CCO 2.0 Proposed HIT Policy Options
Overview of Public Comments from Ad-Hoc HITOC-Sponsored Meetings

Note: Please see Resources and One-Pagers (link: bit.ly/2NR2jme) for resources provided in response to some of the questions raised by the public comments.

Policy Option 1: EHR Incentives for Behavioral Health

Big idea: CCOs help prioritize behavioral health providers so that electronic health record (EHR) incentive dollars go to the providers who need them most. Legislative approval of incentive program is needed.

What it might look like:

- CCOs consult with communities and advise OHA about how to prioritize use of limited funds
- Critical behavioral health providers are able to adopt or upgrade their EHRs or other related HIT

Possible upside: OHA understands local community needs when making decisions about priority providers; incentive dollars make a bigger impact.

Possible downside: Providers may lack staff capacity to implement workflow changes needed for effective use of EHRs.

Public Comments (June 27 and July 19 sessions):

- *Clarification – "behavioral health" refers to both mental health and substance use disorder*
- Need more information about how many behavioral health (BH) providers today lack EHRs, including urban vs rural settings
- This is important for upgrading, making changes as new requirements come through, like Value-Based Payment
- Need to differentiate between embedded BH using shared HIT with primary care and standalone mental health and BH services that may

not have been well served by vendors, or that may not have received incentives through the Medicare/Medicaid EHR Incentive Program

- Should encourage integrating BH and primary care, including adoption of interoperable technologies for improving care coordination between all a patient's providers, especially coordinating between BH, primary care, acute care, and jails
- Prioritizing resources to enable state-wide HIE participation would be very useful
- Some community health needs assessments lack the information they need to plan better. Cannot access BH data now and that data is crucial; EHRs could help with access to BH data, a broader range of race and ethnicity categories, information to see which social determinants of health affect which populations, and broader “real life” patient information that affects outcomes
- Involve providers; concern about time BH providers spend entering data into EHR taking away from patient care time leading to high rates of turnover and workforce issues
- Consider aligning with any other state programs or if future federally-funded incentive program is established for behavioral health providers—it may be difficult to set up an Oregon-only Meaningful Use program for BH
- Make sure that providers in rural Oregon can access incentives
- There are fewer quality EHR options for behavioral health
- Need to ensure privacy and security and consider/enforce HIPAA
- Need to ensure patient access to their own data and ability to correct mistakes in medical records
- CCOs may be able to help with EHR costs and influence interoperability
- Need to consider ongoing EHR costs, not just upfront costs, and consider the whole system: connect the need for EHRs to other state goals, so investments are seen as important to sustain over time

Policy Option 2: Support EHR Adoption

Big idea: CCOs support EHR adoption among behavioral and oral health providers, helping to close the "digital divide" in health IT.

What it might look like:

- CCOs would establish targets for EHR adoption, focusing on each provider type (physical, behavioral, and oral health)
- CCOs would work with their key contracted providers to remove barriers to EHR adoption and use
- Patients would have better access to their health information electronically through an EHR's patient portal

Possible upside: Behavioral and oral health providers would adopt and use EHRs at higher rates, allowing them to better participate in care coordination, and contribute clinical data for population health efforts, and better engage in value-based payment arrangements.

Possible downside: Providers may lack resources to invest in EHRs or lack staff capacity to implement workflow changes needed for effective use of EHRs

Public Comments:

- Will work best if #1 is also adopted
- Clinic staff capacity may be a barrier—EHR incentive funds might help with that
- Important to align with other adoption efforts—CCOs are limited in leverage with smaller independent practices, but PCPCH, ACO, and MIPS will have a longer reach
- Need information about how targets would work/accountability
- Need to consider EHR quality, standards/interoperability – would CCOs or OHA identify standards for the quality of EHRs, or develop a list of preferred EHRs?
- Consider OHA's role to support this policy option

- Considering adopting the Regional Extension Center model to provide technical assistance for adopting EHRs could be helpful
- Consider potential relationship to Clinical Quality Metrics Registry
- Need to consider standards around interoperability (for instance, BH screenings, dental standards, LOINC, tooth numbering charts)
- Consider group EHR purchases, cross-platform training, and sharing lessons learned between CCOs
- EHRs are very expensive; corrections can't afford the same EHRs that hospitals can
- Not all providers can adopt Epic EHRs—does not offer the kind of chart segmentation needed for substance use disorder information and does not meet all the Community Mental Health Program needs. OHA should continue to support providers making their own business decisions about which EHR is best for them.
- EHR technology is a competitive for-profit business and there is no incentive for vendors to coordinate or collaborate. Each provider thinks their workflow is unique and each developer thinks their code is the best.

