# UHA 2023 HIT Roadmap

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

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

**Please be sure to:**

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

Table of Contents


Guidance, Evaluation Criteria & Report Template, **Option A** 1

Guidance Document 3

Purpose & Background 3

Overview of Process 4

HIT Roadmap Approval Criteria 5

2023 HIT Roadmap Template 9

Instructions & Expectations 9

**1. HIT Partnership** 11

**2. Support for EHR Adoption** 11

A. Support for EHR Adoption: 2022 Progress 11

B. Support for EHR Adoption: 2023-2024 Plans 18

C. Optional Question 21

3. **Support for HIE – Care Coordination** (excluding hospital event notifications, CIE) 21

A. Support for HIE – Care Coordination: 2022 Progress 21

B. Support for HIE – Care Coordination: 2023-2024 Plans 27

C. Optional Question 29

**4. Support for HIE – Hospital Event Notifications** 29

A. Support for HIE – Hospital Event Notifications: 2022 Progress 29

B. Support for HIE – Hospital Event Notifications: 2023-2024 Plans 40

C. Optional Question 43

**5. HIT to Support SDOH Needs** 43

A. HIT to Support SDOH Needs: 2022 Progress 43

B. HIT to Support SDOH Needs: 2023-2024 Plans 49

C. Optional Question 53

**6. Other HIT Questions (Optional)** 54

Appendix 55

Example Response: Support for HIE – Care Coordination 55

A. 2021 Progress 55

B. 2022-2024 Plans 59

# Guidance Document

## Purpose & Background

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

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

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

**Changes for Contract Year 4 (2023):**

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

**Reminders for Contract Year 4 (2023):**

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

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

## Overview of Process

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

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

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

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

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

### *2023 HIT Roadmap* Timeline

**Last Revised 10/27/2022**

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

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

## HIT Roadmap Approval Criteria

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

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

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

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

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

# 2023 HIT Roadmap Template

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

**CCO:** Umpqua Health Alliance

**Date:** 3/15/2023

## Instructions & Expectations

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

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

Each required topic includes the following:

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

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

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

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

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

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

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

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

**A note about the template***:*

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

***HIT Roadmap Template Strategy Checkboxes***

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

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

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

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

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

## 1. HIT Partnership

Please attest to the following items.

| | | |
|---|---|---|
| **a.** | ☒Yes<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

Please describe your progress supporting increased rates of EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers. In the spaces below, please
1. Select the boxes that represent strategies pertaining to your 2022 progress.
2. Describe the progress of each strategy in the appropriate narrative sections.
3. In the descriptions, include any accomplishments and successes related to your strategies.

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

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

| | |
|---|---|
| ☒ EHR training and/or technical assistance<br>☒ Assessment/tracking of EHR adoption and capabilities<br>☒ Outreach and education about the value of EHR adoption/use<br>☒ Collaboration with network partners<br>☒ Incentives to adopt and/or use EHR | ☒ Financial support for EHR implementation or maintenance<br>☒ Requirements in contracts/provider agreements<br>☐ Leveraging HIE programs and tools in a way that promotes EHR adoption<br>☐ Offer hosted EHR product<br>☒ Other strategies for supporting EHR adoption<br>**Supporting Legacy EHR Data** |

**i. Progress across provider types**

**Strategy 1 - EHR training and technical assistance**

In 2022, Umpqua Health Alliance (UHA) worked closely with a large RHC clinic (Umpqua Health Newton Creek) on several key projects, including:

- Implementing kiosks for their patient check-in process. This helped the clinic go paperless, reduced their check-in times, reduce data entry errors and increased staff productivity.
- Migrated their analog fax lines to a modern cloud-based e-fax solution. This increased efficiency because staff no longer had to print and scan documents, they simply had to attach them to the correct patient chart.
- Integrate their EHR system eClinicalWorks with an artificial intelligence (AI) dictation solution called Nuance DAX. Providers simply walk in the room and have a natural conversation with the patient and the system automatically picks up the clinical information that will go into the patient's chart. Nuance then reviews the chart note for accuracy before the data is entered into the patient's chart. This helps the providers be more engaged with the patients and provide better patient care.

**Activities/Milestones**

| ***Strategy 1: EHR Training and Technical Assistance*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Review existing patient check-in process and workflow* | *O* | *X* | | | | | | | | | | |
| *Review kiosk options* | *O* | *X* | | | | | | | | | | |
| *Assist clinic with hardware purchase* | *O* | *X* | | | | | | | | | | |
| *Collaborate with clinic on a deployment strategy* | *O* | *X* | | | | | | | | | | |
| *Provide technical assistance with backend system configuration* | | *O* | *X* | | | | | | | | | |
| *Discuss new patient check-in workflow* | | *O* | *X* | | | | | | | | | |
| *Deploy several kiosks for a pilot program* | | *O* | *X* | | | | | | | | | |
| *Deploy all kiosks* | | *O* | *X* | | | | | | | | | |
| *Discuss analog fax workflow and benefits of digital faxing* | | *O* | *X* | | | | | | | | | |
| *Coordinate cloud fax migration project with EHR vendor* | | *O* | *X* | | | | | | | | | |
| *Provide technical assistance on faxing workflow and EHR integration* | | *O* | *X* | | | | | | | | | |
| *Evaluate scribe and dictation solutions, vendor selection* | | *O* | *X* | | | | | | | | | |
| *Nuance DAX Product Demo and discussion around EHR integration* | | *O* | *X* | | | | | | | | | |
| *Assist clinic with purchasing mobile devices* | | *O* | *X* | | | | | | | | | |
| *Facilitate project activities with Nuance and eCW* | | *O* | *X* | | | | | | | | | |
| *Deploy mobile devices to providers* | | *O* | *X* | | | | | | | | | |
| *Nuance DAX Go-Live assistance* | | *O* | *X* | | | | | | | | | |

| Clinic Feedback – monthly Zoom meetings with the clinic | | O | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

O Start Date
X Completion Date
Ongoing Effort

**Strategy 2: Support and expand existing solutions to exchange clinical data**

UHA's HIT Tiger Team was assembled to support clinics in HIT adoption and integration which includes technical assistance with clinical data feeds in helping provider offices meet CCO metrics and qualify for the UHA's HIT Bonus Program. The Tiger Team was spearheaded by the Director of Provider Network Operations and made up of Umpqua Health Business Intelligence (UHBI) Developers, Quality and Provider Relations Staff. The purpose of the HIT Tiger Team was to create a pathway for UHA's subject matter experts to meet regularly with contracted clinics through video conference calls and office visits. The goal was to meet with the clinics at least once a month or more frequently as needed in helping the clinics achieve the HIT Bonus Program requirements and to work through any barriers the clinics are experiencing.

UHA uses UHBI for analyzing and reporting on CCO incentive measures. Providers can access the Provider Portal housed by UHBI, which allows them to analyze their clinic or provider level data. Additionally, clinical data is provided directly to UHBI by many of our contracted providers using a certified EHR vendor. The HIT Tiger team meetings are used to train providers on the provider portal, share portal enhancements, and review provider level and clinic level data for closing gaps and troubleshoot any issues or barriers clinics are experiencing discuss data feeds, provider outreach, and opportunities for improvement. As we identify gaps in these data feeds, we work directly with the EHR vendor or follow up with each individual clinic to address any missing data.

In 2022, UHA worked with our provider network and their EHR vendors to create additional data feeds from their respective EHR into UHA's case management system, Arcadia. The primary focus was to prioritize data feeds from provider offices that see a large portion of our member population. Currently, we are receiving data feeds from several clinics including 1 FQHC, 5 Primary Care, 1 Behavioral Health and the local hospital, Mercy Medical Center. This represents approximately 62% of our members, in which UHA is importing clinical EHR data into its case management system. To assist network providers, UHA provided financial assistance by paying for the EHR vendor fees. We plan to continue this strategy in 2023-2024.

Additionally, UHA provided technical assistance to a large RHC clinic (Umpqua Health Newton Creek) to add more data elements to their CCO Metrics data feed. This required working with our Business Intelligence (BI) department and the EHR vendor eClinicalWorks on the technical specs, backend system updates and the data extract. UHA also worked with the clinic to update their EHR templates to ensure that all the required data is collected as part of their existing workflows.

**Activities/Milestones**

| ***Strategy 2: Support and expand existing solutions to exchange clinical data*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Review new data requirements* | | O | X | | | | | | | | | |
| *Collaborate with RHC clinic on process for data collection* | | O | X | | | | | | | | | |
| *Update EHR templates* | | O | X | | | | | | | | | |
| *Coordinate required updates to the data extract with EHR vendor* | | O | X | | | | | | | | | |
| *Testing and Validation of EHR Data Feed to UHBI* | | | O | X | | | | | | | | |

| *Deploy new data extract to the live/production environment* | | | *O* | *X* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Engage with clinics on additional data feed to UHA's Case Mgmt System* | *O* | | | *X* | | | | | | | | |
| *Coordinate technical specs between EHR vendor and Arcadia* | *O* | | | *X* | | | | | | | | |
| *Testing and validation of data feed into Arcadia* | *O* | | | *X* | | | | | | | | |
| *Deployment into live/production environment* | *O* | | | *X* | | | | | | | | |
| *Monitoring and Feedback* | | | | *O* | | | | | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**Strategy 3 - Assessment/tracking of EHR adoption and capabilities**

- UHA continues to collect information through the provider onboarding packet for newly enrolled providers.
- For existing providers, UHA collects data and tracks progress annually as part of the HIT Bonus Program.
- In 2022, we had 1 new physical health provider join the network with an EHR.
- This is an ongoing effort that will continue through 2023-2024.

