

2026 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 Health Information Technology (health IT) Roadmaps 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 support their contracted physical, behavioral, and oral health providers, as well as community-based organizations (CBOs) and social service providers in their communities, with:

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

This document summarizes the CCO strategies for health IT to support SDOH submitted in the Health IT Roadmaps in April 2026. It describes CCOs' 2025 activities and their plans for 2026-2029 both within the CCO and to support their contracted providers, CBOs, and social service providers, including Health-Related Social Needs (HRSN) Service Providers. **The 2026 Roadmaps include responses from 12 different CCO parent organizations, which represent all 16 CCOs in**

operation in 2025. For readability, the parent organizations will be referred to as 'CCOs'. Note: CCO strategies and investments have potentially changed since the 2026 Roadmaps were submitted.

This summary includes:

- CCO-implemented and -supported health IT tools for SDOH
- CCO internal strategies for using health IT to support SDOH
- CCO strategies for supporting partners with health IT to support SDOH
- CCO requirements and exceptions for CIE use for HRSN service providers
- 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 [social determinants of health have greater impacts on health outcomes than clinical care](#), leveraging health IT to address members' SDOH needs has become more critical and has 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 OHA's [SDOH: Social Needs Screening and Referral CCO incentive metric](#) and Oregon's [2022-2027 1115 Medicaid Demonstration Waiver](#), in particular to address [HRSN](#).

Health IT tools for SDOH implemented and supported by CCOs

CCOs have implemented a variety of health IT tools to support SDOH (see *Figure 1* below). These include [community information exchange \(CIE\)](#), 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 management, care coordination, and care management. CCOs also support partner use of some of these tools; for example, CCOs may help get contracted providers and CBOs set up to electronically receive and respond to referrals or they may use tools to support them 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 and one fewer CCO mentioning use of 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 for which they included a meaningful description. These are likely not all tools CCOs use for care management, population health, payment, etc.

Figure 1: 2025 and 2026-2029 health IT tools* used to support SDOH needs

Type of tool	Tool	# of CCOs that use tool within CCO	# of CCOs that support partners' use of tool
CIE	Connect Oregon/Unite Us	11	11
CIE	Healthy Klamath Connect/Findhelp	1	1
Care/case management	Epic Compass Rose	3	–
Care/case management	Activate Care	1	–
Care/case management	CCO Provider Portal	–	1
Care/case management	Gainwell Essette (formerly HMS Essette)	1	–
Care/case management	Phreesia	–	1
Care/case management	Smartsheet (HRSN)	1	1
Care/case management	TriZetto Clinical CareAdvance (formerly Cognizant)	1	–
Care/case management	TruCare	1	–
Care/case management	Elligint Health Helios (formerly VirtualHealth HELIOS)	1	1
Payment and eligibility	HealthTrio	–	3
Population health/data analytics	Johns Hopkins ACG GeoHealth module	2	–
Population health/data analytics	Tableau	2	–
Population health/data analytics	Arcadia	1	1
Population health/data analytics	Centelligence Data Hub	1	–
Other	Epic Payer Platform	2	1
Other	Epic Care Everywhere	1	–
Other	HRSN Service Request webform	1	1
Other	PointClickCare	–	1

*A dash (–) means none. Not all tools are used within the CCO *and* offered to providers.

CCO strategies for health IT to support SDOH needs

This summary reflects strategies reported by CCOs in the Health IT to Support SDOH: Progress and Plans sections of the 2025 and 2026 Roadmaps. These strategies may not reflect all activities a CCO is pursuing. *Figure 2* includes the number of CCO parent organizations that reported using each strategy within CCO, while *Figure 3* includes the number that reported using each strategy to support their partners. *Appendix B* provides additional details about what has been included in each strategy category.

Note: All CCOs reported continuing their existing strategies for using health IT to support SDOH and supporting partners with using health IT for SDOH; as a result, planned strategies for 2026-2029 are the same as those shown for 2025 in both the *within CCO* and *supporting partners* sections and are not discussed separately.

Within CCO

As shown in *Figure 2* below, all CCOs continued to implement health IT for social needs screening and referrals in 2025, and plan to continue. 10 CCOs maintained or increased focus on strategies related to:

- Using data to identify members' SDOH experiences and health-related social needs (10 CCOs in both 2024 and 2025)
- Care coordination and care management (up from nine in 2024)
- CCO-led problem solving efforts and collaboration with their partners (up from nine in 2024)

A majority of CCOs maintained focus on integration or interoperability of health IT systems that support SDOH with other tools, though decreased from nine to eight since the prior year. Seven CCOs reported using health IT to support CCO metrics related to SDOH, a strategy that remained steady across 2024 to 2025. Six CCOs reported strategies related to supporting HRSN services in 2025 (see *Supporting HRSN services* section below). Five CCOs reported on CCO use of data

