

Assuring Health Equity in Health Systems Transformation



Webinar #1: Overview

Oregon
Health
Authority



Office of
Equity & Inclusion

Goal for today

Inform CCO leadership of the rich opportunities to embed health equity, cultural competence, diversity and inclusion into their transformation plans – and the impetus for doing so.

Training objectives

Participants will understand:

How and why health equity, diversity and cultural competence are part of Health Systems Transformation in Oregon and nationally

How Transformation Plans can incorporate key health equity building blocks

Upcoming learning opportunities and available resources

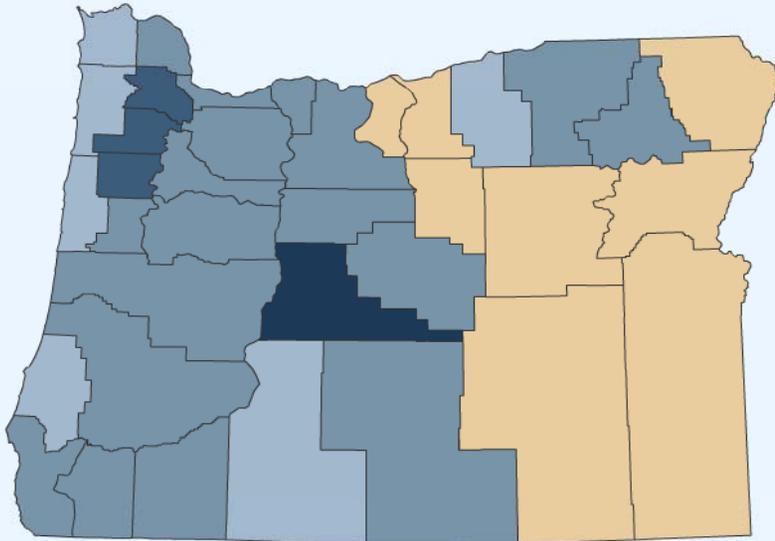
2010 CENSUS RESULTS

Oregon

STATE POPULATION: 3,831,074

POPULATION CHANGE BY COUNTY: 2000-2010

LOSS 0-5% 5-15% 15-25% 25% +



BACK TO U.S. MAP

HIDE FULL SCREEN

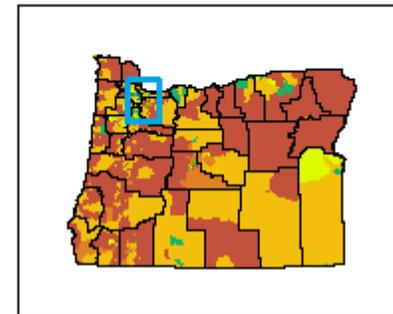
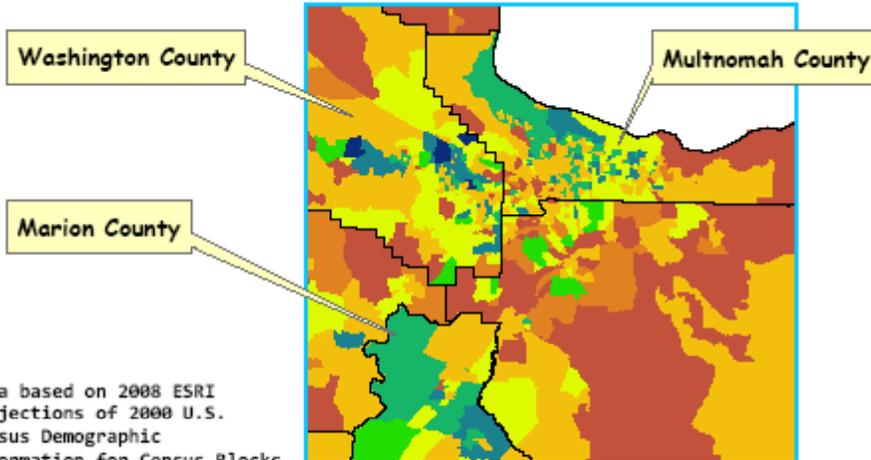
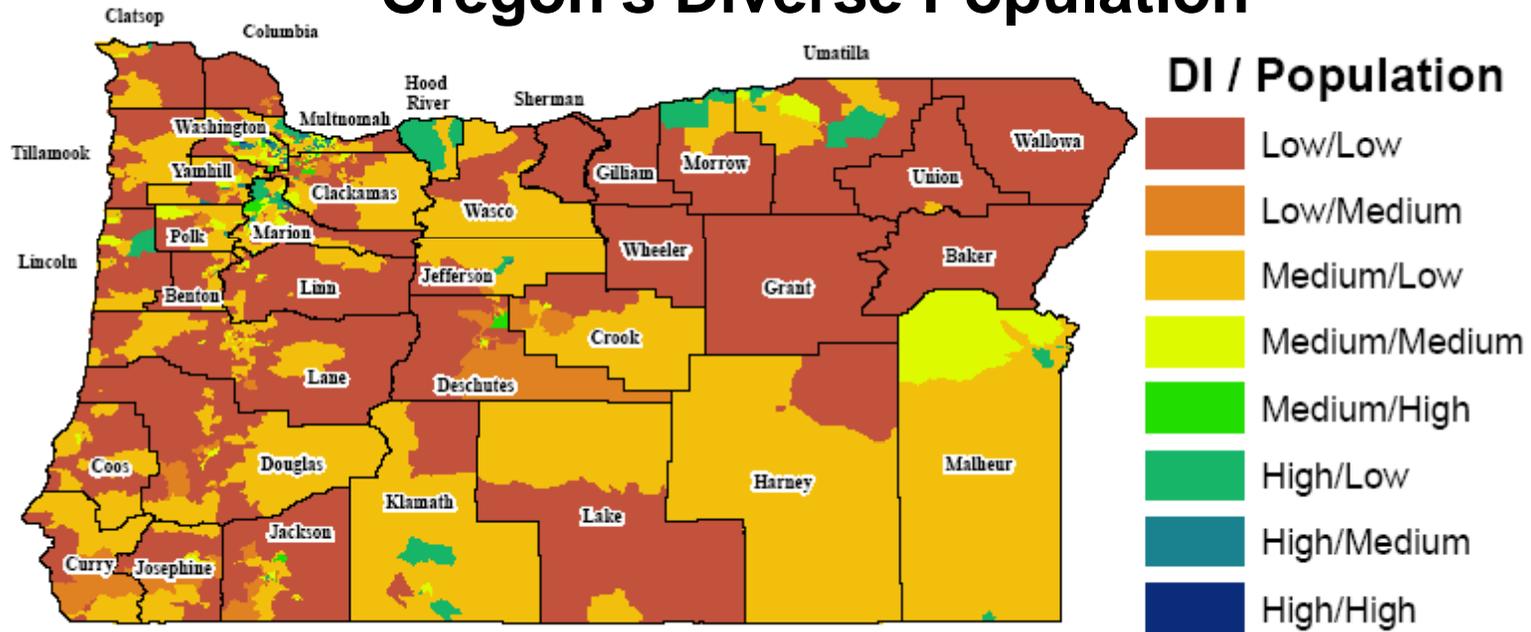
STATE POPULATION BY RACE
OREGON: 2010

PERCENT OF POPULATION	CHANGE 2000-2010
White alone 83.6%	8.2% ↑
Black or African American alone 1.8%	24.3% ↑
American Indian and Alaska Native alone 1.4%	17.7% ↑
Asian alone 3.7%	39.4% ↑
Native Hawaiian and Other Pacific Islander alone 0.3%	68.1% ↑
Some Other Race alone 5.3%	41.3% ↑
Two or More Races 3.8%	38.2% ↑

