

2026 Health Share of Oregon 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

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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:

1. Health IT partnership
2. Support for EHR adoption, use and optimization
3. Use of and support for HIE for care coordination and hospital event notifications
4. Health IT to support social determinants of health (SDOH), including but not limited to social needs screening and referrals
5. Other health IT questions (optional section)

Each required topic includes the following:

- Narrative sections to describe your 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: [Click or tap here to enter text.](#)

1. Health IT partnership

Please attest to the following items.

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

☒ Yes

☐ No

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

☒ Yes

☐ No

- c. 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.)

☒ Yes *(Partner health plans have members on the Board)*

☐ No

- d. 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.**

Health Share's structure is based on collaboration and partnership between 11 founding members and 5 risk-holding delivery system networks. These networks are known as **Integrated Delivery Systems (IDS)** and an **Integrated Community Network (ICN)**. These networks serve all Health Share members and receive payments in value-based risk-adjusted payment arrangements with the CCO. Most of the activities in the HIT Roadmap represent the efforts and priorities of each entity in service to the broader CCO collaborative and the needs of their populations. Health Share plays a critical role in building alignment and partnership across these organizations to work on shared priorities based on the needs of the population. This alignment is done through formal committees and operational workgroups within the CCO's governance structure, with communication and alignment occurring through the CCO's monthly Health Information Technology Governance Committee. The HIT Governance Committee includes representatives from Health Share's 11 founding partners and HIT leadership from across the collaborative. It was created to set a forum for alignment and collaboration in the development of Health Share's initial HIT Roadmap and has been meeting regularly ever since.

New 2026 priorities at this level include leveraging data analytics investments to identify and address the high-acuity behavioral health needs population and the intersection of health and housing by exchanging data with county housing agencies and integrating data via an Enterprise Master Person Index (EMPI) system. We believe this technology will also assist with member data matching for the Reentry Benefit and related carceral care initiatives. With the provisions of HR1 nearing implementation, we expect to employ our systems and analytics

capabilities to identify vulnerable populations and tailor outreach to be as effective as possible.

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
2. Which category(ies) pertain to each strategy
3. The strategy status
4. Provider types supported
5. 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
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

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

The number of contracted **physical** health providers ***without*** EHRs decreased from seven in 2025 to **six** in 2026. The number of providers with an “unknown” EHR status went down from 449 to 413. The number of **behavioral** Health practices without EHRs went down from ten to **nine**, with the number of unknowns going down from 267 to 256. **Oral** health providers were the same as last year, numbering **sixteen** without EHRs.

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

CareOregon, which maintains contracts with 85% of Health Share's overall network, collects EHR usage information through their Provider Information Form (PIF). All contracted providers for physical and behavioral health complete this form as part of the new contract process. They also use this form when they need to update provider information such as adding individual providers to their organization, changes of address etc. Data from the PIF is then uploaded into QNXT, our claims processing system. CareOregon Dental (representing 100% of Health Share oral health providers) uses the same standardized internal PIF process for contracted partners. For subcontracted dental plans, CareOregon partners with the dental plans to review network composition and related activities.

Other health plan partners conduct surveys, including some formally on an annual basis, to obtain information on EHR's used by the network providers. OHSU's 2026 configuration of a new credentialing system will include collection and storage of EHR information.

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.**

Health Share's health plan partners demonstrate strong support for EHR adoption through standardized EHR use, robust interoperability strategies with other platforms, and expanded health information exchange capabilities.

Examples include:

Kaiser Permanente (KP) operates a unified Epic EHR instance across its internal providers, enabling consistent documentation and data sharing. KP supports information exchange with contracted clinicians through multiple interoperability pathways, including Care Everywhere for Epic users, Carequality, the Epic QHIN, and direct HL7 and FHIR-based integrations to support non-Epic systems. Contracted providers also access the Online Affiliate Link for information sharing and order placement. KP's recent implementation of TEFCA (which Legacy is also expanding use of) further strengthens cross-organizational data exchange.

OHSU Health IDS (OHSUH IDS) follows a Care Continuum Model that acknowledges varied EHR adoption levels across its provider network. While not all providers operate on Epic, over 80% of IDS members are served by two Epic systems supporting three hospital organizations (OHSU, HMC, and AHPL). OHSUH IDS emphasizes data structure, access, and integrity as foundational to its health IT strategy.

Epic is the primary platform supporting population health and care management activities, including member roster ingestion, quality measurement, SDOH documentation, care coordination, and risk stratification. Epic health information exchange tools connect OHSUH IDS to external providers not on its Epic instance (also including use of Epic's Healthy Planet application), supplemented by integrations with partners such as PointClickCare for emergency department data and Connect Oregon via secure file transfer.

For analytics and reporting, OHSUH IDS utilizes Epic's Data Warehouse, which integrates internal and external data sources. Standard enterprise reporting tools—including Business Objects, Tableau, and Power BI—support dashboards and reports for leadership, staff, and end users.

Legacy's approach to supporting EHR use and optimization in care coordination includes extending the EHR to **Community Connect** partners, and leveraging web based and direct messaging tools across organizations and care settings to facilitate care coordination and encourage EHR adoption. Examples include using a combination of web portal and Direct messages to engage post-acute care management and placement resources, use of direct FHIR integration with Point Click Care for shared care planning, and utilizing C-CDA content and Direct messaging infrastructure to facilitate region-wide burn treatment consultation and referrals.

CareOregon has also implemented Epic's Payer Platform allowing for new opportunities to connect with EHR's, further encouraging their use to potentially increase collaboration and reduce administrative burden.

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

Brief description:

Through their team of Network Optimization Specialists, CareOregon provides technical assistance or practice coaching throughout their physical health provider network to support various clinic and system transformation goals. This includes identifying opportunities to use EHRs more meaningfully to improve workflows, support CCO Quality Metric documentation, support Value Based Payment performance, and exchange clinical data to inform a comprehensive and shared picture of member and population health.

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, CareOregon continued deepening their relationship with OCHIN in mutually supporting our shared Community Health Center network by providing approximately 25 hours of technical assistance through learning collaborative sessions and site visits. The focus of these activities was workflow optimization, both in terms of using new data received through [Epic] Payer Platform connections and in terms of specific improvements in problem list clean-up and management, risk capture documentation, and leveraging extended care team members in these processes.

While the VBPM pilot was completed in Q2 of 2025, the pilot sites, OCHIN and CareOregon teams identified multiple opportunities to address and implement enhancements to the tools prior to launching a first wave expansion to additional CHC partners. CareOregon decided to use the 2nd half of 2025 and Q1 of 2026 to refine the VBPM dashboard views, add additional informational metrics, and configure the quality and performance metrics to align with the true metric specifications as outlined in VBP contracts. The pilot was subject to Epic corporation implementation requirements that only enabled 'out of the box' measure selection. Once the pilot was over, OCHIN was able to begin custom measure builds, which has recently been completed for 2026 CareOregon VBP contract performance measures.

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

CareOregon will continue providing support to make optimal use of data shared through EPP exchange features. Plans for expansion of new EPP features, as well as participation within the ICN network, are fundamental to these efforts and are described in Strategy #2 of section 4A. While CareOregon intends to continue

providing optional funding for FQHC partner adoption of the VBPM and HEDIS measure analytic tools, financial constraints have led to challenging sustainability-based decisions, limiting the number of new partners offered this funding in 2026. Additionally, CareOregon is partnering with OCHIN to hold 1-2 webinars for shared network partners focused on EHR developments and workflow improvements planned and in-process focused on CHC preparedness for HR1 changes in redetermination timelines and work requirements.

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 funding for adoption of VBPM/HEDIS analytic tools to OCHIN Epic network partners.	A. 1 additional FQ partners will adopt VBPM & Certified HEDIS measures analytic tools by Q1 2027.
2. Provide TA to network partners participating in EPP on optimization of data shared through existing and new exchange features.	B. Hold 1-2 webinars in partnership with OCHIN on HR1 impacts and plans/developments in process for CHC preparedness by end of Q3 2026.

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

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

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

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

Strategy categories: Select which 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, the five providers collectively known as the SHIFT cohort—Cascadia, Clackamas Health Centers, Morrison, New Narrative, and Volunteers of America—carried out the tasks outlined in their approved business and implementation plans. Each provider included at least one EHR focused objective aimed at expanding and optimizing their business intelligence capabilities.

Completed objectives and strategies included developing data and IT infrastructure such as segmentation and risk stratification tools, integrating demographic and historical county data into dashboards, improving documentation efficiency by streamlining intake and assessment workflows through technology, and completing early EHR optimization activities such as data integrity reviews, go live cleanup, and user guide development. Basic computer skills training using staff's preferred learning methods were also provided.

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

In 2026, the cohort is pursuing several key objectives to strengthen population health analytics and care coordination. These include expanding team-based care and tracking progress through EHR based management metrics, including: Advance EHR enhancements to strengthen Provider-level population-health analytics capabilities. Improving the completeness of REALD demographic data, developing measures for service utilization, quality outcomes, and a rolling five-year cost and capacity forecast, and creating a comprehensive business intelligence roadmap to guide

ongoing data-driven strategy.

