States Making the Case for Innovations in Health and Social Services: What We Are Learning

Welcome!

The webinar will begin shortly.

In the meantime:

This meeting is being recorded and will be circulated to attendees

Participants will be muted upon entry

Use the Q&A feature to ask questions

Please edit your name to include your organization and state

If you experience video or audio issues, please call-in using the number provided in your registration confirmation email

The Pilots Have Literally Changed My Life

During a routine doctor's appointment, an enrollee was identified as having multiple unmet health-related needs. The most pressing was transportation, as he had not had reliable transportation in five years. He lives in a rural county that does not have public transit and his car has needed constant repairs.

Through the Healthy Opportunities Pilots, he was able to have his brakes repaired, which has allowed him to keep medical appointments and reconnect with his community, which is helping with his depression.

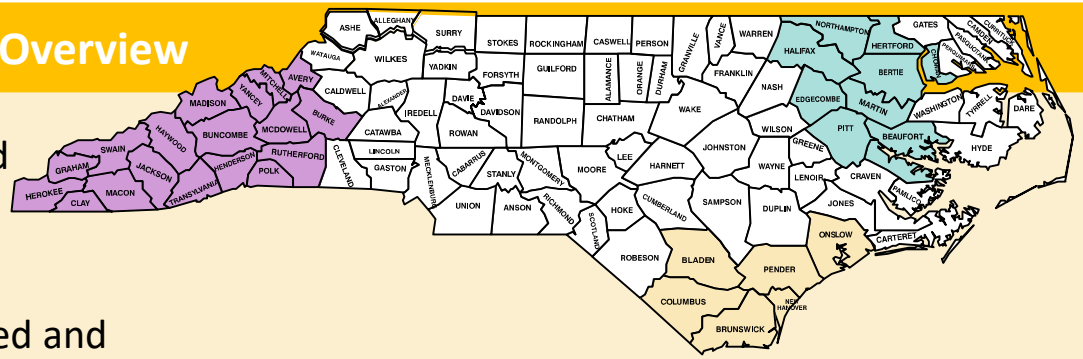
In addition to the car repair, he is also receiving a fruit and vegetable prescription and his wood-burning furnace is being repaired just in time for winter. When asked about how the Healthy Opportunities Pilots have impacted him, he shared that *"the Healthy Opportunities Pilots have literally changed my life."*

- Healthy Opportunities Pilots at Work | NCDHHS

Healthy Opportunities Pilots (NC HOP) Overview

Healthy Opportunities Pilot Overview

- **NC's 1115 Medicaid transformation waiver** authorizes **up to $650M** in state and federal Medicaid funding for the Healthy Opportunities Pilots
- **Pilot funds are used to:**
  - Pay for 29 **evidence-based, federally-approved, non-medical services** defined and priced in NC DHHS' Pilot fee schedule
  - **Build capacity of local community organizations** and **establish infrastructure** to bridge health and human service providers[1]
- **Pilot Vision and Goals:**
  - Integrate evidence-based, non-medical services into Medicaid to:
    - **Improve health outcomes** for Medicaid members
    - **Promote health equity** in the communities served by the Pilots
    - **Reduce costs** in North Carolina's Medicaid program
  - **Evaluate** which services are highest value & impact for which populations
    - CMS-approved SMART design (randomized trial) to provide rapid-cycle feedback, concluding in a summative evaluation
  - Create **accountable infrastructure**, **sustainable partnerships** and **payment vehicles** that support integrating highest value non-medical services into the Medicaid program sustainably **at scale**



Awarded Healthy Opportunities Network Leads

Access East, Inc.
Beaufort, Bertie, Chowan, Edgecombe, Halifax, Hertford, Martin, Northampton, Pitt

Community Care of the Lower Cape Fear
Bladen, Brunswick, Columbus, New Hanover, Onslow, Pender

Impact Health
Avery, Buncombe, Burke, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey

Priority Domains for All Healthy Opportunities Initiatives

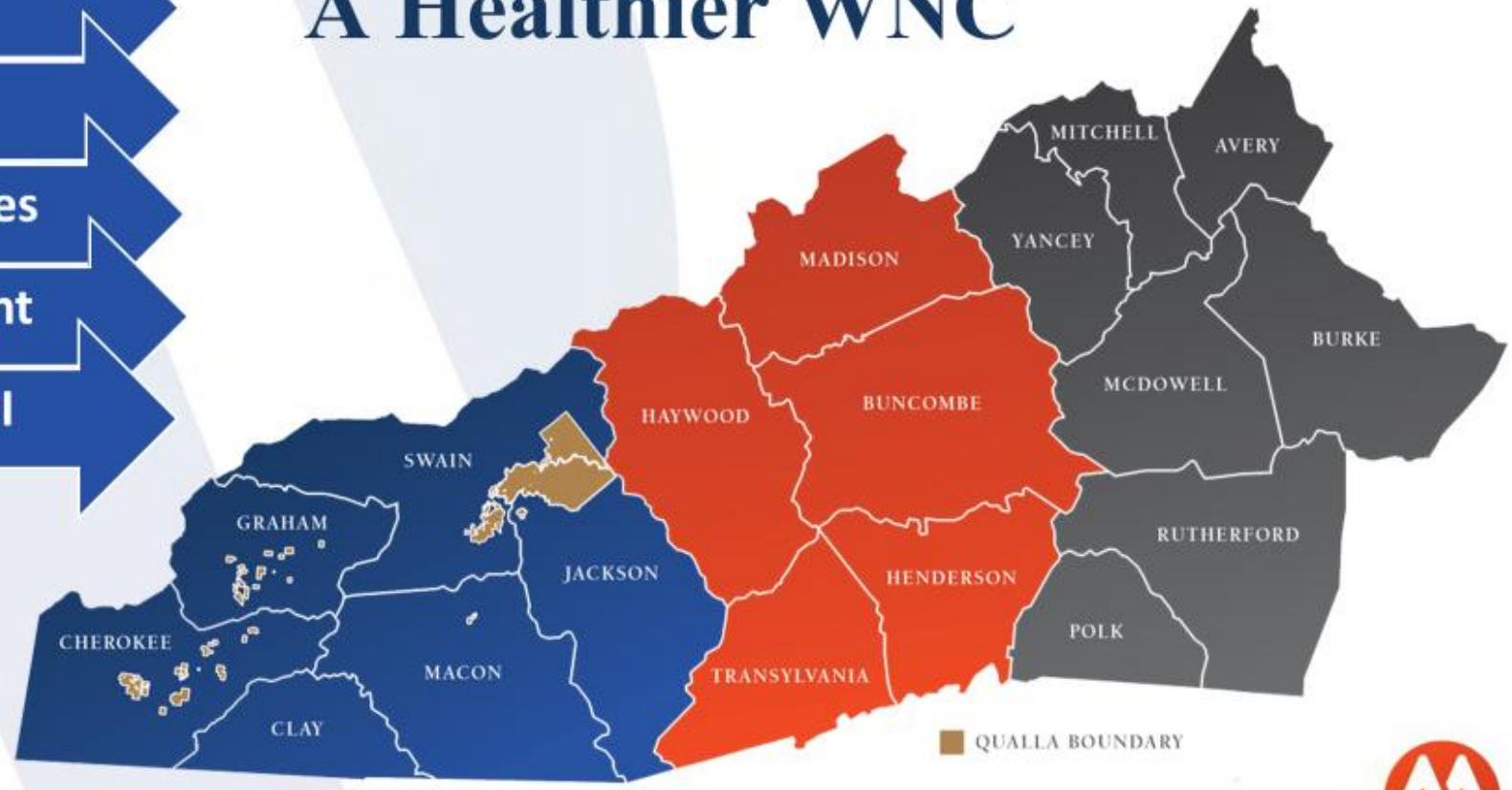
Housing | **Food** | **Transportation** | **Interpersonal Violence**

