# How CCOs Are Advancing Health Equity

**May 16, 2017**

## What Is Health Equity?

## Why Is Health Equity Important?

## How Can CCOs Advance Health Equity?

U.S. Department of Health & Human Services

NATIONAL PARTNERSHIP FOR ACTION
to End Health Disparities

Health equity is attainment of the *highest level of health for all people*. Achieving health equity requires valuing everyone equally with focused and ongoing *societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities*.


NORTHWEST HEALTH FOUNDATION

# Health Equity Consultations with CCOs: Technical Assistance Team

- Voluntary technical assistance offered, not compliance review or audit
- OHA Transformation Center staff and Technical Assistance Bank consultant
- OHA Innovator Agents
- OHA Office of Health Analytics
- OHA Office of Equity & Inclusion
- We went to the CCOs: on site, tailored consultation at each CCO

# Health Equity Consultations with CCOs

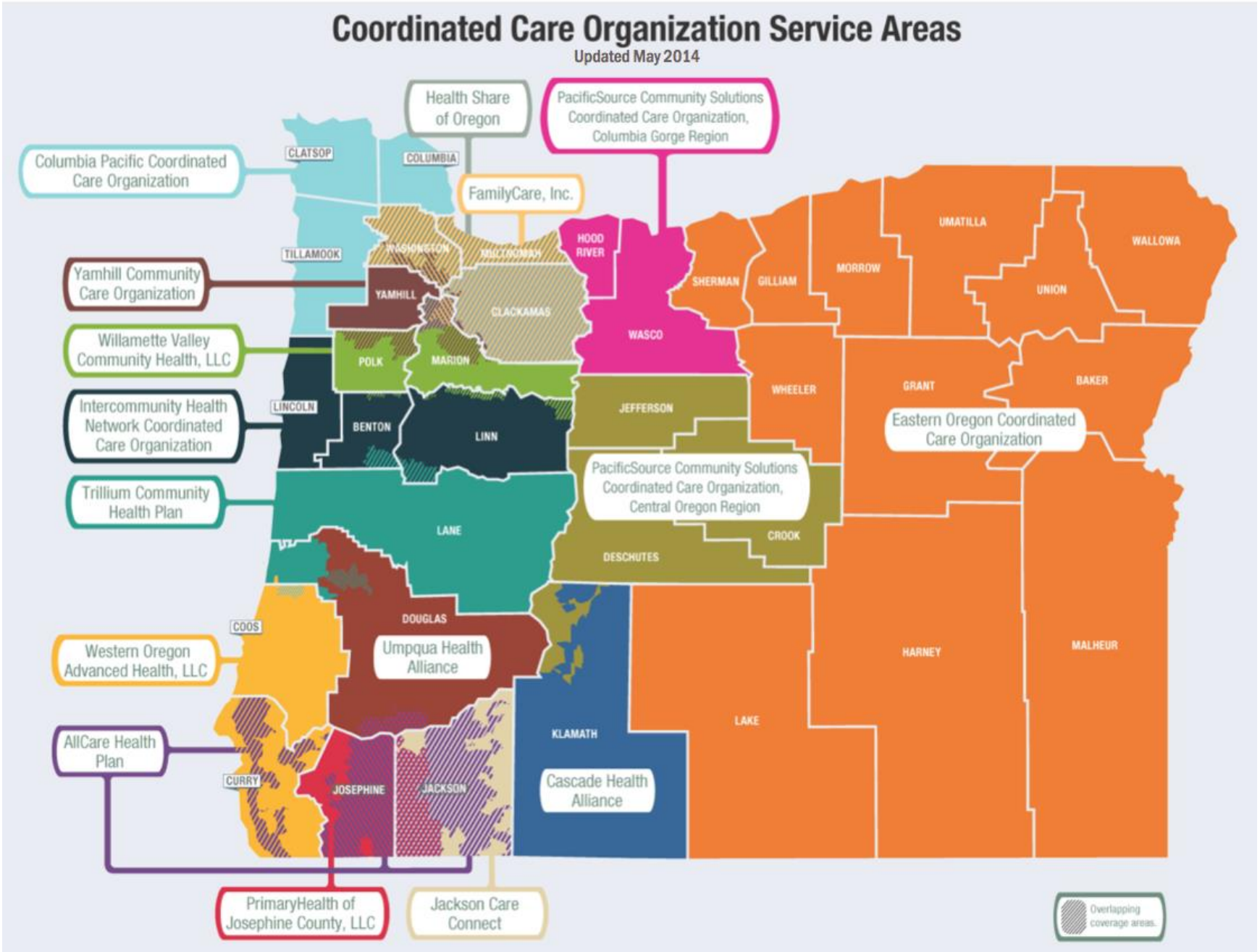
- CCOs invited staff, board, providers, community participants (CAC members, regional health equity coalitions, etc.)
- Technical assistance team had pre-call, two-hour consultation on-site at CCO, debrief call
- Shared data and written materials with CCO before consultation
- Shared written summary with CCO after consultation

# Health Equity Consultations with CCOs

- May 2016 -> November 2016
- All 16 CCOs participated; 144 total participants
- 5 CCOs had “equity staff” (full- or part-time)
- 9 CEOs/equivalents, 5 CMOs/equivalents, 5 COOs/equivalents
- Quality, data, provider relations, IT staff
- 7 CAC coordinators/equivalents
- Regional health equity coalitions

# Coordinated Care Organization Service Areas

Updated May 2014



# Health Equity Consultations with CCOs: Data and Materials Reviewed

- **Demographic data about CCO members: race and ethnicity, household language, members with disability**
- **Incentive measure data, stratified by member demographics, when available**
- **CCO Transformation Plan**
- **CCO Community Health Improvement Plan**

# Health Equity Consultations with CCOs: Data and Materials Reviewed

- **Demographic data about CCO members: race and ethnicity, household language, members with disability**
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# Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update