It is important to note that, although each provider is approaching EHR optimization differently, they are actively sharing lessons learned with one another through a Data Specialist-focused meeting that the cohort launched and manages independently of CareOregon. These grassroots and collaborative efforts suggest that the SHIFT initiative is positioned to have a sustainable impact well beyond the final performance year in 2026.

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. Advance EHR enhancements to strengthen Provider-level population-health analytics capabilities.	A. 4-of-5 Providers will deploy updated data analytics dashboards by 12/31/2026.
2. Strengthen Business Intelligence (BI) Governance and Roadmap Development.	B. All Providers will quarterly report on EHR metrics in accordance with their agency's plan to monitor outcome measurements reflecting the impact of team-based care approaches by 3/31/2027.
3. Establish improved documentation workflows and review processes to reduce staff burden and increase data quality.	C. 4-out-5 Providers will implement prioritized workflow optimization changes by 12/31/2026.

Strategy 3 title: OHSU - Extend Epic capabilities overall for AHPL / HMC / OHSU

Brief description: Enhancing SDOH documentation, risk scoring, and external integration

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):

OHSU successfully extended Epic's SDOH functionality to AHPL (Adventist Health Portland) in 2025 and developed other workflows and processes for Cheers (Epic's customer relationship management application) across OHSU, HMC (Hillsboro Medical Center), and AHPL. Cheers campaigns were created and run to inform CCO members of climate-related events, well-care visits, diabetes A1c, colorectal cancer screening, etc. were implemented in primary care across OHSU,

HMC, and AHPL. These campaigns provided significant improvements for the corresponding quality measures. OHSUH, however, ran into organizational challenges for leveraging Cheers campaigns for health risk assessments, which forced OHSUH to use a different strategy for collecting health risk assessments.

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

OHSUH will continue work on refining risk scoring calculations so that it will now include Behavioral Health claim data. In addition, [internal] risk scoring for pediatric members will also be applied. Also in 2026, OHSU will largely focus on the necessary actions to support AHPL transitioning to their corporate instance of Epic while maintaining the required data exchange and coordination to support the critical functions of the IDS.

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. Reviewing and assessing impacted areas	A. AHPL transition date 8/30/26
2. Developing a transition plan	B. Various reports that contain risk scores will also now include pediatric members.
3. Establish expectations between OHSUH IDS and AHPL following the transition	C. Inclusion of BH data in risk calculation.
4. Application of risk calculation to pediatric age members	
5. Include BH claim data in risk score calculation	

Strategy 4 title: OHSU - EHR utilization in Complementary medicine and Ancillary services

Brief description: Supporting ancillary provider with EHR 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):

Work was stopped due to cost barriers to the ancillary providers. Most ancillary providers without an EHR were doulas working independently and not participating in a specific doula group or hub. Two acupuncturists did not adopt an EHR because the cost was prohibitive.

(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
1. N/A	A. N/A

Strategy 5 title: OHSU - Campaigns using Epic Cheers

Brief description: Utilize the Epic platform for member outreach

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):

The IDS was successful in utilizing CHEERS campaigns for specific member notification of extreme weather events throughout the year while also partnering with Primary Care to

launch multiple campaigns that ultimately yielded positive impacts to our quality performance.

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

OHSUH IDS will continue partnering with OHSU Primary Care to identify areas where Cheers campaigns will positively impact both primary care and the OHSUH IDS.

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. Supporting Cheers campaigns in ambulatory care 2. Cheers will support outreach efforts to reach members during climate events such as heat or cold weather periods to inform of options for safety.	A. Cheers campaigns for climate events will be ongoing as events arise. The process is established and working as intended.

Strategy 6 title: Providence – Support EHR Optimization

Brief description: Population Health and HIE integration

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):

1: Continued implementation of Innovacer Population Health tool to aggregate EMR and hospital event data into pediatric HIE and for reporting of eCQM reports for all Children’s Health Alliance (CHA) clinics: Still relevant/accurate, no updates. 2: Established additional practice, Dr. Shannon Brigman, in February 2025. 3: Established community Epic users to meeting regularly and help identify and enhance alignment in documentation methods and workflows across practices within the EHR 4. Created EHR interface “health check” reports to address any issues prior to reporting deadlines.

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

1: East Portland Pediatrics (EPPC) will transition from a CCDA based data interface to a direct database connection in March/April 2026. 2: Children’s Health Alliance pediatric practices intend to continue utilizing the Innovacer Population Health tool to aggregate EMR data into pediatric HIE and for reporting of eCQM reports through 2026 and possibly beyond.

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. Prepare for EPPC transition to direct database connection 2. Expand interface data quality checks, including automation 3. Forecast and plan the Children's Health Alliance population health analytics strategy for 2027-2029 4. Continued use of QI reporting dashboards for provider-level data, care gap lists, equity analysis and documentation for reporting across WCC, Immunizations, and Screenings 5. Assist clinics with eCQM reporting, Language Access documentation and reporting and contract performance 6. Facilitate discussions and trainings to support additional documentation and reporting capabilities within EHRs for eQMs 7. Establish year-over-year analysis and additional opportunities to close gaps by year-end	A. Complete EPPC interface transition B. Data interface quality dashboard documentations completed C. Monthly updates to QI dashboards completed within 2 week so of month-end D. Ensure all reporting requirements for are completed and performance is optimized for all CHA clinics by completion of each quarter E. Meet with clinic users quarterly to align expectations and workflows for streamlined data collection from EMRs to HIE

Strategy 7 title: Legacy Community Connect

Brief description: Legacy Health offers a robust Community Connect program (EHR hosting). The program has been in place since 2012 and remains a large strategy for CCO EHR adoption, although it is no longer enrolling new partner organizations.

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):

Legacy Health has funded a subsidized EHR adoption program for 13 years called Legacy Connect. This program has connected over 30 Oregon/ Southwest Washington private practices and over 500 providers (primary care, specialty, behavioral health). This program has enabled EHR adoption to providers who

would not otherwise be able to contract with Epic and therefore connecting providers into the community ecosystem of exchange. Separately, but related...as part of being part of Legacy Health Partners (CIN), it is required that partners have a certified electronic health record. This further supports related ONC requirements. Partnering with “competing” Connect programs to ensure all community and statewide find a fit for EHR adoption programs. Additional progress specific to behavioral health providers: Legacy Connect program also supports a sub-acute behavioral health inpatient center and one critical access hospital.

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

Continue supporting the program by restarting implementations previously paused due to the pandemic with focus on Primary Care, Pediatrics.

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
8. N/A	B. N/A

Strategy 8 title: Legacy – Furthering Health Information Exchange

Brief description: Expand TEFCA data exchange framework support

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):

Expanding support for TEFCA (*Trusted Exchange Framework and Common Agreement*) framework

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

- Participate in pilot EMS/EHR integration -- expand CCD and Direct Message based wound consult partnerships.
- Assessing Epic Payer Platform for both data exchange and workflow automation around authorizations and referrals.
- Expanded and standardized use of Care Everywhere Referrals Management and 360x for closed loop referral communication.
- Expanded and standardized use of Care Everywhere Image Exchange to reduce the need for duplicative diagnostic imaging studies.

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. Pilot EMS/EHR integration	A. Pilot go-live Q2 2026
2. Expand CCD and Direct Message-based wound consults	B. Live – expand through 2026
3. Assess Epic Payer Platform	C. Initial use Q4 2026
4. Expand Care Everywhere Referrals and 360x	D. Live – looking for trading partners for 360x
5. Expand Care Everywhere Image Exchange	E. Q3 2026

B. EHR support barriers

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

In 2025, competing priorities across CCO staff, network partners and technology vendors has been the largest barrier to progress.

Funding limitations due to OHA rate

challenges have also impacted previously planned expansion of financial support to the provider network.

The SHIFT project cohort partners have experienced delays due to staff turnover and policy changes relative to the timelines submitted in

2024. However, CareOregon has adjusted plans and Providers remain on track to complete all tasks by December 31, 2026.

Unclear guidelines for documentation or overly administratively burdensome guidelines in new benefits often lead to non-compliance or bad data integrity. i.e., Language Access requirements, HRSN Climate Benefit.

Costs and resources to maintain the program: Legacy subsidizes the Connect Program at 70%, which over time can be very costly.

Provider resource challenges continued to reduce the time and willingness for partners to engage on this topic.

C. OHA support needs

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

OHA can support efforts by providing additional funding to CCOs with promising practices to support EHR uptake and expansion, including support for all continuum of care providers to adopt EHR technology that integrates with HIE. Additionally, continue to align CCO incentive metric specifications with nationally recognized and standardized metrics to enable easier EHR configuration, workflow changes, and reporting ability. Lastly, providing targeted grant funding for SHIFT would support expanded analysis and report development focused on the lessons learned from that cohort of providers as they enhanced their EHR and business intelligence capabilities. OHA can encourage providers in-network with OHP fee-for-service to adopt and utilize EHR (and HIE) to better support coordination with CCO-contracted providers. It would help to provide more clarity about expectations related to complementary medicine and ancillary providers, if these provider types are to be part, or not part, of the movement towards EHR adoption. If intended to be part of this work, financial incentives and support are necessary. Phased-in requirements for data reporting that allows ample time for system set up, testing and modification: The expectation of being ready days / weeks prior to release of final rules is unrealistic.

