



ROADMAP TO WHOLE PERSON HEALTH

STRIVING TO CREATE A HEALTHCARE SYSTEM

designed to meet the holistic needs of each Pennsylvanian by promoting equity, improving value, and addressing the social determinants of health.





Introduction

At the direction of Governor Tom Wolf, the Department of Human Services (DHS) has undertaken many different reforms that have progressed our Commonwealth towards a vision of Whole Person Health. The goal is to create a healthcare system that is increasingly designed to meet the holistic needs of each person, instead of forcing each person try and fit their needs into a siloed healthcare system. Down to the cellular level, each person is a complicated conglomeration of emotions, behaviors, and organic chemistry, born and raised in vastly different circumstances and communities across the Commonwealth with varying levels of institutional barriers and opportunities that manifest themselves in different ways throughout a person's lifetime. This beautiful complexity demands a healthcare system that conforms to whole persons and individual needs, and not the other way around.

To achieve this vision of Whole Person Health, DHS is pursuing three interwoven components: Value, Equity, and the Social Determinants of Health (SDOH). Fortunately, progress towards any one of these goals invariably advances the other two—creating a positive feedback loop towards a more whole-person future. This roadmap does not include portions of the Whole-Person Health Reform effort that are outside of DHS' purview, including the Interagency Health Reform Council (primarily led by the Governor's Office) and the Health Value Commission (would require new legislation), but these entities would operate synergistically with the vision described in the roadmap.

This roadmap is broken down into three different sections. First, it will describe how the three interwoven components of Value, Equity, and SDOH relate to one another. Next, it will describe and place many of the reforms that our Department has undertaken to date into context within these interwoven components of Whole Person Health. Then, the roadmap will identify how DHS is continually monitoring our progress towards Whole-Person health. Finally, the roadmap concludes by looking toward the future.

The Interwoven Components of Whole-Person Health



Value

When we think of the word value—we often think of a thrifty consumer who is able to walk down the aisles of a store, comparing prices and quality of different goods to “get the best for their money.” The same is true for our healthcare system. Value in our healthcare system is defined similarly—the highest quality of care delivered for the lowest total cost. Often in our healthcare system, it is payors (Medicaid, Medicare, commercial insurance carriers) that are paying for a large part of the care delivered to patients. Historically, providers have been paid for each service they perform without regard to how their patients fare. Value-based purchasing (VBP), in contrast, ties provider payments to patient outcomes, aligning incentives to improve care and reduce unnecessary costs.

In Pennsylvania, the largest amount of dollars that are spent by the Commonwealth to pay for healthcare flow through Medical Assistance, our Medicaid program. In Medical Assistance, managed care organizations (MCOs) coordinate delivery and coordination of care and other supportive services for individuals enrolled in their program.

Physical Health MCOs (PH-MCOs) administer Pennsylvania’s Physical HealthChoices system and are expected to facilitate access to and help coordinate care and services for members’ physical health and well-being. In 2017, DHS began holding PH-MCOs accountable to use value-based contracting for a steadily increasing percentage of their provider payments. In 2020, this percentage was 50%, with at least half of this coming in the form of medium- or high-risk arrangements. A medium- or high-risk arrangement means that providers are incentivized both to improve quality and reduce costs, and in Pennsylvania the different types of these arrangements include shared savings, shared risk, bundled payments, and global payments.

In 2018, DHS expanded VBP requirements to include the Behavioral HealthChoices system. In Behavioral HealthChoices, the primary contractor is often county-based, and this county entity, in turn, usually holds the contract with a Behavioral Health MCO. Behavioral Health MCOs manage behavioral health services for members to treat their mental and/or substance use disorders. In 2020, the required percentage of provider payments in Behavioral HealthChoices linked to value is 20%, with at least half coming in the form of medium- or high-risk arrangements.

Finally, Community HealthChoices (CHC) MCOs coordinate physical health and long-term services and supports for Pennsylvanians who use both Medicaid and Medicare as well as Pennsylvanians with physical disabilities who require long-term services and supports. There have not been historic VBP requirements for CHC-MCOs, although

the Department is looking towards this as part of the future move towards value, as an integral component of Whole Person Health.

These steadily increasing VBP requirements—50% in Physical HealthChoices, 20% in Behavioral HealthChoices, and upcoming in Community HealthChoices—may be met by a wide variety of different types of arrangements with different types of providers. Allowing for flexible targets fosters innovative models. But simultaneously, we know that the vast array of VBP models can be disjuncting for providers. Because any one provider may be paid by a multitude of different payors, alignment across arrangements is also important and can help providers focus their attention on key quality metrics, costs, and overall value. It is for this reason that it is important to align with other payors outside of Medicaid, like Medicare and commercial insurers.

As a result, DHS will continue to collect information about the types of VBP arrangements that are occurring between MCOs and providers. When a model has proven its success, the Department will seek to require its use across MCOs, achieving better alignment. DHS will also explore with other agencies opportunities to align these arrangements with commercial insurers and Medicare. DHS has required certain models across payors, such as the Transitioning to the Community model in behavioral health, and the Maternity Care Bundle in physical health. The Roadmap will go into further depth, and how some of these aligned models move us closer to Whole Person Health.

