MEDICAID ADVISORY COMMITTEE
May 23, 2018
9:00am-Noon
Oregon State Library, Room 102-103, 250 Winter Street, Salem OR 97301

Webinar registration: https://attendee.gotowebinar.com/register/7487251259119701506
Conference line: 1-888-398-2342; Member code 3732275

Meeting Objectives

- Regular business (e.g. approve minutes)
- Understand the latest updates for the Medicaid program from OHA and DHS
- Discuss and consider approval of recommendations on SDOH for OHA
- Discuss and consider approval of cover letter for MAC SDOH recommendations
- Better understand the issues experienced by OHA members, through hearing update from Ellen Pinney, OHA Ombudsperson
- Hear update on ONE System and Integrated Eligibility from OHA and DHS staff
- Hear public comment

Time	Item	Presenter(s)	Purpose
9:00	Welcome and Introductions • Adopt minutes • Recruitment	Co-chairs	Action
9:15	OHA/DHS Medicaid update	David Simnitt, Interim Medicaid Director, OHA Anna Lansky, Deputy Director of the Office of Developmental Disability Services, DHS	Informational
9:35	MAC Social Determinants of Health recommendations to OHA & cover letter	Co-chairs	Discussion and Action
10:35	Stretch/rest break		
10:45	Ombuds update	Ellen Pinney, OHA Ombudsperson	Informational
11:05	ONE System & Integrated Eligibility update	Vivian Levy, OHA Business Director – IE & ME ONE Project Nathan Singer; Deputy Operations Director, APD, DHS IE/ME Project Office Sam Osborn, DHS OHP Statewide Manager	Informational
11:45	Public Comment		
11:55	Closing comments		

Next Meeting:
July 25 9:00am – Noon
Oregon State Library, 250 Winter Street, Room 102/103, Salem, 97301

AGENCY UPDATES
FOR MEDICAID ADVISORY COMMITTEE
May 23, 2018

Department of Human Services (DHS)

***May updates in bold**

ONE OHP Enrollment System Update

- **Update to be provided in person via ONE/Integrated Eligibility Presentation.**

Aging and People with Disabilities

Tightening APD Eligibility:

- APD is amending administrative rules that will determine who we can serve in Medicaid-funded Long Term Services and Supports. These changes, required to meet the Department's 2017-2019 budget, will impact approximately four (4) percent of APD's current service eligible consumer. Approximately 55 percent of these consumers live in their own homes while the remaining live in licensed care settings. This went live on October 1st and implementation is occurring smoothly.
- To mitigate the potential risk to consumers losing eligibility, APD amended its waiver with the Centers for Medicare and Medicaid Services. The waiver will allow APD to continue to provide services if loss of eligibility would mean that the consumer would face re-institutionalization, have inadequate housing or would face potential abuse or exploitation. Less than fifteen consumers are currently being served via this option. **We estimate 100 individuals will access these services. Eligibility is determined through OAR 411-015-0030 Extended Waiver Eligibility.**
- Consumers will continue to receive minimal long term services and support and ongoing case management.* Consumers will also be able to access Transition Supports that will help them move from licensed care settings to a family home or an apartment or home of

their own. Less than fifteen consumers are being served under this new option**. *the definition of "minimal long term services support" is person-centered. Individuals receive the minimal services necessary to prevent homelessness, exploitation, abuse, and deterioration.**

Office of Developmental Disabilities Services

- **No updates this month.**

Oregon Health Authority

CCO 2.0

- Governor Kate Brown has asked the Oregon Health Policy Board, which oversees OHA's work, to focus on four areas for improvement:
  - Maintain sustainable cost growth
  - Increase value-based payments that pay for performance
  - Focus on social determinants of health and equity
  - Improve the behavioral health system
- OHA has developed policy teams working on each of these areas to come up with possible policy strategies for CCO 2.0. The teams are identifying strategies based on existing stakeholder recommendations, state and local models, and evidence of what works.
- OHA is currently conducting a public feedback process to share these possible strategies with various state committees (e.g. MAC), community groups (e.g. Allies for a Healthier Oregon), current CCOs and CACs, and OHP members and members of the general public. Public feedback will be incorporated into straw model recommendations for the Oregon Health Policy Board in early June.
- Learn more: http://health.oregon.gov; click on "Learn more about CCO 2.0" for more information about public forums and meetings, topic area work plans, and other details.
- **OHA is wrapping up the initial public input process for the policy development phase. The process included a survey, four public forums, tribal consultations, and presentations to numerous stakeholder committees, including the MAC.**
- **Draft recommendations will be presented to the Oregon Health Policy Board at its June 5th meeting.**

Agency Realignment

- **The agency is proposing a realignment which would have several impacts on the current structure of the Medicaid program.**
- **The purpose of these changes is to align OHA's structure, improve business rigor, and strengthen transparency and accountability in the agency**
- **The current proposal reflects feedback from OHA employees, tribes, and community partners and other external stakeholders.**
- **The key goals of the proposed realignment are to:**
    - **Consolidate Medicaid policy and operations:**
        - **Realigning Medicaid operations and policy as a distinct section in the Health Systems Division (HSD) that are currently spread between Health Systems and Health Policy and Analytics divisions. This consolidation is meant to bring more cohesion and accountability in the way we manage and operate our Medicaid program and improve services for Oregon Health Plan members.**
        - **Moving the Medicaid director from Health Policy and Analytics Division to the Health Systems Division to lead a Medicaid program area.**
        - **The Medicaid group would also include the Physical, Oral and Tribal Health, Quality Assurance and Hearings, Provider Services, and a newly established Medicaid policy group.**
    - **Consolidate behavioral health:**
        - **Realigning behavioral health programs that are currently spread among OHA Health Systems, Health Policy and Public Health divisions. This change is designed to elevate behavioral health as a program area, make behavioral health efforts and outcomes more transparent, and strengthen accountability to tribes, consumers, communities and partners.**
    - **Strengthen the service OHA provides consumers and stakeholders:**
        - **Strengthening OHA's relationships with CCOs, stakeholders, community partners and consumers through the Oregon Health Plan and the Oregon**

State Hospital, by consolidating and expanding important communication, service, support and outreach roles under the chief of staff.

- **This includes the Innovator Agents, who are currently in Provider Services, and would move to the External Relations Division**

<u>State Plan Amendments</u>

Recently approved:

- **Increase dental rates for preventive and diagnostic services by 10%, and oral surgery by 30% over 2017 rates. Effective 1/1/18.**
- **Received CMS approval to pay supplemental payment to ground emergency medical transportation providers.**

Pending approval:

- **1915(k) plan revisions. Adding support system activities as a discrete service in order for the Division to claim an additional 6% FMAP.**

In development:

- **Dental incentive program: Division working on an incentive program to increase the number of new members seen by dental providers for preventive services.**

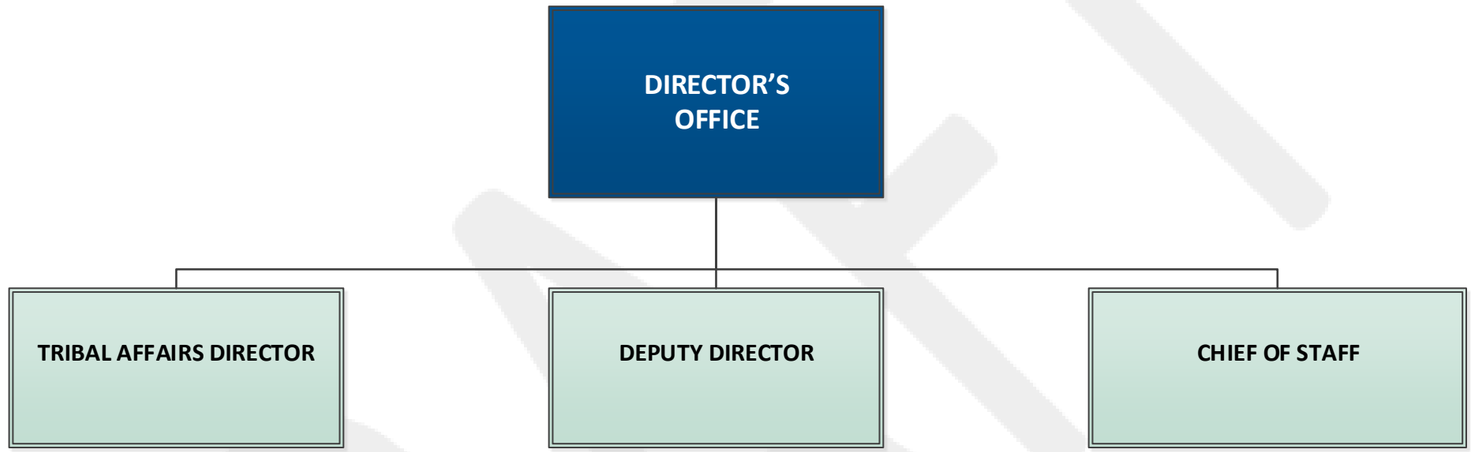
- **Mental Health Parity- OHA contractor Mercer is performing analysis on CCO's parity and FFS. The FFs analysis will be submitted with the state plan to CMS targeted for June 2018.**

- **DME regulation for Medicaid rate not to be higher than Medicare rate. Division performing analysis on impact in order to determine if there is a need to make any changes to the rate.**

<u>FFS Enrollment</u>

- **Update provided via separate attachment.**

Oregon Health Authority
Functional Organizational Chart



OFFICE OF EQUITY & INCLUSION

- Compliance & Civil Rights
- Health Equity

OREGON STATE HOSPITAL

- OSH Salem
- OSH Chief Medical Officer
- Hospital Systems Analysis & Management
- OSH Chief Financial Officer
- Nursing
- Pendleton Cottage
- OSH Junction City

FISCAL

- Program Integrity
- Health Care Finance
- Budget
- Actuarial Services

AGENCY OPERATIONS

- Office of Information Services
- Office of Human Resources
- Central Operations

PUBLIC HEALTH

- Center for Public Health Practice
- Center for Prevention & Health Promotion
- Center for Health Protection
- Public Health Officer
- Policy & Partnerships
- Program Operations
- Fiscal & Business Operations

EXTERNAL RELATIONS

- Communications
- Government Relations
- Stakeholder & Member Support

HEALTH POLICY & ANALYTICS

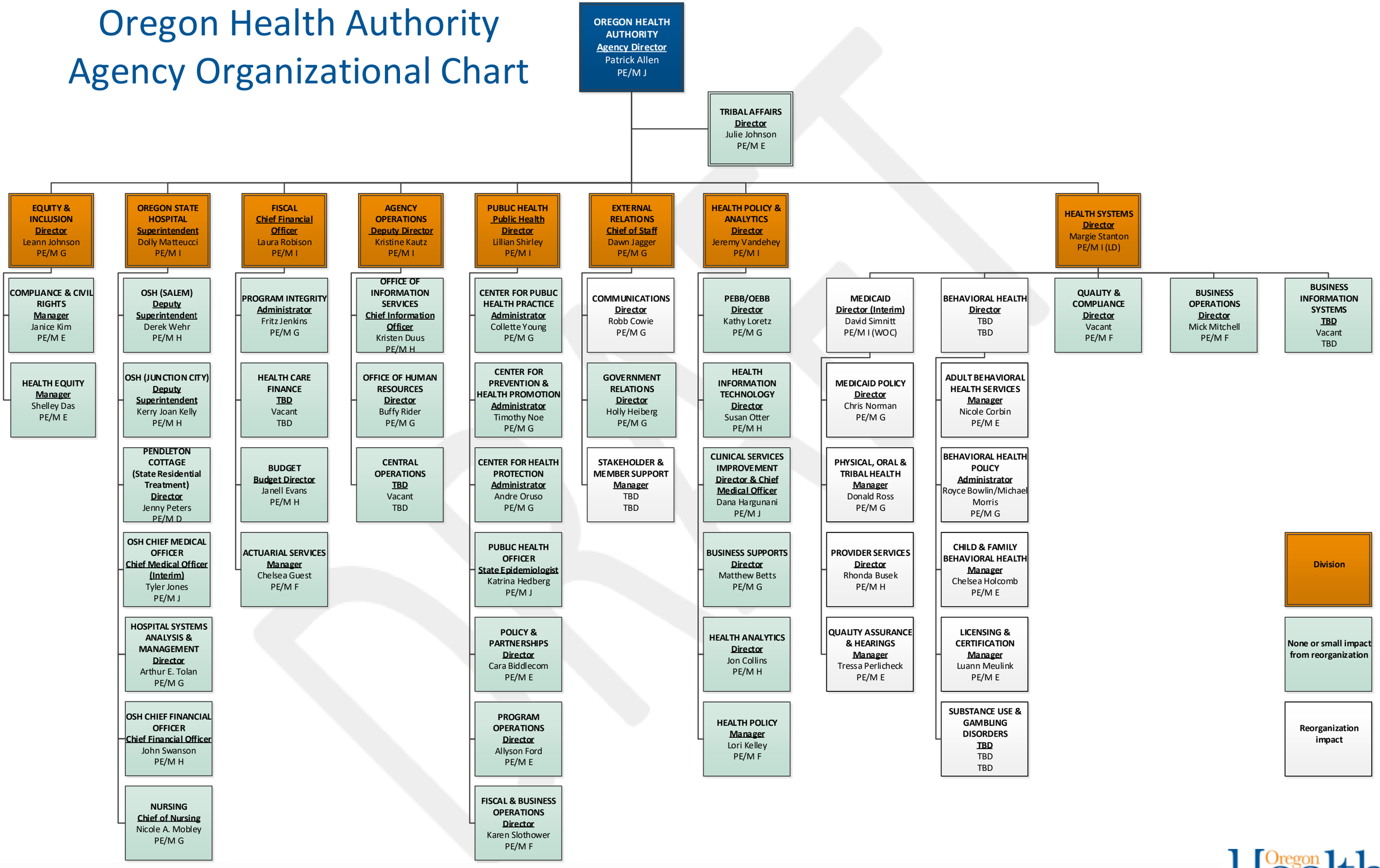
- PEBB/OEBB
- Health Information Technology
- Clinical Services Improvement
- Business Supports
- Health Analytics
- Health Policy

HEALTH SYSTEMS

- Medicaid
- Behavioral Health
- Quality & Compliance
- Business Operations
- Business Information Systems

*Proposed structure effective July 1, 2018

Oregon Health Authority
Agency Organizational Chart



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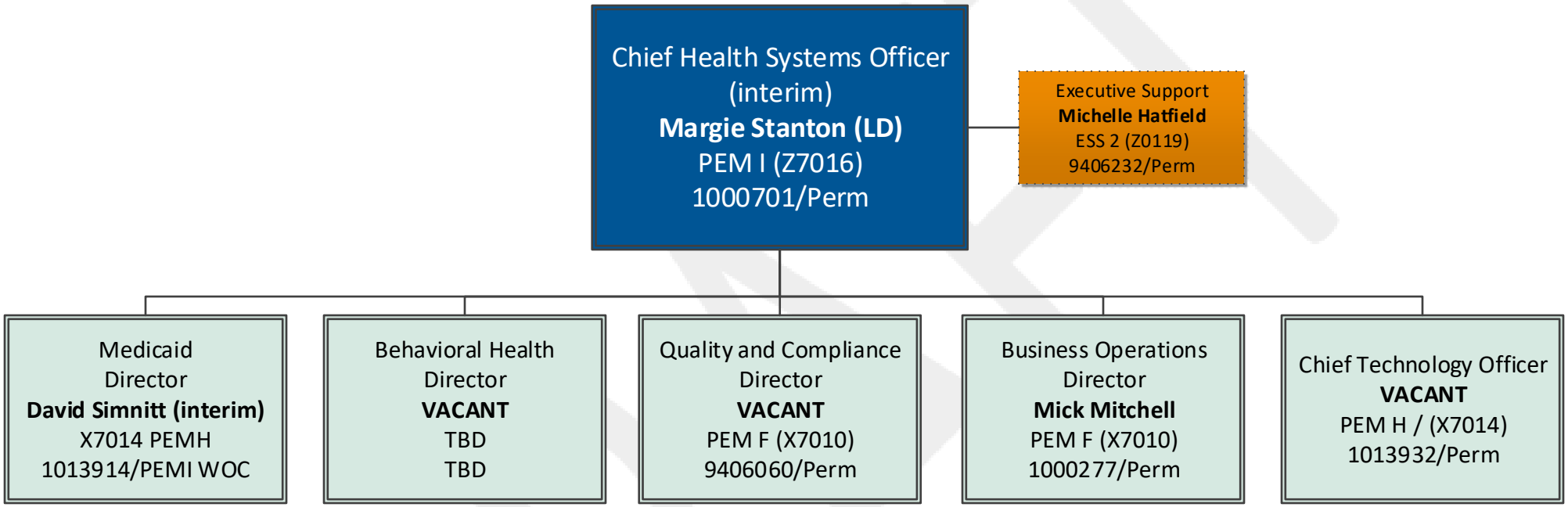
Health Systems Division



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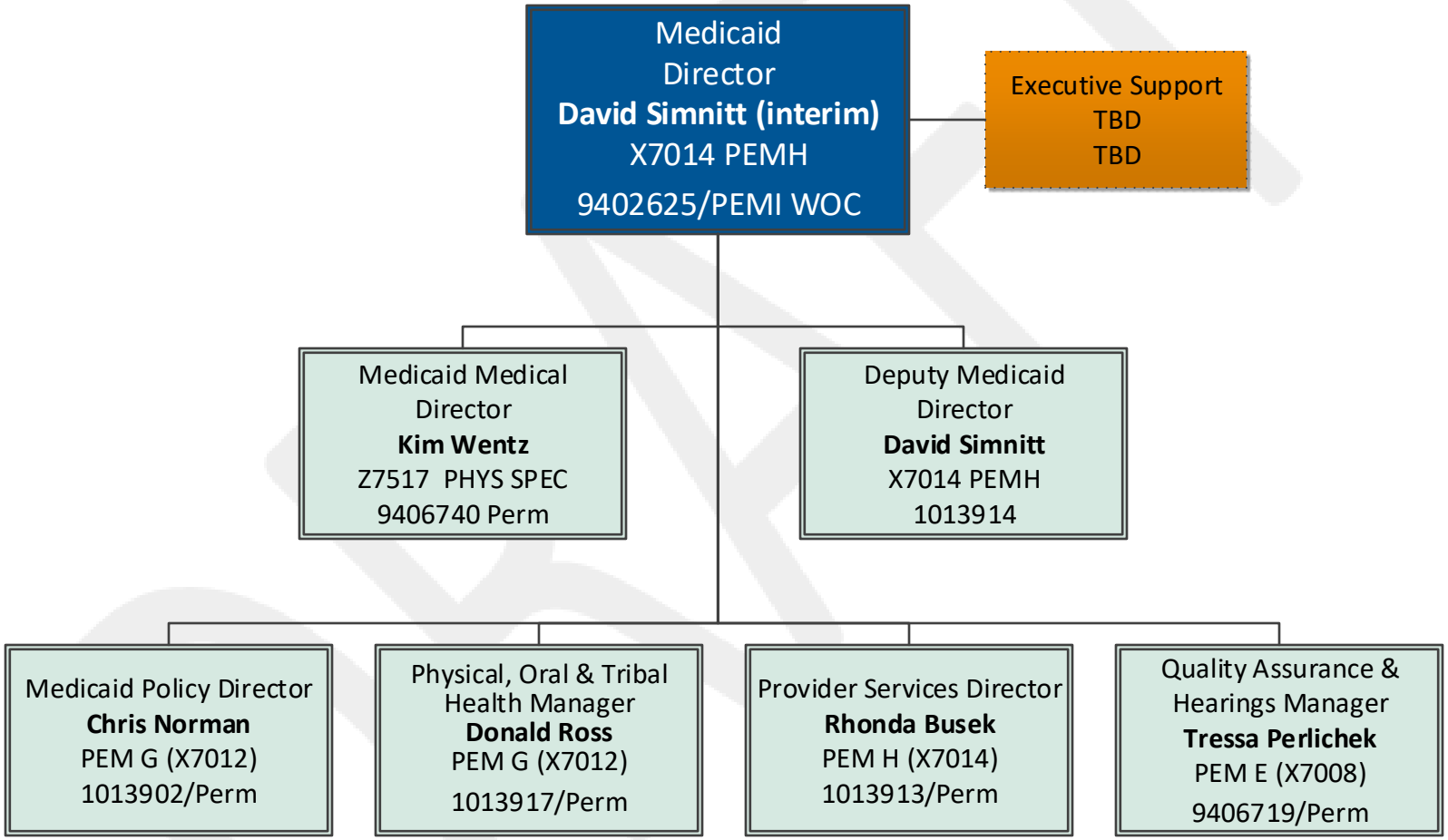
Health Systems Division: Medicaid



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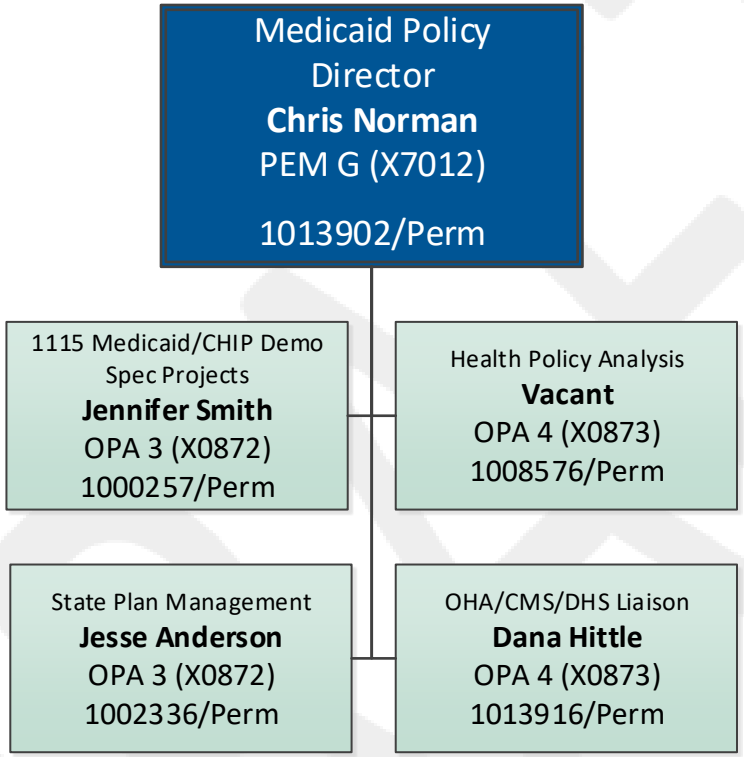
Oregon Health Authority

Medicaid:
Medicaid Policy



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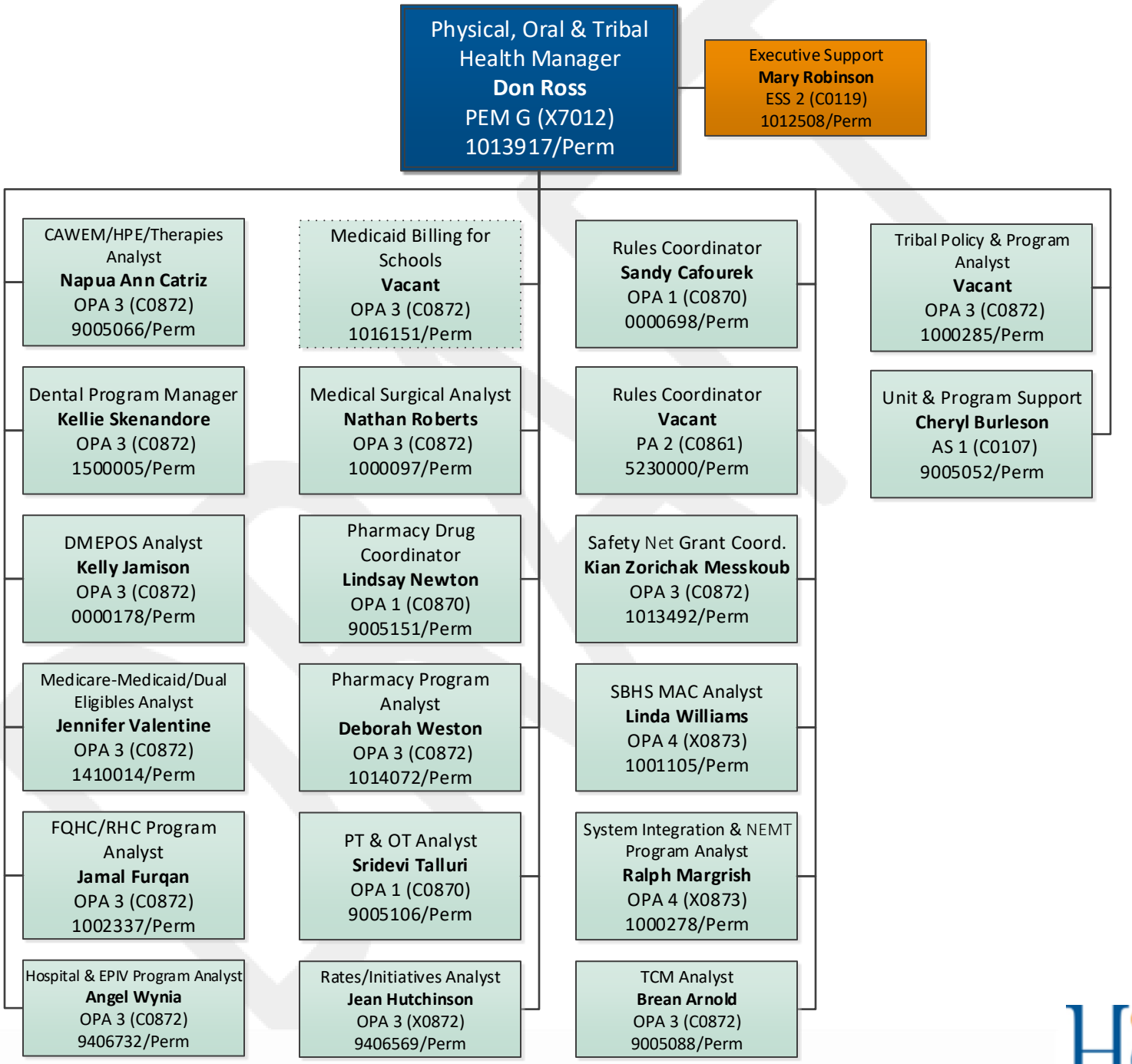
Medicaid: Physical, Oral & Tribal Health



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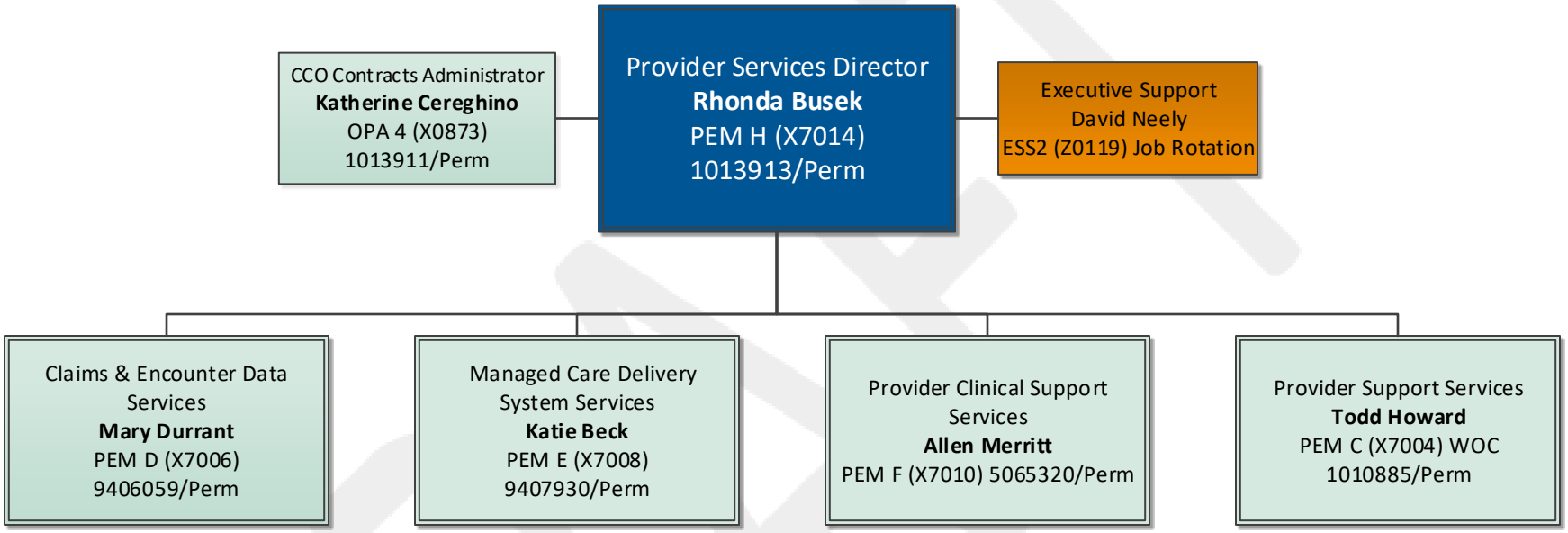
Oregon Health Authority

Medicaid: Provider Services



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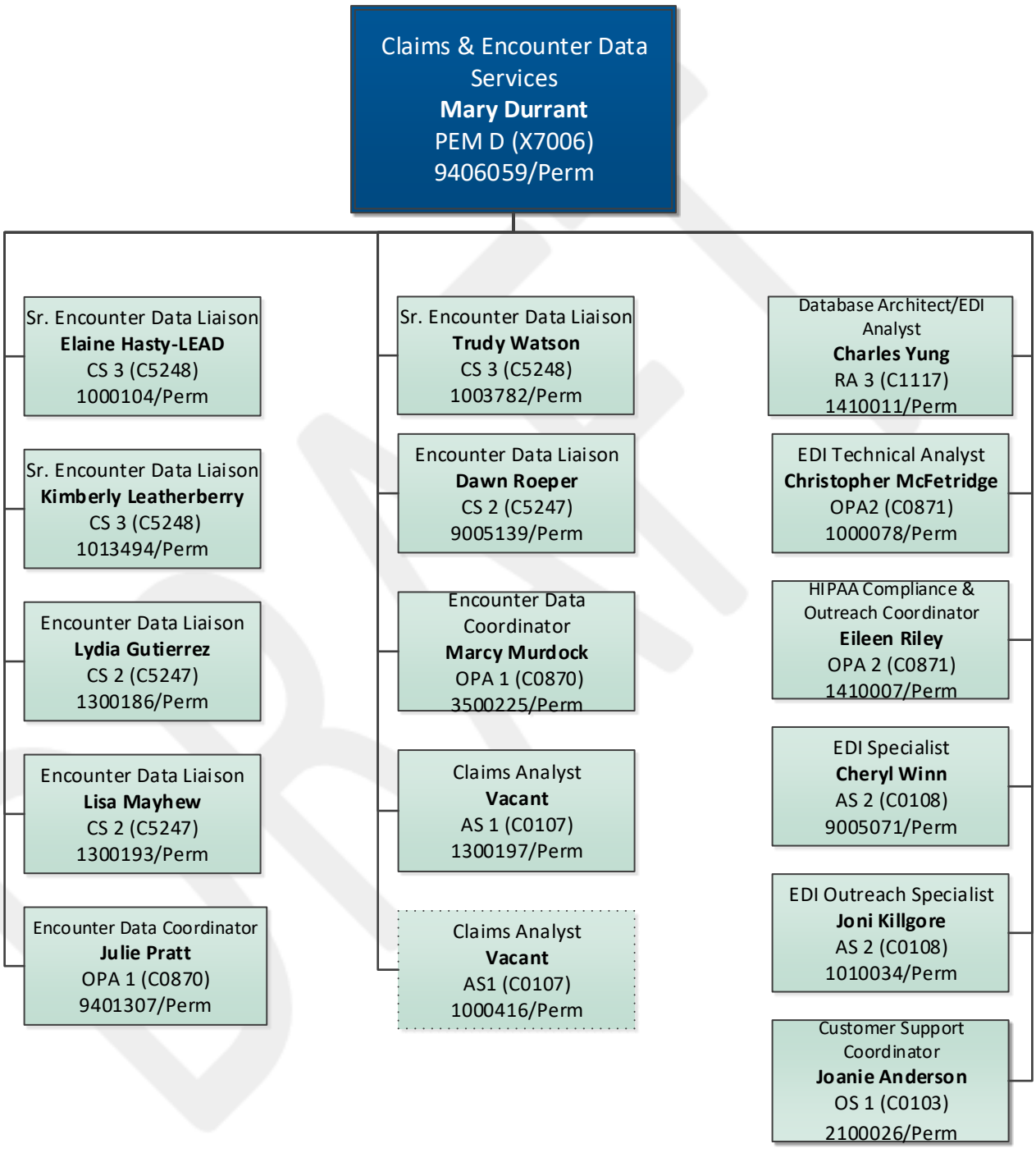
Medicaid: Provider Services
Claims & Encounter Data Services



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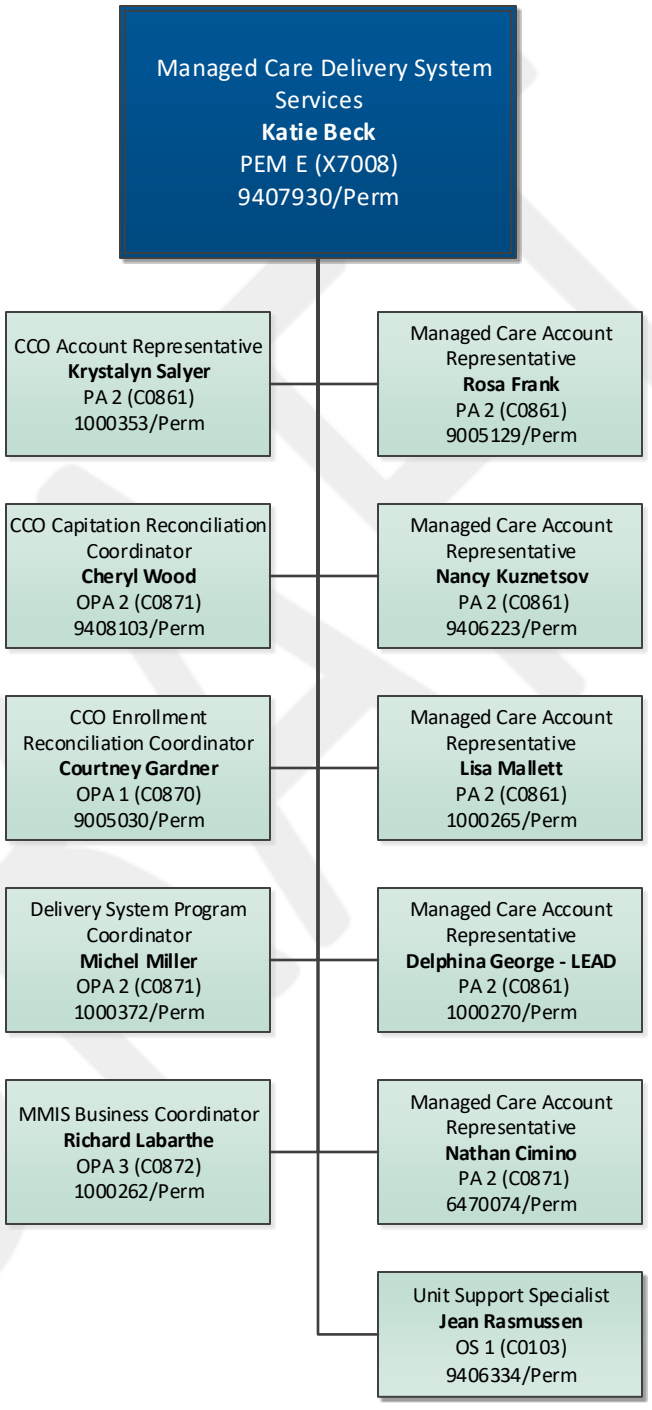
Oregon Health Authority

