Opportunities for Oregon's Coordinated Care Organizations to advance health equity

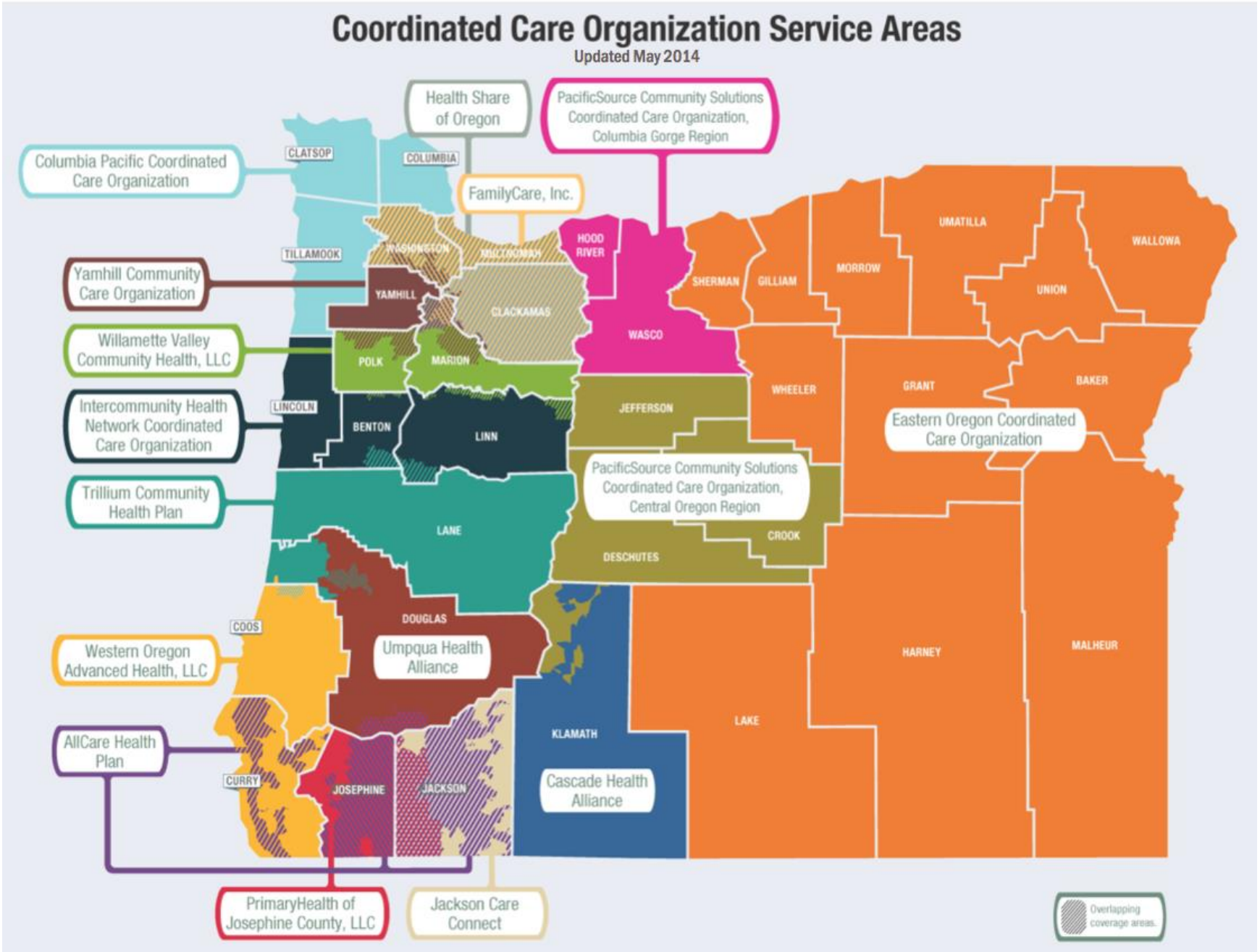
http://www.oregon.gov/oha/HPA/CSI-TC/Documents/CCO-Opportunities-to-Advance-Health-Equity.pdf

