2024 CCO Health IT Roadmap

2024 Guidance, Evaluation Criteria & Reporting Template

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

Please:

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

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

TABLE OF CONTENTS

Guidance Document

1. Purpose & Background

Per the CCO 2.0 Contract, 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
- 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]

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 2023 Health IT Roadmap as the basis for their 2024 Health IT Roadmap.

Changes for Contract Year 5 (2024):

1. Given the success of the 2023 'Template B' from both the CCO and OHA perspectives, only one Health IT Roadmap template will be provided in 2024, following the 2023 'Template B' format and structure. Roadmap TA sessions will be provided to assist CCOs with completion, as needed.
2. In support of OHA's effort to align CCO deliverables, the scope of the 2024 Health IT Roadmap is focused on health IT in support of care coordination. Strategies in support of VBP and metrics (except for support of the SDOH metric) are to be reported in other deliverables (e.g., VBP Questionnaire).
3. In response to CCO input and to align with previously reported efforts, the EHR section has been expanded to be inclusive of support for EHR 'use' and 'optimization', with a focus on care coordination. This expansion recognizes that though CCOs continue supporting EHR adoption, in order to support care coordination, some organizations need CCO support for EHR use and optimization.
4. To limit redundancy in reporting, Support for HIE – Care Coordination and Support for HIE – Hospital Event Notifications section have been combined. The section is now called 'Use of and Support for HIE' to more accurately reflect the reporting expectations (CCO use of HIE and CCO support of HIE among contracted providers). The HIE section has also been expanded to include support of HIE use.
5. An optional section has been added to help inform OHA of CCO's current and planned EHR access and use for care coordination purposes.
6. In response to CCO previous submissions, optional sections/boxes have been added to create space for overview descriptions of CCO efforts/approaches (e.g., Overview of CCO Health IT Approach, Overview of EHR Support, Overview of strategy plans).
7. Strategy categories and strategy status checkboxes have been added for each CCO strategy.

[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)

Reminders for Contract Year 5 (2024):

1. Limit the Progress sections to 2023 activities and accomplishments and include planned activities for 2024 through 2026 in the Plans sections.
2. In each Plans section, be sure to include activities and milestones for each strategy. If some strategies are missing activities and milestones, CCOs may be asked to revise and resubmit their Roadmap.
3. Add all CCO-collected health IT data to the Health IT Data Reporting File prior to submitting it with your Roadmaps on 3/15/2024. Data reported in the Roadmaps should align with the Data Reporting File.

2. Overview of Process

Each CCO shall submit its 2024 Health IT Roadmap to OHA for review on or before **March 15th** of each Contract Year. CCOs are to use the *2024 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 2024 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 it. 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 6/21/24 with their top two meeting choices.
    a. These meetings are only available from 6/20/2024 through 7/10/2024.
    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 7/17/2024.
3. OHA will complete its review of all resubmissions and provide written notice of the approval status within 30 days of resubmission receipt, by 8/16/2024.

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 2024 Health IT Roadmap submission and review process. m

2024 Health IT Roadmap Timeline

Last Revised 12/15/2023

	March - June 2024	June - July 2024	Aug - Sep 2024
	***2024 HIT Roadmap* Submission and Review**	**CCO/OHA Communication and Collaboration**	***Revised 2024 HIT Roadmap* Submission to OHA for Review**
Activities	**List of activities**	**List of activities**	**List of activities**
	CCOs submit *2024 HIT Roadmap* and HIT Data Reporting File to OHA by **3/15/24**	If not approved, CCO contacts OHA by **6/21/24** to schedule a meeting to discuss required revisions	CCO submits Revised 2024 HIT Roadmap to OHA by **7/17/24** CCOs with approved 2024 Roadmaps meet with OHA by **9/20/24**
	OHA reviews *2024 HIT Roadmap*	If approved, CCO contacts OHA by **7/10/24** to schedule a Roadmap follow-up meeting	OHA reviews CCO *Revised 2024 HIT Roadmap*
	OHA sends initial *2024 HIT Roadmap* result letter to CCO by **6/17/24**	Collaborative meeting(s) occur between OHA and CCOs required to revise and resubmit their *2024 HIT Roadmap* by **7/10/24**	OHA sends *Revised 2024 HIT Roadmap* result letter to CCO by **8/16/24**

OHA expects all CCOs will have an approved 2024 HIT Roadmap by 8/30/24.

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 5 (2024) 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 *2024 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 MOU and adheres to the terms • Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons Memorandum of Understanding (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. Support for EHR Adoption, ***Use, and Optimization***	A. 2023 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 2023 ○ Specific accomplishments and successes for 2023 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.
	2024-2026 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 2024-2026 related to supporting increased EHR adoption, ***use, and optimization in support of care coordination***, and addressing barriers to adoption among contracted physical, oral, and behavioral health providers ○ Specific activities and milestones for 2024-2026 related to each strategy • 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
3. Use of and support for HIE	A. 2023 Progress using HIE for care coordination and timely hospital event notifications <u>within the CCO</u>	• Description of progress includes: ○ HIE tool(s) CCO is using within their organization for care coordination and timely hospital event notifications ○ HIE strategies used for care coordination and timely hospital event notifications within the CCO ○ Specific accomplishments and successes for 2023 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.
	2024-2026 Plans using HIE for care coordination and timely hospital event notifications <u>within CCO</u>	• Description of plans includes: ○ Additional tool(s) (if any) CCO is planning to use for care coordination and timely hospital event notifications ○ Additional strategies for 2024-2026 to use HIE for care coordination and timely hospital event notifications within the CCO ○ Specific activities and milestones for 2024-2026 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible
	B. 2023 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 2023 ○ Specific accomplishments and successes for 2023 related to increasing access to ***and use of*** HIE for care coordination and timely hospital event notifications (including the number of 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.
	2024-2026 Plans for supporting contracted physical, oral, and behavioral health providers with increased access to and use of HIE for care	• 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

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
	coordination and timely hospital event notifications	○ Additional strategies for 2024-2026 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 2024-2026 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.
4. Health IT to support social determinants of health needs	A. 2023 Progress using health IT to support SDOH needs within the 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 2023 ○ Any accomplishments and successes for 2023 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
	2024-2026 Plans for using health IT to support SDOH needs within the 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 2024-2026 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
	B. 2023 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,	• 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 2023

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
	including but not limited to social needs screening and referrals	○ Any accomplishments and successes for 2023 related to each strategy ○ **Any planning and/or preparation CCO has done in anticipation of 2024 requirement to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals, such as developing grants, technical assistance, outreach, education, and feedback mechanisms for HRSN Service Providers.** • Sufficient detail and clarity to establish that activities are meaningful and credible
	2024-2026 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 2023 ○ Specific activities and milestones for 2024-2026 related to each strategy ○ **Specific plans to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals during Contract Years 2024-2026, such as developing grants, technical assistance, outreach, education, and feedback mechanisms for HRSN Service Providers.** • Sufficient detail and clarity to establish that activities are meaningful and credible.

2024 Health IT Roadmap Template

Please complete and submit this template via CCO Contract Deliverables Portal by **March 15, 2024.**

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 2023 strategies, progress, accomplishments/successes, and barriers
- Narrative sections to describe your 2024-2026 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 HIT 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 encouraged not to include 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 proposed 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 2024). **Note**: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.

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.

HIT Roadmap Template Strategy Checkboxes

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

- *Support for EHR Adoption*
- *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: 3/15/2024

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. (Optional) Overview of CCO Health IT Approach

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

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**) or the **Integrated Community Network (ICN)**. These networks serve all Health Share members and receive payments in a value-based payment arrangement 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 population. 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 various 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 IT/IS representatives from Health Share's 11 founding partners and HIT leadership from across the collaborative, and it was created to set a forum for alignment and collaboration in alignment with Health Share's initial HIT Roadmap.

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

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

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

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

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

Notes:

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

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

The number of contracted organizations without EHR information totals 432. 246 of these organizations are Physical health primary, 166 are Behavioral health primary, and 20 are Oral health primary.

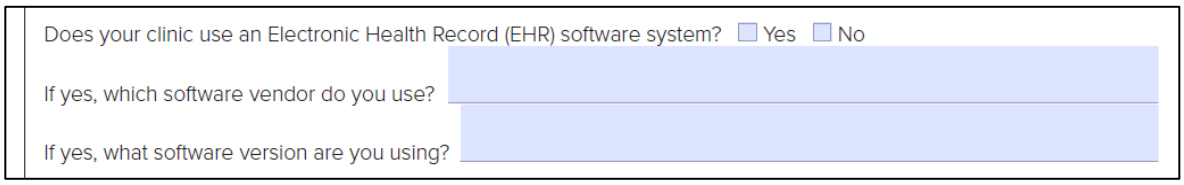
Physical – 246 (220 EHR Status Unknown, 21 have EHR – vendor unknown, 5 with no EHR)
Oral – 20 (12 EHR Status Unknown, 3 have EHR – vendor unknown, 5 with no EHR)
Behavioral Health – 166 (145 EHR Status Unknown, 11 have EHR – vendor unknown, 10 with no EHR

At the time of this submission, this is the number of unique providers that OHSUH IDS was not able to identify an EHR. All considered Physical Health providers.

