2025 CCO Health Information Technology (HIT) Roadmap

Guidance, Evaluation Criteria & Reporting Template

Contract or rule citation	Exhibit J, Section 2
Deliverable due date	April 30, 2025
Submit deliverable via:	CCO Contract Deliverables Portal

Please:

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

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

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2025 Health IT Roadmap Template

Please complete and submit this template via CCO Contract Deliverables Portal by **April 30, 2025.**

Instructions & Expectations

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

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

Each required topic includes the following:

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

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

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

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

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

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

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

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

A note about the template*:*

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

Health IT Roadmap Template Strategy Checkboxes

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

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

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

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

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

CCO: Cascade Health Alliance
Date: 4/30/2025

1. Health IT Partnership

Please attest to the following items.

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

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

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

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

3. (Optional) Overview of CCO Health IT Approach

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

4. Support for EHR Adoption, Use, and Optimization

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

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

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

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

Notes:

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

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

CHA currently has (48) 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 (0) Physical, (14) Behavioral, and (0) Oral Health organizations identified with unknown EHR status. With fourteen (14) behavioral health clinics with EHR status unknown, behavioral health is CHA's largest area of opportunity. In 2025, 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 2025, CHA plans to work with one (1) behavioral health provider to discuss adopting an EHR and work with seven (7) behavioral health organizations to identify their EHR status.

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

In 2023, CHA created and distributed a HIT survey to providers/clinics. CHA refined the HIT survey for providers in 2024 and plans to continue to distribute this survey at least annually to collect HIT information from providers. CHA will also utilize individual clinic engagement meetings and larger group meetings to gather HIT information from providers and remind them to fill out the survey.

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

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

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

Strategy 1 title: Assessment/Tracking of EHR Adoption and Capabilities
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 category(ies) pertain to this strategy
☐ 1: TA ☒ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Incentives ☐ 6: Financial support
☐ 7: Contracts ☐ 8: Leverage HIE ☐ 9: Hosted EHR ☐ 10: EHR selection ☐ 11: Optimization ☐ 12: Other:

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In September 2024, the HIT survey was distributed to providers to reassess the use of HIT tools by our provider network and to compare with the data received from the 2023 survey. Fourteen (14) providers responded to the survey. The information was then used to compare and add to previously collected data. CHA will continue to make edits to the survey to ensure all necessary data is captured, send it out to providers at least annually, and engage with providers to capture missing data. CHA added technical assistance as a standing agenda item to the Metrics Workgroup meeting and to the individual clinic check-in meetings with the Quality Department. A centralized provider/clinic contact list was created and shared in 2024. The next phase is to refine the list to be filterable by specific providers for different department outreach efforts. CHA has increased internal collaboration

on provider engagement efforts utilizing multi-department meetings. The departments meet to discuss the information needed from providers/clinics that the Quality Transformation Coordinator (QTC) collects from individual clinic meetings and reports the findings back to the departments. This approach was created in response to provider/clinic feedback as an effort to maximize efficiency with provider/clinic interactions with CHA and to reduce the number of CHA staff outreaching to providers/clinics to request information.

(Optional) **Overview of 2025-26 plans for this strategy**:
In 2025, this strategy is shifting to a refine and expansion phase with a focus on alignment across departments for engagement processes and workflows, as well as strengthening the centralized clinic/provider contact list to include additional departments and continue the annual HIT survey distribution.

Planned Activities	**Planned Milestones**
1. Continue distributing HIT survey to providers at least annually.	1. 2025-2026
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.	2. 2025-2026
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.	3. By Q4 2025
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.	4. By Q4 2025

Strategy 2 title: EHR Training and Technical Assistance
Provide technical assistance for providers (when needed or requested) for implementing/upgrading EHR. Offer technical assistance (TA) for building reporting for EHR metrics.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
CHA continues to meet monthly with seven (7) primary care clinics, five (5) are PCPCH clinics, to discuss OHA incentive metrics and quality improvement, as well as planning strategies for improvement in the Metrics Workgroup. In 2024, the Metrics Workgroup was expanded to include three (3) dental offices. In 2025, monthly metrics meetings with behavioral health providers will be established to encourage more collaboration and engagement in OHA metrics and quality improvement. CHA continued individual clinic engagement meetings with the primary care clinics, and successfully added three (3) dental offices into the individualized check-ins. Individualized check-ins with behavioral health providers will be prioritized in 2025 while continuing to engage with primary care and oral health. CHA continued to provide technical assistance in 2024 for EHR incentive metrics, specifically around ensuring screenings and interventions were captured by clinics as structured data in their EHRs for accurate reporting. In 2024, CHA continued to provide technical assistance with EHR reports for OHA metrics. CHA worked with two (2) primary care providers and their EHR vendors to build out reports applicable to metrics and requirement changes.

(Optional) **Overview of 2025-26 plans for this strategy**:
In 2025, CHA is working closely with one of the PCPCH clinics on their data collection and reporting structure processes to ensure accurate metrics reporting and efficient use of their EHR. Additional technical assistance will

be provided to the providers/clinics able to provide structured data from their EHRs to build the MLA and SDOH metric reports.

Planned Activities	Planned Milestones
1. Continue including HIT section in annual provider training with offer for TA.	1. 2025-2026
2. Continue providing TA for incentive metric workflow and data report building in EHRs.	2. 2025-2026
3. Continue providing ad hoc TA for providers/clinics when requested.	3. 2025-2026
4. Continue regularly scheduled physical and oral health clinic engagement meetings.	4. 2025-2026; By end of Q3 2025, establish meetings with behavioral health providers
5. Continue to have HIT as a standing agenda item at clinic engagement meetings.	5. 2025-2026; By end of Q3 2025, include HIT as an agenda item in monthly meetings with behavioral health providers
6. 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.	6. 2025-2026

Strategy 3 title: Outreach and Education
Utilize data from HIT Roadmap data reporting file to target outreach efforts for EHR adoption. Use annual provider training and monthly meetings with clinics and providers to educate about importance and benefit of HIT use along with an EHR.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, the Quality Transformation Coordinator (QTC) continued routine check-ins with PCP clinics and expanded to include dental clinics in partnership with the Quality Management (QM) Director. In 2025, the check-ins will be expanded to include behavioral health providers. These check-ins are to provide clinics with an opportunity to get technical assistance if needed, check-in about on-going initiatives, or schedule technical assistance with others if needed. In 2024, CHA provided TA in the form of assisting clinics with access to the provider portal to view auths and submit claims, TA to clinics for developing quality data reports, and help assessing what their current EHR metric reports are capturing and where improvements can be made in clinical workflows and documentation in order to capture the work that is being performed.

