Reflecting on Learnings from
Oregon's Integrated Care for Kids (InCK)
Related to HIE/CIE

Collaborative Discussion
2/9/2022

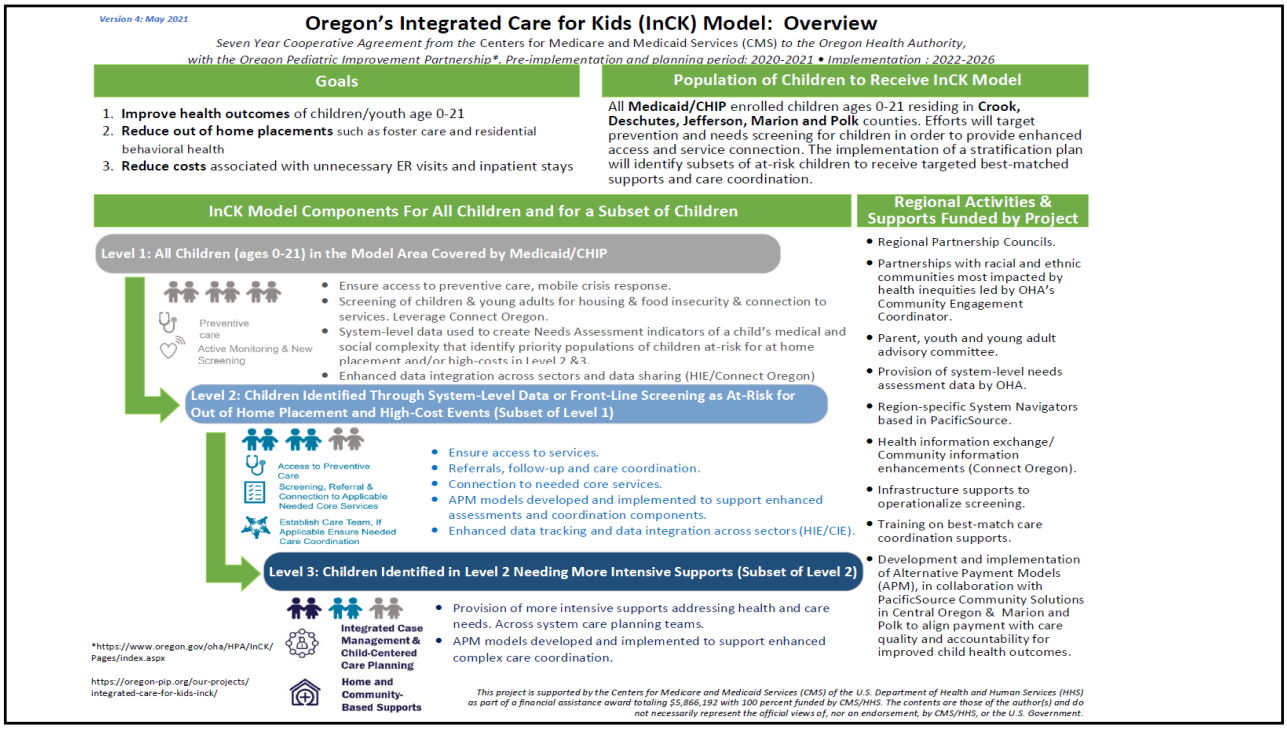
OPIP

Proposed Agenda

I. High-Level Overview of the Goals of InCK and Leveraging HIE and CIE to support:
   - Sharing cross sector data to inform access, engagement and assurance of physical, behavioral and health related needs for subset of children with **medical** (in CCO 2.0) and social complexity
   - Use of HIE and CIE to support **integration and coordination of care received**

II. Summary of Learnings from the InCK model pre-implementation period on:
   - **Health Information Exchange**
   - **Community Information Exchange**
     - Opportunities to Leverage in future Oregon priorities including CCO incentive measures

