2024 CCO Health IT Roadmap Summary

March 2025

Each year, Oregon's Coordinated Care Organizations (CCOs) are required to submit Health Information Technology (Health IT) Roadmaps[1] to Oregon Health Authority (OHA) outlining their strategies for accomplishing health IT goals. In the four major sections of the Roadmap, CCOs describe how they will support their contracted physical, behavioral, and oral health providers with:

- Electronic health record (EHR) adoption and use
- Health information exchange (HIE) for care coordination and hospital event notifications (HEN)
- Health IT to support social determinants of health (SDOH) needs

This document summarizes the Health IT Roadmaps CCOs submitted in March 2024, describing their 2023 activities and plans for 2024-2026. CCO strategies and investments have potentially changed since the 2024 roadmaps where submitted. The 2024 Roadmaps include responses from 12 different CCO organizations, which represent all 16 CCOs. This document is a compilation of three summaries, which cover the following three sections of the CCO Health IT Roadmaps:

- Support for EHR adoption, use, and optimization in support of care coordination
- Use of and support for HIE for care coordination and HEN
- Health IT to support SDOH needs

In addition to their annual Health IT Roadmaps, CCOs are also required to submit an annual Data Reporting File that includes data on Health IT adoption, including EHRs and HIE tools, across their contracted provider network. This information is used to inform CCO health IT strategies as well as OHA's health IT reporting, such as OHA's *2022 Health IT Report to Oregon's Health IT Oversight Council (HITOC)*[2]. The *2022 Health IT Report to HITOC* presents an overview of Oregon's health IT landscape, summarizing available health IT information across many sources, and helps inform HITOC's strategic planning.

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[1] Redacted 2024 CCO Health IT Roadmaps are posted on OHA's CCO Health IT Advisory Group website.
[2] Read the report here: https://www.oregon.gov/oha/HPA/OHIT/Documents/2022ReportOnOregonsHealthITLandscape.pdf.

Contents

Supporting Electronic Health Record (EHR) Adoption

This section summarizes the EHR section of the Health IT Roadmaps that coordinated care organizations (CCOs) submitted in March 2024, describing their 2023 activities and plans for 2024-2026. It describes CCO strategies to support EHR adoption and use among their contracted providers and places those strategies in context. This section includes:

- Status of EHR data completeness
- CCO strategies for EHR data collection
- CCO strategies for supporting EHR adoption and use
- Spotlights and Honorable Mentions
- CCO-identified barriers to EHR adoption and use
- Requests for OHA support for EHR adoption and use

EHR data gaps, data collection, and need for ongoing adoption support

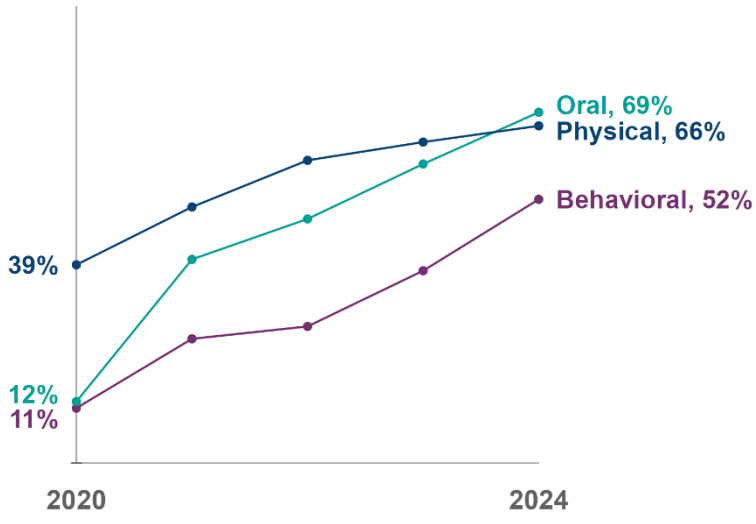
EHRs are foundational to health IT progress

Oregon's health system transformation relies on health IT, and EHRs are the foundational health IT tool. EHRs allow providers to electronically collect, store, and use clinical information. This helps providers participate in information sharing and care coordination (including electronic referrals), contribute clinical data for quality reporting and population health efforts, and engage in value-based payment (VBP) arrangements. EHRs also collect other data, including screening, assessment, and demographic information. Finally, EHRs can help providers share information with patients, their families, and their caregivers.

Incomplete EHR data remains an issue, but CCO efforts are paying dividends

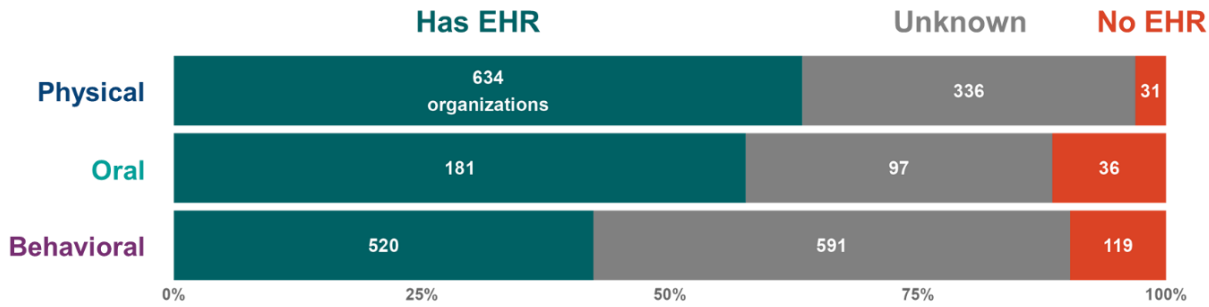
CCOs need accurate information about their contracted organizations' EHRs to accurately understand existing EHR needs and effectively prioritize support efforts in their regions. CCOs gathered and provided updated EHR information for nearly 300 organizations with their 2024 Roadmaps, reflecting CCOs' dedication to collecting this data. However, significant EHR data gaps remain. *Figure 1* shows improvements in rates of EHR data completeness for CCO-contracted organizations over time. *Figure 2* breaks out the data completeness rates for 2024 into three categories: organizations known to use an EHR, those known not to use an EHR, and those for

Figure 1: EHR data completeness for CCO-contracted organizations 2020-2024



whom EHR adoption status is unknown. EHR data sources include the *2021 Health IT Survey*[3] and other CCO data collection efforts[4]. Rates are included for each type of organization across all CCO-contracted organizations[5]. EHR information is missing for 48% of behavioral, 31% of oral, and 33% of physical health organizations. While there is ample room for improvement, these rates reflect considerable progress compared with last year's rates for behavioral (62%) and oral health (41%), with physical health remaining relatively flat. Organizations with missing EHR information are disproportionately small, behavioral, and relatively new to CCO contracting. Physical health organizations without EHR information are more likely to be specialists than primary care providers.

Figure 2: Current (2024) state of EHR data completeness for CCO-contracted organizations



This provider type-specific missing data discrepancy continues to mirror the digital divide identified in OHA's *2022 Health IT Report to HITOC*: physical health organizations have the most complete EHR information and are the most likely to use an EHR. From the report:

> **Although physical, behavioral, and oral health providers are participating in health information exchange at increasing rates, substantial digital divides persist.** These digital divides are complex but run largely along lines of access to resources, creating two "worlds." This disparity impacts some more significantly than others, but ultimately affects the whole health care system.

EHR adoption floors continue to increase among CCO-contracted organizations

Given that many organizations lack EHR adoption information, we provide minimum estimates—or "floors"—for EHR adoption rates. *Figure 3* shows how these adoption floors have increased over time for the organizations contracted with CCOs in 2023. *Figure 4* further breaks out physical organizations into primary care providers (PCPs) and specialists. True EHR adoption rates will be higher than those reported in *Figures 3* and *4* if any organizations with missing EHR information use an EHR. The increases in these figures represent both improved data collection

[3] A summary of the *2021 Health IT Survey* can be found in the *2022 Health IT Report to HITOC* appendix.
[4] CCO Data Reporting File revisions, submitted with their Roadmaps, are incorporated.
[5] Per OHA instructions, CCOs' Data Reporting Files aggregate data to the organization-level (rather than clinic- or provider-level).

and new EHR adoptions. For most organizations, available data is not sufficient to distinguish between these two factors.

For all provider types, rates are notably higher when weighted by the number of unique provider NPIs, as given on the 2023 Q2 Delivery Service Network (DSN) files. Larger organizations with more individual providers are more likely to have adopted an EHR, and we are more likely to have information on their adoption status, increasing the weighted rates.

EHR adoption support remains a priority

Figure 3 below shows the adoption floors for CCO-contracted physical, behavioral and oral providers over time. *Figure 4* further breaks down physical health organizations into PCPs and specialists.

> *[S]maller independent behavioral health providers struggle with connecting… Although these providers only see a small percentage of our members, they are essential for access and choice for our members, but the limited connectivity can be a barrier.*
>
> - CCO Roadmap

The vast majority of CCO members are assigned to a primary care provider using an EHR; however, current data indicates that EHR adoption rates lag for many other providers: behavioral and oral providers (see *Figure 3*), specialty practitioners (see *Figure 4*), and small organizations. This disparity limits the value of EHRs, both for EHR adopters and for CCO members. As a result, continued support for EHR adoption—in addition to EHR use and optimization—remains a priority.

Figure 3: EHR adoption floors for physical, behavioral, and oral health organizations, unweighted organization counts (top row) and organization counts weighted by number of unique provider NPIs (bottom row)

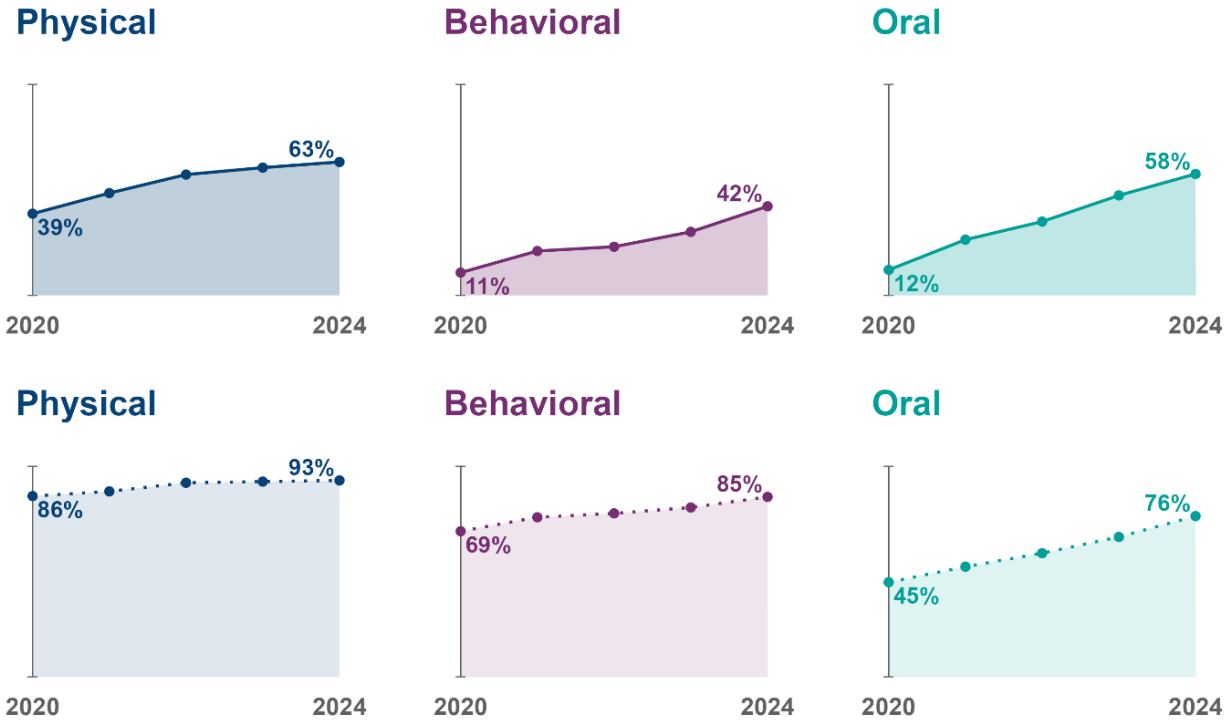
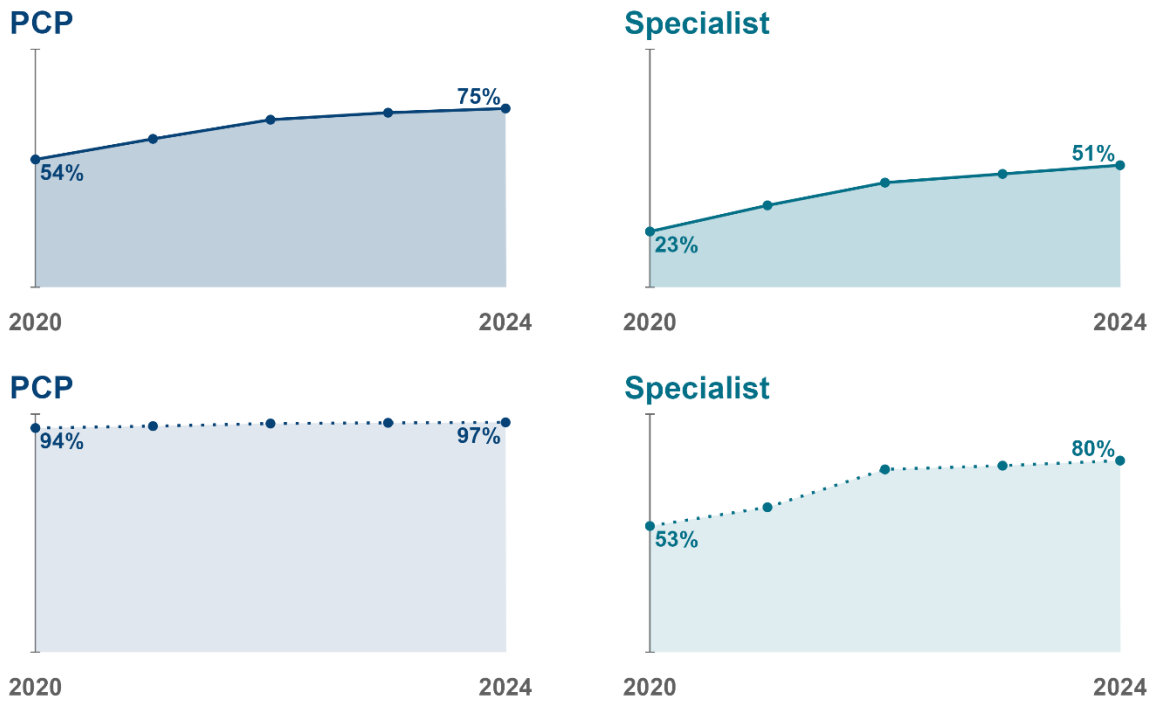


Figure 4: EHR adoption floors for primary care and specialists, weighted and unweighted by number of provider NPIs



EHR data collection remains a priority

Given current data gaps, additional data collection is needed to better understand which organizations have not adopted an EHR and what their challenges and needs are. In their 2023 Roadmaps, CCOs reported a variety of strategies for gathering this information from providers. Many strategies leveraged existing processes, such as contracting and credentialing, to reduce provider reporting burden. Other strategies included collecting EHR adoption information during meetings and site visits or through surveys of providers.

CCO strategies for supporting EHR adoption

Figure 5 below represents the number of CCO organizations that reported using different strategies in the *Support for EHR adoption, use, and optimization in support of care coordination*: *2022* and *2023 Progress* and *2024-2026 Plans* sections of their 2024 Health IT Roadmaps. Please see this section's appendix for additional details on what activities have been included in each strategy category.

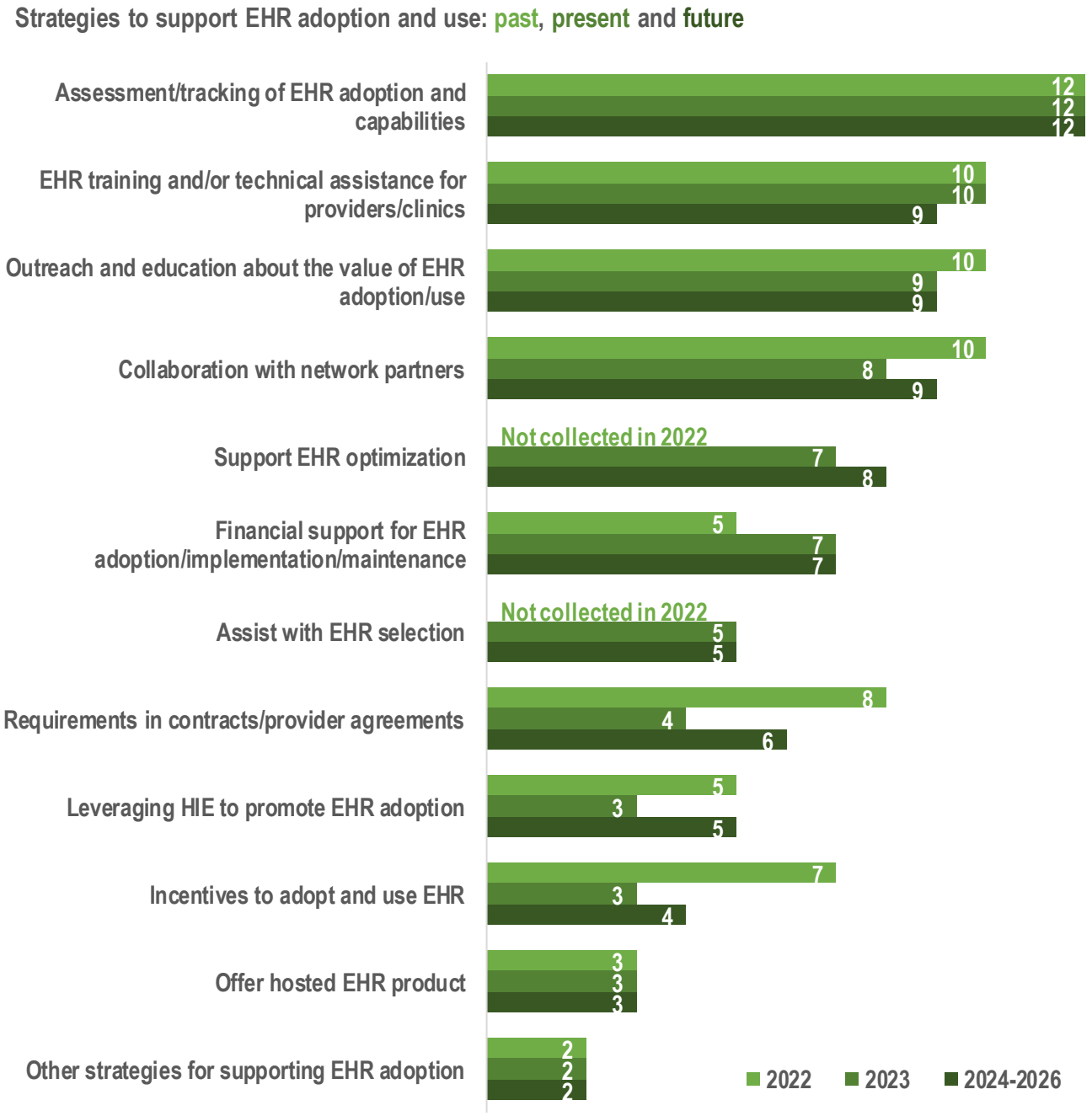
CCOs universally continue to assess and track EHR adoption and capabilities within their provider networks and plan to maintain these efforts. Like in 2022, most CCOs offer EHR training or other technical assistance for providers, provide outreach and education about the value of EHRs, and collaborate with network partners.