In 2023, CHA's Risk Adjustment department created a "Documentation and Coding Quick Guide" that was distributed to five (5) clinics/providers. This guide provides helpful information for providers regarding coding tips, some Hierarchical Condition Categories (HCCs), and documentation recommendations within EHRs. The Risk Adjustment Manager also prepared a document with the top three (3) Risk Adjustable diagnoses, HCCs, by specialty type for presentation at the Klamath Falls Independent Practitioner Association (KFIPA). In 2024, the Risk Adjustment Manager used the education materials created in 2023 and met with primary care physician groups, specialist IPA groups, hospital staff, the residency group, and the Klamath Medical Society to provide training and education on capturing visits appropriately and accurately within EHRs. Cross over training was also provided in partnership with our affiliated Medicare Advantage plan by the Atrio Chief Medical Officer.

(Optional) **Overview of 2025-26 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	Planned Milestones

1. Continue offering annual provider training with HIT section.	1. 2025-2026
2. Continue to explore additional education/TA opportunities with clinics.	2. 2025-2026
3. Explore opportunities with the next provider manual update to include HIT information.	3. Q4 2025
4. Continue to use data from HIT survey to identify target areas of outreach efforts to providers not utilizing HIT platforms.	4. 2025-2026
5. Provide targeted outreach to clinics/providers at metrics workgroup meetings, monthly behavioral health clinic meetings, and individual clinic engagement meetings.	5. 2025-2026; By Q4 2025, provide two (2) targeted outreach sessions.
6. Use individual engagement meetings with behavioral health clinics to collect more complete HIT Data.	6. By end of Q4 2025, outreach to seven (7) BH clinics/providers that have "EHR status unknown" in the data reporting file.
7. Meet with physician and specialist IPA groups, and the Klamath Medical Society at least annually to share information about HIT tools.	7. 2025-2026

Strategy 4 title: Leverage HIE Tools
When talking to clinics, emphasize the symbiotic relationship EHRs and HIE tools have, and the increased benefits seen when HIE tools are used alongside an EHR.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2023, CHA started work with Sky Lakes Medical Center to create flags in [redacted] for quality metrics and risk. It was discovered that quality care gap recommendations are available in [redacted] but they are limited due to the system level changes that need to be approved by Asante/[redacted] directly. In 2024, Asante denied Sky Lakes' request for the system level change to add the quality care gap flags in [redacted].
In 2024, CHA decided to not utilize [redacted] to embed CHA's formulary at the point of care. Instead, CHA launched a new searchable drug formulary page on the CHA website in October 2024 which is easily accessible to any provider, clinic staff, pharmacy staff, or individual that needs it.
CHA was unable to make progress on integrated oral health providers onto Reliance eHealth due to lack of buy-in and support from the oral health providers. Thus, this strategy is retiring.

Strategy 5 title: Explore Requirements in Contracts
Explore expanding contract language that encourages EHR adoption/use, HIE use, and other HIT initiatives.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Contract changes were explored in 2024, but no contract changes were made at the time.

Planned Activities	**Planned Milestones**

1. Continue to explore contract language options for encouraging EHR adoption, HIE adoption/use, and other HIT initiatives.	1. 2025-2026

Strategy 6 title: Collaboration with Partners
Work with clinic and community partners to enhance the use of HIT, specifically EHRs, in Klamath County.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
This strategy was created to support the planned activity of exploring a community EHR. This activity is no longer supported by partners, thus this strategy is ending.

Strategy 7 title: Explore Financial Support Options for Providers
Explore funding options available to support provider EHR adoption or upgrades.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, CHA continued to explore options for providing financial support to providers, however no requests were received, or needs identified.

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. 2025-2026
2. Explore alternative payment methods (APMs) as encouragement to implement an EHR.	B. 2025-2026

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

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

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

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

partnered with Sky Lakes through the vendor procurement process in early 2025. Sky Lakes selected IKS as the vendor they were going to move forward with. IKS is a technology and AI platform that includes overseas resources and support. IKS will support
Overview of 2025-26 plans for this strategy (Optional): Partner with Sky Lakes to validate newly implemented tool to support EHR optimization.

Planned Activities	Planned Milestones
1. Support Sky Lakes through implementation of IKS	1. Q2 2024
2. Work with Hospital staff to validate the IKS tool through claims processing reviews, chart reviews, data validation, and provide review to ensure quality and accuracy in diagnosis coding including ICD-10 and HCC codes.	2. By end of Q4 2025 partner with Sky Lakes to fully implement a validated platform.

B. EHR Support Barriers:

Please describe any barriers that inhibited your progress to support EHR adoption, use, and/or optimization among your contracted providers.
Barriers CHA's providers have expressed about EHR adoption and optimization are that the clinics, especially small clinics, do not have the time needed to dedicate to implementing a new EHR system, and the clinics also have staffing constraints that contribute to their inability to adopt, use, or optimize an EHR system. Small clinics have expressed that the high cost of an EHR system in addition to the expense of adding additional technology required to implement and run an EHR are too prohibitive to EHR adoption.

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 financial support to adopt and implement an EHR.

