

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:

- A. Narrative sections to describe your 2025 strategies, progress, accomplishments/successes, and barriers
- B. 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:

- C. 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.
- D. 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).
- E. Feel free to delete any unused strategy sections (e.g., if CCO only includes three strategies, fourth strategy section can be deleted).
- F. If CCO is not pursuing a strategy beyond 2025, note "N/A" in the Planned Activities and Planned Milestones sections.
- G. If CCO is implementing a strategy beginning in 2026, please indicate "N/A" in the progress section for that strategy.
- H. If CCO is continuing a strategy from prior years, please continue to report and indicate "Ongoing" or "Revised" as appropriate.

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.**

CHA is prioritizing easier to use population health and risk stratification health IT tool(s) for easier oversight, monitoring, and care coordination as well as to improve leadership decision making capabilities. CHA is also exploring how to leverage AI to improve process efficiency.

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:

- I. 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.

- J. Include plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialing, Letters of Interest).
- K. 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.
- L. **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.**

CHA currently has (54) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently, there are (2) Physical, (0) Behavioral, and (0) Oral Health organizations identified with no EHR. CHA will continue working with these physical health providers to understand the barriers to adopting an EHR. Currently, there are (2) Physical, (16) Behavioral, and (1) Oral Health organizations identified with unknown EHR status. With sixteen (16) behavioral health clinics with EHR status unknown, behavioral health is CHA's largest area of opportunity. In 2026, CHA will give special attention to the Behavioral Health provider type to outreach to these providers to fill the identified data gap and better understand the barriers or opportunities for EHR adoption. By Q4 2026, CHA plans to work with eight (8) behavioral health organizations to identify their EHR status.

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

In 2023, CHA developed and distributed a Health IT (HIT) survey to contracted providers to capture EHR adoption, vendor, and functionality information. The survey was refined in 2024 to improve clarity and response quality and is distributed at least annually. In 2025, CHA supplemented the annual HIT survey with targeted outreach during existing provider engagement activities, including individual clinic engagement meetings and larger group forums such as metrics workgroup meetings. These touchpoints are used to gather missing EHR information, validate survey responses, and remind providers to complete or update the HIT survey, ensuring more complete and accurate EHR data over time.

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: Assessment/Tracking of EHR Adoption and Capabilities

Brief description: Develop and utilize Provider Engagement Plan to document EHR contacts at clinics, track clinic activities with EHR use and adoption, and identify barriers providers/clinics have with EHR adoption.

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

CHA continues to assess and track EHR adoption and capabilities across its provider network using established and evolving engagement processes. In May 2025, CHA distributed the annual Health IT (HIT) survey to reassess provider use of Health IT tools and compare results to data collected in 2024. Thirteen (13) providers responded, and results were used to validate, supplement, and update previously collected EHR information. CHA will continue to refine the HIT survey

as needed, distribute it at least annually, and use provider engagement activities to capture missing or updated data. To support consistent tracking and follow-up, CHA maintains a centralized provider and clinic tracking system that is continually modified to reflect evolving data needs. The Quality Department has served as the primary group incorporating requirements from other departments to ensure the system captures key EHR adoption details, provider engagement activities, and identified barriers. Once stabilized, the tracking system is being rolled out to additional departments for their own tracking and coordination purposes. CHA added technical assistance and Health IT-related discussions as standing agenda items in Metrics Workgroup meetings and individual clinic check-in meetings with the Quality Department. Health IT topics were also incorporated into Metrics agendas to allow for more in-depth discussion with clinics. In 2024, CHA developed and shared a centralized provider and clinic contact list to support coordinated outreach. In 2025, ongoing maintenance of this resource continued through collaboration between the Quality Transformation Coordinator (QTC) and Provider Network Manager, though some progress was temporarily impacted by staffing changes. CHA has strengthened internal collaboration on provider engagement through multi-department coordination involving the Quality Department, Member Services, Provider Network Management, and Case Management. Departments meet regularly to align on information needs and share findings gathered by the QTC during individual clinic meetings. This coordinated approach was implemented in response to provider feedback to streamline engagement, reduce duplicative outreach, and reduce administrative burden on clinics while improving the completeness and accuracy of EHR and HIE adoption data.

(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 distributing HIT survey to providers at least annually.	A. 2026-2029
2. Continue carrying out Provider Engagement Plan and collecting information from clinics, adjusting the plan and HIT survey as necessary based on continuous improvement efforts.	B. 2026-2029
3. Provider Engagement Plan activity: continue to collect contacts and create a filtered system to capture who is being contacted in the clinics based upon type of communication.	C. By Q4 2026
4. Provider Engagement Plan activity: continue to align provider engagement efforts from multiple departments to decrease number of interactions with providers/clinics and maximize time with providers/clinics through centralized tracking mechanism.	D. By Q4 2026

Strategy 2 title: EHR Training and Technical Assistance Outreach and Education

Brief description: Provide technical assistance for providers (when needed or requested) for implementing/upgrading EHR. Offer technical assistance (TA) for building reporting for EHR metrics and target outreach efforts to support EHR adoption.

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

CHA continues to provide ongoing EHR training and technical assistance (TA) to support providers with EHR implementation, upgrades, and accurate reporting of OHA incentive metrics. In 2025, CHA met monthly with seven (7) primary care clinics, including five (5) PCPCH clinics, through the Metrics Workgroup to review

OHA incentive metrics, discuss quality improvement opportunities, and plan targeted improvement strategies. While CHA does not currently meet with behavioral health providers on a monthly, collective basis, targeted engagement efforts were undertaken in 2025 to better understand barriers to broader participation. The Quality Transformation Coordinator (QTC), in collaboration with the Provider Network Manager, completed an analysis of individual behavioral health clinics to assess EHR capabilities, engagement readiness, and contributing factors limiting meaningful participation in larger group forums. Findings from this analysis are being used by the Provider Network Manager to address clinic-specific challenges and relationship dynamics that have discouraged behavioral health providers from engaging at scale. CHA conducted broad provider engagement outreach across behavioral health, primary care, and oral health providers and continued individualized clinic engagement meetings with primary care clinics. As a result of targeted behavioral health outreach, CHA successfully added two (2) behavioral health clinics into regularly scheduled individualized check-ins. Individualized engagement with behavioral health providers will continue to be prioritized in 2026 while maintaining ongoing engagement with primary care and oral health clinics. Throughout 2025, CHA provided technical assistance to support accurate EHR documentation and reporting for OHA incentive metrics, with a focus on ensuring screenings and interventions were captured as structured data within clinic EHR systems. CHA also provided technical assistance related to EHR reporting and evolving OHA metric requirements. In collaboration with EHR vendors, CHA worked with four (4) primary care providers to build and refine EHR reports aligned with metric specifications and reporting changes. Throughout 2025, CHA provided outreach and education in the form of targeted technical assistance, including support with provider portal access for viewing authorizations and submitting claims, assistance with developing and interpreting quality data reports, and review of existing EHR metric reports to assess what data are being captured. This

outreach also included education on workflow and documentation improvements needed to better capture clinical activities as structured data for accurate reporting. Despite continued outreach and education efforts, CHA was not successful in encouraging EHR adoption at Klamath Dentistry and the Merrill Clinic. CHA will continue to monitor opportunities for future engagement should clinic readiness or circumstances change.

