1. EOHHS: AE Program Updates
   • Onboarding Community Based Organizations to Unite Us

2. RI Commission on the Deaf and Hard of Hearing (CDHH): Workforce Training

3. NORC: HSTP/AE Program Evaluation Overview
AE Attribution Update

December 2021 AE Attribution Counts, by MCO

<table>
<thead>
<tr>
<th>MCO</th>
<th>NHP</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>BVCHC</td>
<td>13,824</td>
<td>6,416</td>
</tr>
<tr>
<td>Coastal</td>
<td>7,479</td>
<td>21,264</td>
</tr>
<tr>
<td>IHP</td>
<td>8,198</td>
<td>26,066</td>
</tr>
<tr>
<td>Integra</td>
<td>26,247</td>
<td>40,111</td>
</tr>
<tr>
<td>PCHC</td>
<td>10,123</td>
<td>13,181</td>
</tr>
<tr>
<td>Prospect</td>
<td>10,634</td>
<td>6,707</td>
</tr>
<tr>
<td>Thundermist</td>
<td>17,693</td>
<td></td>
</tr>
</tbody>
</table>
AE Program Updates

We are currently in Q3 of Program Year (PY) 4 of the AE program. While still focused on PY4 operations, AE/MCOs are preparing for a new contract year (PY5).

- Total Cost of Care Program Year 4, Quarter 1 reports underway; Program Year 3, Final Performance reports will be underway in March.

- Participatory budgeting applications posted and submissions due today, 2/22; award notifications will be issued 3/8.

- Centers for Health Care Strategies (CHCS) technical assistance will end on March 31, 2022.
  - 2/25 - Webinar on Strategies for Meaningful Patient Engagement in Health Care Design
  - 3/25 - Final Rhode Island Accountable Entity TA Learning Collaborative meeting

- AE Certification/Re-Certification applications are underway; recertifications due to EOHHS by 3/1 (new applications by 3/15) and will formally communicate certification determinations in April.

- HSTP Project Plans due to EOHHS by 5/2; these plans identify the AE's core HSTP projects, functioning as opportunities to earn incentive funds for the improvement of AE operations and the outcomes of their attributed populations.
Thank you to everyone who filled out the recent Community Resource Platform (CRP) Survey.

- Feedback has been helpful in planning the next steps for the CRP.
- Survey results showed a strong desire to see an expansion of CBOs on the Unite Us platform.
  - EOHHS strongly encourages AEs to reach out to the CBOs that they are most interested in having on the platform.
  - Outreach that comes from organizations that provide referrals will be more meaningful than if it were to come from EOHHS.
RI Commission on the Deaf and Hard of Hearing
Healthcare System Transformation Project
# Presentation Overview

## Part 1

**Project Background**
- Presenters
- RIC DHH
- Population Statistics
- Rationale for Project
- Staff

## Part 2

**Project Goals**
- Data Collection
  - Baseline Findings
  - Survey Deaf Community
  - Survey HC Workforce
- Workforce Training
  - Video Testimonials
  - Deaf HC Professionals
  - Virtual Training Series
- Workforce Development
  - RIC Interpreter Program

## Part 3

**Next Steps**
- Sustainability
- Funding
- Partnerships
The Rhode Island Commission on the Deaf and Hard of Hearing (RICDHH) is an advocating, coordinating, and service providing entity committed to promoting an environment in which deaf and hard of hearing individuals in Rhode Island are afforded equal opportunity in all aspects of their lives.