2



Version 4: May 2021

Oregon's Integrated Care for Kids (InCK) Model: Overview

Seven Year Cooperative Agreement from the Centers for Medicare and Medicaid Services (CMS) *to the Oregon Health Authority, with the Oregon Pediatric Improvement Partnership*. Pre-implementation and planning period: 2020-2021 • Implementation : 2022-2026*

Goals

1. **Improve health outcomes** of children/youth age 0-21
2. **Reduce out of home placements** such as foster care and residential behavioral health
3. **Reduce costs** associated with unnecessary ER visits and inpatient stays

Population of Children to Receive InCK Model

All **Medicaid/CHIP** enrolled children ages 0-21 residing in **Crook, Deschutes, Jefferson, Marion and Polk** counties. Efforts will target prevention and needs screening for children in order to provide enhanced access and service connection. The implementation of a stratification plan will identify subsets of at-risk children to receive targeted best-matched supports and care coordination.

InCK Model Components For All Children and for a Subset of Children

Level 1: All Children (ages 0-21) in the Model Area Covered by Medicaid/CHIP

Preventive care
Active Monitoring & New Screening

- Ensure access to preventive care, mobile crisis response.
- Screening of children & young adults for housing & food insecurity & connection to services. Leverage Connect Oregon.
- System-level data used to create Needs Assessment indicators of a child's medical and social complexity that identify priority populations of children at-risk for at home placement and/or high-costs in Level 2 &3.
- Enhanced data integration across sectors and data sharing (HIE/Connect Oregon)

Level 2: Children Identified Through System-Level Data or Front-Line Screening as At-Risk for Out of Home Placement and High-Cost Events (Subset of Level 1)

Access to Preventive Care
Screening, Referral & Connection to Applicable Needed Core Services
Establish Care Team, If Applicable Ensure Needed Care Coordination

- Ensure access to services.
- Referrals, follow-up and care coordination.
- Connection to needed core services.
- APM models developed and implemented to support enhanced assessments and coordination components.
- Enhanced data tracking and data integration across sectors (HIE/CIE).

Level 3: Children Identified in Level 2 Needing More Intensive Supports (Subset of Level 2)

Integrated Case Management & Child-Centered Care Planning
Home and Community-Based Supports

- Provision of more intensive supports addressing health and care needs. Across system care planning teams.
- APM models developed and implemented to support enhanced complex care coordination.

Regional Activities & Supports Funded by Project

- Regional Partnership Councils.
- Partnerships with racial and ethnic communities most impacted by health inequities led by OHA's Community Engagement Coordinator.
- Parent, youth and young adult advisory committee.
- Provision of system-level needs assessment data by OHA.
- Region-specific System Navigators based in PacificSource.
- Health information exchange/ Community information enhancements (Connect Oregon).
- Infrastructure supports to operationalize screening.
- Training on best-match care coordination supports.
- Development and implementation of Alternative Payment Models (APM), in collaboration with PacificSource Community Solutions in Central Oregon & Marion and Polk to align payment with care quality and accountability for improved child health outcomes.

*https://www.oregon.gov/oha/HPA/InCK/Pages/index.aspx

https://oregon-pip.org/our-projects/integrated-care-for-kids-inck/

This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $5,866,192 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Oregon's Integrated Care for Kids Model

1. ***Early identification of children*** with multiple physical, behavioral, or other health-related needs and risk factors through population level assessments and risk stratification.
   - Leverage **children's health complexity** system-level data to identify priority populations who have higher needs for care coordination.
2. ***Integrated care coordination and case management*** across physical health, behavioral health, and other local service providers.
   - Oregon's InCK Model will provide **training and dissemination of best practices in care coordination and community-based services** with a focus on culturally and linguistically responsive care.
3. ***Health Information Exchange & Community Information Exchange:*** Enhancements and regional service integration coordinators to support care coordination for children with health complexity.
4. ***Development and Implementation of Alternative Payment Models (APM)*** to align payment with care quality and accountability for improved child health outcomes.

