# 2024 CCO Health IT Roadmap

## 2024 Guidance, Evaluation Criteria & Reporting Template

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|---|---|
| **Contract or rule citation** | Exhibit J, Section 2, Paragraph d. |
| **Deliverable due date** | March 15, 2024 |
| **Submit deliverable via:** | CCO Contract Deliverables Portal |

**Please:**

1. **Submit a Microsoft Word version of your Health IT Roadmap and**
2. **Use the following file naming convention for your submission: CCOname_2024_HealthIT_Roadmap**

**For questions about the CCO Health IT Roadmap, please send an email to CCO.HealthIT@odhsoha.oregon.gov**

**CCO:** AllCare Health

**Date: 3/12/2024**

## 1. Health IT Partnership

Please attest to the following items.

| | | |
|---|---|---|
| **a.** | ☒ Yes<br>☐ No | Active, signed HIT Commons MOU and adheres to the terms. |
| **b.** | ☒ Yes<br>☐ No | Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU. |
| **c.** | ☒ Yes<br>☐ No<br>☐ N/A | Served, if elected, on the HIT Commons governance board or one of its committees. (Select N/A if CCO does not have a representative on the board or one of its committees) |
| **d.** | ☒ Yes<br>☐ No | Participated in an OHA HITAG meeting, at least once during the previous Contract year. |

## 2. (Optional) Overview of CCO Health IT Approach

**This will be read by all reviewers.** This section is optional but can be helpful to avoid repetitive descriptions in different sections. Please provide an overview of CCO's internal health IT approach/roadmap as it relates to supporting care coordination. This might include CCO's overall approach to investing in and supporting health IT, any shift in health IT priorities, etc. Any information that is relevant to more than one section would be helpful to include here and referenced as needed (rather than being repeated in multiple sections).

AllCare has re-evaluated its HIT Roadmap process and has changed the approach for 2024. The process model for the 2024 HIT Roadmap submission was to create a program team comprised of internal and external subject matter experts and leaders in each relevant area that is represented in the roadmap. Project management, consolidation, and review of the team's work was performed by external experts to ensure quality.

In the 2024 calendar year the strategies outlined in the 2024 HIT Roadmap will be reviewed monthly by the program team members in each of their responsible areas for tracking activities and milestones and modifying the strategy approach if a course change is needed.

This new approach to the roadmap resulted in retiring a number of strategies from the 2023 submission as they were not specific enough, relevant, operationalizable, or tracked through milestones.

In a technical assistance session held by OHA for AllCare on March 1st, 2024, AllCare indicated its intention to retire a number of items. It was recommended by OHA that there was no need to include past strategies that were duplicative or no longer relevant, and to focus on the 2024 roadmap as a point-in-time forward approach.

AllCare recognizes the high number of oral, and behavioral health organizations that do not currently have access to an HIE tool for care coordination or for hospital event notifications. AllCare will continue to review and investigate how to best address this gap with plans to develop a new strategy in 2024 during our monthly program team meetings. Prior attempts to move this forward have stalled due to the expense involved for individual offices. We will continue to participate in conversations at the State level at the State Oral Health forum to keep informed.

## 3. Support for EHR Adoption, Use, and Optimization in Support of Care Coordination

### A. Support for EHR Adoption, Use, and Optimization: 2022 Progress and 2023-24 Plans

Please describe your 2023 progress and 2024-26 plans for supporting increased rates of EHR adoption, use, and optimization in support of care coordination, and addressing barriers among contracted physical, oral, and behavioral health providers. In the spaces below (in the relevant sections), please:

1. Report the number of physical, oral, and behavioral health organizations without EHR information using the Data Completeness Table in the OHA-provided CCO Health IT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.
2. Include plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialling, Letters of Interest).
3. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
4. (Optional) Provide an overview of CCO's approach to supporting EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination.
5. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 to support EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. The strategy status
    d. Provider types supported
    e. A description of 2023 progress, including:
        - accomplishments and successes (including number of organizations, etc., where applicable)
        - challenges related to each strategy, as applicable

        Note: Where applicable, information in the CCO Health IT Data Reporting File should support descriptions of accomplishments and successes.
    f. (Optional) An overview of CCO 2024-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

**Notes:**

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2024, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

Using the Data Completeness Table in the OHA-provided CCO Health IT Data Reporting File, **report on the number of contracted physical, oral, and behavioral health organizations without EHR information**

| Measure | Physical Health | | Behavioral Health | | Oral Health | |
|---|---|---|---|---|---|---|
| | Org count | Rate | Org count | Rate | Org count | Rate |
| **Number of organizations (denominator)** | **137** | | **67** | | **10** | |
| **No EHR** | 18 | 13% | 33 | 49% | 2 | 20% |
| **EHR status unknown** | 5 | 4% | 13 | 19% | 0 | 0% |

**Briefly describe CCO plans for collecting missing EHR information via CCO existing processes**

AllCare plans to collect missing EHR information by leveraging its existing processes, such as online quarterly provider profile updates, and implementing a targeted strategy to reach out to providers without an EHR system through a revised marketing plan. In addition, AllCare is reevaluating its approach to Behavioral Health and Oral Health providers.

**Strategy category checkboxes**
Using the boxes below, please select which strategies you employed during 2023 and plan to implement during 2024-26. Elaborate on each strategy and your progress/plans in the sections below.

| Progress | Plans | | Progress | Plans | |
|---|---|---|---|---|---|
| ☒ | ☐ | 1. EHR training and/or technical assistance | ☐ | ☐ | 7. Requirements in contracts/provider agreements |
| ☒ | ☐ | 2. Assessment/tracking of EHR adoption and capabilities | ☐ | ☐ | 8. Leveraging HIE programs and tools in a way that promotes EHR adoption |
| ☒ | ☐ | 3. Outreach and education about the value of EHR adoption/use | ☐ | ☐ | 9. Offer hosted EHR product |
| ☒ | ☐ | 4. Collaboration with network partners | ☒ | ☐ | 10. Assist with EHR selection |
| ☐ | ☐ | 5. Incentives to adopt and/or use EHR | ☒ | ☐ | 11. Support EHR optimization |
| ☐ | ☐ | 6. Financial support for EHR implementation or maintenance | ☐ | ☐ | 12. Other strategies for supporting EHR adoption (please list here) |

(Optional) **Overview of CCO approach to supporting EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination**

**Strategy 1**: **EHR Training and/or Technical Assistance**
AllCare eHealth Services is dedicated to providing top-quality training and technical assistance with its regionally supported EHR product Veradigm (Allscripts). Our tailored training approach and technical support will ensure that our providers can successfully adopt and utilize EHR systems to transform their healthcare practices.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: TA ☐ 2: Assessment ☒ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☐ 10: EHR selection ☒ 11: Optimization ☐ 12: Other:

**Strategy status:**
☒ Ongoing ☐ New ☐ Paused ☒ Revised ☐ Completed/ended/retired/stopped

**Provider types supported with this strategy:**
☐ Across provider types OR specific to: ☒ Physical health ☐ Oral health ☐ Behavioral health

**Progress**
In 2023, AllCare eHealth successfully migrated all remaining offices from Prime Suite to Veradigm (Allscripts), consolidating all eHealth provider offices onto the Veradigm platform. As a result, we are revising/updating this strategy to focus on optimization.

**Overview of 2024-26 plans for this strategy** (optional):
Our primary objective for this year is optimization. We are committed to collaborating with all our offices to guarantee the full utilization of the system for providers. Additionally, we will continue to attract new physical health providers through targeted marketing initiatives.

## Planned Activities

To achieve our goal of optimization and expansion, we have devised the following comprehensive action plan:

1. **Provider Engagement and Training**
    - Conduct personalized training sessions with each office to ensure a comprehensive understanding and full utilization of the system.
    - Implement regular check-ins and to address any challenges faced by providers during the transition.
2. **Marketing Strategy**
    - Develop and implement a targeted marketing strategy to attract new physical health providers.
    - Leverage digital marketing channels, local events, and partnerships to effectively reach and engage with potential providers.
3. **Network Expansion**
    - Explore opportunities to expand our network of physical health through strategic partnerships and outreach efforts.
4. **Feedback Mechanism**
    - Establish a feedback mechanism to gather insights from existing and potential providers, allowing us to continuously improve our services and address their specific needs.
5. **Resource Allocation**
    - Allocate resources towards initiatives that support optimization, training, and marketing efforts.
6. **Communication and Collaboration**
    - Foster open communication and collaboration between our team, existing providers, and potential partners to create a supportive and inclusive environment for growth and optimization.

## Planned Milestones

**Milestones for Optimization and Provider Expansion**

In order to achieve our goal of optimization and expansion, we have devised the following comprehensive action plan with specific milestones:

1. **Provider Engagement and Training**
    - Milestone 1: Complete personalized training sessions with ten offices by the end of Q4 2024.
    - Milestone 2: Establish regular check-ins by the end of Q2 2024 to address any challenges faced by providers.
2. **Marketing Strategy**
    - Milestone 1: Finalize and implement the targeted marketing strategy by the end of Q2 2024.
    - Milestone 2: Achieve a 10% increase in new provider sign-ups by the end of the end of Q4 2024.
3. **Network Expansion**
    - Milestone 1: Identify and initiate discussions with potential partners by the end of Q2 2024.
4. **Feedback Mechanism**
    - Milestone 1: Implement the feedback mechanism (survey) by the end of Q2 2024.
5. **Resource Allocation**
    - Milestone 1: Allocate additional resources towards optimization, training, and marketing efforts by the end of Q1 2024.
6. **Communication and Collaboration**
    - Milestone 1: Establish regular forums by the end of Q1 2024.

| | |
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| By diligently executing this action plan and monitoring our progress of milestones, we aim to optimize our operations while expanding our network of physical health and behavioral health providers, ultimately driving the success and effectiveness of our platform. | |

**Strategy 2**: Revised Marketing Plan for All Health Providers

The eHealth team will align marketing strategies with the needs and preferences of independent practices to effectively increase the adoption of the Allscripts-hosted EHR system within the community. Regular evaluation and adaptation of the strategy will occur to ensure sustained engagement and utilization of the EHR system.

Revised: The eHealth team at AllCare aims to align marketing strategies with the needs and preferences of independent practices to effectively increase the adoption of the Allscripts-hosted EHR system within the community. To achieve this goal, the team will conduct regular evaluations and feedback sessions to ensure the relevance and effectiveness of the marketing strategies.

**Strategy categories:** Select which category(ies) pertain to this strategy

☒ 1: TA ☒ 2: Assessment ☒ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☒ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**

☒ Ongoing ☐ New ☐ Paused ☒ Revised ☐ Completed/ended/retired/stopped

**Provider types supported with this strategy:**

☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
The primary focus of 2023 was to transition the Prime Suite sites to Veradigm. Due to resource constraints, the eHealth team didn't have sufficient bandwidth to market and increase the adoption of new EHR sites. This resulted in limited marketing efforts to expand the adoption of the EHR system within the community.

**Overview of 2024-26 plans for this strategy** (Optional):

| Planned Activities | Planned Milestones |
|---|---|
| **1. Needs Assessment**<br>• Conduct surveys and interviews to understand independent practices' specific needs and preferences regarding EHR systems.<br>• Analyze feedback and data to identify the target audience's key pain points and requirements.<br>**2. Customized Messaging and Content Creation**<br>• Develop tailored marketing messages and content that address independent practices' identified needs and preferences.<br>• Create personalized educational materials, such as success stories, showcasing how | **1**. Surveys and interviews will be done to gather initial insights into the needs and preferences of independent practices conducted by the end of Q2 2024<br>• Initial data analysis to identify common pain points and requirements to be completed by the end of Q2 2024.<br>**2**.<br>• Develop tailored marketing messages based on independent practices' identified needs and preferences by the end of Q2 2024.<br>• Create initial customized educational content, such as case studies and success stories by the end of Q2 2024.<br>**3.** |

| | |
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| the EHR system meets the unique requirements of independent practices.<br><br>**3. Personalized Outreach**<br>• Customize outreach efforts to resonate with independent practices' specific pain points and preferences.<br>• Establish direct communication channels to address queries and concerns regarding the Veradigm (Allscripts)-hosted EHR system.<br><br>**4. User Engagement and Support**<br>• Implement user support mechanisms tailored to the specific needs of independent practices, such as dedicated training sessions or onboarding assistance.<br>• Provide ongoing engagement and support resources to ensure independent practices can utilize the EHR system effectively.<br><br>**5. Continuous Feedback Collection**<br>• Establish feedback loops to gather ongoing insights from independent practices regarding their experience with the Veradigm (Allscripts).<br>• Regularly assess the effectiveness of the marketing strategies in addressing the identified needs and preferences. | • Launch personalized outreach campaigns with messaging tailored to independent practices' specific needs and pain points by the end of Q3 2024.<br>• Initiate direct communication channels to address queries and concerns from independent practices by the end of Q3 2024.<br><br>4.<br>• Implement user engagement and support mechanisms customized to the identified needs of independent practices, ensuring ongoing progress and adaptation to evolving needs and preferences measuring progress quarterly.<br>• Provision of initial onboarding assistance and training resources tailored to specific requirements is already in process and will continue to improve with the evolving needs and preferences measuring progress quarterly.<br><br>**5.**<br>• Quarterly collection and analysis of feedback to adapt the marketing strategies and support mechanisms as per the evolving needs of the target audience.<br>• Develop a feedback-driven refinement plan for the upcoming phases based on the accumulated insights by the end of Q4 2024. |

**Strategy 3**: **Use of Veradigm for Behavioral Health**

The eHealth Services Team will review an alternate version of the Veradigm (Allscripts) EHR more suitable for small behavioral health providers and will determine if this service will add value for small behavioral health practices.

**Strategy categories:** Select which category(ies) pertain to this strategy

☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☒ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**

☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Provider types supported with this strategy:**

☐ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☒ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

Veradigm's software lacked a tailored version to meet the specific requirements of behavior health providers, as it was not originally designed for this specialized field. Moreover, the cost was a significant barrier for most small behavioral health practices, making it financially unfeasible for them to adopt the system.

