CCO 2023 HIT Roadmap

Guidance, Evaluation Criteria & Report Template, **Option B**

Contract or rule citation	Exhibit J, Section 2 d.
Deliverable due date	March 15, 2023
Submit deliverable to:	mailto:CCO.MCODeliverableReports@odhsoha.oregon.gov and cc: CCO.HealthIT@odhsoha.oregon.gov

Please be sure to:

1. **Submit both Word and PDF versions of your Roadmap and**
2. **Use the following file naming convention for your submission: CCOname_2023_HIT_Roadmap**

2023 HIT Roadmap Template

Please complete and submit to CCO.MCODeliverableReports@odhsoha.oregon.gov and cc: CCO.HealthIT@odhsoha.oregon.gov by **March 15, 2023.**

CCO: Cascade Health Alliance

Date: 3/15/2023

Instructions & Expectations

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

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

Each required topic includes the following:

- Narrative sections to describe your **2022 progress, strategies, accomplishments/successes, and barriers**
- Narrative sections to describe your **2023-2024 plans, strategies, and related activities and milestones**. For the activities and milestones, you may structure the response using bullet points or tables to help clarify the sequence and timing of planned activities and milestones. These can be listed along with the narrative; it is not required that you attach a separate document outlining your planned activities and milestones. However, you may attach your own document(s) in place of filling in the activities and milestones sections of the template (as long as the attached document clearly describes activities and milestones for each strategy and specifies the corresponding Contract Year).

Narrative responses should be concise and specific to how your efforts support the relevant HIT area. OHA is interested in hearing about your progress, successes, and plans for supporting providers with HIT, as well as any challenges/barriers experienced, and how OHA may be helpful. CCOs are expected to support physical, behavioral, and oral health providers with adoption of and access to HIT. That said, CCOs' HIT 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 HIT environment evolves and changes, and that plans from one year may change to the next. For the purposes of the HIT Roadmap responses, the following definitions should be considered when completing responses.

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

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

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

Milestones: Significant outcomes of activities or other major developments in CCO's overall strategy, with indication of when the outcome or development will occur (e.g., Q1 2023). **Note**: Not all activities may warrant a corresponding milestone. For activities without a milestone, at a minimum, please indicate the planned timing.

A note about the template*:*

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

HIT Roadmap Template Strategy Checkboxes

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

- *Support for EHR Adoption*
- *Support for HIE – Care Coordination*
- *Support for HIE – Hospital Event Notifications*
- *HIT to Support SDOH Needs*

The checkboxes represent themes that OHA has compiled from strategies listed in CCOs' previous HIT 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 Updated HIT Roadmap template to CCO.HealthIT@odhsoha.oregon.gov

1. HIT Partnership

Please attest to the following items.

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

2. Support for EHR Adoption

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

Please describe your 2022 progress and 2023-24 plans for supporting increased rates of EHR adoption and addressing barriers to adoption among contracted physical, oral, and behavioral health providers. In the spaces below (in the relevant sections), please:

1. Select the boxes that represent strategies pertaining to your 2022 progress and 2023-24 plans.
2. Report the number of physical, oral, and behavioral health organizations without EHR information using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.
3. Include plans for collecting missing EHR information via CCO already-existing processes (e.g., contracting, credentialling, Letters of Interest).
4. Provide a title and description of each strategy CCO implemented in 2022 and/or will implement in 2023-24.
5. Describe the 2022 progress of each strategy in the appropriate narrative sections. In the descriptions, include:
    a. accomplishments and successes (including number of organizations, where applicable), and
    b. challenges related to each strategy, as applicable.

    Where applicable, information in the CCO HIT Data Reporting File should support descriptions of accomplishments and successes.
6. Describe activities and milestones related to each strategy CCO plans to implement in 2023-24.

Notes:

1. 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).
2. If CCO is not pursuing a strategy beyond 2022, note 'N/A' in Planned Activities and Planed milestones sections.
3. If CCO is implementing a strategy beginning in 2023, please indicate 'N/A' in the progress section for that strategy.
4. If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

Strategy checkboxes
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

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

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

CHA currently has (55) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently, there are (4) Physical, (17) Behavioral, and (2) Oral Health organizations identified with unknown EHR information. One (1) Oral Health clinic does not have an EHR. With seventeen (17) behavioral health clinics with EHR status unknown, that is CHA's largest area of opportunity. By Q4 2023, CHA plans to work with (3) additional providers to implement an EHR solution, one in each provider type category for Physical, Oral, and Behavioral Health providers. In 2023, CHA will give special attention to the Behavioral Health opportunity for EHR adoption. By Q4 2024, CHA plans to work with (1) more from each category of provider types to adopt an EHR.

