2025 CCO Health Information Technology (HIT) Roadmap

Guidance, Evaluation Criteria & Reporting Template

Contract or rule citation	Exhibit J, Section 2
Deliverable due date	March 15, 2025
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_2025_HealthIT_Roadmap**

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

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Guidance Document

1. Purpose & Background

CCOs are required to maintain an Oregon Health Authority (OHA) approved Health Information Technology (IT) Roadmap. The Health IT Roadmap must describe how the CCO (1) currently uses and plans to use health IT (including hospital event notifications) to achieve desired outcomes and (2) supports contracted physical, behavioral, and oral health providers throughout the course of the Contract in these areas:

- Electronic health record (EHR) adoption, use, and optimization
- Access to health information exchange (HIE) for care coordination and access to timely hospital event notifications
- Health IT for value-based payment (VBP) and population health management (Contract Years 1 & 2 only)[1]
- Health IT to support social determinants of health (SDOH) needs, including social needs screening and referrals (Starting in Contract Year 3)[2], including for community-based organizations (CBOs)

For Contract Year 1 (2020), CCOs' responses to the Health IT Questionnaire formed the basis of their draft Health IT Roadmap. For remaining Contract Years, CCOs are required to submit an annual Health IT Roadmap to OHA reporting the progress made from the previous Contract Year, as well as plans, activities, and milestones detailing how they will support contracted providers in future Contract Years. OHA expects CCOs to use their approved 2024 Health IT Roadmap as the basis for their 2025 Health IT Roadmap.

Reminders for Contract Year 6 (2025):

1. There are no changes to the Roadmap template. TA sessions are available upon request via CCO.HealthIT@odhsoha.oregon.gov.
2. Limit the Progress sections to 2024 activities and accomplishments and include planned activities for 2025 through 2026 in the Plans sections.
3. If CCO includes previous year progress (i.e., 2023 or earlier) for context/background, be sure to label it as such. 2024 progress should be clearly labeled and described.
4. If CCO is continuing a strategy from prior years, please continue to report it and indicate "Ongoing" or "Revised" as appropriate.
5. In each Plans section, be sure to include activities and milestones for each strategy. If some strategies are missing activities and milestones, CCO may be asked to revise and resubmit their Roadmap.
6. Be sure to include milestones beyond 2025, as applicable.
7. When adding additional strategy reporting sections, please be sure to copy and paste the strategy section from the same part of the Roadmap (checkboxes differ section to section and so will be incorrect if copied and pasted from other parts of the Roadmap).
8. If interested, CCOs again have the opportunity to provide OHA with a draft of their 2025 Health IT Roadmap (via CCO.HealthIT@odhsoha.oregon.gov) between January 13 and February 28, 2025 for input. OHA will require 1-2 weeks to review and provide high-level feedback.
9. Add all CCO-collected health IT data to the Health IT Data Reporting File prior to submitting it with your Roadmaps on 3/15/2025. Data reported in the Roadmaps should align with the Data Reporting File.

[1] Starting in Contract Year 3 (2022), CCOs' VBP reporting will include their health IT efforts; therefore, this content will not be part of the Health IT Roadmap moving forward.
[2] New Health IT Roadmap requirement beginning Contract Year 3 (2022)

2. Overview of Process

Each CCO shall submit its 2025 Health IT Roadmap to OHA for review on or before **March 15th** of each Contract Year. CCOs are to use the *2025 Health IT Roadmap Template* for completing this deliverable and are encouraged to copy and paste relevant content from their previous Health IT Roadmap if it's still applicable. Please submit the completed 2025 Health IT Roadmap via the CCO Contract Deliverables Portal.

OHA's Health IT staff will review each CCO's Health IT Roadmap and provide written notice of the approval status, along with a separate document with detailed evaluation results (the Results Report). If the CCO's Health IT Roadmap is not approved, then the CCO must make the required correction/s and resubmit. OHA requests the CCO participate in a meeting to discuss the results and required correction/s prior to resubmission, as follows:

1. CCO is to review the available meeting days/times included in the Results Report and contact OHA by 6/20/25 with their top two meeting choices.
    a. These meetings are only available from 6/23/2025 through 7/9/2025.
    b. CCO is expected to have thoroughly reviewed its results prior to the meeting and to be prepared for an in-depth discussion.
2. CCO resubmission is due 7/16/2025.
3. OHA will complete its review of all resubmissions and provide written notice of the approval status within 30 days of resubmission receipt, by 8/15/2025.

The aim of this process is for CCOs and OHA to work together to better understand how to achieve an approved Health IT Roadmap.

Please refer to the timeline below for an outline of steps and action items related to the 2025 Health IT Roadmap submission and review process.

2025 Health IT Roadmap Timeline

Last Revised 12/2/2024

	March - June 2025	June - July 2025	July - Aug 2025
	***2025 HIT Roadmap* Submission and Review**	**CCO/OHA Communication and Collaboration**	**Revised *Roadmap* Submission & Review, CCO/OHA meetings**
Activities	**List of activities**	**List of activities**	**List of activities**
	CCOs submit *2025 HIT Roadmap* and HIT Data Reporting File to OHA by **3/15/25**	If not approved, CCO contacts OHA by **6/20/25** to schedule a meeting to discuss required revisions	CCO submits Revised 2024 HIT Roadmap to OHA by **7/16/25** OHA reviews CCO Revised 2025 HIT Roadmap
	OHA reviews *2025 HIT Roadmap*	If approved, CCO contacts OHA by **6/27/25** to schedule a Roadmap follow-up meeting	OHA sends Revised 2025 HIT Roadmap result letter to CCO by **8/15/25**
	OHA sends initial *2025 HIT Roadmap* result letter to CCO by **6/16/25**	Collaborative meeting(s) occur between OHA and CCOs required to revise and resubmit their *2025 HIT Roadmap* by **7/9/25**	CCOs with approved Roadmaps meet with OHA by **8/30/25**

OHA expects all CCOs will have an approved 2025 HIT Roadmap by 8/29/2025

3. Health IT Roadmap Approval Criteria

The table below contains evaluation criteria outlining OHA's expectations for responses to the required Health IT Roadmap questions. Modifications for Contract Year 6 (2025) are in ***bold italicized font***. Please review the table to better understand the content that must be addressed in each required response. Approval criteria for Health IT Roadmap optional questions are not included in this table; optional questions are for informational purposes only and do not impact the approval of a Health IT Roadmap. Additionally, the table below does not include the full version of each question, only an abbreviated version. Please refer to the *2025 Health IT Roadmap Template* for the complete question when crafting your responses.

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
1. Health IT Partnership	CCO attestation to the four areas of health IT Partnership	CCO meets the following requirements: • Active, signed HIT Commons Memorandum of Understanding (MOU) and adheres to the terms • Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU • Served, if elected on the HIT Commons governance board or one of its committees • Participated in an OHA's HITAG meeting at least once during the previous Contract Year
2. CCO Data for 2025 SDOH Social Needs Screening and Referral Measure	***CCO attests to inclusion of data collected for three elements of SDOH Social Needs Screening and Referral Measure***	***CCO included data/information collected for the following SDOH Social Needs Screening and Referral Measure:*** • ***Element 3: Systematic assessment of whether and where screenings are occurring by CCO and provider organizations.*** • ***Elements 6 and 7: Identification of screening tools or screening questions in use by CCO and provider organizations.*** • ***Element 13: Environmental scan of data systems used in the CCO's service area to collect information about members' social needs, refer members to community resources, and exchange social needs data.***
4. Support for EHR adoption, use, and optimization	A. 2024 Progress supporting contracted physical, oral, and behavioral health providers to increase EHR adoption, use, and optimization in support of care coordination	• Description of progress includes: ○ Strategies used to support increased rates of EHR adoption, use, and optimization in support of care coordination, and address barriers among contracted physical, oral, and behavioral health providers in 2024 ○ Specific accomplishments and successes for 2024 related to supporting EHR adoption, use, and optimization in support of care coordination • Sufficient detail and clarity to establish that activities are meaningful and credible.

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
	2025-2026 Plans for supporting contracted physical, oral, and behavioral health providers to increase EHR adoption, use, and optimization in support of care coordination	• Description of plans includes: ○ The number of organizations (by provider type) for which no EHR information is available (e.g., 10 physical health, 22 oral health, and 14 behavioral health organizations) ○ Plans for collecting missing EHR information via CCO existing processes ○ Additional strategies for 2025-2026 related to supporting increased EHR adoption, use, and optimization in support of care coordination, including risk stratification, and addressing barriers to adoption among contracted physical, oral, and behavioral health providers ○ Specific activities and milestones for 2025-2026 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
5. Use of and support for HIE for care coordination and hospital event notifications	A. 2024 Progress using HIE for care coordination and timely hospital event notifications within CCO	• Description of progress includes: ○ HIE tool(s) CCO is using within their organization for care coordination, including risk stratification, and timely hospital event notifications ○ HIE strategies used for care coordination, including risk stratification, and timely hospital event notifications within the CCO ○ Specific accomplishments and successes for 2024 related to CCO's use of HIE for care coordination and timely hospital event notifications • Sufficient detail and clarity to establish that activities are meaningful and credible.
	2025-2026 Plans using HIE for care coordination and timely hospital event notifications within CCO	• Description of plans includes: ○ Additional tool(s) (if any) CCO is planning to use for care coordination, including risk stratification, and timely hospital event notifications ○ Additional strategies for 2025-2026 to use HIE for care coordination, including risk stratification, and timely hospital event notifications within the CCO ○ Specific activities and milestones for 2025-2026 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible
	B. 2024 Progress supporting contracted physical, oral, and behavioral health providers with increased access to and use of HIE for care coordination and timely hospital event notifications	• Description of progress includes: ○ Tool(s) CCO provided or made available to support providers' access to HIE for care coordination and timely hospital event notifications ○ Strategies CCO used to support increased access to and use of HIE for care coordination and timely hospital event notifications for contracted physical, oral, and behavioral health providers in 2024 ○ Specific accomplishments and successes for 2024 related to increasing access to and use of HIE for care coordination and timely hospital event notifications (including the number of

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
		organizations of each provider type that gained increased access or use as a result of CCO support, as applicable) • Sufficient detail and clarity to establish that activities are meaningful and credible.
	2025-2026 Plans for supporting contracted physical, oral, and behavioral health providers with increased access to and use of HIE for care coordination and timely hospital event notifications	• Description of plans includes: ○ The number of organizations (by provider type) that have not adopted an HIE for care coordination or hospital event notifications tool (e.g., 18 physical health, 12 oral health, and 22 behavioral health organizations) ○ Additional HIE tool(s) CCO plans to support or make available to providers for care coordination and/or timely hospital event notifications ○ Additional strategies for 2025-2026 related to supporting increased access to ***and use of*** HIE for care coordination and timely hospital event notifications among contracted physical, oral, and behavioral health providers ○ Specific activities and milestones for 2025-2026 related to each strategy (including the number of organizations of each provider type expected to gain access to ***or use of*** HIE for care coordination and hospital event notifications as a result of CCO support, as applicable • Sufficient detail and clarity to establish that activities are meaningful and credible.
6. Health IT to support SDOH needs	A. 2024 Progress using health IT to support SDOH needs within CCO, including but not limited to social needs screening and referrals	• Description of progress includes: ○ Current health IT tool(s) CCO is using to support SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) have closed-loop referral functionality ○ Strategies for using health IT within the CCO to support SDOH needs, including but not limited to social needs screening and referrals in 2024 ○ Any accomplishments and successes for 2024 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
	2025-2026 Plans for using health IT to support SDOH needs within CCO, including but not limited to social needs screening and referrals	• Description of plans includes: ○ Additional health IT tool(s) CCO plans to use to support SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) will have closed-loop referral functionality ○ Additional strategies planned for using health IT to support SDOH needs, including but not limited to social needs screening and referrals ○ Specific activities and milestones for 2025-2026 related to each strategy

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
		• Sufficient detail and clarity to establish that activities are meaningful and credible.
	B. 2024 Progress supporting contracted physical, oral, and behavioral health providers as well as, social services and community-based organizations (CBOs) with using health IT to support SDOH needs, including but not limited to social needs screening and referrals	• Description of progress includes: ○ Health IT tool(s) CCO supported or made available to contracted physical, oral, and behavioral health providers, as well as social services and CBOs, for supporting SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) have closed-loop referral functionality ○ Strategies used for supporting these groups with using health IT to support SDOH needs, including but not limited to screening and referrals in 2024 ○ Any accomplishments and successes for 2024 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible
	2025-2026 Plans for supporting 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 social needs screening and referrals	• Description of progress includes: ○ Health IT tool(s) CCO is planning to support/make available to contracted physical, oral, and behavioral health providers, as well as social services and CBOs for supporting SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) will have closed-loop referral functionality ○ Additional strategies planned for supporting these groups with using health IT to support social needs screening and referrals beyond 2024 ○ Specific activities and milestones for 2025-2026 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
	C. 2024 Progress and 2025-2027 Plans for using technology to support HRSN Services within the CCO	• ***Description includes:*** ○ ***Specific 2024 progress and 2025-27 plans within CCO to adopt and use technology needed to facilitate HRSN Service provision, such as for closed loop referrals, service authorization, invoicing, and payment*** ○ ***Any accomplishments and successes for 2024 related to each strategy*** ○ ***Specific activities and milestones for 2025-2027 related to each strategy*** • ***Sufficient detail and clarity to establish that activities are meaningful and credible.***
	2024 Progress and 2025-2027 Plans to support and incentivize HRSN Service Providers to adopt and use	• ***Description includes:*** ○ ***Specific 2024 progress and 2025-2027 plans to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals, such as grants, technical***

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
	technology for closed loop referrals	***assistance, outreach, education, engaging in feedback, and other strategies for adoption and use*** ○ ***Any accomplishments and successes for 2024 related to each strategy*** ○ ***Specific activities and milestones for 2025-2027 related to each strategy*** • ***Sufficient detail and clarity to establish that activities are meaningful and credible.***

2025 Health IT Roadmap Template

Please complete and submit this template via CCO Contract Deliverables Portal by **March 15, 2025.**

Instructions & Expectations

Please respond to all of the required questions included in the following Health IT Roadmap Template using the blank spaces below each question. Topics and specific questions where responses are not required are labeled as optional. The template includes questions across the following five topics:

1. Health IT Partnership
2. Support for EHR Adoption, Use, and Optimization
3. Use of and Support for HIE for Care Coordination and Hospital Event Notifications
4. Health IT to Support Social Determinants of Health (SDOH) Needs, including but not limited to social needs screening and referrals
5. Other health IT Questions (optional section)

Each required topic includes the following:

- Narrative sections to describe your 2024 strategies, progress, accomplishments/successes, and barriers
- Narrative sections to describe your 2025-2026 plans, strategies, and related activities and milestones. For the activities and milestones, you may structure the response using bullet points or tables to help clarify the sequence and timing of planned activities and milestones. These can be listed along with the narrative; it is not required that you attach a separate document outlining your planned activities and milestones. However, you may attach your own document(s) in place of filling in the activities and milestones sections of the template (as long as the attached document clearly describes activities and milestones for each strategy and specifies the corresponding Contract Year).

Narrative responses should be concise and specific to how your efforts support the relevant health IT area. OHA is interested in hearing about your progress, successes, and plans for supporting providers with health IT, as well as any challenges/barriers experienced, and how OHA may be helpful. CCOs are expected to support physical, behavioral, and oral health providers with adoption of and access to health IT. That said, CCOs' Health IT Roadmaps and plans should:

- ✓ be informed by the CCO's Data Reporting File,
- ✓ be strategic, and activities may focus on supporting specific provider types or specific use cases, and
- ✓ include specific activities and milestones to demonstrate the steps CCOs expect to take.

OHA also understands that the health IT environment evolves and changes, and that plans may change from one year to the next. For the purposes of the Health IT Roadmap, the following definitions should be considered when completing responses.

- *Health IT to support care coordination*: While CCOs use health IT to support many different functions that relate to care coordination*, for the purposes of the Health IT Roadmaps, OHA is focused on health IT to support care coordination activities between organizations caring for the same person. Note: This definition is not a change from previous Roadmap expectations. What has changed is that CCO is now discouraged from including strategies in the Roadmap specific to VBP, population health, or metrics unless they are specifically called out (as in the Health IT to Support SDOH Needs section).

  *OHA's Care Coordination rules (410-141-3860, 410-141-3865, and 410-141-3870) provide more detail around broader care coordination activities.

- *Strategies*: CCO's approaches and plans to achieve outcomes and support providers.

- *Accomplishments/successes:* Positive, tangible outcomes resulting from CCO's strategies for supporting providers.
- *Activities*: Incremental, tangible actions CCO will take as part of the overall strategy.
- *Milestones*: Significant outcomes of activities or other major developments in CCO's overall strategy, with indication of when the outcome or development will occur (e.g., Q1 2025). **Note**: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.
- *Meaningful:* Strategy descriptions are sufficiently informative, applicable to the Roadmap expectations, and align closely with provided approval criteria.
- *Credible*: Strategy descriptions include sufficient detail and a realistic timeline supporting plausibiilty of their achievability.

A note about the template*:*

This template has been created to help clarify the information OHA is seeking in each CCO's Health IT Roadmap. The following questions are based on the CCO Contract and Health IT Questionnaire (RFA Attachment 9); however, in order to help reduce redundancies in CCO reporting to OHA and target key CCO Health IT information, certain questions from the original Health IT Questionnaire have not been included in the Health IT Roadmap template. Additionally, at the end of this document, some example responses have been provided to help clarify OHA's expectations on the level of detail for reporting progress and plans.

Health IT Roadmap Template Strategy Checkboxes

To further help CCOs think about their health IT strategies as they craft responses for their Health IT Roadmap, OHA has included checkboxes in the template that may pertain to CCOs' efforts in the following areas:

- *Support for EHR Adoption, Use, and Optimization*
- *Use of and Support for HIE for Care Coordination and Hospital Event Notifications*
- *Health IT to Support SDOH Needs*

The checkboxes represent themes that OHA compiled from strategies listed in CCOs' previous Health IT Roadmap submissions.

