2024 CHA Health IT Roadmap

2024 Guidance, Evaluation Criteria & Reporting Template

Contract or rule citation	Exhibit J, Section 2, Paragraph d.
Deliverable due date	March 15, 2024
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_2024_HealthIT_Roadmap**

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

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2024 Health IT Roadmap

Please complete and submit this template via CCO Contract Deliverables Portal by **March 15, 2024.**

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 2023 strategies, progress, accomplishments/successes, and barriers
- Narrative sections to describe your 2024-2026 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 HIT 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 encouraged not to include 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 proposed 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 2024). **Note**: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.

A note about the template*:*

This template has been created to help clarify the information OHA is seeking in each CCO's 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.

HIT Roadmap Template Strategy Checkboxes

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

- *Support for EHR Adoption*
- *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: 3/15/2024

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. (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. 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).

3. Support for EHR Adoption, Use, and Optimization in Support of Care Coordination

A. Support for EHR Adoption, Use, and Optimization: 2022 Progress and 2023-24 Plans

Please describe your 2023 progress and 2024-26 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:

1. 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.
2. Include plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialling, Letters of Interest).
3. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
4. (Optional) 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.
5. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 to support EHR adoption, use, and optimization among contracted physical, oral, and behavioral health providers in support of care coordination include:
    a. A title and brief description
    b. Which category(ies) pertain to each strategy
    c. The strategy status
    d. Provider types supported
    e. A description of 2023 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.
    f. (Optional) An overview of CCO 2024-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

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 not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2024, 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 (37) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently, there are (0) Physical, (7) Behavioral, and (0) Oral Health organizations identified with unknown EHR With seven (7) behavioral health clinics with EHR status unknown, that is CHA's largest area of opportunity. In 2024, CHA will give special attention to the Behavioral Health opportunity for EHR adoption. By Q4 2024, CHA plans to work with one (1) behavioral health provider to discuss adopting an EHR.

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 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 2023 and plan to implement during 2024-26. 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)

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 February 2023, the first draft of the HIT survey was distributed to providers to assess the baseline of HIT tools used by our provider network. Twenty (20) providers responded to the first round of the survey then edits were made to the survey to make sure all needed information is being captured from providers. The HIT survey was sent out again in Q3 2023. CHA will continue to make edits to the survey to ensure all necessary data is captured and send it out to providers at least annually and engage with providers to capture missing data. A working draft of the Provider Engagement Plan was finalized in Q4 2023. CHA will continue to refine the Provider Engagement Plan as needed while aligning it with planned provider engagement activities in Department Strategies.

Overview of 2024-26 plans for this strategy (optional):
In 2024, this strategy is shifting to a maintenance phase with a focus on alignment across departments for engagement processes and workflows, as well as creation of a centralized clinic/provider contact list to streamline clinic/provider communications and annual HIT survey distribution.

Planned Activities	Planned Milestones
1. Continue distributing HIT survey to providers at least annually.	1. 2024-2026
2. Continue carrying out Provider Engagement Plan and collecting information from clinics,	2. 2024-2026

adjusting the plan and HIT survey as necessary based on continuous improvement efforts.	
3. Provider Engagement Plan activity: capture and centralize provider/clinic contact information in [redacted] for all engagement efforts.	3. By Q4 2024
4. Provider Engagement Plan activity: align provider engagement efforts from multiple departments to decrease number of interactions with providers/clinics and maximize time with providers/clinics.	4. By Q1 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. CHA continued to provide TA in 2023 for EHR incentive metrics, specifically around ensuring screenings and interventions were captured by clinics as structured data in their EHRs for accurate reporting. Discussions on EHR integration/interfacing capabilities continued to take place with several oral and behavioral health providers to explore if TA would be helpful to increase adoption of HIE to better coordinate care for members who may receive services outside of the traditional settings for things such as blood pressure monitoring, Point-of-Care Testing (POCT) for HbA1c's, fluoride application, and more. Regular individual clinic engagement meetings were successfully established with the primary care clinics in 2023. The regular individual clinic engagement meetings and TA provided in 2023 will move into phase 2 in 2024 targeting the oral health providers. Assistance provided to Klamath Dental Center for documentation storage, referrals, and automation within their EHR reducing the dependency on old technology or manual processes. CHA's Risk Adjustment Manager provided guidance and subject matter expertise to Sky Lakes Medical Center for reviewing risk models and selecting a risk module to implement within [redacted]

Overview of 2024-26 plans for this strategy (Optional):
In 2024, the EHR data provided by clinics for incentive metrics will be used to inform any areas of low performance as it relates to quality of care. This will in turn be used to provide feedback on areas for improvement or possible corrective action for clinics during one-on-one check in sessions.

Planned Activities	Planned Milestones
1. Continue including HIT section in annual provider training with offer for TA.	1. 2024-2026
2. Continue providing TA for incentive metric workflow and data report building in EHRs.	2. 2024-2026
3. Continue providing ad hoc TA for providers/clinics when requested.	3. 2024-2026
4. Establish regularly scheduled clinic engagement meetings.	4. By end of Q4 2024, establish meetings with dental clinics
5. HIT is a standing agenda item at clinic engagement meetings.	5. 2024-2026

6. TA is a standing agenda item at clinic engagement meeting and, if clinic requests TA, CHA supplies TA outside of the clinic engagement meeting.	6. 2024-2026

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 2023, the Quality Transformation Coordinator (QTC) started routine check-ins with PCP clinics. In 2024 this will be expanding to dental clinics in partnership with the QM Director. These check-ins are to provide clinics an opportunity to get TA if needed, check-in about on-going initiatives, or schedule TA with others if needed. In 2023, 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, help assessing what their current reports are capturing and where improvements can be made in clinical workflows and documentation in order to capture the work that is being performed. Starting in August 2023, all five (5) PCPCH clinics and one (1) pediatric clinic began receiving monthly one-on-one check-ins. Starting in September 2023, the small rural clinic in Merrill/Bonanza started monthly engagement meetings with the QTC. The clinic engagement meetings with PCPs will continue in 2024 and check-in with PCD clinics will be added. 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).

