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: Jackson Care Connect

Date: 3/15/2025

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:

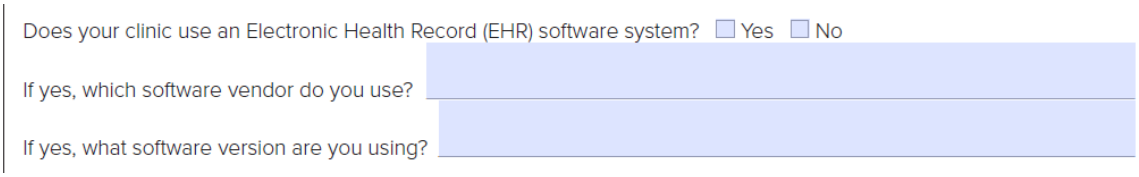
- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is continuing a strategy from prior years, please 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**

The number of contracted organizations without EHR information totals 44. 9 of these organizations are physical health, 33 are behavioral health, and 2 are oral health.

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

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



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

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**

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

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

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

In 2024, the innovation team supported the primary care network through individual technical assistance and learning collaboratives that discussed content around health information technology. Primary focuses in 2024 included a Social Needs Screening Learning Series, Practice Coaching for Primary Care Transformation, and 1:1 Technical Assistance for metric support (Diabetes A1c, Well Child Checks, Childhood Immunizations). In the Social Needs Learning Series participants discussed how to maintain person centered care while using a Community Information Exchange platform for referrals and care coordination, which is in service of the SNS metric. The Practice Coaching for Primary Care Transformation session included how to leverage telehealth and remote patient monitoring for better engagement and care team utilization for patient outcomes. Finally, technical assistance for JCC metrics was centered around accessing internal FIDO dashboards so that they could regularly review and monitor diabetes reports and provided support around how to optimize EHRs for more streamlined WCCs from a team-based care approach (i.e., which team members can input which pieces of information). In addition to technical assistance, contracting with OCHIN was executed to fund participation of the two pilot FQs in adoption of the VBPM and Certified HEDIS measure analytics. We are in the process of implementation with projected go-live Q1 of 2025. Post-pilot completion, the option to spread adoption of the tools and associated funding will be made available to clinics on OCHIN that participate in shared risk arrangements and EPP. Currently, JCC has 2 clinics that are on EPP that will be eligible for VBPM and Certified HEDIS measure analytics post-pilot. JCC has no major challenges to report for this strategy.

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

Technical assistance will continue to be provided to clinics around optimization of EHRs. However, opportunities will be developed on an as needed basis in consultation with primary care clinic partners. Additionally, JCC will continue providing optional funding to our Federally Qualified Health Centers who elect to participate with us in the EPIC Payer Platform (EPP) data exchanges, to adopt EPIC's Value-based

Performance Management (VBPM) and NCQA Certified HEDIS measure analytics tools. These tools are designed to enhance each FQ's ability to manage and monitor performance and the health of populations associated with our value-based payment contracts and make optimal use of the data exchanges enabled through EPP.

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

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

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

- Integrated Team Based Care
- Training & Development
- Client-Focused Timely Access
- Leadership
- Whole Person Care Service Array
- Business Intelligence & Applied Use of Data
- Population Focused Care
- Change Management Infrastructure for Transformation

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

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

After a competitive application process, one JCC agency (ColumbiaCare) was selected for SHIFT. In 2024, grants and robust consultation and training were made available to the providers. As a result, all providers completed the current Business Intelligence (BI) assessment and assessment of EHR capabilities as facilitated by consultants funded by CareOregon. Providers developed implementation plans to ensure their BI/EHRs can support integrated team-based care, population health management, and Feedback Informed Treatment (FIT), which are all required per the SHIFT model. By the end of 2024, ColumbiaCare is working on individualized activities outlined in their approved Business and Implementation Plan. These activities include identifying and executing EHR improvements, FIT data integration improvements, and hiring an external system consultant to support their final EHR decision making.

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

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

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

D. EHR Support Barriers:

Please describe any barriers that inhibited your progress to support EHR adoption, use, and/or optimization among your contracted providers.
Competing priorities across CCO staff, network partners and technology vendors has been the largest barrier to progress this year.

