2024 CCO Health IT Roadmap

2024 Guidance, Evaluation Criteria & Reporting Template

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

Please:

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

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

TABLE OF CONTENTS

Guidance Document

1. Purpose & Background

Per the CCO 2.0 Contract, CCOs are required to maintain an Oregon Health Authority (OHA) approved Health Information Technology (IT) Roadmap. The Health IT Roadmap must describe how the CCO (1) currently uses and plans to use health IT (including hospital event notifications) to achieve desired outcomes and (2) supports contracted physical, behavioral, and oral health providers throughout the course of the Contract in these areas:

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

For Contract Year 1 (2020), CCOs' responses to the Health IT Questionnaire formed the basis of their draft Health IT Roadmap. For remaining Contract Years, CCOs are required to submit an annual Health IT Roadmap to OHA reporting the progress made from the previous Contract Year, as well as plans, activities, and milestones detailing how they will support contracted providers in future Contract Years. OHA expects CCOs to use their approved 2023 Health IT Roadmap as the basis for their 2024 Health IT Roadmap.

Reminders for Contract Year 5 (2024):

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

coordination. This expansion recognizes that though CCOs continue supporting EHR adoption, in order to support care coordination, some organizations need CCO support for EHR use and optimization.

4. To limit redundancy in reporting, Support for HIE – Care Coordination and Support for HIE – Hospital Event Notifications section have been combined. The section is now called 'Use of and Support for HIE' to more accurately reflect the reporting expectations (CCO use of HIE and CCO support of HIE among contracted providers). The HIE section has also been expanded to include support of HIE use.
5. An optional section has been added to help inform OHA of CCO's current and planned EHR access and use for care coordination purposes.
6. In response to CCO previous submissions, optional sections/boxes have been added to create space for overview descriptions of CCO efforts/approaches (e.g., Overview of CCO Health IT Approach, Overview of EHR Support, Overview of strategy plans).
7. Strategy categories and strategy status checkboxes have been added for each CCO strategy.

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

2. Overview of Process

Each CCO shall submit its 2024 Health IT Roadmap to OHA for review on or before **March 15th** of each Contract Year. CCOs are to use the *2024 Health IT Roadmap Template* for completing this deliverable and are encouraged to copy and paste relevant content from their previous Health IT Roadmap if it's still applicable. Please submit the completed 2024 Health IT Roadmap via the CCO Contract Deliverables Portal.

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

1. CCO is to review the available meeting days/times included in the Results Report and contact OHA by 6/21/24 with their top two meeting choices.
    a. These meetings are only available from 6/20/2024 through 7/10/2024.
    b. CCO is expected to have thoroughly reviewed its results prior to the meeting and to be prepared for an in-depth discussion.
2. CCO resubmission is due 7/17/2024.
3. OHA will complete its review of all resubmissions and provide written notice of the approval status within 30 days of resubmission receipt, by 8/16/2024.

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

Please refer to the timeline below for an outline of steps and action items related to the 2024 Health IT Roadmap submission and review process. m

2024 Health IT Roadmap Timeline

Last Revised 12/15/2023

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

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

3. Health IT Roadmap Approval Criteria

The table below contains evaluation criteria outlining OHA's expectations for responses to the required Health IT Roadmap questions. Modifications for Contract Year 5 (2024) are in ***bold italicized font***. Please review the table to better understand the content that must be addressed in each required response. Approval criteria for Health IT Roadmap optional questions are not included in this table; optional questions are for informational purposes only and do not impact the approval of a Health IT Roadmap. Additionally, the table below does not include the full version of each question, only an abbreviated version. Please refer to the *2024 Health IT Roadmap Template* for the complete question when crafting your responses.