- independent state agency
- 9 legislative mandates
- 4 full-time staff, currently 4 contractors
- direct services- interpreter referral service, emergency and public communication access program, information and referral services
- located in Providence on Capitol Hill
- www.cdhh.ri.gov
Estimated Population of People Who are Deaf or Hard of Hearing in Rhode Island*

*20.3% is according to a study led by Johns Hopkins researchers and published in the Nov. 14, 2011, Archives of Internal Medicine, Frank Lin, M.D., Ph.D, an assistant professor with dual appointments in both the Department of Otolaryngology-Head & Neck Surgery at the Johns Hopkins School of Medicine and in the Department of Epidemiology at the Johns Hopkins Bloomberg School of Public Health, John Niparko, M.D. of the Johns Hopkins University School of Medicine, and Luigi Ferrucci, M.D., Ph.D, of the National Institute of Aging.
Rationale

Language and Cultural Barriers
Inequities in access to healthcare due to lack of language concordant medical professionals and qualified American Sign Language (ASL) interpreters.

Health Outcomes
Disparities in health outcomes for Deaf community due to lack of access to healthcare, health information, education, economic resources.

Cost of Care
Deaf community more likely to seek services in the emergency department than to see a primary care physician.
HSTP Staff

Christine West
Project Director

Alexander Laferriere
Outreach Coordinator

Thomas Darden
Operations Coordinator

Lyndsey Conway
Communications Coordinator

Dr. Marie Lynch
RIC Collaborator
Project Goals

Data Collection

Workforce Training

Workforce Development
HSTP Goal One:

Data Collection

- Baseline Findings
- Survey for the Deaf Community
- Survey for Healthcare Professionals
Survey of the Deaf Community

N=105

- 72% obese or overweight
- 43% depression or anxiety disorder
- 35% arthritis
- 34% hypertension
- 26% diabetes
- 22% lung disease/asthma

Survey of Healthcare Professionals

N=1,557

- 72% do not know how to request an interpreter
- 64% not aware of VRS
- 71% not aware of VRI
- 56% not aware of RICDHH
- 73% don’t know difference between hearing/Deaf interpreters
- 61% unaware of ADA regarding use of interpreters
HSTP Goal Two:

Workforce Training

- Video Testimonial Campaign
- Virtual Spotlight Series: Deaf Healthcare Professionals
- Virtual Training Series for Healthcare Professionals
HSTP Goal Three:

**Workforce Development**

- Public Health and Equity Sign Language Interpreting Program at Rhode Island College
Next Steps...

**Data Infrastructure**
Design, develop, and establish a vision, architecture, and program that will capture relevant health data to guide solutions and inform policy.

**Sustained Workforce Training**
Continuous long-term strategy to outreach to the medical community and partners committed to advancing the linguistic and cultural competence of healthcare professionals.

**Accessible Health Information**
Create accessible websites, health vlogs and PSAs in sign language, so that the Deaf community can access critical health information in a language that is accessible to them.

**Healthcare Navigation/Information**
Training of a cadre of Deaf and hard of hearing individuals to serve as community health workers to educate about healthcare navigation, services, insurance, and health education opportunities.

**Advocacy and Accountability**
Failure to provide access to Deaf patients has resulted in litigation and trauma for Deaf community members. A dedicated Ombudsperson who has the linguistic and cultural competence to work with this community, will restore trust and reduce the likelihood of lawsuits.

**Workforce Development Partnerships**
Develop critical linkages with state, non-profit, and private partners to increase workforce capacity of interpreters and language concordant medical personnel.
AE Program Evaluation
Overview
Evaluation of Rhode Island’s Section 1115 Medicaid Waiver

AE Advisory Committee Meeting
February 22, 2022
Evaluation Overview

• In 2018, RI EOHHS contracted with NORC to conduct an independent evaluation of the state’s Section 1115 Medicaid Waiver extension.

