2024 CCO Health IT Roadmap

2024 Guidance, Evaluation Criteria & Reporting Template

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

Please:

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

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

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CCO: Umpqua Health Alliance

Date: 12/27/2023

1. Health IT Partnership

Please attest to the following items.

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

2. (Optional) Overview of CCO Health IT Approach

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

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

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

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

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

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

Notes:

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

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

- 2 Behavioral Health organizations without EHR
- 3 Oral Health organizations without EHR
- 3 Physical Health organizations without EHR

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

UHA provides technical assistance with clinical data feeds which helps provider offices meet CCO metrics and qualify for the Umpqua Health HIT Bonus program. The HIT Tiger team meetings are used to train providers on the provider portal, share portal enhancements, and review provider level and clinic level data for closing gaps and troubleshoot any issues or barriers clinics are experiencing discuss data feeds, provider outreach, and

opportunities for improvement. We have regular meetings to discuss data feeds, provider outreach, and opportunities for improvement. As we identify gaps in these data feeds, we work directly with the EHR vendor or follow up with each individual clinic to address any missing data. More details on this are covered within our strategies below.

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

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

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

Strategy 1 title: Support EHR enhancements for member engagement

Explore mobile app utilization for member engagement and outreach with large RHC clinic (Umpqua Health Newton Creek).

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 2023 we completed an internal needs assessment for functional requirements of a member focused health plan mobile application. We approached this via a survey to all of our member facing department leaders to focus on key features and functionality within a mobile application that would add value for the member. Challenges inherent within this strategy are competing priorities which necessitate that this initiative come second to other higher priorities. Additionally, the cost benefit analysis and return on investment presents challenges.

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

Planned Activities	Planned Milestones

1. In 2024 and 2025 we plan to continue discovery in this area as time allows. As a part of additional discovery, we are considering surveying a subset of the member population to allow for direct member input into the key features and functionality of a member focused mobile application. Additionally, we plan to engage in an evaluation of mobile app development partners in the market to determine whether a build or buy approach will best serve our organizational needs.	1. By 2024, finalize all preliminary research, including engaging with members and conducting phase one of marketplace analysis. 2. In 2025, initiate and complete a Request for Proposal (RFP) proposal, assess potential vendors against our specific requirements, and establish a proposal for either vendor collaboration or the development of an internal project plan and organizational investment. 3. In 2026, if the proposal is determined a priority, engage in the build of a member application.

Strategy 2 title: Expand CCO Metrics Data Collection from EHRs (REALD+SOGI)

UHA provides technical assistance with clinical data feeds which helps provider offices meet CCO metrics and qualify for the Umpqua Health HIT Bonus program. UHA uses an in-house developed application for analyzing and reporting on CCO incentive measures and we receive clinical data feeds from many of our contracted providers. We have regular meetings to discuss data feeds, provider outreach, and opportunities for improvement. As we identify gaps in these data feeds, we will either work directly with the EHR vendor or follow up with each individual clinic to address any missing data.

- Provide technical assistance to 14 clinics that use a common EHR (eClinicalWorks) to add more data elements to their CCO Metrics data feed, specifically REALD and SOGI.
- Work closely with each clinic, UHA Business Intelligence (BI) department and the EHR vendor on the technical specs, backend system updates and the data extract.
- Provide guidance and workflow recommendations, including updates to existing EHR templates and forms to ensure that all the required data is collected.

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 early 2023 we updated our internal specification to collect the REALD/SOGI data in our clinical data feeds. We communicated these changes to Reliance and provided an update to eCW (who acts on behalf of our eCW clinics). We also provided the updates to all our direct clinical submitters.

More specifically, we successfully finished the updated integration with Advantage Dental and Canyonville. For the other clinics, we are still in the extract delivery configuration stage (we're still working with them to ensure adherence to the new spec). This has taken longer than expected, but not because of any particular challenges – eCW is just a large organization and the coordination process has been slow-moving.

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

Planned Activities	**Planned Milestones**

1. In 2024, we will be continuing to work with eCW and the remaining clinics to update their respective feeds. 2. In addition, we will be evaluating what is necessary to ensure all data received from clinical partners is correctly normalized for use in our systems.	1. Q3 2024 – Complete analysis and make any necessary changes to ensure data normalization. 2. Q4 2024 – Complete data feed updates with remaining clinics.

Strategy 3 title: Automate EHR clinical data submission for CCO Metrics

- Automate EHR clinical data submission for 14 clinics that use a common EHR (eClinicalWorks). This is currently a manual process which is burdensome, error prone and has inherent delays in data submission. The automation will streamline the process, reduce human error, and improve efficiency.
- Work with each clinic, UHA Business Intelligence (BI) department and the EHR vendor on the automation process
- UHA provides financial assistance for the monthly vendor fees related to the automation.

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):

We completed all milestones in 2023 - eCW used Newton Creek as the prototype and this is fully up and running with automation for all 14 clinics. We are retiring this strategy for 2024.

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

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

Strategy 4 title: EHR training and technical assistance

In 2022, Umpqua Health Alliance (UHA) worked closely with a large RHC clinic (Umpqua Health Newton Creek) on several key projects, including:

- Implementing kiosks for their patient check-in process. This helped the clinic go paperless, reduced their check-in times, reduce data entry errors and increased staff productivity.
- Migrated their analog fax lines to a modern cloud-based e-fax solution. This increased efficiency because staff no longer had to print and scan documents, they simply had to attach them to the correct patient chart.
- Integrate their EHR system eClinicalWorks with an artificial intelligence (AI) dictation solution called Nuance DAX. Providers simply walk in the room and have a natural conversation with the patient and the system automatically picks up the clinical information that will go into the patient's chart. Nuance then reviews the chart note for accuracy before the data is entered into the patient's chart. This helps the providers be more engaged with the patients and provide better patient care.

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):

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

As of the end of 2023, we have completed all previous milestones for this strategy. Additionally, in 2023 we updated Umpqua Health Newton Creek's eCW environment to use a text-to-speech product from DAX, as a replacement for the AI-driven Nuance product.

Other than the occasional technical support call, there is no further ongoing work associated with this strategy, so we are retiring it for 2024.

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

Strategy 5 title: Assessment/tracking of EHR adoption and capabilities

- UHA continues to collect information through the provider onboarding packet for newly enrolled providers.
- For existing providers, UHA collects data and tracks progress annually as part of the HIT Bonus Program.

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

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

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

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

In 2023, we continued to assess and track EHR adoption rates and capabilities amongst providers. Towards the end of the year, we also collected and analyzed data necessary to administer the HIT bonus program.

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

Planned Activities	**Planned Milestones**
1. In 2024-26 we will continue to perform this work on an ongoing basis.	1. Q4 2024 – End of year data collection and review for HIT bonus program.

Strategy 6 title: Outreach, Education and Collaboration with Network Partners

Outreach to providers, including:

- Provider Monthly Talking Points
- Direct outreach via email, in-person site visits, phone or Zoom meetings
- Quarterly Provider Meetings

- In-person office visits

In 2022 UHA's HIT Tiger Team placed approximately 24 outreach calls and attended 48 individual meetings with the clinics. The outreach calls were made to engage providers in the HIT Bonus Program and CCO Metrics.

- UHA identified improvement opportunities around CCO Metrics and worked closely with providers to address deficiencies.
- Zoom calls/meetings were held to provide further support and to answer additional questions (typically involved a wide range of folks within the organization).

Updated HIT Bonus FAQ available on the Umpqua Health website.

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 2023, we conducted 3 rounds of HIT Tiger Team outreach. These efforts represented engagement with 35 different clinics and included over 20 in-person discussions and over 50 technical assistance sessions.

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

Planned Activities	**Planned Milestones**
UHA will be hosting quarterly Tiger Team engagements with interested practices. We will use these discussions to: 1. Review quality metric performance 2. Provide HIT information and support 3. Provide data feed support/updates 4. Identify general improvement opportunities within the practice UHA will also host monthly Quality Metric Subcommittee meetings with our providers.	1. Q1, Q2, Q3, Q4 (2024-26) – Conduct quarterly Tiger Team outreach meetings. 2. Monthly Quality Metric Subcommittee meetings with providers.

Strategy 7 title: Support legacy EHR data in cloud-based archive

- UHA successfully migrated clinical data from a legacy EHR system to a cloud-based archive system in 2021. The legacy EHR was widely used by providers in the community for many years and this helped providers maintain continuity of care as they transitioned to new EHRs.
- UHA continues to pay for the hosting fees, manages access and provide technical support for the archive.
- The Cloud archive system serves as an important asset, as it contains over 15 years of historical clinic information.

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 2023 we continued to provide cloud-based hosting for legacy EHR data. UHA paid for the hosting, managed access and provided technical support.

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

Planned Activities	**Planned Milestones**
1. For 2024-26, we will continue to provide this service for providers who need access to legacy EHR data.	1. N/A – This is an ongoing service.

Strategy 8 title: Engage with HIT-related committees and workgroups

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):

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

Planned Activities	**Planned Milestones**
1. Participate in noted committees on an ongoing basis for 2024-26. 2. Prepare presentations for HITAG as needed. 3. Our Director of Quality serves as the Chair of the Quality Health Outcomes Committee.	1. Q1, Q2, Q3, Q4 (2024-26) – Ensure we have UHA representation in each one of the noted committees.

Strategy 9 title: Created a community forum for clinics using a common EHR (eClinicalWorks)

- Created a framework for provider offices to share how they're using the system, what they found to be most effective and share best practices.
- Opportunity to foster innovation and knowledge sharing.
- UHA helped facilitate the provider meetings.
- UHA reviewed changes to the CCO Metrics data feed requirements and provided a comprehensive step-by-step user guide and follow-up training on how to update EHR templates.

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 2023, held a quarterly community forum for eCW vendors as planned, led by our IT department. At the end of 2023, we experienced some IT leadership staffing changes and are currently working to fill some open positions. This will result in a hiatus for this community forum for the first part of 2024.

