# CCO 2023 HIT Roadmap

## PacificSource CO_CG_LN_MP, Report Template **Option B**

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

**Please be sure to:**

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

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# 2023 HIT Roadmap

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

**CCO:** PacificSource: Columbia Gorge, Central Oregon, Lane and Marion-Polk

**Date: 3/15/2023**

## 1. HIT Partnership

Please attest to the following items.

| | | |
|---|---|---|
| **a.** | ☒ Yes<br>☐ No | Active, signed HIT Commons MOU and adheres to the terms. |
| **b.** | ☒ Yes<br>☐ No | Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU. |
| **c.** | ☒ Yes<br>☐ No<br>☐ 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<br>☐ No | Participated in an OHA HITAG meeting, at least once during the previous Contract year. |

## 2. Support for EHR Adoption

### A. Support for EHR Adoption: 2022 Progress and 2023-24 Plans

Please describe your 2022 progress and 2023-24 plans for supporting increased rates of EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers.

**Strategy checkboxes**
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans 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): |

Per the Data Completeness Table in the OHA-provided CCO HIT Data Reporting File, the following tables identify the number of contracted physical, oral, and behavioral health organizations without EHR information, by CCO region:

| **CCO:** **Central Oregon** | Number of Contracted Providers | Number w/out EHR Adoption | Percent w/o EHR Adoption | Number of contracted PCPCHs | Number w/o EHR Adoption | Percent w/o EHR Adoption |
|---|---|---|---|---|---|---|
| Physical Health | 80 | 29 | 36% | 18 | 0 | 0% |
| Behavioral Health | 202 | 159 | 79% | 0 | 0 | 0% |
| Oral Health | 24 | 17 | 71% | 0 | 0 | 0% |

| **CCO:** **Columbia Gorge** | Number of Contracted Providers | Number w/o EHR Adoption | Percent w/o EHR Adoption | Number of contracted PCPCHs | Number w/o EHR Adoption | Percent w/o EHR Adoption |
|---|---|---|---|---|---|---|
| Physical Health | 27 | 8 | 30% | 10 | 0 | 0% |
| Behavioral Health | 28 | 17 | 61% | 1 | 0 | 0% |
| Oral Health | 9 | 5 | 56% | 0 | 0 | 0% |

| **CCO:** **Lane** | Number of Contracted Providers | Number w/o EHR Adoption | Percent w/o EHR Adoption | Number of contracted PCPCHs | Number w/o EHR Adoption | Percent w/o EHR Adoption |
|---|---|---|---|---|---|---|
| Physical Health | 99 | 42 | 42% | 25 | 0 | 0% |
| Behavioral Health | 238 | 178 | 75% | 1 | 0 | 0% |
| Oral Health | 41 | 21 | 51% | 0 | 0 | 0% |

| **CCO:** **Marion Polk** | Number of Contracted Providers | Number w/o EHR Adoption | Percent w/o EHR Adoption | Number of contracted PCPCHs | Number w/o EHR Adoption | Percent w/o EHR Adoption |
|---|---|---|---|---|---|---|
| Physical Health | 93 | 22 | 24% | 38 | 0 | 0% |
| Behavioral Health | 111 | 74 | 67% | 2 | 0 | 0% |
| Oral Health | 42 | 26 | 62% | 0 | 0 | 0% |

[redacted]

**General Summary:**

PacificSource Community Solutions (PCS) continued to see turbulence in the provider environment throughout 2022 due to the ongoing COVID-19 pandemic. As a result, we continued to minimize non-critical outreach to providers and kept focusing on internal steps to improve our data collection methodology and reporting. We also focused on collecting missing EHR information via existing processes. None of these activities increased the burden on our provider partners while they continued dealing with the fallout of the pandemic.

We started the year incorporating EHR data from the Oregon Health Authority's (OHA) 2021 HIT Survey and accompanying 2021 HIT Data Reporting file received in January into our internal HIT data reporting and tracking database to establish a baseline from which to work. Throughout the year, we used a multitude of internal methods to add or correct information and fill gaps.

We also took an opportunity to review "Open-ended responses" in the OHA's 2021 HIT Survey Mini Report to identify organizations that voiced a need for support. An example was a Central Oregon organization that requested IT consulting around data collection system setup. As PCS does not provide this service, we facilitated a hand-over to the Central Oregon Independent Practice Association (COIPA), who does.

While not an activity noted in our 2022 HIT Roadmap, PCS also took time to increase general health information technology (HIT) knowledge internally. Many PCS staff engage directly with providers throughout our CCO regions. These internal education sessions prepared them for potential provider-facing conversations around HIT-related technologies and data.

- Delivered a Health Information Exchange (HIE) Overview to:
    - Provider Services staff, supplemented with an HIE Terminology and Purpose handout
    - The Business Intelligence Team
    - An All-IT Staff Meeting

- Updated our "HIE System Login How-To Guide" used by staff in roles with a need for EHR/HIE system access. The Guide provides step-by-step instructions for requesting system access and engaging with the PCS Health Information Exchange & Technologies (HIET) Program team.

These steps continued our progress in building a more solid foundation from which to drive adoption as the pandemic subsides and providers return to normal operations.

**Briefly describe CCO plans for collecting missing EHR information via CCO already-existing processes:**

Plans to collect missing EHR information via existing processes includes using a collection of technology methods and relationship-based activities. General strategies are noted below. More specific details about these strategies are detailed in Strategy 1.

- Analyze and incorporate information from the 2021 HIT Data Reporting File into internal tracking tools to confirm and enhance existing data results and establish a baseline from which to work.
- Collaborate with provider-facing internal teams.
- Leverage partnerships with external organizations such as IPAs and Health Councils.
- Introduce and maintain community binding opportunities such as HIT Collaboratives and Joint Operating Committees.
- Leverage and enhance our customer relationship management (CRM) technology to support provider partnerships and maintain more detailed records on HIT.

**Strategy 1 title**: **Develop Assessment & Monitoring Process for EHR Adoption Across Provider Types**
Description: Establish a process for gathering and tracking EHR adoption data.

**Provider types supported with this strategy:**

☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS received its 2021 HIT Survey and HIT Data Reporting file from the OHA in late January and transferred the data into an internal HIT tracking database to establish a baseline from which to drive 2022 activities. Once the data was staged, we used the following methods throughout the year to verify, correct and supplement the information:

- Partnered with internal teams that meet face-to-face with providers to gather knowledge of EHR use during one-on-one conversations. Internal roles included Provider Services, Population Health Strategists and Coaches, CCO Directors and Regional Community Health Coordinators.
- Asked partners at key IPAs, such as COIPA and the Willamette Health Authority (WVP) in the Marion-Polk region, to provide and/or verify data about the EHR tools used in their contracted provider networks.
- Gathered insight from Health Council partners about EHR use throughout their communities.
- Asked community-based HIT Collaborative provider members about the EHR systems they use, and any input or awareness they have into what their peers are using.
- Sourced EHR data from the Quality Incentive Metrics Outreach Survey.
- Reviewed Delivery Service Network reports showing actively contracted providers to ensure our database remained comprehensive.
- Corroborated information against available external resources, like the Certified Health IT Product list.
- Used our customer relationship management (CRM) technology to support provider partnerships and maintain more detailed records on HIT.
- Specific to DCO adoption, worked with the PCS Dental Services Program Manager to better understand DCO EHR adoption, capture opportunities and organize discussions with our contracted DCOs.

Starting mid-year, Provider Services gently re-introduced minimal outreach to providers and used its Site Visit and Evaluation Form to gather HIT data. The results were captured in our CRM database. All provider and facility types were eligible for these visits including primary care physicians (PCPs), specialists and behavioral health (BH) providers. Unfortunately, Provider Services has continued to receive a lot of resistance to meeting with providers, both due to ongoing pandemic impacts and because providers do not want to bring more people into their physical office space unnecessarily. For this reason, visits were limited only to those providers who initiated a conversation with the Provider Services team for any reason and then indicated a willingness for a more extensive, onsite conversation. We are eager to see if this trend continues as it seems that in late Q4 2022 and in early Q1 2023 we are seeing increased willingness from providers to come to the table as the pandemic pressures wane.

To support and validate the above activities and methods, we also completed an annual review of our Electronic Health Records Adoption Policy.

**Plans:**

We are considering deploying a new HIT survey with our contracted providers in 2023, as it will be two years since the OHA HIT Survey was completed. We have yet to determine whether to survey the entire PCS delivery service network (DSN) or target only providers for whom we have a particular gap in data. Other internal teams have a need to survey the same audience on the same timeline to support the initial phase of the Social Determinants of Health (SDOH) Quality Improvement Metric (QIM). As we finalize survey plans, we will be thoughtful to not create additional burden and survey fatigue with providers. We will also explore how we might leverage our CRM to store additional HIT data.

| Completed Activities | Planned Milestones |
|---|---|
| By prototyping HL7 transmissions for EHR data, assess feasibility (Reliance) | N/A |
| **Planned Activities – Ongoing** | |
| Collect data on EHR status across range of health providers. | 2023 – 2024 |
| Use Delivery System Network report to identify in-scope providers. | 2023 – 2024 |
| Compare in-scope list with catalog of contributors from Regional Health Information Organization (RHIO) operating in region (e.g., Reliance in areas where they are providing services). | 2023 – 2024 |
| Collect data from providers with unknown status. | 2023 – 2024 |
| Corroborate baseline against any available external sources (e.g., Certified Health IT Product List). | 2023 – 2024 |
| Continue to re-integrate internal and external data to report progress. | 2023 – 2024 |
| Formalize and document PCS policy and procedure for assessment and monitoring, and review/update annually. | 2023 – 2024 |
| Collect EHR data via Provider site visits | 2023 – 2024 |
| Add updated EHR data to CRM database | 2023 – 2024 |
| **Planned Activities – New** | |
| Explore deploying HIT survey with CCO contracted providers | 2023 |
| Explore CRM for storing additional HIT data | 2023 |

**Strategy 2 title**: **Build approach and model for deploying adoption support resources.**
Brief description: Identify and implement methods for setting adoption goals and advancing awareness, adoption and ultimately usage of EHR systems.

**Provider types supported with this strategy:**

☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

Given the ongoing nature of the COVID-19 pandemic throughout 2022, our primary focus continued to be the advancement of awareness and education with our CCO governing boards and key provider partners about our approach to this work. To this end we:

- Maintained a regular virtual meeting cadence with Joint Operating Committees (JOC) across regions where those committees exist. These JOCs provide important connecting points to drive our awareness and education efforts forward, can be used to monitor the pulse of provider capacity to engage with HIT, and discuss potential gaps in community EHR adoption that create a negative impact such as a key provider whose lack of an electronic health record negatively impacts their ability to transition care to other regional partners. Examples include St. Charles and the COIPA JOCs in Central Oregon, the WVP Health Authority and Kaiser JOCs in Marion-Polk, and others. In regions where JOCs do not exist such as the Columbia Gorge, this work is done via direct payer/provider relationships.
- Collaborated with each CCO Health Council to deliver region-specific updates on plans and progress.
- Leveraged community binding opportunities connected through the regional Health Councils to share and collaborate on specific HIT goals for their respective communities. Examples of PCS delivered presentations include to the Marion-Polk CCO HIT Collaborative and the Central Oregon HIE (COHIE) Community Meeting.
- Maintained contractual and supportive arrangements with IPAs to support their endeavors to offer a multitude of important, HIT-related consulting, advising and technical services to small independent provider practices.

In considering a threshold to determine which non-EHR clinics should receive adoption support, we gathered data detailing assigned members and claims volume and noted which of the high-volume providers used an EHR. We also developed region-specific adoption reports from the data results, which we shared and discussed with the CCO Directors and Health Council partners highlighting EHR adoption status and gaps

within each region's contracted provider services network. Together, we refined engagement targets based on their community-based insight into specific population needs.

(Note: Some of our 2022 named activities were very specific to how we would create a regional threshold for adoption support (for example, >2% of assigned members or encounters with >2% of CCO population, annually). In retrospect we found it more effective to consult with internal CCO Directors and external Health Councils to identify specific pain points and identify where support could drive the most improvement. We found these conversations more helpful in setting goals than identifying specific percentage growth baselines. Given the change in focus, the volume of organizations identified for adoption support may be more or less than the >2% initially identified.)

Status on progress:

- EHR adoption in the Columbia Gorge is fairly mature; no additional targets were identified for now although we did learn of one provider that is considering replacing its existing EHR. To support their search, PCS shared which EHRs are in use by others in our delivery service networks of a similar provider type to help them narrow their search focus, which they shared was quite difficult given the many options to choose from. Another provider in this region is transitioning to a new EHR as a result of an acquisition, which we expect to be disruptive.
- After presenting Marion-Polk data to our internal CCO Director, Community Health Coordinator and the external Health Council Clinical Advisory Panel (CAP) Manager, discussions continue within the HIT Collaborative that is managed under the Health Council CAP.
- Central Oregon (CO) data was presented to the internal PCS CCO Director and Community Health Coordinator, and to the new CO Health Council Executive Director after she came on board mid-year.
- Lane data was presented to the internal CCO Director, Community Health Coordinator and the external Health Council Executive Director. Conversations have begun with the Health Council and the other CCO serving Lane County around how this information might be used in a joint HIT Collaborative-type forum coordinated through the Health Council in 2023.

Discussions with Health Councils to identify engagement targets included a review of the PCS Electronic Health Record Adoption Policy, which highlights the Health Council's role in identifying regional providers whose EHR gap causes care coordination issues within the community – a critical benchmark for receiving adoption support.

Another method that has proven effective in identifying an EHR need or readiness is looking for a provider who needs support in *any* area of HIT and then steering that conversation to discuss EHR if appropriate. For example, PCS reached out to a key provider in the Columbia Gorge to discuss their Collective Medical (CMT) eligibility file to optimize their use of that platform. During that conversation, PCS learned the organization was actively evaluating a new EHR. PCS used this unexpected information to discuss EHR adoption and, as noted earlier, shared a list of EHR tools used by other PCS-contracted providers of a similar service type.

We will continue working with the regional Health Councils and CAPs in early 2023 to refine and finalize adoption strategies and plans for the year. We have modified the relevant activity below to reflect the changes in how we will set regional thresholds for adoption support discussed above.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| Review and analyze 2021 HIT Survey data and OHA HIT Data Reporting File and return updates to OHA. | **N/A** |
| **Planned Activities – Ongoing** | |
| Develop peer relationships through payer and provider Joint Operating Committees with high impact provider partners as a conduit to education/awareness activities. | 2023 – 2024 |
| Debrief Health Councils on successes and opportunities with EHR. | 2023 – 2024 |

| | |
|---|---|
| Establish regional threshold above which non-EHR clinics receive adoption support in partnership with the Health Council. | |
| Complete scoping analysis of resources needed to address gaps in EHR adoption. | 2023 – 2024 |
| Use baseline to categorize providers without EHR by impact based on assigned CCO members or annual visits by CCO members. | 2023 – 2024 |
| Consult Health Council and CAP to define high-priority populations—e.g., members affected by chronic pain, behavioral health conditions, incarceration, limited English proficiency, or foster care involvement. | 2023 – 2024 |
| Present proposed adoption improvement targets to Health Council and CAP, as appropriate, in each region. | 2023 – 2024 |

**Strategy 3 title: Encourage and support EHR Adoption.**
Brief description: Support and monitor EHR implementations and report back to key stakeholders. Operationalize the process where possible.

**Provider types supported with this strategy:**
☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

In each of our regions, EHR adoption remains high for the majority of our larger practices and systems. There are known gaps with our smaller practices that we continue to evaluate. We remain strategically focused on the partners who will have the most impact and those who will be more amendable to move forward because of expanded contractual relationships or other factors.

For smaller practices that are not as able to engage, we continue to develop a core set of educational resources.

- We learned some providers are confused by the different HIT tools available and the purpose and function of each. To support better general HIT education and future adoption, we created an “HIE Terminology and Purpose” handout for sharing as needed.
- PCS teams have access to an “Electronic Medical Record Access” handout to share with providers explaining why we request access to their EHR. It highlights the scope of use and benefits of access to the EHR for different internal PCS organizations such as Appeals and Grievances and Care Management, among others, for whom this information is critically important.
- We also make connections where possible to connect those seeking information with the appropriate resource.

PCS also supports smaller practices indirectly via our relationships and support of the IPAs in our CCO regions who provide front-line adoption and technical support for many of the independent small providers.

After reviewing the existing data with Health Councils as described in EHR Strategy 2 – Build approach and model for deploying adoption support resource, the discussion pivoted to identifying which non-adopting providers could generate the most benefit from EHR adoption and whether they were ready to start this engagement. Our stated goal for 2022 was to deploy at least one resourcing strategy with five non-adopting providers. However, we paused as there continued to be challenges to engage on this topic given the ongoing nature of the COVID-19 pandemic and its impacts on the care delivery system. And similar to earlier comments, we felt it more appropriate to set targets based on specific needs of the community rather than identify a set, numerical count by region.