Planned Activities	**Planned Milestones**
1. Continue offering annual provider training with HIT section.	1. 2024-2026
2. Explore additional education/TA opportunities with clinics.	2. 2024-2026
3. Explore opportunities with the next provider manual update to include HIT information.	3. Q4 2024
4. Use data from HIT survey to identify target areas of outreach efforts for providers not utilizing HIT platforms.	4. By Q3 2024
5. Provide targeted outreach to clinics/providers at the individual clinic engagement meetings, or at the monthly provider meeting.	5. By end of Q4 2024, provide three (3) targeted outreach sessions
6. Conduct outreach efforts to the BH providers that have "EHR status unknown" in the data reporting file.	6. By end of Q4 2024
7. Meet with physician and specialist IPA groups, and the Klamath Medical Society at least annually to share information about HIT tools.	7. 2024-2026

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):
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. CHA was unable to make progress in integrated oral health providers onto Reliance eHealth. CHA will explore this with dental providers through the clinic engagement meetings in 2024.

Planned Activities	Planned Milestones
1. Utilize Collective Medical and Reliance to promote EHR adoption.	1. 2024-2026
2. Work with Sky Lakes on creating flags in [redacted] for additional identification of needs related to Quality metrics and Risk.	2. Q4 2024
3. Increase the number of dental providers integrated into Reliance eHealth HIE.	3. By end of Q4 2024, at least 25% of Oral Healthcare providers able to perform medical screenings and at least 50% of Primary Care Providers able to receive and act on Oral Healthcare referrals
4. Develop workflows for preventive medical screenings and referrals via Reliance eHealth by oral health providers.	4. By end of Q4 2024, at least 25% of Oral Healthcare providers able to perform medical screenings and at least 50% of Primary Care Providers able to receive and act on Oral Healthcare referrals
5. Explore [redacted] to embed CHA's formulary at point of care.	5. By end of Q4 2024

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 2023, but no contract changes were made at the time.

Planned Activities	Planned Milestones
1. Explore contract language options for encouraging EHR adoption, HIE adoption/use, and other HIT initiatives.	1. 2024-2026

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):
No progress made on this strategy in 2023. Discussions planned for 2024.

Planned Activities	Planned Milestones
1. Work with hospital to explore community EHR.	1. By end of Q4 2024
2. Additional activities dependent on outcome of exploring community EHR.	2. 2025-2026

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 2023, 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.	1. 2024-2026
2. Explore alternative payment methods (APMs) as encouragement to implement an EHR.	2. 2024-2026

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

Overview of 2024-26 plans for this strategy (Optional):
This is a new strategy to explore options for optimizing PCP EHR for improved point-of-care code capture and care gap closure.

Planned Activities	Planned Milestones
1. Research third party vendor options for risk adjustment coding overlay for major PCP EHR.	1. Q2 2024
2. If vendor selected, implement vendor.	2. Q4 2024
3. If vendor implemented, work with major PCP to integrate/optimize EHR.	3. TBD, reliant on activity 1 and 2.

4. EHR Support Barriers: (Optional)

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

C. OHA Support Needs: (Optional)

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

1. 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: 2023 Progress & 2024-26 Plans

Please describe your 2023 progress and 2024-26 plans for using HIE for care coordination 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 2023 progress and 2024-26 plans.
2. List and describe specific tool(s) you currently use or plan to use for care coordination and timely hospital event notifications.
3. (Optional) Provide an overview of CCO's approach to using HIE for care coordination and hospital event notifications.
4. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 for using HIE for care coordination and hospital event notifications within the CCO 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 2023 progress, including:
        - accomplishments and successes (including number of organizations, etc., where applicable)
        - challenges related to each strategy, as applicable
    f. (Optional) An overview of CCO 2024-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

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 not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned milestones sections.

- If CCO is implementing a strategy beginning in 2024, 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 2023 and plan to implement during 2024-26. 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. Other strategies for supporting HIE access or use (please list here): • Explore Member Portal Options – Implementing Member Portal • Explore HRA Vendor Options • 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 2023, CHA successfully applied three (3) version upgrades, 4.9 - 4.11, 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 and Reliance have continued a partnership for engagement activities such as provider education concerning HIE benefits to networked providers and encouraging adoption. CHA's Case Management department utilizes Reliance to look up members in the CHR to see services the member is receiving as well as to view notes to help with care coordination and ensuring the member's needs are being met. CHA's Quality Management department utilizes HbA1c data from Reliance to target outreach to members in the poor control range.

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 [redacted] 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 help improve member health outcomes and overall patient care.

Reliance eHealth: The Community Health Record is used by CHA staff to look up additional member contact information, chart notes, and review pre-built cohort reports.
The IET metric is built in Reliance and CHA utilizes this report to monitor performance for the IET metric. In 2023, CHA used A1c data from Reliance to support the Diabetes Poor Control metric.

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

Strategy 1 title: Care Coordination and Care Management
Utilize the data from HEN platform, PCC/Collective Medical, 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: Other:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2023, CHA had several cohorts built in PCC/Collective Medical (COPD, CHF, Inpatient, Postpartum, etc.). CHA has LTSS notifications from PCC/Collective Medical turned on, and other cohorts are being checked directly in the PCC platform daily.

Overview of 2024-26 plans for this strategy (Optional):

Planned Activities	Planned Milestones
1. Explore and build, if needed, additional cohorts in Collective Medical for care coordination intervention strategies (i.e., pediatric admissions, etc.).	1. 2024-2026 as needed/identified
2. Ensure notifications are set up for applicable staff to receive notifications for applicable cohorts (i.e. LTSS cohort, ICC cohort, etc.), especially as new cohorts are added.	2. 2024-2026
3. Build Risk Stratification Model for care management/care coordination.	3. Q3 2024
4. Implement Risk Stratification Model.	4. By end of 2024

Strategy 2 title: Exchange of care plans and care information
Explore and potentially implement new and innovative uses of Collective Medical 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: Other:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2023, through the exploration of the Care Teams section of PCC/Collective Medical, it was discovered that case manager contact information is being passed to PCC/Collective Medical via the extracts. The case manager contact information is automatically included in the Care Team section. Next step is to education providers about the location of this information. CHA established a workflow with DHS-Aging People with Disabilities for utilization of PCC to view care plans from CHA for members receiving care coordination services.