Health Equity

Health equity is defined by the American Public Health Association as everyone having the opportunity to attain their highest level of healthⁱ. Unfortunately, inequities continue to persist in Pennsylvania, as they do throughout communities across this nation. Studies in Pennsylvania have shown that there is more than a 10% difference in access to well-child visits between black infants and white infants in Medical Assistance. Furthermore, the life expectancy of a baby born in Pennsylvania is strongly tied to ZIP code. A newborn in certain census tracts of North Philadelphia has a life expectancy of 64 years, when just a couple miles to the south newborns are expected to live to 87, a difference of 23 life years. To put this vast life expectancy difference into context, if we were to eliminate heart disease altogether, this would lead to a life expectancy difference of about 4 yearsⁱⁱ. No conceivable medical intervention comes within the magnitude of the effect of place on healthⁱⁱⁱ.

Health shouldn't be predetermined by the ZIP code where you live, the color of your skin, the language that you speak, the country where you were born, the religion that you practice, or your sexual orientation, gender, or gender identity. As such, DHS has made changes to improve health equity specifically.

In 2019, the Department of Human Services required that PH-MCOs achieve or be working towards the National Committee for Quality Assurance (NCQA) Distinction in Multicultural Health Care^{iv}. For patients to receive the best care possible, organizations responsible for that care must be aware of and sensitive to their populations' racial, cultural, and language differences—and the NCQA Distinction in Multicultural Health Care verifies that MCOs are providing culturally and linguistically sensitive services and working to reduce health disparities. The first MCO to achieve the distinction is from Pennsylvania, and almost all PH-MCOs have now achieved the distinction. In 2020, DHS expanded this requirement to BH-MCOs and CHC-MCOs.

DHS, in collaboration with other agencies, has also begun to start cataloguing the disparities that exist across the Commonwealth. The PA Health Equity Analysis Tool (HEAT) is intended to provide a granular geographic

perspective of areas that have significant opportunities to improve equity. Some of the areas with the most profound health inequities to this day are the same areas that have a history of being redlined. Redlining is the historic practice of identifying certain neighborhoods, particularly those that were predominantly comprised of racial and ethnic minorities, as too risky to lend to. This practice was started in the 1930s but was used as justification for years by public and private entities to deny loans to people in Black communities —linking together historical racism, place, and helping to explain the profound inequities observable by neighborhood across Pennsylvania. This also ties into recommendations in the Trauma-Informed PA Plan^v to rectify the communal trauma experienced by communities of color and also the DHS Racial Equity Plan.

Social Determinants of Health

Social Determinants of Health (SDOH) are the conditions in the environments in which people are born, live, learn, work, play, worship, and age, that affect a wide range of health, functioning, quality-of-life outcomes and risks.^{vi} There have been increasing amounts of evidence that providing social supports for individuals can improve their health outcomes. For example, states that have a higher ratio of social-to-health spending had better subsequent health outcomes for adult obesity, asthma, days with poor mental health, days with activity limitations, and mortality rates for lung cancer, acute myocardial infarction, and type 2 diabetes.^{vii} Similarly, socioeconomic deprivation has been found to have a strong link with premature death.^{viii}

As such, DHS is developing a process for systematically integrating SDOH into our healthcare system. This includes screening for SDOH in clinical settings, referring people to community-based organizations to meet unmet social needs, and supporting those organizations that are providing social services. The Department is aiming to adopt a statewide resource and referral tool, called the Resource Information and Services Enterprise (RISE PA). This would be an interactive online platform will serve as a care coordination system for providers, including healthcare, social services organizations, and a closed-loop referral system that will report on the outcomes of the referrals. It would also serve as an access point to search and obtain meaningful information to help Pennsylvanians find and access the services they need to achieve overall well-being.

To coordinate the screening of individuals for SDOH, the state has identified nine SDOH domains that must be screened for: food insecurity, medical access and affordability, housing, transportation, childcare, employment, utilities, clothing, and financial strain. But it would be insufficient to merely screen for SDOH and refer individuals to community-based organizations (CBOs) without further supporting those organizations to handle increased referrals. As such, DHS is also including requirements to incorporate CBOs into VBP activities for MCOs, which is further described later in the Roadmap. To better acclimate CBOs for integration into our health care system more broadly, DHS has also sponsored a series of trainings for CBOs on how to work with MCOs and providers.



Linking SDOH, Equity, and Value

Addressing SDOH is essential for improving health care value and addressing health equity. Research has shown that use of healthcare is a relatively weak determinant of health and that health outcomes are driven by numerous

factors, including genetics, health behaviors, and social and environmental factors.^{ix} Health behaviors, such as smoking, diet, exercise, and social and economic factors have been shown to be primary drivers of health outcomes, and social and economic factors can shape individuals' health behaviors.^x The root cause of these inequities often results from systemic racism, intergenerational trauma, and poverty leading to SDOH differences—for example, historic racist redlining deprived certain communities of color of access to capital, stable sources of food, adequate housing, and employment opportunities.