In 2023, fewer CCOs offered incentives to adopt EHRs, while more CCOs now offer other financial support for EHRs. CCOs often use financial incentives to promote EHR adoption, while

other forms of financial support, such as grants, are offered for EHR maintenance costs, upgrades, or transitions to higher quality EHRs. This shift from incentives to other types of financial support may reflect that CCOs are placing greater emphasis on optimizing contracted providers' EHR systems. Seven CCOs reported strategies supporting EHR optimization, with an eighth planning to join them in 2024-2026.

A long-standing barrier to EHR adoption, especially for smaller providers, is the profusion of EHR vendors, products, and configurations. The number of options can make it difficult for a provider to identify the option that's right for them. In response, five CCOs in 2023 developed strategies to assist providers with EHR selection.

Figure 5: 2022, 2023, & 2024-2026 Strategy Comparison



CCO Spotlights: Supporting EHR adoption

Columbia Pacific CCO (CPCCO) conducted a series of listening sessions with behavioral health partners to gauge interest in EHR adoption and identify support needs for implementing and optimizing certified EHRs. CPCCO held group and individual sessions with three Community Mental Health Programs (CMHPs), featuring OCHIN Epic demonstrations. These sessions lead to a substantial funding allocation to one CMHP for their transition to OCHIN Epic. This transition will enhance medical record systems, care coordination, and access to shared medical records. A second CMHP expressed interest in exploring conversion options, and conversations will continue.

AllCare has partnered with TherapyNotes to offer a discounted rate to its network of behavioral health providers. A provider needs assessment had previously identified TherapyNotes as a highly regarded EHR vendor. However, several challenges have hindered progress with this strategy. Engaging meaningfully with behavioral health providers—primarily solo practitioners with full patient panels and minimal administrative support—has proven difficult. Despite these obstacles, one provider has successfully adopted TherapyNotes at the discounted rate negotiated by AllCare. AllCare continues to make this offer available to all its contracted behavioral health providers.

PacificSource developed an "EHR FAQ" aimed at helping Population Health staff discuss information-sharing benefits with behavioral health providers. This resource specifically targets small behavioral health providers, who have historically faced resistance to EHR adoption and may lack exposure to relevant information. The FAQ successfully initiated conversations, revealing that many small, independent providers already use digital charts in their practices. Insights gained from these discussions were invaluable for updating the HIT Data Reporting file for this provider population, enhancing understanding of EHR utilization among behavioral health providers.

Eastern Oregon CCO (EOCCO) approved two health IT-related grants as part of their annual Community Benefit Initiative Reinvestment. One project included funding to integrate Unite Us CIE data into a Federally Qualified Health Center's instance of Epic. Integration of social health needs information from a CIE solution like Unite Us into a clinical system like Epic may help CCO clinician providers in assessing and intervening to help address a patient's SDOH needs. A second grant will establish a telehealth network for behavioral health services.

Honorable Mentions: CCO support of EHR adoption

The strategies listed below are notable examples of how CCOs supported EHR adoption and use in 2023 or how CCOs plan to support it in 2024-2026. These strategies have been rolled up into the strategies included in *Figure 5*.

- **AllCare** worked with Veradigm and Reliance to include Reliance integration as a standard part of the hosted EHR package AllCare offers.
- **Cascade Health Alliance (CHA)** leveraged HIT Roadmap data to enhance outreach for EHR adoption through regular check-ins and training for PCP and dental clinics, while providing technical assistance to improve clinical workflows, and distributing a "Documentation and Coding Quick Guide" to support effective coding and documentation practices.
- **CHA** proactively checked in with primary care providers to offer technical assistance related to their EHRs. Going forward, CHA will expand this practice to dental clinics.
- **EOCCO** met with most of their behavioral health organizations to review, validate and update their health IT data, including EHR vendor. EOCCO also collects health IT information from Advantage Dental's annual provider survey, which includes follow up with every non-response and partial response.
- **EOCCO** facilitates conversations with EHR vendors to improve reporting capabilities and has plans to hire a health IT subject matter expert to help navigate vendor relationships, provide technical assistance to provider partners, and assist in future HIT implementation and platform enhancements.
- **Health Share** (CareOregon) provided substantial financial support to physical and behavioral health organizations for EHR upgrades, facilitating improved interoperability, enhanced quality metrics, and better integration of social needs data.
- **Health Share** (Legacy) provides subsidized EHR adoption through Legacy Connect, which supports over 30 private practices in Oregon and SW Washington.
- **Jackson Care Connect (JCC)** collects information about providers' EHR adoption and use through their Provider Information Form, which providers complete during initial contracting and whenever they need to update provider information.
- **PacificSource** collected additional health IT adoption information through their Quality Incentive Metrics Outreach Survey.
- **PacificSource** provided indirect support for Central Oregon IPA's (COIPA's) effort to provide essential structural, financial, and technical assistance to eight independent health practices transitioning to Epic Garden Plot.
- **Trillium** provided two grants to support EHR adoption and optimization in 2023 and is evaluating changes to their grant process to better serve health IT-related requests.

- **Umpqua Health Alliance (UHA)** provided technical assistance to 14 clinics on a common EHR (eClinicalWorks) to accurately capture and report REALD and SOGI data in their EHRs.
- **UHA** continued work supporting local pharmacies to implement and optimize an EHR-lite. Support included funding and technical assistance.

2023 barriers to supporting EHR adoption

Figure 6 below shows the number of CCO parent organizations that voluntarily reported barriers they experienced while supporting EHR adoption in their 2024 Health IT Roadmap. For the second year in a row, limited clinic staff capacity and IT expertise was the most-cited barrier. The ongoing health care workforce shortage followed as the second most-cited barrier, and both issues were mentioned more than in 2022, indicating that clinics are facing staffing challenges on multiple fronts. Some CCOs also mentioned internal staffing shortages.

> *The lack of adequate workforce combined with high turnover and shrinking workforce pipelines mean a loss of historical knowledge and difficulty teaching basic job skills, resulting in lack of time to take on new projects.*
>
> - CCO Roadmap

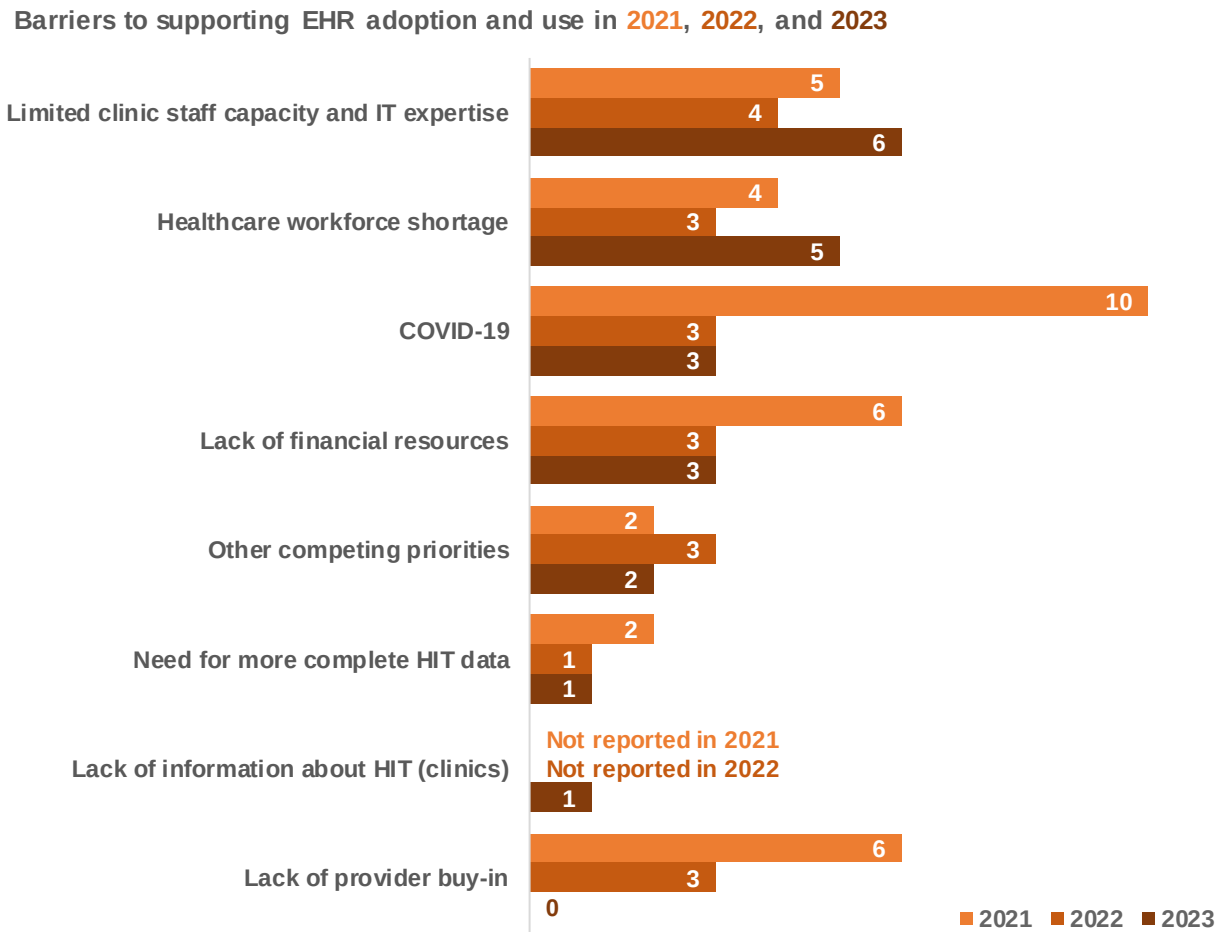
Three CCOs noted that COVID-19 continues to strain clinics' capacity for new health IT projects. Additionally, three CCOs identified cost or lack of financial resources as a barrier for clinics, down from six in 2021.

A few CCOs mentioned other barriers, including shifting internal priorities, the need for more complete EHR adoption data, and clinics' lack of information about health IT. Notably, no CCOs discussed challenges with provider buy-in beyond those already mentioned.

CCOs also shared additional insights into the barriers they and their providers face:

- Workforce and cost challenges are especially severe for oral health providers.
- Providers struggle to capture race, ethnicity, language, and disability (REALD) and interpreter needs information in their EHRs, affecting the quality of data available to CCOs.
- Burdensome and unclear guidelines for new benefits or requirements can also lead to non-compliance and low-quality data.
- The shift to home-based telehealth for behavioral health has led to a decreased focus on EHR adoption for many providers.

Figure 6: 2021, 2022 and 2023 comparison of barriers to supporting EHR adoption and use



OHA support requests

CCOs responded to an optional question about how OHA can better support them in encouraging providers to adopt and optimize EHRs. We received six responses, which highlighted several key areas of focus.

Four of the CCOs emphasized the importance of financial support, noting that flexible funding would be crucial since clinic needs can vary. Two CCOs suggested that offering incentives could be especially effective in motivating providers to enhance their EHR systems. Two responses addressed the need to reduce administrative burdens associated with EHR implementation. One CCO proposed phasing in reporting requirements to allow clinics more time to adjust. Another noted that reducing new requirements in other areas would help clinics dedicate more resources to EHR improvements.

Moreover, two CCOs underscored the vital role of OHA as a convener and coordinator within Oregon's health IT landscape. They suggested that OHA assist CCOs in developing, analyzing, and sharing best practices. Collaborative efforts to create resources and educational materials for providers were also recommended, alongside guidance on how to effectively leverage federal resources. Lastly, one response highlighted the need for support in establishing low-cost, standards-based integrations from EHRs to HIEs and Community Information Exchanges (CIEs).

Supporting Health Information Exchange (HIE) for Care Coordination and Hospital Event Notifications (HEN)

This section summarizes the HIE section of the Health IT Roadmaps that coordinated care organizations (CCOs) submitted in March 2024, describing their 2023 activities and plans for 2024-2026. It summarizes CCO strategies in these areas both within the CCO organization and among their contracted providers.

This section includes:

- CCO-implemented and -supported health IT tools
- CCO strategies for supporting contracted providers
- Spotlights and honorable mentions
- CCO-identified barriers
- Requests for OHA support

HIE tools implemented and supported by CCOs

CCOs have implemented a variety of HIE tools to support care coordination and hospital event notifications. *Figure 7* below lists the HIE tools that CCOs used, supported, or made available to their contracted providers in 2023, as well as those they plan to use, support, or make available in 2024-2026. This table also includes the corresponding number of CCOs for each tool. OHA selected one category for each tool, but some tools fit multiple categories.

Figure 7: 2023 & 2024-2026 Health IT tools used and supported by CCOs

Type of tool	Tool	# of CCO orgs (n=12) *
Health Information Exchange	PointClickCare (aka Collective)	12
	Reliance eHealth Collaborative	7
	Epic Payer Platform	4
	Epic Care Everywhere	2
	Proprietary FHIR API	1
	1upHealth	1
Care management/ Case management	Epic Care Link (EHR chart review)	4
	Epic Compass Rose	3
	HMS Essette	3
	TriZetto Clinical CareAdvance (Cognizant)	2
	Activate Care	1
	Ayin Community Integration Manager	1
	TruCare	1
	VirtualHealth HELIOS	1
Population health management/Data analytics	Arcadia	3
	CCO Provider Portal (not otherwise specified)	2
	CareOregon's Fully Integrated Data Organizer (FIDO)	1
	Innovaccer Population Health Tool	1
	Milliman MedInsight	1

* The 2024 Roadmaps include responses from 12 different CCO parent organizations, representing all 16 CCOs.

CCOs use and support a variety of HIE tools. These tools serve different purposes, and all CCOs use and support more than one. Some tools interface with other systems and tools. This list includes only those tools reported in the CCO Health IT Roadmaps; some CCOs that use or support these tools may not have included them in their Roadmap. In addition, the Health IT Roadmap no longer requires CCOs to report on health IT to support value-based payment arrangements, likely leading some CCOs to exclude the population health management and data analytics tools they are using from their reporting.

Figure 8 details the number of CCO organizations that reported either using or supporting their contracted providers to have access to various tools for timely hospital event notifications (HEN) in their *2024 Health IT Roadmap*. The PointClickCare platform (formerly EDIE/ Collective Medical) remains the most widely adopted tool for sharing HEN data, with 100% adoption across CCOs.

Figure 8: 2023 & 2024-2026 HEN Tools Used by CCOs and Providers

Tool	# of CCO orgs (n=12)
PointClickCare (aka Collective)	12
Reliance eHealth Collaborative	6
Epic tools (e.g., Care Everywhere)	3
Arcadia	3
TriZetto Clinical CareAdvance	2
TruCare	1
VirtualHealth HELIOS	1
Activate Care	1

Adoption of HIE tools among CCO-contracted organizations

HIE tools are critical to supporting care coordination and timely hospital event notifications across unaffiliated providers and different provider types. This section provides a summary of HIE tool adoption rates across various CCO-contracted organizations. The "Data Definitions" textbox below explains the measurement methods and provider types used in the following figures.

Almost half (45%) of CCO-contracted **physical** health organizations have adopted an electronic information exchange tool that helps them share and access information from non-affiliated providers (*Figure 9*). These organizations vary in type (e.g., primary care, specialist) and size (e.g., health systems with many clinics, one-site clinics). Larger organizations are much more likely to adopt HIE tools. As a result, HIE adoption rates are higher (90%) when weighted by number of providers, as displayed in the dashed lines in *Figure 9*. Rates are lower for **behavioral** and **oral** health organizations, but these organizations exhibit the same pattern as **physical** health organizations, with significantly higher weighted rates of HIE adoption.

Higher adoption rates for organizations with more providers are expected as larger organizations tend to be better resourced, however, more than half of CCO-contracted physical health clinics have not adopted an HIE tool, indicating that ongoing CCO support is needed.

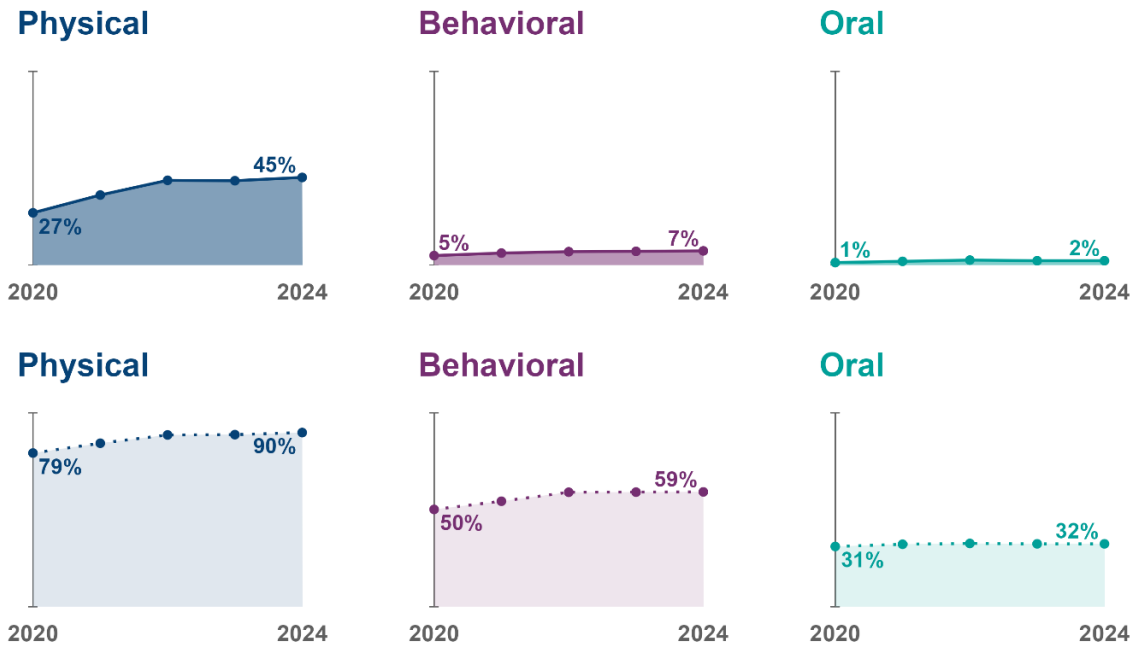
Similar analyses for adoption of specific HIE tools by provider type can be found in *Appendix C: Additional HIE tool adoption figures*.

DATA DEFINITIONS

- **Physical**, **behavioral**, and **oral** health organizations are those that appear on the Data Reporting Files CCOs submitted with their 2024 Roadmaps.
- To determine **provider counts** for each organization, we use the number of unique National Provider Identifiers (NPIs) associated with each organization, as provided on CCO-submitted Delivery Service Network (DSN) tables. These counts are used as a loose proxy for organization size, which permits approximate calculation of HIE adoption rates weighted by size.
- **Key clinics** in *Figure 10*, and throughout this document, are physical health organizations that are, or include a site that is, a hospital, Rural Health Clinic (RHC), Patient-centered Primary Care Home (PCPCH), Federally Qualified Health Center (FQHC), Community Mental Health Program (CMHP), or Certified Community Behavioral Health Clinic (CCBCH). All 14 of Oregon's health systems are included as key clinics. These key clinics, with the exception of CMHPs and CCBHCs, are also among the physical health organizations in *Figure 9* and among the PCPs in *Figure 11*.
- **Primary care** organizations (e.g., *Figure 11*) are **physical** health organizations that appear with a Primary Care (PCP) flag on DSN tables in at least one third of their rows. Because the PCP flag may be used inconsistently across CCOs, organizations are also classified as primary care if 40% of their taxonomy codes are Primary Care under California's Taxonomy Crosswalk.
- **Specialists** (e.g., *Figure 11*) are physical health organizations that are not classified as key clinics or primary care organizations.
- When determining whether organizations are connected to "**Any HIE tool including Collective**" or "**HIE tools for Care Coordination excluding Collective**," the set of HIEs includes Carequality, CommonWell, Reliance, eHealth Exchange, Epic Care Everywhere, Epic CareLink, and Arcadia (as well as the Collective platform, as specified).