January 2016

Oregon Health Authority

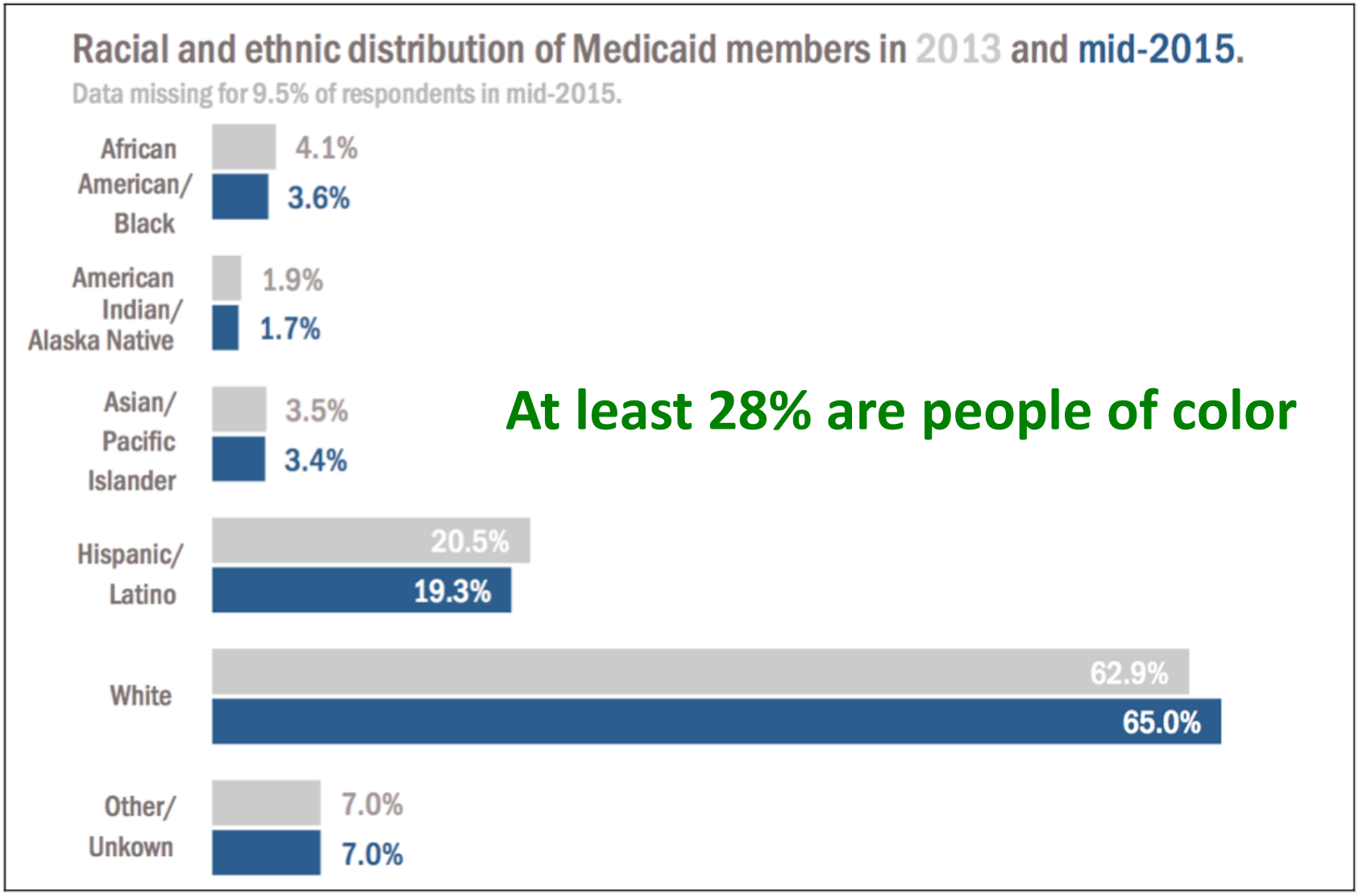
MEASUREMENT PERIOD:
July 2014–June 2015
Version 1.1
JANUARY 20, 2016

# 25% of Oregon's Population Are People of Color (>1 million of 4 million)

| HISPANIC OR LATINO AND RACE | | | |
|---|---|---|---|
| Total population | 4,028,977 | ***** | 4,028,977 |
| Hispanic or Latino (of any race) | 511,898 | ***** | 12.7% |
| Mexican | 419,208 | +/-8,812 | 10.4% |
| Puerto Rican | 12,734 | +/-2,342 | 0.3% |
| Cuban | 8,582 | +/-2,356 | 0.2% |
| Other Hispanic or Latino | 71,374 | +/-7,990 | 1.8% |
| Race alone or in combination with one or more other races | | | |
| Total population | 4,028,977 | ***** | 4,028,977 |
| White | 3,606,157 | +/-11,976 | 89.5% |
| Black or African American | 109,403 | +/-2,892 | 2.7% |
| American Indian and Alaska Native | 129,579 | +/-5,524 | 3.2% |
| Asian | 227,243 | +/-1,966 | 5.6% |
| Native Hawaiian and Other Pacific Islander | 29,529 | +/-2,657 | 0.7% |
| Some other race | 124,070 | +/-9,291 | 3.1% |

Source: American Community Survey, **2015** One-Year Estimate (Table DP05)

# 7/2014-6/2015




**At least 28% are people of color**

| Subject | Total | | Percent | Percent speak English less than "very well" | |
|---|---|---|---|---|---|
| | Estimate | Margin of Error | Estimate | Estimate | Margin of Error |
| Population 5 years and over | 3,799,838 | +/-1,866 | (X) | 6.0% | +/-0.3 |
| Speak only English | 3,226,975 | +/-13,520 | 84.9% | (X) | (X) |
| Speak a language other than English | 572,863 | +/-13,512 | 15.1% | 39.5% | +/-1.4 |

Source: American Community Survey, **2015** One-Year Estimate (Table S1601)

>15% of Oregon's ~3.8 million residents 5 years and over, or >572,000 residents, speak a language other than English

>39% of them, or >226,000, are likely to need language assistance services

# >8% live in households with primary languages other than English

| Household Language July 2014-June 2015 | English | Spanish | Russian | Viet-nam-ese | Canton-ese | Somali | Arabic | Burm-ese | Nepali | Karen |
|---|---|---|---|---|---|---|---|---|---|---|
| CCO Members 1,132,846 | 649,178<br>57.3% | 71,282<br>6.3% | 6,751<br>0.6% | 3,990<br>0.4% | 2,044<br>0.2% | 1,789<br>0.2% | 1,215<br>0.1% | 510<br><0.0% | 441<br><0.0% | 403<br><0.0% |

| Household Language July 2014-June 2015 | Korean | Farsi | Roman-ian | Hmong | Cambo-dian | Bosnian | Laotian | Swahili | Amharic | Oromo |
|---|---|---|---|---|---|---|---|---|---|---|
| CCO Members 1,132,846 | 354<br><0.0% | 350<br><0.0% | 333<br><0.0% | 240<br><0.0% | 221<br><0.0% | 146<br><0.0% | 136<br><0.0% | 133<br><0.0% | 123<br><0.0% | 110<br><0.0% |

| Household Language July 2014-June 2015 | Afrikaans | Other Languages (<100 for any Language) | Other/ Undetermined | Missing |
|---|---|---|---|---|
| CCO Members 1,132,846 | 107<br><0.0% | 1,048<br>0.1% | 324,133<br>28.6% | 67,809<br>6.0% |

# >12% of Oregon's Population Are Individuals with a Disability

| DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION | | | |
|---|---|---|---|
| Total Civilian Noninstitutionalized Population | 316,450,569 | +/-15,477 | 316,450,569 |
| With a disability | 39,906,328 | +/-98,669 | 12.6% |
| | | | |
| Under 18 years | 73,491,931 | +/-34,195 | 73,491,931 |
| With a disability | 3,033,788 | +/-32,418 | 4.1% |
| | | | |
| 18 to 64 years | 196,521,616 | +/-29,493 | 196,521,616 |
| With a disability | 20,411,546 | +/-69,415 | 10.4% |
| | | | |
| 65 years and over | 46,437,022 | +/-22,258 | 46,437,022 |
| With a disability | 16,460,994 | +/-57,954 | 35.4% |