11 Chiropractic
13 Acupuncture
6 Dietitian
15 Doula
4 Home Health
11 Licensed Clinical Social Worker
16 Nurse Midwife

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

CareOregon collects information from providers on their EHR usage through a Provider Information Form (PIF). All contracted providers for physical, behavioral and oral health complete this form as part of the new contract process. They also use this form when they need to update provider information such as adding individual providers to their organization, changes of address etc. This means that we have the opportunity to update missing EHR information any time an organization makes a change to their PIF. Data from the PIF is then uploaded into QNXT, CareOregon's claims processing system, so there is ongoing real-time access to the most current information.



Additionally, updated EHR information is received from all subcontracted DCOs on an annual basis for the dental providers they contract with directly.

OHSU will track / trend utilization to develop targeted outreach to those providers not on an EHR and begin conversations to uncover barriers. They will also develop possible work plans, incentives, or an APM for establishing an EHR. Provider information will be renewed during contracting, and will build requirements for EHR use into contracts. A possible enhancement to the process may include confirming and documenting EHR use during credentialing. This will allow for strategic process improvement going forward.

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

Progress	Plans		Progress	Plans	
☒	☒	1. EHR training and/or technical assistance	☐	☒	7. Requirements in contracts/provider agreements

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

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

Strategy 1 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 their EHRs more meaningfully to improve workflows, support CCO Quality Metric documentation, and support Value Based Payment performance. Additionally, they help clinic partners modify their operations and EHRs to support telehealth visits.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

The primary metric workflow/EHR optimization support main areas of focus are:

- Depression and SBIRT
- vaccinations and WCC
- social needs screening
- IBH templates

In 2023, the innovation team supported the primary care network for over 100 hours of individual technical assistance and learning collaboratives that discussed content around health information technology. A primary focus in 2023 was helping clinics to better understand how to document and track their SBIRT measure within their EHR. Based on TA provided, many clinics saw improvement in performance on this metric through better tracking and data management. Additional metrics supported through EHR workflow exploration included the depression screening metric, vaccinations, well-child visits and the social needs screening metric.

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

This strategy is in a maintenance phase. Technical assistance will continue to be provided to clinics around optimization of their EHRs however, opportunities will be developed on an as needed basis in consultation

with primary care clinic partners. Additionally, CareOregon will be 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 Measures analytics tools. These tools are designed to enhance each FQ's ability to manage and monitor their performance and the health of their populations associated with our value-based payment contracts and make optimal use of the data exchanges enabled through EPP.

Planned Activities	**Planned Milestones**
• Fund Multnomah County Health Centers and Virginia Garcia Memorial Health Centers participation in OCHIN's VPBM pilot • Communicate the funding offer to our FQ partners currently implementing EPP in Q1 and Q2, 2024 • Organize with OCHIN the post-pilot launch of first wave of FQ partners' participation in VBPM and HEDIS measures • Evaluate possibilities to extend funding offer to additional primary care network partners currently using EPIC EHR.	• Pilot completed by end of Q4, 2024 • Organized and completed contracting with OCHIN to support our FQ partners' adoption of VBPM and Certified HEDIS measures by Q2, 2024 • 4-5 additional FQ partners will adopt the VBPM and Certified HEDIS measures by Q4, 2025 • Determine funding availability for expansion of participation by Q1, 2026

Strategy 2 title: Extend OHSU's instance of Epic to Adventist Health Portland (AHPL)

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):

AHPL went live on OHSU's instance of Epic in March of 2023. With the transition of AHPL to OHSU's instance of Epic the majority of the OHSUH IDS members are now seen and cared for in a single EHR which provides better alignment within OHSUH IDS Primary Care clinics, and improved quality measure data across the three major systems (OHSU, HMC, AHPL).

Overview of 2024-26 plans for this strategy (optional): Continue Epic enhancements/modifications to improve integration

Planned Activities	**Planned Milestones**
1. Incorporate [redacted] language access data into EMR; stand alone Language access data driven software 2. Implementation of Epic Systems Home Infusion Module (Dorothy). OHSU currently uses [redacted] *[3rd party EMR]* as the Home Health EMR. This will be a transition to utilizing Epic to enable a more complete EMR and support for home health.	A. Q2-2024 [redacted] roll out B. Q1 2025 launch of Epic Dorothy for home infusion

Strategy 3 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. [redacted]
2. Olson Pediatrics transitioned EMR from Aprima to EPIC LEAP -- Update: Olson Pediatrics completed EMR transition from Aprima to EPIC LEAP
3. Pediatric Associates of the NW transitioned EMR from Athena/Centricity to Physicians Computer Company -- Update: Pediatric Associates of the NW completed EMR transition from Athena/Centricity to Physicians Computer Company

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

1. Update: Westside Pediatric clinic plans in 2024 to transition their EMR from Centricity to Physicians Computer Company
2. Update: The Children's Clinic plans in 2024 to transition their EMR from Centricity to the Legacy LEAP instance of EPIC

Planned Activities	Planned Milestones
1. Q1-2024: Prepare for Westside EMR transition including data exchange with CHA population health tool. 2. Q1-2024 Prepare for The Children's Clinic EMR transition including data exchange with CHA population health tool. 3. Q1-2024: explore options for stratifying The Children's Clinic complex patients and plan for changes in data capture and exchange. 4. Q2-2024 Prepare for The Children's Clinic EMR transition including data exchange with CHA population health tool. 5. Q2-2024 Commence work on new data interface connection between Westside EMR and CHA population Health tool. 6. Q2-2024 Commence data quality analytics on new data interface connection between Westside EMR and CHA population Health tool. 7. Q3-2024 Commence work on new data interface connection between The Children's Clinic EMR and CHA population Health tool. 8. Q3-2024 Commence data quality analytics on new data interface connection between The Children's Clinic EMR and CHA population Health tool.	A. Q2-2024: Completion of Westside EMR transition B. Q2-2024: Start of new data interface connection between Westside EMR and CHA population Health tool C. Q3-2024: Completion of new data interface connection between Westside EMR and CHA population Health tool D. Q3-2024: Completion of The Children's Clinic EMR transition E. Q3-2024: Start of new data interface connection between The Children's Clinic EMR and CHA population Health tool F. Q4-2024: Completion of new data interface connection between The Children's Clinic EMR and CHA population Health tool

Strategy 4 title: Legacy - Subsidize an EHR adoption program

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 12 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.

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

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

Planned Activities	**Planned Milestones**
1. The Children's Clinic will be implementing Legacy's Epic	A. The Children's Clinic go-live May 2024 B. 2024 Q3-Q4 Review further pediatric and adult primary care adoption opportunities C. 2024-2025 Implement new technology for Connect partner sites that include: • new virtual visit platform • text messaging capabilities for patients • Patient Portal improvements such as Financial Assistance planning, multilingual offering • credit card processing vendor change • AI provider dictation

Strategy 5 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 CareOregon which will be used in part to enhance and improve HIT infrastructure including EHR optimization.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

This strategy is new for 2024, however, in 2023 CareOregon opened an application cycle for contracted behavioral health organizations. Applications were reviewed and pilot organizations were selected to begin participating in 2024.

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

SHIFT will begin in January of 2024 with preparation and planning. CareOregon will work collaboratively with the participating organization to assess current state and redesign a new future state with implementation beginning in Q4 and continuing until 2026.

Five organizations were selected to participate in SHIFT:

1. Cascadia Health
2. Clackamas County Health Centers
3. Morrison Child and Family Services
4. New Narrative
5. VOA Oregon

Planned Activities	**Planned Milestones**
1. Begin planning and orientation with participating organizations 2. Conduct assessments of current state and design future state	G. Disperse initial grant funding in Q1 H. Launch cohort in March

Strategy 6 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):

● Prioritization of Oral Health - Started conversations with Oral Health partners, identified key contributors and goals; gathered some preliminary data and then project paused for Housing Benefit Pilot Program implementation. Internal resources from all sides involved seem to be biggest barrier to this project.

● Ancillary services intentionally placed on the back burner due to overall utilization and prioritization of Oral Health collaboration.

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

OHSUH IDS plans to re-engage these efforts given that the Housing Benefit Pilot Program ended.

Planned Activities	**Planned Milestones**
1. Reestablish Oral Health team meeting to identify next steps 2. Discuss credentialing / contracting process; determine if updates are feasible. 3. Strategize ancillary providers	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

Strategy 7 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):

EHR adoptions and/or upgrades were financially supported for:

- Multnomah County - $1,800,000 in 2022
- Central City Concern - $2,800,000 between 2022 and 2023
- Cascadia Behavioral Health - $6,250,000 between 2022 and 2024)
- Recovery Works NW - $124,614 between 2022 and 2023
- Portland Mental Health and Wellness - $189,130 between 2022 and 2023
- NARA - $2,000,00 between 2022 and 2023
- Fora - $150,000 between 2022 and 2023
- Options.

