2022 Updated HIT Roadmap

Guidance, Evaluation Criteria & Report Template

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

Guidance Document

Purpose & Background

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

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

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

Other changes for Contract Year Three (2022):

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

Overview of Process

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

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

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

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

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

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

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

Updated HIT Roadmap Timeline

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

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

Updated HIT Roadmap Approval Criteria

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

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

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

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

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

2022 Updated HIT Roadmap Template

Jackson Care Connect

April 28, 2022

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

Instructions & Expectations

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

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

Each required topic includes the following:

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

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

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

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

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

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

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

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

A note about the template*:*

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

New for *2022 Updated HIT Roadmap Template*

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

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

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

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

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

1. HIT Partnership

Please attest to the following items.

a.	☒Yes ☐No	Active, signed HIT Commons MOU and adheres to the terms.
b.	☒Yes ☐No	Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU.
c.	☒Yes ☐No ☐N/A	Served, if elected, on the HIT Commons governance board or one of its committees. (Select N/A if CCO does not have a representative on the board or one of its committees)

d.	☒Yes ☐No	Participated in an OHA HITAG meeting, at least once during the previous Contract year.

Jackson Care Connect (JCC) has been a leader in supporting EHR adoption and HIE platform creation and spread since the beginning of CCOs. We have actively participated in the OHA's various HIT committees, and we continue to promote adoption and best practices for HIT as a critical element to create shared actionable information to meet member, provider, population, and plan needs to drive value.

It should be noted that the pandemic had a significant impact on our providers and our ability to move initiatives forward. Many of our efforts that were started in 2020 and 2021 were paused while our internal resources and network capacity focused on vaccines and providing care to members impacted by COVID. Below we share our current and future efforts to bring value and improve health by supporting further adoption and spread of health information technology. As a reasonably small CCO serving rural communities, we benefit from our relationship with CareOregon, which provides us with the sophisticated HIT expertise and resources of a large CCO that we could not otherwise afford. CareOregon serves approximately 300,000 Medicaid members across the state and has developed a comprehensive technology strategy to support its partner CCOs with member assignments and technology support functions. As you review the document, you will see us reference both JCC and CareOregon staff. Although CareOregon is the backbone for many of our infrastructure needs, our local JCC Board, comprised of community stakeholders, providers and members, creates the vision and defines our organizational strategies based on the health and social support needs unique to our members and communities.

2. Support for EHR Adoption

A. 2021 Progress

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

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

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

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

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

☒ Incentives to adopt and/or use EHR	☐Other strategies for supporting EHR adoption (please list here)

i. Progress across provider types

Current Landscape:

Physical Health:

The majority of our physical health providers have adopted Epic through our hospital partners Providence and Asante and through OCHIN, which hosts our two FQHCs, Rogue Community Health Center and La Clinica Health. Smaller clinics use a variety of CEHRT platforms.

In 2021, 87% of JCC members were seen in a clinic system that had an EHR. With significant efforts in the past by OHA, hospital systems and CCOs to support EHR adoption through resourcing and technical assistance, the few clinics that remain on uncertified EHRs or paper charts do so due to cultural resistance to change and not due to lack of resourcing. In the near term, we will continue to work with these providers to encourage EHR adoption. However, given the limited provider availability in some of our rural communities, we must balance the desire to attain 100% EHR adoption with the need to maintain an adequate network of high-quality providers to serve our members.

Behavioral Health:

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 2022.

Oral Health:

JCC partnered with its dental plans and surveyed its entire network of dental providers at the end of 2021. Of the 30 dental clinics surveyed, we found:

- 26 (87%) are using an EHR
- 4 (13%) are using paper charts

Those on paper charts are mainly small general practice dentists. 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:

- EagleSoft – 7 clinics
- EPIC Wisdom – 5 clinics
- Dentrix – 4 clinics

Across provider types, given that such a small percentage of our members are served by clinics without an EHR, we have adjusted our focus from EHR adoption to EHR optimization support through workflow and process improvement technical assistance. We will align this work with our transformation priorities and in

areas that provide value to our provider partners without creating unnecessary additional burdens or contributing to clinician burnout.

Our Key Strategies:

1. Strategy 1 – Refine our 5-Year HIT Plan
2. Strategy 2 – Continue to support adoption and optimization through technical assistance, financial incentives, and care coordination processes
3. Strategy 3 – Support EHR use to further telemedicine

Strategy 1 – Refine 5-Year HIT Plan

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

To advance the imperative to bring value and improve health by supporting further adoption and spread of health information technology, COQHO has chartered a HIT subcommittee that will guide the development and implementation of the HIT strategies and activities to support COQHO's clinical vision. This multidisciplinary committee is responsible for overseeing the enterprise and regional-level Five-Year HIT Roadmap. The intention of the committee is to advise on the development of an overarching HIT strategy to guide the HIT related initiatives in all CareOregon lines of business and regions, including EHR adoption, barriers, and incentives. Portions of the workplan focused on better understanding adoption are summarized below.

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

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

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

Key successes include:

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

In 2020 we started an environmental scan by collecting information about EHR utilization within our network. We did this by surveying our primary care providers and delegated dental plan partners, and updating our Provider Information Form (PIF), to capture EHR information during our provider onboarding process. However, we did not complete the environmental scan or engage our network partners in a process to inform our overall HIT Strategy as originally planned for Year 1. When COVID-19 hit, we shifted our focus to other matters, primarily EHR optimization related to telemedicine. As things shift in 2022, we plan to hold network discussions on ways we can partner and support HIT strategies and initiatives at large, as well as approaches specific to optimizing EHR capabilities in 2022 and beyond. We will use the progress made on telemedicine as an opportunity to cultivate more partnerships within our network to support EHR optimization.

Strategy 2 – Continue to Support and Encourage EHR Adoption and Optimization
In 2021, JCC continued to encourage improved use of EHRs through our technical assistance, financial incentives (e.g., PCPCH payment program) and care coordination.

1. **Technical Assistance/Practice Coaching:** Through our team of Innovation Specialists, JCC provides technical assistance and practice coaching to our provider network partners to support various clinic and system transformation goals. This includes identifying opportunities to more meaningfully use EHRs to improve workflows, supporting CCO Quality Metric documentation, and supporting Value-Based Payment performance.
   Here are some of the ways we have helped them 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- ACEs)

2. **Financial Incentives:** JCC employs a variety of financial incentives that encourage improved EHR use. 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 can pull and submit data from their EHR.
   - Clinic designation – JCC has developed financial incentives to encourage organizations to achieve greater levels of organizational designation (e.g., Tier 3 PCPCH). The designations require increased levels of EHR functionality.
   - Value-based payment – JCC engages with our providers in value-based payment arrangements, including shared risk, 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.

3. **Care Coordination**: JCC's Regional Care Team incorporates the use of provider EHRs into regular interdisciplinary care coordination and case conference meetings that include health professionals from primary, behavioral health, and oral health organizations. Participants bring laptops and actively work within their agencies' EHRs to create and maintain consistent documentation across care settings.

Strategy 3 – Support EHR use to Further Telemedicine

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

ii. Additional progress specific to physical health providers

See Progress Across Provider Types

iii. Additional progress specific to oral health providers

See Progress Across Provider Types

iv. Additional progress specific to behavioral health providers

The crises of COVID and workforce shortages have hampered abilities to focus specifically on EHR adoption among behavioral health agencies. Rather, in 2021, our technological support for BH providers was focused on adopting and leveraging the use of Collective to enhance system-wide care coordination efforts and to support vaccination efforts among BH populations. In partnership with Collective and the Oregon Health Leadership Council, Jackson Care Connect supported two of its largest SUD providers as well as four anchor mental health providers to onboard the Collective Platform and to upskill/further support existing users of the platform. With the guidance and support of JCC's Innovation Specialist for Specialty BH, each provider developed goals and objectives for effective use of the platform unique to their agency's needs. In addition to the general upskilling and onboarding of BH providers to the platform, there was additionally a focused effort on increasing use of the vaccine status information to support vaccination efforts amongst members with mental health and substance use disorders. The Collective Vaccine Status Report, and later Patient Profile tag, was created as a response, and Collective worked in conjunction with our Jackson Care Connect team to ensure that it was available to our behavioral health partners. This report allowed targeted and specific outreach strategies for members who access mental health and substance use services.

v. Please describe any barriers that inhibited your progress

Key barriers include:

- Timing of OHA EHR survey competing with other network priorities.
- Perceiving gaps in data as actual lack of adoption.
- Collecting information without adding administrative burden.
- Balancing competing network priorities/asks.
- Clinic cost and staff resource for implementation.
- The strength and breadth of both our mental health and primary care networks means that we work with many small independent providers who serve a small number of JCC members. Our large clinics (and those involved in PCPCH) are all on EHRs. Our ability to support and incentivize the smaller practitioners is limited. Their interest and capacity in adopting EHRs is also limited.
- The COVID pandemic and continued fallout from the September 2020 fires made it necessary for us to divert our internal staff resources. More importantly, these two events significantly impacted the capacity of our clinical providers, and they have not had the capacity to focus on EHRs. As mentioned above, most of our clinic providers were focused on "keeping their doors open" given changes in revenue and increases in costs associated with adapting their organizations to respond to the COVID-19 pandemic.

