2021 Updated HIT Roadmap

Guidance Document & Template

Oregon Health Authority

December 12, 2020

Contents

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. As described in the HIT Questionnaire (RFA Attachment 9), the HIT Roadmap must describe how the CCO currently uses HIT to achieve desired outcomes and support contracted providers, as well as outline the CCO's plans for the following areas throughout the course of the five-year contract:

- Support for Electronic Health Record (EHR) adoption for physical, behavioral, and oral health providers
- Support for Health Information Exchange (HIE) for Care Coordination and Hospital Event Notifications for physical, behavioral, and oral health providers, and CCO use of Hospital Event Notifications
- Health IT for Value-Based Payment (VBP) and Population Health Management

For Contract Year One, CCOs' responses to the HIT Questionnaire formed the basis of their draft HIT Roadmap. For Contract Years Two through Five, 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 any new information, activities, milestones, and timelines which were not included in the HIT Roadmap for the previous Contract Year. OHA expects CCOs to use their approved 2019 HIT Roadmap as a foundation/starting point when completing their 2020 Updated HIT Roadmap.

Overview of Process

The Updated HIT Roadmap shall be submitted to OHA for review and approval on or before **March 15** of Contract Years Two through Five. CCOs will use the Updated HIT Roadmap Template for Contract Years Two through Five reporting, rather than resubmit the original HIT Roadmap submitted with the CCO 2.0 application. Please submit the completed Updated HIT Roadmap to Jessi Wilson at CCO.HealthIT@dhsoha.state.or.us.

Similar to Contract Year One, OHA will review each CCO's Updated HIT Roadmap and will send a written approval or a request for additional information and discussion. If immediate approval is not received, the CCO will need to participate in an Updated HIT Roadmap Work Plan to achieve an approved Updated HIT Roadmap for Contract Year Two. The aim of the Work Plan will be for CCOs to

1. Communicate with OHA to better understand how to achieve an approved Updated HIT Roadmap for Contract Year Two
2. Revise Updated HIT Roadmap and resubmit to OHA for review and approval

Additional information about the Updated HIT Roadmap Work Plan 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 Updated HIT Roadmap submission and review process.

Updated HIT Roadmap Timeline

March - May 2021	June - July 2021	July - Sept. 2021
Updated HIT Roadmap Submission and Review	**CCO/OHA Communication and Collaboration**	**CCO HIT Response Resubmission to OHA for Review**

	List of activities	List of activities	List of activities
Activities	CCOs submit completed Updated HIT Roadmap Templates to OHA by **3/15/21**.	If approved, no further action required of CCOs on Updated HIT Roadmap for Contract Year 2.	CCO submits revised Updated HIT Roadmap to OHA for review by **7/30/21**.
	OHA reviews Updated HIT Roadmaps.	If not approved, CCO contacts OHA by **6/11/21** to schedule the Updated HIT Roadmap Work Plan meeting.	OHA reviews CCO's resubmitted Updated HIT Roadmap.
	OHA sends Updated HIT Roadmap result letter to CCO by **5/31/21**.	Collaborative meeting(s) occur between CCO and OHA by **7/02/21**.	OHA sends second Updated HIT Roadmap Review result letter to CCO by **9/10/21**.

OHA anticipates that all 15 CCOs will have an approved Updated HIT Roadmap by **10/1/21**.

Updated HIT Roadmap Approval Criteria

The table below contains high-level criteria outlining OHA's expectations for responses to the required Updated HIT Roadmap questions. Please review the table to better understand the content that must be addressed in each required response. Please note, approval criteria for Updated HIT Roadmap optional questions are not included in this table because 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 Updated HIT Template for the complete question when crafting your responses.

Updated HIT Roadmap Section	Question(s) – Abbreviated *Please see 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 MOU • Served, if elected on the HIT Commons governance board or one of its committees • Participated in OHA's HITAG at least once during the previous Contract Year

2. Support for EHR Adoption	a. 2020 Progress supporting EHR adoption for contracted physical, oral, and behavioral health providers?
	
	b. 2021 – 2024 Plans for supporting EHR adoption for contracted physical, oral, and behavioral health providers?
		Sufficient detail and clarity to establish that activities are meaningful and credible.
		
		• Description of progress includes
		  o Strategies used to support EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers in 2020
		  o Specific accomplishments and successes for 2020 related to EHR adoption
		• Description of plans includes
		  o 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)
		  o Additional strategies for 2021 – 2024 to support increased rates of EHR adoption and address barriers to adoption among the three provider types
		  o Specific activities and milestones for 2021 – 2024 representative of the CCO's understanding of different EHR needs for different provider types

3. Support for HIE – Care Coordination	a. 2020 Progress supporting access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers?	Sufficient detail and clarity to establish that activities are meaningful and credible.
		
		• Description of progress includes
		  o Specific HIE tools supported or made available in 2020
		  o Strategies used to support HIE for Care Coordination access for contracted physical, oral, and behavioral health providers in 2020
		  o Specific accomplishments and successes for 2020 related to HIE for Care Coordination access

Updated HIT Roadmap Section	Question(s) – Abbreviated *Please see template for complete question.	Approval Criteria

3. Support for HIE – Care Coordination	b. 2021 – 2024 Plans for supporting access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers?	• Description of plans includes
		  o 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)
		  o Additional HIE tools supported or made available
		  o Additional strategies for 2021 – 2024 to support increased rates of access to HIE for Care Coordination among the three provider types
		  o Specific activities and milestones for 2021 – 2024 representative of the CCO's understanding of different HIE needs for different provider types

4. Support for HIE – Hospital Event Notifications	1. a. 2020 Progress ensuring timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers?
	
	1. b. 2021 – 2024 Plans for ensuring timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers?
		Sufficient detail and clarity to establish that activities are meaningful and credible.
		
		• Description of progress includes
		  o Current tool CCO is providing and making available/planning to make available to providers for Hospital Event Notifications
		  o Strategies used to support access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health in 2020
		  o Specific accomplishments and successes for 2020 related to Hospital Event Notification access
		• Description of plans includes
		  o 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)
		  o Additional tool CCO planning to make available to providers for Hospital Event Notifications
		  o Additional strategies for 2021 – 2024 to support increased rates of access to timely Hospital Event Notifications for the three provider types
		  o Specific activities and milestones for 2021 – 2024 representative of the CCO's understanding of different Hospital Event Notification needs for different provider types

4. Support for HIE – Hospital Event Notifications	2. a. 2020 Progress using timely Hospital Event Notifications **within** your organization?
	
	2. b. 2021 – 2024 Plans using timely Hospital Event Notifications within your organization?
		Sufficient detail and clarity to establish that activities are meaningful and credible.
		
		• Description of progress includes
		  o Current tool CCO is using within their organization for Hospital Event Notifications
		  o Strategies used for timely Hospital Event Notifications within CCO's organization for 2020
		  o Specific accomplishments and successes for 2020 related to CCO's use of Hospital Event Notifications
		• Description of plans includes
		  o Additional tool CCO is planning to use for Hospital Event Notifications
		  o Additional strategies for 2021– 2024 to use timely Hospital Event Notifications within the CCO
		  o Specific activities and milestones for 2021 – 2024

Updated HIT Roadmap Section	Question(s) – Abbreviated *Please see template for complete question.	Approval Criteria

6. Health IT for VBP and Population Health Management
 	
a. HIT Tools and Workforce
	HIT capabilities for the purposes of supporting VBP and population management?	Sufficient detail and clarity to establish that activities are meaningful and credible.
		
		• Description of capabilities includes
		   o HIT Tools used for VBP and population management
		      ▪ HIT tool(s) to manage data and assess performance
		      ▪ Analytics tool(s) and types of reports generated routinely
		   o Clear details around CCO staffing model for VBP and population management analytics

6. Health IT for VBP and Population Health Management
 	
b. HIT to Administer VBP Arrangements
	2021 – 2024 Plans and 2020 Progress around using HIT to administer VBP arrangements?	Sufficient detail and clarity to establish that activities are meaningful and credible.
		
		• Description includes
		   o Clear strategies for 2021 – 2024 for using HIT to administer VBP arrangements, including a description of the CCO's plan to scale VBP arrangements over the course of the Contract and spread VBP arrangements to different care settings and enhance or change HIT.
		   o Specific activities and milestones related to using HIT to administer VBP arrangements
		   o Progress in 2020 using HIT for administering VBP arrangements

6. Health IT for VBP and Population Health Management
 	
c. Support for Providers with VBP
	2021 – 2024 Plans and 2020 Progress around using HIT to support Providers so they can effectively participate in VBP arrangements?	Sufficient detail and clarity to establish that activities are meaningful and credible.
		
		• Description includes
		   o Clear strategies for 2021 – 2024 for using HIT to support Providers so they can effectively participate in VBP arrangements and support Providers with:
		      ▪ timely information on measures used in VBP arrangements
		      ▪ accurate and consistent information on patient attribution
		      ▪ information to identify patients who needed intervention, including risk stratification data and Member characteristics
		   o Specific activities and milestones for 2021 – 2024 related to supporting Providers in VBP arrangements
		   o Specific HIT tools used to deliver information
		   o The percentage of Providers with VBP arrangements at the start of the year who had access to the above data
		   o Progress in 2020 related to this work

Updated HIT Roadmap Template

CCO: Health Share of Oregon
Date: 3/31/2021

Instructions

Please complete all of the required questions included in the following Updated HIT Roadmap Template. Topics and specific questions where responses are not required are labeled as optional. The layout of the template includes questions across the following seven topics:

1. HIT Partnership
2. Support for EHR Adoption
3. Support for HIE – Care Coordination
4. Support for HIE – Hospital Event Notifications
5. Health IT and Social Determinants of Health and Health Equity (optional section)
6. Health IT for VBP and Population Health Management
7. Other HIT Questions (optional section)

Each topic includes the following:

- Narrative sections to describe your 2020 progress, accomplishments/successes, and barriers
- Narrative sections to describe your 2021 – 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 to attach a second document outlining their planned activities and milestones as was required for Contract Year One. However, you may attach your own documents in place of filling in the activities and milestones sections of the template (as long as the attached document clearly describes activities and milestones and specifies the corresponding Contract Year).

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 HIT. That said, CCOs' Updated HIT Roadmaps and plans should be informed by OHA-provided HIT data. Updated HIT Roadmaps should be strategic, and activities may focus on supporting specific provider types or specific use cases. OHA expects Updated HIT Roadmaps will 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.

Strategy: CCO's approach and plan to achieve outcomes and support 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 CCOs' Updated HIT Roadmaps. 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 HIT Questionnaire have not been included in the Updated HIT Roadmap template. Additionally, at the end of this document, examples have been provided to help clarify OHA's expectations for reporting progress and plans. For questions about the Updated HIT Roadmap template, please contact Jessi Wilson at 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 OHA's HITAG, at least once during the previous Contract year.

2. Support for EHR Adoption

a. 2020 Progress

Please describe your progress supporting EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers. In your response, please describe
1. The strategies you used to support EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers in 2020.
2. 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.

i. Progress Across Provider Types

Health Share's IDS's represent physical health delivery systems that are based on integrated networks spanning employed inpatient, specialty and outpatient providers. As such, these systems have near universal adoption of EHR and interoperability across service types. The Data Completeness Table in the provider file indicates very low rates (13%) of EHR adoption across these systems and as such Health Share has great concern on how this survey was measured and collected in 2020. We look forward to working closely with OHA and these IDS partners to ensure completeness of this file in the future, which will inform on-going EHR adoption efforts across the CCO.

