2025 CCO Health Information Technology (HIT) Roadmap

Guidance, Evaluation Criteria & Reporting Template

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

Please:

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

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

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Guidance Document

1. Purpose & Background

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

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

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

Reminders for Contract Year 6 (2025):

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

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

2. Overview of Process

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

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

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

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

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

***2025 Health IT Roadmap* Timeline**

Last Revised 12/2/2024

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

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

3. Health IT Roadmap Approval Criteria

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

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

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

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

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

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

2025 Health IT Roadmap Template

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

Instructions & Expectations

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

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

Each required topic includes the following:

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

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

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

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

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

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

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

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

A note about the template*:*

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

Health IT Roadmap Template Strategy Checkboxes

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

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

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

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

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

CCO: PacificSource Community Solutions; Columbia Gorge, Central Oregon, Lane and Marion-Polk
Date: 3/15/2025

1. Health IT Partnership

Please attest to the following items.

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

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

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

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

3. (Optional) Overview of CCO Health IT Approach

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

Our vision is to be the lifelong trusted partner of our members and communities—helping to improve their health and well-being, healthcare experience, and access to affordable care.

In 2024, PacificSource Community Solutions (PCS) committed to heavily investing current and future resources in Health IT. We are leveraging Health IT to care for our members and communities as both individuals with unique needs and as members of wider communities.

This 2025 CCO HIT Roadmap describes strategies and associated activities that support our organizational goals to:

- Meet members as real people with unique health and support needs
- Serve as a bridge for our members to access needed healthcare and community resources
- Mitigate confounding socioeconomic factors that impede health improvements
- Support localized decision-making and resource allocation for each distinctive community
- Earn the trust of our members by investing in our communities
- Steward resources responsibly and effectively for the benefit of our members and communities

Investment in Health IT

In 2024, we focused on Health-Related Social Needs (HRSN), a challenging undertaking given that various systems were not designed to support HRSN referrals and payments.

Connecting members to HRSN service providers offering climate supports, housing, and nutrition meant mapping, developing, and implementing new pathways. This in turn meant extensive collaboration, resource provision, and adaptability across stakeholders.

We continued to invest in interoperability, adoption of the Health Information Exchanges (HIE) and Community Information Exchanges (CIE), and expansion of existing programs.

Moving forward into 2025 and 2026, we will invest in Epic Payer Platform (EPP), improve HRSN administration, and advance care coordination with available HIT resources.

Tools and Systems

We used existing HIE and CIE platforms for care coordination and to implement HRSN supports.

2024 Systems

- **HIE:** PointClickCare (PCC), formerly Collective Medical Technology (CMT)
- **HIE:** Reliance eHealth Collaborative
- **CIE:** Unite Us / Connect Oregon

In 2024 we made the difficult decision to reallocate resources and termed our contract with Reliance effective 12/31/24.

2025 Systems

- **EHR/HIE:** Epic Payer Platform (begin implementation)
- **HIE:** PointClickCare
- **CIE:** Unite Us / Connect Oregon

As a part of the Program of All-Inclusive Care for the Elderly (PACE), we will implement OCHIN Epic.

Internal Staff and Partnerships

We partnered with internal teams, vendors, CCO health councils, other CCOs, and OHA to identify and advance HIT for care coordination.

While we used staff departures as an opportunity to thoughtfully redesign internal structures in 2024, turnover did create temporary disruptions to ongoing work.

Data Collection Methods

We gathered, verified, corrected, and supplemented HIT adoption information in 2024 by:

- Partnering with internal roles for site visits and one-on-one conversations
- Collaborating with independent practice associations (IPAs) to verify data
- Gathering insights from health council partners and community-based HIT Collaborative/workgroup provider members
- Using Delivery Service Network (DSN) reports, surveys, and external resources

Challenges and Adaptations

Developing internal and external collaborations remains both a priority and challenge as we foster new technologies. Our HIT teams focused on connecting with individuals and groups that work directly with provider partners to identify opportunities for advancement.

Adapting systems to handle use cases beyond the scope of their original design continues to be a challenge.

During 2025-2026, our HIT teams will continue to strengthen collaborations with vendor partners, community stakeholders, and members. To support broad interoperability with providers who use Epic, we will implement Epic Payer Platforms (EPP). Additionally, we will work with all providers – not just those on Epic – to facilitate interoperability for electronic prior authorizations via the EPP system.

4. Support for EHR Adoption, Use, and Optimization

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

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

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

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

Notes:

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

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

Electronic Health Record (EHR) Implementation

Most of our provider partners use an EHR or Practice Management Software (PMS), even those who initially check the "No EHR" box. Further digging usually reveals a functional equivalent.

HIT Data Collection Strategy

Our strategy includes the following efforts:

- Maintain an internal database of provider HIT data
- Build internal relationships among teams that have direct provider relations
- Educate internal partners on what HIT is and why it matters
- Have internal partners gather HIT information during provider interactions
- Incorporate new information from annual OHA HIT Data Reporting file
- Leverage relationships with dental care organizations (DCOs) to gather dental provider HIT data
- Create new HIT tracking tools and strategies to identify provider engagement opportunities

Takeaways

- Most “No EHR” providers actually have an EHR or PMS.
- Gathering HIT information from new and existing providers remains challenging.
- Smaller providers tend to use PMS solutions specific to their field.
- PMS solutions generally lack interoperability, limiting opportunities for real-time care coordination.

2024 Electronic Health Record (EHR) Saturation by CCO Region

CCO: 2024 Central Oregon	Number of Contracted Providers	Number w/out EHR Information	Percent w/o EHR Information	Number of contracted PCPCHs	Number w/o EHR Information	Percent w/o EHR Information
Physical Health	100	39	39%	17	0	0%
Behavioral Health	251	141	56%	1	0	0%
Oral Health	17	9	53%	0	0	0%

CCO: 2024 Columbia Gorge	Number of Contracted Providers	Number w/o EHR Information	Percent w/o EHR Information	Number of contracted PCPCHs	Number w/o EHR Information	Percent w/o EHR Information
Physical Health	27	5	19%	8	0	0%
Behavioral Health	29	19	66%	0	0	0%
Oral Health	6	1	17%	0	0	0%

CCO: 2024 Lane	Number of Contracted Providers	Number w/o EHR Information	Percent w/o EHR Information	Number of contracted PCPCHs	Number w/o EHR Information	Percent w/o EHR Information
Physical Health	127	55	43%	25	0	0%
Behavioral Health	278	207	74%	2	0	0%
Oral Health	36	15	42%	0	0	0%

CCO: 2024 Marion Polk	Number of Contracted Providers	Number w/o EHR Information	Percent w/o EHR Information	Number of contracted PCPCHs	Number w/o EHR Information	Percent w/o EHR Information
Physical Health	105	27	26%	35	0	0%
Behavioral Health	165	92	56%	3	0	0%
Oral Health	38	19	56%	0	0	0%

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

2025 HIT Data Collection Strategy

Our 2025 strategy includes the following efforts:

- Strengthen relationships with providers
- Create educational materials and presentations for internal teams with direct provider contact
- Educate teams and partner organizations on what EHRs are and why they matter
- Create workflow under which internal teams gather EHR data during provider interactions and disseminate to HIT team for internal tracking
- Partner with DCOs to gather missing EHR data from dental providers
- Create new HIT tracking tools and strategies to identify provider engagement opportunities

Strategy category checkboxes

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

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

(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**

2025 EHR Adoption, Use, and Optimization Strategies

We will approach supporting care coordination via EHR with three related efforts:

1. Develop assessment and monitoring process for EHR adoption across provider types
2. Build approach and model for deploying adoption support resources
3. Encourage and support EHR adoption and optimization

Strategy 1: **Develop Assessment & Monitoring Process for EHR Adoption Across Provider Types**
Establish a process for gathering and tracking EHR adoption data

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

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

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

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

In 2024 we continued strengthening partnerships with internal and external partners to gather and update EHR data.

Internal Partnerships
To increase internal cohesion, we brought together teams that work on these areas:

- Population health (behavioral and physical)
- Provider network
- Dental services

Data Sources
Our collaboration focused on gathering and tracking EHR adoption data from these sources:

- Delivery Service Network Reports
- 2023 PCS HIT Provider Survey
- Quality Incentive Metrics Outreach Survey
- Dental care organizations

Internal Processes
We reviewed our Electronic Health Records Adoption Policy, which supports EHR adoption by:

- Using a multi-pronged approach to identify adoption rates
- Implementing annual strategies
- Allocating community resources to address unique scenarios in support of adoption

Adaptability
In special cases, we can partner with specific clinics to meet EHR needs in support of community goals. In such instances, EHR adoption-related activities can be completed by subcontractors, including dental care organizations.

These cases typically require:

- Agreement by a collective of community partners
- Identification of a specific negative community impact caused by a provider's lack of EHR

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

Planned Activities	Planned Milestones
Collect data on EHR status across range of health providers	2025 – 2026
Use Delivery Service Network report to identify in-scope providers	2025 – 2026
Compare in-scope list with catalog of contributors from HIE operating in region	2025 – 2026
Collect data from providers with unknown status	2025 – 2026
Corroborate baseline against any available external sources	2025 – 2026
Collect data via Provider Site Visits	2025 – 2026
Complete annual review/update of Electronic Health Record Adoption Policy	2025 – 2026
Add updated EHR data to internal HIT database	2025 – 2026
Explore opportunities for storing additional HIT data	2025 – 2026

Strategy 2: **Build Approach and Model for Deploying Adoption Support Resources**
Identify and implement methods for setting adoption goals and advancing awareness, adoption and ultimately usage of EHR systems

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):

Our primary EHR adoption support mechanism remains partnering with CCO governing boards and key provider partners. Maintaining regular communication and leveraging community collaborations helps to identify and address gaps in EHR adoption and improve care coordination.

EHR Awareness and Education
To support awareness and education, our approach is to:

- Focus on adoption support resources
- Partner with our health councils
- Partner with key provider partners

Community Health Councils
We partner with CCO health councils to share, educate, and collaborate. Annually, we work with each council to tailor HIT goals that reflect unique community priorities, culture, and resources.

As community stakeholders, health councils are uniquely positioned to identify gaps in care coordination caused by insufficient EHR utilization. Our Electronic Health Record Adoption Policy highlights this important role.

In 2024, the Willamette Health Council moved away from separate HIT Collaborative meetings and began addressing HIT topics in quarterly Clinical Advisory Panel meetings. The Central Oregon HIE met bi-monthly.

Provider Partnership
We hold virtual meetings with key provider partners across CCO regions to drive awareness, monitor provider capacity and identify gaps in EHR adoption.

We also maintain contractual arrangements with Independent Physician Associations to support HIT-related consulting, advising, and technical services for small independent provider practices.

Data Collection
Collaborating with health councils, we prioritized outreach to providers whose EHR status was uncertain. We used the following data sources:

- Region-specific adoption reports
- Assigned member volume
- Claims volume

Vendor Partnership
In 2024, we contracted with a third-party consultant to develop a strategic action plan to enhance quality and risk adjustment performance with select primary care providers.

Goals for this partnership included:

- Improve health outcomes
- Improve access to quality care
- Support data management
- Garner resource assistance
- Focus on quality and risk data integration

Because this work led to more supplemental clinical data sources for our Medicare plans, we may choose to do similar work for Medicaid in 2025.

2024 Accomplishments

- Worked directly with clinics to implement CPTII coding
- Produced and distributed a guide for Epic Reporting Workbench
- Created and distributed a crosswalk for SNS-E and Oregon SDOH metrics

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

We will continue working with our CCO Directors and health councils to develop regional adoption and optimization plans.

The 2025 ongoing work between PCS and a third-party consultant includes:

- Working directly with a provider to produce a SNS-E/Oregon SDOH metric SDS file
- Presenting a proposal to OCHIN to complete a SDS file build that includes SNS-E and the Oregon SDOH metrics (Q1 2025)

Planned Activities	Planned Milestones
1. Develop peer relationships with high-impact provider partners through system integrations and system relationships as a conduit to education/awareness	2025 – 2026
2. Categorize providers without EHR by impact (e.g. member/claims volume)	2025 – 2026
3. Engage health councils and Clinical Advisory Panels (as appropriate) on success and opportunities with EHR; define high-priority populations that may be better served by EMR adoption and establish regional goals and provider targets	2025 – 2026
4. As needed, complete analysis of resources needed to address identified gaps in EHR adoption and develop adoption and optimization plans	2025 – 2026

Strategy 3: **Encourage and Support EHR Adoption and Optimization**
Support and monitor EHR implementations and report back to stakeholders; operationalize the process where possible

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

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

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

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

EHR adoption remains high among larger practices and systems in each of our CCO regions.

In larger communities, we strategically focus on provider partners that are most likely to have a high impact and be willing to engage due to factors like expanded contractual relationships.

We provide educational information for smaller communities and practices that may struggle to engage due to resource constraints.

Educational information includes explaining what EHR, HIE, and CIEs are and why they matter.

For example, if a provider is not familiar with HIT tools and their purposes, we might share the "HIE Terminology and Purpose" handout.

Health Information Exchange Terminology & Purpose

Acronym	Title	Description
HIT	Health Information Technology	Technology software and systems that deal with the storage, retrieval, sharing and use of healthcare information and data. Providers use these systems to various degrees depending on the type of care being provided (physical, oral, behavioral health) and the size of the practice, among other factors.
EHR	Electronic Health Record	An electronic (digital) patient chart. OHA requests the name of the Electronic Health Record system the provider uses, if any, and the year the software was certified.
HIE	Health Information Exchange	An organization or technology system that facilitates the exchange of information, AND the process of moving healthcare information electronically between organizations. OHA requests the name of the Health Information Exchange system the provider uses, if any.
HEN	Hospital Event Notification	A health information exchange application that provides notifications of admits, discharges and transfers of a provider's patients from/to hospitals and emergency departments. OHA requests the name of the system the provider uses to receive this type of information, if any.
CIE	Community Information Exchange	Software applications used to make referrals to community based organizations for social services focused around social determinants of health (SDOH). OHA requests the name of the system provider uses, if any.

Core HIT Platforms used by PacificSource

While there are many different Health Information Technology tools available, PacificSource has adopted three primary platforms for our Health IT programs:

Health Information Exchange platform: Reliance eHealth Collaborative

- Reliance eHealth Collaborative: www.reliancehie.org
  - Most prevalent use currently in Central Oregon and Columbia Gorge CCOs
  - Currently working to build network in Lane CCO
  - Not much involvement yet in Marion-Polk CCO
- A detailed clinical data exchange and repository
- Can search and view up-to-date patient records including lab and diagnostic tests, hospital reports, discharge summaries and care summaries that providers have contributed to the system

Hospital Event Notification platform: Collective Medical / PointClickCare

- Collective Medical: www.collectivemedical.com
- Formerly known as PreManage (the primary care portion) and EDIE (emergency department information exchange)
- Functions primarily to identify admit, discharge and transfers from hospitals and emergency departments for care coordination
- Providers can define the types of alerts received about their patients using cohorts and reports built around their patient membership/roster files
- Providers can use it to coordinate follow-up care and compliance deliverables around timelines and responsiveness

Community Information Exchange platform: Connect Oregon

- Connect Oregon: www.Oregon.uniteus.com
- Network of health and social service providers throughout Oregon
- Supports social determinants of health referrals
- Coordination center is powered by 211info and supports community engagement

HIE Terminology and Purpose Handout

When we need EHR access to manage critical functions like transitions of care, the "Electronic Medical Record Access" document educates on how EHR access is used and how EHR access helps the provider, PCS, and the member.

Electronic Medical Record Access

Health Services

Area	Scope of Use	Benefits
Appeals and Grievances	• Clinical and non-clinical A&G team members leverage provider EMRs for appeal reviews. •Medical directors review EMR chart notes to evaluate member grievances regarding quality of care.	• Rapid identification and retrieval of documentation to avoid delays in approving authorizations, resulting in members having faster access to care. •Avoidance of PacificSource making authorization appeal decisions without comprehensive chart notes, in the event provider administrative staff are unable to respond to data requests.
Care Management	•Clinical and non-clinical team members utilize EMR data to support coordination of care. Coordination of care activities include reviewing care summaries, identifying updates to a member's care, assisting members with obtaining necessary medical supplies, and confirming whether providers are in-network. •EMR access allows for care teams to identify a member's social determinants of health and better support members at risk. •Care teams utilize EMR to identify care gaps and help members schedule appointments. •Care teams utilize EMR to assist with Transition of Care activities.	•Enhanced member/patient experience through more efficient collaboration between PacificSource and provider groups, resulting in less burden on provider group administrative staff to complete data sharing requests. •Better understanding of members' health, enhancing positive health outcomes.
Quality	•EMR access is utilized for medical record review to drive performance gap closures. Specifically, data collection and aggregation for performance metric reporting is conducted more efficiently, allowing for more accurate plan ratings. •Quality team members identify gaps in care and coordinate with the Care Management team to close those gaps.	•Significant savings of time and resources for provider groups during chart review periods, allowing PacificSource to directly access necessary member/patient chart information. • In the event of incentive contracts, provider groups receive bonuses for performance on quality measures.
Risk Adjustment	•PacificSource utilizes EMR data to conduct coding review activities, sometimes resulting in additional diagnosis codes identified. •EMR allows the RA team to more efficiently close HCC gaps and identify provider education opportunities through chart reviews.	•Significant savings of time and resources for provider groups during audit periods, allowing PacificSource to directly access necessary member/patient chart information. •In the event of risk sharing contracts, provider groups receive incentive bonuses for additional diagnosis codes found through RA team coding review activities.
Utilization Management	•PacificSource utilizes EMR data to conduct concurrent reviews and respond to authorization requests, allowing the UM team to more accurately and quickly identify the medical necessity of a service. •EMR access assists with the claims review process in the event of validating billed amounts greater than DRG.	•Enhanced member/patient experience through more efficient concurrent reviews and responses to requests for authorizations. •Elimination of the need to make authorization decisions without full chart notes and patient histories. •Reduced administrative burden for provider groups and hospital systems due to automatic data transfers.

