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Networks for Health

Member Roundtable Series: Political Determinants of Health

November 29, 2023

HOUSEKEEPING REMINDERS

- This is a Zoom meeting
- Please mute yourself when you are not actively speaking.
- Please use the raise hand function to chime in with questions or comments and/or use the chat to share.
- Please share video if you are able.
- For questions following the meeting, reach out to contact@civitasforhealth.org

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Agenda

- Welcome & Civitas Updates – Jolie Ritzo
- Presentation: Medicaid pathways and partnerships and how Civitas members can provide value-added services featuring Health Impact Ohio and West Virginia Health Information Network along with Civitas Team members – Alan Katz, Kate Ricker, Jenelle Hoseus, and Sonia Chambers
- Discussion – All encouraged to chime in!

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Upcoming Civitas Events

- Last quarter of 2023 **Public Policy Briefing** with Troutman Pepper Strategies and Alston & Bird on Monday, December 4 from 4-5 pm ET.

- **Collaboratives in Action** – December 5 and 12, both days 3-4 pm ET! This two-part event will feature our Gravity Project partnership and both the pilots and co-design workstreams. Please share these events with your members and partners as they are open to the public.

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PDOH Definition

The Political determinants of health involve the systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities. - Daniel E. Dawes (2020), The Political Determinants of Health, Johns Hopkins University Press

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Takeaways from Session 1 – Building Bipartisan Support

- To influence policy, coalition building is critical.
- Convene partners to build relationships and to educate on both baseline information and more complex topics. Let this be a catalyst for future discussion.
- Be sure that partners know what legislative opportunities exist and provide summaries of what is and isn't happening.
- As you offer educational opportunities, be sure to measure increased understanding overtime.
- Building shared understanding increases the opportunity for greater influence.
- Think of the coalition, key partners, and legislators as an advocacy ecosystem.
- Remember to listen.
- Timely response is essential.
- And, always be mindful of your political environment and when to use political capital.

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Takeaways from Session 2 – Tribal Health and Interoperability

- Data standards and producing accurate data are critically important to tribal health.
- Privacy and security are even more important when building trust.
- Trust cannot be overlooked with tribal populations and in working with tribal leaders; leaders need to know what you are doing with the data and that they still own the data.
- Having data at the point of care also helps with building trust.
- Work with tribes on specific use cases.
- In working with state representatives on tribal health, educate them about the populations they serve.
- Bring people together to problem solve, use real-life data to help people understand, and once there is shared understanding solutions will emerge.

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Brief Medicaid Overview

- Total Annual Medicaid Spending: **$804.1 billion** in FY 2022
- **54.9%** ($441.1 billion) on managed care (MCOs and PCCMs)i
- **20.5%** ($164.4 billion) on fee-for-service acute care
- **19.2%** ($154.4 billion) on fee-for-service long-term care
- **3.3%** ($26.3 billion) on payments to Medicare
- **2.2%** ($17.9 billion) on disproportionate share hospital (DSH) payments