[1] Administrative, care management, and value-based payments are also being made to support and incentivize Pilot entities to perform optimally

Impact Health Network Lead

- Invest in Community Assets
- Improve Drivers of Health
- Strengthen Communities
- Optimize Investment
- Increase ROI

A Healthier WNC



EPISCOPAL HEALTH FOUNDATION

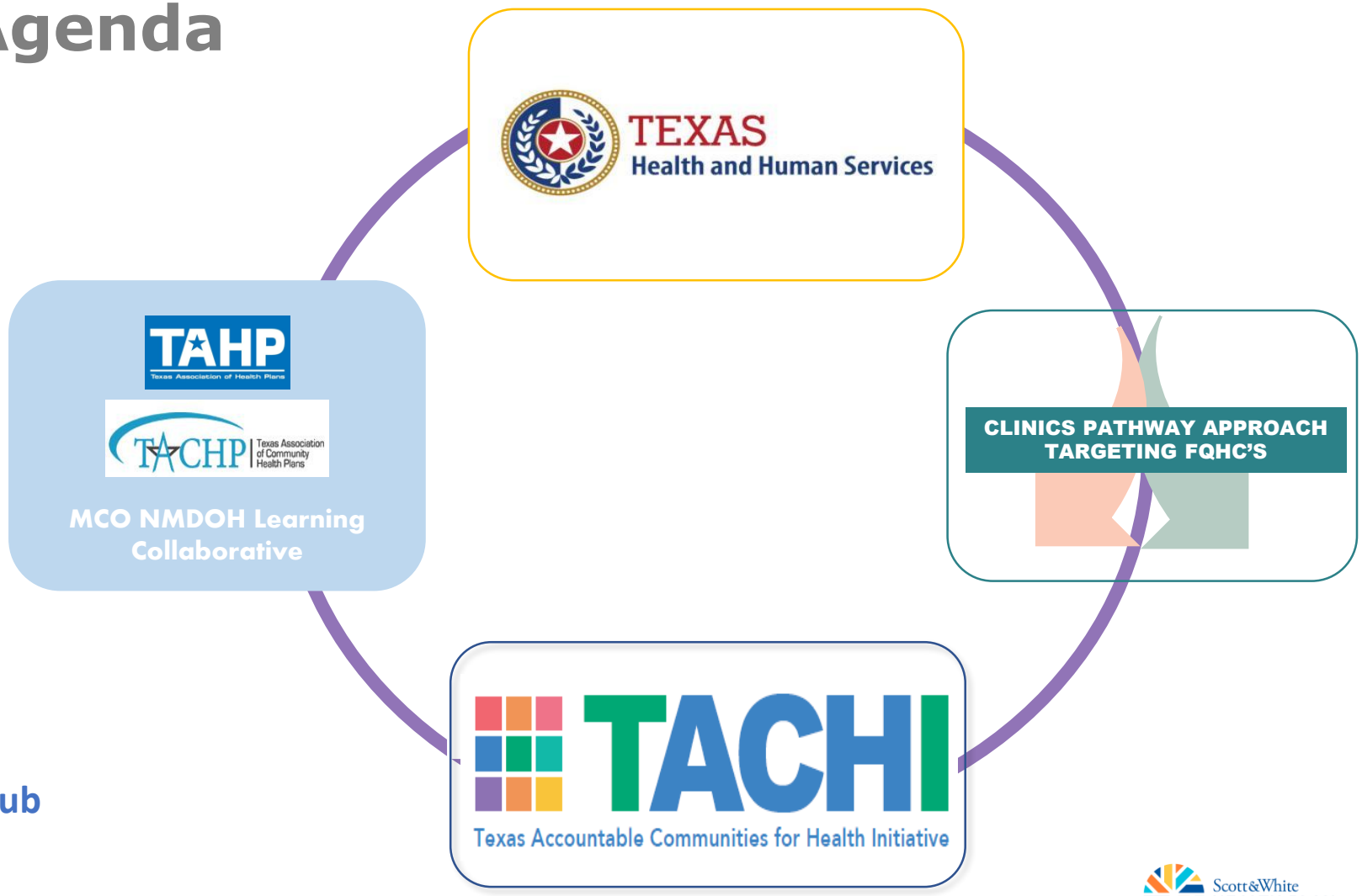
Overview of EHF's Non-Medical Drivers Of Health (NMDOH) Efforts in Texas

Funders Forum on Accountable Health Convening

August 31, 2023

Shao-Chee Sim, PhD,
Vice President for Research, Innovation and Evaluation

EHF's Comprehensive Approach to Support HHSC, MCOs, FQHCs, and Cross Sectoral Collaboratives in Advancing NMDOH Agenda



