2025 CCO Health IT Roadmap Summary: Health IT to Support Social Determinants of Health Needs

Introduction

Each year, Oregon's Coordinated Care Organizations (CCOs) are required to submit a Health Information Technology (IT) Roadmap[1] to the Oregon Health Authority (OHA) outlining their strategies for accomplishing health IT goals. In the three major sections of the Roadmap, CCOs describe how they use health IT and how they support community-based organizations (CBOs) and social service providers, and their contracted physical, behavioral, and oral health providers with health IT, including:

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

This document summarizes the CCO strategies for health IT to support SDOH needs submitted in the Health IT Roadmaps in April 2025. It describes CCOs' 2024 activities and their plans for 2025-2026 both within the CCO and to support their contracted providers, social service providers, and CBOs (partners). It also includes a summary of health IT use to support Health-Related Social Needs (HRSN) Services, both within the CCO and CCO support for HRSN service providers. CCO strategies and investments have potentially changed since the 2025 Roadmaps were submitted. **The 2025 Roadmaps include responses from 12 different CCO parent organizations, which represent all 16 CCOs.**

This summary includes:

- CCO-implemented and -supported health IT tools for SDOH
- CCO internal strategies for using health IT for SDOH
- CCO strategies for supporting partners with health IT for SDOH
- CCO strategies for using health IT to support HRSN service provision within the CCO and for HRSN providers

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[1] Redacted 2025 CCO Health IT Roadmaps will be posted on OHA's CCO Health IT Advisory Group website: https://www.oregon.gov/oha/HPA/OHIT/Pages/HITAG.aspx.

- Spotlights and Honorable Mentions for noteworthy strategies
- CCO-identified barriers to supporting health IT for SDOH
- Requests for how OHA can support health IT use for SDOH

Given that SDOH have greater impacts on health outcomes than clinical care[2], leveraging health IT to address members' SDOH needs has become more critical and required substantial investment from CCOs. Care coordination needs and health care transformation shifts continue to demand substantial CCO attention and innovative planning. CCO progress and planning have similarly been driven by the SDOH: Social Needs Screening and Referral CCO incentive metric[3] and the 2022-2027 1115 Medicaid Demonstration Waiver[4], in particular to address HRSN[5].

Health IT tools for SDOH implemented and supported by CCOs

CCOs have implemented a variety of health IT tools to support SDOH needs (see *Figure 1* below). These include community information exchange (CIE)[6], care and case management, population health management, and data analytics tools. Each serves a different purpose and many serve more than one purpose to help CCOs identify and support members' SDOH needs.

The majority of tools listed below are used within the CCO to support CCO activities such as identifying member SDOH needs, population health, care coordination, and care management. CCOs also support contracted provider and CBO use of some of these tools; for example, CCOs may help get partners set up to receive and respond to referrals or they may use tools to support partners by providing relevant information in the form of reports or dashboards. Some tools, like CIE, are used by both CCOs and their partners.

Some changes from last year include a decrease in CCOs mentioning use of Reliance HIE to support SDOH, and one fewer CCO mentioned using a CCO Data Warehouse to support SDOH work.

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.

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[2] Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135.

[3] https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx

[4] https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Waiver-Renewal.aspx

[5] https://www.oregon.gov/OHA/HSD/Medicaid-Policy/Pages/HRSN.aspx

[6] For more information about CIE, see: https://www.oregon.gov/oha/HPA/OHIT/Pages/CIE-Overview.aspx

Figure 1: 2024 & 2025-2026 Health IT tools used to support SDOH needs

Type of tool	Tool	# of CCO orgs (n=12)
Community Information Exchange	Connect Oregon/Unite Us	11
	Findhelp (aka Healthy Klamath Connect)	1
Care/case management/	Epic Compass Rose	3
	CCO Provider Portal (not otherwise specified)	2
	TriZetto Clinical CareAdvance (Cognizant)	2
	Activate Care	1
	HMS Essette	1
	Phreesia	1
	Smartsheet (HRSN)	1
	TruCare	1
	VirtualHealth HELIOS	1
Population health management/Data analytics	CCO Data Warehouse	3
	Johns Hopkins ACG GeoHealth module	3
	Arcadia	2
	Epic Healthy Planet	2
	Centelligence Data Hub	1
	Dynamo/Case Trakker	1
	Innovaccer Population Health Tool	1
	Tableau	1
Payment and eligibility	HealthTrio	3
	EZ-CAP	1
Other tools	Epic Payer Platform	4
	PointClickCare (fka Collective Medical)	4
	CCO Member Portal	2
	Epic Care Everywhere	2
	Reliance eHealth Collaborative	2
	Blackbaud Grant Management	1
	HRSN Service Request webform	1

*The 2025 Roadmaps include responses from 12 different CCO parent organizations, representing all 16 CCOs.

CCO strategies for health IT to support SDOH needs

This summary reflects strategies reported by CCOs in the Health IT to Support SDOH Needs: 2024 Progress and 2025-2026 Plans sections of their Health IT Roadmaps. These strategies may not reflect everything a CCO is doing. *Figure 2* includes the number of CCO parent organizations that reported using different strategies within CCO, while *Figure 3* includes the number that reported using different strategies to support their partners. Tables 1 and 2 in *Appendix A* include additional details about what has been included in each strategy category.

