2025 CCO Health Information Technology (HIT) Roadmap

Guidance, Evaluation Criteria & Reporting Template

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

Please:

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

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

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Guidance Document

1. Purpose & Background

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

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

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

Reminders for Contract Year 6 (2025):

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

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

2. Overview of Process

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

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

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

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

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

2025 Health IT Roadmap Timeline

Last Revised 12/2/2024

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

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

3. Health IT Roadmap Approval Criteria

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

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

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

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

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

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

2025 Health IT Roadmap Template

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

Instructions & Expectations

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

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

Each required topic includes the following:

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

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

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

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

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

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

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

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

A note about the template*:*

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

Health IT Roadmap Template Strategy Checkboxes

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

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

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

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

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

CCO: Umpqua Health Alliance

Date: 4/30/2025

1. Health IT Partnership

Please attest to the following items.

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

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

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

UHA data can be found here: UHA's SDoH Screening and Referral Dashboard

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

3. (Optional) Overview of CCO Health IT Approach

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

4. Support for EHR Adoption, Use, and Optimization

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

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

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

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

Notes:

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

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

Using the OHA-provided Data Completeness Table, 1 physical health, 3 oral health, and 3 behavioral health organizations do not have EHR information reported.

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

UHA leverages multiple existing processes to collect missing EHR information. We collaborate closely with many network providers to establish clinical data feeds directly from their EHR systems, ensuring timely access to current EHR data. In addition, we participate in the OHA EHR Data Submission process to gather updated EHR information from primary care practices. To further support data completeness, UHA also distributes a survey to all contracted providers to collect any remaining EHR information needed for the HIT Data File and UHA's HIT Incentive Program.

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

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

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

Strategy 1 title: Support EHR Enhancements for Member Engagement

Explore mobile app utilization for member engagement and outreach with large RHC clinic (Umpqua Health Newton Creek). The goal was to work with Umpqua Health Newton Creek and their EHR (eClinicalWorks), to enhance their member outreach.

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

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

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

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

To enhance member engagement and outreach, Umpqua Health Newton Creek successfully implemented the Healow app for their clinic members. This initiative aimed to streamline communication, improve access to health information, and provide a convenient platform for managing healthcare needs. Here are the key steps and benefits of this implementation:

1. **Setup and Access**:
   - Members were instructed to download the Healow app on their smartphones from the iOS or Android app stores
   - Upon downloading, members entered their name and date of birth, followed by the practice code to link their account to Umpqua Health Newton Creek
   - Members then selected their cell phone number to receive a text confirmation number, which they entered the app to verify their identity
   - After agreeing to the terms and conditions, members created a 4-digit PIN for secure access to the app
2. **Features and Functionality**:
   - The Healow app provided members with a secure platform to access their health information, including appointment schedules, lab results, and medication lists
   - Members could send secure messages to their healthcare providers, reducing the need for phone calls and enabling prompt responses to non-urgent health queries.
   - The app also allowed members to receive notifications and reminders for upcoming appointments, ensuring they stayed informed and engaged with their healthcare
3. **Patient Portal Integration**:
   - The Healow app was integrated with the existing patient portal, allowing members to log in using their portal credentials
   - This integration ensured that members had a seamless experience accessing their health information and communicating with their providers through a single platform
4. **Support and Training**:
   - Detailed instructions were provided to members on how to download and set up the Healow app
   - The Umpqua Health Newton Creek team offered support to members who encountered any issues during the setup process, ensuring that everyone could successfully use the app.
5. **Benefits to Members**:
   - The implementation of Healow significantly improved member engagement by providing a convenient and user-friendly platform for managing healthcare needs
   - Members appreciated the ability to access their health information on the go, communicate securely with their providers, and receive timely notifications and reminders
   - The app's secure messaging system enhanced communication efficiency, allowing members to address their health concerns promptly and effectively

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

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

Strategy 2 title: Expand Clinical Data Collection from EHRs to include REALD/SOGI and SDOH Data

UHA is committed to expanding the capture and reporting of REALD/SOGI and SDOH data to strengthen CCO metrics performance and support provider participation in the Umpqua Health HIT Incentive Program. UHA has implemented updates to their Clinical Data submission specifications to allow clinics to submit REALD/SOGI and SDOH data. Additionally, UHA provides technical assistance to clinic organizations to help establish and enhance clinical data feeds from their EHR systems. This includes regular meetings to review performance, coordinate provider outreach, and identify areas for improvement.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

UHA successfully established more technical assistance opportunities with clinic organizations and provided more data validation support than ever before in 2024. However, each Electronic Health Record (EHR) system presents unique complexities in how data is aggregated and structured for reporting purposes.

Currently 6 of the 24 clinics that submit Clinical Data to UHA are submitting some combination of REALD, SOGI, and SDOH data. UHA intends to expand both the number of clinics and the comprehensiveness of the data received in the coming year.

Challenges include being able to report on and submit all the various data points related to REALD/SOGI and SDOH data from all the various EMR systems. This will continue to be a challenging point as clinics change EMR vendors and as Federal and State reporting requirements evolve. Overcoming these challenges will require collaboration from UHA, the clinics, EMR vendors, and HIE vendors. While meaningful strides have been made in addressing these challenges, the effort remains very much in progress.

Lastly, 2024 was the first year that UHA included a REALD and SOGI reporting incentive in its HIT Incentive Program. UHA hopes that this will continue to incentivize practices to collect and provide this data to UHA.

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

Planned Activities	**Planned Milestones**
1. In 2025, UHA will be continuing to work with eCW and the remaining clinics to update their respective feeds to include the REALD/SOGI and SDOH data points. 2. We will be evaluating what is necessary to ensure all data received from clinical partners is correctly normalized for use in our systems.	1. Q2 2025 – Coordinate specification updates with any remaining clinics or EMR vendors. 2. Q3 2025 – Work with ECW clinics to implement PRAPARE form implementation (similar to UH Newton Creek) and begin data submissions. 3. Q3 2025 – Implement validation processes to ensure accurate and non-conflicting data is being submitted. 4. Q1 2026 – Increase the number of clinics reporting REALD, SOGI, and SDOH data from 6 to 8.

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

Strategy 3 title: Assessment/Tracking of EHR Adoption and Capabilities

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

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

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy): UHA's EHR adoption data collection process is explained in the section above titled "Briefly describe CCO plans for collecting missing EHR information via CCO existing processes" therefore, this strategy will be retired from reporting in this section.

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

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

Strategy 4 title: Outreach, Education and Collaboration with Network Partners

Outreach to providers, including:

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

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

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

Updated HIT Bonus FAQ available on the Umpqua Health website.