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

Expand monthly clinic engagement meetings and check-ins to behavioral health providers to encourage more conversations around their EHR systems to better understand their workflow processes and possibly identify ways to capture more applicable data in relation to the metrics.

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 providing TA and education for incentive metric workflow and data report building in EHRs.	A. 2026-2029
2. Continue providing ad hoc TA and education for providers/clinics when requested.	B. 2026-2029

Planned activities	Planned milestones
3. Continue regularly scheduled physical, behavioral health and oral health clinic engagement meetings.	C. 2026-2029
4. Continue to have Health IT as a standing agenda item at clinic engagement meetings.	D. 2026-2029
5. TA is a standing agenda item at clinic engagement meetings and, if a clinic requests TA, CHA supplies TA outside of the clinic engagement meeting.	E. 2026-2029
6. Update the provider manual to include Health IT information.	F. Q3 2026

Strategy 3 title: Explore Requirements in Contracts

Brief description: Explore expanding contract language that encourages EHR adoption/use, HIE use, and other Health IT initiatives.

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):

Initial goal was to explore contract options for additional clinic EHR adoption. Majority of providers are on an EHR, those who are not have remained resistant to adopting an EHR, primarily due to short time until retirement. This strategy is being retired, but CHA will remain ready to assist if clinics are willing to expand in this area.

(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. None	A. N/A

Strategy 4 title: Explore Financial Support Options for Providers

Brief description: Explore funding options available to support provider EHR adoption or upgrades.

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

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

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

In 2025 the adoption of EHR and HIE were part of routine provider visits and the providers were made aware of possible financial support for adoption. These meetings and conversations will continue and if the need for financial support is indicated internal meetings will be used to explore options.

(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. Continue to explore options with Health-Related Services (HRS) spending for providers to assist in EHR adoption/upgrading when it might be cost prohibited for them.	A. 2026-2029
2. Explore alternative payment methods (APMs) as encouragement to implement an EHR.	B. 2026-2029

Strategy 5 title: Support EHR Optimization

Brief description: Explore options for EHR optimization to support improved code capture at point-of-care, increased care gap closure, and better reporting.

Strategy categories: Select which categories pertain to this strategy

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

Strategy status:

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

Provider types supported with this strategy:

- ☒Across provider types **OR** specific to:

☐Physical health

☐Oral health

☐Behavioral health

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

In 2024, CHA partnered with Sky Lakes Medical Center and Primary Care Clinic to review potential platform vendor options for optimizing their EHR to include a risk adjustment overlay or other additional features. In early 2025, CHA partnered with Sky Lakes through the vendor procurement process. Sky Lakes selected IKS, a technology and AI platform that includes overseas resources and support as their claims vendor. However, after collaboration between CHA and the Sky Lakes Chief Information Officer, Sky Lakes opted to use enhancements to their instance of █ to identify risk adjustment opportunities instead of using IKS. The enhanced EHR went live in Q3 2025.

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

Partner with Sky Lakes and other local providers who have █ to implement a similar EHR optimization at their clinic offices. .

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. Collaborate with providers to explore and build, if possible, risk adjustment EHR enhancements for other local instances of █	A. 2026

Planned activities	Planned milestones
2. Collaborate with providers to explore and build, if possible, risk adjustment EHR enhancements for other EHRs.	B. 2027

B. EHR support barriers

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

CHA providers have consistently identified several barriers to EHR adoption and optimization, particularly among smaller clinics. Providers report limited staff capacity and competing operational priorities that make it difficult to dedicate the time required to implement, maintain, or optimize an EHR system. Staffing constraints further limit clinics' ability to support workflow redesign, training, and ongoing system use. In addition, small clinics have expressed that the cost of EHR systems along with the expense of required hardware, infrastructure, and supporting technology creates a significant financial barrier to adoption. These combined resource and cost constraints continue to limit EHR adoption and optimization across parts of CHA's provider network.

C. OHA support needs

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

CHA's smaller clinics would benefit from targeted financial and technical support to address varying stages of EHR adoption and optimization. For clinics that have recently transitioned to a new EHR, such as Konnect Dental Kare (KDK), support

focused on strengthening quality reporting functionality and optimizing workflow documentation would help reduce administrative burden and improve efficiency. For clinics that remain paper-based, including the Merrill and Bonanza Clinics, EHR adoption would significantly enhance care coordination, reporting, and operational efficiency. However, limited provider readiness and staffing capacity remain barriers to adoption. Financial support, paired with readiness and engagement assistance, could help reduce these barriers should providers reconsider transitioning to an EHR. Overall, OHA support that combines financial assistance with implementation and optimization support would help small clinics strengthen quality reporting, streamline workflows, and improve participation in statewide quality initiatives.

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:

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

- E. **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.

██████████: The 2021 upgrade of ██████████ allows for CHA to receive the platform updates as they are made available by ██████████; the previous version of ██████████ that CHA was using was very customized, so updates could not be applied. In 2025, CHA successfully applied two (2) version upgrades, 4.14.3 and 4.15.2, which enhanced and expanded features in the platform.

██████████ **Provider Portal:** The portal allows providers to submit authorizations and view the status of previously submitted authorizations as well as related correspondence, like authorization summaries, NOABDs, pharmacy receipt notification, and pharmacy approved letters. The 2021 CHA-created training manual with step-by-step walkthroughs of the portal for providers and clinic staff to use is located on the Provider Portal page of the CHA website. In 2024, a similar training manual was added for pharmacy authorizations. In 2025 CHA began to add assessments to authorizations in the portal. This provides prompts to providers for required documentation to allow for timely processing of authorizations and decreased requests for additional information from providers. Other reference documents for providers and clinic staff are posted to the Provider Resource Center section of CHA's website. Individual TA is available for all provider types, with many providers and clinics continuing to utilize the individual TA opportunity from CHA Utilization Management staff.

Reliance eHealth Collaborative: Reliance offers the Community Health Record (CHR) portal. CHA's Case Management department utilizes Reliance to look up members in the CHR to see services the member is receiving, review pre-built cohort reports, as well as to view chart notes to help with care coordination and ensuring the member's needs are being met. CHA's Quality Management

department utilizes HbA1c data from Reliance to target outreach to members in the poor control range. The IET metric is also built in Reliance and CHA utilizes this report to monitor performance for the IET metric. In 2025, CHA continued to use A1c data from Reliance to support the Diabetes Poor Control metric.