Planned Activities	Planned Milestones
1. Explore options with Collective Medical and Reliance eHealth to share care plans and care information across different providers and entities.	1. Q4 2024
2. Educate providers regarding the availability of care plans and care manager information in the Care Team section of PCC/Collective Medical.	2. By end of Q4 2024
3. Explore options to incentivize providers to access care plans in PCC/Collective Medical.	3. By end of Q4 2024

Strategy 3 title: Integration of Disparate Information and/or Tools with HIE
CHA's Case Management department integrates information from Collective Medical and Reliance eHealth into CHA's care coordination tool to assist in member/provider interventions and coordinating care plans. 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: Other:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
CHA completed exploration of potential automation with PCC/Collective Medical and discovered that there were no opportunities for streamlined automation at this time. Will readdress and explore again in the future.

Planned Activities	Planned Milestones
1. Explore opportunities with Reliance, Collective Medical, and [redacted] to automate integration of information from one system to the other.	1. 2024-2026
2. Partner with Reliance eHealth to expand the amount of SDOH data available in the platform to improve SDOH care coordination.	2. By Q4 2024

3. Explore integration options for assistance with transition of care work, specifically for behavioral health and maternity.	3. By Q1 2025

Strategy 4 title: Enhancements to HIE tools
Partner with Collective Medical 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: Other:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2023, there was not any progress made on this strategy due to limited bandwidth and staffing changes in the Case Management department. CHA Case Management in collaboration with the Business Intelligence department and Operations Project Management will work on this strategy in 2024.
CHA received a demo from PCC/Collective Medical for the Transitions of Care (TRC) component. CHA decided not to implement TRC at this time but will look into it as an option again in the future.

Planned Activities	Planned Milestones
1. Partner with Collective Medical to explore enhancements to the platform to improve access to data to better work with members.	1. By end of Q4 2024

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: Other:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
CHA Case Management worked with DHS-Aging People with Disabilities (APD) and Developmental Disability Services to use PCC/Collective Medical. CHA uses information from PCC/Collective Medical in coordinated care meetings with clinics.
CHA discussed gaining read access to EHR with a clinic not using [redacted] but clinic said not at this time. CHA will try again in the future.

Planned Activities	Planned Milestones
1. Explore enhancement of weekly collaborative care meetings between many clinics/provider types.	1. By end of Q3 2024
2. Explore getting read access to additional clinic's EHRs (non-Epic EHRs).	2. By end of 2024
3. Explore collaboration options with Sky Lakes for care coordination.	3. By end of Q3 2024, better understand Sky Lakes' current processes/workflows for social workers.
4. Meet with physician and specialist IPA groups, and the Klamath Medical Society at least annually to discuss workflows for capturing visits correctly within EHR, and to support care coordination.	4. 2024-2026

Strategy 6 title: Implement Member Portal (Previously: Explore Member Portal Options)

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

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: Other: Explore Member Portal Options

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2023, CHA explored Member Portal vendor options. After narrowing the list down to three (3) vendors, CHA received demos from each vendor and selected one (1) vendor to move forward with. By the end of Q4 2023, CHA and Health Portal Solutions created a test site, received leadership feedback, and trained department leaders on the admin portal.

Overview of 2024-26 plans for this strategy (Optional):
This strategy has moved into the implementation phase, and thus has been renamed from 2023's strategy.

Planned Activities	Planned Milestones
1. Finalize data relay for Member Portal.	1. By end of Q1 2024
2. Fully implement phase 1 of the Member Portal project.	2. Q2 2024
3. Start phase 2 of the Member Portal project, exploring integration options with [redacted]	3. Q3 2024

Strategy 7 title: Explore Health Risk Assessment (HRA) Vendor Options
Research HRA vendor opportunities to help automate the HRA process, improve reporting internally and data sharing with providers, and enhance care coordination for members with identified needs.

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: Other: Explore HRA Vendor Options

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2023, CHA explored three (3) vendor options for Health Risk Assessments. After receiving demos and reviewing the capabilities of each vendor against the OHA requirements, CHA decided to implement an internally created Health Risk Assessment to ensure compliance with OHA requirements.

Strategy 8 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: 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 Q4 2023, CHA implemented [redacted] for the CHA population. [redacted] was already utilized for our Medicare Advantage population. In Q1 2024, CHA is training Case Management and Utilization Management staff on the [redacted] platform to incorporate into existing workflows for member care coordination.
The Behavioral Health department is utilizing information from PCC/Collective Medical cohorts to inform coordinated care meetings with care teams on specific member cases.

Planned Activities	Planned Milestones
1. Continue to utilize Collective Medical to monitor events and issues affecting service	1. 2024-2026; by Q3 2024, build high spend cohorts in PCC (i.e., transplants)

availability, high spend, or cohorts that are high risk.	
2. Continue to utilize BH and ED cohorts in Collective Medical to monitor use.	2. 2024-2026
3. Update internal Case Management processes for the utilization of Collective Medical and [redacted]	3. 2024-2026
4. Continue to operationalize use of [redacted] for targeted care coordination and utilization management.	4. By Q4 2024
5. Include utilization data in building the Risk Stratification model for care coordination/case management.	5. Q3 2024

Strategy 9 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: 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):
Thanks to the successful implementation of the IET Notifications through Reliance, CHA reduced the time it took to help members initiate SUD services, leading to 3 times the engagement rates from previous year. Based on most recent state dashboards with IET Data, CHA is performing 4.5% and 6.5% respectively above the state average, as the top performer on both initiation and engagement. The key difference has been the success of early notifications and timely referrals being made.
Point Click Care/Collective Medical provided a demo on additional cohorts available to support incentive metrics. Most metrics were HEDIS based and would be beneficial to MA plans. CHA has turned on the cohorts for some of the incentive metrics, but there has been little movement or easy actionality for Case Management to be able to utilize them.

