

2026 CCO Health Information Technology Roadmap

Reporting Template

Contract or rule citation	Exhibit J, Section 2
Deliverable due date	April 30, 2026
Submit deliverable via:	CCO Contract Deliverables Portal

Please:

1. Submit a Microsoft Word version of your Health IT Roadmap using the template and
2. Use the following file naming convention for your submission:
CCOname_2026_HealthIT_Roadmap

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

Table of Contents

Instructions and expectations	4
1. Health IT partnership	6
2. (Optional) Overview of CCO health IT approach.....	6
3. Support for EHR adoption, use and optimization	8
A. Support for EHR adoption, use and optimization: 2025 progress and 2026-29 plans	8
B. EHR support barriers.....	23
C. OHA support needs	24
4. Use of and support for HIE for care coordination and hospital event notifications	25
A. CCO use of HIE for care coordination and hospital event notifications: 2025 progress and 2026-29 plans.....	25
B. Supporting increased access to and use of HIE among providers: 2025 progress and 2026-29 plans.....	42
C. HIE for care coordination barriers.....	56
D. OHA support needs.....	57
E. CCO access to and use of EHRs	57
5. Health IT to support SDOH	58
A. CCO use of health IT to support SDOH: 2025 progress and 2026-29 plans	58
B. CCO support of providers with using health IT to support SDOH: 2025 progress and 2026-29 plans.....	72

C. Exceptions process if CCO requires CIE.....	89
D. Health IT to support SDOH barriers.....	92
E. OHA support needs	92
6. (Optional) Other health IT questions.....	93

Instructions and expectations

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

Health IT partnership

Support for EHR adoption, use and optimization

Use of and support for HIE for care coordination and hospital event notifications

Health IT to support social determinants of health (SDOH), including but not limited to social needs screening and referrals

Other health IT questions (optional section)

Each required topic includes the following:

- Narrative sections to describe your 2025 strategies, progress, accomplishments/successes, and barriers
- Narrative sections to describe your 2026-2029 plans, strategies, and related activities and milestones

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

- ✓ be informed by the CCO's Data Reporting File

- ✓ be strategic, and activities may focus on supporting specific provider types or specific use cases
- ✓ include specific activities and milestones to demonstrate the steps CCO expects to take

Review the Health IT Roadmap Guidance for additional detail on filling out this template.

Notes:

- As part of OHA’s digital accessibility effort, the 2026 Roadmap materials are formatted differently than in past years, but the content is familiar. **CCOs are encouraged to check the “Navigation Pane” box in the View tab of Microsoft Word to help with navigation of this document.** If you have any concerns or challenges with using the new template, please email CCO.HealthIT@odhsoha.oregon.gov to troubleshoot.
- Four strategy sections have been provided for each section of the template. Please copy and paste additional strategy sections as needed. When adding additional strategy reporting sections, please be sure to copy and paste the strategy section from the same part of the Roadmap (checkboxes differ section to section and so will be incorrect if copied and pasted from other parts of the Roadmap).
- 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 2025, note “N/A” in the Planned Activities and Planned Milestones sections.
- If CCO is implementing a strategy beginning in 2026, please indicate “N/A” in the progress section for that strategy.
- If CCO is continuing a strategy from prior years, please continue to report and indicate “Ongoing” or “Revised” as appropriate.

CCO Name: AllCare CCO

1. Health IT partnership

Please attest to the following items.

- 1. CCO has an active, signed HIT Commons MOU and adheres to the terms.**

☒ Yes

☐ No

- 2. CCO paid the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU.**

☒ Yes

☐ No

- 3. CCO 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.) **N/A**

☐ Yes

☐ No

- 4. CCO participated in an OHA Health IT Advisory Group (HITAG) meeting at least once during the previous Contract Year.**

☒ Yes

☐ No

2. (Optional) Overview of CCO health IT approach

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

AllCare maintains a comprehensive Health Information Technology (HIT) roadmap to support care coordination, risk stratification, and population health management across its network. For 2026, this roadmap reflects a continued focus on advancing interoperability, strengthening provider connectivity, and optimizing the use of data to improve member outcomes. AllCare's HIT strategy is guided by organizational priorities, regulatory expectations, and alignment with Oregon Health Authority (OHA) requirements. AllCare utilizes a structured governance and project management framework, including subject matter experts, and enterprise tracking through Asana, to monitor progress, ensure accountability, and support continuous improvement across HIT initiatives. AllCare is focused on strengthening the use and adoption of Health Information Exchange (HIE) to support timely, coordinated care. This includes expanding access to hospital event notifications, improving transitions of care, and increasing provider utilization of HIE tools. As part of this strategy, AllCare is supporting provider adoption of solutions such as PointClickCare to enhance real-time data access and reduce avoidable emergency department utilization. To support care coordination and risk stratification, AllCare continues to invest in data integration and analytics. Power BI dashboards are used to monitor Health Risk Assessments (HRAs), stratify member risk, and identify care gaps, enabling more proactive and targeted interventions. The HIT roadmap also incorporates Social Determinants of Health (SDOH) by improving data capture, referral workflows, and coordination across physical health, behavioral health, and

community-based services to support whole-person care. Interoperability remains a core focus, with continued investment in secure and timely data exchange across systems and care settings. Overall, AllCare’s approach emphasizes optimization of existing tools, increased provider engagement, and enhanced use of data to support coordinated, high-quality care and improved member outcomes.

3. Support for EHR adoption, use and optimization

A. Support for EHR adoption, use and optimization: 2025 progress and 2026-29 plans

Please describe your 2025 progress and 2026-29 plans for supporting increased rates of EHR adoption, use, and optimization in support of care coordination, and addressing barriers among contracted physical, oral, and behavioral health providers. In the spaces below (in the relevant sections), please:

- Report the number of physical, oral, and behavioral health organizations without EHR information using the Data Completeness Table in the OHA-provided CCO Health IT Data File (e.g., “Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information”). CCOs are expected to use this information to inform their strategies. Where applicable, information in the CCO Data Reporting File should support descriptions of accomplishments and successes.
- Include plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialing, Letters of Interest).
- Provide an overview of CCO’s approach to supporting EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination.

- **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 to support EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination include:

1. A title and brief description

Which category(ies) pertain to each strategy

The strategy status

Provider types supported

A description of 2025 progress, including:

- i. Accomplishments and successes (including number of organizations, etc., where applicable)
 - ii. Challenges related to each strategy, as applicable
 - iii. How the strategy supports each type of provider selected
- (Optional) An overview of CCO 2026-29 plans for each strategy
- Activities and milestones related to each strategy CCO plans to implement in 2026-29

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.**

Using the OHA-provided Data Completeness Table, 15 physical health, 12 oral health, and 47 behavioral health organizations lack EHR information.

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

AllCare plans to collect missing EHR information through existing operational processes, including online quarterly provider profile updates, contracting and credentialing workflows, and targeted provider outreach. These processes will be used to confirm current EHR status, close data gaps, and update records for contracted physical, oral, and behavioral health providers. AllCare will also continue focused outreach to providers without an EHR and will reassess engagement strategies for behavioral health and oral health providers to improve participation and data completeness.

Complete list of strategy categories

Please review the list of strategies below that you may have employed during 2025 and/or plan to implement during 2026-29. Check the applicable boxes for each strategy and describe your progress/plans in the sections below.

1. EHR training and/or technical assistance
2. Assessment/tracking of EHR adoption and capabilities
3. Outreach and education about the value of EHR adoption/use
4. Collaboration with network partners
5. Incentives to adopt and/or use EHR
6. Financial support for EHR implementation or maintenance
7. Requirements in contracts/provider agreements
8. Leveraging HIE programs and tools in a way that promotes EHR adoption
9. Offer hosted EHR product
10. Assist with EHR selection

11. Support EHR optimization

12. Other strategies for supporting EHR adoption

(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.**

AllCare supports Electronic Health Record (EHR) adoption, utilization, and optimization across contracted physical, oral, and behavioral health providers as a core component of advancing care coordination. The organization employs a multi-faceted approach that includes targeted technical assistance, provider training, and ongoing outreach to support effective EHR use in clinical workflows. Through this structured and proactive approach, AllCare continues to strengthen EHR capabilities across its network, supporting improved coordination of care, enhanced data quality, and better outcomes for members.

Strategy 1 title: EHR Adoption Support and Marketing Alignment Initiative

Brief description: AllCare's eHealth Services is committed to supporting the successful adoption and utilization of the regionally supported Veradigm (Allscripts) EHR system among independent healthcare providers. This initiative combines comprehensive EHR training and technical assistance with a revised, provider-centered marketing approach. Through tailored training, technical support, and proactive engagement strategies, AllCare will ensure providers are equipped to effectively implement the EHR system. Regular evaluations and feedback sessions will be conducted to refine both training methods and marketing efforts, aligning them with provider needs and maximizing community-wide adoption.

Strategy categories: Select which categories 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 2025, eHealth made significant strides in partnering with independent offices utilizing the Veradigm (Allscripts) EHR system to enhance clinical efficiency and patient outcomes. Through one-on-one collaboration with each practice, eHealth worked to design and refine customized templates and workflows that support providers in closing care gaps, capturing risk data, and improving overall care delivery. This hands-on approach ensured that each practice's unique needs and workflows were aligned with the broader goals of quality improvement and data accuracy. To further strengthen provider efficiency, eHealth implemented the use of Ambient Scribe, an integrated AI-powered scribing tool embedded within the Veradigm platform. This technology assists providers with real-time documentation during patient encounters, allowing them to focus more fully on

direct patient care while reducing administrative burden. Initial feedback from participating practices has been positive, with reported improvements in both charting accuracy and documentation time. Alongside these technical advancements, eHealth continued to expand its outreach and training initiatives, emphasizing provider engagement and continuous optimization. Regular check-ins, targeted training sessions, and updated support materials helped providers maximize the system's capabilities and adopt new features with confidence. Together, these efforts reflect eHealth's ongoing commitment to ensuring that technology adoption directly translates into better care coordination, efficiency, and patient outcomes across the network. In 2024, eHealth made significant strides in optimizing EHR systems and strengthening provider support. Customized training plans were developed for existing offices, ensuring tailored guidance for each practice's unique needs. EHR optimization efforts began in earnest, highlighted by the integration of AI scribe technology into the Veradigm platform. Currently, the AI product has not been fully rolled out, as a few technical issues are still being addressed. Once these issues are resolved, we will re-evaluate the product and determine an appropriate timeline for broader implementation with our provider network. In addition, initiatives related to provider engagement, marketing alignment, and network expansion were successfully launched, supporting our long-term strategic goals. As we move forward, we remain committed to continuous optimization and enhancement to better serve our offices and providers.

(Optional) **Overview of 2026-29 plans for this strategy:**

Building on the foundational work of 2024 and 2025, eHealth's 2026–2029 strategy will focus on deepening EHR optimization, expanding integration with advanced Veradigm tools, and strengthening provider engagement through data-driven innovation. Over this period, eHealth will collaborate closely with

Veradigm to implement system enhancements that improve documentation, billing efficiency, and quality reporting. Key initiatives will include expanded use of Ambient Scribe, rollout of Veradigm’s billing optimization program to reduce revenue bottlenecks between chart completion and payment collection, and full integration of the Veradigm Payer Insights (VPI) program. These efforts will allow providers to proactively address CMS and APM quality gaps from within the EHR, improving both care quality and reimbursement outcomes. eHealth will continue to host provider forums, deliver advanced EHR training, and maintain structured feedback cycles to ensure optimization efforts remain responsive to provider needs. Continuous data analysis and quarterly progress assessments will guide iterative improvements and long-term sustainability of these tools across AllCare’s clinical network.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Continue partnering with independent offices to refine Veradigm templates and workflows, and provide ongoing technical support to improve usability and documentation.	A. Complete updated workflow reviews with participating offices by Q4 2026 and complete follow-up optimization reviews in 2027
2. Expand use of Ambient Scribe to support provider documentation, reduce charting burden, and improve patient care.	B. Increase Ambient Scribe adoption across participating offices by Q3 2026 and evaluate provider use and feedback by Q1 2027

Planned activities	Planned milestones
3. Work with Veradigm to implement the billing program and reduce revenue bottlenecks from chart completion to payment collection.	C. Launch the billing optimization program by Q1 2026 and review early billing workflow improvements by Q4 2026.
4. Implement VPI to help providers identify CMS and other APM-related care gaps and support gap closure within the HER.	D. Launch VPI and complete provider training by Q4 2026, with progress reviews on gap closure completed by Q4 2027
5. Continue provider training, check-ins, and support to strengthen adoption and use of Veradigm tools.	E. Provide ongoing training throughout 2026–2027 and complete annual provider feedback reviews each year.