Oregon's Coordinated Care Organizations

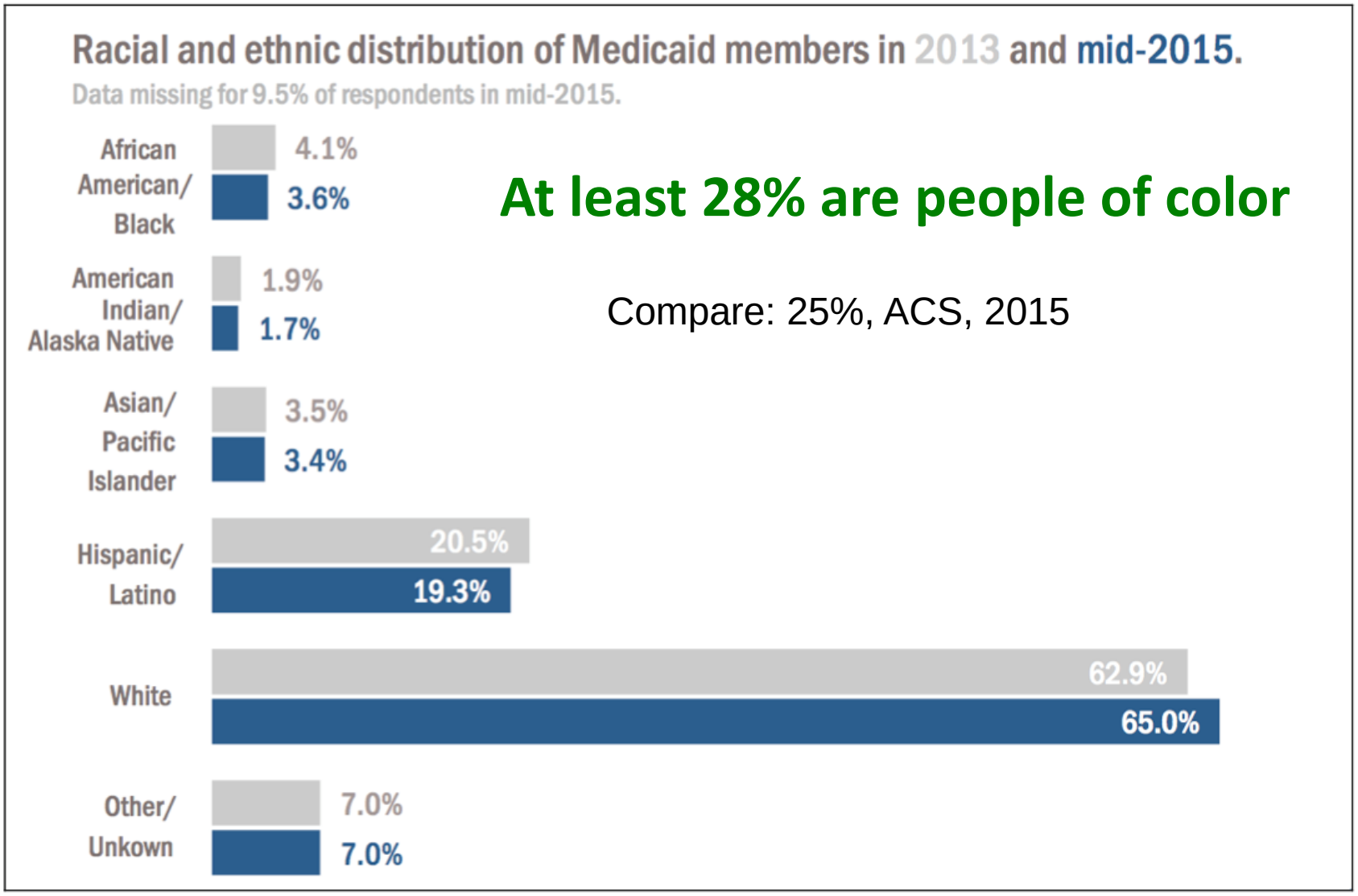
- Began in 2012 with Medicaid Section 1115 waiver; also received an ACA State Innovation Model grant in 2012
- 16 CCOs: existing health plans, expanded organizations, new organizations
- Medicaid expansion implemented in 2014
- 28% Oregon residents on Medicaid in mid-2015
- Technical assistance consultations on health equity May-November 2016

Coordinated Care Organization Service Areas

Updated May 2014



July 2014 - June 2015



At least 28% are people of color

Compare: 25%, ACS, 2015

>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 57.3%	71,282 6.3%	6,751 0.6%	3,990 0.4%	2,044 0.2%	1,789 0.2%	1,215 0.1%	510 <0.0%	441 <0.0%	403 <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 <0.0%	350 <0.0%	333 <0.0%	240 <0.0%	221 <0.0%	146 <0.0%	136 <0.0%	133 <0.0%	123 <0.0%	110 <0.0%

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

Compare: 6%, ACS, 2015

July 2014- June 2015	Members Without Disability	Members With Disability
CCO Members 1,132,846	1,061,759 93.7%	71,087 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"

Compare: 12%, ACS, 2015

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

$168 million in incentive funds available in 2015 (4% of total paid to CCOs)

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:

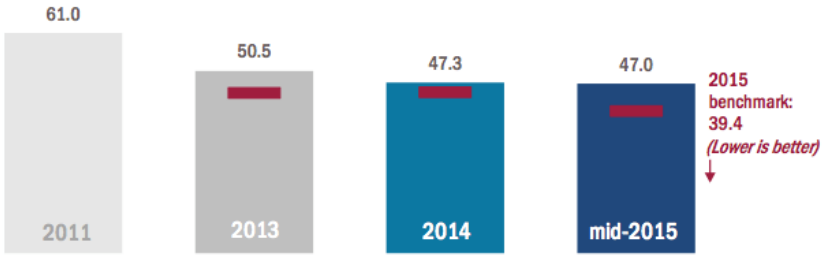
- ✓ African American / Black
- ✓ White

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

About these data:

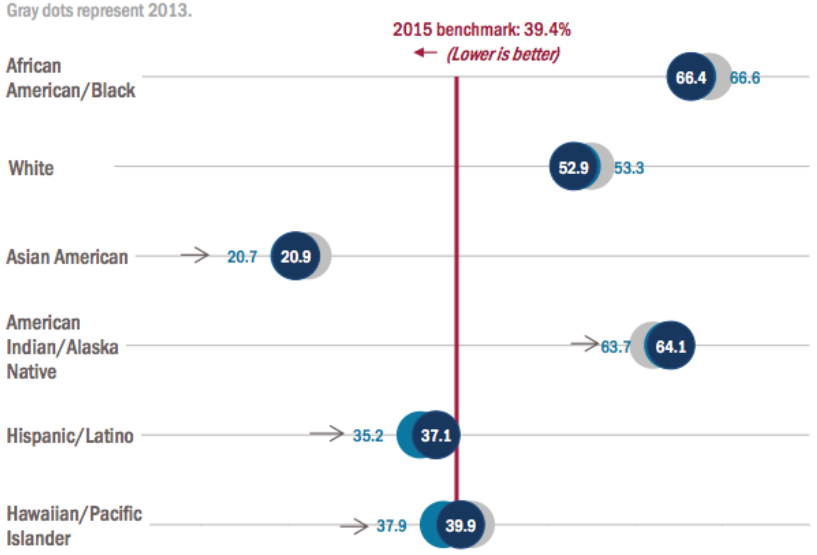
- N= 10,644,736 member months
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 90th percencentile
- Race and ethnicity data missing for 12.6% of respondents
- Each race category excludes Hispanic/Latino
- 2014 benchmark: 44.6

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



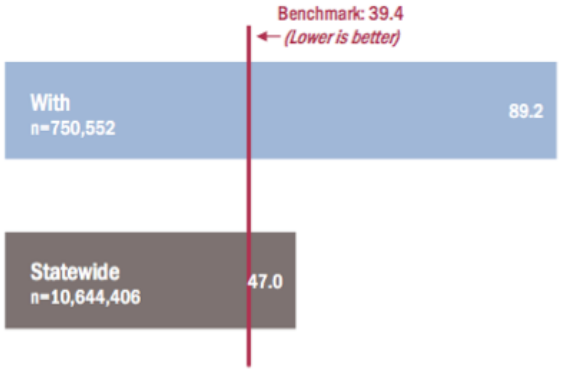
Emergency department utilization was lowest among Asian American members in both 2014 & mid-2015.

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

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

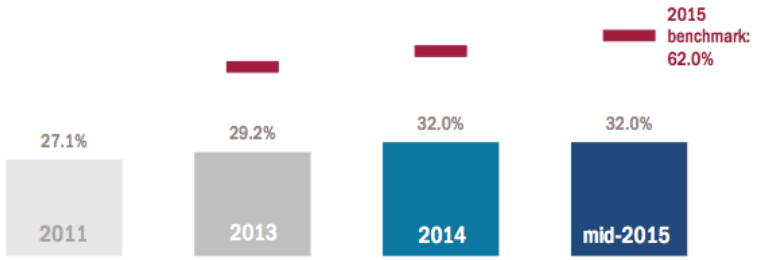
Statewide, the percentage of adolescents who had at least one well-care visit remains well below the benchmark. Barriers to improvement may include providers performing acute care visits when a patient would benefit from comprehensive well care; changes in recommendations for clinical care; and concerns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