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
1. Health IT Partnership	CCO attestation to the four areas of health IT Partnership.	CCO meets the following requirements: • Active, signed HIT Commons MOU and adheres to the terms • Paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons Memorandum of Understanding (MOU) • Served, if elected on the HIT Commons governance board or one of its committees • Participated in an OHA's HITAG meeting at least once during the previous Contract Year
2. Support for EHR Adoption, ***Use, and Optimization***	A. 2023 Progress supporting contracted physical, oral, and behavioral health providers to increase EHR adoption, ***use, and optimization in support of care coordination***	• Description of progress includes: ○ Strategies used to support increased rates of EHR adoption, ***use, and optimization in support of care coordination***, and address barriers among contracted physical, oral, and behavioral health providers in 2023 ○ Specific accomplishments and successes for 2023 related to supporting EHR adoption, ***use, and optimization in support of care coordination*** • Sufficient detail and clarity to establish that activities are meaningful and credible.
	2024-2026 Plans for supporting contracted physical, oral, and behavioral health providers to increase EHR adoption, ***use, and optimization in support of care coordination***	• Description of plans includes: ○ The number of organizations (by provider type) for which no EHR information is available (e.g., 10 physical health, 22 oral health, and 14 behavioral health organizations) ○ Plans for collecting missing EHR information via CCO existing processes ○ Additional strategies for 2024-2026 related to supporting increased EHR adoption, ***use, and optimization in support of care coordination***, and addressing barriers to adoption among contracted physical, oral, and behavioral health providers ○ Specific activities and milestones for 2024-2026 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
3. Use of and support for HIE	A. 2023 Progress using HIE for care coordination and timely hospital event notifications <u>within the CCO</u>	• Description of progress includes: ○ HIE tool(s) CCO is using within their organization for care coordination and timely hospital event notifications ○ HIE strategies used for care coordination and timely hospital event notifications within the CCO ○ Specific accomplishments and successes for 2023 related to CCO's use of HIE for care coordination and timely hospital event notifications • Sufficient detail and clarity to establish that activities are meaningful and credible.
	2024-2026 Plans using HIE for care coordination and timely hospital event notifications <u>within CCO</u>	• Description of plans includes: ○ Additional tool(s) (if any) CCO is planning to use for care coordination and timely hospital event notifications ○ Additional strategies for 2024-2026 to use HIE for care coordination and timely hospital event notifications within the CCO ○ Specific activities and milestones for 2024-2026 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible
	B. 2023 Progress supporting contracted physical, oral, and behavioral health providers with increased access to ***and use of*** HIE for care coordination and timely hospital event notifications	• Description of progress includes: ○ Tool(s) CCO provided or made available to support providers' access to HIE for care coordination and timely hospital event notifications ○ Strategies CCO used to support increased access to ***and use of*** HIE for care coordination and timely hospital event notifications for contracted physical, oral, and behavioral health providers in 2023 ○ Specific accomplishments and successes for 2023 related to increasing access to ***and use of*** HIE for care coordination and timely hospital event notifications (including the number of organizations of each provider type that gained increased access ***or use*** as a result of CCO support, as applicable) • Sufficient detail and clarity to establish that activities are meaningful and credible.
	2024-2026 Plans for supporting contracted physical, oral, and behavioral health providers with increased access to and use of HIE for care 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

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
		○ Additional strategies for 2024-2026 related to supporting increased access to ***and use of*** HIE for care coordination and timely hospital event notifications among contracted physical, oral, and behavioral health providers ○ Specific activities and milestones for 2024-2026 related to each strategy (including the number of organizations of each provider type expected to gain access to ***or use of*** HIE for care coordination and hospital event notifications as a result of CCO support, as applicable • Sufficient detail and clarity to establish that activities are meaningful and credible.
4. Health IT to support social determinants of health needs	A. 2023 Progress using health IT to support SDOH needs within the CCO, including but not limited to social needs screening and referrals	• Description of progress includes: ○ Current health IT tool(s) CCO is using to support SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) have closed-loop referral functionality ○ Strategies for using health IT within the CCO to support SDOH needs, including but not limited to social needs screening and referrals in 2023 ○ Any accomplishments and successes for 2023 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
	2024-2026 Plans for using health IT to support SDOH needs within the CCO, including but not limited to social needs screening and referrals	• Description of plans includes: ○ Additional health IT tool(s) CCO plans to use to support SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) will have closed-loop referral functionality ○ Additional strategies planned for using health IT to support SDOH needs, including but not limited to social needs screening and referrals ○ Specific activities and milestones for 2024-2026 related to each strategy • Sufficient detail and clarity to establish that activities are meaningful and credible.
	B. 2023 Progress supporting contracted physical, oral, and behavioral health providers as well as, social services and community-based organizations (CBOs) with using health IT to support SDOH needs, including but not limited to	• Description of progress includes: ○ Health IT tool(s) CCO supported or made available to contracted physical, oral, and behavioral health providers, as well as social services and CBOs, for supporting SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) have closed-loop referral functionality ○ Strategies used for supporting these groups with using health IT to support SDOH needs, including but not limited to screening and referrals in 2023 ○ Any accomplishments and successes for 2023 related to each strategy