All organizations are actively working towards adopting or upgrading their EHRs. One barrier experienced was that the implementation timelines from the EHR companies were slower than anticipated. This means that implementation will continue into 2025 for Central City Concern, Multnomah County, Cascadia and NARA. Additionally, Fora, Portland Mental Health and Wellness and Recovery Works NW faced unanticipated capability limitations for the EHR vendor they had selected and are actively exploring other vendors.

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

Planned Activities	**Planned Milestones**

1. Continue support of EHR upgrades/implementation for existing LOAs	A. To be completed in 2025: Central City Concern, Multnomah County, Cascadia and NARA

Strategy 8 title: OHSU - [redacted] Evaluate Reliance HIE and other HIE technologies

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):

Not applicable, this is a new strategy.

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

OHSUH IDS is exploring the benefits of connecting with [redacted] HIE given the many challenges experienced in connecting and pulling external data from our community-based clinics.

Planned Activities	Planned Milestones
2. Exploring benefits of [redacted] HIE 3. [redacted] 4. Analysis on improvements in external data	1. Feb-April 2024 assessment of [redacted] toolset and improved integration into Epic Care Everywhere. 2. May 2024 determine to pursue deeper/custom integration with [redacted] beyond existing connectivity to the network.

Strategy 9 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):

Not applicable, this is a new strategy.

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

OHSU is implementing campaign functionality using Epic's Cheers: Campaigns license. Campaigns, in Epic, offer a standard means of automated, timely & targeted outreach to members through text, and MyChart.

Planned Activities	Planned Milestones
1. Form Campaigns Steering Committee 2. Stand-up Epic Cheers	1. Project kickoff March April 2024 and continuation through November 2024.

3. Determine and implement initial selected campaigns 4. Assess and refine campaign-related processes 5. Implement additional campaigns as directed by the Campaigns Steering Committee	2. Rolling launch of three campaigns specifically focused on OHSU Health IDS members and Primary Care. a. Childhood/adolescent immunization b. Diabetes A1c c. Well child checks 3. Implement Epic Cheers Campaign module to improve efficiency in connecting with new members and for different forms of outreach, e;g;, climate outreach.

B. EHR Support Barriers: (Optional)

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

There is a lack of ability to adequately capture REALD and interpreter information in EHR systems. This is a systemic problem, and it impacts clinic ability to meaningful use REALD/interpretation data. It also limits the ability of the CareOregon to capture this information from the clinics to use as an internal data source.

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.

Cost barriers associated with EHR [Epic] conversions remain for some independent group practices (Providence).

Pandemic-related challenges continued to reduce the time and willingness for partners to engage on this topic (Legacy).

C. OHA Support Needs: (Optional)

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

● Support efforts, especially at the Federal level, to define and mandate patient demographics standards for EHRs nationwide and align Oregon REALD/SOGI data standards.

● More clarity about the expectations related to complementary medicine and ancillary providers, and insight as to how they are intended to be part, or not part, of the movement towards EHR adoption. If intended to be part of this work, then incentives and support is necessary.

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

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

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

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

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.

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

Notes:

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

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

Progress	Plans		Progress	Plans	
☒	☒	1. Care coordination and care management	☒	☒	4. Enhancements to HIE tools (e.g., adding new functionality or data sources
☒	☒	2. Exchange of care information and care plans	☒	☒	5. Collaboration with external partners
☒	☒	3. Integration of disparate information and/or tools with HIE	☐	☐	6. Other strategies for supporting HIE access or use (please list here):

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

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.

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 planned for 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

Legacy's Care Management team is piloting new claims-based pharmacy use cases and Assigned/Not-Established functionality.

Legacy has built 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

Compass Rose is the new Epic-based care coordination platform implemented by CareOregon in November of 2023. It has replaced GSI, the previous care coordination 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 uses this module in their Epic system.

Care Everywhere is a module of Epic EHR that allows for the exchange of patient health information between providers who use Epic. All Health Share partners leverage this capability within Epic. Health Resilience Specialists and Panel Coordinators who are embedded in clinics that use Epic have access to Care Everywhere. It contains referrals management functionality for syncing referral information with other organizations using Epic.

Connect Oregon - Continued development work with Connect Oregon to facilitate enhanced program support and data reporting of services accessed and utilized by members.

Innovaccer Population Health Tool enables patient stratification for care management and offers timely care gap analytics and coordination worklists.

Reliance is a HIE used in several regions throughout Oregon. Legacy transmits all care events to this platform (one-way data).

Happy Together Notes and Happy Together Genomics - Kaiser plans to implement these modules 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.

(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.

At least one integrated delivery system partner (Kaiser) will explore the capability to send and sync referrals with external organizations who do not use Epic's EHR via **Epic's "360X"** feature.

Strategy 1 title: CareOregon - Optimizing and expanding the use of Point Click Care by the Regional Care Teams

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

- 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
- ED Admits in 90 Days
- 5 ED Visits in 12 months
- Pediatric ED Activity
- Rising Risk ED/IP/OBS/SNF – Admit
- Members initiating and engaging in treatment for substance use
- Medicare ED outreach
- Members who have been inpatient >7 days

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

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

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

Strategy status:

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

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

Over the past year CareOregon stabilized this process through the previous care coordination platform, GSI. In November of 2023, they went live on a new care coordination platform, Epic's Compass Rose. Many workflows were built incorporating Point Click Care notifications within the new platform utilizing "in basket" messages. Several challenges have occurred with the implementation of this new platform and will continue to be worked out over the next year including accurate triage of transition cases based on member RCT assignment and increased volume of work.

Additionally, CareOregon dental and all delegated DCOs utilize Point Click Care to coordinate care for shared members who have had a dental related emergency. This is ongoing work and there are no specific progress updates for 2023 or planned activities in 2024.

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

Due to a consistent increase in the number of transitions cases CareOregon receives, teams often have to prioritize working with members who have discharged over members still in the hospital. We will be creating a new process utilizing a weekly case conference held to review members who hit the 7-day mark of being in the hospital. The goal of this case conference is to determine outreach and engagement strategies prior to discharge.

Planned Activities	**Planned Milestones**
1. Identify team to review cases 2. Schedule weekly meetings 3. Build cohort within point click care 4. Develop workflow for running a report, gathering info, and presenting out at weekly meetings 5. Develop prioritization and triage process 6. Develop and implement outreach and engagement strategies including in person engagement prior to discharge	A. Implement weekly review process with new IP >7-day cohort Q2 2024

Strategy 2 title: OHSU - Expand Epic's Population Health Query to additional sites

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

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

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

Strategy status:

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

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

- Added additional non-Epic EHR clinics to Population Health Query processes. This expands the ability to receive external clinical data from partners.
- Attempted to expand Population Health Query to other IDS partners with Health Share (Kaiser, Legacy, and Providence); however, stalled largely due to Information Privacy & Security concerns.
- Resource prioritization became an issue with competing timelines and other CCO / IDS. All drinking from the same fountain for much of this work i.e. language access, Epic, internal ITG resources etc.
- Project Management turnover within PCC and Connect Oregon. Turnover in Project leaders from both vendors stalled work, which inhibited progress.

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

Planned Activities	**Planned Milestones**
1. Incorporation of PAC Management Module through PCC 2. Incorporation of HRSN Climate Benefit within Connect Oregon 3. Incorporation of HRSN Housing Benefit within Connect Oregon 4. Incorporation of HRSN Food Benefit within Connect Oregon	A. PAC Management Demo held on 02.26.2024 B. Go live with HRSN Climate benefit 03.01.2024

Strategy 3 title: CareOregon - Epic Payer Platform (EPP) implementation

Epic Payer Platform is a tool that facilitates 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: Other:

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

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

Throughout the latter half of 2023, CareOregon worked closely with a subset of our primary care provider network partners on Epic Payer Platform implementation readiness. Additionally, we initiated partnership work with OCHIN to align efforts for the Community Health Centers that we mutually support around EPP. This work included OCHIN board approval for prioritizing these efforts, and a shift in the initial approach of onboarding 2-3 network partners to a broader offering for all CHCs in CareOregon's network who are members of OCHIN. While these activities delayed our projected Q4 implementation kick-off, it has substantively improved our reach regarding network awareness of the EPP work and benefits and widened our initial participant pool from 2 to 5 Community Health Centers participating in this first wave of implementation, which touches over 100,000 of CareOregon's members.

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

Planned Activities	Planned Milestones
1. Q1 implementation kick-off of 4 EPP exchange features: Clinical Data Exchange, Health Plan Clinical Summary, Schedule Notifications, and Claims Exchange with OCHIN and the 5 participating Community Health Centers. 2. Outreach to remaining OCHIN membership within CareOregon's CCOs/network, inviting their participation in EPP 3. Approach EPP participation with regional hospital systems and associated Community Connect providers 4. Continue support of Epic upgrade/implementation of Payer Platform features 5. Continue communication to participating network partners of Epic upgrades/implementations of Payer Platform features	A. Projected go-live with Clinical Data Exchange, Health Plan Clinical Summary, Schedule Notifications, and Claims Exchanges features by April 2024 with first wave organizations. B. Make EPP-applicable/live features available to all OCHIN membership within CareOregon's CCOs/Network in 2024. C. Hold discussions with all hospital systems in CareOregon's CCOs/Network to explore EPP participation by Q1 2025.

