Updated HIT Roadmap Template

***Please complete and submit to OHA at CCO.HealthIT@dhsoha.state.or.us by March 15, 2021.**

CCO: Jackson Care Connect
Date: 3/26/2021

Instructions

Please complete all of the required questions included in the following Updated HIT Roadmap Template. Topics and specific questions where responses are not required are labeled as optional. The layout of the template includes questions across the following seven topics:

1. HIT Partnership
2. Support for EHR Adoption
3. Support for HIE – Care Coordination
4. Support for HIE – Hospital Event Notifications
5. Health IT and Social Determinants of Health and Health Equity (optional section)
6. Health IT for VBP and Population Health Management
7. Other HIT Questions (optional section)

Each topic includes the following:

- Narrative sections to describe your 2020 progress, accomplishments/successes, and barriers
- Narrative sections to describe your 2021 – 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 to attach a second document outlining their planned activities and milestones as was required for Contract Year One. However, you may attach your own documents in place of filling in the activities and milestones sections of the template (as long as the attached document clearly describes activities and milestones and specifies the corresponding Contract Year).

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 HIT. That said, CCOs' Updated HIT Roadmaps and plans should be informed by OHA-provided HIT data. Updated HIT Roadmaps should be strategic, and activities may focus on supporting specific provider types or specific use cases. OHA expects Updated HIT Roadmaps will include specific activities and milestones to demonstrate the steps CCOs expect to take. OHA also understands that the HIT environment evolves and changes, and that plans from one year may change to the next. For the purposes of the Updated HIT Roadmap responses, the following definitions should be considered when completing responses.
Strategy: CCO's approach and plan to achieve outcomes and support providers
Activities: Incremental, tangible actions CCO will take as part of the overall strategy
Milestones: Significant outcomes of activities or other major developments in CCO's overall strategy, with indication of when the outcome or development will occur (e.g. Q1 2022).

Note: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.

A note about the template*:*
This template has been created to help clarify the information OHA is seeking in CCOs' Updated HIT Roadmaps. 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 HIT Questionnaire have not been included in the Updated HIT Roadmap template. Additionally, at the end of this document, examples have been provided to help clarify OHA's expectations for reporting progress and plans. For questions about the Updated HIT Roadmap template, please contact Jessi Wilson at CCO.HealthIT@dhsoha.state.or.us

1. HIT Partnership

Please attest to the following items.

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

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

Below we share our current and future efforts to bring value and improve health by supporting further adoption and spread of health information technology. As a reasonably small CCO serving rural communities, we benefit from our relationshipwith CareOregon which provides us with the sophisticated HIT expertise and resources of a large CCO that we could not otherwise afford. CareOregon serves approximately 300,000 Medicaid members across the state and has developed a comprehensive technology strategy to support its partner CCOs with member assignments and technology support functions. As you review the document, you will see us reference both JCC and CareOregon staff. Although CareOregon is the backbone for many of our infrastructure needs, our local JCC Board, comprised of community stakeholders, providers and members, creates the vision and defines our organizational strategies based on the health and social support needs unique to our members and communities.

2. Support for EHR Adoption

a. 2020 Progress

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

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

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

i. Progress Across Provider Types

Current Landscape:

Physical health:

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

Eighty-nine percent (89%) of our members are assigned to tier-3 or higher PCPCH clinics with certified EHRs. With significant efforts in the past by OHA, hospital systems and CCOs to support EHR adoption through resourcing and technical assistance, the few clinics that remain on uncertified EHRs or paper charts do so due to cultural

resistance to change and not due to lack of resourcing. In the near term, we will continue to work with these providers to encourage EHR adoption. However, given there is limited provider availability in some of our rural communicates, we have to balance the desire to attain 100% EHR adoption with the need to maintain an adequate network of high-quality providers to serve our members.

Behavioral health
JCC's primary behavioral health partners are on or in the process of implementing certified EHRs. Kairos, ColumbiaCare and Jackson County Mental Health are on CareLogic and our substance abuse providers, ARC and OnTrack are on Dr. Cloud. JCC provided financial support to help resource the successful implementation of these EHRs. Approximately 75% of our outpatient behavioral health services are provided by these partners. JCC also has contracts with several small behavioral health specialists who are largely not on certified EHRs and we will assess their interest in adoption of EHR as part of the environmental scan planned for 2021.

Oral health
Based on a survey conducted in 2020 by our dental plan partners, 86% of dentists associated with our delegated dental partners are on an EHR and 14% are unknown or not on an EHR (n = 76). The EHR systems the dentists use include: Dentirx, Epic, Open Dental, Daisy and AxiUm.

Across provider types, given that such a small percent of our members are served by clinics without an EHR, we have adjusted our focus from EHR adoption to EHR optimization support through workflow and process improvement technical assistance. We will align this work with our transformation priorities and in areas that provide value to our provider partners without creating unnecessary additional burdens or contributing to clinician burn-out.

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

Our key strategies:

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

Strategy 1 – Develop 5-Year HIT Plan
In 2020, JCC created a multidisciplinary Steering Committee with JCC and CareOregon leadership responsible for overseeing JCC's Five-Year HIT Roadmap. The intention of the committee is to advise on the development of an overarching HIT strategy to guide the HIT related initiatives within the JCC region. In today's health system, HIT is a vital tool to help members and communities achieve improved health outcomes. Recognizing this, we wanted to develop a clinical vision on which to anchor our 5-year HIT road map. This clinical vision will ultimately guide the development and implementation of the strategies and activities related to HIT within our region. The intention was to review the overall vision, conduct an environmental scan related to EHR requirements within our network, and identify opportunities for improvement related to EHR optimization.

In 2020, we started an environmental scan by collecting information about EHR utilization within our network. We did this by surveying our primary care providers and delegated dental plan partners, and also updating our Provider Information Form (PIF), to capture EHR information during our provider onboarding process (see results in Attachment A). However, we did not complete the environmental scan or engage our network partners in a process to inform our overall HIT Strategy as originally planned for Year 1. When COVID-19 hit, we shifted our focus to other matters, primarily EHR optimization related to telemedicine. As things shift in 2021, we plan to hold network discussions on ways we can partner and support HIT strategies and initiatives at large, as well as approaches specific

to optimizing EHR capabilities in 2021 and beyond. We will use the progress made on telemedicine as an opportunity to cultivate more partnership within our network to support EHR optimization.

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

In 2020, JCC continued to encourage improved use of EHRs through our technical assistance, financial incentives (e.g. PCPCH payment program) and care coordination:

- **Technical assistance/practice coaching:** Through our team of Innovation Specialists, JCC provides technical assistance / practice coaching to our provider network partners to support various clinic and system transformation goals. This includes identifying opportunities to more meaningfully use their EHRs to improve workflows, support CCO Quality Metric documentation, and support Value Based Payment performance.

  Here are some of the ways we have helped them improve the use of their EHRs:
  - Optimizing documentation of clinical quality metrics in EHRs
  - Data reporting capabilities (pulling reports)
  - Referral documentation, reporting and closing loops
  - "Dot phrases" (time-saving macros) for EHR efficiencies (Adolescent well check, depression, SBIRT, one key question, ACE's)

- **Financial Incentives:** JCC employs a variety of financial incentives that encourage improved EHR use. These include:
  - Quality Pool distribution - JCC partners with our clinical providers in achieving the OHA CCO Incentive Metrics. Many of these metrics require documentation and reporting of clinical information. Increased quality pool payout is reserved for organizations that can pull and submit data from their EHR.
  - Clinic designation - JCC has developed financial incentives to encourage organizations to achieve greater levels of organizational designation (e.g., Tier 3 PCPCH). The designations require increased levels of EHR functionality.
  - Value-based payment - JCC engages with our providers in value-based payment arrangements, including shared risk, total cost of care models. EHRs are important tools for promoting workflows and providing information necessary to achieve the desired financial and clinical results encouraged by our VBP arrangements.