Health IT Roadmap Section	Question(s) – Abbreviated (Please see report template for complete question)	Approval Criteria
	social needs screening and referrals	○ **Any planning and/or preparation CCO has done in anticipation of 2024 requirement to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals, such as developing grants, technical assistance, outreach, education, and feedback mechanisms for HRSN Service Providers.** • Sufficient detail and clarity to establish that activities are meaningful and credible
	2024-2026 Plans for supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs, with using health IT to support SDOH needs, including but not limited to social needs screening and referrals	• Description of progress includes: ○ Health IT tool(s) CCO is planning to support/make available to contracted physical, oral, and behavioral health providers, as well as social services and CBOs for supporting SDOH needs, including but not limited to social needs screening and referrals, including a description of whether the tool(s) will have closed-loop referral functionality ○ Additional strategies planned for supporting these groups with using health IT to support social needs screening and referrals beyond 2023 ○ Specific activities and milestones for 2024-2026 related to each strategy ○ **Specific plans to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals during Contract Years 2024-2026, such as developing grants, technical assistance, outreach, education, and feedback mechanisms for HRSN Service Providers.** • Sufficient detail and clarity to establish that activities are meaningful and credible.

2024 Health IT Roadmap Template

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

Instructions & Expectations

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

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

Each required topic includes the following:

- Narrative sections to describe your 2023 strategies, progress, accomplishments/successes, and barriers
- Narrative sections to describe your 2024-2026 plans, strategies, and related activities and milestones. For the activities and milestones, you may structure the response using bullet points or tables to help clarify the sequence and timing of planned activities and milestones. These can be listed along with the narrative; it is not required that you attach a separate document outlining your planned activities and milestones. However, you may attach your own document(s) in place of filling in the activities and milestones sections of the template (as long as the attached document clearly describes activities and milestones for each strategy and specifies the corresponding Contract Year).

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

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

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

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

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

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

- *Accomplishments/successes:* Positive, tangible outcomes resulting from CCO's strategies for supporting providers.
- *Activities*: Incremental, tangible actions CCO will take as part of the overall strategy.
- *Milestones*: Significant outcomes of activities or other major developments in CCO's overall strategy, with indication of when the outcome or development will occur (e.g., Q1 2024). **Note**: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.

A note about the template*:*

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

HIT Roadmap Template Strategy Checkboxes

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

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

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

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

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

CCO: Jackson Care Connect

Date: March 15, 2024

1. Health IT Partnership

Please attest to the following items.

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

2. (Optional) Overview of CCO Health IT Approach

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

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

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

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

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

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

Notes:

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

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

The number of contracted organizations without EHR information totals 55. Twenty of these organizations are physical health, 35 are behavioral health, and 0 are oral health.

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

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 have the opportunity to update missing EHR information any time an organization makes a change to their PIF. Data from the PIF is then

uploaded into QNXT, our claims processing system, so that we have ongoing and real-time access to the most current information we have on file.

Does your clinic use an Electronic Health Record (EHR) software system? ☐ Yes ☐ No

If yes, which software vendor do you use?

If yes, what software version are you using?

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 2023 and plan to implement during 2024-26. Elaborate on each strategy and your progress/plans in the sections below.

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

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

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

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

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

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

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

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

- Depression and SBIRT

- Vaccinations and WCC
- Social needs screening
- IBH templates

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

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

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

Planned Activities	**Planned Milestones**
• Communicate the funding offer to our FQ partners currently implementing EPP in Q1 and Q2, 2024 • Organize with OCHIN the post-pilot launch of first wave of FQ partners' participation in VBPM and HEDIS measures • Evaluate possibilities to extend funding offer to additional primary care network partners currently using EPIC EHR.	• Organized and completed contracting with OCHIN by Q2, 2024 to support our FQ partners' adoption of VBPM and Certified HEDIS measures • 1-2 additional FQ partners will adopt the VBPM and Certified HEDIS measures by Q4, 2025 • Determine funding availability for expansion of participation by Q1, 2026

Strategy 2 title: 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 JCC which will be used in part to enhance and improve HIT infrastructure including EHR optimization.

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

☒ 1: TA ☒ 2: Assessment ☐ 3: Outreach ☒ 4: Collaboration ☐ 5: Incentives ☒ 6: Financial support

☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☐ 10: EHR selection ☒ 11: Optimization ☐ 12: Other:
Strategy status: ☐ Ongoing ☒ New ☐ Paused ☐ Revised ☐ Completed/ended/retired/stopped
Provider types supported with this strategy: ☐ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☒ Behavioral health
Progress (including previous year accomplishments/successes and challenges with this strategy): This strategy is new for 2024; however, in 2023 JCC opened an application cycle for contracted behavioral health organizations. Applications were reviewed and pilot organizations were selected to begin participating in 2024.
Overview of 2024-26 plans for this strategy (optional): SHIFT will begin in January of 2024 with preparation and planning. JCC will work collaboratively with the participating organization to assess current state and redesign a new future state with implementation beginning in Q4 and continuing until 2026. ColumbiaCare Services was selected to participate in SHIFT.