C. OHA Support Needs:

How can OHA support your efforts to support your contracted providers with EHR adoption, use, and/or optimization?
Provide additional funding to CCOs with promising practices to support uptake and spread.

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

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

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

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

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

Notes:

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

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

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

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

Point Click Care is a Health Information Exchange that hospitals across Oregon connect to. CareOregon Regional Care Teams use this as a source of hospital inpatient and Emergency Department admission and discharge data to trigger care coordination referrals and our transitional support process. Delegated Dental Care Organizations also utilize Point Click Care to assist with oral health related care coordination and outreach.

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

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

Epic Payer Platform

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

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

- Clinical Data Exchange
  - Automated electronic release of appropriate information to insurers
  - Reduces manual records requests, denials, and time spent processing claims
- Scheduling Notifications

- Automated notifications to insurers when members schedule/reschedule/cancel appointments
- Increase compliance with follow-up care and support care coordination

CareOregon Link

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

Reliance is a health information exchange available in Jackson County. Jackson Care Connect's network partners have bidirectional access to Reliance allowing them to send and receive medical record information on their patients with other providers in the community. Jackson Care Connect also has access to this HIE which can be used to coordinate care for members.

Symplr is a clinical communication tool that care teams at Asante Rogue Regional Hospital use to communicate about patients. In 2024 a JCC Care and Outreach Specialist was embedded within that system and will use this tool as part of their care coordination process.

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

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

JCC's Regional Care Teams (Care Coordination Teams) and other outreach teams use Point Click Care to receive Hospital Event Notifications. The event notifications feed directly into our care coordination platform, refresh hourly, and alertcare coordination teams when one of the members on their panel is experiencing an event. We also use cohorts and reports from the application to proactively identify and refer members into care coordination. Examples of cohorts and reports include:

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

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

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

Strategy status:

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

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

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

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

JCC has no major challenges to report for this strategy.

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

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

Strategy 2 title: Epic Payer Platform (EPP) implementation

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

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

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

Strategy status:

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

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

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

All OCHIN members within JCC's network have been offered the option to join EPP at no cost to them. Currently, all JCC clinics on OCHIN have elected to participate in EPP (2 out of 2 clinics). JCC has no major challenges to report for this strategy.

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

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

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

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

- Within JCC, participation by Providence and Asante in addition to OCHIN participating providers would account for approximately 82% of JCC membership.

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

Strategy 3 title: Implementation of a New Care Coordination Platform

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

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

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

Strategy status:

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

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

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

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

JCC implemented and went live with Compass Rose in November 2023. We transitioned to Compass Rose when our contract ended with GSI, this led to barriers around timelines for implementation. Therefore, our ongoing efforts are focused on stabilizing the system and building out additional workflows. At the moment, Epic data sources and Point Click Care are are the primary data priorities.

Planned Activities	**Planned Milestones**
1. Continue to stabilize the build in 2025.	

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

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

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

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

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

Notes:

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).

- If CCO is continuing a strategy from prior years, please continue to report and indicate “Ongoing” or “Revised” as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note ‘N/A’ in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2025, please indicate ‘N/A’ in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy’s activities and milestones.

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

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

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

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

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

Rubicon MD is an e-consult platform that enables primary care providers to access specialists for consult support to review cases, provide guidance, and help determine the necessity of referral to an in-person specialist.

Reliance is a health information exchange available in Jackson County. JCC’s network partners have bidirectional access to Reliance, allowing them to send and receive medical record information on their patients with other providers in the community.

Symplr is a clinical communication tool that care teams at Asante Rogue Regional Hospital use to communicate about patients. In 2024, a JCC Care and Outreach Specialist was embedded within the system and is utilizing this tool as part of their care coordination process.

(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**:

The number of contracted organizations that do not have HIE tools or hospital event notifications totals 136. 42 of these organizations are physical health, 81 are behavioral health, and 13 are oral health.

Strategy 1 title: Optimizing and expanding the use of FIDO

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

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

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

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

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

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

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

JCC's Behavioral Health team has formalized provider engagement plans with 12 anchor providers that rely on regular claims data analysis from FIDO dashboards. During quarterly provider meetings, data is reviewed and evaluated in the context of elevating and better understanding health inequities, member reach, and member impact.