**Activities/Milestones**

| ***Strategy 3: Assessment/tracking of EHR adoption and capabilities*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Collection EHR data upon enrollment* | *O* | | | | | | | | | | | |
| *Update EHR data for established providers.* | *O* | | | | | | | | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**Strategy 4 – Outreach, Education and Collaboration with network partners**

- Outreach to providers, including:
  - Provider Monthly Talking Points
  - Direct outreach via email, in-person site visits, phone or Zoom meetings
  - Quarterly Provider Meetings
  - In-person office visits
- In 2022 UHA's HIT Tiger Team placed approximately 24 outreach calls and attended 48 individual meetings with the clinics. The outreach calls were made to engage providers in the HIT Bonus Program and CCO Metrics.
  - UHA identified improvement opportunities around CCO Metrics and worked closely with providers to address deficiencies.
  - Zoom calls/meetings were held to provide further support and to answer additional questions (typically involved a wide range of folks within the organization).
- Updated HIT Bonus FAQ available on the Umpqua Health website
- This is an ongoing effort that will continue through 2023-2024

**Activities/Milestones**

| ***Strategy 4: Outreach, Education and Collaboration*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Update HIT bonus FAQ for 2023* | | *O* | *X* | | | | | | | | | |
| *Present HIT information and requirements at the Provider Network meetings* | | *O* | | | | | | | | | | |
| *Create HIT Tiger Team* | | *O* | *X* | | | | | | | | | |
| *Review CCO Metrics data to identify improvement areas* | | *O* | *X* | | | | | | | | | |
| *Provider engagement and outreach* | | *O* | | | | | | | | | | |
| *Facilitate provider meetings* | *O* | | | | | | | | | | | |
| *Tracking and Feedback* | *O* | | | | | | | | | | | |

*O Start Date*
*X Completion Date*
*Ongoing Effort*

**Strategy 5 - Incentives to Adopt, Financial Support and Requirements in Contracts**

- Promote HIT bonus program in provider communications (meetings, newsletters, etc.)
- Quarterly provider meetings. This is a general overview covering the HIT Bonus program, EHR adoption requirements and criteria used to qualify.
- This program is offered annually to all contracted providers that meet specific criteria, including EHR adoption and clinical data feeds.
- The HIT bonus program is outlined in all provider contracts. The Provider Relations team includes an overview of the program when onboarding new providers.
- UHA offers technical assistance from the initial engagement throughout the onboarding process.
- Through this program, over 42% of our provider network will receive some form of financial incentive which is in line with the previous year. UHA plans to award over $740,000 to providers for their efforts.
- Provide partial incentives to practices that were able to make partial progress within the Program.
- In late 2022, UHA partnered with AssureCare to provide an "EMR-lite" system for local independent pharmacies. The system will allow the pharmacies to document its clinical and patient care activities to ensure a clinical medical record in maintained. The pharmacies intend to participate in initiatives including tobacco cessation, vaccination, diabetes testing and management, and Medication Therapy Management (MTM). AssureCare is providing technical support to the pharmacies, and UHA is providing financial assistance with the implementation. In 2022, UHA, AssureCare, and five local independent pharmacies began initial planning and collaboration. In 2023, UHA will enter a value-based contract with those pharmacies to provide additional incentives for member outcomes, deploy the technology, and implement the clinical programs in phases.

| ***Strategy: HIT Stipend*** | ***2019*** | | ***2020*** | | | | ***2021*** | | | | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Tactic 2.a: Provider Education* | | | *O* | | | | | | | | | | | | | | | | | | | |
| *Tactic 2.b: Financial Support* | | | | *O* | | | | | | | | | | | | | | | | | | |
| *Tactic 2.c: Technical Assistance* | | | *O* | | | | | | | | | | | | | | | | | | | |

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 6 – Support legacy EHR data in cloud-based archive**

- UHA successfully migrated clinical data from a legacy EHR system to a cloud-based archive system in 2021. The legacy EHR was widely used by providers in the community for many years and this helped providers maintain continuity of care as they transitioned to new EHRs.
- UHA continues to pay for the hosting fees, manages access and provide technical support for the archive.
- The Cloud archive system serves as an important asset, as it contains over 15 years of historical clinic information.
- This is an ongoing effort that will continue through 2023-2024

| ***Strategy 6 : Support legacy EHR data in cloud-based archive*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Financial support for vendor hosting fees* | *O* | | | | | | | | | | | |
| *Manage user access and technical support* | *O* | | | | | | | | | | | |

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 7: Engage with OHA committees and workgroups**
To ensure we stay well informed of OHA's HIT programs and priorities, our CCO participates in several workgroups, including:

- Health Information Technology Advisory Group (HITAG)
- Pharmacy committee
- Behavioral Health workgroup
- Appeals and Grievances workgroup
- Language Access Technical Assistance workgroup
- Quality health outcomes committee
- Primary care payment reform collaborative
- Transitions of Care collaborative
- MEPP – Prometheus User group
- Community Information Exchange (CIE) Workgroup

**Strategy 8 – Created a community forum for clinics using a common EHR (eClinicalWorks)**

- Created a framework for provider offices to share how they're using the system, what they found to be most effective and share best practices.
- Opportunity to foster innovation and knowledge sharing.
- UHA helped facilitate the provider meetings.
- UHA reviewed changes to the CCO Metrics data feed requirements and provided a comprehensive step-by-step user guide and follow-up training on how to update EHR templates.

**Activities/Milestones**

| *Strategy 1: EHR Community Forum* | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Provider Outreach to determine interest* | *O* | *X* | | | | | | | | | | |
| *Facilitate and host 1st meeting* | | *O* | *X* | | | | | | | | | |
| *Discuss meeting frequency and plan future meetings* | | *O* | *X* | | | | | | | | | |
| *Facilitate and host Quarterly EHR provider meetings* | | | *O* | | | | | | | | | |
| *EHR Survey - System Satisfaction, Usefulness, Utility to inform future provider meetings and CCO Support* | | | | | | | *O* | *X* | | | | |

*Legend*

*O Start Date*

*X Completion Date*

*Ongoing Effort*

**ii. Additional progress specific to physical health providers**

93% of UHA's contracted primary care clinics have been verified with certified EHR system in place. Two clinics have not adopted a certified EHR system even with numerous outreach efforts and available incentives. See the Progress Across Provider Types section for updates.

**iii. Additional progress specific to oral health providers**

Advantage Dental, UHA's contracted Dental Care Organization utilizes Dentrix as a certified EHR system. See the Progress Across Provider Types section for updates.

**iv. Additional progress specific to behavioral health providers**

Approximately 68% of UHA's contracted behavioral health clinics have been verified with certified EHR system in place. See the Progress Across Provider Types section for updates.

**v. Please describe any barriers that inhibited your progress**

We previously reported several barriers that were noticed through our engagement with the provider community.

1) Older providers that are close to retirement have expressed very little interest in adopting a certified EHR
2) Single provider behavioral health practices have limited technical and financial resources; therefore, they have a difficult time justifying the cost of an EHR system. Additionally, some of the platforms that are being utilized by behavioral health practices have very limited functionality and interoperability, making it a challenge in connecting with outside systems, such as HIEs.
3) Many provider offices continue to have trouble with submitting clinical data to UHA for a variety of reasons. This includes EMR vendor limitations, lack of qualified local IT resources, staff turnover, etc. Each situation required its own evaluation to identify the bottleneck, and subsequent strategies/tactics to address.

In 2022, we began addressing the problem with clinical data submission by leveraging our partnership with Reliance. We worked closely with a large RHC clinic (Evergreen Family Medicine) and the Reliance team on the technical specs, data validation, testing and go live. This required frequent conversations and ongoing engagement with both parties which led to a successful outcome. We are taking a similar approach with other clinics and are actively working with Reliance and some of our network providers that previously had trouble submitting clinical data to UHA.

## B. Support for EHR Adoption: 2023-2024 Plans

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

1. Select the boxes that represent strategies pertaining to your 2023-2024 plans.
2. Describe the following in the appropriate narrative sections:
    a. The number of physical, oral, and behavioral health organizations without EHR information using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.
    b. Plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialling, Letters of Interest).
    c. Strategies you will use to support increased rates of EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers beyond 2022.
    d. Activities and milestones related to each strategy.

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

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

**Overall Plans**

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

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

**i. Plans across provider types, including activities & milestones**

Using the OHA-provided Data Completeness Table, 2 physical health providers and 6 behavioral health providers have not adopted a certified EHR. However, the reporting table does not accurately reflect the penetration rate of using EHR adoption as most of these providers are single provider offices and only see a very small percentage of our member population. At this point, UHA only assigned Members to PCPs with certified EHRs, which represents 99% of its memberships. The two outliers in physical health are nearing retirement, and the members that are assigned to them have had long established clinical relationship with the provider.

These providers have additional barriers to adoption, namely cost and limited technical resources for implementation and ongoing support. UHA plans to continue outreach efforts through various means (monthly talking points, direct outreach, quarterly provider meetings and in-person office visits). Additionally, UHA offers the HIT Bonus Program to all providers as a way to incentivize technology adoption, including EHR adoption.

**Strategy 1 – Support EHR enhancements for member engagement**

- Explore mobile app utilization for member engagement and outreach with large RHC clinic (Umpqua Health Newton Creek)

**Activities/Milestones**

| *Strategy 1: Support EHR enhancements for member engagement* | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Engage with clinic on mobile app utilization* | | *O* | *X* | | | | | |
| *Evaluate options for patient engagement* | | *O* | *X* | | | | | |
| *Explore using mobile app for patient check-in process* | | | *O* | *X* | | | | |
| *Collaborate with clinic and identify best practice* | | | *O* | *X* | | | | |
| *Monitoring and Feedback* | | | | | | | | |

*Legend*

*O Start Date*

*X Completion Date*

*Ongoing Effort*

**Strategy 2: Expand CCO Metrics Data Collection from EHRs (REALD + SOGI)**

UHA provides technical assistance with clinical data feeds which helps provider offices meet CCO metrics and qualify for the Umpqua Health HIT Bonus program. UHA uses an in-house developed app for analyzing and reporting on CCO incentive measures and we receive clinical data feeds from many of our contracted providers. We have regular meetings to discuss data feeds, provider outreach, and opportunities for improvement. As we identify gaps in these data feeds, we will either work directly with the EHR vendor or follow up with each individual clinic to address any missing data.

- Provide technical assistance to 14 clinics that use a common EHR (eClinicalWorks) to add more data elements to their CCO Metrics data feed, specifically REALD and SOGI.
- Work closely with each clinic, UHA Business Intelligence (BI) department and the EHR vendor on the technical specs, backend system updates and the data extract.
- Provide guidance and workflow recommendations, including updates to existing EHR templates and forms to ensure that all the required data is collected.

**Activities/Milestones**

| *Strategy 3: Expand CCO metrics data collection* | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Review data requirements with EHR vendor* | *O* | *X* | | | | | | |
| *Collaborate with clinic on process for data collection* | *O* | *X* | | | | | | |
| *Review clinic workflows and make recommendations* | *O* | *X* | | | | | | |
| *Coordinate required updates to the data extract with EHR vendor* | *O* | *X* | | | | | | |
| *Testing and Validation* | | *O* | *X* | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| *Deploy new data extract to the live/production environment* | | *O* | *X* | | | | | |
| *Monitoring and Feedback* | | | | *O* | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**Strategy 3: Automate EHR clinical data submission for CCO Metrics**

- Automate EHR clinical data submission for 14 clinics that use a common EHR (eClinicalWorks). This is currently a manual process which is burdensome, error prone and has inherent delays in data submission. The automation will streamline the process, reduce human error and improve efficiency.
- Work with each clinic, UHA Business Intelligence (BI) department and the EHR vendor on the automation process
- UHA provides financial assistance for the monthly vendor fees related to the automation.