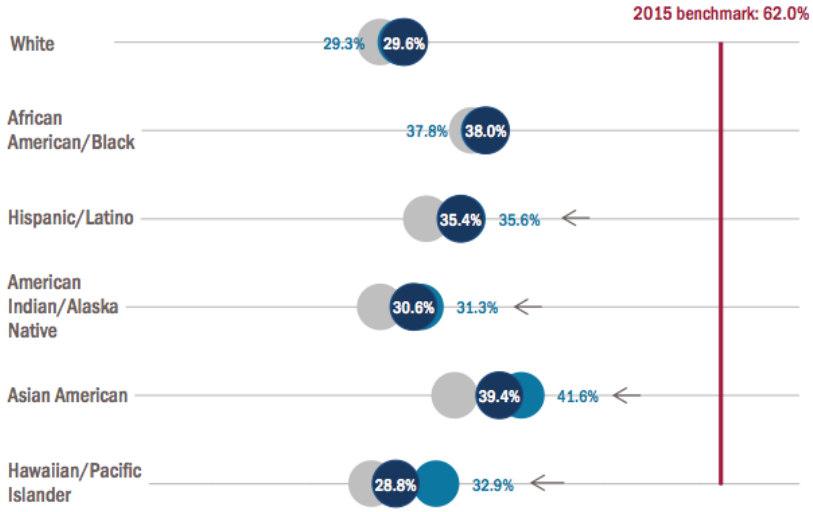
- N=139,396
- Data source: Administrative (billing) claims
- Benchmark source: 2014 national Medicaid 75th percentile (administrative data only)
- Race and ethnicity data missing for 11.9% of respondents
- Each race category excludes Hispanic/Latino
- 2014 benchmark: 57.6%

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



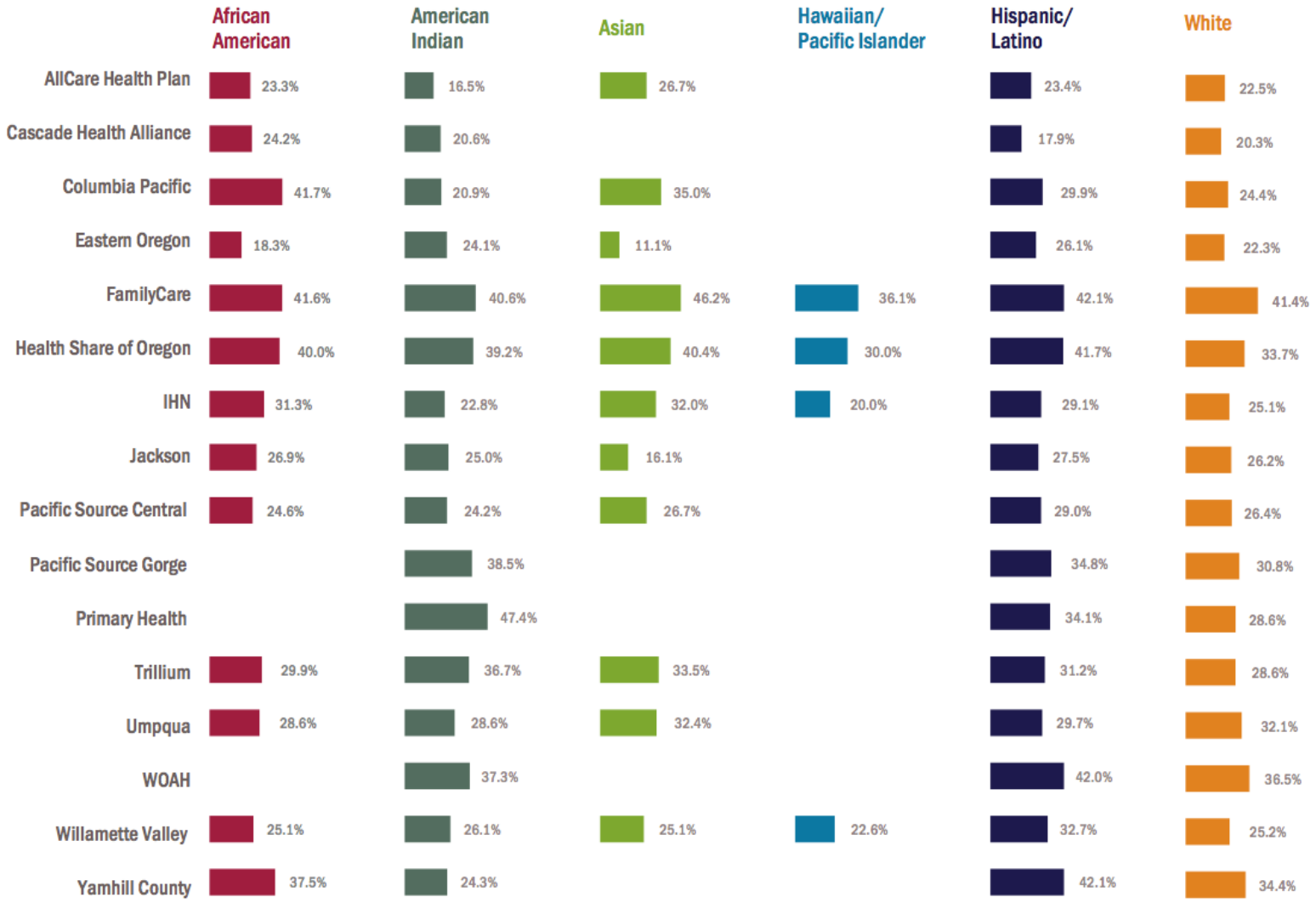
The percentage of Hawaiian / Pacific Islander adolescents receiving well-care visits declined between 2014 and mid-2015.