Medicaid: Provider Services
Managed Care Delivery System Services



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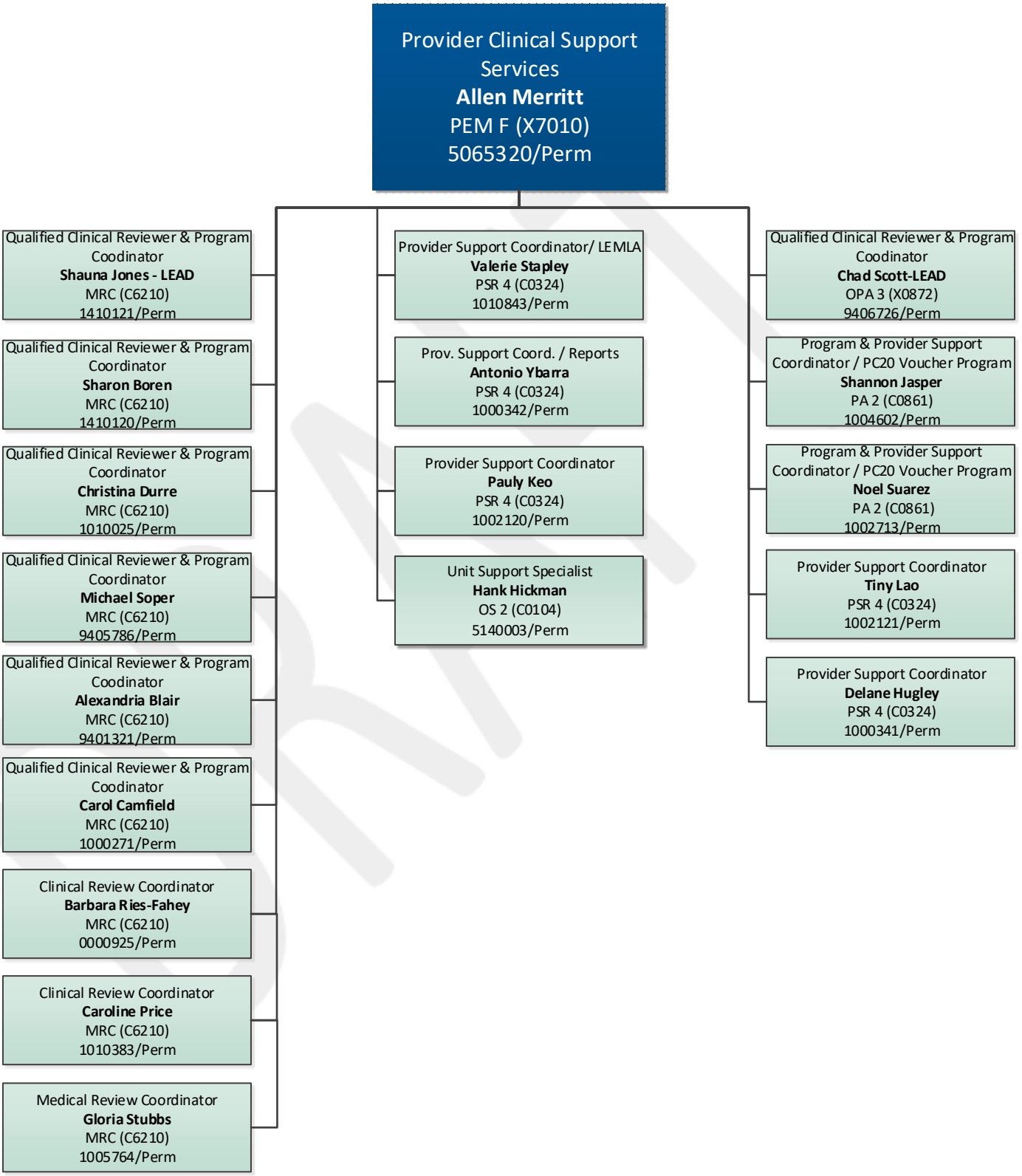
Medicaid: Provider Services
Provider Clinical Support Services



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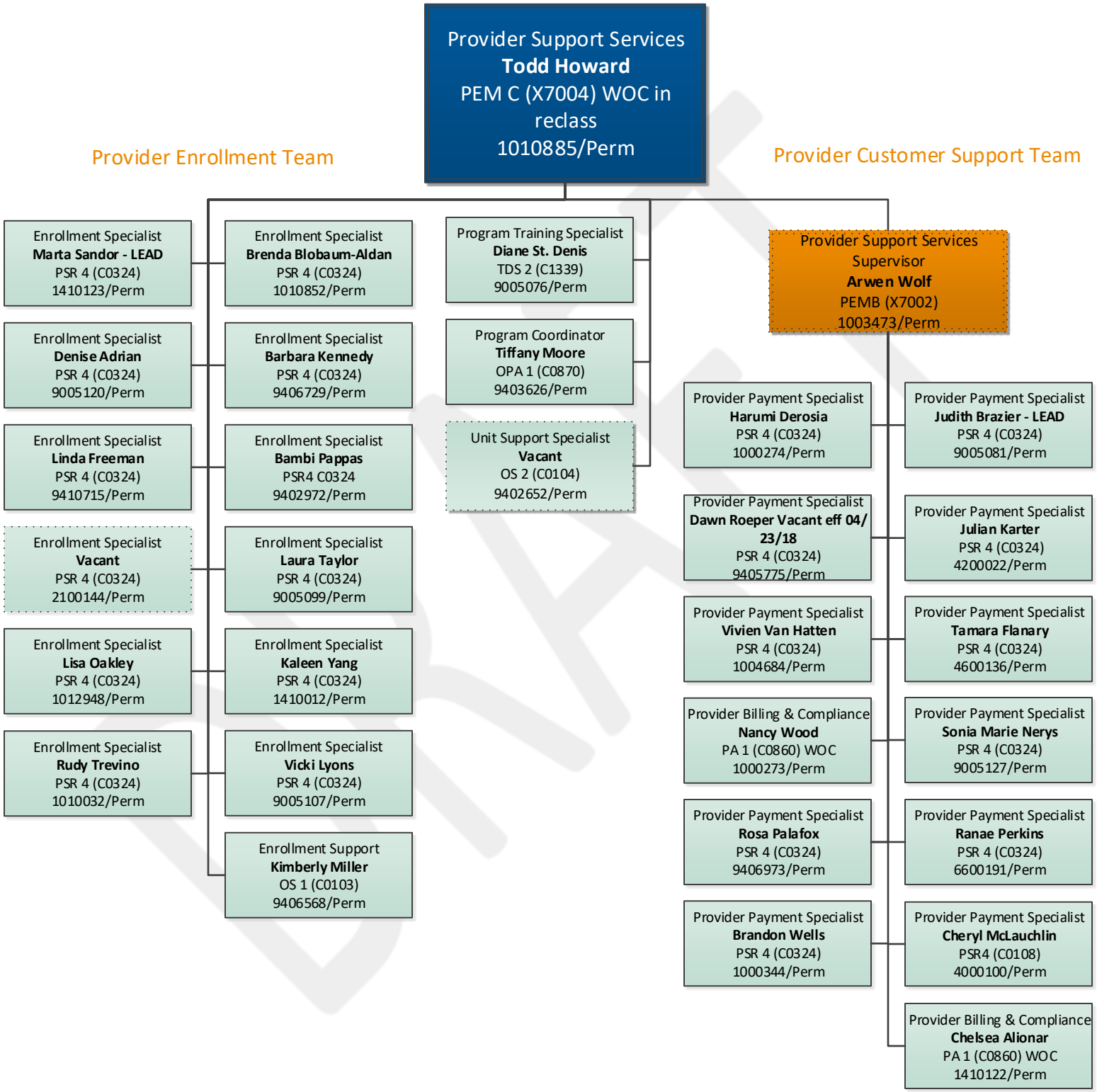
Provider Support Services



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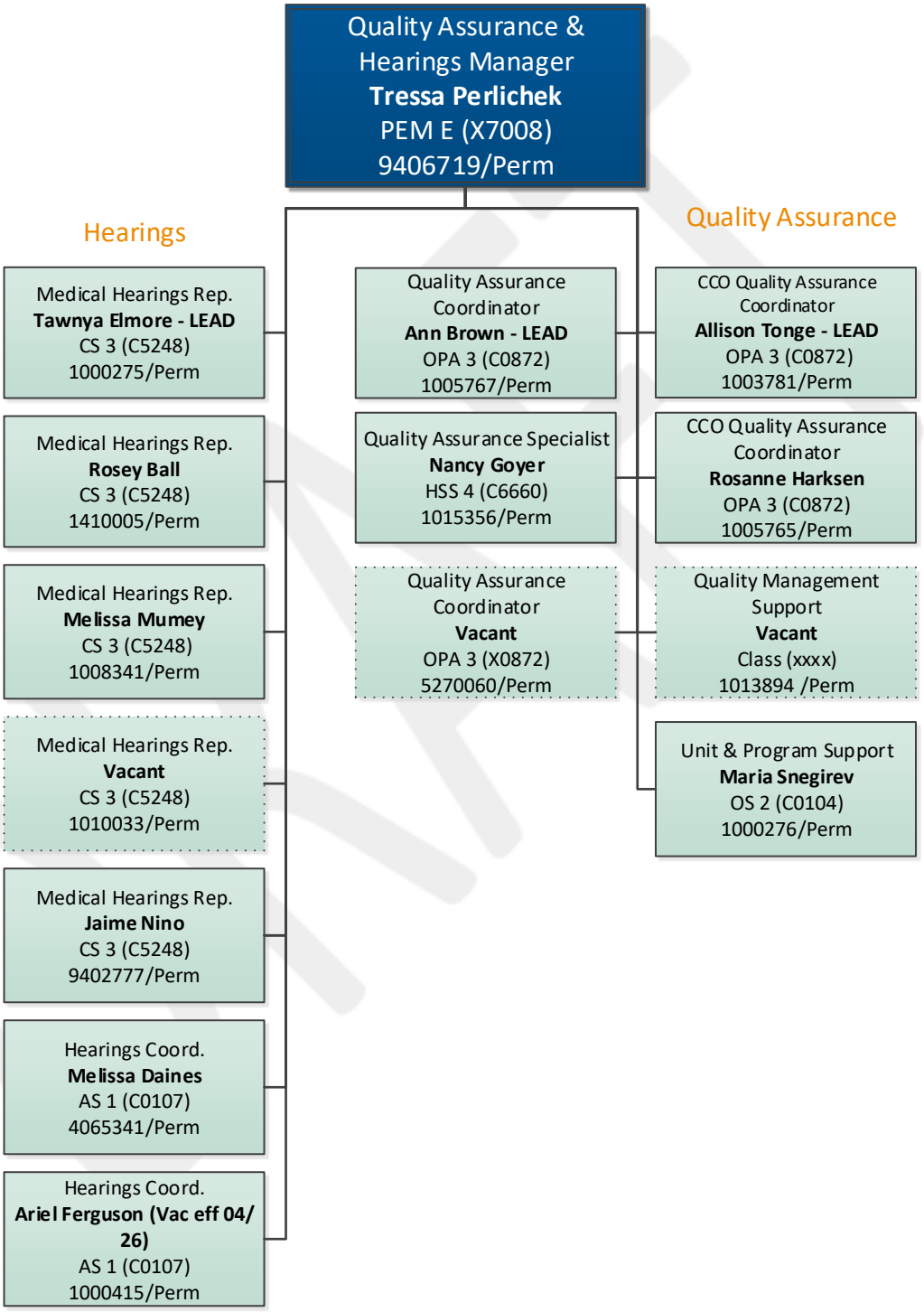
Oregon Health Authority

Medicaid:
Quality Assurance & Hearings



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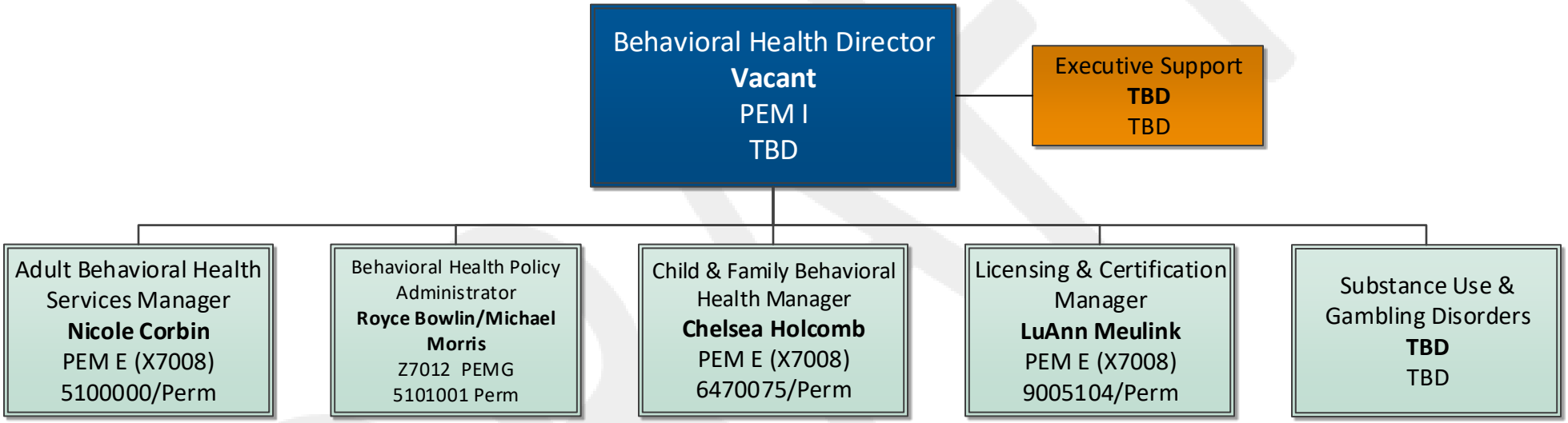
Oregon Health Authority

Health Systems Division: Behavioral Health



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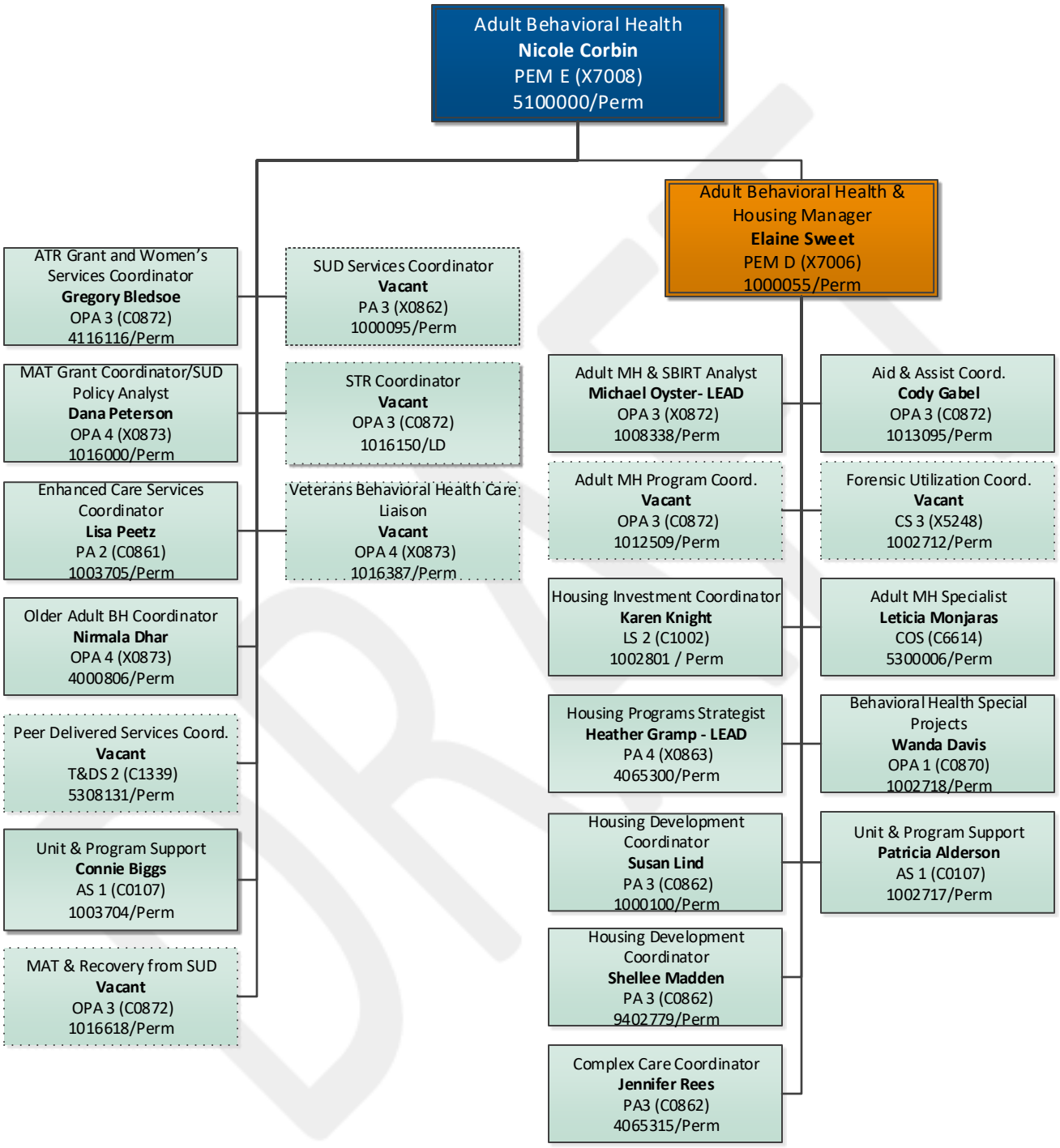
Behavioral Health:
Adult Behavioral Health Services



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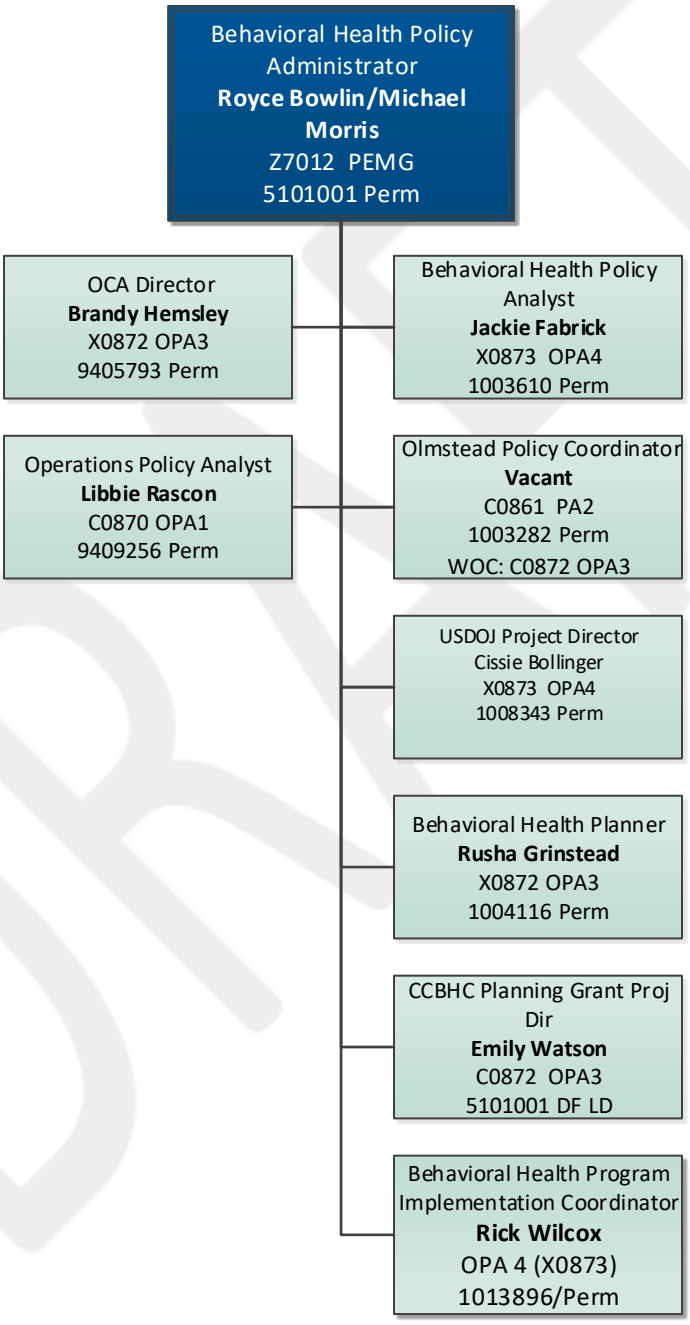
Oregon Health Authority

Behavioral Health: Health Policy



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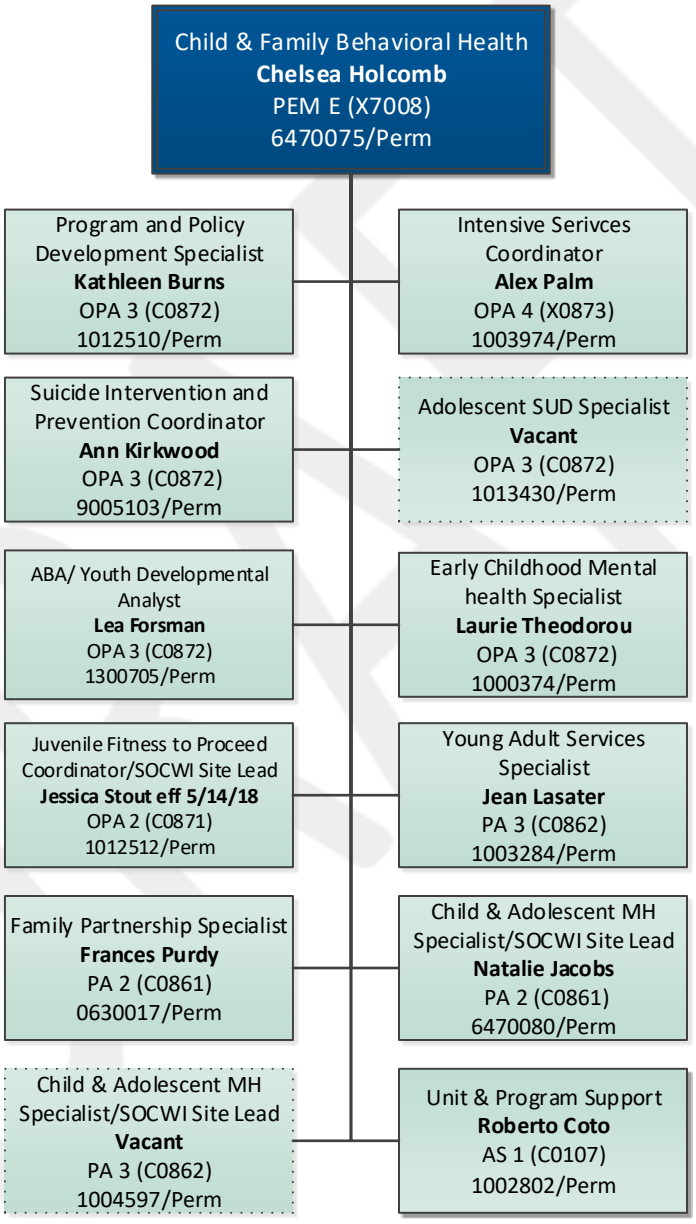
Behavioral Health:
Child & Family Behavioral Health



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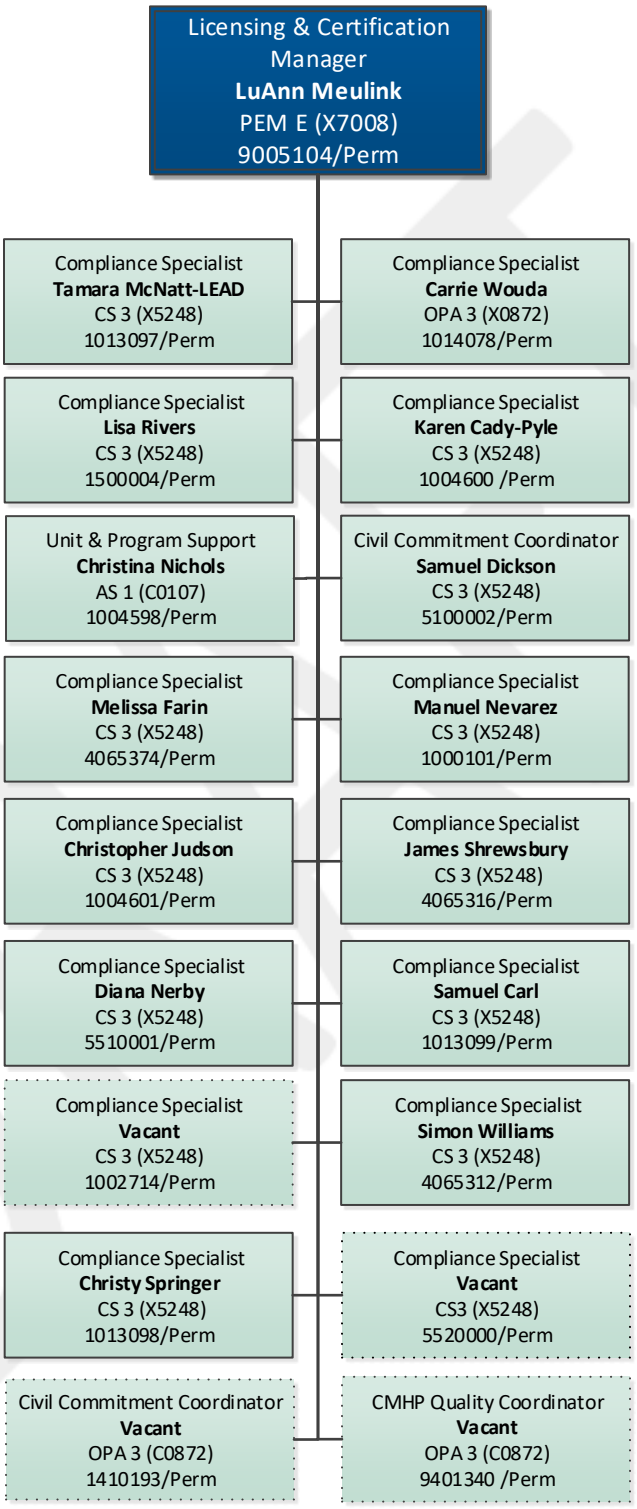
Oregon Health Authority

Behavioral Health:
Licensing & Certification



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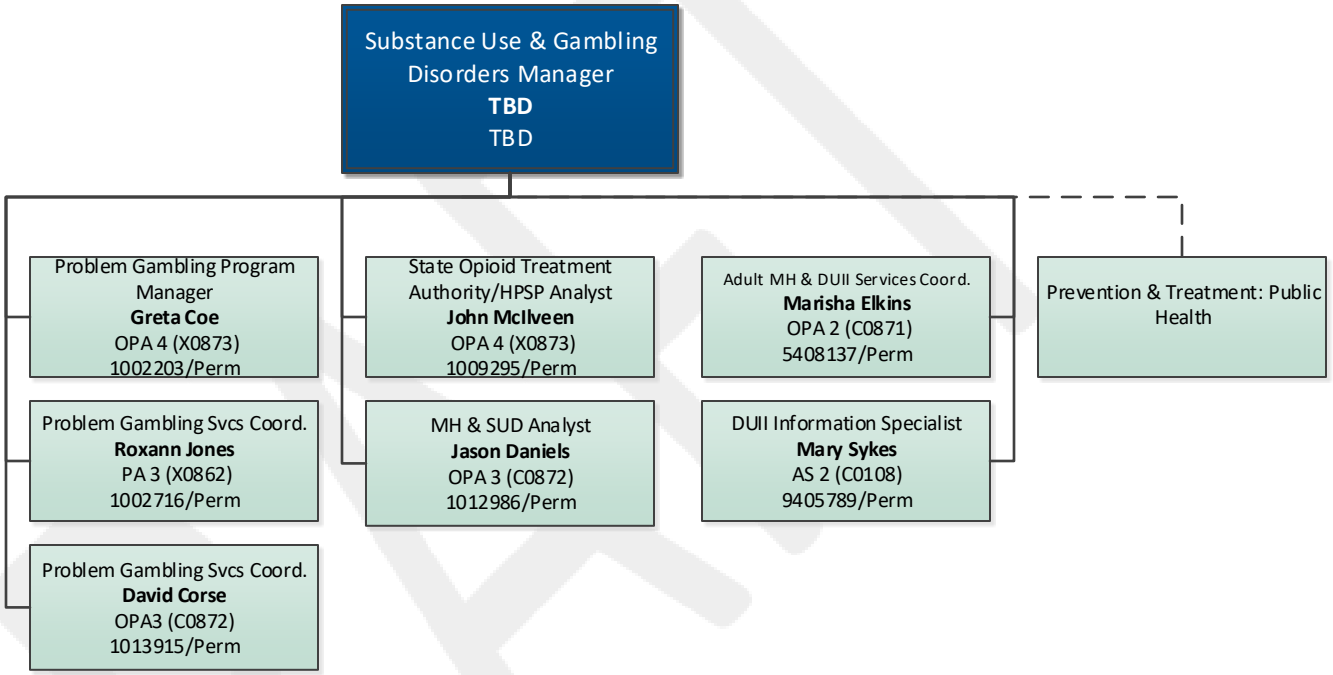
Behavioral Health:
Substance Use & Gambling Disorders



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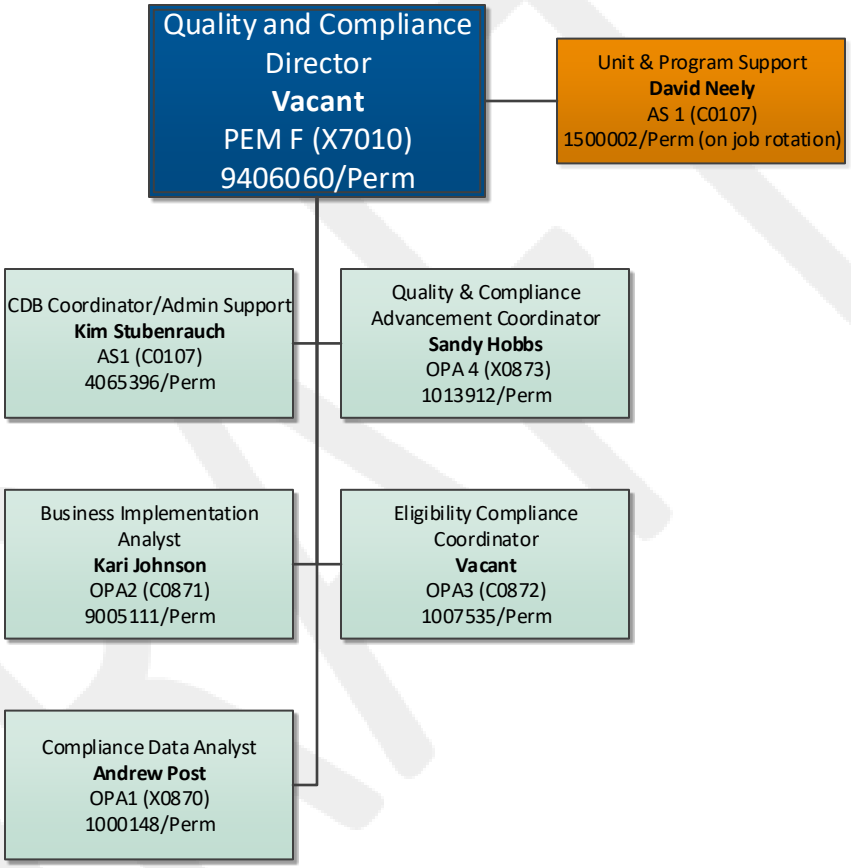
Quality and Compliance



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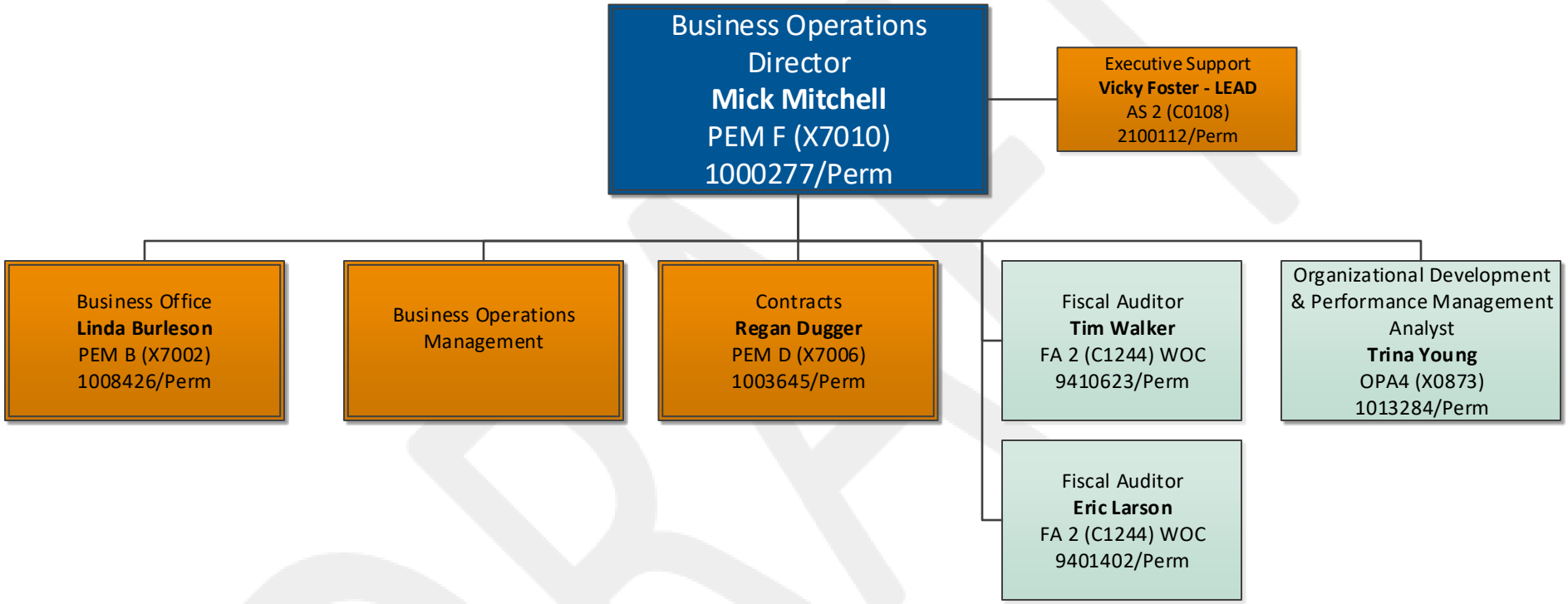
Business Operations