Policy Option 3: Support Health Information Exchange (HIE)

Big idea: CCOs ensure that their contracted physical, behavioral and oral health providers have access to electronic health information exchange (HIE) options which include sharing patient information for care coordination and timely hospital event notifications.

What it might look like:

- CCOs could support physical, behavioral, and oral health providers' participation in regional, statewide or national HIE efforts to connect providers electronically for care coordination
- CCOs would use Oregon's statewide hospital event notifications system or other mechanisms to ensure providers have timely information that can help manage populations and target interventions and follow up

Possible upside: Providers have the information needed to deliver better care, patients get the right care at the right time, and costly hospital use is reduced.

Possible downside: Providers may lack resources to participate in HIE or lack staff capacity to implement workflow changes needed for effective use of HIE.

Public Comments:

- Consider CCO support for HIE vs other payers' support for HIE
- Lack of resources, staff capacity, to implement workflow changes needed for effective use of HIE is one of the biggest challenges. Consider incentives in this area.
- Consider incentives for CCOs to adopt more robust HIE solutions in addition to EDIE/PreManage. Can incentives support HIE solutions selected by CCOs?
- Need to understand relationship of this option to OHA's HIE Onboarding Program (link: bit.ly/2K1Mt64)
- Hopeful that the implementation of HIE will also include data from other sectors, i.e. a Social Health Information Exchange. If we are serious about addressing social determinants we need to include other sector data at the beginning, not in 5 years.
- Understanding the different types of HIE can be confusing, and support for BH providers new to the idea of HIE would be helpful.
- Need clarity on difference between "information for care coordination" and "hospital event notifications" –
    - Would the Emergency Department Information Exchange (EDIE)/PreManage alone meet this requirement?
    - Allowing hospital event notifications to meet HIE expectations will not have the intended impact on reducing cost of care. OHA should consider a narrower definition of HIE and require more than event notification.
    - OHA should consider encourage a broader definition of care coordination to meet this requirement, that acknowledges care

coordination happens when physical, oral, BH providers are all able to connect.

  - Difficult for providers to balance working with multiple HIE platforms.

- Both OHA and CCOs should share recurring costs
- Consider issue of HIE and providers sharing substance use disorder information that is subject to 42 CFR Part 2. Clinics need more support/guidance.
- HIE projects may involve more vendor time than staff time, costs can also be an issue.
- Consider Direct secure messaging as a possible solution
- EDIE has been successful and affordable—HIE should follow that model
- Consider all the partners that need to be in the exchange
  - Families and caregivers (need to consider language needs)
  - Non-emergency medical transportation for patients being discharged from hospitals—right now patients may wait for hours
  - BH providers and jails—particularly to track transitions in/out of jail and share information at those transitions. Having information available at booking has helped inmates who otherwise can end up waiting to get previously prescribed psychiatric medications in jails
- Consider having CCOs place a portion of the quality incentives they earn into a fund to help support provider costs around HIT/HIE
- HIEs are extremely helpful, but very few BH systems can easily integrate with HIEs, and there is a cost to integrate. There is a huge cost involved with training, follow-up, and workflow.
- There are benefits and pitfalls to sharing information. Does my dentist need to know about my hysterectomy? What about genetic information? If you're using your community clinic and the person

who works at the front desk is your neighbor, do they need to know your private information?