Within CCO

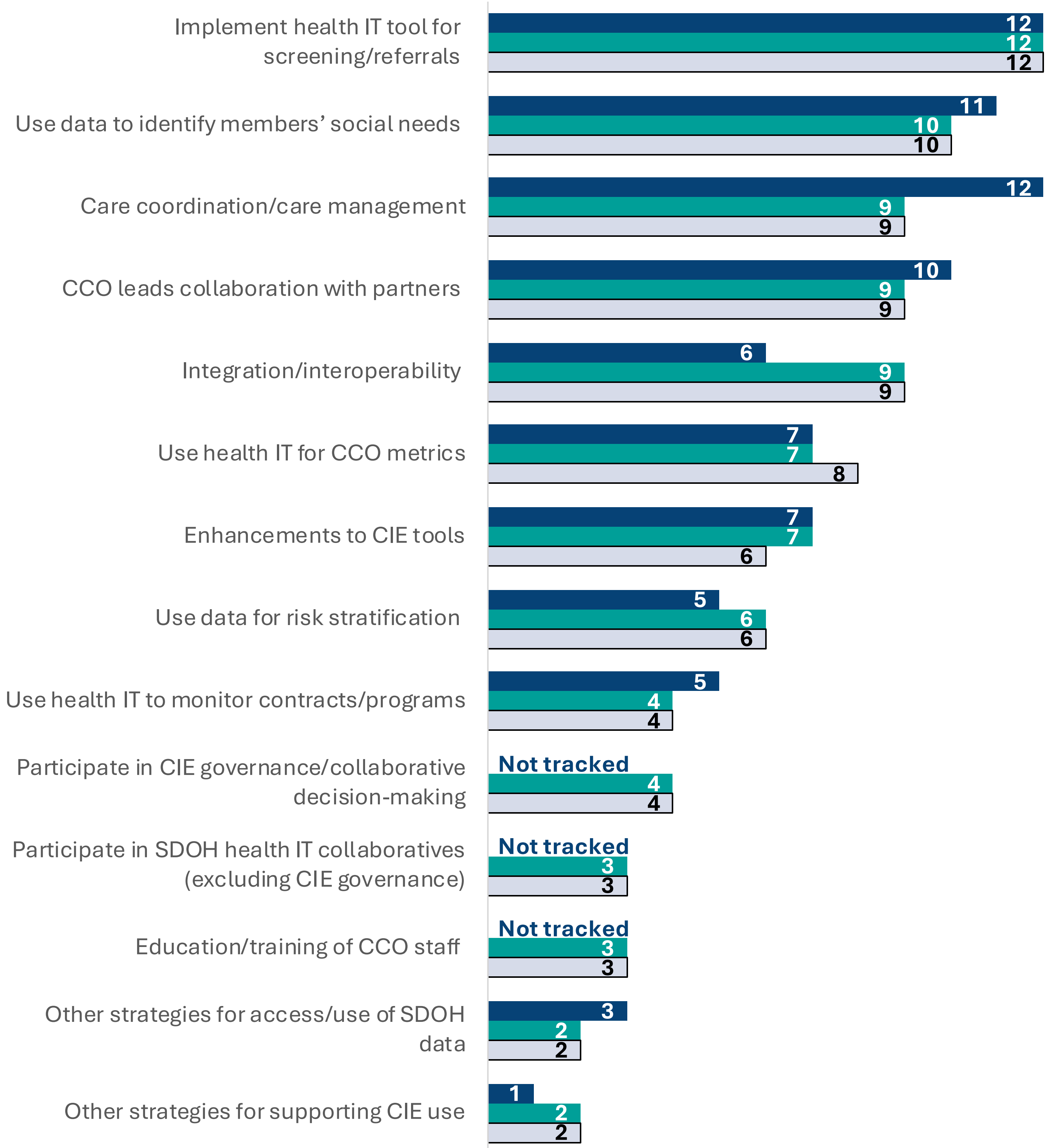
All CCOs implemented health IT for social needs screening and referrals in 2023 and 2024, and all CCOs plan to continue these strategies into 2025-2026 (see *Figure 2*). Although fewer CCOs reported on strategies in the following categories in 2024 compared to 2023, they remained a high priority among the majority of CCOs:

- Use data to identify members' SDOH experiences and social needs
- Care coordination and care management
- CCO-led problem solving efforts and collaboration with their partners

CCOs are placing increased emphasis on integration or interoperability of health IT systems that support SDOH with other tools. Use of data for risk stratification has also seen an upward trend from 2023 to 2024. A majority of CCOs maintained focus on strategies related to using health IT to support CCO metrics related to SDOH, with one additional CCO planning to pursue this in 2025-2026. Most CCOs also maintained focus on strategies related to enhancements to CIE tools, such as adding a new functionality. Use of health IT to monitor or manage contracts/programs to meet members' SDOH needs saw a small drop between 2023 and 2024.

A new strategy was tracked this year for education/training of CCO staff about the value and use of health IT to support SDOH needs, which three CCOs reported on. Additionally, four CCOs reported strategies related to participation in CIE governance or collaborative decision-making in 2024. This was tracked separately from strategies related to participation in SDOH-focused health IT convenings, collaboratives, or education that are not focused on CIE governance this year, for which three CCOs reported related efforts. CCOs plan to maintain all three of these strategies through 2026.

