



2026 CCO Health Information Technology (HIT) 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 and**
- 2. Use the following file naming convention for your submission: CCOname_2026_HealthIT_Roadmap**

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

TABLE OF CONTENTS

INSTRUCTIONS & EXPECTATIONS	3
1. HEALTH IT PARTNERSHIP	4
2. (OPTIONAL) OVERVIEW OF CCO HEALTH IT APPROACH	4
3. SUPPORT FOR EHR ADOPTION, USE, AND OPTIMIZATION	6
A. Support for EHR Adoption, Use, and Optimization: 2025 Progress and 2026-29 Plans	6
B. EHR Support Barriers.....	10
C. OHA Support Needs	10
4. USE OF AND SUPPORT FOR HIE FOR CARE COORDINATION AND HOSPITAL EVENT NOTIFICATIONS	11
A. CCO Use of HIE for Care Coordination and Hospital Event Notifications: 2025 Progress & 2026-29 Plans .	11
B. Supporting Increased Access to and Use of HIE Among Providers: 2025 Progress & 2026-29 Plans	16
C. HIE for Care Coordination Barriers	22
D. OHA Support Needs	22
E. CCO Access to and Use of EHRs	22
5. HEALTH IT TO SUPPORT SDOH	23
A. CCO Use of Health IT to Support SDOH: 2025 Progress & 2026-29 Plans	23
B. CCO Support of Providers with Using Health IT to Support SDOH Needs: 2025 Progress & 2026-29 Plans .	27
C. Exceptions Process If CCO Requires CIE	31
D. Health IT to Support SDOH Barriers	32
E. OHA Support Needs.....	32
6. (OPTIONAL) OTHER HEALTH IT QUESTIONS	32

Instructions & 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:

- 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.

1.1.H

Please attest to the following items.

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

2. (Optional) Overview of CCO Health IT Approach

This will be read by all reviewers. This section is optional but can be helpful to avoid repetitive descriptions in different sections. Please provide an overview of CCO's internal health IT approach/roadmap as it relates to supporting care coordination, 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).

System Definitions:

Clinical Care Advance (CCA) - Clinical CareAdvance is a care management software platform from Cognizant's TriZetto Healthcare Products that supports health plans in automating and coordinating utilization management, case management, and disease management activities. It is designed to transform care management into a data-driven, rules-based, and workflow-automated process that improves efficiency, quality, and member outcome.

Facets - core administrative processing platform from Cognizant's TriZetto Healthcare Products that health plans use to configure benefits, enroll members, manage provider networks, process claims, and administer premium billing and financials across commercial, Medicaid, Medicare Advantage, and other lines of business.

Arcadia - a cloud-based healthcare data and analytics platform that aggregates, normalizes, and analyzes clinical, claims, pharmacy, and social determinants of health (SDoH) data to support population health management and value-based care for payers, providers, and government organizations.

Point Click Care (PCC) – Also known as Collective Medical, is a cloud-based electronic health record (EHR) and care management platform purpose-built for the long-term and post-acute care (LTPAC) sector, including skilled nursing facilities, senior living communities, and home health providers. The platform integrates clinical documentation, medication management, care coordination, and financial administration to support safe, compliant, and efficient care delivery across post-acute settings.

Unite Us (UU) - a social care coordination and data infrastructure platform that enables healthcare organizations, government agencies, and community-based organizations (CBOs) to identify social needs, make secure electronic referrals, close the loop on services delivered, and measure outcomes across a shared community network.

Empower Health Plan Extended Reporting (hpXr) – enterprise reporting and analytics data warehouse used by Empower health plans to consolidate, normalize, and store administrative and clinical operations data—including eligibility, claims, encounters, authorizations, provider, and financial data—for regulatory reporting, operational oversight, and performance analytics.

Curitus - Provider Data Management (PDM) platform that enables health plans, health systems, and government programs to collect, validate, curate, govern, and publish provider data, including demographics, credentials, locations, network status, and compliance attributes—across all downstream systems from a single source of truth.

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**

Physical:

- No EHR = 2 (4%)
- EHR Status Unknown = 4 (7%)

Oral:

- No EHR = 3 (12%)
- EHR Status Unknown = 3 (12%)

Behavioral Health:

- No EHR = 41 (21%)
- EHR Status Unknown = 14 (7%)

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

IHN-CCO collected EHR adoption information from new providers by incorporating data collection into its Participating Provider Agreements. Though reporting on EHR status has been included in its provider agreements prior to 2024, IHN-CCO improved this process by requiring a structured EHR data collection field to be completed at the point of contracting.

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

IHN-CCO is advancing a phased HIE strategy to improve bi-directional data exchange with county and provider partners in alignment with OHA EHR and HIE Roadmap priorities. The strategy focuses on strengthening care coordination, improving timely access to information, and supporting whole-person care, with an emphasis on community mental health, high-risk maternal care, and primary care integration.

IHN-CCO currently supports information sharing with the Benton County Health Department and Lincoln County primary care partners. HIE-sourced data, including hospital admission and discharge notifications, can be utilized by county partners to support trusted outreach and timely follow-up for members identified as needing additional services.

IHN-CCO is also developing inbound data exchange from county partners related to mobile crisis and other behavioral health interventions where CCO care management involvement may be appropriate. These activities support a broader, multi-year implementation plan to fully integrate Benton, Lincoln, and Linn County mental health data into the HIE.