Gray dots represent 2013.



Adolescent Well Care Visits

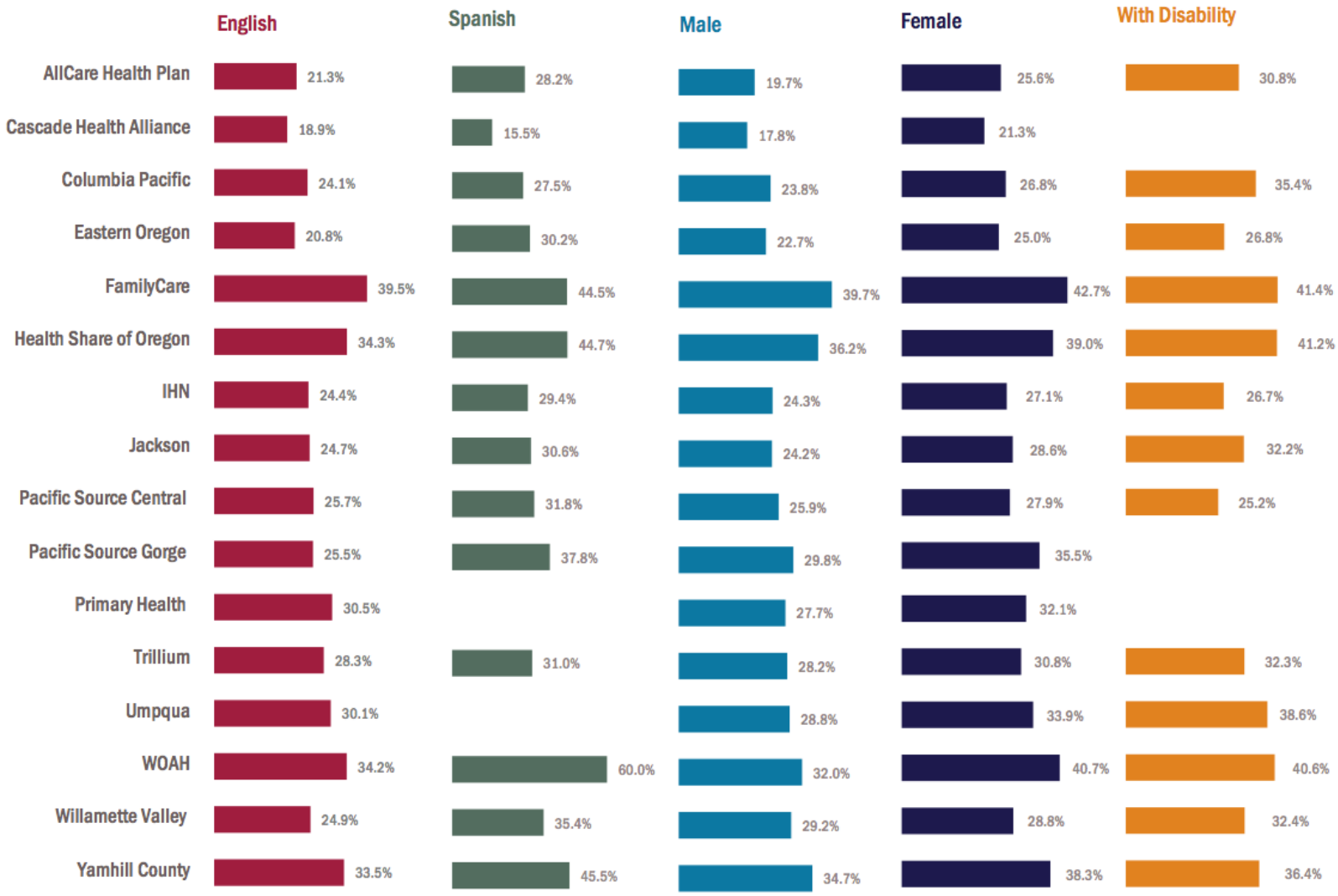
July 2014 - June 2015



Data suppressed n<30

Adolescent Well Care Visits

July 2014 - June 2015



Data suppressed n<30

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.

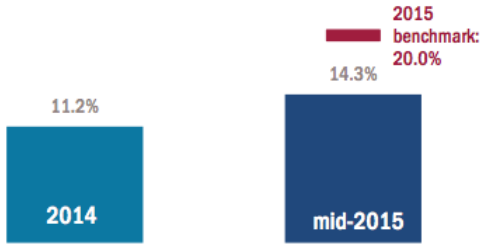
Dental sealants is a new incentive measure beginning in 2015. Results are stratified by age groups (see pages 46-49) for reporting and monitoring purposes only. Incentive payments are based on all ages combined.

