Health Equity and Social Determinants of Health Maturity Assessment of CCO 1.0

January 9, 2018

Background

In September 2017, Governor Brown asked the Oregon Health Policy Board (OHPB) to focus on social determinants of health (SDOH) and equity when considering the future of CCOs. Both equity and prevention were considered priorities in the initial vision of health system transformation. As health system transformation has progressed, there has been growing awareness that social determinants of health, such as housing and education, have a greater impact on health than health care services. Prevention has subsequently expanded to encompass far "upstream" actions that address SDOH – and there is potential to grow this work even further.

The OHPB, other state committees, and the Oregon Health Authority (OHA) have recently focused attention and initiatives to address the social determinants of health and equity:

- OHPB established its Health Equity Subcommittee in fall 2017.
- Social Determinants of Health are a priority in Oregon's recently renewed 2017-2022 Medicaid 1115 Waiver.
- Oregon's Medicaid Advisory Committee (MAC) is developing recommendations on addressing SDOH through Oregon CCOs, including a standard definition of SDOH (see Appendix A).
- OHA has established an internal SDOH workgroup to coordinate and expand SDOH work connected with health system transformation.

Definitions

Health Equity: Reaching the highest possible level of health for all people. Historically, health inequities result from health, economic, and social policies that have disadvantaged communities. *(OHPB 2012 implementation plan)*

Social Determinants of Health (SDOH): The social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. *(Draft MAC definition of social determinants of health & equity for Oregon CCOs)*

The Social Determinants of Equity: Structural factors, such as racism, that determine how different groups of people experience SDOH. *(MAC)*

See Appendix for more information

Indicators of Oregon's Performance

The lack of detailed tracking mechanisms and data related to health equity and SDOH contributes to the challenge of understanding how CCOs have impacted these areas over the last five years. However, the measures below give insight into the current picture.

Measure	Data	Limitations/ considerations
Flexible Services ("flex" services) – now called health-related services (HRS)		
% flex services of total member services expenses[i]	0.14%	Financial data limited, likely underreported
% flex services of total operating expenses[ii]	0.13%	Same as above
% flex services of total member services expenses – range by CCO[iii]	High: 0.7% (1 CCO) Low: 0 (1 CCO)	Same as above

Measure	Data	Limitations/ considerations
Reported individual-level flex services related to SDOH[iv]	**Frequently:** rental assistance, temporary housing **Less frequently:** Shelter repairs (e.g. plumbing), veggie RX, transportation	Self-report via interview
Reported group-level flex services related to SDOH[v]	Parenting program, Community Health Worker hub, abuse prevention, farmer's market, peer support drop-in center, employment services (SUD members)	Same as above
CCO investment in SDOH initiatives		
% of CCOs reporting planned or current investment in SDOH[vi]	100%	Source incl. planned work from CHIPs, transformation plans, reports (no proof of implementation). OHA staff categorization
Number of CCOs reporting interventions by health equity/SDOH category[vii]	**Healthy Equity:** 10/16 **Top 3 SDOH reported:** Trauma (12/16); Housing/built environment (12/16); Adverse Childhood Experiences (ACEs)s (11/16) **Lowest SDOH reported:** crime/public safety (6/16)	Same as above
CCOs reporting supporting housing-related services[viii]	100%	Self-report, no data on financial invest., 94% RR[ix]
Partnerships between CCOs and broader community		
% of CCOs with an MOU with Early Learning Hub (ELH)[x]	100%	Self-report sources. ELHs have partnership requirements; CCOs have recommendations
% of CCOs that participate on governance of ELH[xi]	100%	Same as above
% of CCOs that have made investments in ELHs[xii]	Over 50%	Same as above
# of Regional Health Equity Coalitions in Oregon that meaningful engagement with CCOs[xiii]	6 of 6	
Proportion of CCOs that include public health representative on Community Advisory Council (CAC)[xiv]	11/16 CCOs	Self-report, data may have changed since survey (2016)
% of CCOs with shared Community Health Assessment (CHA), Community Health Improvement Plan (CHP), or regional health improvement plan with Local Public Health (LPH) department[xv]	At least 10/16 CCOs	Not all LPHs complete a full CHA/CHP process (voluntary part of national public health accreditation); CCOs without a fully shared