PCS also reviewed its existing CCO provider contract language for possible amendments that could drive EHR adoption and use. While the language doesn’t explicitly require a provider to adopt an EHR, it does include compliance language about enabling PCS access to an EHR when one exists, which we believe is sufficient and appropriate. That said, we do expect providers to follow Health Information Technology for Economic and Clinical Health (HITECH) Act standards for obtaining an EHR.

**Additional Progress Specific to Oral Health Providers:**

To encourage support and adoption with oral health providers, our HIET Program team partners with the PCS Oral Health Program Manager to discuss HIT tool adoption and develop related strategies specific to this provider type.

**Additional Progress Specific to Behavioral Health Providers:**

PCS experienced staffing changes in its Population Health – BH team during 2022, which slowed progress in this area. Once a new team leader onboarded, the HIET Team introduced its HIT program and goals and restarted discussions around opportunities and challenges specific to BH providers.

Our HIET Team also supports the BH Performance Improvement (PIP) Group. This work includes support for BH barrier analysis and identification of program-level interventions.

The HIET team begin drafting an "EHR FAQ," which includes strategic talking points for Population Health teams to use when talking about information-sharing between providers. The intent is to create a resource that conveys potential EHR benefits to BH providers and their clients. It is specific to small BH providers because this care type has had the most resistance to, and lowest level of, EHR adoption. Many small, independent BH providers are those just entering the field and may not have exposure to this type of information yet.

The majority of 2022 activities continue in 2023. We also intend to review our existing Provider Manual for potential amendments that might drive EHR adoption.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| Review provider contract language and work with Provider Network to determine if contract amendments should be made. | N/A |
| **Planned Activities – Ongoing** | |
| Facilitate peer learning to inform understanding of landscape | 2023 – 2024 |
| Use resource assessments derived from EHR adoption plans to support requests made through the annual enterprise IT planning process | 2023 – 2024 |
| Evaluate internal and external resources and acquire additional resources as needed. | 2023 – 2024 |
| Identify providers and sites to target for EHR adoption. | 2023 – 2024 |
| Set numeric targets for future change in adoption rates in consultation with regional Health Councils, HIT Community Collaboratives and CAP. | 2023 – 2024 |
| Create EHR/HIE information packet to deploy. | 2023 – 2024 |
| Conduct a readiness assessment of non-EHR providers to adopt an EHR. | 2023 – 2024 |
| Complete deployment of at least one resourcing strategy listed above with non-adopting providers as determined with Health Councils. | 2023 – 2024 |
| Conduct a readiness assessment of non-EHR providers to adopt an EHR. | 2023 – 2024 |
| Support and monitor EHR implementations and report back to Health Council, HIT Community Collaboratives and CAP on progress. | 2023 – 2024 |
| **Planned Activities – New** | |
| Review Provider Manual for potential amendments to drive EHR adoption | 2023 |

**Please describe any barriers that inhibited your progress supporting EHR adoption among your contracted providers**

- Pandemic-related challenges continued to reduce the time and willingness for partners to engage.
- While the level of data quality, consistency, and accuracy required to establish an accurate baseline improved, there are still gaps in knowledge of actual adoption rates.
- Focus continued to be placed on other more pandemic relevant HIT Roadmap areas, primarily Community Information Exchange (CIE) and Hospital Event Notifications (HEN). This resource

rebalancing, in conjunction with barrier 1 above, continued to defer some work around Roadmap EMR access.

- Emerging standards and an immature vendor solution landscape for Fast Healthcare Interoperability Resources (FHIR) based interoperability continue to cause delays in market alignment around these technology options.
- Small providers without dedicated IT staff are not as apt to devote time to implement new technology.
- Cost of implementing a new EHR system continues to be an obstacle and, in some cases, has increased because of additional financial pressures on providers. All provider types are impacted.
- Providers don't have a sense of which EHR might be appropriate for an organization of their service type and size and the research can be overwhelming and confusing.
- Smaller (and new) BH providers in private practice don't always understand how an EHR adds value.

### B. Optional Question

| **How can OHA support your efforts in supporting your contracted providers with EHR adoption?** |
|---|
| New or additional State level funding offsets given Medicaid Promoting Interoperability EHR incentive program ended at the end of 2021. Would also appreciate further support for low-cost, standards-based integrations from EHRs to other systems such as Reliance, Connect Oregon, and so on. |

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

### A. Support for HIE – Care Coordination: 2022 Progress and 2023-24 Plans

Please describe your 2022 progress and 2023-24 plans for supporting increased access to HIE for Care Coordination, ***excluding hospital event notifications and CIE***, among contracted physical, oral, and behavioral health providers.

**Strategy checkboxes**
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

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

**HIE for care coordination tools CCO supports or provides** (excluding hospital event notifications and CIE)

**List and briefly describe tools**:

**Reliance eHealth Collaborative** – PCS continues to be a strong supporter of the Reliance eHealth Collaborative, which leverages IMAT technology to host its clinical data repository. We have seen the

strongest adoption of Reliance in our Central Oregon and Columbia Gorge regions. In addition to being a recipient of Reliance health record data, PCS also contributes administrative claims data to Reliance, including filled prescriptions, so newly on-boarded providers in those regions will see encounter history even if the providers who delivered the service are not yet contributing data. In 2022 we added the claims data for the Marion-Polk region to our data feed.

**Reliance eHealth Referrals** – Reliance maintains a specialty referral capability within its platform; however, this capability is only leveraged in the Columbia Gorge CCO, and adoption is waning.

**EpicCare Everywhere** – The majority of members in our service areas are covered by physical health providers that use Epic, including the hospital systems and Federally Qualified Health Centers (FQHCs). This allows Epic providers in our community to communicate directly through Epic or through "look in" functionality using EpicCare Everywhere, which provides clinical data for providers who use Epic and other affiliated electronic health systems. We have bi-furcated our strategy to capitalize on the significant capability provided by EPIC and its various HIT components while always working to ensure parity of capabilities between non-Epic providers, and between EPIC and non-Epic providers.

**EpicCare Link** – Similar to EpicCare Everywhere, EpicCare Link provides non-Epic users access to Epic-based records through a web portal rather than direct Epic-to-Epic communication. EpicCare Link provides PCS Care Management and Utilization Management staff access to Epic-based member records to manage care coordination.

As an extension of EpicCare Link functionality, in late 2022 PCS learned of **Epic Happy Together Link**, a method to simplify access to multiple Care Link portals via a button on the Care Link portal interface. Happy Together Link provides single sign-on functionality to all Epic Care Link accounts to which a Care Link user has credentials, without requiring the user to log into each account separately. Epic encourages healthcare entities to install this free utility as part of their Epic installation; however, implementation does require effort by the healthcare organization so actual availability depends on the healthcare organization's priorities.

**CCO Provider Portal** - Our CCO provider portal offers several different tools in support of care coordination such as patient assignment, quality performance and Member Insight Population Health Reporting (MiPi).

**CCO Member Portal** – Launched in 2022, a new CCO member portal offers a new digital experience that transformed our Community Solutions website into a dedicated Medicaid Members section on PacificSource.com. This new secure web portal improves accessibility and access to care by helping CCO members stay connected online or on their mobile phone. CCO members have direct access to personalized information about their care, allows them to view, print and order ID cards, learn about benefits, find a doctor, see claims and explanations of benefits, track pre-authorizations and referrals, and ultimately get the most from their benefit plan. Requirements included Spanish localization, ADA accessibility, Medicaid-specific content and customizations including by CCO region and type.

**Telehealth** - Our CCO supports telemedicine in physical and behavioral health settings. We continue to leverage a suite of Analytics to understand our members' ability to access telehealth care equitably. These analytics help support and bring visibility to the value of telehealth in maintaining care continuity when physical access to care is limited. We maintain this data and share it with our providers during JOC Committee meetings.

In 2022, PCS participated in the Deschutes County Broadband Action Team tasked with gaining a clear picture of the current broadband environment across Deschutes County (part of the Central Oregon CCO service area) and then using funding available to local governments to expand options for broadband access across their cities/counties to reach underserved and unserved populations. To get those funds, organizations must clearly articulate where and how the funds will be allocated and who they will impact. PCS is a voice at the table to help identify underserved/unserved areas and populations through our health

plan perspective. This work aligns with the PCS value of working to advance equity in the community and our strategy of engaging and investing in our communities. It continues into 2023.

**Secure Messaging** – Direct secure messaging is limited in each of our regions. PCS does not currently maintain a direct secure messaging platform for use in care coordination.

**Secure File Transfer (SFTP)** – PCS exchanges significant care coordination information with provider partners using this method. A significant volume of monthly reporting and other analysis is transmitted using this method.

**Fax/e-Fax** – The fax infrastructure in facilitating the exchange of health information is still key in supporting numerous provider-to-provider and CCO-to-provider workflows. In a number of CCO regions, this is still the primary method for health information exchange.

**FHIR** - PCS continues its work building FHIR-based interoperability capabilities focused on extension/engineering of internal data resources, integrations with existing business platforms and development of HIE and other partnerships in support of the patient portal requirements of the Office of National Coordinator (ONC)/Centers for Medicare & Medicaid Services (CMS) rules with HIE. The PCS interoperability roadmap was extended to enable use of FHIR to support internal and partner data exchange beyond those required for regulatory purposes.

Per the Data Completeness Table in the OHA-provided CCO HIT Data Reporting File, the following tables identify the number of contracted physical, oral, and behavioral health organizations without HIE for Care Coordination information, by CCO region:

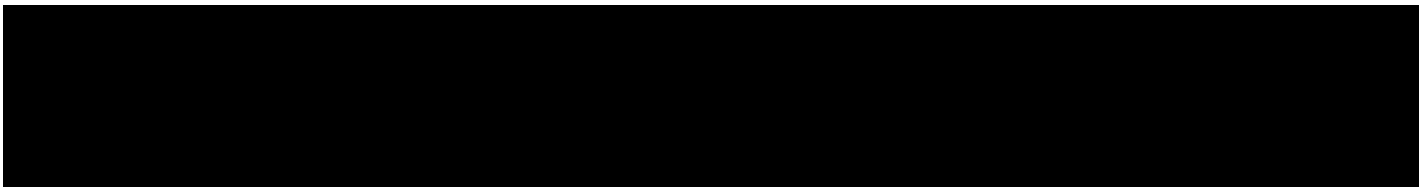
| **CCO:** **Central Oregon** | Number of Contracted Providers | Number w/o HIE Adoption | Percent w/o HIE Adoption | Number of contracted PCPCHs | Number w/o HIE Adoption | Percent w/o HIE Adoption |
|---|---|---|---|---|---|---|
| Physical Health | 80 | 41 | 51% | 18 | 1 | 6% |
| Behavioral Health | 202 | 197 | 98% | 0 | 0 | 0% |
| Oral Health | 24 | 22 | 92% | 0 | 0 | 0% |

| **CCO:** **Columbia Gorge** | Number of Contracted Providers | Number w/o HIE Adoption | Percent w/o HIE Adoption | Number of contracted PCPCHs | Number w/o HIE Adoption | Percent w/o HIE Adoption |
|---|---|---|---|---|---|---|
| Physical Health | 27 | 11 | 41% | 10 | 0 | 0% |
| Behavioral Health | 28 | 24 | 86% | 1 | 0 | 0% |
| Oral Health | 9 | 7 | 78% | 0 | 0 | 0% |

| **CCO:** **Lane** | Number of Contracted Providers | Number w/o HIE Adoption | Percent w/o HIE Adoption | Number of contracted PCPCHs | Number w/o HIE Adoption | Percent w/o HIE Adoption |
|---|---|---|---|---|---|---|
| Physical Health | 99 | 56 | 56% | 25 | 3 | 12% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Behavioral Health | 238 | 233 | 98% | 1 | 0 | 0% |
| Oral Health | 41 | 39 | 95% | 0 | 0 | 0% |

| **CCO:**<br><br>**Marion Polk** | Number of Contracted Providers | Number w/o HIE Adoption | Percent w/o HIE Adoption | Number of contracted PCPCHs | Number w/o HIE Adoption | Percent w/o HIE Adoption |
|---|---|---|---|---|---|---|
| Physical Health | 93 | 56 | 60% | 38 | 14 | 37% |
| Behavioral Health | 111 | 106 | 95% | 2 | 1 | 50% |
| Oral Health | 42 | 40 | 95% | 0 | 0 | 0% |



**General Summary:**

As noted earlier, PCS continued to minimize non-critical outreach to providers during 2022 as COVID-19 and related staffing challenges persisted in consuming provider attention and resources. While this delayed implementation of our HIE strategy, we did continue to build out high value use cases by focusing efforts on state and regional challenges presented by the pandemic. We also focused on internal efforts to build infrastructure and solve systemic problems. Our continued, reduced external outreach gave us more time to continue building the growth and network health of the Connect Oregon community information exchange (CIE) in all our CCO regions as internal teams had more bandwidth to assist our Social Determinants of Health (SDOH) and Equity team in the clinical and technological phases of implementation.

We made good progress maintaining existing and establishing new community HIE engagement opportunities, primarily through HIT Collaboratives across each of our CCO regions. Given the specific and nuanced needs of each region, each is moving forward on a unique pace matching its level of adoption readiness.

- Engagement continued with COHIE, our most established and long-standing HIT community collaborative.
- Engagement re-started in Marion-Polk; PCS partnered with the Willamette Health Council to re-establish the HIT Collaborative under the Health Council CAP and met several times throughout the year.
- Engagement was started in Columbia Gorge with participants developing an initial charter. Collaboration was paused while discussions continued about how to move forward with CIEs in the region.
- Engagement topics were discussed in Lane, but an HIT Collaborative was not ultimately started while a Behavioral Health CIE workflow pilot was underway.

Internal activities included integrating disparate information and/or tools with HIE, as follows:

- Expanded algorithms developed in 2022 to identify members experiencing social determinants of health issues using specific Reliance reports, Collective Medical data feeds, Connect Oregon/Unite Us database copies, claims data, electronic medical record data feeds, internal case management data, and eligibility files. This process assists in case management services, Health Council

reporting, population health assessments, identification of members eligible for program and services, and more.

- Improved COVID-19 member vaccination registry and tracking that informed member outreach strategies, monitoring, and collaborative outreach initiatives with community partners. Data sources included medical and pharmacy claims and reports from OHA, Collective Medical, Reliance, and CMS.
- Worked to improve the supplemental data feed from Reliance that was trialed in late 2021.

To support a more collaborative HIE environment, PCS continued to share its knowledge and expertise, where relevant and invited, at industry events. Examples include participating in an HIT Summary Spotlight and CCO panel at a Health Information Technology Advisory Group (HITAG) meeting in spring 2022.

PCS also arranged for others with HIE expertise to present information and knowledge at industry events. An example was inviting a COIPA representative to present on the value of HIE at Healthier Together Oregon (HTO), the State Health Improvement Plan, in May. This event focused on technology and innovation. The presentation highlighted how the combination of clinical and claims data from payers can close information gaps at the point of care. As an example, clinics often need to know if a patient has had an eye exam. While all providers might not be contributing this encounter to the HIE, if the health plan sends the claim information to an HIE, providers using the HIE can still confirm that the eye exam occurred.

PCS is currently the only payer adding this type of claims information to Reliance. The data being sent is currently limited to the Central Oregon and Columbia Gorge regions (where provider data contribution is currently most prevalent) and the Marion-Polk region, where data feeds began flowing to Reliance in 2022. PCS expects to add all claims for all regions and all lines of business to Reliance in 2023.

**Strategy 1 title**: **Develop assessment and monitoring process for HIE access and data contribution rates across provider types**
Brief description: Identify and implement methods to gather and track HIE adoption and usage.

**Provider types supported with this strategy:**
☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

In late January 2022, PCS received its 2021 HIT Survey and HIT Data Reporting file from the OHA and transferred the HIE data into an internal HIT tracking database to establish a baseline from which to drive 2022 activities. After staging the data, we used the following methods throughout the year to verify, correct and supplement the information:

- Partnered with internal teams that meet face-to-face with providers to gather knowledge of HIE use during one-on-one conversations. Internal roles included Provider Services, Population Health Strategists and Coaches, CCO Directors and Regional Community Health Coordinators.
- Asked partners at key IPAs, such as COIPA in Central Oregon and WVP in Marion-Polk to provide and/or verify data about the HIE tools used in their contracted provider networks.
- Gathered insight from Health Council partners about HIE use throughout their communities.
- Asked community-based HIT Collaborative provider members about the HIE systems they use, and any input or awareness they have into what their peers are using.
- Reviewed Delivery Service Network reports showing contracted providers to ensure our database remained comprehensive.
- Corroborated information against available external resources like the Certified Health IT Product list.
- Used our CRM technology to support provider partnerships and maintain more detailed records on HIT.

- Specific to DCO adoption, worked with the PCS Dental Services Program Manager to better understand DCO HIE adoption, capture opportunities and organize discussions with these contracted partners.

Starting mid-year, Provider Services gently re-introduced minimal outreach to providers and used their Site Visit and Evaluation Form to gather HIE data and capture the results in our CRM database. All provider and facility types were eligible for these visits including PCPs, specialists and BH providers. Unfortunately, Provider Services has continued to receive resistance to meeting with providers due to ongoing pandemic impacts including a desire to physically limit the number of extraneous visitors. For this reason, PCS only visited offices after a provider initiated a conversation with Provider Services for any reason and agreed to an onsite conversation.