Strategy 4 title: OHSU - Prior Authorization Reporting Improvement: Improve the content and exchange of Prior Authorization information

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

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

Strategy status:

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

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

Established process to connect and receive prior authorization data used by care coordination team for follow up and proactive coordination as needed. Refinement of prior authorization reporting still under review. Track and trend for improvement to overall utilization of this information.

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

Explore usability enhancements of prior authorization report delivered to CICP staff
Explore direct access to PA system for improved access to real-time data eliminating the current PA report.

Planned Activities	Planned Milestones
1. Track and trend then revisit in Q3 2024	A. Draft go-forward plan Q3 2024

Strategy 5 title: CareOregon - Implementation of a new Care Coordination platform

CareOregon is selecting and implementing a new care coordination platform to be used by care coordination teams that will allow for improved workflows as well as integration of social determinants of health and social needs data. Our selection will be 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 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: Other:

Strategy status:

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

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

CareOregon went through an RFP process to evaluate several care management platforms' abilities to meet our need. We selected Epic's Compass Rose application as our new platform. We had a tight timeline for implementation which was a challenge in itself. We hired a new analyst team and had several members complete certification in order to build out our environment. Initial building and training took place in Q3 of 2023 and we went live on the platform on 11/6/23 with our basic programs and workflows built out. We now have over 200 care coordinators actively utilizing the system to document their daily activities and complete their coordination workflows. The next several years will be geared toward optimizing our new platform, building out new programs, and onboarding external partners.

Overview of 2024-26 plans for this strategy (Optional):
Epic's Compass Rose platform was selected, and we went live on 11/6/23. The next several years will be geared toward optimizing our new platform, building out new programs, and onboarding external partners.

Planned Activities	**Planned Milestones**
1. Project manager request for help with HRAT rebuild 2. Stabilize current build by end of Q2 3. Identify and Scope out workflows for new teams onboarding onto the platform 4. DHS Metric build out 5. Implements bulk PDFs – uploaded into the system 6. Develop and implement Communication Policy for secure chat usage 7. Continue support of Epic upgrade/implementation	A. Launch new HRAT and HRSN program with Compass Rose in Q4 2024 B. Implement build, training, and workflows for coordination services that live outside of the care coordination department (dental, OABHI, CareBaby, maternity and others) in 2024

Strategy 6 title: OHSU - Housing Benefit Pilot Program (HBPP): Central Benefit Administrator (CBA) roll.

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

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

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

Collaboration in a pilot program with Health Share (HSO), CBOs and third parties hired by HSO, to fully develop a housing benefit administered to a select Medicaid population.
● Developed processes, tools, forms, trackers and financial reports within Epic in order to process referrals, enroll and manage members participating in the HBPP.
● Established data sharing guidelines and processes necessary in order to share data within OHSUH IDS partners and other key partners. These files include: -Data dictionary, daily and monthly enrollment, demographic, Health Risk Assessment, SDOH.
●Other Member forms required for participation in the program include: Member Agreement, ROI Authorization, and 30 Day check-in, all of which were collected from Housing Navigators from various CBOs.

Several challenges presented due mostly in part to Privacy & Security rules, lack of HIE or unified system for all sides to utilize and technology in general. The other major hurdle pertained to overall funding for this project. Competing resources and newness of CBOs working with health partners (and vice versa). All proved to be fruitful but not without breaking down and having to reset a few times.

Overview of 2024-26 plans for this strategy (Optional):
Institute lessons learned from pilot and revised implementation to suit new housing benefit.

Planned Activities 1. Incorporate OHA guidelines into the program	**Planned Milestones** A. Go live November 2024

Strategy 7 title: OHSU - Transition Adventist Health Portland (AHPL) to OHSU's instance of Epic

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

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

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

Completed all phases of AHPL's transition on to OHSU's instance of Epic. Clinical integration is now possible between all three hospital systems within the OHSUH IDS network. This creates additional efficiencies in care coordination, care management and timely hospital event notifications.

Overview of 2024-26 plans for this strategy (Optional):
Continue to enhancement of Epic tools system wide while monitoring outliers in specific areas of concern.

Planned Activities 1. Extend new functionality to AHPL as these become available in OHSU Health's instance of Epic. Examples: Epic Cheers: Campaigns, SDoH inpatient screening, external data integrations.	**Planned Milestones** A. March 2024 SDoH for Inpatient go-live B. November 2024 Cheers Campaigns

Strategy 8 title: OHSU - Hospital Event Notifications - Point Click Care

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

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

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

Ongoing work with Point Click Care to improve accuracy and data integrity with information provided to OHSUH IDS regarding admission and discharge of members. This work provides higher usability and data quality necessary for care management. Main challenge due to leadership changes on both sides as well as competing resources and other projects for those doing the work.

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

Exploring Point Click Care's PAC Management tool for predictive modeling for SNF readmissions.

Planned Activities 1. Exploring Point Click Care's PAC Management tool for predictive modeling for SNF admissions 2. Revisit Housing Benefit notifications 3.Ongoing validation for quality assurance of data integrity	**Planned Milestones** A. Demo for PAC Network Management 2/2024

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

Please describe your 2023 progress and 2024-26 plans for supporting increased access to and use of HIE for care coordination and timely hospital event notifications for contracted physical, oral, and behavioral health providers. Please include any work to support clinical referrals between providers. In the spaces below (in the relevant sections), please:

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

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

Notes:

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

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

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

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

Point Click Care is a Health Information Exchange that hospitals across Oregon connect to. Network partners are able to use is 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. Incorporates Epic's Population Health Query.

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.

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.

Epic Care Management Tools used for specific reporting for identified metrics, SDOH, LTSS, etc.

Connect Oregon facilitates referrals to community benefit organizations who help address SDOH needs.

Epic Healthy Planet and Healthy Planet Link Primary care clinics provided refresher training on accessing shared quality metric reports and gap lists available through these services.

CMS Interoperability Implemented and optimizing:

- OHSUH IDS implemented 37 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

Epic CCD/TOC exchange used to coordinate care setting transitions and exchange information among providers

Epic to Epic Referral Exchange (Legacy started with OCHIN in 2019).

Kaiser plans to give providers the capability to manually route specific encounter reports to external providers via **Direct messaging**, as needed. Kaiser is also planning to 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. Kaiser leverages **eHealth Exchange**, **eHealth Hub, and Carequality** to exchange records with external organizations utilizing other EHRs. They also provide external organizations access to an **Online Affiliate web portal** to view clinical data.

Prescription Drug Monitoring Program (PDMP)

Oregon Capacity System helps coordinate hospital bed utilization (HOSCAP requirement)

(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**

CareOregon provides financial support to facilitate access to select HIE platforms among contracted providers. CareOregon staff work directly with HIE vendors to develop new and improve existing reports and functionality. CareOregon Innovation specialists work directly with network partners to facilitate their engagement with the platforms, specifically working with clinics to optimize their care delivery workflows and processes to best capitalize on the HIEs.

Kaiser will encourage more external organizations to participate in PointClickCare (Collective Medical Technologies) notifications to receive event notifications from Kaiser.

Legacy offers a hosted Epic EHR which incorporates HIE functionality and integration capability with PointClickCare.

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**:

The number of organizations contracted by CareOregon that do not have HIE tools or hospital event notifications totals 194. 161 of these organizations are Physical health primary, 29 are Behavioral health primary, and 4 are Oral health primary.

Primary Care clinics with the network have access to Point Click Care to obtain information on timely hospital event notifications.

In addition to Point Click Care, OHSUH IDS uses Connect Oregon (UniteUs) as a tool for care coordination in identifying and provisioning resource needs

11	Chiropractic
13	Acupuncture
6	Dietitian
15	Doula
4	Home Health
11	Licensed Clinical Social Worker
16	Nurse Midwife

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 in order 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 2023, the behavioral health department collaborated with the analytics team to develop a Care Coordination Tool that details the likelihood of available access for members. There were challenges with the data quality that slowed the creation of this tool and affect its final development. Plans to expand FIDO access in the dental network were delayed in 2023 due to staffing and IS infrastructure barriers. This work has resumed in 2024.

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

For 2024 and beyond the behavioral health team is focused on bringing in additional data points from providers focused on “wait times” for programs, e.g., ICM and “time from referral to assessment” to include in the access dashboard. Our planned activities also include providing our subcontracted dental plan partners access to FIDO dashboard reports to include a holistic view of the members physical health, behavior heal prescription history by the end of Q1. Our second milestone is scheduled for Q3 and will include the implementation of on demand FIDO reports that will display the dental partners monthly, yearly, and historical metric performance. Finally, we plan to expand the member profile dashboards to include a deeper level of member data and the ability to access gap lists for outreach efforts by the end of Q4.