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

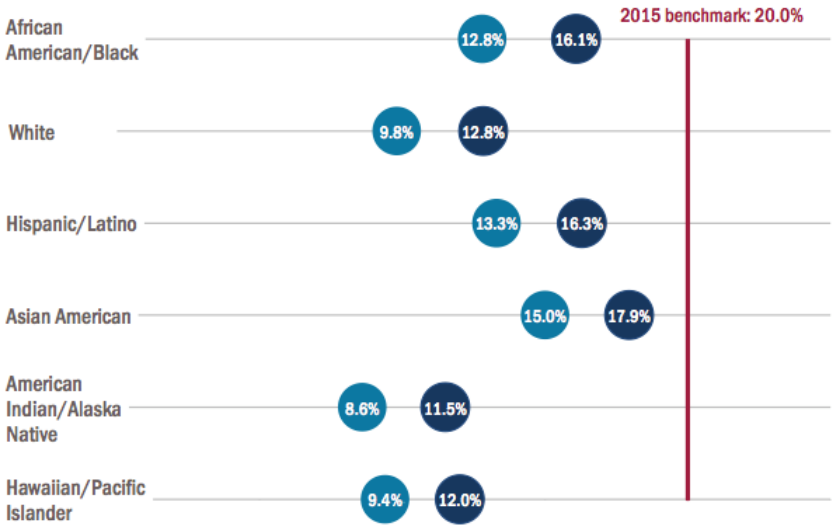
About these data:

- 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.