Electronic Medical Records Access Handout

In 2024, we were allowed access to the following EMRs:

Service Provider	Access Method
Bend Transitional Care	Avamere website
Columbia Gorge Family Medicine	VPN
Community Health Centers of Lane County	Next Gen Health Care
Fall Creek Internal Medicine	idmserver
High Lakes Health Care / Praxis Medical Group	Citrix portal
Legacy Health	EpicCare Link
Mid-Columbia Center for Living	VPN on per-patient basis
Mosaic Medical	EpicCare Link
Northwest Specialty Clinics	Carefinity
Northwest Medical Homes	ECWCloud
OHSU	EpicCare Link
One Community Health	EpicCare Link
Oregon Medical Group	EpicCare Link
PeaceHealth	AccessNow portal
Providence	EpicCare Link
Salem Clinic	Citrix
Salem Health	EpicCare Link
Samaritan Health Services	EpicCare Link
Santiam Hospital	St. Charles EpicCare Link
St. Charles	EpicCare Link
Summit Health	EpicCare Link

Local Partnerships
We support smaller practices indirectly through relationships with IPAs such as COIPA in Central Oregon. These associations provide front-line adoption and technical support for independent small providers.

Progress by CCO Region
Columbia Gorge EHR adoption in the Columbia Gorge remains strong, with no new targets identified. We are closely monitoring a key regional provider transitioning to a new EHR system due to an acquisition.

Central Oregon Central Oregon had robust support for EHR adoption through COIPA, which offered structural, financial, and technical support to a group of eight independent health practices dedicated to transitioning to Epic Garden Plot – Epic's software-as-a-service, web-based EHR designed for independent health organizations with 20-80 providers specializing in primary care, orthopedics, and obstetrics/gynecology.

COIPA identified these areas for improvement during transition:

- Customize Staff Training: They plan to perform an in-depth assessment of staff jobs and functions and use that information to tailor training specifically for go-live.
- Increase Preparation Time: Epic Garden Plot was implemented approximately 4 months from the contract date. Allowing 6-9 months would have improved the go-live experience.

Lane EHR adoption data was presented to our internal CCO Director and external Lane Community Health Council Executive Director early in 2024. Creating a Lane Regional HIT Collaborative in partnership with the health council and the Trillium CCO remains a goal.

Marion-Polk Marion-Polk adoption data was presented to our internal CCO Director, Community Health Coordinator and external health council staff to help determine CAP priorities in 2024.

Additional Progress Specific to Oral Health Providers
Our HIT team partners with our Dental Services Program Manager to develop strategies to support the adoption of EHR technologies specific to oral health.

Oral health providers often struggle with new technology cost, limited staff resources, and a lack of IT staff when implementing an EHR. Most oral health providers use a dental practice management software which lack interoperability capabilities.

We work directly with DCOs to support oral health providers. DCOs use scale to provide resources and support that individual oral practices would otherwise lack.

Clinical Dental Referrals FAQ

When and how to refer

A formal referral should be made when:

- An oral health assessment or screening indicates the presence of dental disease or other concerns; and/or
- The patient is not established with a dentist

For Medicaid patients, referrals should ideally be from/between the primary care provider and the dental provider of record or assigned dental care organization (DCO).

Dental referrals should be **documented and tracked for completion**, like other types of referrals initiated by primary care. Note that PacificSource considers merely advising a patient to visit a dentist or call their DCO or plan as guidance, rather than a formal referral.

Though not ideal, there may be situations where giving a patient guidance to visit a dentist is the best option, due to a lack of information needed to make a referral.

Referral pathways

- **Medicaid/Oregon Health Plan (OHP) members with an assigned DCO (most OHP members):** Send referral to the member's DCO. Please refer to the OHP Dental Benefit System Reference Guide for Care Coordinators.
- **Medicaid/OHP members who do not have a DCO (no DCO on their member ID and no DCO assignment in InTouch for Providers), and have dental benefits directly with the state:** Send referral to the dentist (dental home) with whom the member is established. If member isn't established with a dental home, send referral to the OHP Care Coordination team: 800-562-4620 (fax: 866-350-1311), or to the OHP Client Services team: 800-273-0557.
- **Patients with commercial or individual dental insurance:** Send referral to the dentist (dental home) with whom the member is established. If member isn't established with a dental home, send referral to the plan contact on the insurance ID, or instruct the patient to call their plan for help choosing a dentist.
- **Patients without dental insurance who are ineligible for OHP:** Referral should be made to the patient's dentist (dental home) if the member is established with one. If not, providers should share low-cost dental care resources from the Oregon Dental Association: OregonDental.org/for-the-public/low-cost-dental-care.

Health Information Technology (HIT) and referrals

PacificSource encourages clinics to use HIT systems to send, track, and close referrals when possible and appropriate.

Despite the advantages of HIT systems, sending referrals in this manner can be challenging when the referring and receiving providers use different technology platforms.

Continued >

PacificSource Health Plans and PacificSource Community Solutions PRV904_0724

Some tips for commonly used referral systems:

Connect Oregon is a community information exchange network built on the Unite Us platform. Though primarily used for social needs referrals, it can also be used for social care entity-to-clinical provider referrals, and clinical provider-to-provider referrals when the clinical information exchanged is minimal (such as from primary care to dentist or DCO).

PacificSource providers have free access to Connect Oregon. Learn more at UniteUs.com/networks/oregon or by contacting Provider Services at ORProviderService@PacificSource.com.

Epic Electronic Health Record (EHR): Each organization's instance of Epic is unique to that organization, so the instructions below are provided as a guide only. Sending and receiving providers will need to collaborate on details.

- **Epic-to-Epic:** Sending and receiving providers can use Epic's Care Everywhere Referral Management (CERM) to send and receive referrals.
- **Non-Epic to Epic:** If the receiving provider offers EpicCare Link, the referring provider can use a web portal to log in to the receiving provider's Epic instance to place the referral. The referring provider must first request and establish an account in the receiving provider's Epic instance.
- **Epic to non-Epic:** There is currently no formal, Epic-based referral system from Epic to non-Epic EHR systems. In this scenario, organizations typically leverage other methods that use basic standards for interoperability, such as Direct Secure Messaging.

Direct Secure Messaging: Also called Direct Exchange or just Direct, this is an encrypted email tool used for exchanging health information, including referrals, between healthcare entities.

Direct uses identity-proofing to ensure messages are accessible only to intended recipients, per the Health Insurance Portability and Accountability Act (HIPAA).

Direct is flexible and can be used broadly across the healthcare ecosystem. However, many providers have access to multiple Direct accounts, and there can be difficulty integrating this information into a provider's workflow. For more information, see HealthIT.gov's Direct Secure Messaging Basics: Q&A for Providers (PDF) (PacSrc.co/dsm-for-providers).

Secure File Transfer Protocol (SFTP) uses file encryption to establish secure channels between computers over the internet. It can be used to transfer referrals and supporting documentation from a referring provider to a receiving provider. A unique "key" is needed to open the information on the receiving end.

This method works well as a data sharing mechanism. Only one side of a data sharing relationship is required to host the SFTP.

Additional Progress Specific to Behavioral Health Providers
Our HIT team introduced the HIT program and led discussions around opportunities and challenges specific to Behavioral Health (BH) providers with members of our Population Health – Behavioral Health team. The HIT team also supported the BH Performance Improvement Group by providing BH technology barrier analysis and identification of program-level interventions.

The HIT team worked with our BH Team to institute a series of strategy and development meetings bi-monthly to facilitate communication with external partners. We are sending out BH and Social Determinants of Health (SDOH) reports to two FQHCs. The most significant development in these early efforts was to ensure the HEDIS IET cohort in PointClickCare is aligned with OHA's IET Metric. We then conveyed this

information out to our provider partners with detailed but simple instructions for how to get the most up to date IET cohort from PCC.

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

Planned Activities	Planned Milestones
1. Facilitate peer learning with health councils and IPAs to help them better understand the EHR landscape	2025 – 2026
2. Set targets for adoption rates in consultation with regional health councils, HIT Community Collaboratives and CAP, where relevant	2025 – 2026
3. Identify specific providers and sites to target for EHR adoption or optimization	2025 – 2026
4. Deploy provider facing EHR/HIE information guides as alternative approach	2025 – 2026
5. Use resource assessments derived from EHR adoption plans to support requests made through our annual enterprise IT planning process	2025 – 2026
6. Support and monitor EHR implementations and report back to stakeholders (e.g., health council, HIT Community Collaboratives, CAP, etc.)	2025 – 2026
7. Develop and add health information technology tools section to provider manual	2025 – 2026
8. Develop new integration pathways using Epic Payer Platform	2026

B. EHR Support Barriers:

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

1. **Staff constraints:** Provider staff resource shortages continued to reduce the time and willingness for partners to engage.
2. **Data gaps:** While the level of data quality, consistency, and accuracy required to establish an accurate baseline improved, there are still gaps in knowledge of actual adoption rates.
3. **Prioritization:** Focus continued to be placed on other relevant HIT Roadmap areas, primarily CIE and Hospital Event Notifications (HEN).
4. **Emerging tech landscape:** Emerging standards and an immature vendor solution landscape for Fast Healthcare Interoperability Resources (FHIR) based interoperability continue to cause delays in market alignment around these technology options.
5. **IT resource constraints:** Small providers without dedicated IT staff are not as apt to devote time to implement new technology.
6. **Expense of solutions:** Cost of implementing a new EHR system continues to be an obstacle and, in some cases, has increased because of additional financial pressures on providers. All provider types are impacted.
7. **Tech acumen:** Providers often don't have a sense of which EHR might be appropriate for an organization of their service type and size and the research can be overwhelming and confusing.
8. **Business acumen:** Smaller (and new) BH providers in private practice don't always understand how an EHR adds value.
9. **Expense of integration:** It remains very expensive to enable integration between HIT systems, which is a barrier to interoperability between HIT from different vendors.

C. OHA Support Needs:

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

- **Funding:** New or additional state funding offsets with a preference for behavioral health and small independent providers.
- **Rulemaking:** Additional leverage for technology vendors to provide low cost / free options for interoperability by default. This could be done through rulemaking or alternatively through state-oriented funding.

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

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

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

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

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

Notes:

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

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

Progress	Plans		Progress	Plans	
☒	☒	1. Care coordination and care management	☒	☒	4. Enhancements to HIE tools (e.g., adding new functionality or data sources

☒	☒	2. Exchange of care information and care plans	☒	☒	5. Collaboration with external partners
☒	☒	3. Integration of disparate information and/or tools with HIE	☒	☒	6. Risk stratification and population segmentation
			☐	☐	7. Other strategies for supporting HIE access or use (please list here):

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

PointClickCare (PCC) – formerly Collective Medical and PreManage: We remain a vocal proponent of the PCC hospital event notification platform. Widely adopted across all our regions, it has proven to be a key tool as internal operations supports care coordination with customized cohorts and reports. We manage data from PCC within our internal clinical data warehouse. We appreciate the impact of OHA's ongoing financial support for PCC in removing barriers to adoption.

Emergency Department Optimization (EDO) – formerly EDIE: All hospitals in our service areas have adopted EDO – the emergency department function of the PCC platform. Our internal care teams use the information generated by EDO to support care management. In 2021, the HIT Commons worked to bring Prescription Drug Monitoring Program (PDMP) information to emergency departments through an integration of the Oregon PDMP registry with EDO. Although HIT Commons continues to add clinics and encourage vendors to push FHIR-based integration forward, progress is slow. The current FHIR-related focus of HIT Commons is to make Oregon POLST Registry data available to providers from their EHR.

Secure File Transfer Protocol (SFTP): We exchange significant health and care coordination information with provider partners using this method. Stakeholders also rely on STFP to share a substantial volume of monthly reporting and other analysis.

Reliance eHealth Collaborative: Reliance eHealth Collaborative uses IMAT technology to host its clinical data repository. In 2024 we received Reliance health record data and also contributed administrative claims data to Reliance, including filled prescriptions. This enabled newly on-boarded providers in those regions to see encounter history even if the providers who delivered the service are not yet contributing data. We made the difficult decision to terminate the contract with Reliance eHealth Collaborative effective 12/31/2024.

Epic Payer Platform (EPP): In 2024 we formally evaluated EPP as a mechanism to improve interoperability between our provider partners on Epic and our systems. While noting a significant implementation cost, the evaluation team ultimately recommended moving forward with EPP given: 1) its robust data sharing capabilities, 2) preference for EPP by many of our largest provider partners, and 3) the EPP integration with Epic Tapestry.

Epic Tapestry: The evaluation team also recommended moving forward with Epic Tapestry, replacing the unsatisfactory VirtualHealth Helios. Under our Tapestry implementation, Epic has committed to supporting the electronic prior authorization requirements for all providers (Epic and non-Epic) required under federal interoperability rules.

EpicCare Link: The majority of our members are treated by physical health providers that use an Epic EHR. This includes many hospital systems and FQHCs. This means that our Care Management and Utilization Management staff can easily access member records via the EpicCare Link web portal. Our Quality, Risk, and Appeals and Grievances teams use a similar route for rapid identification and retrieval of documentation to support chart reviews, audits, and decision making.

Staff can also use **Epic Happy Together Link** to access multiple EpicCare Link portals via a button on the portal interface. Happy Together Link provides single sign-on functionality to all of a user's credentialed EpicCare Link accounts. While the utility is free as part of an Epic installation, implementation does require effort by the healthcare organization, creating friction in adoption.

CCO Provider Portal: Our CCO provider portal offers several tools to support care coordination. These include patient assignment, benefits confirmation, quality performance, and Member Insight Provider Insight (MiPi) population health reporting. Providers access the portal via a OneHealthPort landing page. Internal staff rely on provider use of this portal to receive critical information, including requests for prior authorization approval.

CCO Member Portal: Our CCO member portal offers a digital experience via a dedicated Medicaid Members section on PacificSource.com. This secure web portal improves accessibility and access to care by helping our members stay connected online via desktop or mobile devices. Members have direct access to personalized information about their care. They can view, print and order ID cards, learn about benefits, find a doctor, see claims and explanations of benefits, track pre-authorizations and referrals, and ultimately get the most from their benefit plan. Requirements include Spanish localization, ADA accessibility, Medicaid-specific content and customizations by CCO region and type.

Fax/e-Fax: Fax technology still supports numerous provider-to-provider and CCO-to-provider workflows. In several CCO regions, this is still the primary method for health information exchange.

FHIR: We continue to build FHIR-based interoperability capabilities focused on extension/engineering of internal data resources, improvements to authentication, authorization, and consent management. We also continue to pursue integrations with existing business platforms and development of HIE and other partnerships in support of existing and new requirements of the Office of National Coordinator/Centers for Medicare & Medicaid Services rules with HIE. We extended our interoperability roadmap to cover use of FHIR to support internal and partner data exchange beyond those required for regulatory purposes. We have also planned for key infrastructure components, including streaming/messaging clusters, FHIR stores/servers, Open Authorization/OpenID Connect services, API Management services, and "FHIRstore/endpoint servers" to support FHIR-based use cases.

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

Strategy 1: **Develop Assessment and Monitoring Process for HIE Access and Data Contribution Rates Across Provider Types**
Identify and implement methods to gather and track HIE adoption and usage

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

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

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

We corroborated our internal PointClickCare adoption information against the quarterly 2024 Oregon Collective Platform Onboarding and Engagement Report received from CCO Health IT at the OHA.

While this information is included in the annual HIT Data Reporting file received from OHA at the end of the year, the quarterly updates are a good way to confirm the information we have stays accurate throughout the year.

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

The majority of 2024 assessment and monitoring processes for HIE access and data contribution rates across provider types continue in 2025.

Planned Activities	Planned Milestones
1. Continue collecting data on HIE status across range of providers using internal and external sources	2025 – 2026
2. Use Delivery System Network report to identify in-scope providers	2025 – 2026
3. Compare in-scope list with catalog of data contributors from Regional Health Information Organization operating in region	2025 – 2026
4. Collect data from providers with unknown status	2025 – 2026
5. Corroborate baseline against any available external sources (e.g., Certified Health IT Product List)	2025 – 2026
6. Continue to re-integrate internal and external data to report progress	2025 – 2026

Strategy 2: **Establish and Maintain Appropriate Resourcing/Staffing to Support Multiple CCO Regions**
Maintain an internal team to meet the needs of the program

Strategy categories: Select which category(ies) pertain to this strategy
☐ 1: Care Coordination ☐ 2: Exchange care information ☐ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☐ 6: Risk stratification & population segmentation
☒ 7: Other: HIE Program Staffing Support

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

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

Our HIT team was staffed with a Program Manager and Program Coordinator under IT leadership and a Care Coordination Strategist under Care Management leadership through September of 2024.

