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 assistance, outreach, education, engaging in feedback, and other strategies for adoption and use***

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
	technology for closed loop referrals	○ ***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: Health Share of Oregon

Date: 4/25/2025

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).
Health Share's structure is based on collaboration and partnership between 11 founding members and 5 risk-holding delivery system networks. These networks are known as **Integrated Delivery Systems** (**IDS**) and an **Integrated Community Network (ICN)**. These networks serve all Health Share members and receive payments in value-based risk-adjusted payment arrangements with the CCO. Most of the activities in the HIT Roadmap represent the efforts and priorities of each entity in service to the broader CCO collaborative and the needs of their populations. Health Share plays a critical role in building alignment and partnership across these organizations to work on shared priorities based on the needs of the population. This alignment is done through formal committees and operational workgroups within

the CCO's governance structure, with communication and alignment occurring through the CCO's monthly Health Information Technology Governance Committee. The HIT Governance Committee includes representatives from Health Share's 11 founding partners and HIT leadership from across the collaborative. It was created to set a forum for alignment and collaboration in the development of Health Share's initial HIT Roadmap and has been meeting regularly ever since.

This past year and going through 2025, a large investment of time and resources has gone into implementing the HRSN benefit and associated administrative processes. Health Share and its IDS/ICN networks are leveraging Connect Oregon for many of these critical workflows and have developed administrative and care provisioning processes supported by technology to ensure social needs providers have the resources they need.

Health Share's networks employ multiple objective and subjective methods for risk stratification including diagnostic, utilization, enrollment parameters, program participation, and care coordination information in gauging risk. Health Share also leverages actuarial risk stratification internally and to risk-adjust reimbursement to its partners incentivizing risk sharing, population management, and proactive care coordination. In 2025, Health Share will incorporate risk stratification scoring into its data warehouse for population analytics and monitoring.

Comments from health plan partners:

OHSU

- OHSU Health IDS (OHSUH IDS) overview of Health IT is based off the Care Continuum Model, keeping in mind that not all providers of service operate within the EPIC EHR system. Establishing data structure, access and integrity is pivotal. Over 80% of the OHSUH IDS membership is serviced within one Epic system, which represents three hospital systems: OHSU, HMC and AHPL.
- The Health IT approach largely uses, but is not limited to, Healthy Planet tools within the Epic EHR (referred to generally as Epic for the remainder of this section). Epic consumes member rosters, calculates quality measure performance, provides operational reports, documents SDOH and facilitates care coordination and care management. Additionally, the use of HCCs and risk stratification tools help identify priority populations for care coordination and care management.
- HIE tools are utilized within Epic to connect to external sites to obtain external data from community-based clinics that are not on the OHSUH IDS instance of Epic. In addition, connection with other external partners such as Point Click Care for ED visits and Post Acute Care Management; as well as Connect Oregon through file sharing over SFTP, provides additional tools in the care continuum.
- Epic's Data Warehouse, which houses both internal data from Epic and external data from our partner sites, is the repository for reporting. Standard tools like Business Objects, Tableau, and Power BI provide analytical reports & dashboards for IDS Leadership, staff and end-users.

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**

For this reporting period, data collected from OHA and supplemented by Health Share partner organizations reflected in the Reporting Table of the provided spreadsheet indicates 0.4% of physical health providers, 3% of behavioral health providers, and 10% of dental providers *do not have EHR's*.

The percentage of *unknown* EHR status is: 42% for physical health, 49% behavioral health and 34% for dental.

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

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**

OHSU's Health IT approach largely uses, but is not limited to, Healthy Planet tools within the Epic EHR (referred to generally as Epic for the remainder of this section). Epic consumes member rosters, calculates quality measure performance, provides operational reports, documents SDOH and facilitates care coordination and care management. Additionally, the use of HCCs helps identify priority populations for care management and risk stratification. Epic utilizes HIE tools to connect to external sites to obtain external data from community-based clinics that are not on the OHSUS IDS instance of Epic. In addition, connection with other external partners such as Point Click Care (formerly Collective Medical) and Connect Oregon through file sharing over SFTP, provides additional tools in the care continuum.

Kaiser also leverages a highly integrated Epic based solution for EHR, care coordination and population health. This include modules such as Compass Rose for care coordination and Healthy Planet for population health.

Strategy 1 title: CareOregon - Technical Assistance to Support the Optimization of Electronic Health Records

Through our team of Innovation Specialists, CareOregon provides technical assistance / practice coaching to our provider network partners to support various clinic and system transformation goals. This includes identifying opportunities to use EHRs more meaningfully to improve workflows, support CCO Quality Metric documentation, and support Value Based Payment performance.

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 innovation team supported the primary care network through individual technical assistance and learning collaboratives that discussed content around health information technology. Primary focuses in 2024 included a Social Needs Screening Learning Series, Practice Coaching for Primary Care Transformation, and 1:1 Technical Assistance for metric support (Diabetes A1c, Well Child Checks, Childhood Immunizations). In the Social Needs Learning Series participants discussed how to maintain person centered care while using a Community Information Exchange platform for referrals and care coordination, which is in service of the SNS metric. The Practice Coaching for Primary Care Transformation session included how to leverage telehealth and remote patient monitoring for better engagement and care team utilization for patient outcomes. Finally, technical assistance for metrics was centered around supporting the integration and optimization of diabetes dashboards for better patient monitoring and bringing clinics together to share lessons learned in utilizing Compass Rose for better diabetes management. In addition to technical assistance, contracting with OCHIN was executed to fund participation of the two pilot FQs in adoption of the VBPM and Certified HEDIS measure analytics. CareOregon's pilot implementation was delayed due to unforeseen technical requirements. Those requirements are now in the process of being satisfied with an updated projected completion date in Q2, 2025. Post-pilot completion, the option to spread adoption of the tools and associated funding will be made available to clinics on OCHIN that participate in shared risk arrangements and EPP. Currently, there are 5 clinics that are on EPP that will be eligible for VBPM and Certified HEDIS measure analytics post-pilot.

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

This strategy is in a maintenance phase. Technical assistance will continue to be provided to clinics around optimization of EHRs. However, opportunities will be developed on an as needed basis in consultation with primary care clinic partners. Additionally, CareOregon will continue providing optional funding to our Federally Qualified Health Centers who elect to participate with us in the EPIC Payer Platform (EPP) data exchanges, to adopt EPIC's Value-based Performance Management (VBPM) and NCQA Certified HEDIS measure analytics tools. These tools are designed to enhance each FQ's ability to manage and monitor performance and the health of populations associated with our value-based payment contracts and make optimal use of the data exchanges enabled through EPP.

Planned Activities	**Planned Milestones**
1. Fund Multnomah County Health Centers and Virginia Garcia Memorial Health Centers participation in OCHIN's VPBM pilot. 2. Organize with OCHIN the post-pilot launch of first wave of FQ partners' participation in VBPM and HEDIS measures. 3. Evaluate possibilities to extend funding offers to additional primary care network partners currently using EPIC EHR.	A. VBPM pilot completed by Q2 2025. B. 4-5 additional FQ partners will adopt VBPM & Certified HEDIS measures by Q4 2025. C. Determine funding availability to expand to additional primary care network partners using Epic by Q1 2026.

Strategy 2 title: CareOregon - Strategic Healthcare Investment for Transformation (SHIFT)

SHIFT is a pilot initiative that aims to transform how behavioral health services are delivered through member-driven and outcomes-focused team-based care models that reduce health disparities and prepare providers for advanced value-based payments. SHIFT was developed on the foundation of the Building Blocks Model which emphasizes:

- Integrated Team Based Care
- Training & Development
- Client-Focused Timely Access
- Leadership
- Whole Person Care Service Array
- Business Intelligence & Applied Use of Data

- Population Focused Care
- Change Management Infrastructure for Transformation

Participating organizations will receive technical assistance and financial support from which will be used in part to enhance and improve HIT infrastructure including EHR optimization. SHIFT providers are using this opportunity to support HIT work via optimization of EHR, data reporting capabilities and usage of HIE's.

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):

After a competitive application process, 5 providers (Cascadia, Clackamas Health Centers, Morrison, New Narrative, and Volunteers of America) were selected for SHIFT. In 2024, grants and robust consultation and training were made available to the providers. As a result, all providers completed the current Business Intelligence (BI) assessment and assessment of EHR capabilities as facilitated by consultants funded by CareOregon. Providers developed implementation plans to ensure their BI/EHRs can support integrated team-based care, population health management, and Feedback Informed Treatment (FIT), which are all required per the SHIFT model. By the end of 2024, all agencies were working on individualized activities outlined in their approved Business and Implementation Plans.

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

To advance this initiative, efforts will continue to implement provider and practice specific plans while developing workflows that further operationalize team-based care. This includes ensuring that operational needs are met to support SHIFT's goals, particularly in terms of interoperability. Additionally, new activities will be launched to enhance care coordination among behavioral health and primary care. These activities may involve the use of HIE tools, as well as platforms such as Point Click Care, Unite Us, and other communication pathways to facilitate collaboration.

Planned Activities	**Planned Milestones**
1. Complete implementation activities for each agency. 2. Establish workflows 3. Determine required activities to support coordination of care.	1. Completion of business plan deliverables by Q4 2026.

Strategy 3 title: CareOregon - Financial support for EHR implementation and upgrades

CareOregon provides significant financial support for physical and behavioral health organizations seeking to upgrade or change EHRs to improve functionality. This financial support makes it possible for organizations to upgrade to systems that allow for improved interoperability, better support for quality metrics, increased integration of social needs data and more advanced participation in value-based payment arrangements.

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, one clinic system, Central City Concern, upgraded their EHR to OCHIN EPIC. Quality Improvement Analysts worked with the clinic system to assist with the upgrade by reporting metrics and transferring information. This strategy is being retired as no specific financial investments were allocated in 2024, and there are no future plans for funding.

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

QI analysts will continue to provide support in reporting, data validation, triaging provider issues/questions, assisting clinics with EHR upgrades, and completing regulatory requirements as directed by OHA.

