



February 9, 2019

Dear Committee Members:

CCO Oregon's members and contributors are CCOs and other payers, hospitals and clinic systems, provider associations, local governments, and community based organizations. We regularly convene conversations addressing health and human services delivered through Oregon's coordinated care system. We respectfully submit the following comment from our Social Determinants of Health and Health Equity, Behavioral Health, and Dental and Oral Health Workgroups for your consideration. We appreciate your time and consideration, and we are happy to provide further information or specification as needed.

Thank you,

Samantha Shepherd  
Executive Director  
CCO Oregon

---

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 (SDOH) and health 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 the HPQMC endorsed the creation of a new SDOH workgroup to focus on developing such measures; we look forward to working with this group when they convene later this year to develop metrics for 2021. We offer our recommendation to you now for potential adoption to the 2020 metric set as a first step because this work is too important to wait and we need to begin setting benchmarks for future work.

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.

This new 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, this new metric could specify z-codes for the CCOs to track in year one. 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, [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 already 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 implementation, opportunities to leverage existing systems, and what may be a path to greater data collection and use to inform SDOH and health equity 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 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.

---

The **CCO Oregon Behavioral Health Workgroup** appreciates your work to foster innovative collaboration across the coordinated care health system and is pleased to submit this comment for your consideration as you look to 2020.

Behavioral health has been a prime focus of CCO 2.0 development with expectations around delivery, access, and integration. Likewise, we expect there may be changes to the CCO incentive metrics and other measurement criteria as the new CCO contracts launch in 2020. We appreciate the work of the Health Plan Quality Metrics and Metrics and Scoring Committees in the metrics development process and look forward to further collaboration.

At this time, we recommend transitioning the SBIRT measurement to move beyond "screen and refer" to a measurement of engagement in Substance Use Disorder treatment services. This transition could leverage SBIRT in a new composite or "round" metric that honors the commitment to patient outcomes and integration. Moreover, specific access points or provider types, such as community health workers or peer supports, could be part of such a composite metric, which may further efforts to assess equity and lessen disparities.

Ultimately, we would like measurements to further evaluate if patients identified via SBIRT or comparable screening tool are receiving the needed services and where may be more efficacious in our treatment of substance use disorder, depression, and other behavioral health conditions that data shows are most pervasive across the populations we serve. For instance, incentivizing measurement of the percentage of members receiving substance use disorder services may motivate health and provider systems to proactively find people in need of further services to improve overall population health and lower system costs through preventative measures. We also support the development of composite measures that allow analysis of behavioral health treatment services alongside human services and care aimed at mitigating the social determinants of health.

Regarding the current PCPCH enrollment metric, as Oregon now has a few years under the PCPCH belt, we may be primed to up the expectation. How might CCO metrics incentivize higher levels of PCPCH certification and/or better behavioral health integration across the system? PCPCH certification does not necessitate behavioral health integration, but a measure with a higher benchmark than enrollment or a composite metric that weighs enrollment and PCPCH tier-level may improve outcomes.

Moreover, Oregon's PCPCH standards are slated for review with public input in the second half of 2019. Currently, the top two tiers do not include behavioral health integration. We will be convening our membership and tracking this process to advocate for any potential system wide gains. We may have future metric recommendations for your consideration as a result.

We are pleased with how the "Emergency department utilization among members with mental illness" (EDMI) CCO metric helps motivate providers to collaborate in ways they haven't before. In 2019, a new State Quality Measure (SQM) will measure "Follow-up after emergency department visit for mental illness" (FUM) per [HEDIS specifications](#). Aligning the CCO metric with this new SQM would allow the data to be evaluated across payer type. Two rates are reported for FUM:

- ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

We appreciate the alignment that has occurred across CCOs, OEBC, and PEBB over the past few cycles. Altering this metric or leveraging FUM and EDMI in a composite metric would further inform and motivate behavioral health care coordination and integration.

---

The **CCO Oregon Dental and Oral Health Workgroup** is pleased to offer comment to the Health Plan Quality Metrics and Metrics and Scoring Committees as you make important decisions that will impact the health of Oregonians and develop further opportunities to motivate and incentivize dental and oral health integration.

