2022 Updated HIT Roadmap

Guidance, Evaluation Criteria & Report Template

Contract or rule citation	Exhibit J, Section 2 d.
Deliverable due date	April 28, 2022 (extended from March 15, 2022)
Submit deliverable to:	CCO.MCODeliverableReports@dhsoha.state.or.us and cc: CCO.HealthIT@dhsoha.state.or.us

Guidance Document

Purpose & Background

Per the CCO 2.0 Contract, CCOs are required to maintain an Oregon Health Authority (OHA) approved Health Information Technology (HIT) Roadmap. The HIT Roadmap must describe how the CCO currently uses HIT and plans to use HIT to achieve desired outcomes and support contracted physical, behavioral, and oral health providers throughout the course of the Contract in the following areas:

- Electronic Health Record (EHR) adoption and use
- Access to Health Information Exchange (HIE) for Care Coordination
- Access to timely Hospital Event Notifications, as well as CCO use of Hospital Event Notifications
- HIT for Value-Based Payment (VBP) and Population Health Management (Contract Years 1 & 2 only)[1]
- **New requirement for 2022:** HIT to support social needs screening and referrals for addressing social determinants of health (SDOH) needs (Contract Years 3-5 only)[2]

For Contract Year One (2020), CCOs' responses to the HIT Questionnaire formed the basis of their draft HIT Roadmap. For Contract Years Two through Five (2021-2024), CCOs are required to submit an annual Updated HIT Roadmap to OHA reporting the progress made on the HIT Roadmap from the previous Contract Year, as well as plans, activities, and milestones detailing how they will support contracted providers in future Contract Years. OHA expects CCOs to use their approved 2021 Updated HIT Roadmap as foundation when completing their 2022 Updated HIT Roadmap.

Other changes for Contract Year Three (2022):

1. Within the *Support for EHR Adoption and Use: 2022-2024 Plans* section, CCOs are now required to include a description of their plans to collect missing EHR information via already-existing processes (e.g., contracting, credentialing, Letters of Interest).
2. Within the *Support for HIE – Care Coordination* and *Support for HIE – Hospital Event Notifications* sections, CCOs are now asked to include the number of organizations of each provider type that gained /are expected to gain increased access to HIE for Care Coordination and HIE for Hospital Event Notifications as a result of CCO support.
3. CCOs are now required to submit their HIT Data Reporting File with their Updated HIT Roadmaps. CCOs are expected to use available data to inform the HIT strategies described in their Updated HIT Roadmap. For example, if the data reveal that across its network, oral health providers have a low rate of EHR adoption, the CCO should leverage that information for strategic planning and relevant strategies should be detailed in the 2022 Updated HIT Roadmap.

Overview of Process

Each CCO shall submit its 2022 Updated HIT Roadmap to OHA for review on or before **April 28** of Contract Year Three[3], and **March 15** of Contract Years Four and Five. CCOs are to use the *2022 Updated HIT Roadmap Template* for completing this deliverable and are encouraged to copy and paste relevant content from their 2021 Updated HIT Roadmap if it's still applicable. Please submit the completed Updated HIT

[1] Starting in Contract Year 3 (2022), CCOs' VBP reporting will include their HIT efforts; therefore, this content will not be part of the HIT Roadmap moving forward.
[2] New HIT Roadmap requirement for Contract Year 3 (2022)
[3] Due date was extended from March 15, 2022, to April 28, 2022, in the memo dated January 10, 2022.

Roadmap to the CCO deliverables mailbox at CCO.MCODeliverableReports@dhsoha.state.or.us and cc: CCO.HealthIT@dhsoha.state.or.us.

OHA's Office of Health IT staff will review each CCO's Updated HIT Roadmap and send a written approval or a request for additional information. If immediate approval is not received, the CCO will be required to

1. Meet with OHA's Office of Health IT staff to discuss required revisions; and
2. Make revisions to their Updated HIT Roadmap and resubmit to OHA

The aim of this process is for CCOs and OHA to communicate to better understand how to achieve an approved Updated HIT Roadmap. Additional information about this process will be provided to any CCO that does not receive an immediate Updated HIT Roadmap approval from OHA.

Please refer to the timeline below for an outline of steps and action items related to the 2022 Updated HIT Roadmap submission and review process.

Updated HIT Roadmap Timeline

	April - July 2022	July - August 2022	August - October 2022
	Updated HIT Roadmap Submission and Review	**CCO/OHA Communication and Collaboration**	**CCO HIT Response Resubmission to OHA for Review**
Activities	**List of activities**	**List of activities**	**List of activities**
	CCOs submit completed Updated HIT Roadmap and HIT Data File to OHA by **4/28/22.**	If approved, no further action required of CCOs on HIT Roadmap for Contract Year 3.	CCO submits revised HIT responses to OHA for review by **9/20/22**.
	OHA reviews Updated HIT Roadmaps.	If not approved, CCO contacts OHA by **7/26/22** to schedule a meeting to discuss required revisions.	OHA reviews CCO's resubmitted HIT responses.
	OHA sends initial Updated HIT Roadmap result letter to CCO by **7/13/22.**	Collaborative meeting(s) occur between CCO and OHA by **8/23/22**.	OHA sends second Updated HIT Roadmap Review result letter to CCO by **10/21/22**.

OHA anticipates that all 12 organizations will have an approved 2022 Updated HIT Roadmap by 10/31/22.

Updated HIT Roadmap Approval Criteria

The table below contains evaluation criteria outlining OHA's expectations for responses to the required Updated HIT Roadmap questions. New requirements for Contract Year Three (2022) are in **bold italicized font**. Please review the table to better understand the content that must be addressed in each required response. Approval criteria for Updated HIT Roadmap optional questions are not included in this table; optional questions are for informational purposes only and do not impact the approval of an Updated HIT Roadmap. Additionally, the table below does not include the full version of each question, only an abbreviated version. Please refer to the *2022 Updated HIT Template* for the complete question when crafting your responses.

Updated HIT Roadmap Section	**Question(s) – Abbreviated (Please see report template for complete question)**	**Approval Criteria**
1. HIT Partnership	CCO attestation to the four areas of HIT Partnership.	CCO meets the following requirements: • Active, signed HIT Commons MOU and adheres to the terms • Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons Memorandum of Understanding (MOU) • Served, if elected on the HIT Commons governance board or one of its committees • Participated in an OHA's HITAG meeting at least once during the previous Contract Year
2. Support for EHR Adoption	A. 2021 Progress supporting increased rates of EHR adoption for contracted physical, oral, and behavioral health providers?	• Description of progress includes: ○ Strategies used to support increased rates of EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers in 2021 ○ Specific accomplishments and successes for 2021 related to supporting EHR adoption • Sufficient detail and clarity to establish that activities are meaningful and credible.
	B. 2022-2024 Plans for supporting increased rates of EHR adoption for contracted physical, oral, and behavioral health providers?	• Description of plans includes: ○ The number of organizations (by provider type) for which no EHR information is available (e.g., 10 physical health, 22 oral health, and 14 behavioral health organizations) ○ ***Plans for collecting missing EHR information via CCO already-existing processes*** ○ Additional strategies for 2022-2024 related to supporting increased rates of EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers ○ Specific activities and milestones for 2022-2024 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
3. Support for HIE – Care Coordination	A. 2021 Progress supporting increased access to HIE for Care Coordination	• Description of progress includes: ○ Specific HIE tools CCO supported or made available to support contracted physical, oral, and behavioral health providers' access to HIE for Care Coordination

Updated HIT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
	among contracted physical, oral, and behavioral health providers?	○ Strategies CCO used to support increased access to HIE for Care Coordination for contracted physical, oral, and behavioral health providers in 2021 ○ Specific accomplishments and successes for 2021 related to increasing access to HIE for Care Coordination ***(including number of organizations of each provider type that gained access to HIE for Care Coordination as a result of CCO support, as applicable)*** • Sufficient detail and clarity to establish that activities are meaningful and credible.
	B. 2022-2024 Plans for supporting increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers?	• Description of plans includes: ○ The number of organizations (by provider type) that have not adopted an HIE for care coordination tool (e.g., 18 physical health, 12 oral health, and 22 behavioral health organizations) ○ Additional HIE tools CCO plans to support or make available ○ Additional strategies for 2022-2024 related to supporting increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers ○ Specific activities and milestones for 2022-2024 related to each strategy ***(including the number of organizations of each provider type expected to gain access to HIE for Care Coordination as result of CCO support, if applicable)*** • Sufficient detail and clarity to establish that activities are meaningful and credible.
4. Support for HIE – Hospital Event Notifications (Progress)	A.1**.** 2021 Progress supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers?	• Description of progress includes: ○ Tool(s) CCO provided or made available to support providers' timely access to Hospital Event Notifications ○ Strategies used to support increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers in 2021 ○ Specific accomplishments and successes for 2021 related to supporting increased access to timely Hospital Event Notifications ***(including the number of organizations of each provider type that gained increased access to HIE for Hospital Event Notifications as a result of CCO support, as applicable)*** • Sufficient detail and clarity to establish that activities are meaningful and credible.

Updated HIT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
	A.2. 2021 Progress using timely Hospital Event Notifications within CCO's organization?	• Description of progress includes: ○ Tool(s) CCO is using within their organization for timely Hospital Event Notifications ○ Strategies used for timely Hospital Event Notifications within CCO's organization for 2021 ○ Specific accomplishments and successes for 2021 related to CCO's use of timely Hospital Event Notifications • Sufficient detail and clarity to establish that activities are meaningful and credible.
4. Support for HIE – Hospital Event Notifications (Plans)	B.1. 2022-2024 Plans for supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers?	• Description of plans includes: ○ The number of organizations (by provider type) that have not adopted an HIE for Hospital Event Notifications tool (e.g., 18 physical health, 12 oral health, and 22 behavioral health organizations) ○ Additional tool(s) CCO is planning to support or make available to providers for timely Hospital Event Notifications ○ Additional strategies for 2022-2024 related to supporting increased access to timely Hospital Event Notifications contracted physical, oral, and behavioral health providers in 2021 ○ Specific activities and milestones for 2022-2024 related to each strategy ***(including the number of organizations of each provider type expected to gain access to HIE for Hospital Event Notifications as a result of CCO support, as applicable)*** • Sufficient detail and clarity to establish that activities are meaningful and credible.
	B.2. 2022-2024 Plans using timely Hospital Event Notifications within CCO's organization?	• Description of plans includes: ○ Additional tool(s) (if any) CCO is planning to use for timely Hospital Event Notifications ○ Additional strategies for 2022-2024 to use timely Hospital Event Notifications within the CCO's organization ○ Specific activities and milestones for 2022-2024 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible
5. HIT to support social needs screening and referrals for addressing social determinants of	A.1. 2021 Progress using HIT to support social needs screening and referrals addressing SDOH needs?	• ***Description of progress includes:*** ○ ***Current tool(s) CCO is using for social needs screening and referrals.*** ○ ***Strategies for using HIT to support social needs screening and referrals in 2021*** ○ ***Any accomplishments and successes for 2021 related to each strategy*** • ***Sufficient detail and clarity to establish that activities are meaningful and credible.***

Updated HIT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
health needs (Progress)	A.2. 2021 Progress supporting contracted physical, oral, and behavioral health providers, social services, and CBOs with using HIT to support social needs screening and referrals for addressing SDOH needs?	• ***Description of progress includes:*** ○ ***Tool(s) CCO supported or made available to contracted physical, oral, and behavioral health providers, social services, and CBOs, for social needs screening and referrals for addressing SDOH needs for, including a description of whether the tool(s) have closed-loop referral functionality*** ○ ***Strategies used for supporting these groups with using HIT to support social needs screening and referrals in 2021*** ○ ***Any accomplishments and successes for 2021 related to each strategy*** • ***Sufficient detail and clarity to establish that activities are meaningful and credible***
5. HIT to support social needs screening and referrals for addressing social determinants of health needs (Plans)	B.1. 2022-2024 Plans for using HIT to support social needs screening and referrals for addressing SDOH needs?	• ***Description of plans includes:*** ○ ***Tool(s) CCO will use for social needs screening and referrals for addressing SDOH needs, including a description of whether the tool(s) will have closed-loop referral functionality*** ○ ***Additional strategies planned for social needs screening and referrals for addressing SDOH needs*** ○ ***Specific activities and milestones for 2022-2024 related to each strategy*** • ***Sufficient detail and clarity to establish that activities are meaningful and credible.***
	B.2. 2022-2024 Plans supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs, with using HIT to support social needs screening and referrals for addressing SDOH needs?	• ***Description of progress includes:*** ○ ***Tool(s) CCO is planning to support/make available to contracted physical, oral, and behavioral health providers, social services, and CBOs for social needs screening and referrals for addressing SDOH needs, including a description of whether the tool(s) will have closed-loop referral functionality*** ○ ***Additional strategies planned for supporting these groups with using HIT to support social needs screening and referrals beyond 2021*** ○ ***Specific activities and milestones for 2022-2024 related to each strategy*** • ***Sufficient detail and clarity to establish that activities are meaningful and credible.***

2022 Updated HIT Roadmap Template

Please complete and submit to CCO.MCODeliverableReports@dhsoha.state.or.us and cc: CCO.HealthIT@dhsoha.state.or.us by **April 28, 2022.**

CCO: Add your text

Date: Click or tap to enter a date.

Instructions & Expectations

Please respond to all of the required questions included in the following Updated HIT Roadmap Template using the blank spaces below each question. Topics and specific questions where responses are not required are labeled as optional. The template includes questions across the following six topics:

1. HIT Partnership
2. Support for EHR Adoption
3. Support for HIE – Care Coordination
4. Support for HIE – Hospital Event Notifications
5. HIT to Support Social Needs Screening and Referrals for Addressing SDOH Needs
6. Other HIT Questions (optional section)

Each required topic includes the following:

- Narrative sections to describe your **2021 progress, strategies, accomplishments/successes, and barriers**
- Narrative sections to describe your **2022-2024 plans, strategies, and related activities and milestones**. For the activities and milestones, you may structure the response using bullet points or tables to help clarify the sequence and timing of planned activities and milestones. These can be listed along with the narrative; it is not required that you attach a separate document outlining your planned activities and milestones. However, you may attach your own document(s) in place of filling in the activities and milestones sections of the template (as long as the attached document clearly describes activities and milestones for each strategy and specifies the corresponding Contract Year).