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:
 1. A title and brief description
 2. Which category(ies) pertain to each strategy
 3. Strategy status
 4. 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
 5. (Optional) An 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. 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.

Point Click Care (PCC) is a Health Information Exchange that hospitals across Oregon connect to. CareOregon Regional Care Teams use this as a source of hospital inpatient and Emergency Department admission and discharge data to trigger care coordination referrals and transitional support processes. Delegated Dental Care Organizations also utilize Point Click Care to assist with oral health related care coordination and outreach. Health Share's **Integrated Delivery Systems (Legacy/PacificSource (2025), Kaiser, OHSU, and Providence)** have implemented this system in hospitals/EDs, provider practices, and health plan

settings. Additionally, **Kaiser Permanente** is part of a vast health information exchange network, with the ability to exchange patient records with nearly 145,000 healthcare organizations and individual practitioners nationwide through the **Carequality, eHealth Exchange, TEFCA** (Legacy also participates), and **Care Everywhere** frameworks.

Information exchanged includes a clinical summary, encounters, lab results, non-lab results, care plans, images, and much more. Multiple partners leverage standard clinical document sharing standards such as Coordination of Care Documents (**CCD**) and **FHIR APIs** to exchange information with providers. **Care Everywhere** is a module of Epic EHR that allows for the exchange of patient health information between providers who use Epic. This technology is in use among all Health Share partners. Health Resilience Specialists and Panel Coordinators who are embedded in clinics that use Epic have access to Care Everywhere. **Compass Rose** is the new Epic-based care coordination platform implemented by CareOregon in November of 2023. Admission/Discharge/Transfer (ADT) data from Point Click Care enter Compass Rose directly so that care teams are only required to interface with one tool. **Epic Payer Platform (EPP)** is an Epic module CareOregon uses to exchange data with participating network partners (see next section) to provide a more complete picture of our members' health, risks, and to facilitate closer communications with our provider-partners. There are multiple features within Payer Platform that allows us to receive, send, or exchange data for various purposes. Two that are currently operational are:

- Clinical Data Exchange
 - Automated electronic release of appropriate information to insurers
 - Reduces manual records requests, denials, and time spent processing claims
- Scheduling Notifications
 - Automated notifications to insurers when members schedule/reschedule/cancel appointments
 - Increase compliance with follow-up care and support care coordination.

CareOregon Link An extension of Compass Rose, Healthy Planet Link (titled

CareOregon Link within their network) is an additional Epic module (website-based portal) utilized by select, delegated, external community partners. It offers care management functionalities such as documentation (e.g. assessments and program enrollment) and analytics. As of April 2024, our delegated CareOregon Link partners include Housecall Providers' Advanced Illness Care team.

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

Health plans within Health Share use **Point Click Care** as a source for hospital inpatient and Emergency Department admission and discharge data to trigger care coordination referrals and related member supports. DCOs also utilize Point Click Care to assist with oral health related care coordination and outreach. Reports from the PCC system provides risk stratification and specialty population information to help organize outreach efforts. Integrated Delivery systems additionally leverage native Epic functionality to deliver real-time hospital event notifications to providers on that platform. We are also seeing growth in national data sharing networks either through Epic or independent organizations some of our partners are participating in.

Strategy 1 title: CareOregon - Optimizing and Expanding the Use of Point Click Care by the Regional Care Teams

Brief description: Optimizing and expanding the use of PointClickCare (PCC) by the Regional Care Teams and other outreach teams. Regional Care Teams (Care Coordination Teams) and other outreach teams use PCC to receive Hospital Event Notifications. The event notifications feed directly into our care coordination

platform, refresh hourly, and alert care coordination teams when one of the members on their panel is experiencing an event. We also use cohorts and reports from the application to proactively identify and refer members to care coordination. Examples of cohorts and reports include:

- DSNP Members with Acute Care Admits
- Medicaid members hospitalized for ≥ 4 days
- Psychiatric Acute Care Admits and Discharges
- BH Cohort – Members who present to the ED for a behavioral health related concern
- Diabetes Cohort – Members who present to the ED or Inpatient for diabetes related concern
- 3 ED Visits in 90 Days
- 5 ED Visits in 12 months
- Pediatric Asthma ED Activity
- Rising Risk ED/IP/OBS/SNF – Admit
- Members initiating and engaging in treatment for substance use
- Medicare Members w/Multiple Chronic Conditions/ ED outreach

Strategy categories: Select which 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):

In 2025, CareOregon launched a new workflow to strengthen use of PointClickCare (PCC) hospital notifications: **Medicaid Proactive Rounding**. Through this process, Regional Care Teams review PCC reports identifying Medicaid members who have been hospitalized for more than four days. Each week, every RCT meets with its assigned medical director to discuss these cases, focusing on whether any members may be clinically ready for discharge but remain inpatient due to social determinants of health (SDOH) barriers. When SDOH related barriers are identified, a care coordinator is assigned to collaborate with the hospital care team to address those barriers and support the member's discharge back to the community or to a more appropriate level of care. This program was launched in October of 2025. We worked with our Informatics and Evaluation team to come up with cost avoidance measures related to the launch of this program. Population estimates were based on the first 3 months of the program which the RCTs were able to engage 156 members. While the final evaluation of this program will occur at the end of 2026, the cost avoidance assumptions include: reduced ED rate post discharge, reduced readmission rate, and increased PCP/specialty care engagement.

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

CareOregon has several initiatives planned for implementation over the next few years to expand transitional support capabilities. Soon, we will launch a transitional support program for members who are inpatient due to complications related to Congestive Heart Failure (CHF). Because CHF members experience higher readmission rates than most other populations, this program will focus on providing post discharge support aligned with each member's

discharge plan, with the goal of preventing avoidable readmissions or emergency department visits. In addition, we plan to implement two more transitional support programs: one designed for members residing in Skilled Nursing Facilities, and another for members who are inpatient with a substance use disorder diagnosis.

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. Determine diagnosis codes to include in for CHF	A. Launch of the CHF Transitional Support Program – 3/30/2026
2. Meet with PCC to talk through program and cohort design	B. Implementation of SUD Transitional Support Program 7/1/2026
3. Build cohort within PCC	C. Determine whether to implement SNF transitions workflow (dependent on contract approval terms) – 7/1/2026
4. Test ADT feed from PCC to Compass Rose	
5. Repeat steps 1-4 for Substance Use Disorder	
6. Meet with PCC to determine how best to use SNF data in PCC	
7. Determine whether we can build a SNF feed from PCC to Compass Rose	

Planned activities	Planned milestones
8. Update contract to include SNF ADT feed if indicated and approved by CO leadership	

Strategy 2 title: CareOregon - Epic Payer Platform (EPP) Implementation

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

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):

In 2025, CareOregon achieved complete participation in Payer Platform of all OCHIN Epic network partners.

CareOregon's initial discussion with OHSU showed interest, but we were unable to establish a timeline for participation as OHSU was, at the time, tracking

towards a merger with Legacy Health Systems. Decision was made to pause the conversation for 2025. Plans to approach Providence paused with intent to revisit when additional exchange features focused on quality metrics and member attribution were live.

Due to rising concerns regarding organizational sustainability amidst Federal and State financial constraints and challenges, priorities and subsequently staffing and resources necessarily shifted in 2025. As a result, planned implementations of new Payer Platform features were pushed out to 2026.

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

CareOregon intends to continue exploratory conversations with Epic-using network partners regarding participation in Payer Platform. In 2026 and 2027, CareOregon will be implementing the following additional features: **Clinical Analytics Document (CAnD)**: Pulls targeted supplemental clinical data from a broader set of visits to improve quality measure accuracy. **Care Gaps Exchange**: Sends CCO-calculated care gap statuses for attributed populations. **Member and Attribution Exchange (MAX)**: Automated membership data feed inclusive of total assigned/attributed populations, creates an Epic record for members assigned but not yet seen, and enables clinics to manage population health needs, gaps, and outreach for the entire population in the EHR. **ID Card Exchange**: Shares health plan ID card images from payer to provider. Reduces registration time by eliminating need to manually scan ID cards. **Coverage Finder Exchange**: Enables real-time eligibility queries between provider and health plan. Eliminates need to transcribe insurance card IDs during registration. In mutual recognition and desire to support shared network partners, CareOregon staff continues to meet with OCHIN's project team weekly

to discuss progress, triage issues and plan next steps. This will continue through, at minimum, end of 2027.

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. Approach EPP participation with regional hospital systems. 2. Continue support of Epic upgrades/implementation of Payer Platform features. 3. Continue communication to participating network partners of Epic upgrades/implementations of Payer Platform features.	A. Engage in discussions with OHSU hospital system and Legacy hospital system to explore EPP participation by Q1 2027. B. Implement, socialize and support network partners in uptake of the following Payer Platform features: C. CAnD – by end of Q4, 2026 D. MAX – by end of Q4, 2026 E. Care Gaps Exchange – by end of Q4, 2026 F. Coverage Finder – by Q1, 2027 G. ID Card Exchange – by Q1, 2027

Strategy 3 title: CareOregon - Implementation of a New Care Coordination Platform

Brief description: CareOregon selected and implemented a new care coordination platform in late 2023 which is primarily used by our care coordination and outreach teams. The new platform allows for improved workflows as well as

integrated social determinants of health and social needs data.