Please note: the checkboxes do not represent an exhaustive list of strategies, nor do they represent strategies CCOs are required to implement. It is not OHA's expectation that CCOs implement all of these strategies or limit their strategies to those included in the template. OHA recognizes that each CCO implements different strategies that best serve the needs of their providers and members. The checkboxes are in the template to assist CCOs as they respond to questions and to assist OHA with the review and summarizing of strategies.

Please send questions about the Health IT Roadmap template to CCO.HealthIT@odhsoha.oregon.gov

CCO: Eastern Oregon Coordinated Care Organization

Date: 3/14/2025

1. Health IT Partnership

Please attest to the following items.

a.	☒ Yes ☐ No	Active, signed HIT Commons MOU and adheres to the terms.
b.	☒ Yes ☐ No	Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU.
c.	☐ Yes ☐ No ☒ 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 ☐ No	Participated in an OHA HITAG meeting, at least once during the previous Contract year.

2. CCO Data for 2025 SDOH Social Needs Screening and Referral Measure

CCO must submit information collected from the following 2025 Social Determinants of Health: Social Needs Screening and Referral Measure, Component 1 elements. Please select the checkboxes indicating whether you have included the data/information with your Health IT Roadmap submission:

a.	☒ Yes ☐ No	**Element 3**: Systematic assessment of whether and where screenings are occurring by CCO and provider organizations, including whether organizations are screening members for (1) housing insecurity, (2) food insecurity, and (3) transportation needs.
b.	☒ Yes ☐ No	**Elements 6 and 7**: Identification of screening tools or screening questions in use by CCO and provider organizations, including available languages and whether tools and questions are OHA-approved or exempted.
c.	☒ Yes ☐ No	**Element 13**: Environmental scan of data systems used in the CCO's service area to collect information about members' social needs, refer members to community resources, and exchange social needs data.

3. (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, including risk stratification. 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).

In general, EOCCO strives to support its network of contracted providers and local community partners in adoption and utilization of health IT platforms. As in previous years, in 2024 the CCO has attempted to reduce some of the most common barriers to adopting EHR and HIE platforms by vetting and researching potential platforms, providing education and technical assistance on available tools, and providing financial incentives to help defray cost. These activities take place across physical, behavioral, and oral health providers. Please note that EOCCO's oral health provider network is split between two dental care organizations (DCOs), ODS Community Dental and Advantage Dental. Some dental-specific strategies only apply to one DCO, in which case the DCO is identified in the strategy description.

EOCCO has previously worked toward hiring an additional staff member to serve as a health IT subject matter expert for internal CCO staff, HIT vendors, and external provider partners. Since last year's Roadmap the CCO has shifted toward trying to fill this position with an existing staff member with HIE and health systems knowledge. The ultimate goal is still to create this position to help CCO staff navigate vendor relationships, provide technical assistance to provider partners, and assist in future HIT implementation and platform enhancements.

4. Support for EHR Adoption, Use, and Optimization

A. Support for EHR Adoption, Use, and Optimization: 2024 Progress and 2025-26 Plans

Please describe your 2024 progress and 2025-26 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:

- 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.
- Include plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialling, Letters of Interest).
- Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.
- 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.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 to support EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination include:
    - A title and brief description
    - Which category(ies) pertain to each strategy
    - The strategy status
    - Provider types supported
    - A description of 2024 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.
    - (Optional) An overview of CCO 2025-26 plans for each strategy
    - Activities and milestones related to each strategy CCO plans to implement in 2025-26

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 continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2025, 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**

Contracted Organization Type	# Organizations w/ Unknown EHR Vendor, No EHR, or EHR Status Unknown	% Organizations w/ Unknown EHR Vendor, No EHR, or EHR Status Unknown

Physical	24	30.1%
Behavioral	3	18.8%
Oral	8	25.0%

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

- **Physical Health:** EOCCO did not distribute a formal survey to physical health providers in 2024 due to low response rates from previous survey efforts. The physical health team continued to focus on utilizing the Clinical Quality Measure (CQM) Reporting Process to collect EHR vendor and version information from clinics that submit clinical data. Through providing reporting technical assistance and incentive measure support the CCO has also been able to gather EHR vendor information from sites that do not formally submit CQM data. EOCCO will explore the possibility of including HIT questions in the physical health provider contracting process in the future.
  - The CCO aims to reduce the percentage of contracted physical health organizations with unknown or missing EHR information from 30.1% to 27.0% by 12/31/2025.
- **Behavioral Health:** EOCCO reviewed behavioral health contracts that were executed or amended in 2024 to collect data on the adoption and use of EHR and HIE platforms for the HIT Data File. EOCCO made changes to its contracting processes starting in 2021 so that all new behavioral health contract requests for EOCCO would include questions on the adoption and use of EHR and HIE platforms. The expanded HIT questioning is required for updated contracts and contract amendments.
  - There are no contracted behavioral health providers with unknown or missing EHR information, just three sites without EHR systems. The percentage reported in the table above is unlikely to change by next year unless one or more organizations adopt an EHR for the first time.
- **Oral Health:** Advantage Dental will send out its annual provider survey in January 2025. This survey asks about EHR adoption, including vendor/product/version information along with CEHRT certification status of the EHRs. If a provider does not respond to the survey or does not address all sections of the survey, Advantage Dental's provider relations team will reach out to the provider by phone to collect any missing information. ODS will continue to collect information about EHR use among its dental providers, including vendor/product version and CEHRT status and year in 2025. This will inform the EHR utilization rate and trends in products and versions among ODS providers. This information will be collected through the Annual Provider survey distributed via email. ODS will follow up with providers that do not provide a response to ensure this information is received by 12/31/2025.
  - The CCO aims to reduce the percentage of contracted oral health organizations with unknown or missing EHR information from 25.0% to 20.0% by 12/31/2025.

Strategy category checkboxes
Using the boxes below, please select which strategies you employed during 2024 and plan to implement during 2025-26. 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**

EHR Adoption – Strategy 1: **CBIR HIT Opt-in Fund**

EOCCO developed a Community Benefit Initiative Reinvestment (CBIR) fund specifically for EHR adoption and HIT optimization to support comprehensive and coordinated patient care. The CBIR Opt-in project is open to physical health, behavioral health, and oral health providers that serve 100 or more EOCCO members. Applicants can apply for up to $50,000 of funds to support enhanced HIT for their organization.

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):

At the end of 2023 the EOCCO Grants Subcommittee and Board of Directors approved HIT funding for two HIT CBIR projects to be implemented in 2024. Both of these projects were implemented in 2024 however, only one of the funded projects is truly tied to EHR adoption, use, and optimization. The "OCHIN Epic Unite Us Interface" project received $29,000 to integrate Unite Us CIE data into an FQHC's instance of Epic. To date, the FQHC has submitted required progress reports but has not been able to complete the data integration due to delays on the Unite Us side. EOCCO approved an extension for the FQHC to submit their final progress report in July 2025 rather than January 2025 to allow more time for Unite Us to complete the infrastructure build. Because of these delays, EOCCO only partially achieved the 2024 Roadmap milestone of fully implementing and evaluating two projects by 12/31/2024. This milestone has been updated for 2025.

EOCCO also released the 2025 CBIR RFA in Q3 2024 and received three applications for the HIT Opt-In project. The EOCCO Board approved one of these projects, which will provide $50,000 in funds to support telehealth expansion via equipment upgrades for Malheur County's community mental health program (CMHP). The CMHP was notified of this decision but funding contracts had not been signed as of 12/31/2024.

(Optional) **Overview of 2025-26 plans for this strategy**:

While the approved 2025 HIT CBIR project will expand access to behavioral health services for EOCCO members, it does not expand EHR adoption, use, and optimization and will not be tracked for the HIT Roadmap in 2025.

EOCCO's Grants Subcommittee will determine which topics to include in the 2026 CBIR RFA in Q3 2025. The EOCCO Quality Supervisor and Grants Manager will advocate to continue the HIT Opt-In grant again for the 2026 grant cycle. Because the definitely of "HIT" has been more loosely interpreted by the Grants Subcommittee in recent years, the Quality Supervisor will encourage the team drafting the CBIR RFA to more explicitly define requirements for what types of HIT projects may receive grant funding. If the Grants Subcommittee would prefer to continue funding projects outside of EHR adoption and optimization, the Quality Supervisor will request that projects focused on EHR adoption, use, and optimization be eligible for additional funds to incentivize applications.

Planned Activities	**Planned Milestones**
1. Evaluate the success of the 2024 HIT CBIR Opt-in project once final reports are received in Q3 2025.	1. By 12/31/2025, the 2024 FQHC Unite Us-Epic data integration project will have been completed

2. Update the 2026 CBIR Opt-In RFA to promote more HIT applications specific to EHR adoption and optimization.	and the grant recipient will have submitted their final progress report to EOCCO. 2. By 12/31/2025, EOCCO will have received and funded two grant applications specific to EHR adoption and optimization for the 2026 grant year.

EHR Adoption – Strategy 2: **EHR Technical Assistance & Vendor Alignment with FHIR Standards**

EOCCO continues to work closely with its contracted physical health providers as they adopt and upgrade their EHRs. EOCCO has a dedicated quality improvement team that works with clinics to ensure that their EHRs have reporting capabilities for the incentive measure program, particularly for the EHR-based clinical quality measures (CQMs). If clinics are not able to report on specific metrics, the EOCCO quality team will work with the clinic to modify clinic workflows to align with improved EHR data extraction and assess usability and reliability of data. The team also facilitates conversations with EHR vendors to improve clinic reporting capabilities.

EOCCO also has a robust Value-Based Payment structure that supports EHR adoption and improvement efforts through financial incentives. As part of the quality amendment in our risk model, EOCCO awards clinics with a quality bonus payment based on their performance on a certain subset of the quality measures. The risk model contract states that clinics are only eligible to receive payment for clinical quality measures if a practice reports in alignment with the requirements documented in the EHR-based measure guidance document published annually on OHA's website.

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):

EOCCO collected data from physical health providers on EHR adoption status, vendor, and version data in Q4 2024 and Q1 2025 for the 2024 measurement year. This data has been updated in EOCCO's HIT Data Reporting File.

During 2024, EOCCO Quality staff also provided reporting guidance to a primary care clinic wishing to submit Clinical Quality Measure (CQM) data for the first time. The Quality team met with the clinic owner and a representative from their EHR Athena on several occasions to explain what EHR data elements need to be captured in order to submit standardized reporting to EOCCO and OHA. As a result of this collaboration, this practice will be submitting CQM data to the CCO on all five measures for the first time for the 2024 measurement year. Because this is the first year this practice will be submitting data, the CCO chose not to include this practice on the official CQM Submission to OHA. This will allow both the clinic and the CCO to troubleshoot potential issues with the Athena data pull.

The CCO continued to use its Value-Based Payment structure to incentivize clinics to adopt EHR systems with reporting capabilities in 2024. Four of eleven measures in the 2024 payment formula required standard data submission from EHR reporting. EOCCO was able to report on a the same percentage of available Clinical Quality Measures for 2024 (85.5%) as in 2023 (85.5%). EOCCO also submitted data from almost the same number of entities for the 2024 measurement year (33) for a similar total number of measures (141) as in the 2023 measurement year. This decrease is due to the merging of two clinics between the 2023 and 2024 measurement periods. This means that EOCCO did not achieve the first milestone from the 2024 Roadmap, which was to increase the number of measures reported on the CQM Submission to 155 by March 2025.

As of the time of this Roadmap submission, the health district mentioned in the 2024 Roadmap is still in the midst of their transition to a new EHR meeting FHIR standards. Because this process has taken much longer than anticipated, the health district will not be submitting CQM data from its three primary care clinics for the 2024 measurement year. This has resulted in EOCCO not achieving the second milestone from the 2024 Roadmap to help one additional organization transition to a new EHR.

(Optional) **Overview of 2025-26 plans for this strategy**:

EOCCO will continue working with the clinic using Athena in their CQM reporting to ensure that the EHR data used follows standardized MU CEHRT requirements for reported measures. The goal will be to add this clinic's data to the official Clinical Quality Measure data submission to OHA for the 2025 measurement year.

Because the number of reportable CQMs in the 2025 measure set is decreasing from five to three in the 2025 measurement year, the CCO will change milestone calculation for this strategy from the number of measures reported to the percentage of possible measures reported to OHA. This will allow for easier comparison between years, even if the number of reporting entities and/or number of measures changes.

Planned Activities	**Planned Milestones**
1. Continue supporting clinics in using EHR products that align with OHA reporting and FHIR standards. This will be done through technical assistance calls and review of reporting requirements with potential vendors.	1. By 3/31/2026, EOCCO will have added at least one organization to the 2025 Clinical Quality Measure Submission. 2. By 3/31/2026, EOCCO will increase the percentage of measures reported on the 2025 Clinical Quality Measure Submission to 90.0%.

EHR Adoption – Strategy 3: EHR Education Campaign among Dental Practices (Advantage Dental)

Advantage Dental educates its provider network about EHR adoption through an annually-updated provider-facing policy. In the policy, Advantage recommends the use of a 2015 Certified Electronic Health Record (EHR) system to improve the quality and coordination of care for patients by providing immediate access to their complete and secure health record. Providers are required to review and attest to reviewing the policy each year.

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):

In 2024 the Advantage team updated its EHR policy and distributed it to the provider network. The DCO team researched current dental EHR products and updated the existing set of resources meant to help providers determine which vendor could best suit their practice's needs. All providers reviewed and attested to the policy again in 2024, meeting the 2024 Roadmap milestone. No new EHR systems were adopted within the Advantage provider network in 2024.

(Optional) **Overview of 2025-26 plans for this strategy**:

Planned Activities	**Planned Milestones**
1. Advantage Dental will perform the 2025 policy review in January 2025. 2. Advantage will require its contracted providers to review and attest to the policy.	1. By 12/31/2025, all contracted Advantage providers will attest to reviewing the 2025 EHR policy.

EHR Adoption – Strategy 4: Incentives for EHR Adoption among Dental Practices (ODS)

ODS previously provided bonus dollars to its capitated providers that participate in EHR initiatives. Providers who reviewed materials provided by ODS, responded to survey questions, and considered participation in pilot programs regarding EHR adoption had an opportunity to earn additional funding. Funding was only made available if providers achieved all seven bonus participation standards and if they met or exceeded targets for quality and performance measures, submitted all member encounter data and complied with all OHP requirements as outlined by the CCO, OHA, and ODS. Their achievement of this standard was assessed through regular communications and meetings held with these providers and their survey response.

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):

In 2024 ODS revised its provider contract and chose to remove the financial incentive for providers to adopt EHR systems. This was largely due to low participation from dental providers in this incentive program as a result of the barriers described in the 2024 Roadmap submission: EHR expense, staff time, and general workforce shortages. For most of ODS' contracted clinics, the focus has shifted away from adopting new technology and instead is aimed to maintain clinical operation levels to keep up with current patient loads. As such, the CCO did not meet the 2024 Roadmap milestone to add two newly capitated providers to its network.

(Optional) **Overview of 2025-26 plans for this strategy**:

This strategy is being paused due to the contract updates made in 2024. ODS will continue to educate providers about new EHR pilot programs and general HIT opportunities as they become available. The DCO will consider re-adding EHR adoption incentives to provider contracts in the future if it becomes financially feasible and the dental clinics' capacity to adopt new tools increases.

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

EHR Adoption – Strategy 6: EHR Technical Assistance for Non-Community Mental Health Program (CMHP) BH Providers

EOCCO has worked to develop EHR technical assistance (TA) resources for behavioral health providers identified in the HIT Data File and through subsequent analysis. The analysis identified which providers should be prioritized based on volume of services provided and potential for the organization to viably sustain independent EHR adoption. Additionally, the CCO has compiled documentation of EHR resources and best practices to include in the technical assistance plan to help provide a framework for these efforts. The technical assistance plan is aimed at supporting EHR adoption by the smaller behavioral health providers and supporting behavioral health providers who are transitioning or upgrading their EHR tools.

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):

EOCCO reviewed and updated the initial resource document for behavioral health (BH) EHR adoption and re-distributed in December of 2024. This met the milestone in the 2024 Roadmap, though the document distribution occurred after the planned completion date of 7/1/2024. This revised version continues to provide comprehensive information on the importance of EHR adoption, current certifications and requirements, contacts for EHR vendors utilized by BH providers in the region, and key contacts at EOCCO for technical assistance. The updated document reflects any changes or developments in the field of EHR adoption and incorporates feedback received from BH providers.

In 2024, the behavioral health team contacted the two BH providers who did not have an EHR solution based on the previous year's HIT Data Reporting File to offer targeted support for EHR adoption. Ultimately the CCO was not able to schedule meetings with either of these sites and fell short of the 2024 milestone to hold five TA meetings with contracted providers. This milestone has been pushed out to 2025 and the number of planned meetings reduced to three to accommodate the many competing priorities faced by BH organizations.

(Optional) **Overview of 2025-26 plans for this strategy**:

The technical assistance resource document remains integrated into the BH technical assistance plan for 2025.

Planned Activities	**Planned Milestones**
1. EOCCO will update and redistribute the EHR adoption technical assistance resource document using latest EHR information and guidance via direct email and GOBHI's monthly provider newsletter. 2. EOCCO's behavioral health Analytics team will outreach to all BH providers who do not currently have an EHR, as identified via the HIT Data Reporting File, or who have self-identified as undergoing a EHR transition, to offer technical assistance and support.	1. By 12/31/2025, EOCCO will have distributed the updated EHR adoption technical assistance resource document to BH providers. 2. By 12/31/2025, EOCCO staff will have held at least three individualized EHR technical assistance meetings with contracted BH providers.