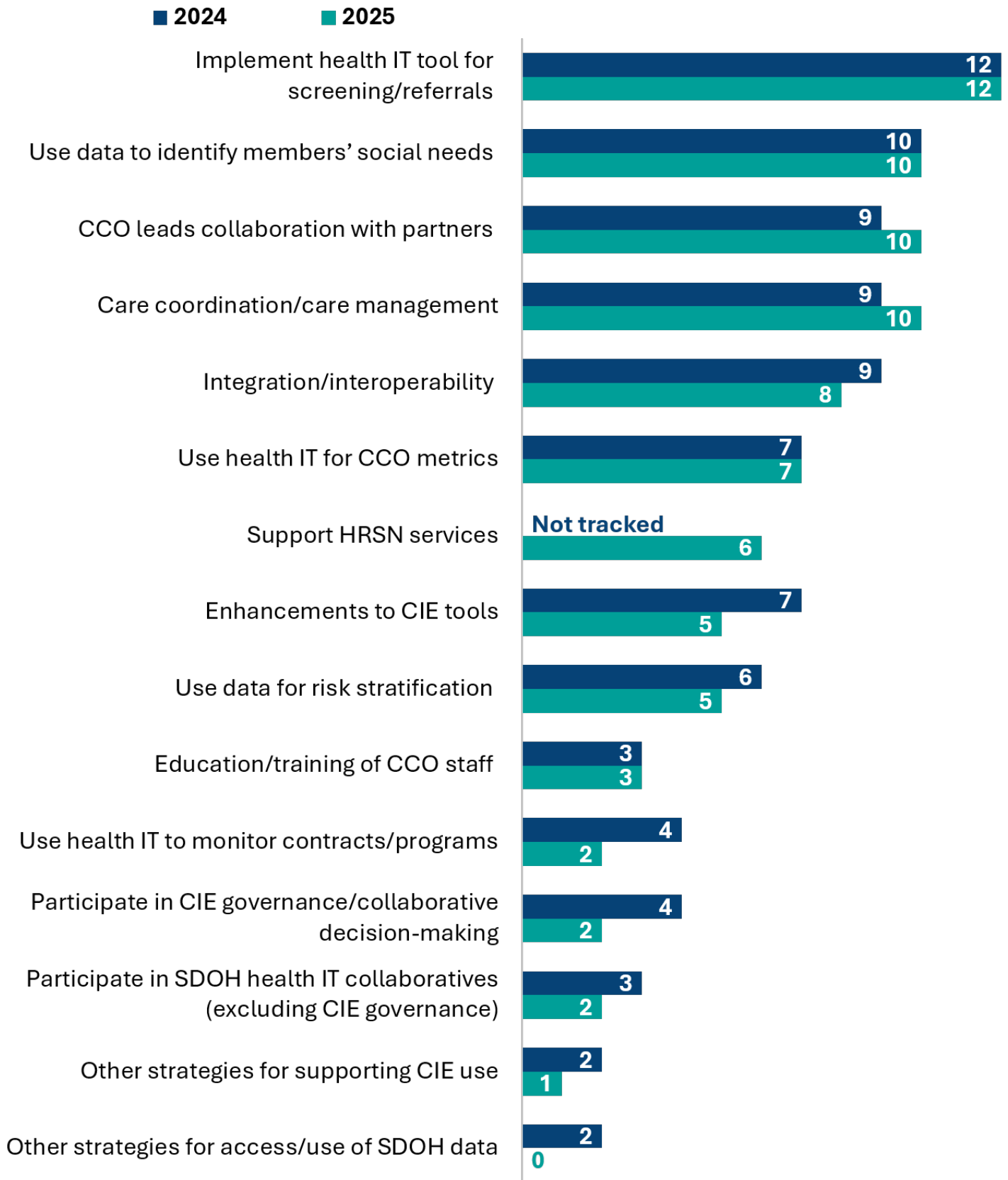
for risk stratification and on enhancements to CIE tools (e.g., adding new functionality). These strategies saw a slight decline from 2024 to 2025 (from six and seven CCOs, respectively). Education and training of CCO staff about the value and use of health IT to support SDOH needs remained consistent, with three CCOs reporting on the strategy in both years.

Two CCOs reported using health IT to monitor or manage contracts/programs to meet members' SDOH needs and two reported strategies related to participation in CIE governance or collaborative decision-making in 2025. In addition, two CCOs reported strategies related to participation in SDOH-focused health IT convenings, collaboratives, or education that were not focused on CIE governance. All three of these strategies saw a slight decrease in focus between 2024 and 2025 (from four, four, and three CCOs, respectively). One CCO reported other strategies for supporting CIE use in 2025 (down from two in 2024), and no CCOs reported other strategies for access to or use of SDOH data in 2025 (down from two in 2024).

Supporting HRSN services

CCO efforts to support HRSN services were tracked separately in 2024, but are now tracked as part of all CCO SDOH strategies. Six CCOs reported strategies with an HRSN focus. These strategies included CIE use for HRSN screening, closed loop referrals, benefit implementation, and service delivery. Some areas of focus within HRSN-related work included use of existing health IT tools to accommodate the staged roll-out of HRSN benefits or making enhancements to health IT tools to support the benefits. Examples include increasing CIE functionality to add additional screening forms or to support invoicing, developing standalone webforms to support HRSN requests and referrals, and integrating CIE with other health IT systems used internally to support HRSN service delivery. CCOs plan to continue these HRSN strategies.

Figure 2: 2024 (top bar) and 2025 (bottom bar) strategies for health IT to support SDOH needs *within* CCO (n=12 CCOs)



Supporting partners

As shown in *Figure 3*, in supporting providers and CBOs, all 12 CCOs maintained their sponsorship of CIE platforms for the community and all 12 CCOs reported strategies focused on training and technical assistance (TA) in 2025, as they did in 2024. Nearly all (11 CCOs) reported outreach and education about the value of health IT to support SDOH needs in 2025 just as in 2024. In addition, there was an increased focus on supporting referrals between CBOs and clinical providers (i.e., to physical, behavioral, and oral health providers), with ten CCOs focusing on this strategy in 2025 (up from seven in 2024). Eight CCOs also reported on enhancements to CIE tools to support contracted providers and CBOs in 2025, one fewer than in 2024.