- Need audit trails to see who accessed your health information. You can see who accessed your credit report—why not your private health information?
- When considering all the EHRs, portals, and HIEs, OHA could really help by helping manage identity for users (CCO members and health care organization staff). We would love to have some type of federation (and single sign-on) with OHA ONE eligibility system for access to our member portal and to set up accounts all at one time that can be used widely. Possibly combined with managing/organizing common consent and sharing policies – who can share what.
- OHA could help by being in the middle of defining "minimum necessary" for appropriate data sharing. For example, what is the "relevant" Physical health and BH information that should be provided to dental health and vice versa. Same for to/from BH providers. Especially when it comes to social determinants data between healthcare and community organizations, or education/justice operations.

Policy Option 4: Support Public/Private Partnership

Big idea: CCOs participate in the HIT Commons, a public-private partnership that promotes HIT for statewide health system transformation, and pay their fair share of HIT Commons dues (currently being paid by OHA).

Current HIT Commons initiatives include the Emergency Department Information Exchange (Oregon's statewide hospital event notification system), and the Oregon Prescription Drug Monitoring Program Integration Initiative.

What it might look like:

- CCO involvement ensures that HIT Commons initiatives are successful and support Medicaid objectives.
- CCO members and providers benefit from statewide HIT including EDIE and PDMP integration, ensuring better coordination for high-risk populations

Possible upside: HIT Commons continues to support CCO and Medicaid objectives and is informed about the needs of Oregonians across the state.

Possible downside: Some CCOs may prefer to focus on local HIT initiatives in the future.

Public Comments:

- Need information on dues [*Dues information is now added to the* 1-pager *(link:* bit.ly/2NR2jme*)]*
- Need more information on purpose of HIT Commons and relationship to local efforts
- Consider having the HIT Commons take on the HIE issue and help with negotiations.
- Consider how this might affect HIE standardization

Policy Option 5: Use HIT to Engage Patients

Big idea: CCOs would use HIT to engage patients, including participation in their own care and access to their own health information. This would be linked to health equity plans.

What it might look like:

- CCOs could ensure members can access their health records electronically and work with contracted providers to improve education to patients, taking into consideration language and alternate formats.
- CCOs could offer evidence-based mobile health programs like Text4Baby

Possible upside: Patients better understand their health issues and treatment plans. Health disparities are addressed through targeted HIT-based programs that take into consideration member demographics, language, accessibility, and literacy.

Possible downside: Some providers lack the systems to engage with their patients electronically. Some systems may lack the ability to support needed language and accessibility modifications.

Public Comments:

- Open Notes is one option to consider
- What percentage of BH clients are choosing to access their clinical records and notes? To what extent are BH providers participating in Open Notes
- Not sure how to incentivize members—can't make members use HIT. May need incentives for CCO.
- Many CCOs could leverage efforts already in place (e.g., the PCPCH program already requires this)
- Consider EHR neutral, state-hosted engagement platforms that bring together all of a patient's records so patients do not have to juggle multiple portals
- Need a strong strategy plan to ensure system and CCO success
- Need support and guidance from OHA
- Need consolidated patient portals where patients can see records from multiple EHRs in one place. Lucy/MyChartCentral is difficult to use. (Another participant stated that Epic has a roadmap for combining MyChart instances.)
- Not all patients have access to the internet or other technology needed to engage with their health records or providers. Are there studies on who cannot afford or access the internet? Using the internet at the library is not acceptable because there is no privacy. Consider making private data stations in rural areas.
- CCOs do not have EHRs and cannot provide patients' EHR records to them

- Consider creating statute of limitations on information in patient charts. Some patients have been recovered from substance use disorders for decades, but continue to face stigma because the information never leaves their medical chart. People need a chance to start a new chapter. The patient should get to decide what information in their chart is still relevant.
- Patients with mental health diagnoses may get multiple diagnoses from multiple doctors to the point where they do not know their own diagnosis. Some are outdated or incorrect. Information control is critical.
- Need to identify what we want patient engagement to accomplish and then align the use or support for technology to that goal. Run the risk of implementing technology without the goal in mind.

Policy Option 6: Standardize Telehealth Coverage

Big idea: All CCOs would be required to cover telehealth services if they cover those same services when delivered in person, regardless of if the patient is in an urban, rural, or frontier area.

What it might look like:

- CCOs would cover a “virtual” visit to a provider when the patient faces barriers to traveling to an office
- Providers could have consistency across CCOs for how telehealth services are covered, increasing the availability of care for patients throughout Oregon, including urban areas

Possible upside: Reduced barriers to telehealth services, better access to specialty and behavioral health care in frontier/rural areas, and reduced health disparities based on geographic location.