Planned Activities	**Planned Milestones**
1. Continue to use IET notification report from Reliance to inform providers of SUD care opportunities timely.	1. 2024-2026
2. Continue to use the maternity cohort report to support the prenatal and postpartum care metric.	2. 2024-2026
3. Explore opportunities to expand metrics captured and tracked in PCC/Collective Medical.	3. 2024-2026

Strategy 10 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: 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):
Point Click Care/Collective Medical provided a demo on additional cohorts available to support incentive metrics. Most metrics were HEDIS based and possibly beneficial to MA plans. No opportunities for supporting MEPP with PCC/Collective Medical identified at this time.

CHA successfully implemented [redacted] for the CHA population to replace [redacted] Analytics in Q4 2023. [redacted] was successfully tested with existing workflows and the Quality Management Department helped to create addition reports for the Utilization Management department in the [redacted] platform.	
Planned Activities	**Planned Milestones**
1. Explore and expand use of [redacted] for potentially avoidable cost monitoring	1. By end of Q4 2024
2. Explore using Collective Medical to support MEPP and TQS activities.	2. By end of Q3 2024

B. Supporting Increased Access to and Use of HIE Among Providers: 2023 Progress & 2024-26 Plans

Please describe your 2023 progress and 2024-26 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:

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. 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.
3. 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.
4. (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.
5. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 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 2023 progress, including:
        - 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)
        - 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 2024-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

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 not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2024, 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 2023 and plan to implement during 2024-26. Elaborate on each strategy and your progress/plans in the sections below.

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

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

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/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.

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 (37) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently, there are (13) Physical, (3) Behavioral, and (2) Oral Health organizations identified as having HIE for care coordination. Currently, CHA has identified (2) Physical, (11) Behavioral, and (6) Oral Health providers without an HIE for care coordination. By Q4 2024 CHA plans to work with (3) more additional providers to add HIE care coordination capabilities, one in each provider type category for Physical, Oral, and Behavioral Health providers. By Q4 2025 CHA plans to add (2) 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):
During a monthly Behavior Health providers meeting, CHA staff was able to assist BH providers with Reliance use and to explore alternate options for referral platform options since Reliance discontinued their referral platform in 2023.
CHA's Medicare Advantage affiliated partner finalized implementation of Reliance in Q1 2024, which will provide additional information for dual member care coordination through the Reliance portal.

Planned Activities	Planned Milestones
1. Continue to offer technical assistance to providers for HIT tools for care coordination.	1. 2024-2026
2. Continue to offer technical assistance to providers for PCC/Collective Medical platform.	2. 2024-2026

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 February 2023, the first draft of the HIT survey was distributed to providers to assess the baseline of HIT tools used by our provider network. Twenty (20) providers responded to the first round of the survey then edits were made to the survey to make sure we are capturing all needed information from providers. The HIT survey was sent out again in Q3 2023. CHA will continue to make edits to the survey to ensure all necessary data is captured and send it out to providers at least annually and engage with providers to capture missing

data. A working draft of the Provider Engagement Plan was finalized in Q4 2023. CHA will continue to refine the Provider Engagement Plan as needed while aligning it with planned provider engagement activities in Department Strategies.

Overview of 2024-26 plans for this strategy (Optional):

Planned Activities	Planned Milestones
1. Continue to utilize HIT survey to assess and track provider adoption/use of HIT for care coordination and hospital event notification (HEN).	1. 2024-2026
2. Continue carrying out Provider Engagement Plan and collecting information from clinics, making adjustments to the plan and HIT survey as necessary based on continuous improvement efforts.	2. 2024-2026
3. Provider Engagement Plan activity: capture and centralize provider/clinic contact information in [redacted] for all engagement efforts.	3. By Q4 2024
4. Provider Engagement Plan activity: align provider engagement efforts from multiple departments to decrease number of interactions with providers/clinics and maximize time with providers/clinics.	4. By Q1 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 Collective Medical 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):

CHA continued to utilize annual provider training to provide information on HIE platforms to providers.

Planned Activities	Planned Milestones
1. Continue to educate and promote HIE use with providers, including during coordinated care meetings.	1. 2024-2026
2. Continue including HIT section in annual provider training with offer for technical assistance.	2. 2024-2026
3. Create pre-recorded webinars to further inform providers about HIE opportunities.	3. By end of Q4 2024
4. Meet with physician and specialist IPA groups, and the Klamath Medical Society at least annually to share information about HIT tools.	4. 2024-2026

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 2023, progress for this strategy was limited. Case Management worked with PCC/Collective Medical to setup a postpartum care cohort and use PCC for notifications for maternity case management. CHA was able to increase communication between nurse case manager and pediatric providers in 2023. Looking to expand this to regular coordinated care meetings in 2024. CHA established a workflow with DHS-Aging People with Disabilities for utilization of PCC to view care plans from CHA for members receive care coordination services. CHA received demos from PCC to expand use of the platform in Quality and Care Coordination. CHA worked with PCC to activate the MARA Readmission score in the platform and the quality metric cohorts. Additionally, CHA requested a Spanish speaking members cohort in PCC to ensure equitable access to services and ability to address needs for this target population.

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 Q2 2025
2. Create new process collaboratively with OB and PCP clinics that provide care to pregnant CHA members.	2. By end of Q3 2025
3. Implement new process with OB clinics.	3. By end of Q4 2025
4. Start coordinated care meetings with care teams for high risk and newly pregnant members.	4. By end of Q4 2025
5. Establish regular coordinated care meetings with care teams for high needs pediatric members.	5. By end of Q4 2024
6. Explore network use of PCC/Collective Medical for better care coordination and information sharing.	6. By end of Q4 2024
7. Create plan for expanding use of PCC/Collective Medical in Klamath.	7. By end of Q4 2024
8. Explore options to expand use of Valera Health (telehealth provider) with members.	8. By end of Q4 2024, explore options for use by Dual and Atrio members.