Financial support to adopt or use health IT that supports SDOH, such as incentives or grants to providers and CBOs, and integration or interoperability of health IT systems that support SDOH with other tools remained consistent from the previous reporting year, with six CCOs implementing such strategies.

Requirements to use health IT in contracts and provider agreements increased significantly, from two CCOs reporting on this type of strategy in 2024 to six in 2025. Four CCOs reported strategies related to tracking or assessing CIE/SDOH tool adoption and use in 2025, down from five in 2024. Support for partner participation in CIE governance or collaborative decision-making increased from one CCO in 2024 to two in 2025 while one CCO reported supporting participation in SDOH-focused health IT collaboratives, education, and convening across reporting years. One CCO reported other strategies for supporting access to or use of SDOH data in both 2024 and 2025, and no CCOs reported other strategies for supporting adoption of health IT in 2025 (down from two in 2024).

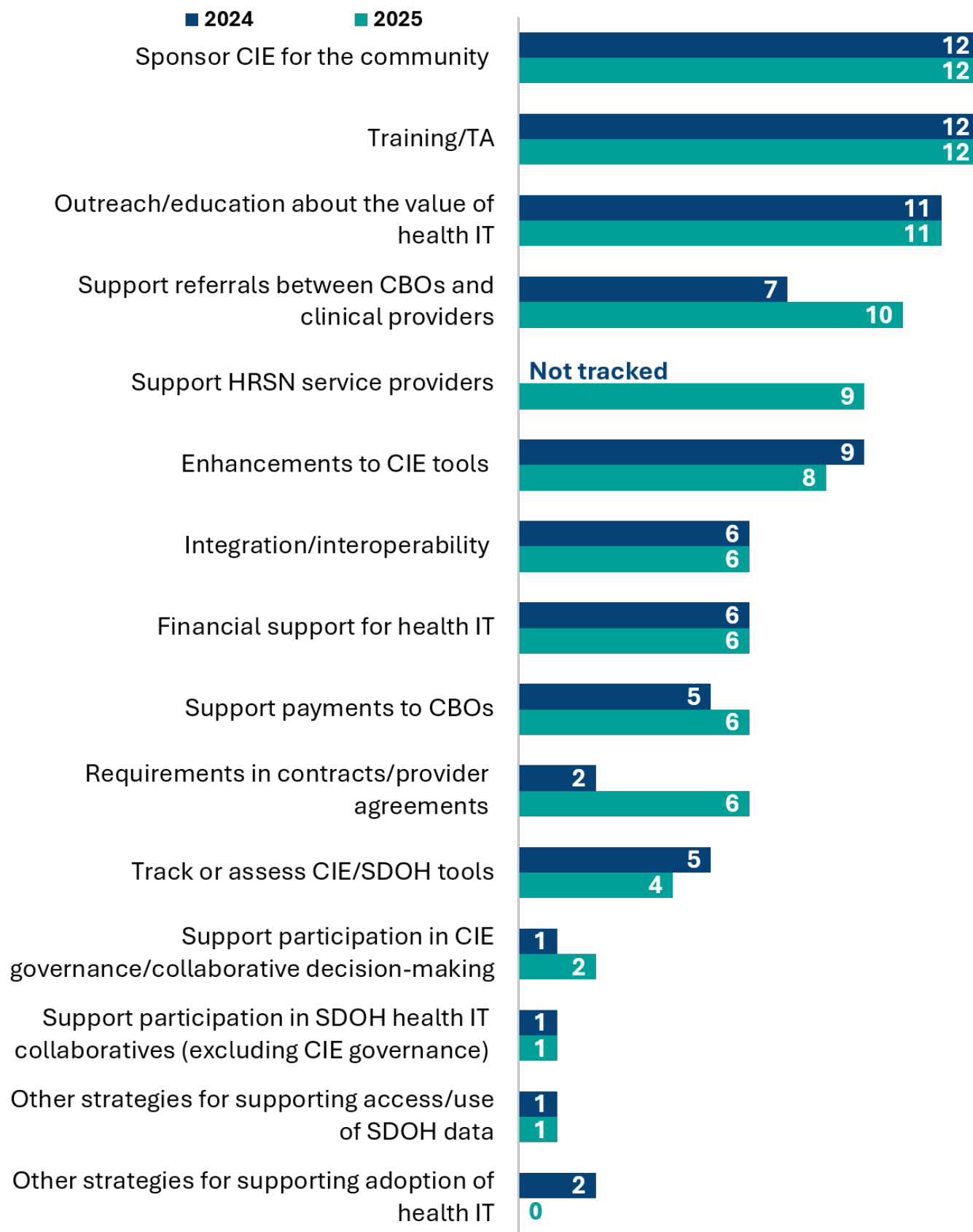
Supporting HRSN providers

CCO efforts to support HRSN providers were tracked separately in 2024 but are now tracked as part of CCOs' broader SDOH strategies. Nine CCOs reported on

this strategy and indicated a plan for this work to continue. CCOs continued to focus on supporting provider use of CIE to facilitate closed loop referrals for HRSN services, including expanding their networks and supporting providers through TA and training, in part to support the roll out of additional HRSN benefits launched in 2025. One CCO attributed the increase of CIE use in their region to enrollment of HRSN service providers as their network expanded to support HRSN. Some CCOs moved strategies forward focused on supporting HRSN service providers in using invoicing functionality either via CIE or through other health IT platforms. From 2024 to 2025, more CCOs focused on using health IT to support payments to CBOs (from five to six).

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, sponsoring CIE, use of SDOH data, and collaboration both internally and with external partners. CCOs continue to expand their efforts to support HRSN services. The continued investment in these areas highlights the ongoing importance of and commitment to leveraging health IT to effectively address SDOH.