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

Planned Activities	**Planned Milestones**
1. Hire to fill vacant IT leadership roles. 2. Align with new leadership on purpose of community forum and establish a new schedule.	1. Q4 2024 – Relaunch community forum.

Strategy 10 title: Support and expand existing solutions to exchange clinical data

UHA's HIT Tiger Team was assembled to support clinics in HIT adoption and integration which includes technical assistance with clinical data feeds in helping provider offices meet CCO metrics and qualify for the UHA's HIT Bonus Program.

Additionally, UHA uses UHBI (Umpqua Health Business Intelligence platform) for analyzing and reporting on CCO incentive measures. Providers can access the Provider Portal housed by UHBI, which allows them to analyze their clinic or provider level data. Additionally, clinical data is provided directly to UHBI by many of our contracted providers using a certified EHR vendor. The HIT Tiger team meetings are used to train providers on the provider portal, share portal enhancements, and review provider level and clinic level data for closing gaps and troubleshoot any issues or barriers clinics are experiencing discuss data feeds, provider outreach, and opportunities for improvement. As we identify gaps in these data feeds, we work directly with the EHR vendor or follow up with each individual clinic to address any missing data.

In 2022, UHA worked with our provider network and their EHR vendors to create additional data feeds from their respective EHR into UHA's case management system, Arcadia. The primary focus was to prioritize data feeds from provider offices that see a substantial portion of our member population. Currently, we are receiving data feeds from several clinics including 1 FQHC, 5 Primary Care, 1 Behavioral Health and the local hospital, Mercy Medical Center. This represents approximately 62% of our members, in which UHA is importing clinical EHR data into its case management system. To assist network providers, UHA provided financial assistance by paying for the EHR vendor fees. We plan to continue this strategy in 2023-2024.

Additionally, UHA provided technical assistance to a large RHC clinic (Umpqua Health Newton Creek) to add more data elements to their CCO Metrics data feed. This required working with our Business Intelligence (BI) department and the EHR vendor eClinicalWorks on the technical specs, backend system updates and the data extract. UHA also worked with the clinic to update their EHR templates to ensure that all the required data is collected as part of their existing workflows.

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):

UHBI
In 2023, we conducted 3 rounds of HIT Tiger Team outreach. These efforts represented engagement with 35 different clinics and included over 20 in-person discussions and over 50 technical assistance sessions.

Additionally, we met with Reliance to discuss our HIE clinical connectors on a weekly basis.

We also conducted a provider network scan to find out what forms and software applications our providers are using to collect and input supplemental data (used for measure calculations), so that we could ensure we were accounting for these sources appropriately.

Arcadia
In 2023, we identified a disparity in data processing times between Arcadia and the clinical data that is available in UHBI (Umpqua Health Business Intelligence platform). To create parity across our enterprise, we engaged in a project with Arcadia to upgrade their Foundry data platform to a latest version which provides significantly improved data processing speeds. We prioritized this work over adding new clinical data feeds in order to strengthen our core data foundations before integrating additional feeds.

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

Planned Activities

1. **Arcadia:** In 2024, we will evaluate the feasibility of integrating a Reliance data feed into Arcadia in lieu of a handful of independent clinic integrations. If this approach does not result in high-quality data, we will then work with our existing clinic partners to build additional data feeds, prioritizing those with the largest member populations served.
2. **UHBI:** Continue to improve the data quality of the supplemental data files we receive from clinic partners.

Planned Milestones

Arcadia Milestones

1. Q2 2024 – Begin discussions with Arcadia vendor.
2. Q3 2024 – Complete data discovery & scoping.
3. Q4 2024 – Decide on best approach for final integration.

UHBI Milestones

1. Q4 2024 – Confirm successful ingestion of supplemental data files according to our defined spec for at least 4 of our 6 clinical partners.

Strategy 11 title: Contract requirements, financial support and incentives to adopt EHRs

- Promote HIT bonus program in provider communications (meetings, newsletters, etc.)
- Quarterly provider meetings. This is a general overview covering the HIT Bonus program, EHR adoption requirements and criteria used to qualify.
- This program is offered annually to all contracted providers that meet specific criteria, including EHR adoption and clinical data feeds.
- The HIT bonus program is outlined in all provider contracts. The Provider Relations team includes an overview of the program when onboarding new providers.
- UHA engages pharmacies to participate in incentives related to quality gap closure, including tobacco cessation, vaccination, diabetes testing and management. Efforts around EHR adoption for this strategy are addressed under a separate strategy.
- UHA offers technical assistance from the initial engagement throughout the onboarding process.
- Provide partial incentives to practices that were able to make partial progress within the Program.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

In 2023, UHA expanded our HIT-participating providers by 34%, reaching a total of 117 vendors who are now participating in the program (use of an EHR is a program requirement).

UHA also provided additional financial incentives related to tobacco cessation and vaccination metrics. Specifically, there was a $200 incentive per member who stopped smoking in the calendar year and a $200 incentive per member who received at least one qualifying vaccination.

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

Planned Activities	**Planned Milestones**
1. In 2024, we will begin offering incentives for REALD/SOGI data collection via EHR clinical feeds. 2. We will also continue to offer the tobacco cessation and vaccination incentives, along with other HIT incentives from previous years.	1. January 2024 – Update HIT Incentive Program to include REALD/SOGI data collection incentives. 2. Q1, Q2, Q3, Q4 (2024-26) – Monitor data delivery cadence and quality as it relates to REALD/SOGI data components.

Strategy 12 title: EHR adoption in local pharmacies

In 2022 UHA partnered with AssureCare to implement EHR-lite systems within local pharmacies to assist pharmacies in documenting clinical services they would be rendering. As these pharmacies would be providing vaccination and clinical education, an EHR is needed to document those encounters.

Smaller pharmacies see UHA members and want to offer services such as vaccines and birth control, but don't have an effective way to record this information and provide data to UHA.

Community pharmacies are an untapped resource for providing patient care, addressing gaps, collecting data, and improving the quality of care. Independent community pharmacies have consistently demonstrated strong local relationships, professional autonomy, programmatic agility, and ability to deliver quality outcomes. They also are in a unique position to expand access to care, as many of these pharmacies are in underserved areas. This innovative pilot would be unique to Oregon and the United States, as no one has done anything exactly like this.

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 2023, we set up a data connection with AssureCare to push patient lists to pharmacies and collect data needed for incentive metrics, REALD/SOGI reporting and other internal use (HRAs, etc.).

3 pharmacies were onboarded (our original goal was 5 but we had reduced capacity to support the project within the year). To encourage participation and support these partners, we offered a $10,500 set-up incentive to help offset implementation costs.

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

Planned Activities	**Planned Milestones**
1. In 2024, we will continue to offer the $10,500 set-up incentive for independent pharmacies. 2. Evaluate opportunity to onboard 2 additional pharmacies.	1. Q4 2024 – Evaluate this pilot's impact on the respective quality performance metrics and determine ongoing prioritization of this program for 2025-26.

4. EHR Support Barriers: (Optional)

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

C. OHA Support Needs: (Optional)

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

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

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

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

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. List and describe specific tool(s) you currently use or plan to use for care coordination and timely hospital event notifications.
3. (Optional) Provide an overview of CCO's approach to using HIE for care coordination and hospital event notifications.
4. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 for using HIE for care coordination and hospital event notifications within the CCO include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. Strategy status

d. Provider types supported
e. A description of 2023 progress, including:
   - accomplishments and successes (including number of organizations, etc., where applicable)
   - challenges related to each strategy, as applicable
f. (Optional) An overview of CCO 2024-26 plans for each strategy
g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

Notes:

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

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

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

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

- Arcadia Care Management– Case Management System
- Arcadia Vista – Dashboards/Reporting
- Reliance – Health Information Exchange (HIE)
- Tableau – Data Visualization
- Connect Oregon (Unite Us) – Community Information Exchange (CIE)
- CIM – Patient Records
- Point Click Care (Collective Medical) – Hospital Event Notifications

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

Strategy 1 title: Facilitate information sharing

Case Managers add their contact information to the care team in the patient's overview when they are actively working with the patient. Completed care plans and transitional care assessments are uploaded as attachments. Advanced care plans are uploaded in the Advance Care Plan section.

UHA's Care Coordination staff uses the patient overview to locate updated demographics for members that are difficult to reach, identify other members of the patient's care team (i.e., APD case worker), review care guidelines and uploaded advanced care plans, or other attachments.

Information sharing through Point Click Care had enhanced care team collaboration while protecting member information as users only see information on an individual whom they have an established HIPAA-TPO relationship.

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

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

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

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

In 2023, we continued to utilize this established workflow to ensure that we are effectively sharing information with the right care team members at the right time. This eliminates the need to contact each agency individually, reducing administrative workload and allowing care managers to concentrate on aiding members. This has been particularly beneficial within the LTSS care workflow.

We have encountered an ongoing challenge in maintaining the accuracy of case manager assignments amidst staff and other process changes over the past year. However, this is a known limitation of this manual process.

Because this is now an established process and we don't anticipate making further changes over the next couple of years, we are retiring this strategy for 2024.

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

Strategy 2 title: Integrate Point Click Care (Collective Medical) hospital event notifications with Arcadia to automate notifications for "triggering events"

UHA had custom automation built in Arcadia's case management platform to utilize a connector with Point Click Care that places members with a hospital event in a triggering event queue. The queue facilitates timely outreach to members to screen for intensive care coordination eligibility and case manager contact for members that are currently enrolled in ICC case management.

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

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

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

We successfully utilized these notifications throughout 2023 as part of our Care Coordination workflows. However, we are retiring this strategy going into 2024 due to changes in the Care Coordination OARs, which have replaced "triggering events" with "changes in health-related circumstances." The latter will be addressed under its own strategy (Arcadia ADT Integration Optimization).

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

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

Strategy 3 title: Arcadia ADT Integration Optimization

In the 2024 updates to the Care Coordination OARs, language surrounding "triggering events" was replaced with "changes in health-related circumstances." While we believe we still be able to leverage much of the automation we had built out for triggering events in previous years, we believe we will need to modify and expand our workflows, and potentially invest in additional technical platform updates during 2024.