STATE POPULATION BY HISPANIC OR LATINO ORIGIN
OREGON: 2010

PERCENT OF POPULATION	CHANGE 2000-2010
Hispanic or Latino 11.7%	63.5% ↑
Not Hispanic or Latino 88.3%	7.5% ↑

Oregon's Diverse Population



Data based on 2008 ESRI
Projections of 2000 U.S.
Census Demographic
Information for Census Blocks

40% of Oregon Health Plan Enrollees are People of Color

DISTRIBUTION OF AGE, RACE/ETHNICITY AND GENDER AMONG CLIENTS ON THE OREGON HEALTH PLAN

1/15/2011 Totals

AGE by RACE/ETHNICITY									AGE by GENDER			
AGE	Black or African-American	American Indian or Alaska Native	Asian, Native Hawaiian or Other	White	Hispanic or Latino	Other/Unknown ¹	TOTAL	% of OHP	Female	% Female	Male	% Male
<1	785	293	726	12,778	7,130	2,934	24,646	4.0%	12,009	48.7%	12,637	51.3%
1-5	4,021	1,540	2,823	54,114	35,163	11,444	109,105	17.9%	53,135	48.7%	55,970	51.3%
6-12	5,043	2,342	3,504	63,605	38,175	9,873	122,542	20.1%	59,770	48.8%	62,772	51.2%
13-18	3,966	1,986	2,714	49,294	22,109	5,910	85,979	14.1%	42,612	49.6%	43,367	50.4%
19-21	994	416	552	13,255	3,447	1,725	20,389	3.3%	13,715	67.3%	6,674	32.7%
22-35	3,515	1,517	2,165	55,388	15,254	7,255	85,094	14.0%	59,352	69.7%	25,742	30.3%
36-50	2,849	1,354	2,192	51,155	8,222	3,220	68,992	11.3%	40,569	58.8%	28,423	41.2%
51-64	2,252	1,161	1,695	43,072	2,565	879	51,624	8.5%	29,491	57.1%	22,133	42.9%
65+	<u>1,022</u>	<u>452</u>	<u>4,285</u>	<u>32,062</u>	<u>3,126</u>	<u>671</u>	<u>41,618</u>	6.8%	<u>28,204</u>	67.8%	<u>13,414</u>	32.2%
TOTAL	24,447	11,061	20,656	374,723	135,191	43,911	609,989		338,857		271,132	
% of OHP	4.0%	1.8%	3.4%	61.4%	22.2%	7.2%			55.6%		44.4%	

GENDER by RACE/ETHNICITY							
Female	13,297	6,214	11,705	210,775	72,328	24,538	338,857
% Female	54.4%	56.2%	56.7%	56.2%	53.5%	55.9%	55.6%
Male	11,150	4,847	8,951	163,948	62,863	19,373	271,132
% Male	45.6%	43.8%	43.3%	43.8%	46.5%	44.1%	44.4%

Includes all Medicaid recipients: OHP Plus, Standard benefits and recipients eligible under the classes: QB, QS, NP, CW, and BC.

¹This count contains a substantial number of clients of Hispanic ethnicity. The database no longer uniquely captures Hispanic ethnicity. #2131; Version 1

State of Oregon, Division of Medical Assistance Programs, 500 Summer Street NE, Salem, OR 97301-1016

Source: DMAP DSSURS data warehouse: DateLoad = 2/9/2011

GOAL: Triple Aim

A new vision for a healthy
Oregon

- 1 Better health.
- 2 Better care.
- 3 Lower costs.

SB 1580 reference to Health Equity, Cultural and Linguistic Competence:

SECTION 5. ORS 414.635, as amended by section 9, chapter 602, Oregon Laws 2011, is amended to read:

414.635. (1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:

(a) Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.

(b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

(c) Must have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

(d) Shall be encouraged ~~within all aspects of the integrated and coordinated health care delivery system~~ to use wellness and prevention resources and to make healthy lifestyle choices.

