2022 Updated HIT Roadmap Template

Please complete and submit to CCO.MCODeliverableReports@dhsoha.state.or.us and cc: CCO.HealthIT@dhsoha.state.or.us by **April 28, 2022.**

CCO: Cascade Health Alliance

Date: 4/28/2022

Instructions & Expectations

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

1. HIT Partnership
2. Support for EHR Adoption
3. Support for HIE – Care Coordination
4. Support for HIE – Hospital Event Notifications
5. HIT to Support Social Needs Screening and Referrals for Addressing SDOH Needs
6. Other HIT Questions (optional section)

Each required topic includes the following:

- Narrative sections to describe your **2021 progress, strategies, accomplishments/successes, and barriers**
- Narrative sections to describe your **2022-2024 plans, strategies, and related activities and milestones**. For the activities and milestones, you may structure the response using bullet points or tables to help clarify the sequence and timing of planned activities and milestones. These can be listed along with the narrative; it is not required that you attach a separate document outlining your planned activities and milestones. However, you may attach your own document(s) in place of filling in the activities and milestones sections of the template (as long as the attached document clearly describes activities and milestones for each strategy and specifies the corresponding Contract Year).

Narrative responses should be concise and specific to how your efforts support the relevant HIT area. OHA is interested in hearing about your progress, successes, and plans for supporting providers with HIT, 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 HIT. That said, CCOs' Updated HIT Roadmaps and plans should

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

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

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

Accomplishments/successes: Positive, tangible outcomes resulting from CCO's strategies for supporting providers.

Activities: Incremental, tangible actions CCO will take as part of the overall strategy.

Milestones: Significant outcomes of activities or other major developments in CCO's overall strategy, with indication of when the outcome or development will occur (e.g., Q1 2022). **Note**: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.

A note about the template*:*

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

New for *2022 Updated HIT Roadmap Template*

To further help CCOs think about their HIT strategies as they craft responses for their 2022 Updated HIT Roadmap, OHA has added checkboxes to the template that may pertain to CCOs' efforts in the following areas:

- *Support for EHR Adoption*
- *Support for HIE – Care Coordination*
- *Support for HIE – Hospital Event Notifications*

The checkboxes represent themes that OHA has compiled from strategies listed in CCOs' 2021 Updated HIT Roadmaps.

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

Please send questions about the Updated HIT Roadmap template to CCO.HealthIT@dhsoha.state.or.us

1. HIT Partnership

Please attest to the following items.

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

2. Support for EHR Adoption

A. 2021 Progress

Please describe your progress supporting increased rates of EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select the boxes that represent strategies pertaining to your 2021 progress.
2. Describe the progress of each strategy in the appropriate narrative sections.
3. In the descriptions, include any accomplishments and successes related to your strategies.

Note: If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.

Overall Progress
Using the boxes below, please select which strategies you employed during 2021. Elaborate on each strategy and the progress made in the sections below.

☒ EHR training and/or technical assistance	☐ Financial support for EHR implementation or maintenance
☒ Assessment/tracking of EHR adoption and capabilities	☒ Requirements in contracts/provider agreements
☒ Outreach and education about the value of EHR adoption/use	☒ Leveraging HIE programs and tools in a way that promotes EHR adoption
☐ Collaboration with network partners	☐ Offer hosted EHR product
☐ Incentives to adopt and/or use EHR	☐ Other strategies for supporting EHR adoption (please list here)

i. Progress across provider types

Outreach and education about the value of EHR adoption/use
In 2021, CHA completed provider training virtually utilizing [redacted] VOIP platform to allow providers and staff to watch the video sessions at their convenience (within a designated timeframe determined by CHA). One session was dedicated to HIT and EHR capabilities. The session highlighted the benefits of EHR adoption and

HIE use for our members as well as for the providers. Another session focused on the updates made to the provider portal in 2021 with a walkthrough of the steps to submit authorizations in the portal and how to track the status.

Assessment/tracking of EHR adoption and capabilities
To assist in collecting EHR use information in 2021, CHA's Provider Network Manager sent out follow-up emails for the HIT Survey to providers that had not responded. This outreach effort was successful in gaining information from several additional providers that did not originally respond to the HIT Survey sent by OHA.

EHR training and/or technical assistance
In 2021, CHA continued to support the local FQHC in converting from [redacted]. Significant progress was made in 2021, after stalled progress in 2020 due to the global pandemic, with expected completion by Q3 2022. CHA continued to provide technical assistance to one pediatric clinic for EHR metric reporting after their EHR conversion to [redacted] 2020.

Leveraging HIE programs and tools in a way that promotes EHR adoption
Reliance HIE Onboarding Program summary: Program ended on June 30, 2021. In 2021, one behavioral health provider joined as a contributor and another behavioral health provider joined as a portal participant for the Community Health Record (CHR). Six additional providers onboarded as CHR participants, while two other providers joined as eReferrals participants for a total of eight clinics onboarding as a Reliance portal participant in 2021.

CHA leverages the Collective Medical and Reliance eHealth platforms to promote EHR adoption among contracted providers due to the additional benefits that come from using both platforms in conjunction with an EHR.

Requirements in contracts/provider agreements
In 2020, CHA included an amendment in provider contracts that included verbiage for meaningful engagement and participation in HIT initiatives and HIE opportunities and continued use of amendment in 2021 contracts.

ii. Additional progress specific to physical health providers

See *Across Provider Types* section.

iii. Additional progress specific to oral health providers

One oral health provider changed to [redacted] which helped them to work out previous claims submission issues that they were having and allowed them to solely submit electronic claims starting in July 2021. The same oral health provider onboarded with Reliance as a portal participant in 2021. One additional oral health provider joined Reliance as a portal participant for the Community Health Record access.

iv. Additional progress specific to behavioral health providers

One behavioral health provider onboarded with Reliance as a data contributor (they were using the CHR previously) and another behavioral health clinic joined as a portal participant for the CHR.

v. Please describe any barriers that inhibited your progress

CHA operates in a rural area with a smaller population, where clinics are small with small patient panels. For small clinics, the expense to implement and maintain an EHR is too great. In addition to not having the financial resources to implement an EHR, most small clinics also lack the human resources needed to implement an EHR. Due to the ongoing pandemic, most clinics experienced resource and bandwidth constraints. Many clinics also had open staff and provider positions which hindered engagement with the clinics, reduced new project initiation, and put many initiatives on hold.

B. 2022-2024 Plans

Please describe your plans for supporting increased rates of EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select the boxes that represent strategies pertaining to your 2022-2024 plans.
2. Describe the following in the appropriate narrative sections:
    a. The number of physical, oral, and behavioral health organizations without EHR information using the Data Completeness Table in the OHA-provided CCO HIT 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.
    b. Plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialling, Letters of Interest).
    c. Strategies you will use to support increased rates of EHR adoption and address barriers to adoption among contracted physical, oral, and behavioral health providers beyond 2021.
    d. Activities and milestones related to each strategy.

Notes: Strategies described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy; however, please make note of these strategies in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2022-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and include activities and milestones in the sections below.