B. 2022-2024 Plans

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

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

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

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

Overall Plans

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

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

i. Plans across provider types, including activities & milestones

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

Service Type	# of organizations (denominator)	EHR adoption	
		Org count	Rate
Physical	87	51	58%
Behavioral	64	23	36%
Oral	20	17	85%

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

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

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

Activities	**Milestones and/or Contract Year**
Evolve governance structure to align to CareOregon and JCC structure, and to ensure provider input (e.g., via Clinical Advisory Panel or Network and Quality Committee).	Q1-Q3 2021 and Q1 –Q3 2022
Conduct further assessment of EHR use by provider type (e.g., other physical health, behavioral health, dental, etc.) to augment existing information from OHA, CareOregon and JCC.	Q2-Q3 2021/2022
Define the current state and anticipated future EHR capabilities needed to further JCC's health system transformation and quality improvement goals. At a minimum, we will consider EHR functionality for physical, behavioral and oral health to support: 1. Data collection and reporting on existing and new metrics, as well as registries to improve population health 2. Data interoperability, blending EHR data with claims for a more robust population health picture 3. Accurate coding 4. Recording of screenings and other preventive services 5. Integration between behavioral and oral health services in the primary care setting 6. Cross-system care coordination, including coordination with community-based organizations providing social services. 7. Provision of services both in-person and virtually (via phone or telehealth) 8. Improved access to health information for members through patient portals	Q3 2022
Finalize updated HIT Plan Strategy and Plan	Q4 2022
Board and/or CAP approves revised 5-Year HIT Plan	Q4 2022
Launch any new initiatives to further EHR adoption/optimization	Q1-Q4 2022
Next stage of spread in current efforts	Q1-Q4 2023
Spread best practices	2023-2024
Assess ROI - deepen implementation of HIT and eliminate HIT services that do not support existing priorities and support value. Adjust resources and refine practices.	2023-2024

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

Surveying the PH (Physical Health) Specialty network in Q1 2023

As mentioned above, one of our key strategies to encourage EHR adoption and optimization is providing technical assistance to clinics pursuing higher levels of PCPCH designation. Below are key activities and milestones related to our PCPCH technical assistance plans:

Activities	Milestones and/or Contract Year
JCC's Innovation Specialist-Primary Care (IS-PC) will develop and offer a readiness assessment for clinics within JCC's network that are not recognized as a PCPCH, and to learn which clinics are ready for technical assistance and practice level coaching to help them meet their goals. **Progress:** JCC had nine clinics that were not PCPCH certified. Our Innovation Specialist – Primary Care staff reached out and three clinics agreed to meet to discuss PCPCH certification. One of those three clinics agreed to pursue PCPCH recognition and completed the certification process with additional technical assistance.	Q3-Q4 2021
Plan to continue to offer TA (Technical Assistance) for clinics interested in pursuing PCPCH for 2022 and monitor the effect of the technical assistance and practice coaching of the IS-PC to increase the number of members assigned to a PCPCH-recognized clinic.	Q4 2021 - Q3 2022
Progress: Will be evaluated at the end of 2022 for new targets to be established.	Q4 2022

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

Re-surveying the oral health network in Q4 2022.

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

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

Activities **Strategy 1 – Refine 5-year HIT Plan (EHR elements specific to behavioral health)**	Milestones and/or Contract Year
Evolve governance structure to ensure behavioral health input (e.g., via CAP, JCC staff or subcommittee).	Q2-Q3 2021
Assess the EHR utilization by remaining JCC contracted small-group practice and sole-practitioner behavioral health providers, and gauge provider interest in transitioning to an EHR.	Q2 2021
Define the current state and anticipated future EHR capabilities needed to further JCC health system transformation and quality improvement goals related to behavioral health. At a minimum, we will consider EHR functionality for behavioral health to support: 1. Maintaining compliance with all documentation elements required by applicable Oregon Administrative Rules. 2. Adaptation of successful strategies from physical health workplans to behavioral health scenarios as applicable and needed.	Q3 2021

3. Identification of best practices regarding EHR use and configuration and development of a process to share, extend, and standardize these best practices. 4. Expansion of closed loop/bi-directional referral processes between primary care and behavioral health. 5. Population health initiatives (e.g., population segmentation).	

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

Activities	Milestones and/or Contract Year
In 2022, JCC will continue to provide technical assistance to our large behavioral health partners to improve their ability to capture and extract data from their EHRs necessary for OHA (e.g., for ACT) and JCC metric reporting.	Q2-Q4 2022

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

A. 2021 Progress

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

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

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

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

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

☒ Enhancements to HIE tools (e.g., adding new functionality or data sources) ☒ Integration of disparate information and/or tools with HIE ☐ Requirements in contracts/provider agreements	☐ Other strategies that address requirements related to federal interoperability and patient access final rules (please list here) ☐ Other strategies for supporting HIE access or use (please list here)

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

We currently support several platforms and activities to facilitate care coordination across a variety of provider types:

Unite Us

In 2021, CareOregon continued to make significant investments in a Community Health Information Exchange (often termed CHIE or CIE) through the Unite Us/Connect Oregon platform. This platform allows care coordination referrals between clinical and community-based organizations (CBOs). We supported the development of this network by providing technical assistance to onboard 87 organizations to the platform during the year, and by sponsoring the licensing and integration costs for an additional 5 JCC clinics that were onboarded during the 2021 calendar year. Information exchanged on the platform relates to demographics of members and their social needs, all of which require member permission before information is shared with clinics or other agencies.

Collective Medical

CareOregon continues to support care plans and utilization data exchange through this platform. In addition to provider onboarding support, we have begun exploring more consistent use of Collective through hospital value-based payment arrangements. We also surveyed our delegated dental providers in Q4 2021 to determine who is currently utilizing the Collective platform. All dental plans – Advantage Dental Services, Capitol Dental Care, ODS, and Willamette Dental Group – use Collective daily for hospital event notification and to aid in care coordination. At the clinic level, all Willamette Dental sites and seven Capitol Dental providers (including both FQHCs) are utilizing Collective. Based on the dental provider assessment, 9 of 30 (30%) dental providers surveyed are using Collective directly in their office. The other providers obtain information gleaned from Collective from their contracted dental plans for care coordination purposes. This is due to a variety of reasons, including members not being assigned to a dental clinic and plans to take a more hands-on, supportive approach to care coordination.

Epic's Care Everywhere

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

EDIE

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

JCC Provider Portal

The JCC provider portal supports referrals among primary care and dental plan partners. Through our provider portal, providers can request dental service in the portal where our providers submit prior

authorization requests. JCC has provided technical assistance to physical and behavioral health providers and their teams, as well as community-based organizations to integrate the workflow into their care coordination processes. We also track utilization data to identify opportunities for improvement.

Medecision Health Coordinator – Care Coordination Platform

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

We implemented improvements to Health Coordinator that increased our efficiency. The platform has given us greater access to comprehensive assessments and integrated care planning. It allows our Regional Care Team to work from one common care plan for each member. Care plans are pushed to Collective and to the Provider Portal for increased coordination across the member's care/treatment team. Care Coordination staff also receive notification alerts of hospital admits, allowing for quick follow-up and responsiveness.

We uploaded a list of PERC codes to member profiles that may be attached to a prioritized population such as foster care, long-term services and supports, and members deemed eligible for intensive care coordination (ICC). This allows our Regional Care Teams to proactively engage members in care coordination and prioritize referrals if needed.

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.

FIDO

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

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

Transitions of Care

Care plan and authorization information is shared with other CCOs to facilitate continuation of care when members change CCO enrollment.

Secure Messaging

In addition to Collective, our JCC Regional Care Team communicates with providers using secure messaging through their email. Health Coordinator (care coordination platform) also allows for secure messaging directly through the platform.