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

Strategy 4 title: (Original) Extend OHSU's instance of Epic to Adventist Health Portland (AHPL)
(Revised) Extend OHSU's Epic capabilities overall for AHPL / HMC / OHSU

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):

2024 Progress – Planned activity #1 OHSU's implementation of [redacted] (3rd party software) to address the needs of tracking and documenting interpreter services faced many challenges and the project was halted. Not long into the implementation OHSU faced challenges with the vendor meeting agree upon deliverables, missing deadlines, etc. As OHSU's confidence in the vendor became a real concern, the project team started a contingency plan which centered on the configuration and use of Epic. Eventually, the contingency plan became the path forward for OHSU, but the new plan to use Epic was not without its own set of challenges. The challenges with the use of Epic center around who will document the necessary information required for the Meaningful Language Access metric. Furthermore, the project to use Epic has been paused while OHSU regroups and works through the challenges regarding documentation.

2024 Progress – Planned activity #2 OHSU completed the implementation of specific functionality within Dorothy, Epic's Home Health application, to support home infusions. OHSU has not transitioned fully to Dorothy for Home Health.

2024 Progress – (NEW) Unplanned activity Implemented Cheers Campaign to support member outreach for climate-related events such as extreme cold & heat, and wildfires.

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

OHSUH IDS has plans to continue extending population health tools in Epic to AHPL/HMC/OHSU, such as SDOH and Cheers. For example, we plan to leverage Cheers functionality to support outreach for health risk assessments (HRA). Leveraging Cheers for HRA outreach is still early in the discovery phase of the project.

We are evaluating solutions to extend clinical information sharing for care management collaboration with behavioral health providers.

Planned Activities	**Planned Milestones**

1. Continue rolling out SDOH at AHPL/HMC/OHSU 2. Continue rolling out Cheers outreach across the Health System 3. Interpreter services documentation project	1. All new clinics w/in AHPL / HMC / OHSU will be connected to SDOH w/in 90 days of opening. 2. Climate event notices up and running by Q2 – 2025; with HRA campaign following. 3. Revisit Interpreter services documentation project in Q2- 2025 for reprioritization & revisions.

Strategy 5 title: OHSU EHR utilization in Complementary medicine and Ancillary services

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

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

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

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

2024 Progress – Planned activity #1 Prioritization of Oral Health – Pick up conversations with Oral Health partners and review preliminary data previously gathered after project paused for Housing Benefit Pilot Program implementation. Internal resources from all sides involved seem to be biggest barrier to this project.

2024 Progress – Planned activity #2 Revisions made in contracting processes. Credentialing process paused due to system upgrades.

2024 Progress – Planned activity #3 Ancillary services intentionally placed on the back burner due to overall utilization and prioritization of Oral Health collaboration.

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

Planned Activities	**Planned Milestones**
1. TQS created for Oral Health project. 2. Reestablish Oral Health team meeting to identify next steps. 3. Intervention (address each component): (1): Our interventions can be categorized into three buckets. First, we will review and modify workflows to ensure that once the IDS is notified that a member needs some sort of a screening per the metric definition, we are able to work with ODS to appoint those members with an appropriate dental professional. (2): The second intervention will focus on building a process so that the IDS assigned team members can receive the needed data fields in a timely manner from ODS so the information can be uploaded into the HSO portal for reporting purposes. (3): Our third intervention is a two-part intervention, first, we will review the demographic data for adults with diabetes who	1. Will identify activities and milestones when we re-engage in these efforts. 2. Evaluate feasibility of integrating additional Oral Health data into OHSU Health Epic 3. Explore re-initiating the First Tooth Program across additional OHSUH IDS pediatric locations

are part of the quality metric and then we will design specific tactics to develop and disseminate culturally appropriate educational messaging highlighting the importance of good oral care for patients with diabetes.	

Strategy 6 title: OHSU - Connecting to Reliance HIE

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):

2024 Progress – Planned activities 1-3 After closely examining the cost-benefit analysis of connecting with Reliance, OHSUH IDS chose not to pursue this strategy. We have found that our existing connectivity through Epic CareEverywhere to Carequality results in like-for-like data and connectivity to Reliance would be redundant.

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

Planned Activities	**Planned Milestones**
N/A	N/A

Strategy 7 title: OHSU - Campaigns using Epic Cheers

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):
2024 Progress – Planned activities 1-5 OHSU successfully implemented Epic's Cheers application which provides automated outreach campaigns to applicable members through text, and MyChart. OHSU established a steering committee to govern the implementation of the application, and the operational aspects of initiating campaigns. The initial campaigns implemented include breast cancer screening and well child visits. More recently, OHSU implemented a campaign to perform outreach for climate-related events. OHSU has plans of using campaigns for health risk assessment outreach and diabetes A1C.

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

OHSU has plans of leveraging campaigns for performing outreach for health risk assessments and diabetes A1C. We are currently strategizing how we can incorporate the campaign functionality into our existing health risk assessment and Diabetes workflows as well as other clinical workflows and processes. The Patient-Entered Data Committee at OHSU requested that we reconcile the health risk assessment with existing tools and questions such that it does not become a silo of information. No concerns raised for implementation of Diabetes A1c campaigns.

Planned Activities	Planned Milestones
1. Reconcile health risk assessment with existing clinical tools & questions. 2. Develop patient-entered questionnaire. 3. Identify target population and begin campaign outreach. 4. Align Diabetes outreach and care management workflows to campaign timing.	1. Reconcile health risk assessment with existing clinical tools & questions. 2. Develop patient-member questionnaire. 3. Identify target population and begin campaign outreach. 4. Diabetes A1C go-live in April 2025

Strategy 8 title: OHSU – Improved tracking and trending of EHR utilization: Integration of contracting and credentialing processes and technology

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):

- 2024 Progress Planned activity paused for the installation of a new credentialing platform. Begin documentation of EHR by clinic through either credentialing of physicians (MSOW system) or through contracting Smart Sheet.
- In 2025 mid-process of a second software upgrade to the credentialing system scheduled for completion in Fall 2025.
- Barrier to completion is staffing and other priority projects related to OHA audits; same staff involved.
- 2024 Progress Planned activity#1 completed review of screening contracting template and updated verbiage.
- 2024 Progress Planned activity#2 updated BAA for bidirectional use but still need approval from OHSU Risk Management, Privacy and legal teams.

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

Planned Activities	Planned Milestones
1. Review network and document current EHR in new credentialing platform / Smartsheet (if unavailable) 2. Report to ITG team for outreach and collaboration. 3. Upgrade to CredentialStream, credentialing software 4. Track EHR system in CredentialStream.	1. Target Q3-2025 to complete review & document 2. Submit updated EHR list to OHSU IT

Strategy 9 title: OHSU Tracking and trending current utilization of EHR

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):

2024 Progress Planned activity paused for the installation of a new credentialing platform. Begin documentation of EHR by clinic through either credentialing of physicians (MSOW system) or through contracting Smart Sheet.

In 2025 mid-process of a second software upgrade to the credentialing system scheduled for completion in Fall 2025.

Barrier to completion is staffing and other priority projects related to OHA audits; same staff involved.

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

Planned Activities	**Planned Milestones**
1. Review network and document current EHR in new credentialing platform / Smartsheet (if unavailable) 2. Report to ITG team for outreach and collaboration. 3. Upgrade to CredentialStream, credentialing software 4. Track EHR system in CredentialStream.	1. Target Q3-2025 to complete review & document 2. Submit updated EHR list to OHSU IT

Strategy 6 title: OHSU- Updated Screening Contract Template (for EHR adoption) and BAA
Previously titled: Updated Contracting requirement and BAA

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):

2024 Progress Planned activity#1 completed review of screening contracting template and updated verbiage.
2024 Progress Planned activity#2 updated BAA for bidirectional use but still need approval from OHSU Risk Management, Privacy and legal teams.

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

Planned Activities	**Planned Milestones**
1. Survey providers for EHR utilization. 2. Include updated BAA for bidirectional.	1. Begin utilizing new screening template Q2-2025 2. Begin utilizing new BAA template Q2-2025

Strategy 7 title: Legacy Community Connect
Legacy Health offers a robust Community Connect program. The program has been in place since 2012 and remains a large strategy for CCO EHR adoption.

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

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

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

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

- Legacy Health has funded a subsidized EHR adoption program for 13 years called Legacy Connect.
- This program has connected over 30 Oregon/ Southwest Washington private practices and over 500 providers (primary care, specialty, behavioral health).
- This program has enabled EHR adoption to providers who would not otherwise be able to contract with Epic and therefore connecting providers into the community ecosystem of exchange.
- Separately, but related…as part of being part of Legacy Health Partners (CIN), it is required that partners have a certified electronic health record. This further supports related ONC requirements.
- Partnering with "competing" Connect programs to ensure all community and statewide find a fit for EHR adoption programs.

Additional progress specific to behavioral health providers:
- Legacy Connect program also supports a sub-acute behavioral health inpatient center and one critical access hospital.

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

- Continue supporting the program by restarting implementations previously paused due to the pandemic.
- Focus on Primary Care, Pediatrics

Planned Activities	**Planned Milestones**
1. Continue to subsidize Legacy Connect program. 2. Additional smaller sites in planning	1. Major sites on hold until OHSU plans are clear

Strategy 8 title: PacificSource/Legacy furthering Health Information Exchange

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):

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

Planned Activities	**Planned Milestones**
1. Expanding support for TEFCA *(Trusted Exchange Framework and Common Agreement*) framework	1. Sharing adoption experience with partners 2. Continue to collaborate with the Regional User Group (Epic users) 3. Analysis of expanding use of Reliance HIE

Strategy 9 title: Providence support for EHR adoption

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

1. Implementation of Innovaccer Population Health tool to aggregate EMR data into pediatric HIE and for reporting of eCQM reports for all Children's Health Alliance (CHA) clinics: Still relevant/accurate but no update
2. The Children's Clinic transitioned EMR from Centricity to EPIC LEAP in May 2024
3. Westside Pediatrics transitioned EMR from Centricity to Physicians Computer Company in August 2024
4. Added data integration quality reporting analytics to ensure >99% data exchange rates from EPIC to the Innovaccer Population Health Analytics tool

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

1. Newberg Pediatrics (Dr. Whittaker), plans to transition from Centricity EMR to Physician's Computer Company in February 2025
2. Children's Health Alliance pediatric practices intend to continue utilizing the Innovaccer Population Health tool to aggregate EMR data into pediatric HIE and for reporting of eCQM reports through 2026 and possibly beyond.