Our IDS' did not have updated EHR adoption metrics for their provider networks readily available to meet the timeframe of this report. In 2020, we can report that significant efforts have been made to ensure telehealth visits were achievable in their current EHR systems in response to COVID-19, large efforts/progress were made to meet the CMS interoperability patient access requirement this year which they needed to prepare current EHR

systems for this requirement. All in all, our primary focus has been on being responsive to the COVID-19 pandemic and regular scheduled projects have been shifted to in order to meet new business needs to ensure quality service and care of our members through this crisis.

Health Share's ICN includes a subcontracted network of primary care, specialty, behavioral health and oral health providers which equates to 42% of our physical health network. Because this system provides vital services for all Health Share members and is not built on an integrated delivery system backbone, the majority of EHR adoption strategy focus in 2020 occurred within this part of the network. Our ICN closely tracks these EHR adoption metrics.

During 2020 Health Share's Integrated Community Network (CareOregon), completed an assessment of all PCP and the larger Behavioral Health practices' EHR systems. They updated their Provider Information Form (PIF), the tool used to collect provider information, and the process for obtaining this information to ensure they have a repeatable data capture mechanism for future additions and tracking. This information becomes a part of the Provider Record in CareOregon's Enterprise Data Warehouse.

As was the case for the IDS' within Health Share's network, COVID-19 shifted HIT priorities significantly away from focusing on broader EHR adoption toward helping providers adapt their operations to serve our members virtually, including adoption of telehealth technologies. CareOregon offered technical assistance to hundreds of practices that implemented telehealth services. CareOregon's Innovation Specialist Teams developed a Telehealth Toolkit and provided practice coaching and hosted collaboratives to help their clinic partners modify their operations, including workflows tied to their EHRs to support telehealth visits.

CareOregon routinely assists providers in optimizing their use of EHR systems through their team of Innovation Specialists. Optimization includes identifying opportunities to more meaningfully use their EHRs to improve workflows, support CCO Quality Metric documentation, and support Value Based Payment performance:

> Here are some of the ways our ICN has helped 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, one key question, ACE's)
> - Medication reconciliation best practices including at-the-elbow support with EHR vendors for optimization

ii. Additional Progress Specific to Physical Health Providers

Our ICN reported during their 2020 EHR adoption assessment physical health providers are at 92% of EHR adoption rate. As stated above, Health Share does not have accurate physical health EHR adoption rates based on the Data Completeness table provided from the State.

iii. Additional Progress Specific to Oral Health Providers

100% of Delegated Dental Providers through our ICN were contacted through an email campaign sponsored by the ICN's Oral Health Department. They were able to obtain responses to two questions as part of their survey, 1) EHR System 2.) PDP's using Collective. Responses to the survey have not yet been analyzed but will form the basis of on-going improvement efforts to ensure broad use and optimization of EHR's within the dental network.

CareOregon Dental offered technical assistance to its Primary Dental Provider network providers to implement expanded teledentistry services. The expansion of teledentistry capabilities has leveraged dental plans' investments in EHR technology to provide access to dental care during the pandemic. The ability to implement teledentistry supports the investments in EHR, as without ubiquitous access to patient records, it would be much

more difficult to have efficient virtual visits. In addition, conducting teledentistry visits in conjunction with an established EHR greatly improves the ability to document, track and report on these virtual visits.

iv. Additional Progress Specific to Behavioral Health Providers

Within a short window of time, CareOregon's Behavioral Health network of outpatient providers converted their care delivery from office-based care to virtual visits/telehealth. This would not have been possible had organizations not invested in EHR technology which they were able to leverage during a time of crisis. Because providers had accessible and functional EHRs, the primary focus within the network was not on accessing records but on navigating the considerable change to workflow and patient engagement needs. CareOregon offered technical assistance to over 200 Behavioral Health providers to implement telehealth services, which included responding to urgent provider questions and connecting providers to the latest local and national training and guidelines for EHR documentation, billing, and privacy standards as providers shifted to telehealth.

v. Please describe any barriers that inhibited your progress.

Providers were understandably strained due to the COVID-19 pandemic. Behavioral Health providers will require follow up in early 2021 to understand on-going challenges with EHR optimization and adoption, which is now underway (March2021).

b. 2021 - 2024 Plans

Please describe your plans for supporting EHR adoption among contracted physical, oral, and behavioral health providers. In your response, please include
1. 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.
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.
3. Associated activities and milestones related to each strategy.

Notes:
- Strategies described in the *2020 Progress* section that remain in your plans for 2021 – 2024 **do not need to be included** in this section unless there is new information around how you are implementing/supporting the strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and 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. Additional Strategies Across Provider Types, Including Activities & Milestones

According to the December 2020 CCO HIT Data File (Completeness Table) these are what OHA collected

Service Type	Number of organizations (denominator)	EHR adoption	
		Org count	Rate
Physical	484	65	13%
Behavioral	104	16	15%
Oral	183	7	4%

Health Share does not believe these numbers are representative of the actual state of EHR adoption based on previous assessments and our knowledge of the contracted network. As noted in Health Share's RFA, a 2016 scan (Oregon's Health Systems Transformation Report) found that more than 78% of eligible CCO providers had already adopted certified EHRs and we believe that number has only increased in the intervening years. Health Share will participate in conducting an EHR and HIE assessment survey this year, in alignment with OHA's improved survey methodology, with our partners to understand the gaps that the State is reporting and reconcile any differences and work with the ICN/ICNs on adoption strategies. Health Share would also like to be a part of the survey design committee to further detail and refine OHA's data collection approach for 2021.

Given that such a small percent of our members are served by Primary Care clinics without an EHR, our ICN/IDS' intend to focus a majority of efforts on EHR optimization. Health Share's partners will align this work with their transformation priorities and in areas that provide value to our provider partners without creating unnecessary additional burdens or contributing to clinician burn-out.

It is also our belief that success in many forms of Value Based Payment arrangements require savvy use of EHRs (married with CCO-provided data and analytics), and we anticipate conversations about EHR utilization as a part of our continuing VBP rollout strategy. Our ICN/IDS' maintain a dedicated team that offers support to provider practices in optimizing their use of EHRs and associated workflows to ensure successful and efficient data collection of elements necessary to help meet quality and VBP goals.

Please see attached HIT Roadmap Document for detailed workstreams spanning 2021 and beyond. Brief highlights are noted below.

2021

A phone campaign and electronic survey are planned for early 2021 to augment data captured through CareOregon Provider Information Forms.

As part of Health Share, all of our IDS and ICN partners will engage with the Health Share HIT Governance structure to identify and prioritize EHR adoption strategies and support activities informed by OHA data and internally collected information compiled in 2020 on EHR usage.

Given that such a small percent of our members are served by Primary Care clinics without an EHR, our ICN/IDS' intend to focus a majority of efforts on EHR optimization. The Plans will align this work with their transformation priorities and in areas that provide value to our provider partners without creating unnecessary additional burdens or contributing to clinician burn-out.

It is also our belief that success in many forms of Value Based Payment arrangements require savvy use of EHRs (married with CCO-provided data and analytics), and we anticipate conversations about EHR utilization as a part of our continuing VBP rollout strategy. Our ICN/IDS' maintain a dedicated team that offers support to provider practices in optimizing their use of EHRs and associated workflows to ensure successful and efficient data collection of elements necessary to help meet quality and VBP goals.

2022
- Launch any new EHR adoption / optimization initiatives
- Next stage of spread in current efforts

- Align resources (APM's, Technical Assistance and other resources) for HIT driven Quadruple Aim outcomes

2023 - 2024
- Spread of best practice, deepened implementation of HIT and elimination of HIT services that do not support value.
- Assess ROI for HIT programs. Adjust resources and refine practices

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ii. Additional Strategies Specific to Physical Health Providers, Including Activities & Milestones

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iii. Additional Strategies Specific to Oral Health Providers, Including Activities & Milestones

CareOregon will differentiate primary dental providers from specialty dental providers and determine EHR adoption trends among the two groups. This assessment will then be used to evaluate and determine strategies to incentivize/encourage adoption within the Delegated Dental Plan and CareOregon Dental Provider Networks.

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

CareOregon will conduct a full survey of Behavioral Health Providers in Q1 2021. There is funding set aside for upgrades specific to culturally specific providers.

Optional Question

How can OHA support your efforts in supporting your contracted providers with EHR adoption?
As noted above, we look forward to participating with OHA in refining EHR tracking methodology so we can work with a shared understanding of network adoption and spread.

3. Support for HIE – Care Coordination

a. 2020 Progress

Please describe your progress supporting increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers. In your response, please include
1. Specific HIE tools you supported or made available in 2020
2. The strategies you used to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers in 2020
3. 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.

i. Progress Across Provider Types

When Health Share initially submitted our CCO 2.0 HIT roadmap, we had fully intended to explore a centralized HIE platform, specifically Reliance. However, when Reliance became an unrealistic option in the metro area, we collectedly shifted towards a decentralized HIE strategy. During 2020 the focus of our work has been to identify what we currently have in place that has enables provision of data to our IDS/ICNs which can be utilized for Care Coordination activities. Thus far we have 5 categories within our inventory:

Workstream 2.2: HSO Data Distribution
- When a Health Share member is assigned to one of the IDS/ICNs or switches between them, we send a 2-year claim history for that member to each of the IDS/ICN in which the member is assigned.
- In partnership with OCHIN we piloted sending Epic consumable claims data to FHQCs to be used in Epic's Healthy Planet – specifically Multnomah County and Virginia Garcia FQHCs
    - In addition, we are slated in Q2 2021 to add other FHQCs – Wallace Medical Concern, Central City Concern, and Neighborhood Health to that group to offer a more complete population health perspective.
- We send Epic consumable claims data to OHSU to supplement their EHR systems and support VBP analysis.
- We have created a corporate, Board-approved data sharing policy (INFOSEC-08) to enable quicker and easier sharing of data complete with a matrix that pre-defines all sharing that is enabled under HIPAA requiring only that we verify the appropriate data sharing, business associate, or data use agreement are in place.

Workstream 2.3: Leveraging TOC
- In fulfilling our 2020 Transitions of Care (TOC) requirements from the State, we upload Care Plans to the Collective Medical Platform for any member, not just TOC eligible, that are transitioning to Health Share. The Collective Medical Platform enables physicians and care teams' immediate access to new patient information. We also send Care Plans to all other CCOs in Oregon for any member that transitions from Health Share to a different CCO. The sharing of Care Plans is critical for care coordination.

Workstream 2.4: Collective Medical Technologies
- Send risk level and conditions to CMT based on TOC conditions for all members
- Send TOC indicator flags so that assigned plans, providers, and care managers can be made aware of new patients transitioning to their care
- Specifically, Health Share has created 8 flags to send to CMT on a daily basis, and these flags are applied to everyone on our member list (that we also send daily) so all HSO stakeholders can see this information in the tool. Here is a summary of the flags:

    - Medical risk level based on an algorithm of conditions and severity level
    - Whether a member is transitioning to another plan or CCO
    - Whether the member has a care plan (and the care plan pdf is attached)
    - Whether they are a user of NEMT services
    - Whether they have been identified as having both a behavioral health and a diabetes need to support integrated diabetes programs

Workstream 2.5: Leveraging Health Share Bridge (Tableau Dashboards, member-level detail)

Health Share Bridge is the CCO's secure, shared analytics environment connecting information for better health. It allows partners to interact with regional health data in a way the makes sense for them, their health systems, and their patients. Insights from Bridge can be combined with other sources of information so that collectively we can transform the system to equitably deliver better care resulting in, smarter spending, and healthier people.