• NORC’s approach is organized around the three primary goals for the waiver extension:
  1. Pay for value, not volume
  2. Coordinate physical, behavioral, and long-term care
  3. Rebalance the delivery system away from high-cost settings

• The approved evaluation design is posted here on the CMS website (Attachment Y)
EVALUATION OVERVIEW

**Research Domains**

- **Pay for Value, not Volume**
  Increase coordination of services among medical, behavioral, and specialty providers, resulting in better outcomes and decreased costs of care

- **Coordinate Care**
  Coordinating beneficiaries’ care to increase primary care physician (PCPs) and other preventative visits so that ambulatory sensitive emergency department visits and inpatient stays decrease

- **Rebalance the Delivery System**
  Deliver appropriate care in least restrictive community setting to rebalance services and costs, increase HCBS, and decrease custodial care placements

**Data Sources**

- **Program Data**
  - Program documents & reports
  - Program guidance and requirements
  - ECHHS reports to CMS
  - Section 1115 waiver review

- **Secondary Data**
  - RI Medicaid claims & enrollment data
  - BHDDH behavioral health data
  - ECHHS Quality Evaluation data

**Analytic Methods**

- **Descriptive Analysis**
  - Summary statistics
  - Serial cross-sectional analysis

- **Impact Analysis**
  - Interrupted time-series analysis
  - Difference-in-differences analysis (Impact analyses conducted as feasible)

**Findings**

- **Impact on Core Measures**
  - Total Medicaid expenditures
  - Hospitalizations
  - Annual wellness visit
  - Emergency department visits
  - 30-day readmissions
  - Percent of members enrolled

- **Impact on Program Measures**
  - Use of program-specific services
  - Oral health outcomes
  - Prenatal and postnatal care
  - Use of home visits
  - Use of behavioral health services
  - Use of home- and community-based services

- **Member & Provider Experience**
  - Implementation experience
  - Member and provider satisfaction
  - Care coordination strategies
The Interim Evaluation Report (IER) will assess five waiver programs:

- Health System Transformation Project (HSTP)
- Piloting Dental Case Management
- Behavioral Health Link
- Peer Recovery Specialist (PRS) and Family/Youth Support Partners (FYSP) Programs
- Promoting Access to Appropriate, High-Quality Mental Health and Substance Use Treatment by Waiving the Institutions of Mental Disease (IMD) Exclusion
<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percent of members enrolled</strong>*</td>
<td>Percentage of members enrolled and/or attributed to each of the waiver programs</td>
</tr>
<tr>
<td><strong>Total Medicaid spending</strong>*</td>
<td>Total Medicaid expenditures per enrollee per quarter</td>
</tr>
<tr>
<td><strong>Hospitalizations</strong>*</td>
<td>Number of all-cause acute care inpatient stays per enrollee per quarter, calculated as the total count of inpatient stays per year</td>
</tr>
<tr>
<td><strong>All-cause readmissions</strong>*</td>
<td>Occurrences of unplanned hospitalization within 30 days of discharge from hospital per beneficiary per quarter</td>
</tr>
<tr>
<td><strong>ED visits</strong>*</td>
<td>Number of ED visits and observation stays per enrollee per quarter not resulting in a short-term inpatient hospitalization.</td>
</tr>
<tr>
<td><strong>Annual wellness visit</strong>*</td>
<td>Number of continuously enrolled members who have had at least 1 wellness visit with a provider within the span of the quarter</td>
</tr>
<tr>
<td><strong>Potentially avoidable ED visits</strong></td>
<td>Rate of potentially avoidable ED visits per the “patched” NYU algorithm</td>
</tr>
<tr>
<td><strong>Breast cancer screening</strong></td>
<td>Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer per year</td>
</tr>
<tr>
<td><strong>Follow-up after hospitalization for mental illness</strong></td>
<td>Percentage of patients who were hospitalized with selected illness diagnoses and who had a follow-up visit with a mental health provider reported within 30 days and 7 days</td>
</tr>
</tbody>
</table>

* Core metric measured across all waiver programs
• **Descriptive Analyses**
  
  – **Summary Statistics**: Frequencies and percentages of unadjusted beneficiary characteristics and outcomes by treatment and comparison groups.
  
  – **Pre-Post Analysis**: Selected utilization, cost, and quality measures in the baseline and performance years.