**Prototype / Evaluate HL7 transmissions for HIE data:** The original intent of this activity was to ingest Health Level Seven (HL7) data files from Reliance into our data warehouse to increase supplemental data file returns for Healthcare Effectiveness Data and Information Set (HEDIS) and QIM reporting. After an initial evaluation, the HL7 method was replaced with our existing, standard flat file approach. PCS now receives regular Medicaid and Medicare data files from Reliance to source our data warehouse. We are eager to see the Auditor's response to our Medicare Supplemental Data File for HEDIS submission in 2023 given we expect a significant increase in the number of records being submitted that were accepted using this method last year

The majority of 2022 activities continue in 2023.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| Prototype Evaluate HL7 transmissions for HIE data. (Reliance) | N/A |
| **Planned Activities – Ongoing** | |
| Continue collecting data on HIE status across range of providers using internal and external sources | 2023 – 2024 |
| Use Delivery System Network report to identify in-scope providers | 2023 – 2024 |
| Compare in-scope list with catalog of data contributors from Regional Health Information Organization (RHIO) operating in region (e.g., Reliance in areas where they are providing services). | 2023 – 2024 |
| Collect data from providers with unknown status. | 2023 – 2024 |
| Corroborate baseline against any available external sources (e.g., Certified Health IT Product List). | 2023 – 2024 |
| Continue to re-integrate internal and external data to report progress. | 2023 – 2024 |

**Strategy 2 title: Establish and maintain appropriate resourcing and staffing to support multiple CCO regions**
Brief description: As noted by strategy title.

**Provider types supported with this strategy:**
☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

In 2022, the internal HIE program was renamed to Health Information Exchange & Technologies (HIET) to better reflect its broader goals and charter. It became fully staffed once a replacement HIET Program Coordinator was hired in February. PCS also continues to fund a full-time Care Management HIET Strategist who is embedded within the Care Management organization and is a matrixed member of the HIET team.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Monitor staffing annually and adjust as needed | 2023 – 2024 |

**Strategy 3 title: Prototype new high value use cases**
Brief description: Identify new use cases that we believe will provide high value in improving the level of care we provide to our CCO members, and develop, test and deploy them through HIE systems where possible.

**Provider types supported with this strategy:**

☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS devotes a significant amount of time each month toward building relationships with Reliance leadership through meetings to discuss strategy, technical development and implementation, and account and network development. PCS meets monthly with Reliance Executive Leadership and its Account and Technical team members. Reliance expects to add quarterly business reviews to our meeting schedule starting early 2023.

One of COHIE's long-stated priority objectives has been to identify high-value HIE use cases to illustrate and increase its value to providers of all types and other CCOs who have not yet adopted a centralized community health record. One of the top Reliance benefits is supporting provider and CCO performance on annual QIMs such as the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) metric, which historically has shown to be very difficult to meet. The fact that substance use disorder (SUD) episodes can occur in a variety of health settings (hospital, ambulatory, specialty, or mental health facilities) means SUD episode awareness must encompass an entire health community.

Key PCS use cases during 2022 included:

**Support ongoing and enhanced COVID-19 vaccine outreach:** PCS continued using its suite of tools that empowered internal and external teams to understand vulnerable populations, drive vaccination strategies, and increase healthcare equity. One tool was a set of dashboards geared at distilling insights to advance vaccine equity among Medicaid membership. Internal teams and partners used these dashboards to tailor vaccine outreach in more culturally responsive and linguistically inclusive ways. Teams also analyzed the dashboard to strategize on key community partners and trusted community leaders to engage in cross-continuum collaboration. The dashboard supported an understanding of geographic locations of unvaccinated Black, Indigenous, and People of Color (BIPOC) member populations to target locations for mobile vaccination clinic placement.

**Internally and externally available vaccine gap list:** This list allowed sorting of members so we could target critical groups for vaccination outreach and follow-up. For example, using this report, PCS identified members by vaccination status who had CDC-defined comorbid issues that could lead to severe COVID outcomes. We then cross-referenced that information with available REALD and SDOH measures such as housing and transportation insecurity to identify high-risk members with linguistic and transportation barriers that might complicate their ability to get fully vaccinated. We offered the member gap list to provider partners with assigned PCS membership to enhance their member outreach strategies.

**Incorporate lab test results:** We developed new methods to incorporate lab test results combined with claims data to create flagging for members who appear to have had COVID-19. COVID-19 history provides their first and most recent infection dates based on available data, whether and when they had a hospitalization for COVID-related illnesses, and whether or when they were diagnosed with post-COVID syndrome. This history is then made available in interactive member profile tools that Care Managers can use when working with high needs members. This information is intended to provide information that could be relevant to the care plan, needs, and health history of a member. This information also was used as a key performance indicator (KPI) in support of weekly COVID huddles held with PCS senior leadership and was used to support weekly updates to all staff by the PCS Chief Medical Officer.

**IET Report Pilot**: With PCS support, Reliance and COHIE held a pilot with four health organizations in Central Oregon to test and validate its new IET notification report, which is an alerting service to notify care management teams of IET index events in their patient population. The pilot used PCS member data and ran for six months [redacted]. Participants primarily focused on validating the IET notifications, timeliness, accuracy, and patient attribution to the clinic. Some used the IET notifications to operationalize outreach and track their patients.

All practices found the SUD push notifications from Reliance beneficial, timely and actionable for two primary reasons:

1. Timely awareness - notifications are triggered/produced next day, after the eligible SUD encounter. This is significantly faster than previous methods such as using claims data, which is critically important because the IET metric is time-based; the sooner the clinic knows of an event, the sooner they can engage and connect the patient for treatment.

   Reliance SUD notifications also perform a lookback period of ~14 days, added to ensure the report captured SUD encounters that were closed/signed up to 14 days after the patient had been seen. (Note: No notification will be picked up by Reliance until the encounter is signed. Occasionally encounters are signed days after the visit occurred.)

2. Combined with the SUD notifications, clinic staff used the Reliance Community Health Record (CHR) to view patient activity across much of the health community who contribute data to Reliance. This resource improved caregiver decision-making around care coordination, thus reducing phone calls to find out what happened, where the patient was, and who was caring for them. Most of this information could be sourced from Reliance CHR, but not all.

An issue uncovered by the pilot is that there is currently little to no visibility of patient activity in Reliance from BH or substance treatment facilities that fall under the 42 CFR Part 2 consent model. As a result, caregivers had a more difficult time discovering whether a patient had engaged with a SUD treatment facility. Pilot clinics underscored how important these facilities are and the important role they play in the treatment for SUD and in meeting the IET metric. Clinics currently receive IET quality measure data from insurance payers, sourced from claims data. Claims-based reports require more time to produce and don't include peripheral patient activity that clinics need. Many organizations are struggling with how to protect and/or share the type of information subject to 42 CFR Part 2 consent. Reliance is working on a proposed design to address data related to this consent challenge; it is currently noted for delivery in late 2023. PCS is also following the Notice of Proposed Rulemaking (NPRM) on 42 CFR Part 2 updates for guidance on how to proceed.

**Pharmacy Based Use Cases:** As a potential to drive future pharmacy-related use cases, a PCS Senior Clinical Pharmacist attended a Pharmacy use case overview and presentation with Reliance and Jackson Care Connect. While no specific pharmacy use case has resulted in Reliance yet from that presentation, having a better understanding of the capabilities could drive this type of use in the future.

**Oral Health Roster Files:** Specific to oral health providers, PCS worked with Reliance to develop DCO roster files for Advantage Dental and Capitol Dental that contained the PCS CCO members assigned to each DCO. This allowed the DCO affiliated clinic care managers to access PCS data for their assigned PCS patients within the Reliance CHR rather than having to obtain this information from outside sources such as faxing, phone calls, and other more manual methods. PCS continues to provide monthly roster updates to Reliance to keep these membership lists current for DCO use.

**Regular data feeds:** Reliance began sending PCS regular data files for Medicaid members in a format that is incorporated into PCS's existing EMR data staging extract, transform and load (ETL) data integration processes. Numerous new and/or enhanced algorithms were developed in 2022 to identify members who may have increased needs or health risks using diagnoses, procedures, and prescriptions. Data received from Reliance is also used in conjunction with other data sources such as pharmacy claims, medical claims, and CMT data feeds to identify members who may have:

- Chronic conditions such as autoimmune disorders, dementia, eating disorders, late prenatal care, low birthweight, neonatal abstinence syndrome, post-traumatic stress disorder, epilepsy, sickle cell,

cardiovascular conditions, multiple sclerosis and transverse myelitis, coronary artery disease, chronic respiratory conditions, and many others.

- Disability or impairment such as deaf or hearing loss, mobility impairment, and intellectual/developmental disability

To better equip PCS to respond in public health emergencies such as fire evacuations, rolling black outs, and so on, enhanced algorithms were drafted in 2022 that use Reliance and several other data sources to identify high needs members who may have a history of or dependency on:

- Wheelchair or scooter use
- Ventricular assist device
- Ventilator
- Oxygen
- Infusion pump
- Suction pump
- Home dialysis
- Enteral feeding
- Electric bed
- Other indicators of high need for outreach or assistance during public health emergencies

In addition to continuing activities from 2022, in 2023 we intend to pursue additional priority connections within Reliance related to clinical, lab and other data types, and compare and verify chart info for additional risk assessment.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Attend regular Reliance eHealth Meetings | 2023 – 2024 |
| Work with Reliance to identify and establish high-value use cases | 2023 – 2024 |
| **Planned Activities – New** | |
| Track Reliance handling of potential 42 CFR Part 2 data | 2023 – 2024 |
| Add priority connections in Reliance (clinical, lab, BH and OH data) | 2023 – 2024 |
| Complete chart data chase in Reliance for risk assessment | 2023 – 2024 |

**Strategy 4 title: Community Health Record as Proxy for Direct EHR Access**
Brief description: Expand the amount of claims data we submit to Reliance and expand the number of internal care team members using Reliance to access member data to reduce use of multiple, direct EHR logins to access the same information.

**Provider types supported with this strategy:**
☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

A key internal metric established in our strategy is the percentage of partner EHRs our clinical teams have access to (calculated based on a percentage of member encounters) for care coordination and quality performance activities. We have had a longstanding goal of leveraging a centralized HIE/Community Health Record as a proxy for this direct access. Maintaining the EHR access is often complex with a significant variance in methods for access. For illustration, some require individual tokens to be issued to allow for direct virtual private network (VPN) access by named individuals, and audit records of activity must be kept for compliance purposes. Maintaining access to hundreds of EHRs across Oregon now requires dedicated staffing to support, as well as specially trained Help Desk personnel to assist with technical support for these varied systems.

In 2022, PCS again increased the number of Care and Utilization Management, Pharmacy, and Member Support Specialists accessing Reliance to evaluate the care coordination and quality performance of the system. Initially the expanded user base highlighted that Reliance was missing some qualitative information from outpatient primary care and specialist providers, particularly around reasons for member visits and resulting outcomes and follow-up. PCS suspected it might be a training issue with these users and

coordinated specialized training to be delivered from our Reliance Account Manager. The training confirmed the information we desired did exist in the Reliance interface. We also identified some additional social care information availability we were previously unaware of.

By removing the misperception that data was missing, we removed some of the resistance from internal users and were able to increase awareness and excitement about Reliance capabilities.

Below are some activities noted for 2023 to forward our goals of using Reliance as a proxy for direct EHR access:

- Increase the volume of member claims data we contribute to the platform. Until now we have only supplied claims for CCO members in the Central Oregon and Columbia Gorge regions where Reliance has the most provider adoption, and for CCO members in the Marion-Polk region starting in 2022.
- Contract with Reliance to increase the volume of member data visible to internal PCS users. Similar to the claims data feeds, the visibility of member data has previously been restricted to CCO members in the Central Oregon and Columbia Gorge regions only.
- Establish single sign-on functionality to make internal login easier.
- Continue increasing the number of internal PCS users.
- Reduce barriers to use by working with PCS users to understand the specific information they look for in an EHR by role/function and educate on how Reliance can be used instead to access that detail.
- Complete a virtual chart pilot by gathering sample chart PDFs from an EHR (such as colonoscopy and eye exam reports) and assess whether Reliance can replicate the data. We need EHR chart data to fulfill many aspects of treatment, payment, and operations. We will work with Reliance to request these records dynamically and in bulk to confirm Reliance can fulfill this need.
- Provide feedback to Reliance on data quality issues or concerns as we use the platform. For example, after the Reliance platform upgrade late 2022 we noticed some documentation from a specific provider wasn't opening correctly. Via this feedback we learned the provider submits documents in a format that impacts viewability. Reliance is working with them to correct the issue.
- Related to the data quality activity above, work with Reliance on a format for CCDs that meets the needs of our clinicians. PCS staff have access to many charts in Reliance, but the data can be verbose, missing important narrative or formatted in a way staff find unfriendly to use. These issues cause staff to revert to the EHR for a more readable format, negating the value of Reliance as a proxy for EHR use.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Validate / invalidate Reliance as a proxy for use cases that require EHR access. | 2023 – 2024 |
| Report results to Reliance and identify opportunities for improvement. | 2023 – 2024 |
| **Planned Activities – New** | |
| Increase the volume of member claims data contributed to the platform. | 2023 Q2 |
| Contract with Reliance to increase the volume of member data visible to internal PCS users. | 2023 Q2 |
| Establish single sign-on functionality | 2023 Q2 |
| Complete a virtual chart pilot | 2023 Q3 |
| Provide feedback to Reliance on data quality issues | 2023 – 2024 |

**Strategy 5 title: Community Health Record as source of supplemental data for Quality programs**
Brief description: Explore how Reliance can be used as an accepted standard for supplemental data in support of the various CCO quality metrics that rely on clinical data as a component for measurement.

**Provider types supported with this strategy:**

☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

Since early 2021, PCS – in partnership with Reliance and their vendor IMAT Solutions – has been exploring how to leverage contributed HIE data directly into quality programs as supplemental data. To support this goal, Reliance was pursuing certification through the National Committee for Quality Assurance Data Aggregator Validation program (often referred to as the NCQA DAV). The focus of DAV certification is in support of HEDIS for Medicare and Commercial business lines and establishes a certified process for payers to receive supplemental data from their provider partners. This creates a high value use case enabling administrative simplification for both providers and payers.

Our initial intent with this strategy was that it would create a strong incentive for payers and providers to join a centralized HIE like Reliance and dramatically grow the coverage of HIEs that work to receive this certification. In our experience, most providers who service CCO members also have a strong panel of Medicare and/or Commercial members. We have been hopeful this program would also establish an accepted standard for supplemental data in support of the various CCO Quality metrics that rely on clinical data as a component for measurement.

In late 2021, while waiting for Reliance to pursue/achieve DAV certification, we expanded our data model to include additional diagnosis and SNOMED codes fed from Reliance data, then added this information to our clinical data warehouse and finally, loaded this data from the data warehouse into our HEDIS program as standard supplemental data. While the results considered compliant and approved as supplemental data by our auditors were limited, it did prove the model as a proof of concept for the work.

During 2022, Reliance was moved from the summer DAV cohort to the fall cohort and ultimately moved again to the December cohort. Upon learning of these delays and given the initial success of the proof of concept noted above, in mid-2022 PCS launched phase two of the alternative supplemental data verification process to continue enriching data for use in our HEDIS and QIM quality programs. Reliance has identified areas of improvement with member matching, provider matching and provider/NPI parsing. Through multiple iterations of Reliance and PCS sharing test files and validation feedback, by early December we saw a significant improvement in quality and quantity of supplemental data being returned.

PCS is now receiving regular Medicaid and Medicare data files from Reliance to source our data. We are eager to see the auditor's response to our Medicare Supplemental Data File for HEDIS submission in 2023 given we expect a significant increase over last year in the number of records being submitted. Given the success of this alternative supplemental data method, Reliance has paused on pursuing formal DAV certification but does expect to complete the documentation and process improvements started as part of the DAV process. PCS may choose to re-evaluate the DAV program in the future, but currently it doesn't seem to be required to meet audit requirements for the National Committee for Quality Assurance (NCQA).

| **Canceled Activities** | **Planned Milestones** |
|---|---|
| Identify data feed formats for specific measures applicable to Reliance NCQA DAV certification | N/A |
| Validate test data feeds with Reliance to support DAV certification | N/A |
| **Planned Activities – New** | |
| Continue to improve alternative supplemental data verification process with Reliance | 2023 |

**Strategy 6 title: Maintain an Enterprise Technology Roadmap for Health Information Exchange**
Brief description: Develop forward-looking, strategic plans to guide internal HIE technology development.

**Provider types supported with this strategy:**

☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

As a part of our enterprise strategic planning process, the PCS Executive Team, in collaboration with its Board of Directors, continued EHR/HIE/HIT as a critical initiative on the 2022 enterprise strategic plan. As a formal initiative, we maintained and updated a program roadmap, an annual initiative charter and a quarterly crosswalk of activities.