This user-friendly platform provides valuable information related to member demographics, per member per month spending, incentive metrics performance, health disparities, patient risk stratification and special populations and initiatives. This information is updated every day and is available to health plan, provider, and community partners as allowed under HIPAA.

- A patient medical summary for all our members is available to all oral, behavior, and physical health providers that have an association with the member. The patient summary is available in Tableau on Health Share's

Bridge portal. The Health Share Bridge portal contains chronic condition indicators, immunizations, demographics, plan and provider assignments, recent visits, recent prescriptions, and total encounters year to date.

- Patient Stratification dashboard allows you to identify and prioritize subgroups of patients for care management interventions: create and view a targeted worklist, export worklists to influence care management provider workflows, identify at risk patients before they become high risk, high-cost patients, and prioritize patients for targeted inventions.

- Pregnancy dashboards provides high level member statistics and member level details on women currently believed to be pregnant. In addition, there is a completed pregnancy dashboard that provides high level statistics on completed pregnancy episodes for population health analysis.

ii. Additional Progress Specific to Physical Health Providers

Workstream 2.1 Epic to Epic Data Sharing

- Members of Health Share's HIT Governance committee performed an analysis of Epic-to-Epic sharing capabilities and determined that the major IDS' and some FQHCs are able to readily share information across EHRs currently. The CCO will explore further opportunities to expand these information sharing capabilities in coming years as much of the focus of expanded efforts has been consumed by COVID response in 2020 and early 2021. Here is the current list of Epic-to-Epic sharing:
  - Kaiser
  - Legacy
  - Providence
  - OHSU
  - Multnomah County
- Epic has two continuity of care documents (CCDs) both standard and specialty. Both CCDs have significant data elements and are able to be passed from one Epic system to the other.

In this example below created by our IDS' ██████████, this is how patient data is exchanged in order to improve care coordination

Health Information Exchange – Carequality example @ ███
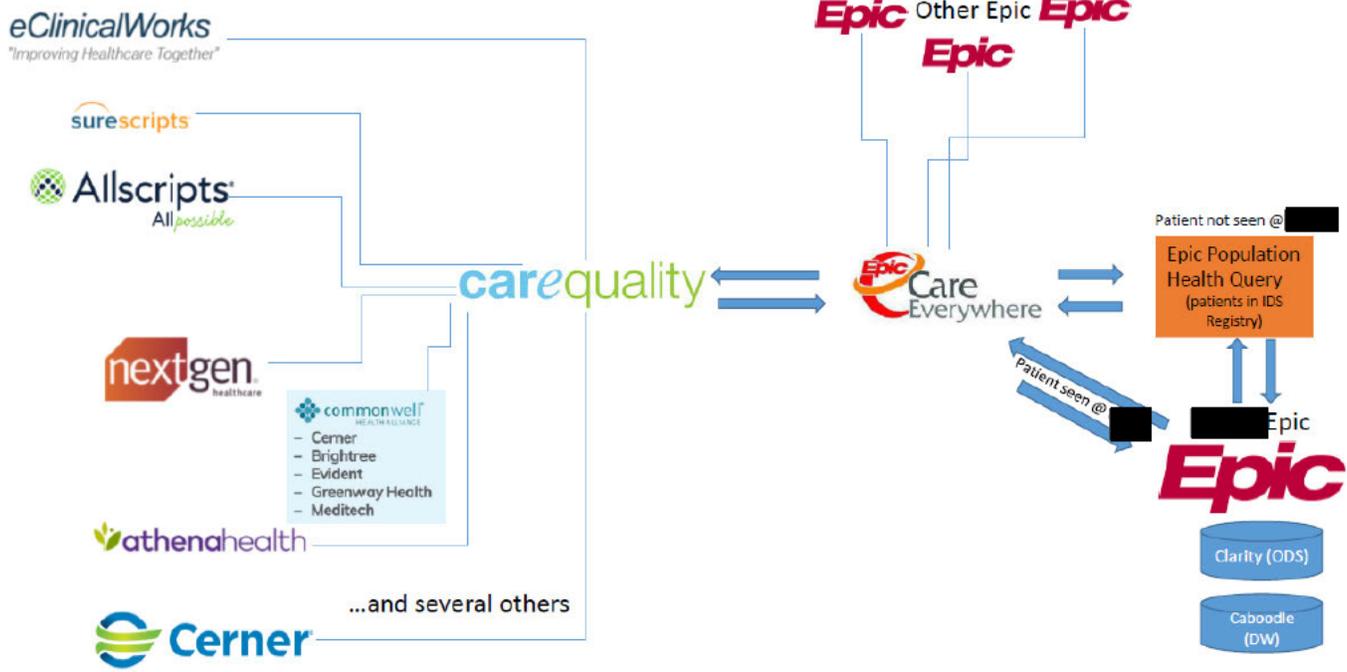
iii. Additional Progress Specific to Oral Health Providers

Assessments have been completed on our delegated Oral Health providers who utilize the Collective platform. This was to help us understand the Primary Dental Provider (PDP) utilization of the platform. From our delegated dental providers Willamette and some ODS providers are utilizing Collective.

Oral Health partners are also able to access Health Share Bridge for the reports and tools noted above, including information about metric performance and assigned populations. As Health Share Bridge enhancements are made they will continue to benefit from this level of information exchange.

iv. Additional Progress Specific to Behavioral Health Providers

Twenty-eight behavioral health clinics utilize the Collective platform and 16 have not implemented or are not engaged.

CareOregon began onboarding Community Mental Health Providers onto the Collective platform to support their internal care coordination activities. They have kicked off a project to onboard new behavioral health providers in the region and optimize utilization by our Community Mental Health Programs (CMHPs). This work is led by our ICN's Behavioral Health Director and their Behavioral Health Innovation Specialists. The ICN has also extended internal population segmentation group flags to behavioral health providers to support proactive outreach and care coordination.

v. Please describe any barriers that inhibited your progress.

As noted above, Health Share and partners were open to exploring a centralized HIE option but financial issues for the potential HIE vendor combined with expanded capabilities of the major regional EHR/EMR systems, as well as the on-set of COVID led the group toward a collaborative, decentralized strategic model.

b. 2021 - 2024 Plans

Please describe your plans for supporting increased access to HIE for Care Coordination for contracted physical, oral, and behavioral health providers. In your response, please include
   1. 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
   2. Any additional HIE tools you plan to support or make available.
   3. Additional strategies you will use to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers beyond 2020.
   4. Associated activities and milestones related to each strategy.

Notes:
   - Strategies and HIE tools described in the *2020 Progress* section that remain in your plans for 2021 – 2024 **do not need to be included** in this section unless there is new information around how you are implementing/supporting the strategy and/or HIE tool.
   - If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
   - If a strategy and 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. Additional Strategies Across Provider Types, Including Activities & Milestones

Our initial HIT roadmap had extensive plans to explore implementation of a single HIE platform, Reliance. However, as noted above, for numerous reasons we have altered our approach and aligned toward a decentralized exchange model. In our new HIE section of our HIT roadmap (see attached roadmap), 2020 was used to inventory what data was currently being exchanged and evaluate what gaps exists.

Currently Health Share is in the process working from our HIT roadmap project plan on 2.0 Work Stream - Compile Inventory & Use Cases to support Hospital Event Notification & Care Coordination which is slated to be completed by the end of Q1 of 2021.

From the inventory it will lead to 3.0 Work Stream - Identify HIE Gaps. If there are significant findings, we will take these back to our Health Share's HIT Governance committee to discuss recommendations how we will remediate these gaps. The HIT Governance committee will prioritize gap remediation efforts based on greatest impact to member care and create a realistic plan to implement. If too many gaps are identified, all remediation plans may not be able to all be implemented in 2021. This is where the group will decide priority. In subsequent years, there will be opportunity to continue remediate gaps and create project plans to execute.

The last activity in 2021 5.0 Work Stream - 2021 HIE Execution. After the plan is approved by the HIT Governance committee, we will execute recommendations/solutions. Subsequent years 2022-2024 we have two primary milestones of "HIE planning" with our HIT Governance committee and act upon any solutions through "HIE execution" each year. Please refer our HIT Roadmap project plan on HIE tab for more details.

ii. Additional Strategies Specific to Physical Health Providers, Including Activities & Milestones

iii. Additional Strategies Specific to Oral Health Providers, Including Activities & Milestones

Based on the oral health provider assessment, perform an analysis how the PDPs are using Collective and any barriers for our oral health providers to implement and utilize Collective. We will continue outreach and

engagement to gain insights, develop use cases and encourage more oral health providers to utilize the Collective platform.

iv. Additional Strategies Specific to Behavioral Health Providers, Including Activities & Milestones
Continue to support our behavioral health providers who have not implemented or have been engaged with Collective. Outreach and perhaps further assessments needed to see if there are any barriers and how we can assist to adopt usage.

Optional Question

How can OHA support your efforts in HIE for Care Coordination?
Collective continues to play a significant role in Health Share's service area and has served as a crucial backbone for many care coordination functions, including TOC and high-risk patient flagging. We understand that OHA is shifting cost toward CCOs and away from OHA for budgetary reasons. While we certainly understand the need to balance costs, we would ask that OHA collaborate with CCOs early and often to ensure a smooth transition of any costs and to explore a gradual transition if at all possible. Support from OHLC toward broader adoption and use of Collective has been incredibly useful in keeping focus on this important work, and continued support of their involvement as part of the CCO landscape will be much appreciated.

4. Support for HIE – Hospital Event Notifications

a. 2020 Progress

1. Please describe your progress supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers in 2020. In your response, please include
   a. A description of the tool that you are providing and making available to your providers for Hospital Event Notification
   b. The strategies you used to support increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers in 2020
   c. Accomplishments and successes related to your strategies

   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.
   - If you participated in the 2020 HIT Commons interviews regarding the use of the Collective Platform, feel free to use that information in this section

i. Progress Across Provider Types
Collective Medical/EDIE is currently in use at all regional hospitals in Health Share's service area. Health Share continues to support sending member data and risk flags to Collective Medical/EDIE. Health Share has a staff member that sits on the HIT Commons Board of Directors to promote continued financial support for the platform. EDIE connects hospital emergency departments (EDs) across the State of Oregon to provide a comprehensive snapshot of high risk, high need individuals in real time. When a patient registers in any emergency department (ED) in Oregon, EDIE is alerted and pushes back a real time EDIE notification to the emergency department if certain patient criteria are met. The Collective Platform provides this hospital event notification to healthcare organizations outside of the hospital system that includes CCOs, providers (physical, behavioral and oral), clinics, and health plans, in real time when a patient or a member has a hospital event.

Health Share assumes financial responsibility for the Collective platform for our IDS/ICNs and their provider networks to have access. ███████████████████████████████████ ███████████████████████
ii. Additional Progress Specific to Physical Health Providers
As noted elsewhere, many physical health providers are leveraging either the Collective Platform or EHR-based ADT notification to provide prompt care coordination services following hospital discharge.
iii. Additional Progress Specific to Oral Health Providers
Assessments have been completed on our delegated Oral Health providers who utilize the Collective platform. This was to help us understand the PDP utilization of the platform.
iv. Additional Progress Specific to Behavioral Health Providers
Twenty-eight clinics engaged in using Collective and 16 have not implemented or not engaged.
v. Please describe any barriers that inhibited your progress.