B. EHR Support Barriers:

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

Similar to previous years, workforce shortages, high costs of EHR and reporting software, and limited administrative infrastructure continue to be significant barriers to progress in EHR adoption and optimization across EOCCO's rural and frontier service areas. In 2024, these challenges remained especially acute for small and independent providers, who often lack the capacity to apply for or implement new health information technology solutions, even with funding opportunities such as the CBIR HIT Opt-in grant. Additionally, organizations face competing priorities and constrained staff bandwidth, which hinder efforts to transition or upgrade electronic health record systems. These limitations are particularly pronounced in the dental sector, where providers report persistent difficulties in aligning EHR functionality with value-based care and reporting requirements.

C. OHA Support Needs:

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

EOCCO's contracted Dental Care Organizations (DCOs), including ODS Dental and Advantage Dental, continue to highlight the need for financial support to motivate EHR adoption and optimization among rural and frontier providers. While grant funding and contract incentives remain essential, additional support from OHA is needed to

address persistent capacity challenges. This includes technical assistance for implementation, clearer guidance on available funding opportunities, training and peer learning collaboratives, and alignment on data reporting and interoperability standards. Enhanced support in these areas would help reduce administrative burden and build provider readiness to engage in value-based care.

5. 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: 2024 Progress & 2025-26 Plans

Please describe your 2024 progress and 2025-26 plans for using HIE for care coordination, including risk stratification, 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 2024 progress and 2025-26 plans.
2. List and describe specific tool(s) you currently use or plan to use for care coordination, including risk stratification, and timely hospital event notifications.

- (Optional) Provide an overview of CCO's approach to using HIE for care coordination and hospital event notifications.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 for using HIE for care coordination, including risk stratification, and hospital event notifications within the CCO include:
  1. A title and brief description
  2. Which category(ies) pertain to each strategy
  3. Strategy status
  4. Provider types supported
  5. A description of 2024 progress, including:
     i. accomplishments and successes (including number of organizations, etc., where applicable)
     ii. challenges related to each strategy, as applicable
  6. (Optional) An overview of CCO 2025-26 plans for each strategy
  7. Activities and milestones related to each strategy CCO plans to implement in 2025-26

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 continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2025, 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 2024 and plan to implement during 2025-26. 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. Risk stratification and population segmentation
			☒	☒	7. Other strategies for supporting HIE access or use (please list here): Utilization monitoring & management

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

- **Arcadia Analytics Population Health Management Platform with Care Coordination Features**: Our CCO uses a robust population health management platform that integrates claims and Electronic Health Record (EHR) data to deliver real time data at the point of care. This allows internal CCO staff, including the care coordination and case management teams, to provide coordinated patient care.

- **HMS Essette:** The EOCCO Behavioral Health care coordination (BH CC) team uses HMS Essette to track and document care plans for members. Charting is visible to members of the Physical Health Case Management (PHCM) team as well, which avoids duplication of services and allows both teams to remain up to date on the current care planning and goals for each member.

- **Clinical Care Advance (CCA):** CCA is the Utilization and Disease Management platform for EOCCO's Healthcare Services department and Physical Health Case Management (PHCM) team. It is a flexible, automated tool that reduces operating costs and helps case managers amplify their impact and enables better member health outcomes. Its diagnosis-driven assessments generate customizable care plans in alignment with NCQA standards, ensuring optimal member health outcomes. The PHCM team uses this charting tool to document care plans for members. Charting is visible to members of the BH CC team as well, which helps to avoid duplication of services and allows both teams to remain up to date on the current care planning and goals for each member.

- **Point Click Care (fka Collective Medical)**: The PCC platform supports care coordination among providers and our CCO, through real-time event communication as well as a shared care plan. The shared use of the Collective Platform between primary care, EDs, CMHPs, and DCOs is intended to bring attention and coordinated intervention to those members who present to emergency service and hospital settings.

- **Smartsheet:** Smartsheet is a web-based tool that allows users to share reports, workflows, dashboards, and surveys. Patient information can be shared and updated securely between users at different organizations. Within the CCO this tool is primarily used to support communication regarding incentive measure tracking, outreach for visit scheduling, care coordination, and health-related social needs (HRSN) requests. We support users at the physical, behavioral, and dental care organizations that make up the CCO.

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

HIE for CC & HEN – Strategy 7: Care Management Vendor Solution

The Medicaid Services Director has continued to explore care management and health coaching vendor options for EOCCO members. The goal is to select an organization that can help the health plan conduct health risk assessments, integrate and share the resulting data across HIE tools, and provide care to members with special health care needs. All vetted organizations are assessed for their ability to identify the rising risk population and provide at-risk members with access to a health coach or case manager as needed.

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: Risk stratification & population segmentation
☐ 7: Other:

Strategy status:

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

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

EOCCO has not yet selected a centralized Care Management vendor solution and has continued to focus its efforts on supporting existing initiatives and vendors who provide care management services to EOCCO members. As mentioned in the 2024 Roadmap, it continues to be challenging to find a vendor that is the right fit for the diverse needs of the CCO's geographically large rural and frontier population. Though the Medicaid Director and Quality supervisor researched care management platforms in use at other Oregon CCOs with rural service areas, none of the tools in use seemed to meet EOCCO's needs for care management and care coordination of its membership. Because this research did not yield any suitable vendor candidates EOCCO did not interview any potential comprehensive Care Management vendors in 2024 so the 2024 benchmark to examine at least one new vendor was not achieved. This milestone will be rolled forward into 2025.

The CCO continued to contract with several vendors that provide management and health coaching services for specific conditions and needs in 2024:

- The CCO maintained its contract with the Oregon Rural Practice-based Research Network (ORPRN) to administer social needs screenings to high-risk EOCCO members using a tailored version of the Accountable Health Communities (AHC) tool. ORPRN screeners used these interactions as a means to refer members to EOCCO's Case Management services to address any care coordination or higher level of care needs. (*See SDoH Needs Strategy 24 for more information on this program*).
- The Quality team continues to support the Teladoc diabetes management (DM) program. Eligible members who opt into the DM program gain access to blood glucose meters, unlimited test strips and refills, and health coaching services to help control their diabetes and A1c levels. As of December 2024, Teladoc had enrolled [redacted] EOCCO members in this program, representing [redacted] of the eligible member population. This falls short of the 2024 milestone to enrol[redacted] of the eligible population by 12/31/2024. This slowed enrollment is not surprising considering the rebranding from Livongo to Teladoc that this vendor rolled out midway through 2024, which likely resulted in at least some member and provider confusion.
- In 2024 the Quality team also collaborated with the Healthcare Services department to maintain the Strive Health vendor solution for individuals with chronic kidney disease (CKD) or end-stage renal disease (ESRD). Strive provided health coaching, dietitian consultation, educational resources on CKD, and care coordination to eligible individuals who opted into the program. The CCO requested that the Strive health coaches incorporate self-reported blood pressure readings and A1c levels into Strive care plans where appropriate in order to gather a more complete picture of enrolled members' health. As of December 2024, Strive Health had enrolled [redacted]EOCCO members in their kidney health programs, representing [redacted] of admissible members. This far surpassed the 2023 milestone of onboarding at least[redacted] of eligible members by 12/31/2024.

(Optional) **Overview of 2025-26 plans for this strategy**:

In 2025, EOCCO will continue to explore the feasibility of implementing a centralized care management and health coaching vendor solution that meets the unique needs of our geographically large and diverse service area. Building on prior research, the Medicaid Services Director and Quality team will engage directly with other rural-serving CCOs to learn from their care coordination workflows, vendor experiences, and integration approaches across HIE platforms. This peer engagement is intended to narrow the pool of potential vendors and identify platforms with proven success in similarly rural environments. EOCCO will prioritize vendors that demonstrate the ability to conduct health risk assessments, stratify member risk, support data exchange across disparate systems, and provide flexible care management services that can be tailored to local provider capacity. In addition, EOCCO plans to evaluate its current care management contracts and determine where existing vendor efforts—such as those supporting diabetes and kidney disease management—can be scaled or better integrated into broader care coordination workflows. This will include assessing opportunities for improved data

sharing and alignment between vendor-reported outcomes and internal care management metrics. The 2024 benchmark to evaluate at least one new vendor will be rolled forward into 2025, with the goal of conducting at least one vendor interview and assessing integration feasibility by the end of the year.

Planned Activities	**Planned Milestones**
1. The Director and Medicaid Quality Supervisor will continue vetting potential centralized care management vendors who can support members with special health care needs and integrate health risk assessment data. 2. The Quality team will continue partnering with Teladoc on the DM program. The team will work with both the vendor and internal CCO Marketing team in Q1 2025 to create more EOCCO-branded promotional materials to engage eligible members in the DM program services. 3. The Quality team will also maintain its partnership with Strive Health in order to support care management for members with CKD and ESRD. The CCO will follow up with Strive health to confirm that blood pressure and A1c checks were incorporated into care plans in mid 2025.	1. By 12/31/2025, EOCCO will have examined at least one new potential care management vendor. 2. By 12/31/2025, EOCCO will have increased enrollment in the Teladoc DSM to at least [redacted] members or [redacted] of the eligible population, whichever is higher. 3. By 12/31/2025, EOCCO will have increased enrollment in the Strive Health kidney programs to at least [redacted] members or [redacted] of the admissible population, whichever is higher.

HIE for CC & HEN – Strategy 8: Adding Case Manager Contacts in PointClickCare

Physical Health Case Management (PHCM) staff continue to add their names and contact information to the Care Team section in the PCC platform. Adding this information allows better collaboration between external providers and internal case managers who work closely with members. This strategy informs providers that the case managers that are calling the clinics are truly involved in the members' care and reduces the concern for HIPAA violations.

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: Risk stratification & population segmentation
☐ 7: Other:

Strategy status:

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

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

EOCCO PHCM team continued to attach their names and contact information to the Care Team section of a member's file in the PCC tool. In 2024, the PHCMs continued removing themselves from specific members' cases if the member declined services or stopped responding to outreach. This process has been helpful for providers when they are unsure of the validity of the case manager calling for information on a patient. In this situation the case manager can point the provider or clinic staff to PCC to verify their contact information. This strategy also meets part of the CCO's MOU with Adults and Persons with Disabilities (APD) by providing additional contact information on members.

The PHCM team was able to successfully train the BH Care Coordination (BHCC) team on adding themselves to the Care Team in the PCC platform for case managed members. As of the end of 2024, all EOCCO case managed members had an assigned BH care coordinator or PH case manager on their PCC Care Team.

(Optional) **Overview of 2025-26 plans for this strategy**:

This strategy has been completed and will be retired from future HIT Roadmaps. While the CCO will work with both the BHCC and PHCM teams to ensure they continue assigning themselves to case managed members in PCC, this will be considered a part of their daily clinical workflow and will not be tracked as a distinct Roadmap strategy.

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

HIE for CC & HEN – Strategy 9: Use of PointClickCare to Facilitate Daily ED Rounds

Greater Oregon Behavioral Health, Inc. (GOBHI), as part of EOCCO, uses PCC to support care coordination for members who utilize the Emergency Department (ED). Since 2018, GOBHI's utilization management team has held "Daily ED Rounds" to monitor ED Utilization among its members and ensure proper follow up and coordination of care. The intent of these rounds is to identify high ED utilizers and to ensure that interventions are put into place to help provide services to these individuals and reduce unnecessary ED utilization.

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: Risk stratification & population segmentation
☒ 7: Other: Utilization monitoring & management

Strategy status:

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

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

EOCCO's Behavioral Health Medical Director continued to meet with the GOBHI Care Management team and representatives from each Eastern Oregon CMHP every weekday to review PCC ED Census reports and cases in 2024. The team continued to enter care plans for high-risk behavioral health members, including those with a severe and persistent mental illness (SPMI) diagnoses and/or who are engaged in assertive community treatment (ACT) services, into PCC. Analysts also worked to integrate EOCCO encounter and enrollment data into the daily ED report from PCC to provide additional patient utilization histories and additional risk stratification.

Month	**2023 ED Encounters**	**2024 ED Encounters**
Jan.		
Feb.		
Mar.		
Apr.		
May		
June		
July		
Aug.		
Sept.		
Oct.		
Nov.		
Dec.		
Total		

EOCCO unfortunately observed an increase in the average ED encounters per member between 2023 and 2024, and did not reach the 2024 Roadmap milestone to decrease this data point to 0.70 encounters per member. For 2025, EOCCO will look to stabilize the increasing ED utilization trend and return to previous year's rate of encounters.

Year	**End of year Membership**	**Total ED Encounters**	**Average Encounters per Member**
2023	75,163		
2024	76,867		

The ED Rounds team was not able to begin meetings with non-CMHP providers in 2024 due to limited resources and staffing and did not achieve the 2024 Roadmap milestone.

(Optional) **Overview of 2025-26 plans for this strategy**:

Planned Activities	Planned Milestones
1. GOBHI will continue holding daily ED Rounds for its Care Management team and CMHP representatives in 2025. 2. This team will also continue work to expand behavioral health care management meetings to non-CMHP providers by arranging meetings with non-CMHP sites to review PCC case information related to their clients to demonstrate the platform's value. This outreach may be combined with existing engagement efforts with these providers for initiatives such as the IET incentive measure outreach, social-emotional health interventions for children ages 1-5, and assessments for children in DHS custody.	1. By 12/31/2025, the annual average number of ED encounters will decrease to 0.72 per member. 2. By 12/31/2025, care management staff will meet with at least 3 non-CMHP providers to discuss onboarding to PCC and joining daily ED Rounds.

B. Supporting Increased Access to and Use of HIE Among Providers: 2024 Progress & 2025-26 Plans

Please describe your 2024 progress and 2025-26 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:

- Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.
- 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.
- 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.
- (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.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 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 2024 progress, including:
        i. 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)
        ii. 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 2025-26 plans for each strategy

g. Activities and milestones related to each strategy CCO plans to implement in 2025-26

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 continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2025, 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 2024 and plan to implement during 2025-26. Elaborate on each strategy and your progress/plans in the sections below.

Progress	Plans		Progress	Plans	
☒	☒	1. HIE training and/or technical assistance	☒	☒	6. Integration of disparate information and/or tools with HIE
☒	☒	2. Assessment/tracking of HIE adoption and capabilities	☒	☒	7. Requirements in contracts / provider agreements
☒	☒	3. Outreach and education about value of HIE	☒	☒	8. Financially support HIE tools and/or cover costs of HIE onboarding
☒	☒	4. Collaboration with network partners	☒	☒	9. Offer incentives to adopt or use HIE
☒	☒	5. Enhancements to HIE tools (e.g., adding new functionality or data sources)	☐	☐	10. Offer hosted EHR product (that allows for sharing information between clinics using the shared EHR and/or connection to HIE)
☐	☐	11. Other strategies that address requirements related to federal interoperability and patient access final rules (please list here):			
☐	☐	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.

- **Arcadia Analytics Population Health Management Platform with Care Coordination Features**: Our CCO sponsors utilization of this tool for providers interested in its use for care coordination, patient reporting, measure tracking, and more. CCO sponsorship of Arcadia allows onboarded providers and other members of the care team to provide better coordinated patient care.

- **Emergency Room and Inpatient Notification (ER-IP) Reports:** EOCCO distributes weekly hospital event notification reports to all contracted primary care practices. These reports inform physical health practices of their assigned patients that encountered at any Emergency Department so they can provide appropriate follow-up outreach and services.

- **Point Click Care (FKA Collective Medical):** The PCC platform supports care coordination among providers and our CCO, through real-time event communication as well as a shared care plan. The shared use of PCC between primary care, EDs, CMHPs, and DCOs is intended to bring attention and coordinated intervention to those members who present to emergency service and hospital settings.

- **Smartsheet:** Smartsheet is a web-based tool that allows users to share reports, workflows, dashboards, and surveys. Patient information can be shared and updated securely between users at different organizations. While EOCCO does not grant full user licenses to individuals outside of its component CCO companies, CCO do staff use the reporting and form functions in Smartsheet to share both patient-level and system-level information with contracted providers.

(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**:

Contracted Organization Type	# Organizations without *any* HIE Care Coordination Tool	% Organizations without *any* HIE Care Coordination Tool
Physical	31	38.7%
Oral*	31	96.9%
Behavioral	9	56.2%

**Note: The Care Coordination team from Advantage Dental is connected to Reliance and Unite Us on behalf of its provider network.*

HIE for CC & HEN – Strategy 10: Arcadia Analytics Adoption & Technical Assistance

EOCCO supports and utilizes the Arcadia Analytics HIE tool for care coordination. Clinic staff can use this tool to view gap lists, monitor quality measure performance, prepare for upcoming visits, and compare performance by provider. The tool also includes a full patient registry with condition history, risk scores, and cost saving data. Access to this information allows for much smoother care coordination between different care settings and types. The EOCCO Quality team strives to promote this tool to contracted physical health organizations, provide technical assistance to existing clinic users, and offer onboarding assistance and financial sponsorship to future clinic partners.

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

Over the past year EOCCO has continued to educate contracted physical health organizations on the benefits of using the Arcadia Analytics HIE tool for patient care coordination. These conversations occurred at both biannual clinic trainings and standing monthly meetings with engaged practices. For clinics that are already onboarded with Arcadia, the Quality team served as the first point of contact for technical assistance needs such as help navigating the platform, future enhancement requests, and potential data discrepancies.

Throughout 2024 CCO Quality staff met with Arcadia Analytics account representatives and support staff on a biweekly basis to focus on continuously improving platform performance for care coordination. Recruiting and training new physical health organizations to the tool remained on hold for most of the year while back-end data file improvements were made. In late Q2 2024 the CCO Data Science and Business System Analysts made several improvements to the provider hierarchy files sent to Arcadia on a monthly basis. This resulted in much more accurate member attribution data, allowing for more efficient measure tracking and care coordination efforts for both CCO and clinical users. The CCO Data Science and Business System Analysts also collaborated with Arcadia staff to identify data integration issues and platform settings impacting how eligible members were displayed in the tool. These issues were largely resolved in Q4 2024. CCO and Arcadia staff also determined that no updates were needed for the claims files, so the 2024 Roadmap milestone to complete revisions to the CCO eligibility, claims, and provider files was achieved.