In 2018, we provided comment calling for two adult dental health metrics, in particular. We were pleased to see the addition of an adult oral health metric, "Oral evaluation for adults with diabetes", to the 2019 CCO metrics set. The second metric we recommended, "Preventive dental service utilization for adults", has yet to be adopted and we hope you will consider its addition to the 2020 set. Additionally, as noted in our 2018 comment, we support all of the current pediatric dental metrics and encourage the Committee to maintain balance between the number and desired outcomes of adult and pediatric metrics to motivate transformational efforts equitably.

Looking ahead to 2020 and beyond, we support the development of composite metrics such as the existing DHS metric and the proposed metric from the Health Aspects of Kindergarten Readiness (HAKR) Workgroup that incorporates primary care, behavioral, dental, and social-emotional health. In particular, we support the HAKR dental component, "Preventive Dental visits for children 1-5 years old". Another opportunity may be the new state quality measure (SQM): "Any dental service", which may be leveraged in the development of composite metrics as a measure of access to dental care and utilization.

For several years, we've heard mention of dental and oral health integration as a priority, and yet this aspect of coordinated care has not reached its potential. We hope your Committees will help put action to those words and continue to take strides that motivate further dental and oral health innovation and integration. In doing so, we strongly encourage careful consideration regarding the resources needed and potential impacts to the delivery system, such as:

- The role of HIT: What is the minimum data set(s) and systems needed? Who needs access to the data? Will HIE and current HIT initiatives meet these needs and, if yes, when?
- Organizing and aligning the policy and implementation: How do we organize, prioritize and align: care delivery; adoption and use of EHRs; inception and proliferation of HIT; and advancement of value-based payment (VBP) models?
- Impact on transition to and evolution of VBP: How do we ensure the measures available best support the policy options included in the [Oregon Health Policy Board's CCO 2.0 Report](#) (October 2018)?

In Summer 2018, our workgroup reviewed [metrics released by the Dental Quality Alliance \(DQA\)](#) and made selections for a menu of metrics. We've included this menu below for your reference. The menu is broken into two tables for children and adults, and includes links to the relevant DQA specifications sheet. Please review these measures as options for implementation.

Specific to the Metrics and Scoring Committee (MSC) current conversations, we offer the following for your consideration:

- Oral Evaluation for Adults with Diabetes
  - We recommend that, for the purposes of establishing denominator specification, the involved metrics committees strive to mitigate definitional variation of "diabetics" (claims-based versus EHR-based) as this could have a significant impact on care coordination efforts.
  - Overall, we support the inclusion of the diabetes/dental measure even if the denominators cannot be aligned.
- Dental sealants on permanent molars for children (changes slated for 2020)
  - We encourage the MSC to address the specification issue of the rolling denominator.
  - Further, if a risk-based measure is to be implemented in 2020, we recommend reconsidering how the benchmark is set and to move away from the current trajectory of an annual 3% increase.
  - And, we note that moving to a risk-based measure in 2020 will be complicated as risk scores are currently reported at a low rate in Oregon and because it is unclear how risk will be defined.
- Assessment for children in DHS custody (changes slated for 2020)
  - The impact of decreasing days allotted for dental and physical health assessments is significant. Despite the fact that 15 CCOs improved in 2017 and 13 CCOs met the target, we are still not meeting the statewide benchmark of 90% for this metric.
  - This is especially true upstream, at a relational level, wherein existing collaboration between stakeholders is already challenging, if not lacking, and only exacerbates the downstream data issues.
  - Underestimating the administrative and operational challenges could have an adverse impact and regressive results. Current challenges in acquiring accurate data will

exacerbate further under-truncated assessment timelines. Accordingly, it would be prudent to use 2019 as an opportunity to inform 2020 specifications and resolve pre-existing data barriers. When metric specifications aren't based in the "on the ground" reality, it can make measures unattainable, which can have significant adverse impacts.

- We support ongoing discussion and operational advancements to improve the ability of Child Welfare within DHS to provide timely information to CCOs for this metric.

