1. HIT Partnership

Please attest to the following items.

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

2. Support for EHR Adoption

a. 2020 Progress

Please describe your progress supporting EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers. In your response, please describe

1. The strategies you used to support EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers in 2020.
2. Accomplishments and successes related to your strategies

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

i. Progress Across Provider Types

IHN-CCO's response applies to all provider types.

IHN-CCO determined that a less burdensome approach would need to be conducted in 2020 due to COVID. IHN-CCO's HIT adoption and use approach included:

- analyzing the provider network based on member attribution and claim costs
- educating the provider network on HIT requirements
- identify existing workflows to collect and catalog HIT adoption and use
- crafting an annual provider HIT survey

IHN-CCO analyzed and ranked the IHN-CCO provider network to **prioritize providers** assigned to IHN-CCO members and those providers rendering most of the physical, behavioral, and oral care to our IHN-CCO members. Using the HIT Data File and our Provider Network department, IHN-CCO has started to collect and catalog HIT adoption and use.

IHN-CCO augmented the Provider Manual to include the requirements of HIT adoption and use. This has served as a general communication method to ensure the provider network is aware of the HIT requirements. In addition, we have updated our IHN-CCO Provider Participation Agreement to include the HIT requirements.

IHN-CCO believes altering existing processes to **collect HIT adoption and use** will have a better outcome than to create the separate process providers would use to self-report. IHN-CCO is currently in the planning stage to determine which Provider touchpoints should be augmented to collect HIT adoption and use.

IHN-CCO drafted a HIT survey to collect information on how IHN-CCO can assist the providers in achieving HIT adoption and use. Results will be cataloged and compiled over time to track progress. IHN-CCO sent the survey to 192 providers and as of March 11, 2021 has received 99 responses.

IHN-CCO also focused on implementing the Unite Us platform to provide support for members impacted by COVID and the Oregon wildfires. IHN-CCO facilitated the implementation of Unite Us across Samaritan Health Services to allow physical health providers to refer patients to social agencies based on their social needs. IHN-CCO facilitated the integration of SHS Epic and Unite Us to provide a seamless transition for the user to create a referral in Unite Us. In addition, several community-based organizations were added to the IHN-CCO network.

IHN-CCO convened the HIT/HIE Advisory Committee (HIAC) in May 2020 with the purpose to bring organizational expertise to facilitate strategic alignment on CCO 2.O HIT/HIE to improve the coordination of patient care. And to assist contracted facilities meet the required annual HIT data reporting and roadmap deliverables. Membership includes IHN-CCO, Counties, Dental Plans, Primary Care Physician (PCP) representative(s), Department of Human Services, Samaritan Health Services, and more. The HIAC focuses on assisting with the implementation and use of the following: 2020 - OHA-Approved HIT Data File, Health IT Data Collection and Reporting (EHR Adoption/HIE Adoption), Timely Hospital Event Notifications, 2021-2024 HIT/HIE Roadmap Strategy.

The COVID-19 Pandemic of 2020 has completely reshaped the landscape of telemedicine. IHN-CCO aligned all internal procedures with benefit and payment guidelines released by Medicaid and Medicare including rate parity allowing for the expansion of modality by which telemedicine is performed. IHN-CCO's Provider Relations representatives made vast and thorough outreach to the provider community to quickly and effectively relay changes to telemedicine requirements and regulations to ensure that providers had the most updated information needed to decide if telemedicine was the right for their practices and our members. Medical, Behavioral, Alternative Care, and Dental providers have all implemented telemedicine solutions to provide direct access to care to our members. In addition, IHN-CCO has an existing system called My Chart that enables its members to access telehealth providers for Mental Health and Medical Services. In addition, IHN-CCO recently entered into an agreement with a telemedicine vendor, TeleDoc, for 24/7 telemedicine services for low acute medical situations. While the practice of dentistry is difficult to conduct at a distance, our Dental Health partners also saw changes to the provision of dental care via telemedicine platforms by expanding on existing processes formerly used to serve our members that are homebound and the implementing telephonic screenings and triage to assess further need for in-person care. Additionally, one of our partners, Advantage Dental, launched a mobile dentistry pilot program intended to serve our members in Lincoln County. This service is a hybrid of in-person mobile dentistry with radiography done through telemedicine.

ii. Additional Progress Specific to Physical Health Providers

See the *Progress Across Provider Types* section.

iii. Additional Progress Specific to Oral Health Providers

See the *Progress Across Provider Types* section.

iv. Additional Progress Specific to Behavioral Health Providers

See the *Progress Across Provider Types* section.

v. Please describe any barriers that inhibited your progress.

IHN-CCO's progress was slowed due to COVID which impacted IHN-CCO employees and IHN-CCO's provider network. In addition, IHN-CCO was looking to work with OHA to finalize the HIT Data File to ensure our provider network understanding was synchronized.

Specific to behavioral health providers, individual private practitioners have been problematic in incentivizing adoption of EHR. Small practices do not see the need for EHR adoption with a small client base.

b. 2021 - 2024 Plans

Please describe your plans for supporting EHR adoption among contracted physical, oral, and behavioral health providers. In your response, please include

1. The number of physical, oral, and behavioral health organizations without EHR information using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information). CCOs are expected to use this information to inform their strategies.
2. Additional strategies you will use to support increased rates of EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers beyond 2020.
3. Associated activities and milestones related to each strategy.