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

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

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

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

The level of interaction and involvement with the provider community, through the Quality Department is significant, that the Tiger Team was deemed obsolete. Strategy #8 outlines UHA's progress and plans for continued provider engagement and collaboration.

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

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

Strategy 5 title: Support Legacy EHR Data in Cloud-Based Archive

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

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

There are no new accomplishments, strategies, or milestones for this program. UHA pays for and interacts with a cloud-based archive that is used to collect and forward data onto various providers in the UHA network who seek historical information on the patients in their care. The data represents 15 years' worth of data collected in the Centricity community EMR system that was phased out in 2020/2021.

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

Continue to pay for the ongoing support and access to this system – which will likely run through 2048.

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

Strategy 6 title: Support, Expand, and Optimize Clinical Data Feeds

UHA uses an in-house platform called UHBI (Umpqua Health Business Intelligence) for analyzing and reporting on CCO incentive measures. Providers can access the Provider Portal housed by UHBI, which allows them to analyze their clinic level data. Clinical data is provided directly to UHBI by many of our contracted providers using a certified EHR vendor. UHA's Data Solutions and Quality teams train providers on the provider portal, share portal enhancements, review clinic level data for closing gaps, and troubleshoot any issues or barriers clinics are experiencing. As we identify gaps in these data feeds, we work directly with the EHR vendor, HIE, or follow up with each individual clinic to address any missing data.

UHA has expanded the scope of the clinical data collection process to include REALD/SOGI data elements along with SDOH data elements; both of which are being adopted and submitted by clinics, EMR vendors, and at least 1 Health Information Exchange (HIE). This has increased substantially since the project started in 2022 at 62% membership representation via clinical data feeds.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

UHA expanded the number of clinics, EMR systems, and HIE's that are supplying clinical data to UHA. As of 2025, UHA has received clinical data for over 87% of its active member population through these data sources. UHA also expanded the data points necessary for CCO Incentive Measure processing through the UHBI platform. It has been challenging to onboard smaller clinics that do not have strong technical resources capable of extracting and submitting data to UHA.

When data gaps are identified, UHA works directly with EHR vendors and individual clinics to resolve issues. Our efforts in 2024 included:

- Supporting clinics using common platforms (e.g., eClinicalWorks) and those submitting data via Reliance HIE to incorporate additional data elements into their feeds.
- Completing extensive data validation with clinics that provide data via Reliance HIE. Many issues were identified with these data feeds throughout 2024 which required UHA's Data Solutions team to dedicate efforts to address these issues with both Reliance, the clinic, and their EHR vendor.
- Collaborating closely with each clinic and their EHR vendor to address technical specifications, backend system updates, and data extraction needs.
- Offering workflow guidance and recommended EHR templates and form updates to ensure complete and accurate data collection.

(Optional) **Overview of 2025-26 plans for this strategy**:
Building on our strong foundation of establishing clinical data feeds with partner practices, UHA—currently the CCO submitting the highest percentage of EHR-based data to the OHA—will shift our 2025 focus toward data validation and optimization of existing feeds. These efforts aim to enhance data quality, reliability, and usability across the network.

Planned Activities	**Planned Milestones**
1. Establish standardized validation report process with clinics who provide clinical data to UHA. 2. Work with clinics one on one to validate their clinical data 3. Implement claims validation process compared to clinical data. 4. Provide the clinics with tools to validate data being provided to UHA through the clinical data report in UHBI. Modify the report to include higher priority data elements and trend data. 5. Consider exploring development of a tableau dashboard to establish "seat belts"	1. Establish an automated validation report for clinics that will be emailed out to them when errors are identified by Q2 2025. 2. Update the clinical data report in UHBI by Q3 2025. 3. Work with UHA's Decision Support team to establish a tableau dashboard for the Quality team to use to identify significant variations in metric performance among clinics submitting clinical data by Q4 2025.

Strategy 7 title: Created a Community Forum for Clinics using a Common EHR (eClinicalWorks)

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

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy): The community forum was retired due to staffing turnover. Collaboration opportunities are provided to clinics who use eClinicalWorks as needed.

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

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

Strategy 8 title: HIT Incentive Program – Contract requirements, financial support, incentives, and technical assistance to adopt EHRs

- Promote HIT incentive program in provider communications (meetings, newsletters, etc.)
- Monthly provider meetings for interested organizations where the HIT incentive program, EHR adoption/upgrades/optimization, and clinical data feeds are discussed.
- The HIT incentive program is outlined in all provider contracts as an opportunity for all contracted providers that meet specific criteria, including EHR adoption, to participate in.
- UHA offers technical assistance from the initial engagement throughout the onboarding process.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
UHA's Quality team established monthly meetings with clinics serving greater than 80% of our members in 2024. The other local PCP offices are outreached to regularly, to keep them up to date on impactful changes and opportunities for growth and improvement.

The Quality team continues to offer ad-hoc TA, in-person and virtually, for all of our local provider partners to fill any gaps in education.

The Quality team also engages clinics directly when there are issues discovered through analysis of their performance, to offer assistance in troubleshooting and resolving the barriers hindering their improvement efforts.

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

Planned Activities	**Planned Milestones**
1. Modify the HIT incentive program to be more impactful and align with OHA and UHA priorities that demonstrate improvement in utilization and optimization of EHR tools.	1. By 1/1/25 modify the HIT incentive contract language and communicate changes to contracted providers. 2. Hold monthly meetings with primary care clinics that represent 80% of UHA's

2. Continue to engage with primary care clinics to ensure they are making progress towards EHR adoption. 3. Partner with UHA's Behavioral Health team to work with more behavioral health practices on EHR adoption.	assigned membership throughout 2024 and 2025. 3. Outreach to two behavioral health practices in UHA's network to offer assistance and incentives for EHR adoption through the HIT incentive program by 8/31/25.

Strategy 9 title: EHR Adoption in Local Pharmacies

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

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

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

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

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

Strategy status:

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

Provider types supported with this strategy:

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

Progress (including previous year accomplishments/successes and challenges with this strategy): This pilot program ended due to staffing turnover.

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

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

B. EHR Support Barriers:

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

UHA experiences variability in EHR adoption among provider types. Behavioral health providers often require more specialized features, creating challenges with one-size-fits-all EHR systems. Primary care providers have different EHRs depending on practice size and smaller practices are less likely to engage in clinical data exchange via their EHR due to having limited technical staff available.

C. OHA Support Needs:

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

Emphasize the value for behavioral health specific needs and curate EHR system recommendations that are better aligned with behavioral health workflows/documentation needs. Help offset the costs associated with larger, more established certified EHRs.