**Activities/Milestones**

| ***Strategy 3: Automate EHR clinical data submission*** | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Initial Project Scoping and Sign Agreement* | *O* | *X* | | | | | | |
| *Review data extract requirements with EHR vendor* | *O* | *X* | | | | | | |
| *Create SFTP site for each clinic* | *O* | *X* | | | | | | |
| *EHR vendor to create scheduled report* | | *O* | *X* | | | | | |
| *Testing and Validation* | | *O* | *X* | | | | | |
| *Deploy automation to the live/production environment* | | *O* | *X* | | | | | |
| *Monitoring and Feedback* | | | | *O* | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**Strategy 4: EHR Adoption in local pharmacies.**

- As mentioned earlier, in 2022 UHA partnered with AssureCare to implement EHR systems within local pharmacies to assist pharmacies in documenting clinical services they would be rendering. As these pharmacies would be providing vaccination and clinical education, an EHR is needed to document those encounters.
- Smaller pharmacies see UHA members and want to offer services such as vaccines and birth control, but don't have a good way to record this information and provide data to UHA.
- Community pharmacies are an untapped resource for providing patient care, addressing gaps, collecting data, and improving the quality of care. Independent community pharmacies have consistently demonstrated strong local relationships, professional autonomy, programmatic agility, and ability to deliver quality outcomes. They also are in a unique position to expand access to care, as many of these pharmacies are in underserved areas. This innovative pilot would be unique to Oregon and the United States, as no one has done anything exactly like this.
- In 2023, UHA will contract with the pharmacies to provide these clinical services.

- Participating pharmacies will implement the EHR with AssureCare in 2023.

**Activities/Milestones**

| ***Strategy 4: EHR Adoption in Local Pharmacies*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Program design* | | | | *O* | *X* | | | | | | | |
| *Develop contract* | | | | *O* | *X* | | | | | | | |
| *Engage interested pharmacies* | | | | *O* | | | | | | | | |
| *Enroll pharmacies* | | | | | *O* | *X* | | | | | | |
| *Execute contract with pharmacies* | | | | | *O* | *X* | | | | | | |
| *Pharmacies install EMR* | | | | | *O* | *X* | | | | | | |

*Legend*

*O Start Date*

*X Completion Date*

*Ongoing Effort*

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

See the Strategies Across Provider Types section for 2023-2024 plans.

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

See the Strategies Across Provider Types section for 2023-2024 plans.

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

See the Strategies Across Provider Types section for 2023-2024 plans.

### C. Optional Question

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

Last year we reported that smaller independent behavioral health providers struggle with connecting and partnering on broader EHR and HIT Programs. This was still a common theme in 2022, even after numerous outreach efforts. Although these providers only see a small percentage of our members, they are essential for access and choice for our members, but the limited connectivity can be a barrier. UHA would suggest OHA provides technical advisory, and even possibly financial assistance to move some smaller behavioral health provider on to modern EHRs.

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

### A. Support for HIE – Care Coordination: 2022 Progress

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

1. Select the boxes that represent strategies pertaining to your 2022 progress

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

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

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

☒ HIE training and/or technical assistance

☒ Assessment/tracking of HIE adoption and capabilities

☒ Outreach and education about value of HIE

☒ Collaboration with network partners

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

☒ Integration of disparate information and/or tools with HIE

☒ Requirements in contracts/provider agreements

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

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

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

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

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

UHA supports the following HIE Tools:

| Name | Description |
|---|---|
| Arcadia | Case Management System |
| Reliance | Health Information Exchange (HIE) |
| Tableau | Data Visualization |
| Connect Oregon | Community Information Exchange (CIE) |

**Strategy 1: Reliance HIE Onboarding Support**

- Promote Reliance HIE in provider communications (meetings, newsletters, etc.)
- Encourage participation and technology adoption.
- Facilitated agreements between Reliance and a new provider office (Holmes Family Care).
- Ongoing work with Reliance, Mercy hospital and Centennial Medical Group (CMG) on additional data feeds for a richer data set (i.e. ADT, CCDs, lab results, imaging, transcriptions).
  - Centennial Medical Groups (CMG) is now live with CCDs from EPIC
  - Mercy Medical Center is now live with ADTs and CCDs
- Continued engagement with providers that had not adopted an HIE
  - Canyonville Health & Urgent Care
  - Cow Creek Health & Wellness
  - Advantage Dental

**Activities/Milestones**

| *Strategy 1: Reliance HIE Onboarding Support (Canyonville and Cow Creek)* | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *CCO Outreach to clinical practices to promote HIE* | | | *O* | *X* | | | | | | | | |
| *Connect clinical practice with Reliance* | | | *O* | *X* | | | | | | | | |
| *Integrate Reliance into clinical practice* | | | *O* | *X* | | | | | | | | |
| *Establish data feeds to CCO* | | | | *O* | *X* | | | | | | | |
| *Automate data feeds to CCO* | | | | | | *O* | *X* | | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**Strategy 2: Support new solutions to exchange clinical data between EHRs, CCO and Reliance**

- Partnered with Reliance and a large RHC clinic (Evergreen) to facilitate clinical data exchange between the clinic and UHA with a successful implementation and go-live by the end of December 2022
  - Clinical data includes elements needed for CCO Metrics reporting.
  - Improves care coordination by having the data flow into the HIE.
  - Creates a more robust data set that allows more practices to have access to clinical data via HIE.
- Started project for exchanging clinical data between UHA, large FQHC clinic (Aviva) and two other primary care clinics (Cow Creek Health and Wellness Center and Canyonville Health and Urgent Care).
  - Reliance serves as a conduit between clinics and UHA.
  - UHA provides technical specs and works closely with Reliance on testing and validation.
- Regular meetings with Reliance HIE
  - Review current level of adoption.
  - Discuss progress on active implementations.
  - Discuss future implementations.
  - Evaluate additional data feeds for enhanced care coordination (i.e. 837 files).

**Activities/Milestones**

| *Strategy 2: Clinical Data Exchange* | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Clinic outreach to discuss new solution for sending clinical data to UHA* | *O* | *X* | | | | | | | | | | |
| *Provide technical specs for data exchange* | *O* | *X* | | | | | | | | | | |
| *Review technical specifications with Reliance and individual clinics* | | *O* | *X* | | | | | | | | | |
| *Weekly meetings with clinic and Reliance to review progress and address issues* | | *O* | | *X* | | | | | | | | |
| *Clinic sends data to Reliance* | | *O* | | *X* | | | | | | | | |
| *Reliance validation of clinical data import* | | *O* | | *X* | | | | | | | | |
| *UHA to create SFTP site for receiving files from Reliance* | | *O* | *X* | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *UHA receives test file from Reliance* | | *O* | | *X* | | | | | | | | |
| *Clinical Data File Review and Feedback* | | *O* | | *X* | | | | | | | | |
| *UHA validation of data received from Reliance* | | *O* | | *X* | | | | | | | | |
| *Go-Live approval for 2021 Data* | | *O* | *X* | | | | | | | | | |
| *Receive production file (2021)* | | *O* | *X* | | | | | | | | | |
| *Discuss technical specs for 2022 data due to workflow changes at the clinic* | | *O* | *X* | | | | | | | | | |
| *Clinic to start sending sample files with 2022 data* | | | *O* | *X* | | | | | | | | |
| *Reliance works with Evergreen to validate 2022 data* | | | *O* | *X* | | | | | | | | |
| *UHA receives 2022 data file from Reliance* | | | *O* | *X* | | | | | | | | |
| *UHA validation of 2022 data received from Reliance* | | | *O* | *X* | | | | | | | | |
| *Production Data Feed to UHA for 2022 Evergreen data* | | | *O* | *X* | | | | | | | | |
| *Engage with Reliance and clinics, provide technical specs* | | | | *O* | *X* | | | | | | | |
| *Facilitate meetings, monitor and track progress* | | | | *O* | | | *X* | | | | | |
| *UHA validation of Aviva data received from Reliance* | | | | | *O* | *X* | | | | | | |
| *UHA validation of Cow Creek data received from Reliance* | | | | | *O* | *X* | | | | | | |
| *UHA validation of Canyonville data received from Reliance* | | | | | *O* | *X* | | | | | | |
| *Production Data Feed to UHA for Aviva, Cow Creek, Canyonville* | | | | | | *O* | *X* | | | | | |
| *Provide Ongoing Technical Assistance* | | | | *O* | | | | | | | | |

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 3: Offer financial incentives through the Umpqua Health HIT Bonus program.**

- UHA continues to promote its HIT bonus program in provider communications (meetings, newsletters, etc.)
- This program is offered annually to all contracted providers that meet specific criteria, including HIE adoption.
- Include the program in all provider contracts.
- Through this program, 42% of our provider network will receive some form of financial incentive which is in line with the previous year. UHA plans to award over $1.05m to providers for their efforts.
- Provide partial incentives to practices that were able to make partial progress within the Program.
- This is an ongoing effort that will continue through 2023-2024

**Activities/Milestones**

| | ***2019*** | ***2020*** | ***2021*** | ***2022*** | ***2023*** | ***2024*** |
|---|---|---|---|---|---|---|

| *Strategy 3: HIT Stipend* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Tactic 2.a: Provider Education* | | | *O* | | | | | | | | | | | | | | | | | | | |
| *Tactic 2.b: Financial Support* | | | | *O* | | | | | | | | | | | | | | | | | | |
| *Tactic 2.c: Technical Assistance* | | | *O* | | | | | | | | | | | | | | | | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**Strategy 4: Provider Engagement and Education**

- Promote Reliance HIE in provider communications (meetings, newsletters, etc.)
- Outreach to providers to introduce Reliance and assist those interested with the onboarding process. This includes:
  - Provider Monthly Talking Points.
  - Direct outreach via email, in-person site visits, phone or Zoom meetings.
  - Quarterly Provider Meetings.
  - In-person office visits.
- Updated HIT Bonus FAQ available on the Umpqua Health website.
- This is an ongoing effort that will continue through 2023-2024.