Planned Activities	**Planned Milestones**
1. Begin planning and orientation with participating organizations 2. Conduct assessments of current state and design future state	A. Disperse initial grant funding in Q1 B. Launch cohort in March C. Business Plan confirmed for Columbia Care (noting HIE investments with SHIFT dollars) D. Completion of business plan deliverables by end of 2026

E. EHR Support Barriers: (Optional)

Please describe any barriers that inhibited your progress to support EHR adoption, use, and/or optimization among your contracted providers.
Continuing barriers exist in our network that still linger after the COVID pandemic and overlapping fires that impact workforce, recruitment, and retention. Workforce challenges have continued to impact our network with capacity issues across the continuum of providers (primary care, specialty, RN's, MA's, Behavioral Health workforce.) The lack of adequate workforce combined with high turnover and shrinking workforce pipelines mean a loss of historical knowledge and difficulty teaching basic job skills, resulting in lack of time to take on new projects.

C. OHA Support Needs: (Optional)

How can OHA support your efforts to support your contracted providers with EHR adoption, use, and/or optimization?
Additional funding that has flexibility to meet the needs specific for each clinic – workforce, development, training, etc. Fewer new requirements in other areas will open capacity to focus on EHR improvements.

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

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

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

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. List and describe specific tool(s) you currently use or plan to use for care coordination and timely hospital event notifications.
3. (Optional) Provide an overview of CCO's approach to using HIE for care coordination and hospital event notifications.

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

Notes:

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

Strategy category checkboxes (within CCO)

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

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

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

Point Click Care is a Health Information Exchange that hospitals across Oregon connect to. JCC 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 JCC/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 JCC 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.

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.

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

- Psychiatric Acute Care Admits and Discharges
- BH Cohort – Members who present to the ED for a behavioral health related concern
- Diabetes Cohort – Members who present to the ED or Inpatient for diabetes related concern
- ED Admits in 90 Days
- 5 ED Visits in 12 months
- Pediatric ED Activity
- Rising Risk ED/IP/OBS/SNF – Admit
- Members initiating and engaging in treatment for substance use
- Medicare ED outreach
- Members who have been inpatient >7 days

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

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

Strategy status:

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

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

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

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

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

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

Planned Activities	**Planned Milestones**
1. Identify team to review cases 2. Schedule weekly meetings 3. Build cohort within point click care 4. Develop workflow for running a report, gathering info, and presenting out at weekly meetings	A. Implement weekly review process with new IP >7-day cohort Q2 2024

5. Develop prioritization and triage process 6. Develop and implement outreach and engagement strategies including in person engagement prior to discharge	

Strategy 2 title: Epic Payer Platform (EPP) implementation

Epic Payer Platform is a tool that facilitates bi-directional data exchange with Epic EHR users in network by leveraging technology specifically developed for payor-provider partnerships. Epic is the most common EHR used by physical health providers in 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: Other:

Strategy status:

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

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

Throughout the latter half of 2023, JCC/CareOregon worked closely with a subset of our primary care provider network partners on Epic Payer Platform implementation readiness. Additionally, we initiated partnership work with OCHIN to align efforts for the Community Health Centers that we mutually support around EPP. This work included OCHIN board approval for prioritizing these efforts, and a shift in the initial approach of onboarding 2-3 network partners to a broader offering for all FQHCs in CareOregon's network who are members of OCHIN. While these activities delayed our projected Q4 implementation kick-off, it has substantively improved our reach regarding network awareness of the EPP work and benefits and widened our initial participant pool from 2 to 5 FQHCs participating in this first wave of implementation. One FQHC in the JCC service area is in the initial participant pool representing more than 15,000 JCC members.

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

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

Strategy 3 title: Implementation of a new Care Coordination platform

JCC/CareOregon is selecting and implementing a new care coordination platform to be used by our care coordination teams that will allow for improved workflows as well as integrated of social determinants of health and social needs data. Our selection will be based on high integration with current technology and tools, improved workflows and efficiencies for our Care Coordination teams to support our members as well as ability to better report and adapt to the changing needs and requirements. This intervention also applies to the HIT for SDOH section of this report.

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

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

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

Strategy status:

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

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

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

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

Epic's Compass Rose platform was selected, and we went live on 11/6/23. The next several years will be geared toward optimizing our new platform, building out new programs, and onboarding external partners.