4

What *Opportunities* and *Barriers* did the HIT Team Identify for HIE through work on InCK

Overarching Framing about Oregon's Integrated Care for Kids Model Application

Given Oregon's strategy focused on leveraging existing data and focused on SHARING of data and USE of data for the following:

- **Sharing cross sector data WITH CCO and then the CCO sharing with front-line providers** to inform access, engagement and assurance of physical, behavioral and health related needs for subset of children with **medical** (in CCO 2.0) and social complexity
- Use of HIE and CIE to support **integration and coordination of care received**

HIE and CIE elements were critical to support the child-level work and connections that were proposed.

Learnings About Elements Noted in Application that Ended Not To Fully Be There…Yet…to Support the Child-Work Needed and InCK

- **HIE**
  - In Central Oregon, could not use Reliance (as was noted); in Marion and Polk not any central platform
  - Barriers to collective use at a population level for children in these practices
  - Existing data sharing from CCO to clinical partners
  - Existing use of data within CCO to inform population management, intensive case coordination
  - No HIE for Shared Plans of Care for Medically Complex
- **CIE**

✓ Central Oregon pilot focused on adults
✓ New outreach and connection in Marion and Polk, Low adoption
✓ Need for learning about how this works for socially complex, children
✓ Different of organizations on to REFER vs. organizations on to accept referral
✓ Difference of organizations CCO contract with vs those on

6

Parent, Youth and Young Adult Advisory Group:
Learning relative to policies, structure, processes and opportunities:

- **Specific gaps in access to, services for, and coverage of**:
  - Behavioral health
  - Wraparound or comprehensive care supports
  - Inpatient behavioral health
  - Oral health
- Targeted focus on **community engagement and coordination with schools** for children with medical and behavioral needs for which the system doesn't coordinate well.
- For **adolescents transitioning to young adults**, supports for the primary role of overseeing health care and health care services and for supports that address work and life.
- **Centralized Case Management** was requested by all members, across services, and positively received by those who had a case manager in the past.
  - Important to note: for these medically and socially complex, the PCP was not the right place
- An online **Centralized Hub** for sharing information across specialists and school professionals was recommended by group members.

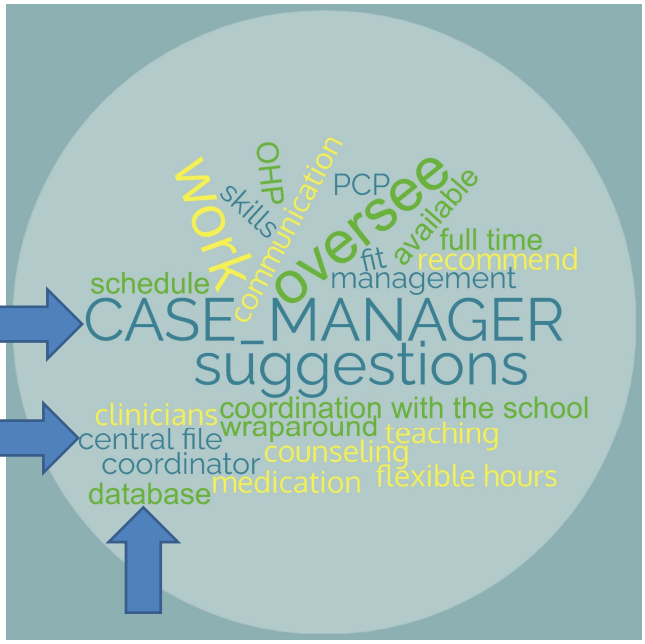
7

OPIP
Oregon Pediatric Improvement Partnership

Visioning Question #2 – If You Could Improve Your Experiences

What do you wish existed that would help in managing, coordinating, and balancing the different services and supports your child(ren) receive and need?