Notes:

- Strategies described in the *2020 Progress* section that remain in your plans for 2021 – 2024 **do not need to be included** in this section unless there is new information around how you are implementing/supporting the strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

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

Pursuant to a survey conducted earlier this year, IHN-CCO has identified the following number and types of providers without an EHR as of August 2021:

- Physical: 32
- Behavioral: 37
- Oral: 1

While IHN-CCO remains committed to the strategies outlined in its OHA-approved Health Information Technology (HIT) Roadmap, it continues to evolve these strategies in response to the COVID-19 environment. These strategies, for supporting EHR adoption and use, apply for all provider types. As explained in greater detail above, the COVID-19 Pandemic significantly impacted the way in which both member and providers view health information technologies, particularly telemedicine. Although these environmental changes are generally positive and are helping to accelerate both patients' and providers' willingness to utilize telemedicine, it has created other challenges to EHR adoption. With the immediate challenge of a global pandemic facing providers they, understandably, shifted attention away from work that may have been focused on EHR adoption and implementation efforts to those more directly focused on immediate coronavirus related matters. Although many providers have come to better understand the value proposition of an EHR, they are simultaneously faced with critical financial and patient care issues. As a result, IHN-CCO is working with our provider partners to continue to understand what types of assistance would be most effective in this environment to best aid EHR adoption efforts. As a result, IHN-CCO is evolving its existing strategies to include the following:

1. Augment the IHN-CCO Provider Contracting process to more clearly outline HIT requirements and provide a more direct opportunity to partner with providers in their EHR adoption efforts.
2. Develop new materials to help educate IHN-CCO's provider network of the benefits of EHR adoption in the current environment and redouble distribution efforts to include both traditional and web-based platforms.

3. IHN-CCO made the decision in early 2020 that it would pivot away from its plans to develop the Regional Health Information Collaborative (RHIC). This allowed IHN-CCO to better optimize its health information technology efforts under CCO 2.0. Part of this work has included transforming the RHIC governing framework into a new Health Information Advisory Committee (HIAC). The HIAC includes representation from physical health, oral health, behavioral health. These stakeholders help to ensure alignment of HIT/HIE efforts across the IHN-CCO service area, including providing a forum for input on how best IHN-CCO can promote EHR adoption.
4. Prioritize IHN-CCO providers to target for EHR adoption and use.
5. Conduct analysis to understand the specific barriers for prioritized providers. IHN-CCO has had significant EHR adoption rates since 2015. As a result, those remaining providers who have not yet adopted an EHR are often smaller or philosophically opposed to traditional efforts of incentivizing adoption.
6. Create targeted methods to reduce or eliminate barriers to HIT adoption and use.
7. Evaluate hosting Epic to serve up to those less technological advanced providers (2021).
8. Offer certified EHR to provider network (2022).

IHN-CCO had also been investigating the ability to provide access to an EHR through Samaritan's relationship with Epic. However, this process was interrupted by the COVID-19 pandemic and the need to prioritize other initiatives. IHN-CCO is restarting this process and will be initiating discussions with network providers following the completion of a more thorough assessment with Samaritan Health Services and its Epic team. IHN-CCO expects this work to restart in late 2021 and continue into 2022. Milestones related to this effort include:

Activities	Milestones and/or Contract Year
Re-Engage in Provider Discussions regarding Epic EHR access at IHN-CCO's expense	Q4 2021
Identify pilot Provider(s) to work with	Q1 2022
Implement pilot Provider(s)	Q2 2022
Evaluate pilot results	Q3 2022
Continue Roll-out to additional Providers	Q4 2022

What specific requirements do you plan to include in the IHN-CCO Provider contract that will support EHR adoption?
IHN-CCO is also looking at incorporating additional contract terms that would incentivize/penalize our contracted providers for either adopting or failing to utilize an EHR solution. IHN-CCO is early in this process but is working towards the following:

Activities	Milestones and/or Contract Year
Identify Provider Contract opportunities to create incentives/penalties. Examples may include: (i) an increase in rates for those providers that have adopted an EHR to compensate for the costs of implementation and ongoing maintenance, (ii) a freeze on rate increases for those providers that have not yet adopted an EHR, or (iii) a slight decrease in rates for those providers that do not utilize an EHR.	Q2 2022
Identify Incentives to Offer with Criteria for Adherence	Q3 2022
Evaluate Provider Contract impact and negotiate Contract	Q4 2022
Track Adherence and Pay/Deny Incentives	2023

IHN-CCO is continually exploring collaborative ways to partner with Providers to encourage EHR adoption.

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

See the *Strategies Across Provider Types* section.

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

See the *Strategies Across Provider Types* section.

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

See the *Strategies Across Provider Types* section.

Optional Question

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

Continue to assist in communicating to all providers the value and importance of EHR adoption and utilization to help drive both quality and financial outcomes.

3. Support for HIE – Care Coordination

a. 2020 Progress

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

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

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

i. Progress Across Provider Types

IHN-CCO's response applies to all provider types. In 2020, IHN-CCO had to shift focus to identify low cost, high value work as to not create additional burden on the provider network.

Internal Operations

In 2020, IHN-CCO carefully evaluated its core functional processes and clinical programs to ensure not only alignment and appropriate resource allocation, but also how best to optimize its health information technology efforts under CCO 2.0. After analyzing the various requirements and balancing those with an honest evaluation of the strengths and weaknesses of the existing technology platform, a decision was made that the Regional Health Information Collaborative's (RHIC) health information exchange platform, "CareTeam Link" would no longer be supported.

IHN-CCO conducted an environmental scan, gap and SWOT analysis to design a future organizational state to achieve the deliverables of CCO 2.0. IHN-CCO reorganized Medical Management and created a Clinical Services Division with four departments:

- Population Health / Quality
- Care Coordination
- Behavioral Health
- Pharmacy

IHN-CCO evaluated more than 30 health information technology and data systems in use within the Clinical Services Division. This inventory was compared with requirements necessary to effectively manage care, track referrals and notifications from care facilities, and clinical summaries, as well as assessing population needs, condition categories, and risk levels. The analysis identified the need for an operating system or clinical platform

and workflows, data warehouse and predictive analytics to support population assessment, risk stratification and segmentation. As a result, several projects were initiated in 2020.

IHN-CCO is investing significant resources in enhancing its Clinical Services Division population health, clinical, and quality applications and systems to improve efficiency and enhance care coordination functions.

