

2026 CCO Health Information Technology Roadmap

Reporting Template

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

Please:

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

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

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Instructions and expectations

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

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

Each required topic includes the following:

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

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

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

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

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

Notes:

- As part of OHA's digital accessibility effort, the 2026 Roadmap materials are formatted differently than in past years, but the content is familiar. **CCOs are encouraged to check the "Navigation Pane" box in the View tab of Microsoft Word to help with navigation of this document.** If you have any concerns or challenges with using the new template, please email CCO.HealthIT@odhsoha.oregon.gov to troubleshoot.
- Four strategy sections have been provided for each section of the template. Please copy and paste additional strategy sections as needed. When adding additional strategy reporting sections, please be sure to copy and paste the strategy section from the same part of the Roadmap (checkboxes differ section to section and so will be incorrect if copied and pasted from other parts of the Roadmap).
- Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- If CCO is not pursuing a strategy beyond 2025, note "N/A" in the Planned Activities and Planned Milestones sections.
- If CCO is implementing a strategy beginning in 2026, please indicate "N/A" in the progress section for that strategy.
- If CCO is continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.

CCO Name: Umpqua Health Alliance

1. Health IT partnership

Please attest to the following items.

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

☒ Yes

☐ No

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

☒ Yes

☐ No

c. CCO served, if elected, on the HIT Commons governance board or one of its committees. (Select N/A if CCO does not have a representative on the board or one of its committees.)

☐ Yes

☐ No

☒ N/A

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

☒ Yes

☐ No

2. (Optional) Overview of CCO health IT approach

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

Umpqua Health has a multi-pronged internal approach to supporting care coordination through Health IT.

Risk Stratification is imbedded in Case Manager workflows through integration in the software they utilize to perform their care coordination workflows.

Both the Arcadia and PointClickCare Case Management modules present Risk Stratification data and allow for systemic and automated workflows to be established, increasing efficacy and reducing administrative burden for the Case Managers.

Risk Stratification data is also embedded into Umpqua's "Provider Portal", for use in future deployments of network-wide Risk Stratification-based coordinated workflows. This visibility in Risk Scores for their assigned members will improve their practice-specific workflows for care coordination.

UHA's expansions in the contracted products utilized within both PointClickCare and in Arcadia have and will continue to enhance workflow optimization for these purposes.

Community and partner integration and education with HIT systems that utilize these data and are part of Umpqua's care coordination workflow are underway through multi-modal outreach and engagement.

As future enhancements are made, this will be continuously communicated to the system of care to ensure that users across the network are educated in the use and understanding of the risk stratification informed work done by Umpqua Health and also on how they can use their integrated systems in tandem with the CCO to improve the overall quality of healthcare outcomes for members.

3. Support for EHR adoption, use and optimization

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

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

- Report the number of physical, oral, and behavioral health organizations without EHR information using the Data Completeness Table in the OHA-provided CCO Health IT Data File (e.g., “Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information”). CCOs are expected to use this information to inform their strategies. Where applicable, information in the CCO Data Reporting File should support descriptions of accomplishments and successes.
- Include plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialling, Letters of Interest).
- Provide an overview of CCO’s approach to supporting EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination.
- **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 to support EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination include:
 1. A title and brief description
 2. Which category(ies) pertain to each strategy

3. The strategy status
4. Provider types supported
5. A description of 2025 progress, including:
 - i. Accomplishments and successes (including number of organizations, etc., where applicable)
 - ii. Challenges related to each strategy, as applicable
 - iii. How the strategy supports each type of provider selected
6. (Optional) An overview of CCO 2026-29 plans for each strategy
7. Activities and milestones related to each strategy CCO plans to implement in 2026-29

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

Using the OHA-provided Data Completeness Table, 1 physical health, 3 oral health, and 6 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 (ending after 2025).

Complete list of strategy categories

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

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

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

Click or tap here to enter text.

Strategy 1 title: Expand Clinical Data Collection from EHRs to include REALD/SOGI and SDOH Data

Brief description: UHA is committed to expanding the capture and reporting of REALD/SOGI and SDOH data to strengthen CCO gap analysis, disparity analysis, strategy development in population health and health equity initiatives for the entire membership population. UHA has implemented updates to their Clinical Data submission specifications to allow and encourage 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

UHA successfully established more technical assistance opportunities with clinic organizations and provided more data validation support than ever before in 2025. However, each Electronic Health Record (EHR) system presents unique complexities in how data is aggregated and structured for reporting purposes. Currently 11 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 years. 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 EHR systems. This will continue to be a challenging point as clinics change EHR vendors and as Federal and State reporting requirements evolve. Overcoming these challenges will require collaboration from UHA, the clinics, EHR vendors, and HIE vendors. While meaningful strides have been made in addressing these challenges, the effort remains very much in progress.

Lastly, 2025 was the last year that UHA included a REALD and SOGI reporting incentive in its HIT Incentive Program. UHA hopes that this will resume in the coming year(s) to incentivize practices to collect and provide this data to UHA.

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

Click or tap here to enter text.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Continue to provide assistance and work directly with the providers to increase potential uptake in	A. Obtain 3-5% growth in the volume of providers supporting the

Planned activities	Planned milestones
reporting of this data from the provider community.	collection and reporting of these data to UHA per year.

Strategy 2 title: Support Legacy EHR Data in Cloud-Based Archive

Brief description: • 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

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 physical health and behavioral health data collected in the Centricity community EMR system that was phased out in 2020/2021.