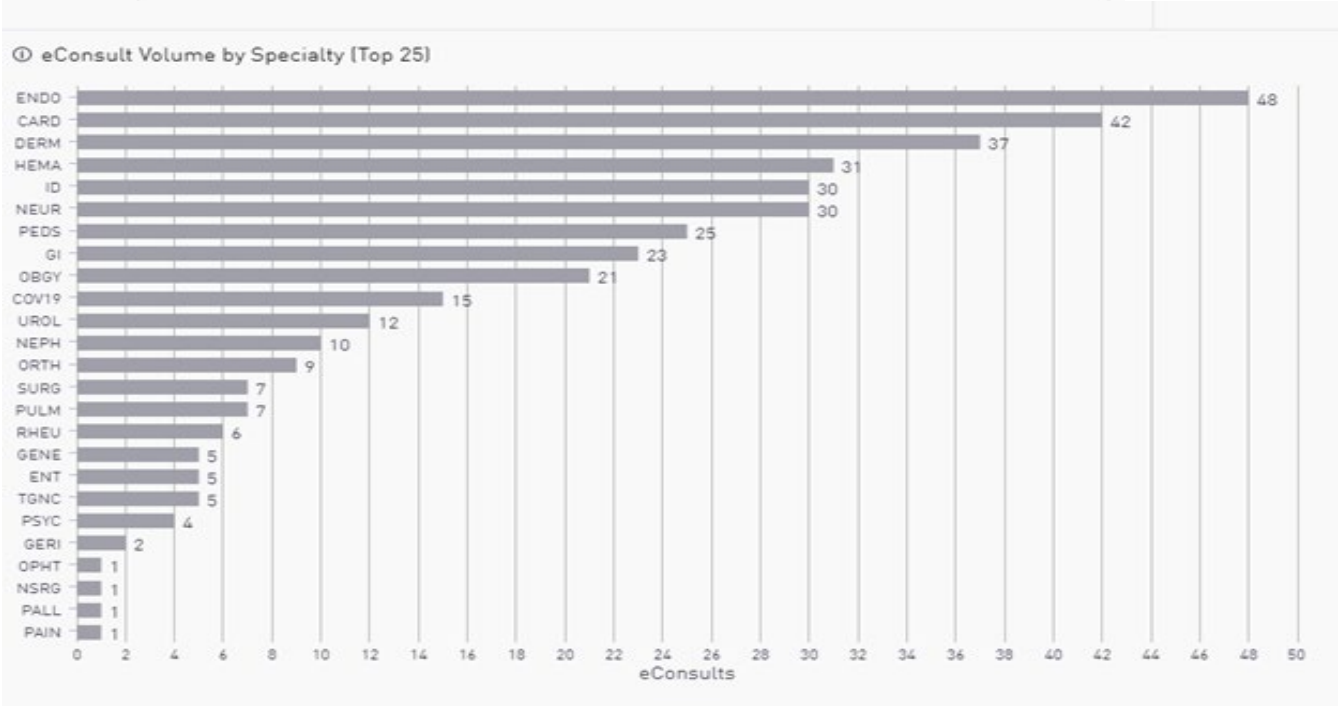
CMS Interoperability

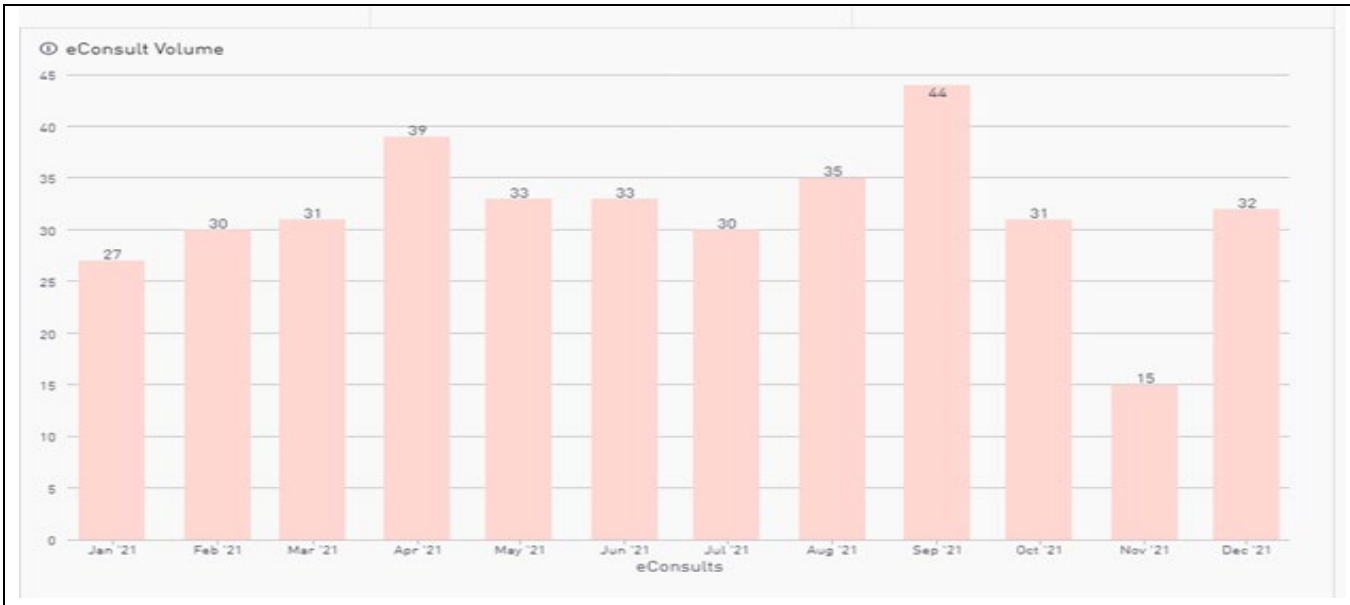
CareOregon deployed APIs to facilitate sharing health data with members. Payer-to-payer data exchange implementation is planned for 2022.

E-consults through RubiconMD

RubiconMD is an e-consult platform that providers use to consult with a national network of board-certified specialists for guidance on diagnosis workups and treatment advice options. Platform can be integrated with clinicians' EHRs and clinical workflows. 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 the care they deserve, regardless of whether they are affiliated with JCC. In addition, Rubicon provides up to 20 hours of CME for completed consultations, at 0.5 hours of continuing medical education (CME) per consult. We view this as an upskilling tool for our providers to effectively manage patient needs, while simultaneously using technology to expand the services patients can receive. The graphs below show the utilization of JCC's two FQHCs (Federally Qualified Health Center). Due to workforce shortages, we anticipate in the coming year the use of RubiconMD will increase.

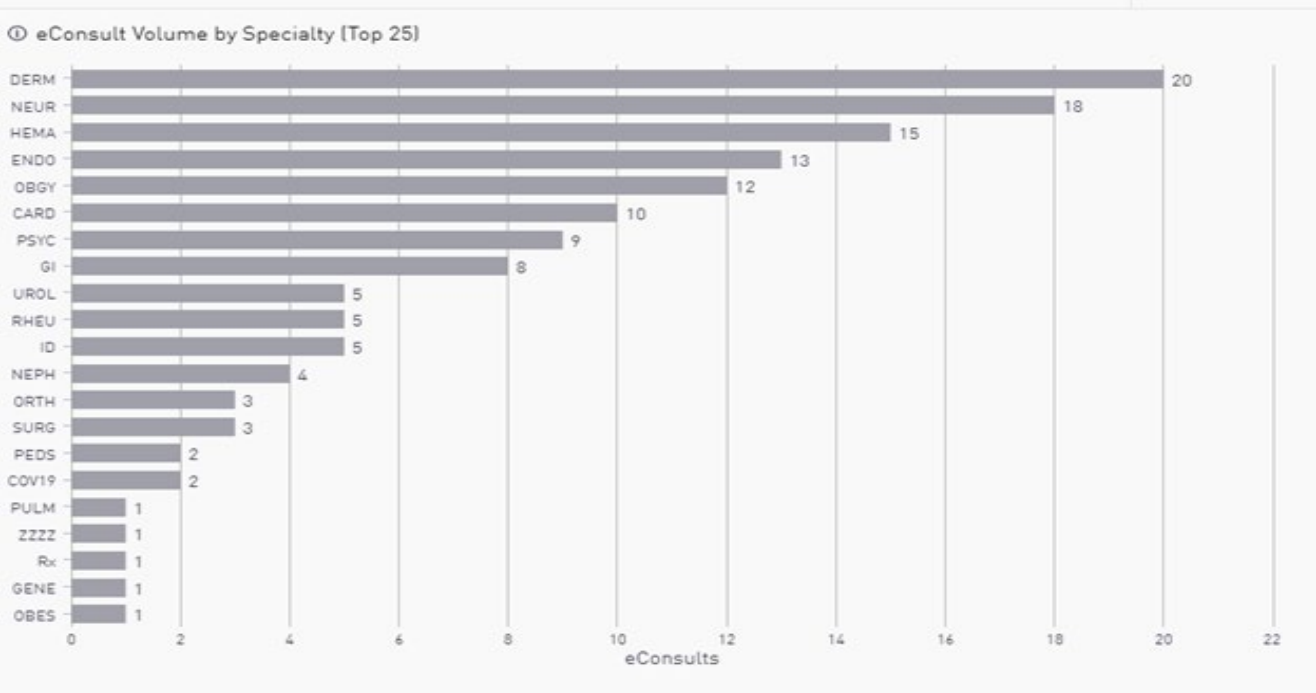
Data from LaClinica:

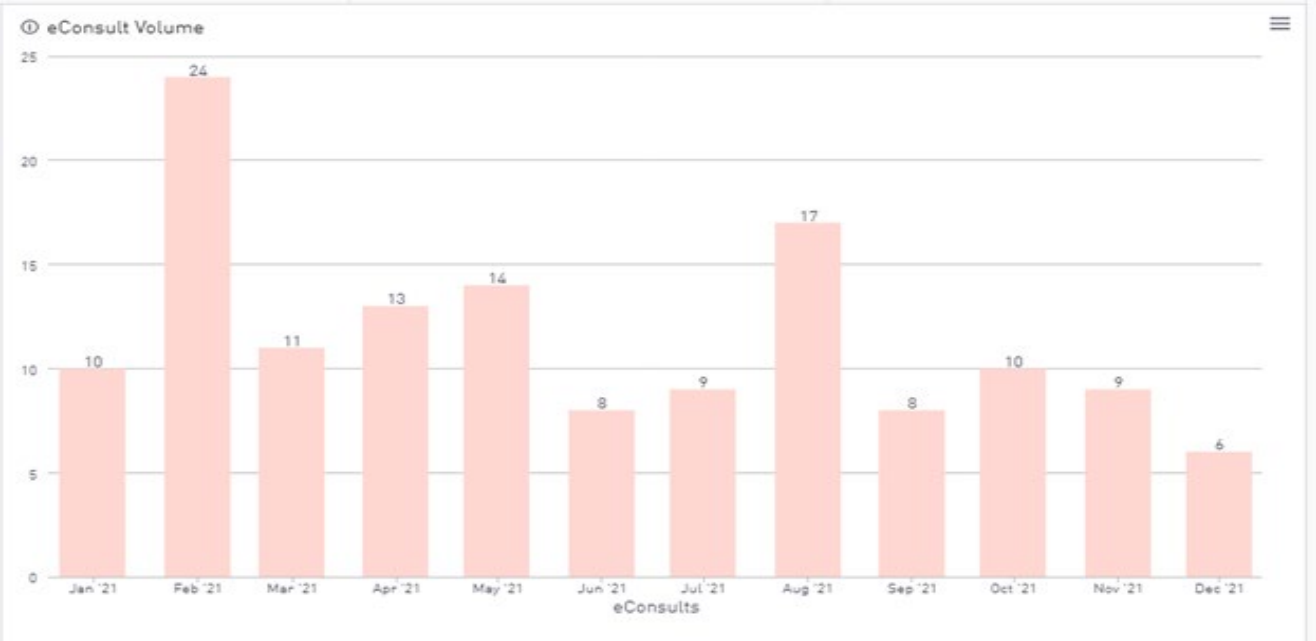




Data from Rogue Community Health:

139 Total eConsults	39% Avoided Service Rate	37% eConsults Claiming CME
90.7k Est. Patient Wait Days Avoided	$167.6k Est. Patient Cost Savings	51 eConsults Claiming CME





Project ECHO

JCC currently supports and has funded providers to participate in Project ECHO, a peer-based learning platform that has shown significant effectiveness in upskilling providers on complex medical and behavioral health topics. JCC and CareOregon sponsored an ECHO in 2021 that focused specifically on adult psychiatry. This ECHO was offered in two parts, with 5 out of the 31 slots in each cohort reserved for JCC providers. The following were reported by those participating in the program:

- 62% of respondents to the post-program survey provided at least one informal case consultation for a colleague on a patient with a mental health disorder.
- 44% of respondents to the post-program survey convened a “multi-disciplinary group within my practice to discuss improving care for patients with mental health disorders” one or more times.

Telehealth

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

CareOregon is expanding our existing electronic dental referral process with additional physical and oral health providers. We are exploring ways of improving electronic communications between oral health and other provider types (e.g., Unite Us), and we are also exploring expanding access to CareOregon's care coordination platform to our dental plan partners.
In addition, we offer products to enhance clinician's ability to expand access to care, and improve quality for patients by additional clinics supports through the platforms described below.

Strategy 1: Refine our 5-year Plan (HIE)

1. We created the governance structure and elements of the HIT plan described in the EHR section above.

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

1. JCC and CareOregon developed a comprehensive plan to improve our member communication strategies and tools. In Q4 2020, we implemented a new telephonic system. NICE in Contact CXone is a state-of-the-art cloud contact center platform that now provides JCC/CareOregon with enhanced performance, reliability, and fault tolerance. Additionally, it provides improved tools for customer experience, reporting and team management.
2. We increased utilization and availability of smart and flip phones that could be sent to clinics for members' use or sent to individuals directly upon request.
3. We piloted a program to provide members who are dually eligible with smartphones to allow them to complete their annual wellness visits virtually.
4. To support our care coordination efforts, we launched a targeted texting initiative to our highest risk members to encourage COVID-19 vaccinations, and to offer navigation support. We are exploring ways to more broadly text members, but due to current legalities, were not able to do so in 2021.

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

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

1. All members engaged with the Regional Care Team (RCT) who have an IP discharge are enrolled into our transition of care program. Now by adding the ADT data feed into Medecision's Health Coordinator platform, these notifications are pushed in real time to our regional care team staff.
2. We utilized targeted cohorts in the Collective tool to identify priority populations that were at increased risk of experiencing adverse impacts of COVID-related care restrictions. Such cohorts included members with a possible overdose event and members struggling to manage their diabetes. Both cohorts directly mapped to a workflow for identification and follow up and then targeted programs and/or interventions.
3. We utilized cohorts within Collective to identify members who were experiencing COVID-like symptoms and to identify confirmed COVID-positive members. These cohorts helped inform our COVID-positive, post-hospital discharge program aimed to wrap services around those who needed to be quarantined away from family and friends. Our objective was to reduce transmission of the

virus by providing temporary housing accommodations at local hotels and coordinating services to ensure food and medications were available to members requiring quarantine.
4. We worked with OHLC and our hospital system partners to add a flag within Collective to identify members who tested positive for COVID.
5. Our Innovation Specialist team developed an internal, JCC-facing dashboard to help us to track network engagement with the Collective platform. This dashboard informs internal strategies to increase network monitoring, improve engagement, and identify opportunities for optimization.

B. Reliance - Expanded use of Reliance

1. JCC refined the Reliance report built in 2020 to generate weekly reports on our members who presented to the ED (Emergency Department) for an asthma-related issue. This was used to do chart reviews and identify members for pharmacy-related interventions. Those members who had an intervention are being tracked. This was used in Q1 2021 to inform asthma-related work for MEPP (previously Prometheus). The pilot was concluded in 2021 and while a good proof of concept for monitoring a population for a specific health event, the interventions did not produce the desired outcomes on member health outcomes. The proof of concept, however, was a valuable lesson learned and could be used as a potential tool for other populations with specific health conditions in the future.

C. CareOregon Portal –Supporting Communication between JCC and providers via our Provider Portal

1. In 2020, via our provider portal, we improved the referral process between primary care and our dental plan partners. Through our provider portal, physical health providers can request the member's dental plan reach out to the member to schedule a dental appointment in the same online portal where our providers submit prior authorization requests. JCC has continued to provide technical assistance and support to physical health providers and their teams to integrate the workflow into their clinic's care coordination processes. In 2021, JCC expanded this workflow to community-based and governmental organizations so that additional provider types and case workers can easily request dental outreach, navigation and coordination services by the member's dental plan. In 2020, 558 JCC members were referred for dental coordination by four organizations. In 2021, 947 members were referred by nine organizations – a 70 percent increase in members referred by more than twice as many organizations.
2. Leveraging our provider portal, we have started data sharing partnerships with perinatal care providers who can provide timely and accurate information on members' pregnancy status in a way that helps JCC target care and care coordination support both during pregnancy and postpartum. We are actively working on file sharing with our first clinic partner and are actively developing additional partnerships.

D. System to Support Transitions of Care – To support transitions of care between provider organizations, we have coordinated with external and community partners in order to automate the exchange of authorizations and care plans to and from dental plan delegates and any CCO statewide.

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

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

Strategy 4: Support the use of health IT to expand access and quality to services in rural areas
A. Telehealth
JCC continued to support the expansion of telemedicine through changes in our payment policies and targeted grants. Our Innovation Specialists provided technical assistance and support to allow clinics to provide access to services remotely through:

- 1:1 provider outreach and support
- Dissemination of written guidance/materials
- Virtual provider meetings

We assessed our network partners to understand and assist with telehealth implementation, staffing concerns, access issues, and other needs related to COVID-19. Network responses informed us of what we developed in terms of TA materials.

Strategy 5: Connect health care and health data through interoperable health IT infrastructure
We are actively improving our capability to both ingest and produce data sets for clinical and community partners. This includes developing the capability to produce and distribute claims data sets on a clinic-by-clinic basis to help partners better understand their patients' utilization, risk profiles, and referral patterns, and to use the information to inform their patient-specific outreach and care coordination activities.