Planned Activities	**Planned Milestones**
1. Dental plan partner access to FIDO Dashboard that will include holistic Member data. 2. Dental plan partner access to FIDO Metric’s Dashboard 3. Expand FIDO membership and include access to gap reports 4. Update report to include more provider fed data 5. Post report online for provide use.	A. FIDO Membership access end of Q1 B. Metric Dashboard Access end of Q3 C. Expansion of Membership end of Q4 D. Wide scale use of coordination tool by regional coordination teams

Strategy 2 title: OHSU - Track and trend current utilization of EHR

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):

Overview of 2024-26 plans for this strategy (Optional):
Begin documentation of EHR by clinic through either credentialing of physicians (MSOW system) or through contracting SmartSheet

Planned Activities	**Planned Milestones**
1. Review network and document current EHR 2. Report to ITG team for outreach and collaboration.	

Strategy 3 title: Legacy – Support for FQHC claims data exchange

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):
Continued supporting OCHIN's FQHC focused HEDIS pilot to implement claims-based functionality in OCHIN Epic to support advanced forms of value-based payment by funding the cost of the PacificSource claims file conversion from a flat file format into the Epic spec, and then sending OCHIN three standard extract files (Medical claims, Pharmacy claims and Eligibility) monthly.

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

Planned Activities	**Planned Milestones**

Strategy 4 title: Legacy – Electronic Prior Authorizations

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 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.

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

Planned Activities	**Planned Milestones**
1. PacificSource will review the recently announced CMS 0057 final rule and	A. Present recommendation by October 2024

continue exploring opportunities for electronic prior authorizations accordingly.	

Strategy 5 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 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.
4. CHA has an ADT interface between EDIE and our Population Health Tool which enables pediatric providers access to timely ED and Inpatient event notifications.

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

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

Planned Activities

1. Q1-2024: Focus on WCC QI reporting including provider-level data and care gap lists
2. Q1-2024: Enhance data quality reviews inour population health tool data aggregation processes
3. Q2-2024: Enhance clinic QI training and education offerings
4. Q2-2024: Facilitate discussions and trainings to support additional documentation and reporting capabilities within EHRs for eCQM measures
5. Q3-2024: Focus on Immunization QI reporting including provider-level data and care gap lists
6. Q4-2024: Focus on year-over-year analysis and additional opportunities to close gaps by year-end

Planned Milestones

A. March 30 – add EMR data sets in Epic to support documentation and data collection of Behavioral Health services
B. May 30 - Add 10% more data fields flowing from Epic to our population health tool
C. Sept 30 – add EMR data sets in Epic and PCC to support documentation and data collection of Care Management services
D. Dec 31 – Assure supplemental data collection is optimized for year-end reporting

Strategy 6 title: CareOregon - 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 closed 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

The enterprise-wide HIT enhancement has successfully transitioned to an automated referral data sharing process as of November 2023. This enhancement provides the subcontracted dental plan partners daily access to PCP referral data sharing. It also provides referrals for pregnant members and members who requested oral health care coordination through completion of a Health-Risk Assessment Questionnaire. Monthly reports containing all referrals and care coordination outreach outcomes are submitted by the dental plan partners via the same automated process. The information reported back from the dental plan partners will be cross shared with the PCP clinics through the implementation of a Fully Integrated Data Organizer (FIDO) dashboard scheduled to launch Q2 2024

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

CareOregon is in the final phases of implementing the FIDO dashboard that will grant PCP clinics access to view dental referral care coordination reports. The first phase will allow PCPs to view results of care coordination outreach efforts conducted by the dental plan partners on submitted dental referrals. The target for full implementation and onboarding of PCP clinics is scheduled for Q2 2024. The final phase will provide FIDO reporting to include claims detail for referrals submitted by the PCP clinics resulting in member engagement. The final phase is scheduled to be fully accessible to clinics in Q3 2024. Access both FIDO reporting features will provide valuable information with the overarching goal of improving care coordination and quality of care for our members

Planned Activities	**Planned Milestones**
1. Develop and validate FIDO referral dashboard 2. Onboarding of clinics to the new dashboard 3. Enhance referral outcome report	A. Completion of FIDO Referral Outcome Dashboard Q2 2024 B. Update to Referral outcome report to include associated claims detail of member engagement Q3 2024

Strategy 7 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. The Innovation Specialist team identifies opportunities to help clinic partners modify their operations and optimize the use of Point Click Care. CareOregon has expanded its access to telehealth only providers. With recent proposed rule changes by OHA regarding OAR 410-120-1990 telehealth only providers will be required to refer out members needing a higher level of care. We are exploring HIE systems such as Point Click Care as way for telehealth only providers to better coordinate care for individuals who are too complex for their services.

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):

CareOregon provided support to Clackamas Health Centers in cohort cleanup and optimization of ED discharge reports to better leverage the use of Point Click Care through 1:1 TA and connection to account managers at Point Click Care.

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

Planned Activities	**Planned Milestones**
1. Pilot implementation of Point Click Care in Clackamas County jail Medical. 2. Partner with Point Click Care to develop population management tools for Hep C testing pathway.	A. Hep C Testing Pathway tool developed by Q4 2024

Strategy 8 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 telementoring 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 workflow. 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):

The innovation team supported clinics across the network in onboarding and technical support to the e-consult platforms RubiconMD and AristaMD.

Rubicon MD

- (Central City, Clackamas, Multnomah (Jan – May, they switched to AristaMD), NHC, Outside In, VG, Wallace)

Total eConsults: 1,925 (1,028 of the total were CO members)

Top Specialties: 1) Dermatology 2) Cardiology 3) Endocrinology

Highlights: 10 more users added to CCC

CareOregon piloted AristaMD, a new eConsult platform with one partner organization in 2023. This required onboarding support to one of our largest clinic systems, Multnomah County Health Clinics. November 2023 saw 160 e-consults on the new platform, with the top four specialties being Dermatology, Neurology, Hematology, and Endocrinology.

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

Planned Activities	**Planned Milestones**
1. Maintain funding for current RubiconMD and Arista users	A. N/A

C. HIE for Care Coordination Barriers: (Optional)

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

OHSUH IDS experienced challenges connecting to community-based practices to obtain external data for care coordination as noted above under the HBPP.

Providence:

1. Patient level Health Complexity data from OPIP would improve care coordination activities update: Patient Level Health Complexity data from OPIP has been made available in 2024, however the lack of specificity of the contributing factors limits the ability to act upon the information. It can be used to identify members who may not already have been identified as having social needs.
2. Interoperability with Connect Oregon/Unite Us with our Population Health tool would improve care coordination activities update: Interoperability between Connect Oregon/Unite Us and the EMR and/or our population health tool may improve care coordination activities. Use of UniteUs in 2023 has uncovered the need for the system to improve referral processes and availability of services for members.
3. Data sharing from school-based health centers and CBO's would improve care coordination activities.
4. CHA providers self-fund a Population Health Tool to interface clinical, claims and other data for an aggregated patient record and HIE, this is a challenging cost to sustain.
5. Notification of patient encounters at urgent care centers is not always available via EDIE but is desired.
6. Notification of patient discharges from inpatient behavioral health settings is not always available via EDIE but is desired.

D. OHA Support Needs (Optional)

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

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

Optional: Please describe CCO current or planned access to contracted provider EHRs. Please include which EHRs CCO has or plans to have access to including how CCO accesses or will access them (e.g., Epic Care Everywhere, EpicCare Link, etc.), what patient information CCO is accessing or will access and for what purpose, whether patient information is or will be exported from the EHR and imported into CCO health IT tools.

Which EHRs does CCO have or will have access to and how does or will CCO access them (e.g., Epic Care Everywhere, EpicCare Link, etc.)?

CareOregon's Health Resilience Specialists and Panel Coordinators have direct access to the EHR system of their host clinic with the permission to view and edit records for HSO 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.

OHSUH EHRs: Epic, Athenahealth, Aprima DrChrono, Amazing Charts, Office Practicum

Legacy, Kaiser, Providence: Epic

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 to and schedule appointments for members due for preventive visits and to those with identified gaps in care. They also scrub the charts of members with upcoming visits to ensure that they receive critical preventive and chronic disease management services during the visit. Additionally, they may use their EHR access to assist their host clinics with other quality improvement or outreach priorities.

OHSU leverages any 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.

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

CareOregon's regional care teams and panel coordinators do not export information from EHRs into CCO health IT tools.

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

Health Share is initiating an effort to gather SDOH screening data from EHRs and integrate into Health Share's Datawarehouse to inform HRSN network development and service provisioning as well as population risk stratification and intervention strategies.

5. Health IT to Support SDOH Needs

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

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

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

Notes:

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

Strategy category checkboxes (within CCO)

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

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

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

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 - Expand SDOH to AHPL and specialty practices across OHSUH IDS: Epic platform that includes the SDOH Assessment Tool. MyChart for completion of SDOH Assessments, particularly for primary care and OHSU Health IDS.

