Jackson Care Connect CCO 2023 HIT Roadmap Update

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

CCO: Jackson Care Connect

Date: 3/15/2023

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) (Amit Shah)
d.	☒Yes ☐No	Participated in an OHA HITAG meeting, at least once during the previous Contract year. (Nate Corley)

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

Report Overview
This report is intended to be an update to the information provided last year in the 2022 HIT Roadmap. As such, we have not repeated all information previously reported, although some is included for reference. Unless specifically indicated, all strategies that have been previously described and are fully implemented have been maintained. The information included below is primarily focused on strategies that are new, have evolved, or have not made as much progress as anticipated. This overview is included at the beginning of each section within this report in the event that each section is reviewed independently. Last, Point Click Care and Collective Medical are used interchangeably in this report given the recent acquisition.

We encourage reviewers to draw on all sources of information provided to the OHA to fully understand the breadth of how HIT supports and is incorporated within JCC's operational, quality improvement and clinical strategy activities. In particular, there are several examples of data reports and tools included in the 2023 Transformation and Quality Strategy that illustrate our use of data exchange, disaggregation, and analysis in support of member outcomes and our provider network.

Progress across provider types
As reported last year, JCC's key strategies were to refine our 5-year HIT plan and evolve the governance structure to better align activities and network needs. We also aimed to continue supporting adoption and optimization through technical assistance as well as encourage EHR use to further telemedicine. Activities slated for completion in Q4 2022 have been delayed slightly as described below. However, we successfully evolved our governance structure and additional assessment of EHR use. A brief progress narrative follows.

The CareOregon Quality and Health Outcomes Steering Committee (COQHO) guides the enterprise-wide quality and health outcomes structure and population health framework that determines cross-departmental, cross regional and benefit-related clinical quality improvement strategies and initiatives, including those employed by JCC. The group is responsible for overseeing the Five-Year HIT Roadmap, including EHR adoption, barriers, and incentives. In 2022, CO engaged a consulting firm to conduct an assessment to identify opportunities, gaps, and best practices for using health IT solutions to support the organization's clinical quality goals and improve overall data availability. The intention of the assessment was to guide CO in strategy refinement and provide recommendation for where to focus limited resources. This was an important step in ensuring the most efficient and focused use of internal resources, even though it delayed some discrete activities by approximately six months. Even with this delay, our overarching plan for provider support has not changed.

Activities across provider types include:

- Collaboration with network partners
    - Nearly all of the activities in this report are conducted in collaboration with network partners as described
- Assessment/tracking of EHR adoption and capabilities
    - Understanding the specific adoption barriers experienced by our providers
    - Identifying priority providers for increasing EHR adoption
    - Performing a detailed gap assessment for our prioritized providers
- EHR training and/or technical assistance; Outreach and education about the value of EHR adoption/use
    - Continuing to identify opportunities through our Innovation Specialist team to help clinic partners modify their operations and optimize use of EHRs to support telehealth visits
- Incentives to adopt and/or use EHR
    - Working within our HIT governance model to define the support and incentives that can be offered

Progress on each of these categories is provided in the sections below.

Understanding the specific adoption barriers experienced by our providers; identifying priority providers for increasing EHR adoption; and performing a detailed gap assessment for our prioritized providers.

In 2022, we analyzed the OHA EHR/HIT survey results and found the biggest areas of opportunity for additional information gathering within the specialty physical and behavioral health networks. We are planning to gather additional information from our specialty networks in 2023, as previously reported/planned.

Working within our HIT governance model to define the support and incentives that can be offered.

