology

	Outcomes, Quality, and Efficiency
Access	•Resources driven to highest risk clients •Budget allocation for training, reimbursement of certified/qualified health care interpreters, community health workers, peer wellness specialists, etc. •Resources for engaging in efforts to improve social determinants of health in CCO region •Request to move from Community Engagement to Access: Subcontracts to specific partner organizations serving diverse populations.
Consumer Engagement	•Outreach/engagement resources dedicated to specific communities •Specific data collection efforts (focus groups, storytelling, marketing data (Social Determinants of Health-SDOHs)) •Subcontracts to specific partner organizations serving diverse populations. •Have a transparent process for determining and distributing shared savings so their communities may participate or at least understand how these decisions are made and where the savings are being directed.
Health Care Delivery	•Line items for nontraditional health care workers (CHWs, HCIs, Doulas) •Subcontracting with telephonic and/or videoconference interpreter services/translation services/signage •Incentives and pay differentials for providers/interns for culturally diverse backgrounds •Requirement that with global budgeting providers will engage interpreters for patients global budgeting, •Ensure diverse staffing that is able to engage populations in best practice/emerging practice approaches that seek to enhance health and reduce health disparities. •Budgets include supporting the client's personal choice of post long-term care support (in home care provider – family member, close friend, etc.)
Quality Improvement	•Budget associated with QI efforts focused on eliminating health care disparities •Establish a payment structure to reward the defined work of provider teams who help their patients achieve better health, while accounting for patients' complex psychosocial factors as well as their complex medical factors.

Appendix C: Federal Waivers for Medicare and Medicaid

	Outcomes, Quality, and Efficiency
Access	• Development of strong partnerships with Patient Centered Primary Care Homes (PCPCH), including migrant, homeless and community health centers • Equitable enrollment in Medical Advantage and Special Needs Plans • Mental/behavioral health literacy to address cultural barriers to services • Linguistically appropriate information re: dual eligibility, CCO disenrollment if care is inadequate
Consumer Engagement	• Clear and transparent grievance process described in multiple formats/flow charts
Health Care Delivery	• Inclusion of families*** as part of health care team • Self-management care process • Treatment summaries in patient record include culture, literacy, social supports, *** "Family" means any person(s) who plays a significant role in an individual's life. This may include a person(s) not legally related to the individual. Members of "family" include spouses, domestic partners, and both different-sex and same-sex significant others. "Family" includes a minor patient's parents, regardless of the gender of either parent. Solely for purposes of visitation policy, the concept of parenthood is to be liberally construed without limitation as encompassing legal parents, foster parents, same sex parent, stepparents, those serving in loco parentis, and other persons operating in caregiver roles.
Quality Improvement	• Transition plan after long term care – social supports included • Assuring standardized assessment of needs is culturally and medically comprehensive • Identification and enhancement of existing family, community and social supports and protective factors, as well as key challenges (including social determinants of health) • Effective data sharing and appropriate utilization of race, ethnicity and language (REAL) data to identify potential and existing health disparities