Narrative responses should be concise and specific to how your efforts support the relevant HIT area. OHA is interested in hearing about your progress, successes, and plans for supporting providers with HIT, as well as any challenges/barriers experienced, and how OHA may be helpful. CCOs are expected to support physical, behavioral, and oral health providers with adoption of and access to HIT. That said, CCOs' Updated HIT Roadmaps and plans should

- be informed by the OHA-provided HIT Data Reporting File,
- be strategic, and activities may focus on supporting specific provider types or specific use cases, and
- include specific activities and milestones to demonstrate the steps CCOs expect to take.

OHA also understands that the HIT environment evolves and changes, and that plans from one year may change to the next. For the purposes of the Updated HIT Roadmap responses, the following definitions should be considered when completing responses.

Strategies: CCO's approaches and plans to achieve outcomes and support providers.

Accomplishments/successes: Positive, tangible outcomes resulting from CCO's strategies for supporting providers.

Activities: Incremental, tangible actions CCO will take as part of the overall strategy.

Milestones: Significant outcomes of activities or other major developments in CCO's overall strategy, with indication of when the outcome or development will occur (e.g., Q1 2022). **Note**: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.

A note about the template*:*

This template has been created to help clarify the information OHA is seeking in each CCO's Updated HIT Roadmap. The following questions are based on the CCO Contract and HIT Questionnaire (RFA Attachment 9); however, in order to help reduce redundancies in CCO reporting to OHA and target key CCO HIT information, certain questions from the original HIT Questionnaire have not been included in the Updated HIT Roadmap template. Additionally, at the end of this document, some example responses have been provided to help clarify OHA's expectations on the level of detail for reporting progress and plans.

New for *2022 Updated HIT Roadmap Template*

To further help CCOs think about their HIT strategies as they craft responses for their 2022 Updated HIT Roadmap, OHA has added checkboxes to the template that may pertain to CCOs' efforts in the following areas:

- *Support for EHR Adoption*
- *Support for HIE – Care Coordination*
- *Support for HIE – Hospital Event Notifications*

The checkboxes represent themes that OHA has compiled from strategies listed in CCOs' 2021 Updated HIT Roadmaps.

Please note, the strategies included in the checkboxes do not represent an exhaustive list, nor do they represent strategies CCOs are required to implement. It is not OHA's expectation that CCOs implement all of these strategies or limit their strategies to those included in the template. OHA recognizes that each CCO implements different strategies that best serve the needs of their providers and members. The checkboxes are in the template to assist CCOs as they respond to questions and to assist OHA with the review and summarizing of strategies.

Please send questions about the Updated HIT Roadmap template to CCO.HealthIT@dhsoha.state.or.us

1. HIT Partnership

Please attest to the following items.

a.	☒Yes ☐No	Active, signed HIT Commons MOU and adheres to the terms.
b.	☒Yes ☐No	Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU.
c.	☒Yes ☐No ☐N/A	Served, if elected, on the HIT Commons governance board or one of its committees. (Select N/A if CCO does not have a representative on the board or one of its committees)
d.	☒Yes ☐No	Participated in an OHA HITAG meeting, at least once during the previous Contract year.

2. Support for EHR Adoption

A. 2021 Progress

Please describe your progress supporting increased rates of EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select the boxes that represent strategies pertaining to your 2021 progress.
2. Describe the progress of each strategy in the appropriate narrative sections.
3. In the descriptions, include any accomplishments and successes related to your strategies.

Note: If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.

Overall Progress
Using the boxes below, please select which strategies you employed during 2021. Elaborate on each strategy and the progress made in the sections below.

☒ EHR training and/or technical assistance	☐ Financial support for EHR implementation or maintenance
☒ Assessment/tracking of EHR adoption and capabilities	☒ Requirements in contracts/provider agreements
☐ Outreach and education about the value of EHR adoption/use	☒ Leveraging HIE programs and tools in a way that promotes EHR adoption
☒ Collaboration with network partners	☐ Offer hosted EHR product
☒ Incentives to adopt and/or use EHR	☐ Other strategies for supporting EHR adoption (please list here)

i. Progress across provider types

Current Landscape: **Physical health:**
The majority of our physical health providers have adopted Epic through our hospital partners (Providence Seaside, Legacy St Helens and OHSU Scappoose), except for Columbia Memorial Hospital and Adventist Tillamook/Vernonia

who are on Cerner. Yakima Valley Farmworker's Clinic operates FQHCs, Coastal and Clatskanie clinics, and are on their own version of EPIC. Tillamook County Health Department, Rinehart Clinic, Columbia Health Services, and our school-based clinics, are all on OCHIN EPIC.

Ninety-three percent of our members are assigned to tier-3 or higher PCPCH clinics with certified EHRs; therefore, a small percent of our members are served by clinics using non-certified EHRs or paper charts. With significant efforts in the past by OHA, hospital systems and CCOs to support EHR adoption through resourcing and technical assistance, the resistance by the few clinics that have not adopted certified EHRs is not due to lack of resourcing. In the near term, we will continue to work with these providers to encourage EHR adoption. However, given that there is limited provider availability in some of our rural communities, we have to balance the desire to attain 100% EHR adoption with the need to maintain an adequate network of high-quality providers to serve our members. We therefore have not moved forward with reassignment.

Behavioral health
The primary behavioral health partners for CPCCO are Columbia Community Mental Health Center, Clatsop Behavioral Healthcare, Tillamook Family Counseling Center, and CODA's Seaside Recover Center. Together they, along with our Primary Care network, provide more than 90% of the outpatient behavioral health services to our members. All the behavioral health providers mentioned above are on certified EHRs. CPCCO also contracts with a small number of behavioral health specialists, most of whom are not on certified EHRs. It was our intention in 2021 to assess their interest in EHR adoption but the pandemic and subsequent behavioral health workforce crisis led us to deprioritize this work. We will assess their interest in adoption of certified EHRs once the network has stabilized.

Oral health
Based on a survey conducted in 2021 with our dental partners, all contracted dentists are on an EHR (n = 12). The EHR systems the dentists use include: Dentirx, Epic, Open Dental, Daisy and AxiUm.

Across provider types, given that such a small percent of our members are served by clinics without an EHR, we have adjusted our focus from EHR adoption to EHR optimization support through workflow and process improvement technical assistance. We will align this work with our transformation priorities and in areas that provide value to our provider partners without creating unnecessary additional burdens or contributing to clinician burn-out.

The strategies you used to support EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers in 2021 AND Accomplishments and successes related to your strategies:

Our key strategies

- Strategy 1 – Develop an overall Health Information Technology Strategy, that broadens our current HIT plan
- Strategy 2 - Continue to support adoption and optimization through technical assistance, financial incentives and care coordination processes
- Strategy 3- EHR support related to telemedicine

Strategy 1 – HIT Strategy

The CareOregon Quality and Health Outcomes Steering Committee (COQHO) guides the enterprise-wide quality and health outcomes structure and population health framework that determines cross-departmental, cross regional and benefit-related clinical quality improvement strategies and initiatives. COQHO achieves its objectives through ensuring that clinical strategies and improvement efforts are prioritized, resources are appropriate, barriers are addressed, and work moves forward.

To advance the imperative to bring value and improve health by supporting further adoption and spread of health information technology, COQHO has chartered a HIT subcommittee that will guide the development and

implementation of the HIT strategies and activities to support COQHO's clinical vision. This multidisciplinary committee is responsible for overseeing the enterprise and regional-level Five-Year HIT Roadmap. The intention of the committee is to advise on the development of an overarching HIT strategy to guide the HIT related initiatives in all CareOregon lines of business and regions, including EHR adoption, barriers, and incentives. Portions of the workplan focused on better understanding adoption are summarized below.

In 2021 we developed plans to survey the remaining network providers that we did not have EHR information for in 2020, but due to COVID-19 there was a significant shift in our priorities from focusing on broader EHR adoption to helping providers adapt their operations to serve members virtually, including adoption of telehealth technologies and supports. Future efforts to resume data collection will be guided by the COQHO HIT Subcommittee as described above in 2022. Activities common across provider types include:

- Understanding the specific adoption barriers experienced by our providers
- Identifying priority providers for increasing EHR adoption
- Performing a detailed gap assessment for our prioritized providers
- Continuing to identify opportunities through our Innovation Specialist team to help clinic partners modify their operations and optimize use of EHRs to support telehealth visits and increase general efficiencies
- Working within our HIT governance model to define the support and incentives that can be offered either by CareOregon, Health Share or our partners.

Our primary focus continues to be driven by needs arising from the COVID-19 pandemic. Previously scheduled projects have been shifted to meet new business needs ensuring quality service and care of our members in this altered environment. Even though we are entering into a "new phase" of COVID, our network and members are still feeling the grave impact of the pandemic.

Key successes include:

- Engaged in statewide EHR survey effort(s) underway at OHA, using the common survey tool provided
- Offered technical assistance and support to hundreds of practices that implemented telehealth services
- Developed a Telehealth Toolkit, provided practice coaching, and hosted collaboratives to help clinic partners modify operations, including workflows to support telehealth visits.

Strategy 2 - Continue to support and encourage EHR adoption and optimization

In 2021, CPCCO continued to encourage improved use of EHRs through our technical assistance, financial incentives (e.g. PCPCH payment program) and care coordination:

- **Technical assistance/practice coaching:** Through our team of Innovation Specialists, CPCCO provides technical assistance / practice coaching to our provider network partners to support various clinic and system transformation goals. This includes identifying opportunities to use their EHRs more meaningfully to improve workflows, support CCO Quality Metric documentation, and support Value Based Payment performance.

Here are some of the ways we have helped our network providers improve the use of their EHRs:

- Optimizing documentation of clinical quality metrics in EHRs
- Data reporting capabilities (pulling reports)
- Referral documentation, reporting and closing loops
- "Dot phrases" (time-saving macros) for EHR efficiencies (Adolescent well check, depression, SBIRT, adverse childhood experiences)

- **Financial Incentives:** CPCCO employs a variety of financial incentives that encourage improved EHR use. These include:

- Quality Pool Distribution – CPCCO partners with our clinical providers in achieving the OHA CCO Incentive Metrics. Many of these metrics require documentation and reporting of clinical information. Increased quality pool payout is reserved for organizations that are able to pull and submit data from their EHR.
- Clinic designation. CPCCO has developed financial incentives to encourage organizations to achieve greater levels of organizational designation (e.g., Tier 3 PCPCH). The designations require increased levels of EHR functionality.
- Value-based payment: CPCCO engages with our providers in value-based payment arrangements, including a county-based total cost of care model. EHRs are important tools for promoting workflows and providing information necessary to achieve the desired financial and clinical quality results encouraged by our VBP arrangements.

- **Care coordination**: CPCCO's Regional Care Teams incorporate the use of provider EHRs into regular interdisciplinary care coordination and case conference meetings that include health professionals from primary, behavioral health and oral health organizations. Participants bring laptops and actively work within their agencies' EHRs to create and maintain consistent documentation across care settings. CPCCO also embeds panel coordinators within clinics, who have access to the EHR, and can help with efficiencies, documentation, outreach and coordination.

To further support care coordination, CPCCO has implemented a robust care coordination platform (Medecision) and developed interfaces between it and our data warehouse (EDW). Medecision delivers a care plan to our provider web portal and delivers secure messages directly to the provider's EHRs. This messaging further streamlines workflow and encourages use of EHRs.

Strategy 3- EHR support related to telemedicine

Although we continued to support the activities above, our priorities shifted to focus on helping our clinic partners optimize their operations to serve our members within the constraints created by COVID-19. Our Innovation Specialist Teams developed a Telehealth Toolkit, provided individual 1:1 practice coaching, and hosted network partner convenings to help our clinic partners modify their operations, including workflows tied to their EHRs to support telehealth visits. (Additional information about support for telehealth in HIE Section).

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ii. Additional progress specific to physical health providers

See Progress Across Provider Types

iii. Additional progress specific to oral health providers

CareOregon partnered with its dental plans and surveyed its dental provider network at the end of 2021. Of the 12 dental clinics surveyed in the region, we found:

- 12 (100%) are using an EHR

CareOregon will work to optimize use by providers through workflow and process improvement technical assistance. We will align this work with our transformation priorities and in areas that provide value to our provider partners without creating unnecessary additional burdens or contributing to clinician burn-out.
Currently, the most commonly used EHR's are:

- Daisy – 4 clinics
- Dentrix – 3 clinics
- axiUm – 2 clinics

iv. Additional progress specific to behavioral health providers

The crises of COVID and workforce shortages has hampered abilities to focus specifically on EHR adoption amongst behavioral health agencies. Rather, in 2021, technological supports to BH providers was focused on adopting and leveraging the use of Collective to enhance system-wide care coordination efforts and to support vaccination efforts amongst BH populations. In partnership with Collective and the Oregon Health Leadership Council, CareOregon supported its network of Metro SUD providers to onboard to the Collective Platform and to upskill/further support existing users of the platform. In addition to the general upskilling and onboarding of BH providers to the platform, there was additionally a focused effort on increasing use of the vaccine status information to support vaccination efforts amongst members with mental health and substance use disorders. The Collective Vaccine Status Report, and later Patient Profile tag was created as a response, and Collective worked in conjunction with our CareOregon team to ensure that it was available to our Behavior Health Partners. This report allowed targeted and specific outreach strategies for Members who access Mental Health and Substance Use services.

v. Please describe any barriers that inhibited your progress

As mentioned above, many of our clinic providers were focused on 'keeping their doors open' given changes in revenue and increases in costs associated with adapting their organizations to respond to COVID-19. This has continued throughout 2021 and into 2022 due to workforce shortages. These shortages are particularly acute for our Behavioral Health partners and for partners' ability to hire medical assistants.

Further barriers less related to COVID is our need to maintain and adequate network. As noted above, despite multiple attempts over many years to support certain smaller clinics to adopt an EHR, there has been some resistance, and we have not been successful in getting 100 percent of our membership to be assigned to organizations with an EHR. Because of geography, and the limited number of organizations in our region, we have not been able to reassign.

