CCO 2023 HIT Roadmap

Guidance, Evaluation Criteria & Report Template, **Option A**

Contract or rule citation	Exhibit J, Section 2 d.
Deliverable due date	March 15, 2023
Submit deliverable to:	CCO.MCODeliverableReports@odhsoha.oregon.gov and cc: CCO.HealthIT@odhsoha.oregon.gov

Please be sure to:

1. **Submit both Word and PDF versions of your Roadmap and**
2. **Use the following file naming convention for your submission: CCOname_2023_HIT_Roadmap**

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Guidance Document

Purpose & Background

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

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

For Contract Year 1 (2020), CCOs' responses to the HIT Questionnaire formed the basis of their draft HIT Roadmap. For Contract Years 2 through 5 (2021-2024), CCOs are required to submit an annual HIT Roadmap to OHA reporting the progress made on the HIT Roadmap from the previous Contract Year, as well as plans, activities, and milestones detailing how they will support contracted providers in future Contract Years. OHA expects CCOs to use their approved 2022 HIT Roadmap as the foundation for completing their 2023 HIT Roadmap.

Changes for Contract Year 4 (2023):

1. Expanded scope for HIT to Support SDOH Needs. CCOs are now required to report on all strategies involving HIT to support SDOH needs, including but not limited to social needs screening and referrals.
2. Strategy checkboxes have been added to the HIT to Support SDOH Needs Progress and Plans sections.
3. To limit redundancy in reporting, Support for HIE – Care Coordination section will now exclude hospital event notification and community information exchange (CIE) tools and strategies, which instead will be included in the Support for HIE – Hospital Event Notifications and HIT to Support SDOH Needs sections, respectively.

Reminders for Contract Year 4 (2023):

1. Limit the Progress sections to 2022 activities and accomplishments and include planned activities for 2023 and 2024 in the Plans sections.
2. In each Plans section, be sure to include activities and milestones for each strategy. If some strategies are missing activities and milestones, CCO may be asked to Revise and Resubmit their Roadmap.
3. Add all CCO-collected HIT data to the HIT Data Reporting File prior to submitting it with your Roadmaps on 3/15/2023. Data reported in the Roadmaps should align with Data Reporting File.

[1] Starting in Contract Year 3 (2022), CCOs' VBP reporting will include their HIT efforts; therefore, this content will not be part of the HIT Roadmap moving forward.
[2] New HIT Roadmap requirement beginning Contract Year 3 (2022)

Overview of Process

Each CCO shall submit its 2023 HIT Roadmap to OHA for review on or before **March 15** of Contract Years 4 and 5. CCOs are to use the *2023 HIT Roadmap Template* for completing this deliverable and are encouraged to copy and paste relevant content from their 2022 HIT Roadmap if it's still applicable. Please submit the completed HIT Roadmap to the CCO deliverables mailbox at CCO.MCODeliverableReports@odhsoha.oregon.gov and cc: CCO.HealthIT@odhsoha.oregon.gov .

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

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

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

Please refer to the timeline below for an outline of steps and action items related to the 2023 HIT Roadmap submission and review process.

2023 HIT Roadmap Timeline

Last Revised 10/27/2022

	March - June 2023	June - July 2023	Aug - Sep 2023
	***2023 HIT Roadmap* Submission and Review**	**CCO/OHA Communication and Collaboration**	***Revised 2023 HIT Roadmap* Submission to OHA for Review**
Activities	**List of activities**	**List of activities**	**List of activities**
	CCOs submit *2023 HIT Roadmap* and HIT Data Reporting File to OHA by **3/15/23.**	If not approved, CCO contacts OHA by **6/30/23** to schedule a meeting to discuss required revisions.	CCO submits Revised 2023 HIT Roadmap to OHA by **8/11/22**. CCOs with approved 2023 Roadmaps meet with OHA by **8/31/2023**.
	OHA reviews *2023 HIT Roadmap* .	If approved, CCO contacts OHA by **7/14/2023** to schedule a Roadmap follow-up meeting.	OHA reviews CCO *Revised 2023 HIT Roadmap* .
	OHA sends initial *2023 HIT Roadmap* result letter to CCO by **6/16/23.**	By **7/14/23** collaborative meeting(s) occur between OHA and CCOs required to revised and resubmit their *2023 HIT Roadmap* .	OHA sends *Revised 2023 HIT Roadmap* result letter to CCO by **9/22/23**.

OHA expects all CCOs will have an approved 2023 HIT Roadmap by 9/30/23.

HIT Roadmap Approval Criteria

The table below contains evaluation criteria outlining OHA's expectations for responses to the required HIT Roadmap questions. Modifications for Contract Year 4 (2023) are in ***bold italicized font***. Please review the table to better understand the content that must be addressed in each required response. Approval criteria for HIT Roadmap optional questions are not included in this table; optional questions are for informational purposes only and do not impact the approval of an HIT Roadmap. Additionally, the table below does not include the full version of each question, only an abbreviated version. Please refer to the *2023 HIT Template* for the complete question when crafting your responses.

HIT Roadmap Section	**Question(s) – Abbreviated (Please see report template for complete question)**	**Approval Criteria**
1. HIT Partnership	CCO attestation to the four areas of HIT Partnership.	CCO meets the following requirements: • Active, signed HIT Commons MOU and adheres to the terms • Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons Memorandum of Understanding (MOU) • Served, if elected on the HIT Commons governance board or one of its committees • Participated in an OHA's HITAG meeting at least once during the previous Contract Year
2. Support for EHR Adoption	A. 2022 Progress supporting increased rates of EHR adoption for contracted physical, oral, and behavioral health providers	• Description of progress includes: ○ Strategies used to support increased rates of EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers in 2022 ○ Specific accomplishments and successes for 2022 related to supporting EHR adoption • Sufficient detail and clarity to establish that activities are meaningful and credible.
	B. 2023-2024 Plans for supporting increased rates of EHR adoption for contracted physical, oral, and behavioral health providers	• Description of plans includes: ○ The number of organizations (by provider type) for which no EHR information is available (e.g., 10 physical health, 22 oral health, and 14 behavioral health organizations) ○ Plans for collecting missing EHR information via CCO already-existing processes ○ Additional strategies for 2023-2024 related to supporting increased rates of EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers ○ Specific activities and milestones for 2023-2024 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
3. Support for HIE – Care Coordination ***(excluding hospital event***	A. 2022 Progress supporting increased access to HIE for Care Coordination ***(excluding hospital***	• Description of progress includes: ○ Specific HIE tools CCO supported or made available to support contracted physical, oral, and behavioral health providers' access to HIE for Care Coordination

HIT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
notifications and community information exchange (CIE))	***event notifications and CIE)*** among contracted physical, oral, and behavioral health providers	○ Strategies CCO used to support increased access to HIE for Care Coordination, excluding hospital event notifications and CIE, for contracted physical, oral, and behavioral health providers in 2022 ○ Specific accomplishments and successes for 2022 related to increasing access to HIE for Care Coordination (including number of organizations of each provider type that gained access to HIE for Care Coordination as a result of CCO support, as applicable) • Sufficient detail and clarity to establish that activities are meaningful and credible.
	B. 2023-2024 Plans for supporting increased access to HIE for Care Coordination ***(excluding hospital event notifications and CIE)*** among contracted physical, oral, and behavioral health providers	• Description of plans includes: ○ The number of organizations (by provider type) that have not adopted an HIE for care coordination tool (e.g., 18 physical health, 12 oral health, and 22 behavioral health organizations) ○ Additional HIE tools CCO plans to support or make available ○ Additional strategies for 2023-2024 related to supporting increased access to HIE for Care Coordination, excluding hospital event notifications and CIE, among contracted physical, oral, and behavioral health providers ○ Specific activities and milestones for 2023-2024 related to each strategy (including the number of organizations of each provider type expected to gain access to HIE for Care Coordination as result of CCO support, if applicable) • Sufficient detail and clarity to establish that activities are meaningful and credible.
4. Support for HIE – Hospital Event Notifications (Progress)	A.1. 2022 Progress using timely Hospital Event Notifications within CCO	• Description of progress includes: ○ Tool(s) CCO is using within their organization for timely Hospital Event Notifications ○ Strategies used for timely Hospital Event Notifications within CCO's organization for 2022 ○ Specific accomplishments and successes for 2022 related to CCO's use of timely Hospital Event Notifications • Sufficient detail and clarity to establish that activities are meaningful and credible.

HIT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
	A.2. 2022 Progress supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers	• Description of progress includes: ○ Tool(s) CCO provided or made available to support providers' timely access to Hospital Event Notifications ○ Strategies used to support increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers in 2022 ○ Specific accomplishments and successes for 2022 related to supporting increased access to timely Hospital Event Notifications (including the number of organizations of each provider type that gained increased access to HIE for Hospital Event Notifications as a result of CCO support, as applicable) • Sufficient detail and clarity to establish that activities are meaningful and credible.
4. Support for HIE – Hospital Event Notifications (Plans)	B. 2. 2023-2024 Plans using timely Hospital Event Notifications within CCO	• Description of plans includes: ○ Additional tool(s) (if any) CCO is planning to use for timely Hospital Event Notifications ○ Additional strategies for 2023-2024 to use timely Hospital Event Notifications within the CCO's organization ○ Specific activities and milestones for 2023-2024 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible
	B. 1. 2023-2024 Plans for supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers	• Description of plans includes: ○ The number of organizations (by provider type) that have not adopted an HIE for Hospital Event Notifications tool (e.g., 18 physical health, 12 oral health, and 22 behavioral health organizations) ○ Additional tool(s) CCO is planning to support or make available to providers for timely Hospital Event Notifications ○ Additional strategies for 2023-2024 related to supporting increased access to timely Hospital Event Notifications contracted physical, oral, and behavioral health providers in 2022 ○ Specific activities and milestones for 2023-2024 related to each strategy (including the number of organizations of each provider type expected to gain access to HIE for Hospital Event Notifications as a result of CCO support, as applicable) • Sufficient detail and clarity to establish that activities are meaningful and credible.

