Welcome

to

The Vision of Health-related Services & the Path Ahead

November 5, 2019

Oregon Convention Center

Oregon Health Authority

The Vision of Health-related Services

Lori Coyner, MA

Medicaid Director

Oregon Health Authority

Health-related Services: The Path Ahead

Chris DeMars, MPH
Director, Transformation Center

Oregon Health Authority

HRS examples

Yamhill CCO

- Supported parent coaching and education for 63 members within the Transitional Treatment Recovery Services homes
  - Focused on helping residents retain custody of children, close their DHS case, and remain clean and sober.

Trillium

- Provided “Family Check Up,” an evidence-based parenting education and skills-building program for 700 members.

HRS examples

Umpqua Health Alliance

- Provided transportation services for 254 members for Women, Infants and Children (WIC) appointments, Department of Human Services appointments, Alcoholics/Narcotics Anonymous meetings, court appearances, and grocery shopping.

Cascade Health Alliance

- Provided a year-long weight loss, exercise and healthy eating program to 232 members.

HRS examples

Eastern Oregon CCO

- Provided cribs and safe sleeping education to 220 members with newborns in an effort to prevent infant sleep-related deaths.

Health Share of Oregon

- Provided legal assistance 56 members facing housing eviction and other related issues.

Current HRS supports

- **HRS website: www.transformationcenter.org, "Health-related Services"** on left-hand side
  - HRS Brief: Posted 11/17, updated 7/18
  - HRS FAQ doc: Posted early 2018, updated 8/18
  - HRS & Housing guidance document: Posted 8/19, updated 9/19
- **Health.RelatedServices@state.or.us email**
  - Submit any HRS-related questions
- **Oregon Rural Practice-based Research Network convening calls**
  - Supported shared learning and best practices across CCOs on HRS
  - Developed topics for this meeting
- **This event!**

Planned HRS Guidance Documents

- Community benefit initiatives*
- Care coordination/case management*
- Exhibit L
- Health information technology
- Home and community-based services coverage
- HRS policies
- Medical interpreters
- Supporting healthy housing & addressing environmental concerns
- Permanent supportive housing
- Traditional health workers
- **OTHERS?**

*In development

Future HRS support and questions for OHA?

Discussion

- Think about other ways OHA can help support your HRS work. Write ideas and questions on the “Questions Wall” and we will circle back to this at the end of the day.

Health-Related Services Interviews and Work Group

Anne King, MBA, Associate ORPRN Director, OHSU

-Thanks to Cullen Conway, MPH and Max Schwarzer who helped with this work-

Oregon Health Authority

Interviews and work group

- Purpose of interviews was to understand:
  - CCO needs for guidance, training, technical assistance
  - Barriers to increasing HRS expenditures to improve health
  - Why HRS may be underreported
- Purpose of work group was to:
  - Share ideas and best practices across CCOs
  - Further understand CCO needs around HRS
- Review of Exhibit L reports to:
  - Identify common categories of spending
  - Better understand reporting challenges

Participating CCOs

Interviews:

- 35 individuals
- 13 CCOs

Work group:

- 26 individuals
- 12 CCOs

Participants:

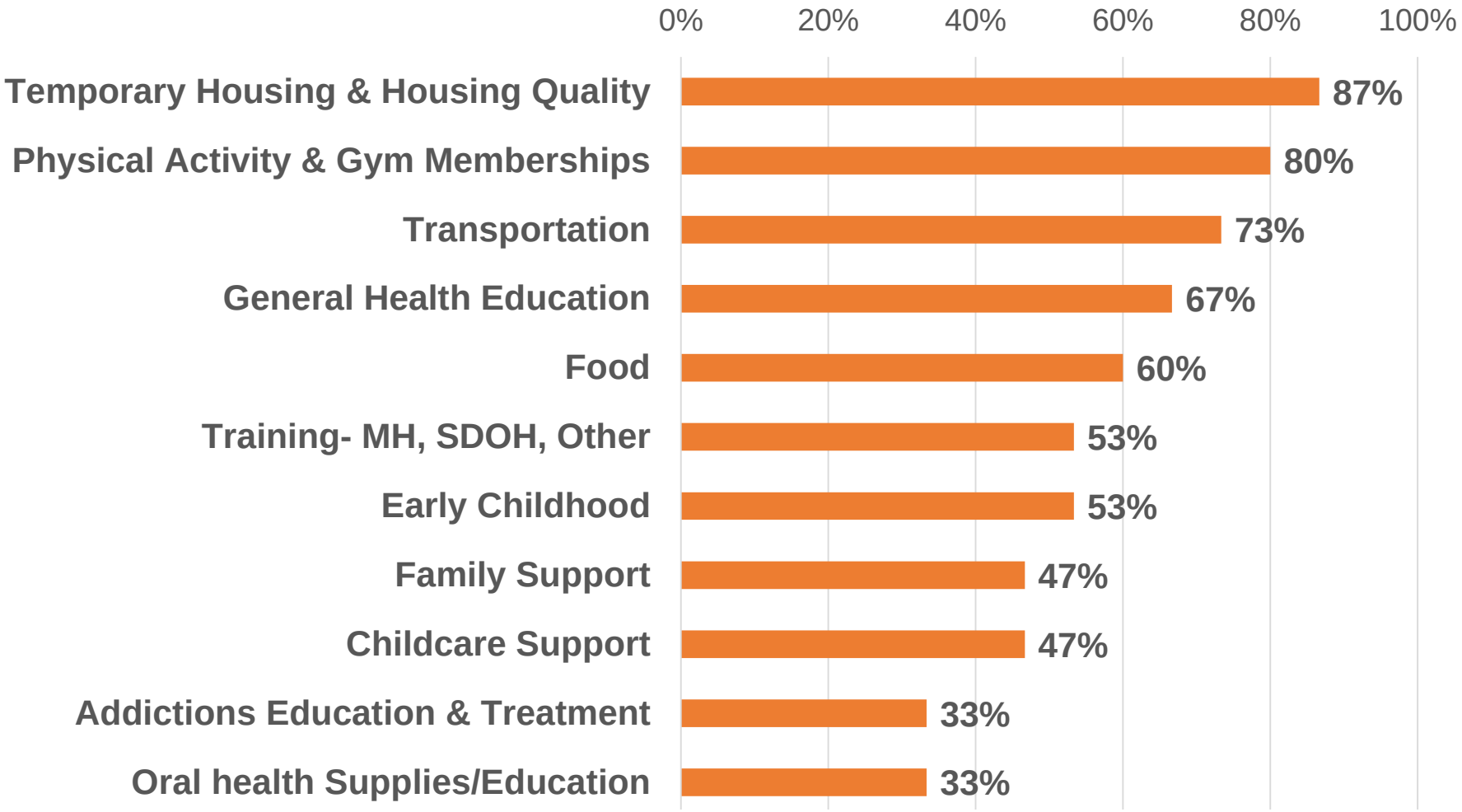
Actuaries, care coordination managers, clinic managers, CEOs, CFOs, COOs, equity officers, finance staff, medical directors, network managers, quality managers, strategy directors

Thank you to everyone who participated!

Oregon Health Authority

HRS spending focus- from Exhibit L

"What types of health-related services do you currently support with Medicaid funds?"



Percent of CCOs that Spend by category

HRS barriers identified by CCOs

- Reporting is a major barrier due to:
  - heavy administrative burden
  - too much detail for small dollar amounts
  - challenges getting partners to provide sufficient information
  - need for policy clarification or better definitions
- Many providers are unaware of how to request flexible services

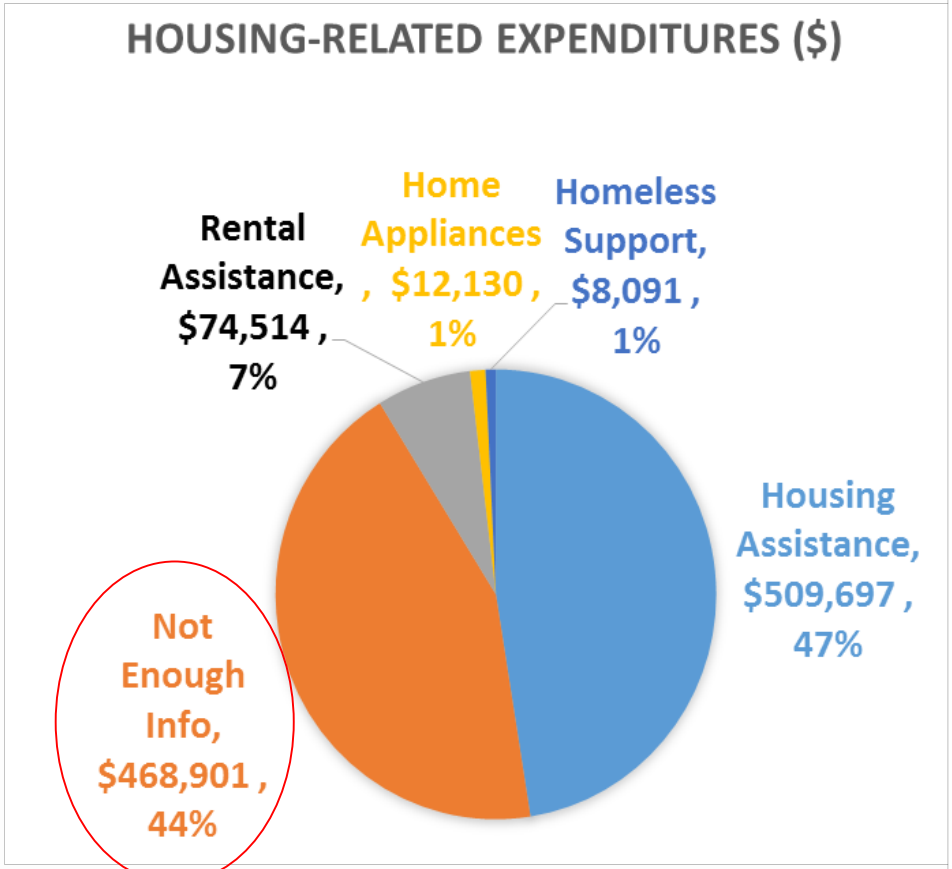
"Evaluation is a massive struggle"

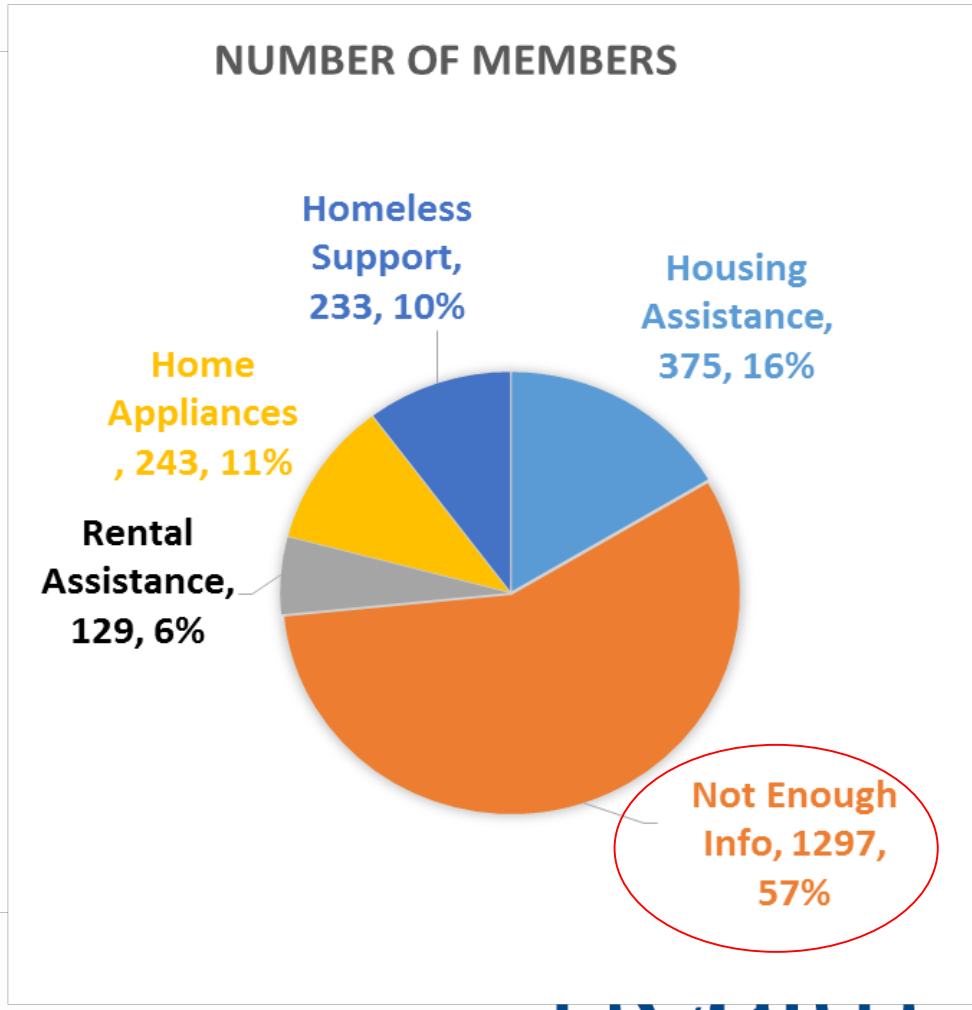
"We are spending more (time reporting) small items than they are worth"

Reporting and under reporting: CCOs

- Most CCOs believe they under-report HRS, including:
  - care coordination
  - traditional health workers
  - subcontractor services
  - small items that are easier to expense under administration
- CCOs shared many programs and investments that weren't identifiable on Exhibit L.
- There is a tension between wanting more standardization across HRS to make reporting easier, and concerns that this could lead to less autonomy and flexibility

CCO reporting: Challenge of sharing best practices with limited information





HRS barriers identified by clinics

- Concern that budgets provided by CCOs are too small and funds will run out
- Growth in requests has been hard to manage
- Some providers are unaware of how to request flex services
- High administrative burden of request process, documentation and follow up

"It became much bigger than we anticipated"

"I'll be honest, I don't really track/document these because I have so much difficulty getting approved."

Reporting and under-reporting: Clinics

- Clinics balance the reporting burden when deciding whether to report small items
- They only report on what they have to, not everything provided to members regardless of funding source
- Care coordination/management not captured under HRS
- Some clinics stopped using HRS altogether due to paperwork burden

"Whenever (CCO) in the past has asked for data around this, they wanted complicated before-and-after care plans… and I have to admit that these were very burdensome and became obstacles and barriers for us."

Potential best practices for CCOs

- Ability for CCO staff to independently approve requests under certain dollar threshold
- Data systems to easily track, follow and report on requests
- Standardized process for community benefit requests by external organizations
- In addition to finance staff, program staff participate in reporting to ensure context is included
- Regular provider education on when and how to use HRS
- Tie HRS delivery to answers on health risk assessments

CCO support requests

- Convene CCOs to share what they are doing, how they are reporting, HRS ideas and strategies
- OHA guidance on any effect CCO 2.0 might have on HRS
- Simplify reporting
- Guidance documents on traditional health workers, care coordination/case management, housing

Health-Related Services 2020: Medical Loss Ratio, Capitation Rates and Performance-Based Reward

Zachary Goldman, MPP, Economic Policy Advisor

Oregon Health Authority

Summary of health-related services in 2020

1. HRS and medical loss ratio (MLR)
   - Same as prior years

2. 2020 capitation rates
   - HRS considered, same as prior years

3. HRS and performance-based reward (PBR)
   - 2020 HRS will factor into 2022 cap rates

1. HRS and medical loss ratio

What is medical loss ratio?

Spending on member services must be at least 85% of CCO premium revenue (as defined in regulations).

CCOs are held to an 85% minimum medical loss ratio for their total member population.

Instructions for the reporting period ending Dec. 21, 2019 are posted here:

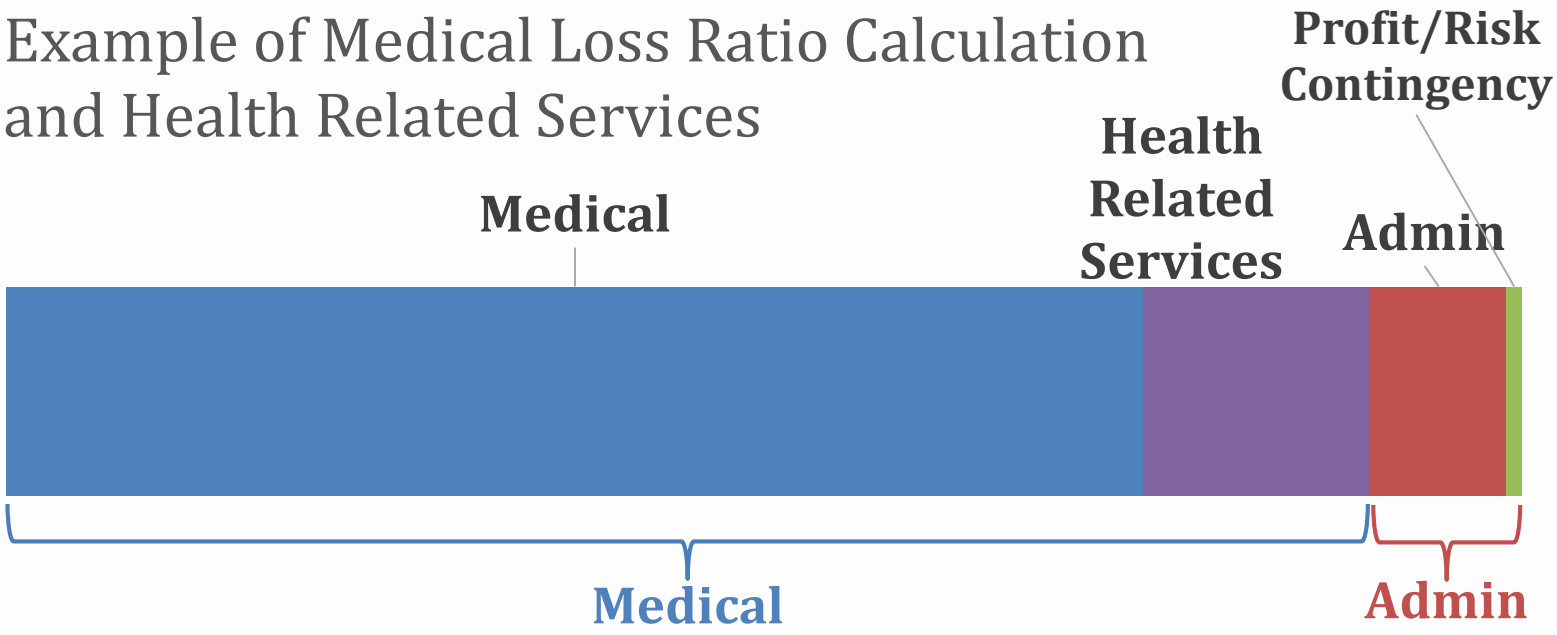
https://www.oregon.gov/oha/HSD/OHP/CCO/2019%20MLR%20Instructions.pdf

1. HRS and medical loss ratio

For 2020 there are **no changes** to how health-related service expenditures interact with CCOs' medical loss ratio.

1. HRS and medical loss ratio

Similar to previous years, CCOs' HRS spending will be included as **medical expenditures** in the medical loss ratio (MLR), helping the CCO meet the state's MLR standard.



Note: the graphic above is illustrative. Relative sizes of the bar chart components are not intended to be meaningful.