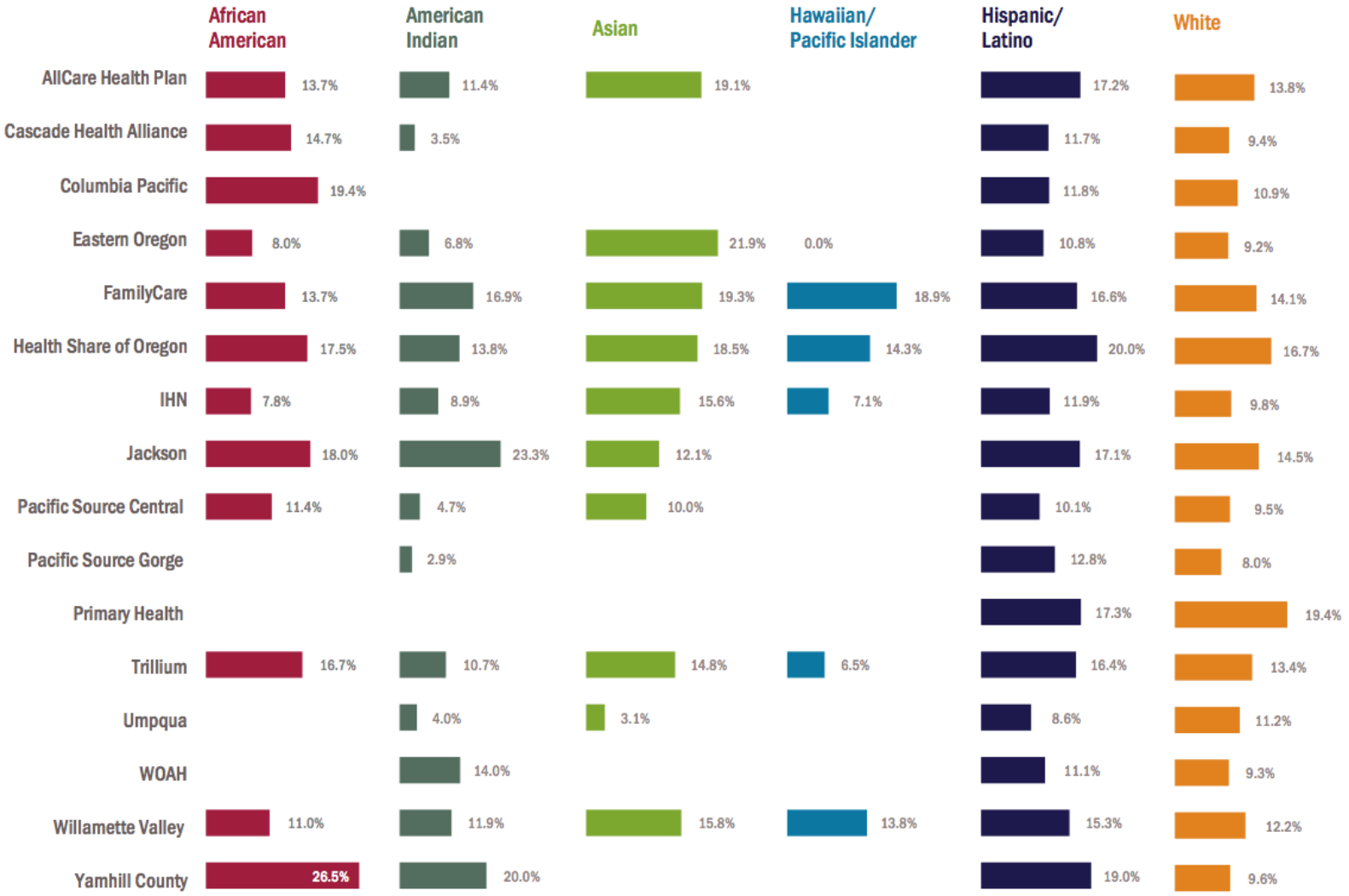


Asian American children ages 6-14 received dental sealants more frequently than other races and ethnicities in both 2014 & mid-2015.



Dental Sealants (ages 6-14)

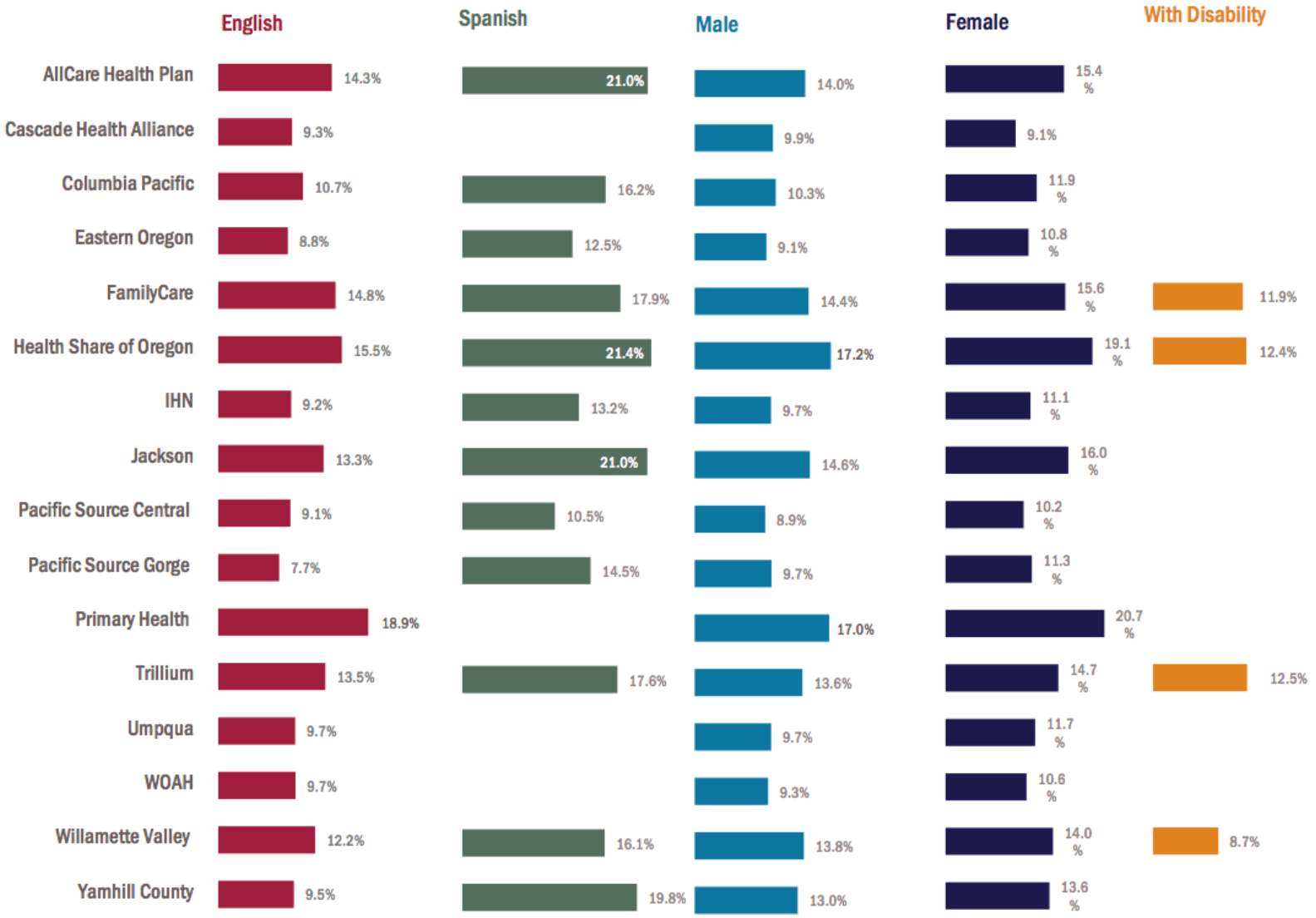
July 2014 - June 2015



Data suppressed n<30

Dental Sealants (ages 6-14)