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

Planned Activities	**Planned Milestones**
1. Provide dental plan partner access to FIDO Metric's Dashboard. 2. Expand FIDO membership and include access to gap reports.	1. FIDO Metric Dashboard Access by Q1 2025. 2. Onboard an analyst to improve the care coordination tool and address limitations by Q1 2025. 3. Identify a timeline for publishing the care coordination tool by Q2 2025. 4. Expansion of FIDO membership by Q4 2025.

Strategy 2 title: Optimization of dental referral platform

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

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

☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☒ 4: Collaboration ☒ 5: Enhancements ☒ 6: Integration ☐ 7: Contracts ☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 12: Other:

Strategy status:

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

Provider types supported with this strategy:

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

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

In 2024, the dental referral platform project was rescoped in order to more efficiently exchange data with dental plans. Planning and development of the new web application was initiated in Q3 2024. The application will provide daily access to PCP referral data sharing and monthly reports containing all referrals and care coordination outreach outcomes from dental plan partners. All information will be cross shared through a Fully Integrated Data Organizer (FIDO) dashboard. Development is on schedule for both the new application and the FIDO dashboard for Q3 2024. JCC has no major challenges to report for this strategy.

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

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

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

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

JCC's Behavioral Health team will meet quarterly to anchor providers, review their internal workflows, and review their adherence to a daily review of Point Click Care data and outreach to all members currently enrolled. This Point Click Care strategy will support increased IET metric data and MOUD engagement.

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

☒ 1: TA ☐ 2: Assessment ☒ 3: Outreach ☒ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 12: Other:

Strategy status:

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

Provider types supported with this strategy:

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

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

In 2024, JCC continued the reinforcement of Point Click Care (PCC) utilization amongst all established providers, including the usage of the FIDO Network Engagement dashboard to target providers who are not demonstrating engagement and to encourage technical assistance. JCC continued to provide assistance for oral health providers. PCC is primarily used for Emergency Visit notifications amongst oral health providers as usage is limited due to a lack of Epic in many dental clinics.

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

- Development of a flag within PCC for primary language to complement the language access metric.
- Refined a workflow in PCC to support proactive outreach for members presenting to the Emergency Department with Substance Use Disorder related needs.
- Internal PCC 101 sessions including representatives from behavioral health, physical health, care coordination, and informatics & evaluation.

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

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

Planned Activities	**Planned Milestones**
1. Create and provide consistent messaging on new PCC features.	1. Determine what is necessary to increase PCC adoption by Q2 2025. 2. Use FIDO dashboard to track adoption and utilization. Define what positive engagement for providers looks like by Q3 2025. 3. Complete additional provider refresher courses and training by Q4 2025. 4. Identify successes and barriers of the proactive outreach for SUD work by Q4 2025.

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

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

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

☒ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☒ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 12: Other:

Strategy status:

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

Provider types supported with this strategy:

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

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

ECHO Progress:

JCC had a total of 11 providers participate in 30 unique ECHOs. Of those providers who participated, 17 were MDs, 8 NPs, 4 PA-Cs, 3 pharmacists, 13 LCSW/LPCs, and 8 were nurses.

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

- La Clinica (14)
- Rogue Community Health (12)
- Asante (8)
- Providence (7)
- Oasis (3)

The top 5 programs within the JCC network included:

- Substance Use Disorders in Hospital Care (11)
- Substance Use Disorders in Adolescents (10)
- Substance Use Disorders in Emergency Departments (8)
- Deflection Implementation and Leadership (7)
- Substance Use Disorders in Pre and Perinatal Care (6)

RubiconMD Progress:

JCC executed an updated contract with RubiconMD to maintain current user access. There were 110 active providers with a total number of 633 e-consults in 2024, see below for a further breakdown. The top 3 specialties used were pediatrics, neurology, and endocrinology. The Innovation Team continued to provide RubiconMD support by promoting the benefits, especially around access to specialists and referrals. As a result, 3 new clinics were onboarded (Southern Oregon Pediatrics in August, Valley Family Practice in October, and Oasis in December).