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

Strategy 3- Support EHR use to further telemedicine

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

ii. Additional Progress Specific to Physical Health Providers

See Progress Across Provider Types

iii. Additional Progress Specific to Oral Health Providers

JCC's subcontracted dental plans successfully implemented expanded teledentistry services within their plans and provider networks and conducted a survey of their dental networks about EHR system implementation and the use of Collective. The expansion of teledentistry capabilities has leveraged dental plans' investments in EHR technology to

provide access to dental care during the pandemic. The ability to implement teledentistry supports the investments in EHR, as without ubiquitous access to patient records, it would be much more difficult to have efficient virtual visits. In addition, conducting teledentistry visits in conjunction with an established EHR greatly improves the ability to document, track and report on these virtual visits.

iv. Additional Progress Specific to Behavioral Health Providers

See Progress Across Provider Types

v. Please describe any barriers that inhibited your progress.

We have two main barriers for this work, which hold true for the entirety of this report.

1. The strength and breadth of both our mental health and primary care networks means that we work with many small, independent providers who serve very low number of JCC members. Our large clinics (and those involved in PCPCH) are all on EHRs. Our ability to support and incentivize the smaller practitioners is limited. Their interest and capacity in adopting EHRs is also limited.
2. The COVID pandemic and September 2020 fires caused us to redivert our internal staff resources. More importantly, these two events significantly impacted the capacity of our clinical providers and they have not had the capacity to focus on EHRs. As mentioned above, most of our clinic providers were focused on 'keeping their doors open' given changes in revenue and increases in costs associated with adapting their organizations to respond to the COVID-19 Pandemic.

2021 - 2024 Plans

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

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

Notes:

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

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

Service Type	Number of Organizations	EHR Adoption	
Physical	**516**	**221**	**43%**
Behavioral	159	70	44%
Oral	40	19	48%

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

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

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

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

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

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

Activities	Milestones and/or Contract Year
JCC's Innovation Specialist-Primary Care (IS-PC) will develop and offer a readiness assessment for clinics within JCC's network that are not recognized as a PCPCH. The IS-PC will glean from this assessment information on the readiness of the clinic to apply and provide technical assistance and practice level coaching to help them meet their goals.	Q3-Q4 2021
Offer Technical Assistance and Practice Coaching to non-recognized clinics that are interested in being recognized as a PCPCH.	Q4 2021 - Q3 2022
Monitor the effect of the technical assistance and practice coaching of the IS-PC to increase the number of members assigned to a PCPCH recognized clinic.	Q4 2022

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

Strategy 1 – Develop 5-year HIT Plan (EHR elements specific to oral health)

Activities	Milestones and/or Contract Year
Evolve governance structure to ensure oral health input (e.g., via CAP, DCOs, JCC staff or subcommittee)	Q1-Q3 2021
Conduct further assessment of EHR use by primary and specialty dental providers to augment existing information from OHA, CareOregon and DCOs	Q2 2021
Define the current state and anticipated future EHR capabilities needed to further JCC's health system transformation and quality improvement goals related to oral health. At a minimum, we will consider EHR functionality for oral health to support: • Adaptation of successful strategies from physical and behavioral health workplans to oral health scenarios as applicable and needed. • Identification of best practices regarding Electronic Dental Record (EDR) use and configuration and development of a process to share, extend, and standardize these best practices. • HIE solutions to improve current referral processes including use of Medecision care coordination system, Collective, HIE services and JCC's provider portal.	Q3 2021

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

Strategy 1 – Develop 5-year HIT Plan (EHR elements specific to behavioral health)

Activities	Milestones and/or Contract Year
Evolve governance structure to ensure behavioral health input (e.g., via CAP, JCC staff or subcommittee)	Q2-Q3 2021
Assess the EHR utilization by remaining JCC contracted small-group practice and sole-practitioner behavioral health providers and gauge provider interest in transitioning to an EHR.	Q2 2021
Define the current state and anticipated future EHR capabilities needed to further JCC health system transformation and quality improvement goals related to behavioral health. At a minimum, we will consider EHR functionality for behavioral health to support: • Maintaining compliance with all documentation elements required by applicable Oregon Administrative Rules. • Adaptation of successful strategies from physical health workplans to behavioral health scenarios as applicable and needed. • Identification of best practices regarding EHR use and configuration and development of a process to share, extend, and standardize these best practices. • Expansion of closed loop/bi-directional referral processes between primary care and behavioral health. • Population health initiatives (e.g., population segmentation)	Q3 2021

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

Activities	Milestones and/or Contract Year
In 2021, JCC will provide technical assistance to our large behavioral health partners to improve their ability to capture and extract data from their EHRs necessary for OHA (e.g. for ACT) and JCC metric reporting.	Q2-Q4 2021

Optional Question

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

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

3. Support for HIE – Care Coordination

a. 2020 Progress

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

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

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

i. Progress Across Provider Types

Specific Tools you supported or made available in 2020

In 2020, 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 used by JCC and our network.

Collective Platform (FKA PreManage) - JCC 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. We use Collective to identify members who would benefit from mini multidisciplinary case conferences that include internal care coordination team members and external network partners such as primary care, behavioral health, and community paramedicine. We also use information on recent hospital utilization to facilitate care coordination discussions and develop a shared, collaborative care plan for the member.

Reliance HIE - Reliance facilitates the exchange of information among providers through 1) its community health record, 2) provider to provider referrals and 3) provider to provider secure messaging. Reliance gives timely clinical information from participating provider EHRs to support our patient outreach and clinic quality improvement efforts. As an example, the information we receive on new pregnancies among our member population allows us to identify members early in their pregnancies to ensure they are engaging in prenatal care. Similarly, we get information about members with hepatitis C, which allows us to reach out to member directly or inform their primary care clinic to ensure eligible members receive treatment.

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

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

JCC Provider Portal – The JCC provider portal supports referrals among primary care and dental plan partners. Through our provider portal, physical health providers can request dental service in the portal where our providers submit prior authorization requests. JCC has provided technical assistance to physical health providers and their

teams to integrate the workflow into their clinic's care coordination processes. We also track utilization data to identify opportunities for improvement.

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

Secure Messaging - In addition to Collective, our JCC Regional Care Team communicates with providers using Secure messaging through their email and directly from our Care Coordination platform.

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

In addition, we offer products to enhance clinician's ability to expand access to care, and improve quality for patients by additional clinics supports through the following platforms:

E-consults through RubiconMD - RubiconMD is an e-consult platform that providers use to consult with a national network of board-certified specialists for guidance on diagnosis workups, and treatment advice options. Platform can be integrated with clinicians' EHRs and clinical workflows. To expand our provider capabilities for specialty referral and consultation, JCC has negotiated licenses for providers to access this service without charge. We hope this allows every patient to get the care they deserve regardless of affiliation with JCC. In addition, Rubicon provides up to 20 hours of CME for completed consults, 0.5 hours of continuing medical education (CME) per consult. We view this as an upskilling tool for our providers to effectively manage patient needs, while simultaneously using technology to expand the services patients can receive.

Project ECHO - JCC currently supports and has funded providers to participate in Project ECHO, a peer-based learning platform that has shown significant effectiveness in upskilling providers on complex medical and behavioral health topics.

The strategies you used to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers in 2020 AND Accomplishments and successes related to your strategies

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

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

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

- JCC and CareOregon developed a comprehensive plan to improve our member communication strategies and tools. In Q4 2020, we implemented a new telephonic system. NICE in Contact CXone is a state-of-the-art cloud contact center platform which now provides JCC/CareOregon with enhanced performance, reliability, and fault tolerance. Additionally, it provides improved tools for customer experience, reporting and team management.
- We increased utilization and availability of smart and flips phones that could be sent to clinics for members' use or sent to individuals directly upon request.

- We piloted a program to provide members who are dually eligible with Smartphones to allow them to complete their Annual Wellness visits virtually.