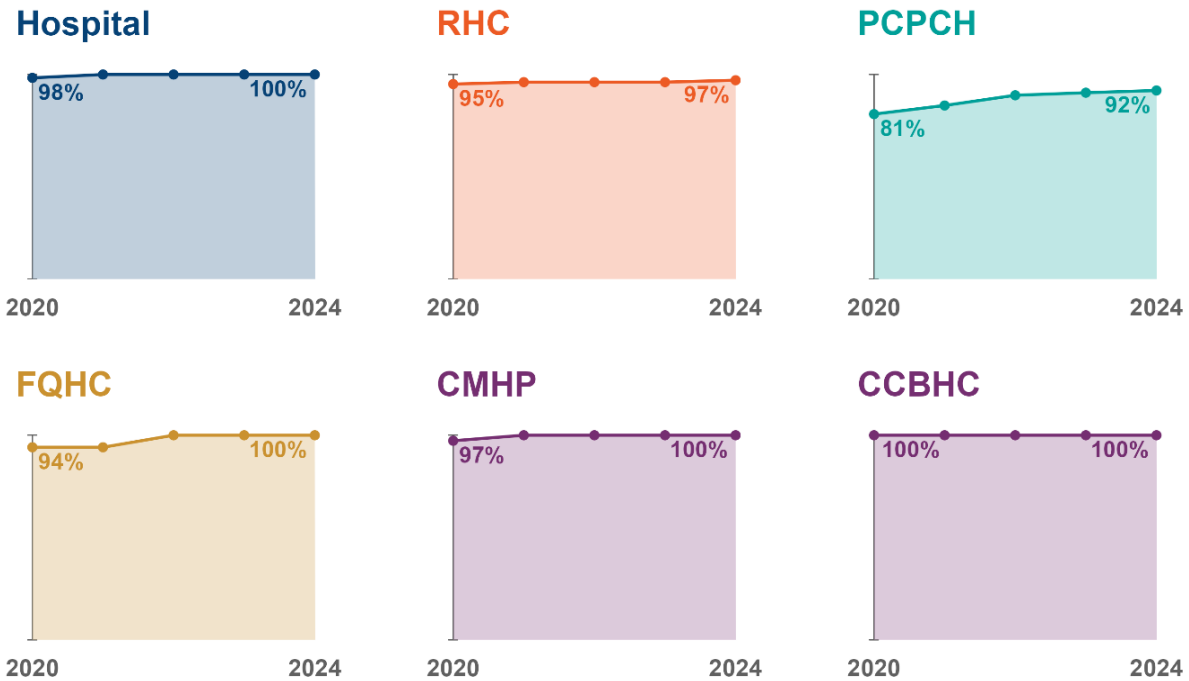
For comparison, *Figure 10* shows the weighted HIE tool adoption rates for **key clinics**, as defined in the "Data Definitions" textbox above. Key clinics tend to be large and well-funded, and their rates of HIE adoption are high. Additional analyses for key-clinic adoption of specific HIE tools can be found in *Appendix C: Additional HIE tool adoption figures*.

Figure 9: HIE adoption rates of any HIE tool including PointClickCare among CCO-contracted physical, behavioral, and oral health organizations, unweighted organization counts (top row) and organization counts weighted by number of unique provider NPIs (bottom row)



N: 1,001 Physical; 1,230 Behavioral; 314 Oral

Figure 10: Weighted HIE adoption rates of any HIE tool including PointClickCare among CCO-contracted key clinics



N: 61 hospitals; 107 RHCs; 640 PCPCHs; 34 FQHCs; 30 CMHPs; 12 CCBCHs

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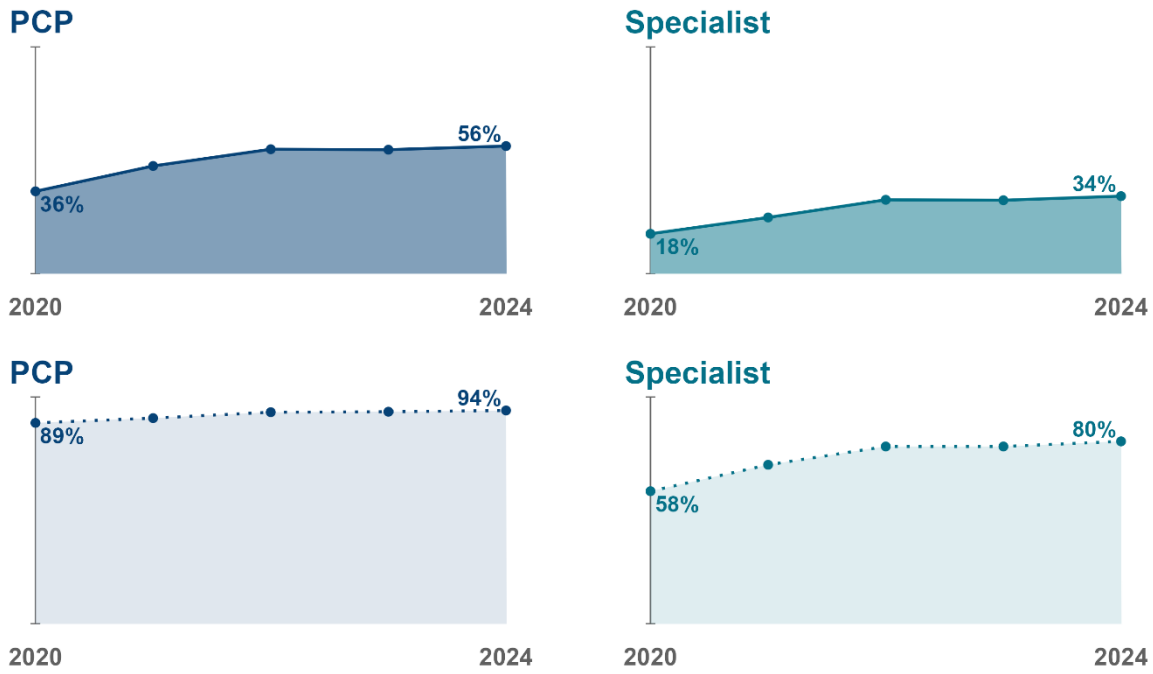
Figure 11 examines physical health organizations more closely, specifically primary care (PCP) and specialist organizations (see the "Data Definitions" textbox above for further definition). Primary care providers have higher HIE tool adoption rates than specialists. Similar analyses for non-key physical health provider adoption of specific HIE tools can be found in *Appendix C: Additional HIE tool adoption figures*.

Figure 11: HIE adoption rates of any HIE tool including PointClickCare among CCO-contracted primary care (including key clinics) and specialist physical health organizations, unweighted organization counts (top row) and organization counts weighted by number of unique provider NPIs (bottom row)



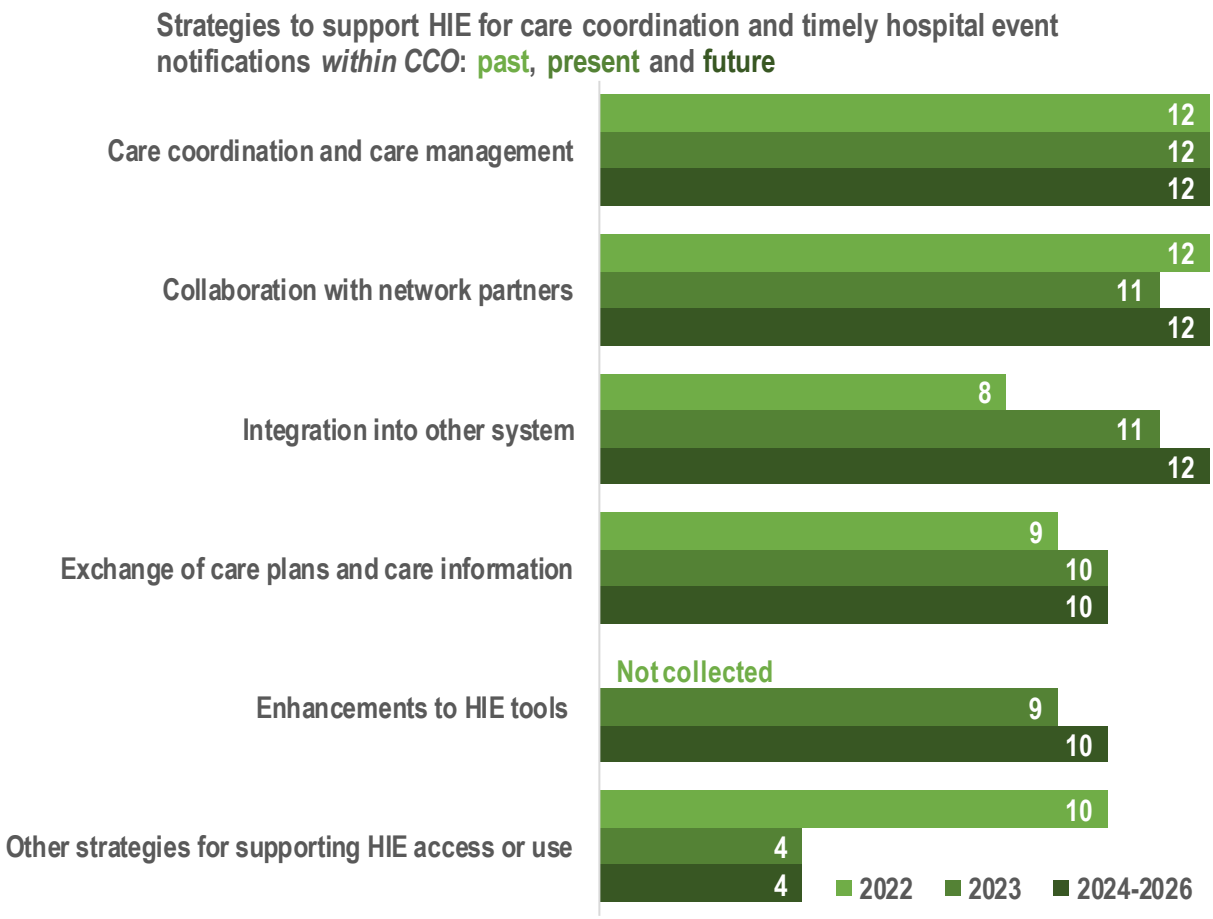
N: 509 PCP; 492 Specialist

Strategies for using HIE within the CCO

This section describes the specific contents of CCOs' *2024 Health IT Roadmaps*, covering CCOs' strategies for supporting the use of HIE tools for care coordination and timely hospital event notifications *within their organization*. *Figure 12* below represents the strategies CCOs reported using in 2022 and 2023, along with CCOs' planned strategies for 2024-2026. (See *Appendix D: Definitions and examples of CCO strategies for supporting HIE* for additional details on which strategies have been included in each category.)

Compared with 2022, 2023 saw more CCOs focus on integrating HIE tools and/or data into other systems. This reflects a greater focus on the interoperability of HIE tools and data used by CCOs, a theme observed in the *2024 Health IT Roadmap* responses. Strategies involving collaboration with network partners, exchange of care plans and care information, and enhancements to existing HIE tools remained popular strategies in 2023 and in future CCO plans.

Figure 12: Strategy comparison for using HIE within CCO: 2022, 2023 and 2024-2026

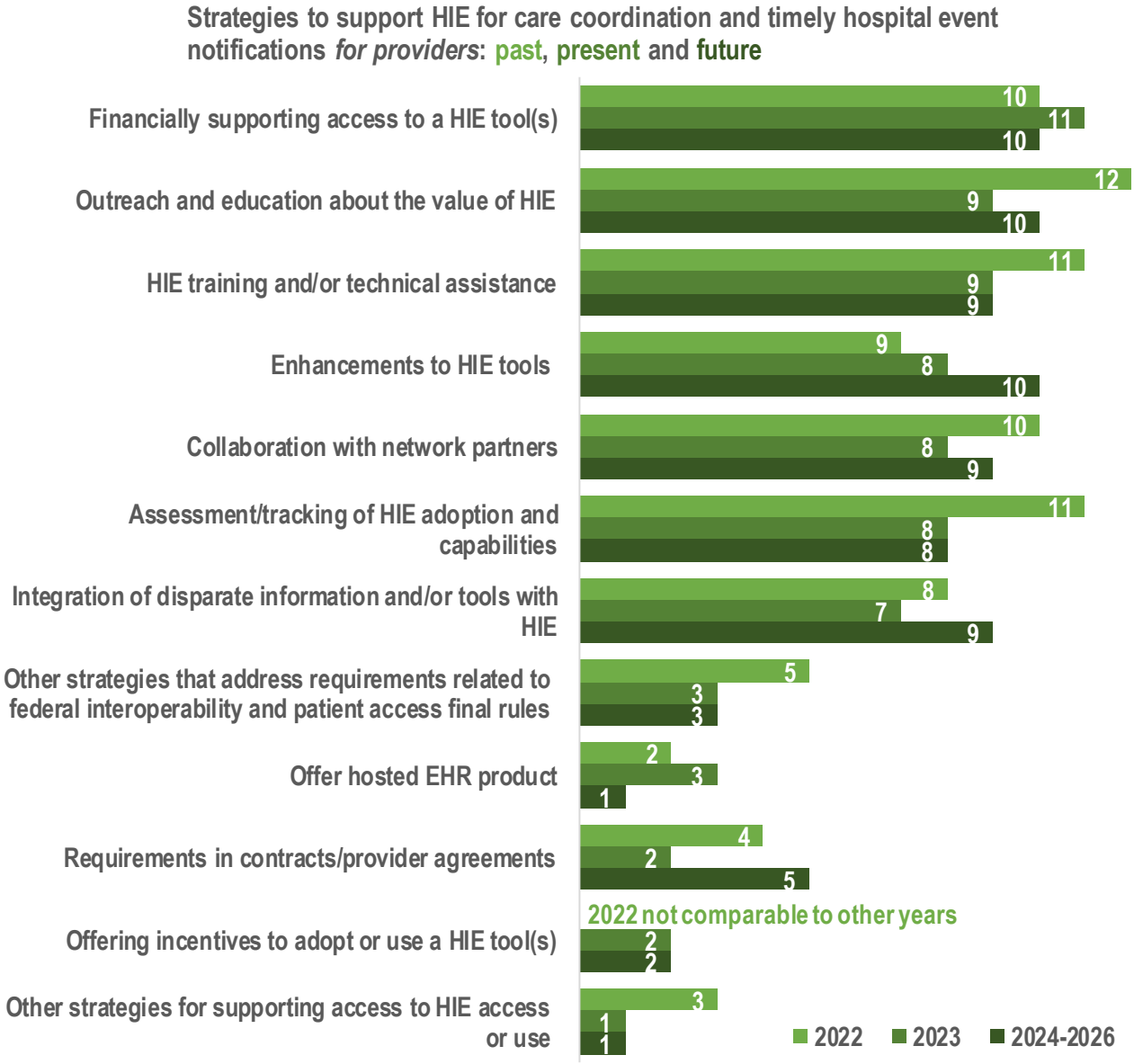


Strategies for supporting HIE adoption and use by providers

This section covers CCOs' strategies for supporting increased access to and use of HIE for care coordination and hospital event notifications *by their contracted providers*. *Figure 13* below represents the strategies CCOs reported using in 2022 and 2023, along with planned strategies for 2024-2026. (See *Appendix D: Definitions and examples of CCO strategies for supporting HIE* for additional details on which strategies have been included in each category.)

In general, CCOs are shifting how they support their contracted providers away from outreach and adoption strategies such as education on the value of HIE, and clinic assessment and tracking toward more structural strategies such as integration with and enhancement of existing tools, and requiring HIE use in contracts.

Figure 13: Strategy comparison for supporting HIE for providers: 2022, 2023 and 2024-2026



CCO Spotlights: HIE for care coordination and hospital event notifications

PointClickCare cohort development and support

AllCare plans to design and develop two new HEN cohorts focusing on care plan creation for their prioritized populations in PointClickCare (LTSS and Primary Diagnosis Hypertension). Development includes identification of workflows and training of staff.

CHA developed cohorts, reports and notifications in PointClickCare, allowing for more effective care management of priority populations, including COPD, CHF, Inpatient, and Postpartum. CHA also receives LTSS notifications outside of the platform and flags the members in the case management platform.

EOCCO created a Quality Team workgroup that identified the lack of timely notifications as a major challenge for providers in meeting the treatment deadlines associated with the IET measure. The workgroup plans to partner with PointClickCare to support providers to enable and use the IET measure cohort in the platform to receive notifications of SUD-related hospital diagnoses.

Implementation of new platforms

Yamhill Community Care procured and began implementing a new enterprise software for managing care, utilization, and appeals and grievances, VirtualHealth's HELIOS platform. The CCO has prioritized connecting HELIOS to HIE and CIE systems, including establishing a feed of hospital admit, discharge, transfer (ADT) event data from PointClickCare. Integration of ADT data into HELIOS will enable automatic notifications and tasks in the platform for care management and member service purposes.

CareOregon (Columbia Pacific CCO (CPCCO), Jackson Care Connect (JCC), and Health Share of Oregon (HSO)) procured and implemented a new care coordination platform, Epic Compass Rose, which simplifies the care coordination process for the CCO care teams by integrating with other HIE tools.

Four CCOs incorporated the Epic Payer Platform (EPP) into their HIE strategies. **CareOregon** made the decision to implement EPP in 2023 (including access for **CPCCO**, **JCC**, and **HSO**) and began planning for its launch, considering the potential value and uses for its CCO teams as well as contracted providers, where EPP may provide an opportunity for greater and more efficient bi-directional exchange with the CCOs. **PacificSource** explored the feasibility of implementing EPP, resulting in a decision in 2024 to do so to improve care coordination and value-based care arrangements with contracted providers that use an Epic EHR. Both organizations reported the large amount of clinical data available in the platform as a major value proposition.

Integration of disparate information and/or tools within HIE

CareOregon integrated hospital ADT feeds from PointClickCare directly into a newly procured and implemented care coordination platform, Epic Compass Rose. The integration will allow care teams to be notified about new member events and proactively identify and refer members into care coordination workflows.

Expanding HIE tool use for care coordination

EOCCO promoted Arcadia Analytics HIE tool to support care coordination between different care settings and types. EOCCO covers the cost of the platform for multiple clinic systems and provides onboarding and ongoing technical assistance. Clinic staff can use Arcadia to view gap lists, monitor quality measure performance, prepare for upcoming visits, and compare performance by provider.

Honorable Mentions: HIE for care coordination and hospital event notifications

The strategies listed below are notable examples of how CCOs support or plan to support increased access to and use of HIE for care coordination and hospital event notifications among their contracted providers. These strategies are represented in the strategies reported in *Figure 12* and *Figure 13*.