Word Cloud of PYYAG Responses



Health Information Exchange: Alignment with CCO 2.0 Requirements

Policy #33:
Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange (HIE) technology that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications

Intended impact:

- Behavioral, oral and physical health ***providers have the information needed to deliver better care, patients get the right care at the right time***, and costly hospital use is reduced.
- Increasing the adoption of HIE among priority providers in support of priority populations will support care coordination and improve patient care, particularly around integration and coordination across physical, behavioral and oral health care.

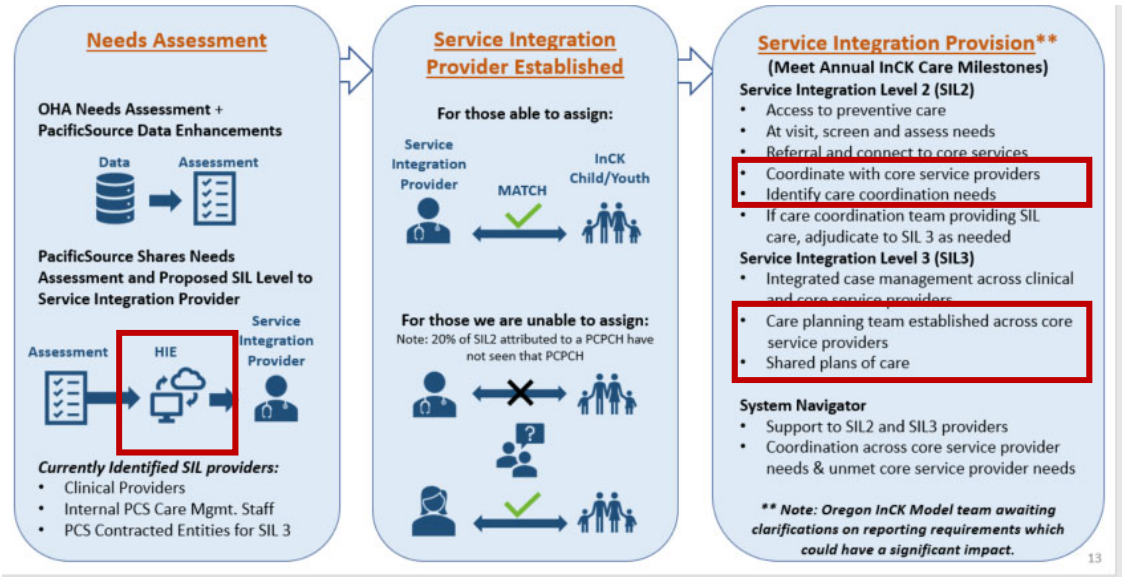
Dashboard

	Fulfills state or federal mandate
Priority area:	**BH/HIT**
How heavy is lift?	●●○
How large is impact?	●●○
	2019 POP planned
	Requires legislation
	Recommendation for OHA
✓	**Exists in contract; needs strengthening or improved monitoring**
✓	**Health equity impact assessment**
✓	**Potential to impact children**
✓	**May require OHA TA support**
✓	**Increases transparency**

Information derived from: https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report-Appendix-A.PDF

9

Opportunities Identified in InCK to Leverage Health Information Exchange:



Learnings from InCK Pre-Implementation to Inform Meaningful Operationalization of HIE Adoption with CCO 2.0 Requirement

In Partnership with HITCommons, OPIP helped to facilitate onboarding and "Discovery Calls" with our initial Service Integration Providers and below are some key learnings:

- Overriding desire of Primary Care practices was to have ***easily accessible*** medical, behavioral and oral health records/events through HIE to support point in time care coordination – and were excited to engage on this topic
- Most high functioning medical homes were ***NOT*** yet utilizing HIE platforms in a meaningful way to align with the **goals** of CCO 2.0:
  - Most sites could not leverage Collective for the initial Needs Assessment sharing due to limited infrastructure
  - Sites "using" Collective, were on to meet hospital event requirements, ***but not for care coordination***
    - Hospital Event Notifications was the only place that OHA TA was provided
  - If care coordination was happening on HIE, it was for a very small subset of patients and often not pediatrics