☒ EHR training and/or technical assistance	☒ Financial support for EHR implementation or maintenance
☒ Assessment/tracking of EHR adoption and capabilities	☒ Requirements in contracts/provider agreements
☒ Outreach and education about the value of EHR adoption/use	☒ Leveraging HIE programs and tools in a way that promotes EHR adoption
☒ Collaboration with network partners	☐ Offer hosted EHR product
☐ Incentives to adopt and/or use EHR	☐ Other strategies for supporting EHR adoption (please list here)

i. Plans across provider types, including activities & milestones

CHA currently has (56) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently there are (9) Physical, (13) Behavioral, and (3) Oral Health organizations identified with unknown EHR information. There are multiple providers that do cross-over multiple provider type categories. So, CHA has an opportunity to gain a greater impact by working with those organizations providing multiple types of services in the provider network. By Q4 2023 CHA plans to work with (3) additional providers to implement an EHR solution, one in each provider type category for Physical, Oral, and Behavioral Health providers. By Q4 2024 CHA plans to add (1) more from each category of provider types.

Please see the inserted table for 2022-2024 strategies related to EHR adoption.

EHR Adoption

Assessment/tracking of EHR adoption and capabilities

Strategy 1: Develop Provider Engagement Plan

CHA is developing a provider engagement plan that will include updates on strategies and collaboration with providers for documenting EHR leads, their activities related to EHR and assist with identifying any barriers providers might have with EHR adoption. This plan will include all provider types.

Activities:	Milestones and/or Contract Year:
Outline Provider Engagement Plan with section for EHR adoption/use and get leadership approval	By end of Q2 2022
Finalize Provider Engagement Plan	By end of Q3 2022
Implement Provider Engagement Plan and collect from providers HIT use, activities, and barriers	By end of Q4 2022
Identify any lessons learned and modify Provider Engagement Plan accordingly	By end of Q1 2023
Continue carrying out Provider Engagement Plan and collecting information as prescribed by plan	2023 and 2024

EHR training and/or technical assistance

Strategy 2: Training and Technical Assistance

Provide technical assistance for providers (when needed) for implementing/upgrading EHR. Offer technical assistance (TA) for building reporting for EHR metrics. This plan will include all provider types.

Activities:	Milestones and/or Contract Year:
Enhance virtual training and technical assisstance structure	By end of Q3 2022.
Implement new technology platform for provider training	By end of Q4 2023
HIT is part of annual provider training	2022-2024
Establish reguarly scheduled clinic engagement meetings	By end of Q4 2022
HIT is a standing agenda item at clinic engagement meetings	2023-2024
Technical Assistance (TA) is a standing agenda item at clinic engagement meeting and, if clinic requests TA, CHA supplies TA outside of the clinic engagement meeting	2023-2024

Outreach and education about the value of EHR adoption/use

Strategy 3: Outreach to providers and educate about the value of HIT

Utilize the annual provider training in different ways to better educate about HIT and promote use/adoption of HIT, explore additional education/technical assistance options/opportunities. Additionally, use virtual training and will be looking to potentially utilize a new technology platform by Q4 2023 that can be utilized throughout the year moving forward, leading to enhanced collaboration and increased provider and staff attendance through a heavy focus on the value of HIT. This plan will include all provider types.

Activities:	Milestones and/or Contract Year:
Enhance virtual training and technical assisstance structure	By end of Q3 2022.
Implement new technology platform for provider training	By end of Q4 2023
HIT is part of annual provider training	2022-2024
Establish reguarly scheduled clinic engagement meetings	By end of Q4 2022
HIT is a standing agenda item a clinic engagement meetings	2023-2024
Technical Assistance (TA) is a standing agenda item at clinic engagement meeting and, if clinic requests TA, CHA supplies TA outside of the clinic engagement meeting	2023-2024

Leveraging HIE programs and tools in a way that promotes EHR adoption

Strategy 4: Leverage HIE tools

Use HIE tools to promote EHR adoption and improve care coordination.

Activities:	Milestones and/or Contract Year:
Utilize Collective Medical and Reliance to promost EHR adoption	2022-2024
Increase the number of dental providers integrated into Reliance eHealth (Health Information Exchange, HIE)	By end of Q4 2023, 2 additional network oral health provider utilizie Reliance eHealth to its full capacity (total of 3)
Develop workflows for preventive medical screenings and referrals via Reliance eHealth by oral health providers.	By end of Q4 2022, at least 70% of Oral Healthcare providers able to perform medical screenings and at least 70% of Primary Care Providers able to receive and act on Oral Healthcare referrals
Explore [redacted] to embed CHA's formulary at point of care	By end of Q2 2023

Requirements in contracts/provider agreements

Strategy 5: Explore requirements in contracts

Explore expanding contract language that encourages EHR adoption/use, HIE, and other HIT initiatives

Activities:	Milestones and/or Contract Year:
Explore contract expansion	By end of Q2 2023
Contracts include language encourages EHR adoption/use, HIE, and other HIT initiatives	2024

Collaboration with network partners

Strategy 6: Collaboration with partners

Work with clinic and community partners to enhance the use of HIT in Klamath County.

Activities:	Milestones and/or Contract Year:
Work with hospital to explore community EHR	By end of Q4 2022
Additional activities dependent on outcome of activity related to exploring community EHR	2023-2024

Financial support for EHR implementation or maintenance

Strategy 7: Explore Financial Support Options for Providers

Explore funding options available to support provider adoption and use of HIT.

Activities:	Milestones and/or Contract Year:
Explore options with Health-Related Services (HRS) spending for providers to assist in EHR adoption when it might be cost prohibitive for them	2022-2023
Explore alternative payment methods (APMs) as encouragement to implement an EHR	2022-2023

ii. Additional plans specific to physical health providers, including activities & milestones

See *Across Provider Types* section.

iii. Additional plans specific to oral health providers, including activities & milestones

See *Across Provider Types* section.

iv. Additional plans specific to behavioral health providers, including activities & milestones

See *Across Provider Types* section.

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with EHR adoption?

3. Support for HIE – Care Coordination

A. 2021 Progress

Please describe your progress supporting increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select the boxes that represent strategies pertaining to your 2021 progress
2. Describe the following in the appropriate narrative sections
    a. Specific HIE tools you supported or made available in 2021
    b. The strategies you used to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers in 2021
    c. Accomplishments and successes related to your strategies (Please include the number of organizations of each provider type that gained access to HIE for Care Coordination as a result of your support, as applicable).

Note: If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.

Overall Progress
Using the boxes below, please select which strategies you employed during 2021. Elaborate on each strategy and the progress made in the sections below.

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

i. Progress across provider types, including specific HIE tools supported/made available

HIE training and/or technical assistance
In 2021, CHA provided technical assistance and worked with one oral health provider to onboard with Reliance to improve care coordination between oral health and behavior and physical health providers for their assigned member population.

Assessment/tracking of HIE adoption and capabilities
CHA utilizes the Contributors list and Participants list created by Reliance to track network providers that are contributing data to Reliance and participating in use of the Community Health Record. Two providers were added in 2021 to Reliance: one behavioral health treatment provider and an oral health provider. Through use of the lists from Reliance, CHA can target education to providers not on the Reliance platform.

Outreach and education about value of HIE
In 2021, CHA completed provider training virtually utilizing [redacted] VOIP platform to allow providers and staff to watch the video sessions at their convenience (within a designated timeframe determined by CHA). One session was dedicated to HIT and covered the Community Information Exchange platform (Healthy Klamath Connect), the Health Information Exchange platforms (Reliance eHealth Collaborative, and Collective Medical), and Electronic Health Record adoption. The session highlighted the benefits of EHR adoption and HIE use for our members as well as for the providers. Another session focused on the updates made to the provider portal in 2021 with a walkthrough of the steps to submit authorizations in the portal and how to track the status.