Given the operational maturity and standardization of activities developed over the last three years to support this work, the PCS Executive Team decided to remove EHR/HIE/HIT as a formal initiative starting in 2023 – it becomes "standard work" going forward. Even with this change, we intend to maintain a Steering Committee as a guiding body for these activities with a goal of meeting at least three times a year to provide ongoing feedback and direction. We also expect to maintain an annual crosswalk of activities. We may return to formal initiative status in 2024 depending on new activities identified throughout the next year.

Below are some current roadmap highlights:

**Meet CMS Interoperability Requirements including ability to exchange health data via FHIR interfaces:** PCS continued building FHIR-based interoperability capabilities, focusing on extension/engineering of internal data resources, integrations with existing business platforms and development of HIE and other partnerships in support of the patient portal requirements of the Office of National Coordinator (ONC)/Centers for Medicare & Medicaid Services (CMS) rules with HIE. The PCS interoperability roadmap continues to reflect use of FHIR to support internal and partner data exchange beyond those currently required for regulatory purposes. See Strategy 10: Interoperability for more details. Related activities are noted in that strategy.

We are also following updates being provided by CMS for the "Advancing Interoperability and Improving Prior Authorization Processes" (CMS-0057) proposed rule and have drafted a tentative three-year timeline should the proposed rule be implemented.

**Medical Management Platform Implementation and Integration with Clinical Data from HIE Sources:** In 2020, PacificSource selected a new core medical management/population health solution (VirtualHealth Helios) that will allow for the real-time integration of HIE, CIE, and HIT. We had expected to launch Phase 1 of the new Helios platform in 2022 but the project has been delayed. The first wave of Phase 1 supporting Utilization Management, Pharmacy, and Grievances and Appeals is currently expected to launch soon. We will begin the second wave of Phase 1 supporting Care Management, Disease Management and Quality soon thereafter, with HIE/CMT integration to follow in Phase 2.

**Expand InTouch web portal for CCO members:** PCS officially launched a new digital experience that transformed its Community Solutions website into a dedicated Medicaid Members section on PacificSource.com. This new secure web portal improves accessibility and access to care for Medicaid members by helping them stay connected online or on their mobile phone. The secure portal will give CCO members direct access to personalized information about their care, allow them to view, print and order ID cards, learn about benefits, find a doctor, see claims and explanations of benefits, track pre-authorizations and referrals, and ultimately get the most from their benefit plan. Requirements included Spanish localization, ADA accessibility, Medicaid-specific content and customizations including by CCO region and type.

**Explore viability of provider reported eCQM metrics such as PHQ9 scores and ECDS**: PCS explored its desire to use inbound interoperability and/or health information exchange data feeds to capture data from providers that PCS can then use to report on provider-reported measures such as Patient Health Questionnaire-9 (PHQ9) depression screening scores and HEDIS electronic clinical data systems (ECDS) performance reporting. There is an increasing need, particularly in the BH space, to support alternative methods for gathering data to support these claim-based measures. As a result of this exploration, PCS intends to pursue a formal project in 2023 to assess and document viability of using FHIR-based technology to support provider-reported eCQM metrics such as PHQ9 scores and ECDS for quality measurement and quality reporting. We expect this project to lay the groundwork for support of more value-focused FHIR-based interoperability objectives to support provider-reported measures.

| Completed Activities | Planned Milestones |
|---|---|
| Expand InTouch web portal for CCO members | N/A |

| | |
|---|---|
| Explore viability of provider reported eCQM metrics | N/A |
| **Planned Activities – Ongoing** | |
| Continue internal HIE Steering Committee and meetings | 2023 – 2024 |
| Maintain and update roadmap for PCS enterprise HIE Program | 2023 – 2024 |
| Maintain and update annual HIET program crosswalk | 2023 – 2024 |
| Meet CMS Interoperability requirements including ability to exchange health data via FHIR interfaces | 2023 – 2024 |
| Implement medical management platform & integrate with HIE sources | 2023 – 2024 |
| **Planned Activities – New** | |
| Assess and document the viability of provider reported eCQM metrics such as PHQ9 scores and ECDS | 2023 |

**Strategy 7 title**: **HIE Governance**
Brief description: Implement and follow a consistent process to receive HIT program direction, guidance, and oversight.

**Provider types supported with this strategy:**
☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS continued its hybrid IT/clinical change control process that consists of a bi-weekly meeting with internal subject matter experts from all relevant teams across all lines of business to discuss proposed technology and other changes and provide a method for communication back to the associated teams. This structure not only protects workflows but also guarantees visibility of all changes to all end users for oversight. This process continues expansion of our internal user base beyond Care Management by bringing representation from our Utilization Management, Quality, and Pharmacy teams onto our HIET Strategy team.

PCS also maintained a quarterly meeting with the HIT/HIE/Interoperability Steering Committee – a standing forum for internal leadership to provide direction, guidance, and oversight of HIE and HIT initiatives. Even though PCS is removing EHR/HIE/HIT as a formal critical initiative in 2023 (see comments in HIE Strategy 6 - Maintain an Enterprise Technology Roadmap for Health Information Exchange immediately above), this Steering Committee will remain a guiding and governing body for related activities throughout the year to provide input to program goals to ensure they are set, accomplished, and championed throughout the PCS organization. HIET Program team members continue to meet monthly with the PCS Chief Medical Officer to discuss high-value opportunities.

**Re-establish Internal Care Management / Population Health Strategy & Development Teams**: Building on learnings in 2021 for leveraging a monthly internal advisory team to share updates and highlights about HIT program activities and receive front-line guidance for how to support effective care coordination with HIT tools among internal care teams, in 2022 we modified the group's structure for operational efficiency. The primary issue with the 2021 format was too much content and too many voices spread across too few, consolidated forums.

The restructured process includes separate meetings with disparate care teams allowing each discussion to be focused on the specialty area each care team represents. Meetings are now organized as follows, noting their meeting cadence:

- Medicaid Care Managers and Member Support Specialists (Quarterly)
- Medicare, Commercial and Special Populations Care Managers and Member Support Specialists (Quarterly)
- Utilization Management Team (all lines of business) (Quarterly)
- Quality and HEDIS/STARS/QIMs (Biannual)
- Physical Health Population Health (Quarterly)
- Behavioral Health Population Health (Quarterly, staring Q1 2023)

- Traditional Health Workers (Quarterly)
- LaneCare Care Managers and Member Support Specialists (Quarterly, starting Q1 2023)
- Ad-hoc groups in Pharmacy, Administration, and IT

A similar activity to be focused on a broader collaborative statewide scale (at the CCO level) is in the early development stage. PCS helped facilitate an exploratory discussion about setting up a statewide Clinical HIT Specialists meeting. Working with CareOregon, we plan to hold our first meeting by mid-year 2023.

**Develop an HIE/HIE/Interoperability Annual Plan:** As noted in HIE Strategy 6, even though we will not continue EHR/HIE/HIT as a formal critical initiative on the PCS 2023 enterprise strategic plan, we continue to develop and maintain formal program plans.

**Update Master Services Agreement with Reliance:** We began discussions to update and renew our master services agreement with Reliance to reflect additional services and to incorporate all our business lines into its scope. This new agreement will refine products and services as well as service level agreements.

From a general HIE governance perspective, the PCS Vice President of IT, Infrastructure and Analytics assumed the role of Co-Chair of the HITOC HIE Workgroup newly formed in 2022.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| Re-establish internal Care Management/Population Health Strategy Teams | N/A |
| **Planned Activities – Ongoing** | |
| Regularly convene HIT Steering Committee Meetings | 2023 – 2024 |
| Develop an HIT/HIE/Interoperability Annual Plan | 2023 – 2024 |
| Update Master Service Agreement with Reliance | 2023 |
| **Planned Activities – New** | |
| Maintain Care Management/Population Health Strategy and Advisory Teams | 2023 – 2024 |
| Pursue Statewide Clinical HIT Specialist Collaboration | 2023 |
| Maintain presence on HITOC HIE Workgroup as needed | 2023 |

**Strategy 8 title**: **Centralize Data Exchange with Federally Qualified Health Centers**
Brief description: Provide a standardized data feed of claims records for inclusion in OCHIN's Epic instance for distribution and dissemination to downstream OCHIN-Epic clinics.

**Provider types supported with this strategy:**
☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

*OCHIN is implementing claims-based functionality within their Epic EHR to provide health centers with information to serve their patient populations in more advanced forms of value-based payment. OCHIN has created a pilot, called the HEDIS Pilot, to evaluate the value of the following claims-based tools to enhance patient care, improve quality outcomes and support system solutions for serving the health centers' assigned populations:

- Cost and Utilization Dashboard – provide overview of health center's total cost of care for assigned populations
- Claims info displaying within the EHR providing the clinicians a broader picture of their patient's total health journey
- NCQA-certified HEDIS measures

Implementing this functionality will allow these health centers to be early adopters of Epic's Value-Based Pay model due to be released in 2023, which will provide additional tools to support health centers with their population health and value-based payment goals. (*Overview contributed by OCHIN.)

In support of this pilot, in late 2022 PCS began the process to provide a standardized data feed of claims records for inclusion in OCHIN's Epic instance for distribution and dissemination to downstream OCHIN-Epic clinics. [redacted] Once the process is fully tested and files are flowing seamlessly to OCHIN starting early 2023, PCS will provide three standard extract files (Medical claims, Pharmacy claims and Eligibility) monthly going forward.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| Align with OCHIN on claims feed specification | N/A |
| **Planned Activities – Ongoing** | |
| Generate and deliver initial historical file | 2023 Q1 |
| Setup ongoing delivery | 2023 Q1 |

**Strategy 9 title**: **Explore Epic Payer Platform**
Brief description: Explore the feasibility of implementing Epic Payer Platform to improve care coordination and value-based care arrangements with contracted providers who use the Epic EHR.

**Provider types supported with this strategy:**
☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

To help reduce costs and improve efficiencies, PCS began exploring the implementation of Epic Payer Platform (EPP), Epic's software solution and interoperability network that supports communication between payers and providers. This integration could improve care coordination and value-based care arrangements by allowing network providers to exchange relevant clinical records bi-directionally with affiliated payers without the need for manual intervention or point-to-point interfaces. There are many use cases a platform like Epic could address – prior authorizations, chart access for care management, chart hydration back to an internal care management system, and supplemental data to support our HEDIS and QIM programs.

After several demonstrations and conversations with Epic in 2022, PCS agrees the efficiency gains of a system like EPP are compelling, especially given a majority of our members are assigned to provider organizations that use Epic. The biggest barrier is cost – Epic is a very expensive solution. And PCS would still need to maintain parallel methods for providers who do not use the Epic platform.

For this reason, PCS intends to evaluate other platform agnostic solutions outside Epic before making a final decision. In addition to Epic conversations, in 2022 PCS held preliminary conversations with third party vendors Apixio and Moxe Health, who were identified through the Epic App Orchard and whose services offer access to Epic data. PCS also desires to learn more about the provider-to-provider referral tool 360x, which appears to include embedded prior auth functionality. A solution like 360x is a timely topic both regionally and statewide, as given the many challenges in the industry and the heavy investment load, it is PCS's hope to refocus efforts around adoption of interoperability standards for closed loop referrals over the coming years.

Because there is much to be considered to support this strategy, PCS approved a formal exploratory project for 2023 to identify and evaluate the available options and plot the best course technical solution available to improve the patient experience and quality of care. During the evaluation, PCS will also consider how a potential solution would support the recently proposed rule by CMS (Advancing Interoperability and Improving Prior Authorization Processes – CMS-0057) to expand access to health information and improve the prior authorization process by 2026, should that rule be implemented.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Demo Epic Payer Platform and Alternative Solutions | 2023 Q3 |
| Review how EPP could facilitate our EHR access requirements | 2023 Q3 |
| Create implementation recommendations for PCS Leadership | 2023 Q3 |

**Strategy 10 title**: **Develop Interoperability**

Brief description: Develop and execute a roadmap that meets CMS interoperability requirements and furthers internal PCS goals to use FHIR to support internal and partner data exchange.

**Provider types supported with this strategy:**

☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

In late 2021, CMS delayed enforcement of the payer-to-payer provisions of the Interoperability rule until they can address implementation challenges through future rulemaking. PCS continued work on the patient portal aspects of the CMS/ONC requirements throughout 2022 as it awaited more information.

While efforts continued to be largely focused on compliance with those CMS/ONC rules, our strategy is also geared to address business-to-business interoperability use cases as well as more value driven use cases. PCS continued actively working with HIE partners to enable FHIR-based exchanges to replace or supplement legacy HL7 v2/v3 alternatives. Over an undefined timeframe, we view FHIR-based interoperability as a likely replacement technology for many of our older data exchange technologies internally and as a means of bringing much more robust externally sourced data to bear in support of our member health information needs.

Highlights of 2022 accomplishments include:

- Worked with Reliance and IMAT, their platform vendor, to build a new internal FHIR server to support the process of a member using an application programming interface (API) to request and receive their records from PCS.
- Worked to develop integrations for member authentication, consent management and third-party application registration. Completion is expected in Q1 2023.
- Investigated FHIR integrations with VirtualHealth Helios, our future internal care management platform.
- Started reviewing and planning for TEFCA options. Roadmap development is continuing.
- Have started considerations for a high-value interoperability partner roadmap.

Unfortunately, the following activities didn't make the progress we'd anticipated during the year:

- The initial design around the architecture for insourcing of OAuth 2.0 authentication did not gain as much traction as expected.
- The project to pilot a FHIR-based solution for ingestion of business-to-business (B2B) provider data was delayed due to staffing constraints. It has been rescheduled for 2023.

The PCS effort to design and develop FHIR-based prior authorizations has been re-aligned with the new CMS proposed rule (CMS—0057P) which targets January 1, 2026, for readiness. PCS is also exploring FHIR based prior authorizations as part of the evaluations noted in HIE Strategy 9 – Explore Epic Payer Platform and will follow that timeline.

Priorities for 2023 include getting our patient portal live and focusing on architecture activities that will be needed to support the January 2026 goals of the new CMS proposed rule once the rule comment period ends and the final rule is announced.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Develop and iterate on interoperability roadmap including regulatory approach, industry-alignment, technology, and partner opportunities. | 2023 - 2024 |
| Core interoperability capabilities architecture and design. | 2023 – 2024 |
| Interoperability data source preparation, FHIR platform build-out, and security engineering. Initial FHIR-based integrations with HIE partners. | 2023 Q2 |
| Architecture and design for insourcing of OAuth 2.0 authentication, patient matching, and consent management capabilities in support of interoperability. | 2023 |

| | |
|---|---|
| Business-to-business (B2B) interoperability pilots with selected partners for eligibility, clinical, and provider data exchanges. | 2023 |
| Design and development of FHIR-based prior authorization capabilities. | See HIE Strategy 9 |
| Research TEFCA and Payer-to-Payer Options and develop TEFCA roadmap | 2023 |
| Pilot FHIR-based solution for ingestion of provider data (same as the B2B activity above – these dates changing to 2023 instead.) | 2023 |
| Develop high-value interoperability partner roadmap | 2023 |
| Develop interface between HIE data sources, proprietary analytics algorithms (CPIA) and new care management platform | 2023 – 2024 |

### B. Optional Question

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

The most significant barrier in HIE for Care Coordination is in supporting the significant costs for a centralized community health record. We still believe that as high-value use cases are established in Reliance, additional participants will be drawn in with the goal of driving down the per-member per-month costs to CCOs.

Regarding interoperability, the OHA can best help in this space by taking care not to over-drive interoperability requirements in ways that would risk departure from CMS/ONC guidance, which continues to adjust. OHA can also assist by accelerating or restarting development of its own FHIR-based resources (e.g., a FHIR-based vaccination registry or a FHIR-based Medicaid eligibility roster, etc.). OHA should continue to broker peer engagements for providers and payers around topics involving interoperability.

## 4. Support for HIE – Hospital Event Notifications

### A. Support for HIE – Hospital Event Notifications: 2022 Progress and 2023-24 Plans

Please describe your 2022 progress and 2023-24 plans for using timely Hospital Event Notifications within your organization.

**Strategy checkboxes**
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

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

**Tools used by CCO for timely hospital event notifications**

**List and briefly describe tool(s)**:

Below is a list of hospital event notification (HEN) platforms currently in use by PCS or supporting PCS internal processes and activities:

**Collective Medical (formerly PreManage)**: PCS remains a vocal proponent of the Collective Medical (CMT) platform, recently purchased by PointClickCare (PCC). This platform, widely adopted across all PCS regions, has proven to be a key capability for internal operations in supporting care coordination efforts. The pandemic environment highlighted the significant value this platform brings in understanding member status.

We continue to appreciate OHA's ongoing financial support for CMT as it has helped remove many barriers to its adoption. In late 2022 we became aware PCC intends to modify its contract sponsorship model wherein payers sponsor platform use for their contracted providers. We look forward to learning more about the potential changes in 2023 and are actively working with HIT Commons and PCC on updating our contract in alignment with other CCO network partners. It is relevant to note a few provider partners who have become aware of the re-contracting exercise have voiced a concern about whether their current access and use will be impacted in any way.