**Activities/Milestones**

| ***Strategy 4: Provider Engagement and Education*** | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Identify priority list of targeted clinics* | *X* | | | | | | | |
| *Update HIT bonus FAQ for 2023* | *O* | *X* | | | | | | |
| *Present HIT information and requirements at the Provider Network meetings* | | *O* | *X* | | | | | |
| *Introduce Reliance HIE to newly enrolled providers during the onboarding process* | | | | | | | | |
| *Begin outreach meetings with remaining Specialty clinics* | | | *O* | *X* | | | | |
| *Tracking and Feedback* | | | | | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**Strategy 6: Assessment/Tracking of HIE Adoption and Capabilities**

- UHA continues to collect information through the provider onboarding packet for newly enrolled providers.
- For existing providers, UHA collects data and tracks progress annually as part of the HIT Bonus Program.
- Reliance provides UHA with a clinic status report on a quarterly basis which is used to help prioritize and drive engagement strategies.
- This is an ongoing effort that will continue through 2023-2024.

| *Strategy 6: Assessment/tracking of HIE adoption and capabilities* | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Collection HIE data upon enrollment* | *O* | | | | | | | | | | | |
| *Update HIE data for established providers.* | *O* | | | | | | | | | | | |

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 7: Engage with OHA committees and workgroups**
To ensure we stay well informed of OHA's HIT programs and priorities, our CCO participates in several workgroups, including:

- Health Information Technology Advisory Group (HITAG)
- Pharmacy committee
- Behavioral Health workgroup
- Appeals and Grievances workgroup
- Language Access workgroup
- Quality health outcomes committee
- Primary care payment reform collaborative
- Transitions of Care collaborative
- MEPP – Prometheus User group
- Community Information Exchange (CIE) workgroup

**ii. Additional progress specific to physical health providers**

See the Progress Across Provider Types section for updates.

**iii. Additional progress specific to oral health providers**

See the Progress Across Provider Types section for updates.

**iv. Additional progress specific to behavioral health providers**

See the Progress Across Provider Types section for updates.

**v. Please describe any barriers that inhibited your progress**

We previously reported several barriers that we observed through our engagement with the provider community. See our 2022 progress below.

1) Data available in the HIE is dependent on EHR vendor capabilities and do not generally include a complete EHR chart.
    a. In 2022, UHA spent a significant amount of time engaging clinics through our Tiger Team initiative. This included direct outreach efforts and multiple Zoom and face-to-face meetings to answer questions and track progress. We were successful in connecting clinics to Reliance and getting some providers to submit clinical data.
2) EHR integrations often lack certain data elements that providers find useful (i.e. progress notes).
3) Providers are not as likely to utilize the HIE unless it's integrated with the EHR and easily accessible
    a. In 2022, UHA created an EHR forum for community providers that use the same EHR system. We are using these meetings to train provider offices on accessing HIE data from within their EHR.

4) Workflows for accessing HIE data are highly dependent on the EHR platform and office staff willingness and expertise. It takes continued effort for an effective change in workflow and utilization of available HIE information.
    a. We continue to train new providers on accessing HIE data through their EHR system.
5) Smaller independent providers often lack the technical and financial resources to implement an HIE.
6) Some behavioral health providers are reluctant to share information citing privacy laws. UHA does take the approach in providing education to those providers but there still is hesitancy.

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

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

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

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

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

**Overall Plans**

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

☒ HIE training and/or technical assistance

☒ Assessment/tracking of HIE adoption and capabilities

☒ Outreach and education about value of HIE

☒ Collaboration with network partners

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

☒ Integration of disparate information and/or tools with HIE

☒ Requirements in contracts/provider agreements

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

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

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

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

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

Using the OHA-provided Data Completeness Table, 9 physical health and 16 behavioral health organizations have not adopted an HIE for Care Coordination tool. This is a 56% improvement from last year. Although it looks like a high percentage of contracted providers are not using an HIE, the reporting table does not accurately reflect the penetration rate of using HIE for care coordination. Most of the providers that are not currently using an HIE are single provider practices that see a small percentage of our members. These providers have additional barriers to adoption, namely cost and limited technical resources for implementation and ongoing support. UHA plans to continue outreach efforts through various means (monthly talking points, direct outreach, quarterly provider meetings and in-person office visits). Additionally, UHA offers the HIT Bonus Program to all providers as a way to incentivize technology adoption, including HIE for care coordination.

**Strategy 1: Support new solutions to exchange clinical data between EHRs, CCO and Reliance**

- Partner with Reliance to facilitate clinical data exchange between UHA, large FQHC clinic (Aviva) and two other primary care clinics (Cow Creek Health and Wellness Center and Canyonville Health and Urgent Care).
    - Clinical data includes elements needed for CCO Metrics reporting.
    - Reliance serves as a conduit between clinics and UHA.
    - UHA provides technical specs and works closely with Reliance on testing and validation.

| *Strategy 1: Clinical Data Exchange* | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Clinic outreach to discuss new solution for sending clinical data to UHA* | | | *O* | *X* | | | | | | | | |
| *Provide technical specs for data exchange* | | | *O* | *X* | | | | | | | | |
| *Review technical specifications with Reliance and individual clinics* | | | *O* | *X* | | | | | | | | |
| *Weekly meetings with clinic and Reliance to review progress and address issues* | | | | *O* | | *X* | | | | | | |
| *Clinic sends data to Reliance* | | | | *O* | | *X* | | | | | | |
| *Reliance validation of clinical data import* | | | | *O* | | *X* | | | | | | |
| *UHA to create SFTP site for receiving files from Reliance* | | | | *O* | *X* | | | | | | | |
| *UHA receives test file from Reliance* | | | | | *O* | | *X* | | | | | |
| *Clinical Data File Review and Feedback* | | | | | *O* | | *X* | | | | | |
| *UHA validation of data received from Reliance* | | | | | *O* | | *X* | | | | | |
| *Production Data Feed to UHA* | | | | | | | *O* | *X* | | | | |
| *Provide Ongoing Technical Assistance* | | | | | | | | | *O* | | | |

*Legend*

*O Start Date*

*X Completion Date*

*Ongoing Effort*

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

See the Strategies Across Provider Types section for 2023-2024 plans.

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

See the Strategies Across Provider Types section for 2023-2024 plans.

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

See the Strategies Across Provider Types section for 2023-2024 plans.

### C. Optional Question

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

The HIE Onboarding Program was a useful tool in promoting HIE participation to providers. With the Program sunsetting in September 2021, newer providers participating in HIEs do not have the same financial incentives as their peers in the past. OHA looking into reoffering the HIE Onboarding Program would be helpful.

## 4. Support for HIE – Hospital Event Notifications

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

1. Please describe your (CCO) progress using timely Hospital Event Notifications within your organization. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2022 progress
    b. Describe the following in the narrative section
        i. The tool(s) that you are using for timely Hospital Event Notifications
        ii. The strategies you used in 2022
        iii. Accomplishments and successes related to each strategy.

**Overall Progress**
Please select which strategies you employed during 2022.

☒ Care coordination and care management

☒ Risk stratification and population segmentation

☒ Integration into other system

☒ Exchange of care plans and care information

☒ Collaboration with external partners

☒ Utilization monitoring/management

☒ Supporting CCO metrics

☒ Supporting financial forecasting

☐ Other strategies for using Hospital Event Notifications (please list here)

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

UHA uses Collective Medical for Hospital Event Notifications. Strategies used in 2022 include:

**Strategy 1 – Utilize daily reports to provide care coordination support**

- Daily reports utilized by UHA care coordination include:
    - Daily ED and IP Admissions and Discharges
    - Daily Post-Acute Care Admissions and Discharges
    - ER Visits
- UHA's Transitional care staff utilize the Daily ED and IP admission and discharge reports daily. The report facilitates case manager visits with the member while hospitalized (local hospital only) to plan discharge and outreach to the member within 1 business day of discharge to schedule a home visit within the week of discharge. This leads to an increased likelihood of post discharge PCP appointments and a decrease in 30-day readmissions. UHA transitional care staff can successfully follow up with members that are admitted to OON hospitals within the same timeframe as those admitted to the local hospital.
- The Daily Post-Acute Care Admissions and Discharges are monitored daily by the Transitional Care staff to track members that are discharged from acute care into post-acute care. Assistance with discharge planning is provided to the local skilled nursing facilities. Upon discharge home the members are offered a transitional care home visit. Those transitioning to long term care are provided ICC case management.
- Care coordination navigators monitor the daily ER visits for members that have 10 or more ER visits within the current year. The member is sent to an assigned care coordinator to complete an assessment and create a care plan to decrease further ER visits.
- This is an ongoing effort that will continue through 2023-2024

**Activities/Milestones**

| ***Strategy 1: Utilize daily reports to provide care coordination support*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Review and update daily report in the Collective Medical Platform* | *O* | X | | | | | | | | | | |
| *Update workflows for staff to utilize the daily report.* | *O* | *X* | | | | | | | | | | |
| *Educate staff on the workflow and implement new processes.* | O | *X* | | | | | | | | | | |
| *Monitor daily ER visits, post acute care admissions and discharges* | | *O* | | | | | | | | | | |

*Legend*
*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**Strategy 2 – Facilitate information sharing**

- Case Managers add their contact information to the care team in the patient's overview when they are actively working with the patient. Completed care plans and transitional care assessments are uploaded as attachments. Advanced care plans are uploaded in the Advance Care Plan section.
- UHA's Care Coordination staff uses the patient overview to locate updated demographics for members that are difficult to reach, identify other members of the patient's care team (i.e., APD case worker), review care guidelines and uploaded advanced care plans, or other attachments.

- Information sharing through Collective Platform had enhanced care team collaboration while protecting member information as users only see information on an individual whom they have an established HIPAA-TPO relationship.
- This is an ongoing effort that will continue through 2023-2024.

**Activities/Milestones**

| ***Strategy 2: Facilitate information sharing*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Collaborate with Collective Medical on best practices for Advanced Care Plans* | O | X | | | | | | | | | | |
| *Review care guidelines* | *O* | *X* | | | | | | | | | | |
| *Update staff workflows* | *O* | *X* | | | | | | | | | | |
| *Educate staff on the workflow and implement new processes* | O | *X* | | | | | | | | | | |

*Legend*
*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**Strategy 3 – Develop cohorts to improve case management delivery**

- UHA created and began utilizing a cohort titled "Top 50 ED Utilizers Encounters" to enable engagement of those members while in the ED. This cohort is updated monthly for accuracy and efficiency in managing utilization and cost.
- UHA works in collaboration with Healthful (fka,Vituity) ED navigators to follow the Top 50 ED Utilizers. These navigators have access to the Collective Platform and the cohort above enabling them to be alerted when one of the top utilizers are in the ED. When the navigator is onsite at the hospital, they visit the member at bedside in attempt to identify barriers and facilitate a follow up appointment with the member's PCP.
- Two cohorts were developed to assist care coordination of UHA's TANF population.
- TANF Admissions.
- TANF Discharges.
- This is an ongoing effort that will continue through 2023-2024.