Strategy 2 title: EHR Adoption and/or Technical Assistance for Oral Health

Brief description: AllCare will continue to actively survey and monitor the adoption and utilization of Oral Health EHR systems across dental practices within our service area, with a focus on identifying gaps in adoption, barriers to implementation, and opportunities for increased integration. In partnership with our Dental Subcontractors, we will promote ongoing evaluation and adoption of acceptable and certified EHR platforms that meet regulatory requirements and support interoperability.-AllCare will also collaborate closely with oral health professionals in our network to research and identify EHR platforms that are compatible with, and capable of interfacing with, medical EHR systems. Emphasis will be placed on care coordination, and improved visibility into member health information to better address whole-person care and SDOH-E needs. To ensure

accountability and progress, follow-up engagement will occur monthly with each Dental Subcontractor to assess status, and address barriers.

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

This strategy is particularly challenging due to the difficulty of different EHR systems not communicating effectively with each other. Additionally, most Oral Health EHRs are not true EHRs unless EPIC products, such as Wisdom Tooth, are utilized. However, in September 2024, Capitol Dental built a custom-built Dental Practice Information System was successfully implemented, and fully integrating with Reliance. This integration enables real-time read-and-write access to medical information and offers a seamless user experience through single sign-on functionality. The system supports both brick-and-mortar dental offices and mobile units. Key highlights of the integration:

EHR System: Capitol uses a custom-owned EHR built into the Denticom practice management platform.

Integration Partner: The solution was developed collaboratively by the Capitol IT team, Reliance, and Denticom, at zero cost.

Utilization: Capitol reports a 99% utilization rate.

Access Improvement: Wait times for hospital dentists have decreased from 2–3 months to just 2 weeks.

National Leadership: Capitol is currently the only organization in the country with this level of integrated dental and medical EHR functionality. This achievement marks a major milestone in our HIT Roadmap, significantly improving dental care coordination and patient outcomes. Capitol Dental presented their achievements at AllCare’s Dental Summit in 2025. The Dental Subcontractors were able to voice their barriers and hear how other may have overcome them, as well as how they could work together to make progress on the shared barriers of implementing EHR’s within their network.

AllCare continues to do monthly check-in with each of our dental subcontractors. Advantage Dental is finalizing the testing phase and will be transitioning to Denticom later this year. This transition represents an initial step toward future system enhancements, with further integration with Reliance identified as a subsequent project milestone.

ODS reported that many contracted providers have independently invested in separate oral health practice management systems, creating ongoing challenges to standardization and adoption of a shared interoperable platform. Although incentives, including no-cost software options, have been offered to support migration to a common system, provider uptake has remained limited. Feedback gathered through monthly discussions identified transition costs, workflow disruption, training needs, and existing investments in current systems as primary barriers. Based on these findings, the CCO will continue targeted technical assistance efforts with each DCO, including sharing successful models,

promoting peer learning opportunities, supporting vendor discussions, and identifying realistic phased approaches.

(Optional) **Overview of 2026-29 plans for this strategy:**

Click or tap here to enter text.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Advantage Dental plans to transition to Denticom later this year.	A. Advantage Dental will complete the transition to the Denticon EHR Platform, including system implementation, data migration, and provider onboarding, by Q4 2026 to enhance interoperability and support coordination.
2. AllCare will be attending a software demonstration with a local dental provider who is exploring implementation of an integrated platform designed to support both oral and physical health services within their practice, with the goal of informing potential adoption and broader implementation strategies across the network.	B. AllCare will participate in a software demonstration with a local dental provider to evaluate an integrated oral and physical health platform, with findings and recommendations completed by Q3 2026 to inform potential network-wide adoption and implementation strategies

Strategy 3 title: Tracking EHR Adoption

Brief description: The Provider Services Team will track and support EHR adoption through quarterly provider profile reviews, enhanced by the implementation of Symplr as a centralized provider data management platform. Provider profiles serve as a comprehensive record of practice-level information, including EHR adoption status, EHR vendor selection, interoperability capabilities, network participation, and compliance with reporting requirements.

Through Symplr, AllCare is strengthening its ability to systematically collect, maintain, and analyze provider data across contracted provider types, including primary care, specialty, behavioral health, oral health, and ancillary providers. This transition supports more accurate tracking of EHR adoption and changes over time, including identifying providers without EHR systems, monitoring EHR selection and connectivity, and segmenting adoption trends by provider type. This infrastructure also supports targeted outreach and technical assistance by allowing the Provider Services Team to identify gaps, prioritize support, and monitor progress toward increased EHR adoption, optimization, and interoperability across the network.

Strategy categories: Select which categories 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 2025, AllCare expanded the Provider Engagement Team by adding additional staff to serve as dedicated representatives for contracted providers. These team members act as a consistent resource for provider offices, helping answer questions, provide support, and ensure timely completion of quarterly provider portal roster updates. The Provider Portal remains an important online tool for all offices, allowing providers to review and update their information every 90 days and supporting more accurate and current provider data across the network. In addition, 2025 marked the beginning of implementation planning for the transition from Intellicred to Symplr. Weekly transition calls were established to support a smooth sunset of Intellicred and ensure that all data is transferred cleanly, accurately, and without disruption to provider operations. This ongoing work reflects AllCare's commitment to maintaining strong provider data management and ensuring continuity during the system transition. AllCare's 2024 strategy has demonstrated greater success than in previous years, largely due to the creation and implementation of the Provider Engagement Team. Each Provider Engagement Specialist is assigned to a group of practices and is responsible for ensuring that quarterly provider profile updates are completed. These updates have significantly improved the tracking of EHR adoption, enhanced provider support, and strengthened overall progress monitoring across our network. This proactive and structured approach has allowed AllCare to identify gaps better and drive continuous improvements in EHR adoption efforts. A key component of this strategy includes leveraging provider profile

information to track which EHR systems are utilized within each practice. All information gathered during the quarterly updates is entered into AllCare's credentialing and contracting software, Intellicred, which is the source of truth for internal provider data management and network monitoring. Although AllCare established a partnership with TherapyNotes to encourage EHR adoption among behavioral health providers, this partnership has not yet resulted in new implementations within behavioral health organizations. Despite this, AllCare remains optimistic that ongoing collaboration with TherapyNotes will lead to increased EHR adoption among behavioral health providers over time. AllCare is implementing a strategy to enhance provider data management by improving the Provider Portal, enabling providers to directly update their profiles. A key challenge identified in this strategy is the planned retirement of the Intellicred platform, which the vendor will sunset in 2025. As a result, AllCare will transition to a new credentialing and contracting system. Although this presents operational challenges, AllCare is proactively preparing for the transition to maintain data integrity and ensure the ongoing effectiveness of provider engagement, monitoring, and network management efforts.

(Optional) **Overview of 2026-29 plans for this strategy:**

Building on the progress made in 2025, AllCare will continue strengthening its provider engagement infrastructure and improving the accuracy and accessibility of provider information across the network. Over the next three years, the Provider Services Team will support contracted providers through the Provider Engagement Team, which serves as a direct resource for questions, assistance, and ongoing communication. The team will continue helping practices complete quarterly provider portal roster updates and ensure that provider information remains current and accurate. During this period, AllCare will also continue the transition from Intellicred to Symplr to improve credentialing and contracting

functions. This transition will be managed carefully through regular implementation meetings and data validation efforts to ensure a smooth transfer of information and continuity of operations. By the end of Q4 2026, AllCare will implement the symplr Clinical Communications Collaboration Platform, which will allow providers to enter their own credentialing information. The Provider Portal will remain an accessible online resource for providers to review and update their information every 90 days, supporting better data quality, improved coordination, and more effective tracking of provider participation and EHR adoption.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Continue expanding the Provider Engagement Team to serve as a direct resource for contracted providers, answer questions, and provide support with portal and roster updates.	A. Maintain assigned provider support coverage throughout 2026–2029 and complete quarterly outreach to contracted providers each year.
2. Support all contracted offices in completing quarterly provider portal roster updates and ensure providers can review and update their information every 90 days.	B. Achieve completion of quarterly roster reviews for all participating offices beginning in 2026 and continue through 2029
3. Promote regular use of the Provider Portal as the primary online resource for provider profile	C. Maintain 90-day review and update cycles for provider information throughout 2026–2029 and monitor

Planned activities	Planned milestones
review and updates. Assist offices with corrections and updates as needed.	improvement in data accuracy each year.
4. Complete the transition from Intellicred to Symplr through weekly implementation calls, data validation, and transfer planning to ensure a smooth changeover.	D. Complete system transition activities in 2026, validate transferred data for accuracy, and fully operationalize Symplr by Q1 2027.
5. Use the symplr Clinical Communication Collaboration Platform and provider portal processes to improve credentialing, contracting, and ongoing provider data management.	E. By the end of Q4 2026, AllCare will implement and operationalize the Symplr Communication Collaboration Platform and enhanced provider portal processes to improve efficiency, accuracy, and timeliness in credentialing, contracting and ongoing provider data management.
6. Continue monitoring provider participation, portal compliance, and engagement trends to identify gaps and provide targeted support.	F. Complete annual performance reviews for 2026, 2027, and 2028 and use findings to guide improvements for the 2029.

B. EHR support barriers

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

While most physical health providers have already adopted EHR systems, a small number remain unwilling to transition, which limits further adoption efforts in that group. For dental and behavioral health providers, barriers continue to include high implementation costs, limited financial incentives, and ongoing technical challenges. Many of these providers lack the funding or reimbursement support needed to move forward, and available EHR systems in these settings can still present interoperability concerns and workflow disruptions. In addition, changes in credentialing and system transitions have required significant staff time and coordination, which can slow progress and divert attention from EHR optimization efforts.

Our large Behavioral Health clinics that provide mental health, substance use and physical health services have had ongoing challenges finding EHRs that work for this type of integration. They have historically used a BH friendly EHR like Credible or Dr. Cloud as their primary system and have used a secondary EHR for their primary care providers. This barrier is becoming an issue for more of our BH clinics who are applying to become Certified Community Behavioral Health Clinics (CCBHCs) in 2026. This expands the problem for three additional clinics if they are granted CCBHC. The three additional clinics currently provide mental health and substance use disorder services and will be adding primary care/medical services within the next year. They are finding it difficult to find EHRs that will meet their needs. The ones that are known and available, like OCHIN, are too expensive.

C. OHA support needs

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

AllCare would benefit from OHA support in several key areas to further advance EHR adoption, use, and optimization among contracted providers, particularly within the Behavioral Health network. Targeted incentives or grant opportunities

for smaller practices would help offset the financial barriers that continue to limit EHR adoption. In addition, OHA-supported peer learning collaboratives or technical assistance forums would provide providers with an opportunity to share best practices, learn from one another, and address common implementation challenges. Continued partnership and guidance from OHA will be important in helping AllCare expand EHR adoption, strengthen provider engagement, and improve long-term integration across the network.

4. Use of and support for HIE for care coordination and hospital event notifications

A. CCO use of HIE for care coordination and hospital event notifications: 2025 progress and 2026-29 plans

Please describe your 2025 progress and 2026-29 plans for using HIE for care coordination, including risk stratification, AND timely hospital event notifications **within your organization**. In the spaces below (in the relevant sections), please:

- List and describe specific tool(s) you currently use or plan to use for care coordination, including risk stratification, and timely hospital event notifications.
- (Optional) Provide an overview of CCO's approach to using HIE for care coordination and hospital event notifications.
- **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 for using HIE for care coordination, including risk stratification, and hospital event notifications within the CCO include:
 7. A title and brief description
 8. Which category(ies) pertain to each strategy

9. Strategy status

10. A description of 2025 progress, including:

- i. **Accomplishments and successes** (including number of organizations, etc., where applicable)
- ii. Challenges related to each strategy, as applicable

11. (Optional) An overview of CCO 2026-29 plans for each strategy

12. **Activities and milestones** related to each strategy CCO plans to implement in 2026-29

Complete list of strategy categories (within CCO)

Please review the list of strategies below that you may have employed during 2025 and/or plan to implement during 2026-29. Check the applicable boxes for each strategy and describe your progress/plans in the sections below.

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

List and briefly describe tools used by CCO for care coordination and timely hospital event notifications. The use of these tools should also be included in the applicable HIE strategies below.