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 2023, CHA pulls HbA1c data from Reliance to incorporate with incentive metric gap lists for providers, and to target population outreach for those in poor control range. CHA, FindHelp, and Reliance signed data sharing agreements as the first step to SDOH data integration from FindHelp to Reliance eHealth. CHA worked with FindHelp to get mySQL setup for the data sharing. This work will continue with activity three (3.) below.

Planned Activities	Planned Milestones
1. Increase the number of dental providers integrated into Reliance eHealth (Health Information Exchange, HIE).	1. By end of Q3 2024, work with KDK to connect with Reliance in order to share information with PCPs when kids receive preventative services through the sealant program or at community events.
2. Develop workflows for preventive medical screenings and referrals via Reliance eHealth by oral health providers.	2. By end of Q4 2024, at least 25% of Oral Healthcare providers able to perform medical screenings and at least 50% of Primary Care Providers able to receive and act on Oral Healthcare referrals.
3. Partner with Reliance eHealth to expand the amount of SDOH data available in the platform to improve SDOH care coordination.	3. Q4 2024
4. Explore reactivating the integration of HL7 messages from Reliance into [redacted]	4. Q4 2024

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 2023, but no contract changes were made at the time.

Planned Activities	Planned Milestones
1. Explore contract language options for encouraging EHR adoption, HIE adoption/use, and other HIT initiatives.	1. By end of Q3 2024

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/Collective Medical tool for the provider network in 2023.

Planned Activities	Planned Milestones
1. Continue to financially support PCC/Collective Medical EDie Insights tool.	1. 2024-2026
2. Explore additional financial support opportunities for HIE tools for care coordination and HEN for providers.	2. 2024-2026

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):
Previously this strategy was to explore opportunities with FHIR vendor to expand use of FHIR data for care coordination, however no progress was made on this in 2023. With the new final rule from CMS for interoperability being published in January 2024, CHA decided to pivot this strategy to meet the new interoperability and patient access requirements.

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. Review new interoperability final rule requirements.	1. By end of Q3 2024
2. Create project plan to address new requirements and steps required to comply.	2. By end of Q4 2024
3. Work internally and with FHIR vendor to implement new requirements.	3. 2025-2026

C. HIE for Care Coordination Barriers: (Optional)

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

D. OHA Support Needs (Optional)

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?

E. CCO Access to and Use of EHRs (Optional)

Optional: 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.

5. Health IT to Support SDOH Needs

A. CCO Use of Health IT to Support SDOH Needs: 2023 Progress & 2024-26 Plans

Please describe CCO 2023 progress and 2024-26 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:

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. 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).
3. (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.
4. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 for using health IT within the CCO to support SDOH needs, including but not limited to 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 2023 progress, including:
        - accomplishments and successes (including number of organizations, etc., where applicable)
        - challenges related to each strategy, as applicable
    f. (Optional) An overview of CCO 2024-26 plans for each strategy
    g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

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 not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned Milestones sections.
- If CCO is implementing a strategy beginning in 2024, 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 2023 and plan to implement during 2024-26, within your organization. Elaborate on each strategy and your progress/plans in the sections below.

Progress	Plans		Progress	Plans	
☐	☐	1. Implementation/use of health IT tool/capability for social needs screening and referrals	☐	☒	6. Integration or interoperability of health IT systems that support SDOH with other tools
☒	☒	2. Care coordination and care management of individual members	☒	☒	7. Collaboration with network partners
			☒	☒	8. CCO metrics support
☒	☒	3. Use data to identify individual members' SDOH experiences and social needs	☐	☐	9. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)
☒	☒	4. Use data for risk stratification	☐	☐	10. Participate in SDOH-focused health IT collaboratives, convening, and/or governance
☐	☐	5. Use health IT to monitor and/or manage contracts and/or programs to meet members' SDOH needs	☐	☐	11. Other strategies for supporting CIE use within CCO (please list here):
☐	☐	12. 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

Reliance eHealth Collaborative: CHA, provider partners, and community partners continued participation with the local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative (Reliance eHealth). Reliance eHealth has some SDOH reporting which includes housing and food insecurities. CHA shares 834 data files with Reliance eHealth, and some other healthcare organizations share SDOH data from their electronic health records (EHRs). The 834 data files are member eligibility files which include member demographics data. Data from Reliance is used to further stratify populations to identify gaps in care, members needing further assistance, and improvement opportunities for both internal processes as well as provider outreach. Utilizing this tool allows participating in-network providers to share captured information for other providers assisting those patients as well. In 2023, CHA continued to partner with Reliance to further expand its SDOH capturing and reporting capabilities, including data sharing agreements with Reliance, CHA, and FindHelp to further share SDOH data captured from PRAPARE screenings in HKC with Reliance to help reduce the amount of SDOH rescreening.