Key barriers include:

- Timing of OHA EHR survey competing with other network priorities
- Perceiving gaps in data as actual lack of adoption
- Collecting information in a non-burdensome/administrative way
- Balancing competing network priorities/asks
- Clinic cost and staff resource for implementation

B. 2022-2024 Plans

Please describe your plans for supporting increased rates of EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select the boxes that represent strategies pertaining to your 2022-2024 plans.
2. Describe the following in the appropriate narrative sections:
    a. The number of physical, oral, and behavioral health organizations without EHR information using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.
    b. Plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialling, Letters of Interest).
    c. Strategies you will use to support increased rates of EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers beyond 2021.
    d. Activities and milestones related to each strategy.

Notes: Strategies described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting

the strategy; however, please make note of these strategies in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2022-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and include activities and milestones in the sections below.

☒ EHR training and/or technical assistance	☐ Financial support for EHR implementation or maintenance
☒ Assessment/tracking of EHR adoption and capabilities	☐ Requirements in contracts/provider agreements
☐ Outreach and education about the value of EHR adoption/use	☒ Leveraging HIE programs and tools in a way that promotes EHR adoption
☒ Collaboration with network partners	☐ Offer hosted EHR product
☐ Incentives to adopt and/or use EHR	☐ Other strategies for supporting EHR adoption (please list here)

i. Plans across provider types, including activities & milestones

1. OHA provided the following information on the CPCCO HIT Data File

Service Type	**# of organizations** (denominator)	**EHR adoption**	
		Org count	**Rate**
Physical	23	20	87%
Behavioral	7	6	86%%
Oral	6	6	100%

CPCCO contracts with CareOregon for its entire provider network to ensure members have access to a broad network of providers. The numbers above represent information for providers across three different CCO regions. CPCCO has conducted surveys to augment this information and to better understand the EHR adoption rate for providers primarily serving our members within the CPCCO's service area. We will use our current understanding of our market (highlighted above), OHA's data and future survey results to inform our EHR strategies and plans. We will work with OHA and other CareOregon affiliated CCO's to better understand the data and address the discrepancies.

2. Additional strategies you will use to support increased rates of EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers beyond 2020 AND Associated activities and milestones related to each strategy

Strategy 1 – Refine 5-Year HIT Plan (EHR elements)

Activities	**Milestones and/or Contract Year**

Evolve governance structure to align to CareOregon and CPCCO structure, and ensure provider and network input (e.g., via Clinical Advisory Panel (CAP) or subcommittee of CPCCO's Board)	Q3-Q4 2021, and Q1-2 2022
Conduct further assessment of EHR use by provider type (e.g., other physical health, behavioral health, dental, etc.) to augment existing information from OHA, CareOregon, and CPCCO	Q2-Q3 2021
Define the current state and anticipated future EHR capabilities needed to further CPCCO's health system transformation and quality improvement goals. At a minimum, we will consider EHR functionality for physical, behavioral and oral health to support: • data collection and reporting on existing and new metrics, as well as registries to improve population health • data interoperability, blending EHR data with claims for a more robust population health picture • accurate coding • recording of screenings and other preventive services • integration between behavioral and oral health services in the primary care setting • cross-system care coordination, including coordination with community-based organizations providing social services • provision of services both in-person and virtually (via phone or telehealth) • Improved access to health information for members through patient portals	Q3 2022
Finalize updated HIT Strategy and Plan	Q4 2022
Board or CAP approves revised 5-Year HIT Plan	Q4 2022
Launch any new initiatives to further EHR adoption/optimization	Q1-4 2023
Next stage of spread in current efforts	Q1-Q4 2023
Spread best practices	2023-2024
Assess ROI - deepen implementation of HIT and elimination of HIT services that do not support existing priorities and support value. Adjust resources and refine practices	2023-2024

ii. Additional plans specific to physical health providers, including activities & milestones

See Strategies Across Provider Types

- Surveying the PH Specialty network in Q1 2023

iii. Additional plans specific to oral health providers, including activities & milestones

See Plans across provider types

- Re-surveying the oral health network in Q4 2022.

iv. Additional plans specific to behavioral health providers, including activities & milestones

In 2022, CPCCO will be: • Surveying remaining BH network partners that we do not have EHR information for in Q4 2022 • Partnering with stakeholders to educate behavioral health providers on how organizations can and have addressed barriers to adoption • Incorporating patient privacy into our HIE strategy to address concerns • Supporting OHA sponsored activities, such as the Behavioral Health Information Sharing Advisory Group • Collaborating with the Alliance of Culturally Specific Providers on developing VBP mechanisms that may support adoption and/or enhanced use of EHRs	Q2-Q4 2022

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with EHR adoption?
The only thing that we believe will push those clinics still using paper charts or non-certified EHRs would be for OHA to require EHR adoption of certified EHRs for all clinical practices and include incentives for smaller organizations to do so. We also believe we should collectively move away from focusing on adoption, to focusing on optimization of EHR utilization.

3. Support for HIE – Care Coordination

A. 2021 Progress

Please describe your progress supporting increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select the boxes that represent strategies pertaining to your 2021 progress
2. Describe the following in the appropriate narrative sections
    a. Specific HIE tools you supported or made available in 2021
    b. The strategies you used to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers in 2021
    c. Accomplishments and successes related to your strategies (Please include the number of organizations of each provider type that gained access to HIE for Care Coordination as a result of your support, as applicable).

Note: If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.

Overall Progress
Using the boxes below, please select which strategies you employed during 2021. Elaborate on each strategy and the progress made in the sections below.

☒ HIE training and/or technical assistance	☒ Financially supporting HIE tools, offering incentives to adopt or use HIE, and/or covering costs of HIE onboarding
☐ Assessment/tracking of HIE adoption and capabilities	☐ Offer hosted EHR product (that allows for sharing information between clinics using the shared EHR and/or connection to HIE)
☐ Outreach and education about value of HIE	☐ Other strategies that address requirements related to federal interoperability and patient access final rules (please list here)
☒ Collaboration with network partners	☐ Other strategies for supporting HIE access or use (please list here)
☐ Enhancements to HIE tools (e.g., adding new functionality or data sources)	
☐ Integration of disparate information and/or tools with HIE	
☐ Requirements in contracts/provider agreements	

i. Progress across provider types, including specific HIE tools supported/made available

Specific Tools you supported or made available in 2021

In 2021 our CCO and clinic partners leveraged a wide variety of health information exchange tools and other HIT platforms that support care coordination. We put these to action in supporting our network and membership regarding COVID-19. Below is a list of platforms currently supported by our CCO and in use by us and our network.

Collective Platform (FKA PreManage) - CPCCO continues to support the spread of the Collective Platform in our region. The tool supports care coordination among providers, and between providers and our CCO through real-time event communication as well as a shared care plan. We use Collective to identify members who would benefit from mini multidisciplinary case conferences that include internal care coordination team members and external network partners such as primary care, behavioral health, and community paramedicine. We also use information on recent hospital utilization to facilitate care coordination discussions and develop a shared, collaborative care plan for the member.

Epic Care Everywhere - The majority of contracted physical health providers in our service area are on Epic, including the hospital systems, FQHCs, rural health clinics and our school-based health centers. This allows providers in our community to communicate directly through Epic or through "look in" functionality through Epic's Care Everywhere, which provides clinical data for providers who use Epic and other affiliated electronic health systems.

EDIE - All hospitals in our service area have adopted EDIE, which is an HIE tool that provides real time alerts to emergency departments, identifying patients who are frequent utilizers of the emergency department or have had an inpatient admission in a 12-month period. EDIE allows for additional flexibility in setting up proactive identification of high-risk patients, such as those with rare diseases or unique care plans that require strict adherence for the safety of the patient.

CPCCO Provider Portal – The CPCCO provider portal supports referrals among primary care and dental plan partners. Through our provider portal, physical health providers can request dental service in the portal where our providers submit prior authorization requests. CPCCO has provided technical assistance to physical health providers and their teams to integrate the workflow into their clinic's care coordination processes. We also track utilization data to identify opportunities for improvement.

Medecision - Care Coordination Platform - CPCCO uses a robust Care Coordination Platform that has dramatically increased our efficiency in care coordination. The platform provides greater access to comprehensive assessments, uses standardized workflows to improve efficiency and avoid errors, and allows the CPCCO Regional Care Team (RCT) to work from a common care plan. The platform delivers a care plan to the provider portal so the provider is aware of what is happening for the member, and we are able to deliver secure messages directly to EHRs (when authorized). For those providers without secure messaging, CPCCO uses the provider portal to communicate the care plan and we will generate a care plan via Collective for members with acute needs.

Secure Messaging - In addition to Collective, our CPCCO Regional Care Team communicates with providers using Secure messaging through their email and directly from our Care Coordination platform.

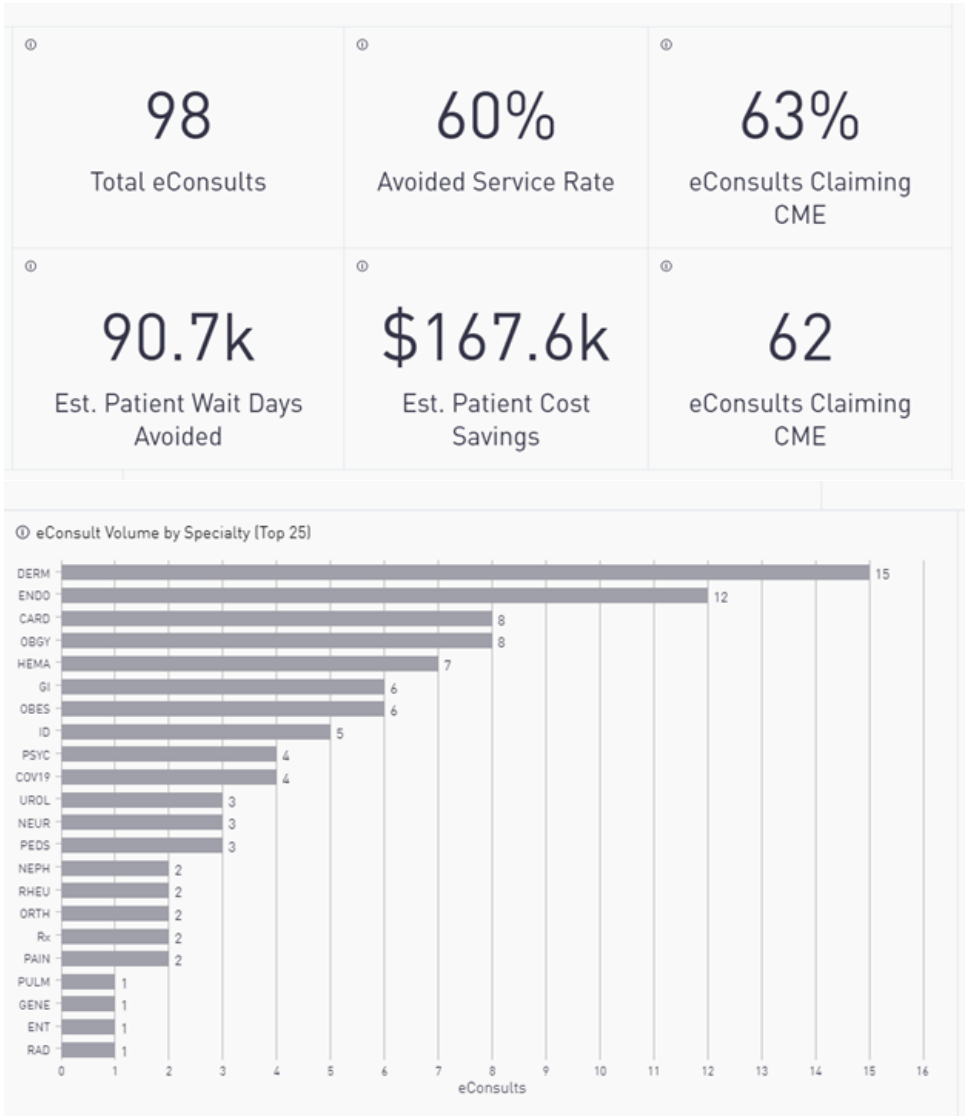
Telehealth –CPCCO actively supports telemedicine across all provider types. Before COVID, we primarily supported use of telehealth in the behavioral health setting to provide psychiatry support and coordinate care with providers outside of our service area. However, with many barriers to telehealth being eliminated in response to COVID, CPCCO saw enormous potential to continue and increase access to virtual care, particularly in our rural communities with limited specialty providers, and geographic barriers to access.

BlockIt—CPCCO provided funding for Tillamook and Columbia Counties' Public Health Departments to utilize BlockIt, a centralized scheduling platform, to support their local vaccination efforts. This platform allowed for a centralized scheduling process that enabled community residents to schedule vaccination appointments with a variety of local physical health partners.

In addition, we offer products to enhance clinician's ability to expand access to care, and improve quality for patients by additional clinics supports through the following platforms:

E-consults through RubiconMD - RubiconMD is an e-consult platform that providers use to consult with a national network of board-certified specialists for guidance on diagnosis workups, and treatment advice options. The platform can be integrated with EHRs and clinical workflows. To expand our provider capabilities for specialty referral and consultation, CPCCO has negotiated licenses for providers to access this service without charge. We hope this allows every patient to get the care they deserve regardless of affiliation with CPCCO. In addition, Rubicon provides up to 20 hours of CME for completed consults, 0.5 hours of continuing medical education (CME) per consult. We view this as an upskilling tool for our providers to effectively manage patient needs, while simultaneously using technology to expand the services patients can receive. Below is a snapshot of use from two of our providers:

Tillamook County Community Health Center



Columbia Health Services

Project ECHO- **Project ECHO**- CPCCO currently supports and has funded providers to participate in Project ECHO which provides telementoring where expert teams lead virtual clinics. This peer-based learning platform that has shown significant effectiveness in upskilling providers on complex medical and behavioral health topics. CPCCO's Medical Director currently serves on the ECHO Advisory Board.

Strategy 1: Refine 5 year HIT Plan

We created the governance structure and elements of our overarching Health Information Technology plan (that includes HIE) described in the EHR section above.

