November 7, 2022

Centering Equity in Health Related Services Flexible Services Programs

Part 3: HRS Flex Policies & Procedures (P & Ps)

Oregon Health Authority

ORPRN
Oregon Rural Practice-Based Research Network

OHSU

collective health strategies

Technology

- Please **change your zoom name** to add your CCO (Example: Mary Smith, CCO X)
- Participants feel free to **unmute yourselves, type in the chat or use the raise hand** function
- Reach out to **Hannah Bryan with any tech issues**
- **Register** if you haven’t already (link in the chat)

Agenda for today

- Walking through the HRS request/approval process with an equity lens
- Examples of HRS Policies & Procedures that promote equity
- Activities and discussion:
  - Self-evaluation of HRS Policy & Procedure for your CCO
  - Small group discussions about findings

Plans for TA sessions

Session 1: Oct 24, 10-11 am

- Centering equity in communications with members and providers
- *Activity: Communications planning*

Session 2: Oct 31, 10-11 am

- Connecting HRS Flex with CHA/CHIP/CAC goals
- *Activity: Identifying community needs*

Session 3: Nov 7 , 10-11 am

- HRS Policies and Procedures
- *Activity: Review/strengthen policies/procedures together*

OHA Health Equity Definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

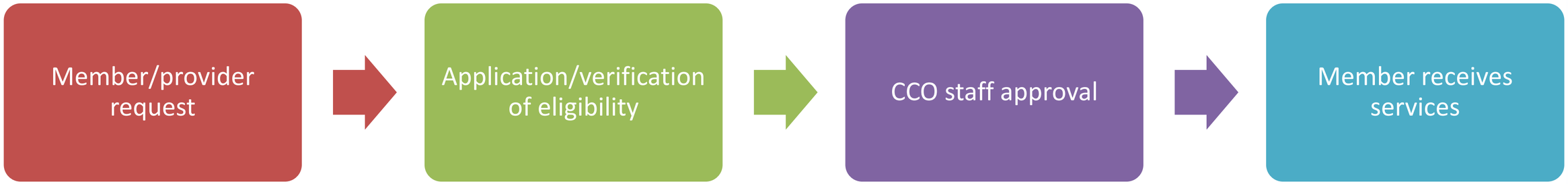
- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Goal

CCO members, in particular **those experiencing the greatest health inequities**, are **aware** of HRS Flex services available to them, and **understand how to access** them when needed.

CCO providers know how to **reach those members experiencing the greatest health inequities**, are **aware** of HRS Flex offerings, and **understand how to access** them when needed.

HRS Flex decision making process



Example of coordination with CHP/CAC

OVERSIGHT & MONITORING

Documentation, Tracking and Monitoring

Care Coordination Supervisor completes regular case reviews. All flexible spending is reviewed monthly by the Care Coordination Flex Spending (CC Flex) workgroup who then provide summaries, trends and analysis of the spending.

The work of the CC Flex group is reported to the CHIP committee and CCO Community Advisor Council in all three counties for additional recommendations and oversight.

Example of timeliness of response to members

4.1.2.1 Determinations will be made in the following timeframes:

- 4.1.2.1.1 CCO Flex Fund Services are not available as emergency or crisis funding. Any request submitted within less than one business day of the date needed will not be reviewed for funding.
- 4.1.2.1.2 Urgent requests will be decided in two to three business days.
- 4.1.2.1.3 Standard requests will be decided within ten business days.
- 4.1.2.1.4 Requests over $1,000 require executive committee review and will be decided within fifteen business days.

Example of alignment with Health Equity Plan & TQS

6.1 The Director of Customer Experience and Health Equity is responsible for the overall administration of the HRS Plan and its supporting policies and procedures and ensures its compliance with CHA's Policies and Procedures as well as CHA's contract with the Oregon Health Authority (OHA), including:

6.1.1 CHA members who receive Flex Fund will receive a follow up call within 6 months of the intervention to receive feedback on the effect of the Flex Fund intervention of the given member's health and/or wellbeing. This feedback will be documented to inform decisions on similar interventions in future.

6.1.3 CHA's Health Equity Council (beginning with its Member Experience Subcommittee) will review and analyze individual level feedback and data collected for monitoring and tracking from these projects in order to identify spending effectiveness in alignment with CHA's Health Equity Plan and Transformation and Quality Strategy. Projects whose outcomes inform quality improvement will be considered for continued and/or future funding from CHA.

Example of outreach to community based organizations

B. Health Share delegates to Plan Partners the responsibility to:
   1. Notify Members, Providers, and care coordinators about HRS, including the process to request them. Notification may happen via community forums,

      provider trainings, provider manuals, or individual outreach. Any Provider may request Flexible Services on behalf of a Member by working with the Member's care coordination team. This includes clinical Providers such as Care Coordinators, Primary Care Providers, Discharge Planners, Social Workers, or others working directly to meet the health-related social needs of members. Non-clinical Providers may include Navigators, Community Health Workers, or others.
   2. Educate Providers and Community-Based Organizations about HRS requests, documentation, and monitoring protocols; and

Example of equity as an approval criteria

2. Flexible Service requests are evaluated within the Care Coordination care management team using the following criteria:
   A. The service requested improves health outcomes compared to a baseline and reduce health disparities among specified populations;
   B. Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge;
   C. Improve patient safety, reduce medical errors, and lower infection and mortality rates; and
   D. Implement, promote and increase wellness and health activities.
   E. Medicaid funded and/or non-Medicaid funded service alternatives such as but not limited to; Long Term Services and Supports and/or Developmental Disabilities K Plan funding, Community Services Consortium and Department of Human Services.

Example of equity as an prioritization criteria

HRS funds may be prioritized for specific higher-risk populations, including populations with severe and persistent mental illness, those with high social determinant of health or equity needs, and for those experiencing any health disparities. YCCO will use its member demographic data, claims analysis, and Community Health Assessment to identify and prioritize areas of high need. HRS should be primarily designed to meet at least one of the following:

Summary of equity strategies to integrate into HRS P & P

- Language access beyond Spanish and English
- Consider how to match outreach with preferred member channels and formats
- Define a pre-approved list of services
- Describe outreach process to members experiencing the greatest health inequities
- Outreach to key CBOs in the community, name them
- Process for CAC reviewing FLEX spending and comparing to current member needs and making changes based on data (common for CBI)
- Make health inequities a criteria for decision making around Flex Services

Small group breakouts

- What is currently in your HRS P & P that is supportive of equity?
- What are 2-3 things you could strengthen to center equity?
- What will be the most challenging part of implementing changes to center equity? What will be easy?

For more information

Oregon Health Authority, Transformation Center. Health-Related Services website

- **https://www.oregon.gov/oha/hpa/dsi-tc/pages/health-related-services.aspx**

Ongoing support and technical assistance

- **OHA HRS Team: Health.RelatedServices@dhsoha.state.or.us**
- **Oregon Rural Practice-Based Research Network, OHSU TA Providers**
  - **Nancy Goff: nancy055@gmail.com**
  - **Anne King: kinga@ohsu.edu**