Figure 2: 2023, 2024 & 2025-2026 Strategies for health IT to support SDOH needs within CCO



Supporting partners

In supporting providers and CBOs, all CCOs have maintained their sponsorship of CIE platforms for the community (see *Figure 3*). All CCOs reported 2024 strategies focused on training and technical assistance (TA), an increase from 2023. Almost all CCOs continued to prioritize outreach and education about the value of health IT to support SDOH needs in 2024, although one fewer CCO reported on the strategy than in 2023.

From 2023 to 2024, more CCOs focused on using health IT to support payments to CBOs, likely impacted by the efforts to support HRSN benefit processes. There is also an upward trend in supporting referrals between CBOs and clinical providers (i.e., to physical, behavioral, and oral health providers) as well as enhancements to CIE tools to support contracted providers and CBOs.

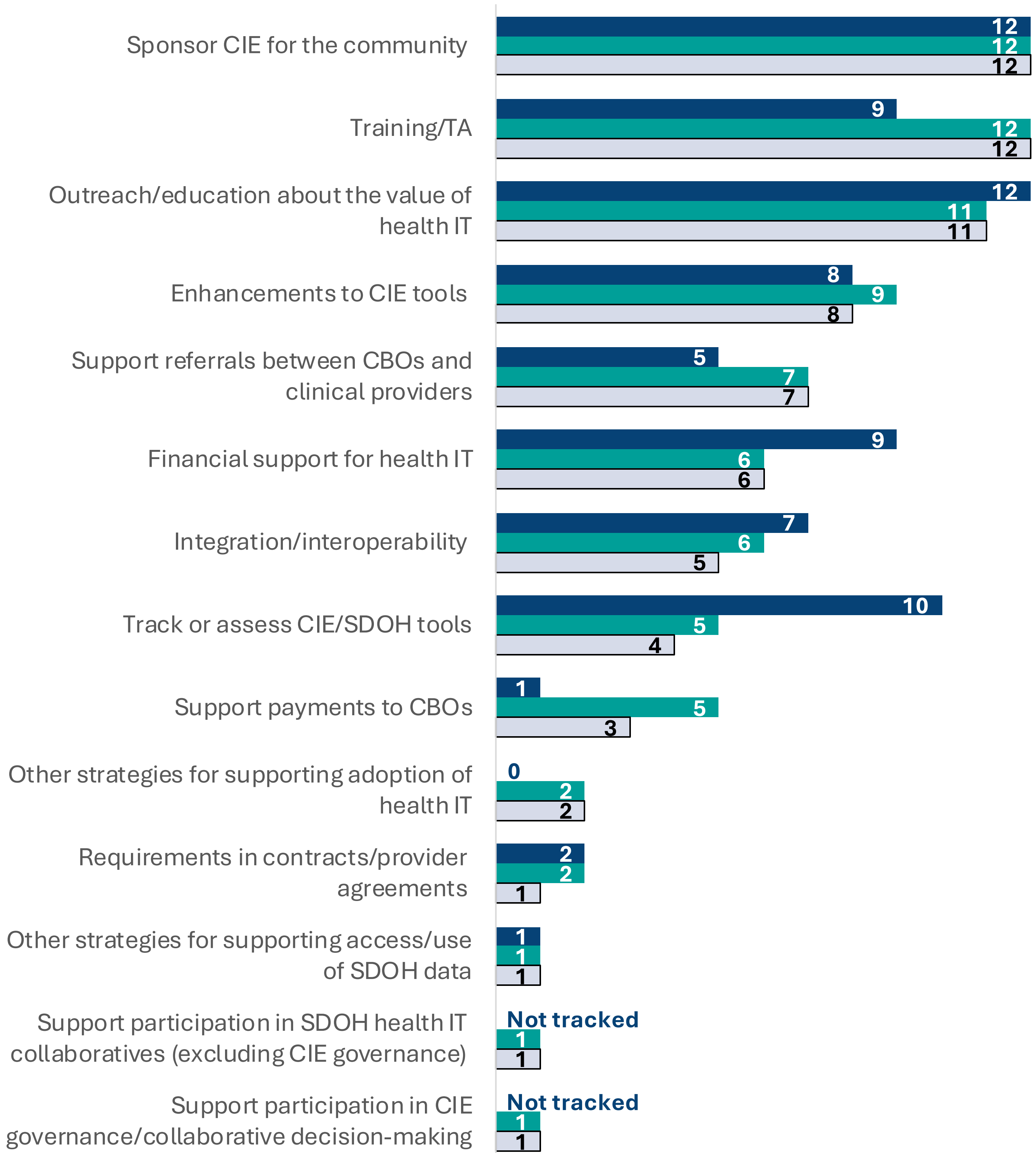
Fewer CCOs reported on strategies in the following categories in 2024:

- Track or assess CIE/SDOH tool adoption and use
- Financial support to adopt or use health IT that supports SDOH, such as incentives or grants to providers and CBOs
- Integration or interoperability of health IT systems that support SDOH with other tools (Of note, more CCOs reported on this strategy within CCO instead)

Requirements to use health IT in contracts and provider agreements have seen minimal changes, with a small decrease in the number of CCOs continuing to pursue this type of strategy. One CCO reported on supporting participation in SDOH-focused health IT collaboratives, education, and convening and another reported on supporting partner participation in CIE governance or collaborative decision-making.