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

CHA already uses surveys via [redacted] to collect information from network clinics for topics like capacity and provider changes. For continual collection and monitoring of EHR adoption and use, CHA decided to use the existing process and create a new HIT survey in [redacted]. The link for the survey is distributed to contracted clinic contacts via email. The plan for 2023 is to distribute the survey quarterly to test the new survey and process for collecting this type of information. In future years, the cadence for HIT survey distribution may be scaled back to twice a year.

Strategy 1 title: Assessment/Tracking of EHR Adoption and Capabilities
Brief description: Develop and utilize Provider Engagement Plan to document EHR contacts at clinics, track clinic activities with EHR use and adoption, and identify barriers providers/clinics have with EHR adoption.

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 2022, the Provider Engagement Plan and HIT survey were drafted to document the process for engaging with providers on HIT tools, and how data on HIT tools use will be collected from clinics.

Planned Activities	Planned Milestones
1. Distribute first draft of HIT survey to contracted clinics	1. By end of Q1 2023
2. Review responses and make edits to survey as needed	2. By end of Q2 2023
3. Finalize documenting the survey process within the Provider Engagement Plan	3. By end of Q3 2023
4. Continue carrying out Provider Engagement Plan and collecting information from clinics, making adjustments to plan and survey as necessary based on continuous improvement efforts	4. 2023 and 2024

Strategy 2 title: Training and Technical Assistance

Brief description: Provide technical assistance for providers (when needed) for implementing/upgrading EHR. Offer technical assistance (TA) for building reporting for EHR metrics.

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 meets monthly with six (6) primary care providers who are designated PCPCH's and are assigned about 98% of CHA's total members. Discussions on OHA incentive metrics and quality improvement take place, as well as strategies for improvement. EHR and clinical documentation workflows are shared, and recommendations for areas of improvement are made. During the first six months of 2022, CHA identified lower than expected performance rates on several EHR reported metrics around preventative screenings and conducted a root cause analysis that determined that although appropriate screenings and interventions were done, they were not being properly captured in several clinics EHR's to be retrieved as structured data in reports. CHA provided technical assistance on ways to document and retrieve data via LOINC and SNOMED codes, as well as full technical specifications to correctly write reporting queries so that they were mapped and retrieving data from the right locations in charts. CHA provided in depth TA to one small clinic in partnership with their EHR vendor to create enhancements to their EHR to better improve their clinical workflows. TA for building reporting for EHR metrics was provided to two clinics with new EHR systems. The work was in depth and spanned the entire year of 2022. Discussions on EHR integration/interfacing capabilities took 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.

Planned Activities	**Planned Milestones**
1. Continue including HIT section in annual provider training with offer for TA	1. 2023-2024
2. Continue providing TA for incentive metric workflow and data report building in EHRs	2. 2023-2024
3. Establish regularly scheduled clinic engagement meetings	3. By end of Q4 2023
4. HIT is a standing agenda item at clinic engagement meetings	4. 2023-2024
5. TA is a standing agenda item at clinic engagement meeting and, if clinic requests TA, CHA supplies TA outside of the clinic engagement meeting	5. 2023-2024

Strategy 3 title: Outreach and Education
Brief description: 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.

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):
New provider trainings were recorded in 2022. The HIT provider training section was revamped to include specific examples of HIT/HIE, such as Reliance and Collective Medical, with the benefits of provider participation explained from the user perspective. The cross-department collaboration allowed for more comprehensive overviews to be covered in the session compared to previous years. Information about the importance of having an EHR and the work being done with Healthy Klamath Connect was also included in the HIT provider training session. In 2022, eighty providers and clinic staff attended the annual provider training, including the HIT training session.

Planned Activities	**Planned Milestones**
1. Continue offering annual provider training with HIT section	1. 2023-2024
2. Explore additional education/TA opportunities with clinics	2. By end of Q4 2023

3. Use data from HIT survey to identify target areas of outreach efforts for providers not utilizing HIT platforms	3. Q4 2023
4. Provide targeted outreach to clinics/providers at the individual clinic engagement meetings, or at the monthly provider meeting	4. By end of Q4 2024, provide three (3) targeted outreach sessions
5. Conduct outreach efforts to the 19 BH providers that have "EHR status unknown" in the data reporting file	5. By end of Q4 2023

Strategy 4 title: Leverage HIE Tools
Brief description: 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.