[redacted] ([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. Since the PRAPARE had minimal and inconsistent use in 2021, 2022, and 2023, CHA intends to standardize workflows and enhance staff training during 2023 and 2024. CHA is also working on revamping HRAs to get enhanced information from members, including SDOH data. CHA intends to use the PRAPARE and HRAs to help inform CHA's Health Related Services (HRS) program which includes Flex Funds for individual

members. Additionally, data from PRAPARE and HRAs and data already captured in [redacted] (including, but not limited to, data from the 834 eligibility data files, authorizations, and manually entered Case Management assessments) will be utilized to help enhance the member profile in [redacted]

findhelp - Healthy Klamath Connect (HKC): Since 2020, CHA contracts with 3rd party vendor findhelp, a Community Information Exchange (CIE) platform dba Healthy Klamath Connect (HKC) and formerly named Aunt Bertha. HKC functions as a central repository for the listing and availability of resources and services options for all community members (including CHA members) addressing SDOH needs. The platform also functions as a closed-loop referral system for Klamath County residents to connect with available health and social services. HKC can be used as a closed-loop referral system when programs have been claimed by the CBOs that run them. When a CBO claims their program, they gain access to a user interface that allows the staff to manage the referrals they receive and the referrals they send to other programs on behalf of their clients. CHA staff have a specific user interface to assist with managing CHA members based on captured SDOH from assessments and case management and other member, provider, and community partner interactions. All interaction types are documented in [redacted] (CHA's Case Management platform). In 2023, HKC continued to receive financial and technical support via CHA. As of February 2024, there are over (102) local community-based organizations offering services in Klamath County in the online platform offering over (150) programs for goods and services ranging from clothing, medical supplies, and food to housing advice, temporary shelter, transit services, and advice related to housing, money, work, and legal needs.

(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: Health IT Implementation ☒ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☐ 7: Collaboration ☐ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: 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 2023, HKC was used for closed-loop referrals by CHA's Case Management department. To ensure consistent use of HKC as the primary SDOH referral tool, work will continue internally to train and inform staff on HKC for SDOH screening and referring.

Planned Activities	Planned Milestones
1. Continue to standardize internal workflows for HKC that include any changes made to systems or data sharing/availability capabilities.	1. 2024-2026

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: Health IT Implementation ☐ 2: Care coordination ☒ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☐ 7: Collaboration ☐ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: Other SDOH data:

Strategy status:

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Work progressed in 2023 toward updating the PRAPARE screening tool within [redacted] and Healthy Klamath Connect. The PRAPARE screening tool is expected to be live in both [redacted] and HKC by the end of first quarter 2024. To assist in identifying member's individual experiences and needs, a field was added to [redacted] to capture member's pronouns.

Planned Activities	Planned Milestones
1. Standardize internal workflows to utilize PRAPARE screening tool in [redacted] more consistently and data captured is integrated with other data.	1. By Q3 2024, new process is established.
2. Enhance internal workflows to better utilize social needs information from Health Risk Assessments (HRAs) included within [redacted] through the integration of HRA data with other data.	2. By Q4 2024, new process is established.
3. Add SDOH data to member profile in [redacted]	3. By Q4 2024, gap analysis completed to show differences between current member profile and Population Health Dashboard.
	4. By Q2 2025, enhanced member profile completed.
4. Continue to explore pilot project options with Collective Medical for SDOH Insights.	5. 2024-2026, continue to explore in regular meetings with Point Click Care to see if timing and project scope work for both parties.

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: Health IT Implementation ☐ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☒ 7: Collaboration ☐ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: 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 2023, the existing SDOH data sharing agreements were reviewed. It was discovered that there weren't many SDOH-specific data sharing agreements in place. Current agreements were assessed and are pending updates based on data sharing needs and HRSN requirements. Through HKC work in 2023, (144) programs/CBOs were identified to establish or ensure agreements are sufficient for SDOH data sharing. This work will occur in 2024. In 2023, agreements were signed by CHA, HKC, and Reliance to start the work to establish a path for sharing SDOH data.

Planned Activities	Planned Milestones
1. Review 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 Q3 2024, review current agreements and identify if additional agreements are needed.
	2. By Q2 2024, update 100% of current agreements including HRSN additions.
	3. By Q3 2024, establish at least 50% of additional agreements that are identified as being needed.
	4. By Q4 2024, establish at least 100% of additional agreements that are identified as being needed.

2. Continue work to establish path to share SDOH data through Healthy Klamath Connect, Reliance eHealth Collaborative, and other means with clinic partners and community benefit organizations (CBOs). Once established, utilize newly established path to prevent or reduce rescreen.	5. By end of Q4 2024, new workflows established with providers to reduce SDOH rescreening.

Strategy 4 title: CCO Metrics Support
Utilize Healthy Klamath Connect, Reliance eHealth Collaborative, [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: Health IT Implementation ☐ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☐ 7: Collaboration ☒ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: 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 2023, quarterly PIP reports were successfully submitted for the Establish SDOH Screening and Referral Process Performance Improvement Project. For the SDOH Screening and Referral OHA Incentive Metric, all must pass elements were met in 2023.

Planned Activities	Planned Milestones
1. Carry out SDOH Screening and Referral Process Performance Improvement Project (PIP).	1. 2024-2026, submit quarterly report to OHA. 2. Q4 2024, CHA can attest to all Measurement Year (MY) 2 Must-Pass elements.
2. Meet requirements for SDOH Screening and Referral OHA Incentive Metric.	3. Q4, 2024, 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: Health IT Implementation ☐ 2: Care coordination ☐ 3: Use data to ID SDOH ☒ 4: Risk stratification
☐ 5: Contracts ☐ 6: Integration ☐ 7: Collaboration ☐ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: 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 is working internally to define and create a Population Health Dashboard. Due to conflicting priorities and staffing changes in 2023, progress was limited for this strategy.

Overview of 2024-26 plans for this strategy (Optional):

Planned Activities	Planned Milestones
1. Population Health Dashboard implemented.	1. Q3 2024 2. Q4 2024

2. Use Population Health Dashboard to identify a health disparity to address through a project.	3. Q1 2025
3. Complete project identified in activity 2.	4. Q4 2025

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: Health IT Implementation ☐ 2: Care coordination ☐ 3: Use data to ID SDOH ☐ 4: Risk stratification
☐ 5: Contracts ☒ 6: Integration ☐ 7: Collaboration ☐ 8: Metrics support ☐ 9: CIE Enhancements
☐ 10: Governance ☐ 11: Other CIE Use: ☐ 12: Other SDOH data:

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

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

Overview of 2024-26 plans for this strategy (Optional):
This strategy is partially new as it is an internal-focused piece of 2023's provider-focused *Strategy 6: Integration or interoperability of HIT systems that support SDOH with other tools*

Planned Activities	Planned Milestones
1. Explore options of data integration from Healthy Klamath Connect into other internal HIT tools/systems ([redacted] and Member Portal).	1. Q4 2024, complete exploration for integration for 1 internal system.
	2. By Q1 2025, data is consistently shared amongst all applicable applications/systems.
	3. By Q2 2025, workflows are created to utilize integrated data.