HIT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
5. HIT to support social determinants of health needs (Progress)	A.1. 2022 Progress using HIT to support SDOH needs, ***including but not limited to social needs screening and referrals***	• Description of progress includes: ○ Current tool(s) CCO is using for social needs screening and referrals. ○ Strategies for using HIT to support SDOH needs, including but not limited to social needs screening and referrals in 2022 ○ Any accomplishments and successes for 2022 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
	A.2. 2022 Progress supporting contracted physical, oral, and behavioral health providers as well as, social services and CBOs with using HIT to support SDOH needs, ***including but not limited to social needs screening and referrals***	• Description of progress includes: ○ Tool(s) CCO supported or made available to contracted physical, oral, and behavioral health providers, as well as social services and CBOs, for supporting SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) have closed-loop referral functionality ○ Strategies used for supporting these groups with using HIT to support SDOH needs, including but not limited to screening and referrals in 2022 ○ Any accomplishments and successes for 2022 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible
5. HIT to support social determinants of health needs (Plans)	B.1. 2023-2024 Plans for using HIT to SDOH needs, ***including but not limited to social needs screening and referrals***	• Description of plans includes: ○ Tool(s) CCO will use for social needs screening and referrals for addressing SDOH needs, including a description of whether the tool(s) will have closed-loop referral functionality ○ Additional strategies planned for using HIT to support SDOH needs, including but not limited to social needs screening and referrals ○ Specific activities and milestones for 2023-2024 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
	B.2. 2023-2024 Plans for supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs, with using HIT to support SDOH needs, ***including but not limited to social needs screening and referrals***	• Description of progress includes: ○ Tool(s) CCO is planning to support/make available to contracted physical, oral, and behavioral health providers, as well as social services and CBOs for supporting SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) will have closed-loop referral functionality ○ Additional strategies planned for supporting these groups with using HIT to support social needs screening and referrals beyond 2022 ○ Specific activities and milestones for 2023-2024 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.

2023 HIT Roadmap Template

Please complete and submit to CCO.MCODeliverableReports@odhsoha.oregon.gov and cc: Tby **March 15, 2023.**

CCO: Health Share of Oregon

Date: 3/15/2023

Instructions & Expectations

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

1. HIT Partnership
2. Support for EHR Adoption
3. Support for HIE – Care Coordination
4. Support for HIE – Hospital Event Notifications
5. HIT to Support Social Determinants of Health (SDOH) Needs, including but not limited to social needs screening and referrals
6. Other HIT Questions (optional section)

Each required topic includes the following:

- Narrative sections to describe your **2022 progress, strategies, accomplishments/successes, and barriers**
- Narrative sections to describe your **2023-2024 plans, strategies, and related activities and milestones**. For the activities and milestones, you may structure the response using bullet points or tables to help clarify the sequence and timing of planned activities and milestones. These can be listed along with the narrative; it is not required that you attach a separate document outlining your planned activities and milestones. However, you may attach your own document(s) in place of filling in the activities and milestones sections of the template (as long as the attached document clearly describes activities and milestones for each strategy and specifies the corresponding Contract Year).

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

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

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

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

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

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

Milestones: Significant outcomes of activities or other major developments in CCO's overall strategy, with indication of when the outcome or development will occur (e.g., Q1 2023). **Note**: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.

A note about the template*:*

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

HIT Roadmap Template Strategy Checkboxes

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

- *Support for EHR Adoption*
- *Support for HIE – Care Coordination*
- *Support for HIE – Hospital Event Notifications*
- *HIT to Support SDOH Needs*

The checkboxes represent themes that OHA has compiled from strategies listed in CCOs' previous HIT Roadmap submissions.

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

Please send questions about the Updated HIT Roadmap template to CCO.HealthIT@odhsoha.oregon.gov

1. HIT Partnership

Please attest to the following items.

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

2. Support for EHR Adoption

A. Support for EHR Adoption: 2022 Progress

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

1. Select the boxes that represent strategies pertaining to your 2022 progress.
2. Describe the progress of each strategy in the appropriate narrative sections.
3. In the descriptions, include any accomplishments and successes related to your strategies.

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

Overall Progress
Using the boxes below, please select which strategies you employed during 2022. Elaborate on each strategy and the progress made in the sections below.

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

i. Progress across provider types

Health Share Structure Overview and Roadmap Approach:

Health Share's structure is based on collaboration and partnership between 11 founding members and 5 risk-holding delivery system networks. These networks are known as Integrated Delivery Systems (IDS) or the Integrated

Community Network (ICN). These networks serve all Health Share members and receive payments in a value-based payment arrangement with the CCO. Most of the activities in the HIT Roadmap represent the efforts and priorities of each entity in service to the broader CCO collaborative and the needs of their population. Health Share plays a critical role in building alignment and partnership across these organizations to work on shared priorities based on the needs of the population. This alignment is done through various operational workgroups within the CCO's governance structure, with communication and alignment occurring through the CCO's monthly Health Information Technology Governance Committee. The HIT Governance includes IT/IS representatives from Health Share's 11 founding partners and HIT leadership from across the collaborative, and it was created to set a forum for alignment and collaboration in alignment with Health Share's initial HIT Roadmap.

Strategies:

Third party consultation
Identifying gaps and opportunities in using health IT solutions to support the organization's clinical quality goals and improve overall data availability.

Identifying adoption barriers experienced by providers
Financial and resourcing burden: Certain sizes of clinics not cost effective to implement Epic. Analyzed the OHA EHR/HIT survey results and found the biggest areas of opportunity for additional information gathering within the specialty physical health and behavioral health networks.

Upgrades and optimization of EHRs
Continuing to identify opportunities through ICN's Innovation Specialist team to help clinic partners modify their operations and optimize use of EHRs to support telehealth visits. EHR optimization through financial support from our ICN, Central City Concern (CCC), Cascadia Health, and Native American Rehabilitation Association (NARA) received financial support through system investments for upgrading to EPIC through OCHIN.

CCC, Cascadia Health, and NARA are large integrated BH providers and are also FQHC's and CCBHC's in the region. These EHR upgrades will improve their ability to coordinate care through Care Everywhere, allow for safer prescribing, MyChart access for members and will increase employee satisfaction through efficient processes. We continue to provide support to interested providers on EHR optimization and push for more use of HIE in 2023 and beyond.

Other partners have implemented numerous clinical updates and modules in Epic including screenings, management, pharmacy, and documentation workflows.

Financial support and incentives
One IDS has funded a subsidized EHR adoption program for 12 years called Legacy Connect. This program has connected over 30 Oregon/Southwest Washington private practices and over 500 providers (primary care, specialty, behavioral health). This program has enabled EHR adoption to providers who would not otherwise be able to contract with Epic and consequently connecting more providers into the community health information exchange ecosystem.

Health Share's ICN has provided other financial support to providers exceeding 10 million dollars of funding to support EHR platforms and integration.

Quality Pool Distribution
Our ICN partners with clinical providers in achieving the OHA CCO Incentive Metrics. Many of these metrics require documentation and reporting of clinical information. Increased quality pool payouts are reserved for organizations that can extract and submit data from their EHRs.

Clinic designation
Our ICN created a Primary Care Payment Model (PCPM) with financial incentives to encourage organizations to achieve greater levels of organizational designation (e.g., Tier 3 PCPCH). Eligibility for the model requires clinics to achieve at least Tier 3 PCPCH. Earning a Tier 3 PCPCH designation or higher increased levels of EHR functionality.

Value-based payment
Our ICN engages with its providers through a wide range of value-based payment arrangements, including the Primary Care Payment Model and community-based total cost of care models resulting in shared savings. EHRs are important tools for promoting workflows and providing information necessary to achieve the desired financial and clinical results

encouraged by their VBP arrangements. Clinics utilize EHRs to provide reporting on many key quality elements of their VBP arrangements.

ii. Additional progress specific to physical health providers

Continuing to identify opportunities through ICN's Innovation Specialist team to help clinic partners improve their operations and optimize use of EHRs to support telehealth visits.

Our ICN's Metro team continued to encourage improved use of EHRs among the physical health providers through our technical assistance support. Through the ICN's team of Innovation Specialists, Metro provides technical assistance and practice coaching to our provider network partners to support various clinic and system transformation goals. This includes identifying opportunities to use their EHRs more meaningfully to improve workflows, support CCO Quality Metric documentation, and support Value Based Payment performance.

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

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

Much of the EHR work in 2022 was specifically centered around supporting FQHCs in reporting on clinical quality measures and other data reporting capabilities. Clinics were provided templates and individual technical assistance to support increased understanding of preferred workflows for documentation and tracking.

The ICN also provided a detailed presentation at the Quality Learning lab on how to document meaningful language access and leveraged a creative matrix to explore ways EHR-based or supported technology could facilitate member engagement in a variety of different settings. Common themes were patient portals, texting platforms, remote patient monitoring and virtual visits. The final results are below:

	How might we help patients establish care in our clinic for the first time? (Think about both newly assigned & not newly assigned but not yet engaged)	How might we bring patients back in when they haven't been seen in 2+ years? (Established but unengaged?	Ho might we optimize access for patients at the right time and in the right modality for them?	How might we optimize and prioritize patient engagement in an environment with limited resources?	How might we build and nurture trust with our patients?
Technology	-Have rolled out an **RPM (remote patient monitoring)** program through a grant and connected folks to BP cuffs, glucometers, etc. -RPM through MyChart -**Text** outreach with a link to schedule appt. -Figure out both the back and front end of MyChart -**Explain how/why** they would use **MyChart**	-Medicare seems to like to engage with **telephone visits**, also we offer a home visit with Signify -Get phone plans to not charge for data used in doctor appt. video visits	-**Teach and help pts. understand** how to use such systems fluently -Ability to schedule online via the health portal -**Pt. portal** scheduling and **telehealth appts.** are huge pt. satisfiers -Increase **MyChart** usage -Where technology can streamline processes so that people can do people work -Broadband access for the tri-county area -Ability to have access to Wi-Fi/technology -High risk people get personal outreach; lower risk people get technology outreach	-Blast **MyChart** reminders to provide general reminders of the frequency of routine appts. "Did you know that if you live with Diabetes, you should check in with your provider at least every 6 months," etc. -**Remote patient monitoring** such as Diabetic management -New Pop Health tool and training. And connecting different systems to make communication easier -Using **MyChart** for reminders and communication -**CareMessage** for certain patient groups with messages related to DM and hypertension -Implement communication for important tests, labs, appts., etc. How can we communicate data to pts.? -Asking pts. what kind of appts. /technology they wish we had and consider utilizing -There are certain apps that have pers that work with cohorts of people for support -Increase social media presence and follow other like-minded organizations as a way to connect with their followers and also promote our work	-Having **video visits** for our BHC's -Building engagement dashboards to better track and prevent duplication of work -Collective -**CareMessage**: a messaging system which send out text for appt. reminders and health tips -Klara platform

Training and continued education around EHRs
Other IDS partners focused on initial onboarding, continuing EMR education, use of signal data to analyze EMR efficiency to tailor training strategies for providers, and bi-weekly communications on changes/optimizations occurring in IDS' EMR.