No new organizations were onboarded to the tool in 2024, so the 2024 Roadmap milestones to add a new clinical connector and increase EOCCO membership assigned to organizations actively onboarded to Arcadia to 50% were not achieved. See below for current active physical health clinical connectors and their assigned membership:

Clinic System Name	EOCCO Population *(As of 12/2024)*	Connected EHR	Arcadia Live Date	Arcadia Inactive Date
[redacted]				
Total *(excluding inactive sites)*	**35,343**			

	43.1% of CCO membership			

One challenge encountered in the past year with this strategy is accessing usable platform utilization data from the Arcadia vendor. CCO staff have requested data on user log-ins report downloads, dashboards accessed, etc. from the Arcadia team on multiple occasions to help inform future technical assistance and outreach efforts to clinical users. The CCO has been told that clients are required to purchase an additional reporting package in order to access this data, which CCO leadership has been hesitant to do considering the already substantial fees associated with the platform.

(Optional) **Overview of 2025-26 plans for this strategy**:

Now that many data fixes have been implemented, CCO staff will focus on optimizing HIE utility for currently connected clinics. In order to do this CCO staff need access to the platform utilization data mentioned above. Staff will continue working with both CCO and Arcadia leadership to determine how to get access to this data.

Through working with other internal CCO staff the Quality team has determined that the Arcadia tool has not been used to its full capacity, and that it may have more fitting uses beyond incentive measure tracking and reporting. The Quality team and Medicaid Services Director will collaborate with the CCO's Business Systems Salesforce Architect to explore how clinics can best use this tool for care coordination, risk adjustment, tracking high utilizers, and other functions.

Planned Activities

1. CCO staff will continue providing technical assistance to contracted organizations currently onboarded to the platform via email, phone, and live meetings.
2. CCO staff will continue meeting with Arcadia staff on a biweekly basis to continuously improve platform performance and support implementation if new clinical connector opportunities are identified.
3. CCO staff will use platform utilization data (if received) to identify areas of improvement or expansion in Arcadia platform use, especially related to expanding utilization beyond quality and incentive measure reporting.
4. CCO staff (including Business Systems Salesforce Architect) will explore additional uses of the Arcadia platform.

Planned Milestones

1. By the end of Q2 2025, EOCCO will have obtained platform utilization data and will have used it to identify areas of opportunity in promoting regular use of the tool and its functions to clinical connectors.
2. By the end of Q3 2025, CCO staff will have identified at least one additional platform function to promote to clinical users in 2026 to support their care coordination efforts.
3. By 12/31/2025, EOCCO will onboard one new physical health organization to the Arcadia platform.

HIE for CC & HEN – Strategy 11: Arcadia Analytics Care Coordination Training

As mentioned in Strategy 10 the Arcadia tool has multiple care coordination features that can be used by members of a patient's care team. This interactive web tool provides Eastern Oregon clinic partners with real time data to allow them to provide coordinated patient care. Users can take advantage of the pre-visit planning tool to coordinate services and close gaps in care and can view condition and visit history on the patient registry and in individual patient charts. The EOCCO Quality team works in collaboration with Arcadia account representatives to ensure users are aware of these features and can use them to have a more complete picture of a patient's care.

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

☒ 1: TA ☐ 2: Assessment ☒ 3: Outreach ☒ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 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):

As noted in Strategy 10 above the physical health Quality team continued to meet with many engaged clinics and provide Arcadia technical assistance in 2024. These TA sessions were aimed at using the tool for incentive measure reporting and quality initiatives rather than focusing on care coordination as in previous years. The 2024 milestone to hold at least six Arcadia refresher trainings with clinical connectors on care coordination use cases was not achieved.

While the EOCCO physical and behavioral health Case Management teams maintained their Arcadia account access, engagement with the tool remained limited due to the ongoing data repairs noted in Strategy 10 above. Neither Case Management team had the bandwidth to attend platform refresher trainings in the past year, so that 2024 Roadmap milestone was not achieved.

(Optional) **Overview of 2025-26 plans for this strategy**:

Due to the lack of progress made in 2024 and EOCCO's organizational shift to identify areas of improvement or expansion in Arcadia platform use, this strategy will be paused in 2025.

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

HIE for CC & HEN – Strategy 12: Expansion of CMHP Participation with Arcadia Analytics

EOCCO has been working toward getting all contracted CMHPs fully connected to the Arcadia Analytics platform. All CMHPs in Eastern Oregon are past users of Arcadia's HIE service and we are hopeful that this process of reengagement will shorten onboarding timelines as a result. EOCCO data sharing agreements have been updated and all CMHPs have agreed to future participation and project timelines.

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

In December 2024, EOCCO finalized updates to its behavioral health Value-Based Payment (VBP) program with its seven contracted CMHPs in the region. The updated VBP program incorporated language surrounding the tracking of quality measures through Arcadia Analytics into the contract. This achieved the 2024 Roadmap milestone of including guidelines for tracking CMHP quality metrics in future CMHP VBP contracts. Collaboration with GOBHI and CMHP directors has facilitated this integration. The upcoming 2025 EOCCO BH VBP quality incentive measure set includes three measures from the CCO incentive measure set that CMHPs would be able to track progress using the Arcadia Analytics platform, adding further incentive for platform adoption.

Feedback from CMHPs has highlighted the continued challenge of administrative burdens, particularly among smaller clinics with limited reporting capacity in their behavioral health EHRs. EOCCO is exploring financial incentives to encourage platform adoption and address these challenges. Additionally, the new contracts emphasize utilizing Arcadia Analytics for tracking quality measures, with direct financial incentives under active consideration.

(Optional) **Overview of 2025-26 plans for this strategy**:

EOCCO plans to leverage the alignment between the 2025 BH VBP measure set and CCO incentive measures to foster further CMHP adoption of Arcadia Analytics. The updated VBP contracts with CMHPs will serve as a foundation for continued engagement and support. Plans also include evaluating potential financial incentives to mitigate administrative burdens.

Planned Activities	**Planned Milestones**
1. The CCO will continue to promote adoption by remaining CMHPs in regular care coordination meetings and communication. 2. The CCO will review and explore financial incentives for adoption in the coming months, including examing what other CCOs have done to encourage HIE use among contracted BH sites.	1. By 12/31/2025, the CCO will have drafted contract language on incentives for CMHPs to adopt HIE tools like Arcadia. 2. By 12/31/2026, the CCO will have incorporated financial or cost-sharing incentives into CMHP contracts to encourage continued adoption.

HIE for CC & HEN – Strategy 13: HIE Education Among Dental Practices (ODS)

HIE adoption rates continue to be low within the dental industry as this type of tool is fairly new in this sector, aside from the use of PCC in some clinics and at some DCOs. Further information about the different platforms available, their benefits and uses case for dental is needed to help educate and promote HIE use among our providers.

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

☐ 1: TA ☒ 2: Assessment ☒ 3: Outreach ☒ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 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):

ODS is still trying to educate themselves on the use of HIEs to be able to better engage the provider network. Given that not all of EOCCO's oral health providers currently use a known EHR, the CCO's Dental Care Organizations (DCOs) will keep this strategy on hold in order to focus on increasing the use of electronic health record systems before advancing to using HIE platforms. Increasing basic EHR utilization will allow dental practices to make better use of an HIE tool.

(Optional) **Overview of 2025-26 plans for this strategy**:

DCOs will be encouraged to re-visit this strategy in early 2026 in hopes that the percent of contracted dental providers using a known EHR system will have increased sufficiently to warrant adding HIE tools to their practices as well.

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

HIE for CC & HEN – Strategy 14: Depression Screening in Dental Offices Pilot

EOCCO works with Advantage Dental and ODS oral health practices to pilot the depression screening in dental offices project. The dental offices participating in this pilot have implemented the distribution of the Patient Health Questionnaire (PHQ)-2 and PHQ-9 to patients. For patients who received a score of 10 or above on the PHQ-9, they were referred to EOCCO's Behavioral Health (BH) Case Management (CM) team who then reaches out to

the patients to connect them with BH resources. This program uses the Smartsheet tool to securely track screening results and make referrals to the BH CM team as needed.

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

☒ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☒ 4: Collaboration ☐ 5: Enhancements ☒ 6: Integration ☒ 7: Contracts ☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 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):

In Q1 2024, EOCCO continued to collaborate with [redacted], and Behavioral Health (BH) Care Case Management team run through Greater Oregon Behavioral Health (GOBHI) on this initiative. Smartsheet is still the primary HIE tool used to share information between oral and behavioral health partners for this pilot. Meeting quarterly, the team goes over organization updates, tracking screenings accurately, and current PHQ scores and referral rates coming out of the [redacted] clinics. During these meetings the CCO project lead reviewed proper documentation and referral practices in Smartsheet to ensure that all screenings and results are captured. This achieved the 2024 Roadmap milestone to improve data accuracy in Smartsheet.

Currently [redacted] is still pausing their screening and referral progress as there has been staff turnover within their organization. However, there are plans to recruit [redacted] clinics to participate and EOCCO is supporting [redacted] through this process and is ready to train [redacted] dental clinic staff on this pilot when needed. The CCO did not achieve the 2024 Roadmap milestone to onboard two additional dental sites to the program. This milestone has been revised for 2025 with the new goal being for [redacted] to identify one site to join this pilot work on 2025.

The two participating [redacted] clinics continue to distribute PHQ-2 and 9 screening forms and consistently use Smartsheet to send out referrals to GOBHI as needed when patients score highly on these screenings. Using Smartsheet to analyze screening and referral rates, it was found that in 2024, [redacted] had offered to screen [redacted] patients for depression. Out of those [redacted] patients, [redacted] refused to fill out the form, and out of the remaining [redacted] patients who completed the screening, [redacted] patients scored high enough that they were then referred to BH case management.

These high rates of patient refusal and resulting low referral rates gave the EOCCO team an opportunity to develop other tactics to reach patients who may not feel comfortable completing the screening in the dental office. The pilot team understands the possible barrier a form might be to a patient that is experiencing depression and/or mental health crisis. Because of this, the participating dental clinics now offer the patient the option to fill out a PHQ form OR simply receive a direct referral to BH case management, giving more autonomy to the patient. The Smartsheet tracking form has been updated to reflect this change and allows the dental clinic staff to place referrals directly.

Lastly, in 2024, EOCCO offered [redacted] the opportunity to join existing Question, Persuade, Refer (QPR) trainings to address dental staff discomfort in discussing BH topics with patients. This knowledge would hopefully decrease the number of refusals to take the PHQ form as staff and patients are fully informed of what is expected of them. Unfortunately, no [redacted] were able to attend a QPR training in 2024 and EOCCO did not achieve the 2024 Roadmap milestone of providing QPR training opportunities to dental clinic staff.

(Optional) **Overview of 2025-26 plans for this strategy**:

Overall, EOCCO, [redacted], and GOBHI will continue to meet quarterly to check on project progress, discuss barriers to success, Smartsheet tracking accuracy, and other avenues to reach patients in need. Currently, the CCO is working to expand the pilot to at least one [redacted] in the service area and hopes to lower rates of

patient refusal to complete the screening by continuing to train dental staff on discussing BH topics with patient and offering direct BH CM referrals when appropriate.

Planned Activities	**Planned Milestones**
1. Continue to meet with [redacted] and GOBHI quarterly to stay updated on pilot progress. 2. Continue to offer QPR trainings to all dental staff. 3. Offer a Motivational Interviewing (MI) training to dental staff, especially dentists and dental hygienists 4. Continue to improve tracking accuracy with Smartsheet by educating the project team on proper documentation and referral processes	1. By Q3 2025, EOCCO will offer a Motivational Interviewing training to dental staff 2. By Q4 2025, ODS will have identified at least one new clinic to onboard to this program 3. By Q1 2026, rates of patient refusals to complete the PHQ screening will lower by 10% 4. By Q2 2026 patient referrals to BHCM will double from 2 to 4.

HIE for CC & HEN – Strategy 15: Increase PointClickCare Platform Adoption & Engagement

EOCCO is committed to increasing the number of contracted physical health organizations onboarded with and actively using PointClickCare (PCC) to access timely hospital event notifications. The CCO will sponsor PCC platform onboarding and participation for physical health practices in order to reduce the financial and administrative burden that adding a new HIE tool can place on contracted organizations. The CCO Quality team also provides technical assistance to engaged clinics when possible via regular quality check-ins with both clinic staff and PCC account managers.

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

☒ 1: TA ☒ 2: Assessment ☒ 3: Outreach ☒ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☒ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 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):

In 2024 the EOCCO Quality team continued allocating time during monthly meetings with engaged physical health providers for an “HIT Check-In”. This agenda item provided an opportunity for clinics already using the PCC platform to bring up questions or requests about the tool and allowed the Quality team to promote the PCC platform as a hospital event notification tool for clinics that were not yet using. The Quality team also focused on reminding engaged primary care clinics about the PCC tool during the spring 2024 in-person clinic visits (see flyer to the right). These efforts included both encouraging PCP sites that are not onboarded to PCC to consider engaging with the tool and providing high-level refresher information on PCC functions to onboarded sites. The Quality team facilitated conversations between the PCC Customer Success Manager and interested clinics when needed.


PointClickCare

Solution Sheet

Ambulatory Solution

Improve patient outcomes with real-time insights to support high-quality, coordinated, and collaborative care.

Our Ambulatory Solution allows care coordinators and providers to track acute encounters for their patients in real time, surface patients with high risk, and share care insights with broader care teams leading to more effective and efficient care coordination and collaboration.

Coordinate Care for Patients Using Real-Time Data and Insights.

Ambulatory and behavioral health providers may not be notified or aware of acute encounters unless the patient or their caregivers notify the provider, schedule follow-up appointments, or the care team gathers it through claims data.

Low visibility and inefficient ways of retrieving accurate, complete, and timely patient encounter information results in delays in care, duplicative services and costs, and can result in unwanted patient outcomes.

Our Ambulatory Solution offers a single system to monitor and manage patients as they move to other care settings. Providing care managers and coordinators with patient encounter information in real time, the ability to highlight and focus on patients with high risk and share care plans with broader care teams.

How does our Ambulatory Solution help?

- Provides real-time data from acute encounters for more visibility into patient conditions and utilization.
- Facilitates more timely patient follow up, education and chronic care management.
- Enables sharing of patient care insights with broader care teams regardless of user EMR.
- Adds ambulatory providers to the care team visible to other treating providers, increasing collaboration across settings.
- Reduces time-consuming phone and fax follow up, delivering patient data at the point of care.
- Highlights patients requiring more immediate attention through our proprietary readmission risk model and additional enhanced alerts.
- Custom cohorts, reports, enhanced behavioral health tracking, and additional ADT feeds also available.

Though the Quality team connected with the two clinics identified as needing outreach in the 2024 Roadmap [redacted] in the past year, high rates of staff turnover at those clinics meant that current contacts at [redacted] were not able to explain why they moved from ‘‘Actively Engaged” in the PCC tool to “Not Yet Engaged” in early 2024. And while the [redacted] is still “Not Yet Engaged” on the latest PCC report, the parent [redacted] and associated [redacted] are both “Actively Engaged” as of the July 2024 report. The Quality team hopes to use this momentum to encourage [redacted] primary care clinic staff to further engage with the tool in 2025.

The 2025 HIT Data Reporting File reflects that EOCCO currently has [redacted] of contracted physical health providers onboarded with PCC. While this is a [redacted] increase from the 2024 DRF, it still falls slightly short of the 2024 Roadmap milestone to reach [redacted] by 12/31/2024.

EOCCO used the OHA HITAG committee’s quarterly “Oregon Collective Platform Onboarding and Engagement” reports to identify organizations that are actively engaged and highly engaged with PCC. The most recent report published in October 2024 indicates that [redacted] of EOCCO’s contracted physical health organizations fall into the “Actively Engaged” or “Highly Engaged” categories, meaning they regularly provide eligibility files, log into the platform, and edit patient content. This means that [redacted] of EOCCO’s physical health organizations that use PCC are actively engaged in the platform and [redacted] of *all* contracted physical health organizations are active users. The percent of physical health organizations that are actively engaged with PCC decreased slightly from the rate reported in the 2024 Roadmap [redacted] so EOCCO did not achieve the 2024 milestone of [redacted].

	Count	% of PCC-Onboarded Physical Health Orgs	% of All Physical Health Orgs
Total Contracted Physical Health Orgs	79	n/a	100.0% *(79/79)*
Contracted Physical Health Orgs on PCC	33	100.0% *(33/33)*	41.8% *(33/79)*
Contracted Physical Health Orgs “Actively” or “Highly Engaged” in PCC	[redacted]		

One challenge that EOCCO has encountered in this strategy is reconciling conflicting or missing information on PCC onboarding and engagement status across different data sources. For example, the quarterly reports received from OHA do not always include out of state entities. EOCCO's service area borders both Idaho and Washington, and as such the CCO contracts and works closely with multiple large health systems based out of those states. It has been challenging to not have access to PCC utilization data on those groups. Additionally, naming conventions for healthcare providers often differ between the quarterly OHA reports, internal CCO data, PCC tracking systems, and the annual HIT DRF template. This makes it hard to verify which contracted providers are truly connected to the tool and to set realistic milestones for adoption and utilization rates.

(Optional) **Overview of 2025-26 plans for this strategy**:

Planned Activities

1. The Quality team will continue holding "HIT Check-Ins" at monthly meetings with engaged physical health organizations.
2. The CCO will reach out to [redacted] and [redacted] to determine their barriers to actively using the PCC tool again in the future. For [redacted] specifically, the Quality team will set up conversations between their [redacted] to facilitate sharing of PCC best practices.
3. The CCO will strive to reconcile platform utilization data and reporting by working with representatives from PCC and OHA to ensure that all entities have access to a single "source of truth" report of platform engagement for contracted providers.

Planned Milestones

1. By 12/31/2025, the percentage of EOCCO-contracted physical health organizations utilizing PCC will increase to at least [redacted].
2. By 12/31/2025, the percentage of contracted physical health partners falling into the "Actively Engaged" or "Highly Engaged" categories on the quarterly HITAG reports will increase to at least [redacted].