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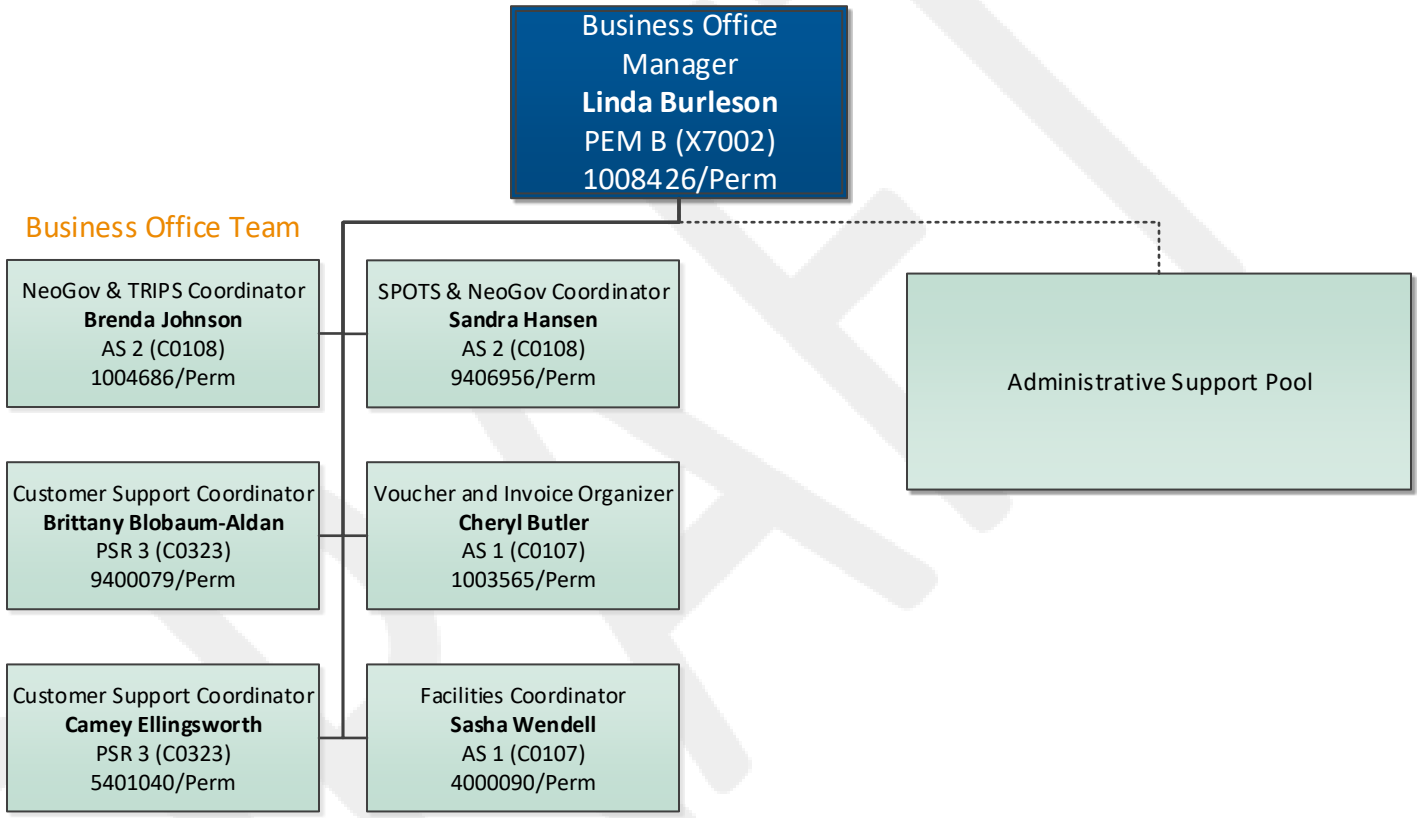
Business Operations: Business Office



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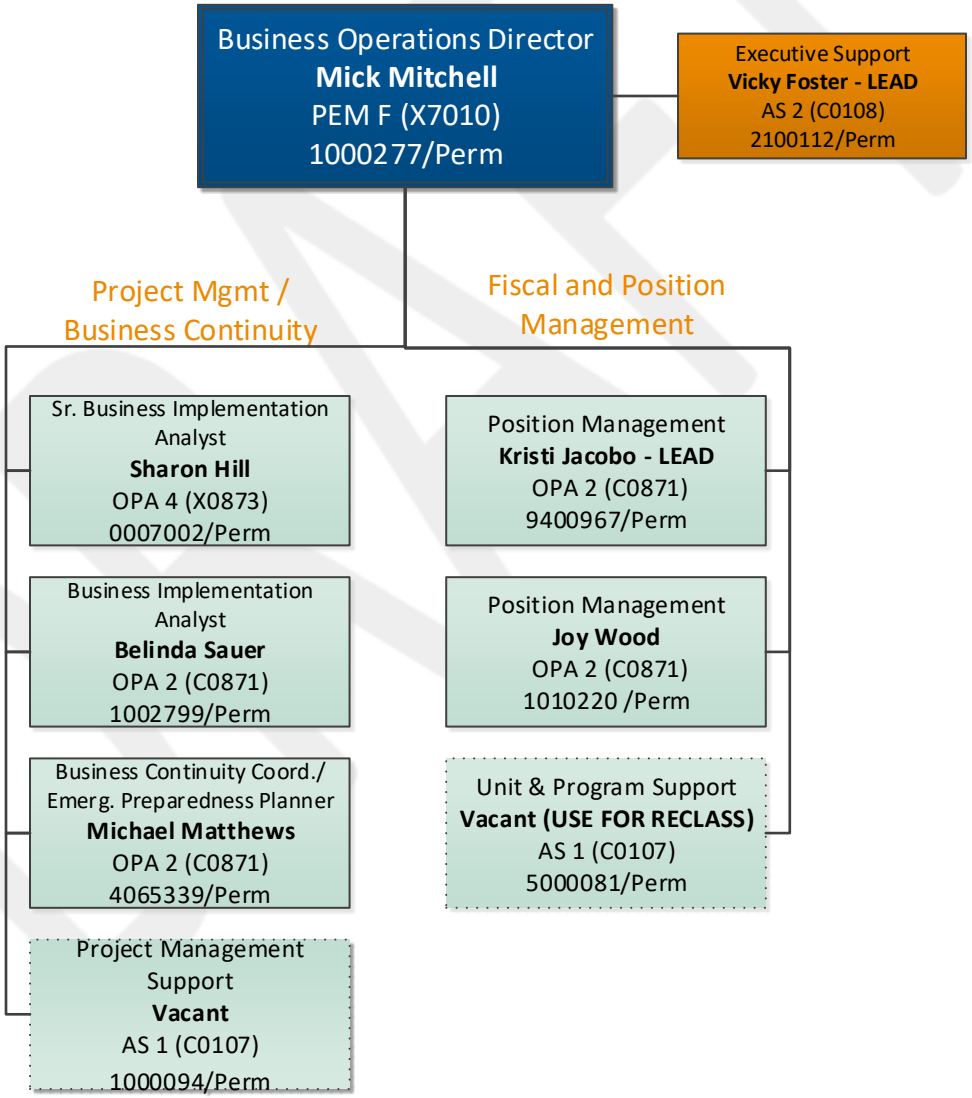
Business Operations:
Business Operations Management



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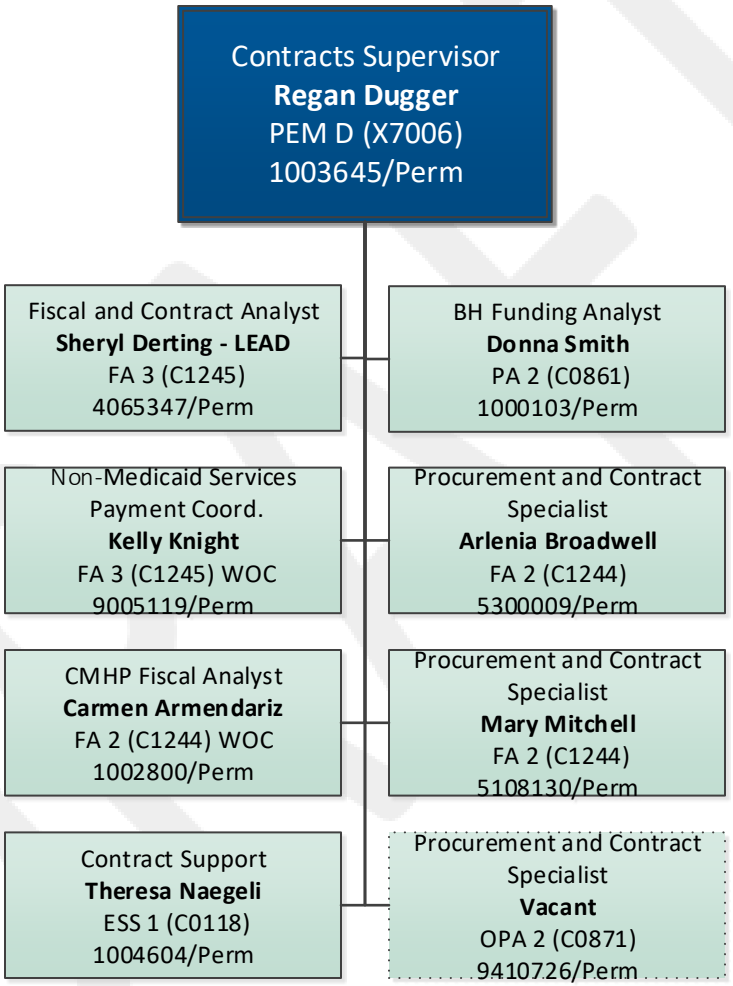
Oregon Health Authority

Business Operations: Contracts



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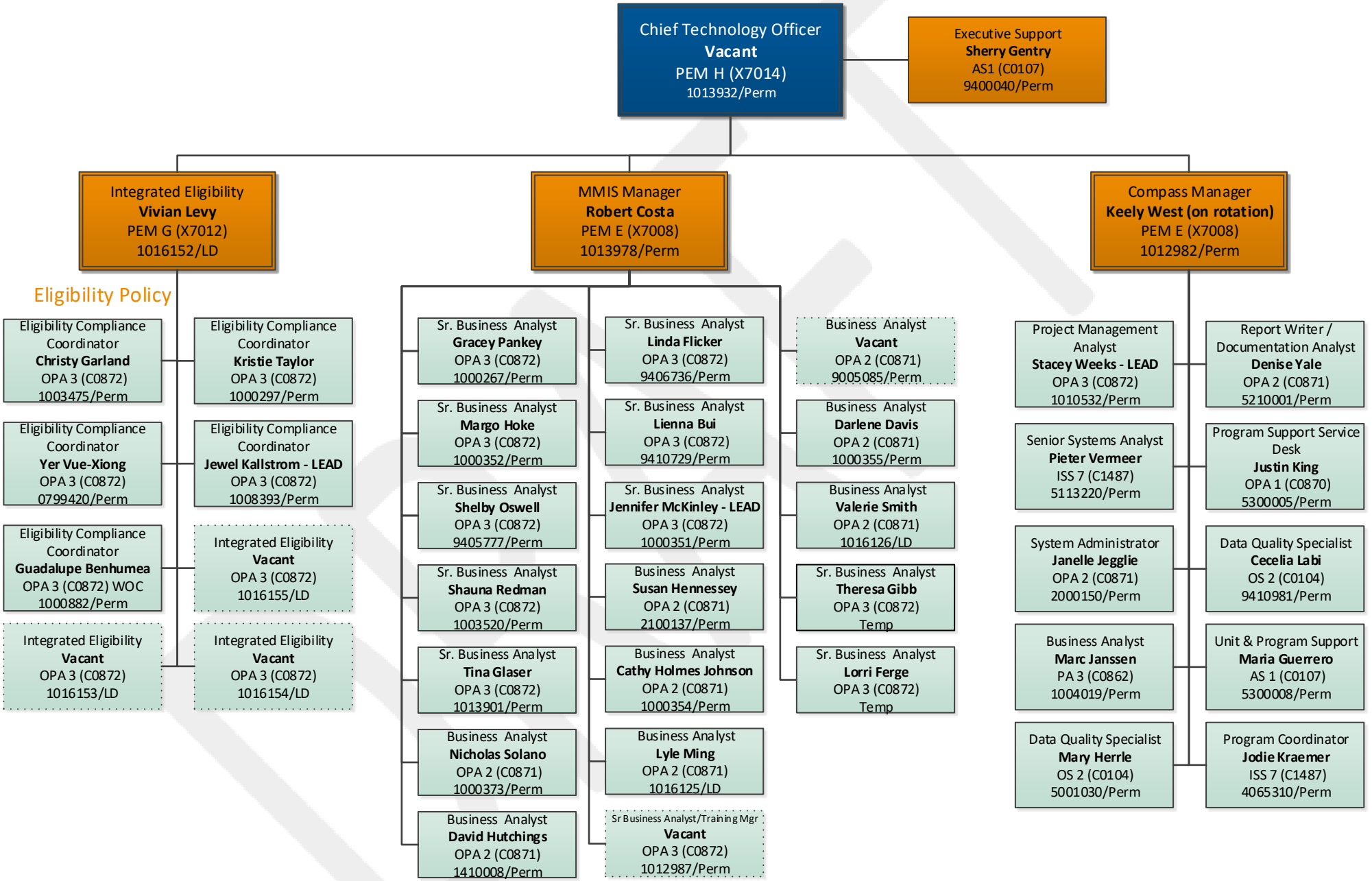
Business Information Systems



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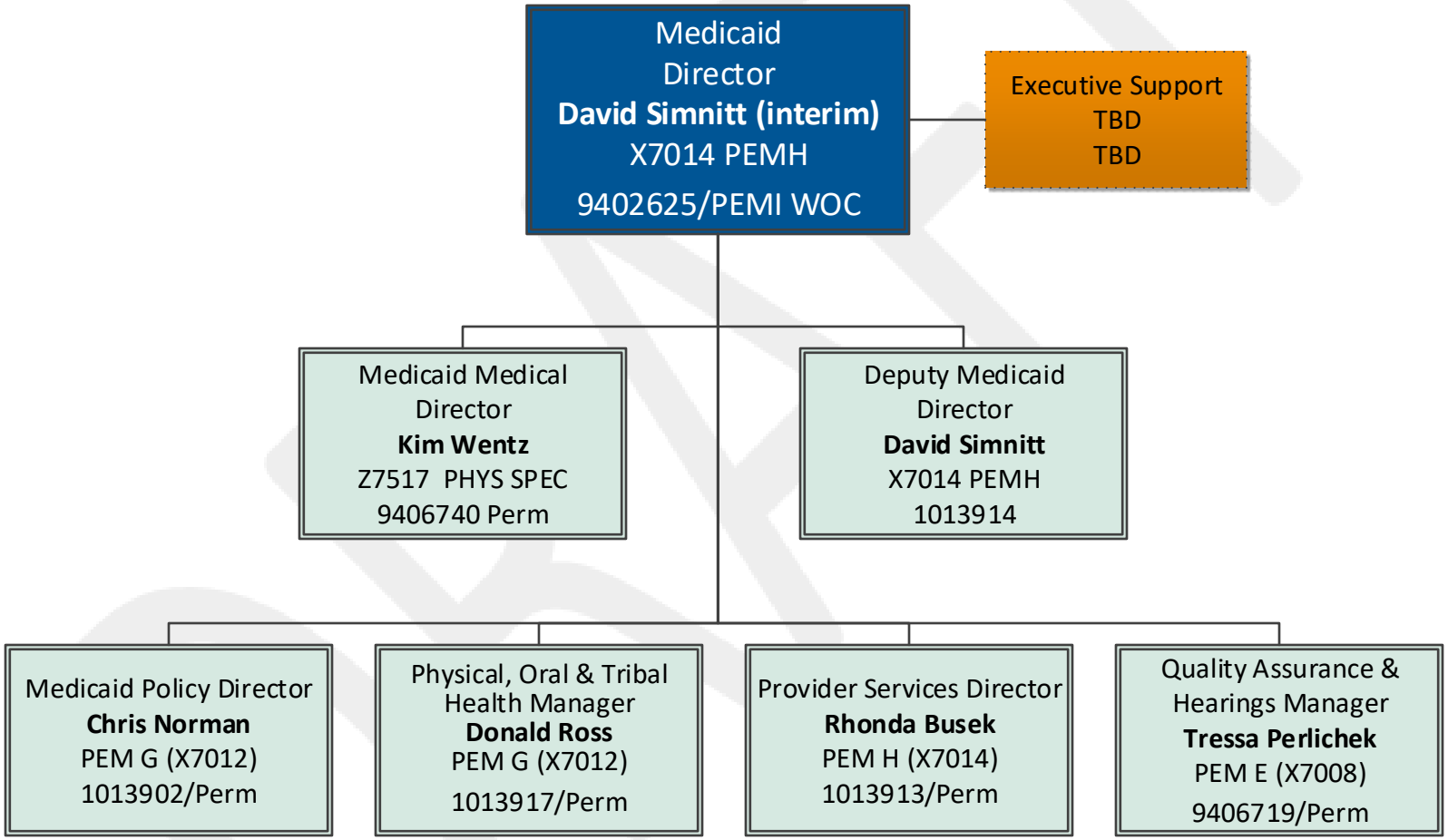
Oregon Health Authority

Health Systems Division: Medicaid



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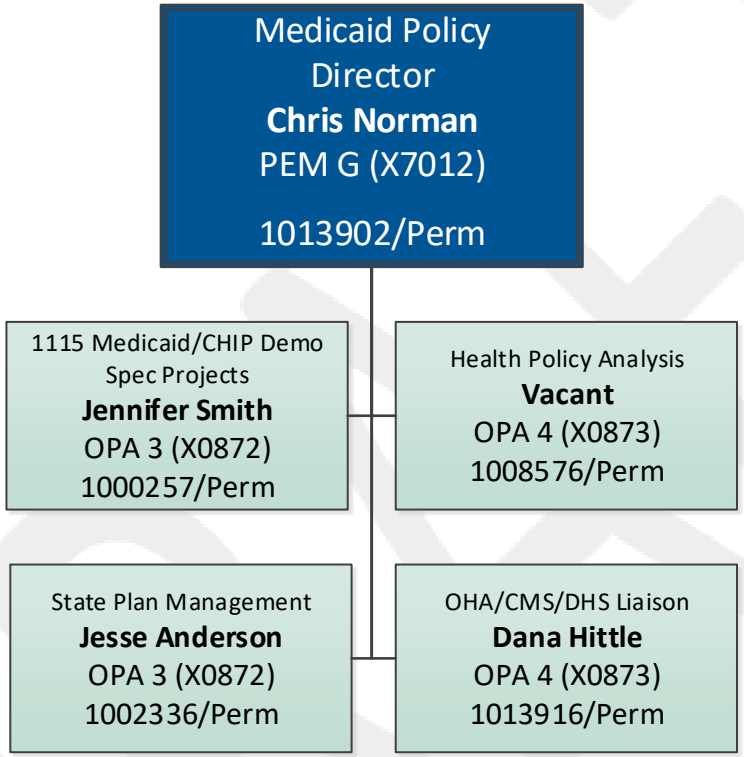
Medicaid Policy



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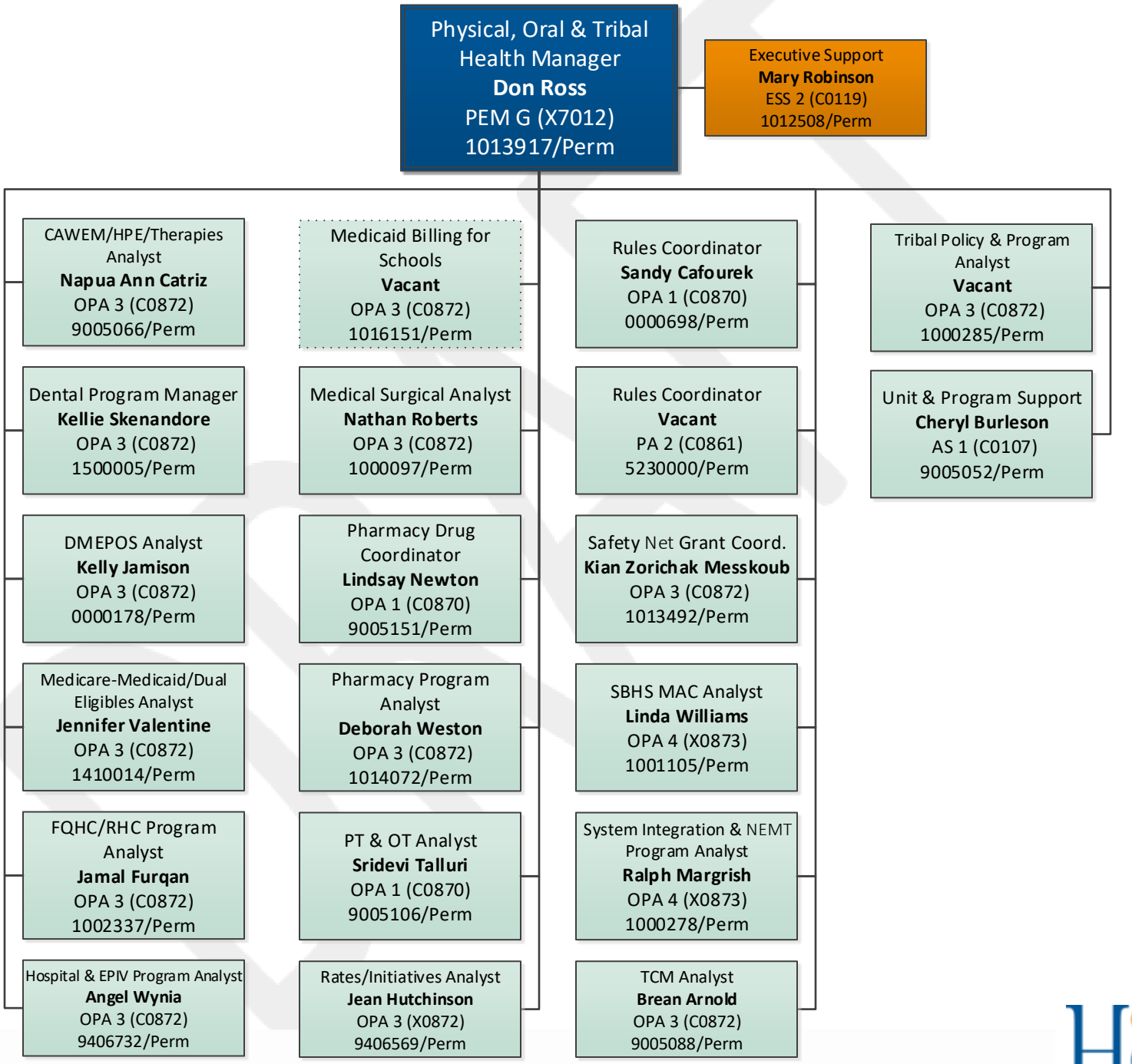
Medicaid: Physical, Oral & Tribal Health



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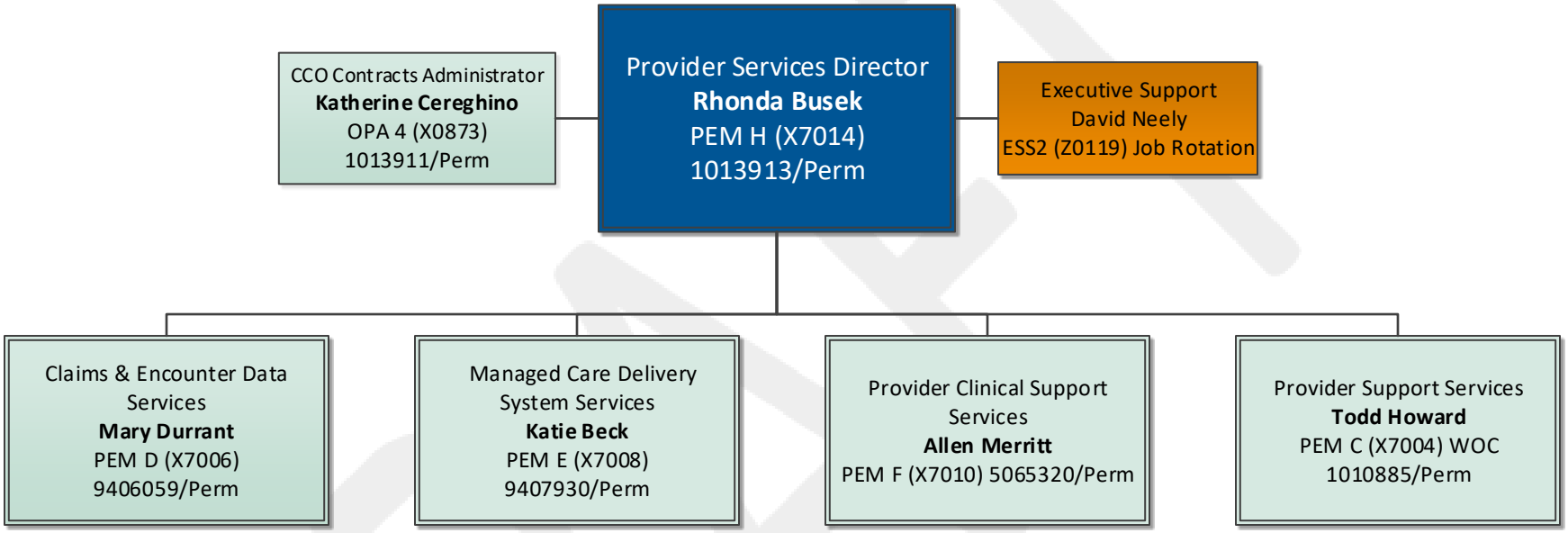
Oregon Health Authority

Medicaid: Provider Services



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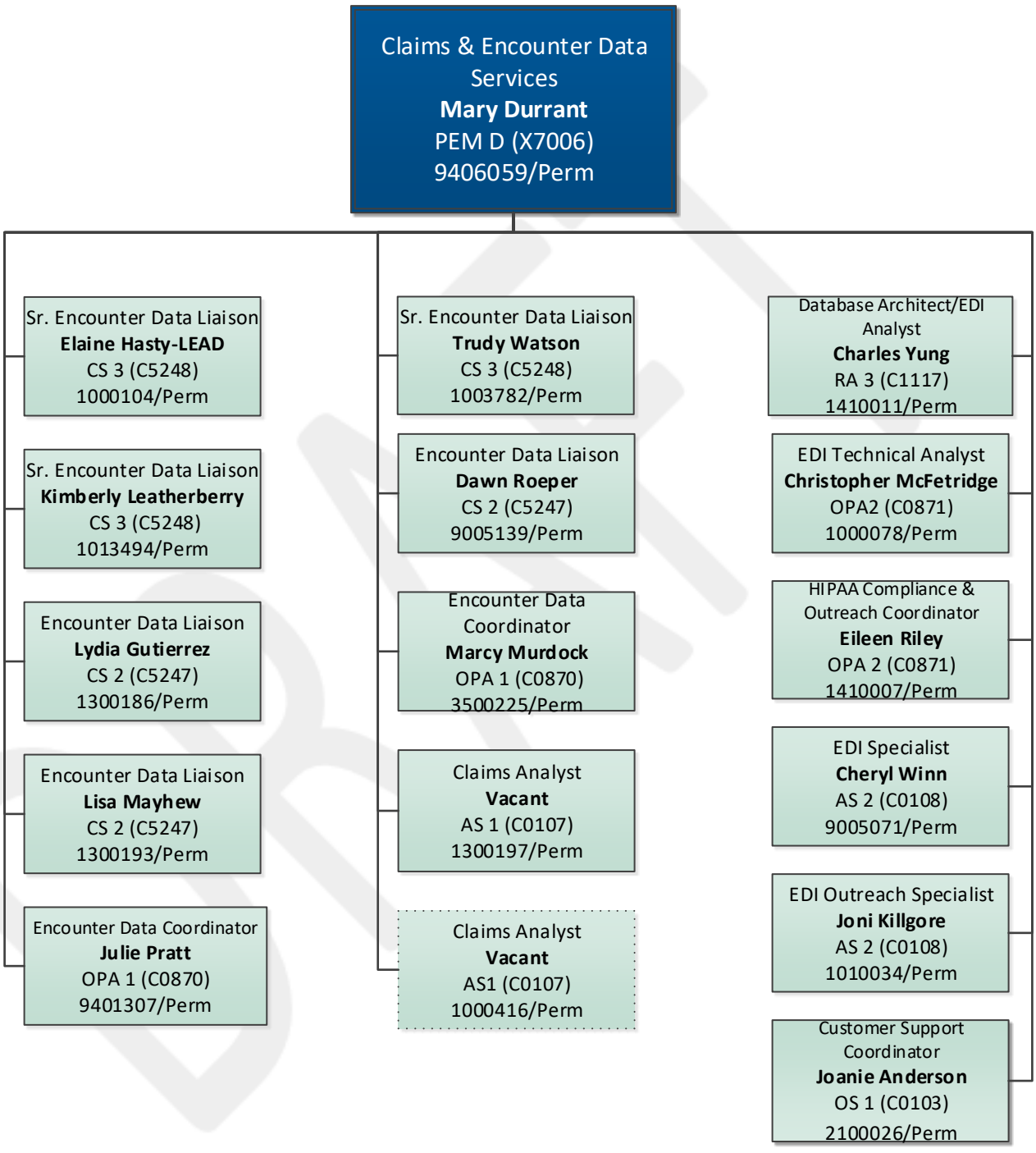
Medicaid: Provider Services
Claims & Encounter Data Services



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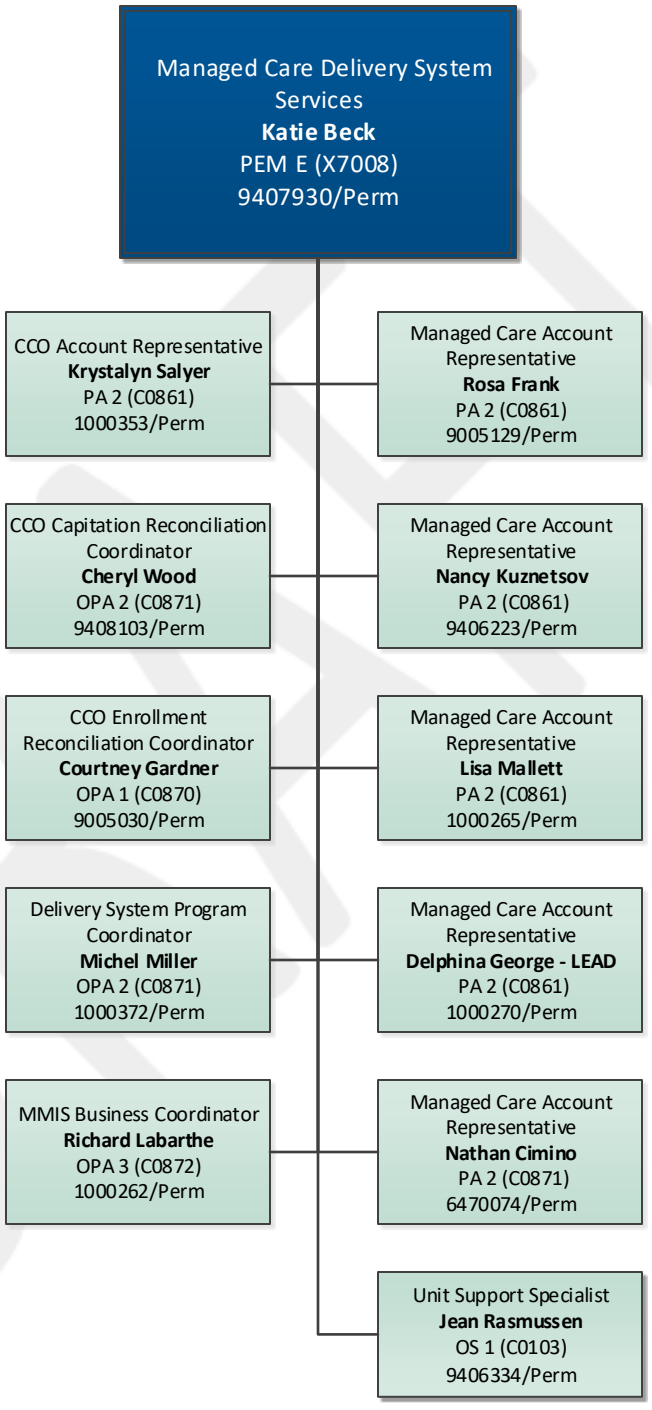
Oregon Health Authority

Medicaid: Provider Services
Managed Care Delivery System Services



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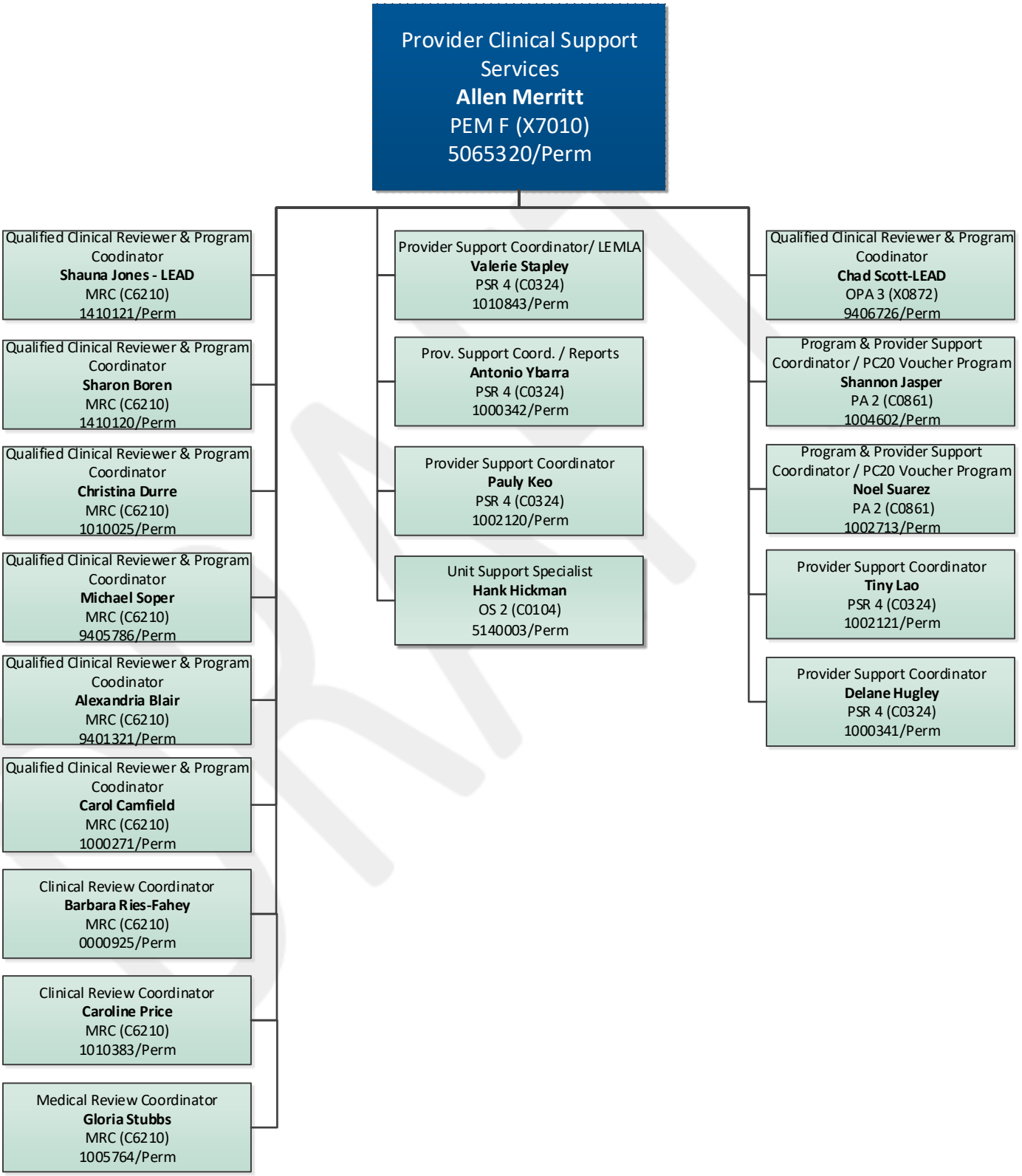
Medicaid: Provider Services
Provider Clinical Support Services