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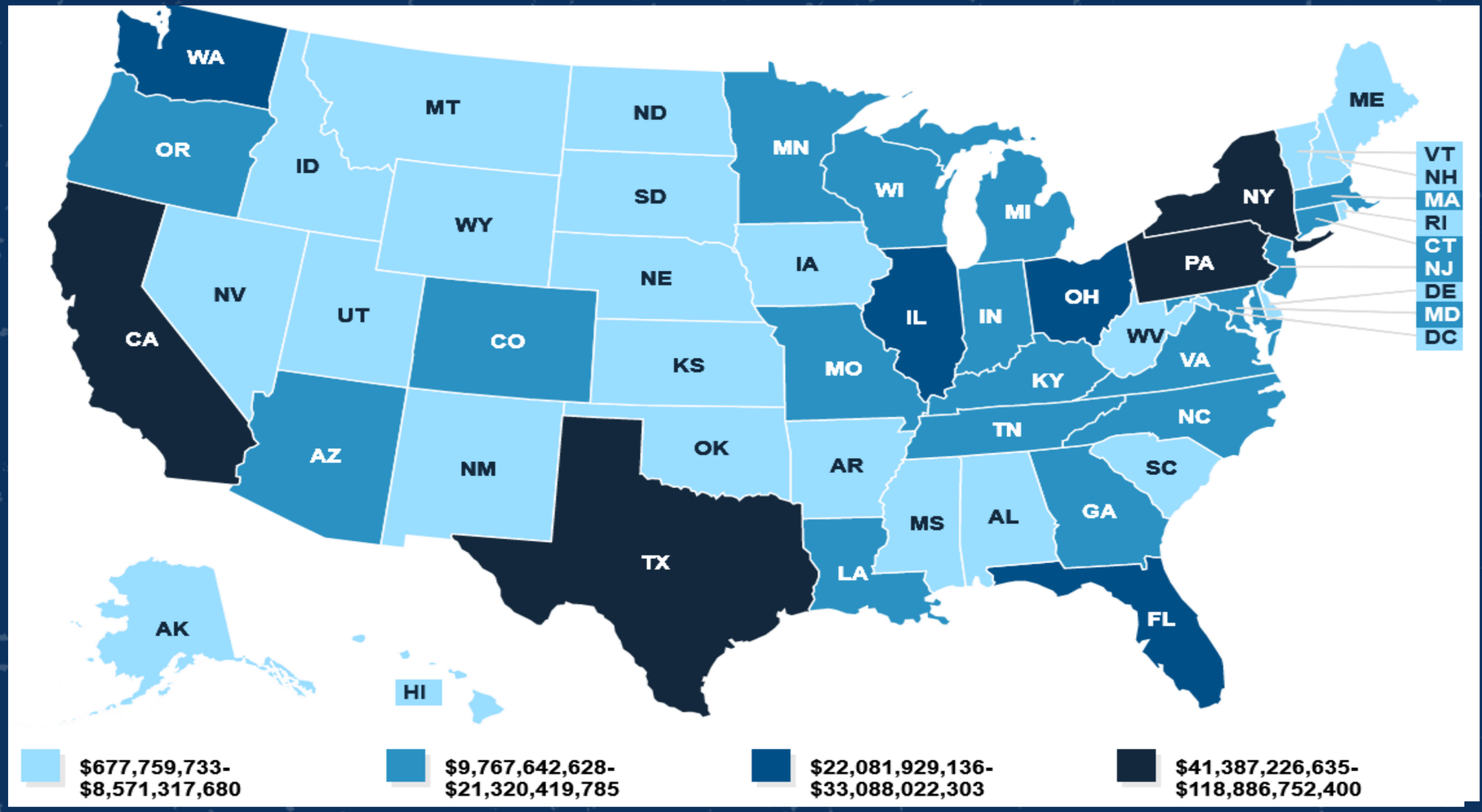
Medicaid Overview



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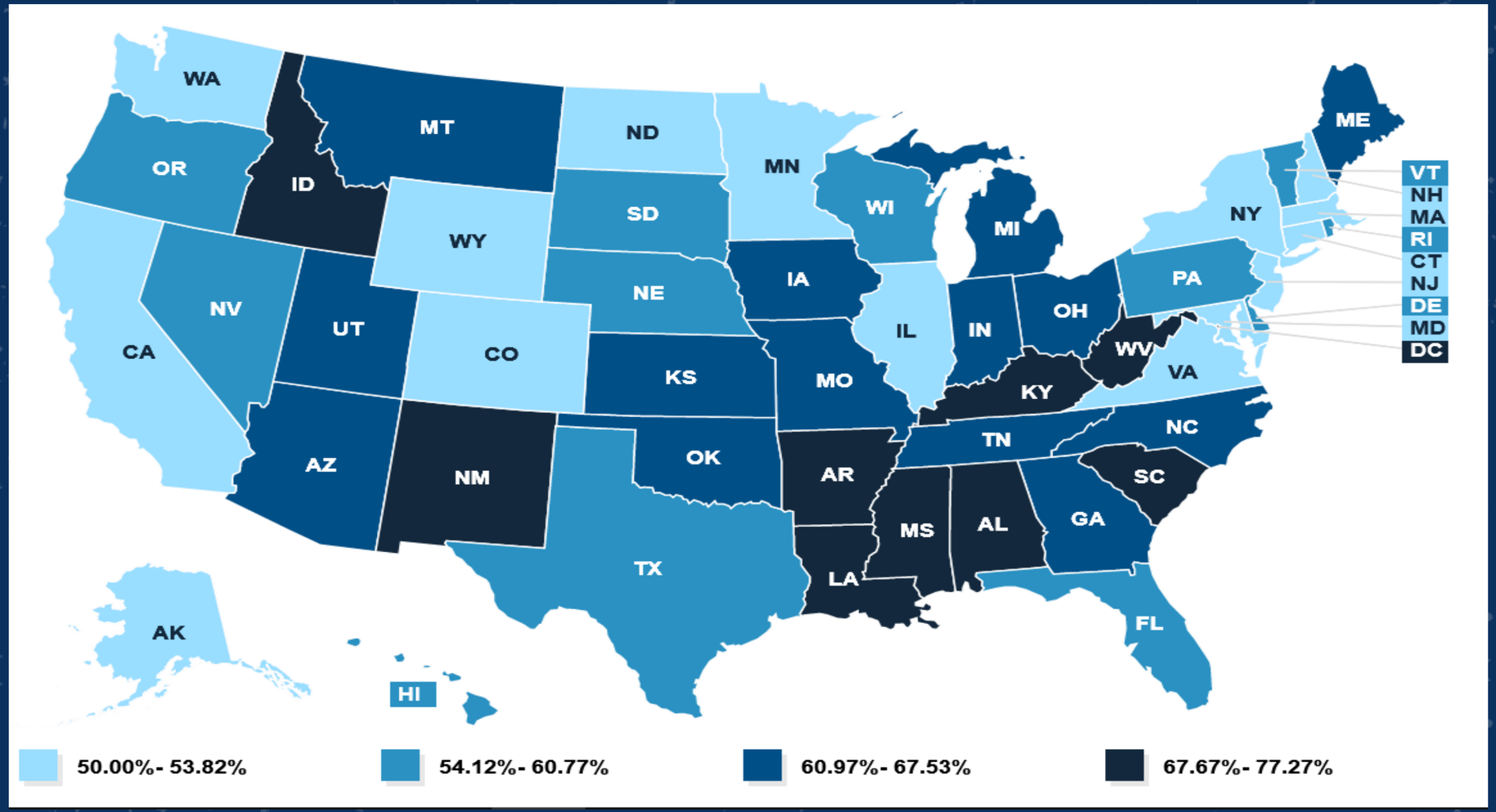
Medicaid Overview