Following the departure of the Program Manager in September, HIT Program leadership shifted to a new Health Data Platforms IT Manager role.

Matrixed to the team is a senior-level IT Service Technician, focused on gaining staff access to EMRs via queries to provider partners. This role maintains related request forms, processes and tools, account auditing functions, and the relationship with technical peers at provider offices.

Because many of our staff engage directly with providers, the HIT team continually works to increase general HIT knowledge internally. Internal education sessions prepare staff for provider-facing conversations around HIT technologies and data.

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

Planned Activities	Planned Milestones
1. Monitor staffing annually and adjust as needed	2025 – 2026
2. Continue HIE education of internal users	2025 – 2026

Strategy 3: **Implement New High Value, Internal HIE Use Cases**
Identify new use cases that will provide high value in improving the level of care to CCO members and develop, test, and deploy them through HIE systems where possible

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

☐ 7: Other:

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

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

Reliance Activities
While Reliance data has proven impactful for several use cases, it is only available for two of our four major regions. This work continued through 2024. Now, given the limited breadth of providers contributing data, we have spun down these activities and terminated the Reliance contract.

Lab Test Results
Beginning in 2022, we developed methods to combine lab test results from Reliance with PCS claims data to flag members likely to have had COVID-19. This history continued to be available in 2024 via interactive member profile tools that Care Managers can use when working with high needs members. The intent is to provide information relevant to member care plan, needs, and health history. COVID-19 history indicates: 1) first and most recent infection dates based on available data, 2) hospitalizations for COVID-related illnesses and relevant dates, and 3) diagnoses of post-COVID syndrome and relevant dates.

Member Identification with Data Feeds
Both Reliance and PCC regularly sent us member data files, formatted for incorporation under our existing EMR data staging extract, transform, and load data integration processes. In 2023, we enhanced several algorithms to better identify members with increased needs or health risks using diagnoses, procedures, and prescriptions. We have used data from Reliance and PCC along with pharmacy and medical claims to identify members who may have:

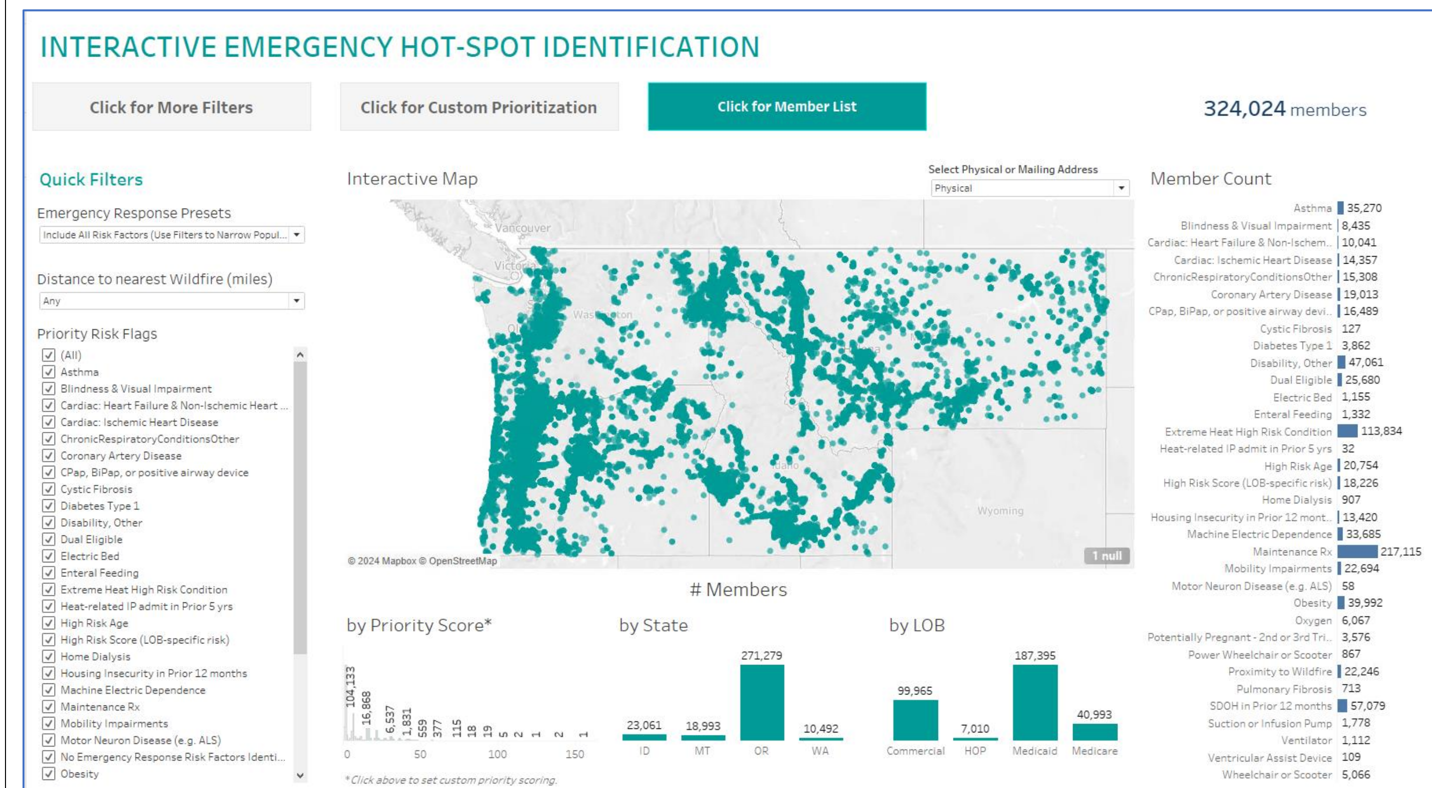
- Chronic conditions such as autoimmune disorders, dementia, eating disorders, late prenatal care, low birthweight, neonatal abstinence syndrome, post-traumatic stress disorder, epilepsy, sickle cell, cardiovascular conditions, multiple sclerosis and transverse myelitis, coronary artery disease, chronic respiratory conditions, and many others
- Disability or impairment such as deaf or hearing loss, mobility impairment, and intellectual/developmental disability
- Homebound, parenteral or enteral nutrition, organ transplants, immune compromised, and prior history of severe burns

Disastrous Events and Climate Emergencies
We have experienced an increasing need for rapid response outreach to better address public health emergencies such as fire evacuations, rolling black outs, and other climate emergencies or natural disasters. To do so, we have combined enhanced algorithms built on nonlocal data with regional information such as fire perimeters to create an interactive “Climate Emergency” tool. The solution allows for customized queries to uniquely respond to each context. The solution also includes an interactive reporting tool that enables our Member Support Services Rapid Response Team to create customized lists of high-risk members in specific geographic areas based on experience of emergencies such as fire evacuations, excessive heat, electric outages, extreme cold, floods, and others. We can identify high-risk members based on different condition states or characteristics, which put the member at increased risk in that context. For example, during the 2024 heat waves, we identified members with conditions exacerbated by high heat. During extreme cold snaps that resulted in power outages in the beginning of 2024, we prioritized outreach to members medically dependent on electricity (because, for example, they were on a ventilator). During the potential evacuations caused by the 2024 wildfires, we prioritized members with oxygen needs, mobility challenges, machine dependency, ventilator requirements, and similar needs.

Rapid Response Team members could use custom map-based geographic selections, standard zip code, city, or county selections, or selections based a perimeter drawn around an active event.

We compile report results from numerous data sources. We store code for member identification and staging of the tables in SQL and with interactive self-serve reporting performed in Tableau. The report function provides the ability to get counts of members, but then also to download a member-level detail list with addresses and phone numbers, etc. that can be used for outreach. From these lists, Response Team staff can make calls to help our members get the resources they need during extreme heat, extreme cold or ice storms, wildfires, and power outages. We have also recently partnered with our vendor, Cotiviti, to use an Interactive Voice Response (IVR) to quickly reach an even wider span of our membership. The IVR tool provides for warm transfers back to our internal teams at member request.

This work improved organizational capacity to respond quickly to emergencies and leveraged multiple HIE data sources to accomplish more complete identification of at-risk members.



INTERACTIVE EMERGENCY HOT-SPOT IDENTIFICAT

Click for More Filters | Click for Custom Prioritization

Close | Click for Member Lis

Prioritize members - Your way

Customize how you prioritize by entering weights in each category below.

Category	Weight	Category	Weight	Category	Weight
Oxygen	15	Potentially Pregnant - 2nd or 3rd trimester	10	Power Wheelchair / Scooter	10
Home Dialysis	20	Housing Insecurity (Prior 12 moths)	15	Mobility Impairments	3
Ventilator	30	Maintenance Rx	1	Wheelchair or Scooter	1
Suction or Infusion Pump	1	Obesity	15	Blindness /Visual Impairment	1
Ventricular Assist Device	30	Any SDOH Flagged in Prior 12 months	15	Disability (other)	1
Enteral Feeding	1	High Risk Score (LOB-specific)	5	Heart Failure & Non-ischemic Hear..	1
Electric Bed	1	High Risk Age Group: Very Young or Very Old	1	Coronary Artery Disease	1
CPAP, BiPap, Positive Airway Device	1	Condition Susceptible to Extreme Heat (OHA method)	5	Ischemic Heart Disease	1
Machine or Electric Dependence (Other)	20			Pulmonary Fibrosis	15
				Motor Neuron Disease (& ALS)	30

*Click above to set custom priority scoring.

024 members

Quick Filters

Emergency Response Presets: Include All Risk Factors (Use Filters to Narrow Popul...

Distance to nearest Wildfire (miles): Any

Priority Risk Flags

- (All)
- Asthma
- Blindness & Visual Impairment
- Cardiac: Heart Failure & Non-Ischemic Heart ...
- Cardiac: Ischemic Heart Disease
- ChronicRespiratoryConditionsOther
- Coronary Artery Disease
- CPap, BiPap, or positive airway device
- Cystic Fibrosis
- Diabetes Type 1
- Disability, Other
- Dual Eligible
- Electric Bed
- Enteral Feeding
- Extreme Heat High Risk Condition
- Heat-related IP admit in Prior 5 yrs
- High Risk Age
- High Risk Score (LOB-specific risk)
- Home Dialysis
- Housing Insecurity in Prior 12 months
- Machine Electric Dependence
- Maintenance Rx
- Mobility Impairments
- Motor Neuron Disease (e.g. ALS)
- No Emergency Response Risk Factors Identi...
- Obesity

Interactive Map

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by Priority Score*: 104,133; 16,868; 6,537; 1,831; 559; 377; 115; 18; 19; 6; 5; 2; 1; 1; 2; 1 (axis 0, 50, 100, 150)

by State: ID 23,061; MT 18,993; OR; WA 10,492

LOB: Commercial 99,965; HOP 7,010; Medicaid; Medicare 40,993

*Click above to set custom priority scoring.

Member Count	
Asthma	35,270
...ual Impairment	8,435
...& Non-Ischem...	10,041
...c Heart Disease	14,357
...onditionsOther	15,308
...Artery Disease	19,013
...ive airway devi...	16,489
Cystic Fibrosis	127
...Diabetes Type 1	3,862
...isability, Other	47,061
Dual Eligible	25,680
Electric Bed	1,155
Enteral Feeding	1,332
...h Risk Condition	113,834
...nit in Prior 5 yrs	32
High Risk Age	20,754
...OB-specific risk)	18,226
Home Dialysis	907
...Prior 12 mont...	13,420
...tric Dependence	33,685
Maintenance Rx	217,115
...ity Impairments	22,694
...sease (e.g. ALS)	58
Obesity	39,992
Oxygen	6,067
...- 2nd or 3rd Tri...	3,576
...chair or Scooter	867
Proximity to Wildfire	22,246
Pulmonary Fibrosis	713
SDOH in Prior 12 months	57,079
Suction or Infusion Pump	1,778
Ventilator	1,112
Ventricular Assist Device	109
Wheelchair or Scooter	5,066

INTERACTIVE EMERGENCY HOT-SPOT IDENTIFICATION

Click for More Filters | Click for Custom Prioritization | Click for Member List

33,845 members

Quick Filters

Emergency Response Presets: Electric / Machine Dependency

Distance to nearest Wildfire (miles): Any

Priority Risk Flags

- (All)
- Asthma
- Blindness & Visual Impairment
- Cardiac: Heart Failure & Non-Ischemic Heart ...
- Cardiac: Ischemic Heart Disease
- ChronicRespiratoryConditionsOther
- Coronary Artery Disease
- CPap, BiPap, or positive airway device
- Cystic Fibrosis
- Diabetes Type 1
- Disability, Other
- Dual Eligible
- Electric Bed
- Enteral Feeding
- Extreme Heat High Risk Condition
- Heat-related IP admit in Prior 5 yrs
- High Risk Age
- High Risk Score (LOB-specific risk)
- Home Dialysis
- Housing Insecurity in Prior 12 months
- Machine Electric Dependence
- Maintenance Rx
- Mobility Impairments
- Motor Neuron Disease (e.g. ALS)
- No Emergency Response Risk Factors Identi...
- Obesity

Interactive Map

Select Physical or Mailing Address: Physical

© 2024 Mapbox © OpenStreetMap | 1 null

Members

by Priority Score*: 14; 2,749; 2,458; 671; 147; 22; 16; 6; 1; 1; 1; 1 (axis 50, 100, 150)

by State: ID 3,339; MT 1,998; OR 27,496; WA 939

by LOB: Commercial 8,714; HOP 176; Medicaid 19,594; Medicare 8,002

*Click above to set custom priority scoring.

Member Count	
Asthma	7,192
Blindness & Visual Impairment	1,399
...rdiac: Heart Failure & Non-Ischem...	4,521
Cardiac: Ischemic Heart Disease	4,664
ChronicRespiratoryConditionsOther	6,784
Coronary Artery Disease	6,265
CPap, BiPap, or positive airway devi...	16,489
Cystic Fibrosis	69
Diabetes Type 1	812
Disability, Other	5,943
Dual Eligible	6,466
Electric Bed	1,155
Enteral Feeding	1,332
Extreme Heat High Risk Condition	22,749
Heat-related IP admit in Prior 5 yrs	11
High Risk Age	2,429
High Risk Score (LOB-specific risk)	4,132
Home Dialysis	907
Housing Insecurity in Prior 12 mont...	833
Machine Electric Dependence	33,685
Maintenance Rx	24,483
Mobility Impairments	5,580
Motor Neuron Disease (e.g. ALS)	22
Obesity	8,286
Oxygen	6,067
Potentially Pregnant - 2nd or 3rd Tri...	51
Power Wheelchair or Scooter	867
Proximity to Wildfire	1,236
Pulmonary Fibrosis	347
SDOH in Prior 12 months	5,849
Suction or Infusion Pump	1,778
Ventilator	1,112
Ventricular Assist Device	109
Wheelchair or Scooter	2,463

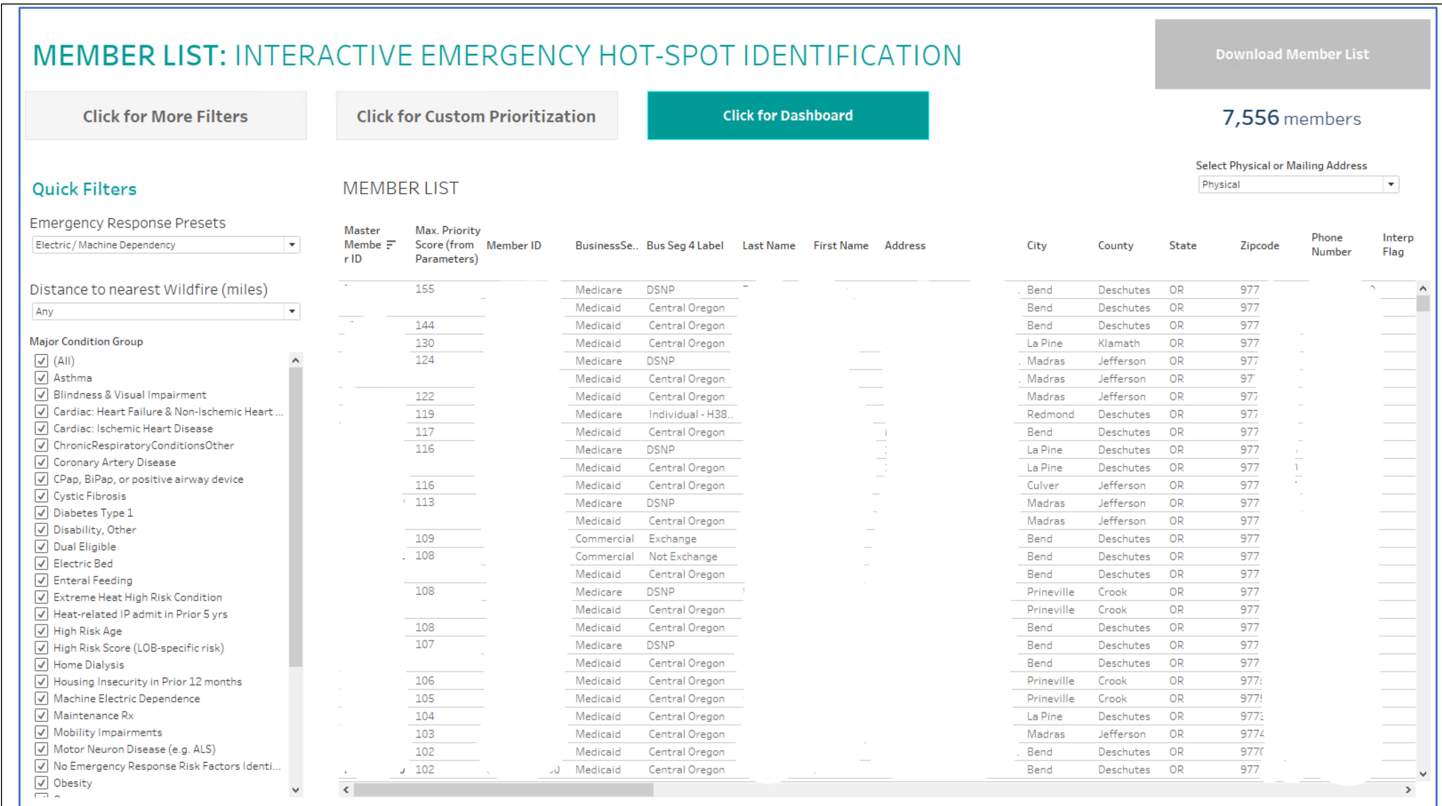


Figure 1. Interactive Emergency Hot-Spot Identification Results

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

We expect to use data from Epic Payer Platform similarly to how Reliance has been used in the past, but to even greater effect given two factors:

1. Epic's broad footprint across our core service area.
2. Improved native integration with organizations using Epic.

This work will start in earnest nearer to the end of solution implementation.