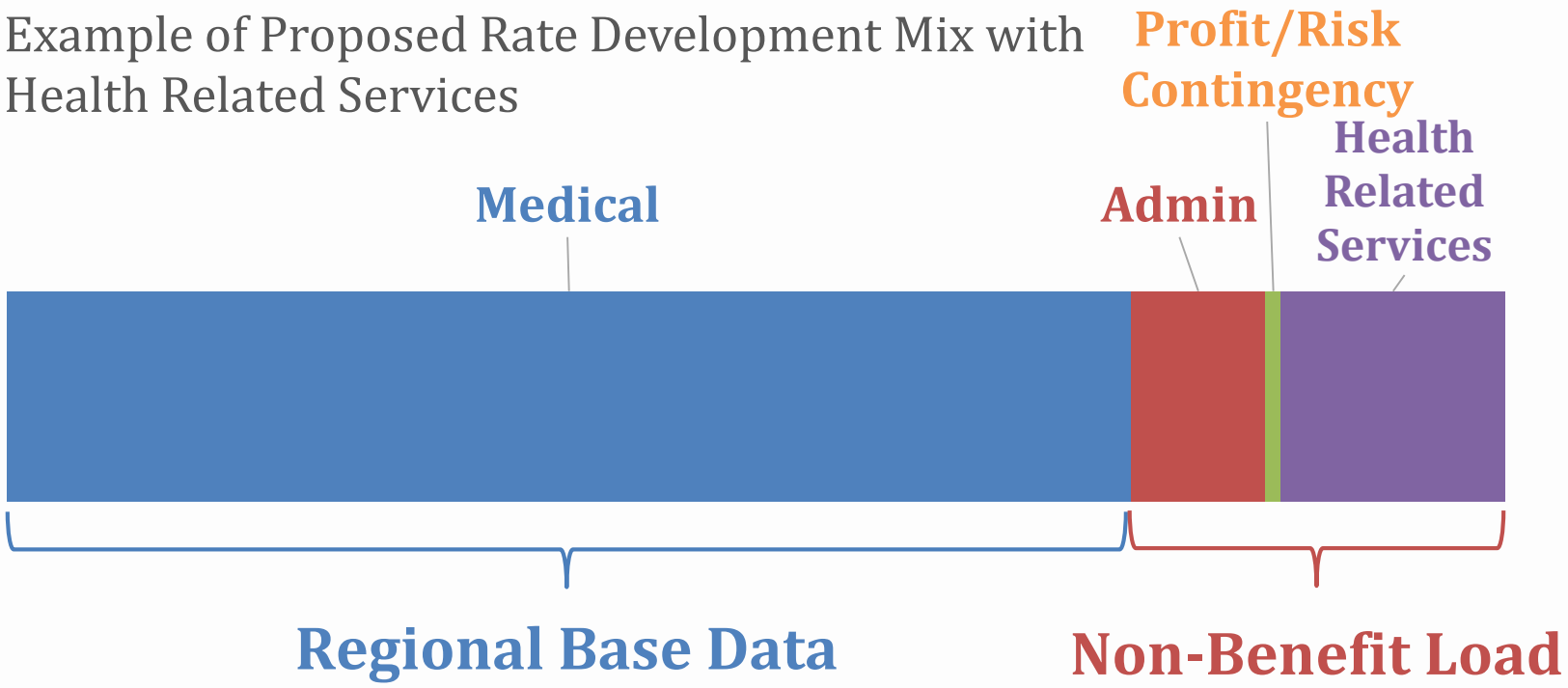
2. HRS and capitation rates

- Like previous years, CCOs' HRS expenditures were considered in developing the non-medical load in the 2020 capitation rate.

- HRS expenditures must be paid for from CCOs' savings and more efficient use of resources.

HRS and rate development

Similar to previous years, HRS spending will be considered for rate development within non-benefit load



3. HRS and performance-based reward

- CCO-specific performance-based reward rates authorized by 2017 waiver renewal
- Waiver language specifies goal to motivate effective HRS use by CCOs

3. HRS and performance-based reward

OHA has made the policy decision to use Prometheus Analytics to inform the variable margin component (Performance-based reward policy option recommended by the Oregon Health Policy Board) of the CCO 2.0 program.

As part of this policy, OHA intends to incent CCOs to invest in Health Related Service (HRS), including Social Determinants of Health and Equity (SDOH-E) while striving to achieve levels of growth consistent with the defined sustainable rate of growth of 3.4% annually.

More details can be found: Oregon Health Authority "CCO 2.0 Procurement Rate Methodology. January 1, 2020 – December 31, 2020 Capitation Rates" https://www.oregon.gov/oha/OHPB/CCODocuments/Attachment-12-Oregon-CY20-Procurement-Rate-Methodology-2018.12.21.pdf

3. HRS and performance-based reward

Performance-based reward (PBR) measurements begin in 2020. HRS spending is a primary driver of PBR.

CCOs' performance including HRS spending in 2020 will be reported and approved by OHA in 2021 and reflected in the 2022 rates.

Questions?

-Break-

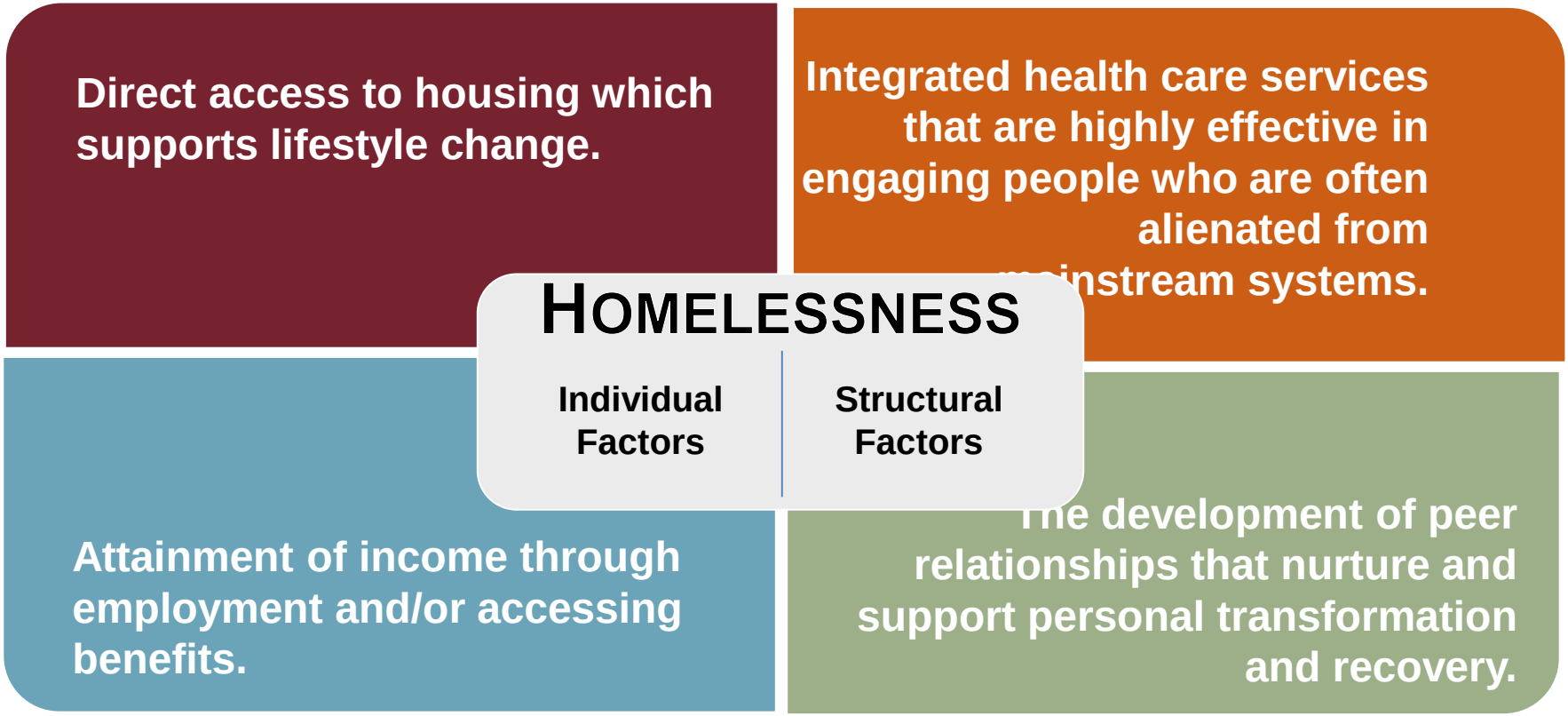
Oregon Health Authority

CCO Housing Partnerships: Health Share and Central City Concern

Sean Hubert

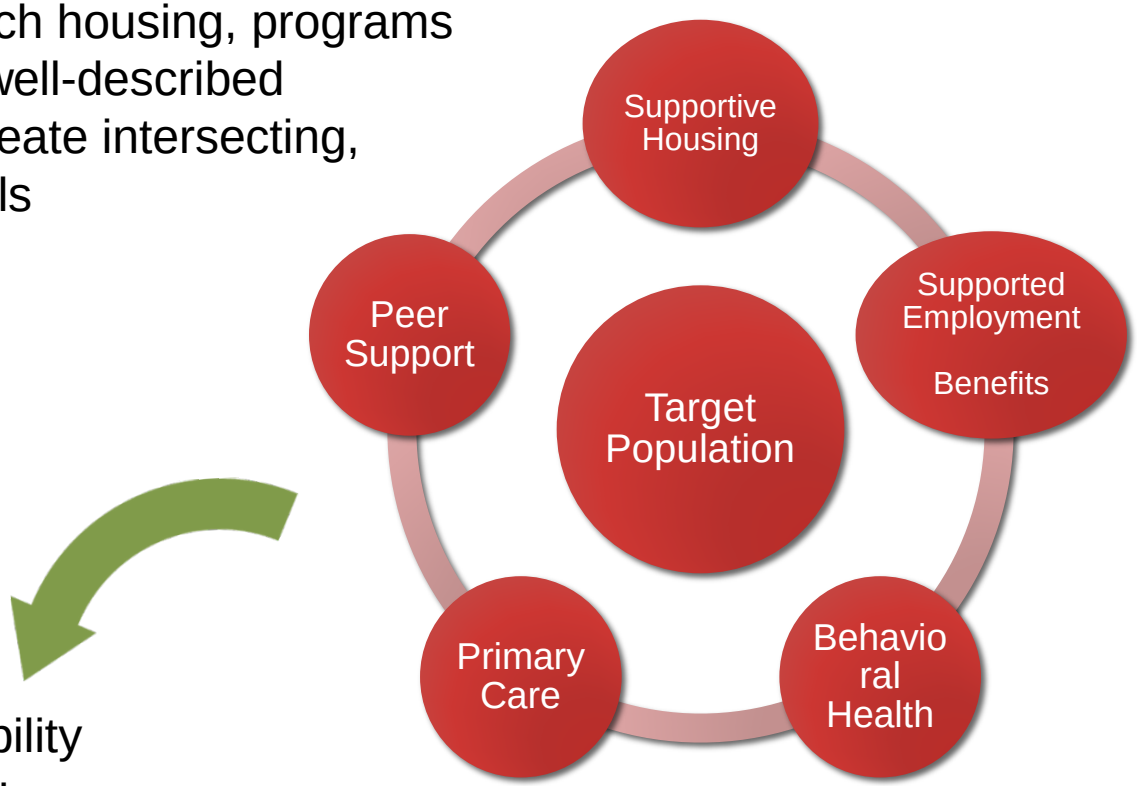
Chief Housing and Strategy Officer

CENTRAL CITY CONCERN: COMPREHENSIVE SOLUTIONS



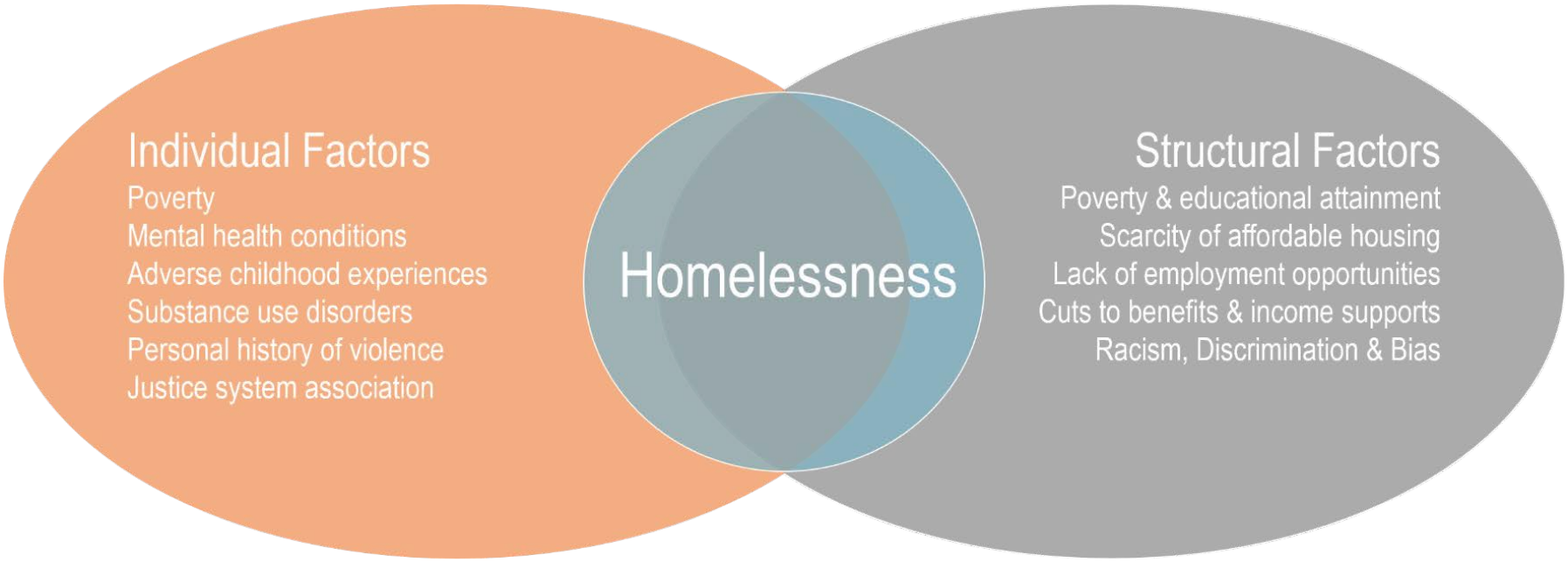
Integrated, Team-Based Models of Care

Intentionally match housing, programs and services to well-described populations to create intersecting, supportive models

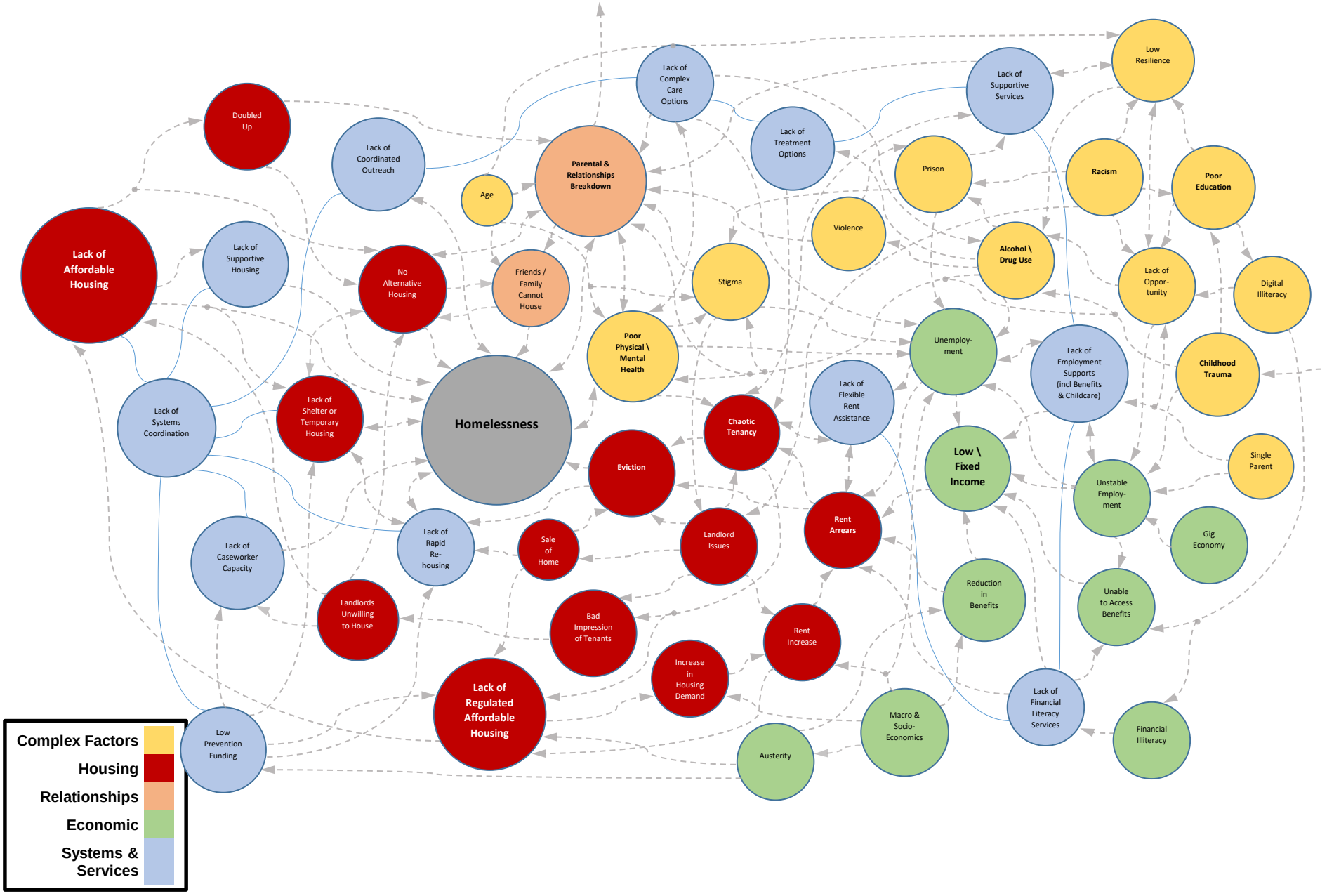


- Housing access and stability
- Improved health and well-being
- Economic resiliency
- Social Connectedness

Intersectionality of Homelessness



Homelessness Causal Map



Recuperative Care Program (RCP)

- Low barrier short-term housing and intensive case management for homeless people with a severe medical condition that would benefit from stabilization, focused on disrupting the cycle of disease by addressing social determinants of health including homelessness and access to timely and appropriate care.
- One of over 200 respite care programs in the US.