In 2021 JCC integrated our claims data sets to add another of our clinic partners via Arcadia & Wakely to assist the clinics with patient utilization, risk profiles, and performance gaps.

Strategy 6: Engage with State Committees/Entities
JCC staff participated in HITAG, HITOC and Unite Us/Connect Oregon Funders forums.

ii. Additional progress specific to physical health providers

See Progress Across Provider Types

iii. Additional progress specific to oral health providers

See Progress Across Provider Types

iv. Additional progress specific to behavioral health providers

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

- All our large behavioral health partners are onboarded onto Collective Medical and are active users of the platform to support their internal care coordination activities. In 2020, we kicked off an internal project to onboard new behavioral health providers in the region and optimize utilization by our behavioral health partners.
- JCC provided FAQ documents related to telehealth and offered technical assistance to our behavioral health providers to implement telehealth services across JCC's network.

v. Please describe any barriers that inhibited your progress

Unite Us/Connect Oregon
The first year of Unite Us implementation focused on increasing the number of participants in the referral network. Successes included completing significant amounts of training and onboarding activities during a challenging year. The primary barriers relate to helping organizations move from onboarding to consistent

usage. Key drivers of these barriers include gaps in network coverage, workflow inefficiencies at partner organizations, and the absence of a corresponding financial support to help build the capacity needed for more organizations to accept more referrals for social health needs.

Collective:
Successes include development of COVID vaccine report and flag, which was populated into the Collective portals of our provider network. Notably, this is a particular success as it is the only means by which our behavioral health providers can access vaccine status. Additionally, JCC has onboarded on the platform two new SUD providers. Barriers live predominantly in the space of platform optimization. We are continuing to engage with our BH and SUD network to upskill providers on how to use the platform most effectively to complement their other work. Globally, we continue to work with the JCC network in total to understand why Collective is an important tool to communicate across service types (BH/SUD/PH/ED).

In 2021, we continued to experience barriers as our network pivoted to respond to the COVID-19 pandemic. This has caused much of our work to slow down; however, we worked to provide updated information on utility features of the Collective platform with our provider network, such as the COVID testing flags developed in mid-2020. We shifted our focus from expanding HIT support of broad care coordination to how HIT tools, like Collective, can help support COVID-19 specific care coordination and COVID-19 response at large.

B. 2022-2024 Plans

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

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

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

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

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

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

☒ Assessment/tracking of HIE adoption and capabilities ☒ Outreach and education about value of HIE ☒ Collaboration with network partners ☒ Enhancements to HIE tools (e.g., adding new functionality or data sources) ☒ Integration of disparate information and/or tools with HIE ☒ Requirements in contracts/provider agreements	☐ 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

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

To advance the imperative to bring value and improve health by supporting further adoption and spread of health information technology, COQHO has chartered a HIT subcommittee that will guide the development and implementation of the HIT strategies and activities to support COQHO's clinical vision. This multidisciplinary committee is responsible for overseeing the enterprise and regional-level Five-Year HIT Roadmap. The intention of the committee is to advise on the development of an overarching HIT strategy to guide the HIT-related initiatives in all CareOregon lines of business and regions, including increasing adoption rate for HIE care coordination. The workplan includes:

1. Data to support our HIE strategies:

Data from OHA – CCO HIT Data File

HIE for care coordination excluding Collective Platform*		
Service Type	**Org count**	**Rate**
Physical	41	47%
Behavioral	6	9%
Oral	3	15%

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

Clinic Type	N Clinics/ Organization	Approximate % Members Supported	Overall Level of Engagement with Platform*
Primary Care Provider	8	56.5%	Active-Highly Engaged (7) *(6 Not Yet Engaged)*

Behavioral Health Provider (including CMHPs)	5	100% (county level service coverage)	Active-Highly Engaged
Mobile Integrated Health – EMS Agency	1	100% (county level service coverage)	Actively Engaged
Social Services Agency	1	100% (county level service provider)	Not Yet Engaged

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

We will use the dashboard, OHA's data and future survey results to inform our 2021-2024 HIE adoption and optimization strategies. We will work with OHA and other CareOregon affiliated CCO's to better understand the data and address discrepancies.

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

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

2.Strategies, activities and milestones:

Strategy 1: Create a 5-year HIT Plan (HIE elements)

Activities	Milestones and/or Contract Year
Evolve governance structure to align to CareOregon and JCC structure, and ensure provider input (e.g., via CAP, Quality Improvement Committee of JCC's Board of Directors)	Q1- Q2 2021 and Q1 –Q2 2022
Create the plan that may include the following components: • Educating providers and provider staff on existing HIE capabilities and benefits • Developing a regional workplan called for by the HIE onboarding program • Identifying opportunities to improve care transition • Increasing and streamlining automated referral workflows • Optimizing the use of the HIEs functionality • Promoting interoperability of HIEs to simplify end-user environment • Monitoring mechanisms to ensure continued improvement in HIE utilization and resulting patient care coordination	Q3 2022
Board or CAP approves revised 5-year HIT plan	Q4 2022
• Begin to implement the plan • Continue to monitor HIE utilization and work with HIE vendors (including Collective and Unite Us) to achieve optimal adoption. • Explore HIE interoperability solutions with EDIE/PreManage, Epic CareEverywhere and Medecision Care Coordination platform were deemed effective and feasible (e.g., host community conversation, agree on standards)	Q1 2023

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

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

Activities	**Milestones and/or Contract Year**
Improve our communication with members to support their care coordination needs by updating our digital platforms and hiring staff to focus on improving our communication for members whose primary language is not English: 1. Hire bilingual Social Media Specialist 2. Hire Language Access Coordinator 3. Add advanced website translation with Motionpoint for human translation of web content.	Q1-Q4 2021 Q1 – 4 2021
Improve functionality of JCC/CareOregon's Member Portal 1. Update our Member Portal to include care plans that both members and providers can access.	Q3 2021
Increase use of mobile applications: • Explore enhanced texting messaging capabilities for COVID-19 outreach, potentially using Arcadia technology • Develop and launch Portal Mobile app, which will include digital member ID card, ability to review status of prior authorizations and send e-messages to JCC, and other value-add functions to be determined during design process. • Evaluate means to improve member access to information in their electronic health records through interoperability plans and API development • Explore text messaging capabilities to members • Explore member mobile apps	Q1-Q2 2021 Q3 2021 – Q 3 2022 Q4 2021 – Q1 2022 Q2 2022 –Q3 2022
Explore ways to reduce implementation costs and enhance members' access to virtual visits (e.g., support purchase of hardware, defray broadband costs, etc.)	Ongoing

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

Activities	Milestones and/or Contract Year
Collective: JCC is committed to increasing adoption of Collective among our provider network and support optimization of Collective through integration into workflows and clinical care coordination activities for those who are currently onboarded to the Collective platform. We will use our internal Collective Network Engagement Dashboard to monitor utilization within our clinical network and partner with the Collective team to identify opportunities for improvement to achieve optimal adoption and use. Specifically, we will: 1. Evaluate Collective analytics modules to determine ROI and appropriateness of each solution. 2. Partner with our innovation team to enhance technical assistance for optimizing Collective platform utilization. 3. Assess how we might identify shared populations across disciplines including those engaged across different provider types, such as patients engaged with primary care and CMHPs, to facilitate proactive communication, develop collaborative care plans, and ensure closed loop referral process. 4. Continue to expand types of data shared via Collective - Extend admit data to include diagnosis data. (Collective currently stores this data and will need to work with Medecision to add the data to the existing data load) - Include observation/post-acute care visits. Collective has estimated this to be a low lift. Internally, we will need to add another data class to the major classes of data we are already sending in the ADT feed. - Ingest [COVID] vaccination data - Develop population cohorts for care coordination Continue to create incentives for improved use of Collective (e.g., include language in our hospital contract that sets expectations for use of Collective via contribution of content via Care Insights.)	Q4 2021 – Q4 2022 Q4 2021 Q1 2022 Q2 2022 Q1-Q4 2022 2021-2024
Reliance HIE □ Continue to monitor usage and evaluate opportunities to integrate data from Reliance and our other HIE platforms	2021-2024
Provider Portal Continue to expand care coordination functionality through our portal □ Update our Provider portal to include care plans that both members and providers can access	Q3 2021
Implement Unite Us (see in Section 5) □ Continue to implement and optimize the UniteUs platform (see SDOH section)	Q1 2021 – Q4 2022
Support interoperability □ Begin to support and develop HIE interoperability solutions between Collective, Epic CareEverywhere and Medecision Care Coordination	2022-2024

platform where deemed effective and feasible. (e.g., convene community, agree on standards, etc.)	
Secure messaging - Explore the possibility for our Care Coordination teams to send secure messaging between Medecision and EHRs.	2022
Strategy 4: Support the use of health IT to expand access and quality to services in rural areas	
Activities	**Milestones and/or Contract Year**
Telehealth Develop a strategy for ongoing telemedicine evaluation, optimization and support, post-COVID including: - Network evaluation of telehealth utilization and best practices. - Regional evaluation of cultural and linguistic needs/opinions related to telehealth within the network. - Data evaluation of telehealth services. - Support for telehealth toolkit. - Support the expansion of telemedicine through possible payment strategies, clinical partnerships, policy support and targeted technical assistance. Support the expansion of telemedicine through possible payment strategies, clinical partnerships, policy support and targeted technical assistance. Beta-test a new platform within Medecision, Arial Engage, which will support care coordination through telehealth.	Start Q2 2021; evaluation and network engagement in 2022
Explore ways to increase availability and affordability of broadband in collaboration with our counties and local municipalities (e.g., through FCC, grants, etc.).	Ongoing
ECHO Support Oregon ECHO programs through advisement, funding and participation.	Ongoing