Planned Activities	**Planned Milestones**
1. Continue enhancing HIE data feeds to enhance member identification	2025 – 2026
2. Implement Epic Payer Platform	2025 – 2026

Strategy 4: **Implement New High Value, Internal Hospital Event Notification (HEN) Use Cases**
Identify new HEN use cases that will provide high value in improving the level of care to CCO members

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

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

Strategy status:

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

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

We devote time each month to building relationships with PCC through regularly scheduled meetings to discuss strategy, technical development and implementation, and account and network development. High-value customized cohorts and reports support changes in regulatory requirements, new QIM measures, and innovation from our internal teams including the front-line strategy and development meetings noted in *Strategy 8 – Internal HIE Governance* lower in this section.

In 2024, we continued to build new PCC reports and cohorts to support a broad set of Care Management use cases. We also have been able to build a prototype flag for identifying homelessness which has been useful in our CIE and Care Management workflows as well as reports supporting hospital follow-up and transitions of care such as Medicare Observations Transitions and new ED Discharge Weekend Reports for workflows launched in late 2024.

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

Continue to seek and identify new high-value HEN use cases, including those made possible through new ADT data that starts flowing into the PCC platform during 2024, such as the Oregon State Hospital ADT data.

Planned Activities	Planned Milestones
1. Integrate real time ADT feeds in PacificSource Data Warehouse	Q2 2025
2. Attend regular PCC vendor partnership meetings	2025 – 2026
3. Work with PCC and internal teams to identify additional high-value use cases	2025 – 2026
4. Review PCC cohorts for revisions related to State Hospital ADT data	2025 – 2026

Strategy 5: **Reliance Community Health Record as Proxy for Direct EHR Access**
Expand the amount of claims data we submit to Reliance and expand the number of internal care team members using Reliance to access member data to reduce use of multiple, direct EHR logins to access the same information

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

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

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

A key internal metric established in our strategy is the percentage of partner EHRs that clinical teams have access to (calculated based on a percentage of member encounters) for care coordination and quality performance activities.

2024 Activities:

- Supplemental Data
- Chart Chase
- NPI Improvements
- Reliance contract termination 12/31/24

We have had a longstanding goal of leveraging a centralized HIE/Community Health Record as a proxy for this direct access. Maintaining the EHR access is often complex with a significant variance in methods for access. For illustration, some require individual tokens to be issued to allow for direct virtual private network access by named individuals, and audit records of activity must be kept for compliance purposes. Maintaining access to so many EHRs requires dedicated staffing to support, as well as specially trained IT Help Desk personnel to assist with technical support for these varied systems. During 2023, 327 new EHR access requests were processed for our internal users, while a similar number of existing accounts were maintained.

Below are activities pursued to forward goals of using Reliance as a proxy for direct EHR access:

- **Virtual Chart Pilot Project**: We need EHR chart data to fulfill many aspects of treatment, payment, and operations. We have a desire to identify what an optimal patient chart would look like in the Reliance HIE if virtualized based on the clinical record. To confirm Reliance can meet these needs in lieu of sourcing the charts from individual EHRs, we performed a Virtual Chart Pilot project that gathered sample chart PDFs from an EHR and assessed whether Reliance can replicate the data in a way that meets regulatory requirements. Ultimately, a goal is to be able to request these kinds of records dynamically and in bulk from Reliance, reducing the need for direct EHR login to so many different systems.

  Our staff have access to many charts in Reliance but advise the data can sometimes be verbose, missing important narrative or formatted in a way staff find unfriendly to use. These issues cause staff to revert to the EHR for a more readable format, negating the value of Reliance as a proxy for EHR use. Given the Virtual Chart Pilot looked at the overall quality and format of the Reliance record, relevant PCS teams were asked for specific feedback about their chart needs by role/function and that feedback was incorporated into the patient record modifications requested by the pilot.
- **Staff Access to Reliance:** Continued increasing the number of our internal users with access to Reliance but at a reduced scale from previous years, with only 13 new users added. In addition to adding accounts for Care Management and Utilization Management staff, this year we also added users from the Quality and Risk Assessment teams so they could help identify data quality issues specific to their unique use cases and goals in support of the virtual chart pilot described above. We expect the number of new internal accounts to increase in 2024 as the Virtual Chart Pilot record format improvements are finalized.
- **Reliance Quality Issues:** Provided feedback to Reliance on data quality issues or concerns as we use the platform. For example, continued to diagnose and explore the root cause of documentation display issues noted with documents submitted by a specific provider that impacts those records viewability. Reliance is working with them to correct the issue.

We continued this strategy under the Reliance contract throughout 2024. It was largely successful, but, ultimately, we feel we can invest elsewhere with greater effectiveness.

(Optional) **Overview of 2025-26 plans for this strategy**:
This activity completed in 2024.

Planned Activities	**Planned Milestones**

Strategy 6: **Reliance Health Record as Source of Supplemental Data for Quality Programs**

Explore how Reliance can be used as an accepted standard for supplemental data in support of the various CCO quality metrics that rely on clinical data a component for measurement

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

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

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

We have partnered with Reliance eHealth Collaborative since 2021 to explore leveraging contributed HIE data directly into quality programs as a supplemental data source (SDS). SDS could potentially automate gap closures for Healthcare Effectiveness Data and Information Set (HEDIS). Closing HEDIS gaps is currently a costly and labor-intensive process.

Our HIT and Risk teams continued this work through Q3 of 2024 when we decided to end the contract with Reliance.

Since beginning this work, we have:
- Expanded our data model to include additional diagnosis and SNOMED codes fed from Reliance data
- Added this information to our clinical data warehouse
- Loaded this data via the data warehouse into our HEDIS program as standard supplemental data
- Identified and implemented improvements in member and provider matching and provider/NPI parsing in partnership with Reliance
- Implemented automated monthly member data feeds between Reliance and PCS

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

N/A: Concluded in 2024

Planned Activities	**Planned Milestones**
N/A	

Strategy 7: **Maintain an Enterprise Technology Roadmap for Health Information Exchange**
Develop forward-looking strategic plans to guide internal HIE technology development

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

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

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

Medical Management Platform Implementation and Integration with Clinical Data from HIE Sources
We have previously identified scalability challenges with our existing care management platform. In 2023, efforts were made towards implementing a replacement solution, VirtualHealth HELIOS, by 2024. The initial phase of this new platform was anticipated to be released in 2024. However, due to implementation challenges, it has been decided to instead pursue the implementation of Epic Tapestry. Consequently, we will now proceed with plans to transition to Epic Tapestry in 2025.

Ability to Exchange Health Data via FHIR Interfaces and other CMS Interoperability Requirements
We continued building FHIR-based interoperability capabilities, focusing on extension/engineering of internal data resources, integrations with existing business platforms, and development of HIE and other partnerships to support the patient portal requirements of the Office of National Coordinator/Centers for Medicare & Medicaid Services (CMS) rules covering HIE. Our interoperability roadmap continues to reflect use of FHIR to support internal and partner data exchange beyond those currently required for regulatory purposes. See *Section 4. B. Supporting Increased Access to and use of HIE Among Providers, Strategy 7: Develop Interoperability* for more details. Related activities are noted in that strategy.

We continued following updates provided by CMS for the “Advancing Interoperability and Improving Prior Authorization Processes” (CMS-0057) final rule.

Additionally, as mentioned above, through our Epic Tapestry exploration we have begun planning efforts around systems implementations to support the Electronic Prior Authorization rule.

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

Planned Activities	Planned Milestones
1. Implement Epic Payer Platform and Tapestry 2. Implement Payer to Payer API	2025-2026 2025-2026

Strategy 8: **Internal Health Information Exchange Governance**
Implement and follow a consistent process to receive HIT program direction, guidance and oversight

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

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

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

We maintained an HIT/HIE/Interoperability Steering Committee – a standing forum for internal leadership to provide direction, guidance, and oversight of HIE and HIT initiatives – as a guiding body for these activities. The HIT Steering Committee met twice in 2024.

We continued a hybrid IT/clinical change control process that consists of a bi-weekly meeting with internal subject matter experts from all relevant teams across all lines of business to discuss proposed technology and other changes and provide a method for communication back to the associated teams. This structure not only protects workflows but also guarantees visibility of all changes to all end users for oversight. This process continues expansion of our internal user base beyond Care Management by bringing representation from our Utilization Management, Quality, and Pharmacy teams onto our HIE Strategy team.

Front-Line Strategy & Development (S&D) Teams
2024 Update: In 2024, we refined our HIT Governance model by focusing our S&D Teams on Population Health Teams, both Physical and Behavioral. This shift allowed us to develop valuable partnerships, particularly with FQHC partners, and streamline communication through standardized templates. These efforts have enhanced care management quality and platform adoption without disrupting frontline caregivers' work.

We continued leveraging internal advisory team meetings with select, internal care functions as a method for the HIET Team to share updates and highlights about HIT program activities, provide HIE training, and receive front-line guidance for how to support effective care coordination with HIT tools.

These teams continued to meet to support internal and external partner feedback loops that:
- Identify opportunities to improve relationships
- Add functionality to existing tools
- Address unmet needs
- Communicate general tones and attitudes among internal users and provider partners

Led by the HIE Care Coordination Strategist, these discussions foster open feedback while educating and building relationships among the internal partners. The Care Coordination Strategist adapts the feedback into ongoing strategy and development work with a goal of returning effective solutions to these internal HIE partners. Annual review of objectives, meeting design, groups and attendees ensures ongoing alignment and engagement.

Meetings are intended to:

- Clarify and update goals, objectives and key results
- Identify internal and external partner challenges and successes
- Determine if a potential HIE solution exists and develop pilots and use cases as appropriate
- Create solutions, often by building custom cohorts and reports
- Develop potential use cases, including functionality pilots
- Improve existing structures including workflows, communication strategies, cohorts and reports
- Identify internal support materials, such as an HIE common issues FAQ or menu of available cohorts and reports
- Create a pipeline via the Physical and Behavioral Population Health teams for ongoing external provider partner development and support, including communicating the availability of HIE resources to external partners

Community HIE Governance
In service of the OHA's goals for transforming healthcare in Oregon, our executive leaders continued supporting statewide IT efforts around centralized policy work, strategic planning, oversight, and assessment.

- Our Executive VP and Chief Operating Officer remained a Council Member of the Health Information Technology Oversight Council until the completion of his term June 2024. Subsequently, our Vice President of IT, Infrastructure and Analytics became a member.
- Our Vice President of IT, Infrastructure and Analytics served as Chair of the HIT Commons Board of Managers.
- Our IT Director of Business Intelligence attends and participates in the OHA's CCO Health Information Technology Advisory Group.

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

Planned Activities	Planned Milestones
1. Maintain internal Strategy & Development Team meetings	2025 – 2026
2. Maintain community HIE governance presence	2025 – 2026

Strategy 9: **Make Structural PointClickCare System Improvements for Internal Use**
Identify and implement ways to improve the utility of the PCC platform for internal use

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

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

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

Internal Structural PCC Improvements
We partnered internally to identify and standardize high-value reports across CCO Regions in 2024. These standardized reports began to roll out in Q3 and Q4 and are ongoing.

Care Management implemented significant structural changes in 2024 to better support members across multiple lines of business including adding weekend support. This identified needs for weekend workflow specific reports.

Specialty reports that are accessed less frequently would go dormant after two months without access. For these specialty reports intended for only periodic use, we worked with PCC to change this to improve the availability of these less commonly used reports.

(Optional) **Overview of 2025-26 plans for this strategy**:	
Planned Activities 1. Continue to monitor PCC system for improvements to support internal use	**Planned Milestones** 2025 – 2026

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

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

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

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

Notes:

- Four strategy sections have been provided. Please copy and paste additional strategy sections as needed. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.
- If CCO is not pursuing a strategy beyond 2024, note 'N/A' in Planned Activities and Planned milestones sections.

- If CCO is implementing a strategy beginning in 2025, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

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

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

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.

PointClickCare (PCC) – formerly Collective Medical and PreManage: We remain a vocal proponent of the PCC platform. This platform, widely adopted across all our regions, has proven to be a key capability for operations in supporting care coordination efforts through the use of customized cohorts and reports. We appreciate the impact of OHA's ongoing financial support for PCC in removing barriers to adoption.

Emergency Department Optimization (EDO) – formerly EDIE: All hospitals in our service areas have adopted EDO – the emergency department function of the PCC platform. Our internal care teams use the information generated by EDO to support care management. In 2021, the HIT Commons worked to bring Prescription Drug Monitoring Program (PDMP) information to emergency departments through an integration of the Oregon PDMP registry with EDO. Although HIT Commons continues to add clinics and encourage vendors to push FHIR-based integration forward, progress is slow. The current FHIR-related focus of HIT Commons is to make Oregon POLST Registry data available to providers from their EHR.

Reliance eHealth Collaborative: Reliance eHealth Collaborative uses IMAT technology to host its clinical data repository. In 2024 we received Reliance health record data and also contributed administrative claims data to Reliance, including filled prescriptions. This enabled newly on-boarded providers in those regions to see encounter history even if the providers who delivered the service are not yet contributing data. We made the difficult decision to terminate the contract with Reliance eHealth Collaborative effective 12/31/2024.

Epic: The majority of members in our service areas are covered by physical health providers that use Epic EHR, including the hospital systems and Federally Qualified Health Centers (FQHCs).

- **Epic Care Everywhere** – When two organizations both have Epic, both can use Care Everywhere to communicate, access and share clinical information directly between each other's Epic system.
- **EpicCare Link** –When an organization does NOT have Epic, it can access clinical records in a provider's Epic system via the EpicCare Link web portal. Our Care Management and Utilization Management staff use the EpicCare Link web portal to access member records in providers' Epic systems to manage care coordination. EpicCare Link is also used by our Quality, Risk, and Appeals and Grievances teams for rapid identification and retrieval of documentation from Epic systems to support chart reviews, audits, and decision making.
- Our staff may also use **Epic Happy Together Link**, a method to simplify access to multiple EpicCare Link portals via a button on the Care Link portal interface. Happy Together Link provides single sign-on functionality to all EpicCare Link accounts to which an EpicCare Link user has credentials, without requiring the user to log into each account separately. Epic encourages healthcare entities to install this free utility as part of their Epic installation; however, implementation does require effort by the healthcare organization so actual availability depends on the healthcare organization's priorities.

CCO Provider Portal: Our CCO provider portal offers several tools to support care coordination. These include patient assignment, benefits confirmation, quality performance, and Member Insight Provider Insight (MiPi) population health reporting. Providers access the portal via a OneHealthPort landing page. Internal staff rely on provider use of this portal to receive critical information, including requests for prior authorization approval.

CCO Member Portal: Our CCO member portal offers a digital experience via a dedicated Medicaid Members section on PacificSource.com. This secure web portal improves accessibility and access to care by helping our members stay connected online via desktop or mobile devices. Members have direct access to personalized information about their care. They can view, print and order ID cards, learn about benefits, find a doctor, see claims and explanations of benefits, track pre-authorizations and referrals, and ultimately get the most from their benefit plan. Requirements include Spanish localization, ADA accessibility, Medicaid-specific content and customizations by CCO region and type.