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“Post-HITECH” Medicaid FFP & Utilization

- “Post-HITECH” division of formulas between 90/10 for planning, design, development, and implementation, and 75/25 for operational services, with no standing beneficiary cost-allocation carve-out
- Civitas-UCSF-ONC National Survey: 61% of HIEs surveyed nationwide receive ongoing Medicaid MES/MMIS formula allocations, and 67% either have a formal quality reporting partnership with their State Medicaid Agency or are in the process of finalizing one
- The median percentage of total revenue reported from MMIS/MES funds was 40%
- These figures do not include other MCO contracts or reimbursement utilized by both HIE and RHIC members

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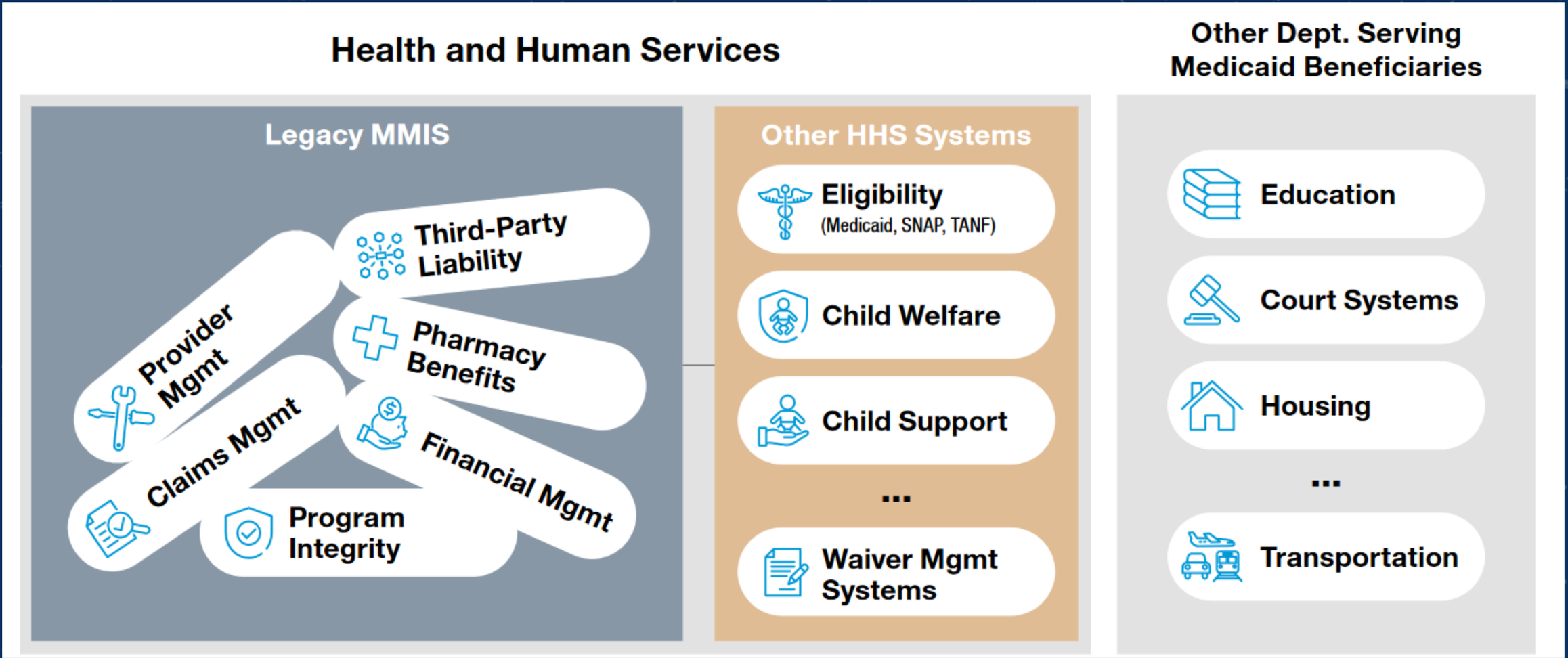
MMIS to MES Transition