RCP as SDoH Intervention

- ***Radically grounded in the day to day reality of people experiencing homelessness***

Housing

Employment and Benefits

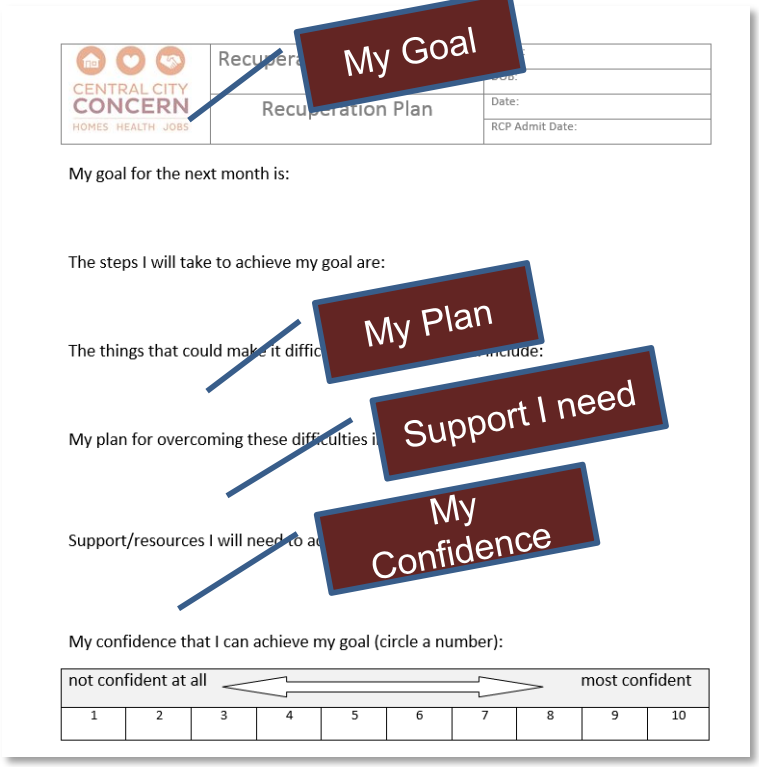
Health Care

Goals During Recuperative Care Program

Need	Done		Need	Done		Need	Done	
		Primary Care			TPI Waitlist Registration			Birth Certificate
		Mental Health			Veteran Resources			Identification
		Home Health			Employment Access Center			BEST Referral
		Wound Care			Women's Programs			Food Stamps
		Medication Box			Honored Citizen Pass			OHP Application
		Daily Weights			Ride Connection			Meals on Wheels
		Hooper Detox			Wheelchair Van			Clothing
		CCCRC			Assisted Communication			S/O Registration
		Narcotics: Y N			Tuberculosis Card			

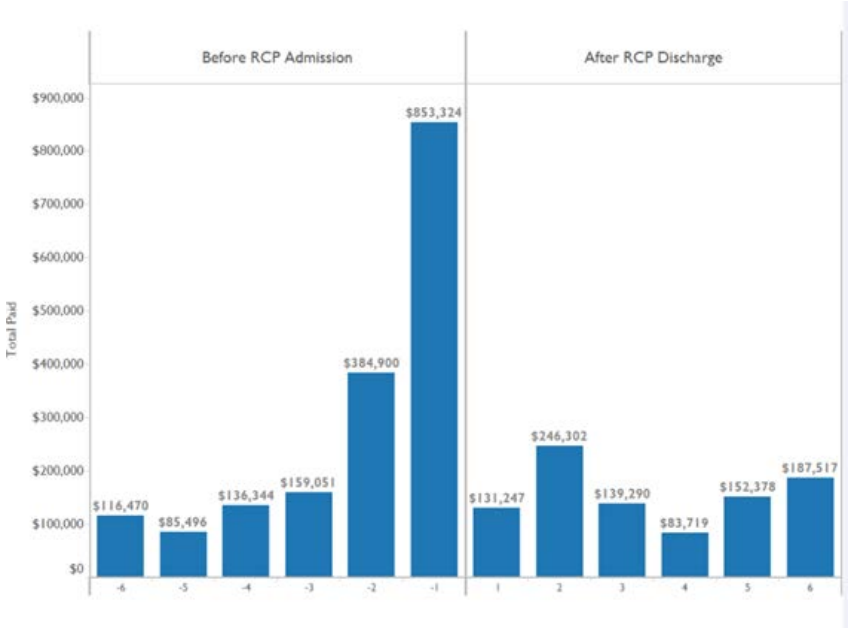
RCP as SDoH Intervention

Strong emphasis on self-efficacy and self-determination



RCP Outcomes: Cost of Care

Total Cost Before and After Central City Concern Recuperative Care Program (n=50)



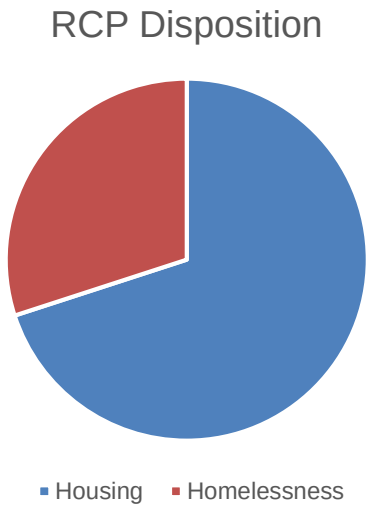
6 months leading up to RCP stay	$1,735,585
6 months after admitted to RCP	$940,453
Savings	**$795,132**
5 months before RCP stay	$882,261
5 months after RCP stay	$809,206
Savings	**$73,055**

8% decrease in total cost of care

RCP Outcomes: Housing

All people experiencing homelessness when admitted to RCP

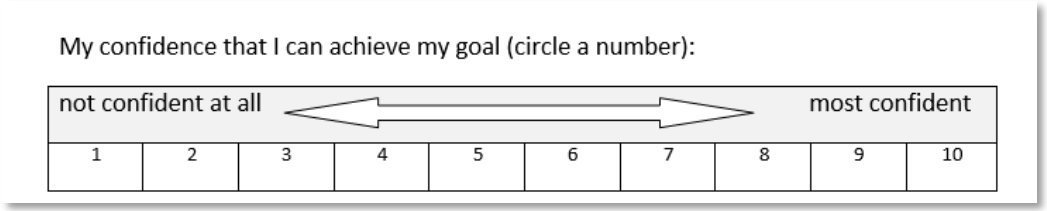
70% are discharged to some sort of housing, including transitional and treatment



RCP Outcomes: Self-efficacy

Self Management Goal Setting Confidence

- At admission: 7
- At discharge: 9



The Housing is Health Initiative

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

@cccportland

Making Headlines: Housing is Health

- $21.5 million donation from six health systems toward 380 units of housing and new health center announced in Fall 2016.

- National news including ***New York Times, Washington Post*** and ***ABC News.***

PROVIDENCE Health & Services

LEGACY HEALTH

CareOregon

Adventist Health

KAISER PERMANENTE®

OHSU

Housing is Health

Charlotte B. Rutherford Place

- 51 units of affordable housing for families
- Priority placement for families historically displaced from neighborhood
- Part of N/NE Housing Neighborhood Strategy for neighborhood return

Hazel Heights

- 153 units of work force family housing
- Collaboration with Native American Recovery Association
- Collaboration with local school district

Blackburn Center

- 80 Transitional SUD units
- 34 Permanent recovery units
- 51 Transitional respite units – Physical + Mental Health
- Integrated Primary Care + Outpatient Treatment + Mental Health + Pharmacy + Employment Services

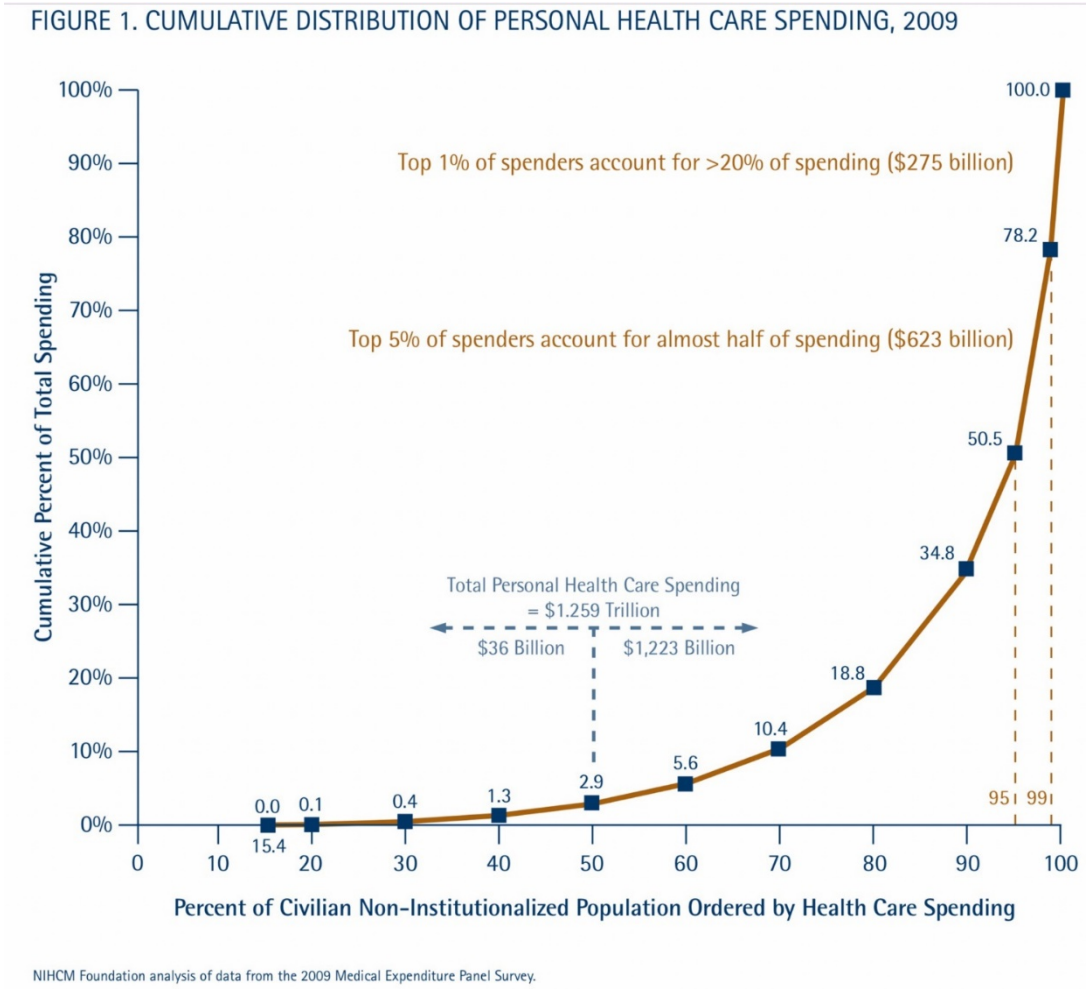
Relationships: Trust, Understanding, and Experience

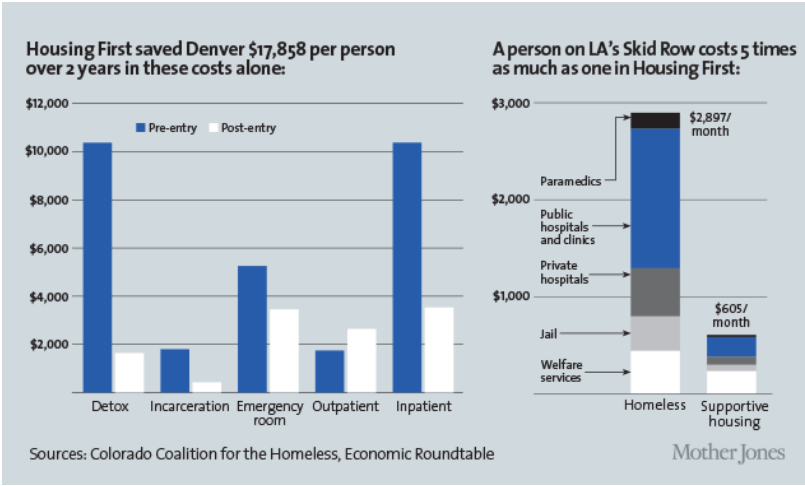
- Past experience with hospitals via the Recuperative Care Program (2005) ~6% 30-day readmission rate
- Executives from 3 of the hospitals/health systems served on CCC's Board of Directors
- CCC's President & CEO and CEOs from local hospitals were founding board members of local CCO Health Share of Oregon (2009)
- Unity Hospital Psychiatric Collaboration (2016)
- Conversations led to health system CEO who championed the effort among the wider healthcare system

Getting to a Shared Understanding

- What public funders of housing measure: Units
- What health systems track: longitudinal population costs and care outcomes
- Language differences
  - FPL
    - 100% $12,140
    - 200% $24,280
  - MFI
    - 30% 17,220
    - 50% 28,700
    - 60% 34, 440
- Best Practice differences
  - Patient-Centered Medical Home - funded
  - Permanent Supportive Housing – not funded

Looking at the Data Together





Closing in on a Concept

- Had **specific opportunities** which could be “bundled”
- Health Systems could make a “**collective impact**” investment to meaningfully address gaps in care
- Investment could be **catalyst for additional private investment + public policy shift**
  - Investment will leverage additional funding: $1 can leverage $3+ from other sources
- Investment could make a **dramatic difference** in the lives of vulnerable populations
  - Reduce repeat hospitalizations and other public costs
  - Improve care, coordination, and outcomes
- **Opportunity for shared learning**, research and evidence advancement
  - CORE – Center for Outcomes and Research

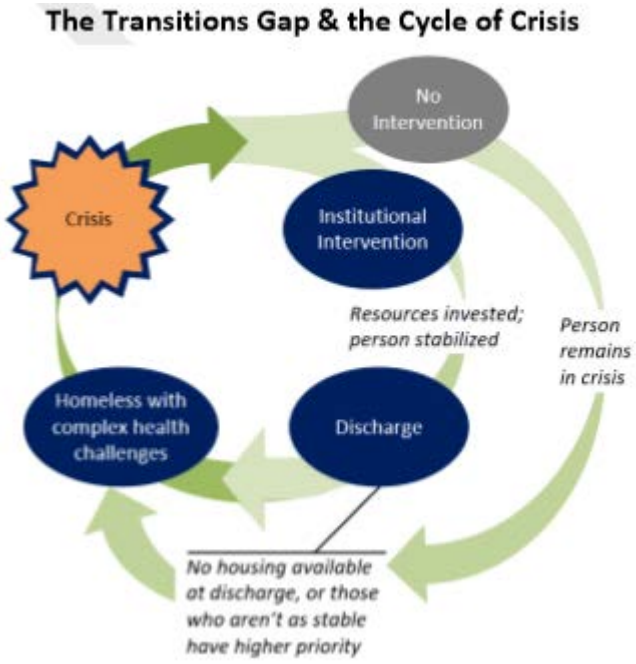
Advancing Knowledge

Center for Outcomes Research and Education (CORE) and the Center for Health Research at Kaiser Permanente :

- Housing retention
- Employment Outcomes
- Clinical Outcomes
- Healthcare Utilization and Total Cost of Care
- Opportunity for other cross sector evaluation:
  - Education (School Days Missed)
  - Criminal Justice (Jail Days, Recidivism)

Where the Collaboration is Headed

- **RSHIF – *Regional Supportive Housing Impact Fund***
- Flexible fund concept designed to work in tandem with other regional efforts, such as affordable housing bonds
- RSHIF emphasizes connecting very low-income persons with complex health challenges to deeply affordable supportive housing options that include the services they need to remain stable and housed.
- **Capital, Services, Rent Assistance**
- Includes Housing is Health Partners plus: Health Share, Several Foundations, other Health Systems, and advisors including ECONorthwest and CSH.



TWINING HOUSING AND HEALTH INTERVENTIONS

Advancing Knowledge & Research

Of clients who completed Hooper Detox in 2015:

117 entered Recovery Housing

891 received “treatment as usual”

We tracked their outcomes for a year…

Clients who entered Recovery Housing after detox were:

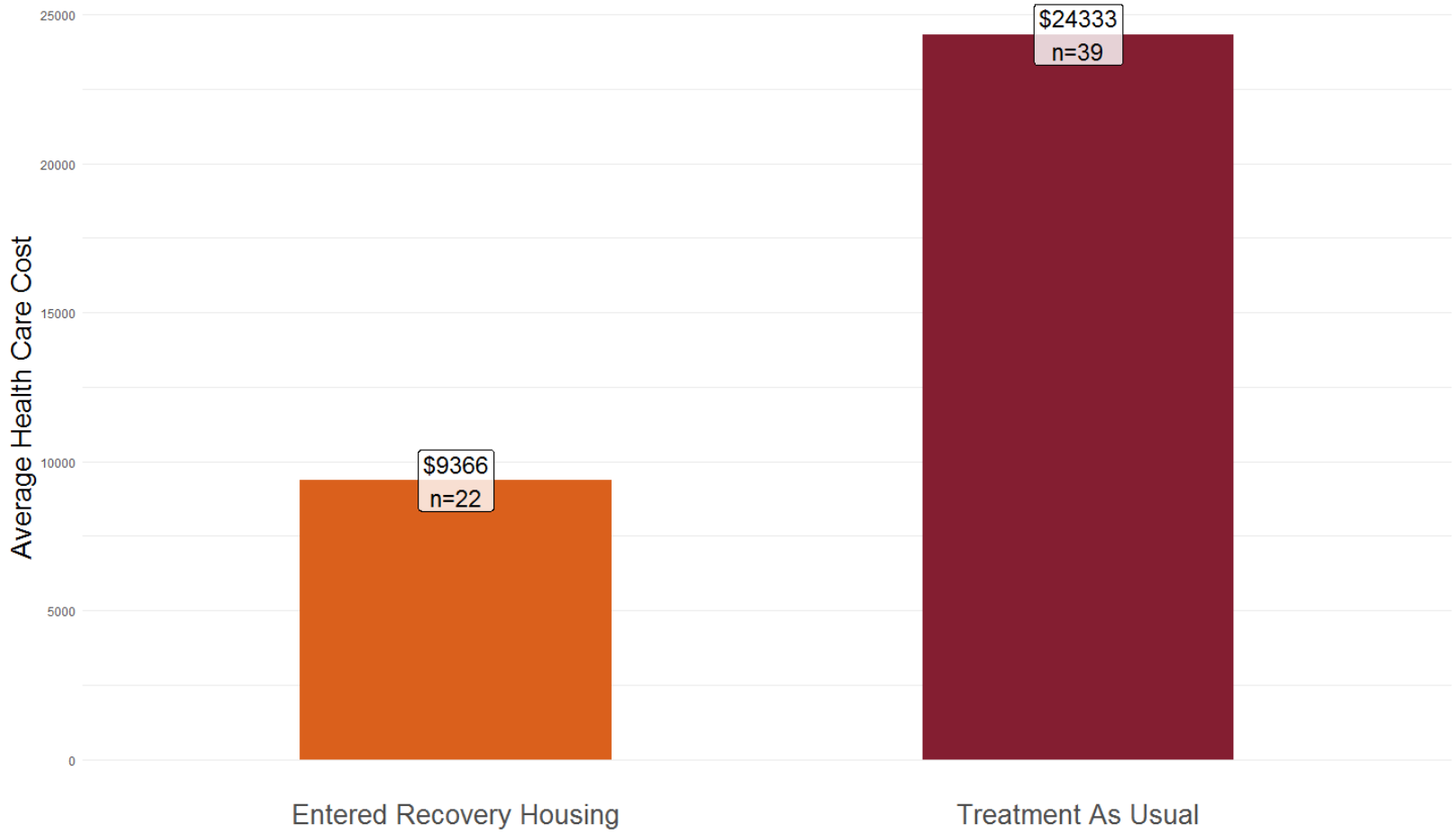
3 times as likely to complete SUD treatment

10 times as likely to engage in primary care at Old Town Clinic

n=1,046; all results are statistically significant at $p < 0.001$ level; adjusted for drug of choice, age, gender, and race/ethnicity