FFindhelp - Healthy Klamath Connect (HKC): CHA Case Management 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. CHA Case Management also educates members directly on how to navigate the HKC site to empower members to be able to self-advocate and quickly seek resources on their own. This is done one-on-one on a case-by-case basis. Additional information on the HKC platform is in the Health IT to Support SDOH Needs section below.

██████████: CHA implemented ██████████ in 2023, after ██████████ discontinued the PRM Analytics platform. ██████████ is a platform that ingests and aggregates CHA claims data to compare against benchmarking, identify quality of care improvements, perform custom analysis on claims data with groupers and metrics, identify cost drivers and savings opportunities, improve risk adjustment modeling and efforts, and measure cost of care. The reporting received through the ██████████ portal allows CHA to track utilization of services, help to improve member health outcomes through targeted outreach and interventions, and help improve overall patient care.

PointClickCare (PCC): PointClickCare is utilized daily by the CHA Case Management department to monitor cohorts built in PointClickCare, and service utilization by members with open cases to coordinate care, ensure member needs are being met, and reduce unnecessary use of services. CHA's behavioral health (BH) case management team reviews the Emergency Department (ED) and

hospital admission reports daily in PointClickCare. These reports are used to contact members with open case management cases, as well as members who do not have an open case that were recently admitted and discharged from the ED or hospital for mental health or substance use disorder concerns or issues. The BH case manager conducts outreach with these members to offer case management services and opens new cases for the members interested. Additionally, CHA case managers post CCO care plans to PCC for availability to community partners and providers for shared members.

(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: Care Coordination and Care Management

Brief description: Utilize the data from HEN platform, PCC/PointClickCare, HIE platform, Reliance, and internal case management system, [REDACTED], to identify members in need of and follow-up on care coordination or case management.

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, we continued to optimize our cohorts within Point Click Care (PCC). Follow up for health-related circumstance change (HRCC) occurs through regular review of the ED visits, with outreach provided through a resource mailing for most visits. High risk visits or those with multiple ED visits (five or more in six months) are assigned to a care coordinator. We continue to monitor and work directly with PCC for optimization as need is identified. We have adjusted our Risk Stratification model to use internal claims data for the review for medical risk. The change allows for the claims data to be incorporated into the risk stratification model sooner than the previous vendor. Education and process standardization occurred this year with case managers to ensure consistent follow up with members and the members with high and moderate risk are case managed. Our Utilization Review (UR) analysts have expanded the review of inpatients so concurrent review includes assessment of discharge readiness with the appropriate referrals to care coordination as needed.

(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. Explore and build, if needed, additional cohorts in PointClickCare for care coordination intervention	A. 2026-2029 as needed/identified

Planned activities	Planned milestones
strategies (i.e., pediatric admissions, etc.).	
2. Ensure notifications are set up for applicable staff to receive notifications for applicable cohorts (i.e. LTSS cohort, ED cohort, etc.), especially as new cohorts are added.	B. 2026-2029 as needed/identified
3. Fully optimize, monitor, and refine the Risk Stratification Model for care coordination as needed.	C. 2026-2029

Strategy 2 title: Exchange of care plans and care information

Brief description: Explore and potentially implement new and innovative uses of health information technology platforms to better serve members

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 2024, it was discovered that DHS-Aging People with Disabilities is not able to use PointClickCare to access member care plans. CHA continued to explore other electronic options for sharing care plans with DHS-Aging People with Disabilities. CHA is currently sharing care plans with DHS-Aging People with Disabilities via telephone calls, fax, and encrypted email. In 2025, there was not an opportunity to expand on the DHS access or engagement with the shared care plans. Education was provided on process standards with case managers to ensure CHA care plans are uploaded for care team review. Care plans are faxed to provider offices and a solution has not been identified for access to care plans through the provider portal.

(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. Explore options with the Member Portal to share care plans electronically with members.	A. Q4 2026

Strategy 3 title: Integration of Disparate Information and/or Tools with HIE
Brief description: CHA’s Case Management department integrates information from PointClickCare and Reliance eHealth into CHA’s care coordination tool to

assist in member interventions and coordinating care plans with providers. Utilize Reliance eHealth for integration of information and to improve data sharing, care coordination, and transition 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:

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):

CHA was not able to integrate platforms or connect disparate data in 2025 and will continue to explore options with software upgrades and other connections in 2026.

(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. Explore opportunities with Reliance, PointClickCare, and ████████ to automate integration of information from one system to the other.	A. 2026-2029
2. Partner with Reliance eHealth to expand the amount of SDOH data available in the platform to improve SDOH care coordination.	B. 2026-2029

Strategy 4 title: Enhancements to HIE tools

Brief description: Partner with PointClickCare to explore enhancements to the platform to improve access to data to better work with members.

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, training and education was provided to case

managers from PCC. Staffing challenges and turnover during the year prevented full exploration of enhancement options. A full exploration of enhancement options will continue in 2026. A new module was added to PCC to review members with upcoming care gaps. This module was introduced to case managers in training and will be explored further in the coming year.

(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 partner with PointClickCare account manager to explore opportunities and capabilities in the PointClickCare tool.	A. Utilize monthly meetings to explore upcoming enhancement opportunities 2026-2029

Strategy 5 title: Collaboration with external partners

Brief description: Work with clinic and community partners to enhance the use of Health IT in Klamath County.

Strategy categories: Select which categories pertain to this strategy

☐1: Care coordination ☐2: Exchange care information

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

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

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

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy): In 2025, CHA continued to meet with community providers as outlined in other strategies. Conversations were resumed with providers not utilizing ██████ regarding read only access to EHRs and CHA was not able to secure access to any additional EHRs at this time. CHA improved collaboration with Klamath County Public Health through incorporation into monthly Metrics Workgroup meetings. Additionally, conversations brainstorming options to improve processes and data sharing were had around substance use disorder treatment with providers at collaborative meetings. CHA will continue to use the regularly scheduled meetings to share information and promote HIE with partners.

(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 enhancement of weekly collaborative care meetings	A. 2026-2029

Planned activities	Planned milestones
between many clinics/provider types.	
2. Continue to explore opportunities for read access to additional clinic's EHRs (non-██████ EHRs).	B. 2026-2029

Strategy 6 title: Implement and Optimize Member Portal

Brief description: 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 be limited to ordering new cards, getting benefit information, and finding assigned providers.

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: Implement and Optimize Member Portal

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy): In October 2025, CHA rolled out the member portal to members. Member communication included a notification banner on the homepage of the CHA website, a Facebook post, updates to Member Services call scripts, and distribution of flyers in the new member packets as well as CHA's

office lobby. In February 2026, a text message was also sent to members. At the end of 2025, a total of 66 members were enrolled on the platform. Due to the later rollout, CHA did not have an opportunity in 2025 to explore other HIE platform integration with the member portal.

