March 28, 2018

Dear Members of Oregon's Medicaid Advisory Committee:

The CCO Oregon Social Determinants of Health (SDOH) Workgroup commends the Medicaid Advisory Committee (MAC) for your work and discussion on the potential roles of Coordinated Care Organizations (CCOs) in mitigating the effects of SDOH and equity on community members being served by the coordinated care model in Oregon.

We are under the umbrella of CCO Oregon, which convenes workgroups across select focus areas to facilitate collaboration with multiple voices and organizational perspectives invested in the coordinated care model. We are a newer workgroup that meets monthly and convenes CCOs, provider groups, and other community-based organizations from across Oregon that directly provide critical services every day, including housing, food, peer counseling, and primary care. The population we serve contains geographic, socioeconomic, and racial diversity.

Your recommendations presented earlier this month to the Quality and Health Outcomes Committee (QHOC) aligned with many of our thoughts:

- We agree value-based models are a strong strategy for CCOs and their partners to incentivize particular practices and outcomes. To assist with this goal, the coordinated care system (the Oregon Health Authority (OHA), CCOs, workgroups/committees, and stakeholders) may need to:
    - Develop and disseminate best practices for coding and billing to CCOs and other coordinated care stakeholders
    - Share ideas for care team workflows (from physician to peer support worker) that strive for balance between data tracking and direct patient care
    - Identify best practices for how health related services may best operate in this model
    - Provide guidance on operations and fiscal sustainability within a value-based model for CCOs and other care access points (as many partners are still fee-for service)

- We also agree that greater direct investments in SDOH and equity projects are needed, even with the recent passage of HB 4018 and beyond CCOs. Other potential funding sources may come from continuing to:
    - Encourage the use of community benefit dollars on data-based SDOH and equity projects
    - Identify metrics to incentivize SDOH and equity work by CCOs and insurers, and incorporate measurement of existing projects
    - Develop communications for social service providers and other partners to know more about securing potential funding
    - Contract directly with workforce teams specifically trained to serve populations adversely affected by SDOH such as peer support specialists and traditional health workers
    - Support diverse workforce teams by incentivizing health worker training and/or reimbursement for different types of care team visits

- Your presentation at QHOC called out the development of screening tools, greater access to electronic health records for more types of care or service delivery providers, and disseminating compiled data more broadly back to providers and partners -- we agree. And, we identified a few additional components:

    - Streamline the collection of data and potential screening tools:
        - Optimize current systems and assess existing screening tools
        - Strive for the greatest cohesion across how screening questions are asked (for consistency)
        - Ensure that when data and screens are collected they "roll up" into larger datasets (for analysis and targeting)
    - Strengthen work across the OHA, the Department of Human Services (DHS), and Public Health to align systems, data collection, and dissemination

- As your presentation notes, it is important for CCOs, OHA, and other coordinated care stakeholders to align priorities with community needs and goals, and not duplicate efforts. We agree that when possible SDOH and equity projects should leverage existing structures within the coordinated care model and maximize efficacy. For instance:

    - Continue and increase Community Advisory Council (CAC) trainings on how to engage, set expectations, and attain goals for the committee members themselves and the CCO staff working with the CACs
    - Embrace and prioritize diversity and health equity in daily decisions throughout OHA and CCOs [not just in projects with SDOH or equity titles]; including the development of health equity metrics across care access points that measure existing and new work
    - Incorporate current Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) recommendations into forward-thinking organizational plans; develop mechanisms for CHNA and CHIP implementation and continue to report plan accomplishments
    - Increase learning opportunities for CCOs and potential coordinated care partners to build skills that aid local partnerships with those organizations focused on homelessness, ACEs, education, criminal justice, foster care, and more
    - Strengthen statewide and regional referral networks and the ability for providers and care teams across referred resources to communicate electronically

We acknowledge the importance of local CCO and care partnerships to best address the unique needs of the members in a given community. Strategic relationships across clinical and non-clinical care providers, social service agencies, community-based organizations, and system-wide structures like transportation and education can harness the experience and population-specific resources from each facet. A challenge to this work is how to best measure success and how to appropriately reimburse within the structure of the global budget that the coordinated care model leverages in Oregon. We will be discussing those challenges at a retreat in May and will provide you and other entities with further comment.

Again, we appreciate the leadership that the MAC has taken with this work. We encourage your consideration and integration of our thoughts into your discussions with the Oregon Health Policy Board and other bodies as Oregon continues to further health system transformation and advance the Quadruple Aim.

Thank you,
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Social Determinants of Health Workgroup Co-Chairs