PointClickCare- for real-time Hospital, Emergency Department, Observation Status, Skilled Nursing Facility – admission and discharge information: 1) Allows for prioritized outreach 2) Ensures continuity of care for members 3) Identifies members who may be experiencing new triggering events 4) Addition of PAC Management to ensure superior discharge planning and collaboration with skilled nursing facilities. Reliance eHealth – Health Information Exchange provides clinical information from participating providers. This data is accessed within the tool itself (for example Positive Pregnancy Reports, SDOH reports) as well as ingested into our various applications. 1) Facilitates exchange of information through offering: a) Community Health Record: -Demographics -CCD (Continuity of Care Documents) -Claims -Admit and discharge -Member visit summary -Lab and Radiology -Transcription Transcribed reports b) Secure Provider messaging. -Essette Care Management System Care Coordination: documentation of care plans including goals and interventions, member HEN/SNF notification documentation, outreach, engagement, and IDT documentation, emergency outreach. Behavioral Health: The BH Clinical Transition Team opens cases and generates care plans for all BH members who: A. Are admitted to a BHU or hospital setting for MH or SUD B. Are admitted to an out of area hospital or residential setting C. Have high ED utilization for BH needs D. Are admitted to or discharged from OSH (370, PSRB, Civil) 1A. We document notifications to all community providers as well as follow ups that occur within the allotted period of time (3/30 days or 7/34 days depending upon the pathway). This would encompass all ‘outreach and engagement’ documentation. 1B. Under ‘tasks’ in Essette, we note each HRCC (Health Related Circumstance Change) [formerly HEN] as well as tasks for IDT attendance and documentation. Wellness

Coordination: documentation of care plans wellness programs (e.g. adult and pediatric weight loss) and tobacco cessation including goals and interventions, outreach, engagement, and record keeping for member interactions. 4, Power BI and other data reports 1. Dashboards to monitor care coordination activities, (i.e. HRA completion rates, and Risk Stratification.)

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

AllCare CCO Benefit Management, Behavioral Health and Population Health teams utilize HIE tools to monitor member data in real time to ensure the most comprehensive and effective outreach and engagement. This work also supports effective care planning and communication with members care team, ensuring provider communication will take place to support effective care for our members and reduce duplication of efforts.

Strategy 1 title: Population Health Targeted Cohort Development

Brief description: The Population Health Care Coordination Team will continue to monitor developed cohorts of patients for Hospital Event Notifications and ED/Hospital utilization and monitoring for referrals to Care Coordination. Additional cohorts will be developed throughout 2024 and beyond to ensure the identification of specific cohorts and target care coordination services to those strategic populations.

Strategy categories: Select which categories pertain to this strategy

- ☒1: Care coordination ☒2: Exchange care information
- ☒3: Integration of disparate information ☒4: HIE tool enhancements
- ☒5: Partner collaboration ☒6: Risk stratification and population segmentation

☐7: Other: [Click or tap here to enter text.](#)

Strategy status:

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

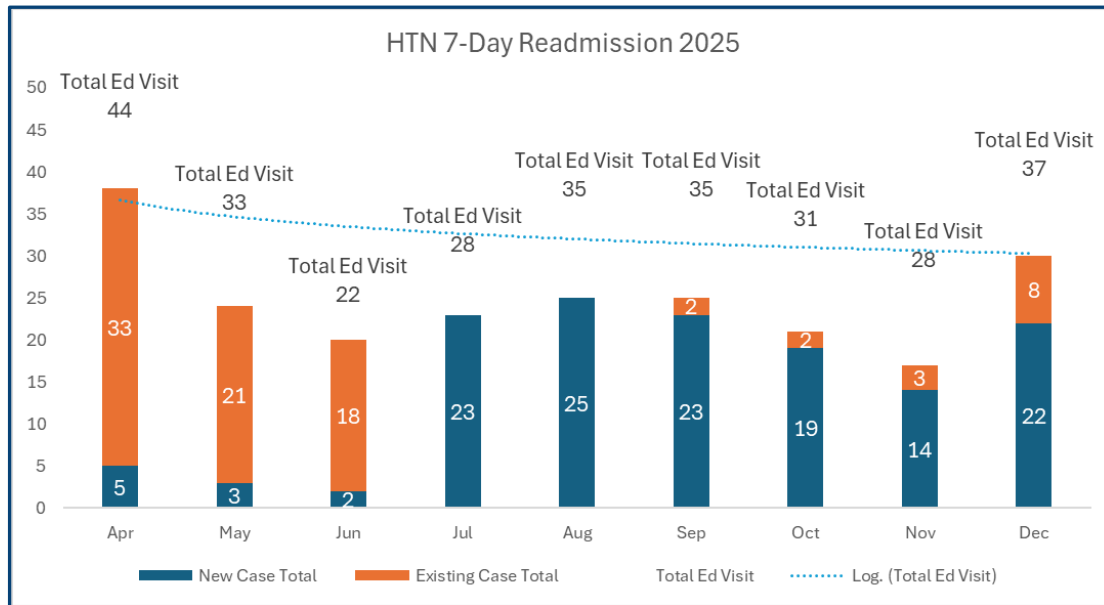
Progress (including previous year accomplishments/successes and challenges with this strategy):

CY24: AllCare Population Health Leadership is engaged with PointClickCare and has developed a pilot cohort for LTSS members to monitor Emergency Department/Inpatient/Observation Admission and Discharges to identify vulnerable members who are eligible for Population Health care coordination and care plan updates. Additional cohort development will be considered for readmission rates. AllCare Population Health Leadership is currently focusing on a primary hypertension readmission cohort as our primary criterion to assess whether developing this and additional cohorts will benefit our members. Based on our findings related to the hypertension readmission cohort, we may consider expanding our efforts to address other complex medical needs. **Success:** The ED/IP/Obs-Hypertension Readmission - 7 Days feature in PointClickCare enables our Population Health Leadership team to monitor the hypertension readmission cohort daily. This includes members diagnosed with Primary Hypertension who either visited the emergency room or were readmitted to the hospital within seven days of discharge. In these cases, the assigned case owner is notified, or a new case is opened for care coordination and planning. Population Health Leadership can identify members in real-time and connect them to care coordination services, ensuring members receive education regarding their Primary Hypertension diagnosis, medication adherence, and any durable medical

equipment (DME) they may need. Population Health Care Coordinators were able to identify members and assist 89% of those members within the readmission cohort. Support provided included education around their diagnosis, DME, and medication adherence. Population Health Leadership will continue to review the Primary Hypertension cohort data monthly in 2025 to ensure all members receive adequate support and experience a reduction in hospital re-admissions and/or emergency room visits for avoidable visits. **Challenges:** Due to the complexity of the hypertension readmission cohort, the LTSS cohort development and implementation has been pushed to 2025. Staff turnover and changing OARs were also an impact.

CY25: AllCare Population Health Leadership continued its work with the ED/IP/Obs Hypertension 7-Day Readmission Cohort to identify members with hypertension-related readmissions who may not have been captured through different PCC cohorts. By monitoring readmissions, this cohort allows AllCare to identify members who may not have been previously recognized due to claims lag. This in turn allows for Care Coordinators to assist members by coordinating services, developing and updating care plans, managing transitions of care, and addressing barriers. Targeted education focuses on medication adherence, proper use of automated blood pressure cuffs, and nutrition support through outreach with a Registered Dietitian. Based on data from this cohort, Population Health Leadership continues to monitor and track effectiveness and is working with PointClickCare to expand monitoring to include members with any cardiac diagnosis later in CY2026. Together, the hope is that this cohort provides an added layer of support by ensuring timely outreach following Health-Related Circumstance Change (HRCC) events and connecting members to appropriate resources. AllCare Population Health Leadership also partnered with PointClickCare to launch an LTSS cohort that monitors the Emergency Department, Inpatient, and Observation admissions and discharges to identify

members who may benefit from care coordination. However, due to the complexity and the short duration of data collection for the ED/IP/Obs Hypertension 7-Day Readmission cohort, this initiative is currently on hold. This will ensure that focus remains on the additional cohort and enables reporting on its outcomes.



Success: The PointClickCare Cohort enables our team to quickly identify members with a hypertension diagnosis and track hospital readmissions within seven days of discharge. Our ED/IP/Obs Hypertension 7-Day Readmission Cohort continues to show overall success. AllCare Health Leadership identified members who were readmitted and received care coordination outreach, resulting in fewer emergency room returns in April – June (existing members that were experiencing readmissions). Targeted Care Coordination is provided, and readmissions show a decline (April – June). In July onward newly identified members who meet the hypertension readmission criteria, care coordinators provide outreach and engagement showing an overall reduction in readmissions. Population Health Leadership did notice an increase in readmissions during the colder months, as well as new members joining the plan, but our care coordination team provided timely outreach. Our hope is to expand this cohort to include all cardiac diagnoses and to assign care coordinators accordingly. We

continue to collaborate with our PCC representative to support these efforts.

Challenges: The primary hypertension readmission cohort has taken more time to evaluate than anticipated due to challenges with claims lag, and diagnosis code updates that occur within PointClickCare, that impact the ability to act in real time on data elements. For example, a member may generate within the cohort and then fall off or on the list due to a corrected diagnosis in the system. This has created the need for longer evaluation of the effectiveness of this cohort, and AllCare is committed to identifying additional ways to support this work. Due to the complexity of the Hypertension readmission cohort, the development and implementation of the LTSS cohort have been pushed to Q3 CY2026. OAR changes and staff turnover remain ongoing challenges.

(Optional) **Overview of 2026-29 plans for this strategy:**

CY26: AllCare Population Health Leadership will build on the success of the Primary Hypertension readmission cohort developed with PointClickCare. The team will focus on improving real-time tracking of Emergency Department, Inpatient, and Observation visits for members with a Hypertension diagnosis. Updated workflows ensure cases are assigned promptly, outreach occurs sooner, and members receive education on managing a cardiac diagnosis, taking medications as prescribed, and using durable medical equipment (DME) appropriately. These efforts aim to further reduce avoidable hospital and emergency room visits. AllCare Health Leadership will continue to apply the Plan-Do-Study-Act (PDSA) cycle and report on utilization. These efforts will ensure Population Health initiatives remain data-driven, responsive, and aligned with AllCare's commitment to improving member outcomes and reducing preventable hospital utilization. We hope to collect enough data in 2026 on the ED/IP/Obs Hypertension 7-Day Readmission cohort so we can focus on additional cohorts, such as LTSS.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Continue to monitor readmission of Primary Diagnosis Hypertension Readmission –7 Day cohort members for reduced hospitalization rates. Evaluate and analyze data to determine impacts, and if additional interventions are needed. If successful, consider creation of cohorts for complex medical conditions. Identify additional activities that may be related to this cohort if successful.	A. Present Hypertension Readmission cohort data to the Quality Improvement Committee (Quarterly). a. Present baseline data and identify improvement targets (monthly). b. Ensure all barriers to care are identified, work to engage member’s care team, and create care plans (quarterly). c. Review data for readmission rates and determine success of cohort monitoring by end of CY226 and determine if improvement target is met.
2. Development work with PointClickCare on new cohort design: LTSS Emergency Department/inpatient/Observation LTSS admits and Emergency Department /inpatient/Observation LTSS discharge.	B. LTSS Cohort training by end of Q4 2026. 1. Identify tracking measures to align with LTSS MOU and DSNP SMAC (Q4 2026).

Planned activities	Planned milestones
3. Ensure all barriers to care are identified, work to engage member's care team, and create care plans for LTSS members in cohort (Q4 2026).	C. Staff to start outreach and create documented care plan for targeted members in identified cohort (Q4 2026)

Strategy 2 title: Technical Solution For Risk Stratification

Brief description: AllCare is seeking a technical solution allowing the ability to risk stratify our membership into the following categories:

- 1) no- or low-risk
- 2) moderate-risk
- 3) high-risk

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

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

CY24: Identification of a technical vendor and work engaged to implement a solution for the risk stratification of our membership. In March of 2024 Population Health Leadership engaged with the OHA workgroups regarding workflow discussions and began contract discussions. AllCare CCOs Data HIT team utilized information from a variety of data sources including PointClickCare, HIE, CIE, Claims and utilization data and developed our Risk Stratification Model. This work was completed and approved by the OHA, AllCare CCO Health IT data analytics team implemented a Risk Stratification model based on a range of risk predictive/adjusted models, with stratified risk categories to inform the level of intensity and intervention required for care coordination gap closure, care profile management and ongoing data analysis. The team has incorporated methodologies tailored to predict high cost and high-risk members, supporting the ability to improve allocation of resources to members who are most likely to benefit from care planning. All members are risk stratified. **Successes:** Utilized internal teams to solve and meet OAR standards.

CY25: AllCare identified that our internal process may not be sufficient in capturing data effectively and began to explore other vendors that may be better able to align risk stratification of our membership, and support our internal goals of reducing costs, increasing care to members while also allowing us to better serve members overall health needs. Several vendors were reviewed, and demonstrations took place, and we identified one vendor who was preferred among all candidates. Through an existing relationship with the ONCHC, AllCare was able to collaborate and secure a contract with their version of the application, allowing us the ability to gain the services and tools needed, and in addition have EHR data from regional FQHCs that we wouldn't have otherwise in a timely manner. Contracts were signed at the end of 2025, and implementation of several modules began in the first quarter of 2026.