Our selection was based on high integration with current technology and tools, improved workflows and efficiencies for our care coordination teams to support members as well as the ability to better report and adapt to changing needs and requirements. This intervention also applies to the HIT for SDOH.

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):

CareOregon implemented several new workflows in Compass Rose and onboarded multiple new teams, including a dental care coordination team. They also launched a High Risk Pregnancy program, which involved creating a dedicated assessment, care plan, and documentation templates to capture the key data points needed to measure program outcomes and success. In addition, with the rollout of Epic Payer Platform (EPP), they can now view clinic notes from participating providers, giving care coordination teams timely access to critical information related to each member's pregnancy journey.

CareOregon implemented a workflow that allows bulk PDF uploads into the

system, saving valuable staff time and improving efficiency. In addition, HRSN workflows are now fully implemented across the platform. The workflow related to the DHS metric, designed to ensure timely delivery of services for youth new to foster care, has not yet been built or deployed into Compass Rose. Although this has not yet been integrated into the system, the workflow is currently happening and documented to capture reporting for the metric. Competing priorities and several higher impact workflow implementations required focus earlier in the year.

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

2026-2029 plans for this strategy are directly related to plans for strategy #1 above, including the implementation of new transitional support programs for members with CHF, SUD, and for members in SNFs.

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. Review what Epic currently has built in the system for CHF, SUD, and SNF admissions	A. Launch of the CHF Transitional Support Program – 3/30/2026
2. Determine new build needs	B. Implementation of SUD Transitional Support Program – 7/1/2026
3. CHF - System Configuration and testing	C. Implementation of SNF Transitional Support Program – 9/1/2026
4. CHF – Clinical and workflow training for staff	

Planned activities	Planned milestones
5. SUD - Develop strategy 6. SUD – System Configuration and Testing 7. SUD – Clinical and workflow training for staff 8. SNF - Develop strategy 9. SNF – System Configuration and Testing 10. SNF – Workflow training for staff	

Strategy 4 title: OHSU - Third Party EMR Social Needs Data Exchange

Brief description: Formerly titled: Expand Epic’s Population Health Query to additional sites.

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):

HRSN – begin to utilize Insights reporting provided through Connect Oregon.
PAC – discontinued due to other internal reporting available.
Connect Oregon – social needs referral status.
Risk – OHSUH IDS developed a custom tool for calculating risk and created standard processes and workflows that use the risk score.
Cheers – Campaigns were created and utilized to notify members of climate related events.

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

No new / additional plans. Continuing with current plans.

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. Monitor HRSN utilization and data reporting from Connect Oregon; continued participation in Connect Oregon Payments workgroup.	A. Cheers campaigning to align with primary care on a quarterly basis.
2. Monitor HRSN utilization and data reporting from CBA.	
3. Build Risk Stratification workflow and reporting SOPs.	B. Q2 2026 incorporate pediatric and behavioral health data.
4. Work with Connect Oregon to evaluate connectivity to EPIC for social needs referral status.	

Strategy 5 title: OHSU - Development of a [new] Risk Stratification tool

Brief description: A predictive model, developed for care management team use. Tool combines historical data from EHR and claims data to calculate a risk score, then prioritizes based on highest at 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):

Completed development of a Risk Stratification tool, that is integrated within Epic, which allows care integration team to identify member's health risk score, prioritize engagement, and measure long term member care.

(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
1. Track / Trend strategy from UM and Care Management perspectives. 2. Review Risk results against Actuarial results. 3. Integrated the risk scores into Epic 4. Incorporate behavioral health and pediatric data into the risk scores.	A. Quarterly check-in for process improvement B. Year-end review with results provided by HSO Finance.

Strategy 6 title: Continued and enhanced use of Point Click Care

Brief description: Leverage PCC data to identify and address the needs of high-acuity behavioral health needs population

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: Population insights and Operational optimization

Strategy status:

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

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

Health Share created a “High Acuity Behavioral Health” flag in the PCC system to capture insights related to this population that will be integrated with Health Share’s data warehouse. The intent is to inform care coordination strategies, utilization modeling, benefit operations and governance. An interactive High Acuity Behavioral Health dashboard was built to support this work in 2025.

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

Provide key metrics and analysis to monitor quality/performance related to behavioral health benefits including network and facility utilization patterns, KPI reporting. Continue to build out the High Acuity Behavioral Health dashboard in support of that population.

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. Behavioral Health benefit utilization and performance dashboard(s)	A. 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:

- List and describe specific HIE tool(s) you currently or plan to support or provide for care coordination and hospital event notifications. CCO-supported or provided HIE tools must cover both care coordination and hospital event notifications. Please include an overview of key functionalities related to care coordination.
- Report the number of physical, oral, and behavioral health organizations that have not currently adopted HIE tools for care coordination or do not currently have access to HIE for hospital event notifications using the Data Completeness Table in the OHA-provided CCO Health IT Data File (e.g., “Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information”). CCOs are expected to use this information to inform their strategies. Where applicable, information in the CCO Data Reporting File should support descriptions of accomplishments and successes.
- (Optional) Provide an overview of CCO’s approach to supporting increased access to and/or use of HIE for care coordination and hospital event notifications among contracted physical, oral, and behavioral health providers.
- **For each strategy** CCO implemented in 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.

Point Click Care is a Health Information Exchange that hospitals across Oregon connect to. Network partners can use it to access real time hospital inpatient and Emergency Department admission and discharge data. **Care Everywhere** is a module of Epic EHR that allows for the exchange of patient health information between providers who use Epic. **Epic Payer Platform** is a set of exchange features that facilitate bi-directional data exchange with Epic EHR users in network by leveraging technology specifically developed for payer-provider partnerships. **Rubicon MD** is an e-consult platform that enables primary care providers to access specialists for consult support to review cases, provide guidance, and help determine the necessity of referral to an in-person specialist. Contract ended 12/31/2025. **AristaMD** is an e-consult platform that enables primary care providers to access specialists for consult support to both review and determine the necessity of referral. Additionally, **Kaiser** participates in national HIE networks and exchanges data through Carequality, eHealth Exchange, and TECCA (Legacy participates as well) frameworks. Epic **“Happy Together”** functionality reconciles and integrates HIE data with EHRs. **EpicCare Link** is used by providers to directly view member clinical data from IDS partners. Some primary care practices access **[Epic] Health Planet** and/or **Healthy Planet Link** to view quality metric reports and gap lists.

All plan partners have published Interoperability (FHIR) APIs as required by CMS with multiple applications registered for access, though not much adoption has been observed.

(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:**

Counts from the HIT Data Reporting spreadsheet show the number of practices that do not use *or that there is no information that they use* an HIE -- Physical Health: 205, Oral Health: 189, Behavioral Health: 379.

Strategy 1 title: CareOregon - Optimizing and Expanding the Use of FIDO

Brief description: The Fully Integrated Data Organizer (FIDO) is CareOregon's data and analytics platform. Analysts across the organization can develop and publish analytic dashboards to support sharing of data, care coordination, quality improvement, and more. FIDO has the capability to make member level and aggregate data accessible to network partners in a secure way.

It is a mechanism for sharing CCO data on members with provider partners to improve care coordination and quality of care.

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

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

In 2025, the Behavioral Health Department used FIDO for review of access measurements and other utilization data and continued collaborating with the analytics team to develop and update a care coordination tool that details the likelihood of available access for members.

Starting in Q1 of 2025, CareOregon's Behavioral Health and Information and Evaluation team designed a bi-weekly generated survey to capture real time

access in clinics with Mental Health Outpatient services. This self-report tool is then fed into a FIDO dashboard which produces actionable information related to access for outpatient and medication services across the lifespan.

In Q2 of 2025 this tool was rolled out with 10 providers for beta testing. Upon completion of beta testing and validation of workflow the tool was expanded to 114 Metro Providers.

In Q3 of 2025, the tool was rolled out internally to CareOregon care coordination teams to begin utilization. The Behavioral health team engaged in a review to determine the return rate of surveys, noting a 53% return rate at that time. Outreach was conducted to Providers in an effort to help increase the return rate and ensure accuracy of workflow.

In Q4 of 2025 the Behavioral Health team began the process to share this dashboard externally with our Provider partners for whom this information would be useful. The internal review and Voice of Customer process was completed by year end.

Oral Health: In Q3 2025, FIDO metric dashboards were made available to external users, including CareOregon's dental metrics dashboard, and are now available to all CareOregon's dental plan partners. Partners can monitor progress on oral health measures which include CCO incentive measures as well as other key quality measures of performance, including data assessment by language, race/ethnicity and age.

Our bidirectional referral work is now more fully automated and is using the FIDO platform in two ways. Primary care and other nondental providers who submit dental referrals can now view the outcome of dental outreach in an external FIDO dashboard. In addition, CCO staff have an internal dashboard that

aggregates care coordination and outreach outcomes by our dental plan partners for internal monitoring and quality assessment. FIDO dashboard availability was communicated to plan partners who were encouraged to utilize the reports, share awareness with other partners, and request access if not already established. CareOregon will continue to build and add internal dashboards that support our oral health quality strategy and the dental benefit, such as third-next-available reporting for dental appointments, oral health services in primary care settings, and meaningful language access in the dental setting.