**Activities/Milestones**

| ***Strategy 3: Develop cohorts to improve case management delivery*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Create cohort for "Top 50 ED Utilizers"* | O | X | | | | | | | | | | |
| *Create cohort for TANF population* | O | X | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Train ED Navigators on the new cohort* | O | X | | | | | | | | | | |
| *Create cohorts for TANF population.* | O | X | | | | | | | | | | |
| *Monthly updates* | | O | | | | | | | | | | |

*Legend*
*O Start Date*
*X Completion Date*
*Ongoing Effort*

**Strategy 4 – Integrate Collective Medical hospital event notifications with Arcadia to automate notifications of "triggering events."**

- UHA had custom automation built in Arcadia's case management platform to utilize a connector with Collective Medical that places members with a hospital event in a triggering event queue. The queue facilitates timely outreach to members to screen for intensive care coordination eligibility and case manager contact for members that are currently enrolled in ICC case management.
- ADT connector is in place between Collective Medical and Arcadia. Automation factors in Arcadia place members into a Triggering Event Program queue when an ED or Inpatient event occurs in Collective Medical.
- Workflows for Care Coordination Navigators and Case Managers facilitate member contact, screen for ICC and update care plans for those enrolled in ICC services.
- This is an ongoing effort that will continue through 2023-2024

**Activities/Milestones**

| ***Strategy 4: Integrate Collective Medical hospital event notifications with Arcadia case management*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Work with vendor on automation script* | O | X | | | | | | | | | | |
| *Develop workflow for staff to utilize the event queue.* | O | X | | | | | | | | | | |
| *Educate staff on the workflow and implement new processes.* | O | X | | | | | | | | | | |
| *Update care plans for members enrolled in ICC services* | | O | | | | | | | | | | |

*Legend*
*O Start Date*
*X Completion Date*
*Ongoing Effort*

**Strategy 5 – Develop a cohort for UHA members receiving Long Term Services and Supports**

- Develop and maintain the LTSS cohort monthly. UHA's intensive case managers utilize the cohort to track their assigned LTSS members as they move in and out of the hospital setting. Real time notification of hospital admission ensures the assigned care coordinator outreaches to the member and hospital staff to facilitate a successful transition back home. Decreasing the likelihood of hospital readmission.
    - Built automated report for members receiving Medicaid funded long term services and supports. Developed a tableau dashboard which includes a roster with all the members with this flag, the report is shared with Aging and People with Disabilities (APD) to facilitate coordination of care for these members. UHA recognized we had a gap and addressed it. The dashboard is updated daily using flags from the 834 files and is easily downloaded into various formats including Excel.

**Activities/Milestones**

| ***Strategy 5: Develop a cohort for UHA members receiving Long-Term Services and Supports*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Create cohort in the Collective Medical Platform* | | O | | *X* | | | | | | | | |
| *Develop workflow for Intensive Case Managers to utilize the cohort.* | | | *O* | *X* | | | | | | | | |
| *Educate Intensive Case Managers on the workflow and implement new processes.* | | | | *O* | *X* | | | | | | | |
| *Track readmission rates for the Long-Term Services and Supports population to monitor program effectiveness.* | | | | | *O* | | | | | | | |

*Legend*

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 6 – Develop a daily report for Skilled Nursing Facility admissions and discharges**

- This report is utilized by the transitional care staff daily to facilitate connection with the member while admitted; allowing the transitional care nurse to be involved in discharge planning. Discharge notifications facilitate connection with the member within 1 business day of discharge to schedule a home visit that increases the successful transitions between settings.

**Activities/Milestones**

| ***Strategy 6: Develop a daily report for Skilled Nursing Facility admissions and discharges.*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Create daily report in the Collective Medical Platform* | O | X | | | | | | | | | | |
| *Develop workflow for Transitional Care staff to utilize the daily report.* | O | X | | | | | | | | | | |
| *Educate Transitional Care staff on the workflow and implement new processes.* | O | X | | | | | | | | | | |
| *Track Skilled Nursing Facility admissions, discharges, and number of home visits post discharge to monitor program effectiveness.* | | O | | | | | | | | | | |

*Legend*

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 7: Participate in the IMPACTS grant program**

UHA participates in the IMPACTS grant program that was established by the Oregon Legislature in recognition of the shortage of comprehensive community support and services for individuals with mental health or substance use disorders that lead to their involvement with the criminal justice system, hospitalizations, and institution placements. UHA is providing all the data analytics for it, including facilitating the one-way jail feed to Collective Medical for bookings and releases for the IMPACTS cohort (i.e. Douglas County residents booked 4 or more times into the Jail who were also Umpqua Health Alliance members).

- The IMPACTS program offers comprehensive community support and services for individuals with mental health or substance use disorders that lead to their involvement with the criminal justice system, hospitalizations, and institution placements.
- Reduce ED visits and healthcare costs by early engagement and intervention to address physical and mental healthcare issues complicated by housing instability.
- Develop cohort groups in Collective Medical to identify high risk/high utilization.
- Facilitate daily data feed to Collective Medical of jail booking and release information that allows ICC teams to contact individuals prior to release from jail.
- Engage with local hospital and CMHP on member engagement strategies, reports and dashboard development.
- Real-time access to information for cohort members who are incarcerated for opportunities to intercept them prior to release.

**Activities/Milestones**

| ***Strategy 7: Participate in IMPACTS grant program*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Negotiate data use agreement with Douglas County jail* | *O* | *X* | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Create one-way jail data feed to Collective Medical* | *O* | *X* | | | | | | | | | | |
| *Create IMPACTS cohort group to identify high risk/high utilization* | | *O* | *X* | | | | | | | | | |
| *Collective Medical to create/upload flags for IMPACTS members* | | *O* | *X* | | | | | | | | | |
| *Collaborate with Mercy Hospital and local CMHP on member engagement strategies* | | *O* | *X* | | | | | | | | | |
| *Licensing and hardware acquisition* | | | *O* | *X* | | | | | | | | |
| *Setup Infrastructure* | | | *O* | *X* | | | | | | | | |
| *Develop content for the platform, including Tableau dashboards* | | | *O* | | | | | | | | | |
| *Grant secure access to local hospital and CMHP to the IMPACTS Tableau instance* | | | *O* | *X* | | | | | | | | |
| *Facilitate initial training for Mercy Hospital and Adapt (offer multiple sessions via Zoom)* | | | | *O* | *X* | | | | | | | |
| *User Education and Training* | | | | *O* | | | | | | | | |
| *Add REAL-D information to IMPACTS cohort members* | | | *O* | *X* | | | | | | | | |
| *Create cost avoidance report* | | | *O* | *X* | | | | | | | | |
| *UHA annually provides updated cohort list to Collective Medical* | | | | *O* | | | | | | | | |

*Legend*

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

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

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

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

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

☒ Hospital Event Notifications training and/or technical assistance

☒ Assessment/tracking of Hospital Event Notification access and capabilities

☒ Outreach and education about the value of Hospital Event Notifications

☒ Financially supporting access to a Hospital Event Notification tool(s)

☒ Offering incentives to adopt or use a Hospital Event Notification tool(s)

☒ Requirements in contracts/provider agreements

☐ Other strategies for supporting access to Hospital Event Notifications (please list here)

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

UHA plans to continue using Collective Medical for hospital event notifications.

**Strategy 1: Offer financial incentives through the Umpqua Health HIT Bonus program.**

- Promote bonus program in provider communications (meetings, newsletters, etc.).
- This program is offered annually to all contracted providers that meet specific criteria, including HIE adoption.
- Include the program in all provider contracts.
- Through this program, over 42% of our provider network will receive some form of financial incentive which is in line with the previous year. UHA plans to award over $1.05m to providers for their efforts.
- Provide partial incentives to practices that were able to make partial progress within the Program.
- This is an ongoing effort through 2023-2024.

**Activities/Milestones**

| *Strategy: HIT Stipend* | *2019* | | *2020* | | | | *2021* | | | | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Tactic 2.a: Provider Education* | | | *O* | | | | | | | | | | | | | | | | | | | |
| *Tactic 2.b: Financial Support* | | | | *O* | | | | | | | | | | | | | | | | | | |
| *Tactic 2.c: Technical Assistance* | | | *O* | | | | | | | | | | | | | | | | | | | |

*O Start Date*
*X Completion Date*
*Ongoing Effort*

**Strategy 2: Provider Training**

- In collaboration with Collective Medical, UHA facilitated provider training sessions in June and November of 2022 which had several objectives:
    - Provide a forum to promote collaboration and best practice sharing.

- To present an overview and demonstration by a representative of Collective Medical.
  - To give clinics an opportunity to share how they are making use of Collective Medical.
  - To share how Umpqua Health Alliance is making use of the platform.
  - To identify staff members who currently use or plan to use Collective Medical, to outline their interventions along with the cohorts of focus.
- This is an ongoing effort through 2023-2024.

**Activities/Milestones**

| ***Strategy 2: Provider Training*** | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Collective Medical/UHA facilitated training sessions* | O | | | X | | | | | | | | |
| *Review monthly dashboards* | O | | | X | | | | | | | | |
| *Outreach to clinics who are going dormant or with eligibility files older than 30-days* | O | | | X | | | | | | | | |
| *Tracking and Feedback* | | O | | | | | | | | | | |

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 3: Provider Engagement**

- Encourage participation and technology adoption.
- Continued engagement with providers that are not currently using Collective.
- Promote Collective Medical in provider communications (meetings, newsletters, etc.).
- Outreach to providers to introduce Collective Medical and assist those interested with the onboarding process. This includes:
  - Provider Monthly Talking Points.
  - Direct outreach via email, in-person site visits, phone or Zoom meetings.
  - Quarterly Provider Meetings.
  - In-person office visits.
- Updated HIT Bonus FAQ available on the Umpqua Health website.
- UHA's care coordination department receives a monthly engagement dashboard from Collective Medical and this allows our team to see how providers are using the platform. For instance, we can identify gaps in data submission, and we can see how often the clinics are logging into the Collective Medical system. This provides an opportunity for UHA to reach out to provider offices and have a meaningful conversation about using this tool for improved care coordination.
  - Provider Network Outreach
  - Tiger Team Outreach
- Monthly meetings with Collective Medical
  - Review current level of adoption.
  - Strategies for future growth.
  - Discuss best practices for provider engagement.
  - Discuss progress on active implementations.
  - Discuss future implementations.
  - Best practices for provider engagement
  - Improvement opportunities
- This is an ongoing effort through 2023-2024