JCC employs a variety of financial incentives that encourage improved EHR use to support clinic and system transformation goals. These include:

- Quality Pool Distribution: JCC partners with our clinical providers in achieving the OHA CCO Incentive Metrics. Many of these metrics require documentation and reporting of clinical information. Increased quality pool payout is reserved for organizations that are able to pull and submit data from their EHR.
- Clinic designation: JCC has developed 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 requires increased levels of EHR functionality.
- Value-based payment: JCC 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. EHRs are important tools for promoting workflows and providing information necessary to achieve the desired financial and clinical results encouraged by our VBP arrangements. Clinics utilize EHRs to provide

reporting on many key quality elements of our VBP arrangements.

ii. Additional progress specific to physical health providers

Continuing to identify opportunities through our Innovation Specialist team to help clinic partners modify their operations and optimize use of EHRs to support telehealth visits

The innovation team provides coaching and technical assistance as it relates to increased access to HIT 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.

In 2022, JCC continued to encourage improved use of EHRs among our physical health providers through our technical assistance supports. Through our team of Innovation Specialists, JCC provides technical assistance / practice coaching to our provider network partners to support various clinic and system transformation goals. This includes identifying opportunities to use their EHRs more meaningfully to improve workflows, support CCO Quality Metric documentation, and support Value Based Payment performance.

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

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

Much of the EHR work in 2022 was specifically centered around supporting clinics in OCHIN reporting. Clinics were provided templates and individual technical assistance to support increased understanding on preferred workflows for documentation and tracking. Providence Medical Group received TA on their SBIRT reporting, receiving TA around proper documentation and dot phrase tracking so that they could properly report on the metric.

iii. Additional progress specific to oral health providers

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

JCC partnered with its dental plans and surveyed its entire network of dental providers at the end of 2022. Of the 17 organizations in Jackson County (representing 27 individual dental clinics) surveyed, we found:

- 26 (96%) are using an EHR
- 1 (4%) are using paper charts

The provider on paper charts is a small practice. Given that most of our members' Primary Dental Providers are using electronic health records, our focus will be on optimizing its use through workflow and process improvement technical assistance. We will align this work with our transformation priorities and in areas that provide value to our provider partners without creating unnecessary additional burdens or contributing to clinician burnout.

Currently, the most commonly used EHRs by our dental providers are Dentrix, EagleSoft and EPIC Wisdom.

iv. Additional progress specific to behavioral health providers

Identifying priority providers for increasing EHR adoption

JCC's primary behavioral health partners are utilizing or in the process of implementing certified EHRs. Kairos and ColumbiaCare are on CareLogic. Both Jackson County Mental Health (Next Step) and Options for Southern Oregon (Credible) implemented new EHRs in the past year. Our substance abuse providers, ARC and OnTrack, are on Dr. Cloud. JCC provided financial support to help resource the successful implementation of these EHRs. Approximately 75% of our outpatient behavioral health services are provided by these partners. JCC also has contracts with several small behavioral health specialists who are largely not on certified EHRs, and we will assess their interest in adoption of EHR as part of the environmental scan planned for 2023.

v. Please describe any barriers that inhibited your progress

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

Using the OHA-provided Data Completeness Table, 189 physical health, 2 oral health, and 36 behavioral health organizations lack EHR information.

As mentioned above, CO engaged a consulting firm to conduct an assessment to identify opportunities, gaps, and best practices for using health IT solutions to support the organization's clinical quality goals and improve overall data availability. In 2023, we will work to implement key recommendations as well as continue work that was previously underway. The tables below provide an overview of 2023 milestones for new activities, including the following strategies:

- Collaboration with network partners
  - Epic Payor Platform implementation: We recently began implementation of bi-directional data exchange with Epic EHR users in network by leveraging technology specifically developed for payor-provider partnerships.
- Assessment/tracking of EHR adoption and capabilities
  - Gathering missing EHR information
  - Re-survey oral health network (oral health)
- EHR training and/or technical assistance; Outreach and education about the value of EHR adoption/use
  - Continuing to identify opportunities through our Innovation Specialist team to help clinic partners modify their operations and optimize use of EHRs to support telehealth visits
- Incentives to adopt and/or use EHR
  - Support of EPIC upgrade/implementation

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 networks	Q4 2023
Continue support of EPIC upgrade/implementation	Continuous in 2023

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

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?