Planned Activities	**Planned Milestones**
1. Q1-2025: Prepare for Newberg EMR transition including data exchange with CHA population health tool. 2. Q2-2025: Complete all development work to enhance the Innovaccer Population Health tool for pediatric use cases 3. Q3-2025: Implement additional data quality checks to ensure optimal data exchange between CHA clinic EMRs and the Innovaccer Population Health tool Q4-2025: Forecast and plan the CHA population health analytics strategy for 2026-2028	1. Q2-2025: Completion of Newberg EMR transition 2. Q3-2025: Implementation summary for all development work in the Innovaccer Population Health tool 3. Q4-2025: Implementation summary for all additional data quality checks for interoperability 4. Q1-2026: CHA Board of Directors review of CHA strategic plan for Population Health Analytics

B. EHR Support Barriers:

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

OHSU

● EHR transitions at external sites (i.e., Mountain View) resulted in limited involvement by these medical groups in data validation and providing patient-level extracts for accuracy verification.

● PHQ limitations due to lookback and data availability resulted in exploring additional options for collecting external quality measure data.

●Unclear guidelines for documentation or overly administratively burdensome guidelines in new benefits often lead to non-compliance or bad data integrity. i.e., Language Access requirements, HRSN Climate Benefit

●Generally, OHSUH IDS has more control over EHR optimization efforts for clinics within OHSU's instance of Epic (OHSU, HMC and AHPL). The smaller community-based clinics are not on a level playing field regarding EHR resources and vendor support.

Legacy

● Costs and resources to maintain the program: Legacy subsidizes the Connect Program at 70%, which over time can be very costly.
● Provider resource challenges continued to reduce the time and willingness for partners to engage on this topic.

C. OHA Support Needs:

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

● Provide additional funding to CCOs with promising practices to support uptake and spread such financial incentives for hosting sites.

● Provide financial incentive for all continuum of care providers to adopt EHR technology that fully supports health information exchange (HIE).

● More clarity about the expectations related to complementary medicine and ancillary providers, and insight to intent of these provider types to be part, or not part, of the movement towards EHR adoption. If intended to be part of this work, financial incentives and support is necessary.

● Phased in requirements for data reporting that allows ample time for system set up, testing and modification. The expectation of being ready days / weeks prior to release of final rules is unrealistic and unattainable by all.

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):

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

Point Click Care is a Health Information Exchange that hospitals across Oregon connect to. CareOregon Regional Care Teams use this as a source of hospital inpatient and Emergency Department admission and discharge data to trigger care coordination referrals and our transitional support process. Delegated Dental Care Organizations also utilize Point Click Care to assist with oral health related care coordination and outreach. Health Share's **Integrated Delivery Systems** (**Legacy, Kaiser, OHSU, Providence**) have implemented this system in both hospital/ED and health plan settings.

Compass Rose is the new Epic-based care coordination platform implemented by CareOregon in November of 2023. It has replaced GSI, our previous software. ADT feeds from Point Click Care will enter Compass Rose directly so that care teams are only required to interface with one tool. Kaiser also utilizes this application for care coordination.

Care Everywhere is a module of Epic EHR that allows for the exchange of patient health information between providers who use Epic. This technology is in use among all Health Share partners. Health Resilience Specialists and Panel Coordinators who are embedded in clinics that use Epic have access to Care Everywhere.

CareOregon Epic Payer Platform

Payer Platform is the name of the functionality within Epic we are using to exchange data between ourselves and select network partners (see next section) to provide a more complete picture of our members' health, risks, and to facilitate closer communications with our provider-partners.

There are multiple features within Payer Platform that allows us to receive, send, or exchange data for various purposes. Two that are currently up and running for our organization are:

- Clinical Data Exchange
    - Automated electronic release of appropriate information to insurers
    - Reduces manual records requests, denials, and time spent processing claims
- Scheduling Notifications
    - Automated notifications to insurers when members schedule/reschedule/cancel appointments
    - Increase compliance with follow-up care and support care coordination

CareOregon Link

An extension of Compass Rose Healthy Planet Link (titled CareOregon Link for our organization) is an additional Epic module (website-based portal) utilized by select, delegated, external community partners. It offers care management functionalities such as documentation (e.g. assessments and program enrollment) and analytics. As of April 2024, our delegated CareOregon Link partners include Housecall Provider's Advanced Illness Care team and TriCounty 911.

OHSU

- Leveraged internal hospital event notifications from OHSU, Adventist Portland, and Hillsboro Medical Center within **Epic** for timely care coordination and care management follow-up.
- Continued support of the data feed from **Point Click Care (PCC)** for external hospital event notifications. Integrated data from PCC feeds into a daily report of all hospital admissions referenced by Care Managers in identifying members for care coordination and/or care management follow-up.
- Continued development work with **Connect Oregon** to facilitate enhanced program support and data reporting of services accessed and utilized by members.
- "New" **PAC Management** tool incorporation, through PCC, which allows users to monitor real-time metrics at each post-acute facility that includes: 30-day readmission rate, ALOS, patient census, readmission risk score, real-time vitals, orders, therapy notes and progress notes etc.
- "New" BH Collaborative Care Model (CoCM) development. This model of care is designed to improve treatment identification & planning, efficiencies within psychiatrist's & PCP clinics and improve monitoring of utilization measurements for identified patients with specific behavioral health condition.
- Development of a Risk Stratification tool that is integrated within Epic which allows care integration team to identify member's health risk, to prioritize engagement and to measure long term member care.

Legacy/PacificSource

- Emergency Department Optimization (EDO, formerly EDIE) through **PointClickCare (PCC, formerly Collective Medical (CM))**
- **Reliance** (all events - one way data)
- Discussing plans to expand EDO/EDIE; specifically, **FHIR integration with Epic and PointClickCare**
- PacificSource high-value cohorts and reports
    - Heat mitigation, including direct member outreach for A/C unit distribution
    - Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) report

- Long-Term Services and Supports (LTSS) and Dual Eligible Special Needs Plan (DSNP) reports
- Care Management piloting new CM functionality:
  - Claims-based pharmacy use cases

Kaiser

- **Care Everywhere Referrals Management** – Electronically send and sync referrals with external organizations utilizing Epic's EHR..
- **360X** – Explore the capability to send and sync referrals with external organizations who do not use Epic's EHR.
- Conduct more extensive mapping of external lab results to internal lab records for even more integration, including trending and decision support.
- Give providers the capability to manually route specific encounter reports to external providers via Direct messaging, as needed on an ad hoc basis.
- Implement Happy Together Notes and Happy Together Genomics, once released from Epic. These projects will utilize **FHIR** standards to retrieve rich text notes and discrete genomic variants from external Epic organizations and integrate the information alongside internal data.
- Give patients the ability to share their patient portal clinical information with external providers via Epic's "Share Everywhere" tool. This tool gives providers one-time access (with the patient's permission) to log into a web portal and view clinical information the patient can see in the patient portal.

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

Significant investment of time, funding and testing from all parties involved will only improve member outcomes and experience. Focusing on the member, in an equitable manner, to eliminate barriers to the delivery of care is of primary importance.

Strategy 1 title: Leveraging HRSN related data sources to inform care coordination and risk stratification

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):

Health Share's health plan partners are leveraging Connect Oregon to share and collaborate on social needs related elements of care plans.

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

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

Strategy 3 title: CareOregon - Optimizing and expanding the use of Point Click Care by the Regional Care Teams

CareOregon's Regional Care Teams (Care Coordination Teams) and other outreach teams use Point Click Care to receive Hospital Event Notifications. The event notifications feed directly into our care coordination platform, refreshing hourly, which alerts the care coordination teams of an event for members with whom they are working. They also use cohorts and reports from the application to proactively identify and refer members into care coordination. Examples of cohorts and reports include:

- DSNP Members with Acute Care Admits
- Medicaid members hospitalized for >10 days
- Psychiatric Acute Care Admits and Discharges
- BH Cohort – Members who present to the ED for a behavioral health related concern
- Diabetes Cohort – Members who present to the ED or Inpatient for diabetes related concern
- 3 ED Visits in 90 Days
- 5 ED Visits in 12 months
- Pediatric Asthma ED Activity
- Rising Risk ED/IP/OBS/SNF – Admit
- Members initiating and engaging in treatment for substance use
- Medicare Members w/Multiple Chronic Conditions/ ED outreach

[Brief description]

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):

In 2024, CareOregon implemented proactive Medicaid rounds in October. A list is pulled from Point Click Care (PCC) for members who have been inpatient for more than 10 days. A small group, including 2 medical directors, a pharmacist, a nurse, and a behavioral health professional, huddle weekly to review the list and determine next steps which may include:

- Refer into the RCT
- Refer to palliative care
- Refer to Housecall Providers for in home Primary Care
- Refer to pharmacy coordination team

Since October, 77 members have been reviewed.

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

Planned Activities	**Planned Milestones**
1. Modify prioritization of the member list based on feedback from the huddle group. 2. Continue meeting weekly to review cases. 3. Meet with the Housecall Providers Advanced Illness Care team to confirm meaningful referrals. 4. Develop a better tracking system for the outcomes of each member.	1. Complete the initial review and assessment of members reached since deployment. Identify if average length of stay and readmission rates have improved by 7/1/2025. 2. Perform more thorough impact analysis by 10/31/2025.

Strategy 4 title: CareOregon - Epic Payer Platform (EPP) implementation

Epic Payer Platform is a set of exchange features that facilitate bi-directional data exchange with Epic EHR users in network by leveraging technology specifically developed for payor-provider partnerships. Epic is the most common EHR used by physical health providers in CareOregon's network.