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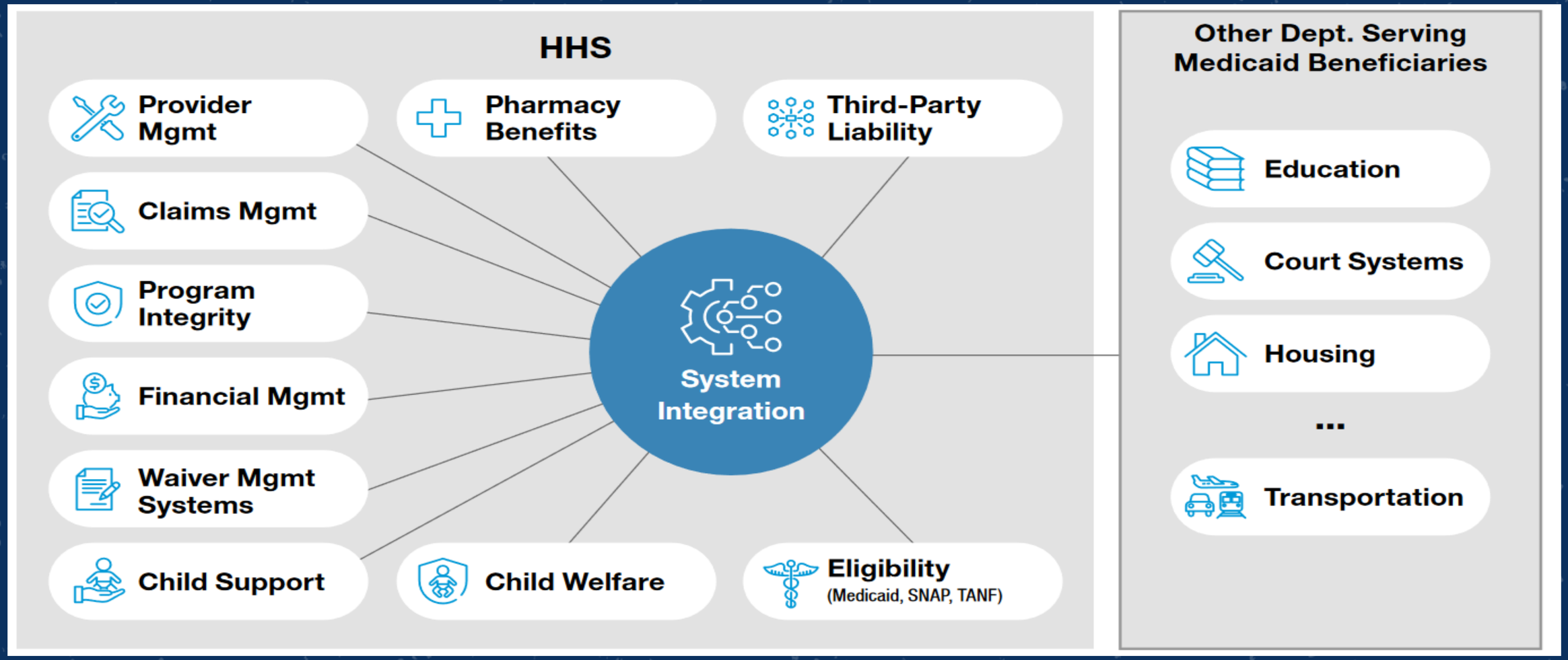
MMIS to MES Transition