IHN-CCO implemented TriZetto's **Clinical CareAdvance** (CCA) clinical operating system. The CCA clinical operating system is integrated with claims data and provides a 360-view of the member. The CCA clinical operating system, along with the initial assessment of the member, identifies all providers involved in the member's care. Through CCA, care managers are able to track member referrals and care transitions across multiple systems and specialized treatment programs. Care managers use CCA to document interdisciplinary care team (ICT) meetings. MCG clinical guidelines, which are integrated within CCA enable clinical decision making to determine the appropriate level of care, utilization of services, and timely coordination of care. Thus, enabling IHN-CCO to improve outcomes and mitigate additional health and safety issues while members are in other systems, i.e., criminal justice, Oregon State Hospital, or specialized treatment programs. Care managers are able to share care coordination referrals, notes, and care plans electronically with providers involved in the member's care and treatment. Through CCA, IHN-CCO care managers can effectively coordinate multiple services and supports, such as behavioral health, oral health and specialty providers, traditional health workers, transportation and community-based support agencies. CCA enables care managers to effectively track and coordinate care transitions between episodes, treatment providers and settings, including hospitals, Oregon State Hospital (OSH), acute and rehabilitative facilities, transitional housing, and home. All this is documented in the CCA shared plan of care.

Arcadia was selected as the Population Health Management and Health Intelligence platform and applications vendor to accelerate the implementation of value-based care. The Arcadia Analytics specialize in aggregating multiple sources of data (claims and clinical), which allows analysts to drill down to identify the unique complexities within the IHN-CCO member population. This analytic capability allows for more accurate risk stratification, and segmentation of the population for applicable care interventions. Arcadia Analytics advances quality and performance improvement through calculation and presentation of cost and utilization trends and member-level information for effective intervention. The sophisticated Arcadia software calculates quality, cost and utilization metrics, including member risk level for provider scorecards. Arcadia is also useful in outreach and pre-visit planning as it provides member-level care gap information in real-time to the assigned IHN-CCO provider.

The **Collective Medical** platform provides a common technology platform for real-time care coordination. IHN-CCO worked with partners and stakeholders to develop a regional HIE/HIT approach through Collective Platform and Epic Care Everywhere to improve communication, care coordination, and management of individuals across the continuum, including the criminal justice system and specialty care programs. Through Collective, IHN-CCO is able to support its high-risk vulnerable members and provide a shared care plan and event tracking across hospitals, primary and specialty care, post-acute care, behavioral health providers, and community-based service organizations. Collective Platform member tracking and event notification reports are used to identify members in the emergency department and or who are transitioning between levels of care, providers, or settings.

Given the strong preference for Epic, IHN-CCO was late to implement Collective Platform across its provider network. IHN-CCO providers prefer to use the Epic care coordination tools and Collective Platform shared care plans are used inconsistently. However, Collective Platform is the preferred method of timely hospital event notification for IHN-CCO.

Collective shared care plans are used by providers who support youth involved in Wraparound and ICC, and adults involved in Assertive Community Treatment (ACT). Shared care plans are reviewed and updated through interdisciplinary care team meetings to ensure that services are available and coordinated through transitions and meet the individual need of the members.

Referrals for social supports and services are coordinated through Community Connect, a closed loop referral system powered by Unite Us. Community Connect facilitates continuous communication and closed loop referrals between IHN-CCO, CMHPs, OCWCOG, PCP (PCPCH, BHH, FQHC), and community-based organizations.

IHN-CCO care coordinators maintain a directory of housing resources and can easily make referrals to housing assistance programs through Community Connect (Unite Us) closed loop referral system. Through Community Connect, the intensive care coordination (IICC) coordinator can locate available housing resources and assist members through the process to find the most appropriate housing option as well as other resources.

Provider Network Progress
IHN-CCO worked with Samaritan Health Services to understand the information being sent when a patient was discharged. Samaritan Health Services accounts for most of our ED and IP services and is sending transition of care (TOC) and clinical care document (CCD) when a patient is discharged. The document is sent to the primary care provider within four hours of discharge.

IHN-CCO also focused on implementing the Unite Us platform to provide support for members impacted by COVID and the Oregon wildfires. IHN-CCO facilitated the implementation of Unite Us across Samaritan Health Services to allow physical health providers to refer patients to social agencies based on their social needs. IHN-CCO facilitated the integration of SHS Epic and Unite Us to provide a seamless transition for the user to create a referral in Unite Us. In addition, several community-based organizations were added to the IHN-CCO network.

Arcadia: The Arcadia Analytics platform was implemented to accelerate the implementation of value-based care. The Arcadia Analytics aggregates multiple sources of data (claims and clinical) which allows analysts to drill down to identify the unique complexities within the IHN-CCO member population. This analytic capability allows for more accurate risk stratification, and segmentation of the population for applicable care interventions. Arcadia Analytics advances quality and performance improvement through calculation and presentation of cost and utilization trends and member-level information for effective intervention. The sophisticated Arcadia software calculates quality, cost and utilization metrics, including member risk level for provider scorecards. Arcadia is also useful in outreach and pre-visit planning as it provides member-level care gap information in real-time to the assigned IHN-CCO provider. Arcadia will be a database source for social determinants of health data. Inputs include EHR records, claims data, and Unite Us/Connect Oregon data. This is a large part of the strategy for analyzing REALD data (Race, Ethnicity, Language, Disability) as well as social service information such as housing, food security, and transportation needs.

- Arcadia was originally implemented in 2020 and IHN-CCO has continued to add data feeds and leverage various Arcadia capabilities in 2021
- In 2021 and 2022, IHN-CCO is working to include other, non-contracted provider data with what is currently in Arcadia (which is Epic EMR data from Samaritan Health System Providers and other pertinent data available internally to IHN-CCO). IHN-CCO has contracted with Arcadia to provide additional data feeds from organizations including:
    - Benton County
    - Lincoln County
    - Corvallis Family Medicine
    - The Corvallis Clinic
    - OHA Alert Feed
    - Valley Clinics*
    - Willamette Family Medicine*

  *On hold due to technology limitations on the Provider side

Interdisciplinary Care Team: The interdisciplinary care team (ICT) is an integral part of the IHN-CCO strategy to improve care coordination across the continuum of care. IHN-CCO convenes and staffs the cross-continuum interdisciplinary care team (ICT), which includes internal and external professionals and social supports working together to coordinate care for the member. During the ICT, the care team, the member, and their supports meet to review and update care plan. Through the ICT process, strengths are identified, barriers are addressed, resources are authorized, and referrals are made to ensure that services are available, coordinated and meet the individual need of the member and their supports. This capability is already in use at IHN-CCO.

