Social Determinants of Health Workgroup
Recommendations to IHN-CCO for CCO 2.0
March 2019

Introduction

These recommendations were developed through a collaborative effort of the Delivery System Transformation (DST) Committee's four workgroups; Social Determinants of Health (SDOH), Health Equity, Traditional Health Workers (THW), and Universal Care Coordination (UCC). Broad representation and input from health care and community organizations was involved. Early in the discussion the SDOH workgroup acknowledged that health equity and social determinants of health are intertwined; one cannot be addressed without the other. Inherent in these recommendations is consideration of health equity, and an effort to reduce health disparities.

The next focus for the SDOH workgroup will be to begin discussion on how to measure success; establishing desired goals and outcomes for SDOH work, aligning with CCO 2.0 metrics, and developing more specific work plans to achieve desired outcomes. The SDOH workgroup would also like to encourage internal operations of IHN-CCO to consider integration of priority areas outlined within this strategic plan through evidence of documentation (policies, processes, and procedures) to assist in fulfilling contractual obligations outlined by the State of Oregon for the use of Medicaid funds.

For a list of all acronyms used in this document, please see page 7.

Foundational to Addressing Social Determinants of Health (SDOH)	IHN-CCO Role	Work Group	CAC CHIP Priorities
Recommendation #1: Establish a universal standard for screening for SDOH	Convener		SD1-4
a) Identify targeted SDOH & health equity screening elements and implement universal screening in health care and community settings.		UCC	
Recommendation #2: Identify the functionality needed to use the Regional Health Information Collaborative (RHIC) as the data hub for SDOH	Direct Investment & Data Analytics Support		SD1-4
a) Identify the feasibility of health care providers and community agencies reporting to the RHIC common data elements on SDOH & health equity to create a SDOH report to be used by IHN-CCO and community members		RHIC	

Foundational to Addressing SDOH *(continued)*	IHN-CCO Role	Work Group	CAC CHIP Priorities
Recommendation #3: Recognize Traditional Health Workers (THW) as a critical component of the workforce for SDOH; requiring certification to be eligible for APM (Alternative Payment Methodology) payment and expanding the number of certified THWs in the region	Workforce & VBP		A2 BH1-6 CY1-3 HL1 M1-2 SD1-4
a) Complete the development of the Tri-County Traditional Health Worker Training hub to include; • *Oregon Health Authority (OHA) certified curriculum for Community Health Workers, Doulas, Peer Specialists, and Peer Wellness (when completed)* • *On-going CEU training to maintain credentialing for THW and activities to foster networking and connections among the THW workforce* • *Established fidelity standards and a method for monitoring & reporting accountability*	Collaboration & Direct Investment	THW	
b) Develop an expansion strategy for all types of THW's to work in community settings to include: • *Identification of community agencies interested in having THW's and what type of THW will best meet their service needs* • *Identifies the frequency of CHW training and mentoring program to be offered each year* • *How many can be trained in each cohort*	APM	THW	
c) Develop an expansion strategy for Clinical Navigators to include: • *Development of an additional curriculum and mentoring program that trains THW beyond the basic training to enhance their skills to work in a health care setting* • *Identify clinics interested in having a Clinical Navigator on-site* • *Formalize a training approach for Clinic Managers and Clinical Care Teams to assist them in understanding how to successful use Clinical Navigators* • *Identifies the frequency of CHW training and mentoring program to be offered each year* • *How many can be trained in each cohort*	APM	THW	
d) Continue to support opportunities for other types of workers in the community to impact SDOH (example Community Paramedics, health educators) by; supporting potential pilots, fostering conversations and sharing among others doing similar work, encouraging coordination with THW's, and assessing the feasibility/appropriateness of certification for other types of workers	General Alignment/ Collaboration	DST	

Foundational to Addressing SDOH *(continued)*	IHN-CCO Role	Work Group	CAC CHIP Priorities
Recommendation #4: Establish a user-friendly & efficient Resource Hub to be used by care coordinators, THW's, and others to identify and link community resources to client needs	Direct Investment/ Resource clearinghouse		A1-3 SD1-4
a) Implement Unite Us as the platform for the Resource Hub for health care providers and community agencies and integrate functionality with the RHIC	Infrastructure	UCC	
b) Establish an end-user workgroup to provide input into identifying key elements and desired functionality for the Resource Hub and testing options	Convener	UCC	
Recommendation #5: Create a document that acknowledges the critical importance of a shared commitment to community input and participation in transformational system change and a commitment from executive leadership to collaborative decision-making in investments that have broad impact in the region	Collaboration	RPC	A1-3 SD1-4
a) Develop and ratify a Declaration of Synergy to include: • *Brief history of the development & evolution of IHN-CCO, the community impact model, committee and workgroup structure, and successful engagement of community members to date* • *Strategic plan/priorities as identified in IHN-CCO application to OHA* • *The action/strategic plan for addressing SDOH & health equity*		RPC	
b) Organize and execute outreach strategy • *Identify targeted agencies/leadership to include in the commitment statement* • *Obtain a signature of commitment from community partner leadership identifying what tools & resources exist, and what each agency is ready and willing to commit to* • *Affirm IHN-CCO commitment to gain input and vet options through existing committees and workgroups prior to decision-making regarding tools and resources that will be deployed for community use*	Convener & Collaboration	RPC	