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 the 2022 provider training, HIE programs were highlighted with emphasis on added benefits of use with an EHR. This was done to promote EHR and HIE use collaboratively to enhance patient care coordination. One new pediatric clinic recognized the benefits of utilizing an EHR and Reliance eHealth, thus implemented a new EHR in 2022 and in 2023 the clinic is working through Reliance implementation.

Planned Activities	Planned Milestones
1. Utilize Collective Medical and Reliance to promote EHR adoption	1. 2023-2024
2. Work with Sky Lakes Medical Center on creating flags in [redacted] for additional identification of needs related to Quality metrics and Risk	2. Q4 2023
3. Increase the number of dental providers integrated into Reliance eHealth HIE	3. By end of Q4 2024, at least 50% 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 50% 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 Q2 2023

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

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 in 2022 for this strategy as other items were prioritized for the contracts for 2023.

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 2023

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

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 2022 as it is planned for 2023 and 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. 2023-2024

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

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 2022, CHA provided funding to one clinic for an EHR transition/upgrade and to another clinic for a new EHR implementation.

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

Please describe any barriers that inhibited your progress supporting EHR adoption among your contracted providers

Increasing requirements, staffing changes, and bandwidth limited the amount of outreach efforts, engagement, and TA that CHA could provide in 2022.

B. Optional Question

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

3. **Support for HIE – Care Coordination** (excluding hospital event notifications, CIE)

A. Support for HIE – Care Coordination: 2022 Progress and 2023-24 Plans

Please describe your 2022 progress and 2023-24 plans for supporting increased access to HIE for Care Coordination, ***excluding hospital event notifications and CIE***, among contracted physical, oral, and behavioral health providers. In the spaces below (in the relevant sections), please:

1. Select the boxes that represent strategies pertaining to your 2022 progress and 2023-24 plans.
2. List and describe specific HIE for care coordination tools you currently or plan to support or provide.
3. Report the number of physical, oral, and behavioral health organizations that have not currently adopted an HIE for Care Coordination tool using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.

4. Provide a title and description of each strategy CCO implemented in 2022 and/or will implement in 2023-24 to support increased access to HIE for Care Coordination among contracted physical, oral, and behavioral health providers.
5. Describe the 2022 progress of each strategy in the appropriate narrative sections. In the descriptions, include:
    a. accomplishments and successes (including the number of organizations of each provider type that gained access to HIE for Care Coordination tools as a result of your support, as applicable), and
    b. challenges related to each strategy, as applicable.

   Where applicable, information in the CCO-revised data reporting file should support descriptions of accomplishments and successes.
6. Describe activities and milestones related to each strategy CCO plans to implement in 2023-24.

Notes:
1. 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).
2. If CCO is not pursuing a strategy beyond 2022, note 'N/A' in Planned Activities and Planed milestones sections.
3. If CCO is implementing a strategy beginning in 2023, please indicate 'N/A' in the progress section for that strategy.
4. If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

Strategy checkboxes
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

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

HIE for care coordination tools CCO supports or provides (excluding hospital event notifications and CIE)

List and briefly describe tools:
[redacted]**:** The 2021 upgrade of [redacted] allows for CHA to receive the platform updates as they are made available by [redacted]; the previous version of [redacted] that CHA was using was very customized, so updates could not be applied. In 2022, CHA successfully applied two version upgrades, 4.7 and 4.8, which enhanced and expanded features in the platform including a plain language field.

[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 and eReferrals. At this time, CHA only uses the Community Health Record, thus there is an opportunity for CHA to explore the eReferrals module to see if it could aid care coordination. 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.

Collective Medical: Collective Medical is utilized daily by 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.

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 Social Needs Screening and Referrals for Addressing SDOH Needs* section below.

[redacted]**:** This is a predictive model platform that ingests CHA claims monthly and applies patented algorithm logic models. Reports are generated through the user interface based on cohorts built within the tool. CHA Medical Management utilizes this tool to build cohorts to manage care and monitor spending, as well as by Quality Management for MEPP project tracking and reporting.

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

[redacted] **Video:**
In 2022, CHA took the same approach to the annual provider training as 2021. Subject matter experts (SMEs) created presentation slides and then used [redacted] Video to record their presentation. All of the videos were compiled and shared with the providers. Communication was sent to providers and clinic staff to watch the video sessions at their convenience (within a designated timeframe determined by CHA). Again, one session was dedicated to HIT platforms and the benefits of adopting an EHR and using available HIT tools/systems like Reliance eHealth, Collective Medical, and Healthy Klamath Connect.