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

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

Strategy status:

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

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

N/A

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

Planned Activities	Planned Milestones
1. We are currently in the discovery phase of understanding the new rules and developing a proposed implementation plan, both for our internal workflows as well as our technical/platform partners. 2. Once this is finalized, we will move into an implementation phase. 3. Lastly, we intend to fully document any new care management workflow processes. 4. Barring any further changes to the OARs for 2025/26, we would then use this new automation and associated workflows on an ongoing basis.	1. Q1 2024 - Discovery Phase and Implementation Plan Development. 2. Q2 2024 - Implementation and Process Documentation. 3. Q3 2024 - Launch.

Strategy 4 title: Engage with HIT-related committees & workgroups

To ensure we stay well informed of OHA's HIT programs and state priorities, our CCO participates in several workgroups, including:

- Health Information Technical Advisory Group (HITAG)
- Metrics & Scoring
- All Plan System Technical Workgroup
- HIT Commons
- Douglas County Connect Oregon User Group
- Connect Oregon Statewide User Group
- OHLC/Unite Us Payments Workgroup
- CCO HRSN Workgroup

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

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

Strategy status:

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

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

In 2023, we continued engaging with the noted HIT-related committees.

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

Planned Activities	**Planned Milestones**
1. Participate in noted committees on an ongoing basis for 2024-26. 2. Prepare presentations for HITAG as needed. 3. Our Director of Quality serves as the Chair of the Quality Health Outcomes Committee. 4. Our Community Engagement Manager leads Douglas County Connect Oregon User Group.	1. Q1, Q2, Q3, Q4 (2024-26) – Ensure we have UHA representation in each one of the noted committees.

Strategy 5 title: Implement use of Care Guidelines

- Develop a workflow for case managers to enter care guidelines to facilitate information-sharing with providers, specialists, caseworkers, and hospitals that participate in Point Click Care (Collective Medical) and have a member in common with UHA.
- Implement the use of care guidelines in the daily workflow for UHA case managers.
- Provide education to network providers that use Point Click Care on care guideline 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: Other:

Strategy status:

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

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

In 2023, progress on this strategy was interrupted due to a significant Q4 platform update where Care Guidelines was changed to Care Insights. Following the update, our team met about the change and identified a new high-level vision and workflow that will focus on members who have a care plan or safety issues that would be critical for hospital teams to be aware of.

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

Planned Activities	**Planned Milestones**
1. Fully adopt new platform format and leverage Care Insights **2.** Increase team's comfort level with the platform for greater effectiveness & efficiency **3.** Finalize and document new workflows and administer training to relevant staff **4.** In 2025/26, continue utilizing workflows developed for Care Insights.	1. Q3 2024 – Complete process documentation. 2. Q4 2024 – Complete team training overview session.

Strategy 6 title: Utilize daily reports to provide care coordination support

In previous years, we reported on the following two strategies:

1. Utilize daily reports to provide care coordination support.
2. Develop a daily report for Skilled Nursing Facility (SNF) admissions and discharges.

For 2024, we are combining these into a single strategy as they are related. Together, these strategies have included the following activities across multiple years:

- UHA's Transitional care staff utilize the daily ED & IP admission and discharge reports on a daily basis. The report facilitates case manager visits with the member while hospitalized to plan discharge and outreach to the member within 1 business day and to schedule a home visit within the week of discharge. This leads to an increased likelihood of post-discharge PCP appointments and a decrease in 30-day readmission. UHA transitional care staff can successfully follow up with members that are admitted to OON hospitals within the same timeframe as those admitted to the local hospital.
- The Daily Post-Acute Care Admissions & Discharges are monitored daily by the Transitional care staff to track members that are discharged from acute care into post-acute care. Assistance with discharge planning is provided to the local skilled nursing facilities. Upon discharge, the members are offered a transitional care home visit. Those transitioning to long term care are provided ICC case management.
- Care Coordination navigators monitor the daily ER visits for members that have 10 or more ER visits within the current year. The member is sent to an assigned care coordinator to complete an assessment and create a care plan to decrease further ER visits.
- Our transitional care staff utilizes the Skilled Nursing Facility report to connect with members while they are admitted, allowing the transitional care nurse to be involved in discharge planning. Discharge notifications facilitate connection with the member within 1 business day of discharge to schedule a home visit that increases the successful transition between settings.

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

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

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

Strategy status:

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

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

In 2023, we continued to utilize these daily reports as a significant part of our workflow.

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

Planned Activities	**Planned Milestones**
1. Assess 2024 OAR updates for LTSS to identify any reporting requirement changes and submit LTSS MOU report. 2. Continue utilizing reports in our daily workflows.	1. Q2 2024 – LTSS MOU Report Submission

Strategy 7 title: Develop cohorts to improve case management delivery

In previous years, we reported on the following two strategies:

1. Develop cohorts to improve case management delivery
2. Develop a cohort for UHA members receiving LTSS

For 2024, we are combining these into a single strategy since they are related. Together, these strategies have included the following activities leading up to 2023:

- UHA created and began utilizing a cohort titled "Top 50 ED Utilizers Encounters" to enable engagement of those members while in the ED. This cohort is updated monthly for accuracy and efficiency in managing utilization and cost.
- UHA works in collaboration with Healthful (fka, Vituity) Ed navigators to follow the top 50 ED utilizers. These navigators have access to the Point Click Care platform and the cohort above, enabling them to be alerted when one of the top utilizers are in the ED. When the navigator is onsite at the hospital, they visit the member at the bedside in an attempt to identify barriers and facilitate a follow up appointment with the member's PCP.
- Two cohorts were developed to assist care coordination of UHA's TANF population:
    - TANF Admissions
    - TANF Discharges

- Develop and maintain the LTSS cohort monthly. UHA's intensive care managers utilize the cohort to track their assigned LTSS members as they move in and out of the hospital setting. Real time notification of hospital admission ensures the assigned care coordinator outreaches to the member and hospital staff to facilitate a successful transition back home, decreasing the likelihood of readmission.
- Built a report for members receiving Medicaid funded LTSS. Developed a Tableau dashboard showing a roster of all LTSS members and shared it with Aging and People with Disabilities (APD) to facilitate care coordination for these members. The dashboard is updated daily using the 834 files and is easily downloadable in various formats including Excel.

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

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

Strategy status:

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

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

In 2023, we automated the import of this data into our care management platform to reduce the administrative burden associated with having to manually update the data each month.

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

Planned Activities	**Planned Milestones**
1. Clean up cohort structure to better support care coordination requirements related to 2024 OAR updates. 2. Establish a workgroup with lead care coordinators to lead the clean-up effort. 3. Continue utilizing these cohorts & reports on an ongoing basis to support workflows for 2024-2026.	1. Q3 2024 – Cohort clean-up finished.

Strategy 8 title: Member Risk Stratification

In accordance with the 2024 updates to the Care Coordination OARs, UHA will be working to design and implement a member risk stratification methodology to accurately identify members as no/low, moderate or high risk based on numerous data points and sources.

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

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

Strategy status:

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

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

N/A

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

Planned Activities	**Planned Milestones**
1. The first step will be focused on designing a risk stratification methodology that considers all of the data sources specified in the new OARs. 2. We will then need to submit this to OHA for approval before we move to implementation.	1. Q2 2024 – Risk stratification methodology designed and approved by OHA. 2. Q3 2024 – Workflow changes identified for Care Coordination team. 3. Q4 2024 – Risk stratification model built in care management platform.

3. It is currently our plan to build this risk stratification model within our care management platform, Arcadia, so that this information is readily available to our entire care management team at the point of care. 4. The Risk Stratification technology & workflows would launch in 2024, and then be utilized in 2025/26 as part of our Care Coordination process.	

Strategy 9 title: Member Flags & Program Automation

UHA has been working to display member-level flags within our care management platform that can be used to drive program enrollment/automation as part of our workflows. This includes LTSS (Long Term Services & Supports), SPMI (Severe & Persistent Mental Illness), Foster Care and SHCN (Special Health Care Needs). While some of these flags existed in other locations in our data ecosystem, we are striving to have all of them displayed in one location to create greater efficiency and improve care.

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

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

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

Strategy status:

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

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

While this is a new strategy for 2024, we began work in 2023 on connecting several of our technology partners to ensure availability of some existing member flags within our care management platform.

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

Planned Activities	**Planned Milestones**
1. In 2024, we will be working to build a new and improved SHCN flag for identifying members with Special Health Care Needs. 2. We will be designing and implementing program enrollment automation within our care management platform for LTSS, SPMI, Foster Care & SHCN. 3. This automation should go live in 2024, and then will be used on an ongoing basis in 2025/26 for Care Coordination workflows.	1. Q2 2024 – SHCN Flag Design Complete 2. Q4 2024 – Program enrollment automation complete for SHCN, LTSS, SPMI and Foster Care.

Strategy 10 title: Testing AI in Care Management Workflows

UHA will be participating in a pilot of a new AI-driven product developed by our care management platform partner, Arcadia. In short, this tool summarizes an overview of a member's health status and provides recommendations to care managers.

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

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

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

Strategy status:

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

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

N/A

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

Planned Activities	**Planned Milestones**
1. Review initial versions of the tool both internally and with Arcadia to provide feedback before the pilot officially begins. 2. Develop a custom prompt that is unique to UHA's needs and Care Coordination workflows. 3. Schedule and conduct a 3-month pilot test. During this time, our care management team will evaluate the accuracy of the tool, as well as the benefits/value it provides. Our intent is to determine whether or not the functionality can seamlessly fit with existing workflows, while quickly surfacing essential information to care managers. 4. Following the pilot, we will assess whether the product created enough value to formally adopt. 5. Further activities or use of the tool in 2025/26 will be dependent on the success of the pilot test.	1. Q1 2024 – Evaluation of tool and design of custom prompt. 2. Q2 2024 – Conduct pilot test. 3. Q3 2024 – Go / no-go decision based on observed value during pilot.

Strategy 11 title: Payer Supplied Measure (PSM) Implementation

UHA has worked to load a suite of measure calculations into our care management platform to make this information available to our care management team at the point of care.