2. Please describe how you used timely Hospital Event Notifications <u>within your organization</u>. In your response, please include
    a. The HIE tools you are using
    b. The strategies you used in 2020
    c. Accomplishments or successes related to your strategies

As noted above, Health Share is supporting Hospital Event Notification with a region-wide contract to cover the Collective platform. Health Share's CCO model includes delegation of care coordination functions to each of the IDS and ICN networks. As such, Health Share the entity does not utilize ADT for daily care coordination functions, though the CCO is capable of receiving and incorporating the data for HIE and analytic purposes. Our ICN CareOregon which provides benefits to nearly 100% of Health Share's members through their oversight of the specialty behavioral health network, has integrated event notifications into their GIS Health Coordinator/Med decisions tool. Admission discharge notifications are sent to the platform, so case managers have cases identified and regional care teams can respond according to risk level and clinical program. Critical tags push to the working panel to identify an event. They still rely on reviewing daily in the Collective platform for any new members that are not in a case. This technology has been more fully adopted within the ICN in 2020 and they continue to promote enhancements to the offerings under Collective to broaden the types of notifications and responses the platform offers.

b. 2021 – 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 your response, please include
    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). CCOs are expected to use this information to inform their plans.
    b. Any additional HIE tools you are planning to make available to your providers for Hospital Event Notifications

i. Additional Strategies Across Provider Types, Including Activities & Milestones

Moving forward, our IDS' will continue to integrate and optimize workflows that utilize hospital event notifications. They plan to do some discovery around opportunities for refinement in the utilization of the Collective tool and which particular use cases require more defined workflows. COVID has thwarted some of the expected progress in aligning around these opportunities.

Our ICN is interested in exploring how they can 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.

Our ICN is also looking to expand a diabetes flag for other CCOs, which metro already has. The roadmap over the next few years includes enabling care plans to be ingested into GIS Health Coordinator/Med decisions tool also shared within the Collective platform so the care coordination is available to provider networks. There will be more discovery around which EHR platforms within the ICN network can ingest notifications around hospital events. This will be extremely helpful for providers who have more sophisticated EHRs.

A proof of concept is being developed in 2021/2022 which will look at what % of the provider network would benefit from having automated processes of notifications into their EHR. Collective is very active in making improvements and has identified their roadmap which includes the continued development of intelligent readmission scores, risk modeling of ED visits, and enhancing flags. We are looking at creating a Collective collaborative forum amongst our IDSs/ICN quarterly to continue our improved efforts around hospital event notifications, workflows, and tools.

According to the December 2020 CCO HIT Data File (Completeness Table) OHA collected related to HIE Hospital Event notifications. Health Share will participate in conducting an EHR and HIE assessment survey this year in line with OHA's refined data collection survey, with both our ICN and IDS' to understand the gaps that the State is reporting and reconcile any differences and work with the ICN/ICNs on adoption strategies.

Service Type	Number of organizations (denominator)	Hospital event notifications (i.e., Collective Platform*)	
		Org count	Rate
Physical	484	17	4%
Behavioral	104	16	15%
Oral	183	0	0%

ii. Additional Strategies Specific to Physical Health Providers, Including Activities & Milestones

iii. Additional Strategies Specific to Oral Health Providers, Including Activities & Milestones
From the oral health provider assessment, do an analysis how the PDPs are using Collective. It would also be helpful to understand if there are any barriers for our oral health providers to implement and utilize Collective. We will continue outreach and engagement to get more oral health providers utilizing the Collective platform.

iv. Additional Strategies Specific to Behavioral Health Providers, Including Activities & Milestones
Continue to support our behavioral health providers who have not implemented or have been engaged with Collective. Outreach and perhaps further assessments needed to see if there are any barriers and how we can assist to adopt usage.

2. Please describe your strategies for using timely Hospital Event Notifications <u>within your organization</u> beyond 2020. In your response, please describe
   a. Additional HIE tools you plan on using
   b. Additional strategies you will use
   c. Activities and milestones related to your strategies

As noted above, Health Share as an entity, delegates all care coordination activities to the IDS/ICN networks, who collaborate to ensure timely and comprehensive care coordination services across all care domains.

Our IDS' will continue to use the Collective platform as a source of real time to update information that alerts a need for our members. There are opportunities to map interventions to subpopulations by analyzing the data in Collective to ensure our IDS' programs and interventions are appropriate. Another opportunity is to identify members who are escalating into a higher risk category enabling more meaningful strategies around care coordination and outreach. A final strategy is to create flags that indicate if a member is utilizing services across multiple domains to create communications bidirectionally and share care plan development for members who engage with different health care systems which as (primary care or behavioral health). Unfortunately, due to the urgency of responding to COVID, plans to engage with Health Share's HIT Governance Committee on these enhancements have been delayed.

Optional Question

How can OHA support your efforts in HIE related to hospital event notifications?
As noted above, Health Share would appreciate collaboration on any decisions about changes to OHA's funding of CMT efforts so CCOs have sufficient time to plan for reallocation of resources. Also, continued collaboration between OHA, OHLC and CCOs related to this and other efforts would be greatly appreciated. That partnership has been incredibly useful in promoting and expanding adoption of these important tools.

5. Health IT and Social Determinants of Health and Health Equity (Optional)

This section is optional, however OHA would encourage CCOs to share their efforts here. Please describe how you are using HIT and plan to use HIT to support addressing social determinants of health (SDOH) and health equity (HE), including Community Information Exchange (CIE) or other tools.

i. Overall Strategy in Supporting SDOH & HE with HIT

Health Share is actively working to utilize CIE to better address social determinants of health and health equity across all areas of CCO work.

The CCO's strategic role is to work within and across sectors to explore data sharing opportunities that will help the health system better understand where social needs are, what resources are available to address those social needs, and to improve both care coordination and policy advocacy to drive system change. The CCO has had recent successful data sharing initiatives that span both the housing and criminal justice domains. These efforts have served as a proof-of-concept about merging data across these sectors to promote a different type of system response and intervention in alignment with the CCO's Community Health Improvement Plan and focus on addressing SDOH. Heath Share's role as a data aggregator and analytic hub is key to the development of a multi-year strategic plan focused on achieving health equity by addressing social determinants of health and system integration.

The work currently centers around a few key initiatives that will be continuing to evolve over the next few years. These include Health Share's early adoption and support of the Connect Oregon initiative, which aims to connect health system providers, county public health and social programming, and community-based organizations to ease referrals and resource finding for all of these important parts of the network. It also includes a distinct focus on housing, which was the top priority identified in the CCO's Community Health Improvement plan in an initiative called the Regional Supportive Housing Impact Fund (RSHIF). RSHIF has developed both a data sharing and evaluation framework centered in community voice and multi-partner governance. It will continue to evolve in parallel to other local housing initiatives, including the local Metro housing bond, where Health Share plans to be a strong partner with local housing authorities and county government to address the regional housing shortage. Health Share has also been actively engaged with both housing and criminal justice under the Frequent User System Engagement (FUSE) initiative, which included sharing data across those three sectors in Multnomah county to understand the overlap of Medicaid, homelessness and incarceration. This work will likely lead to further collaboration with the criminal justice system to better meet the needs of individuals who engage in both.

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

Health Share is in the early stages of adopting the Connect Oregon (Unite Us) platform to allow electronic referrals between clinics, county programs and community-based organizations. The CCO's contract enables virtually all providers in the region, all CBOs and all publicly funded programs to engage with the network at no cost to them, essentially creating low barrier access to this important service.

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?

As noted above, Health Share has a number of projects aimed at achieving this goal. The CCO is able to perform member matching work to link social information with claims data to better understand both clinical need and potential impact of social determinants interventions.

Types of data being incorporated into Health Share's data warehouse
1. CIE data coming back to HSO—Under the Connect Oregon initiative Health Share is working with Unite Us and other CCOs across the state to enable member matching and output files from the CIE to allow for deeper analysis of need and potential resourcing options.
2. Criminal justice data—Under the FUSE project Health Share combined data on bookings from Multnomah County jails and Health System data to analyze the characteristics of individuals who touched both

systems. This work is likely to continue with more robust data sharing, with the goal of improving programs and interventions to better support our members.

3. RSHIF and Metro housing projects—Health Share's work in FUSE and RSHIF has included preliminary data sharing agreements that enable information flow from the housing system to be combined with health system data. This work is continuing but has strong support from both housing and health leadership.

4. Pediatric Complexity Data—Oregon Pediatric Improvement Partnership and OHA have worked together to create children's health complexity datasets that offer perspectives on both clinical and social risk for pediatric populations. One of Health Share's areas of strategic impact is in early life health, so this data has helped offer new perspectives on where social need exists and how it interfaces with medical complexity.

The overarching goal of each of these areas of work is to create a more complete picture of the drivers of health in the social domain, and to create a common language and outcomes for cross-sector collaboration. This is a function that Health Share is well positioned to play, as the technical challenges of incorporating the data, creating data sharing agreements, matching members and, critically, ensuring that this is done ethically with a strong lens toward health and racial equity, is both challenging and logistically complex. Health Share does this work on behalf of its partners and through a transparent governance process that enables strategic decision making and intentional allocation of resources to meet shared goals. Although technology is only one part of this work, along with strategic investment, community engagement, etc., our partners and community recognize the catalytic role that a CCO can play in this space and how it is fundamentally different from the role a traditional health plan might play in a community.

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

Hesitancy to share data across sectors—need to build trust about intent and use of data, and ensure that all data use agreements are legal.

Ethical guidelines—many of the systems that are engaged in this work are built upon a history of structural racism. The power and decision-making processes that have traditionally guided these efforts come with considerable and justifiable mistrust of these institutions, including the health care system. Therefore, combining these data in new ways needs to include community engagement, patience to not simply rely on the 'easy' approach to combining big data, and agreement about the uses and limitations of the information.

Insufficient resources among CBOs to integrate technology into their social resource provision efforts.

Optional Question

How can OHA support your efforts using HIT to support SDOH/HE?

OHA could help forge the necessary relationships to help build trust, communicate/advocate the intent and use of the data, as well as ensure there is a standard template for data use agreements, so not every organization has their own flavor or template. This will help expedite the data sharing process as well share information in a more uniform way.

6. Health IT for VBP and Population Health Management

a. HIT Tools and Workforce

Describe your HIT capabilities for the purposes of supporting value-based payment (VBP) and population management. In your response, include information about the following items: 1. Tools: Please identify the HIT tools you use for VBP and population management including: a. HIT tool(s) to manage data and assess performance

b. Analytics tool(s) and types of reports you generate routinely
2. Workforce: Please describe your staffing model for VBP and population management analytics, including in-house, contractors or a combination, who can write and run reports and help other staff understand the data.

i. HIT Tools for VBP and Population Management

Health Share's HIT Roadmap related to VBP and Population Management is extensive. Health Share's VBP approach includes sub-capitated arrangements with IDS and ICN partners who are at risk for their population with enhanced payments based on quality metric performance. In 2020 many of these requirements were waived both by OHA and by the CCO due to the substantial changes due to COVID. However, this primary arrangement whereby Health Share's VBP goals are largely addressed through a LAN-4C arrangement based on Quality performance measures, means that the CCO's provision of data, specifically as it relates to quality metrics, is crucial. Additionally, as a central aggregator of population level data, Health Share's data sharing supports many population management functions among and across partners, including perspectives on integration across care categories, risk stratification, and tracking patient movement from one CCO or IDS/ICN to another.