TriZetto's' Clinical CareAdvance: IHN-CCO implemented Clinical CareAdvance (CCA), a clinical operating system to provide our internal care management and utilization review team with a 360 view of the member. Through CCA, IHN-CCO care managers can effectively coordinate multiple services and supports, such as behavioral health, oral health and specialty providers, traditional health workers, transportation and community-based support agencies. CCA enables care managers to effectively track and coordinate care transitions between episodes, treatment providers and settings, including hospitals, Oregon State Hospital (OSH), acute and rehabilitative facilities, transitional housing, and home. All this is documented in the CCA shared plan of care and ICT meeting minutes. CCA has integrated MCG clinical guidelines, which enable clinical decision making to determine the appropriate level of care, utilization of services, and timely coordination of care transitions.

- CCA was originally implemented for Utilization Management and Care Management in 2020

Additional Questions:

1. Does Clinical CareAdvance only include IHN data? Does it provide IHN-contracted providers with access to patient information? If so, how (e.g., via reports, portal)?
   CCA is used for Care Coordination for all lines of business that Samaritan Health Plans manages including Medicare and Commercial. CCA does not provide patient information to IHN-CCO Providers.

2. How does Arcadia support health information exchange for care coordination (i.e., provide non-affiliated providers with access to patient information)?
   IHN-CCO envisions Arcadia as being an excellent tool to help with Care Coordination. Arcadia can help IHN-CCO understand individual member risk and can provide that along with information to complete care gap closures to Providers.

   IHN-CCO is currently in the process of working with Arcadia to produce CCO metrics and HEDIS measures. IHN-CCO's planned roadmap includes the integration of SDOH data and analytics using a combination of Arcadia-supplied data and data provided by IHN-CCO.

   Through these processes IHN-CCO is looking to give Providers a 360-degree view of our members as part of their care plan. These capabilities are currently being implemented with the Samaritan Medical Group, which provides healthcare to approximately 60% of IHN-CCO members. Until the Arcadia-based metrics are available, IHN-CCO is providing Gap List reports to Providers. The Arcadia-based functionality is intended to be in place by the end of 2021

   Following the Samaritan Medical Group implementation IHN-CCO will move forward with implementing Lincoln and Benton County (OCHIN clinics) next. Development of the data feeds to go into Arcadia is currently in process and then IHN-CCO can start the analytics implementation.

3. How does IHN support the increased adoption and use of the Collective Platform among its providers (e.g., information dissemination, financial support, advocate for increased functionality)?

   IHN-CCO has custom reports from Collective Platform for EDIE and Admission Notifications that are used for Care Coordination purposes. IHN-CCO is working to have the capability to monitor for mental health related admissions as well. Collective Plan includes additional capabilities that we have not taken advantage of yet but would like to use in the future.
   For internal Care Coordination Team, IHN-CCO created a series of lists for certain cohorts to alert team members of EDIE and Hospital Admissions. IHN-CCO is also considering the use of registries to identify at risk populations and receive notifications when certain services are received by these members

   IHN-CCO uses EDIE and Collective Medical but is having challenges convincing Providers of the importance of the use of these tools and exploring opportunities to help Providers understand the value. IHN-CCO will be providing additional education and developing use cases to share with Providers to

increase the understanding of the value and provide a level of practicality that may help with adoption rates.

4. Can you please describe the regional HIE/HIT approach developed with partners and stakeholders?

   IHN-CCO has taken an incrementally approach to regional HIE/HIT approach with partners and stakeholders. We are staying apprised of regional and state HIE efforts through HITAC, HIT Commons, and other collaborative activities. In that process IHN-CCO has been developing an approach to exchange data to best leverage our system investments.

   IHN-CCO has been utilizing the HIAC as a forum to facilitate strategic alignment on CCO 2.O HIT/HIE to improve the coordination of patient care. And to assist contracted facilities meet the required annual HIT data reporting and roadmap deliverables. Membership includes IHN-CCO, Counties, Dental Plans, Primary Care Physician (PCP) representative(s), Department of Human Services, Samaritan Health Services, and more. The HIAC focuses on assisting with the implementation and use of the following: 2020 - OHA-Approved HIT Data File, Health IT Data Collection and Reporting (EHR Adoption/HIE Adoption), Timely Hospital Event Notifications, 2021-2024 HIT/HIE Roadmap Strategy.

   IHN-CCO invested in the community implementation of Connect Oregon (powered by Unite Us), a coordinated referral network bringing together providers, community partners, local government, citizens, and members. By coordinating care delivery across health and human service providers, the focus shifts from the system to the human. This allows IHN-CCO, healthcare providers, and community-based organizations to address health proactively and improve outcomes.

   The coordinated network connects providers (care coordinators in the healthcare system, housing agencies, child and family services, behavioral health providers, transportation providers, and more) through a shared technology platform to communicate in real-time, make electronic referrals, securely share member/client information, and track outcomes to measure the impact of services provided and allow for informed decision-making by community care teams.

   Connect Oregon supports care coordination by storing all information on a HIPAA compliant platform where members are matched with providers or programs for which they qualify, and information is captured once and shared on their behalf. This allows service providers to have insight into the member's entire journey and to easily refer and connect members to local services in the community. Connect Oregon tracks the outcome of referrals and services delivered for members through the closed-loop system.

5. Please describe how DCOs use PreManage data for care coordination?
6. IHN-CCO does not require DCOs to use EDIE or Collective Medical (formerly PreManage). However, some DCOs began using the system when ED utilization was a component of their scorecard in their contracts with IHN-CCO but this metric has since retired. DCOs should still be using EDIE and IHN-CCO plans to explore DCO use of Collective Medical and other integrated technology platforms to add value in care coordination efforts.
   How does IHN support the use of Unite Us among its contracted providers?
   IHN-CCO invested $450,000 in Unite Us implementation and ongoing licenses for CBOs and the provider network in 2018-2019. The licenses brought 31 CBOs onto the network. IHN-CCO is supporting the provider network with licenses continuing into 2020-2021. As of 2020, Unite Us provides CBOs and other agencies such as Federally Qualified Health Centers (FQHCs) with free licenses. IHN-CCO continues to evaluate the need for further Electronic Health Record (EHR) integration and support for CBOs and the provider network through internal processes and a community-facing Connect Oregon Workgroup with healthcare system and community chairpersons.