**Activities/Milestones**

| *Strategy 3: Provider Engagement* | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Update HIT bonus FAQ for 2023* | *O* | *X* | | | | | | | | | | |
| *Present HIT information and requirements at the Provider Network meetings* | *O* | | | | | | | | | | | |
| *Provider Newsletter Article* | *O* | | | | | | | | | | | |
| *Introduce Collective Medical to newly enrolled providers during the onboarding process* | *O* | | | | | | | | | | | |
| *Outreach PCPCH clinics who are not currently using Collective Medical* | *O* | | | | | | | | | | | |
| *Outreach Behavioral Health clinics who are not currently using Collective Medical* | *O* | | | | | | | | | | | |
| *Monthly meetings with Collective Medical* | *O* | | | | | | | | | | | |
| *Tracking and Feedback* | *O* | | | | | | | | | | | |

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 4: Assessment/Tracking of Collective Medical Adoption and Capabilities**

- UHA continues to collect information through the provider onboarding packet for newly enrolled providers.
- For existing providers, UHA collects data and tracks progress annually as part of the HIT Bonus Program.
- Collective provides UHA with a monthly dashboard which is used to help prioritize and drive engagement strategies.
- This is an ongoing effort through 2023-2024

**Activities/Milestones**

| ***Strategy 4: Assessment/tracking of Collective Medical adoption and capabilities*** | **2022** | | | | **2023** | | | | **2024** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Collection of CMT data upon enrollment* | *O* | | | | | | | | | | | |
| *Update CMT data for established provider on their CMT usage..* | *O* | | | | | | | | | | | |

**Strategy 5 – Create a Collective Medical Workgroup**

- UHA created a workgroup to promote and support the Collective Medical platform. The goal is to have an open forum for provider offices to engage with each other, the CCO and the local hospital Mercy Medical Center.
- This was an opportunity for providers to share how they're using the system, what's helpful for them and what they want to see for coordinating care.
- Assisted provider offices to use Collective more efficiently and find ways to improve care coordination in the community.

**Activities/Milestones**

| *Strategy 6: Collective Medical Workgroup* | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Provider Outreach to determine interest* | *O* | *X* | | | | | | | | | | |
| *Engage with Collective Medical to collaborate on strategy* | | *O* | *X* | | | | | | | | | |
| *Facilitate and host 1st meeting* | | *O* | *X* | | | | | | | | | |
| *Discuss meeting frequency and plan future meetings* | | *O* | *X* | | | | | | | | | |
| *Facilitate and host Quarterly provider meetings* | | | *O* | | | | | | | | | |
| *Follow up with Collective Medical on any action items as needed* | | | *O* | | | | | | | | | |
| *Survey - System Satisfaction, Usefulness, Utility to inform future provider meetings and CCO Support* | | | | | | | *O* | *X* | | | | |

**Legend**

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 7: Engage with OHA committees and workgroups**
To ensure we stay well informed of OHA's HIT programs and priorities, our CCO participates in several workgroups, including:

- Health Information Technology Advisory Group (HITAG)
- Pharmacy committee
- Behavioral Health workgroup
- Appeals and Grievances workgroup
- Language Access Technical Assistance workgroup
- Quality health outcomes committee
- Primary care payment reform collaborative
- Transitions of Care collaborative
- MEPP – Prometheus User group

**ii. Additional progress specific to physical health providers**

See the Progress Across Provider Types section for updates.

**iii. Additional progress specific to oral health providers**

See the Progress Across Provider Types section for updates.

**iv. Additional progress specific to behavioral health providers**

See the Progress Across Provider Types section for updates.

| v. Please describe any barriers that inhibited your progress |
|---|
| There are no additional barriers identified by UHA. |

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

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

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

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

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

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

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

**Strategy 1 – Implement use of care guidelines**

- Develop a workflow for case managers to enter care guidelines to facilitate information sharing with providers, specialists, caseworkers, and hospitals that participate in Collective Medical and have a member in common with UHA.
- Implement the use of care guidelines in the daily workflow for UHA case managers.
- Provide education to network providers that regularly use Collective Medical on care guideline use.

**Activities/Milestones**

| ***Strategy 1: Develop a workflow for case managers to enter care guidelines to facilitate information sharing with providers, specialists, caseworkers, and hospitals that participate in Collective Medical and have a member in common with UHA. Implement the use of care guidelines in the daily workflow for UHA case managers.*** | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| *Revise current UHA case manager workflow to include care guidelines.* | | O | X | | | | | |
| *Provide care coordination staff education on developing care guidelines.* | | *O* | *X* | | | | | |
| *Implement new processes.* | | *O* | *X* | | | | | |
| *Provide Education to network providers* | | | *O* | *X* | | | | |
| *Track the number of members with care guidelines to monitor program effectiveness.* | | | *O* | | | | | |

*Legend*

*O* *Start Date*

*X* *Completion Date*

*Ongoing Effort*

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

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

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

**Overall Plans**

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

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

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

UHA reviewed the hospital event notification adoption rates using the OHA-provided Data Completeness Table. We found that 14 physical health and 17 behavioral health organizations have not adopted Collective Medical for hospital event notifications. Although it looks like it's a high percentage of contracted providers, the reporting table does not accurately reflect the penetration rates. There's a large number of specialists included as physical health providers and their use of the Collective platform is somewhat limited in scope. Specialists have a different use case than a PCP so it's more difficult to gain wider adoption. For example, specialists will not typically follow up with patients post hospitalization, unless it's related to a specific procedure or surgery. The remaining providers that are not currently using Collective Medical are single provider practices that see a small percentage of our members. These providers have additional barriers to adoption, namely cost and limited technical resources for implementation and ongoing support. UHA plans to continue outreach efforts through various means (monthly talking points, direct outreach, quarterly provider meetings and in-person office visits). Additionally, UHA offers the HIT Bonus Program to all providers as a way to incentivize technology adoption, including hospital event notifications.

**Strategy 1: Automate patient roster data submission**

- Automate patient roster data submission for 14 clinics that use a common EHR (eClinicalWorks). This is currently a manual process which is burdensome, error prone and has inherent delays in data submission. The automation will streamline the process, reduce human error, and improve efficiency.
- Work with each clinic, EHR vendor and Collective Medical on the automation process.
- UHA provides financial assistance for the monthly EHR vendor fees related to the automation.

**Activities/Milestones**

| *Strategy 1: Automate patient roster data submission* | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Initial Project Scoping and Sign Agreement* | *O* | *X* | | | | | | |
| *Review data extract requirements with EHR vendor* | *O* | *X* | | | | | | |
| *Work with Collective Medical to create SFTP site for each clinic* | *O* | *X* | | | | | | |
| *EHR Vendor to create scheduled report* | | *O* | *X* | | | | | |
| *Testing and Validation* | | *O* | *X* | | | | | |
| *Deploy automation to the live/production environment* | | *O* | *X* | | | | | |
| *Monitoring and Feedback* | | | | *O* | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

| |
|---|
| |
| **ii. Additional plans specific to physical health providers, including activities & milestones** |
| See the Strategies Across Provider Types section for 2023-2024 plans. |
| **iii. Additional plans specific to oral health providers, including activities & milestones** |
| See the Strategies Across Provider Types section for 2023-2024 plans. |
| **iv. Additional plans specific to behavioral health providers, including activities & milestones** |
| See the Strategies Across Provider Types section for 2023-2024 plans. |

### C. Optional Question

| How can OHA support your efforts in supporting your contracted providers with access to Hospital Event Notifications? |
|---|
| OHA could support efforts by sharing best practices from other CCOs on how they utilize Hospital Event Notifications within their networks. |

## 5. HIT to Support SDOH Needs

### A. HIT to Support SDOH Needs: 2022 Progress

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

**Overall Progress**
Please select which strategies you employed during 2022.

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

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

This section should include:
   a. A description of the tool(s) you are using. Please specify if the tool(s) have closed-loop referral functionality (e.g., Community Information Exchange or CIE).
   b. The strategies you used in 2022.

c. Any accomplishments and successes related to each strategy.

**Strategy 1 – SDOH Data Collection**

UHA continues to refine our HIT (Health Information Technology) strategies for collection of SDoH/E and is hopeful to develop more robust data through the implementation of Arcadia with primary care and behavioral health clinics, the adoption and usage of a community-based CIE, and through more robust SDoH/E screening mechanisms in our network Electronic Health Record System.

**Activities/Milestones**

| ***Strategy 4: SDOH Data Collection*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Prioritize clinics for data feeds to Arcadia* | *O* | *X* | | | | | | | | | | |
| *Engage clinics and EHR vendors and provide technical specs for Arcadia data connectors* | | *O* | | *X* | | | | | | | | |
| *Build data connector between Valley Ridge Family and Arcadia* | | *O* | *X* | | | | | | | | | |
| *Build data connector between White Oak and Arcadia* | | *O* | *X* | | | | | | | | | |
| *Build data connector between Aviva (FQHC) and Arcadia* | | | *O* | *X* | | | | | | | | |
| *Build data connector between Adapt and Arcadia* | | | *O* | *X* | | | | | | | | |
| *Build data connector between Mercy hospital and Arcadia* | | | *O* | *X* | | | | | | | | |
| *Establish data feed from Unite Us to UHA* | | *O* | *X* | | | | | | | | | |

Legend

*O* *Start Date*

*X* *Completion Date*

*Ongoing Effort*

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

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

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

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

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

**Strategy 1 – Implement and Support SDOH screening tools**

Unite Us, CIE has a closed-loop referral functionality and houses the PRAPARE (Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences) and AHC (Accountable Health Communities) tools that are available for use. Unite Us is made available to all contracted physical, oral, and behavioral health providers, social services, and CBOs at no cost. Through provider engagement it was discovered that many clinics are performing screenings using the PRAPARE and the AAFP (American Academy of Family Physicians) screening tools. Some clinics designed their own SDoH/E screening tool to capture needed information. The Unite Us team is evaluating other screening tools to add to its inventory of tools available through the platform. CCOs can provide feedback on useful screening tools. There is an interest in encouraging the use of the PRAPARE tool as the preferred screening tool among our network of providers.