Lastly, we recommend integrating dental services in diverse care settings and utilizing dental providers, when possible, as access points for other metrics, such as immunizations. Taken one step further, while it may not be current common practice, how may dental providers expand their impact on individual patient and population health by providing "new" services like nutritional counseling or social determinant of health screenings in the dental chair.

<b>Children's Dental Metrics Set</b>			
<b>Metric Name and Stats</b>	<b>Description</b>	<b>Numerator</b>	<b>Denominator</b>
<b>Utilization of Services</b> Process measure evaluating utilization and access Source: <a href="#">Dental Quality Alliance, NQF #2511</a>	Percentage of all enrolled children who received at least one dental or oral health service within the reporting year	Unduplicated number of children under age 21 who received at least one dental or oral health service	Unduplicated number of all enrolled children under age 21 in the reporting period
<b>Preventive Services for Children at Elevated Caries Risk</b> Process measure evaluating utilization Source: <a href="#">Dental Quality Alliance</a>	Percentage of enrolled children who are at "elevated" risk (i.e., "moderate" or "high") who received a topical fluoride application and/or sealants within the reporting year	Unduplicated number of children at "elevated" risk with one or more of the following CDT Codes in the reporting period <sup>1</sup> : D1110, D1120, D1206, D1208, D1351	Unduplicated number of enrolled children at "elevated" risk in the reporting period
<b>Oral Evaluations</b> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance, NQF Endorsed #2517</a>	Percentage of enrolled children who received a comprehensive or periodic oral evaluation within the reporting year	Unduplicated number of children under age 21 who received a comprehensive or periodic oral evaluation as a dental or oral health service	Unduplicated number of enrolled children under age 21 in the reporting period
<b>Topical Fluoride for Children at Elevated Caries Risk</b> Process measure evaluating quality of care	Percentage of enrolled children who are at "elevated" risk (i.e. "moderate" or "high") who received at least two topical fluoride	Unduplicated number of children age 1–21 years at "elevated" risk who received at least two topical fluoride applications	Unduplicated number of enrolled children age 1–21 years at "elevated" risk in the reporting period

<sup>1</sup> Depending on appropriate age bands.

Source: <a href="#">Dental Quality Alliance, NQF Endorsed #2528</a>	applications within the reporting year		
<b>Sealants for Children Age 6-9 at Elevated Risk</b> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance</a>	Percentage of enrolled children at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar within the reporting year	Unduplicated number of all enrolled children age 6–9 years at “elevated” risk who received a sealant on a permanent first molar	Unduplicated number of enrolled children age 6–9 years at “elevated” risk in the reporting period
<b>Sealants for 10–14 year-old Children at Elevated Risk</b> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance</a>	Percentage of enrolled children at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent second molar tooth within the reporting year	Unduplicated number of enrolled children age 10–14 years at “elevated” risk who received a sealant on a permanent second molar tooth as a dental service	Unduplicated number of enrolled children age 10–14 years at “elevated” risk in the reporting period
<b>Emergency Department (ED) Follow-up for Children with Non-Traumatic Dental Issues</b> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance, NQF #2695</a>	Percentage of non-traumatic dental issue-related ED visits among children in the reporting period for which the member visited a dentist within (a) 7 days; (b) 30 days; and, (c) 60 days <sup>2</sup> of the ED visit	Number of non-traumatic dental issue-related ED visits among children age 0-20 years in the reporting period for which the member visited a dentist within (a) 7 days; (b) 30 days; and, (c) 60 days of the ED visit	Number of non-traumatic dental issue-related ED visits among children age 0-20 years in the reporting period
<b>Caries Risk Documentation</b> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance</a>	Percentage of enrolled children who have caries risk documented in the reporting year <sup>3</sup>	Unduplicated number of children under age 21 with caries risk documented	Unduplicated number of enrolled children under age 21 in the reporting period
<b>Care Continuity<sup>4</sup></b> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance</a>	Percentage of all children enrolled for two consecutive years who received a comprehensive or periodic oral evaluation in both years	Unduplicated number of children who received a comprehensive or periodic oral evaluation as a dental service in both years	Unduplicated number of all children enrolled in two consecutive years

<sup>2</sup> Recommend adding 60 days to measurements collected.