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

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

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

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

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

6. (Optional) An overview of CCO 2025-26 plans for each strategy
7. Activities and milestones related to each strategy CCO plans to implement in 2025-26

Notes:

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

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

Progress	Plans		Progress	Plans	
☒	☒	1. Care coordination and care management	☒	☒	4. Enhancements to HIE tools (e.g., adding new functionality or data sources
☒	☒	2. Exchange of care information and care plans	☒	☒	5. Collaboration with external partners
☒	☒	3. Integration of disparate information and/or tools with HIE	☒	☒	6. Risk stratification and population segmentation
			☒	☐	7. Other strategies for supporting HIE access or use (please list here): • Implement and Optimize Member Portal • Utilization Monitoring/Management • Supporting CCO Metrics • Supporting Financial Forecasting

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

[redacted] The 2021 upgrade of [redacted] allows for CHA to receive the platform updates as they are made available by Gainwell; the previous version of [redacted] that CHA was using was very customized, so updates could not be applied. In 2024, CHA successfully applied three (3) version upgrades, 4.11.5, 4.12, and 4.13.1, which enhanced and expanded features in the platform.

[redacted] **Provider Portal:** The portal allows providers to submit authorizations and view the status of previously submitted authorizations. 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. 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 2023 and 2024, CHA used A1c data from Reliance to support the Diabetes Poor Control metric.

findhelp - 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 *HIT to Support SDOH Needs* section below.

[redacted] In 2023, [redacted] decommissioned PRM Analytics. In its place, CHA implemented [redacted] 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 [redacted] 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.

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

Strategy 1 title: Care Coordination and Care Management

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 category(ies) pertain to this strategy

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

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, CHA built a new cohort for all emergency department visits in PointClickCare. This new cohort is utilized daily to track emergency department utilization and follow-up timely with members. CHA has LTSS notifications from PointClickCare turned on, and other cohorts are being checked directly in the PCC platform daily.
CHA also built a risk stratification model for identifying members' risk levels for care coordination.

Planned Activities	Planned Milestones
1. Explore and build, if needed, additional cohorts in PointClickCare for care coordination	1. 2025-2026 as needed/identified

intervention 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.	2. 2025-2026
3. Fully optimize, monitor, and refine the Risk Stratification Model for care coordination as needed.	3. 2025-2026

Strategy 2 title: Exchange of care plans and care information
Explore and potentially implement new and innovative uses of health information technology platforms to better serve members.

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, 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.

Planned Activities	Planned Milestones
1. Explore options with the Member Portal to share care plans electronically with members.	1. Q1 2026
2. Explore use of [redacted] Provider Portal to share care plans with care teams.	2. By end of Q4 2025

Strategy 3 title: Integration of Disparate Information and/or Tools with HIE
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 category(ies) pertain to this strategy
☐ 1: Care Coordination ☐ 2: Exchange care information ☒ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☐ 6: Risk stratification & population segmentation
☐ 7: Other:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Due to other high priority projects, CHA did not explore automation or integration options with [redacted] PointClickCare, or Reliance in 2024.
With implementing the HRSN benefits in 2024, CHA will prioritize partnering with Reliance in 2025 to expand the amount of SDOH data available in the platform.

Planned Activities	Planned Milestones
1. Explore opportunities with Reliance, PointClickCare, and [redacted] to automate integration of information from one system to the other.	1. 2025-2026

2. Partner with Reliance eHealth to expand the amount of SDOH data available in the platform to improve SDOH care coordination.	2. By Q4 2025
3. Explore integration options for assistance with transition of care work, specifically for behavioral health and maternity.	3. By Q4 2025

Strategy 4 title: Enhancements to HIE tools
Partner with PointClickCare to explore enhancements to the platform to improve access to data to better work with members.

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Additional progress on exploration of enhancements was not completed in 2024. A primary technology focus for care coordination in 2024 was developing the risk stratification model for care coordination and care planning.

Planned Activities	Planned Milestones
1. Continue to partner with PointClickCare account manager to explore opportunities and capabilities in the PointClickCare tool.	1. Utilize monthly meetings to explore enhancement opportunities by the end of Q4 2025.
2. Reevaluate the Transitions of Care (TRC) component in PointClickCare as an enhancement option to implement.	2. By end of 2025, decide if implementing TRC component of PointClickCare.
3. Explore enhancement options with other platforms.	3. By end of 2025, explore opportunities with [redacted] and Reliance.

Strategy 5 title: Collaboration with external partners
Work with clinic and community partners to enhance the use of HIT in Klamath County.

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, CHA worked with the social workers at Sky Lakes to better understand their workflows/process to enhance collaboration for care coordination.
In 2024, the Risk Adjustment Manager used the education materials created in 2023 and met with primary care physician groups, specialist IPA groups, hospital staff, the residency group, and the Klamath Medical Society to provide training and education on capturing visits appropriately and accurately within EHRs. Cross over training was also provided in partnership with our affiliated Medicare Advantage plan by the Atrio Chief Medical Officer.

Planned Activities	Planned Milestones
1. Continue enhancement of weekly collaborative care meetings between many clinics/provider types.	1. By end of 2025, enhance collaboration with the social worker in Sky Lakes' Emergency Department.
2. Continue to explore opportunities for read access to additional clinic's EHRs (non-[redacted] EHRs).	2. By end of 2025
3. Continue to meet with physician and specialist IPA groups, and the Klamath Medical Society at	3. 2025-2026

least annually to discuss workflows for capturing visits correctly within EHR, and to support care coordination.	

Strategy 6 title: Implement and Optimize Member Portal

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 category(ies) pertain to this strategy

☐ 1: Care Coordination ☐ 2: Exchange care information ☐ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☐ 6: Risk stratification & population segmentation
☒ 7: Other: 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 2024, CHA worked with the member portal vendor to finalize the member portal content, including links to Healthy Klamath Connect, the member handbook, and additional helpful information on the CHA website. Once the content was finalized, the production site was launched with test member data. CHA staff reviewed the test member data in the production site to ensure links were working and content was correct. CHA presented information about the member portal and demonstrated the test data to the CAC to get feedback and input on the site content. The CHA Member Services team was trained on the member portal and the live chat feature.

Planned Activities	Planned Milestones
1. Finalize communication plan, print promotional materials, and rollout Member Portal to members	1. By end of Q2 2025
2. Explore options for other HIT platform integrations with the Member Portal (phase 2 of project).	2. By end of Q3 2025
3. Explore options for adding the HRA into the Member Portal for electronic submission and automation.	3. By end of Q4 2025
4. Explore options for sharing member care plans with members through the Member Portal	4. Q1 2026

Strategy 7 title: Utilization monitoring/management

Use HIT platforms to monitor and manage member utilization of services, inform intervention planning, and risk stratification.