Advancing Knowledge & Research

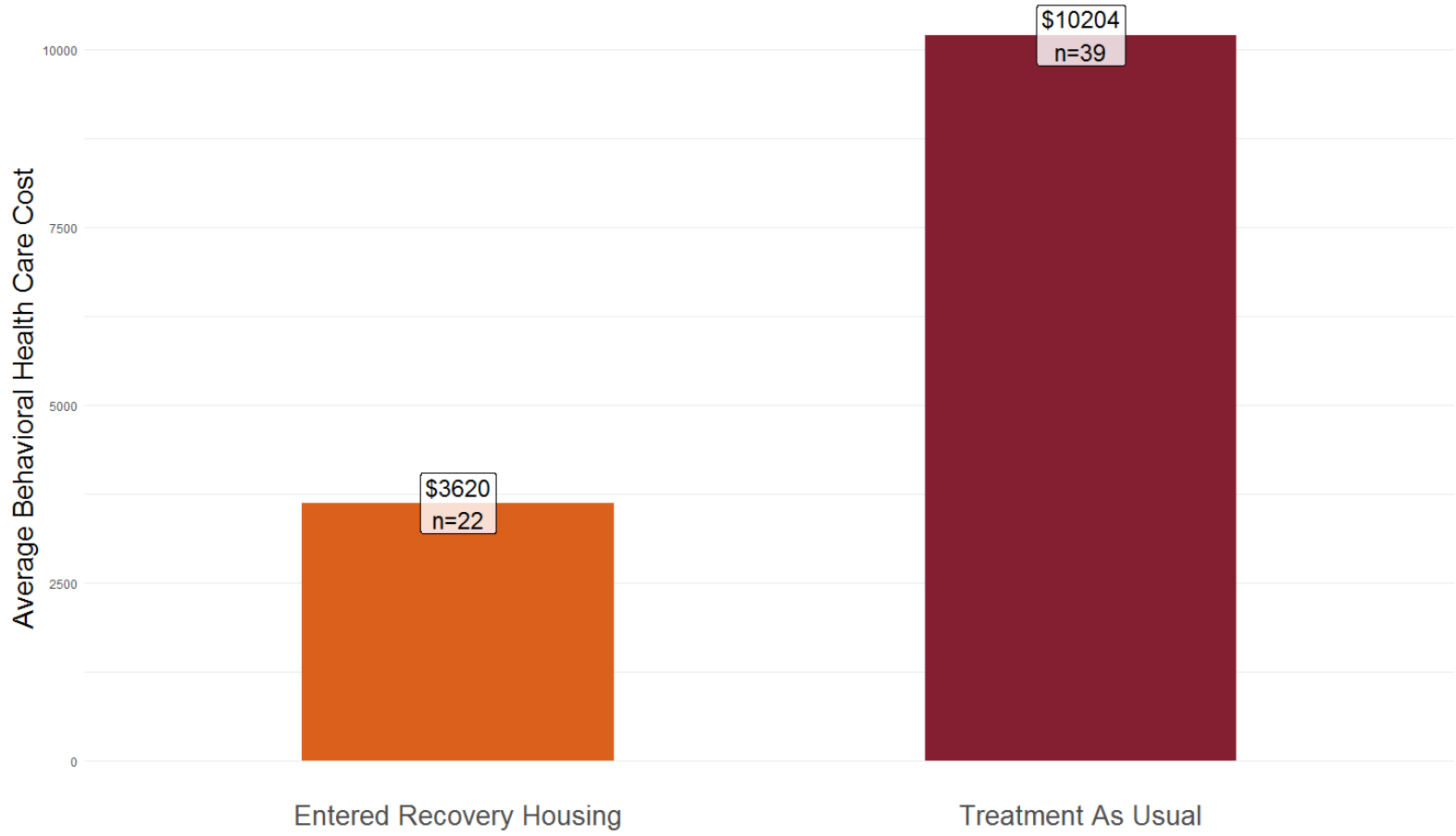
Total Health Care Cost



Differences are statistically significant, but sample size is small; average cost for 12 calendar months following month of detox admission

Advancing Knowledge & Research

Behavioral Health Care Cost



Differences are statistically significant, but sample size is small; average cost for 12 calendar months following month of detox admission

Other Community Impacts

- 87 participants in recovery housing, outpatient treatment, peer mentorship
- Prior to entering CCC:
  - Spent $206/day on drugs
  - 93% reported criminal activity, with average monthly income of $1,978 ($2 million/year loss to Portland)
  - 29% of this cohort of clients regularly exchanged sex for drugs and 22% exchanged sex for money
- After entering CCC (average 325 days):
  - 95% reduction in drug use (no daily use)
  - 93% reduction in criminal activity
  - $5,729,750 not spent on drugs

Thank you!

Sean Hubert
sean.hubert@ccconcern.org

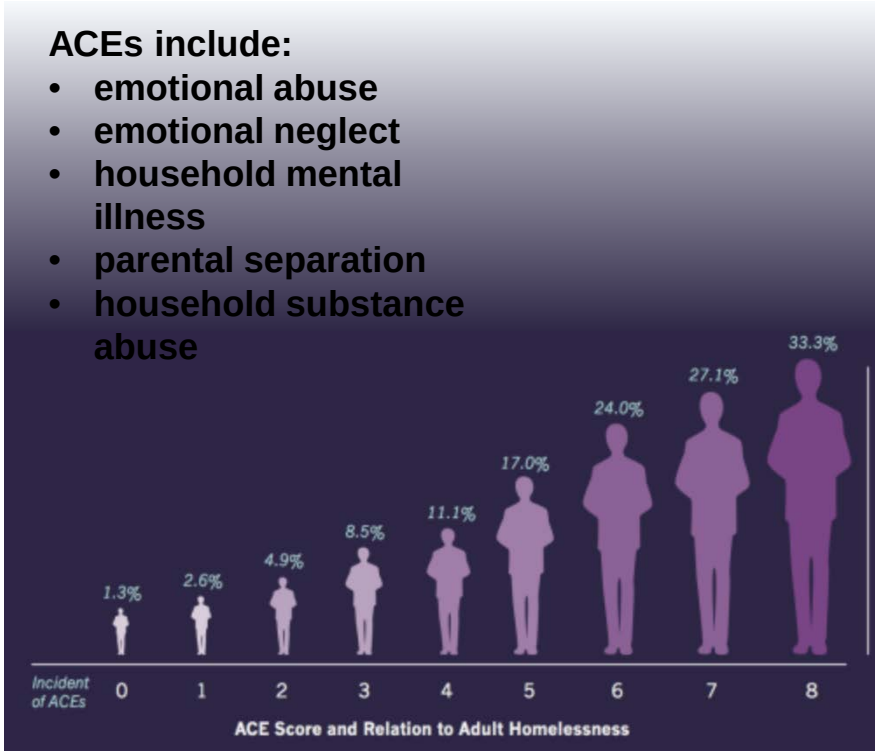
Brandy's Time at RCP

- Life threatening medical emergency after multiple hospitalizations for substance use related medical problems
- Complicated medical course
- Mental Health Prescribing and Counseling
- Substance Use Disorder Services

Goal: Stability

What Led Brandy to CCC

- Personal Trauma and ACEs
  - Adverse Childhood Events
- Family Trauma and Life disruption
- Return to use
- Inadequate treatment services
- Scarcity of housing
- Homelessness
- **Medical emergency**



Source: Seattle University Project on Family Homelessness, 2016

What Brandy Experienced at CCC

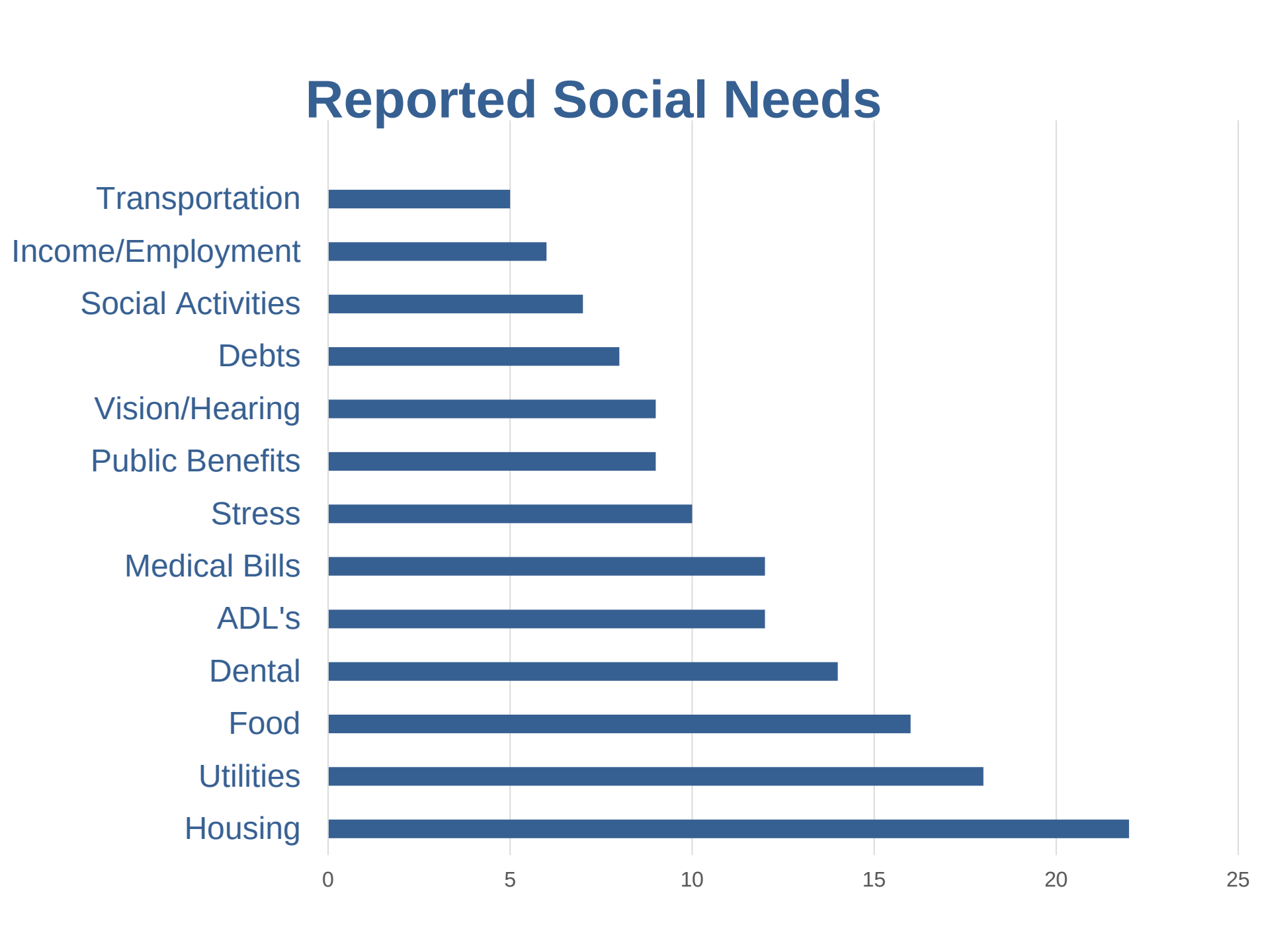
- Recuperative Care Program (RCP)
- Primary Care
- Mental Health services
- Substance Use services
- Recovery Housing
- Employment
- Permanent Housing!

Brandy today

- Housing
- Health
- Kids
- Job
- Education

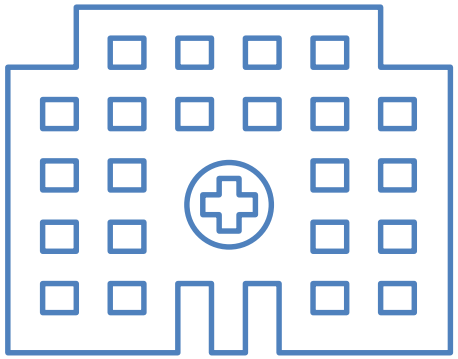
They helped rebuild me as a whole."
-Brandy

THE HEALTH SYSTEM PERSPECTIVE


Reported Social Needs
Transportation
Income/Employment
Social Activities
Debts
Vision/Hearing
Public Benefits
Stress
Medical Bills
ADL's
Dental
Food
Utilities
Housing
0
5
10
15
20
25

Hospital Community Benefit

What's the Issue?



- Tax-exempt hospitals are required to provide community benefits
- **Affordable Care Act requires nonprofit hospitals to periodically complete a community health needs assessment (CHNA)**
- Traditional Uses:
  - Charity Care/ "Free Care"/ Indigent Care
  - $ and Staff to Community Health Center
  - Investing in Walkable Communities
  - Healthy Lifestyle Programs

What Housing-Related Activities Count?

Supporting Housing Services
Screening for Housing Needs
Health Assessments
Legal Aid
Housing Quality Improvements
Accommodations During Treatment
Housing Subsidies
Short-Term Rental Assistance
On-Site Trainings
Community Health Research
Contributions to Housing Organizations
Contributions to Homeless Shelters
Surplus Property
Capital Grants
Administrative Support
Operational Capacity

Potential Health System Roles

1. Convene stakeholders and shape strategies
2. Board Membership
3. Engage new partners
4. Leverage in-house expertise
    - Development/project management
    - Structuring deals and investments
    - Fund-raising
    - Policy
5. Bring grants to the table
6. Make aligned financial investments
    - Permanent supportive housing
    - Supportive services
    - Fund innovative programs
7. Raise public awareness and combat stigma

Southern Oregon Temporary Housing and Housing Supports

Sam Engel, Manager Social Determinants of Health, AllCare

Samantha Watson, MS, Community Health Manager, Jackson Care Connect

Alissa Robbins, Systems Innovation Manager, OHA

Oregon Health Authority

AllCare Health and Rogue Retreat:

Community Benefit Contract for improved member outcomes

Sam Engel

Social Determinants of Health Manager

Partnerships work

AllCare Health –

CCO and Independent Physicians Association, providing Medicare and Medicaid service in Josephine, Jackson, Curry, and Southern Douglas counties.

Rogue Retreat –

Since 1998, Rogue Retreat has offered affordable housing options in Medford, Oregon. Currently, they operate approximately 200, scattered site units and several different housing and shelter models

CORE –

Center for Outcomes, Research, and Education; CORE is an independent research team focused on improving the health of underserved populations.

Case Management

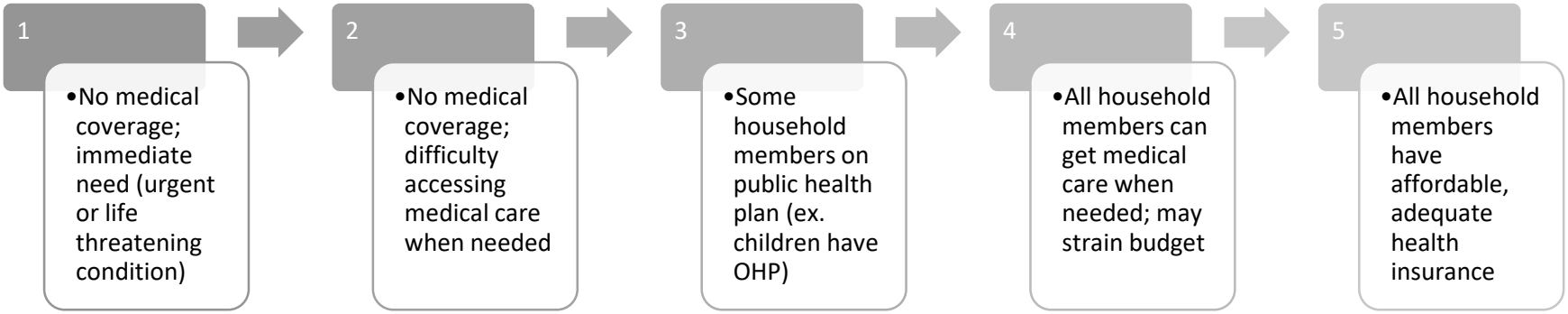
Case Management sets Rogue Retreat apart from other housing providers

Participants have weekly support from a case manager who helps them set goals and work towards a better life.

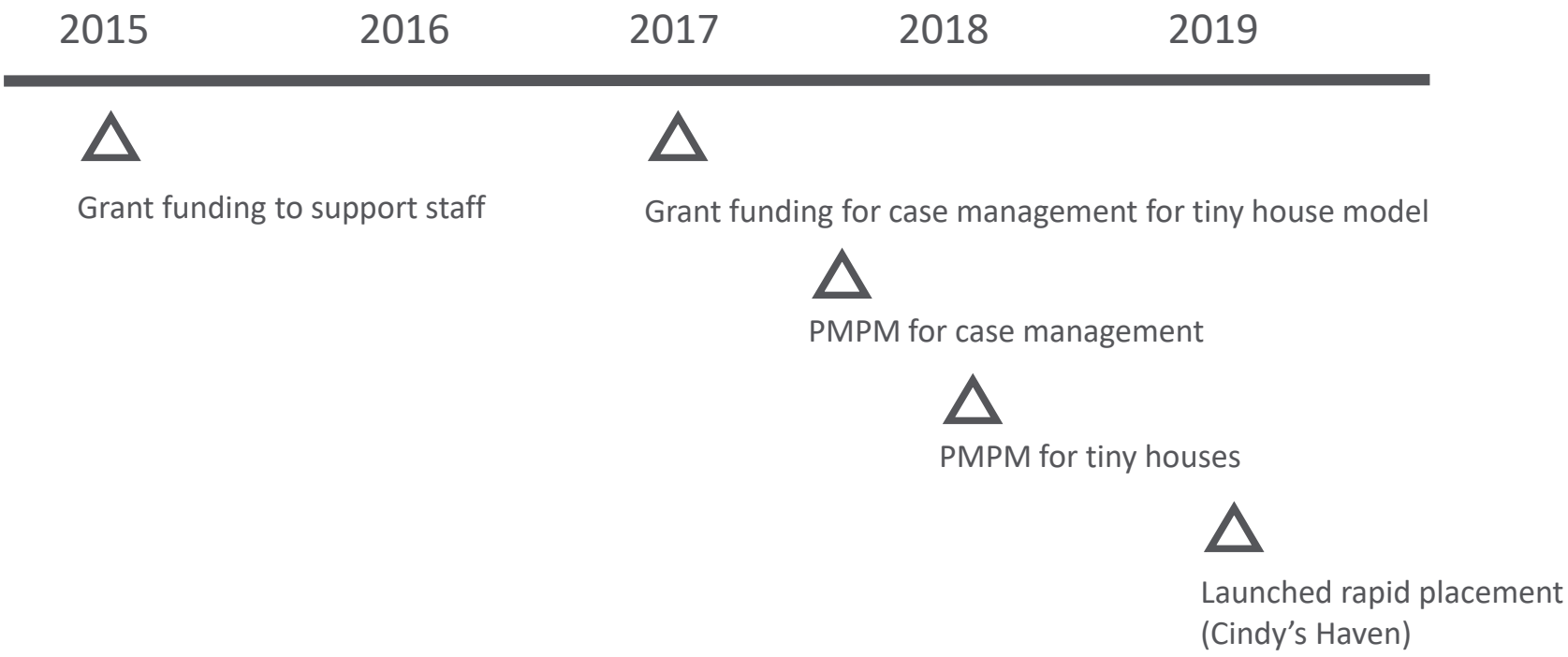
Self-Sufficiency Assessment

Rogue Retreat assesses clients using a 15-domain self-sufficiency tool at intake, and then at regular intervals to determine progress.