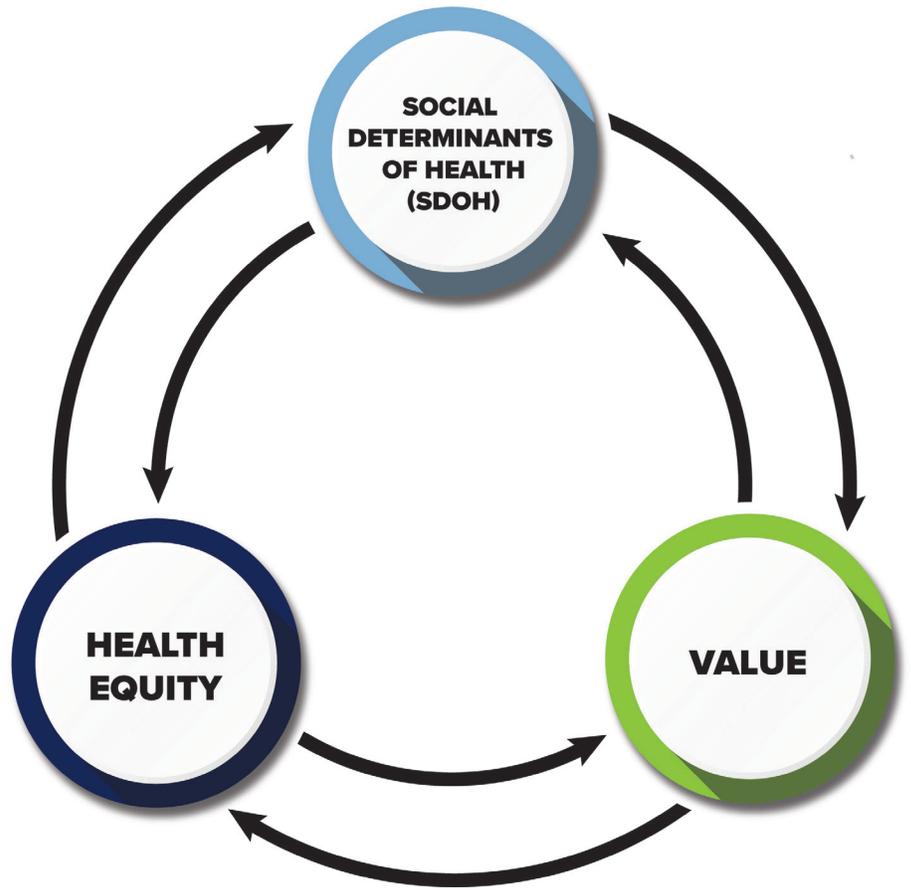
Such inequities have been exacerbated by our current system's payment framework

of reimbursing for the quantity of services but not for meaningful outcomes for the individual. For example, current care coordination contracts are primarily focused on “work products” (e.g., caseloads, phone calls, forms completed) and not on the outcome of connecting clients to services they need. In addition, there is little incentive for the multiple agencies providing support services to communicate or collaborate with each other, leading to duplication and inefficiencies.

Pennsylvania has an opportunity to change this where communities can work toward an accountable system focused on identifying and paying for reducing risk factors and improving overall health. VBP requires providers to improve patient outcomes at a lower cost. VBP success is dependent on using community-based networks that individuals typically access and use to support improving their health. Paying for value means that for providers to truly improve quality, they must also examine where there are gaps—causing increased focus on areas of inequity.

For example, if a person does not have access to transportation, it can become difficult to maintain a schedule of treatment appointments. Once an individual's foundational needs are met, both the individual and the provider are better able to focus on improving the individual's health.

In addition, SDOH intervention programs have been shown to return financial value. There is growing evidence demonstrating that such programs can bring down costs while improving outcomes. For example, studies of Medicare members have found that vulnerable patients enrolled in care transition programs, such as those with programs to provide community linkages, achieved a reduction in both 30-day readmissions and in overall