(Optional) **Overview of 2026-29 plans for this strategy:**

CY26: Ongoing planned activities and milestones noted below. Implementation of Risk stratification for our membership as well as better, seamless data aggregation in order to leverage data to support our membership, network, utilization management and care coordination activities. Utilization of this application will allow for targeted identification and innovative processes to better serve our provider network and members, reducing costs while providing superior services and engagement

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Execute an acceptable contract with a vendor.	A. End of Q 4 2025
2. Implement a technical solution to ensure continued compliance 1. Core configurations 2. Dashboard modules 3. Risk Navigator 4. SDOH Dashboards 5. Data feeds (initial) i. Future data feeds planned 6. Implementation of Data base workbench	B. Phase 1 implementation a. Core Configuration by end Q 2, 2026 b. Risk Navigator module by mid of Q 3, 2026 c. Vista Dashboards by end of Q 3, 2026 d. Connectors: i. Data Feeds (initial) end of Q 1, 2026

Planned activities	Planned milestones
7. Report authority	ii. Future data feeds (Reliance, PointClickCare, Pharmacy) planned end of Q3 2026 e. Foundry Workbench data base end of Q 2, 2026
3. Identify possibility of new workflows for Risk Stratification	C. Internal work for AllCare Teams, End of Q 3, 2026
4. Train staff on new functionality and documentation requirements	D. Internal work for AllCare teams, End of Q 4, 2026
5. Ensure monitoring, tracking and compliance standards are in place and identify improvement targets	E. Internal work for AllCare Teams, End of Q 4 2026

Strategy 3 title: Technical Solution for Care Coordination module

Brief description: AllCare is seeking a technical solution to replace the legacy Care Management System. The new Care Management System will support early identification of members at risk, support improved care coordination outreach and engagement and communication with members individualized care team, and improve member satisfaction

Strategy categories: Select which categories pertain to this strategy

☒1: Care coordination ☒2: Exchange care information

☒3: Integration of disparate information ☐4: HIE tool enhancements

☒5: Partner collaboration ☒6: Risk stratification and population segmentation

☐7: Other: [Click or tap here to enter text.](#)

Strategy status:

☒Ongoing ☐New ☐Paused ☐Revised ☐Completed

☐Ended/retired/stopped

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

CY2025: End of Q4 2025 contracts were signed to initiate implementation with vendor for Care Management Module. This kick off was in Nov 2025, and intensive work happened in 2025 to begin preparation for implementation, workflow documentation and configuration of our new environment. Due to work that had already taken place internally regarding documentation for our DSNP plan as well as for Risk Stratification demonstrations, AllCare CCO already had existing detailed documented workflows, which supported a smooth workflow discussion. This pre-work makes the future configuration work less intensive and provides significant benefits to our configuration.

CY 2026 – see planned Activities and milestones

(Optional) **Overview of 2026-29 plans for this strategy:**

[Click or tap here to enter text.](#)

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Implementation kick off for Care Management module 1. Schedule demos, identify core functionality, clinical content review, define organizational decisions, identify Care management workflows, identify impacted reporting, develop custom templates, goals and interventions and assessments	A. Q4 2025 – end of Q1 2026 a. Q1 2026
2. Discovery Phase 1. Workflow requirements 2. Documentation 3. Eventium clinical content review 4. Templates/assessments 5. Configuration documentation	B. (a-e) Q4 2025 – Q1 2026
3. Care Management Configuration 1. Identify programs 2. Role/user permissions and configuration 3. Assessment configuration	C. (a-e) Q4 2025 – Q1 2026

Planned activities	Planned milestones
4. Templates 5. Documentation	
4. Care management training 1. Super user training 2. Educational materials 3. Vista care management training	D. (a-c) Q1 – Q2 2026

Strategy 4 title: PointClickCare PAC Management Implementation

Brief description: Implementation of PointClickCare PAC Management module, with access provided to Benefit Management (BM) team, Behavioral Health (BH) Team, and Population Health (PH) Team to ensure access to PCC connected Skilled Nursing Facilities data and care coordination content. Supportive access to SNF encounters, health related circumstance changes (HRCC), and discharge data allows for support for safe discharge planning, better communication across teams, timely referrals to APD/AAA and ensure appropriate support for our LTSS identified members

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

☐Ongoing

☐New

☐Paused

☐Revised

☒Completed

☐Ended/retired/stopped

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

CY 2025: PCC Pac Management was implemented in 2025. The Behavioral Health, Benefit Management and Pharmacy Services team, and Population Health teams utilize PCC Pac Management to support and work closely with our delegated and contracted providers to ensure they are initiating and engaging members we refer to the best of their ability, cover in real time discharge planning and utilize the information to support members who may be experiencing transitions of care. PCC Pac Management allows AllCare CCO to support members in real time, identify needs quickly and reduce utilization and transition members to higher or lower levels of care based on their unique individual needs. **Challenge:** Not all participating SNFs data is within in PCC Pac Management application. Additionally, not all SNFs that are participating are contributing all data elements, for example notes on individual member cases

(Optional) **Overview of 2026-29 plans for this strategy:**

Click or tap here to enter text.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Click or tap here to enter text.	A. Click or tap here to enter text.

Strategy 5 title: Sharing HIE Information with Contracted Behavioral Health Providers

Brief description: The Behavioral Health Team will share HIE information with contracted behavioral health providers to ensure that members receive timely Behavioral Health Care Coordination pertaining to hospital admit, discharge planning, and outpatient follow-up

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

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

Average # of MH **admits** in 2025 per quarter: 50.75 Average % of 'successful' follow up rates in 2025 (once within 3 days of discharge and another within 30 days): 70.5% Average # of SUD **admits** in 2025 per quarter: 57.25 Average % of 'successful' follow up rates in 2025 (once within 7 days of discharge and another within 34 days): 29.75% ***Industry average is about 28%** Average total number of BH **admits** per quarter: 125.25 Though we did see an increase in mental health hospitalizations in quarter 4 of 2025, going from 65 in Q3 to 92 in Q4, the mental health follow-up rate was maintained in the 70th percentile. The mental health providers have excelled at quickly engaging members upon discharge. In SUD

we have also seen an increase in admits during the last quarter of the year. At 19%, the follow-up success rate in Q4 was much lower than previous quarters. This is likely due to the increase in hospitalization combined with holiday staffing issues. This population is difficult to reach and engage with, especially in the short timeframe of seven days. We do see that providers have some success in making contact with these individuals in the 10-to-12-day window. However, this does not meet the seven-day metric. Overall, the SUD follow-up rate is slightly higher than industry standard, and our goal is to continue to build and improve in this area.

(Optional) **Overview of 2026-29 plans for this strategy:**

Our data over the past year has allowed us to see which providers are most successful in achieving follow-up within the dictated timeframes. This information allows us to funnel members to the providers with the highest levels of success. We have adopted this process as a best practice to ensure our members receive timely follow-up care upon discharge. Having this in place has increased the speed at which members are engaged in services, helping to reduce repeat admissions.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Transitions Team to monitor HIE information each weekday and share with potential BH providers; reviewed quarterly for progress	A. BH Team coordination will increase successful follow-up by 3% by end of Q4 2026 as measured by a BH "Successful" follow-up within 3 days of discharge and a second

Planned activities	Planned milestones
	follow-up within 30 days of discharge. This milestone encompasses progress on all three activities.
2. BH Team to track daily and review acute psychiatric hospital discharge	B. Please see (a) for planned milestone activities
3. BH Team is notified and tracks daily 370 members who admit and discharge from OSH toward likely re-enrollment	C. Please see (a) for planned milestone activities.

Strategy 6 title: Hospital Qualifying Events – Behavioral Health

Brief description: The Behavioral Health Clinical Transitions Supervisor will use the PointClickCare platform daily to monitor local, regional, and national hospital usage for AllCare members, specifically those identified as LTSS, 'ED Disparity Measure', or those identified as 'High Readmit Risk'. Qualifying hospital events (HRCC) are reported to active Care Coordinators, contracted SUD and MH providers, and if member does not have a case open currently in the case management software, to all Population Health leadership for case review and assignment.

Strategy categories: Select which categories pertain to this strategy

☒1: Care coordination ☒2: Exchange care information

☒3: Integration of disparate information ☐4: HIE tool enhancements

☐5: Partner collaboration ☐6: Risk stratification and population segmentation

☐7: Other: [Click or tap here to enter text.](#)

Strategy status:

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

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

Average number of **referrals** to SUD providers per quarter from ED: 339 Average number of **referrals** to MH providers per quarter from ED: 346.25 Average number of BH **referrals** to Care Coordination Leadership from ED: 318.25 Average TOTAL number of BH **referrals** from the BH Clinical Transitions team in 2025 per quarter: 1003.5 The Behavioral Health team has supported the Care Coordination team by completing an HRCC each time a behavioral health member is admitted and/or discharged from a hospital setting. The internal referrals to Care Coordination decreased throughout the year as the process changed from referring to Care Coordination to referring these members to the BH Navigator. As there is only one BH Navigator on staff, **these referrals are limited to individuals who have never had an open case.**

(Optional) **Overview of 2026-29 plans for this strategy:**

As mentioned above, the BH Navigator is now doing outreach to members who haven't had an open case previously. The Navigator makes contact with the member to follow up on their hospital visit, and to offer information about their behavioral health benefit. If the member is agreeable, the Navigator will send a referral to a local provider for same-day outreach and access to services. The purpose for tracking the total number of BH referrals is to demonstrate a reduction in the number of referrals quarter over quarter. This would suggest a

decrease in ED visits as well as a possible correlation between engagement in ongoing BH care and the reduced need for emergency BH interventions.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Daily checks of PointClickCare information and cohorts to monitor admission into ED and BHU to assist with successful transition back to the community.	A. Quarterly review demonstrates automated tracking established.
2. Track internal notifications to Population Health care coordination by email, spreadsheet, and/or AllCare's case management system.	B. Establish improvement processes for internal notifications by end of Q4 2026.

B. Supporting increased access to and use of HIE among providers: 2025 progress and 2026-29 plans

Please describe your 2025 progress and 2026-29 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:

3. 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.

4. 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. Where applicable, information in the CCO Data Reporting File should support descriptions of accomplishments and successes.
5. (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.
6. **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 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:
 1. A title and brief description
 2. Which category(ies) pertain to each strategy
 3. Strategy status
 4. Provider types supported
 5. A description of 2025 progress, including:

- i. **Accomplishments and successes** (including the number of organizations of each provider type that gained access to HIE for care coordination tools and HIE for hospital event notifications as a result of your support, where applicable)
 - ii. Challenges related to each strategy, as applicable
6. (Optional) An overview of CCO 2026-29 plans for each strategy
7. **Activities and milestones** related to each strategy CCO plans to implement in 2026-29

Complete list of strategy categories (supporting providers)

Please review the list of strategies below that you may have employed during 2025 and/or plan to implement during 2026-29. Check the applicable boxes for each strategy and describe your progress/plans in the sections below.

1. HIE training and/or technical assistance
2. Assessment/tracking of HIE adoption and capabilities
3. Outreach and education about value of HIE
4. Collaboration with network partners
5. Enhancements to HIE tools (e.g., adding new functionality or data sources)
6. Integration of disparate information and/or tools with HIE
7. Requirements in contracts/provider agreements
8. Financially support HIE tools and/or cover costs of HIE onboarding
9. Offer incentives to adopt or use HIE
10. Offer hosted EHR product (that allows for sharing information between clinics using the shared EHR and/or connection to HIE)

11. Other strategies that address requirements related to federal interoperability and patient access final rules
12. Other strategies for supporting HIE access or use

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. The use of these tools should also be included in the applicable HIE strategies below.

- A) PointClickCare - for real-time Hospital, Emergency Department, Observation status, Skilled Nursing Facility – admission and discharge information: Allows for prioritized outreach, Ensures continuity of care for members, Identifies members who may be experiencing new triggering events
- B) Reliance E Health (Veradigm Allscripts) – Health Information Exchange provides clinical information from participating providers. Facilitates exchange of information through offering: Community Health Record, Admit and discharge, Member visit summary, Lab and Radiology, Transcribed reports, Provider secure messaging
- C) Phreesia – allows for in network SDOH-E screening, identification of member care coordination needs, and connection to resources. Allows for text communication to members, for support of various notifications including education, scheduling, and resourcing.
- D) UniteUs (CIE) Facilitates closed loop referrals for members with SDOH-E and other needs and ensures seamless connection to resources. Allows tracking and data collection.

(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**

Click or tap here to enter text.