HIE for CC & HEN – Strategy 16: Encourage Use of the IET Cohort in PCC Platform

The EOCCO Quality Team has a workgroup focusing on improving performance on the Initiation and Engagement of Substance Use Disorder Treatment (IET) CCO incentive measure. One of the frequent barriers encountered in this work is the lack of timely notification when a member or patient receives a diagnosis of substance abuse or dependence. The workgroup has received feedback from behavioral and physical health providers that it is challenging to meet the 14 and 34-day treatment deadlines set by this measure when they aren't immediately aware that a patient may have entered the measure denominator. The workgroup plans to partner with the PCC CCO Customer Success Manager to help clinics that already use PCC enable and use the standardized IET cohort. This will allow these clinics to receive real-time notifications when their patients receive SUD diagnoses in emergency care settings.

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

☒ 1: TA ☒ 2: Assessment ☒ 3: Outreach ☒ 4: Collaboration ☒ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 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):

In early 2024 the CCO staff determined that none of its contracted physical or behavioral health organizations had the comprehensive IET-HEDIS cohort enabled yet. The IET workgroup chose to address the IET cohort in its quarterly provider-facing IET Learning Collaborative webinars. At the April 2024 Collaborative CCO staff

presented on possible solutions to lack of timely SUD episode notification and encouraged attendees to enable the standardized IET cohort. The workgroup framed this solution as a way to reduce the impact of claims lag on provider and clinic staff's ability to meet the measure's strict treatment deadlines.

After this Collaborative the CCO received inquiries from two physical health clinics (St. Luke's Eastern Oregon Medical Associates and St. Anthony Hospital Family Care) asking for more information on the IET cohort. One of these organizations (St. Luke's) was not yet connected to the PCC platform at all. The IET workgroup connected both organizations to the PCC Customer Success Manager for assistance in connecting to tool and enabling the cohort. As of December 2024 St. Anthony's had not yet enabled the IET cohort and St. Luke's was still not connected with the platform. Please note that the challenges in accessing accurate reporting on which EOCCO-contracted organizations are truly connected to PCC (see barriers listed in Strategy 15 above) apply to this strategy as well. This has made it difficult to confirm cohort use with 100% certainty.

In late 2024 the CCO confirmed that all eight of it's contracted community mental health program (CMHPs) are connected to PCC, but none of them have the IET-HEDIS cohort enabled.

Lastly, the CCO worked directly with the PCC Customer Success Manager and Support teams to enable the standardized IET-HEDIS cohort at the CCO level. This cohort and corresponding daily reports were enabled in Q3 2024. The internal CCO IET workgroup has discussed incorporating use of this report into its weekly outreach to providers on CCO members who have entered the IET measure. The report is not currently incorporated into outreach on a consistent basis.

(Optional) **Overview of 2025-26 plans for this strategy**:

Planned Activities

1. The CCO will partner with the PCC Customer Success Manager to create basic educational resources and sample workflows on how to use the HEDIS-IET cohort to better coordinate care for patients with SUD diagnoses. The CCO will strive to create separate versions of these resources for physical and behavioral health/CMHP providers. The CCO will work with its behavioral health arm to capitalize on existing PCC promotion tactics outlined in Strategy 18 to share this information with CMHPs.
2. The IET workgroup will continue engaging with the PCC CCO Customer Success Manager and Clinic Customer Success Manager to outreach to physical health organizations who have expressed interest in enabling the IET cohort.

Planned Milestones

1. By end of Q3 2025, the CCO and PCC staff will have drafted educational resources for both physical and behavioral health providers on using the IET cohort and reports.
2. By end of Q4 2025, CCO and PCC staff will have finalized and distributed educational resources for both physical and behavioral health providers on using the IET cohort and reports.
3. By end of Q2 2026, at least four contracted organizations (two physical and two behavioral) will enable and actively use the IET cohort in PCC.

HIE for CC & HEN – Strategy 17: Engagement of Non-CMHPs in the Use of PointClickCare

EOCCO looks to expand the use of PCC among behavioral health providers not currently utilizing the platform, which tend to be smaller, single therapist agencies. EOCCO currently offers behavioral health providers in its network support in setting up access either through an EOCCO instance of Point Click Care or through independent provider instances. The CCO will be reaching out to each of the behavioral health providers identified in the HIT data file to assess current barriers to adoption and develop a plan for future use.

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

☒ 1: TA ☒ 2: Assessment ☒ 3: Outreach ☒ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☒ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 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):

In 2024, EOCCO continued its efforts to support contracted non-CMHP behavioral health providers in utilizing PCC for hospital event notifications, care coordination, and quality improvement. Key focus areas included discharge planning and supporting members with severe or persistent mental illness (SPMI) through timely hospital event notifications.

Care coordination and IT teams collaborated with providers to increase the number of active PCC users and ensure care plans were consistently updated. Outreach was successfully extended to the six non-CMHP behavioral health providers not currently using PCC, which achieved one of the 2024 Roadmap milestones for this strategy. EOCCO's BH care coordinators providing education on PCC's benefits and offering technical assistance to facilitate onboarding. This outreach targeted high-risk member providers, including those serving assertive community treatment (ACT)-eligible members and individuals with frequent ED visits. As of 12/31/2024 none of these providers had onboarded to the PCC tool, meaning that the CCO did not achieve the second 2024 Roadmap milestone to onboard at least three non-CMHP SUD providers to PCC by the end of the year. This milestone will be pushed out to 2025 and the number of onboarded organizations meetings reduced to two to accommodate the many competing priorities faced by BH organizations.

These efforts helped address adoption barriers, although smaller practices still noted challenges related to administrative capacity. EOCCO is exploring additional support strategies to mitigate these challenges.

(Optional) **Overview of 2025-26 plans for this strategy**:

Planned Activities	**Planned Milestones**
1. EOCCO staff will continue to provide technical assistance as requested to non-CMHP providers on the further adoption and use of PCC. 2. EOCCO care coordinators will outreach to providers identified as serving "high risk" members who had visited the ED three or more times in the last 24 months or who were ACT eligible but are not yet utilizing PCC. Care Coordinators will provide education on the value of using PCC and assistance onboarding if necessary.	1. By 12/31/2025, EOCCO will help onboard at least two non-CMHP SUD providers to PCC.

HIE for CC & HEN – Strategy 18: Develop Training Modules on Integrating PointClickCare Data into Behavioral Health Clinical Workflows

EOCCO's care coordination and care management teams provide ongoing individual technical assistance and training to behavioral health providers that utilize PCC. The CCO has created a training curriculum designed to engage providers in platform best practices including identifying at high-risk populations, outlining care plans, pulling reports centered on CCO priorities, and integrating the use of the platform into clinical workflows. With these training offerings, EOCCO staff aim to create further buy-in from currently participating providers, aid in recruitment of new providers to the platform, and optimize current care coordination efforts for our most vulnerable in the behavioral health service array.

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

In 2024, EOCCO expanded its training efforts by delivering updated materials to behavioral health providers, emphasizing the integration of PCC data into clinical workflows. The BH Care Coordination team recorded significant progress, with seven new behavioral health providers contributing to care plans in PCC, surpassing the 2024 Roadmap milestone of five providers for the year. Training sessions reached 9 agencies, coming just short of meeting the milestone of providing updated trainings to interested providers within 60 days of their request.

These achievements demonstrate progress in improving provider engagement with PCC and enhancing care coordination practices. Challenges remain in ensuring ongoing participation and addressing administrative capacity issues for smaller providers, but the 2024 milestones represent a strong foundation for future improvements.

(Optional) **Overview of 2025-26 plans for this strategy**:

EOCCO will continue updating training modules to reflect evolving best practices and platform capabilities in 2025 and 2026. The focus will remain on outreach to providers who have not yet contributed to care plans and ensuring those already participating have the tools and knowledge needed for effective use.

Planned Activities	**Planned Milestones**
1. EOCCO staff will update the training modules focused on integrating PCC data into behavioral health clinical workflows for 2025. 2. EOCCO care coordinators will continue offering these trainings to all in-network behavioral health providers and will provide them to those who express interest.	1. By 12/31/2025, at least 7 contracted BH practitioners who have not added care plans in PCC as of 1/1/2025 will contribute to care plans. 2. By 12/31/2025, EOCCO will deliver updated trainings to at least 15 BH agencies within 60 days of their request.

HIE for CC & HEN – Strategy 20: Care Coordination, Care Management and Collaborations with External Partners

EOCCO Physical Health Case Managers (PHCMs) work to expand the use of PCC by adding tags and identifying information to help flag members who may need additional support or case management services within the organization. This information can also be used to help connect members to external resources, including, but not limited to contracted providers and Aging and People with Disabilities (APD).

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

EOCCO continued to share a list of hospital event notifications with the APD department on a biweekly basis to collaborate on care for these members and notify APD of frequent ED users during 2024. APD receives this information via a tab on the securely shared biweekly multidisciplinary team (MDT) spreadsheet. APD employees reviewed the information to ensure their case managers are aware of frequent ED visits by EOCCO members.

Cases that have more than one ED visit in a two-week period are called out in biweekly meetings and CCO Case Managers will offer additional resources and case information to APD if applicable.

EOCCO also maintained the Long-Term Services and Supports (LTSS) cohort and report in PCC for the PH Case Management team's use in 2024. The CCO used this report to send weekly inpatient HENs to APD, allowing the CCO and APD to collaborate to ensure efficient and safe patient discharges are completed. One challenge encountered in the past year was that the report was incorrectly capturing the county in which the member was seen in the ED, which defeated the purpose of using the report to update the members' home county. This was addressed with the PCC team and has since been effective in capturing and updating the member's home county when needed.

Another challenge occurring in the past year was the LTSS flag from the OHA 834 file not matching reports of members receiving LTSS with local branches. EOCCO is working with OHA to remedy this as the CCO uses the 834 file is used to update member eligibility.

The CCO also worked with PCC in 2024 to incorporate assigned PCP information to each patient's Care Team section within the PCC portal. This milestone was achieved in early 2024 and all members now have their PCP information displayed in their PCC Care Team.

The PHCM team chose to add the Transitions of Care (TRC) model to its instance of PCC in Q1 2024. Since it has been added, Case Managers use this add-on to review member history for case managed members, specifically with regards to ED and IP hospital visits. One barrier encountered in 2024 is that this information is not immediately available to the PHCM team and often takes 7-10 days to appear in PCC. This makes it difficult to use for immediate member follow-up that is typically done shortly after an ED or hospital visit. This delay also means that partners like the APD department do not receive timely HEN on shared members.

(Optional) **Overview of 2025-26 plans for this strategy**:

Planned Activities	**Planned Milestones**
1. The PHCM team will continue to share biweekly HENs for shared members with APD via the Multidisciplinary Team group and LTSS cohort and report in PCC. 2. EOCCO's Healthcare Services Director will meet with the PCC account team to discuss the delayed data received through the TRC add-on. Currently the TRC function is not useful for the PHCM team or its external partners.	1. By Q2 2025, PCC will either resolve the data delay issue with the TRC add-on or EOCCO will have terminated that portion of the PCC contract.

C. HIE for Care Coordination Barriers

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

Similar to the previous year's Roadmap, EOCCO providers continue to face significant barriers in adopting and effectively using Health Information Exchange (HIE) tools to support care coordination. A key challenge remains the fragmented HIE landscape—there are multiple competing tools, each with different capabilities, and it is difficult to generate widespread buy-in when clinic staff are already stretched thin. With ongoing workforce shortages, it is understandably difficult for providers to dedicate time and attention to learning and integrating yet another system into their workflow. This challenge is particularly acute for smaller and rural practices, where there is rarely dedicated health IT staff to support implementation or troubleshooting, resulting in long onboarding timelines and inconsistent tool usage.

EOCCO has also encountered unique barriers within the oral health provider network. Many dental providers, especially standalone practices, lack clarity on which members are assigned to them. This uncertainty limits their willingness to engage with HIE tools, as some Primary Care Dentists (PCDs) have expressed concerns about receiving referrals for members outside their assigned panels. While some Dental Care Organizations (DCOs), such as Advantage Dental, have taken steps to connect to HIEs on behalf of their provider networks, this

approach presents limitations. The DCO's participation in HIE does not necessarily translate into direct engagement at the provider level—where care coordination activities most often occur. As such, it may not be reasonable to expect year-over-year increases in HIE adoption among dental providers if their primary interaction with HIE occurs indirectly through their DCO.
Additionally, we want to highlight that cost, time, training needs, and disruption to workflows are particularly burdensome for standalone dental clinics. The implementation of HIT systems in these environments can significantly interrupt operations and strain limited resources. These realities underscore the importance of adjusting expectations for HIT expansion within dental networks and present a compelling case for the development of incentives, technical assistance, and realistic adoption benchmarks tailored to the unique needs of dental providers. A more nuanced approach to HIE measurement and support—one that accounts for the role of DCOs and the infrastructure disparities across provider types—would help EOCCO and its partners continue to make incremental progress in care coordination through HIE.

D. OHA Support Needs

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?

Similar to the feedback shared in the 2024 Roadmap, EOCCO would benefit from additional technical assistance and/or HIE subject matter experts support from OHA to support practices in onboarding to and using new HIE tools. This would be particularly helpful for standalone dental practices where HIE use is extremely rare.

For tools like PointClickCare where OHA is involved in producing utilization reports, it would be helpful to have more transparency into how the reports are generated and how PCC is tracking engagement. Many CCOs would also benefit if these reports were expanded to include organizations in states bordering Oregon, as this would provide a much more complete picture of CCO HIE utilization.

E. CCO Access to and Use of EHRs

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)?

EOCCO does not have permanent access to any provider EHRs. However, the Quality team will be able to gain temporary access to EpicCare Link at several sites for the purposes of incentive measure data collection and chart review. These sites are: [redacted]

What patient information is CCO accessing or will CCO access and for what purpose?

EOCCO will be granted temporary access to charts, flowsheets, and visit notes for a specific list of patients included in OHA's sample for the Timeliness of Prenatal and Postpartum Care measure and members included in the denominator for the Meaningful Language Access incentive measure. The Quality team will review patient information for proof of services related to either incentive measure and will document this information in OHA's 2024 reporting templates.

Is/will patient information being/be exported from the EHR and imported into CCO health IT tools? If so, which tool(s)?

No.

6. Health IT to Support SDOH Needs

A. CCO Use of Health IT to Support SDOH Needs: 2024 Progress & 2025-26 Plans

Please describe CCO 2024 progress and 2025-26 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:

- Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.
- 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).
- (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.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 for using health IT within the CCO to support SDOH needs, including but not limited to screening and referrals, include:
    1. A title and brief description
    2. Which category(ies) pertain to each strategy
    3. Strategy status A description of 2024 progress, including:
        i. accomplishments and successes (including number of referrals, etc., where applicable)
        ii. challenges related to each strategy, as applicable
    4. (Optional) An overview of CCO 2025-26 plans for each strategy
    5. Activities and milestones related to each strategy CCO plans to implement in 2025-26

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 continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned Milestones sections.
- If CCO is implementing a strategy beginning in 2025, 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 2024 and plan to implement during 2025-26, within your organization. Elaborate on each strategy and your progress/plans in the sections below.

Progress	Plans		Progress	Plans	
☒	☒	1. Implement or use health IT tool/capability for social needs screening and referrals	☐	☐	7. Use data for risk stratification
☒	☒	2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)	☐	☐	8. Use health IT to monitor and/or manage contracts and/or programs to meet members' SDOH needs
☒	☒	3. Integration or interoperability of health IT systems that support SDOH with other tools	☐	☒	9. Use health IT for CCO metrics related to SDOH

☒	☒	4. CCO leads problem solving efforts and collaboration with their partners	☐	☐	10. Education/training of CCO staff about the value and use of health IT to support SDOH needs
☒	☒	5. Care coordination and care management	☐	☐	11. Participate in SDOH-focused health IT convenings, collaborative forums, and/or education (excluding CIE governance)
☒	☒	6. Use data to identify members' SDOH experiences and social needs	☐	☐	12. Participate in CIE governance or collaborative decision-making
☐	☐	13. Other strategies for adoption/use of CIE or other health IT to support SDOH needs within CCO (please list here):			
☐	☐	14. 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

- **Clinical Care Advance (CCA):** CCA is the Utilization and Disease Management platform for EOCCO's Healthcare Services department and Physical Health Case Management (PHCM) team. It is a flexible, automated tool that reduces operating costs and helps care managers amplify their impact and enables better member health outcomes. Its diagnosis-driven assessments generate customizable care plans in alignment with NCQA standards, ensuring optimal member health outcomes.

- **Health Risk Assessment (HRA) webform**: EOCCO is working toward building an HRA webform on the EOCCO website. This would allow members to directly input their HRA responses to the form, which would then load automatically to the CCA system. There are several questions related to social needs screening in the HRA, so pulling these responses into the CCA system will allow the PHCM team to use the CCA tool to support members' SDOH needs. This will also improve the efficiency to which the answers are added to the system that are then utilized in the EOCCO Risk Stratification Model.

- **Smartsheet:** Smartsheet is a web-based tool that allows users to share reports, workflows, dashboards, and surveys. Patient information can be shared and updated securely between users at different organizations. Within the CCO this tool is primarily used to support communication regarding incentive measure tracking, outreach for visit scheduling, care coordination, and health-related social needs (HRSN) requests. EOCCO supports users at the physical, behavioral, and dental care organizations that make up the CCO.

- **Unite Us:** Unite Us is a Community Information Exchange (CIE) tool which connects health care and social service providers through a shared secure web-based technology platform. In Unite Us organizations can conduct social need screenings, send referrals for clients, and track outcomes in real time, holistically addressing the SDoH needs of individuals and communities more broadly. Connect Oregon is the Unite Us network specific to the state of Oregon.