   IHN-CCO has received community input through collaboration efforts in relation to Unite Us and Collective Plan that are working to integrated into our roadmap and for future systems prioritization. This feedback resulted in the following key points:

   - Unite Us connects to Epic, but that connection is really only a link to an EPIC sign-on page.

- Unite Us has added a way to pay providers for use, but IHN-CCO needs to explore these payment mechanisms
- IHN-CCO would like to ensure a standardized way to screen, perhaps via a common intake form, across Unite Us and Collective Plan

IHN-CCO is continuing to engage additional CBOs and Providers with Unite Us. There is now an additional incentive for the CBOs to use Unite Us which is related to United Way grants to provide CBOs using the tool with funding. At this point in time there are not enough CBOs using Unite Us for the value of the tool to be realized. IHN-CCO is inventorying CBOs to see which are and which are not currently using Unite Us and plans to use this information to target CBOs for education and adoption.

7. What are the Collective Platform concerns raised by some ACT programs?
   What IHN-CCO has seen is that there is a clear preference to use Epic instead of EDIE or Collective Medical. IHN-CCO believes that there is a lot of value in Collective Medical and that there needs to be more education and encouragement to increase the use of Collective Medical to enable "warm handoffs" for transition of care.

   To accomplish the education and encouragement aspect IHN-CCO plans to develop use cases to share with the various providers so that the concepts are more appropriately communicated and have a level of practicality that the providers can see.

ii. Additional Progress Specific to Physical Health Providers

See the *Progress Across Provider Types* section.

iii. Additional Progress Specific to Oral Health Providers

The **Clinical CareAdvance** application has integrated oral health questions for screening.

PreManage - All Dental Care Organization's (DCO's) utilize PreManage data for care coordination and case management efforts.

iv. Additional Progress Specific to Behavioral Health Providers

See the *Progress Across Provider Types* section.

v. Please describe any barriers that inhibited your progress.

IHN-CCO's progress was slowed due to COVID which impacted IHN-CCO employees and IHN-CCO's provider network.

In addition, Collective Plan is not widely used across the IHN-CCO provider network for sharing care plans which limited the effectiveness of the tool. Community Mental Health Authorities are using it for Assertive Care Treatment (ACT) but not for all programs due to reliability concerns.

b. 2021 - 2024 Plans

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

1. The number of physical, oral, and behavioral health organizations that have not currently adopted an HIE for Care Coordination tool using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations have not adopted an HIE for Care Coordination tool). CCOs are expected to use this information to inform their strategies
2. Any additional HIE tools you plan to support or make available.

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

Notes:

- Strategies and HIE tools described in the *2020 Progress* section that remain in your plans for 2021 – 2024 **do not need to be included** in this section unless there is new information around how you are implementing/supporting the strategy and/or HIE tool.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

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

As of August 2021, IHN-CCO can report the following numbers of Providers that have not yet adopted an HIE tool for Care Coordination:

- Physical: 74
- Behavioral: 88
- Oral: 2

- Focus on Epic and Healthy Planet
- Longitudinal Plan of Care is being considered for the future but not currently planned

Response does not include details on additional HIE tools you plan to support or make available, or any additional strategies you will use to support HIE for care coordination. Please provide additional details on any tools or strategies you plan to support (e.g., please elaborate on "Epic and Healthy Planet", and "Longitudinal Plan of Care").

Clinical Care Advance

During the implementation of CCA there were compromises made which resulted in the delay of implementing certain pieces of functionality in exchange for meeting the project timeline requirements. IHN-CCO plans to revisit these deferred items, upgrade CCA to the latest version, implement disease management capabilities, and continue to build data integrations between Arcadia and CCA.

Activities	Milestones and/or Contract Year
Increase use of available functionality in CCA	2021 – 2022
Complete upgrade of CCA, granting access to new functionality	2022
Implement Disease Management capabililties in CCA	2022
Continue to build data integrations between Arcadia and CCA	2022 - 2023

Epic Care Everywhere/Healthy Planet: IHN-CCO also supports integration of the Epic EHR, which is used in many of our Community Health Centers, Federally Qualified Health Centers, Community Mental Health Programs, and Samaritan Health Services (SHS). SHS is the largest provider system in the region and accounts for most of our ED and IP services. Through Epic, SHS hospitals send a transition of care (TOC) and clinical care document (CCD) when a patient is discharged. These documents are sent to primary care providers within four hours of discharge. Epic has additional tools that support care coordination. Epic Care Everywhere allows providers on the system to securely share patient records with other health care providers. Epic Healthy Planet is a software module that, through its suite of reports, dashboards, and workflow tools, compiles that patient data, which allows healthcare organizations' care managers to manage patient populations. IHN-CCO has decided not to pursue the use of Healthy Planet at this time but may revisit it in the future.

IHN-CCO sees value in implementing a Longitudinal Plan of Care program but for the time being is remaining focused on improving the use of Arcadia and CareAdvance as a first strategy due to the expected value that will be provided to IHN-CCO Members.

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

See the *Strategies Across Provider Types* section.

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

See the *Strategies Across Provider Types* section.

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

See the *Strategies Across Provider Types* section.

Optional Question

How can OHA support your efforts in HIE for Care Coordination?