Source: American Community Survey, **2015** One -Year Estimate (Table DP02)

| July 2014-<br>June 2015 | Members<br>Without Disability | Members<br>With Disability |
|---|---|---|
| CCO Members<br>1,132,846 | 1,061,759<br>93.7% | 71,087<br>6.3% |

**Members with disability** is defined as:

"people who qualify for Medicaid based on an impairment that has prevented them from performing substantial gainful activity for at least one year, or is expected to prevent them from performing substantial gainful activity for at least one year;

this may include physical, mental, emotional, learning, developmental or other disabilities;

these individuals may or may not also be qualified for Medicare"

# Health Equity Consultations with CCOs: Data and Materials Reviewed

- **Demographic data about CCO members: race and ethnicity, household language, members with disability**
- **Incentive measure data, stratified by member demographics, when available**
- **CCO Transformation Plan**
- **CCO Community Health Improvement Plan**

| CCO Incentive Measures | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| Adolescent well-care visits | x | x | x | x | x |
| Alcohol or other substance misuse screening (SBIRT) | x | x | x | x | [1] |
| Ambulatory care: emergency department visits (per 1,000 mm) | x | x | x | x | x |
| CAHPS composite: access to care | x | x | x | x | x |
| CAHPS composite: satisfaction with care | x | x | x | x | x |
| Childhood immunization status | | | | x | x |
| Cigarette smoking prevalence | | | | x | x |
| Colorectal cancer screening | x | x | x | x | x |
| Controlling high blood pressure | x | x | x | x | x |
| Dental sealants | | | x | x | x |
| Depression screening and follow-up plan | x | x | x | x | x |
| Developmental screening (0-36 months) | x | x | x | x | x |
| Early elective delivery | x | x | | | |
| Diabetes: HbA1c poor control | x | x | x | x | x |
| Effective contraceptive use | | | x | x | x |
| Electronic health record adoption | x | x | x | | |
| Follow-up after hospitalization for mental illness | x | x | x | x | x |
| Follow-up for children prescribed ADHD medication | x | x | | | |
| Health assessments within 60 days for children in DHS custody | x | x | x | x | x |
| Patient centered primary care home enrollment | x | x | x | x | x |
| Timeliness of prenatal care | x | x | x | x | x |

# AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION

## Ambulatory care: emergency department utilization

**Measure description:** Rate of patient visits to an emergency department. Rates are reported per 1,000 member months and a lower number suggests more appropriate use of this care.

**Purpose:** Emergency departments are sometimes used for problems that could have been treated at a doctor's office or urgent care clinic. Reducing inappropriate emergency department use can help to save costs and improve the health care experience for patients

## mid-2015 data

Statewide change since 2014: **-0.6%** (lower is better)

Number of CCOs that improved: **9**

Racial and ethnic groups experiencing improvement:

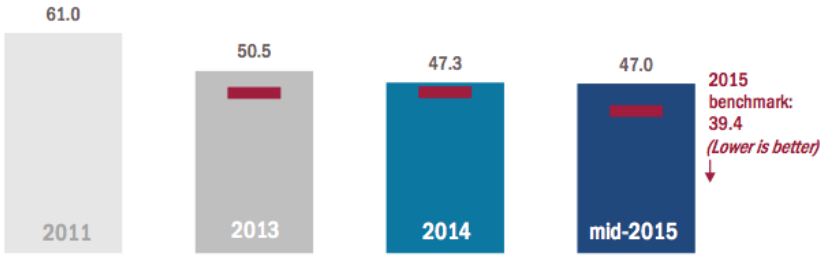
- ✓ African American / Black
- ✓ White

See pages 94, 99, and 104 for results stratified by members with- and without disability and mental health diagnoses.

### About these data:

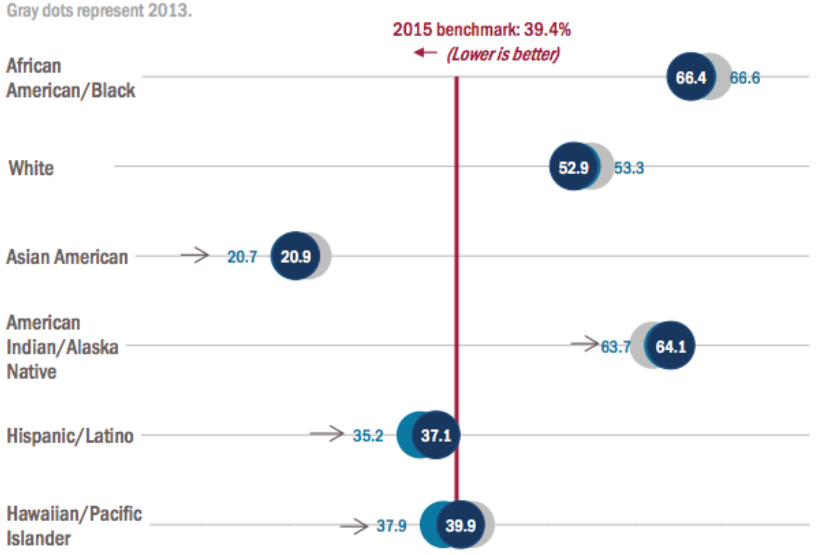
- N= 10,644,736 member months
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 90th percencentile
- Race and ethnicity data missing for 12.6% of respondents
- Each race category excludes Hispanic/Latino
- 2014 benchmark: 44.6

### Statewide, emergency department utilization remained steady between 2014 and mid-2015.



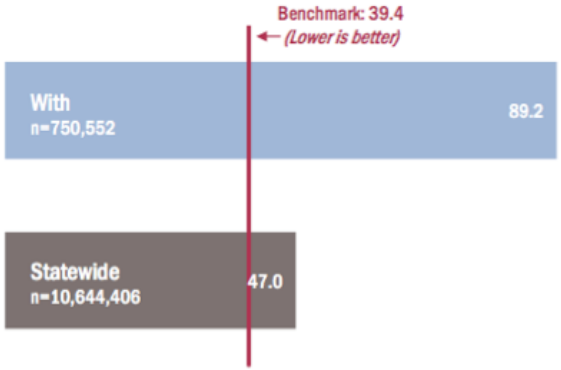

### Emergency department utilization was lowest among Asian American members in both 2014 & mid-2015.

Gray dots represent 2013.



# MEASURES BY DISABILITY

**Emergency department utilization among members with disability compared with statewide.**




## Mid-2015 data

Members with disability have higher rates of emergency department utilization, which mirrors national data (lower rates are better).

Members with disability are more likely to receive timely follow-up (within 7 days) after hospitalization for mental illness than statewide. Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of re-hospitalization.