OHSU will deploy interpreter scheduling software [redacted] that integrates with Epic to better capture interpreter services documentation for language services for HB 2359 and language services metrics (planned).

Kaiser is expanding use of the Epic SDOH module to allow for identification of social health needs and coordination across teams

Compass Rose is the new Epic-based care coordination platform implemented by CareOregon in November of 2023. It has replaced GSI, our 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.

211 Coordination Center - provide support for community partners to use the close loop referral function of the CIE (ConnectOregon)

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**

Strategy 1 title: CareOregon - Implementation of HealthTrio to support CBO payment arrangements

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

Strategy status:

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

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

In 2023, CareOregon extended access to HealthTrio (our provider portal) to contracted community-based organizations. HealthTrio offers our CBO partners an opportunity to verify CCO enrollment for the clients they serve and to securely share reports and invoices that contain PHI, to meet the payment terms within their contracts.

Configured HealthTrio to allow CBO access

HealthTrio is the platform that hosts our provider portal, CareOregon Connect. In 2023, we completed configuration to extend access to the platform to CBOs that hold contracts with CareOregon. This included allowing a non-billable provider profile, developing a CBO-specific view with limited functions, and configuring CBO-specific mailboxes for secure data sharing. CBO accounts were established for 7 CBOs using this configuration.

Established CBO contracts, including fee schedules and BAAs

In 2023, CareOregon signed four new CBO contracts including that will allow us to pay the CBOs for support they provide for the community. Contract terms require the CBOs to verify member eligibility and reflect this in monthly reports on services provided to our members. The contract and associated Business Associates Agreement provide access to HealthTrio for these CBOs so that they can meet these requirements.

Developed standard onboarding process for CBOs and completed onboarding

To support contract compliance and use of HealthTrio, we developed a standard onboarding process for contracted CBOs. Onboarding includes a 90-minute overview and discussion of contract terms, review of reporting requirements, and an orientation to HealthTrio. CBOs receive a guide to accessing and using HealthTrio, and instructions for obtaining technical assistance. Our systems configuration and social health teams are available to provide ongoing technical assistance to CBOs as needed or requested to resolve barriers and challenges. In 2023, 7 CBOs completed onboarding to the HealthTrio platform.

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

Between 2024 and 2026, CareOregon plans to establish contracts with additional CBOs and onboard them to HealthTrio to support payment terms in their contracts; and explore use of HealthTrio to support the Health-Related Social Needs (HRSN) service provider agreements.

Planned Activities	Planned Milestones
1. Establish contracts with 2 additional CBOs 2. Onboard CBOs to HealthTrio and provide ongoing technical assistance as needed 3. Incorporate use of HealthTrio into HRSN service provider agreements	A. CBO contracts a. Contracts negotiated and signed with CBOs by Q3 2024 b. CBOs onboarded to their contracts by Q3 2024 B. HRSN benefit a. Identify HealthTrio functionality needed to support the HRSN benefit by Q2 2024 b. Develop HRSN service provider contract and BAA templates, incorporating HealthTrio access by Q3 2024 c. Establish contracts and onboard housing HRSN service providers to HealthTrio by Q4 2024 d. Establish contracting and onboard nutrition HRSN service providers to HealthTrio by Q1 2025

Strategy 2 title: OHSU - Expand SDOH to AHPL (Adventist Health Portland) and specialty practices across OHSUH IDS

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

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

Strategy status:

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

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

Deployed Epic SDoH assessments and wheel within the Epic Longitudinal Plan of Care, which shows risk levels for each domain (total of 11 domains) to AHPL. These tools are used regularly by care coordinator and case management teams in the OHSUH IDS, OHSU Primary Care, and Hillsboro Medical Center Primary Care.

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

Deployed Epic SDoH assessments and wheel within the Epic Longitudinal Plan of Care, which shows risk levels for each domain (total of 11 domains) to specialty clinics w/ inpatient setting.

Planned Activities	Planned Milestones
1. Rollout SDOH wheel to specialty clinics and Inpatient	A. Project Kickoff Jan 2024 B. Project Go-live Mar 2024

Strategy 3 title: CareOregon - Development of population segmentation program that integrates SDOH

CareOregon is redesigning its population segmentation model to include social determinants of health and social needs data. This data is newly available through Connect Oregon and the new care coordination platform. The segmentation model will be used to inform population health interventions and prioritize the deployment of care coordination resources.

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

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

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

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

In 2023, CareOregon planned to hire additional staff who could support population segmentation and risk analysis activities, develop segmentation and analysis methods that leveraged social needs, and test those methods for predictive and descriptive effectiveness.

Hire population segmentation and risk analysis staff - Complete

2023 brought significant progress in the development of the infrastructure to incorporate social needs data into the CareOregon's population segmentation activities. CareOregon hired a new leader, a director of data science and informatics, to lead a new team of analysts to support population segmentation work. Additionally, CareOregon signed a contract to add Johns Hopkins ACG Geographic module to its current ACG software, allowing for the incorporation of multiple social health indicators into the population segmentation process.

Develop segmentation and analysis methods/Test segmentation and analysis models – In process

The unexpected necessity to implement a new care coordination platform delayed the implementation of this new ACG software until 2024, but the new care coordination platform helpfully allows the unified capture of discrete data on members' health related social needs, adding an additional member-identified data source that can be paired with the ACG data to advance the precision and available use cases for population segmentation. Additionally, CareOregon is currently implementing Epic's Payor Platform module, which will allow information exchange between CareOregon and its provider networks in the future, including social health needs data.

In 2023, social needs data were incorporated for the first time in a segmentation process used for long-term strategy and support; CareOregon worked to bring social need considerations to supporting the Medicare model of care's most vulnerable dually eligible members.

We continue to focus on developing new segmentation models for specific use cases that can consider social health needs. For example, member spoken language, race, and ethnicity data were used to sub-segment members at high risk for climate impacts in an effort to prioritize equity in our teams' outreach activities.

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

Between 2024 and 2026, CareOregon plans to move forward with the following work to increase the presence and use of SDOH and social need data into population segmentation processes. The planned activities and milestones below are pathways to achieve the following:

1. Increase the quality, quantity, reliability, and appropriateness of social needs data available for population segmentation.
2. Test and validate small-scale segmentation methods that incorporate those social needs data.
3. Leverage social needs data to target outreach campaigns related to meeting individual-level social needs.
4. Learn from small-scale segmentation methods that can be applied to broader organizational segmentation approaches.

Planned Activities	**Planned Milestones**
1. **Software Upgrade**: Upgrade to the newest version of Johns Hopkins ACG, including the newly accessible geographic risk module that includes social health data and visualization tools 2. **Clinic Engagement**: Engage clinic partners in developing a condition-focused segmented risk prediction model that includes social needs data 3. **HRSN Eligibility Mining**: Use existing data sources to identify members potentially eligible for the HRSN benefit through membership in a transition population with social and clinical needs	A. March 2024 – a. **Software Upgrade**: Secure information systems resources to implement new and upgraded ACG software modules b. **Clinic Engagement**: Engage clinic partners to determine the aim of a co-developed segmented risk prediction model B. April 2024 – **HRSN Eligibility Mining**: Begin to leverage social needs data from screenings to identify prospectively eligible members for the HRSN climate benefit C. July 2024 – **Clinic Engagement**: Engage clinic partners to select social needs data that is strongly

4. **Current state check-in & inventory**: Develop current state assessment of company-wide segmentation and stratification activities. Develop inventory of social needs data sources 5. **Segmentation Process & Method Update Plan**: Develop scope and plan for an updated all-member segmentation process that leverage social needs data sources 6. **Data Governance Update**: Create infrastructure to improve data governance related to social needs data	correlated with the selected condition in the co-developed segmented risk prediction model D. October 2024 – **Software Upgrade**: Complete implementation of new and upgraded ACG software E. December 2024 – a. **Clinic Engagement**: Finalize risk prediction algorithm in co-developed segmented risk prediction model b. **HRSN Eligibility Mining**: Begin to leverage social needs data from screenings to identify prospectively eligible members for the HRSN housing benefit F. January 2025 – **Current state check-in & inventory**: Complete current state assessment of company segmentation and stratification activities G. March 2025 – **Current state check-in & inventory**: Develop inventory of highly predictive social needs data sources from plan activities, partner data sharing, and publicly available data sources. H. April 2025 – **Segmentation Process & Method Update Plan**: Scope 2024-2025 project for update to all-member segmentation method and processes I. October 2025 – **Segmentation Process & Method Update Plan**: Complete work plan for 2024-2025 all-member segmentation method and process J. December 2025 - **Data Governance Update**: Develop data governance model to bring together how organization stratifies/segments populations and defines certain types of risks (ensuring that social health needs data are considered in these activities)

Strategy 4 title: OHSU - Expand trauma informed care training as part of the foundation for SDOH screening

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

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

Strategy status:

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

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

Developed Trauma Informed Care training program, made available widely, across the network in 2023. This is essential in SDOH screening and referrals as a foundational competency that staff need to have when engaging patients in this way. Funded through quality dollars; need to find something more sustainable moving forward.