**Overview of 2024-26 plans for this strategy** (Optional):

**Planned Activities**

**1.**

**Strategy 4**: Outreach And Education for Behavioral Health EHR

The AllCare eHealth team will organize a comprehensive initiative to promote EHR adoption and outreach across our entire network of behavioral health providers to market and implement the Therapy Notes platform effectively.

**Strategy categories:** Select which category(ies) pertain to this strategy

☒ 1: TA ☐ 2: Assessment ☒ 3: Outreach ☒ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☒ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**

☒ Ongoing ☐ New ☐ Paused ☒ Revised ☐ Completed/ended/retired/stopped

**Provider types supported with this strategy:**

☐ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☒ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
AllCare has partnered with Therapy Notes to offer a discounted rate for their network of behavioral health providers.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|
| Increasing EHR Adoption for Behavioral Health Providers<br><br>To address specific needs and encourage the adoption of Electronic Health Records (EHR) in the Behavioral Health providers, below are the following planned activities<br><br>1. Provider Assessment without EHR<br><br>• Comprehensive Needs Assessment: Conduct a thorough evaluation of behavioral health providers currently without EHR systems. Identify their specific challenges, workflow requirements, and concerns related to EHR adoption.<br><br>• Understanding Barriers: Identify the barriers that prevent providers from adopting EHR systems. This may include concerns about cost, training requirements, or perceived disruptions to existing workflows.<br><br>2. Marketing Plan for Outreach<br><br>• Targeted Messaging: Develop a targeted marketing plan to effectively communicate the benefits of EHR adoption to behavioral health providers. Highlight how EHR systems can improve patient care, | • Complete a comprehensive needs assessment of behavioral health providers without EHR systems by the end of Q2 2024.<br><br>• Develop and launch a targeted marketing plan that includes targeted messaging, engagement strategies and showcasing success stories for outreach by the end of Q2 2024. |

| | |
|---|---|
| streamline operations, and support regulatory compliance.<br>• Engagement Strategies: Implement engagement strategies, such as direct outreach, and partnerships with Therapy Notes, to raise awareness about the benefits of EHR adoption in Behavioral Health.<br>• Showcasing Success Stories: Share success stories and testimonials from behavioral health providers who have successfully adopted EHR systems. Highlight the positive impact on patient care, practice efficiency, and regulatory compliance.<br>By implementing these planned activities, the barriers to EHR adoption in Behavioral Health can be identified and addressed, and providers can be encouraged to embrace technology that will ultimately enhance patient care and practice operations. | |

**Strategy 5: Support for behavioral health providers**
The Behavioral Health Team and the eHealth Services Team will pursue solutions to support behavioral health providers with their implementation/continuation of telehealth services.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☒ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Provider types supported with this strategy:**
☐ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☒ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy)
AllCare has partnered with Therapy Notes to offer a discounted rate for their network of behavioral health providers.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. | **1**. |

**Strategy 6**: **Patient-Level Data EHR Based Measure**

The Healthcare Network Management will implement a patient-level data EHR based measure as a VBP bonus measure for Primary Care and Pediatric providers.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☒ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Provider types supported with this strategy:**
☐ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☒ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
Due to do the provider feedback, this strategy will be discontinued to the ongoing work force challenges in the area. Providers continue to experience limited workforce issues both in support staff and credentialed staff. Shortages in staffing create barriers to development of additional innovation strategies.

**Overview of 2024-26 plans for this strategy** (Optional):

**Planned Activities**
**1.**

**Strategy 7: EHR Adoption and/or Technical Assistance**
The Sr. Director of Oral Health Services will explore funding opportunities to support Oral Health EHR Adoption.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☒ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Provider types supported with this strategy:**
☐ Across provider types OR specific to: ☐ Physical health ☒ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy): There was difficulty securing funding to support this strategy. The dental EHR is extremely cost prohibitive for the offices to implement. It was decided to pursue a different approach.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. | 1. |

**Strategy 8**: **Integration of EHR and HIE**
The eHealth Team will continue its work to ensure the AllCare eHealth EHR products (Allscripts) seamlessly integrate with Reliance HIE via directional interfaces.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☒ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Provider types supported with this strategy:**
☐ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☒ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
Reliance is now part of the EHR package.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. | **1.** |

**Strategy 9**: **Tracking EHR adoption**
The Provider Services Team will track EHR adoption and change through the review and monitoring of quarterly provider profiles; by doing this we can effectively monitor progress, identify areas for improvement, and provide targeted support to enhance the overall adoption of Electronic Health Record systems within provider offices.

**Strategy categories:** Select which category(ies) pertain to this strategy

☐ 1: TA ☒ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☒ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**

☒ Ongoing ☐ New ☐ Paused ☒ Revised ☐ Completed/ended/retired/stopped

**Provider types supported with this strategy:**

☒ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
The eHealth team's efforts to track EHR adoption progress were hindered as they dedicated a significant portion of their resources to transitioning sites from Prime Suite to Veradigm, leading to a slowdown in the tracking process.

**Overview of 2024-26 plans for this strategy** (Optional):

| Planned Activities | Planned Milestones |
|---|---|
| 1. 1. **Established Data Collection Methods**<br>• Collect data on the EHR adoption and change through quarterly provider profiles | 1. Complete, as this is already being performed. |
| **2. Defining Key Metrics**<br>• Specific metrics to track, such as EHR utilization rate, training and support requests, system update frequency, and user feedback. | 2. Finalize key metrics to be included in the quarterly provider profiles will be completed by the end of Q2 2024. |
| **3. Data Analysis and Insights**<br>• Analyze the collected data to derive insights regarding EHR adoption and change trends, challenges, and areas for improvement. | 3. Present first set of insights from the data analysis by end of Q3 2024. |
| **4. Actionable Recommendations**<br>• Formulate actionable recommendations based on the insights gained from the data analysis to support EHR adoption and facilitate transitions. | 4. Develop and present actionable recommendations derived from the data analysis by the end of Q3 2024. |
| **5. Continuous Improvement Review**<br>• Conduct a review of the effectiveness of the tracking strategy and make any necessary adjustments to the data collection methods and key metrics. | 5. Complete review and implementation of any identified improvements to the tracking strategy by the end of Q4 2024. |

**Strategy 10**: **Encourage participation of utilizing CEHRT**
The Provider Services Team and eHealth Services Team will engage offices that have not adopted an EHR and will encourage participation through discussion of the importance and benefits associated with utilizing CEHRT.

**Strategy categories:** Select which category(ies) pertain to this strategy

☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☒ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**

☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Provider types supported with this strategy:**
☐ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☒ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
The strategy is being incorporated in strategy 3 & 10.

**Overview of 2024-26 plans for this strategy** (Optional):

| Planned Activities | Planned Milestones |
|---|---|
| 1. | **1**. |

**Strategy 11**: **EHR Adoption and/or Technical Assistance for Oral Health**
AllCare will continue to survey and monitor the adoption and utilization of oral health EHR in dental practices within our service area and will partner with the Dental Care Organizations (DCO's) to encourage continued investigation of acceptable and certified EHR. AllCare will continue to collaborate with the oral health professionals in AllCare's service area by researching EHR platforms that are compatible and able to interface with medical EHR platforms. AllCare will touch base with the DCO's on the monthly check in meetings we have with them. This strategy will be monitored quarterly.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: TA ☐ 2: Assessment ☒ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☐ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

**Strategy status:**
☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped

**Provider types supported with this strategy:**
☐ Across provider types OR specific to: ☐ Physical health ☒ Oral health ☐ Behavioral health

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
This strategy is challenging due to the difficulty in the different EHR's not communicating with each other, oral health EHR is nonexistent unless you use the EPIC products. There were a few offices that converted from paper charts to highly effective dental practice management software, but not an integrated EHR.

**Overview of 2024-26 plans for this strategy** (optional):

| Planned Activities | Planned Milestones |
|---|---|
| 1. In 2024, Capitol Dental began working with the American Dental Association on a unique software that would function similar to the oral health EPIC product called Wisdom Tooth. AllCare will continue to obtain updates from Capitol Dental Care on the progress of design and implementation. | 2. Capitol Dental to complete this by end of Q3 2024 and implement by end of Q4 2024. |

## B. EHR Support Barriers: (Optional)

**Please describe any barriers that inhibited your progress to support EHR adoption, use, and/or optimization among your contracted providers.**

### C. OHA Support Needs: (Optional)

| **How can OHA support your efforts to support your contracted providers with EHR adoption, use, and/or optimization?** |
|---|
| |

## 4. Use of and Support for HIE for Care Coordination and Hospital Event Notifications

### A. CCO Use of HIE for Care Coordination and Hospital Event Notifications: 2023 Progress & 2024-26 Plans

Please describe your 2023 progress and 2024-26 plans for using HIE for care coordination AND timely hospital event notifications within your organization. In the spaces below (in the relevant sections), please:

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. List and describe specific tool(s) you currently use or plan to use for care coordination and timely hospital event notifications.
3. (Optional) Provide an overview of CCO's approach to using HIE for care coordination and hospital event notifications.
4. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 for using HIE for care coordination and hospital event notifications within the CCO include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. Strategy status
    d. Provider types supported
    e. A description of 2023 progress, including:
        - accomplishments and successes (including number of organizations, etc., where applicable)
        - challenges related to each strategy, as applicable
    f. (Optional) An overview of CCO 2024-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

**Notes:**

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2024, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

**Strategy category checkboxes (within CCO)**
Using the boxes below, please select which strategies you employed during 2023 and plan to implement during 2024-26. Elaborate on each strategy and your progress/plans in the sections below.

| Progress | Plans | | Progress | Plans | |
|---|---|---|---|---|---|
| ☒ | ☒ | 1. Care coordination and care management | ☒ | ☒ | 4. Enhancements to HIE tools (e.g., adding new functionality or data sources |

| | | | | | |
|---|---|---|---|---|---|
| ☒ | ☒ | 2. Exchange of care information and care plans | ☒ | ☒ | 5. Collaboration with external partners |
| ☒ | ☒ | 3. Integration of disparate information and/or tools with HIE | ☐ | ☐ | 6. Other strategies for supporting HIE access or use (please list here): |

**List and briefly describe tools used by CCO for care coordination and timely hospital event notifications**

A. PointClickCare- for real time Hospital, Emergency Department, Observation Status, Skilled Nursing Facility – admission and discharge information, in real time.
    1. Allows for prioritized outreach
    2. Ensures continuity of care for members
    3. Identifies members who may be experiencing new triggering events
B. Reliance E Health – Health Information Exchange provides clinical information from participating providers.
    1. Facilitates exchange of information through offering:
        a. Community Health Record
            1. Admit and discharge
            2. Member visit summary
            3. Lab, Radiology
            4. Transcribed reports
        b. Provider secure messaging

(Optional) **Overview of CCO Approach to using HIE for care coordination and hospital event notifications**

AllCare CCO Behavioral Health and Population Health teams utilize HIE tools to monitor member data in real time to ensure the most comprehensive and effective outreach and engagement, care planning and provider communication will take place to support effective care for our population.

**Strategy 1**: **Population Health Targeted Cohort Development.**
The Population Health Care Coordination team will continue to monitor developed cohorts of patients for Hospital Event Notifications and ED/Hospital utilization and monitoring for referral to Care Coordination. Additional cohorts will be developed throughout 2024 and beyond to ensure the identification of specific cohorts and target care coordination services to strategic populations.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: Care Coordination ☒ 2: Exchange care information ☒ 3: Integration of disparate information
☒ 4: HIE tool enhancements ☒ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**
☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped

**Overview of 2024-26 plans for this strategy** (Optional):
Population Health management is engaged with PointClickCare to develop a pilot cohort for LTSS members to monitor Emergency Department/Inpatient/Observation Admission and Discharges to identify vulnerable members who are eligible for Population Health Care Coordination, and possible care plan updates. Additional cohort development will be considered for readmission rates. Primary hypertension as the initial main criteria will be explored first as our pilot cohort to identify and determine if this cohort will be beneficial to members. Based on the work related to this cohort, we may expand to other complex medical needs.

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
**CY22**: Population Health Care Coordination Transition of Care TOC and Maternal Child Health (MCHA) hubs monitored appropriately designated cohorts of patients for HEN and ED/hospital utilization and monitored for referral Care Coordination services. **Successes** of this work include: ability to engage with members more quickly, in real time, to ensure members are supported with the appropriate resources. Members are provided a Health Risk Assessment and an Intensive Care Coordination Assessment if applicable to identify any SDOH-E needs as well as any medical supports related to their stay.
**CY23:** AllCare Population Health management continued to identify additional cohorts for risk stratification related to special health care needs (prioritized populations), or conditions that allowed us to target interventions quickly

to support members. In the last quarter of 2023 AllCare Population Health management developed a cohort for members who were designated LTSS. This allowed the Population Health Care Coordination team to monitor ED/Inpatient/Observation status for admission and allowed us to engage those members into Care Coordination appropriately. **Challenges**: staff turnover, changing OARs.

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. Development work with PointClickCare on new cohort design: LTSS Emergency Department/inpatient/Observation LTSS admits and Emergency Department /inpatient/Observation LTSS discharge.<br>2. Identify workflow and train Population Health team members on PointClickCare LTSS cohort monitoring and Hospital Event Notifications into Care Management System.<br>3. Ensure all barriers to care are identified and work to engage members care team, care plan creation for LTSS members in cohort.<br>4. Development work with PointClickCare on new cohort design: Primary Diagnosis Hypertension Readmission cohort<br>5. Identify workflow and train Population Health team members on PointClickCare Primary Diagnosis Hypertension Readmission cohort monitoring and Hospital Event Notifications into Care Management System.<br>a. Education member<br>b. Remove barriers<br>c. Connect with Hospital<br>d. Plan with PCP/Care team<br>6. Monitor readmission of Primary Diagnosis Hypertension cohort members for reduced hospitalization rates. If successful, consider creation of cohorts for complex medical conditions. Identify additional activities that may be related to this cohort if successful. | 1. LTSS Cohorts finalized by end of Q1 2024.<br>2. LTSS Cohort training and monitoring completed end of Q2 2024.<br>3. Staff outreach, and documented care plan created 100% of targeted members in identified cohort by end of Q4 2024.<br>4. Primary Diagnosis Hypertension Readmission cohort created and finalized by end of Q1 2025.<br>5. Primary Diagnosis Hypertension Readmission cohort workflow training and monitoring completed end of end of Q3 2025.<br>6. Review data for readmission rates and determine success of cohort monitoring by end of 2026 and determine baseline and set possible target for reduction. |

**Strategy 2**: **Technical Solution allowing The Ability To Share A Member's Care Plan Electronically With The Member.**

AllCare is seeking to provide Member care plans available electronically to members in their preferred language, upon completion, or when there is a change / update to the care plan.