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

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

- We updated our care coordination documentation platform (Medecision) to receive ADT data, which includes Admit, Discharge, and Transfer notifications from Collective in real time. This data feed supports our case management and care coordination activities and workflows. All active Regional Care Team (RCT) clients who have an IP discharge are enrolled into our transition of care program. Now by adding the ADT data feed into Medecision, these notifications are pushed in real-time to our regional care team staff.
- We developed targeted cohorts in the Collective tool to identify priority populations that were at increased risk of experiencing adverse impacts of COVID-related care restrictions. Such cohorts included members with a possible overdose event and members struggling to manage their diabetes. Both cohorts directly mapped to a workflow for identification and follow up and then targeted programs and/or interventions.
- We developed cohorts within Collective to identify members who were experiencing COVID-like symptoms and a cohort to identify confirmed COVID positive members. These cohorts helped inform our COVID positive, post-hospital discharge program aimed to wrap services around those who needed to be quarantined away from family and friends. Our objective was to reduce transmission of the virus by providing temporary housing accommodations at local hotels and coordinating services to ensure food and medications were available to members requiring quarantine.
- We worked with OHLC and our hospital system partners to add a flag within Collective to identify members who tested positive with COVID.
- We included language in our hospital contracts that set expectations for use of Collective via contribution of content via Care Insights.
- Our Innovation Specialist team developed an internal, JCC facing, dashboard to help us to track network engagement with the Collective platform. This dashboard informs internal strategies to increase network monitoring, improve engagement, and identify opportunities for optimization.
- We onboarded 2 new full-time staff on both medical and behavioral health teams dedicated to providing network partner technical assistance to promote use and expansion of Collective Medical

B. Reliance - Expanded use of Reliance

- In 2020, JCC built and refined a Reliance report to generate weekly reports on our members who presented to the ED for an asthma-related issue. This was used to do chart reviews and identify members for pharmacy-related interventions. Those members who had an intervention are being tracked. This will be used in 2021 to inform asthma-related work for MEPP (previously Prometheus).

C. CareOregon Portal – supporting communication between CareOregon, providers via our Provider portal.

- In 2020, via our provider portal, we improved the referral process between primary care and our dental plan partners (see more in the Oral Health Section.) Through our provider portal, physical health providers can request dental service in the same online portal where our providers submit prior authorization requests. JCC has provided technical assistance to physical health providers and their teams to integrate the workflow into their clinic's care coordination processes. Because of COVID-19 and the resultant decreased availability of dental services, the utilization in 2020 was low, but the processes were improved and continued.

D. Unite Us – supporting coordination of services and close loop referrals between health care providers and social support organizations.

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

E. Medecision – Expanded use Medecision for care coordination

- We implemented improvements to Medecision that increased our efficiency. The platform has given us greater access to comprehensive assessments and integrated care planning. It allows our Regional Care Team to work from one common care plan for each member. Care Plans are pushed to Collective and to the Provider Portal for increased coordination across the Member's Care/Treatment Team. Care Coordination staff also receive notification alerts of hospital admits allowing for quick follow-up and responsiveness.
- We uploaded a list of PERC codes to member profiles that may be attached to a prioritized population such as Foster Care, Long Term Services and Supports, and Member's deemed ICC Eligible. This allows our Regional Care Teams to proactively engage members into care coordination and prioritize referrals if needed.

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

Strategy 4: Support the use of health IT to expand access and quality to services in rural areas

A. Telehealth

In 2020, JCC supported the expansion of telemedicine through changes in our payment policies and targeted grants. Our Innovation Specialists provided technical assistance and support to allow clinics to provide access to services remotely through; 1) 1:1 provider outreach and support, 2) dissemination of written guidance/materials, and 3) virtual provider meetings. We assessed our network partners to understand and assist with telehealth implementation, staffing concerns, access issues, and other needs related to COVID-19. Network responses informed what we developed in terms of TA materials.

Based on needs expressed, the JCC Innovation Specialist team collated and shared information on:

- Video platform vendors information
- Implementation of video platforms
- Integration of video visits into workflows
- Guidance on best practices for using video capabilities
- Processes/criteria for determining need for video visit vs. other telemedicine/telehealth option

We also:

- Addressed third party interpreter services in telehealth. The team developed additional information in the topic areas of video visit platforms information, workflow integration, and video visit etiquette to align our TA resources and messaging to the provider network and the interpreter network regarding telehealth modalities and access.
- Offered TA support around operational and administrative questions about telehealth, including the CareOregon telehealth coding guidance and FAQ documents posted on our provider website.
- Distributed stabilization funds to many of our network partners to help support them financially during the transition from almost entirely in-person visits to mostly telehealth visits, as necessary during the early phase of the pandemic.

B. Other technology that supports virtual consultation and learning

- Rubicon –In 2020 CareOregon approved adding 100 more providers to platform. JCC added 2 new providers.

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

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

In 2020 JCC, integrated our claims datasets to one of our clinic partners via Arcadia & Wakely to assist the clinics with patient utilization, risk profiles and performance gaps.

Strategy 6: Engage with state committees/entities

JCC staff participated in HITAG, HITOC and UniteUs Funders forums

C. Additional Progress Specific to Physical Health Providers

See Progress Across Provider Types

D. Additional Progress Specific to Oral Health Providers

JCC has invested in tools to support enhanced communication between our primary care, oral health and other providers. In 2020, JCC implemented the following strategies specific to oral health providers and achieved the listed accomplishments/successes:

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

Completion of an assessment among our delegated Oral Health providers to establish a baseline understanding of PDP's using Collective.

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

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

A. Collective

All JCC'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 emergency department for dental issues receives outreach, care coordination, and support in scheduling a visit. JCC 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.

B. JCC Provider Portal

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 2020,

- We evaluated the use of the dental request referral process by PCPs
- We continued to support and encourage further utilization of the portal platform and the exchange of information between PCPs and dental plans for improved care coordination

C. Secure Messaging

- In 2020, JCC supported the regular, secure exchange of physical health information to its dental plan partners to promote population health for prioritized populations. This included providing comprehensive information to the dental plans on their members with diabetes and pregnant members. In addition, Health Risk screening information was regularly shared with dental plans for support in dental navigation and care coordination.

Strategy 4: Support the use of health IT to expand access and quality to services in rural areas

Telehealth - JCC's subcontracted dental plans see potential in expanding the use of teledentistry to increase access to dental providers, particularly in our rural communities with geographic barriers to access. In 2020, JCC's subcontracted dental plans supported the expansion of teledentistry throughout the region.

D. Additional Progress Specific to Behavioral Health Providers

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

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

E. Please describe any barriers that inhibited your progress.

In 2020, we experienced barriers as our network pivoted to respond to the COVID19 pandemic. This has caused much of our work to slow down; however, we worked to provide updated information on utility features of the Collective platform with our provider network, such as the COVID testing flags developed in mid-2020. We shifted our focus from expanding HIT support of broad care coordination to how HIT tools, like Collective, can help support COVID19 specific care coordination and COVID19 response at large.

b. 2021 - 2024 Plans

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

- 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
- Any additional HIE tools you plan to support or make available.
- Additional strategies you will use to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers beyond 2020.
- Associated activities and milestones related to each strategy.

Notes:

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

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

1. Data to support our HIE strategies:

Data from OHA – CCO HIT Data File

HIE for care coordination excluding Collective Platform*		
Service Type	**Org count**	**Rate**
Physical	105	20%
Behavioral	33	20%
Oral	8	20%

JCC contracts with CareOregon for its entire provider network to ensure members have access to a broad network of providers. CareOregon has created an internal dashboard to monitor's provider's engagement with Collective. Based on the dashboard, the following providers within JCC's service area had adopted Collective by end of 2020.

Clinic Type	N Clinics/ Organizations	Approximate % Members Supported	Overall Level of Engagement with Platform*
Primary Care Provider	11	56.5%	Active-Highly Engaged (6) *(5 Not Yet Engaged)*
Behavioral Health Provider (including CMHPs)	5	100% (county level service coverage)	Active-Highly Engaged
Mobile Integrated Health – EMS Agency	1	100% (county level service coverage)	Actively Engaged
Social Services Agency	1	100% (county level service provider)	Not Yet Engaged

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

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

We plan to continue our use of and support for the HIT/HIE tools listed in the 2020 Progress section and build upon all the strategies we previously described and those outlined below. Additionally, we will monitor national and local HIT/HIE initiatives to stay apprised of any developments in HIE tools or opportunities.