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

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

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

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. List and describe specific HIE tool(s) you currently or plan to support or provide for care coordination and hospital event notifications. CCO-supported or provided HIE tools must cover both care coordination and hospital event notifications. Please include an overview of key functionalities related to care coordination.
3. Report the number of physical, oral, and behavioral health organizations that have not currently adopted HIE tools for care coordination or do not currently have access to HIE for hospital event notifications using the Data Completeness Table in the OHA-provided CCO Health IT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.
4. (Optional) Provide an overview of CCO's approach to supporting increased access to and/or use of HIE for care coordination and hospital event notifications among contracted physical, oral, and behavioral health providers.

5. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 to support increased access to and/or use of HIE for care coordination and hospital event notifications among contracted physical, oral, and behavioral health providers include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. Strategy status
    d. Provider types supported
    e. A description of 2023 progress, including:
        - accomplishments and successes (including the number of organizations of each provider type that gained access to HIE for care coordination tools and HIE for hospital event notifications as a result of your support, where applicable)
        - challenges related to each strategy, as applicable

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

Notes:

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

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

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

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

Point Click Care is a Health Information Exchange that hospitals across Oregon connect to. Network partners are able to 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. 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.

SympIr 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 is embedded within that 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**

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

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 109. Forty-four of these organizations are physical health, 47 are behavioral health, and 15 are oral health.

Strategy 1 title: Optimizing and expanding the use of FIDO

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

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

For 2024 and beyond the behavioral health team is focused on bringing in additional data points from providers focused on "wait times" for programs, e.g., ICM and "time from referral to assessment" to include in the access dashboard. Our planned activities also include providing our subcontracted dental plan partners

access to FIDO dashboard reports to include a holistic view of the members' physical health, behavior health, and prescription history by the end of Q1. Our second milestone is scheduled for Q3 and will include the implementation of on demand FIDO reports that will display the dental partners monthly, yearly, and historical metric performance. Finally, we plan to expand the member profile dashboards to include a deeper level of member data and the ability to access gap lists for outreach efforts by the end of Q4.

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

Strategy 2 title: Optimization of dental referral platform

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

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

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

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

Planned Activities	**Planned Milestones**

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

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

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

JCC facilitated connection between Point Click Care and behavioral health providers to assist in cohort creation and platform utilization effectiveness. For 2023 we provided more details to providers of telehealth regarding requirements for coordination of care. Point Click Care is used by delegated DCO partners to coordinate care for shared members. This is ongoing work, but no specific oral health activities occurred in 2023 or is planned for 2024.

Overview of 2024-26 plans for this strategy (Optional):
JCC is exploring the potential to use an Asante Physicians Partners based tool for coordination of care. CHESS HEALTH is a web-based application that offers solutions to gaps in adolescent and youth adult substance use disorder treatment.

Planned Activities	Planned Milestones
1. JCC is developing a workgroup to support the use of CHESS HEALTH a. Plan for a successful pilot b. Understand stakeholder feedback on CHESS	A. Begin pilot usage of CHESS Health

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 telementoring where expert teams lead virtual clinics. RubiconMD is an electronic consultation (e-consult) platform that connects primary care providers to a national network of board-certified specialists that provide guidance on diagnosis work up and treatment advice options. The platform can be integrated with EHRs and clinical workflow. Both interventions aim to improve the quality of care received by members, as well as improve the quality of referrals/transitions from primary to specialty care.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
JCC continued financial support for access to Rubicon MD. The innovation team supported clinics across the network in onboarding and technical support for the platform.

In 2023, La Clinica del Valle and Rogue Community Health used Rubicon MD.

- These clinics sent 477 in 2023 (213 out of the total were JCC members)
- The top specialties were 1) Endocrinology 2) Hematology 3) Neurology

A large FQHC system engaged in a refresher course and training on new capabilities with Rubicon in 2023 Q4. Initial conversations started in 2023 Q4 about adding JCC clinics to the platform and will be pursued through 2024.

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

Planned Activities	**Planned Milestones**
1. Continue discussions with network partners begun in Q4 2023	A. Continued management of relationship and contract with Vendors and provision of applications to current users. B. Hold discussions with three network partners by Q4 2024.

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, and
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. 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.

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):

Diabetes HbA1c Poor Control: Reliance was initially employed to help capture lab visit data to improve the Diabetes HbA1c poor control rates. However, in 2023, upon further validation, JCC and partner clinics have concluded that other EHR/HIE tools are more robust and are already previously in use. Current contracts with Reliance continue to exist to explore other use cases.