Strategy 2: Support and expand existing technology solutions that provide timely information to members

- CPCCO and CareOregon developed a comprehensive plan to improve our member communication strategies and tools. In Q4 2020, we implemented a new telephonic system. NICE in Contact CXone is a state-of-the-art cloud contact center platform which now provides CPCCO/CareOregon with enhanced performance, reliability, and fault tolerance. Additionally, it provides improved tools for customer experience, reporting and team management.
- We increased utilization and availability of smart and flips phones that could be sent to clinics for members' use or sent to individuals directly upon request.

- We piloted a program to provide members who are dually eligible with Smartphones to allow them to complete their Annual Wellness visits virtually.
- In order to support our care coordination and outreach efforts, we launched a targeted texting initiative to our highest risk members to encourage COVID-19 vaccination, as well as to offer navigation supports. We are exploring ways to more broadly text members, but due to current legalities, were not able to in 2021.

Strategy 3: Integrate health information across disciplines and between clinical and community entities by supporting increased use of existing platforms and implementing new ones

A. Collective (formally known as PreManage & EDIE) – Expanded use of Collective for care coordination

- In 2021, we updated our care coordination documentation platform (Medecision) to receive Admit, Discharge and transfer (ADT) data, which includes Admit, Discharge, and Transfer notifications from Collective in real time. This data feed supports our case management and care coordination activities and workflows. All active Regional Care Team (RCT) clients who have an inpatient discharge are enrolled into our transition of care program. By adding the ADT data feed into Medecision, these notifications are pushed in real-time to our regional care team staff.
- Integration of Medecision,Collective data, and claim data within our Enterprise Data Warehouse provides our teams with an ability to look 'across' benefits (PH, BH, and Dental) for a given member or population.
- We developed targeted cohorts in the Collective platform to identify priority populations that were experiencing adverse impacts of COVID-related care restrictions. Such cohorts included members with a possible overdose event and members struggling to manage their diabetes. These cohortsohorts directly map to a workflow for identification and follow up and then targeted programs and/or interventions.
- We developed cohorts within Collective to identify members who were experiencing COVID-like symptoms and a cohort to identify confirmed COVID positive members. These cohorts helped inform our COVID positive, post-hospital discharge program aimed to wrap services around those who needed to be quarantined away from family and friends. Our objective was to reduce transmission of the virus by providing temporary housing accommodations at local hotels and coordinating services to ensure food and medications were available to members requiring quarantine.
- We worked with OHLC and our hospital system partners to add a flag within Collective to identify members who tested positive with COVID.
- We included language in our hospital contracts that set expectations for use of Collective via contribution of content via Care Insights.
- Our Innovation Specialist team developed an internal, CPCCO facing, dashboard to help us to track network engagement with the Collective platform. This dashboard informs internal strategies to increase network monitoring, improve engagement, and identify opportunities for optimization.

B. CPCCO Portal – supporting communication between CPCCO and providers via our Provider portal

In 2020, via our provider portal, we improved the referral process between primary care our dental plan partners. Through our provider portal, physical health providers can request the member's dental plan reach out to the member to schedule a dental appointment in the same online portal where our providers submit prior authorization requests. CPCCO continues to provide technical assistance and support to physical health providers and their teams to integrate the workflow into their clinic's care coordination processes. In 2020, 29 CPCCO members were referred for

dental coordination by six organizations. In 2021, 46 members were referred by eight organizations – a 59 percent increase in members referred by a third more organizations.

C. Connect Oregon (Unite Us) – supporting coordination of services and close loop referrals between health care provider and social support organizations

We began implementing a tool that allows us to capture and share social health information and service referrals. (See details related to Connect Oregon/Unite Us in section 5 - Health IT and Social Determinants of Health and Health Equity)

D. Medecision – Expanded use of Medecision for care coordination

- We implemented improvements to Medecision that increased our efficiency. The platform has given us greater access to comprehensive assessments and integrated care planning. It allows our Regional Care Team to work off of one common care plan for each member. Care Plans are pushed to Collective and to the Provider Portal for increased coordination across the Member's Care/Treatment Team. Care Coordination staff also receive notification alerts of hospital admits allowing for quick follow-up and responsiveness.
- We uploaded a list of Provider Eligibility Resource Codes (PERC) to member profiles that may be attached to a prioritized population such as Foster Care, Long Term Services and Supports, and Member's deemed ICC Eligible. This allows our Regional Care Teams to proactively engage members into care coordination and prioritize referrals if needed.

E. System to Support Transitions of Care

We continue to support transitions of care for members who change CCOs by exchanging authorizations and care plans to and from any CCO statewide.

F. FIDO:

We are expanding content and access to FIDO, CareOregon's data platform, including:

- Scorecards and quality metric data (PCP only)
- Member profile data including claims history (PCP only)
- Planned expansion to PDPs and DCOs for 2022
- Exploring expansion to BH providers for 2023

Strategy 4: Support the use of health IT to expand access and quality to services in rural areas

Telehealth

In 2021, CPCCO continued to support the expansion of telemedicine through changes in our payment policies and targeted grants. Our Innovation Specialists provided technical assistance and support to allow clinics to provide access to services remotely through; 1) 1:1 provider outreach and support, 2) dissemination of written guidance/materials, and 3) virtual provider meetings. We assessed our network partners to understand and assist with telehealth implementation, staffing concerns, access issues, and other needs related to COVID-19. Network responses informed what we developed in terms of TA materials.

Based on needs expressed, the CPCCO Innovation Specialist team collated and shared information on:

- Video platform vendors information
- Implementation of video platforms

- Integration of video visits into workflows
- Guidance on best practices for using video capabilities
- Processes/criteria for determining need for video visit vs. other telemedicine/telehealth option

We also:

- Addressed third party interpreter services in telehealth. The team developed additional information in the topic areas of video visit platforms information, workflow integration, and video visit etiquette to align our TA resources and messaging to the provider network and the interpreter network regarding telehealth modalities and access.
- Offered 1:1 TA support around operational and administrative questions about telehealth, including the CPCCO telehealth coding guidance and FAQ documents posted on our provider website.
- Provided immediate grants to support the purchases of the infrastructure needed for telehealth services, such as laptops. These grants were made available to all CPCCO's network along with our regional social safety net providers.

B. **Other technology that support virtual consultation and learning**

- Rubicon – In 2021 we continued to offer e-consultation through the Rubicon platform.
- ECHO - In 2021 the CPCCO medical director participated in the OHA ECHO on COVID. The CPCCO Medical Director also sits on the Oregon ECHO Advisory board. In addition, we supported and developed virtual learning sessions through our Meds Ed program on Alcohol Use Disorder, as well as one on equity and cultural responsiveness.

Strategy 5: Connect health care and health data through interoperable health IT infrastructure

We are actively improving our capability to both ingest and produce data sets for clinical and community partners.

This includes developing the capability to produce and distribute claims datasets on a clinic-by-clinic basis to assist partners to better understand their patients' utilization, risk profiles and referral patterns, and use the information to inform their patient-specific outreach and care coordination activities.

In 2021 CPCCO,

- Continued to provide our claims datasets to Yakima Valley Health Workers (YVFW) clinics via Arcadia & Wakely to assist those clinics with patient utilization, risk profiles and performance gaps.
- Ingested YVFW clinical (EHR) data via Arcadia in order to develop use cases enabled by a combined 'Claims + EHR' data set.
- Explored other opportunities to broaden our ability to integrate with network EHRs. We plan to develop and implement new partnerships in 2022.

Strategy 6: Engage with state committees/entities

CPCCO participates in HITAG, HITOC and UniteUs Funders forums

ii. Additional progress specific to physical health providers

See Progress Across Provider Types

iii. Additional progress specific to oral health providers

See Progress Across Provider Types

iv. Additional progress specific to behavioral health providers

Strategy 3: Integrate health information across disciplines and between clinical and community entities

- All three of CPCCO's contracted community behavioral health providers are onboarded onto Collective and are active users of the platform to support their internal care coordination activities. In 2020, we kicked off an internal project to onboard two new behavioral health providers in the region and optimize utilization by our CMHPs.
- We piloted use of new population segmentation group flags in Collective with one of our BH providers to support proactive care coordination, and increased information sharing to support the management of chronic conditions.

CPCCO contracts with CareOregon for our provider network. CPCCO has provided FAQ documents related to telehealth and has offered technical assistance to our behavioral health providers to implement telehealth services across CPCCO's network.

v. Please describe any barriers that inhibited your progress

In 2021, we continued to experience barriers as our network continued to respond to the COVID19 pandemic. This has caused much of our work to slow down; however, we worked to provide updated information on utility features of the Collective platform with our provider network, such as the COVID testing flags developed in mid-2020. We shifted our focus from expanding HIT support of broad care coordination to how HIT tools, like Collective, can help support COVID19 specific care coordination and COVID19 response at large.

Additionally, we supported two of our counties' Public Health Departments in contracting with BlockIt to allow them to have a centralized, county-level scheduling platform to assist with COVID vaccinations.

B. 2022-2024 Plans

Please describe your plans for supporting increased access to HIE for Care Coordination for contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select that boxes that represent strategies pertaining to your 2022-2024 plans.
2. Describe the following in the appropriate narrative sections
    a. The number of physical, oral, and behavioral health organizations that have not currently adopted an HIE for Care Coordination tool using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations have not adopted an HIE for Care Coordination tool). CCOs are expected to use this information to inform their strategies.
    b. Any additional HIE tools you plan to support or make available.
    c. Strategies you will use to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers beyond 2021.
    d. Activities and milestones related to each strategy (Please include the number of organizations of each provider type you expect will gain access to HIE for Care Coordination as a result of your support, as applicable)

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2022-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and include activities and milestones in the sections below.

☒ HIE training and/or technical assistance

☐ Assessment/tracking of HIE adoption and capabilities

☒ Outreach and education about value of HIE

☒ Collaboration with network partners

☐ Enhancements to HIE tools (e.g., adding new functionality or data sources)

☐ Integration of disparate information and/or tools with HIE

☐ Requirements in contracts/provider agreements

☐ Financially supporting HIE tools, offering incentives to adopt or use HIE, and/or covering costs of HIE onboarding

☐ Offer hosted EHR product (that allows for sharing information between clinics using the shared EHR and/or connection to HIE)

☐ Other strategies that address requirements related to federal interoperability and patient access final rules (please list here)

☐ Other strategies for supporting HIE access or use (please list here)

i. Plans across provider types, including additional tools you will support/make available, and activities & milestones

1. Data to support our HIE strategies:

Data from OHA – CCO HIT Data File

HIE for care coordination excluding Collective Platform*		
Service Type	**Org count**	**Rate**
Physical	23	52%
Behavioral	7	0%
Oral	6	17%

CPCCO contracts with CareOregon for its entire provider network to ensure members have access to a broad network of providers. CPCCO has created an internal dashboard to monitor provider engagement with Collective. Based on the dashboard, the following providers within CPCCO's service area were using Collective by end of 2021.

Clinic Type	N Clinics/Organizations	Approx % Members Supported	Overall Level of Engagement with Platform*
Primary Care Provider	6	62%	Unengaged – Actively Engaged
Community Mental Health Provider	3 (all CMHPs in CCO region)	100%	Actively – Highly Engaged
Community Paramedicine – Fire & Rescue Agency	1	39%	Unengaged

*based on engagement metrics such as N logins, content creation (i.e., care plans), and eligibility file age

We will use this dashboard, OHA's data, collaboration with our partner CCOs, and future survey results to inform our 2022-2024 HIE adoption and optimization strategies. We will work with OHA, and other CareOregon affiliated CCOs to better understand and address the discrepancies in respective data.

We plan to continue our use of and support for the HIT/HIE tools listed in the *2021 Progress* section and build upon all the strategies we previously described and those outlined below. Additionally, we will monitor national and local HIT/HIE initiatives to stay apprised of any developments in HIE tools or opportunities

Collective: Successes include development of COVID vaccine report and flag which was populated into the Collective portals of our provider network. Notably, this is a particular success as this is the only means by which our behavioral health providers can access vaccine status. Additionally, Metro has onboarded to the platform 8 new SUD providers, which helps support the CPCCO network, since some of our members receive care in the Portland metro region.Barriers live predominantly in the space of platform optimization. We are continuing to engage with our BH and SUD network to upskill providers on how to use the platform most effectively to compliment their other work. More globally, we continue to work with the network in total tocommunicate why Collective is an important tool to improve collaboration across services types (BH/SUD/PH/ED).

Unite Us: The first year of Unite Us implementation focused on growing the number of participants in the referral network. Successes included completing significant amounts of training and onboarding activities during a challenging year. The primary barriers relate to helping organizations move from onboarding to consistent usage. Key drivers of these barriers include gaps in network coverage, workflow inefficiencies at partner organizations, and the absence of a corresponding financial support to help build the capacity needed for more organizations to accept more referrals for social health needs.