Enhancements to HIE tools

- **Advanced Health** successfully integrated eligibility files into Activate Care, making the process of creating care plans more efficient by pre-populating member data from OHA eligibility files. Future plans include integrating HIE data from Reliance (lab results, diagnoses, and visit information) and dental care team information from a Dental Care Organization contractor.
- **Umpqua Health Alliance (UHA)** developed a plan to implement PCC's Care Insights functionality (formerly called Care Guidelines) by CCO staff. UHA identified a vision and workflow that considered recent functionality enhancements to the Care Insights feature and will focus on sharing critical information to hospital teams about members who have care plans or safety issues of note.
- **UHA** will participate in a pilot project for a new AI-driven product developed by their care management platform partner, Arcadia. The tool gives a summary of a member's health status and provides recommendations to care managers.

Exchange of care plans and care information

- **Advanced Health** collaborated with ODHS by inviting case managers to upload their assessments to Activate Care to improve information exchange between providers and case managers.
- **CHA** collaborated with ODHS-APD to develop a workflow for APD staff to access CCO-authored care plans within the PointClickCare platform.

Training and/or technical assistance

- **EOCCO** plans to work with clinics to create a list of desired care coordination-related functions in the Arcadia platform. EOCCO will then collaborate with the Arcadia account team to create content for an updated care coordination-focused virtual training.
- **HSO** provided direct technical assistance to Clackamas Health Centers, in partnership with account managers at PointClickCare, to optimize ED discharge reports and other cohorts in PointClickCare.
- **PacificSource** is designing a simple menu of HIE tools and resources for its Population Health team to reference when directly connecting with providers to discuss HEN contribution status in PointClickCare (PCC) and to deploy new cohorts and reports. PCS plans to expand these types of resources to include how-to information on PCC functions, allowing the CCO team to guide providers in PCC use and engage in simple PCC-related problem-solving.

Outreach and education about the value of HIE

- **UHA** is conducting outreach to PCPCH and behavioral health clinics to promote Unite Us and PointClickCare. These efforts are based on identified gaps in care as well as SDOH, REALD, and SOGI inequities within the network.

Collaboration with network partners

- **HSO** partnered with OCHIN to align efforts for Community Health Centers (CHCs) that they were mutually supporting in the Epic Payer Platform implementation process. The partnership expanded outreach efforts about EPP, increasing the initial participant pool from two to five CHCs.

Other strategies to support HIE

- **PacificSource** integrated data from HIE sources with member demographics to build an interactive "Climate Emergency" dashboard to support its Member Support Services Rapid Response Team. The tool draws data from HIE sources, plots members geographically, and allows CCO staff to filter by proximity to an event (e.g., distance to wildfire) and health conditions that may make members more vulnerable (e.g., limited mobility, ventilator use). The tool can produce a report with contact information to assist staff with outreach to affected populations to help get them the resources needed during events like extreme heat, extreme cold or ice storms, wildfires, and power outages. This work improved organizational capacity to respond quickly to emergencies and leveraged multiple HIE data sources to accomplish more complete identification of at-risk members.
- **PacificSource** continued to develop and implement a comprehensive roadmap to meet CMS interoperability rule requirements, including launching a patient access application programming interface (API). Current and former members can now request and receive their PacificSource health records via the OneRecord mobile application, which uses this

API. The CCO also published a set of member support tools for using OneRecord to its website.

2023 barriers to supporting HIE

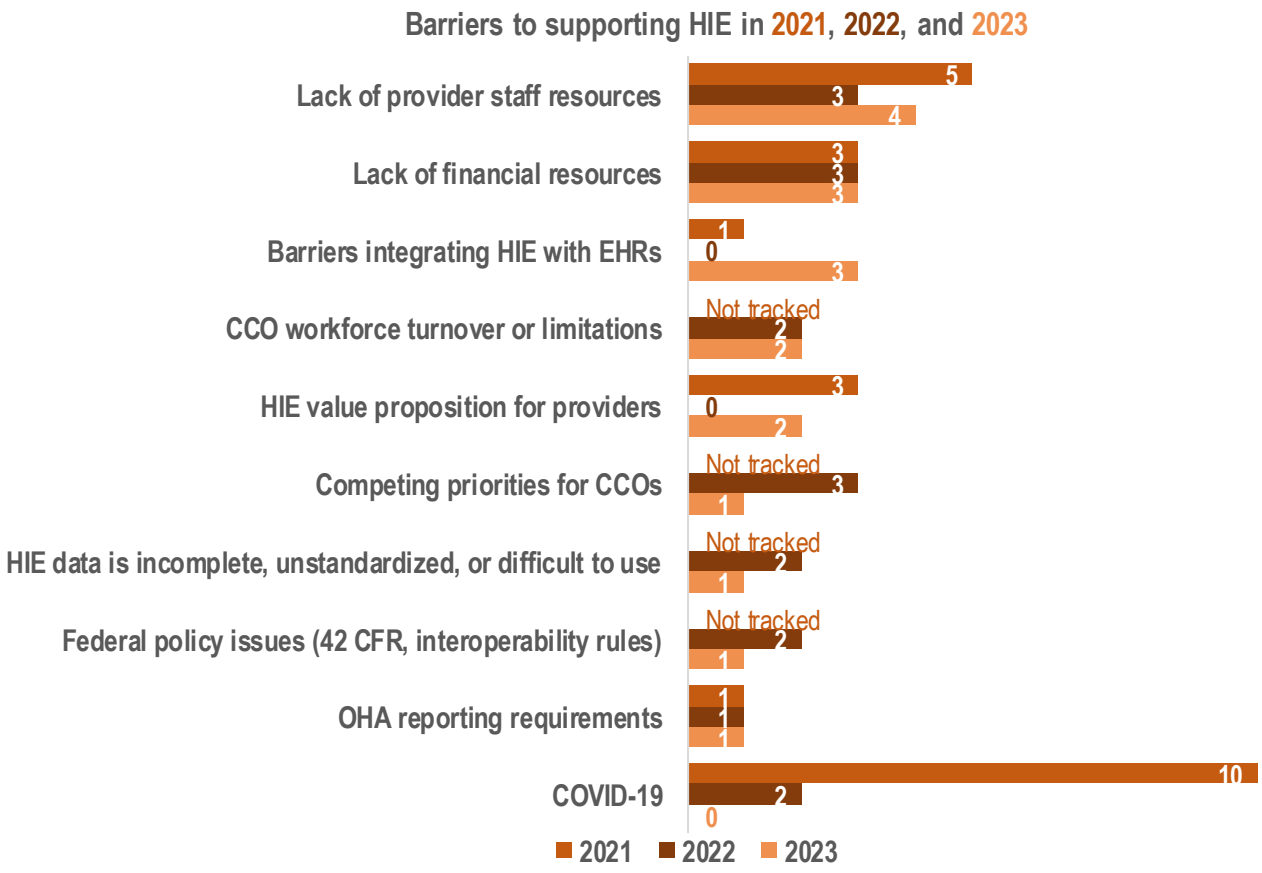
Figure 14 represents the number of CCO organizations that reported different barriers to supporting their contracted physical, oral, and behavioral health providers with HIE for Care Coordination and Hospital Event Notifications.

The following barriers to supporting HIE were cited most often by CCOs in their 2023 Roadmaps:

- Challenges integrating HIE tools with EHRs (e.g., these systems lacking sufficient interoperability capabilities)
- Lack of provider staff resources (e.g., competing priorities and workflow issues make it difficult for clinics to resource new IT initiatives or tools)
- Lack of financial resources
- Lack of HIE value propositions for providers sufficient to incentivize adoption and use

Some kinds of barriers were reported less often over time including the COVID-19 pandemic and CCO workforce turnover or limitations. While this may hint at organizations shifting focus and resources back to health IT following the pandemic, CCOs continue to report clinic staff limitations as a major barrier to providers engaging in HIE and data sharing efforts.

Figure 14: CCO-reported barriers to supporting HIE



OHA support requests

Figure 15 shows CCO organizations' preferences for how OHA could assist in supporting them and/or their contracted healthcare providers with HIE for care coordination and hospital event notifications.

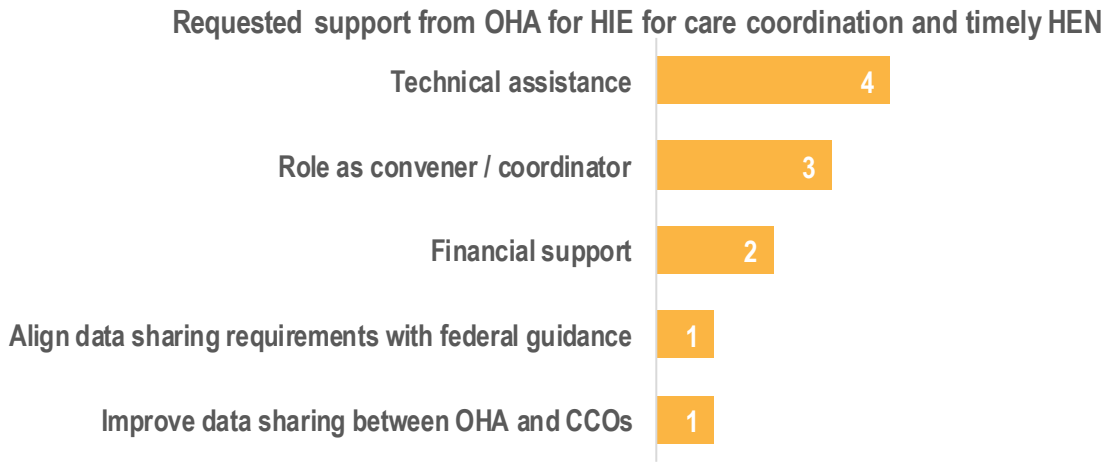
To support HIE for care coordination, CCOs proposed several improvements to data exchange processes among OHA, payers, and vendors. These recommendations include avoiding over-driving state health plan interoperability requirements in ways that could risk departure from the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary for Technology Policy (ASTP, formerly ONC) guidance and requirements. Establishing state level interoperability requirements may create a split focus for CCOs as they work towards compliance with existing federal rules.

Technical assistance (TA) to benefit providers was the most common request for OHA support in 2023. CCOs requested more HIE TA or subject matter expertise resources to support provider practices in understanding the value of adopting HIE tools (e.g., what current roadblocks does a tool help alleviate) and assist them with onboarding and optimal use of HIE.

CCOs also identified specific areas where financial support would benefit their HIE strategies. They highlighted the significant costs associated with establishing tools that provide for a longitudinal record for patients across the state vs. regionally.

Finally, CCOs also described several areas where OHA could be an effective convener for payers and providers. OHA could, for example, arrange forums for partners to coordinate standardized screening tools, harmonize strategies related to interoperability, and reduce duplication of efforts to onboard new providers to HIE.

Figure 15: 2023 CCO-requested support from OHA for HIE for care coordination and hospital event notifications



Health IT to Support Social Determinants of Health (SDOH) Needs

This section summarizes the Health IT Roadmaps CCOs submitted in March 2024, focused on CCO strategies for health IT to support SDOH needs. It describes their 2023 activities and plans for 2024-2026 both within the CCO and among their contracted providers and community-based organizations (CBOs). CCO strategies and investments have potentially changed since the 2024 roadmaps were submitted.

Multiple factors underscore the importance of these areas of work. Care coordination needs and health care transformation shifts continue to demand substantial CCO attention and innovative planning. Given the evidence that SDOH have greater impacts on health outcomes than clinical care, leveraging health IT to address members' SDOH needs has also required substantial investment from CCOs. CCO progress and planning have similarly been driven by the SDOH: Social Needs Screening and Referral CCO incentive metric[6] and the 2022-2027 1115 Medicaid Waiver[7] and the ability to address health-related social needs (HRSN)[8], the social and economic needs that affect one's ability to maintain health and well-being.

This section includes:

- CCO-implemented and -supported health IT tools for supporting SDOH needs
- CCO strategies for supporting contracted providers and CBOs with health IT to support SDOH needs
- Spotlights and Honorable Mentions for especially noteworthy strategies
- CCO-identified barriers to supporting health IT to support SDOH needs
- Requests for OHA support for supporting health IT use for SDOH needs

Health IT tools to support SDOH needs implemented and supported by CCOs

CCOs have implemented a variety of health IT tools to support SDOH needs (see *Figure 16* below). These include community information exchange (CIE)[9], care and case management, population health management, and data analytics tools. Each serves a different (or more than one) purpose and helps CCOs identify and support members' SDOH needs.

CCOs have supported contracted provider and CBO access to and/or implementation of some of these tools, and other tools are used to support CCO activities, including providing relevant information to providers and CBOs.

[6] https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx
[7] https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Waiver-Renewal.aspx
[8] https://www.oregon.gov/OHA/HSD/Medicaid-Policy/Pages/HRSN.aspx
[9] For more information about CIE, see: https://www.oregon.gov/oha/HPA/OHIT/Pages/CIE-Overview.aspx

Please note that the tools below are those identified by CCOs as used **in their SDOH efforts**, and are likely not reflective of all tools used for care management, population health, payment, etc.

Figure 16: 2023 & 2024-2026 Health IT tools used to support SDOH needs

Type of Tool	Tool	# of CCO parent organizations (n=12) *
Community Information Exchange	Connect Oregon/Unite Us	11
	findhelp (also known as Healthy Klamath Connect)	1
Care Management/Care Coordination/ Case Management	Activate Care	1
	CCO Provider Portal (not otherwise specified)	2
	Epic Care Everywhere/Healthy Planet	1
	Epic CareLink	1
	Epic Compass Rose	3
	Essette Care Management Platform	1
	Phreesia	1
	Smartsheet	1
	TriZetto's Clinical CareAdvance (Cognizant)	2
	TruCare	1
Population Health/Metrics Tracking/Data Analytics	Arcadia Analytics	2
	CCO Data Warehouse	4
	Dynamo/Case Trakker	1
	Innovaccer Population Health Tool	1
	Johns Hopkins ACG Geographic module	2
Payment and Eligibility	HealthTrio	2
Other Tools	CCO Member Portal	1
	Collective Medical	3
	Epic Payer Platform	3
	Reliance	4

* The 2024 Roadmaps include responses from 12 different CCO parent organizations, representing all 16 CCOs.

CCO strategies for health IT to support SDOH needs

CCOs reported strategies across two categories for health IT to support SDOH needs: those implemented internally (within CCO) and those to support their contracted providers and CBOs. This summary reflects only what was reported by CCOs in their 2024 HIT Roadmaps and may not capture everything a CCO is doing. *Figures 17* and *18* below represent the numbers of CCO parent organizations that reported using different strategies in each of these categories in the *Health IT to Support SDOH Needs*: 2023 Progress and 2024-2026 Plans sections of their Health IT Roadmap. Tables 1 and 2 in *Appendix E* include additional details about what has been included in each strategy category.

All CCOs implemented health IT for social needs screening and referrals and care coordination and care management of individual members in 2022 and 2023, and all CCOs plan to continue these strategies into 2024-2026 (see *Figure 17*). Similarly, using health IT to identify individual members' SDOH experiences and social needs remained a high priority, with nearly all CCOs participating across the years.

CCOs are placing increased emphasis on enhancing existing health IT functionality, for example by adding custom forms to CIE and exploring or implementing invoicing functionality. The use of data for CCO metrics support has seen an upward trend from 2022 to 2023, with more plans for 2024-2026. There is also a growing focus on integrating or achieving interoperability of health IT systems for SDOH with other tools, with a majority of CCOs planning to adopt this strategy going forward. Collaboration with network partners saw a small drop between 2022 and 2023, with one CCO planning to reinstitute this strategy in 2024-2026.

In supporting providers and CBOs, all CCOs have maintained their sponsorship of CIE platforms for the community. Additionally, all continue to invest in outreach and education about the value of health IT for SDOH needs (see *Figure 18*). Assessment and tracking of CIE/SDOH tool adoption and use is becoming more prevalent, with an increasing number of CCOs engaging in this strategy over time. Training and technical assistance, as well as financial support of health IT that supports SDOH, are consistently supported by the majority of CCOs.

Notably support for participation in SDOH-focused collaboratives and incentives or grants to adopt health IT that supports SDOH have remained steady strategies. There has been a slight decrease in the number of CCOs providing support for CBOs sending referrals to clinical providers. Requirements in contracts and provider agreements for health IT use have also seen minimal changes, with a small number of CCOs continuing to pursue these measures.

Overall, while there have been some fluctuations in the adoption of specific strategies, CCOs continue to prioritize key areas such as social needs screening, use of SDOH data, and collaboration both internally and with external partners. The continued investment in these areas highlights the ongoing commitment to leveraging health IT to effectively address SDOH needs.

Figure 17: 2022, 2023 & 2024-2026 Strategies for Health IT to support SDOH needs within CCO