**Strategy categories:** Select which category(ies) pertain to this strategy

☒ 1: Care Coordination ☒ 2: Exchange care information ☒ 3: Integration of disparate information

☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**

☐ **Ongoing** ☒ **New** ☐ **Paused** ☐ **Revised** ☐ **Completed/ended/retired/stopped**

**Progress (including previous year <u>accomplishments/successes</u> and <u>challenges</u> with this strategy):**

We are in the initiation stage of our plan to identify a technical vendor. Challenges: OARs were not approved until 2/1/24, cost of systems reviewed, new software application adoption.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. Define requirements<br>2. Identify a viable vendor to ensure compliance with OARs<br>3. Demos with vendors<br>4. Execute an acceptable contract with vendor. | 1. Define requirements by end of Q1 2024.<br>2. Identify an appropriate technical vendor to ensure member care plans can be shared electronically, in members preferred language, in electronic format by end of Q3 2024. |

| | |
|---|---|
| 5. Implement a technical solution to ensure compliance<br>6. Identify workflows and train staff on new functionality and documentation requirements | 3. View demos by end of Q3 2024.<br>4. Execute contract by end of Q4 2024.<br>5. Implementation of technical solution by end of Q4 2024.<br>6. Identify new workflows, create desk procedures, and train staff by end of Q4 2024. |

**Strategy 3**: **Technical Solution For Risk Stratification**.
AllCare is seeking a technical solution allowing the ability to risk stratify our membership into the following categories no- or low-risk, moderate-risk, high-risk.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: Care Coordination ☐ 2: Exchange care information ☐ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☒ 6: Other: Provide better care, prioritize care

**Strategy status:**
☐ Ongoing ☒ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
Identification of a technical vendor, and work engaged, to implement a solution for the risk stratification of our membership. In March of 2024 Population Health Leadership will engage with the OHA workgroups regarding workflow discussion, and starting contract discussion. Challenges: OHA has not provided guidance on their approved risk stratification algorithm.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. Identify a viable vendor to ensure compliance with OARs.<br>2. Execute an acceptable contract with vendor.<br>3. Implement a technical solution to ensure compliance.<br>4. Identify possibility of new workflows<br>5. Train staff on new functionality and documentation requirements<br>6. Identify targeted care program models based on Population Health improvements to capture efficiencies and improve health and allow members to make high dollar/value care decisions.<br>7. Identify strategies that are successful and build off of those models of care. | 1. Identify an appropriate vendor to ensure member care plans can be shared electronically to members in a proper format by end of Q2 2024.<br>2. Execute contract by end of Q3 2024.<br>3. Implement technical solution by end of Q3 2024.<br>4. Document workflows, create desk procedures by Q4 2024.<br>5. Train Population Health staff on risk stratification and new care planning requirements for members that fall into med/risk, high risk stratification, by end of Q4 2024.<br>6. Monitor data to determine changes to existing QAPI and set baselines, use 6 months of data to set baseline end of Q2 2025.<br>7. Determine QAPI improvement targets Q2 2025. |

**Strategy 4**: **Sharing HIE Information With Contracted Behavioral Health Providers**
The Behavioral Health Team will share HIE information with contracted Behavioral Health providers to ensure that members receive timely Behavioral Health Care Coordination pertaining to hospitalization, discharge planning and outpatient follow up.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: Care Coordination ☒ 2: Exchange care information ☐ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☒ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**
☒ Ongoing ☐ New ☐ Paused ☒ Revised ☐ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
Behavioral Health Transitions Team navigates members from hospital to care placement. In 2024 the Behavioral Health team will identify total numbers from 2023 and implement a process for tracking and review.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|

| | |
|---|---|
| 1. Transitions team to monitor HIE information each weekday and share with potential BH providers, reviewed quarterly for progress.<br>2. BH Team to daily track and review acute psychiatric hospital discharge.<br>3. BH Team is notified and tracks daily, 370 members who admit and discharge from OSH towards likely re-enrollment. | 1. BH Team coordination will increase successful hospital follow-up by 3% by end of Q4 2024 as measured by a BH follow up within 3 days of discharge, and a second follow up within 30 of discharge. This milestone encompasses progress on all three activities. |

**Strategy 5**: **Hospital Qualifying Events – Behavioral Health**

The Behavioral Health Clinical Transitions Supervisor will use the PointClickCare platform daily to monitor local, regional, and national hospital usage for AllCare members, specifically those identified as LTSS, 'ED Disparity Measure', or those identified as 'High Readmit Risk'. Qualifying hospital events are reported to active Care Coordinators, contracted SUD and MH providers, and, if member does not have a case open currently in the case management software, to all Population Health Leadership for case review and assignment.

**Strategy categories:** Select which category(ies) pertain to this strategy

☒ 1: Care Coordination ☒ 2: Exchange care information ☒ 3: Integration of disparate information

☐ 4: HIE tool enhancements ☒ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**

☒ Ongoing ☐ New ☐ Paused ☒ Revised ☐ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy): Transitions Coordinator to automate tracking for internal notifications made.

**Overview of 2024-26 plans for this strategy** (Optional):

| Planned Activities | Planned Milestones |
|---|---|
| 1. Daily checks of PointClickCare information and cohorts to monitor admission into ED and BHU in order to assist with successful transition back to the community.<br>2. Track internal notifications to population health care coordination by email, spreadsheet, and/or Essette. | 1. Quarterly review demonstrates automated tracking established.<br>2. Baseline for internal notifications by end of Q4 2024. |

**Strategy 6**: **Monitoring of Hospital Event Notifications**

The Population Health Team, Behavioral Health Team, and the Sr. Director of Oral Health Services will monitor Hospital Events Notifications daily.

**Strategy categories:** Select which category(ies) pertain to this strategy

☒ 1: Care Coordination ☐ 2: Exchange care information ☐ 3: Integration of disparate information

☐ 4: HIE tool enhancements ☒ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**

☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy): This process has been operationalized and at this time we are in the stages of refining workflows to identify new cohorts of members for care coordination, outreach, targeted outreach, or for engagement for population health improvement. See strategy 1 above that is created regarding targeted cohort development.

**Overview of 2024-26 plans for this strategy** (Optional):

| Planned Activities | Planned Milestones |
|---|---|

**Strategy 7**: **Forwarding PointClickCare Platform**

AllCare Care Coordination Team will distribute reports from the PointClickCare platform to dedicated staff to identify frequent users of hospital services (avoidable events and over-utilization) as well as any person engaged in care coordination.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: Care Coordination ☒ 2: Exchange care information ☒ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☒ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
CY22: AllCare Care Coordination management determined that utilizing the PointClickCare platform application, rather than a report, allows for real time action and intervention to engage with members where they are at.
**CY23:** This strategy will be retired as there is more efficient technology available, (PointClickCare) to do this work in real time, and those workflows are adopted to address members needs more efficiently.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|

**Strategy 8**: **Utilization of PointClickCare application to identify Hospital Notification and ED Utilization**
Through the utilization of PointClickCare application, Population Health Care Coordination Transitions of Care (TOC) and Maternal Child Health (MCH) Hubs will monitor appropriately designated cohorts of patients for Hospital Event Notifications and ED/hospital utilization and monitoring for referral to Care Coordination services.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: Care Coordination ☒ 2: Exchange care information ☒ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☒ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
This workflow was continued throughout 2023 and fully operationalized. The quick identification of members has allowed us to engage members while they are experiencing health issues. **Successes:** ability to rapidly engage with members, in real time, to ensure members are supported with the appropriate resources, allowing for the initiation of referrals faster and in a timelier fashion. **Challenges:** staff turnover, changing OARs.

**Overview of 2024-26 plans for this strategy** (Optional):
Strategy has been completed.

| **Planned Activities** | **Planned Milestones** |
|---|---|

**Strategy 9**: **Engaging Members And Community Partners**
The Population Health Department will utilize Hospital Event Notifications and Skilled Nursing Facility Notifications to engage members and community partners like Hospital discharge teams, APD, Nursing Homes, and Rehabilitation facilities to coordinate care when members experience these transitions.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: Care Coordination ☐ 2: Exchange care information ☒ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☒ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
All Population health staff are trained on PointClickCare, upon onboarding. AllCare Care Coordination management will continue to monitor existing cohorts for event notifications that happen in real time, conduct refresher trainings, review data and metrics for the creation of any new/targeted cohorts. **Successes**: ability to engage with members more quickly, in real time, to ensure members are supported with the appropriate resources, allowing for the initiation of referrals faster and in a timelier fashion. **Challenges**: staff turnover created frequent training, and gaps to knowledge base.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|

**Strategy 10**: **Enhancing Oral Health Focus During Care Coordination**
The Sr. Director of Oral Health Services will participate in regularly scheduled monthly Care Coordination meeting's or Interdisciplinary Team Meetings (IDTs). This will aid staff in navigating the needs for members with oral health issues, complex dental needs, and dental emergencies.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: Care Coordination ☒ 2: Exchange care information ☒ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress (including previous year accomplishments/successes and challenges with this strategy):**
This happens ad hoc now and will continue as needed. Population Health holds weekly Interdisciplinary Team Meetings, this meeting is attended by Population health team members, Sr. Director of Oral Health, Medical Directors, Behavioral Health Team members, providers, members, and any other associated care team providers. IDT members are invited on an as needed basis, and attendance is ad hoc and when it is appropriate to best suit member's needs.

**Overview of 2024-26 plans for this strategy (Optional):**

| **Planned Activities** | **Planned Milestones** |
|---|---|

**Strategy 11**: **HIE for Utilization Management**
The Utilization Management Team uses Point ClickCare which provides the team with inpatient information for concurrent review purposes when members are inpatient and out of the area which guides their referrals to specialists and to the AllCare Population Health Care Coordination team.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: Care Coordination ☐ 2: Exchange care information ☒ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☒ 5: Partner collaboration ☐ 6: Other:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Overview of 2024-26 plans for this strategy** (Optional):

**Progress** (including previous year accomplishments/successes and challenges with this strategy): Utilization Management Team continued to utilize the Reliance and PointClickCare platforms to augment EPIC information for concurrent review of inpatient stays. This tool proved to be essential when assisting members with complex medical care needs in the inpatient setting and ensuring that their transition of care needs were addressed. These systems provided vital information needed to link members, family members, and/or care providers to social service supports and other available resources.

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. | 1. |

## B. Supporting Increased Access to and Use of HIE Among Providers: 2023 Progress & 2024-26 Plans

Please describe your 2023 progress and 2024-26 plans for supporting increased access to and use of HIE for care coordination and timely hospital event notifications for contracted physical, oral, and behavioral health

providers. Please include any work to support clinical referrals between providers. In the spaces below (in the relevant sections), please:

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. List and describe specific HIE tool(s) you currently or plan to support or provide for care coordination and hospital event notifications. CCO-supported or provided HIE tools must cover both care coordination and hospital event notifications. Please include an overview of key functionalities related to care coordination.
3. Report the number of physical, oral, and behavioral health organizations that have not currently adopted HIE tools for care coordination or do not currently have access to HIE for hospital event notifications using the Data Completeness Table in the OHA-provided CCO Health IT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.
4. (Optional) Provide an overview of CCO's approach to supporting increased access to and/or use of HIE for care coordination and hospital event notifications among contracted physical, oral, and behavioral health providers.
5. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 to support increased access to and/or use of HIE for care coordination and hospital event notifications among contracted physical, oral, and behavioral health providers include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. Strategy status
    d. Provider types supported
    e. A description of 2023 progress, including:
        - accomplishments and successes (including the number of organizations of each provider type that gained access to HIE for care coordination tools and HIE for hospital event notifications as a result of your support, where applicable)
        - challenges related to each strategy, as applicable

       Note: Where applicable, information in the CCO Health IT Data Reporting File should support descriptions of accomplishments and successes.
    f. (Optional) An overview of CCO 2024-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

**Notes:**

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2024, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

**Strategy category checkboxes (supporting providers)**

Using the boxes below, please select which strategies you employed during 2023 and plan to implement during 2024-26. Elaborate on each strategy and your progress/plans in the sections below.

| Progress | Plans | | Progress | Plans | |
|---|---|---|---|---|---|
| ☐ | ☐ | 1. HIE training and/or technical assistance | ☐ | ☐ | 8. Financially support HIE tools and/or cover costs of HIE onboarding |
| ☐ | ☐ | 2. Assessment/tracking of HIE adoption and capabilities | | | |

| | | | | | |
|---|---|---|---|---|---|
| ☒ | ☒ | 3. Outreach and education about value of HIE | ☒ | ☒ | 9. Offer incentives to adopt or use HIE |
| ☐ | ☐ | 4. Collaboration with network partners | ☐ | ☐ | 10. Offer hosted EHR product (that allows for sharing information between clinics using the shared EHR and/or connection to HIE) |
| ☐ | ☐ | 5. Enhancements to HIE tools (e.g., adding new functionality or data sources) | | | |
| ☐ | ☐ | 6. Integration of disparate information and/or tools with HIE | ☒ | ☐ | 11. Other strategies that address requirements related to federal interoperability and patient access final rules (please list here): |
| ☐ | ☐ | 7. Requirements in contracts / provider agreements | | | |
| ☐ | ☐ | 12. Other strategies for supporting HIE access or use (please list here): | | | |

**List and briefly describe tools supported or provided by CCO that facilitate care coordination and/or provide access to timely hospital event notifications.** HIE tools must cover both care coordination and hospital event notifications.