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

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

Strategy status:

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

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

While this is a new strategy for 2024, we completed the bulk of the initial implementation in 2023. We worked with our internal Data Solutions team and Arcadia to load a set of measure data into our care management platform. This data will continue to be updated automatically via a regular feed, supporting reporting/dashboards, and allowing the measure calculations to be visible to our care management team at the point of care.

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

Planned Activities	**Planned Milestones**
1. In 2024-26, we will continue to refresh the measure data in Arcadia via the automated feed we completed at the end of 2023. 2. Configure 2024 Plan Initiatives in Arcadia. 3. For 2025 and 2026, we will be working with Arcadia to implement data health and recency dashboards to enable data health monitoring.	1. Q1 2024 – Finish configuration of 2024 Plan Initiatives in Arcadia.

Strategy 12 title: Participate in the IMPACTS grant program

UHA participates in the IMPACTS grant program that was established by the Oregon Legislature in recognition of the shortage of comprehensive community support and services for individuals with mental health or substance use disorders that lead to their involvement with the criminal justice system, hospitalizations, and institution placements. UHA is providing all the data analytics for it, including facilitating the one-way jail feed to Collective Medical for bookings and releases for the IMPACTS cohort (i.e. Douglas County residents booked 4 or more times into the Jail who were also Umpqua Health Alliance members).

- The IMPACTS program offers comprehensive community support and services for individuals with mental health or substance use disorders that lead to their involvement with the criminal justice system, hospitalizations, and institution placements.
- Reduce ED visits and healthcare costs by early engagement and intervention to address physical and mental healthcare issues complicated by housing instability.
- Develop cohort groups in Point Click Care to identify high risk/high utilization.
- Facilitate daily data feed to Point Click Care of jail booking and release information that allows ICC teams to contact individuals prior to release from jail.
- Engage with local hospital and CMHP on member engagement strategies, reports, and dashboard development.
- Real-time access to information for cohort members who are incarcerated for opportunities to intercept them prior to release.

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

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

Strategy status:

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

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

Umpqua Health facilitated the one-way data feed of jail bookings into Point Click Care to track cohort members who have been recently booked or released from the Douglas County Jail. The IMPACTS ICC team (employed by Adapt) monitors PointClickCare (formerly Collective Medical) for Emergency Department admissions and Jail bookings to enable outreach and engagement of the target population.

UH developed a Tableau dashboard that integrates data from the Jail booking and release feed, claims data, IMPACTS ICC logs, and OHA member eligibility files, to monitor success metrics in real time and share data with key stakeholders. The IMPACTS dashboard has been well received by local partners, including the CJC, OHSU Technical Support, OHA and other interested parties. In 2023, Mercy Medical and Adapt Integrated Healthcare were granted access to the IMPACTS dashboards to better align goals and improve outcomes.

UH conducted a comprehensive annual evaluation at the end of 2023 to measure success towards the overarching IMPACTS program goal to reduce involvement with the legal and criminal justice systems and reduce the cost and utilization of high-intensity healthcare resources. This included two categories of SMART goals: ICC engagement outcomes and cost and utilization. Overall, for IMPACTS cohort members engaged in ICC, UH saw an increase in community supports and services, increase in low-cost health care services, and a decrease in average # of days in jail. The IMPACTS program contributed to significant healthcare cost savings as well.

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

Planned Activities	**Planned Milestones**
1. Continue to update and improve the IMPACTS Tableau dashboard. Incorporate input and feedback from Mercy Medical and Adapt Integrated Healthcare.	1. Q3 2024 – Modify and improve IMPACTS Tableau dashboard. 2. Q4 2024 – Conduct an annual evaluation of IMPACTS outcomes data.

2. Update the cohort methodology in Tableau to filter to specific cohort years to effectively evaluate outcomes data. Each cohort year will be defined as members who were incarcerated four or more times within that specific year. 3. Facilitate any opportunities for improvement with the Point Click Care feed to ensure optimization with the IMPACTS ICC team.	

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

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

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

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

Notes:

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

- If CCO is not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2024, please indicate 'N/A' in the progress section for that strategy.
- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

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

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

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

- Arcadia Care Management – Care plans
- Reliance – Health Information Exchange (HIE)
- CIM – Member data & claims
- Point Click Care (Collective Medical) – Hospital Event Notifications
- Connect Oregon – Community Information Exchange (CIE)

(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**:

Physical Health

- 4 organizations without HIE for care coordination (excluding Collective)
- 22 organizations without HIE for hospital event notifications
- 8 organizations without HIE for care coordination (including Collective)

Behavioral Health

- 6 organizations without HIE for care coordination (excluding Collective)
- 31 organizations without HIE for hospital event notifications
- 7 organizations without HIE for care coordination (including Collective)

Oral Health

- 0 organizations without HIE for care coordination (both excluding and including Collective)
- 7 organizations without HIE for hospital event notifications

Strategy 1 title: Support innovative solutions to exchange clinical data between EHRs, CCO & Reliance

In previous years, we reported two similar strategies for this same topic area, focused on different clinics. For 2024, we are combining these into a single strategy since they are directly related. Together, these strategies have included the following:

- Partnered with Reliance and clinics to facilitate clinical data exchange between the clinics and UHA.
  - Clinical data includes elements needed for CCO metrics reporting.
  - Improves care coordination by having the data flow into the HIE.
  - Creates a more robust data set that allows more practices to have access to clinical data via HIE.
- Regular meetings with Reliance HIE.
  - Review current level of adoption.
  - Discuss progress on active implementations.
  - Discuss future implementations.
- Evaluate additional data feeds for enhanced care coordination (i.e. 837 files).

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):

All of our 2023 milestones were achieved for this strategy. We successfully implemented feeds for Aviva, Cow Creek & Canyonville; we also set up a feed for an additional clinic beyond our 2023 goals (Jorgenson). This brought our total clinic count to 5, including Evergreen. This required overcoming some challenges:

[redacted]

- Though we've been working with Evergreen for a while, they've run into some issues with data formatting that will require a significant manual effort on their part to address. This is still ongoing.

All these clinics send daily files of CCD data to Reliance, who then passes it to us. The clinics also send ad hoc files of supplemental data (assessments, labs, etc.) which we use for reporting on metrics performance.

We met weekly with Reliance to discuss data quality, monitor data loads, address necessary spec changes, etc. Clinics were not involved at every meeting but participated on an as-needed basis.

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

Planned Activities	**Planned Milestones**
1. Solidify a regular cadence for sending supplemental data that we use for metrics reporting. Our PSE contract requires a monthly submission at a minimum, to help ensure that our incentives are aligned with our data needs. 2. Onboard our 6th clinic – Douglas Cares.	1. Q4 2024 – Establish a monthly cadence (at a minimum) for supplemental data file ingestion for at least 4 of the 6 clinics. 2. Q4 2024 – Successfully onboard Douglas Cares.

Strategy 2 title: Reliance HIE Onboarding Support

- Encourage participation and technology adoption.
- Facilitated agreements between Reliance and provider offices.
- Ongoing work with Reliance, Mercy Hospital and Centennial Medical Group (CMG) on additional data feeds for a richer data set (i.e. ADT, CCDs, lab results, imaging, transcriptions).
- Continued engagement with providers that have not adopted an HIE.

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):

This work is completed – any related ongoing elements will be captured within other strategies. We are retiring this strategy for 2024.

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

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

Strategy 3 title: Provider Engagement & Education for Reliance HIE

- Promote Reliance HIE in provider communications (meetings, newsletters, etc.).
- Outreach to providers to introduce Reliance and assist those interested with the onboarding process. This includes:
  - Provider Monthly Talking Points
  - Direct outreach via email, in-person site visits, phone or Zoom meetings.
  - Quarterly provider meetings.
  - Updated HIT Bonus FAQ available on Umpqua Health website.
- Regular meetings with Reliance, which includes discussions on best practices for provider engagement, current adoption levels and opportunities to improve platform use.

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

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

Strategy status:

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

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

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

In 2023, we held 3 quarterly meetings with our HIT Tiger Team and PCP clinics. 90% of the member population was represented over the course of these meetings. In our discussions, we socialized 2024 incentive program changes, including the weighting of engagement with the Reliance platform. We also provided technical assistance and discussed platform benefits.

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

Planned Activities

1. Reliance will make up 30% of our overall HIT Incentive Program for 2024.
2. Ongoing Activities
    a. Update HIT Bonus FAQ
    b. Present HIT at Provider Network meetings
    c. Introduce Reliance during provider onboarding
    d. Conduct outreach to PCPCH & BH clinics that are not using the platform Outreach to BH providers is a focal point for several initiatives and will be tied into the current outreach strategy that includes promoting Unite-Us and Point Click Care concurrently. Prioritization is based on a combination of identified gaps in care, SDoH, REAL-D and SO/GI inequities within the network.
3. Conduct regular meetings with Reliance
    a. UHA has quarterly check-in meetings with Reliance to discuss topics of interest such as product enhancements, network trends and other items.
    b. The Data Solutions department has weekly meetings with the Reliance tech team to discuss status of connections and data integrations.

Planned Milestones

1. January 2024 – Update weighting of Reliance to 30% within the HIT Incentive Program.
2. Q1, Q2, Q3, Q4 (2024-26) – Quarterly check-ins with Reliance.
3. Q4 2024 – Update HIT Bonus FAQ

Strategy 4 title: Offer financial incentives through the Umpqua Health HIT Bonus Program

In 2023, we reported on two versions of this strategy, one for Hospital Events and one for HIE. Under the new template for 2024, we've combined these into a single strategy.

UHA continues to promote its HIT bonus program in provider communications (meetings, newsletters, etc.). This program is offered annually to all contracted providers that meet specific criteria, including HIE adoption; we include the program in all provider contracts. We also provide partial incentives to practices that were able to make partial progress within the Program.

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

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

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

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

In 2023, UHA expanded participation in the HIT incentive program by 34%, reaching a total of 117 vendors who are now participating in the program.