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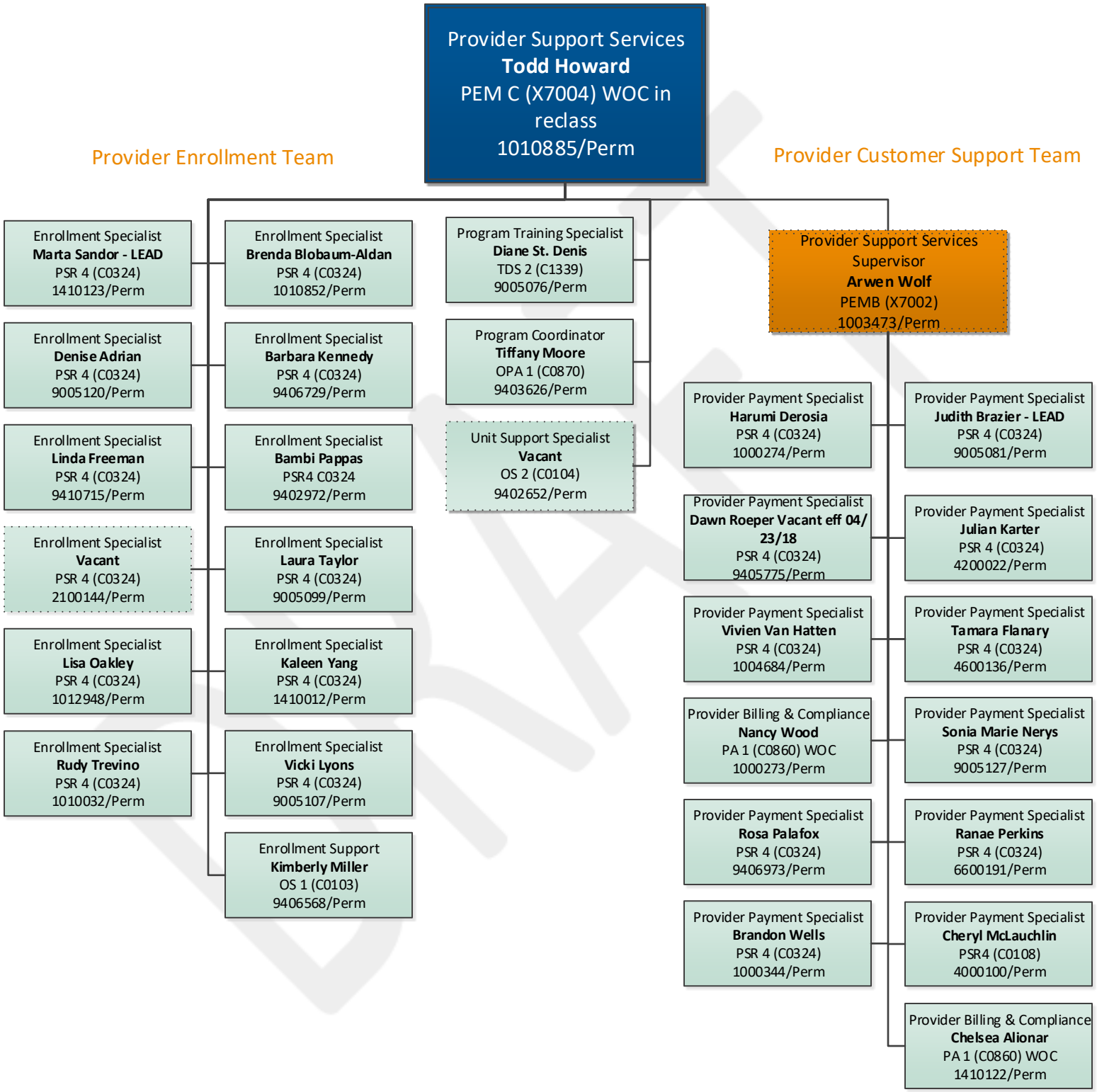
Oregon Health Authority

Medicaid: Provider Services
Provider Support Services



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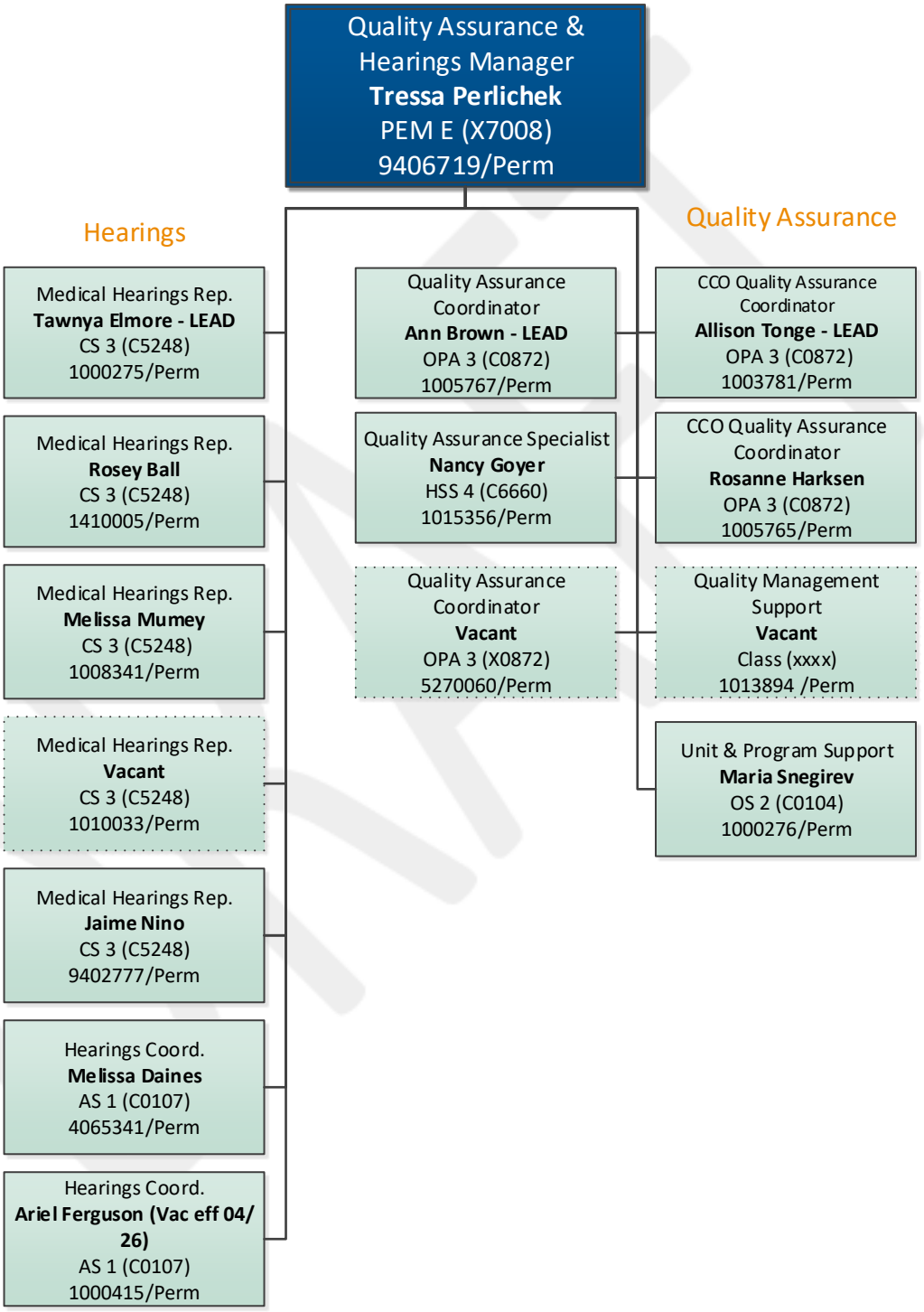
Oregon Health Authority

Medicaid:
Quality Assurance & Hearings



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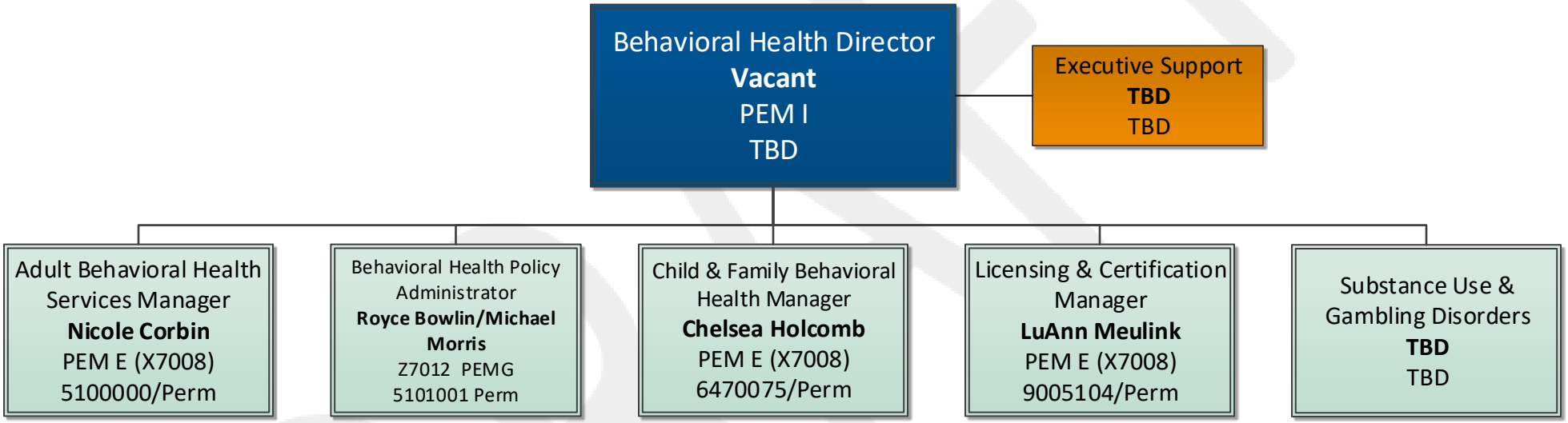
Oregon Health Authority

Health Systems Division: Behavioral Health



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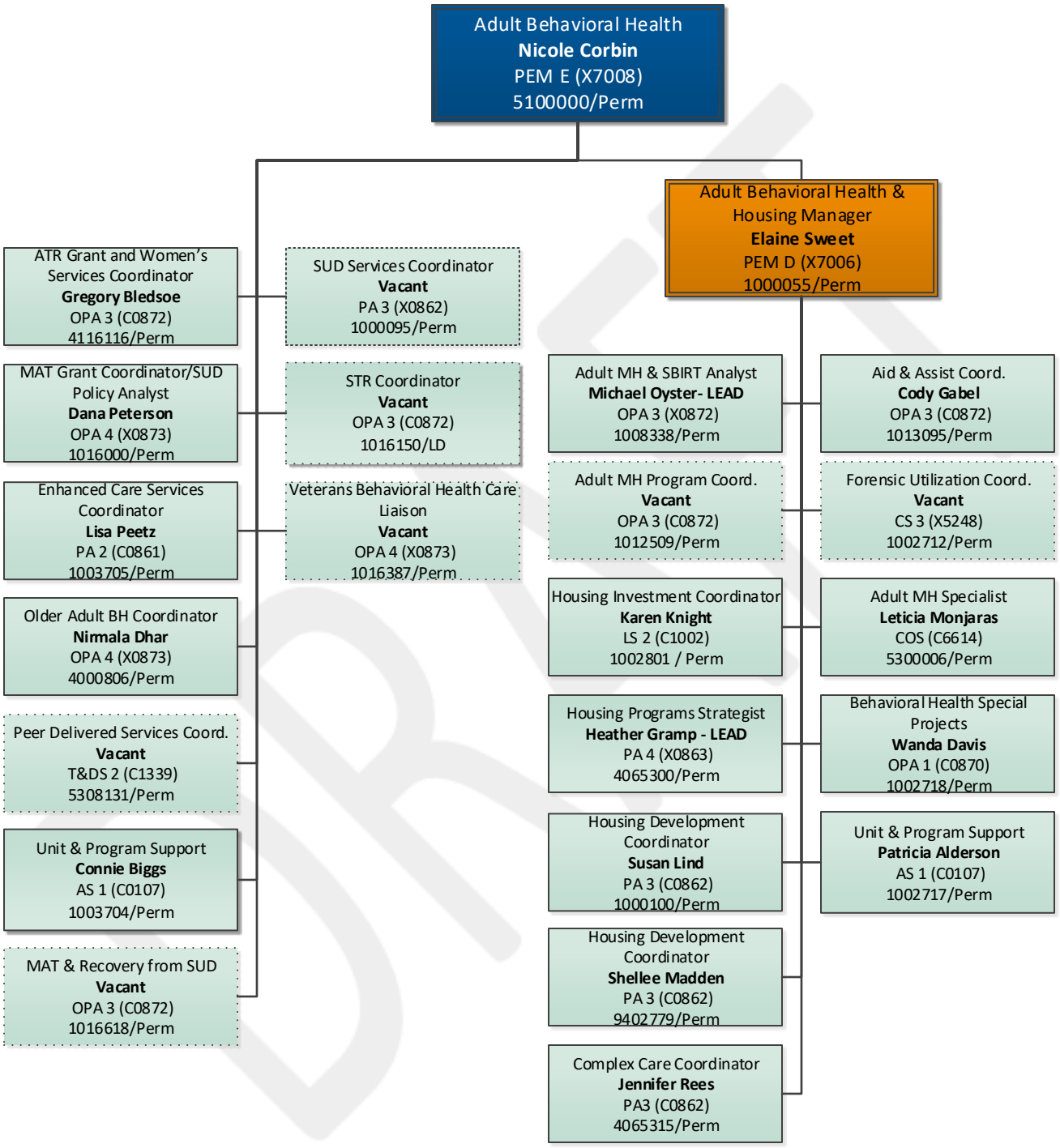
Behavioral Health:
Adult Behavioral Health Services



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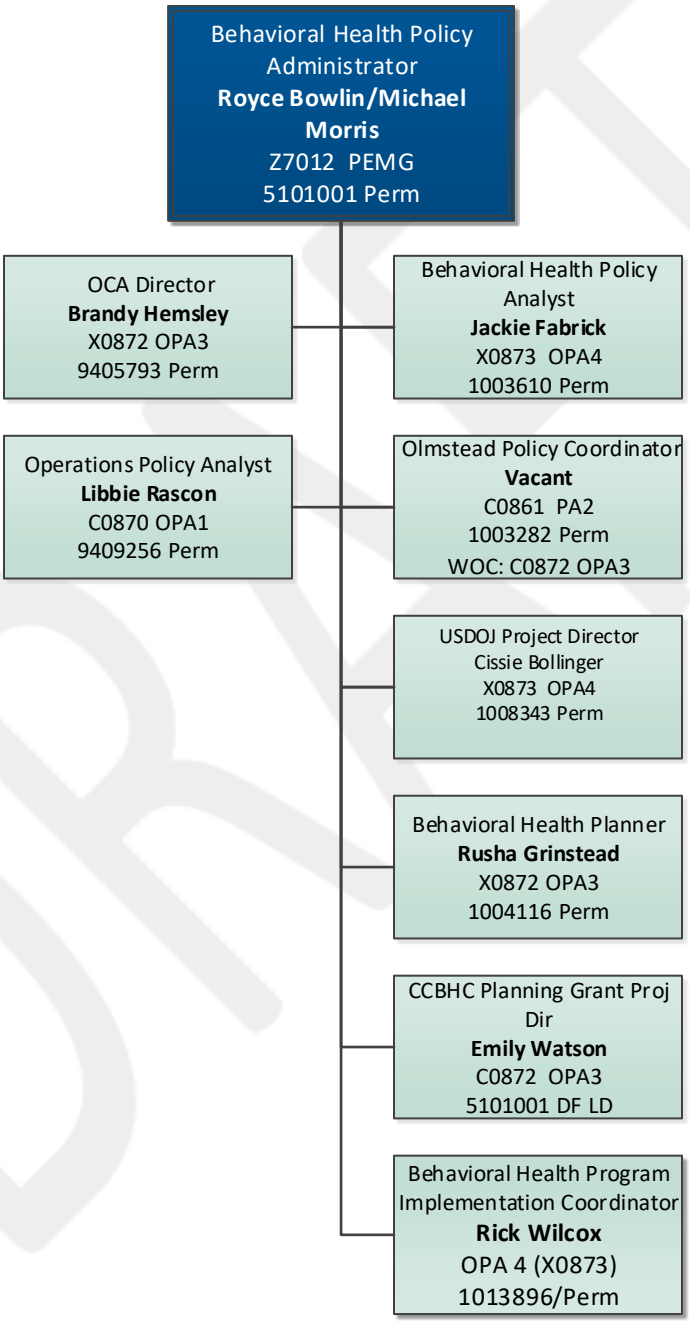
Oregon Health Authority

Behavioral Health: Health Policy



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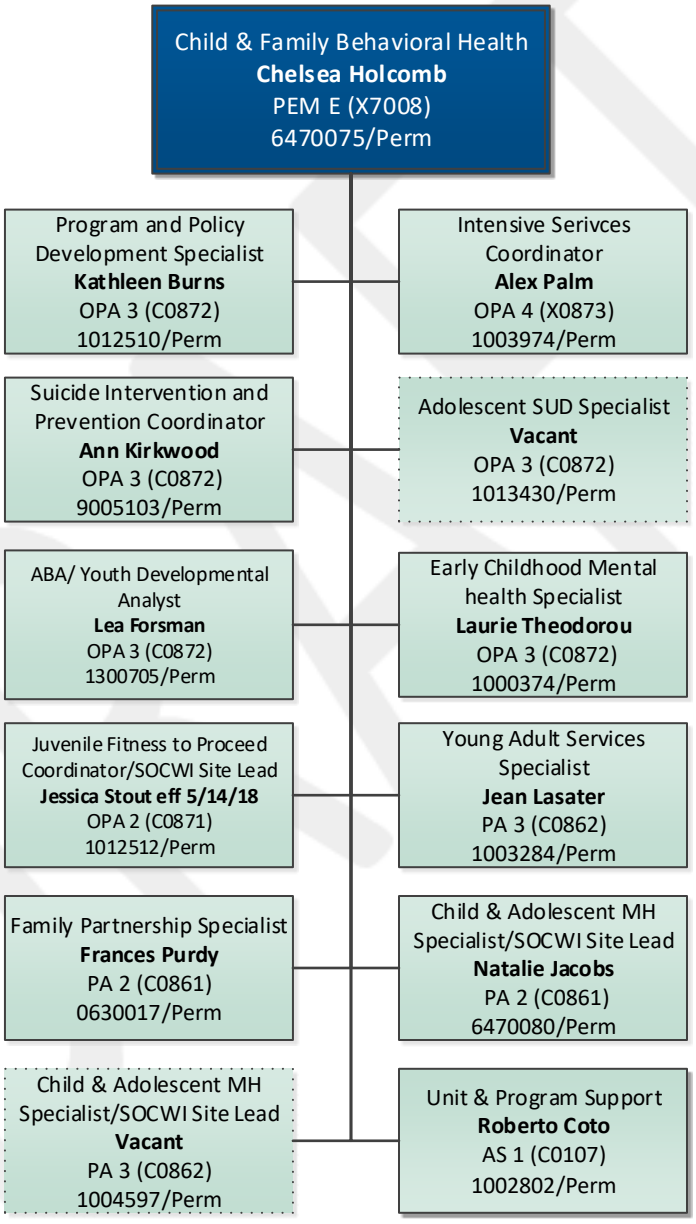
Behavioral Health:
Child & Family Behavioral Health



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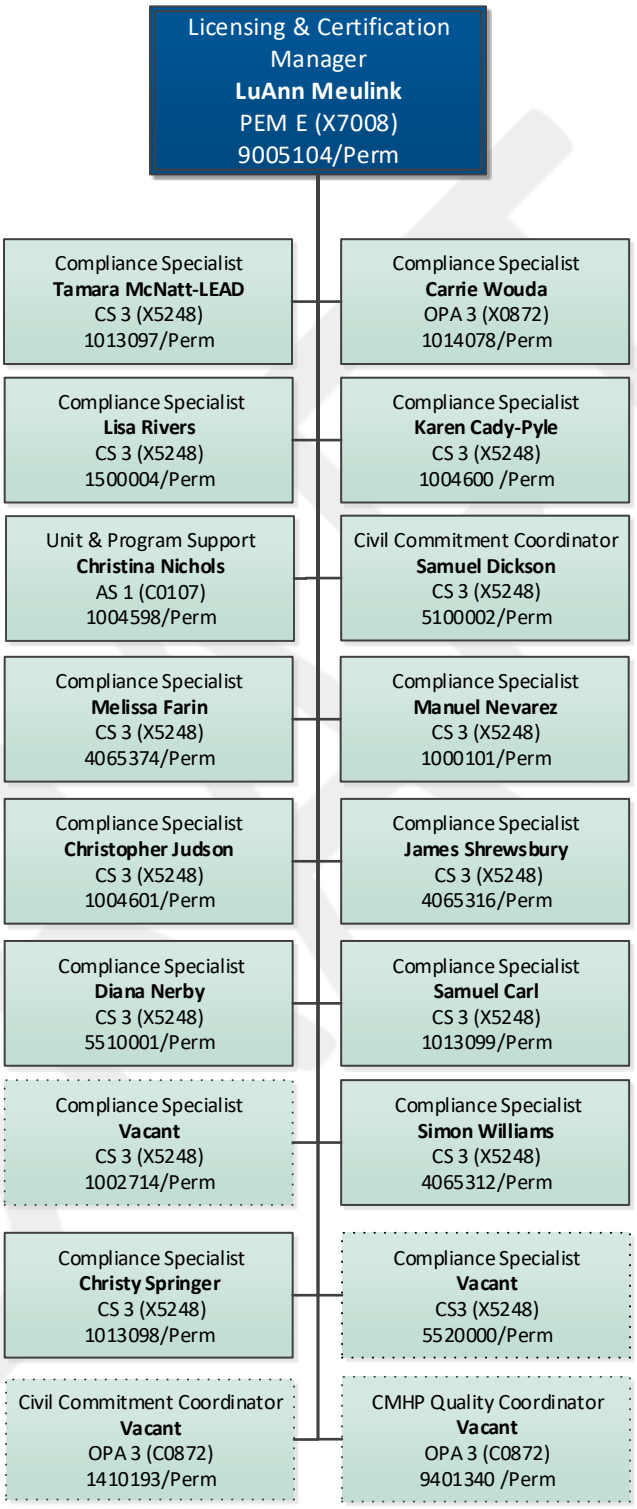
Behavioral Health:
Licensing & Certification



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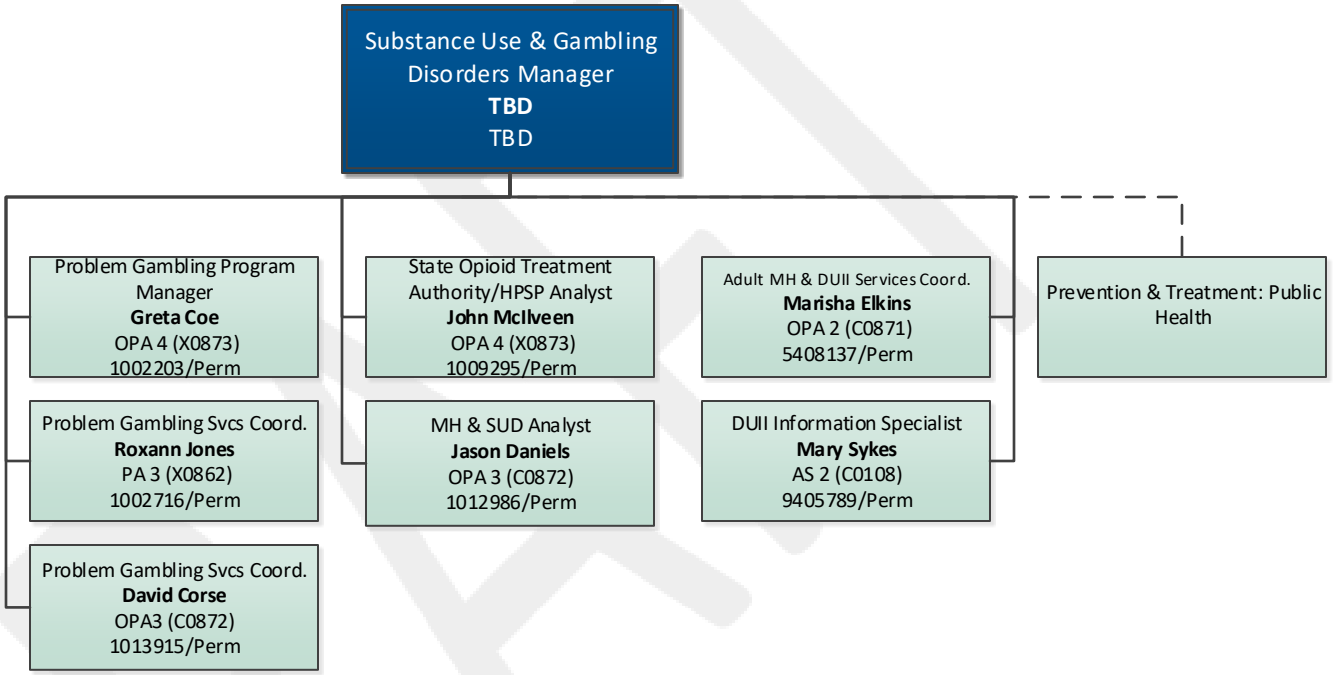
Behavioral Health:
Substance Use & Gambling Disorders



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Oregon Health Authority

Oregon
Medicaid Advisory Committee

Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon's CCO Model

Report and Recommendations

May 2018

Oregon Health Authority

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MEMORANDUM

DATE: May ____, 2018
TO: David Simnitt, Interim Medicaid Director and Jeremy Vandehey, Director of Health Policy and Analytics Division
FROM: Medicaid Advisory Committee
RE: Addressing the Social Determinants of Health in the Second Phase of Health Systems Transformation: Recommendations for Oregon's CCO Model

Dear Mr. Simnitt and Mr. Vandehey,

While the Medicaid Advisory Committee (MAC) recognizes the importance of quality and accessible clinical health services, we know that social factors such as housing, food insecurity, and transportation ultimately play a much larger role in determining a person's health. These social, economic, political, and environmental conditions in which people are born, grow, work, live, and age, are called the social determinants of health (SDOH). Yet, as a nation, we spend significantly more on clinical services than we do on addressing SDOH and thereby improving health equity. Since the inception of CCOs in 2012, the model has offered the potential to move the role of health care upstream to address prevention and social factors, in order to prevent downstream health care costs. As a committee, we offer a set of recommendations to harness this opportunity more directly as the state moves into its second contracting period with Oregon CCOs.

More specifically, the MAC has produced a set of recommendations to respond to a gap in guidance for CCOs that OHA identified in the spring of 2017. After a year of exploring the issue, researching, and gathering stakeholder feedback, we are pleased to submit our report and recommendations regarding:

- An explanation of why it is important to address the SDOH through Oregon CCOs (pg. __)
- Standard definitions of SDOH and social determinants of health equity that can be used for all Oregon CCOs (pg.__)
- A set of five general recommendations for CCOs when addressing SDOH (pgs x-xx)
- A set of roles that CCOs as health care plans can play addressing SDOH (pg x)

In order for these recommendations to be most effective, the MAC urges OHA to use the upcoming 2020-2025 contracting cycle to require that CCOs move forward on each of the MAC's five general recommendations on CCOs and SDOH in line with the committee's standard definitions of SDOH and social determinants of health equity. More specifically, the MAC recommends OHA:

- Increase tracking of CCO SDOH initiatives and policies, spending, and outcomes data, and share information publicly to identify best practices for improvement. From increased tracking and data, establish clear goals and metrics to assess CCO spending and work on SDOH and equity.
- Increase expectations for CCOs to assess health inequities and establish infrastructure and systems to improve health equity.
- Ensure CCOs are investing savings and profits back into the community to impact SDOH
- Strengthen requirements for Community Health Assessments (CHA) and Community Health Improvement Plans (CHP) to ensure CCOs work with appropriate community partners and include SDOH and equity strategies in their CHAs and CHPs
- Establish clear expectations that CCOs have the connections and relationships in the community necessary to advance community-driven work in SDOH
- Provide SDOH learning and information sharing opportunities for CCOs to promote replication and scaling up of SDOH efforts

These additional recommendations directed to OHA are detailed in the accompanying document: State Actions to Support and Hold CCOs Accountable to Addressing the Social Determinants of Health: Recommendations to the Oregon Health Authority.

Throughout our work, we were struck by the innovative work already happening in Oregon CCOs and their surrounding communities to address SDOH. We hope our recommendations help the OHA and CCOs to leverage and build on this work in the next five years.

Sincerely,

Jeremiah Rigsby
Co-Chair, Medicaid Advisory Committee

Laura Etherton
Co-Chair, Medicaid Advisory Committee

cc: Patrick Allen, Director, OHA

Medicaid Advisory Committee Members

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ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH IN THE SECOND PHASE OF HEALTH SYSTEM TRANSFORMATION: *MEDICAID ADVISORY COMMITTEE RECOMMENDATIONS FOR OREGON'S CCO MODEL*

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I. Executive Summary

The Oregon Health Plan's Coordinated Care Organization (CCO) model is on the cusp of its second phase, with a new set of CCO contracts and expectations coming in 2020. CCOs were originally designed to focus on prevention and improving community health. More and more, this requires working outside of the health care system to impact factors where we live, learn, work, and play. These factors are the social determinants of health (SDOH).

In the spring of 2017, the Oregon Health Authority (OHA) identified the need for more definition and guidance related to how Oregon's CCOs address SDOH, and brought this work to the state's Medicaid Advisory Committee (MAC). The MAC took up this charge to develop a set of recommendations, to include:

- An explanation of why it is important to address the SDOH through Oregon CCOs
- Standard definitions of SDOH and social determinants of health equity that can be used for all Oregon CCOs
- A set of general recommendations for CCOs when addressing SDOH
- A set of roles that CCOs as health care plans can play addressing SDOH
- A guide for how CCOs could use health-related services in a specific priority area

The first four of these are the focus of this document. The fifth, the health-related services guide, is being developed by the MAC and OHA staff under a separate timeline.

To inform its recommendations, the MAC's work involved gathering research and insights from national and local stakeholders, as well as allowing for consultation and feedback to refine the recommendations with key OHA staff, committees, and community stakeholders. This included:

- compiling and considering definitions from local, national and international sources to develop a definition specific for Oregon CCOs (e.g. World Health Organization, CDC, Oregon's public health modernization);
- hearing presentations and public comment from local stakeholders, including CCOs, community health centers, regional health equity coalitions, and community partners,
- consulting with key OHA staff, including the Office of Equity and Inclusion and the OHA internal SDOH workgroup on the definition of SDOH;
- developing and fielding a stakeholder survey on social determinants of health activities, priorities, and barriers among all 15 CCOs, Community Advisory Councils, and a selection of key community partners, including community health centers, local public health, tribal public health, regional health equity coalitions, and behavioral health providers; and
- consulting and incorporating feedback from a selection of OHA committees and community groups to inform the final recommendations, including: the OHPB's Health Equity Committee (HEC), Allies for a Healthier Oregon, OHPB's Health Information Technology Oversight Council (HITOC), the Health Information Technology Advisory Group (HITAG), and the Quality and Health Outcomes Committee (QHOC).

As the MAC was in the process of developing its recommendations, OHA and the Oregon Health Policy Board (OHPB) launched a process to develop policies for the second phase of CCOs, otherwise known as "CCO 2.0." To guide this policy development, Governor Brown directed the OHPB to focus on four priority areas, including social determinants of health and equity. The MAC encourages the OHA and the OHPB to consider its recommendations to inform specific policies and expectations in CCO 2.0.

Recommendations

After nine months of investigation, the MAC concludes that CCOs should have responsibility for addressing SDOH, because:

1. Addressing SDOH is essential to reach Oregon's triple aim of better health, better care, and lower costs, since SDOH impact health much more than health care services.
2. SDOH must be addressed in order to eliminate health inequities, since certain groups are disproportionately impacted by SDOH due to structural factors, such as racism and sexism.
3. Addressing SDOH can directly cut healthcare costs, based on a growing body of evidence.
4. The CCO model is particularly well-suited to address SDOH, given its emphasis on coordinated, whole-person care, local control, paying for value, and addressing inequities (see Appendix A).

The MAC subsequently advises OHA to adopt the following recommendations to expand and improve the work of CCOs addressing SDOH.

Recommended definition of social determinants of health and equity

The MAC recommends OHA adopt a definition of social determinants of health and equity across CCOs, to support a common understanding and more targeted investment across regions. The following definitions were adapted from existing national and international definitions, and modified for an Oregon context with consideration of feedback from the committees and groups referenced above.

Definition begins on next page.

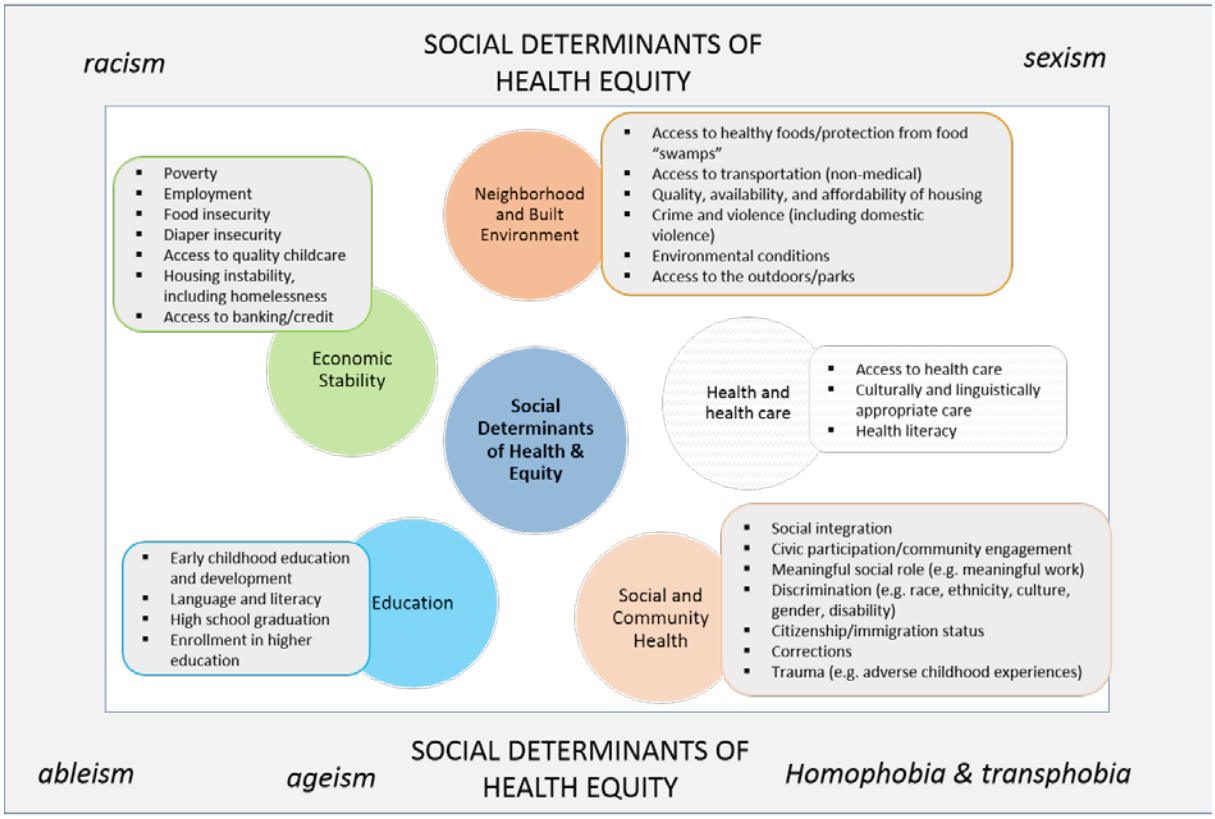
Social Determinants of Health and Equity: Definitions for CCOs

Most of our health is shaped by factors outside the clinic or hospital, in the places where we live, learn, work, and play.

Social determinants of health: The social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities.

Social determinants of health equity: Systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. These structural factors are evident in social norms, policies, and political systems, both historical and current. Institutionalized racism is one example.

See graphic for a list of factors that fit the definitions above.



Addressing Social Determinants of Health in the Second Phase of Health System Transformation (2017-2022): Medicaid Advisory Committee Recommendations for Oregon's CCO Model

Five general recommendations to guide CCO efforts to address SDOH

The MAC identified five general recommendations to guide overall direction for CCO focus and spending on SDOH. The MAC encourages OHA to use these recommendations as guidelines when establishing expectations and accountabilities for CCOs related to SDOH.