Secure Messaging: Direct secure messaging is limited in each of our regions. We do not currently maintain a direct secure messaging platform for use in care coordination.

Secure File Transfer Protocol (SFTP): We exchange significant health and care coordination information with provider partners using this method. Stakeholders also rely on STFP to share a substantial volume of monthly reporting and other analysis.

Fax/e-Fax: Fax technology still supports numerous provider-to-provider and CCO-to-provider workflows. In several CCO regions, this is still the primary method for health information exchange.

FHIR: We continue to build FHIR-based interoperability capabilities focused on extension/engineering of internal data resources, improvements to authentication, authorization, and consent management. We also continue to pursue integrations with existing business platforms and development of HIE and other partnerships in support of existing and new (CMS—0057) requirements of the Office of National Coordinator/Centers for Medicare & Medicaid Services rules with HIE. We extended our interoperability roadmap to cover use of FHIR to support internal and partner data exchange beyond those required for regulatory purposes. We have also planned for key infrastructure components, including streaming/messaging clusters, FHIR stores/servers, Open Authorization/OpenID Connect services, API Management services, and "FHIRstore/endpoint servers" to support FHIR-based use cases.

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

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

Health Information Exchange (HIE) Implementation

Health Information Exchange (HIE) adoption and utilization remains high among larger providers and limited among smaller providers.

HIT Data Collection Strategy

Our strategy includes the following efforts:

- Maintain an internal database of provider HIT data
- Build internal relationships with teams that have direct provider relations
- Educate internal partners on what HIT is and why it matters
- Have internal partners gather HIT information during provider interactions
- Incorporate new information from annual OHA HIT Data Reporting file
- Leverage relationships with DCOs to gather dental provider HIT data
- Create new HIT tracking tools and strategies to identify provider engagement opportunities

Takeaways

- Gathering HIT information from new and existing providers remains a major challenge.
- Smaller providers tend to lack the resources and value proposition to adopt and use HIE.

2024 Health Information Exchange (HIE) Saturation by CCO Region

CCO: 2024 Central Oregon	Number of Contracted Providers	Number w/o HIE Information (includes PCC)	Percent w/o HIE Information (includes PCC)	Number of contracted PCPCHs	Number w/o HIE Information	Percent w/o HIE Information
Physical Health	100	46	46%	17	0	0%
Behavioral Health	251	242	96%	1	0	0%
Oral Health	17	15	88%	0	0	0%

CCO: 2024 Columbia Gorge	Number of Contracted Providers	Number w/o HIE Information (includes PCC)	Percent w/o HIE Information (includes PCC)	Number of contracted PCPCHs	Number w/o HIE Information	Percent w/o HIE Information
Physical Health	27	12	44%	8	1	13%
Behavioral Health	29	25	86%	0	0	0%
Oral Health	6	5	83%	0	0	0%

CCO: 2024 Lane	Number of Contracted Providers	Number w/o HIE Information (includes PCC)	Percent w/o HIE Information (includes PCC)	Number of contracted PCPCHs	Number w/o HIE Information	Percent w/o HIE Information
Physical Health	127	68	54%	25	1	4%
Behavioral Health	278	258	93%	2	0	0%
Oral Health	36	34	94%	0	0	0%

CCO: 2024 Marion Polk	Number of Contracted Providers	Number w/o HIE Information (includes PCC)	Percent w/o HIE Information (includes PCC)	Number of contracted PCPCHs	Number w/o HIE Information	Percent w/o HIE Information
Physical Health	105	45	43%	35	2	6%
Behavioral Health	165	148	90%	3	1	33%
Oral Health	38	36	95%	0	0	0%

When comparing adoption percentages to last year, because provider contracting is done annually, the composition of the groups being measured changes each year, making that comparison difficult.

Strategy 1: **Develop High Value Health Information Exchange Use Cases for Providers**
Identify and implement HIE use cases that providers can use to increase the value of care they provide to their patients

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: Data Exchange

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

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

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

2024 Update: We rolled out significant improvements to initiatives within our communities based on the streamlined Strategy and Development team structure discussed above.

Examples:

1. Established standard reports with Northwest Human Services regarding homelessness and drug and alcohol abuse
2. Assisted Northwest Human Services in identifying and correcting existing reporting issues
3. Collaborated to ensure PCC IET process would support both Medicare and Medicaid

Reliance HIE
We met with HIE vendor Reliance eHealth Collaborative through regularly scheduled meetings to discuss strategy, technical development and implementation, and account and network development.

2024 Activities One of COHIE's long-stated priority objectives has been to identify high-value HIE use cases to illustrate and increase its value to providers of all types and other CCOs who have not yet adopted a centralized community health record. One of the top Reliance benefits is supporting provider and CCO performance on annual QIMs such as the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) metric, which historically has been difficult to meet. The fact that substance use disorder (SUD) episodes can occur in a variety of health settings (hospital, ambulatory, specialty, or mental health facilities) means SUD episode awareness must encompass an entire health community.

IET Report Pilot The Reliance IET notification report is an alerting service to notify care management teams of IET index events in their patient population.

Reliance launched its new Behavioral Health Dashboard in Q1 2024, which includes the following three reports:

- **IET Report:** Initiation and Engagement of Substance Use Disorder treatment
- **Depression:** Patients aged 12 and older screened for clinical depression
- **SBIRT:** Screening, Brief Intervention and Referral Treatment

A nominal annual subscription fee is required, and provider organizations must be active contributors to the Reliance platform to participate (which requires an integration between the provider organization's EMR and Reliance), as this is how Reliance gets access to the related and relevant patient information. While Reliance does not charge a provider for the integration, the provider's EHR partner may. Reliance has seen EHR integration fees range from $0 to $12,000 or slightly more. Despite significant work which continued throughout 2024, we were never able to successfully engage a provider partner to use the Reliance delivered IET tool. With our termination of the Reliance contract, we will refocus efforts elsewhere to support IET.

Epic HIE

Expanded community access in Marion-Polk We continued to partner with the Willamette Health Council to raise awareness and adoption of the EpicCare Link HIE across the region. As noted earlier, EpicCare Link is a health information exchange function within Epic that provides access to Epic clinical records via a standard web portal to providers and community-based organizations that do not, themselves, have Epic.

The EpicCare Link workgroup formed in 2023 continued to champion and support regional efforts to increase adoption and use of EpicCare Link at Salem Hospital, Santiam Hospital and Legacy Health Silverton throughout 2024. It created and shared with the community a two-page guide titled "EpicCare Link: Guide to Community Connections" that contained step-by-step instructions for how to request EpicCare Link access from each of the three care organizations.

Epic Payer Platform As previously outlined; we conducted a thorough evaluation to assess the Epic Payer Platform as a central mechanism for Health Information Exchange. This evaluation culminated in a recommendation to proceed with implementation. During this process, we examined several high-value use cases that will enhance our collaboration efforts in care coordination and the sharing of quality measure data with our provider partners.

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

Planned Activities	**Planned Milestones**
1. Implement Epic Payer Platform (EPP) 2. Work with available providers to engage in the EPP network.	1. 2025-2026 2. Ongoing

Strategy 2: **Develop High Value Hospital Event Notification Use Cases for Providers**
Identify and implement HEN use cases, cohorts, and reports that providers can use to increase the value of care they provide to their patients

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):

We continued to provide financial support for provider use of PCC via the contract sponsorship model incorporated into the PCS/PCC contract.

We engaged as a thought partner and subject matter expert on how HEN can be leveraged to support community efforts on issues like homelessness and ED utilization. We increased engagement with our Population Health Teams (Physical and Behavioral Health) which helped generate bilateral communication with provider partners about what is available in PCC and helped internal teams to better address provider needs.

2024 Updates:

Federally Qualified Health Center Development
The HIT team helped Northwest Human Services (a Marion County FQHC) audit their system utilization and cohort builds. The team also implemented a new homeless report to help the FQHC perform outreach directly in the hospital to members with no fixed address or phone number. In Q4 2024 we began work with Community Health Centers of Lane County, an FQHC with multiple regional locations. We will fully report on this effort in 2025. Our goal is to create best practice about how to best demonstrate PCC value to external partners. We believe the best way to drive engagement is to create clear value in the mind of a provider partner.

IET Metric Overhaul
To develop the original IET Metric we collaborated with the Oregon Health Leadership Council and Care Oregon. Initially, the metric required manual updates because it differed from the OHA metric. However, after thorough investigation in collaboration with PCC during the latter half of 2024, we confirmed that these discrepancies no longer exist, allowing for the direct application of the HEDIS metric. This has streamlined the process of accessing the IET Cohort and implementing future modifications, as PCC now offers a "turnkey" cohort that is easily accessible and will automatically be updated to reflect any changes made by HEDIS.

Assigned/Unengaged
A pilot to help Primary Care Providers identify assigned but unengaged patients has moved forward intermittently due to provider resource limitations.

Homeless Initiatives
In 2024, we stood up our first report based on a Housing Insecurity Confirmed flag that had been entered into PCC during the pandemic but went unused. While the flag still has some bugs, we have increased visibility and are piloting the new report and testing value with Northwest Human Services.

Inpatient Psychiatric Events: We created a report tracking inpatient psychiatric discharges in individual CCO regions and across the state. This report is used by both internal and external users.

Assigned/Not Established Patients Functionality Pilot: This pilot tests a method to more rapidly inform PCPs of new patient assignments. Today, clinics receive assignment reports from different payers at different intervals via different workflows and portals. Consequently, patients may not receive timely health care protocols from their new PCP. The problem is that those patients are not yet included in the provider's patient roster to PCC and thus won't appear in the provider's PCC cohorts and reports for follow-up. To bridge the gap, PCC can use information in the payer's eligibility file to inform a provider of an assignment by adding the new member to the provider's existing cohorts and reports. Clarity here will maximize reimbursement for plans and clinics, reduce clinic staff overhead, and ultimately ensure the best outcomes in patient care.

Explore potential of leveraging CCDs via PCC: We explored this potential early in the year but, unfortunately, could not establish a viable solution. Our Care Management teams helped establish that the information currently available in PCC is not comprehensive enough to replace the traditional method of using direct EMR access. We reviewed viability again in Q4 based on new PCC specifications covering updated CCD functionality. We will continue to explore this possibility based on further PCC updates.

Homeless Management Information System (HMIS) Flag Including Related Partnership Efforts with Lane County, Trillium CCO and PCC: Working with PCC and thought partners in our Central Oregon and Marion/Polk CCO regions, we explored ways to make homeless populations more visible in PCC than currently possible using only the Z59 ICD-10 code. We continue to explore improvements to visibility of this important flag and will provide updates.

Lane County Emergency Shelter Support
In Q1 2024 the Public Health Department for Lane County Health & Human Services (LCHHS) asked us for help in capturing real-time hospital census data in Lane County during community emergencies.

LCHHS wanted an automated report with real-time admit information provided via PointClickCare as a way to reduce the need for manual coordination among organizations already under stress.

Using our eligibility file, we created a simple report, ran it for two weeks, and presented the results to LCHHS. With the caveat that the report is based only on our membership, LCHHS was satisfied. Using the same template, they want to work with the Trillium CCO to get more comprehensive information about the Lane County population. We will make further changes as we learn more about the needs of LCHHS. Meanwhile, the report remains available to help during future emergencies.

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

Planned Activities	**Planned Milestones**
1. Continue adding high-value customized cohorts and reports	2025 - 2026

Strategy 3: **Develop Pharmacy Hospital Event Notification Use Case**
Combine pharmacy claims data contributed by PCS with hospital event notifications within PCC to identify pharmaceutical-based use cases

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 addition to the governance model changes and the IET work previously discussed, we have continued to develop an innovative PCC report. This report leverages hospital event notifications and PCS pharmacy claims to enhance the care of pediatric asthma patients. Together with pharmacy partners, we selected pediatric asthma given its potential value. Primary interventions are pharmaceutical, and hospital admissions are largely preventable.

The challenges we have encountered in producing the initial report include scheduling difficulties with provider partners and meeting quality control standards. The PCC is confident that these technical issues will be resolved by early 2025.

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

Planned Activities	**Planned Milestones**
1. Explore existing and new use cases for our pharmacy partners	2025 – 2026
2. Determine viability of sharing what we build with external partners	2025 – 2026

Strategy 4: **Develop Assessment & Monitoring Process for Provider Hospital Event Notification Access and Data Contribution Rates**
Establish a process for gathering and tracking provider HEN adoption data

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

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

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

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

Changes to governance and resourcing have impeded our progress on this strategy.

That said, as a result of the Strategy & Development Population Health meetings (see *Section 4. A. CCO Use of HIE for Care Coordination and Hospital Event Notifications, Strategy 8 – Internal HIE Governance)*, we have an enhanced method to identify provider HEN access and data contribution. While we continue to ingest PCC Engagement Tableau reports, they have limitations that make them difficult to use for this purpose. The information is not comprehensive enough to provide a clear picture of engagement.

The professional connections already in place between our Population Health team and community providers allow for a direct connection to these providers to discuss HEN contribution status and to deploy new cohorts and reports. An "HIE Menu" of sorts was designed for the Population Health team to reference during conversations with providers. It includes a mix of examples of ala carte, pre-made report options with details of what each type of report includes.

PointClickCare/Collective Report Menu

Brought to you by the Health Information Exchange (HIE) Team at PacificSource

Pre-Built Reports

☐ Inpatient Psych Discharges
☐ SNF Admits & Discharges
☐ Hospital Birth Events
☐ Substance Use Disorder ED Events
☐ All Cause Readmissions
☐ Child Welfare ED Events

Build Your Own Report

Diagnosis (ICD-10 Codes)	Point of Service	Service Provider	Encounter Information	Delivery Cadence
☐ All	☐ All	☐ All	☐ Service Date	☐ Daily
☐ Diabetes	☐ ED	☐ PeaceHealth	☐ Encounter Facility	☐ Weekly
☐ CHF	☐ Inpatient	☐ Providence	☐ Discharge Type	☐ Monthly
☐ Asthma	☐ Observation	☐ Salem Hospital	☐ ED/IP Visit Count	☐ Quarterly
☐ Other	☐ IP Psych	☐ St Charles	☐ Phone Number	☐ Custom
________	☐ SNF	☐ ________	☐ ________	________

Advanced Support

☐ Eligibility File Development
☐ System Optimization
☐ Complex Report Builds

Please reach out to discuss specific needs and options

For further questions and discussion please email:

Ryan Hart
Ryan.Hart@PacificSource.com
Care Coordination Health Information Exchange (HIE) Strategist at PacificSource

Figure 8. HIE Menu for PointClickCare Reports

As needed, we will continue to develop customized cohorts and reports and assist with complex problem-solving.

Finally, the Collective Platform Onboarding and Engagement Report distributed to all CCOs by the OHA has been helpful for tracking quarterly updates about provider PCC usage.

(Optional) **Overview of 2025-26 plans for this strategy**:
We will continue our existing methods and activities to assess and monitor HEN participation and will identify new effective resources.

Planned Activities	**Planned Milestones**
1. Collect data on HEN participation status and update internal tracking	2025 – 2026
2. Complete guides and aids for Population Health team and other provider-facing roles	2025 – 2026

Strategy 5: **Explore Epic Payer Platform**
Explore Epic Payer Platform to improve care coordination and value-based care arrangements with contracted providers who use the Epic EHR

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

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

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

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

In partnership with Epic, healthcare organizations, and other health plans, we continued exploring the value of Epic Payer Platform (EPP) – Epic's software solution and interoperability network that supports communication between payers and providers. A tighter integration between Epic-based organizations will improve care coordination and value-based care arrangements. Network providers will be able to easily exchange clinical records bi-directionally with affiliated payers, avoiding manual interventions and point-to-point interfaces. We anticipate that EPP can also address prior authorizations, chart access for care management, chart capture back to an internal care management system, and supplemental data to support our HEDIS and QIM programs.

After evaluation, we have decided to begin EPP implementation in 2025.

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

Planned Activities	**Planned Milestones**
1. Implement Epic Payer Platform	2025-2026

Strategy 6: **Develop Interoperability**
Develop and execute a roadmap that meets CMS interoperability requirements and furthers our internal goals to use FHIR to support internal and partner data exchange

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

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):

Our interoperability efforts continued to be largely focused on compliance with CMS/ONC rules. In addition to OneRecord, implemented in 2023, current and former PCS members may now request and receive their PCS health records via the FlexPA mobile application. This API makes data available via internally hosted FHIR infrastructure and supporting systems built over the course of 2020-2023.

Members can access support tools for using OneRecord via pacificsource.com/resources, which includes a member FAQ, interoperability resources about privacy and consent, API usage terms and conditions, and member access instructions. The volume of data accessed via OneRecord has been minimal. We are taking advantage of the current low volumes to identify a best path for fielding external inquiries that can flexibly meet increasing request volumes.