Measure	Data	Limitations/ considerations
		CHP may still have LPH participation
Workforce		
# of THWs registered[xvi]	2320 certified (statewide) as of December 2017; (1506 certified in 2016)	Certification does not mean THWs are being *utilized* by CCOs
# of CCOs reported funding/ supporting THWs to provide services[xvii]	6/16	Based on review of 2015-2017 transformation plans; health equity activities
Cultural Competency Continuing Education (CCCE) [xviii]	All 22 medical boards required to report to OHA their cultural competency training; 2 boards have made CCCE a requirement	
# of OHA-certified Health Care Interpreters (HCI) in OHA registry[xix]	490 registered HCI, increasing by ~ 20/month	27 languages represented in registry; no data on *use* of certified HCI by CCOs
Geographic distribution of HCIs[xx]	85% employed in tri-county area	
% of health care providers who speak languages other than English[xxi]	20%	No data on proficiency, certification or actual language use by providers
Disparities		
Access to care[xxii]	Less likely to have access to care: Asian-American children and adults; Hawaiian/Pacific Islander adults (trending downward)	Self-report
Satisfaction with care (CAHPS)[xxiii]	African-American adults the least satisfied with care (66.2%) compared to benchmark (89.2%)	Self-report
Racial/Ethnic Disparities - Quality measures[xxiv]	See below – racial/ethnic disparities	
Disparities for members with SPMI	Worse performance in: utilization of the ED (higher); follow-up after hospitalization for mental illness; outpatient utilization (higher)	
Disparities for members with disability	Worse performance in: effective contraceptive use for adolescents; dental sealants; follow-up care for children prescribed ADHD medication; follow-up after hospitalization for mental illness	

Racial/ethnic disparities

- Hispanic/Latina women less likely to have timely prenatal care
- American Indian children less likely to receive developmental screening, likely to receive immunizations.
- American Indian and Hawaiian/Pacific Islander children less likely to receive dental sealants
- Adolescents of color and from households speaking languages other than English are less likely to receive adolescent well care.
- Latinos/Hispanics are less likely to receive colorectal cancer screening
- American Indians have the highest rates of smoking.
- Asian Americans are less likely to receive screening for alcohol and substance misuse.
- Asian American women at risk for unintended pregnancy are less likely to have effective contraception use.
- American Indians, African Americans/Blacks have higher rates of emergency department use.

Note: above disparities from 2015 data. Beginning in 2016, racial/ethnic demographics data has significant missing data, leading to unreliable findings. An increase in missing data after 2015 is largely due to differences in how the ONE system captures data compared with the previous system. Comparisons between pre-2016 and post-2016 data should be made with caution, and assessing improvement post-2015 would require more complex statistical analysis.

Lessons Learned

- CCOs have reported minimal investment in flex services/HRS, particularly those related to SDOH, in financial reports. Current reporting has significant limitations, including: CCOs focusing on services attributable to specific members, rather than community-level benefits (including workforce investments, such as community health workers); reports don't include investments outside of flexible service funds (e.g. transformation grants, other grant funds). Additional limitations include: low use of flexible services due to lack of guidance/understanding; time needed to develop/implement policies.
- Based on CCO reporting, CCOs have begun investing in areas of SDOH, with particular focus on housing and trauma/Adverse Childhood Experiences (ACEs). Data is limited to self-report, and doesn't include information on actual financial investment, guarantee of implementation, or results.
- CCOs have partnered, to varying degrees, with community partners that can support work related to health equity and social determinants of health, including Early Learning Hubs, Public Health Departments, and Regional Health Equity Coalitions. CCOs have limited expectations in statute or contract related to these partnerships.
- While statewide workforce data is available, little is known about CCO employment/utilization of key providers who address health disparities and social determinants of health, such as traditional health workers and health care interpreters.
- Disparities in access to and quality of care are evident related to race/ethnicity, disability, and behavioral health status. However, claims data (including data used for performance metrics) has significant limitations starting in 2016, making comparison difficult over time.

CCO 2.0 Questions for 2018 Investigation

Based upon lessons learned, existing data, and subject matter expertise, the gray boxes below identify questions that could be further explored in 2018 in order to build upon the first phase of CCOs. At the 2018 OHPB retreat, board members will consider and confirm whether answering these specific questions will address the lessons learned and give them the information needed to develop final recommendations for CCO 2.0.

Workgroups, OHA staff, stakeholders, members of the public and OHPB members will all be consulted and included in the process to investigate these questions and consider next steps and potential policy options in the spring/summer of 2018.