SDOH Regional Priority Areas

Housing	IHN-CCO Role	Work Group	CAC CHIP Priorities
Recommendation #6: Identify a mechanism for funding safe, stable, affordable housing services and supports within the parameters of allowable Medicaid funding and that builds on strategies developed through previous DST pilots	Direct Investment		
a) Review previous community based DST pilots that addressed housing supports to build on successful strategies	General Alignment	SDOH	
b) Call for proposals and select pilots that address any of the following strategies; • *Assisting individuals/families to get into housing;* • *Supporting people to stay in housing (eviction prevention)* • *Improvements that promote healthy homes* • *Bringing health and wellness options into housing (such as; education, gym equipment, classes)*	Direct investment & Convener	DST	Align where relevant with 10 year plan to end homelessness
c) The SDOH committee will mentor new pilots and make recommendations to DST regarding sustainable approaches to expanding successful strategies		SDOH	
d) Identify and document policy/advocacy positions regarding housing to support community, state, and federal initiatives	Policy	SDOH	
Recommendation #7: Identify a process that supports connections between the SDOH Committee and CAC and invites and accepts recommendations from the CAC that address priorities outlined in the CHIP	General Alignment/ Collaboration	SDOH & CAC	
a) Foster linkages between County & hospital CHIP workgroups to support alignment where possible			

Food Security	IHN-CCO Role	Work Group	CAC CHIP Priorities
Recommendation #8: Establish a funding mechanism that supports access to healthy food	Direct Investment		SD3-4
a) Review the current SDOH DST pilots to identify successful strategies	General Alignment	SDOH	
b) Call for proposals and select pilots that address any of the following strategies; • *Provides screening and links access to food options in PCPCH and health care settings; such as veggie Rx, farmers market stands at clinics, food baskets at discharge* • *Improves referral pathways to healthy food options* • *Expands the capacity of community organizations to serve more individuals/families with healthy food options* • *Provides education and training on selecting and preparing healthy food options and assuring food safety* • *Flexible spending to support purchase of items to prepare and store healthy food*		DST	
c) The SDOH committee will mentor new pilots and make recommendations to DST regarding sustainable approaches to expanding successful strategies		SDOH	
d) Identify and document policy/advocacy positions regarding food security to support community, state, and federal initiatives	Policy	SDOH	
Recommendation #9: Identify a process that supports connections between the SDOH Committee and CAC and invites and accepts recommendations from the CAC that address priorities outlined in the CHIP	General Alignment/ Collaboration	SDOH & CAC	
a) Foster linkages between County & hospital CHIP workgroups to support alignment where possible			

Transportation	IHN-CCO Role	Work Group	CAC CHIP Priorities
Recommendation #10: Establish a mechanism for funding transportation to activities identified in a health care management plan that is jointly agreed between the member and a service provider that promotes health and wellness	Direct Investment		SD_2 SD_4
a) Review the current Well Care pilot with Ride Line to identify successful strategies		SDOH	
b) Call for proposals and select pilots that address any of the following strategies; • *Increase awareness of transportation options currently available* • *Expand options for transportation in rural areas* • *Expand alternative options for 'real time' transportation such as; mileage reimbursement, Uber Health, volunteer bus option* • *Improve coordination of transportation and appointments between service providers* • *Screening to identify other gaps to accessing transportation*	Convener	DST	
c) The SDOH committee will mentor new pilots and make recommendations to DST regarding sustainable approaches to expanding successful strategies		SDOH	
d) Identify and document policy/advocacy positions regarding transportation to support community, state, and federal initiatives			
Recommendation #11: Identify a process that supports connections between the SDOH Committee and CAC and invites and accepts recommendations from the CAC that address priorities outlined in the CHIP	General Alignment/ Collaboration	SDOH & CAC	All
a) Foster linkages between County & hospital CHIP workgroups to support alignment where possible			

Acronym List

APM – Alternative Payment Methodology
CAC – Community Advisory Council
CEU – Continuing Education Units
CHW – Community Health Worker
CHIP – Community Health Improvement Plan
CCO – Coordinated Care Organization
DST – Delivery System Transformation Committee
IHN-CCO – InterCommunity Health Network Coordinated Care Organization
OHA – Oregon Health Authority
PCPCH – Patient-Centered Primary Care Home
RHIC – Regional Health Information Collaborative
RPC – Regional Planning Council
SDoH – Social Determinants of Health
THW – Traditional Health Worker
UCC – Universal Care Coordination
VBP – Value Based Payments

CAC CHIP Areas
A – Access
BH – Behavioral Health
CY – Child and Youth Health
HL – Healthy Living
M – Maternal Health
SD – Social Determinants of Health and Equity

Strategic Plan for Behavioral Health 2020 – 2024

Develop a comprehensive plan for behavioral health services in our region designed to empower members to live, work, and thrive in their communities.