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

Figure 3: 2023, 2024, and 2025-26 Strategies for health IT to support SDOH needs for providers and CBOs



CCO strategies for health IT to support health-related social needs (HRSN) services

CCOs used existing health IT tools and added some targeted tools and efforts to implement HRSN services. Most CCOs are using CIE for HRSN closed loop referrals. Other health IT in use by CCOs includes SmartSheet and case management programs. Some CCOs reported using CIE for HRSN invoicing/billing. CCOs reported a variety of different strategies for using health IT to support HRSN Services, with a few highlighting that implementation of the HRSN benefit drove CIE adoption and required process and workflow changes at the CCO and provider levels. The health IT strategies that CCOs used to administer HRSN benefits included technology and workflows related to closed loop referrals, HRSN payments and invoicing, and support for CCO staff and providers involved in the HRSN benefit such as training and financial support. Several unique successes and challenges also emerged from CCO reporting.

Closed loop referrals

CCOs' health IT strategies for HRSN focused on developing and refining processes and workflows to implement the HRSN benefit, including the use of CIE and other health IT platforms to make, receive, and track closed loop referrals for HRSN services. CCOs also worked to reduce barriers to member HRSN requests, with a few reporting launching external-facing request forms on their websites that could be used to direct member requests to HRSN or to other appropriate programs, like Flexible Services (formerly called Health-Related Services), in instances where a member was ineligible or their request was outside the HRSN benefit scope. CCOs invested significant resources in improving automation, standardizing processes, training CCO staff, and developing accurate reporting. Some CCOs needed to hire and onboard new staff to meet the demands of the HRSN program and high volume of requests being received after its launch.

CCO strategies to support provider health IT use also centered on development and streamlining of processes and workflows, as well as training. There was variation across HRSN providers' adoption of CIE. While some CCOs indicated most of their partners were using CIE for HRSN referrals, one CCO reported that because HRSN vendors are not currently required to use CIE, they are continuing to use the phone to communicate with HRSN housing remediation and modification vendors. CCOs also used health IT to monitor the timeliness of referrals and service delivery by HRSN providers. Multiple CCOs reported gathering user feedback to streamline and improve processes, and to inform requests for system enhancements from CIE vendors to ensure systems aligned with user needs and HRSN benefit requirements. Overall, CCOs reported plans to continue CIE use for HRSN service referrals, and to continue exploring further enhancements and process updates to improve user experience.

Authorization, invoicing, and payments

CCOs reported a range of approaches to invoicing and payment for HRSN services, including developing ways to track authorizations and establishing new capabilities for payments specific to the HRSN benefit. CCOs also developed processes to identify member eligibility such as through review of multiple data sources and the creation of flags in health IT systems. Four CCOs have reported

adopting the Unite Us invoicing and payments module to enable invoicing and billing for HRSN services, however other health IT platforms are also being used for billing, such as SmartSheet and other internal systems. One CCO indicated they are developing a payments module as part of an existing webform to allow providers to request payments.

CCOs coordinated with vendors to identify system enhancements. Some CCOs are collaborating with each other and the Oregon Health Leadership Council (OHLC) to strategize, plan, and implement the Unite Us payments module. Some requested enhancements including support for retroactive billing, editing authorization requests, and applying authorization caps and variable rates related to HRSN services. One CCO is customizing Findhelp for HRSN housing claims and billing. CCOs continue to monitor whether current health IT solutions meet their needs; one CCO reported plans to explore other platforms, such as HealthTrio, for HRSN invoicing.

Support

Strategies related to support focused on assessing readiness and training of CCO staff and providers, as well as providing financial support. To support their provider networks, CCOs monitored their networks for gaps, conducted focused outreach to potential providers, and explored barriers to their participation in HRSN and related health IT like CIE. Provider support took a variety of forms including individual training, weekly meetings, monthly group meetings or workgroups, webinars, and onboarding trainings. Training subjects included specific HRSN benefits such as housing and nutrition, closed loop referrals, authorizations, claims, reporting, and specific CCO tools such as provider portals. In addition to in-person trainings and one-on-one support, some CCOs developed workflow documents, CIE guides, and flyers for providers. CCOs also provided education about and supported providers to enroll as Medicaid providers to be able to bill for HRSN services.

Support for HRSN providers was also provided by CCOs through incentives and financial support such as Community Capacity Building Funds (CCBF) and other grants. Some CCOs elicited partner feedback to better develop their HRSN service provider networks and to review and approve CCBF applications. While some CCOs reported that they awarded CCBF funds to most of the HRSN providers in their network, other CCOs focused their CCBF awards on providers of specific HRSN benefits such as housing, nutrition, and outreach & engagement. Some others focused on awarding CCBF to support health IT use, such as for CIE adoption, systems to monitor and report on HRSN, or adjusting providers' existing health IT systems such as care coordination or EHR platforms to better align with the functionality needed to support HRSN.