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):

In 2024, CareOregon successfully partnered with OCHIN to go-live with Clinical Data Exchange, Health Plan Clinical Summary, Schedule Notifications, and Claims Exchange features with first and second wave organizations. OCHIN's project team meets with CareOregon staff weekly to discuss progress, triage issues and plan next steps. This will continue through at least 2025.

All OCHIN members within CareOregon's network have been offered the option to join EPP at no cost to them. Currently, 9 of 11 clinics on OCHIN have elected to participate in EPP.

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

In 2025, CareOregon will be implementing the following additional EPP features:

- Clinical Analytics Document: Pulls targeted supplemental clinical data from a broader set of visits to improve quality measure accuracy.
- Care Gaps Exchange: Sends CCO-calculated care gap statuses for attributed populations.
- CCO assigned membership: Automated membership data feed inclusive of total assigned/attributed populations. Creates Epic record for members assigned but not yet seen and enables clinics to manage population health needs, gaps, and outreach for the entire population in the EHR.

Additionally, CareOregon will be approaching several hospital system partners regarding participation in EPP with us. By focusing on engaging with hospital systems, we will enable further connection with non-OCHIN providers who hold a separate instance of Epic.

Planned Activities	**Planned Milestones**
1. Approach EPP participation with regional hospital systems as well as remaining OCHIN members. 2. Continue support of Epic upgrades/implementation of Payer Platform features. 3. Continue communication to participating network partners of Epic upgrades/implementations of Payer Platform features.	1. Hold discussions with hospital systems in network to explore EPP participation by Q3 2025. a. Specifically, OHSU & Providence.

Strategy 5 title: CareOregon - Implementation of a New Care Coordination Platform

CareOregon has selected and implemented a new care coordination platform used by our care coordination and outreach teams. The new platform allows for improved workflows as well as integrated social determinants of health and social needs data. Our selection was based on high integration with current technology and tools, improved workflows and efficiencies for our care coordination teams to support our members as well as the ability to better report and adapt to the changing needs and requirements. This intervention also applies to the HIT for SDOH section of this report.

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):

In 2024, CareOregon launched the new Health Risk Assessment in October and the new HRSN program throughout the year within Compass Rose. The HRSN program launches included climate on 6/1/2024, housing on 11/1/2024, and nutrition launched on 1/1/2025. Challenges for this strategy in 2024 were operational governance limitations and build prioritizations related to HRSN and Oregon Administrative Rules. Due to these limitations, CareOregon was not able to implement coordination services that live outside of the care coordination department (dental, OABHI, CareBaby, maternity, etc.) and will resume this work in 2025.

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

CareOregon implemented and went live with Compass Rose in November 2023. We transitioned to Compass Rose when our contract ended with GSI, this led to barriers around timelines for implementation. Therefore, our ongoing efforts are focused on stabilizing the system and building out additional workflows. At the moment, non-Epic data sources are not a priority besides Point Click Care integration.

Planned Activities	**Planned Milestones**
1. Continue to stabilize the build in 2025. 2. Continue support of Epic upgrades/implementation. 3. Continue discussions around implementing Skilled Nursing Facility notifications in Compass Rose.	1. Implement the ability to upload bulk PDFs into the system by Q2 2025. 2. Complete the DHS Metric build out by Q3 2025. 3. Implement build, training, and workflows for coordination services that live outside of the care coordination department (dental, OABHI, CareBaby, maternity and others) by Q4 2025. 4. Map out and implement the new referral triage workflow for HRSN by Q4 2025.

Strategy 6 title: OHSU - Expand Epic's Population Health Query to additional sites.
(REVISED TITLE): Third Party EMR Social Needs Data Exchange

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):
2024 Progress – Planned activity #1 PAC Management Demo held on 02.26.2024; contract signed 09.30.2024; Go live 02.21.2025.

2024 Progress – Planned activities #2 -#4 Continue moving forward incorporating new and expanded benefits for climate, food, and housing. Focusing on the integration of community benefit organizations keeping a health equity focus in perspective. Go live with HRSN Climate benefit Q1-2024; Go live with HRSN Housing & Food supports Q4-2024.

Challenges surrounding benefit clarification from OHA early on. Data reporting through Connect Oregon as well as some other network providers for all HRSN benefits. These providers & vendors were not set up to manage this on such a short runway. Lack of adequate funding for benefit administration and set up.

2024 Progress – (New) Unplanned activity developed Risk Management Stratification tool to compliment Epic risk tool. Reviewed by OHA in Q4 2024. Feedback provided and improvements currently under way.

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

Planned Activities	**Planned Milestones**
2. Monitor HRSN utilization and data reporting from Connect Oregon; continued participation in Connect Oregon Payments workgroup. 3. Monitor HRSN utilization and data reporting from CBA. 4. Build Risk Stratification workflow and reporting SOPs. 5. Build PAC Mgmt stratification workflow / SOP. 6. Work with Connect Oregon to evaluate connectivity to EPIC for social needs referral status.	2. Cheers campaigning for member notifications in time for climate events and HRA requests.

Strategy 7 title: OHSU - Hospital Event Notifications - Point Click Care PAC Management Tool

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):

2024 Progress Planned activity #1 - Explored Point Click Care's PAC Management tool for predictive modeling for SNF readmissions. PAC Management Demo held on 02.26.2024; contract signed 09.30.2024; Go live 02.21.2025.
2024 Progress Planned activity #2 – Housing Benefit notification completed during Housing Pilot. Pilot program ended 12/31/2024.
2024 Progress Planned activity #3 – Regular monthly meetings w/ PCC team to discuss data integrity issues, validation, and other projects etc.

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

Planned Activities	**Planned Milestones**
1. Develop Quarterly ROI savings report. 2. Track / Trend strategy from UM and Care Management perspectives. 3. Attend PCC 2025 Summit to gain best practices and super user connections.	1. 1st report out of Cost Savings 06-2025 2. Lookback at EOY for process improvement opportunities 3. Implement best practices Q2-2025

Strategy 8 title: (NEW) OHSU - BH Collaborative Care Model (CoCM) development

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):

N/A

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

This model of care is designed to improve treatment identification & planning, efficiencies within psychiatrist's & PCP clinics and improve monitoring of utilization measurements for identified patients with specific behavioral health condition.

Planned Activities	Planned Milestones
1. Finalize project plans & data sharing by end of Q1-2025. 2. Go live in Q2 - 2025	1. 1st report out of Cost Savings 06-2025 2. Lookback at EOY for process improvement opportunities

Strategy 9 title: (NEW) OHSU - Development of a Risk Stratification tool utilizing HIE-provided data

Strategy categories: Select which category 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):

N/A

(Optional) **Overview of 2025-26 plans for this strategy**:
"New" Development of a Risk Stratification tool that is integrated within Epic which allows care integration team to identify member's health risk score, to prioritize engagement and to measure long term member care.

Planned Activities	Planned Milestones
1. Track / Trend strategy from UM and Care Management perspectives. 2. Review Risk results against Actuarial results.	1. Quarterly check-in for process improvement 2. YE review with results provided by HSO Finance

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.

Point Click Care is a Health Information Exchange that hospitals across Oregon connect to. Network partners are able to use it to access real time hospital inpatient and Emergency Department admission and discharge data.

Care Everywhere is a module of Epic EHR that allows for the exchange of patient health information between providers who use Epic.

CareOregon

- **Rubicon MD** is an e-consult platform that enables primary care providers to access specialists for consult support to both review and determine the necessity of referral.
- **AristaMD** is an e-consult platform that enables primary care providers to access specialists for consult support to both review and determine the necessity of referral.

OHSU

- **Epic Care Everywhere**, **Population Heath Query, EpicCare Link** (formerly OHSU Connect)
- Claims Integration
    - Consumption of all claims data for members into Epic and custom analytic tools
- **Point Click Care (PCC)**
    - Hospital Notification system
    - Post Acute Care Management system
- **Epic Care Management** Tools
    - Specific reporting for identified metrics, SDOH, LTSS, etc.
- **Connect Oregon**
    - Referrals to community benefit organizations who help address SDOH needs.
- HIE training
    - Primary care clinics provided refresher training on accessing shared quality metric reports and gap lists available through **Healthy Planet and Healthy Planet Link.**

CMS Interoperability: Implemented and optimizing.

- OHSUH IDS implemented 37 work items for fixes and improvements related to CMS Interoperability efforts. 33 of the 37 work items have been closed and deployed to production.
- Eight (8) patient access applications registered for FHIR and assigned security keys.
- Four (4) Council for Affordable Quality Healthcare (CAQH) endpoints configured for test and prod use.
- HIT Interoperability collaboration meetings and research CMS interoperability updates.

Legacy/PacificSource

- **Epic CCD/TOC** exchange
- **Epic to Epic Referral Exchange** (Legacy started pilot with OCHIN – 2019)
- Prescription Drug Monitoring Program (PDMP)
- Participate in data sharing to Oregon Capacity System (HOSCAP requirement) for hospital bed coordination
- PacificSource expanded its data sharing to Reliance eHealth Collaborative to include claims and member data for all Oregon members across all PacificSource lines of business, not just Medicaid (previously only provided for Central Oregon and Columbia Gorge CCO's)
- FHIR API

Kaiser

- **Care Everywhere Referrals Management** – Electronically send and sync referrals with external organizations utilizing Epic's EHR..