2.Strategies, activities and milestones

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

Activities	**Milestones and/or Contract Year**
Evolve governance structure to ensure provider input (e.g., via CAP or subcommittee of CCO Board)	Q1- Q2 2021
Conduct further assessment of HIE use by provider type to augment our existing information and that provided by OHA • 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 JCC HIE adoption efforts.	Q3 2021
Create the plan that may include the following components: • Educating providers and provider staff on existing HIE capabilities and benefits • Developing a regional workplan called for by the HIE Onboarding Program • Identifying opportunities to improve care transition • Increasing and streamlining automated referral workflows • Optimizing the use of the HIEs functionality • Promoting interoperability of HIEs to simplify end-user environment • Monitoring mechanisms to ensure continued improvement in HIE utilization and resulting patient care coordination	Q4 2021
Board or CAP approves revised 5-Year HIT Plan	Q4 2021

Begin to implement the plan • Continue to monitor HIE utilization and work with HIE vendors (including Collective and Unite Us) to achieve optimal adoption. • Explore HIE interoperability solutions with EDIE/PreManage, Epic CareEverywhere and Medecision Care Coordination platform where deemed effective and feasible (e.g., host community conversation, agree on standards) • Continue to engage with State entities to ensure JCC efforts align with other initiatives. • In conjunction with State efforts, evaluate mechanisms and solutions to incorporate SDOH service providers into referral and care coordination workflows. • Focus on developing solutions to allow for integrated care across disciplines (physical, behavioral, oral and SDOH), in service to member-centered integrated services and health.	Q1 2022
Next stage of spread in current efforts	Q1-Q4 2022
Spread best practices • Continue to engage and track HIE vendor plans and enhancements to ensure JCC gains optimal value from HIE technology. • Deploy, monitor and optimize HIE interoperability solutions identified in Year 2 and approved for deployment. • Focus on implementing solutions for incorporating SDOH service providers into care coordination and referral workflows • Focus on developing solutions to allow for integrated care across disciplines (physical, behavioral, oral and SDOH), in service to member-centered integrated services and health.	2023-2024
Assess ROI - deepen implementation of HIT and elimination of HIT services that do not support existing priorities and support value. Adjust resources.	2023-2024

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

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

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

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

Strategy 4: Support the use of health IT to expand access and quality to services in rural areas

Activities	Milestones and/or Contract Year
Telehealth • Develop a strategy for ongoing telemedicine evaluation, optimization and support, post-COVID including: - Discuss with our CAP what they have learned through a year of using telehealth, including pros/cons, best practices, equitable access, pay parity, other. This will help inform our decision making about the best way to support appropriate use of telehealth after the pandemic and into the future. - Other network evaluation of telehealth utilization and best practice - Regional evaluation of cultural and linguistic needs/opinions related to telehealth within the network - Data evaluation of telehealth services - Support for Telehealth toolkit • Support the expansion of telemedicine through possible payment strategies, clinical partnerships, policy support and targeted technical assistance • Beta-test a new platform within Medecision, Arial Engage, that will support care coordination through telehealth	Start Q2 2021, with network engagement Q3-Q4 2021 2021-2024 2022
Explore ways to increase availability and affordability of broadband in collaboration with our counties and local municipalities (e.g.,through FCC, grants, etc.)	Ongoing

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

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

Strategy 6: Engage with state committees/entities

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

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

See the Strategies Across Provider Types section

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

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

Activities	Milestones and/or Contract Year

Working with our subcontracted dental plans, we will finalize our HIE strategy for our dental network focusing on: • Data needed to fuel workflows • The abilities of Electronic Dental Records (EDRs) to hold and display the data • The HIE methods supported by vendor systems	Q4 2021
Begin implementation of the developed strategy in partnership with our dental plan partners.	Q1 2022

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

Activities	Milestones and/or Contract Year
Expand existing electronic dental referral process with physical and oral health providers via our provider portal	Q3-4, 2021
Promote further use of Collective for emergency department and urgent care event notifications for oral health related diagnoses	Q3-4, 2021
Support efforts identified in years 1 and 2 to further health information exchange between oral health and others	2022 – 2024
Continue to explore ways to improve electronic communication between oral health and other types of providers (e.g. Unite Us) by allowing any kind of provider to request services and care coordination from any other health discipline.	2022 – 2024
Explore the use of expanding access to Medecision to the dental plan partners	2022 - 2024
Work with the DCOs to integrate closed-loop electronic referrals and/or preauthorization's within their providers' EDR workflows	2022 – 2024

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

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

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

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

Activities	Milestones and/or Contract Year
Collective: We will continue to support our behavioral health provider network in optimizing their use of the Collective tool specifically related to: • Hospital event follow-up • Multidisciplinary care coordination • Bidirectional communication with primary care for shared members	Q4 2021-ongoing

Optional Question

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

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

4. Support for HIE – Hospital Event Notifications

a. 2020 Progress

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

Notes:

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

i. Progress Across Provider Types

a) A description of the tool that you are providing and making available to your providers for Hospital Event Notification

JCC makes the Collective platform available to our provider partners for hospital event notifications.

b) The strategies you used to support increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers in 2020

Physical Health Providers

We have supported the onboarding of our physical health providers in our network with varied levels of engagement by clinic. Our primary care Innovation Specialist team uses a dashboard to identify opportunities to expand utilization. We also discussed Collective as a tool in transitions of care in regional care planning/transitions of care meetings, and in meetings we held focusing on behavioral health in the ED.

Oral Health Providers

All JCC's dental plans are actively using Collective to identify and coordinate dental care for members going to the emergency department for non-traumatic dental issues. The dental plans have continued to explore the expanded information available to them and how to improve functionality within oral health. We completed an assessment among our delegated dental plans' oral health providers to establish a baseline understanding of PDP's using Collective.

Behavioral Health Providers

Our behavioral health provider network utilized Collective to facilitate behavioral health provider outreach to clients in the ED using a combination of traditional health workers and QMHPs from the crisis, ACT, ICM and youth serving programs depending on the needs of the client and previous program affiliation.

c) Accomplishments and successes related to your strategies

In 2020, we worked with our ICM-contracted providers to address barriers within post-hospital follow-up and improve coordination with hospital systems and referring parties.

ii. Additional Progress Specific to Physical Health Providers

See Progress for All Provider Types

iii. Additional Progress Specific to Oral Health Providers

See Progress for All Provider Types

iv. Additional Progress Specific to Behavioral Health Providers

JCC's five largest behavioral health providers are enrolled with Collective. The behavioral health providers will continue to outreach to clients in the ED using a combination of traditional health workers and QMHPs from the crisis, ACT, ICM and youth serving programs depending on the needs of the client and previous program affiliation. When JCC members are admitted to emergency department, JCC has contracts in place with Columbia Care Services to ensure the delivery of outreach and follow up services.

v. Please describe any barriers that inhibited your progress.

Much of our network was at capacity responding to the COVID pandemic in 2020. As such, our ability to move the work discussed above was limited.

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

a) The HIE tools you are using

JCC/CareOregon use Collective for notification of hospital events.

b) The strategies you used in 2020

Our care coordination and utilization management teams use Collective in a variety of ways: 1) to receive admit and discharge notifications for ALL dual eligible members with a medical admission, and ALL members with a psychiatric inpatient admission, 2) to proactively identify members who may benefit from care coordination, 3) to notify care coordinators when members currently on their panel present to the ED or admit to an inpatient unit, 4) provide Transitions of Care information to providers.

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

Care coordination triggered by hospitalization: Our Triage Coordinators pull daily reports from Collective which include dual eligible members with a recent medical inpatient admission and members with a psychiatric inpatient admission. The Triage Coordinators then send alert tasks to our care coordination teams for follow up. Our care coordination teams also receive alert notifications via Collective for each emergency room visit and inpatient admission for any member already assigned to them and engaged in care coordination. Upon notification, our care

coordinators (Transition Nurse Care Coordinators and Behavioral Health Care Coordinators) review the admission details and initiate our transitions of care workflow.