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:**

2026 HIE Adoption Rates														
Measure	Physical Health (# of orgs)	Physical Health (% of orgs)	Behavioral Health (#)	Behavioral Health (%)	Oral Health (#)	Oral Health (%)	PCPCH (#)	PCPCH (%)	FQHC (#)	FQHC (%)	Incentive Measures Reporting (#)	Incentive Measures Reporting (%)	RHC (#)	RHC (%)
Total organizations (denominator)	136	100%	73	100%	24	100%	30	100%	4	100%	16	100%	5	100%
HIE for care coordination excluding PointClickCare	74	54%	9	12%	2	8%	26	87%	4	100%	15	94%	5	100%
Hospital event notifications (PointClickCare)	13	10%	7	10%	2	8%	12	40%	4	100%	4	25%	3	60%
HIE for care coordination including PointClickCare	74	54%	12	16%	3	13%	26	87%	4	100%	15	94%	5	100%

Strategy 1 title: Promote HIE/CIE Adoption And Usage Through Education and Incentives

Brief description: Educate providers on options instead of Reliance for closed-loop referrals such as Unite Us or other HIE such as PointClickCare to promote to the providers. Outreach and education through training in the systems.

Strategy categories: Select which categories 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):

On-site Unite Us training was offered to providers in April and September 2025, along with additional training sessions for AllCare Medical Group providers, with 30 attendees overall. AllCare continued to encourage utilization of HIE/CIE by incorporating Clinical Submission to Reliance HIE and Social Needs Assessment/Unite Us or Connect Oregon as incentive measures within its Alternative Payment Models and communicating these opportunities through provider meetings, collaboratives, provider communications, and technical assistance support. In support of provider adoption, AllCare provides ongoing technical assistance and education related to clinical submission to Reliance HIE, including working with provider offices on interface opportunities directly with Veradigm and Reliance to strengthen connectivity and data exchange. While interface development remains an important support strategy, this strategy has been primarily focused on increasing provider office adoption and practical use of Unite Us and PointClickCare to improve care coordination and hospital event notification workflows. Through training, provider outreach, APM incentives, and

hands-on support, AllCare continues to advance provider engagement with these tools and support broader HIE/CIE utilization.

(Optional) **Overview of 2026-29 plans for this strategy:**

We will continue to offer regular Unite Us and related HIE/CIE training across all counties within our service region, with a goal of increasing both provider participation and tool utilization year over year. Training will include a mix of on-site, virtual, and targeted group sessions based on clinic needs. We will also strengthen our collaboration with Connect OR to stay current on platform updates, workflows, and available community resources. This will allow us to provide timely education and support to providers and to help ensure they have the tools and knowledge to address patients' clinical and social needs. Additionally, we will focus on increasing engagement and utilization in Jackson County by providing outreach and training opportunities.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Expand Unite Us utilization in Jackson County	A. Offer at least one training by Q3 for Jackson County clinics
2. Increased outreach to Jackson County to educate clinics on the Unite Us platform and resources available.	B. The provider engagement team will outreach to all contracted clinics in Jackson County to offer education and encourage utilization and implementation by Q2.

Planned activities	Planned milestones
3. Continue monitoring data from our EHR, Veradigm and other organization's EHRs that are part of the Reliance clinical data feed.	C. The Provider Engagement team will monitor data being fed to Reliance on a quarterly basis to identify any errors in the feed.
4. Provider Services will collaborate with Population Health to develop a plan for training provider offices to use PointClickCare.	D. We will offer at least one group training to provider offices on PointClickCare by Q4, 2026.

Strategy 2 title: Expand HIE Utilization & ED Avoidance Through PointClick Care Integration

Brief description: Increase provider adoption and effective use of tools to improved real time care coordination, reduce avoidable Emergency Department (ED) utilization, and enhance transitions of care specifically by encouraging participation in Point Click Care in the provider offices.

Strategy categories: Select which categories 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):

Click or tap here to enter text.

(Optional) **Overview of 2026-29 plans for this strategy:**

AllCare's 2026–2029 Health Information Technology (HIT) strategy includes a focused, multi-year initiative to expand provider adoption and effective use of Health Information Exchange (HIE) tools, with a specific emphasis on implementing PointClickCare within provider offices to strengthen care coordination and reduce avoidable Emergency Department (ED) utilization. Beginning in 2026, AllCare will prioritize targeted engagement with provider offices, particularly those serving high-risk populations and experiencing elevated ED utilization, to support onboarding and integration of PointClickCare into daily workflows. This includes facilitating contracting, providing technical and operational support, and redesigning care team workflows to ensure effective use of real-time hospital event notifications. The goal is to equip provider offices with actionable, timely data to proactively manage patient care transitions and intervene earlier to prevent unnecessary ED visits. From 2027 through 2029, AllCare will scale PointClickCare adoption across the network, moving beyond implementation to optimization and performance integration. Provider offices will incorporate HIE data into care coordination protocols, risk stratification efforts, and routine clinical workflows. This work will be reinforced through value-

based payment alignment, including incentives tied to HIE utilization, timely follow-up after ED visits, and measurable reductions in avoidable utilization. By 2029, AllCare expects the use of PointClickCare across participating provider offices, with standardized processes for managing hospital alerts and coordinating post-acute care. This will result in improved provider visibility into patient activity across care settings, stronger collaboration between primary, specialty, and post-acute providers, and sustained reductions in avoidable ED visits and readmissions. Ultimately, this initiative positions AllCare to deliver more coordinated, data-driven, and patient-centered care across its network.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Identify target providers & select pilot site Implemented Pilot Project	A. By the end of Q1 have pilot site selected.
2. Develop Infrastructure, workflows and contracting approach	B. Have standard workflow documented, contracting pathway established and provider facing education by the end Q2.
3. Implement Pilot Project	C. Implement pilot site by end of Q2 and initial care coordination workflows operational.

Planned activities	Planned milestones
4. Monitor, evaluate and refine	D. Track ED visits alert, follow up completion rates, identify barriers by Q3
5. Expansion Across Network	E. By Q4 and 2027 Expansion of Point Click care across network

C. HIE for care coordination barriers

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

AllCare CCO has identified several key barriers in 2025 that have inhibited progress in supporting access to and use of HIE for care coordination and timely hospital event notifications among contracted providers. These barriers include, but are not limited to, limited time and resources within provider offices, the complexity of integrating HIE functionality directly into existing EMR workflows, lack of awareness and understanding of available tools, and ongoing data privacy and security concerns. Additionally, dental and behavioral health providers face unique challenges that further limit participation. These include high implementation and maintenance costs, limited financial incentives, and technical complexities associated with available systems. Many of these providers lack sufficient funding or reimbursement structures to support engagement with HIE tools, and interoperability limitations can create workflow disruptions that reduce usability. Collectively, these factors have slowed adoption and effective utilization of HIE solutions, impacting the ability to achieve seamless care coordination and timely hospital event notifications across the network.

D. OHA support needs

How can OHA support your efforts to support your contracted providers with access to and use of HIE for care coordination and/or hospital event notifications?

OHA can support these efforts by addressing key operational, financial, and educational barriers that limit provider participation in HIE. Providing dedicated funding would help offset the costs of integration and ongoing use, particularly for dental and behavioral health providers who face greater financial constraints. Simplifying integration requirements and advancing interoperability standards would also reduce the technical burden on provider offices.

E. CCO access to and use of EHRs

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

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

AllCare has access to contracted provider information through Reliance HIE, which supports exchange of clinical information across participating providers and care organizations. In addition, AllCare supports provider EHR-related work through the Veradigm (Allscripts) EHR used by independent practices in the network, and provider data management is supported through the Provider Portal and credentialing/contracting systems. Access to exchanged information is

generally obtained through HIE and through provider-approved portals or interfaces used for care coordination and reporting purposes.

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

AllCare accesses patient information primarily to support care coordination, continuity of care, quality improvement, and follow-up. Information available through Reliance HIE may include clinical summaries, encounter information, results, and other shared records needed to support treatment planning and care management. In the EHR and provider portal context, AllCare's focus is on using information to support EHR adoption, workflow optimization, and provider assistance rather than routine review of full patient charts.

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

Patient information may be exchanged through Reliance HIE and, when appropriate, through provider EHR connectivity tools. Any data received is used for care coordination, quality support, or operational purposes as permitted. Provider profile and practice information are also maintained in AllCare's Provider Portal and credentialing/contracting systems. If patient-level data is exchanged into internal tools, it is limited to what is necessary for reporting, care management, or coordination activities.

5. Health IT to support SDOH

A. CCO use of health IT to support SDOH: 2025 progress and 2026-29 plans

Please describe CCO 2025 progress and 2026-29 plans for using health IT **within your organization** to support social determinants of health (SDOH), including

but not limited to screening and referrals. In the spaces below (in the relevant sections), please:

- List and describe the specific health IT tool(s) you currently use or plan to use for supporting SDOH. **For listed tools, include an explanation of their use/role in the strategy descriptions.**
- (Optional) Provide an overview of CCO's approach to using health IT within the CCO to support SDOH needs, including but not limited to screening and referrals.
- **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 for using health IT within the CCO to support SDOH, including but not limited to screening and referrals, include:
 1. Title and brief description
 2. Which category(ies) pertain to each strategy
 3. Strategy status
 4. Description of 2025 progress, including:
 - i. **Accomplishments and successes** (including number of referrals, etc., where applicable)
 - ii. Challenges related to each strategy, as applicable
 5. (Optional) Overview of CCO 2026-29 plans for each strategy
 6. **Activities and milestones** related to each strategy CCO plans to implement in 2026-29

Complete list of strategy categories (within CCO)

Please review the list of strategies below that you may have employed during 2025 and/or plan to implement during 2026-29. Check the applicable boxes for each strategy and describe your progress/plans in the sections below.

1. Implement or use health IT tool/capability for social needs screening and referrals
2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)
3. Integration or interoperability of health IT tools to systems that support SDOH with other tools
4. CCO leads problem solving efforts and collaboration with their partners
5. Care coordination and care management
6. Support HRSN services
7. Use data to identify members' SDOH experiences and social needs
8. Use data for risk stratification
9. Use health IT to monitor and/or manage contracts and/or programs to meet members' SDOH needs
10. Use health IT for CCO metrics related to SDOH
11. Education/training of CCO staff about the value and use of health IT to support SDOH needs
12. Participate in SDOH-focused health IT convenings, collaborative forums, and/or education (excluding CIE governance)
13. Participate in CIE governance or collaborative decision-making
14. Other strategies for adoption/use of CIE or other health IT to support SDOH needs within CCO
15. Other strategies for CCO access or use of SDOH-related data within CCO

List and briefly describe health IT tools used by CCO for supporting SDOH needs, including but not limited to screening and referrals. The use of these tools should also be included in the applicable SDOH strategies below.

AllCare uses a variety of Health IT tools that can be utilized by providers, community partners, and members. These tools can be used for social needs screening and referrals. Current tools include:

- 1) Provider Portal – Providers can check member eligibility, request PCP and DCO changes, and request care coordination for members via secure messaging. Providers can also submit and verify prior authorizations and view claims statuses including for services that address SDOH concerns such as Health-Related Services (flex services) and Health Related Social Needs Services (HRSN).
- 2) Member Portal – AllCare CCO members have access to the Health Risk Assessment on the online member portal and can complete this at a time of their choosing. Once completed, it is forwarded to the Population Health Team for follow-up. Members can request PCP changes, DCO changes, and demographic changes through the online member portal. Additionally, members can utilize secure messaging through the member portal with any member concerns or questions. Care Coordination Requests, HRS, and HRSN requests may be submitted via the member portal. If a request for an HRSN or flex service is made through the member portal, it is forwarded to the appropriate benefit management team to enter a service request in service authorization programs. The member information is also forwarded to Care Coordination as a referral for case management when the member requests help from the plan including requests for services.
- 3) Connect Oregon- Is a coordinated care network consisting of healthcare, government, nonprofit, and other organizations. These network partners use 'Unite Us' software, a Community Information Exchange (CIE) platform, to securely identify and deliver services that address the needs of individuals within

their communities through a no wrong door approach. Unite Us receives resource data from 211 info and provides a non-English mode to assist for screening and document accessibility for non-English speaking individuals. This mode is a simple language assistance button that one can click and select their preferred language for translation. Additionally, multiple OHA approved screening tools are imbedded within the system. This platform enables secure, meaningful information sharing across sectors using state and federal certifications. In 2024, AllCare CCO created referral forms within the Unite Us platform to allow members, community partners, and providers to request HRSN services. These referrals are then forwarded to the HRSN benefit management team to enter a service request in service authorization programs. The requestor is notified in Unite Us when the referral is accepted, and again when a decision has been made. A copy of the approval or denial letter mailed to the members is included in Unite Us for requestors acting on behalf of members.

4) Phreesia is used in our network clinics to conduct SDOH screening, which involves assessing patients for social needs that may impact their health and well-being. This is typically done through a survey or questionnaire that covers various aspects of patient's social circumstances, such as housing, food security, transportation, and financial resources. When a patient screens positive for one or more social needs and agrees to receive assistance, a referral is processed through Unite Us.

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

Click or tap here to enter text.