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

Explore and implement Member Portal enhancements to better serve members, to support care coordination, and to improve communication. These enhancements include, but are not limited to, Health IT platform integrations, HRA automation, secure two-way communication, site banner to spread awareness of community events and to provide prevention reminders, and addition of member care plans, claims data, and letters.

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. Explore member portal enhancements.	A. By end of Q4 2026, implement at least two (2) member portal enhancements.
2. Implement member portal enhancements.	B. Q1 2027
3. Continue educating members about the member portal.	C. Through 2026-2029, use multiple modes of communication (phone calls, text messages, website messages, flyers/mailers, social

Planned activities	Planned milestones
	media, and outreach events) to inform about and promote the member portal.

Strategy 7 title: Utilization monitoring/management

Brief description: Use Health IT platforms to monitor and manage member utilization of services, inform intervention planning, and risk stratification.

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: Utilization monitoring/management

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy): In 2025, CHA revised the risk stratification model. The HRCC response process was enhanced to ensure ED reports are regularly reviewed and outreach initiated based on utilization trends and diagnosis. PCC training was provided to the case managers, case assistants and UR IP reviewers. The CHA Clinical Operations team is continuously evaluating, improving, and identifying opportunities in PCC for new cohorts and reports to better monitor member utilization and improve member 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. Continue to utilize PointClickCare and [REDACTED] to monitor events and issues affecting service availability, high spend, or cohorts that are high risk.	A. 2026-2029
2. Continue to utilize BH and ED cohorts in PointClickCare to monitor use.	B. 2026-2029
3. Update internal Case Management processes, including annual training for staff, for the utilization of PointClickCare, Reliance, and [REDACTED]	C. 2026-2029
4. Continue to expand use of utilization data in the Risk Stratification model for care coordination/case management.	D. 2026-2029

Strategy 8 title: Supporting CCO metrics

Brief description: Use Health IT platforms to track and support incentive metrics work, as well as identify areas of opportunity.

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: Supporting CCO metrics

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy): In 2025, CHA continued to receive Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) notifications through Reliance and worked with providers to support timely initiation of substance use disorder (SUD) services for members. These notifications remained a key tool for identifying members in need of follow-up and supporting provider outreach efforts.

In 2025, CHA implemented a new Quality Insights tool through Ayin Health Solutions, providing providers with access to incentive metric data for their assigned members. The additional metric-level and demographic insights available through the Ayin Community Integration Manager (CIM) tool support providers in identifying care gaps, prioritizing outreach, and improving performance on quality measures, including SUD-related metrics. Training on the CIM tool was provided to all providers to support effective adoption and use.

Implementation of the Ayin tool took longer than initially anticipated due to internal and external process requirements and technology capability constraints. There continues to be challenges with shifting provider assignments and thus have implemented a regular review of assigned members for the PCP offices to review and provide updates so CIM data is current to the PCP’s assigned members. Despite these challenges, CHA successfully completed implementation and continues to support provider onboarding and ongoing use of the tool.

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

Continue to provide ongoing support of the CIM tool.

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 use IET notification report from Reliance to inform providers of SUD care opportunities timely.	A. 2026-2029
2. Continue to use the maternity cohort report to support the prenatal and postpartum care metric.	B. 2026-2029
3. Explore opportunities to expand metrics captured and tracked in PointClickCare.	C. 2026-2029

Strategy 9 title: Supporting financial forecasting

Brief description: Utilize data from Health IT platforms to guide care coordination, interventions, and program creation.

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: Supporting financial forecasting

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy): The time lag for [REDACTED] makes monitoring utilization challenging and limits CHA's ability to prevent potentially avoidable costs. In 2025, as a quick solution, CHA explored internal data options and built an internally created report for more timely reporting of trends and identification of high-cost members. With this new report, CHA can identify high-spend events sooner and assign members with high-spend events to care coordination accordingly. In 2026, CHA will continue to explore Health IT options to improve timely reporting capabilities.

(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 expand and refine reports in [REDACTED] to guide care coordination and population health program creation.	A. 2026-2029
2. Explore using PointClickCare to support financial forecasting and population health program creation.	D. 2026-2029

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:

- E. 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.
- F. 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.

- G. (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.
- H. **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.

PointClickCare: CHA's network providers that use the PointClickCare platform can access cohort reports and notifications for their patients to assist with care coordination. Additionally, CHA case managers post CCO care plans to PCC for availability to community partners and providers for shared members.

Reliance eHealth Collaborative: Reliance offers the Community Health Record (CHR) portal. Many of CHA's network providers contribute data to Reliance's CHR. CHA contributes member eligibility and claims data to the CHR. All clinics that are portal participants have access to the CHR and the shared data to assist with care coordination, continuity of care, and help improve patient outcomes. Other services available to providers and clinics that are Reliance participants: orders and results delivery, admissions, discharges, and transfers (ADT) interface, and the continuity of care documents (CCD) interface. If providers/clinics choose EHR connectivity/integration with Reliance, a wide variety of clinical results can be sent directly into the EHR to support improved efficiency in accessing records for patients and reporting.

(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:**

CHA currently has (54) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently, CHA has identified (3) Physical, (19) Behavioral, and (6) Oral Health providers without an HIE for care coordination. By Q4 2026, CHA plans to work with three (3) additional providers to add HIE care coordination capabilities, one in each provider type category of Physical, Oral, and Behavioral Health providers. By Q4 2027, CHA plans to explore opportunities to increase HIE use and adoption with three (3) more from the behavioral health category since that is the category with the largest area of opportunity.

Strategy 1 title: Training and Technical Assistance

Brief description: Provide technical assistance for providers (when needed) to support the use of Health IT for hospital event notifications (HEN), including, but not limited to, platform recommendations and workflow review.

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 2026, CHA continued to offer training and technical assistance to partners across the various health information technology platforms in use. CHA provided targeted technical assistance by collaborating with EHR vendors to support clinics in developing and refining the reports necessary for accurate metric reporting. CHA also conducted multiple audits throughout the year, which identified opportunities where clinics were completing required clinical activities, but the work was not being captured in a reportable way that counted toward performance metrics. In response, the Quality Director worked directly with clinics and EHR vendors to address documentation, workflow, and reporting gaps, ensuring that services provided were appropriately reflected in metric outcomes reporting.

(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 offer technical assistance to providers and care teams for Health IT tools for care coordination.	A. 2026-2029
2. Continue to offer technical assistance to providers and care teams for the PointClickCare platform.	B. 2026-2029

Strategy 2 title: Assessment/tracking of HIE adoption and capabilities

Brief description: Utilize HIT survey and Provider Engagement Plan to document strategies for collaboration with providers to use Health IT to support care coordination, track clinic adoption and use of Health IT for care coordination and assist with identifying any barriers providers might have with adopting and using Health IT for care coordination.