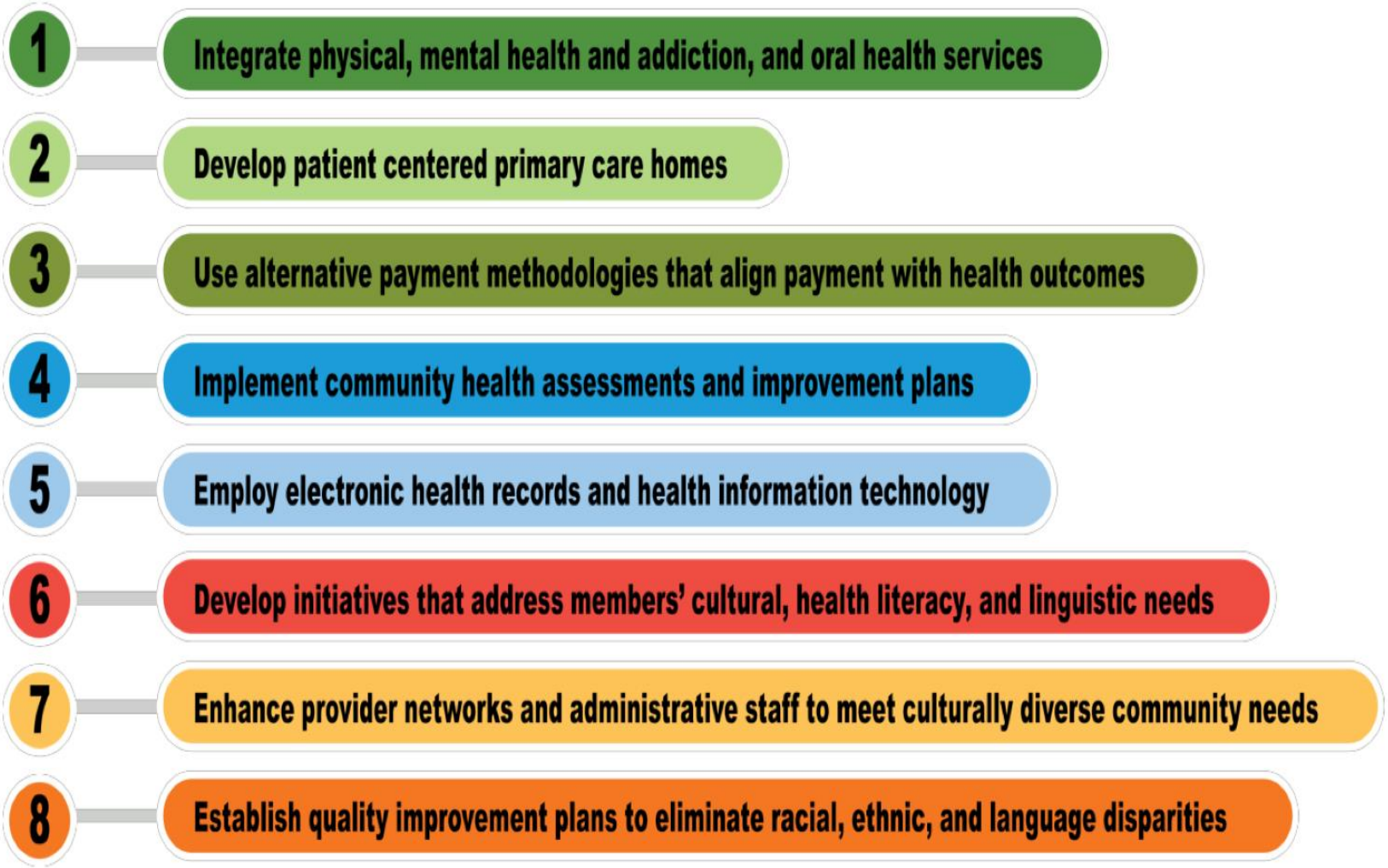
July 2014 - June 2015



Data suppressed n<30

- **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**

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

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

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

1. Integrate physical, mental health and addiction, and oral health services
2. Develop patient centered primary care homes
3. Use alternative payment methodologies that align payment with health outcomes
4. Implement community health assessments and improvement plans
5. Employ electronic health records and health information technology

How CCOs Are Advancing Health Equity: Lessons to Use

- Use both requirements and incentives
- Start with data, data, data (patients, communities, providers)
- Stratify existing quality measures
- Require specific disparity reduction plans and measureable objectives
- Leverage public reporting and accountability