Integration of disparate information and/or tools with HIE
Reliance eHealth is used by CHA to integrate the disparate information from multiple EHRs used within our service area. CHA pulls data from Reliance to validate and supplement EHR metric reporting. CHA's Business Intelligence department uses Reliance to help supplement member demographic information in reports sent to providers and partners, as well as reports used internally.

Requirements in contracts/provider agreements
In 2020, CHA included an amendment in provider contracts that included verbiage for meaningful engagement and participation in HIT initiatives and HIE opportunities and continued use of amendment in 2021 contracts.

Specific HIT tools supported/made available

[redacted] CHA upgraded our Case Management Software in Q2 2021. The upgrade included addition of many assessments (HRAs, comprehensive assessments, and various screening tools) within the CM module for which reports can be pulled, streamlining and improving workflows, and updates to the Provider Portal where providers submit prior authorizations. The model of care was updated in the CM module to reflect the additions in the platform upgrade.

[redacted] After the [redacted] upgrade went live in May 2021, CHA created new training manuals and videos with step-by-step walkthroughs of the portal for providers and clinic staff to use. All reference documents are posted to the Provider Resource Center section of CHA's website. Individual technical assistance is available for all provider types, with many providers and clinics utilizing the individual technical assistance opportunity from CHA Utilization Management staff.

Reliance eHealth Collaborative: Community Health Record (CHR) portal and eReferrals:
CHA and Reliance have continued a partnership for engagement activities such as provider education concerning HIE benefits to networked providers and encouraging adoption. CHA's Case Management (CM) department utilizes Reliance to look up members in the CHR to see services the member is receiving as well as to view notes to help with care coordination and ensuring the member's needs are being met. Additional information about 2021 progress with providers onboarding with Reliance in the 2. *Support for EHR Adoption A. 2021 Progress i. Progress across provider types*.

Collective Medical: Collective Medical is utilized daily by CHA CM department to monitor cohorts built in Collective Medical, and service utilization by members with open cases to coordinate care, ensure member needs are being met, and reduce unnecessary use of services.

findhelp - Healthy Klamath Connect (HKC): CHA CM department staff utilize the internal staff site to help assist members with identified health, social, and SDOH-HE needs by sending referrals within the HKC platform to community-based organizations (CBOs) with services claimed on the HKC site. Additional information on the HKC platform is in the *HIT to Support Social Needs Screening and Referrals for Addressing SDOH Needs* section below.

[redacted]

This is a predictive model platform that ingests CHA claims monthly and applies patented algorithm logic models. Reports are generated through the user interface based on cohorts built within the tool. CHA Medical Management utilizes this tool to build cohorts to manage care and monitor spending.

[redacted] **Access:** For all Sky Lakes Medical Center related providers, CHA's CM department is utilizing [redacted] access daily for checking records, treatment notes from visits, reviewing hospital admissions, reviewing current activity for selected members, and directly messaging providers within [redacted] assist in care coordination efforts. Information gathered in [redacted] when needed, is added into CHA's case management system and all member-related information is utilized in weekly collaborative care meetings between CHA and providers and community case managers also involved in a members' care.

[redacted]
In 2021, CHA completed provider training virtually utilizing [redacted] VOIP platform to allow providers and staff to watch the video sessions at their convenience (within a designated timeframe determined by CHA). One session was dedicated to HIT platforms and the benefits of adopting an EHR and using available HIT tools/systems.

ii. Additional progress specific to physical health providers

See *Across Provider Types* section.

iii. Additional progress specific to oral health providers

See *Across Provider Types* section.

iv. Additional progress specific to behavioral health providers

See *Across Provider Types* section.

v. Please describe any barriers that inhibited your progress

Due to the ongoing pandemic, most clinics experienced resource and bandwidth constraints. Many clinics also had open staff and provider positions which hindered engagement with the clinics, reduced new project initiation, and put many initiatives on hold.
Additionally, competing efforts and priorities within the clinics inhibits bandwidth to collaborate on new projects or undertake large projects like implementing a new platform.

B. 2022-2024 Plans

Please describe your plans for supporting increased access to HIE for Care Coordination for contracted physical, oral, and behavioral health providers. In the spaces below, please

1. Select that boxes that represent strategies pertaining to your 2022-2024 plans.
2. Describe the following in the appropriate narrative sections
    a. The number of physical, oral, and behavioral health organizations that have not currently adopted an HIE for Care Coordination tool using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations have not adopted an HIE for Care Coordination tool). CCOs are expected to use this information to inform their strategies.
    b. Any additional HIE tools you plan to support or make available.
    c. Strategies you will use to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers beyond 2021.
    d. Activities and milestones related to each strategy (Please include the number of organizations of each provider type you expect will gain access to HIE for Care Coordination as a result of your support, as applicable)

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are

implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2022-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and include activities and milestones in the sections below.

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

i. Plans across provider types, including additional tools you will support/make available, and activities & milestones

CHA currently has (56) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently there are (15) Physical, (3) Behavioral, and (1) Oral Health organizations identified as having HIE for care coordination. There are multiple providers that do cross-over multiple provider type categories. So, CHA has an opportunity to gain a greater impact by working with those organizations providing multiple types of services in the provider network. Currently CHA has identified (10) Physical, (17) Behavioral, and (9) Oral Health providers without an HIE for care coordination. By Q4 2023 CHA plans to work with (3) more additional providers to add HIE care coordination capabilities, one in each provider type category for Physical, Oral, and Behavioral Health providers. By Q4 2024 CHA plans to add (3) more from each category.

Please see inserted table below for 2022-2024 strategies and activities with milestones related to HIE for Care Coordination.

HIE – Care Coordination

Assessment/tracking of HIE adoption and capabilities

Strategy 1: Develop Provider Engagement Plan

CHA is developing a provider engagement plan that will include updates on strategies and collaboration with providers for using HIT to support care coordination, their activities related to using HIT for care coordination and assist with identifying any barriers providers might have with using HIT for care coordination. This plan will include all provider types.

Activities:	Milestones and/or Contract Year:
Outline Provider Engagement Plan with section for HIE and get leadership approval	By end of Q2 2022
Finalize Provider Engagement Plan	By end of Q3 2022
Implement Provider Engagement Plan and collect from providers HIT use, activities, and barriers	By end of Q4 2022
Identify any lessons learned and modify Provider Engagement Plan accordingly	By end of Q1 2023
Continue carrying out Provider Engagement Plan and collecting information as prescribed by plan	2023 and 2024

HIE training and/or technical assistance

Strategy 2: Training and Technical Assistance

Provide technical assistance for providers (when needed) to support the use of HIT for care coordination, including, but not limited to, platform recommendations and workflow review. Additionally, CHA will work with the local Medicare Advantage plan to explore adoption of Reliance eHealth for additional care coordination for dual members. This plan will include all provider types.

