2025 CCO Health Information Technology (HIT) Roadmap

Guidance, Evaluation Criteria & Reporting Template

Contract or rule citation	Exhibit J, Section 2
Deliverable due date	March 15, 2025
Submit deliverable via:	CCO Contract Deliverables Portal

Please:

1. **Submit a Microsoft Word version of your Health IT Roadmap and**
2. **Use the following file naming convention for your submission: CCOname_2025_HealthIT_Roadmap**

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

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Guidance Document

1. Purpose & Background

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

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

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

Reminders for Contract Year 6 (2025):

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

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

2. Overview of Process

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

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

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

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

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

2025 Health IT Roadmap Timeline

Last Revised 12/2/2024

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

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

3. Health IT Roadmap Approval Criteria

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

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

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

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

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

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

2025 Health IT Roadmap Template

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

Instructions & Expectations

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

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

Each required topic includes the following:

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

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

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

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

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

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

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

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

A note about the template*:*

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

Health IT Roadmap Template Strategy Checkboxes

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

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

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

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

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

CCO: IHN-CCO

Date: 4/30/2025

1. Health IT Partnership

Please attest to the following items.

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

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

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

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

3. (Optional) Overview of CCO Health IT Approach

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

4. Support for EHR Adoption, Use, and Optimization

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

Please describe your 2024 progress and 2025-26 plans for supporting increased rates of EHR adoption, use, and optimization in support of care coordination, and addressing barriers among contracted physical, oral, and behavioral health providers. In the spaces below (in the relevant sections), please:

- Report the number of physical, oral, and behavioral health organizations without EHR information using the Data Completeness Table in the OHA-provided CCO Health IT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.
- Include plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialling, Letters of Interest).
- Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.
- Provide an overview of CCO's approach to supporting EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 to support EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination include:
    - A title and brief description
    - Which category(ies) pertain to each strategy
    - The strategy status
    - Provider types supported
    - A description of 2024 progress, including:
        - accomplishments and successes (including number of organizations, etc., where applicable)
        - challenges related to each strategy, as applicable

      Note: Where applicable, information in the CCO Health IT Data Reporting File should support descriptions of accomplishments and successes.
    - (Optional) An overview of CCO 2025-26 plans for each strategy
    - Activities and milestones related to each strategy CCO plans to implement in 2025-26

Notes:

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2025, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

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

Physical: Of the 51 Physical Health providers in our denominator, 2 confirmed not having an EHR and 1 where the status of their EHR is unknown due to lack of response to our outreach efforts.

Oral: Of the 20 Oral Health providers in our denominator, 3 confirmed not having an EHR and 0 with an unknown EHR status.

Behavioral: Of the 187 Behavioral Health providers in our denominator, 41 confirmed not having an EHR and 3 where the status of their EHR is unknown due to lack of response to our outreach efforts.

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

The CCO plans to collect missing EHR information through a two-pronged approach. First, the CCO will disseminate targeted provider education to those who do not currently use an EHR or have not responded to previous outreach. This communication will emphasize the importance of EHR adoption and include examples of commonly used systems and their estimated annual costs to encourage implementation. Second, the CCO updated its Letter of Interest form to include a required field for EHR details. This change occurred back in 2022/23 when these surveys first went out as a collaborative effort between OHA and IHN. This applies to any provider requesting a new contract, rate adjustment, or BHDP increase, supporting the ongoing effort to maintain a complete and up-to-date list of provider EHR systems. The addition of this field has been very successful and can be attributed to our low "EHR status unknown" rates.

Strategy category checkboxes
Using the boxes below, please select which strategies you employed during 2024 and plan to implement during 2025-26. Elaborate on each strategy and your progress/plans in the sections below.

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

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

CCO efforts to support the adoption, use, and optimization of EHR among contracted providers—across physical, oral, and behavioral health—are rooted in a multi-pronged approach that combines policy alignment, data collection infrastructure, education, and technical assistance to drive better care coordination and data sharing across the network.

A foundational component of this strategy has been the integration of EHR status reporting requirements into Participating Provider Agreements. While this requirement has existed in provider contracts for some time, recent improvements to provider onboarding and contracting workflows now include a structured EHR data field, which must be completed at the point of contracting. This has resulted in a significant reduction in the number of providers with "unknown EHR status" and a slight but meaningful shift from "No EHR" to providers now reporting the use of named EHR systems. However, we recognize that not all contracted providers are currently meeting this requirement, and as such, upcoming education and outreach efforts will specifically remind providers of this obligation, as outlined in their signed agreements.

To further support provider engagement, the CCO is launching a provider education initiative focused on the value and impact of EHR adoption. This effort emphasizes how EHR use strengthens care coordination by

enabling real-time access to patient data, improving transitions of care, supporting accurate referrals, and reducing duplicative services. The campaign will also highlight commonly used, affordable, and user-friendly EHR platforms—such as Athenahealth, Kareo, and Practice Fusion—already adopted by other providers within the network. By sharing real-world examples and peer experiences, we aim to reduce barriers to adoption and build confidence among providers who may still be using paper-based or fragmented systems.

In addition to education and contracting enhancements, the CCO is working to improve the tracking and monitoring of EHR capabilities across provider types. This includes ongoing data validation, feedback loops with provider relations staff, and planning for technical assistance resources that can offer tiered support—from basic onboarding to advanced optimization for population health and data reporting.

Together, these efforts reflect a long-term commitment to building an interoperable network that enables comprehensive, person-centered care. By aligning contractual expectations with education, infrastructure, and continued provider support, the CCO is driving forward the adoption and effective use of EHRs as a key enabler of coordinated care across physical, oral, and behavioral health systems.

Strategy 1 title:
Outreach and education about the value of EHR adoption/use

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

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

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

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

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

To support increased adoption of Electronic Health Records (EHR) among providers, we will focus on educating providers about the importance and benefits of EHR systems. This includes explaining how EHRs improve care coordination, enhance patient safety, reduce errors, and support better health outcomes. Clear messaging will emphasize how EHR use can streamline documentation, make patient information more accessible, and support compliance with reporting requirements.

As part of this effort, we will share examples of affordable and user-friendly EHR systems that are already being used successfully by other providers in the network. These may include platforms such as **Athenahealth**, **Kareo**, and **Practice Fusion**, which are known for being cost-effective, easy to implement, and supportive of smaller practices. By highlighting real-world use cases and provider testimonials, we aim to build trust and confidence in the adoption process, showing that transitioning to an EHR system is both achievable and beneficial.

Planned Activities	**Planned Milestones**
1. Education Development 2. Dissemination to targeted group of providers (ex: providers on list with either “No EHR’” or “EHR status unknown” 3. Provision of support with questions around selection, implementation, and cost.	A. **Number/percentage of providers** who begin EHR implementation after the campaign. B. **Growth in EHR adoption** will be measured for next year’s submission, giving one year for measurement.

Strategy 2 title:
Assessment/tracking of EHR adoption and capabilities

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):

As part of our ongoing effort to assess and track EHR adoption and capabilities across the provider network, we have made notable progress in improving data accuracy and visibility. A key advancement has been the implementation of structured EHR data field collection at the point of provider contracting. By embedding this requirement early in the provider onboarding process and the recontracting/renegotiation process, we have significantly reduced the volume of providers listed with an “unknown EHR status” in our system.

Prior to this enhancement, a substantial portion of our network lacked complete or verified EHR information, which hindered our ability to analyze adoption trends and plan targeted outreach. Since the implementation, we've observed a marked improvement in data completeness—most notably, a sharp decrease in the number of providers categorized under “unknown EHR status.” Providers are now prompted to supply EHR details during contracting, ensuring we capture this information upfront rather than relying on post-contract outreach.

In addition, we’ve seen a modest but meaningful shift in the number of providers previously identified as having “NO EHR” who have since been updated with a named EHR platform. While many of these updates have come from ongoing outreach and education efforts, the improved tracking infrastructure has made it easier to follow up with providers and monitor changes in adoption over time.

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

Plan to continue tracking this information by having it as a required data field in the contracting intake process.

Planned Activities	**Planned Milestones**
1. Continue requiring this data field during the contracting/recontracting/renegotiation process.	1. Extraction of this data at time HIT Roadmap measurement cycle.

Strategy 3 title:

Requirements in contracts/provider agreements

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):

A key component of our strategy to enhance EHR adoption tracking has been the inclusion of EHR reporting requirements within provider contracts and Participating Provider Agreements. By formalizing the expectation that providers disclose their EHR status and platform during the contracting process, we’ve created a consistent mechanism for collecting this data at the outset of the provider relationship. This approach has already

contributed to improved data completeness and has reduced gaps in our understanding of the network's EHR landscape.

It is important to acknowledge, however, that while this contractual requirement has been in place for some time, many providers in our network still either do not have an EHR or have not reported their EHR system as required. This disconnect underscores the need for continued education and engagement. As part of our upcoming provider education initiative, we will include a targeted reminder that reporting EHR status is not only a best practice for enhancing care coordination and quality—it is also a contractual obligation outlined in the agreements they have signed.