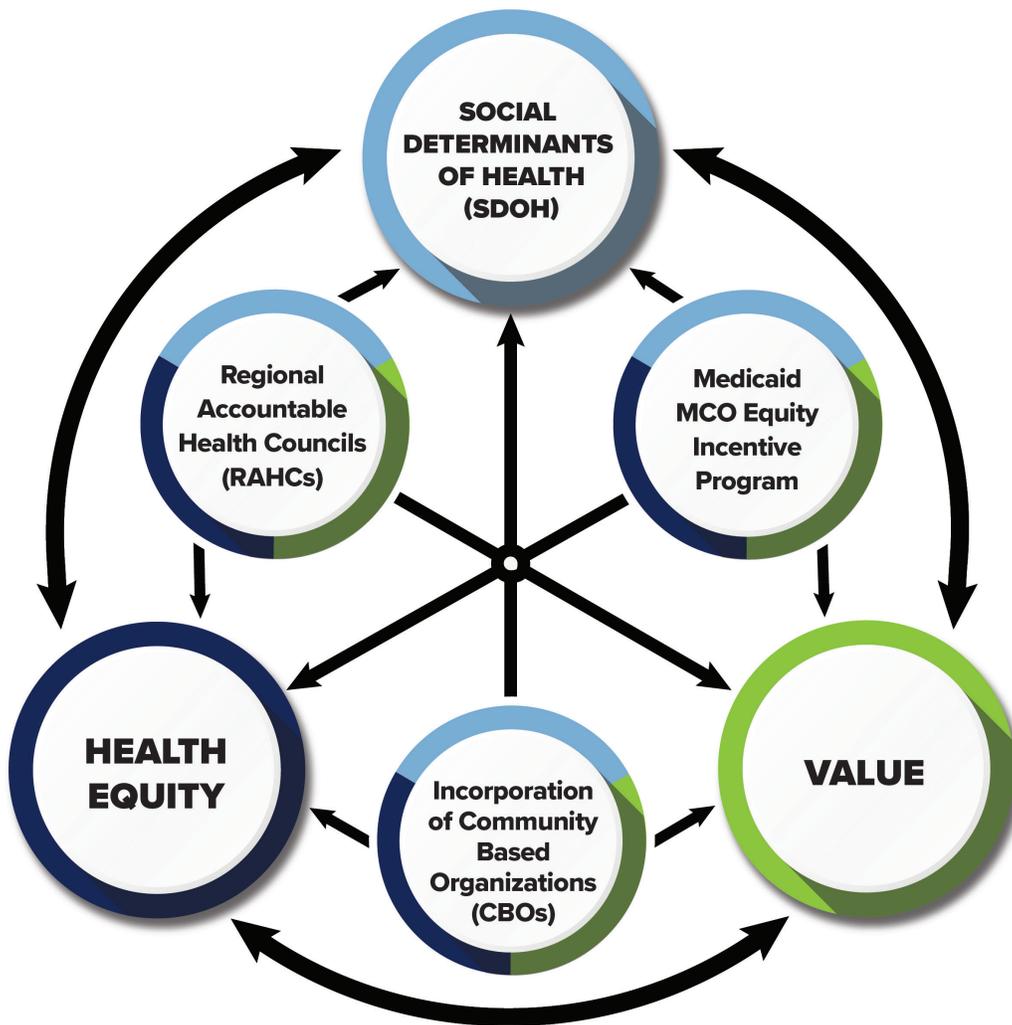


healthcare costs.^{xixixiii} Other studies have shown that care coordination programs addressing housing, income, and nutrition, as well as more proactive programs (e.g., health screenings, vaccinations), have likewise decreased healthcare costs while also improving outcomes.^{xiv}



Whole-Person Interventions

Several of the changes that Pennsylvania DHS has been pursuing have occurred at the nexus of these three core interwoven components of Health Equity, SDOH, and Value. This is done intentionally because these interventions collectively move us as a Commonwealth towards Whole-Person health.



Regional Accountable Health Councils (RAHCs)

As stated earlier in the Roadmap, there are profound disparities across the Commonwealth based on the ZIP code where a person is born. Babies born in some ZIP codes are expected to live into their sixties, when just a

few minutes or miles away, babies may live into their eighties. Often these inequities persist because of historic policies that redlined certain racial or ethnic minorities, and perpetuated housing segregation across generations.

These inequities are bigger than any one payor, any one provider, any one community-based organization, and even any one agency. We need everybody to play a role to start to chip away at these inequities. Therefore, as part of the whole-person health care reform package announced by Governor Wolf in October 2020, Regional Accountable Health Councils (RAHCs) were created through the Medical Assistance agreements between DHS and physical health MCOs, behavioral health primary contractors, and Community HealthChoices MCOs.

RAHCs are forums for strategic health planning to coordinate activities that promote health equity, address regional SDOH needs, and improve value with the goal of advancing a more accountable and equitable health care system.^{xv} Their primary goal in 2021 is to identify these areas of profound disparities, called Health Equity Zones (HEZs), identify the upstream drivers of these inequities, and strategize on how to collectively combat these inequities through community-level interventions.^{xvi} The RAHCs would also have to identify milestones in each HEZ to track their progress in eliminating these inequities throughout 2022. In turn, DHS, DOH, and other agencies would examine our funding streams, incentives, and programs, to ensure that there was a focus on improving the HEZs as well.

A longer-term goal is to also use the RAHCs to help align VBP arrangements across payors. Because any one provider may interact with a multitude of different payors— each with its own quality measures and payment mechanisms— alignment of VBP arrangements is important in order to focus population health efforts. Given that MCOs and other payors are spread throughout the state geographically, a place-based alignment effort makes sense here as well.

The RAHCs are a manifestation of the idea that to tackle some of these profound inequities, we must consider the “place” in which a person is born and raised. This idea is crucial to the movement towards whole-person care, and interwoven components of health equity, social determinants of health, and value.