Activities:	Milestones and/or Contract Year:
Work with local Medicare Advantage plan to explore adoption of Reliance eHealth for additional care coordination for dual members	2022-2023
Enhance virtual training and technical assisstance structure	By end of Q3 2022.
Implement new technology platform for provider training	By end of Q4 2023
HIT is part of annual provider training	2022-2024
Establish reguarly scheduled clinic engagement meetings	By end of Q4 2022
HIT is a standing agenda item at clinic engagement meetings	2023-2024
Technical Assistance (TA) is a standing agenda item at clinic engagement meeting and, if clinic requests TA, CHA supplies TA outside of the clinic engagement meeting	2023-2024

Outreach and education about value of HIE

Strategy 3: Outreach to providers and educate about the value of HIT

Utilize the annual provider training in different ways to better educate about HIT and promote use/adoption of HIT, explore additional education/technical assistance options/opportunities. Additionally, use virtual training and will be looking to potentially utilize a new technology platform by Q4 2023 that can be utilized throughout the year moving forward, leading to enhanced collaboration and increased provider and staff attendance through a heavy focus on the value of HIT. This plan will include all provider types.

Activities:	Milestones and/or Contract Year:
Enhance virtual training and technical assisstance structure	By end of Q3 2022.
Implement new technology platform for provider training	By end of Q4 2023
HIT is part of annual provider training	2022-2024
Establish reguarly scheduled clinic engagement meetings	By end of Q4 2022
HIT is a standing agenda item a clinic engagement meetings	2023-2024

Technical Assistance (TA) is a standing agenda item at clinic engagement meeting and, if clinic requests TA, CHA supplies TA outside of the clinic engagement meeting	2023-2024

Requirements in contracts/provider agreements

Strategy 5: Explore requirements in contracts

Explore expanding contract language that encourages EHR adoption/use, HIE, and other HIT initiatives.

Activities:	Milestones and/or Contract Year:
Explore contract expansion	By end of Q2 2023
Contracts include language encouraging EHR adoption/use, HIE, and other HIT initiatives	2024

Collaboration with network partners

Strategy 6: Collaboration with partners

Work with clinic and community partners to enhance the use of HIT in Klamath County.

Activities:	Milestones and/or Contract Year:
CHA intends to upgrade the current CIE platform with findhelp to Enterprise licensing, that would allow integration for direct referral from provider's EHR platform	By end of Q4 2023
Explore a new platform for maternity case management	By end of Q4 2022

Integration of disparate information and/or tools with HIE

Strategy 8: Integration of disparate information and/or tools with HIE

Utilize Reliance eHealth for integration of information and to improve data sharing and care coordination.

Activities:	Milestones and/or Contract Year:
Increase the number of dental providers integrated into Reliance eHealth (Health Information Exchange, HIE)	By end of Q4 2023, 2 additional network oral health provider utilizie Reliance eHealth to its full capacity (total of 3)
Develop workflows for preventive medical screenings and referrals via Reliance eHealth by oral health providers.	By end of Q4 2022, at least 70% of Oral Healthcare providers able to perform medical screenings and at least 70% of Primary Care Providers able to receive and act on Oral Healthcare referrals
Implement use of Reliance eHealth for IET notifications to CHA staff	By end of Q2 2022
Explore use of Reliance eHealth for IET notification to diagnosing providers	2022-2023
Partner with Reliance eHealth to expand the amount of SDOH data available in the plaftform to improve SDOH care coordination	2022-2023
Use Reliace eHealth to identify HbA1c results and integrate with other data	2022-2024

Other strategies that address requirements related to federal interoperability and patient access final rules: pilot project with FHIR vendor

Strategy 9: Pilot project with FHIR vendor

Explore opportunities to expand use of FHIR data to increase access to better member data to create more complete member profiles that can be used for enhanced care coordination which leads to improved health outcomes.

Activities:	Milestones and/or Contract Year:
Collaborate with current FHIR solution vendor to explore future capabilities and expanded use of structured data and potential pilot project opportunities in 2023 and 2024 to support care coordination	2022
Dependent on outcome of 2022 exploration: Potential pilot project to support care coordination	2022-2023

Other strategies for supporting HIE access or use: Member Portal

Strategy 10: Explore Member Portal Options

CHA intends to implement an integrated member portal solution to assist in member collaboration, transparency of services available, and self-service features that would include but not limited to ordering new cards, connecting with local needed social and health services, and collecting HRAs.

Activities:	Milestones and/or Contract Year:
Research member portal options	By end of Q4 2022
Present top three member portal options to leadership	By end of Q1 2023
Select top choice and implement member portal	By end of Q4 2024

ii. Additional plans specific to physical health providers, including activities & milestones

See *Across Provider Types* section.

iii. Additional plans specific to oral health providers, including activities & milestones

See *Across Provider Types* section.

iv. Additional plans specific to behavioral health providers, including activities & milestones

See *Across Provider Types* section.

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with access to HIE for Care Coordination?
Support from OHA on other HIE platforms utilized in Oregon. Appears that UniteUs is the only HIE platform with preference from OHA and it's partners.

4. Support for HIE – Hospital Event Notifications

A. 2021 Progress

1. Please describe your progress supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2021 progress
    b. Describe the following in the appropriate narrative sections
        i. The tool(s) you supported or made available to your providers in 2021
        ii. The strategies you used to support increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers in 2021
        iii. Accomplishments and successes related to your strategies (Please include the number of organizations of each provider type that gained increased access to HIE for Hospital Event Notifications as a result of your support, as applicable)

Notes: If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.

Overall Progress
Using the boxes below, please select which strategies you employed during 2021. Elaborate on each strategy and the progress made in the sections below.

☐ Hospital Event Notifications training and/or technical assistance	☒ Financially supporting access to a Hospital Event Notification tool(s)
☒ Assessment/tracking of Hospital Event Notification access and capabilities	☐ Offering incentives to adopt or use a Hospital Event Notification tool(s)
☒ Outreach and education about the value of Hospital Event Notifications	☒ Requirements in contracts/provider agreements
	☐ Other strategies for supporting access to Hospital Event Notifications (please list here)

i. Progress across provider types, including specific tools supported/made available

Assessment/tracking of Hospital Event Notification access and capabilities
CHA receives the Clinic Network Engagement Metrics report from Collective Medical that shows utilization metrics for the clinics in our network. This report is utilized to track adoption and target education for clinics not currently engaged in Collective Medical.

Outreach and education about the value of Hospital Event Notifications
In 2021, CHA completed provider training virtually utilizing [redacted] VOIP platform to allow providers and staff to watch the video sessions at their convenience (within a designated timeframe determined by CHA). One session was dedicated to HIT. The HIT session highlighted the platforms that CHA's provider network has access to and the benefits of adoption and use of HIT for our members as well as for the providers.

Requirements in contracts/provider agreements
In 2020, CHA included an amendment in provider contracts that included verbiage for meaningful engagement and participation in HIT initiatives and HIE opportunities and continued use of amendment in 2021 contracts.

Financially supporting access to a Hospital Event Notification tool(s)
CHA continued to financially support the Collective Medical EDie Insights tool for the provider network in 2021.

Specific HIE - HEN tools supported/made available
Collective Medical EDie Insights: CHA's network providers that use the Collective Medical platform can connect Collective and their EHR to receive automatic alerts within the EHR's interface. CHA also ensures providers have access to the Insights reports through Collective Medical EDie that provide additional information about the alert including care history for the patient to assist with care coordination.