Total number of e-consults:

- La Clinica – 336
- Rogue Community Health – 184
- Southern Oregon Pediatrics – 103
- Valley Family Practice – 10

JCC clinics that integrate RubiconMD into their EHR clinical workflow:

- Rogue Community Health
- La Clinica

JCC has no major challenges to report for this strategy.

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

Planned Activities	**Planned Milestones**
1. Maintain funding for current RubiconMD users.	1. Continued management of the relationship and contract with RubiconMD, along with the provisions of applications to current users through December 31, 2025.

Strategy 5 title: Optimizing and expanding the use of Reliance HIE

Reliance facilitates the exchange of information among providers through its:

1) Community health record
2) Provider-to-provider referrals
3) Provider-to-provider secure messaging

Reliance gives timely clinical information from participating provider EHRs to support our patient outreach and clinic quality improvement efforts. As an example, the information JCC receives on new pregnancies among our member population allows us to identify members early in their pregnancies to ensure they are

engaging in prenatal care. This information is used in partnership with our provider network to engage and provide care for members throughout their pregnancy. Similarly, we get information about members with hepatitis C, which allows us to reach out to members directly or inform their primary care clinic to ensure eligible members receive treatment. This also helps guide development of new programs and helps us discover areas in which diabetes care can be improved. In order to support and improve utilization of Reliance, two of JCC's providers, La Clinica (FQ) and Oasis (specialty clinic focused on high-risk members), both received funds from JCC to improve their reporting and utilization capacity for Reliance. Both entities continue to explore the optimal use of information available in Reliance for improving coordination of member care.

Note: La Clinica and Oasis were selected to receive financial support to utilize Reliance as they were willing to expand on their current practices for member outreach and specifically requested support to integrate the additional data provided by Reliance. Additionally, La Clinica and Oasis serve specific marginalized populations that benefit from improved data.

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

☒ 1: TA ☒ 2: Assessment ☒ 3: Outreach ☒ 4: Collaboration ☒ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☒ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 12: Other:

Strategy status:

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

Provider types supported with this strategy:

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

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

In 2024, Reliance began producing a pregnancy roster that matches partner-clinic's EHR systems. JCC is utilizing this list for outreach with high confidence. Additionally, work for a postpartum gap list started. However, additional layers of evaluations are required in order to ensure the accuracy of the data. Ongoing evaluation occurred and will continue in 2025 to assess if Reliance HIE can provide:

1. SDOH related screening results for food, housing, and transportation needs of members

Identification of Diabetes HbA1c poor control values.

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

Planned Activities	**Planned Milestones**
1. Validate postpartum care data 2. Evaluate SDOH screening data related to the SNS incentive metric. 3. Validate Diabetes HbA1c data 4. Begin postpartum outreach	1. Integrate postpartum care data into gap lists by Q4 2025. 2. Use SDOH SNS data to provide outreach lists by Q4 2025. 3. Use Diabetes HbA1c data to inform metric strategy plans by Q4 2025.

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

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

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 can support our efforts by increasing the adoption of the HIE or compatible interfaces to increase the breadth of data that is available. Expanded use of HIE data sharing in dental and behavioral health would also be useful amongst plan partners.

E. CCO Access to and Use of EHRs

Please describe CCO current or planned access to contracted provider EHRs. Please include which EHRs CCO has or plans to have access to including how CCO accesses or will access them (e.g., Epic Care Everywhere, EpicCare Link, etc.), what patient information CCO is accessing or will access and for what purpose, whether patient information is or will be exported from the EHR and imported into CCO health IT tools.
Which EHRs does CCO have or will have access to and how does or will CCO access them (e.g., Epic Care Everywhere, EpicCare Link, etc)?
CareOregon's Health Resilience Specialists and Panel Coordinators have direct access to the EHR system of their clinics with the permission to view and edit records for CareOregon members assigned to the clinic. The Regional Care Teams and other outreach teams also have EMR access to hospitals and facilities across the state. Gaining access to these systems is part of our standard onboarding process for new hires. Panel Coordinators, the Regional Care Teams and other outreach teams have access to Epic OCHIN and Care Everywhere. A Care and Outreach Specialist who is embedded at Asante Rogue Regional has access to Symplr which is a clinical communication tool that care teams at Asante Rogue Regional Hospital use to communicate about patients.
What patient information is CCO accessing or will CCO access and for what purpose?
CareOregon Regional Care Teams, outreach teams, and panel coordinators use their EHR access to outreach and schedule appointments for members due for preventative visits and to those with identified gaps in care. EHR access is also used to support quality and performance measure accuracy and completeness.
Is/will patient information being/be exported from the EHR and imported into CCO health IT tools? If so, which tool(s)?
Data sent via Epic Payer Platform to JCC is populated into Compass Rose and stored in the CCO EDW to support future-state analysis for quality and performance measure reporting, risk gaps and closures, and member attribution management.