# Ambulatory Care: Emergency Department Utilization

July 2014 - June 2015


*Data suppressed n<360 member months*

# Ambulatory Care: Emergency Department Utilization

July 2014 - June 2015


*Data suppressed n<360 member months*

- **Ensure Patient-Centered Primary Care Homes (PCPCHs)**
- **Review member education/engagement materials**
- **Review access to after-hours and urgent care services**
- **Address eligibility issues for American Indians, access barriers for members with disability**
- **Engage diverse members/communities/ Indian tribes**

# ADOLESCENT WELL-CARE VISITS

## Adolescent well-care visits

**Measure description:** Percentage of adolescents and young adults (ages 12-21) who had at least one well-care visit during the measurement year.

**Purpose:** Youth who can easily access preventive health services are more likely to be healthy and able to reach milestones such as high school graduation and entry into the work force, higher education, or military service.

## mid-2015 data

Statewide change since 2014: **0%**

Number of CCOs that improved: **10**

Racial and ethnic groups experiencing improvement:

- ✓ White
- ✓ African American / Black

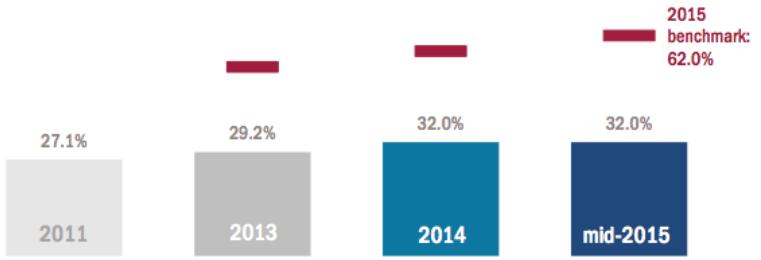
Statewide, the percentage of adolescents who had at least one well-care visit remains well below the benchmark. Barriers to improvement may include providers performing acute care visits when a patient would benefit from comprehensive well care; changes in recommendations for clinical care; and concerns about confidentiality for sensitive services.

See pages 97 and 103 for results stratified by members with- and without disability and mental health diagnoses.

**About these data**

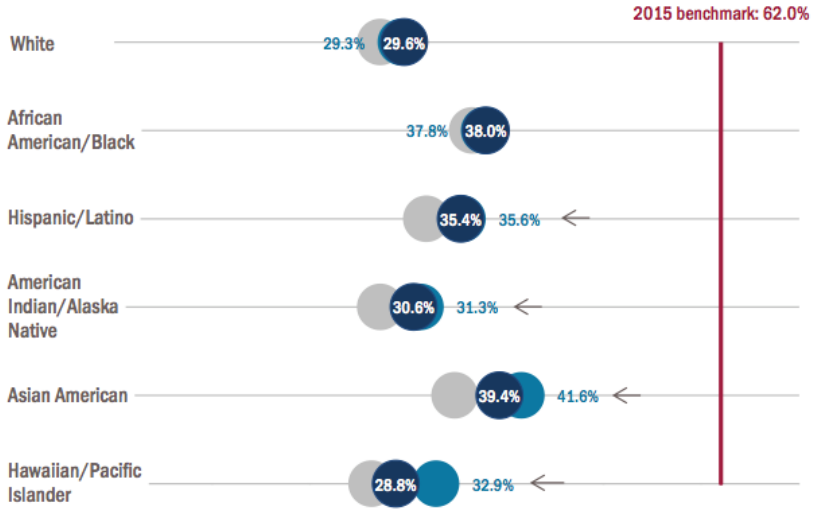
- N=139,396
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile (administrative data only)
- Race and ethnicity data missing for 11.9% of respondents
- Each race category excludes Hispanic/Latino
- 2014 benchmark: 57.6%

### Statewide, the percentage of adolescents receiving well-care visits remained steady between 2014 and mid-2015.



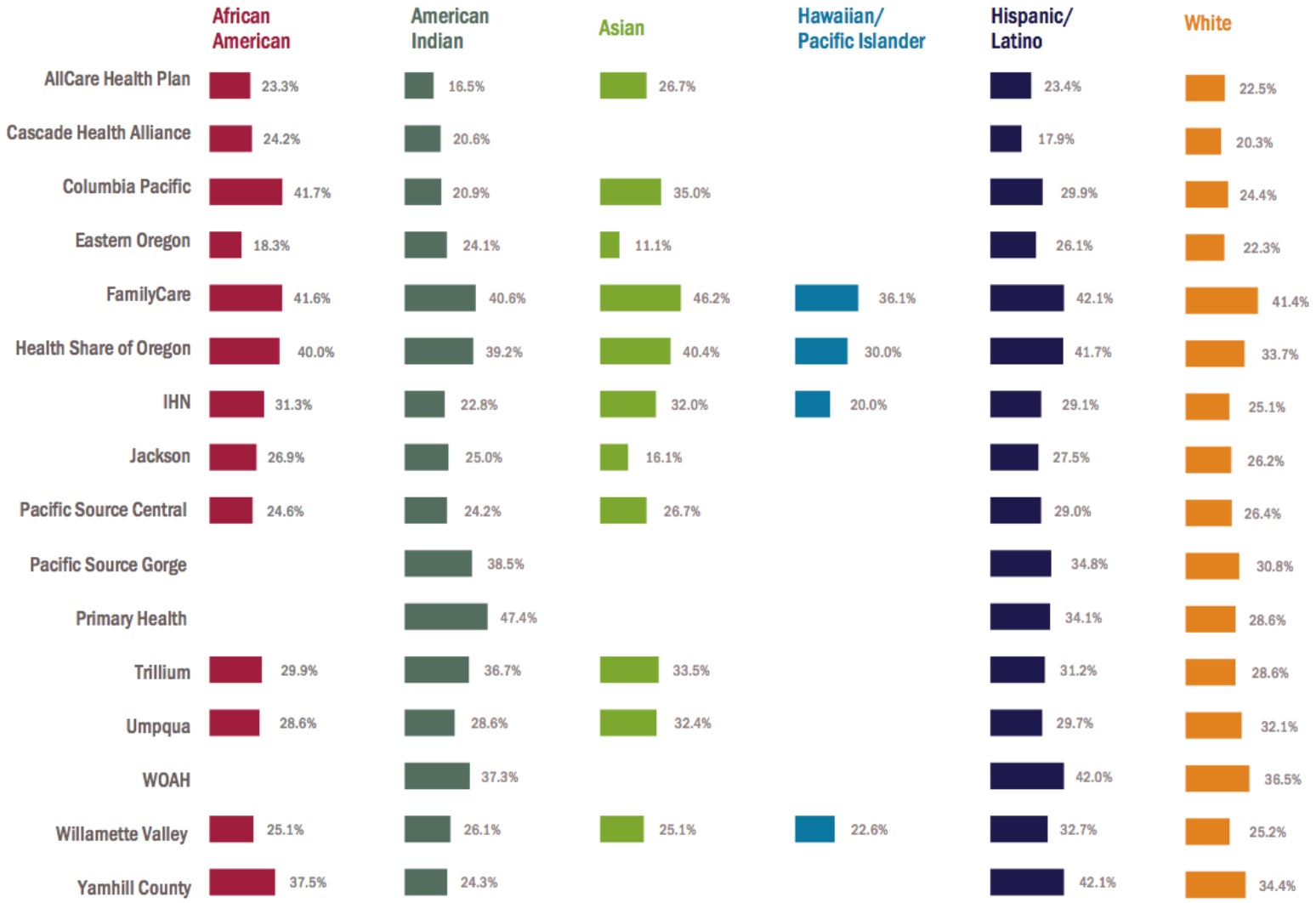

### The percentage of Hawaiian / Pacific Islander adolescents receiving well-care visits declined between 2014 and mid-2015.