The only thing we believe will push those clinics still using paper charts or non-certified EHRs would be for OHA to require EHR adoption of certified EHRs for all clinical practices and to include incentives for smaller organizations to do so.

We also believe we should collectively move away from focusing on adoption, to focusing on optimization of EHR utilization.

3. **Support for HIE – Care Coordination** (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 ☒ Assessment/tracking of HIE adoption and capabilities ☒ Outreach and education about value of HIE	☒ Financially supporting HIE tools, offering incentives to adopt or use HIE, and/or covering costs of HIE onboarding

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

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

Report Overview

This report is intended to be an update to the information provided last year in the 2022 HIT Roadmap. As such, we have not repeated all information previously reported, although some is included for reference. Unless specifically indicated, all strategies that have been previously described and are fully implemented have been maintained. The information included below is primarily focused on strategies that are new, have evolved, or have not made as much progress as anticipated. This overview is included at the beginning of each section within this report in the event that each section is reviewed independently. Last, Point Click Care and Collective Medical are used interchangeably in this report given the recent acquisition.

We encourage reviewers to draw on all sources of information provided to the OHA to fully understand the breadth of how HIT supports and is incorporated within JCC's operational, quality improvement and clinical strategy activities. In particular, there are several examples of data reports and tools included in the 2023 Transformation and Quality Strategy that illustrate our use of data exchange, disaggregation, and analysis in support of member outcomes and our provider network.

Progress across provider types

As reported last year, JCC's key strategies included refining our 5-year HIT plan and evolving the governance structure to better align activities and network needs. We also aimed to continue supporting:

- Existing technology solutions for timely information exchange for both members and providers;
- Health IT to expand access and quality in rural areas;
- Interoperability; and
- Engagement with state-sponsored entities.

Some 2022 activities have been modified or delayed slightly as described below. However, we successfully evolved our governance structure as well as continued to optimize current and expand to new technologies. A brief progress narrative follows.

The CareOregon Quality and Health Outcomes Steering Committee (COQHO) guides the enterprise-wide quality and health outcomes structure and population health framework that determines cross-departmental, cross regional and benefit-related clinical quality improvement strategies and initiatives. The group is responsible for overseeing the Five-Year HIT Roadmap, including health information exchange. In 2022, CO engaged a consulting firm to conduct an assessment to identify opportunities, gaps, and best practices for using health IT solutions to support the organization's clinical quality goals and improve overall data availability. The intention of the assessment was to guide CO in strategy refinement and provide recommendation for where to focus limited resources. This was an important step in ensuring the most efficient and focused use of internal resources, even though it delayed some discrete activities by approximately six months. Even with this delay, our overarching plan for HIE in care coordination has not changed.

The workplan includes:

- Collaboration with network partners
  - Nearly all of the activities in this report are conducted in collaboration with network partners as described
- Integration of disparate information and/or tools with HIE
  - Increasing bi-directional data exchange:
    - Epic Payor Platform implementation
- Outreach and education about value of HIE; Assessment/tracking of HIE adoption and capabilities; HIE training and/or technical assistance
  - Optimizing use of current platforms and expanding technology solutions:
    - UniteUs
    - Collective Medical now known as Point Click Care
    - FIDO (CareOregon's Fully Integrated Data Organizer platform)
    - Member mobile app
    - Reliance HIE
  - Continuing support for virtual consultation
    - Project ECHO: provides telementoring where expert teams lead virtual clinics
    - RubiconMD: e-consult platform that connects primary care providers to national network of board-certified specialists that provide guidance on diagnosis workups and treatment advice options. The platform can be integrated with EHRs and clinical workflows.

A brief progress update on these activities is provided below. Updates specific to behavioral health or dental are included in their respective sections.