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

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

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

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

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

Notes:

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

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

Progress	Plans		Progress	Plans	
☒	☒	1. Care coordination and care management	☒	☐	4. Enhancements to HIE tools (e.g., adding new functionality or data sources
☒	☒	2. Exchange of care information and care plans	☒	☒	5. Collaboration with external partners

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

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

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

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

Strategy 1 title: Arcadia ADT Integration Optimization

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

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

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

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, UHA collaborated with Arcadia's Customer Success Manager, Senior Applications Enablement Analyst, and Director of Customer Success to develop an automation plan for six of the 19 Changes in Health-Related Circumstances as defined in OAR 410-141-3865.

The broad scope of Changes in Health-Related Circumstances presents challenges in developing specific automation without generating unmanageable workloads for staff. Additionally, limited data sources for many of the defined circumstances further complicate automation efforts.

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

Planned Activities	**Planned Milestones**
1. Implement automation in Arcadia 2. Evaluate efficiency of the automation 3. Review workload and workflow	1. Complete implementation of automation during Q2 2025. 2. Evaluate, review and revise automation and workflows quarterly beginning Q3 2025.

Strategy 2 title: Implement use of Care Guidelines

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

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

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

Strategy status:

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

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

UHA's Case Manager workflows in PointClickCare (PCC) were updated in 2024 to include care guidelines, insight review, and entry of member insights when appropriate. Challenges included high staff turnover mid-year and the onboarding of new case managers, which led to decreased PCC utilization.

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

Planned Activities	**Planned Milestones**
1. Complete updates to annual PCC training for staff. 2. Implement an annual training for network providers regarding information that is shared by the CCO in PCC to assist with Care Coordination.	1. Implement trainings by Q4 2025.

Strategy 3 title: Utilize Daily Reports to Provide Care Coordination Support

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

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

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

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

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

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

☒ 4: HIE tool enhancements ☐ 5: Partner collaboration ☒ 6: Risk stratification & population segmentation
☐ 7: Other:

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

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

In November 2024, UHA integrated the PAC Management platform into PointClickCare (PCC). This enhancement enables case managers to receive real-time alerts when a member in their caseload is admitted to a skilled nursing facility (SNF). It also provides access to labs, chart notes, risk alerts, and insights into factors influencing changes in risk levels. This integration strengthens UHA case managers' ability to coordinate discharge planning in collaboration with the member, SNF staff, and other care team members.

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

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

Strategy 4 title: Develop Cohorts to Improve Case Management Delivery

In previous years, we reported on the following two strategies:
1. Develop cohorts to improve case management delivery
2. Develop a cohort for UHA members receiving LTSS

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

- UHA created and began utilizing a cohort titled “Top 50 ED Utilizers Encounters” to enable engagement of those members while in the ED. This cohort is updated monthly for accuracy and efficiency in managing utilization and cost.
- UHA works in collaboration with Healthful (fka, Vituity) Ed navigators to follow the top 50 ED utilizers. These navigators have access to the Point Click Care platform and the cohort above, enabling them to be alerted when one of the top utilizers are in the ED. When the navigator is onsite at the hospital, they visit the member at the bedside in an attempt to identify barriers and facilitate a follow up appointment with the member’s PCP.
- Two cohorts were developed to assist care coordination of UHA’s TANF population:
  - TANF Admissions
  - TANF Discharges
- Develop and maintain the LTSS cohort monthly. UHA’s intensive care managers utilize the cohort to track their assigned LTSS members as they move in and out of the hospital setting. Real time notification of hospital admission ensures the assigned care coordinator outreaches to the member and hospital staff to facilitate a successful transition back home, decreasing the likelihood of readmission.
- Built a report for members receiving Medicaid funded LTSS. Developed a Tableau dashboard showing a roster of all LTSS members and shared it with Aging and People with Disabilities (APD) to facilitate care coordination for these members. The dashboard is updated daily using the 834 files and is easily downloadable in various formats including Excel

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

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

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

In 2024, UHA continued utilizing designated cohorts to support care coordination efforts. UHA maintained its collaboration with Rely Health to conduct outreach to members visiting the Emergency Department (ED). Onsite

Rely Health navigators proactively engage with members from the top 50 ED utilizers list at Mercy Medical Center (MMC), providing resources and assistance to help reduce ED utilization and establish primary care connections.

Additionally, UHA continues to utilize the Tableau dashboard to monitor and identify new members receiving LTSS. A prioritized member list is regularly shared with local APD to facilitate collaborative service coordination.

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

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

Strategy 5 title: Member Risk Stratification

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

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

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

Strategy status:

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

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

In 2024, UHA collaborated with the Arcadia Customer Success Team to leverage existing ACG risk score tools within the Arcadia Care Management platform to develop an automated risk stratification method. This method enables ongoing monitoring of risk across the UHA member population, categorizing members as no, low, moderate, or high risk.

UHA's risk stratification model and workflow received OHA approval in Q4 2024.

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

Planned Activities	**Planned Milestones**
1. Implement the risk stratification model and workflow. 2. Develop and implement reporting strategies to effectively monitor and evaluate the success of the program. This will include defining key performance indicators (KPIs), establishing data collection methods, and creating regular reporting structures to assess program outcomes and identify areas for improvement.	1. Implement risk stratification model and workflows by the end of Q2 2025. 2. Develop reporting and monitoring strategies by the end of Q3 2025. 3. Conduct a quarterly program evaluation based on reporting insights in Q4 2025.

Strategy 6 title: Member Flags & Program Automation

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

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

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

☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☒ 6: Risk stratification & population segmentation
☐ 7: Other:

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

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

During 2024, UHA collaborated with Arcadia's Customer Success team to enhance the identification and monitoring of key populations requiring care coordination. As a result, members in the LTSS, SPMI, Foster Care, Maternity, and SHCN populations are now systematically flagged within the Arcadia platform, allowing for improved tracking and targeted interventions.

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

Planned Activities	**Planned Milestones**
1. Finalize automation logic and complete the implementation of programs and workflows.	1. Complete implementation of flag automation and workflows by the end of Q3 2025.

Strategy 7 title: Testing AI in Care Management Workflows

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

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

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

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

UHA has piloted Arcadia's AI-driven product, "Summarize," providing feedback on the content that would be most beneficial for the care coordination team when reviewing a member's care profile. Through our collaborative efforts, we successfully configured the program to display the majority of the data we needed. The use of the Summarize feature has the potential to reduce the time care coordinators spend researching various resources related to recent member encounters, claims, provider visits, medications, and more. This efficiency can significantly increase the productivity of care coordinators.