The intent of this educational outreach is not only to promote the benefits of EHR adoption but also to ensure providers are aware of their responsibilities and to encourage compliance through a more collaborative, informed approach. By combining contractual alignment with ongoing education, we aim to improve data transparency, strengthen our provider partnerships, and support a more interoperable and value-driven healthcare network.

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

Planned Activities

1. Education Development
4. Dissemination to targeted group of providers (ex: providers on list with either "No EHR'" or "EHR status unknown"
5. Provision of support with questions around selection, implementation, and cost.

Planned Milestones

C. **Number/percentage of providers** who begin EHR implementation after the campaign.
D. **Growth in EHR adoption** over a year.

E. EHR Support Barriers:

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

Despite ongoing efforts to support EHR adoption, use, and optimization among our contracted providers, several barriers have inhibited full progress—particularly among the behavioral health provider community. While we have made strides in improving EHR data collection at contracting and increasing provider education on the value of EHRs, a significant portion of behavioral health providers continue to report "NO EHR" or remain in the "EHR status unknown" category.

One of the primary challenges driving this trend appears to be the shifting structure of behavioral health delivery. Over the past several years, we have observed a marked migration of behavioral health professionals from larger group or organizational settings into solo practice arrangements. Many of these independent providers now operate from their homes via telehealth platforms, offering flexibility and access but often doing so with limited administrative or technical support. For these solo practitioners, the adoption of an EHR can be cost-prohibitive and perceived as burdensome due to the steep learning curve, ongoing maintenance, and perceived lack of immediate value. As a result, many rely on basic documentation tools rather than full-scale, interoperable EHR systems.

This trend poses a unique barrier to coordinated care, as the absence of interoperable systems among a growing segment of the behavioral health network limits our ability to achieve full integration across physical, oral, and behavioral health services.

C. OHA Support Needs:

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

We believe that a stronger, unified message from the Oregon Health Authority (OHA) could help shift this dynamic. Specifically, CCOs would benefit from OHA-developed branding and messaging that clearly articulates the importance of EHR adoption and the expectation that all providers—regardless of practice size or modality—move toward systems that support care coordination and data sharing. An OHA-branded campaign could lend additional authority and consistency across CCO efforts, helping to reinforce the message that EHR adoption is not only a best practice but an essential element of delivering high-quality, person-centered care.

We remain committed to supporting our providers through education, technical assistance, and contract alignment, but broader systemic support and messaging from OHA would greatly strengthen our efforts and help address the persistent gaps in behavioral health EHR adoption.

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

A. CCO Use of HIE for Care Coordination and Hospital Event Notifications: 2024 Progress & 2025-26 Plans

Please describe your 2024 progress and 2025-26 plans for using HIE for care coordination, including risk stratification, AND timely hospital event notifications within your organization. In the spaces below (in the relevant sections), please:

1. Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.
2. List and describe specific tool(s) you currently use or plan to use for care coordination, including risk stratification, and timely hospital event notifications.

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

Notes:

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2025, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

Strategy category checkboxes (within CCO)
Using the boxes below, please select which strategies you employed during 2024 and plan to implement during 2025-26. Elaborate on each strategy and your progress/plans in the sections below.

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

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

- **Arcadia Population Health System:** Configured to integrate provider electronic health record (EHR) data with other data sources, supporting care coordination and metric performance through the exchange of member data.
- **Clinical CareAdvance (CCA):** A care coordination data system that has been updated for greater configurability and support of data exchange for care coordination purposes.
- **PointClickCare/Collective Medical:** A statewide system providing hospital event notifications and care management notes to support care coordination and management of high-risk populations.
- **UniteUs Platform:** Enhanced for data exchange functionality, integrating referral capabilities across contracted providers and community-based organizations, and adding case management and touch point tracking capabilities.
- **Secure File Transfer Protocol Site:** Previously utilized for exchanging member data for transitions of care between CCOs (now decommissioned and under evaluation for alternative solutions).
- **OCHIN/EPIC/CareLink:** Utilized to enhance care coordination and patient support, including patient record access, information lookup/sharing, communication.
- **John's Hopkins ACG:** Platform to develop risk level and scores using claims and population health analytics software.

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

Our approach integrates leveraging technology platforms like Arcadia, CCA, and PointClickCare, among others, to facilitate real-time data sharing and collaboration across the healthcare continuum. Our strategy emphasizes the importance of bi-directional data exchange, interoperability, and utilizing hospital event notifications to enhance care coordination, particularly for high-risk populations. Through engaging providers in educational forums and leveraging data for performance improvement, we aim to foster a data-driven ecosystem that supports comprehensive care coordination efforts.

For the period 2025-2026, we aim to expand upon our current HIE infrastructure and capabilities to facilitate more customized and tailored healthcare interventions. This includes leveraging HIE/event notification data to create composite risk scores, augmenting this data with claims and health risk assessment data to design targeted care plans for members with high complexity/needs, and implementing additional connectors to intake data directly from healthcare providers into our Arcadia system for conducting population health activities aimed at closing gaps in care.

As we move forward into the 2025-2026 period, IHN-CCO is committed to significantly advancing our strategies around the utilization of health information exchange (HIE) and hospital event notification data. Our plans are to enhance our risk stratification processes and implement targeted care interventions more effectively. These initiatives are not only geared towards meeting the latest Oregon Administrative Rules (OAR) requirements but are also aimed at refining our internal processes for better health outcomes for our members.

Key Components of the 2025-2026 Strategy:

1. Developing a Robust Composite Risk Stratification Process- Identifying member needs with greater precision.
2. Enhancements to Data Integration and Reporting-Transforming complex data into actionable insights.
3. Leveraging Hospital Event Notifications (HEN) for Real-time Insight- Responding faster to critical events.
4. Targeted Care Coordination and Interventions- Delivering personalized care based on individual needs.
5. Automate HIE data integration internally to support care coordination and improve member outcomes.

Our goal for the next three years is to leverage advanced technology and data integration to provide a more personalized and efficient healthcare experience for our members. This will involve close collaboration with our technology partners, ongoing process optimization, and a steadfast commitment to meeting the evolving needs of our members through innovative care coordination strategies. By levering technology and data, through close collaboration with our technology partners, continuous improvement, and innovative care coordination strategies, we aim to set a new standard in member care- **proactive, responsive, and focused on optimal health outcomes.**

Strategy 1 title: : **Develop a Robust Composite Risk Stratification Process**

To create and implement a risk stratification system that integrates multiple data sources, including HIE data from John's Hopkins ACG, Arcadia, PointClickCare (POINTCLICKCARE), health risk assessments from patients/members, and claims utilization data. This composite risk stratification process will enable us to assess members' risk levels accurately and stratify them into categories that will inform specific referrals and outreach by care coordinators. For instance, the approach to care coordination for members identified as 'High' risk will be distinct from those categorized under 'Moderate' risk.

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

☒ 1: Care Coordination ☐ 2: Exchange care information ☐ 3: Integration of disparate information
☒ 4: HIE tool enhancements ☐ 5: Partner collaboration ☒ 6: Risk stratification & population segmentation
☐ 7: Other:

Strategy status:

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

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

1. Developed and Implement a Composite Risk Stratification Process utilizing data from John's Hopkins ACG and Arcadia Population Health System
2. Scaled the utilization of HEN and HIE Data for real-time alerts and Targeted Interventions as required in the OAR requirements.
3. Evaluated and adjusted Care Coordination Strategies with robust policies and work-instructions.
4. Developed a framework for creating composite risk scores using HIE/event notification data, medical claims, and health risk assessments.

5. Completed the enhancement of the data warehouse to support the integration of diverse data sources. This step is crucial for the actionable packaging of data for risk stratification.

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

1. Monthly Risk Stratification reporting
2. Weekly change in health-related circumstance reporting.
3. Continuing to refine our process of outreach and assessment completion

Planned Activities	**Planned Milestones**
1. Train staff and implement risk stratification model. 2. Continue collaborating with HPIS for integration of the approved risk stratification model.	1. By Q1 2025, create new training material and documentation for the CM team regarding the targeted intervention and/or workflows that incorporate the Risk Stratification methodology.

Strategy 2 title: **Enhancements to Data Integration and Reporting**

Significant enhancements are planned for our system to facilitate the ingestion, integration, and packaging of diverse data types across disparate data systems to enhance integration and reporting capabilities. These enhancements are crucial for making the information actionable for risk stratification and ensuring our team has the best insights into our members' health statuses in the timeliest manner possible.