(e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.

(2) The authority shall establish and maintain an enrollment process for individuals who are dually eligible for Medicare and Medicaid that promotes continuity of care and that allows the member to disenroll from a coordinated care organization that fails to promptly provide adequate services and:

(a) To enroll in another coordinated care organization of the member's choice; or

(b) If another organization is not available, to receive Medicare-covered services on a fee-for-service basis.

SB 1580 reference to Health Equity, Cultural and Linguistic Competence:

authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria adopted by the authority under this section must *[be designed]* include, but are not limited to, the coordinated care organization's demonstrated experience and capacity for:

- (a) Managing financial risk and establishing financial reserves.
 - (b) Meeting the following minimum financial requirements:
 - (A) Maintaining restricted reserves of \$250,000 plus an amount equal to 50 percent of the coordinated care organization's total actual or projected liabilities above \$250,000.
 - (B) Maintaining a net worth in an amount equal to at least five percent of the average combined revenue in the prior two quarters of the participating health care entities.
 - (c) Operating within a fixed global budget.
 - (d) Developing and implementing alternative payment methodologies that are based on health care quality and improved health outcomes.
 - (e) Coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services.
 - (f) Engaging community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the coordinated care organization's members and in the coordinated care organization's community.
- (2) ~~In addition to the criteria specified in subsection (1) of this section, the authority must adopt by rule requirements for coordinated care organizations contracting with the authority so that:~~
- (a) Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.
 - (b) ~~Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.~~

SB 1580 reference to Health Equity, Cultural and Linguistic Competence:

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures, objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

OAR References to Health Equity, Cultural and Linguistic Competence:

- **410-141-3015 Certification Criteria for Coordinated Care Organizations**

(24) CCOs' health care services must focus on achieving health equity and eliminating health disparities. Applicants must:

(a) Describe their strategy for ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors;

(b) Engage in a process that identifies health disparities associated with race, ethnicity, language, health literacy, age, disability (including mental illness and substance use disorders), gender, sexual orientation, geography, or other factors through community health assessment;

(c) Collect and maintain race, ethnicity and primary language data for all members on an ongoing basis in accordance with standards jointly established by the Authority and the Department.

OAR References to Health Equity, Cultural and Linguistic Competence:

410-141-3145 Community Health Assessment and Community Health Improvement Plans

(8) Through their community health assessment and plan, CCOs shall identify health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, behavioral health status, geography, or other factors in their service areas such as type of living setting, including but not limited to home, independent support living, adult foster home or homeless.

CCOs shall collect and maintain data on race, ethnicity and primary language for all members on an ongoing basis in accordance with standards established jointly by the Authority and the Department. CCOs shall track and report on any quality measure by these demographic factors and shall develop, implement, and evaluate strategies to improve health equity among members. CCO's shall make this information available by posting on the web.

RFA References to Health Equity, Cultural and Linguistic Competence:

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of Health System Transformation. As required by HB 3650, CCOs will be held accountable for their performance on outcomes, quality, health equity and efficiency measures identified by OHA through a robust public process in collaboration with culturally diverse stakeholders. CCO accountability metrics will function both as an assurance that CCOs are providing quality care for all of their Members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650.

National Focus on Health Equity, Cultural and Linguistic Competence:

- Department of Health and Human Services
 - CLAS Standards
 - Race, ethnicity, and language data collection
- American Medical Association
- National Committee for Quality Assurance
 - Multicultural Health Care Distinction
- Civil Rights Law
 - Language access
 - Client rights and responsibilities

CLAS Standards

The CLAS Themes

Culturally Competent Care
Standards 1-3

Language Access Services
Standards 4-7

Organizational Supports
Standards 8-14

Office of Minority Health's Recommended¹ National Standards for Culturally and Linguistically Appropriate Services in Health Care

Culturally Competent Care

1. Health care organizations should ensure that patients/consumers² receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in CLAS delivery.