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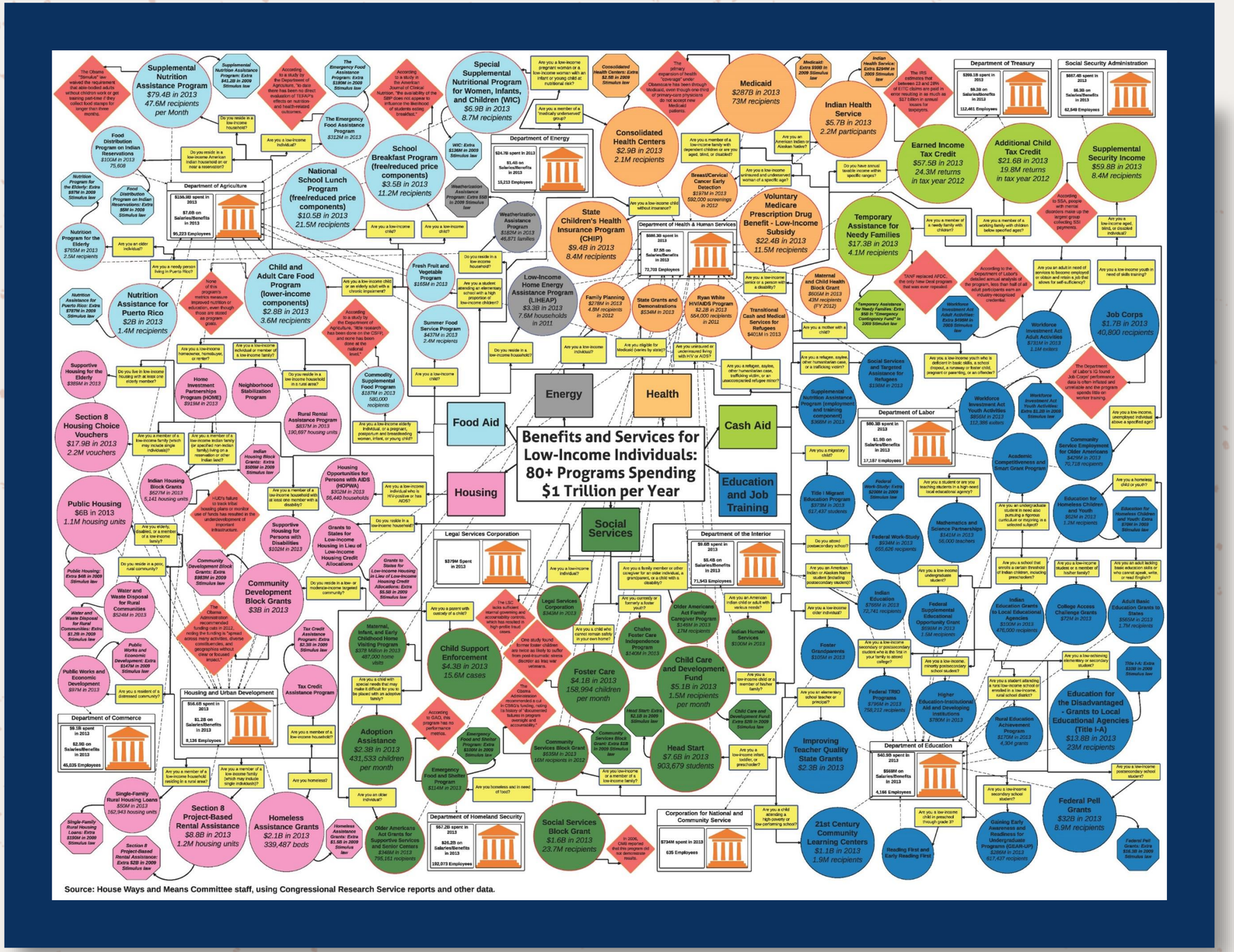
Programs

BENEFITS and SERVICES for LOW-INCOME INDIVIDUALS

80+ programs

Public health programs are not included



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Source: House Ways and Means Committee staff, using Congressional Research Service reports and other data. Accessed from https://aligningforhealth.org/wp-content/uploads/2022/09/Slides-Coordinating-Funding-and-Data-to-Address-SDOH-FINAL.pdf

Alignment

- Align priorities across programs' data, interoperability, and technical infrastructures needs
- Mitigate risk of potential for parallel funding, decentralized IT infrastructure, and duplicative investments for different populations
- Stack the funding specific to programs with targeted populations and use authorities to develop a foundational, reusable infrastructure available for communities and service providers

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Braiding and Blending Funding

Braiding Funding

Refers to coordinating two or more funding streams while maintaining each funding stream's connection back to its original source to keep its specific identity

Blending Funding

Refers to pooling of two or more funding sources into one funding stream, making funds more flexible. Individual funding sources therefore lose its specific identity

Stacking Funding

Refers to layering two or more funding sources into a shared service or resource making reinvestments into existing infrastructure