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

Planned Activities	**Planned Milestones**
1. Continue collaborating with Arcadia to enhance the consistency of responses. 2. Integrate the use of the Summarize feature into care coordinators' daily workflows.	1. Review user feedback with Arcadia by the end of Q2. 2. Implement updates to Summarize logic in partnership with Arcadia based on user feedback by Q3 2025. 3. Pilot daily use across select teams and gather feedback on usability and impact by Q4 2025.

Strategy 8 title: Payer Supplied Measure (PSM) Implementation in Arcadia Analytics

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

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

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

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024 – UHA began supplying PSM information to Arcadia through routine data feeds. These are based on CCO incentive measure calculations made in the UHBI data platform (developed and maintained by UHA). Arcadia exposes this data to UHA's care management team who can utilize it at the point of care.

(Optional) **Overview of 2025-26 plans for this strategy**:
Continue to submit PSM information via routine data feeds to Arcadia and continue to utilize these calculated values in UHA's care management system.

Augment the PSM data feeds with newly calculated measures pertaining to Social & Emotional Health as well as Language Access.

Planned Activities	**Planned Milestones**
1. Update the PSM measures to align with the 2025 measure specifications. 2. Develop internal measure calculations for Language Access and Social & Emotional Health measures. 3. Deliver these results to Arcadia via the existing data feed process.	1. Complete 2025 specification updates by Q1 2025. 2. Complete new measure builds by Q1 2025. 3. Add new measures to the PSM data feeds by Q2 2025.

Strategy 9 title: Participate in the IMPACTS Grant Program

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

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

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

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

Strategy status:

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

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

1. Within the IMPACTS dashboard that UHA maintains, UHA's Decision Support team modified the ICC Overview tab, year over year visualizations to better demonstrate the increase in overall ICC services over time. This allowed for comparative analyses rather than having to toggle between multiple years.
2. The IMPACTS annual evaluation for CY 2024 was completed.

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

Planned Activities	**Planned Milestones**
1. Add a metric centric dashboard that highlights major improvement targets or areas for improvement. 2. Complete CY 2025 Annual Evaluation	1. Add metric centric tab to dashboard for evaluation/performance tracking by Q3 2025. 2. Conduct dashboard visualization overhaul, streamlining/simplifying data points by Q4 2025. 3. Complete annual evaluation for CY 2025 by Q1 2026.

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

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

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

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

Notes:

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

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

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

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

- Arcadia Care Management – Care Plans
- Reliance – Health Information Exchange (HIE)
- Point Click Care (Collective Medical) – Hospital Event Notifications
- Connect Oregon (Unite Us) – Community Information Exchange (CIE)

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

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

Using the OHA-provided Data Completeness Table, 14 physical health, 8 oral health, and 26 behavioral health organizations do not have HIE information reported or do not currently have access to an HIE for care coordination or for hospital event notifications.

Strategy 1 title: Support Innovative Solutions to Leverage Additional Data from the Reliance HIE

Since 2019, UHA has participated in the Reliance eHealth collaborative subscription agreement for health plan services for one service, a claims/data delivery interface between the HIE and UHA's UHBI platform for use in clinical data calculations. While UHA supports providers onboarding to the Reliance Community Health Record tool, UHA does not currently have access to this tool. In 2025, UHA plans to explore other ways to leverage data and tools from the Reliance HIE to support care coordination and hospital event notification efforts through two different strategies:

- **Reliance Integrated Data Exchange (RIDE) Project**: Increase the scope of data received from Reliance HIE to include 'ALL Source' information which represents data from all providers/vendors Reliance HIE partners with which includes UHA's local hospital, three additional primary care practices, and additional providers outside of UHA's service area.
- **Initiation and Engagement in SUD Treatment (IET) Pilot**: Pilot the IET Report in the Reliance HIE Community Health Record platform with UHA's primary care providers to give them real time actionable data on their assigned members who receive SUD diagnoses outside of their clinic, particularly those that occur at the hospital and ED. UHA has been using PCC for this but would like to explore the capabilities within Reliance now due to the expanded reach of data received by the HIE.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
UHA updated its current agreement with Reliance HIE, to allow UHA to receive data feeds based on all UHA members and on all sources that Reliance has access to instead of the limited clinics and members that has previously been in place since 2019.

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

Planned Activities	**Planned Milestones**
1. Integrate Reliance 'All Source' information into Metrics Processing for population health and care coordination activities that clinics conduct through UHA's UHBI platform. 2. Evaluate Reliance 'All Source' information for use by Customer Care, Care Management and Behavioral Health departments. 3. Pilot IET Report process with two clinics in order for clinics to be apprised of their patients who receive SUD diagnoses outside of their practice so they can ensure their patients get connected to SUD treatment services.	1. Integrate Reliance HIE data into UHA's UHBI platform by Q3 2025. 2. Evaluate additional data points provided in the Reliance HIE data for use in other UHA programs by Q4 2025. 3. Establish access to Reliance Community Health Record IET Report by Q2 2025. 4. Work with two clinics to pilot the IET Report by Q3 2025.

Strategy 2 title: Provider Engagement & Education for Reliance HIE

UHA support providers in connecting to the Reliance Health Information Exchange (HIE) platform and offers technical assistance opportunities. UHA promotes the Reliance HIE in provider communications such as clinic meetings, UHA's Quality Metrics Subcommittee, and UHA's providers newsletter. The Reliance HIE offers a Community Health Record as well as the opportunity for clinics to send clinical data to UHA.

- Clinical data includes elements needed for CCO metrics reporting.
- Improves care coordination by having the data flow into the HIE.
- Creates a more robust data set that allows more practices to have access to clinical data via HIE.

Outreach to providers to introduce Reliance and assist those interested with the onboarding process includes:

- Agenda item at monthly provider meetings
- Direct outreach via email, in-person site visits, phone or virtual meetings
- Monthly Quality Metrics Subcommittee meetings

Additionally, UHA holds regular meetings with Reliance, which includes discussions on best practices for provider engagement, current adoption levels, progress on active implementation, discuss future implementations, opportunities to improve platform use, and periodic validation of all Reliance data feeds.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
UHA met weekly with Reliance in 2024 and communicated regularly with all five primary care clinics that are connected to the Reliance HIE. UHA and Reliance invested considerable effort in reviewing the raw data received from clinic EHR systems and assessing how that information is extracted into the event files that Reliance sends to UHA on the clinic's behalf. Although the CCD data format is standardized, variations and nuances across different EHR vendors have presented some challenges. In 2024, Reliance encountered issues with event date accuracy and with extracting events from certain EHR sections (such as family history or social history) where the data did not represent valid events. Reliance, UHA, and the clinics worked hard to remediate those issues however, some issues still persist.