Strategy 1 title:

IHN-CCO strengthened provider EHR Adoption

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

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

☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☐ 10: EHR selection ☐ 11: Optimization ☐ 12: Other: (list here)	
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 <u>accomplishments/successes</u> and <u>challenges</u> with this strategy): IHN-CCO strengthened provider EHR adoption tracking by requiring standardized EHR data collection within Participating Provider Agreements at the point of contracting, improving the accuracy and consistency of EHR readiness information across the provider network.	
(Optional) Overview of 2026-29 plans for this strategy: To support increased adoption of Electronic Health Records (EHR) among providers, we will continue to focus on educating providers about the importance and benefits of EHR systems. This includes explaining how EHRs improve care coordination, enhance patient safety, reduce errors, and support better health outcomes. Clear messaging will emphasize how EHR use can streamline documentation, make patient information more accessible, and support compliance with reporting requirements. The education will include how providers can standardize EHR data collection to meet the requirements of their Participating Provider Agreements. As part of this effort, we will share examples of affordable and user-friendly EHR systems that are already being used successfully by other providers in the network. These may include platforms such as Athenahealth , Kareo , and Practice Fusion , which are known for being cost-effective, easy to implement, and supportive of smaller practices. By highlighting real-world use cases and provider testimonials, we aim to build trust and confidence in the adoption process, showing that transitioning to an EHR system is both achievable and beneficial.	
Planned Activities 1. Frequently monitor EHR adoption through contractual agreements by tracking supplemental data submissions 2. Yearly audit to ensure each contracted provider is adhering to the contractual EHR adoption agreement. 3. Quarterly provides meetings to communicate an educate	Planned Milestones A. Number/percentage of providers who begin EHR implementation after the campaign. B. Growth in EHR adoption will be measured for next year's submission, giving one year for measurement.
Strategy 2 title: Assessment/tracking of EHR adoption and capabilities	
Strategy categories: Select which category(ies) pertain to this strategy ☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☒ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support ☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☐ 10: EHR selection ☐ 11: Optimization ☐ 12: Other: (list here)	
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 <u>accomplishments/successes</u> and <u>challenges</u> with this strategy): IHN-CCO identified incomplete and inconsistent EHR adoption data across its provider network as a barrier to accurately assessing EHR readiness and alignment with OHA EHR Roadmap requirements. Improving the reliability and timeliness of EHR status data for new providers was prioritized to support compliance monitoring, technical assistance planning, and future interoperability investments.	
(Optional) Overview of 2026-29 plans for this strategy: As part of our ongoing effort to assess and track EHR adoption and capabilities across the provider network, we have made notable progress in improving data accuracy and visibility. A key advancement has been the implementation of structured EHR data field collection at the point of provider contracting. By embedding this requirement early in the provider onboarding process and the recontacting/renegotiation process, we have significantly reduced the volume of providers listed with an “unknown EHR status” in our system. Prior to this enhancement, a substantial portion of our network lacked complete or verified EHR information, which hindered our ability to analyze adoption trends and plan targeted outreach. Since the implementation, we've observed a marked improvement in data completeness—most notably, a sharp decrease in the number of providers categorized under “unknown EHR status.” Providers are now prompted to supply EHR details during contracting, ensuring we capture this information upfront rather than relying on post-contract outreach. In addition, we've seen a modest but meaningful shift in the number of providers previously identified as having “NO EHR” who have since been updated with a named EHR platform. While many of these updates have come from ongoing outreach and education efforts, the improved tracking infrastructure has made it easier to follow up with providers and monitor changes in adoption over time.	
Planned Activities Continue requiring this data field during the contracting/recontacting/renegotiation process.	Planned Milestones Extraction of this data at time HIT Roadmap measurement cycle
Strategy 3 title:	
Strategy categories: Select which category(ies) pertain to this strategy ☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support ☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☐ 10: EHR selection ☐ 11: Optimization ☐ 12: Other: (list here)	
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 <u>accomplishments/successes</u> and <u>challenges</u> with this strategy):	
(Optional) Overview of 2026-29 plans for this strategy:	
Planned Activities	Planned Milestones
Strategy 4 title:	
Limited bi-directional data exchange with county partners, particularly related to community mental health and crisis services, was identified as a barrier to timely care coordination and whole-person care. Advancing HIE connectivity	

aligned with OHA HIE Roadmap priorities and supported IHN-CCO's goals related to behavioral health integration, high-risk maternal care, and collaboration with community-based partners.

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

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

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):

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

Planned Activities

A.

Planned Milestones

1.

B. EHR Support Barriers

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

Despite ongoing efforts to support EHR adoption, use, and optimization among our contracted providers, several barriers have inhibited full progress—particularly among the behavioral health provider community. While we have made strides in improving EHR data collection at contracting and increasing provider education on the value of EHRs, a significant portion of behavioral health providers continue to report “NO EHR” or remain in the “EHR status unknown” category.

One of the primary challenges driving this trend appears to be the shifting structure of behavioral health delivery. Over the past several years, we have observed a marked migration of behavioral health professionals from larger group or organizational settings into solo practice arrangements. Many of these independent providers now operate from their homes via telehealth platforms, offering flexibility and access but often doing so with limited administrative or technical support. For these solo practitioners, the adoption of an EHR can be cost-prohibitive and perceived as burdensome due to the steep learning curve, ongoing maintenance, and perceived lack of immediate value. As a result, many rely on basic documentation tools rather than full-scale, interoperable EHR systems.

This trend poses a unique barrier to coordinated care, as the absence of interoperable systems among a growing segment of the behavioral health network limits our ability to achieve full integration across physical, oral, and behavioral health services.

C. OHA Support Needs

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

We believe that a stronger, unified message from the Oregon Health Authority (OHA) could help shift this dynamic. Specifically, CCOs would benefit from OHA-developed branding and messaging that clearly

articulates the importance of EHR adoption and the expectation that all providers—regardless of practice size or modality—move toward systems that support care coordination and data sharing. An OHA-branded campaign could lend additional authority and consistency across CCO efforts, helping to reinforce the message that EHR adoption is not only a best practice but an essential element of delivering high-quality, person-centered care.

We remain committed to supporting our providers through education, technical assistance, and contract alignment, but broader systemic support and messaging from OHA would greatly strengthen our efforts and help address the persistent gaps in behavioral health EHR adoption.