Figure 3: 2024 (top bar) and 2025 (bottom bar) strategies for health IT to support SDOH needs for providers and CBOs (n=12 CCOs)



CCO requirements and exceptions for CIE use

Starting in 2026, CCOs were allowed to choose whether to require HRSN service providers to use CIE for closed loop referrals for HRSN services. CCOs were required to implement an exceptions process available to their providers if they instituted a CIE requirement.

Five CCOs instituted a CIE requirement for HRSN service providers and developed an accompanying exceptions process. Across CCOs requiring CIE, the exceptions request process was similar. These CCOs described a team approach to the review of any exceptions request, either by operational teams or leadership in combination with partners, or by an HRSN-specific committee.

Of the five CCOs requiring CIE use by their HRSN service providers, only one CCO received a request for an exception in 2025. This request was made by a provider working with members experiencing domestic violence and was approved by the CCO.

The remaining seven CCOs reported they did not require HRSN service providers to use CIE.

CCO Spotlights: Health IT to support SDOH needs

Support of HRSN



Advanced Health increased referrals for HRSN benefits by leveraging Unite Us for HRSN referrals during the 2025 Health Risk Assessment collection process. The CCO partnered with Unite Us to ensure the USDA six-item short form screener was available in Unite Us to support the HRSN nutrition benefit launch.



Columbia Pacific CCO (CPCCO) and **Jackson Care Connect (JCC)** focused on building CBO capacity to sustain participation in HRSN benefits, particularly for providers new to Medicaid billing. This support centered on financial reconciliation and Medicaid claims processes, such as how to accurately interpret invoicing/payment information and manage payment workflows.



Eastern Oregon Coordinated Care Organization (EOCCO) developed member materials to support multiple ways to access the assistance request form, including a QR code and a phone line for members with limited digital literacy or internet access.



Health Share of Oregon incorporated CIE into their service request process for both HRSN and flexible services. This streamlined review of requests helped identify urgent requests and supported timely HRSN authorization and flexible services funding determinations. Incorporating CIE in this way improved clarity, prioritization, and operational efficiency across teams.

Provider outreach and training to support CIE use



AllCare CCO proactively identified challenges with CIE case resolution and worked with Unite Us to outreach to providers, identify causes for unresolved cases, and update program descriptions where needed. This

resulted in improvements in accurate referral rates and a decrease in unresolved case rates over each quarter in 2025.



EOCCO implemented a multi-modal strategy to support physical health providers and Traditional Health Workers (THWs) in using CIE for social needs screening and referrals. This included:

- Hosting two learning collaborative webinars for physical health providers participating in the SDOH incentive measure to provide best practices for implementing social needs screening and referrals.
- Disseminating a clinical partner-focused Connect Oregon informational video to the EOCCO provider network.
- Offering an opt-in Community Benefit Initiative Reinvestment grant for social needs screening to support clinical partner integration of Unite Us into their instance of OCHIN Epic for closed loop referrals and SDOH reporting.
- Developing a referral pathway for doulas—the first referral pathway specific to THWs—and ultimately onboarding 66 total THWs by the end of 2025.



PacificSource Community Solutions (PCS) hosted a spring provider training for SDOH partners to support new transportation initiatives funded by a SHARE grant and required all seven transportation grantees to use Connect Oregon to track screenings and referrals. PCS also partnered with Unite Us to host a follow-up training in the fall on adopting Connect Oregon for SDOH screening and referrals.



Yamhill Community Care (YCCO), in collaboration with Unite Us, supported over 21 training sessions for providers to support CIE adoption in 2025.

Advancing work around SDOH data



Trillium completed a project to align SDOH assessment questions with the Social Need Screening and Intervention (SNS-E) National Committee for Quality Assurance (NCQA) measure, allowing the CCO to incorporate more EHR data into an ongoing SDOH project. Alignment with the national standard will support future SDOH data sharing across multiple systems and make SDOH data available in most electronic environments where a member's information exists.



Trillium engaged with advisory boards and clinical advisory panels to inform an SDOH risk model and developed a process to annually update aggregated member and census tract data to inform community investments with Board input.

Honorable mentions: Health IT to support SDOH needs

CIE network growth and increased use

- **AllCare** trained an additional 70 Unite Us users in 2025 and utilized training sessions to respond to questions with more complexity, indicating some increase in user sophistication. Exceeded 15% monthly referral growth, averaging 93 CIE referrals per month in 2025.
- **CHA** reported that 105 out of 151 programs listed in Healthy Klamath Connect (local name for Findhelp) have been claimed in CIE and are managed directly by their organizations.
- **EOCCO** configured 302 organizations in Unite Us and saw a near 60% increase in the number of partners onboarded to CIE in 2025.
- **Trillium** continued the growth of the Unite Us/Connect Oregon network and increased utilization, resulting in a total of 3700 referrals made in 2025.
- **YCCO** increased cases in CIE from 282 to 948 over a single year, with 2,477 referrals made in 2025. Increased Unite Us/Connect Oregon license use by 39 users over two years. Twelve out of 13 contracted and active HRSN service providers are now using Unite Us.
- **InterCommunity Health Network CCO** hired a full-time program manager dedicated to HRSN and CIE to better support community and HRSN service provider needs.

Leveraging data to support Member SDOH needs

- **AllCare** increased Member Portal enrollment by 25% through continuation of a successful gift card incentive program, supporting easier access to Health Risk Assessments for members.