Gray dots represent 2013.



# Adolescent Well Care Visits

July 2014 - June 2015

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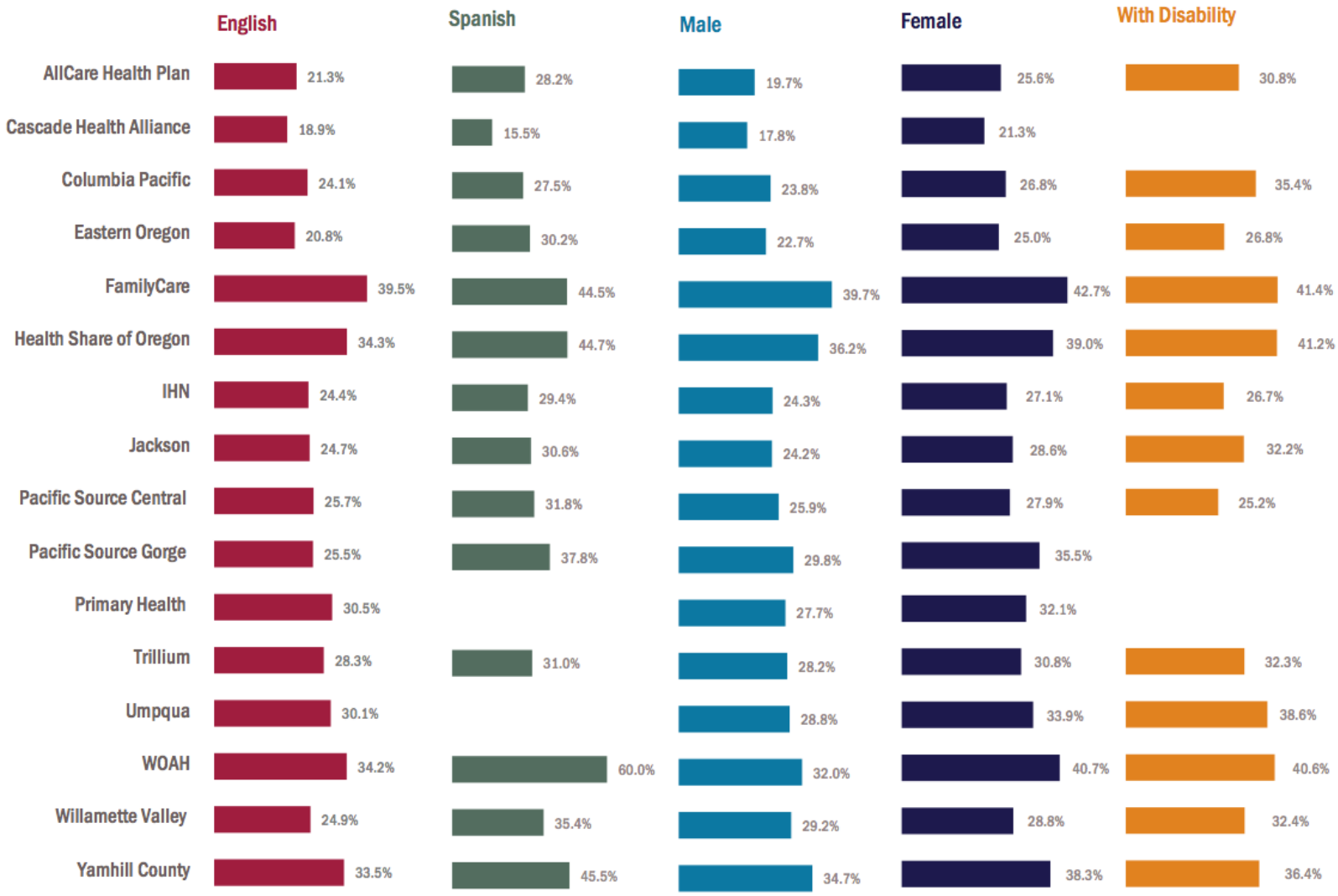
# Adolescent Well Care Visits

**July 2014 - June 2015**

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- **Ensure Patient-Centered Primary Care Homes (PCPCHs)**
- **Use holistic approach, e.g., routine primary care, preventive services**
- **Use translated member education/outreach materials**
- **Partner with schools/sports programs**
- **Engage diverse members/communities/ Indian tribes to develop interventions**

# DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN - ALL AGES (6-14)

## Dental sealants on permanent molars for children (all ages)

**Measure description:** Percentage of children ages 6-14 who received a dental sealant during the measurement year.

**Purpose:** Dental sealants are a widely recognized tool used to prevent tooth decay. Childhood tooth decay causes needless pain and infection, and can affect a child's nutrition and academic performance.

### mid-2015 data

Statewide change since 2014: **+28%**

Number of CCOs that improved: **all 16**

**All** racial and ethnic groups experienced improvement.

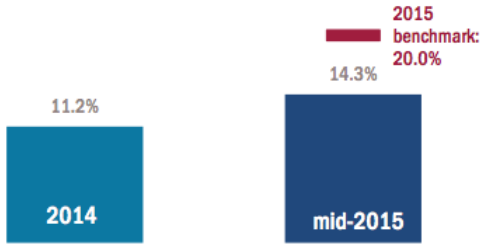
Dental sealants is a new incentive measure beginning in 2015. Results are stratified by age groups (see pages 46-49) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

See pages 96 and 102 for results stratified by members with- and without disability and mental health diagnoses.