Robust policies around EMR usage including but not limited to, reporting on closing patient encounters in a timely manner and sharing patient data with them in compliance with the 21st Century Cures Act.

Leveraging HIE programs
One of Health Share's IDS partners is part of Oregon Reliance User Group - to discuss HIE priorities, problems, and tactics to continue to enhance health information exchange with Oregon's participating organizations. Increased adoption of CareEverywhere to ensure providers have comprehensive view of patient's health care to date.

Shared instances of Epic
This will provide numerous benefits related to care management, SDoH data capture and referrals to community-based organizations, operations, and analytics.

iii. Additional progress specific to oral health providers

Identifying priority providers for increasing EHR adoption and continuing to identify opportunities through ICN's Innovation Specialist team to help clinic partners modify their operations and optimize use of EHRs

Health Share's ICN partnered with its dental plans and surveyed its entire dental provider network at the end of 2022. Of the 255 individual dental clinics surveyed in Multnomah, Clackamas, and Washington counties, they found:

- 218 (85.5%) are using an EHR
- 2 (0.8%) are using paper charts
- 35 (13.7%) were unable to reach or unknown vendor

Given that most of our members' Primary Dental Providers are using electronic health records, the ICN's focus will be on optimizing its use through workflow and process improvement technical assistance. They 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.

Currently, the most used EHR's are for oral health are: Dentrix, EPIC Wisdom and Eaglesoft.

iv. Additional progress specific to behavioral health providers

Central City Concern, Cascadia Health, and NARA are large integrated BH providers and are also FQHC's and CCBHC's in the region. These EHR upgrades will improve their ability to coordinate care through Care Everywhere, allow for safer prescribing, MyChart access for members and increase employee satisfaction through efficient processes. Health Share's ICN continues to provide support to interested providers on EHR optimization and push for more use of HIE in 2023 and beyond.

One IDS' program supports a sub-acute behavioral health inpatient center and one critical access hospital.

v. Please describe any barriers that inhibited your progress

Pandemic-related challenges continued to reduce the time and willingness for partners and providers to engage on this topic.

Epic Population Health Query (PHQ) limitations due to lookback and data availability resulted in exploring additional options for collecting external quality measure data.

B. Support for EHR Adoption: 2023-2024 Plans

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

1. Select the boxes that represent strategies pertaining to your 2023-2024 plans.
2. Describe the following in the appropriate narrative sections:

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

Notes: Strategies described in the *2022 Progress* section that remain in your plans for 2023-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy; however, please make note of these strategies in this section and include activities and milestones for all strategies you report.

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

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2023-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and include activities and milestones in the sections below.

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

i. Plans across provider types, including activities & milestones

Health Share's current data completeness and reporting EHR adoption

Health Share's file continues to show high numbers of unconfirmed EHR adoption in behavioral and oral health care settings. However, we plan to spend some time with the ICN to do data validation of discrepancies between the OHA file and their network tracking to provide that update to OHA to enhance overall data completeness. Health Share's Data Completeness results in the 2022 files are as shown below:

Care Domain	Total Number of Orgs	Number with Confirmed EHR	Unconfirmed/Status Unknown	% Unconfirmed/Unknown (2021 % in parentheses)
Physical	355	175	180	50.7% (53%)
Behavioral	235	102	133	56.5% (57%)
Oral Health	177	43	134	75.7% (62%)

ICN data completeness and reporting
As mentioned above, our ICN CareOregon engaged a consulting firm to conduct an assessment to identify opportunities, gaps, and best practices for using health IT solutions to support the CCO's clinical quality goals and improve overall data availability. In 2023, they will work to implement key recommendations as well as continue work that was previously underway. The table below provides an overview of 2023 milestones.

Activity	Completion Date
Prioritize HIT consultant recommendations for implementation	Q1 2023
Create implementation work plan	Q2 2023
Implement Epic Payor Platform to optimize bi-directional data exchange	Q4 2023
Gathering missing EHR information, focusing on specialty health care network	Q4 2023
Evaluate use of grant funds to support HIT	Q4 2023
Continue support of EPIC upgrade/implementation	Continuous in 2023
Support clinic use of EHR data through participation in OCHIN HEDIS pilot	Continuous in 2023

Other IDS' plan to continue and support EHR implementations previously paused due to the pandemic. Focusing on primary care and pediatrics. They also plan to collect data about their complementary medicine and ancillary providers and their current EHR usage as well as barriers to EHR adoption.

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

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

Activity	Completion Date
Re-survey oral health network	Q4 2023
Update data completeness based on survey	Q4 2023

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

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with EHR adoption?

More clarity about the expectations related to complementary medicine and ancillary providers, and how they are intended to be part of the movement towards EHR adoption. If they are intended to be part of this work, then alignment of incentives and requirements across health programs at the state and local level would be helpful.

3. **Support for HIE – Care Coordination** (excluding hospital event notifications, CIE)

A. Support for HIE – Care Coordination: 2022 Progress

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

1. Select the boxes that represent strategies pertaining to your 2022 progress
2. Describe the following in the appropriate narrative sections
    a. Specific HIE tools you supported or made available in 2022
    b. The strategies you used to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers in 2022
    c. Accomplishments and successes related to your strategies (Please include the number of organizations of each provider type that gained access to HIE for Care Coordination as a result of your support, as applicable).

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

Overall Progress
Using the boxes below, please select which strategies you employed during 2022. Elaborate on each strategy and the progress made in the sections below.

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

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

Health Share has committed substantial effort and resources within its Integrated Delivery Systems and Integrated Community Network to optimize use of Health Information Exchange technology and leverage new methods of information sharing.

<u>Optimizing and Enhancing Existing Platforms</u>

- Implemented Direct messaging for provider-to-provider secure messaging and to push patient records to external organizations during certain referrals and hospital discharges.
- Implemented Care Everywhere Image Exchange, which provides the ability to send photos, scanned documents, EKG tracings and reference-quality Radiology images to external organizations through Care Everywhere. It also gives the capability to receive these image types from other organizations who send them.
- Our large integrated delivery systems provide external organizations with the ability to view clinical data via their web portals.
- All Health Share partners maintain FHIR-based interoperability services for sharing claims information with members through third-party apps as required by CMS. At least 8 patient access applications have been registered for FHIR data exchange and assigned security keys.

- Ongoing support for Epic's Population Health Query (PHQ). Identified and proposed improvements in Fall 2022 to expand PHQ to compatible sites belonging to adjacent integrated delivery systems (i.e. Legacy, Kaiser, Providence) and community practices.
- PointClickCare (formerly Collective) is used to build cohorts and get daily reporting to refer members into the appropriate care team. The platform is also used to prioritize outreach efforts. In addition, Observations were added to the feed between PointClickCare and our largest care management platform. This broadens the transparency of a member's status when presenting at the ED and allows us to appropriately prioritize outreach.
- Worked with PointClickCare to provide lists of enrolled members with a global flag that provides an alert and allows users from adjacent health systems to see that their members are enrolled in the Health Share Housing Benefit Program.
- Children's Health Alliance clinics, Health Share's largest Pediatric network, use the Innovaccer Population Health Tool and populate EMR data as well as payer data and EDIE data into a pediatric HIE which enables patient stratification for care management and offers timely care coordination worklists such as patients needing ED visit follow-up.
- These practices also interface with Oregon's IMM ALERT IIS to communicate and coordinate vaccine data.

Expanding Information Exchange

- One of our large integrated delivery systems has joined the eHealth Exchange, eHealth Hub and Carequality to exchange records with external organizations utilizing other EHRs – and are connected to nearly 30,000 organizations and individual practices through these networks.
- Implemented Direct messaging for provider-to-provider secure messaging and to push patient records to external organizations during certain referrals and hospital discharges.
- Implemented Epic's Reconcile Outside Information Activity (ROIA) for providers to reconcile external medications, allergies, problems, and immunizations in the patient's chart. It also includes the auto reconciliation of received COVID-19 vaccines.
- Began an Epic-to-Epic referral exchange between Legacy and OCHIN (provides EHR hosting to FQHCs among others).
- Data exchange is in place with Reliance eHealth Collaborative and adding Metro eligibility to Reliance (previously only provided for Central Oregon and Columbia Gorge CCO's)
- Legacy/PacificSource is supporting OCHIN's FQHC focused HEDIS pilot to implement claims-based functionality in OCHIN's Epic system to support advanced forms of value-based payment.
- Establish data exchange with Portland Fire and Rescue, including connecting them to the Collective platform and establishing emergent chat procedures for direct referral pathway with the use of Unite Us for identified CO members needing care coordination.

Provider Supports and Education

- Technical assistance is regularly provided to providers to access and interpret quality and analytics dashboards to manage their patient populations. Providers are connected with Quality Improvement Analysts for more in-depth training and support on the platform. Individual clinic technical assistance is also provided on a regular basis as needed.
- Health Share's Integrated Community Network currently supports and has provided funding for providers to participate in Project ECHO. This is a peer-based learning platform that has shown significant effectiveness in upskilling providers on complex medical and behavioral health topics. In 2022, Child and Adult Psychiatry ECHOs was co-sponsored with spots reserved for additional network partners. Targeted outreach was provided to the network to encourage provider participation.
- Health Share's Integrated Community Network (ICN) negotiated licenses for providers to access the Rubicon MD service without charge to expand provider capabilities for specialty referrals and consultations. We believe this help patients get the care they need regardless of payer affiliation. We view this as an upskilling tool for our providers to effectively manage patient needs, while simultaneously using technology to expand the services patients can receive. Currently 6 network partners in Metro utilize RubiconMD.

