MAKING CONNECTIONS TO SOCIAL SUPPORT FOR A HEALTHIER COMMUNITY

A rural community's efforts to address the health and social needs of its low-income residents.

The past decade brought a rapid growth in interest by state Medicaid leaders in addressing social needs, such as housing and transportation —also referred to as "social determinants of health" (SDOH).[1,2] In 2012, Oregon advanced its SDOH and health equity (SDOH-HE) plans through spending mechanisms and contractual requirements with its 16 coordinated care organizations (CCO), a type of managed care entity responsible for the health care outcomes and costs of Medicaid members in its region.[3]

In an earlier Issue Brief (June 2021),[4] we described Oregon's efforts to use CCOs to address SDOH. These efforts included:

The **use of health-related services** (HRS), a mechanism that allows CCOs to spend funds on services that are not "medically necessary"

Requirements that CCOs reinvest a percentage of revenues in SDOH and health equity projects through the **Supporting Health for All through Reinvestment (SHARE) initiative**

State performance-based rewards for CCOs to offset any lowering of capitation rates when achieving favorable cost and quality outcomes, particularly from health-related services spending

New contracts between the Oregon Health Authority and CCOs in 2020 —dubbed "CCO 2.0"— brought more requirements and accountability to CCOs in SDOH-HE planning and spending, as well as increased involvement of the CCO's community advisory council (CAC) in these activities.

KEY FINDINGS

- A CCO created an independent community governance structure that extends beyond the CCO —fostering community leadership and collaboration
- The community advisory council demonstrated a consistent, high level of participation at their meetings and prioritized Medicaid members' voices and needs, including offering bilingual communications
- Medicaid members faced resource challenges of insufficient affordable housing and limited numbers of bilingual providers and behavioral health providers in this rural region

OHSU *Center for* HEALTH SYSTEMS EFFECTIVENESS

"The formation of the Columbia Gorge CCO was a paradigm shift for its service providers in two counties, Hood River and Wasco"

This Issue Brief describes how a community and health plan leveraged shared goals to address SDOH-HE for the CCO and its surrounding region. The PacificSource Community Solutions: Columbia Gorge CCO lies along the Columbia River and Oregon's northernmost border. The Columbia Gorge's scenery draws in tourism and the region hosts orchards, wineries, forestry, and a growing technology industry. The rural region encompasses five Oregon counties and two Washington counties,with the Columbia River acting as a natural boundary. The CCO provides health care coverage in only two of the counties, both in Oregon. In 2016, the Robert Wood Johnson Foundation awarded the Columbia Gorge region its Culture of Health Prize, underscoring some of the achievements of collaboration among the CCO and its community partners.[5]