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 & 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

- **Arcadia Population Health System:** Configured to integrate provider electronic health record (EHR) data, claims data, and with other data sources, supporting care coordination and metric performance through the exchange of member data.
- **Clinical CareAdvance (CCA):** A care coordination data system that has been updated for greater configurability and support of data exchange for care coordination purposes.
- **PointClickCare/Collective Medical:** A statewide system providing hospital event notifications and care management notes to support care coordination and management of high-risk populations.
- **UniteUs Platform:** Enhanced for data exchange functionality, integrating referral capabilities across contracted providers and community-based organizations, and adding case management and touch point tracking capabilities.
- **Secure File Transfer Protocol Site:** Previously utilized for exchanging member data for transitions of care between CCOs (now decommissioned and under evaluation for alternative solutions).
- **OCHIN/EPIC/CareLink:** Utilized to enhance care coordination and patient support, including patient record access, information lookup/sharing, communication.
- **John's Hopkins ACG:** Platform to develop risk level and scores using claims and population health analytics software.

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

Our approach integrates leveraging technology platforms like Arcadia, CCA, and PointClickCare, among others, to facilitate real-time data sharing and collaboration across the healthcare continuum. Our strategy emphasizes the importance of bi-directional data exchange, interoperability, and utilizing hospital event notifications to enhance care coordination, particularly for high-risk populations. Through engaging providers in educational forums and leveraging data for performance improvement, we aim to foster a data-driven ecosystem that supports comprehensive care coordination efforts.

For the period 2025-2026, we aim to expand upon our current HIE infrastructure and capabilities to facilitate more customized and tailored healthcare interventions. This includes leveraging HIE/event notification data to create composite risk scores, augmenting this data with claims and health risk assessment data to design targeted care plans for members with high complexity/needs, and implementing additional connectors to intake data directly from healthcare providers into our Arcadia system for conducting population health activities aimed at closing gaps in care.

As we move forward into the 2025-2026 period, IHN-CCO is committed to significantly advancing our strategies around the utilization of health information exchange (HIE) and hospital event notification data. Our plans are to enhance our risk stratification processes and implement targeted care interventions more effectively. These initiatives are not only geared towards meeting the latest Oregon Administrative Rules (OAR) requirements but are also aimed at refining our internal processes for better health outcomes for our members.

Key Components of the 2025-2026 Strategy:

1. Developing a Robust Composite Risk Stratification Process- Identifying member needs with greater precision.
2. Enhancements to Data Integration and Reporting-Transforming complex data into actionable insights.
3. Leveraging Hospital Event Notifications (HEN) for Real-time Insight- Responding faster to critical events.
4. Targeted Care Coordination and Interventions- Delivering personalized care based on individual needs.
5. Automate HIE data integration internally to support care coordination and improve member outcomes.

Our goal for the next three years is to leverage advanced technology and data integration to provide a more personalized and efficient healthcare experience for our members. This will involve close collaboration with our technology partners, ongoing process optimization, and a steadfast commitment to meeting the evolving needs of our members through innovative care coordination strategies. By leveraging technology and data, through close collaboration with our technology partners, continuous improvement, and innovative care coordination strategies, we aim to set a new standard in member care- **proactive, responsive, and focused on optimal health outcomes.**

Strategy 1 title:

Develop a Robust Composite Risk Stratification Process

To create and implement a risk stratification system that integrates multiple data sources, including HIE data from John's Hopkins ACG, Arcadia, PointClickCare (POINTCLICKCARE), health risk assessments from patients/members, and claims utilization data. This composite risk stratification process will enable us to assess members' risk levels accurately and stratify them into categories that will inform specific referrals and outreach by care coordinators. For instance, the approach to care coordination for members identified as 'High' risk will be distinct from those categorized under 'Moderate' risk.

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

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

Strategy status:

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

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

1. Developed and Implemented a Composite Risk Stratification Process utilizing data from John's Hopkins ACG and Arcadia Population Health System
2. Scaled the utilization of HEN and HIE Data for real-time alerts and Targeted Interventions as required in the OAR requirements.
3. Evaluated and adjusted Care Coordination Strategies with robust policies and work-instructions.
4. Developed a framework for creating composite risk scores using HIE/event notification data, medical claims, and health risk assessments.
5. Completed the enhancement of the data warehouse to support the integration of diverse data sources. This step is crucial for the actionable packaging of data for risk stratification.

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

1. Collaborating with IT working with Arcadia to problem solve high risk maternity to realize accurate risk stratification for that population.
2. Implement monthly Risk Stratification reporting to visualize new members with risk scores as well as members who have had a change in risk scores.

Planned Activities 1. Working with our business analysts and Arcadia to be able to identify high risk maternity population 2. Implementing Risk strat reporting on a monthly basis to identify new members with risk scores and members who have risk scores that have changed. 3. Work with business analysts and configuration to create automation with business rules that will send tasks for new risks por change in risk level	Planned Milestones 1. Work to begin quarter 3 2026 2. Work to begin in Q3 2026 3. Work to Q3 2026
--	--

Strategy 2 title: Enhancements to Data Integration and Reporting

Significant enhancements are planned for our system to facilitate the ingestion, integration, and packaging of diverse data types across disparate data systems to enhance integration and reporting capabilities. These enhancements are crucial for making the information actionable for risk stratification and ensuring our team has the best insights into our members' health statuses in the timeliest manner possible.

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

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

Strategy status:

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

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

1. Continued to refine and optimize data into the data warehouse (such as Arcadia risk tables, HRA information, etc.) to use this information in tandem with other source data and across disparate systems for more robust analytics.
2. Drew together Arcadia's ACG score, HRA information, demographics, claims data, etc. to calculate an overall risk score to me OAR requirements.
3. The calculated clinical risk score is in the patient header in Clinical Care Advance.