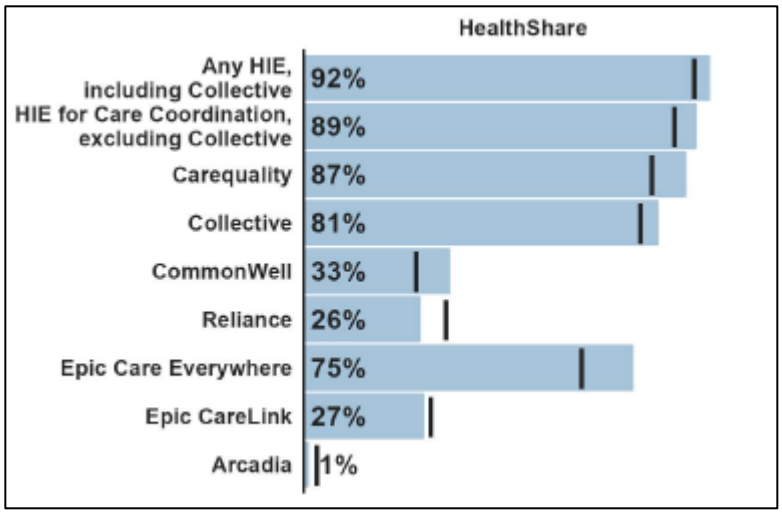
ii. Additional progress specific to physical health providers

As Health Share's HIE adoption rate in physical health has grown along with the provider network. The data collected this year shows a large majority of practices participating in data exchange using platforms other than or in addition to Collective (PointClickCare). We believe this is an important factor to consider when formulating HIE strategies across Oregon.

All physical health providers:

	2021	2022
Physical Providers (Primary Type)	340	355
Physical Providers with "Any HIE" flag	95 (27.9%)	122 (34.3%)
Physical Providers with "Any HIE + Collective" flag	107 (31.4%)	131 (36.9%)
Physical Providers without "Any HIE" flag	**245 (72%)**	**233 (65.6%)**
Physical Providers without "Any HIE + Collective" flag	**233 (68.5%)**	**224 (63.1)**

Physical Health Providers weighted by number of providers (sourced from OHA materials):



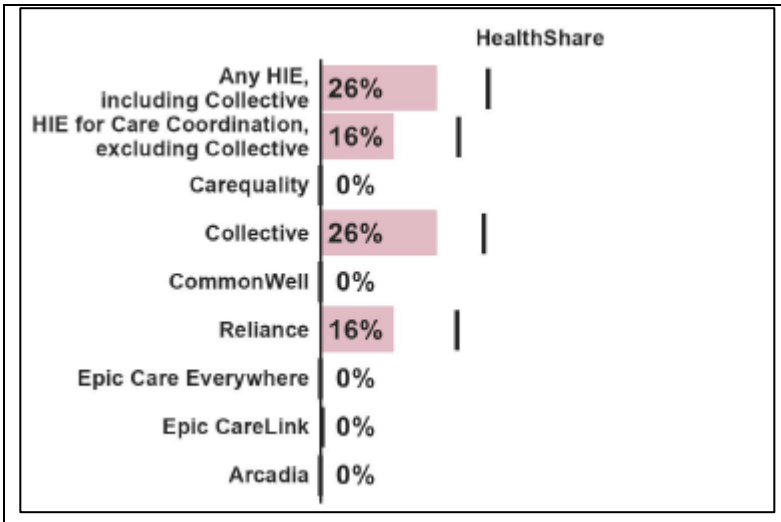
iii. Additional progress specific to oral health providers

Data on oral health provider HIE utilization has been challenging to obtain which is reflected in the survey results. The majority of oral health providers using HIE technology are leveraging Collective.

Oral Health Providers (Primary Type)

Oral Health providers	177
Oral Health providers with "Any HIE" flag	2
Oral Health providers with "Any HIE + Collective" flag	4
Oral Health providers without "Any HIE" flag	**175**
Oral Health providers without "Any HIE + Collective" flag	**173**

Oral Health organizations weighted by number of providers (sourced from OHA materials):



iv. Additional progress specific to behavioral health providers

Behavioral Health has expanded its access to telehealth-only providers. With recent proposed rule changes by OHA regarding OAR 410-120-1990, telehealth-only providers will be required to refer out members needing a higher level of care. We are exploring HIE systems such as Collective Medical (PointClickCare) as way for telehealth-only providers to better coordinate care for individuals who are too complex for their services.

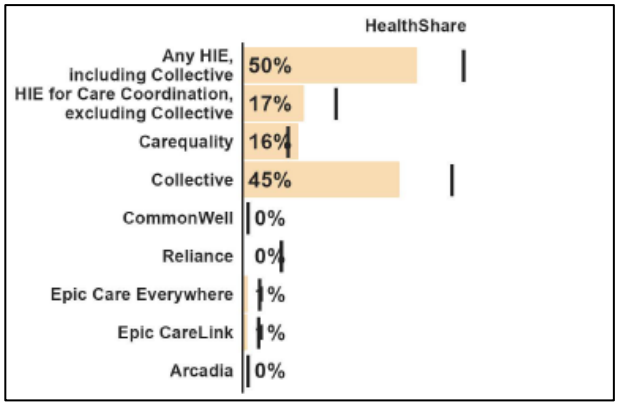
The Behavior Health network has grown from previous years, which is how we are interpreting the relative decrease in adoption statistics. As can be seen in the chart below, the majority of HIE adoption centers on Collective.

Updated for 2022:

Behavioral Health providers (Primary Type)

	2021	2022
Behavioral Health providers	182	235
BH providers with "Any HIE" flag	6 (3.3%)	6 (2.5%)
BH providers with "Any HIE + Collective" flag	19 (10.4%)	24 (10.2%)
BH providers without "Any HIE" flag	**176 (96.7%)**	**229 (97.4%)**
BH providers without "Any HIE + Collective" flag	**163 (89.6%)**	**211 (89.7%)**

Behavioral Health Providers weighted by number of providers (sourced from OHA materials):



v. Please describe any barriers that inhibited your progress

B. Support for HIE – Care Coordination: 2023-2024 Plans

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

1. Select that boxes that represent strategies pertaining to your 2023-2024 plans.
2. Describe the following in the appropriate narrative sections
    a. The number of physical, oral, and behavioral health organizations that have not currently adopted an HIE for Care Coordination tool using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations have not adopted an HIE for Care Coordination tool). CCOs are expected to use this information to inform their strategies.
    b. Any additional HIE tools you plan to support or make available.
    c. Strategies you will use to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers beyond 2022.
    d. Activities and milestones related to each strategy (Please include the number of organizations of each provider type you expect will gain access to HIE for Care Coordination as a result of your support, as applicable)

Notes: Strategies and tools described in the *2022 Progress* section that remain in your plans for 2023-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

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

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2023-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and include activities and milestones in the sections below.

☒ HIE training and/or technical assistance

☐ Assessment/tracking of HIE adoption and capabilities

☒ Outreach and education about value of HIE

☒ Collaboration with network partners

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

☒ Integration of disparate information and/or tools with HIE

☒ Requirements in contracts/provider agreements

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

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

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

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

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

In addition to the initiatives described below, the HIE Workgroup commissioned through HITOC is expected to deliver top five priorities/concepts for HIE in early 2023, which will also inform planning activities going forward.

Below are a list of activities that will be underway in 2023.

Enhance HIE Integration with EHRs

- Conduct more extensive mapping of external lab results to internal lab records for even more integration, including trending and decision support.
- Give providers the capability to manually route specific encounter reports to external providers via Direct messaging, as needed on an ad hoc basis.
- Increase the use of electronic, close-loop clinical referrals.
- Support claims data exchange with OCHIN (EHR provider for FQHCs) to support transparency in quality measure performance and advanced forms of value-based payment.
- OHSU is planning to expand Epic's Population Health Query among compatible sites such as Legacy, Kaiser, & Providence. They are working through Legal and Compliance discussions. Once approved and the configurations are complete on their system, they will receive additional information for their member population that will aid in care coordination and confirmation of quality metric performance.
- Add additional community practices onto Population Health Query.
- Children's Health Alliance clinics continue to add care gap analytics relevant to pediatric population management using the Innovaccer Population Health system.

Implement New Information Exchange Technologies/Workflows

- Care Everywhere Referrals Management – Electronically send and synchronize referrals with external organizations utilizing Epic's EHR. Organizations in scope are still TBD.
- Implement Epic's Happy Together Notes and Happy Together Genomics, once released from Epic. These projects will utilize FHIR standards to retrieve rich text notes and discrete genomic variants from external Epic organizations and integrate the information alongside internal data.
- Patients will be given the ability to share their patient portal clinical information with external providers via Epic's "Share Everywhere" tool. This tool gives providers one-time access (with the patient's permission) to log into a web portal and view clinical information the patient can see in the patient portal.
- Complete development of the initial data exchange model for Health Share's Housing Benefit program.
- CareOregon, Health Share's Integrated Community Network, will implement Epic's Payor Platform to enable bi-directional data exchange with Epic EHR users in network by leveraging technology specifically developed for payor-provider partnerships.

Opportunities for Learning and Innovation

- At least one Health Share partner will evaluate potential onboarding onto the Trusted Exchange Framework, Common Agreement (TEFCA) to further exchange records nationally and for more use cases than just treatment. TEFCA is still in its infancy, so we will be learning more in 2023.
- Explore the "360X" Referral Coordination data sharing technology. Look for other opportunities to send and receive referral information in a discrete/standard way including any EHR to any EHR; provider-to-provider (P2P) using a healthcare information service provider (HISP). Many certified EHRs included.
- Explore opportunities to implement and expand electronic prior authorizations. New CMS requirements (final rules under development) for 2026 will eventually mandate this.
- We are exploring utilizing PointClickCare's access to EHR data for Post-Acute Care Centers and their "Assigned and yet not engaged panel" to allow direct access to members who have not engaged with a provider.
- CareOregon is actively seeking a care coordination system vendor. The selection will be based on integration with current technology and tools, improved workflows, and efficiencies for Care Coordination teams as well as the ability to better report and adapt to changing needs and requirements.