(Optional) **Overview of 2025-26 plans for this strategy**:
To improve the completeness and accuracy of the data Reliance extracts from EHR systems and support re-enabling the 2025 data feeds, Reliance will be establishing a monthly one-hour data review meeting throughout Q2. They will conduct an accuracy review and completeness check which will include cross referencing events received with EHR data.

Planned Activities	**Planned Milestones**
1. Continue to meet with Reliance to discuss best practices, clinic involvement, and adoption levels at minimum biweekly. 2. Initiate data validation processes with Reliance to ensure accuracy and completeness.	1. By Q2 2025, Reliance will hold accuracy review meetings with all five clinics. 2. By Q3 2025, UHA will connect with all five Reliance clinics to ensure confidence in the Reliance data.

Strategy 4 title: Offer Financial Incentives through the Umpqua Health HIT Incentive Program

UHA continues to offer its HIT Incentive Program annually to all contracted providers that meet specific criteria, including HIE adoption; we include the program in all provider contracts. We also provide partial incentives to practices that were able to make partial progress within the Program.

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

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

Strategy status:

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

Provider types supported with this strategy:

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

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

In addition to the financial incentives outlined in our provider contracts to support the use of Reliance, we continue to actively engage providers and promote adoption of the platform. While community engagement levels have varied, communication efforts remain consistent, and we continue to reinforce the value and benefits of utilizing reliance.

As new practices are established and additional qualifying healthcare and service entities join the network, we proactively introduce them to the platform and encourage participation to support broader adoption

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

Planned Activities	**Planned Milestones**
1. Update the HIT Incentive to include HIE and PCC connection as a requirement to participate in the HIT Incentive Program in 2025. 2. Monitor non-HIE participating clinics to identify any new enrollments with the PCC platform following the 2025 contract change. 3. Track and document provider response to the updated HIT incentive structure, which now requires PCC enrollment for eligibility. 4. Collect data on any newly engaged clinics, although the high saturation of PCC in community settings suggests minimal additions are expected.	1. By Q1 2025, implement changes to the UHA HIT Incentive Program to include HIE and PCC participation as a required gate. 2. By Q2 2025, communicate changes to the HIT incentive with providers. 3. By Q3 2025, work with non-HIE participating clinics to encourage them to enroll particularly for those who were previously eligible for the HIT Incentive prior to the 2025 changes.

Strategy 5 title: Provider Engagement & Education for Point Click Care (Collective Medical)

UHA covers the cost for providers to connect to Point Click Care (PCC) and offers technical assistance opportunities. UHA promotes PCC in provider communications such as clinic meetings, UHA's Quality Metrics Subcommittee, and UHA's providers newsletter.

Outreach to providers to introduce PCC and assist those interested with the onboarding process includes:

- Agenda item at monthly provider meetings
- Direct outreach via email, in-person site visits, phone or virtual meetings
- Monthly Quality Metrics Subcommittee meetings
- PCC resources on the Umpqua Health website

Additionally, UHA holds regular meetings with PCC, which includes discussions on best practices for provider engagement, current adoption levels and opportunities to improve platform use.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, UHA held monthly meetings with many of its contracted clinics to discuss PCC workflows. UHA also had PCC present to the provider community directly at one of our Quality Metrics Subcommittee meetings in 2024. There is increasing interest in utilizing this platform to assist in improving outcomes for several of the CCO incentive measures, but the development of programs internally was delayed during 2024 with staffing changes in the departments who would be engaging in that work.

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

Planned Activities	**Planned Milestones**
1. Continue to share PCC workflow resources with clinics who are currently onboarded to PCC to encourage higher rates of utilization. 2. Connect with newly contracted clinics to share PCC resources and encourage them to connect.	1. Check-in with onboarded clinics at minimum bi-annually to review workflows and monitor utilization patterns. 2. Connect two additional clinics to PCC by Q4 2025.

Strategy 6 title: Pilot Test for “Assigned but Not Yet Engaged” Population Cohort in PCC

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

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Umpqua Health Newton Creek (UHNC) dedicated Quality staff to utilize this report on a monthly basis to reach out to assigned members that are not engaged in primary care services to establish care. UHNC experienced barriers around members showing up in the cohort that visited their urgent care but are not actually assigned to UHNC for primary care services. This is being addressed with PCC.

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

Planned Activities	**Planned Milestones**
1. UHA and UHNC will work with PCC to ensure that the cohort only includes members assigned to UHNC. 2. Newton Creek will do outreach to members on the list of members in the “assigned but not yet engaged” cohort monthly.	1. By Q2 2025, clean up the PCC cohort for UHNC. 2. By Q4 2025, conduct monthly outreach to members in the PCC cohort. 3. By Q1 2026, provide feedback to PCC on the pilot program.

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
UHA hasn't experienced many barriers in accessing HIE tools for care coordination however, utilization rates of the tools have been low despite efforts to share workflows and provide technical assistance opportunities particularly with Point Click Care. Additionally, UHA experienced barriers with the Reliance HIE data feeds that led to significant gaps in data throughout 2024.

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 could assist with reinforcing messaging around the value add for providers to use HIE tools for care coordination and hospital event notifications. It seems like shifting our focus to utilization and optimization in this space is key.

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)?
UHA care management and quality staff have direct access to the front end of the following EHRs: Athena, eClinicalWorks, and Meditech. Additionally, UHA receives clinical data feeds from the following EHRs either directly or via Reliance: Athena, Greenway, eClinicalWorks, Office Ally, Henry Schein Dentrix, and OCHIN Epic. Some clinics provide data to UHA via Arcadia Analytics as well this includes the following EHRs: Epic, Athena, Meditech, and eClinicalWorks.
What patient information is CCO accessing or will CCO access and for what purpose?
For the data accessed through direct front end EHR access, staff are accessing chart notes for care coordination activities and quality validation processes such as the hybrid review. For the clinical data feeds, this primarily includes standardized data submission files such as CCD data as well as supplemental data used in quality metric calculations in addition to REALD, SOGI, and SDOH data.
Is/will patient information being/be exported from the EHR and imported into CCO health IT tools? If so, which tool(s)?
The chart note data is not being imported into CCO health IT tools. The clinical data feeds are integrated into UHA's UHBI platform and some are also fed into Reliance and/or Arcadia Analytics.