Learnings from InCK Pre-Implementation to Inform Meaningful Operationalization of HIE Adoption with CCO 2.0 Requirement

Barriers identified by Phase 1 sites to utilization of HIE:

- Limited integration with EHR; required additional panel management platforms, duplicative workflow, or additional FTE of Care Coordinator/staff to support ingestion of data
- Critical partners not engaged on HIE platforms for care coordination
  - ➢ Pain point from primary care was that there was minimal communication with Behavioral Health Services and Child Welfare that are co-managing patient needs

Learnings from InCK Pre-Implementation to Inform Meaningful Operationalization of HIE Adoption with CCO 2.0 Requirement

Key Considerations for OHA to support HIE goals:

Aligned with the Examples of Accountability within CCO 2.0, consider asking CCO's to provide: "CCO sets and reports on targets for percentage of providers health information exchange **for care coordination**, broken out by type of health information exchange, and type of provider (physical, behavioral, oral)"

And consider asking questions such as:

- How is care coordination defined
  - Hospital event notification is just one part of integration and use – ensure there is work to support other care coordination efforts
- For what populations is this work being done

What *Opportunities* and *Barriers* did the HIT Team Identify for *CIE through work on InCK*

Learnings from InCK Pre-Implementation to Inform Meaningful Operationalization of CIE Adoption

InCK provided our Oregon team robust detail on the opportunities to leverage CIE, and with the end of InCK it will be important to infuse these learnings into Oregon's upcoming strategies:

Two levers our team identified in leveraging Community Information Exchange aligned with our learnings include:

1) CCO measure – SDOH measure
2) CCO Measure – System-Level Measure Supporting Social-Emotional Health

Recommended glide path for measure concept

Potential Glide Path	Year 1	Year 2	Year 3	Year 4	Year 5+
Structural measure: • CCOs submit plan to implement screening in an equitable and trauma-informed way (e.g., REALD, workflows to avoid rescreening) • CCOs conduct environmental scan and create data collection/sharing plan (e.g., assess available data systems & population covered)					
Reporting (SAMPLE) • CCO reports data on **sample list** of members (provided by OHA) • OHA to calculate rates based on CCO's member-level data submission: (a) screening rate; (b) of those screened, % with need					

Outcome/Performance (SAMPLE)
• CCO reports data on **sample list** of members (provided by OHA)
• OHA to calculate rates (a) screening rate; (b) of those screened, % with need; (c) of those with a need, % with a referral made
  ○ Benchmark / to meet measure:
  ▪ Report (a), (b), (c)
  ▪ Meet target on (a) - % screened*					

Goal: Outcome/Performance (FULL POPULATION) Logistical elements (e.g. data submission/system to capture data) still to be determined					

**Note: Metrics & Scoring to determine whether pay-for-performance begins in year 3 or 4.*

Oregon Health

Source: April 2021 HPQMC Meeting, Presentation on SDOH Metric

Opportunities Identified in InCK to Leverage Community Information Exchange- Social Determinates of Health

Integrated Care for Kids (InCK): Efforts will target prevention and needs screening for children in order to provide ***enhanced access and connection to services***.

Populations: Publicly insured children birth to 21. InCK Model in Marion and Polk, Deschutes, Jefferson and Crook County

PacificSources Commitment to ConnectOregon: Connect Oregon is a network of health and social care providers. Partners in the network are connected through Unite Us, which enables them to:

- ✓ Send and receive electronic referrals
- ✓ Address people's social needs
- ✓ Improve health across communities

Overlap between Initiatives: Commitment to Social Determination of Health as a critical component to overall Health

There is an emphasis on periodic and **population-level collection** of **Child-Level Metrics,** which include:

- ✓ Housing Insecurity Screening
- ✓ Food Insecurity Screening

PacificSource's vision is that all providers in network are **empowered to identify and connect members to needed resources**.