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

EOCCO has implemented Unite Us across its 12-county service area. EOCCO has collaborated with Unite Us and partner organizations to build out SDoH screening forms and is leveraging the closed-loop referral system built into the CIE to support meeting members' SDoH and care coordination needs. EOCCO has also added the SDoH screening request (aka assistance request) form to the tool and plans to leverage Unite Us data to inform Social Needs Screening & Referral metric implementation and support reporting requirements. EOCCO

participates in the statewide Connect Oregon CCO Use Case Workgroup, helping to identify opportunities for leveraging the CIE tool to support CCOs in meeting state requirements and best serving OHP members.

HIT for SDoH Needs – Strategy 21: Unite Us Onboarding with Case Managers

The CCO will onboard physical and behavioral health case management teams to Unite Us and will work to develop best practices, document organizational policies, and process member and provider flex service (HRS) or assistance requests.

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

☐ 1: Implement/use health IT ☐ 2: Enhancements ☐ 3: Integration ☒ 4: Collaboration ☒ 5: Care coordination
☐ 6: Data to ID SDOH ☐ 7: Risk stratification ☐ 8: Manage contracts ☐ 9: Metrics ☐ 10. Education/training
☐ 11: Convenings ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

Strategy status:

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

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

EOCCO continued to support its Physical Health Case Management (PHCM) team in utilizing Unite Us throughout 2024. However, following further feedback, it became evident that the PHCM team would fully transition to internal workflows and discontinue the use of Unite Us for case management in order to better align with the new initiatives related to the 1115 Medicaid waiver. To support this shift, the PHCM team developed internal standardized workflows for managing both Flex Funds and Health-Related Social Needs (HRSN), ensuring a smooth and efficient flow of services across multiple teams on the CCA platform. CCA allows the PHCM team to efficiently receive and evaluate member requests directly through patient charts, encouraging streamlined tracking and communication.

Given the limited utilization of Unite Us for Flex Funds and the low volume of requests received through the platform, EOCCO has decided to retire this strategy. It will be revisited as needed or when the CM team expresses interest in integrating Unite Us into their internal workflows.

(Optional) **Overview of 2025-26 plans for this strategy**:

This strategy will be retired from future HIT Roadmaps and potentially revisted depending on interest from EOCCO's CM team.

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

HIT for SDoH Needs – Strategy 22: Unite Us Member Assistance Request Process

The CCO will customize and release an Assistance Request Form (ARF) that EOCCO members may use to request social needs services directly from the CCO via a Unite Us form embedded in the EOCCO website.

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

☐ 1: Implement/use health IT ☒ 2: Enhancements ☒ 3: Integration ☒ 4: Collaboration ☒ 5: Care coordination
☐ 6: Data to ID SDOH ☐ 7: Risk stratification ☐ 8: Manage contracts ☐ 9: Metrics ☐ 10. Education/training
☐ 11: Convenings ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

Strategy status:

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

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

During 2024, EOCCO made strides toward implementing an organization-specific Assistance Request Form (ARF) in Unite Us. Progress within this strategy is ahead of EOCCO's aim to re-start ARF work during 2025.

To align with other ongoing Unite Us projects/initiatives, EOCCO decided to embed the ARF form and workflow within the Accountable Health Communities (AHC) Screening Project (*See Strategy 24 below*). Through the ARF, also called the "SDoH Screening Request Form", EOCCO members can request an SDoH screening directly from the AHC screening team and be navigated to local services or CCO resources/benefits to address any identified health or social needs. By the end of 2024, the ARF form was built into Unite Us and ARF workflows were in an internal testing state with intent to launch the form and accept member submissions starting in 2025.

(Optional) **Overview of 2025-26 plans for this strategy**:

In 2025, EOCCO plans to fully launch the ARF in Unite Us. To prepare for form launch, EOCCO will build out a web-based link on the member-facing EOCCO website to direct members to the ARF in Unite Us. EOCCO will also work collaboratively with the AHC Screening and Community Engagement teams to develop a communication plan and materials to inform members and community and provider partners about the SDoH screening and service navigation supports available to members. It is intended that by the end of 2025 internal ARF workflows will be standardized, and EOCCO members and community/clinical partners will be aware of, and utilizing, the ARF to request an SDoH screening and social services from EOCCO.

Planned Activities	**Planned Milestones**
1. Collaborate with EOCCO's marketing team to build out an informational SDoH web-page and ARF form link on the member-facing EOCCO website. 2. Develop communications and supporting materials to advertise the ARF to various community/clinical partners and groups including: Traditional ealth Workers (THWs), Local Community Health Partnerships (LCHPs), EOCCO provider newsletter, and OHA's Community Partner Outreach Programs (CPOPs).	1. By 6/30/2025, EOCCO will fully launch the ARF form to accept member submissions. 2. By 12/31/2025, EOCCO will receive and process at least 20 unique ARF form submissions through Unite Us.

HIT for SDoH Needs – Strategy 23: SDoH Data Integration

EOCCO is working to map and operationalize the member-level social needs screening and referral data fed through Unite Us into a usable form that will allow for evaluation of SDoH need trends across EOCCO's service area. The Quality and Analytics teams also aim to integrate this data into shareable reports that can be used across CCO departments and shared with EOCCO's contracted provider network to support SDoH screening best-practice and SDoH Incentive Measure reporting.

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

☐ 1: Implement/use health IT ☐ 2: Enhancements ☒ 3: Integration ☐ 4: Collaboration ☐ 5: Care coordination
☒ 6: Data to ID SDOH ☐ 7: Risk stratification ☐ 8: Manage contracts ☒ 9: Metrics ☐ 10. Education/training
☐ 11: Convenings ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

Strategy status:

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

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

EOCCO made strides toward the 2024 planned Unite Us SDoH data integration milestones, but did not achieve the goal to have preliminary draft SDoH reports by 12/31/2024. The EOCCO Quality and Analytics teams worked throughout 2024 to map and operationalize the social needs screening and referral data elements fed through Unite Us into the internal CCO data warehouse, and the Analytics team is in process of converting the data into the SDoH reports. As other deliverables and reporting priorities appeared on the Analytics team's plate, the SDoH report work was deprioritized with the intent to pick back up the work in Q1 2025. The goal is to ensure that reports are finalized by end of year to support SDoH metric strategies and reporting. As such, the planned activities and milestones delineated for 2024 will be revised and carried over into 2025.

(Optional) **Overview of 2025-26 plans for this strategy**:

In 2025, the EOCCO Quality and Analytics teams will finalize the two SDoH reports being developed from member-level Unite Us Social Needs Screening and Referral data. The two output SDoH reports are:

1) **SDoH Provider Report** integrated into EOCCO's monthly Quality Measure Reports for contracted providers. This report will contain information on the Unite Us social needs screening and referral history for providers assigned EOCCO members with the intent to reduce the risk of over-screening members for social needs and ensure that providers are informed of any identified social needs and referrals their members received to support holistic and patient-centered care delivery.
2) **Internal SDoH Report** that will aggregate the member-level social needs screening & referral and REALD data fed through Unite Us and contain all the data fields required for SDoH metric reporting to the state. This report will also support analysis of social need prevalence and trends across our service area and will help inform the SDoH and health equity work of EOCCO.

Planned Activities	**Planned Milestones**
1. The EOCCO Quality team will continue working in partnership with EOCCO Analytics to transform the preliminary SDoH reports into finalized versions that capture key SDoH data elements relevant for Social Needs Screening & Referral metric reporting and contracted providers. 2. EOCCO Analytics will develop the logic to support integration of the final SDoH Provider Report into the primary care provider Quality Report.	1. By 3/31/2025, EOCCO Analytics team will develop draft versions of the SDoH Provider Report and Internal SDoH Report. 2. By 12/31/2025, the draft Internal SDoH Report will be transformed into a finalized version that captures key SDoH data reporting elements. 3. By 12/31/2025, EOCCO Analytics will integrate the final SDoH Provider Report into the primary care provider Quality Report.

HIT for SDoH Needs – Strategy 24: Accountable Health Communities Project Expansion

EOCCO works to provide SDoH screenings to members through the Accountable Health Communities (AHC) Screening Project conducted in partnership with the Oregon Rural Practice-based Research Network (ORPRN). Members are identified for screening via PCC hospital event notifications for individuals with two or more ED visits in the past twelve months as well as members who have no history of primary care engagement according to internal service claims data. EOCCO sends weekly member outreach lists from the PCC cohort and internal claims data to ORPRN AHC screening team. REALD data is also collected for each member who consents to receive the AHC screening. The ORPRN AHC screening team inputs screening result data directly into Unite Us and utilizes the platform to navigate and refer members to community resources/services. The AHC screening team can also refer members to internal CCO benefits/resources resources (such as Case Management, HRS/Flex, and/or HRSN) depending on identified need(s) and eligibility.

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

☒ 1: Implement/use health IT ☐ 2: Enhancements ☐ 3: Integration ☒ 4: Collaboration ☒ 5: Care coordination ☒ 6: Data to ID SDOH ☐ 7: Risk stratification ☐ 8: Manage contracts ☐ 9: Metrics ☐ 10. Education/training ☐ 11: Convenings ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

Strategy status:

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

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

In 2024, the EOCCO Quality team secured funding to sustain the AHC Screening Project for another year.

Between January and December 2024 the ORPRN Screening team made [redacted] phone calls to EOCCO members. Of those members called, [redacted] were reached and [redacted] participated in the AHC screening and were connected to local resources to meet identified social needs. Of the members screened during 2024, the top identified social needs included housing[redacted], food [redacted], and transportation [redacted]). EOCCO has continued to use the social need data and REALD data collected through the AHC screening project to

analyze social need trends among EOCCO's member population and inform SDoH and health equity projects and work across the CCO.

In 2024 EOCCO continued to see a trending decline in the number of members screened for social needs through the AHC screening project. In 2023, [redacted] EOCCO members participated in the AHC screening, meaning that EOCCO did not achieve the 2024 Roadmap milestone of a [redacted] increase in members screened. Even with this trending decline in the number of members screened, EOCCO recognizes the value of this project and plans to develop additional evaluative strategies beyond screening completion metrics to better assess and understand project impact.

In 2024, EOCCO met the 2024 milestone of implementing at least two quality improvement initiatives within the AHC screening project. The quality improvement initiatives included:

1) Implementing more equitable and inclusive screening outreach criteria to reach more members through the AHC screening project. EOCCO did this by expanding the screening outreach criteria to include members who have no history of primary care engagement. Beginning in August 2024 EOCCO developed internal procedures to pull member primary care engagement reports on a monthly cadence for integration into the AHC screening outreach call lists.
2) Establishing different modes for member engagement through the AHC screening project in addition to the current cold call phone screening model. In 2024, EOCCO worked in partnership with the AHC Screening team to develop a member-self referral initiative to allow a member (or a representative on behalf of a member) to request an SDoH screening directly from EOCCO. This initiative is a component of the Unite Us Member Assistance Request Form work outlined in *Strategy 22* above.

EOCCO did not make progress toward integrating EOCCO PHCM flex fund requests into the AHC project workflow in 2024 (see *Strategy 21* for more details). EOCCO plans to continue the work of identifying opportunities for Unite Us workflows to support internal referral processes between the AHC Screening team and other EOCCO teams utilizing the platform.

(Optional) **Overview of 2025-26 plans for this strategy**:

In 2025, EOCCO plans to integrate additional evaluation strategies into the AHC screening project to better understand and assess project impact and benefit for members. EOCCO intends to develop a survey to disseminate to members six months after receiving an SDoH screening through the AHC project to assess member experience with the screening encounter and whether any identified social needs were adequately addressed and/or resolved. EOCCO will utilize quantitative and qualitative data gathered through this survey to create an evidence base to inform the trajectory of, and quality improvement strategies associated with, this project over the coming years.

Additionally, as more EOCCO teams and contracted THW partners onboard to Unite Us (see *Strategy 27* below), EOCCO plans to develop internal referral workflows between the AHC Screening program and other EOCCO programs in Unite Us. This will allow for standardization of referral processes between internal programs and enhanced care coordination for members.

EOCCO expects that the QI initiatives implemented during 2024 should contribute to an overall increase in the number of members screened through AHC Screening Project in 2025.

Planned Activities	**Planned Milestones**
1. EOCCO will continue to fund the AHC screening project and utilize aggregate project data to better understand social need prevalence and disparities among its member populations. 2. The EOCCO QI Team will collaborate with the ORPRN AHC Screening Team and EOCCO THW Liaison to develop internal program referral workflows in Unite Us.	1. By 12/31/2025, the number of EOCCO members screened through the AHC Screening Project will increase by [redacted] from 2023 year-end baseline to a minimum of [redacted] screened. 2. By 9/30/2025, the EOCCO THW Program and AHC Screening program will establish internal workflows for referring members through Unite Us.

3. The EOCCO Quality team will develop an evaluation plan to assess long-term project impact for members who received a social needs screening.	3. By 12/31/2025, the EOCCO QI team will develop and implement an AHC Screening Project evaluation plan.

B. CCO Support of Providers with Using Health IT to Support SDOH Needs: 2024 Progress & 2025-26 Plans

Please describe your 2024 progress and 2025-26 plans for supporting community-based organizations (CBOs), social service providers in your community, and contracted physical, oral and behavioral health providers with using health IT to support SDOH needs, including but not limited to screening and referrals. In the spaces below, (in the relevant sections), please:

- Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.
- 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).
- (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.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 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 2024 progress, including:
        i. 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)
        ii. Challenges related to each strategy, as applicable
    f. (Optional) An overview of CCO 2025-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2025-26

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 continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2025, 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 2024 and plan to implement during 2025-26 to support contracted providers and CBOs with using health IT to support SDOH needs. Elaborate on each strategy and your progress/plans in the sections below.

Progress	Plans		Progress	Plans	

☒	☒	1. Sponsor CIE for the community	☐	☐	7. Support payments to CBOs through health IT
☐	☐	2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)	☐	☐	8. Requirements to use health IT in contracts/provider agreements
☐	☐	3. Integration or interoperability of health IT systems that support SDOH with other tools	☒	☒	9. Track or assess CIE/SDOH tool adoption and use
☒	☒	4. Training and/or technical assistance	☒	☒	10. Outreach and education about the value of health IT to support SDOH needs
☒	☒	5. Support referrals from CBOs to clinical providers and/or from clinical providers to CBOs	☐	☐	11. Support participation in SDOH-focused health IT convenings, collaborative forums and/or education (excluding CIE governance)
☒	☒	6. Financial support to adopt or use health IT that supports SDOH (e.g., incentives, grants)	☐	☐	12. Support participation in CIE governance or collaborative decision-making
☐	☐	13. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs (please list here):			
☐	☐	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**.**

- **Unite Us:** Unite Us is a Community Information Exchange (CIE) tool which connects health care and social service provides through a shared secure web-based technology platform. In Unite Us organizations can conduct social need screenings, send referrals for clients, and track outcomes in real time, holistically addressing the SDoH needs of individuals and communities more broadly. Connect Oregon is the Unite Us network specific to the state of Oregon.

(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**

EOCCO has sponsored licensed access to Unite Us CIE platform for the entire Eastern Oregon region, supporting training and technical assistance for providers and community partners while continuously assessing adoption and utilization of the tool. EOCCO's HIT and Social Needs Screening Implementation opt-in Community Benefit Initiative Reinvestment (CBIR) grant opportunities offer an incentive for organizations to adopt Unite Us and integrate it into new or existing social needs screening and referral workflows.

HIT for SDoH Needs – Strategy 25: Community Information Exchange Implementation & Adoption

EOCCO will continue working to promote best practices for care coordination by implementing and promoting a community information exchange (CIE) in all 12 Eastern Oregon counties. EOCCO and its partner organizations have recognized CIEs as a key framework to share care coordination strategies with healthcare and community-based organizations. EOCCO is becoming a leader in CIE care coordination workflows by using Unite Us to send referrals to community partners and receive referrals from community partners, innovatively integrating HIE tools

to improve healthcare and social service delivery and ensuring meaningful use of the platform to address members' social needs.

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

☒ 1: Sponsor CIE ☐ 2: Enhancements ☐ 3: Integration ☒ 4: TA Assessment ☐ 5: Clinical←→CBO referrals
☐ 6: Financial support ☐ 7: Payments ☐ 8: Contract requirements ☒ 9: Track use ☒ 10: Outreach/education
☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

Strategy status:

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

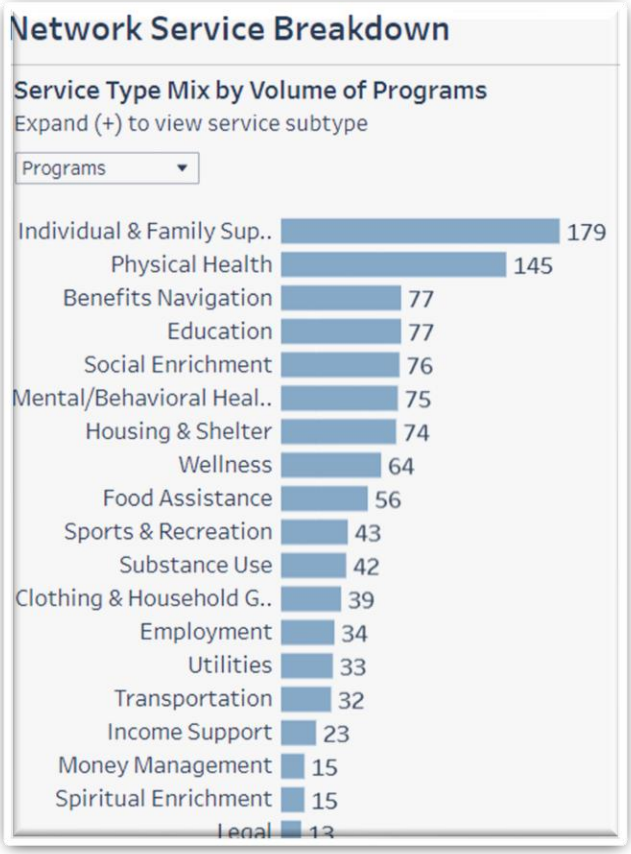
Provider types supported with this strategy: ☒ Across provider types OR specific to:

☐ Physical health ☐ Oral health ☐ Behavioral health ☐ Social Services ☐ CBOs

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

During 2024, EOCCO continued strategies related to supporting user onboarding and utilization of the Unite Us CIE. EOCCO maintained steady growth of the Unite Us network in its 12 county-service area, with a total of 247 unique organizations (including statewide organizations) configured to Connect Oregon by the end of 2024. Most of the Eastern Oregon organizational partners in Unite Us provide services or programs related to: Individual or Family Support (179), Physical Health (145), Benefits Navigation (77), Education (77), Social Enrichment (76), Mental/Behavioral Health (75), Housing & Shelter (74), Wellness (64), and Food Assistance (56) [*See Figure 1 Below*]. Though EOCCO did not meet its set milestone of [redacted] organizational growth from 2024 baseline (259 unique organizations), network efficiency data shows that organizations within the Unite Us network are better able to meet the needs of clients served through the platform.