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

Planned Activities	**Planned Milestones**
1. Transitioning funding and content management to OHSU Human Resources team in 2024. Training will remain available to all who participate in the IDS network free of charge. 2. Partner with Health Equity and Trauma Informed Oregon on updating training materials and content.	A. Trained over 700 network clinicians and staff in 2023 on Trauma Informed Care B. Launched 2024 Spring Training Classes in March 2024.

3. Offer two training series in 2024: March-June and Sept-Dec.	

Strategy 5 title: OHSU - CBO network development & utilization within Connect Oregon.

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

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

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

Continue development of CBO network within Connect Oregon, promote overall use and adoptions as well as referrals for HRSN benefits including, Climate, Food, and Housing to promote alignment across the region to ease the burden on CBOs

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

Planned Activities	**Planned Milestones**
1. Strategize HRSN benefits	A. Go live w/ HRSN beginning with Climate in March 2024

Strategy 6 title: OHSU - Epic integrated Language Services Software

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

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

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

Deploy interpreter scheduling and documentation software, Service Hub, which integrates with Epic to capture interpreter services specifics as spelled out in HB2359 and language services metrics. Competing resources internally and externally as well as funding prevented original start up. Clarity around reporting requirements also impeded progress.

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

Continue project to implement Service Hub and the report development necessary to support metric reporting.

Planned Activities	**Planned Milestones**
1. Begin software deployment in Q2 – 2024	A. Go live in by end of Q2 2024

Strategy 7 title: Housing benefit data exchange and analytics

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

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

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

2023 pilot of the benefit model included data exchange with partners and county housing programs/systems (HMIS) and work to enhance Health Share's data warehouse to integrate housing services information. This included defining populations experiencing housing insecurity and contributed to the "Ecosystem Analysis" this past year for members with psychosis to correlate screening and referral/provisioning data with utilization.

Overview of 2024-26 plans for this strategy (Optional):
Develop and deploy a housing analytics dashboard correlating housing needs, member demographics, and housing services information with health care utilization.

Planned Activities	**Planned Milestones**
1. Housing Dashboard rollout to partners	A. Q2-Q3 2024

Strategy 8 title: Ecosystem Analysis

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

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

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

Building underlining data structures to understand populations with high potentially avoidable utilization risk. For example, we identified a cohort of 9% of our population that accounts for 42% of inpatient utilization. Housing information was a crucial component of the analysis. The Substance Use Disorder/Mental Health Conditions Dashboard was published December 2023.

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

Planned Activities	**Planned Milestones**
1. Building care models 2. Financial alignment with care models (eg APMs) 3. Tracking data analytics	A. Identify care models to scale/spread Q2 2024 B. Population risk analysis report to Board by end of 2024. C. Budget for additional work advancing care models for 2025

Strategy 9 title: Connect Oregon data warehouse integration and analytics

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

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

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

Integrated SDOH screening, case notes, referral information, and outcomes data from Connect Oregon into Health Share's data warehouse. Developed an analytics dashboard detailing network services/development, screening and referral activity correlated with member demographics enabling service availability and equity analysis.

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

Support adoption and use of the new dashboard among Health Share's partners to inform ongoing utilization of Connect Oregon. Build capability to publish the dashboard externally to expand community collaboration.

Planned Activities	**Planned Milestones**
1. Dashboard rollout to partners 2. Publish externally (CBOs, providers, government)	A. Q2 2024 B. 2025

Strategy 10 title: HRSN populations development

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

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

Strategy status:

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

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

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

Building member lists reflecting populations receiving HRSN services to be used for reporting/analysis
HRSN utilization will be cross referenced with identified needs in an interactive dashboard to inform network development, contracts, services provisioning and operations integration.

Planned Activities	**Planned Milestones**
1. Population development in data warehouse 2. Dashboard(s)	A. Q2 2024 B. 2025

Strategy 11 title: Social Needs Screening and Referral Metric

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

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

Strategy status:

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

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

Completed an environmental scan of social needs screening and referral activities.

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

Piot, testing and deployment of solution for ingesting, integrating and using for analysis social needs screening and referral information from EHRs as well as unmet needs to inform strategy, contracting, network development, provisioning.

Planned Activities	**Planned Milestones**
1. Population development in data warehouse 2. Dashboard(s)	A. Q2 2024 B. 2025

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

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

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

Notes:

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

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

Progress	Plans		Progress	Plans	
☒	☒	1. Sponsor CIE for the community	☐	☐	8. Requirements in contracts/provider agreements
☒	☒	2. Financial support for CIE implementation and/or maintenance	☒	☒	9. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)
☐	☐	3. Training and/or technical assistance	☒	☒	10. Integration or interoperability of health IT systems that support SDOH with other tools

☒	☒	4. Assessment/tracking of CIE/SDOH tool adoption and use	☒	☒	11. Support CBOs sending of referrals to clinical providers (i.e., to physical, oral, and behavioral health providers)
☒	☒	5. Outreach and education about the value of health IT adoption/ use to support SDOH needs	☐	☐	12. Utilization of health IT to support payments to community-based organizations
☒	☒	6. Support participation in SDOH-focused health IT collaboratives, education, convening, and/or governance	☐	☐	13. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs (please list here):
☐	☐	7. Incentives and/or grants to adopt and/or use health IT that supports SDOH	☒	☐	14. Other strategies for supporting access or use of SDOH-related data (please list here): Legacy/PS processing SDOH information from Reliance HIE for analytics use cases. *(see next section)* Legacy/PS Member Support Services processing incoming referrals from members in Connect Oregon. Legacy/PS Flexible Services incoming referral process

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.

The clinics on OHSU's instance of Epic and CICP staff use the SDOH screening tools in Epic. The screening tools span 13 domains: Tobacco, Alcohol, Financial Resource Strain, Food Insecurity, Transportation Needs, Physical Activity, Stress, Social Connections, Intimate Partner Violence, Depression, Housing Instability, and Utilities.

Legacy has implemented FHIR integration between Connect Oregon and Epic.Member Support teams are processing incoming referrals in Connect Oregon.

Innovaccer Population Health Tool integrates EHR, EDIE, and Payer information enabling patient stratification for care management. It also has integration with a pediatric HIE.

Epic Healthy Planet is Epic's population health solution. Members can input information regarding SDOH needs. Multiple Health Share integrated delivery system partners leverage this functionality.

Epic CCD data interchange - SDOH data elements are mapped to Legacy Epic CCD as discrete values

Reliance – Legacy/PacificSource processing SDOH information from Reliance for analytics use cases, most notably health equity plan.

(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**

CareOregon provides financial support to ensure that health care and social service providers in the region can access the Connect Oregon network at no cost. This includes paying for software integration for local FQHCs. CareOregon also provides trainings and ongoing technical assistance to these organizations to implement & optimize their use of Unite Us, provides opportunities for providers to give feedback on the platform, and advocates with Unite Us for changes to address barriers to use of the platform.

Supporting and Incentivizing HRSN Service Providers

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

CareOregon has begun planning and preparing to support and incentivize HRSN Service providers to use HealthTrio and Unite Us to support HRSN closed loop referrals. Preparation steps include:

- Providing input on closed loop referral requirements and HRSN service provider needs to OHA through CCO engagement sessions and written feedback
- Participating and presenting at Unite Us presentations about Unite Us Payments, to inform and gather feedback from potential HRSN service providers about referral, authorization, and payment workflows for the benefit
- Convening internal stakeholders to develop a plan for incentivizing use of the Unite Us platform
- Evaluating initial outcomes from providing incentive grants for use of Unite Us in 2022-2023. The evaluation concluded that incentive grants did not result in increased referral activity within the platform,
- Beginning planning for HRSN service provider contracts, onboarding, and technical assistance processes, including closed loop referral workflows and access to HealthTrio to confirm CCO enrollment, a necessary step in sending accurate referrals
- Supporting House Bill 4150 to bolster improvements and engagement with Community Based Organizations

Kaiser is providing support for the 211 Coordination Center to provide support for community partners to use the close loop referral function of the CIE (ConnectOregon)

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

Specific plans to support and incentivize HRSN Service Providers to use CIE for closed loop referrals include:

- **Awarding Community Capacity Building Funding (CCBF) to potential HRSN Service Providers.** Requests to support CIE technology costs and workflow development to prepare for the HRSN benefit will be considered during the CCBF application review process.
- **Incorporating CIE outreach into HRSN Service Provider contracting conversations**. Contracting conversations will establish agreements about the methods for conducting closed loop referrals and identify any support the organization needs to receive closed loop referrals through CIE.
- **Conducting onboarding for HRSN service providers in Q4 2024**. Onboarding will include training on use of CIE to send and receive closed loop HRSN referrals for all HRSN service providers that choose to participate.
- **Providing 1:1 education and technical assistance and workflow development for HRSN service providers.** Technical assistance will be available for all HRSN service providers to support workflow development and address barriers to using CIE for closed loop referrals.
- **Establishing feedback mechanisms for HRSN Service Providers.** Plans include regularly scheduled 1:1 meetings with HRSN Service Providers to provide feedback about HRSN workflows and processes (including closed loop referral processes), and HRSN Service Provider convenings which will include opportunities to learn, provide feedback, and coordinate across organizations.