A. PointClickCare - for real time Hospital, Emergency Department, Observation status, Skilled Nursing Facility – admission and discharge information, in real time.
    1. Allows for prioritized outreach
    2. Ensures continuity of care for members
    3. Identifies members who may be experiencing new triggering events
B. Reliance E Health (Veradigm Allscripts) – Health Information Exchange provides clinical information from participating providers.
    1. Facilitates exchange of information through offering:
        a. Community Health Record
            1. Admit and discharge
            2. Member visit summary
            3. Lab, Radiology
            4. Transcribed reports
        b. Provider secure messaging

(Optional) **Overview of CCO approach to supporting increased access to and/or use of HIE for care coordination and hospital event notifications among contracted providers**

Using the Data Completeness Table in the OHA-provided CCO Health IT Data Reporting File, **report on the number of contracted physical, oral, and behavioral health organizations that do not currently have access to an HIE tool for care coordination or for hospital event notifications**:

| Measure | Physical Health | P | Behavioral Health | | Oral Health | |
|---|---|---|---|---|---|---|
| | Org count | Rate | Org count | Rate | Org count | Rate |
| **Number of organizations (denominator)** | **137** | | **67** | | **10** | |
| **No HIE** | 8 | 6% | 52 | 78% | 7 | 70% |

**Strategy 1: Hospital Event Notifications Training and/or Technical Assistance**

AllCare's Senior Leadership will continue its financial support of the Reliance platform to ensure providers across various services have access to needed training and/or technical assistance on adopting and/or utilizing HIE for Hospital Event Notification.

**Strategy categories:** Select which category(ies) pertain to this strategy

☐ 1: Care Coordination ☐ 2: Exchange care information ☐ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☒ 6: Other: HEN/Reliance HIE

**Strategy status:**

☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Overview of 2024-26 plans for this strategy** (Optional):

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
This has been operationalized by our Leadership team and has been retired.

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. | 1. |

**Strategy 2**: **Promote HIE/CIE Adoption And Usage Through Education and Incentives**

Educate providers on options instead of Reliance for closed loop referrals such as Unite Us or other HIE such as PointClickCare to promote to the providers. Outreach and education through training in the systems.

**Strategy categories:** Select which category(ies) pertain to this strategy

☒ 1: Sponsor CIE ☒ 2: Financial ☐ 3: TA ☐ 4: Assessment ☒ 5: Outreach/Education ☐ 6: Participation
☒ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☒ 11: Clinical referrals: ☐ 12: Payments
☒ 13: Other adoption: ☐ 14: Other data access/use:

**Strategy status:**

☐ Ongoing ☐ New ☐ Paused ☒ Revised ☐ Completed/ended/retired/stopped

**Provider types supported with this strategy:** ☒ Across provider types OR
specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☐ Social Services ☐ CBOs

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
In 2023, AllCare increased the number of practices participating and utilizing the Unite Us platform. AllCare is providing user licenses for our IPA practices to reduce potential financial barriers that offices may have with implementation. Onsite training has also been provided for offices in collaboration with Unite Us and the Oregon Health Leadership Council (OHLC). Some internal AllCare users also have the capability to view and track utilization and referral trends.

**Overview of 2024-26 plans for this strategy** (Optional):
Provide additional onsite training with Unite Us and OHLC. Promote HIE/CIE adoption and usage through education and inclusion as an incentive measure in the Alternative Payment Models

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. Monthly Unite Us online education, training and user support https://events.uniteus.com/?state=oregon.<br>2. Referrals through UniteUs reviewed for trends by provider using UniteUs Insights.<br>3. HIE/CIE incentive measures added to Primary Care/Pediatrics, Specialty, Behavioral Health and Dental APMs | 1. Additional onsite Unite Us training completed by end of Q3 2024.<br>2. Referral Trend reporting reviewed on a quarterly basis starting in Q2 2024.<br>3. Measures that were included in 2023 APMs, submitted responses will be reviewed for trends by end of Q3 2024. |

## C. HIE for Care Coordination Barriers: (Optional)

| **Please describe any barriers that inhibited your progress to support access to and use of HIE for care coordination and/or timely hospital even notifications among your contracted providers** |
|---|
| |

## D. OHA Support Needs (Optional)

| **How can OHA support your efforts to support your contracted providers with access to and use of HIE for care coordination and/or Hospital Event Notifications?** |
|---|
| |

## E. CCO Access to and Use of EHRs (Optional)

| **Optional**: Please describe CCO current or planned access to contracted provider EHRs. Please include which EHRs CCO has or plans to have access to including how CCO accesses or will access them (e.g., Epic Care Everywhere, EpicCare Link, etc.), what patient information CCO is accessing or will access and for what purpose, whether patient information is or will be exported from the EHR and imported into CCO health IT tools. |
|---|
| **Which EHRs does CCO have or will have access to and how does or will CCO access them (e.g., Epic Care Everywhere, EpicCare Link, etc)?** |
| |
| **What patient information is CCO accessing or will CCO access and for what purpose?** |
| |
| **Is/will patient information being/be exported from the EHR and imported into CCO health IT tools? If so, which tool(s)?** |
| |

## 5. Health IT to Support SDOH Needs

### A. CCO Use of Health IT to Support SDOH Needs: 2023 Progress & 2024-26 Plans

Please describe CCO 2023 progress and 2024-26 plans for using health IT within your organization to support social determinants of health (SDOH) needs, including but not limited to screening and referrals. In the spaces below (in the relevant sections), please:

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. List and describe the specific health IT tool(s) you currently use or plan to use for supporting SDOH needs. Please specify if the health IT tool(s) have closed-loop referral functionality (e.g., Community Information Exchange or CIE).
3. (Optional) Provide an overview of CCO's approach to using health IT within the CCO to support SDOH needs, including but not limited to screening and referrals.
4. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 for using health IT within the CCO to support SDOH needs, including but not limited to screening and referrals, include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. Strategy status
    d. Provider types supported
    e. A description of 2023 progress, including:
        - accomplishments and successes (including number of organizations, etc., where applicable)
        - challenges related to each strategy, as applicable
    f. (Optional) An overview of CCO 2024-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

**Notes:**

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned Milestones sections.
- If CCO is implementing a strategy beginning in 2024, please indicate 'N/A' in the Progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

**Strategy category checkboxes (within CCO)**

Using the boxes below, please select which strategies you employed during 2023 and plan to implement during 2024-26, within your organization. Elaborate on each strategy and your progress/plans in the sections below.

| Progress | Plans | | Progress | Plans | |
|---|---|---|---|---|---|
| ☒ | ☐ | 1. Implementation/use of health IT tool/capability for social needs screening and referrals | ☐ | ☐ | 6. Integration or interoperability of health IT systems that support SDOH with other tools |
| ☒ | ☐ | 2. Care coordination and care management of individual members | ☐ | ☒ | 7. Collaboration with network partners |
| | | | ☐ | ☐ | 8. CCO metrics support |
| ☒ | ☐ | 3. Use data to identify individual members' SDOH experiences and social needs | ☐ | ☐ | 9. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources) |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | ☐ | 4. Use data for risk stratification | ☐ | ☒ | 10. Participate in SDOH-focused health IT collaboratives, convening, and/or governance |
| ☐ | ☐ | 5. Use health IT to monitor and/or manage contracts and/or programs to meet members' SDOH needs | ☐ | ☐ | 11. Other strategies for supporting CIE use within CCO (please list here): |
| ☐ | ☐ | 12. Other strategies for CCO access or use of SDOH-related data within CCO (please list here): | | | |

**List and briefly describe Health IT tools used by CCO for supporting SDOH needs**, including but not limited to screening and referrals

At this time, AllCare uses a variety of Health IT tools that can be utilized by providers, community partners, and members. These tools can be used for social needs screening and referrals. Current tools include:

- Provider Portal Providers can check eligibility of members, request PCP and DCO changes, providers can request care coordination for members via secure messaging. Providers can also submit and verify Prior authorizations, view claims statuses.
- Member Portal – AllCare CCO members have access to the Health Risk Assessment on the online member portal, and are able to complete this at a time of their choosing, once completed it is forwarded to the Population Health team for follow up. Member's can request PCP changes, DCO changes, and demographic changes through the online member portal. Additionally, members can utilize secure messaging through the member portal with any member concerns or questions. Care Coordination Requests, HRS, and HRSN requests may be submitted via the member portal as well.
- Unite Us
    - Is a closed-loop referral system with multiple OHA SDOH-E approved screening tools imbedded within the system. This platform provides a non-English mode to assist for screen and document accessibility for Spanish speaking individuals.
- Phreesia is used in our network clinics to conduct SDOH screening, which involves assessing patients for social needs that may impact their health and well-being. This is typically done through a survey or questionnaire that covers various aspects of patients' social circumstances, such as housing, food security, transportation, and financial resources. When a patient screens positive for one or more social needs and agrees to receiving assistance, a referral is processed through Unite Us.

(Optional) **Overview of CCO approach to using health IT within the CCO to support SDOH needs, including but not limited to screening and referrals**

**Strategy 1**: **Identification And Electronic Referral Of Members Who Have SDOH-E Needs**

Through completion of our Health Risk Survey, community referrals, and provider referrals, we will identify members who have SDOH-E needs and utilize the Unite Us application to send referrals to community partners.

**Strategy categories:** Select which category(ies) pertain to this strategy

☐ 1: Health IT Implementation ☒ 2: Care coordination ☒ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☒ 7: Collaboration ☒ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: Other SDOH data:

**Strategy status:**

☐ Ongoing ☒ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped

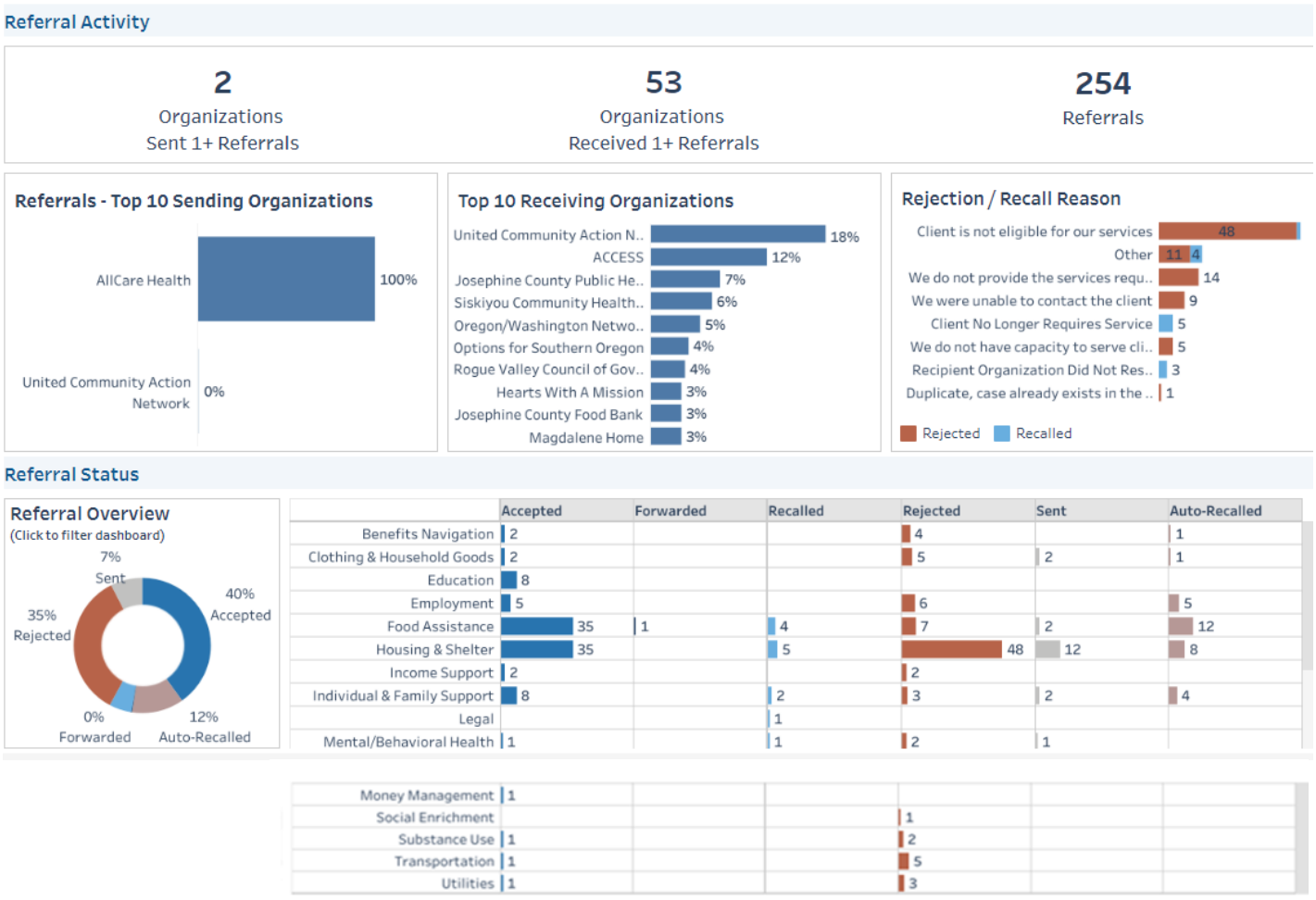
**Progress** (including previous year accomplishments/successes and challenges with this strategy):

Population Health management has standardized a training process to onboard team members on the CIE. All Population Health team members receive training, as all team members may engage with members by completing the Health Risk Survey and identifying SDOH-E needs. If a member declines to complete a Health Risk Survey they may still indicate a need, and choose to have a closed loop referral sent through the CIE.

**Success:** Training of all staff and approach which prioritizes members being served at any time for any need.

In 2023 AllCare Population Health Care Coordination staff initiated 254 referrals on behalf of members. We were able to support members with the following referral pathways: Benefits Navigation, Clothing and Household Goods, Education, Employment, Food Assistance, Housing and Shelter, Income Support, Individual and Family Support, Legal Support, Mental and Behavioral Health, Money Management, Substance Use, Transportation, and Utilities.

Capturing this information allows us to understand the common resources our members need most. This information helps to inform Community Advisory Council decisions and provides data to our internal Community Benefit initiatives. Challenges: Not enough community partners utilizing the CIE to create robust utilization.