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

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

Referral platform

The dental department of CareOregon (Health Share's dental plan partner) is working on an enterprise-wide HIT enhancement to improve the dental care referral platform and bidirectional communication. This enterprise-wide project

has been secured with CareOregon Executive Leadership as a priority to improve dental access and utilization of services for our members. The goal is to improve referral data sharing with DCOs for all dental care coordination lists, including the dental care requests, and to improve the referring PCP's ability to access referral outreach and visit completion data in efforts to move to a closed loop system.

FIDO Expansion for Dental Providers

The dental plan's data analytics and dashboard platform (FIDO) is being built out to track the percentage of children who had a dental care request form submitted by the physical health provider and who completed a dental visit. In addition, FIDO access is being expanded across our dental health network.

Activity	Completion Date
Referral platform optimization	Q3 2023
Dashboard optimization	Q3 2023

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

Increasing bi-directional data exchange and optimizing use of current platforms

A new dashboard will be deployed showing real-time availability of behavioral health providers. The goal is to support seamless care coordination and expedite access to treatment for members.

Activity	Completion Date
Internally facing access dashboard launched	Q3 2023
Externally facing access dashboard launched	Q4 2023

C. Optional Question

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

- There are perpetually challenges with syncing and staying up-to-date with provider directories. The directories need to be current so that clinicians can effectively coordinate care with their peers at external organizations using Direct messaging.
- Transitions of Care data sharing methods are labor intensive and not in alignment with federal standards for claims data exchange among payers. With the upcoming standards for sharing Pre-Authorization information going into effect in 2026 at the federal level, that might be an ideal time to convert all TOC data sharing processes over to that technology.
- Patient level Health Complexity data from OPIP would improve care coordination activities.
- Interoperability with Connect Oregon/Unite Us with our Population Health tool would improve care coordination activities.
- Data sharing from school-based health centers and CBO's would improve care coordination activities
- CHA providers self-fund our Population Health Tool to interface clinical, claims and other data for an aggregated patient record and HIE, this is a challenging cost to sustain.
- There are always challenges with data harmonization in knowing that external result "XYZ" is the same as internal result "ABC," for example. There are opportunities for organizations to improve their coding and mapping for even better integration of external data in the local systems.
- Frequently there are challenges when exchanging across EHR vendors. Certain vendors may send less robust content, send content in non-discrete format, cannot send information until the patient is discharged, have limitations with their automated query capabilities, fail to provide unique reference IDs with discrete data and so forth.

4. Support for HIE – Hospital Event Notifications

A. Support for HIE – Hospital Event Notifications: 2022 Progress

1. Please describe your (CCO) progress using timely Hospital Event Notifications within your organization. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2022 progress
    b. Describe the following in the narrative section

i. The tool(s) that you are using for timely Hospital Event Notifications
ii. The strategies you used in 2022
iii. Accomplishments and successes related to each strategy.

Overall Progress
Please select which strategies you employed during 2022.

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

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

All Health Share partner Integrated Delivery Systems and the Integrated Community Network uses PointClickCare's (Collective) admission notifications and reporting. Integrated Delivery Systems also transmit notifications to internal PCPs via messages in the Epic EHR. Highlight of how our partner organizations are leveraging this technology include:

OHSU, one of Health Share's Integrated Delivery System partners, leverages internal hospital event notifications from OHSU, Adventist Portland, and Hillsboro Medical Center within Epic for timely care coordination and care management follow-up. Integration of Adventist into OHSU's broader EMR platform was a key activity in 2022 and is scheduled for completion in early 2023.

Legacy/PacificSource is piloting new care management functionality in Collective:
- Claims-based pharmacy use cases
- Assigned / Not Established functionality

CareOregon, Health Share's Integrated Community Network, receives Hospital Event Notifications from PointClickCare (Collective). They have integrated an hourly feed into their care coordination platform to alert internal care coordination teams of an event for members they are working with. They use cohorts and reports from the application to proactively identify and refer members into care coordination. Examples of cohorts and reports include:
- Psychiatric Acute Care Admits and Discharges
- CPCCO BH Cohort – Members who present to the ED for a behavioral health related concern
- Diabetes Cohort – Members who present to the ED or Inpatient for diabetes related concern
- 3 ED Admits in 90 Days
- 5 ED Visits in 12 months
- Pediatric ED Activity
- Rising Risk ED/IP/OBS/SNF – Admit

Supporting CCO Metrics
In addition to the above, an IET cohort was successfully added in 2022 that providers can use to support their clients in initiating and engaging in treatment for Substance Use events.

2. Please describe your progress supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers. In the spaces below, please
   a. Select the boxes that represent strategies pertaining to your 2022 progress
   b. Describe the following in the appropriate narrative sections
      i. The tool(s) you supported or made available to your providers in 2022
      ii. The strategies you used to support increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers in 2022

iii. Accomplishments and successes related to your strategies (Please include the number of organizations of each provider type that gained increased access to HIE for Hospital Event Notifications as a result of your support, as applicable)

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

Overall Progress
Using the boxes below, please select which strategies you employed during 2022. Elaborate on each strategy and the progress made in the sections below.

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

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

Supporting Access, EHR Integration
Integrated Delivery System partner facilities Epic Care Everywhere Event Notifications to external Epic organizations anytime a hospital event occurs for a patient, so long as there is already a Care Everywhere link/match established between the two organizations and the external organization has a PCP on record for the patient.

Partner facilities also send hospital event notifications to PointClickCare (Collective Medical Technologies, aka CMT). External organizations can submit their patient population information to CMT and CMT will send that organization a notification anytime one of those patients has a hospital event. Epic organizations also push messages to the PCP through Care Everywhere Event Notifications, primarily from PeaceHealth and OHSU pediatrics. Implemented inbound routing rules were implemented to minimize duplicate and unnecessary notifications in provider in-baskets

Legacy and Pacific Source additionally leverage the Reliance system to communicate hospital events.

Leveraging Event Notifications for Care Coordination and Population Health
Several high value “Cohorts” and reports have been implemented in the Collective system to address the clinical and care coordination needs of identified populations. Some examples include:

- Heat mitigation, including direct member outreach for A/C unit distribution
- Skilled nursing facility (SNF) data flows
- Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) report
- Long-Term Services and Supports (LTSS) and Dual Eligible Special Needs Plan (DSNP) reports

One of our large pediatric group practices, Children’s Health Alliance, uses the Innovaccer Population Health Tool which incorporates EMR data as well as payer data and EDIE (hospital notification) data into a pediatric HIE which enables patient stratification for care management and offers timely care coordination worklists such as patients needing ED visit follow-up.

Health Share’s Integrated Community Network, CareOregon, submits daily file feeds that identifies population segments of risk through groups/tags and shares these with community partners to support their work with our members. See section 4.A.1 above for example cohorts.

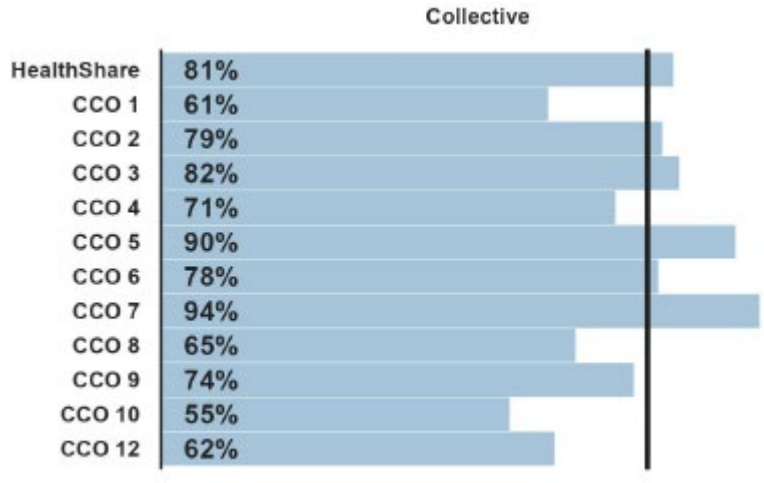
Outreach, Education, and Technical Assistance
CareOregon’s Innovation Team provides coaching and technical assistance to increase access and optimization of PointClickCare for hospital event notifications and care coordination through one-on-one support with individual clinics, which can occur on an ad hoc basis when clinics request support or through regularly scheduled check-in meetings. Additionally, the Innovation Team supports the network through multi-health-system convening meetings where

collaboration and technical assistance is provided for all participants. Action items are explored or more in-depth follow up support happens after the convening meetings during the one-on-one support.

ii. Additional progress specific to physical health providers

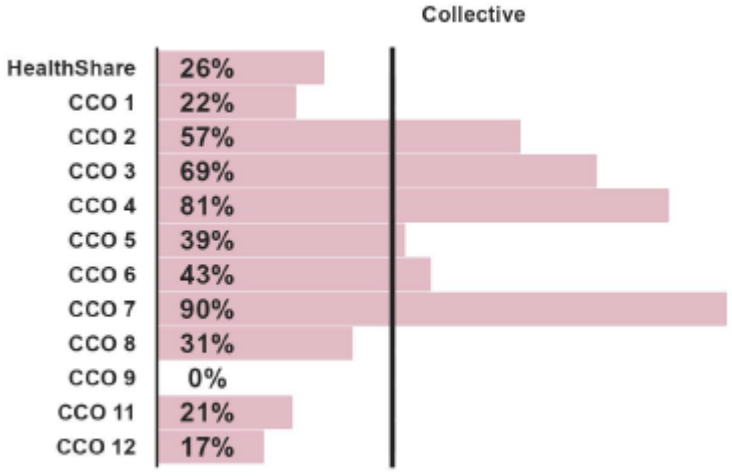
As shown in the chart below, physical health organization adoption weighted by number of providers is extensive.