2.Strategies, activities and milestones

Strategy 1: Refine the 5 year HIE Plan

Activities	**Milestones and/or Contract Year**
Evolve governance structure to align to CareOregon and CPCCO structure, and ensure provider and network input (e.g., via Clinical Advisory Panel (CAP) or subcommittee of CPCCO's Board)	Q4 2021- Q3 2022
Consider the HIE elements of the plan that may include the following components: • Educating providers and provider staff on existing HIE capabilities and benefits • Developing a regional workplan called for by the HIE Onboarding Program • Identifying opportunities in to improve care transitions • Increasing and streamlining automated referral workflows • Optimizing the use of the HIEs' functionality • Promoting interoperability of HIEs to simplify end-user environment • Monitoring mechanisms to ensure continued improvement in HIE utilization and resulting patient care coordination	Q3 2022
Board or CAP approves revised 5-Year HIT Plan	Q4 2022
Begin to implement the plan • Continue to monitor HIE utilization and work with HIE vendors (including Collective and Unite Us) to achieve optimal adoption.	2023

• Explore HIE interoperability solutions with Collective, Epic CareEverywhere and the Medecision Care Coordination platform where deemed effective and feasible (e.g., host community conversation, agree on standards) • Continue to engage with State entities to ensure CPCCO efforts align with other initiatives. • In conjunction with State efforts, evaluate mechanisms and solutions to incorporate SDOH service providers into referral and care coordination workflows. • Focus on developing solutions to allow for integrated care across disciplines (physical, behavioral, oral and social health) in service to member-centered integrated services and health.	
Next stage of spread in current efforts	Q1-Q4 2023
Spread best practices • Continue to engage and track HIE vendor plans and enhancements to ensure CPCCO gains optimal value from HIE technology. • Deploy, monitor and optimize HIE interoperability solutions identified in Year 2and approved for deployment. • Focus on implementing solutions for incorporating SDOH service providers into care coordination and referral workflows. • Focus on developing solutions to allow for integrated care across disciplines (physical, behavioral, oral and social health), in service to member-centered integrated services and health.	2023-2024
Assess ROI - deepen implementation of HIT and elimination of HIT services that do not support existing priorities and support value. Adjust resources	2023-2024

Strategy 2: Support and expand existing technology solutions that provide timely information to members

Activities	**Milestones and/or Contract Year**
Improve our communication with members to support their care coordination needs by updating our digital platforms and hiring staff to focus on improving our communication for members whose primary language is not English • Hire bi-lingual Social Media Specialist • Hire Language Access Coordinator **Added Advanced website translation with Motionpoint for human translation of web content	Q1-Q4 2021 Q1-4 2021
Improve functionality of CPCCO's Member Portal • Update our Member portal to include care plans that both members and providers can access	Q3 2021
Increase use of mobile applications: • Explore enhanced text messaging capabilities for COVID-19 outreach, potentially using Arcadia technology • Develop and launch Portal Mobile app, which will include a digital member ID card, the ability to review status of prior authorizations, and send e-messages to CPCCO members and other value-added functions to be determined during the design process • Evaluate means to improve member access to information in their electronic health records through interoperability and API development • Explore text messaging capabilities to members • Explore member mobile apps	Q1-Q2 2021 Q3 2021-Q3 2022 Q4 2021-Q12022 Q2 2022- Q 3 2022

Explore ways to reduce implementation costs and enhance member's access to virtual visits (e.g., support purchase of hardware, defray broadband costs, etc.)	Ongoing

Strategy 3: Integrate health information across disciplines and between clinical and community entities by supporting increased use of existing platforms and implementing new ones

Activities	Milestones and/or Contract Year
Collective: CPCCO is committed to increasing adoption of Collective among our provider network and support optimization of Collective through integration into workflows and clinical care coordination activities for those who are currently onboarded to the Collective platform. We will use our internal Collective Network Engagement Dashboard to monitor utilization within our clinical network and partner with the Collective team to identify opportunities for improvement to achieve optimal adoption and use.	Q4 2021- Q42022
Specifically, we will	
• Evaluate Collective analytics modules to determine ROI and appropriateness of each solution.	Q4 2021
• Partner with our Innovation Specialist team to enhance technical assistance for optimizing Collective platform utilization.	Q1 2022
• Assess how we might identify shared populations across disciplines – those engaged across different provider types, such as patients engaged with primary care and CMHPs, in an effort to facilitate proactive communication, develop collaborative care plans and ensure closed-loop referral process.	Q2 2022
• Continue to expand types of data shared via Collective o Extend admit data to include diagnosis data. (Collective currently stores this data and will need to work with Medecision to add the data to the existing data load) o Include Observation/Post-Acute Care visits. Collective has estimated this to be a low lift. Internally, we will need to add another data class to the major classes of data we are already sending in the ADT feed. o Ingest [COVID] vaccination data o Develop population cohorts for care coordination	Q1-Q4 2022
• Continue to create incentives for improved use of Collective (e.g., include language in our hospital contract that sets expectations for use of Collective via Care Insights content.)	
• Identify specifications for mapping of data into Medecision for Encounters to support transition of care.	
Provider Portal - Continue to expand care coordination functionality through our portal • Update our Provider portal to include care plans that both members and providers can access	Q3 2021
Implement Unite Us (see in Section 5) • Continue to implement and optimize the Unite Us platform (see SDOH section)	Q1 2021 – Q4 2022
Support interoperability • Begin to support and develop HIE interoperability solutions between Collective, Epic CareEverywhere and Medecision Care Coordination platform, where deemed effective and feasible. (*e.g.*, convene community, agree on standards, etc.)	2022-2024
Secure messaging • Explore the possibility for our Care Coordination teams to send secure messaging between Medicision and EHRs.	2022

Strategy 4: Support the use of health IT to expand access and quality to services in rural areas

Activities	Milestones and/or Contract Year

Telehealth
• Develop a strategy for ongoing telemedicine evaluation, optimization and support, post-COVID including:
  ○ Network evaluation of telehealth utilization and best practice
  ○ Regional evaluation of cultural and linguistic needs/opinions related to telehealth within the network
  ○ Data evaluation of telehealth services
  ○ Support for Telehealth toolkit
  ○ Support and funding of clinic infrastructure to support telehealth functionality in rural areas (generators)
  ○ Continue to support and offer e-consults
• Support the expansion of telemedicine through possible payment strategies, clinical partnerships, policy support and targeted technical assistance
• Beta-test a new platform within Medecision, Arial Engage, that will support care coordination through telehealth
	Start Q2 2021; evaluation and network engagement in 2022

Explore ways to increase availability and affordability of broadband in collaboration with our counties and local municipalities (e.g., through FCC, grants, etc.)	Ongoing
ECHO – Support Oregon ECHO programs through advisement, funding and participation	Ongoing

Strategy 5: Connect health care and health data through interoperable health IT infrastructure

Activities	Milestones and/or Contract Year
• Evaluate tools that promote national standards for sharing information among different EHRs. (e.g., Carequality, CommonWell, etc.) • Implement Patient Access API and Provider Directory API as required by CMS • Implement Payer to Payer API as required by CMS • Implement Payer to Provider API as required by CMS • Improve our capability to both ingest and produce data sets for clinical and community partners. We currently send claims data to, and ingest EHR data from Yakima Valley Farmworkers Clinic	Ongoing Q2 2021 2002 2003 Q3 2021-2022

Strategy 6: Engage with state committees/entities

Activities	Milestones and/or Contract Year
Participate in the State Funders Forum to ensure CPCCO implementation of Connect Oregon (Unite Us) efforts align with other CIE and/or SDoH-E initiatives.	Ongoing

The CareOregon Quality and Health Outcomes Steering Committee (COQHO) guides the enterprise-wide quality and health outcomes structure and population health framework that determines cross-departmental, cross regional and benefit-related clinical quality improvement strategies and initiatives. COQHO achieves its objectives through ensuring that clinical strategies and improvement efforts are prioritized, resources are appropriate, barriers are addressed, and work moves forward.

To advance the imperative to bring value and improve health by supporting further adoption and spread of health information technology, COQHO has chartered a HIT subcommittee that will guide the development and implementation of the HIT strategies and activities to support COQHO's clinical vision. This multidisciplinary

committee is responsible for overseeing the enterprise and regional-level Five-Year HIT Roadmap. The intention of the committee is to advise on the development of an overarching HIT strategy to guide the HIT related initiatives in all CareOregon lines of business and regions, including increasing adoption rate for HIE care coordination. The workplan includes:

- Implementing bi-directional data exchange with Portland Fire and Rescue, including connecting them to the Collective platform and establishing emergent chat procedures for identified CO members
- Unite Us: Future years' strategies pivot from primary focus on network partner onboarding to optimization of network health. This will involve work designed to introduce strategic payment into community health systems, identifying and removing organization-specific barriers, and technical assistance in partnership with the Unite Us vendor's own support efforts.
- The new Social and Emotional metric will also require HIE supports between clinical and community efforts, and using the Unite Us platform can help meet this need.

ii. Additional plans specific to physical health providers, including activities & milestones

See the Strategies Across Provider Types section

iii. Additional plans specific to oral health providers, including activities & milestones

See plans across provider types

- Expanding external access of FIDO Web (CO's data platform) to primary dental clinics beginning Q3 2022
- Continue to explore ways to improve electronic communication between oral health and other types of providers (*e.g.*, Unite Us) by allowing any kind of provider to request services and care coordination from any other health discipline.
- Explore the use of expanding access to Medecision to the dental plan partners

iv. Additional plans specific to behavioral health providers, including activities & milestones

Strategy 1: Refine and implement a 5-Year HIT Plan

Activities	Milestones and/or Contract Year
Conduct assessment of the HIE functionality and needs among contracted behavioral health providers serving members from CPCCO region. Based on the results of the survey, CPCCO will determine if the barriers to HIE adoption for behavioral health providers differ significantly from those of the physical health providers. If so, CPCCO will develop a separate HIE adoption strategy	Q3 2021
CPCCO's CAP will identify a group to focus specifically on behavioral health information exchange workflows and privacy issues (42 CFR)	Q4 2021
Begin implementation of the developed strategy in partnership with our behavioral health providers	Q1 2022

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with access to HIE for Care Coordination?

- OHA could provide technical assistance, and accountability to smaller Critical Access Hospitals (CAHs)and rural facilities focused on EHR support needed for effective health information exchange: Within the CPCCO region we have some Critical Access Hospitals who need support in optimizing their data feeds into the Collective platform. One of our critical hospitals that sees the largest volume of our ED and IP visits for our members does not provide diagnosis data in their current data feed set up. As such, this creates unintended consequences on behalf of the member, as we know we are missing critical events that would trigger care coordination internally and multidisciplinary case huddles with external partners.
- OHA could provide some TA on best practice/advisement related to HIE, care coordination and 42 CFR. 42 CFR is a barrier to our ability to effectively share actionable data with our network partners, related to SUD. This hinders our ability to effectively care coordinate for this population.
- OHA could actively identify and attract federal dollars to support broadband infrastructure development and subsidize costs to providers and members to further use of virtual technology.
- OHA could also support enhancement to Collective to:
  - Expand use to include the criminal justice system
  - Address inconsistencies in hospital ADT feeds
  - Create shared definition of risk stratification across CCOs
  - Address demographic gaps in Collective platform (e.g., working to create more REAL-D components)
  - Integrate more primary care workflows in Collective

Support more global flags (e.g., children in foster care, patients who need long-term care services and aging, blind and disabled populations)

4. Support for HIE – Hospital Event Notifications

A. 2021 Progress

1. Please describe your progress supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers. In the spaces below, please
   a. Select the boxes that represent strategies pertaining to your 2021 progress
   b. Describe the following in the appropriate narrative sections
      i. The tool(s) you supported or made available to your providers in 2021
      ii. The strategies you used to support increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers in 2021
      iii. Accomplishments and successes related to your strategies (Please include the number of organizations of each provider type that gained increased access to HIE for Hospital Event Notifications as a result of your support, as applicable)

Notes: If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.

Overall Progress
Using the boxes below, please select which strategies you employed during 2021. Elaborate on each strategy and the progress made in the sections below.

☒ Hospital Event Notifications training and/or technical assistance ☒ Assessment/tracking of Hospital Event Notification access and capabilities ☒ Outreach and education about the value of Hospital Event Notifications	☐ Financially supporting access to a Hospital Event Notification tool(s) ☐ Offering incentives to adopt or use a Hospital Event Notification tool(s) ☐ Requirements in contracts/provider agreements ☐ Other strategies for supporting access to Hospital Event Notifications (please list here)

i. Progress across provider types, including specific tools supported/made available

a) A description of the tool that you are providing and making available to your providers for Hospital Event Notification

CPCCO makes the Collective platform available to our provider partners for hospital event notifications.

b) The strategies you used to support increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers in 2021

Physical Health Providers
We have supported the onboarding of our physical health providers in our network with varied levels of engagement by clinic. Our primary care Innovation Specialist team uses a dashboard to identify opportunities to expand utilization. We also discussed Collective as a tool in transitions of care as part of CAP, in regional care planning/transitions of care meetings, and in meetings we held focusing on behavioral health in the ED. Our physical health partners use Collective as an outreach tool for transitions of care and as a way to refer patients into CPCCO Care Coordination.

Oral Health Providers
All CPCCO's dental plans are actively using Collective to identify and coordinate dental care for members going to the emergency department for non-traumatic dental issues. The dental plans have continued to explore the expanded information available to them and how to improve functionality within oral health. We completed an assessment among our delegated dental plans' Oral Health providers to establish a baseline understanding of PDP's using Collective.

Behavioral Health Providers
Our behavioral health provider network utilizes Collective to facilitate behavioral health provider outreach to clients in the ED using a combination of traditional health workers and QMHPs from the crisis, ACT, ICM and youth serving programs depending on the needs of the client and previous program affiliation.

a) Accomplishments and successes related to your strategies

Successes include development of the Diabetes/Behavioral health flag into the Collective portal. This flag, focuses on members with diagnoses of both diabetes type 2 and SPMI, to allow for proactive outreach to support this priority population. Similarly, we developed, and populated in our provider partner portals, the IET flag which allows providers to engage members in care around SUD.

ii. Additional progress specific to physical health providers

See Progress for All Provider Types

iii. Additional progress specific to oral health providers

See Progress for All Provider Types

iv. Additional progress specific to behavioral health providers

CPCCO's three largest behavioral health providers are enrolled with Collective. The behavioral health providers will continue to outreach to clients in the ED using a combination of traditional health workers and QMHPs from the crisis, ACT, ICM and youth serving programs depending on the needs of the client and previous program affiliation. When CPCCO members are admitted to emergency department, CPCCO has contracts in place with Clatsop Behavioral Health; Columbia Community Mental Health and Tillamook Family Counseling center to ensure the delivery of outreach and follow up services.

v. Please describe any barriers that inhibited your progress

Much of our network was at capacity responding to the COVID pandemic in 2021. As such, our ability to move the work discussed above was limited, and some of our other initiatives were intentionally delayed to support our clinical network.

Additional barriers include continued confusion between organizations around 42 CFR and ability to share information. Organizations have differing degrees of comfort of risk they like to accept, leading some to share and some to not which creates inconsistencies.

2. Please describe your (CCO) progress using timely Hospital Event Notifications within your organization. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2021 progress
    b. Describe the following in the narrative section
        i. The tool(s) that you are using for timely Hospital Event Notifications
        ii. The strategies you used in 2021
        iii. Accomplishments and successes related to each strategy.

Overall Progress
Please select which strategies you employed during 2021.