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

☐ 1: Care Coordination ☐ 2: Exchange care information ☐ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☒ 6: Risk stratification & population segmentation
☒ 7: Other: 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 Q1 2024, CHA completed training of Case Management and Utilization Management staff on the [redacted] platform to incorporate into existing workflows for member care coordination.
The Behavioral Health department continues to use information from PCC cohorts to inform coordinated care meetings with care teams on specific member cases.
In 2024, CHA built the risk stratification model to use utilization data from [redacted] as well as MARA scores to identify member medical/physical health risk levels.

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.	1. 2025-2026; by Q4 2025, build high spend cohorts in PCC and utilization reports in [redacted] (i.e., transplants)
2. Continue to utilize BH and ED cohorts in PointClickCare to monitor use.	2. 2025-2026
3. Update internal Case Management processes, including annual training for staff, for the utilization of PointClickCare, Reliance, and [redacted]	3. 2025-2026
4. Continue to operationalize use of [redacted] for targeted care coordination and utilization management.	4. 2025-2026
5. Continue to expand use of utilization data in the Risk Stratification model for care coordination/case management.	5. 2025-2026

Strategy 8 title: Supporting CCO metrics
Use HIT platforms to track and support incentive metrics work, as well as identify areas of opportunity.

Strategy categories: Select which category(ies) pertain to this strategy
☐ 1: Care Coordination ☐ 2: Exchange care information ☐ 3: Integration of disparate information
☐ 4: HIE tool enhancements ☐ 5: Partner collaboration ☐ 6: Risk stratification & population segmentation
☒ 7: Other: 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 2024, CHA continued to receive the IET Notifications through Reliance and to work with providers to get members to timely initiate SUD services.

(Optional) **Overview of 2025-26 plans for this strategy**:
In 2025, CHA is implementing a new Quality Insights tool with Ayin Health Solutions that will give providers access to incentive metrics data for their assigned members. The additional metric and demographic data insights the Ayin Community Integration Manager (CIM) tool provides will help providers close care and metric gaps with their patients.

Planned Activities	Planned Milestones
1. Continue to use IET notification report from Reliance to inform providers of SUD care opportunities timely.	1. 2025-2026
2. Continue to use the maternity cohort report to support the prenatal and postpartum care metric.	2. 2025-2026
3. Explore opportunities to expand metrics captured and tracked in PointClickCare.	3. 2025-2026
4. Finalize Ayin Quality Insights implementation	4. By end of Q2 2025, validate data feeds and metrics data
5. Rollout the CIM tool to providers/clinics and provide training on use of the CIM tool. Providing individual technical assistance when requested.	5. Q3 2025, train providers/clinic staff on CIM tool in the Metrics Workgroup.

Strategy 9 title: Supporting financial forecasting
Utilize data from HIT platforms to guide care coordination, interventions, and program creation.

Strategy categories: Select which category(ies) pertain to this strategy
☐ 1: Care Coordination ☐ 2: Exchange care information ☐ 3: Integration of disparate information

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
CHA worked with the [redacted] support team to build utilization reports in the [redacted] platform in 2024. This work will continue and expand in 2025.

Planned Activities	Planned Milestones
1. Continue to expand and refine reports in [redacted] to guide care coordination and population health program creation.	1. 2025-2026
2. Explore use of [redacted] for potentially avoidable cost monitoring	2. By end of Q4 2025
3. Explore using PointClickCare to support financial forecasting and population health program creation.	3. By end of Q1 2026

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

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

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

    Note: Where applicable, information in the CCO Health IT Data Reporting File should support descriptions of accomplishments and successes.

f. (Optional) An overview of CCO 2025-26 plans for each strategy
g. Activities and milestones related to each strategy CCO plans to implement in 2025-26

Notes:

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

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

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

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

PointClickCare: CHA's network providers that use the PointClickCare platform can access cohort reports and notifications for their patients to assist with care coordination.

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**

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 (48) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently, there are (14) Physical, (3) Behavioral, and (4) Oral Health organizations identified as having HIE for care coordination. Currently, CHA has identified (2) Physical, (19) Behavioral, and (6) Oral Health providers without an HIE for care coordination. By Q4 2025 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 2026 CHA plans to add 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
Provide technical assistance for providers (when needed) to support the use of HIT for hospital event notifications (HEN), including, but not limited to, platform recommendations and workflow review.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, CHA continued to offer training and technical assistance to partners for the different health information technology platforms in use.

Planned Activities	Planned Milestones
1. Continue to offer technical assistance to providers and care teams for HIT tools for care coordination.	1. 2025-2026
2. Continue to offer technical assistance to providers and care teams for the PointClickCare platform.	2. 2025-2026

Strategy 2 title: Assessment/tracking of HIE adoption and capabilities
Utilize HIT survey and Provider Engagement Plan to document strategies for collaboration with providers to use HIT to support care coordination, track clinic adoption and use of HIT for care coordination and assist with identifying any barriers providers might have with adopting and using HIT for care coordination.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In September 2024, the HIT survey was distributed to providers to reassess the use of HIT tools by our provider network and to compare with the data received from the 2023 survey. Fourteen (14) providers responded to the survey. The information was then used to compare and add to previously collected data. CHA will continue to make edits to the survey to ensure all necessary data is captured, send it out to providers at least annually, and engage with providers to capture missing data. CHA added technical assistance as a standing agenda item to the Metrics Workgroup meeting and to the individual clinic check-in meetings with the Quality Department. A centralized provider/clinic contact list was created and shared in 2024. The next phase is to refine the list to be filterable by specific providers for different department outreach efforts. CHA has increased internal collaboration on provider engagement efforts utilizing multi-department meetings. The departments meet to discuss the information needed from providers/clinics that the Quality Transformation Coordinator (QTC) collects from individual clinic meetings and reports the findings back to the departments. This approach was created in response to provider/clinic feedback as an effort to maximize efficiency with provider/clinic interactions with CHA and to reduce the number of CHA staff outreaching to providers/clinics to request information.