4. Support for HIE – Hospital Event Notifications

a. 2020 Progress

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

Notes:

- If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.
- If you participated in the 2020 HIT Commons interviews regarding the use of the Collective Platform, feel free to use that information in this section

i. Progress Across Provider Types

IHN-CCO's response applies to all provider types. IHN-CCO worked with Samaritan Health Services to upgrade the EDIE environment and more work is needed to automatically integrate the alerts and notifications into Epic. Our Clinical Technology Advisory Committee is meeting later in March 2021 to discuss the possibility of working with the CMT team with their chosen product or to configure our Epic system to set up event notifications in order to meet the May timeline requirement.

ii. Additional Progress Specific to Physical Health Providers

The majority of providers serving the IHN-CCO member population use Epic and receive hospital event notifications directly through their EHR. IHN-CCO has implemented Collective Platform as a solution for emergency department and inpatient utilization, as well as leveraging this system for alerts and notifications. Care management plans are coordinated between the patient's care providers and uploaded into Collective Platform. IHN-CCO receives the emergency department, inpatient and care management information back to merge into the longitudinal patient view.

iii. Additional Progress Specific to Oral Health Providers

IHN-CCO and our dental plan partners have implemented Collective Platform to ensure timely hospital event notifications based on the member's primary dental care assignment. These timely event notifications allow for care coordination of members who present in the ED with Non-Traumatic Dental Conditions.

iv. Additional Progress Specific to Behavioral Health Providers

IHN-CCO implemented Collective Platform to ensure behavioral health providers have access to timely hospital event notifications. We are currently working with the behavioral health providers to create implementation strategies for timely hospital event notifications based on the member's assigned county behavioral health organization. Community mental health programs use Collective Platform to manage member cohorts for the ACT program. Additionally, IHN-CCO is collaborating with Linn, Benton and Lincoln county behavioral health providers to establish care plans in Collective Platform for SPMII, special needs and other high-risk members.

v. Please describe any barriers that inhibited your progress.

Response to September wildfires and the Covid-19 pandemic has slowed progress toward Collective Platform implementation strategies. There were several initiatives that stalled, including efforts to provide technical assistance to small practices to assist them in submitting eligibility files to Collective Medical and integrating hospital event notification through Epic. Our county health clinics and mental health programs have Collective Platform integrated through Epic, but others do not. In addition, IHN-CCO was looking to work with OHA to finalize the HIT Data File to ensure our understanding of the provider network was synchronized.

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

a) IHN-CCO has various methods for receiving hospital event notifications. IHN-CCO requires notification of all emergent admissions and observation stays to ensure that the member's care is appropriately coordinated. However Collective Platform is the preferred tool for timely hospital event notification. The Collective Medical platform has real-time notification of hospital admissions as well as monitoring reports for members with frequent ED visits. IHN-CCO care managers use several cohort reports to identify trigger events, i.e., ED visits and hospitalizations within the high-risk cohort. IHN-CCO receives Epic admissions, discharge, transfer (ADT) files directly from SHS where most members are seen.

b) IHN-CCO deployed the following strategies in 2020 but faced numerous barriers in implementation.
   1. **Survey providers to understand current use of Collective Platform** for Timely Hospital Event Notifications. The survey was sent to 175 provider groups and 63 responded. Of the 63 responses, 7 provider groups indicated they were using hospital event notification and 56 were not. However, 41 providers expressed interest in receiving more education and 17 requested assistance. Complete
   2. **Document current use** of SHS ED and inpatient notifications sent via EPIC. Incomplete
   3. Create, evaluate and prioritize **use cases.** Incomplete
   4. **Upgrade EDIE** in Samaritan Hospitals and ED. Complete
   5. Through collaboration **improve workflows and establish training materials**. The Behavioral Health Quality Committee held several workflow mapping sessions, but more work is needed to finalize and develop training. Incomplete
   6. Inventory and prioritize all **collaborative forums** that include both internal and external participants for implementation. Partial work has been done with several collaborative forums and the most progress has been made with interdisciplinary care teams. Incomplete
   7. **Implement Collective Platform** across all providers not currently getting timely event notifications. Incomplete

8. Establish census or **performance reports** from Collective Platform and RHIC data for all Inpatient and ED metrics. Census and performance reports have been established however, more development is needed to support metrics, and RHIC was sunset. Incomplete
9. Training and workflow **optimization materials** provided to all collaborative forums identified in the catalog annually. Incomplete
10. Monitor provider utilization and **follow-up with ongoing training** and communication for providers with barriers to prevent full utilization of Hospital Event Notifications. Technical assistance efforts were suspended due to Covid-19. Incomplete

c) Accomplishments:
- 19 cohorts, 3 daily reports, 4 weekly and 5 general reports in use for care coordination.
- Advances in oral health ED intervention with Collective Platform event notifications.
- Provider HIT survey completed and identified needs for future planning.
- 3 Virtual ED workflow mapping sessions were held.
- EDIE was upgraded for SHS.

b. 2021 – 2024 Plans

1. Please describe your plans for ensuring increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers. In your response, please include
   a. The number of physical, oral, and behavioral health organizations that do not currently have access to HIE for hospital event notification using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g. Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations do not have access to HIE for hospital event notifications). CCOs are expected to use this information to inform their plans.
   b. Any additional HIE tools you are planning to make available to your providers for Hospital Event Notifications
   c. Additional strategies you will use to support increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers beyond 2020.
   d. Associated activities and milestones related to each strategy.

Notes:
- Strategies and HIE tools described in the *2020 Progress* section that remain in your plans for 2021 – 2024 **do not need to be included** in this section unless there is new information around how you are implementing/supporting the strategy and/or HIE tool.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

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

Using the OHA-provided Data Completeness Table, 87 physical health, 3 oral health, and 105 behavioral health organizations do not have access to HIE for hospital event notifications.

IHN-CCO is not implementing any strategies or HIE tools not already described in its existing plans.

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

See the *Strategies Across Provider Types* section.

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

See the *Strategies Across Provider Types* section.

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

See the *Strategies Across Provider Types* section.

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

IHN-CCO is not implementing any strategies or HIE tools not already described in its existing plans.

Optional Question

How can OHA support your efforts in HIE related to hospital event notifications?

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

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

i. Overall Strategy in Supporting SDOH & HE with HIT

IHN-CCO was the first adopter of Unite Us in Oregon and is now a part of the Connect Oregon network with many providers, community-based organizations, social service agencies, and more. Unite Us is the cloud-based social determinants of health referral platform that tracks outcomes and identifies services gaps. In the IHN-CCO region, Unite Us/Connect Oregon is a community driven, participation required, and locally sustained tool for social determinants of health screening and referrals.

IHN-CCO is committed to increasing community-based organization recruitment through the Universal Care Coordination Workgroup of the Delivery System Transformation Committee. This Workgroup will be the community driver of Connect Oregon with the following strategic goals:

- Identify and overcome barriers to implementation
- Identify areas of opportunity to increase usage and better support community health
- Support integration with other systems

IHN-CCO also supports integration with the larger health system (SHS) as well as other medical providers. Unite Us is working on OCHIN integration (county health departments utilize this EHR). Epic (SHS's EHR system is already integrated.