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

Cohorts tracked and outreached by JCC RCT in 2020:

- 3 ED Admits in 90 Days
- 5 ED Visits in 12 months
- Pediatric ED Activity
- Rising Risk ED/IP/OBS/SNF – Admit
- Diabetes Cohort – Members who present to the ED or Inpatient for diabetes related concern

c) Accomplishments or successes related to your strategies

- In 2020, we created a SUD ED cohort for the Regional Care Team to identify members who presented to the ED due to an overdose event. This allowed the RCT to follow up with these members whose ED visit did not result in a hospitalization. Staff worked closely with the EDs to ensure these members could get connected to behavioral services in a timely manner.
- Worked with OHLC and our hospital system partners to add a tag within Collective to identify members who tested positive with COVID.

b. 2021 – 2024 Plans

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

Notes:

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

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

a. The number of physical, oral, and behavioral health organizations that do not currently have access to HIE for hospital event notification using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g. Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations do not have access to HIE for hospital event notifications).
b. CCOs are expected to use this information to inform their plans.

1.Data from OHA – CCO HIT Data File

Hospital Event Notifications (i.e. Collective Platform*)		
Service Type	**Org count**	**Rate**
Physical	63	12%
Behavioral	36	23%
Oral	7	18%

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

2. Strategy

To ensure increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers, we plan to continue to support improvements to Collective. We do not plan to make available any additional tools to providers related to Hospital Event Notifications. However, we plan to do some discovery around opportunities for refinement in our utilization of the Collective tool. Specifically, we are interested in exploring how we might identify shared populations – those engaged across different provider types, such as patients engaged with primary care and CMHPs to facilitate proactive communication, development of collaborative care plans, and eventually closed loop referrals.

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

See Strategies for All Provider Types

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

See Strategies for All Provider Types

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

See Strategies for All Provider Types

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

We will continue to use our Collective platform internally as a source of real time data/information that signals a need on behalf of our members. We will expand on our approach developed in 2020, and continue work on:

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

Care coordination identified through cohort review: We will continue review of collective cohorts, as done in 2020, but are expanding current cohorts to more conditions. This will allow us to identify members who would benefit from care coordination earlier (a member with 2 ED visits AND uncontrolled DM versus a member with 3 ED visits).

- As described above, in 2020, we created a SUD ED cohort for the Regional Care Team to identify members who presented to the ED due to an overdose event. We will continue and expand this work in 2021 and beyond with closer alignment with IET and EDMI metrics specs for cohort tracking and outreach based on established BH and Population Health strategies

- We plan to increase outreach to perinatal population as we build out our maternal child youth strategy, specifically for women who admit to the ED for OB-related care when not engaged in OB care setting or for

newly delivered members who need assistance navigating to needed care for themselves or newborn, with specific focus on Spanish speaking members. (2022 and beyond)

Optional Question

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

- OHA could support enhancement to Collective to add discharge diagnosis.
- See additional recommendations in preceding section under HIE for Care Coordination

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

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

i. Overall Strategy in Supporting SDOH & HE with HIT

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

Our primary strategy to collect and aggregate social determinants of health data is the implementation of Unite Us. In 2020, in collaboration with AllCare CCO, we began evaluating Unite Us as a community-based solution to improve coordination of social support services among health care providers and community-based organizations. Unite Us is a closed-loop referral platform for social needs that allows for bi-directional information sharing and transparency across referrals networks. JCC and AllCare are planned to go live with the Southern Oregon Region version of the Unite Us Platform on 4/20/21.

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

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

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

1. Improve quality of information captured through claims
    - Z-codes - JCC will partner with our entire network to encourage broader use and collection of Z-codes (specifically within the Z59.xx group) which identify and track needs related to social determinants of health and health equity. There is strong interest and alignment around increasing the use of these codes to track more closely the correlation between member need and outcomes.
    - Improving accuracy coding - JCC, in partnership with CareOregon and the Oregon Primary Care Association, has offered training opportunities to FQHCs, RHCs, and non-CHC primary care providers that

focus on improving coding practices aimed at capturing accurate patient complexity, inclusive of SDOH. These trainings are hosted by OPCA and a contracted coding organization with deep experience in supporting safety net providers. We hope to continue offering these training opportunities in the future, once the COVID-19 pandemic is controlled and there is greater capacity for participation.

2. Other Data: (see below iii)

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

The data will be integrated into the CareOregon Enterprise Data Warehouse (EDW) in August 2021. This EDW integration will enable JCC staff to understand our member's utilization of community based organizations, and identify barriers to services that our teams can address through care coordination. Over time we hope to be able to correlate SDOH access with members overall health and wellness.

Additionally, JCC has provided support to the provider network for system integration between Epic and Unite us, so referrals may be made directly from the Epic system.

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

UniteUs Data: Data from UniteUs will be aggregated using the DMAP ID and CCO Flags that are being fed into Unite Us on a weekly basis in the Member Roster File. An outbound data feed will be built by Unite Us to feed the data to JCC/CareOregon. The data will be joined with Member Demographic data in our Enterprise Data warehouse and will be used for analytical reporting and Program Development. JCC will also explore integrating Vision Link and HMIS content for pairing with the Unite Us data for future data analysis in 2021.

Pediatric Data: Also, through a partnership with DHS, OHA and the Oregon Pediatric Improvement Partnership(OPIP), JCC received SDOH data for our pediatric membership that reports health complexity based on a combined medical and social complexity score. Social complexity factors include poverty (received TANF), foster care, parental incarceration, substance abuse, child abuse or neglect, parental disability, limited English proficiency, mental health services, and parental death. JCC, in partnership with CareOregon, has convened a Pediatric Complexity Steering Committee to determine how to best utilize the health complexity data to align with internal strategies that address identified population risk, needs and disparities. The committee's current objectives include identifying areas of health disparities for resource allocation, completing an environmental scan and providing recommendations for a Pediatric APM model. We will also work with our CAP and CAC to inform how to utilize this data within provider clinics and the community. Additionally, JCC will be submitting requests for the data with the following areas of focus:

- ACEs crosswalk with available risk factors
  - Identify databases which may have info related to risk factors in the ACE questionnaire.
  - Intention: Use the information for 1) provider training and supports 2) community awareness and building resiliency
- Foster care placements and coordination support
  - JCC staff will be doing proactive outreach to families upon DHS placement and hoping to tap into additional data which may identify gaps in resources/programs/referrals.
  - Utilize data to inform ways of improving supports and services which can contribute to preventing DHS placements (parental factors)
  - Identify ongoing supports for prioritization outside of the initial assessments (initial assessments are tracked due to CCO metric)

Data to support Equity work: CareOregon's Quality Improvement Team is in the process of developing a training curriculum on how to use data to support equity work. This training covers best practices on centering equity in analyses and when making data-driven decisions. We are currently seeking feedback from key stakeholders, with a focus on partners of color and organizations that serve communities that have been marginalized. By improving both the quality of our data and shifting our culture around how we use data, we hope to build better strategies to support our members. In 2021, all analysts that support JCC will complete the training and work with strategy leads to incorporate practices into their strategy development.

The Quality Improvement Workgroup will continue to focus on data disaggregation. In 2021, we are working to ensure that when we share data we disaggregate it in every meeting. We will also plan to offer technical assistance to network providers on disaggregating data and data equity practices and encourage providers to share disaggregated data with us and their peers.

Other Data:

- **Community Health Assessment and Accountable Health Communities SDOH Data:** JCC collects member level data on five SDOH; housing, utilities, food insecurity, domestic violence and transportation. This data is analyzed with member risk scores, claims and a population segmentation tool to compare what these data sets are capturing and how they relate to medical complexity.

- **NEMT:** The NEMT team screens each member for physical and behavioral health conditions that would require specific and alternative modes of transportation to accommodate any disabilities and/or special needs. As part of that screening process, member profiles are created and special needs are documented within the NEMT scheduling and electronic health record system.

- **Dental:** Dental Plans use referral and claims reporting to track and trend disease prevalence and utilization. Utilization analyses assist in informing specialty network adequacy and care coordination needs. With the adoption of the oral exam for Adult Members with Diabetes metric in 2019, dental plans began receiving information about their members with diabetes and began targeted outreach to those members to ensure they received dental services at least annually.

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

The entire Unite Us integration must be custom built. CareOregon, HSO, and PacificSource have collaborated with the vendor to develop specification on how to build this integration.

There are multiple CIE platforms being utilized in Jackson County, including VisionLink to support wildfire survivors, and HMIS for coordinated entry. Platform integration with Unite Us via CareOregon and JCC advocacy is needed to ensure that DHS and state funded community-based organizations are not forced to navigate multiple platforms in process of addressing social needs of our population, particularly for wildfire survivors, hardest hit in our region in 2020.