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

Planned Activities	**Planned Milestones**
1. Addition of Unite Us as an incentivized program. 2. Promote the HIT incentive program through provider education, financial support & technical assistance. The HIT incentive program is marketed to the provider network via the Quality Metrics Subcommittee at least twice a year. It is also discussed at length during quarterly outreach meetings (Tiger Team) with providers engaged.	1. January 2024 – Unite Us will be added as an incentivized HIT program. 2. Q1, Q2, Q3, Q4 (2024-26) – Quarterly Tiger Team outreach meetings with providers. 3. Q2 & Q4 (2024-26) – Promote HIT Incentive Program during Quality Metrics Subcommittee.

Strategy 5 title: Provider Training for Point Click Care (Collective Medical)

In collaboration with Point Click Care, provide training sessions with the following objectives:

- Provide a forum to promote collaboration and best practice sharing.
- To present an overview and demonstration by a representative of Point Click Care.
- To give clinics an opportunity to share how they are making use of Point Click Care.
- To share how Umpqua Health Alliance is making use of the platform.
- To identify staff members who currently use or plan to use Point Click Care, to outline their interventions along with the cohorts of focus.

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):

Upon review, it was determined that the primary objectives of the training sessions—such as promoting collaboration, best practice sharing, and effective use of Point Click Care —had been achieved by the end of 2023. The success of these sessions in meeting their goals prompted a reevaluation of the necessity of continuing these specific efforts into 2024. Feedback from participants of the training sessions indicated that while valuable, the continuation of the strategy in its existing form may not be the most effective use of resources. By concluding the training sessions with Point Click Care, we can reallocate these resources to other areas where they may have a more significant impact on improving healthcare outcomes and efficiency.

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

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

Strategy 6 title: Provider Engagement & Education for Point Click Care (Collective Medical)

- Promote Point Click Care in provider communications (meetings, newsletters, etc.).
- Outreach to providers to introduce Point Click Care and assist those interested with the onboarding process. This includes:
  - Provider Monthly Talking Points
  - Direct outreach via email, in-person site visits, phone or Zoom meetings.
  - Quarterly provider meetings.
  - Updated HIT Bonus FAQ available on Umpqua Health website.
- Regular meetings with Point Click Care, which includes discussions on best practices for provider engagement, current adoption levels and opportunities to improve platform use.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

In 2023, our HIT Tiger Team conducted 3 phases of outreach with our PCP clinics, which included over 20 in-person engagements and over 50 technical assistance sessions. 90% of the member population was represented over the course of these meetings. In these discussions we socialized 2024 incentive program changes, including the weighting of engagement with the Point Click Care platform. We also provided technical assistance and recommended ways to leverage the platform to help meet metrics (e.g. A1c, prenatal postpartum and IET).

Our Care Coordination department receives a monthly engagement dashboard from Point Click Care, and this allows our team to see how providers are using the platform. For instance, we can identify gaps in data submission, and we can see how often the clinics are logging into the Collective Medical system. This provides an opportunity for UHA to reach out to provider offices and have a meaningful conversation about using this tool for improved care coordination.

Our Care Coordination department also developed a process in Point Click Care to conduct follow-up around the IET measure, with the goal of helping to ensure provider performance and quality care.

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

Planned Activities	**Planned Milestones**
1. In 2024, Point Click Care will make up 20% of our overall HIT Incentive Program. 2. In addition, we will continue to do perform the following activities on an ongoing basis: a. Update HIT bonus FAQ b. Present HIT at Provider Network meetings c. Promote in the Provider Newsletter d. Introduce Point Click Care during provider onboarding e. Conduct outreach to PCPCH & BH clinics who are not using the platform. Outreach to BH providers is	1. January 2024 – Update weighting of Point Click Care to 20% within our HIT Incentive Program. 2. Q1, Q2, Q3, Q4 (2024) – Point Click Care & CCO Collaborative Workgroup Meetings

a focal point for several initiatives and will be tied into the current outreach strategy that includes promoting Unite-Us and Reliance HIE concurrently. f. UHA will continue to meet monthly with PCC to discuss issues, product enhancements and use cases. g. UHA has also participate in the quarterly PCC CCO collaborative meetings established by PCC late in 2023.	

Strategy 7 title: Create a Point Click Care (Collective Medical) Workgroup

UHA previously created a workgroup to promote and support the Point Click Care platform. The goal was to have an open forum for provider offices to engage with each other, the CCO and the local hospital Mercy Medical Center. This was an opportunity for providers to share how they're using the system, what's helpful for them and what they want to see for coordinating care. We also assisted provider offices to use PCC more efficiently and find ways to improve care coordination in the community.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

In 2023, we focused on the Point Click Care platform in one of our quarterly Provider Network meetings. We assessed that there was limited interest amongst office managers in an ongoing, standalone workgroup meeting. Our Provider Relations Director left the organization in Q4 2023, and as a result it is currently unclear whether the intended System Satisfaction survey took place (this was a goal for 2023). Regardless, we do not intend to pursue this strategy further in 2024 due to the overall low interest amongst provider officer managers. We will consider this strategy "retired" as of this roadmap submission.

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

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

Strategy 8 title: Automate patient roster data submission

We previously established a goal to automate patient roster data submission for 14 clinics that use a common EHR (eClinicalWorks). This was a manual process which was burdensome, error prone and had inherent delays in data submission. The automation would streamline the process, reduce human error, and improve efficiency.

UHA provides financial assistance for the monthly EHR vendor fees related to the automation.

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 completed all milestones in 2023. We used Umpqua Health Newton Creek as a prototype / pilot test, before continuing the work with the other 13 clinics. As of the end of 2023, the automation is fully up and running with all 14 clinics. We are retiring this strategy for 2024.

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

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

Strategy 9 title: Pilot test for “assigned but not yet engaged” population cohort

Newton Creek has agreed to be part of a handful of clinics across the state for a pilot that will attempt to engage the "assigned but not yet engaged" population (in regard to primary care).

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

N/A

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

Planned Activities	**Planned Milestones**
1. We will collaborate with the other pilot program participants and participate in associated activities to help validate the effectiveness of the program.	1. TBD - This is still a developing program so further specifics with the work have yet to be defined.

Strategy 10 title: Engage in HIT-related committees and workgroups

To ensure we stay well informed of OHA’s HIT programs and state priorities, our CCO participates in several workgroups, including:

- Health Information Technical Advisory Group (HITAG)
- Metrics & Scoring
- All Plan System Technical Workgroup
- HIT Commons
- Douglas County Connect Oregon User Group
- Connect Oregon Statewide User Group
- OHLC/Unite Us Payments Workgroup
- CCO HRSN Workgroup

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

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

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

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

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

In 2023, we continued engaging with the noted HIT-related committees and workgroups.

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

Planned Activities	**Planned Milestones**
1. Participate in noted committees on an ongoing basis for 2024-26. 2. Prepare presentations for HITAG as needed. 3. Our Director of Quality serves as the Chair of the Quality Health Outcomes Committee. 4. Our Community Engagement Manager leads Douglas County Connect Oregon User Group.	1. Q1, Q2, Q3, Q4 (2024-26) – Ensure we have UHA representation at each of the noted committees.

Strategy 11 title: Assessment/Tracking of HIE adoption and capabilities

In 2023, we reported two versions of this strategy – one for HIE and one for Hospital Events. Under the 2024 template, we've combined these into a single strategy.

UHA continues to collect information through the provider onboarding packet for newly enrolled providers. For existing providers, UHA collects data and tracks progress annually as part of the HIT Bonus Program.

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 perform this work on an ongoing basis in 2023.

At the beginning of 2024, we distributed a survey to the provider network to collect updated data to support 2024's HIT Roadmap and to support the distribution of our HIT bonus program incentives.

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

Planned Activities	**Planned Milestones**
1. We will continue to collect HIE data upon enrollment and ensure it stays updated for established providers.	1. Q1 2025 – Submit survey to provider network to collect updated data to support 2025 HIT Roadmap Submission and the distribution of our HIT bonus program incentives.

C. HIE for Care Coordination Barriers: (Optional)

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

D. OHA Support Needs (Optional)

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

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

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

5. Health IT to Support SDOH Needs

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

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

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

Notes:

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

Strategy category checkboxes (within CCO)

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

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

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

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

UniteUs: UniteUs is utilized by UHA and our community partners to facilitate screenings and referrals for services to address Social Determinants of Health (SDoH), as well health-related flex fund services and care coordination services.

Arcadia: Arcadia enhances this ecosystem by integrating with the UniteUs platform, offering valuable SDoH insights to our care coordination and utilization management teams within their care management and population health platform.

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

- SDoH Screening and Referrals
- Pilot of payments module within UniteUs
- Integrate UniteUs data into our population health and care management platform for use at point of care and SDoH metric development
- Incorporated RELD and SOGI data collection incentives into the HIT bonus
- Developed statements of process around internal use of RELD and SOGI data collection and use

Adoption of UniteUs Platform for SDoH Screening and Referrals: We are committed to enhancing the effectiveness of Social Determinants of Health (SDoH) screenings and referrals through the strategic adoption of the UniteUs platform. Our approach emphasizes the use of the Community Information Exchange (CIE) as the main conduit for SDoH screenings within the community. This preference stems from the need to not only identify but also directly address members' needs. The CIE platform facilitates a seamless and standardized pathway to services, avoiding the limitations of screenings conducted through Electronic Medical Records (EMR) that may identify needs without ensuring access to solutions.
Moreover, prioritizing the CIE for screenings minimizes the risk of excessive screening by various community partners, including Community-Based Organizations (CBOs) and medical providers, thereby safeguarding members from the potential stress of redundant assessments without a clear path to support.
Our strategy focuses firstly on empowering CBOs to fully integrate and leverage the CIE platform, enhancing our community's capacity to consistently meet SDoH needs. Secondly, we aim to expand the engagement of medical providers with the platform, thereby increasing the breadth of SDoH screenings. This dual-focus approach ensures a robust infrastructure and resources are in place, preventing the exposure of members to screenings without the guarantee of adequate support and interventions.