☒ Care coordination and care management	☐ Utilization monitoring/management
☒ Risk stratification and population segmentation	☒ Supporting CCO metrics
☐ Integration into other system	☐ Supporting financial forecasting
☒ Exchange of care plans and care information	☐ Other strategies for using Hospital Event Notifications (please list here)
☒ Collaboration with external partners	

Elaborate on each strategy and the progress made in the section below.

a) The HIE tools you are using

CPCCO utilizes the Collective Platform to receive hospital event notifications and data in general.

b) The strategies you used in 2021

Our care coordination and utilization management teams use Collective in three ways 1) to receive admit and discharge notifications for ALL dual eligible members with a medical admission, and ALL members with a psychiatric inpatient admission, 2) to proactively identify members who may benefit from care coordination, and 3) to notify care coordinators when members currently on their panel present to the ED or admit to an inpatient unit.

Care coordination triggered by hospitalization: Our Triage Coordinators pull daily reports from Collective which include dual eligible members with a recent medical inpatient admission and members with a psychiatric inpatient admission. The Triage Coordinators then send alert tasks to our care coordination teams for follow up. Our care coordination teams also receive alert notifications via Collective for each emergency room visit and inpatient admission for any member already assigned to them and engaged in care coordination. Upon notification, our care coordinators (Transition Nurse Care Coordinators and Behavioral Health Care Coordinators) review the admission details and initiate our transitions of care workflow.

Care coordination identified through cohort review: Our Regional Care Teams review the Collective cohorts daily to identify members who may benefit from care coordination or weekly interdisciplinary care team review. The purpose of this weekly meeting is to make decisions regarding the best plan to coordinate and support the member's specific needs.

Examples of cohorts and reports include in Collective:

- Psychiatric Acute Care Admits and Discharges
- CPCCO BH Cohort – Members who present to the ED for a behavioral health related concern
- Diabetes Cohort – Members who present to the ED or Inpatient for diabetes related concern
- 3 ED Admits in 90 Days
- 5 ED Visits in 12 months
- Pediatric ED Activity
- Rising Risk ED/IP/OBS/SNF – Admit
-

c) Accomplishments or successes related to your strategies

Worked with OHLC and our hospital system partners to add a tag within Collective to identify members who tested positive with COVID.

B. 2022-2024 Plans

1. Please describe your plans for ensuring increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2022-2024 plans.
    b. Describe the following in the appropriate narrative sections
        i. The number of physical, oral, and behavioral health organizations that do not currently have access to HIE for hospital event notification using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations do not have access to HIE for hospital event notifications). CCOs are expected to use this information to inform their plans.
        ii. Any additional HIE tools you are planning to support or make available to your providers for Hospital Event Notifications
        iii. Additional strategies for supporting increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers beyond 2021.

Activities and milestones related to each strategy (Please include the number of organizations of each provider type that will gain increased access to HIE for Hospital Event Notifications as a result of your support, as applicable).

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2022-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and the include activities milestones in the sections below.

☐ Hospital Event Notifications training and/or technical assistance	☐ Financially supporting access to Hospital Event Notification tool(s)
☒ Assessment/tracking of Hospital Event Notification access and capabilities	☐ Offering incentives to adopt or use a Hospital Event Notification tool(s)
☐ Outreach and education about the value of Hospital Event Notifications	☐ Requirements in contracts/provider agreements
	☐ Other strategies for supporting access to Hospital Event Notifications (please list here)

i. Plans across provider types, including additional tools you will support/make available, and activities & milestones

a. The number of physical, oral, and behavioral health organizations that do not currently have access to HIE for hospital event notification using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations do not have access to HIE for hospital event notifications).

b. CCOs are expected to use this information to inform their plans.

1.Data from OHA – CCO HIT Data File

Hospital Event Notifications (i.e., Collective Platform*)		
Service Type	**Org count**	**Rate**
Physical	10	43%
Behavioral	4	57%
Oral	1	17%

CPCCO contracts with CareOregon for its entire provider network to ensure members have access to a broad network of providers. CPCCO has created an internal dashboard to monitor's provider's engagement with Collective (see above under HIE Strategy). We will use this dashboard, OHA's data and future survey results to inform our 2021-2024

Hospital Event Notification strategies. We will work with OHA and other CareOregon affiliated CCO's to better understand the data and address discrepancies.

2.Strategy

To ensure increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers, we plan to continue to support improvements to Collective. We do not plan to make available any additional tools to providers related to Hospital Event Notifications. However, we plan to do some discovery around opportunities for refinement in our utilization of the Collective tool. Specifically, we are interested in exploring how we might identify shared populations – those engaged across different provider types, such as patients engaged with primary care and CMHPs to facilitate proactive communication, development of collaborative care plans, and eventually closed loop referrals.

ii. Additional plans specific to physical health providers, including activities & milestones

See the Strategies Across Provider Types section

iii. Additional plans specific to oral health providers, including activities & milestones

See the Strategies Across Provider Types section

iv. Additional plans specific to behavioral health providers, including activities & milestones

See the Strategies Across Provider Types section

2. Please describe your (CCO) plans to use timely Hospital Event Notifications within your organization. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2022-2024 plans
    b. Describe the following in the narrative section
        i. Any additional tool(s) that you are planning on using for timely Hospital Event Notifications
        ii. Additional strategies for using timely Hospital Event Notifications beyond 2021
        iii. Activities and milestones related to each strategy

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2022-2024.

☒ Care coordination and care management	☐ Utilization monitoring/management
☐ Risk stratification and population segmentation	☐ Supporting CCO metrics
☐ Integration into other system	☐ Supporting financial forecasting
☐ Exchange of care plans and care information	☐ Other strategies for supporting access to Hospital Event Notifications (please list here)
☒ Collaboration with external partners	

Elaborate on each strategy (if not previously described in the *Progress* section) and include activities and milestones in the section below.

We will continue to use our Collective platform internally as a source of real time data/information that signals a need on behalf of our members. We will expand on our approach developed in 2020, and continue work on:

Care coordination triggered by hospitalization: We will continue and improve on our internal process related to using Collective data to identify members needing care coordination. We are refining our care coordination criteria to take a more population health lens, and will be expanding those entering into care coordination, as resources allow.

Care coordination identified through cohort review: We will continue review of collective cohorts, as done in 2020, but are expanding current cohorts to more conditions. This will allow us to identify members who would benefit from care coordination earlier (a member with 2 ED visits AND uncontrolled DM versus a member with 3 ED visits).

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with access to Hospital Event Notifications?
OHA could support enhancement to Collective to add discharge diagnosis. OHA could continue to support funding of Collective as a core component of HIE in Oregon. See additional recommendations in preceding section under HIE for Care Coordination

5. HIT to Support Social Needs Screening and Referrals for Addressing SDOH Needs

A. 2021 Progress

1. Please describe any progress you (CCO) made using HIT to support social needs screening and referrals for addressing social determinants of health (SDOH) needs. In the space below, please include
    a. A description of the tool(s) you are using. Please specify if the tool(s) have closed-loop referral functionality (e.g., Community Information Exchange or CIE).
    b. The strategies you used in 2021.
    c. Any accomplishments and successes related to each strategy.

Overall Progress
Elaborate on each strategy and the progress made in the section below.

i. Overall Strategy in Supporting SDOH & HE with HIT

Our primary strategy to collect and aggregate social determinants of health data is the implementation of Unite Us. In 2020, we began evaluating Unite Us as a community-based solution to improve coordination of social support services among health care providers and community-based organizations. Unite Us is a closed-loop referral platform for social needs that allows for bi-directional information sharing and transparency across referrals networks.

CPCCO went live with the Network and Platform on 2/23/21. Partners including counties, FQHC's and clinics, and community-based organizations were implemented in this first wave. Wave two will be rolled in Q2 of 2021 for use by our CPCCO Care Management staff supporting Tillamook, Clatsop and Columbia County. We have partnered closely with our community wellness hubs and coalitions to gain engagement and approval in adoption of the Unite Us tool. We also engaged our Clinical Advisory Panel (CAP) and CCO Board of Directors in gain input and approval to move forward the CIE work and in selecting Unite Us as our CIE solution.

In addition to implementing Unite Us, CPCCO is committed to improving information captured through claims and other data sources to inform our social determinants and health equity strategies.

1. Improve quality of information captured through claims:
    - **Z-codes** - CPCCO will partner with our entire network to encourage broader use and collection of Z-codes (specifically within the Z59.xx group) which identify and track needs related to social determinants of health and health equity. There is strong interest and alignment around increasing the use of these codes to track more closely the correlation between member need and outcomes.
    - **Improving accuracy coding** - CPCCO, in partnership with CareOregon and the Oregon Primary Care Association, has offered training opportunities to FQHCs, RHCs, and non-CHC primary care providers that focus on improving coding practices aimed at capturing accurate patient complexity, inclusive of SDOH. These trainings are hosted by OPCA and a contracted coding organization with deep experience in supporting safety net providers. We hope to continue offering these training opportunities in the future, once the COVID-19 pandemic is controlled and there is greater capacity for participation.
2. Other Data: (see below iii)

ii. **Tools for Addressing SDOH, including identifying social supports and making referrals, such as CIE**

The data will be integrated into the CareOregon Enterprise Data Warehouse (EDW) in August 2021. This EDW integration will enable CPCCO staff to understand our member's utilization of community based organizations, and identify barriers to services that our teams can address through care coordination. Over time we hope to be able to correlate SDOH access with members overall health and wellness.

iii. **What plans, if any, do you have for collecting and aggregating data on SDOH/HE that may come from sources other than claims, such as data reported by members, by community-based organizations, or from providers' EHRs? Can you match other sources of demographic and SDOH/HE-related data with claims data?**

Unite Us Data: We will integrate data from Unite Us into our EDW using the DMAP ID and CCO Flags that are being fed into Unite Us on a weekly basis in the Member Roster File. Unite Us will build an outbound data feed to export data to CPCCO. The data will be joined with Member Demographic data in our Enterprise Data warehouse and will be used for analytical reporting and program development in support of PH, BH, and Dental initiatives.

Pediatric Data: Also, through a partnership with DHS, OHA and the Oregon Pediatric Improvement Partnership (OPIP), CPCCO received SDOH data for our pediatric membership that reports health complexity based on a combined medical and social complexity score. Social complexity factors include poverty (received TANF), foster care, parental incarceration, substance abuse, child abuse or neglect, parental disability, limited English proficiency, mental health services, and parental death. CPCCO, in partnership with CareOregon, has convened a Pediatric Complexity Steering Committee to determine how to best utilize the health complexity data to align with internal strategies that address identified population risk, needs, and disparities. The committee's current objectives include identifying areas of

health disparities for resource allocation, completing an environmental scan, and providing recommendations for a Pediatric APM model. We will also work with our CAP and Community Advisory Councils to inform how to utilize this data within provider clinics and the community.

Data to support Equity work: CPCCO's Quality Improvement Team is in the process of developing a training curriculum on how to use data to support equity work. This training covers best practices on centering equity in analyses and when making data-driven decisions. We are currently seeking feedback from key stakeholders, with a focus on partners of color and organizations that serve communities that have been marginalized. By improving both the quality of our data and shifting our culture around how we use data, we hope to build better strategies to support our members. In 2021, all analysts that support CPCCO will complete the training and work with strategy leads to incorporate practices into their strategy development.

The Quality Improvement Workgroup will continue to focus on data disaggregation. In 2021, we are working to ensure that when we share data we disaggregate it in every meeting. We will also plan to offer technical assistance to network providers on disaggregating data and data equity practices and encourage providers to share disaggregated data with us and their peers.

Other Data - CPCCO plans to collect additional data through alternate methods such as client and provider surveys and questionnaires, Health Risk Assessments, provider data uploads (SFTP transfers) and Electronic Health Record information.

iv. Please describe any barriers or challenges you faced using HIT to support SDOH/HE.

The entire Unite Us integration must be custom built. CPCCO, CareOregon, Health Share and PacificSource have collaborated with the vendor to develop specifications for building this integration.

Many community based organizations (CBOs) do not have the infrastructure in place to support formal data collection and reporting. It will be important to help CBOs identify approaches, data collection processes, and tools for analyses that would help demonstrate ROI and program effectiveness. The following are ways in which the OHA could support community based organizations (CBOs) in this space:

- Support alignment of efforts across the state for Connect Oregon/Unite Us
    - Facilitate integration of data from legacy systems such as HMIS
    - Reduce number of new systems being implemented, such as VisionLink
- Provide webinars, learning sessions along with TA
- Provide capacity building grants or incentives for CBOs to engage

2. Please describe any progress you made in 2021 supporting contracted physical, oral, and behavioral health providers with using HIT to support social needs screening and referrals for addressing SDOH needs. Additionally, describe any progress supporting social services and community-based organizations (CBOs) with using HIT in your community. In the spaces below, please include

a. A description of the tool(s) you supported or made available to your contracted physical, oral, and behavioral health providers, social services, and CBOs. Please specify if the tool(s) have closed-loop referral functionality (e.g., CIE).
b. The strategies you used to support these groups with using HIT to support social needs screening and referrals.
c. Any accomplishments and successes related to each strategy.

Note: If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.

i. Progress across provider types, including social services and CBOs, and tool(s) supported/made available

Population Management: We use three major Health IT solutions related to population health management. Johns Hopkins ACG is a risk segmentation that we use to perform descriptive and predictive analysis related to health outcomes, quality risks, cost, and utilization. This tool forms the backbone of many of our analyses and visualizations that inform population health management priorities. We also use the Arcadia platform as a data integrator with select clinic partners' EHR data. During the public health emergency, we have also leveraged Arcadia as an outreach tool for member messaging designed to nudge member behavior towards COVID vaccination activity. Finally, for direct care coordination and outreach, we use Health Coordinator (Medecision/GSI), integrated with patient education program Healthwise and Hospital Event Notifications from Collective, to document care coordination and education activities that contribute to population health management.

FIDO. FIDO is Columbia Pacific CCO's external data sharing platform. We are expanding content and access to FIDO, including:

- Scorecards and quality metric data (PCP only)
- Member profile data including claims history (PCP only)
- Planned expansion to PDPs and DCOs for 2022
- Exploring expansion to BH providers for 2023

FIDO. Our web-based analytics and report delivery system, FIDO, enables us to provide single sign-on, enhanced dashboard functionality and expand the types of dashboards available to external users. This allows providers to access information on performance, including Oregon's CCO incentive metrics, HEDIS measures, cost and utilization. Enhancements will continue to expand our ability to deliver additional measures and metrics, as appropriate based on VBP arrangement participation, to providers on a regular and automated basis. Providers will be able to view a broad menu of measures, as well as those applicable only to their payment arrangements.