We took steps to make internal and external member stakeholders aware of portal availability. As we anticipate 2025 improvements and next steps, we will emphasize:

- Improving how member ID is used to identify and select data for display
- Enabling access via additional mobile application vendors
- Improving ease of onboarding for new FHIR data partners via automation, sandbox self-provisioning, and so on

Our strategy remains geared toward addressing business-to-business interoperability use cases and more value driven use cases. We continued working with HIE partners to enable FHIR-based exchanges to replace or supplement legacy HL7 v2/v3 alternatives. Over an undefined timeframe, we view FHIR-based interoperability as a likely replacement technology for many of our older data exchange technologies internally and as a means of bringing more robust externally sourced data to bear in support of our member health information needs.

Highlights of additional 2024 accomplishments include:

- We explored an FHIR-based solution to source public payer endpoints likely to have demographic data overlap with our provider population. We developed interface capabilities for using those endpoints to retrieve provider data to improve our internal data details such as provider specialty, address, and contact information. This work was done primarily through a capstone project with students from Oregon State University. In addition to using FHIR to validate the data channel, we suggested the use of ChatGPT and other consumer data services as secondary sources for building panels of provider data for comparison purposes. This seemed a perfect low-risk use case for artificial intelligence – it pulled public data, involved no personal health information, and was inexpensive.
- We continued reviewing and planning for Trusted Exchange Framework and Common Agreement (TEFCA) options, as possible. We continue to monitor Qualified Health Information Network and TEFCA movement but do not plan to participate until we have a better understanding of the organizations to be involved in these processes as that will change the nature of how we trade and interoperate around data.
- We continued to explore considerations for a high-value interoperability partner roadmap in the areas of provider, clinical, enrollment and/or claims data exchange partners supported by FHIR.
- We continued work on architecture, design, and implementation for insourcing of OAuth 2.0 authentication, patient matching, and consent management capabilities in support of interoperability.

- We evaluated the use of Epic Tapestry to address FHIR-based prior authorization capabilities required by the ONC rules.
- We continued work on interoperability data source preparation, FHIR platform build-out, and security engineering.

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

Priorities for 2025 include continuing development and application of FHIR-based solutions for ingesting and improving our provider data quality and pursuing architecture activities needed to support the January 2027 goals of the CMS proposed rule once the final rule is announced. One of the first pieces of infrastructure will support a master member ID that consolidates all potential and individual member IDs.

Planned Activities	Planned Milestones
1. Develop and iterate on interoperability roadmap including regulatory approach, industry-alignment, technology, and partner opportunity	2025 – 2026
2. Track CMS 0057 Final Rule and develop associated roadmap	2025 – 2026
3. Research TEFCA and Payer-to-Payer Options and develop TEFCA roadmap	2025 – 2026
4. Continue exploring FHIR-based solutions for ingestion of provider data	2025 – 2026

C. HIE for Care Coordination Barriers

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

We made several major technology shifts in 2024, including cancelling our Helios Implementation and Reliance contracts, implementing Unite Us to support our HRSN benefit, and initiating planning efforts for multiple Epic solutions to replace the cancelled strategies. Consequently, we are reevaluating and redirecting our efforts in many areas to support these significant initiatives. This adjustment has led to some setbacks, but it positions us to make substantial progress moving forward. We are optimistic about the prospects of these new solutions, recognizing that they present both challenges and opportunities as we move into 2025.

D. OHA Support Needs

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

The most significant barrier to HIE for care coordination is the cost of a centralized community health record.

In general, the OHA can assist by continuing to align with Federal requirements for data sharing. This reduces the administrative burden on health plans and providers operating under multiple state and federal rulesets.

E. CCO Access to and Use of EHRs

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

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

Refer to the data table in *Section 3. Support for EHR Adoption, Strategy 3: Encourage and support EHR Adoption and Optimization.*

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

See the Electronic Medical Records Access Handout provided in *Section 3. Support for EHR Adoption, Strategy 3 – Encourage and support EHR adoption and Optimization*.

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

We transmit EHR data collected from our provider partners to our data warehouse and integrate it with systems – mainly Quality, Care Management, and Risk Adjustment – that use the data warehouse as a source. The data from these EHRs does not alter our core data; instead, it augments and fills information gaps not otherwise addressed.

6. Health IT to Support SDOH Needs

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

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

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

Notes:

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

Strategy category checkboxes (within CCO)

Using the boxes below, please select which strategies you employed during 2024 and plan to implement during 2025-26, within your organization. Elaborate on each strategy and your progress/plans in the sections below.					
Progress	**Plans**		**Progress**	**Plans**	
☒	☒	1. Implement or use health IT tool/capability for social needs screening and referrals	☒	☒	7. Use data for risk stratification
☒	☒	2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)	☒	☒	8. Use health IT to monitor and/or manage contracts and/or programs to meet members' SDOH needs
☒	☒	3. Integration or interoperability of health IT systems that support SDOH with other tools	☒	☒	9. Use health IT for CCO metrics related to SDOH
☒	☒	4. CCO leads problem solving efforts and collaboration with their partners	☒	☒	10. Education/training of CCO staff about the value and use of health IT to support SDOH needs
☒	☒	5. Care coordination and care management	☒	☒	11. Participate in SDOH-focused health IT convenings, collaborative forums, and/or education (excluding CIE governance)
☒	☒	6. Use data to identify members' SDOH experiences and social needs	☐	☐	12. Participate in CIE governance or collaborative decision-making
☐	☐	13. Other strategies for adoption/use of CIE or other health IT to support SDOH needs within CCO (please list here):			
☐	☐	14. Other strategies for CCO access or use of SDOH-related data within CCO (please list here):			

List and briefly describe Health IT tools used by CCO for supporting SDOH needs, including but not limited to screening and referrals
Unite Us/Connect Oregon/CIE: To address social determinants of health (SDOH), we continue to invest in the Connect Oregon CIE network powered by the Unite Us platform. Our contract with Unite Us has empowered our employees, contracted providers, and community partners to access the Connect Oregon system. Our purchase of unlimited Connect Oregon licenses effective across regions continues to be a key component of our HIE strategy. Our Unite Us contract includes coverage for Social Care – nonclinical services reimbursable when rendered to qualifying members. We are incorporating SDOH screenings into workflows that support HRSN eligibility as well as SDOH referrals. **PointClickCare (PCC) –** formerly Collective Medical and PreManage: The PCC platform has been widely adopted across our regions and has proven key to supporting both internal operations and providers' care coordination. To better flag members at risk for housing insecurity, we use addresses from this platform. We cross-reference the addresses with shelter addresses, shelter names, and phrases associated with housing insecurity. We also incorporate PCC data to enhance SDOH and chronic condition identification. PCC data feeds are staged in our data warehouse and integrated into SDOH identification logic. **Reliance eHealth Collaborative:** Reliance eHealth Collaborative uses IMAT technology to host its clinical data repository. In 2024 we received Reliance health record data and also contributed administrative claims data to Reliance, including filled prescriptions. This enabled newly on-boarded providers in those regions to see encounter history even if the providers who delivered the service are not yet contributing data. We made the difficult decision to terminate the contract with Reliance eHealth Collaborative effective 12/31/2024.

Epic Payer Platform Evaluation: After evaluating EPP, we concluded that it can significantly improve our ability to 1) improve provider screening and referral workflows with data we have and 2) increase the screening and referral data we can collect. We will likely learn more about this through our EPP implementation.

(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: **Community Information Exchange Governance**
Implement activities to ensure CIE program direction, guidance and oversight

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

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

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

We continued addressing SDOH as a major internal strategic initiative in 2024 with executive level sponsorship and continued working with Unite Us to execute the internal deployment plan.
Our staff continued growing their knowledge of the national SDOH screening and referral landscape through education opportunities and industry events.

We continue to participate in the SDOH workgroup hosted by CCO Oregon. This statewide workgroup is a standalone non-profit that focuses on all things SDOH to inform statewide CCO strategies and legislative priorities. Each year they host an October conference where we are a regular presenter and content contributor. They also offer a set of eight workgroups with participation by CCO staff and leadership.

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

In 2025, we plan to maintain executive level sponsorship and collaborate with Unite Us to implement an internal deployment strategy. In 2024, the HIT team concentrated on deploying CIE to fulfill HRSN and SDOH screening requirements. To help operationalize this initiative, we dedicated well over 20,000 hours in implementation and configuration efforts. We also continued a strong partnership with HIT Commons and other CCOs to deploy CIE consistently across regions.

Planned Activities	Planned Milestones
1. Manage SDOH as a major strategic initiative	2025 – 2026
2. Build industry SDOH knowledge	2025 – 2026

Strategy 2: **Connect Oregon and Unite Us Implementation – Internal**
Increase adoption and use of the Connect Oregon platform within our organization

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

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

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

We have 232 internal users on Connect Oregon from various teams, including Utilization Management, Population Health, Provider Service, Traditional Health Work, and Health Equity.

We have a dashboard to monitor workforce and network usage, helping to identify areas needing more training.

We continued a program under which Deschutes County Health Services uses Connect Oregon to direct incoming referrals to our BH Navigation team. To ensure a closed loop referral, the program uses these steps:

1. Deschutes County Health Services sends a referral through Connect Oregon.
2. An email notification alerts our BH Navigation Member Support Specialists of the new referral.
3. Our Member Support Specialists log into Connect Oregon and address the needs of the referral and add a note in the member's record, providing Deschutes County Health Services with updates and/or indicator of completion.

We have partnered with Unite Us to optimize internal user "Groups" with access to the Unite Us platform. These groups were restructured, and users were reassigned by role and scope within their respective regions to improve efficiencies and responsiveness.

In 2024, we made internal organizational adjustments to better align teams that were processing Health-related Social Needs (HRSN) and Health-Related Services (HRS) / Flexible Services (FS) for eligible members. The transition created new opportunities to adjust workflow processes and establish criteria that better aligned with the purpose of HRSN and FS set by the OHA. There had been a steady increase in the variety and number of requests without set criteria to assist with reviewing for appropriateness and cost effectiveness. The increase in volume and variety brought a challenge to ensuring parity across CCOs and decision makers. The HRSN housing-related supports launch, in particular, strained the system. In the first month (November 2024), we received over 1,000 assistance requests – many from people facing imminent eviction – which required highly individualized, manual work. The new criteria increased parity, increased cost-effective decision making, and increased efficiency though we remain strained with HRSN housing-related supports requests. In the first 11 months of HRSN benefit availability we served close to 2,000 members and provided over 3,500 climate-related and housing-related supports.

Throughout 2024, our Training Department, MSS Strategist, and HRSN Leadership in partnership with Connect Oregon performed continuous training courses on system functionality, core platform, internal referral processes, closed loop referral process, utilization management review process, and service fulfillment process. Due to the unprecedented volume of requests, additional staff members throughout the organization were onboarded and trained on front end member merge and enrollment processes including Medicaid Admin, Community Health, non-UM support staff, regional CCOs teams, and non-clinical assistance staff. Each new HRSN benefit required a process adjustment, workflow establishment, and training opportunities for current and support staff. We also partnered with external stakeholders to build new HRSN Service Provider networks, review and approve grant applications for Community Capacity Building Funding and assess strengths and gaps in HRSN community supports regionally.

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

In 2025, we will continue to train additional internal staff, including Utilization Management, Care Management, and HRS/HRSN teams. PCS in partnership with Unite Us will continue to train external community partners and HRSN Service Providers for benefit provisioning using the Unite Us Platform. We will explore opportunities for streamlining workflows within the Unite Us system, including form flexible request form alignment and invoicing. We will continue partnering with Unite Us to enhance the platform functionality to better support HRS, HRSN, and connect members with additional supports and services. Additional training will also expand the number of internal champions available to answer questions, promote the use of the network and the screening and referral tools therein, and offer introductions and warm hand-offs of providers or community partners to Unite Us.

Planned Activities	Planned Milestones
1. Continue to monitor for additional internal onboarding opportunities 2. Continue to train internal staff for additional provider and community partner support opportunities 3. Explore opportunity to add FS to the Connect Oregon platform and align HRS/HRSN functionality, where possible	2025 – 2026 2025 – 2026 2025 - 2026

Strategy 3: **Assess Unite Us and Health Information Exchange Interoperability Opportunities**
Seek opportunities to integrate Connect Oregon with other HIE functionality and seek opportunities to integrate Connect Oregon with other HIE functionality

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

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

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

In 2024, we successfully completed an evaluation of Epic Payer Platform (EPP). We hope that implementing EPP will make it easier for provider partners on Epic to share screening and referral data with us.

Unite Us and PCC continue sharing information within the PCC user interface to help address social needs for individuals and families in Oregon. We worked with PCC to add tracking flags for clients who were served by Connect Oregon and who have a housing, food, or transportation referral history within the previous six months.

In 2024, we continued to report these tracking flags internally. In Q4 2024, we decided to pull this data in summary and ready it for updated presentations to community partners highlighting what is available in PCC. We will make these presentations at the next appropriate opportunity.

(Optional) **Overview of 2025-26 plans for this strategy**:
We will focus on expanding and stabilizing the Connect Oregon network within each CCO region. We will handle interoperability on a case-by-case basis, considering a strategy for existing partner platforms.
We will continue to be alert for areas where interoperability might provide enhanced tools.

In addition, we will implement EPP to assist with the interoperability and exchange of social care data between providers, PCS, and CBOs.

Finally, we will explore the feasibility of a new integration standard to collect SDOH information directly from providers via flat file supplemental data exchange.

Planned Activities	Planned Milestones
1. Continue to explore potential new use cases where HIEs and Connect Oregon can share information 2. Continue assessing how HIE platforms can serve as bi-directional exchange for SDOH and HIE information 3. Implement Epic Payer Platform and understand SDOH information capabilities 4. Explore new file-based integration standard to collect SDOH information	2025 – 2026

Strategy 4: **HIE as a Source of SDOH Information**
Use HIE sources to gather SDOH information

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

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

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

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

We continued using, adding, and augmenting data sources in 2024 to incorporate SDOH data into Care Program Identification Algorithms (CPIA) throughout the year:

- Connect Oregon / Unite Us data feeds
- PCC data feeds (including addresses)
- Reliance SDOH-specific reports and data feeds
- Member eligibility files
- PCS claims
- Internal Population Health Management Platform / Case Management Software (currently Dynamo / CaseTrakker)

Connect Oregon as Source of SDOH Information

We maintain a bi-directional interface between PCS and Connect Oregon and continue to incorporate ingested information into our proprietary Intensive Care Coordination (ICC) Prioritized Population, CPIA, internal social complexity algorithms, and Member Insight Provider Insight (MiPi) member profiles.

In addition to referrals, we look at information from case descriptions, service types, and programs to find members with needs of interest. This has allowed us to implement more comprehensive ways to pull in data for identifying members with SDOH needs. In this context, we refer to “SDOH signals” to characterize information that suggests a member may have an SDOH need. Using multiple data sources, we aim to identify the potential need, process the data, and amplify it so the information can be provided in a consolidated location for action. As such, Connect Oregon SDOH signals proliferate into each place SDOH data flows in the process.

Currently, our SDOH process includes:

- Identifying SDOH signals from multiple data sources
- Mapping signal from different data sources to the appropriate SDOH
- Storing tables of SDOH signals in an enterprise data warehouse to allow for use by Analytics and Business Intelligence teams for additional report development, analyses, member lists, and ad hoc project work
- Flowing data into existing products such as MiPi and CPIA, exposing information to users in member profiles
- Developing and maintaining reporting – including interactive and customizable reporting – on SDOH signal prevalence (for example, monitoring prevalence of members with SDOH and diabetes or members with housing insecurity and diabetes)

We use Connect Oregon submission, referral, and case data combined with data from other sources to identify members with challenges related to housing, finances, health care access, social support and connection, transportation, stress, safety, incarceration, and other SDOH. We used these enhanced methods in 2024’s annual population health assessment reporting to better understand the scope of member needs and variation in potential screening or documentation rates.