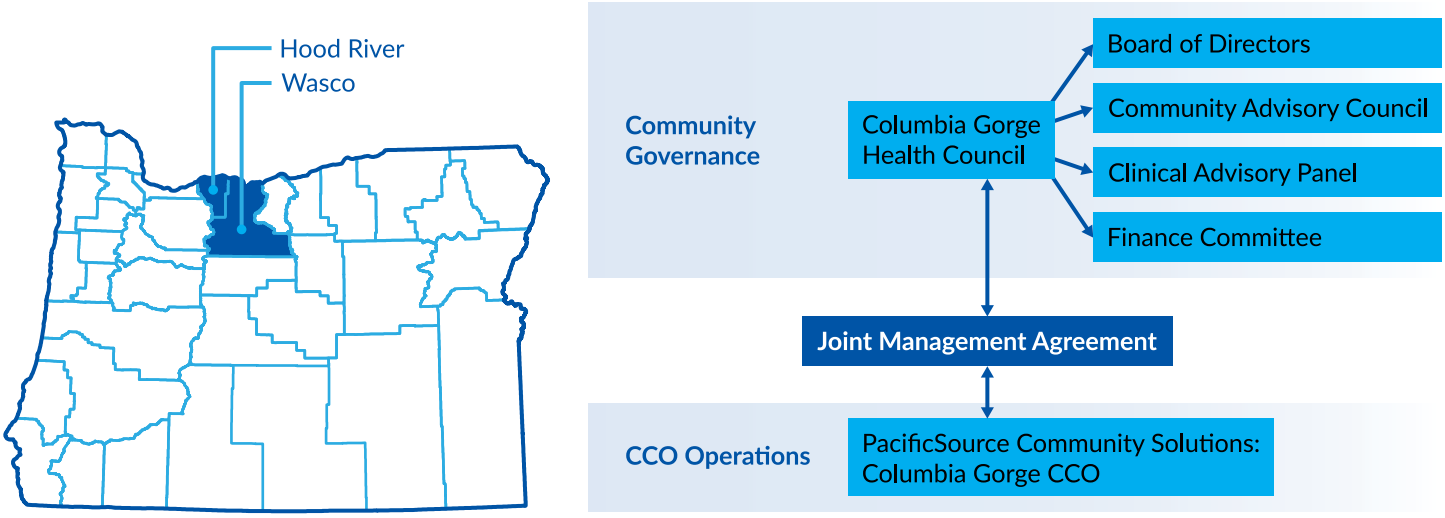
We highlight salient features of the CCO's efforts on SDOH-HE based on 13 individual interviews on SDOH-HE topics during April-May 2021 with the Health Council Board of Directors' members and staff, community health workers, and Medicaid members on the CAC; and a focus group of Medicaid members at a CAC meeting.

CCO UNITES HEALTH CARE PLANNING IN TWO COUNTIES

The formation of the Columbia Gorge CCO was a paradigm shift for its service providers in two counties, Hood River and Wasco, which previously competed for limited funding, resources and patients. The advent of the CCO created the impetus for these counties to collaborate to achieve the goals set out by the CCO and the Oregon Health Authority, including meeting quality measure targets. Before the launch of the CCO, leaders from the two major hospitals and other local agencies took steps to proactively engage in the planning process. Community leaders expressed a preference for a community governance approach since community partners were familiar with each other and local issues.

Ensuing discussions between PacificSource Health Plans, a nonprofit organization, and local health care leaders resulted in a Joint Management Agreement to establish the Columbia Gorge Health Council as an independent 501(c)(3) nonprofit. This umbrella organization houses the CCO board, CAC, finance committee, and the clinical advisory panel, a committee made up of local health care providers. Together, these Health Council committees provide on-the-ground direction, strategic planning, and community engagement for the CCO. The CCO operations role of PacificSource includes state and provider contracting, workforce development, and health plan benefits administration.

CCO – Health Council Relationship



THE HEALTH COUNCIL STRENGTHENS COMMUNITY VOICES AND RELATIONSHIPS

The community governance model differs from a more traditional approach in that the focus extends beyond CCO Medicaid members. A community CAC provides health and social care planning for all low-income individuals in the larger Columbia Gorge region. Community partners come together to employ a collective impact approach to tackle complex health and social issues —a concept promoting collaboration and information sharing among partners with a central organizer.[6,7]

As an independent nonprofit, the Health Council maintains flexibility to adapt to and address community needs. In the first year of the COVID-19 pandemic, the Oregon Health Authority provided an early release of quality incentive measure withhold funds to CCOs, and mandated funds address COVID impacts. The Health Council acted swiftly to bring together clinic, agency, and community partners on vaccine education and coordination. It offered COVID-19 relief funding, such as food and protective equipment, to community members and provided grants to behavioral health providers to help keep them open.

The board brings direction to the running of the CCO. It develops the CCO strategic plan, approves the annual CCO operating budget, and provides oversight for all Health Council committees. It includes CEOs from CCO-contracted health care agencies, county commissioners, community members-at-large, Medicaid members, and a PacificSource Community Solutions representative. The board decides how to distribute community funds for SDOH-HE and other programs, as well as grant-funded projects. These funds come from any shared savings remaining from the CCO's net revenue, plus half of the quality incentive measure payments earned by the CCO.