- **CPCCO** and **JCCO** tested and piloted a member data table ahead of schedule and implemented for all Medicaid members with CPCCO & JCC physical health coverage.
- **EOCCO** successfully finalized internal social needs screening & referral report, using data pulled from CIE, for use as primary source for SDOH measure reporting.
- **CPCCO** and **JCCO** are developing a data sharing agreement with Multnomah County Corrections to improve post-corrections outcomes for members with substance use disorders.
- **PCS** funded seven CBOs to develop transportation resources, and included Connect Oregon use as a grantee requirement.
- **Umpqua Health Alliance** conducted a third gap analysis of Douglas County to assess SDOH needs. Developed SDOH Action Plan Dashboard to leverage insights from gap analyses to plan support for CBO capacity through workflow refinement, CIE implementation, data utilization, training and support.

CIE Improvements

- **CHA** standardized CIE workflows and developed tracking mechanisms specific to specialized staff roles to better streamline and monitor care coordination with closed loop referrals.
- **CPCCO** and **JCCO** implemented Connect Oregon/Unite Us enhancements to support CIE use for flex service requests and to improve authorization determinations.
- **EOCCO** achieved significant reduction of platform referral rejection rates in Unite Us in 2025, down 15% from EOY 2024 baseline.
- **PCS** implemented the Unite Us/Connect Oregon Enhanced Screening protocol, inclusive of data for SDOH Quality Incentive Measure & screening

tools in languages other than English to better meet provider, community, and reporting needs.

Barriers to supporting health IT for SDOH needs

CCOs reported a range of barriers impacting their ability to support CBOs, social service providers, and contracted providers in using health IT to address SDOH needs (see *Figure 4*). Many of these barriers are interrelated and were also reported in prior years. The two barriers CCOs reported most frequently in 2025 were difficulty integrating CIE into other health IT systems or workflows (nine CCOs) and resource limitations for CBOs and providers (seven CCOs). Five additional CCOs reported difficulty integrating CIE than in 2024, and four additional reported resource limitations for CBOs and providers. In contrast, the two most reported barriers in 2024, multiple competing systems and additional functionality or manual processes still needed, were each reported by fewer CCOs in 2025 (from six to four CCOs reporting multiple competing systems and from five to three CCOs for additional functionality still needed). Other barriers reported in 2025 included lack of CBO buy-in (five CCOs, up from four in 2024), CCO resource limitations (four CCOs, up from three in 2024), and staffing turnover and shortages (three in both 2024 and 2025). Two CCOs each reported HRSN/Medicaid complexity and platform support/training, which were new categories in 2025.

Difficulty integrating CIE into other IT systems

Several CCOs indicated that a lack of CIE and EHR integration is a barrier for CIE use among physical health providers. Some noted that integrating CIE into existing partner workflows may also be challenging and this difficulty may also negatively impact CIE use. An overall lack of investment in interoperability for IT tools was also suggested by a few CCOs as a barrier to adoption. Additionally, getting enough users or “a critical mass” on CIE for it to be useful is challenging

and further limits adoption. When IT systems are challenging to use in conjunction with existing systems, or when they do not easily incorporate into existing workflows, buy-in from CBOs may be limited; this can create a self-reinforcing cycle that negatively impacts CBOs and providers from adopting IT systems.

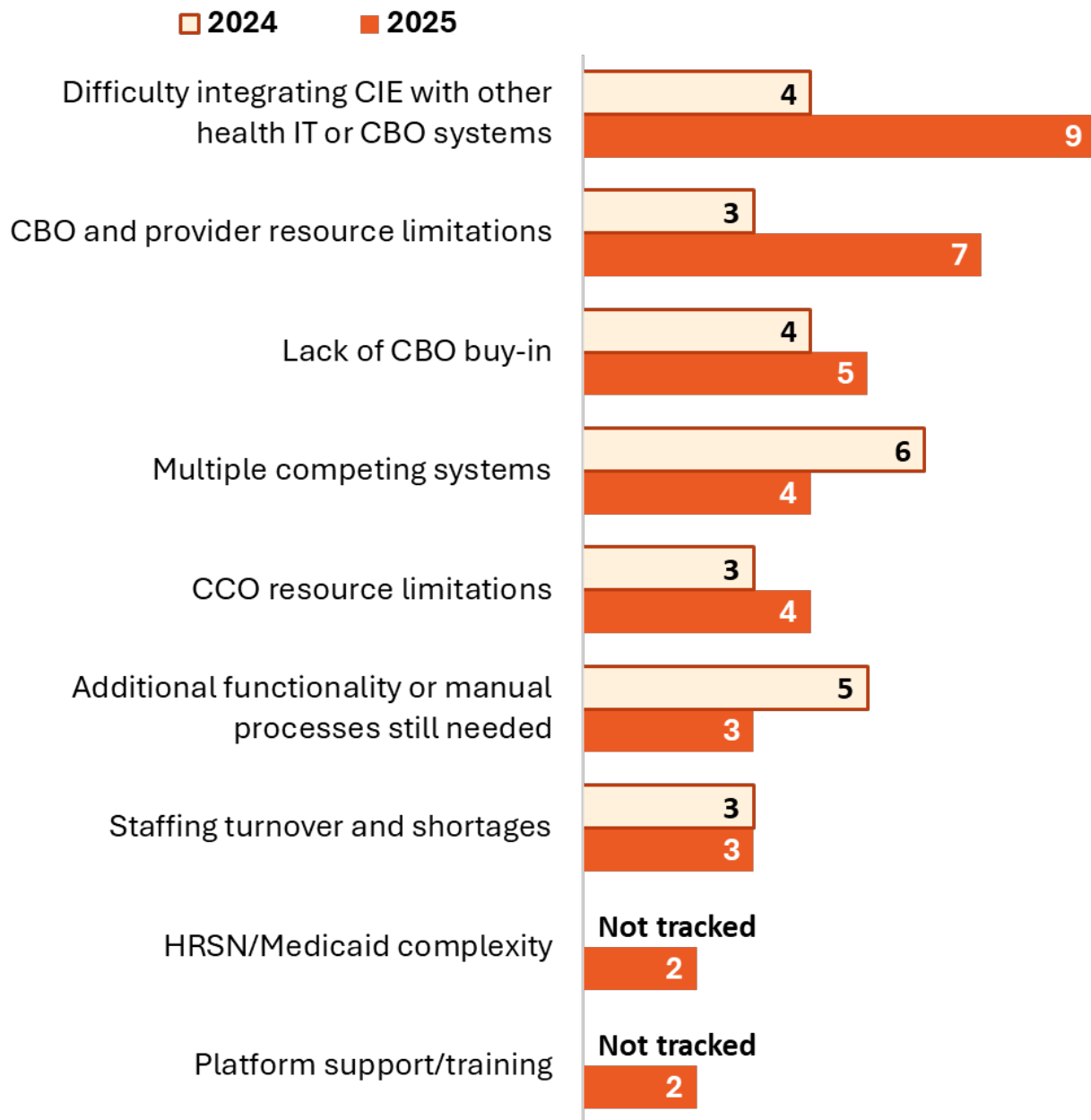
“While CIE platforms represent a meaningful advancement over traditional communication methods such as fax, email, and phone, they have not yet achieved the level of integration necessary to support seamless, end-to-end care coordination.”