Domain: HEALTH CARE



AllCare Health's Investment in Rogue Retreat

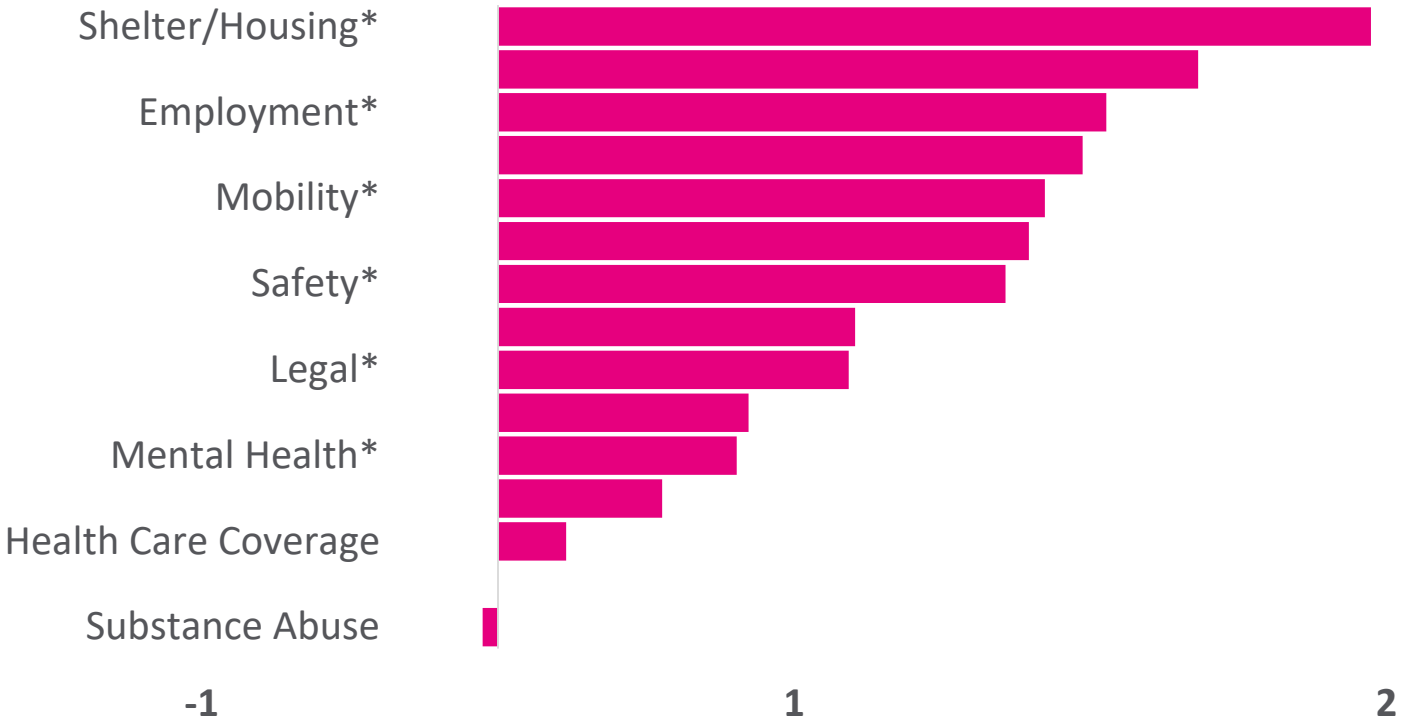


Study Population: Baseline Self-Sufficiency

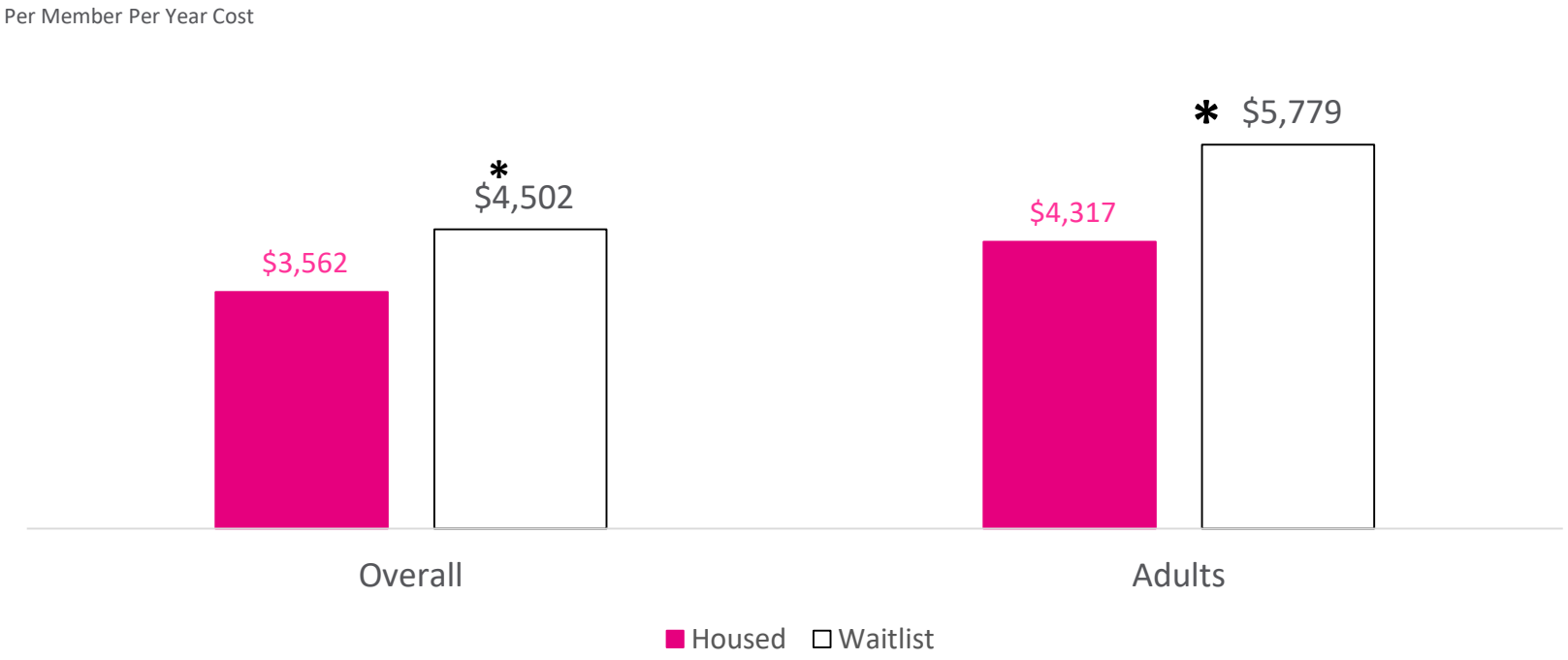
Changes in Self-Sufficiency Scores After Engaging with Rogue Retreat

* Indicates statistically significant change

N=78



Differences in the Average Cost Of Health Care Per Person, Aug 2015 – March 2019



*indicates statistically significant difference

Next Steps

Under development: Foundry Villa

Building off the success of Hope Village in Medford, we are working with:

- City and Law Enforcement
- Faith Community
- Health Plans
- Grassroots organizers
- Developer
- Realtors
- Homeless People

allcare health™

Certified B Corporation

Recent development: Cindy's Haven

- Triaged or "rapid, priority-based" placement
- Focuses on pregnant women and women with small children
- Easily replicable
- Build on trust, as everything is based on trust and respect
- **Currently being reviewed as a pilot project**

https://youtu.be/Rk2ZKaxv3HE

allcare health™

Certified B Corporation

Barriers and Beyond: Service Contracting

Barriers

- Data collection
- Data validation
- Unaligned systems
- Multiple partners= multiple systems

Opportunities

- Stronger use of internal data
- Technical assistance
- Aligned systems
- Community-wide system

allcare health™

Certified B Corporation

Thank you!

Any questions?

Sam Engel
SDoH-E Manager, AllCare Health
541 471-4701
Sam.engel@allcarehealth.com

Reducing Disparities in Health and Housing

Samantha L. Watson, MS
Community Health Manager
Jackson Care Connect

Jackson Care Connect™

Jackson County at a Glance

Community Health Assessment of Jackson and Josephine Counties

Housing

Mental Health

Source: Jefferson Regional Health Alliance, All In For Health, jeffersonregionalhealthalliance.org

How is Jackson Care Connect using health related services to reduce disparities in health and housing?

“Housing First” Philosophy

- ColumbiaCare Services’ Rental Assistance Program (RAP) is designed to help high-needs individuals obtain independent housing in the community.
  - Diagnosis of serious mental illness
  - Stepping down from higher levels of care such as state hospital or licensed treatment facility
  - Typically face many barriers to obtaining housing, goal is to help individuals overcome obstacles

RAP - The Process at Work

- 30 beds available for Jackson Care Connect members
  - All must have a diagnosis of severe persistent mental illness
  - 15 of 30 beds specifically slated for Veterans and transition aged youth (18-25)

Focus – Goal setting to GRADUATION

Transitional Housing

JCC Members may be directly referred by any community mental health provider

ColumbiaCare Services– Two 5 bed homes serving JCC members who need extra supports for ongoing stabilization

A step between higher levels of care and more permanent, independent housing environments.

Maximum stay of up to 60 days with case by case extensions where appropriate. On-site staff during the day, 7 days a week

Swing Lane – Established 2018

A 7unit Supportive Housing Program for JCC members living with severe and persistent mental illness. Located near public transportation and a variety of community resources.

5 private housing units with wraparound services including meals, mental health counseling, skills training, medication support and awake and on-call staff support.

Two 3 bedroom units of supportive transitional supportive housing. Room and board services are provided 7 days a week.

- ColumbiaCare acts as a mental health friendly landlord
- Tenants are responsible for their rent and utilities
- Tenants screened for clinical appropriateness by ColumbiaCare and JCC
- HRS funds may bridge any gaps outside of what is a billable service

Rogue Retreat Partnership

Partnership since 2015 to provide housing and case management for members in recovery from addiction or homelessness.

Members served

- Nearly 350 JCC members have been housed at Rogue Retreat since our partnership began

Sustainability

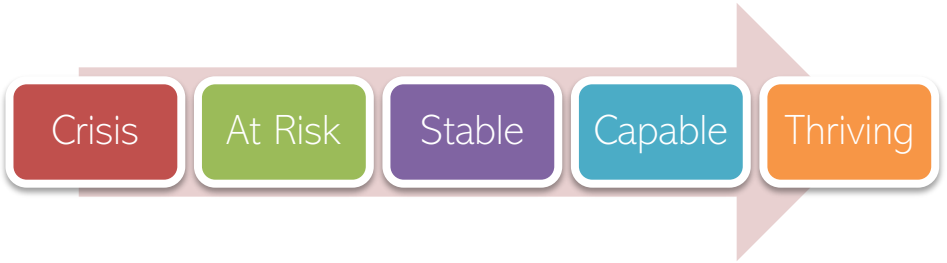
- 2018 – Case rate contract
- 2019 – Funding of Rogue Retreat staff as Peer Support Specialists
- 2020 – Value based payment model

Impact and outcomes

- Greater continuity of OHP enrollment
- Increased engagement in primary care
- Decrease in emergency room visits
- Focus on preventative care

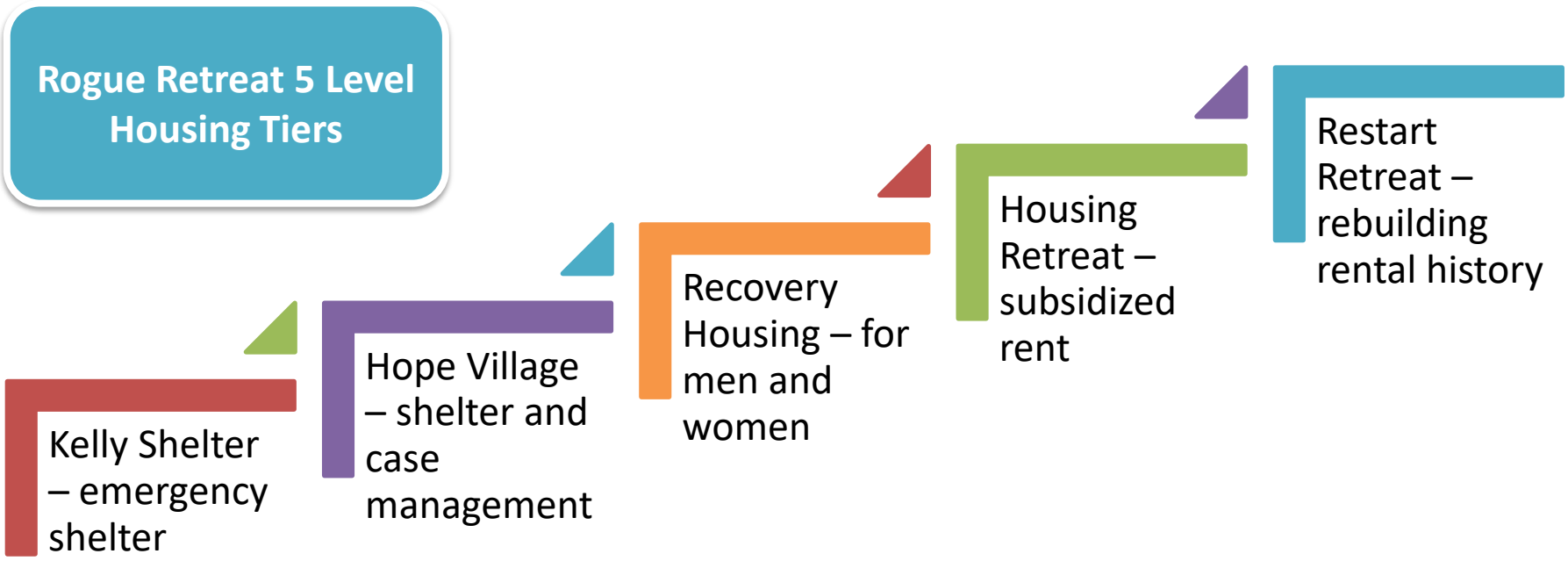
Rogue Retreat Case Management

1. Shelter / Housing
2. Employment
3. Income
4. Food and Nutrition
5. Childcare
6. Children's Education
7. Adult Education
8. Health Care
9. Life Skills
10. Family Relations
11. Mobility
12. Community Involvement
13. Parenting Skills
14. Legal
15. Mental health
16. Substance Abuse
17. Safety



- Average length of stay: 7 months
- JCC members on average increased by 1.2 levels in 2018

Rogue Retreat Housing



Providing Hope

"Whenever they are ready—whenever that might be—there are so many people in the community, at so many levels, from food banks up to legislators, that are coming together to work together to be able to offer that help," she says. "There are people out there who care. Don't get discouraged. There is hope, and there is love out there." – Jennifer Covarrubius

Looking Towards the Future

- Improve cross system care coordination including long term housing workflows
- Look into options for comorbid integrated transitional housing (behavioral and physical health)
- Analyze data to determine ROI for current programs with an eye on expansion

Thank you!

Getting Value out of HRS Evaluation

Sarah Bartlemann, MPH, Program Manager
Lisa Angus, MPH, Program Manager
Providence CORE

Oregon Health Authority

Getting Value out of HRS Evaluation

Lisa Angus and Sarah Bartelmann
November 5, 2019

CORE | Center for Outcomes Research and Education

Today

Spark ideas,
share examples,
and
offer tools

Why evaluate?

What is evaluation really?

What, when, how?

Exercise

Resources

Why does anyone evaluate

Because someone told you to.

*We advise against this

OHA does not require CCOs to do formal evaluation or share evaluation data, but encourages evaluation where possible

Interest in learning collectively about the value of HRS

Learning & sharing what works well for addressing health equity, social determinants, and controlling costs

Maintaining waiver flexibility

Evaluation can help you

- Improve program or organization performance

Evaluation can help you

- Improve program or organization performance
- Make better decisions (↑ transparent, ↓ reactive)

Evaluation can help you

- Improve program or organization performance
- Make better decisions (↑ transparent, ↓ reactive)
- **Target resources more effectively**

Evaluation can help you

- Improve program or organization performance
- Make better decisions (↑ transparent, ↓ reactive)
- Target resources more effectively
- **Articulate value propositions**

Evaluation can help you

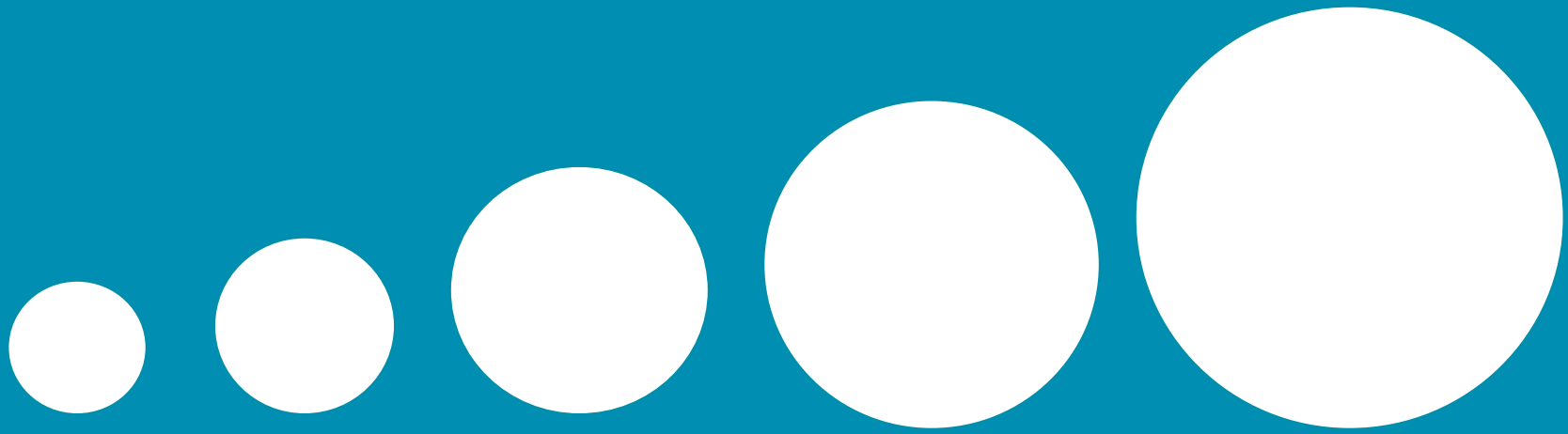
- Improve program or organization performance
- Make better decisions (↑ transparent, ↓ reactive)
- Target resources more effectively
- Articulate value propositions
- **Generate new ideas**

Evaluation can help you

- Improve program or organization performance
- Make better decisions (↑ transparent, ↓ reactive)
- Target resources more effectively
- Articulate value propositions
- Generate new ideas
- **Plan for the future**

What is evaluation, anyway

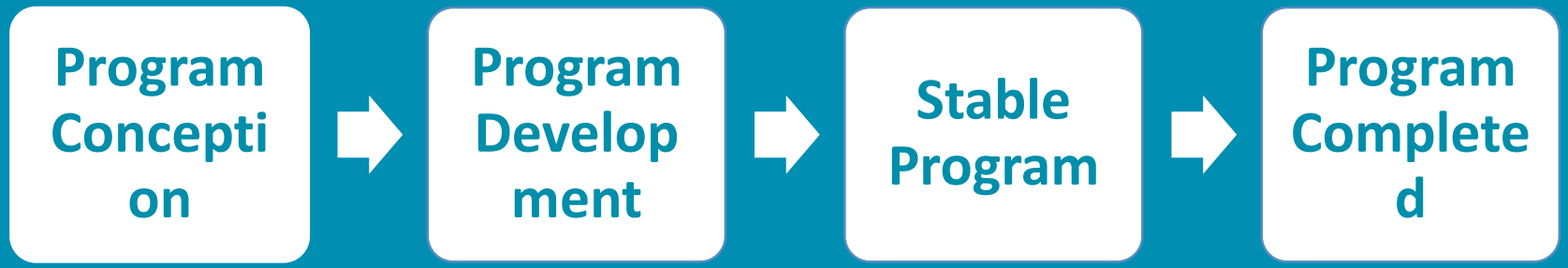
Evaluation happens at many scales



Simple questions
Small sample or pilot
Use existing data

Complex study design
Longitudinal
Original data collection

and at different stages of a program



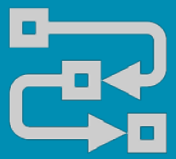
Gain insight
Clarify objectives
Lay foundation

Improve practice
Re-define scope and expectations

Assess effect
Monitor program

Build capacity
Spread and scale
Document learnings

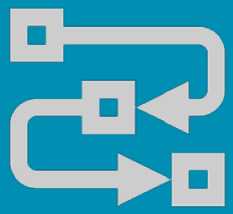
and has many flavors



Process Evaluation

Outcome Evaluation

Economic Evaluation

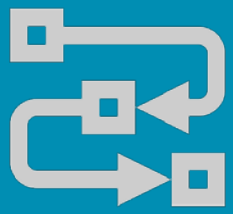


Process Evaluation

Formative evaluation, developmental evaluation

→

Are the groups we thought would benefit from CDSM classes the ones actually participating?