PacificSource will ***work closely with each region's Health Council*** and partners to promote engagement and collaboration

Overlap between Initiatives:

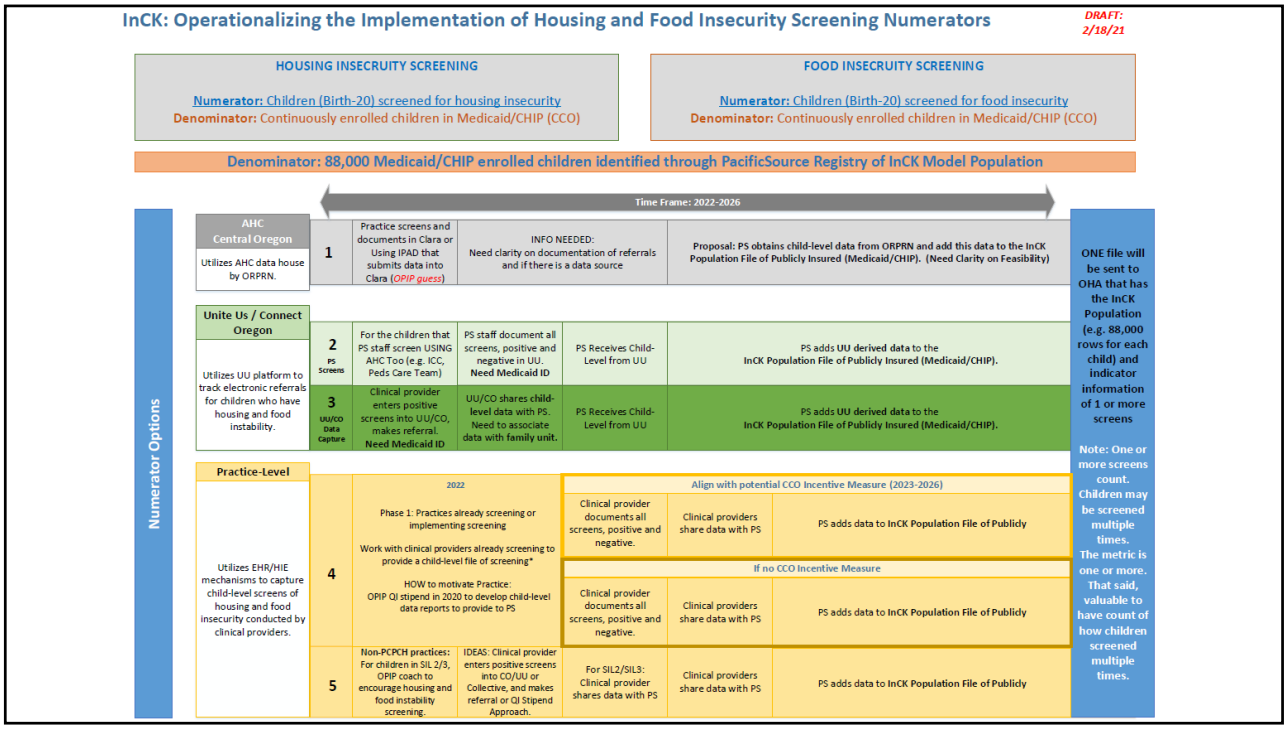
For screens that identify a need for food or housing resources, ConnectOregon could be used