InterCommunity Health Network CCO

Population Assessment	Workforce & Provider Network	Delivery System	Financing & Payment Models	Leadership and Accountability
Design delivery system to meet the needs of population	Support provider network to achieve mental health parity and health equity for members	Provide access to full array of services, that are responsive to member needs, including focus on OHA identified special populations	Implement financing models, including Value Based Payments to advance quality, evidence-based practice and integration	Establish system oversight and accountability
• Combine disparate data sources, including SDoH to provide a comprehensive view of member needs • Assess population needs through robust tools and analytics • Develop prevalence reports • Identify subpopulations – e.g., SUD/SMI – Pregnancy and 0-5 yrs., develop cohorts • Identify service needs based on prevalence of conditions • Standardized screening and assessments	• Catalogue the current provider network, include detail on capacity and diversity of workforce to ensure parity with members • Develop strategy to address gaps and increase available workforce • Partner with local and state resources on workforce development initiatives • Ensure workforce receives cultural responsiveness training and trauma informed care principles	• Alignment, quality improvement and integration through PCPCH/BHCH model • Provide effective coordination of multiple services and supports • Culturally-responsive care pathways and handoffs structured and supported • Seamless referral and access pathways • Prioritized access for special populations • Specialized services – e.g., ACT, Wraparound • Ongoing member, family and community engagement and feedback	• Advance APMs that increase provision of services and supports • Evaluate BH spend and risk sharing • Align payment and incentives for screening, early identification, early intervention, and recovery supports • Risk sharing agreements across providers • Design and implement risk-sharing arrangement with Oregon State Hospital	• Establish clear roles and accountability • Define data and tools necessary for operations, care coordination, VBP, and population health • Define accountability standards across provider types and network • Refine outcome-based system management • Streamline regulatory reporting • Develop oversight strategy for IHN and sub contractors, LMHA • Standardize care pathways

ACCESS TO CARE (CAHPS SURVEY)

Access to care (CAHPS)

Percentage of members who thought they received appointments and care when they needed them.

Data source:
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of providers and ease of access to health care services.

2017 benchmark source:
2016 national Medicaid 75th percentile; weighted average of adult and child rates.

2017 data (N=5,385)

- Statewide percent change since 2016: **+0.4%**
- Number of CCOs that improved: **8**
- Number of CCOs achieving target: **6**

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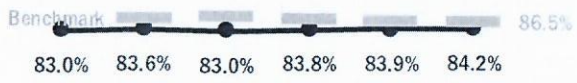
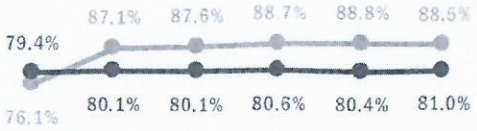
Statewide, access to care has remained steady over time.

All ages combined



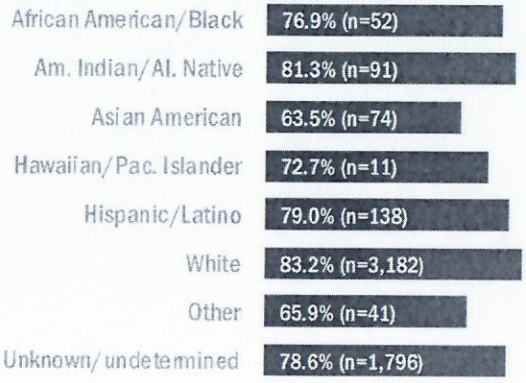
2011 '13 '14 '15 '16 2017

Adults and children



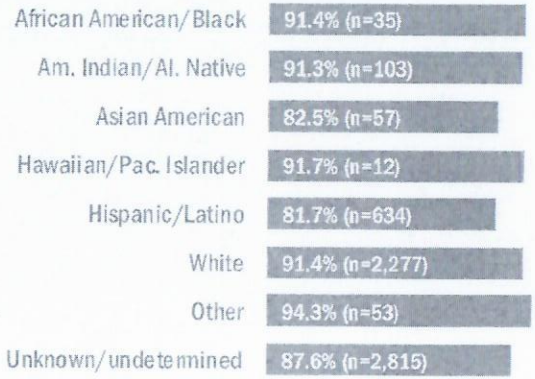
2011 '13 '14 '15 '16 2017

By race and ethnicity (adults) in 2017



^ data suppressed (n<10)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

By race and ethnicity (children) in 2017



^ data suppressed (n<10)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

ACCESS TO CARE (CAHPS SURVEY)

Access to care (all ages) in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.

ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Assessments for children in DHS custody

Percentage of children ages 4+ who received a mental, physical, and dental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care). Physical and dental health assessments are required for children under age 4, but not mental health assessments.

Data source:
Administrative (billing) claims + ORKids

2017 benchmark source:
Metrics and Scoring Committee consensus

2017 data (N=2,013)

- Statewide percent change since 2016: **+11.3%**
- Number of CCOs that improved: **15**
- Number of CCOs achieving target: **13**

Results prior to 2014 are not comparable to later years due to change in methodology (dental assessments were added to the metric).