Social Determinants of Health & Equity Initiatives ➢ Existing recommendations related to this area: Summative Evaluation of Oregon's Medicaid Waiver; MAC CCO 2.0 recommendations; 2016 CCO Listening Sessions; Health-related Services Rules Advisory Committee	
How can OHA encourage CCOs to invest more in social determinants of health & equity work, and hold CCOs accountable for these investments?	*Potential next steps and policy options to consider:* (1) value-based payment (2) defining and directing CCO investment in priority areas (3) requirements for spending (SDOH, flex/health-related services) (4) CHP implementation expectations/requirements (5) training (6) workforce and infrastructure (e.g. health equity position at CCO) (7) CCO risk-based adjustment considering SDOH factors
Partnerships ➢ Existing recommendations related to this area: MAC CCO 2.0 recommendations; 2016 CCO Listening Sessions; OHPB CCO 2.0	
How do we strengthen CCO partnerships and ensure meaningful engagement to support social determinants of health & equity work?	*Potential next steps and policy options to consider:* (1) CAC /governance representation (2) governance/CAC connections (3) formal/informal partnerships (e.g. MOUs) between CCOs and community partners (e.g. ELHs) (4) shared plans (e.g. CHIP, equity) (5) requirements for partnerships (e.g. VBP/SDOH)
Workforce ➢ Existing recommendations related to this area: Traditional Health Worker Commission; Health Care Interpreter Evaluation	
How do we better ensure provider cultural competency, language accessibility, and a diversified workforce within a CCO and its provider network that reflects the population served by the CCO?	*Potential next steps and policy options to consider:* (1) workforce availability of providers by race, ethnicity, gender, type of care within service area based on demographics of members (2) workforce availability of essential providers for health equity, social determinants of health work (e.g. THW, HCI), including network adequacy guidance/requirements (provider/member ratios) (3) cultural competency reporting

	(4) Provider Incentive Fund targets (5) health equity process measures (6) partnership/representation strategies (e.g. committees) (7) certification system and related requirements
SDOH & Equity Tracking/Reporting & Data collection ➢ Existing recommendations related to this area: Summative Evaluation of Oregon's Medicaid Waiver; CCO Equity Report (see xxii); OHPB CCO 2.0	
What changes can we make to improve our understanding of social determinants of health & equity initiatives, and disparities?	*Potential next steps and policy options to consider:* (1) reporting requirements – CCO and OHA public reporting (including non-discrimination, ADA and ACA 1557 compliance) (2) REALD implementation[xxv] and CCO reporting (3) data collection improvements (e.g. agency intake procedures, training) (4) expand data collection strategies (e.g. Medicaid Behavioral Risk Factors Surveillance System (BRFSS) survey)

[i] CCO financial reports, 2017 Q1-Q3
[ii] Ibid.
[iii] Ibid.
[iv] Summative Evaluation of Oregon's Medicaid Waiver, 2017 CCO interviews
[v] Ibid.
[vi] OHA Transformation Center CCO Reports and Good Ideas Database, 2013-2017
[vii] Ibid.
[viii] Oregon CCO Housing Supports: Survey Report 2016
[ix] Response rate (RR)
[x] CCO/Early Learning Hub survey and reports, 2016 survey
[xi] Ibid.
[xii] Ibid.
[xiii] RHEC Evaluation Report 2017
[xiv] Transformation Center CCO Governance Survey 2016
[xv] Transformation Center staff review of CCO CHP contract deliverable (CHA is not a contract deliverable), Plan year varies by CCO
[xvi] Statewide Needs Assessment for the Traditional Health Worker (THW). PACIFIC Research & Evaluation, LLC. 2015.
[xvii] Opportunities for Oregon's Coordinated Care Organizations to Advance Health Equity, OHA Transformation Center, June 2017.
[xviii] OHA Office of Equity and Inclusion data
[xix] Ibid.
[xx] Ibid.
[xxi] The Diversity of Oregon's Health Care Workforce, OHA Health Analytics, February 2017 report, based on 2015-2016 data
[xxii] Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, 2016, found in CCO Metrics 2016 Final Report
[xxiiixxiii] Ibid.
[xxiv] Opportunities for Oregon's Coordinated Care Organizations to Advance Health Equity, OHA Transformation Center, June 2017.
[xxv] The REALD legislation requires OHA and DHS requires standardized data collection in race, ethnicity, language, and disability (REALD). In July 2017, the ONEligibility system portal became REALD compliant.

Social Determinants of Health and Equity (SDOH&E)
CCO 1.0 Maturity Assessment

OHPB Retreat – January 16, 2018

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Governor's Letter

Governor Brown sent a letter to the OHPB in Sept 2017 detailing the need for improvement in the areas of social determinants of health (SDOH) and equity in CCO 2.0, including:

- Build stronger partnerships between health care and social system
- Align outcomes across systems to advance community health improvement plans
- Increase investment in social determinants and prevention

Definitions

- **Health Equity:** Reaching the highest possible level of health for all people. Historically, health inequities result from health, economic, and social policies that have disadvantaged communities. *(OHPB 2012 implementation plan)*

- **Social Determinants of Health (SDOH):** The social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. *(Draft Medicaid Advisory Committee (MAC) definition of social determinants of health & equity for Oregon CCOs)*

- **The Social Determinants of Equity:** Structural factors, such as racism, that determine how different groups of people experience SDOH. *(MAC)*

SDOH&E Topic Area: SDOH&E Initiatives

Lessons learned: CCOs have begun investing in areas of SDOH, with particular focus on housing and trauma/Adverse Childhood Experiences (ACEs). CCOs have reported minimal investment in flexible services/health-related services, particularly in SDOH.