Language Access Services

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with LEP at all points of contact and in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must ensure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide CLAS.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to make available regularly to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

¹ CLAS standards are nonregulatory and therefore do not have the force and effect of law. The standards are not mandatory but they greatly assist health care providers and organizations in responding effectively to their patients' cultural and linguistic needs. Compliance with Title VI of the Civil Rights Act of 1964 is mandatory and requires health care providers and organizations that receive Federal financial assistance to take reasonable steps to ensure LEP persons have meaningful access to services.

² CLAS standards use the term patients/consumers to refer to "individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services" (page 5 of the comprehensive final report, see <http://www.omhrc.gov/clas>).

Health Equity in Transformation Plans



Oregon
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Office of
Equity & Inclusion

Transformation Plan Element 4:

(4) Preparing a strategy for developing Contractor's Community Health Assessment and adopting an annual Community Health Improvement Plan consistent with 2012 Oregon Laws, Chapter 8 (Enrolled SB 1580), Section 13.

- Assessment - identifies health disparities in CCO community
- Plan - Prioritizes health disparities CCO will address
- Both are opportunities to address social determinants of health

Health Equity Learning Opportunities for Transformation Plan Element #4

Date	Time	Topic
December 18	2:00 – 3:00 pm	Collecting Race, Ethnicity, and Language Data to assure Health Systems Transformation
December 20	3:00 – 4:00 pm	Language Access Service for LEP Clients

Health Equity Learning Opportunities for Transformation Plan Element #4

Date	Time	Topic
December 21	1:00 – 2:00 pm	Achieving Health Equity through Member Engagement
December 27	10:00 – 11:00 pm	Quality Improvement for Health Equity
January 4	1:00–2:00 am	Tribal Health and Engagement
January 7	10:00 – 11:00 am	Best practices for diverse engagement on CACs
January 10	1:00 – 2:00 pm	Guidelines for Analyzing, Interpreting and Disseminating Data by Race and Ethnicity