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

Activities	**Milestones and/or Contract Year**
• Evaluate tools that promote national standards for sharing information among different EHRs. (e.g., Carequality, CommonWell). • Implement Patient Access API and Provider Directory API as required by CMS. • Implement Payer to Payer API as required by CMS. • Implement Payer to Provider API as required by CMS. • Improve our capability to both ingest and produce data sets for clinical and community partners.	Ongoing Q2 2021 2022 2023 Q1 2021 - 2022

Strategy 6: Engage with state committees/entities

Activities	**Milestones and/or Contract Year**
To ensure we stay abreast of and inform OHA's HIT priorities, members of JCC/CareOregon team actively engaged in several state workgroups, including:	Ongoing

☐ HITAG, HITOC, HIT Commons and Unite Us/Connect Oregon Funders Forum.	

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

To advance the imperative to bring value and improve health by supporting further adoption and spread of health information technology, COQHO has chartered a HIT subcommittee that will guide the development and implementation of the HIT strategies and activities to support COQHO's clinical vision. This multidisciplinary committee is responsible for overseeing the enterprise and regional-level Five-Year HIT Roadmap. The intention of the committee is to advise on the development of an overarching HIT strategy to guide the HIT related initiatives in all CareOregon lines of business and regions, including increasing adoption rate for HIE care coordination. The workplan includes:

- Unite Us: Future years' strategies pivot from primary focus on network partner onboarding to optimization of network health. This will involve work designed to introduce strategic payment into community health systems, identifying and removing organization-specific barriers, and technical assistance in partnership with the Unite Us vendor's own support efforts.
- The new Social and Emotional metric will also require HIE supports between clinical and community efforts and using the Unite Us platform can help meet this need.

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

See the Strategies Across Provider Types section

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

See plans across provider types

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

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

Strategy 1: Refine and implement a 5-Year HIT Plan (HIE elements)

Activities	Milestones and/or Contract Year
Conduct assessment of the HIE functionality and needs among contracted behavioral health providers serving members from JCC region. Based on the results of the survey, JCC will determine if the barriers to HIE adoption for behavioral health providers differ significantly from those of the physical health providers. If so, JCC will develop a separate HIE adoption strategy.	Q3 2021-2022
JCC's CAP will identify a group to focus specifically on behavioral health information exchange workflows and privacy issues (42 CFR).	2022-2023
Begin implementation of the developed strategy in partnership with our behavioral health providers.	2022-2023

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

Activities	Milestones and/or Contract Year

Collective: We will continue to support our behavioral health provider network in optimizing their use of the Collective tool specifically related to: • Hospital event follow-up • Multidisciplinary care coordination • Bidirectional communication with primary care for shared members **Unite Us:** Future years' strategies pivot from primary focus on network partner onboarding to optimization of network health. This will involve work designed to introduce strategic payment into community health systems, identifying and removing organization-specific barriers, and technical assistance in partnership with the Unite Us vendor's own support efforts.	Q4 2021-ongoing

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with access to HIE for Care Coordination?
• OHA could provide some TA on best practices/advisement related to HIE, care coordination and 42 CFR. The latter, 42 CFR, is a barrier to our ability to effectively share actionable data with our network partners related to SUD. This hinders our ability to effectively care coordinate for this population. • Actively identify and attract federal dollars to support broadband infrastructure development and subsidize costs to providers and members to further use of virtual technology. • OHA could also support enhancement to Collective to: - Expand use to include the criminal justice system - Address inconsistencies in hospital ADT feeds - Create shared definition of risk stratification across CCOs - Address demographic gaps in Collective platform (e.g., working to create more REAL-D components) - Integrate more primary care workflows in Collective - Support more global flags (e.g., children in foster care, patients who need long-term care services and aging, blind and disabled populations)

4. Support for HIE – Hospital Event Notifications

A. 2021 Progress

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

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

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

☒ Hospital Event Notifications training and/or technical assistance	☐ 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

CareOregon receives Hospital Event Notifications from Collective Medical. 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.

CareOregon submits daily file feeds that identifies population segments of risk through groups/tags and shares these with community partners to support their work with our members.

Successes include development and population into Collective portals of the diabetes/behavioral health flag. This flag, focused on members with co-morbid diagnoses of diabetes type 2 and SPMI, increased engagement in a high priority population. Similarly, we developed and populated in our provider partner portals the IET flag, which allowed providers to engage members in care around SUD.

We are highly engaged with all anchor behavioral health providers in providing TA around their use of Collective for hospital event notifications. Each anchor provider has been included in training events that match their developmental stage of use and an individualized plan for deepened use has been created with quarterly achievement markers to be reviewed during formal meetings with provider executive leadership. Our Clinical Innovation Specialist provides an update on actual use during these meetings and works closely with the operational management team to ensure staff use leads to high impact in service delivery efforts; strategies include close coordination with the regional care team and intensive case management, ACT, crisis resource/stabilization centers, and the behavioral health units/ED departments. Routine “barrier busting” meetings are held to review issues in notification alerts and follow up on communication that occurs between each entity.

A description of the tool that you are providing and making available to your providers for Hospital Event Notification:
JCC makes the Collective platform available to our provider partners for hospital event notifications.

The strategies you used to support increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers in 2021:
Physical Health Providers
We have supported the onboarding of our physical health providers in our network with varied levels of engagement by clinic. Our Primary Care Innovation Specialist team uses a dashboard to identify opportunities to expand utilization. We also discussed Collective as a tool in transitions of care in regional care planning/transitions of care meetings, and in meetings we held focusing on behavioral health in the ED. Collective is utilized in 13 primary care settings, 6 BH settings, and 1 CCO.

Oral Health Providers

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

completed an assessment among our delegated dental plans' oral health providers to establish a baseline understanding of PDP's using Collective.

Behavioral Health Providers
Our behavioral health provider network utilized Collective to facilitate behavioral health provider outreach to clients in the ED using a combination of traditional health workers and QMHPs from the crisis, ACT, ICM and youth serving programs depending on the needs of the client and previous program affiliation. Our 6 largest BH agencies were actively engaged in utilizing Collective Medical.

Accomplishments and successes related to your strategies:
In 2021, we worked with our ICM-contracted providers to address barriers within post-hospital follow-up and improve coordination with hospital systems and referring parties. Two SUD providers were onboarded to Collective Medical in 2021. For our 4 MH Collective agencies we were able to establish outcomes-based goals that are tied to contracts.

Due to the increase in volume due to COVID, JCC Regional Care Team staff also participated in Region 5 hospital discharge meetings at the height of the Delta surge. JCC was able to utilize the tools indicated above to help track and assist the hospital with the decompression efforts.

ii. Additional Progress Specific to Physical Health Providers

See Progress for All Provider Types

iii. Additional progress specific to oral health providers

See Progress for All Provider Types

iv. Additional progress specific to behavioral health providers

JCC's six largest behavioral health providers are enrolled with Collective. The behavioral health providers will continue to outreach to clients in the ED using a combination of traditional health workers, QMHAs and QMHPs from outpatient, and crisis, ACT, ICM and youth-serving programs, depending on the needs of the client and previous program affiliation. When JCC members are admitted to emergency department, JCC has workflows in place that are dependent on the engaged status of the members. Those engaged in services with one of our large providers will receive follow-up from the specific provider, while those unengaged will be referred to a Behavioral Health Care Coordinator who will refer the member to the appropriate provider.

v. Please describe any barriers that inhibited your progress

Barriers include continued confusion between organizations around 42 CFR and ability to share information. Organizations have differing degrees of comfort of risk they like to accept, so some will share and some will not, which creates inconsistencies. In addition, COVID had a significant impact as our hospitals were full, resulting in the creation of a decompression unit and Region Five interdisciplinary team being set up to manage the complexity of hospital discharges.

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

Overall Progress
Please select which strategies you employed during 2021.

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

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

The Tools Used:

JCC/CareOregon uses Collective Medical for notification of hospital events.