Using the Data Completeness Table in the OHA-provided CCO HIT Data Reporting File, please report on the number of contracted physical, oral, and behavioral health organizations that have not currently adopted an HIE for Care Coordination tool:

CHA currently has (55) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently, there are (14) Physical, (6) Behavioral, and (5) Oral Health organizations identified as having HIE for care coordination. There are multiple providers that do cross-over multiple provider type categories. So, CHA has an opportunity to gain a greater impact by working with those organizations providing multiple types of services in the provider network. Currently, CHA has identified (9) Physical, (23) Behavioral, and (7) Oral Health providers without an HIE for care coordination. By Q4 2023 CHA plans to work with (3) more additional providers to add HIE care coordination capabilities, one in each provider type category for

Physical, Oral, and Behavioral Health providers. By Q4 2024 CHA plans to add (3) more from each category.

Strategy 1 title: Assessment/tracking of HIE adoption and capabilities
Brief description: Develop and utilize 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.

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 2022, the Provider Engagement Plan and HIT survey were drafted. In Q1 2023, the HIT survey was deployed to test the process of collecting information on HIT systems being used by contracted provider clinics. Once the test is completed, the process will be reviewed for successes, challenges, and areas for improvement, and then changes will be made to the process and Provider Engagement Plan. Once changes have been made, the Provider Engagement Plan will be finalized. The survey will be sent out again at the end of each quarter in 2023.

Planned Activities	Planned Milestones
1. Finalize and implement provider engagement plan	1. By end of Q2 2023
2. Utilize HIT survey to track provider adoption use of HIT for care coordination	2. 2023-2024

Strategy 2 title: Training and Technical Assistance
Brief description: Provide technical assistance for providers (when needed) to support the use of HIT for care coordination, including, but not limited to, platform recommendations and workflow review. Additionally, CHA will work with the local Medicare Advantage plan to explore adoption of Reliance eHealth for additional care coordination for dual members.

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):
Technical assistance for care coordination was not requested in 2022.

Planned Activities	Planned Milestones
1. Work with local Medicare Advantage plan to explore adoption of Reliance eHealth for additional care coordination for dual members	1. 2023
2. Continue to offer TA to providers	2. 2023-2024

Strategy 3 title: Outreach and Education About Value of HIE
Brief description: Provide education to providers not utilizing HIE platforms with targeted efforts through live meetings, information sent via email, and pre-recorded webinars. Utilize the annual provider training to continue to share about HIT, HIE platforms, and other HIT initiatives/opportunities.

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):
New provider trainings were recorded in 2022. The HIT training session was recorded in separate parts by the different subject matter experts and then the videos were compiled with post-production editing. For care coordination, Reliance eHealth and Collective Medical were highlighted by a SME to demonstrate how the platforms work and the benefits of use.

Planned Activities	Planned Milestones
1. Continue to educate and promote HIE use with providers, including during coordinated care meetings	1. 2023-2024

2. Continue including HIT section in annual provider training with offer for technical assistance	2. 2023-2024
3. Create pre-recorded webinars to further inform providers about HIE opportunities	3. 2023-2024

Strategy 4 title: Collaboration with Network Partners
Brief description: Work with clinic and community partners to enhance the use of HIT in Klamath County.

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 in 2022 on activities, however plans were created for 2023 and 2024 work.

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. Q2 2023
2. Create new process collaboratively with OB and PCP clinics that provide care to pregnant CHA members	2. By end of Q2 2023
3. Implement new process with OB clinics	3. Q3 2023
4. Start coordinated care meetings with care teams for high risk and newly pregnant members	4. By June 2023
5. Create coordinated care meetings with care teams for high needs pediatric members	5. By end of Q4 2023
6. Explore network use of Collective Medical for better care coordination and information sharing	6. By end of Q3 2023
7. Create plan for expanding use of Collective Medical in Klamath	7. By end of Q4 2023

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

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 2021, CHA worked with Reliance to have a self-service report created from EHR data with members that had a recent SUD diagnosis from a hospital admission or an ED visit. In 2022, the report was finalized and CHA was able to successfully implement a new workflow to pull the report daily on weekdays, with Monday's report having a 3-day lookback to capture events from the weekend, split the repot out by assigned PCP, and then securely share the member-level lists with the point of contact at each clinic. Once the clinics have their list, they are able to follow-up timely with patients to engage them in treatment during the window of opportunity. Since the creation of this report in the Reliance CHR dashboard, many Reliance clients in Klamath County have asked for access to the report for their population.