[redacted] **Access:** For all Sky Lakes Medical Center related providers, CHA's CM department is utilizing [redacted] access daily for checking records, treatment notes from visits, reviewing hospital admissions, reviewing current activity for selected members, and directly messaging providers within [redacted] to assist in care coordination efforts. Information gathered in [redacted] when needed, is added into CHA's case management system and all member-related information is utilized in weekly collaborative care meetings between CHA and providers and community case managers also involved in a members' care.

ii. Additional progress specific to physical health providers

See *Across Provider Types* section.

iii. Additional progress specific to oral health providers

See *Across Provider Types* section.

iv. Additional progress specific to behavioral health providers

The two largest behavior health providers in CHA's network utilize Collective Medical.

v. Please describe any barriers that inhibited your progress

Due to the ongoing pandemic, most clinics experienced resource and bandwidth constraints. Many clinics also had open staff and provider positions which hindered engagement with the clinics, reduced new project initiation, and put many initiatives on hold.

2. Please describe your (CCO) progress using timely Hospital Event Notifications within your organization. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2021 progress
    b. Describe the following in the narrative section
        i. The tool(s) that you are using for timely Hospital Event Notifications
        ii. The strategies you used in 2021
        iii. Accomplishments and successes related to each strategy.

Overall Progress

Please select which strategies you employed during 2021.

☒ Care coordination and care management	☒ Utilization monitoring/management
☐ Risk stratification and population segmentation	☒ Supporting CCO metrics
☒ Integration into other system	☒ Supporting financial forecasting
☒ Exchange of care plans and care information	☐ Other strategies for using Hospital Event Notifications (please list here)
☒ Collaboration with external partners	

Elaborate on each strategy and the progress made in the section below.

Care coordination and care management

Reports received and reviewed daily with specific cohorts identified and follow-up is initiated with a member when needed and information is shared with providers and community case managers where applicable. Information from Collective Medical is entered into the case management system when necessary.

Integration into other system

CHA's Case Management (CM) department integrates information from Collective Medical and Reliance eHealth into CHA's care coordination tool to assist in member/provider interventions and coordinating care plans.

Collaboration with external partners

CM department utilizes [redacted] access, for the local hospital, Sky Lakes Medical Center, and related providers, daily for checking records, treatment notes from visits, reviewing current activity for selected members to assists in care coordination efforts, and when needed using the direct message feature to collaborate directly with Primary Care Providers.

Utilization monitoring/management

CHA's CM department uses Collective Medical, Reliance eHealth, and [redacted] access to monitor use of the Emergency Department, hospital admissions, and other services accessed by members.
CHA receives a monthly report from Collective Medical that shows internal CHA users use of the platform.

Supporting CCO metrics

CHA uses Collective Medical and Reliance to support metric management. Collective Medical has a monthly report that has members flagged in the ED-MI denominator. CHA's BI department receives that report then filters the report down to members that have more than 10 visits in the last 12 months and at least 1 visit in the last month, BI adds an identifier for new members, and then shares the report with a behavioral health case manager for outreach. The Behavioral Health cohort and report in Collective Medical supports the Initiation and Engagement in Treatment (IET) metric. The Maternity cohort report supports the prenatal and postpartum care metric.

Reliance eHealth: The IET metric is built in Reliance and CHA utilizes this report to monitor performance for the IET metric. In 2021, CHA used A1c data from Reliance to support the Diabetes Poor Control metric. In 2021, CHA partnered with Reliance to develop an IET notification report. The intent of the IET notification report is to produce near real-time alerts based on EHR data to support near real-time response and outreach to members by assigned providers. Reliance worked to translate the OHA claims measure specification to be used with EHR data, created the IET notification report, and completed validation on the notifications. The next step is to pilot the report with our providers in 2022.

B. 2022-2024 Plans

1. Please describe your plans for ensuring increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2022-2024 plans.
    b. Describe the following in the appropriate narrative sections
        i. The number of physical, oral, and behavioral health organizations that do not currently have access to HIE for hospital event notification using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations do not have access to HIE for hospital event notifications). CCOs are expected to use this information to inform their plans.
        ii. Any additional HIE tools you are planning to support or make available to your providers for Hospital Event Notifications
        iii. Additional strategies for supporting increased access to timely Hospital Event Notifications among contracted physical, oral, and behavioral health providers beyond 2021.
        Activities and milestones related to each strategy (Please include the number of organizations of each provider type that will gain increased access to HIE for Hospital Event Notifications as a result of your support, as applicable).

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

Overall Plans

Using the boxes below, please select which strategies you plan to employ 2022-2024. Elaborate on each strategy (if not previously described in the *Progress* section) and the include activities milestones in the sections below.

☒ Hospital Event Notifications training and/or technical assistance ☒ Assessment/tracking of Hospital Event Notification access and capabilities ☒ Outreach and education about the value of Hospital Event Notifications	☒ Financially supporting access to Hospital Event Notification tool(s) ☐ Offering incentives to adopt or use a Hospital Event Notification tool(s) ☒ Requirements in contracts/provider agreements ☐ Other strategies for supporting access to Hospital Event Notifications (please list here)

i. Plans across provider types, including additional tools you will support/make available, and activities & milestones

CHA currently has (56) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently there are (5) Physical, (3) Behavioral, and (1) Oral Health organizations identified as having access to hospital event notifications. This leaves a great opportunity for CHA to encourage and work with providers identified without access to these notifications. There are multiple providers that do cross-over multiple provider type categories. So, CHA has an opportunity to gain a greater impact by working with those organizations providing multiple types of services in the provider network. Currently CHA has identified (20) Physical, (17) Behavioral, (9) Oral Health providers, and (1) FQHC without hospital event notifications. By Q1 2023 CHA plans to add (6) more additional providers to the Collective Medical EDie Insights tool, two in each provider type category for physical, oral, and BH providers. By Q4 2024 CHA plans to add (3) more, one from each category.

Please see inserted table below for 2022-2024 strategies and activities with milestones related to HIE for Hospital Event Notifications with providers.

HIE – Hospital Event Notifications - External

Assessment/tracking of Hospital Event Notification access and capabilities

Strategy 1: Develop Provider Engagement Plan

CHA is developing a provider engagement plan that will include updates on strategies and collaboration with providers for using HIT for Hospital Event Notifications (HEN), their activities related to using HIT for HEN and assist with identifying any barriers providers might have with using HIT for HEN. This plan will include all provider types.

Activities:	Milestones and/or Contract Year:
Add more providers to the Collective Medical EDie Insights tool	By Q4 2022, CHA plans to add (2) more oral health providers. By Q4 2023, CHA plans to add (3) more providers, one from each provider type category for physical, oral, and BH providers. By Q4 2023, CHA plans to add (2) more additional oral health providers.
Explore notificaiton options with Reliance	2022-2023
Outline Provider Engagement Plan with section for HIE – Hostial Event Notifications and get leadership approval	By end of Q2 2022
Finalize Provider Engagement Plan	By end of Q3 2022
Implement Provider Engagement Plan and collect from providers HIT use, activities, and barriers	By end of Q4 2022
Identify any lessons learned and modify Provider Engagement Plan accordingly	By end of Q1 2023
Continue carrying out Provider Engagement Plan and collecting information as prescribed by plan	2023 and 2024

Hospital Event Notifications training and/or technical assistance

Strategy 2: Training and Technical Assistance

Provide technical assistance for providers (when needed) to support the use of HIT for hospital event notifications (HEN), including, but not limited to, platform recommendations and workflow review. This plan will include all provider types.