Process Evaluation Example: Parents Anonymous®

Intervention	Evaluation Plan	Results
Facilitated community groups for parents to address child abuse and neglect	Describe model and operation; Understand variations & what might contribute to variation	Described how groups operate Described variations

https://www.nccdglobal.org/sites/default/files/publication_pdf/evaluation-parents-anonymous.pdf

Outcome Evaluation

Impact evaluation, summative evaluation → Do members who receive bus passes miss fewer days or work or school?

Outcome Evaluation Example: Food as Medicine

Intervention	Evaluation Plan	Results
Home-delivered meals and nutritional counseling for 200 patients with diabetes	Clinical values and utilization pre and post intervention	▼ in all utilization categories
	Member experience survey	100% felt better prepared to make healthier food choices

https://www.healthpartnersplans.com/media/100225194/food-as-medicine-model.pdf

Economic Evaluation

Cost benefit,
cost effectiveness,
Return on Investment (ROI)

→

What's the cost of providing intensive case management to emergency department high utilizers?

Economic Evaluation Example: Gym Memberships

Intervention	Evaluation Plan	Results
Health plan sponsored gym memberships	Frequency of visits to gyms and associated factors Effects on health care costs and utilization	More primary care, specialty visits, but fewer inpatient admissions = lower overall costs

https://www.ncbi.nlm.nih.gov/books/NBK114676/ and https://www.ncbi.nlm.nih.gov/pubmed/18082003

Economic Evaluation Example: Project Nightingale

Intervention	Evaluation Plan	Results
Post-acute medical care (respite beds) for homeless individuals	Readmission rates Effects of wraparound case management Financial impact	*In process* • Who benefits? • Actual costs? • Reinvestment ?

https://nff.org/blog/partnering-health-and-homelessness


Don’t boil the ocean.

“Value” is broader than return on investment or cost savings.

More members served or increased member engagement

Improved member experience

New relationships

Process efficiencies or improvements

VALUE

How do you know **what** to evaluate

How do you know **when** to evaluate

How do you **start**

Clear Intent

Right Timing

Answerable Questions

Hi, I donated $20 last year.
Can you tell me exactly how many
Children I've saved?

freshspectrum.com

Developing Answerable Questions

Not-So-Great	Better
Are our disease self-management programs working?	Do patients in in our diabetes self-management program experience changes in HbA1C measurements following program participation?
Are our nutrition classes reducing obesity rates?	Who is attending our nutrition education program? How do participants describe the impact of participation?

More Questions

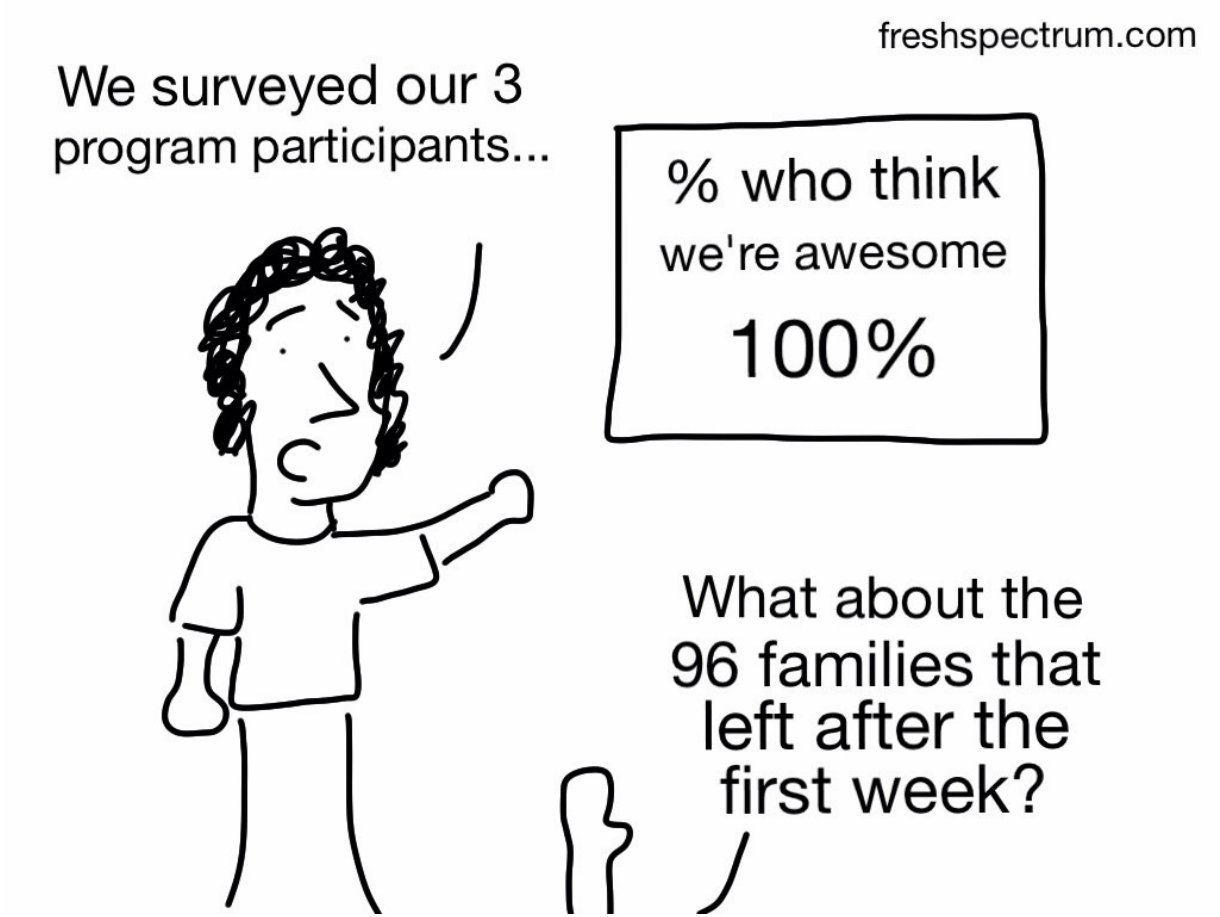
- What share of our HRS investments are going to clinical partners / services vs. community-based partners / services?
- How well are our screening tool(s) identifying member needs that we could address via flexible services?
- To what degree are members and community residents shaping the direction of HRS investments?

Identify Stakeholders

Who are our evaluation stakeholders?	How might they be involved? What might they do?	What might they be interested in learning from the evaluation?	What do we need to do to get them involved?	What will they need to stay engaged?

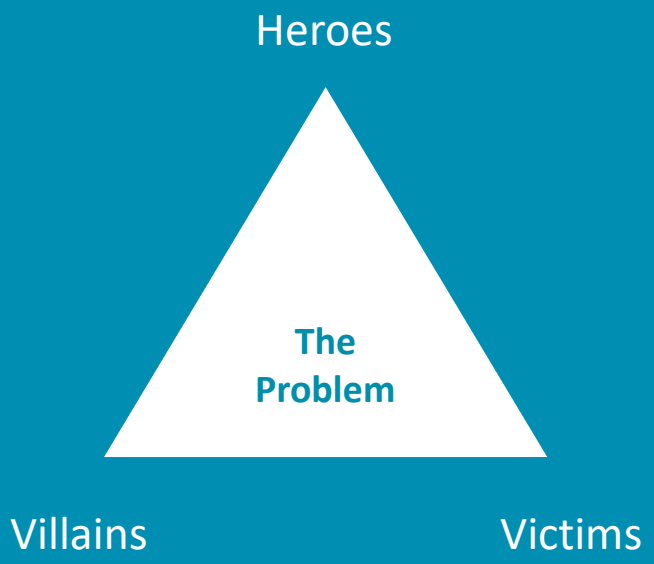
Adapted from Cottage Health Evaluation Toolkit
https://www.cottagehealth.org/population-health/learning-lab/toolkit/engage-stakeholders/

Think About Equity

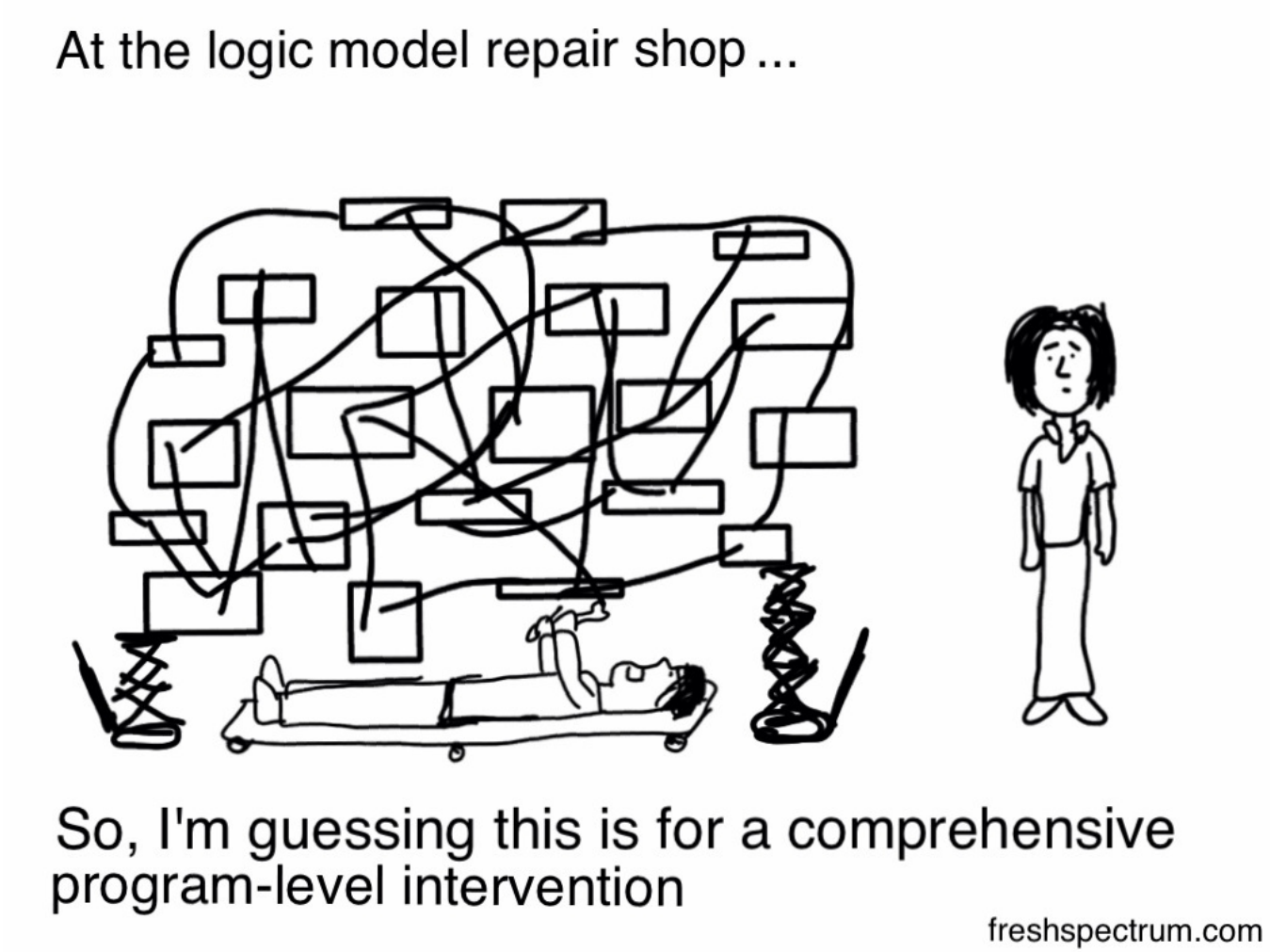


Equitable Evaluation

- How are you thinking about the problem? Whose problem is it?
- Whose values and concerns are reflected? Is anyone missing?
- Who is reflected in the data? Is anyone missing?



Start Small


At the logic model repair shop ...
So, I'm guessing this is for a comprehensive program-level intervention
freshspectrum.com

What are the KEY outcomes to track?

How many participants?

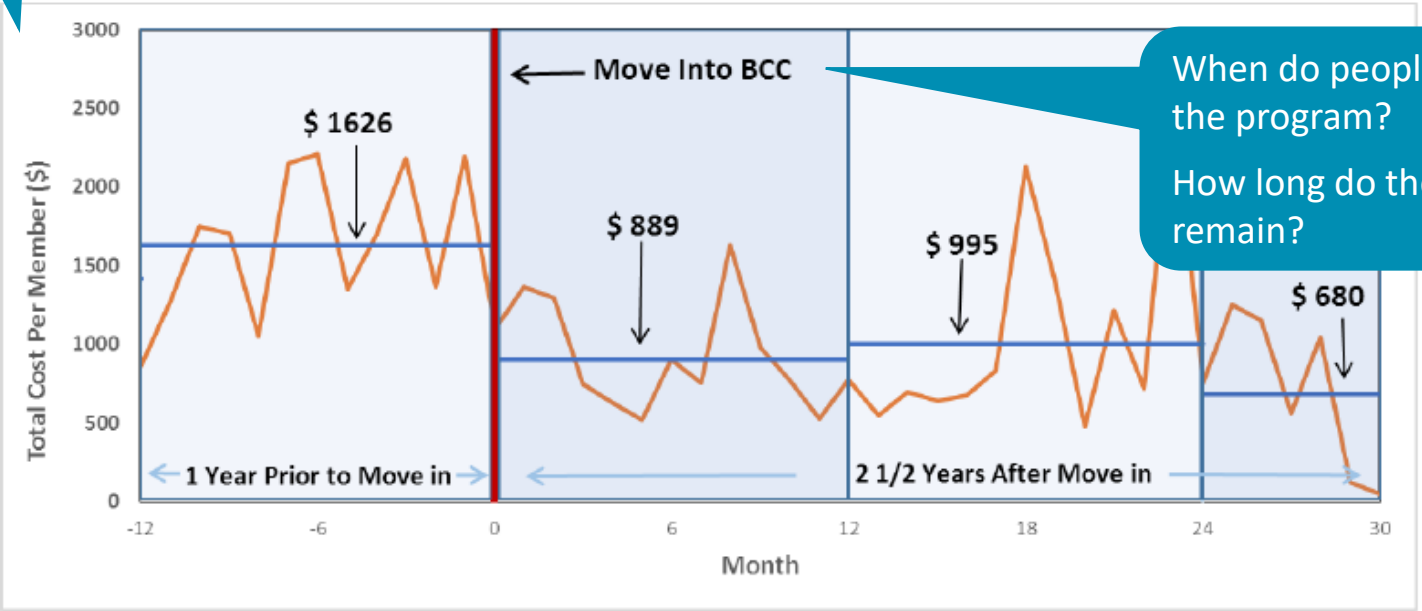
Who are they?

What are their characteristics?

What is the intervention?

Are all participants getting / doing the same thing?

Exhibit 2. Total Costs Per Member Month (PMPM) Before and After Moving in to BCC



When do people enter the program?

How long do they remain?

Where do I go from here

Evaluation Readiness Exercise

Suggested Resources

BetterEvaluation.org *Managers Guide to Evaluation*

Spark Policy Institute *Developmental Evaluation Toolkit*

ReThink Health *Developing a Value Proposition Narrative*

Equitable Evaluation Initiative *Framework and Principles*

CORE | Center for Outcomes Research and Education

www.providenceoregon.org/CORE

Lunch Time Conversation:
Social Determinants of Health and Equity:

Meaningful Changes and What Others Can Teach Us

Bruce Goldberg, MD
Anne King, MBA

Special thanks to Alex Chau

ORPRN
Oregon Rural Practice-Based Research Network

OHSU

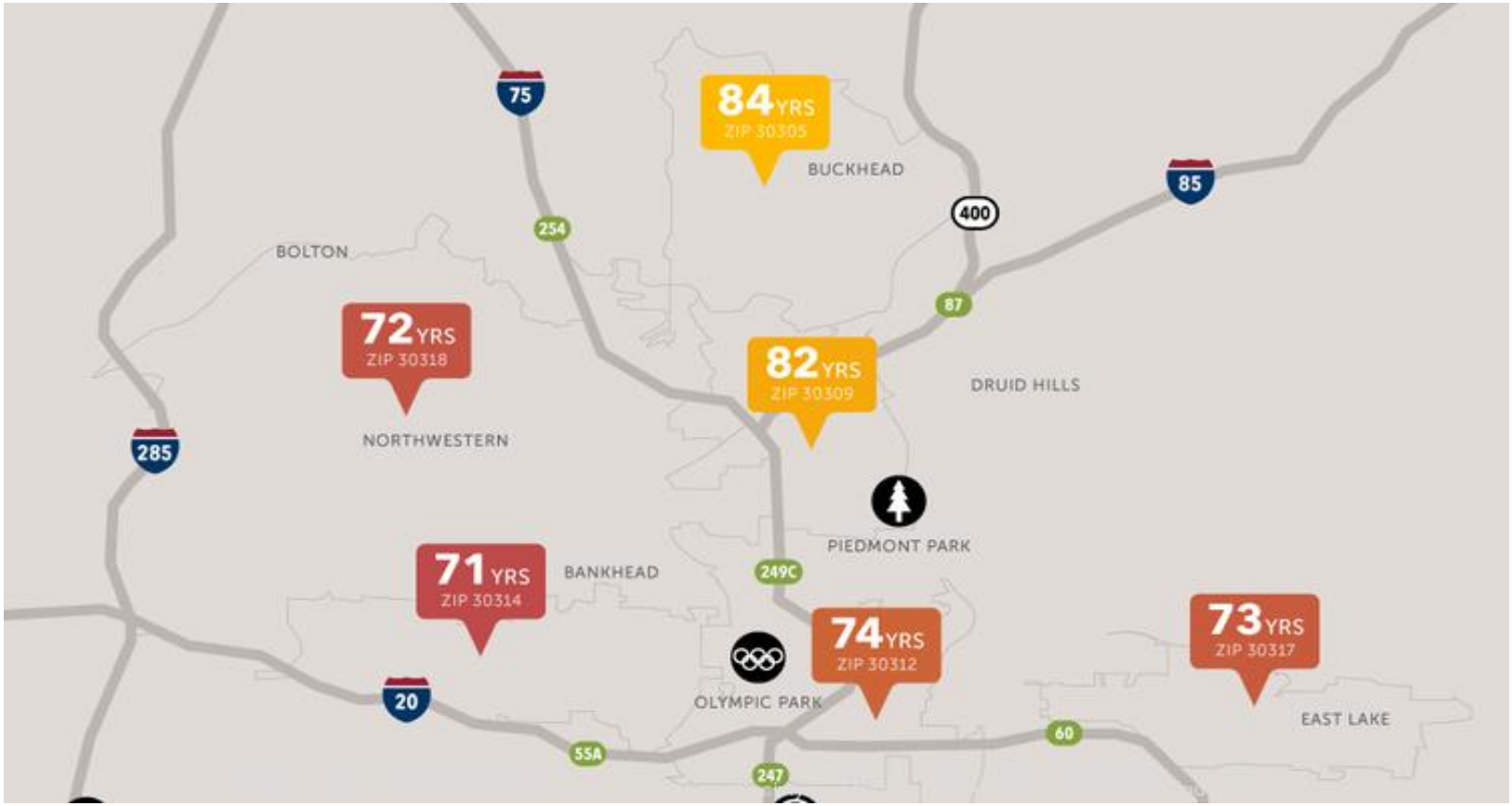
What are Social Determinants of Health?