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



iii. Additional progress specific to oral health providers

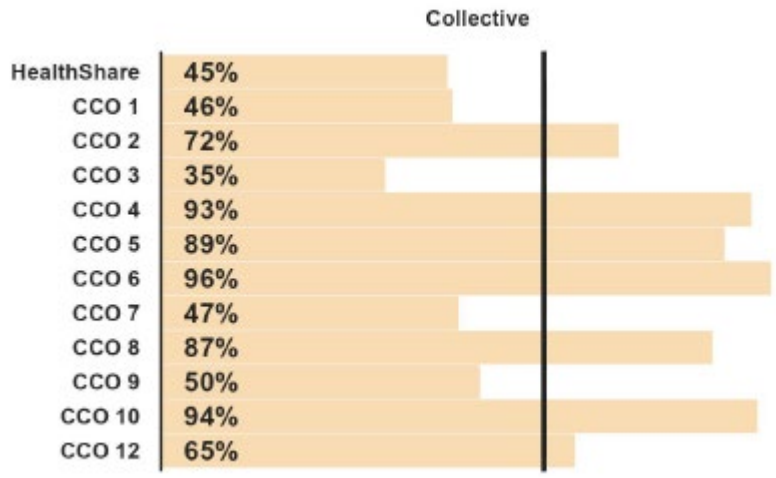
All of Health Share's dental plans are actively using Collective to identify and coordinate dental care for members going to the emergency department for non-traumatic dental issues. The dental plans have continued to explore the expanded information available to them and how to improve functionality within oral health. We surveyed our delegated dental plans' oral health providers on their use of Collective in the provider office. Only 41 of 255 providers surveyed use Collective in their office due to the exceptional use of it at the dental plan level.



iv. Additional progress specific to behavioral health providers

The past few years have been challenging for behavioral health providers and those seeking care with a recognized shortage of needed providers statewide. While Health Share has increased the size of its behavioral health provider

network, there is ongoing effort needed to foster adoption among these providers (and obtain accurate data about their use of this technology).



v. Please describe any barriers that inhibited your progress

Finalized guidance on 42 CFR Part 2 changes that enable sharing of substance use and treatment information would likely remove significant barriers to adoption among behavioral health providers and facilities providing treatment for substance use related conditions.

B. Support for HIE – Hospital Event Notifications: 2023-2024 Plans

2. Please describe your (CCO) plans to use timely Hospital Event Notifications within your organization. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2023-2024 plans
    b. Describe the following in the narrative section
        i. Any additional tool(s) that you are planning on using for timely Hospital Event Notifications
        ii. Additional strategies for using timely Hospital Event Notifications beyond 2022
        iii. Activities and milestones related to each strategy

Notes: Strategies and tools described in the *2022 Progress* section that remain in your plans for 2023-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

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

Overall Plans

Using the boxes below, please select which strategies you plan to employ in 2023-2024.

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

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

Expand use of the Epic Compass Rose module, which receives hospital event notifications, to support care coordination and case management while enhancing reporting and analysis capabilities.

Expand hospital event notifications to Adventist Portland when they join OHSU's instance of Epic.

Continue working with PointClickCare (Collective) to identify strategies to improve the timeliness and accuracy of data provided and gain additional value from the system.

Continue development and refinement of Collective event notifications, member cohorts, and reports to monitor utilization, stratify risks/populations. This allows care coordination teams to develop and manage care plans to address issues contributing to CCO metric performance. See section 4.A.1 for current examples of this work.

1. Please describe your plans for ensuring increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2023-2024 plans.
    b. Describe the following in the appropriate narrative sections
        i. The number of physical, oral, and behavioral health organizations that do not currently have access to HIE for hospital event notification using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations do not have access to HIE for hospital event notifications). CCOs are expected to use this information to inform their plans.
        ii. Any additional HIE tools you are planning to support or make available to your providers for Hospital Event Notifications
        iii. Additional strategies for supporting increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers beyond 2022.
        Activities and milestones related to each strategy (Please include the number of organizations of each provider type that will gain increased access to HIE for Hospital Event Notifications as a result of your support, as applicable).

Notes: Strategies and tools described in the *2022 Progress* section that remain in your plans for 2023-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

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

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2023-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and the include activities milestones in the sections below.

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

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

Using the OHA-provided Data Completeness Table, 229 physical health, 175 oral health, and 205 behavioral health organizations do not have access to HIE for hospital event notifications. Health Share will pursue the actions described below to enhance and expand access.

Outreach and Assistance

- Encourage more external organizations to participate in Collective Medical Technologies notifications to receive event notifications.
- Work in partnership with external organizations to better understand any gaps and remedy those gaps.
- Provide technical assistance to expand use of Collective in the community with Adventist's adoption of the Epic through OHSU.
- Continue to identify opportunities through an Innovation Specialist Team to help clinic partners modify their operations and optimize use of PointClickCare.

The innovation team provides coaching and technical assistance as it relates to increased access and optimization of PointClickCare for hospital event notification and care coordination through one-on-one support with individual clinics, which can occur on an ad hoc basis when clinics request support or through regularly scheduled check-in meetings. Additionally, the innovation team supports the network through multi-health system convening meetings where collaboration and technical assistance is provided for all participants. Action items are explored or more in-depth follow up support happens after the convening meetings during the one-on-one support.

System Improvements

- Work with PointClickCare (Collective Medical) to improve hospital event notification data availability.
- Continue development work with Collective Medical to improve notification of hospital admissions across internal and external facilities to improve information accuracy.
- Continue submission of daily feeds that identifies population segments of risk through groups/tags and share these with community partners to support their work with our members. See section 4.A.1 above for example cohorts.
- Investigate enhancing EHR integration with Collective using FHIR standards/technologies.
- Continue to share updated provider directories so external facilities have correct Direct Messaging contact information to communicate with other providers.

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

The primary care Innovation Specialist team in Health Share's Integrated Community Network will continue to use of a dashboard to identify opportunities to expand use of Collective and as tool for care planning/transitions of care, and in meetings focusing on behavioral health in the ED. Physical health partners will continue to use Collective as an outreach tool for transitions of care and as means to refer patients into Care Coordination.

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

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

Given the increase in access to telehealth-only providers, we will be targeting this group of providers for outreach and education on use of PointClickCare.

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with access to Hospital Event Notifications?

As stated above, availability and access to Collective Data has been useful in identifying embers in need of Care Coordination and/or support services. While useful in concept, this has not been without challenges. Due to its nature and inability to enforce process steps performed by hospital systems, sometimes discharge data is not accurately captured. If the hospital fails to update the hospital file and report the discharge data, this results in inaccurate

information being shared with the end-user. This issue creates challenges in the accuracy of data available utilized for care transition monitoring and intervention.

OHA can help support resolution of this issue by aiding in identifying and implementing state-wide standards for how discharge data is captured at hospitals, along with timeliness and accuracy. With the majority of Oregon's hospitals being on Epic EMR, there appear to be clear opportunities to standardize data capture techniques, data fields, and data transfer technologies.

Other opportunities include:

- Capturing and routing to care team members beyond the specified PCP and maintaining updated provider directories.
- Expanding notification of patient encounters at urgent care centers
- Expanding notification of patient discharges from inpatient behavioral health

5. HIT to Support SDOH Needs

A. HIT to Support SDOH Needs: 2022 Progress

1. Please describe any progress you (CCO) made using HIT to support social determinants of health (SDOH) needs, ***including but not limited to screening and referrals***. In the space below, please include
    a. A description of the tool(s) you are using. Please specify if the tool(s) have closed-loop referral functionality (e.g., Community Information Exchange or CIE).
    b. The strategies you used in 2022.
    c. Any accomplishments and successes related to each strategy.

Overall Progress
Please select which strategies you employed during 2022.

☒ Implementation of HIT tool/capability for social needs screening and referrals	☒ Integration or interoperability of HIT systems that support SDOH with other tools
☒ Care coordination and care management of individual members	☒ Collaboration with network partners
☒ Use data to identify individual members' SDOH experiences and social needs	☐ CCO metrics support
☐ Use data for risk stratification	☒ Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources)
☐ Use HIT to monitor and/or manage contracts and/or programs to meet members' SDOH needs	☒ Engage in governance of CIE
	☐ Other strategies for supporting CIE use within CCO (please list here):

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

Implementation of HIT tool/capability for social needs screening and referrals:

- Health Share continues to provide community-wide access to the Unite Us platform, under the Connect Oregon initiative, for all Health Share partners, their affiliated network providers, and each of the three counties in the region. Unite Us offers closed loop referral functionality.
- In 2022 the CCO began exploring opportunities to integrate the tool for the new CCO Social Screening and Referral Measure, which CCOs will be accountable for in 2023. This exploration included understanding the mechanism by which social needs screening tools are incorporated into the tool workflow and captured in data accessible to the CCO.

Care coordination and care management of individual members

- Health Share works with its partners to sponsor access to PANOW and C3CAP/TrackVia technology's voucher-based system using TrackVia software to enable referral to and payment for health-related social needs.

Use data to identify individual members' SDOH experiences and social needs:

- In 2022 Health Share continued refining the data ingestion and cleaning process from the Unite Us platform.
- A routine data feed was established from Unite Us to Health Share, populated with the experiences of Health Share members gathered through the platform—analytics and dashboarding planned for 2023.

Collaboration with network partners:

- In 2022 the CCO hosted a monthly user workgroup to encourage partners to expand use of the tool for numerous purposes.
- Health Share participated in a regular forum with national sites using Unite Us in a learning collaborative format (not sponsored by Unite Us). This provided affinity and connection with other sites attempting to expand use of Community Information Exchange, including those doing so in a largely Medicaid context.

Enhancements to CIE tools:

- Health Share worked with the CIE vendor to pilot use of a new form within the platform that could be used to replace secure email submission request form for Health-Related Service provision.
- Developed workflow to enable CBOs to request housing benefits from our central benefit administrator for housing services through a standard referral form that has been built in Connect Oregon. Receiving entity has been set up and trained to accept these referrals in the Connect Oregon platform. These CBOs are receiving payment for these benefits.

Engage in governance of CIE:

- Health Share participated in a statewide funders group with other participating CCOs to build alignment on use cases and to provide input on key product developments.
- The CCO also had a seat on the Unite Us partner advisory group with users of the platform from across the country.
- The CCO has also been participating in an evolving effort with OHLC to support a multi-year project evaluating the impact of CIE adoption with the SIREN group.

2. Please describe any progress you made in 2022 supporting contracted physical, oral, and behavioral health providers with using HIT to support SDOH needs, ***including but not limited to screening and referrals***. Additionally, describe any progress made supporting social services and community-based organizations (CBOs) with using HIT in your community. In the spaces below, please include
    a. A description of the tool(s) you supported or made available to your contracted physical, oral, and behavioral health providers, as well as social services, and CBOs. Please specify if the tool(s) have screening and/or closed-loop referral functionality (e.g., CIE).
    b. The strategies you used to support these groups with using HIT to support social needs, including but not limited to social needs screening and referrals.
    c. Any accomplishments and successes related to each strategy.