6. Health IT to Support SDOH Needs

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

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

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

Notes:

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

Strategy category checkboxes (within CCO)

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

Progress	Plans		Progress	Plans	
☒	☒	1. Implement or use health IT tool/capability for social needs screening and referrals	☐	☒	7. Use data for risk stratification
☒	☒	2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)	☐	☐	8. Use health IT to monitor and/or manage contracts and/or programs to meet members' SDOH needs
☒	☒	3. Integration or interoperability of health IT systems that support SDOH with other tools	☒	☒	9. Use health IT for CCO metrics related to SDOH
☒	☒	4. CCO leads problem solving efforts and collaboration with their partners	☐	☒	10. Education/training of CCO staff about the value and use of health IT to support SDOH needs

☒	☒	5. Care coordination and care management	☒	☒	11. Participate in SDOH-focused health IT convenings, collaborative forums, and/or education (excluding CIE governance)
☒	☒	6. Use data to identify members' SDOH experiences and social needs	☐	☐	12. Participate in CIE governance or collaborative decision-making
☐	☐	13. Other strategies for adoption/use of CIE or other health IT to support SDOH needs within CCO (please list here):			
☐	☐	14. Other strategies for CCO access or use of SDOH-related data within CCO (please list here):			

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

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

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

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

Strategy 1 title: Integrate Unite Us Data Feed into Arcadia Analytics

Implement measure calculations for SDoH Screening and Referral Component 2 Rates 1, 2 & 3 per the Measure specifications by the end of CY2025 within Arcadia Analytics.

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

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

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

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
UHA made progress with Arcadia Analytics on the SDoH Component 2 measure build in 2024. UHA successfully established a new clinical connector to integrate CIE data from Unite Us into the Arcadia Analytics tool. Arcadia also completed the measure build for all three rates of the SDoH measure. UHA's Quality Director presented at the Arcadia Analytics conference and shared about this innovative measure build.

UHA's care management team updated the health risk assessment to align the SDoH screening questions with the OHA-approved PRAPARE screening tool and provided a z-code mapping to Arcadia Analytics of the questions.

UHA has encountered several barriers in data collection for the SDoH measure build. A primary challenge is the lack of screening and referral data within the Unite Us platform, which limits visibility into social needs interventions. Some of this is due to organizations not using Unite Us regularly and some of this had to do with restrictions related to sensitive data types and 42 CFR Part 2 from Unite Us. Additionally, with no updated coding guidance provided by OHA for the current measurement year, UHA is utilizing the standardized code set from the 2023 measure specification to support measure development. It would be helpful to have an updated code set from OHA to ensure consistency and reliability of data capture and reporting.

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

Planned Activities	**Planned Milestones**
1. Map the SDoH screening and referral data terms in Arcadia from the Unite Us source. 2. Integrate screening data from UHA's Health Risk Assessment into the SDoH measure calculation. 3. Integrate screening and referral data from other existing clinical connectors in Arcadia such as UHA's primary care clinics.	1. Complete term mapping in Arcadia by Q2 2025. 2. Integrate the SDoH screening data from the HRA by Q3 2025. 3. Integrate screening and referral data from 2 clinical connectors in Arcadia by Q1 2026.

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

The overall goal is to connect members to resources that address social needs.

UHA's Care Coordination Team aims to:

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

UHA's Utilization Management Team aims to:

- Increase the source of referrals and availability of applying for HRS Flex services to our members.
- Unite Us plays a crucial role in facilitating communication and coordination between UHA and community partners. By enabling initial screenings and referrals for services related to HRS flex, Unite Us allows us to streamline processes and foster more efficient collaboration.

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

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

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Members now have improved access to referrals and support services across multiple platforms, including the Unite Us platform. Through Unite Us, members can directly communicate with UHA. Each member is assigned a care navigator, care coordinator or UM specialist who provides ongoing support throughout the application process and is available to respond to both member and UHA needs.

Additionally, network clinics have increased their use of Unite Us to submit referrals for Care Coordination services, enhancing closed-loop communication and streamlining service delivery.

(Optional) **Overview of 2025-26 plans for this strategy**: Expand use of the Unite Us platform to facilitate multiple channels of communication regarding member needs with UHA.

Planned Activities	**Planned Milestones**
1. Continue to educate and train staff on the importance of using Unite Us to send referrals for SDoH needs. 2. Socialize information with the community to ensure they are aware that they can send referrals to UHA as well.	1. Increase the number of referrals sent through Unite Us by UHA's Care Coordination and UM teams from 294 referrals in CY 2024 to 350 referrals in CY 2025 measured in Q1 2026. 2. Increase the number of referrals received by UHA from other organizations (providers and CBOs) from 97 referrals in CY 2024 to 125 referrals in CY 2025 measured in Q1 2026.

Strategy 3 title: SDOH Screening & Referral Data Collection

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

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

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

Strategy status:

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

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

UHA conducted a second gap analysis of the Douglas County service area to assess food, housing, and transportation needs, providing deeper insights into the social determinants of health (SDoH) landscape. The analysis utilized data from the Oregon Hunger Task Force, Oregon Housing Alliance, and Rural Health US Food and Drug Administration to compare Douglas County with statewide trends. Additionally, a 2022 study of the Medicaid population was reviewed alongside UHA health risk assessment (HRA) and claims data to identify potential gaps in screenings and referrals. To enhance understanding, UHA developed a Tableau dashboard incorporating claims and HRA data, allowing for a detailed view of member social needs, community-based organization (CBO) distribution, and stratification by REALD identifiers.

Key findings from the 2024 gap analysis indicate that Douglas County has higher rates of poverty and food insecurity than the state average. Screening rates for food and housing remained low, as did referrals for transportation, food, and housing services. However, referrals sent through Unite Us have increased notably from 2023 to 2024. The analysis also revealed that housing and food referrals were the most commonly declined, and a significant portion of SDoH needs are being met outside the county. Additionally, while transportation needs have increased, the number of transportation CBOs has declined. Notably, in 2024, the Hispanic population in Douglas County had a disproportionately high number of SDoH-related diagnoses relative to their demographic representation.

UHA remains committed to expanding the use of SDoH data through further integration of our Community Information Exchange (CIE) data feed, Unite Us, into our population health and care management platform.

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

Planned Activities	**Planned Milestones**
1. Continue to update social needs prevalence data in the Tableau Dashboard and monitor gaps/trends. 2. Educate clinical and CBO partners on data capture workflows for SDoH screening and	1. Update the social needs data available in our dashboard by Q3 2025. 2. Meet with clinical partners to discuss optimization opportunities for data feeds

referral data via meetings and the development of an SDoH reporting document. 3. Track SDoH screening and referral workflows and reporting mechanisms for key provider partners and CBOs using a Smartsheet tracking document.	including the capture of SDoH data throughout Q2-Q4 2025. 3. Increase the number of organizations who can report on SDoH data to UHA through standard data formats from zero to 5 by Q4 2025.