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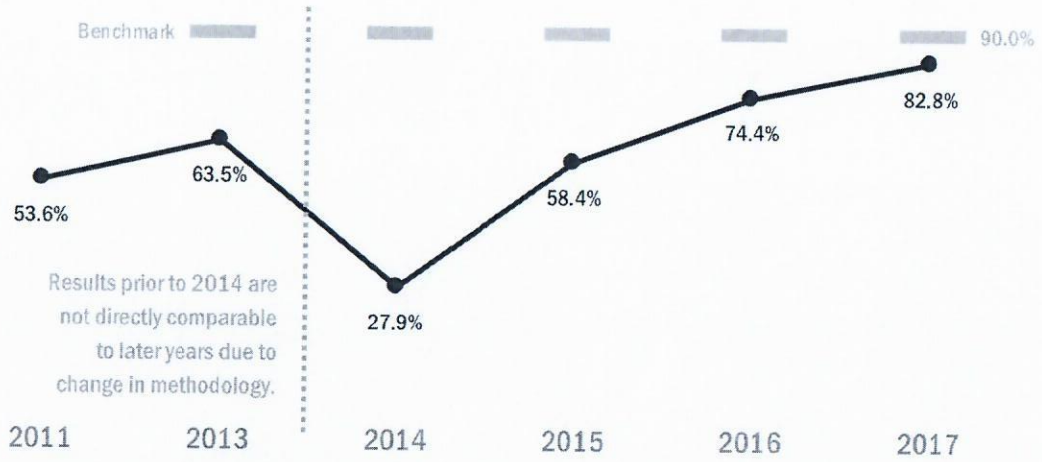
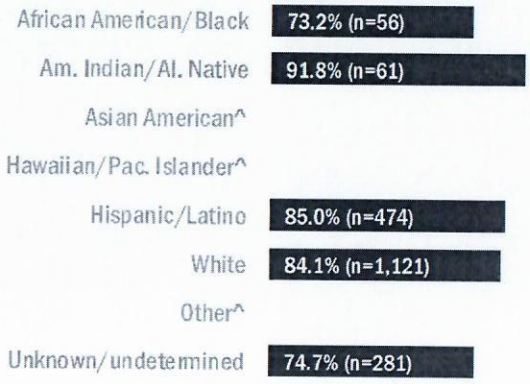
Statewide, assessments for children in DHS custody continue to increase.



By race and ethnicity (2017)



^ data suppressed (n<30)
n = subpopulation denominator
Each race category excludes Hispanic/Latino

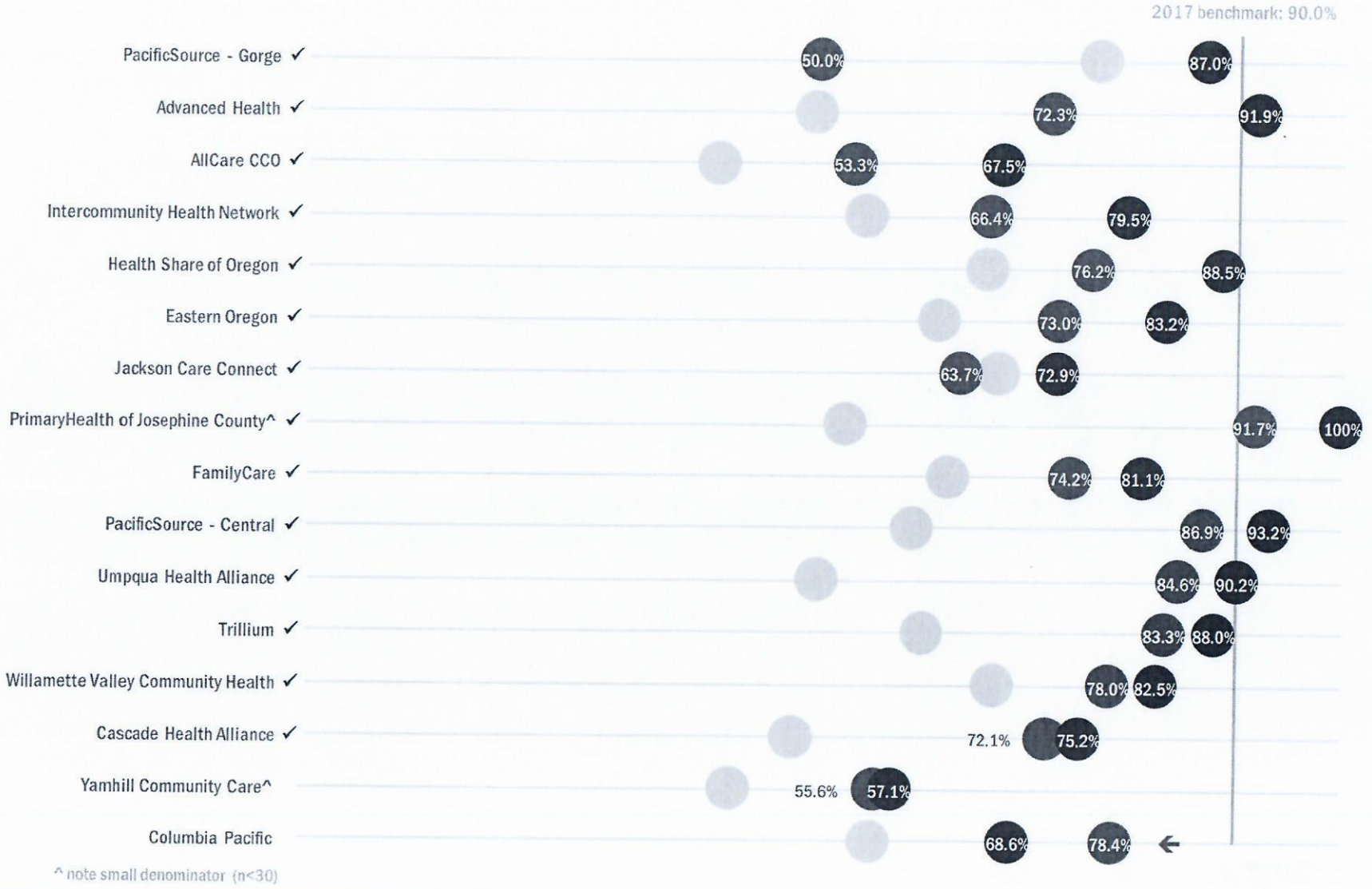
By household language (2017)

^ data suppressed (n<30)
n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

Assessments for children in DHS custody in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.