Challenges and Successes

Challenges that CCOs encountered in using health IT for HRSN related broadly to change management, implementing new workflows, adapting technology, and the capacity of their networks to implement new benefits and systems. Specifically, CCOs faced challenges contracting and onboarding new HRSN providers, managing the volume of new HRSN requests, and adopting new or updating existing technology to adequately meet the needs and demands of the new HRSN benefit. Multiple CCOs highlighted that the demands of HRSN implementation required a significant amount

of time and attention, and one mentioned they could not focus on other health IT goals for SDOH such as expanding use of CIE beyond HRSN.

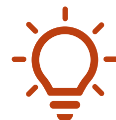
Despite these challenges, several CCOs reported success in expanding their networks of HRSN providers in 2024, meeting their organizational goals for HRSN referrals and service delivery, and were able to serve thousands of members seeking HRSN services.

CCO Spotlights: Health IT to support SDOH needs

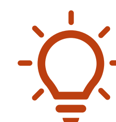
Progress bringing SDOH data together

Cascade Health Alliance (CHA) supported SDOH data sharing among various systems. PRAPARE screenings are collected in Healthy Klamath Connect (HKC) and then uploaded into Essette. SDOH screening and Health Risk Assessments in Essette communicate with each other, auto-populating responses with relevant content from previously completed screenings. REALD and SOGI data are also collected through HKC and Essette. All these data feed into an SDOH Risk Stratification report.

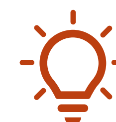
Eastern Oregon CCO (EOCCO) is developing two structured reports to share SDOH data analysis internally and to providers. The SDOH Provider Report will include information on screening and referral history to reduce over-screening risk. The Internal SDOH Report will aggregate member-level data fields necessary for SDOH metric reporting to OHA.



Health Share of Oregon (HSO) continued to support their ecosystem population health initiative that uses multiple data points and sources to identify and address the needs of specific populations. The initiative uses analytics that look across medical comorbidities and social needs as well as indicators of social health, like a custom-developed housing insecurity flag, to gauge risks, address inequities, and guide funding priorities. HSO engages in data sharing with the Joint Office of Homeless Services to incorporate housing system perspectives on high-risk individuals and identify opportunities for cross-sector intervention.



PacificSource Community Solutions (PacificSource) continued to incorporate SDOH data sources into Care Program Identification Algorithms (CPIA) to make SDOH data available for use and decision-making. This includes using SDOH signals, created using multiple data sources, to indicate that a member may have an SDOH need. These signals feed into each place data flows, incorporating SDOH data into member profiles for care manager access, SDOH prevalence reporting, children's health complexity dashboards, and the housing and diabetes project.



Trillium Community Health Plan (Trillium) created dashboards for workflow use, including a revised SDOH risk model (Neighborhood Economic and Social Trait).

Trillium also held discussions with two advisory boards and two clinical advisory panels on plans and challenges for dashboard use.

CIE use for additional provider types

EOCCO improved Connect Oregon utility for Traditional Health Workers (THW) through outreach to all THWs in Eastern Oregon, offering TA and onboarding training, sponsoring licenses for all interested THWs, and encouraging partner organizations to onboard their THWs. EOCCO also facilitated two Connect Oregon training sessions and covered platform licenses for 11 birth doulas. These efforts increased the number of THWs on Connect Oregon, serving 10 counties in the EOCCO region and eight beyond it.

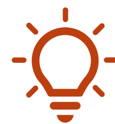
PacificSource continued to improve use of CIE for behavioral health (BH) by supporting Deschutes County Health Services' use of Connect Oregon to send referrals to the PacificSource BH Navigation team.

CCO Spotlights: Health IT to support SDOH needs (HRSN-specific)

HRSN provider support

Advanced Health provided TA individually and in groups and supplied standardized workflow documentation to CBOs that are expected to interact with HRSN regardless of contracted status. Additional focused education is provided when issues arise, such as timeliness of referral acceptance or completion in CIE. In the future, Advanced Health will consider providing incentive funds to use Unite Us with the SDOH measure.

AllCare CCO provided ongoing HRSN training sessions for community partners, including training on health IT platforms, and is starting bi-weekly virtual and in-person CCO-led HRSN office hours for HRSN service providers. They will lead training in at least three rural areas to meet the needs of providers in smaller and remote locations.



Trillium provided one-to-one meetings, technical assistance calls, and Community Capacity Building Funds (CCBF) to HRSN providers to support HRSN onboarding and CIE adoption. Trillium continues to look for additional grant funding streams beyond CCBF.

CIE use for HRSN

AllCare CCO created HRSN processes within their platforms (Provider Portal and EZ-CAP) to allow for authorization, claims generation, and report creation within one electronic form. Through these processes, they met their goals to make 95% of decisions within the required compliance timeframe and deliver 90% of approved services.

CHA is using Healthy Klamath Connect (HKC) for referrals to HRSN services. Members and providers can apply for assistance through HKC, using an adaptive screening questionnaire that includes questions specific to the types of support requested. HKC also supports uploading of documents related to these service requests.

