February 9, 2019

Dear Committee Members:

The CCO Oregon Social Determinants of Health and Health Equity Workgroup notes the success we've seen in motivating transformational work through the CCO quality pool and other metrics. We are encouraged by the emphasis on social determinants of health and equity in the CCO 2.0 process, which resulted in several policy options aimed at mitigating social determinants and inequity included in the Oregon Health Policy Board's CCO 2.0 Report from October 2018.

To align with the work happening in CCO 2.0 and the priorities outlined by Governor Brown, we strongly encourage the Health Plan Quality Metrics (HPQMC) and Metrics and Scoring (MSC) Committees to consider a metric that begins to address social determinant aspects of health for the 2020 quality pool. Further, we encourage the development of "round" metrics (as presented by OHA at the November 2018 Metrics and Scoring Committee meeting) that not only measure screenings and utilization but strive to assess the ability of the delivery system -- across health care and social services -- to address need.

We know there are many conversations happening across multiple workgroups to identify social determinant and health equity metrics. And, we are aware that HPQMC has endorsed the creation of a new SDOH workgroup to focus on developing such measures; we look forward to working with this group when then begin convening later this year to develop metrics for 2021. We offer our recommendation to you now for the 2020 set as a first step because this work is too important to wait and we need to begin setting benchmarks.

We recommend incentivizing screening and data collection across coordinated care partners and leveraging z-codes to accomplish this. Z-Codes are an existing opportunity within the ICD-10 system already in use by some providers to indicate a social determinant potentially impacting health; z-codes essentially modify the existing ICD-10 code enhancing what is known about that patient to inform the provider's care planning for the individual and the system about overall population health. While each health system will make their own business decisions about which electronic health record (EHR) to use and which screening tools to use, z-codes span these differences. The use of z-codes may be incentivized across provider types thereby increasing the frequency of screening, the development of related care workflows and referrals, and even identifying opportunities for alternative payment models.

The metric could be broad and call for CCOs to identify in partnership with their Community Advisory Council (CAC) and/or Community Health Improvement Plan (CHIP) three z-codes from a menu of options to track in the 2020 year. Conversely, the metric could be focused on a few metrics. As a first step, we

recommend the broad approach with a menu of codes, which could be narrowed and honed in future cycles.

While there are many screening tools in use, the Accountable Health Communities (AHC) and PRAPARE are the most frequently used screens across coordinated care currently in Oregon. We compared AHC and PRAPARE and identified a few z-codes and screening questions that align across these tools:

- Z59.0 - Homelessness
- Z59.1 - Housing insecure/inadequate
- Z59.4 - Lack of adequate food and safe water

We further suggest data collection on transportation need, but there is not a z-code dedicated to this population need or one that aligns across AHC and PRAPARE. The closest we identified is:

- Z59.8 - Problem related to housing and economic circumstances

In addition to those codes already mentioned, we recommend the following z-codes be added to a menu for CCOs in partnership with their CACs and CHIP to choose from:

- Education and Literacy - variants listed under Z56
- Employment - variants listed under Z55
- Health Services Unavailable - Z75.3
- Violence - see variants under T74.11xA

The variance in these codes and their use across the health care systems necessitates greater work on z-codes and other data-based strategies to understand the challenges of the implementation, opportunities to leverage existing systems, and what may be a path to greater data collection and use to inform SDOH-HE investment and potential social risk calculations for alternative payment models. CCO Oregon would gladly assist by hosting conversations focused on data collection strategies and offer further recommendations to the various metric committees. We welcome guidance from your committee and others to ensure we're not duplicating efforts and providing a value-add to the conversation.

Lastly, while we understand the gravity of the housing crisis across Oregon and appreciate the Governor and OHA's focus in this area, in many rural areas transportation is the greatest crisis and driving up system costs. We request that you don't lose sight of the differing experiences across Oregon when it comes to the SDOH or health equity, and also remind you that local decision making and priority setting is a hallmark of the coordinated care model.

Thank you for your consideration,
The CCO Oregon Social Determinants of Health and Health Equity Workgroup

For further information or discussion, please contact Samantha Shepherd, CCO Oregon Executive Director at samantha@ccooregon.org or 928-699-1343.