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

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

Planned activities and milestones

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

Planned activities	Planned milestones
1. Continue to pay for the ongoing support and access to this system	A. NA

Strategy 3 title: Support, Expand, and Optimize Clinical Data Feeds

Brief description: 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 by many of our contracted providers using a certified EHR vendor to UHBI. 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

UHA expanded the number of clinics, EMR systems, and HIE's that are supplying clinical data to UHA. As of 2026, UHA has received clinical data for over 86% 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 2025 included:

- Supporting clinics using common platforms (e.g., eClinicalWorks) and those submitting data to UHA to incorporate additional data elements into their feeds.
- Completing extensive data validation with clinics that directly provide data.

Many issues were identified with these data feeds throughout 2025 which required UHA's Data Solutions team to dedicate efforts to address these issues with the clinics, and their EHR vendors.

- 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.

Despite numerous complications that resulted in a total pivot from utilizing HIE as an intermediary to direct data submission from these clinics, UHA maintained reporting on this data for greater than 85% of assigned membership in 2025.

(Optional) **Overview of 2026-29 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 maintain our focus toward data validation and optimization of existing feeds into the coming years. These efforts aim to enhance data quality, reliability, and usability across the network.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Establish a reporting mechanism to demonstrate, evaluate and analyze the quality of care over time within the UHA network by integrating multiple HIT solutions into one oversight-oriented mechanism that will support our network adequacy, VBP and QAPI strategies.	A. 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 2026. B. Incorporate this comparative reporting mechanism into a larger reporting system that covers multiple metrics across the UHA system of care by end of year 2027.

Strategy 4 title: HIT Incentive Program – Contract requirements, financial support, incentives, and technical assistance to adopt EHRs

Brief description: • 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

UHA's Quality team established monthly meetings with clinics serving greater than 80% of our members in 2025. 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. These efforts continue and these assistive services are still offered and provided by UHA to providers. However, the HIT program as it was in prior years was ended 12/31/2025. UHA hopes that this will resume in the coming year(s) to incentivize practices to collect and provide this data to UHA. In the interim,

alternative plans to engage and incentivize providers in this work are being developed and deployed as possible. A model of fortifying the relations and systems that had previously been incentivized through this program leads the efforts, so that providers know and understand that the prior models of the HIT program, beneficial as they were did not serve the system of care the best of its potential. New models are being discussed and feedback obtained so that when the time is right, a more meaningful and ultimately more effective HIT program can be stood up in place of this one.

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

The HIT program as it was in prior years was ended 12/31/2025. UHA hopes that this will resume in the coming year(s) to incentivize practices to collect and provide this data to UHA.

Planned activities and milestones

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

Planned activities	Planned milestones
1. NA	A. NA

B. EHR support barriers

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?

The OHA can focus efforts to emphasize the value for behavioral health specific needs and curate EHR system comparison reports that better aligned with behavioral health workflows/documentation needs. Practices, especially the smaller ones consistently request help to offset the costs associated with larger, more established certified EHRs. Some form of financial assistance for a BH-oriented HITEC certified EHR system would be an invaluable method of increasing uptake by these smaller practices and also address the majority of data-sharing barriers that exist with the BH-IT topography.

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

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

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

- List and describe specific tool(s) you currently use or plan to use for care coordination, including risk stratification, and timely hospital event notifications.
- (Optional) Provide an overview of CCO's approach to using HIE for care coordination and hospital event notifications.

- **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 for using HIE for care coordination, including risk stratification, and hospital event notifications within the CCO include:
 1. A title and brief description
 2. Which category(ies) pertain to each strategy
 3. Strategy status
 4. A description of 2025 progress, including:
 - i. **Accomplishments and successes** (including number of organizations, etc., where applicable)
 - ii. Challenges related to each strategy, as applicable
 5. (Optional) An overview of CCO 2026-29 plans for each strategy
 6. **Activities and milestones** related to each strategy CCO plans to implement in 2026-29

Complete list of strategy categories (within CCO)

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

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

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

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

Click or tap here to enter text.

Strategy 1 title: Arcadia ADT Integration Optimization

Brief description: UHA leverages Arcadia’s ADT integration to identify members undergoing care transitions or experiencing episodes that may increase their risk. Through real-time alerts, care coordinators are notified early, enabling proactive outreach and timely coordination of services to support members during critical points in their care.

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

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

In 2025, UHA collaborated with Arcadia's Customer Success Manager, Senior Applications Enablement Analyst, and Director of Customer Success to implement automation for three of the six planned Changes in Health-Related Circumstance (CHRC) programs. 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 2026-29 plans for this strategy:**

Click or tap here to enter text. UHA plans to implement automation for the remaining three CHRC programs. In addition, enhancements will be made to the ADT-driven program by separating it into two distinct programs: one to identify members experiencing an inpatient stay and another to identify members who meet high emergency department utilization criteria. This approach will allow for a more targeted case management focus and improved care coordination.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Complete development and implementation of the remaining three CHRC programs. 2. Configure and implement automation within Arcadia to separate inpatient admission notifications from high emergency department (ED) utilization alerts.	A. Complete implementation of the three remaining CHRC programs by 2027. B. Complete implementation of the separate ADT notification programs in Arcadia by 2027.

Strategy 2 title: Implement use of Care Guidelines

Brief description: • 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 revision for 2026 forward is the focus on utilizing the Pac Management module in PCC, rather than focusing specifically on the Care Guidelines within PCC.

Strategy categories: Select which categories pertain to this strategy

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

☐7: Other: Click or tap here to enter text.