Key information:

- *0.14% of total member services expenses spent on flexible services (now "health-related services")*
- *10 of 16 CCOs report interventions on health equity*
- *75% of CCOs report interventions on trauma, housing, ACEs*

CCO 2.0 Question for 2018 Investigation:	**Potential next steps and policy options to consider:**
How can OHA encourage CCOs to invest more in social determinants of health & equity work, and hold CCOs accountable for these investments?	(1) Value-based payment (VBP) (2) Defining and directing CCO investment in priority areas (3) Requirements for spending (SDOH, health-related services) (4) Community Health Improvement Plan (CHP) implementation expectations/requirements (5) Training (6) Workforce and infrastructure (e.g. health equity position at CCO) (7) CCO risk-based adjustment considering SDOH factors

SDOH&E Topic Area: Partnerships

Lessons learned: CCOs have partnered, to varying degrees, with community partners that can support work related to health equity and SDOH, including Early Learning Hubs, Public Health Departments, and Regional Health Equity Coalitions.

Key information:

- *Over 50% of CCOs have reported investment in Early Learning Hub*
- *11 of 16 CCOs included public health rep on Community Advisory Council*
- *10 CCOs share community health assessment, improvement plan, or regional improvement plan with local public health department*

CCO 2.0 Question for 2018 Investigation:	**Potential next steps and policy options to consider:**
How do we strengthen CCO partnerships and ensure meaningful engagement to support social determinants of health & equity work?	(1) CAC/governance representation (2) Governance/CAC connections (3) Formal/informal partnerships (e.g. MOUs) between CCOs and community partners (e.g. Early Learning Hubs) (4) Shared plans (e.g. CHP, equity) (5) Requirements for partnerships (e.g. VBP/SDOH)

SDOH&E Topic Area: Workforce

Lesson learned: Little is known about CCO employment/utilization of key providers who address health disparities and social determinants of health

Key information:

- *2320 certified traditional health workers (THW); only 6/16 CCOs report funding/supporting THWs*
- *85% of HCIs are employed in tri-county areas*
- *20% of providers speak a non-English language*

CCO 2.0 Question for 2018 Investigation:	**Potential next steps and policy options to consider:**
How do we better ensure provider cultural competency, language accessibility, and a diversified workforce within a CCO and its provider network that reflects the population served by the CCO?	(1) Workforce availability of providers by race, ethnicity, gender, type of care within service area based on demographics of members (2) Workforce availability of essential providers for health equity, social determinants of health work (e.g. THW, health care interpreters), including network adequacy guidance/requirements (provider/member ratios) (3) Cultural competency reporting (4) Provider Incentive Fund targets (5) Health equity process measures (6) Partnership/representation strategies (e.g. committees) (7) Certification system and related requirements

SDOH&E Topic Area: Reporting & data collection

Lessons learned: Disparities in access to and quality of care are evident related to race/ethnicity, disability, and behavioral health status. Data collection is challenging.

Key information:

- *Members with a disability experience worse performance on four metrics*
- *American Indian children are less likely to receive dev screenings, immunizations*
- *American Indian adults have the highest rates of smoking, ED use*
- *Asian Americans less likely to receive alcohol/substance misuse screenings*
- *Latina/Hispanics less likely to receive timely prenatal care, col. cancer screening*

CCO 2.0 Question for 2018 Investigation:	**Potential next steps and policy options to consider:**
What changes can we make to improve our understanding of social determinants of health & equity initiatives, and disparities?	(1) reporting requirements – CCO and OHA public reporting (including non-discrimination, ADA and ACA 1557 compliance) (3) REALD implementation and CCO reporting (4) data collection improvements (e.g. agency intake procedures, training) (5) expand data collection strategies (e.g. Medicaid Behavioral Risk Factors Surveillance System (BRFSS) survey)

CCO 2.0 Questions for 2018 Investigation

- How can OHA encourage CCOs to invest more in social determinants of health & equity work, and hold CCOs accountable for these investments?
- How do we better ensure provider cultural competency, language accessibility, and a diversified workforce within a CCO and its provider network that reflects the population served by the CCO?
- How do we strengthen CCO partnerships and ensure meaningful engagement to support social determinants of health & equity work?
- What changes can we make to improve our understanding of social determinants of health & equity initiatives and disparities?