- **360X** – Explore the capability to send and sync referrals with external organizations who do not use Epic's EHR.
- Give patients the ability to share their patient portal clinical information with external providers via Epic's "**Share Everywhere**" tool. This tool gives providers one-time access (with the patient's permission) to log into a web portal and view clinical information the patient can see in the patient portal.
- **Direct messaging** for provider-to-provider secure messaging and to push patient records to external organizations during certain referrals and hospital discharges.
- **Care Everywhere Image Exchange**, which provides the ability to send photos, scanned documents, EKG tracings and reference-quality Radiology images to external organizations through Care Everywhere. It also gives the capability to receive these image types from other organizations who send them
- **Epic's "Happy Together**" projects, which integrate external encounters, lab results, imaging results and media alongside internal information in the chart instead of in a separate section just for external data.
- **Epic's Reconcile Outside Information Activity** (ROIA) for providers to reconcile external medications, allergies, problems and immunizations in the patient's chart. It also includes the auto reconciliation of received COVID-19 vaccines.
- Send and receive event notifications via HL7 interfaces, Direct messaging, Care Everywhere Outside Event notifications and with **Collective Medical Technologies**.
- KP also provides external organizations the ability to view clinical data via the **Online Affiliate web portal**.

(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**

Point Click Care -- Health Share provides licenses for all network partners and their provider networks that are able to use it to access real-time hospital inpatient and Emergency Department admission and discharge data. Additional clinical and social needs information is exchanged supporting individual members and population health goals.

Exploring opportunities for electronic prior authorizations

PacificSource completed an exploratory project to identify and evaluate potential electronic prior authorization solutions from three different vendors. It learned that while there was some linking to provider workflow, truly embedded EHR ePA technology/functionality has not yet been thoroughly developed. PacificSource will review the recently announced CMS 0057 final rule and continue exploring opportunities for electronic prior authorizations accordingly.

Explore the 360X Referral Coordination data sharing message type.

Look for other opportunities to send and receive referral information in a discrete/standard way including any EHR to any EHR; provider-to-provider (P2P) using a healthcare information service provider (HISP). Many certified EHRs included.

Kaiser plans to give providers the capability to manually route specific encounter reports to external providers via Direct messaging, as needed on an ad hoc basis.

Kaiser also plans to implement **Happy Together Notes** and **Happy Together Genomics**, once released from Epic. These projects will utilize **FHIR** standards to retrieve rich text notes and discrete genomic variants from external Epic organizations and integrate the information alongside internal data.

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**:

Counts of practices that do not use *or that there is no information that they use* an HIE.

- Physical Health: 274
- Oral Health: 152
- Behavioral Health: 327

Strategy 1 title: CareOregon - Optimizing and expanding the use of FIDO

The Fully Integrated Data Organizer (FIDO) is CareOregon's data and analytics platform. Analysts across the organization can develop and publish analytic dashboards to support sharing of data, care coordination, quality improvement, and more. FIDO has the capability to make member level and aggregate data accessible to network partners in a secure way. It is a mechanism for sharing CCO data on members with provider partners to improve care coordination and quality of 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):

In 2024, the behavioral health department used FIDO for review of access measurements and other utilization data and continued collaborating with the analytics team to develop and update a care coordination tool that details the likelihood of available access for members. At present, the care coordination tool does not reside in FIDO. This tool is still in the early phases and will be used internally for now. Data quality issues have delayed the publication of this tool; however, the first iteration is on track for Q1 2025.

Plans to expand FIDO access in the dental network were actively pursued in 2024. Due to the complexity of completing the dental metrics table, dashboard development is delayed. CareOregon is on track to provide access to FIDO Metric Dashboards and to expand the FIDO member profile dashboards to include a deeper level of member data and the ability to access and download gap lists for outreach efforts in 2025.

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

Planned Activities	**Planned Milestones**
1. Provide dental plan partner access to FIDO Metric's Dashboard. 2. Expand FIDO membership and include access to gap reports. 3. Publish and improve the care coordination tool.	1. FIDO Metric Dashboard access by Q1 2025. 2. Publish the first iteration of the care coordination tool by Q1 2025. 3. Go live with updated version of the care coordination tool by Q3 2025. 4. Expansion of FIDO membership by Q4 2025.

Strategy 2 title: Optimization of dental referral platform

The dental department of CareOregon is working on an enterprise-wide HIT enhancement to improve our dental care referral platform and bidirectional communication. This project strives to improve dental access and utilization of services for our members. Cross-departmental teams are working to automate and optimize the current process. The goal is to improve referral data sharing with DCOs for all dental care coordination lists, including the dental care requests, and to improve the referring PCP's ability to access referral outreach and visit completion data in efforts to move to a close loop system.

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 dental referral platform project was rescoped to more efficiently exchange data with dental plans. Planning and development of the new web application was initiated in Q3 of 2024. The application will provide daily access to PCP referral data sharing and monthly reports containing all referrals and care coordination outreach outcomes from dental plan partners. All information will be cross shared through a Fully Integrated Data Organizer (FIDO) dashboard. Development is on schedule for both the new application and the FIDO dashboard for Q3 2025.

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

Planned Activities	**Planned Milestones**
1. Develop and validate the application and FIDO dashboard. 2. Onboard clinics to the new dashboard.	1. Completion of application and FIDO Referral Outcome Dashboards by Q3 2025. 2. Update Referral Outcome Report to include associated claims detail of member engagement by Q4 2025.

Strategy 3 title: CareOregon - Optimizing and expanding the use of Point Click Care by providers

CareOregon supports the use of Point Click Care by physical, behavioral, and oral health providers. CareOregon identifies opportunities to help clinics modify their operations and optimize the use of Point Click Care through workflow development, development of platform-based tools, and innovative ways to use the platform that close care gaps.

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, CareOregon continued the reinforcement of Point Click Care (PCC) utilization amongst all established providers, including the usage of the FIDO Network Engagement dashboard to target providers who are not demonstrating engagement and to encourage technical assistance. CareOregon remained in maintenance mode for oral health providers. PCC is primarily used for Emergency Visit notifications amongst oral health providers as usage is limited due to a lack of Epic in many dental clinics.

The following was developed and implemented in 2024 to increase PCC relevance:

- Development of a flag within PCC for primary language to complement the language access metric.
- Refined a workflow in PCC to support proactive outreach for members presenting to the Emergency Department with Substance Use Disorder related needs.

- Internal PCC101 sessions including representatives from behavioral health, physical health, care coordination, and informatics & evaluation.

The pilot of PCC in Clackamas County Jail is now monitoring for barriers to see what is unique in a jail system and to determine the ability to track movement through incarcerations. CareOregon made the decision in 2024 to no longer pursue the Hepatitis C testing pathway tool, after further scoping it did not appear to be feasible with resources and concerns around confidentiality.

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

In 2025, CareOregon will be communicating with PCC about their payment model changes with OHA and how that will impact our sponsorship of onboarding additional providers to PCC. Overall, emphasis will be on continuing the spread of PCC, increasing optimization, and expanding pilots/innovative utilization.

Planned Activities	**Planned Milestones**
1. Create and provide consistent messaging on new PCC features.	1. PCC is fully functional in Clackamas County Jail system by Q2 2025. 2. Use FIDO dashboard to track adoption and utilization. Define what positive engagement for providers looks like by Q3 2025. 3. Identify successes and barriers of the proactive outreach for SUD work by Q4 2025. 4. Assess implications of PCC in a jail system by Q4 2025. 5. Develop further outcomes and assess for expansion of the jail pilot by Q2 2026.

Strategy 4 title: CareOregon - Use of telehealth to improve communication, referrals, and quality of care

CareOregon provides financial and technical support for providers to participate in telehealth initiatives Project ECHO and RubiconMD. Project ECHO provides telemonitoring where expert teams lead virtual clinics. RubiconMD is an electronic consultation (e-consult) platform that connects primary care providers to a national network of board-certified specialists that provide guidance on diagnosis work up and treatment advice options. The platform can be integrated with EHRs and clinical workflows. Both interventions aim to improve the quality of care received by members as well as improve the quality of referrals/transitions from primary to specialty 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):

AristaMD Progress:

In 2024, CareOregon continued to support Multnomah County Health Department's (MCHD) usage of AristaMD as an e-consult platform. Currently, Cascadia Healthcare and MCHD are the only two clinics using AristaMD.

ECHO Progress:

In 2024, CareOregon had 744 providers participate in 33 unique ECHOs. Of those who participated, 159 were MDs, 49 NPs, 32 PA-Cs, 19 pharmacists, 72 LCSWs, and 45 were nurses.

The top 5 highest participating clinics within the CareOregon network included:

- Multnomah County (36)
- Virginia Garcia Memorial Health Center (26)
- Central City Concern (14)
- Clackamas Health Centers (13)
- Cascadia Health (9)

The top 5 programs within the CareOregon network included:

- Substance Use Disorders in Adolescents (82)
- Substance Use Disorders in Hospital Care (47)
- Substance Use Disorders in Pre and Perinatal Care (43)
- Sexually Transmitted Infections-Syphilis Focused (29)
- Chronic Pain in Opioids (28)

RubiconMD Progress:

CareOregon executed a maintenance contract with RubiconMD to maintain current user access. There were 224 active providers with a total number of 2,088 e-consults in 2024, see below for a further breakdown. The top 3 specialties used were dermatology, pediatrics, and cardiology. The Innovation Team continued to provide RubiconMD support by assisting providers via email to set up their accounts and providing recent screenshots from the dashboard to use, as well as providing data for the quarterly leadership meetings with Wallace, Virginia Garcia, Clackamas, Neighborhood Health, Outside In, and Central City Concern clinics.

Total number of e-consults:

- Virginia Garcia – 953
- Outside in – 296
- Neighborhood Health – 222
- Central City Concern – 216
- Clackamas – 163
- Wallace – 146
- Housecall – 92

CareOregon clinics that integrate RubiconMD into their EHR clinical workflow:

- Virginia Garcia
- Neighborhood Health
- Outside In
- Wallace
- Central City Concern

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

CareOregon is in the process of assisting MCHD with renegotiating their AristaMD rates. Upon completion, we plan to offer Cascadia Health support in 2025 with the same platform.

Planned Activities	**Planned Milestones**
1. Maintain funding for current RubiconMD and AristaMD users.	1. Continued management of the relationship and contract with RubiconMD, along with the provision of applications to current users.