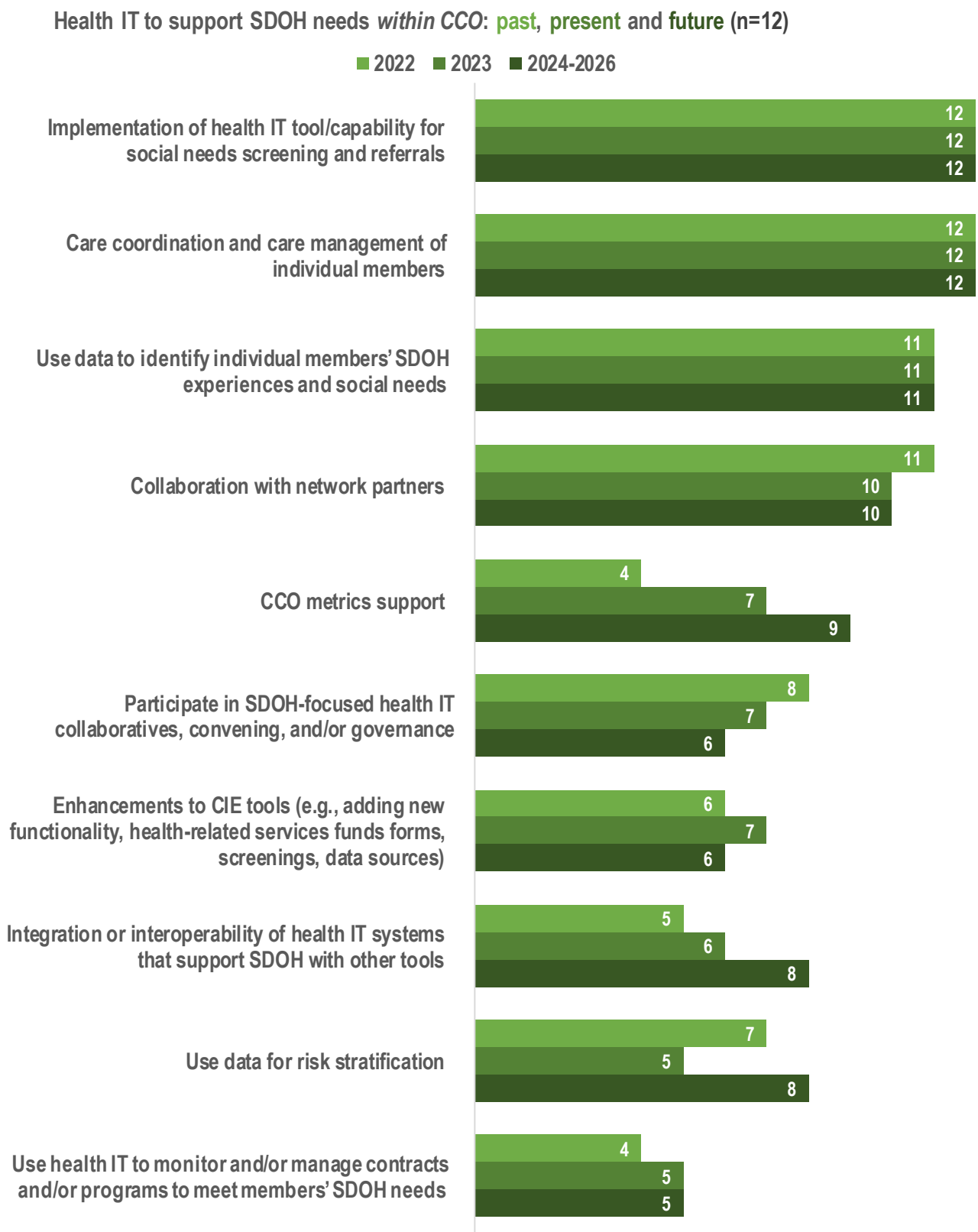
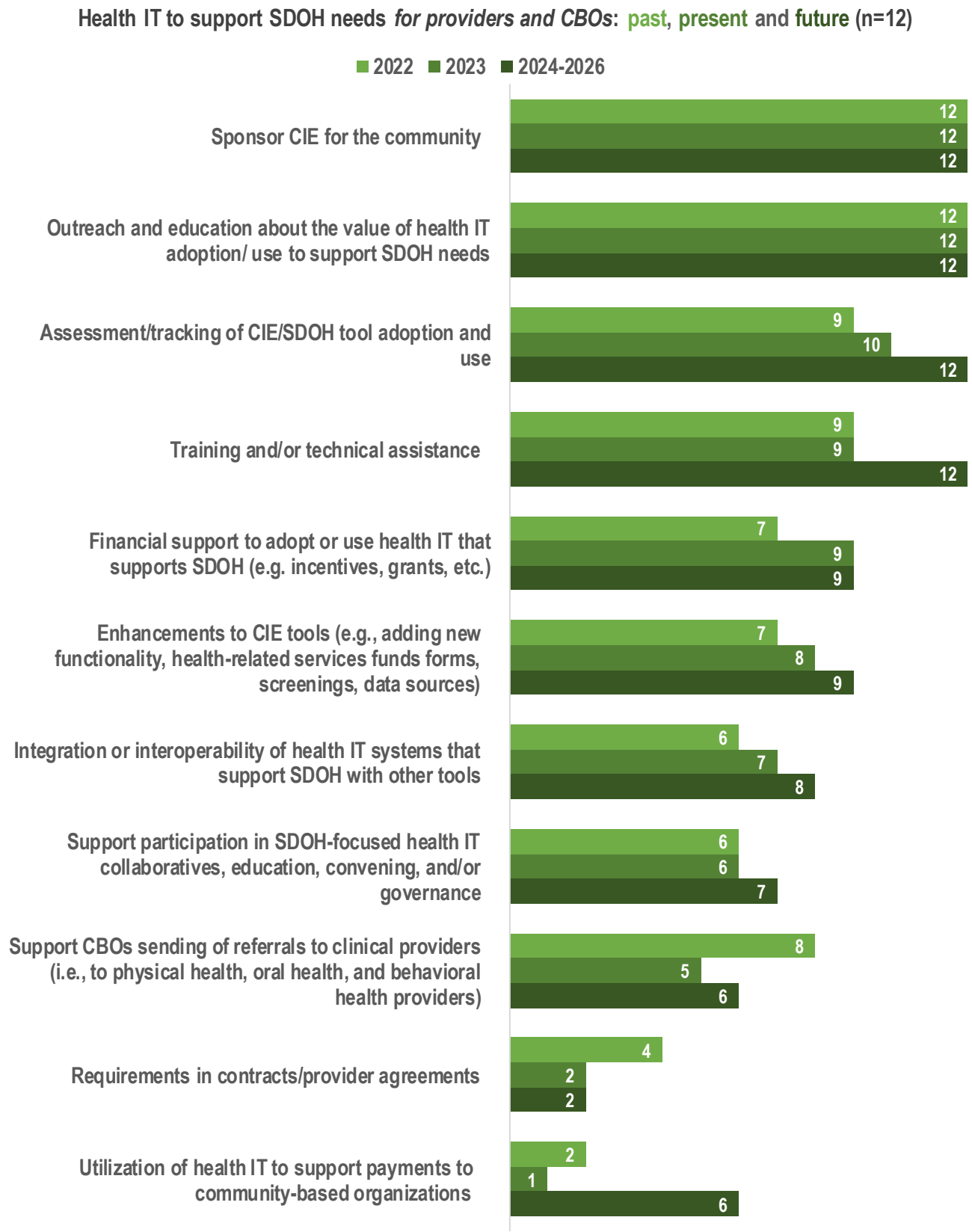


Figure 18: 2022, 2023, and 2024-26 Strategies for Health IT to support SDOH needs for providers & CBOs



CCO Spotlights: Health IT to support social determinants of health needs

Progress bringing SDOH data together

Health Share (Care Oregon), CPCCO, and JCCO are redesigning their population segmentation model to increase the presence and use of SDOH and social needs data, bringing in newly available data from Connect Oregon/Unite Use and Compass Rose, their new care coordination platform, to inform population health interventions and prioritization of resources for care coordination.

PacificSource incorporates SDOH data from multiple sources, including Connect Oregon/Unite Us, PointClickCare, Reliance, and EHRs into their data warehouse to comprehensively identify members with SDOH needs, referred to as "SDOH signals." This is used across various workflows including in member profiles for care managers, care program identification algorithms, to identify priority populations, inform community collaboration, and inform the annual population health assessment, quality, outreach, and other strategies.

Gather and use feedback from CBOs and providers

Advanced Health conducted listening sessions with Consumer Advisory Councils in two counties to understand member perceptions of the SDOH screening process, which involves screening in Unite Us, and to prevent over-screening. They also held end user feedback sessions to improve ease of use and mitigate barriers to adoption of Unite Us.

IHN-CCO leveraged community partner and provider feedback and collaborated to improve the value of Unite Us, including offering incentive grants through United Way and working with its regional workgroup to identify and overcome barriers.

Umpqua Health Alliance launched a local CIE governance effort in Douglas County appointing initial members to a community-led advisory body. The group uses community feedback to inform decisions about CIE and serves as a venue for knowledge and best practice sharing around CIE implementation.

Behavioral health pilot

PacificSource increased its use of CIE for behavioral health referrals in Deschutes County through multiple activities including: a pilot with Deschutes County Health Services to support incoming behavioral health referrals to PacificSource and in a separate use case, shifting from tracking via a shared spreadsheet to using CIE for closed loop referrals with Deschutes County Behavioral Health.

Accountable Health Communities (AHC) project and expansion

EOCCO, as part of their Accountable Health Communities (AHC) project and in partnership with the Oregon Rural Practice-based Research Network (ORPRN), provides SDOH screening to members with two or more ED visits in the past 12 months. The ORPRN team puts screening results into Unite Us and refers members to community resources or EOCCO Case Management. They also use zip code and

REALD data to identify social need disparities across member populations and their service area.

Broad outreach about the value of health IT to support SDOH

CHA has instituted a communication strategy to share information about Healthy Klamath Connect (HKC) with partners, members, and the broader community. This includes texts to members, a quick access link to HKC on their home page, discussions with providers and their Community Advisory Council (CAC), flyers, and live demos at in person events, a local billboard, and articles.

Honorable Mentions: Health IT to support social determinants of health needs

The strategies listed below are examples of how CCOs support, or plan to support, health IT for SDOH needs. These strategies have been rolled up into the strategies included in *Figures 17* and *18*.

Utilization of health IT to support payments to CBOs

- **HealthShare (Care Oregon) JCCO, and CPCCO**, expanded access to HealthTrio, their provider portal, to include CBOs so they can verify CCO enrollment for their clients, share reports, invoice, and meet payment contract requirements. They developed a standard onboarding process for contracted CBOs including a review of contract terms, reporting requirements, and an orientation to HealthTrio. This is accompanied by a written guide to HealthTrio and access to ongoing technical assistance, as needed.

Enhancements to CIE tools

- **Advanced Health** built a custom form with Connect Oregon/Unite Us that collects all required information for HRSN climate services.
- **EOCCO** collaborated with Connect Oregon/Unite Us and partner organizations to build custom SDOH screening forms.
- **PacificSource** embedded an Assistance Request Form (ARF) on webpages for Lane County Coordinated Entry and the Mid-Columbia Community Action Council to support housing or shelter self-referral by community members. ARF embedding resulted in increased referrals for these programs and will be used as a strategy going forward.

Various strategies for CIE network growth

- **AllCare** engaged in monthly community outreach, internal monthly strategic planning meetings, and quarterly educational webinars for external partners which have increased CIE use; the number of cases increased by 72%, managed cases by 50%, and referred cases by 40%. They also use CIE data to inform CACs and internal community benefit initiatives. AllCare also standardized a training process for their internal Population Health Care Coordination staff who then made 254 referrals via CIE in 2023. This will support their goal to increase referrals made via CIE by 10% in 2024.
- **CHA's** broad outreach efforts, described in Spotlights, helped increase claimed local programs on findhelp to 61% in 2023.

- **EOCCO** now has adoption of Connect Oregon/Unite Us CIE by organizations across all counties in their service area with 199 unique organizations joining by the end of 2023. Network utilization increased 150% with 1,090 referrals being made via the platform.
- **IHN-CCO** collaborated at regional and state levels, leveraging community partner and provider feedback to ultimately expand the number of providers and CBOs receiving referrals through Connect Oregon/Unite Us from 97 at the end of 2022 to 145 in the 4th quarter of 2023.
- **PacificSource** onboarded an additional 70 internal users to Connect Oregon/Unite Us throughout 2023 including Population Health and Provider Service representatives, Traditional Health Worker Liaisons, and Health Equity Liaisons. They also started a workforce management dashboard to better track utilization and identify training needs.
- **UHA** used targeted outreach to onboard new organizations to Connect Oregon/Unite Us, including all but two Tier 4 & 5 PCPCH (Patient-Centered Primary Care Home) clinics. Of 34 CBO organizations Umpqua prioritized for Connect Oregon/Unite Us participation, 19 were onboarded by the end of 2023, and 2023 referral sending increased by 163% while referral receiving increased by 110%.

Financial support to adopt or use health IT that supports SDOH (e.g., incentives, grants)

- **JCC** made multiple financial investments to support CIE use, through SDOH Tier 1 Initiative support in the amount of $125,000 per clinic for those using CIE to send or receive referrals, and $42,000 total for parole and probation programs accessing CIE using tablets.
- **EOCCO** offered a grant to support integration of Connect Oregon/Unite Us into clinical social needs screening workflows and connect members to services.

Integration or interoperability of health IT systems that support SDOH with other tools

- **HealthShare (Care Oregon) JCCO, and CPCCO** financially supported integration for FQHCs to access and integrate the Connect Oregon/Unite Us Platform, including a Connect Oregon/Unite Us integration for Asante.
- **IHN-CCO** supported integration of linked navigation to Connect Oregon/Unite Us across various Epic platforms, increasing utility for providers.

Use data to identify individual members' SDOH experiences and social needs

- **UHA** used internal and external data to complete a gap analysis comparing state and Douglas County-level food, housing, and transportation needs. Results show lower rates of screenings for food and housing, and referrals for food, housing, and transportation.

Data sharing agreements to share SDOH data through Health IT

- **CHA** identified 144 programs and CBOs, through HKC work, to establish or ensure existing agreements are sufficient for SDOH data sharing which will occur in 2024. Agreements were also signed by CHA, HKC, and Reliance to work on a path for sharing SDOH data.

Support participation in SDOH-focused health IT collaboratives, education, convening, and/or governance

- **UHA** engaged CBO partners to review and assess the Connect Oregon/Unite Us payments module for potential HRSN use.
- **YCCO** sponsored listening sessions with referral partners to help facilitate sharing of challenges and successes among community resources.

Use data to identify individual members' SDOH experiences and social needs, care coordination, and CCO metrics support

- **EOCCO** is developing a member-level social needs screening and referral report using CIE data. This will be incorporated into the monthly Member Roster reports distributed to primary care providers to inform providers of social needs and associated referrals received by members and to potentially reduce over screening.
- **PacificSource** is using data flags from PointClickCare to cross reference member addresses with shelter addresses, names, and terms and phrases associated with housing insecurity. In one use case, PacificSource case management teams used data flags to begin routine outreach to members with housing insecurity and diabetes to engage them in primary care and behavioral health, close care gaps, and support their SDOH needs.
- **UHA** completed testing of a data feed with 27 unique files from their CIE which will be used internally to visualize SDOH data using a Tableau dashboard. This will be used to support the SDOH metric and inform care coordination.

2023 barriers to implementing strategies for health IT to support SDOH needs

CCO responses reveal a variety of barriers primarily to their progress supporting contracted physical, oral, and behavioral health providers, as well as social service and CBO partners in using health IT to address SDOH needs.

Limited resources and staff capacity of CBOs and provider partners are prominent and widely experienced barriers. Several CCOs noted that insufficient CBO and provider staffing and funding, as well as staff turnover, severely limit their ability to engage in health IT initiatives. CBOs and providers are overwhelmed by multiple new projects and initiatives. Limited funding and financial resources make it challenging for them to invest in the necessary technologies and support their adoption, including costs and resources to implement CIE. A lack of interoperability between tools (such as EHRs, population health tools, and between CIEs), and the issue of adding an additional platform, also complicates CBO and provider workflows and hinders health IT adoption. Additionally, there is some discomfort around moving from personal relationships to a health IT tool, as well as concern about being unable to handle referral volume, provide enough services, or change current processes.

Cost and technical integration challenges with existing systems further complicate efforts. For example, integrating CIE with existing health IT systems has proven to be technically and operationally difficult. Ensuring seamless data exchange and interoperability between different

systems is a complex task that requires significant resources and expertise. One CCO notes that claims data interfaces from all payers would improve care coordination and SDOH activities.

Pilot program challenges and provider engagement issues also pose barriers. Encouraging providers to participate in pilot programs is difficult, as they are often hesitant to adopt new systems due to concerns about workflow disruptions and additional administrative burdens. Similarly, lack of buy-in and engagement from CBOs and providers remains a significant hurdle. Resistance to change, as well as change fatigue, makes it difficult to encourage adoption of new health IT systems and to sustain these initiatives.

These barriers underscore the need for coordinated efforts, increased funding, and strategic initiatives to foster collaboration and system integration, ultimately enhancing the ability to support SDOH needs through health IT.

OHA Support Requests

Four CCOs responded to the question of how OHA can support their health IT for SDOH efforts, highlighting several key themes and requests.

One significant theme across responses is the need for standardization and guidance. CCOs emphasize that although many CCOs are engaged with the same CIE platform, each operates independently regarding functional requirements in the platform. This creates inconsistencies and inefficiencies. One CCO suggests that OHA could provide guidance and support to ensure the standardization of the CIE platform across CCOs. This would streamline efforts, enhance the effectiveness of referrals, and encourage expansion of the platform's use throughout community-partner networks. Another CCO proposes a single program to track SDOH needs, screenings, and referrals throughout the state. This could reduce fragmentation and improve the coordination and tracking of services, making it easier to address and monitor SDOH needs comprehensively.

Guidance and standardization were also requested on the social need screening code lists for the SDOH: Social Needs Screening & Referral CCO incentive metric. Such guidance would help physical health partners better document and refer members to services and resources that address social needs. Standardized codes would facilitate more accurate data collection and analysis, thereby improving the overall effectiveness of social needs screening and referral processes.

Finally, the related themes of sustainable funding and broader adoption of CIE are highlighted by another CCO. They support the recommendations from the Health Information Technology Oversight Council (HITOC) and the CIE Workgroup[10], which emphasize that the success of CIE depends on widespread adoption by CBOs. They suggest that OHA can support these efforts by developing sustainable funding mechanisms to help CBOs adopt and utilize CIE. Additionally, they point out that many CIE partners are eager to see OHA and ODHS programs join CIE platforms to receive incoming referrals, which would further enhance the network's effectiveness.

[10] House Bill 4150 Final Report: Supporting Statewide Community Information Exchange https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/HB4150FinalReportExecSummary_CIE.pdf

These responses highlight the need for standardization, guidance, unified tracking systems or programs, and sustainable funding to support the effective use of health IT in addressing SDOH, particularly for CBOs.

Appendix A: Acronyms and abbreviations

CCOs

Advanced Health	Advanced Health
AllCare	AllCare Health
CHA	Cascade Health Alliance
CPCCO	Columbia Pacific CCO
EOCCO	Eastern Oregon CCO
Health Share or HSO	Health Share of Oregon
IHN-CCO	InterCommunity Health Network
JCC	Jackson Care Connect
PacificSource or PCS	PacificSource Community Solutions (4 regions)
Trillium	Trillium Community Health Plan (2 regions)
UHA	Umpqua Health Alliance
YCCO	Yamhill CCO

Other terms

ADT	Hospital admission, discharge, and transfer
CBO	Community-based organization
CCO	Coordinated care organization
CIE	Community information exchange
COHIE	Central Oregon Health Information Exchange
DCO	Dental care organization
DSN	Delivery System Network
D-SNP	Dual-eligible Special Needs Plan
EDIE	Emergency Department Information Exchange
EHR	Electronic health record
FQHC	Federally Qualified Health Center
HEDIS	Healthcare Effectiveness Data and Information Set
HEN	Hospital event notification
HIE	Health information exchange
HIT	Health information technology
HITAG	Health Information Technology Advisory Group
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
IMPACTS	Improving People's Access to Community-based Treatment, Supports, and Services
OCHIN	Oregon Community Health Information Network
ODHS	Oregon Department of Human Services
OHA	Oregon Health Authority
OHLC	Oregon Health Leadership Council
ORPRN	Oregon Rural Practice-based Research Network
PCPCH	Patient-Centered Primary Care Home
REALD	Race, ethnicity, language, and disability
RHC	Rural Health Clinic
SUD	Substance use disorder

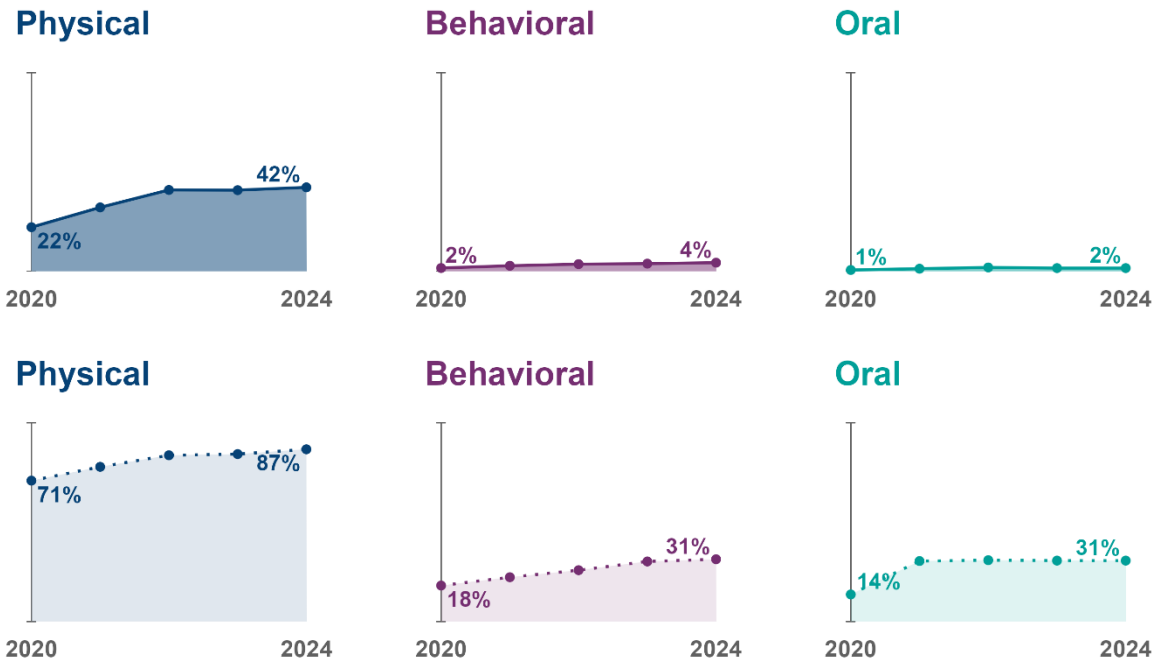
Appendix B: Definitions and examples of CCO strategies for supporting EHR adoption