Strategy status:

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

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

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. In 2025 there were additional revisions to workflows. However, due to continued difficulties and a similar process already existing for the CM staff in Arcadia; attention in PCC was shifted to the PAC Management module instead. There has been significant uptake and utilization of the Pac Management module within PCC and this will be the focus of this project moving into the future.

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

Establish oversight over newly developed workflows and features of the Pac Management module in PCC.

Incorporate the items initially outlined as Care Guidelines to the Pac Management workflows and strategies where applicable.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Develop a workflow for case managers 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 Pac Management in the daily workflow for UHA case managers. • Provide education to network providers that use Point Click Care on platform use cases relating to this project.	A. Standardize workflows and develop SOPs for the uses of Pac Management by 2027. B. Engage the provider network at least twice regarding the use of PCC at least twice per year through 2029.

Strategy 3 title: Member Risk Stratification

Brief description: 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 categories pertain to this strategy

☒ 1: Care coordination ☒ 2: Exchange care information

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

- ☒5: Partner collaboration
- ☒6: Risk stratification and population segmentation
- ☐7: Other:

Click or tap here to enter text.

Strategy status:

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

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

In 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. Development of risk stratification based care coordination workflows and use cases has continued into 2025 and 2026 since being approved by the OHA.

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

Click or tap here to enter text.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Develop a workflow for case managers to facilitate information-	A. Standardize workflows and develop SOPs for the uses of risk-

Planned activities	Planned milestones
sharing with providers, specialists, caseworkers, and hospitals regarding risk-stratification informed care coordination. 2. Implement the use of risk-stratification in the daily workflow for UHA case managers. 3. Provide education to network providers that commonly engage with UHA in care coordination relating to this project and how they can be more meaningfully involved.	stratification in care coordination by 2027. B. Engage the 5 largest provider partners in our local network at least twice regarding the use of risk-stratification in care coordination at least twice per year through 2029.

Strategy 4 title: Member Flags & Program Automation

Brief description: 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 categories pertain to this strategy

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

☐7: Other:

Strategy status:

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

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

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.

In 2025, UHA continued collaboration with the Arcadia team to develop dynamic patient lists for the identified member populations and initiated testing of program automation designed to alert care coordinators when members are attributed to these populations.

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

Planned activities and milestones

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

Planned activities	Planned milestones
1. Implement program automation for LTSS, SPMI, Foster Care, Maternity, and SHCN populations, including automated task assignments that notify the member's care coordinator of special population attribution.	A. Complete program automation for the populations noted by the end of Q3 2026.

Strategy 5 title: Testing AI in Care Management Workflows

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

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

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 AI – driven features 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 2026-29 plans for this strategy:**

Click or tap here to enter text. UHA will continue leveraging Arcadia's Summarize feature to reduce care coordinator time spent reviewing multiple data sources and gathering information needed to assess member needs. Additionally, UHA will evaluate and adopt future AI-driven capabilities introduced by Arcadia that enhance care coordination accuracy, efficiency, and overall effectiveness.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Review, evaluate, and implement AI-driven functionalities that enhance the care management (CM) module within Arcadia to improve efficiency and time management for Care Coordinators.	A. Evaluate newly released AI capabilities intended to enhance Arcadia's Care Management (CM) module. Implement and operationalize approved AI features across appropriate workflows by the end of 2027.

Strategy 7 title: Participate in the IMPACTS Grant Program

Brief description: 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 categories pertain to this strategy

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

☐7: Other:

Strategy status:

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

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

UHA’s leadership has tasked UHA’s Decision Support team with modifying the annual IMPACTS report with more complete content, including what’s working well as well as which areas require improvement. The report will be more comprehensive for lessons learned and be used for program enhancements in other areas of the organization.

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

Planned activities and milestones

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

Planned activities	Planned milestones
1. Generate enhanced reporting for more meaningful oversight and awareness of this program.	A. Modify the annual IMPACTS report with more complete content, including what’s working well as well as which areas require improvement by June 30, 2026.

Strategy 6 title: Payer Supplied Measure (PSM) Implementation in Arcadia Analytics

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

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

In 2025 – UHA continues 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 2026-29 plans for this strategy:**

Click or tap here to enter text. UHA continues to submit weekly updates with the PSM information to Arcadia.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Continue to provide PSM data to Arcadia to fortify CM awareness of gaps in member care.	A. Complete at least 48 PSM updates to Arcadia through the data connection in 2026.
2. Create a reporting system that will allow for oversight of the integration and utilization by the CM staff.	B. Complete at least 48 PSM updates to Arcadia through the data connection in 2026.

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

Please describe your 2025 progress and 2026-29 plans for supporting increased access to and use of HIE for care coordination and timely hospital event notifications for **contracted physical, oral, and behavioral health providers**. Please include any work to support clinical referrals between providers. In the spaces below (in the relevant sections), please:

- List and describe specific HIE tool(s) you currently or plan to support or provide for care coordination and hospital event notifications. CCO-supported or provided HIE tools must cover both care coordination and hospital event notifications. Please include an overview of key functionalities related to care coordination.
- Report the number of physical, oral, and behavioral health organizations that have not currently adopted HIE tools for care coordination or do not currently have access to HIE for hospital event notifications using the Data

Completeness Table in the OHA-provided CCO Health IT Data File (e.g., “Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information”). CCOs are expected to use this information to inform their strategies. Where applicable, information in the CCO Data Reporting File should support descriptions of accomplishments and successes.