**EDIE** - All hospitals in our service area have adopted EDIE – the emergency department information exchange. In 2021, the HIT Commons worked to bring Prescription Drug Monitoring Program (PDMP) information to emergency departments through an integration of the Oregon PDMP registry with the EDIE platform. HIT Commons continues to add clinics on at a slowly declining pace and expects this trend to continue in 2023. To encourage ongoing adoption, they intend another communication campaign in spring 2023. HIT Commons is also beginning to explore the use of FHIR integration to PDMP but expect this to take some time as organizations with functioning integrations are not likely to be interested in replacing their existing interface without a significant benefit.

**Secure File Transfer Protocol (SFTP**) – PCS exchanges significant care coordination information with provider partners using this method. A significant volume of monthly reporting and other analysis is transmitted this way.

Across all HIE types and use cases, HEN continues to be the most robustly adopted type of HIE in each of our CCO regions. The data feeds we implemented in 2020 between CMT and our care management system continue to provide timely and good quality data. In 2021, we reported on scalability challenges with our existing care management platform and plans to implement a new solution (VirtualHealth Helios) to support Pharmacy, Appeals and Grievances, Utilization Management, Care Management, Disease Management, and Quality. Because the data resources we currently receive from CMT are not in a format that can easily integrate into Helios, we will need to evaluate an HIE data infrastructure we can use to integrate these feeds, including identifying actions to continue and expand on supporting population health in real time. As with today's tools, even after this change we would expect to retain processes with smaller hospital systems where daily census is obtained via phone or fax.

The data integration between CMT and Helios will not be in place when Helios initially becomes operational. We continue to ingest and stage data from CMT in our internal clinical data warehouse and will make it available to the new care management platform to consume until such a time as we can complete the direct integration between the two. Ingesting this data serves a dual purpose, as it will also make the CMT data available for deeper reporting and analysis internally.

We had expected to launch Phase 1 of the new Helios platform in 2022, but the project has been delayed. The first wave of Phase 1 supporting Utilization Management, Pharmacy, and Grievances and Appeals is currently expected to launch soon. We will begin the second wave of Phase 1 supporting Care Management, Disease Management and Quality soon thereafter. HIE/CMT integration will follow later, in Phase 2.

**Strategy 1 title: Add additional high value HEN cohorts and reports and keep curated library**
Brief description: Develop and implement new cohorts and reports in CMT that will provide the most value to internal care management and population health teams and keep a comprehensive list of the cohorts and reports available for use.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

High-value customized cohorts and reports represent ongoing work that supports changes in regulatory requirements, new QIM measures, and innovation from internal PCS teams or from the newly formed internal Strategy and Development meetings noted in Section 3. Support for HIE – Care Coordination, Strategy 7 – HIE Governance.

Over the course of 2022, PCS built 23 new cohorts and reports covering all lines of business. Some cohorts were focused on specific member-facing teams such as Long-Term Support Services (LTSS) and Dual Eligible Special Needs Plans (DSNP) while others were focused on specific issues such as high-vulnerability member discharges and birth events. Additionally, we requested seven, one-time historical reports for our Analytics, Quality, and Care Management teams, and made several updates to existing reports to enhance their functionality such as adding DSNP and LTSS columns to our Medicare high-vulnerability report. More information about the DSNP and LTSS reports are available in Strategy 2 – Develop the Eligibility file, below.

One specific highlight is the **Daily and Weekly "All Medicaid" Discharge Report.** After speaking with the Utilization Management team about their use with CMT we discovered their process for getting discharge notifications from hospital partners could be greatly simplified by turning on a simple report in CMT that captured all Medicaid discharges for all diagnoses. This report was activated and is now in use.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Add high value customized cohorts and reports built around specific needs of internal PCS users | 2023 – 2024 |

**Strategy 2 title: Develop the Eligibility File**
Brief description: Continue to enhance the information provided in the PCS daily eligibility file sent to CMT to enable tracking new use cases for disparate population groups.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS continued to adjust its CMT eligibility file to allow tracking of additional populations that cannot be identified solely using Collective's logic. Highlights of eligibility file enhancements explored or implemented in 2022 include:

**Cover All Kids / Healthier Oregon Program Eligibility File Updates:** Starting July 1, 2022, more adults became eligible for Oregon Health Plan (OHP) benefits and other services and supports under the new Healthier Oregon Program. PCS added a new group identifier in its CMT eligibility file for these members that now triggers a "PacificSource CCO" global flag to indicate these members are attributed to the PCS CCO for care coordination. PCS deployed a similar group identifier for Cover All Kids (CAK) OHP program recipients at the same time.

**Assigned/Not Established Patients Functionality:** It can be confusing for clinic staff to know when a payer has assigned a new patient to them as clinics receive assignment reports from different payers at different intervals via different workflows and portals. Consequently, patients may not receive health care protocols from their new PCP in a timely manner because those patients are not yet included in the provider's patient roster sent to CMT and thus won't appear in the provider's CMT cohorts and reports for follow-up.

To bridge the gap between payer assignment and provider awareness, CMT can use information in the payer's eligibility file to inform a provider that a new patient has been assigned to them by adding that member to the provider's existing cohorts and reports. Being able to deliver this clarity would maximize reimbursement for plans and clinics, reduce clinic staff overhead, and ultimately ensure the best outcomes in patient care.

PCS believes this is a high value use case and intends to engage in this pilot. During preliminary conversations in 2022 we have identified a few provider partners interested in testing this functionality and intend to engage with them on next steps in early 2023.

**LTSS and DSNP Reporting Against Tracking Measures:** To facilitate adherence to QIM measures and follow-up with vulnerable members, PCS Care Management teams requested the addition of both our LTSS and DSNP member groups to our CMT eligibility file as well as development of reports specifically designed to support these workflows among Care Management Clinician and Member Support Specialist staff in all our CCO regions.

- We created five active daily reports for LTSS – one for each of our four CCO regions and one for our Legacy Health Share IDS partner.
- We created two active cohorts for DSNP that also run as daily reports.

We continue working with Care Management to develop new LTSS and DSNP cohorts in relation to required metrics and also to improve the quality of care and breadth of resources available to this population. We will also continue adding an LTSS column to non-LTSS reports to track LTSS and DSNP members as subset populations in these other reports.

Due to a new DSNP requirement, we needed to trigger a new Health Risk Assessment (HRA) to be sent after a "Change in health status" for DSNP members. While this use case is probably a better fit for the Reliance HIE, we have better coverage with CMT currently via our CMT full daily census files. In short, we developed an algorithm that will output a list of members we have deemed to have had a material change in health status using CMT and/or Reliance so we can meet the compliance requirement of sending them a new HRA.

**Oral health claims to populate SUD diagnosis history:** There was a discussion at a CCO/DCO Collaborative hosted by the Oregon Health Leadership Council (OHLC) in early December regarding the potential use of dental claims to populate SUD diagnosis history. A DCO shared insight on the vicious cycle that exists between poor oral health and poor behavioral health. It was suggested the inclusion of "last dental visit" within CMT may better inform BH providers and prompt for greater referrals to DCOs to prevent or address oral health disease. For this use case to be tested, PCS will first need to start sharing its oral health claims to CMT, which is not currently being done.

We plan to continue working with our Care Management team throughout 2023 to be proactive in evaluating the eligibility file with a more clinical lens, identifying ways we can continue expanding the file to support better care for our members. We will also explore adding oral health claims to our CMT claims feed.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| LTSS Reporting against tracking measures | N/A |
| DSNP Cohorts and Reports | N/A |
| **Planned Activities – Ongoing** | |
| Continue exploring best practices for eligibility files | 2023 – 2024 |
| Pilot Assigned/Not Established Patients Functionality | 2023 |
| Explore new use cases for eligibility files | 2023 – 2024 |
| **Planned Activities – New** | |
| Add oral health claims to CMT claims feed | 2023 |

**Strategy 3 title**: **Develop high value use cases for internal use**
Brief description: Identify and implement uses cases in CMT that increase the value of care provided by internal PCS Care Management teams.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

The majority of the CMT high value use cases that PCS developed in 2022 were created for external provider partners and are documented in the next strategy. Below are the few that were developed for internal use.

**Heat mitigation efforts:** In July, PCS took a multi-pronged approach to identify, outreach, and distribute air conditioning units to members at risk from high heat events. OHA provided an initial list of priority and high-risk members, which PCS supplemented using CMT data that identified possible heat-related events from our 24-hour census reports over the previous month and data about members with conditions vulnerable to heat as provided by the Analytics team.

Using the consolidated list, multiple PCS teams contacted high-risk members, ultimately reaching out to more than 1,400 individuals across our four CCO regions and Legacy Health Share. PCS provided air

conditioning units to more than 350 individuals. The disparity between the number of individuals contacted and the number of units dispensed was due to the number of members we were able to reach, how many responded, and who indicated they wanted an A/C unit. In some cases, they may not have wanted an A/C unit because they already had one, and in other cases they may not have responded to our outreach at all.

One member described getting her new air conditioner as “truly life-changing.” Another unit was provided to a single mother with two babies who had been taking the babies to the local public library during the day to keep cool but was very worried about overheating in their apartment after the library closed each day. She was so relieved not to have to worry all night about how the babies would manage the heat in the home.

Because high-heat events are more common and expected to re-occur each summer, PCS plans off-season improvements via a Disastrous Event Member Identification project in 2023 to evaluate and develop analytics infrastructure and tools to better respond to reporting and outreach needs in future disastrous events.

**Add Risk Stratification Universal Flag in Collective**: After further internal discussion about adding a new risk stratification universal flag in CMT, PCS decided not to pursue it. A risk stratification flag would not be self-explanatory and might cause confusion for those trying to use it in the CMT platform. Risk scores have been proven to have racial bias and showing them in a way that isn’t self-explanatory could end up unintentionally harming members by not giving them fair prioritization.

**Ad Hoc Unique Use Cases:** PCS occasionally receives unique, one-off requests for information that we support through ad hoc CMT cohorts or reports. As an example, a Care Management team member encountered a unique challenge involving one of her most vulnerable CCO members who, due to unique circumstances, was unable to use the non-emergency medical transport benefit. This limited the member, who has several high-risk medical conditions, from receiving important outpatient procedures and tests. The Care Management clinician suggested that if we knew when the member was in the hospital, we could coordinate the medical care she needed as an outpatient while already under medical supervision. We created an emergency department notification for this member with restricted visibility to protect the confidentiality needed in this situation, to ensure the member could receive the outpatient procedures and tests she needed.

| **Canceled Activities** | **Planned Milestones** |
|---|---|
| Discuss addition of the RS tag as a universal flag in CMT | N/A |
| **Planned Activities – Ongoing** | |
| Continue developing high value use cases for internal use | 2023 – 2024 |
| Explore current tools where Risk Strat might be an effective value add | 2023 – 2024 |
| **Planned Activities – New** | |
| Complete Disastrous Event Member Identification Project | 2023 |

**Strategy 4 title**: **Make Structural Collective System Improvements**
Brief description: Identify and implement ways to improve the utility of the CMT platform for internal use.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

Over time, the ongoing addition of new cohorts and reports within the PCS CMT web portal made the application interface increasingly cluttered and difficult to navigate. To make it easier for internal users to find the desired cohort or report within an ever-expanding list, we instituted a naming convention for both cohorts and reports that follows this basic format: [Line of Business] – [Service Area] – [Tracking Criteria].

As a result of this change, PCS CMT users can now sort cohorts and reports by line of business, and search alphabetically significantly increasing their speed of navigation.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| Institute cohort naming convention | N/A |
| **Planned Activities - Ongoing** | |

| | |
|---|---|
| Evaluate for Collective system improvements | 2023 – 2024 |

**Strategy 5 title**: **Review Provider Contract Language**
Brief description: Review and evaluate existing provider contract language for improvements that might encourage or facilitate the adoption of HIE tools within our contracted provider's practices.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS reviewed its existing CCO provider contract template for possible amendments that could drive HIE adoption and use, noting that our contracting practice is to start with a template so the final, individual contracts may vary based on negotiations.

While the language doesn't explicitly require a provider to adopt a hospital event notification platform, our template does incorporate compliance language around a provider participating and/or promoting data sharing via various methods.

In 2023, PCS will review its existing Provider Manual for any potential amendments that might also drive HEN adoption.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| Review provider contract language | N/A |
| Work with Provider Network to determine if amendments should be made to contracts | N/A |
| **Planned Activities – New** | |
| Review Provider Manual for potential amendments | 2023 |

Please describe your 2022 progress and 2023-24 plans for supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers.

**Strategy checkboxes**
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans 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 Notifications 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): |

**Tools supported or provided by CCO that facilitate access to timely hospital event notifications**

**List and briefly describe tools**:

**Collective Medical (formerly PreManage)**: PCS remains a vocal proponent of CMT, recently purchased by PointClickCare (PCC). This platform, widely adopted across all PCS regions, has proven to be a key capability in supporting providers' care coordination efforts. The pandemic environment highlighted the significant value this platform brings in understanding patient status. While PCS continued to face pandemic-related outreach barriers, we worked with our provider-facing Population Health team to surface provider needs and deliver remote digital solutions to them via this platform where possible.

We continue to appreciate OHA's ongoing financial support for CMT, which has helped remove many barriers to its adoption. In late 2022 we became aware PCC intends to modify its contract sponsorship model wherein payers sponsor platform use for their contracted providers. We look forward to learning more about

the potential changes in 2023 and are actively working with HIT Commons and PCC on updating our contract in alignment with other CCO network partners. It is relevant to note a few provider partners who have become aware of the re-contracting exercise have voiced a concern about whether their current access and use will be impacted in any way.

**EDIE** - All hospitals in our service area have adopted EDIE – the emergency department information exchange. In 2021, the HIT Commons worked to bring Prescription Drug Monitoring Program (PDMP) information to emergency departments through an integration of the Oregon PDMP registry with the EDIE platform. HIT Commons continues to add clinics on but at a slowly declining pace and expects this trend to continue in 2023. To encourage ongoing adoption, HIT Commons intends another communication campaign in spring 2023. HIT Commons is also beginning to explore the use of FHIR integration to PDMP but expects this to take some time as organizations with functioning integrations are not likely to be interested in replacing their existing interface without a significant benefit.

**Secure File Transfer Protocol (SFTP**) – PCS exchanges significant care coordination information with provider partners using this method. A significant volume of monthly reporting and other analysis is transmitted using this method.

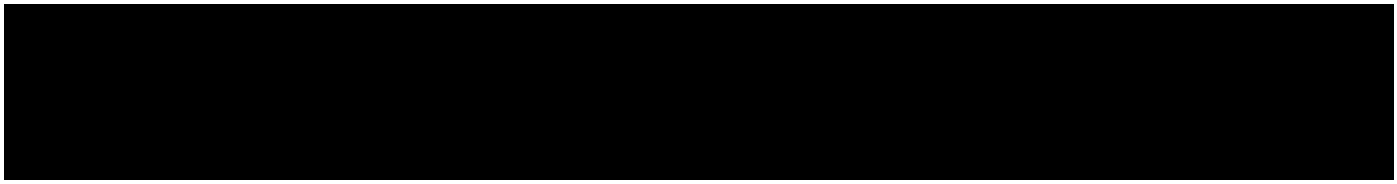
Per the Data Completeness Table in the OHA-provided CCO HIT Data Reporting File, the following tables identify the number of contracted physical, oral, and behavioral health organizations without HIE for Hospital Event Notifications information, by CCO region:

| **CCO:** **Central Oregon** | Number of Contracted Providers | Number w/o HEN Access | Percent w/o HEN Access | Number of contracted PCPCHs | Number w/o HEN Access | Percent w/o HEN Access |
|---|---|---|---|---|---|---|
| Physical Health | 80 | 65 | 81% | 18 | 6 | 33% |
| Behavioral Health | 202 | 198 | 98% | 0 | 0 | 0% |
| Oral Health | 24 | 22 | 92% | 0 | 0 | 0% |

| **CCO:** **Columbia Gorge** | Number of Contracted Providers | Number w/o HEN Access | Percent w/o HEN Access | Number of contracted PCPCHs | Number w/o HEN Access | Percent w/o HEN Access |
|---|---|---|---|---|---|---|
| Physical Health | 27 | 20 | 74% | 10 | 3 | 30% |
| Behavioral Health | 28 | 25 | 89% | 1 | 0 | 0% |
| Oral Health | 9 | 8 | 89% | 0 | 0 | 0% |

| **CCO:** **Lane** | Number of Contracted Providers | Number w/o HEN Access | Percent w/o HEN Access | Number of contracted PCPCHs | Number w/o HEN Access | Percent w/o HEN Access |
|---|---|---|---|---|---|---|
| Physical Health | 99 | 76 | 77% | 25 | 7 | 28% |
| Behavioral Health | 238 | 222 | 93% | 1 | 0 | 0% |
| Oral Health | 41 | 39 | 95% | 0 | 0 | 0% |

| CCO: Marion / Polk | Number of Contracted Providers | Number w/o HEN Access | Percent w/o HEN Access | Number of contracted PCPCHs | Number w/o HEN Access | Percent w/o HEN Access |
|---|---|---|---|---|---|---|
| Physical Health | 93 | 62 | 67% | 38 | 12 | 34% |
| Behavioral Health | 111 | 97 | 87% | 2 | 1 | 50% |
| Oral Health | 42 | 40 | 95% | 0 | 0 | 0% |



In 2023, we intend to focus prioritization on onboarding providers with the most impact. Depending on provider type, this could be based on the number of members assigned to a PCP, claim quantities, claim totals, or other appropriate metrics. Regardless of what metrics are used, the goal remains to improve health outcomes for CCO members through the use of HEN technologies. We expect to focus on both onboarding new providers and building the health and quality of existing HEN implementations.