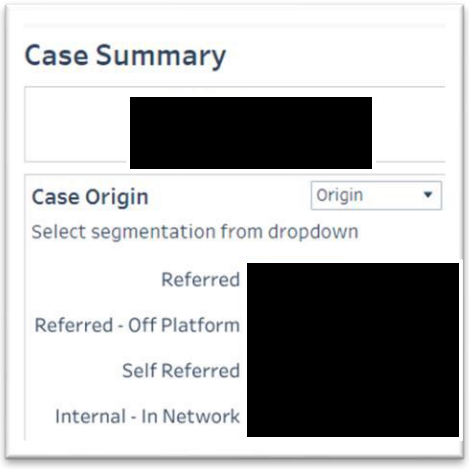
Figure 1. Eastern Oregon region and statewide partners by service type (CY 2024)



By the end of 2024, the percentage of referrals rejected in the Eastern Oregon Unite Us regional network had decreased to [redacted] down from [redacted] at the end of 2023, marking significant progress since the platform's launch on April 1, 2022. Additionally, EOCCO saw a notable increase in the number of organizational programs configured to accept referrals on the Unite Us platform. By year-end 2024, [redacted] were set

up to accept referrals, up from [redacted] at the close of 2023. EOCCO also achieved a key milestone by reducing the percentage of off-platform client referrals sent to organizations not connected to the Unite Us network. EOCCO surpassed its goal of a [redacted] in off-platform referrals, achieving a [redacted]. Specifically, the percentage of off-platform referrals decreased from [redacted] (see Figure 2). In December 2024, there were [redacted] referrals made via Unite Us, with [redacted] sent off-platform. These improvements in network efficiency demonstrate the Eastern Oregon Unite Us network's growing ability to effectively meet clients' health and social needs directly within the platform.

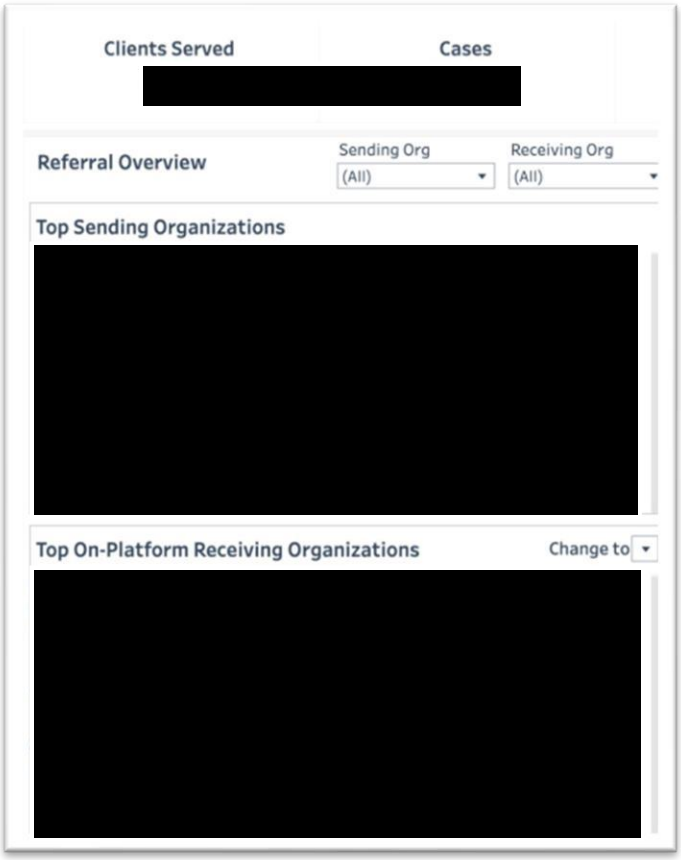
Figure 2. *Eastern Oregon region Unite Us client cases referred since platform launch (4/1/22).*



Throughout the year, EOCCO continued its efforts to promote the Unite Us platform and support organizational partners in developing workflows to enhance platform utilization and align with referral standards. EOCCO successfully achieved the milestone of hosting Unite Us training sessions with at least three key partners providing critical SDoH services in the region. Training efforts were focused on delivering tailored workflow support and platform education to organizations such as the [redacted] all of which receive a significant volume of client referrals through the platform (see *Figure 3* below).

However, EOCCO did not meet the planned milestone of implementing two specific quality improvement strategies aimed at optimizing Unite Us utilization and network efficiency. These initiatives will be carried over into 2025, with a more systematic and collaborative approach to ensure their successful execution.

Figure 3. Top referral sending and top referral receiving organizations on Eastern Oregon's Unite Us network since platform launch (4/1/22)



(Optional) **Overview of 2025-26 plans for this strategy**:

During 2025, EOCCO plans to continue community engagement strategies to expand its regional Unite Us network and increase onboarding and utilization of Unite Us by contracted physical, dental, and behavioral health partners, social service providers, CBOs, and public health agencies. Specific plans are outlined in the HIT for SDoH Needs Strategies 26 - 29 below. In order to ensure interested healthcare partners that do not qualify for a free Unite Us license are able to onboard the platform, EOCCO plans to expand available licenses for partners in 2025 by funding the purchase of additional Unite Us licenses. This expansion of available licenses is expected to facilitate broader platform adoption among both internal and external partners, driving further innovation in the CIE space.

Additionally, EOCCO intends to continue efforts related to ensuring clients served in Unite Us are able to have their health or social needs met in a timely manner by developing and implementing QI strategies related to platform best practice.

These efforts may include:

1. Collaborating directly with organizational users that have long referral closure times to align referral processing and response time with Unite Us platform standards (2 business days)
2. Conducting targeted outreach to organizations receiving a high volume of off-platform referrals to provide individualized Unite Us education or TA and support platform onboarding if interested
3. Working to onboard local organizations that provide programs or services that can address the most prevalent social needs of clients served in the platform (food, housing, and transportation).

To better track organizations in the Unite Us network that specifically serve Eastern Oregon counties, EOCCO will reset the organizational onboarding baseline for 2025. By removing statewide organizations from the [redacted] organizations counted at the end of 2024, EOCCO will focus on [redacted] organizations that provide services within Eastern Oregon counties. Going forward, EOCCO will use this baseline to set Unite Us network growth

milestones. Additionally, EOCCO will continue to monitor network efficiency metrics to evaluate and refine the QI strategies in place. In 2025, EOCCO will introduce a new milestone focused on reducing the percentage of referrals rejected on the platform.

Planned Activities	**Planned Milestones**
1. Develop a funding proposal to amend EOCCO's Unite Us contract and expand EOCCO's available Unite Us licenses for contracted healthcare partners. 2. Conduct outreach to off-platform referral receivers and Eastern Oregon region CBOs providing services aligned with prevalent needs among clients and the SDoH Metric (including food, housing, and transportation) to encourage more widespread implementation and adoption of the tool. 3. Develop QI efforts to support current Unite Us users in effectively utilizing the platform and accepting and closing case referrals in a timely manner.	1. By 12/31/2025, the percentage of referrals rejected in the Unite Us platform will decrease by at least [redacted] from 2024 year-end baseline (a [redacted] referral rejection rate or lower). 2. By 12/31/2025, EOCCO will provide personalized Unite Us training or TA sessions to at least 3 high-priority SDoH service type organizations. 3. By 12/31/2025, EOCCO will increase the number of onboarded Unite Us partners by at least [redacted] to a minimum of [redacted] unique partner organizations. 4. By 12/31/2025, EOCCO will collaboratively develop at least two QI strategies to address network efficiency, effective utilization, and/or timely referral closure in the platform.

HIT for SDoH Needs – Strategy 26: Unite Us Technical Assistance for Physical Health Partners

EOCCO strives to enhance adoption and meaningful utilization of Unite Us by covering the cost of licenses for contracted physical health providers. Through technical assistance opportunities, EOCCO supports providers in gaining comfort with utilizing the tool to conduct social needs screenings and to send/receive referrals to appropriately address members' social needs and care gaps. EOCCO also provides funding pathways through the CBIR opt-in HIT and Social Needs Screening implementation grants to support clinic integration of Unite Us into new or existing social needs screening and referral workflows.

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

☒ 1: Sponsor CIE ☐ 2: Enhancements ☐ 3: Integration ☒ 4: TA Assessment ☒ 5: Clinical←→CBO referrals
☒ 6: Financial support ☐ 7: Payments ☐ 8: Contract requirements ☒ 9: Track use ☒ 10: Outreach/education
☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

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 <u>accomplishments/successes</u> and <u>challenges</u> with this strategy):

In 2024 EOCCO continued to see growth and increased utilization of Unite Us across its regional Unite Us network. By the end of December 2024, [redacted] contracted EOCCO physical health partners were configured to the Connect Oregon network in Unite Us with [redacted] new physical health partners joining during the year. Utilization of the Unite Us platform also increased compared to 2023 baseline [redacted] cases referred) with [redacted] cases referred during the year ([redacted] increase). Though this increase did not achieve EOCCO's lofty set milestone of [redacted] utilization increase [redacted] cases referred), the continued growth in utilization of Unite Us by onboarded users is encouraging. The Unite Us utilization milestone will be revised to reflect the slower rate of organizational onboarding that has occurred after the initial rapid growth of the Eastern Oregon Unite Us network after launch in April of 2022.

During 2024, EOCCO continued work of socializing use of Unite Us, providing TA opportunities for contracted physical health providers/clinics, and identifying and addressing providers' concerns or barriers to increase utilization. In the Spring and again in the Fall, the EOCCO Quality Improvement team traveled to meet with

contracted physical health providers/clinics in-person and presented Unite Us as a tool for conducting social needs screenings and referring patients to local services that are best match for their needs. EOCCO's Unite Us Customer Success representative also met with six Eastern Oregon clinics over the course of the year to provide individualized TA and develop clinic-specific workflows to support platform utilization for social needs screenings and referrals. EOCCO achieved the milestone of hosting a provider focused training session related to social needs screening implementation by 9/1/24, with a training held on June 25th which shared information on Unite Us as a tool to support social need screening & referral processes and reporting.

EOCCO did not meet the milestone of developing a Unite Us utilization educational resource for contracted physical partners as energy was focused on providing individualized TA to clinical partners. EOCCO plans to carry this milestone over into 2025, with goal to develop a resource relevant to utilizing Unite Us to support social need screening & referral workflows.

Additionally, there were no clinical partners who applied for the opt-in Social Needs Screening CBIR funding in 2024. Though many other incentive measure and quality-related projects were funded through EOCCO'S CBIR opt-in grants, it's likely that a lack of specific and targeted communication to relevant partners about the Social needs Screening opt-in opportunity contributed to no clinical SDoH screening projects being developed and funded for 2024.

(Optional) **Overview of 2025-26 plans for this strategy**:

EOCCO plans to continue the provider engagement and funding strategies described above into 2025 to encourage adoption and utilization of Unite Us by physical health providers. Through the lens of platform utility in supporting Social Needs Screening & Referral metric requirements and reporting, EOCCO plans to develop resources, provide TA, and host trainings to encourage Unite Us utilization in clinical settings. Additionally, EOCCO will continue the Social Needs Screening CBIR opt-in funding opportunity and conduct targeted outreach to advertise the opportunity to clinical partners not currently screening patients for social needs (as identified through EOCCO's 2025 Social Needs Screening survey). It's intended that the Social Needs Screening CBIR opt-in will support integration of Unite Us into developed clinical social needs screening workflows.

EOCCO expects that referral activity in Unite Us will continue to increase over 2025 as more organizations across all service types adopt the platform within Eastern Oregon. EOCCO has adjusted the case referral milestone to achieve a 15% increase in platform utilization during 2025 from 2024 year-end referral baseline.

Planned Activities

1. Provide individualized Unite Us support and TA to onboarded physical health partners.
2. Collaborate with the Unite Us account team to create physical health clinic-facing resources on platform workflows and functionality specifically related to Social Needs Screening & Referral metric reporting and requirements.
3. Provide peer-learning opportunities and trainings for physical health providers to help socialize use of Unite Us for improving care coordination, addressing members' social needs, and meeting Social Needs Screening & Referral metric requirements.
4. Continue to offer the opt-in Social Needs Screening CBIR funding opportunity to support integration of Unite Us into clinical social needs screening workflows and conduct targeted outreach to clinical partners to advertise this funding opportunity.

Planned Milestones

1. By 12/31/2025 EOCCO will host at least one provider-focused training session related to social needs screening & referral processes and best-practices.
2. By 12/31/2025 EOCCO and Unite Us will have created and disseminated at least one educational resource related to SDoH screening & referral workflows and reporting in Unite Us.
3. In 2025, EOCCO will fund at least one Social Needs Screening opt-in CBIR project related to social needs screening and/or Unite Us implementation and integration.
4. By 12/31/2025, utilization of the Unite Us platform will increase by [redacted](minimum of [redacted]cases referred during 2025) across the service area from 2024 year-end referral baseline.

HIT for SDoH Needs – Strategy 27: Unite Us Technical Assistance for Community Partners

EOCCO will continue to leverage community connections and network champions to onboard Traditional Health Workers (THWs) within community benefit organizations (CBOs) and social service partners to the Unite Us tool. The CCO will also provide assistance and guidance to enhance THW use of the tool, as well as to increase the number of SDoH referrals sent throughout the platform.

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

☐ 1: Sponsor CIE ☐ 2: Enhancements ☐ 3: Integration ☒ 4: TA Assessment ☒ 5: Clinical←→CBO referrals
☐ 6: Financial support ☐ 7: Payments ☐ 8: Contract requirements ☐ 9: Track use ☒ 10: Outreach/education
☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

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 2024, EOCCO collaborated with both internal and external teams to enhance the visibility of community-based organizations (CBOs) and social service organizations on the Unite Us platform. This initiative was part of EOCCO's ongoing effort to identify resource referral needs and provide timely support.

To engage community partners, EOCCO encouraged Unite Us to present to social service organizations and community-based groups, including clinics that serve their local populations, to increase both platform exposure and understanding. Throughout the year, Unite Us conducted presentations at [redacted] and also provided individual demonstrations and technical assistance upon request for organizations across Eastern Oregon.

EOCCO actively mapped available resources and services on Unite Us, using this information to develop EOCCO's 2024 Community Resource Guide, which was distributed to all providers and CBOs in the region. EOCCO consistently monitored the onboarding and usage metrics for organizations, providing outreach and assistance to ensure CBOs and clinics achieved optimal results in areas such as case acceptance, case closure, and the collection of key data including REAL-D, SOGI, and SDoH. Through targeted outreach, EOCCO successfully increased the number of onboarded organizations that are located in or specifically serve Eastern Oregon counties to [redacted] by the end of 2024.

In an effort to further engage providers, CBOs, and social service organizations, EOCCO expanded the platform's utility for Traditional Health Workers (THWs). EOCCO facilitated two Unite Us training sessions for birth doulas, enrolling [redacted] participants and covering their platform licenses. These trainings focused on platform navigation and encouraged continued exposure for THWs within the Unite Us ecosystem. EOCCO also created the “Traditional Health Workers” program under its organization, which allows contracted THWs to send and receive both internal and external referrals, be assigned clients, and share resources. This initiative successfully onboarded [redacted] within the first month of launch and is set to expand throughout 2025. The goal is to integrate THWs into CBOs and various care settings, making it easier to address social determinants of health.

Additionally, EOCCO conducted outreach to all THWs in Eastern Oregon, offering technical assistance and onboarding training. EOCCO sponsored all interested THWs on Unite Us and encouraged partner organizations to onboard their THWs, increasing the number of THWs on Unite Us [redacted] far surpassing the goal [redacted] This group of THWs, which includes all THW types--CHWs, birth doulas, PSSs, PWSs, and PHNs—represents Baker, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, and Wheeler counties, and serves an additional ten counties (eight outside of EOCCO’s primary region), Benton, Clackamas, Gilliam, Marion, Multnomah, Polk, Sherman, Wasco, Washington, and Yamhill , showcasing a diverse range of specialties to meet referral needs throughout the state. EOCCO looks forward to further expanding the THW program in 2025 to all EOCCO counties and broadening the array of available resources.

(Optional) **Overview of 2025-26 plans for this strategy**:

In 2024, the continued development of both internal and external training programs for THWs has proven to be highly successful. This progress will continue into 2025 to further accelerate the adoption of Unite Us across the EOCCO service area. Additionally, it will support the expanded integration of THWs into the delivery of health care and health-related services. EOCCO plans to refine and develop workflows that facilitate the effective operation of its Traditional Health Worker Program, while also onboarding additional THWs, especially those who do not have support from clinic or CBO affiliations.

To strengthen this ongoing adoption and expansion, EOCCO will host specialized Unite Us training sessions tailored to THWs. These training sessions will cover the essentials of Unite Us system navigation, onboarding processes, and workflows for conducting social needs screenings. They will also focus on how THWs can effectively connect clients to local resources, ensuring a seamless integration of THWs into the broader health and social services landscape.