Strategies used in 2021:

We primarily use Collective in three ways:

1) to receive admission and discharge notifications for ALL dual eligible members with a medical admission, and ALL members with a psychiatric inpatient admission,

2) to proactively identify members who may benefit from care coordination, and

3) to notify care coordinators when members currently on their panel present to the ED or admit to an inpatient unit.

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

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

Examples of cohorts and reports included in Collective:

- 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

Accomplishments:

We have created several new cohorts within Collective that trigger workflows within the Regional Care Team to start outreach and engagement with members experiencing mental health crises. The RCT works closely with the hospital EDs and BHU to ensure members are followed throughout their hospital admission and are connected to BH services in a timely way.

The strategies you used in 2021:

Our care coordination and utilization management teams use Collective in a variety of ways: 1) to receive admit and discharge notifications for ALL dual eligible members with a medical admission, and ALL members with a psychiatric inpatient admission, 2) to proactively identify members who may benefit from

care coordination, 3) to notify care coordinators when members currently on their panel present to the ED or admit to an inpatient unit, 4) provide Transitions of Care information to providers.

The Transitions of Care program between JCC and Mercy Flights Mobile Community Paramedic team leverages Collective Medical to auto notify Mercy Flights when a JCC member (child or adult) admits to the hospital for a physical health event (excludes scheduled surgeries, delivery, or MH crisis). Members receive 30 days of post-discharge support. Mercy Flights also uses Collective Medical to identify JCC members that were admitted to the emergency department, (child and adult) and had not been seen in primary care in the past 24 months. Mercy Flight staff complete an assessment that includes physical, behavioral, oral, and social health needs and connects members to their primary care provider and other services accordingly.

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

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

Cohorts tracked and outreached by JCC RCT in 2021:

1. 3 ED admits in 90 days
2. 5 ED visits in 12 months
3. Pediatric ED activity
4. Rising risk ED/IP/OBS/SNF – admit
5. Diabetes cohort – Members who present to the ED or Inpatient for diabetes-related concern

Accomplishments or successes related to your strategies:
In 2020, we created a SUD ED cohort for the Regional Care Team to identify members who presented to the ED due to an overdose event. Into 2021, this allowed the RCT to follow up with these members whose ED visit did not result in a hospitalization. Staff worked closely with the EDs to ensure these members could get connected to behavioral services in a timely manner.

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

As indicated earlier, JCC was also able to utilize these tools to assist with the Region 5 surge that occurred during the Delta surge to help facilitate discharge of members from the stressed provider network.

B. 2022-2024 Plans

1. Please describe your plans for ensuring increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2022-2024 plans.
    b. Describe the following in the appropriate narrative sections
        i. The number of physical, oral, and behavioral health organizations that do not currently have access to HIE for hospital event notification using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations do not have access to

HIE for hospital event notifications). CCOs are expected to use this information to inform their plans.

ii. Any additional HIE tools you are planning to support or make available to your providers for Hospital Event Notifications

iii. Additional strategies for supporting increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers beyond 2021.
Activities and milestones related to each strategy (Please include the number of organizations of each provider type that will gain increased access to HIE for Hospital Event Notifications as a result of your support, as applicable).

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

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

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

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

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

We are planning to continue working with the BH network to adopt the Collective platform.

1. ***Data from OHA – CCO HIT Data File***

Hospital Event Notifications (i.e. Collective Platform*)		
Service Type	**Org count**	**Rate**
Physical	8	9%
Behavioral	5	8%
Oral	3	15%

JCC contracts with CareOregon for its entire provider network to ensure members have access to a broad network of providers. JCC has created an internal dashboard to monitor a provider's engagement with Collective (see above under HIE Strategy). We will use the dashboard, OHA's data, and future survey results to inform our 2021-2024 Hospital Event Notification strategies. We will work with OHA and other CareOregon- affiliated CCOs to better understand the data and address discrepancies.

2. Strategy

To ensure increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers, we plan to continue to support improvements to Collective. We do not plan to make available any additional tools to providers related to Hospital Event Notifications. However, we plan to do some discovery around opportunities for refinement in our utilization of the Collective tool. Specifically, we are interested in exploring how we might identify shared populations. We plan to continue to develop the outcomes-based goals with providers currently at that stage, and to expand it to the newer adopters of Collective Medical. CareOregon has been working to refine the cohorts within Collective, or the "net" that members are identified to reach more members and improve coordination of care with a larger population.

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

See Strategies for All Provider Types

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

See Strategies for All Provider Types

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

See Strategies for All Provider Types

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

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

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

Overall Plans

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

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

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

We will continue to use our Collective platform internally as a source of real time data/information that signals a need on behalf of our members. We will expand on our approach developed in 2021, and continue work on:

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

Care coordination identified through cohort review: We will continue review of Collective cohorts, as done in 2021, but are expanding current cohorts to more conditions. This will allow us to identify members who would benefit from care coordination earlier (a member with 2 ED visits AND uncontrolled DM versus a member with 3 ED visits).

- As described above, in 2020-2021, we created a SUD ED cohort for the Regional Care Team to identify members who presented to the ED due to an overdose event. We will continue and expand this work in 2022 and beyond with closer alignment with IET and EDMI metrics specs for cohort tracking and outreach based on established BH and Population Health strategies.
- We plan to increase outreach to the perinatal population as we build out our maternal/child/youth strategy, specifically for women who admit to the ED for OB-related care when not engaged in OB care setting or for newly delivered members who need assistance navigating to needed care for themselves or newborn, with specific focus on Spanish-speaking members. (2023 and beyond).

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with access to Hospital Event Notifications?
• OHA could support enhancement to Collective to add discharge diagnosis. • See additional recommendations in the preceding section under HIE for Care Coordination

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

A. 2021 Progress

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

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

Collecting and aggregating social determinants of health data is critical to shifting both interventions and investments within the CCO model. Expansion of capabilities through alignment within the CCO will be a major area of focus over the next five years.

Our primary strategy to collect and aggregate social determinants of health data is the implementation of Unite Us. In 2020, in collaboration with AllCare CCO, we began evaluating Unite Us as a community-based solution to improve coordination of social support services among health care providers and community-based organizations. Unite Us is a closed-loop referral platform for social needs that allows for bi-directional information sharing and transparency across referrals networks. JCC and AllCare went live with the Southern Oregon Region version of the Unite Us Platform in April of 2021.

In partnership with Unite Us, JCC implemented a community engagement strategy that included cross-sector collaboration with community-based organizations and physical, oral, and behavioral health providers in the following forums:

1. Community Network Advisory Board: advisory body to ensure existing care coordination best practices and community knowledge are incorporated into the implementation and maintenance of the network.
2. Community strategy sessions including kickoff, demos and onboarding sessions for providers and CBOs.
3. Targeted presentations to organizations and collaboratives for socialization to the platform.

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

Improve quality of information captured through claims:
JCC, in partnership with CareOregon and the Oregon Primary Care Association, has offered training opportunities to FQHCs, RHCs, and non-CHC primary care providers that focus on improving coding practices aimed at capturing accurate patient complexity, inclusive of SDOH. These training courses are hosted by OPCA and a contracted coding organization with deep experience in supporting safety net providers. We hope to continue offering these training opportunities in the future.

2. Please describe any progress you made in 2021 supporting contracted physical, oral, and behavioral health providers with using HIT to support social needs screening and referrals for addressing SDOH needs. Additionally, describe any progress supporting social services and community-based organizations (CBOs) using HIT in your community. In the spaces below, please include
    a. A description of the tool(s) you supported or made available to your contracted physical, oral, and behavioral health providers, social services, and CBOs. Please specify if the tool(s) have closed-loop referral functionality (e.g., CIE).
    b. The strategies you used to support these groups with using HIT to support social needs screening and referrals.
    c. Any accomplishments and successes related to each strategy.

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

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

In addition to the utilization of Unite Us/Connect Oregon, JCC supported the utilization of the strategies and tools below to support social needs and referrals for addressing SDOH needs of our members:

Population Management:

We use three major Health IT solutions related to population health management. Johns Hopkins ACG is a risk segmentation that we use to perform descriptive and predictive analysis related to health outcomes, quality risks, cost, and utilization. This tool forms the backbone of many of our analyses and visualizations that inform population health management priorities. We also use the Arcadia platform as a data integrator with select clinic partners' EHR data. During the public health emergency, we have also leveraged Arcadia

as an outreach tool for member messaging designed to nudge member behavior towards COVID vaccination activity. Finally, for direct care coordination and outreach, we use Health Coordinator (MEDecision/GSI), integrated with patient education program Healthwise and Hospital Event Notifications from Collective, to document care coordination and education activities that contribute to population health management.

VBPs:
We use a software platform that supports PMPM VBP administration. This VBP tool, a leading third party application, currently allows us to administer population-based payments and adjust performance-based payments. We use this software to manage payments for our PCPM, CPC+ and IBH programs.