- (Optional) Provide an overview of CCO’s approach to supporting increased access to and/or use of HIE for care coordination and hospital event notifications among contracted physical, oral, and behavioral health providers.
- **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 to support increased access to and/or use of HIE for care coordination and hospital event notifications among contracted physical, oral, and behavioral health providers include:
 1. A title and brief description
 2. Which category(ies) pertain to each strategy
 3. Strategy status
 4. Provider types supported
 5. A description of 2025 progress, including:
 - i. **Accomplishments and successes** (including the number of organizations of each provider type that gained access to HIE for care coordination tools and HIE for hospital event notifications as a result of your support, where applicable)
 - ii. Challenges related to each strategy, as applicable
 6. (Optional) An overview of CCO 2026-29 plans for each strategy

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

Complete list of strategy categories (supporting providers)

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

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

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

HIE tools must cover both care coordination and hospital event notifications. The use of these tools should also be included in the applicable HIE strategies below.

- 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

Click or tap here to enter text.

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

Using the OHA-provided Data Completeness Table, 12 physical health, 8 oral health, and 29 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

Brief description: 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.

In 2026, the Initiation and Engagement in SUD Treatment (IET) "Pilot" has been incorporated into UHA's standard operations, supplanting the "RIDE" project entirely. At this time the "RIDE" concept is being retired but the "IET Advanced Notification" workflows are being adopted as standard operation procedures at UHA. This collaboration enables UHA to identify members with a new SUD diagnosis more quickly based on data from any provider within the Reliance

network who interacts with a UHA member. See the UHA “SUD IET PIP-2026 Annual Progress Report” for more information on this project.

Strategy categories: Select which categories pertain to this strategy

- ☐1: TA ☐2: Assessment ☒3: Outreach ☒4: Collaboration
- ☒5: Enhancements ☒6: Integration ☐7: Contracts ☐8: Financial support
- ☐9: Incentives ☐10: Hosted EHR
- ☐11: Other (requirements): [Click or tap here to enter text.](#)
- ☐12: Other: [Click or tap here to enter text.](#)

Strategy status:

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

Provider types supported with this strategy:

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

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

UHA has launched the “IET Advanced Notification” workflow across all primary care practices, using the Reliance-generated data as a real-time identification method for members newly diagnosed with SUD.

The goal is to improve care coordination and timely intervention, ultimately supporting better outcomes for members with SUD by sending daily reports to the pilot practices within 24 hours of a new SUD diagnosis. The timely alert

system gives primary care providers a critical window to engage patients and initiate SUD treatment within the 14-day IET measure.

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

Continue to report directly to our in-network PCPs regarding these advanced notices while also continuing the one on one engagement with Reliance to improve the quality and efficacy of their “SUD IET” reporting logic within the HIE coding environment.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Continue bi-weekly outreach to PCP offices regarding potential IET events for their assigned membership. 2. Continue meeting with Reliance HIE to improve the quality of their reporting engine to reduce manual secondary review required to eliminate the administrative burden generated by excluded events not currently excluded by their code logic.	A. Report bi-weekly outreach to PCP offices regarding potential IET events for their assigned membership at least 80 times during 2026. B. Meet with Reliance HIE at least 20 times during 2026 to improve the quality of their reporting engine to reduce manual secondary review required to eliminate the administrative burden generated by excluded events not currently excluded by their code logic.

Strategy 2 title: Provider Engagement & Education for Reliance HIE

Brief description: 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 categories pertain to this strategy

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

☐ 12: Other:

Strategy status:

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

Provider types supported with this strategy:

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

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

UHA met weekly with Reliance in 2025 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 2025, Reliance continued to encounter 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, these have not been fully resolved. Due to the technical complexities in these data sources and the likelihood of continued issues, the focus has shifted to exclude this as a source of data for quality metrics reporting. However, there is still significant work underway to expand the Reliance system in the UHA Behavioral Health network. It continues to be a valuable source of information for assisting in early notifications and for care coordination.

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

Click or tap here to enter text.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Work with Reliance to establish a Behavioral Health oriented module that more specifically addresses the privacy and data sharing concerns of the BH system of care.	A. Host a collaborative with Reliance, targeting the BH community locally by 12/31/2026. B. Sponsor or otherwise support Reliance data connection to at least ten of the smaller BH practices in the UHA network to increase uptake and utilization of the platform by our BH providers by 12/31/2028. C. Develop a resource to communicate functional use cases and platform features relevant to the unique needs of both BH and Physical providers, to enhance understanding of the platform and increase utilization in their respective workflows to reinforce care coordination across the UHA system of care by 12/31/2026.

Strategy 3 title: Offer Financial Incentives through the Umpqua Health HIT Incentive Program

Brief description: 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.

This program has been retired effective 1/1/2026.

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

Support efforts continue and TA services are still offered and provided by UHA to providers. However, the HIT program as it was in prior years was ended 12/31/2025. UHA hopes that this will resume in the coming year(s) to incentivize practices to collect and provide this data to UHA. In the interim, alternative plans to engage and incentivize providers in this work are being developed and deployed as possible. A model of fortifying the relations and systems that had previously been incentivized through this program leads the efforts, so that providers know and understand that the prior models of the HIT program, beneficial as they were, did not serve the system of care the best of its potential. New models are being discussed and feedback obtained so that when the time is right, a more meaningful and ultimately more effective HIT program can be stood up in place of this one.

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

Click or tap here to enter text.