PacificSource aligned and adjusted the workflows of HRSN and Flexible Services teams, including those supported by health IT tools, to better address the increase in member requests in 2024. These improvements increased parity and efficiency by using established criteria to review requests for appropriateness and cost effectiveness. In the first 11 months of HRSN, close to 2,000 members were served and over 3,500 climate- and housing-related supports were provided.

Honorable Mentions: Health IT to support SDOH needs

CIE network growth and increased use

- **AllCare CCO** saw a 50% increase in CIE referrals between 2023 and 2024, exceeding their 2024 goal of a 10% increase.
- **CHA** engaged in a comprehensive and multi-modal public awareness campaign for Healthy Klamath Connect (HKC) using a robust outreach strategy to inform members of HKC access and functionality, including a new direct link to HKC via the Member Portal.
- **EOCCO** grew their Unite Us network using targeted outreach, including in person presentations, distribution of a Community Resource Guide, and outreach to CBOs and clinics. They improved their ability to meet client needs by increasing the number of programs set up to accept referrals, from 64.4% to 81.8%, and decreasing rejected referrals from 58.5% to 43.2% by the end of 2023. By the end of 2024, 247 unique organizations were configured in Connect Oregon. In 2024 they also Increased the number of organizations serving eastern Oregon counties to 193, and number of programs to 401.
- **Umpqua Health Alliance** (UHA) saw an increase in CIE referrals in 2024, when 42 organizations sent referrals and 99 organizations received at least one referral, as compared to 2023, when 29 organizations sent referrals and 80 organizations received them. Overall, they supported 493 clients using CIE, with 954 CIE referrals sent throughout the year.

CIE training

- **AllCare CCO** conducted onsite Unite Us training for 158 individuals, with a hybrid option, as well as holding virtual training for a region where in-person was not possible.
- **PacificSource** monitors workforce and network usage using a dashboard that supports identification of training needs. With 232 CIE users overall, they have provided internal training on CIE use across many teams including Utilization Management, Population Health, Provider Service, Traditional Health Work, and Health Equity. Additional teams have been trained to handle HRSN volume.

Incorporate CIE into Flexible Services program

- **HSO** identified opportunities to incorporate Unite Us into the Flexible Services program request process and established a plan to begin implementing by mid-2025.

Accountable Health Communities expansion

- **EOCCO** expanded screening outreach criteria for the Accountable Health Communities project to allow member self-referral and to include members who have not engaged in primary care. In 2024, a web based Unite Us form was built and internally tested for members to request an SDOH screening from the AHC team starting in 2025. Screening and referrals are also in Unite Us. Members are also identified for screening through Point Click Care (PCC) hospital event notifications and newly developed internal procedures to pull lists of members with no primary care engagement on a monthly cadence.

General HRSN request forms

- **EOCCO** developed a general request form to support members seeking HRSN services, but uncertain what benefit they may need or be eligible for. This uses a single webform whose responses are reviewed by HRSN Services Managers to appropriately assign members to a contracted HRSN provider or refer to an appropriate CBO.

CCO Quality Incentive Measures (QIM) support

- **PacificSource** took the following steps to support the SDOH and Social-Emotional QIMs: creating a three-part governance structure, which includes discussion of opportunities and challenges around Unite Us, in support of the SDOH QIM; establishing two Community Quality Coordinators to support the Social-Emotional QIM, including looking at related CIE/HIE needs; and using a monthly dashboard to monitor and share CCO performance across their system to support provider strategies.