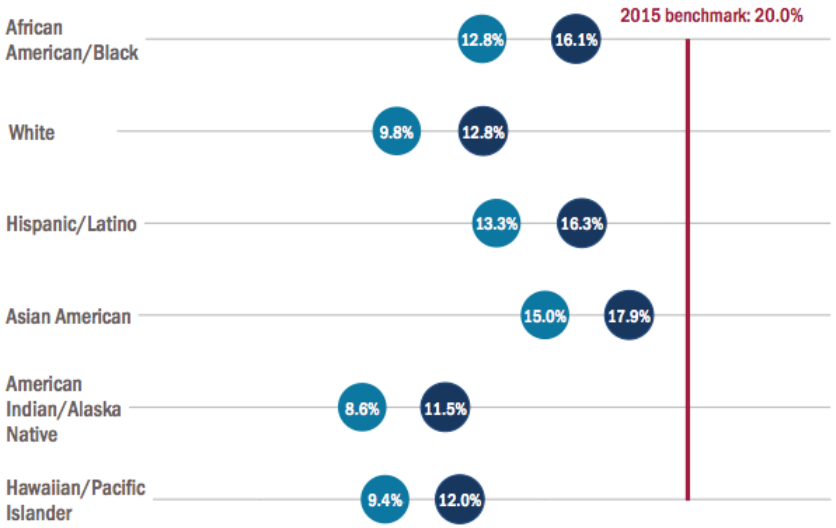
### About these data:

- N=149,048
- Data source: Administrative (billing) claims
- Benchmark source: Metrics and Scoring Committee consensus
- Race and ethnicity data missing for 10.3% of respondents
- Each race category excludes Hispanic/Latino
- 2011 and 2013 results are not available for this measure

## Statewide, the percentage of children ages 6-14 who received dental sealants has increased.

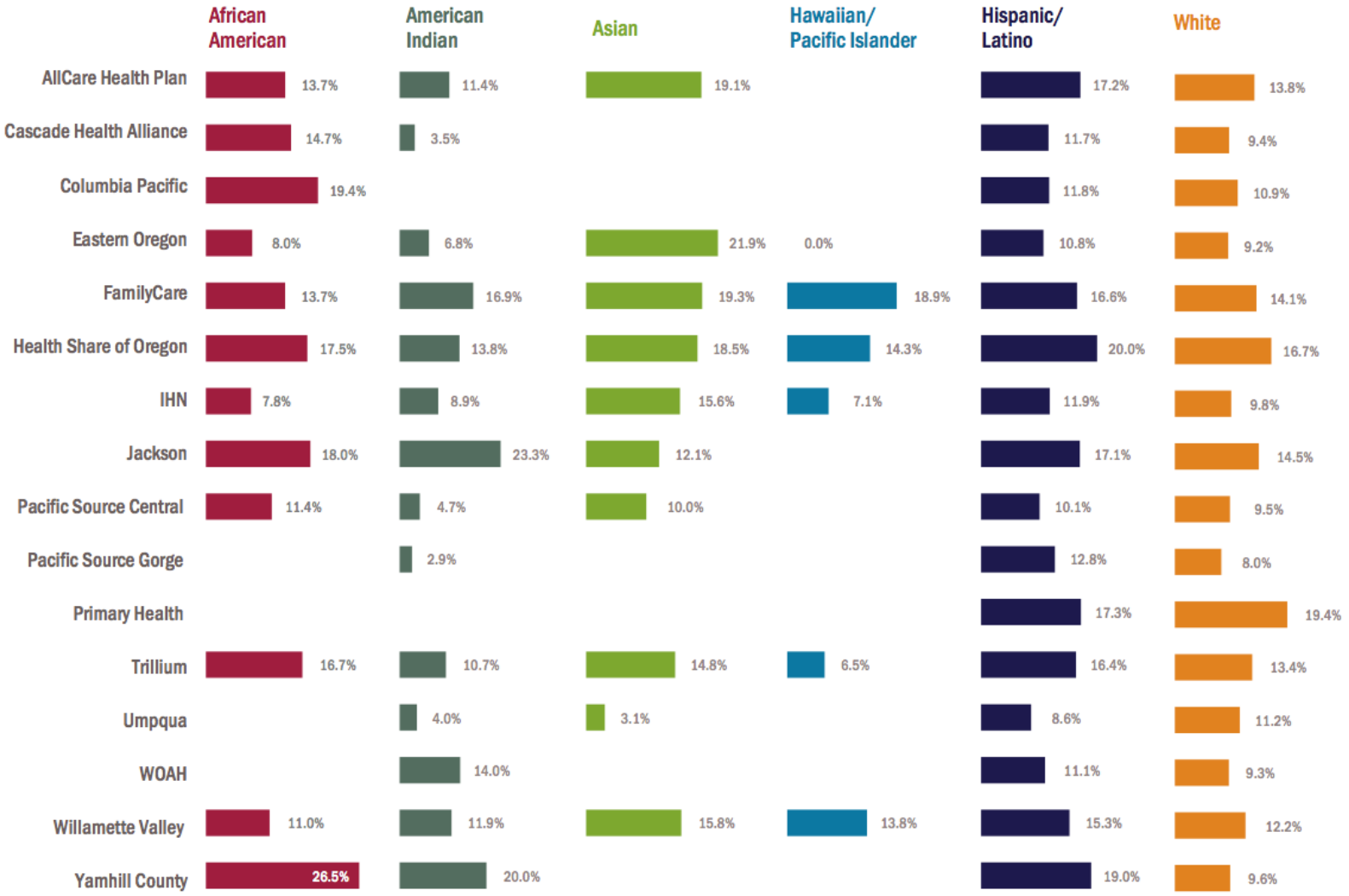



## Asian American children ages 6-14 received dental sealants more frequently than other races and ethnicities in both 2014 & mid-2015.