Pathway Community Hub

- Brazos County
- Bexar County
- Houston/harris county
- Williamson county

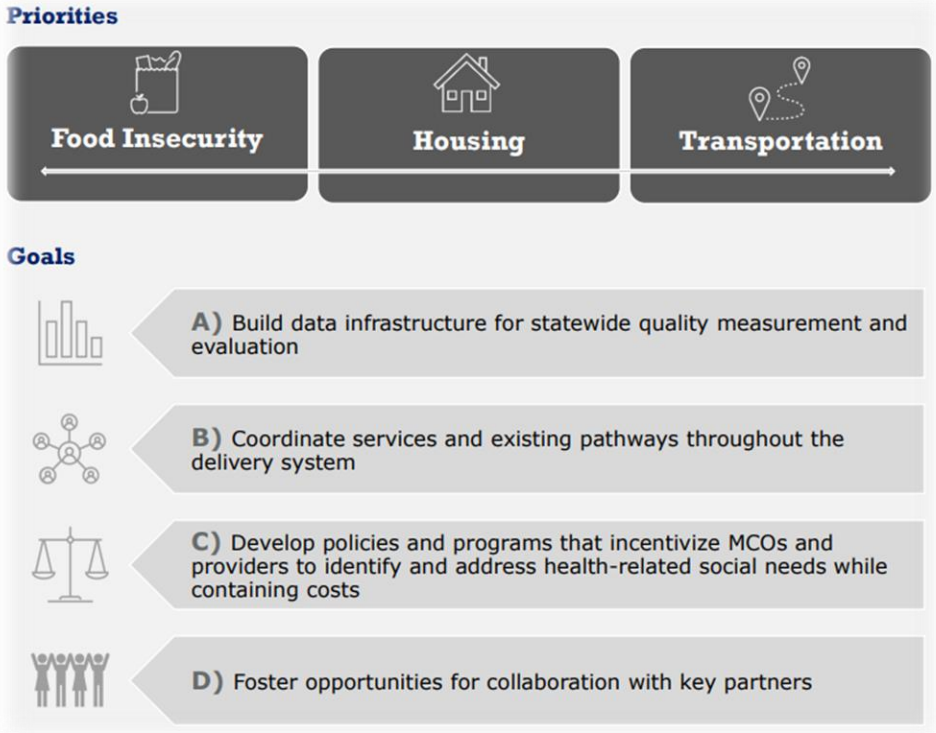
Evaluation of MCO NMDOH Interventions

Scott&White HEALTH PLAN
Driscoll HEALTH PLAN
COMMUNITY HEALTH CHOICE
superior healthplan
MOLINA HEALTHCARE
United Healthcare

Major State Policy Advancements

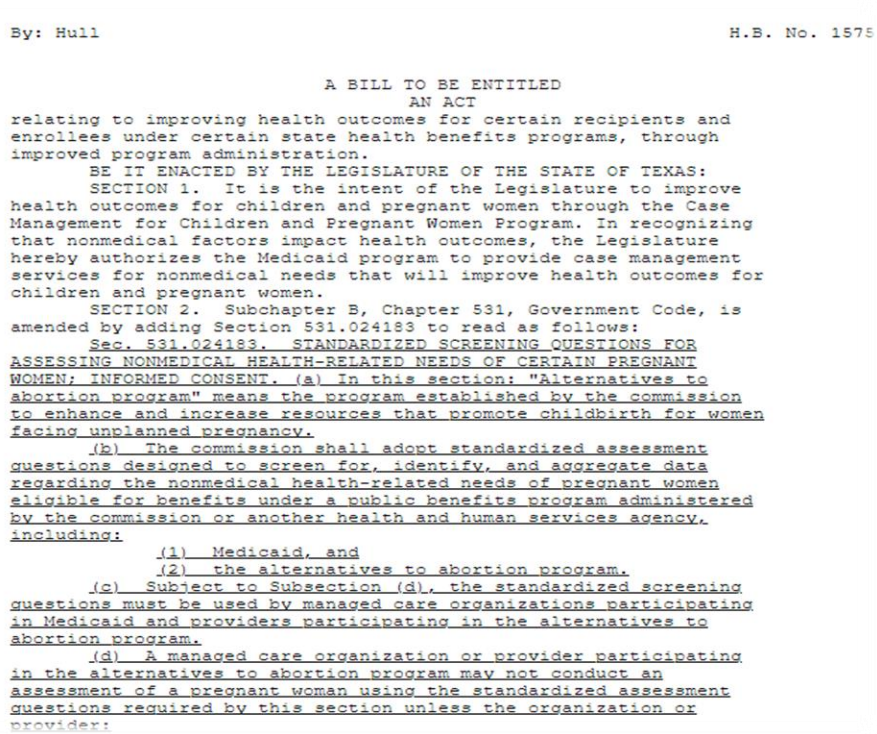
Texas Health & Human Services Medicaid & CHIP Services

Non-Medical Drivers of Health (NMDOH) Action Plan



88th Texas State Legislative Session

HB1575: Development of Standardized NMDOH Screening Questions & Inclusion of CHW & Doula as Medicaid Billable Provider under HHSC Children & Pregnant Women



By: Hull H.B. No. 1575

A BILL TO BE ENTITLED
AN ACT

relating to improving health outcomes for certain recipients and enrollees under certain state health benefits programs, through improved program administration.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. It is the intent of the Legislature to improve health outcomes for children and pregnant women through the Case Management for Children and Pregnant Women Program. In recognizing that nonmedical factors impact health outcomes, the Legislature hereby authorizes the Medicaid program to provide case management services for nonmedical needs that will improve health outcomes for children and pregnant women.

SECTION 2. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.024183 to read as follows:

Sec. 531.024183. STANDARDIZED SCREENING QUESTIONS FOR ASSESSING NONMEDICAL HEALTH-RELATED NEEDS OF CERTAIN PREGNANT WOMEN; INFORMED CONSENT. (a) In this section: "Alternatives to abortion program" means the program established by the commission to enhance and increase resources that promote childbirth for women facing unplanned pregnancy.

(b) The commission shall adopt standardized assessment questions designed to screen for, identify, and aggregate data regarding the nonmedical health-related needs of pregnant women eligible for benefits under a public benefits program administered by the commission or another health and human services agency, including:

(1) Medicaid, and

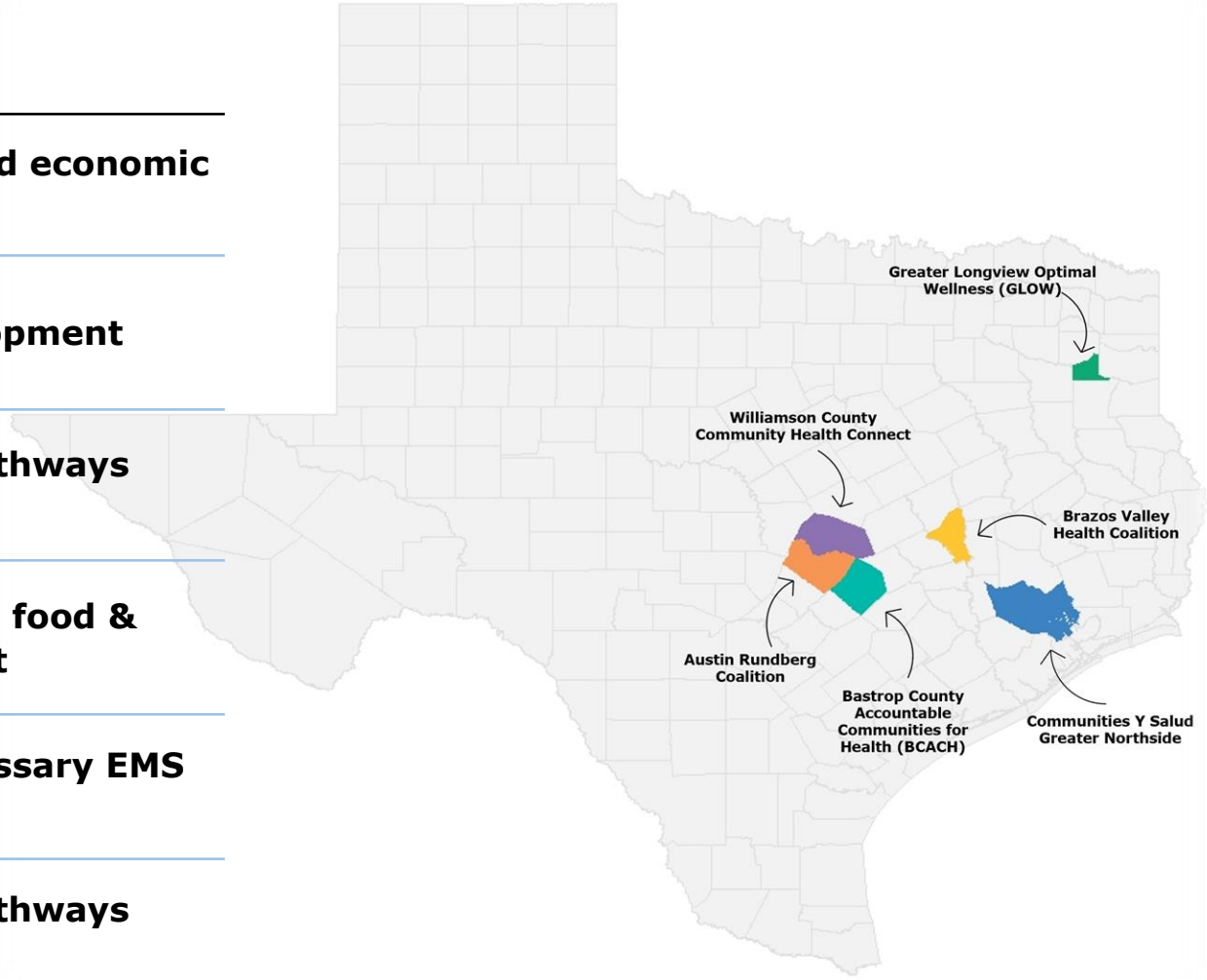
(2) the alternatives to abortion program.

(c) Subject to Subsection (d), the standardized screening questions must be used by managed care organizations participating in Medicaid and providers participating in the alternatives to abortion program.

(d) A managed care organization or provider participating in the alternatives to abortion program may not conduct an assessment of a pregnant woman using the standardized assessment questions required by this section unless the organization or provider:

Six TACHI Sites

Site	Primary SDOH Focus
Austin/Rundberg Backbone: GAVA	Neighborhood and economic stability
Bastrop County Backbone: Bastrop County Cares	Workforce development
Brazos Valley Backbone: Texas A&M Health	Establishing a Pathways Community Hub
Greater Northside Backbone: Avenue CDC	Access to healthy food & built environment
Gregg County Backbone: City of Longview	Reducing unnecessary EMS & ED utilization
Williamson County Backbone: United Way of Austin	Establishing a Pathways Community Hub



Greater Longview Optimal Wellness (GLOW) Program

Gregg County

City of Longview

- Longview Fire Department/EMS
- Police OutReach Team (P.O.S.T. Officer)
- Housing/Homeless Services

Greater Longview United Way

Community Healthcore

CHRISTUS Good Shepherd

Longview Regional Medical Center

Special Health Resources

Wellness Pointe

GLOW

GREATER LONGVIEW OPTIMAL WELLNESS

Greater Longview Optimal Wellness (GLOW) Program

-Implemented in 2021 to reduce the number of 911 calls for an over-utilizing cohort of individuals in Longview, Texas

-Current number of participants enrolled in longitudinal study: **69**

-Avg. annual number of 911 calls *prior* to joining GLOW: **12**

-Avg. time spent in GLOW: **8 months**

-Avg. age of participants: **55**

-Racial breakdown of participants:
- -Caucasian: 51%
- -African-American: 44%
- -Hispanic: 5%

GLOW

GREATER LONGVIEW OPTIMAL WELLNESS

Social Determinants of Health (SDOH)

-Poverty Status

- **-911 calls for GLOW patients tend to occur in geographic areas where poverty is more concentrated in Longview** (areas where at least 25% of the population live below the poverty threshold, per 2020 American Community Survey)

-Education

- **-911 calls for GLOW patients also tend to occur in geographic areas where postsecondary educational attainment is lower** (areas where less than 25% have an associate's degree or higher, per 2020 American Community Survey)

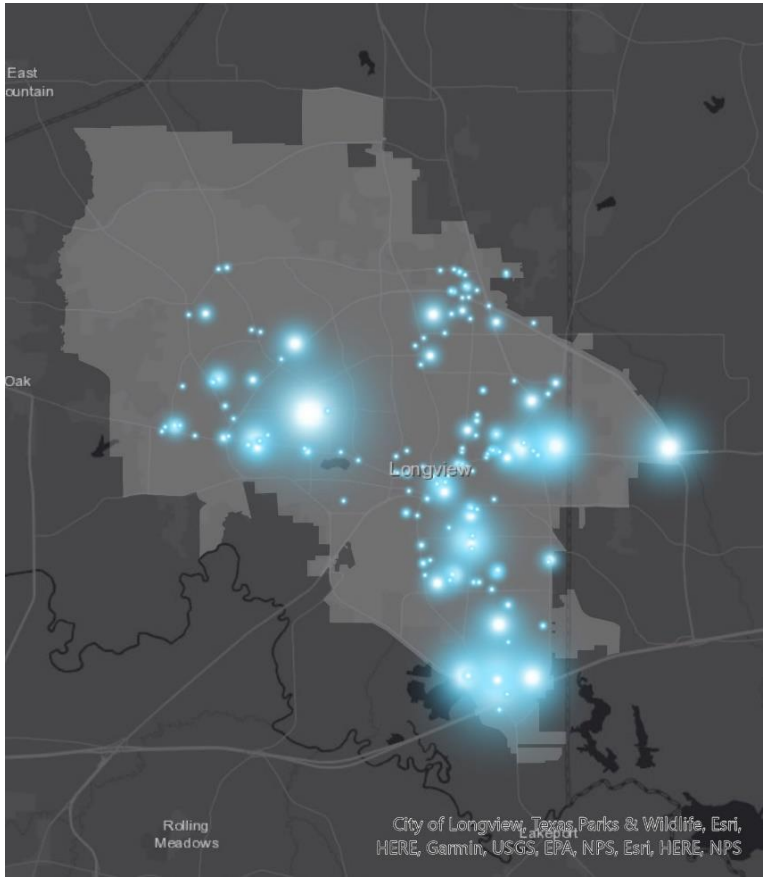
-Mental Health

- **-Psychiatric issues is the number one Initial EMS complaint for GLOW Patients (nearly 16% of all 911 trips)**

-Housing

- **-Nearly 30% of GLOW patients have experienced homelessness at some point in the last two years**

-More research to be conducted in this area by UT Tyler study



GREATER LONGVIEW OPTIMAL WELLNESS

Early Program Outcomes

-The avg. number of annual 911 calls has reduced approximately **50%-55%** per patient since joining GLOW.