Considering potential ongoing adaptations required by the pandemic and potential ongoing fatigue, we will re-establish provider relationships that have been on hold, assess current providers who are not currently using the tools to provide targeted education and support, and be thoughtful in our encouragement of implementing new technologies.

**Strategy 1 title**: **Develop High Value Use Cases for Providers**
Brief description: Identify and implement uses cases, cohorts, and reports in CMT that providers can use within their own CMT application to increase the value of care they provide to their patients.

**Provider types supported with this strategy:**

☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS continued to support provider cohort and report development in CMT throughout 2022 as follows:

**Championing general use**: In March, the Provider Relations Specialist at WVP in the Marion-Polk region shared with CMT their desire to start conversations with their member clinics about actively using the CMT platform. Through these conversations, three clinics voiced a desire to join and are currently in various stages of onboarding. PCS helped facilitate conversations between WVP and CMT to support these efforts. These activities reflect the general support PCS offers its contracted providers to improve their use of the platform. The PCS HIE Strategist is also available to work on custom builds that directly apply to clinic needs, including modifications to existing cohorts.

**Assigned/Not Established Patients Functionality Pilot:** As noted in Support for HIE – Hospital Event Notifications for *internal* use, Strategy 2 – Develop Eligibility Files, it can be confusing for clinic staff to know when a payer has assigned a new patient to them as clinics receive assignment reports from different payers at different intervals via different workflows and portals. Consequently, patients may not receive health care protocols from their new PCP in a timely manner because those patients are not yet included in the provider's patient roster sent to CMT and thus won't appear in the provider's CMT cohorts and reports for follow-up. To bridge the gap between payer assignment and provider awareness, CMT can use information in the payer's eligibility file to inform a provider that a new patient has been assigned to them by adding that member to the provider's existing cohorts and reports. Being able to deliver this clarity would maximize reimbursement for plans and clinics, reduce clinic staff overhead, and ultimately ensure the best outcomes in

patient care.

PCS believes this is a high value use case and intends to engage in this pilot. During preliminary conversations in 2022 we identified a few provider partners interested in testing this functionality. The next steps, expected in early 2023, include confirming the accuracy of the attribution data we can provide and starting the engagement with our pilot partners.

**Explore potential of leveraging CCDs via CMT:** PCS explored this potential but, unfortunately, was unable to establish a viable solution within CMT. Working with our Care Management teams, it was determined the information currently available in CMT is not comprehensive enough to replace the more traditional method of using direct EMR access. PCS will continue to explore this possibility as CMT keeps developing this use case.

**Explore potential to develop post-acute HIE data flows – Skilled Nursing Facilities (SNF):** At the request of the PCS Population Health team, we developed simple reports for provider partners that notify of patient admits and discharges from a SNF (titled “Discharge to SNF from Hospital” and “Admit to and Discharge from SNF”.) While SNF admission is available from hospital ADTs in the discharge disposition section, it doesn't identify which SNF the member is going through, making utilization of SNF ADTs for this information a significant upgrade. Now that these reports exist, all providers can ask CMT to build them into their CMT portals.

Internally, PCS built the same report and segmented it by line of business and CCO region. At the request of our Care Management team, we modified the internal version to allow for more nuanced and targeted follow-up for our high-vulnerability members and called out in the report if they were in our DSNP and/or LTSS populations.

We believe there are other complex and nuanced applications of this concept and continue to pursue those with both internal and external partners.

**Explore potential use case for communicable disease:** Per a request from the Deschutes County Communicable Disease team, we discussed with CMT a potential report that would identify the community members with high-risk conditions that the Communicable Disease team is responsible for tracking. While the County can communicate with most of the people on this list, some are housing insecure and/or don't have known contact information. This report would alert the Communicable Disease team of all emergency department admissions for these members so the Team could follow-up with hospital clinical staff while the person was physically present. To address the concern about the sensitive nature of the conditions being tracked, we used a “group” addition to the County’s eligibility file rather than trigger off emergency department admission diagnoses so the conditions themselves aren't explicitly identified.

**Engagement of Alcohol and Other Drug Use Treatment (IET) Metric Cohort:** PCS worked with the OHLC and CareOregon CCO to update the hospital event report criteria of the CMT IET report that proactively identifies SUD populations for providers to follow up with inside a specific timeframe. This update was necessary to incorporate new specifications released by the OHA, identifying the addition of fentanyl. This report is available as a standardized statewide solution to all providers. The PCS Population Health team, the OHLC, and CMT partnered to communicate the updates to CMT users.

**Health Management Information System (HMIS) Flag Including Related Partnership Efforts with Lane County, Trillium CCO and CMT:** PCS believes there are many potential use cases for the HMIS flag in CMT given the limited number of available housing options and related difficulty supporting our homeless population. To this end, PCS began an exploratory effort with partners from Lane County, Trillium CCO, PeaceHealth, and multiple community-based organizations (CBOs) and providers across Lane County to identify what those use cases might be. Unfortunately, the lingering pandemic and the complex nature of coordinating among multiple community stakeholders kept this activity from moving forward quickly. In late 2022, renewed community interest and receding pandemic-related exhaustion gave some renewed

momentum to the work and the group began to explore the utility of the HMIS information. It noted a major challenge is a lack of medical respite for homeless members discharging from the hospital while still needing more care than traditional shelters can provide.

Plans starting early 2023 include researching respite center bed availability and discharges for certain diagnoses that are likely to require medical respite, and then comparing that information against filled PCS claims submitted by those respite centers. If successful, we believe this would be the first active use using medical claims in CMT, which are typically problematic given their lag time in reporting.

**Warm Springs Engagement:** The PCS Care Coordination HIE Strategist and PCS Tribal Liaison to the Confederated Tribes of Warm Springs (CTWS) began discussing potential CMT use cases to present to the CTWS Tribal Council. Engagement with CTWS requires a more culturally sensitive approach and we acknowledge it may take some time for these use cases to form. We are hopeful for a meeting with the CTWS Tribal Council during 2023 to discuss a use case to pilot.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Add high-value customized cohorts and reports | 2023 – 2024 |
| Pilot “Assigned/Not Established Patients” Functionality | 2023 |
| Explore leveraging CCDs via CMT to support HEDIS Transitions of Care Metric | 2023 |
| Explore additional post-acute HIE data flows (SNF) | 2023 |
| **Planned Activities – New** | |
| Explore Hospital Discharge to Respite Shelters - Lane | 2023 |
| Health Management Information System Flag Uses | 2023 |
| Develop Warm Springs Tribal Use Case | 2023 |

**Strategy 2 title**: **Develop Pharmacy Use Case**
Brief description: Combine pharmacy claims data contributed by PCS with hospital event notifications within CMT to identify pharmaceutical-based use cases.

**Provider types supported with this strategy:**
☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS made progress continuing an innovative CMT report that uses hospital event notifications and PCS pharmacy claims to aid the care of pediatric asthma patients. Pediatric asthma was chosen through collaboration with pharmacy partners both internal and external to PCS who called out the potential significant value of this particular use case because it is a condition that is primarily managed via pharmaceutical intervention and because hospital admissions for pediatric asthma should be mostly preventable. We believe the return on investment for reporting and interventions to likely be significant and beneficial to families and especially children in our CCO regions.

To test the potential for success, in May PCS ran a preliminary report to determine the number of hits such a cohort might identify. We started with a broad scope and ended up with 34,000 hits against 14,000 people over the previous six months across all lines of business and all ages. Given the positive results, we modified the report to narrow the age to 17 and under and added more columns for better sorting. Given this preliminary success, PCS representatives presented this use case at the EDIE Steering Committee meeting in June.

In September, PCS started testing the report with WVP in the Marion-Polk region, and CMT. WVP requested several enhancements before we ultimately reached out to a pediatric provider to implement the pilot report with its patients. Shortly after this step we learned CMT/PCC intends to modify their contracts with CCOs, which has caused some concern by the pilot provider that it may impact their sponsored use of that platform in some way. This has created some hesitancy to move forward with the report testing activities until they learn more about their future CMT use via a potentially modified sponsorship model. We are hopeful the work will restart in early 2023.

| Planned Activities – Ongoing | Planned Milestones |
|---|---|
| Explore existing and new use cases for our pharmacy partners | 2023 – 2024 |
| Determine viability of sharing what we build with external partners | 2023 – 2024 |
| Beta test pediatric asthma claims report in Collective | 2023 |

**Strategy 3 title: Develop assessment and monitoring process for HEN access and data contribution rates across provider types**
Brief description: Establish a process for gathering and tracking HEN adoption data.

**Provider types supported with this strategy:**
☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

To improve CMT data tracking and monitoring, PCS added engagement tracking to our CMT Tableau report to identify when provider-provided eligibility/roster files are significantly out of date, as outdated patient rosters negatively impact the accuracy and effectiveness of a provider's cohorts and reports.

We anticipate using these metrics to target provider outreach as the pandemic recedes and providers show more interest in optimizing their use of CMT. Not only can this activity bring a provider's eligibility file current to support better patient care, it may also identify provider-based CMT super users with whom PCS can partner to develop potential uses cases, or identify organizations with limited CMT knowledge who need additional PCS support.

| Planned Activities – Ongoing | Planned Milestones |
|---|---|
| Collect data on HEN participation status | 2023 – 2024 |

**Please describe any barriers that inhibited your progress to support access to timely Hospital Event Notifications among your contracted providers**

BH providers especially have a general resistance to sharing patient information through HIT applications due to the sensitive nature of their patient interactions. Several resources have been made available through the CMT Customer Community online help resource to provide information to ease this resistance. When we encounter these concerns with CMT users, we direct them to these online materials for additional information and support.

### B. Optional Question

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

Identification or information about other or new high-value use cases that leverage hospital event notifications.

## 5. HIT to Support SDOH Needs

### A. HIT to Support SDOH Needs: 2022 Progress and 2023-24 Plans

Please describe your 2022 progress and 2023-24 plans for using HIT within your organization to support social determinants of health (SDOH) needs, ***including but not limited to screening and referrals***.

**Strategy checkboxes**
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

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

**HIT tools used by CCO for Support of SDOH needs**

**List and briefly describe tool(s)**:

**Unite Us/Connect Oregon/CIE** – In an ongoing effort to address social determinants of health, PCS continues its significant investment in the Connect Oregon CIE network powered by the Unite Us platform. PCS also serves as an active member of the Unite Us' Customer Advisory Panel. Through our contract with Unite Us, PCS has empowered all PCS employees, contracted providers and community partners to access the Connect Oregon system. [redacted].

**Collective Medical (formerly PreManage)**: The CMT platform is widely adopted across all PCS regions and has proven to be a key capability for both internal operations and in supporting providers' care coordination efforts. We have begun leveraging CMT data for enhanced housing insecurity identification by leveraging addresses provided from this platform. These addresses are cross-referenced against shelter addresses and names as well as terms and phrases associated with housing insecurity to flag members. PCS also incorporated CMT data to enhance its SDOH and chronic condition identification. CMT data feeds are staged in the PCS data warehouse and integrated into SDOH identification logic.

**Reliance eHealth Collaborative** – Reliance leverages IMAT technology to host its clinical data repository. We have seen the strongest adoption of Reliance in our Central Oregon and Columbia Gorge CCO regions. In addition to being a recipient of Reliance health record data, PCS also contributes administrative claims data to Reliance, including filled prescriptions, to provide a complete picture of encounters to providers treating PCS members. PCS has implemented data exchange with Reliance and is receiving numerous reports to source SDOH information.

**Strategy 1 title**: **Community Information Exchange Governance**
Brief description: Implement activities to ensure CIE program direction, guidance, and oversight.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS continued SDOH as a major internal strategic initiative with Executive level sponsorship and continues working with Unite Us to execute its internal deployment plan.

PCS also participates as a member of the Health Information Technology Oversight Council's (HITOC) Community Information Exchange Workgroup, whose role is to provide recommendations to HITOC and the OHA on strategies to accelerate, support and improve CIE across the state.

PCS staff continued growing their knowledge of the national SDOH screening and referral landscape through education opportunities and industry events, including the CIE California Forum in August, where they engaged in CIE readiness.

| **Planned Activities** | **Planned Milestones** |
|---|---|

| | |
|---|---|
| Manage SDOH as major strategic initiative | 2023 – 2024 |
| Build industry SDOH knowledge | 2023 – 2024 |
| Participate on the HITOC CIE Workgroup | 2023 |

**Strategy 2 title**: **Connect Oregon and Unite Us Implementation - Internal**
Brief description: Increase adoption and use of the Connect Oregon platform within the PCS organization.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS onboarded several new internal teams to Connect Oregon throughout the year including a new PCS DSNP Care Management team in January and a new BH Navigation team in September. Outside of the CCO program, PCS also onboarded its Commercial Care team in August to extend consistency and use of the tool throughout all PCS lines of business.

PCS has worked with Unite Us to integrate the Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities (AHC) social needs screening into the Unite Us platform. PCS Care Management departments across all its lines of business have been trained to use this screening within the platform to assess members' social needs.

PCS launched Connect Oregon incoming referrals directed to the PCS Care Management teams supporting all CCO regions and including Portland Metro in August. Referrals to PCS Care Management may come from any Connect Oregon partners including providers, CBOs, and county health departments. Referrals are sent through the Connect Oregon platform and an email notification alerts the PCS Care Management Member Support Specialists of the new referral. The PCS Member Support Specialists log into Connect Oregon and address the needs of the referral and add a note in the member's record, providing the original referral sender with updates and/or completion. This provides a closed loop referral.

In 2023, PCS will train additional internal staff, including Population Health and Provider Service representatives, Traditional Health Worker Liaisons, and Health Equity Liaisons, on Connect Oregon features and functionality. This additional training will expand the number of internal champions available to answer questions, promote the use of the network and the screening and referral tools therein, and offer introductions and warm hand-offs of providers or community partners to Unite Us staff, as appropriate, during site visits, provider trainings, and ad hoc conversations.

[redacted]

| **Completed Activities** | **Planned Milestones** |
|---|---|
| Onboard DSNP Care Management | N/A |
| Onboard BH Navigation Team | N/A |
| PCS CM incoming referrals launch | N/A |
| **Planned Activities – Ongoing** | |
| Continue to monitor for additional internal onboarding opportunities | 2023 – 2024 |
| Continue to train internal staff for additional provider and community partner support opportunities | 2023 – 2024 |
| Quarterly Health Council status reporting including referral and assessment volumes | 2023 – 2024 |
| **Planned Activities – New** | |
| Navigate contract renewal with Unite Us | 2023 Q3 |

**Strategy 3 title**: **Assess Unite Us and HIE Interoperability Opportunities**
Brief description: Seek opportunities to integrate Connect Oregon with other HIE functionality.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS continues to focus on the expansion and stabilization of the Connect Oregon network within each of our CCO regions. Active work on interoperability will be handled ad-hoc as we consider what an interoperability strategy for existing partner platforms might look like.

That said, in February 2023 Unite Us and CMT/PCC will begin sharing information in a pilot capacity to help address social needs for individuals and families in Oregon. Clients served by Connect Oregon with a

housing, food or transportation referral history within the last six months will have flags on their records in the CMT platform. PCS intends to help test this functionality.

We continue to be alert for other areas where interoperability might provide enhanced tools.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Explore potential new use cases where HIEs and Connect Oregon can interoperate to create tools superior to either operating on its own. | 2023 – 2024 |
| Assess how HIE platform can serve as bi-directional exchange for SDOH & HIE Information | 2023 – 2024 |
| **Planned Activities – New** | |
| Help test integration of Unite Us social needs flags in CMT | 2023 Q2 |

**Strategy 4 title**: **HIE as a source of SDOH Information**
Brief description: Use various HIE sources to gather SDOH information.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

**Connect Oregon as Source of SDOH Information:**

In 2021, PCS initiated a bi-directional interface between PCS and Connect Oregon. In 2022, we began incorporating that ingested information into our proprietary Intensive Care Coordination Prioritized Population (ICC), Care Program Identification Algorithm (CPIA), internal social complexity algorithms, and Member Insight Provider Insight (MiPi) member profiles.

In August 2022, Unite Us released a new version of its database that changed how they captured and structured information, which required PCS to modify the process it uses to bring member data into our data warehouse including restricting and rewriting internal algorithms and logic to accommodate the new data structure, field names, and values. These modifications were necessary to ensure Connect Oregon data would continue to be integrated into member identification and analysis.

As a result of the PCS process coding changes, in addition to referrals, we are also looking at information from case descriptions, service types and programs to find members with needs of interest. It has allowed PCS to implement broader and more comprehensive ways to pull in data for identifying members with SDOH needs. Connect Oregon SDOH signals proliferate into each place SDOH data flows in the process.