CCOs address social determinants of health with the primary purpose of improving health equity. This approach means that CCOs:

a) Use evidence of community health inequities to drive strategic efforts to address the SDOH that most contribute to these disparities.
b) Build the critical infrastructure necessary to address the structural factors that influence SDOH (e.g. institutional racism). For example, ensure culturally competent CCO leadership, staff, and services.
c) Publicly communicate, through a plan, staff, and/or other process, how the CCO is considering equity in directing its SDOH work.
d) Recognize that improving social determinants of health and equity is a continuous process, and adjust efforts as necessary to respond to emerging and changing health disparities and social determinants of health challenges.

CCOs support, leverage, and augment existing internal (CCO), community, and provider efforts and capacities to address SDOH, in order to increase the effectiveness of these efforts. This approach means that CCOs:

a) Select appropriate role(s) (see Table 1, pg. 29) based on the needs and resources in a given community.
b) Work directly with Community Advisory Councils (CACs), providers, public health, and other community partners already engaged in addressing the SDOH.

c) Consider regional assessments and plans, such as Community Health Assessments and Community Health Improvement Plans,[1] and other available assessments of community health (e.g. public health surveys) to drive SDOH strategies. It is critical for OHA to monitor these assessments and plans.

CCOs build from their roles as the main Medicaid payer in a community, and use the unique tools provided by the CCO model to spend funds on SDOH, including:

a) Health-related services
b) Value-based payment strategies[2] that incent and enable providers for work to address SDOH and refer patients with complex social needs.

CCOs support health care teams and community partners in working together and with patients to identify and address the SDOH challenges patients face and would like help to resolve. This approach means that CCOs:

a) Address the variety of health care team and community partner needs to impact SDOH (e.g. need for data systems or technology to track and address SDOH)
b) Ensure providers have the necessary SDOH data to deliver both SDOH-informed and SDOH-targeted healthcare[3]

---

[1] CCOs are required to conduct Community Health Assessments and develop and report on Community Health Improvement Plans. CACs are required to oversee a Community Health Improvement Plan and adopt a Community Health Improvement Plan.

[2] Value-based payment: A strategy to pay health care providers for quality outcomes and value, rather than quantity or volume of services provided.

3 SDOH Informed healthcare: using information on social needs in clinical decision-making; SDOH Targeted healthcare: implementing interventions to address social needs (e.g. connecting individuals to social service resources).

c) Ensure two-way data flow by facilitating reporting of SDOH efforts and outcomes from health care teams and community partners
d) Offer health care teams resources to help facilitate connection to or coordination with SDOH community partners

CCOs address SDOH in a way that promotes person and family-centered care, including tailoring SDOH efforts around member needs and desires. This means CCOs and their provider networks:

a) Provide member-based services (e.g. flexible services)[4] in a way that takes into account a member's desires and priorities when it comes to addressing SDOH challenges or barriers.
b) Tailor population-based SDOH initiatives (e.g. community benefit initiatives) to the community needs and priorities identified through community health assessments and other relevant public health assessments.

10 recommended roles for CCOs in addressing SDOH

Building off of its five general recommendations, the MAC recommends CCOs be encouraged to identify the most appropriate role for their organization to play in addressing SDOH based on community- and issue-specific needs, partnerships, and capacities. With this in mind, the MAC identified one foundational and nine additional possible roles for CCOs addressing SDOH in their communities (for more detail, see Table 1, pg.29):

Foundational role:

- **Internal and infrastructure changes:** Hiring, training, retention, recruitment, and community engagement strategies necessary to

[4] Flexible services are the type of health-related services that are provided directly to individual members, as a part of their care plan. In contract, community benefit services are provided at a community or population level.

ensure organization and provider network's competency to address SDOH.

Additional possible roles:

- **Direct investment:** Grants or more permanent funding, often to providers and community-based organizations, to build infrastructure in communities to addressing SDOH.
- **Health-related services (HRS):** Non-state plan, non-covered services intended to improve care delivery and member health. HRS include flexible services (member-specific services) and community benefit initiatives.
- **Value-Based Payment:** Payment models designed to pay for value (i.e. outcomes) rather than volume (i.e. services). Payment can be designed to incentivize SDOH activities; allow flexibility to address both medical and social needs to improve health.
- **Workforce:** Contracting with or otherwise funding healthcare workers to address SDOH (e.g. community health workers).
- **General alignment/collaboration:** Aligning CCO SDOH priorities with community-selected goals or strategies.
- **Convener:** Bringing together diverse, multi-sectoral partners to identify common priorities and work toward addressing SDOH. Further, communicating with other CCOs to share best practices and innovations around SDOH.
- **Data/analytics support:** Providing health care data or data resources (e.g. Health IT, supporting development of Health Information Exchange) to partners, such as social service entities.
- **Social needs/resource clearinghouse:** Compiling and distributing social needs/resource data to providers and other partners.
- **Policy/government relations:** Advocating for policies that address SDOH in communities.

II. Background and Process

In 2012, Oregon begin enrolling most Oregon Health Plan members in Coordinated Care Organizations (CCOs), a new type of managed care organization with a focus on primary care, prevention, and achieving better health, better care, and lower costs (the "triple aim"). The CCOs were designed to be accountable to their local communities for improving overall health through a patient-centered, coordinated, and integrated approach. Over the past five years, the focus on prevention has led many CCOs to move beyond the clinic walls to consider and address factors outside the health care system that impact member health – such as housing, transportation, and food insecurity. These factors, called the social determinants of health (SDOH), play a much larger role in determining health than either genetics or healthcare services.

In January 2017, Oregon obtained approval from CMS for a new 5-year Section 1115 waiver, which prioritizes SDOH and enhances incentives and guidance for CCOs to use their global budgets to fund SDOH-related work and initiatives.[5] Subsequently, the Oregon Health Authority (OHA) identified the need for more definition and guidance related to how Oregon's CCOs could most effectively address SDOH, in order to expand this work in the coming years. As the state's main stakeholder advisory body for the Medicaid program, the MAC was uniquely positioned to take on this work.

Deliverables

The OHA and the Medicaid Advisory Committee agreed on five deliverables for the MAC's SDOH recommendations:

[5] The 2017-2022 1115 waiver includes additional guidance on the use of health-related services, which are non-state-plan services that CCOs can fund to improve health, such as activities related to the social determinants of health.

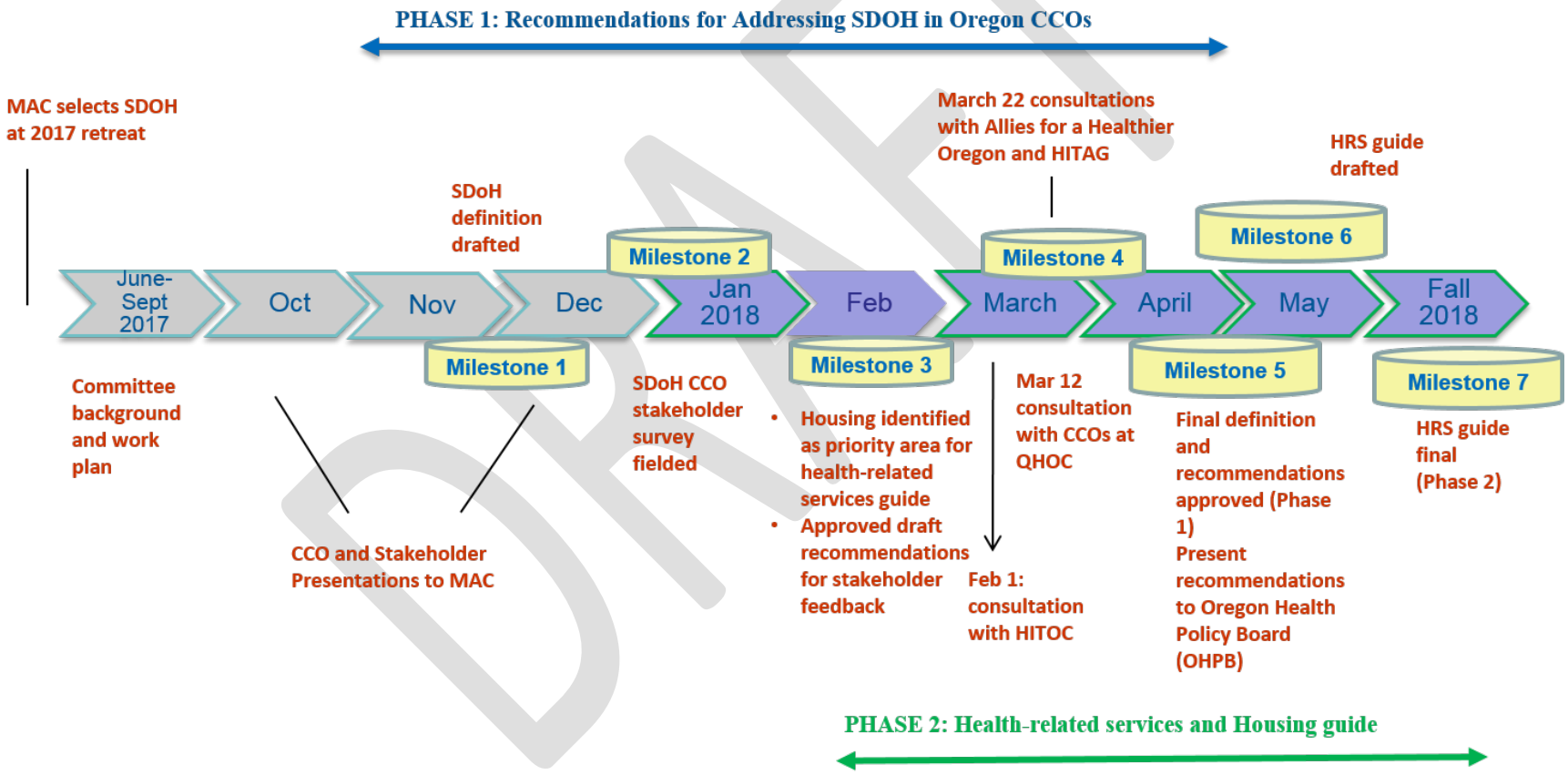
1. An explanation of why it is important to address the SDOH through Oregon CCOs
2. Standard definitions of SDOH and social determinants of health equity that can be used for all Oregon CCOs
3. A set of general recommendations for CCOs when addressing SDOH
4. A set of roles that CCOs as health care plans can play addressing SDOH
5. A guide for how CCOs could use health-related services in a specific priority area

The first four of these are the focus of this document. The fifth, the health-related services guide, is being developed under a separate timeline.

Process

The MAC identified SDOH as a top policy priority during its annual retreat in spring of 2017. Subsequently, the MAC developed a work plan and timeline to complete its recommendations by mid-2018. The work plan involved two phases: phase 1, including the development of the MAC's overall recommendations on SDOH, encompassing the first four of its deliverables; and phase 2, involving the development of a health-related services guide on a priority area of SDOH. (See timeline and key milestones, next page)

MAC SDOH Timeline & Critical Milestones



The committee's work involved gathering research and insights from national and local stakeholders, as well as allowing for consultation and feedback to refine the recommendations with key OHA staff, committees, and community stakeholders. This included:

- compiling and considering definitions from local, national and international sources to develop a definition specific for Oregon CCOs (e.g. World Health Organization, CDC, Oregon's public health modernization);
- hearing presentations and public comment from local stakeholders, including CCOs, community health centers, regional health equity coalitions, and community partners (see Sidebar, right);
- consulting with key OHA staff, including the Office of Equity and Inclusion and the OHA internal SDOH workgroup on the definition of SDOH;
- developing and fielding a stakeholder survey on social determinants of health activities, priorities, and barriers among all 15 CCOs, Community Advisory Councils, and a selection of key community partners, including community health centers, local and tribal public health, regional health equity coalitions, and behavioral health providers. (See Appendices C & D, Survey Instrument and Results); and
- consulting and incorporating feedback from select OHA committees and community groups to inform the final recommendations,

Stakeholder presentations and public comment to the Medicaid Advisory Committee regarding Social Determinants of Health programs (July 2017 – March, 2018)

- Accountable Health Communities
- All Care
- CCO Oregon (see Appendix B)
- Health Share of Oregon
- Jackson Care Connect
- Lane Early Learning Alliance
- Next Door, Inc.
- Oregon Primary Care Association
- Columbia Gorge Health Council
- Rogue Community Health Center
- Trillium Community Health Plan
- SO Health-E Regional Health Equity Coalition

including: the OHPB's Health Equity Committee (HEC), Allies for a Healthier Oregon, OHPB's Health Information Technology Oversight Council (HITOC), the Health Information Technology Advisory Group (HITAG), and the Quality and Health Outcomes Committee (QHOC).

This process resulted in a set of recommendations that are informed by the perspectives, work, and experiences of Oregon CCOs, key community partners, and agency staff.

Recommendations begin on next page.

III. Why Social Determinants of Health in Oregon CCOs?

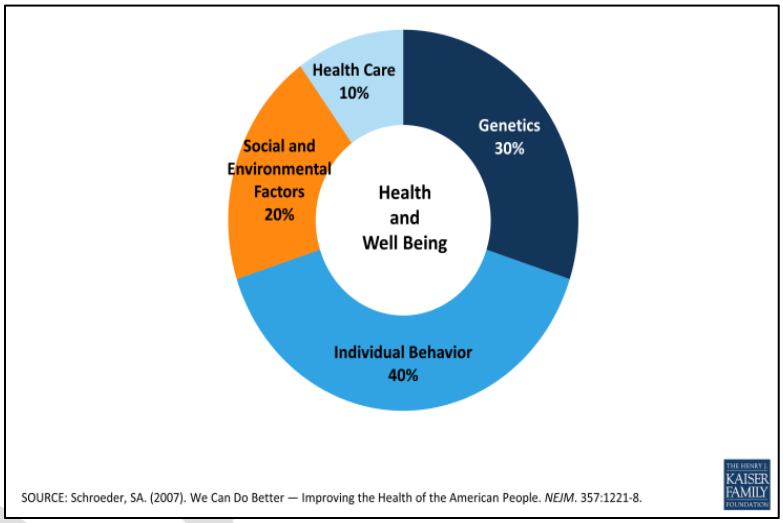
There is a growing acknowledgement that "place matters" when it comes to a person's health; indeed, a person's zip code is often more predictive of their health than their genetic code. These place-based factors are often referred to as the social determinants of health (SDOH) – the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age (*see page 19, definition of social determinants of health & equity for Oregon CCOs*).

Oregon's CCOs can play an important role in addressing SDOH for their members and thereby improving overall health in their communities, reducing health disparities, and cutting health care costs. The MAC proposes four reasons this work should be a responsibility and essential component of a CCO's role:

1. Addressing SDOH is essential to reach Oregon's triple aim of better health, better care, and lower costs, since SDOH impact health much more than health care services.
2. SDOH must be addressed in order to eliminate health inequities, since certain groups are disproportionately impacted by SDOH due to structural factors, such as racism and sexism.
3. Addressing SDOH can directly cut healthcare costs, based on a growing body of evidence.
4. The CCO model is particularly well-suited to address SDOH, given its emphasis on coordinated, whole-person care, local control, paying for value, and addressing inequities (see Appendix A).

The impact of SDOH on health

Figure 1. Impact of Different Factors on Risk of Premature Death (Kaiser Family



In order to reach Oregon's triple aim of better health, better care and lower costs, it is essential that coordinated care organizations (CCOs) work toward addressing the social, environmental, and political factors that both predispose certain groups to health conditions and pose particular challenges to a person's recovery. Research has shown that SDOH have a significantly larger impact on health, length of life, and quality of life than clinical health care (*see figure 1*).

Health inequities

The MAC recognizes that certain groups are disproportionately impacted by poor social and economic conditions and experience unfair barriers to social resources and opportunities according to race/ethnicity, gender, disability status, behavioral health, sexual orientation, and other characteristics. Institutional racism – racism reflected in policies and social systems – and discrimination can impact access to housing, employment opportunities, neighborhood characteristics, such as safety and access to healthy food retail, and other SDOH.[i] Oregon's history of structural inequalities, institutional racism, and embedded discriminatory policies have slowed the economic progress, social standing, and health outcomes of racial minorities across generations. For example, the State's constitutional ban on black residency and covenants on home ownership for blacks, Chinese, and Jewish families created and sustained systematic poverty and economic

disfranchisement decades beyond each individual laws' reach.[ii] These structural factors - called the social determinants of equity (see definition, pg.19) help determine the distribution of SDOH in populations. It is necessary to address both SDOH and the social determinants of health equity in order to improve health.[iii]

Cutting healthcare costs

While evidence in this area is still nascent, research is beginning to show return on investment for addressing SDOH. For example, research in central Florida found that providing supportive housing to the chronically homeless cost $10,051 per person per year, compared with a total cost of $31,065 per person per year in higher rates of inpatient hospitalizations, ED visits, incarceration and other system costs.[iv] These include savings to the health care system, corrections (prison system), and broader community, illustrating the importance of collaborative, community-wide efforts to address social determinants (for example, partnerships between health care entities and the prison system). Research has also shown a link between social determinants of health, such as housing insecurity and household income, and pediatric hospital readmissions.[v] Here in Oregon, Providence Center for Outcomes Research and Education (CORE) found that Medicaid costs declined by 12% on average after people moved into affordable housing, with even higher savings for members moving into Permanent Supportive Housing (14%) and housing for seniors and people with disabilities (16%).[vi]

CCO model and SDOH

In general, the Medicaid program is a strong avenue to address SDOH. Medicaid members are often among those most negatively impacted by SDOH (e.g. food insecurity), and are often eligible for or already enrolled in other social service programs, such as SNAP (food stamps). Additionally, recent updates to Medicaid Managed Care rule facilitate Medicaid

investments in SDOH interventions, such as including community health workers in care teams.[vii]

Moreover, aspects of Oregon's CCO model are especially well designed for meaningful work to address SDOH. Appendix A identifies alignment between key components of health system transformation under CCOs and strategies to address SDOH. For example, CCO authorizing legislation (HB 3650) requires that CCO members "receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters…community health workers, and personal health navigators." Community health workers and other traditional health workers (THWs) can be a key workforce to address SDOH. THWs often share lived experience with members and can connect members to critical social services and other resources to address SDOH.

IV. Defining Social Determinants of Health and Equity for Oregon CCOs

Oregon CCOs are already addressing social determinants of health in a variety of ways (see Appendix D, Survey Results, Appendix E, table of SDOH initiatives & roles by CCO and Appendix F, CCO presentations to MAC). However, the degree of CCO investment in SDOH initiatives varies by community, and CCOs may have different definitions of SDOH. The MAC developed a definition of SDOH for Oregon CCOs in order to help drive more focused and concentrated impact. The following definition builds off of existing definitions from national and international health experts, and was developed in collaboration with OHA staff and in consultation with various committees and community groups (see work timeline, page 12).

Definition begins on next page.

Social Determinants of Health & Equity: Definitions for CCOs

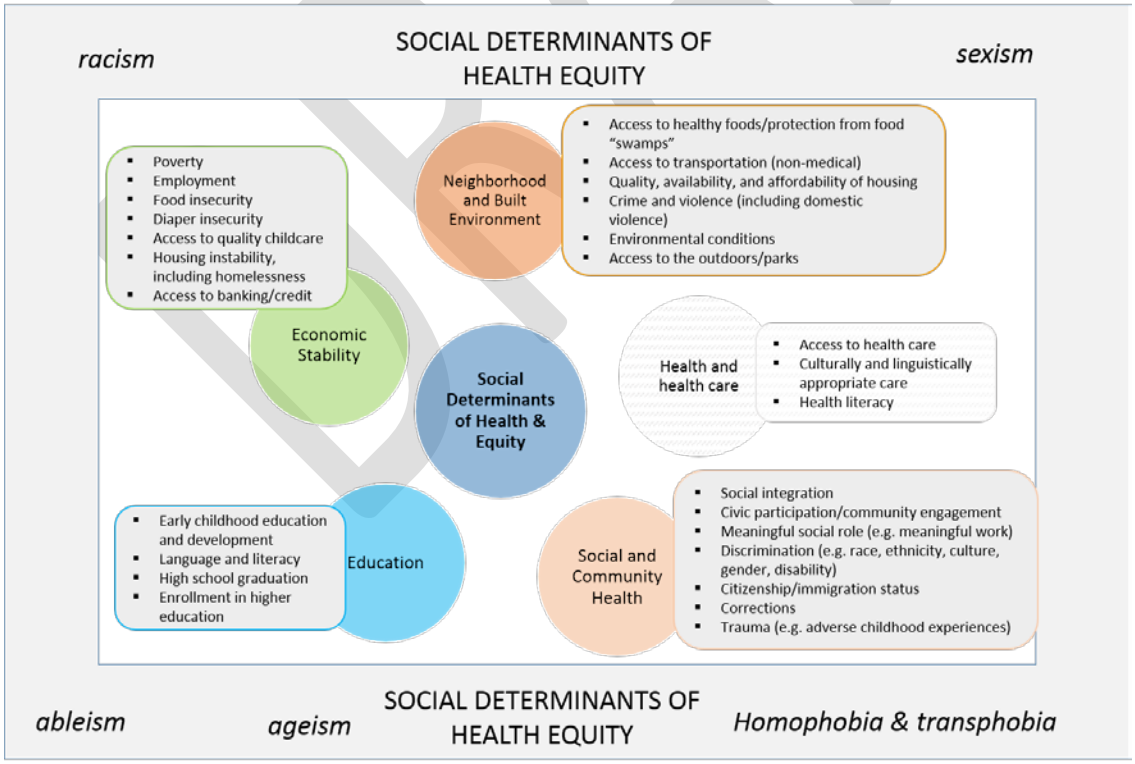
Most of our health is shaped by factors outside the clinic or hospital, in the places where we live, learn, work, and play.

Social determinants of health: the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities.

Social determinants of health equity: Systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. These structural factors are evident in social norms, policies, and political systems, both historical and current. Institutionalized racism is one example.

Figure 2 includes SDOH and equity factors that meet these definitions.

Figure 2. Social Determinants of Health & Equity Factors



Social determinants of health and equity factors

The MAC built from work of the Healthy People 2020 initiative[6] and the input from key stakeholders and community groups to identify a list of SDOH factors and underlying social determinants of health equity (see Figure 2, above). SDOH factors are categorized under five broad areas identified in Healthy People 2020:

1. **Economic stability**, including factors such as poverty and employment
2. **Education**, including from early childhood to adult education
3. **Neighborhood and built environment**, including exposure to crime/violence and access to resources such as food, transportation and housing
4. **Social and community health**, including general societal integration and role as well as particular challenges such as incarceration or trauma
5. **Health and health care**, including access to care, particularly culturally and linguistically appropriate care

Underlying all of these factors, are the structural inequities (including systematic discrimination based on race, gender, and other factors) that make up the social determinants of equity.

It is important to note that health care-related SDOH factors, such as access to care, cultural competency and health literacy, are less emphasized in this figure. While important, these factors are already integral to the CCO model, and the MAC recommends the primary focus of CCOs be on the four remaining areas. However, the MAC strongly recommends that any health care-related activities to address racism and inequities in the health care

[6] Healthy People 2020 is a federal interagency effort to establish 10-year objectives for improving the health of Americans

system – such as ensuring culturally competent services – be part of a CCO's foundational work in SDOH.

V. MAC general recommendations for Oregon CCOs in addressing the social determinants of health

As health care systems expand their focus from health care to overall community health and well-being, more and more providers and payers have turned their attention to SDOH. Although the impact of SDOH on health is well established, historically and today SDOH have been addressed outside of the health care system by social service organizations, community-based organizations, and government entities. While it is critical for the health care system to consider and address the SDOH to improve health, it is important to consider the risks that might be inherent in this work. Through consultation with stakeholders and research, the MAC identified the following set concerns and risks that should be considered as CCOs address SDOH.

- **Ignoring infrastructure needs:** It's important to ensure CCOs develop the staffing and training needed to address SDOH effectively.
- **Over- or under-medicalization:** In expanding beyond a traditional health care role to address SDOH, a CCO may run the risk of "over-medicalizing," or using an overly clinical approach to addressing a social need (such as prioritizing screenings over community interventions). CCOs and providers may also run the risk of "under-medicalizing," as when a neurological or physiological health condition is overlooked when addressing a social need.
- **Duplication/reinventing the wheel**: Community organizations, social service entities, providers, and other community partners have ongoing efforts to address SDOH that can be enhanced and built from.
- **Lack of research or community engagement:** Similarly, it is important to learn from national and local efforts, and also from direct community engagement, to identify the "right" work for a CCO's community.

- **Lack of sustained investment:** Focusing exclusively on short term investments could result in lower long term impact and limit the data available to measure effectiveness.
- **Relying on a one-size-fits-all approach:** As with all health care, some strategies may need to be modified for different populations. For example, a strategy for people with physical disabilities may not be transferable to the full disability community (e.g. including people with Intellectual and Developmental Disabilities (I/DD).
- **Lack of clear communication around work**: Clear communication will be important, including communicating a CCO's role in the work, in order to avoid confusion among partners and members.

Five recommendations for CCOs addressing SDOH

Drawing from these considerations and from the research and consultations with stakeholders, the committee offers five recommendations for CCOs addressing SDOH. The MAC encourages OHA to consider its recommendations when establishing future expectations and accountabilities for CCOs related to this work, including the next round of CCO contracts.

CCOs address social determinants of health with the primary purpose of improving health equity. This approach means that CCOs:

a) Use evidence of community health inequities to drive strategic efforts to address the SDOH that most contribute to these disparities.
b) Build the critical infrastructure necessary to address the structural factors that influence SDOH (e.g. institutional racism). For example, ensure culturally competent CCO leadership, staff, and services.
c) Publicly communicate, through a plan, staff, and/or other process, how the CCO is considering equity in directing its SDOH work.
d) Recognize that improving social determinants of health and equity is a continuous process, and adjust efforts as necessary to respond to

emerging and changing health disparities and social determinants of health challenges.

CCOs support, leverage, and augment existing internal (CCO), community, and provider efforts and capacities to address SDOH, in order to increase the effectiveness of these efforts. This approach means that CCOs:

a) Select role(s) (see Table 1, pg. 29) based on the needs and resources in a given community.
b) Work directly with Community Advisory Councils (CACs), providers, public health, and other community partners already engaged in addressing the SDOH.
d) Consider regional assessments and plans, such as Community Health Assessments and Community Health Improvement Plans,[7] and other available assessments of community health (e.g. public health surveys) to drive SDOH strategies. It is critical for OHA to monitor these assessments and plans.

CCOs build from their roles as the main Medicaid payer in a community, and use the unique tools provided by the CCO model to spend funds on SDOH, including:

a) Health-related services
b) Value-based payment strategies[8] that incent and enable providers for work to address SDOH and refer patients with complex social needs.

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[7] CCOs are required to conduct Community Health Assessments and develop and report on Community Health Improvement Plans. CACs are required to oversee a Community Health Improvement Plan and adopt a Community Health Improvement Plan.

[8] Value-based payment: A strategy to pay health care providers for quality outcomes and value, rather than quantity or volume of services provided.

CCOs support health care teams and community partners in working together and with patients to identify and address the SDOH challenges patients face and would like help to resolve. This approach means that CCOs:

a) Address the variety of health care team and community partner needs to impact SDOH (e.g. need for data systems or technology to track and address SDOH)
b) Ensure providers have the necessary SDOH data to deliver both SDOH-informed and SDOH-targeted healthcare[9]
c) Ensure two-way data flow by facilitating reporting of SDOH efforts and outcomes from health care teams and community partners
d) Offer health care teams resources to help facilitate connection to or coordination with SDOH community partners

CCOs address SDOH in a way that promotes person- and family-centered care, including tailoring SDOH efforts around member needs and desires. This means CCOs and their provider networks:

a) Provide member-based services (e.g. flexible services)[10] in a way that takes into account a member's desires and priorities when it comes to addressing SDOH challenges or barriers.
b) Tailor population-based SDOH initiatives (e.g. community benefit initiatives) to the community needs and priorities identified through

9 SDOH Informed healthcare: using information on social needs in clinical decision-making; SDOH Targeted healthcare: implementing interventions to address social needs (e.g. connecting individuals to social service resources).

[10] Flexible services are the type of health-related services that are provided directly to individual members, as a part of their care plan. In contract, community benefit services are provided at a community or population level.

community health assessments and other relevant public health assessments.

VI. The role of CCOs in addressing social determinants of health

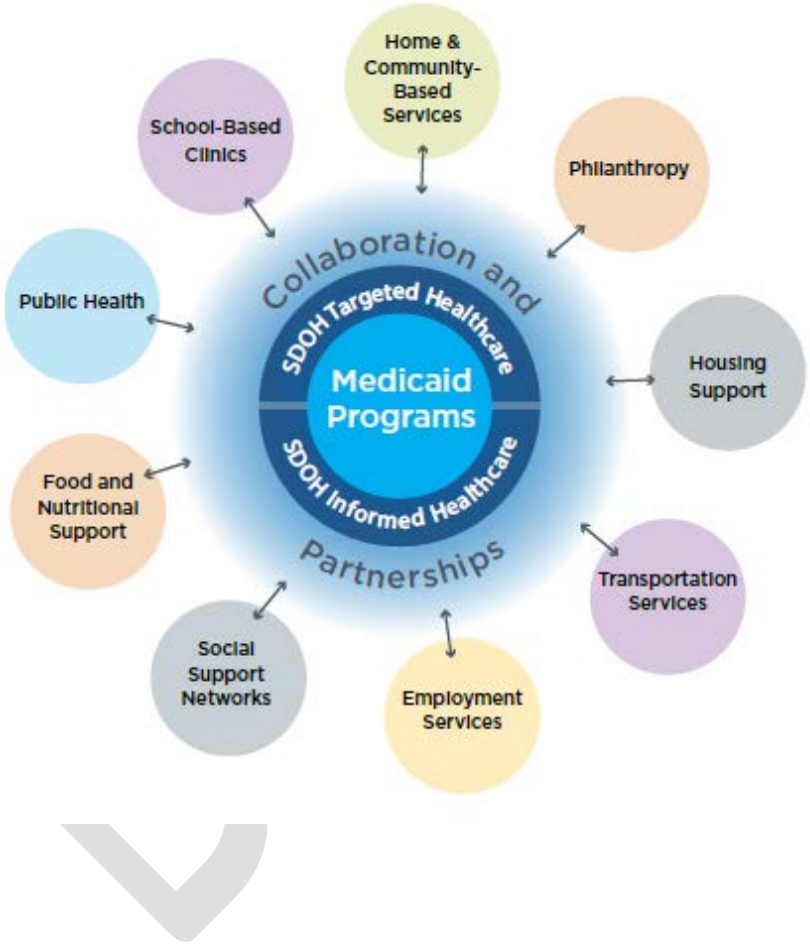
The MAC's general recommendations can help to inform a set of possible roles that CCOs can and are playing to address SDOH in their communities. For example, CCOs might act in their role as Medicaid payer to directly invest in community organizations addressing SDOH or to create value-based payment structures that help providers to solve the most pressing social needs of their patients, rather than tying payment only to clinical care. To develop a set of possible roles, the MAC first looked to national research on the role of the health care system in this work.

National perspectives

National stakeholders have begun to develop recommendations and frameworks for health care's role in addressing SDOH. Taylor et al. described a hub-and-spoke model in which health care entities could either take the role of the "hub" or the role of a "spoke" in their collaborative efforts to address SDOH.[viii] There are advantages and risks to a health care entity in either role. For example, health care's significant funding advantage and experience contracting make it well suited to play the role of a community hub. However, because many communities have competing health care entities, and due to concerns about over-medicalizing SDOH work, in many situations health care entities might better leave the hub role to a non-health care partner.

The National Quality Forum (NQF), along with a panel of expert stakeholders, developed a useful framework for the role of Medicaid programs, specifically, as "hubs" in addressing SDOH (see Figure 3).[11]

Figure 3. A framework for Medicaid programs to address SDOH, NQF



[11] National Quality Forum. (December 22, 2017). A framework for Medicaid programs to address social determinants of health: food insecurity and housing instability. Available at https://www.qualityforum.org/Publications/2017/12/Food_Insecurity_and_Housing_Instability_Final_Report.aspx

A particularly useful aspect of NQF's framework is its description of three broad types of SDOH work for health care entities:

- *SDOH informed healthcare* – using information on social needs in clinical decision-making
- *SDOH targeted healthcare* – implementing interventions to address social needs (e.g. connecting individuals to social service resources)
- *Collaboration and partnerships* – for example, purchasing social services from community organizations

These national conversations informed the MAC's recommendations for CCOs in Oregon and the committee's consideration of the types of roles that CCOs can and should play in this work. Ultimately, rather than recommending the CCO play either the role of "hub" or "spoke," the MAC recommends a more flexible and community-based approach, by encouraging CCOs to draw from a standard set of useful roles depending on community needs.

Ten roles for Oregon CCOs

Oregon CCOs are unique health care entities designed to use care coordination and whole person care to achieve better health, better care, and lower costs in their communities. To better understand the possible roles CCOs can play in addressing SDOH, the MAC heard from CCOs and community partners through presentations and its SDOH survey. The MAC then identified 10 SDOH roles for Oregon CCOs. Appendices E and F provided examples of CCOs already taking on these roles to improve SDOH in their communities. The MAC identified one foundational role as an essential role that supports all other CCO efforts: internal and infrastructure changes. Preparing a CCO's internal and provider infrastructure to address SDOH can increase effectiveness and helps to address the social determinants of equity (e.g. institutional racism). Examples of internal and infrastructure changes to support SDOH work include:

- supporting equity and social determinants of health trainings;

- supporting cultural competence training among a CCO's staff and provider network, and otherwise combating racism in a clinic setting (see sidebar, right);
- employing culturally diverse staff to work with specific populations;
- employing staff to manage health equity and/or SDOH-related work;
- working directly with the CCOs Community Advisory Council(s) (CACs) to provide feedback on how to adapt the agency's CHA to fully address SDOH.

Cultural Competence Continuing Education Committee (CCCE) Recommendations for CCOs*

1. Adopt and apply [CCCE Committee] standards for cultural competence continuing education
2. Require cultural competence continuing education for providers and staff
3. Support funding to develop continuing education options

*Report available at: http://www.oregon.gov/oha/oei/reports/Cultural%20Competence%20Continuing%20Education%20Report.pdf

In addition, the MAC named nine possible roles from which CCOs can select, through collaboration with community partners, to address SDOH (Table 1, page 29). In total, the ten roles offer CCOs a range of options, spanning from activities that address an individual or family need (e.g. flexible services), to supporting community efforts that affect groups of members (e.g. aligning or grant-making), to making systems and policy changes that affect whole populations. These roles further enable CCOs to support and engage in SDOH-informed healthcare, SDOH-targeted healthcare, and collaboration and partnership as described in the NQF framework above.

Table of roles on next page.