> *I really do see the difference just by having a board of directors that's really rooted in our community and understands our unique challenges.*
>
> *– Board member*

The CAC leads community initiatives on planning and grant awards

The CAC guides the community health assessment and community health improvement plan and has decision-making authority on awarding grants to community partners for projects that address SDOH-HE. A Health Council staff member and community member-at-large lead the CAC. They aim for meaningful engagement of the CAC —focusing on priority issues where the CAC can make an impact. They require presenters to use plain language; provide oral and written interpretation in Spanish; and offer childcare, meals, and wheelchair assistance to CAC attendees, as needed.

The CAC prides itself on engaged participation, consistently turning out 30-40 representatives (voting and non-voting members) from various local organizations and the community at their monthly meetings. Medicaid members represent over half of voting members of the CAC, per state requirements. The Columbia Gorge CCO frequently seeks input from the CAC, requesting feedback on CCO member materials and ways to improve the quality of member services. Medicaid members share their knowledge and experiences on barriers and gaps in health care and social services.

The CAC leads an extensive regional community health assessment and community health improvement plan for most of the Columbia Gorge region, covering three Oregon and two Washington counties. The community health assessment benefits the larger region, serving needs assessment requirements for public health agencies, hospitals, and other partners. It eliminates duplicative assessments and facilitates the use of common definitions (e.g., food insecurity). Community agencies employ the community health assessment findings for their grant proposals and planning, contributing to over $24 million from awards in the region over a seven-year period. The Health Council works collaboratively with partners to distribute surveys and contribute funds to the community health assessment development.

The CCO lays the groundwork for administering social benefits to Medicaid members

PacificSource Community Solutions provides additional support for Medicaid members through the administration of social benefits. It offers supportive services to Medicaid members, such as non-emergency medical transportation for physical, oral, or behavioral health appointments. The state allows the CCO to supplement medical care benefits with health-related services, which can take the form of individual "flexible services" or "community benefit initiatives" within the CCO global budget.

The CCO reviews requests for flexible services, which are intended to address clinical diagnoses and vary from temporary housing after hospitalization to vouchers for a farmer's market. The CCO's member support specialists

connect Medicaid members to health care and social services, often making requests for flexible services for them. Furthermore, the CCO takes charge of state contractual requirements for the development of a formal health equity plan; a community engagement plan; and a plan to employ and grow the traditional health workforce, such as community health workers and peer support specialists.

The Health Council and CCO synergize activities for mutual success

The Health Council and the CCO integrate their efforts to achieve SDOH-HE goals. The Health Council awards contracts and grants to community partners for SDOH-HE projects, and the CCO often manages these agreements. The CCO communicates with the Health Council about its contractual requirements from the state. One of these requirements is the development of a health equity plan, which entails the development of equity goals, assessment, and staff training. The CAC supported the CCO with outreach and coordination for "listening sessions" on health equity with the community. In addition, CCO representatives participate in Health Council committees, including the board, clinical advisory panel, and finance committee.

The Health Council board budgets a portion of its CCO shared savings funds for its patient navigation hub and allocates 10 percent of its quality incentive measure payments for SDOH-HE grant awards to community partners. This arrangement incentivizes the Health Council and CCO to work together to achieve quality targets and shared savings for investment in SDOH-HE projects for the community. The Health Council's clinical advisory panel, along with the CAC and board, strategize to meet CCO quality measure targets. CAC Medicaid members provide insights about the community that help the CCO achieve these metrics.

Medicaid members perceive improvements in the CCO but inadequate resources in the community

Based on interviews and the CAC focus group, Medicaid members perceived the CAC as an effective forum to raise and attend to community issues on SDOH-HE for individuals with low income, regardless of whether they were on Medicaid coverage or were uninsured. They valued the strong representation of community members and partners at meetings. Medicaid members believed CAC leadership made concerted efforts to listen to their voices and encouraged diversity in CAC representation with bilingual meetings.