Planned activities and milestones

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

Planned activities	Planned milestones
1. N/A	A. N/A

Strategy 4 title: Provider Engagement & Education for Point Click Care (Collective Medical)

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

In 2025, UHA held monthly meetings with many of its contracted clinics to discuss PCC workflows. UHA has also continued to include support for and education in PCC workflows and use-cases across the UHA System of care. Delays persisted throughout 2025. This was enhanced by the change in the agreement between the OHA and PCC that led to PCC removing sponsored access to additional cohorts for sponsored practices. These enhanced cohorts included the IET cohorts related to the CCO Incentive Measure stewarded by HEDIS. With this loss, new practices cannot make use of this valuable cohort in PCC. Fortunately, those in the UHA network before this change, were “grandfathered in” and still have access to this cohort in their catalogue of available cohorts.

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

Moving forward, due to the near 100% uptake in this system across UHA’s physical provider system of care, focus will shift more towards use cases for dental/oral and Behavioral Health providers to increase adoption and utilization of the platform by these traditional non-adoptive partners.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Communicate use cases and best practices to our network Dental/Oral Health and Behavioral Health providers.	A. Increase the number of BH provider practices utilizing the platform by at least ten, before June 2027. B. Increase the number of Oral/Dental partners utilizing the platform by at least three, by December 2027.

Strategy 5 title: Pilot Test for “Assigned but Not Yet Engaged” Population Cohort in PCC

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

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.

Feedback on the pilot and rates of utilization throughout were communicated by clinical staff to the PCC pilot team for use in product improvement.

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

The pilot completed in December 2025.

Planned activities and milestones

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

Planned activities	Planned milestones
1. N/A	A. N/A

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 and 2025.

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)?

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 Dentrax, 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.

5. Health IT to support SDOH

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

Please describe CCO 2025 progress and 2026-29 plans for using health IT **within your organization** to support social determinants of health (SDOH), including but not limited to screening and referrals. In the spaces below (in the relevant sections), please:

- List and describe the specific health IT tool(s) you currently use or plan to use for supporting SDOH. **For listed tools, include an explanation of their use/role in the strategy descriptions.**
- (Optional) Provide an overview of CCO's approach to using health IT within the CCO to support SDOH needs, including but not limited to screening and referrals.

- **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 for using health IT within the CCO to support SDOH, including but not limited to screening and referrals, include:
 1. Title and brief description
 2. Which category(ies) pertain to each strategy
 3. Strategy status
 4. Description of 2025 progress, including:
 - i. **Accomplishments and successes** (including number of referrals, etc., where applicable)
 - ii. Challenges related to each strategy, as applicable
 5. (Optional) Overview of CCO 2026-29 plans for each strategy
 6. **Activities and milestones** related to each strategy CCO plans to implement in 2026-29

Complete list of strategy categories (within CCO)

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

1. Implement or use health IT tool/capability for social needs screening and referrals
2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)
3. Integration or interoperability of health IT tools to systems that support SDOH with other tools
4. CCO leads problem solving efforts and collaboration with their partners
5. Care coordination and care management

6. Support HRSN services
7. Use data to identify members' SDOH experiences and social needs
8. Use data for risk stratification
9. Use health IT to monitor and/or manage contracts and/or programs to meet members' SDOH needs
10. Use health IT for CCO metrics related to SDOH
11. Education/training of CCO staff about the value and use of health IT to support SDOH needs
12. Participate in SDOH-focused health IT convenings, collaborative forums, and/or education (excluding CIE governance)
13. Participate in CIE governance or collaborative decision-making
14. Other strategies for adoption/use of CIE or other health IT to support SDOH needs within CCO
15. Other strategies for CCO access or use of SDOH-related data within CCO

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

Unite Us:

Unite Us 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 Unite Us 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.**

Click or tap here to enter text.

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

Brief description: 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 categories pertain to this strategy

☒1: Implement/use health IT ☐2: Enhancements ☒3: Integration

☐4: Collaboration ☐5: Care coordination ☐6: Support HRSN

☒7: Data to ID SDOH ☐8: Risk stratification ☐9: Manage contracts

☒10: Metrics ☐11: Education/training ☐12: Convenings

☐13: Governance ☐14: Other (adoption/use):

☐15: Other (SDOH data):

Strategy status:

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

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

UHA maintained the Arcadia Analytics build for the SDoH measure in 2025. UHA’s care management team updated the health risk assessment to align the SDoH screening questions with the OHA-approved PRAPARE screening tool. A connector was established between UHA’s Care Management Module in Arcadia and Arcadia’s Core Web platform. UHA engaged in term mapping efforts for both the Care Management connector and the Unite Us connector to ensure accurate data capture in the measure rates. UHA has encountered several barriers in data collection for the SDoH measure build related to the Unite Us connector. A primary challenge is the continued lack of screening and referral data within the Unite Us platform, which limits visibility into social needs interventions.

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

Click or tap here to enter text.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Continue working with Unite Us and Arcadia to address barriers to	A. Accurately capture all screening data that is input

Planned activities	Planned milestones
accurate and complete data capture through Unite Us related to SDOH screenings. 2. Identify ways to surface this data to UHA’s Care Coordination and member-facing teams.	into Unite Us from clinic partners by September 30, 2026 to surface in the Arcadia platform for internal use.

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

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

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

Providers, Community Based Organizations (CBOs), and UHA's Care Coordination team have improved access to referrals and support services for members across multiple platforms, including the Unite Us platform. Network clinics have increased their use of Unite Us to submit referrals for Care Coordination services, enhancing closed-loop communication and streamlining service delivery. The Care Coordination team re-established workflows in 2025 to use Unite Us more regularly for social needs referrals including "off-platform" referrals.

