

ADDRESSING SOCIAL DETERMINANTS AND HEALTH EQUITY: RECOMMENDATIONS TO THE OREGON HEALTH AUTHORITY

June 13, 2018

Patrick Allen, Director, Oregon Health Authority

Zeke Smith, Chair, Oregon Health Policy Board

Dear Director Allen and Chair Smith:

The Health Equity Committee of the Oregon Health Policy Board has reviewed the social determinants of health workplan and policy options as part of the next phase of Coordinated Care Organization (CCO) contracting – hereby termed CCO 2.0. We want to formally submit our reactions to the plan, strategic thinking around this body of work, and our agreement with the recently shared Medicaid Advisory Committee definition for the social determinants of health and equity.

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. [MAC definition as of April 25 2018]

Our alignment with this definition has helped ground our own committee in the recommendations to CCO 2.0 we want to provide in response to questions below:

- 1. How can OHA encourage CCOs to invest more in social determinants of health & equity work, and hold CCOs accountable for these investments?**
 - a. Additional ways to promote CCO use and reporting of Health-related Services (HRS)**
 - i. Find ways to ease administrative burden and time required by providers/clinics to request HRS funding. Develop set of clear guidelines based on:
 1. examples where funding has been used successfully in the past

2. focus groups with CCOs around barriers to using HRS

Of note: It will be important to consider whose role this is (OHA, CCO Oregon, new group) and appropriately resource the development of these guidelines.

b. Requirements or other ways to promote or increase spending related to social determinants of health and equity (SDOH&E)

- i. We are supportive of the concept of requiring a portion of a CCO global budget be spent on SDH&E. Recent research indicates addressing patients' social determinants of health and connecting them to appropriate social services could reduce healthcare costs by as much as 11%.ⁱ Not only is this a win for patients, providers and payers, but it's a sustainable way to address upstream needs. Using small grants/seed money does not create sustainable opportunity to address SDH&E or evaluate that funding for effectiveness. This requirement would only increase a CCO's foundational commitment to equity rather than a "lens" a CCO can take on and off.
- ii. We're supportive of the requirement that CCOs publish their SDH&E spending allocations and justification as a mechanism for accountability and to cross pollinate solutions that work in other areas of the state.

Of note: Just like HRS, CCOs will need guidance on the boundaries with this work. Initial global budget spending requirement for CCOs could be aggregated across the state to build staffing, resource a new or existing body to consider what type of projects would qualify as "SDH spending" for future years.

c. Community Health Improvement Plan (CHIP) implementation requirements/expectations

- i. CHIPs are critical places where folks come together; consider encouraging CCOs to build on already existing CHIP/CHA plans developed by local health departments, hospitals and health systems. Work with hospitals and health systems to integrate their Community Benefit Plan Implementation Strategy into the CHIP. Or at a minimum, create space to fold these potentially conflicting plans together.

d. CCO incentive metrics that address SDOH & Equity

- i. Studies have shown very real increases in screening, interventions and referrals that are attached to incentive payments compared to those not.ⁱⁱ Support development of incentive metrics that are more upstream than what is currently in the metric pool.
- ii. Consider incenting a common screening tool to standardize and collect larger SDH data across the system. Researchers across the country are finding use in combinations of state-level, census or neighborhood-level *and* patient-reported SDH. We need all types of this data in combination with better sharing across systems to effectively use it.
- iii. Consider an incentive metric for health plans/CCOs that make incremental progress toward becoming 100% accessible and achieving their ADA Transition plans given over one fifth of Oregonian's report having a disability.ⁱⁱⁱ

Of note: It will be important to ensure there is community voice in the development of these metrics. Consider creating a consistent policy/structure around “how to build a new metric” that engages stakeholders, builds time for user-testing before go live, and requires Office of Equity and Inclusion staff participation.

e. Defining SDOH & Equity for CCOs

- i. We support the idea of a consistent definition across CCOs.

Of note: Given this work is cross-sectoral, consider creating space to define these notions more broadly across education, transportation, dept. of justice, housing, etc.

2. How do we strengthen CCO partnerships and ensure meaningful engagement to support social determinants of health and equity work?

a. Community Advisory Council (CAC) and Governance connections and representation

- i. Reconsider organizational structure of CACs to determine official capacity of the council to increase engagement. Options could include:
 - 1. dedicating funding to members so there is time/incentive to truly engage;
 - 2. empowering CACs to do outreach to communities and resource this work;
 - 3. encouraging several reps from one community for sustainability in turn over and conflicts during meeting time.
- ii. Develop a system whereby CAC is involved in reviewing reporting/spending on social determinants of health to ensure dollars are actually supporting community needs.
- iii. Use already strong local health departments, hospitals, health systems, and community-based organizations who understand the needs rather than developing separate assessments and/or already existing tools.
- iv. We support metrics and incentives for CCOs to provide ongoing funded partnerships with organizations working with communities experiencing health disparities and regional health equity coalitions, in order to strengthen local relationships and accountability to health equity and the social determinants of health.