**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. Continue to train-onboard Population Health staff, which will lead to the sending of referrals through the CIE platform.<br>2. Refine training as needed (evaluate continuously).<br>a. Should community need change, reevaluate process and ensure training is appropriate. | 1. Run monthly reports to identify referral usage.<br>a. Approx. 24 referrals a month<br>2. Monthly reports that identify changes to the community network reviewed with Population Health team during monthly All Staff meetings.<br>3. Increase outgoing referrals by 10% for 2024. |

| | |
|---|---|
| b. HRSN benefit impacts to community may create changes to our referral network/needs<br>3. Create engagement for Population Health All Staff meetings to identify new providers in network and communicate this during Population Health All Staff meetings monthly.<br>a. Create refresher for staff to understand who is on platform<br>b. Identify potential training gaps<br>c. a and b will work to increase referrals sent through the CIE platform<br>4. Q & A training with Unite Us mid-year to provide updates / education refresher on platform changes, this planned education will serve to not only provide education but engagement as well. Tracking number of staff and referrals sent to determine if training has impacts to CIE usage. | a. 2023=254 total referrals<br>b. 2024=280 total referrals (10% increase for the year)<br>4. Track number of Pop Health staff Unite Us Q & A training and education session completed by end of Q2 2024. |

**Strategy 3**: **Educating On The Importance of CIE for Oral Health**
AllCare will actively participate in at least one oral health state governance meeting driving the importance of CIE expansion and utilization to support SDOH-E needs identified by members.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: Sponsor CIE ☐ 2: Financial ☐ 3: TA ☐ 4: Assessment ☒ 5: Outreach/Education ☐ 6: Participation
☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

**Strategy status:**
☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped

**Provider types supported with this strategy:** ☐ Across provider types OR
specific to: ☐ Physical health ☒ Oral health ☐ Behavioral health ☐ Social Services ☐ CBOs

**Progress** (including previous year accomplishments/successes and challenges with this strategy): AllCare attends and continues to attend monthly Oral Health Forum meetings at the State level to drive home the importance of CIE use in the dental offices.

**Overview of 2024-26 plans for this strategy** (Optional):

| Planned Activities | Planned Milestones |
|---|---|
| 1. Adding importance of CIE expansion to Oral Health Governance meeting as an agenda item<br>2. Continue monthly meetings with DCO partners to get reports on CIE usage. | 1. Include agenda item by end of Q3 2024.<br>2. Increase CIE usage by 10% by Q4 2025<br>3. Increase CIE usage by 20% by Q4 2026 |

**Strategy 4: Maximizing HIE To Support Communities During Emergencies**
AllCare IT, Compliance, PACE, Utilization Management and Population Health will maintain communications with the State's Office of Emergency Management, ODHS-EM, and local emergency management groups as shifts to utilization of the Unite Us Platform take place to maximize supports available to communities during future emergency events.

**Strategy categories:** Select which category(ies) pertain to this strategy

☐ 1: Health IT Implementation ☒ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☒ 7: Collaboration ☐ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☒ 11: Other CIE Use: Emergency Management ☐ 12: Other SDOH data:

**Strategy status:**

☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
This strategy is now built into AllCare's operational practices. AllCare attends a variety of emergency management meetings such as the Southwest Oregon Healthcare Preparedness Organization (SWOHPO) Healthcare Coalition and the Josephine County Healthcare Partners Meeting. AllCare maintains a close working relationship with the ODHS Office of Resilience and Emergency Management (OREM). Communication can fluctuate depending on local and regional emergent needs. During the Rum Creek fire, AllCare reiterated the necessity in utilizing Unite Us to OREM and other collaborative partners. It is believed that this continual championing of a CIE during disasters resulted in OREM's recent transition and use of the Unite Us platform for climate related emergency referrals.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. N/A | 1. N/A |

**Strategy 5**: **Maintaining Early Childhood Collaborative Partnerships To Support And Forward HIE Strategies**

AllCare to continue collaborative partnership with Oregon Health Leadership Council (OHLC) and Unite Us to conduct quarterly webinars for CBOs who are providing SEH services for children ages 0-5 in AllCare's service area. This strategy provides CBOs with the tools and knowledge specific to SEH services that would result in efficient and increased referrals to SEH local services. This will provide an improved coordination of care for children/families throughout our region.

**Strategy categories:** Select which category(ies) pertain to this strategy

☐ 1: Health IT Implementation ☐ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☒ 7: Collaboration ☒ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: Other SDOH data:

**Strategy status:**

☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
AllCare successfully collaborated with OHLC and Unite Us hosting the first onsite in-person Unite Us trainings since Covid-19. The training was offered to AllCare internal staff, Early Childhood Educators (ECE), BH service providers, and physical health service providers. The training material aligned with SEH metric requirements. All three in-person trainings were conducted in a four-hour training block which was offered over a 2-day period. Each training session provided an opportunity for participants to obtain access, learn how to use the referral platform, problem solve workflow barriers, make new connections, and develop new pathways supporting CIE community expansion.

The region did see an increase in CIE utilization following each webinar and in-person trainings. Additionally, AllCare's internal referral usage increased. These efforts have now placed AllCare as one of the top 5 referring entities in Southern Oregon. Continual resources are now in place to maintain CIE utilization and success. Such resources include online Unite Us monthly training opportunities open to any platform user: ECE partners, CBOs, and all service area providers. Based on this success and other CIE work continuing, AllCare this strategy has been completed and efforts have been shifted to focus on the SDOH metric.

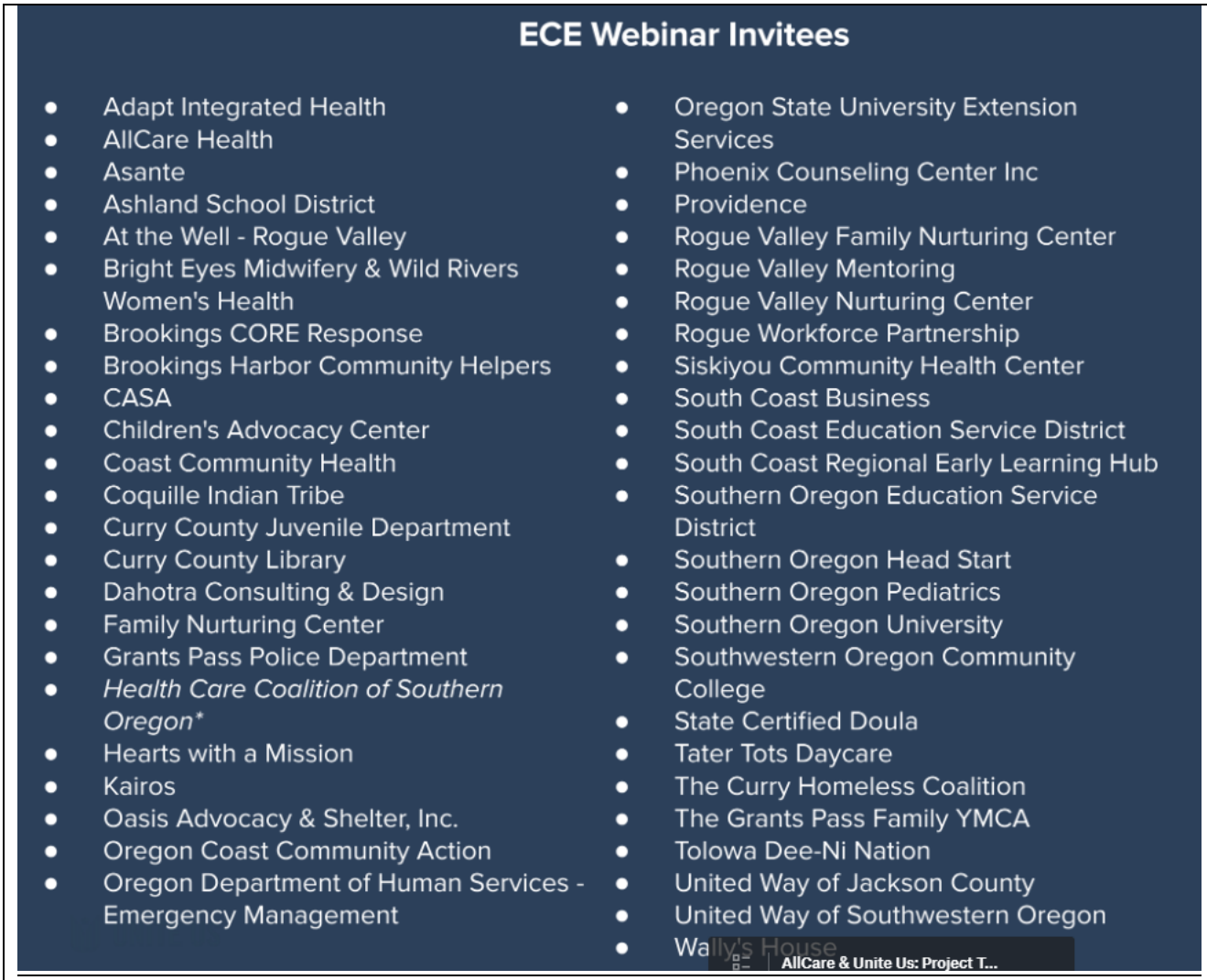
Provider Onsite October 2023

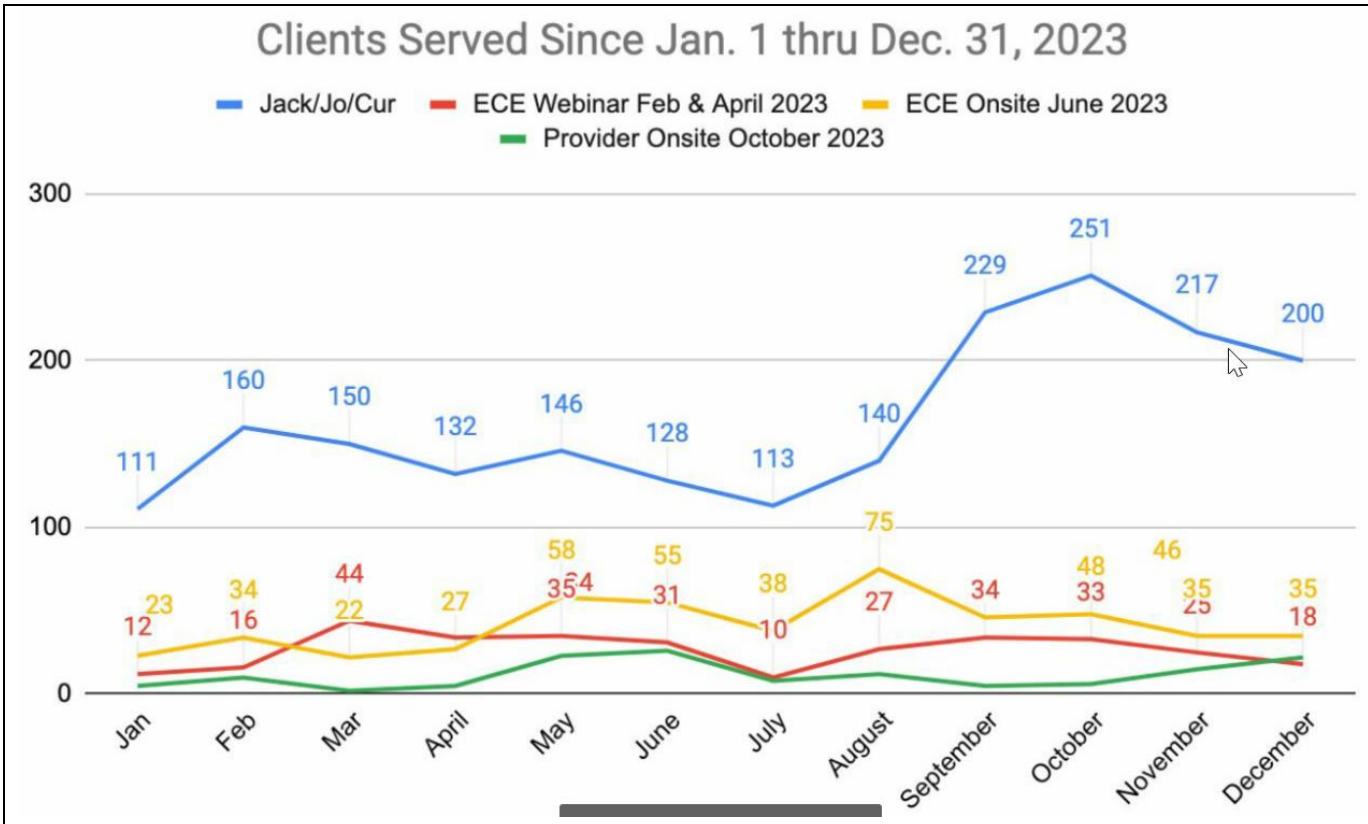
15 Clinics Represented
28 Individual Provider Attendees

ECE Onsite June 2023

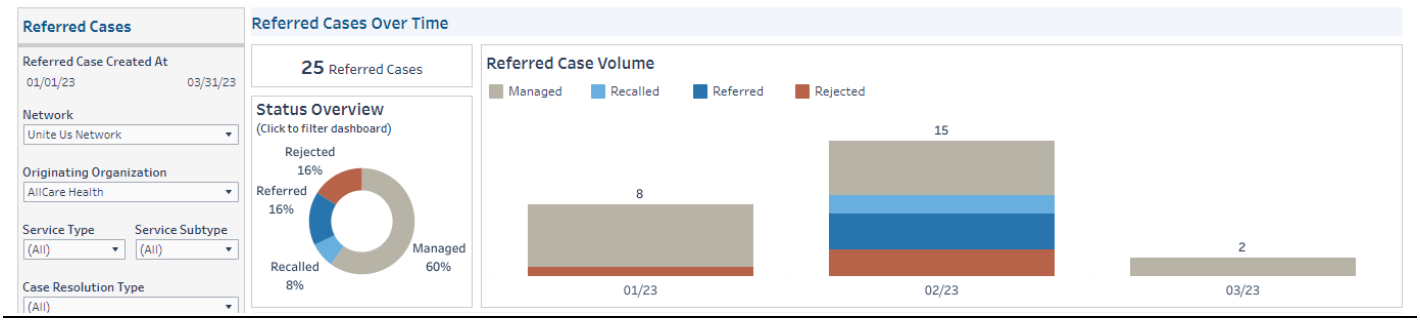
| Org | Attendee Count |
|---|---|
| AllCare | 29 |
| Boys & Girls Club | 1 |
| Family Nurturing Center | 15 |
| GP Sobering Center | 1 |
| GP YMCA | 1 |
| Jackson Co WIC | 1 |
| Josephine County Public Health | 1 |
| Options | 2 |
| SCREL | 1 |
| Siskiyou Community Health Center | 7 |
| SO ESD | 1 |
| SO Headstart | 4 |
| **Total** | **64** |