Additionally, the current infrastructure of many of our local community based organizations does not support data collection systems along with the staffing of data analysts, making the collection and sharing of data challenging.

Optional Question

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

Many community based organizations (CBOs) do not have the infrastructure in place to support formal data collection and reporting. It will be important to help CBOs identify approaches, data collection processes, and tools for analyses that would help demonstrate ROI and program effectiveness. The following are ways in which the OHA could support community based organizations (CBOs) in this space:

- Support alignment of efforts across the state for Connect Oregon/Unite Us
  - Facilitate integration of data from legacy systems such as HMIS
  - Reduce number of new systems being implemented, such as VisionLink
- Provide webinars, learning sessions along with TA
- Provide capacity building grants or incentives for CBOs to engage

6. Health IT for VBP and Population Health Management

a. HIT Tools and Workforce

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

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

i. HIT Tools for VBP and Population Management

Please note: For this section, see detailed activities and milestones in Attachment C – HIT Roadmap for VBP and Population Management.

Information about the following items:

(1) Tools: Please identify the HIT tools you use for VBP including:
(a) What HIT tool(s) do you use to manage the data and assess performance?
We use industry standard tools, processes, and practices for managing data and for assessing performance. Our tool set includes comprehensive EDW and Data Marts as data repositories. Our data repositories are primarily SQL Server Enterprise running on robust infrastructure. We use SSIS as our tool of choice for moving data between systems and databases. We use third party software platforms, such as Cotiviti, as well as internally programmed applications to assist with clinical quality measure calculation.

(b) What analytics tool(s) do you use? What types of reports do you generate routinely (e.g., daily, weekly, monthly, quarterly)?
We use a variety of industry-leading tools to drive analytics. VBP data is ingested into our EDW, whereas Tableau is used for generating and distributing robust, meaningful, and easy-to-understand analysis dashboards and scorecards. Our Tableau infrastructure delivers these dashboards within our CCO and to our clinic partners. These dashboards are refreshed between weekly and quarterly depending on business needs.

We use SQL Server Reporting Services to deliver transactional and detailed reports to users on regular basis. Frequency of these reports varies from real-time to quarterly depending on business needs.

Excel is used as reporting tool where it is appropriate. JCC uses SAS auto jobs and other tools to generate these files on regular basis. Frequency of refresh for these files varies from weekly to quarterly depending on business needs.

Tools such as R, SAS, SPSS, and Python are used for statistical and predictive modeling to answer advanced analytics questions such as identifying populations at risk of adverse health related events.

Tools such as the Johns Hopkins ACG are used for risk assessments and stratification of population, and other third-party tools are used to distribute reports. We use our care Coordination platform to provide up-to-date information on care coordination activities.

ii. Workforce for VBP and Population Management Analytics

2) Workforce: Please describe your staffing model for VBP and population management analytics, including in-house, contractors or a combination, who can write and run reports and help other staff understand the data

We have robust data and reporting teams. In collaboration with CareOregon, we have 30 permanent data and analytics staff members who manage our HIT and databases, assure data quality, develop reports, conduct statistical analyses, develop predictive models, and perform other data/analytics functions across the enterprise. We can also

subcontract to outside vendors if additional specialized skills are needed. Our team includes software developers, data architects, database administrators, business analysts and healthcare analysts; these skill sets cover the entire spectrum of activities and skills needed to deliver high quality analytics.

In addition, we have dedicated quality improvement and technical assistance staff to offer support for data/report translation and implementation activities both internally and externally. Our quality improvement staff are skilled in explaining data to internal staff and external provider partners on the level that meets the need. Our staff have dedicated time over the past year to honing data visualization skills in order to better communicate complex analyses to wider audiences. Our quality improvement team has also directly helped clinics run reports, especially as related to disaggregated data reports.

Our Innovation Specialist team offers technical assistance directly to providers and can help with report reading and translation as necessary. This team also assists providers with using data in meaningful ways for quality improvement purposes. Lastly, our Panel Coordinators, working full-time directly in the provider's offices, are also available to assist clinic staff in understanding data and reports.

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

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

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

Additionally, describe

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

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

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

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

1. Ensure payment systems can administer non-FFS based arrangements

We continue to leverage the Provider Incentive Payment System (PIPS), a tool which streamlines the administration of PMPM payments. The tool facilitates a programmatic structure to manage attributed member-based payments made according to different quality performance levels, and population risk tiers. The system is integrated with our claims system taking advantage of existing provider EFT payment pathways. This infrastructure has added significant efficiency to the process of evaluating and ultimately making PMPM payments to providers. In 2021, we plan to continue to migrate other PMPM based payment programs into PIPS to leverage the workflow and reporting capabilities. This will include all of our current and future Primary Care capitation contracts.

2. Ensure metrics calculation and analytics tools can generate robust reports

The CCO's HIT infrastructure, which is powered by CareOregon's analytics platform and resources, will play a key role in monitoring both CCO performance and accountability of its partners. Our analytics platform is the result of considerable investments to ensure that validated and reliable metrics are available. Data and measures will be regularly shared with partners to identify opportunities and drive performance. See section 6.a.1 for additional detail.

Our platform is capable of attributing members to particular clinics (PCPCH assignment) and can also track members as they move from one delivery network to another. It also manages attributions for dental relationships. Maintenance of provider attribution information has required considerable effort and will be an area of continuous improvement to ensure that performance is tracked accurately in an increasingly risk-bearing environment for physical, dental and behavioral health.

CareOregon continues to partner with Wakely, our consulting actuaries, to provide monthly reporting packets to our Total Cost of Care VBP partners. These reports are reviewed in depth at our monthly provider meetings. We plan to continue this partnership with plans to enhance reporting and bring pieces of the work in house. All of this will enhance our flexibility and nimbleness in meeting the needs of our provider partners.

3. Explore additional enhancements and technologies

While the PIPS tool remains a key to our VBP programs and oversight, we are continuing to evaluate the market for tools to enhance our capabilities. We are evaluating a potential RFP process in Q2 2021 to identify additional tools and opportunities.

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

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

Activities	Milestones and/or Contract Year
Hospital VBPs – establish standard report sets for VBPs implemented with hospital partners	2021
Develop and implement a Behavioral Health VBP model, including development of performance management infrastructure	2021
Develop and implement a Maternity VBP model, including development of performance management infrastructure	2021
Develop and implement a Children's Health VBP model, including development of performance management infrastructure	2022
Develop and implement an Oral Health VBP model, including development of performance management infrastructure	2022
Conduct semi-annual reviews of existing reporting and performance management infrastructure. Identify opportunities to further develop and update HIT to streamline program administration	2021 - 2024

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

JCC currently has implemented VBP arrangements with several providers and is committed to increasing VBP over the next five years. Our arrangements incentivize and hold partners accountable for performance on Oregon's CCO incentive metrics as well as other measures of clinical quality. While the measures for these arrangements are currently aligned with OHA priorities, future governance decisions and VBP needs could expand these measures of accountability to include engagement with high-priority populations, elimination of health disparities, or other measures related to quickly emerging VBP arrangements.

To that end, we are well poised to operationalize these evolving arrangements through our software platform, PIPS, that supports PMPM VBP administration. This VBP tool, a leading third-party software, currently allows us to administer payments, adjust performance-based payments, and integrate VBP and claims data. This functionality is critical to our ability to report on payment arrangements by LAN category, as required.

We use this software to manage payments for our PCPM, CPC+ and IBH programs. The evolution of work in this area may seem intuitive, however, administration of non-claims-based payments in a health system that was built on a FFS system, has required a significant amount of operational overhaul. Moving from manually processing checks to integrating this work into our claims processing system, including records of performance has greatly improved efficiency and allows us to administer and record performance and associated payment in one location. In 2020, we expanded use of this tool to include capitation payments and other PMPM contract models.