	2. Offer Cascadia Health support with AristaMD by Q4 2025.

Strategy 5 title: Legacy/PacificSource – data exchange supporting providers with value-based payment arrangements

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):

PacificSource to continue sending three standard extract files (Medicaid claims, Pharmacy claims and eligibility) monthly to support OCHIN's FQHC focused HEDIS project to implement claims-based functionality in OCHIN Epic to support advanced forms of value-based payment

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

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

Strategy 6 title: Providence support for HIE – Children's Health Alliance

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):

1. Children's Health Alliance (CHA) clinics license the Innovaccer Population Health Tool and interface EMR data as well as payer data and EDIE data into a pediatric HIE which enables patient stratification for care management and offers timely care coordination worklists such as patients needing ED visit follow-up. Still relevant/accurate but no update
2. CHA clinics interface with Oregon's IMM ALERT IIS to communicate and coordinate vaccine data. Still relevant/accurate but no update
3. CHA has an ADT interface between EDIE and our Population Health Tool which enables pediatric provider access to timely ED and Inpatient event notifications.
5. CHA and Providence have a data sharing agreement to exchange claims data monthly for the shared population. This is used to enhance care management activity and improve the quality of care delivery.
6. CHA and Providence have a data sharing agreement to exchange Member Eligibility data on a monthly basis for the shared population. This is used to enhance patient engagement and onboarding as well as care management activity and improve the quality of care delivery.
7. Challenges exist with the increasing interest in sharing and measuring Social Needs data. The medical record is not designed for this data documentation, and clinical analytics tools are costly and must be maintained. There is opportunity for health plans to support this data upstream in the member registration process and develop solutions for this to be visible in a timely way to providers at the point of care.

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

Continue CHA use of the Innovaccer Population Health Tool and continue to add care gap analytics relevant to pediatric population management.

Planned Activities	**Planned Milestones**
1. Q1-2025: Focus on WCC QI reporting including provider-level data, care gap lists and equity analysis 2. Q1-2025: Assist clinics with eCQM reporting, Language Access documentation and reporting and contract performance 3. Q2-2025: Focus on SDOH QI reporting including provider-level data, care gap lists, equity analysis and documentation for reporting 4. Q2-2025: Facilitate discussions and trainings to support additional documentation and reporting capabilities within EHRs for eCQM measures 5. Q2-2025: Assist clinics with eCQM reporting, Language Access documentation and reporting and contract performance 6. Q3-2025: Focus on Immunization QI reporting including provider-level data and care gap lists 7. Q3-2025: Assist clinics with eCQM reporting, Language Access documentation and reporting and contract performance 8. Q4-2025: Assist clinics with eCQM reporting, Language Access documentation and reporting and contract performance 9. Q4-2025: Focus on year-over-year analysis and additional opportunities to close gaps by year-end	1. March 31 – ensure all reporting requirements for Q1 are completed and performance is optimized for all CHA clinics 2. May 30 - Add 10% more data fields flowing from Epic to our population health tool 3. June 30 – ensure all reporting requirements for Q2 are completed and performance is optimized for all CHA clinics 4. September 30 – ensure all reporting requirements for Q3 are completed and performance is optimized for all CHA clinics 5. December 31 – Assure supplemental data collection is optimized for year-end reporting

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

CareOregon relates that due to time and resource constraints, they have not yet integrated SNF notifications from Point Click Care into Compass Rose. This absence has posed a challenge to our care coordination team, as it leads to less efficient workflows. Additionally, providers often express the need for more technical assistance/IT resources to assist with Point Click Care implementation, specifically around submitting eligibility files.

OHSUH IDS experienced challenges connecting to community-based practices to obtain external data for care coordination. Several challenges remain due mostly in part to Privacy & Security rules, lack of HIE or unified system for all sides to utilize technology in general. The other major hurdle pertains to overall funding for this work. Competing resources and newness of CBOs working with health partners (and vice versa).

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?

Provide financial incentive for all continuum of care providers to adopt EHR technology that fully supports health information exchange (HIE).

More clarity about the expectations related to the CBOs, complementary medicine, and ancillary providers, and insight to intent of these provider types to be part, or not part, of the movement towards EHR adoption. If intended to be part of this work, financial incentives and support is necessary.

Phased in requirements for data reporting that allows ample time for system set up, testing and modification, Dr. Chrono, Amazing Charts, Office Practicum.

Clarity regarding new 42 CFR Part 2 rules vs. HIPAA to enable HIE for this information.

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)?

CareOregon's Health Resilience Specialists and Panel Coordinators have direct access to the EHR system of their clinics with the permission to view and edit records for CareOregon members assigned to the clinic. The Regional Care Teams and other outreach teams also have EMR access to hospitals and facilities across the state. Gaining access to these systems is part of our standard onboarding process for new hires.

Health Resilience Specialists and Panel Coordinators have access to Kareo, Athena, Workday, Credible, and Greenway Integrity. Panel Coordinators, the Regional Care Teams and other outreach teams also have access to Epic OCHIN EHRs.

OHSU utilizes Epic, Athenahealth, Aprima DrChrono, Amazing Charts, and Office Practicum

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

CareOregon Regional Care Teams, outreach teams, and panel coordinators use their EHR access to outreach and schedule appointments for members due for preventative visits and to those with identified gaps in care. EHR access is also used to support quality and performance measure accuracy and completeness.

OHSU accesses data necessary to calculate quality measures such as labs, immunizations, procedures, screenings, and visits. Some member demographic or other clinical information such as progress notes for care coordination and care management may also be gathered.

(New) Health Risk Assessment information related to SDOH and SEH will now be gathered, tracked, and reported.

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

Data sent via Epic Payer Platform to CareOregon is populated into Compass Rose and stored in the CCO EDW to support future-state analysis for quality and performance measure reporting, risk gaps and closures, and member attribution management.

OHSUH IDS uses Epic's HIE tools to connect with and obtain external data from community-based clinics and other external partners.

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

Connect Oregon is a network of health care and social service providers that are linked through a shared technology platform called Unite Us. Providers use the platform to securely send and receive referrals for care and social needs, such as food and housing assistance, and employment support. Plan to continue CBO network development and promoting use of the platform.

Epic platform - Epic platform that includes the SDOH Assessment Tool. MyChart for completion of SDOH Assessments, particularly for primary care and OHSU Health IDS.

Compass Rose is the Epic-based care coordination platform implemented by CareOregon in November of 2023. It has replaced GSI, their previous software. Compass Rose allows for improved collection and use of social needs information.

Epic Payor Platform module allows information exchange between the CCO and its provider networks, which will include data on SDOH needs.

Epic Healthy Planet is an integrated population health management application with the Epic platform.

Johns Hopkins ACG is a population health analytics software that has a new SDOH module that CareOregon is adding. It will provide social needs markers that are driven by medical and diagnostic codes in claims.

Enterprise Data Warehouse – Health Share maintains a data warehouse consolidating data from all administrative data from its partners and external sources. This system has been enhanced to incorporate SDOH information from multiple systems. Health Share builds numerous reports, extracts, and interactive dashboards from this database.

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

As with other technology solutions, Health Share holds a central contract that enables community partners to access the Unite Us product without additional charges. This has facilitated easy access to a common CIE and enabled easier adoption and alignment around the tool. Unite Us is central to Health Share's approach to delivering Health Related Social Needs benefits, enabling review and transmission of screening and referral information to UM teams for authorization and payment.

Each of Health Share's partners collects social screening and referral data in different ways, largely through EMRs or customer service portals, or both. Health Share is in the process of standardizing a data collection methodology to collect more of this site-based SDOH screening information in our EDW for the Social Needs Screening and Referral metric as well as to enhance available data in our EDW for care coordination and analytics.

Using our role as central contract holder (and as HIPAA covered entity for Medicaid), Health Share has also been undertaking data sharing projects with each of the tri-county housing systems. This has resulted in a robust data sharing agreement between Health Share and the Joint Office of Homeless Services (JOHS) in Multnomah County, and numerous project-based DSAs with the other counties to enable care coordination activities.

Strategy 1 title: Ecosystem/High Risk Behavioral Health Analysis and SDOH Response

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):

Ecosystem population health initiative:

- Analytics looks across medical comorbidities and social needs for SUD population—identifying high risk individuals who are engaging in disproportionate amount of acute care, early mortality and high morbidity.
- Leveraging indicators of social health, including a Housing Insecurity flag custom developed by Health Share based on multiple data sources to gauge ED, inpatient and mortality risks.
- Leveraging novel data sharing with JOHS to incorporate housing system perspectives on high risk individuals to identify opportunities for cross-sector intervention
- Will be employed to target capacity building, address inequities, guide funding priorities and inform activities for integrating SDOH services and the Connect Oregon CIE platform to address health risks.

2024 Accomplishments

- Enhanced analytics/analysis of this population, including use of housing flag, to identify the significant interplay between high acuity BH conditions, acute care, and housing insecurity
- Analysis identifying referral and utilization patterns of the population, including likelihood for follow-up with BH providers following Medical IP stays
- Finalized data sharing agreement with JOHS to incorporate more complete housing data
- Incorporate Ecosystem flags into Point Click Care technology to enable care coordination activities

Barriers

- Considerable acuity of population
- Challenges of instable workforce
- Medicaid funding gaps, especially in BH
- Different scope of HRSN implementation (unhoused vs. at risk of houselessness)

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

Planned Activities	**Planned Milestones**
1. Implement first phase of ecosystem investments in acute care, street-based care, and wound care programs 2. Enhanced program monitoring and evaluation (creation of central dashboards and reporting) 3. Incorporate available housing data (JOHS data sharing) into evaluation and analysis of the population, including shared definition of “high risk” populations of focus	1. All programs established by Q4, 2025 2. All programs have monitoring mechanisms established by Q4, 2025 3. Early view into overlap of JOHS and Health Share ecosystem population by Q3 2025

Strategy 2 title: Leveraging Connect Oregon for SDOH related care plan content and information sharing (All)

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):

Accomplishments/Successes:

- Adopted Unite Us Payments platform to enable payments and encounter information between health and community resources