-The percentage of EMS trips classified as *non-transport trips* has also reduced from **19% to 4%** per patient since joining GLOW.

GREATER LONGVIEW OPTIMAL WELLNESS

Rhode Island

Funders Forum on Accountable Health

Rhode Island Department of Health

Health Equity Zone Framework

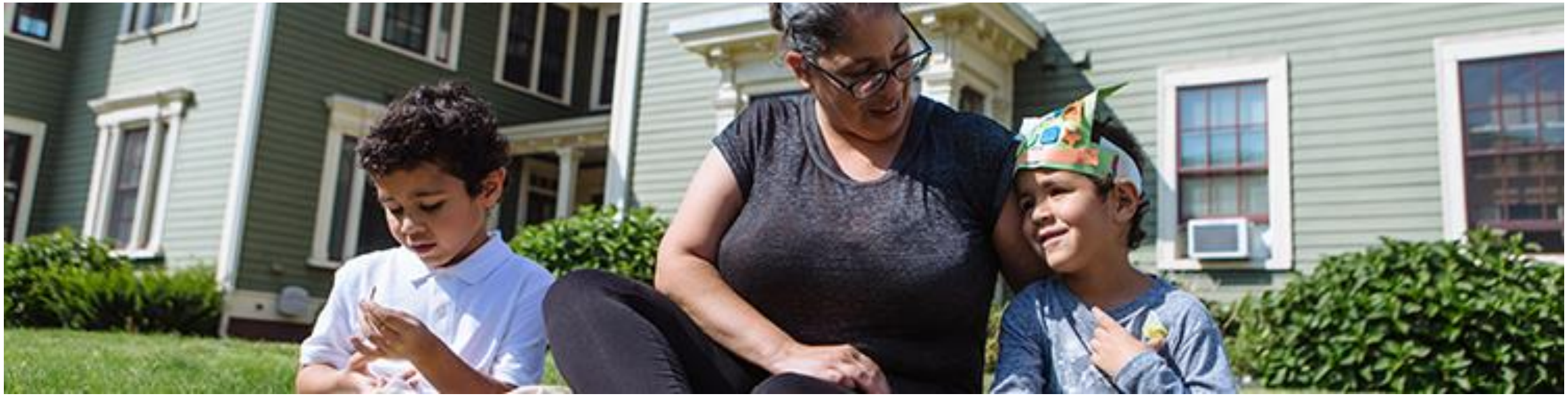
Confirm Geographic Location

Build a Collaborative

Assess Community Needs and Assets

Prioritize Needs

Develop an Action Plan



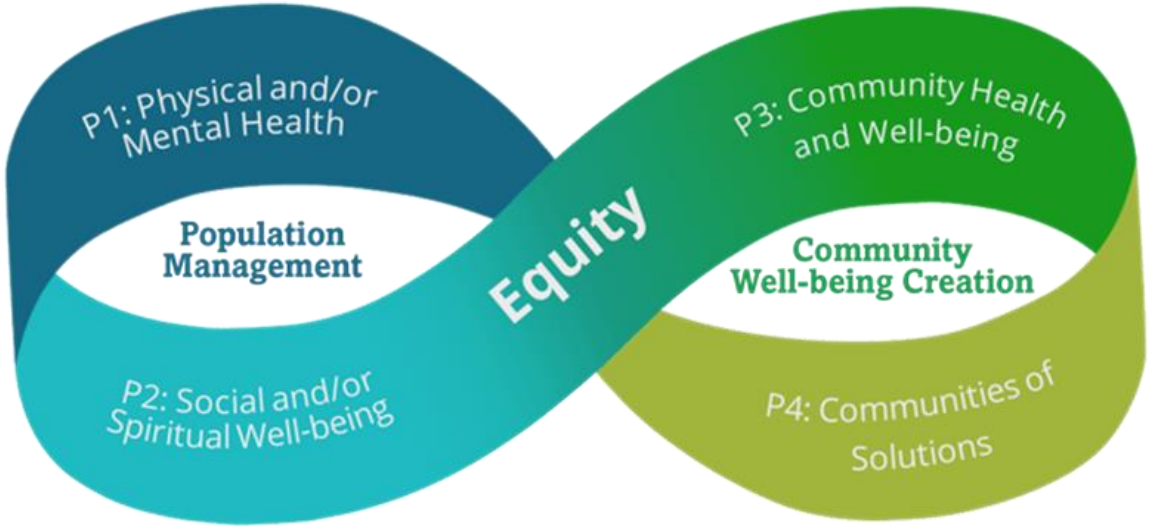
HEZ Continuum

	Pre HEZ	Startup	Developing	Established
Community Collaboration	*Project specific, ad hoc, time limited, low trust, competitive, low resident engagement, some existing relationships*	*Resolving past conflicts, alignment, development of partnerships, building trust, resident engagement, staffing up*	*Increased diversity, more resident representation, more trust, establishing shared values, developing & standardizing practices, power sharing*	*Diverse, resident led, representative, formal governance, working groups, steering committees, increased capacity for systems change, fidelity*
Assessment of Community Needs and Assets	*Driven by funding/funder, project specific, ad hoc, extractive, static, siloed, needs identified with limited to no community engagement*	*Creating space for residents, baseline assessment-needs & assets, responsive to community and funders, mid-downstream*	*Driven by and responsive to the community, longitudinal, upstream, ongoing community check ins to share data, compensating community*	*Owned and led by the community, upstream, complex, longitudinal, comprehensive, dynamic feedback accountable to community, culturally competent, capacity focused*
Prioritization of Needs with Residents	*Atypical, in-kind, project & population specific, extractive, requires incentives, transactional, siloed, low community involvement, services without solutions-reactive*	*Restorative justice, unexpected, low empowerment, requires incentives, low trust, increased resident involvement, assets AND challenges, focused on equity*	*Deliberate, intentional, moves at the speed of trust, for the community, able to build on prior work, implementation and leadership roles for community,*	*Owned by the community, expected, genuine empowerment, responsive, continuous & agile reprioritization, oriented to systems level change(policies/advocacy), proactive*
Development of an Action Plan	*Driven by funding/funder, project specific, ad hoc, top down, siloed, reactive, lack of outreach, low community involvement, reactive*	*Initial plan development, responsive to funder, programmatic, downstream, alignment of existing priorities, building trust, forum for engagement*	*Responsive to community, attracting diverse & aligned funding, development of new priorities/programming, revised plan, includes racial equity priorities*	*Owned by community, generating new funding, infrastructure resources, upstream strategies, agnostic to priority or funder, accountable to community, proactive*
Implementation and Evaluation	*Driven by funding/funder, project specific, ad hoc, compliance based, counting widgets, reactive*	*Responsive to funder, program and project oriented, low trust, low value, dev. baselines, down-midstream, establishing methods*	*Community informed, fragmented, adequately funded, sustainability focused, resident designed, data equity*	*Community owned, empowerment eval., community led perf. management, CQI, upstream-leading/lagging, evaluation driving strategy*