**Activities/Milestones**

| *Strategy 1: Implement and Support SDOH screening tools* | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Facilitate Quality Metrics (QM) provider meetings* | *O* | | | | | | | | | | | |
| *Introduce SDOH screening tools, including PRAPARE and AAFP* | | *O* | *X* | | | | | | | | | |
| *Collaborate with Unite Us on additional screening tools* | | *O* | *X* | | | | | | | | | |
| *Monitoring and Feedback* | *O* | | | | | | | | | | | |

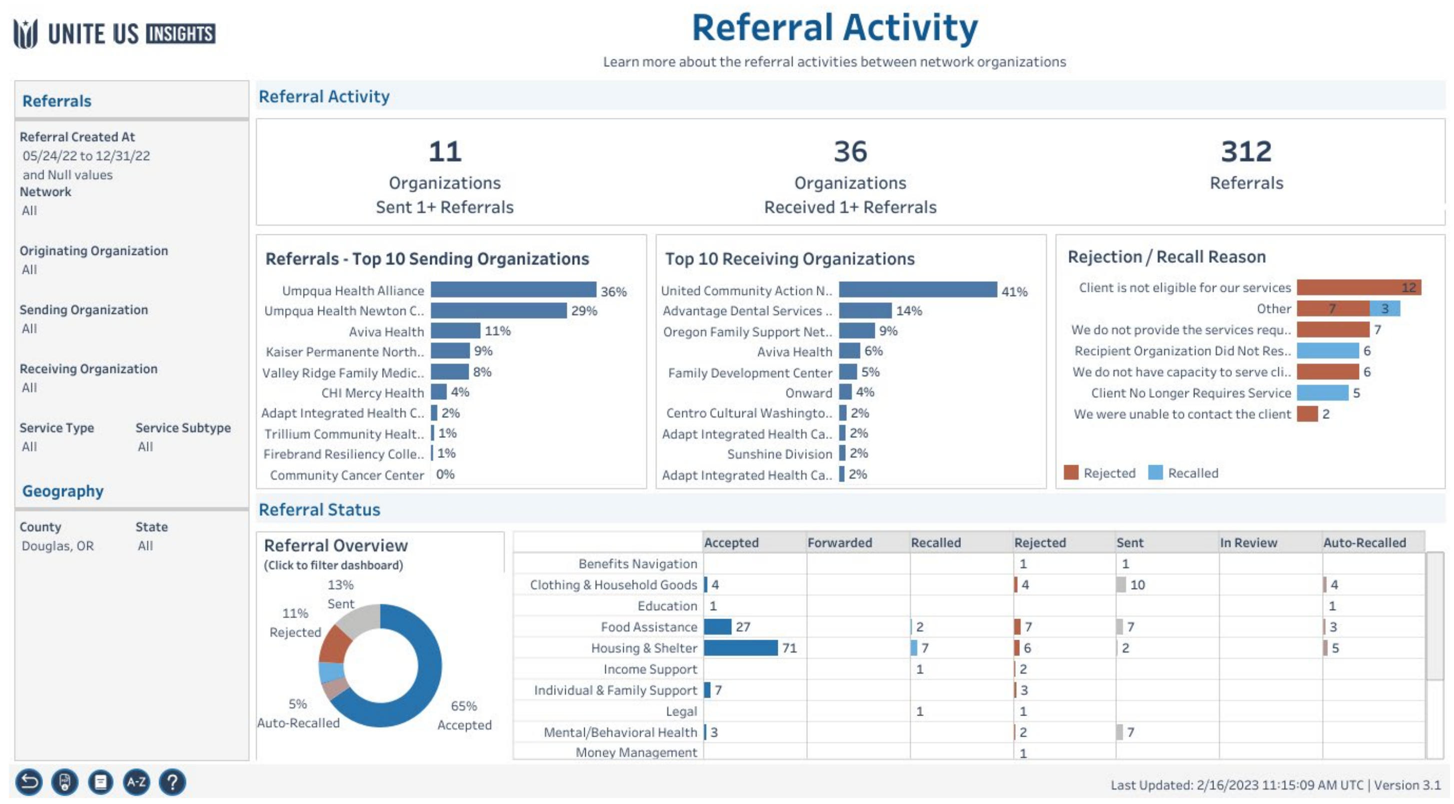
Legend

| | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

**Strategy 2 – Implement the Unite Us Community Information Exchange (CIE) with healthcare, social services, and CBO Partners**

UHA's implementation of Unite Us in May of 2022 was an immense success and exceeded expectations in terms of growing the network in year 1. By the end of 2022, the Unite Us Network included several local community-based

organizations, primary care clinics (PCPs), behavioral health and substance use disorder clinics, the Cancer Community Center, and UHA's contracted Dental Care Organization Advantage. A total of 36 organizations went live on the Unite Us platform with 11 of these organizations responsible for sending at least one or more referrals and all 36 organizations receiving at least one referral. There were 312 referrals made in this period, with 113 leading to accepted referrals addressing SDoH/E. There are approximately 24 organizations that have been identified as priority candidates for engagement in 2023.




**Activities/Milestones**

| *Strategy 2: Unite Us (CIE) Implementation* | *2022* | | | | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Engage with Unite Us to discuss implementation and roll-out strategy* | *O* | *X* | | | | | | | | | | |
| *Implementation Kickoff* | *O* | *X* | | | | | | | | | | |
| *Community Partner Identification (Providers and CBOs)* | *O* | *X* | | | | | | | | | | |
| *Platform Demonstration for UHA implementation team* | *O* | *X* | | | | | | | | | | |
| *Discuss Prioritization and Outreach Strategy* | *O* | *X* | | | | | | | | | | |
| *Schedule Engagement Kickoff Sessions with providers and CBOs* | *O* | *X* | | | | | | | | | | |
| *Outreach to priority populations (incl. Cow Creek Band of Indians and Umpqua Tribe of Indians)* | *O* | | | | | | | | | | | |
| *Introductory session for UHA staff* | *O* | *X* | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Collaboration meeting with UHA, All Care and Unite Us* | *O* | *X* | | | | | | | | | | |
| *Unite Us workflow planning sessions with clinics and CBOs* | *O* | *X* | | | | | | | | | | |
| *UHA User Training* | *O* | *X* | | | | | | | | | | |
| *Community Go-Live – Douglas County Launch Event -May 24th* | *O* | *X* | | | | | | | | | | |
| *Unite Us to send sample data file to UHA* | | *O* | *X* | | | | | | | | | |
| *UHA performs data validation* | | *O* | *X* | | | | | | | | | |
| *UHA starts receiving data on a regular schedule* | | | *O* | *X* | | | | | | | | |
| *Data Analysis and Reporting – explore using data to create Tableau reports and sharing this with UHA staff and community partners* | | | | *O* | | | | | | | | |

*Legend*

*O* *Start Date*

*X* *Completion Date*

*Ongoing Effort*

**Strategy 3 – Provider Engagement and Outreach**

Outreach to providers included an introduction to the Unite Us platform and the embedded screening tools within the planform. UHA assisted clinics in the onboarding process and engaged the Unite Us team to provide a demo of the platform when requested.

Additional efforts to promote the Unite Us platform included:

- In collaboration with Unite Us, a presentation and demo made available to our clinical and community partners at our community-wide event.
- Provider Monthly Talking Points.
- Direct outreach via email, in-person site visits, phone or Zoom meetings.
- Quarterly Provider Meetings .

**Activities/Milestones**

| ***Strategy 3: Provider Engagement and Outreach*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Provider Outreach to introduce Unite Us platform* | *O* | | | | | | | | | | | |
| *Facilitate demos of the Unite Us platform* | | *O* | *X* | | | | | | | | | |
| *Host Community wide event* | | *O* | *X* | | | | | | | | | |
| *Promote Unite Us (newsletter, direct outreach, meetings)* | *O* | | | | | | | | | | | |
| *Monitoring and Feedback* | *O* | | | | | | | | | | | |

Legend

*O* *Start Date*

*X* *Completion Date*

*Ongoing Effort*

**Strategy 4 – Care Coordination Grant Program and Network Advisory Board**

In addition to supporting and engaging CBOs on the platform, in 2022 UHA deployed a Care Coordination Grant Program in which CBOs can apply for funding for staff to support the deployment of the solution. Knowing that resource constraints are a primary barrier, the Grant Program made available $600,000 in funding to CBOs to deploy and hire (if needed), additional staff to support the engagement. This reduces one of the primary barriers reported by CBOs of not having enough staffing resources to support CIE utilization.

**Activities/Milestones**

| ***Strategy 4: Care Coordination Grant Program*** | ***2022*** | | | | ***2023*** | | | | ***2024*** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Establish Care Coordination Grant Program* | | *O* | *X* | | | | | | | | | |
| *Communicate Grant Program availability to providers and CBOs – direct email outreach, quarterly provider meetings, provider newsletter* | | | *O* | *X* | | | | | | | | |
| *UHA to attend Southern Oregon CIE forum* | | | *O* | *X* | | | | | | | | |
| *Collaborate with community stakeholders to create a Community Network Advisory Board* | | | *O* | | | | | | | | | |

*Legend*

*O* *Start Date*

*X* *Completion Date*

*Ongoing Effort*

**ii. Additional progress specific to physical health providers**

See the Progress Across Provider Types section for updates.

**iii. Additional progress specific to oral health providers**

Advantage Dental's care coordination team implemented a standard referral process through the Unite Us platform as part of the Connect Oregon network. Clinical and community partners can submit referrals for dental assistance needs in addition to social needs. UHA's CIE engagement plan for 2023 includes targeted outreach to PCP clinics to promote and encourage the use of Unite Us to submit referrals to Advantage Dental.

**iv. Additional progress specific to behavioral health providers**

See the Progress Across Provider Types section for updates.

**v. Additional progress specific to social services and CBOs**

2023 will be focused on expansion of utility and rental assistance program supports and will also include increase in HRS screenings. While we currently do utilize HRS funds for some rental and utility assistance, in 2023 we'll also work to build out our programs and processes in this area to server a larger and clearly identified population in alignment with the transitioning populations identified in the 1115 waiver.

| |
|---|
| |
| **vi. Please describe any barriers that inhibited your progress** |
| Clinics who have chosen to use a paper version of their own SDoH/E screening tool has presented a challenge for us to ensure simplified and enhanced workflows with regards to referrals for physical and behavioral health services as well as SDoH/E resources. Ideally, clinical and community partners who are active on the Unite Us platform shall use a screening tool within the platform to ensure consistency and robust data collection. |

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

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

**Notes:** Strategies and tools described in the *2022 Progress* section that remain in your plans for 2023-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

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

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

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

**Strategy 1 – Unite Us Data Feed**

UHA is currently in the final phase of testing files to be able to ingest a comprehensive data feed from Unite Us including 27 unique files. UHA plans to utilize this data for:
- SDOH screening and referral metric reporting
  - UHA will determine whether we build this in-house through UBHI or utilize Arcadia
- Monitor and assess capacity of overall social services network for HRS and program development

**Activities/Milestones**

| *Strategy 2: Unite Us Data Feed* | 2023 | | | | 2024 | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Review technical specifications of the SDOH Metric* | | *O* | *X* | | | | | |
| *Evaluate internal vs. external build of the metric* | | *O* | *X* | | | | | |
| *Participate in SDOH metric Technical Assistance with OHA* | | *O* | *X* | | | | | |
| *Data mapping and validation* | | *O* | *X* | | | | | |
| *Dashboard design and development for HRSN program development* | | | *O* | *X* | | | | |
| *Evaluate incorporating data into provider reporting* | | | *O* | *X* | | | | |
| *Evaluate integration with other HIT Tools* | | | | | *O* | | | |

*Legend*

*O* *Start Date*

*X* *Completion Date*

*Ongoing Effort*

**Strategy 2 – Expand use of Unite Us Platform for Care Coordination Services**

- The overall goal is to connect members to resources that address social needs. UHA's care coordination team aims to:
  - Increase outgoing referrals for SDOH services.
  - Begin receiving referrals for care coordination services through the Unite Us platform.
  - Begin accepting HRS Flex Spending requests through Unite Us.
  - Embed an Assistance Request button on the UHA website for members to be able to request social services.