B. CCO Support of Providers with Using Health IT to Support SDOH Needs: 2023 Progress & 2024-26 Plans

Please describe your 2023 progress and 2024-26 plans for supporting contracted physical, oral, and behavioral health providers with using health IT to support SDOH needs, including but not limited to screening and referrals. Additionally, describe any progress made supporting social services and community-based organizations (CBOs) with using health IT in your community. In the spaces below, (in the relevant sections), please:

1. Select the boxes that represent strategies pertaining to your 2023 progress and 2024-26 plans.
2. 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).
3. (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.
4. For each strategy CCO implemented in 2023 and/or will implement in 2024-26 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 2023 progress, including:

- 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)
- challenges related to each strategy, as applicable

f. (Optional) An overview of CCO 2024-26 plans for each strategy

g. Activities and milestones related to each strategy CCO plans to implement in 2024-26

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 not pursuing a strategy beyond 2023, note 'N/A' in Planned Activities and Planned milestones sections.
- If CCO is implementing a strategy beginning in 2024, 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 2023 and plan to implement during 2024-26. Elaborate on each strategy and your progress/plans in the sections below.

Progress	Plans		Progress	Plans	
☒	☒	1. Sponsor CIE for the community	☐	☐	8. Requirements in contracts/provider agreements
☐	☐	2. Financial support for CIE implementation and/or maintenance	☒	☒	9. Enhancements to CIE tools (e.g., new functionality, health-related services funds forms, screenings, data sources)
☒	☒	3. Training and/or technical assistance	☒	☒	10. Integration or interoperability of health IT systems that support SDOH with other tools
☒	☒	4. Assessment/tracking of CIE/SDOH tool adoption and use	☐	☐	11. Support CBOs sending of referrals to clinical providers (i.e., to physical, oral, and behavioral health providers)
☒	☒	5. Outreach and education about the value of health IT adoption/ use to support SDOH needs	☐	☐	12. Utilization of health IT to support payments to community-based organizations
☐	☐	6. Support participation in SDOH-focused health IT collaboratives, education, convening, and/or governance	☐	☐	13. Other strategies for supporting adoption of CIE or other health IT to support SDOH needs (please list here):
☐	☐	7. Incentives and/or grants to adopt and/or use health IT that supports SDOH	☐	☐	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.

Refer to the "**Health IT tools used by CCO for supporting SDOH needs**" section for the list of tools used by CHA and supported for use by clinics/providers..

(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**

Supporting and Incentivizing HRSN Service Providers

Any planning and/or preparation CCO has done in anticipation of 2024 requirement to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals, such as developing grants, technical assistance, outreach, education, and feedback mechanisms for HRSN Service Providers.

CHA plans to hold monthly meetings with HRSN service providers to offer TA office hours that will cover feedback on process and education as changes with the benefits emerge. All HRSN providers will be trained on using the CIE, Healthy Klamath Connect (HKC) for submitting claims and sending referrals. Data analytics will be set up to help CHA and HRSN providers track and understand referrals and utilization of the benefit.

Specific plans to support and incentivize HRSN Service Providers to adopt and use technology for closed loop referrals during Contract Years 2024-2026, such as developing grants, technical assistance, outreach, education, and feedback mechanisms for HRSN Service Providers.

All HRSN Service providers in CHA's network are already actively using the CIE, Healthy Klamath Connect. In addition to the above plans, CHA plans to explore options for quality incentive metric inclusion and allocation for HRSN providers for SDOH work as a mode of incentivization.

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: Financial ☐ 3: TA ☐ 4: Assessment ☐ 5: Outreach/Education ☐ 6: Participation ☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments ☐ 13: Other adoption: ☐ 14: Other data access/use:

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 2023, CHA upgraded to the enterprise+ license with FindHelp. This upgrade will enable additional integration of systems including EHRs and care platforms, as well as expanded reporting, customized social determinants screener, and configurable search results. CHA worked with FindHelp to setup mySQL for the expanded reporting and data connection this year. This step is laying the foundation for the future system integration work that is possible with FindHelp and our network providers and CBOs.

Overview of 2024-26 plans for this strategy (Optional):

Planned Activities	Planned Milestones
1. Continue sponsoring Healthy Klamath Connect for the community.	1. 2024-2026
2. Continue working through Enterprise+ upgrade.	2. By Q4 2024, work with network providers to start EHR and care platform integrations.

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: Financial ☒ 3: TA ☐ 4: Assessment ☐ 5: Outreach/Education ☐ 6: Participation
☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

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 2023, CHA expanded local programs claimed to 61%. Outreach work continues with local programs to claim their program on the HKC site. To help make the outreach efforts more successful, an intern was hired in Q3 2023. The intern attended a train-the-trainer training with HKC to expand CHA's outreach capabilities. These outreach efforts included emails, calls, 1:1 trainings, technical assistance, and demos. Trainings were provided to WorkSource, DHS, and Grace Williams. Demos were provided to Klamath Tribal Health and KLCAS. Additionally, a HKC introductory video was produced and posted on CHA's YouTube channel. Due to the success of the internship, a 0.5 FTE position dedicated to HKC Community Outreach has been added to the Health Equity Department. This position will continue to provide ongoing technical assistance and local support for the HKC site.

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 2024, 75% of identified local programs are claimed.
2. Increase the number of claimed programs with closed-loop referral capabilities.	2. By end of Q4 2024, increase claimed programs using closed-loop referrals from 53% to 90%.
3. 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.	3. By Q3 2024, hire for newly developed position, Community Outreach Coordinator, to continue offering community trainings and technical assistance. 4. By Q3 2024, review and update Healthy Klamath Connect training that is included with annual Provider Network Training. 5. 2024-2026, provide technical assistance as needed.