Planned Activities	Planned Milestones
1. Increase the number of dental providers integrated into Reliance eHealth (Health Information Exchange, HIE)	1. By end of Q4 2023, 2 additional network oral health provider utilize Reliance eHealth to its full capacity (total of 3)
2. Develop workflows for preventive medical screenings and referrals via Reliance eHealth by oral health providers.	2. By end of Q4 2024, at least 50% of Oral Healthcare providers able to perform medical screenings and at least 70% of Primary Care Providers able to receive

	and act on Oral Healthcare referrals
3. Partner with Reliance eHealth to expand the amount of SDOH data available in the platform to improve SDOH care coordination	3. 2023-2024
4. Use Reliance eHealth to identify HbA1c results and integrate with other data	4. 2022-2024
5. CHA Case Managers to improve use of Reliance to view member information in the CHR and improve care coordination	5. 2023-2024

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

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 in 2022 for this strategy as other items were prioritized for the contracts for 2023.

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 2023

Strategy 7 title: Pilot Project with FHIR Vendor
Brief description: Explore opportunities to expand use of FHIR data to increase access to better member data to create more complete member profiles that can be used for enhanced care coordination which leads to improved health outcomes.

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 in 2022. Moved exploration work to 2023.

Planned Activities	Planned Milestones
1. Collaborate with current FHIR solution vendor to explore future capabilities, expanded use of structured data, and potential pilot project opportunities in 2024 to support care coordination	1. By end of Q4 2023
2. Dependent on outcome of 2022 exploration: Potential pilot project to support care coordination	2. 2024

Strategy 8 title: Explore Member Portal Options
Brief description: CHA intends to implement an integrated member portal solution to assist in member collaboration, transparency of services available, and self-service features that would include but not limited to ordering new cards, connecting with local needed social and health services, and collecting HRAs.

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
Initial research was conducted to identify potential member portal options. Work will continue to demo each potential option and narrow down to top three options.

Planned Activities	Planned Milestones
1. Research member portal options	1. By end of Q1 2023
2. Present top three options to leadership	2. By end of Q2 2023
3. Implement selected member portal	3. By end of Q4 2024

Strategy 9 title: Explore Health Risk Assessment (HRA) Vendor Options
Brief description: 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.

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

Progress (including previous year accomplishments/successes and challenges with this strategy):
This is a new strategy in 2023, however, initial vendor research started in Q4 2022.

Planned Activities	Planned Milestones
1. Research vendors and create short list to explore further	1. Q4 2022
2. Platform demos with shortened list of vendors	2. Q1 2023
3. Create proposal of top three options with suggestion for top option	3. Q2 2023
4. Once selected, move forward with implementation	4. Q3 2023

Please describe any barriers that inhibited your progress to support access to HIE for Care Coordination among your contracted providers

Increasing requirements, staffing changes, and bandwidth limited the amount of outreach efforts, engagement, and TA that CHA could provide in 2022.

B. Optional Question

How can OHA support your efforts in supporting your contracted providers with access to HIE for Care Coordination?

4. Support for HIE – Hospital Event Notifications

A. Support for HIE – Hospital Event Notifications: 2022 Progress and 2023-24 Plans

1. Please describe your 2022 progress and 2023-24 plans for using 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 2022 progress and 2023-24 plans.
    2. List and describe specific tool(s) you currently use or plan to use for timely Hospital Event Notifications.
    3. Provide a title and description of each strategy CCO implemented in 2022 and/or will implement in 2023-24 for using hospital event notifications within your organization.
    4. Describe the 2022 progress of each strategy in the appropriate narrative sections. In the descriptions, include:
        i. accomplishments and successes and
        ii. challenges related to each strategy, as applicable.
    5. Describe activities and milestones related to each strategy CCO plans to implement in 2023-24

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 2022, note 'N/A' in Planned Activities and Planed milestones sections.
- If CCO is implementing a strategy beginning in 2023, 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 checkboxes

Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

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

Tools used by CCO for timely hospital event notifications

List and briefly describe tool(s):
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 2022, CHA used A1c data from Reliance to support the Diabetes Poor Control metric.

Collective Medical: Collective Medical is utilized daily by 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
Brief description: Utilize the HEN platform, Collective Medical, to identify members in need of care coordination or case management.

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2022, CHA case managers continued to review reports and notifications daily for specific cohorts in the platform and initiate follow-up with a member when needed and share information with providers and community case managers where applicable. Information from Collective Medical is entered into the case management system for members that have an open case with any case manager in order to alert the case manger to follow-up with the member and other providers of their care team in a timely manner.

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. 2023-2024 as needed
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. 2023-2024

Strategy 2 title: Integration into Other System
Brief description: 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.

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

In 2022, CHA continued following established processes for integrating information from HIEs into CHA's case management software, [redacted].