Resource limitations

Limited resources and capacity continue to impact use of CIE and hinder adoption of IT tools by providers and CBOs. CCOs reported that both a lack of financial resources and staffing capacity at the organizational level continue to result in slower CIE adoption and lower rates of use among their provider and CBO partners. Limitations in funding for health IT at the state level, staffing turnover or restructuring at the organizational level, and a limited number of organizations offering service types in high demand result in providers and CBOs having limited capacity to use existing health IT to the fullest capacity, or to adapt to new health IT systems or related workflow changes.

“A primary barrier was the impact of state-level funding constraints[...]. These financial pressures limited the capacity of clinics and community partners to prioritize investment in new or enhanced health IT tools.”

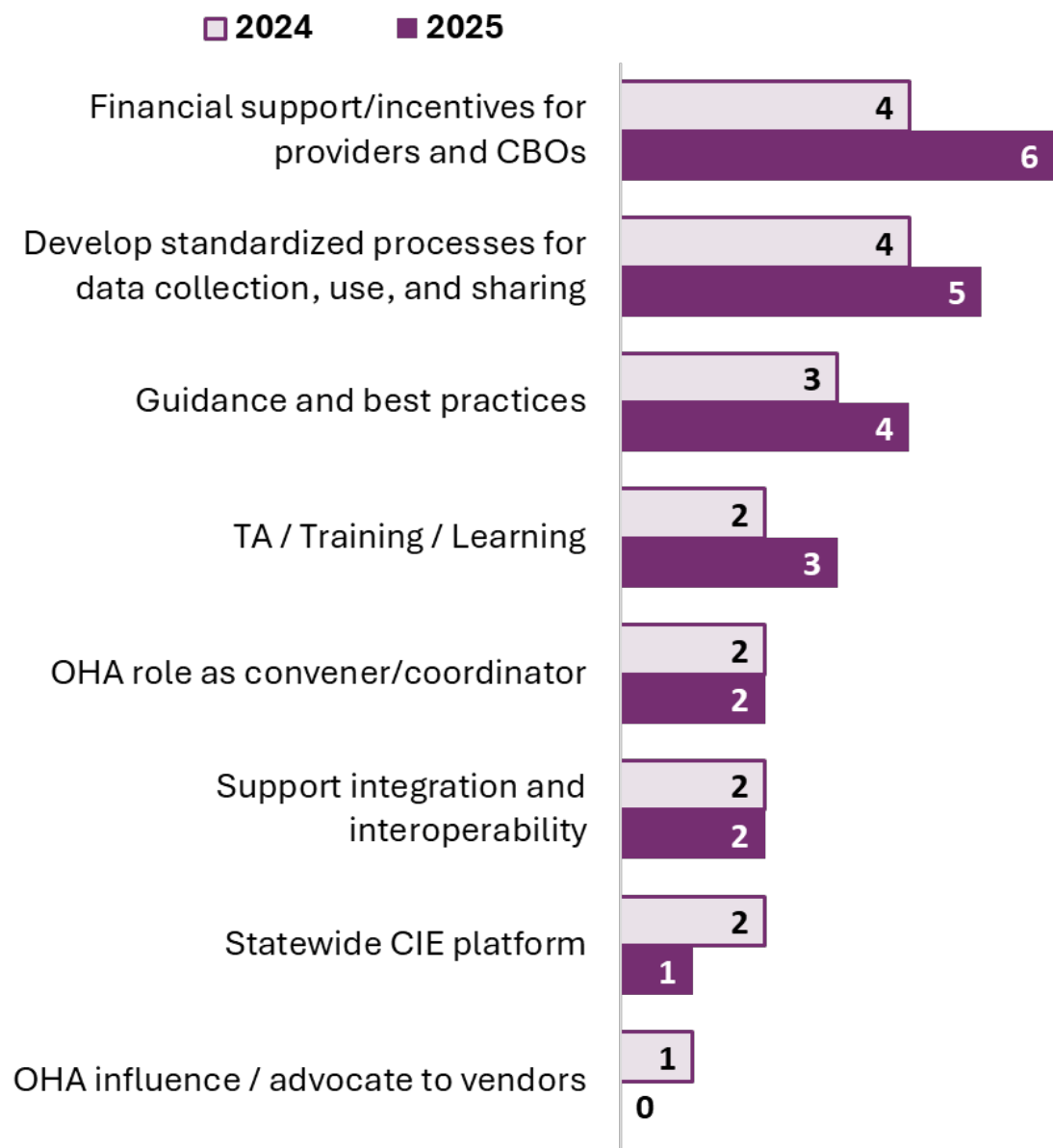
Figure 4: CCO-reported barriers to supporting health IT for SDOH needs in 2024 (top bar) versus 2025 (bottom bar)