Equity Incentive Program

For many years, the Office of Medical Assistance Programs has had an MCO Pay-for-Performance plan. This program incentivizes MCOs to hit certain national benchmarks on specific quality measures. and, for several years, DHS has identified racial inequities in certain quality measures that are reported to the Department.

In 2020, for the first time, DHS created an equity incentive as part of the larger MCO pay-for-performance program to incentivize a reduction in racial disparities for Black members. The equity incentive contained two quality measures in 2020—Timeliness of Prenatal Care (HEDIS®) and Well Child Visits in the first 15 months of life (HEDIS®). Data analysis in the Medical Assistance program found significant disparities in these measures in the past, and these disparities may be partly responsible for wide gaps in maternal mortality and infant mortality across the Commonwealth.

In 2021, the Equity Incentive will also grow to include measures for postpartum care, controlling high blood pressure, and management of diabetes. MCOs that attain certain national benchmarks for quality amongst their Black membership specifically will be eligible for payouts under the Equity Incentive Program.

The Equity Incentive Program drives us towards whole-person care in a variety of ways. On its face, the Equity Incentive Program will increasingly reward MCOs that focus on equity amongst their enrolled population and have

demonstrated results. Second, the root causes of many of these inequities are social factors—and so MCOs that work with their partners to address upstream determinants will similarly be rewarded. Lastly, the Equity Incentive Program highlights those areas where MCOs can improve performance on quality measures by focusing on those populations that have historically been underserved. MCOs can create new VBP models, specifically, that continue to incentivize equity amongst disadvantaged groups.

Incorporation of Community-Based Organizations (CBOs)

Community-based organizations are nonprofit organizations that work at a local level to improve life for residents and normally focus on building equity across society in many areas, including but not limited to social services. CBOs have historically provided the social services that address unmet SDOH needs, whether they be related to food, housing, clothing, utilities, financial strain, employment, and more. They are also comprised of a labor force that usually live within the communities they are aiding, and many are well-known and trusted entities. This trust is highly important— interventions aimed at reducing racial inequities have been shown to be effective when built using local, trusted community partners. For example, a randomized control trial found that interventions connected with local barbers were an effective way to reduce high blood pressure in Black men.^{xvii}

Local trust and historic experience tackling social issues make CBOs primed for a larger role interfacing with the healthcare system more broadly. As such, in both DHS’ physical health MCO and behavioral health primary contractor/ MCO agreements, DHS has revamped its community-based care management program to allow community-based organizations to perform care management activities. As part of community-based care management, a new home visitation program has also been established for new or at-risk mothers and newborns. MCOs are partnering with CBOs to participate in these maternal home visits, whereby a trusted community-member visits the mother’s home and offers support, and incentives are being provided to MCOs to offer additional visits. Overall, these changes mean that MCOs can fund CBOs to provide a more holistic and local approach to care management, to ensure that members’ physical, behavioral, and social needs are being met.

Also, as Pennsylvania seeks to roll out the Resource Information and Services Enterprise (RISE PA), an upcoming statewide resource and referral tool that would create an interactive online platform that will serve as a care coordination system for providers, including a closed-loop referral system to CBOs, it is important that we also ensure that our CBOs have sustainable funding streams to handle additional referrals. And we know that provision of these social services can lower the total cost of health care— improving value in our system overall. As such, new requirements were added to the physical health and behavioral health HealthChoices programs for 2021.

Specifically, CBOs must be incorporated into medium- and high-risk VBP arrangements. The reason DHS linked incorporation of CBOs to medium- and high-risk arrangements, specifically, is because these types of arrangements provide incentives for the reductions in the total cost of care—and we know that addressing unmet SDOH needs such as food and housing can cause reduced health care utilization and costs. By June 1, 2021, 50% of medium- and high-risk VBP arrangements must incorporate at least one CBO that addresses at least one SDOH domain. By September 1, 2021, 75% of medium- and high-risk VBP arrangements must incorporate at least one CBO that addresses at least one SDOH domain, and 25% of medium- and high-risk VBP arrangements must incorporate one or more CBOs that address two or more SDOH domains. The SDOH domains are the same that are mandatory for

assessment in RISE PA. CBOs can be incorporated into VBP either through a contract between the CBO and the MCO, or a contract between the CBO and the provider (when the provider has a value-based arrangement with the primary contractor or MCO).

DHS understands that this is a new world for many CBOs, many of which have not historically interfaced with the health care system. So, in order to help CBOs better understand how to engage and contract with payors and providers, DHS is sponsoring a series of trainings for CBOs.^{xxiii} CBOs provide the essential infrastructure to address the social needs of Pennsylvanians, a fundamental component of improving value, addressing equity, and achieving whole-person care.