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. Q3 2023

Strategy 3 title: Exchange of care plans and care information
Brief description: Explore and potentially implement new and innovative uses of Collective Medical to better serve members.

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2022, there was no progress made on the activities for this strategy.

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. By end of Q4 2023
2. CHA case managers to add their contact information into the Collective Platform's Care Team section to help improve information exchange between providers and case managers that are both working with the same member/patient	2. By end of Q3 2023

Strategy 4 title: Collaboration with external partners
Brief description: Work with clinic and community partners to enhance the use of HIT, specifically HEN in Klamath County.

Progress (including previous year accomplishments/successes and challenges with this strategy):
Due to staffing changes in Case Management in 2022 including the addition of two new managers, one for Medicaid and the other for Medicare, progress was not made on identified activities for this strategy. More focus will be put on this strategy in 2023.
CHA's Case Management department continued to utilize [redacted] access, for the local hospital, Sky Lakes Medical Center, and related providers, daily for checking records, treatment notes from visits, reviewing current activity for selected members to assists in care coordination efforts, and when needed use the direct message feature to collaborate directly with Primary Care Providers.

Planned Activities	Planned Milestones
1. Explore enhancement of weekly collaborative care meetings between many clinics/provider types.	1. By end of Q2 2023
2. CHA case managers to add their contact information into the Collective Platform's Care Team section to help improve collaboration between providers and case managers that are both working with the same member	2. By end of Q3 2023
3. Explore getting read access to other clinic's EHRs that don't use [redacted]	3. By end of 2023

Strategy 5 title: Utilization monitoring/management
Brief description: Use HIT platforms to monitor and manage member utilization of services and inform intervention planning.

Progress (including previous year accomplishments/successes and challenges with this strategy):
CHA's Case Management department uses Collective Medical, Reliance eHealth, and [redacted] access to monitor use of the Emergency Department, hospital admissions, and other services accessed by members. CHA receives a monthly report from Collective Medical that shows internal CHA users use of the platform. In 2022, CHA continued to use Collective Medical to monitor member utilization of the Emergency Department and hospital admissions. Additionally, CHA Case Management and the Business Intelligence departments worked directly with Collective Medical to expand on the cohorts for ATRIO and DSNP members. Cohorts were created to capture events surrounding joint replacements as it was reported by the

hospital staff as a problematic area. Since creation, the cohorts are reviewed daily by the Medicare Manager of Clinical Operations to look for patterns and intervene prior to it becoming a larger issue.

Planned Activities	Planned Milestones
1. Continue to utilize Collective Medical to monitor events and issues affecting service availability, spend, or that are high risk.	1. 2023-2024 as needed
2. Continue to utilize SUD and ED cohorts in Collective Medical to monitor use	2. 2023-2024
3. Update internal Case Management processes for the utilization of Collective Medical	3. By end of Q4 2023

Strategy 6 title: Supporting CCO metrics
Brief description: Use HIT platforms to track and support incentive metrics work, as well as identify areas of opportunity.

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2022, CHA continued to use Reliance eHealth to support the incentive metrics work, including the Initiation and Engagement of Substance Use Disorder Treatment (IET) metric. CHA worked with Reliance in 2021 and 2022 to build a report for IET notifications based on clinical EHR data for ED visits or hospital admissions with a qualifying diagnosis. The member-level report is pulled daily by a CHA Quality Management Analyst, broken up by assigned provider, securely shared with the clinic point of contact, and then the clinic care navigation staff work off the list to engage members in treatment quickly. This process was launched at the end of Q1 2022 and was continuously improved throughout 2022 as issues were identified.

Planned Activities	Planned Milestones
1. Continue to use IET notification report from Reliance to inform providers of SUD care opportunities timely.	1. 2023-2024
2. Explore options with Collective Medical for incentive metrics support.	2. By end of Q4 2023
3. Continue to use the maternity cohort report to support the prenatal and postpartum care metric.	3. 2023-2023
4. Explore opportunities to expand metrics captured and tracked in Collective Medical	4. 2023-2024

Strategy 7 title: Supporting financial forecasting
Brief description: Utilize data from HIT platforms to guide care coordination, interventions, and program creation.

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2022, CHA was using [redacted] for financial forecasting, MEPP support, and member risk stratification and identification. [redacted] is scheduled to be discontinued by [redacted] and fully replaced by [redacted]. In Q4 2022, CHA began the implementation process with [redacted]. The implementation is expected to be completed by the end of Q2 2023.