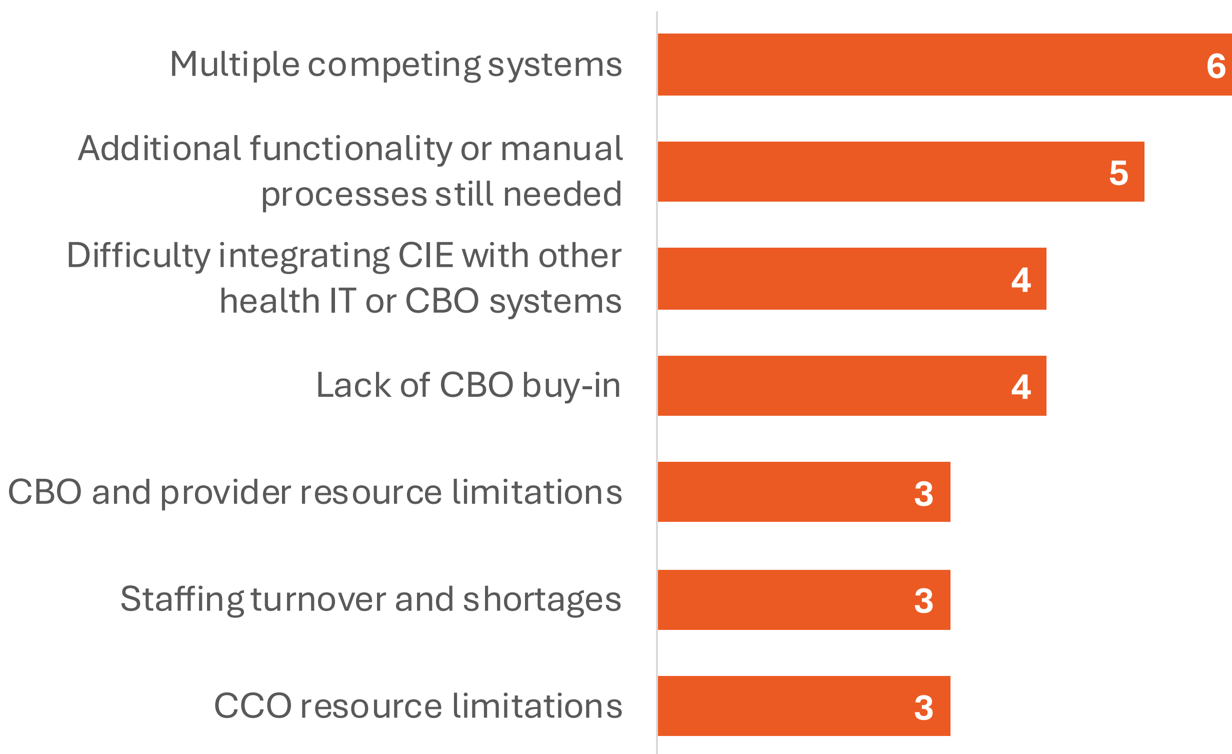
SDOH data mapping

- **CareOregon** (HSO, Jackson Care Connect (JCC) and Columbia Pacific CCO (CPCCO)) focused on internal mapping and inventory of social needs data to ensure their relevance for future strategies, interventions, and deliverables. This approach includes an upgrade to Johns Hopkins ACG software to add social needs data into an existing data table that will be used to inform future work.

Barriers to supporting health IT for SDOH needs

CCO responses reveal a variety of barriers to their progress supporting CBO partners, social service providers, and contracted providers in using health IT to address SDOH needs (see *Figure 4*). Many of these barriers are recurring and systemic. The top two most cited barriers by CCOs in their 2024 Roadmaps were multiple competing systems (cited by half of all CCOs) and additional functionality or manual processes still needed (cited by five CCOs). Several of the themes cited by CCOs as barriers are interrelated, such as multiple competing systems and difficulty integrating CIE with other health IT or CBO systems.

Figure 4: CCO-reported barriers to supporting health IT for SDOH needs



Limited interoperability between systems

The overlapping barriers of multiple competing systems, a need for additional functionality or manual processes, and difficulty integrating CIE with other health IT or CBO systems reflect the larger, systemic issue of limited interoperability between systems. Ensuring seamless data exchange and interoperability between different systems is a complex task that requires significant resources and expertise. This is further complicated by the large variety of systems in use by CBO partners. Integrating CIE with existing health IT systems has also proven to be technically and operationally difficult.

The resulting lack of interoperability between tools (such as EHRs, population health tools, and CIEs), as well as the challenges that come with adding any additional platform, complicates CBO and provider workflows. It increases administrative burden and requires time and effort to shift existing organizational workflows, straining their already limited capacity. Additionally, even with multiple systems, the functionalities are not always sufficient to support requirements or needed workflows, resulting in manual processes still being used; this ultimately makes it difficult for them to commit to the time-consuming and costly process of adoption and use.

“Each group has its own systems and processes, with limited capacity to engage with others' preferred methods for sharing data, resulting in a largely manual data-sharing process.”

Lack of CBO buy-in

Lack of buy-in and engagement from CBOs and providers remains a significant hurdle to health IT adoption. Many CBOs have existing workflows and systems and the complexity of finding a system that can meet all functionality needs for an organization feeds into a lack of CBO buy-in. Resistance to change, as well as change fatigue, makes it difficult to encourage adoption of new health IT systems while staff capacity and turnover make it difficult to sustain these initiatives.

CIE, in particular, is most valuable when more partners are using it. The burden of adopting a new technology also impacts organizations inequitably, with rural providers and CBOs struggling the most to join a new technology while experiencing limited resources, connectivity, and access to supports.

There is also some discomfort among CBOs about 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.

“[S]ome contracted health care partners, social services agencies, and CBOs have expressed hesitancy to onboard to Unite Us given the perception that organizations within the Unite Us network are not able to adequately address client or community needs.”

Resource limitations of CBOs, providers, and CCOs

The last three themes of CBO and provider resource limitations, staffing turnover and shortages, and CCO resource limitations are closely related. Limited resources and staff capacity of CBOs and provider partners continue to be prominent and widely experienced barriers. A few CCOs noted that insufficient CBO and provider staffing, funding, and staff turnover, severely limit CBO and providers’ ability to engage in health IT initiatives. CBOs, providers, and CCOs themselves are overwhelmed by

multiple new projects and initiatives. Limited financial resources make it challenging for CBOs and providers to invest in the necessary time and technology to support adoption of new tools, including the costs and resources to implement CIE.

> **"A primary barrier continues to be the pace of change within the ecosystem. [P]rojects, programs, and products [...] are being introduced that [cause] constraints on their time and resources..."**

OHA support requests

CCOs described how OHA can support their health IT for SDOH efforts, highlighting several key themes and areas of need (see *Figure 5*).

Figure 5: CCO-requested support from OHA to support use of health IT for SDOH needs

The need for sustainable funding for providers and CBOs continues to be a significant theme. CCOs support the recommendations from the Health Information Technology Oversight Council (HITOC)

and the CIE Workgroup[7], 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 use CIE. A few CCOs mentioned that funding for integration and interoperability among existing systems would support alignment in efforts to use health IT for SDOH for providers, CBOs, and members.