6. Health IT to Support SDOH Needs

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

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

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

Notes:

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

Strategy category checkboxes (within CCO)

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

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

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

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

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

Compass Rose is the Epic-based care coordination platform implemented by CareOregon in November 2023. It has replaced GSI, our previous software. Compass Rose allows for improved collection and use of social needs information. Multiple assessments built in Compass Rose include or address social needs. Examples include the Health Risk Assessment (HRA), along with Epic builds that maintain their own SDOH question set database, and clinical assessments like the Signify Assessment, Care Coordination Assessment, and Transitional Support Assessment all address social needs like comprehension of medical instructions/medications, housing, and transportation.

The Epic Payer Platform module allows information exchange between the CCO and it provider networks, which includes data on SDOH needs. Social needs screening data flows via the Clinical Data Exchange (CDE) Epic Payer Platform feature.

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

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

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

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

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

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

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

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

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

Expanded Social Health Provider Network Contracts:

- Negotiated contract terms and fee schedules with 1 new CBO. This contract was fully executed by Q4 2024.

Developed Standard Onboarding Process for Social Health Providers:

- Onboarding includes a 90-minute overview and discussion of contract terms, review of reporting requirements, and an orientation to HealthTrio.
- CBOs receive a guide for accessing and using HealthTrio, along with instructions for obtaining technical assistance.
- Our systems configuration and social health teams are available to provide ongoing technical assistance to CBOs as needed.
- This process was used to onboard 1 additional social health provider in 2024.

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

In 2025, JCC plans to maintain the work happening through the existing social health provider contracts and explore the use of HealthTrio to support Health Related Social Needs (HRSN) providers as we get more experience with the new benefit.

Planned Activities	**Planned Milestones**
1. Continue incorporating the use of HealthTrio into HRSN service provider agreements as the network expands.	1. Establish contracting and begin onboarding nutrition HRSN service providers to HealthTrio by Q1 2025. 2. Establish contracting and begin onboarding housing HRSN service providers to HealthTrio by Q3 2025.

Strategy 2 title: Development of social needs member table to inform population segmentation models

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

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

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

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

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

A couple challenges with the initial approach delayed implementation and prompted us to revise our strategy:

Challenge 1: JCC currently has multiple data sources that house social needs data, and we cannot turn it into actionable information to inform outreach and segmentation without understanding the overarching regulatory requirements and strategic social needs data points. The process of comparing requirements to the data that we have is taking longer than anticipated due to the implementation of the HRSN benefit. The HRSN benefit requires significant resources, including IS support, which has created resource constraints including delays in data development.
Challenge 2: JCC is no longer pursuing co-developed risk segmentation with clinics due to workforce issues and clinics expressing their priority of engagement with members. They do not have the capacity to develop a risk model at this time.

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

Planned Activities	**Planned Milestones**
1. Upgrade to the newest version of Johns Hopkins ACG, including the new SDOH module. 2. Review and document SDOH regulatory and metric data requirements. 3. Complete environmental scan and mapping of social needs data coming from Connect Oregon, Compass Rose, EPP, and ACG. 4. Create social needs data dictionary, to be used across all data systems. 5. Secure technical resources to build out the master data table. 6. Build the master data table. 7. Pilot use of the data table. Determine validity and make adjustments.	1. Launch a social health needs team to begin scoping and creating a data plan by Q1 2025. 2. Document organization wide SDOH data requirements by Q2 2025. 3. Secure technical resources by Q2 2025. 4. Complete the ACG upgrade by Q3 2025. 5. Data systems have social needs data identified and mapped out by Q3 2025. 6. Social needs dictionary created by Q4 2025. 7. Build the member data table by Q3 2026. 8. Begin testing/piloting the data table by Q4 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**.**

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

(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**

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

Connect Oregon/Unite Us is a community information exchange that allows bi-directional information sharing and transparency across referral networks. JCC has a multi-pronged approach to advance the use of this tool among clinical providers, community-based organizations, and JCC staff that includes financial support, educational/technical assistance, use case identification, and addressing adoption barriers and challenges.