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

Specific enhancements include implementation of APIs and/or data exchange capabilities that will enable IHN to ingest population health, gaps in care, and member risk data from Arcadia into our care coordination platform CCA and vice versa. Similar bidirectional data enhancements are planned for Facets, our claim system, and CCA., This will include pulling information from Facets that is not currently visible to the care coordination module of CCA, such as appeals and grievance, and making it more readily available to the care management team

Planned Activities 1. Refine and optimize data tables in the data warehouse 2. Update reporting and data flows to CCA with the refined and optimized data 3. Implement bidirectional data enhancements between Facets and CCA	Planned Milestones 1. Data optimization implanted in the data warehouse 2. Accurate reporting and data flows into CCA 3. Accurate, timely, and meaningful data enhancements implanted between Facets and CCA
Strategy 3 title: Leveraging Hospital Event Notifications (HEN) for Real-time Insight A pivotal part of our strategy includes utilizing HEN for instant alerts and insights, enabling us to capture and identify changes in members' health statuses quickly. This real-time data is instrumental in our ability to respond promptly with appropriate care coordination protocols. Specifically, this includes alerts for the following types of events, though the list is not exhaustive: Rising risk, High risk pregnancy diagnosis; change in health-related status; new diagnosis of medical severity or high priority; etc. This is in addition to existing alerts, such as the one for our member population that fall into the substance use disorder category. These alerts, in tandem with new workflows being designed through the Care Coordination Redesign work, may trigger proactive or comprehensive care coordination activities such as member outreach, notifying or contacting a member's PCP, ensuring that proper follow-up is observed for members to improve outcomes and that gaps in care are being properly closed to improve quality and CCO metric performance.	
Strategy categories: Select which category(ies) pertain to this strategy ☒ 1: Care coordination ☒ 2: Exchange care information ☐ 3: Integration of disparate information ☒ 4: HIE tool enhancements ☐ 5: Partner collaboration ☒ 6: Risk stratification & population segmentation ☐ 7: Other: (list here)	
Strategy status: ☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed ☐ Ended/retired/stopped	
Progress (including previous year <u>accomplishments/successes</u> and <u>challenges</u> with this strategy): • Scaled the utilization of HEN and HIE Data for real-time alerts and Targeted Interventions as required in the OAR requirements. • Streamlined Workflows: We revised care coordination workflows to ensure efficient follow-up after notifications from PointClickCare to ensure timely and tailored response from our care management team. • Enhanced Data Exchange: We upgraded APIs in CCA for better data flow from PointClickCare and Epic, improving care management and coordination. • Improved Member Identification: We refined how we use Hospital Event Notifications (HEN) to include identifying members needing care coordination.	
(Optional) Overview of 2026-29 plans for this strategy: 1. Continue to improve notification validity for DSNP members being admitted to SNF 2. Implement weekly change in health-related circumstance reporting.	

Planned Activities 1. Coordinating with IT services on the delivery of member data for accurate identification of DSNP members 2. Implementing weekly automated calling for health related circumstance change instances and ingesting the outcome of the outreach 3. Ingesting data into warehouse for CCA from county mobile crisis call/outreach 4. Developing care coordination workflows and work instructions		Planned Milestones 1. By the end of Q3 2026, being able to accurately identify DSNP members admitted to SNF 2. Identify workflow and ingestion of data by Q2. Implementation in Q3 2026 3. Implementation Q1 2026 4. Work begun in Q2 2026
Strategy 4 title: Targeted Care Coordination and Interventions By implementing targeted interventions based on the refined risk stratification process and real-time insights from HEN and other HIE information, we aim to improve health outcomes. Our care team will be equipped to manage our IHN members' health proactively, tailoring interventions to meet the specific needs of different risk categories		
Strategy categories: Select which category(ies) pertain to this strategy ☒ 1: Care coordination ☒ 2: Exchange care information ☐ 3: Integration of disparate information ☒ 4: HIE tool enhancements ☒ 5: Partner collaboration ☐ 6: Risk stratification & population segmentation ☐ 7: Other: (list here)		
Strategy status: ☐ Ongoing ☐ New ☐ Paused ☐ Revised ☒ Completed ☐ Ended/retired/stopped		
Progress (including previous year <u>accomplishments/successes</u> and <u>challenges</u> with this strategy): 1. Evaluated and refined care coordination strategies based on the revised OAR. A. Implemented targeted interventions for Mod and High Risk stratified members B. Implemented Care Plans for all Mod/High Risk stratified members and all LTSS members 2. Completed leveraging of Arcadia in support of care coordination, which includes staff training and upskilling, as well as enhanced API connections with the Clinical Care Advance platform to further promote data integration for care coordination		
(Optional) Overview of 2026-29 plans for this strategy:		
Planned Activities 1.	Planned Milestones 1.	

B. Supporting Increased Access to and Use of HIE Among Providers: 2025 Progress & 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:
 - a. A title and brief description
 - b. Which category(ies) pertain to each strategy
 - c. Strategy status
 - d. Provider types supported
 - e. A description of 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
 - iii. How the strategy supports each type of provider selected
 - f. (Optional) An overview of CCO 2026-29 plans for each strategy
 - g. 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.

Point Click Care (PCC) - IHN-CCO utilizes PCC as our main platform to provide timely hospital event notifications. Care Coordination pulls appropriate reports from the PCC platform to identify hospital events for timely follow-up.

Clinical CareAdvance – CCA is the platform that the SHP Care Coordination team uses to enter care plans, member preferences, goals, milestones, and other critical information needed to treat members in a holistic manner. Certain PCC notifications and clinical identifications such as enhanced ADT feeds will also be integrated into CCA as part of our Care Management Redesign. This will allow for the care management team to have timely information from facilities available on a single platform and have targeted tasks/notifications related to important changes of health condition for each member. Additional automation or complexity can be built upon this foundation, as these specific identifications for various clinical indicators will assist with providing timely and appropriate care for members. Reporting for members having these PCC flags for certain conditions will also be available, allowing IHN-CCO to perform more robust population analytics and see trends over time that will inform the effectiveness of our care management strategies.

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

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

	Orgs	Orgs w/o EHR	Orgs w/No PCC and No EHR	Orgs w/HIE Tool	Orgs w/PCC	Orgs w/HIE Tool or PCC	Orgs w/o HIE Tool or PCC
Physical	43	4	0	26	8	26	17
Behavioral	193	54	0	4	4	6	187
Oral	24	6	0	3	3	4	20

Strategy 1 title:

Advancing a Phased HIE Strategy

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

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

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):

IHN-CCO is advancing a phased HIE strategy to improve bi-directional data exchange with county and provider partners in alignment with OHA EHR and HIE Roadmap priorities. The strategy focuses on strengthening care coordination, improving timely access to information, and supporting whole-person care, with an emphasis on community mental health, high-risk maternal care, and primary care integration.