Expand the use of UniteUs for Care Coordination and HRS Flex Services Referrals: In alignment with our organizational strategy of the UniteUs platform as our primary route for SDoH screening and referral, UHA is focused on enablement and expansion of community driven care coordination and HRS flex service referrals to UHA care coordination and utilization management teams within the platform.

Development HRSN Payments Module: The development of health-related social needs (HRSN) payments is a strategic initiative that addresses SDoH related benefit management needs both internal to

UHA as well as external to our provider and CBO network. Like many of our fellow CCOs, we are managing the provision of this benefit with our internal staff as we launch, with plans to quickly expand to managing the provision of these services alongside our CBO partners. The development of this module creates a unified system and workflow for benefit management for both UHA internal staff as well as our full provider and CBO network.

SDoH data integrations: In 2023, UHA achieved a significant milestone by integrating UniteUs data into our population health and care management platform. This integration enriches our point-of-care strategies with vital SDoH insights, empowering our care coordination teams to deliver more informed support. Additionally, this data feed integration will support our build of the SDoH screening and referral quality incentive metric. Moving forward into 2024, UHA plans to enhance our data capabilities further by incorporating a Homeless Management Information System (HMIS) data feed. This advancement will enable us to identify members who are homeless or at risk of homelessness more effectively, an essential step as we prepare for the launch of the HRSN housing benefit in November. This strategic integration underscores our commitment to leveraging comprehensive data to improve member outcomes and address critical SDoH challenges.

RELD/SOGI data components and data governance: In 2024, UHA will be updating our data feeds to increase our collection of RELD/SOGI data components. This includes the new comprehensive data files we began receiving from the OHA near the end of 2023. Additionally, we're working to incorporate RELD/SOGI data elements received on our member files from our claims administrator, into our population health and care management platform. Those data will be used at point of care for our care managers and also better inform some of our health disparity analyses. Alongside the broadening of collection of this data UHA has also developed standard operating procedure that details how UHA analyzes and prioritizes data sources of RELD and SOGI data within our systems.

Strategy 1 title: Unite Us Data Feed – Incorporate data integrations of SDoH-related data into metrics, member workflows and processes.

Implement measure calculations for SDoH Screening and Referral Component 2 Rates 1, 2 & 3 per the Measure specifications by the end of CY2024 within Arcadia Analytics.

- Integrate Unite Us data feeds into Arcadia to support measure calculations.
- Identify & implement operational process changes needed to support the tracking and reporting requirements associated with the Measure.
- Utilize existing clinical data sources for additional screening & referral data to use in the rate calculations including care management HRA data.
- Expand and deepen UHA's insight into the social factors influencing our members' health.

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

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

Strategy status:

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

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

In 2023 UHA completed the final phase of testing to be able to ingest a comprehensive data feed from Unite Us including 27 unique files. UHA is utilizing this data for in house tableau dashboards that further visualize the Unite Us data. Additionally, this data feed is being utilized to build the SDoH screening and referral metric. Further, these data are being successfully ingested into our care management platform to further inform our care coordination at point of care of SDoH related indicators, referrals, and activities.

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

In 2024 we will be focused on leveraging the feed to power the build of our SDoH screening and referral metrics. In future years, we hope to further incorporate the SDoH risk factors within this data feed into a comprehensive risk stratification strategy.

Planned Activities	**Planned Milestones**
1. Continue working with Unite Us to identify SDoH screening data from the data feed in order to successfully map it to the SDoH component 2 measure build. 2. Map the HRA data which includes PRAPARE screening data in Arcadia through the SDoH component 2 measure build. 3. Work with Arcadia to identify additional data sources to integrate into the SDoH measure build. 4. Validate and finalize rates 1, 2, and 3 of the SDoH measure build. 5. Monitor SDoH screening and referral data from Unite Us and additional sources to improve member care and inform quality improvement efforts. This will be an ongoing activity throughout 2024-2026.	1. June 2024 – Complete Unite Us data mapping in Arcadia for SDoH metric component 2 2. September 2024 – Complete Care management HRA data mapping in Arcadia for SDoH metric component 2 3. December 2024 - Validate SDoH metric build for rates 1, 2, & 3 in Arcadia

Strategy 2 title: Expand use of Unite Us platform for Care Coordination and HRS Flex services.

The overall goal is to connect members to resources that address social needs. UHA's care coordination team aims to:

- Increase outgoing referrals for SDOH services.
- Begin receiving referrals for care coordination services through the Unite Us platform.
- Begin accepting HRS Flex Spending requests and HRSN Requests through Unite Us.
- Embed an Assistance Request button on the UHA website for members to be able to request social services.

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

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

Strategy status:

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

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

In 2023, we enabled a pilot for care coordination referrals. By the end of the year, this was beginning to pick up in use. We brought this to the DC COUG to increase awareness of Unite Us amongst community members in our July, September and November meeting. During these discussions we presented about HRS Flex via the Unite Us platform, conducted Q&A, and explained how referrals could be completed. We socialized the platform in our Provider Newsletter several times – for example, in May and September we had an article about HRS Flex and Unite Us, with a link to our website where folks could sign up. Our Director of Utilization Management presented at our Umpqua Innovation Conference in October and the ORPRN conference to promote the work we're doing with HRS Flex and Unite Us. Finally, Unite Us worked to increase awareness amongst CBOs and clinics who are already on the platform.

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

Planned Activities	**Planned Milestones**
In 2024, we will be continuing to socialize the availability of the referral functionality within Unite Us – this will support both our workflows and several other ongoing initiatives and measures. 1. Present about Unite Us platform benefits and functionality at DC COUG meetings. 2. Promote Unite Us in the Provider Newsletter periodically throughout the year. 3. Our Care Coordination department intends to begin tracking engagement with this service on the platform. Referral data will be reviewed quarterly for the number of referrals received, number of referring organizations and referral acceptance rate.	1. Q2 2024 - Present at DC COUG on care coordination and HRS flex referral functionality 2. Q3 2024 – Launch the HRS Flex embedded assistance request form on our website. 3. Q1, Q2, Q3, Q4 (2024-26) - Review referral data

Strategy 3 title: SDOH Data Collection

UHA continues to refine our strategies for collection of SDoH/E and aims to develop more robust data through the increasing adoption and usage of a community-based CIE and the use of approved SDoH screening tools within the CIE, the improvement in data collection with primary care and behavioral health clinics, and through more robust SDoH/E screening mechanisms in our network electronic health record systems.

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

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

Strategy status:

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

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

UHA conducted a gap analysis of the Douglas County service area related to food, housing, and transportation needs. The gap analysis used data from the Oregon Hunger Task Force, Oregon Housing Alliance, and Rural Health US Food and Drug Administration to understand where Douglas County stands compared to Oregon statewide. Additionally, the gap analysis reviewed a 2022 study of Medicaid population compared to UHA health risk assessment (HRA) and claims data to estimate potential gaps in screenings and referrals. UHA developed a Tableau Dashboard using claims and HRA data to provide a deeper understanding of UHA member social needs prevalence and CBO distribution by the social need domain, as well as stratifying this data by REALD identifiers.

The main findings of the gap analysis were that Dougals County experiences a higher prevalence of poverty and food insecurity compared to state averages. Additionally, there are low rates of food and housing screenings, as well as low rates of transportation, food, and housing referrals in the county.

UHA worked to broaden the use of our current SDoH data feeds through the integration of our CIE (UniteUs) data feed into our population health and care management platform.

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

Planned Activities 1. Initiate contracts or agreements with the identified CBOs from the gap analysis findings. 2. Assess financial, infrastructure, and staffing strategies to increase resource capacity to meet members' housing, food, and transportation needs. 3. Educate clinical and CBO partners on screening and referral workflows. 4. Continue to update social needs prevalence data in the Tableau Dashboard and monitor gaps/trends. 5. Work with clinics on incorporating and better capture of RELD/SOGI data components into their data feeds.	**Planned Milestones** 1. Q3 2024 – Update the social needs data available in our dashboard. 2. Q2, Q3, Q4—convene with clinical partners to discuss optimization opportunities for data feeds, including the improved capture of RELD/SOGI data components.

Strategy 4 title: Develop HRSN-related functionality for internal use.

Partner with Unite Us, other CCOs and OHLC to strategize, plan and implement the Unite Us Payments module to support the HRSN benefit.

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

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

Strategy status:

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

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

N/A

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

Planned Activities In 2024, we will be launching multiple workstreams to implement the Unite Us HRSN Payments Module. 1. Participation in the collaborative CCO/OHLC/Unite Us payments workgroup, beginning in February. 2. Operations implementation to identify & optimize workflows, design necessary forms and validate functionality for multiple business units. 3. Claims/technical implementation to help automate the payer workflow functionality and deliver the required claims information to OHA.	**Planned Milestones** 1. Q1 2024 – Phase 1 implementation of payments module complete. 2. Q3 2024 – Phase 2 implementation of payments module complete. 3. Q3 2024 – Claims integration complete.

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

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

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

Notes:

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

Strategy category checkboxes (supporting providers)

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

Progress	Plans		Progress	Plans	
☐	☐	1. Sponsor CIE for the community	☐	☐	8. Requirements in contracts/provider agreements
☐	☐	2. Financial support for CIE implementation and/or maintenance	☐	☒	9. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)

☐	☒	3. Training and/or technical assistance	☐	☐	10. Integration or interoperability of health IT systems that support SDOH with other tools
☒	☒	4. Assessment/tracking of CIE/SDOH tool adoption and use	☐	☒	11. Support CBOs sending of referrals to clinical providers (i.e., to physical, oral, and behavioral health providers)
☐	☐	5. Outreach and education about the value of health IT adoption/ use to support SDOH needs	☐	☒	12. Utilization of health IT to support payments to community-based organizations
☐	☐	6. Support participation in SDOH-focused health IT collaboratives, education, convening, and/or governance	☐	☐	13. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs (please list here):
☐	☐	7. Incentives and/or grants to adopt and/or use health IT that supports SDOH	☐	☐	14. Other strategies for supporting access or use of SDOH-related data (please list here):

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

UniteUs: UniteUs is utilized by UHA and our community partners to facilitate screenings and referrals for services to address Social Determinants of Health (SDoH), as well health-related flex fund services and care coordination services.