(Optional) **Overview of 2025-26 plans for this strategy**:
In 2025, this strategy is shifting to a refine and expansion phase with a focus on alignment across departments for engagement processes and workflows, as well as strengthening the centralized clinic/provider contact list to include additional departments and continue the annual HIT survey distribution.

Planned Activities	**Planned Milestones**
1. Continue distributing HIT survey to providers at least annually.	1. 2025-2026
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.	2. 2025-2026
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.	3. By Q4 2025
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.	4. By Q4 2025

Strategy 3 title: Outreach and Education About Value of HIE
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 HIT, HIE platforms, and other HIT 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 category(ies) pertain to this strategy
☐ 1: TA ☐ 2: Assessment ☒ 3: Outreach ☐ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts
☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☐ 11: Other (requirements): ☐ 12: Other:

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, CHA continued to utilize annual provider training to provide information on HIE platforms to providers. In 2024, the Risk Adjustment Manager used the education materials created in 2023 and met with primary care physician groups, specialist IPA groups, hospital staff, the residency group, and the Klamath Medical Society to provide training and education on capturing visits appropriately and accurately within EHRs. Cross over training was also provided in partnership with our affiliated Medicare Advantage plan by the Atrio Chief Medical Officer.

Planned Activities	Planned Milestones
1. Continue to educate and promote HIE use with providers, including during coordinated care meetings.	1. 2025-2026
2. Continue including HIT section in annual provider training with offer for technical assistance.	2. 2025-2026
3. Create pre-recorded webinars to further inform providers about HIE opportunities.	3. By end of Q4 2025
4. Continue to meet with physician and specialist IPA groups, and the Klamath Medical Society at least annually to share information about HIT tools.	4. 2025-2026

Strategy 4 title: Collaboration with Network Partners
Work with clinic and community partners to enhance the use of HIT in Klamath County for care coordination and HEN.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Due to many staffing changes in the Case Management department in 2024 and a major effort focused on building the risk stratification model, progress for this strategy was limited.

Planned Activities	Planned Milestones
1. Explore a new platform/process for maternity case management to receive notifications as timely as possible for pregnant members.	1. By Q4 2025
2. Create new process collaboratively with OB and PCP clinics that provide care to pregnant CHA members.	2. By end of Q4 2025
3. Implement new process with OB clinics.	3. By end of Q1 2026
4. Start coordinated care meetings with care teams for high risk and newly pregnant members.	4. By end of Q2 2026
5. Continue regular coordinated care communication with care teams for high needs pediatric members.	5. 2025-2026
6. Explore network use of PointClickCare for better care coordination and information sharing.	6. By end of Q4 2025
7. Continue to offer information and training in annual provider training on PointClickCare to help expand use in Klamath County.	7. 2025-2026

Strategy 5 title: Integration of Disparate Information and/or Tools with HIE
Utilize Reliance eHealth for integration of information and to improve data sharing and care coordination.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, CHA decided to retire this strategy due to lack of buy-in and support from oral health providers. Also, this strategy aligned with a TQS project that was also retired.

(Optional) **Overview of 2025-26 plans for this strategy**:
This strategy is not continuing in 2025.

Strategy 6 title: Explore Requirements in Contracts/Provider Agreements
Explore expanding contract language that encourages EHR adoption/use, HIE, and other HIT initiatives.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Contract changes were explored in 2024, but no contract changes were made at the time.

Planned Activities	Planned Milestones
1. Continue to explore contract language options for encouraging EHR adoption, HIE adoption/use, and other HIT initiatives.	1. By end of Q3 2025

Strategy 7 title: Explore Financial Support Options for Providers
Explore funding options available to support provider HIE for HEN adoption and Care Coordination.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
CHA continued to financially support the PointClickCare tool for the provider network in 2024.

Planned Activities	Planned Milestones
1. Continue to explore options to financially support PointClickCare for provider clinics.	1. 2025-2026
2. Explore additional financial support opportunities for HIE tools for care coordination and HEN for providers.	2. 2025-2026

Strategy 8 title: FHIR Project
Work with FHIR vendor to comply with new CMS final rule for interoperability.

Strategy categories: Select which category(ies) pertain to this strategy
☐ 1: TA ☐ 2: Assessment ☐ 3: Outreach ☐ 4: Collaboration ☐ 5: Enhancements ☐ 6: Integration ☐ 7: Contracts

☐ 8: Financial support ☐ 9: Incentives ☐ 10: Hosted EHR ☒ 11: Other (requirements): 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 2024, CHA worked with FHIR vendor to understand the new interoperability final rule requirements through monthly meetings with customer success manager and through attending two webinars hosted by FHIR vendor.
Overview of 2024-26 plans for this strategy (Optional): With the release of the 2024 CMS Final Rule, this strategy has pivoted to address those new requirements.

Planned Activities	Planned Milestones
1. Create internal project team	1. By end of Q2 2025
2. Create project plan to address new requirements and steps required to comply.	2. By end of Q3 2025
3. Work internally and with FHIR vendor to implement new requirements.	3. 2025-2026

C. HIE for Care Coordination Barriers

Please describe any barriers that inhibited your progress to support access to and use of HIE for care coordination and/or timely hospital even notifications among your contracted providers

About one third of CHA members are seen at one major primary care provider. This provider implemented a new electronic medical record (EMR). For many months there was no information flowing into Reliance's Community Health Record, which is CHA's main HIE. Care coordinators could not access office visit notes to better understand members' medical needs and help care plan development. Efficiency of care coordination was negatively impacted. Unplanned leadership changes at this provider's office also delayed connecting the new EMR to the Reliance HIE.

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: Care Everywhere is a section in [redacted] that allows sharing of records from any other [redacted] instance. Connecting PCC and Reliance information flows to [redacted] Care Everywhere 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 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.

E. CCO Access to and Use of EHRs

Please describe CCO current or planned access to contracted provider EHRs. Please include which EHRs CCO has or plans to have access to including how CCO accesses or will access them (e.g., Epic Care Everywhere, EpicCare Link, etc.), what patient information CCO is accessing or will access and for what purpose, whether patient information is or will be exported from the EHR and imported into CCO health IT tools.
Which EHRs does CCO have or will have access to and how does or will CCO access them (e.g., Epic Care Everywhere, EpicCare Link, etc)?
[redacted] **Access:** For all Sky Lakes Medical Center related providers, CHA's Case Management department is utilizing [redacted] access 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.