IHN-CCO currently supports information sharing with the Benton County Health Department and Lincoln County primary care partners. HIE-sourced data, including hospital admission and discharge notifications, can be utilized by county partners to support trusted outreach and timely follow-up for members identified as needing additional services.

IHN-CCO is also developing inbound data exchange from county partners related to mobile crisis and other behavioral health interventions where CCO care management involvement may be appropriate. These activities support a broader, multi-year implementation plan to fully integrate Benton, Lincoln, and Linn County mental health data into the HIE.

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

This strategy involves expanding partnerships with counties and providers to enhance data sharing capabilities, focusing on seamless integration of care coordination and collaboration tools to support a more coordinated care model across the network. Although early in ideation, this promises to significantly impact our ability to coordinate care, share critical information, and monitor progress on key health outcomes collaboratively.

Our focus for the 2024-26 period is set on laying a solid foundation for a more integrated care model. This initiative is poised to enhance our approach to care coordination, leveraging partnerships to address the complexities of healthcare delivery and information management. This includes:

1. Targeted Pilot Programs and expansion of network partnerships: Selecting a few pilot programs based on partner readiness to engage in enhanced data sharing practices and member needs. Initial areas will include community mental health, high-risk maternal care, and other CCO performance metrics.
2. Collaborative Framework: Establishing agreements with partners outlining shared goals, responsibilities, and data sharing expectations. The goal is ensure that all parties are aligned and committed to improving health outcomes through integrated efforts.
3. Enhanced Data Sharing Capabilities: Upgrading IT infrastructure to enable seamless data exchange and ensure care teams have actionable real-time information as outlined in section 2A
4. Collaboration Tools: Integrating tools that facilitate the exchange of care plans, monitoring of CCO metrics, and tracking of progress on shared health outcomes communication and coordination among care teams. This enhancement means leveraging additional tools in Arcadia such as the Arcadia complex care management Impact Score to identify and share members most in need of care coordination or with care coordination gaps, and Arcadia's Assess module, which directly connects IHN-CCO to our partner clinics and their EHR, enabling communication and information exchange, such as enabling the IHN-CCO team to review clinical documentation about members, their gaps in care, and other quality/clinical information. It also enables our partners to upload supplemental documentation for quality and value-based payment initiatives. Another tool facilitating information exchange are the HIE tools mentioned in section 2A; OCHIN/EPIC/CareLink. These collaboration tools enable our team to review other providers and community partner information. For instance, our CM team is now able to view care plans and documentation for the County MCM programs, which they have been unable to see in the past. This is paramount because

we are often coordinating care and care planning for members that are also receiving similar services from other programs or providers.

5. **Monitoring and Evaluation:** Continuously monitoring the impact of these efforts on key health outcomes, allowing adjustments to enhance care coordination.
6. **Promoting Value-Based Care:** Enhanced data sharing and collaboration will enable us to leverage collective resources and expertise, improving care delivery efficiency and promoting value-based care.

This strategy we anticipate will strengthen our network's capacity for delivering comprehensive, coordinated care, thereby supporting our overarching goals of improving health outcomes, enhancing patient experience through coordinated care, and promoting value-based care. It will also create a more integrated, efficient, and responsive healthcare ecosystem that prioritizes our members' needs

Planned Activities

1. Expand Data Sharing Agreements and Integration with Pilot Partners
2. Launch a discovery process with Point Click Care on how to better utilize their platform for data sharing and care coordination activities.
3. Launch Pilot Projects to Utilize HIE Information and Integrated Care Models to Improve Care Outcomes. Benton county has agreed to work with IHN on this pilot of utilizing Point Click Care to support inter-organization care coordination management

Planned Milestones

1. By Q4 2024, identify specific care coordination and outcome improvement opportunities that can benefit from enhanced HIE information use and coordinated care models. This will involve working closely with pilot partners to pinpoint areas to have the most impact.
2. By Q2 2024, complete discovery process with Point Click Care to begin planning for pilot with Benton County
3. By Q1 2025, finalize and establish new data sharing/integrated care agreements with at least two additional county or provider entities.
4. Between Q4 2024 and Q1 2025, officially launch pilot projects designed to leverage HIE information for designing targeted care plans and coordinating care across different service providers.
5. By mid-2026, evaluate the outcomes of pilot projects to identify successful interventions and practices that can be scaled. This evaluation will focus on improvements in care coordination, patient outcomes, and efficiency gains.

Strategy 2 title:

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

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

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 <u>accomplishments/successes</u> and <u>challenges</u> with this strategy):	
(Optional) Overview of 2026-29 plans for this strategy:	
Planned Activities 1.	Planned Milestones 1.
Strategy 3 title:	
Strategy categories: Select which category(ies) pertain to this strategy ☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): (list here) ☐ 12: Other: (list here)	
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 <u>accomplishments/successes</u> and <u>challenges</u> with this strategy):	
(Optional) Overview of 2026-29 plans for this strategy:	
Planned Activities 1.	Planned Milestones 1.
Strategy 4 title:	
Strategy categories: Select which category(ies) pertain to this strategy ☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts ☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): (list here) ☐ 12: Other: (list here)	
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 <u>accomplishments/successes</u> and <u>challenges</u> with this strategy):	
(Optional) Overview of 2026-29 plans for this strategy:	
Planned Activities 1.	Planned Milestones 1.

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.

The complexity of integrating diverse data sources for comprehensive targeted interventions and bi-directional data exchange proved more challenging than expected, and for the most part still a manual process. Work is continuing on how to enhance and possibly automate this process.

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?

No identified needs from OHA for support .