Another critical tool supporting VBP expansion is the financial model developed by Wakely, an actuarial consulting service, which provides the architecture that supports our Total Cost of Care (TCOC) and Medical Loss Ratio (MLR) risk agreements. This financial model calculates the total cost of care for a primary care partner's assigned membership, along with detailed cost data analytics allowing the provider to identify trends, and areas of opportunity to better manage resources. In 2020, Wakely further developed modules within this model that aid in the process of risk recapture and managing the health of a population. The risk recapture/population health module allows the provider to search for members previously diagnosed with high-risk conditions, without a recent claim showing that diagnosis. This tool can also be used to proactively outreach to members with chronic conditions to ensure they are receiving preventive care.

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

All of the systems that house data needed to administer VBP arrangements, including those supported by the OHA, contain different file formats, fields, and provider identification information. Therefore, generating the information to respond to OHA's payment arrangement reporting is difficult. We have to combine both claims payment data, along with other types of payments made in relation to a VBP (e.g., PCP risk agreement includes both the FFS claims data, and settlement payments made when the agreement year ends with a surplus). It can be challenging when combining data from the general ledger, with claims data to match up those payments with the right provider contracts, and so associating with the correct LAN category.

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

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

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

Additionally, please describe

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

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

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

Strategy 1: Provide timely and accurate performance data

The CCO regularly shares data, at least quarterly, with its providers. We are currently expanding this capability to ensure that data provided to clinics is specific to VBP arrangements in which they participate. Our existing analytics infrastructure and software tools allow us to deliver Oregon's CCO incentive metrics and select HEDIS–NCQA measures to providers on a regular basis. Enhancements will continue to expand our ability to deliver additional measures, as appropriate based on VBP arrangement participation, to providers on a regular and automated basis. Providers will be able to view a broad menu of measures, as well as those applicable only to their payment arrangements. Scorecards include both aggregate (clinic-level) and member-level information, making data more actionable for intervention. See section 6.a.1 for additional detail.

The CCO is also in collaborative risk arrangements in Jackson County. The partners include hospitals, primary care, and community mental health partners. The CCO shares performance data related to their total cost of care with each set of county partners every other month and quality metric performance data quarterly. For our more advanced partners, the CCO provides a claims data feed that enables their internal population segmentation tool to include cost analysis.

Moving forward, providers will have access to a more comprehensive array of reports through our FIDO web portal (the front end for our EDW). We are currently piloting access to a limited group of users including one of our FQHCs, with full implementation planned by the end of 2021.

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

Strategy 2: Ensure providers have access to accurate and consistent patient attribution data

Our reporting platform includes data on patient assignment and utilization. For purposes of VBP arrangements, we calculate performance based on the providers assigned member population. In instances where members are inappropriately assigned, we have staff that work to quickly reconcile and reassign as appropriate and coordinate these activities with providers. We also employ auto-assignment for new members, and auto-reassignment for existing membership. New members are assigned to a PCP based on their address, history of OHP eligibility and PCP assignment, assignment of eligible family members, etc. Current members are automatically reassigned to a new PCP if their actual utilization patterns indicate they see a different PCP. Information on patient assignment is available both through our data reporting platform as well as our provider portal. Transparency of this information allows for productive conversations around population health management expectations under our VBP arrangements.

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

Strategy 3: Implement a multi-prong approach to facilitate population management in service to population health and quality improvement. These approaches include:

Member level data as a tool for population management:

1. We can generate member-level data and lists to identify gaps in care are provided to our clinic partners, so our network can outreach and provide clinical services to close the gaps. We are working to integrate physical health data and oral health data in order to provide a member-centered population management list. Contracted providers within our network have regular/real-time access to data and patient-lists through our data portal (FIDO). JCC also has executed a LOA with Jackson County Public Health to share member lists related to vaccines, including COVID-19, as an opportunity to close gaps in care more broadly than within contracted clinics.
2. Risk stratification (member level and population level) reports are currently being enhanced to include several markers of risk, including health care condition recapture data. These reports are the foundation for discussion of clinical quality improvement best practices held at our network-wide learning collaboratives and one-on-one technical assistance meetings.
3. Population Health explorer: We have developed a dashboard called population health explorer that allows us to look at member level data from a variety of lenses in order to develop care plans, gaps in care.

4. We have developed a COVID-19 dashboard, both in general and one focusing on vaccines. We used an equity-data approach to categorize populations, and can pull member lists to share with our network or public health department for direct outreach.
5. Collective for population management: We have many providers using Collective to outreach to unengaged members seeking care through the Emergency Department and using our Medecision care coordination platform to coordinate services for members with complex chronic health problems or psychosocial issues. The team is also working to identify a member caseload for each JCC panel coordinator based on risk criteria and will be responsible for ensuring that each member has meaningful contact, gaps in care addressed, and are engaged with their primary care provider.

Support to use data for action:
In addition to external provider reporting, the CCO has internal staff that directly support identification and coordination of members in need of services. We have a team of panel coordination staff who are out-stationed in our network and act directly as a part of the clinic care team. This team uses the reports previously described, as well as data obtained directly through chart review, to prepare providers for member office visits. They currently focus primarily on needed services identified by a gap in a CCO incentive, CMS Star measure, or lack of engagement with their primary care provider. With onset of COVID and COVID-19 vaccine efforts, these staff also are helping with outreach to members to ensure they have necessary services and will be outreaching related to access to COVID-19 vaccine.

Population Level Data- though not used for direct patient outreach, this level of data does greatly contribute to overall improved health outcomes.
CareOregon and JCC use sophisticated methods to pull and analyze claims data based on different populations, incorporating pharmacy data, NEMT data, geomapping, as well an ensuring data is disaggregated based on REAL-D. This data is utilized to develop broader population health strategies and initiatives to help improve health outcomes for our membership. These strategies are developed in a data-informed way, in partnership with our CAC and CAP, and informed by our regional health improvement plan.

- **Population level data available to the network:** We make data inclusive of clinical quality measure performance and health system utilization available to providers continuously through an online platform. We also present this data to help inform strategy development on a larger systems level, informed by our network. We have developed multiple other population level data dashboards focusing of different populations and elements of care (SUD, specialty access, opioid prescribing). These are not available for external use, but we do share the data individually with clinics, and with our region clinical advisory panel. We also use this data for strategy development.

- **Population level data for strategy development:** The same dashboards described in #3 above are used for population level strategy development. We also have developed a tool entitled “population health explorer,” that allows both a member view (as described above) and a population view to identify population-level gaps and opportunities. As noted above, we have a COVID-19 dashboard that can also be used for planning, tracking, and continual improvement at a population level.

- **Predictive modeling**: On a quarterly basis, we also use the Johns Hopkins ACG model to generate risk scores for our population. We stratify our population using advanced clustering and machine learning to identify populations which may benefit from interventions. Our regional care teams use information from these tools to guide their work in the Medecision care coordination platform. This data also helps to inform targeted population-level strategies, as noted above.

- **Equity data approach:** Our Quality Improvement Team is in the process of developing a training curriculum on how to use data to support equity work. This training covers best practices on centering equity in analyses and when making data-driven decisions. We are currently seeking feedback from key stakeholders, with a

focus on partners of color and organizations that serve communities that have been marginalized. By improving both the quality of our data and shifting our culture around how we use data, we hope to build better strategies to support our members.

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

Contracted providers within our network have regular/real-time access to data and patient-lists through our data portal (FIDO)(see above).

As indicated, we also can share data from dashboards that are not yet externally facing with individual organizations, in a more manual manner, or through an interactive meeting.

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

Total number and proportion of those clinics/groups with access to:

a) Performance metrics (at least quarterly): 100%
b) Patient attribution data: 100%
c) Actionable member-level data: 100%

100% of our primary care providers participating in VBP arrangements had access to the data referenced above. Providers that participate in our risk agreements (TCOC, MLR) also have access to the Wakely financial model providing additional data regarding utilization patterns, and costs of services provided by other providers in the network.

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

Progress, including accomplishments and successes, are all described in the specific sections above.

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

Technology available to CCOs has not quite caught up with the increasing VBP reporting demands, particularly as categorized by the LAN. While the aim of the reporting requirements is directionally correct, fulfilling them remains equally or more challenging than implementation of the VBP arrangements themselves.

Optional Questions

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

We offer extensive provider technical assistance through our quality improvement, provider relations, innovation specialist, and panel coordination teams as described in various sections throughout this document.