Table 1. Ten possible roles for CCOs to Address the Social Determinants of Health

CCO Role	Description	Example
Internal and infrastructure changes (Foundational Role)	Hiring, training, retention, recruitment, and community engagement strategies necessary to ensure organization and provider network's competency to address SDOH	CCO employs staff to meet the social, racial, and cultural needs of the community
Direct Investment	Grants or more permanent funding, often to providers and community-based organizations, to build infrastructure in communities for addressing SDOH	CCO partners with local farmers' market organization to establish a farmers' market in a food desert/food swamp (area with limited access to healthy food)
Health-related Services (HRS)	Non-state plan, non-covered services intended to improve care delivery and member health, including flexible services (member-specific) and community benefit initiatives.	CCO funds non-medical transportation for members to go to parenting classes, food bank, job interview
Value-Based Payment (VBP)	Payment models designed to pay for value (i.e. outcomes) rather than volume (i.e. services). Payment can be designed to incentivize SDOH activities; allow flexibility to address both medical and social needs to improve health	CCO provides incentive payments to providers to support SDOH work, e.g. incentives for SDOH screenings, for PCPCHs to adopt standard 5.E.C. for tracking community/social service referrals (see Spotlight on PCPCH Appendix G)

CCO Role	Description	Example
Workforce	Contracting with or otherwise funding healthcare workers to address SDOH (e.g. community health workers)	CCO contracts with community health worker (CHW) to provide social service referrals to high utilizers or operates a care coordination hub, such as the Pathways model (see Spotlight on CHWs, Appendix G)
General alignment / collaboration	Aligning CCO SDOH priorities with community-selected goals or strategies	CCO adopts common metrics with local early learning hub
Convener	Bringing together diverse, multi-sectoral partners to identify common priorities and work toward addressing SDOH. Further, communicating with other CCOs to share best practices and innovations around SDOH.	CCO engages social service and other community partners to integrate SDOH into its community health assessment and community health improvement plan; facilitate selection of common priorities for community
Data / analytics support	Providing health care data or data resources (e.g. Health IT, supporting development of Health Information Exchange) to partners, such as social service entities	CCO tracks and/or compiles data related to SDOH factors and pairs with medical data to support evaluation of SDOH interventions
Social needs / resource clearinghouse	Compiling and distributing social needs/resource data to providers and other partners	CCO assembles social needs data on members and shares risk scores (see Spotlight on OPIP, Appendix G) with providers to inform care
Policy / government relations	Advocating for policies that address SDOH in communities	CCO advocates for improved transportation options for residents in service area

VII. Conclusion

As Oregon's CCO model enters its second phase, there is an opportunity to increase the system's focus on SDOH, due to the significant impact these factors have on member and community health. While CCOs and community partners have already begun initiatives and programs to address these factors, such as housing, food insecurity, and trauma, more alignment and guidance can increase the impact of these efforts across the state. The MAC recommends that OHA use its definition to achieve a common understanding of SDOH and SDOH factors among CCOs. Additionally, the committee makes five general recommendations for CCOs addressing SDOH to ensure that the work improves health equity; enhances existing community efforts; capitalizes on the CCO role as a Medicaid payer; supports provider efforts; and holds true to the principles of person- and family-centered care. Finally, the committee recommends a menu of roles CCOs can take, including a foundational role and nine additional roles, as the organizations increase their work in this area.

As the MAC was in the process of developing its recommendations, OHA and the Oregon Health Policy Board (OHPB) launched a process to develop policies for the second phase of CCOs, known as "CCO 2.0." To guide this policy development, Governor Brown directed the OHPB to focus on four priority areas, including social determinants of health and equity. The MAC encourages the OHA and the OHPB to consider its recommendations to inform specific policies and expectations in CCO 2.0.

VII. Appendix A. Alignment of Health System Transformation Expectations and Work to Address Social Determinants of Health

CCO model	Expectation (Source)	SDOH alignment
HB 3650 Authorizing Legislation		
Local accountability and governance, including community advisory council	Each coordinated care organization convenes a community advisory council…with consumers making up a majority of the membership…that meets regularly to ensure that the health care needs of the consumers and the community are being addressed. (4)(1)(o)(C))	Enables CCOs to target SDOH needs of their communities, as SDOH factors and priorities vary by region
	Each coordinated care organization has a governance structure that includes…the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community; and at least one member of the community advisory council.	Provides opportunity to engage community partners in governance of CCO to help shape SDOH efforts, such as public health, housing, food system, transportation, city planning, education
Metrics to improve quality and access	[OHA] shall incorporate [quality] measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements	SDOH can be targeted to improve incentive metrics – for example, improving access to healthy food can help improve HbA1c control for people with diabetes;

		providing affordable housing could help lower ED visits.
Coordinated, person-centered, whole person care	Each member [of a CCO] has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.	• CCOs can explore innovative care team arrangements that include members to address SDOH, such as community health workers and social workers • Addressing the "whole person" should ideally incorporate efforts to address the social determinants contributing to a person's health
	Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.	
Patient-centered primary care (PCPCH) homes	Each coordinated care organization shall implement, to the maximum extent feasible, patient centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations.	The PCPCH model emphasizes whole person care and care coordination, with the primary care provider as epicenter of care. PCPCHs can choose to track social service referrals as part of their attestation process to be recognized.
	The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible.	

Traditional health workers	Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, as defined in ORS 409.615, community health workers and personal health navigators who meet competency standards established by the authority under section 11 of this 2011 Act or who are certified by the Home Care Commission under ORS 410.604 (HB 3650) Members..must have access to advocates, including qualified peer wellness specialists, peer support specialists, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services. (ORS 414.635)	Community health workers and other traditional health workers (THWs) can be a key workforce to address SDOH. THWs often share lived experience with members and can connect members to critical social services and other resources to address SDOH.
Focus on high-utilizers and reducing emergency department use	Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical	Research has shown addressing social determinants of health can reduce emergency

	dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions. (HB 3650)	department use and hospital readmissions.
Address health inequities	Communities and regions are accountable for …reducing avoidable health gaps among different cultural groups (HB 3650, Section 1(3)(d)	As described above, addressing social determinants of health is important to improve health equity.
Alternative payment methodologies/value-based payment (APM/VBP) (payment for value, not volume)	The Oregon Health Authority shall encourage coordinated care organizations to use alternative payment methodologies that…promote prevention…and reward comprehensive care coordination using delivery models such as patient centered primary care homes (HB 3650)	APMs/VBPs can be designed to support SDOH work (e.g. incentives for SDOH screening) or can be designed to allow providers flexibility to address SDOH factors (e.g. global payment)
Health Information Technology (HIT) and Health Information Exchange (HIE)	Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable (HB 3650)	SDOH information can be factored into HIT (such as EHRs) to provide a more holistic picture of a person's health concerns
2012 RFA Transformation Scope Elements (Appendix H)		
Community health assessment/community	Contractor's CAC partners with the local public health authority, local mental health	CHA and CHIP offer ideal opportunities to identify

health improvement plan	authority, community based organizations and hospital system to develop a shared community health assessment and adopt a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by Contractor. (2012 RFA, Appendix H – Transformation Scope Elements)	SDOH needs and build strategic partnerships and collaboration in a CCOs service area
Community partnership	CCOs to work with Providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including culturally specific community based organizations; work to develop formal relationships with providers, community health partners, including culturally and socially diverse community based organizations and service providers, and state and local government support services in its service area(s); participate in the development of coordination agreements between those groups (2012 RFA, Appendix H – Transformation Scope Elements)	Partnerships with community-based organizations and local public health partners are critical to addressing SDOH in communities. Partners likely have ongoing efforts that CCOs can support or with which CCOs can align.
	Contractor partners with local public health and culturally, linguistically and professionally diverse community partners	

	to address the causes of health disparities (2012 RFA, Appendix H – Transformation Scope Elements)	
CCO Contract		
Health care services beyond medical care may be provided to improve health (i.e. health-related services	CCOs are required to include health-related services in covered benefits, and to have policies and procedures to provide these services (CCO contract)	Health-related services can be used to address SDOH at an individual level (e.g. providing housing transition services or non-medical transportation) and a community level (e.g. farmers market in a food desert)

March 28, 2018

Dear Members of Oregon's Medicaid Advisory Committee:

The CCO Oregon Social Determinants of Health (SDOH) Workgroup commends the Medicaid Advisory Committee (MAC) for your work and discussion on the potential roles of Coordinated Care Organizations (CCOs) in mitigating the effects of SDOH and equity on community members being served by the coordinated care model in Oregon.

We are under the umbrella of CCO Oregon, which convenes workgroups across select focus areas to facilitate collaboration with multiple voices and organizational perspectives invested in the coordinated care model. We are a newer workgroup that meets monthly and convenes CCOs, provider groups, and other community-based organizations from across Oregon that directly provide critical services every day, including housing, food, peer counseling, and primary care. The population we serve contains geographic, socioeconomic, and racial diversity.

Your recommendations presented earlier this month to the Quality and Health Outcomes Committee (QHOC) aligned with many of our thoughts:

- We agree value-based models are a strong strategy for CCOs and their partners to incentivize particular practices and outcomes. To assist with this goal, the coordinated care system (the Oregon Health Authority (OHA), CCOs, workgroups/committees, and stakeholders) may need to:
    - Develop and disseminate best practices for coding and billing to CCOs and other coordinated care stakeholders
    - Share ideas for care team workflows (from physician to peer support worker) that strive for balance between data tracking and direct patient care
    - Identify best practices for how health related services may best operate in this model
    - Provide guidance on operations and fiscal sustainability within a value-based model for CCOs and other care access points (as many partners are still fee-for service)

- We also agree that greater direct investments in SDOH and equity projects are needed, even with the recent passage of HB 4018 and beyond CCOs. Other potential funding sources may come from continuing to:
    - Encourage the use of community benefit dollars on data-based SDOH and equity projects
    - Identify metrics to incentivize SDOH and equity work by CCOs and insurers, and incorporate measurement of existing projects
    - Develop communications for social service providers and other partners to know more about securing potential funding
    - Contract directly with workforce teams specifically trained to serve populations adversely affected by SDOH such as peer support specialists and traditional health workers
    - Support diverse workforce teams by incentivizing health worker training and/or reimbursement for different types of care team visits

- Your presentation at QHOC called out the development of screening tools, greater access to electronic health records for more types of care or service delivery providers, and disseminating compiled data more broadly back to providers and partners -- we agree. And, we identified a few additional components:

    - Streamline the collection of data and potential screening tools:
        - Optimize current systems and assess existing screening tools
        - Strive for the greatest cohesion across how screening questions are asked (for consistency)
        - Ensure that when data and screens are collected they "roll up" into larger datasets (for analysis and targeting)
    - Strengthen work across the OHA, the Department of Human Services (DHS), and Public Health to align systems, data collection, and dissemination

- As your presentation notes, it is important for CCOs, OHA, and other coordinated care stakeholders to align priorities with community needs and goals, and not duplicate efforts. We agree that when possible SDOH and equity projects should leverage existing structures within the coordinated care model and maximize efficacy. For instance:

    - Continue and increase Community Advisory Council (CAC) trainings on how to engage, set expectations, and attain goals for the committee members themselves and the CCO staff working with the CACs
    - Embrace and prioritize diversity and health equity in daily decisions throughout OHA and CCOs [not just in projects with SDOH or equity titles]; including the development of health equity metrics across care access points that measure existing and new work
    - Incorporate current Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) recommendations into forward-thinking organizational plans; develop mechanisms for CHNA and CHIP implementation and continue to report plan accomplishments
    - Increase learning opportunities for CCOs and potential coordinated care partners to build skills that aid local partnerships with those organizations focused on homelessness, ACEs, education, criminal justice, foster care, and more
    - Strengthen statewide and regional referral networks and the ability for providers and care teams across referred resources to communicate electronically

We acknowledge the importance of local CCO and care partnerships to best address the unique needs of the members in a given community. Strategic relationships across clinical and non-clinical care providers, social service agencies, community-based organizations, and system-wide structures like transportation and education can harness the experience and population-specific resources from each facet. A challenge to this work is how to best measure success and how to appropriately reimburse within the structure of the global budget that the coordinated care model leverages in Oregon. We will be discussing those challenges at a retreat in May and will provide you and other entities with further comment.

Again, we appreciate the leadership that the MAC has taken with this work. We encourage your consideration and integration of our thoughts into your discussions with the Oregon Health Policy Board and other bodies as Oregon continues to further health system transformation and advance the Quadruple Aim.

Thank you,
John Duke, MBA, Cascadia Behavioral Health
Sam Engel, AllCare Health CCO
Social Determinants of Health Workgroup Co-Chairs

MAC Social determinants of health survey

MAC Social Determinants of Health (SDOH) Survey

BACKGROUND

The Oregon Medicaid Advisory Committee (MAC) is currently developing recommendations for addressing social determinants of health (SDOH) through Coordinated Care Organizations (CCOs). The MAC has developed a draft definition of the social determinants of health and health equity for Oregon CCOs, available here for reference. This brief survey aims to better understand current work and priorities around SDOH within your community. Your time is valuable, and we thank you for completing the survey.

INSTRUCTIONS

We expect this survey to take approximately 30 minutes to complete. Please complete one (1) survey per organization.

HOW WE WILL USE THE DATA

The MAC will use the results of this survey to develop policy recommendations for Oregon Health Authority regarding (1) the role of CCOs in addressing social determinants of health, and (2) how CCOs can use health-related services to address social determinants needs in their communities.

The Oregon Health Authority will also use the results of this survey to better understand how CCOs and their community partners are addressing social determinants of health, including successes and challenges of this work.

Survey results and summary data will be posted on the Medicaid Advisory Committee website: http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx

CONFIDENTIALITY

Your privacy is important. Results of this survey will only be reported with summary data; your individual responses will not be linked to your identity. However, as part of the survey, you'll be asked if we can contact you for more questions or to clarify information. If you consent, some information you share may be identified as your organization's work (e.g. project case study).

CONTACT INFORMATION

For questions, please contact Amanda Peden at amanda.m.peden@dhsoha.state.or.us

MAC Social determinants of health survey

MAC Social Determinants of Health (SDOH) Survey

* 1. Name

2. Title/role

* 3. Organization

* 4. Contact email/phone

* 5. In what ZIP code is your organization located? (enter 5-digit ZIP code; for example, 00544 or 94305)

* 6. Can we contact you to clarify your answers or ask follow up questions?

- [ ] Yes
- [ ] No

* 7. In what role are you completing this survey today?

- ( ) Coordinated Care Organization staff
- ( ) Health Plan Partner staff (i.e. health plan contracting with a CCO)
- ( ) Community Advisory Council member/coordinator
- ( ) Regional Health Equity Coalition coordinator
- ( ) Community Health Center Leadership/Staff
- ( ) Local public health authority staff
- ( ) Tribal public health authority staff
- ( ) Other healthcare provider, e.g. behavioral health (please specify title)

MAC Social determinants of health survey

SDOH survey for CCOs and Health Plan Partners

8. Please indicate the degree to which your organization is engaged in work to address the social determinants of health (see MAC definition)?

- ○ My organization currently does this
- ○ My organization will do this within six (6) months
- ○ My organization is not doing this
- ○ Other (please specify)

MAC Social determinants of health survey

SDOH Survey for CCOs and Health Plan Partners: Part 2

Question tip: The following questions will ask about your organization's work addressing the social determinants of health, including the role your organization has played in this work. Please use the following definitions as guidelines for questions related to your role.

Role of CCOs/Health Plans in Addressing SDOH

Direct investment: For example, investing in or funding a program in a community-based organization focused on social determinants of health, or partnering with other health care entities to support a larger initiative (e.g. housing).

Utilize health-related services (HRS) (flexible services/community benefit): For example, CCOs have used health-related services to provide trauma-informed care training in schools, fund intensive case management in permanent supportive housing, fund non-medical transportation (such as transportation to WIC, farmers markets), and other innovative ways to address social determinants of health.

Convener: For example, partnering with local community and health organizations to complete a community health assessment and prioritize actions related to social determinants of health

General alignment/collaboration: For example, participating in a regional health equity coalition; aligning CCO priorities with community organizational priorities

Workforce: For example, funding community health workers that address social determinants of health

Data/analytics/technology support: For example, producing utilization and cost data for program evaluation purposes to identify health impacts of community social determinants of health initiative OR providing TA or incentivizing providers to integrate social determinants of health into EHR systems

Alternative Payment Models (APMs)/Value-based Payment (VBP): APMs/VBP are payment arrangements that pay for value (outcomes) rather than volume of care (services). These pay arrangements can be designed to give providers more flexibility or even incentives to address the social determinants of health.

Policy advocacy/government relations: For example, developing and/or advocating for policies to address social determinants of health and inequities, such as increasing housing stock, strengthening rental protections, increasing the minimum wage, paid family leave, healthy retail policies, universal pre-k, etc.

Internal training/infrastructure changes to support SDOH activities: For example, training staff in trauma-informed care or hiring a social determinants of health coordinator.

9. In the grid below, please indicate the role(s) that your organization currently plays or has played in the past in each of the identified areas of social determinants of health. Check the role definitions above for help.

Note: You can check more than one box in each row. If your organization has never worked in this area, select "not applicable."

	Not applicable	Direct investment	Utilize Health-related services (HRS)	Convener	General Alignment/ Collaboration	Workforce	Data support	APMs/VBP	Policy advocacy/ govt relations	Internal training/ infrastructure to support SDOH activities
Economic stability (e.g., poverty, employment, addressing food or diaper insecurity, access to quality childcare, housing instability, including homelessness)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neighborhood/physical environment (e.g., quality/availability/affordability of housing; transportation (non-medical); crime and violence (including domestic) access to healthy food; environmental/neighborhood conditions; access to outdoors/parks)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Education (e.g., language and literacy, early childhood education, high school graduation, enrollment in higher education)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Community and social context (e.g., social integration, community engagement, discrimination [race, ethnicity, age, gender], incarceration)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other (please indicate the role your organization plays in this work)

10. How did your organization select the specific areas (e.g. housing, education) related to social determinants of health in which you work? (choose all that apply)

- [ ] Through a community health assessment or other assessment
- [ ] Through a member survey or member screening
- [ ] Through collaboration with community advisory council
- [ ] Through collaboration with partner organization(s)
- [ ] Identified promising practice by other CCO or health care organizations
- [ ] Other (please specify)

11. Please briefly describe up to three of your projects in the social determinants of health.

Project 1

Project 2

Project 3

12. Is your social determinants of health work targeted to specific populations? For example, people who are homeless, people with a specific health condition (like diabetes), certain age groups (like children), etc.

- ( ) No
- ( ) YES. Please describe

13. Do you have any outcome data/program evaluation data related to your work in social determinants of health?

- ( ) No
- ( ) YES. Please (briefly) describe/share links to reports:

MAC Social determinants of health survey

SDOH Survey for CCOs and Health Plan Partners: Part 3

Question tip: Please use the following definitions as guidelines for questions related to your role.

Role of CCOs/Health Plans in Addressing SDOH

Direct investment: For example, investing in or funding a program in a community-based organization focused on social determinants of health, or partnering with other health care entities to support a larger initiative (e.g. housing).

Utilize health-related services (HRS) (flexible services/community benefit): For example, CCOs have used health-related services to provide trauma-informed care training in schools, fund intensive case management in permanent supportive housing, fund non-medical transportation (such as transportation to WIC, farmers markets), and other innovative ways to address social determinants of health.

Convener: For example, partnering with local community and health organizations to complete a community health assessment and prioritize actions related to social determinants of health

General alignment/collaboration: For example, participating in a regional health equity coalition; aligning CCO priorities with community organizational priorities

Workforce: For example, funding community health workers that address social determinants of health

Data/analytics/technology support: For example, producing utilization and cost data for program evaluation purposes to identify health impacts of community social determinants of health initiative OR providing TA or incentivizing providers to integrate social determinants of health into EHR systems

Alternative Payment Models (APMs)/Value-based Payment (VBP): APMs/VBP are payment arrangements that pay for value (outcomes) rather than volume of care (services). These pay arrangements can be designed to give providers more flexibility or even incentives to address the social determinants of health.

Policy advocacy/government relations: For example, developing and/or advocating for policies to address social determinants of health and inequities, such as increasing housing stock, strengthening rental protections, increasing the minimum wage, paid family leave, healthy retail policies, universal pre-k, etc.

Internal training/infrastructure changes to support SDOH activities: For example, training staff in trauma-informed care or hiring a social determinants of health coordinator.

14. Based on your experience and the work of your organization, what is the most effective role(s) a CCO/health plan partner can play in addressing social determinants of health? Why?

* 15. What are the 3 biggest challenges that prevent your organization from doing more work addressing the social determinants of health **(please choose up to 3)**

- [ ] Don't know how to identify the need
- [ ] Don't know how to appropriately engage in the work (e.g. which strategies to use)
- [ ] Challenges prioritizing which area(s) to work on
- [ ] Lack of funding/funding challenges
- [ ] Billing issues
- [ ] Don't see the impact on member health/CCO operations
- [ ] Lack of partners/challenges collaborating
- [ ] Lack of leadership support
- [ ] Not a current organizational priority
- [ ] Don't understand the role or responsibility of a CCO to address social determinants of health
- [ ] Other (please specify)

* 16. Which area(s) of Social Determinants of Health would your organization be most interested in addressing based on the priorities of your organization and community? **(please choose up to three)**. These can include areas of current work or areas of future work.

- [ ] Housing
- [ ] Food or diaper insecurity
- [ ] Employment support
- [ ] Transportation (non-medical)
- [ ] Crime & violence (including domestic)
- [ ] Environmental/neighborhood conditions and safety
- [ ] Early childhood education
- [ ] Language & Literacy
- [ ] Parenting education
- [ ] Discrimination
- [ ] Incarceration
- [ ] Trauma
- [ ] Other (please specify)

MAC Social determinants of health survey

SDOH survey for CCOs and Health Plan Partners: Part 4

The last two questions ask about health-related services. Health-related servcies are non-medical services that CCOs can pay for to improve a member's health. For example, a CCO can use health-related services to cover transportation not covered under State Plan benefits (i.e. other than transportation to a medical appointment). OHA recently released new guidance on health-related services, available here.

* 17. What are the three (3) main reasons that may prevent your organization from using health-related services to address the social determinants of health? **(please choose up to 3)**

- [ ] Don't know how to identify member needs
- [ ] Don't know how to appropriately engage in the work
- [ ] Don't see the impact on member health/CCO operations
- [ ] Challenges prioritizing which area(s) to work on/which needs to address
- [ ] Billing issues
- [ ] Lack of funding/funding issues
- [ ] Lack of partners/challenges collaborating
- [ ] Lack of leadership support
- [ ] Not a current organizational priority
- [ ] Other (please specify)

* 18. Which area(s) of Social Determinants of Health would you be most interested in addressing through health-related services, but are experiencing barriers in doing so (e.g. don't know how, don't know whether the work is a good fit for health-related services)? **(please choose up to three)**

- [ ] Housing
- [ ] Food or diaper insecurity
- [ ] Employment support
- [ ] Transportation (non-medical)
- [ ] Crime & violence (including domestic)
- [ ] Environmental/neighborhood conditions and safety
- [ ] Early childhood education
- [ ] Language & Literacy
- [ ] Parenting education
- [ ] Discrimination
- [ ] Incarceration
- [ ] Trauma
- [ ] Other (please specify)

MAC Social determinants of health survey

SDOH survey for Community Advisory Councils

Question tip: The next question asks about your CAC's work in social determinants of health. For example, some CACs provide grants (direct investment of CCO money) to community organizations like a food bank or housing organization. CACs could also complete a member or community survey related to social determinants of health. Or, CACs could work on social determinants of health in another way.

19. Is your CAC actively engaged in any work to improve social determinants of health in your community?

- ◯ No
- ◯ Yes

MAC Social determinants of health survey

SDOH Survey for Community Advisory Councils: Part 2

20. Please briefly describe up to three of your organization's projects in the social determinants of health.

Project 1

Project 2

Project 3

21. How did you identify and/or prioritize the specific areas (e.g. housing, education) related to social determinants of health in which you work? (select all that apply)

- [ ] From a community health assessment or other assessment
- [ ] From a member survey or member screening
- [ ] The CCO identified/prioritized the area for our CAC
- [ ] Through a CAC meeting
- [ ] Through collaboration with partner organization(s)
- [ ] Identified promising practice by other CCO or health care organization
- [ ] Other (please specify)

22. Is your social determinants of health work (indicated in question 19) targeted to specific groups? Examples of groups include people who are homeless, people with a specific health condition (like diabetes), certain age groups (like children), etc.

- ◯ No
- ◯ Yes. Please describe:

23. Has your CAC identified an area of high need related to social determinants of health in your community that could use more support or resources?

- ◯ Unsure
- ◯ No
- ◯ YES. Please indicate the area(s).

* 24. Based on the needs in your community, which area(s) of the social determinants of health would your organization be most interested in addressing? **(Please choose up to 3)**

- [ ] Housing
- [ ] Food or diaper insecurity
- [ ] Employment support
- [ ] Transportation (non-medical)
- [ ] Crime & violence (including domestic)
- [ ] Early childhood education
- [ ] Language & Literacy
- [ ] Parenting education
- [ ] Discrimination
- [ ] Incarceration
- [ ] Trauma
- [ ] Other (please specify)

MAC Social determinants of health survey

SDOH survey for Regional Health Equity Coalitions, providers, tribal and local public health

25. Is your organization actively engaged in any work to improve social determinants of health in your community?

- ◯ No
- ◯ Yes

MAC Social determinants of health survey

SDOH survey for Regional Health Equity Coalitions, providers, tribal and local public health: Part 2

Question tip: The following questions will ask about your organization's work addressing the social determinants of health and how this work is or is not connected with your local CCO. The organization will also ask about the role your CCO plays in your social determinants of health work (if applicable). Please use the following definitions as guidelines for questions related to your role.

Role of CCOs/Health Plans in Addressing SDOH

Direct investment: For example, investing in or funding a program in a community-based organization focused on social determinants of health, or partnering with other health care entities to support a larger initiative (e.g. housing).

Utilize health-related services (HRS) (flexible services/community benefit): For example, CCOs have used health-related services to provide trauma-informed care training in schools, fund intensive case management in permanent supportive housing, fund non-medical transportation (such as transportation to WIC, farmers markets), and other innovative ways to address social determinants of health.

Convener: For example, partnering with local community and health organizations to complete a community health assessment and prioritize actions related to social determinants of health

General alignment/collaboration: For example, participating in a regional health equity coalition; aligning CCO priorities with community organizational priorities

Workforce: For example, funding community health workers that address social determinants of health

Data/analytics/technology support: For example, producing utilization and cost data for program evaluation purposes to identify health impacts of community social determinants of health initiative OR providing TA or incentivizing providers to integrate social determinants of health into EHR systems

Alternative Payment Models (APMs)/Value-based Payment (VBP): APMs/VBP are payment arrangements that pay for value (outcomes) rather than volume of care (services). These pay arrangements can be designed to give providers more flexibility or even incentives to address the social determinants of health.

Policy advocacy/government relations: For example, developing and/or advocating for policies to address social determinants of health and inequities, such as increasing housing stock, strengthening rental protections, increasing the minimum wage, paid family leave, healthy retail policies, universal pre-k, etc.

Internal training/infrastructure changes to support SDOH activities: For example, training staff in trauma-informed care or hiring a social determinants of health coordinator.

26. Please briefly describe up to three of your organization's projects in the social determinants of health.

Project 1

Project 2

Project 3

27. Do you partner with a CCO in any of your work to improve the social determinants of health in your community?

- ◯ No
- ◯ Yes
- ◯ Unsure

28. In the grid below, please indicate the role that a CCO currently plays or has played in the past in each of the identified areas of social determinants of health in which your organization works. Note: You can check more than one box in each row.

	My organization does not partner with a CCO in this work	Direct investment	Utilize Health-related services (HRS)	Convener	General Alignment/ Collaboration	Workforce	Data support	APMs/VBP	Policy advocacy/ govt relations	Internal training/ infrastructure to support SDOH activities
Economic stability (e.g., poverty, employment, addressing food or diaper insecurity, access to quality childcare, housing instability, including homelessness)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neighborhood/physical environment (e.g., quality/availability/affordability of housing; transportation (non-medical); crime and violence (including domestic) access to healthy food; environmental/neighborhood conditions; access to outdoors/parks)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Education (e.g., language and literacy, early childhood education, high school graduation, enrollment in higher education)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Community and social context (e.g., social integration, community engagement, discrimination [race, ethnicity, age, gender], incarceration)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other (please indicate the role a CCO plays in this work)

29. Is your social determinants of health work targeted to specific populations? For example, people who are homeless, people with a specific health condition (like diabetes), certain age groups (like children), etc.

- ○ No
- ○ YES. Please describe.

30. Do you have any outcome data/program evaluation data related to your work in social determinants of health?

- ◯ No
- ◯ YES. Please (briefly) describe/share links to reports:

* 31. Based on the needs in your community, which area(s) of the social determinants of health would your organization be most interested in addressing? **(please choose up to 3)**

- ☐ Housing
- ☐ Food or diaper insecurity
- ☐ Employment support
- ☐ Transportation (non-medical)
- ☐ Crime & violence (including domestic)
- ☐ Early childhood education
- ☐ Language & Literacy
- ☐ Parenting education
- ☐ Discrimination
- ☐ Incarceration
- ☐ Trauma
- ☐ Other (please specify)

MAC Social determinants of health survey

Thank you!

Thank you for taking the time to complete this survey. Your feedback will help the Medicaid Advisory Committee and the Oregon Health Authority to better support CCOs in addressing the social determinants of health!

If you have any questions about this survey, please contact Amanda Peden at amanda.m.peden@dhsoha.state.or.us

MAC Social Determinants of Health Survey
January 2018 Results

Oregon Health Authority

Who responded to the survey?

66 total respondents

Types of respondents	Number of respondents
Coordinated Care Organizations (CCOs)	15
Community Advisory Councils	21
Community Health Centers	10
Regional Health Equity Coalitions	5
Behavioral Health Providers	5
Local Public Health Authorities	9
Tribal Health Clinics	1

Responses by CCO service area

Coordinated Care Organizations	Number of Partners who responded					
	Community Advisory Councils	Regional Health Equity Coalitions	Community Health Centers	Behavioral Health Providers	Local public health authorities	Tribal health
AllCare CCO, Inc	3	1	1			
Cascade Health Alliance, LLC		1				1
Columbia Pacific CCO	3		2		1	
Eastern Oregon CCO	5			1	2	
FamilyCare, Inc **(No CCO Response)**	1		2	1	2	
Health Share of Oregon	1		2		2	
InterCommunity Health Network CCO	1	1	1		2	
Jackson Care Connect	2	1	1			
PacificSource Columbia Gorge	1	1	2		1	
PacificSource Central Oregon	1	1			1	
PrimaryHealth of Josephine County				1		
Trillium Community Health Plan, Inc			1	1		
Umpqua Health Alliance	1		1			
Western Oregon Advanced Health LLC	1					
Willamette Valley Community Health LLC	1		1	1		
Yamhill Community Care Organization	1					

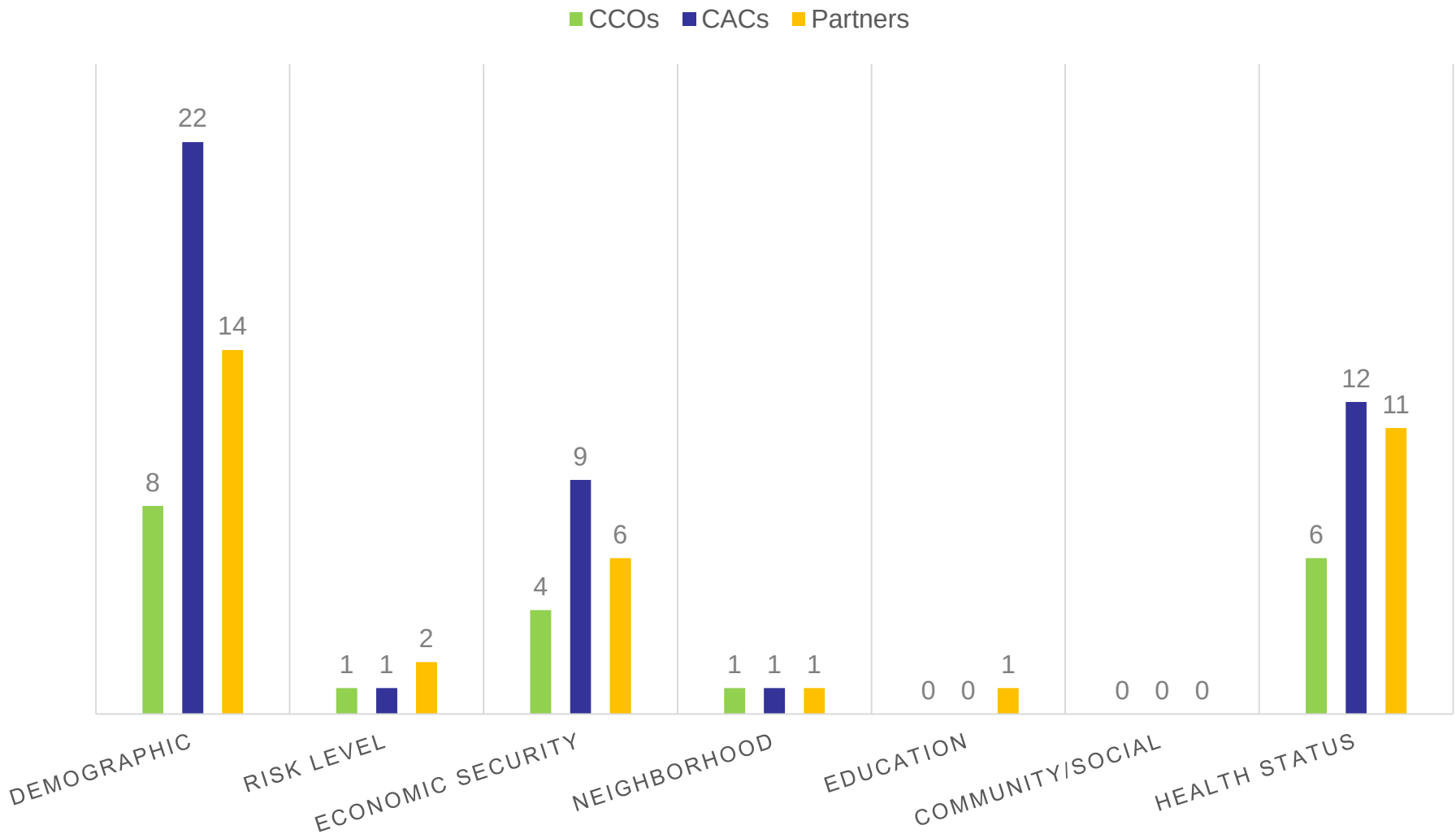
What SDOH-related projects are CCOs and partners doing?