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 September 2024, CHA distributed the Health IT (HIT) survey to providers to reassess the use of Health IT tools across the provider network and to compare results with data collected in 2023. Fourteen (14) providers responded to the survey, and results were used to validate, supplement, and update previously collected Health IT and EHR information. CHA will continue to refine the survey as needed, distribute it at least annually, and use provider engagement activities to capture missing or updated data. To support consistent data collection and follow-up, CHA added technical assistance as a standing agenda item in Metrics Workgroup meetings and individual clinic check-in meetings with the Quality Department. In 2024, CHA also created and shared a centralized provider and clinic contact list to support coordinated outreach efforts. The next phase of this work includes refining the contact list to allow filtering by provider type and department to better support targeted outreach across teams. CHA strengthened internal collaboration on provider engagement through multi-department meetings focused on aligning information needs and reducing duplicative outreach. Departments meet regularly to discuss data and information collected by the Quality Transformation Coordinator (QTC) during individual clinic meetings, with findings shared back across teams. This approach was implemented in response to provider feedback to maximize efficiency in provider interactions and reduce the number of CHA staff outreaching to clinics for the same information. In 2025, this strategy shifted into a refinement and expansion

phase, with a focus on strengthening alignment across departments for provider engagement processes and workflows. Efforts prioritized collaboration with the Member Services department and the Provider Network Manager to further enhance the centralized provider and clinic contact list and check in tracker.

(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 distributing HIT survey to providers at least annually.	A. 2026-2029
2. Continue carrying out Provider Engagement Plan and collecting information from clinics, adjusting the plan and HIT survey as necessary based on continuous improvement efforts.	B. 2026-2029
3. Provider Engagement Plan activity: continue to collect contacts and create a filtered system to capture who is being contacted in the clinics based upon type of communication.	C. 2026-2029

Planned activities	Planned milestones
4. Provider Engagement Plan activity: continue to align provider engagement efforts from multiple departments to decrease number of interactions with providers/clinics and maximize time with providers/clinics through centralized tracking mechanism.	D. 2026-2029

Strategy 3 title: Outreach and Education About Value of HIE

Brief description: Provide education to providers not utilizing HIE platforms with targeted efforts through live meetings, information sent via email, and pre-recorded webinars. Utilize the annual provider training to continue to share about Health IT, HIE platforms, and other Health IT initiatives/opportunities. Also, provide targeted education to providers not utilizing PointClickCare about the benefits of the platform for real-time care coordination.

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, CHA revised the annual provider training, and the Health IT section was not revised and included due to staff turnover. CHA will explore revision options and additional Health IT education opportunities with providers in 2026.(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 educate and promote HIE use with providers, including during coordinated care meetings and individual clinic meetings.	A. 2026-2029
2. Explore options for provider education and training on Health IT.	B. By Q4 2026

Planned activities	Planned milestones
3. Create pre-recorded webinars to further inform providers about HIE opportunities.	C. By end of Q4 2026

Strategy 4 title: Collaboration with Network Partners

Brief description: Work with clinic and community partners to enhance the use of Health IT in Klamath County for care coordination and HEN.

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):

Click or tap here to enter text. In 2025, meetings with clinics included discussions about PointClickCare and ways to enhance community connectivity through this platform. The Quality Department remained available to assist with implementation for any clinics interested in utilizing this system. The maternity reports have been refined as criteria are identified. Meetings with Reliance have been held to identify additional ways to utilize the pregnancy notification lists to ensure full capture of maternity case management needs. This continues to be refined and implemented into workflows during 2026.

(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 refine and implement process for maternity case management to receive notifications as timely as possible for pregnant members through Reliance.	A. By Q1 2027
2. Click or tap here to enter text. Continue coordinated care meetings with care teams for high risk and newly pregnant members.	B. 2026-2029

Planned activities	Planned milestones
3. Continue regular coordinated care communication with care teams for high needs pediatric members.	C. 2026-2029
4. Continue to explore additional network use of PointClickCare for better care coordination and information sharing.	D. By end of Q4 2026
5. Continue to offer information and training in annual provider training on PointClickCare to help expand use in Klamath County	E. 2026-2029

Strategy 5 title: Explore Requirements in Contracts/Provider Agreements

Brief description: Explore expanding contract language that encourages EHR adoption/use, HIE, and other Health IT initiatives.

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):

With no momentum on changing contract language to encourage HER or HIE adoption and use, CHA decided to retire this strategy.

(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
None	N/A

Strategy 6 title: Explore Financial Support Options for Providers

Brief description: Explore funding options available to support provider HIE for HEN adoption and Care Coordination.

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):

CHA continued to financially support the PointClickCare tool for the provider network in 2025.

(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. Continue to explore options to financially support PointClickCare for provider clinics.	A. 2026-2029
2. Explore additional financial support opportunities for HIE tools for care coordination and HEN for providers.	B. 2026-2029

Strategy 7 title: FHIR Project

Brief description: Work with FHIR vendor to comply with new CMS final rule for interoperability.

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): FHIR Project
☐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, CHA worked with FHIR vendor to outline statement of work, project plan, and timeline to implement the required changes for the new CMS interoperability 0057 rule. CHA will engage with FHIR vendor in 2026 to implement project for new requirements.

(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. CHA to work with FHIR vendor to implement new CMS interoperability rule for prior authorization, provider access, patient access, and payer to payer.	A. By end of 2026
2. Work internally with project team to implement new requirements.	B. By end of 2026
3. Track additional CMS interoperability proposed rules.	C. 2026-2029

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 event notifications among your contracted providers.

Census cohorts and reports from PointClickCare (PCC) always have multiple discharged patients without a discharge date. PCC receives Admit, Discharge, Transfer (ADT) messages from hospitals all over the country. Workflows at each hospital for sending ADT messages are highly variable. Aligning discharge messages with a given admission is difficult. PCC engineers are aware of this challenge and have not yet identified a solution. Standardizing workflows for sending ADT messages could theoretically help reduce the impact of this issue.

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?

HIE provider access and use can be improved by OHA supporting full integration of HIE's into medical record systems. Needing to access a separate system to view hospital notifications and shared records is burdensome. Finding a way to seamlessly integrate HIE information into current EMR workflows would be ideal. Example: [REDACTED] is a section in [REDACTED] that allows sharing of records from any other [REDACTED] instance. Connecting PCC and Reliance information flows to [REDACTED] [REDACTED] would be a huge win for providers, CCO staff and community-based organizations. OHA can fund building HIE functionality that allows CCOs to share Care Plans. Currently a PDF document of a care plan can be uploaded to PCC. Reliance eHealth Collaborative does not have this functionality. Making CCO created care plans available in a providers EMR would be helpful. OHA could add a requirement for DMAP providers to access and use a HIE tool for care

coordination and HEN. OHA could assist with other state agency adoption of PCC and sharing of care plans, specific to the LTSS population and DDS clients.