Activities:	Milestones and/or Contract Year:
Add more providers to the Collective Medical EDie Insights tool	By Q4 2022, CHA plans to add (2) more oral health providers. By Q4 2023, CHA plans to add (3) more providers, one from each provider type category for physical, oral, and BH providers. By Q4 2023, CHA plans to add (2) more additional oral health providers.
CHA will encourage network providers on the benefits of real-time notifications and solidify role as a guide for its network	2022-2024
CHA plans to utilize any new capabilities available from innovations with Reliance eHealth Collaborative, and with the hospital event notification merger with Collective Medical and PointClickCare.	2022-2024
Enhance virtual training and technical assisstance structure	By end of Q3 2022.
Implement new technology platform for provider training	By end of Q4 2023
HIT is part of annual provider training	2022-2024
Establish reguarly scheduled clinic engagement meetings	By end of Q4 2022
HIT is a standing agenda item a clinic engagement meetings	2023-2024
Technical Assistance (TA) is a standing agenda item at clinic engagement meeting and, if clinic requests TA, CHA supplies TA outside of the clinic engagement meeting	2023-2024

Outreach and education about the value of Hospital Event Notifications

Strategy 3: Outreach to providers and educate about the value of HIT

Utilize the annual provider training in different ways to better educate about HIT and promote use/adoption of HIT, explore additional education/technical assistance options/opportunities. Additionally, use virtual training and will be looking to potentially utilize a new technology platform by Q4 2023 that can be utilized throughout the year moving forward, leading to enhanced collaboration and increased provider and staff attendance through a heavy focus on the value of HIT. Also, provide targeted education to providers not utilizing Collective Medical on the benefits of real-time care coordination. This plan will include all provider types.

Activities:	Milestones and/or Contract Year:
Enhance virtual training and technical assisstance structure	By end of Q3 2022.
Implement new technology platform for provider training	By end of Q4 2023
HIT is part of annual provider training	2022-2024
Establish reguarly scheduled clinic engagement meetings	By end of Q4 2022
HIT is a standing agenda item at clinic engagement meetings	2023-2024
Technical Assistance (TA) is a standing agenda item at clinic engagement meeting and, if clinic requests TA, CHA supplies TA outside of the clinic engagement meeting	2023-2024

Requirements in contracts/provider agreements

Strategy 5: Explore requirements in contracts

Further explore contract language and encouraging HIT use among providers.

Activities:	Milestones and/or Contract Year:
Explore contract expansion	By end of Q2 2023
Contracts include language encourages EHR adoption/use, HIE, and other HIT initiatives	2024

Financially supporting access to Hospital Event Notification tool(s)

Strategy 7: Explore Financial Support Options for Providers

Explore funding options available to support provider adoption and use of HIT.

Activities:	Milestones and/or Contract Year:
Explore funding options available to support provider adoption and use of Hosptial Event Notifcation (HEN) tool(s)	By end of Q2 2023

ii. Additional plans specific to physical health providers, including activities & milestones

See *Across Provider Types* section.

iii. Additional plans specific to oral health providers, including activities & milestones

With the data from the HIT data file, CHA has identified oral health providers as the largest area of opportunity for engagement and adoption of the Collective Medical platform. CHA plans to work with contracted oral health providers to implement the Collective Medical platform

iv. Additional plans specific to behavioral health providers, including activities & milestones

See *Across Provider Types* section.

2. Please describe your (CCO) plans to use timely Hospital Event Notifications within your organization. In the spaces below, please
    a. Select the boxes that represent strategies pertaining to your 2022-2024 plans
    b. Describe the following in the narrative section
        i. Any additional tool(s) that you are planning on using for timely Hospital Event Notifications
        ii. Additional strategies for using timely Hospital Event Notifications beyond 2021

iii. Activities and milestones related to each strategy

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

Overall Plans
Using the boxes below, please select which strategies you plan to employ 2022-2024.

☒ Care coordination and care management	☒ Utilization monitoring/management
☒ Risk stratification and population segmentation	☒ Supporting CCO metrics
☐ Integration into other system	☒ Supporting financial forecasting
☒ Exchange of care plans and care information	☒ Other strategies for supporting access to Hospital Event Notifications (please list here) Pilot Project with Collective Medical
☒ Collaboration with external partners	

Elaborate on each strategy (if not previously described in the *Progress* section) and include activities and milestones in the section below.

Please see inserted table below for 2022-2024 strategies and activities with milestones related to HIE for Hospital Event Notifications for CHA.

HIE – Hospital Event Notifications - Internal	
Collaboration with external partners; Exchange of care plans and care information	
Strategy 6: Collaboration with partners Work with clinic and community partners to enhance the use of HIT in Klamath County.	
Activities:	**Milestones and/or Contract Year:**
Explore enhancement of weekly collaborative care meetings between many clinics/provider types.	By end of Q4 2022
Continue to utilize SUD and ED cohorts in Collective Medical	2022-2024
Explore opportunites to expand metrics captured and tracked in Collective Medical	By end of Q4 2022
Care coordination and care management; Risk stratification and population segmentation; Utilization monitoring/management; Supporting CCO metrics; Supporting financial forecasting	
Strategy 11: Enhance the internal use of Collective Medical Explore and potentially implement new and innovative uses of Collective Medical to better serve members.	
Activities:	**Milestones and/or Contract Year:**
Explore and build, if needed, additional cohorts in Collective Medical for care coordination intervention strategies (i.e. diabetes cohort)	As needed 2022-2024
Ensure notifications are set up for applicable staff to receive notifications for applicalbe cohorts (i.e. LTSS cohort)	As needed 2022-2024
Explore how to enhance current use of Collective Medical for risk stratification	By end of Q2 2023
Explore how to enhance current use of Collective Medical for population segmentation	By end of Q2 2023
Continue to utilize Collective Medical for utilization montioring and management	2022-2024
Explore opportunites to enhance the use of Collective Medical for utilization montitoring and managemnt	By end of Q4 2023
Continue to utilize SUD and ED cohorts in Collective Medical	2022-2024
Explore opportunites to expand metrics captured and tracked in Collective Medical	By end of Q4 2022
Explore using Collective Medical to support MEPP and TQS activities	By end of Q1 2023
Other strategies for supporting access to Hospital Event Notifications: Pilot Project with Collective Medical	
Strategy 12: Pilot Project with Collective Medical Partner with Collective Medical to explore enhancements to the platform to improve access to data to better work with members.	
Activities:	**Milestones and/or Contract Year:**
CHA intends to partner on a pilot project with Collective Medical for SDOH for insights and improve hospital event notifications with enhanced member details	2022

C. Optional Question

How can OHA support your efforts in supporting your contracted providers with access to Hospital Event Notifications?
OHA can continue to support with State and/or Federal funding for Oregon hospital systems access to Collective Medical.

5. HIT to Support Social Needs Screening and Referrals for Addressing SDOH Needs

A. 2021 Progress

1. Please describe any progress you (CCO) made using HIT to support social needs screening and referrals for addressing social determinants of health (SDOH) needs. In the space below, please include
   a. A description of the tool(s) you are using. Please specify if the tool(s) have closed-loop referral functionality (e.g., Community Information Exchange or CIE).
   b. The strategies you used in 2021.
   c. Any accomplishments and successes related to each strategy.

Overall Progress
Elaborate on each strategy and the progress made in the section below.