CareOregon maintains a comprehensive enterprise data warehouse combining data from administrative, care coordination, clinical, and analytic sources. Population Health teams utilize the Population Health Explorer dashboard, built cost and utilization dashboards, and population segmentation built on this platform, to create interventions and programs. CareOregon's technology also includes machine learning enabled risk stratification tools that feed into this analysis. Our enterprise data warehouse has continued to evolve to support deeper integration of data between financial, clinical, contracting, and claims systems. As richness of information in the underlying data warehouse grows it will open further opportunities for partnering with our providers to drive improved performance and care.

Provider Scorecards. For information not currently accessible via FIDO, providers participating in VBPs currently have access to scorecards and other data via secure email. Scorecards include both aggregate (clinic-level) and member-level information, making data more actionable for intervention.

Care Coordination Platforms. In addition to supporting performance analytic capabilities, we support access to the GSI care coordination platform, UniteUs, and Collective Medical which supports care activities needed to succeed in a VBP environment.

CareOregon leverages the Collective Platform for transparency of ADT data and sponsor our providers and provide Community of Practice sessions through our network to support teams to leverage the tool more in their day-to-day operations as well as identify unique contracting to include the tool in their practice. CareOregon along with the other Health Share partners, exchanges member care plans with each other through Collective when a member transfers from one partner to another. CareOregon has incorporated population and risk segmentation in the system with flags that indicate a member's risk level which are available to provider at the point of care.

ii. Additional progress specific to physical health providers

iii. Additional progress specific to oral health providers

iv. Additional progress specific to behavioral health providers

v. Additional progress specific to social services and CBOs

vi. Please describe any barriers that inhibited your progress

B. 2022-2024 Plans

1. Please describe your plans for using HIT for social needs screening and referrals for addressing SDOH needs within your organization beyond 2021. In your response, please include
    a. Any additional tool(s) you will use. Please specify if the tool(s) will have closed-loop referral functionality (e.g., CIE).
    b. Additional strategies you will use beyond 2021.
    c. Activities and milestones related to each strategy.

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

Overall Plans

Elaborate on each strategy (if not previously described in the *Progress* section) and the include activities milestones in the section below.

CPCCO has invested both human and financial resources to help develop the Connect Oregon community information exchange, using the Unite Us platform. Part of that investment allows us to collect, summarize, and analyze data related to requests for social health support. These data are one of several new SDOH-related data sources we plan to incorporate into CCO operations and partnerships between 2022 and 2024.

Over the next three years, leveraging the partnership and collaboration detailed above, the following will likely be novel sources of information to better understand social risk in addition to Unite Us needs.

- Member responses to annual health risk assessment and screenings
- Member responses to social risk needs captured by partnered clinics (where possible)
- Public health data sets related to environmental and structural determinants of health
- Broader adoption of SDoH-related Z-codes on submitted claims

We plan to incorporate the sources above, including Unite Us utilization data, into a more structured data system that will drive improvements in the following areas related to addressing SDoH:

- Care coordination: improve our ability to have visibility to social challenges that could impact care coordination approaches and priorities
- Proactive outreach: improve our ability to identify risk factors that could result in poor health outcomes
- Population health program development: design preventive and supportive programs with social health needs in mind
- Risk stratification: better recognize, fund, and reward partners as they take financial risk for members with SDoH needs and concerns

When added to existing data sources that describe components of member health (from care coordination platforms, claims data, shared data feeds with clinical partners, and health information exchange), we can better target preventive care and program investments and identify acute risks that may require prioritized support from CCO team members.

Current plans are focused on optimizing receipt and structuring of Unite Us data, and this work will continue through the end of 2022. Additional data sources will be incorporated into the data model throughout 2023, with new proactive outreach efforts beginning in 2023 as well. We plan to enhance our segmentation and risk stratification methods in 2024, using those tools to improve care coordination targeting and other population health program development.

2. Please describe your plans for supporting contracted physical, oral, and behavioral health providers with using HIT to support social needs screening and referrals for addressing SDOH needs. Additionally, describe your plans for supporting social services and CBOs with using HIT in your community. In the spaces below, please include
    a. A description of any additional tool(s) you will support or make available to contracted physical, oral, and behavioral health providers, social services, and CBOs. Please specify if the tool(s) will have closed-loop referral functionality (e.g., CIE).
    b. Additional strategies for supporting contracted physical, oral, and behavioral health providers, social services, and CBOs with using HIT for social needs screening and referrals for addressing SDOH needs beyond 2021.
    c. Activities and milestones related to each strategy.

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

i. Plans across provider types, including social services and CBOs, and tool(s) you will support/make available

Data gathered in the efforts described above will be most effective if standardized, well-defined, and broadly accepted. We anticipate state-driven adoption of social risk screening quality metrics to be an impetus for these standardization and adoption conversations with our provider partners, and these conversations will surface provider needs related to HIT where the CCO could support.

We will continue supporting physical, oral, behavioral, and community health partners in their onboarding and successful use of the Connect Oregon (powered by Unite Us). This will involve technical assistance support and, in some cases, direct funding of Connect Oregon licenses for partners. Technical assistance will focus on developing successful communication use cases for the closed loop referral functionality of the Connect Oregon network between community and clinical partners.

ii. Additional plans specific to physical health providers

iii. Additional plans specific to oral health providers

iv. Additional plans specific to behavioral health providers

v. Additional plans specific to social services and CBOs

C. Optional Question

How can OHA support your efforts in supporting the use of, and using HIT to support social needs screening and referrals for addressing SDOH needs?

6. Other HIT Questions (Optional)

The following questions are optional to answer. They are intended to help us assess how we can better support the work you are reporting on.

A. How can OHA support your efforts in accomplishing your HIT Roadmap goals?

If you can change the template so it is not so disjointed, that would be helpful. We have documents that note our overall goals related to HIT etc… but it doesn't fit in this template, because it is a strategic synthesis of all, not only focused on each element. By making this template so disjointed, it leads to a more siloed approach to HIT, versus an approach that uses HIT tools to support and improve population health and health outcomes (which is actually the approach we are taking).

B. How have your organization's HIT strategies changed or otherwise been impacted by COVID-19? What can OHA do to better support you?
COVID has caused everything to be delayed. We needed to honor the fact that our network did not have capacity to engage in this beyond expanding telehealth, and at the same time, we believe that COVID has increased the need to focus on HIT.
C. How have your organization's HIT strategies supported reducing health inequities? What can OHA do to better support you?

Appendix

Example Response: Support for HIE – Care Coordination

The examples below are meant to help CCOs understand the level of detail and type of content OHA is looking for in responses detailing 2021 progress and 2022-2024 plans. The examples are based on content in past CCO HIT Roadmaps and include specific tools and/or strategies reported by CCOs. OHA edited original submissions for the sake of providing a concise example, but CCOs may wish to provide more context or detail in some cases. Please note, these examples are not exhaustive. Through these examples, OHA is not endorsing specific products or tools, but merely highlighting the level of specificity for meaningful and credible content and providing clarity on how the responses may be formatted. Even though the examples are specific to HIE for care coordination, the level of detail and format should be modeled in other topic responses as well.

Definitions: For the purposes of the Updated HIT Roadmap responses, the following definitions should be considered when completing responses.

Strategies: CCO's approaches and plans to achieve outcomes and support providers.

Accomplishments/successes: Positive, tangible outcomes resulting from CCO's strategies for supporting providers.

Activities: Incremental, tangible actions CCO will take as part of the overall strategy.

Milestones: Significant outcomes of activities or other major developments in CCO's overall strategy, with indication of when the outcome or development will occur (e.g., Q1 2022). **Note**: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.

A. 2021 Progress

Please describe your progress supporting increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select the boxes that represent strategies pertaining to your 2021 progress
2. Describe the following in the appropriate narrative sections
    a. Specific HIE tools you supported or made available in 2021
    b. The strategies you used to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers in 2021
    c. Accomplishments and successes related to your strategies (Please include the number of organizations of each provider type that gained access to HIE for Care Coordination as a result of your support, as applicable)

Note: If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.

Overall Progress
Using the boxes below, please select which strategies you employed during 2021. Elaborate on each strategy and the progress made in the sections below.

☒ HIE training and/or technical assistance

☒ Assessment/tracking of HIE adoption and capabilities

☒ Outreach and education about value of HIE

☒ Collaboration with network partners

☒ Enhancements to HIE tools (e.g., adding new functionality or data sources)

☐ Integration of disparate information and/or tools with HIE

☐ Requirements in contracts/provider agreements

☒ Financially supporting HIE tools, offering incentives to adopt or use HIE, and/or covering costs of HIE onboarding

☐ Offer hosted EHR product (that allows for sharing information between clinics using the shared EHR and/or connection to HIE)

☒ Other strategies that address requirements related to federal interoperability and patient access final rules (please list here)

- *Implemented Patient Access API*

☒ Other strategies for supporting HIE access or use (please list here)

- *Assisted with the development of best practice standards for hospital EDs*

i. Progress across provider types, including HIE specific tools supported/made available

In 2021, our CCO and clinic partners leveraged a wide variety of health information exchange tools and other HIT platforms that support care coordination. Below is a list of platforms currently supported by our CCO and in use by us and/or our network.

Collective Platform (FKA PreManage) - Our CCO has been a leader in the implementation and spread of the Collective Platform in our region. The tool supports care coordination among providers and between providers and our CCO, through real-time event communication as well as a shared care plan. The shared use of the Collective Platform between primary care, EDs and CMHPs is intended to bring attention and coordinated intervention to those members who present in emergency service and hospital settings.

EDIE - All hospitals in our service area have adopted EDIE. EDIE connects hospital ED's across the state to provide a comprehensive snapshot of high risk, high need individuals in real time. When a patient registers in any ED in Oregon, EDIE is alerted and can push back an EDIE notification. Providers and care coordinators outside the hospital system can receive timely notifications when their patients or members have a hospital event via the Collective Platform.

Epic's Care Everywhere - The majority of contracted physical health providers in our service area are on Epic, including the hospital systems, FQHCs, rural health clinics and our school-based health centers. This allows providers in our community to communicate directly through Epic or through "look in" functionality through Epic's Care Everywhere, which provides clinical data for providers who use Epic and other affiliated electronic health systems.

CCO Provider Portal - Our CCO provider portal supports referrals among primary care and DCOs.

Care Coordination Platform - Our CCO has implemented a robust Care Coordination Platform that delivers a care plan to the provider portal so the provider is aware of what is happening for the member.

Secure Messaging - Our CCO Care Team communicates/coordinates with providers using Secure messaging through their email and directly from our Care Coordination platform.

Our 2021 progress centered around the following strategies our CCO implemented. The 2021 accomplishments and successes related to our strategies are listed below each strategy.

Strategy 1: Develop and implement a 5-Year HIT plan

In partnership with the Clinical Advisory Panel, our CCO developed a 5-Year HIT plan that includes the following components to help guide our strategies for the duration of the Contract:

- Identifying HIT/HIE priorities
- Educating providers and provider staff on existing HIE capabilities and benefits
- Developing a regional workplan called for by the HIE Onboarding Program to identify priority Medicaid providers that would benefit from participation.
- Identifying opportunities in care transition
- Increasing and streamlined referral automated workflows
- Optimizing the use of the HIEs functionality
- Promoting interoperability of HIEs to simplify end-user environment
- Monitoring mechanisms to ensure continued improvement in HIE utilization and resulting patient care coordination

Strategy 2: Support and expand existing technology solutions that provide timely patient information to providers and care coordinators

- Our CCO helped remove barriers to adoption for some of our providers by paying for Collective licenses and partnering with the vendor to help our clinics design workflows that leverage the tool. We increased access for an additional 8 physical health and 6 behavioral health providers.
- We coordinated with the emergency department Medical Directors at the hospitals to develop best practice standards for Care Recommendations and workflows to enhance cross-system care coordination. To further support successful adoption and use of Collective, we covered the costs for provider partners to attend statewide collaboratives to share with their peers and learn about best practices.
- Referrals to our CCO's care team come from providers and from our CCO's triage coordinator, who utilizes targeted cohorts in Collective to identify members who would benefit from a collaborative, multi-disciplinary care plan and subsequent outreach and wraparound services in an effort to prevent future inappropriate costly emergency department visits and inpatient stays.
- As a CCO we monitored the volume of care recommendations developed by each organization and offered technical assistance to each system in order to tailor the support to meet their specific needs, from workflow development to IT support to advance their adoption of the tool.

Strategy 3: Support patient access to their health information: implement Patient Access API

- In 2021, we began implementation of a secure, standards-based (HL7 FHIR Release 4.0.1) API that allows patients to easily access their claims and encounter information, including cost, as well as a defined subset of their clinical information through third-party applications of their choice.

Strategy 4: Enhance coordination between physical, behavioral, oral and SDOH organizations

- Expanded functionality of closed loop referrals via CCO Provider Portal
- Researched and implemented a tool to capture and share SDOH
- Expanded use of CCO Care Coordination Platform to create an electronic mechanism for tri-directional referrals in which providers from physical, behavioral, or oral health can request service navigation and care coordination services from our care coordination team.

- Convened multidisciplinary team meetings where primary care, Community Mental Health Programs, and dental come together to develop shared care plans for specific members who have complex needs that are then entered into the Collective Platform.