Assessment/ tracking of EHR adoption and capabilities	CCO-facilitated activity that results in the collection of data and increased understanding of providers' EHR capabilities, gaps, and barriers and can be used to inform EHR adoption strategy, resource allocation, and targets. Examples include: - Environmental scans/health IT ecosystem investigation - Provider surveys and interviews on EHR adoption and utilization - Provider readiness assessments - Assessment of EHR products and return on investment - Defining current state and future EHR capabilities needed - EHR adoption/utilization tracking methodology - Collect data on EHR use through existing processes (e.g., letter of interest forms, onboarding, contracting, credentialing, auditing, site visits, evaluation forms) - Regular meetings with clinics and providers to identify EHR needs and barriers
EHR training and/or technical assistance for providers/clinics	CCO has staff, expertise, and resources to provide training or technical assistance (TA) to providers who are procuring or implementing an EHR, or who already have an EHR and need help learning to use or optimizing their use. Examples include: - EHR procurement, vendor liaising/navigation, and market research - EHR implementation, upgrade, or conversion - EHR user training/best practices - Data migration, capture, or extraction - Workflow optimization and improvement, including referral documentation, reporting, and closing loops - Funding and marketing for external TA consultants
Outreach and education about the value of EHR adoption/use	CCO-facilitated activity that encourages providers to adopt an EHR. Through various methods of outreach, CCO shares value of EHR and business cases. Examples include: - Calling, emailing, or meeting in-person with providers - Sending newsletters - Conducting webinars - Hosting town hall meetings - Inventory of resources for EHR support
Collaboration with network partners	CCO-created opportunities or forums for collaboration with partners and providers on supporting EHR adoption. Examples include: - The creation of a multidisciplinary steering committee/governance body that includes providers

	- Collaboration with dental and behavioral partners on efforts to convert EHRs and track ED visits via the Collective Platform (Emergency Department Information Exchange – EDIE) - Hosting network partner convenings to discuss EHR needs/conversations with clinic staff - Partnership with dental plans/DCOs in efforts to increase dental provider EHR adoption rates - Partnership with CCBHCs in efforts to increase behavioral health provider EHR adoption rates
Requirements in contracts /provider agreements	CCO has included requirements in provider contracts/agreements around the use of an EHR or participation in a program that leverages the use of an EHR. Examples include: - Requiring the use of a certified EHR system - Requiring participation in the HIE Onboarding Program - Subcontractor requirements around ability to share electronic information with network providers - While not an example of a contract requirement, some CCOs include contract language encouraging EHR use, informing of incentive programs, etc.
Incentives to adopt and use EHR	CCO offers financial incentives to providers related to EHR adoption and use. Examples include: - Quality pool payout for organizations that adopt an EHR and can pull and submit data from their EHR - Bonus incentives to PCPs who can report on quality metrics using their CEHRT - Incentives for greater levels of designation in the PCPCH program for EHR functionality - Incentives tied to achieving results of value-based payment arrangements - Health IT stipend to incentivize connecting with a CEHRT
Financial support for EHR adoption, implementation, or maintenance	CCOs provides funding (partial or complete) for EHR implementation and maintenance and operations. Examples include: - Funding a grant for an organization to implement an EHR - Sharing the cost to implement and/or maintain a community-wide EHR with community providers - Allocating funds through Health-Related Services (HRS) to assist with EHR adoption
Leverage HIE to promote EHR adoption	CCO promotes EHR adoption by supporting HIE connectivity and promoting HIE tools during education/TA sessions - Ensuring CCO-hosted EHR product integrates with Reliance eHealth Collaborative - Highlighting potential value of HIE tool integration into/access via EHR - Developing an enhanced provider portal that includes capability to exchange EHR data with providers and members
Offer hosted EHR Product	CCO offers and fully supports an EHR product. Contracted providers can adopt and use the EHR and pay the CCO a monthly fee. The CCO provides training and technical support for EHR users.

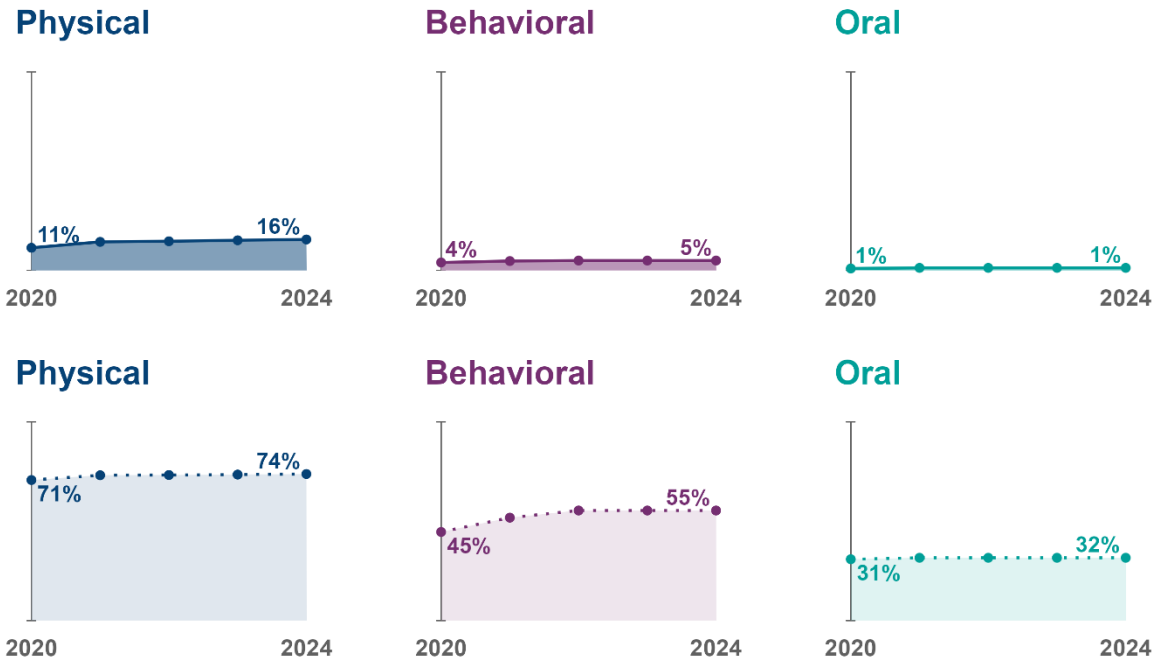
Appendix C: Additional HIE tool adoption figures

Figure 19: HIE adoption among CCO-contracted physical, behavioral, and oral health organizations – Any HIE tool for care coordination excluding PointClickCare



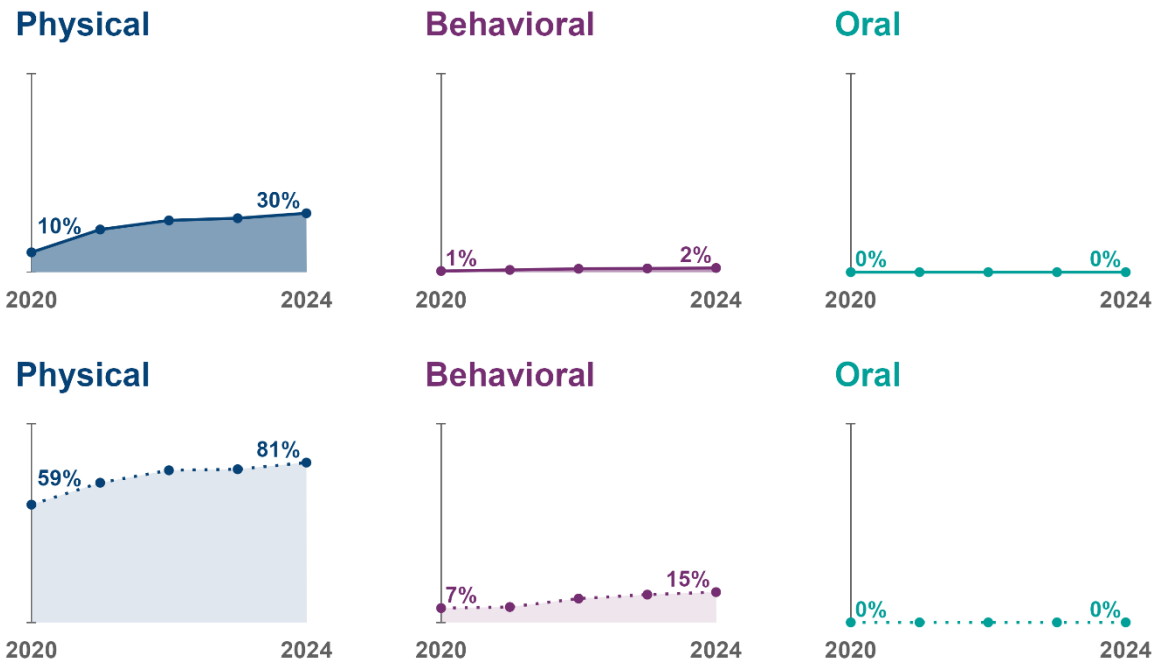
N: 1,001 Physical; 1,230 Behavioral; 314 Oral

Figure 20: HIE adoption among CCO-contracted physical, behavioral, and oral health organizations – PointClickCare



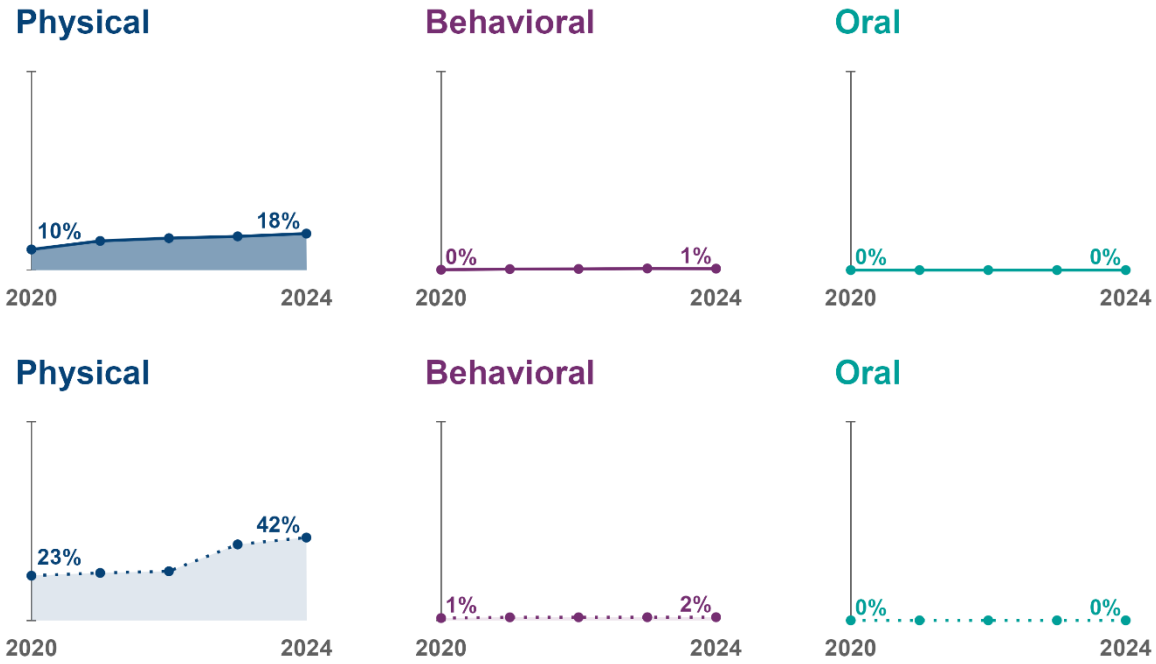
N: 1,001 Physical; 1,230 Behavioral; 314 Oral

Figure 21: HIE adoption among CCO-contracted physical, behavioral, and oral health organizations – Carequality



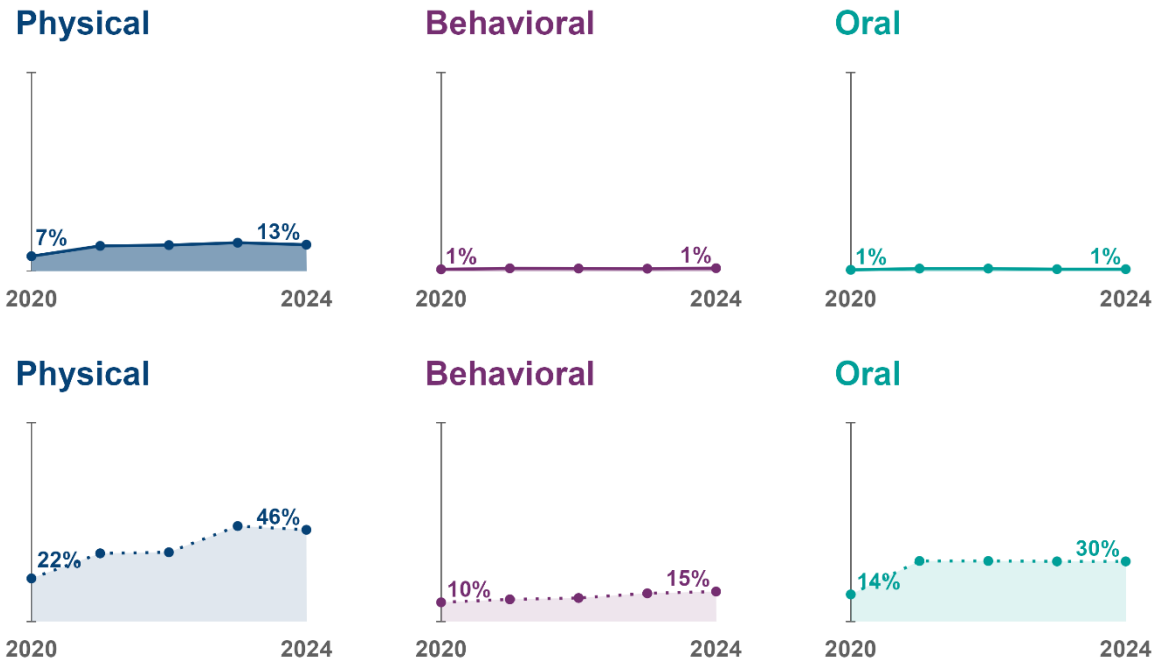
N: 1,001 Physical; 1,230 Behavioral; 314 Oral

Figure 22: HIE adoption among CCO-contracted physical, behavioral, and oral health organizations – CommonWell



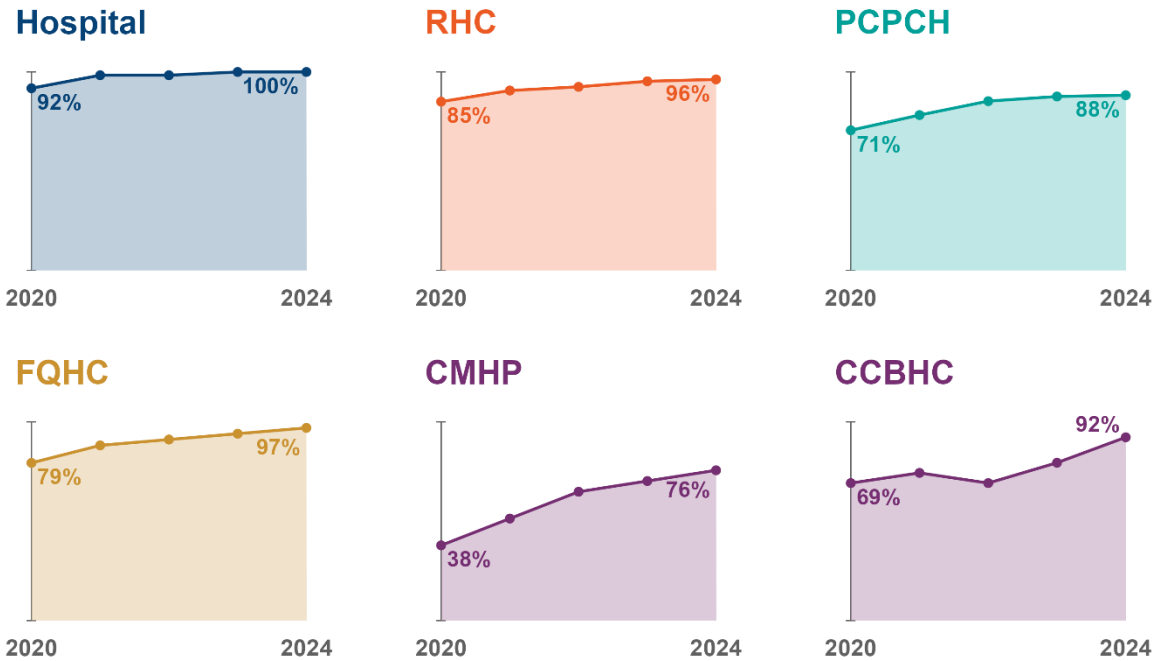
N: 1,001 Physical; 1,230 Behavioral; 314 Oral

Figure 23: HIE adoption among CCO-contracted physical, behavioral, and oral health organizations – <u>Reliance</u>



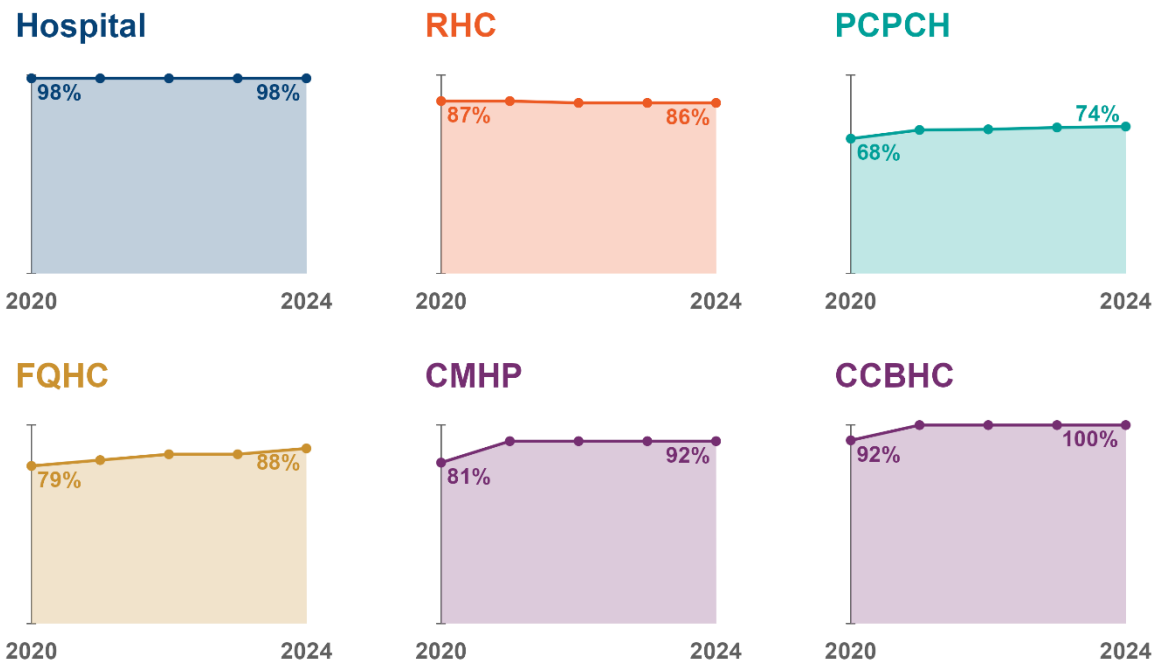
N: 1,001 Physical; 1,230 Behavioral; 314 Oral