# Dental Sealants (ages 6-14)

July 2014 - June 2015

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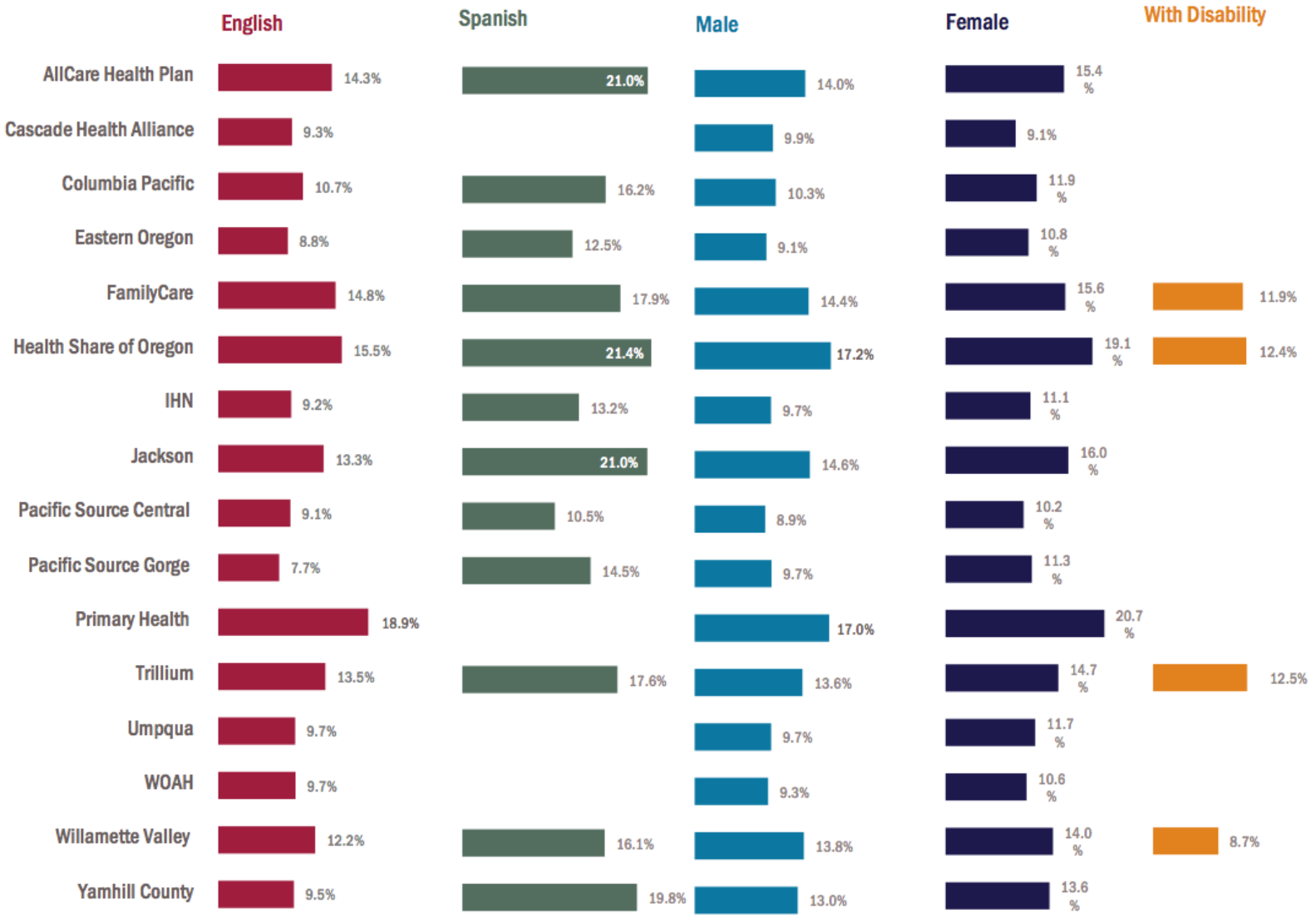
# Dental Sealants (ages 6-14)

July 2014 - June 2015

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- **Ensure assignment of oral health providers**
- **Work with school-based health programs**
- **Address linguistic and cultural barriers**
- **“Bundle” with other preventive services**
- **Engage diverse members/communities/ Indian tribes**

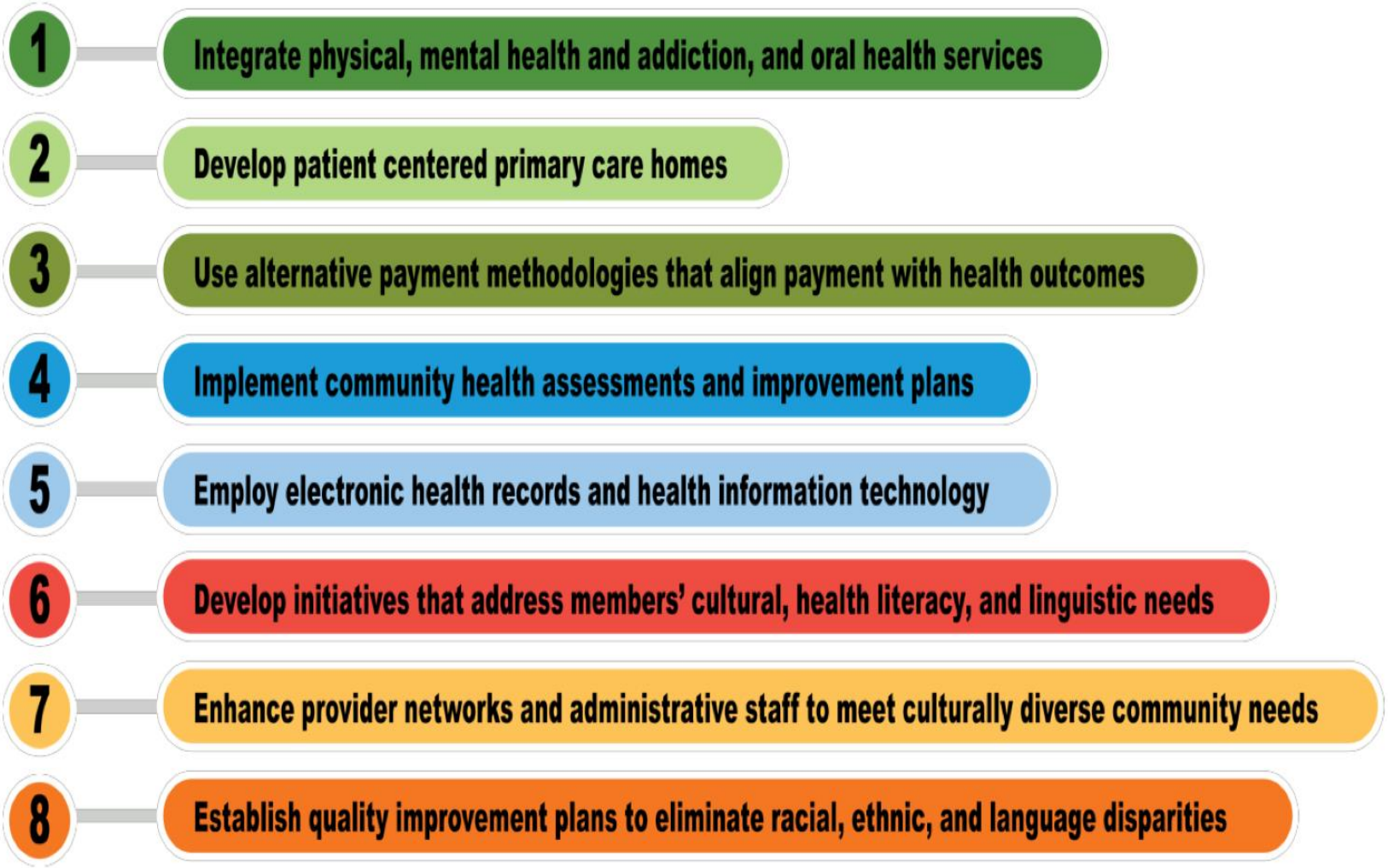
| CCO Incentive Measures | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|
| Adolescent well-care visits | x | x | x | x | x |
| Alcohol or other substance misuse screening (SBIRT) | x | x | x | x | [1] |
| Ambulatory care: emergency department visits (per 1,000 mm) | x | x | x | x | x |
| CAHPS composite: access to care | x | x | x | x | x |
| CAHPS composite: satisfaction with care | x | x | x | x | x |
| Childhood immunization status | | | | x | x |
| Cigarette smoking prevalence | | | | x | x |
| Colorectal cancer screening | x | x | x | x | x |
| Controlling high blood pressure | x | x | x | x | x |
| Dental sealants | | | x | x | x |
| Depression screening and follow-up plan | x | x | x | x | x |
| Developmental screening (0-36 months) | x | x | x | x | x |
| Early elective delivery | x | x | | | |
| Diabetes: HbA1c poor control | x | x | x | x | x |
| Effective contraceptive use | | | x | x | x |
| Electronic health record adoption | x | x | x | | |
| Follow-up after hospitalization for mental illness | x | x | x | x | x |
| Follow-up for children prescribed ADHD medication | x | x | | | |
| Health assessments within 60 days for children in DHS custody | x | x | x | x | x |
| Patient centered primary care home enrollment | x | x | x | x | x |
| Timeliness of prenatal care | x | x | x | x | x |