- Projects focused on:
  - Workforce development (e.g., CLAS training, utilizing THWs)
  - Food insecurity (e.g., VeggieRx, Kitchen Garden project)
  - Housing (e.g., funding partner orgs, supporting transitional housing)
  - Infrastructure and training (e.g., health equity strategic plans, SDOH workgroups, community ed on trauma-informed care)
  - Education (e.g., ELHub partner)
  - Adverse Childhood Experiences (ACEs)
  - Environment (e.g., invest in local parks, improve air quality)

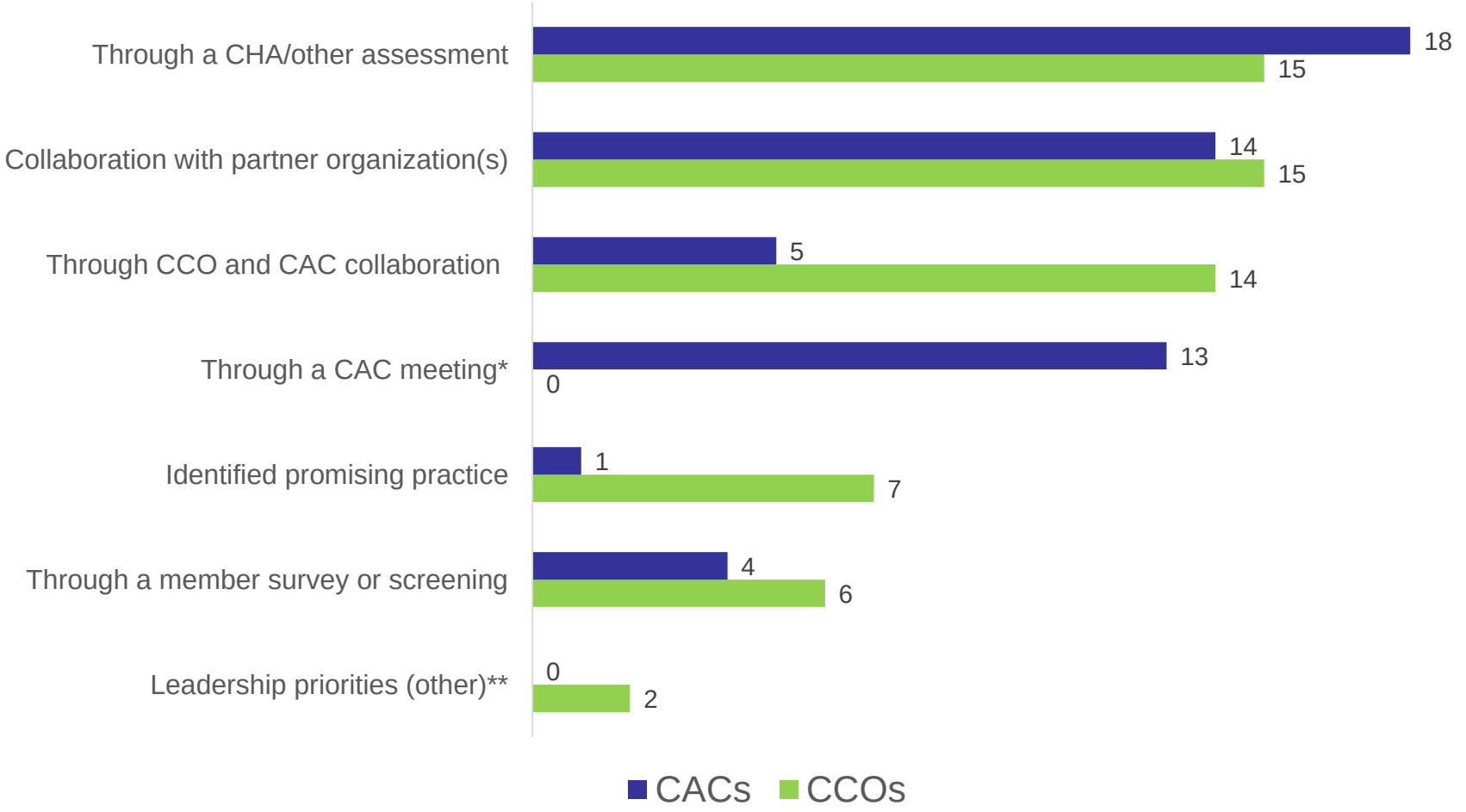
70% of partners indicated working with a CCO on addressing SDOH


Pathways
wellness
BlueZones
outreach
training
literacy
VeggieRx
refrigerated
TRACEs
case-management
referral
FoodBucks
ACES
integration
education
food
readiness
strategic
ACEs
assessments
neighborhood
SafeRoutestoSchools
invested
criminal
truck
assessment
equity
justice
graduation
business
opportunity
school
screening
regional
grants
planning
fitness
life-jackets
vouchers
members
FoodBank
advocacy
virtual
bank
CLAS
grant
partnerships
YMCA
high-utilizer
security
health
CHW
team
Hub
leaching
investment
healthy
Social
family
ride
children
navigator
HRS
build
families
pain
SUD
resilience
oral
mobile
insurance
tribes
system
Food
homes
fresh
referrals
multidisciplinary
resilience
classes
housing
diversity
enrollment
Helmets
at-risk
women
obesity
parks
inclusion
medical
cooking
mothers
PM2.5
PowerClean
Norms
walking
discharge
kitchen
opioid
toolkit
yoga
learning
lessons
gym
WarmingStation
ELHUB
clothing
SDOHscreening
CARE
access
LGBTQ
gardener
donation
perinatal
Blueprint
group needs
homeless
ELHub
workgroup
engagement
trauma
transport
network
trainings
CSA
swimming
matching
NEMT
kindergarten
disparities
recuperation
garden
behavioral
safety
insecurity
SystemofCare
reproductive
collaboration
medical-legal
partnership
pregnant

Are CCOs and partners targeting specific populations in their SDOH work?



How are CCOs & CACs prioritizing/ selecting their work in SDOH?



*option for CAC survey, not CCO
**leadership priorities indicated as "other" response

What roles do CCOs play? (CCO responses)

Q: Please indicate the role(s) that your organization currently plays or has played in the past in each of the identified areas of social determinants of health

	Internal training/ infrastructure	Policy advocacy	APMs/ VBP	Data support	Workforce	Collaboration	Convener	Utilize HRS	Direct $$
Economic Stability (e.g. poverty, food insecurity, homelessness)	53.3%	60.0%	33.3%	53.3%	73.3%	93.3%	66.7%	86.7%	100.0%
Neighborhood & Physical Environment (e.g. transportation, crime/violence)	60.0%	46.7%	33.3%	60.0%	46.7%	93.3%	66.7%	66.7%	80.0%
Education	60.0%	53.3%	26.7%	40.0%	46.7%	93.3%	66.7%	46.7%	93.3%
Community & Social Context (e.g. discrimination, incarceration)	86.7%	46.7%	20.0%	53.3%	66.7%	86.7%	80.0%	53.3%	93.3%

Green >75% Blue 50-75%
Peach 35-50% Gray <25%

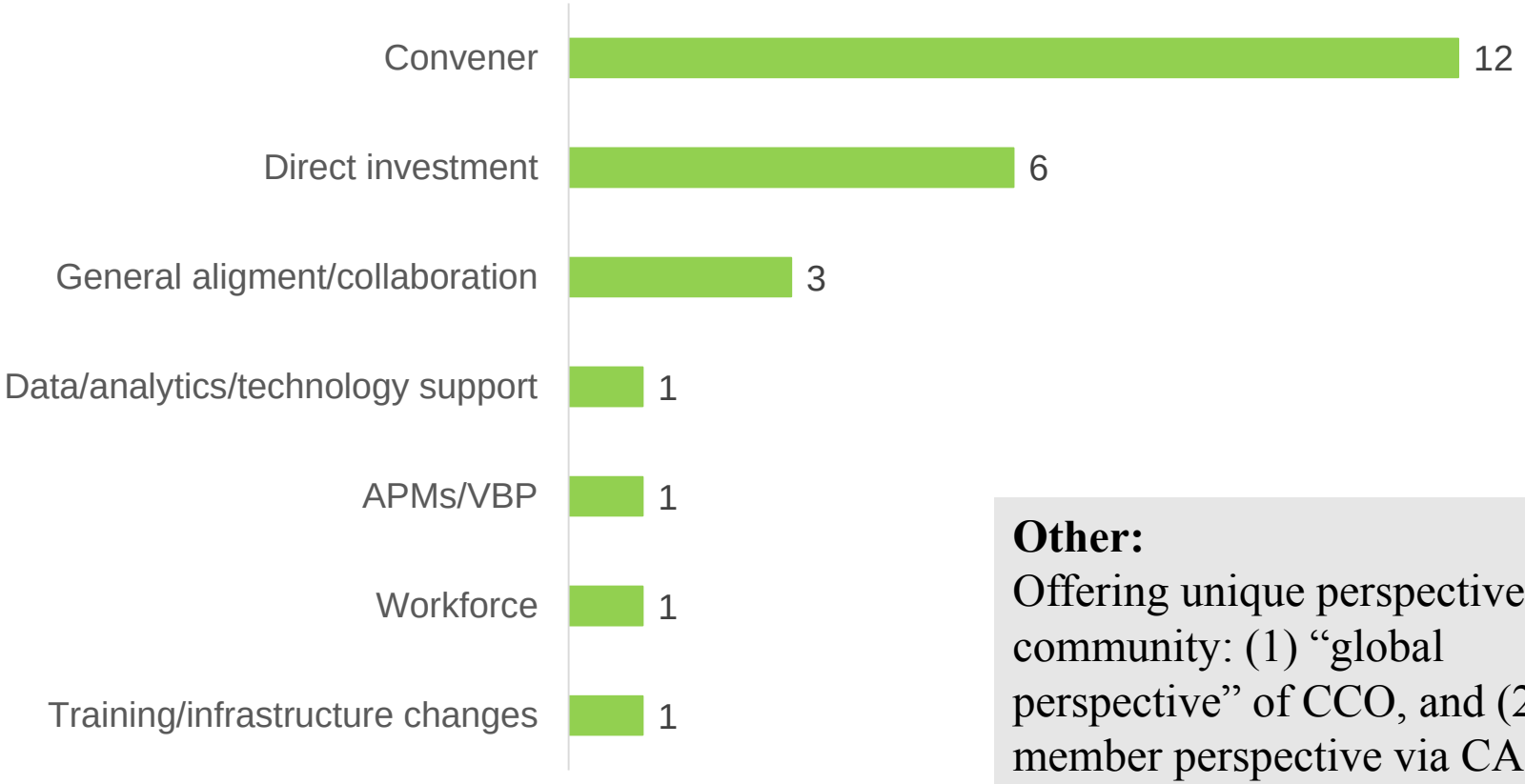
What roles do CCOs play? (partner responses)

Q: Please indicate the role(s) that a CCO currently plays or has played in the past in each of the identified areas of social determinants of health in which your organization works.

	Internal training/ infrastructure	Policy advocacy	APMs/ VBP	Data support	Workforce	Collaboration	Convener	Utilize HRS	Direct $$	No partner-ship
Economic Stability (e.g. poverty, food insecurity, homelessness)	14.81%	3.70%	11.11%	14.81%	3.70%	40.74%	14.81%	11.11%	18.52%	37.04%
Neighborhood & Physical Environment (e.g. transportation, crime/violence)	14.81%	3.70%	11.11%	11.11%	3.70%	37.04%	7.41%	3.70%	22.22%	55.56%
Education	7.41%	0.00%	0.00%	7.41%	0.00%	29.63%	11.11%	3.70%	18.52%	62.96%
Community & Social Context (e.g. discrimination, incarceration)	19.23%	7.69%	3.85%	11.54%	3.85%	38.46%	7.69%	11.54%	19.23%	34.62%

Green >75% Blue 50-75%
Peach 35-50% Gray <25%
Lilac 0

Most effective role for CCOs (CCO question)

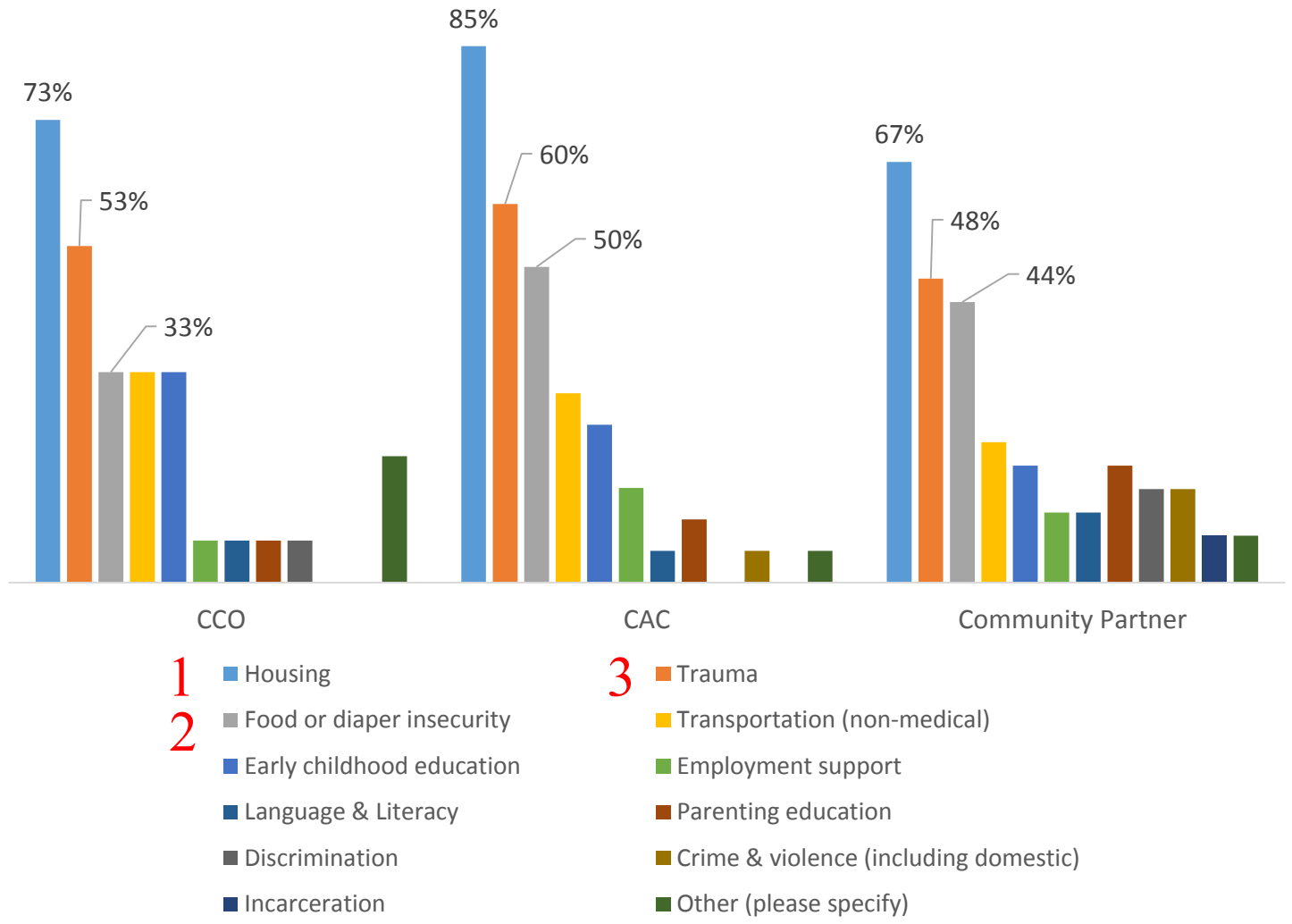


Other:
Offering unique perspectives to community: (1) "global perspective" of CCO, and (2) member perspective via CAC

(n=14)

Note: analyst categorized qualitative answers

Priority areas for future work in SDOH



Other priority areas for future work

- Environmental/neighborhood conditions, including safe, affordable recreation
- Health equity and access
- Workforce development
- Social isolation
- Community engagement

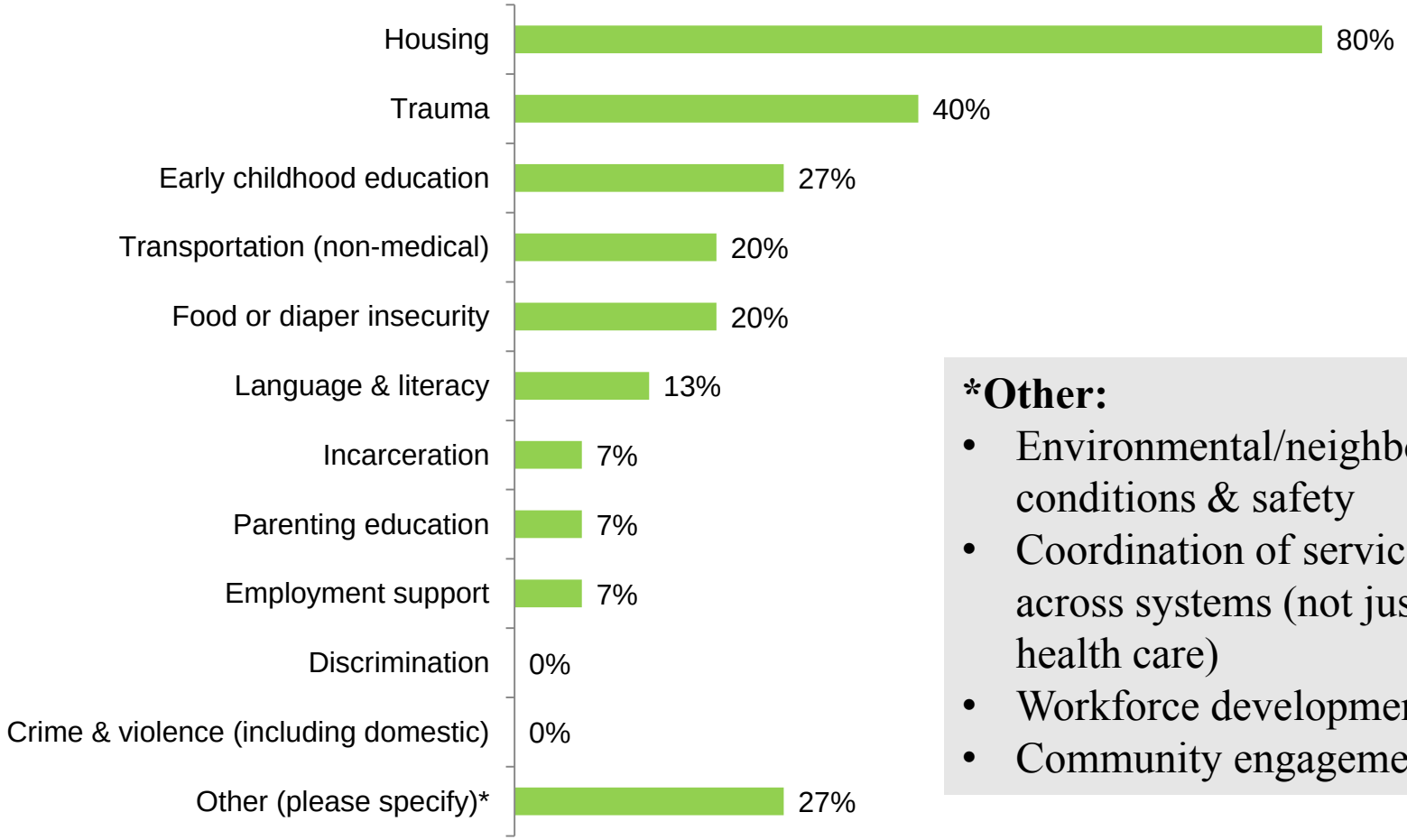
What are the barriers to SDOH work, according to CCOs?

(n=15)

***Other:**

- Slow return on investment
- Hard to spread risk across stakeholders
- Lack of evidence-based strategies
- Concerns about sustainability

Top areas of SDOH CCOs would like to address using health-related services, but are experiencing barriers

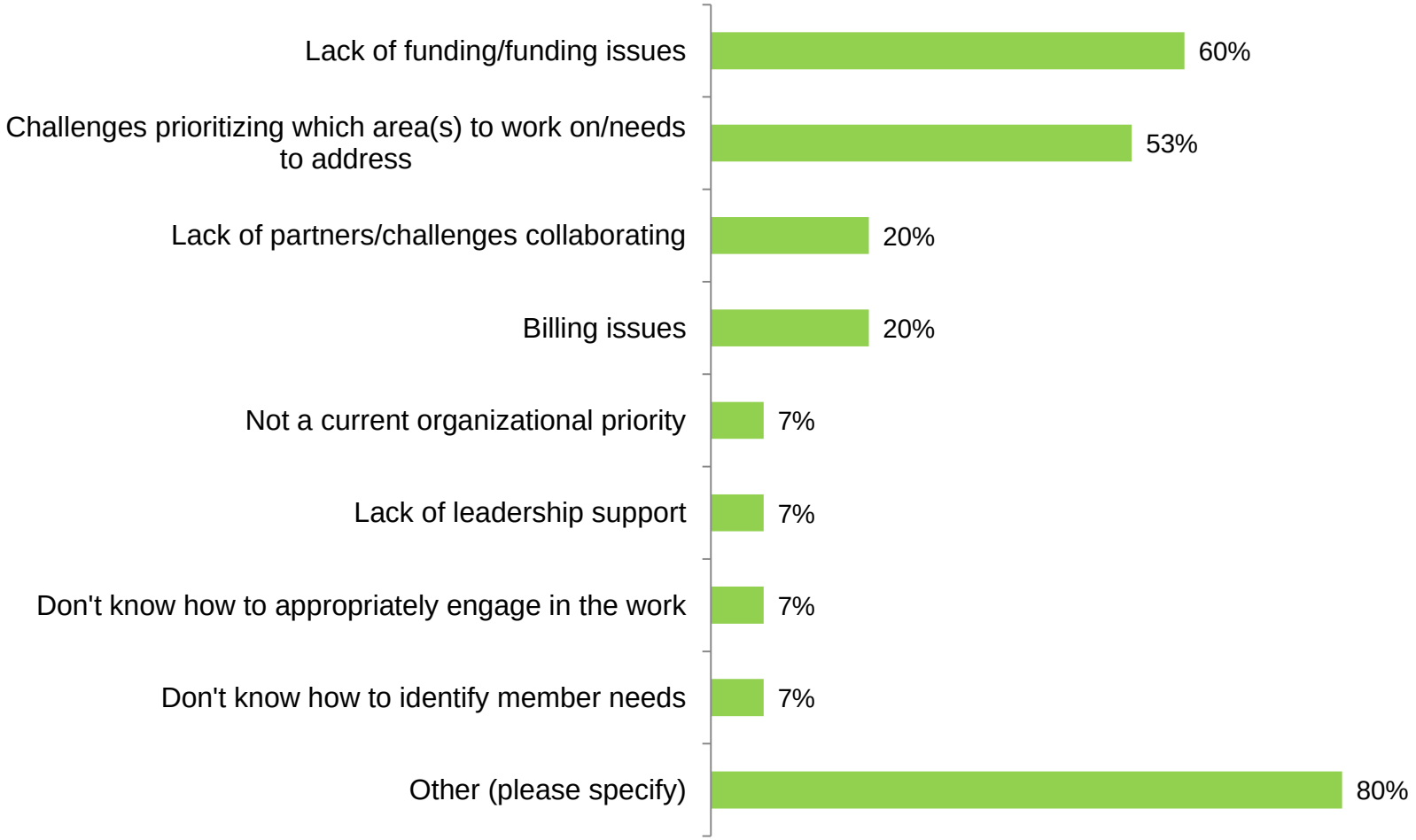


***Other:**

- Environmental/neighborhood conditions & safety
- Coordination of services across systems (not just health care)
- Workforce development
- Community engagement

(n=15)

Barriers to using health-related services to address SDOH



(n=15)

Other barriers to using health-related services

- Other funding challenges
  - Lack of consistent vision for CCO global budget
  - Dueling last resort funding pools
  - Demand feels endless compared to CCO budget
- Safe harbors for funding housing
- Other partnership challenges
  - Sharing risk
  - Knowledge among partners re: SDOH, heath-related services, how to partner
- Difficulty evaluating impact
  - Linking services provided to outcomes
  - Proving ROI
- Administrative complexity
- Implementing consistent & fair treatment for all members within funding restrictions

The role of CCOs in addressing the social determinants of health: Examples from CCO Transformation Plans and Reports*

Direct Investment	Utilize health-related services	Alternative Payment Models/Value-based Payment	Workforce	Policy/government relations	Convener	Data/analytics support	General alignment/collaboration	Internal training/infrastructure changes to support SDOH activities
Support community food projects: food bank programs, projects to increase access to healthy foods, food security screenings, Veggie Rx ********** AllCare Health, Columbia Pacific, InterCommunity Health Network, PacificSource Central Oregon	**Housing-related assistance:** hotel rooms post discharge, rental assistance, temporary housing, plumbing, roof repair, small construction projects (e.g. steps up to a home), utility bills, support for a homeless shelter		**Community Health Workers:** help connect patients with organizations to meet daily living needs, provide care coordination and assistance with daily living (e.g. escort to pharmacy, shopping) ********** Cascade Health Alliance, PacificSource Central Oregon	**Early childhood health and preventing abuse:** Work with policymakers to advance awareness of lifetime social and economic impact of child maltreatment, to ensure support for programs to reduce maltreatment (i.e. Nurse Family Partnership, Healthy Families) ********** PacificSource Central Oregon	**Convene cross-sector partners around an issue** including Child Abuse System Task Force; education-related partners to address health improvement strategies for students; and partners to address child poverty ********** PacificSource Central Oregon	**Data/mapping to identify community issues:** Using GIS technology and other mapping software, describe points of food access for all communities in service region ********** Columbia Pacific	**Collaborate on programs and service provision:** Cross-sector partnerships to secure funding and provide services for healthy food ********** PacificSource Columbia Gorge	**Train staff** on trauma-informed care; ACES, health equity; social determinants of health ********** Cascade Health Alliance; InterCommunity Health Network; Primary Health of Josephine County; Yamhill Community Care; Columbia Pacific; Jackson Care Connect; Willamette Valley Community Health; Umpqua Health Alliance
Bridges to Health: Pathways Hub model that uses "community care coordinators" (e.g. community health workers) to connect individuals to care and social resources. (note – model uses braided funding through health-related services, health council, CCO, grants, etc.) ********** PacificSource Columbia Gorge	**Food insecurity/access to healthy food:** Veggie RX (providers write prescriptions for vegetables); farmers market		**Provider/Community training:** Conduct trauma/resilience training to address ACES in clinical and non-clinical settings (e.g. schools); educate/train providers, reduce wait times for victims of person crimes or abuse, and increase patients seeking follow-up care; providers integrate ACE and resilience scores into well child visits to inform anticipatory guidance ********** Columbia Pacific; InterCommunity Health Network; Health Share of Oregon	**Healthy food system:** Modify beliefs and create sustainable policies that eliminate constraints to creating a regional healthy food system ********** Columbia Pacific		**Survey members/review data identify disparities and social determinants of health in membership:** Comprehensive survey; evaluate ER data to identify disparities by race, ethnicity, and residential location ********** Health Share of Oregon; Umpqua Health Alliance	**Align goals/policies with community stakeholders:** Promote policies that support universal screening tools, data sharing, and service coordination between health/education partners; adopt at least one early learning goal in addition to developmental and screening rates; implement policies adopted in Central Oregon 10-year Homelessness Plan; collaborate with early learning hub to promote parent-child reading at well child visits ********** PacificSource Central Oregon; Umpqua Health Alliance	**Train CACs** in social determinants of health and applications to CHA/CHIP work ********** Western Oregon Advanced Health

*Project/initiative information is not exhaustive. Information gathered from OHA Transformation Center CCO Reports and Good Ideas Database (including Transformation and Community Health Improvement Plans, as well as Transformation Fund Grant reports and miscellaneous reports of CCO innovations). Health-related services data pulled from separate survey report and not tied to specific CCOs.

November 29, 2017

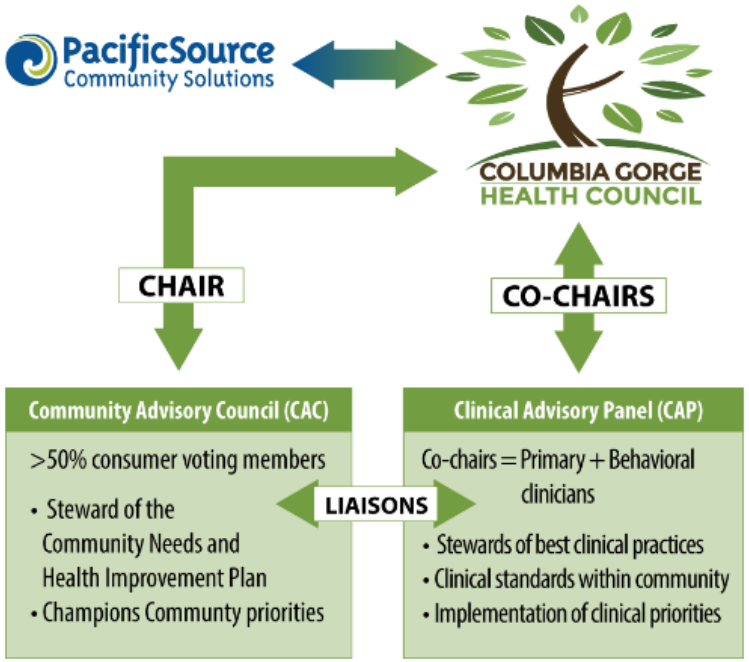
Direct Investment	Utilize health-related services	Alternative Payment Models/Value-based Payment	Workforce	Policy/government relations	Convener	Data/analytics support	General alignment/collaboration	Internal training/infrastructure changes to support SDOH activities
Implement a Healthy Homes Demonstration Pilot ********** Columbia Pacific	**Transportation assistance:** bicycles, car repairs, car seats, vouchers for gasoline		**Integrate health care staff into local social resources:** Integrate housing and health services through partnership with local affordable housing communities ********** InterCommunity Health Network	**Transportation:** Advocate at the city or state level to improve transportation safety and options ********** Columbia Pacific; Trillium		**Provide data/technology supports to partners:** Create registry of ASQ-SE (Ages and Stages Questionnaire); Partner with Oregon Food Bank to assess impact of healthy food access on health, economy ********** Willamette Valley Community Health; Columbia Pacific		**Learning Collaborative** on trauma-informed care ********** Jackson Care Connect
Provide crisis respite services to member children through partnership with Partner with Morrison Child & Family Services ********** InterCommunity Health Network	**Employment:** employment services for members with substance use disorders		**Community service/involvement opportunities for members**: targeted to youth involved in juvenile justice programming ********** PacificSource Central Oregon	**Engage community partners in systems change:** Increase participation by local food retailers in "Fresh Alliance" program, donating fresh foods to local food pantries ********** Columbia Pacific				**Compensate members** to participate in CAC ********** Eastern Oregon CCO
	Crime and violence: abuse prevention		**Individualized case management** for at-risk youth to decrease further involvement in juvenile justice system ********** PacificSource Central Oregon					
	Education: parenting programs		**Recruitment/training of mentors** (including peer mentors) for youth to increase protective factors and encourage positive life choices ********** Columbia Pacific					
	Multiple SDOH: community health worker hub							

*Project/initiative information is not exhaustive. Information gathered from OHA Transformation Center CCO Reports and Good Ideas Database (including Transformation and Community Health Improvement Plans, as well as Transformation Fund Grant reports and miscellaneous reports of CCO innovations). Health-related services data pulled from separate survey report and not tied to specific CCOs.

Columbia Gorge Health Council/Pacific Source Columbia Gorge

Coco Yackley, Operations Manager

Oregon Health Authority



Using the Coordinated Care Organization structure we…

- …..“turned an ordinary requirement from Oregon lawmakers into an extraordinary opportunity to improve the health and wellness of all residents.”

  -RWJF Culture Of Health Prize

- Columbia Gorge CCO =
  - PacificSource (Health Plan)
  - Columbia Gorge Health Council (501c3)
  - Medicaid (low income) client
  - ~25% of residents; +50% of kids
  - Hood River & Wasco Counties

For More Information Contact:
Suzanne Cross, MPH, CHW
Snr. Program Manager
Suzanne@gorgehealthcouncil.org

Bridges to Health Pathways Community HUB

The Columbia Gorge's implementation of the Pathways Community HUB model

Funding provided by:

Columbia Gorge CCO-(Columbia Gorge Health Council and PacificSource Community Solutions), Meyer Memorial Trust, Oregon Community Foundation, PacificSource Foundation, PacificSource Health Plans, Providence Clinical Transformation Council, Providence Hood River Memorial Hospital

Pathways is centralized system that coordinates, tracks and measures both the process and the resources that allow for Community Care Coordination of those served.
Pathways ties payments to milestones that improve clients health and well being.

Sarah Redding, MD, MPH, co-developed the Pathways Model with her husband, Mark Redding, MD, in 2001 and successive work led to the Pathways Community HUB Model

The Pathways Model Overview:

- Community Care Coordination with clients **outside the office** walls
- Uses a skeleton of steps (in a Pathway) to meet an **outcome**
- A **closed loop** system using **shared measurements**
- Recognizes the importance of **social issues & health issues**
- Uses a "**hub**" (neutral clearinghouse) and **many agencies**

Bridges to Health

CORE PATHWAYS (Needs)

- Behavioral Health
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Food
- Immunization
- Pregnancy
- Postpartum
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication
- Smoking Cessation
- Social Service Referral (transportation, debt management, utility assistance, legal, documentation, etc.)

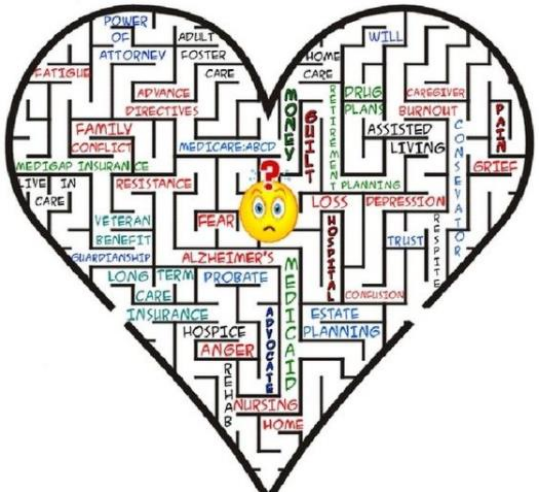
Bridges to Health Pathways Community HUB:

TARGET POPULATION: "HOUSING CHALLENGED"

Doubling up, transportation concerns, DHS custody related, inadequate square footage, struggling to cover rent, at risk of losing home, unsafe housing situation, homeless, etc.

PROGRAM GOALS:

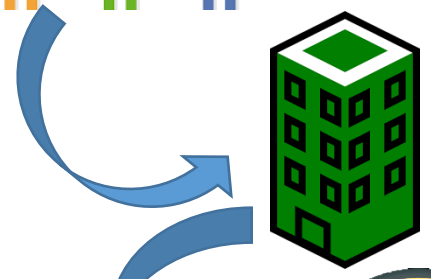
- Ability to address the needs of the **HOUSEHOLD**
- Build on community strengths and collaboration
- Limit duplication of services
- Standard process regardless of agency (CLARA software)
- Data-driven decision making



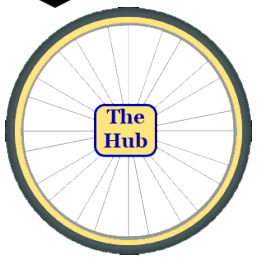
Workforce:

Community Care Coordinators- CCC's:

Community Health Worker (CHW certification or equivalent)



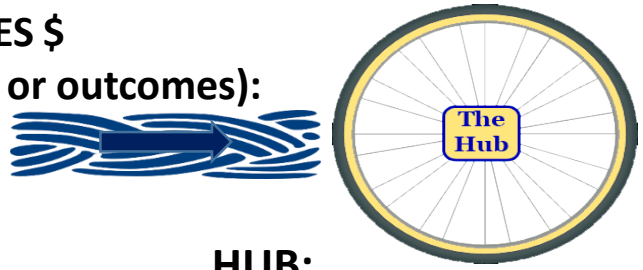
Employed by Community Care Agencies (CCA's)



Paid by HUB (based on time or outcome)

HUB Payment Structure:

$ FUNDING POSSIBILITIES $
(may cover populations or outcomes):
Grant Funding
Health Plans
Hospital Foundations
Local Government Funding

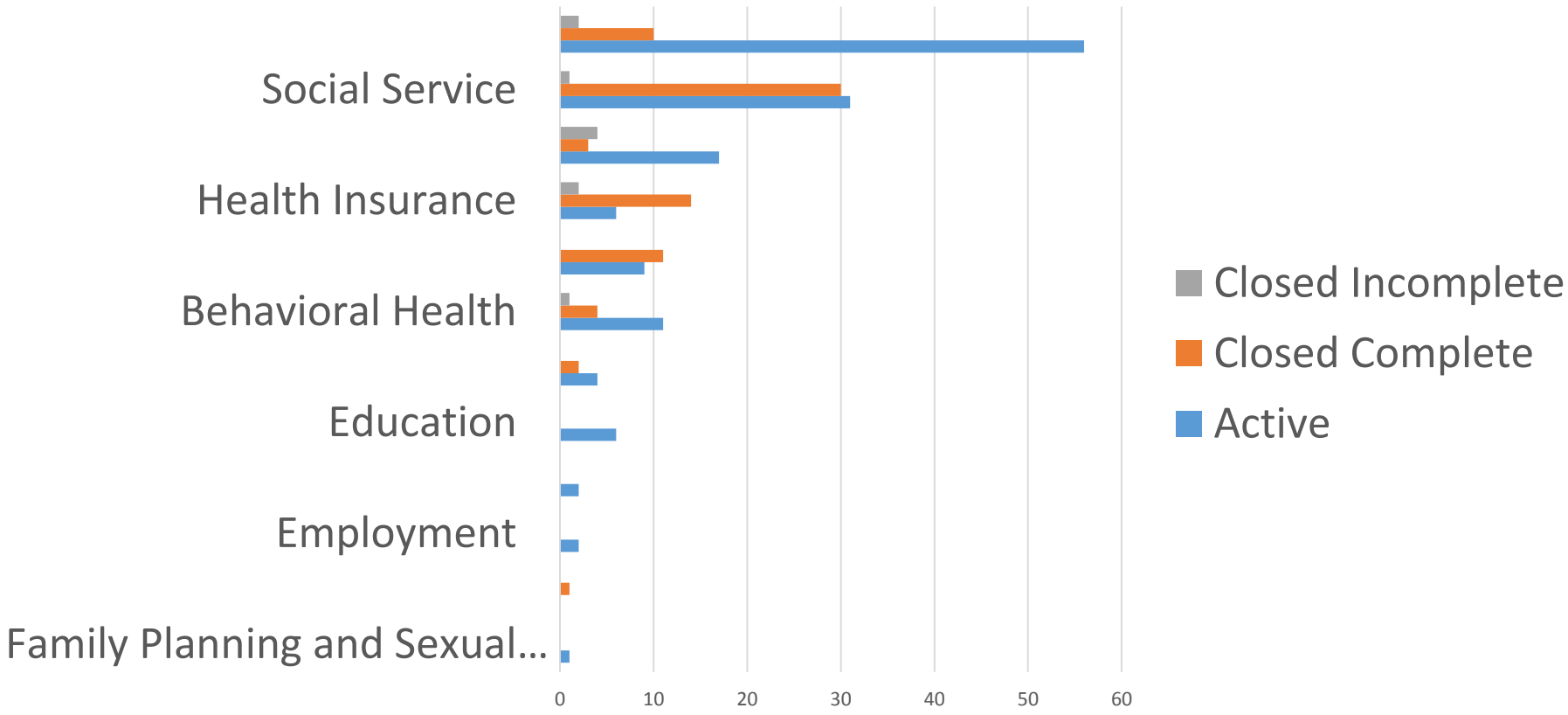


HUB:

- **Braids funding to cover payments for the work (outcomes)**
- **Tracks demographics of clients/outcomes to ensure payments go to the right population per funding mechanism**

Community Care Agencies (CCA's) employ Community Care Coordinators to provide services to clients

Pathways of Current Bridges to Health Clients



Responsibilities of the Bridges to Health HUB:

- General Infrastructure:
  - Support & Training (Model, Software, Hosting a Community of Practice)
  - Monitor quality improvement
  - Reporting
  - Evaluation & Research
- Software and data management
- Fiscal oversight and staffing to constantly move towards ongoing sustainable funding mechanisms

Thank you!