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

Behavioral Health: In Q1 of 2026, CareOregon will conduct its second return rate review and outreach with the goal to increase return rate by 6% over 2026. In 2026, external access to the FIDO dashboard will be shared with HSO, County teams, and Specialty BH Providers who are already onboarded to the FIDO platform. In 2027, CareOregon will evaluate further access opportunities and expansion of information in the system.

Oral Health: CareOregon plans to continue to build out oral health specific content in our FIDO dashboard portfolio. This includes additional optimization and disaggregation of some of our current reports such as dental engagement, as well as building new measures such as ED Visits for Nontraumatic Dental needs.

As we continue to expand the portfolio of oral health dashboards, we will consider how external users may be able to benefit from use. We are continuing to educate external partners about the availability of FIDO dashboards.

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. Increase provider completion rate and expand access to data across provider types. 2. Build oral specific content into FIDO portfolio dashboards to include optimization of current dashboards. 3. Continue to educate external partners about the availability of FIDO dashboards	A. Complete second return rate review and outreach to providers to attempt to increase return rate by Q1 2026. B. FIDO Access Dashboard will be made available to providers who are already onboard with FIDO (including HSO, County Partners, 4 Behavioral Health Partners, and 1 Primary Care Partner) by Q2 2026. C. Complete third return rate analysis and identify additional outreach needs by Q3 2026. D. Assess implications of FIDO dashboard access at select providers mentioned in milestone B by Q4 2026. E. In 2027, scoping and feasibility assessment will begin with focus on determining additional clinics for roll out of the FIDO Dashboard. F. Launch FIDO dashboard with oral specific content by Q4 2026. G. Educate partners about the availability of FIDO dashboards by Q4 2026.

Strategy 2 title: Optimization of Dental Referral Platform

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

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):

CareOregon's bidirectional dental referral work is now more fully automated. Primary care and other nondental providers can continue to submit dental care requests to the CCO through the provider portal. That information is then electronically shared with the member's dental plan. Results of care coordination activities are added to the platform by the dental plan partner and then viewable and reportable by the CCO. Individual member results and outcomes are now available to primary care in an externally facing dashboard for our primary care providers. This work will allow primary care providers to fulfill "closed loop" referrals for oral health and dental services for their patients. We also added an internal dashboard that supports the CCO's monitoring and aggregations of care coordination and outreach outcomes by our dental plan partners.

1. The FIDO Referral Outcome Dashboard was completed and made available for both internal and external use in Q4 2025.
2. The Referral Outcome Report, which includes outreach outcomes and associated claims detail reflecting member engagement, was also completed in Q4 2025. The completion of both milestones represents a significant achievement in ensuring timely communication of referral management and care coordination between the dental plans and primary care.

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

CareOregon's 2026-2029 plans include continuing to optimize the use and functionality of the dashboards. We also plan to continue to promote increased use of dental referral submissions by primary care clinics. Activities to promote increased use include sharing opportunities through provider newsletters and workgroups. |

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. Optimize use and functionality of dashboards. 2. Promote FIDO dashboard availability in Physical Health Networks through opportunities such as provider newsletters and workgroups.	A. Promote increased use of dental referrals by primary clinics by Q4 2027.

Strategy 3 title: Optimization and Expanding Use of Point Click Care by Providers

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

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):

In Q2 of 2025, PCC went live in Clackamas County jail. Key accomplishments during this project include ability to gauge the onboarding time for a jail setting in the platform and celebrating the first time jail medical staff have had insight into member information available via the platform. Since the go live date Clackamas County jail has experienced a few setbacks. In May of 2025, they transitioned to a new management system which had unintended consequences on their file upload, and to date they are still working to remedy this setback. Additionally, they have surfaced complications related to member matching based on demographic information without access to Member's DMAP identification numbers.

PCC was utilized to identify members discharging from the ED or IP with a SUD related diagnosis. Care Coordination Rapid Response Teams (RRT) engaged in proactive outreach to support members at hospital discharge. RRT was trained on PCC list utilization and SUD outreach best practices. Barriers to proactive outreach included limited connections with members post discharge even with PCC support and RRT workload and competing priorities.

Throughout 2025, CareOregon worked collaboratively to

track Specialty Behavioral Health and Physical Health Provider adoption and utilization of the platform. CareOregon leveraged Cross Regional Mental Health and Substance Use workgroups to further define successful engagement with the platform. The workgroups use Average Age of Eligibility File, Average Active Users in the Past month, and Average Patient Records to help identify a picture of engagement. Additionally, CareOregon networks completed a deeper scan regarding current network utilization, identifying current workflows and opportunities for further adoption and enhancements moving forward.

Additionally, CareOregon continued to leverage Point Click Care to support oral health care coordination. PCC enhances oral health care coordination by improving access to current contact information provided at facilities. This helps in reducing failed outreach attempts and providing visibility into the members' physical and behavioral health needs to support their dental care.

Work focused on increasing adoption of PCC and provision of provider focused training on the platform was delayed after staffing reductions and reallocation of work in 2025. These goals will continue to drive efforts in 2026.

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

The Clackamas County Jail pilot will continue through 2026 with plans to solve for the management system issues and explore remedy options related to Member matching information. The 2026 year, and final pilot year, will conclude with a look back including lessons learned, successes, and a comparison analysis of the information available in PCC versus Epic and usability for jail medical staff. Final product review will be produced in 2027.

RRT proactive outreach work was discontinued due to staffing and resource changes in 2025. In 2026, the CareOregon’s Mental Health and SUD workgroups will use the engagement metrics defined in 2025 to identify high and low performers. This information will help inform targeted technical assistance, and identification of additional clinics to onboard with the platform. Targeted TA will continue through 2027, with a review period for effectiveness occurring in 2028. In 2026 and 2027, additional Behavioral Health clinics will be identified for onboarding and upskilling to the platform. Additional provider education related to platform maximization will be offered as needed.

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. Completion and evaluation of Clackamas County Jail Pilot. 2. Increase provider adoption and utilization of Point Click Care.	A. Attempt resolution of current Member matching issue by 12/31/2026. B. Complete pilot final review report by 4/1/2027. C. Identify high and low performers across regions by 6/1/2026. D. Develop targeted technical assistance package and deploy across identified provider cohorts by 3/31/2027.

Planned activities	Planned milestones
	E. Complete evaluations of targeted technical assistance impact by 12/31/2027. F. Identify additional providers in not currently on PCC 12/31/2026. G. Conduct outreach to providers and determine feasibility of onboarding by 12/31/2027. H. Identify and provide any additional provider supports identified to maximize utilization by newly onboarded providers by 12/31/2028.

Strategy 4 title: Use of Telehealth to Improve Communication, Referrals, and Quality of Care

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

Strategy categories: Select which 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): [Click or tap here to enter text.](#)
- ☐12: Other: [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

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

CareOregon sunset RubiconMD contracts during Q3 2025 due to funding constraints.

CareOregon had a 2-year contract with MCHD for use of AristaMD as their platform of choice for e-consults and referrals to specialty providers. This was canceled in Q3 2025 due to funding restraints. MCHD has, however continued to pay for AristaMD services on their own, and continue to do so if their budget allows.

CareOregon continues to provide support through Project ECHO. In 2025, we had a total of 854 providers from our networks register for Project ECHO offerings.

Project ECHO included a total of 34 different programs in 2025 including: Foundations of Substance Use Disorders, Implementing Pharmacologic Weight Management in Primary Care, Psychiatry in Primary Care Community of Practice, Sexually Transmitted Infections – Syphilis Focus, Suicide Prevention, and others. Per Project ECHO’s annual report, 97% of participants agree that “participating and learning through Project ECHO is an effective way for our practice to enhance it’s expertise.”

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

CareOregon continues to support its provider network through Project ECHO. In 2026 we are supporting the development of programming around a topic related to chronic care management and prescribing that was proposed by our Medical Director to support networks in better utilization and management of those with chronic illnesses. We consider this to be in a maintenance stage and therefore are not seeking to actively plan enhancements in the future.

CareOregon is also actively exploring in 2026 contracting with one or more telehealth providers specific to specialty services.

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. Evaluate telehealth vendors	A. Develop RFP by end of 2026.
2. Select vendor for prioritized specialties	B. Contract with selected vendor for defined prioritized specialties by end of Q1 2027.
3. Implement telehealth vendor services	

Planned activities	Planned milestones
	C. Implement vendor services, socialize with primary care referral network by Q3 2027.

Strategy 5 title: Kaiser – Happy Together implementation

Brief description: Integrates data from HIE's with the Epic EHR

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

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

Kaiser is now live with many of Epic's "Happy Together" features that reconcile the outside data received through HIE alongside internal data in the patient's chart. Features include Encounters, Labs, Imaging, Media, care team members and, most recently, Notes. Kaiser plans to be live with Happy Together Genomics by the end of 2026 as well.

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

Happy Together Genomics implementation in 2026. Outside data that can be discretely reconciled into the patient's chart also includes medication, allergies, immunizations, problems and OB history.

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
3. Happy Together Genomics	B. Q4 of 2026

Strategy 6 title: OHSU – Updated Provider Contracting Requirements

Brief description: Incorporate language within provider contract and BAA that includes specific language that requires EHR utilization and connection to their integrated network.