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

Expand use of the Unite Us platform to facilitate multiple channels of communication regarding member needs with UHA. Ensure workflows are functioning efficiently among UHA's Care Coordination team and network clinics as well as CBOs.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Monitor utilization of the platform for HRS flex services and referrals to UHA's Care Coordination team.	A. Establish a new baseline rate for referral volume to UHA's Care Coordination team from network partners and CBOs by June 30, 2026.
2. Provide continuous training and workflow review with UHA's Care Coordination team.	B. Establish a new baseline rate for HRS flexible services received through the Unite Us platform by June 30, 2026.
	C. Review workflows with Care Coordination team by September 30, 2026.

Strategy 3 title: SDOH Screening & Referral Data Collection

Brief description: 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 categories pertain to this strategy

☐ 1: Implement/use health IT ☐ 2: Enhancements ☒ 3: Integration

- ☒4: Collaboration ☐5: Care coordination ☐6: Support HRSN
- ☐7: Data to ID SDOH ☐8: Risk stratification ☐9: Manage contracts
- ☐10: Metrics ☐11: Education/training ☐12: Convenings
- ☐13: Governance ☐14: Other (adoption/use): [Click or tap here to enter text.](#)
- ☒15: Other (SDOH data): [Click or tap here to enter text.](#)

Strategy status:

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

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

UHA conducted a third 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.

The gap analysis highlights significant social needs across Douglas County, particularly in food access, housing stability, and transportation. Countywide indicators show higher rates of food insecurity, poverty, and housing cost burden compared to Oregon overall, with rural transportation challenges compounding

barriers to essential services and economic mobility. Community Themes and Strengths Assessment (CTSA) findings reinforce these concerns, as residents consistently identified food access, safe and affordable housing, healthcare access, and economic stability as key priorities and unmet needs. These structural challenges create a landscape where many residents face overlapping barriers that directly influence health outcomes and overall well-being. Screening and referral data reveal that UHA is conducting far more social needs screenings than predicted based on national Medicaid ACO study benchmarks, with 14,881 screenings completed compared to the estimated 9,833; however, housing, food, and transportation needs appear under identified compared to study results, and referrals across all domains remain lower than expected. Despite these gaps, referral volume is increasing year over year, indicating growth in system capacity and improved integration of the Unite Us platform. Additionally, Tableau dashboards developed by UHA show that the vast majority of members with SDoH-related diagnoses reside within Douglas County and that available community-based organization (CBO) resources are unevenly distributed, particularly in transportation, where no CBOs currently provide services aside from UHA's contracted provider. Equity-focused analyses further reveal disproportionate impacts among certain demographic groups. Members with unknown race, American Indian/Alaska Native members, and Black members all show higher rates of SDoH diagnoses relative to their representation in the overall UHA population. Non-Hispanic members are also slightly overrepresented in social needs diagnoses. Combined, these findings underscore the need for targeted strategies to improve screening accuracy, expand culturally responsive referral pathways, strengthen CBO partnerships—particularly in high-need domains—and ensure ongoing REALD-informed monitoring as UHA advances its 2026 SDoH Action Plan.

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

Click or tap here to enter text.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Conduct SDoH collaboratives with providers, SDoH partners and other key stakeholders.	A. Conduct at least two SDoH collaboratives each year to keep providers aware of the value of referral services through Unite Us.
2. Monitor utilization of the Unite Us platform among key partners for SDOH screening and referrals.	B. Work with Unite Us to identify reasons why UHA may not be receiving all screening data that is inputted from network clinics into Unite Us and reconcile differences by June 30, 2026.
3. Reconcile reporting differences between Unite Us reported data from account meetings and data from UHA's Unite Us data feed.	C; Provide targeted outreach on platform to partners identified through reporting as under-utilizing the platform at least twice yearly.
4. Engage low utilizing partners with additional TA on the system.	

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

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

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

This strategy has ended without completion. An alternate mechanism to the Unite Us payments module was selected for the final method for HRSN payment workflows.

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

NA

Planned activities and milestones

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

Planned activities	Planned milestones
1. NA	A. NA

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

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

- List and describe the specific tool(s) you currently or plan to support or provide to your contracted physical, oral, and behavioral health providers, as well as social services and CBOs. **For listed tools, include a description of their use/role in the strategy descriptions.**
- (Optional) Provide an overview of CCO's approach to supporting contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals.
- **For each strategy** CCO implemented in 2025 and/or will implement in 2026-29 to support contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using health IT to support social needs, including but not limited to social needs screening and referrals, include:
 1. Title and brief description
 2. Which category(ies) pertain to each strategy
 3. Strategy status
 4. Provider types supported
 5. Description of 2025 progress, including:
 - i. **Accomplishments and successes** (including the number of organizations of each provider type that gained access to health

IT to support SDOH needs as a result of your support, where applicable)

- ii. Challenges related to each strategy, as applicable
 - iii. How the strategy supports each type of provider selected
6. (Optional) Overview of CCO 2026-29 plans for each strategy
 7. **Activities and milestones** related to each strategy CCO plans to implement in 2026-29

Complete list of strategy categories (supporting providers)

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

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

12. Support participation in SDOH-focused health IT convenings, collaborative forums and/or education (excluding CIE governance)
13. Support participation in CIE governance or collaborative decision-making
14. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs
15. Other strategies for supporting access or use of SDOH-related data

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

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

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

Click or tap here to enter text.

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

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

UHA has currently paused any further implementation of the Payments platform. UHA implemented a closed-loop referral process beginning in February 2025 and maintained this process throughout the remainder of the year. This marked a key step in strengthening referral tracking and care coordination. As a newer process, ongoing efforts have focused on workflow refinement, staff adoption, and ensuring consistent use across teams. UHA worked with HRSN service providers

to train them on the workflow and remind them about Unite Us as a resource for referrals.