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

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

Strategy status:

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

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

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

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

In 2024, JCC focused on building out the platform referral and new payment capabilities to support the launch of the HRSN benefit. Through this focused effort we have successfully:

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

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

Challenges related to this strategy in 2024 include the time and resources needed to increase general use of Unite Us for social needs referrals.

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

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

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

JCC is utilizing a Community Information Exchange (CIE), Unite Us, to make closed loop referrals to HRSN service providers. Assessment of HRSN service provider readiness to utilize CIE takes place prior to contracting, and HRSN service providers receive training and technical assistance to support the use of CIE. HRSN service providers are expected to respond to referrals within 3 business days of receiving them, by either accepting or denying the referral. Referrals include member information (e.g., name, address, contact information), information about the authorized service (e.g., service authorized, service dates, amount authorized), and any member preferences established during the PCSP process. Documentation includes sending the initial referral, acceptance or denial of the referral and denial reason if applicable, and case closure date and resolution (resolved or unresolved). HRSN providers may also choose to add notes into the referral to share status updates about the member's case. These expectations are the same for all HRSN service providers. Since HRSN vendors are not expected to use the CIE, information sharing for housing modification and remediation benefits is conducted over phone or email. More information about closed loop referrals is available in the JCC HRSN procedures submitted to OHA as part of the HRSN benefit required deliverables.JCC has no major challenges to report for this strategy.

2025-27 Plans:

JCC will continue partnering closely with the CIE vendor to implement platform functionality improvements and to identify enhancements to support a streamlined and simplified user experience for HRSN providers and requestors

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):

HRSN provider contracting has been completed, and we have successfully onboarded 6 providers. HRSN provider onboarding included an overview of the CIE platform and reviewed expectations regarding HRSN referrals and the use of a CIE. Unite Us, was implemented for the closed loop referral process and for submission of claims for HRSN services. We've also offered weekly office hours, monthly refresher training, and a 2-hour initial training to support providers. All HRSN providers also received a CIE manual describing how to use Unite Us for each of the HRSN benefits.JCC has no major challenges to report for this strategy.

2025-27 Plans:
JCC will continue to provide technical assistance and support to existing and new HRSN providers to support enhanced utilization of the CIE platform. Additionally, CareOregon will continue to strongly encourage HRSN providers to become authorized users of the Unite Us platform for purposes of accepting or denying HRSN service referrals from CareOregon.

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.

While progress was made, JCC continued to balance moving forward the HIT/SDOH program with limited capacity to engage in new work. Significant staffing losses during the pandemic while experiencing an increase in utilization due to delayed or missed routine and preventative care has resulted in managing patient populations who are experiencing higher levels of illness. While we have established workflows, processes, and policies to address social health needs, the costs and effort to adopt new platforms are the main barriers.

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?

Integrating existing systems and key EHRs, like OCHIN Epic, HMIS, and core CIEs, such as Unite Us, would be helpful in moving the dial towards interoperability. Establishing real time bidirectional data exchange between systems would allow us to implement and adopt new workflows, tools, and platforms. This would also significantly reduce the likelihood of repeated social needs screenings and the potential traumatization of members. Funding to support this work would ensure an aligned experience statewide for providers, CBOs, and members, especially those who seek services across CCO boundaries.

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.
B. How can **OHA support** your efforts in accomplishing your Health IT Roadmap goals?
C. What have been your organization's **biggest challenges** in pursuing health IT strategies? What can OHA do to better support you?
D. How have your organization's health IT strategies supported **reducing health inequities**? What can OHA do to better support you? 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?

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.