OHA support requests related to SDOH

CCOs described how OHA can support their health IT for SDOH efforts, highlighting several key themes and areas of need which are consistent with those reported for 2024 (see *Figure 5*). CCOs identified a need for sustainable financial support and incentives for adoption and use of health IT tools, such as CIE, by providers and CBOs to support SDOH, with two more indicating a need for this type of support in 2025 than in 2024 (six CCOs, up from four). A few specifically identified a need to financially support the integration of existing health IT tools and bidirectional data exchange. The second most frequently requested support in 2025 was the development of standardized processes for data collection, use, and sharing (five CCOs, up from four in 2024), which could reduce operational burden and improve efficiency for partners as well as accuracy of data reporting. Guidance and best practices along with TA, training, and learning were each requested by one more CCO in 2025 than 2024 (four and three CCOs, respectively). Additional requests for support included OHA acting as a convener, and support for integration and interoperability, each requested by two CCOs in both 2024 and 2025. One CCO requested a statewide CIE platform, one fewer than in 2024. No CCOs requested OHA influence or advocacy with vendors in 2025, down from one in 2024.

Figure 5: CCO-requested support from OHA to support use of health IT for SDOH needs in 2024 (top bar) versus 2025 (bottom bar)



You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Health IT Policy and Program Unit at CCO.HealthIT@odhsoha.oregon.gov or 503-373-7859. We accept all relay calls.

Health Policy and Analytics Division
Office of Health IT and Analytics Infrastructure
800 NE Oregon St, Suite 900
Portland, OR 97232

503-373-7859

CCO.HealthIT@odhsoha.oregon.gov

<https://www.oregon.gov/oha/HPA/OHIT/pages/hitag.aspx>



Appendix A: Acronyms and abbreviations

CCOs

Advanced Health

AllCare

CHA

CPCCO

EOCCO

HSO

IHN-CCO

JCC

PCS

Trillium

UHA

YCCO

Coordinated Care Organizations

Advanced Health

AllCare Health

Cascade Health Alliance

Columbia Pacific CCO

Eastern Oregon CCO

Health Share of Oregon

InterCommunity Health Network

Jackson Care Connect

PacificSource Community Solutions (4 regions as of 2025)

Trillium Community Health Plan (2 regions)

Umpqua Health Alliance

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
SOGI	Sexual orientation and gender identity
SUD	Substance use disorder
THW	Traditional Health Worker

Appendix B: Definitions and examples of CCO strategies

This section is organized by each of the two main SDOH sections of the Health IT Roadmap: (1) CCO use of health IT to support SDOH and (2) CCO support of partners' use of health IT to support SDOH. Each section contains a number of strategy categories under which CCOs' reported strategies may fall. Each strategy category includes a definition and examples of the strategy.

CCO use of health IT to support SDOH

Strategy 1: Implement or use health IT tool/capability for social needs screening and referrals

CCO adopts health IT tools that support social needs screening and referrals, such as:

- Connect Oregon/Unite Us
- Findhelp/Healthy Klamath Connect
- PRAPARE screening through Activate Care

Strategy 2: Enhancements to CIE tools (e.g., new functionality, flexible services forms, screenings, data sources)

CCO invests in or otherwise works 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 flexible services form to CIE
- Adding invoicing functionality to CIE

Strategy 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. Examples include:

- 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

Strategy 4: CCO leads problem solving efforts and collaboration with their partners

CCO creates 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
- Creating 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 on how health IT tools that support SDOH needs could be useful to them

Strategy 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 Assessment and identifying member social needs
- Epic Compass Rose for care coordination assessments

Strategy 6: Support HRSN services

CCO uses health IT to support HRSN services, particularly for closed-loop referrals. Examples include:

- Using care coordination and population health tools to identify members for HRSN services
- Using CIE to make closed loop referrals to HRSN providers, and to update the status of those referrals and HRSN services

Strategy 7: 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'
- Integrating data from different health IT tools to cross-reference member needs and community-level data, to better identify high-risk members in need of additional supports

Strategy 8: 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
- Using the Johns Hopkins ACG system for risk segmentation
- Using value-based payment (VBP) software for primary care payment models, comprehensive primary care+ and integrated behavioral health programs
- Using population health tools to stratify populations

Strategy 9: 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. Examples include:

- Compiling member information to evaluate social risk for use in determining VBP
- Incorporating use of health IT into provider agreements, including reporting requirements

Strategy 10: Use health IT for CCO metrics related to SDOH

CCO conducts activities to support metrics and compliance with required metrics. Examples include:

- Incorporating CIE screening and referral volume criteria into quality pool payment methodology for the SDOH screening metric
- Identifying opportunities in CIE to support the SDOH Screening and Referral and Social-Emotional Health Quality Incentive measures