Optimizing use of current platforms

- Unite Us/Connect Oregon

  Southern Oregon Pediatrics and Oasis started receiving (and continue to receive) support around the Unite Us integration into their EHR. We began exploring this process with them in 2022 and the work continues into 2023. Part of the technical assistance included connecting the health centers to Asante for further support. Platform integration into EHRs is paramount for health centers as it streamlines workflows and decreases barriers to use of new technology. Jackson Care Connect in conjunction with Unite Us also provided technical assistance to both Asante and Providence hospitals. Funds have also been identified and earmarked to assist both hospitals when they are through their testing process, expected in 2023 to go live on the platform.

  During the April Quality Improvement Workgroup, meaningful language access was discussed and Unite Us was featured as a tool that can support the some of the work as it relates to increasing language services in clinics. Unite Us was highlighted as a technology platform to connect clinics to community partners, enhance referrals, and decrease language barriers for patients.

- FIDO

  The innovation team regularly provides technical assistance around the FIDO dashboard. Every clinic system gets TA that ranges from general awareness (e.g., how to log-in, changing providers, etc.) to deeper dives into the various dashboards around equity and claims lags. The dashboard is highlighted as a tool at each Quality Improvement Workgroup as well as at clinic leadership meetings. During Q3 and Q4 clinics will get additional support around FIDO as it relates to gap lists, how to read their reports, and assuring everyone on their team has access. JCC also incorporated dental data, diabetes oral evaluation, to Primary Care Provider (PCP) dashboards in Q4 2022.

- Reliance HIE

  Reliance facilitates the exchange of information among providers through its:

  1) community health record,
  2) provider-to-provider referrals, and
  3) provider-to-provider secure messaging.

  Reliance gives timely clinical information from participating provider EHRs to support our patient outreach and clinic quality improvement efforts. As an example, the information we receive on new pregnancies among our member population allows us to identify members early in their pregnancies to ensure they are engaging in prenatal care. Similarly, we get information about members with hepatitis C, which allows us to reach out to members directly or inform their primary care clinic to ensure eligible members receive treatment. JCC is also able to obtain A1C lab results and classification of types of diabetes for our OHA metric reporting. This also helps guide development of new programs and helps us discover areas in which diabetes care can be improved.

Continuing support for virtual consultation

- ECHO

  JCC currently supports and has funded providers to participate in Project ECHO which provides telementoring where expert teams lead virtual clinics. This is a peer-based learning platform that has shown significant effectiveness in upskill providers on complex medical and behavioral health topics. In 2022, JCC co-sponsored Child and Adult Psychiatry ECHOs with spots reserved for JCC participants. The innovation team provided targeted outreach to the network to encourage participation of providers.

- Rubicon MD

  To expand our provider capabilities for specialty referral and consultation, JCC has negotiated licenses for providers to access this service without charge. We hope this allows every patient to get care they deserve regardless of affiliation with JCC. 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. The Primary Care Innovation Specialist provides routine onboarding support to La Clinica and Rogue Community health.

ii. Additional progress specific to physical health providers

Optimizing use of current platforms

- Point Click Care (formerly Collective):

  JCC continues to use the application to build cohorts and get daily reporting to refer members into the appropriate care team. We also use the platform to prioritize outreach efforts. In addition, we added Observations to our ADT feed between Point Click Care and our Care Management Tool, GSI. This broadens the transparency of a member's status when presenting at the ED and allow us to appropriately prioritize outreach in GSI.

iii. Additional progress specific to oral health providers

iv. Additional progress specific to behavioral health providers

Continuing support for virtual consultation

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 as way for telehealth only providers to better coordinate care for individuals who are too complex for their services.

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

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

Using the OHA-provided Data Completeness Table, 40 physical health, 15 oral health, and 59 behavioral health organizations have not adopted an HIE for Care Coordination tool.