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

Click or tap here to enter text.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Maintain active Unite Us access for the majority of contracted HRSN service providers and CBO partners.	A. Reduce off-platform communication and duplicate documentation by reinforcing Unite Us as the primary referral and coordination platform.
2. Achieve consistent provider use of Unite Us for referral acceptance, documentation, and closure for HRSN services.	B. Continue alignment with OHA expectations for closed-loop referral tracking and reporting.

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

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

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 2026-29 plans for this strategy:**

The goals moving forward for this project focus less on expansion and more in fortifying the utilization of the platform by internal staff and external partners.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Conduct SDoH collaboratives with providers, SDoH partners and other key stakeholders.	A. Conduct at least two SDoH collaboratives each year to keep providers aware of the value of referral services through Unite Us.
2. Monitor utilization of the platform.	
3. Engage low utilizing partners with additional TA on the system.	B. Provide targeted outreach on Unite Us platform to clinic partners identified through reporting as under-utilizing the platform at least twice yearly.

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

Brief description: 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 Unite Us 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

Having established a robust network of connected partners in the local community as outlined in prior submissions, UHA is focusing on reinforcement of the current network to optimize utilization and collaborative efforts across the system of care.

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

The goals moving forward for this project focus less on expansion and more in fortifying the utilization of the platform by internal staff and external partners.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Continue onboarding and supporting HRSN service providers and CBOs on the Unite Us platform for HRSN closed loop referrals. 2. Standardize closed loop referral workflows in Unite Us across HRSN service domains (housing, nutrition, climate supports). 3. Provide ongoing technical assistance, office hours, and training resources to support consistent adoption and documentation. 4. Reinforce Unite Us as the shared, real-time system of record for referral status updates, outreach attempts, service delivery, and case closure.	A. Maintain active Unite Us access for the majority of contracted HRSN service providers and CBO partners. B. Achieve consistent provider use of Unite Us for referral acceptance, documentation, and closure for HRSN services. C. Reduce off platform communication and duplicate documentation by reinforcing Unite Us as the primary referral and coordination platform. D. Continue alignment with OHA expectations for closed loop referral tracking and reporting.

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

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

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 additional surveys, gap analyses, and Community Advisory Council (CAC) feedback collection to assess

screening practices, tools, and data systems within the service area. These gap analyses 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 analyses 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 2026-29 plans for this strategy:**

The goals moving forward for this project focus less on expansion and more in fortifying the utilization of direct reporting to the CCO through direct-data connections by external partners.

Planned activities and milestones

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

Planned activities	Planned milestones
1. UHA will continue to work with clinic partners one on one to provide workflow technical assistance and ensure they are using an approved SDOH screening tool. 2. UHA will continue to monitor and expand upon SDOH data collection through direct data connection with clinical partners.	Provide one on one technical assistance to contracted clinics to support workflows and data capture related to SDOH screening and referrals. Monitor and track SDOH screening and referral workflows and associated data by clinic and CBO partner in Smartsheet. Identify a way to aggregate all SDOH screening and referral data sources for ongoing monitoring by September 30, 2026.

Strategy 5 title: Expand Clinical Data Collection to Include SDOH

Brief description: 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 categories pertain to this strategy

☐ 1: Sponsor CIE ☐ 2: Enhancements ☒ 3: Integration ☐ 4: TA/training

- ☐5: Clinical/CBO referrals ☐6: Support HRSN ☐7: Financial support
- ☐8: Payments ☐9: Contract requirements ☐10: Track use
- ☐11: Outreach/education ☐12: Convenings ☐13: Governance
- ☒14: Other (adoption/use): Direct-data submission for reporting via EHR
- ☒15: Other (SDOH data): Direct-data submission for reporting via EHR

Strategy status:

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

Provider types supported with this strategy:

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

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

UHA successfully established more technical assistance opportunities with clinic organizations and provided more data validation support than ever before in 2024 and 2025. However, each Electronic Health Record (EHR) system presents unique complexities in how data is aggregated and structured for reporting purposes. Currently 11 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.

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

The goals moving forward for this project focus less on expansion and more in fortifying the utilization of the direct data reporting through direct-data connection by external partners.

Planned activities and milestones

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

Planned activities	Planned milestones
1. UHA will continue to monitor and expand upon SDoH data collection through direct data connection with clinical partners.	A. UHA will expand and enforce the parameters for types and formats for this reporting as the OHA and other authorities (Interoperability standards, HITEC etc.) continue to evolve.
2. UHA will continue to expand and improve upon SDoH reporting by including REALD and SO/GI elements in our data collection activities.	B. Monitor and track SDoH screening and referral workflows and associated data by clinic and CBO partner in Smartsheet.

Strategy 6 title: Establish Community Governance of Unite Us Platform

Brief description: 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 categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

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.

In 2026 and forward, this has been wrapped into the meaningful strategies of hosting SDoH collaboratives to overcome the single-use limitation of the DC COUG.

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

The goals moving forward for this project focus less on expansion and more in fortifying the utilization of the platform by internal staff and external partners.

Planned activities and milestones

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

Planned activities	Planned milestones
1. 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 and Clinic partners into the CCO 2027 contract cycle.	A. Conduct at least two SDOH collaboratives each year to keep providers aware of the value of referral services through Unite Us and discuss social needs screening and referral workflows.