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., [REDACTED], [REDACTED] 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)?

[REDACTED] Access: For all Sky Lakes Medical Center related providers, CHA's Case Management department is accessing [REDACTED] via [REDACTED] Link.

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

CHA staff use [REDACTED] access to check patient records, treatment notes from visits, review hospital admissions, review current activity for selected members receiving care coordination services, and directly messaging providers within [REDACTED] to assist in care coordination efforts. The member-related information is utilized in weekly collaborative care meetings between CHA, providers, and community case managers also involved in a members' care.

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

Information gathered in [REDACTED] is manually added into CHA's case management system, [REDACTED] when needed.

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:

- D. 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.**
- E. (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.
- F. **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.

██████████ is CHA's Case Management Platform. The platform has enhanced digital assessments, including a digital version of the PRAPARE Assessment Tool (PRAPARE) for Case Management and other departments to gather social needs information and to utilize data gathered while working with members. Additionally, Health Risk Assessment (HRA) information is stored in ██████████ and includes questions about food insecurity, homelessness, and transportation. CHA expanded the use of the PRAPARE screener extensively in 2025, utilizing the screener to identify needs for all members that apply for Flexible Services or Health-Related Social Needs (HRSN) benefits. CHA is also working on revamping HRAs to get enhanced information from members, including additional SDOH data. CHA uses the PRAPARE and HRAs to help inform CHA's Flexible Services program. Data captured in PRAPARE screenings and HRAs are utilized to create a risk score for members which is viewable on the member dashboard.

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. HKC is utilized to receive referrals for both the Flexible Services and HRSN programs through the Integrated SDOH Services program, which includes request details from the member alongside the PRAPARE screener. These requests act as referrals that can be closed by CHA when services are provided, allowing the initial referrer to keep track of their request. As of April 2026, there are 151 listed programs in Klamath County offering 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. 105 of those programs are marked as claimed (meaning managed directly by their organization).

(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: Care Coordination and Care Management of Individual Members

Brief description: Enhance care coordination and connecting members to needed services within a closed-loop referral system.

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):

In 2025, CHA focused on standardizing internal HKC workflows, establishing additional programs to support member coordination, and expanding training efforts for CHA staff, providers, and CBOs on effective use of the HKC platform. To support consistency and accountability, CHA developed role-specific trackers for the SDOH Coordinators to monitor referrals, follow-up activities, and workflow adherence. These efforts support more coordinated care management, improved referral completion, and strengthened closed-loop referral processes across the network.

(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. Continue to standardize internal HKC workflows, establish new programs for member coordination, and train CHA employees, providers, and CBO's on the HKC system.	A. Engage at least 20 providers/CBO's annually and connect 100% of them to the HKC platform
2. Conduct analysis and develop project plan to improve workflows and overall use of HKC with FindHelp.	B. Complete analysis and develop project plan for improving use and deployment of HKC by Q4 2026.
3. Provide training of HKC to all CHA staff members.	C. HKC training for all staff by Q4 2026.

Strategy 2 title: Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)

Brief description: Integrate and utilize assessments within platforms for a holistic view of a member to guide person-centered care plans.

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):

The SDOH Services Request Form was created and deployed within HKC for CHA members to complete within the platform when requesting services. Additional modifications to the request form were identified. Improvement opportunities for related workflows and reporting were also identified.

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

In May 2026, CHA will work with FindHelp to develop a strategy for improving workflows and use of the overall platform with a subsequent project plan to be developed and deployed. These enhancements will ensure CHA is using best practices and providing the most efficient experience for both members and SDOH Coordinators as they connect CHA members with resources. They will also allow for improved access to analytics related to closed-loop referrals.

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. Improve member-facing requests and workflows in Healthy Klamath Connect (HKC).	A. Evaluate and implement changes of SDOH Services program questionnaire in Healthy Klamath Connect by Q4 2026.
2. Utilize HKC programs and screeners to complete closed-loop referrals for HRSN and Flexible Services.	B. Close loop on 100% of HRSN referrals via HKC by Q4 2026.

Strategy 3 title: Collaboration with Network Partners

Brief description: Enhance data sharing related to SDOH needs, screening, and referring data to better meet member needs and to decrease duplication.

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):

In 2024, data sharing agreements were built around CHA’s SDOH Services programs, leading to some new data sharing agreements that allow for SDOH data to be shared in pursuit of more equitable member service. With limited progress in 2025, there is still significant work to do on CHA’s existing data sharing agreements to be more in-line with SDOH work. Agreements including SDOH data or services have been utilized for HRSN Service Providers, Vendors, and CHA’s CIE platform.

(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 review of current SDOH data sharing agreements with network providers, community providers, and community-based organizations and, if needed, update current agreements, or create new agreements.	A. By Q4 2026, review current agreements with partners and identify additional agreements to be made or amended.

Planned activities	Planned milestones
2. Create further paths for sharing SDOH data via Healthy Klamath Connect (HKC).	B. Complete analysis of current SDOH data sharing pathways by Q4 2026
3. Analyze workflows for receiving SDOH data from providers and partners.	C. Complete analysis of SDOH data received from providers and partners by Q4 2026.

Strategy 4 title: CCO Metrics Support

Brief description: Utilize Healthy Klamath Connect, [REDACTED], [REDACTED], and other platforms to help meet the annual requirements of the SDOH Screening and Referral OHA Incentive Metric. Efforts are documented and project managed through the Establish SDOH Screening and Referral Process Performance Improvement Project (PIP).

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):

In 2025, CHA continued to support sustained performance on the SDOH Screening and Referral Metric by monitoring workflow adherence, referral activity, and data completeness across Healthy Klamath Connect (HKC), ██████████, ██████████, and other supporting platforms. CHA used ongoing data review and provider engagement to validate that screening and referral processes remained in place and were functioning as intended. Metric-related activities and refinements continued to be tracked and managed through the SDOH PIP to ensure alignment with OHA requirements and to support continuous improvement. CHA also focused on strengthening documentation, tracking, and internal coordination to support ongoing metric compliance, including refinement of workflows, reinforcement of closed-loop referral processes, and collaboration across departments involved in screening, referral, and reporting activities. These efforts support metric sustainability and readiness for future measurement years.

(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. Carry out SDOH Screening and Referral Process Performance Improvement Project (PIP).	A. 2026-2029, submit quarterly report to OHA.

Planned activities	Planned milestones
	B. By Q4 2026, CHA attests to all Measurement Year (MY) 3 Must-Pass elements.
2. Meet requirements for SDOH Screening and Referral OHA Incentive Metric.	C. Q4 2026, CHA will report on sample population meeting 90% reporting requirement.