Strategy 1 title: Identification And Electronic Referral of Members Who Have SDOH-E Needs

Brief description: Through completion of our Health Risk Assessment, community referrals, and provider referrals, we will identify members who have SDOH-E needs and utilize the Unite Us platform to send referrals to community partners, ensuring members who experience health changes are identified quickly and have access to resources needed to improve outcomes

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

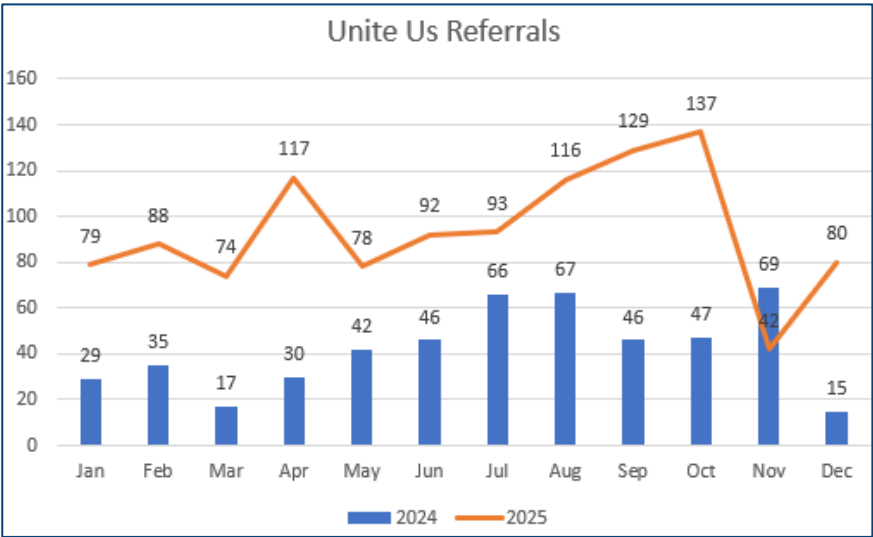
Progress (including previous year accomplishments/successes and challenges with this strategy):

CY 2024: In 2024 Population Health Care Coordination staff initiated 509 referrals on behalf of 287 individual members. Care Coordination staff supported members with the following referral pathways through closed loop referrals (order by case volume): Food Assistance 45%, Housing and shelter 18%, Individual and Family Support 13%, Income support 4%, Education 4%, Mental/Behavioral

Health 3%, Benefits Navigation 3%, Transportation 2%, Utilities 2%, Clothing and household goods 2%, Employment 2%. Demographics of the members supported were primarily female, adults aged 18-44. Population Health Leadership had set a target of 10% increase in referrals in 2024, an average of 24 referrals a month target to meet that 10% goal. Each month but two exceeded the target goal of 24 referrals; however, our annual total increase over the previous year indicated a 50% increase over the previous year in utilization. **Success:** Team continues to learn and find value in the engagement of this tool. Goal was met successfully overall, and a new benchmark was set for 2025. **Challenges:** Not enough community partners utilize the CIE to create robust utilization.

CY2025: AllCare Population Health set a new benchmark of a 15% growth target for 2025 and averaged 93 referrals per month in 2025. The team supported 579 members through the CIE platform to help address Social Determinants of Health (SDOH) needs. Population Health also launched a pilot program with a targeted community partner to receive referrals, which allowed members to receive support more quickly through the platform. Through this targeted pilot program, AllCare Population Health averaged receiving 42 referrals a month. Throughout the year, Population Health Leadership tracked referral activity, shared weekly updates on referral numbers, recognized top performers, and provided additional training when needed. Ongoing monitoring helped identify and celebrated strong users of the system as well as team members who needed extra support. **Success:** AllCare Population Health met and exceeded the 15% monthly referral growth goal for CY2025. The team also reached important milestones earlier than expected for the pilot program, meeting projected received referral targets in Q3 of CY2025. 247 members were supported by the CIE through collaboration with the Women's Health Center of Southern Oregon with a focus on high-risk members. Population Health Leadership plans to continue this work into CY2026. **Challenges:** Not enough community partners

utilize the CIE to create robust utilization.



Total Referrals Received from Identified Community Partner in Unite Us (CY2025)		Members Assisted
	Referrals	
7/31/2025	32	29
8/30/2025	41	41
9/30/2025	46	45
10/31/2025	66	65
11/30/2025	34	34
12/31/2025	33	33
Total	252	247

(Optional) **Overview of 2026-29 plans for this strategy:**

CY2026: AllCare Population Health Leadership will increase our monthly referral goal to 15% over the previous year for CY2026. The Population Health Leadership team will monitor and provide monthly updates on the number of referrals sent, recognize top performers, and provide any ongoing and additional training needed. The monitoring of this and consistent report to team members assists with identification of super users, and those that may need additional support. AllCare Population Health Leadership will meet quarterly with the Unite Us team to ensure that information about newly identified community partners is up to date, identify any barriers, and provide feedback about potential new community connections. AllCare Population Health Leadership and Unite Us will discuss any barriers and gaps in care and work collaboratively to ensure that AllCare is on track to meet the 15% sent referral target. Additionally, AllCare Health Leadership is currently receiving referrals from a targeted community-partner and will continue refining the workflow and training staff to improve efficiency. This partnership, supported by Unite Us, serves as a pilot to streamline processes and model future collaborations.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Establish a new “sent” referral goal of a 15% monthly increase over the previous year (1123 referrals in 2025). 1. Monitor referral volume and progress toward target (monthly). 2. Track and document training completion for both new and existing team members (monthly). 3. Increase the frequency of team communication regarding progress toward referral targets (monthly). 4. Share referral goals, performance updates, and expectations during All-Staff meetings (monthly).	A. Monthly reports starting in Q1 2026 identifying changes to the Community Information Exchange (CIE) and reviewing with the Population Health team during All Staff meetings. a. Target 107 referrals per month to achieve a 15% increase over CY2024. b. Provide updates to the team (monthly). c. Ensure proper training is provided and reported (monthly). d. Reports that identify changes to the CIE (monthly).
2. The AllCare Population Health Leadership team will conduct	B. Newly identified community partner information will be shared with the Population Health team (monthly).

Planned activities	Planned milestones
check-ins with the application team and targeted community partner. i. Ensure effective communication and provide up-to-date information to the Population Health team to support collaboration.	a. Complete standing meetings set up by Q1 2026- Quarterly check-ins to identify gaps in the CIE work, updates, and any changes in the platform.
3. Continue to receive referrals to the Population Health team from targeted community partner to promote collaboration. ii. Train team (monthly). iii. Streamline workflow (quarterly).	C. Continue to establish a consistent referral process with a targeted community partner (quarterly). a. Train all new hires upon hire and review (train monthly, review quarterly). b. Monitor and provide feedback/workflow changes if barriers are identified (quarterly).

Strategy 2 title: Educating On the Importance of CIE for Oral Health

Brief description: Our CCO will actively participate in at least one oral health state governance meeting, advocating for the expansion and utilization of CIE to better support SDOH-E needs identified by members. In addition to this engagement, we will explore opportunities to host a Lunch and Learn session focused on appropriate orthodontic documentation, aimed at improving provider understanding, documentation accuracy, and alignment with clinical guidelines.

To further strengthen collaboration and drive continuous improvement, we will also evaluate the potential of establishing our Dental Summit as an annual event. This forum will bring together key stakeholders to share best practices, review outcomes, and identify opportunities to enhance current CIE strategies and overall oral health initiatives.

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

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

AllCare has made meaningful progress toward advancing oral health collaboration and interoperability initiatives. The organization participated in state-level oral health governance discussions, reinforcing its commitment to expanding and utilizing Community Information Exchange (CIE) to better address members' SDOH-E needs. In addition, AllCare successfully hosted its Dental Summit, which served as a key forum for engagement and knowledge sharing across dental partners. During the summit, one of the Dental Care Organizations

(DCOs) presented on their interoperability efforts with Reliance and their contracted providers, highlighting practical applications of data exchange to improve care coordination and integration between oral and physical health services. The Dental Summit also provided an opportunity to evaluate its value as an ongoing, annual meeting. Feedback and participation levels indicated strong interest in continuing this forum to support alignment on best practices, documentation standards, and system integration strategies. Planning for a focused Lunch and Learn session on orthodontic documentation remains under consideration as part of continued provider education efforts.

(Optional) **Overview of 2026-29 plans for this strategy:**

Click or tap here to enter text.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. A planned Lunch and Learn session will focus on orthodontic documentation requirements, with an emphasis on improving the accuracy, completeness, and consistency of clinical records submitted by providers. In addition to core documentation standards, the session will include dedicated content and targeted slides	A. By Q4 2026, AllCare will develop and deliver a Lunch and Learn session.

Planned activities	Planned milestones
addressing the role of CIE in oral health.	
2. A 2 nd annual Dental Summit is being discussed, that will bring together key stakeholders across the network, with dedicated time focused on education and discussion of CIE as it relates to oral health.	B. By Q4 2026, AllCare will plan and host its 2nd Annual Dental Summit, convening key oral health stakeholders across the network.

Strategy 3 title: Increase Member Portal Membership

Brief description: Through the increase in membership to and utilization of our online member portal, AllCare CCO can provide more streamlined communication and access to information related to member's health plan benefits and care.

Strategy categories: Select which categories pertain to this strategy

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

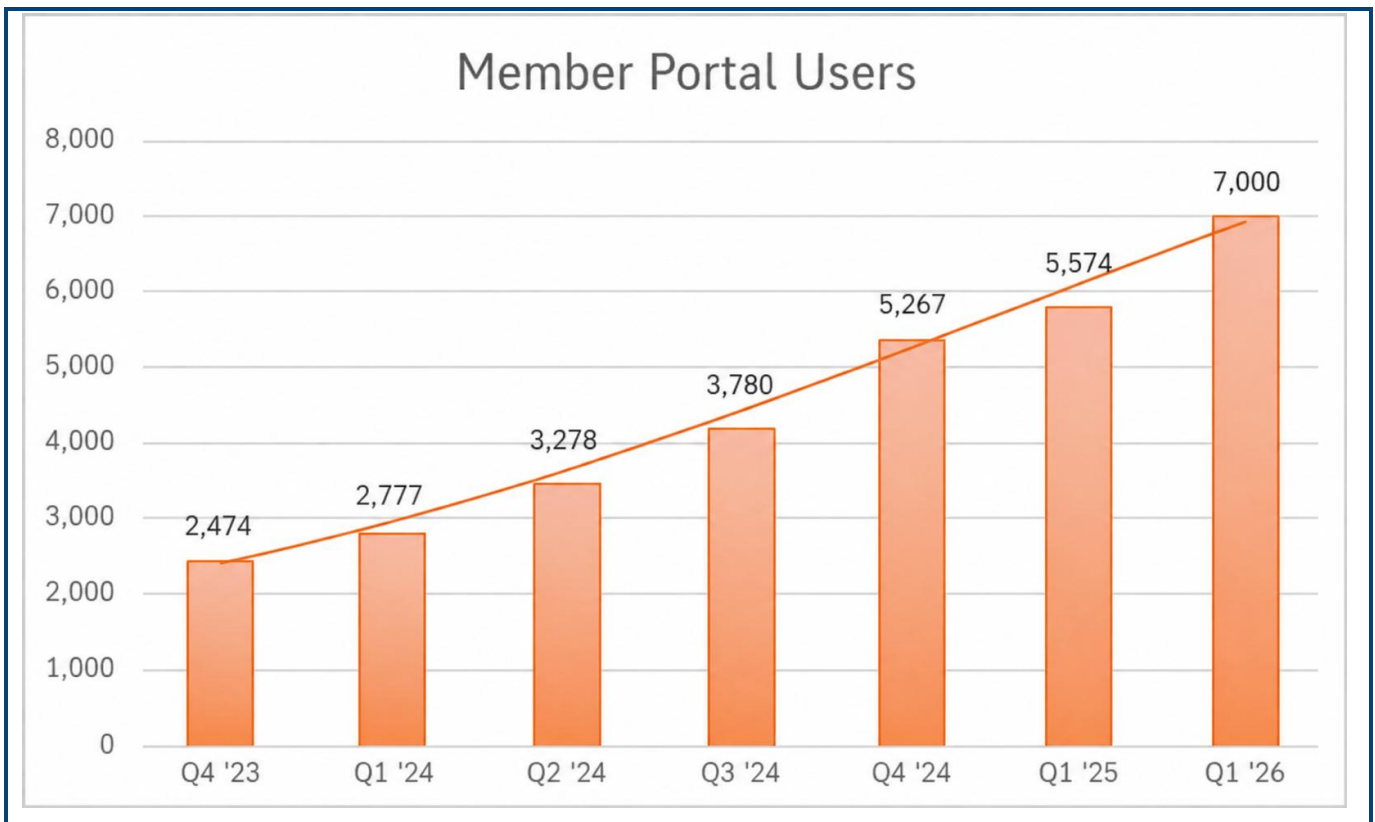
Strategy status:

- ☒Ongoing ☐New ☐Paused ☐Revised ☐Completed

☐ Ended/retired/stopped

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

As of March 9, 2026, approximately 7,000 members have enrolled in the Member Portal representing a 25% increase from 2025. This growth is partly attributed to the incentive program launched in 2024. Although the incentive ended in 2025 and was communicated to members by mail, engagement has remained strong. The Member Portal also provides easy access to the Health Risk Assessment, allowing members to complete and submit it directly to the Care Coordination team.