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

The workplan includes:

- Collaboration with network partners
    - Nearly all of the activities in this report are conducted in collaboration with network partners as described
- Integration of disparate information and/or tools with HIE
    - Increasing bi-directional data exchange
        - Epic Payor Platform implementation
            - We recently began implementation of bi-directional data exchange with Epic EHR users in network by leveraging technology specifically developed for payor-provider partnerships.
- Outreach and education about value of HIE; Assessment/tracking of HIE adoption and capabilities; HIE training and/or technical assistance
    - Optimizing use of current platforms
        - Unite Us
            - Future years' strategies pivot from a primary focus on network partner onboarding to optimization of network health. This will involve work designed to introduce strategic payment into community health systems, identifying and removing organization-specific barriers, and technical assistance in partnership with the Unite Us vendor's own support efforts. We are also planning to leverage Unite Us, moving away from a paper submission process, to submit requests for Mom's Meals to deliver food to our members who qualify for the benefit. The addition of the two hospitals will also further enhance the utilization of the platform.
        - Point Click Care (formerly known as Collective Medical)
            - We are exploring utilizing Point Click Care'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.
        - FIDO
            - Expand FIDO access across dental and behavioral health networks.

- Care Coordination Platform
  - Actively seeking a care coordination vendor. Our selection will be based on high integration with current technology and tools, improved workflows and efficiencies for our Care Coordination teams to support our members as well as ability to better report and adapt to the changing needs and requirements.
- Member mobile app
  - We are currently implementing a mobile application that will allow members to find benefit information, seek care, log into our member portal, and more.
- Member Electronic Communications
  - Implemented CareMessage as an SMS text messaging tool for members to receive critical information, including updates related to the end of the Public Health Emergency. In 2023, CareOregon has a focus on opting members into electronic communications for secure message, SMS text messaging, and general email updates.
- Reliance HIE
  - Continue to monitor usage and evaluate opportunities to integrate data from Reliance and our other HIE platforms

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
Coordinate Moms Meals delivery through Unite Us	Q3 2023
Assess use of Point Click Care “Assigned by not seen” panel	Q3 2023
Expand FIDO across dental network	Q3 2023
Expand FIDO to behavioral health	Q4 2023
Providence and Asante Hospitals Live on Unite Us	Q4 2023
Select care coordination platform	Q2 2023
Member mobile app go-live	Q3 2023
Continue to monitor Reliance usage and opportunities	Continuous 2023

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

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

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

- Referral platform

  The dental department of CareOregon is working on an enterprise-wide HIT enhancement to improve our dental care referral platform and bidirectional communication. This enterprise-wide project has been secured with CareOregon Executive Leadership as a priority to ultimately improve dental access and

utilization of services for our members. Cross-departmental teams are working to automate and optimize the current process. 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

  Data analytics and dashboard buildout on the percentage of children who had a dental care request form submitted by the physical health provider and who completed a dental visit.

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

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

Continuing support for virtual consultation

JCC has expanded its access to service by contracting with telehealth only providers such as Brightways. In late 2022 and continuing into 2023 we will be working with telehealth only providers on pathways for care coordination using HIE's such as collective medical.

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

- FIDO

  Create access dashboard indicating real-time availability of behavioral health providers. 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
Evaluate opportunities to optimize care coordination with telehealth vendors using HIE	Q4 2023

C. Optional Question

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

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	Bidirectional data exchange and optimization of current platforms

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

Report Overview
This report is intended to be an update to the information provided last year in the 2022 HIT Roadmap. As such, we have not repeated all information previously reported, although some is included for reference. Unless specifically indicated, all strategies that have been previously described and are fully implemented have been maintained. The information included below is primarily focused on strategies that are new, have evolved, or have not made as much progress as anticipated. This overview is included at the beginning of each section within this report in the event that each section is reviewed independently. Last, Point Click Care and Collective Medical are used interchangeably in this report given the recent acquisition.

We encourage reviewers to draw on all sources of information provided to the OHA to fully understand the breadth of how HIT supports and is incorporated within JCC's operational, quality improvement and clinical strategy activities. In particular, there are several examples of data reports and tools included in the 2023 Transformation and Quality Strategy that illustrate our use of data exchange, disaggregation, and analysis in support of member outcomes and our provider network.