**Activities/Milestones**

| *Strategy 2: Expand use of Unite Us Platform for Care Coordination Services* | 2023 | | | | 2024 | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Engage with Unite Us to discuss implementation and roll-out strategy* | *O* | *X* | | | | | | |
| *Workflow development for UHA staff* | *O* | *X* | | | | | | |
| *Train UHA staff that will be receiving referrals* | *O* | *X* | | | | | | |
| *Educate network providers and community partners on UHA programs available for referral on Unite Us* | *O* | *X* | | | | | | |
| *Start accepting requests for HRS Flexible Services* | | *O* | *X* | | | | | |
| *Start accepting referrals for Care Coordination Services* | | *O* | *X* | | | | | |
| *Embed Assistance Request button on UHA website* | | | *O* | *X* | | | | |
| *Monitoring and Feedback* | | | | | *O* | | | |

| *Legend* | |
|---|---|
| *O* | *Start Date* |
| *X* | *Completion Date* |
| | *Ongoing Effort* |

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

**Notes:** Strategies and tools described in the *2022 Progress* section that remain in your plans for 2023-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

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

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

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

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

**Strategy 1: Expand Clinical Data Collection to include SDOH**

- UHA will encourage clinics to adopt an SDOH data collection tool such as PRAPARE
- Provide technical assistance to 14 clinics that use a common her (eClinicalWorks) to add more data elements to their CCO Metrics data feed, specifically SDOH data
- Work closely with each clinic, UHA Business Intelligence (BI) department and their EHR vendor on the technical specs, backend system updates and the data extract
- Provide guidance and workflow recommendations, including updates to exchange EHR templates and forms to ensure that all the required data is collected

**Activities/Milestones**

| *Strategy 1: Expand CCO metrics data collection* | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Clinic outreach to discuss SDOH data collection requirements – Bi-Monthly Tiger Team meetings and Quarterly eCW forum* | *O* | | | | | | | |
| *Review SDOH data collection requirements with a pilot clinic* | | *O* | *X* | | | | | |
| *Review data requirements with EHR vendor* | | *O* | *X* | | | | | |
| *Collaborate with clinic on process for data collection (i.e. PRAPARE)* | | *O* | *X* | | | | | |
| *Review clinic workflows and make recommendations* | | *O* | *X* | | | | | |
| *Coordinate required updates to the data extract with EHR vendor* | | | *O* | *X* | | | | |
| *Testing and Validation* | | | *O* | *X* | | | | |
| *Go-Live with Pilot Clinic (Newton Creek)* | | | *O* | *X* | | | | |
| *Engage with remaining clinics on SDOH data collection and implementation* | | | | *O* | *X* | | | |
| *Deploy new data extract to the live/production environments* | | | | | *O* | *X* | | |
| *Monitoring and Feedback* | | | | *O* | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**<u>Strategy 2: Expand the Use and Adoption of CIE by Contracted Clinical Partners</u>**

- In 2023, UHA's HIT Tiger Team will engage several clinics to encourage the adoption of Unite Us through targeted outreach and education.
- UHA's Goals include:
    - Add all contracted Tier 4 and Tier 5 PCPCH (Patient Centered Primary Care Home) Clinics to the Unite Us Network.
    - Add all contracted pediatric clinics to the Unite Us Network.
    - Add all contracted behavioral health providers who provide social-emotional health services to children birth to 5 years old to the Unite Us Network.

- Ongoing engagement and supporting CBO partners

**Activities/Milestones**

| *Strategy 1: Expand CIE adoption across UHA's Contracted Clinical Partners.* | *2023* | | | | *2024* | | | |
|---|---|---|---|---|---|---|---|---|
| | *Q1* | *Q2* | *Q3* | *Q4* | *Q1* | *Q2* | *Q3* | *Q4* |
| *Identify priority list of targeted clinics* | *O* | *X* | | | | | | |
| *Develop HIT Tiger Team outreach plan* | *O* | *X* | | | | | | |
| *Begin outreach meetings with PCPCH clinics* | *O* | | | | | | | |
| *Begin outreach meetings with pediatric clinics* | | *O* | | | | | | |
| *Begin outreach meetings with BH (Behavioral Health) clinics* | | *O* | | | | | | |
| *By December 31st, 2023, 65% of the targeted clinics are live on the Unite Us Network* | *O* | | | *X* | | | | |
| *Ongoing engagement and supporting CBO partners* | | | | | | | | |
| *Tracking and Feedback* | | | | | | | | |

*O* *Start Date*
*X* *Completion Date*
*Ongoing Effort*

**ii. Additional plans specific to physical health providers**

See the Strategies Across Provider Types section for 2023-2024 plans.

**iii. Additional plans specific to oral health providers**

See the Strategies Across Provider Types section for 2023-2024 plans.

**iv. Additional plans specific to behavioral health providers**

See the Strategies Across Provider Types section for 2023-2024 plans.

**v. Additional plans specific to social services and CBOs**

See the Strategies Across Provider Types section for 2023-2024 plans.

## C. Optional Question

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

Funding and support for CBOs will continue to be a struggle. Historically, many CBOs have been operating using a different approach for receiving referrals. When we encourage CIE participation, many CBOs are hesitant to withdraw from the previous approach in receiving referrals, and often express not having enough staff to support CIE implementation. OHA providing funding to CBOs would help with this transition.

## 6. Other HIT Questions (Optional)

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

| A. Describe CCO HIT tools and efforts that support **metrics**, both within the CCO and with contracted providers. Include CCO challenges and priorities in this work. |
|---|
| |
| B. Describe CCO HIT tools and efforts that **patient engagement**, both within the CCO and with contracted providers. |
| |
| C. How can **OHA support** your efforts in accomplishing your HIT Roadmap goals? |
| |
| D. What have been your organization's **biggest challenges** in pursuing HIT strategies? What can OHA do to better support you? |
| |
| E. How have your organization's HIT strategies supported **reducing health inequities**? What can OHA do to better support you? |
| |

# Appendix

## Example Response: Support for HIE – Care Coordination

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

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

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

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

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

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

### A. 2021 Progress

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Strategy 1: Develop and implement a 5-Year HIT plan**
In partnership with the Clinical Advisory Panel, our CCO developed a 5-Year HIT plan that includes the following components to help guide our strategies for the duration of the Contract:

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

- Monitoring mechanisms to ensure continued improvement in HIE utilization and resulting patient care coordination

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

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

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

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

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

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

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

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

**Strategy 6: Engage with state committees/entities**
To ensure we stay abreast of and inform OHA's HIT priorities, members of our team actively engaged in several state workgroups, including:

- HIT Commons - EDIE Steering Committee
- Metrics & Scoring Committee
- Health Information Technology Advisory Group

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

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

**ii. Additional Progress Specific to Physical Health Providers**

**Strategy 8: Provide workflow TA**

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

**iii. Additional Progress Specific to Oral Health Providers**

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

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

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

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

**Strategy 9: Explore oral health HIE**

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

**Strategy 10: Pursue improvement of the dental request referral process**

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

**iv. Progress Specific to Behavioral Health Providers**

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

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

**Strategy 11: Assess the state of behavioral health HIE**
- Assessed behavioral health provider interest and determined best way to support their engagement with the OHA HIE Onboarding Program
- Identified HIE elements that need to be modified, eliminated or added due to special behavioral health requirements

**Strategy 1: Develop and implement a 5-year plan**
- Included elements specific to behavioral health providers
- Identified a group to focus specifically on behavioral health workflows and privacy issues
- Ensured behavioral health providers were a priority in the HIE Onboarding Program, including small providers' use of HIE portals
- Evaluated the Reliance Consent Module and other HIE workflows

**Strategy 8: Provide workflow TA**
- CCO staff continued to provide workflow redesign support to further adoption and use of Collective Platform, specifically related to increasing the number of members who have care plans generated after presenting at emergency department and being flagged by Collective.
- Provided technical assistance to physical health providers and their teams to integrate Provider Portal workflow into their clinic's care coordination processes.

**v. Please describe any barriers that inhibited your progress.**

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

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

## B. 2022-2024 Plans

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

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

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

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

**Overall Plans**

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

☒ HIE training and/or technical assistance

☒ Assessment/tracking of HIE adoption and capabilities

☒ Outreach and education about value of HIE

☒ Collaboration with network partners

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

☒ Integration of information and/or disparate tools with HIE

☐ Requirements in contracts/provider agreements

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

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

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

- *Maintain Patient Access API*

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

**i. Strategies across provider types, including activities & milestones**

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

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

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

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

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

| | |
|---|---|
| providing technical assistance and training in appropriate use of application. | |

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

| Activities | Milestones and/or Contract Year |
|---|---|
| Explore the ability to transition to a closed loop referral mechanism from our care coordination platform. In our next phase of development, we will create the functionality to allow our oral health or behavioral health providers to request care coordination and navigation support. | Q1-Q3 2022: Exploration, research, development<br>Q4 2022: Pilot closed-loop referral mechanism with 8 behavioral health and 4 oral health providers |
| In conjunction with State efforts, evaluate mechanisms to incorporate SDOH service providers into referral and care coordination workflows. | Q3 2022 |
| Support a closed loop referral process to create a tri-directional navigation and referral system that can support or augment future and more robust HIE development and implementation. | 2022-2024: Closed-loop referral process achieved |
| Focus on solutions for incorporating SDOH service providers into care coordination and referral workflows. | 2022-2024 |
| Develop robust systems for the integration of claims and EHR data in order to share insights about members to improve outcomes. This exchange will add patient detail which may not be present in either system alone. | 2022-2024 |

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

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

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

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

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

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

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

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

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

See *Across Provider Types* section.

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

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

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

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

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

**Strategy 6: Engage with state committees/entities**

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

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

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

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

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

**Strategy 6: Engage with state committees/entities**

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

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

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