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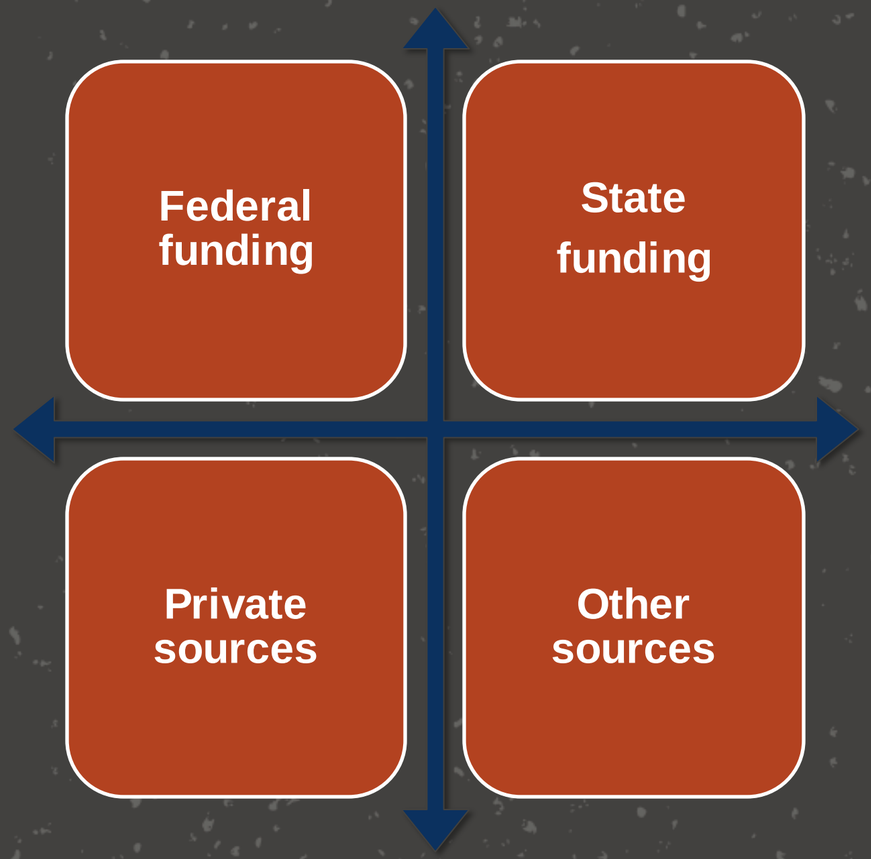
Source: https://aligningforhealth.org/wp-content/uploads/2022/09/Slides-Coordinating-Funding-and-Data-to-Address-SDOH-FINAL.pdf

Funding Partnerships

- **Lead agencies -** Specific state agencies may only access certain federal funds. Thus, the state agency must approve and administer the funding request on behalf of other state agencies and partners. Sharing a coordinated vision and continuous coordination is important.

- **Identification and reuse -** To ensure states are not duplicating investments, many federal funding sources require identifying other federal funding used to build or enhance technical capabilities.
-
- **Matching funds -** Many federal funding sources require a state matching fund contribution to offset the costs of programs, technical investments, staff, and non-staff costs. Matching funds cannot be leveraged from other federal funding sources (e.g., a public health grant awarded to the public health agency cannot serve as matching funds for CMS Federal Funding Participation requests).



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Funding Partnership Tactics

1. Coordinate public and private data and technology strategies and investments
2. Integrate data, interoperability, and technology needs into all health transformation and modernization activities, programs, and services
3. Communicate benefits and value adds to all partners
4. Maximize federal match technology planning, implementation, and maintenance
5. Align programs and investments at the county or community level

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HEALTH IMPACT OHIO

Civitas: PDOH Session 3

Wednesday, November 29, 2023

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Introductions

Jenelle Hoseus, MBA
Chief Policy and

Crisis in Ohio

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Table 1: Ohio Infant Mortality by Race and Ethnicity (2016-2020)*

	2016		2017		2018		2019		2020	
	Infant Deaths	IMR*	Infant Deaths	IMR*	Infant Deaths	IMR*	Infant Deaths	IMR*	Infant Deaths	IMR*
All Races**	1,023	7.4	982	7.2	938	6.9	929	6.9	864	6.7
Race										
White	609	5.8	550	5.3	553	5.4	518	5.1	493	5.1
Black	369	15.2	384	15.6	339	13.9	356	14.3	326	13.6
American Indian/ Alaska Native	2	‡	0	‡	2	‡	3	‡	1	‡
Asian/Pacific Islander	18	3.8^	20	4.2	18	3.8^	21	4.4	18	4.1
Ethnicity										
Hispanic	54	7.3	54	7.2	45	6.1	45	5.8	40	5.2
Non-Hispanic***	969	7.4	927	7.2	893	7.0	884	7.0	824	6.8