IHN-CCO also supports Unite Us adoption and implementation with Dental Care Organizations (DCOs). Two DCOs have utilized Unite Us for social determinant of health closed loop referrals in rural Lincoln and Linn counties.

IHN-CCO also supports SHS, the largest provider system in the region, in its efforts to increase utilization of Healthy Planet. Healthy Planet is an Epic software module that, through its suite of reports, dashboards, and workflow tools, compiles that patient data, which allows healthcare organizations' care managers to manage patient populations.

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

Unite Us – Connect Oregon
Healthy Planet Integration with Epic
Claims data (z-codes)

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

IHN-CCO is anticipating the Arcadia platform will be a database source for social determinants of health data. Inputs include EHR records, claims data, and Unite Us/Connect Oregon data. This is a large part of the strategy for analyzing REALD data (Race, Ethnicity, Language, Disability) as well as social service information such as housing, food security, and transportation needs.

IHN-CCO also collects and integrates data from the Transformation pilots. These pilots often reach members that historically are not reached. Data from the pilots will be included in the Arcadia platform.

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

Recruitment of healthcare providers is the biggest challenge for Unite Us/Connect Oregon.

Widespread use of Z-codes to help us identify SDoH needs through claims is limited.

Optional Question

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

Encouraging/incentivizing providers to use SDOH Z-Codes would be helpful.

REALD data is of high importance to IHN-CCO; however, OHA currently collects this data at enrollment. Rather than depending on providers or the CCOs to create yet another touchpoint with members, OHA could streamline and support the process at enrollment to encourage appropriate collection of REALD data with members.

6. Health IT for VBP and Population Health Management

a. HIT Tools and Workforce

Describe your HIT capabilities for the purposes of supporting value-based payment (VBP) and population management. In your response, include information about the following items:

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

i. HIT Tools for VBP and Population Management

IHN-CCO utilizes multiple data sources to support our VBP programs. IHN-CCO has robust claims reporting through SQL queries, crystal reporting, and the HPXR/Empower data warehouse. We also use supplemental data, stored in our data warehouse, from the Provider to evaluate performance and compare to reimbursement expectations. IHN-CCO is going live with Arcadia as the primary VBP platform in 2021. This tool will enable near real time reporting on quality and cost performance, utilization trends, and other performance measures.

Currently VBP Scorecards and financial reports are generated monthly and quarterly. Monthly scorecards are focused on Quality measure tracking to achieve performance goals and achievement of the Quality Pool. Capitated providers receive Financial reporting that tracks assumed costs and encounters. This allows IHN-CCO to compare expected service levels to what has been reimbursed. IHN meets regularly with the providers to review the mentioned reports. These meetings are productive in driving towards expected performance level.

ii. Workforce for VBP and Population Management Analytics

To support the VBP program IHN-CCO cross coordinates across several functions:

- Finance – The VBP Analyst, Finance Dept, and Finance Director are responsible for VBP scorecard and report publishing. The department develops the reports based on contracts, financial goals, and aligned incentives. Finance also develops VBP payment models, strategy, and provides analysis of VBP objectives.
- Network Strategy – The VBP Coordinator, Provider Relations Team, and Director of Network Strategy distribute and coordinate VBP scorecards and contracts. The team matches the best VBP model for the Providers services, cost profile, and operational capabilities. This team is key in education and evaluation of VBPs.
- Quality – The Quality Analysts and Director of Population Health are key in identifying and developing the quality metrics used in VBP contracts. The department looks at the health priorities of IHN and establishes metrics and targets that will improve Health Outcomes of our IHN members.
- Information Technology – The IT supports the above departments with the data warehouses, data feeds, and reporting solutions required to maintain VBP processes.

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

Describe your plans for using HIT to administer VBP arrangements (for example, to calculate metrics and make payments consistent with its VBP models). In your response, please include

1. Strategies for using HIT to administer VBP arrangements, including how you will ensure you have the necessary HIT as you scale your VBP arrangements rapidly over the course of the Contract and spread VBP to different care settings each strategy. Additionally, include plans for enhancing or changing HIT if enhancements or changes are needed to administer VBP arrangements for the remainder of the Contract.
2. Specific activities and milestones related to using HIT to administer VBP arrangements

Additionally, describe

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

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

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

IHN-CCO's goal is to centralize and simplify VBP arrangements to maximize our HIT capabilities. This means reducing the number of custom metrics to reduce development workloads. With Arcadia we will utilize their set of OHA, NCQA, and HEDIS measures wherever possible. We will also limit the number of metrics in scorecards so that Providers can focus on the key drivers of performance. In 2020 we reduced the number of measures per scorecard and the number of custom measures to ease HIT workloads.

Payment models will also be standardized based on service type and size. Only Providers over a certain attribution size would be allowed to deviate from a standard VBP contract. This will simplify configuration and HIT requirements for each VBP contract administered. It will also ease education of the VBP payment structures. In 2020 we shifted from SHS's capitation model, which was costly to administer, to a rate of growth target model. This continued into 2021 with simplified County, PCPCH, and THW models.

Long term IHN-CCO will develop standardized PCP VBP models that incorporate Risk Scores, SDOH, and Rate of Growth targets. This work will require Arcadia risk modeling to achieve. Episode payments are also on the horizon, pending contracting HIT solutions. Beyond that VBPs models will require HIT that allows us to disconnect the underlying VBP payment structure from FFS to either a Value/Outcome payment structure and/or market-based pricing.

IHN-CCO is also moving away from "custom" metrics to more standardized metrics via Arcadia.

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

IHN-CCO made great strides in 2020 by implementing Arcadia data feeds and development. We also developed or expanded VBP scorecard tracking and performance monitoring. Utilizing data, we were able to shift major contracts (SHS and Benton County) to new VBP models in 2021 that will simplify payments while aligning long term financial and quality goals. IHN-CCO rolled out PCPCH tier-based payment capability in 2020 and expanded it in 2021.