- "…the economic and social conditions that influence ... Health." (Commission on Social Determinants of Health, 2008)

- "…the conditions in which people are born, grow, live, work, and age." (World Health Organization, 2019)

National Context

- Health care costs growing faster than other economic indicators
- Outcomes are varied and inconsistent
- National health reform efforts – SIM, Medicare, PCMH, CPC+
- A plethora of state health reform efforts
- Growing evidence of importance of social investments, care coordination, primary care


84 YRS
ZIP 30305
BUCKHEAD
75
85
400
254
BOLTON
87
72 YRS
ZIP 30318
82 YRS
ZIP 30309
DRUID HILLS
285
NORTHWESTERN
PIEDMONT PARK
71 YRS
ZIP 30314
BANKHEAD
249C
74 YRS
ZIP 30312
73 YRS
ZIP 30317
OLYMPIC PARK
20
60
55A
EAST LAKE
247

Income Inequality and Health

- Lower income contributes to:
  - Higher rates of unhealthy behaviors (e.g. poor diet, smoking, physical inactivity)
  - Higher rates of chronic disease
  - Lower life expectancy

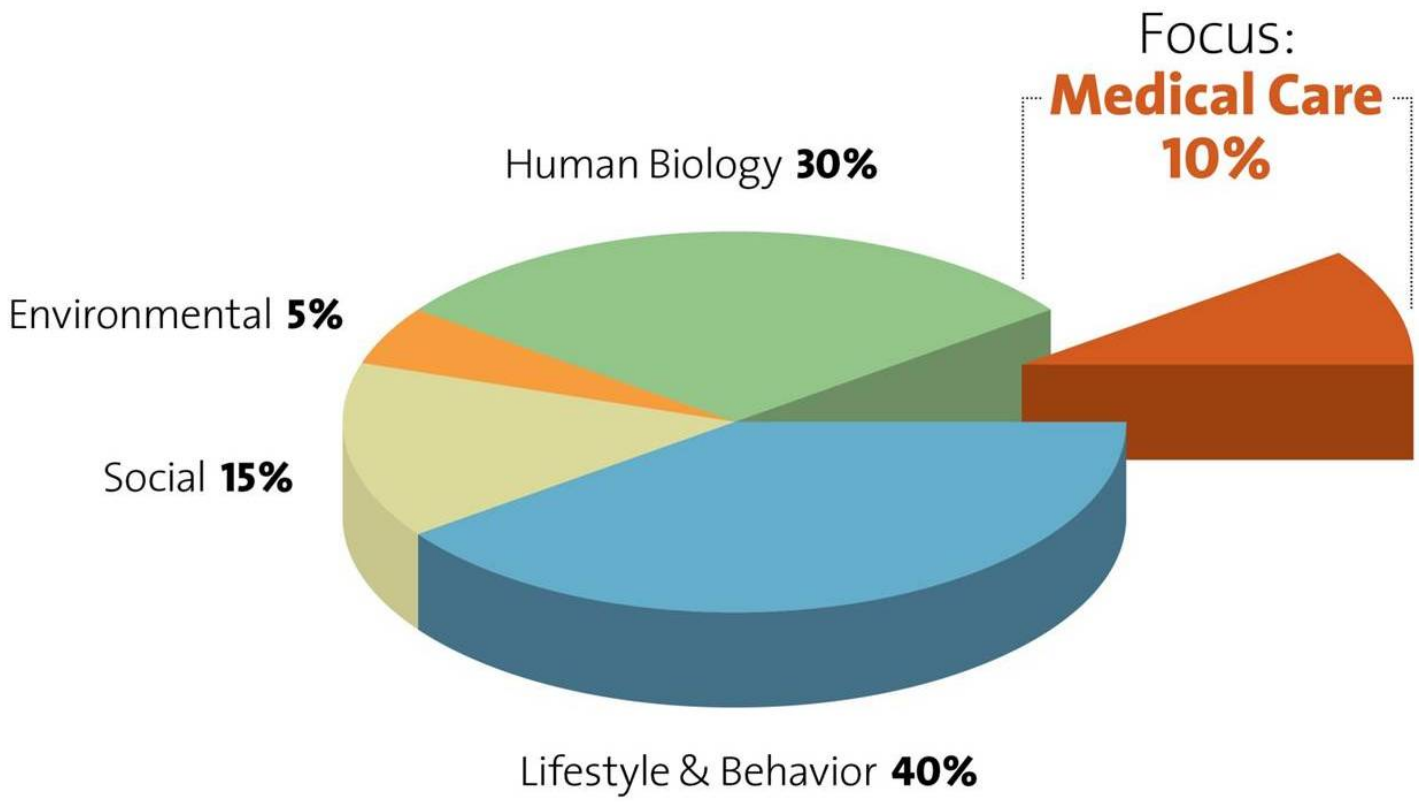
https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70442

Social Needs & Health

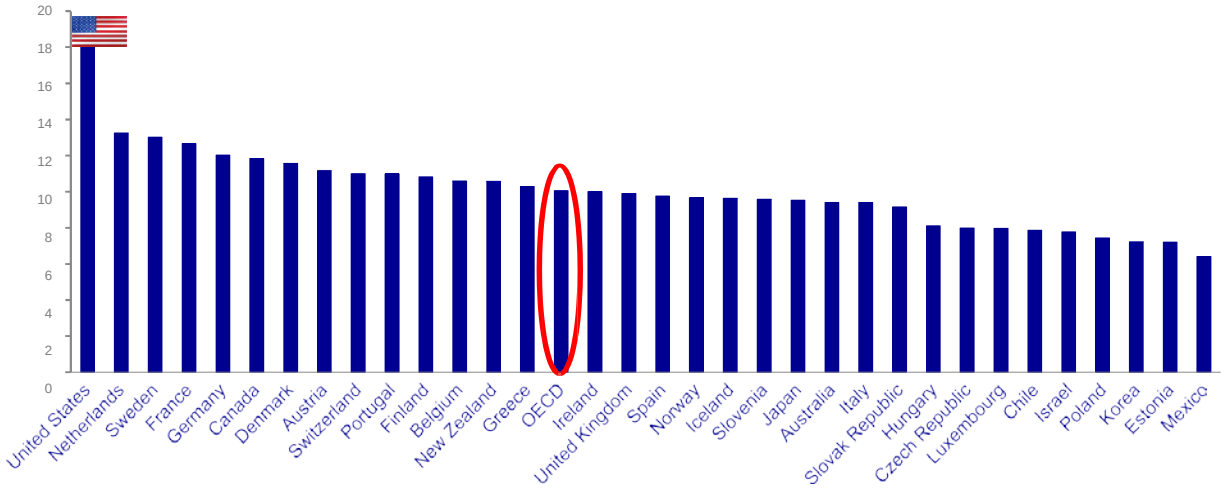
- People with social needs (housing, food, etc.):
  - Obtain fewer preventive services
  - Use more emergency services
  - Have higher readmission rates

(McKelvey, 2017) (Meddings, 2017)

Contributors to Health



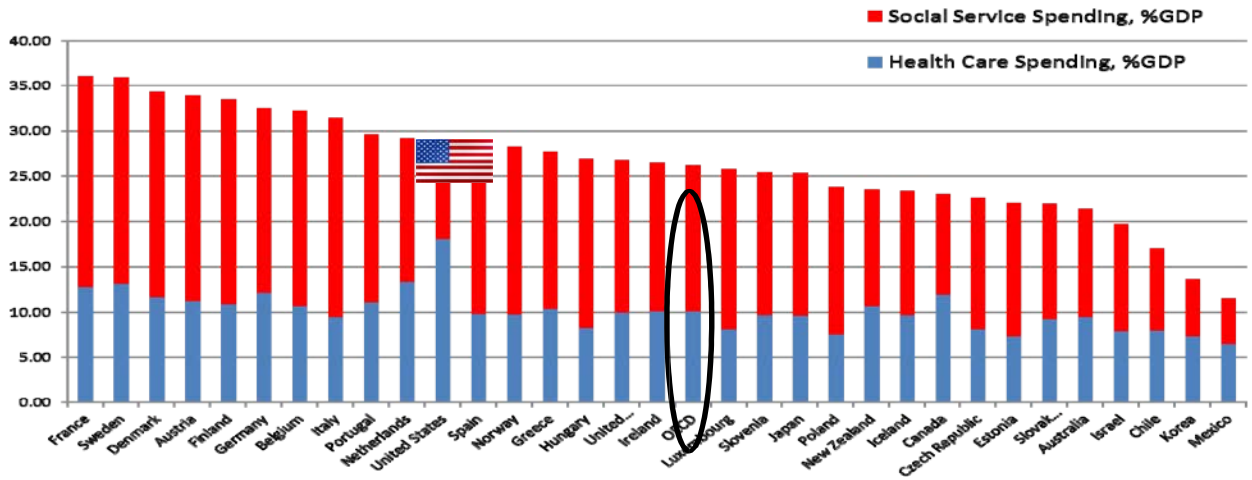
Spending on Health Care



Elizabeth Bradley, PhD

Yale Global Health Leadership Institute

Spending on Social Services



Elizabeth Bradley, PhD
Yale Global Health Leadership Institute

Opportunity Costs!

- 1 ED Visit = 1 months rent
- 2 hospitalizations = 1 year of child care
- 20 MRIs = 1 social worker per year
- 60 echocardiograms = 1 public school teacher per year

SGIM Presidential Speech, Dr. Moran, 2015

How do you increase investments made into social determinants and equity?

State efforts to improve health & increase investments in social spending

- Foster better value and efficiency in health delivery systems through payment reforms, value based purchasing and delivery system changes
- Invest some of those savings into social enterprises that improve health
- Increased partnerships across health and social service endeavors
- Creating coordinating/integrating organizations

The Alphabet Soup of Approaches

- ACO
- CCO
- ACC
- ACH
- CPC
- AHC
- RCCO
- MCO
- PCMH

States that Address SDOH in Medicaid Contracts

- California
- Colorado
- Connecticut
- Delaware
- Massachusetts
- Michigan
- Minnesota
- New York
- North Carolina
- Oregon
- Rhode Island
- Vermont
- Washington

Frequently included: transportation, housing services, and relationships with community organizations to address SDOH

https://nashp.org/wp-content/uploads/2018/08/Social-Determinants-of-Health-in-Medicaid-Contracts-plus-CT-12_6_2018.pdf

Case in Point- North Carolina

- 1115 waiver allows non-medical interventions that address housing instability, transportation needs, food insecurity, interpersonal violence and toxic stress for patients with physical or behavioral risk factors and social risk factors

- $650 million pilot

- Two mechanisms- cost-based reimbursement and bundled payments

- Services are handled through enhanced case management. The case/care manager recommends the services at the lowest intensity level that could reasonably meet the patient's needs.

Case in Point- North Carolina

- Services must be from a CMS-approved menu
- Regional Lead Pilot Entities develop, pay and oversee network of human service organizations that deliver the care to patients

Figure 1

North Carolina Healthy Opportunities Pilots Eligibility Criteria and Services

Health Risk Factors	Social Risk Factors	Pilot Services
• Adults with two or more chronic conditions or repeated emergency room use or hospital admissions • High-risk pregnant women • High-risk infants and children or infants and children with one or more chronic conditions	• Homelessness and housing insecurity • Food insecurity • Transportation insecurity • At risk of witnessing or experiencing interpersonal violence	• Tenancy support; housing quality and safety; legal referrals; security deposit and first month rent; short-term post-hospitalization housing assistance • Food support and meal delivery • Non-emergency health-related transportation • Interpersonal violence-related transportation, legal referrals, and parent-child supports

https://www.kff.org/report-section/a-first-look-at-north-carolinas-section-1115-medicaid-waivers-healthy-opportunities-pilots-issue-brief/

Case in Point- Massachusetts

- MassHealth's 1115 waiver authorized $1.8 billion over five years in Delivery System Reform Incentive Program (DSRIP) funding to restructure care.
- $149 million was allocated to fund a Flexible Services Program which pays for nutrition and tenancy preservation supports for certain ACO members.

https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program#flexible-services-

Case in Point- Oregon

- CCO
- CPC+
- PCPCH
- AHC
- etc.

Oregon Accountable Health Communities (AHC)

- Screening Medicaid & Medicare beneficiaries for 5 health-related social needs (housing, food, utilities, transportation & safety)
- Connecting patients to community services (or understanding where resources are not available)
- Providing information on available social services
- Providing navigation to social services for highest risk patients

AHC – A look at the needs identified statewide

Statewide:

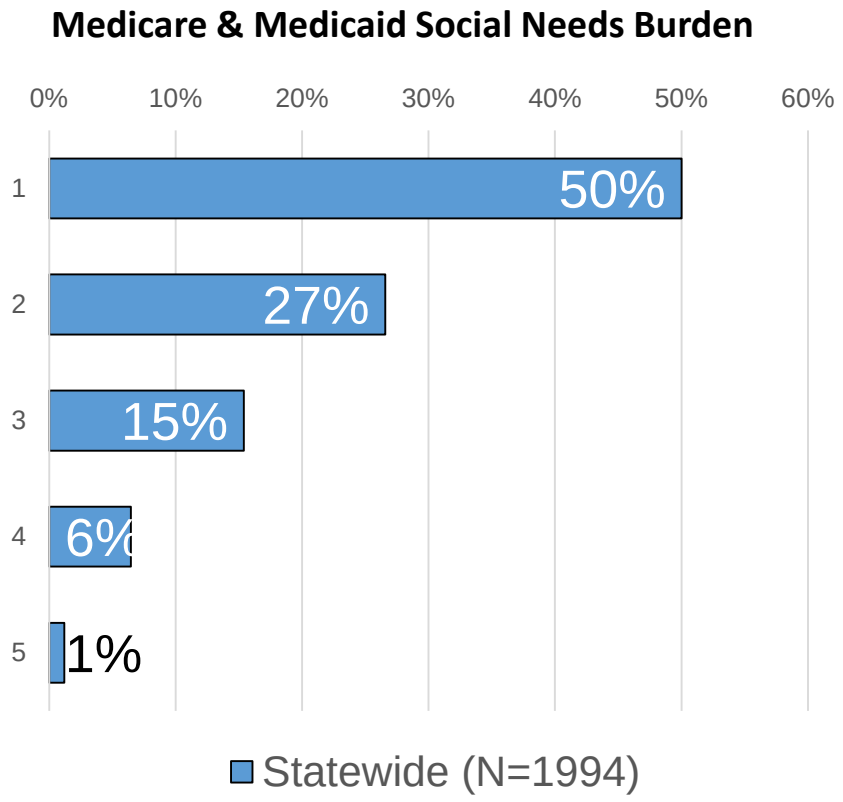
- Clinical sites have screened 4,982 people so far

- 50% of Medicaid Patients, and 40% of all patients (Medicaid and Medicare)report a social need

Note: Non-community dwellers were excluded from analysis

AHC- Health-related social needs in Oregon

- **Of patients with social needs, 50% have more than one**



AHC- Needs of Population Screened

- **Medicaid Members Report:**
  - 40% food insecurity
  - 25% housing insecurity
  - 16% transportation needs
  - 14% utilities needs
  - 4% safety concerns

AHC- Needs of Population Screened by Ethnicity and Race

- **51% of Hispanics report a social need compared to 40% of non-Hispanics**
    - **To date, Hispanics are reporting food insecurity at a higher rate than non-Hispanics**
- **54% of non-whites have social needs compared to 40% of whites**

Note: Non-community dwellers and unknowns were excluded from analysis

AHC- Needs of Population Screened by Rural/Urban Areas

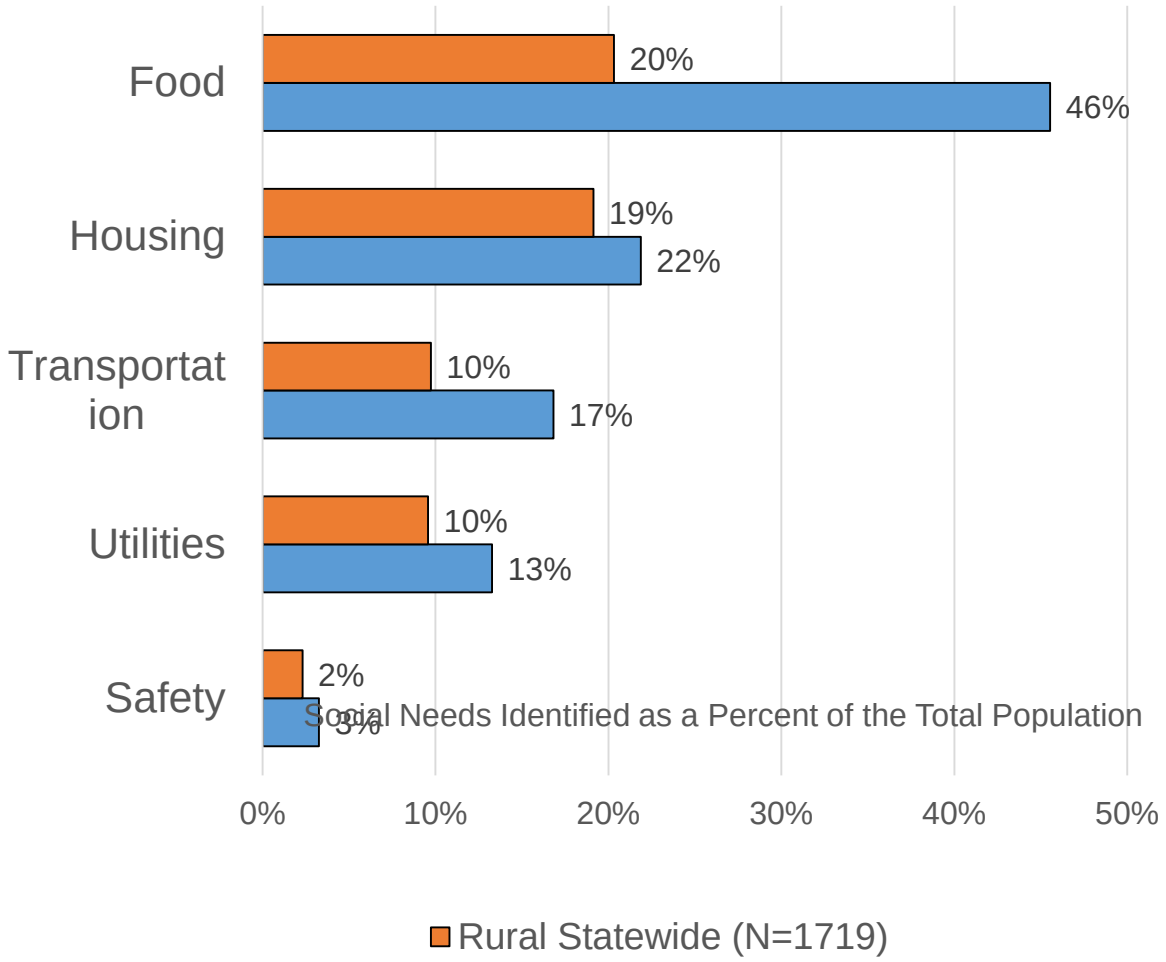


Table Discussions

- We know that there is tremendous health-related social need in Oregon.
- What do you want your organization to do next to address your members' social determinants of health?