Over the years, CAC Medicaid members saw improvements in the CCO's ability to address SDOH-HE needs. The CCO offered improved access to providers, materials, and services in Spanish. One Medicaid member mentioned that the CCO-contracted transportation brokerage offered more routes and frequency for its non-emergency transportation service, making it easier to get to medical appointments. However, Medicaid members shared concerns that the community still lacked sufficient bilingual providers and behavioral health providers accepting Medicaid. Furthermore, a rapid rise in housing costs and a lack of affordable housing raised consternation for Medicaid members as a foremost social concern.

> *I think that we have one of the most successful CACs around. I think that we have almost—in fact, I would say that we have every single agency represented.*
>
> *– Medicaid member on CAC*

COMMUNITY PARTNERS CREATE A PATIENT NAVIGATION HUB TO SUPPORT COMMUNITY MEMBERS WITH COMPLEX HEALTH AND SOCIAL NEEDS

An early success of the Health Council was establishing a large patient navigation hub, "Bridges to Health," with nine community partners. It employs the nationally-recognized Pathways Community HUB model.[8] Prior to the CCO formation, plans for the hub started as a joint effort by more than 30 agencies to create wraparound services for clients with complex health and social needs —an approach to providing a comprehensive range of services to low-income community members. The partner consortium selected the Health Council as the most qualified organization to lead and administer the hub. The Health Council provides funding and manages Bridges to Health primarily from shared savings and health-related services community benefit initiative funds. The CAC receives regular reports on Bridges to Health and renews its funding annually.

Image of the Bridges to Health Pathways program logo[9]

The hub promotes efficient coordination among participating agencies by streamlining access to services for clients and avoiding duplicate work. Partner agencies participate in the hub by embedding hub or agency-employed community health workers, funded by the hub, in their agencies. Each agency sends a supervisor to monthly Bridges to Health administrative meetings. To receive services through the hub, community members must have at least two unmet service needs, such as food insecurity or housing, struggle to access services on their own, and live within the two-county CCO service area. The hub receives referrals from providers, partner agencies, and community members themselves. Community health workers communicate and track client information on a software platform. The program uses the data collected to drive decisions and educate around service gaps in the region.

> *It's [affordable housing] very limited. It's always been limited. It's a struggle especially if they're trying to get Section 8 apartments. The wait lists are extremely long.*
>
> *– Community health worker*

CHALLENGES IN SCOPE AND RESOURCES

The Columbia Gorge CCO's community governance approach is intended to strengthen collective community efforts to support social needs, but challenges remain. The Columbia Gorge region covers a large area, requiring navigation of laws, rules, and regulations of two states and multiple counties. Due to limited funding and scope, the Health Council has focused more attention on the services and areas covered by the CCO. Community health workers and Medicaid members highlighted deficiencies in affordable housing, behavioral health providers, and bilingual services. Multiple social care spending streams added more time and complexity for the CAC and CCO on planning and reporting, as each has different spending rules and funding cycles.

IMPLICATIONS

An independent, community-led governance body for a CCO, such as a Health Council, promotes community engagement and leadership for the region. The Health Council serves as a neutral convener and central organizing agency for the health and social needs of individuals with low income in the community.

A community health assessment that extends beyond the CCO fosters collaboration with other community partners and agencies on its implementation and funding. It reduces duplicative assessments and definitions while fulfilling need assessment requirements for multiple organizations and grant proposals.

A shared savings approach allows CCOs to make more dollars available for health and social service programs in the region. The decision-making roles of the board and the CAC in community reinvestment incentivizes collaboration with the health plan to achieve quality measure targets and shared savings.

A multi-partner patient navigation hub for wraparound services promotes partner collaboration for individuals most in need of health and social services. The hub engages community partners to coordinate and reduce duplication of services while strengthening relationships.

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