Progress across provider types

Relevant to all strategies selected above

Bidirectional data exchange and Optimization of current platforms

As mentioned previously, our overall HIT workplan includes *optimizing use of current platforms*. We continued our activities from 2021 as it relates to hospital event notifications through Collective Medical, now known as Point Click Care. JCC receives Hospital Event Notifications from Collective. We have integrated an hourly feed into our care coordination platform to alert our internal care coordination teams of an event for members they are working with. We also 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
- JCC 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

In addition to the above we successfully added an IET Cohort 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

Bidirectional data exchange and Optimization of current platforms

JCC submits daily file feeds that identify 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.

HEN training and technical assistance; Assessment/tracking of access and capabilities; Outreach and education about the value of HEN

Continuing to identify opportunities through our Innovation Specialist team to help clinic partners modify their operations and optimize use of Collective

The innovation team provides coaching and technical assistance as it relates to increased access and optimization of Collective 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.

ii. Additional progress specific to physical health providers

HEN training and technical assistance; Assessment/tracking of access and capabilities; Outreach and education about the value of HEN

Continuing to identify opportunities through our Innovation Specialist team to help clinic partners modify their operations and optimize use of Collective

The innovation team provided targeted support around Collective to Providence Medical Group throughout 2022. Due to staffing turnover throughout 2022, there was a need to onboard new staff and reacquaint them with the Collective platform. The innovation team worked one-on-one with Providence to help them understand what is available to them within the Collective Platform and how to leverage the resources to reduce ED admissions. Additionally, the innovation team connected the new Providence staff to internal Providence supports as well as the external Collective team so that they could learn more about the reporting tools.

During the March Quality Improvement Workgroup, Collective was highlighted along with the specific cohorts as a tool to support the IET metric. La Clinica received follow up one-on-one TA after the QIW on IET to further discuss the Collective IET Cohort. They were provided support on how to further utilize the cohort to create personalized gap lists.

iii. Additional progress specific to oral health providers

Optimization of current platforms

All JCC'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 learn 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 2 of 17 organizations surveyed (representing 27 provider sites in Jackson County) 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

Optimization of current platforms

JCC continues to support provider usage of the Collective Medical platform for coordination of care. We plan to expand this support to telehealth only providers and gather information from provider network on any gaps with the usage of HIE.

v. Please describe any barriers that inhibited your progress

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.

We are going to continue the same activities from 2021 and 2022 as described above and in previous reports. We do not plan to augment these at this time.

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, 39 physical health, 15 oral health, and 51 behavioral health organizations do not have access to HIE for hospital event notifications

We are going to continue the same activities from 2021 and 2022 as described above and in previous reports. With the exception of behavioral health as described below, we do not plan to augment these at this time.

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

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 Collective.

Activity	Completion Date
Develop outreach and education plan for telehealth-only providers	Q3 2023
Implement outreach plan	Q4 2023

C. Optional Question

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

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.

Report Overview
This report is intended to be an update to the information provided last year in the 2022 HIT Roadmap. As such, we have not repeated all information previously reported, although some has been included for context. Unless specifically indicated, all strategies that have been previously described and are fully implemented have been maintained. The information included below is primarily focused on strategies that are new, have evolved, or have

not made as much progress as anticipated. This overview is included at the beginning of each section within this report in the event that each section is reviewed independently.

We encourage reviewers to draw on all sources of information provided to the OHA to fully understand the breadth of how HIT supports and is incorporated within JCC's operational, quality improvement and clinical strategy activities. In particular, there are several examples of data reports and tools included in the 2023 Transformation and Quality Strategy that illustrate our use of data exchange, disaggregation, and analysis in support of member outcomes and our provider network.