Of note: Be cautious of putting this all on CCOs, cross-sectoral state offices should also be required to ensure this is happening.

Be cautious of CAC churn – hard to review CAC data and/or ensure meaningful engagement when folks are coming on and off the CACs frequently. Good opportunity to engage Office of Equity and Inclusion.

3. How do we better ensure provider cultural competency, language accessibility, a diversified workforce, and access to critical services across the state within a CCO and its provider network that reflects the population served by the CCO?

- a. CCO Internal workforce/infrastructure requirements (e.g. health equity position, health equity plan, cultural competency criteria) to coordinate and support health equity activities**
- i. In support of requiring each CCO have a leadership equity position, with budgetary oversight, to ensure opportunity to shift the culture and drive the work forward. Yet, you can dedicate positions but unless there are resources allocated the work in the community won't change. You need both the leadership and the funding from question 1 above.
 - ii. Require CCOs to develop a plan on how to diversify their own workforce to reflect the demographic composition of the community at all levels, and incentivize health centers to do the same.
 - iii. We support equity plans at the CCO level and encourage CCOs be given the freedom to develop these based on relevance to their communities and existing CHIP/CHAs.
 - iv. We recommend changing the language when referring to cultural competence – no one reaches competency nor can we train to that as a society. Cultural humility or responsiveness are more commonplace and respectful language in the field.^{iv}
 - v. Require CCOs perform accessibility assessments of clinical/hospital built-environment, medical/screening equipment, and provider/staff training around accessibility and inclusion. California health plans are currently required to do so.^v
 - vi. Require CCO's to fully adopt and implement the HB 2611 cultural competency training for health professionals and HB 2134 data equity standards.

Of note: The HEC could be involved in the development of the health equity plan templates for a high-level consistency across CCOs.

- b. Strengthening requirements for Traditional Health Worker contracting and utilization**
- i. Encourage development of a partnership between the THW commission and CCOs to aid removing barriers CCOs face to incorporate THW workforce.
 - ii. Support opportunities for CCOs to fund both items below in an effort to build out CHW/THW capacity within clinical and community settings (EOCCO^{vi} is already doing this and could be a strong example):
 1. billable services
 2. training and education

4. What changes can we make to improve our understanding of social determinants of health & equity initiatives and disparities?

a. SDOH & Equity Data and Accountability

- i. We strongly support the notion that equity needs to be a foundational block for CCOs and their work.
- ii. We encourage requirement or financial support of a population health “provider” or in-house data role at either clinic or CCO level to help guide collection of data, analysis of data, and development of needed programs to address inequities.

- iii. We support the development of a health equity index and request that HEC help drive this work from inception to implementation.
- iv. Consider opportunity to incent a standardized data collection tool on SDH and equity metrics across the system.
- v. Consider where existing SDH data may live: census tract level (neighborhood) and/or State run programs where that data is collected for client eligibility. Explore opportunity to data share across departments to decrease burden on clients/patients.

Of note: Currently, CCOs don't get info on sexual orientation, housing status, immigrant/refugee status. Either need access to these or a way to see de-identified data in order to better provide program planning. Access to data is a barrier.

We are happy to discuss further and kindly request follow up on what decisions are made and how the HEC can be helpful in describing or fleshing any policy options out further.

Sincerely,



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Co-chairs Health Equity Committee



Michael Anderson-Nathe

Cc: Oscar Arana, OHPB Liaison
Leann Johnson, Director Office of Equity & Inclusion
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ⁱ Pruitt Zachary, Emechebe Nnadozie, Quast Troy, Taylor Pamme, and Bryant Kristopher. Expenditure Reductions Associated With Social Referral Program. *Population Health Management* .<http://doi.org/10.1089/pop.2017.0199>

ⁱⁱ McConnell KJ. Oregon's Medicaid Coordinated Care Organizations. *JAMA*. 2016;315(9):869-870. doi:10.1001/jama.2016.0206. Accessed June 5, 2018

ⁱⁱⁱ OHSU Oregon office on disability and health report 2016. <https://www.ohsu.edu/xd/research/centers-institutes/oregon-office-on-disability-and-health/programs/upload/Oregon-Chartbook-2016-Draft5.pdf> Accessed June 5, 2018

^{iv} Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998 May;9(2):117-25.

^v Mudrick, N.R., Breslin, M., Liang, M., Jee, S. (2012). Physical accessibility in primary health care settings: Results from California on-site reviews. *Disability and Health*, 5, 159-167. Retrieved May 30, 2018.

^{vi} Eastern Oregon CCO Community Health Worker reimbursement policy <http://www.oregon.gov/oha/OEI/Documents/EOCCO-CHW-Policy.pdf>