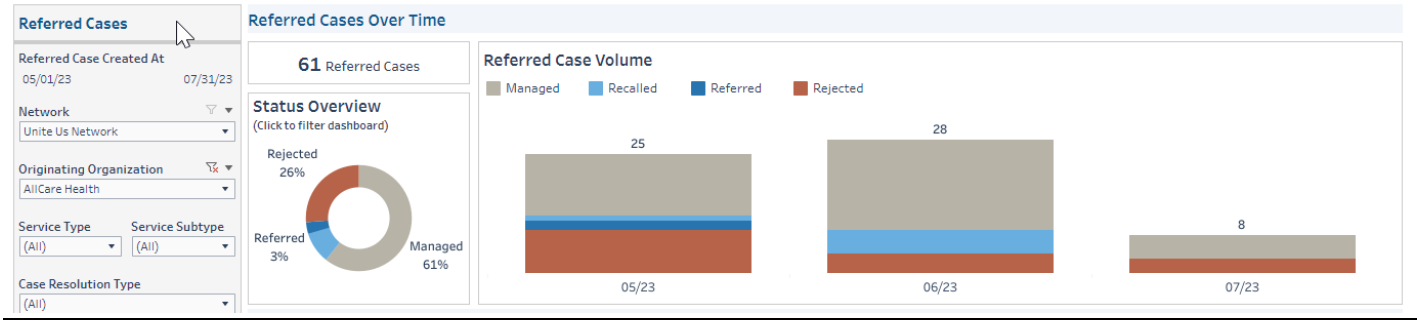
ECE Webinar Training 2023

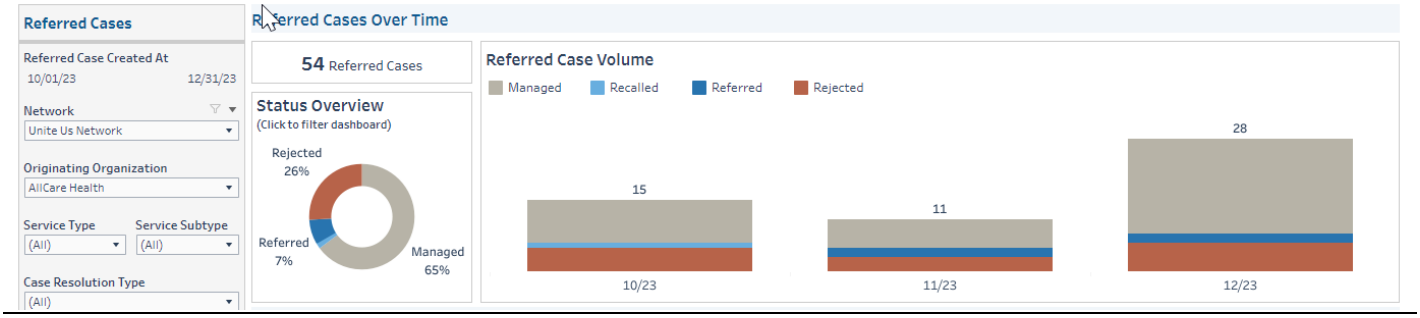

ECE Webinar Invitees
Adapt Integrated Health
AllCare Health
Asante
Ashland School District
At the Well - Rogue Valley
Bright Eyes Midwifery & Wild Rivers Women's Health
Brookings CORE Response
Brookings Harbor Community Helpers
CASA
Children's Advocacy Center
Coast Community Health
Coquille Indian Tribe
Curry County Juvenile Department
Curry County Library
Dahotra Consulting & Design
Family Nurturing Center
Grants Pass Police Department
Health Care Coalition of Southern Oregon*
Hearts with a Mission
Kairos
Oasis Advocacy & Shelter, Inc.
Oregon Coast Community Action
Oregon Department of Human Services - Emergency Management
Oregon State University Extension Services
Phoenix Counseling Center Inc
Providence
Rogue Valley Family Nurturing Center
Rogue Valley Mentoring
Rogue Valley Nurturing Center
Rogue Workforce Partnership
Siskiyou Community Health Center
South Coast Business
South Coast Education Service District
South Coast Regional Early Learning Hub
Southern Oregon Education Service District
Southern Oregon Head Start
Southern Oregon Pediatrics
Southern Oregon University
Southwestern Oregon Community College
State Certified Doula
Tater Tots Daycare
The Curry Homeless Coalition
The Grants Pass Family YMCA
Tolowa Dee-Ni Nation
United Way of Jackson County
United Way of Southwestern Oregon
Wally's House
AllCare & Unite Us: Project T...




Internal Unite Us Referrals






**Overview of 2024-26 plans for this strategy** (Optional):
N/A

| Planned Activities | Planned Milestones |
|---|---|
| 1. N/A | 1. N/A |

**Strategy 6**: **Leveraging Data To Meet Members SDOH Needs**
AllCare's Community Health Improvement Team will use the data obtained from members who have completed a Health Risk Survey captured in AllCare's case management system (Essette). The quarterly data will be used to make informed HRS, SHARE, and HRSN investments matching member's Health Related Survey SDOH-E needs.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: Health IT Implementation ☒ 2: Care coordination ☒ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☐ 7: Collaboration ☒ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: Other SDOH data:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
There were multiple challenges with this strategy. The case management program where the Health Risk Survey/Assessment is documented does not easily produce the necessary data to support this strategy. To better align with internal processes and keep workflows consistent with clean data, AllCare will utilize the Unite Us Insights application to capture data, map trends, capture SDOH-E service needs, and identify additional referrals made within the platform. This strategy will be retired.

**Overview of 2024-26 plans for this strategy** (Optional):

| Planned Activities | Planned Milestones |
|---|---|
| 1. N/A | 1. N/A |

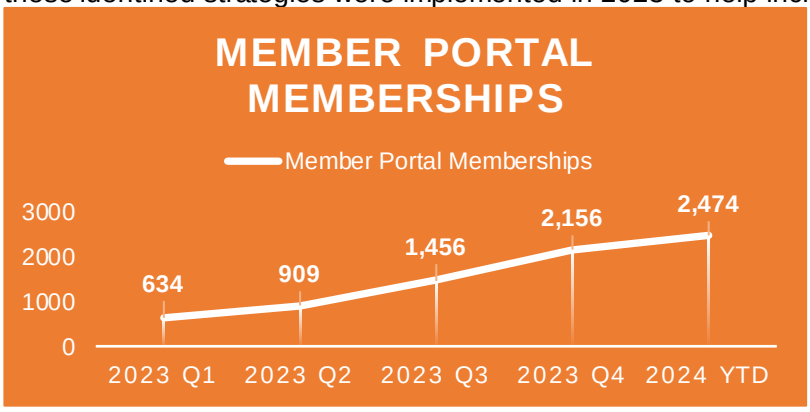
**Strategy 7**: **Increase Member Portal Membership**
Through the increase in membership to and utilization of our online Member Portal, AllCare CCO can provide more streamlined communication and access to information related to members' health plan benefits and care.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: Health IT Implementation ☒ 2: Care coordination ☒ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☐ 7: Collaboration ☐ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: Other SDOH data:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☒ Revised ☐ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy): AllCare CCO currently has 2,474 Member Portal memberships. In 2023, we posted about the Member Portal on our Public Website, Social Media pages, added Member Portal information to our call recordings when members are waiting

in the phone queue, and created Member Portal flyers that are now inserted into new member packets. All of these identified strategies were implemented in 2023 to help increase our engagement by the following amounts.




**Overview of 2024-26 plans for this strategy** (Optional): To work with the Finance team on planned Member incentives to increase Member Portal Memberships, with a goal of reaching 15% portal memberships by EOY.

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. Work with AllCare finance staff to identify potential incentives.<br>2. Increase utilization on the Member Portal to 15% as measured through HealthTrio reports.<br>3. Present at Quarterly Provider Meetings.<br>4. Work with Branding to create a Member Portal information page on our public website. | 1. Develop an incentive plan in collaboration with the Finance team by end of Q2 2024.<br>2. Develop a utilization report with measures by end of Q2 2024.<br>3. Complete 4 presentations to the Provider meetings by the end of Q4 2024.<br>4. Develop a Member Portal information by x date. |

## B. CCO Support of Providers with Using Health IT to Support SDOH Needs: 2023 Progress & 2024-26 Plans

Please describe your 2023 progress and 2024-26 plans for supporting contracted physical, oral, and behavioral health providers with using health IT to support SDOH needs, including but not limited to screening and referrals. Additionally, describe any progress made supporting social services and community-based organizations (CBOs) with using health IT in your community. In the spaces below, (in the relevant sections), please:

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. List and describe the specific tool(s) you currently or plan to support or provide to your contracted physical, oral, and behavioral health providers, as well as social services, and CBOs. Please specify if the tool(s) have screening and/or closed-loop referral functionality (e.g., CIE).
3. (Optional) Provide an overview of CCO's approach to supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals.
4. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 to support contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals, include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. Strategy status
    d. Provider types supported
    e. A description of 2023 progress, including:

- accomplishments and successes (including the number of organizations of each provider type that gained access to health IT to support SDOH needs as a result of your support, where applicable)
- challenges related to each strategy, as applicable

f. (Optional) An overview of CCO 2024-26 plans for each strategy

g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

**Notes:**

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2024, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones

**Strategy category checkboxes (supporting providers)**
Using the boxes below, please select which strategies you employed during 2023 and plan to implement during 2024-26. Elaborate on each strategy and your progress/plans in the sections below.

| Progress | Plans | | Progress | Plans | |
|---|---|---|---|---|---|
| ☒ | ☐ | 1. Sponsor CIE for the community | ☐ | ☐ | 8. Requirements in contracts/provider agreements |
| ☒ | ☐ | 2. Financial support for CIE implementation and/or maintenance | ☐ | ☐ | 9. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources) |
| ☒ | ☐ | 3. Training and/or technical assistance | ☐ | ☐ | 10. Integration or interoperability of health IT systems that support SDOH with other tools |
| ☐ | ☐ | 4. Assessment/tracking of CIE/SDOH tool adoption and use | ☐ | ☐ | 11. Support CBOs sending of referrals to clinical providers (i.e., to physical, oral, and behavioral health providers) |
| ☒ | ☐ | 5. Outreach and education about the value of health IT adoption/ use to support SDOH needs | ☐ | ☐ | 12. Utilization of health IT to support payments to community-based organizations |
| ☐ | ☐ | 6. Support participation in SDOH-focused health IT collaboratives, education, convening, and/or governance | ☐ | ☐ | 13. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs (please list here): |
| ☐ | ☐ | 7. Incentives and/or grants to adopt and/or use health IT that supports SDOH | ☐ | ☐ | 14. Other strategies for supporting access or use of SDOH-related data (please list here): |

**List and briefly describe health IT tools supported or provided by CCO that support SDOH needs,** including but not limited to screening and referrals**.**

At this time, AllCare uses a variety of Health IT tools that can be utilized by providers, community partners, and members. These tools can be used for social needs screening and referrals. Current tools include:

- Provider Portal – Providers can check eligibility of members, request PCP and DCO changes, providers can request care coordination for members via secure messaging. Providers can also submit and verify prior authorizations, and view claims statuses.

- Member Portal - AllCare CCO members have access to the Health Risk Assessment on the online member portal and are able to complete this at a time of their choosing. Once completed it is forwarded to the Population Health team for follow up. Members can request PCP changes, DCO changes, and demographic changes through the online member portal. Additionally, members can utilize secure messaging through the member portal with any member concerns or questions. Care Coordination Requests, HRS, and HRSN requests may be submitted via the member portal as well.
- Unite Us - Is a closed-loop referral system that houses various screening tools for providers and community partners to access. This system receives data from 211 info making it a robust tool. This platform provides a non-English mode to assist for screening and document accessibility for Spanish speaking individuals. This system is free to use for non-profits, Patient-Centered Primary Care Home Programs (PCPCH) and Federally Qualified Health Centers (FQHC). At this time, AllCare covers the cost for a limited number of physical, oral, and behavioral health services providers to have access to the Unite Us platform. There are currently four OHA SDOH screening tools embedded in the platform for use:
    - PRAPARE
    - Accountable Health Communities (AHC)
    - Health Leads
    - Hunger Vital Signs

(Optional) **Overview of CCO approach to supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals**

**Supporting and Incentivizing HRSN Service Providers**

**Any planning and/or preparation CCO has done in anticipation of 2024 requirement to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals, such as developing grants, technical assistance, outreach, education, and feedback mechanisms for HRSN Service Providers.**

In 2024, AllCare CCO is working with Unite Us and the Oregon Health Leadership Council (OHLC) to implement a closed loop process to accept referrals for HRSN services. AllCare CCO is exploring using the Unite Us platform for invoicing, payment and encountering for HRSN services for 2025.

**Specific plans to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals during Contract Years 2024-2026, such as developing grants, technical assistance, outreach, education, and feedback mechanisms for HRSN Service Providers.**

2024

- Build referral forms for potential partners
- Identify potential partners for CIE closed loop referrals
- Engage, contract and credential potential partners
- Training and education for partners for Unite Us referrals
- Go live date 6/1/24

2024 and 2025

- Develop additional referral pathways for HRSN (housing and nutrition focused)
- Start discovery process for payment platform module in Unite Us

**Strategy 1**: **Advancing And Standardizing Functionality And Use Of CIE The Platform.**

The Director of HIT, in collaboration with the Director of Community Engagement, will work internally with key stakeholders and externally with other CCOs as well as our CIE vendor, Unite Us. Through these collaborations, we will advocate the needs for and the development of the Unite Us CIE platform. The goal is to standardize necessary functionality and encourage use of the platform.