The six workstreams mentioned in our attached roadmap are as follows:

1.0 Risk Stratification Tools: Health Share has started to convene our IDS/ICNs in 2020 to discuss population health and risk stratification needs. This year we are focused on assessing local and national risk stratification methods, create a workgroup to discuss and create use cases, and then get approval from IDS/ICNs as well a provider on risk markers and stratification. Additionally, the CCO has focused substantial risk stratification efforts on emerging COVID vaccine provision efforts and ensuring equitable distribution. This including clinical risk and population risk based on known disparities due to language and race (see additional section of roadmap, "O.COVID)

2.0 Improve Bridge (Tableau dashboards): As mentioned in the above HIE Care Coordination section, Health Share Bridge is widely used amongst up IDS/ICNs and partners. The dashboards are slated to be improved over the next year to increase speed, efficiency, look for any opportunities to enhance data sharing for better care of our members. In addition, we are looking at improving the overall usability of the interactive dashboards and filters to make them more seamless.

3.0 Composite Score in Behavioral Health: Refining the accuracy and availability of our provider data sets to lead to developing a score for SUD detox, residential, outpatient, and MAT programs.

4.0 Improve operational data collection and quality / Data Source: There are many manual reports that our IDS/ICNs send on a frequent basis, we are currently taking inventory of manual reports to see how we can operationalize them and create process improvements. We started this project in Q4 of 2020 and continue our efforts through our HIT Governance committee. To name a few we are currently operationalizing the DSN quarterly data submissions as well as the monthly PCPCR reports. There are more opportunities we are inventorying and prioritizing for process improvements.

5.0 Dissemination of Data: Tableau Public: Provide aggregate population data in order to provide transparency and insights into the metro region Medicaid population as it pertains to condition prevalence rates, BIPOC, race, ethnicity and engagement in health activities.

6.0 Incorporate Geo-mapping: Incorporate geo-mapping into all relevant dashboards to enable more location relevant action and outreach programs.

ii. Workforce for VBP and Population Management Analytics

Going into 2020 Health Share had one IT team that consisted of 2 analysts, 2 business analysts, 1 project manager, and 1 systems administrator. The vision for the department was to substantially increase the analytics half of the department, as well as the technology half to increase responsiveness to requests for information, depth of analytics skills, and a create robust data platform.

Mid-year 2020 Health Share moved away from an IT department and rebranded themselves the IS (Information Services) department. The new department now employs an analytics manager and an IT manager to set strategic roadmaps and direction for analytics and technology, respectively. The analytics team now has 4 dedicated analysts reporting to the analytics manager. The IT team now has 1 DBA, 2 system administrators, 1 help desk person, and 1 project manager reporting to the IT manager. The additional staff and proper team infrastructure have allowed us to initiate building a proprietary enterprise data warehouse (EDW) which will allow for the ingestion of SDOH data along with many other non-health related information. We are currently halfway through this intense project.

b. HIT to Administer VBP Arrangements: 2021 – 2024 Plans and 2020 Progress

Describe your plans for using HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models). In your response, please include
1. Strategies for using HIT to administer VBP arrangements, including how you will ensure you have the necessary HIT as you scale your VBP arrangements rapidly over the course of the Contract and spread VBP to different care settings each strategy. Additionally, include plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the Contract.
2. Specific activities and milestones related to using HIT to administer VBP arrangements

Additionally, describe
1. Progress you made in 2020 using HIT for administering VBP arrangements, including any accomplishments and successes.
2. Challenges related to using HIT to administer VBP arrangements

Note: If preferred, you may submit a separate document detailing each strategy's activities and milestones.

i. Strategies for administering VBP arrangements, including activities and milestones

Between our IDS' and ICN, since the start of 2020, we estimate that at least 68% of Health Share's provider payments qualify as HCP-LAN 2C or above. While these numbers are continuing to be finalized we anticipate that the CCO is on track to hit VBP targets initially established in the RFA.

Although we are starting from a position of strength in this area, we still have a lot of work to do to continue to advance VBP in our region. Health Share will build upon this strong baseline from year one and focus on:

1. Increasing the number and breadth of VBPs
2. Progressing existing VBPs beyond a LAN 2C status
3. Supporting our IDS partners' expansion of VBP within the LAN 4C payment category by expanding service categories covered by the IDSs (e.g., specialty behavioral health and dental)
4. Addressing social determinants of health and health equity through VBP

In years three and four, we will focus on developing HIT support for OHA's VBP payment priorities: hospital, maternity, children's health, pharmacy, behavioral health, and oral health.

In late 2020 and early 2021 we have completed a VBP assessment with each our IDS' in their progress towards VBP arrangements and provider contracts. According to the original HIT Roadmap, the majority of areas for VBP growth for these IDS's occur in future years and as such these goals are largely on track. Health Share feels they have made sufficient progress in year one and will continue to set important dates/milestones for the subsequent years as the strategy in key population areas matures. Unfortunately, the shared focus on COVID response and, now, vaccinations has made alignment more difficult.

As indicated in the original HIT Roadmap, a majority of the VBP work will exist within the ICN where direct payment arrangements between non-integrated PCPCHs, BH and Oral Health providers comprise the VBP arrangements.

Our ICN is uniquely positioned with not only physical health coverage but also manages all dental and behavior health as well as our non-emergency transport (NEMT). The ICN will support integration of behavioral health and oral health benefit administration on behalf of the broader network in partnership with Health Share, through the provision of data to behavioral health providers to ensure accurate panel management and improvement on key quality measures. We will also continue HIT strategies to hit the 70% VBP target by 2024.

In year five and beyond, we will pursue further integration of NEMT and SDOH event capture and benefit administration for non-health care provider entities. Developing and improving the HIT capacity to ensure accountability and measurement of these systems will be critical to monitoring the health and functioning of these efforts as they relate to VBP models.

We wanted to showcase the VBP work that CareOregon (ICN and largest partner) has put forth:

CareOregon's 2020 Payment Arrangement File submission, based on 2019 payment data, showed that over 72% of payments had a link to a qualifying VBP contract utilizing LAN categories and the OHA methodology defining that link. CareOregon anticipates this proportion will increase over time.

CareOregon's VBP arrangements incentivize and hold partners accountable for performance on Oregon's CCO incentive metrics as well as other measures of clinical quality. While the measures for these arrangements are currently aligned with OHA priorities, future governance decisions and VBP needs could expand these measures of accountability to include engagement with high-priority populations, elimination of health disparities, and other measures.

To that end, CareOregon is well poised to operationalize these evolving arrangements through their software platform that supports PMPM VBP administration. This VBP tool, a leading third-party application, currently allows us to administer payments, adjust performance-based payments, and integrate VBP and claims data. This functionality is critical for their ability to report on payment arrangements by LAN category, as required.

CareOregon will use this software to manage payments for our PCPM, CPC+ and IBH programs. The evolution of work in this area may seem intuitive, however, administration of non-claims-based payments in a health system that was built on a fee-for-service system has required a significant amount of operational overhaul. Moving from manually processing checks to integrating this work into our claims processing system, including records of performance has greatly improved efficiency and allows us to administer and record performance and associated payment in one location. In 2020, they expanded use of this tool to include capitation payments and other PMPM contract models.

Another critical tool supporting VBP expansion is the financial model developed by Wakely, an actuarial consulting service, which provides the architecture that supports our primary care Total Cost of Care (TCOC), and Medical Loss Ratio (MLR) risk agreements. This financial model calculates the total cost of care for a primary care partner's assigned membership, along with detailed cost data analytics allowing the provider to identify trends, and areas of opportunity to better manage resources. In 2019 and 2020, Wakely further developed modules within this model that aid in the process of risk recapture and managing the health of a population. The risk recapture/population health module allows the provider to search for members previously diagnosed with high-risk conditions, without a recent claim showing that diagnosis. This tool can be used to proactively outreach to members with chronic conditions to ensure they are receiving preventive care.

ii.	Progress in 2020 in using HIT for administering VBP arrangements, as well as any accomplishments and successes.

Because Health Share's VBP arrangements include significant risk sharing among Integrated Delivery Systems who are held to Quality Incentive Measures, the arrangements largely classify as LAN-4C. Health Share provided key data related to both population health and quality measures to each of these systems as it has in the past, including both aggregate, year-to-date, and annualized performance reports on all key measures, data sets identifying gaps in care (ALERT and DHS Metrics) and other key clinical quality measures data. Unfortunately, due to COVID, OHA's Metrics Program—the backbone of Health Share's VBP arrangements with these IDSs—was suspended and so development of the nuances of this data sharing was suspended so the system could collectively focus on COVID response.

Similarly, within Health Share's ICN, 100% of the providers participating in VBP arrangements had access to the data referenced in the above section. Providers that participate in the ICNs risk agreements (TCOC, MLR) also have access to the Wakely financial model providing additional data regarding utilization patterns, and costs of services provided by other providers in the network.

The BH composite score quality payment methodology Health Share has adopted remains in place supported by CareOregon's data warehouse and associated analytics tools. This methodology offers quality incentive payments to providers for performance relative to a set of Behavioral Health quality metrics. In the future, the CCO plans to continue to update this program structure to incorporate downside risk, and augment quality metrics with outcomes-related metrics. The current iteration of the program should meet the BH CDA requirement.

v. Please describe any challenges you face related to using HIT to administer VBP arrangements.

As noted above, many of the typical developments related to quality metrics data sharing to support VBP arrangements were necessarily delayed due to critical COVID response. However, over the course of 2020, the ICN nevertheless implemented a quality metric based VBP with a hospital partner that includes both up and downside risk for quality metric performance. This was particularly challenging as it required engaging with the system to determine metrics both parties felt they could influence with membership where their assigned PCP resides outside of that system and where the system does not have a direct connection with that member as it relates to their preventive care needs. This arrangement will satisfy the Hospital CDA requirement and is being implemented with other systems for 2021 and beyond.

c. Support for Providers with VBP: 2021 – 2024 Plans and 2020 Progress

Please describe your plans for using HIT to support Providers in the following areas (i. – iv.) so they can effectively participate in VBP arrangements. In your response, please include
1. Strategies for using HIT to support Providers so they can effectively participate in VBP arrangements
2. Activities and milestones related to using HIT to support Providers so they can effectively participate in VBP arrangements
3. If used, specific HIT tools used to deliver information

Additionally, please describe
1. The percentage of Providers with VBP arrangements at the start of the year who had access to the following data
   a. timely information on measures used in VBP arrangements
   b. accurate and consistent information on patient attribution
   c. information to identify patients who needed intervention, including risk stratification data and Member characteristics
2. Progress in 2020 related to this work, including accomplishments and successes
3. Challenges related to this work

Note: If preferred, you may submit a separate document detailing each strategy's activities and milestones.

i. How you provide Providers with VBP arrangements with timely (e.g. at least quarterly) information on measures used in the VBP arrangements applicable to the contracted Providers.

Health Share has three primary mechanisms for sharing critical data and information (1) through Health Share Bridge, we have a number of Tableau dashboards and member lists in which plans, and providers can access, (2) we have secure Health Share Bridge SharePoint pages in which reports, and member information can be shared with providers, plans and the community at large, and (3) sending data to Collective Medical Technologies' which allows providers, plans and care coordinators to access critical patient information real time.