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

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

2025 Progress Completed review of screening contracting template and updated verbiage. Updated BAA and sent out to contracted clinics.

(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. Survey providers for the use to EHR utilization when contracting 2. Include updated BAA for bidirectional contracting.	A. Ongoing

C. HIE for care coordination barriers

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

Due to time and resource constraints, **CareOregon** has not yet integrated SNF notifications from Point Click Care into Compass Rose. This absence has posed a challenge for our care coordination team, as it leads to less efficient workflows. Additionally, providers often express the need for more technical assistance/IT resources to assist with Point Click Care implementation, specifically around submitting eligibility files. Exchanges also require providers to make investments in time and resources to participate in a period of increasing financial challenges. **OHSU** IDS experienced challenges connecting to community-based practices to obtain external data for care coordination. Several challenges remain due mostly in part to Privacy & Security rules, lack of HIE or unified system for all sides to utilize technology in general. The other major hurdle pertains to overall funding for this work. Competing resources and newness of CBOs working with health partners (and vice versa). Adventist Health will be transitioning to their own instance of Epic; we will work with them to ensure reporting is complete, accurate and timely.

D. OHA support needs

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

OHA can support our efforts by increasing the adoption of HIE or compatible interfaces to increase the breadth of data that is available. Expanded use of HIE data sharing in dental and behavioral health would also be useful amongst plan partners. OHA could provide more financial support to improve the integration of HIE vendors with EHR vendors. It is a limitation to adoption when providers have to sign on to multiple platforms or are pulled out of their EHR to access additional data. OHSU remarks it would be helpful if there were more clarity about the expectations related to the CBOs, complementary medicine, and ancillary providers, and insight into the intent of these provider types to be part, or not

part, of the movement towards EHR adoption. If intended to be part of this work, financial incentives and support is necessary. Phased in requirements for data reporting that allows ample time for system set up, testing and modification.

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)?

CareOregon's Health Resilience Specialists and Panel Coordinators have direct access to the EHR system of their clinics with the permission to view and edit records for CareOregon members assigned to the clinic. The Regional Care Teams and other outreach teams also have EMR access to hospitals and facilities across the state. Gaining access to these systems is part of our standard onboarding process for new hires. Health Resilience Specialists and Panel Coordinators have access to **Kareo, Athena, Workday, Credible, and Greenway Integrity**. Panel Coordinators, the Regional Care Teams and other outreach teams also have access to **Epic** OCHIN EHRs. Kaiser **utilizes Epic Care Everywhere, TEFCA, Carequality, eHealth Exchange, EpicCare Link**, online affiliate. **OHSU** EHRs: **Epic, Athenahealth, Aprima DrChrono, Amazing Charts, Office Practicum**. OHSU IDS care management team utilizes **Epic** for documentation of all care coordination and care management activities, including SDOH and HRSN related work. OHSU IDS care management documentation is

fully integrated with the patient records that are viewed and utilized by the OHSU IDS provider network that utilizes Epic for clinical documentation. Both **Care Everywhere** and **EpicCare Link** are available for community providers to access and review information within OHSU's instance of Epic.

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

CareOregon Regional Care Teams, outreach teams, and panel coordinators use their EHR access to outreach and schedule appointments for members due for preventative visits and to those with identified gaps in care. EHR access is also used to support quality and performance measure accuracy and completeness. At **Kaiser**, Information is exchanged for treatment and care coordination purposes. Information includes patient-level summaries, encounters, labs, non-lab results, imaging, and more. **OHSU**: Any data necessary to calculate quality measures such as labs, immunizations, procedures, screenings, and visits. Some member demographic or other clinical information such as progress notes for care coordination and care management may also be gathered. (New) Health Risk Assessment information related to SDOH and SEH will now be gathered, tracked, and reported. Since care coordination and care management documentation occurs in Epic, the OHSU IDS care management team directly accesses clinical notes, results and data in Epic as a routine part of their review of members requiring care coordination and care management services.

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

Data sent via Epic Payer Platform to **CareOregon** is populated into [Epic] Compass Rose and stored in the CCO EDW to support future-state analysis for quality and performance measure reporting, risk gaps and closures, and member

attribution management. **OHSU** IDS uses Epic’s HIE tools to connect with and obtain external data from community-based clinics and other external partners. OHSU IDS utilizes Epic as one of its health IT tools, and a significant amount of data, including both clinical and claims data, are combined within the Epic platform for the development of reporting and analytics. This data is also exported into business intelligence and analytics tools for additional analysis and reporting.

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.

Health Share (including its partner plans) utilizes a number of health IT tools to support SDOH needs. These include: **Connect Oregon** (all partners) (Community Information Exchange for social needs referral and HRSN benefit administration, aka Unite Us); Multiple **Epic-based tools** (all partners), including **Compass Rose**, **SDOH Wheel**, **Integrated SDOH screening in My Chart**, and the **Epic Payer Platform**. CareOregon is beginning to utilize the **Johns Hopkins ACG** risk stratification tool (CareOregon) to highlight social needs information along with its traditional clinical risk model.

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

Health Share's primary focus in 2025 was on operationalizing HRSN benefits for members. The most challenging area in this domain remained housing and the implementation of CIE within the workflow to receive referral accompanying information, and using this to facilitate authorization and delivery of services. This involved a lot of engagement with Unite Us to optimize the tool for this purpose and to make adjustments to functionality both for the CCO's delivery network for these housing services (CareOregon) and for end users. In addition, the CCO has been building out connections with local housing authorities to better understand the overlap of housing insecurity/houselessness and high acuity behavioral health, particularly the relation between these circumstances and high utilization of healthcare, and unsuccessful housing placements.

Strategy 1 title: Increased Adoption and Use of Connect Oregon

Brief description: Health Share has held a contract for Connect Oregon (UniteUs) for a number of years. This contract includes use for all partner health plans and community based organizations. With the advent of HRSN the CCO (through CareOregon) also began using the payment module to manage HRSN related referrals and payments to organizations who choose to be part of the network. All Health Share partners have made efforts to increase use of Connect Oregon within their organizations.

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): [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

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

Over the past year, the primary focus has been on HRSN implementation. CareOregon identified and operationalized new use cases for the Community Information Exchange (CIE) to receive, track, and manage HRSN benefit and flexible services requests. Use of the CIE is a standard requirement included in all HRSN service provider contracts, establishing the platform as the primary and consistent source for request submission and end-to-end tracking across social health supports. As part of this work, CareOregon fully integrated the flexible services request process into our CIE platform, UniteUs, further streamlining intake, review, and decision-making processes.

CareOregon has implemented several enhancements to the flexible services digital request form, including new fields to identify urgent flexible service requests for specific scenarios and new functionality to streamline request review and support timely HRSN benefit authorization decisions or flexible services funding determinations. These improvements improved clarity, prioritization, and operational efficiency across teams.

To support adoption and ensure the platform met provider needs, CareOregon established ongoing technical assistance and feedback mechanisms. They held

monthly office hours with HRSN service providers to gather real-time feedback on user experience and referral workflows. Insights from these sessions directly informed system enhancements, refinements to technical assistance offerings, and the development of supporting documentation made available on our social needs assistance webpage. Together, these efforts strengthened provider engagement, reinforced consistent use of the CIE, and enhanced its role as core infrastructure for social needs supports requests and coordination.

In addition to the primary focus on HRSN adoption and workflow simplicity, each of Health Share's partners has made efforts to better integrate Connect Oregon with their EMR or systems of record, and to promote use within their provider networks.

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

Moving forward, Health Share aims to enable document attachments within Connect Oregon's digital request form, both at the time of initial submission and additional documentation submitted later in the process. We also plan to streamline and consolidate questions across the climate, housing, nutrition, and flexible services forms to reduce length and improve usability, ensuring that only relevant questions are presented based on the member's request. Additionally, CareOregon is exploring the feasibility of establishing a data connection between UniteUs and their member app and/or portal to provide updates on a member's request. This would allow the information to be easily accessed and viewed by the member rather than requiring a call to get a status update. Part of this exploration would include the ability to send text messages with updates to members. All of this is in service to broader member digital experience strategic goals for the next three years.

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. HRSF Request Process 2. Member SMS text messaging	A. Align form questions and use of document upload feature by end of Q2, 2026 B. Send automated text messages to members to indicate status changes to HRSN or flex-service requests by end of Q3, 2026

Strategy 2 title: Collection of Social Screening and Referral Data

Brief description: Health Share has started collecting Social Screening and referral data to meet the requirements of the Social Screening Quality Measure

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: Payments ☐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):

In 2025 Health Share embarked on a goal of collecting partner’s Social Needs Screening data. This data collection included a standard format to indicate which members had received a known social screening and had a follow-up service documented in the data record. The work was challenging due to constrained resources across the network and due to the reduction in payment for the quality pool (which was a considerable driver of the work). By the end of 2025 Health Share had collected this information from 4 of the 5 CCO physical health subcontracted organizations and this information was incredibly helpful in complete the requirements of the quality measure.

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

This strategy is currently unclear. Multiple competing priorities and barriers exist. One of them is the technical support at each partner organization to collect, organize and report on this data. A second is engagement of provider organizations who need to make some of these data available to Health Share’s partners—as the Quality Measures diminish in value their VBP contracts may be adjusted and priority of this work is likely to diminish as well. Health Share needs to assess the viability of continuing this work and weigh the benefits of simplifying data collection for this measure against the technical resources needed to collect them accurately.