Progress across provider types

Our primary strategy to collect and aggregate social determinants of health data is the implementation of Unite Us, which has not changed since our last submission. Unite Us is a closed-loop referral platform for social needs that allows for bi-directional information sharing and transparency across referrals networks. For purposes of this report, we have provided brief progress updates specific to each of the selected OHA template strategies:

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

- JCC completed a multiyear project to update our health risk screening and assessment, integrate it into our care coordination software (HealthCoordinator), and align the social determinants of health-related question with state-approved social needs screening language.

Care coordination and care management of individual members

- JCC completed customization of our care coordination solution (HealthCoordinator) to generate automated care coordination tasks related to structural determinants of health, with specific prompts for clinically high-risk members to prompt identification of bias or disparity related to members' race, ethnicity, age, and primary language that could contribute to worse health outcomes.

Issue/Needs Title: Member risk related to access of health care services - cognitive and/or physical barriers	
Member Priority	Medium
Care Team Member Priority	Medium
Status	Unreviewed

Long-Term & Short-Term Goals

Objective/Goal (Status: Suggestion)
Member has access to access to appropriate health care services to support their needs

Comments

Treatment/Rehabilitation/Intervention

Plan
Referral for In Home services and/or primary or specialty care

Status **Responsibility**
Suggestion

Comments

Use data for risk stratification

- In response to recurring seasonal heat and smoke emergencies, we used data related to social determinants of health to create a custom algorithm (prior to OHA outreach requests) that included housing and demographic data to prioritize and target outreach to members who may be impacted to SDoH-related disparities for receipt of 23 life-saving air conditioning and air filtration appliances.

Engage in governance of CIE

- We actively engaged in regional and state governance of the CIE Connect Oregon network; we invested significant staff time in providing improvement feedback for tool and facilitating new relationships that could lead to referral pathways between medical and non-medical partners that addressed and were sensitive to social challenges and health related social needs.

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	☐ 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	

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

JCC has partnered with our provider network to support the following activities:

- Sponsor CIE for the community
- 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

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

JCC completed its third year of community sponsorship of the Unite Us/Connect Oregon CIE platform. JCC continued to lead the conversation in our communities on how to effectively use a CIE tool by:

- Sponsoring the platform through payment on behalf of JCC members in the region,
- Financially supporting clinics' integration with the tool,
- Convening local official and unofficial governance and decision-making groups, and
- Advocating to the CIE vendor on behalf of community needs.

As a result, referrals in Jackson County grew 6-fold in 2022 with more than 1600 referrals made during the year with 39 organizations sending at least one referral and 82 organizations receiving one or more referrals.

ii. Additional progress specific to physical health providers

Financial support for CIE implementation and/or maintenance

- As part of the sponsoring outlined above, Jackson Care Connect continued to support for an additional year the costs of local FQHCs in accessing and integrating the Connect Oregon platform. The financial support, along with the technical assistance outlined below, resulted in significant growth in referrals from FQHCs, especially the clinics associated with La Clinica Del Valle which accounted for 18% of the total network traffic last year.

Training and/or technical assistance

- Jackson Care Connect provided ongoing assistance to physical health partners as they built workflows around using the Connect Oregon platform as part of their clinical and operations workflows. This support contributed to the significant impact that both FQHCs had on the vitality of the CIE network in Jackson County.

iii. Additional progress specific to oral health providers

Training and/or technical assistance

- All three of JCC's subcontracted dental plans are working with the Unite Us / Connect Oregon CIE platform and participate in a cross-regional Dental Plan/CCO workgroup to develop and support use of the platform.

iv. Additional progress specific to behavioral health providers

Training and/or technical assistance

- Jackson Care Connect provided ongoing technical assistance to multiple behavioral health providers, focusing on both referrals from behavioral health providers to physical and social health needs and referrals into behavioral health services from social services partners who were in a strong position to support members seeking out and receiving trauma informed care.

v. Additional progress specific to social services and CBOs

Training and/or technical assistance

- Jackson Care Connect provided technical assistance to CBOs interested in incorporating the use of the Connect Oregon CIE into their workflows and hosted communication sessions and distributed use cases to help CBOs identify useful applications for the populations they serve.