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

☒ 1: Care Coordination ☐ 2: Exchange care information ☒ 3: Integration of disparate information
☒ 4: HIE tool enhancements ☐ 5: Partner collaboration ☒ 6: Risk stratification & population segmentation
☐ 7: Other:

Strategy status:

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

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

1. Incorporated additional data into the data warehouse (such as Arcadia risk tables, HRA information, etc.) to use this information in tandem with other source data and across disparate systems for more robust analytics.
2. Made additional information readily available such as risk tables for long-term and self-servicing reporting needs.
3. Created Power BI datasets and/or dashboards by having greater access to CM data and provide timely operational information. Continuing to collaborate with HPIS on report readiness. Making widely versatile data sets also allows IHN-CCO to create report mockups more quickly and expedite report development for upcoming reporting needs

4. Throughout 2025, evaluate and report on the impact of automation on closing care gaps and promoting value-based care

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

Specific enhancements include implementation of APIs and/or data exchange capabilities that will enable IHN to ingest population health, gaps in care, and member risk data from Arcadia into our care coordination platform CCA and vice versa. Similar bidirectional data enhancements are planned for Facets, our claim system, and

CCA., This will include pulling information from Facets that is not currently visible to the care coordination module of CCA, such as appeals and grievance, and making it more readily available to the care management team

Planned Activities	**Planned Milestones**
1. Establish short and long-term plans for getting on a regular cadence for upgrading Clinical CareAdvance (May 2025) and Facets (August 2025). This will allow for IHN-CCO to frequently adopt new features and functionality in the CM module of the CCA platform.	1. By Q3 2025, develop and deploy enhanced reporting capabilities informed by progress of 2024 to Q1 2025, designed to support comprehensive population health initiatives and data-driven decision-making, improving care coordination activities, and enhancing HIE data exchange. 2. By 2026, utilize enhanced reporting to launch additional targeted care coordination activities based on insights derived from integrated data analysis.

Strategy 3 title: **Leveraging Hospital Event Notifications (HEN) for Real-time Insight**

A pivotal part of our strategy includes utilizing HEN for instant alerts and insights, enabling us to capture and identify changes in members' health statuses quickly. This real-time data is instrumental in our ability to respond promptly with appropriate care coordination protocols.

Specifically, this includes alerts for the following types of events, though the list is not exhaustive: Rising risk, High risk pregnancy diagnosis; change in health-related status; new diagnosis of medical severity or high priority; etc. This is in addition to existing alerts, such as the one for our member population that fall into the substance use disorder category. These alerts, in tandem with new workflows being designed through the Care Coordination Redesign work, may trigger proactive or comprehensive care coordination activities such as member outreach, notifying or contacting a member's PCP, ensuring that proper follow-up is observed for members to improve outcomes and that gaps in care are being properly closed to improve quality and CCO metric performance.

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

☒ 1: Care Coordination ☒ 2: Exchange care information ☐ 3: Integration of disparate information
☒ 4: HIE tool enhancements ☐ 5: Partner collaboration ☒ 6: Risk stratification & population segmentation
☐ 7: Other:

Strategy status:

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

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

1. Scale the utilization of HEN and HIE Data for real-time alerts and Targeted Interventions as required in the OAR requirements. (See bullets 1-3 under achievements)
2. Throughout 2024, we addressed and improved workflows that utilize HENs and HIE data to guide specific care coordination activities. (See bullets 4 and 5 under achievements)

Care Coordination and Care Management:

Achievements:

- Improved Member Identification: We refined how we use Hospital Event Notifications (HEN) to include identifying members needing care coordination.

- Targeted Support for High-Risk Groups: We leveraged Epic and PointClickCare to identify at-risk members, focusing on high-risk pregnancies and emergency department visits (use cases). This allows for earlier intervention from our care management team. This has also laid the framework for reactivation events (ED and inpatient admits and discharges) and provided a proactive identification and early notification of members with certain conditions or events of interest, such as the high-risk maternity cohort.
- Streamlined Workflows**:** We revised care coordination workflows to ensure efficient follow-up after notifications from PointClickCare to ensure timely and tailored response from our care management team.
- Enhanced Data Exchange**:** We upgraded APIs in CCA for better data flow from PointClickCare and Epic, improving care management and coordination.
- Secure Communication: We continued secure data exchange with providers and explored alternative methods for improved efficiency.

The journey toward fully integrating and utilizing HIE and event notification data has not been without its challenges.

Challenges included:

- The complexity of integrating diverse data sources for comprehensive risk scoring and targeted interventions. Bi-directional data exchange proved more challenging than expected, and for the most part still a manual process. Work is continuing how to enhance and possibly automate this process.

Despite these challenges, IHN-CCO has made progress in configuring our platforms to meet the evolving needs of our members and providers. Our collaboration with PointClickCare to develop critical reports, the focus on high-priority conditions, and enhancing our data exchange and communication frameworks stand as testaments to our commitment to advancing the use of HIE and event notification data for improving care coordination and health outcomes.

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

Planned Activities	**Planned Milestones**
1. Scale the utilization of HEN and HIE Data for real-time alerts and Targeted Interventions as required in the OAR requirements.	1. By Q3 2025, integrate HEN events into the care coordination workflows to align with OAR requirements. Real time hospital and skilled nursing notifications will be available to guide the level of care coordination intervention.

Strategy 4 title: **Targeted Care Coordination and Interventions**

By implementing targeted interventions based on the refined risk stratification process and real-time insights from HEN and other HIE information, we aim to improve health outcomes. Our care team will be equipped to manage our IHN members' health proactively, tailoring interventions to meet the specific needs of different risk categories

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

☒ 1: Care Coordination ☒ 2: Exchange care information ☐ 3: Integration of disparate information
☒ 4: HIE tool enhancements ☒ 5: Partner collaboration ☒ 6: Risk stratification & population segmentation
☐ 7: Other:

Strategy status:

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

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

1. Updated and created new care coordination workflows to holistically capture future state for clinical operations.
   A. Implemented monthly reporting for newly identified high/mod risk stratified members and members with rising risk scores from no/low to mod/high

B. Implemented weekly reporting for change in health related circumstance changes for targeted outreach for newly identified care management needs.

2. Evaluated and refined care coordination strategies based on the revised OAR.
   A. Implemented targeted interventions for Mod and High Risk stratified members
   B. Implemented Care Plans for all Mod/High Risk stratified members and all LTSS members
   3. Completed leveraging of Arcadia in support of care coordination, which includes staff training and upskilling, as well as enhanced API connections with the Clinical Care Advance platform to further promote data integration for care coordination

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

Planned Activities	**Planned Milestones**
1. Throughout 2025-2026, utilize enhanced reporting to launch targeted care coordination strategies based on insights derived from integrated data analysis. 2. 2025-2026, use the insights gained from the initial evaluations to make necessary adjustments to strategies and care plans. This iterative process is aimed at continuously improving the effectiveness of care coordination and targeted interventions.	1. By Q1 2025, begin incorporating the Risk Stratification methodology outlined in Strategy 1 into the CM workflow design, ensuring that members are receiving tailored interventions based on their risk level.

Strategy 5 title: Automate HIE data integration internally to support care coordination and improve member outcomes

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):

Milestone 1 and 2 encompassed within 5B of this report. Milestone 3 is encompassed in strategy 2 and 3 above. Milestones 4 and 5 is noted and encompassed in Strategy 2 above regarding enhanced reporting capabilities.

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

As mentioned in the opening remarks above, our vision for 2024-2026 is to create a more connected, efficient, and responsive ecosystem that leverages the full potential of data to improve care outcomes and promote value. By focusing on enhancing system interoperability, updating our data measures, and supporting our providers with the resources they need, we aim to make significant strides in improving the health of our members and the effectiveness of our care coordination efforts.

Planned Activities	**Planned Milestones**
1. Implement Additional Modules for Interoperability and Data Exchange	1. Complete the integration of additional data connectors into Arcadia for direct data intake from 90% of primary care providers that are most utilized

2. Invest in Enhanced Reporting to support care coordination activities. 3. Increase Staff Capabilities and Continue Technology Investment	by our membership by Q1-Q2 2024. This will impact our county FQHC clinics in our tri-county area, as well as Coastal Health and Valley Clinics and represents a total of 9 large health systems/medical provider groups spanning the region, many with multiple clinic locations. 2. Implemented Q1 2024 Arcadia's Assess module to give healthcare providers the ability to provide proof of real time care gaps closure. This helps streamline and provide a more accurate picture of remaining care gaps that may require health plan care coordination efforts. 3. By the end of Q1 2024, complete a roadmap of leveraging Arcadia in support of care coordination, which will include staff training and upskilling, as well as enhanced API connections with the Clinical Care Advance platform to further promote data integration for care coordination 5. Throughout 2025, evaluate and report on the impact of automation on closing care gaps and promoting value-based care 5. By 2026, utilize enhanced reporting to launch additional targeted care coordination activities based on insights derived from integrated data analysis.