Pregnant Member Identification: Focused work on using Reliance HIE has steadily improved the capture of data to identify pregnant members. This identification was previously difficult and prone to error. Multiple

validation efforts have occurred throughout 2023 and more efforts are underway. The current state of the report looks promising.

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

Planned Activities	**Planned Milestones**
1. Exploration of additional use cases for Reliance HIE outside of Diabetes HbA1c. This work will be in tandem with the partner network. 2. Continued pregnant member data validation for member outreach and engagement. This ongoing process is done monthly with each new iteration. Coordination is accomplished by weekly meetings directly between JCC and Reliance.	A. Data verification to confirm pregnancy roster validity. This milestone will be achieved if historical lookback data from Reliance matches claims data. B. To achieve a pregnancy roster suitable for distribution to clinic systems for member outreach during pregnancy. C. Identify additional use cases for Reliance HIE, particularly those related to behavioral health and specialty referrals.

C. HIE for Care Coordination Barriers: (Optional)

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

Programs that notify providers of hospital events are not integrated within their EHRs, resulting in the need to access a separate application. This is a barrier for provider systems and is prohibitively expensive to integrate.

42 CFR Part 2 greatly inhibits the ability to notify primary care providers when one of their patients is seen in the emergency department or hospital for care related to substance use disorders.

Not all providers allow CCO care coordinators to access their EHR systems, greatly inhibiting CCO ability to coordinate care.

D. OHA Support Needs (Optional)

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

Invest dollars in supporting interfacing between various electronic systems for improved integration.

Create a mechanism that allows notification of primary care providers when their patients received substance use disorder care in another setting so that care can be coordinated.

Assist with care coordination rules that would support CCO efforts to try and integrate care.

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

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)?

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

JCC 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?
JCC Regional Care Teams, outreach teams, and panel coordinators use their EHR access to outreach to and schedule appointments for members due for preventive visits and to those with identified gaps in care. They also scrub the charts of members with upcoming visits to ensure that they receive critical preventive and chronic disease management services during the visit. Additionally, they may use their EHR access to assist their host clinics with other quality improvement or outreach priorities.
Is/will patient information being/be exported from the EHR and imported into CCO health IT tools? If so, which tool(s)?
The regional care teams and panel coordinators do not export information from EHRs into CCO health IT tools.

5. Health IT to Support SDOH Needs

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

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

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

Notes:

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

Strategy category checkboxes (within CCO)

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

Progress	Plans		Progress	Plans	
☒	☒	1. Implementation/use of health IT tool/capability for social needs screening and referrals	☐	☐	6. Integration or interoperability of health IT systems that support SDOH with other tools
☐	☐	2. Care coordination and care management of individual members	☐	☐	7. Collaboration with network partners
			☐	☐	8. CCO metrics support
☒	☒	3. Use data to identify individual members' SDOH experiences and social needs	☐	☐	9. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)
☐	☐	4. Use data for risk stratification	☐	☐	10. Participate in SDOH-focused health IT collaboratives, convening, and/or governance
☒	☒	5. Use health IT to monitor and/or manage contracts and/or programs to meet members' SDOH needs	☐	☐	11. Other strategies for supporting CIE use within CCO (please list here):
☐	☐	12. 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 new Epic-based care coordination platform implemented by CareOregon in November of 2023. It has replaced GSI, our previous software. Compass Rose allows for improved collection and use of social needs information.

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

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

Strategy status:

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

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

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

Configured HealthTrio to allow CBO access
HealthTrio is the platform that hosts our provider portal, CareOregon Connect. In 2023, we completed configuration to extend access to the platform to CBOs that hold contracts with the CCO. This included allowing a non-billable provider profile, developing a CBO-specific view with limited functions, and configuring CBO-specific mailboxes for secure data sharing. CBO accounts were established for 4 CBOs in Jackson County using this configuration.

Established CBO contracts, including fee schedules and BAAs
In 2023, JCC signed two new CBO contracts including fee schedules that will allow us to pay the CBOs for services provided to our members on a monthly basis. Contract terms require member eligibility verification and monthly reporting and invoicing. The contract and associated Business Associates Agreement provide access to HealthTrio for these CBOs so that they can meet these requirements.

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

Overview of 2024-26 plans for this strategy (Optional):
Between 2024 and 2026, JCC plans to establish contracts with additional CBOs and onboard them to HealthTrio to support payment terms in their contracts; and explore use of HealthTrio to support the Health Related Social Needs (HRSN) service provider agreements.