6. Health IT to Support SDOH Needs

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

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

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

Notes:

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

Strategy category checkboxes (within CCO)

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

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

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

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

[redacted] 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 [redacted] 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 applied 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 Health Related Services (HRS) program which includes Flexible Services for individual members. 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 February 2025, there are 143 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. 93 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**

Strategy 1 title: Care Coordination and Care Management of Individual Members
Enhance care coordination and connecting members to needed services within a closed loop referral system.

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, Healthy Klamath Connect was utilized to great effect to serve CHA members, including coordinating with other organizations for member care, screening members for SDOH needs, and accepting requests for various SDOH services CHA provides. Four new programs were developed or are in development since February 2024 – SDOH Services, HRSN Housing, HRSN Nutrition, and SDOH Referrals. All of these new programs allow for closed-loop referrals of members to meet SDOH needs in a variety of ways.

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

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.	1. Engage at least 20 providers/CBO's annually and connect 100% of them to the HKC platform

Strategy 2 title: Use Data to Identify Individual Members' SDOH Experiences and Social Needs
Integrate and utilize assessments within platforms for a holistic view of a member to guide person-centered care plans.

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
The PRAPARE screening tool is now being used on HKC when receiving SDOH requests, and the data is uploaded into [redacted] The SDOH screening and the HRAs in [redacted] communicate with one another, automatically populating questions with the same content as previously completed screenings. REALD and SOGI data are also now being captured through HKC and [redacted] in order to improve data collection. This information feeds into our SDOH Risk Stratification report, which helps CHA identify and stratify disparities amongst marginalized populations.

(Optional) **Overview of 2025-26 plans for this strategy**: This strategy was completed in 2024, so it is being replaced by the new Strategy 2 below.

Strategy 2 title: Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)
Integrate and utilize assessments within platforms for a holistic view of a member to guide person-centered care plans.

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

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

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

Planned Activities	Planned Milestones
1. Improve member-facing requests and workflows in Healthy Klamath Connect.	1. Full automation of SDOH Services program questionnaire in Healthy Klamath Connect by Q3 2025

2. Utilize HKC programs and screeners to complete closed-loop referrals for HRSN and HRS services.	2. Close loop on 100% of HRSN referrals via HKC by Q1 2026.

Strategy 3 title: Collaboration with Network Partners
Enhance data sharing related to SDOH needs, screening, and referring data to better meet member needs and to decrease duplication.

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

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

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

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.	1. By Q4 2025, review current agreements with partners and identify additional agreements to be made or amended.
2. Create further paths for sharing SDOH data via Healthy Klamath Connect.	2. Complete the CHA SDOH Provider Referrals program by Q2 2025
3. Establish a dedicated workflow for receiving SDOH data from providers and partners.	3. Begin standardized reception of SDOH data by Q3 2025.

Strategy 4 title: CCO Metrics Support
Utilize Healthy Klamath Connect, [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 category(ies) pertain to this strategy
☐ 1: Implement/use health IT ☐ 2: Enhancements ☐ 3: Integration ☐ 4: Collaboration ☐ 5: Care coordination
☐ 6: Data to ID SDOH ☐ 7: Risk stratification ☐ 8: Manage contracts ☒ 9: Metrics ☐ 10. Education/training
☐ 11: Convenings ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, CHA attested to all Measurement Year (MY) 2 Must-Pass elements for the SDOH Screening and Referral Metric. Quarterly reports have not been submitted to OHA as of February 2025, as the measure is not in measurement status yet. Hybrid Sample reporting will not begin until EOY 2025, as there was not a 2024 sample.

Planned Activities	Planned Milestones
1. Carry out SDOH Screening and Referral Process Performance Improvement Project (PIP).	1. 2025-2026, submit quarterly report to OHA. 2. Q4 2025, CHA attests to all Measurement Year (MY) 3 Must-Pass elements.
2. Meet requirements for SDOH Screening and Referral OHA Incentive Metric.	3. Q4 2025, CHA can report on sample population (if applicable).

Strategy 5 title: Use Data for Risk Stratification
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). This will guide CHA during strategic planning and developing interventions to eliminate health disparities.

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Due to continued staffing and priority changes, the Population Health Dashboard has not yet been implemented. CHA has pivoted to partnering with a 3rd party 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. As of February 2025, Ayin Health is developing a dedicated SDOH dashboard for CHA. Internally, CHA has still worked towards an integrated view at population health, including the creation of the SDOH Risk Stratification report that feeds into the member dashboard. This risk score gives an overarching idea of members' SDOH needs.

Planned Activities	Planned Milestones
1. Implement the Population Health Dashboard with Ayin Health	1. Q4 2025
2. Use Population Health Dashboard to identify a health disparity to address through a project.	2. Q1 2026

Strategy 6 title: Integration or Interoperability of Health IT Systems that Support SDOH with Other Tools
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 category(ies) pertain to this strategy
☐ 1: Implement/use health IT ☐ 2: Enhancements ☒ 3: Integration ☐ 4: Collaboration ☐ 5: Care coordination
☐ 6: Data to ID SDOH ☐ 7: Risk stratification ☐ 8: Manage contracts ☐ 9: Metrics ☐ 10. Education/training
☐ 11: Convenings ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
CHA has met with the CIE engineering team for the HKC website to scope some workflows that can be automated from HKC to [redacted] As of February 2025, CHA's BI team is exploring automation that can disaggregate data and upload individual program requests or screeners from HKC into the [redacted] authorization or case management system as appropriate. Additionally, a meeting was held with Sky Lakes Medical Center and FindHelp to discuss the potential for connecting their EHR ([redacted] to HKC. However, due to Sky Lakes not owning their instance of [redacted] which is managed through Asante, this integration is not feasible at this time.