**Strategy categories:** Select which category(ies) pertain to this strategy

☐ 1: Health IT Implementation ☐ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☒ 7: Collaboration ☐ 8: Metrics support ☒ 9: CIE Enhancements
☐ 10: Governance ☒ 11: Other CIE Use: ☐ 12: Other SDOH data:

**Strategy status:**

☐ Ongoing ☒ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

A total of 15 of the 16 CCOs are engaged with the Unite Us organization, of which AllCare is one. Currently, each CCO acts relatively independently in its interaction with Unite Us for functional requirements within the platform, and yet all CCOs are responding to the same need to leverage this platform to encourage referrals and expansion of use throughout their respective community-partner networks.

In order to leverage this platform more efficiently by expanding its functionality, the need to ensure the standardization of the requested functionality becomes more apparent.

This strategy centers around the intent for AllCare Health to reach out to other CCOs to collaborate for needed functionality and respond to Unite Us with one voice to address a common need.

**Overview of 2024-26 plans for this strategy** (Optional):

| **Planned Activities** | **Planned Milestones** |
|---|---|
| 1. Select three CCOs to partner on overall Unite Us functionality.<br>2. Acquire a list of existing platform functionality from Unite Us.<br>3. Acquire a roadmap from Unite Us of planned functionality and rollout for 2024 and 2025.<br>4. In collaboration with other CCOs and Unite Us, establish a list of desired functionalities for 2024 and for 2025 – Determine gaps between list and Unite Us roadmap. | 1. Establish communication with selected three CCOs by end of Q2 2024.<br>2. Receive list of existing platform functionality from Unite Us by end of Q1 2024.<br>3. Receive Roadmap from Unite Us by end of Q2 2024.<br>4. Generate gap list by end of Q3 2024. |

**Strategy 2**: **Expansion Of The Closed-Loop Referral System (Unite Us)**

AllCare will continue the expansion of the closed-loop referral system (Unite Us), internally and externally to AllCare's community partners and providers. This expansion will be conducted by facilitating quarterly educational webinars, monthly community outreach, and internal monthly strategic planning meetings.

**Strategy categories:** Select which category(ies) pertain to this strategy

☒ 1: Sponsor CIE ☒ 2: Financial ☒ 3: TA ☐ 4: Assessment ☒ 5: Outreach/Education ☐ 6: Participation
☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

**Strategy status:**

☒ Ongoing ☐ New ☐ Paused ☒ Revised ☐ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

Over the last several years, AllCare has recognized fluctuating use of the Unite Us platform. These fluctuations have been impacted by staffing changes or turn-over, limited license allocations, community partners/providers navigating multiple systems, plus referrals not being processed in a timely manner. These findings prompted AllCare to take a proactive community approach in re-inviting partners to the CIE platform. This was done by offering monthly onboarding and orientation sessions provided by Unite Us (https://events.uniteus.com/?state=oregon), targeted quarterly educational webinars, and monthly community outreach. By having internal monthly strategic meetings, we were able to identify and resolve barriers, create a supportive CIE action plan to better serve the community, engage multiple internal departments to expand the CIE concept, and support metrics/contract obligations. CIE usage has increased with these efforts:

| | 2022 | 2023 | Total Increase |
|---|---|---|---|
| Clients | 1200 | 1857 | 55% |
| Cases | 1876 | 3223 | 72% |
| Managed cases | 1009 | 2036 | 50% |
| Referred cases | 1795 | 2973 | 40% |

(See network activity number and activity charts)

Monthly Community Outreach

Community outreach has been a collective effort between AllCare and Unite Us. Each month, network activity is reviewed for trends, concerns, or shifts in platform utilization. This review drives community partner outreach. One of the challenges identified in this activity was staff turn-over and limited Unite Us licenses within a medical office. This barrier slowed or stopped referral processes. As a result, AllCare is moving towards purchasing unlimited Unite Us licenses. This will allow total coverage for AllCare's entire service area within Southern Douglas, Curry, Jackson, and Josephine counties. Any medical office will have free Unite Us access and referring capabilities for all staff.

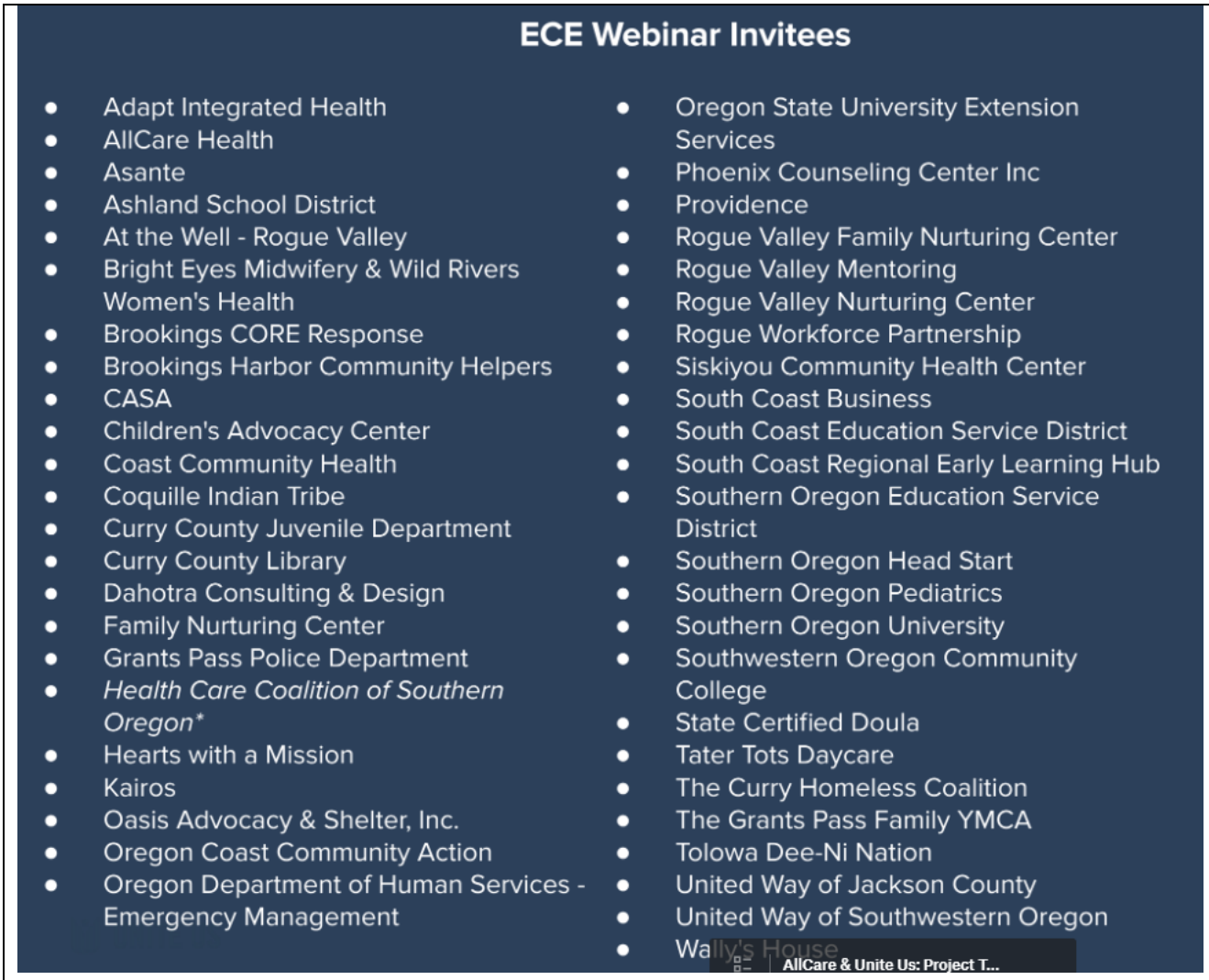
Internal Monthly Strategic Planning Meetings

In 2023, there was recognition to increase internal monthly meetings to weekly. These meetings involved participation from multiple internal departments to support the expansion of the Unite Us platform and meet multiple metrics (i.e., SEH metric, SDOH metric, and HRSN).

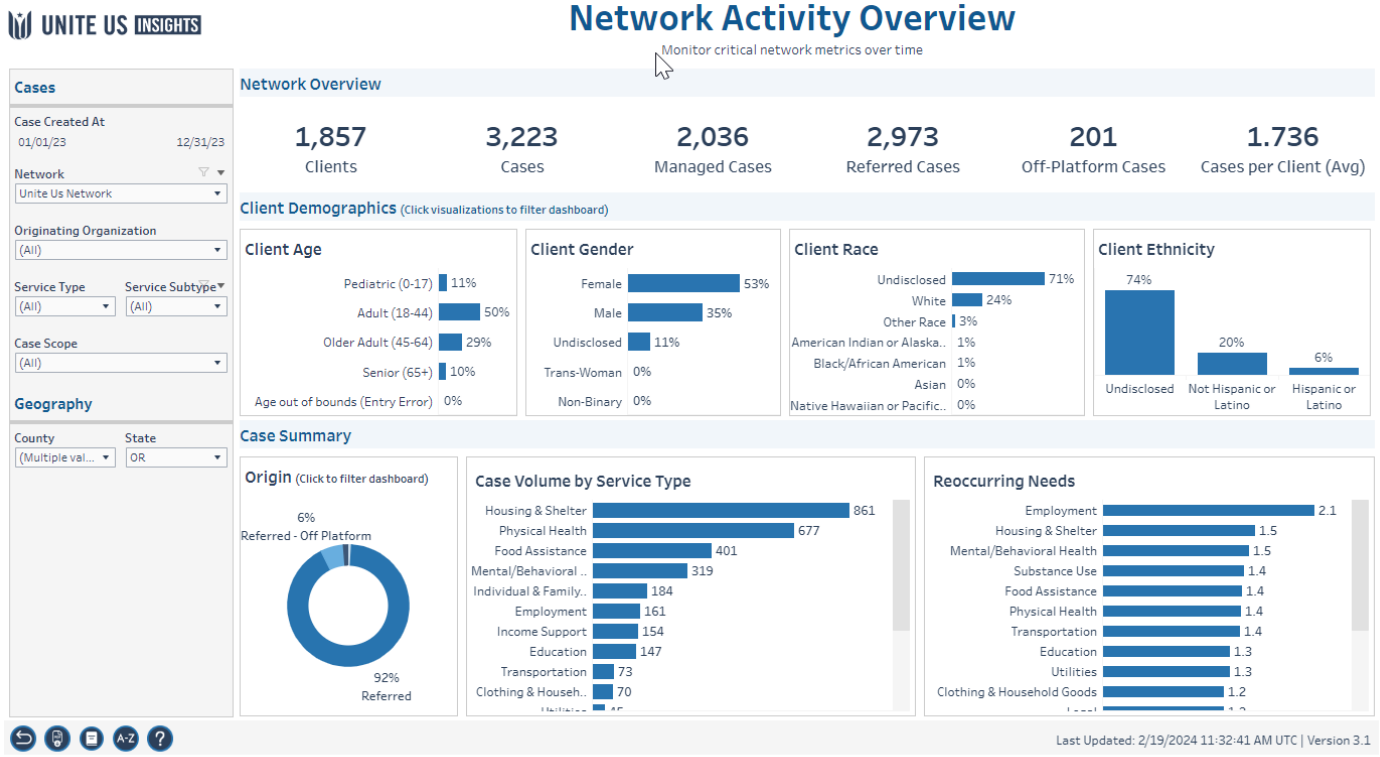
Quarterly Educational Webinars

Quarterly educational webinars are offered by Unite Us. These meetings were originally facilitated by AllCare in 2022-2023 however this strategic effort is now being provided by Unite Us. These current quarterly meetings are known as "Community of Practice". Each quarter a new topic is presented, discussed and worked through. An example from 2023 was discussing federal regulations and privacy rights specific to Health Insurance Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), Confidentiality of Substance Use Disorder 42 CFR part 2, and Violence Against Women Act (VAWA).