^ note small denominator (n<30)

CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status

Percentage of children who received recommended vaccines (DTaP, IPV, MMR, HiB, Hepatitis B, VZV) before their second birthday.

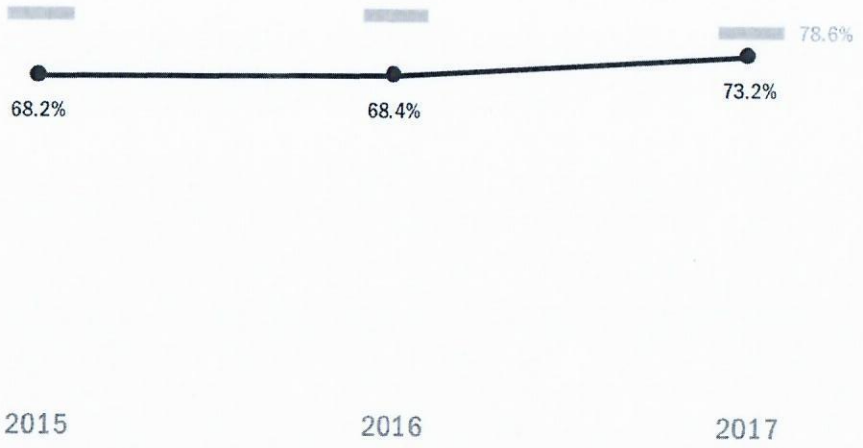
Data source:
Administrative (billing) claims and ALERT immunization data

2017 benchmark source:
2016 national Medicaid 75th percentile

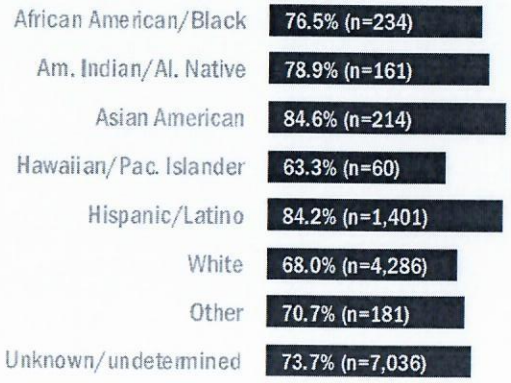
2017 data (N=13,573)

- Statewide percent change since 2016: **+7.0%**
- Number of CCOs that improved: **all 16**
- Number of CCOs achieving target: **all 16**

Statewide, childhood immunizations increased in 2017.

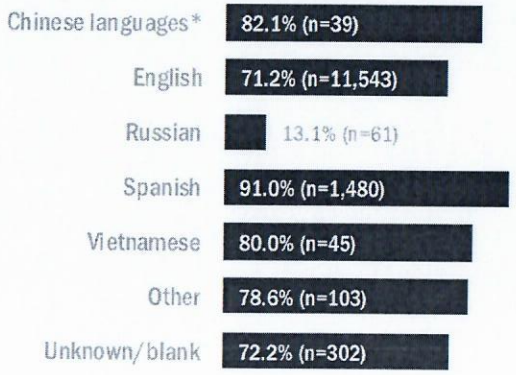


By race and ethnicity (2017)



n = subpopulation denominator
Each race category excludes Hispanic/Latino

By household language (2017)



n = subpopulation denominator
*Cantonese, Mandarin, Other Chinese/Asian, TaoChiew

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CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status in 2016 and 2017, by CCO.

✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.

DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

Developmental screenings

Percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday.

Data source:
Administrative (billing) claims

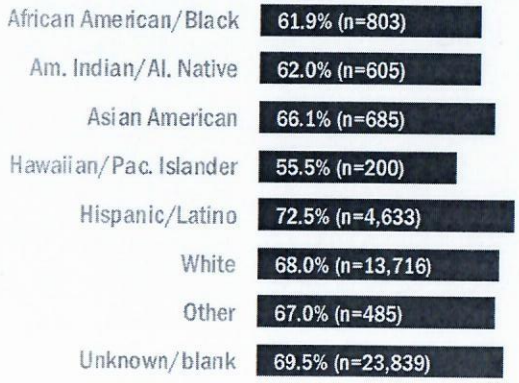
2017 benchmark source:
2015 CCO 75th percentile

2017 data (N=44,966)

- Statewide percent change since 2016: **+10.9%**
- Number of CCOs that improved: **15**
- Number of CCOs achieving target: **all 16**

Statewide, developmental screenings continue to increase.