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

Please describe your 2024 progress and 2025-26 plans for supporting increased access to and use of HIE for care coordination and timely hospital event notifications for contracted physical, oral, and behavioral health providers. Please include any work to support clinical referrals between providers. In the spaces below (in the relevant sections), please:

- Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.
- List and describe specific HIE tool(s) you currently or plan to support or provide for care coordination and hospital event notifications. CCO-supported or provided HIE tools must cover both care coordination and hospital event notifications. Please include an overview of key functionalities related to care coordination.
- Report the number of physical, oral, and behavioral health organizations that have not currently adopted HIE tools for care coordination or do not currently have access to HIE for hospital event notifications using the Data Completeness Table in the OHA-provided CCO Health IT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.
- (Optional) Provide an overview of CCO's approach to supporting increased access to and/or use of HIE for care coordination and hospital event notifications among contracted physical, oral, and behavioral health providers.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 to support increased access to and/or use of HIE for care coordination and hospital event notifications among contracted physical, oral, and behavioral health providers include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. Strategy status
    d. Provider types supported
    e. A description of 2024 progress, including:

i. accomplishments and successes (including the number of organizations of each provider type that gained access to HIE for care coordination tools and HIE for hospital event notifications as a result of your support, where applicable)
ii. challenges related to each strategy, as applicable

Note: Where applicable, information in the CCO Health IT Data Reporting File should support descriptions of accomplishments and successes.

f. (Optional) An overview of CCO 2025-26 plans for each strategy
g. Activities and milestones related to each strategy CCO plans to implement in 2025-26

Notes:

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2025, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

Strategy category checkboxes (supporting providers)
Using the boxes below, please select which strategies you employed during 2024 and plan to implement during 2025-26. Elaborate on each strategy and your progress/plans in the sections below.

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

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

Point Click Care - IHN-CCO utilizes PCC as our main platform to provide timely hospital event notification. We are currently in the beginning stages of conversation with one of our partners in how we elevate the care coordination aspect of care within PCC to drive even more value.

Clinical CareAdvance – CCA is the platform that the SHP Care Coordination team uses to enter care plans, member preferences, goals, milestones, and other critical information needed to treat members in a holistic manner. Certain PCC notifications and clinical identifications such as enhanced ADT feeds will also be integrated into CCA as part of our Care Management Redesign. This will allow for the care management team to have timely information from facilities available on a single platform and have targeted tasks/notifications related to important changes of health condition for each member. Additional automation or complexity can be built upon this foundation, as these specific identifications for various clinical indicators will assist with providing timely and appropriate care for members. Reporting for members having these PCC flags for certain conditions will also be available, allowing IHN-CCO to perform more robust population analytics and see trends over time that will inform the effectiveness of our care management strategies.

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

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

According to the IHN-CCO updated Data Completeness Table, 23 physical health (45%), 160 behavioral health (96%), and 21 oral health providers (84%) do not currently have access to an HIE tool for care coordination or for hospital event notifications.

Strategy 1 title:
[Brief description]

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
As a new strategic direction for IHN-CCO in 2023, Strategy 1 focuses on enhancing data sharing and collaboration with county and provider pilot partners, specifically targeting areas of community mental health, and high-risk maternal care programs.

Although this new strategy in its early stages it is pivotal in addressing the challenges of managing disparate information systems and the historical lack of efficient information sharing/data exchange. While this is a new initiative there are few significant leaps in progress to report, early progress so far has included

- Identifying mental health and maternal health as initial use cases.
- Initiating conversations with potential pilot partners.
- Begun discussions on data exchange and coordinated care planning for maternal health, leveraging CCA and other platforms.

The initiation of Strategy 1 aligns with and supports the broader objectives set forth in previous strategies above aiming to leverage advancements in health information exchange (HIE), interoperability, and data integration to improve care coordination and outcomes across our network. Specifically, it builds on:

- Enhancing Targeted Interventions: The collaboration with pilot partners enables targeted care interventions to be more coordinated and informed. Shared data and insights facilitate the identification of

members at high risk or in need of specific interventions, particularly in community mental health, preventative/wellness care, and high-risk maternal care programs. We began conversations in 2025 with one site, however, due to staffing challenges on their end, we haven't yet fully kicked this off the ground. Met again with the site in March and working towards a September date as they are getting additional staffing, and would be in a better place to work on data integration, transfer and enhanced care coordination between our teams.

- Automating Data Integration: By working to share care plan information and coordinate between care teams, this strategy naturally extends the efforts to automate data integration for real-time data sharing. Increasing data sharing with county and provider pilot partners enhances the effectiveness of these automated systems, ensuring that real-time data sharing translates into actionable insights and coordinated care efforts.

(Optional) **Overview of 2025-26 plans for this strategy**:
This strategy involves expanding partnerships with counties and providers to enhance data sharing capabilities, focusing on seamless integration of care coordination and collaboration tools to support a more coordinated care model across the network. Although early in ideation, this promises to significantly impact our ability to coordinate care, share critical information, and monitor progress on key health outcomes collaboratively.

Our focus for the 2024-26 period is set on laying a solid foundation for a more integrated care model. This initiative is poised to enhance our approach to care coordination, leveraging partnerships to address the complexities of healthcare delivery and information management. This includes:

1. Targeted Pilot Programs and expansion of network partnerships**:** Selecting a few pilot programs based on partner readiness to engage in enhanced data sharing practices and member needs. Initial areas will include community mental health, high-risk maternal care, and other CCO performance metrics.

2. Collaborative Framework: Establishing agreements with partners outlining shared goals, responsibilities, and data sharing expectations. The goal is ensure that all parties are aligned and committed to improving health outcomes through integrated efforts.
3. Enhanced Data Sharing Capabilities: Upgrading IT infrastructure to enable seamless data exchange and ensure care teams have actionable real-time information as outlined in section 2A
4. Collaboration Tools: Integrating tools that facilitate the exchange of care plans, monitoring of CCO metrics, and tracking of progress on shared health outcomes communication and coordination among care teams. This enhancement means leveraging additional tools in Arcadia such as the Arcadia complex care management Impact Score to identify and share members most in need of care coordination or with care coordination gaps, and Arcadia's Assess module, which directly connects IHN-CCO to our partner clinics and their EHR, enabling communication and information exchange, such as enabling the IHN-CCO team to review clinical documentation about members, their gaps in care, and other quality/clinical information. It also enables our partners to upload supplemental documentation for quality and value-based payment initiatives. Another tool facilitating information exchange are the HIE tools mentioned in section 2A; OCHIN/EPIC/CareLink**.** These collaboration tools enable our team to review other providers and community partner information. For instance, our CM team is now able to view care plans and documentation for the County MCM programs, which they have been unable to see in the past. This is paramount because we are often coordinating care and care planning for members that are also receiving similar services from other programs or providers.
5. Monitoring and Evaluation: Continuously monitoring the impact of these efforts on key health outcomes, allowing adjustments to enhance care coordination.
6. Promoting Value-Based Care**:** Enhanced data sharing and collaboration will enable us to leverage collective resources and expertise, improving care delivery efficiency and promoting value-based care.

This strategy we anticipate will strengthen our network's capacity for delivering comprehensive, coordinated care, thereby supporting our overarching goals of improving health outcomes, enhancing patient experience through coordinated care, and promoting value-based care. It will also create a more integrated, efficient, and responsive healthcare ecosystem that prioritizes our members' needs

Planned Activities	Planned Milestones
1. Expand Data Sharing Agreements and Integration with Pilot Partners 2. Launch a discovery process with Point Click Care on how to better utilize their platform for data sharing and care coordination activities. 3. Launch Pilot Projects to Utilize HIE Information and Integrated Care Models to Improve Care Outcomes. Benton county has agreed to work with IHN on this pilot of utilizing Point Click Care to support inter-organization care coordination management	1. By Q4 2024, identify specific care coordination and outcome improvement opportunities that can benefit from enhanced HIE information use and coordinated care models. This will involve working closely with pilot partners to pinpoint areas to have the most impact. 2. By Q2 2024, complete discovery process with Point Click Care to begin planning for pilot with Benton County 3. By Q1 2025, finalize and establish new data sharing/integrated care agreements with at least two additional county or provider entities. 4. Between Q4 2024 and Q1 2025, officially launch pilot projects designed to leverage HIE information for designing targeted care plans and coordinating care across different service providers. 5. By mid-2026, evaluate the outcomes of pilot projects to identify successful interventions and practices that can be scaled. This evaluation will focus on improvements in care coordination, patient outcomes, and efficiency gains.

Strategy 2 title:
[Brief description]

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):
Throughout 2023, IHN-CCO made progress in automating data integration and sharing with clinics to enhance care outcomes and foster value-based care. By the end of Q1 2024, IHN will be connected to seven clinics representing ~90% of our member utilization of services through Arcadia utilizing connector builds to our network provider EHRs. These connectors enable bidirectional communication of information. This directly connects IHN-CCO to our partner clinics and their EHR, enabling communication and information exchange, such as enabling the IHN-CCO team to review clinical documentation about members, their gaps in care, and other quality/clinical information. It also enables our partners to upload supplemental documentation for quality and value-based payment initiatives.

Our progress has been marked by substantial accomplishments in expanding electronic health record (EHR) integrations, leveraging data for care coordination, and overcoming challenges related to system enhancements and staffing. The progress made in 2023 sets a solid groundwork for further advancements in improving outcomes and promoting value-based care across our network.