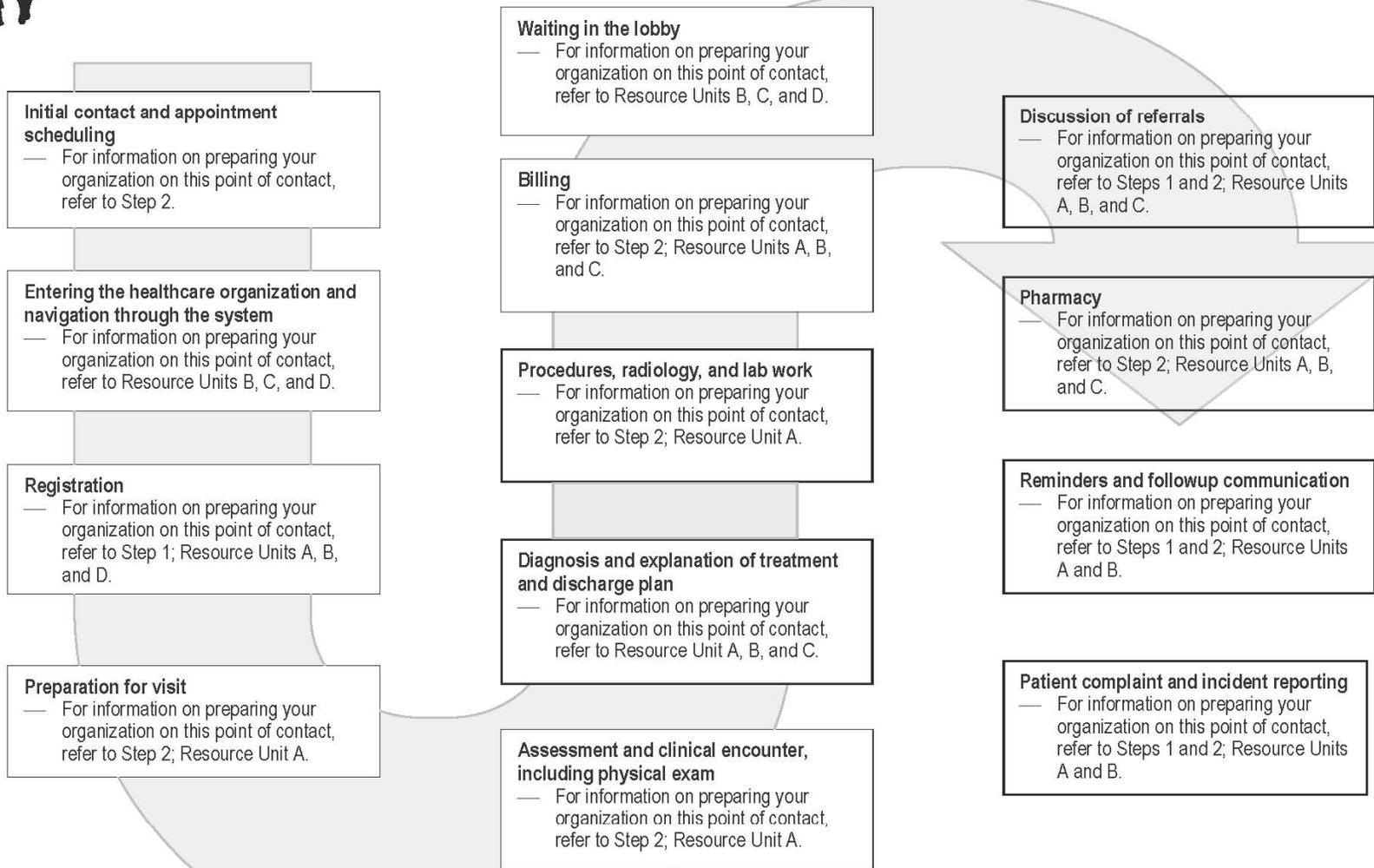
Transformation Plan Element 6:

(6) Assuring communications, outreach, Member engagement, and services are tailored to cultural, health literacy, and linguistic needs.

- Health literacy \neq literacy
- Outreach = “showing up”
- Cultural needs = health beliefs, relational interactions, inclusion of family,
- Linguistic needs at multiple points of contact



Exhibit ES-1: Traveling Through the Points of Contact



Health Equity Learning Opportunities for Transformation Plan Element #6

Date	Time	Topic
December 18	1:00 – 2:00 pm	Language Access Services for LEP Clients – Part 1
December 19	10:00–11:00 am	Elements of a Culturally Competent Organization – From the Waiting Room to the Exam Room
December 20	9:00 – 10:00 am	Non-Traditional Health Care Workers
December 20	2:00- 3:00 pm	Health Care Professional Cultural Competency
December 20	3:00 – 4:00 pm	Language Access Services for LEP Clients – Part 2
December 21	11:00 – 12:00	Diversifying the Health Care Workforce

Health Equity Learning Opportunities for Transformation Plan Element #6

Date	Time	Topic
December 21	1:00 – 2:00 pm	Achieving Health Equity through Member Engagement
January 3	2:00 – 5:00 pm	Health Literacy and Cross Cultural Communications
January 4	1:00–2:00 am	Tribal Health and Engagement
January 7	10:00 – 11:00 am	Best practices for diverse engagement on CACs

Transformation Plan Element 7:

(7) Assuring provider network and staff ability to meet cultural diverse needs of community (cultural competence training, provider composition reflects Member diversity, nontraditional health care workers composition reflects Member diversity).