Strategy 5: Support new solutions to exchange information between EHRs and other organizations

- Engaged with Reliance to ensure CCO providers had the opportunity to participate in the OHA HIE Onboarding Program
- Encouraged our provider partners to participate in OHA's HIE Onboarding Program. An additional 7 organizations (4 physical and 3 behavioral health) participated before the program ended.
- Evaluated tools that promote national standards for sharing information among different EHRs (e.g, Carequality, CommonWell, etc.)
- Supported electronic data exchange between EHRs and OHA and CCO
- Actively participated in state multi-payer data aggregation activities
- Researched bulk electronic communication between EHRs, CCO, and OHA. We improved our capability to both ingest and produce data sets for clinical and community partners. We have started producing and distributing claims data sets on a clinic-by-clinic basis to assist partners to better understand their patients' utilization, risk profiles and referral patterns and use the information inform their patient-specific outreach and care coordination activities.
- Met virtually with HIE vendors operating in our service area and gained insight into:
    - Current level of adoption
    - Practices discussing or planning implementations
    - Practices that implemented, but are underutilizing the available technology
    - Future features and functions in development and timeline for availability
    - How CCO will be informed about advances in HIE utilization
    - How CCO can increase HIE utilization

Strategy 6: Engage with state committees/entities

To ensure we stay abreast of and inform OHA's HIT priorities, members of our team actively engaged in several state workgroups, including:

- HIT Commons - EDIE Steering Committee
- Metrics & Scoring Committee
- Health Information Technology Advisory Group

Strategy 7: HIE Data collection

As further described in the EHR Adoption section, we partnered with OHA to implement the 2021 Oregon HIT Survey to assess HIE adoption, use, needs, and barriers among our contracted providers. Unfortunately, data collection did not start until October 2021, delaying our access to the results until January 31, 2022.

- We provided OHA with email contacts for 64% of our assigned organizations.
    - Through the process of compiling email addresses for OHA we came to learn that we are missing contacts for many organizations. We have since instituted a process to gather emails from all contracted organizations
- We assisted with survey outreach to encourage our providers to submit a survey.

ii. Additional Progress Specific to Physical Health Providers

Strategy 8: Provide workflow TA

- Provided technical assistance to physical health providers and their teams to integrate Provider Portal workflow into their clinic's care coordination processes.

iii. Additional Progress Specific to Oral Health Providers

Our dental partners continue to work directly with their contracted providers to identify opportunities to engage in HIE and share information across the continuum of health care providers.

All of our CCO's delegated dental plan partners have implemented and receive notifications via Collective for their members going to the emergency department for non-traumatic dental issues. They have also implemented a care coordination process whereby each member who goes to the emergency department for dental issues receives outreach, care coordination, and support in scheduling a follow-up dentist visit. Our CCO is working with dental care partners to increase the percentage of members completing a dental visit within 30 days of an emergency department visit for non-traumatic dental issues.

Our CCO has invested in tools to support enhanced communication between our primary care, oral health and other providers. We have created a dental request within the provider portal that allows primary care providers to submit a request for dental navigation and coordination by our dental care coordinators.

In 2021, our CCO implemented the following strategies specific to oral health providers and achieved the listed accomplishments/successes:

Strategy 9: Explore oral health HIE

- We worked with CCOs, DCOs and HIE vendors to examine existing dental health information exchange.
- We explored strategies to expand and connect to other HIEs and platforms (e.g., Reliance, Epic).
- We identified the types of information that will be useful to exchange. Our assessment focused on data needed to fuel workflows, the abilities of Electronic Dental Records (EDRs) to hold and display that data, and the HIE methods supported by vendor systems.

Strategy 10: Pursue improvement of the dental request referral process

- We evaluated the efficacy of the dental request referral process by cross-walking claims data with those members who had a request through the portal to follow up with members and analyze "connection" success rates
- We encouraged further utilization of the one-way electronic referrals to DCO portals for improved care coordination

iv. Progress Specific to Behavioral Health Providers

We understand how health information sharing is critical to ensuring effective care management across physical health and behavioral health and to supporting behavioral health integration efforts. The behavioral health organizations within CCO vary in their capacity to develop the necessary infrastructure and workflows to support health information exchange.

In 2021, our CCO implemented the following strategies specific to behavioral health providers and achieved the listed accomplishments/successes:

Strategy 11: Assess the state of behavioral health HIE

- Assessed behavioral health provider interest and determined best way to support their engagement with the OHA HIE Onboarding Program
- Identified HIE elements that need to be modified, eliminated or added due to special behavioral health requirements

Strategy 1: Develop and implement a 5-year plan

- Included elements specific to behavioral health providers
- Identified a group to focus specifically on behavioral health workflows and privacy issues
- Ensured behavioral health providers were a priority in the HIE Onboarding Program, including small providers' use of HIE portals
- Evaluated the Reliance Consent Module and other HIE workflows

Strategy 8: Provide workflow TA

- CCO staff continued to provide workflow redesign support to further adoption and use of Collective Platform, specifically related to increasing the number of members who have care plans generated after presenting at emergency department and being flagged by Collective.
- Provided technical assistance to physical health providers and their teams to integrate Provider Portal workflow into their clinic's care coordination processes.

v. Please describe any barriers that inhibited your progress.

Our initial plans for developing a technical assistance strategy to support and expand existing technology solutions that provide timely patient information to providers and care coordinators were unable to be fully realized due to the COVID-19 pandemic. The original strategy had included conducting site visits to providers identified in initial physical, oral, and behavioral health use cases in order to better understand their current systems and workflows around HIE for Care Coordination; however, we were unable to complete any onsite walk-throughs. While we did meet with some providers virtually, we were unable to meet with all providers we identified during initial use cases. Our plan is to continue our virtual meetings in 2022.

Also, due to COVID, OHA postponed HIT Data Collection efforts until late 2021.

B. 2022-2024 Plans

Please describe your plans for supporting increased access to HIE for Care Coordination for contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select that boxes that represent strategies pertaining to your 2022-2024 plans.
2. Describe the following in the appropriate narrative sections
    a. The number of physical, oral, and behavioral health organizations that have not currently adopted an HIE for Care Coordination tool using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations have not adopted an HIE for Care Coordination tool). CCOs are expected to use this information to inform their strategies
    b. Any additional HIE tools you plan to support or make available.
    c. Additional strategies you will use to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers beyond 2021.
    d. Activities and milestones related to each strategy. (Please include the number of organizations of each provider type you expect will gain access to HIE for Care Coordination as a result of your support, as applicable)

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please include activities and milestones for each strategy you will use.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2022-2024. Elaborate on each strategy and include activities and milestones in the sections below.

☒ HIE training and/or technical assistance ☒ Assessment/tracking of HIE adoption and capabilities ☒ Outreach and education about value of HIE	☒ Financially supporting HIE tools, offering incentives to adopt or use HIE, and/or covering costs of HIE onboarding

☒ Collaboration with network partners ☒ Enhancements to HIE tools (e.g., adding new functionality or data sources) ☒ Integration of information and/or disparate tools with HIE ☐ Requirements in contracts/provider agreements	☐ Offer hosted EHR product (that allows for sharing information between clinics using the shared EHR and/or connection to HIE) ☒ Other strategies that address requirements related to federal interoperability and patient access final rules (please list here) • *Maintain Patient Access API* ☐ Other strategies for supporting HIE access or use (please list here)

i. Strategies across provider types, including activities & milestones

Using the Data Completeness Table in the OHA-provided HIT Data File, we can see that (including the Collective Platform) 347 physical health, 51 oral health, and 58 behavioral health contracted organizations have not adopted a known HIE tool. We will use this information to develop our 2022-2024 HIE for care coordination strategies.

We will continue to use and support all HIT/HIE tools listed in the *2021 Progress* section and continue to build upon all the strategies we previously described. Additionally, we will monitor national and local HIT/HIE initiatives to stay apprised of any developments in HIE tools or opportunities.

For 2022-2024, our CCO will implement and support the following strategies across provider types:

Strategy 2: Support and expand existing technology solutions that provide timely patient information to providers and care coordinators

Activities	Milestones and/or Contract Year
Evaluate opportunities to extend telemedicine technology for members, including mobile applications that support member's ability to communicate with their care team via mobile technology.	2022: Identify mobile applications to support 2023: If mobile application identified, disseminate application along with relevant patient education
Evaluate, design, develop, and implement HIE interoperability solutions with Reliance.	Q1-Q3 2022: Evaluation and development phase Q4 2022-Q4 2023: Implementation phase; onboard CCO care coordinators, 12 physical, 7 behavioral, and 3 oral health providers
Explore ways to reduce implementation costs, such as subsidizing purchase and maintenance costs for providers and providing technical assistance and training in appropriate use of application.	2022-2024: Realize cost reduction

Strategy 4: Enhance coordination between physical, behavioral, oral and SDOH organizations

Activities	Milestones and/or Contract Year
Explore the ability to transition to a closed loop referral mechanism from our care coordination platform. In our next phase of development, we will create the functionality to allow our oral health or behavioral health providers to request care coordination and navigation support.	Q1-Q3 2022: Exploration, research, development Q4 2022: Pilot closed-loop referral mechanism with 8 behavioral health and 4 oral health providers
In conjunction with State efforts, evaluate mechanisms to incorporate SDOH service providers into referral and care coordination workflows.	Q3 2022
Support a closed loop referral process to create a tri-directional navigation and referral system that can support or augment future and more robust HIE development and implementation.	2022-2024: Closed-loop referral process achieved

Focus on solutions for incorporating SDOH service providers into care coordination and referral workflows.	2022-2024
Develop robust systems for the integration of claims and EHR data in order to share insights about members to improve outcomes. This exchange will add patient detail which may not be present in either system alone.	2022-2024

Strategy 11: Understand HIE technology adoption and use among network physical, behavioral, and oral health providers

We will continue pursuing HIE adoption and use data collection leveraging already existing opportunities to continue to learn about

- Real and perceived barriers to HIE adoption
- Modules, features, and functions that would increase value to Providers
- Technical barriers to adoption
- Financial barriers to adoption (technology costs and labor costs)
- Opportunities and hopes for HIE technology utilization

The results of the data collection will provide us with additional information to modify our plan to appropriately support different providers types with care coordination needs.

Activities	Milestones and/or Contract Year
Determine best means for collecting information from various provider types	Q1 2022: Process for data collection identified and implemented
Collect HIE information from physical, behavioral, oral health providers	Q2-Q3 2022: HIE information collected from a range of provider types including at least 15 physical, 10 behavioral, and 5 oral health providers
Analyze results and explore opportunities for further support and develop workplan	Q3-Q4 2022: Identification of future strategies for supporting providers with HIE for care coordination
Meet with HIE vendors operating in our service area	Q3-Q4 2022: Identification of available solutions/tools
Compare quality and performance metrics of providers utilizing HIE technology to those providers that have not adopted HIE technology. Use this analysis to determine the value of HIE adoption efforts.	2023-2024: Value of HIE technology illuminated

Strategy 12: Support patient access to their health information: maintain Patient Access API

In 2021, we began implementation of a secure, standards-based (HL7 FHIR Release 4.0.1) API that allows patients to easily access their claims and encounter information, including cost, as well as a defined subset of their clinical information through third-party applications of their choice. In 2022, we will maintain the API and monitor patient use. We will also gather patient input on their experience using the API.

Activities	Milestones and/or Contract Year
Maintain Patient Access API and monitor patient use.	Q1-4 2022: Patient Access API remains active. Patient use is monitored quarterly.
We will gather patient input on their experience, needs, challenges, and barriers via existing opportunities (e.g., CAC, patient satisfaction surveys).	Patient input is collected and adjustments to API functionality/patient education are made in response, as needed.

Continue maintaining Patient Access API	2023-2024

ii. Strategies specific to physical health providers, including activities & milestones

See *Across Provider Types* section.

iii. Strategies specific to oral health providers, including activities & milestones

Based on the results of the 2021 survey/data collection, CCO will determine if the barriers to HIE adoption for oral health providers differ significantly from those of the physical health providers. If so, CCO will develop a separate HIE adoption strategy.

Strategy 2: Support and expand existing technology solutions that provide timely patient information to providers and care coordinators

Our CCO will encourage further utilization of the one-way electronic referrals to DCO portals for improved care coordination.

Activities	Milestones and/or Contract Year
Promote further use of EDIE for emergency department and urgent care event notifications for oral health related diagnosis	2022
Explore expansion of current pilots within DCOs using the Collective Platform for high risk oral health conditions and/or members	2022
Expand existing electronic dental referral process with physical and oral health providers	Q2 2022: expand process to additional 10 providers
Support efforts identified in years 1 and 2 to further health information exchange between oral health and others	2022-2024
We will continue to explore and expand ways to improve electronic communication between oral health and other types of providers through our provider portal (e.g., support bi- or tri-directional communication by allowing any kind of provider to request services and care coordination from any other health discipline. This tri-directional ability will alleviate some of the system complexity from the various provider groups to assure a provider friendly mechanism to connect a patient to care.)	2022-2024
Work with the DCOs to integrate closed-loop electronic referrals and/or preauthorization's within their providers' EDR workflows	2022-2024

Strategy 6: Engage with state committees/entities

Activities	Milestones
Continue to engage with State entities to ensure our CCO efforts align with oral health-specific initiatives	2022
Work with OHA and HIT Commons, explore ways to integrate PDMP information into HIE tools/services and downstream to Electronic Dental Record systems	Q2 2022: Begin collaboration with HIT Commons

iv. Strategies Specific to Behavioral Health Providers, Including Activities & Milestones

Based on the results of the 2021 survey/data collection, CCO will determine if the barriers to HIE adoption for behavioral health providers differ significantly from those of the physical health providers. If so, CCO will develop a separate HIE adoption strategy.

Strategy 2: Support and expand existing technology solutions that provide timely patient information to providers and care coordinators

Activities	Milestones and/or Contract Year
Implement Behavioral Health Consent Module, as appropriate	2022
Focus on solutions for connecting behavioral health Providers to SDOH service providers for care coordination.	2022-2024
Support data sharing and exchange through data aggregation, reporting and distribution tools	2022-2024
Adapt for behavioral health providers as necessary, implement the elements identified in the physical health plan.	2022-2024

Strategy 6: Engage with state committees/entities

Activities	Milestones and/or Contract Year
Continue to engage with State entities to ensure CCO efforts align with behavioral health-specific initiatives	2022
Work with the HIT Commons to evaluate expanded use of EDIE to inpatient behavioral health facilities	Q2 2022: Begin collaboration with HIT Commons

Strategy 13: Establish an HIE workgroup specifically for behavioral health workflows

Activities	Milestones and/or Contract Year
Identify subject matter experts, establish group charter and goals	Q1 2022: First meeting with at least 5 SMEs
Develop workplan with priority use cases	Q2 2022: Identify use cases for initial workflow improvement
Continue to utilize workgroup for evolving behavioral health HIE workflow needs	2022-2024