- Academy Health/ CHCS/ Nemours
- Columbia Gorge Health Council
- Gorge Grown Food Network
- Hood River Health Department
- Hood River School District
- Mid-Columbia Children's Council
- Meyer Memorial Trust
- Mid-Columbia Medical Center
- Mid-Columbia Housing Authority
- North Central Public Health District
- North Wasco Co School District
- Oregon Community Foundation
- OSU Extension Services
- PacificSource Community Solutions
- PacificSource Health Plans
- PacificSource Foundation
- Providence Clinical Transformation Council
- Providence Hood River Memorial Hospital
- The Next Door, Inc.
- Work source Oregon

Trillium Community Health Plan®

Creating a Healthy Community

Medicaid Advisory Committee
November 3, 2017

Creating a Healthy Community

- CHIP 2.0
- Community Benefit
- Program Evaluation
- Prevention
- Lane Kids

CHIP 2.0

Community Health Assessment-collaboration with Lane County, PeaceHealth, United Way

- State of Lane County Health
- What we learned

Action plan to improve health core focus areas:

- Increase economic and social opportunities
- Increase and promote healthy behaviors to improve health and well-being

Community Benefit

Increase economic and social opportunities

Cornerstone Community Housing

Healthy Homes Program

Centro Latino

Wrap around services for Spanish speaking families

Medical Recuperation Program

Collaboration with PeaceHealth and Sheltercare

Data Sharing/Program Evaluation

- Community partner keeps registry
- CCO looks at utilization and cost pre- during- and post-program
- Expected movement direction
- Compare with similar population not in program

Evaluation Challenges

- Small sample sizes and outliers
- Enrollment gaps/churn
- Sufficient enrollment

Evaluation Example

SC Stay	Members	Days	ED	UC	BH	PCP	IP	Cost
Before	32	161	877	47	1,499	758	284	$5,502
During	32	46	836	21	1,483	1,233	42	$1,625
After	24	107	821	48	2,560	905	167	$3,676

- Costs were 60% and 33% lower during and post-ShelterCare stays, respectively
- Inpatient rates were 85% lower and 40% lower during and post-ShelterCare stays, respectively
- Little impact on ED utilization
- Behavioral and primary care utilization increased dramatically

Prevention

Increase and promote healthy behaviors

$1.33 PM/PM-Unique public/private partnership

Staff positions at Lane County H&HS

CAC Prevention committee

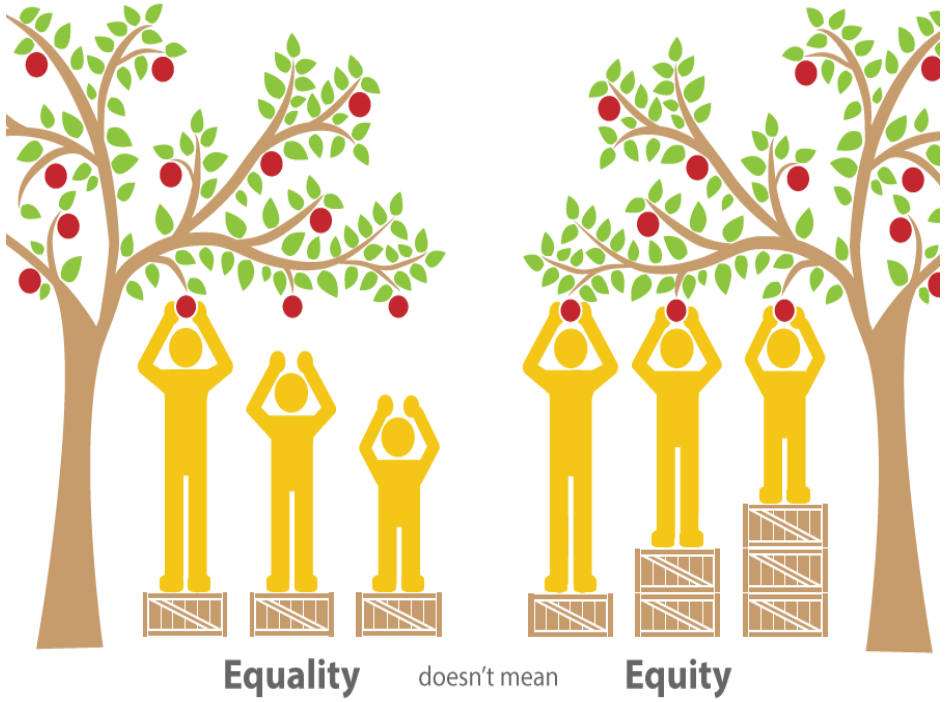
Prevention Program Summary

- Tobacco-GBG, QTIP
- Obesity-Double Up Food Bucks, CATCH
- Mental health-Family Check-up, parenting series
- Lane Kids-Triple P

SO Health-E, AllCare, and Jackson Care Connect

Our Mission…

To advance **policy, systems, and environmental changes** that promote **equity** and address the **social determinants of health**. We prioritize health disparities for underrepresented populations, including racially and ethnically diverse communities, people with disabilities, gender and sexual minorities (GSM), and low-income individuals.



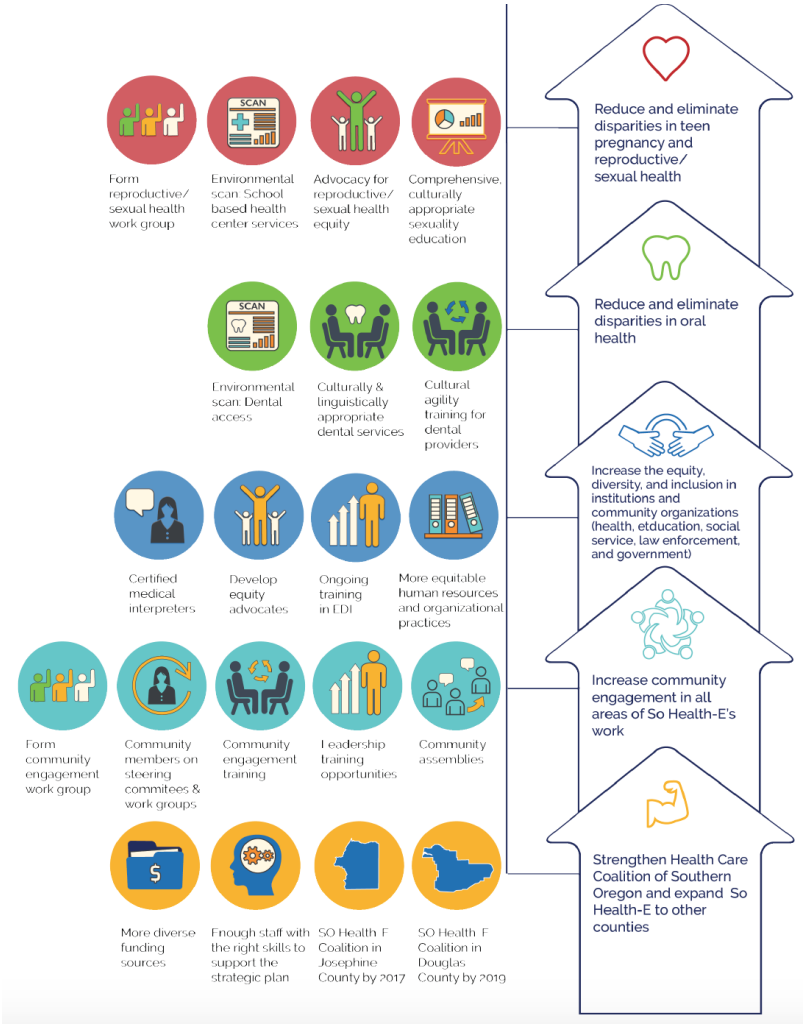
Health equity means that we all have equal opportunity to live healthy and fulfilling lives, that we are able to reach our full potential, and that barriers (based on race, gender/sexuality, income, disability, etc.) to achieve that potential are effectively removed.

Jackson County Steering Committee Chair (far left) Carolina Castañeda del Río and other RHEC coordinators talking with Senator Steiner Hawyard about what the RHECs do!

HCCSO's Community Engagement Advocate Annie Valtierra-Sanchez facilitating a SO Health-E community engagement event called Conozca a sus Oficiales!

RHECs help diverse communities **build on their capacity** to work with **policy and decision makers**, **coordinated care organizations** (CCOs), and other **health systems** to address systemic inequalities that are barriers to communities realizing their full health potential.

SO Health-E Strategic Priorities



Social Determinants

- Housing
- Transportation
- Education
- Oral Health
- Physical environment/Nutrition
- Health Interpreters
- Reproductive Health
- Health Equity/Cultural Agility

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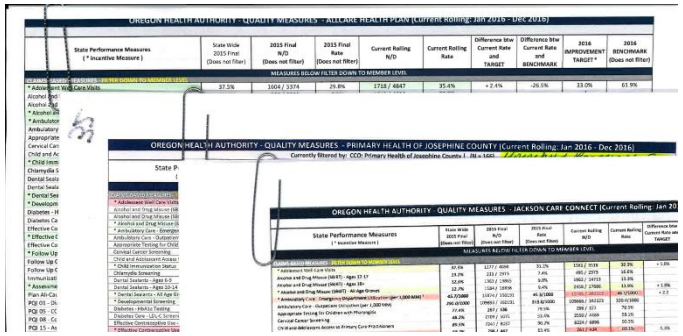
PRESENTATION BY
OREGON DEPARTMENT OF EDUCATIONS
ELY SANDERS

KEY LEADERS TRAINING -
UNDERSTANDING HEALTH EDUCATION AND PREVENTION

PrimaryHealth

THE NONPROFIT ASSOCIATION OF OREGON



Jackson Care Connect

Leading for Equity and Inclusion

A southern Oregon peer learning cohort for rural-serving nonprofit leaders

Thank you!

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Jovita Castillo
CastilloJ@careoregon.org

Stick Crosby
Stick.Crosby@allcarehealth.com

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Social Determinants of Health

Changing healthcare
to work for you.

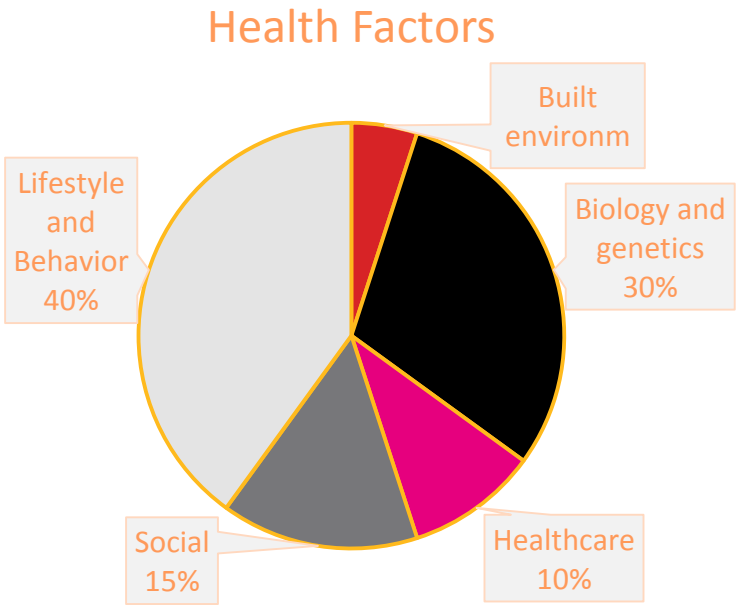
Certified B Corporation

Social Determinants

Education
Housing
Utilities
Natural Environment
Build Environment
Nutrition
Transportation
Violence
Income

Housing
Utilities
Nutrition
Transportation
Violence

Education
Housing
Community Engagement



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~~Silver Bullet~~ *Silver Buckshot*

As a team, company, community, and as individuals, our goal is to tackle interconnected problems concurrently to make the greatest impact for the most people as quickly as possible.

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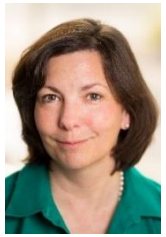
ACEIT Team

AllCare Community Engagement and Investment Team



Cynthia Ackerman, RN
Chief Quality Officer

Built this team and oversees our work in the community

Lana McGregor
Behavioral Health Integration Manager

Oversees and advises all mental and behavioral health integration investments

Andi Ross
Finance Manager

Advises funding methods and policy and budget insight for investment opportunities

Kelley Burnett, D.O.
Associate Medical Director

Provides clinical expertise addressing SDoH in children and families

Laura McKeane
Oral Health Integration Manager

Provides expertise in oral health integration and oversees oral health investments

Sam Engel
SDoH Coordinator
ACEIT Team Facilitator

Oversees housing and nutrition investments and provides integration coordination

Kari Swoboda
Wellness Programs Supervisor

Oversees and advises CHIP integration and Health and Wellness investments.

Susan Fischer
Health and Education Integration Coordinator

Oversees and advises early childhood and education investments

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Oral Health Integration

"Kids that are 0-3 will see their pediatrician 11 times in the first three years of life but most won't see a dentist at all."

-Laura McKeane

Oral Health Integration

- 4x more children 0-6 received Oral Health Assessments at their pediatricians' office with AllCare than with the next highest CCO
- Oral Health included in Care Coordination
- Family oral health education
- Fluoride varnish applied in the providers' offices
- Family practice integration initiative in progress with Oregon Oral Health Coalition

First Tooth Program:

- 250 medical staff trained in all three counties
- Developed dental referral materials
- Over 2,000 children served

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Education and Family Strengthening

"Good things will naturally grow, they don't have to be mandated."

- Teresa Sayre

PAX Good Behavior Game

Trauma Informed School Districts

Support of CASA, Foster Parents, and DHS Child Welfare

Family Strengthening Programs

Cradle to career initiatives

Boys & Girls Club and other youth development programs

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Housing Partner: **Rogue Retreat**

ROGUE RETREAT
Restoring Lives

Many types of housing makes for adaptive service

- Second-chance housing
- Diverse array of options
- Strong case-management
- Evolving investment model
- Member-centric

Research and Evaluation

Internal evaluation and reporting

Third-party external review

- Health outcomes
- Healthcare costs
- Social Determinants improvements
- Member / partner satisfaction
- Engagement
- Sustainability
- Economic impact

SDoH – Quality Metrics – APMs

These three tools, your SDoH foci, Quality Metrics, and provider APMs can work together to be mutually informative and supportive and promote behavior change in the community.

- APMs linked to Quality Metrics
- Quality Metrics used to inform SDoH investments
- Feedback from providers used to prioritize SDoH
- SDoH investments targeting QM and APM areas
- QM and AMPs can be targeted to SDoH needs

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SDoH – Quality Metrics – APMs

Project Baby Check and Siskiyou Pediatric Care Coordinator:

QM: Developmental Screening
Childhood Immunizations
Adolescent Well-Care

APM: Developmental Screening
Childhood Immunizations
Adolescent Well-Care

SDoH: Home environment
Transportation
Trauma-informed
Screenings and assessment

Smoking Cessation:

QM: Smoking Prevalence

APM: Smoking Prevalence
Member Satisfaction

SDoH: Smoking Prevalence
Assessment
Member Satisfaction

Transportation:

QM: Developmental Screening
Childhood Immunizations
Member Satisfaction
ED Visits

APM: Developmental Screening
Childhood Immunizations
Member Satisfaction
(Provider Satisfaction)
ED Visits

SDoH: Trauma-informed
Food security/nutrition
Isolation
Transportation

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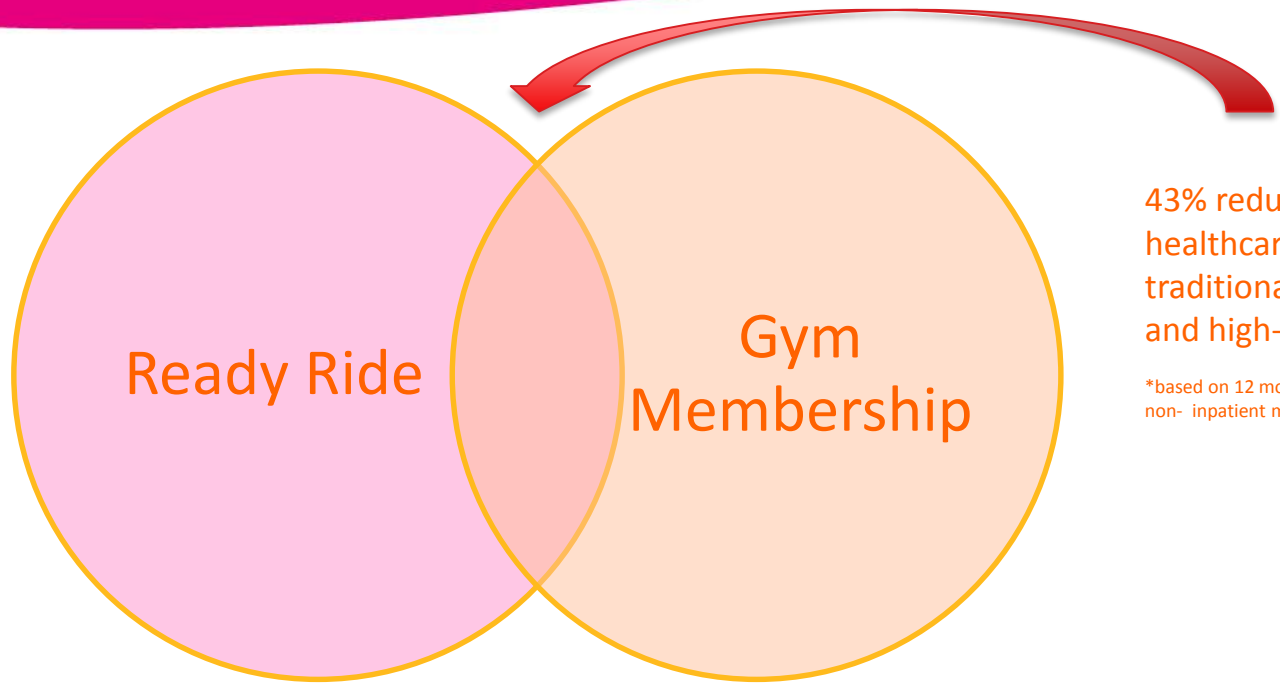
Thank you for the opportunity to share our thoughts and approach to SDoH work and for engaging in this work in your own communities.

If the goal is to improve individual lives and outcomes, therefore improving community wellness; then collectively, we are improving community health as part of making Oregon, as a whole, a healthier state.

Compounded Benefits: Transportation and Fitness



43% reduction in healthcare costs for a traditionally underserved and high-risk population.*

*based on 12 months of fee-for-service non- inpatient medical claims.

QM: Member Satisfaction
APM: Provider and Member Satisfaction
SDoH: Transportation, preventative wellness, fitness, TI

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And with that…

Certified B Corporation

A Healthy Community for All

Health Related Services Investments

Medicaid Advisory Committee

December 2017

Health Share of Oregon

Commitment to Health Equity

Health Share's mission is **to partner with communities to achieve ongoing transformation, health equity, and the best possible health for each individual**.

Everything we do is designed to address a social determinant of health– poverty.

Health Related Services

Two types:

1. Flexible Services
   - Targeted interventions for individual members that supplement covered benefits

2. Community Benefit Initiatives
   - Investments in broader programs that improve population or community health

Flexible Services

- Partnership with Project Access Now (PANOW)
- All Health Share health plans can use Clara system
- Online system allows care coordinators to authorize flexible services for patients

Flexible Services Examples

HEALTH SHARE CATEGORY	EXAMPLES OF SERVICES
1. Training/Education for health improvement or management	Class on health meal preparation or diabetes self-management curriculum
2. Self-help or support group activities	Postpartum depression programs, Weight Watchers groups
3. Home/Living environment items or improvements or non-DME items to improve mobility, access, hygiene, etc	Air conditioner, athletic shoes, or other special clothing
4. Transportation not covered under State Plan Benefits	Ride to a gym, cooking class

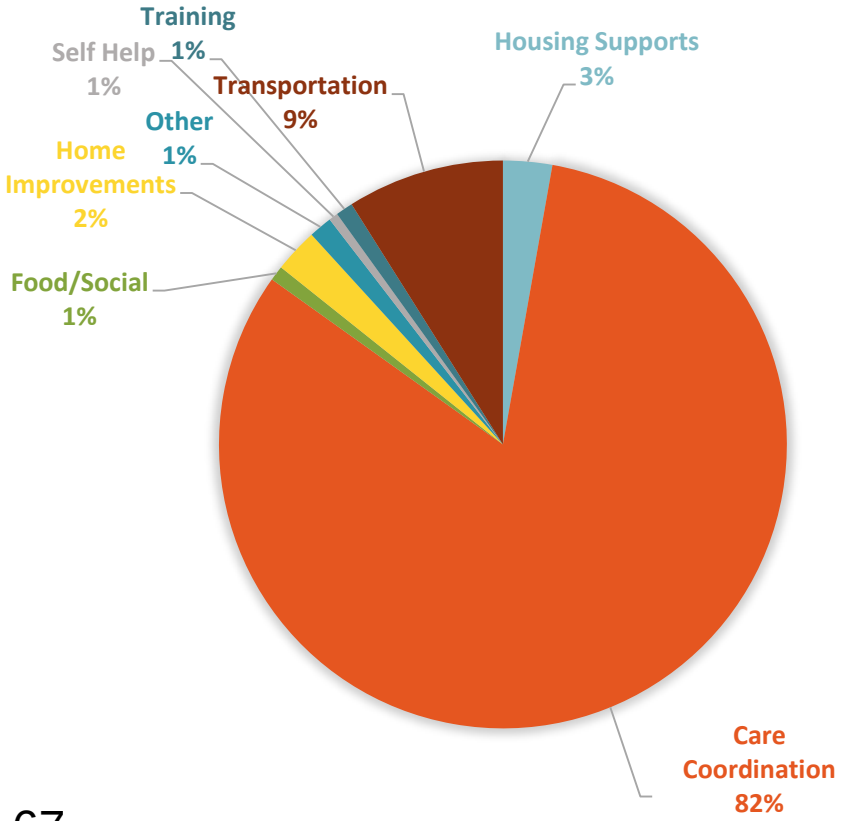
Flexible Services Examples

HEALTH SHARE CATEGORY	EXAMPLES OF SERVICES
5. Housing supports related to social determinants of health	Shelter, utilities, critical repairs, short term rental assistance
6. Care coordination or case management activities	High utilizer intervention programs
7. Assistance with food or social resources	Meals on Wheels
8. Other	Cell phones, Visa gift cards to purchase health-related support items not available through the other categories.

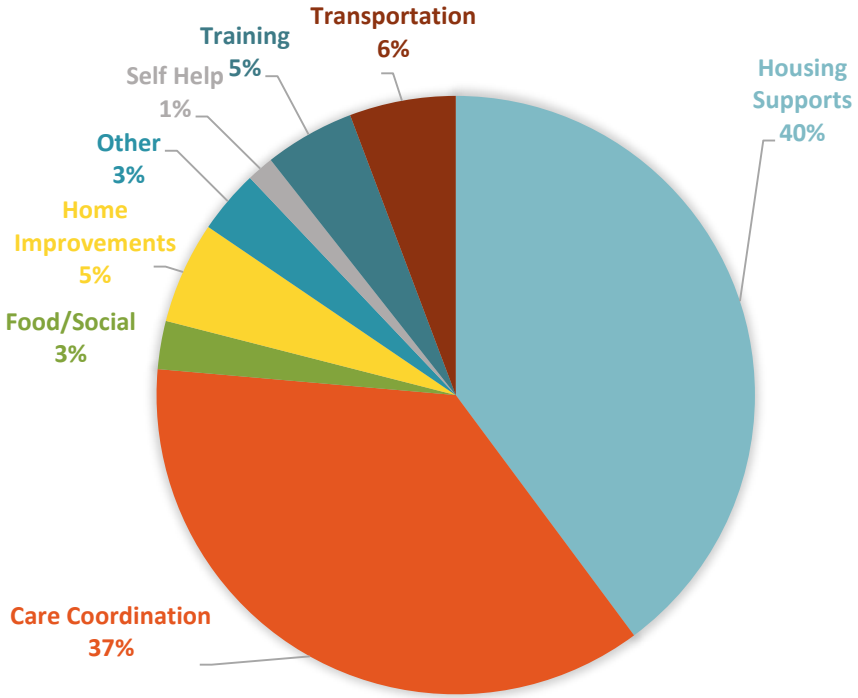
Flexible Services Delivered

2016 Q1 - 2017 Q2

SERVICES BY MEMBERS SERVED



SERVICE CATEGORIES BY COST



health share
Health Share of Oregon

Barriers to Flexible Services

- OHA rules and financial reporting requirements in flux for 5 years
- Provider education
- Lack of guidance from OHA around how to show return on investment

Community Benefit Initiatives

- Highlights from current investments
  - *Medical Legal Partnership Pilot*
  - *Community Health Worker Infrastructure Investment*
- Ready + Resilient Strategic Plan for 2017-2020

health share
Health Share of Oregon

CBI Highlight: Medical Legal Partnership

- Medical Legal Partnership (MLP) is a model that integrates legal services into the health care setting to address legal issues that affect health
  - *Ex: Substandard housing where housing codes are not enforced*
- Also includes transforming health care delivery and focus on public policy to affect population health

CBI Highlight: Medical Legal Partnership

- Health Share piloted the first Medical Legal Partnership in Oregon
- Partnership with OHSU's Richmond Clinic
- In it's first 10 months, the MLP pilot served **154 clients** with **217 distinct legal issues**
- Producing an evaluation of the pilot in 2018 to encourage statewide adoption

CBI Highlight: CHW Workforce Infrastructure

Community Health Worker

Community health workers are trusted members of their community. CHWs serve as a link between individuals and communities with health and social services to improve quality and cultural competence of service delivery.

CBI Highlight: CHW Workforce Infrastructure

Community Health Workers & Social Determinants of Health

Culturally specific and community-based CHWs have increased success building relationships with and connecting Medicaid members to services addressing social determinants of health and improving health outcomes

CBI Highlight: CHW Workforce Infrastructure

$3.3 Million Investment in Infrastructure

- Workforce Development
- CHW Integration
- Technical Assistance
- (ORCHWA) Internal Capacity

Goals:

- **Support workforce stability** and improvement in outcomes through standardized training, professional development and supervision.
- Create a platform to **build necessary information technology** enabling documentation of CHW efforts in a standardized way and evaluates outcomes.
- Create and sustain an **infrastructure** that enables various systems to reliably contract for culturally specific and community-based CHWs.
- Identify a **sustainable payment model** that values community-based community health workers, increasing capacity and support of culturally specific community-based CHWs.

Ready + Resilient

Start Strong: Children are ready for kindergarten, and families are connected to the health and social resources they need to thrive.

Support Recovery: People are able to access quality mental health and substance use services delivered by a trauma-informed workforce when and where they need them.

Share Health: Our equity first approach prioritizes eliminating health disparities for future generations.

Start Strong

Strategy 1: Improve quality and quantity of screening of women and children in health care and community settings

Strategy 2: Build and enhance clinical and community interventions and referral systems

Strategy 3: Improve systems of care for populations with complex needs

Support Recovery

Strategy 1: Strengthen the Behavioral Health Workforce

Strategy 2: Improve the Substance Use Disorder system of care

Strategy 3: Improve the availability of information across care settings

Share Health

All six strategies have **health equity** elements built in to the key outcomes, tactic, metric, or activity level.

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Health Share of Oregon

Together we are

health share

Health Share of Oregon

XIII. Appendix G: SDOH Program Spotlights

Patient-Centered Primary Care Homes (PCPCH)

The PCPCH model includes many aspects that lend it to work to address social determinants of health, including an emphasis on whole person care and care coordination, with a primary care provider as the epicenter of care. About 46% of PCPCHs (283/618) have attested to standard 5.E.3: PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, traditional health workers, and pharmacy services. CCOs could ensure members are connected to a PCPCH, and could explore incentives or other value-based payment strategies for PCPCHs that encourage connection with social referral resources.

Community Health Workers

Under the CCO model, members must have access to community health workers and other advocates part of a member's care team that provide assistance that is culturally and linguistically appropriate to the member's need (414.635 (1)(c)). The American Public Health Association defines a community health worker as a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CCOs can support and utilize community health workers in a variety of ways. For example, in the Pathways model, such as Columbia Gorge Health Council's Bridges to Health program, a care coordination HUB connects members with community health workers and other care coordinators to address their health and social needs. Eastern

Oregon CCO has adopted and posted a policy for FFS reimbursement of community health workers for specific functions, including home visiting, though reimbursement for social service related functions is limited. CCOs can also use health-related services to support community health worker case management for populations that are not currently covered in the Medicaid state plan.

Oregon Pediatric Improvement Project – Health Complexity Score

The Oregon Pediatric Improvement Project (OPIP) and OHA have been partnering to develop a health complexity score for children with complex health care needs. The "health complexity score" combines medical factors (medical risk score) and social factors (social risk score) into a total score for an individual child's health. Social factors include factors such as poverty, child welfare system involvement, and limited English proficiency. OHA is aiming to share health complexity data with CCOs in 2018. CCOs could use this data in a variety of ways, including sharing risk scores with providers to aid in screening and other SDOH initiatives, and incorporating scores into value-based payment methodology to factor in social risk of a population.

XIV. References

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STATE ACTIONS TO SUPPORT AND HOLD CCOS ACCOUNTABLE TO ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH: RECOMMENDATIONS TO THE OREGON HEALTH AUTHORITY

On April 25, 2018, the Medicaid Advisory Committee approved a set of recommendations on addressing the Social Determinants of Health (SDOH) through Oregon's Medicaid model. The recommendations included:

- An explanation of why it is important to address the SDOH through Oregon CCOs
- Standard definitions of SDOH and social determinants of health equity that can be used for all Oregon CCOs
- A set of general recommendations for CCOs when addressing SDOH
- A set of roles that CCOs as health care plans can play addressing SDOH

These recommendations defined actions that could be taken by Oregon CCOs to increase their impact and engagement in improving SDOH factors, such as housing, or food insecurity, in their communities, including:

- CCOs address SDOH with the primary purpose of improving health equity
- CCOs support, leverage, and augment existing internal (CCO), community, and provider efforts and capacities to address SDOH, in order to increase the effectiveness of these efforts
- CCOs build from their roles as the main Medicaid payer in a community, and use the unique tools (health-related services, value-based payment) provided by the CCO model to spend funds on SDOH
- CCOs support health care teams and community partners in working together and with patients to identify and address the SDOH challenges patients face and would like help to resolve
- CCOs address SDOH in a way that promotes person and family-centered care, including tailoring SDOH efforts around member needs and desires

For its CCO recommendations to be most effective, the MAC urges OHA to use the upcoming 2020-2025 contracting cycle with CCOs to support and hold CCOs accountable to addressing SDOH in line with each of the MAC's five general recommendations (above):

Increase tracking of CCO SDOH initiatives and policies, spending, and outcomes data, and share information publicly to identify best practices and areas for improvement. From increased tracking and data, establish clear goals and metrics to assess CCO spending and work on SDOH and equity.

To inform its recommendations, the MAC was able to gather anecdotal evidence of CCO efforts related to the SDOH through CCO presentations, a survey, and examples from CCO Transformation Plan reports. However, comprehensive state-level data on initiatives, policies, spending, and outcomes, is not available. This lack of data leads to challenges understanding and assessing best practices and identifying areas for improvement. The MAC recommends OHA establish a reporting and tracking system of CCO work to address SDOH factors, and to make this information publicly available. Further, the MAC recommends using this system to understand impact of efforts and establish clear goals and metrics for success for the system.

Increase expectations for CCOs to assess health inequities and establish infrastructure and systems to improve health equity

The MAC recommends that CCOs address SDOH with the primary purpose of improving health equity. To support this work, OHA should establish clear expectations that CCOs assess health inequities in their communities through the existing community health assessment process. Additionally, OHA should require CCOs to establish the critical infrastructure necessary to improve health equity and address social determinants of health, including increasing cultural competency among leadership, staff, and provider networks, and communicating via a plan, staff, or other process the CCO's approach to considering equity in its SDOH work.

Ensure CCOs are investing savings and profits back into the community to impact SDOH

One of the primary goals of the CCO model is to improve community health. In line with recently passed legislation – HB 4018 – the MAC encourages OHA to implement strong requirements to ensure that savings and profits gained by CCOs are used to further improve the health of communities in which they are based. Reinvesting savings into addressing the social determinants of health can create even more cost savings for the health care system and other state systems, and will support Oregon's ongoing efforts to bend the health care cost curve and improve population health.

Strengthen requirements for Community Health Assessments (CHA) and Community Health Improvement Plans (CHP) to ensure CCOs work with appropriate community partners and include SDOH and equity strategies in their CHPs

The MAC recommended that CCOs collaborate with community partners and leverage community health assessments and community health improvement plans to ensure SDOH activities align with community needs and priorities. To support this recommendation, OHA could strengthen requirements for community collaboration to create community health assessments and community health improvement plans. OHA could also encourage CCOs to assess SDOH factors in their community health assessments and include these in community health improvement plans.

Establish clear expectations that CCOs have the connections and relationships in the community necessary to advance community-driven work in SDOH (e.g. community based organizations, social service organizations, and public health, etc.)

Much of the work to address the social determinants of health is led by organizations and sectors outside of the health care system, including social service entities, community based organizations, public health, and others. Additionally, a CCOs provider network can play a key role in identifying social needs and connecting members with social service resources. The MAC recommended that CCOs support, leverage, and augment these

existing efforts to address SDOH, rather than establish separate efforts. OHA can support this recommendation by establishing clear expectations that current and future CCOs form and maintain meaningful community partnerships to advance this work.

Provide SDOH learning and information sharing opportunities for CCOs to promote replication and scaling up of SDOH efforts

CCOs have already begun addressing SDOH through various initiatives, investments, and partnerships. While SDOH needs and resources will vary community by community, providing opportunities to share lessons learned and challenges from this work can improve statewide impact.