Figure 24: HIE adoption among CCO-contracted key clinics – <u>Any HIE tool(s) for care coordination excluding PointClickCare</u>



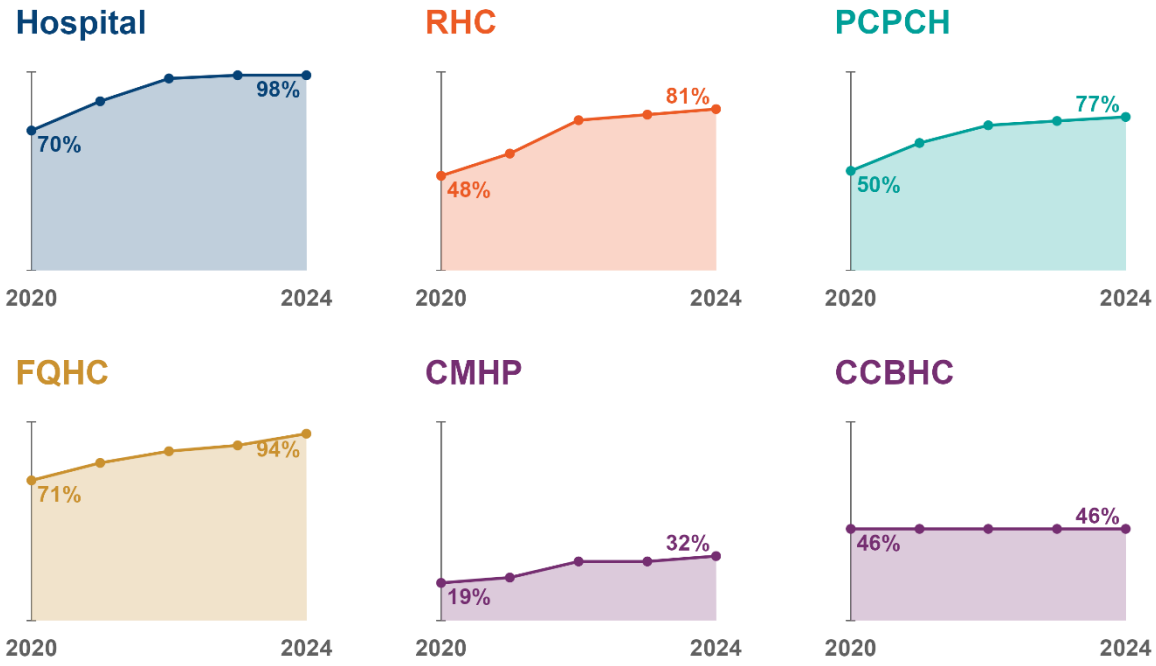
N: 61 hospitals; 107 RHCs; 640 PCPCHs; 34 FQHCs; 30 CMHPs; 12 CCBCHs

Figure 21: HIE adoption among CCO-contracted key clinics – PointClickCare



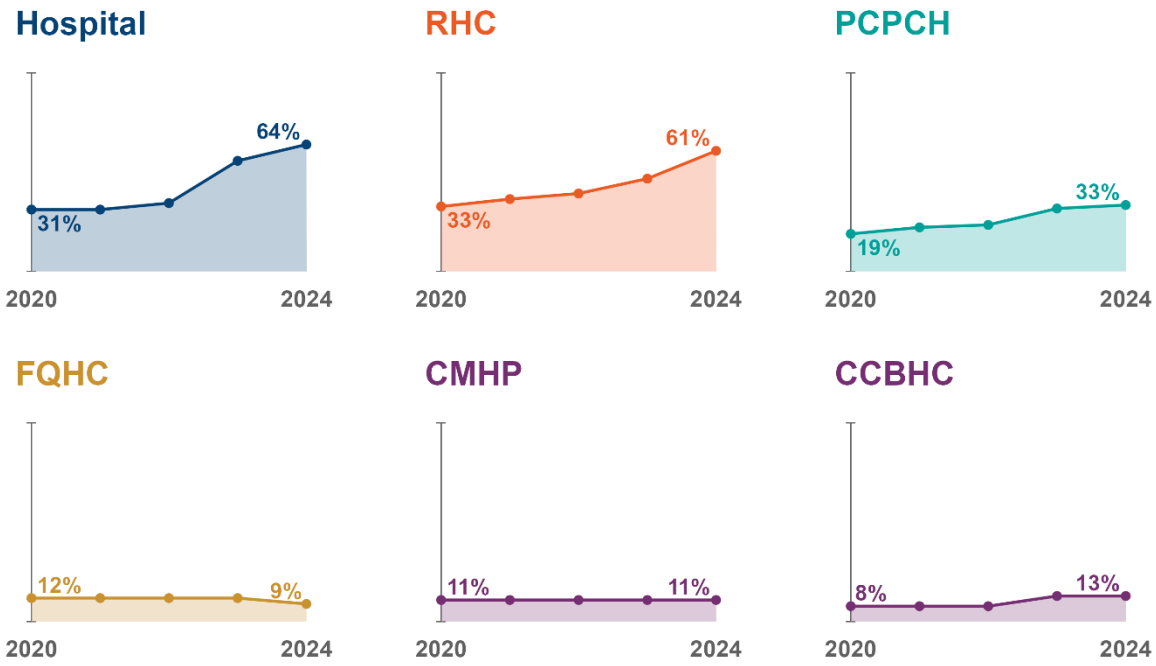
N: 61 hospitals; 107 RHCs; 640 PCPCHs; 34 FQHCs; 30 CMHPs; 12 CCBCHs

Figure 22: HIE adoption among CCO-contracted key clinics – Carequality



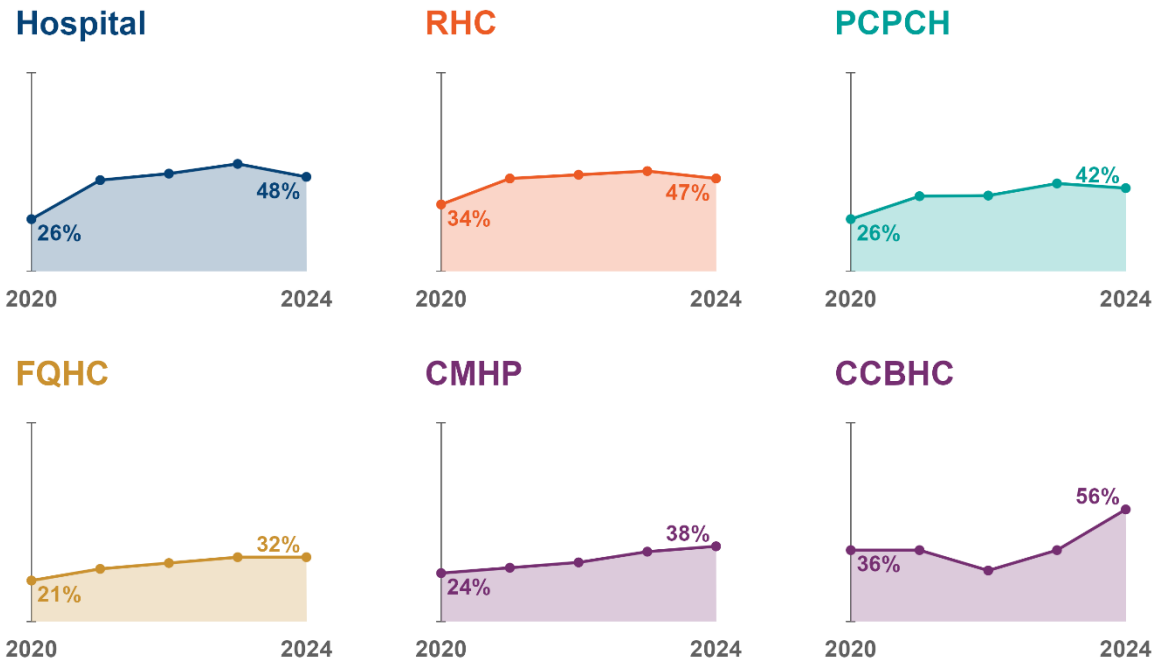
N: 61 hospitals; 107 RHCs; 640 PCPCHs; 34 FQHCs; 30 CMHPs; 12 CCBCHs

Figure 23: HIE adoption among CCO-contracted key clinics – <u>CommonWell</u>



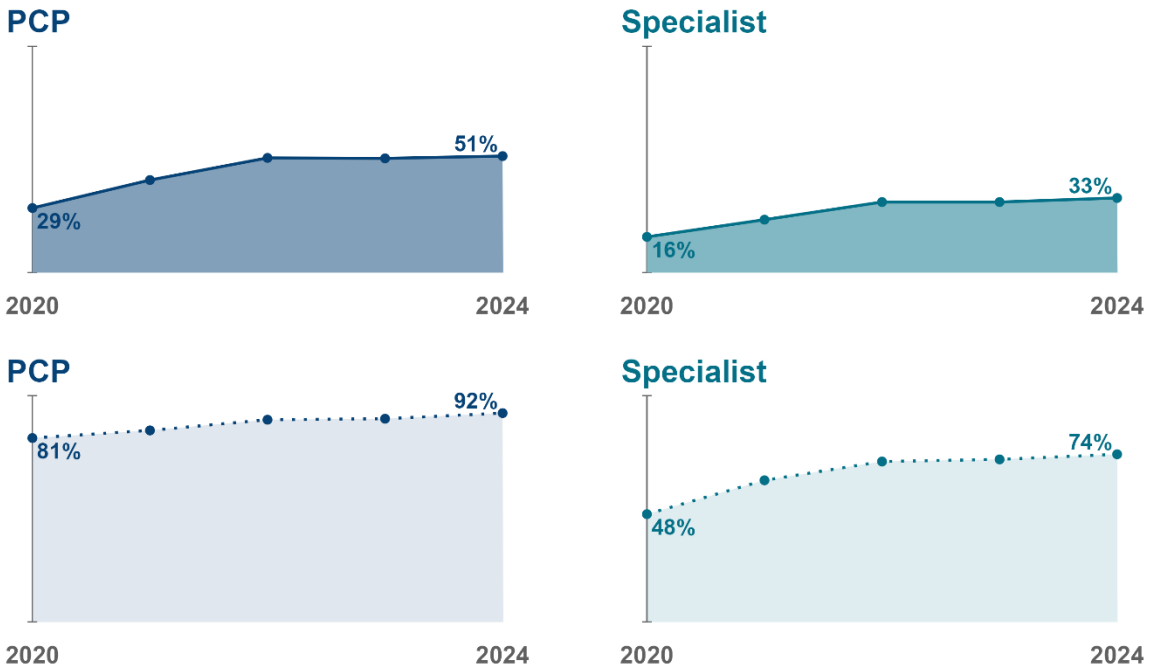
N: 61 hospitals; 107 RHCs; 640 PCPCHs; 34 FQHCs; 30 CMHPs; 12 CCBCHs

Figure 24: HIE adoption among CCO-contracted key clinics – <u>Reliance</u>



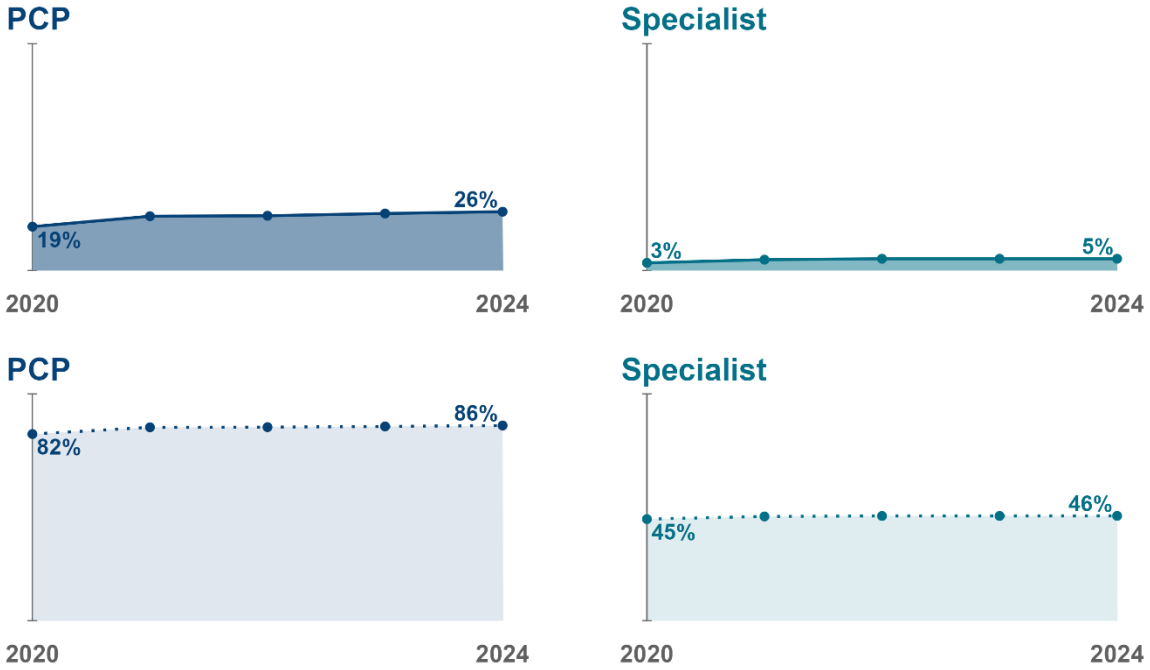
N: 61 hospitals; 107 RHCs; 640 PCPCHs; 34 FQHCs; 30 CMHPs; 12 CCBCHs

Figure 25: HIE adoption among CCO-contracted primary care and specialist physical health organizations – <u>Any HIE tool(s) for care coordination excluding PointClickCare</u>



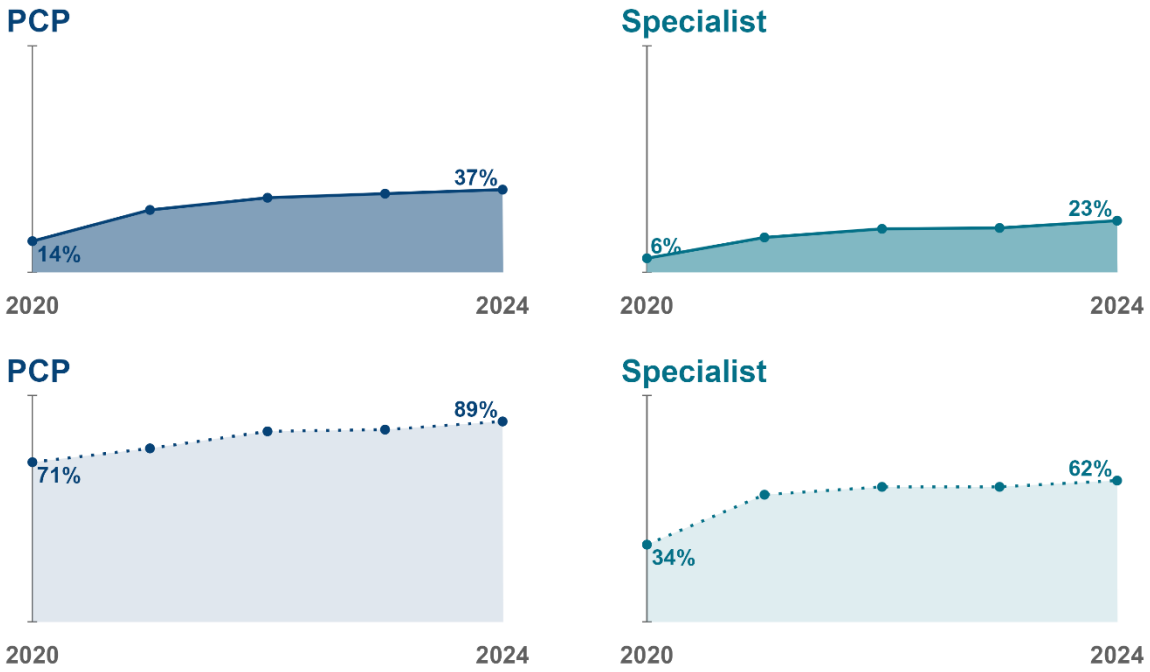
N: 509 PCP; 492 Specialist

Figure 26: HIE adoption among CCO-contracted primary care and specialist physical health organizations – <u>PointClickCare</u>



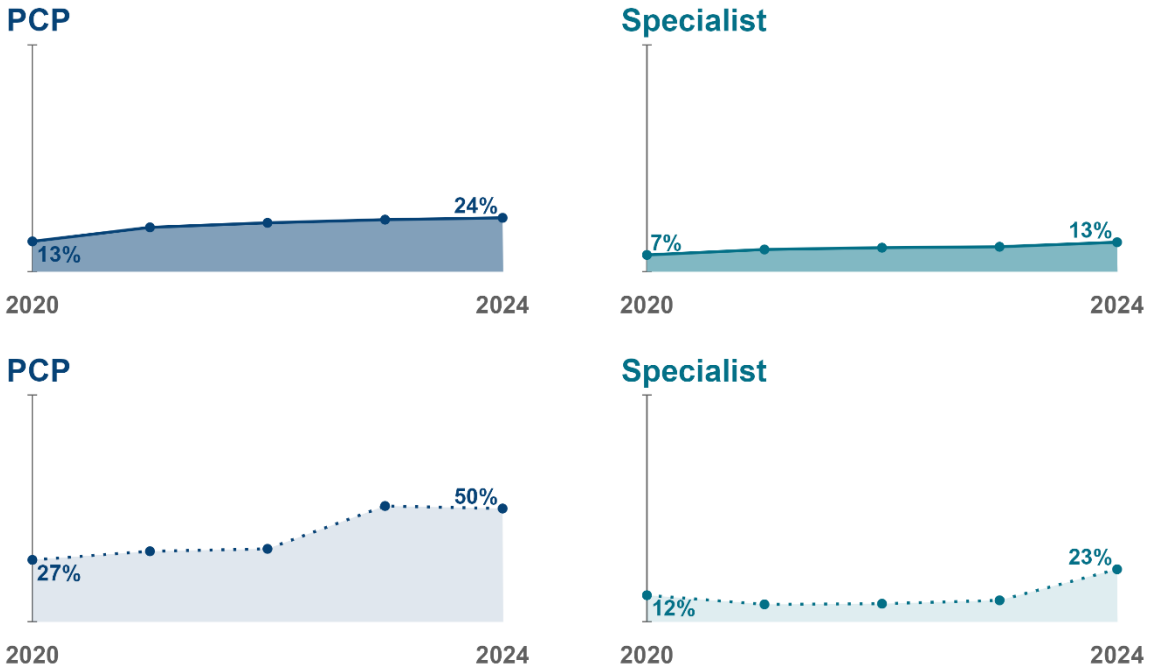
N: 509 PCP; 492 Specialist

Figure 27: HIE adoption among CCO-contracted primary care and specialist physical health organizations – Carequality