We have incorporated data into member profiles for care managers and into care program identification algorithms. Connect Oregon data also feeds into interactive SDOH prevalence reporting, as well as exploratory children’s health complexity dashboards to help drive strategic planning to improve the social and emotional well-being of our pediatric members. Connect Oregon data was also a key input for the 2023 Transformation and Quality Strategy (TQS) project to improve health outcomes for members with housing

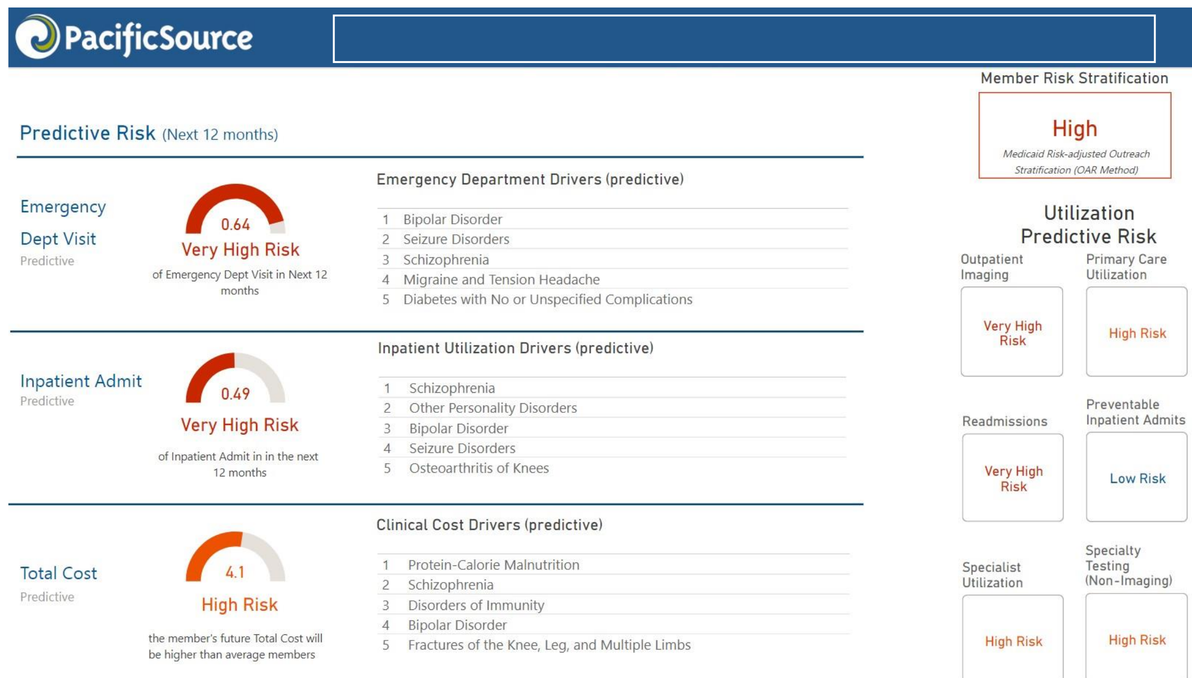
insecurity and diabetes through care management outreach. We used this data to improve accurate identification of members with housing insecurity for outreach. Through this project, we completed outreach to 629 members with housing insecurity and diabetes, helping close gaps in care and connect members to SDOH resources. This specific TQS project was completed in early 2024, but we continue to leverage SDOH signals gleaned through Connect Oregon to improve care program identification algorithms and other operational processes (such as determination of potential eligibility for HRSN benefits).

We have created a multi-year roadmap around the collection, storage, and normalization of Race, Ethnicity, Language and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) data that we expect to include in HIE and CIE sources. We have received OHA REALD/SOGI supplemental files starting in October 2023. We have been working on an implementation plan to enhance the current data with elements from these files and continue to work on that in 2024.

PCC as Source of SDOH Information

- Member addresses found in PCC are cross-referenced against shelter addresses, names, terms, and phrases associated with housing insecurity to flag members in CPIA. An example use case is understanding the unique needs of members with diabetes and housing insecurity, given the potential adverse outcomes of this combination. Case Management teams provide routine outreach to members with housing insecurity and diabetes to foster engagement in primary care and behavioral health, close care gaps, and support the member with SDOH needs through health-related services funding.
- We use dashboards showing different social risk factors to consolidate disparate data, including SDOH data from HIE, to inform community collaboration and identify priority populations. SDOH and connected social risk factor data help internal teams consider the unique needs of members in determining areas of focus for action plans.

  Example dashboard:



- We stage and cleanse PCC data feeds in our data warehouse and integrate that information into SDOH identification logic to enhance chronic condition identification.

Reliance as Source of SDOH Information

Capturing information from an HIE that aggregates data from various sources helps identify population characteristics of housing insecure members, including disease burden, demographics, health care utilization, and costs. We use these analyses during strategic discussions about potential actions and/or investments aimed at improving housing security. We continued to review data around diabetes by type, tobacco use, birth weight, food insecurity, and pregnancy.

To appropriately match data received from Reliance to internal reports, we received a weekly Reliance Member Crosswalk that compares the member IDs we send to Reliance to Reliance's system-generated member IDs.

We received regular data feeds from Reliance in our standard EMR data format. A non-standard ETL process was in place to update our data warehouse with these data files and relevant data until the termination of our agreement on 12/31/2024.

EMR as a Source of SDOH Information:

We integrate data from EMR feeds into our SDOH identification logic. Participating clinics provide EMR feeds to us in a standard format, which are then ingested into the data warehouse. The current feeds do not include SNOMED-CT codes but do provide diagnoses, procedures, and provider information. Diagnosis codes from the EMR feeds are incorporated into the SDOH identification algorithm.

We maintain a list of items for possible enhancement in the future, time and resource permitting. Items on that list – but without a specific timeframe for implementation – include non-emergency medical transportation (NEMT) as an indicator of transportation SDOH, questions about SDOH from Health Risk Assessments (HRAs), and potential SDOH data gathered during home visits and documented in Matrix PDFs.

Per our evaluation, Epic Payer Platform is expected to be a new mechanism for quickly accessing SDOH data from provider's Epic instances if they participate on the EPP network.

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

Planned Activities	Planned Milestones
1. Identify additional data sources and elements containing data relevant to monitoring and addressing SDOH	2025 – 2026
2. Continue data modeling from staged Connect Oregon data	2025 – 2026
3. Explore the mining of Collective data for predictive SDOH variables	2025 – 2026
4. Use EMR feeds as a data source	2025 – 2026
5. Continue to integrate newly identified/relevant data into the Enterprise data warehouse, CPIA and MIPI	2025 – 2026

Strategy 5: **CCO Quality Metrics Support**
Perform necessary annual updates and ongoing enhancements to CCO Quality Metric Reporting.

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

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

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

Our standard work supporting Quality Incentive Measures (QIMs) is through monthly dashboard monitoring for all claims and electronic clinical quality measures (eCQMs). Our Business Intelligence team takes each claims-based measure and transcribes it into code to monitor CCO performance and share it across our

healthcare system monthly. By doing so, we support our provider partners in strategies to ensure each CCO performs well.

We continue to seek solutions using HIE platforms like PCC and Reliance to support QIMs, as we have with the IET Metric cohort and reports. We support exploring and piloting different HIT spaces as providers approach us to collaborate. For 2024, Reliance was recommended as a strategy for providers to meet the IET metric, however we found that providers were not able to embed Reliance into their workflows and this strategy was ultimately unsuccessful. For 2025, we discontinued this strategy given termination of the Reliance contract.

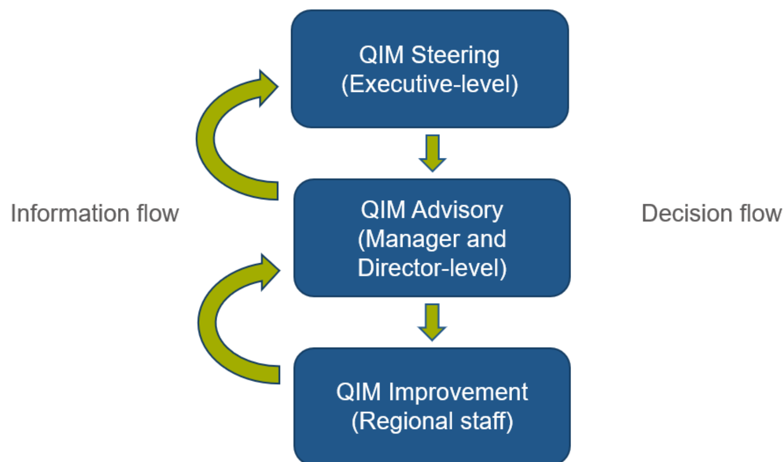
Social-Emotional QIM:

- We continued to use the internal data dashboard that the Analytics team created to ingest the OHA Child Health Complexity data, overlaid with internal data (SDOH, Parent linkage data, REALD, etc.) to illustrate the most accurate picture of at-risk zero-to-five-year-olds. We can filter this data in various ways to understand the factors influencing zero-to-five-year-old's health and their access to social-emotional health services. This data capability enables PCS CCOs to identify reporting trends and monitor the population of focus for this measure. OHA will not provide the Child Health Complexity data in 2025, though we will continue to use internal data sources to best monitor this population.
- We continue to support the provision of clinical and community-based social-emotional health services for zero-to-five-year-olds and recognize the role of a community information exchange and other electronic health technologies in supporting this work and continue to explore opportunities to leverage CIE/HIE platforms for this measure.
- Considering the community-specific nature of this work, we have a Community Quality Coordinators (CQC) working in each CCO region (one CQC to cover the PCS-Central Oregon and PCS-Columbia Gorge regions) to support specific community-derived interventions and specific access issues in the region. Additionally, these dedicated positions allow for greater visibility into the community-specific CIE/HIE needs related to the Social-Emotional QIM. As the complexity of the measure changes, CQC roles have expanded.

SDOH QIM:

- In February 2024, we created a new QIM Governance Structure to support collaboration among internal regional staff across various departments to address QIM performance in all regions. The goal is to discuss new and continued strategies, initiatives, and barriers impacting QIM Program success. There are three levels to the QIM Governance Structure, comprised of the following:
    - QIM Improvement Committee
    - QIM Advisory Committee

- QIM Steering



- Starting in 2024 and continuing into 2025 is a monthly workstream for the SDOH QIM to address opportunities and challenges around Unite Us alignment and integration with the QIM. This is in addition to the monthly internal workgroup that is looking at methods and process for data collection through EHRs and other channels for information exchange.
- We assessed the current screening practices and tools of all providers within our Delivery Service Network (DSN) and Community-Based Organizations (CBOs) with whom we have contracted (directly or indirectly via our health councils). This data informed our external-facing strategy in 2024 and will continue to drive providers and partners to use OHA-approved screening tools and securely share screening and referral information via a CIE and/or HIE platform. This surveying will occur again in 2025 and continue to inform strategy and approach.
- The SDOH QIM calls for using OHA provided REALD member data to identify where we might have gaps in resources on Connect Oregon for members with cultural or linguistic needs. We continue to review the top races, ethnicities and languages spoken in each CCO region to inform a list of priority organizations to onboard. However, tracking utilization disaggregated by race, ethnicity, and language needs of those served on Connect Oregon has been challenging as those fields are optional and often skipped when intaking a member. Additionally, the Connect Oregon platform does not currently capture member disability status. Given the limitations of REALD data in the Connect Oregon platform, we will explore tracking this data in 2025.
- The SDOH QIM requires CCOs to capture the number of member screenings performed (including the number of members who declined screening) for three domains (housing, food, and non-medical transportation), the screening tool used, the number of positive screens, and whether positive screens resulted in a referral to resources. We continue collaborating with Unite Us to explore platform and data exchange enhancements to meet SDOH QIM requirements and promote the broad adoption of Connect Oregon in our regions to support screening engagement and referral tracking.

Are there any **challenges/barriers** you're facing?

- Because the SDOH QIM does not align with national measures, data collection, especially from clinical provider partners is very challenging. Additionally, because OHA has not provided coding and value set guidance, individual CCOs have had to determine different approaches that are not consistent across CCOs/payers. While we will continue to pursue information exchange via CIE and other pathways, the lack of guidance for systematic collection from providers, including alignment with the Medicaid fee schedule and prioritized list, will continue to cause difficulty in reporting for this measure.

(Optional) **Overview of 2025-26 plans for this strategy**: Ongoing activities will continue, as well as additional assessments that align to the measure year, and preparation of data systems and data sharing approaches to support metric measurements and reporting.	
Planned Activities 1. SDOH QIM: Survey providers for existing screening tools, referral pathways and data systems used. 2. SDOH QIM: Maintain data systems to clean and use REALD data 3. SDOH QIM: Maintain a data-sharing approach within the CCO service areas	**Planned Milestones** 2025 2025 2025
Strategy 6: **Cloud Data Sharing Pilot** Pilot a new cloud data sharing approach using Snowflake.	
Strategy categories: Select which category(ies) pertain to this strategy ☐ 1: Implement/use health IT ☐ 2: Enhancements ☒ 3: Integration ☒ 4: Collaboration ☐ 5: Care coordination ☐ 6: Data to ID SDOH ☐ 7: Risk stratification ☐ 8: Manage contracts ☐ 9: Metrics ☒ 10. Education/training ☐ 11: Convenings ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:	
Strategy status: ☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed ☐ Ended/retired/stopped	
Progress (including previous year accomplishments/successes and challenges with this strategy): In 2024, we worked with the OHA to Pilot a new cloud data sharing approach using Snowflake. We were able to securely share test data bi-directionally with the OHA directly within a share Snowflake data environment which the OHA hosted. We are eager to see if this type of data sharing could be useful for any other data collaboration between CCOs and the OHA, but for now we are satisfied with the result of the successful pilot.	
(Optional) **Overview of 2025-26 plans for this strategy**: None, concluded.	
Planned Activities N/A	**Planned Milestones**

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

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

- Select the boxes that represent strategies pertaining to your 2024 progress and 2025-26 plans.
- List and describe the specific tool(s) you currently or plan to support or provide to your contracted physical, oral, and behavioral health providers, as well as social services and CBOs. Please specify if the tool(s) have screening and/or closed-loop referral functionality (e.g., CIE).
- (Optional) Provide an overview of CCO's approach to supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals.
- For each strategy CCO implemented in 2024 and/or will implement in 2025-26 to support contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals, include:
    a. A title and brief description

b. Which category(ies) pertain to each strategy
c. Strategy status
d. Provider types supported
e. A description of 2024 progress, including:
    i. Accomplishments and successes (including the number of organizations of each provider type that gained access to health IT to support SDOH needs as a result of your support, where applicable)
    ii. Challenges related to each strategy, as applicable
f. (Optional) An overview of CCO 2025-26 plans for each strategy
g. Activities and milestones related to each strategy CCO plans to implement in 2025-26

Notes:

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

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

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

☒	☒	4. Training and/or technical assistance	☒	☒	10. Outreach and education about the value of health IT to support SDOH needs
☒	☒	5. Support referrals from CBOs to clinical providers and/or from clinical providers to CBOs	☐	☐	11. Support participation in SDOH-focused health IT convenings, collaborative forums and/or education (excluding CIE governance)
☐	☐	6. Financial support to adopt or use health IT that supports SDOH (e.g., incentives, grants)	☒	☒	12. Support participation in CIE governance or collaborative decision-making
☐	☐	13. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs (please list here):			
☐	☐	14. Other strategies for supporting access or use of SDOH-related data (please list here):			

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

Unite Us/Connect Oregon/CIE: In an ongoing effort to address social determinants of health, we continue a significant investment in the Connect Oregon CIE network powered by the Unite Us platform. Our contract with Unite Us has empowered our employees, contracted providers, and community partners to access the Connect Oregon system. Our purchase of unlimited Connect Oregon licenses effective across regions continues to be a key component of our HIE strategy. Our Unite Us contract includes coverage for Social Care – nonclinical services reimbursable when rendered to qualifying members. We are incorporating SDOH screenings into workflows that support HRSN eligibility as well as SDOH referrals.

PointClickCare (PCC) – formerly Collective Medical and PreManage: The PCC platform has been widely adopted across our regions and has proven key to supporting both internal operations and providers' care coordination. To better flag members at risk for housing insecurity, we use addresses from this platform. We cross-reference the addresses with shelter addresses, shelter names, and phrases associated with housing insecurity. We also incorporate PCC data to enhance SDOH and chronic condition identification. PCC data feeds are staged in our data warehouse and integrated into SDOH identification logic.

Reliance eHealth Collaborative: Reliance eHealth Collaborative uses IMAT technology to host its clinical data repository. In 2024 we received Reliance health record data and also contributed administrative claims data to Reliance, including filled prescriptions. This enabled newly on-boarded providers in those regions to see encounter history even if the providers who delivered the service are not yet contributing data. We made the difficult decision to terminate the contract with Reliance eHealth Collaborative effective 12/31/2024.

(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**

We have contracted with Unite Us for social payments functionality to assist community-based organizations delivering HRSN services in tracking and submitting invoices for payment/reimbursement. To streamline implementation, we are currently working with OHA, to fully understand the requirements, and Unite Us, to implement the technical functionality and related processes and workflows.

- To help support HRSN Service Providers with a system that process requests, closed-loop referrals, provision of services, and supports payments we have opted-in to *Unite Us Payments*, an invoice generation feature in the Unite Us platform, to track encounters and submit invoices for reimbursement of HRSN services.
- We are collaborating with OHLC and other CCOs who are also implementing *Unite Us Payments* to ensure Unite Us is fully informed and aligned on implementation requirements for HRSN service delivery and reimbursement.
- We are working with Unite Us and OHLC to provide technical assistance to HRSN Service Providers in understanding how *Unite Us Payments* functions so they may submit invoices for services rendered and troubleshoot, if needed.

Strategy 1: **Connect Oregon and Unite Us Implementation – Contracted Providers and CBOs**
Increase adoption and use of the Connect Oregon platform by external partners

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

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

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

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

In 2024, the bulk of resources at both PCS and Unite Us were dedicated to the scoping and implementation of HRSN workflows. HRSN implementation also organically drove Connect Oregon expansion as HRSN Service Providers onboarded to participate in the program.