Strategy 4 title: Develop HRSN-Related Functionality for Internal Use

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

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

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

Strategy status:

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

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

We partially implemented the Unite Us Payments platform for HRSN but ran into some functionality roadblocks along the way. We ultimately found solutions to some of these issues using other existing systems.

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

We have currently paused any further implementation of the Payments platform.

Planned Activities	**Planned Milestones**
1. Monitor ongoing rollout of HRSN requirements and guidance to determine if we could benefit from further implementation of Unite Us Payments.	1. N/A

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

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

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

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

Notes:

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

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

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

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

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

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

Strategy 1 title: Develop HRSN-Related Functionality and Supports for Providers & CBO Partners

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

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

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

Strategy status:

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

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

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

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

We partially implemented the Unite Us Payments platform for HRSN but ran into some functionality roadblocks along the way. We ultimately found solutions to some of these issues using other existing systems.

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

We have currently paused any further implementation of the Payments platform. However, we do still intend to begin utilizing Unite Us to support Closed Loop Referrals at some point in 2025.

Planned Activities	**Planned Milestones**
1. Solidify Closed Loop Referral workflows pertaining to CIE. 2. Identify the best window for rollout of these workflows to internal staff and HRSN Service Providers. 3. Conduct necessary training.	1. Onboard staff and Providers to Unite Us for HRSN Closed Loop Referrals by Q4 2025.

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

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

- Add all contracted pediatric clinics to the Unite Us Network.
- Add all contracted behavioral health providers who provide social-emotional health services to children birth to 5 years old to the Unite Us Network.
- Increase the number of organizations who are receiving referrals.
- Ongoing engagement and supporting CBO partners to ensure timely responses to referrals received.

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

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

Strategy status:

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

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

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

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

The initial goals outlined in the strategy—adding all contracted pediatric clinics and behavioral health providers serving children ages 0–5 to the Unite Us network—were successfully completed in 2024. Although the HIT Tiger Team has since retired, UHA continues to promote the use of Unite Us via the Quality team, particularly in connection with the Social Determinants of Health CCO incentive measure. Relevant use cases and engagement efforts are still regularly communicated to providers to support ongoing adoption and alignment with broader quality initiatives.

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

Planned Activities	**Planned Milestones**
1. The Quality team will work with primary care practices to identify barriers to using Unite Us. 2. Work with organizations who are onboarded to Unite Us to increase the number of providers receiving referrals and not just referring only. 3. The Community Engagement team to increase utilization of the Unite Us platform among CBO partners to ensure that referrals they receive from providers are being responded to timely.	1. Identify barriers among UHA's three largest primary care practices by Q2 2025. 2. Meet with three provider organizations who are sending referrals to encourage them to receive referrals by Q3 2025. 3. UHA's Community Engagement team will work with the top five CBOs to reeducate them on how to use Unite Us by Q4 2025.

Strategy 3 title: Implement the Unite Us CIE with Social Services and CBO Partners

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

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

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

Strategy status:

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Umpqua Health Alliance (UHA) identified 34 Community Benefit Organizations (CBOs) to prioritize for onboarding to the Unite Us platform. By the end of 2024, 29 CBOs or social service organizations were designated as active, engaged, or onboarded—an increase from 19 in 2023. Priority was given to organizations providing services related to housing, nutrition, and the social-emotional quality improvement metric (ages 0-5). This initiative included regular training sessions with Unite Us staff, presentations at UHA's annual conference, the inclusion of Unite Us participation as a requirement in all CBO funding agreements for health-related services, and ongoing outreach at community meetings to promote platform engagement.

In 2024, 42 organizations sent referrals, and 99 organizations received at least one referral, reflecting an increase from 2023, when 29 organizations sent referrals and 80 organizations received them. Overall, this initiative supported 493 clients, with 954 referrals sent throughout the year.

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

Planned Activities	**Planned Milestones**
1. Continue to encourage CBO partners to adopt Unite Us. UHA's Community Engagement Team will meet with UHA's Unite Us Account Manger to outline an outreach and engagement strategy aligned with the expanding need for closed-loop referrals as identified in the HRSN benefit and Social Determinants of Health Metric. This community engagement strategy will include both reassessing identified priority partners and supporting utilization of the platform by currently onboarded but unengaged partners. 2. In 2026, UHA will evaluate the current state of Unite Us adoption in the county, revisiting community engagement goals to support continued expansion and adoption of Unite Us by CBOs into the CCO 2027 contract cycle.	1. Outline an outreach and engagement strategy for closed-loop referrals by Q2 2025. 2. Engage at least 80% of identified provider targets in discussion regarding the Unite Us platform by Q4 2025. 3. Onboard at least 20% of combined high priority and mid-priority provider targets by Q4 2025.

Strategy 4 title: Implement & Support SDOH Screening Tools and Establish SDoH Screening Community Standards and Best Practices

Unite Us, CIE has a closed-loop referral functionality and houses the PRAPARE (Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences) and AHC (Accountable Health Communities) tools that are available for use. Unite Us is made available to all contracted physical, oral, and behavioral health providers, social services, and CBOs at no cost. Through provider engagement it was discovered that many clinics are performing screenings using the PRAPARE or designed their own SDoH screening tools.

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

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

Strategy status:

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

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

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

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

UHA reviewed and updated three SDoH policies focused on screening and referral, training requirements and over-screening prevention, and REALD data utilization. To inform these policies, UHA conducted a second year of surveys, gap analyses, and Community Advisory Council (CAC) feedback collection to assess screening practices, tools, and data systems within the service area. The gap analysis also evaluated resource availability, identifying areas needing additional support.

To enhance screening and referral best practices, Unite Us facilitated multiple platform demonstrations for internal staff and external partners. UHA also developed an SDoH Action Plan Dashboard, leveraging insights from the gap analysis to strengthen community-based organization (CBO) capacity through financial and staffing resources. This plan aligns with key initiatives such as Health-Related Services (HRS) funding and the Supporting Health for All through REinvestment (SHARE) Initiative. The action plan prioritizes refining screening and referral workflows, advancing Unite Us implementation, improving data utilization, and providing training and reporting support to providers and CBOs.