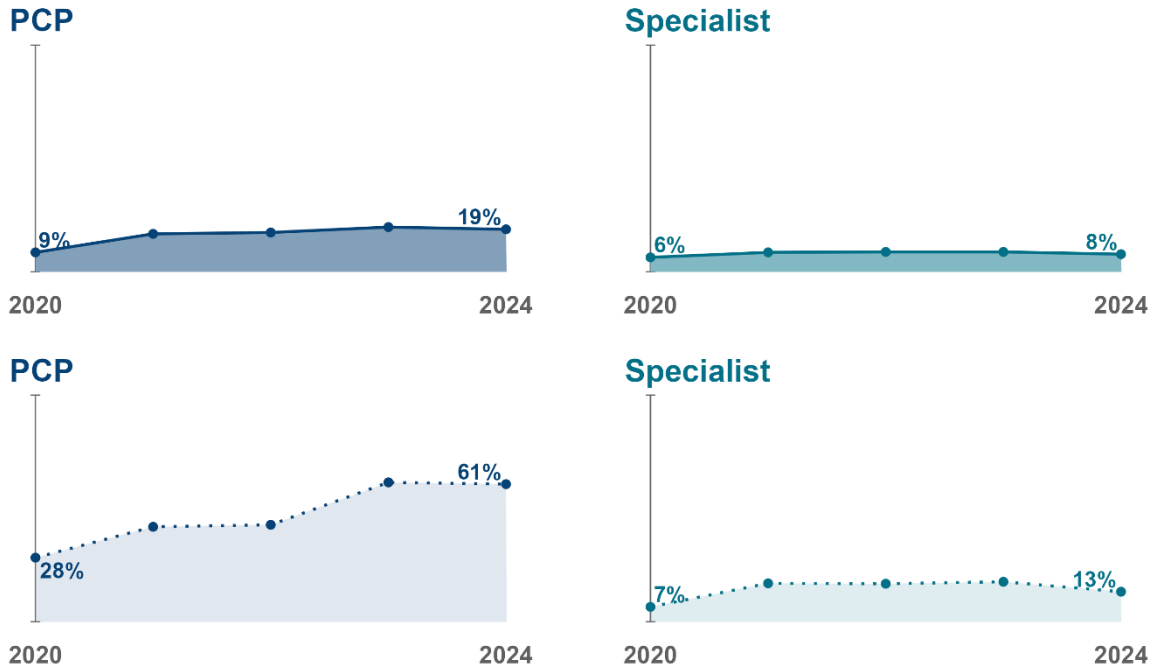
N: 509 PCP; 492 Specialist

Figure 28: HIE adoption among CCO-contracted primary care and specialist physical health organizations – CommonWell



N: 509 PCP; 492 Specialist

Figure 29: HIE adoption among CCO-contracted primary care and specialist physical health organizations – Reliance



N: 509 PCP; 492 Specialist

Appendix D: Definitions and examples of CCO strategies for supporting HIE

Table 1: HIE use within CCO - strategies defined

Care coordination and care management	CCO utilizes HIE or HIE tools to support care coordination, i.e., the deliberate organization of member care activities between two or more participants involved in a member's care to facilitate the appropriate delivery of services. Examples include: - Utilizing PointClickCare platform cohorts and reports as tools for addressing care coordination and population health management - Using an HIE tool to facilitate CCO referrals to care
Collaboration with network partners	CCO convenes regular touch points with external partners using HIE data and/or tools to help plan for the care of specific members. Examples include: - Multidisciplinary team meetings where CCOs, primary care providers, Community Mental Health Programs (CMHPs), dental providers, and/or public health agencies come together to assess specific members who have complex needs (possibly identified using HIE tools) and coordinate on shared care plans, which may be shared more broadly via HIE tools.
Integration into other system	CCO investment or other efforts related to integrating data from or to HIE tools or improving workflow between tools. Examples include: - Integrations between HIE tools and other CCO systems, e.g., a direct feed of ADT messages from PointClickCare into care management software to trigger follow-up activities - Integrating data into one tool for provider use to target/reduce provider fatigue from multiple platforms, Single-Sign-On to HIE in Provider Portal; and - Connecting tools to community-based organizations or other partners, incorporating SDOH service providers into care coordination and referral workflows.
Exchange of care plans and care information	CCO utilization HIE or HIE tools to upload care plans and care information so that it may be shared with across the continuum of care. Examples include: - Entering "Care Insights" into the PointClickCare platform to communicate valuable, relevant information to clinicians that may encounter the member in an ED setting - Attaching care plans to member records in an HIE tool so they are accessible to other providers on the member's care team using the tool
Enhancements to HIE tools	CCO investment or other efforts to improve HIE tools, often by enhancing functionality or adding data sources. Examples include: - HIE/provider portal functionality enhancements, such as ability to refer to CCO care coordination - Adding data related to high value use cases with HIE vendor, such as adding member diagnoses to provider portal, adding SDOH insights, PERC codes to identify priority populations such as Foster Care, Long Term Services and Supports, and Member's deemed ICC Eligible

	- Updating/upgrading care coordination tools to implement new capabilities Collaborating with HIE software vendors to improve system performance, speed, and adopting technical best practices like performance audits

Table 2: Increasing provider access to and use of HIE - strategies defined

Financially supporting HIE tools, offering incentives to adopt or use HIE, and/or covering costs of HIE onboarding	CCO provides funding (partial or complete) for HIE tool implementation, access, or use. Examples include: - Supporting regular, secure exchange of physical health information to dental plan partners to promote health for prioritized populations - Supporting care management or case management tools that support member care coordination efforts - Offering a health IT stipend for providers that meet certain benchmarks (e.g., connecting to Reliance HIE)
Enhancements to HIE tools (e.g., adding new functionality or data sources)	CCO investment or other efforts to improve HIE tools, often by enhancing functionality or adding data sources. Examples include: - HIE/provider portal functionality enhancements, such as the ability to refer to CCO care coordination - Adding data related to high value use cases with HIE vendor, such as adding member diagnoses to provider portal, or adding SDOH insights - Updating/upgrading care coordination tools to implement new capabilities - Collaborating with vendors to improve system performance, speed, and adopting technical best practices like performance audits - Collaborating with providers and partners on optimizing their use and exploring enhancements
HIE training and/or technical assistance	CCO uses staff, expertise, and resources to provide training or technical assistance to providers who are adopting or utilizing HIE tools. Examples include: - Assisting provider's office staff to access or onboard to an HIE tool or platform - Helping providers understand what information can be accessed through the tools they have access to, how to utilize an implemented tool for care coordination, or how to further optimize their use of current tools - Partnering with HIE tool vendors to provide technical assistance to providers/clinics - Augmenting CCO staff with HIE subject matter experts/coaches - Facilitating learning sessions or virtual training to providers on HIE best practices
Collaboration with network partners and others	CCO-created opportunities or forums for collaboration with network partners and providers on supporting HIE adoption. Examples include: - Collaborating on implementing high value HIE use cases (e.g., authorizations, care plans, BH internal care coordination use cases) - Partnering with HIE vendors on meeting needs of CCO and partners - Facilitating multidisciplinary steering committee/governance body that includes providers

	- Developing a regional approach, visioning, and strategic alignment with CCO partners, providers, community - Sharing best practices, use cases with CCO partners or across CCOs - Collaborating with DCOs and/or BH partners to encourage HIE - Coordinating with OHA and other CCOs to enhance data sharing under the transitions of care requirements
Assessment/ tracking of HIE adoption and capabilities	CCO-facilitated activity that results in the collection of data and increased understanding of providers' HIE capabilities, gaps, and barriers and can be used to inform HIE adoption strategy, resource allocation, and targets. Examples include: - Environmental scans/health IT ecosystem investigation - Provider surveys and interviews on HIE adoption and utilization, benefits, and concerns - Provider assessments of readiness and understanding of HIE tool(s) - Assessment of HIE products, EHR sharing capabilities, evaluating success of HIE strategies, and return on investment - Defining current state and future HIE capabilities needed - Compiling HIE use cases - HIE adoption/utilization tracking, including dashboard report for tracking and monitoring provider activity/use of an HIE tool, assessing volume/types of data contributed to HIE
Outreach and education about value of HIE	CCO-facilitated activity that encourages providers to adopt or use HIE for care coordination. Through various methods of outreach, CCO shares the value of HIE and business cases. Examples include: - Conducting introductory meetings with HIE vendors and providers to share benefits of HIE - Conducting face to face meetings, sending letters/emails/newsletters, or making phone calls to providers to explain impact of HIE on patient and clinic outcomes - Developing a provider engagement plan - Educating providers and provider staff on existing HIE capabilities, benefits, and successful use cases - Encouraging the adoption of HIE technology among oral health and behavioral health providers
Integration of disparate information and/or tools with HIE	CCO investment or other efforts related to integrating data from or to HIE tools or improving workflow between tools. Examples include: - Integrations with EHRs, such as HIE into EHRs, ingesting EHR data into care coordination/population management tools, integrating EHRs for referrals into CIE, integrating primary care, behavioral health and DCO EHRs to connect directly - Integrating data including, ADT data from Collective into care coordination or population management tools, dental claims, COVID data, HIE data into quality programs as supplemental data

	- Consolidating information across systems, integrating data within our enterprise data warehouse, providing claims data to providers, developing "claims + EHR" data set for members - Integrations between tools such as: between population management, care coordination, and/or HIE tools - Integrating data into one tool for provider use to target/reduce provider fatigue from multiple platforms, Single Sign On to HIE in Provider Portal - Connecting tools to community-based organizations or other partners, incorporating SDOH service providers into care coordination and referral workflows.
Requirements in contracts/provider agreements	CCO has included requirements in provider contracts/agreements around HIE or use of HIE tools. Examples include: - Adding requirements for HIE adoption and/or use - Adding requirements for digital authorization and claims submission for In-Network providers - Including language in hospital contracts that set expectations for use of a particular HIE tool
Offer hosted EHR product (that allows for sharing of information between clinics using the shared EHR and/or connection to HIE)	CCO supported the implementation of cloud-based EHR in the community that gives providers access to HIE functionality

Appendix E: Definitions and examples of CCO strategies to use health IT to support SDOH needs

Table 1: Using Health IT to Support SDOH Needs <u>Within CCO</u> Strategies Defined (strategy order follows Figures 31 and 32, respectively)

Implementation of health IT tool/capability for social needs screening and referrals	CCO adoption of health IT tool(s) that supports social needs screening and referrals, such as: - Connect Oregon/Unite Us - findhelp - PRAPARE screening through Activate Care
Care coordination and care management of individual members	CCO uses health IT that supports care coordination and care management of individual members' SDOH needs, i.e., the deliberate organization of member care information and activities between two or more participants involved in a member's care to facilitate the appropriate delivery of health care services. Examples include: - Essette for Health Risk Survey and referral tracking - Using the GSI care coordination platform
Use data to identify individual members' SDOH experiences and social needs	CCO uses member data to identify and address their individual SDOH-related needs. Examples include: - Working with data science contractor to enhance identification of SDOH-related needs - Collecting and tracking z-codes - Using Arcadia to combine EHR, REALD, social service and claims data
Collaboration with network partners	CCO-created opportunities or forums for collaboration with network partners, providers, and CBOs on supporting health IT adoption to support SDOH needs. Examples include: - Collaborating on implementing high value CIE use cases - Partnering with shared vendors on meeting needs of CCO and partners - The creation of a multidisciplinary steering committee/governance body that includes providers and CBOs - Developing a regional approach, visioning, and strategic alignment with CCO partners, providers, community - Sharing best practices, use cases with CCO partners, across CCOs - Collaborating with BH (and dental) partners to encourage health IT tools to support SDOH needs
CCO metrics support	Activities to support metrics and compliance with required metrics. For example: - Incorporating CIE referral volume criteria into quality pool payment methodology for the SDOH screening metric

Participate in SDOH-focused health IT collaboratives, convening, and/or governance	CCO participation in workgroups, convenings, collaboratives, and group decision-making processes, including: - Participating in statewide advisory committees, such as the former CIE Workgroup - Participating in local and regional convenings or advisory groups - Participating in learning collaboratives and best practice sharing
Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources)	CCO investment or other efforts to improve health IT tools for screening and closed-loop referrals, often by enhancing functionality or adding new features. Examples include: - Updating/upgrading CIE tools to implement new capabilities - Adding specific screening tools to CIE like the Accountable Health Communities' social needs screening tool - Adding a fillable health-related services funds form to CIE
Integration or interoperability of health IT systems that support SDOH with other tools	CCO integrates health IT systems or data that support SDOH with other health IT tools. For example: - Integrating member profiles into Connect Oregon/Unite Us (Bi-directional interfaces)
Use data for risk stratification	CCO uses member data to support risk stratification efforts, i.e., identifying/segmenting member populations by risk levels to support resource distribution planning and other care coordination activities. Examples include: - Matching eligibility files to community behavioral health reports and claims data - Johns Hopkins ACG system for risk segmentation - Using VBP software for PCPM, CPC+ and IBH programs - Using Reliance to stratify populations
Use health IT to monitor and/or manage contracts and/or programs offered to meet members' SDOH needs	CCO uses health IT and member data to monitor and evaluate ongoing efforts to address members SDOH-related needs. For example: - Compiling member information to evaluate social risk for use in determining value-based payments
Other strategies to use health IT to support SDOH needs	CCO pursued and implemented other strategies that support internal efforts to support members SDOH-related needs with health IT. Examples include: - Build and maintain a data warehouse for SDOH and REALD data - Coordinated with the Oregon Department of Human Services' Office of Resilience and Emergency Management on tools and data for emergency response

Table 2: Using Health IT to Support SDOH Needs <u>Among Contracted Providers</u> Strategies Defined

Sponsor CIE for the community	CCO supports and implements a CIE platform for clinical providers and CBOs. Examples include: - Contracting with CIE vendors and financially supporting the costs of CIE for community use, including CCO contracted providers and CBOs. - Coordinating with clinicians, CBOs, and community partners to identify a CIE platform to sponsor - Providing guidance to providers and CBOs about data confidentiality
Outreach and education about the value of health IT adoption/use to support SDOH needs	CCO-facilitated activity that encourages providers and CBOs to adopt CIE tool into their workflows. Through various methods of outreach, CCO shares value of health IT tools and use cases. Examples include: - Developing a provider/CBO engagement plan - Conducting introductory meetings with CIE vendors and providers to share benefits of CIE - Conducting face to face meetings, sending letters/emails/newsletters, or making phone calls to providers to explain impact of CIE on patient and clinic outcomes - Conducting webinars - Educating CBOs and providers on existing CIE capabilities, benefits, and successful use cases - Sharing the value and encouraging the adoption of CIE technology among oral health and behavioral health providers
Assessment/tracking of CIE/SDOH tool adoption and use	CCO-facilitated activity that results in the collection of data and increased understanding of providers' and CBOs' access to health IT tools to support SDOH and gaps and barriers to adopting and utilizing those tools that can be used to inform CCO strategy, resource allocation, and targets. Examples include: - Environmental scans - Tracking usage of tools by CBOs and providers via reports from vendor - Tracking screened needs and services that are searched, referred, and provided to determine if the services available meet the needs of the individuals in the community - Provider surveys and interviews on CIE adoption and utilization, benefits, and concerns - Provider assessments of readiness and understanding of CIE tool(s) - Assessment of CIE products, EHR data sharing capabilities, evaluating success of CIE strategies, and return on investment (in the context of adoption and/or use) - Defining current state and future CIE capabilities needed - Compiling current and future CIE use cases
Training and/or technical assistance	CCO has staff or contracts with entities, expertise, and resources to provide training or technical assistance to providers and CBOs who are adopting or utilizing health IT tools to support SDOH needs. Examples include: - Training CBO staff on how to change their workflows and utilize CIE to screen and refer members - Technical support for CIE use for providers and CBOs

	- Helping providers and CBOs understand what information can be accessed through the tools they have access to, how to utilize an implemented tool, or how to further optimize their use of current tools - Partnering with CIE tool vendor to provide technical assistance to providers/clinics - Facilitating learning collaboratives or virtual training to providers and CBOs on best practices - TA for contracted CBOs to enter into legal agreements to share de-identified data
Financial support to adopt or use health IT that supports SDOH (e.g., incentives, grants)[11]	CCO directly providing, or coordinating through partners, provision of grants, financial support, or incentives for providers and CBOS related to using tools to support SDOH, including CIE. Excludes sponsorship of CIE, as that is a distinct strategy. Examples include: - Providing support for implementation costs - Providing grants or incentives to CBOs to adopt and use CIE tools - Offering incentives for providers and CBOs to use CIE for referrals and screenings - Providing incentives tied to achieving results of value-based payment arrangements - Developing a VBP that incentivizes the use of CIE - Other types of financial support for clinical providers and CBOs
Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources)	CCO investment or other efforts to improve health IT tools for screening and closed-loop referrals, often by enhancing functionality or adding new features. Examples include: - Adding ability to cross-reference client identifiers within the CIE with Member Status information from MMIS to validate eligibility status at the time of service - Adding ability to cross-reference and clean up data on member addresses using the United States Postal Service elements to enhance ArcGIS mapping - Adding ability to cross-reference and clean up data on Contracted Provider, Contracted Social Care Provider, and Community Based Organization addresses using the United States Postal Service elements to enhance ArcGIS mapping
Integration or interoperability of health IT systems that support SDOH with other tools	CCO investment or other efforts related to integrating data from or to health IT systems that support SDOH tools or improving workflow between tools. Examples include: - Integration with EHR, integrating EHRs for referrals into CIE - Integrating data including - Integrations between tools such as: between care coordination and/or CIE tools - Integrating data into one tool for provider use to target/reduce provider fatigue from multiple platforms

[11] Note: two similar categories were combined

	- Connecting tools to community-based organizations or other partners, incorporating SDOH service providers into care coordination and referral workflows.
Support participation in SDOH-focused health IT collaboratives, education, convening, and/or governance	CCO supports and encourages provider organizations and CBOs to participate in SDOH-focused health IT collaboratives, convening, education, and/or governance. Examples include: - Facilitating community meetings - Actively encouraging partners to engage in governance - Providing stipends or grants for CBOs to participate in activities
Support CBOs sending of referrals to clinical providers (i.e., to physical, oral, and behavioral health providers)	CCO supports efforts to use health IT to send referrals to clinical providers. For example: - Supporting a referral pathway for SUD treatment by leveraging community-based Peer services and using the CIE platform to facilitate and track referrals.
Requirements in contracts/provider agreements	CCO has included requirements in provider contracts/agreements around the adoption and/or use of health IT tools to support members' SDOH needs. For example: - Including language in contracts that sets expectations for using and/or contributing data to a CIE tool
Utilization of health IT to support payments to CBOs	CCO supports the use of health IT to facilitate payments to CBOs. Implement payment modules within CIE and assist partners with using these features for reimbursement
Other strategies for supporting adoption of <u>CIE or other health IT</u> to support SDOH needs	CCOs implemented additional health IT strategies in support of meeting members' SDOH needs among their contracted providers and CBOs. Examples include: - Creating a 5-year health IT plan - Using CIE/SDOH screening to support population health management
Other strategies for supporting access or use of <u>SDOH-related data</u>	CCO implements additional efforts to support access to or use of SDOH-related data. Examples include: - Financial modeling looking at risk agreements: compiles data (eligibility, claims, risk) and incorporates alongside EHRs - Making data available in the provider portal

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