- Cultural Competence training
- Provider diversity
- Nontraditional health care worker diversity

Health Equity Learning Opportunities for Transformation Plan Element #7

Date	Time	Topic
December 19	10:00–11:00 am	Elements of a Culturally Competent Organization – From the Waiting Room to the Exam Room
December 20	9:00 – 10:00 am	Non-Traditional Health Care Workers
December 20	2:00- 3:00 pm	Health Care Professional Cultural Competency
December 21	11:00 – 12:00	Diversifying the Health Care Workforce

Transformation Plan Element 8:

(8) Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, experience of care, and outcomes.

- Opportunities for quality improvement
- Data collection and analysis
- Sharing learning
- Client Civil Rights

Health Equity Learning Series Schedule

Date	Time	Topic
December 18	2:00 – 3:00 pm	Collecting Race, Ethnicity, and Language Data to assure Health Systems Transformation
December 27	10:00 – 11:00 pm	Quality Improvement for Health Equity
January 4	2:00 – 3:00 pm	Client Civil Rights
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Health Equity Resources



Oregon
Health
Authority

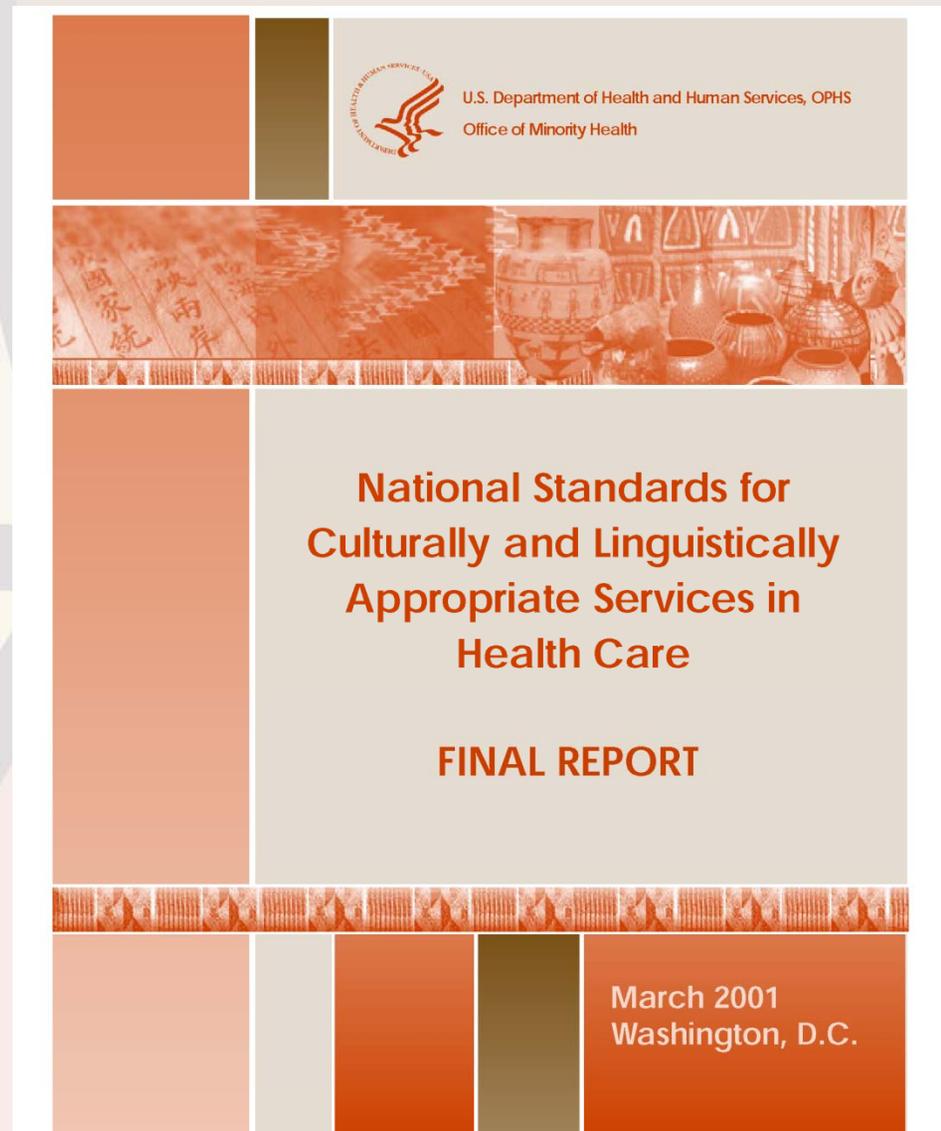


Office of
Equity & Inclusion

CLAS Standards

14 standards are organized by themes:

- Standards 1-3: **Culturally Competent Care**
- Standards 4-7: **Language Access Services**
- Standards 8-14: **Organizational Supports for Cultural Competence**



NCQA Distinction in Multicultural Health Care

- Race Ethnicity and Language Data Collection
- Access and Availability of Language Services
- Practitioner Network Cultural Responsiveness
- Culturally and Linguistically Appropriate Services Program
- Reducing Health Care Disparities

National Committee for Quality Assurance, 2008.

Assuring Healthcare Equity: A Healthcare Equity Blueprint

Quality improvement strategies in 5 categories:

- Create partnerships with the community, patients, and families
- Exercise governance and executive leadership for providing quality and equitable care
- Provide evidence-based care to all patients in a culturally and linguistically appropriate manner
- Establish measures for equitable care
- Communicate in the patient's language – understand and be responsive to cultural needs/expectations

National Public Health and Hospital Institute and National Association of Public Hospitals and Health Systems in collaboration with the Institute for Health Care Improvement, 2008.

Language Access Services

Guidance from DHHS Office of Minority Health

**EXECUTIVE SUMMARY:
A PATIENT-CENTERED GUIDE
TO IMPLEMENTING LANGUAGE ACCESS SERVICES
IN HEALTHCARE ORGANIZATIONS**

SUBMITTED TO:
OFFICE OF MINORITY HEALTH
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEVELOPMENT OF A DRAFT HEALTH CARE
LANGUAGE SERVICES IMPLEMENTATION GUIDE
National Standards for Health Care Language Services Contract

CONTRACT NO. 282-98-0029, TASK ORDER NO. 48
PROJECT OFFICER: GUADALUPE PACHECO

SUBMITTED BY:
AMERICAN INSTITUTES FOR RESEARCH

**FINAL DRAFT
SEPTEMBER 2005**

Developing Equity Leadership through Training and Action (DELTA)

What?

- ❖ New OEI Learning Collaborative
- ❖ Health equity and inclusion leadership training
- ❖ 6-month program
- ❖ Includes classroom training, coaching and mentorship

Who?

- ❖ 20 individuals - community leaders, policy makers, administrators and clinicians

Talk to your CCO Point of Contact if you are interested in participating in the DELTA Program

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Questions?

Tracey Robichaud - Tracey.L.Robichaud@dhs.oregon.gov

- Cascade Health Alliance
- Eastern Oregon Community Care Organization
- Columbia Pacific Coordinated Care Organization, LLC
- PacificSource Community Solution, Inc

Keri Mintun - Keri.A.Mintun@dhs.oregon.gov

- FamilyCare Coordinated Care Organization
- HealthShare of Oregon

Lisa Welch - Lisa.Welch@dhs.oregon.gov

- Western Oregon Advanced Health LLC
- PrimaryHealth of Josephine County, LLC
- Jackson Care Connect

Bevin Hansell – Bevin.L.Hansell@dshoha.state.or.us

- AllCare Health Plan
- Umpqua Health Alliance

Rosanne Harksen - Rosanne.M.Harksen@dhs.oregon.gov

- InterCommunity Health Network Coordinated Care Organization
- Trillium Community Health Plan, Inc.
- Willamette Valley Community Health, LLC
- Yamhill County Care Organization

**Office of Equity and Inclusion
Website:**

<http://www.oregon.gov/OHA/oei>