E. CCO Access to and Use of EHRs

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

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

Samaritan: EpicCare Link
OHSU Epic: EpicCare Link
Legacy Epic: EpicCare Link
Salem Health Epic: EpicCare Link
Providence Epic: EpicCare Link
Peace Health Epic: EpicCare Link
OCHIN Epic (Benton County and Lincoln County): Direct limited view access

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

IHN-CCO, SNP, and Commercial eligible member information only for quality measure validation, HEDIS reporting, care coordination, and pharmacy.

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

Yes, contracted providers who are utilizing Arcadia to close care gaps export clinical encounter information from their EHRs and upload the documentation in Arcadia's Assess Module.

5. Health IT to Support SDOH

A. CCO Use of Health IT to Support SDOH: 2025 Progress & 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.

Arcadia: The Arcadia Analytics platform aggregates multiple sources of data (claims and clinical), which allows analysts to drill down to identify the unique complexities within the IHN-CCO member population. This analytic capability allows for more accurate risk stratification, and segmentation of the population for applicable care interventions. Arcadia Analytics advances quality and performance improvement through calculation and presentation of population health data and will be a key source for social determinants of health data. Inputs include EHR records, claims data, and Unite Us/Connect Oregon data. Allows for analysis of REALD/SOGI data (Race, Ethnicity, Language, and Disability/Sexual Orientation Gender Identity) as well as social service information such as housing, food security, and transportation needs.

Collective Medical: The Collective Medical platform provides a common technology platform for real-time care coordination.

Unite Us/Connect Oregon: Unite Us/Connect Oregon is a community driven and locally sustained tool for social determinants of health screening and closed loop referrals. Connect Oregon facilitates continuous communication and referrals between IHN-CCO, Community Mental Health Providers, Oregon Cascades West Council of Governments (OCWCOG) (the regional Senior and Disability Services), Dental Care Organizations, Primary Care Physicians including Patient-Centered Primary Care Homes, Behavioral Health Homes, and Federally Qualified Health Centers, and community-based organizations. IHN-CCO has invested in and supports the use of Connect Oregon for Samaritan and other contracted providers, providing no-cost licenses and support throughout the region. IHN is in the process of optimizing UniteUs to support the implementation of Health Related Social Needs (HRSN) and is adopting the UniteUs Social Care Payments Module to facilitate an integrated reimbursement model while also integrating UniteUs internally to streamline care coordination and utilization management processes. This combined approach will provide an end-to-end process for facilitating the referral, review, authorization, invoicing and payment processes for HRSN service providers. In addition to the Social Care Payments Module, IHN is working with UniteUs to integrate an SDoH screening tool and to standardize SDoH risk screening while ensuring a trauma-informed approach and has in the process of implementing UniteUs enhancements for Community Investments, member matching data feeds, and SSO functionality. These modules, or enhancements, create sustainable social care capacity and can measurably impact the health of our members and community, they include:

- **Social Care Payments Module** reimburses providers for the services they deliver with the option to manage person-level eligibility and service payment authorization. This will allow for community-based organizations and other partners to provide services for social determinants of health needs, receive payment from IHN-CCO, and manage their member panel.
- **Community Investments** is an enhancement where IHN-CCO provides funding to providers and then monitors the service delivery and spending as it happens. Similar to the Social Care Payments Module, it allows organizations to track provided services, provide IHN-CCO with the data to monitor spending and manage member care more comprehensively.
- **Member Matching Data Feeds** is an automated feature that matches IHN-CCO member data with the data in Unite Us/Connect Oregon. This will lead to better data collection and overall understanding of IHN-CCO member needs, especially social determinant of health needs. The member matching data feeds will allow for insight into SDOH screenings leading to increased data for metrics reporting and evaluation.
- **SSO** is a step towards full integration of the platform allowing users to log in faster and provides a single point of authentication.

Epic Care Everywhere/Healthy Planet: IHN-CCO also supports integration of Epic EHR, which is used by regional Community Health Centers, Federally Qualified Health Centers, Community Mental Health Programs, and Samaritan Health Services (SHS). Through Epic, SDOH screening data is systematically collected and providers are supported with Epic enhancements designed to support care coordination. Epic Care Everywhere allows providers on the system to securely share patient records with other health care providers. Epic Healthy Planet is a software module that, through its suite of reports, dashboards, and workflow tools, compiles patient data and allows healthcare organizations' care managers to manage patient populations more efficiently.

TriZetto's Clinical CareAdvance: IHN-CCO implemented CCA, a clinical operating system to provide our internal care management and utilization review team with a 360 view of the member. Through CCA, IHN-CCO care managers can effectively coordinate multiple services and supports, such as behavioral health, oral health and specialty providers, traditional health workers, transportation, and community-based support agencies. CCA enables care managers to effectively [coordinate](#) and document care transitions between episodes, treatment providers and settings, including hospitals, Oregon State Hospital (OSH), acute and rehabilitative facilities, transitional housing, and home. MCG clinical guidelines are integrated within CCA and support clinical decision

making to determine the appropriate level of care, utilization of services, and timely coordination of care transitions.

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

IHN-CCO is dedicated to developing internal health IT systems that allow for equity driven approaches to SDOH needs. As a regional partner throughout the three-county services area IHN-CCO is able to leverage substantial data resources to not only proactively identify member needs and assess intervention efficacy, but also to inform regional health equity conversations through the sharing, analysis, and facilitation of data systems. In addition to informing immediate outreach, referral pathways, and metric performance analysis, streamlined internal health IT systems will allow for informed long-term investments in community health.

IHN-CCO's shared regional Community Health Improvement Plan includes several goals to improve data quality in Housing, Behavioral Health, and Inclusion, Diversity, Anti-Racism, and Equity that include strategies to increase SDOH referrals and utilize regional HIT to increase the regional understanding of SDOH needs in our membership.

Strategy 1 title: Proactive use of data to identify individual member SDOH experiences and social needs

IHN-CCO maintains a community led approach to addressing SDOH needs; supporting community HIT infrastructure and serving as a resource and data analysis partner. Utilizing NCQA population assessment and data integration tools and working to integrate upstream approaches to SDOH through the Vital Conditions Framework IHN-CCO continues to assess available demographic data as well as community referral patterns captured in Unite Us, CCA, Arcadia, and Epic as part of developing effective SDOH interventions.