Strategy 11: Education/training of CCO staff about the value and use of health IT to support SDOH needs

CCO provides education and/or training about health IT for SDOH needs to CCO staff members. Examples include:

- Providing ongoing training sessions on CIE for closed loop referrals
- Educating staff on health IT platform functionality and workflows to support service delivery to members

Strategy 12: Participate in SDOH-focused health IT convenings, collaborative forums, and/or education (excluding CIE governance)

CCO participates in workgroups, convenings, collaboratives, and education. Examples include:

- Participating in local and regional convenings or advisory groups
- Participating in learning collaboratives and best practice sharing

Strategy 13: Participate in CIE governance or collaborative decision-making

CCO participates in group decision-making processes. Examples include:

- Participating in statewide advisory committees, such as the former CIE Workgroup
- Participating in local or regional governance groups

Strategy 14: Other strategies for adoption/use of CIE or other health IT to support SDOH needs within CCO

CCO implements other strategies that do not fall within the other within-CCO categories but are related to internal efforts to support members SDOH-related needs with health IT. Examples include:

- Building and maintaining a data warehouse for SDOH and REALD data

- Coordinating with the Oregon Department of Human Services' Office of Resilience and Emergency Management on tools and data for emergency response

Strategy 15: Other strategies for CCO access or use of SDOH-related data within CCO

CCO implements other strategies that do not fall within the other within-CCO categories but are related to internal efforts to access or use SDOH-related data within the CCO, such as:

- Creating a 5-year health IT plan
- Using CIE/SDOH screening to support population health management

CCO support of partners' use of health IT to support SDOH

Strategy 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 CIE technology or a platform to sponsor

Strategy 2: Enhancements to CIE tools (e.g., new functionality, flex services forms, screenings, data sources)

CCO invests in or otherwise works 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 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 generate invoices within CIE

Strategy 3: Integration or interoperability of health IT systems that support SDOH with other tools

CCO integrates data from or to health IT systems that support SDOH tools or improving workflow between tools to support partners. Examples include:

- Integrating with EHR for referrals into CIE
- Integrating tools, such as 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

Strategy 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
- Providing technical support for CIE use for providers and CBOs
- Providing guidance to providers and CBOs about data confidentiality
- 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 vendor to provide technical assistance to providers/clinics
- Facilitating learning collaboratives or virtual training to providers and CBOs on best practices
- Providing TA for contracted CBOs to enter into legal agreements to share de-identified data

Strategy 5: Support referrals from CBOs to clinical providers and/or from clinical providers to CBOs

CCO supports CBOs' use of health IT to send referrals to clinical providers and clinical providers' use of health IT 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.
- Using CIE to send referrals between a county health department and a behavioral health navigator team
- Supporting CIE access and technical assistance for Traditional Health Workers and doulas

Strategy 6: Supporting HRSN service providers

CCO supports and incentivizes HRSN providers to adopt and use technology, particularly for closed-loop referrals, e.g., through grants, technical assistance, outreach, education, and engaging in feedback. For example:

- Assessing readiness of HRSN service providers to make closed loop referrals using health IT, and providing technical assistance to support CIE use
- Providing grants or incentives to HRSN service providers to adopt and use technology

Strategy 7: Financial support to adopt or use health IT that supports SDOH (e.g., incentives, grants)

CCO provides—either directly or via partners—grants, financial support, or incentives for providers and CBOs related to using tools to support SDOH, including CIE. This category 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 VBP arrangements
- Developing a VBP that incentivizes the use of CIE
- Providing other types of financial support for clinical providers and CBOs

Strategy 8: Support payments to CBOs through health IT

CCO supports the use of health IT to facilitate payments to CBOs. Examples include:

- Implementing payment modules within CIE and assisting partners with using these features for reimbursement
- Using HealthTrio to support CBO verification of member eligibility and submission of invoices

Strategy 9: Requirements to use health IT in contracts/provider agreements

CCO includes 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 screening in health IT tools or using a CIE.

Strategy 10: Track or assess CIE/SDOH tool adoption and use

CCO facilitates data collection activities to better understand providers' and CBOs' access to health IT tools to support SDOH, as well as gaps and barriers to partners adopting and utilizing those tools. CCO can use this information to inform CCO strategy, resource allocation, and targets. Examples include:

- Conducting environmental scans
- Tracking usage of tools by CBOs and providers via reports from vendor
- Conducting provider surveys and interviews on CIE adoption and utilization, benefits, and concerns
- Conducting provider assessments of readiness and understanding of CIE tool(s)
- Assessing CIE products, EHR data-sharing capabilities, 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

Strategy 11: Outreach and education about the value of health IT to support SDOH needs

CCO facilitates activities that encourage providers and CBOs to adopt CIE tools 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

Strategy 12: 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

Strategy 13: Support participation in CIE governance or collaborative decision-making

CCO supports and encourages partner organizations to participate in collaborative decision-making processes for CIE. Examples include:

- Actively encouraging partners to engage in governance
- Providing stipends or grants for CBOs to participate in activities

Strategy 14: Other strategies for supporting adoption of *CIE or other health IT* to support SDOH needs

CCO implements additional health IT strategies in support of meeting members' SDOH needs among their contracted providers and CBOs. For example, 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.

Strategy 15: Other strategies for supporting access or use of *SDOH-related data*

CCO implements additional efforts to support access to or use of SDOH-related data. Examples include:

- Compiling data and making it available to providers for use in risk agreements (e.g., financial modeling or eligibility, claims, and risk data)
- Making data available in the provider portal