- Created referral pathway using Unite Us to enable 1115 Waiver appropriate Health Related Social needs. This involved partnerships with all three counties in the area, 211info, and a centralized role for CareOregon as program administrator
- Co-creation of workflow spanning numerous organizations to meet requirements of HRSN referrals
- Numerous enhancements to Unite Us platform to enable both information flow (referrals and supporting documentation)

Challenges

- Incredibly complicated workflows and administrative requirements have stretched what the CIE is designed to do
- Challenges with supporting community based organizations (specifically housing providers) to adapt new workflows and administrative requirements
- Lack of clarity about expectations for administering this program
- Incorporating diagnostic information along with social health information in a community information exchange that historically hasn't needed that clearly-documented connection

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

Planned Activities	**Planned Milestones**
1. Continue working with Unite Us to develop necessary enhancements to platform. Top 6 priorities include: Capture of ICD-10 Clinical Codes during authorization; Functionality to retroactively bill based on past dates of service; Improved work list management to track timelines; better visibility of Assistance Request Forms and self-referral information; Ability to edit authorization requests with new information; Ability to apply authorization caps and variable rates depending on service and provider 2. Continued governance and collaboration across Health Share partners to refine workflows and oversee Unite Us enhancements	1. These enhancements are anticipated in 2025

Strategy 3 title: Leveraging SDOH data and information sharing to understand regional need

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):
Accomplishments/Successes:

(Optional) **Overview of 2025-26 plans for this strategy**:
This is a relatively new initiative for the CCO. In 2024 we engaged with our IDS and ICN partners to begin planning and implementation processes to collect standardized SDOH screening status data. In alignment with the Social Needs Screening and Referral measure requirements, we are attempting to gather a routine set of information to identify which members have been screened for social needs, which members have been identified for social needs in domains of food, housing and transportation. This is a significant data alignment and collection effort, largely requiring extracts from partner EMRs or aggregated data warehouses.

Planned Activities	**Planned Milestones**
1. Collect first round of partner data	

2. Clean and review for completeness and accuracy 3. Problem-solve the submission process 4. Analyze the submissions and combine them with available information from UniteUs platform to being understanding social screening patterns of members	1. First round of partner data collected (Q2 2025) 2. Analysis for completeness and performance (Q3-Q4 2025) 3. Understanding opportunity to combine with available UU data (Q4 2025)

Strategy 4 title: Implementation of HealthTrio to support CBO payment arrangements (CareOregon)

CareOregon is working to provide access to a sustainable HIT solution to support contracts with community-based organizations (CBOs). Our standard CBO contract payment terms provide reimbursement for services provided for our members, through CBO submission of monthly reports and invoices. Access to HealthTrio, the selected platform, allows CBOs to verify eligibility and securely submit invoices and PHI-containing reports for payment.

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):

With the expansion of CareOregon's social health provider networks, we continued to extend access to HealthTrio (our provider portal) to contracted social health providers. HealthTrio is the platform that hosts our provider portal, CareOregon Connect. In 2024, we monitored the configuration to ensure provider access throughout the year, expanded social health provider network contracts, and developed standard onboarding processes for social health providers.

Expanded Social Health Provider Network Contracts:

- Negotiated contract terms and fee schedules with 6 new CBOs. All contracts were fully executed by Q4 2024.

Developed Standard Onboarding Process for Social Health Providers:

- Onboarding includes a 90-minute overview and discussion of contract terms, review of reporting requirements, and an orientation to HealthTrio.
- CBOs receive a guide for accessing and using HealthTrio, along with instructions for obtaining technical assistance.
- Our systems configuration and social health teams are available to provide ongoing technical assistance to CBOs as needed.
- This process was used to onboard an additional 6 social health providers in 2024.

(Optional) **Overview of 2025-26 plans for this strategy**:
In 2025, CareOregon plans to maintain the work happening through the existing social health provider contracts and explore the use of HealthTrio to support Health Related Social Needs (HRSN) providers as we get more experience with the new benefit.

Planned Activities	Planned Milestones
1. Continue incorporating the use of HealthTrio into HRSN service provider agreements as the network expands.	1. Establish contracting and onboard nutrition HRSN service providers to HealthTrio by Q1 2025.

	2. Establish contracting and onboard housing HRSN service providers to HealthTrio by Q3 2025.

Strategy 5 title: Development of social needs member table to inform population segmentation models (CareOregon)

CareOregon is doing an environmental scan and mapping of all different sources that have social needs data. The purpose is to develop and design a data table that will allow for a source of truth regarding member identified social needs and to inform strategy outreach and population segmentation models.

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, CareOregon decided to shift the focus for this strategy to internal inventory and mapping of social needs data. This will ensure the quality of our social needs data and the relevance when applying it to future strategies, interventions, and regulatory deliverables. To move forward, CareOregon secured IS resources in 2024 and started the ACG software upgrade build. This build will add social needs data to the platform and will be a part of the data table that will act as a source of truth moving forward.

The below challenges with our previous approach kickstarted this revision and explains our delayed implementation of the ACG upgrade.

Challenge 1: CareOregon currently has multiple data sources that house social needs data, and we cannot turn it into actionable information to inform outreach and segmentation without understanding the overarching regulatory requirements and strategic social needs data points. The process of comparing requirements to the data that we have is taking longer than anticipated due to the implementation of the HRSN benefit. The HRSN benefit requires significant resources, including IS support, resulting in the organization of social needs data sets being deprioritized.

Challenge 2: CareOregon is no longer pursuing co-developed risk segmentation with clinics due to workforce issues and clinics expressing their priority of engagement with members. They do not have the capacity to develop a risk model at this time.

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

Planned Activities	**Planned Milestones**
3. Upgrade to the newest version of Johns Hopkins ACG, including the new SDOH module. 4. Review and document SDOH regulatory and metric data requirements. 5. Complete environmental scan and mapping of social needs data coming from Connect Oregon, Compass Rose, EPP, and ACG. 6. Create social needs data dictionary, to be used across all data systems. 7. Secure technical resources to build out the master data table. 8. Build the master data table. 9. Pilot use of the data table. Determine validity and make adjustments.	2. Launch a social health needs team to begin scoping and creating a data plan by Q1 2025. 3. Document organization wide SDOH data requirements by Q2 2025. 4. Secure technical resources by Q2 2025. 5. Complete the ACG upgrade by Q3 2025. 6. Data systems have social needs data identified and mapped out by Q3 2025. 7. Social needs dictionary created by Q4 2025. 8. Build the member data table by Q3 2026. 9. Begin testing/piloting the data table by Q4 2026.

Strategy 5 title: Expand SDOH to AHPL and specialty practices across OHSUH IDS (OHSU)

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):

2024 Progress Planned activity significant progress on this strategy. We brought up all of Inpatient across the Health System on SDOH in March 2024. We also recently brought up AHPL Primary Care clinics and the Women's Health Clinic at HMC in Epic for SDOH in February of 2025, with plans of bringing up the AHPL Women's Health Clinic in March 2025.

One of the challenges is dealing with timing of rules / regulations around HRA, risk strategy etc. and receiving approval for work in progress. Timing to turn things around is not sufficient. Configuration, testing, and modifications take quite a bit of time to work through the necessary processes. Competing OHSU IT resources and projects.

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

Continue to expand the use of SDOH as appropriate to specialty clinics.

Planned Activities	**Planned Milestones**
4. AHPL Women's Health go-live in March 2025	4. AHPL Women's Health go-live in March 2025

Strategy 6 title: Expand trauma informed care training as part of the foundation for SDOH screening. (OHSU)

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):

2024 Progress Planned activities include completion of:
1. Transitioning funding and content mgmt. to OHSU Training and Development team in 2024. Training will remain available to all who participate in the IDS network free of charge.
2. Partnered with Health Equity and Trauma Informed Oregon on updating training materials and content.
3. Completed two training series in 2024: Mar-Jun and Sep-Dec

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

Planned Activities	**Planned Milestones**
10. Continue to provide administrative support to promote Trauma Informed Care training to the network when offered.	10. Begin to promote in May 2025 next TIC trainings.

Strategy 7 title: Epic integrated Language Services Software (OHSU)

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):

2024 Progress on planned activity also noted above. OHSU has encountered several issues with the implementation of [redacted] (3rd party software) and has officially paused this project. Languages Services is undergoing a Request For Proposal (RFP) process to address the [redacted] vendor issues/provide interpreter and translation services. RFP process will finish by March and a go live with vendor in the summer of 2025. Contingency plans are in process to support the requirements defined in HB 2359 as well as the requirements of the Meaningful Language Access metric.

Barriers to this work include regulatory requirements being too prescriptive resulting in an overly administrative burden that is difficult to automate and track. Epic system not configured to manage requirements. Vendors that can do the work are booked out because we are all trying to comply. Competing ITG resources and time.

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

Ongoing plans for this strategy not finalized, the plans going forward are subject to ongoing discussions about the use of Epic as the primary tool for documenting the required elements.

Planned Activities	**Planned Milestones**
1. Regroup as an organization to determine the path forward.	1. Regroup, determine if it is feasible to use Epic going forward, layout plans for developing workflows and corresponding build in Epic.
2. Interpreter services documentation project for metric capture	2. Improved metric capture rate compared to PY.
3. Languages Services Department to pick a new vendor to provide interpreter and translation services.	3. RFP process completion by March 2025.

Strategy title:

[Brief description]

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):

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

Planned Activities	**Planned Milestones**
1.	2.

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**.**

Connect Oregon is a network of health care and social service providers that are linked through a shared technology platform called Unite Us. Providers use the platform to securely send and receive referrals for care and social needs, such as food and housing assistance, and employment support. Plan to continue CBO network development and promoting use of the platform.

Epic platform - Epic platform that includes the SDOH Assessment Tool. MyChart for completion of SDOH Assessments, particularly for primary care and OHSU Health IDS.

Compass Rose is the Epic-based care coordination platform implemented by CareOregon in November of 2023. It has replaced GSI, their previous software. Compass Rose allows for improved collection and use of social needs information.

Epic Payor Platform module allows information exchange between the CCO and its provider networks, which will include data on SDOH needs.

Epic Healthy Planet is an integrated population health management application with the Epic platform.