Achievements:

- EHR Integration Expansion: Successfully expanded EHR integrations within our region, marking a significant step towards comprehensive data sharing and integration across our service area. This expansion has facilitated better access to patient information, enabling more informed care decisions and efficient care coordination. 90% of primary care clinics that are most utilized by approximately 80% of our IHN members are now connected to IHN through Arcadia in the manner described throughout this

document. These clinics encompass both physical health and behavioral health. Clinics that are/will be connected include Samaritan Health System, Lincoln and Benton County Clinics, The Corvallis Clinic, Coastal Health Practitioners, Corvallis Family Medicine, and Valley Clinics.

- Leveraging utilization data in Arcadia as a foundation of IHN's risk stratification strategy to significantly enhance care coordination.

Challenges:

- Staffing Constraints and Competing Priorities: Faced challenges in updating our Arcadia platform due to staffing constraints and competing priorities.
- As we advance our efforts in automating data integration and sharing with clinics, our focus remains on enhancing system capabilities, expanding provider outreach and education, and refining our strategies to meet the evolving needs of our members.

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

Upcoming strategies include advanced technologies and processes to automate data integration and sharing with clinics, aiming to streamline care coordination processes, close gaps in care, and support the transition to value-based care models.

Building on our progress through 2023, IHN-CCO has laid out a strategy for 2024-2026 to further automate data integration and sharing with clinics, thereby enhancing care outcomes and promoting value-based care across our network.

Our strategy focuses on several key areas, aiming to deepen our engagement with technology and data to support our healthcare providers and ultimately benefit our members and providers.

We are committed to providing more resources and data to our providers, enabling them to deliver the most effective care possible. This includes training, technical support, and access to comprehensive patient data through our integrated systems. Through the new modules and enhanced reporting capabilities, providers will have the tools they need to track progress against the goals set forth for them, both contractually and in terms of quality care delivery metrics.

Our vision for 2024-2026 is to create a more connected, efficient, and responsive ecosystem that leverages the full potential of data to improve care outcomes and promote value. By focusing on enhancing system interoperability, updating our data measures, and supporting our providers with the resources they need, we aim to make significant strides in improving the health of our members and the effectiveness of our care coordination efforts.

Planned Activities	**Planned Milestones**
1. Implement Additional Modules for Interoperability and Data Exchange 2. Invest in Enhanced Reporting and Support Population Health Initiatives and care coordination activities 3. Increase Staff Capabilities and Continue to refine PCP attribution through Arcadia functional PCP assignments, engaging the enrollment team for updates on PCP assignments in Facets. 4. Additional Technology Investment via new modules and staffing resources	1. Complete the integration of additional data connectors into Arcadia for direct data intake from healthcare providers via Arcadia ASSESS module implementation and validation by the end of Q2 2024 2. Identify and select additional modules in Arcadia that support increased interoperability and seamless data exchange with providers.-throughout 2024 3. Throughout 2025, evaluate and report on the impact of automation on closing care gaps, supporting care coordination ` and promoting value-based care. 4. By Q4 2024, develop a framework for identifying and maintaining accurate PCP attribution in EHRs, Arcadia, and Facets to aid in care coordination efforts and ensuring more accurate metrics reporting across disparate systems

Strategy 3 title:
[Brief description]

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):

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

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

Strategy 4 title:
[Brief description]

Strategy categories: Select which category(ies) pertain to this strategy
☐ 1: 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):

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

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

C. HIE for Care Coordination Barriers

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

Point Click Care (PCC) would be ideally utilized by every contracted provider that works with Samaritan. One challenge is reaching out to facilities that do not currently use PCC to track timely event information on members and getting them to start working with this tool. This could potentially be seen as an additional administrative burden performing additional documentation from providers and facilities and could lead to hesitation to adopt the tool. IHN-CCO will be able to campaign and discuss the use of PCC with providers, but there would be no guarantee of facilities converting to using the platform due to various obstacles of adoption on the provider side. Feedback from our HIAC echoes this sentiment, but also optimism that if we are able to leverage PCC as a value add for care coordination between organizations, our network providers may see that as a value add, and a reason to utilize PCC more. A pilot project described in this document with Benton county clinics aims to do just that, so we can have a use story for other network providers.

D. OHA Support Needs

How can OHA support your efforts to support your contracted providers with access to and use of HIE for care coordination and/or Hospital Event Notifications?
OHA could support contracted providers with access and use of HIE for care coordination and Hospital Event Notifications by offering assistance to providers to tackle the tasks that the providers see as roadblocks to adopting the tool. This could take the form of technical assistance, staff augmentation/training, campaigning to leverage the tool by showing positive impacts on care coordination, or having some form of standardization where certain facilities would be asked to adopt and continue to use PCC. This is a tool that becomes increasingly more effective as a greater proportion of (especially Oregon) facilities use the tool to communicate updates about member health status and inpatient stays.

E. CCO Access to and Use of EHRs

Please describe CCO current or planned access to contracted provider EHRs. Please include which EHRs CCO has or plans to have access to including how CCO accesses or will access them (e.g., Epic Care Everywhere, EpicCare Link, etc.), what patient information CCO is accessing or will access and for what purpose, whether patient information is or will be exported from the EHR and imported into CCO health IT tools.
Which EHRs does CCO have or will have access to and how does or will CCO access them (e.g., Epic Care Everywhere, EpicCare Link, etc)?
CCO – IHN RN Care managers have access to EpicCare Link, OHSU Connect, Legacy Health, Providence Oregon, Peace Health, and Salem EpicCare Link. CCO is accessing Member records to review inpatient nursing notes, discharge orders, condition lists, assessments, medication lists, transition of care nursing notes, referral information, and lab/test results. Care managers are using this information to provide individualized care, provide member education, create informed and individualized care plans, and coordinate care.
What patient information is CCO accessing or will CCO access and for what purpose?
CCO is accessing Member records to review inpatient nursing notes, discharge orders, condition lists, assessments, medication lists, transition of care nursing notes, referral information, and lab/test results. Care managers are using this information to provide individualized care, provide member education, create informed and individualized care plans, and coordinate care. The information is accessed for the purpose of validating connectors from EHR to Arcadia to ensure that IHN-CCO is gathering information that aligns with clinical and administrative workflows**.**
Is/will patient information being/be exported from the EHR and imported into CCO health IT tools? If so, which tool(s)?
IHN-CCO clinic partners directly and securely send Arcadia EHR clinical data via flat files and SFTP sites. The data is ingested and processed in Arcadia where the data is available for eligible members and can be extracted through Arcadia's database Foundry. This information is also used as part of the overall data that goes into creating a risk score/level which is used to direct care.

6. Health IT to Support SDOH Needs

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

Please describe CCO 2024 progress and 2025-26 plans for using health IT within your organization to support social determinants of health (SDOH) needs, including but not limited to screening and referrals. In the spaces below (in the relevant sections), please:

- Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.
- List and describe the specific health IT tool(s) you currently use or plan to use for supporting SDOH needs. Please specify if the health IT tool(s) have closed-loop referral functionality (e.g., Community Information Exchange or CIE).
- (Optional) Provide an overview of CCO's approach to using health IT within the CCO to support SDOH needs, including but not limited to screening and referrals.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 for using health IT within the CCO to support SDOH needs, including but not limited to screening and referrals, include:
    1. A title and brief description
    2. Which category(ies) pertain to each strategy
    3. Strategy status A description of 2024 progress, including:
        i. accomplishments and successes (including number of referrals, etc., where applicable)
        ii. challenges related to each strategy, as applicable
    4. (Optional) An overview of CCO 2025-26 plans for each strategy
    5. Activities and milestones related to each strategy CCO plans to implement in 2025-26

Notes:

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned Milestones sections.
- If CCO is implementing a strategy beginning in 2025, please indicate 'N/A' in the Progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

Strategy category checkboxes (within CCO)

Using the boxes below, please select which strategies you employed during 2024 and plan to implement during 2025-26, within your organization. Elaborate on each strategy and your progress/plans in the sections below.

Progress	Plans		Progress	Plans	
☒	☒	1. Implement or use health IT tool/capability for social needs screening and referrals	☒	☒	7. Use data for risk stratification
☒	☒	2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)	☒	☒	8. Use health IT to monitor and/or manage contracts and/or programs to meet members' SDOH needs
☒	☒	3. Integration or interoperability of health IT systems that support SDOH with other tools	☒	☒	9. Use health IT for CCO metrics related to SDOH
☒	☒	4. CCO leads problem solving efforts and collaboration with their partners	☒	☒	10. Education/training of CCO staff about the value and use of health IT to support SDOH needs

☒	☒	5. Care coordination and care management	☒	☒	11. Participate in SDOH-focused health IT convenings, collaborative forums, and/or education (excluding CIE governance)
☒	☒	6. Use data to identify members' SDOH experiences and social needs	☒	☒	12. Participate in CIE governance or collaborative decision-making
☐	☐	13. Other strategies for adoption/use of CIE or other health IT to support SDOH needs within CCO (please list here):			
☐	☐	14. Other strategies for CCO access or use of SDOH-related data within CCO (please list here):			

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

Arcadia: The Arcadia Analytics platform aggregates multiple sources of data (claims and clinical), which allows analysts to drill down to identify the unique complexities within the IHN-CCO member population. This analytic capability allows for more accurate risk stratification, and segmentation of the population for applicable care interventions. Arcadia Analytics advances quality and performance improvement through calculation and presentation of population health data and will be a key source for social determinants of health data. Inputs include EHR records, claims data, and Unite Us/Connect Oregon data. Allows for analysis of REALD/SOGI data (Race, Ethnicity, Language, and Disability/Sexual Orientation Gender Identity) as well as social service information such as housing, food security, and transportation needs.