CHA, clinic partners, and community partners used the following tools to support 2021 Health IT and Social Determinants of Health Equity strategies and will continue to use them to support 2022-2024 HIT to Support Social Needs Screening and Referrals for Addressing SDOH Needs.

Tools

Collective Medical: In early 2021, CHA started communication with Collective Medical on potential future innovations. In 2022, CHA intends to partner on a pilot project with Collective Medical for SDOH for insights and improve hospital event notifications with enhanced member details.

Reliance eHealth Collaborative: CHA, provider partners, and community partners continued participation with the local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative (Reliance eHealth). Reliance eHealth has some SDOH reporting which includes housing and food insecurities. CHA shares 837 data files with Reliance eHealth, and some other healthcare organizations share SDOH data from their electronic health records (EHRs). Data is used to further stratify populations to identify gaps in care, members needing further assistance, and improvement opportunities for both internal processes as well as provider outreach. Utilizing this tool allows participating in-network providers to share captured information for other providers assisting those patients as well. In 2022, CHA will continue to partner with Reliance to further expand its SDOH capturing and reporting capabilities.

[redacted] In Q2 2021, CHA implemented a new platform from Health Management Systems (HMS) with [redacted] version 4.2 [redacted] with enhanced member data and reporting capabilities. [redacted] is CHA's Case Management Platform. With the 2021 enhancements, the platform now has enhanced digital assessments, including a digital version of the PRAPARE Assessment Tool for Case Management and other department to gather social needs information and to utilize data gathered while working with members. Additionally, Health Risk Assessment (HRA) information is stored in [redacted] and includes questions about food insecurity, homelessness, and transportation. Since the PRAPARE Assessment Tool had minimal and inconsistent use in 2021, CHA intends to standardize workflows and enhance staff training during 2022 and 2023.

[redacted] In 2021, CHA adopted and partially implemented [redacted] a customer relationship management (CRM) tool to assist in the capturing of SDOH/HE related data during outreach efforts. To enhance use of the tool and improve workflow efficiencies, CHA integrated it with the phone system. CHA had plans to fully integrate [redacted] with [redacted] using an application programming interface (API) connection, but during implementation it was discovered that the [redacted] does not have an API connection capability. Due to this, interoperability between [redacted] and [redacted] is limited to member-level data sharing with the [redacted] API connection and cannot be used to connect campaigns between the two systems. The implementation team decided the campaigns will still be utilized but separately within each system and collaboration amongst Member Services and Case Management will occur outside of the two systems. Due to unforeseen circumstances, implementation is taking longer than initially expected. Ongoing items continuing into 2022 include training the Member Services team on the tool interface, inclusion of [redacted] in their workflow, and testing the use of [redacted] to ensure it meets the needs of the team.

findhelp - Healthy Klamath Connect (HKC): Since 2020, CHA contracts with 3rd party vendor findhelp, a Community Information Exchange (CIE) platform dba Healthy Klamath Connect (HKC) and formerly named Aunt Bertha. HKC functions as a central repository for the listing and availability of resources and services options for all community members (including CHA members) addressing SDOH needs. The platform also functions as a closed-loop referral system for Klamath County residents to connect with available health and social services. HKC can be used as a closed-loop referral system when programs have been claimed by the CBOs that run them. When a CBO claims their program, they gain access to a user interface that allows the staff to manage the referrals they receive and the referrals they send to other programs on behalf of their clients. CHA staff have a specific user interface to assist with managing CHA members based on captured SDOH in HKC and [redacted] (CHA's Case Management platform). In 2021, HKC continued to receive financial and technical support via CHA. As of April 2022, there are nearly 150 local community-based organizations offering services in Klamath County in the online platform offering over 190 programs for goods and services ranging from clothing, medical supplies, and food to housing advice, temporary shelter, transit services, and advice related to housing, money, work, and legal needs. HKC had 1071 searches in 2020, 2246 searches in 2021, and 1060 searches in Q1 2022. Of the 150 organizations and 190 programs on HKC, only 13.6% (20) of organizations and 23% (44) of programs were claimed, respectively. From the time HKC was implemented on August 31, 2020, through Q1 2022, 73.5% (97 of 132) referrals were closed loop referrals within HKC while 82.5% (66 of 80) referrals were closed loop referrals within HKC in 2021. The remaining referrals had been responded to outside of HKC, so data is not available. CHA continued to recruit additional organization, including service providers, to establish accounts and/or claim programs on HKC. In early 2021, CHA conducted several community trainings, hosted two webinars, and released information/advertising to the community via press release, staff via email, and members via text message. Additional trainings and outreach efforts will occur in 2022.

[redacted] Through [redacted] CHA started to work with [redacted] Data Science as a Service (DSAAS) provider, in 2021 to enhance the identification of SDOH needs. This will allow CHA to more easily identify improvement opportunities and to better allocate resources in 2022-2024.

Strategy

CHA's 2021 Health IT and Social Determinants of Health Equity strategy was to identify and increase the capturing of member's SDOH/HE information, by integrating assessment resources within CHA's technology platforms and other 3rd party web-based platforms, to enhance care coordination and connecting members with necessary social and health services needed within a closed-loop referral system. Most of the accomplishments related to this strategy are explained in the descriptions of tools above.

Additionally, CHA hired a dedicated Health Equity Manager. CHA tested a survey methodology, Health Equity Community Survey, to collect SDOH data from the community and offered financial support to encourage participation. In Q4 2021, CHA stood up a new performance improvement project (PIP), SDOH Screening and Referral Process PIP. Through the PIP, CHA will evaluate, test, and update current processes for social needs screening, data capture, data sharing, and closed-loop referrals. During the process to update CHA's internal infrastructure, CHA will collaborate with local organizations and providers who are already screening members to limit duplicative efforts, establish data-sharing protocols, and increase usage of the Community Information Exchange (CIE) platform for referring members to resources.

CHA's Transformation and Quality Strategy (TQS) has projects focusing on activities to better facilitate CHA's understanding of underlying social issues within our community through data collection and reporting and the need to be more culturally responsive to members and their cultural needs. For example, CHA continued to improve the capture of Race, Ethnicity, Language, and Disability (REALD) through the Transformation and Quality Strategy (TQS) OHA Project #61, the Member Reassignment project which is now named Closed-loop Grievance System. This project will be continued in 2022.

2. Please describe any progress you made in 2021 supporting contracted physical, oral, and behavioral health providers with using HIT to support social needs screening and referrals for addressing SDOH needs. Additionally, describe any progress supporting social services and community-based organizations (CBOs) with using HIT in your community. In the spaces below, please include

a. A description of the tool(s) you supported or made available to your contracted physical, oral, and behavioral health providers, social services, and CBOs. Please specify if the tool(s) have closed-loop referral functionality (e.g., CIE).
b. The strategies you used to support these groups with using HIT to support social needs screening and referrals.
c. Any accomplishments and successes related to each strategy.

Note: If your progress pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Progress Across Provider Types* section and make a note in each provider type section to see the *Progress Across Provider Types* section.

i. Progress across provider types, including social services and CBOs, and tool(s) supported/made available

See *2021 Progress* section for list of tools and progress applicable to all provider types.