(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**

Adoption of UniteUs Platform for SDoH Screening and Referrals: We are committed to enhancing the effectiveness of Social Determinants of Health (SDoH) screenings and referrals through the strategic adoption of the UniteUs platform. Our approach emphasizes the use of the Community Information Exchange (CIE) as the main conduit for SDoH screenings within the community. This preference stems from the need to not only identify but also directly address members' needs. The CIE platform facilitates a seamless and standardized pathway to services, avoiding the limitations of screenings conducted through Electronic Medical Records (EMR) that may identify needs without ensuring access to solutions.
Moreover, prioritizing the CIE for screenings minimizes the risk of excessive screening by various community partners, including Community-Based Organizations (CBOs) and medical providers, thereby safeguarding members from the potential stress of redundant assessments without a clear path to support.
Our strategy focuses firstly on empowering CBOs to fully integrate and leverage the CIE platform, enhancing our community's capacity to consistently meet SDoH needs. Secondly, we aim to expand the engagement of medical providers with the platform, thereby increasing the breadth of SDoH screenings. This dual-focus approach ensures a robust infrastructure and resources are in place, preventing the exposure of members to screenings without the guarantee of adequate support and interventions.

Douglas County Connect Oregon User Group for Community Governance: We are committed to supporting the governance of the community information exchange in Douglas County through the strategic launch of a Douglas County Connect Oregon User Group (DC COUG).
The DC COUG plays a pivotal role in enhancing the functionality and user experience of the Connect Oregon Platform through community-led efforts. By gathering local leaders and key users into an advisory body, this group aims to streamline the process of collecting and acting upon feedback and recommendations from network stakeholders. This initiative helps foster a collaborative environment and emphasizes collective ownership and responsibility towards the success of Douglas County's Community Information Exchange (CIE) efforts.

Supporting the implementation of new requirements under Oregon's 1115 Waiver, including Health-Related Social Needs (HRSN), the COUG is instrumental in addressing community workflow challenges, sharing best practices, and improving local support and user satisfaction.
The COUG is tasked with soliciting feedback from the community, which is then used to inform broader discussions and decisions at the regional and statewide levels, ensuring that Douglas County's voice contributes to the overall strategic direction of Connect Oregon and Unite Us. Membership is composed of local organizations and community champions, whose expertise and on-the-ground knowledge are vital for guiding the CIE's priorities both locally in Douglas County and across the state. Umpqua Health Alliance (UHA) plays a crucial role in providing backbone support and facilitating meetings, with initial members being appointed by UHA and the established COUG responsible for appointing new members to address any vacancies, ensuring the inclusion of key organizations and stakeholders integral to the network's success in Douglas County.

Supporting and Incentivizing HRSN Service Providers

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

In 2023, we undertook a comprehensive review of our internal business requirements to identify the technological needs essential for supporting our Health-Related Social Needs (HRSN) providers. This process included evaluating the capabilities of various vendors to meet these requirements, with UniteUs emerging as a significant partner in our exploration.

We further expanded our collaborative efforts by participating in multiple discovery sessions alongside our fellow Coordinated Care Organizations (CCOs) to assess the needs and potential functionalities of the UniteUs HRSN payments module. Our collaboration extended to engaging with our Community-Based Organization (CBO) partners to review and assess the proposed technological solution.

By late 2023, our decision to contract with UniteUs for the development of this essential functionality marked a significant milestone. This partnership placed us within a collaborative cohort of CCOs, encompassing the majority of our peers, working in conjunction with UniteUs. The initiative is guided by governance leadership from the Oregon Health Leadership Council, ensuring a unified approach to enhancing HRSN provider support through innovative technology solutions.

Additionally, in 2023 we incorporated the adoption of the UniteUs platform in our HIT bonus criteria for our provider network.

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

In alignment with our ongoing efforts to enhance technology utilization and process development, we are actively working on establishing a robust partnership with Connect Oregon/Unite Us, and our HRSN service providers. This work will continue and grow over the course of 2024 and the next several years. This collaboration is aimed at creating a cutting-edge closed-loop referral, invoicing, and reimbursement system tailored to meet the needs of Health-Related Social Needs (HRSN) Service Providers. Our goal is to streamline the payments experience for our CBOs as much as possible while also leveraging the existing and continuously growing adoption of the Connect Oregon UniteUs platform in our community and in the state or Oregon as a whole.
At a high level, this closed loop referral and payment function enables our HRSN connecter and our HRSN service providers to screen and send a referral for an HRSN service for a member over to UHA. UHA can then confirm eligibility and authorization for the service, the HRSN provider can provide the service, track the service, and then on the back end, the service is invoiced back to the UHA for reimbursement to the CBO.

As we navigate through the development phase, we are committed to implementing several strategic initiatives to support and incentivize HRSN Service Providers for the adoption and effective use of this technology during the contract years 2024-2026. These initiatives include:

Grants: We plan to leverage Community Capacity Building Funds in addition to other grant opportunities to offset the costs associated with the adoption and integration of the closed-loop referral technology. This financial support is intended to alleviate any potential barriers to entry for HRSN Service Providers.

Technical Assistance: Recognizing the importance of smooth technology implementation, we will partner with Unite Us to offer comprehensive technical assistance to HRSN Service Providers. This assistance will encompass installation, customization, and troubleshooting support to ensure a seamless transition and operational efficiency.

Outreach and Education: To foster widespread adoption and effective use of the new system, we will conduct targeted outreach and educational programs within the context of our Douglas County Connect Oregon User Group. We'll also feature a live demonstration as a component of our annual Umpqua Health Innovation Conference, and event in which the vast majority of our local CBOs and potential HRSN providers participate. These initiatives will focus on demonstrating the benefits of the closed-loop referral system, highlighting its potential to streamline processes and improve service delivery outcomes.

Feedback Mechanisms: An integral part of our strategy involves establishing open and ongoing channels of communication with HRSN Service Providers. Through regular feedback mechanisms within our Douglas County Connect Oregon User Group, we aim to gather insights into user experiences, identify areas for improvement, and make necessary adjustments to the technology and support services.

By focusing on these areas, we aim to ensure that HRSN Service Providers are well-equipped, informed, and motivated to embrace and leverage the new closed-loop referral technology and to engage in the HRSN benefit more broadly. Our goal is to streamline the payment experience for our Community-Based Organizations (CBOs) while leveraging the growing adoption of the Connect Oregon and UniteUs platform across our community and the state of Oregon, enhancing the efficiency and effectiveness of service delivery to our members.

Strategy 1 title: Develop HRSN-related functionality and supports for providers & CBO partners.

Partner with Unite Us, other CCOs and OHLC to strategize, plan and implement the Unite Us Payments module to support the HRSN benefit. Design workflows to support exchanging referrals with HRSN service providers, and work to onboard CBOs to the platform.

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

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

Strategy status:

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

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

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

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

N/A

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

Planned Activities	**Planned Milestones**
In 2024, we will be launching multiple workstreams to implement the Unite Us HRSN Payments Module.	1. Q1 2024 – Phase 1 implementation of payments module complete.

1. Participation in the collaborative CCO/OHLC/Unite Us payments workgroup, beginning in February. 2. Operations implementation to identify & optimize workflows, design necessary forms and validate functionality for multiple business units. 3. Claims/technical implementation to help automate the payer workflow functionality and deliver the required claims information to OHA. 4. Onboard at least one larger CBO partner to the platform as an official HRSN service provider.	2. Q3 2024 – Phase 2 implementation of payments module complete. 3. Q3 2024 – Claims integration complete. 4. Q4 2024 – Onboard at least one CBO partner to the platform.

Strategy 2 title: Expand the Use and Adoption of CIE by Contracted Clinical Partners

Note – In 2023 we submitted an additional strategy titled “Provider Engagement & Outreach”. For 2024, we have combined that strategy with this one due to close alignment with our progress and planned activities.

UHA’s HIT Tiger Team will engage several clinics to encourage the adoption of Unite Us through targeted outreach and education. UHA’s Goals include:

- Add all contracted pediatric clinics to the Unite Us Network.
- Add all contracted behavioral health providers who provide social-emotional health services to children birth to 5 years old to the Unite Us Network.
- Ongoing engagement and supporting CBO partners

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

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

Strategy status:

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

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

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

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

Office to office discussions of the Unite Us platform took place between UHA and provider offices in three sets of outreach efforts called "Tiger Team" meetings. More than a dozen provider offices engaged with the UHA team on this subject during these Tiger Team meetings. Warm hand-off style introductions to various provider organizations occurred throughout the year as well and from those, many new organizations onboarded with Unite Us in 2023 including:

- CMG East dba Evergreen Family Medicine
- Cow Creek Health & Wellness Center
- Canyonville Health & Urgent Care
- Jorgensen Family Medicine
- Gordon’s Pharmacy & Gifts
- Roseburg Foot and Ankle
- Juniper Tree Counseling LLC
- Lookingglass Community Services

- Positive Behavior Supports

All but 2 Tier 4&5 clinics in our service are connected to Unite Us at this time. The two that aren't are an Internal Medicine clinic with an assigned panel of less than 70 and a clinic in Cottage Grove with a panel of around 200. This represents approximately 0.512% of our member base.

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

Planned Activities	**Planned Milestones**
1. Continue the strategy meetings with the Unite Us staff and prioritize targets based on identified needs and discovered gaps in services for our members will continue in 2024, with a revised strategy for prioritization in place, based on the evolving needs of our service area. 2. Continue warm-handoff type introductions and facilitate further integration throughout the community per the updated list of prioritized targets. 3. Continue to offer liaison services to community partners interested in onboarding with the Unite Us platform. 4. Unite Us will be a HIT Incentive outlined in UHA's PSE for 2024, to further catalyze growth and utilization of the Unite Us network in our service area. 5. Collaborate with ED Case Manager at Mercy Medical Center and the Case Management team at the Adapt family of companies to further incorporate community/partner input in developing and prioritizing targets moving into 2025.	1. Engage the provider network via Tiger Team outreach at least three times during 2024. 2. Q4 2024 - Successfully onboard at least 20% combined of high and mid-priority provider targets. [redacted]Q3 2024 – Onboard Douglas Cares, Evergreen Family Medicine and Canyonville Health & Urgent Care.