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

7. Other HIT Questions (Optional)

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

a. How can OHA support your efforts in accomplishing your HIT Roadmap goals?

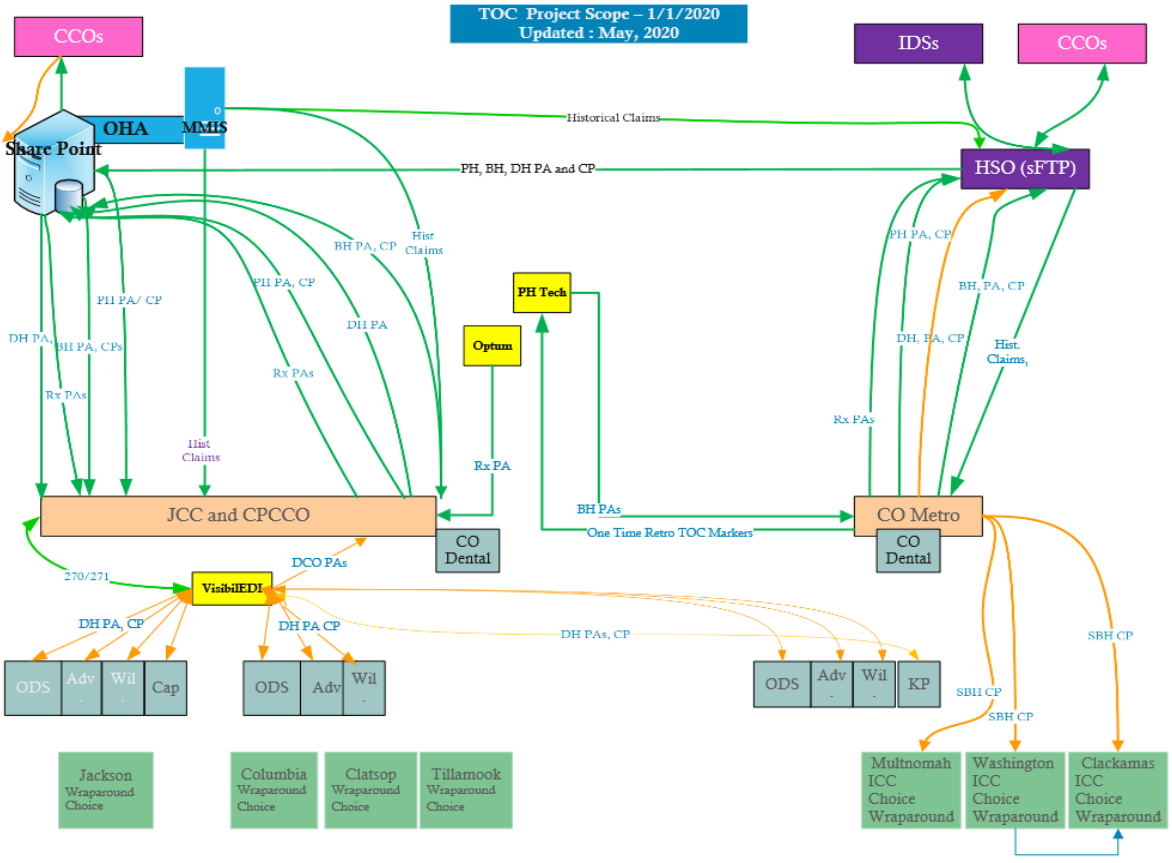
Investigate methods for capturing additional detail related to diversity, ethnicity, and inclusion for those individuals on the Oregon Health Plan. A large percentage of our members come onboard without this information having been captured.

For those instances where we (the CCO) are able to collect that data, it would be helpful if there were a more streamlined way for us to feed that information back to OHA (in order to update those records). We recognize that acquisition of that data has many challenges and would welcome any opportunity to discuss options or brainstorm ways that we can further understand our population in order to best support them.
b. How have your organization's HIT strategies changed or otherwise been impacted by COVID-19? What can OHA do to better support you?

Attachment A – EHR Assessment Results

Teams Document Link (334 Providers = Yes, = No)	CCO EHR Master Data List
Master Data List PDF	CCO HIT Data Collection as of 1-21

ATTACHMENT B – Transitions of Care Diagram



ATTACHMENT C-Updated VBP Roadmap

Attachment
C-Updated JCC Roac

HIT to Administer VBP and Population Health	2021				2022				2023				2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Expand use of VBP Administration system already in use			Additional VBP Models	▲												
Explore integration options (financial, contracting, clinical and claims systems)																
Implement identified roadmap items							Roadmap in Place	▲								
Operationalize identified roadmap items																
External reporting data integration distribution improvements							Integrated Reporting Production	▲			Assessment and Adjustment	▲			Assessment and Adjustment	▲
Enhance reporting capabilities - aligned with VBP Strategies																
Sustaining NEMT (4B)																
Work with Primary Care to sustain 2C																
Evaluate Primary Care data needs for 3B arrangements																
Support expansion of 3B for Primary Care					Tools and data in place	▲					Adjustments Evaluated	▲			Adjustments in place	▲
Support and expand PCPM T1&2 for Pediatrics (2C)					Tools and data in place	▲	Adjustments Evaluated	▲	Adjustments in place	▲	Adjustments Evaluated	▲				
Expand 2B-C for Hospital quality metrics and Bundled Payment (3B)					Tools and data	▲					Adjustments Evaluated	▲			Adjustments in Place	▲
Expand 3B for Provider/Health System Shared risk							Adjustments Evaluated	▲	Adjustments in Place	▲					Adjustments in place	▲
Expand and sustain Maternity care Global Payment Model for SUD (2C, 4B)			Tools and data in place(2C)	▲			Develop tools (4B)	▲			Tools and data in Place(4B)	▲				
Behavioral Health Care				Develop tools(2d ▲			Tools and data in place(3a)	▲								
Oral Health Care								Develop tools (2C) ▲				Tools and data in place(2C) ▲				
Physical Health Care																
Pharmacy																Tools and data in place(2C) ▲
Supporting contracted providers with VBP arrangements																
Deliver quarterly reports and dashboards (see Enhancing analytics platform....section above for miletones)				Launch acess to expanded dashboards and scorecards ▲												
Explore expansion of claims data sharing																
Deliver quarterly member rosters and attribution reports																
Provide on-line member-level portal access and reports for quality measures and risk																
Generate refreshed risk scores each quarter																
Other ways of providing actionable data																
Enhance reporting capabilities to include additional measures, inclusive of SDoH-HE and risk																
Incorporate VBP considerations in HIE analysis and solution design																
Investigate data from HIE platform and data reporting solutions																
HIT data for population health management																
Provide real-time access to JCC's care coordination system - access care plans and population segmentation information			Access model in place	▲												
Monthly or quarterly risk stratification and population segmentation refreshes																
Explore further integration opportunities between claims data, financial data, and clinical data to facilitate modeling, administrating, and monitoring VBP agreements.				Access model completed ▲												
Explore additional opportunities through Acuere health data aggregation platform) and use of pediatric health complexity data																
Explore expanding these models to include additional SDoH categories through incorporation of Z-codes and health complexity data																
Other ways to gather and measure population health status and outcomes																
Expand our abilities to further gather and Integrate data from Health Risk Screenings																
Explore EHR integration with provider partners with our data aggregation and analytics platform																
Explore and enhance QRDA 1 and III exchange capabilities to increase our ability to gather population health status outcomes																
Data Sources																
Expand our abilities to further gather and Integrate data from Health Risk Screenings																
Further improve our data governance processes by chartering subgroups focused on Member and provider data																
glossary and a data dictionary to promote consistent use and interpretation of data																
Improve our data governance processes by chartering subgroups focused on claims and reference data																
Dissemination of analysis																
Expand our capabilities to enable single sign-on to key reporting systems, automate the broadcast of templatized score cards to clinical partners, and launch a new Analytics portal																
Effectiveness of HIT supports																
Maintain governance and customer feedback forums																
Continue working with OHA and other CCOs through HITAG to establish and/or refine needed data standards																
Provide actionable population and member-level information to providers to succeed in these arrangements																
Explore opportunities to integrate clinical data into our data aggregation and analytics platform that provides actionable information to both JCC and providers																