C. Exceptions process if CCO requires CIE

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

☒ Yes

☐ No

Describe your CCO’s exceptions process, including:

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

UHA requires HRSN service providers to use the Unite Us CIE for HRSN closed loop referrals when a member has provided consent to participate in CIE. Unite Us serves as the primary platform for referral transmission, service status tracking, provider documentation, and case closure for HRSN services. UHA recognizes that limited exceptions may be necessary in certain circumstances and

has established an exceptions process consistent with OHA guidance.

How the Exceptions Process Is Communicated:

- The CIE requirement and exceptions process are communicated to HRSN service providers during onboarding, provider trainings, written guidance, and direct provider communications.
- Providers are informed that Unite Us is the preferred and required platform for closed loop referrals when member consent is present, with limited exceptions available.

How Providers Request an Exception

- HRSN service providers may submit an exception request to UHA outlining:
- The reason Unite Us cannot be used (e.g., technical limitations, PHI concerns, lack of system access, or member opt out of CIE participation).
- The anticipated duration of the exception (temporary vs. ongoing).
- Requests are submitted through UHA's HRSN administrative or provider relations channels.

How Requests Are Reviewed and Decided:

- Exception requests are reviewed by UHA's HRSN operational leadership and Health IT stakeholders.
- Requests are evaluated based on:
- Member consent status
- Compliance with OHA requirements
- Ability to maintain closed loop referral documentation and audit readiness through alternate secure processes
- When an exception is approved, UHA requires documentation of referral initiation, service status, and closure to be captured in UHA systems (e.g., CIM and internal tracking tools) to preserve end to end visibility.

How Decisions Are Communicated

- UHA communicates the decision back to the requesting provider in writing.
- If denied, the provider is informed of the reason and provided guidance on steps needed to use Unite Us or address barriers.

CCO exceptions requests from HRSN service providers

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

1. Provider name
2. NPI/Provider ID #
3. Date of request
4. Reason for request
5. Request decision and reason for decision if denied
6. Date decision was communicated to HRSN provider

Provider name	NPI/Provider ID #	Date of request	Reason for request	Request decision and reason for decision if denied	Date decision was communicated to HRSN provider
Peace at Home	500845525	December 1, 2025	The provider requested an alternate referral method due to heightened domestic violence confidentiality requirements and Unite Us data-sharing limitations that restrict assessment visibility and reporting for sensitive organizations.	UHA approved the request to use an alternate referral process due to Peace at Home's domestic violence confidentiality requirements and Unite Us data-sharing limitations for sensitive organizations, ensuring client safety and compliance.	December 15, 2025

D. Health IT to support SDOH barriers

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

UHA experienced several barriers that inhibited progress in supporting contracted physical, oral, and behavioral health providers, as well as social service organizations and CBOs, in using health IT to address SDOH needs. A primary barrier was the impact of state-level funding constraints affecting CCOs and their provider networks. These financial pressures limited the capacity of clinics and community partners to prioritize investment in new or enhanced health IT tools, including those that support standardized SDOH screening and referral workflows.

Additionally, competing priorities within clinical settings continued to challenge adoption and consistent use of SDOH-related health IT solutions. Clinics are managing multiple regulatory requirements, quality metrics, and operational demands, which can make it difficult to integrate new workflows, particularly those that require changes to existing processes or additional staff training. As a result, even when tools and platforms are available, uptake may be slower than anticipated.

Uptake and consistent use of the Unite Us Community Information Exchange (CIE) platform also remained a challenge across the network. The effectiveness of the CIE depends on broad participation from both healthcare providers and CBOs; when engagement is inconsistent, it limits the completeness of referral loops and reduces perceived value among users. UHA has also experienced repeated challenges in collecting SDOH screening and referral data from the Unite Us data feeds once a network partner does implement workflows in the

platform.

Finally, UHA continues to observe variation in health IT readiness and support needs across provider types. CBOs, in particular, often require different technical solutions, infrastructure, and training approaches compared to clinical providers. These differences can create additional complexity in designing and implementing scalable, equitable solutions to support SDOH screening and referral activities across the network.

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 further strengthen CCO and network efforts to use health IT in support of SDOH needs through a combination of financial, operational, and statewide alignment strategies. Continued advancement of a statewide governance model for Community Information Exchanges (CIEs) would promote consistency, interoperability, and trust across systems, which remains critical to long-term sustainability.

Given current funding constraints across CCOs and provider networks, targeted financial support or incentive opportunities for clinics and CBOs to adopt and sustain SDOH-related health IT tools would significantly improve uptake. This could include grant funding, infrastructure investments, or aligned incentives tied to social needs screening and referral activities.

OHA could also support adoption by helping reduce the operational burden on providers. 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.

Finally, expanded technical assistance and shared resources for both providers and CBOs would support more equitable participation. This could include

training, implementation toolkits, and best practice guidance tailored to different organization types, as well as educational materials that clearly demonstrate the value and impact of SDOH health IT tools to drive engagement.

6. (Optional) Other health IT questions

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

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

Click or tap here to enter text.

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

Click or tap here to enter text.

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

One of the most significant challenges in pursuing health IT strategies is navigating federal confidentiality requirements under 42 CFR Part 2, particularly for behavioral health providers. While these regulations are critical for protecting patient privacy, they can create barriers to timely data sharing and care coordination across physical, behavioral, and social service settings. Variability in how organizations interpret and operationalize these requirements further complicates integration efforts, often requiring additional consent workflows, system configurations, and staff training. As a result, these complexities can slow the implementation and scalability of

interoperable health IT solutions that support whole-person care, including SDOH screening and referral processes.

- 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?

Click or tap here to enter text.

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