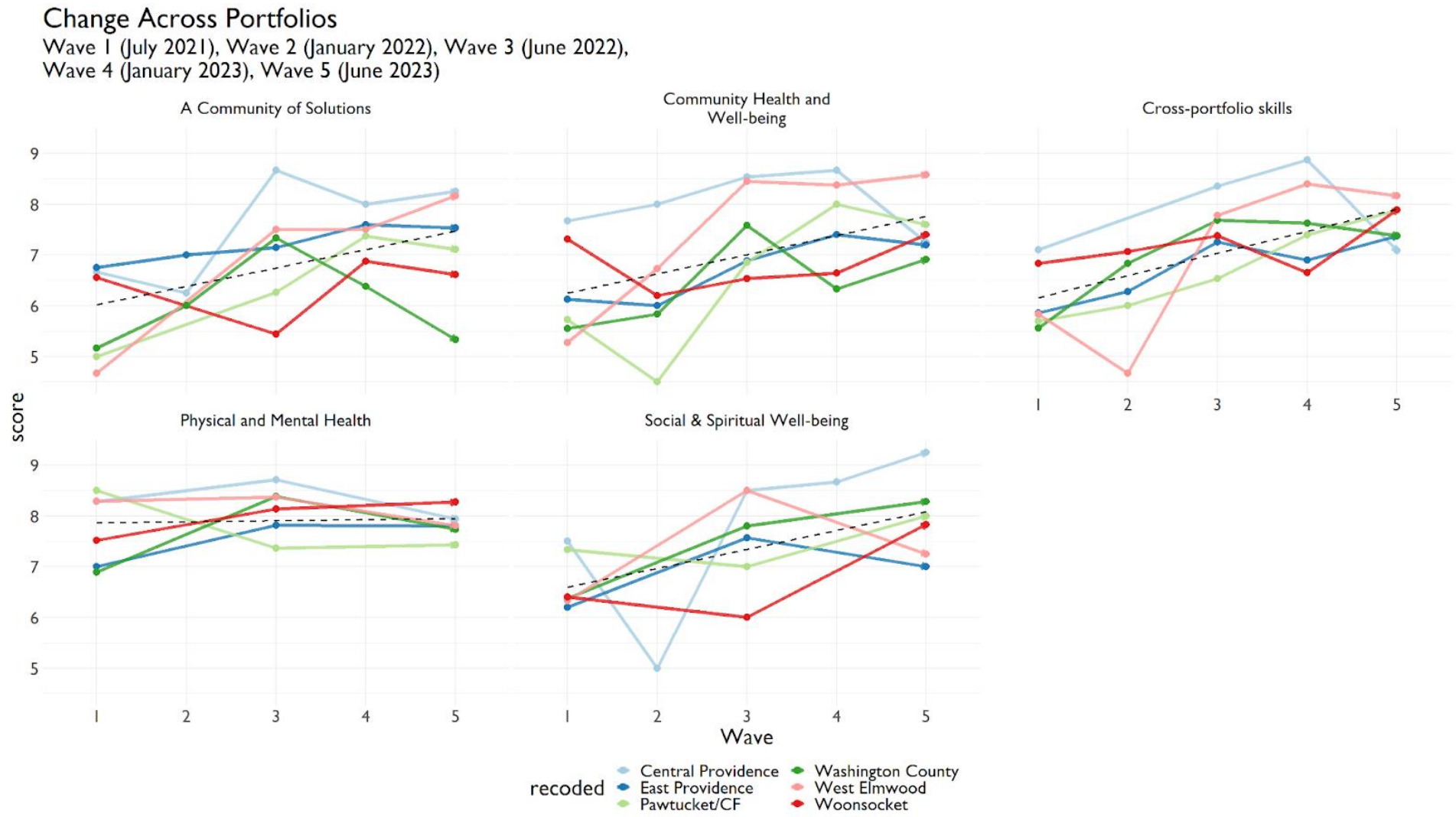
Transactional → ***Growth of Community Infrastructure and Capacity*** → ***Transformational***

Medicaid Investment in HEZ-HSTP

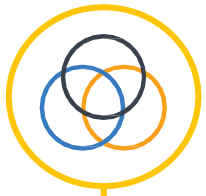
"The Executive office of Health and Human Services (EOHHS) and Rhode Island Department of Health anticipate this work will enable Accountable Entities (AEs) to greatly enhance their capacity to address attributed patients' health related social needs, **by strengthening connections with local social service resources, and increase AE's engagement in place-based efforts to Improve upstream conditions**. **This improved capacity is expected to enhance AEs' ability to improve their patient's health outcomes** and as a result, reduce their health costs and increase AEs' shared savings."



Medicaid Investment in HEZ-HSTP



Medicaid Investment in HEZ – 1115 Waiver



Health Equity Zones (HEZ)

Drives funding to the existing HEZs via managed care strategies and seeks to use the waiver to evaluate the healthcare benefits of HEZ investments to support future federal support for HEZ expenditures.