Collective Medical: The Collective Medical platform provides a common technology platform for real-time care coordination.

Unite Us/Connect Oregon: Unite Us/Connect Oregon is a community driven and locally sustained tool for social determinants of health screening and closed loop referrals. Connect Oregon facilitates continuous communication and referrals between IHN-CCO, Community Mental Health Providers, Oregon Cascades West Council of Governments (OCWCOG) (the regional Senior and Disability Services), Dental Care Organizations, Primary Care Physicians including Patient-Centered Primary Care Homes, Behavioral Health Homes, and Federally Qualified Health Centers, and community-based organizations. IHN-CCO has invested in and supports the use of Connect Oregon for Samaritan and other contracted providers, providing no-cost licenses and support throughout the region. IHN is in the process of optimizing UniteUs to support the implementation of Health Related Social Needs (HRSN) and is adopting the UniteUs Social Care Payments Module to facilitate an integrated reimbursement model while also integrating UniteUs internally to streamline care coordination and utilization management processes. This combined approach will provide an end-to-end process for facilitating the referral, review, authorization, invoicing and payment processes for HRSN service providers. In addition to the Social Care Payments Module, IHN is working with UniteUs to integrate an SDoH screening tool and to standardize SDoH risk screening while ensuring a trauma-informed approach and has in the process of implementing UniteUs enhancements for Community Investments, member matching data feeds, and SSO functionality. These modules, or enhancements, create sustainable social care capacity and can measurably impact the health of our members and community, they include:

- **Social Care Payments Module** reimburses providers for the services they deliver with the option to manage person-level eligibility and service payment authorization. This will allow for community-based organizations and other partners to provide services for social determinants of health needs, receive payment from IHN-CCO, and manage their member panel.
- **Community Investments** is an enhancement where IHN-CCO provides funding to providers and then monitors the service delivery and spending as it happens. Similar to the Social Care Payments Module, it allows organizations to track provided services, provide IHN-CCO with the data to monitor spending and manage member care more comprehensively.
- **Member Matching Data Feeds** is an automated feature that matches IHN-CCO member data with the data in Unite Us/Connect Oregon. This will lead to better data collection and overall understanding of IHN-CCO member needs, especially social determinant of health needs. The member matching data feeds will allow for insight into SDOH screenings leading to increased data for metrics reporting and evaluation.
- **SSO** is a step towards full integration of the platform allowing users to log in faster and provides a single point of authentication.

Epic Care Everywhere/Healthy Planet: IHN-CCO also supports integration of Epic EHR, which is used by regional Community Health Centers, Federally Qualified Health Centers, Community Mental Health Programs, and Samaritan Health Services (SHS). Through Epic, SDOH screening data is systematically collected and providers are supported with Epic enhancements designed to support care coordination. Epic Care Everywhere allows providers on the system to securely share patient records with other health care providers. Epic Healthy Planet is a software module that, through its suite of reports, dashboards, and workflow tools, compiles patient data and allows healthcare organizations' care managers to manage patient populations more efficiently.
TriZetto's' Clinical CareAdvance: IHN-CCO implemented CCA, a clinical operating system to provide our internal care management and utilization review team with a 360 view of the member. Through CCA, IHN-CCO care managers can effectively coordinate multiple services and supports, such as behavioral health, oral health and specialty providers, traditional health workers, transportation, and community-based support agencies. CCA enables care managers to effectively coordinate and document care transitions between episodes, treatment providers and settings, including hospitals, Oregon State Hospital (OSH), acute and rehabilitative facilities, transitional housing, and home. MCG clinical guidelines are integrated within CCA and support clinical decision making to determine the appropriate level of care, utilization of services, and timely coordination of care transitions.

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

IHN-CCO is dedicated to developing internal health IT systems that allow for equity driven approaches to SDOH needs. As a regional partner throughout the three county services area IHN-CCO is able to leverage substantial data resources to not only proactively identify member needs and assess intervention efficacy, but also to inform regional health equity conversations through the sharing, analysis, and facilitation of data systems. In addition to informing immediate outreach, referral pathways, and metric performance analysis, streamlined internal health IT systems will allow for informed long term investments in community health.

Strategy 1 title: **Proactive use of data to identify individual member SDOH experiences and social needs**

IHN-CCO maintains a community led approach to addressing SDOH needs; supporting community HIT infrastructure and serving as a resource and data analysis partner. Utilizing NCQA population assessment and data integration tools and working to integrate upstream approaches to SDOH though the Vital Conditions Framework IHN-CCO continues to assess available demographic data as well as community referral patterns captured in Unite Us, CCA, Arcadia, and Epic as part of developing effective SDOH interventions.

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

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

Strategy status:

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

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

2024 progress included the adoption of a new Community Health Improvement Plan developed in collaboration with members of the Partnership for Community Health and informed by the shared regional health assessment data, a collaborative approach to regional health challenges and priorities. IHN-CCO met or is on track with planned activities and goals for 2024 and is expanding the use of z-codes with contracted partners, supported the establishment of coordinated SDOH screening with health system partners, and has established internal analysis to identify HRSN presumed eligible members.

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

2025-2030 IHN-CCO CHIP includes increased housing data analysis and the development of strategies for data sharing and ongoing collaboration. IHN-CCO looks to develop data driven intervention programs through the

integration of health data (EPIC and IHN-CCO claims data) and housing data (including the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) and others. Baseline analysis of 2024 will occur early 2025 quarterly analysis will continue.

Planned Activities	**Planned Milestones**
1. Annual capture of baseline data 2. Continued education and implementation of z-code utilization, including for HRSN benefit provision 3. Establish data sharing agreements for community held SDOH data	1. Analysis of 2024 baseline data in Q1 2025 to establish improvement targets 2. Review claims data for z-code utilization quarterly 3. Begin integration of community held SDOH housing data (Q2 2025) and analyze (Q4 2025-Q4 2026)

Strategy 2 title: **Implementation of HIT tool/capability for social needs screening and referrals**

Utilization of Unite Us for screening, referrals, and HRSN benefit implementation

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

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

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Health Related Social Needs implementation drove a substantial increase in Unite Us utilization for benefit implementation and the roll out of the Social Care Payment Module. IHN-CCO's early investment in Unite Us as a closed loop screening and referral system allowed for progress to be made in implementing SDOH screening in Unite Us before the launch of HRSN benefits. Progress included an analysis of SDOH screenings being utilized by partners, a survey of partner satisfaction with screening options, and the adoption of the PRAPARE screening as the standard community based screening tool. Challenges have included increased workflow for partners who are utilizing platforms or screenings specific to their specialty (e.g. housing, youth mental health, etc.) and cross-platform communication to minimize over screening of members.

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

Increased outreach and incentivization for the use and reporting of approved SDOH screenings through contracts and value based metric targets. Ongoing optimization of Unite Us workflows, both HRSN and SDOH, though engagement with Unite Us around quality improvements.

Planned Activities	**Planned Milestones**
1. Review SDOH screening metrics and compare year over year engagement with SDOH screening 2. Explore additional Unite Us capabilities for Community Based Organization reimbursement for SDOH screenings	1. Quarterly reports, analysis Q1 2026 and Q1 2027 2. Survey of Community Based Organization partner satisfaction with Unite Us CIE tools.

Strategy 3 title: **Collaboration with network partners**

Collaborating with network partners to develop the technological framework that will support a regional social care network for the streamlined use of HIT/CIE

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

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

Strategy status:

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

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

IHN-CCO continues to engage with the Connect Oregon workgroup statewide and to develop strategies for implementation and optimization of shared HIT/CIE platforms to inform health programming both regionally and statewide. Facilitated collaboratives and workgroups increased knowledge and provided invaluable feedback as to the development of sustainable HIT models. Goals to increase Unite Us utilization and integrate the social care payments module in 2024 were met, however, the necessary focus on HRSN slowed the implementation of network wide utilization. Community partners, particularly small culturally specific CBOs and housing organizations experienced a surge in non-HRSN referrals necessitating a limiting of their engagement outside of the HRSN program.

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

IHN-CCO will continue to subsidize Unite Us licensure costs for the provider network and will expand outreach and technical assistance for non-HRSN use of SDOH tools.