Currently, our SDOH process includes:

- Identifying SDOH signal for members from multiple data sources
- Storing tables of SDOH signal in enterprise data warehouse to allow for use by Analytics and Business Intelligence teams for additional report development, analyses, member lists, and ad hoc project work
- Flowing data into existing products such as MiPi and CPIA, exposing information to users in member profiles
- Developing and maintaining reporting, including interactive and customizable reporting, on SDOH signal prevalence. Monitoring prevalence of members with SDOH and diabetes or members with housing insecurity and Diabetes are examples.

Connect Oregon submission, referral, and case data are used in combination with other disparate data sources to identify members with challenges or barriers related to housing, finances, health care access, social support and connection, transportation, stress, safety, incarceration, and other social determinants of health. These enhanced methods were used in 2022's annual population health assessment reporting to better understand the scope of member needs and variation in potential screening or documentation rates.

Data has also been incorporated into member profiles for care managers and feed into care program identification algorithms. Connect Oregon data also feeds into interactive social determinants of health prevalence reporting, as well as exploratory children's health complexity dashboards to help drive strategic planning to improve the social and emotional well-being of our pediatric members. Additionally, Connect

Oregon data is helping to drive a project included in our 2022 and 2023 Transformation and Quality Strategy (TQS), which aims to improve health outcomes for members with housing insecurity and diabetes through care management outreach.

PCS has created a multi-year roadmap around the collection, storage, and normalization of REALD and SOGI data that we expect to include in HIE and CIE sources. We expect to collaborate with OHA over the coming months around better defining the process of collection and data exchange as part of the implementation of HB 3159.

**Collective as Source of SDOH Information:**

PCS enhanced housing insecurity identification by leveraging addresses provided out of Collective. These addresses are cross-referenced against shelter addresses and names as well as terms and phrases associated with housing insecurity to flag members.

- One specific high-value use case of the housing insecurity algorithm that began in 2022 was a TQS project geared at understanding the unique needs of members with diabetes and housing insecurity. Care management teams have selected this population for targeted outreach after years of first-hand experience in working with vulnerable members who experienced adverse health outcomes. In 2022, Clinical Quality Improvement, Case Management, and Analytics teams worked together to review population data to understand their unique needs and develop a clinical workflow and data reporting tools. In 2023, Case Management teams will begin providing routine outreach to members with housing insecurity and diabetes in order to foster engagement in primary care and behavioral health, close care gaps, and support the member with social determinants of health needs through health-related services funding.
- Another impactful use case of SDOH information was the CCO-led cross-sector community engagement efforts to develop the action plan for the system-level social-emotional health metric. Exploratory dashboards included social risk factors which consolidated disparate data, including SDOH data from HIE, to help inform community collaboration to determine and identify priority populations. These conversations aimed to lay the groundwork for improving the social-emotional health of our pediatric members. SDOH data and connected social risk factor data helped internal teams to consider the unique needs of our members to determine specific area of focus to create data-informed action plans.

PCS also incorporated CMT data to enhance its SDOH and chronic condition identification. CMT data feeds are staged in the PCS data warehouse and integrated into SDOH identification logic.

**Reliance as Source of SDOH Information:**

Analysis of housing insecurity on cost, utilization, and risk: By joining disparate data sources in identifying housing insecurity, we were able to analyze pediatric and adult members who experienced housing insecurity compared to the general population. The goal of the analysis was to understand population characteristics of housing insecure members, including disease burden, demographics, health care utilization, and costs. These analyses were used during strategic discussions among leadership around potential options for actions and/or investments aimed at improving housing security. Based on improvements to how we identify housing insecurity, future analyses will better capture members experiencing challenges. We are excited about our analysis in this area and continue to review additional and potential data in the Reliance HIE around diabetes by type, tobacco use, birth weight, food insecurity, and pregnancy.

Mined additional Reliance data reports for SDOH signals:

- To support our ability to match data received from Reliance to internal reports, we started receiving a weekly Reliance Member Crosswalk that compares the member IDs we send to Reliance to Reliance's system-generated member IDs. The crosswalk greatly improves our ability to appropriately match members in Reliance reports. We expect member matching to improve as Reliance continues

to enhance their internal member matching methods (see also HIE Strategy 9 – Community Health Records as source of supplemental data for quality programs).

- In January 2022, PCS implemented an enhancement to SDOH identification to grab SDOH signals from Reliance COVID-19 reports. Realizing that 1) given the COVID-19 Reliance reports were already regularly provided, a non-standard ETL was already in place internally to update and stage the COVID-19 vaccine report for other uses, and 2) that there were five SDOH flags on that report, we decided to maximize the information we have available and include it as an additional data source. SDOH flags from Reliance provided in the COVID-19 vaccine data feed include financial insecurity, food insecurity, housing insecurity, social insecurity, and transportation insecurity.
- In addition to reports, Reliance agreed to begin sending regular data feeds in the second half of 2022 using the PCS standard EMR data format. A non-standard ETL was put in place to update the PCS data warehouse with these data files, enabling us to incorporate Reliance data feeds as a data source of timely SDOH information.

**EMR as a Source of SDOH Information:**

In 2022, PCS integrated data from EMR feeds into its SDOH identification logic. Participating clinics provide EMR feeds to PCS in a standard format which are then ingested into the data warehouse. The current feeds do not include SNOMED-CT codes but do provide diagnoses, procedures, and provider information. In the second half of 2022, diagnosis codes from the EMR feeds were incorporated into the SDOH identification algorithm.

PCS has continued to enhance and improve its SDOH identification methods throughout 2022 and will continue to do so in 2023. Beyond the improvements mentioned above, additional efforts included:

- Reviewing and enhancing how addresses are used to identify housing insecurity. Four changes were implemented in 2022:
    - Including more addresses for housing shelters that were not previously in the algorithm
    - Updates and enhancements to identification of phrases and keywords that signal housing insecurity in a member's address field
    - Inclusion of addresses from Collective data for identification
    - Incorporating a member's address history in addition to most recent address. This last element helped improve our ability to identify members who may have ever experienced housing insecurity.
- Including Case Management data from our internal Population Health Management Platform (Dynamo / CaseTrakker) into SDOH identification. This enhancement now ensures that when a case manager identifies someone with a SDOH need in a discrete field, that signal is captured for that member.

With the use of multiple data sources and HIE, PCS's SDOH algorithms became more comprehensive and in 2022 included data from:

- Reliance SDOH-specific reports
- Reliance data feeds
- Reliance reports that include SDOH flags (such as COVID-19 vaccine reporting)
- Collective data feeds (including addresses)
- Connect Oregon / Unite Us data feeds
- Member eligibility files
- PCS claims
- Internal Population Health Management Platform / Case Management Software (currently Dynamo / CaseTrakker)

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|

| | |
|---|---|
| Identify additional data sources and elements containing data relevant to monitoring and addressing SDOH | 2023 – 2024 |
| Continue data modeling from staged Connect Oregon data | 2023 – 2024 |
| Explore the mining of Collective data for predictive SDOH variables | 2023 – 2024 |
| Mine additional Reliance data reports for SDOH signals | 2023 – 2024 |
| Use EMR feeds as a data source | 2023 – 2024 |
| Continue to integrate newly identified/relevant data into the Enterprise DW, CPIA and MIPI | |
| **Planned Activities – New** | |
| Incorporate new ICD10 codes available in 2023 for SDOH | 2023 |
| Develop additional SDOH indicators for physical/built environment exposure and occupational exposure | 2023 |
| Improve and enhance the transportation insecurity flag | 2023 |

**Strategy 5 title**: **CCO Metrics Support**
Brief description:

**Provider types supported with this strategy:** ☒ Across provider types OR
specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☐ Social Services ☐ CBOs

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

At PCS, our standard work in supporting QIMs is through our monthly dashboard monitoring for all claims and electronic clinical quality (eCQ) measures. Our Business Intelligence team has taken each claims-based measure and transcribed it into code, where we are able to monitor CCO performance and share it across our healthcare system monthly. By doing so, we can support our provider partners in strategies to ensure each CCO is performing as well as possible.

PCS continues to seek solutions using HIE platforms like CMT and Reliance to support QIMs, such as they have with their IET Metric cohort and reports. We support exploring and piloting different HIT spaces as providers approach us to collaborate.

**Social-Emotional QIM:**

- In 2022, PCS Analytics teams created internal data repositories to ingest the OHA Child Health Complexity data, overlying internal data (SDOH, Parent linkage data, etc.) to illustrate the most accurate picture of these at risk 0–5-year-olds. We were able to slice and filter this data to try to understand the factors influencing the health and access of these children. This led each of our CCOs to select the population they will focus on for this measure over the next three years.
- As part of the action plans, each CCO has considered or adopted the impact of the asset map as a community tool and the role of a community information exchange and how those platforms can support this work. This will continue to be considered over the iteration of the future actions plans for this measure.

**SDOH QIM:**

- In 2022 we began to prepare for the new SDOH QIM incentive measure by building our understanding of its goals and timelines and starting to assess how Connect Oregon might “see” screenings done in other platforms. A future responsibility under the SDOH QIM will be to reduce duplication of screenings and drive providers and partners to use OHA-approved screening tools. We expect this work to have significant focus in 2023.
- Identify additional data sources and elements containing data relevant to monitoring and addressing SDOH: The new SDOH QIM calls for using OHA provided REALD member data to identify where we might have gaps in our resources on Connect Oregon for members with cultural or linguistic needs. In 2022, PCS reviewed the top race, ethnicities and languages spoken in each CCO region to inform a list of priority organizations to onboard. However, it has been challenging to track utilization

disaggregated by race, ethnicity, and language needs of those served on Connect Oregon as those fields are optional and often skipped when intaking a member. Additionally, the Connect Oregon platform does not currently capture member disability status. Given the limitations of REALD data in the Connect Oregon platform, PCS will explore tracking this data in our own systems in 2023.

- The SDOH QIM requires us to capture who was screened (and who declined to be screened) for three domains (housing, food and transportation), what screening tool was used, who screened positive and whether a referral was made to resources. In 2023, we will collaborate with Unite Us to explore platform and data exchange enhancements to meet these requirements.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Social-Emotional QIM: Consider creation of asset map | 2023 |
| **Planned Activities – New** | |
| SDOH QIM – Survey providers for existing screening tools | 2023 |
| SDOH QIM: Explore tracking REALD data internally | 2023 |

Please describe your 2022 progress and 2023-24 plans for supporting contracted physical, oral, and behavioral health providers with using HIT to support SDOH needs, ***including but not limited to screening and referrals***. Additionally, describe any progress made supporting social services and community-based organizations (CBOs) with using HIT in your community.

**Strategy checkboxes**
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

☒ Sponsor CIE for the community

☒ Financial support for CIE implementation and/or maintenance

☒ Training and/or technical assistance

☒ Assessment/tracking of adoption and use

☒ Outreach and education about the value of HIT adoption/use to support SDOH needs

☒ Support participation in SDOH-focused HIT collaboratives, education, convening, and/or governance

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

☒ Requirements in contracts/provider agreements

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

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

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

☐ Utilization of HIT to support payments to community-based organizations

☐ Other strategies for supporting adoption of CIE or other HIT to support SDOH needs (please list here):

☐ Other strategies for supporting access or use of SDOH-related data (please list here):

**HIT tools supported or provided by CCO that support SDOH needs, including but not limited to screening and referrals**

**List and briefly describe tools**:

**Unite Us/Connect Oregon/CIE** – In an ongoing effort to address social determinants of health, PCS continues its significant investment in the Connect Oregon CIE network powered by the Unite Us platform. PCS also serves as an active member of the Unite Us' Customer Advisory Panel. Through our contract with Unite Us, PCS has empowered all PCS employees, contracted providers and community partners to access the Connect Oregon system. [redacted]

**Collective Medical (formerly PreManage)**: The CMT platform is widely adopted across all PCS regions and has proven to be a key capability for both internal operations and in supporting providers' care coordination efforts. We have begun leveraging CMT data for enhanced housing insecurity identification by leveraging addresses provided from this platform. These addresses are cross-referenced against shelter addresses and names as well as terms and phrases associated with housing insecurity to flag members. PCS also incorporated Collective data to enhance its SDOH and chronic condition identification. Collective data feeds are staged in the PCS data warehouse and integrated into SDOH identification.

**Reliance eHealth Collaborative** – Reliance leverages IMAT technology to host its clinical data repository. We have seen the strongest adoption of Reliance in our Central Oregon and Columbia Gorge CCO regions. In addition to being a recipient of Reliance health record data, PCS also contributes administrative claims data to Reliance, including filled prescriptions, to provide a complete picture of encounters to providers treating PCS members. PCS has implemented data exchange with Reliance and is receiving numerous reports to source SDOH information.

**Strategy 1 title**: **Connect Oregon and Unite Us Implementation – Contracted Providers and CBOs**
Brief description: Increase adoption and use of the Connect Oregon platform by external partners.

**Provider types supported with this strategy:** ☒ Across provider types OR
specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☐ Social Services ☒ CBOs

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

Even given the pandemic's ongoing impact to provider partners and CBOs throughout 2022, we continued to make progress developing the Connect Oregon network. Building a robust referral network is a multi-year process and we expect to spend 2023 inviting additional providers and CBOs to join the network and increasing the diversity of the SDOH related resources offered to support the unique needs of the members in each region.

The PCS goal continues to be to onboard as many providers and CBOs across all our CCO regions as possible. [redacted]

Each quarter, Unite Us and PCS review network adoption and utilization data to investigate and strategize ways to improve the health of the network. A primary focus of these quarterly reviews is the list of "active" organizations on Connect Oregon, i.e., the providers and CBOs actively sending and receiving referrals. Unite Us' definition of active is sending or receiving at least one referral in the last three months. Unite Us and PCS review this data to determine outreach opportunities to support network partners.

As a result of the progress noted above, Unite Us and PCS partnered to facilitate the growth of Connect Oregon over the course of 2022 as follows:

| **2022 Connect Oregon Network Growth** | | |
|---|---|---|
| **Region** | **2021 Total On-boarded Partners*** | **2022 Total On-boarded Partners*** |
| Marion & Polk | 50 | 218 |
| Central Oregon | 61 | 80 |
| Lane County | 50 | 98 |

*Including healthcare organizations, community-based organizations, and government entities

| 2022 Connect Oregon Network Health | | | |
|---|---|---|---|
| **Region** | **Total Clients Served** | **Accepted Referrals Rate** | **Resolved Cases** |
| Marion & Polk | 1,065 | 53% | 43% |
| Central Oregon | 450 | 65% | 51% |
| Lane County | 462 | 49% | 48% |

The results of PCS' intensified outreach efforts are evident in the significant increase of onboarded partners across CCO regions. PCS provided introductions and "warm handoffs" to Unite Us' customer success team for follow through with providers and CBOs with whom PCS has strong partnerships. PCS and Unite Us meet monthly to discuss network development, review data, and discuss which providers or community partners require additional outreach or support.

While the number of clients served in each region increased, the accepted referral rate and percent of resolved cases either decreased or remained flat in 2022. Two reasons for lower accepted referrals and unresolved cases are due to client ineligibility for services and/or the receiving organization did not have capacity to serve additional clients. This was especially true in the housing and shelter services sector. Certainly, part of the issue is a lack of staff capacity or inadequate resources, but another is that sending referrers are not paying close attention to the eligibility criteria for services as outlined by the receiving organizations. Additional training in 2023 will help alleviate this issue.

PCS continues to onboard CBOs and providers and assist with establishing Connect Oregon licenses and workflows in ways that are unique to each region's needs.

- Central Oregon
    - In addition to monthly strategic discussions between the PCS and Unite Us teams, the COHIE community group, led by PCS and OHLC, meets quarterly to spotlight key partners in Central Oregon to target for outreach and onboarding to Connect Oregon.
    - The Metric Advisory Committee, funded by the Central Oregon Health Council Regional Health Improvement Project (RHIP) Workgroup: Behavioral Health Access & Coordination, is developing a metric to measure timeliness and engagement when patients are referred from primary care to specialty behavioral health. The Committee (comprised of several regional payers including PCS) is working with several BH providers across the region and in a variety of settings (e.g., community mental health programs, hospital-based, private group, and individual practices) to create the measure and test it. The group is exploring using Connect Oregon as the tool for referrals, data collection, and reporting, which has led to several BH providers joining the network who weren't previously on board.
- Lane
    - Lane County partners are participating in a Behavioral Health Resource Network (BHRN) as part of Measure 110 implementation, which expanded access to substance use disorder treatment. Lane County's BHRN's focus is to make screening health assessment and treatment and recovery services for drug addiction available to all those who need and want access to those services and to adopt a health approach to drug addiction by removing criminal penalties for low-level drug possession. Lane County BHRN is using Connect Oregon in their collaboration effort to send and receive referrals between participating partners.