Possible downside: Some providers and patients lack the systems to engage in telemedicine consults through video. Some remote areas of Oregon lack high-speed broadband capabilities that would enable telehealth.

Public Comments:

- Consider exception for specific services that might not be clinically indicated for telemedicine
- Getting clinical buy-in that certain types of visits or exams are good enough via telehealth will be challenging. Telemedicine is definitely the way to go forward. Can be justified by reducing non-emergency transportation costs.
- Allowing telehealth for those agencies that can provide it, would improve adoption, access and patient satisfaction from the pilots we've done at our agency.
- Telehealth needs to be standardized and ensure patients are protected – some patients have had poor quality care and there is little protection for patients.
- Telehealth can work very well, but you should be careful of unintended consequences, especially in a fee-for-service model. You don't want a call center experience. Be programmatic when telehealth is implemented.
- Consider an emergency telemedicine pilot for people experiencing a mental health crisis. Might help patients and reduce ED use.
- Quality measures for telehealth may be different than for in-person care.
- Telehealth coverage should also be standardized for Medicare Advantage for individuals who are dually-eligible for Medicaid and Medicare.
- Consider privacy and security with telehealth. There have been reports from Unity patients that telehealth/telepsychiatry that consults have been held in open areas where patients could not keep their health information private. Some patients also don't like telepsychiatry—they want in-person care. But telehealth can be beneficial.
- Need to start by identifying the health intervention or other initiative and then look at the technology needed to support that effort. We're running a risk of implementing telehealth for its own sake.

Policy Option 6: Use HIT for Value-Based Payment (VBP)/Population Health

Big idea: CCOs would demonstrate they have sufficient HIT capabilities to manage value-based payment arrangements and population health.

What it might look like:

- CCOs would use HIT to risk stratify populations and target interventions to ensure patients and communities receive the care they need to stay healthy
- CCOs would use HIT to manage value-based payment (VBP) arrangements, including sharing with providers data on patient attribution, patient risk scoring, CCO claims or cost data, and provider performance
- CCOs would show they can use HIT to analyze and manage electronic clinical quality metric data (as a component of VBP arrangements)

Possible upside: CCOs are better able to achieve population health outcomes at lower costs. Providers engaging in VBP contracts have the information and support needed from the CCO to manage financial risk and improve care.

Possible downside: Some providers may lack the capability to use CCO data effectively. Possible proliferation of systems across CCOs and payers.

Public Comments:

- CCOs today may only use claims data to support population health efforts and may not able to get clinical data from contracted providers' EHRs—this goal may be overambitious
- This is so important for value based care. Making CCO contracts more specific would help facilitate key evolutions in population health management practices.
- Challenges in getting and using data, which HIE may help with
- Need to improve timeliness of claims data

- Need to get access to clinical data; claims data doesn't tell CCOs enough about outcomes/ whether what CCOs pay for is truly improving health
- Lack of specificity in current contracts; this proposed policy would facilitate key evolutions in population health management practice
- The future is in EHR-based information. This dovetails well with the Clinical Quality Metrics Registry, and might be ambitious but it moves us in the right direction.
- CCOs need to get more comfortable in aggregation of clinical data at the CCO level
- Most CCOs are investing in these products, but they are all different products. How can we leverage the All Payer All Claims database? OHA could invest in centralizing the data, rather than doing the same thing in 15 different CCOs

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Other public comments:

- Address quality and availability of race, ethnicity, and language data in enrollments and the OHA ONE enrollment system. That is a huge problem for analytics around equity.
- Peer support providers should be able to bill the state directly for services rather than being required to contract through an agency
- How can we use technology to find out what the patients think would work, so that we could save money across the board and be efficient? Do we ask patients what will work for them? Then go spend money on what people will use.
- Can we check program effectiveness? We need to be looking at outcomes of programs, not necessarily people. Is it something that's working to meet people's needs?
- How can we create safe spaces where patients can give true feedback about their care? Some patients don't speak out because of fear of retaliation.