- **Hispanic/Latina women least likely to have timely prenatal care**
- **Hawaiian/Pacific Islander children least likely to receive immunizations**
- **American Indians have highest rate of cigarette smoking**
- **Latinos have lowest rate of colorectal cancer screening**
- **Asian Americans have the lowest rate of screening for alcohol/substance abuse**

# Health Equity Consultations with CCOs: Data and Materials Reviewed

- Demographic data about CCO members: race and ethnicity, household language, members with disability
- Incentive measure data, stratified by member demographics, when available
- CCO Transformation Plan
- CCO Community Health Improvement Plan

# CCO Transformation Plan Elements



## 6 Develop initiatives that address members' cultural, health literacy, and linguistic needs

- Improve information to members and providers about language assistance services available
- Translate member communications into Spanish and other languages (Russian)
- Review member communications for health literacy and for members with disability

## 6 Develop initiatives that address members' cultural, health literacy, and linguistic needs

- *Ensure access to interpreters, including sign language interpreters*
- *Test multilingual staff for second language proficiency*
- *Conduct outreach to/engage with culturally/linguistically diverse members/ communities (e.g., Russian-speaking)*

## 7 Enhance provider networks and administrative staff to meet culturally diverse community needs

- Conduct staff and provider trainings on diverse communities, health literacy, adverse childhood events/trauma-informed care, culture of poverty
- Review CCO staff hiring policies
- Collect cultural competency policies of providers
- Support training and use of CHWs, THWs, health care interpreters

## 7 Enhance provider networks and administrative staff to meet culturally diverse community needs

- *Review provider networks to reflect diverse members/communities served*
- *Improve information in provider directories*
- *Provide more staff trainings*
- *Provide trainings on equity in clinical care processes and outcomes*
- *Engage Clinical Advisory Panels on equity*
- *Leverage CHWs and THWs to support improvements on incentive measures*

## 8 Establish quality improvement plans to eliminate racial, ethnic, and language disparities

- Assign staff/work groups on health equity
- Analyze quality data stratified by member demographic characteristics
- Review member experiences of care, complaints/appeals by diverse members
- Implement interventions for reducing identified disparities
- Participate in/support regional health equity coalitions

## 8 Establish quality improvement plans to eliminate racial, ethnic, and language disparities

- ***Refine health equity objectives (and benchmarks)***
- ***Link health equity objectives to incentive measures***
- ***Improve data collection and analytics to support equity***
- ***Share data about equity with community stakeholders, e.g. CACs, CAPs, governing boards***

2 Develop patient centered primary care homes

5 Employ electronic health records and health information technology

4 Implement community health assessments and improvement plans

1. Integrate physical, mental health and addiction, and oral health services

3. Use alternative payment methodologies that align payment with health outcomes

# Health Equity Consultations with CCOs: Data and Materials Reviewed

- **Demographic data about CCO members: race and ethnicity, household language, members with disability**
- **Incentive measure data, stratified by member demographics, when available**
- **CCO Transformation Plan**
- **CCO Community Health Improvement Plan**

# Community Health Improvement Plans

- **Identify needs of diverse communities in Community Needs Assessment**
- **Collect public health, rural health, other data**
- **Conduct focus groups, surveys of diverse members/communities**
- **Make explicit references, integrating health equity, use an “equity lens”**

# Community Health Improvement Plans

- **Recruit and retain diverse CAC members**
- **Support training on health equity, social determinants of health, etc.**
- **Focus CHP investments, pilots, projects on health equity**
- **Address social determinants of health (transportation, early learning, housing, job training, etc.)**
- **Support regional health equity coalitions**

# Follow-up Health Equity Technical Assistance

- 9 CCOs: September 2016 –> April 2017
- Up to 10 hours of tailored technical assistance for each CCO
- Engage in strategic planning/create equity plan
- Provide staff training
- Engage providers serving Latino members
- Tailor interventions for Latino members
- Review website with equity lens

# How CCOs Are Advancing Health Equity: Lessons Learned

# Advancing Health Equity: Lessons Learned

- Create a plan
- Use your own data
- Partner with diverse members/ communities
- Engage providers
- Build a diverse health workforce
- Integrate into health system transformation
- Be accountable

# Advancing Health Equity: Create a Plan

- **LOTS of opportunities at every CCO: connect the dots, develop a plan, measure progress**
- **Identify an organizational champion/sponsor AND a lead implementer**
- **Use incremental, achievable benchmarks and objectives (not “eliminate disparities this year”)**

# Advancing Health Equity: Partner with Diverse Members/Communities

- Engage diverse members and communities ("don't do anything about me without me")
- Leverage CACs as asset/entry point
- Find community gatekeepers/leaders, build trust and long-term partnerships
- Sustain at big-picture level (Community Needs Assessment/CHP) and every day (every clinical visit, every contact with CCO)

# Advancing Health Equity: Use Your Own Data

- Look at your own data; and keep looking…
- Improve completeness of demographic data from OHA, providers, members
- Support collection and use of additional data (disability, sexual orientation, gender identity, social risk factors, etc.)
- Use public health, rural health, other data

# Advancing Health Equity: Use Your Own Data

- **Collect additional data from members, providers, staff, and community stakeholders**
- **Support quality measure data from electronic health records (will be the best data)**
- **Leverage health information exchange (stratify by member demographics)**

# Advancing Health Equity: Engage Providers

- Start with ensuring Patient-Centered Primary Care Homes (PCPCHs) for all members
- Help providers meet needs of culturally and linguistically diverse members (technical assistance, payment incentives)
- Integrate into quality improvement/ alternative payment models

# Advancing Health Equity: Build a Diverse Health Workforce

- **Support multilingual/multicultural health workforce development (education/training, recruitment, retention, promotion) among CCO staff and providers**
- **Support training of CHWs, THWs, health care interpreters**
- **Support integration of CHWs, THWs into team-based care**

# Advancing Health Equity: Integrate into Health System Transformation

- Health equity is not “separate” or “extra”
- Integrate health equity into Transformation Plan objectives
- Integrate health equity into Community Needs Assessment, Community Health Improvement Plan
- Integrate into strategic and business planning

# Advancing Health Equity: Be Accountable

- Stratify and report member, quality, and other data by member demographics
- Collaborate with Office of Health Analytics on better measures of member experience
- Share progress on health equity activities with members, providers, staff, board, and community stakeholders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