By race and ethnicity (2017)



n = subpopulation denominator
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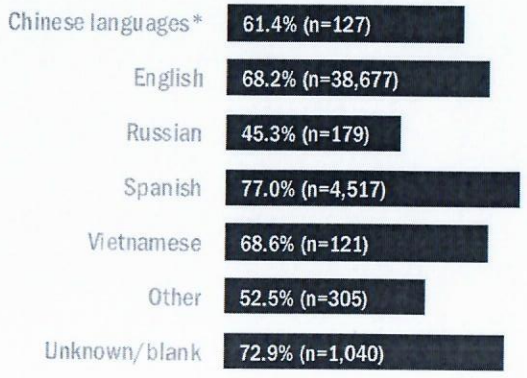
By household language (2017)



n = subpopulation denominator
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DEVELOPMENTAL SCREENINGS IN THE FIRST 36 MONTHS OF LIFE

Developmental screenings and follow-up plan in 2016 and 2017, by CCO.

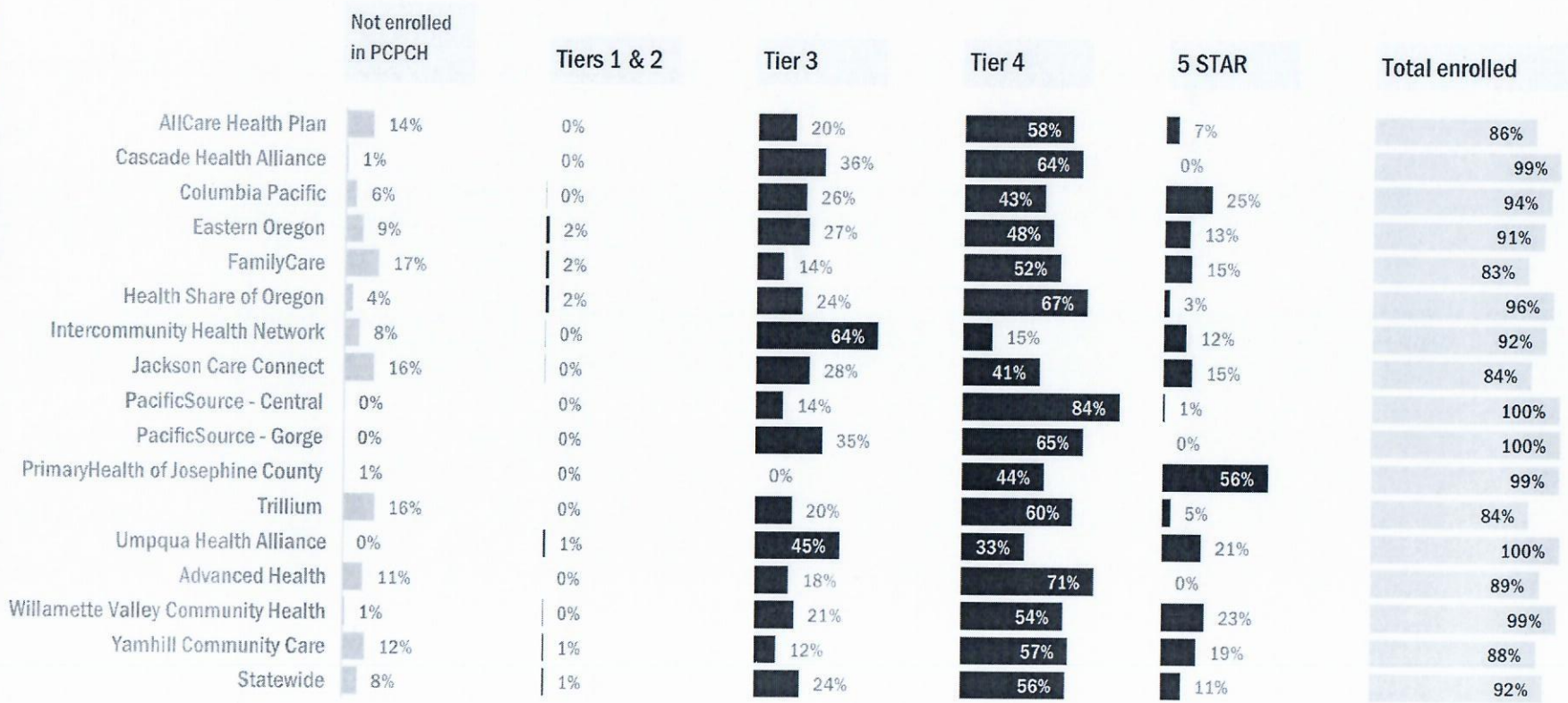
✓ indicates CCO met benchmark or improvement target. Grey dots represent 2015.

PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Statewide in 2017, 92 percent of CCO members are enrolled in a PCPCH, resulting in a weighted score of 70.1 percent.

The Patient-Centered Primary Care Home (PCPCH) enrollment incentive measure uses a weighted methodology to ensure members are not just enrolled in a PCPCH, but are enrolled in the higher PCPCH tiers.