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. Convene partners to understand pros/cons of continuing with this effort 2. Convene partners to understand pros/cons of continuing with this effortIf continued, monitor collection completeness and accuracy for ~~routine~~routine submissions	A. Q2 2026: Determine viability of continuing this effort given competing priorities B. Q2-Q4 2026: If agreement to continue, determine review frequency and QA process to support metrics priorities

Strategy 3 title: Adoption and Enhancement of EMR functionality to support SDOH

Brief description: Health Share’s partners are largely using Epic as an Electronic Health Record. Epic has a number of functions related to SDOH that our partners have been incorporating. Details on their progress and goals listed below.

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):

Click or tap here to enter text.

CareOregon: The Health Risk Assessment Tool (HRAT) helps identify social, access, or coordination needs, and assesses mental, cognitive, physical, psychosocial, and functional health. The HRAT is completed for Medicaid members who are new to the CCO, otherwise known as “new to plan.” Specific questions are flagged to assist with identifying members with the most urgent needs. These elements include, for example, when the HRAT indicates housing instability or food insecurity. All HRAT outreach activities and assessment completions are documented in Epic Compass Rose. A member’s responses are reviewed by care coordination staff to determine care coordination needs and inform the member’s individual care plan and health goals

In 2025, CareOregon has been able to screen members for key social needs, including food insecurity, transportation, and housing stability. This data was then populated into the members' record in Epic Compass Rose and is available for care coordination and navigation team members to reference in their interactions with members, as appropriate.

OHSU: OHSU has worked consistently to implement SDOH screening tools into its integrated EMR system. In 2025 OHSU rolled out the SDOH screening tools and MyChart questionnaires to the Adventist’s Women’s Health clinic.

Providence: [Findhelp/Epic Integration](#): The infrastructure for the MyChart banner was built with Findhelp in 2025, and should be easy to replace that link and make available to Oregon patients. PHA pediatric PCP network Children’s

Health Alliance (CHA) clinics have implemented workflows to screen families for Social Needs and to document referrals to resources as needed within their EMR and/or the Innovaccer Population Health tool.

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

Click or tap here to enter text.

CareOregon: In future years CareOregon would like to use HRAT data, specifically positive screens for housing stability concerns to make proactive referrals to HRSN O&E providers to have an in-depth conversation about individual housing needs and subsequent HRSN housing benefit requests, as needed. Similarly, they would like to pilot proactive responses to positive HRAT food insecurity screening outcomes.

Kaiser Permanente: Kaiser has been centralizing Health Risk screening into its EMR for many years. Continued plans for 2026 and beyond include utilizing Kaiser Permanente NW's Health Risk Assessment to screen for SDOH needs and continued use of social risk factors as diagnoses. The release of Epic Community Resource Network is planned for 2026 as well, which will facilitate improved integration between UniteUs and Epic for referrals for SDOH needs.

OHSU: In 2026 the challenge will be helping keep the SDOH screening tools within Adventist's version of Epic. There will be a necessary configuration and testing period needed, among competing resources, as Adventist undergoes a significant EMR change.

Providence: Findhelp/Epic Integration: In 2025, the Providence System, signed a contract with Findhelp. A part of that integration included added a banner to all MyChart users promoting self-service access to Findhelp. Because Unite Us did not have a public-facing platform at that time, it was not available to Oregon patients. As of February 2026, this is now an option, and Providence intends to replace the Findhelp access link with Unite Us for all Oregon patients utilizing Providence MyChart. Providence also intend to develop a QR code in an Epic SmartPhrase that can be added to an AVS to allow patients to self navigate resources. The goal is to have these strategies live within Q2 2026. CHA clinics will continue to screen for Social Needs and document resources referrals with the goal to improve health supports and health outcomes for children and youth.

Explore Epic “Cappuccino” build: the new Epic “Cappuccino” release offers a number of SDOH optimizations. Providence will be convening stakeholders to assess whether we will adopt these new features and whether they will improve workflow and patient care.

By the end of Q2 2026, stakeholders will decide whether Providence is going to adopt any of these new features, including: the ability to review all patient’s SDOH interventions in one place next to screening results (likely to be approved), automatically adding z codes to patient’s chart based on positive screens (unlikely to be added since we are not billing for SDOH services at this time, so coding for this is not a high priority), updating Epic workbench reports (unlikely to be added since Providence has several other custom-built functional dashboards) and uncover missed SDOH screenings with encounter-level reporting (adoption uncertain at this time).

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. Complete Health Risk Assessment Tool (HRAT) social needs proactive follow up. (CareOregon) 2. Begin implementing Epic's Community Resource Network functionality (throughout 2026) (Kaiser) 3. Support continuation of SDOH tools in Epic for Adventist transition (OHSU) 4. Add Unite Us public-facing link to MyChart banner (Providence) 5. Build SmartPhrase with QR code to add to patient AVS after a positive SDOH screen in settings like the ED (Providence) 6. Decision on whether to include in Cappuccino Epic roll out (Providence)	A. Pilot a workflow for Medicaid members with positive HRAT screening for housing concerns that connects members with HRSN benefit resources by Q1 2027. (CareOregon) B. Support of Community Resource Network, aligning workflows between UniteUs and Epic for referrals (Q4 2026)(Kaiser) C. SDOH screening tools to remain functional in Adventist's Epic implementation (by Q4 2026)(OHSU) D. Q2 2026 (MyChart banner) (Providence) E. Q2 2026 (Smartphrases) (Providence) F. April 2026 (Roll out decision, Providence)

Strategy 4 title: Integration of HMIS Data

Brief description: Health Share has signed data sharing agreements with Clackamas, Multnomah and Washington County to exchange Health Management Information Systems (HMIS) data to enhanced system analysis, planning and coordination

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): [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

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

In 2025 and early 2026 Health Share developed and reached agreement on robust data sharing agreements between the CCO and each county's housing departments to exchange member level health and housing information to support coordination across sectors, and population level analysis to guide strategic planning and program improvement. This development comes with a number of challenges, including developing the actual legal foundation for such data sharing, agreeing on which data were necessary across all three counties,

developing a standardized data flow to enable automated monthly data exchange, and performing a member matching process to identify which individuals in the HMIS system are enrolled in Medicaid.

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

Now that the data sharing agreements are in place, Health Share will be working with the three counties on a number of key initiatives:

- 1) Implement reliable member matching process—Health Share has invested in an Enterprise Master Person Index (EMPI) tool that is intended to help automate reliable matching of individual records generated by HMIS with Medicaid to match records.
- 2) Automate data sharing process—these data sharing arrangements are based on a proof of concept originally performed between Health Share and Multnomah County. That proof of concept did a one-time data match. Moving forward, the goal is for each county to exchange data monthly with Health Share, and for the CCO to match and ingest that data for key dashboards and analysis in an automated fashion. This requires working closely with identified leads at each county to structure the routine and predictable submission of data for matching and ingestion.
- 3) Prioritize analysis and data use—Health Share is convening a regional data governance group to ensure good stewardship of the data and prioritize key analyses with this new data resource. This group also oversees the format and content of the data sharing agreements and what data returns to the counties from Health Share. Initial analyses will be focused on the intersection of health care and permanent supportive housing, specifically the predictors of successful outcomes in PSH as they relate to needs of individuals with High Acuity Behavioral Health conditions.

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. Implement EMPI member matching software and workflows	A. Q2 2026 B. Q3 2026
2. Automate ingestion and matching of all 3 county data sets on monthly basis	C. Q2 2026 D. Q2 2026
3. Preliminary Descriptive Analysis of overlapping data for all three counties	
4. Predictive analysis of individuals with High Acuity BH needs who are in Permanent Supportive Housing (PSH)	

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:

- 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.**

- (Optional) Provide an overview of CCO's approach to supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals.
- **For each strategy** CCO implemented in 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.

Connect Oregon—Health Share pays for a regional license that includes most contracted providers in the CCO’s service area. **HealthTrio** is used by CareOregon to provide access to a sustainable HIT solution to support contracts with community-based organizations. **Apricot**: Some contracted CBO partners who utilize Epic to receive referrals, utilize Apricot, a case management software, to track outcomes and client care. This is used by Providence contractors employed by these agencies, and data is exported to Providence to integrate into SDOH intervention dashboards to track outcomes of referrals tied to SDOH screenings. **Track Via** (Providence) is used to administer voucher-based programs with Project Access NOW. **Innovacer** is used in Providence’s Pediatric network to track cohorts who need screenings or referrals. Finally, **FindHelp**, like Connect Oregon (UniteUs), is a social service resource locator tool that provides ready information about available social services in the community, which has a smaller footprint but is used in a limited capacity. In addition to these tools, some of which are well-established and not requiring dedicated implementation plans, Health Share has taken a considerable role in integrating available social-needs data into the CCO’s data warehouse for further analysis and population health modeling. This is particularly true for integration of HMIS and claims data to enhance analytics and member support.

(Optional) **Overview of CCO approach to supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals.**

Health Share's key partners represent the major provider systems in the Portland region. As such, many of their efforts described above—including implementing CIE or EMR-based upgrades—are directly in service to the providers within their organization. This section will specifically reflect efforts that Health Share or partners are taking *beyond those described above*, to support providers, including CBOs and other social service organizations.