(Optional) **Overview of 2026-29 plans for this strategy:**

In 2026-2029, our goal is to increase our Member Portal usage from 11% of our CCO member population to 25%. The planned strategy is to continue growing the Member Portal through targeted marketing to new members and high utilizers.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Efforts are underway to evaluate options for enhancing the Member Portal to be more robust and user-friendly.	A. Grow portal membership to 25% of the total member base by end of the year.
2. Expand portal participation to 25% by the end of 2026.	B. Marketing campaign: Target new members and high utilizers.
3. Work with Marketing to develop a marketing strategy to encourage member engagement with the Member Portal	C. Member Portal Enhancement: Each phase will ensure key features are delivered, tested, and optimized to meet member needs.

B. CCO support of providers with using health IT to support SDOH: 2025 progress and 2026-29 plans

Please describe your 2025 progress and 2026-29 plans for **supporting** community-based organizations (CBOs), social service providers in your community, and **contracted physical, oral and behavioral health providers** with using health IT to support SDOH, including but not limited to screening and referrals. In the spaces below (in the relevant sections), please:

13. 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. **For listed tools, include a description of their use/role in the strategy descriptions.**
 14. (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.
 15. **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 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:
 1. Title and brief description
 2. Which category(ies) pertain to each strategy
 3. Strategy status
 4. Provider types supported
 5. Description of 2025 progress, including:
 - i. **Accomplishments and successes** (including the number of organizations of each provider type that gained access to health IT to support SDOH needs as a result of your support, where applicable)
 - ii. Challenges related to each strategy, as applicable
 - iii. How the strategy supports each type of provider selected
 6. (Optional) Overview of CCO 2026-29 plans for each strategy
 7. **Activities and milestones** related to each strategy CCO plans to implement in 2026-29
-

Complete list of strategy categories (supporting providers)

Please review the list of strategies below that you may have employed during 2025 and/or plan to implement during 2026-29. Check the applicable boxes for each strategy and describe your progress/plans in the sections below.

1. Sponsor CIE for the community
2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)
3. Integration or interoperability of health IT tools to support SDOH
4. Training and/or technical assistance
5. Support referrals between CBOs and clinical providers
6. Support HRSN service providers
7. Financial support to adopt or use health IT that supports SDOH (e.g., incentives, grants)
8. Support payments to CBOs through health IT
9. Requirements to use health IT in contracts/provider agreements
10. Track or assess CIE/SDOH tool adoption and use
11. Outreach and education about the value of health IT to support SDOH needs
12. Support participation in SDOH-focused health IT convenings, collaborative forums and/or education (excluding CIE governance)
13. Support participation in CIE governance or collaborative decision-making
14. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs
15. Other strategies for supporting access or use of SDOH-related data

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

The use of these tools should also be included in the applicable SDOH strategies below.

AllCare uses a variety of Health IT tools that can be utilized by providers, community partners, and members. These tools can be used for a variety of social needs screening and referrals. Current tools include:

- Provider Portal – Providers can check member eligibility, request PCP and DCO changes, and request care coordination for members via secure messaging. Providers can also submit and verify prior authorizations and view claims adjudication statuses.
- Member Portal (online) - AllCare CCO members have access to the Health Risk Assessment on the member portal and are able to complete this at a time of their choosing. Once completed, it is forwarded to the Population Health Team for follow-up. Members can request PCP changes, DCO changes, and demographic changes through the member portal. Additionally, members can utilize secure messaging through the member portal with any member concerns or questions. Care Coordination Requests, HRS, and HRSN requests may be submitted via the member portal as well.
- Unite Us - Is a closed-loop referral system that houses various screening tools for providers and community partners to access. This system receives data from 211 info making it a robust tool. This platform provides a non-English mode to assist for screening and document accessibility for Spanish speaking individuals. This system is free to use for non-profits, Patient-Centered Primary Care Home Programs (PCPCH), and Federally Qualified Health Centers (FQHC). Currently, AllCare covers the cost for a limited number of physical, oral, and behavioral health services providers to have access to the Unite Us platform. There are currently four OHA SDOH screening tools embedded in the platform for use:
 - ☐ PRAPARE
 - ☐ Accountable Health Communities (AHC)
 - ☐ Health Leads
 - ☐ Hunger Vital Signs

(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.**

Click or tap here to enter text.

Strategy 1 title: Advancing and Improving functionality and Use of CIE The Platform

Brief description: AllCare will work internally with key stakeholders and other CCOs, community partners, and Unite Us to improve standardized functionality and use of the CIE platform when possible. Through these collaborations, we will advocate the needs for and the development for change of Unite Us CIE platform. The goal is to improve standardized functionality in the state of Oregon and encourage use of the platform.

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

☒ Across provider types **OR** specific to:

☐ Physical health

☐ Oral health

☐ Behavioral health

☐ CBOs

☐ Social services

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

CY24: AllCare advanced its collaboration with Unite US, building on the 2024 roadmap and prior enhancements, including the integration of OHA-approved screening tools into the CIE Platform. While national platform constraints limit rapid customization, ongoing statewide coordination had supported incremental improvements.

Successes: Standardized referral pathways, improved provider and community partner education, and aligned workflows. **Challenges:** Variability in platform use across CCOs, competing priorities, and the need for continued provider adoption and training.

CY25: Monthly meetings were conducted with Unite Us with a planned milestone to decrease regional unresolved cases below 10% by Q4 of 2025. This planned activity was chosen to address the SDOH needs for individuals whose referrals were left unmet.

2025 Unresolved Case Rates

18.1% (Q1)

17.3% (Q2)

15.0% (Q3)

12.4% (Q4)

In the monthly meetings, we were able to identify a handful of community partners listed on the CIE platform whose program description was not accurate. This inaccurate information resulted in referral being sent for services not offered, adding to denied and unresolved referrals. Unite Us made outreach to the organizations, and program information was updated reflecting true services offered.

Our team also reviewed case comments on unresolved cases. We found most unresolved cases were the result of exhausted funds for biennium funded programs. Most of these were from Community Action Programs (CAP). These programs receive funding biannually for utility, housing and homelessness assistance programs. Cases are marked unresolved when funding is exhausted, and the individual is placed on a waiting list until funds are replenished. Case increases correlate with increased HRSN Housing referrals to HRSN provider organizations.

Successes: Unresolved case rates decreased each quarter; agency program descriptions are reviewed and monitored by increasing accurate referral rates.

Challenges: Unresolved case rates can be impacted by program funding resulting in unmet SDOH needs for an individual.

(Optional) **Overview of 2026-29 plans for this strategy:**

Despite a planned reduction in unresolved cases, we will continue to review program descriptions of program accuracy and monitor case comments for anomalies. This topic has also been added to the Unite Us training module for new and existing users.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Continue to monitor regional unresolved cases sent through the Unite US platform.	A. Run monthly case rate reports. B. Review case rate reports outcomes with Unite Us monthly.

Strategy 2 title: Expansion Of the Closed-Loop Referral System (Unite Us)

Brief description: AllCare will continue the expansion of the closed-loop referral system (Unite Us), internally and externally, to AllCare's community partners and providers. This expansion will be conducted by facilitating quarterly educational webinars, monthly community outreach, and internal monthly strategic planning meetings.

Strategy categories: Select which categories pertain to this strategy

- ☒1: Sponsor CIE ☐2: Enhancements ☐3: Integration ☒4: TA/training
☐5: Clinical/CBO referrals ☒6: Support HRSN ☐7: Financial support
☐8: Payments ☐9: Contract requirements ☐10: Track use
☒11: Outreach/education ☐12: Convenings ☐13: Governance

☐14: Other (adoption/use): [Click or tap here to enter text.](#)

☐15: Other (SDOH data): [Click or tap here to enter text.](#)

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

☐CBOs

☐Social services

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

CY24: Unite Us unlimited license access was made available to all providers within AllCare's service area March of 2024. This goal supports connecting community members to resources by increasing CIE access, adoption, and utilization within the region and is evident by an increase in network coverage. In 2024, AllCare conducted Unite Us training for 158 individuals that was provided onsite with a hybrid option and virtually. Onsite training was conducted 5/20/24, 5/21/24, and 7/26/24 in Josephine Co. Additional virtual training was provided 10/9/24, 10/15/24, 10/16/24, and 10/21/24 for AllCare's entire service area. Because of difficulties obtaining a training location in Jackson County, both hybrid and online trainings were made available for attendees. There was an attempt to conduct an in-person training for Curry and Coos in collaboration with Advanced Health but due to HRSN roll-out, Unite Us training has been postponed until Q2 of 2025.

CY25: AllCare holds monthly internal staff meetings with multiple departments to evaluate, assess, and progress CIE usage and adoption regionally. These meetings are held in support from Unite Us. The regional Unite Us rep provides technical assistance to any AllCare staff or community partner as needed. Additionally, AllCare continues to have monthly conversations with various Unite Us users. These conversations assess current training needs, accurate platform utilization, correct referral pathways to support the HRSN benefit, and other key functionality of the CIE platform. These conversations guide quarterly training needs for users. In 2025, AllCare and Unite Us provided quarterly in-person Connect Oregon training for all counties within AllCare's service area. Those in attendance were Community Advisory Council members, local providers, HRSN providers, state agencies, AllCare staff, and non-profits. A total of 228 individuals had been trained in 2025.

Josephine and Jackson County - Connect Oregon Training

Training Date	Number of Attendees	Agency Type
4/29/25	21	Contracted Provider
5/13/25	3	SDOH Partner
5/14/25	2	Contracted Provider
5/20/25	13	SDOH Partner
5/20/25	20	AllCare Staff
5/21/25	8	SDOH Partner
5/21/25	3	Contracted Provider
6/05/25	29	AllCare Staff
6/06/25	35	SDOH Partner
7/26/25	15	Contracted Provider
7/26/25	7	AllCare Staff
9/30/25	26	SDOH Partner
10/26/25	27	Contracted Provider

Curry County - Connect Oregon Training

Training Date	Number of Attendees	Location
3/12/25	13	Brookings, Or.
5/13/25	3	Gold Beach, Or.
5/14/25	3	Brookings Or.

Successes: In 2025, AllCare increased training attendance by 70 individuals. We are also noticing that during trainings more complex questions are being asked. This shows an increase in user sophistication of the system.

Challenges: Despite efforts to co-facilitate training with neighboring CCOs, it became clear that the functionality of the Unite Us platform looks different across CCOs. AllCare does not use the payment system in Unite Us for HRSN. It was agreed to keep referral training separate between CCOs.

(Optional) **Overview of 2026-29 plans for this strategy:**

AllCare recognizes the value of in-person training and will continue this model for CIE adoption. We will also partner with Unite Us to provide Insights training for our users. Insights are a useful tool that provides access to data that many organizations lack.

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones
1. Provide onsite training for community partners with a goal of training at least 85 participants in total. 2. Continue monthly internal meetings to support various OHA metrics and CCO contractual obligations. The goal is to increase internal workflows that support Unite Us referrals and usage. 3. Track quarterly CIE utilization to measure strategy success.	A. Conduct a one-day training course for community members. B. Training to be held before the end of Q2 2026; C. Training to be held before the end of Q4 2026; D. Provide Unite Us training fully in Spanish before the end of Q4 2026; training at least 15 participants. E. Use internal mechanisms that support community platform referrals. F. Each quarter, analyze quarterly tableau data on CIE client, case, managed case, and referred case totals.

Strategy 3 title: Accepting HRSN Referrals

Brief description: Create closed-loop process to accept referrals for HRSN services in Unite Us platform.

Strategy categories: Select which categories pertain to this strategy

- ☒1: Sponsor CIE
 ☐2: Enhancements
 ☒3: Integration
 ☐4: TA/training
☐5: Clinical/CBO referrals
☐6: Support HRSN
☒7: Financial support

- ☐8: Payments ☐9: Contract requirements ☐10: Track use
- ☐11: Outreach/education ☐12: Convenings ☐13: Governance
- ☐14: Other (adoption/use): [Click or tap here to enter text.](#)
- ☐15: Other (SDOH data): [Click or tap here to enter text.](#)

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 ☒CBOs
- ☒Social services

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

HRSN closed loop referrals: All service authorization requests, including those for HRSN services, have a closed loop referral requirement. Once a determination is made on a service request, the member and provider (or requestor for HRSN services) are notified of the decision in writing. The member will receive a letter outlining the decision and provided appeal rights if the service was denied. The HRSN requestor will receive the notification of the decision in the method the request was originally received whether that is by fax, mail, or via the Unite Us platform. Additionally, all decisions are available on the AllCare CCO provider portal for a member's PCP to view. Internally, the member's Care Coordinator is notified via email by the Benefit Management staff. Lastly, if the request came through a connector such as Unite Us, the determination letter is attached to the

members file within the Unite Us website and the case is closed.