• **Impact Analyses**
  
  – **Difference-in-differences (DID)**: Estimate the effect of the HSTP program by comparing the changes over time between treatment and comparison groups.
DIFFERENCE-IN-DIFFERENCES DESIGN

July 2014 – June 2016
July 2018 – June 2022

NOTE: The AE pilot program period (July 2016 – June 2018) will be considered an implementation ramp-up period and will be excluded from both baseline and performance periods.
• AE-specific comparison group
  - RI Medicaid-only beneficiaries enrolled in managed care, not attributed to an AE

• Propensity weighting
  - Inverse probability of treatment weights (IPTW) will be used to minimize systematic differences between the AE and comparison groups
  - Weighting variables will include individual-level sociodemographic characteristics, Medicaid enrollment status, health status, and access to care
• Finalizing analytic file

• Descriptive and impact analyses

• Integrate findings into the first draft of Interim Evaluation Report submitted to EOHHS on May 13, 2022

• Due to CMS on December 31, 2022
Questions?
Appendix
### Proposed Balancing Covariates

<table>
<thead>
<tr>
<th>Program</th>
<th>Variable</th>
<th>Definition</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Programs</td>
<td>Age</td>
<td>Enrollee age</td>
<td>RI Medicaid Claims</td>
</tr>
<tr>
<td></td>
<td>Sex</td>
<td>Enrollee sex</td>
<td>RI Medicaid Claims</td>
</tr>
<tr>
<td></td>
<td>Race/ethnicity</td>
<td>Enrollee R/E (Combined R/E variable)</td>
<td>RI Medicaid Claims</td>
</tr>
<tr>
<td></td>
<td>Number of chronic conditions</td>
<td>Enrollee’s number of chronic conditions defined using CCW chronic condition flags</td>
<td>RI Medicaid Claims</td>
</tr>
<tr>
<td></td>
<td>Median household income</td>
<td>Median household income in each enrollee’s zip code</td>
<td>American Community Survey</td>
</tr>
<tr>
<td></td>
<td>Less than high school education</td>
<td>Percentage of enrollee’s zip code with less than a high school education</td>
<td>American Community Survey</td>
</tr>
<tr>
<td></td>
<td>Percent under 100% federal poverty line (FPL)</td>
<td>Percentage of enrollee’s zip code living below the FPL</td>
<td>American Community Survey</td>
</tr>
<tr>
<td></td>
<td>Receipt of Public Assistance</td>
<td>Number of households in enrollee’s zip code receiving SSI, SNAP, or Cash Public Assistance in the last 12 months</td>
<td>American Community Survey</td>
</tr>
<tr>
<td></td>
<td>Unemployment rates</td>
<td>Percentage of enrollee’s zip code fully or partially employed</td>
<td>American Community Survey</td>
</tr>
<tr>
<td></td>
<td>Housing insecurity/homelessness status</td>
<td>Indicator of housing insecurity or recorded homelessness during the baseline period</td>
<td>RI Ecosystem Data</td>
</tr>
</tbody>
</table>

| Health System Transformation Project (HSTP) | IHH enrollment | Flag for enrollment in an IHH | RI Medicaid Claims |
| | BH diagnosis | Flag for behavioral health diagnosis | RI Medicaid Claims |
| | MCO | Categorical indicator for MCO enrollment (MCO name for treatment, 0 for comparison) | RI Medicaid Claims |
| | Line of business | Categorical indicator for Medicaid line of business (LOB_MCAID) | RI Medicaid Claims |
Potential subgroup analyses

- Age (e.g., children, categories of non-elderly adults)
- Race/ethnicity
- Health status (e.g., specific conditions, substance use disorders, multiple chronic conditions, comorbid behavioral and physical health diagnoses, and serious and persistent mental illness)
- Medicaid enrollment category
Upcoming Important Dates

2022 AE Advisory Committee Meeting Schedule

- 19-Apr – 8:30-10:00
- 14-Jun – 8:30-10:00
- 18-Oct – 8:30-10:00
- 13-Dec – 8:30-10:00

Additional stakeholder meetings TBD for Program Year 6 planning.