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: Financial ☐ 3: TA ☒ 4: Assessment ☐ 5: Outreach/Education ☐ 6: Participation
☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

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 2023, environmental scan survey was developed and distributed to providers and CBOs. CHA received thirteen (13) CBO and eight (8) provider responses to the survey. Through conversations with providers at regular monthly meetings, CHA found out that most providers are already completing some form of SDOH screening in their EHRs. CHA will continue to work with providers to explore integration options for ease of data sharing.

Planned Activities	Planned Milestones
1. Work with clinic and community partners to ensure their screenings are captured within a platform that has sharing/reporting capabilities.	1. By Q3 2024, analyze results from surveys sent out to providers and CBOs.
	2. By Q4 2024, assessment implanted and utilized in [redacted] Healthy Klamath Connect, and/or another platform.
2. Increase the percentage of closed loop referrals within Healthy Klamath Connect.	3. By end of Q4 2024, 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: Financial ☐ 3: TA ☐ 4: Assessment ☒ 5: Outreach/Education ☐ 6: Participation ☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☐ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments ☐ 13: Other adoption: ☐ 14: Other data access/use:

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 2023, a quick access link to HKC was added on CHA's website homepage as "Community Resources". There is also a detailed widget under the Member Resources section about HKC. CHA successfully added HKC information to new member outreach calls. An annual CHA staff training for HKC was implemented in 2023. CHA changed text message vendors in 2023, so only one (1) text was sent to members regarding HKC. With the new vendor implemented, CHA is back on track for sending two (2) text messages regarding HKC annually to members. Healthy Klamath Connect is frequently discussed at meetings with physical health and behavioral health providers, as well as at CHA's Community Advisory Council (CAC) meetings. HKC has not been fully discussed with oral health providers as there are other priorities being addressed with the oral health providers at this time, but as soon as there is an opportunity HKC will be discussed with oral health providers. Flyers regarding HKC in English and Spanish are available at every event. A live demo of HKC was provided at the Living Well Health Fair in March 2023. Live demos will continue to be offered at events moving forward. The Outreach Coordinator will bring a laptop to events in 2024 to help connect those in need to resources on HKC in real time. The Healthy Klamath Connect banner was hung across Main Street in May, July, and October 2023 to raise awareness about the availability of the tool. Articles regarding HKC were written and shared in multiple community publications in 2023. An article was also written and shared in a DHS newsletter and a NAMI newsletter. CHA has a local digital billboard that runs a HKC advertisement (along with other CHA advertisements) for 8 seconds every other minute for a total of 720 times per day.

Overview of 2024-26 plans for this strategy (Optional):

Planned Activities	Planned Milestones
1. Expand member awareness and education about Healthy Klamath Connect.	1. By Q2 2024, CHA will add a link to Healthy Klamath Connect in the new Member Portal for quicker access to it.
	2. 2024-2026, continue to include information about Healthy Klamath Connect in member calls and new member packets.

	3. 2024-2026, continue including HKC in annual CHA staff training.
	4. By Q4 2024, members will receive 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. By Q1 2024, an annual CareTalk, provider newsletter, Health Klamath Connect article is written.
	6. 2024-2026, annually review and update the Healthy Klamath Connect training that is included with annual Provider Network Training.
	7. By Q4 2024, Healthy Klamath Connect is discussed 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. 2024-2026, 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 2024-2026, continue to hand out Healthy Klamath Connect flyers and provide a live demo of the platform if able.
	10. By Q4 2024, Healthy Klamath Connect banner is displayed across Main St. at least annually.
	11. 2024-2026, Healthy Klamath Connect article is included in at least two (2) community publications annually (like LivingWell and ActiveSeniors).
	12. By Q4 2024, complete CHIP activities.
	13. 2024-2026, a local digital billboard regularly has information about Health Klamath Connect.

Strategy 5 title: Enhancements to CIE Tools
Explore the addition of SDOH screenings 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: Financial ☐ 3: TA ☐ 4: Assessment ☐ 5: Outreach/Education ☐ 6: Participation
☐ 7: Incentives ☐ 8: Contracts ☒ 9: Enhancements ☐ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

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 been working with FindHelp to add the PRAPARE screener to the HKC site. It will be going live for public use in Q2 2024.

Planned Activities	Planned Milestones
1. Further develop HKC with PRAPARE as a primary SDOH screening tool	1. Q4 2024

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: Financial ☐ 3: TA ☐ 4: Assessment ☐ 5: Outreach/Education ☐ 6: Participation
☐ 7: Incentives ☐ 8: Contracts ☐ 9: Enhancements ☒ 10: Integration ☐ 11: Clinical referrals: ☐ 12: Payments
☐ 13: Other adoption: ☐ 14: Other data access/use:

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 2023, CHA upgraded to Enterprise+ licensing with FindHelp as the foundational work for increased interoperability capabilities for HKC with other HIT tools/systems. Initial conversations were had with Sky Lakes to explore HKC and [redacted] connectivity for SDOH screening and referring. In 2023, agreements were signed by CHA, HKC, and Reliance to start the work to establish a path for sharing and integrating SDOH data.

Planned Activities	Planned Milestones
1. Explore the interoperability of Healthy Klamath Connect with [redacted] Reliance, [redacted] and other HIT systems.	1. Q4 2024, complete interoperability exploration.
	2. By Q3 2024, Work with Sky Lakes and FindHelp on connectivity with [redacted] for SDOH screening work.
	3. By Q4 2025, contracted providers are consistently accessing member SDOH information through HKC or Reliance.
2. With Enterprise+ license for HKC, work with network providers to expand data integration from Healthy Klamath Connect into providers' EHRs.	4. By Q3 2025, have HKC data integrated with one (1) network provider's EHR.

C. Health IT to Support SDOH Needs Barriers (Optional)

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.

D. OHA Support Needs (Optional)

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?

6. 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?