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

Overall Progress

Using the boxes below, please select which strategies you employed during 2022. Elaborate on each strategy and the progress made in the sections below.

☒ Sponsor CIE for the community ☒ Financial support for CIE implementation and/or maintenance ☐ Training and/or technical assistance ☒ Assessment/tracking of adoption and use ☐ Outreach and education about the value of HIT adoption/use to support SDOH needs ☐ Support participation in SDOH-focused HIT collaboratives, education, convening, and/or governance ☐ Incentives and/or grants to adopt and/or use HIT that supports SDOH ☐ Requirements in contracts/provider agreements	☒ Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources) ☒ Integration or interoperability of HIT systems that support SDOH with other tools ☒ Support sending of referrals to clinical providers (i.e., to physical health, oral health, and behavioral health providers) ☐ Utilization of HIT to support payments to community-based organizations ☐ Other strategies for supporting adoption of CIE or other HIT to support SDOH needs (please list here): ☐ Other strategies for supporting access or use of SDOH-related data (please list here):

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

Sponsor CIE for the community

- As noted above, the CCO is holding a centralized contract that enables all network partners unlimited use of the Unite Us platform. Each network partner has subsequently supported their own networks in adoption and use of the tool.
- Investment in 211's Coordination Center to support adoption of Connect Oregon/Unite Us platform and to offer personalized care coordination to supplement the closed loop referral capabilities of the tool.

Financial support for CIE implementation and/or maintenance:

- One of Health Share's partners provided funding through Community Clinic Integration grants to build capacity within community partners to capture and utilize SDOH data to serve those in need.

Assessment/tracking of adoption and use

- Health Share and partners have continued to meet on a monthly basis to review adoption and barriers. This occurs at a monthly Unite Us meeting with the CCO and at a monthly partner workgroup focused on further spread within the delivery system.
- Among numerous improvement efforts, one IDS partner focused on scaling SDOH screening and consistent Epic documentation in the History section of Epic Hyperspace across primary care clinics within a large primary care system. Among all service lines, they increased from screening roughly 89,000 patients in 2021 to more than 133,000 system-wide in 2022. This system is one of Health Share's partners simultaneously adopting Connect Oregon/Unite Us closed loop referral platform.
- One Integrated Delivery System has expanded access to Epic Compass Rose for internally employed Traditional Health Workers, including Community Health Workers and Peer Support Specialists. This will increase both coordination and data access for those who are engaged in addressing SDOH for members.

Integration or interoperability of HIT systems that support SDOH with other tools

- Numerous Health Share delivery systems have implemented FHIR integration of the CIE with their Epic platform, including providing feedback on adoption and exploring care plan writeback functionality.
- Broad continued adoption across Integrated Delivery Systems of Epic SDOH modules to allow for identification of social health needs and coordination across teams.
- SDOH categories have been mapped to Legacy Epic CCD as discrete values, enabling better analysis and collection.
- One of Health Share's IDS partners has started processing SDOH information from Reliance HIE for analytics use cases, most notably in support of its health equity plan.
- One system's Home and Community Care (Home Health Teams) added SDOH screening into their Epic Rover capabilities to enable providers doing home visits to document SDOH results in real time. This will enable

providers to move from paper screeners which need duplicate data entry, hindering accurate and timely documentation.

Enhancements to CIE tools (adding health-related services funds forms)

Health Share's Central Benefit Administrator for housing benefit approached HIT for SDOH in a number of ways:

- Worked with Collective Medical to provide list of enrolled members to be established with a global flag in their platform. The global flag provides an alert and allows users from adjacent Health Systems and IDS entities with visualization that their members are enrolled in the Housing Benefit Program.
- Established the CBA as a receiving entity for referrals into the Housing Benefit Program from community-based organizations and other member facing groups.
- Development and support of care coordination tools, including SDOH information, used as a part of the program.
- Established a process to download and present analyses and audit reports for referrals to community-based organizations who help address SDOH needs.

Support sending of referrals to clinical providers (i.e., to physical health, oral health, and behavioral health providers)

- Health Share's Integrated Community Network developed a process to accept referrals via Unite Us from Portland Fire Rescue CHAT team. Currently exploring user experience feedback in order to identify opportunities for growth, increased user adoption, and improvement.
- One of Health Share's IDS partners has started processing incoming referrals in Connect Oregon to their Member Support Services team, enabling health care access from community sources.

ii. Additional progress specific to physical health providers

See above

iii. Additional progress specific to oral health providers

iv. Additional progress specific to behavioral health providers

Early exploration of opportunities for the Unite Us platform to facilitate referrals to BH providers in the network. Although there is promise that this type of technology could ultimately prove useful for quickly identifying system capacity, provider capacity issues slowed further development of this as a pathway.

v. Additional progress specific to social services and CBOs

vi. Please describe any barriers that inhibited your progress

Preparation for 2024 waiver benefits has slowed some efforts to implement payment mechanisms on our Connect Oregon platform. While there is enthusiasm to begin using the technology to facilitate funds flow and tracking for services, the lack of clarity on expectations and standards for what will be included in these benefits has led to hesitance to develop a system that will need to be rebuilt once there is clarity.

B. HIT to Support SDOH Needs: 2023-2024 Plans

1. Please describe your plans for using HIT to support SDOH needs, ***including but not limited to screening and referrals***, within your organization beyond 2022. In your response, please include
    a. Any additional tool(s) you will use. Please specify if the tool(s) will have closed-loop referral functionality (e.g., CIE).
    b. Additional strategies you will use beyond 2022.
    c. Activities and milestones related to each strategy.

Notes: Strategies and tools described in the *2022 Progress* section that remain in your plans for 2023-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

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

Overall Plans

Using the boxes below, please select which strategies you plan to employ in 2023-2024.

☒ Implementation of HIT tool/capability for social needs screening and referrals	☒ Integration or interoperability of HIT systems that support SDOH with other tools
☐ Care coordination and care management of individual members	☒ Collaboration with network partners
☒ Use data to identify individual members' SDOH experiences and social needs	☒ CCO metrics support
☐ Use data for risk stratification	☒ Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources)
☒ Use HIT to monitor and/or manage contracts and/or programs to meet members' SDOH needs	☒ Engage in governance of CIE
	☐ Other strategies for supporting CIE use within CCO (please list here):

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

Implementation of HIT tool/capability for social needs screening and referrals

Activities	Milestones and/or Contract Year
Continue to refine use of Unite Us platform for referrals to housing benefits through central benefits administrator	Ongoing 2023
In preparation for waiver benefits implementation in 2024 (process/requirements from OHA TBD) identify opportunities for further use of CIE to offer closed-loop referrals	Q4-2023 for clarity on plan;

Use data to identify individual members' SDOH experiences and social needs

Activities	Milestones and/or Contract Year
Scope data sharing and analytic opportunities in alignment with new Social Screening Incentive measure requirements aimed at understanding frequency of SDOH screening by type across network and to avoid members receiving multiple screening services	Q4 2023 for data integration planning and roadmap
Incorporate updated Pediatric Health Complexity into Social Emotional Reach dashboard for collaborative use	By Q3 2023

Use HIT to monitor and/or manage contracts and/or programs to meet members' SDOH needs

Activities	Milestones and/or Contract Year
Incorporate Housing Referrals data from central benefits administration program into broader data and system use analysis of Connect Oregon platform	By end of Q4 2023

Collaboration with network partners

Activities	Milestones and/or Contract Year
Include focus on adoption of CIE and use of 211 Coordination Center offerings into regional collaborative on development of CCO's social health network to prepare for new waiver benefits in 2024	Underway—enhancements through Q4 2023

Integration or interoperability of HIT systems that support SDOH with other tools

Activities	Milestones and/or Contract Year
Establish data sharing agreements with Multnomah County Joint Office of Homeless Services (JOHS) to enable identification of individuals on coordinated access list and identified as high risk within the health system (continuation of Multnomah County FUSE effort)	Q2-Q3 2023—Established DUA/agreement, analysis and data sharing enabled
Explore opportunity to use Event Notification tools (PreManage/Collective) to identify individuals served by both housing and health care providers	Q3-Q4 2023 based on project needs/developing alignment

CCO metrics support

Activities	Milestones and/or Contract Year
Inventory SDOH screening and data resources currently in use across the CCO Collaborative in line with Social Screening and Referral metric	Q4 2023
Collect and analyze available social screening tools captured in Unite Us to support Social Screening and Referral metric requirements	Q4 2023

Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources)

Activities	Milestones and/or Contract Year
Continued exploration of pilot opportunity with Unite Us related to their payments module. This allows direct invoicing and encountering of services by community-based providers for social services rendered in the community. Health Share is actively engaged in scoping this opportunity (Q1, 2023) but ensuring alignment of this effort with upcoming social health network creation and OHA Waiver requirements related to billing/encountering, understanding funds flow from OHA to CCO, etc.,	Q4 2023 to be actively using payments, depending on go/no-go assessment.

Engage in governance of CIE

Activities	Milestones and/or Contract Year
Work directly with other CCOs and OHA to implement technology solutions to enable upcoming waiver benefits for health-related social needs	2023-2024

2. Please describe your plans for supporting contracted physical, oral, and behavioral health providers with using HIT to support SDOH needs, ***including but not limited to screening and referrals***, beyond 2022. Additionally, describe your plans for supporting social services and CBOs with using HIT in your community. In the spaces below, please include
    a. A description of any additional tool(s) you will support or make available to contracted physical, oral, and behavioral health providers, as well as social services and CBOs. Please specify if the tool(s) will have closed-loop referral functionality (e.g., CIE).

b. Additional strategies for supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using HIT to support SDOH needs, including social needs screening and referrals beyond 2022.
c. Activities and milestones related to each strategy.

Notes: Strategies and tools described in the *2022 Progress* section that remain in your plans for 2023-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

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

Overall Plans
Using the boxes below, please select which strategies you plan to employ 2023-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and the include activities and milestones in the sections below.