Data Source: Resident Birth and Mortality Files from the Ohio Department of Health Bureau of Vital Statistics.
**Infant mortality rate per 1,000 live births.*
***The total for all races includes deaths of unknown race.*
****Non-Hispanic deaths include those of unknown or missing ethnicity.*
‡ Rates based on fewer than 10 infant deaths do not meet standards of reliability or precision and are suppressed.
^ Rates based on fewer than 20 infant deaths should be interpreted with caution.

https://odh.ohio.gov/wps/wcm/connect/gov/f972e9db-91c1-4b31-99c6-3d12ab095ddb/Infant+Mortality+Annual+Report+2020+Final.pdf?MOD=AJPERES

Senate Bill 332:

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- Sponsored by Senators Charleta Tavares and Shannon Jones
- Passed on April 6, 2017
- Provided public policy support to decrease Infant Mortality
- Provided the following:
  - CHW Certification Standard through the Ohio Board of Nursing
  - Certified Pathways Standard
  - Provided for reimbursement through Medicaid/Managed Care Plans

[Senate Bill 332 | The Ohio Legislature]

How Do We Respond

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- Regional Health Improvement Collaborative
  - Neutral Convener
  - Entrusted with Community Data
  - Experts in Public Health

- Due Diligence to Start the HUB

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DATA AND IMPACT

How Do We Respond

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- We have a HUB but not enough Certified CHWs
- How do we support what we know works?

State	Current Status	Certification/ Credentialing and Supervision Requirements	Core Competencies	Continuing Education	Certifying Entity
OHIO	The Ohio Board of Nursing issues and renews CHW certificates, as authorized by HB 95 (enacted 2003). The certifications are to be renewed biennially.	Training program must be approved by the Board of Nursing; at least 100 hours of classroom instruction and 130 hours of clinical instruction, standard training exam. Certification needed in order to perform tasks delegated by a nurse. Only an RN may supervise a CHW when performing delegated activities related to nursing care. Grandfathering for those employed as CHWs before 2005.	The standard minimum curriculum for community health workers shall include courses, content, and expected outcomes, relative to the defined role of the community health worker, in the following major areas: 1. Health care 2. Community resources 3. Communication skills 4. Individual and community advocacy 5. Health education 6. Service skills and responsibilities The standard minimum curriculum for community health workers shall also educate students on needs throughout the span of a lifetime including the following: 1. The family during childbearing years 2. The family during pregnancy 3. The newborn, infant, and young child 4. Adolescents 5. Special health care and social needs of target populations such as grandparents raising grandchildren, adults caring for aging parents, and children and adults with disabilities	15 hours continuing education every 2 years.	Ohio Board of Nursing

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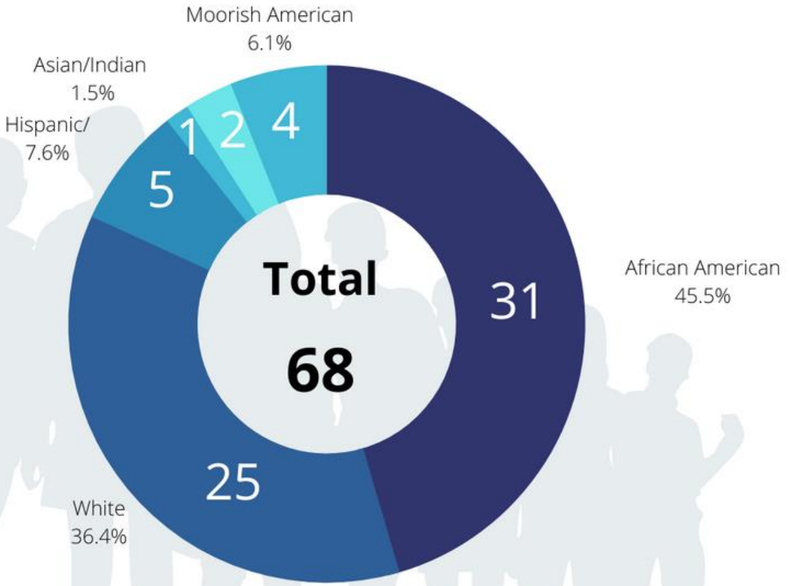
CHW CERTIFICATION PROGRAM

Central Ohio Pathways HUB CHW Certification Program Graduates

Gender:
54 Females
13 Males
1 Nonbinary

Citizenship:
60 US Citizenship
8 Permanent Legal Immigrant

Ages:
23-64



Employment Backgrounds of Participants:
Farhat Advance Medical Interpreting, Heart of Ohio Family Health Center, Kroger, PrimaryOne Health Centers, The Breathing Association, Urban Strategies Inc., Wellness First, Womenkind OB/GYN, Physicians CareConnection, Columbus Urban League, Anthem, Carmella Rose Health Foundation, Bridges to Wellness Tuscarawrus County HUB, Columbus Developmental Center, Insurance Navigator,MetroHealth Medical Center, Neidig Health Care, Physicians CareConnection, Pregnant with Possibilities Resource Center, PrimaryOne Health, Ross County Health District , Senior Resource Connection ,St. Mary's Develpoment, United Church Homes, United Way of Greater Cleveland, Unemployed, Self-Employed