Planned Activities	**Planned Milestones**
1. Continued support to organizations for the increased adoption of Unite Us SDOH modules. 2. Ongoing provider workgroups and community assessment of the Unite Us platform usability and efficacy for partner organizations.	1. Increased enrollment with Unite Us including quarterly referral assessment in 2025 and 2026. 2. Annual SDOH screening survey shows increased usage of PRAPARE and Unite Us capabilities. Q1 2026

Strategy 4 title: **Use HIT to monitor and/or manage contracts and/programs to meet members' SDOH needs**

Implementation of a comprehensive grant/community contract platform to support the development of a robust Social Care Network

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

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

Strategy status:

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

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

IHN-CCO selected and began implementation of Blackbaud grantmaking software to manage SDOH programmatic spending in 2024. Staff received training in Q3/4 for implementation in Q1 2025.

(Optional) **Overview of 2025-26 plans for this strategy**:
Utilization of increased reporting requirements from Unite Us platform to

Planned Activities	**Planned Milestones**
1. Utilization of platform for new RFP and community funding cycles 2. Assess feasibility of utilizing platform for reporting on previous funding cycles 3. Develop pathways to collect and retain reporting through platform	1. Build and utilize platform for 2 grant cycles by Q3 2025 2. Include reporting requirements in platform Q1 2026

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

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

- Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.

- List and describe the specific tool(s) you currently or plan to support or provide to your contracted physical, oral, and behavioral health providers, as well as social services and CBOs. Please specify if the tool(s) have screening and/or closed-loop referral functionality (e.g., CIE).
- (Optional) Provide an overview of CCO's approach to supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 to support contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals, include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. Strategy status
    d. Provider types supported
    e. A description of 2024 progress, including:
        i. Accomplishments and successes (including the number of organizations of each provider type that gained access to health IT to support SDOH needs as a result of your support, where applicable)
        ii. Challenges related to each strategy, as applicable
    f. (Optional) An overview of CCO 2025-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2025-26

Notes:

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2025, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones

Strategy category checkboxes (supporting providers)
Using the boxes below, please select which strategies you employed during 2024 and plan to implement during 2025-26 to support contracted providers and CBOs with using health IT to support SDOH needs. Elaborate on each strategy and your progress/plans in the sections below.

Progress	Plans		Progress	Plans	
☒	☐	1. Sponsor CIE for the community	☒	☐	7. Support payments to CBOs through health IT
☒	☐	2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)	☒	☐	8. Requirements to use health IT in contracts/provider agreements
☒	☐	3. Integration or interoperability of health IT systems that support SDOH with other tools	☒	☐	9. Track or assess CIE/SDOH tool adoption and use
☒	☐	4. Training and/or technical assistance	☒	☐	10. Outreach and education about the value of health IT to support SDOH needs

☒	☐	5. Support referrals from CBOs to clinical providers and/or from clinical providers to CBOs	☒	☐	11. Support participation in SDOH-focused health IT convenings, collaborative forums and/or education (excluding CIE governance)
☐	☒	6. Financial support to adopt or use health IT that supports SDOH (e.g., incentives, grants)	☒	☐	12. Support participation in CIE governance or collaborative decision-making
☐	☐	13. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs (please list here):			
☐	☐	14. Other strategies for supporting access or use of SDOH-related data (please list here):			

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

As outlined and described above, IHN-CCO supports and/or provides the following HIT tools to support SDoH needs:

- Arcadia
- Collective Medical
- Unite Us/Connect Oregon
- Epic Care Everywhere/Healthy Planet
- TriZetto's' Clinical Care Advantage

(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.**

In alignment with the 2025-2030 Community Health Improvement Plan, IHN-CCO is focused on both increasing connectivity of Health and SDoH systems on the shared assessment of data to identify regional health trends, barriers, and opportunities for partnership. Early projects to merge de-identified EPIC and Homeless Management Information System (HMIS) data have shown the methodology to be successful and are continuing. IHN-CCO's commitment to Health Equity focuses on community led adoption and data projects, and as part of the approach to supporting the adoption of CIE/HIT amongst partners IHN-CCO is supporting assessment support to ensure data collection and data security is rooted in the communities they represent. The use of CIE/HIT to incorporate existing programmatic data collection will best support continued partnership.

Strategy 1 title:
Sponsor CIE for the Community and provide Financial support for CIE implementation and/or maintenance.

Strategy categories: Select which category(ies) pertain to this strategy
☒ 1: Sponsor CIE ☐ 2: Enhancements ☒ 3: Integration ☒ 4: TA Assessment ☐ 5: Clinical←→CBO referrals
☐ 6: Financial support ☐ 7: Payments ☐ 8: Contract requirements ☒ 9: Track use ☒ 10: Outreach/education
☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

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

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

Progress IHN-CCO continues to subsidize the licensure cost of Unite Us throughout the region through the purchase of unlimited licenses, which has led to increased provider adoption. Increased utilization by IHN-CCO for the HRSN program expanded interest in adoption as well as increased demand for technical assistance and education support.

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

IHN-CCO plans to continue the sponsorship of CIE and robust technical assistance and educational opportunities for CIE/HIT adoption of Unite Us as preferred CIE platform but not to continue financial incentives for data transfer as this they did not address the actual need.

Planned Activities	**Planned Milestones**
1. Continue to provide technical assistance and training 2. Conduct community assessment of Unite Us functionality and needs outside of the HRSN project	1. Ongoing support through provider workgroups: ongoing in 2025 2. Individualized technical assistance: ongoing in 2025 3. Assess community needs for increased utilization of CIE by Q3 2025

Strategy 2 title:

Enhancements to CIE tools for increased functionality, health equity, SDoH data collection and HRSN utilization

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

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

Strategy status:

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

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

☒ Physical health ☒ Oral health ☒ Behavioral health ☒ Social Services ☒ CBOs

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

IHN-CCO was able to complete the planned assessment of SDoH screening tools and their integration into Unite Us and is currently building plans for a bi-directional connector with Arcadia for Health Plans. These actions are intended to address member feedback regarding the limited nature of the screenings and the need to ensure trauma informed practices with regards to data security, reducing over-screening and allow for increased use of SDoH screenings that reflect community needs. Progress related to HRSN is outlined in that section.

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

In addition to building connectors IHN-CCO in 2025-2026 IHN-CCO plans to assess the successes and challenges of CIE adoption for HRSN and assess ways to integrate existing partner workflows into CIE as well as exploring expanded use of CIE Social payments for grant administration.

Planned Activities	**Planned Milestones**
1. CIE Review and assessment for functionality and needs 2. Development of workflow requests to Unite Us for increased functionality based on partner feedback 3. Assess the ability to include additional 'home grown' SDoH assessments	1. By Q3 2025 2. Ongoing development of workflows 3. Work to include existing SDoH screeings as 'approved' OHA screenings: Q2 2025 and onward.

Strategy 3 title:

Utilization of HIT to support payments to Community Based Organizations

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

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

Strategy status:

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

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

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

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

IHN-CCO successfully implemented the social care payments module in 2024 for HRSN in Q2 of 2024, including the transmission of claims data, with multiple organizations. Extensive support and training for CBOs was necessary and continues to require subtantial staffing time. Challenges were primarily around the complexity of the HRSN program and limitations of the Unite Us platform, particularly relating to the ability to include multiple lines on a single invoice.

(Optional) **Overview of 2025-26 plans for this strategy**: As HRSN payments become operationalized IHN-CCO is developing and expanded plan to include additional payment pathways including grant invoicing, ILOS, and community social care payments.

Planned Activities	**Planned Milestones**
1. Continue HRSN improvements to CIE to increase ease of use and reduce errors 2. Continue assessmen of CCO reporting needs and CBO programmatic needs to prioritize and propose additional expansion of the social care payments module 3. Develop project scope for the addition of additional payment modules	1. Ongoing HRSN process improvement 2. Assessment of needs Q1/2/3 3. Project scope proposed Q2/3 2025

Strategy 4 title:
Integration of interoperability fo HIT systems that support SDoH with other tools

Strategy categories: Select which category(ies) pertain to this strategy
☐ 1: Sponsor CIE ☒ 2: Enhancements ☒ 3: Integration ☐ 4: TA Assessment ☒ 5: Clinical←→CBO referrals
☐ 6: Financial support ☒ 7: Payments ☐ 8: Contract requirements ☐ 9: Track use ☐ 10: Outreach/education
☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Evaluation of feedback regarding the one-way Unite Us/EPIC provider portal integration is ongoing. IHN-CCO has begun the process of building a bi-directional exchange with Unite Us and Arcadia to better ingest community data systems.

Planned Activities	**Planned Milestones**
1. Expand Unite Us bi-directional exchange capability through the development of 'connectors' with other HIT platforms.	1. Ongoing 2. Continue ongoing feedback and improvement processes though community engagement sessions through 2026

C. Using Technology to Support HRSN Services

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

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy): IHN-CCO successfully implemented Unite Us as the preferred CIE for HRSN implementation in 2024 including: closed loop referrals, authorizations, tracking of authorized services (e.g. months of rent, hours of Outreach and Engagement), service referrals, invoicing, claims billing implementation through the social care payment's module, and payment to CBO partners. IHN-CCO is exclusively utilizing Unite Us CIE for these processes (within the requirements of member consent) with external partners, while simultaniously maintaining internal systems to ensure full interoperability of authorizations and payments with established CCO processes.