Access to aggregated data down to specific member attribution and PHI via Health Share's Bridge site is controlled through a rigorous security layer that complies with HIPAA and assurances of appropriate data sharing agreements. At a high level, we ensure that our partners have access they need to regularly refresh reports,

including aggregate and member level on all calculatable measures. We also deliver data like ALERT, DHS measures, etc. The types of data we have available on our Health Share Bridge sites are as follows:

- Detail claims data.
- Patient medical summary which includes such things as demographics, current medications, conditions, PCP, ED visits, inpatient visits and more.
- CCO metric leading indicators and member lists which is sent out each month and details members in the denominator, members in the numerator and members not meeting expectations.
- Member risk stratification tools that allow the user to define what attributes are of interest in calculating 'population at risk'. Attributes available for selection include number of chronic conditions, age, rate code, utilization and 15 others. Once risk attribution has been selected member lists can be generated in order to enable better care coordination and outreach.

Information that we send to Collective Medical Technologies includes TOC eligibility and risk level, care plans for TOC members, diabetic flag etc.

CareOregon subcontracts with a network of PCPCHs, BH providers and oral health providers and as such regularly shares data, at least quarterly, with its providers. They are currently expanding this capability to ensure that data provided to clinics is specific to VBP arrangements in which they participate. Our ICN's existing analytics infrastructure and software tools allow us to deliver Oregon's CCO incentive metrics and select HEDIS–NCQA measures to providers on a regular basis. Enhancements will continue to expand their 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. Scorecards include both aggregate (clinic-level) and member-level information, making data more actionable for intervention.

CareOregon has launched enhanced capabilities which include access to expanded data and scorecards as well as the ability to receive provider scorecards via secure email. These will be tailored to a clinic's VBP program participation and population needs. Their enterprise data warehouse will continue 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 with elements such as SDoH, it will open further opportunities for partnering with CareOregon's providers to drive improved performance and care. In the event that their current reporting applications do not include measures that are applicable to the VBP programs implemented future years, they will upgrade our reporting platforms to ensure that reports are comprehensive.

In addition to supporting performance analytic capabilities, CareOregon provides access to the GSI care coordination platform available to our provider partners which will further support care activities needed to succeed in a VBP environment.

ii. How you provide Providers with VBP arrangements with accurate and consistent information on patient attribution.

Health Share collects and stores current and historic information regarding the PCP/PCPCH, PDP, and Behavior Health provider in which a member is paneled (in the case of PCP/PCPCH and PDP) or has an extended prior authorization (in the case of BH provider), and the dates associated with each panel assignment. The historic panel information allows us to ensure that the plans and current providers in which a member is associated has access to all critical clinical information and full member attribution current and historic.

Health Share's Bridge SharePoint site contains Tableau dashboards that provide full member attribution both current and historic. The member attribution information consists of current and historic PCP, PDP, and behavior health provider, the dates in which the member was associated to each of the providers, and the associated medical, dental and behavior health plans. Using the attribution information our dashboards show utilization by visits and cost categorized into primary care, specialty care, emergency care, pharmacy, hospital, metal health, SUD, and dental.

In addition to providing access on member attribution through Health Share Bridge, we also send out current member attribution information once per week to each plan for all of their currently active members.

Complementary to the work at Health Share, our ICN also has a reporting platform includes data on patient assignment and utilization. For purposes of VBP arrangements, they calculate performance on an "assigned" basis. In instances where members are inappropriately assigned, CareOregon has staff that work to quickly reconcile and reassign as appropriate. Information on patient assignment is available both through their data reporting platform as well as their provider portal. Transparency of this information allows for productive conversations around population health management expectations under our VBP arrangements.

CareOregon continues to use an authorization-based methodology for behavioral health member attribution for VBP performance measurement. This provides a fair and consistent way to align patient responsibility with behavioral health providers and enables comprehensive measurement of provider performance to produce a "composite score" crucial to our VBP incentives for our Behavioral Health providers.

iii. How you use data for population management – to identify specific patients who need intervention, including data on risk stratification and Member characteristics that can inform the targeting of interventions to improve outcomes.

Our IDS/ICN's leverage the Collective Platform for transparency of ADT data and sponsor their providers and provide Community of Practice sessions through their 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. The Health Share partners, exchanges member care plans with each other through Collective when a member transfers from one partner to another.

Health Share maintains a comprehensive enterprise data warehouse combining data from administrative, care coordination, claims, SDOH, and analytic sources. We provide access to our Health Share Bridge platform to all of our plan's Population Health teams which can utilize the Population Health Explorer dashboard, utilization dashboards, and population segmentation built on this platform, to create interventions and programs.

iv. How you share data for population management with Providers with VBP arrangements – so providers can take action with respect to specific patients who need intervention, including data on risk stratification and Member characteristics that can inform the targeting of interventions to improve outcomes.

In addition to the data sharing described above, where Health Share Bridge is used to convey a significant amount of patient health, risk and metric-related information, Health Share currently shares claims detail and member attribution data in an Epic consumable layout for providers interested in receiving a more complete picture of member engagement across systems. Two large FQHC systems are currently the recipients of this data which is then ingested into Epic's Health Planet application specifically designed to support VBP analytics.

Our ICN CareOregon makes reports and interactive dashboards available to providers on VBP arrangements on a continual basis with data refreshes at least quarterly for risk stratification and more frequently for other data elements. Member-level data is available using these tools to identify risks and interventions needed. Our ICN is actively deploying a new web-based analytics and report delivery system we call FIDO Web (Fully Integrated Data Organizer). FIDO Web uses newer technology and a more robust platform which enables them to provide single sign-on, enhanced dashboard functionality and expand the types of dashboards available to external users in the future. Rollout will be complete by the end of the second quarter of 2021.

Our IDS/ICN partners also broadly leverage the Collective Platform for transparency of admission/discharge/transfer data and sponsors providers to obtain access. They facilitate Community of Practice sessions through our network to support teams in leveraging the tool in their day-to-day operations as well as identify unique contracting to include the tool in their practice.

v. Please identify the percentage of Providers (e.g., clinics or groups) with VBP arrangements at the start of the year who had access to these above data. If not all providers with VBP had access to this information, please describe why not.

100% of Health Share's risk arrangements with IDS or ICNs include substantial data sharing arrangements mediated through Health Share Bridge (described above). Each of these organizations receive regular as well as ad hoc data to support their population management and VBP goals and we work regularly with each of them to ensure easy and timely access to reports and dashboards within the platform.

vi. Please describe your progress in 2020 with this work, as well as any accomplishments or successes.

In 2020, as part of its CCO 2.0 redesign, Health Share moved away from the 5 medical health plan, 5 dental plans and 3 behavior health plans to a completely different model. The CCO shifted to a model with 4 Integrated Delivery Systems (IDS) and an Integrated Community Network (ICN), with oral health, behavioral health and NEMT services managed under that network. This shift was considerable and was driven to create a more tightly integrated system, with stronger risk sharing arrangements among all of the local hospital systems and the majority of outpatient clinics in the region. The late stage of 2019 and the initial phase of 2020 was spent refining both data sharing and information flow to ensure the successful shift to this model and we are proud of what we have accomplished in standing up this model. Health Share is confident it will be better for our members and community.

In the new CCO structure we regularly share data, at least monthly, with our new ICD/ICN partners and some providers. Our existing analytics infrastructure and software tools allow them to deliver Oregon's CCO incentive metrics and select HEDIS–NCQA measures to providers on a regular basis.

The CCO's contract with CMT/Collective allows all provider networks to access the platform. The collaborative of partners continue to engage with providers to leverage data from the platform, including reports and dashboards that combine data gathered from Collective with internal information, to assist providers in improving quality and VBP performance.

With respect to behavioral health specifically, CareOregon contracted with OHLC to onboard and train 8 new BH providers in the use of the Collective platform, as well as training CareOregon staff to be able to provide ongoing technical support to current and new providers on the platform.

vii. Please describe any challenges you face related to this work.

Provider capacity due to COVID impacted their ability to engage in this work.

Optional Questions

a. Describe how you educate and train providers on how to use the HIT tools and VBP-related data (e.g., performance metrics, patient attribution, member characteristics) they will receive from the CCOs.

Health Share Bridge is Health Share's platform for sharing data and information with a large selection of Tableau dashboards as described earlier which can aid providers and plans in caring for patients. Health Share routinely offers Bridge on-boarding approach that includes both risk-based contracts and any providers or public entities that engage with Bridge.

CareOregon is planning to conduct a VBP Readiness Assessment for our provider network. This will inform our education and training efforts going forward.

b. How can OHA support your efforts related to data/HIT and VBP?

Align "Exhibit L" and [APAC] Payment Arrangement File submissions to reduce overhead and create a single source of truth for VBP adoption rates. Need clarification on how these are used to calculate VBP adoption rates.

Streamline CCO 2.0 roadmap reporting to reduce duplicative work (e.g. HIT Roadmap and VBP Roadmap reports).

7. 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?

b. How have your organization's HIT strategies changed or otherwise been impacted by COVID-19? What can OHA do to better support you?
As described throughout this document, our HIT strategies have not inherently changed but rather were delayed due to a redirect of staff, partners and providers to focus on preventing the spread of COVID, discharge planning for members with COVID that are homeless or do not have the resources to quarantine, and now on outreach in support of ensuring equitable vaccine distribution. Health Share has taken a critical region-wide role in ensuring access to data to drive regional strategies around vaccine distribution, and this function has required a significant use of staff and resources. We appreciate OHA's continued understanding of the impact of COVID on our (shared) efforts, and believe that the CCO model is a strong vehicle for the type of community response needed to address this critical public health emergency.

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 2020 progress and 2021 – 2024 plans. The examples are based on submitted 2019 CCO HIT Roadmaps and include specific tools and/or strategies. 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.

Strategy: CCO's approach and plan to achieve outcomes and support 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. 2020 Progress

In your response, please describe
1. Specific HIE tools you supported or made available in 2020
2. The strategies you used to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers in 2020
3. 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.

i. Progress Across Provider Types

In 2020, 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 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.

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.

EDIE - All hospitals in our service area have adopted EDIE. In addition, the HIT Commons has been working to bring PDMP information to Emergency Departments through integration of the Oregon PDMP registry with the EDIE platform.

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.

Telehealth - Our CCO supports telemedicine in the behavioral health setting to access adult and child psychiatry support and coordinate care with providers outside of our service area.

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

Our 2020 progress centered around the following strategies our CCO implemented. The 2020 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 the a 5-Year HIT plan that includes the following components that will 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 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.
- Our CCO supported adoption of PDMP/EDIE integration among our hospitals; to date, one hospital is actively using this tool.

Strategy 3: 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 (e.g., Unite Us, Bertha, Clara)
- 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.
- Expanded use of the Collective Platform for care coordination

Strategy 4: 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.
- 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 5: 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:
- Clinical Quality Metrics Registry, Subject Matter Expert Workgroup – helps define rules and technical assistance for providers to electronically submit data to CQMR in 2020.
- Oregon Health Leadership Council - EDIE Steering Committee
- HIT Commons Workgroup
- Metrics & Scoring Committee
- Health Information Technology Advisory Group

ii. Additional Progress Specific to Physical Health Providers

Strategy 6: 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 emergency department for dental issues receives outreach, care coordination, and support in scheduling a 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 2020, our CCO implemented the following strategies specific to oral health providers and achieved the listed accomplishments/successes:

Strategy 7: 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 8: 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 2020, our CCO implemented the following strategies specific to behavioral health providers and achieved the listed accomplishments/successes:

Strategy 9: 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 6: 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 2021.

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

b. 2021 - 2024 Plans

In your response, please include
1. 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

2. Any additional HIE tools you plan to support or make available.
3. Additional strategies you will use to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers beyond 2020.
4. Associated activities and milestones related to each strategy.