Strategy 5 title: Use Data for Risk Stratification

Brief description: Utilize SDOH data in the Population Health Dashboard. The Population Health Dashboard is holistic view of multiple data sources aggregated together with multiple filters. Its purpose is to identify trends or gaps to guide initiatives. The Population Health Dashboard will use quality reports stratified by REALD and SOGI (i.e. disease prevalence, health outcomes, provider assignments, access, utilization, incentive metrics, FBDE, LTSS, SDOH, G&A, improvement project outcome measures, and other member demographics).

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):

Due to continued staffing and priority changes, the Population Health Dashboard has not yet been implemented. CHA has partnered with a 3rd vendor (Ayin Health) to produce quality performance metric dashboards, which include SDOH/REALD filters in order to accomplish the intent of a Population Health Dashboard.

(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. Explore Population Health Dashboard with Ayin Health.	A. Q4 2026

Strategy 6 title: Integration or Interoperability of Health IT Systems that Support SDOH with Other Tools

Brief description: Explore opportunities for integration or interoperability with CIE and CHA’s case management system or other systems used by CHA’s staff.

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):

CHA has met with the CIE engineering team for the HKC website to scope some workflows that can be automated from HKC to ██████. CHA's BI team is exploring automation that can disaggregate data and upload individual program requests or screeners from HKC into the ██████ authorization or case management system as appropriate. Additionally, a meeting was previously held with Sky Lakes Medical Center and Findhelp to discuss the potential for connecting their EHR (██████) to HKC. However, due to Sky Lakes not owning their instance of ██████, which is managed through Asante as a Community Connect, this integration is not feasible at this time but will continue to be revisited each year.

(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. Evaluate current ability to automate the integration of PRAPARE Screenings into [REDACTED]	A. By end of Q3 2026
2. Standardize workflows for the collection of SDOH data via HRA and PRAPARE in [REDACTED]	B. By Q4 2026, evaluate and deploy standardized workflows for the collection of SDOH data into [REDACTED] via HRA and PRAPARE.

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:

- C. 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.**
- D. (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.
- E. **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.

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. HKC is utilized to receive referrals for both the Flexible Services and HRSN programs through the Integrated SDOH Services program, which includes request details from the member alongside the PRAPARE screener. These requests act as referrals that can be closed by CHA when services are provided, allowing the initial referrer to keep track of their request. As of April 2026, there are 151, listed programs in Klamath County offering 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. 105 of these programs are marked as claimed (meaning managed directly by their organization).

(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: Sponsor CIE for the community

Brief description: Sponsor Healthy Klamath Connect for the community to use as a SDOH search tool and referral 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):

CHA continued to fund Healthy Klamath Connect (HKC) through Community-level flexible services, formerly Health-Related Services (HRS) Community Benefit Initiative (CBI) funds, supporting its availability as a community-wide social determinants of health (SDOH) search and referral platform. HKC is accessible to community members at large and to physical health, oral health, behavioral health, social services, and community-based organization (CBO) providers. In 2024, CHA expanded its contract with Findhelp to include Community Engagement Professional Services support. This enhancement enabled Findhelp to conduct targeted outreach to local CBOs, design and refine referral workflows, provide customer support for CBO partners, and strengthen the long-term

stability and sustainability of the community referral network. In 2025, CHA continued to support and operationalize this expanded model. The Quality Transformation Coordinator developed and utilized a centralized tracker to monitor engagement activities, trainings, and outreach conversations related to HKC. This tracking supports accountability and ensures that primary care, dental, and behavioral health clinics receive training on the purpose, referral processes, and meaningful use of HKC as a closed-loop referral platform. These efforts reinforce consistent adoption and effective use of HKC across the provider network and broader community. In 2026, continued refinement of workflows within HKC will be evaluated with Findhelp to ensure best practice, alignment with requirements for the program, and best use of the platform for both members and SDOH Coordinators. Training for all staff will also occur in 2026, in addition to training available for new providers and current providers as needed.

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

In 2026, continued refinement of workflows within HKC will be evaluated with Findhelp to ensure best practice, alignment with requirements for the program, and best use of the platform for both members and SDOH Coordinators. Training for all CHA staff will also occur in 2026, in addition to training available for new providers and current providers as needed.

Planned activities and milestones

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

Planned activities	Planned milestones
1. Continue sponsoring Healthy Klamath Connect (HKC) for the community.	A. 2026-2029
2. Utilize the new Community Engagement Services from Findhelp to increase CBO uptake to HKC.	B. Outreach to 20 providers and engage 100% of them by EOY 2026.
3. Refinement of workflows within HKC and training conducted for all staff and providers.	C. Q4 2026
4. Provide training to new and existing providers when onboarding and as needed.	D. By Q4 2026 and ongoing thereafter for new providers that are onboarded.

Strategy 2 title: Training and/or technical assistance

Brief description: Work with providers and community partners to ensure Healthy Klamath Connect (HKC) is the primary tool for closed-loop referrals, including but not limited to training, and increase of the number of claimed programs in HKC.

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):

As of April 2026, CHA had a local program claim rate of 70% through Healthy Klamath Connect. Outreach to local programs to claim their program on the site was limited in 2024 and 2025 due to staffing issues and clashing priorities. CHA will be reevaluating this process and will work with CBOs and providers to ensure HKC is the primary tool for closed-loop referrals with a goal of 84% claim rate in 2026.

(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. Increase of the number of claimed programs in Healthy Klamath Connect (HKC). (A program needs to be claimed for closed-loop referrals.)	A. By Q4 2026, 75% of identified local programs are claimed.
2. CHA to offer scheduled trainings and technical assistance to community partners. Topics include how to claim program, how to use platform once program is claimed, how to help community members use platform as a search tool and self-referral platform, reporting capabilities, and closed-loop referral capabilities.	B. By Q4 2026, offer monthly to bi-monthly provider HKC trainings for providers. C. By Q4 2026, complete a HKC training at the annual Cascade Health Alliance Provider Training.

Strategy 3 title: Assessment/tracking of adoption and use

Brief description: Integrate and utilize assessments within platforms including Healthy Klamath Connect and [REDACTED]

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): 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):

Since CHA’s environmental scan survey in 2023, CHA has continued to work with community partners on scoping systems and protocols that would allow for the sharing of SDOH Screenings in an effort to reduce the possibility of over-screening. Partners have been made aware of the possibility of using HKC for SDOH screenings. CHA has since integrated the SDOH screening into Healthy Klamath Connect but has not yet created a system to share the screenings between partners as necessary. HKC’s 2025 closed-loop referral rate was 56%.

(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. Collaborate with partners and clinics on a system for sharing SDOH screenings.	A. Meet with the Community Advisory Council to discuss actionable items to prevent over-screening and share SDOH screenings via Health IT systems such as HKC.
2. Increase the percentage of closed-loop referrals within Healthy Klamath Connect.	B. By end of Q4 2026, 67.2% of Healthy Klamath Connect referrals are closed-loop referrals.