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

Getting to a higher level of HIT coordination with our Providers has been a challenge. In some cases that means getting quality data from providers at lower HIT sophistication levels, or complex data from higher level HIT partners. Then IHN-CCO is challenged with reporting back the data in a meaningful way that Providers can ingest and develop actions around.

Past VBPs have been very customized around the Provider's HIT capabilities. Going forward we will have standard data requirements under Arcadia so that we can quickly onboard Providers to a VBP model and report back to them in a consistent well-established method.

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

Please describe your plans for using HIT to support Providers in the following areas (i. – iv.) so they can effectively participate in VBP arrangements. In your response, please include

1. Strategies for using HIT to support Providers so they can effectively participate in VBP arrangements
2. Activities and milestones related to using HIT to support Providers so they can effectively participate in VBP arrangements
3. If used, specific HIT tools used to deliver information

Additionally, please describe

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

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

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

IHN-CCO provided 100% of Providers on a VBP contract either monthly or quarterly scorecards on metric performance. In addition, capitated providers receive financial reports detailing payment history and encounter data.

In 2020 these performance measures were created manually and delivered via SFTP. The strategy 2021 going forward is to automatically deliver robust reporting via Arcadia and provide on-demand performance via Arcadia's web user interface.

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

VBP Providers receive a monthly attribution and gap list of the members being counted towards their Quality measures. This information is accurate at the Clinic level but may vary at the PCP level due to reassignments within the Provider's office.

Future strategies are in development with Arcadia to ingest PCP attribution from the Provider's EHR and/or reassign based on claims-based algorithms (i.e. most frequent PCP utilized).

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

IHN-CCO regularly assesses its population integrating multiple types and sources of data. Medical, pharmacy, behavioral, and oral health claims data are integrated and combined with available member characteristics such as ethnicity, language, race, and disabilities, and social and economic factors such as food insecurity, housing instability and lack of transportation that can impact a member's overall health. Criteria are used to monitor, screen, and risk stratify the population and to identify and segment individual members into cohorts with similar care needs. IHN-CCO identifies members with special health care needs and screens for care coordination needs and Intensive Care Coordination services. The first level of stratification uses claims and demographic data and the second level of risk stratification is based on the health risk and clinical assessment, and other screenings completed with the member.

The risk level segments members with similar complexity and care needs into four levels:

- Low risk (I) – stable medical conditions, able to obtain medical services and access providers without barriers;
- Rising risk (II) – stable medical conditions that require monitoring to ensure medical services are obtained and any barriers addressed;
- High risk (III) – unstabilized condition(s) or recently diagnosed new condition i.e., chronic kidney disease, coronary artery disease, chronic obstructive pulmonary disease, depression, diabetes and issues obtaining medications or adhering to treatments, or barriers accessing providers; and
- Complex (IV) – new health catastrophic event or condition or diagnosis with significant resource needs i.e., motor vehicle accident, traumatic brain injury, spinal cord injury, amputations, difficulty adjusting to new serious diagnosis and not well connected with PCP or specialist, i.e., Lupus, HIV, Multiple Sclerosis, active cancer with chemotherapy and complications, unplanned hospital admission, difficulty performing activities of daily living.

The process of risk stratification is ongoing throughout the member's eligibility. Risk levels may be adjusted based on a change in the member's status identified through clinical review, event notification, screening, and/or referrals.

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

Results of screenings, assessments and risk level are shared with the member's PCP and used to develop the shared plan of care. Member care gap lists are provided monthly.

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

Total number of clinics/groups with VBP arrangement at start of the year: ____19________
Total number and proportion of those clinics/groups with access to:

a) Performance metrics (at least quarterly): ___19_____
b) Patient attribution data: ___19_____
c) Actionable member-level data: ___19___

If not all providers with VBP had access to this information, please describe why not: N/A

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

- IHN-CCO has implemented Arcadia Analytics platform and is testing the output of new risk stratification models that provide deeper insights into the member population.
- Despite initial project delays due to the Covid-19 pandemic, IHN-CCO was able to engage providers in focused project work on three initiatives. The initiatives are focused on identifying and reducing potentially avoidable costs while at the same time, improving member experience and health outcomes. Subsequent data analysis identified three conditions with opportunity – diabetes with co-occurring substance use disorder and/or mental illness, high risk pregnancy, and hypertension.
- Due to Covid-19, 2020 was only a Reporting year. In April, a finial reconciliation will be conducted and we will be able to see how the provider groups preformed for 2020.

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

- Covid-19 response presented challenges for the provider network and IHN-CCO staff;
- Our current processes are manual and some of the VBP Provider Groups do not have EHR systems.
- Consistent data for analysis; and
- Competing priorities.

Optional Questions

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

The Provider VBP Coordinator works one on one with the Provider Groups to ensure they have an understanding of the tools and resources available to them. The Providers are also supplied with a metric Quick Reference Guide. Any on-going questions are answered via email or at the regular quarterly meetings.

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

OHA can make sure that we have adequate funds to ensure all provider groups (including non-PCP) have EHR systems implemented in their clinics.

OHA could provide the metrics specification earlier in the year for the following year in order to prepare VBP models. We have difficulty preparing contracts and updating our metrics reporting at the last minute once the specs are finalized in December.

7. Other HIT Questions (Optional)

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

a. How can OHA support your efforts in accomplishing your HIT Roadmap goals?
OHA can continue to support these efforts by allowing for flexibility in how these goals evolve over time and, as described in more detail below, taking into consideration the environment in which we are operating. HIT is an area of rapid change. Emerging capabilities, solutions and a rapidly changing regulatory environment benefits from OHA continued willingness to be a collaborative partner in these efforts. With respect to those efforts requiring provider partner adoption or utilization, to avoid placing a CCO in the position of having to mandate actions in response to contractual or regulatory directives. This type of environment only create friction between CCOs and their provider partners.
b. How have your organization's HIT strategies changed or otherwise been impacted by COVID-19? What can OHA do to better support you?
IHN-CCO's progress was slowed due to COVID which impacted IHN-CCO employees and IHN-CCO's provider network. In addition, IHN-CCO was looking to work with OHA to finalize the HIT Data File to ensure our provider network understanding was synchronized.