In addition, EOCCO will engage in direct outreach to CBOs that provide services and resources aligned with the most pressing social needs identified through Unite Us screenings. By fostering these partnerships, EOCCO aims to close care gaps and bolster the region's ability to meet the diverse needs of its members. This outreach will further enhance the Eastern Oregon Unite Us network, ensuring a more comprehensive and responsive approach to client care. EOCCO is committed to collaborating with both social service organizations and THWs to innovate and explore ways to integrate the CIE into care delivery, improving service accessibility and quality.

Planned Activities	**Planned Milestones**
1. EOCCO will focus on internal collaboration between Unite Us and the EOCCO Field (Community Engagement) team to increase THW onboarding by attending monthly clinic meetings, presenting at county LCHP meetings, and providing one-on-one technical assistance to organizations that employ THWs. 2. EOCCO will conduct targeted outreach to organizations via email based on THW Clinic Utilization Reports and CBOs who report employing THWs to begin Unite Us conversations and support THW onboarding to the platform. The EOCCO Field Team and Unite Us will provide technical assistance and training as needed. 3. EOCCO will continue to expand the organizational THW program in Unite Us, providing the opportunity for additional contracted THWs to utilize the platform.	1. By 12/31/2025, EOCCO will increase the number of THWs onboarded onto Unite Us by [redacted] 2. By 12/31/2025, EOCCO will build out two THW-specific workflows in the Unite Us platform. 3. By 6/30/2024, EOCCO will host at least two Unite Us trainings for THWs and organizations employing THWs.

HIT for SDoH Needs – Strategy 28: Unite Us Expansion to Oral Health Providers and Dental Care Organizations

One of EOCCO's Dental Care Organizations (DCOs) Advantage Dental expressed interest in using Unite Us at the DCO level. Both Advantage and ODS indicated interest in having dental practices utilize the platform if it provides sufficient benefit to their members. The use of a CIE could be beneficial to capitated providers, especially those that have case management teams onsite. The goal is for DCO Case Management and Care Coordination teams to be able to send and receive referrals in Unite Us for both internal Case Management/Coordination services.

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

☒ 1: Sponsor CIE ☐ 2: Enhancements ☐ 3: Integration ☒ 4: TA Assessment ☐ 5: Clinical←→CBO referrals
☐ 6: Financial support ☐ 7: Payments ☐ 8: Contract requirements ☐ 9: Track use ☒ 10: Outreach/education
☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

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 2024 ODS maintained that Unite Us was not beneficial to its contracted providers or the members it serves without a critical mass of local community organizations that accept referrals using the tool as well. Currently there are not enough community partners using the tool to meet the demonstrated needs of the ODS EOCCO member population. The DCO's care coordination team is integrated with both its members and CCO partners and has successfully connected members to resources in 2024 without the use of a CIE.

Advantage Dental also did not expand the use of Unite Us beyond their centralized DCO Care Coordination team in 2024. The centralized approach continues to function well for their provider network as most contracted clinics have indicated that they do not have the capacity to implement and train staff on the Unite Us tool at this time. The Advantage Care Coordination team actively intercepts referrals via Unite Us. While DCO Care Coordinators are able to send referrals, only three were sent in 2024 due to limited number of community-based organizations that accept referrals via the tool. This is an ongoing barrier experienced across provider types and is not specific to DCO users on Unite Us. Advantage Dental's Community Care team continues to push referrals out to appropriate CBOs on behalf of their provider network.

EOCCO did not achieve the 2024 Roadmap milestone to hold at least one meeting with both DCOs to facilitate discussion of CIE best practices in 2024. This was partially due to lack of enthusiasm for the tool from many dental partners and partially due to the different ways in which each DCO used the tool, with ODS' network use being more dispersed and Advantage's use being more centralized to its Care Coordination team.

(Optional) **Overview of 2025-26 plans for this strategy**:

As mentioned above, ODS will pause their work on this strategy while the pool of community partners using Unite Us grows. The EOCCO Quality Team will re-visit expanding this strategy with both DCOs in early 2026 when the number of community partners accepting referrals via Unite Us will hopefully have expanded enough for the tool to be useful for dental providers.

Planned Activities	**Planned Milestones**
1. Advantage Dental will meet with Unite Us to explore opportunities for primary care dentists (PCDs) to directly use the CIE to send SDOH referrals. 2. Advantage Dental's Care Coordination team will continue to intercept referrals for its members via Unite Us.	1. By Q1 2026, the Quality team will facilitate a discussion with both DCO partners to determine if the CIE network has grown enough to warrant another push for dental providers to onboard to the tool.

HIT for SDoH Needs – Strategy 29: Unite Us Expansion to CMHPs

EOCCO is working to continue expanding its network of referring partners utilizing the Unite Us platform. This extends to all areas of the care continuum including contracted Community Mental Health Programs (CMHPs) in the region. Through technical assistance opportunities, EOCCO supports providers in gaining comfort with utilizing the tool to conduct social needs screenings and to send/receive referrals to appropriately address members' social needs and care gaps.

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

☒ 1: Sponsor CIE ☐ 2: Enhancements ☐ 3: Integration ☒ 4: TA Assessment ☒ 5: Clinical←→CBO referrals
☐ 6: Financial support ☐ 7: Payments ☐ 8: Contract requirements ☐ 9: Track use ☒ 10: Outreach/education
☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

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):

Progress on this initiative remained stalled throughout 2024 despite concerted efforts from the GOBHI Community Engagement team to reengage CMHP partners and promote the adoption of the Unite Us platform. Confusion caused by the presence of multiple CIEs in the region, ongoing challenges with provider adoption and integration, and concerns regarding referral pathway compliance have all contributed to delays in advancing this strategy. As of 12/31/2024, the onboarding status of CMHPs remained unchanged, with [redacted] CMHPs fully onboarded to Unite Us. Moving forward, the EOCCO Behavioral Health Director will work closely with the EOCCO QI team and other stakeholders to overcome barriers and accelerate progress.

During 2024, several CMHPs reiterated the same challenges to full CIE platform adoption, including:

1. **Confusion with Multiple CIEs:** The presence of several different CIEs in the region has continued to cause confusion among partners regarding the differences in platforms and the importance of adopting Unite Us.
2. **Adoption and Integration:** Despite isolated successes in referring members from the CCO to and from behavioral health on Unite Us, providers and community partners remain hesitant to fully collaborate on the platform.
3. **Referral Pathway Compliance:** Concerns about the potential transfer of sensitive behavioral health data persist. Many providers have indicated that additional training is needed to ensure they feel confident in the appropriate and compliant use of the platform for referrals.

(Optional) **Overview of 2025-26 plans for this strategy**:

EOCCO hopes to address the challenges listed above by promoting individualized outreach to each CMHP, working with EOCCO's Unite Us Customer Service Representative to outreach to behavioral health providers, and providing learning opportunities for CMHPs to brainstorm workflows for behavioral health clients.

Planned Activities	**Planned Milestones**
1. Provide individualized outreach to each contracted Community Mental Health Program in the region surrounding the implementation and adoption of the Unite Us platform. 2. Working with the Unite Us Community Engagement team and EOCCO/GOBHI staff, organize presentation opportunities throughout 2025 for contracted behavioral health providers to learn more about platform adoption and the utility of CIE tools. 3. Provide peer-learning opportunities for CMHPs to discuss referral use cases and workflows specific to behavioral health clients.	1. By 12/31/2025, EOCCO will host adoption presentations from Unite Us Engagement team with representatives from each of the seven CMHPs in the region. 2. By 12/31/2025, EOCCO will increase the number of CMHPs utilizing the Unite Us platform to [redacted]

C. Using Technology to Support HRSN Services

Please use this section to describe progress and plans to support use of technology for HRSN Services, particularly for closed loop referrals. Include work and strategies:

1. Within your organization to use technology to support HRSN Services and
2. To support and incentivize HRSN Service Providers to adopt and use technology, particularly for closed loop referrals (such as grants, technical assistance, outreach, education, and engaging in feedback).

Note: If referring to a strategy already described elsewhere, please name the section and number, and ensure it is clear how the strategy supports use of technology for HRSN Services.

Within CCO: Specific progress and plans within CCO to adopt and use technology needed to facilitate HRSN Service provision, such as for closed loop referrals, service authorization, invoicing, and payment.

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

In 2024 the CCO continued to use the Smartsheet tool and a webform integrated to the EOCCO website to facilitate HRSN service requests, authorization, provision, invoicing and payment. Members used the Smartsheet tool to submit requests for climate devices beginning in March 2024 and the webform to submit requests for housing support and getting connected to an HRSN service provider for assistance beginning in November 2024. All service requests are reviewed and authorized if appropriate by the CCO's Case Management team in either the Smartsheet submission view or the webform submission view.

The CCO also created a general request process for members or requesters who need assistance but aren't certain what specific HRSN benefit they may need or be eligible for. This is done through the same HRSN webform as a general "Connect with a service provider for help" request. EOCCO's HRSN Services Manager reviews these requests and will either refer the member for help via a direct referral to relevant community organizations or if they are eligible for an HRSN benefit through the CCO the Manager will assign the member to a contracted HRSN service provider via a Smartsheet form. "Referrals for help" are defined by EOCCO as "requests where a member would like to be connected to a contracted HRSN service provider for help with gathering documentation for a request, submitting a request, and any other Outreach and Engagement-related activities prior to any requests for service and authorizations." The CCO's HRSN team holds weekly meetings with contracted HRSN providers to review members assigned to them for services.

In early 2024 the EOCCO HRSN Services Manager and Medicaid Services Director continued to meet with Unite Us representatives to discuss implementing the CIE Payments functionality. The CCO ultimately determined that the Payments function does not work with current CCO invoicing and tracking processes at this time. In place of using Unite Us, CCO staff have instead set up processes to use both Smartsheet forms and the EOCCO webform to track services and process payments to contracted providers. Providers are currently asked to track the services rendered and attach supporting billing documentation using a Smartsheet form. The CCO HRSN team has engaged with the Finance and web configuration teams to set up a Payments module of the existing webform so providers can request service payments via the form beginning in January 2025.

2025-27 Plans:

Beginning in January 2025 EOCCO will also begin accepting requests for HRSN Nutrition services via the existing EOCCO webform. Climate device requests will also be migrated from Smartsheet to the webform in 2025 so that members and requesters can submit all HRSN-related questions and requests in one place. The CCO also plans to fully implement the Payments module through the webform in Q1 2025. Once this module is developed and tested, contracted HRSN providers will undergo a provider validation process that will allow them to view the module and formally request service payments via the webform.

Support for HRSN Service Providers: Specific progress and plans to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals in 2025 and for Contract Years 2025-2027, such as grants, technical assistance, outreach, education, engaging in feedback, and other strategies for adoption and use.

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

EOCCO funded [redacted] Community Capacity Building Funds (CCBF) grant projects at the end of 2023 for initiatives implemented from Q3 2024 – Q3 2026. CCBF grants in general supported organizations in building capabilities and capacity to provide HRSN services. Two of the four funding categories (*Technology* and *Development of business or operational practices*) supported increasing capacity to send and process HRSN referrals [redacted] CCBF recipients received funding in one or both of those categories. Rather than transitioning to a completely new closed-loop referral system such as a CIE, many of these funded projects included initiatives to adjust existing systems such as [redacted] or their EHR to the HRSN-specific referral structure.

In 2024, HRSN service providers were required to use the CCO's Smartsheet and webform as the main pieces of technology facilitating closed loop referrals. The CCO is still uncertain whether the Unite Us CIE, currently in use on other initiatives across EOCCO [as described in *Strategies 22 and 24*], is the right tool for facilitating HRSN referrals. The EOCCO HRSN Services Manager and Specialist have gathered feedback from current and prospective HRSN providers on using a CIE for referrals and the responses are mixed. As with many forms of HIT, providers are hesitant to incorporate another tool into their already full workloads.

2025-27 Plans:

EOCCO will continue monitoring progress on all current CCBF grant projects, particularly those related to the use of technology in building capabilities and capacity to provide HRSN services. The CCO will collect progress reports from the first wave of grant recipients in Q1 and Q3 2025 and Q1 and Q3 2026. Recipients will be provided technical assistance upon request.

EOCCO will also open applications for Community Capacity Building Funds (CCBF) grant opportunities again in spring 2025 to support providers in implementation of HRSN benefits. Organizations can apply for funds in the same four categories of work (technology, development of business or operational practices, workforce development, and outreach education and convening) as in previous grant cycles. Grant applications will be accepted from April 1st to May 30th 2025 for projects to be implemented from Q1 2026 -Q4 2027.

EOCCO also plans to continue using existing tools like the webform and Smartsheet to facilitate closed-loop referrals and HRSN service provision in 2025. The HRSN team has determined that providers and CCO staff would benefit from seeing a full year of benefit implementation in 2025 before committing to a specific CIE. This will allow the CCO to have a complete picture of what functions and features are needed in a potential CIE tool before committing to a specific vendor once OHA requires CIE use for HRSN in contract year 2026.

D. Health IT to Support SDOH Needs Barriers

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.

There are several barriers which inhibited both utilization and adoption of Unite Us CIE by contracted physical, oral, and behavioral providers, social service agencies, and CBOs across EOCCO's service area. A lack of organizations that provide services/programs in prevalent social need domains poses a challenge for organizations utilizing the platform to meet clients/members' needs. This has likely contributed to the continuation of off-platform referrals being sent by Unite Us users, a high rate of referral rejections, and the prolonged average length of time for referred case closure within the platform. Additionally, some contracted health care partners, social services agencies, and CBOs have expressed hesitancy to onboard to Unite Us given the perception that organizations within the Unite Us network are not able to adequately address client or community needs. EOCCO is planning to focus efforts and quality improvement strategies in the coming years on socializing the Unite Us platform and ensuring the regional Eastern Oregon Unite Us network meets the needs of users and members/clients by supporting network service/resource alignment with prevalent social needs.

The geography and expansiveness of the Eastern Oregon region also poses unique challenges that have prevented unified adoption of the tool across the service area. Some Eastern Oregon counties [redacted] have had substantial Unite Us network growth, while other counties [redacted] have had very few organizations adopt the platform. This has led to network gaps across our service area, preventing some

organizations from being able to utilize Unite Us to make social needs referrals for EOCCO members. Furthermore, there are several different CIEs that exist across the Eastern Oregon region (e.g. Find Help and the Eastern Oregon Community Resource Network). Organizations using different CIEs are hesitant or unwilling to transition to Unite Us, which poses a challenge for growing a unified Eastern Oregon care network oriented around one CIE tool.

Additionally, physical health organizations have expressed challenges with limited EHR integration capability of Unite Us and needing to shift or establish new social need screening and referral workflows in order to move toward organization-wide utilization of the Unite Us platform. Though this poses a significant challenge for some providers, EOCCO hopes that providing funding pathways through CBIR grants will support contracted providers in covering costs related to adopting and integrating the CIE.

E. OHA Support Needs

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?

EOCCO would appreciate additional Social Needs Screening and Referral TA or resources oriented toward supporting clinical and community-based partners. Currently a majority of the TA OHA provides for the *Social Needs Screening & Referral (SDOH)* incentive measure is directed toward CCOs, and engaging other critical partners involved in this work might help identify current barriers and opportunities to support elements of the SDoH incentive measure work including HIT tool adoption/utilization and data sharing.

7. 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.

EOCCO continues to explore innovative ways to enhance patient engagement through health IT, particularly within the constraints of a rural healthcare delivery system. EOCCO does not yet directly deploy health IT tools for member engagement. We support contracted providers in increasing the utilization of patient portals and ensuring member access to tools such as after-visit summaries and other EHR-integrated features.

B. How can **OHA support** your efforts in accomplishing your Health IT Roadmap goals?

To support EOCCO in achieving its Health IT Roadmap goals, we encourage OHA to consider expanding technical assistance and capacity-building resources specific to rural and frontier regions. This could include establishing a centralized training hub with toolkits, webinars, and implementation guides tailored to small practices and rural clinics. In addition, funding opportunities to pilot rural-specific innovations such as remote patient monitoring, broadband support, or scalable referral platforms would accelerate local adoption. Creating a peer learning collaborative across CCOs would allow for shared learning and dissemination of best practices. Finally, we would benefit from access to optional shared infrastructure, such as a customizable statewide referral management system or member-facing portal, which could streamline engagement and reduce duplication of efforts across CCOs.

C. What have been your organization's **biggest challenges** in pursuing health IT strategies? What can OHA do to better support you?

EOCCO and its provider network continue to face several persistent challenges in implementing health IT strategies, primarily driven by workforce shortages, limited staff time, and varying technical capacity among smaller or independent clinics. Many providers operate within EHR systems that lack the functionality needed for seamless integration with HIE tools or advanced reporting. Additionally, buy-in to existing HIE tools remains low due to concerns about data reliability and workflow burden. We believe OHA could provide valuable support by funding or assigning a regional health IT liaison to help CCOs and providers navigate implementation and troubleshooting. Encouraging EHR vendors to participate in interoperability initiatives and offering simplified

reporting pathways for low-resource clinics would also reduce barriers. Continued financial and technical support for rural providers is critical to expanding and sustaining HIT adoption in our region.
D. How have your organization's health IT strategies supported **reducing health inequities**? What can OHA do to better support you? If not already described above, how does your organization use REALD/SOGI data to support reducing health inequities? What has your organization learned about the impact on outcomes?
EOCCO has prioritized the collection and integration of REALD data to identify and address health inequities within our member population. This data is now linked to key quality metrics and outcomes within our data warehouse, allowing us to analyze disparities in preventive care, chronic disease management, and maternal health services. We have supported provider and staff training on the respectful collection and use of REALD and SOGI data, and have begun using these insights to design targeted outreach and culturally responsive programs. However, we continue to face challenges due to data discrepancies between CCO-held records and state enrollment data. We recommend that OHA develop a process to allow CCOs to submit updated REALD data to inform and enhance OHA's enrollment records. Additionally, the availability of standardized SOGI data from OHA would significantly strengthen our ability to evaluate disparities and develop targeted interventions. Improved data alignment and infrastructure would reduce burden on clinics, improve data quality, and ultimately support more equitable outcomes for members.

Note: For an example response to help inform on level of detail required, please refer to the Appendix in 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.