- **Incorporating CIE referral volume criteria into quality pool payment methodology for the SDOH screening metric.** HRSN Service Providers that have sent or received referrals during the measurement year will qualify to receive quality pool payments beginning in 2025.

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

Connect Oregon/Unite is a community information exchange that allows bi-directional information sharing and transparency across referral network. CareOregon has a multi-pronged approach to advance the use of this tool among clinical providers, community-based organizations, and CareOregon 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: Financial ☐ 3: TA ☒ 4: Assessment ☒ 5: Outreach/Education ☒ 6: Participation
☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

Strategy status:

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

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

specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☐ Social Services ☐ CBOs

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

CareOregon completed its fourth year of community sponsorship of the Unite Us/Connect Oregon CIE platform and as a result CareOregon staff sent 465 referrals with an 80% acceptance rate in 2023. They received 69 referrals with a 97% acceptance rate. Additional activities and successes are listed below.

Financial support for CIE implementation and/or maintenance

- CareOregon continued to sponsor the platform through payment on behalf of CCO members.
- As part of this sponsorship, CareOregon continued to financially support an additional year of costs for local FQHCs to access and integrate the Unite Us platform.
- CareOregon awarded 5 organizations a CIE incentive for utilizing the platform in 2023.

Education and technical assistance

- CareOregon provided ongoing assistance to network partners, including in-person sessions with pharmacy providers, as they built workflows using the Unite Us platform to address needs.
- CareOregon provided technical assistance to CBOs interested in incorporating the use of Connect Oregon into their workflows.

Use case identification

- In Q3 and Q4 of 2023, CareOregon Care Coordination teams sent a total of 585 on platform referrals to Mom's Meals to address identified food insecurity for medically complex members.
- We invested significant staff time in facilitating new relationships that could lead to referral pathways between clinics and community-based organizations.

Participation in SDOH-focused HIT collaboratives, education, convening, and/or governance

- We actively engaged in regional and state convenings focused on the Connect Oregon network

We experienced the following challenges while implementing this strategy

- CBO concerns about participation in the Connect Oregon network, including concerns about their capacity to meet referral volume
    - Current mitigation: developing pathways for paying CBOs for services
- Workflow adoption by clinics even with tool integration

- Current mitigation: Advocating with OCHIN and Unite Us to build expedited timelines for more meaningful interoperability, and aligning CIE usage with other social health initiatives

- Low referral acceptance rates leading to disengagement among referring agencies
  - Current mitigation: focusing on identifying use cases that are best suited for use of CIE

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

During 2024-2026, CareOregon will continue to focus on providing financial support, education and technical assistance, and use case identification. Additionally, in 2024 we will begin incorporating the Unite Us platform into our HRS and HRSN contracts and processes.

Planned Activities

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. Prepare to utilize the Unite Us platform for HRSN referrals
5. Support and incentivize use of Unite Us for HRSN referrals

Planned Milestones

A. Education/technical assistance
   a. Provide education and training to support an increase in referrals marked as resolved by 15%, by end of Q4 2024
B. Use case identification
   a. Develop an intake approach to considering and resourcing new referral use cases by Q3 2024
C. HRSF request process
   a. Identify opportunities to incorporate Unite Us into the HRSF request process by Q3 2024
   b. Incorporate the use of Unite Us into the HRSF request workflow by Q4 2024
D. HRSN referral pathway development and incentivization
   a. Develop workflows and configure the software for HRSN service providers to receive HRSN referrals through Unite Us by Q4 2024
   b. Onboard and train housing HRSN service providers on closed loop referral processes by Q4 2024
   c. Train care coordination staff to send HRSN referrals by Q4 2024
   d. Onboarding and train food HRSN service providers on closed loop referral processes by Q1 2025
   e. Convene HRSN service providers to gather input into CIE referral processes by Q3 2025
   f. Incorporate CIE requirements into HRSN service provider contracts in 2026

Strategy 2 title: Providence support for provider use of SDOH technologies

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

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

Strategy status:

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

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

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

1. 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. Innovaccer has interoperability with Aunt Bertha community resources, but has not extensively implemented this since Oregon uses Connect Oregon/Unite Us.
2. CHA clinics have been learning about and beginning implementation and use of Connect Oregon/ Unite Us. Update: All CHA clinics but one have been connected to utilized Connect Oregon/UniteUs in 2023.
3. CHA clinics have been learning about and exploring SDOH screening tools and resource supports. Still relevant/accurate but no update

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

Planned Activities	**Planned Milestones**
1. CHA plans to continue exploring SDOH screening tools and resource connections including Connect Oregon/Unite Us. Update: In 2024, 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.	A. Q1 2024 – CHA access to UniteUs dashboard for CHA clinics B. Q4 2024 - quarterly review of practice engagement with UniteUs and success of referrals to CBOs C. Q2 2024 – Feedback from practices regarding UniteUs platform and connection to CBOs. One-on-one support as needed. Sharing of best practices. D. Q4 - Evaluation of highly utilized CBOs and opportunities for partnership.

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

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

Feedback from Providence:

1. Claims data interfaces from all payers would improve data in our Population Health tool and improve care coordination and SDOH activities.
2. Patient level Health Complexity data from OPIP would improve care coordination and SDOH activities update: Patient Level Health Complexity data from OPIP has been made available in 2024, however the lack of specificity of the contributing factors limits the ability to act upon the information. It can be used to identify members who may not already have been identified as having social needs.
3. Interoperability with Connect Oregon/Unite Us with our Population Health tool would improve care coordination and SDOH activities. Update: Interoperability between Connect Oregon/Unite Us and the EMR and/or our population health tool may improve care coordination activities. Use of UniteUs in 2023 has uncovered the need for the system to improve referral processes and availability of services for members.
4. Data sharing from school based health centers and CBO's would improve care coordination and SDOH activities.
5. CHA providers self-fund our Population Health Tool to interface clinical, claims and other data for an aggregated patient record and HIE, this is a challenging cost to sustain.
6. Medical providers' ability to screen patients for SDOH in ways that don't detract time from physical/medical care, are patient-friendly, culturally responsive, and result in community or service connections is very time intensive at the point of care and administratively. Clinical data records in EMRs are not designed to collect

this data nor to do population level analytics. Medical delivery structures are not designed effectively to be a primary source for this data and work, however medical providers can potentially assist with this data collection and management. Other registry-style HIE structures might be better designed for these surveys, data, and analytics, but would need to have seamless interoperability with EMRs to be useful at the point of care.

7. Ability to share specific components of an SDOH screening completed by the PCP office (i.e. positive screens in specific areas) will be a challenge.to share in a context outside of the office. Not all EHRs have a location to track and monitor the specific elements of a screening assessment and the desired follow-up. Still relevant/accurate but no update
8. Practices would be interested in information sharing of information collected by others (CCOs, other providers) to limit the number of times an individual is asked the same questions. Similarly, it will be helpful to evaluate how to share information that is consistent across families. Still relevant/accurate but no update

D. OHA Support Needs (Optional)

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

6. 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.

CareOregon has launched the MyCareOregon mobile app for iOS and Android smartphones. The MyCareOregon app is designed to offer members a new channel to access their benefit information, to navigate their health care and improve their overall member experience. Using the app, members will be able to view their:

- Digital member ID card and other benefits information
- Own reminders for prescriptions and refills
- Medical appointment history
- Primary care provider contact information
- Dental provider contact information
- CareOregon provider directory
- CareOregon Customer Service

The app adheres to ADA accessibility requirements, is available in multiple languages, and was tested and approved by the CareOregon Community Advisory Board. Members can use the app to request language interpretation and medical transportation services. It will continuously be developed to address top member needs and customer service requests
Information for members on the app is available on the CareOregon website: MyCareOregon mobile app

OHSUH IDS will be implementing Campaigns in Epic to promote patient engagement through timely and targeted outreach to members.

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

Collaboration with CCOs on new guidance and detailed requirements surrounding things like language access, CBO reporting / collaboration and new HRSN benefits.

Prioritization consideration when rolling out new benefit data requirements. A roll out approach spread over time is helpful for implementation, testing and go-live.

C. What have been your organization's **biggest challenges** in pursuing health IT strategies? What can OHA do to better support you?
Limited resources due to funding and competing priorities. Incentive funding for those doing the work needed
D. How have your organization's health IT strategies supported **reducing health inequities**? What can OHA do to better support you?
• HDRC standards were developed and used for reporting. • Capturing/Leveraging Epic for Language Access. • MyChart in Spanish. • Established standard language for Health Share analytics dashboards for "data equity" describing how race ethnicity information should be viewed and the philosophy behind how it should be used. • Health Share Analytics dashboards incorporate demographic disaggregation capabilities which can be used to identify potential inequities. Our Disenrollment dashboard for example was used it identify potential inequities informing outreach activities for redeterminations.

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

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