Maternity Care Bundle

Currently, there are profound inequities in maternal mortality and infant mortality across the Commonwealth, as there is nationwide. Black women are three times more likely to experience a pregnancy-related death than white women.^{xx} Outcomes of infants are strongly linked to the care of the mother, and Black infant mortality is more than three times White infant mortality.^{xx} Nationwide, Black women are less likely to receive prenatal care, more likely to suffer from a perinatal mood and anxiety disorder like postpartum depression, and to suffer in silence without clinical help.^{xxi} Hospitals in areas with higher percentages of Black residents are less likely to provide adequate breastfeeding information and support to new mothers.^{xxii} Only about 66% of Black infants are breastfed compared to more than 82% of White and Latinx infants.^{xxiii} About 34% of the births in the Commonwealth are paid for via Medical Assistance,^{xxiv} so this is a strong lever to help improve maternal mortality and reduce inequities.

As such, starting in 2021, DHS is rolling out a new Maternity Care Bundle to change the way that maternity care is paid for in Medical Assistance. Medicaid programs nationwide have typically provided a single payment for all maternity care services delivered during pregnancy (typically prenatal, labor and delivery, and at least some postpartum care). However, this payment was often triggered by the delivery and not tied to the length and quality of prenatal care or provision of postpartum care because providers can bill at delivery regardless of whether the patient attends her visits.^{xxv} This historical payment structure incentivizes hospital-based births and high-cost interventions that do not necessarily translate into better maternal health outcomes, and did not have an emphasis on equity.

Pennsylvania's new approach is different. The Maternity Care Bundle is a type of value-based payment, which includes all services rendered to treat an individual for an identified condition during a specific time period. Providers that perform well on quality metrics measuring physical health, behavioral health, social determinants, and health equity measures would be eligible to receive additional reward payments if they reduce the total cost of care. Specifically, the quality measures include SDOH screening, initiation of alcohol and other drug use treatment, timeliness of prenatal care, postpartum care, prenatal and postpartum depression screening and follow-up, prenatal immunization status, and receiving the appropriate number of well-child visits. There will be an additional equity incentive incorporated into the model that rewards providers who achieve national benchmarks in these measures amongst their Black members specifically. Also, this model includes both maternity care and newborn care, linking the two together in a payment dyad just as their health outcomes are tied together in life. Finally, because this model is a type of medium-risk VBP model, it triggers requirements for inclusion of CBOs to address SDOH needs.

Integrated Care Program

Individual persons frequently have co-existing physical health diagnoses and behavioral health diagnoses. Because the brain is inextricably linked to one's body—physical health diagnoses affect behavioral health ones, and vice versa. Certain medications used to treat psychoses, for example, can cause diabetes. A person's alcohol use can cause cirrhosis, an often-deadly condition where the liver fails. Major depression is common after a person is recovering from a heart attack. To treat patients effectively, we must treat their physical health and behavioral health conditions, in addition to focusing on the interplay between them.

As such, DHS has sought to encourage physical health MCOs and behavioral health primary contractors and MCOs to work much more closely together through the Integrated Care Program (ICP), which started in 2016. The ICP provides financial incentives based on integrated health measures in order to enhance the coordination of care between physical health MCOs, behavioral health primary contractors and MCOs, and providers.

To receive a payout, at least 1,200 members must receive an integrated care plan by both the physical health and behavioral health MCO. This plan must be reviewed and updated at least annually. Also, each physical health and behavioral health MCO must share the responsibility of all inpatient hospital admissions, coordinate discharge, and coordinate follow-up. This is important because a hospital discharge can be a particularly vulnerable moment for patients (oftentimes medications change on discharge, for example).

There are six performance measures for 2021, which focus on alcohol and drug dependence treatment, adherence to medications, readmission rates, emergency department utilization, hospital admission rates, and diabetes screening for persons on antipsychotic medications. The amount of quality measures is expected to grow over time. So far, from 2017 to 2019 there has been significant improvement in most of these quality measures.^{xxvi}

Overall, the ICP promotes whole-person care by first promoting quality of care and reducing unnecessary health care costs, the key components of value. Aligning incentives between PH and BH MCOs also encourages development of aligned, integrated VBP arrangements with providers and PH and BH MCOs because both stand to share awards for better care of these patients. Furthermore, these ICP measures are in the process of being stratified by race and ethnicity to better understand inequities in care. Lastly, focusing on these integrated quality measures also shines a light on upstream SDOH factors, which when addressed, can cause downstream improvements in the quality measures. Furthermore, SDOH barriers should be focused on as part of the integrated care plans shared between physical health and behavioral health MCOs.

Opioid Use Disorder Centers of Excellence

Pennsylvania had the sixth-highest rate of drug overdose deaths in the country in 2015, according to the Centers for Disease Control and Prevention.^{xxvii} Evidence-based opioid use disorder (OUD) treatment was not as widely available as it is now, which at times resulted in delays and prevented individuals from entering into treatment programs. In 2016, Governor Tom Wolf introduced the Centers of Excellence (COEs) for Opioid Use Disorder as one strategy to address the overdose crisis within the state. The COEs were designed to engage the community to identify persons with OUD and ensure that every one achieved appropriate whole-person care, such as OUD treatment, mental health treatment for conditions such as anxiety or depression, and physical health treatment

such as primary care or screening for infectious disease. Also, each COE screens for needs related to social determinants of health, and connects individuals with resources for housing, transportation, childcare, employment training, and more. The COEs offer a variety of services on-site, while others are made available to clients through community-based organizations (like other efforts described in the Roadmap to incorporate community-based organizations into our health care system).