Planned Activities	Planned Milestones
1. Automate the integration of PRAPARE Screenings into [redacted]	1. By end of Q4 2025
2. Standardize workflows for the collection of SDOH data via HRA and PRAPARE in [redacted]	2. By Q1 2026, 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 Needs: 2024 Progress & 2025-26 Plans

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

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

Notes:

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

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

Progress	Plans		Progress	Plans	
☒	☒	1. Sponsor CIE for the community	☐	☐	7. Support payments to CBOs through health IT
☒	☒	2. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)	☐	☐	8. Requirements to use health IT in contracts/provider agreements

☒	☒	3. Integration or interoperability of health IT systems that support SDOH with other tools	☐	☐	9. Track or assess CIE/SDOH tool adoption and use
☒	☒	4. Training and/or technical assistance	☒	☒	10. Outreach and education about the value of health IT to support SDOH needs
☐	☐	5. Support referrals from CBOs to clinical providers and/or from clinical providers to CBOs	☐	☐	11. Support participation in SDOH-focused health IT convenings, collaborative forums and/or education (excluding CIE governance)
☐	☐	6. Financial support to adopt or use health IT that supports SDOH (e.g., incentives, grants)	☐	☐	12. Support participation in CIE governance or collaborative decision-making
☐	☐	13. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs (please list here):			
☐	☐	14. Other strategies for supporting access or use of SDOH-related data (please list here):			

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

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 February 2025, there are 143 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. 93 of those 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**

Strategy 1 title: Sponsor CIE for the community
Sponsor Healthy Klamath Connect for the community to use as a SDOH search tool and referral platform

Strategy categories: Select which category(ies) pertain to this strategy
☒ 1: Sponsor CIE ☐ 2: Enhancements ☐ 3: Integration ☐ 4: TA Assessment ☐ 5: Clinical←→CBO referrals
☐ 6: Financial support ☐ 7: Payments ☐ 8: Contract requirements ☐ 9: Track use ☐ 10: Outreach/education
☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

Strategy status:

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

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

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

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

CHA continued to fund Healthy Klamath Connect through Health-Related Services (HRS) Community Benefit Initiative (CBI) funds. Healthy Klamath Connect is available for all community members to use (community members at large and physical health, oral health, behavioral health, social services, and CBO providers). In 2024, CHA expanded its contract with FindHelp to include Community Engagement Professional Services Support. This upgrade will allow FindHelp to manage outreach to local CBOs, design workflows for referrals, act as customer support for CBOs, and overall create a more stable long-term network of partners.

Planned Activities	Planned Milestones
1. Continue sponsoring Healthy Klamath Connect for the community.	1. 2025-2026
2. Utilize the new Community Engagement Services from FindHelp to increase CBO uptake to HKC	2. Outreach to 20 providers and engage 100% of them by EOY 2025.

Strategy 2 title: Training and/or technical assistance

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

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

☐ 1: Sponsor CIE ☐ 2: Enhancements ☐ 3: Integration ☒ 4: TA Assessment ☐ 5: Clinical←→CBO referrals

☐ 6: Financial support ☐ 7: Payments ☐ 8: Contract requirements ☐ 9: Track use ☐ 10: Outreach/education

☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

Strategy status:

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

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

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

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

In 2024, CHA had a local program claim rate of 54% through Healthy Klamath Connect. Outreach to local programs to claim their program on the site was limited in 2024 due to staffing issues and clashing priorities. CHA has redefined the Health Equity Outreach Coordinator role to utilize additional FTE time training CBOs on HKC.

Planned Activities	Planned Milestones
1. Increase of the number of claimed programs in Healthy Klamath Connect. (A program needs to be claimed for closed-loop referrals.)	1. By Q4 2025, 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.	2. By Q3 2025, monthly to bi-monthly provider HKC trainings are being conducted by the HE Outreach Coordinator for providers. 3. By Q4 2025, complete a HKC training at the annual Cascade Health Alliance Provider Training.

Strategy 3 title: Assessment/tracking of adoption and use

Integrate and utilize assessments within platforms including Healthy Klamath Connect and [redacted]

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

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

Strategy status:

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

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

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

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

Since CHA's environment 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.

Planned Activities	Planned Milestones
1. Collaborate with partners and clinics on a system for sharing SDOH screenings	1. Meet with the Community Advisory Council to discuss actionable items to prevent over-screening and share SDOH screenings via HIT systems such as HKC.
2. Increase the percentage of closed loop referrals within Healthy Klamath Connect	2. By end of Q4 2025, 90% of Healthy Klamath Connect referrals are closed loop referrals.

Strategy 4 title: Outreach and education about the value of HIT adoption/use to support SDOH needs
Expand community awareness of Healthy Klamath Connect to increase utilization to search for resources and service options for all community members (including CHA members) addressing SDOH needs.

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

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

Strategy status:

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

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

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

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

In 2024, Healthy Klamath Connect flyers and giveaways were distributed at twelve large outreach events, in both English and Spanish. CHA's website continues to give updated information about Healthy Klamath Connect and how to connect with resources on the site. CHA connected providers with HKC at the Annual Provider Training in October 2024. CHA sends two annual text messages about the site to members. Live demos of the site and its capabilities are offered regularly to community partners in scheduled formats.

Planned Activities	Planned Milestones
1. Expand member awareness and education about Healthy Klamath Connect.	1. By Q4 2025, CHA will provide education to members about the direct link to Healthy Klamath Connect in the new Member Portal.
	2. 2025-2026, continue to include information about Healthy Klamath Connect in member calls and new member packets.
	3. 2025-2026, continue including HKC in annual CHA staff training.
	4. 2025-2026, continue 2024 practice of sending members two (2) text messages a year that include a link to Healthy Klamath Connect.

2. Expand community partner awareness and education about Healthy Klamath Connect.	5. 2025-2026, feature Healthy Klamath Connect in a CareTalk article, Provider Newsletter, once a year.
	6. 2025-2026, annually review and update the Healthy Klamath Connect training that is included with annual Provider Network Training.
	7. 2025-2026 continue to discuss Healthy Klamath Connect at least annually during the following external CHA led meetings: metrics workgroup (primary care representatives), behavioral health meeting, and oral health provider check-ins.
	8. 2025-2026, attend at least one (1) regularly scheduled community meeting per quarter to provide information about HKC.
3. Expand community awareness about Healthy Klamath Connect.	9. At community events during 2025-2026, continue to hand out Healthy Klamath Connect flyers and provide a live demo of the platform if able.
	10. 2025-2026, Healthy Klamath Connect banner is displayed across Main St. at least annually.
	11. 2025-2026, Healthy Klamath Connect 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)
Utilize the PRAPARE screening capability in Healthy Klamath Connect as a tool to collect and share screening data.