Notes:
- Strategies and HIE tools described in the *2020 Progress* section that remain in your plans for 2021 – 2024 **do not need to be included** in this section unless there is new information around how you are implementing/supporting the strategy and/or HIE tool.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and 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. 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 2021-2024 HIE for care coordination strategies.

We will continue to use and support all HIT/HIE tools listed in the *2020 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 2021 – 2024, our CCO will implement and support the following strategies across providers 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.	2021: Identify mobile applications to support
Evaluate, design and develop HIE interoperability solutions with Reliance.	Q1-Q3 2021
If approved, deploy, monitor, and optimize Reliance referral module for our CCO Care Coordinators	2022 – 2024
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 3: 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.	2021

In conjunction with State efforts, evaluate mechanisms to incorporate SDOH service providers into referral and care coordination workflows.	Q3 2021
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 10: Understand HIE technology adoption and use among network physical, behavioral, and oral health providers

We will pursue data collection via an online Health IT survey (in conjunction with OHA's Office of Health IT) that will be distributed to contracted organizations currently using as well as not using HIE technology to determine

- Real and perceived barriers to 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 survey will provide us with the necessary information to modify our plan to appropriately support different providers types with care coordination needs.

Activities	Milestones and/or Contract Year
Coordinate with OHA staff on the development and distribution of an online HIT survey	Q1-Q2 2021: HIT information collected from providers currently using/not using HIE technology
Analyze results and explore opportunities for further support and develop workplan	Q3-Q4 2021: Identification of future strategies for supporting providers with HIE for care coordination
Meet with HIE vendors operating in our service area	Q3 2021: 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.	2022 - 2024: Value of HIE technology illuminated

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	2021
Explore expansion of current pilots within DCOs using the Collective Platform for high risk oral health conditions and/or members	2021
Expand existing electronic dental referral process with physical and oral health providers	2021
Support efforts identified in years 1 and 2 to further health information exchange between oral health and others	2022 – 2024
We will continue to expand explore 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 5: Engage with state committees/entities

Activities	Milestones
Continue to engage with State entities to ensure our CCO efforts align with oral health-specific initiatives	2021
Work with OHA and HIT Commons, explore ways to integrate PDMP information into HIE tools/services and downstream to Electronic Dental Record systems	Q2 2021: 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	2021
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 5: 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	2021
Work with the HIT Commons to evaluate expanded use of EDIE to inpatient behavioral health facilities	Q2 2021: Begin collaboration with HIT Commons

Strategy 11: 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 2021: First meeting
Develop workplan with priority use cases	Q2 2021: Identify use cases for initial workflow improvement
Continue to utilize workgroup for evolving behavioral health HIE workflow needs	2022 - 2024

Completed

In Progress

Due

Task	Owner	2020 Q1	Q2	Q3	Q4	2021 Q1	Q2	Q3	Q4	2022 Q1	Q2	Q3	Q4	2023 Q1	Q2	Q3	Q4	2024 Q1	Q2	Q3	Q4
1.0 Work Steam – Multi Disciplinary																					
1.1 Establish HIT Governance structure for EHR adoption efforts		■																			
1.2 Conduct physical and behavioral EHR environmental scans				■																	
1.3 Analyze the members and activities related to non-EHR practices in our networks						■	■														
1.4 Establish resource/advisory workgroup from Governance structure to provide workflow and TA to provider groups					■	■	■														
2.0 Work Stream – Physical Health																					
2.1 Create a ranked set of provider organizations that we will target for EHR adoption support							■														
2.2 Assess the role of contracting, VBP, quality metrics program, and other EHR-relevant programs to promote adoption							■														
2.3 Prioritize regions, and or provider types for outreach based on areas of greatest need							■														
2.4 Develop tailored value propositions and business cases for EHR-adoption or enhanced functionality							■														
2.5 Deliver up to date functionality and workflows of current EMRs to include foundational and best practice standards within the EMRs to include recommended treatment guidelines, decision support, and best practices at the point of care								■	■	■	■	■	■	■	■	■	■	■	■	■	■
2.6 Offer consultative services for care management and patient care navigation										■	■	■	■	■	■	■	■	■	■	■	■
2.7 Assess the range of incentives and support we are offering in regards to the progress made on adoption										■	■	■	■	■	■	■	■	■	■	■	■
2.8 Support EHR planning and technical extension programs and services and start to assess how support can be directed to increasing the more complete and meaningful use of EHRs in place								■	■	■	■	■	■	■	■	■	■	■	■	■	■
2.9 Implement population management tools such as patient registries and workflows										■											
2.10 Provide accessibility across diverse platforms, computers, smartphones and digital mobile devices														■	■	■	■	■	■	■	■
2.11 Provide data sharing across provider systems, assuring a continuum of care for patients that provides visibility for providers caring for that patient, regardless of service location														■	■	■	■				
2.12 Incorporate system alerts on abnormal results, negative trends, and potential drug interactions																			■	■	■
3.0 Work Stream – Behavioral Health																					
3.1 Bring behavioral health leaders, including those from the region's CCBHCs, together to share experiences on journeys to EHR adoption, the value they have realized and the opportunities they see going forward							■	■													
3.2 Create a ranked set of behavioral health provider organizations guided by values of HIT Governance Structure that we will target for EHR adoption support							■														
3.3 Determine how Health Share or our ICN/IDS networks can offer financial or other support for EHR adoption							■														
3.4 Work with our partners to educate behavioral health providers about benefits that result from investments made in the physical health EHR space								■	■	■	■	■									
3.5 Develop tailored gap analyses and adoption business models to better help non-EHR practices overcome barriers and understand the behavioral health functionality of EHRs in physical health settings								■	■												
3.6 Work with the HIT Commons to expand use of EDIE to inpatient behavioral health facilities								■	■	■											
3.7 Work with the HIT Commons to expand direct EDIE/PreManage connections to behavioral health EHRs								■	■	■											
3.8 Explore workflow opportunities to increase automation of claims submission								■	■	■											
3.9 Evaluate and reassess adoption program performance to date, adjust as needed.								■	■	■											
3.10 Work to maximize behavioral health EHR capabilities to incorporate and present physical health data												■	■	■	■	■					
3.11 Work to set up behavioral health EHRs to submit quality measures to the CQMR													■	■	■	■	■	■	■	■	■
3.12 Expand EHR extension offerings to behavioral health entities, capitalizing on physical health learnings and successes															■	■	■	■	■	■	■
3.13 Focus on the capabilities of behavioral health EHR systems to properly document and manage substance use disorder information, including evaluating access controls and limits on external disclosures															■	■	■	■	■	■	■
4.0 Work Stream – Oral Health																					
4.1 Work with DCOs to assess current provider use state, and to identify ways of measuring adoption							■														
4.2 Understand current state use of EDIE/PreManage within DCO landscape, including use cases and opportunities				■																	
4.3 Expand existing electronic referral processes between physical and oral health providers										■	■	■	■	■	■	■	■	■	■	■	■
4.4 Promote further use of EDIE for emergency department and urgent care event notifications for oral health related diagnoses							■	■	■												
4.5 Explore expansion of current pilots within some Health Share DCOs using PreManage for high risk oral health conditions and/or members									■	■	■	■	■	■	■	■	■	■	■	■	■
4.6 Require electronic exchange of clinical information for EHR-related quality measurements									■	■	■	■	■	■	■	■	■	■	■	■	■
4.8 Explore closed loop electronic referrals and/or reauthorization's for dental specialty services										■	■	■	■	■	■	■	■	■	■	■	■
4.9 Identify opportunities for how EHR systems in oral health settings can be augmented to better support care coordination and information sharing with primary care providers														■	■						
4.10 Work with DCOs on contracting opportunities to incorporate EHR adoption and use within existing value-based payment arrangements															■	■	■	■	■		

Barriers

Physical Health
Understand the specific adoption barriers experienced by our providers
Identify priority providers for increasing EHR adoption
Perform a detailed gap assessment for our prioritized providers
Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or our partners

Behavioral Health
Understand the specific adoption barriers experienced by our providers
Identify priority providers for increasing EHR adoption
Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or our partners
Perform a detailed gap assessment for our prioritized providers
Advocate and partner with stakeholders to educate behavioral health providers on how organizations can and have addressed these concerns
Incorporate the privacy topic into our HIE strategy to address concerns about ensuring patient privacy
Support OHA sponsored activities, such as the Behavioral Health Information Sharing Advisory Group

Oral Health
Engage with DCO partners to understand the specific adoption barriers experienced by our providers
Identify priority providers for increasing EHR adoption
Perform a detailed gap assessment for our prioritized providers
Work within our HIT governance model to define the support and incentives that can be offered either by Health Share or CareOregon, as the ICN network administrator responsible for the oral health network

HIE CARE COORDINATION & HOSPITAL EVENT NOTIFICATIONS WORKSTREAMS

Task	Owner	2020 Q1	Q2	Q3	Q4	2021 Q1	Q2	Q3	Q4	2022 Q1	Q2	Q3	Q4	2023 Q1	Q2	Q3	Q4	2024 Q1	Q2	Q3	Q4
1.0 Work Stream - Establish Governance	Owner																				
1.1 Determine governing body	Graham	G																			
1.2 Charter governing body	Graham	G																			
1.3 Record meeting notes	Melissa			G																	
2.0 Work Stream - Compile Inventory & Use Cases																					
Support Hospital Event Notification & Care Coordination																					
2.1 Epic to Epic	Maili				Y	Y															
2.2 HSO data distribution	Jan				Y	Y															
2.3 TOC	Jan				Y	Y															
2.4 CMT	Jan				Y	Y															
2.5 Tableau	Laura				Y	Y															
3.0 Work Stream - Identify HIE Gaps																					
3.1 Validate/review against CCO 2.0						Y															
3.2 Review gaps with Data Gov						Y															
3.3 Data Gov prioritize gaps						Y															
4.0 Work Stream - 2021 HIE Planning																					
4.1 Identify what gaps to address							Y														
4.2 Make recommendations to fill identified gaps							Y														
4.3 Review with Data Gov recommendations							Y	Y													
4.4 Get buy in to execute							Y														
4.5 Create project plan to execute							Y														
5.0 Work Stream - 2021 HIE Execution																					
5.1 Implementation of project plan (solutions)								Y													
5.2 Development and execution of comms plan								Y													
5.3 Develop training materials and documentation for utilization of new solutions								Y													
5.4 Operationalize utilization								Y	Y												
6.0 Work Stream - 2022 HIE Planning																					
6.1 Identify what gaps to address										Y											
6.2 Make recommendations to fill identified gaps											Y										
6.3 Review with Data Gov recommendations											Y										
6.4 Get buy in to execute											Y										
6.5 Create project plan to execute											Y										
7.0 Work Stream - 2022 HIE Execution																					
7.1 Implementation of project plan (solutions)												Y									
7.2 Development and execution of comms plan												Y									
7.3 Develop training materials and documentation for utilization of new solutions												Y									
7.4 Operationalize utilization												Y	Y								
7.5 Update HIE inventory													Y								
8.0 Work Stream - 2023 HIE Planning																					
8.1 Identify what gaps to address														Y							
8.2 Make recommendations to fill identified gaps															Y						
8.3 Review with Data Gov recommendations															Y						
8.4 Get buy in to execute															Y						
8.5 Create project plan to execute															Y						
9.0 Work Stream - 2023 HIE Execution																					
9.1 Implementation of project plan (solutions)																Y					
9.2 Development and execution of comms plan																Y					
9.3 Develop training materials and documentation for utilization of new solutions																Y					
9.4 Operationalize utilization																Y	Y				
9.5 Update HIE inventory																	Y				
10.0 Work Stream - 2024 HIE Planning																					
10.1 Identify what gaps to address																		Y			
10.2 Make recommendations to fill identified																			Y		
10.3 Review with Data Gov recommendations																			Y		
10.4 Get buy in to execute																			Y		
10.5 Create project plan to execute																			Y		
11.0 Work Stream - 2024 HIE Execution																					
11.1 Implementation of project plan (solutions)																				Y	
11.2 Development and execution of comms plan																				Y	
11.3 Develop training materials and documentation for utilization of new solutions																				Y	
11.4 Operationalize utilization																				Y	Y
11.5 Update HIE inventory																					Y