CHA coordinates efforts with local non-profit, Health Klamath Organization, to execute a Community Health Assessment. This is a community needs assessment completed every 3-5 years. CHA is one of the "Core Five" agencies that serve as the guiding force behind the Healthy Klamath partnership which is a coalition (Healthy Klamath Coalition) comprised of over 150 local CBOs, health providers, and Klamath County Public Health who collaborate at every opportunity to improve the health of the community. Additionally, by sending text messages to CHA members and attending local community events, CHA supported Healthy Klamath's initiative to collect Well-Being data through Blue Zones RealAge Test. The RealAge Test compares RealAge of individuals to their biological age. RealAge considers SDOH factors.

ii. Additional progress specific to physical health providers

See *Across Provider Types* section.

iii. Additional progress specific to oral health providers

See *Across Provider Types* section.

iv. Additional progress specific to behavioral health providers

See *Across Provider Types* section.

v. Additional progress specific to social services and CBOs

See *Across Provider Types* section.

vi. Please describe any barriers that inhibited your progress

Progress and efforts in 2021 were slowed by competing priorities, ongoing pandemic response, overstretched resources, and open staffing positions with our providers and community partners as well as internally.

B. 2022-2024 Plans

1. Please describe your plans for using HIT for social needs screening and referrals for addressing SDOH needs within your organization beyond 2021. In your response, please include
   a. Any additional tool(s) you will use. Please specify if the tool(s) will have closed-loop referral functionality (e.g., CIE).
   b. Additional strategies you will use beyond 2021.
   c. Activities and milestones related to each strategy.

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

Overall Plans

Elaborate on each strategy (if not previously described in the *Progress* section) and the include activities milestones in the section below.

CHA's 2022-2024 plans for using HIT to Support Social Needs Screening and Referrals for Addressing SDOH Needs support and align with multiple other CHA initiatives, including but not limited to, Health Equity Plan, Transformation and Quality Strategy (TQS), and Establish SDOH Screening and Referral Process Performance Improvement Project (PIP). CHA's TQS incorporates aspects of HIT into seven of the eight projects. Majority of the projects have an implicit or explicit focus to better facilitate CHA's understanding of underlying social issues within our community through data collection and reporting and the need to be more culturally responsive to members and their cultural needs. See *2021 Progress* section for a list of tools.

Please see inserted table below for 2022-2024 strategies and activities with milestones related to SDOH screening and referring for CHA.

HIT for SDOH Screening and Referrals - Internal	
SDOH Screening and Referring Strategy 1: **Care Coordination** Enhance care coordination and connecting members to needed services within a closed loop referral system.	
Activities:	**Milestones and/or Contract Year:**
Standardize internal workflows to ensure Healthy Klamath Connect (HKC) is the primary tool for closed-loop referrals and data captured in HKC is integrated with other data.	By Q4 2022, new process is established.
SDOH Screening and Referring Strategy 2: **SDOH Screening and Data Capture** Integrate and utilize assessments within platforms.	
Activities:	**Milestones and/or Contract Year:**
Standardize internal workflows to utilize PRAPARE screening tool in [redacted] more consistently and data captured is integrated with other data.	By Q4 2022, new process is established.
Enhance internal workflows to better utilize social needs information from Health Risk Assessments (HRAs) included within [redacted] through the integration of HRA data with other data.	By Q4 2022, new process is established.

2. Please describe your plans for supporting contracted physical, oral, and behavioral health providers with using HIT to support social needs screening and referrals for addressing SDOH needs. Additionally, describe your plans for supporting social services and CBOs with using HIT in your community. In the spaces below, please include
    a. A description of any additional tool(s) you will support or make available to contracted physical, oral, and behavioral health providers, social services, and CBOs. Please specify if the tool(s) will have closed-loop referral functionality (e.g., CIE).
    b. Additional strategies for supporting contracted physical, oral, and behavioral health providers, social services, and CBOs with using HIT for social needs screening and referrals for addressing SDOH needs beyond 2021.
    c. Activities and milestones related to each strategy.

Notes: Strategies and tools described in the *2021 Progress* section that remain in your plans for 2022-2024 do not need to be described again in this section unless there is new information around how you are implementing/supporting the strategy and/or tool; however, please make note of these strategies and tools in this section and include activities and milestones for all strategies you report.

- If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.
- If a strategy and its related activities and milestones pertains to all provider types, it is not necessary to rewrite it in each provider type section; please clarify this in your *Strategies Across Provider Types* section and make a note in each provider type section to see the *Strategies Across Provider Types* section.

i. Plans across provider types, including social services and CBOs, and tool(s) you will support/make available

CHA's 2022-2024 plans for using HIT to Support Social Needs Screening and Referrals for Addressing SDOH Needs align efforts of CHA, provider, and community partners. See *2021 Progress* section for a list of tools.

Please see inserted table below for 2022-2024 strategies and activities with milestones related to SDOH screening and referring for providers and partners.

HIT for SDOH Screening and Referrals - External	
SDOH Screening and Referring Strategy 1: **Care Coordination** Enhance care coordination and connecting members to needed services within a closed loop referral system.	
Activities:	**Milestones and/or Contract Year:**
Provide financial and technical support for Healthy Klamath Connect	2022-2024
Expand community awareness of Healthy Klamath Connect to increase utilization to search for resources and services options for all community members (including CHA members) addressing SDOH needs.	By Q3 2022, use of Healthy Klamath Connect as primary local search engine is normalized.
Work with provider and community partners to ensure Healthy Klamath Connect is the primary tool for closed-loop referrals, including but not limited to, training and increase of the number of claimed programs in Healthy Klamath Connect.	By Q4 2024, 75% of programs are claimed.
Increase the percentage of closed-loop referrals within Healthy Klamath Connect.	By Q4 2024, 90% of Healthy Klamath Connect referrals are closed loop referrals.
SDOH Screening and Referring Strategy 2: **SDOH Screening and Data Capture** Integrate and utilize assessments within platforms.	
Activities:	**Milestones and/or Contract Year:**
Work with clinic and community partners to ensure their assessments are captured within a platform that has reporting capabilities.	By Q4 2022, data is stored in a reportable way by all applicable organizations.
SDOH Screening and Referring Strategy 3: SDOH Data Sharing Enhance data sharing related to SDOH needs, screening, and referring data.	
Activities:	**Milestones and/or Contract Year:**
Establish path to share SDOH data through Healthy Klamath Connect, Reliance eHealth Collaborative, and other means with clinic partners and community benefit organizations (CBOs). Once established, utilize newly established path to prevent or reduce rescreen.	By Q4 2023, data is consistently shared amongst all applicable organizations.

ii. Additional plans specific to physical health providers

See *Across Provider Types* section.

iii. Additional plans specific to oral health providers

See *Across Provider Types* section.
iv. Additional plans specific to behavioral health providers
See *Across Provider Types* section.
v. Additional plans specific to social services and CBOs
See *Across Provider Types* section.

C. Optional Question

How can OHA support your efforts in supporting the use of, and using HIT to support social needs screening and referrals for addressing SDOH needs?
Provide guidance or best practices related to sharing screening data across organizations.

6. Other HIT Questions (Optional)

The following questions are optional to answer. They are intended to help us assess how we can better support the work you are reporting on.

A. How can OHA support your efforts in accomplishing your HIT Roadmap goals?
Continue to work on reducing and removing duplication of CCO deliverables content and reporting.
B. How have your organization's HIT strategies changed or otherwise been impacted by COVID-19? What can OHA do to better support you?
C. How have your organization's HIT strategies supported reducing health inequities? What can OHA do to better support you?