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

Strategy 2 title: Development of population segmentation program that integrates SDOH

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

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

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

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

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

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

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

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

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

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

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

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

Planned Activities

1. **Software Upgrade**: Upgrade to the newest version of Johns Hopkins ACG, including the newly accessible geographic risk module that includes social health data and visualization tools
2. **Clinic Engagement**: Engage clinic partners in developing a condition-focused segmented risk prediction model that includes social needs data
3. **HRSN Eligibility Mining**: Use existing data sources to identify members potentially eligible for the HRSN benefit through membership in a transition population with social and clinical needs
4. **Current state check-in & inventory**: Develop current state assessment of company-wide

Planned Milestones

A. March 2024 –
   a. **Software Upgrade**: Secure information systems resources to implement new and upgraded ACG software modules
   b. **Clinic Engagement**: Engage clinic partners to determine the aim of a co-developed segmented risk prediction model
B. April 2024 – **HRSN Eligibility Mining**: Begin to leverage social needs data from screenings to identify prospectively eligible members for the HRSN climate benefit
C. July 2024 – **Clinic Engagement**: Engage clinic partners to select social needs data that is strongly correlated with the selected condition in the co-developed segmented risk prediction model

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

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

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

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

- challenges related to each strategy, as applicable

f. (Optional) An overview of CCO 2024-26 plans for each strategy

g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

Notes:

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

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

Progress	Plans		Progress	Plans	
☒	☒	1. Sponsor CIE for the community	☐	☐	8. Requirements in contracts/provider agreements
☒	☒	2. Financial support for CIE implementation and/or maintenance	☐	☐	9. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)
☐	☐	3. Training and/or technical assistance	☐	☐	10. Integration or interoperability of health IT systems that support SDOH with other tools
☒	☒	4. Assessment/tracking of CIE/SDOH tool adoption and use	☒	☒	11. Support CBOs sending of referrals to clinical providers (i.e., to physical, oral, and behavioral health providers)
☒	☒	5. Outreach and education about the value of health IT adoption/ use to support SDOH needs	☐	☐	12. Utilization of health IT to support payments to community-based organizations
☒	☒	6. Support participation in SDOH-focused health IT collaboratives, education, convening, and/or governance	☐	☐	13. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs (please list here):
☐	☐	7. Incentives and/or grants to adopt and/or use health IT that supports SDOH	☐	☐	14. Other strategies for supporting access or use of SDOH-related data (please list here):

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**

JCC provides financial support to ensure that health care and social service providers in the region can access the Connect Oregon network at no cost. This includes paying for software integration for local FQHCs. JCC also provides trainings and ongoing technical assistance to these organizations to implement & optimize their use of

Unite Us, provides opportunities for providers to give feedback on the platform, and advocates with Unite Us for changes to address barriers to use of the platform.

Supporting and Incentivizing HRSN Service Providers

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

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

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

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

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

- **Awarding Community Capacity Building Funding (CCBF) to potential HRSN Service Providers.** Requests to support CIE technology costs and workflow development to prepare for the HRSN benefit will be considered during the CCBF application review process.
- **Incorporating CIE outreach into HRSN Service Provider contracting conversations**. Contracting conversations will establish agreements about the methods for conducting closed loop referrals and identify any support the organization needs to receive closed loop referrals through CIE.
- **Conducting onboarding for HRSN service providers in Q4 2024**. Onboarding will include training on use of CIE to send and receive closed loop HRSN referrals for all HRSN service providers that choose to participate.
- **Providing 1:1 education and technical assistance and workflow development for HRSN service providers.** Technical assistance will be available for all HRSN service providers to support workflow development and address barriers to using CIE for closed loop referrals.
- **Establishing feedback mechanisms for HRSN Service Providers.** Plans include regularly scheduled 1:1 meetings with HRSN Service Providers to provide feedback about HRSN workflows and processes (including closed loop referral processes), and HRSN Service Provider convenings which will include opportunities to learn, provide feedback, and coordinate across organizations.
- **Incorporating CIE referral volume criteria into qualify pool payment methodology for the SDOH screening metric.** HRSN Service Providers that have sent or received referrals during the measurement year will qualify to receive qualify pool payments beginning in 2025.

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

Connect Oregon/Unite is a community information exchange that allows bi-directional information sharing and transparency across referral network. JCC is 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: Financial ☐ 3: TA ☒ 4: Assessment ☒ 5: Outreach/Education ☒ 6: Participation
☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

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

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

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

JCC completed its fourth year of community sponsorship of the Unite Us/Connect Oregon CIE platform and as a result JCC staff sent 74 referrals with a 91% acceptance rate in 2023. Additional activities and successes are listed below.