Ability to track data and connection to services

Ability to use data to quantify additional investments needed to support demand

Practice (MP=70% of Population, CO=30%)	EHR	SDoH Tool	Housing Screening	Food Screening	Child Team Using UU -*If* yes, entering screens in UU?. *Screening process.*
CHAoS*	Allscripts	SWYC (well- visits 0-5), We Care	SWYC- NO housing We Care-Homeless risk	SWYC- Yes Food We Care – Yes Food	**Yes,** but **not documenting screening** results, **just applicable referrals**
Salem Pediatrics*	NextGen	*Will be gathering information when we engage practice for baseline understanding. Preliminary understanding is no.*			**No**
Yakima (1 location)*	Epic	Epic Wheel	TBD	TBD	**No.** *Not screening all ages, need to understand Yakima epic wheel items*
Woodburn Pediatrics	NextGen	Homegrown tool	No	Yes, ages 12+	**No**
Willamette Family Medical Center	NextGen	Will be gathering information when we engage practice for baseline understanding			
COPA*	Legacy Epic	AHC	Yes	Yes	**Yes –1 CHW in Redmond. *Entering screens in UU as part of COHC pilot only, but will not do for population-based screens.***
Mosaic Medical*	OCHIN Epic	PRAPARE (not screening peds)	Not for peds	Not for peds	**No** - *For Adult side, Using Components of PRAPARE.*
La Pine CHC*	OCHIN Epic	Subset of PRAPARE, NO Housing	Not often; lack of resources in area	Yes	**No** - *Screening is only done by THW when the provider identifies an issue.*
Madras Medical*	AthenaHealth	Will be gathering information when we engage practice for baseline understanding			**No** - *Part of AHC Effort and has not committed to continuing after. Used AHC IPAD*
St. Charles	Epic	Will be gathering information when we engage practice for baseline understanding			**Yes**. ***Adult only*** *as of right now. Not within the primary care sites.*

****Bold** indicating practice will be part of the phase 1 engagement in 2022*



Learnings from InCK Pre-Implementation to Inform Meaningful Operationalization of *CIE Adoption*

Learnings on Operationalizing Key CIE referrals:

Connection to Housing

- ✓ Priority Partner Identified by PCS to have engaged on ConnectOregon(CO)
- ✓Early Adopter - signed on to Platform
- ✓CO is **NOT how families get referred/connected to Housing Services in Marion and Polk**, this is done on Coordinated Entry – required by HUD
  - ✓**4 components of Coordinated Entry**: 1) Access 2) Assessment 3) Prioritization and 4) Referral
- ✓Platform use by Housing Agency is to connect families they are serving to other services

Connection to Food Banks

- ✓Priority Partner Identified by PCS to have engaged on ConnectOregon
- ✓ **Food Banks do NOT require referrals** for families to be served
- ✓This pathway is purely for data tracking purposes and community resource identification
- ✓WIC/SNAP also have additional eligibility requirements
- ✓Some practices had identified family and equity centered approached that would not be captured
  - ✓ Food boxes in the clinic relevant to specific cultures

Behavioral Health: Is it HIE or CIE for

- Within sites, limited adoption of HIE by Behavioral Health
  - Some "bright spots" of direct connection with some behavioral health providers (e.g. Brightways, Direct Access)
- Potential interest for Behavioral Health
  - In Fall 2021, based on the calls to date, it was our understanding Behavioral Health providers on Connect Oregon were on as an agencies to SEND referrals only.
- Either platform explore, will need to consider the factors that impact meaningful adoption of closed loop referrals to behavioral health and significant barriers identified:
  - Value of "warm information" for the referral
  - Many providers don't accept referrals
  - OARs and time stamp from referral to evaluation
  - Perceptions about inability to communicate, concerns about communicating
  - Feedback about lack of funding to support care coordination and closed loop referral communication