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

☒ 1: Implement/use health IT ☐ 2: Enhancements ☒ 3: Integration ☒ 4: Collaboration ☒ 5: Care coordination ☐ 6: 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: (list here)
☐ 15: Other SDOH data: (list here)

Strategy status:

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

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

2025 Progress included expanding the housing data analysis project begun in 2024 to include additional health data (now includes HMIS, Health System/Hospital and County Health Department records) to increase the value of data from this project. 2025 baseline analysis presented several high priority populations. IHN-CCO has been sharing best practices with Oregon based projects as well as consulting with Boston Medical Center on opportunities.

All OHA approved SDOH screening tools were incorporated into the Unite Us platform to facilitate SDOH screenings.

IHN-CCO established a data sharing MOU with a local agency to facilitate the ingestion of paper sdoh screening records to digital format.

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

IHN-CCO will continue to work with community partners and SDOH service organizations to streamline utilization of HIT tools.

Planned Activities - Continued education on utilization of zcodes beyond HRSN benefits. - Review expanded HMIS/EHR data project	Planned Milestones - Review claims data for utilization - Conduct review and assess findings
Strategy 2 title: Implementation of HIT tool/capability for social needs screening and referrals Utilization of Unite Us for screening, referrals, and HRSN benefit implementation	
Strategy categories: Select which category(ies) pertain to this strategy ☒ 1: Implement/use health IT ☐ 2: Enhancements ☒ 3: Integration ☒ 4: Collaboration ☒ 5: Care coordination ☒ 6: 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: (list here) ☐ 15: Other SDOH data: (list here)	
Strategy status: ☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed ☐ Ended/retired/stopped	
Progress (including previous year accomplishments/successes and challenges with this strategy): 2025 Progress: IHN-CCO has had a successful rollout of the HRSN program within the Unite Us CIE platform. While issues have occurred with claims processing, utilization of CIE for screening and referrals to the HRSN program has expanded the number of community based partners willing to utilize Unite Us for CIE.	
(Optional) Overview of 2025-26 plans for this strategy: Build on HRSN momentum to launch community provider contracts. Require or incentivize utilization of CIE for SDoH Screenings.	
Planned Activities - Establish community provider contracts with all data exchange conducted within Unite Us - Review ingestion of SDoH Screenings conducted as part of HRSN program to inform strategies going forward. - Explore member input possibilities with Unite Us (where member is able to submit a screening to their own profile rather than requiring face time with a provider.	Planned Milestones 1-3 fully executed contracts - Integrate existing HRSN SDoH screenings into partner contracting agreements. - Based on Unite Us implementation timeline and costs.
Strategy 3 title: Collaboration with network partners Collaborating with network partners to develop the technological framework that will support a regional social care network for the streamlined use of HIT/CIE	
Strategy categories: Select which category(ies) pertain to this strategy ☒ 1: Implement/use health IT ☒ 2: Enhancements ☒ 3: Integration ☒ 4: Collaboration ☒ 5: Care coordination ☐ 6: 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: (list here) ☐ 15: Other SDOH data: (list here)	
Strategy status: ☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed ☐ Ended/retired/stopped	
Progress IHN-CCO continues to engage with the Connect Oregon workgroup statewide and to develop strategies for implementation and optimization of shared HIT/CIE platforms to inform health programming both regionally and statewide. Facilitated collaboratives and workgroups increased knowledge and provided invaluable feedback as to the development of sustainable HIT models.	

Challenges have included the implementation of payment models through Unite Us/CIE. While partners are utilizing the social care payments module medical billing is still new territory to community based social care providers and the unpaid claims, delays, and rejections that are understood in medical spaces can be catastrophic for these partners.

Utilization of CIE for SDOH referrals amongst medical providers remains non-existent and while provider groups are not willing to accept referrals community partner organizations are disproportionately impacted with minimal compensation.

(Optional) **Overview of 2025-26 plans for this strategy:** IHN-CCO will continue to subsidize Unite Us licensure costs for the provider network and will expand outreach and technical assistance for non-HRSN use of SDOH tools.

Planned Activities

1. Ongoing review of medical provider utilization
2. Engagement with Behavioral Health providers regarding possible Unite Us/CIE implementation

Planned Milestones

1. Quarterly review of enrolled providers
2. Landscape and feasibility assessment with BH partners for expansion

Strategy 4 title: Use HIT to monitor and/or manage contracts and/programs to meet members' SDOH needs

Implementation of a comprehensive grant/community contract platform to support the development of a robust Social Care Network.

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

- ☒ 1: Implement/use health IT ☐ 2: Enhancements ☐ 3: Integration ☐ 4: Collaboration ☐ 5: Care coordination
☐ 6: 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: (list here)
☐ 15: Other SDOH data: (list here)

Strategy status:

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

Progress IHN-CCO implemented Blackbaud grantmaking software as scheduled for the launch of 2025 RFPs. The platform was found to be cumbersome and required navigating multiple pages per application to be able to access documents. Additionally documents were all stored separately rather than as a complete application. Extensive staff time was required to manage each application. Utilization was paused as partner organizations found the program unusable.