Strategy categories: Select which category(ies) pertain to this strategy
☐ 1: Sponsor CIE ☒ 2: Enhancements ☐ 3: Integration ☐ 4: TA Assessment ☐ 5: Clinical←→CBO referrals
☐ 6: Financial support ☐ 7: Payments ☐ 8: Contract requirements ☒ 9: Track use ☐ 10: Outreach/education
☐ 11: Convenings: ☐ 12: Governance ☐ 13: Other adoption/use: ☐ 14: Other SDOH data:

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
CHA has begun using HKC to complete PRAPARE referrals for all SDOH Services (HRS and HRSN) requests received. CHA plans to continue using HKC to receive PRAPARE screeners, including using a new provider screener submission program, in 2025.

Planned Activities	Planned Milestones
1. Capture SDOH Screenings on all SDOH Requests received through HKC.	1. 100% SDOH Screening rate on SDOH Requests by EOY 2025.
2. Begin capturing positive provider SDOH screenings through the new provider screening program on HKC	2. Launch the Provider SDOH Screenings program on HKC by Q3 2025.

Strategy 6 title: Integration or Interoperability of HIT Systems that Support SDOH with Other Tools
Explore the interoperability of Healthy Klamath Connect with HIT systems already utilized in Klamath, including but not limited to [redacted] Reliance, and [redacted]

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

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, CHA upgraded our 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.

Planned Activities	Planned Milestones
1. Complete integration of HIT systems with Healthy Klamath Connect.	1. Complete HKC system integration with [redacted] by Q4 2025. 2. Complete exploration of HKC system integration with [redacted] EHR by Q1 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.	3. By Q3 2025, have HKC data integrated with one (1) network provider's EHR.

C. Using Technology to Support HRSN Services

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

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

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

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2024, CHA utilized its partnership with FindHelp to make a variety of improvements to the CIE software Healthy Klamath Connect. The improvements have primarily revolved around SDOH and HRSN servicing, namely through the Climate, Housing, and Nutrition benefits.

Requests for all three HRSN benefits are received through the newly designed SDOH Services program on Healthy Klamath Connect, where members and providers can directly apply for assistance. The integrated screening survey in the SDOH Services program functions as an adaptive questionnaire that asks additional questions and receives document uploads based on the types of support requested. This approach allows CHA care coordinators to receive the most information possible about the service request and qualify the member for HRSN benefits whenever possible.

The HRSN Housing program has been established on Healthy Klamath Connect to allow for CHA to refer members to its HRSN Service Provider, Klamath & Lake Community Action Services (KLCAS). This private

program has screening questions that are based around HRSN protocols, and referrals are sent to KLCAS this way once services have been authorized by CHA. This program allows for additional data collection on the side of KLCAS to inform Claims submissions and ensure that members are receiving proper services.

The HRSN Nutrition program has been established on HKC to allow for the Sky Lakes Wellness Center to refer members to CHA once they have been screened for Medically Tailored Meals via the HRSN benefit. This program captures the member's population circumstances, clinical conditions, and nutritional needs for Medically Tailored Meals.

2025-27 Plans:
CHA plans to continue utilizing HKC for the majority of HRSN referral needs. Receiving assistance requests and PRAPARE screening details will continue through the SDOH Services program, and referrals for Nutrition and Housing will continue through their respective private HKC programs. CHA has process improvement plans for the SDOH Services program to improve member navigation, provider usage, and automation of service requests being uploaded from HKC to CHA's case management software, [redacted]

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
CHA currently has three HRSN Service Providers, Sky Lakes Outpatient Care Management (OCM), Klamath & Lake Community Action Services (KLCAS), and the Sky Lakes Wellness Center. All three providers received capacity building grants in order to provide technology, staffing, and other infrastructure for HRSN services. This funding has been used by KLCAS for a full-time employee, technology such as the HRSN Housing program on HKC, and other vital infrastructure for the reception of HRSN referrals and service provisions for members. Funding at the Wellness Center has been used for capacity building in the form of technology such as the use of Healthy Klamath Connect to receive and send SDOH referrals, and improvements in the [redacted] EHR system to capture HRSN processes and services.

OCM is currently using capacity building funding and partnering with CHA to create infrastructure for HRSN Service Provider activities, such as Eligibility Screenings and Outreach and Engagement services. This funding will be used for continued development of their [redacted] EHR system, as well as integrations into the Healthy Klamath Connect system.

2025-27 Plans:
CHA plans to continue to utilize Healthy Klamath Connect in building further HIT infrastructure for HRSN programs. FindHelp is currently working on a custom buildout for the HRSN Housing program to allow for claims billing to be done directly through the program. CHA will be providing regular training on Healthy Klamath Connect programs that are used for HRSN Services to its HRSN Service Providers. CHA will also monitor the HRSN programs on HKC to ensure that the HIT capabilities are meeting Provider needs, and work with FindHelp as necessary to add or change programs to fit needs.

D. Health IT to Support SDOH Needs Barriers

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

CHA's partnered HRSN Service Provider for the Outreach and Engagement services, Sky Lakes Outpatient Care Management, is still working 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 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 HIT systems in compliant and efficient manners.

7. Other Health IT Questions (Optional)

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

A. Describe CCO health IT tools and efforts that support **patient engagement**, both within the CCO and with contracted providers.
B. How can **OHA support** your efforts in accomplishing your Health IT Roadmap goals?
C. What have been your organization's **biggest challenges** in pursuing health IT strategies? What can OHA do to better support you?
D. How have your organization's health IT strategies supported **reducing health inequities**? What can OHA do to better support you? If not already described above, how does your organization use REALD/SOGI data to support reducing health inequities? What has your organization learned about the impact on outcomes?