2025-27 Plans: IHN-CCO is focused on process and workflow improvements for 2025-27 through ongoing engagement with the Connect Oregon statewide group and directly with Unite Us.

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

Progress (including previous year accomplishments/successes and challenges with this strategy): As described above, IHN-CCO has exclusively used CIE for the administration of the HRSN benefit with community partners including: Outreach and Engagement for eligibility referrals, closed loop service referrals, authorization tracking, invoicing and payment, and program monitoring (e.g. uploading of device serial number). In Q1 of 2025 IHN-CCO had 9 organzations actively utilizing CIE to participate in HRSN with an additional 20 enrolling and working to become HRSN providers. IHN-CCO has hosted twice monthly HRSN provider workgroups since Q32024 with CBO partners to actively support their enrollement and adoption of CIE for HRSN use.

2025-27 Plans: As outlined above, IHN-CCO will continue to focus on process and workflow improvements for 2025-27 to eliminate continued inefficiencies currently inherent in the Unite Us platform. The HRSN Provider Workgroup has now split into two groups, one for organizations actively using CIE to provide more technical support, and one for newer organziations for enrollement and orientation to the platform.

D. Health IT to Support SDOH Needs Barriers

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

In addition to the barriers outlined above, the primary barriers to partner adoption of CIE/HIT have been provider capacity and workload, particularly among CBO partners. As medical provider partners primarily utilize one of several large and established programs, CBOs utilize a patchwork of programs developed to meet their specific needs and requirements. As social service and SDoH providers (e.g. housing providers, education providers, etc.) have their own reporting and system requirements (e.g. HMIS) the implementation of CIE has often resulted in duplicate data entry rather than a streamlining of systems. IHN-CCO is working to overcome these but the vast number of programs meeting the varying needs poses significant challenges.

E. OHA Support Needs

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

IHN-CCO is currently exploring the feasibility of requesting screening approvals for sector specific SDoH screeings which would make adoption of CIE for SDoH screening more feasible for CBO partners. Additionally, OHA could review available Unite Us reporting for statewide reporting adoption.

7. Other Health IT Questions (Optional)

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

A. Describe CCO health IT tools and efforts that support **patient engagement**, both within the CCO and with contracted providers.
IHN is launching an upgraded member portal to increase digital engagement and accessibility, empowering users to take more self-service actions and ultimately leading to improved health outcomes for our members. This portal is expected to be in production in Q3 2025. Upon completion, our members will have a fully comprehensive platform from a member perspective. The features will include a single interface for all their health plan information such as benefit information, ID card, etc. IHN is also conducting a gap analysis to ensure that the portal functionality in scope for existing efforts will also address the new OARS requirements for data exchange related to Care Coordination activities. This will assist in determining if any additional features may need to be added to the scope of work involved in the portal build. In addition, IHN is launching a new provider portal that will enhance provider collaboration, streamline administrative processes, and bolster support for value-based care initiatives. The provider portal is expected to be in production in 2025.
B. How can **OHA support** your efforts in accomplishing your Health IT Roadmap goals?
The Oregon Health Authority can bolster IHN's endeavors in achieving the Health IT Roadmap goals by providing comprehensive support, including: Strategic Alignment: Ensuring IHN's objectives with the goals outlined in the Health IT Roadmap are aligned with OHA to ensure synergy and coherence in efforts. Collaboration Facilitation: Facilitating collaboration among stakeholders, including healthcare providers, other CCOs, technology vendors, and government agencies, to foster collective efforts towards our roadmap objectives. Regulatory Guidance: Providing clear regulatory guidance and support to navigate compliance requirements and ensure that health IT implementations adhere to established standards and regulations. Data Sharing and Analysis: Facilitating data sharing and analysis to enable evidence-based decision-making, performance monitoring, and continuous improvement of health IT initiatives. Training and Education: Offering training programs and educational resources to healthcare professionals and stakeholders to enhance their understanding and utilization of health IT tools and systems. Evaluation and Feedback: Conducting regular evaluations and gathering feedback to assess the effectiveness of implemented health IT solutions and identify areas for refinement or enhancement. By actively supporting these initiatives, the Oregon Health Authority can play a pivotal role in advancing IHN's progress towards achieving the Health IT Roadmap goals and improving healthcare delivery and outcomes statewide.
C. What have been your organization's **biggest challenges** in pursuing health IT strategies? What can OHA do to better support you?
Resource Constraints: Limited financial resources and staffing can hinder the implementation of complex health IT systems and initiatives. **Interoperability Issues**: Ensuring seamless communication and data exchange between different IT systems and platforms remains a significant challenge, especially in healthcare, where various systems are not compatible. **Data Privacy and Security Concerns**: Protecting sensitive patient information from unauthorized access and data breaches is a critical concern, requiring robust security measures and compliance with regulations. **Change Management**: Overcoming resistance to change among staff members and stakeholders who may be accustomed to traditional methods of healthcare delivery and record-keeping. **Technological Complexity**: Managing and maintaining intricate IT infrastructures and staying abreast of rapidly evolving technologies can be challenging, especially smaller ones. **Regulatory Compliance**: Navigating complex regulatory requirements and ensuring adherence to standards such as HIPAA, HITECH, and meaningful use criteria poses a significant challenge for organizations.

To better support IHN in overcoming these challenges, OHA can:
Provide Funding and Resources: Offer financial assistance, grants, and technical resources to help implement health IT solutions and address resource constraints.
Facilitate Interoperability: Establish standards and frameworks to promote interoperability among healthcare IT systems and facilitate data exchange between providers, payers, and other stakeholders.
Offer Guidance on Data Privacy and Security: Provide guidance, training, and resources to help organizations comply with data privacy and security regulations and implement best practices for protecting patient information.
Support Change Management: Offer training programs, workshops, and resources to help organizations effectively manage change and transition to new health IT systems and workflows.
Provide Technical Assistance and Expertise: Offer technical assistance, consultation services, and access to IT experts to help organizations navigate technological complexities and make informed decisions about IT solutions.
Advocate for Regulatory Streamlining: Advocate for regulatory reforms and policies that promote interoperability, innovation, and flexibility in health IT implementation while ensuring compliance with necessary regulations.

By taking these proactive steps, OHA can better support organizations in overcoming the challenges associated with pursuing health IT strategies, ultimately enhancing healthcare delivery and outcomes across the state.

D. How have your organization's health IT strategies supported **reducing health inequities**? What can OHA do to better support you? If not already described above, how does your organization use REALD/SOGI data to support reducing health inequities? What has your organization learned about the impact on outcomes?

IHN-CCO is reviewing data policies, usage, and sharing as part of undertaking a health equity assessment of internal structures, policies, and methodologies. Additionally, IHN-CCO has prioritized internal and community focused trainings on data justice, including the *Healing Justice Academy: Community Engagement as a Tool for Equity* training as part of our CHIP goals to not only address health inequities but to ensure data is collected, shared, utilized, and owned within health equity best practices.

Throughout 2024 the standardization of SDoH screenings and the ability to share that data across platforms has been a clear part of the SDoH HIT Plan and in 2025 IHN-CCO expects to be able to begin analysis of that data to inform program development and work towards the IHN-CCO CHIP goals. Additional partners are expected to be included throughout 2025.

Additionally, IHN-CCO currently working on the creation of an SDOH profile for our members. The intent here is to use all available data sources to us to better understand the social risk of our members to enable targeted, meaningful engagement with our members, and in our operations. We intend to use this data to overlay all of our care gaps, operations and interventions. Segmenting all reporting by REALD, SOGI, as well as other social risk factors will give us a baseline of any present inequities, so we can develop quantitative targets around closing those gaps. For example, if upon examining the data, we recognize that our Latinx population generally lag behind in A1c control than our Caucasian population, it gives us a tangible goal towards which we work to ensure that we close that gap.

Challenges include data access, including the multiple data systems used by SDOH partners who are our first partners in addressing health equity. As outlined above, building healthy resilient communities requires engagement across systems and shared data systems between housing, schools, small culturally based CBOs, and large health systems has required administrative duplication and burden on IHN-CCO's providers. OHA can support through payment models that account for administrative work, and through statewide conversations with agencies (ODHS, OHCS, ODE, etc.) on models that support shared systems and data programs. Access to meaningful data across systems that members engage with can help CCOs and our partners work to reduce health inequities. Additionally, OHA can support CCOs by continually sending us be it quarterly or annually, REALD/SOGI data that they have to support CCOs efforts in collecting that data. It will also be helpful to know how OHA is using that data to decrease health inequities for fee-for-service members that perhaps CCOs may emulate if appropriate for the member population that we serve.

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

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