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

Planned Activities	**Planned Milestones**
1. Review the three (3) SDoH policies for annual updates with the CAC. 2. Send reminder to internal CCO staff and external partners about SDoH training requirements outlined in the SDoH training policy. 3. Host Collaborative Screening Workshop for internal and external staff to establish best practices for screening and referral workflows. 4. Review additional SDoH training needs of the service area and continue familiarizing clinical and CBO partners with SDoH screening and referral expectations. 5. Resend 2024 SDoH survey. 6. Continue onboarding Unite Us in the service area and review additional training opportunities for CIE (i.e., host more platform demonstrations).	1. UHA will host a Collaborative Screening Workshop for internal and external staff to improve/implement social needs screenings and referrals for service area by Q3 2025. 2. Two (2) external organizations will conduct social needs screenings directly into Unite Us by Q4 2025. 3. A total of 20% of SDoH survey respondents will utilize an OHA-approved screening tool by Q2 2025.

Strategy 5 title: Expand Clinical Data Collection to Include SDOH

UHA is committed to expanding the capture and reporting of REALD/SOGI and SDOH data to strengthen CCO metrics performance and support provider participation in the Umpqua Health HIT Incentive Program. UHA has implemented updates to their Clinical Data submission specifications to allow clinics to submit REALD/SOGI and SDOH data. Additionally, UHA provides technical assistance to clinic organizations to help establish and enhance clinical data feeds from their EHR systems. This includes regular meetings to review performance, coordinate provider outreach, and identify areas for improvement.

This strategy is the same as strategy #2 in the Support for EHR Adoption section.

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

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

Strategy status:

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
UHA successfully established more technical assistance opportunities with clinic organizations and provided more data validation support than ever before in 2024. However, each Electronic Health Record (EHR) system presents unique complexities in how data is aggregated and structured for reporting purposes.

Currently 6 of the 24 clinics that submit Clinical Data to UHA are submitting some combination of REALD, SOGI, and SDOH data. UHA intends to expand both the number of clinics and the comprehensiveness of the data received in the coming year.

Challenges include being able to report on and submit all the various data points related to REALD/SOGI and SDOH data from all the various EMR systems. This will continue to be a challenging point as clinics change EMR vendors and as Federal and State reporting requirements evolve. Overcoming these challenges will require collaboration from UHA, the clinics, EMR vendors, and HIE vendors. While meaningful strides have been made in addressing these challenges, the effort remains very much in progress.

Lastly, 2024 was the first year that UHA included a REALD and SOGI reporting incentive in its HIT Incentive Program. UHA hopes that this will continue to incentivize practices to collect and provide this data to UHA.

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

Planned Activities	**Planned Milestones**
3. In 2025, UHA will be continuing to work with eCW and the remaining clinics to update their respective feeds to include the REALD/SOGI and SDOH data points. 4. We will be evaluating what is necessary to ensure all data received from clinical partners is correctly normalized for use in our systems.	5. Q2 2025 – Coordinate specification updates with any remaining clinics or EMR vendors. 6. Q3 2025 – Work with ECW clinics to implement PRAPARE form implementation (similar to UH Newton Creek) and begin data submissions. 7. Q3 2025 – Implement validation processes to ensure accurate and non-conflicting data is being submitted. 8. Q1 2026 – Increase the number of clinics reporting REALD, SOGI, and SDOH data from 6 to 8.

Strategy 6 title Establish Community Governance of Unite Us Platform

We are committed to enhancing SDoH workflows and initiatives in Douglas County through the launch of the biannual SDoH Collaborative, which will replace the Douglas County Connect Oregon User Group (DC COUG). This Collaborative will focus on key areas such as Unite Us, SDoH reporting mechanisms, and clinical and CBO workflows. Additionally, it will serve as a platform for external stakeholders to discuss barriers, share initiatives, and strengthen community networks to improve SDoH support and services.

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

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

Strategy status:

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

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

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

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

The DC COUG faced challenges with low attendance and limited agenda topics focused solely on Unite Us. As a result, UHA has retired the DC COUG and established a broader SDoH Collaborative. This new initiative still includes Unite Us but expands discussions to encompass a wider range of SDoH topics, ensuring a more comprehensive approach that aligns with the needs of clinical and CBO partners, as well as UHA.

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

Planned Activities	**Planned Milestones**
1. Develop agenda for the biannual SDoH Collaborative. 2. Invite our community partners to bring relevant topics to this open community engagement. 3. Launch SDoH Collaborative meetings.	1. Finalize agenda of first collaborative by Q2 2025. 2. Host the launch of the SDoH Collaborative by Q2 2025. 3. Host the 2nd SDoH Collaborative of the year by Q4 2025.

C. Using Technology to Support HRSN Services

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

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

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

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

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

Refer to Section 6.A Strategy 4.

In addition to what is outlined in the strategy above, we have successfully implemented an invoicing solution to allow our HRSN Service Providers to be reimbursed for services. This solution ties into our existing authorization and claims system, which helps to ensure that invoices align with authorization limits during claims adjudication.

2025-27 Plans:

Refer to Section 6.A Strategy 4.

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

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

Refer to Section 6.B Strategy 1.

2025-27 Plans:

Refer to Section 6.B Strategy 1.

In addition to what is outlined in the strategy above, the bulk of our existing HRSN Service Providers already have access to CIE (Unite Us) and are open to using it for Closed Loop Referrals. So, when we are ready to ramp up the use of CIE in our own HRSN operations, we don't expect any significant friction with Providers. The Providers who may not utilize CIE are either larger, national providers who have other systems that will make the referral process more streamlined, or are local Providers with potential PHI concerns when it comes to using CIE.

We will be making use of Community Capacity Building Funds (CCBF) in 2025 to continue expanding and building capacity in our network. While this process has not yet started, it is possible that some of our partners may use some of these funds to ramp up their technology infrastructure, which could include use of CIE.

D. Health IT to Support SDOH Needs Barriers

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

In 2024, UHA faced several barriers that inhibited progress in supporting contracted providers, social service organizations and CBOs with using health IT to address SDoH. One major challenge was significant internal staffing turnover, which delayed momentum on key strategies and slowed implementation efforts. In parallel, uptake and consistent use of the Unite Us Community Information Exchange (CIE) platform remained limited among providers and CBOs. The success of the CIE platform is dependent on widespread participation; when only a portion of the network engages, trust in its value and sustainability declines. Additionally, UHA identified that health IT support needs vary across provider types. For example, CBOs often require different technical solutions and levels of support than clinical providers.

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?
OHA can strengthen CCO efforts to use health IT in support of SDoH by continuing to establish a statewide governance model for CIEs, which would promote alignment, consistency, and trust across systems. Additionally, OHA could support provider and CBO engagement by developing and distributing educational materials that highlight the value and impact of these tools. Finally, the inclusion of standardized code sets and clear guidance within the SDoH measure specifications would improve data consistency and support accurate reporting across the state.

7. Other Health IT Questions (Optional)

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

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

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

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