-Transition to Breakout Sessions-

Oregon Health Authority

Breakout Session: Investments in Traditional Health Workers

Jennine Smart, MSW, Equity and Inclusion Manager, Health Share of Oregon

Oregon Health Authority

The What and Why of HRS Financial Reporting

Zachary Goldman, MPP, Economic Policy Advisor, OHA
Tom Wunderbro, MPA:HA, 1115 OHP Waiver Manager, OHA
Anona Gund, MPH, Transformation Analyst, OHA

Oregon Health Authority

Exhibit L – reporting HRS spending

The 2019 Exhibit L reporting template

Quarterly data – tab L6.2:

	Q1-2019				Q2-2019				Q3-2019				Q4-2019				YTD 2019				
	Flexible Services		Community Benefit Initiative		Flexible Services		Community Benefit Initiative		Flexible Services		Community Benefit Initiative		Flexible Services		Community Benefit Initiative		Flexible Services		Community Benefit Initiative		
Health Related Service Category	of Members Receiving	Cost	of Members Receiving	Cost	of Members Receiving	Cost	of Members Receiving	Cost	of Members Receiving	Cost	of Members Receiving	Cost	of Members Receiving	Cost	of Members Receiving	Cost	of Members Receiving	Cost	of Members Receiving	Cost	Short description of service provided
1. **Training and education for health improvement or management** (e.g., classes on healthy meal preparation, diabetes, self-management curriculum)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
2. **Care coordination, navigation, or case management activities** not otherwise covered under State Plan benefits (e.g., high utilizer intervention program)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
3. **Home and living environment items or improvements** not otherwise covered by 1915 Home and Community Based Services (non-Durable Medical Equipment [DME] items to improve mobility, access, hygiene, or other improvements to address a particular health condition, e.g., air conditioner, athletic shoes, or other special clothing)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
4. **Transportation** not covered under State Plan benefits (e.g., other than transportation to a medical appointment)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
5. **Programs to improve community**																					

- Summary data stratified by HRS category
- Quarterly sums

Oregon Health Authority

Exhibit L – reporting HRS spending

The 2019 Exhibit L reporting template

Annual data – tab L6.21:

a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.
Expenditure/Health-related services investment name	**Description of services provided**	**HRS Category**	**Amount incurred for Flexible Services**	**Amount incurred for Community Benefit Initiative**	**Amount incurred for Health Information Technology**	**Total HRS incurred (Flex Services + CBI + HIT)**	**Predicted number of members directly receiving (if applicable)**	**Briefly describe the rationale for this particular investment. Explain the evidence-based, best-practice, widely accepted best clinic practice, and/or criteria used to justify the expenditures.**	**Briefly describe intended measureable outcomes**	**Length of investment or initiative**	**Start date of investment (mm/dd/yyyy)**	**End date of investment (mm/dd/yyyy)**
ex. Housing support referral program or air conditioners		Select a category from the dropdown list	-	-	-	-	-			Select a timeframe from the dropdown list		
		Select a category from the dropdown list	-	-	-	-	-			Select a timeframe from the dropdown list		

- Detailed data stratified by investment name
- Includes dollar amounts, description of intended measurable outcomes, description of projected return on investment, and more

Exhibit L – reporting HRS spending

The 2019 Exhibit L reporting template

Annual data – tab L6.22:

a.	b	c		
Expenditure/Health-related services investment name	**Medicaid Member ID**	**Continue listing IDs -->**		
ex. Housing support referral program or air conditioners				
-				
-				
-				
-				
-				

- Includes Medicaid member IDs for evaluation purposes
- Reminder: Evaluating HRS is one of four key components of the Medicaid 1115 waiver.

2018 CCO Exhibit L submissions

How did the HRS team review the 2018 submissions?

- Evaluated each line item to ensure the expenditure met HRS criteria
- Analyzed submitted versus accepted HRS expenditures within and across CCOs

What was missing in the 2018 submissions?

- Details for each expenditure name and rationale were often insufficient for HRS team to assess whether it met HRS criteria.
- Flexible services were often missing the number of members who received the service.

2018 CCO Exhibit L submissions

What are examples of clear rationale and sufficient details?

EXAMPLE OF AN ACCEPTABLE EXPENDITURE WITH A CLEAR RATIONALE FOR AN EVIDENCE-BASED PRACTICE

PAX Good Behavior Game is an evidence-based, SAMSHA-endorsed framework for increasing student self-regulation and creating nurturing environments within schools and youth programs. The social emotional and academic returns on this investment have been proven over the past two decades and is resulting in reclaimed instructional time, workforce rejuvenation, and student success measures in cognitive and emotional skills. This expenditure encompassed initial trainings to provide the basic skills needed to implement the PAX framework in schools and other youth serving settings.

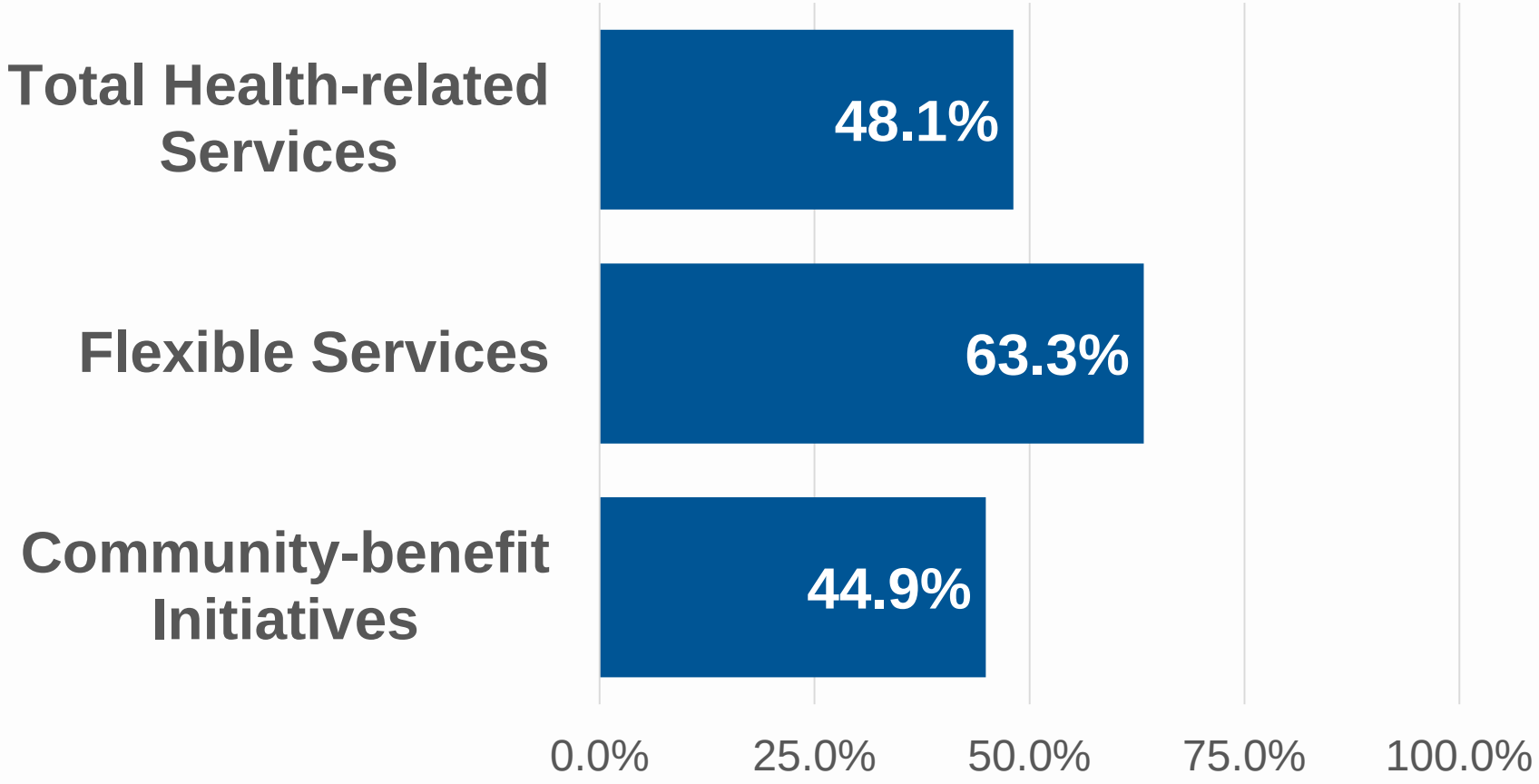
2018 CCO Exhibit L submissions

What are examples of clear rationale and sufficient details?

EXAMPLE OF AN ACCEPTABLE EXPENDITURE WITH A CLEAR RATIONALE FOR A WIDELY-ACCEPTED PRACTICE

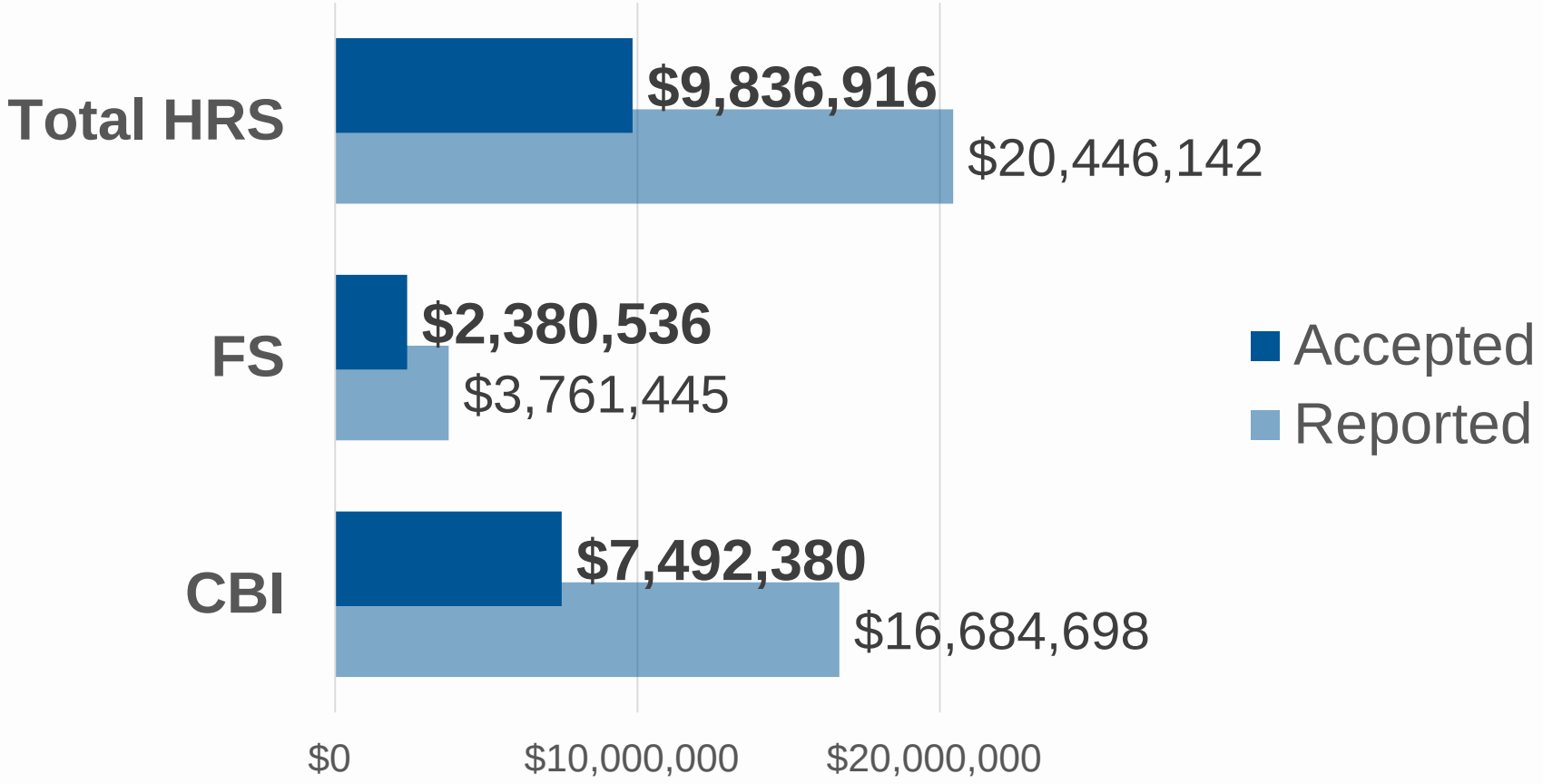
The expenditure provides transportation not covered by Non-Emergent Medical Transportation to improve access to care. Without access to care, health will deteriorate.

2018 CCO Exhibit L analysis:
Percent of accepted expenditures



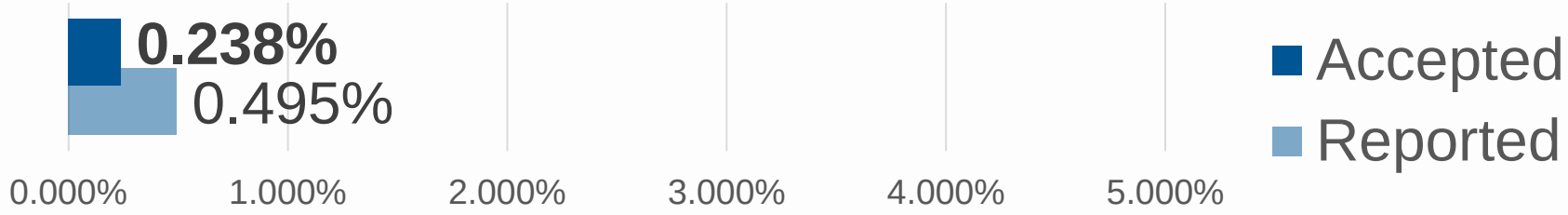
2018 CCO Exhibit L analysis:

Reported versus accepted expenditure amounts

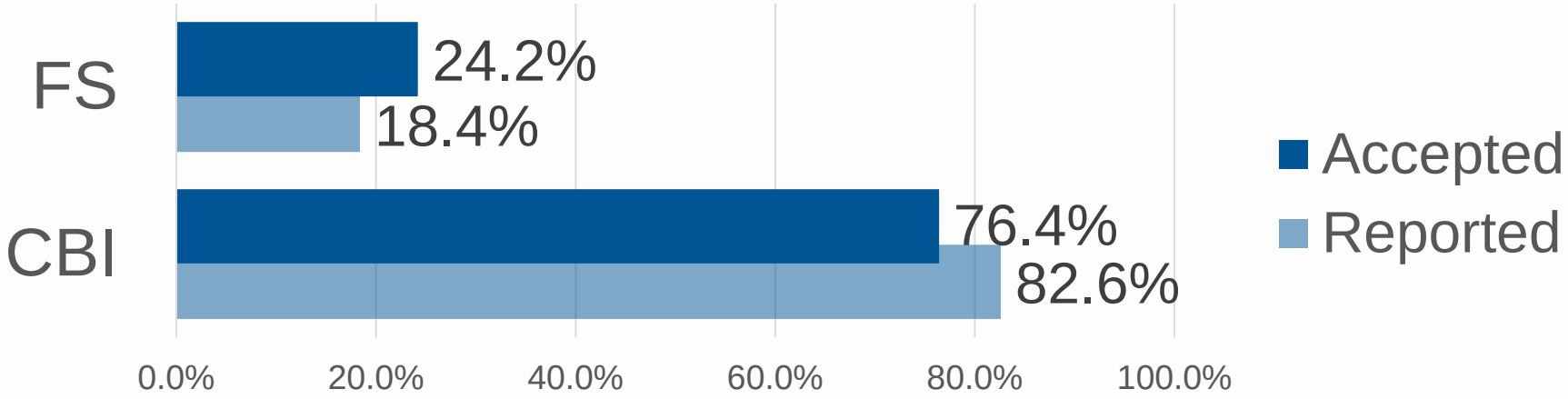


2018 CCO Exhibit L analysis

HRS Percent of Total CCO Spending



Percent of Total HRS Spending



Why HRS data are needed

HRS reporting and 1115 waiver

- HRS is a core component of Oregon's 1115 waiver.
- HRS is one of the four waiver evaluation priorities:

  "Implementation and impact of health-related services, including the degree to which HRS are addressing social determinants of health"
- Contracted evaluation team will use HRS data in their waiver evaluation.

Where do we go from here?

Performance-based reward begins in 2020. CCOs' performance including HRS spending in 2020 will be reported and approved by CMS in 2021 and will be included in the 2022 rates.

CCOs will receive feedback on:

- 2018 HRS expenditures this month
  - Note: OHA team rejected some CCOs' HRS spending based on inadequate description, and accepted other spending even though level of detail was similar. For example, "purchase of transportation" does not require any other detail because it's self-explanatory. However, "purchase of home items" is insufficient because it needs more information about what was purchased and the justification.
- 2019 HRS expenditures in summer of 2020
- 2020 HRS expenditures in summer of 2021

Questions?

Questions, Answers and Additional Assistance

Chris DeMars, MPH, Director, Transformation Center, OHA
Tom Wunderbro, MPA:HA, 1115 OHP Waiver Manager, OHA
Anona Gund, MPH, Transformation Analyst, OHA

Oregon Health Authority

Summary of themes from the day

OHA Updates

- Oregon Administrative Rules for HRS have been posted online:
  - OHA rules page: https://www.oregon.gov/OHA/HSD/Pages/RAC.aspx
  - Old rule: OAR 410-141-3150
  - New Rule: OAR 410-141-3845
  - Oregon Bulletin: https://secure.sos.state.or.us/oard/processLogin.action
- 2020 HRS policy requirements updated and moved to 2020 CCO contract:
  - Exhibit K, Section 9d

Oregon Health Authority

Oregon Health Authority