Strategy 4 title: Outreach and education about the value of Health IT adoption/use to support SDOH needs

Brief description: Expand community awareness of Healthy Klamath Connect (HKC) to increase utilization to search for resources and service options for all community members (including CHA members) addressing SDOH needs.

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):

In 2024, CHA implemented multiple outreach and education efforts to increase community awareness of Healthy Klamath Connect (HKC) as a resource search and referral platform for addressing social determinants of health (SDOH) needs. In 2025, CHA expanded and diversified outreach efforts to reinforce awareness and meaningful use of HKC across multiple communication channels. A communications roadmap was developed for CareTalk (CHA's external newsletter) and QTIP (CHA's internal newsletter) to ensure consistent messaging about HKC. Additional community-facing outreach included placement of an HKC banner on Main Street in July 2025, ongoing promotion via CHA's digital billboard (displayed continuously for eight seconds every minute), and daily Spanish-language HKC advertisements aired four times per day through La Patrona radio. CHA also distributed an HKC-focused SMS message to members in March 2025 and plans to send an additional messages. Targeted outreach was further supported through an HKC advertisement placed with Active Seniors. HKC also remained a standing discussion item during routine provider check-ins, where training and technical assistance were offered to primary care, dental, and behavioral health providers. The Outreach Coordinator consistently discussed HKC during outreach activities, educating members and community-based

organizations (CBOs) on how to access the platform, its value as a resource search and referral tool, and its role in supporting connection to services that address SDOH needs. These repeated touchpoints reinforced awareness, understanding, and appropriate use of HKC across providers, members, and community partners.

(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. Expand member awareness and education about Healthy Klamath Connect (HKC).	A. 2026-2029, CHA will continue to provide education to members about the direct link to Healthy Klamath Connect in the new Member Portal. B. 2026-2029, continue to include information about Healthy Klamath Connect in member calls and new member packets. C. 2026-2029, continue including HKC in annual CHA staff training. D. 2026-2029, continue sending members two (2) text messages a year that include a link to Healthy Klamath Connect.

2. Expand community partner awareness and education about HKC.	E. 2026-2029, feature Healthy Klamath Connect in a CareTalk article, Provider Newsletter, once a year. F. 2026-2029, annually review and update the HKC training that is included with annual Provider Network Training. G. 2026-2029 continue to discuss HKC at least annually during the following external CHA led meetings: metrics workgroup (primary care representatives), behavioral health meeting, and oral health provider check-ins. H. 2026-2029, attend at least one (1) regularly scheduled community meeting to provide information about HKC.
3. Expand community awareness about Healthy Klamath Connect (HKC).	I. At community events during 2026-2029, continue to hand out HKC flyers and provide a live demo of the platform if able. J. 2026-2029, HKC banner is displayed across Main St. at least annually. K. 2026-2029, HKC article is included in at least two (2) community publications annually (like LivingWell and Active Seniors).

Strategy 5 title: Enhancements to CIE Tools (e.g., new functionality, health-related services funds forms, screenings, data sources)

Brief description: Utilize the PRAPARE screening capability in Healthy Klamath Connect (HKC) as a tool to collect and share screening data.

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):

CHA has begun using HKC to complete PRAPARE referrals for all SDOH Services (HRS/Flexible Services and HRSN) requests received. CHA plans to continue using

HKC to receive PRAPARE screeners, including using a new provider screener submission program, in 2025 and 2026.

(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. Capture SDOH Screenings on all SDOH Requests received through HKC.	A. 100% SDOH Screening rate on SDOH Requests by EOY 2026.
2. Continue capturing positive provider SDOH screenings through the new provider screening program on HKC.	B. Evaluate and modify as needed the Provider SDOH Screenings program on HKC by Q3 2026.

Strategy 6 title: Integration or Interoperability of Health IT Systems that Support SDOH with Other Tools

Brief description: Explore the interoperability of Healthy Klamath Connect (HKC) with Health IT systems already utilized in Klamath, including but not limited to █████, Reliance, and █████.

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):

In 2024, CHA upgraded the Findhelp plan to include Community Engagement Professional Services. Utilizing these services and internal efforts, CHA plans to integrate EHR systems into HKC wherever possible to improve patient care and IT efficiency. Findhelp, CHA, and Sky Lakes met in 2024 to scope possible integrations into the [REDACTED] EHR system. However, Sky Lakes Medical Center operates under a shared instance of [REDACTED], which is managed by Asante Health System, preventing them from independently implementing changes or integrations. CHA's internal Business Intelligence team is currently exploring integrations between Healthy Klamath Connect and the [REDACTED] system.

(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. Complete integration of Health IT systems with Healthy Klamath Connect.	A. Complete HKC system integration with [REDACTED] by Q4 2026. B. Continue exploration of HKC system integration with [REDACTED] EHR in 2026.
2. With Enterprise+ license and Community Engagement Services for HKC, work with network providers to expand data integration from Healthy Klamath Connect into providers' EHRs.	C. By Q4 2026, evaluate possibility of having HKC data integrated with one (1) network provider's EHR.

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

N/A

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
N/A	N/A	N/A	N/A	N/A	N/A

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.

CHA's partnered HRSN Service Provider for the Outreach and Engagement services, Sky Lakes Outpatient Care Management, continues to work with CHA to utilize CCBF funding and guidance from CHA to create infrastructure for HRSN services. All of CHA's current HRSN Service Providers are using case management or EHR systems that are different from CHA's Case Management and Authorization system. This means that transfers of member data, case notes, service codes, authorization numbers, etc. must be done through manual means. Encrypted email is an acceptable pathway for this information, but integration of different case/authorization systems are being explored with Healthy Klamath Connect (HKC) as a possible bridging system.

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?

CHA would benefit from additional guidance on the usage of health technology for HRSN services. This includes the transmission of HRSN requests, eligibility screenings, claims, and referrals. Official templates, guides, or administrative rules regarding the transition and usage of this data can help CHA guide its Health IT systems in compliant and efficient manners.

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.

CHA is working on the expansion and promotion of the Member Portal to better serve members, to support care coordination, and to improve communication. Currently, the Member Portal provides self-help capabilities through content that includes some member data and links to Healthy Klamath Connect, the member handbook, and additional helpful information on the CHA website. The Member Portal also has a live chat feature that allows members to chat with CHA staff directly. This feature includes the option to escalate concerns and to have a phone call. In 2026, CHA will explore and implement Member Portal enhancements. These enhancements include, but are not limited to, Health IT platform integrations, HRA automation, secure two-way communication, site banner to spread awareness of community events and to provide prevention reminders, and addition of member care plans, claims data, and letters.

- 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?

CHA's biggest challenge in pursuing health IT strategies is provider burden from regulations and new requirements.

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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