Financial support for CIE implementation and/or maintenance

- JCC continued to sponsor the platform through payment on behalf of CCO members in all three regions.
- As part of this sponsorship, JCC continued to financially support an additional year of costs for local FQHCs to access and integrate the Unite Us platform. This included a $30,000 investment to support Unite Us integration for Asante.
- Jackson County Community Justice (Parole and Probation) implemented Unite Us with tablets for $42,000
- JCC invested $125,000 per clinic for SDOH Tier 1 Initiative for clinics who sent or received platform referrals in 2023.

Education and technical assistance

- JCC provided ongoing assistance to network partners, as they built workflows using the Unite Us platform to address needs.
- JCC provided technical assistance to CBOs interested in incorporating the use of Connect Oregon into their workflows.

Use case identification

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

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

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

We experienced the following challenges while implementing this strategy

- CBO concerns about participation in the Connect Oregon network, including concerns about their capacity to meet referral volume
  - Current mitigation: developing pathways for paying CBOs for services
- Workflow adoption by clinics even with tool integration
  - Current mitigation: Advocating with OCHIN and Unite Us to build expedited timelines for more meaningful interoperability, and aligning CIE usage with other social health initiatives
- Low referral acceptance rates leading to disengagement among referring agencies
  - Current mitigation: focusing on identifying use cases that are best suited for use of CIE

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

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

Planned Activities	**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	A. Education/technical assistance a. Provide education and training to support an increase in referrals marked as resolved by 15%, by end of Q4 2024 B. Use case identification

3. Incorporate the use of Unite Us into the HRSF request process workflow 4. Prepare to utilize the Unite Us platform for HRSN referrals 5. Support and incentivize use of Unite Us for HRSN referrals	a. Develop an intake approach to considering and resourcing new referral use cases by Q3 2024 C. HRSF request process a. Identify opportunities to incorporate Unite Us into the HRSF request process by Q3 2024 b. Incorporate the use of Unite Us into the HRSF request workflow by Q4 2024 D. HRSN referral pathway development and incentivization a. Develop workflows and configure the software for HRSN service providers to receive HRSN referrals through Unite Us by Q4 2024 b. Onboard and train housing HRSN service providers on closed loop referral processes by Q4 2024 a. Train care coordination staff to send HRSN referrals by Q4 2024 b. Onboarding and train food HRSN service providers on closed loop referral processes by Q1 2025 c. Convene HRSN service providers to gather input into CIE referral processes by Q3 2025 d. Incorporate CIE requirements into HRSN service provider contracts in 2026

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

Please describe any barriers that inhibited your progress to support contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support SDOH needs, including but not limited to screening and referrals.
Having a single, Community Information Exchange statewide aids end user capacity to access CIEs without multiple interfaces. Current CIE barriers are vendor level issues.

D. OHA Support Needs (Optional)

How can OHA support your efforts in using and supporting the use of health IT to support SDOH needs, including social needs screening and referrals?
A single program to track all SDoH needs, screenings, and referrals throughout the state.

6. Other Health IT Questions (Optional)

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

A. Describe CCO health IT tools and efforts that support **patient engagement**, both within the CCO and with contracted providers.
CareOregon has launched the MyCareOregon mobile app for iOS and Android smartphones. The MyCareOregon app is designed to offer members a new channel to access their benefit information, to navigate their health care and improve their overall member experience. Using the app, members will be able to view their:

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

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

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?

Programs that notify providers of hospital events are not integrated within their EHRs, resulting in the need to access a separate application. This is a barrier for provider systems and is prohibitively expensive to integrate. OHA can invest dollars in supporting interfacing between various electronic systems for improved integration.

42 CFR Part 2 greatly inhibits the ability to notify primary care providers when one of their patients is seen in the emergency department or hospital for care related to substance use disorders. OHA can create a mechanism that allows notification of primary care providers when their patients received substance use disorder care in another setting so that care can be coordinated.

Not all providers allow CCO care coordinators to access their EHR systems, greatly inhibiting CCO ability to coordinate care. OHA can assist with care coordination rules that would support CCO efforts to try and integrate care, in particular, make it clear that it is legally okay for CCO care coordinators to access member records.

D. How have your organization's health IT strategies supported **reducing health inequities**? What can OHA do to better support you?

Care coordination is most impactful for members who are experiencing significant medical and social life events and have the hardest time navigating the healthcare system. By improving electronic integration, care coordination is far more likely to be successful to bring equitable coordination support to all.

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

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