Another significant theme was the desire for OHA to develop standardized processes for data collection and sharing. CCOs emphasize that although many use the same CIE platform, each have independent approaches to workflows and functionalities in the platform. This variation creates inconsistencies and inefficiencies, especially for partners. The request for OHA to standardize data processes is followed closely by the third most common request for OHA: to provide additional guidance and best practices. Responses suggested OHA could provide guidance and support to ensure the standardization of CIE across CCOs. This would streamline efforts, enhance the effectiveness of referrals, and encourage expansion of CIE use throughout community partner networks. CCOs also requested standardization and guidance related to data collection and reporting for the SDOH screening and referral incentive metric. One CCO mentioned that developing educational materials that highlight the value of health IT tools in addressing SDOH would be especially helpful.

These responses highlight the need for sustainable funding, standardization, and guidance to support the effective use of health IT in addressing SDOH, especially for CBOs.

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

Appendix A: Definitions and examples of CCO strategies

Table 1: Strategies defined: Using health IT to support SDOH needs <u>within CCO</u>

Strategy	Definition and examples
1. Implement or use 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
2. Enhancements to CIE tools (e.g., 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 - Adding invoicing functionality to CIE
3. 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) - Integrating data from SDOH screenings across various tools such as CIE and case management

4. CCO leads problem solving efforts and collaboration with their 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 - Creation of a multidisciplinary steering committee/governance body that includes providers and CBOs - Developing a regional approach, visioning, and strategic alignment with partners, providers, community - Sharing best practices and use cases with partners and across CCOs - Collaborating with behavioral and oral health partners to encourage health IT tools to support SDOH needs
5. Care coordination and care management	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
6. Use data to identify 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 or the CCO's data warehouse to combine EHR, REALD, social service, and claims data - Developing SDOH 'flags'
7. 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 primary care payment models, comprehensive primary care+ and integrated behavioral health programs - Using population health tools to stratify populations
8. Use health IT to monitor and/or manage contracts and/or programs 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
9. Use health IT for CCO metrics related to SDOH	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

10. Education/training of CCO staff about the value and use of health IT to support SDOH needs	Efforts to provide education and/or training about HIT for SDOH needs to CCO staff members, including: - Providing ongoing training sessions on community information exchange for closed loop referrals - Educating staff on HIT platform functionality and workflows to support service delivery to members
11. Participate in SDOH-focused health IT convenings, collaborative forums, and/or education (excluding CIE governance)	CCO participation in workgroups, convenings, collaboratives, and education, including: - Participating in local and regional convenings or advisory groups - Participating in learning collaboratives and best practice sharing
12. Participate in CIE governance or collaborative decision-making	CCO participation in group decision-making processes - Participating in statewide advisory committees, such as the former CIE Workgroup - Participating in local or regional governance groups
13. Other strategies for adoption/use of CIE or other health IT to support SDOH needs within CCO	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
14. Other strategies for CCO access or use of SDOH-related data within CCO	CCO strategies that do not fall within the other within-CCO categories

Table 2: Strategies defined: Using health IT to support SDOH needs <u>among partners</u>

1. 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
2. Enhancements to CIE tools (e.g., 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 service provider, and CBO addresses using the United States Postal Service elements to enhance ArcGIS mapping

3. 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 to support partners. Examples include: - Integration with EHR, integrating EHRs for referrals into CIE - 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 - Connecting tools to CBOs or other partners, incorporating SDOH service providers into care coordination and referral workflows.
4. 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
5. Support referrals from CBOs to clinical providers and/or from clinical providers to CBOs	CCO supports CBOs use health IT to send referrals to clinical providers, and clinical providers to send referrals to CBOs. 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. - Use of CIE to send referrals between a county health department and a behavioral health navigator team
6. Financial support to adopt or use health IT that supports SDOH (e.g., incentives, grants)	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

7. Support payments to CBOs through health IT	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
8. Requirements to use health IT 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
9. Track or assess 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
10. Outreach and education about the value of health IT 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
11. Support participation in SDOH-focused health IT convenings, collaborative forums and/or education (excluding CIE governance)	CCO supports and encourages provider organizations and CBOs to participate in SDOH-focused health IT convenings, collaborative forums, and/or education. Examples include:

	- Facilitating community meetings - Providing stipends or grants for CBOs to participate in activities
12. Support participation in CIE governance or collaborative decision-making	CCO supports and encourages partner organizations to participate in collaborative decision-making processes for CIE • Actively encouraging partners to engage in governance • Providing stipends or grants for CBOs to participate in activities
13. 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
14. 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

Appendix B: Acronyms and abbreviations

CCOs

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

Other terms

CBO	Community-based organization
CCO	Coordinated care organization
CIE	Community information exchange
EHR	Electronic health record
HIE	Health information exchange
HIT	Health information technology
HITAG	Health Information Technology Advisory Group
HRSN	Health-related social needs
ODHS	Oregon Department of Human Services
OHA	Oregon Health Authority
ORPRN	Oregon Rural Practice-based Research Network
REALD	Race, ethnicity, language, and disability
SDOH	Social determinants of health