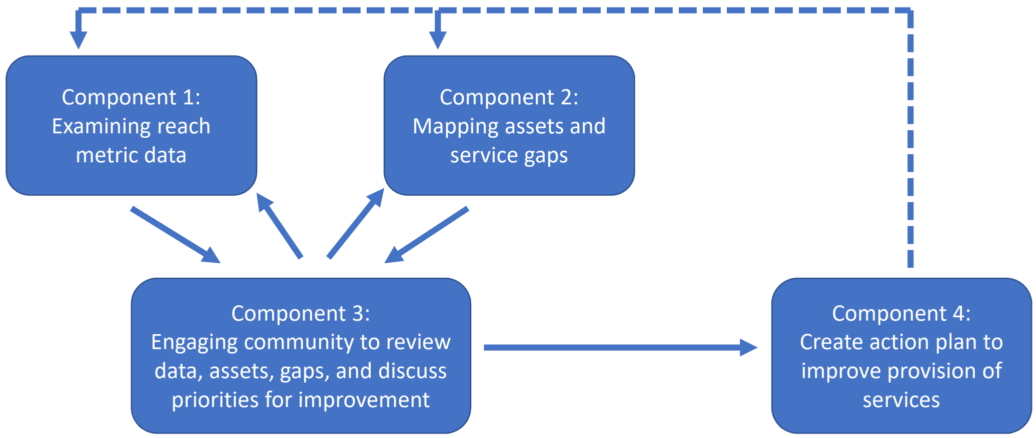
Learnings from InCK Pre-Implementation to Inform Meaningful Operationalization of CIE Adoption

InCK provided our Oregon team robust detail on the opportunities to leverage CIE and with the end of InCK it will be important to infuse these learnings into upcoming strategies

Two levers our team identified in leveraging Community Information Exchange aligned with our learnings include:

1) CCO measure – SDOH measure
2) CCO Measure – System-Level Measure Supporting Social-Emotional Health

Metric Components Build Toward Improving Provision of Social-Emotional Health Services



- Gdwd0dqg#frp p xqlw|0gulyhq#khdok#v|whp #wudqvirup dwlrq
- Dfwlylwhv#exlg#ri#hdfk#rwkhu#fuhdwh#hhgedfn#brs#

23

Opportunities to leverage CO for the SE Measure Asset Mapping

Year 1 Asset Map: Social-Emotional Health Services Provided by Contracted Specialty Behavioral Health Providers	**Location of Clinic Sites (City)**
	County(ies) Served by the Clinic Site
	Number of Providers Who Currently Serve Birth to Five and Have Applicable Skill Sets ***(This will then create a customized form for each provider that will ask the following question)***
	Average Capacity for New Referrals Specific to Birth to Five (per week) ***(Drop down of standardized and feasible # options per provider noted)***
	Provider(s) Identified Race, Ethnicity ***(Drop down of REAL-D Categories)***
	Languages the Provider(s) are able to Provide Services for Birth to Birth to Five ***(Drop down of languages aligned with CLAS metric)***
	Dyadic Therapy Modalities the Provider(s) Offer ***(Drop down of evidence-based modalities for birth to five with "other")*** ***Example on Next Slide***

Opportunities to leverage CO for the SE Measure Asset Mapping

With minor modifications, ConnectOregon could be used to help identify the entities that serve birth to 5

- This population focus could be added to the organizational card

That said, at this time ConnectOregon would not be able to accurately capture the additional elements needed for the asset map as:

- they need to be provided at a PROVIDER level given that impact best match referral, access, and an equity driven approach (informed by proof pilot)
- represent a point in time snapshot for capacity

Connection to Behavioral Health on CIE:

- ✓ Priority Partner Identified by PCS
- ✓ **During Pre-Implementation 3 BH of at least 15 providers were on CO**, but all were only on to SEND referrals to HRN, not to ACCEPT referrals
- ✓ CO is **NOT how children/families get referred to Behavioral Health Services** – this is particularly challenging for CMHA *with OAR's* who must serve families within 7 days of referral or private who can do direct access referral/scheduling
- ✓ Partners using platform to connect patients they ae serving to other services

Learnings from InCK Pre-Implementation to Inform Meaningful Operationalization of CIE Adoption

Strengths of ConnectOregon:

- Resource guide for the community that no longer needs to be maintained by individual clinics
- Provides the opportunity to start facilitating conversations on the additional needs/resources needed in the community and refined pathways to support connection to services

Considerations for OHA and ConnectOregon Users:

- Development of family unit of analysis
- Loading full Medicaid population onto the platform to reduce burden on front line providers