Another critical tool supporting VBP expansion is the financial model developed by Wakely, an actuarial consulting firm, which provides the architecture that supports our primary care Total Cost of Care (TCOC), and Medical Loss Ratio (MLR) risk agreements. This financial model calculates the total cost of care for a primary care partner's assigned membership, along with detailed cost data analytics allowing the provider to identify trends and areas of opportunity to better manage resources. Wakely also supports the transfer of flat files with eligibility, claims, and risk data directly to providers that are participating in a TCOC or MLR risk agreement. This allows providers to incorporate this data alongside their EHR system to improve patient care.

We have multiple modalities for managing data and assessing performance. The items listed below are mechanisms used specifically to share data with external partners:

Financial Modeling Tools:
Providers participating in our risk agreements (TCOC, MLR) have access to the Wakely financial model providing additional data regarding utilization patterns, and costs of services provided by other providers in the network. Providers in risk agreements also receive flat files with eligibility, claims, and risk data. This allows providers to incorporate this data alongside their EHR system to improve patient care.

JCC is committed to further enhancing analytics capabilities to better model, negotiate, administer, and monitor value-based payments by stronger integration of data between financial systems, contracting systems, clinical systems, and claims systems. Integration will allow us to better track the percentage of VBP payments in relation to claims payments and ensure provider expectations are being met. While data integration is the overarching strategy, Individual steps include:

- **Ensure payment systems can administer non-FFS based arrangements –** We continue to leverage the Provider Incentive Payment System (PIPS), a tool that streamlines the administration of PMPM payments. The tool facilitates a programmatic structure to manage attributed member-based payments made according to different quality performance levels, and population risk tiers. The system is integrated with our claims system, taking advantage of existing provider EFT payment pathways. This infrastructure has added significant efficiency to the process of evaluating and ultimately making PMPM payments to providers. In 2022, we plan to continue to migrate other PMPM-based payment programs into PIPS to leverage the workflow and reporting capabilities. This will include all of our current and future primary care capitation contracts.
- **Ensure metrics calculation and analytics tools can generate robust reports –** JCC's HIT infrastructure, which is powered by CareOregon's analytics platform and resources, will play a key role in monitoring both CCO performance and accountability of its partners. Our analytics platform is the result of considerable investments to ensure that validated and reliable metrics are available. Data and measures will be regularly shared with partners to identify opportunities and drive performance. Our platform is capable of attributing members to clinics (PCPCH assignment) and can also track members as they move from one delivery network to another. It also manages attributions

for dental relationships. Maintenance of provider attribution information has required considerable effort and will be an area of continuous improvement to ensure that performance is tracked accurately in an increasingly risk-bearing environment for physical, dental, and behavioral health. CareOregon continues to partner with Wakely, our consulting actuaries, to provide monthly reporting packets to our Total Cost of Care VBP partners. These reports are reviewed in depth at our monthly provider meetings. We plan to continue this partnership with plans to enhance reporting and bring pieces of the work in house. All of this will enhance our flexibility and nimbleness in meeting the needs of our provider partners.

3. **Explore additional enhancements and technologies**

While the PIPS tool remains a key to our VBP programs and oversight, we are continuing to evaluate the market for tools to enhance our capabilities. We are evaluating a potential RFP process in Q2 2022 to identify additional tools and opportunities.

During 2020-2021 we explored integration options and feasibility of integration of these systems, and we developed concrete roadmaps based on findings. In the coming years, we expect to implement identified roadmap items and make them fully operational in years 4 and 5. Additionally, our capability to more nimbly calculate and report on metrics in new care delivery areas will be enhanced as we continue to expand our EDW. Given that we have not yet developed the payment models for future years, we cannot articulate specific data-related milestones as we do not yet know the performance metrics or other parameters associated with those models.

In the latter half of 2020-2021 we implemented a business glossary (data dictionary) in order to support continued data fluency across the organization. We are also migrating our EDW from on premise MSSQL infrastructure to Snowflake (hosted on Microsoft's cloud platform – Azure) in support of the increasingly large datasets which we have cultivated.

Due to the impact of COVID, dates for milestones have been extended an additional year.

VBP Scorecards:
CareOregon provides scorecards with clinic and system-level performance across its VBP programs. The largest program is:

A. Primary Care Payment Model (PCPM). Providers participating in this program receive semi-annual performance reports including data on clinical quality, behavioral health integration, oral health integration, language access, and processes that impact cost of care.

BH Composite Score:
CareOregon has updated the composite score quality payment methodology that Health Share initially developed. The updated methodology includes measurement of Feedback Informed Treatment (FIT) along with a number of other quality metrics relevant to behavioral health services. Providers receive scorecards that outline their performance on these quality metrics in order to improve their performance. This methodology offers quality incentive payments to providers for performance relative to a set of behavioral health quality metrics for both mental health and substance use disorder providers. The current iteration of the program aligns with the BH CDA requirement.

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

- Scorecards and quality metric data (PCP only)

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

Strategies:
Unite Us/Connect Oregon was the major strategy utilized in JCC to bring about the connection of a CIE for CBO and clinic partners.

Successes:
JCC staff were able to provide TA for one of our large CBO partners on implementing both oral and behavioral health screenings into their workflow and contract. This provider's contract was also changed in 2021 to include VBP component for successfully completing these screenings as well as implementing and utilizing Unite Us/Connect Oregon.

JCC's largest FQHC was willing to pilot several projects to improve utilization of the Unite Us/Connect Oregon platform. This included creating innovative ways of improving referral pathways between primary care and behavioral health. This clinic is now in the top 10 providers in the State in receiving and sending referrals utilizing Unite Us/Connect Oregon.

ii. Additional progress specific to physical health providers

See Strategies for All Provider Types

iii. Additional progress specific to oral health providers

See Strategies for All Provider Types

iv. Additional progress specific to behavioral health providers

See Strategies for All Provider Types

v. Additional progress specific to social services and CBOs

See Strategies for All Provider Types

vi. Please describe any barriers that inhibited your progress

- Barriers continued to revolve around the impact of COVID on workforce and bandwidth to implement Unite Us/Connect Oregon.
- Training agencies multiple times due to key turnover of staff.
- The entire Unite Us integration must be custom built. CareOregon, HSO, and PacificSource have collaborated with the vendor to develop specifications on how to build this integration.
- There are multiple CIE platforms being utilized in Jackson County, including VisionLink to support wildfire survivors and HMIS for coordinated entry. Platform integration with Unite Us via CareOregon and JCC advocacy is needed to ensure that DHS and state-funded community-based organizations are not forced to navigate multiple platforms in process of addressing social needs of our population, particularly for wildfire survivors, hardest hit in our region in 2020.
- Additionally, the current infrastructure of many of our local community-based organizations does not support data collection systems along with the staffing of data analysts, making the collection and sharing of data challenging.

B. 2022-2024 Plans

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

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

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

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

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

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

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

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

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

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

Current plans are focused on optimizing receipt and structuring of Unite Us data, and this work will continue through the end of 2022. Additional data sources will be incorporated into the data model throughout 2023,

with new proactive outreach efforts beginning in 2023 as well. We plan to enhance our segmentation and risk stratification methods in 2024, using those tools to improve care coordination targeting and other population health program development.

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

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

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

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

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

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

ii. Additional plans specific to physical health providers

See Strategies for All Provider Types

iii. Additional plans specific to oral health providers

See Strategies for All Provider Types

iv. Additional plans specific to behavioral health providers

See Strategies for All Provider Types

v. Additional plans specific to social services and CBOs

See Strategies for All Provider Types

C. Optional Question

How can OHA support your efforts in supporting the use of, and using HIT to support social needs screening and referrals for addressing SDOH needs?
• Support of Statewide CIE platform • Coordination and support of HMIS platform inter-operability with Unite Us/Connect Oregon • Additional funds for CBOs to support needed upgrades of equipment and staff with expertise in CIE/HIE platforms

6. Other HIT Questions (Optional)

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

A. How can OHA support your efforts in accomplishing your HIT Roadmap goals?
Investigate methods for capturing additional details related to diversity, ethnicity, and inclusion for those individuals on the Oregon Health Plan. A large percentage of our members come onboard without this information having been captured. For those instances where we (the CCO) can collect that data, it would be helpful if there were a more streamlined way for us to feed that information back to OHA (in order to update those records). We recognize that acquisition of that data has many challenges and would welcome any opportunity to discuss options or brainstorm ways that we can further understand our population in order to best support them.
B. How have your organization's HIT strategies changed or otherwise been impacted by COVID-19? What can OHA do to better support you?
The workforce shortage has been one of the biggest challenges for implementing HIT strategies. We have had to suspend many of the areas we had been working on due to capacity issues.
C. How have your organization's HIT strategies supported reducing health inequities? What can OHA do to better support you?