- Marion-Polk
    - Fifty-six new partners were onboarded in the M-P region in 2022. There continues to be a need for additional outreach and support to onboarded and dormant organizations for engagement, training, referral pathway discovery, and workflow planning.
    - Salem Health joined the network in late 2022. Within Connect Oregon, there will be nine unique Salem Health entities on the network, including eight local clinics and Salem Hospital.
    - Willamette Education Service District and 19 school districts in the region have joined Connect Oregon. Weekly meetings on utilization and training will occur in early 2023, with a primary focus on behavioral health services for students.
    - Unite Us presented overviews and demonstrations of Connect Oregon during several HIT Collaborative discussions facilitated by the Willamette Health Council. Expected 2023 activities include identifying potential referral pathways for HIT Collaborative members to begin fully engaging in the platform.
- Columbia Gorge: See Strategy 3 below – Connect Oregon Go-Live in the Columbia Gorge Region

Starting in January 2023, PCS plans to participate with nine other CCOs and 211info, OHLC, and HIT Commons to financially and logistically support an 18-month quantitative and qualitative evaluation of the Connect Oregon rollout. The University of California San Francisco (UCSF) SIREN Evaluation Team will conduct the evaluation.

**Additional Progress Specific to Oral Health Providers:**

- Both Capitol Dental and Advantage Dental are open to receiving referrals via Connect Oregon in all CCO regions.
    - Though participants from both DCOs were consistent attendees of the monthly Lane HIC Cohort meetings intended to create and support referral pathways between mental health providers and the DCOs, no other Lane HIC participants sent them any referrals. The only Lane County organization that sent referrals to Capitol Dental was the PCS Lane Care Management team.
- ODS onboarded to the platform and plan to have case managers send referrals for social care on an as-needed basis. As of mid-November, they had not yet been active on the platform. The intent is to start with sending referrals only, and eventually expand to receiving referrals for physical health service types as well.
- Unite Us facilitated a Connect Oregon Dental Huddle as a space to bring together funders, their DCOs and CBOs to brainstorm workflows and strategize how to leverage Connect Oregon to link community members to oral health. Huddles were attended by most CCOs around Oregon, as well as Advantage Dental, Capitol Dental, and Oregon Dental Services (ODS) Community Dental. The huddles met on a quarterly or bi-annual basis depending on the network's needs. The next huddle is expected in early 2023.
- Workflows between DCOs and CCOs are a high priority; however, many DCOs are reluctant to get started until more CCOs across the state are accepting referrals. This currently represents a barrier to oral health engagement. To date, all four PCS CCOs accept referrals.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Facilitate learning sessions in each region leveraging Unite Us events for learning and support with on-boarded partners | 2023 – 2024 |
| Continue onboarding providers and CBOs and assisting with the establishment of Connect Oregon licenses and workflows | 2023 – 2024 |
| **Planned Activities – New** | |
| Participate in SIREN Evaluation | 2023 |
| Navigate contract renewal with Unite Us | 2023 Q3 |

**Strategy 2 title**: **Connect Oregon and Unite Us Implementation – Members**
Brief description: Increase adoption and use of the Connect Oregon platform by PCS CCO members.

**Provider types supported with this strategy:** ☐ Across provider types OR
specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☐ Social Services ☐ CBOs ☒ N/A

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS teams explored the potential for enabling member self-referrals to PCS via a link on the PCS website. The team also discussed the requirement and feasibility of creating the form in the PCS Medicaid threshold languages. Ultimately, PCS's web design team had to prioritize other website elements to meet other contractual components and had to pause on including any other website enhancements, including this self-referral capability.

Members can currently self-refer for PCS services via the Connect Oregon platform by completing a simple form on the Connect Oregon website that routes them to a resource navigator at the Unite Us Care Center, which will make the referral to PCS from there.

PCS will explore the self-referral opportunity again in 2023. That said, it is unlikely this can be completed on that timeline as it has not yet been identified and resourced for 2023 IT project efforts.

| **Planned Activities** | **Planned Milestones** |
|---|---|
| Explore potential for member self-referral capability | 2023 – 2024 |

**Strategy 3 title**: **Connect Oregon Go-Live in the Columbia Gorge Region**
Brief description: Address unique adoption challenges of the Connect Oregon platform in the Columbia Gorge region.

**Provider types supported with this strategy:** ☒ Across provider types OR
specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☐ Social Services ☒ CBOs

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

Unfortunately, our progress in the Gorge remains sluggish. As the region emerges from the height of COVID-19 response efforts, staff capacity and personnel shortages continue to limit organizational appetite for adopting new technology. Duplication in member data tracking is another primary concern of many providers and community partners as they prefer a solution that includes interoperability with their EHR and/or Activate Care, a care management platform used by many providers and CBOs throughout the Gorge region.

As a mitigation strategy for the latter, PCS worked with Unite Us and Activate Care to explore options for interoperability between the two platforms. This effort did not ultimately bear fruit in 2022 due to several confluent factors. Primarily, however, the costs of the solutions we evaluated (which are fairly significant and increasing on a per-partner basis) are not yet counterbalanced by the value they will provide.

We will continue to evaluate new options in this space in hopes that a solution that is truly scalable to multiple providers and multiple regions can be developed.

- Bridges to Health will use Connect Oregon to send Flexible Services requests to PCS, giving them experience using the tool, hopefully building familiarity and comfort with its capabilities. A few of the Bridges to Health community health workers are co-located within the region's FQHC, which may prompt it to join the network.
- The Mid-Columbia Community Action Council (MCCAC) received funding in 2022 to develop a new Navigation Center in the Gorge that will have an upcoming use case around housing wrap services. MCCAC intends to build a new physical building that will co-house several agencies from across the region, making it easier for community members to access services. Unite Us intends to participate in its Request for Proposal (RFP) process to provide a community information exchange platform to be used by all involved agencies, potentially making some inroads into the Gorge community via this new service partnership.

| **Planned Activities – Ongoing** | **Planned Milestones** |
|---|---|
| Assess interoperability between Connect Oregon and Activate Care | 2023 |
| Establish technical and clinical workflows in advance of go-live | 2023 |

| | |
|---|---|
| Identify high-priority CBOs vital for launch and begin engagement | 2023 |
| Finalize technical and clinical workflows and test for viability | 2023 |
| Explore referral & navigation to resources outside the Columbia Gorge Region | 2023 |

**Strategy 4 title**: **Explore the application of CIE for Clinical Care Coordination**
Brief description: See opportunities to use Connect Oregon to fill gaps in clinical care coordination.

**Provider types supported with this strategy:** ☒ Across provider types OR
specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☐ Social Services ☐ CBOs

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS has been working to use Connect Oregon to fill a gap in clinical care coordination since 2020. One specific use case being pursued is coordinating care between primary care providers and behavioral health providers. To ensure a smooth implementation of this use case, Unite Us took a regionally focused, pilot-style approach to onboarding clinical partners within Connect Oregon.

Given the Lane County region was focused on addressing behavioral health workflows, in 2021 it began a pilot for this use case. Select providers were invited to participate in the Connect Oregon + Healthcare Integration Collaborative (HIC) Pilot in Lane County to leverage a standardized referral form to send and receive electronic referrals for behavioral health, physical health, substance use disorder treatment, and oral health. The team laid the foundation and preparations for the pilot throughout the remainder of the year.

The HIC 1.0 Cohort kicked off in February 2022, led by a PCS BH Strategist. Unite Us built a custom assessment form into the Connect Oregon platform called the Standardized Referral Form for Coordinated/Integrated Care. One of the initial and primary goals of this cohort was to facilitate clinical referrals and workflows on Connect Oregon via a group of interdisciplinary providers – those being physical health, behavioral health and oral health providers. The original goals were to improve collaborative care, ensure accurate referrals between participating provider types, establish shared language across disciplines, remove access barriers for clients seeking services, and focus on centering clients in collaboration across services. The intention was to have these providers use this assessment form when sending clinical referrals amongst each other, and then evaluate the efficacy of the form in capturing the needed details for clinical referrals.

The group met monthly from February through August. During that time, none of the providers participating in the cohort used the Standardized Referral Form, nor did they send referrals amongst each other. This was likely the result of a number of different factors.

- Providers participating in the cohort were at various adoption points in their Connect Oregon process, with some who were not yet onboarded onto the platform. This made it difficult to identify shared experience and challenges across the different providers as different types and levels of support were needed.
- There were few, if any, providers who were actively using the platform at the launch of the cohort pilot. Because there was no baseline level of understanding, the additional step of completing the standardized referral form seemed to act as an additional barrier or challenge to getting any referrals sent.
- For the providers that were on the platform, only one was accepting referrals for any programs, which meant there were limited options available to send referrals to.
- The structure of the group and meetings was also difficult, with many providers participating in a virtual format.
- It was difficult to identify the right role of each provider to participate in conversations, and many providers were still managing workforce and post-COVID limitations.
- Because no referrals were made between partners, the group was unable to assess whether use of the form or platform ultimately had a positive impact on care coordination or client connection to services.

After reviewing and discussing the lack of results from Phase 1, original cohort participants interested in continuing established new goals for Phase 2 and set a new meeting cadence for 2023. Phase 2 goals focused more broadly on identifying referral pathways to move onto Connect Oregon, collaborating to recruit key partners to the platform, and increasing the number of referrals sent/received by cohort participants. Additionally, to qualify as a participating provider, an organization had to be onboarded to the platform, and there were more clear expectations around pilot member time commitments and the expected level and type of engagement.

Discussion during the Phase 2 kickoff meeting identified shared key partners who were interested in establishing referral pathways together. However, during the last quarter of 2022, when there was follow up after the meeting to identify clear goals, there was no response from any participating partners. Despite multiple rounds of direct follow up, engagement did not increase so the decision was made to discontinue meeting, ending the pilot. Individual technical assistance was offered to participating providers on the platform.

As we explore a better understanding of the types of provider-to-provider use cases that could potentially scale, we expect to confirm that provider-to-provider referral success will likely come among smaller, lower-volume providers who have less technology and automation already in place. These providers may not have a reliable mechanism to communicate with specialty providers because they are either not using an EHR or using a different EHR than the receiving provider. While larger systems that receive large volumes of referrals may have the technology, making a change there may be too disruptive without additional and costly development of those tools. Large referral receivers may be resistant to change because they have built a lot of automation around that process, which may not be easy to modify.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| Lane Provider-to-Provider Referral Pilot | N/A |
| **Planned Activities** | |
| Develop understanding of the best types of P2P use cases that could potentially scale | 2023 – 2024 |

**Strategy 5 title**: **Enhancements to CIE Tools**
Brief description: Seek ways to add or improve functionality within Connect Oregon.

**Provider types supported with this strategy:** ☒ Across provider types OR
specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☐ Social Services ☒ CBOs

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

PCS streamlined the process for members to submit requests for Health-Related Services ("Flexible Services") through Connect Oregon by replacing an attachable PDF form with a list of questions embedded directly within Connect Oregon.

PCS and CareOregon collaborated to create a universal form that would meet the requirements for both CCOs and Unite Us then embedded this form into the platform. This universal form will also provide ease for the requestor by knowing that the same information will need to be provided no matter which CCO plan the member might be on. Rather than downloading the request form from a website, filling it out and then attaching it in Connect Oregon, those requesting Flexible Services can now complete the embedded questions within Connect Oregon to make a request.

We believe this method significantly improves the process for both submitting the request and the turnaround times between submission and approval. It also provides the ability to use Connect Oregon to check the status of the request at will. Providers have asked for this technology, and we expect a robust use of it throughout the year.

Plans:

- In 2023, PCS will solicit feedback from users of the Flexible Services form to determine if additional enhancements are needed and to gauge users' level of satisfaction with the ability to send and track requests through Connect Oregon.

- PCS remains attuned to additional opportunities to promote and use Connect Oregon to serve the health-related social needs (HRSN) outlined in OHA's 2022-2027 1115 Medicaid Demonstration Waiver, including referrals for short-term post-transition housing for up to six months, temperature and clean air supports for members during climate emergencies, medically tailored food assistance, and HRSN benefits for at-risk youth.

| **Completed Activities** | **Planned Milestones** |
|---|---|
| HRS – Flexible services incoming referral process enhancement | N/A |
| **Planned Activities – New** | |
| Develop strategy around future 1115 Waiver | 2023 – 2024 |

**Please describe any barriers that inhibited your progress to support contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using HIT to support SDOH needs, including but not limited to screening and referrals.**

- As we encourage providers to engage in piloting new platforms such as Connect Oregon for closed-loop referrals, large referral receivers may be change resistant because they have built a lot of automation around that process, which may not be easy or cost effective for them to change.
- Many social service organizations have relied on personal relationships for a long time to make referrals for services. These personal relationships are more focused on calling someone directly versus using technology. For these individuals it's more about high "touch" than high "tech." For those who appreciate and value that personal approach, moving to a tool like Connect Oregon can feel impersonal and uncomfortable.
- Staff turnover continues to impact the ability of organizations to fully embrace the technology as new individuals need to receive training before using the platform. In addition to resource turnover in provider offices and at CBOs, we have also seen turnover within our regional health councils. Some organizations have been dormant because they just don't have capacity to use the platform (staff to manage the referrals, the programs are at capacity, and so on).
- Referring organizations who want to start their Connect Oregon usage slowly due to staffing and resource constraints are concerned they will not be able to limit incoming referrals to a cadence they can handle (often with just one or a few referral partners) due to technology limitations. Housing partners especially had this concern as they had limited housing resources to make available to clients in need. PCS and Unite Us identified a way to structure the receiving organization's program and eligibility details in such a way as to remove many of the concerns around this barrier.
- Some organizations, such as those serving the unhoused population, preferred to wait to join the platform until Connect Oregon is integrated with other services, such as HMIS, which has also slowed adoption for some specific service types.
- Setup and adoption of new technology takes time, money, and resource that some organizations don't currently have. Areas of concern that can cause an organization not to adopt include:
  - Time and knowledge commitment for someone to understand and manage new technology, new workflows, and then handle an increase in service demand
  - Additional training needs of new staff after staff turnover
  - Operating under limited budgets and staffing structures that are already stretched to capacity
  - Disparity in technology capabilities
    - Healthcare has seen an investment in technology that CBOS haven't seen
    - Limitations for interoperability, leading to duplication in reporting

  Funding opportunities might address some of these issues. Some potential opportunities might include the Legislature, Health Council investments and grants, and Foundation grants.
- [redacted]

- PCS and Unite Us have been working on onboarding Education Service Districts (ESD) and school districts in 2022 to meet the social needs of children, teens, and their families. We have also promoted the use case of referring to BH services. In Central Oregon, High Desert ESD (HDESD) set out to contract with an online platform to improve referral pathways to BH to address the mental health crisis facing many of their region's school-aged youth. HDESD contracted with Care Solace, a platform that provides BH referral concierge services. HDESD declined to also onboard to Connect Oregon at this time for social needs referrals as their focus today is on behavioral health referrals. There is a risk that ESDs and school districts in PCS' other CCO regions may follow suit with a reluctance to onboard to two referral platforms. Given the urgency of connecting students with BH resources, some ESDs may follow HDESD's lead in prioritizing onboarding to a platform designed for BH referrals.

### B. Optional Question

How can OHA support your efforts in using and supporting the use of HIT to support SDOH needs, including **social needs screening and referrals?**

We support the recommendations from HITOC and the CIE Workgroup including that the success of CIE is dependent on widespread adoption by community-based organizations. OHA can support CIE network efforts by developing sustainable funding to support CBOs to adopt and utilize CIE. Additionally, many CIE partners are eager to see OHA and Oregon Department of Human Services (ODHS) programs join CIE platforms to receive incoming referrals.

## 6. Other HIT Questions (Optional)

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

A. Describe CCO HIT tools and efforts that support **metrics**, both within the CCO and with contracted providers. Include CCO challenges and priorities in this work.

PCS has built a robust internal data and analytics tool that tracks each measure continuously throughout the year analyzing both rolling 12-month and year-to-date performance by CCO, PCP and DCO for all claims-based and electronic clinical quality (eCQ) measures. As a result, our internal logic historically matches the OHA final dashboards within a .01 variance. For the four eCQMs, our reporting organizations submit data monthly so we can track performance, spot nuances and address challenges as they arise.

In each of the PCS CCOs, we have full transparency in this program. We share CCO-wide performance by measure across the PCP groups as we believe the population and metrics are cared for by the collective body of providers. Each month our provider partners are shared three sets of documents: CCO Dashboards, Clinic Dashboards and Metric Gap Lists.

The largest set of challenges for this body of work surround the electronic clinical quality metrics (eCQM). These measures require organizations to have technical code writers in each of their organizations that can take standard metrics and adjust them or create custom reporting for the Screening, Brief Intervention and Referral to Treatment (SBIRT) and Cigarette Prevalence measures. This is incredibly challenging. By not using standard HEDIS metrics that most EHR platforms stock as standard workflows, each organization must interpret measure specifications. We work hard with these providers to ensure proper reporting, but the challenge still exists. In 2022 for the 2021 logic, we experienced the OHA Metrics team removing reporting data due to what was believed to be an inadequate answer to clarifying questions.

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

| |
|---|
| C. How can **OHA support** your efforts in accomplishing your HIT Roadmap goals? |
| Continue with CCO collaboration and brainstorming. |
| D. What have been your organization's **biggest challenges** in pursuing HIT strategies? What can OHA do to better support you? |
| |
| E. How have your organization's HIT strategies supported **reducing health inequities**? What can OHA do to better support you? |
| The HIT platforms have provided us with a rich source of information informing our strategy around access to care, vaccinations, and responding to emergencies. We expect this to continue in the future. |