Work WITH the State

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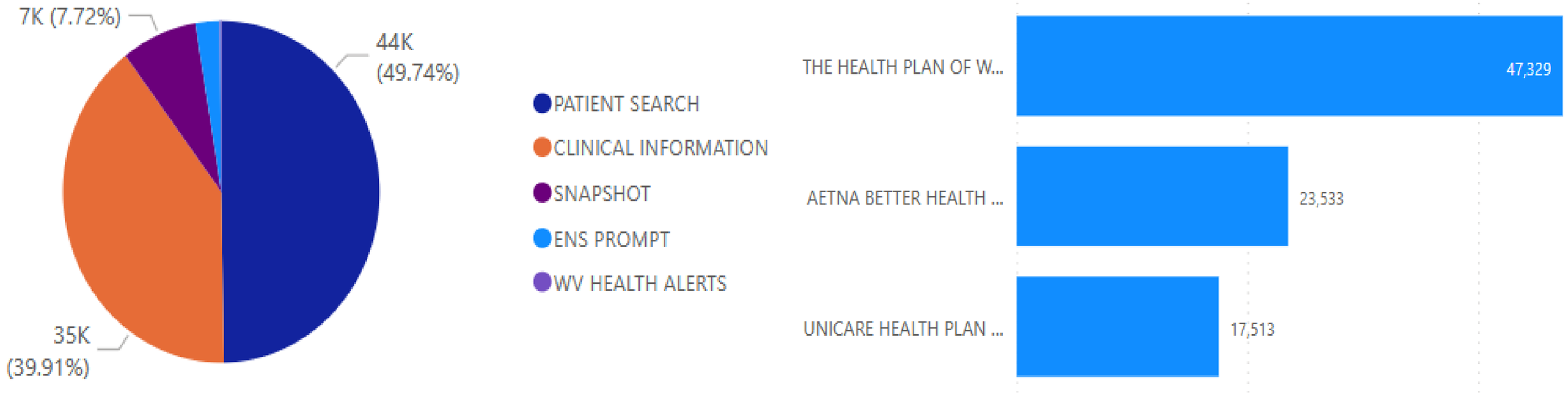
- Work with MCPs
- Align goals of Department of Medicaid
- Show ROI
- Fill gaps that exist in a meaningful way – both in care and healthcare spectrum
- Center for CHW Excellence

WVHIN BRIEF OVERVIEW

- State designated HIE by Secretary of Department of Health and Human Resources
- Non-Profit
  - Board of Directors – (including Secretary's Designee, Representative of State Payers – currently Medicaid)
- Funded by Participant Fees, Grants and Medicaid APD
- All MCOs participate
- Broad Connectivity
- Receive Data from Bureau of Public Health
- WVHIN has a strong relationship with BMS
  - Regular meetings
  - Provide monthly BMS report
  - BMS representation in WVHIN governance – Clinical Committee and Board

WVHIN- MEDICAID USERS

- The WVHIN supports 3 MCO's in WV:
  - Aetna Better Health of WV
  - The Health Plan
  - UniCare
- 518 WVHIN Medicaid Users
- WVHIN YTD Utilization by MCOs:



WVHIN- MCO USE CASES

- Targeted use cases with MCOs to support initiatives since 2019:
  - Lab files with R/E data to close gaps and evaluate quality measures
  - COVID test results
  - COVID vaccines
  - Death alerts
  - UniCare ENS routing to Case Manager for follow-up
  - THP monthly demographic files to support member outreach
  - THP diagnosis code smart alerts (potentially catastrophic claims)
  - Immunizations forthcoming from WVSIIS

WVHIN- MEDICAID SUPPORT

- Portal access and trainings for staff
  - Encounter Notification Service (ENS) Prompt for ADT messages
- Reporting on MCO initiatives
- COVID support through vaccination data with R/E
- Engaging with BMS Quality team
  - Immunization data, R/E data, coordination w/ MCOs
- Providing weekly report to BMS Take Me Home team to identify Medicaid members potentially eligible for program

HOW TO DEVELOP AND MAINTAIN THE RELATIONSHIP

- Identify Key Staff
- Cultivate the Relationship
  - Regular meetings
  - Provide monthly BMS report
  - BMS representation in WVHIN governance
- Provide Valuable Data and Insights
- Have Patience

SCAN

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