☐ Sponsor CIE for the community	☒ Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources)
☒ Financial support for CIE implementation and/or maintenance	☒ Integration or interoperability of HIT systems that support SDOH with other tools
☒ Training and/or technical assistance	☒ Support sending of referrals to clinical providers (i.e., to physical health, oral health, and behavioral health providers)
☐ Assessment/tracking of adoption and use	☒ Utilization of HIT to support payments to community-based organizations
☐ Outreach and education about the value of HIT adoption/use to support SDOH needs	☒ Other strategies for supporting adoption of CIE or other HIT to support SDOH needs (please list here):
☐ Support participation in SDOH-focused HIT collaboratives, education, convening, and/or governance	☐ Other strategies for supporting access or use of SDOH-related data (please list here):
☒ Incentives and/or grants to adopt and/or use HIT that supports SDOH	
☐ Requirements in contracts/provider agreements	

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

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

Each of Health Share's partner networks have extensive efforts related to utilizing HIT to support provision of health-related social needs services, identify social needs in clinical settings, and connecting members with available resources in the community. These efforts largely focus on integrating information from screenings or other data sources with EMR data and leveraging emerging EMR functionality to organize this information. Below are areas where CCO and network efforts are particularly aligned related to health equity, addressing SDOH and the emerging focus on available benefits upcoming under the new 1115 waiver.

Financial Support/Incentives for CIE implementation and/or maintenance

Activities	Milestones and/or Contract Year
Incentivize community partner use of Unite Us community information exchange (numerous IDS/ICN partners)	Build from previous year's approach to encourage adoption and use--2023

Training and or technical assistance

Activities	Milestones and/or Contract Year
All Integrated Delivery Systems developing and deploying additional modalities to screen members for SDOH and to track reach of these activities in integrated platforms (EMR)	Throughout 2023
Provide necessary technical assistance to on-board new CBOs and service providers to the Unite Us tool, particularly in support of community investments related to food delivery and housing	Throughout 2023

Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources)

Activities	Milestones and/or Contract Year
Leverage Unite Us payments module (if adopted, see above) to pilot payment for particular services where invoicing and payment would be better delivered via a closed-loop platform	Throughout 2023

Integration or interoperability of HIT systems that support SDOH with other tools

Activities	Milestones and/or Contract Year
Two sites piloting Unite Us within Epic to further integration, using FHIR-based interoperability, specifically with emerging plan-care writeback functionality	Q1 2023, integration throughout the year
Two Integrated Delivery Systems engaging with Tri-County Housing departments to improve care coordination between health and housing teams. Specifically focused on allowing health entities to access data in Housing Management Integration System (HMIS)	Q1 2023—Pilot with Washington County Q2 2023—Expand to Clackamas County

Support sending of referrals to clinical providers (i.e., to physical health, oral health, and behavioral health providers)

Activities	Milestones and/or Contract Year
One IDS site expanding use of Connect Oregon to link community-based referrals to plan member support services to connect members to appropriate clinical resources	2023 ongoing

ii. Additional plans specific to physical health providers

iii. Additional plans specific to oral health providers

iv. Additional plans specific to behavioral health providers

v. Additional plans specific to social services and CBOs

C. Optional Question

How can OHA support your efforts in using and supporting the use of HIT to support SDOH needs, including social needs screening and referrals?
Community Information Exchange and Waiver Benefits: One of the most important areas of alignment relates to the upcoming 1115 waiver, specifically to health-related social needs benefits. We have documented evidence that use of community information exchange appears correlated with the availability of funding sources in the community. As was clear during COVID, new grants or funding streams increase engagement between CCOs and community-based service providers; however, in the past these sources of funding have been time-limited, grant-based, and often arising at a time of crisis. The waiver benefits offer an opportunity to align dedicated funding and methods of information delivery in a more strategic way. CCOs have requested that OHA be deliberate in its development of these benefits and their operational components to match system developments already in place related to community information exchange. Use of REALD and SOGI data, application to population health strategies: Health Share has a strong commitment to addressing health disparities—health equity is our CCO's overarching goal. OHA has taken great strides in refining its data collection and demographic information sharing with CCOs. Going forward, additional technical assistance and best practice sharing between CCOs, OHA and other leaders in terms of organizing, using and interpreting these critical demographic elements will help accelerate this vital but challenging transformational work.

6. Other HIT Questions (Optional)

The following questions are optional to answer. They are intended to help OHA assess how we can better support the HIT efforts.

A. Describe CCO HIT tools and efforts that support **metrics**, both within the CCO and with contracted providers. Include CCO challenges and priorities in this work.
Health Share spends a considerable amount of its resources on organizing and reflecting its Quality Metrics performance data. This comes in the form of a centralized data repository (Health Share Bridge) accessible to partners and (hopefully soon) to the broader community. Our goal is to reflect not simply the CCO's performance on these metrics but the performance of partners and providers, as well as to reflect differences in performance that might reflect underlying inequities in service delivery or access. Challenges: OHA has recently reduced the frequency of providing this data to CCOs, which lowers the ability to validate CCO calculations against OHA's and increases the need to develop redundant tracking mechanisms at the CCO level. Continued transparency from OHA about their analytic roadmap as it relates to these measures (and other key population health efforts) would be very helpful.
B. Describe CCO HIT tools and efforts that **patient engagement**, both within the CCO and with contracted providers.
Patients will be given the ability to share their patient portal clinical information with external providers via Epic's "Share Everywhere" tool. This tool gives providers one-time access (with the patient's permission) to log into a web portal and view clinical information the patient can see in the patient portal.
C. How can **OHA support** your efforts in accomplishing your HIT Roadmap goals?
D. What have been your organization's **biggest challenges** in pursuing HIT strategies? What can OHA do to better support you?

E. How have your organization's HIT strategies supported **reducing health inequities**? What can OHA do to better support you?
We believe that some of our HIT strategies, particularly around disaggregation of data by race, ethnicity and language, have sharpened our collective focus on underlying health inequities and supported a collective response. This was particularly true related to COVID vaccination rates, where Health Share closed critical gaps in vaccine administration and was able to communicate differences in access and immunizations through multiple lenses that were useful to support community engagement and messaging efforts.

Appendix

Example Response: Support for HIE – Care Coordination

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

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

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

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

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

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

A. 2021 Progress

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

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

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

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

☒ HIE training and/or technical assistance ☒ Assessment/tracking of HIE adoption and capabilities ☒ Outreach and education about value of HIE ☒ Collaboration with network partners	☒ Financially supporting HIE tools, offering incentives to adopt or use HIE, and/or covering costs of HIE onboarding ☐ Offer hosted EHR product (that allows for sharing information between clinics using the shared EHR and/or connection to HIE)

☒ Enhancements to HIE tools (e.g., adding new functionality or data sources) ☐ Integration of disparate information and/or tools with HIE ☐ Requirements in contracts/provider agreements	☒ Other strategies that address requirements related to federal interoperability and patient access final rules (please list here) • *Implemented Patient Access API* ☒ Other strategies for supporting HIE access or use (please list here) • *Assisted with the development of best practice standards for hospital EDs*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Expanded functionality of closed loop referrals via CCO Provider Portal
- Researched and implemented a tool to capture and share SDOH
- Expanded use of CCO Care Coordination Platform to create an electronic mechanism for tri-directional referrals in which providers from physical, behavioral, or oral health can request service navigation and care coordination services from our care coordination team.
- Convened multidisciplinary team meetings where primary care, Community Mental Health Programs, and dental come together to develop shared care plans for specific members who have complex needs that are then entered into the Collective Platform.

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

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

Strategy 6: Engage with state committees/entities

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

- HIT Commons - EDIE Steering Committee

- Metrics & Scoring Committee
- Health Information Technology Advisory Group

Strategy 7: HIE Data collection
As further described in the EHR Adoption section, we partnered with OHA to implement the 2021 Oregon HIT Survey to assess HIE adoption, use, needs, and barriers among our contracted providers. Unfortunately, data collection did not start until October 2021, delaying our access to the results until January 31, 2022.

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

ii. Additional Progress Specific to Physical Health Providers

Strategy 8: Provide workflow TA

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

iii. Additional Progress Specific to Oral Health Providers

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

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

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

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

Strategy 9: Explore oral health HIE

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

Strategy 10: Pursue improvement of the dental request referral process

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

iv. Progress Specific to Behavioral Health Providers

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

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

Strategy 11: Assess the state of behavioral health HIE

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

Strategy 1: Develop and implement a 5-year plan

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

Strategy 8: Provide workflow TA

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

v. Please describe any barriers that inhibited your progress.

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

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

B. 2022-2024 Plans

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

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

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

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

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

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

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

i. Strategies across provider types, including activities & milestones

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

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

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

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

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

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

Activities	Milestones and/or Contract Year
Explore the ability to transition to a closed loop referral mechanism from our care coordination platform. In our next phase of development, we will create the functionality to allow our oral health or behavioral health providers to request care coordination and navigation support.	Q1-Q3 2022: Exploration, research, development Q4 2022: Pilot closed-loop referral mechanism with 8 behavioral health and 4 oral health providers

In conjunction with State efforts, evaluate mechanisms to incorporate SDOH service providers into referral and care coordination workflows.	Q3 2022
Support a closed loop referral process to create a tri-directional navigation and referral system that can support or augment future and more robust HIE development and implementation.	2022-2024: Closed-loop referral process achieved
Focus on solutions for incorporating SDOH service providers into care coordination and referral workflows.	2022-2024
Develop robust systems for the integration of claims and EHR data in order to share insights about members to improve outcomes. This exchange will add patient detail which may not be present in either system alone.	2022-2024

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

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

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

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

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

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

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

Activities	Milestones and/or Contract Year
Maintain Patient Access API and monitor patient use.	Q1-4 2022: Patient Access API remains active. Patient use is monitored quarterly.
We will gather patient input on their experience, needs, challenges, and barriers via existing opportunities (e.g., CAC, patient satisfaction surveys).	Patient input is collected and adjustments to API functionality/patient education are made in response, as needed.
Continue maintaining Patient Access API	2023-2024

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

See *Across Provider Types* section.

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

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

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

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

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

Strategy 6: Engage with state committees/entities

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

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

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

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

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

Strategy 6: Engage with state committees/entities

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

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

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