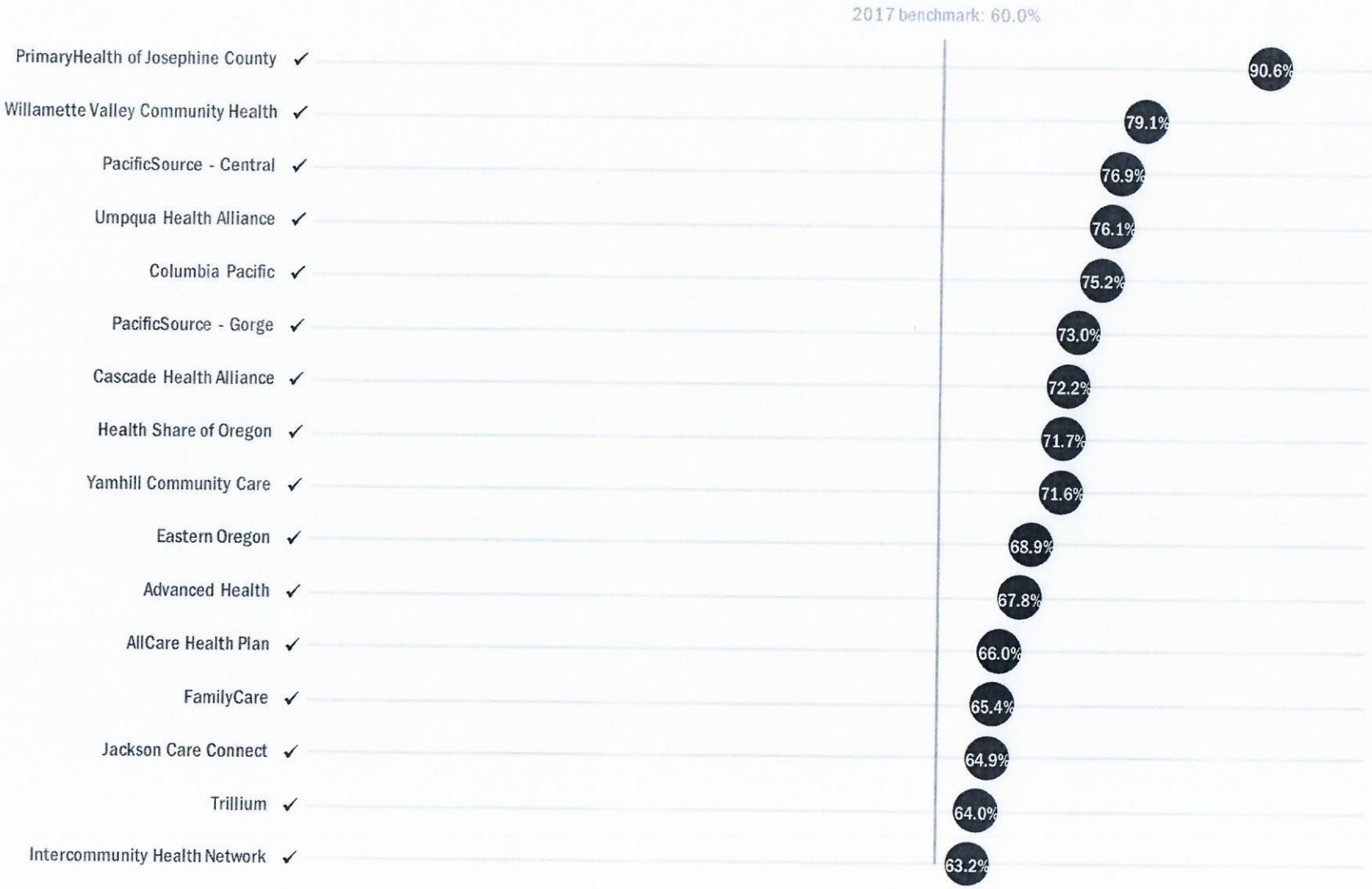
Beginning in 2017, the PCPCH program launched 5 STAR recognition. This new level of recognition was incorporated into the weighting formula for PCPCH score. Thus, scores are not comparable to previous years. The graphs below show member enrollment by CCO across the PCPCH tiers. The next page shows each CCO's PCPCH "score" using the weighted methodology for the incentive measure. A CCO must achieve a score of at least 60 percent to be eligible to earn 100 percent of its quality pool.



PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Patient-Centered Primary Care Home enrollment score in 2017, by CCO.