<sup>3</sup> This measure is designed for use in quality improvement applications to support efforts around caries risk assessment and documentation. This measure is not designed to assess population health or to create population risk profiles.

<sup>4</sup> Recommended only as an Oregon Health Authority monitoring measure.

<b>Adult's Dental Metrics Set</b>			
<b>Metric Name and Stats</b>	<b>Description</b>	<b>Numerator</b>	<b>Denominator</b>
<b>Utilization of Services</b> Process measure evaluating utilization and access Source: <a href="#">Dental Quality Alliance, NQF #2511</a> (adapted child metric)	Percentage of all enrolled adults 21 years and older who received at least one dental or oral health service within the reporting year	Unduplicated number of adults who received at least one dental or oral health service	Unduplicated number of all enrolled adults in the reporting period
<b>Preventive Services for Adults at Elevated Caries Risk</b> Process measure evaluating utilization Source: <a href="#">Dental Quality Alliance</a> (adapted child metric)	Percentage of enrolled adults 21 years and older who are at “elevated” risk (i.e., “moderate” or “high”) who received a topical fluoride application and/or sealants within the reporting year	Unduplicated number of adults at “elevated” risk with one or more of the following CDT Codes in the reporting period <sup>5</sup> : D1110, D1120, D1206, D1208, D1351	Unduplicated number of enrolled adults at “elevated” risk in the reporting period
<b>Topical Fluoride for Adults at Elevated Caries Risk</b> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance</a>	Percentage of enrolled adults 18 years and older who are at “elevated” risk (i.e. “moderate” or “high”) who received at least two topical fluoride applications within the reporting year	Unduplicated number of adults at “elevated” risk who received at least two topical fluoride applications	Unduplicated number of enrolled adults at “elevated” risk in the reporting period
<b>Emergency Department (ED) Follow-up for Adult with Non-Traumatic Dental Issues</b> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance, NQF #2695</a> (adapted child metric)	Percentage of non-traumatic dental issue-related ED visits among adults 21 years and older in the reporting period for which the member visited a dentist within (a) 7 days; (b) 30 days; and, (c) 60 days <sup>6</sup> of the ED visit	Number of non-traumatic dental issue-related ED visits among adults in the reporting period for which the member visited a dentist within (a) 7 days; (b) 30 days; and, (c) 60 days of the ED visit	Number of non-traumatic dental issue-related ED visits among adults in the reporting period
<b>Care for Adults with Diabetes</b> Process measure evaluating utilization Source: <a href="#">Dental Quality Alliance</a> (adapted adult periodontitis metric)	Percentage of enrolled adults identified as having diabetes who received a comprehensive or periodic oral evaluation or a comprehensive	Unduplicated number of adults with one or more of the following CDT Codes in the reporting period: D1110, D1120, D4910, D4341, D4342, D4346, D4355	Unduplicated number of enrolled adults identified as having diabetes in the reporting period

<sup>5</sup> Depending on appropriate age bands.

<sup>6</sup> Recommend adding 60 days to measurements collected.

	periodontal evaluation within the reporting year		
<b>Caries Risk Documentation</b> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance</a> (adapted child metric)	Percentage of enrolled adults 21 years and older who have caries risk documented in the reporting year <sup>7</sup>	Unduplicated number of adults with caries risk documented	Unduplicated number of enrolled adults in the reporting period
<b>Care Continuity</b> <sup>8</sup> Process measure evaluating quality of care Source: <a href="#">Dental Quality Alliance</a> (adapted child metric)	Percentage of all adults enrolled for two consecutive years who received a comprehensive or periodic oral evaluation in both years	Unduplicated number of adults who received a comprehensive or periodic oral evaluation as a dental service in both years	Unduplicated number of all adults enrolled in two consecutive years

<sup>7</sup> This measure is designed for use in quality improvement applications to support efforts around caries risk assessment and documentation. This measure is not designed to assess population health or to create population risk profiles.

<sup>8</sup> Recommended only as an Oregon Health Authority monitoring measure.