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

IHN-CCO will continue to manage grants through previous processes and will review Blackbaud feasibility going forward

Planned Activities

1. Review of Blackbaud platform as related to necessity and efficacy for internal teams

Planned Milestones

1. Decision made in 2026.

B. CCO Support of Providers with Using Health IT to Support SDOH Needs: 2025 Progress & 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.	
As outlined and described above, IHN-CCO supports and/or provides the following HIT tools to support SDOH needs: - Arcadia - Collective Medical - Unite Us/Connect Oregon - Epic Care Everywhere/Healthy Planet - TriZetto's Clinical Care Advantage	
(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.	
IHN-CCO is focused on both increasing connectivity of Health and SDOH systems on the shared assessment of data to identify regional health trends, barriers, and opportunities for partnership. Early projects to merge de-identified EPIC and Homeless Management Information System (HMIS) data have shown the methodology to be successful and are continuing. Serious safety concerns regarding community and sensitive data have dominated community conversations over the last year leading IHN-CCO to limit HIT/CIE requirements for partner organizations where appropriate.	
Strategy 1 title: Sponsor CIE for the Community and provide Financial support for CIE implementation and/or maintenance.	
Strategy categories: Select which category(ies) 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: (list here) ☐ 15: Other SDOH data: (list here)	
Strategy status: ☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed ☐ Ended/retired/stopped	
Provider types supported with this strategy: ☐ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☒ Social Services ☒ CBOs	
Progress IHN-CCO continues to subsidize the licensure cost of Unite Us throughout the region through the purchase of unlimited licenses, which has led to increased provider adoption. Increased utilization by IHN-CCO for the HRSN program expanded interest in adoption as well as increased demand for technical assistance and education support. IHN-CCO has hired a full time HRSN/Unite Us program manager to support community and provider needs.	
(Optional) Overview of 2026-29 plans for this strategy:	
Planned Activities 1. Continue to provider technical assistance and training 2. Support the utilization of Unite Us/CIE amongst Health System providers	Planned Milestones 1. Ongoing support through provider workgroups 2. Expand Health System enrollment by 10%
Strategy 2 title:	

Enhancements to CIE tools for increased functionality, health equity, SDOH data collection and HRSN utilization	
Strategy categories: Select which category(ies) 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: (list here) ☐ 15: Other SDOH data: (list here)	
Strategy status: ☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed ☐ Ended/retired/stopped	
Provider types supported with this strategy: ☐ Across provider types OR specific to: ☒ Physical health ☒ Oral health ☒ Behavioral health ☒ Social Services ☒ CBOs	
Progress (including previous year accomplishments/successes and challenges with this strategy): Demonstrated ability to develop effective program management in Unite Us/CIE including manageable workflows, effective collaboration, and billing mechanisms. Challenges occur between partner's internal systems and utilization of CIE—partners complain of extensive need to duplicate effort in multiple platforms.	
(Optional) Overview of 2026-29 plans for this strategy: In addition to building connectors IHN-CCO in 2025-2026 IHN-CCO plans to assess the successes and challenges of CIE adoption for HRSN and assess ways to integrate existing partner workflows into CIE as well as exploring expanded use of CIE Social payments for grant administration.	
Planned Activities 1. Ingestion of IHN-CCO Member Roster in Unite Us allowing community partner organizations to evaluate an individual's OHP status	Planned Milestones 1. Weekly ingestion of roster files: Q2 2026
Strategy 3 title: Utilization of HIT to support payments to Community Based Organizations	
Strategy categories: Select which category(ies) 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: (list here) ☐ 15: Other SDOH data: (list here)	
Strategy status: ☒ Ongoing ☐ New ☐ Paused ☐ Revised ☐ Completed ☐ Ended/retired/stopped	
Provider types supported with this strategy: ☐ Across provider types OR specific to: ☐ Physical health ☐ Oral health ☐ Behavioral health ☒ Social Services ☒ CBOs	
Progress (including previous year accomplishments/successes and challenges with this strategy): Following the successful implementation of the social care payments module and extensive expansion of the build in 2025 IHN-CCO continues to devote extensive staff time to onboarding and supporting community partners in the utilization of CIE and complexities of medical billing. Challenges include the reimbursement model inherent to medical billing creating substantial liabilities for community partner organizations.	
(Optional) Overview of 2026-29 plans for this strategy:	

As HRSN payments become operationalized IHN-CCO is developing and expanded plan to include additional payment pathways including grant invoicing, ILOS, and community social care payments.

Planned Activities

1. ILOS Billing build in Unite Us
2. Utilization of CIE for Alternative Payment Model contracts

Planned Milestones

1. Operational in 2026
2. Review and begin build in 2026

Strategy 4 title:

Integration of interoperability fo HIT systems that support SDoH with other tools.

Strategy categories: Select which category(ies) 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: (list here)
☐ 15: Other SDOH data: (list here)

Strategy status:

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

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

- ☐ Physical health ☐ Oral health ☐ Behavioral health ☒ Social Services ☒ CBOs

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

Bi-directional exchange with Arcadia was paused. Instead IHN-CCO elected to ingest Unite Us data directly for integration into Arcadia.

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

Review functionality and enhance as needed.

Planned Activities

1. Monitor data ingestion and integration with Arcadia and other health plans systems
2. Review Community needs and explore connectors between Unite Us and additional platforms (e.g. Apricot case management tool)

Planned Milestones

1. Ongoing
2. Ongoing feedback and community engagment

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 on the following page.

- ☐ 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

Use the table below OR your own table formatted with the same columns to report exceptions requests, including:

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

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.

The primary barrier to HIT for SDOH needs remains provider capacity and workload. Providers, organizations, and community partners utilize a wide variety of programs specific to their workflows, needs, and requirements and, while IHN-CCO is working to enhance Unite Us/CIE to better meet partner needs, there has yet to be a streamlining of operations.

This slow adoption has kept the IHN-CCO region from reaching a 'critical mass' where CIE is business as usual which then further limits adoption. IHN-CCO is working to overcome this by utilizing Unite Us/CIE for new projects and contracts where appropriate.

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?

Standardizing of reporting templates in ways that partners utilizing Unite Us are able to take advantage of. With 94% of CCOs utilizing Unite Us, covering the vast majority of Oregon Health Plan members OHA can work with Unite Us to develop reports for CCOs and other OHA administered grants in ways that partners and grantees can easily utilize the platform to get. This will decrease partner frustration, increase accuracy, and provide a standardized view of SDOH needs statewide. Allow us to compare apples to apples as it were!

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.

IHN-CCO has implanted mPulse patient portal in March 2026 and is planning to implement mPulse provider portal in July 202 to support interoperability. Providers are currently using One Health Port provider portal for prior authorizations and communication, but it does not meet new, and upcoming interoperability requirements.

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

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

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