Via 1115 Waiver Authority

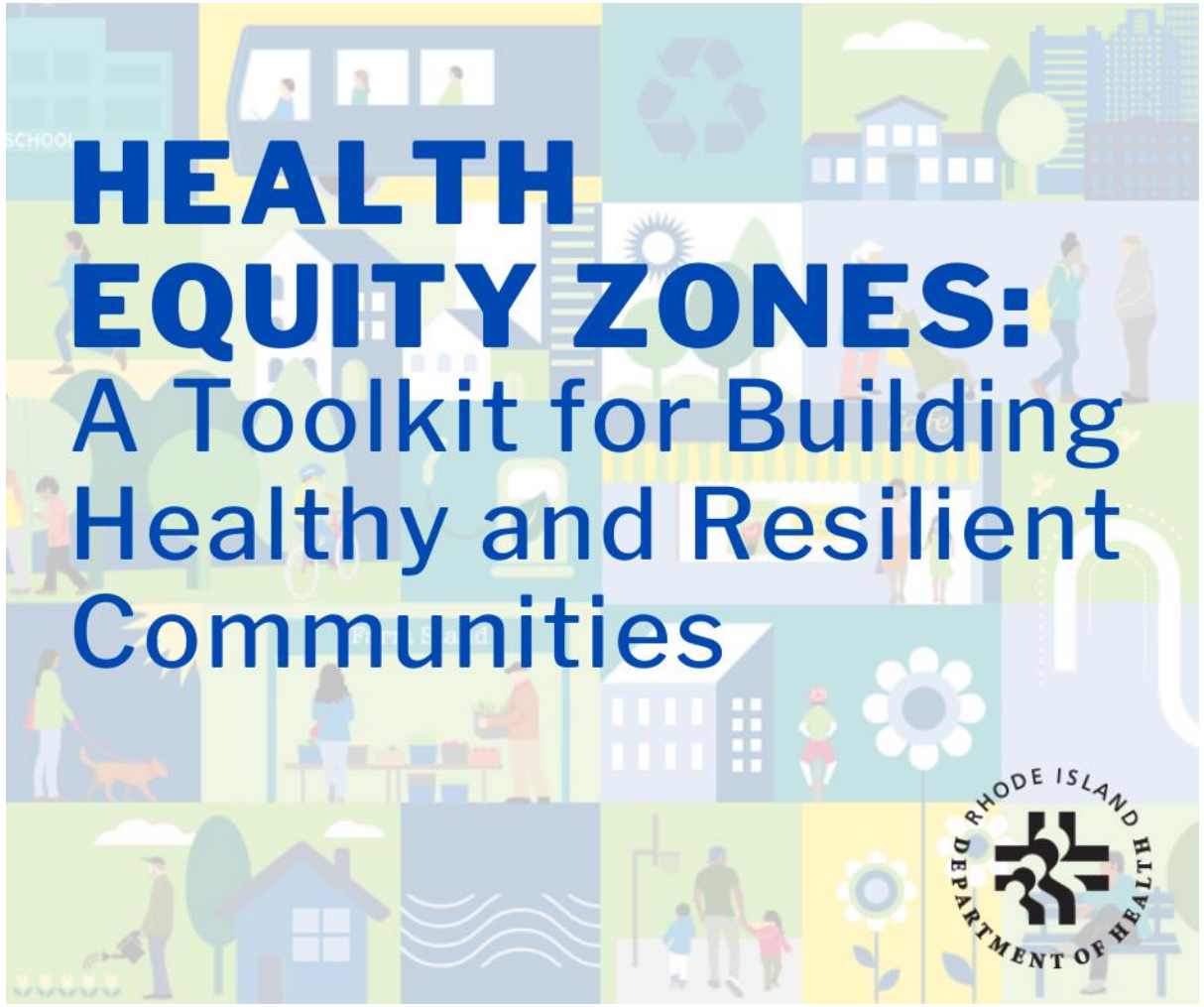
- no specific request for federal funding is being made in this waiver extension
- leverage evaluation component of the waiver to measure the impacts and health outcomes of Medicaid beneficiaries
- signal potential managed care approaches that sustain HEZ model (investment versus reimbursement)
- when waiver approved, the only impact on HEZ is related to the evaluation

via potential contract requirements for MCOs (when reprocured)

• **Community Reinvestment** - consider requiring MCOs to reinvest a portion of their revenues back into the communities being served by supporting HEZ funding. These funds would be limited to a portion of MCO profits.

• **Activities that Support Healthcare Quality**. MCOs are permitted to include non-benefit services in the medical loss ratio (MLR) that are not provided through direct claims. These non-benefit services must meet the definition of an activity that supports healthcare quality. Rhode Island will contemplate whether to structure this arrangement as a request to invest in HEZs or as a requirement.

• **MCO Contracts and Quality Initiatives.** determine whether to pursue an arrangement in which MCOs are required to contract with HEZs. This contracting relationship could be supplemented with quality requirements such as pay-for performance or other value-based purchasing



HEZ Toolkit

health.ri.gov/publications/toolkits/health-equity-zones.pdf

Pamela Orton, NJ Department of Human Services, Office of Medicaid Innovation, Program Lead for the Regional Health Hubs

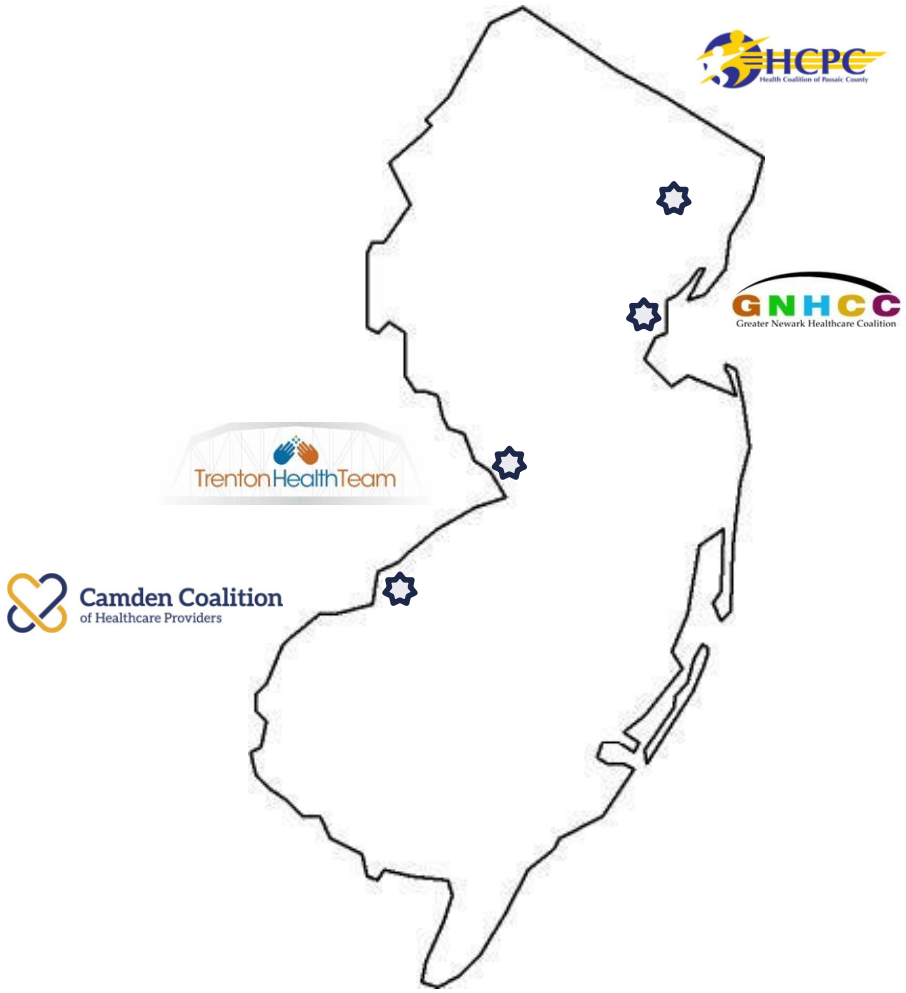
Julia Taylor, Trenton Health Team, Chief Strategy Officer

Victor Murray, Senior Director, Community Engagement and Capacity Building

Regional Health Hubs bring together multiple sectors to address state priorities and other pressing health concerns.