VALUE BASED PAYMENT (VBP) WORKSTREAMS

	Owner	2020				2021				2022				2023				2024			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.0 Work Stream - APMs and Value Based Payments	Owner																				
1.1 Support inpatient 2C	CareOregon																				
1.2 Expand hospital to 3A, 3B, 4B	CareOregon																				
1.3 Add MAT 2C or higher	CareOregon																				
1.4 Expand BH in primary care	CareOregon																				
1.5 Expand primary care to 3A-3B	CareOregon																				
1.6 Expand BH payment for Community BH Services	CareOregon																				
2.0 Work Stream - Enhanced Data Delivery to Partners and Providers / Provision of Performance Improvement Project																					
2.1 Inventory use of existing data and metrics available																					
2.2 Hold traning classes to educate and increase utilization of existing offerings from HSO																					
2.3 Identify gaps in data needed to support VBP (use focus groups or surveys)																					
2.4 Identify gaps or changes in metrics needed to support VBP																					
2.5 Develop project plan to close metric gaps																					
2.6 Develop project pland to close data gaps																					
3.0 Work Stream - Enhanced algorithm for BH provider attribution / Refine Attribution Information for Provider Assignment																					
3.1 HSO analytics to work with CO BH understanding current logic	CareOregon																				
3.2 Conviene analytics and CO BH to define updated algorithm for attribution	CareOregon																				
3.3 Gain approval of BH network on updated algorithm	CareOregon																				
3.4 Develop work plan to configure updated algorithm	CareOregon																				
3.5 Develop/execute comm plan around update attribution algorithm	CareOregon																				
3.6 Deploy updated algorithm	CareOregon																				
3.7 Identify new metric/data needs from providers and plans	CareOregon																				
3.8 Develop project plan to meet new data/metric needs	CareOregon																				
4.0 Work Stream - Expand assignment for members to a PDP to all dental / Refine Attribution Information for Provider Assignments																					
4.1 Evaluate current assignment and attribution methodology	CareOregon																				
4.2 Design proposal for updated process	CareOregon																				
4.3 Gain approval for new process and assciated project proposal	CareOregon																				
4.4 Develop new algorithms and communication plan for dental partners	CareOregon																				
4.5 Implemenent new methodology	CareOregon																				
5.0 Work Stream - Sharing Quality Metrics Data																					
5.1 Refine automated delivery of OHA rolling 12 month reports to IDS/ICN																					
5.2 Refine YTD reports and workbooks for high priority claims based measures																					
5.3 Refine reporting and workbooks for Immunizations (ALERT) Data																					
5.4 Refine Language Access measure collection and sharing																					
5.5 Refine measure specifications for current year metrics, reflect across all shared data																					
5.6 Enhance metric validation automated process																					
6.0 Work Stream - Cross Sector Data Sharing																					
6.1 Inventory data collected from community																					
6.2 Identify high needs and impactful data such as SDOH, housing, school, early life, etc...																					
6.3 Prioritize opportunities																					
6.4 Establish community partners on prioritized list																					
6.5 Understand needs of community partners / reciprocity																					
6.6 2021 targeted opportunities evaluated																					
6.7 2021 project plan for execution																					
6.8 2022 targeted opportunities evaluated																					
6.9 2022 project plan for execution																					
6.10 2023 targeted opportunities evaluated																					
6.11 2023 project plan for execution																					
6.12 2024 targeted opportunities evaluated																					
6.13 2024 project plan for execution																					

POPULATION HEALTH MANAGEMENT WORKSTREAMS

Task	Owner	2020 Q1	Q2	Q3	Q4	2021 Q1	Q2	Q3	Q4	2022 Q1	Q2	Q3	Q4	2023 Q1	Q2	Q3	Q4	2024 Q1	Q2	Q3	Q4
1.0 Work Stream - Risk Stratification Tools	Owner																				
1.1 Convene partners to discuss population health and risk stratification needs																					
1.2 Inventory local and national risk stratification methods																					
1.3 Create work group to create use cases for risk strat needs																					
1.4 Gain approval from Plans and Providers on use cases																					
1.5 Create work group to provide recommendations for risk markers and stratification methods																					
1.5 Gain approval from Plans and Providers on risk markers and stratification																					
1.6 Develop project plan to calculate risk markers and strat algorithms																					
1.7 Develop Tableau dashboard for Risk strat (out with Patient Strat)																					
1.8 Develop/communicate new markers and strat as well as how to operationalize the use thereof																					
2.0 Workstream - Improve Bridge (Tableau dashboards)																					
2.1 Create and implement user experience and needs survey	Health Share																				
2.2 Compile, analyze and develop strategic priorities for enhancements	Health Share																				
2.2.1 Security Redesign	Health Share																				
2.2.2 Member Dashboard Redesign (Pt Summary, PopEx & Pat Strat)	Health Share																				
2.2.3 Targeted Programs Dashboard Redesign (MOUD, Behavioral Health, etc.)	Health Share																				
2.3 Identify opportunities for training program enhancements	Health Share																				
2.4 Schedule & carryout trainings	Health Share																				
2.5 Perform annual user experience and needs survey	Health Share																				
3.0 Workstream - Composite Score in Behavioral Health																					
3.1 Refine accuracy and availability of provider data behind scoring	CareOregon																				
3.2 Develop scoring and data for SUD detox, residential, outpatient and MAT programs	CareOregon																				
4.0 Workstream - Improve operational data collection and quality / Data Source																					
4.1 Inventory operational reporting (DSN, ECQM, etc...)																					
4.2 Evaluate operation reporting for improved automated data collection																					
4.3 HIT data gov to prioritize																					
4.4 2021 project plan																					
4.5 2021 Execution Plan																					
4.4.1 DSN data collection optimization																					
4.4.2 PCPCR data collection optimization																					
4.4.3 Grievance & Appeals data collection optimization																					
4.4.4 LTSS & LTC data collection optimization																					
4.4.5 CQM data collection optimization																					
4.4.5.1 Identify and engage with priority clinics not yet reporting																					
4.4.5.2 Work with CQm workgroup to develop CQM measures																					
4.4.5.3 valid data integration and available for OHA reporting																					
4.6 2022 project plan																					
4.7 2022 execution																					
4.8 2023 project plan																					
4.9 2023 execution																					
4.10 2024 project plan																					
4.11 2024 execution																					
5.0 Workstream - Dissemination of Data: Tableau Public																					
5.1 Gather requirements																					
5.2 Identify high priority opportunities																					
5.3 Pilot specific dashboards																					
5.4 Refine dashboards																					
5.5 Phase II dashboards to add																					
5.5.1																					
5.5.2																					
5.5.3																					
6.0 Workstream - Incorporate Geomapping																					
6.1 Identify and prioritize opportunities																					
6.2 Execute priority items																					
6.2.1																					
6.2.2																					
6.2.3																					
6.2.4																					
6.4 Review Priorities																					
6.5 Execute Phase II																					

SDOH AND HEALTH EQUITY WORKSTREAMS

Task	Owner	2020				2021				2022				2023				2024			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1.0 Work Stream - CIE Implementation (Connect Oregon)																					
1.1 Sign Contract	Health Share																				
1.2 Participate in larger project plan discussion	Regional CCOs																				
1.3 Build technology project plan	Unite Us																				
1.4 Configuration/Build	Unite Us																				
1.4.1 Configuration of data environment complete and infrastructure in place	Unite Us																				
1.4.2 Test data stratgy complete	Unite Us																				
1.4.3 Consent set review complete	Unite Us																				
1.4.4 Member roster implementation complete	Unite Us																				
1.4.5 Member matching implementation	Unite Us																				
1.4.6 Data Feed Extraction & Memeber Eligibility Matching Implementation complete	Unite Us																				
1.5 UAT	Health Share																				
1.6 Migration	Unite Us																				
1.6.1 Move to Production	Unite Us																				
1.6.2 Health Share Data Feed and Member Matching Go Live	Unite Us																				
1.6.3 Health Share Data Feed	Unite Us																				
1.6.4 Health Share Member Matching	Unite Us																				
1.7 Post Go Live monitoring and process alignment complete	Unite Us																				
2.0 Work Stream - HSO Health Equity Plan																					
2.1 Add Race and Ethnicity Data to Grievance and Appeals Data	Health Share																				
2.2 Redesign Race & Ethnicity Data Structure	Health Share																				
2.3 Incorporate Connect Oregon Data	Health Share																				
2.4 Updates to Language Access Reporting	Health Share																				
2.5 Incorporate Clinic EMR Data (timing TBD)	Health Share																				
3.0 Workstream - Create Inferred SDOH scores / SDOH																					
3.1 Research social pediatric risk score algorithms based on use of existing data (parents that are SUD, Foster kid, parents in jail, etc)																					
3.2 Convene pediatrics physicians and BH group to review options																					
3.3 Pediatric physicians and BH group to assist in algorithm development																					
3.4 project plan to create social pediatric risk score																					
3.5 execute project plan																					
3.6 Develop/communicate new markers and strat as well as how to operationalize the use thereof																					
3.7 Research adult behavior health risk score algorithms based on use of existing data (SUD, OD, Mental health conditions, BH hospitalizations etc)																					
3.8 Convene BH group to review options																					
3.9 BH group to assist in algorithm development																					
3.10 Project plan to create adult behavior health risk score																					
3.11 execute project plan																					
3.12 Develop/communicate new markers and strat as well as how to operationalize the use thereof																					

COVID WORKSTREAMS

	Owner	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2	2024 Q3	2024 Q4
1.0 Work Stream - COVID Data																					
1.1 Find available data	Health Share			green	green	green															
1.2 Bring in available data to EDW	Health Share					yellow															
1.2.1 Members at Risk	Health Share					yellow															
1.2.2 ALERT Vaccination Data	Health Share						yellow														
1.2.3 Encounter Reimbursement Data	Health Share																				
1.3 Utilize existing data	Health Share					green															
1.3.1 LTSS service level	Health Share																				
2.0 Work Stream - COVID Analysis																					
2.1 work with stakeholders to define need	Health Share					yellow															
2.2 assess available data	Health Share																				
2.3 prioritize and perform analysis	Health Share																				
2.3.1 Identify at Risk Populations	Health Share					green															
2.3.2 Apply Geomapping to at Risk Populations	Health Share					green															
2.3.3 Identify Members Needing Vaccine or Second	Health Share					yellow															
3.0 Work Stream - COVID dashboard																					
3.1 Work with stakeholders to define	Health Share					yellow															
3.2 Assess available data	Health Share																				
3.3 Build COVID dashboard	Health Share					green															
3.4 Enhance and incorporate new data	Health Share						yellow	yellow	yellow												