The COEs also connect every interested client with a peer who helps the person navigate the recovery process. These certified recovery specialists are uniquely positioned to understand the language of addiction and relate to their clients, including an appreciation for patient needs related to recovery supports and the social determinants of health. Racial disparities in the treatment of opioid use disorder are persistent in Pennsylvania^{xxviii} and across the nation,^{xxix} and pairing each individual with a peer from their community has been shown to be an effective strategy to help overcome these disparities.^{xxx}

Also, each COE provides every client with a community-based care management team who helps the person identify, organize, obtain, and sustain treatment and nontreatment resources. The community-based care management teams consist of an inter-disciplinary group of providers, which may include Licensed Clinical Social Workers, counselors, certified recovery specialists, nurses, peer navigators, care managers, and physicians. Already, the COEs have demonstrated increased rates of access to OUD treatment after receiving an OUD diagnosis, and a decrease in emergency department utilization and hospitalizations related to opioid overdose.^{xxxi} Looking ahead, DHS is aiming to implement value-based payments to COEs, to further incentivize improved quality and value of the services provided, and in line with other whole-person interventions described in the Roadmap.

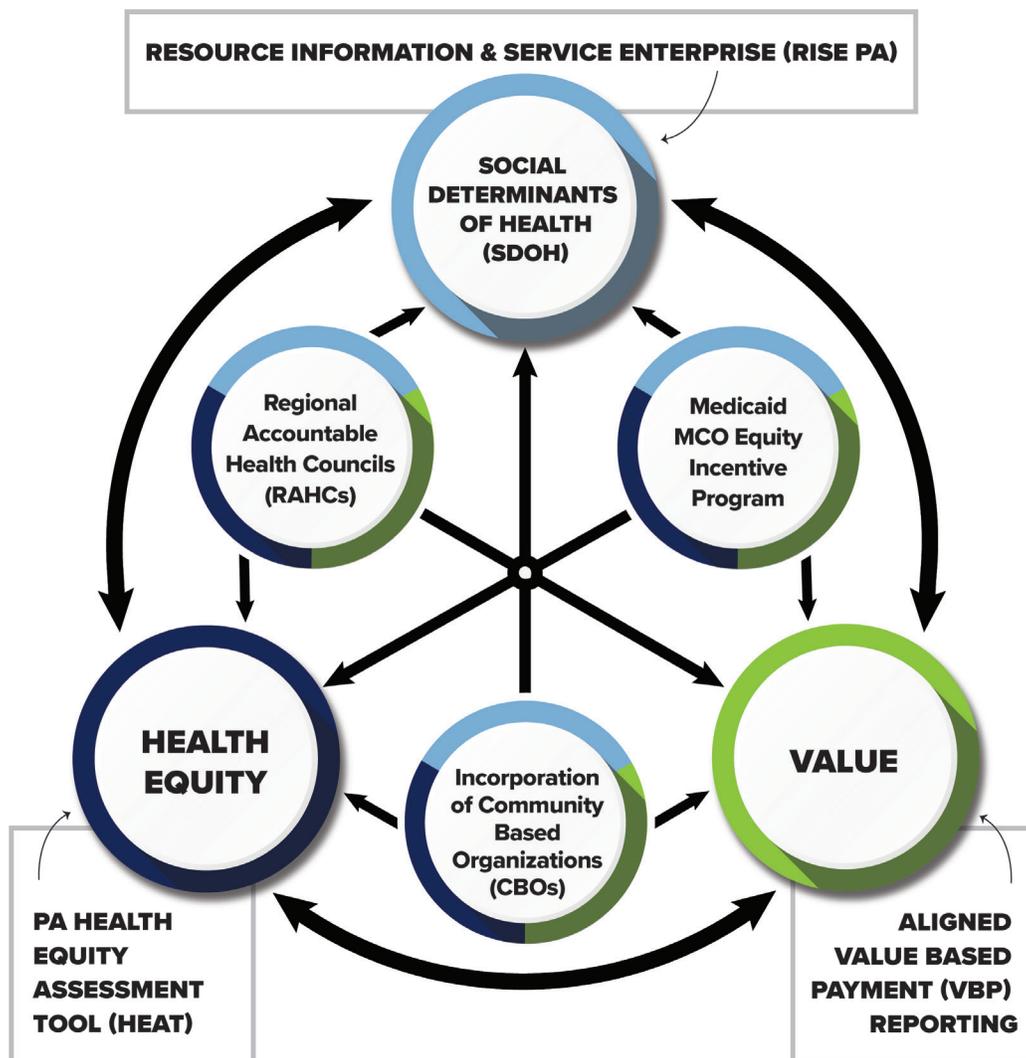


How to measure progress

In order to measure progress in each of the three components of whole-person care, DHS has embarked on separate initiatives to track and measure data.