Planned Activities	Planned Milestones
1. Explore using Collective Medical to support MEPP and TQS activities	1. By the end of Q2 2023
2. Implement [redacted] for the CHA population to replace [redacted]	2. By the end of Q2 2023
3. Test use of [redacted] with existing workflows	3. By end of Q4 2023
4. Explore and expand use of [redacted] for potentially avoidable cost monitoring	4. 2024

Strategy 8 title: Pilot Project with Collective Medical
Brief description: Partner with Collective Medical to explore enhancements to the platform to improve access to data to better work with members.

Progress (including previous year accomplishments/successes and challenges with this strategy):
In 2022, there was not any progress made on this strategy due to limited bandwidth and staffing changes. CHA Case Management in collaboration with the Business Intelligence department and Operations Project Management will work on this strategy in 2023.

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 Q4 2023, have meeting with Collective Medical to scope project

2. Please describe your 2022 progress and 2023-24 plans for supporting increased access to timely Hospital Event Notifications for contracted physical, oral, and behavioral health providers. In the spaces below (in the relevant sections), please:
   1. Select the boxes that represent strategies pertaining to your 2022 progress and 2023-24 plans.
   2. List and describe specific tool(s) you currently or plan to support or provide.
   3. Report the number of physical, oral, and behavioral health organizations that do not currently have access to HIE for hospital event notifications using the Data Completeness Table in the OHA-provided CCO HIT Data File (e.g., 'Using the OHA-provided Data Completeness Table, 10 physical health, 22 oral health, and 14 behavioral health organizations lack EHR information'). CCOs are expected to use this information to inform their strategies.
   4. Provide a title and description of each strategy CCO implemented in 2022 and/or will implement in 2023-24 to support increased access to HIE for hospital event notifications among contracted physical, oral, and behavioral health providers.
   5. Describe the 2022 progress of each strategy in the appropriate narrative sections. In the descriptions, include:
      a. accomplishments and successes (including the number of organizations of each provider type that gained access to HIE for hospital event notifications as a result of your support, as applicable), and
      b. challenges related to each strategy, as applicable.

      Where applicable, information in the CCO HIT Data Reporting File should support descriptions of accomplishments and successes.
   6. Describe activities and milestones related to each strategy CCO plans to implement in 2023-24.

Notes:
1. 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).
2. If CCO is not pursuing a strategy beyond 2022, note 'N/A' in Planned Activities and Planed milestones sections.
3. If CCO is implementing a strategy beginning in 2023, please indicate 'N/A' in the progress section for that strategy.
4. If preferred, you may choose to submit a separate document detailing each strategy's activities and milestones.

Strategy checkboxes
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

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

Tools supported or provided by CCO that facilitate access to timely hospital event notifications

List and briefly describe tools:

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

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

Using the Data Completeness Table in the OHA-provided CCO HIT Data Reporting File, please report on the number of contracted physical, oral, and behavioral health organizations that do not currently have access to HIE for hospital event notifications:

CHA currently has (55) organizations listed as Required for Reporting in the OHA Data Completeness Table. Currently there are (5) Physical, (4) Behavioral, and (1) Oral Health organizations identified as having access to hospital event notifications. This leaves a great opportunity for CHA to encourage and work with providers identified without access to these notifications. There are multiple providers that do cross-over multiple provider type categories. So, CHA has an opportunity to gain a greater impact by working with those organizations providing multiple types of services in the provider network. Currently, CHA has identified (14) Physical, (22) Behavioral, (11) Oral Health providers, and (1) FQHC without hospital event notifications. By Q3 2023, CHA plans to add (6) more additional providers to the Collective Medical EDie Insights tool, two in each provider type category for physical, oral, and BH providers. By Q4 2024, CHA plans to add (3) more, one from each category.

Strategy 1 title: Assessment/tracking of Hospital Event Notifications access and capabilities
Brief description: Develop and utilize Provider Engagement Plan to document strategies for collaboration with providers to use HIT to support hospital event notifications, track clinic adoption and use of HIT for hospital event notifications and assist with identifying any barriers providers might have with adopting and using HIT for hospital event notifications.

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 2022, the Provider Engagement Plan and HIT survey were drafted. In Q1 2023, the HIT survey was deployed to test the process of collecting information on HIT systems being used by contracted provider clinics. Once the test is completed, the process will be reviewed for successes, challenges, and areas for improvement, and then changes will be made to the process and Provider Engagement Plan. Once changes have been made, the Provider Engagement Plan will be finalized. The survey will be sent out again at the end of each quarter in 2023.
CHA receives the Clinic Network Engagement Metrics report from Collective Medical that shows utilization metrics for the clinics in our network. This report is utilized to track adoption and target education for clinics not currently engaged in Collective Medical.