Incentives and/or grants to adopt and/or use HIT that supports SDOH

- Jackson Care Connect offered grants of $5,000 to interested CBOs to help them defray operational training costs associated with onboarding and incorporating CIE use into their work.

vi. Please describe any barriers that inhibited your progress

During 2022, JCC staff and provider partners identified the following major IT barriers to identification, documentation, service delivery, and reporting. Where applicable, we have described our mitigation strategy.

- Barriers to adoption of CIE
    - CBO concerns with having capacity to meet influx of demands
        - Current mitigation: formal contracting with CBOs and multiyear support of community services
    - Integration costs and workflow adoption by clinics even after tool integration prevent maximum adoption
        - Current mitigation: focusing support and resources on the costs and training for most important partners
    - New privacy configuration from Unite Us vendor reducing the perceived value of referrals to and from behavioral health partners
        - Current mitigation: Advocacy with vendor for greater flexibility with configuration in question
- Barriers to payment for SDoH-related services
    - No state-provided solution for CBOs to check member eligibility. This increases difficulty and complexity of payment solutions that require member identification.
        - Current mitigation: use of Jackson Care Connect-specific provider portal that allows secure sharing of HIPAA-protected enrollment information and a decision to allow broad eligibility criteria for these services to limit authorization-related administrative overhead
    - No widely accepted or state-endorsed approach to CBO payment that provides an accessible format and method for reimbursing and reporting on CBO services in an encounterable format.
        - Current mitigation: custom development of low-tech interim payment processes and reporting forms (i.e., spreadsheets) with significant “back end” effort from CCO staff to verify, audit, and process information required for payment and reporting.
- Barriers to identifying addressable SDoH needs
    - Limited interoperability or standards around classifying SDoH needs and the tools that can safely and securely share needs within the health delivery ecosystem to prevent over screening and effective service and care coordination.
        - Current mitigation: None in place

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.

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

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

- Continued roll out and enhancement of risk screening described in previous section

Care coordination and care management of individual members

- We will begin implementation of a new care coordination software platform that better integrates SDoH-related data sources and referral tools

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

- We will enhance our segmentation and risk prediction methods by bringing in new data sources that account for social needs and related health risks

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

- We will begin a search for a vendor partner who can assist in simplifying and automating administrative and payment tasks for contracted CBO partners' services related to SDoH needs
- We are planning to use HIT (HealthTrio) to manage eligibility verification and secure payments from community-based organization partners supporting members' with SDoH-related needs

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

- Interoperability between the Connect Oregon CIE and our new care coordination platform will be included in the implementation indicated above.

Activity	Completion Date
Care coordination software platform selected	Q1 2023
Care coordination software platform implemented	Q1 2024
Hire population segmentation and risk analysis staff	Q2 2023
Develop segmentation and analysis methods	Q3 2023
Test segmentation and analysis models	Q4 2023
Release RFP for administrative simplification vendor	Q2 2023
Develop CBO contract and fee schedule for HealthTrio	Q2 2023
Onboard CBOs to HealthTrio	Q4 2023

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

For all provider types, Jackson Care Connect plans to continue using the methods indicated above to support use and adoption of close loop referrals through the CIE for all interested providers.

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

Requirements in contracts/provider agreements

- Jackson Care Connect will include a request to accept external referrals via a CIE as part of its contracts for CBO SDoH-related services

Activity	Completion Date
Develop contact language	Q2 2023
Onboard CBOs to Connect Oregon	Q4 2023

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?
OHA could speed support of SDoH needs by providing access to MMIS or equivalent enrollment information to state CBOs.

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.
B. Describe CCO HIT tools and efforts that **patient engagement**, both within the CCO and with contracted providers.
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?