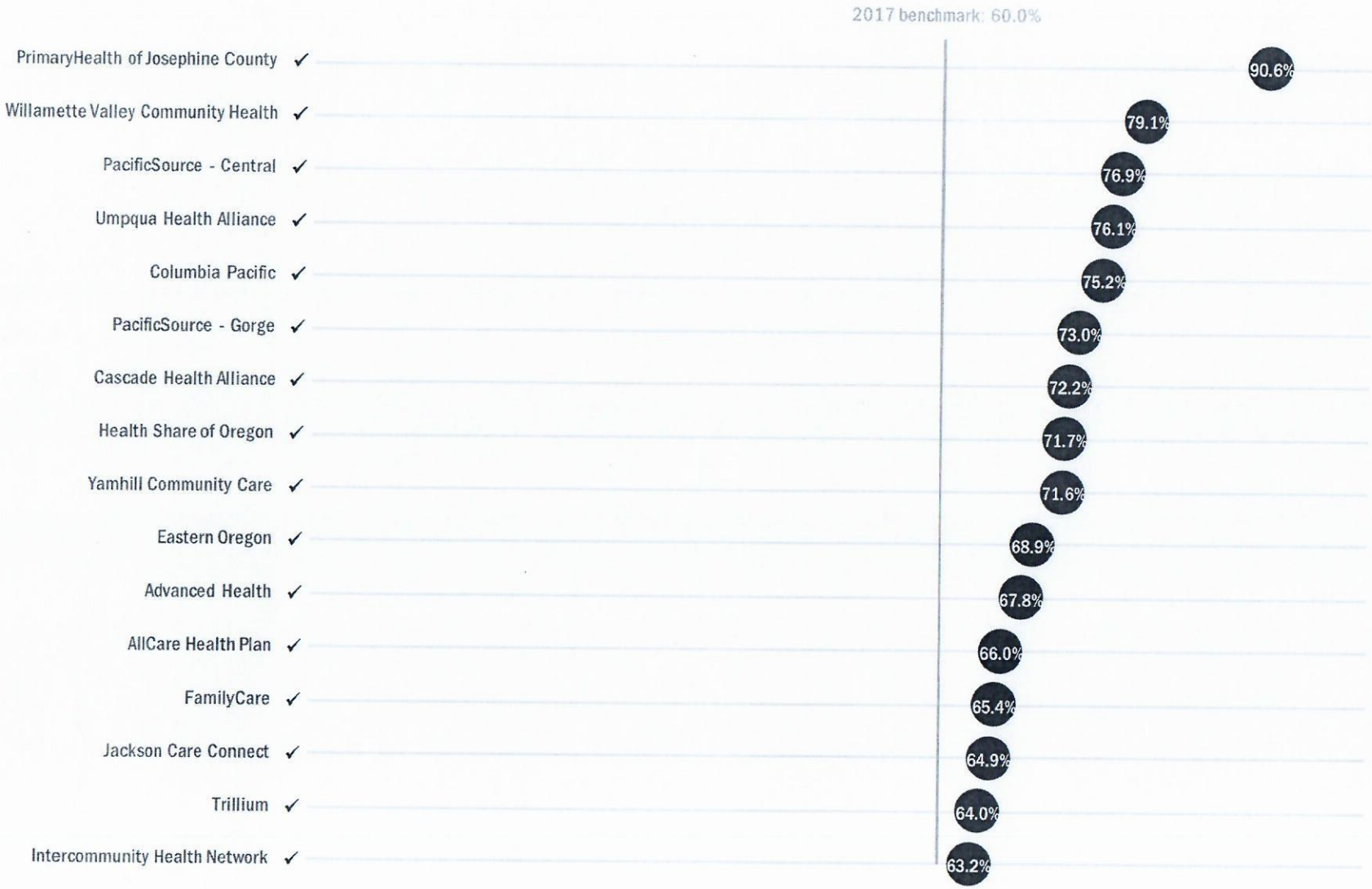
✓ indicates CCO met 60 percent threshold.



PATIENT-CENTERED PRIMARY CARE HOME ENROLLMENT

Patient-Centered Primary Care Home enrollment score in 2017, by CCO.

✓ indicates CCO met 60 percent threshold.



PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

Timeliness of prenatal care

Percentage of pregnant women who received a prenatal care visit within the first trimester or within 42 days of enrollment in Medicaid.

Data source:
Administrative (billing) claims and medical record review

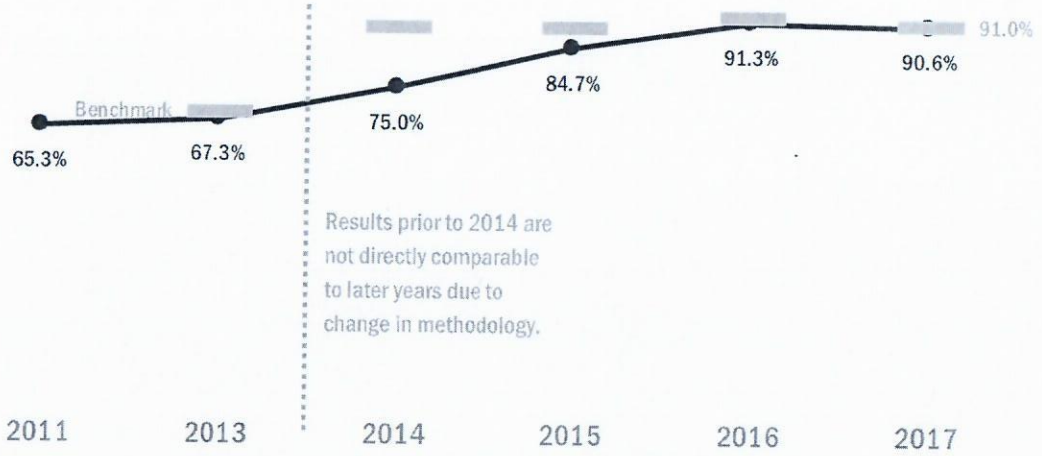
2017 benchmark source:
2016 national Medicaid 90th percentile

2017 data (N=5,702)

- Statewide percent change since 2016: **-0.8%**
- Number of CCOs that improved: **7**
- Number of CCOs achieving target: **11**

Beginning in 2014, measure specifications were modified to include medical record review. Results prior to 2014 are not directly comparable to later years.

Statewide, timeliness of prenatal care remains near the benchmark in 2017.



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