(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**

The above section captures much of this work. The CCO works with and through our subcontracted partners to promote use of health IT to support social needs. Much of this work happens through either expanded use of Unite Us for community information exchange, or through promotion and use of integrated electronic medical records with built-in functionality or modules for capturing SDOH information, screening and referrals.

Strategy 1 title: Supporting the adoption and optimization of Connect Oregon

Connect Oregon/Unite Us is a community information exchange that allows bi-directional information sharing and transparency across referral networks. CareOregon, as Health Share's HRSN Benefits Administrator for Housing and Nutrition services, has a multi-pronged approach to advance the use of this tool among clinical providers, community-based organizations, and staff that includes financial support, educational/technical assistance, use case identification, and addressing adoption barriers and challenges.

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):

Due to team capacity, CareOregon did not do work specific to increasing the general use of Unite Us in 2024 for social needs referrals; rather, we focused on building out the platform referral and new payment capabilities to support the launch of the HRSN benefit. Through this focused effort we have successfully:

- Developed workflows and configured the software for HRSN service providers to receive HRSN referrals through Unite Us.
- Onboarded and trained housing HRSN service providers on closed loop referral processes.
- Trained care coordination staff to send HRSN referrals in Unite Us.
- Onboarded and trained nutrition HRSN service providers on closed loop referral processes.

In addition, CareOregon has identified opportunities to incorporate Unite Us into the Health Related Service Fund (HRSF) program request process and has established a plan to begin implementing by Q2 2025.

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

Plans for 2025-2026 include incorporating Unite Us CIE into the HRSF program request process and piloting within platform referrals for HRSF requests between FQHCs and CareOregon along with a continued focus on HRSN specific activities outlined below.

Planned Activities	**Planned Milestones**
1. Provide education and technical assistance to clinic and community-based organization partners to support use of the platform. 2. Identify referral use cases to transition to the Unite Us platform. 3. Incorporate the use of Unite Us into the HRSF request process workflow. 4. Explore incentivizing the use of Unite Us for HRSN referrals.	1. Use case identification a. Develop an intake approach to considering and resourcing new referral use cases by Q3 2025. 2. HRSF request process a. Incorporate the use of Unite Us into the HRSF request workflow by Q2 2025. b. Complete HRSN referral pathway improvements and convene HRSN service providers to gather input into CIE referral processes by Q3 2025. c. Incorporate CIE requirements into HRSN service provider contracts by Q4 2026.

Strategy 2 title: Support for provider use of SDOH Technologies (Providence)

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):

1. CHA clinics have implemented workflows to screen families for Social Needs and to document referrals to resources as needed within their EMR and/or the Innovaccer Population Health tool.
2. CHA clinics interface SDOH data into the Innovaccer Population Health tool to enable reporting and care gap analytics which include workflows to monitor care related to social needs.
3. CHA clinics have been utilizing Connect Oregon/ Unite Us. Update: All CHA clinics but two have been connected to utilized Connect Oregon/UniteUs in 2024.

1. (Optional) **Overview of 2025-26 plans for this strategy**: CHA clinics will continue to screen for Social Needs and document resource referrals with the goal to improve health supports and health outcomes for children and youth.

Planned Activities	**Planned Milestones**
1. Q1-Q4 2025: CHA clinics will continue to screen for Social Needs and document resource referrals with the goal to improve health supports and health outcomes for children and youth. 2. Q1-Q4 2025 – CHA clinics will work toward quality improvement in SDOH screening and referrals 3. Q3 2025 – CHA will implement a new SDOH QI dashboard in the Innovaccer Population Health tool. In 2025, CHA clinics plan to continue use of Connect Oregon/UniteUs and are hopeful there will be expansion of services for members and improved acceptance rates of referrals.	1. Q1 2025 – Review UniteUs dashboard for CHA clinics 2. Q1-Q4 2025 - quarterly review of practice engagement with UniteUs and success of referrals to CBOs 3. Q3 2025 – Training of CHA practices on a new SDOH QI dashboard in the Innovaccer Population Health tool 4. Q2 2024 – Feedback from practices regarding UniteUs platform and connection to CBOs. One-on-one support as needed. Sharing of best practices. 5. Q4 - Evaluation of highly utilized CBOs and opportunities for partnership.

Strategy 2 title:
[Brief description]

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):

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

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

Strategy 3 title:
[Brief description]

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):

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

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

Strategy 4 title:
[Brief description]

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):

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

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

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):

Health Share and our partners use UniteUs to provide closed loop referrals to support HRSN services. There has been considerable work—and progress—in this work in 2024, though the process still has gaps that are being addressed.

We have agreed on a single central benefit administrator organization, CareOregon, to administer the housing and nutrition benefit on behalf of the collaborative. In addition to simplifying the process for the community, this positions them to work directly with UniteUs and Health Share to refine the CIE functionality, capture data as needed, and ensure that referral, authorization and referral information are flowing as needed throughout the system. Designing this workflow and working with Unite Us to modify their platform to meet these needs has been a huge undertaking and the work will extend into 2025.

Health Share has also contracted with 211info to provide "front door" referral, screening and triage services, creating a significant point of entry into the HRSN system. 211info had already been using the CIE platform through their Coordination Center activities, so it was a somewhat natural transition for them to shift to doing direct HRSN-related administration as part of the new workflow.

Challenges
This work has been incredibly difficult. As noted above, UniteUs is a useful tool for this kind of work but it does not have the native capabilities to collect, organize and maintain all of the information required for HRSN service delivery. This includes the ability to capture and edit ICD-10 codes to justify clinical need for services, the ability to add retroactive dates for services provision (such as the dates that a retroactive payment for rent or utilities is supposed to cover, if that date has already passed), or the ability to edit authorization requests during various stages of process. Given that the workflow to authorize HRSN services requires numerous "touches" including the member, the referring organization/person, a front-door screening entity, and utilization management teams, the system requires multiple steps of date entry on a continuous referral. The system was not designed for that.

Additionally, because the state does not have a preferred CIE, the requirements and expectations of HRSN service delivery—including screening and authorization and appeals—was designed without unique regard for the tools available to actually deliver on the expectations. That means that the system currently requires a considerable amount of workarounds, repeated data entry, and administrative duplication to accomplish all the necessary steps. UniteUs has prioritized some enhancements for 2025 that are intended to address these issues, but in order to meet the demands of a sizeable backlog of requests, there is a lot of hand processing that needs to happen.

2025-27 Plans:

- Work with UniteUs to enhance functionality to meet the detailed requirements of HRSN administration
- Develop new contract with UniteUs for regional coverage and to meet needs of HRSN and other SDOH work
- Continued development of workflow and training to CBOs/service providers to adapt to new requirements, improve efficiency and data capture
- Continued improvement of data reporting for OHA and for internal analysis of HRSN services and other Social Needs data

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):

- Health Share's investment in the UniteUs payments platform was intended to allow for service providers to account for, and therefore receive, payments for the services they deliver under HRSN and potentially other lines of business (Health Related Services).
- At this point the workflows have been established for housing and nutrition services through this centralized tool, and invoices are able to be tracked and billed—this is a significant development for our region.

- Administered CCBF funding to support current HRSN service providers and potential HRSN service providers to develop the infrastructure needed to deliver and track these services

2025-27 Plans:

- Administer 2nd round of CCBF awards to build infrastructure among HRSN Services providers
- Continued support for training by UniteUs/onboarding to the platform for in-network providers
- Advocate for enhanced functionality within the platform, based on service provider input, to reduce administrative burden and simplify the reporting and data collection capabilities in alignment with new workflows

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.
As noted in the above sections, the considerable lift required to implement HRSN benefits took the majority of bandwidth in this area in 2024. That effort included barriers related to technical issues—CIE tool not having appropriate functionality to meet new OHA requirements and reporting expectations. Nonetheless, we made good overall progress in developing a new network of social health providers and delivering on this important benefit with all the required reporting.

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?
In the past we have noted that the lack of statewide alignment on a single CIE platform creates challenges for all CCOs who have aligned around a single platform. This leads to additional costs for CCOs and a lack of economies of scale when seeking platform upgrades or enhancements. It also yields a disconnect between program implementation staff and CCOs, as OHA staff have less visibility into the functionality of the main tool that most CCOs are using to implement the benefit. It would be ideal if CCOs and OHA could be aligned in this effort. OHA leveraging influence to advocate for needed functionality in CIE platforms. Continue to support Meaningful Language Access Workgroup – e.g. to provide more clarity on numerator/ denominator criteria and reduce reporting burden.

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.
High Risk Behavioral Health – utilizing claims data analytics to measure impact of clinically developed high risk member cohorts which is used to develop innovative care models for these populations that are otherwise difficult to engage. Flag developed for us in PointClickCare. OHSU utilizes **Epic Cheers** to support and automate tailored member engagement through MyChart, text message, letters, and email. It gathers data and provides dashboards to monitor success of outreach campaigns.
B. How can **OHA support** your efforts in accomplishing your Health IT Roadmap goals?
Behavioral Health provider financial support for EHR use (ongoing vs. implementation).

Risk stratification requirements on care coordination reporting are infeasible at a member record level as the tracking variables don't exist within commercially available solutions.
C. What have been your organization's **biggest challenges** in pursuing health IT strategies? What can OHA do to better support you?
In 2024 Health Share was required to respond to a larger than typical number of external audits consuming a significant amount of internal capacity for HIT initiatives. These audits have consumed most additional capacity for any operational or IT work within the CCO. In addition, implementation of all aspects of the HRSN waiver benefits have proven extremely time consuming and difficult from a technical perspective, creating a barrier to broader health IT strategies.
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?
Health Share leverages SDOH and SOGI data in internal and shared dashboards and reports to identify inequities. For example, a disenrollment and redeterminations dashboards were used to identify disproportionate numbers of Spanish speaking members that were being disenrolled which resulting in additional recruiting for bilingual customer service staff to assist members. Population analysis such High Risk Behavioral Health is disaggregated using demographic elements such as REALD/SOGI to identify potential inequities.

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.