Functions of a Regional Health Hub:

- Convene stakeholders in healthcare and beyond around state Medicaid priorities.
- Operate and use a Health Information Exchange (HIE).
- Serve NJ Medicaid and other state departments as a local expert, strategic planning partner and program implementer.
- Innovate on population and clinical health interventions in response to local needs.



Supporting CBO Infrastructure in Trenton, NJ

TrentonHealthTeam

- Community Advisory Board (CAB) - Quarterly meetings of 100 organizations from around the region and across sectors
- CAB subcommittees - Regular meetings of stakeholders who determine priorities and take action on focus areas like food security, housing security, and maternal and child health
- Data and analytics to support CAB participants and other partners in making data-driven decisions:
  - Community Health Needs Assessment
  - Free Food Finder, Food Insecurity Index
  - OB Risk Alert, Baby Item Finder
  - Housing Services List, Affordable Housing Database
  - Profile of Medicaid members - demographics, housing, finances

CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE

CACHI

...The Next Generation of Health System Transformation

The California Accountable Communities for Health Initiative: Funders' Forum Webinar on HRSN

Barbara Masters, Director, CACHI

August 31, 2023

1

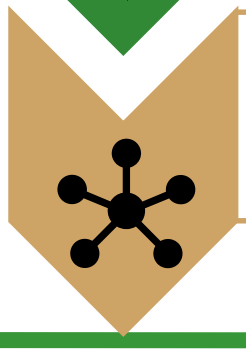
California Health and Human Services Agency: Established a range of initiatives across different departments to address Health Related Social Needs

- Cal AIM: Enhanced Care Management, Community Supports
- Children & Youth Behavioral Health Initiative
- Adverse Childhood Experiences
- Violence Prevention

2 CACHI is a Public-Private Partnership designed to Support the development and implementation of Accountable Communities for Health

- ACHs are places where communities come together for collective problem-solving because no single entity can address today's complex health problems alone

- CACHI is supporting the development and implementation of 37 Accountable Communities for Health in 27 (of 58) counties in California



- ACHs are well suited to facilitate the implementation of state initiatives that are seeking to connect the health care systems with community-based health related social needs

CACHI

3

An Accountable Community for Health (ACH)

A “table” where people and organizations across different sectors build trust and relationship with each other to advance equity

ACHs:

- Set a common vision among institutional players and the community
- Facilitate conversations that are” not naturally occurring”, which lead to innovative solutions to problems
- Bring residents/patients to the decision-making table, thereby addressing power dynamics between system professionals and the people they serve
- Facilitate linkages across organizations and sectors

4 ACHs Engage a Range of CBOs in a Variety of Roles

TYPES of CBOs Participating in ACHs:

- Housing, Community and Economic Development CBOs
- Health Care Clinics and Hospitals
- Direct Services Agency
- Community organizing
- Community Collaborative operating under a fiscal nonprofit

ROLES of CBOs in an ACH:

- Backbone Agency for ACH
- Partner Agency/ Leadership Team member
- Implementing Agency of a Program/Intervention

5

Conclusion and Recommendation

- Enabling Medicaid and other health care programs to pay for health-related needs is a critical step, but it is insufficient to enable a *robust network* of services and programs to meet the full range of needs of Medicaid and other low-income populations.
- States must also invest in the *capacity-building and infrastructure* for developing and sustaining cross-sector partnerships.
- ACHs are *designed for facilitating* such collaborations and elevating community voice to ensure community priorities and equity are centered.

CACHI

SAN DIEGO ACCOUNTABLE COMMUNITY FOR HEALTH

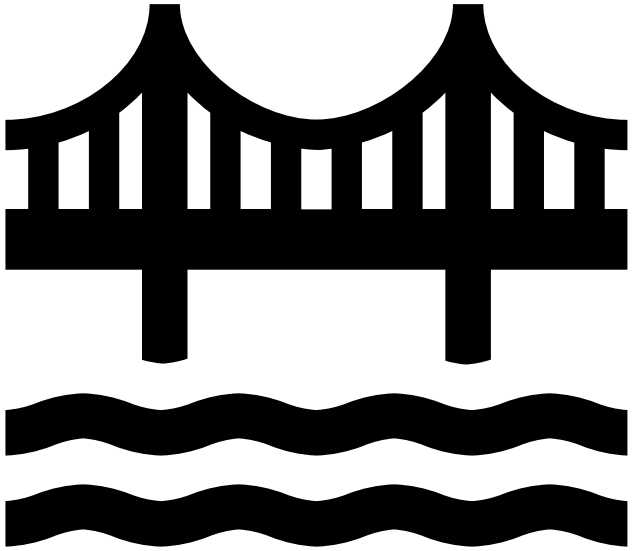
States Making the Case for Innovations in Health and Social Services: What We Are Learning

Kitty Bailey, CEO, San Diego Wellness Collaborative

8/31/23

An initiative of the SDWC San Diego Wellness Collaborative

Supporting CBO infrastructure and capacity for CalAIM



Elevate community voice
Facilitate multi-sector meetings for sharing information, addressing challenges, and developing new approaches with a focus on the needs of the community and CBOs

Facilitate action
Provide Technical Assistance and Subject Matter Expertise to CBOs around CalAIM

Support CBOs and the new workforces in getting involved in CalAIM through informal and formal trainings and learning communities

Build sustainability
Act as an intermediary between CBOs and Medi-MCOs for the new Medi-Cal contracts to ensure new billable revenue sources are available to CBOs

Steward systems change
Create space for a systems-level conversation around CalAIM and the new Medi-Cal benefits and how they can be used to advance equity

Influence policy
Aggregate recommendations for future policy changes and share with state agencies and health plans

SAN DIEGO ACCOUNTABLE COMMUNITY FOR HEALTH