Ongoing work included:
- Meeting monthly with UU to talk about high-priority partners in each region that we'd like to see on the platform/engaging more and help our UU account manager with connecting to the right people and understanding any context for why a provider or CBO might have gone dormant (e.g., staff turnover, workflow complexities, etc.).
- CCO staff often meet with partners and providers to talk about Connect Oregon and hear their concerns. These are often routed to UU to help troubleshoot and help with workflow technical assistance.
- Discussing relevant use cases of using Connect Oregon with providers and partners as we work to set up effective workflows for collecting screening and referral data for the SDOH and SEH QIMs and administering HRSN benefits.
- UU hosts a quarterly "Connect Oregon Community of Practice" for users of the platform. This is a time for users across the state to join a call and discuss issues and elevate concerns to the UU team.

- Engaging in quarterly business reviews with Unite Us to review regional utilization, upcoming enhancements, and overall health of the network and platform.
- Provided multiple training opportunities and office hours throughout the year for HRSN Service Providers for onboarding, testing, and mitigation of the HRSN benefit administration.

In 2024, we continued efforts to expand the Connect Oregon network across all our CCO regions, offering licenses to all in-network healthcare partners and working with Unite Us to engage and onboard diverse community-based organizations (CBOs), who can join for free. In 2023, we added language to contracts with CBOs who employ traditional health workers (THWs) stipulating the CBO will onboard Connect Oregon and participate in the social service referral process, in an effort to expand member access to THW services.

Unite Us and PCS met monthly to review network adoption and utilization data and strategize ways to improve the health of the network, with a focus on a dynamic roster of priority providers and organizations in each region that offer critical healthcare and social services and/or have existing referral pathways that could be moved to Connect Oregon. As in previous years, we continued to provide introductions and “warm handoffs” to the Unite Us’ customer success team for follow through with identified providers and CBOs.

As a result of these efforts, the network continued to grow in 2024.

2024 Connect Oregon Network Growth				
Region	**2021 Total Onboarded Partners***	**2022 Total Onboarded Partners***	**2023 Total Onboarded Partners***	**2024 Total Onboarded Partners***
Central Oregon	61	80	96	100
Columbia Gorge	-	-	3	5
Lane	50	98	113	120
Marion & Polk	50	218	226	233

**Including* healthcare organizations, community-based organizations, and government entities

In addition to network growth, increased utilization of Connect Oregon from onboarded partners is an ongoing area of focus and opportunity for training and improvement. As noted above, PCS and Unite Us meet monthly to discuss network development, review data, and discuss which providers or community partners require additional outreach or support.

The health of the Connect Oregon network is illustrated through the following data:

2024 Connect Oregon Network Health					
Region	**Total Clients Served**	**Total # of Referrals**	**Accepted Referrals Rate**	**Total # of Cases**	**Resolved Case Rate**
Central Oregon	1421	1728	80.2%	2638	56.1%
Columbia Gorge	1167	807	67.0%	1774	37.9%
Lane County	3456	2464	79.6%	5646	65.4%
Marion & Polk	2509	2701	67.9%	4438	51.3%

Additional Progress Specific to Oral Health Providers:

- All dental care organizations (DCOs) – Capitol Dental, ODS and Advantage Dental – are configured to send and receive referrals via Connect Oregon in all areas where they serve, in all CCO regions.

Workflows between DCOs and CCOs are a high priority; however, many DCOs are reluctant to get started until more CCOs across the state are accepting referrals. This currently represents a barrier to oral health engagement. To date, all four PCS CCOs accept referrals.

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

In addition to ongoing activities, we intend to socialize the capabilities of Connect Oregon with Providers and partners to support the SDOH and Social-Emotional QIMs and HRSN benefits. It is on the 2025 Unite Us roadmap to add workflows for Flexible Services and THW Programmatic Payments to its Payments platform to improve efficiencies.

Planned Activities	Planned Milestones
1. Facilitate learning sessions in each region leveraging Unite Us events for learning and support with on-boarded partners	2025 – 2026
2. Continue onboarding providers and CBOs and assisting with the establishment of Connect Oregon licenses and workflows	2025 – 2026
3. Socialize the capabilities of Connect Oregon with Providers and partners to support the SDOH and Social-Emotional QIMs and HRSN benefits	2025

Strategy 2: **Connect Oregon and Unite Us Implementation – Members**
Increase adoption and use of the Connect Oregon platform by PCS CCO members

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

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

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

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

We enabled members to make self-referrals to Connect Oregon via a link on our website and have received thousands of requests. No significant effort beyond this happened in 2024.

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

Work with Unite Us to fully implement functionality that allows members to self-refer for SDOH services.

Planned Activities	Planned Milestones
1. Implement Self-referral capability within Unite Us	2026

Strategy 3: **Connect Oregon Go-Live in the Columbia Gorge Region**
Address unique adoption challenges of the Connect Oregon platform in the Columbia Gorge region

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

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

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

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

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

Connect Oregon is live in the Columbia Gorge region. Ongoing work will be integrated into reporting for all regions, and this strategy will be concluded.

Interoperability between Connect Oregon and Activate Care was assessed and determined to be unfeasible. Barriers included method and cost of integration and achieving a shared understanding of the use of each respective platform.

A referral pathway was set up for VeggieRx with the Columbia Gorge Health Council and Bridges to Health.

Given the alignment in the Gorge to use Unite Us for HRSN, we are closing this strategy with mixed success.

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

Planned Activities	**Planned Milestones**

Strategy 4: **Explore the Application of CIE for Clinical Care Coordination**
Seek opportunities to use Connect Oregon to fill gaps in clinical care coordination

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

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

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

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

We have decided that Connect Oregon is not suitable for supporting clinical care coordination. Due to its overlap with our core Unite Us Implementation strategy, we will close it in 2024.

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

Planned Activities	**Planned Milestones**
1. N/A	1.

Strategy 5: **Enhancements to CIE Tools**
Seek ways to add or improve functionality within Connect Oregon

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

Strategy status:

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

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

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

We continue to streamline the process for members to submit requests for Health Related-Social Needs through Connect Oregon by using a list of questions embedded directly within Connect Oregon.

We continue to work with Unite Us on basic functionality improvements to the process for both submitting the request, receiving the complete request, and referring the request to contracted organizations, performing closed looped referral processes and the turnaround times between submission and approval. We meet with Unite Us regularly to review the status of implementations and identify improvement and discuss the status of those improvements at least weekly. As of the end of 2024 there were ten major requests to platform enhancement or bug fixes being reviewed and planned for implementation.

Enhancement completed in 2024:

1. Clients remain in UU after disenrollment.
2. Enhanced roster ingestion shows completed in 2024; however, roster ingestion issues persist in 2025, so this is not yet complete.
3. Multi-select procedure code/modifier,
4. Provider TIN included in in-app Invoice Export,
5. ARFs sorted from oldest to newest.
6. Other minor usability improvements.

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

Planned Activities	Planned Milestones
1. Enhance referrals to approve/deny them from within the platform in alignment with HRSN work	2025

C. Using Technology to Support HRSN Services

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

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

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

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

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

In 2024, most of our HIT resources were allocated to the implementation of HRSN. The successful launch of Climate, Housing, and Nutrition related supports required substantial collaboration between internal and external partners. Since no existing system was suitable for this purpose, reengineering programs and processes demanded significant resources, development, and problem-solving. It is estimated that over 20,000 staff hours were dedicated to supporting the implementation.

Areas that required the creation of completely new processes included:

- HRSN Invoicing
- HRSN Utilization Management Processes
- HRSN Provider Contracting and general support
- HRSN Provider Onboarding
- HRSN Credentialing and Medicaid ID support
- HRSN Unite Us Support
- HRSN Referrals Support
- HRSN Information
- HRSN Contracting Inquiries
- Member Information and HRSN Application Status

Initial and Ongoing Challenges include:

- Determining what a broadened CIE platform looks like with an HRSN component
- Adding invoicing capability to Connect OR
- Building a payment module into HRSN account settings
- Managing crisis to procure benefits
- Changes to the Unite Us platform
- Interdepartmental visibility in HRSN member journey
- Developing a communication strategy with HRSN service providers
- Developing a provider support strategy
- Creating internal processes and adapting as issues arise
- Determining how to configure OHA rules for a new Medicaid benefit in a system not designed for that purpose

Despite the breadth of these challenges, we went live with:

- Climate Supports on 3/1/24
- Housing Supports and Outreach & Engagement on 11/1/24
- Nutrition Supports on 1/1/25

While we are very proud of our accomplishments in getting our members the care and supports they need that have not traditionally been included in the health insurance model, changing established systems that were not designed, or are even resistant, to the changes needed to administer HRSN benefits, means significant ongoing work to improve on inefficient systems.

2025-27 Plans:

We will continue to use Connect Oregon Payments/Referral Platform for Health-Related Social Needs utilization management processes, referral pathways, closed loop referral processes, invoice and payments processes, and care management integration. We will continue to partner with Unite Us and advocate for regulatory requirements, interdepartmental visibility, and basic functionality enhancements to streamline processes and reduce administrative burden.

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

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

PacificSource is utilizing Connect Oregon to administer HRSN benefits. Incentive measures to encourage use of this platform include the following:

Grants: PacificSource provided Community Capacity Building Funding (CCBF) for 2024-2025 to the majority of currently contracted HRSN Service Providers.

Technical Assistance
PacificSource provided and continues to provide technical assistance for all areas of HRSN service delivery to HRSN Service Providers. This includes contracting, Unite Us support, referrals, claims, general information, onboarding, and ongoing assistance as needed.

Outreach and Education
PacificSource provided outreach to prospective HRSN Service Providers via direct contact/education on HRSN and CCBF, Unite Us – closed loop referrals, participated in webinars, 1:1 and group presentations, flyers, and website information.

Feedback
PacificSource has solicited feedback from HRSN Service Providers about current experiences and challenges operating Connect Oregon while providing HRSN benefits. Feedback has been incorporated to make changes to the platform as well as to workflows to create efficiencies and improve provider experience supporting members.

Initiating HRSN benefits has elicited both known and previously unknown barriers.

1. Encouraging providers to pilot new platforms like Connect Oregon for closed-loop referrals and benefit administration can be challenging, as large referral receivers may resist change due to their existing automated processes, which are not easy or cost-effective to modify.
2. Many social service organizations rely on personal relationships for referrals, focusing on direct calls rather than technology. For those who value this personal approach, using a tool like Connect Oregon can feel impersonal and uncomfortable.
3. Staff turnover affects organizations' ability to fully embrace technology, as new individuals need training before using the platform. This issue is compounded by resource turnover in provider offices and CBOs, leading to some organizations being unable to use the platform due to capacity constraints.
4. Referring organizations with staffing and resource constraints may want to start using Connect Oregon slowly but are concerned about limiting incoming referrals to a manageable cadence due to technology and other limitations. Housing partners, in particular, face this issue due to limited housing resources. PCS and Unite Us have identified ways to structure receiving organizations' programs and eligibility details to attempt to address these concerns.
5. Currently, Connect Oregon lacks a mechanism for providers to attest to screening a member outside the platform before initiating and sending a referral. We have raised this as a potential feature enhancement with Unite Us, as it would improve data reporting for the SDOH QIM.
6. Enhancements and modification to the Connect Oregon Payments platform take time and testing, while request volume remains exorbitantly high.

2025-27 Plans:

- Continue relentless evaluation of the HRSN benefit administration workflow and potential product enhancements from Connect Oregon to improve efficiencies and user experience on the Connect Oregon platform.
- Use cohort of other CCOs using Connect Oregon Payments to administer HRSN benefits, and OHLC, for collaboration, share best practices, and align processes where applicable.
- Better align SDOH screening efforts with HRSN requests.

D. Health IT to Support SDOH Needs Barriers

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

There is a lack of participation in scalable, automated mechanisms for interoperability between providers, vendor partners, and CBOs. Each group has its own systems and processes, with limited capacity to engage with others' preferred methods for sharing data, resulting in a largely manual data-sharing process.

E. OHA Support Needs

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

We support the recommendations from HITOC, including that the success of CIE is dependent on widespread adoption by community-based organizations. OHA can support CIE network efforts by developing sustainable funding to help CBOs adopt and use CIE.

7. Other Health IT Questions (Optional)

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

A. Describe CCO health IT tools and efforts that support **patient engagement**, both within the CCO and with contracted providers.

Continue with CCO collaboration and brainstorming.

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

Continue with CCO collaboration and brainstorming.

C. What have been your organization's **biggest challenges** in pursuing health IT strategies? What can OHA do to better support you?

The two biggest challenges in pursuing health IT strategies are securing adequate funding and accessing unburdened resources across the industry.

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

Our health IT platforms provide valuable information that informs our strategies for improving access to care, vaccinations, and emergency responses, and we expect this support to continue.

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

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

5. Acronym Glossary

The following terms and acronyms are used within this document and are shared here for reference:

ADA – Americans with Disability Act

ADT – Admit, Discharge, Transfer

API – Application Programming Interface

ARF – Assistance Request Form

B2B – Business to Business

BH – Behavioral Health

BHPH – Behavioral Health Population Health

CAP – Clinical Advisory Panel

CBO – Community Based Organization

CCD – Continuity of Care Document

CCDA – Consolidated Clinical Document Architecture

CCO – Coordinated Care Organization

CHR – Community Health Record

CHW – Community Health Worker

CIE – Community Information Exchange

CRF – Code of Federal Regulations

CMS – Centers for Medicare & Medicaid Services

CMT – Collective Medical Technologies (now PointClickCare)

COHIE – Central Oregon Health Information Exchange

COIPA – Central Oregon Independent Practice Association

CPIA – Care Program Identification Algorithm (PacificSource specific term)

CQC – Community Quality Coordinators (PacificSource specific term)

CRM – Customer Relationship Management

CTWS – Confederated Tribes of Warm Springs

DCO – Dental Care Organization

DSN – Delivery Service Network

DSNP – Dual Special Needs Plans

ECDS – Electronic Clinical Data Systems

eCQM – Electronic Clinical Quality Measures

ED – Emergency Department

EDO – Emergency Department Optimization, the ED function of the PointClickCare platform.

ePA – Electronic Prior Authorization

EPP – Epic Payer Platform

EHR – Electronic Health Records

EOB – Explanation of Benefits

ETL – Extract, Transform, Load (data integration process)

EPP – Epic Payer Platform

ESD – Education Service Districts

FAQ – Frequently Asked Questions

FHIR – Fast Healthcare Interoperability Resources

FQHC – Federally Qualified Health Center

HCC – Hierarchical Condition Category

HEDIS – Healthcare Effectiveness Data and Information Set

HEN – Hospital Event Notification

HIE – Health Information Exchange

HIET – Health Information Exchange & Technologies

HIT – Health Information Technology

HITAG – Health Information Technology Advisory Group

HITOC – Health Information Technology Oversight Council

HL7 – A specification for how information should be structured when exchanged between healthcare computer systems

HMIS – Homeless Management Information System

HRA – Health Risk Assessment

HRSN – Health Related Social Needs

ICC – Intensive Care Coordination Prioritized Population (PacificSource specific term)

ID – Identification

IDS – Integrated Delivery System

IET – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

IPA – Independent Practice Association

IVR – Interactive Voice Response

JOC – Joint Operating Committee (PacificSource specific term/function)

LOB – Line of Business

LTSS – Long-Term Support Services

MCCAC – Mid-Columbia Community Action Council (specific to Columbia Gorge region)

MFA – Multi-factor Authentication

MiPi – Member Insight Provider Insight

NCQA – National Committee for Quality Assurance

NEMT – Non-Emergency Medical Transport

NICU – Neonatal Intensive Care Unit

NPRM – Notice of Proposed Rulemaking

OATH – Open Authorization

OCHIN – Oregon Community Health Information Network

ODHS – Oregon Department of Human Services

OHA – Oregon Health Authority

OHLC – Oregon Health Leadership Council

OHP – Oregon Health Plan

OIDC – OpenID Connect

ONC – Office of National Coordinator

PCC – PointClickCare (formerly Collective Medical Technologies)

PCP – Primary Care Physician or Primary Care Provider

PCS – PacificSource Community Solutions

PDMP – Prescription Drug Monitoring Program

PGP – Pretty Good Privacy

PH – Population Health

PHPH – Physical Health Population Health

PHQ9 – Patient Health Questionnaire-9 Depression Screening Scores

PIP – Performance Improvement

QHIN – Qualified Health Information Network

QIM – Quality Incentive Metric

REALD – Race, Ethnicity, Language and Disability

RFI – Request for Information

RFP – Request for Proposal

RHIO – Regional Health Information Organization

S&D – Strategy and Development

SaaS – Software-as-a-Service

SBIRT – Screening, Brief Intervention and Referral to Treatment

SDOH – Social Determinants of Health

SDS – Supplemental Data Source

SFTP – Secure File Transfer Protocol

SNF – Skilled Nursing Facility

SNOMED – Systemized Nomenclature of Medicine – Clinical Terms

SOGI – Sexual Orientation and Gender Identity

SUD – Substance Use Disorder

TEFCA – Trusted Exchange Framework and Common Agreement

THW – Traditional Health Worker

TQS – Transformation and Quality Strategy

VPN – Virtual Private Network

WVP – Willamette Valley Health Authority IPA, which is the Willamette Valley Providers Independent Providers Association in the Marion-Polk region