The AllCare CCO goals for 2024-2025 for HRSN closed loop referrals involving Unite Us were as follows:

- Build referral forms for potential partners. **Completed in 2024 and reported in 2025 HIT Roadmap**
- Identify potential partners for CIE closed-loop referrals. **Completed in 2024 and reported in 2025 HIT Roadmap**
- Engage, contract, and credential potential partners. **Completed in 2024 and reported in 2025 HIT Roadmap**
- Offer training and education for partners on Unite Us referral processes. **Completed in 2024 and reported in 2025 HIT Roadmap**
- Go-live with referral process for climate devices. **Completed in 2024 and reported in 2025 HIT Roadmap**
- Create HRSN referral forms for housing support services. **Completed in Q2 2025**
- Go-live with referral process for housing support services. **Completed in Q2 2025**

2025 HRSN referrals: In the second quarter of 2025, AllCare CCO began taking HRSN referral requests for housing support in Unite Us and met the final two goals for the 2024-2025 HIT roadmap. Although we saw an increase in the number of HRSN referrals via Unite Us from 2024 to 2025, the number of requests from the platform is very small. There were 33 HRSN service requests in 2025 via Unite Us which accounted for less than 2% of the total service requests AllCare received last year. AllCare continues to receive the majority of HRSN referrals outside of the Unite Us platform.

This does not appear to have dampened AllCare's ability to successfully provide services. The below chart is from the Oregon Health Authority's HRSN dashboard for housing support services: [Oregon Health Authority : Health-Related Social Needs Benefits : Office of Health Analytics : State of Oregon](#). It shows through

12/31/2025 AllCare CCO provided more housing supports to OHP beneficiaries than all other CCOs except for Health Share and Pacific Source of Marion County.

Health-Related Social Needs: Member Demographics Last updated: 03-31-2026 | Data captures: 03-01-2024 to 12-31-2025

About HRSN		Population Eligibility Estimates		Member Demographics		Benefits		Providers	
Benefits:		Age	County	Race/Ethnicity	Language	Disability	Gender/Sex		
OHP members receiving HRSN services by Plan and age group Health Plan 0 - 17 18 - 26 27 - 44 45 - 64 65+ Total									
All		Advanced Health	2.1%	1.3%	2.0%	3.0%	2.5%	2.3%	
		AllCare CCO	8.6%	6.9%	7.7%	8.5%	11.5%	8.1%	
		Cascade Health Alliance	*	*	1.0%	1.0%	*	0.9%	
		Columbia Pacific CCO	*	1.4%	2.1%	2.4%	3.2%	2.1%	
		Eastern Oregon CCO	3.4%	6.6%	5.1%	5.5%	4.1%	5.2%	
		Health Share of Oregon	40.5%	27.0%	30.9%	28.3%	28.1%	30.3%	
		InterCommunity Health Network	6.8%	9.6%	8.3%	9.6%	7.4%	8.7%	
		Jackson Care Connect	3.5%	2.6%	3.0%	3.4%	3.9%	3.2%	
		Open Card	3.8%	4.0%	3.3%	2.6%	3.2%	3.2%	
		PacificSource - Central	4.5%	4.5%	4.7%	4.5%	4.1%	4.6%	
		PacificSource - Gorge	*	*	0.3%	*	*	0.3%	
		PacificSource - Lane	6.6%	10.8%	7.7%	7.6%	7.4%	7.9%	
		PacificSource - Marion Polk	8.6%	13.6%	12.0%	10.4%	10.1%	11.3%	
		Trillium Health Plan (SW)	1.4%	1.9%	2.4%	3.4%	4.6%	2.7%	
		Trillium Health Plan (TC)	3.7%	4.1%	5.1%	4.6%	4.4%	4.7%	
		Umpqua Health Alliance	*	1.9%	2.4%	2.5%	3.0%	2.3%	
		Yamhill Community Care	3.7%	2.6%	2.3%	2.6%	*	2.5%	
		Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Data Notes:

- * Indicates suppressed values where the number of individuals is less than 10 (including zero)
- Percentages based on small counts—particularly when the denominator is fewer than 50—may be unreliable and should be interpreted with caution. Counts should be emphasized instead.
- Age is based on age of member at the time they received their first HRSN service.
- If members are enrolled in more than one Health Plan, the member is counted in the rows twice but only once in the total.
- Some members receiving HRSN

AllCare intends to continue to allow for HRSN referrals with Unite Us for current and future HRSN services. Unite Us is another access point for members for HRSN services. At this time, AllCare CCO considers the prior goals for this strategy from the 2024-2025 roadmap successfully completed. AllCare CCO has concluded that our internal systems utilized for closed loop referrals, prior authorization and payment are successful. Section C of the 2025 HIT Roadmap listed the following goals for 2025-27:

- Goal to accept & process HRSN nutrition requests on go live date 1/1/2025.

Completed in Q4 2024.

- Onboard external HRSN Service Providers into the Provider Portal. **Completed in Q3 2025.**

- Accept service authorizations in the portal from external HRSN Service Providers by 5/1/2025. **Completed in Q4 2025.**

- Implement HRSN housing support referral form in Unite Us by 6/1/2025.

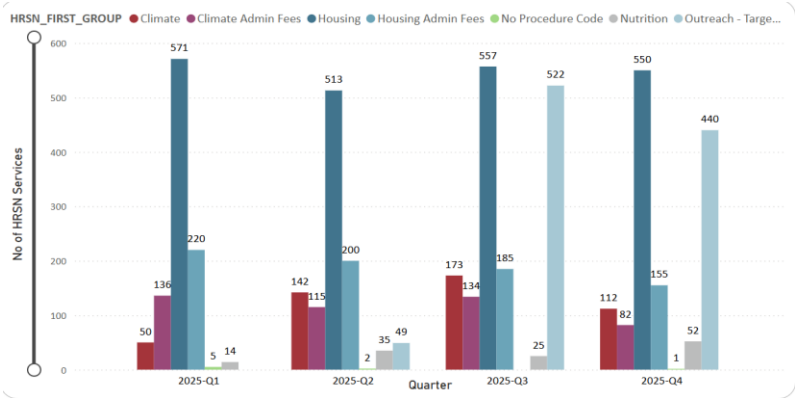
Completed in Q2 2025

Ongoing goals

- Target 95% of decisions made within compliance timeframes-evaluated quarterly. **Met for all four quarters for 2025.**

- Target of 90% of approved services delivered, monitored quarterly. **Exceeded goal with 97% of approved services delivered in 2025.**
- Goal to have 95% of encounters accepted by the State-evaluated quarterly. **Met: >95% of submitted 2025 encounters for HRSN were accepted.**
- Goal of 10% of the identified HRSN eligible population to receive services in 2025. **Not met.** In 2025, 1052 unique members received at least one HRSN service for housing, nutrition, or climate support. Although this is 14% of the baseline eligible HRSN population number (7500), the 1052 were not all flagged as baseline HRSN eligible. We did not meet the goal as it was worded.

The graph below shows the number of HRSN services provided per quarter of 2025. Totals include members that accessed more than one service (e.g. rent x six months) and/or multiple services (e.g. a climate device and rental supports).



(Optional) **Overview of 2026-29 plans for this strategy:**

Planned activities and milestones

Enter planned activities and milestones for this strategy in the table below. Please add or delete lines as needed.

Planned activities	Planned milestones

C. Exceptions process if CCO requires CIE

Does your CCO require HRSN service providers to use CIE for HRSN closed loop referrals? If “Yes,” you are **required** to complete the rest of this section. If “No,” please continue to SDOH section D: Health IT to support SDOH barriers.

☐ Yes

☒ No

Describe your CCO’s exceptions process, including:

1. How this process is communicated to HRSN providers
2. How HRSN providers request an exception to your CCO’s CIE requirement
3. Your CCO’s process for how those requests are reviewed, decided and communicated to the provider

N/A

CCO exceptions requests from HRSN service providers

On the following page, use the table provided **OR** your own table formatted with the same columns to report exceptions requests. You may remove rows or add additional rows as needed. Responses to this question must include:

1. Provider name
2. NPI/Provider ID #
3. Date of request

4. Reason for request
5. Request decision and reason for decision if denied
6. Date decision was communicated to HRSN provider

Provider name	NPI/Provider ID #	Date of request	Reason for request	Request decision and reason for decision if denied	Date decision was communicated to HRSN provider
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

D. Health IT to support SDOH barriers

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

An ongoing challenge in addressing Social Determinants of Health (SDoH) referrals is the limited interoperability across the various systems used by community stakeholders. Platforms such as Unite Us have improved the ability to initiate and coordinate referrals; however, they often lack full visibility into referral outcomes once a request is accepted, as service delivery and documentation frequently occur in external systems. While Community Information Exchange (CIE) platforms represent a meaningful advancement over traditional communication methods such as fax, email, and phone, they have not yet achieved the level of integration necessary to support seamless, end-to-end care coordination. As a result, care teams must still rely on manual follow-up, particularly emails and phone calls, to confirm that members have successfully received the requested SDoH services. Additionally, participation in platforms like Unite Us remains inconsistent across service areas. Rural areas often experience lower adoption rates, contributing to gaps in referral networks and, in some cases, creating service deserts that limit members' access to essential SDoH resources.

E. OHA support needs

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

Providing sustainable financial support for a platform like Unite Us across all stakeholders, including CCOs, would be highly beneficial. Establishing a clear and stable funding model would enable continued technological advancement, strengthen platform capabilities, and support broader adoption. Over time, this could position the platform as a robust, statewide solution, serving as a standardized, universal referral system to streamline SDoH coordination across Oregon.

6. (Optional) Other health IT questions

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.

AllCare uses a range of health IT tools and strategies to support patient engagement across the CCO and its provider network. At the CCO level AllCare uses data systems and dashboards to identify member needs and support outreach and targeted engagement for preventative care and chronic conditions. AllCare supports providers in using EHRs to improve patient engagement tools such as patient portals, secure messaging, online scheduling, and access to health information. Technical assistance is provided to help providers optimize these tools. AllCare is also expanding the use of HIE to improve care coordination, including hospital notifications that allow providers to follow up with patients after emergency department visits or hospital stays. Additionally, AllCare uses Unite Us platform to support referrals for social needs helping member to community resources through closed loop systems. AllCare will continue to expand digital tools and improve

system integration in 2026-2029 to enhance patient engagement across all provider types.

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

OHA can best support AllCare's Health IT Roadmap goals by aligning expectations with adequate funding and practical implementation support. Sustained financial investment is critical, particularly for rural, behavioral health and oral health providers that face ongoing barriers to EHR adoption, interoperability, and staffing. Without this support, progress will remain limited. OHA can also support progress through timely guidance, technical assistance, and realistic implementation timelines that allow providers to adopt new tools while balancing competing operational priorities.

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

AllCare's biggest challenges in advancing health IT strategies continue to center on limited bandwidth, time, and financial resources across both the CCO and contracted providers. Providers, particularly smaller, rural, behavioral health, and oral health organizations often lack the staffing capacity and technical infrastructure to adopt, implement, and sustain new health IT requirements. Competing priorities, including patient care demands and workforce shortages, make it difficult to dedicate time to training, system changes, and workflow redesign. From the CCO perspective, implementing multiple concurrent initiatives, evolving regulatory requirements, and system integrations requires significant internal resources and coordination. Timelines are often compressed, limiting the ability to fully operationalize solutions in a way that ensures long-term success and provider adoption. Financial

constraints also remain a key barrier. Investments in EHR systems, interoperability, HIE/CIE participation, and ongoing maintenance are substantial, and current funding levels do not always fully offset these costs. OHA can better support these efforts by aligning expectations with sustainable funding, simplifying and standardizing requirements across programs, and providing realistic timelines for implementation. Additional technical assistance and flexibility would further support both CCOs and providers in successfully adopting and maintaining health IT solutions.

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

AllCare has created a REALD dashboard from the data received from OHA that is used to identify groups of members with health inequities. This data is then used to identify barriers to care for these members. Using this information, AllCare is able to work with the members experiencing health inequities and find solutions to overcome these barriers.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Health IT Policy & Program Unit at CCO.HealthIT@odhsoha.oregon.gov or 503-373-7859. We accept all relay calls.

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