Strategy 1 title: Health Data Sharing with Counties

Brief description: Health Share is collecting information from county housing departments to facilitate stronger coordination across sectors. Part of this work includes providing information back to counties to enable some population health analysis

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): Health and Housing 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):

Health Share has developed data sharing agreements with each of the regional counties to both receive and exchange data related to health and housing. This includes specifics about information that the CCO will provide back to the counties to enable them to better understand the population they are serving and their overall health needs. This assists with barriers like grant applications, program reporting, and cross-sector case conferencing.

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

This work will continue to evolve. In addition to the system-level analyses above, we plan to adapt the specifics of the data shared to be responsive to the needs of county housing departments (and their providers) as state and federal regulations and priorities shift. This will include ensuring that they have access to key information about who they are serving in an effort to advocate for funding or policy changes based on the health needs of the population they are serving. Prior to these arrangements the majority of advocacy was based on health information collected by the health system, which is substantially limited.

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
- Continued convening of data governance group across the counties - Routine distribution of agreed-upon data set from CCO to Counties - Explore integration of HMIS data into Health Share risk stratification tools and notification systems (PointClickCare)	- Throughout 2026 - Quarterly 2026 - By end of 2026

Strategy 2 title: Data Agreement with Multnomah County Corrections Health

Brief description: Mirroring the agreement for HMIS data, the CCO is exploring a data agreement with County Corrections Health.

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): Health and Corrections 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):

This is a new initiative for 2026

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

Health Share has a significant priority related to individuals struggling with substance use or psychosis. Based on the CCO's data sharing agreement with local housing authorities, Multnomah County Corrections Health has engaged Health Share about a data sharing agreement to look at the overlap of individuals who engage with Corrections Health programs to treat addiction. Specifically, Corrections Health has made significant investments in clinical programming to engage people they serve in SUD services, including induction for Medication Assisted Treatment. Upon leaving the corrections setting it is not clear how successful these individuals are in securing on-going treatment or in staying engaged in treatment. Health Share's data would be able to provide high level performance indicators to help refine program offerings and improve outcomes. 2026 and beyond will be spent developing the required DSAs and identifying which data need to be shared from the CCO to Corrections Health (and vice versa) to enable this work to proceed.

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. Develop cross-sector data sharing agreement with Corrections Health in Multnomah County	A. Q3 2026 B. Q3 2026
2. Agree upon populations/cohorts of interest for analysis and prioritized data sharing, perform analysis	

Strategy 3 title: **Implementation of HealthTrio to Support CBO Payment**

Arrangements

Brief description: CareOregon is working to provide access to a sustainable HIT solution to support contracts with community-based organizations (CBOs). Our standard CBO contract payment terms provide reimbursement for services provided for our members through CBO submission of monthly reports and invoices. Access to HealthTrio, the selected platform, allows CBOs to verify eligibility and securely submit invoices and PHI-containing reports for payment. In addition, CBOs who are contracted HRSN providers use HealthTrio to access claims remittance data reporting to support HRSN benefit claims submission and payment processes and reconciliation

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):

CareOregon was able to contract and onboard five HRSN nutrition service providers by the end of Q1 2025. Twelve new housing providers also joined the region to support the growing need for housing support under the HRSN benefit. All providers use HealthTrio to access their claims remittance reports to review payments made to them by CareOregon for HRSN services. Focused support around financial reconciliation and Medicaid claims processes helps build CBO capacity to accurately interpret remittance data, manage payment workflows, and sustain participation in Medicaid-funded HRSN benefits, particularly for providers new to Medicaid billing.

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

CareOregon will continue to build on its HealthTrio support model to strengthen CBO billing and payment capacity while preparing for provider expansion in 2026. Ongoing support will focus on providing technical assistance to existing contracted providers to ensure effective use of HealthTrio for invoicing, payment workflows, and financial reconciliation. This includes continued guidance on best practices for reconciling Medicaid claims and interpreting remittance data, critical capabilities for HRSN providers, many of whom are newly operating as Medicaid billing organizations. These efforts help ensure providers can meet standard contract payment requirements and sustain participation in HRSN benefits over time. In parallel, CareOregon will expand this support model to onboard new providers in Q2 2026 in advance of the July 1, 2026 launch of the fruit and vegetable and pantry stocking benefit. Onboarding will include orientation to invoicing and payment processes, establishment of HealthTrio access, and training to ensure key staff can verify member eligibility, securely submit invoices and PHI-containing reports, and access remittance and financial reporting. Together, these planned activities reinforce HealthTrio as a scalable, sustainable HIT solution that supports both continued CBO engagement and successful expansion of the HRSN provider 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
3. Provide ongoing technical assistance (TA) focused on Health Trio and Medicaid claims reconciliation and use of remittance reports. 4. Develop and maintain standard guidance (job aids, quick-reference guides) for claim-invoice reconciliation and common payment issues and resolution pathways. 5. Offer targeted 1:1 support for providers experiencing payment delays or reconciliation challenges, prioritizing newer Medicaid billing organizations as they are onboarded	A. Existing HRSN providers can accurately reconcile HealthTrio remittance reports to submitted invoices by the end of Q3 2026. B. Reduction in invoicing errors, rework, or payment-related TA escalations by end of Q4 2026. C. HealthTrio is consistently used as the primary platform and “source of truth” for payments tracking by end of Q3 2026.

Strategy 4 title: Epic integrated Language Services Software

Brief description: The ability to access services in a language that suits the needs of each member is critical to addressing both clinical and social needs. OHSU has purchased specific language software compatible with Epic to document necessary interpreter service data for compliance.

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): Meaningful Language Access Tracking

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):

In 2025, OHSU made the decision to rely on tools in Epic to document the use of interpreter services and updated our reporting accordingly.

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

In 2026 and beyond, OHSU will continue supporting and optimizing the workflows and tools used to capture interpreter services for network providers. Video Remote Interpreting (VRI) services devices will be deployed starting in February 2026. The video modality ensures better access to on-demand video interpreters and languages, with the capacity to improve our data infrastructure and reduce clinicians' documentation burden.

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 working with key stakeholders in Language Services and Clinical Informatics to support and optimize our workflows for documenting interpreter services.	A. Review of the Language Access and Interpreter Report semi-annually, in March 2026 and September 2026.

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

Per OAR requirements, we have established a process for organizations seeking to become HRSN providers to request an exception to the CIE requirement. This process is outlined in the readiness assessment and the HRSN provider contract. Providers requesting an exception must submit a written request via email to the HRSN benefit operations team lead. The CareOregon operations team reviews each request and first offers technical assistance or training to support use of the

CIE. If the provider chooses to proceed with the exception request, the HRSN benefit leadership team evaluates the current provider network to assess adequacy and responsiveness to culturally and linguistically specific populations. If network adequacy would be maintained without the provider, a follow-up discussion is held with the organization's leadership prior to a final decision on contract termination. If approved, the provider would no longer meet the readiness criteria as defined in the HRSN provider contract. **At this time, CareOregon has not received any exception requests.**

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.
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.
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.

While progress was made, Health Share continued to balance moving forward the HIT/SDOH program with limited capacity to engage in new work. Significant financial challenges in 2025, while experiencing an increase in utilization, has resulted in difficulty managing patient populations who are experiencing higher levels of illness. While we have worked with partners to establish workflows, processes, and policies to address social health needs, the costs and effort to adopt new platforms are the main barriers. Ultimately, providing social needs benefits under a Medicaid framework has led to a significant amount of documentation and information flow challenges.

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?

Generally, it is important for OHA to consider the technical abilities and limitations of the systems that CCOs have access to when implementing new programs or benefits like HRSN. While the time may have passed for HRSN workflows to be incorporated into OHA's strategic design process, new emerging issues such as federally mandated work requirements carry similar risks. Having a system by which people can be exempt from work requirements based on administrative data would be highly preferred, however the manner by which this information is collected will be very important to balance operational execution

with what might otherwise be a good idea for exclusion. In other words, if social factors are incorporated for excluding people from work requirements (such as houselessness, or incarceration) the data flows that support those categories must be considered and not presumed to be available to CCOs. Failure to do this may lead to a very well-intentioned policy (excluding people from work requirements due to significant hardship) being executed poorly.

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.

Use of Epic Cheers and MyChart notifications/messaging has grown over the last couple of years and has been helpful in member outreach efforts to close care gaps, address major initiatives such as the recent public health emergency “unwinding” to reinstate the redetermination process, and support the implementation of HRSN benefits.

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

Click or tap here to enter text.

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

Compliance-related activities and production of mandatory deliverables directly compete for resources needed to advance strategies.

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?

Health Share has built REALD/SOGI data into many internal analytics dashboards to help identify and address equity challenges. We have discussed how to appropriately use this data, including the sensitivity and care needed when trying to use data that may create unintended consequences for members that have provided it, incorporating this into our internal policies. We have included these considerations in a standard "Data Equity" statement on the introductory page of all internal analytics dashboards with connections to member demographic information. We leveraged member language information coupled with disenrollment and redetermination roster data to identify a disproportionate number of Spanish speakers losing coverage during the public health unwinding which was used to adjust contact center staffing.

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