Strategy 3 title: Implement the Unite Us Community Information Exchange (CIE) with social services, and CBO partners

In alignment with the 1115 waiver and the launch of the HRSN benefit we will continue our ongoing efforts to build our community services network and supports through the unified and widespread adoption of the UniteUs platform among our CBO partners. We are actively working on establishing a robust partnership with Connect Oregon/Unite Us, and our HRSN connectors as well HRSN service providers.

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

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

Strategy status:

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

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

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

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

Umpqua Health Alliance identified 34 Community Benefit Organizations to prioritize onboarding to Unite Us. By the end of 2023, 19 of these organizations were designated as active, engaged or onboarded to the platform. Community Benefit Organizations that provided services related to housing, nutrition, and the social emotional quality improvement metric (ages 0-5) were prioritized. This work included regular trainings with Unite Us staff, presentations by Unite Us staff at an annual Umpqua Health conference, a requirement in all funding agreements between Umpqua Health Alliance and CBOs for health-related services funding, and regular updates on Unite Us and opportunities to join the platform at various community meetings. In 2023, 29 organizations sent at least one referral, and 80 organizations received at least one referral. This is an increase from 2022, when 11 organizations sent at least one referral, and 38 organizations received one referral, a growth of 163% and 110%, respectively. In 2023, this work served 525 clients with 520 managed cases, with food assistance noted as the most highly requested service type.

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

Planned Activities	**Planned Milestones**
1. Priority targets for 2024 have been identified through UHA decision making, input from several of our largest platform-utilizing partners and the staff at Unite-Us. Currently 119 targets have been identified, and this list is still being expanded. Of the 119 identified targets, 23 have been identified as high priority, 18 have been identified as mid-level. Target identification is being weighted by a variety of factors including needs assessment identified disparities and service gaps, and behavioral health resources for members under 18 years of age. Using this matrix as guidance, UHA will continue to offer the platform to local providers and CBOs including DHS, Douglas CARES and other critical service providers identified. 2. In the 2024-2026 biennium, UHA plans to continue to encourage CBO partners to adopt Unite Us. In Q1 2024, UHA's Community Impact and Engagement Team will meet with UHA's Unite Us Account Manger to outline an outreach and engagement strategy aligned with the expanding need for closed-loop referrals as identified in the HRSN benefit, Social Determinants of Health Metric, and in the implementation of the Unite Us Payments module. This community engagement strategy will include both reassessing identified priority partners and supporting utilization of the platform by currently onboarded but unengaged partners. 3. By the end of 2024, UHA will onboard at least one CBO partner to the Unite Us Payments module to support HRSN service delivery.	1. Q2 2024 – Outline an outreach and engagement strategy for closed-loop referrals. 2. Q4 2024 – Engage at least 80% of identified provider targets in discussion regarding the Unite Us platform. 3. Q4 2024 – Onboard at least 20% of combined high priority and mid-priority provider targets. 4. Q4 2024 – Onboard at least one additional CBO partner to Unite Us payments module.

4. In 2025, UHA will onboard at least one partner to the Unite Us Payments platform to support ILOS service delivery. 5. In 2026, UHA will evaluate the current state of Unite Us adoption in the county, revisiting community engagement goals to support continued expansion and adoption of Unite Us by CBOs into the CCO 2027 contract cycle.	

Strategy 4 title: Implement & Support SDOH screening tools and establish SDoH screening community standards and best practices.

Unite Us, CIE has a closed-loop referral functionality and houses the PRAPARE (Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences) and AHC (Accountable Health Communities) tools that are available for use. Unite Us is made available to all contracted physical, oral, and behavioral health providers, social services, and CBOs at no cost. Through provider engagement it was discovered that many clinics are performing screenings using the PRAPARE and the AAFP (American Academy of Family Physicians) screening tools. Some clinics designed their own SDoH/E screening tool to capture needed information. The Unite Us team is evaluating other screening tools to add to its inventory of tools available through the platform.

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

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

Strategy status:

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

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

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

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

UHA developed three (3) policies to establish SDoH screening and referral standards and best practices for internal CCO staff and clinical and CBO partners. The policies created specifically addressed screening and referral, training requirements and over-screening prevention, and REALD data utilization. To inform these policies, UHA conducted a survey to collect insights about whether/where members are screened, screening tools/questions in use (including available language), and the data systems used in the service area. The policies also incorporated member feedback via the Community Advisory Council (CAC). Furthermore, UHA conducted a gap analysis to assess the capacity of available resources in the service area to better understand where additional resources, training, and funding is required moving forward. Lastly, Unite Us has hosted multiple platform demonstrations to internal staff and external partners to establish screening and referral best practices.

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

Planned Activities	**Planned Milestones**
1. Review the three (3) SDoH policies for annual updates with the internal SDoH Workgroup and the CAC and add process for connecting members to culturally responsive resources in the screening and referral policy.	1. February 2024 - UHA will host a Collaborative Screening Workshop for internal and external staff to improve/implement social needs screenings and referrals for service area.

2. Send reminder to internal CCO staff and external partners about SDoH training requirements outlined in the SDoH training policy. 3. Host Collaborative Screening Workshop for internal and external staff to establish best practices for screening and referral workflows. 4. Review additional SDoH training needs of the service area and continue familiarizing SDoH screening and referral expectations. 5. Update 2023 survey with additional questions regarding staff training and OHA-approved screening tool usage and send to internal CCO staff and external clinical CBO partners. 6. Continue onboarding Unite Us in the service area and review additional training opportunities for CIE (i.e., host more platform demonstrations).	2. December 2024 - Two (2) external organizations will conduct social needs screenings directly into Unite Us. 3. December 2024 - 50% of SDoH survey respondents will utilize an OHA-approved screening tool.

Strategy 5 title: Care Coordination Grant Program & Network Advisory Board

In addition to supporting and engaging CBOs on the platform, in 2022 UHA deployed a Care Coordination Grant Program in which CBOs can apply for funding for staff to support the deployment of the solution. Knowing that resource constraints are a primary barrier, the Grant Program made available $600,000 in funding to CBOs to deploy and hire (if needed), additional staff to support the engagement. This reduces one of the primary barriers reported by CBOs of not having enough staffing resources to support CIE utilization.

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

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

Strategy status:

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

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

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

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

This grant was originally awarded in 2022 to Adapt. The grant cycle has ended as of Q2 2023. Funding was issued to 7 CBOs who applied of and were awarded the grants. The goal was to onboard to Connect Oregon and to fund staff to support the onboarding. Administering this grant had some setbacks and delays due to changes in how the state interpreted the use of these funds. We were able to redesign the purpose in a way that met the new interpretations and limitations and promoted the opportunity to CBOs in the community.

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

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

Strategy 6 title: Expand clinical data collection to include SDOH

- UHA will encourage clinics to adopt an SDOH data collection tool such as PRAPARE
- Provide technical assistance to 14 clinics that use a common her (eClinicalWorks) to add more data elements to their CCO Metrics data feed, specifically SDOH data
- Work closely with each clinic, UHA Business Intelligence (BI) department and their EHR vendor on the technical specs, backend system updates and the data extract
- Provide guidance and workflow recommendations, including updates to exchange EHR templates and forms to ensure that all the required data is collected

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

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

Strategy status:

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

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

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

In early 2023 we updated our internal specification to collect the SDOH data in our clinical data feeds. We communicated these changes to Reliance and provided an update to eCW (who acts on behalf of our eCW clinics). We also provided the updates to all our direct clinical submitters.

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

Planned Activities	**Planned Milestones**
1. In 2024, we will be continuing to work with eCW and the remaining clinics to update their respective feeds. 2. In addition, we will be evaluating what is necessary to ensure all data received from clinical partners is correctly normalized for use in our systems.	1. Q3 2024 – Complete analysis and make any necessary changes to ensure data normalization. 2. Q4 2024 – Complete data feed updates with remaining clinics.

Strategy 7 title: Establish community governance of Unite Us platform

The Douglas County Connect Oregon User Group (DC COUG) is dedicated to guiding the governance of the community information exchange (CIE) in Douglas County, emphasizing community-led efforts to enhance the Connect Oregon Platform's functionality and user experience. By forming an advisory body of local leaders and key users, the DC COUG seeks to efficiently gather and implement feedback from network stakeholders, fostering a collaborative environment and shared responsibility for the CIE's success. This group plays a critical role in addressing community workflow challenges, disseminating best practices, and supporting the implementation of Oregon's 1115 Waiver requirements, including Health-Related Social Needs (HRSN). The COUG's efforts ensure that Douglas County's perspectives influence broader regional and statewide strategic decisions, with Umpqua Health Alliance (UHA) providing essential support and coordination, and membership comprising local experts and organizations crucial for the network's impact in Douglas County and beyond.

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

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

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

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

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

N/A

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

Planned Activities	**Planned Milestones**
1. Socialize the UU payments platform by providing demos, gathering feedback on functionality, and conducting training when new partners are onboarded. 2. Incorporate workflows within the platform to support the IET & SDoH quality metrics. 3. Invite our community partners to bring relevant topics to this open community engagement and governance forum. 4. Optimize engagement with our community assisters to support our organizational goal of meeting our member engagement needs via direct outreach to assister programs to engage with the DC COUG and ongoing tracking of benefits navigation referrals in the user group.	1. January 2024 – 1st SDoH Screening Training 2. March 2024 – Introduce the Unite Us payments functionality. 3. May 2024 – 2nd SDoH Screening Training 4. July 2024 – High level overview of IM program and discussion Unite Us workflows to impact metrics (example: IET) 5. September & November 2024 – Revisit the Unite Us payments functionality.

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

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

D. OHA Support Needs (Optional)

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

6. Other Health IT Questions (Optional)

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

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

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