Measuring Equity—PA Health Equity Analysis Tool (HEAT)

The PA Health Equity Analysis Tool (HEAT) is a public, online mapping tool that allows for a very granular level of analysis of health inequities across the Commonwealth. It incorporates three years of aggregated health outcomes from Medicaid claims data, and publicly available population health surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS), the Census, and the Childhood Opportunity Index. At a census tract and ZIP code level, PA HEAT overlays information related to the racial and ethnic demographics, Medicaid outcomes, and population health outcomes. Not surprisingly, the same areas that tend to have worse population health outcomes as a whole also tend to have worse Medicaid outcomes—indicating the importance of community-level factors in determining our health. Also, areas that are historically redlined and have higher numbers of racial and ethnic minorities appear to be especially affected, linking together race, place, and one’s health. DHS plans to update the information in this tool on an annual basis to assess for improvements of health inequities over time, with the understanding that some of the public population health surveys may not be updated on an annual basis.



PA HEAT was created with the initial intent of allowing the RAHCs to use the tool in identifying areas of profound disparities, or health equity zones. But given its multiple use cases, it was made public so that any community-based organization or provider could use it to identify the disparities in their communities to better target interventions to those areas in most need.

Additionally, there are more than 20 other quality measures in Medicaid that are stratified by race, ethnicity, region, and MCO. This is an annual assessment of inequities that is validated by a third party (called an external quality review organization). This stratification has historically occurred in Physical HealthChoices but is also now being done in Behavioral HealthChoices and Community HealthChoices. These annual results of inequities will also be made public to drive the activities of the RAHCs.

Measuring SDOH— Resource Information and Services Enterprise (RISE PA)

RISE PA would be a tool to identify unmet social services needs, creating an interactive platform that will serve as

a care coordination system for providers, including health care, social services organizations, faith-based groups, and government agencies, and will include a closed-loop referral system that will report on the outcomes of the referrals. It would also serve as an access point for all Pennsylvanians to search and obtain meaningful information and access the services they need to achieve overall well-being and improve health outcomes. It would also allow DHS to track in aggregate how needs related to the SDOH are being addressed across the Commonwealth and measure our progress over time.

The effort to create RISE PA has been a collaborative effort between multiple state agencies, counties, and local non-profits and community organizations, healthcare, and social services providers. Through this collaborative process, there have been nine identified SDOH domains that would be mandatory for assessment, including housing, food, employment, childcare, clothing, transportation, utilities, financial strain, and medical access. For consistency, other interventions discussed in this roadmap aim to identify the same prioritized domains listed in RISE-PA.

By looking at critical social determinants of health, Commonwealth agencies and partners at the county and local level can help the people we serve achieve better long-term health outcomes and maximize the impact of health care dollars. Additionally, as RISE PA becomes statewide, information on SDOH barriers can be aggregated at a community-by-community level, populating new dashboards on the PA Health Equity Analysis Tool, and offering better data on the upstream inequities to focus on for the RAHCs.

DHS has already sought to require regular assessment of SDOH needs at patient-centered medical homes, integrated community wellness centers, COEs, and as part of the new maternity care bundle. Individuals found to have social barriers should be identified through the use of Z-codes (a kind of claims-based code that would help identify food or housing insecure individuals, for example).

Measuring Value— Value-based purchasing (VBP) Reporting

DHS has historically gathered information related to those arrangements that move our health care system away from fee-for-service and towards value. Also, the Office of Medical Assistance Programs (OMAP) has gathered information from physical health MCOs to ensure compliance with the physical health agreement requirements, and the Office of Mental Health and Substance Abuse Services (OMHSAS) has gathered information from the behavioral health primary contractors and MCOs to assess compliance with the behavioral health agreement and to ensure that each VBP arrangement is improving quality and reducing cost. Going forward, and particularly as Community HealthChoices and the Children’s Health Insurance Program look to institute new VBP requirements, DHS is looking to align its VBP reporting and monitoring systems.



Looking forward

With the above interventions either implemented or on their way toward implementation, DHS has made incredible progress toward achieving Whole-Person Care at the direction of Governor Wolf. While this is a very promising start, to truly achieve a vision of a more whole-person future for our healthcare system, it will take a continued process of reform and progress.

As we obtain additional information about how these reforms are working or not working, DHS will make adjustments to ensure that real outcomes are obtained for Pennsylvanians.

Of course, there are many more initiatives to promote equity, address unmet social needs, and move our healthcare system towards value that the agency will undertake. Because these initiatives address the core components of whole-person care, and these components are interwoven, progress towards addressing inequities, tackling SDOH barriers, and increasing the value of health care payments by definition moves us toward a more whole-person future. And this is a future in which every Pennsylvanian— no matter who they are or where they are born— can thrive.

ⁱ American Public Health Association. Available from: <https://www.apha.org/Topics-and-Issues/Health-Equity>

ⁱⁱ Marmot M. The Health Gap: The Challenge of an Unequal World. Bloomsbury; 2015.

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