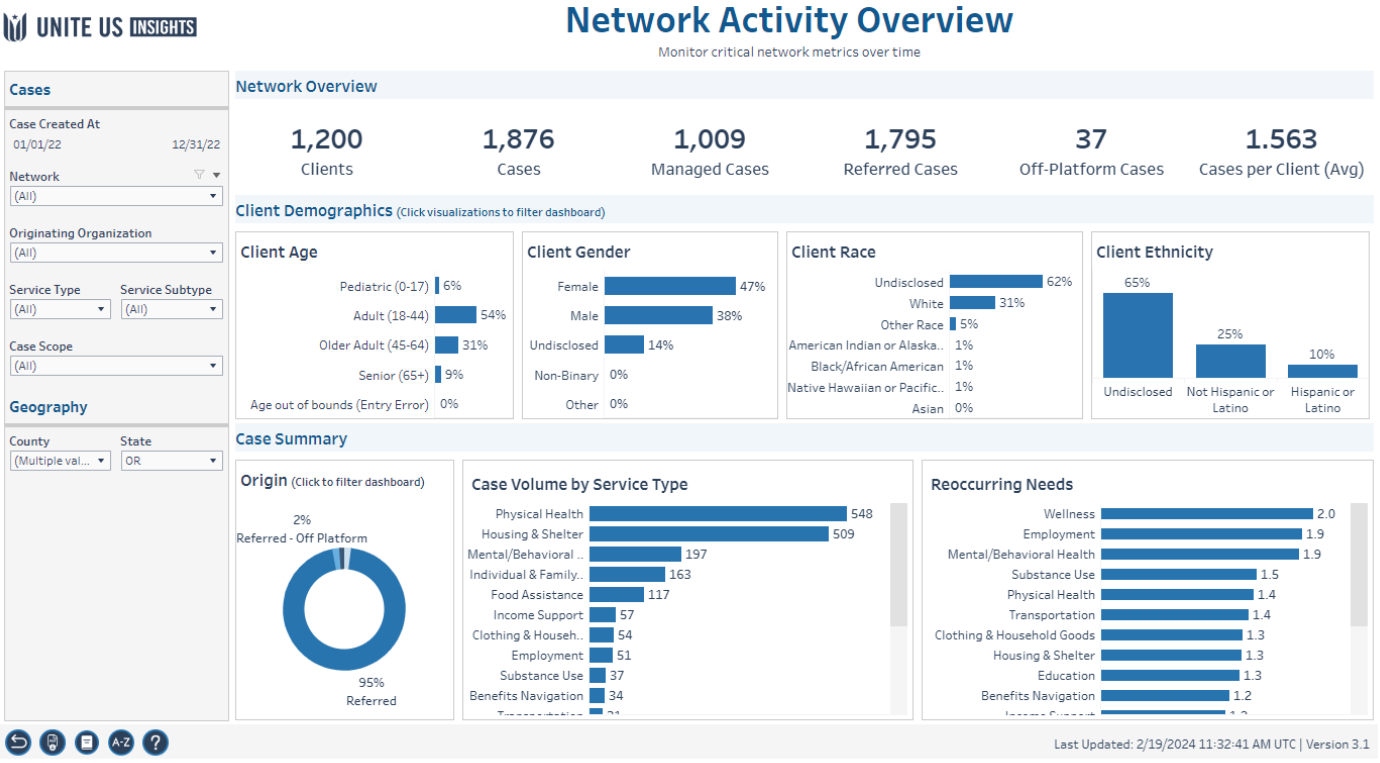
Quarterly 2023 Webinar Attendance



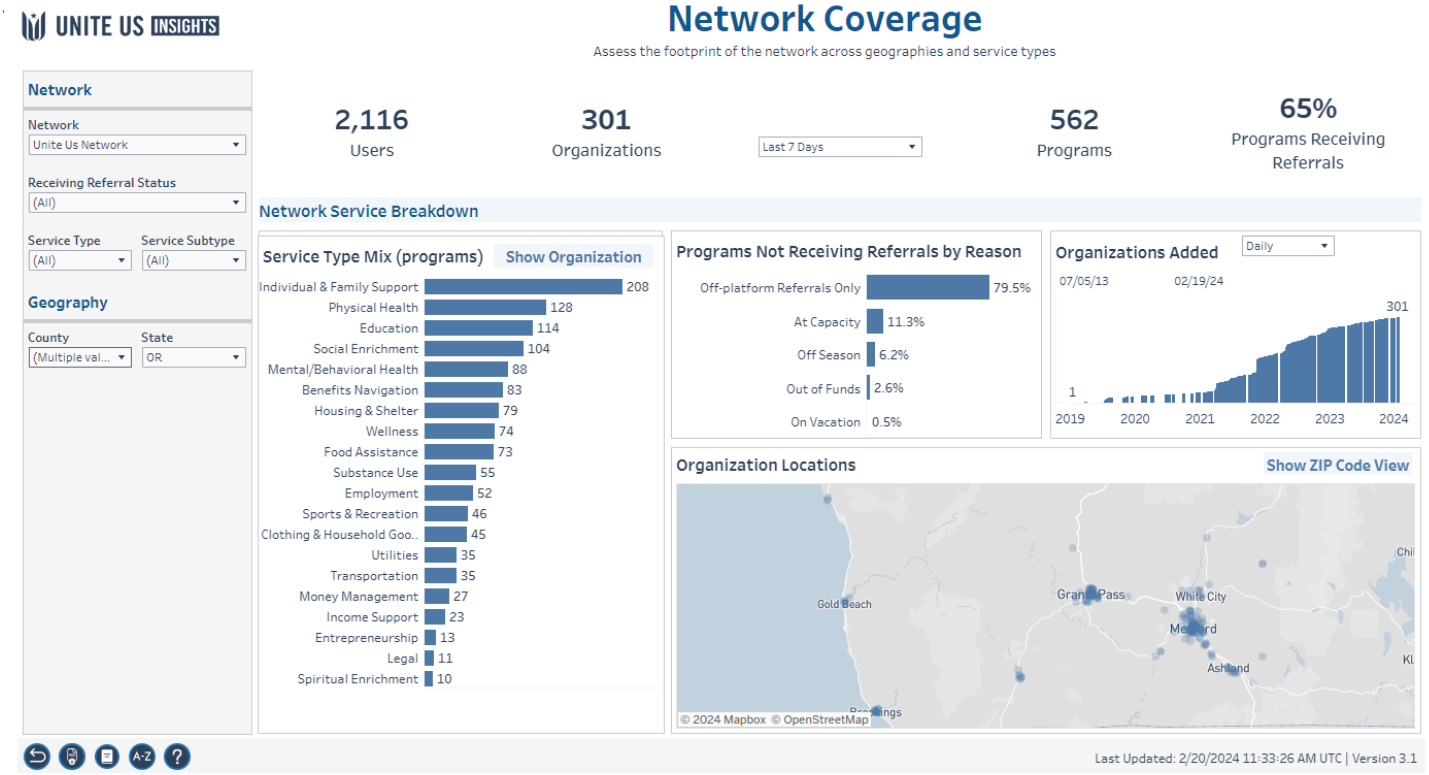

Unite Us Usage 2023




Unite Us Usage 2022




Current Network Coverage




**Overview of 2024-26 plans for this strategy** (Optional):

**Planned Activities**

1. Increase Unite Us license access for AllCare's service area to unlimited licenses before the end of Q1 2024.
2. Provide onsite for community partners before the end of Q2 2024 with a goal of training at least 85 participants total.
3. Continue monthly internal meetings to support various OHA metrics and CCO contractual obligations. The goal is to increase internal workflows that support Unite Us referrals and usage.
4. Track quarterly CIE utilization to measure strategy success.

**Planned Milestones**

1. A completed Unite Us contract amendment for unlimited licenses by end of Q1 2024.
2. Conduct a two-day training for community members.
    a. Training to be held in Jackson Co. before the end of Q2 2024 training at least 35 participants.
    b. Training to be held in Josephine Co. before the end of Q2 2024 training at least 35 participants.
    c. Training to be held in Curry Co. before the end of Q3 2024 training at least 15 participants.
3. Deploy internal mechanisms that support community platform referrals.
    a. Develop and deploy an internal Unite Us flex climate referral by end of Q2 2024.
    b. Develop and deploy a Unite Us referral form on the member portal before the end of Q4 2024.
    c. Develop and deploy a Unite Us referral form on the provider portal before the end of Q4 2024.

| | |
|---|---|
| | 4. Each quarter, analyze quarterly tableau data on CIE client, case, managed case, and referred case totals. |

**Strategy 3**: **Health IT for SDOH Needs (Oral Health)**
AllCare will continue to advocate for the use and expansion of the closed-loop referral system (Unite Us), internally and externally to AllCare's Oral Health providers. This exploration of the expansion will be conducted by participating in monthly meetings with OHA and the dental partners.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: Health IT Implementation ☐ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☐ 7: Collaboration ☐ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☒ 11: Other CIE Use: ☐ 12: Other SDOH data:

**Strategy status:**
☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
**CY 23**: The Sr. Director of Oral Health Services involved the Dental Care Partners in collaborations to launch and encourage the continued use of the Unite Us platform. We participated in meetings facilitated by Unite Us specific to dental partners to increase engagement and use of the platform for CIE. AllCare also actively participated in at least one oral health state governance meeting, the Oral Health Forum, driving the importance of CIE expansion and utilization to support SDOH-E needs identified by members.

**CY 24:** AllCare will continue the 2023 strategy to promote CIE use with the DCO's and all oral health professionals. We will continue to elevate the need for CIE use in the oral health offices.

Implementation and use continue to be challenging due to the inability to integrate the CIE into platforms such as the practice management software currently utilized by the offices.

**Overview of 2024-26 plans for this strategy** (Optional):
N/A

| Planned Activities | Planned Milestones |
|---|---|
| 1. AllCare will add CIE development and implementation to the State's Oral Health Forum monthly meeting agenda and discuss with partners.<br>2. AllCare will propose a learning collaborative at QHOC to discuss oral health CIE usage and how to further use this for SDOH needs. | 1. Add CIE development and implementation to Oral Health Forum April 2024 agenda.<br>2. Work with OHA for a QHOC learning collaborative session in Q3 2024. |

**Strategy 4: Educate And Monitor CIE Utilization**
AllCare will assist in CIE education within AllCare's service area and across the state with DCO's and oral health professionals. This collaboration will provide education while monitoring CIE utilization.

**Strategy categories:** Select which category(ies) pertain to this strategy
☐ 1: Health IT Implementation ☐ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☐ 7: Collaboration ☐ 8: Metrics support ☒ 9: CIE Enhancements
☐ 10: Governance ☒ 11: Other CIE Use: ☐ 12: Other SDOH data:

**Strategy status:**
☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress**
As a result of the webinars and TA for the oral health partners being finished, this strategy is completed.

**Overview of 2024-26 plans for this strategy** (Optional):

| Planned Activities | Planned Milestones |
|---|---|
| 1. N/A | 1. N/A |

**Strategy 5**: **Education Behavioral Health Provider To Increase Use And Adoption Of CIE**

AllCare's Behavioral Health Team will provide consultation to behavioral health providers regarding the general use of CIE and specific assistance with considerations of sensitive service types and applicable 42 CFR rules.

**Strategy categories:** Select which category(ies) pertain to this strategy

☐ 1: Health IT Implementation ☐ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☒ 7: Collaboration ☐ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☒ 11: Other CIE Use: ☐ 12: Other SDOH data:

**Strategy status:**

☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed/ended/retired/stopped

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
BH team and CIE platform met with BH providers to train and answer questions regarding privacy law. Behavioral Health team provided consultation in collaboration with CIE. Action complete.

**Overview of 2024-26 plans for this strategy** (Optional):

| Planned Activities | Planned Milestones |
|---|---|
| 1. N/A | N/A |

**Strategy 6**: **Accepting HRSN Referrals**
Create closed loop process to accept referrals for HRSN services in Unite Us platform

**Strategy categories:** Select which category(ies) pertain to this strategy

☒ 1: Sponsor CIE ☒ 2: Financial ☒ 3: TA ☒ 4: Assessment ☒ 5: Outreach/Education ☒ 6: Participation
☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☒ 11: Clinical referrals: ☐ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

**Strategy status:**

☐ Ongoing ☒ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped

**Provider types supported with this strategy:** ☐ Across provider types OR
specific to: ☒ Physical health ☐ Oral health ☐ Behavioral health ☒ Social Services ☒ CBOs

**Progress** (including previous year accomplishments/successes and challenges with this strategy):

1. Developed pilot parameters with external partners Unite Us and OHLC.
2. Created GAANT chart for project timeline for accepting referrals.
3. Reviewed interactive forms for referral to AllCare CCO for HRSN services in CIE.
4. Began identifying providers for the service to engage for referrals to AllCare CCO.

**Overview of 2024-26 plans for this strategy** (Optional):
In 2024, AllCare CCO is working with Unite Us and the Oregon Health Leadership Council (OHLC) to implement a closed loop process to accept referrals for HRSN services. Referrals will be limited to climate devices in Q2 and Q3 of 2024, with the intent to expand to housing and nutrition in the latter half of 2024 and 2025. AllCare CCO is exploring using the Unite Us platform for invoicing, payment and encountering for HRSN services for 2025.

| Planned Activities | Planned Milestones |
|---|---|
| 1. Build referral forms for potential partners.<br>2. Identify potential partners for CIE closed loop referrals. | Completion planned dates:<br>1. Completed by end of Q1 2024.<br>2. Completed by end of Q1 2024. |

| | |
|---|---|
| 3. Engage, contract and credential potential partners.<br>4. Training and education for partners for Unite Us referrals.<br>5. Go live with referral process for climate devices. | 3. Completed by end of Q2 2024.<br>4. Training and education completed by end of Q2 2024.<br>5. Implemented by end of Q2 2024. |

**Strategy 7**: **Leveraging Current Technology and Resources**
Explore using the Unite Us platform for HRSN service invoicing, payment and encounters.

**Strategy categories:** Select which category(ies) pertain to this strategy
☒ 1: Sponsor CIE ☒ 2: Financial ☒ 3: TA ☐ 4: Assessment ☐ 5: Outreach/Education ☐ 6: Participation
☐ 7: Incentives ☒ 8: Contracts ☒ 9: Enhancements ☒ 10: Integration ☐ 11: Clinical referrals: ☒ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

**Strategy status:**
☐ Ongoing ☒ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped

**Provider types supported with this strategy:** ☐ Across provider types OR
specific to: ☒ Physical health ☐ Oral health ☐ Behavioral health ☒ Social Services ☒ CBOs

**Progress** (including previous year accomplishments/successes and challenges with this strategy):
New strategy

**Overview of 2024-26 plans for this strategy** (Optional):
AllCare CCO is exploring using the Unite Us platform for invoicing, payment and encountering for HRSN services for 2025.

| Planned Activities | Planned Milestones |
|---|---|
| 1. Explore using Unit Us for payment and encounter for nutrition and housing.<br>2. Contract for additional module.<br>3. Training and education for partners for Unite Us payment module. | 1. Begin Q2 2024.<br>2. TBD, prior to 2025.<br>3. TBD, prior to 2025. |

## C. Health IT to Support SDOH Needs Barriers (Optional)

**Please describe any barriers that inhibited your progress to support contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support SDOH needs, including but not limited to screening and referrals.**

## D. OHA Support Needs (Optional)

**How can OHA support your efforts in using and supporting the use of health IT to support SDOH needs, including social needs screening and referrals?**

A total of 15 of the 16 CCOs are engaged with the Unite Us organization, of which AllCare is one. Currently, each CCO acts relatively independently in its interaction with Unite Us for functional requirements within the platform, and yet all CCOs are responding to the same need to leverage this platform to encourage referrals and expansion of use throughout their respective community-partner networks.

OHA could provide needed guidance and support to ensure the standardization of Unite Us among all CCOs.

## 5. Other Health IT Questions (Optional)

The following questions are optional to answer. They are intended to help OHA assess how we can better support the health IT efforts.

| |
|---|
| A. Describe CCO health IT tools and efforts that support **patient engagement**, both within the CCO and with contracted providers. |
| |
| B. How can **OHA support** your efforts in accomplishing your Health IT Roadmap goals? |
| |
| C. What have been your organization's **biggest challenges** in pursuing health IT strategies? What can OHA do to better support you? |
| |
| D. How have your organization's health IT strategies supported **reducing health inequities**? What can OHA do to better support you? |
| |

**Note**: For an example response to help inform on level of detail required, please refer to the 2023 Health IT Roadmap Guidance on the HITAG webpage.

For questions about the CCO Health IT Roadmap, please contact CCO.HealthIT@odhsoha.oregon.gov.