Planned Activities	Planned Milestones
1. Finalize and implement provider engagement plan	1. By end of Q2 2023
2. Utilize HIT survey to track provider adoption use of HIT for hospital event notifications	2. 2023-2024

Strategy 2 title: Hospital Event Notifications training and/or technical assistance

Brief description: 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.

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):
TA for hospital event notifications was not requested in 2022.

Planned Activities	Planned Milestones
1. Continue to offer technical assistance to providers	1. 2023-2024

Strategy 3 title: Outreach and education about the value of Hospital Event Notifications
Brief description: Provide education to providers not utilizing HIE platforms with targeted efforts through live meetings, information sent via email, and pre-recorded webinars. Utilize the annual provider training to continue to share about 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.

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):
New provider trainings were recorded in 2022. The HIT training session was recorded in separate parts by the different subject matter experts and then the videos were compiled with post-production editing. For care coordination, Reliance eHealth and Collective Medical were highlighted by a SME to demonstrate how the platforms work and the benefits of use.

Planned Activities	Planned Milestones
1. Continue including HIT section in annual provider training with offer for technical assistance	1. 2023-2024
2. Create pre-recorded webinars to further inform providers about HIE opportunities	2. 2023-2024

Strategy 4 title: Explore requirements in contracts
Brief description: Explore expanding contract language that encourages EHR adoption/use, HIE, and other HIT initiatives.

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 in 2022 for this strategy as other items were prioritized for the contracts for 2023.

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 2023

Strategy 5 title: Explore Financial Support Options for Providers
Brief description: Explore funding options available to support provider HIE for HEN adoption.

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 Collective Medical EDie Insights tool for the provider network in 2022.

Planned Activities	Planned Milestones
1. Continue financially support Collective Medical EDie Insights tool	1. 2023-2024

Please describe any barriers that inhibited your progress to support access to timely Hospital Event Notifications among your contracted providers

Increasing requirements, staffing changes, and bandwidth limited the amount of outreach efforts, engagement, and TA that CHA could provide in 2022.

B. Optional Question

How can OHA support your efforts in supporting your contracted providers with access to Hospital Event Notifications?

5. HIT to Support SDOH Needs

A. HIT to Support SDOH Needs: 2022 Progress and 2023-24 Plans

1. Please describe your 2022 progress and 2023-24 plans for using HIT 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 2022 progress and 2023-24 plans.
   2. List and describe the specific HIT tool(s) you currently use or plan to use for supporting SDOH needs. Please specify if the tool(s) have closed-loop referral functionality (e.g., Community Information Exchange or CIE).
   3. Provide a title and description of each strategy CCO implemented in 2022 and/or will implement in 2023-24 for using HIT to support SDOH needs, including but not limited to screening and referrals.
   4. Describe the 2022 progress of each strategy in the appropriate narrative sections. In the descriptions, include:
      i. accomplishments and successes and
      ii. challenges related to each strategy, as applicable.
   5. Describe activities and milestones related to each strategy CCO plans to implement in 2023-24

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 2022, note 'N/A' in Planned Activities and Planed milestones sections.
- If CCO is implementing a strategy beginning in 2023, 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 checkboxes
Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

☐ Implementation of HIT tool/capability for social needs screening and referrals	☐ Integration or interoperability of HIT systems that support SDOH with other tools
☒ Care coordination and care management of individual members	☒ Collaboration with network partners
☒ Use data to identify individual members' SDOH experiences and social needs	☒ CCO metrics support

☒ Use data for risk stratification ☐ Use HIT to monitor and/or manage contracts and/or programs to meet members' SDOH needs	☐ Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources) ☐ Engage in governance of CIE ☐ Other strategies for supporting CIE use within CCO (please list here):

HIT tools used by CCO for Support of SDOH needs

List and briefly describe tool(s):

- **Collective Medical:** In early 2021, CHA started communication with Collective Medical on potential future innovations. Due to other priorities, limited bandwidth, and staffing changes, further communication did not occur in 2022. In 2023, CHA intends to partner on a pilot project with Collective Medical for SDOH for insights and improve hospital event notifications with enhanced member details.
- **Reliance eHealth Collaborative:** CHA, provider partners, and community partners continued participation with the local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative (Reliance eHealth). Reliance eHealth has some SDOH reporting which includes housing and food insecurities. CHA shares 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 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 will continue to partner with Reliance to further expand its SDOH capturing and reporting capabilities.
- [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 department to gather social needs information and to utilize data gathered while working with members. Additionally, Health Risk Assessment (HRA) information is stored in [redacted] and includes questions about food insecurity, homelessness, and transportation. Since the PRAPARE had minimal and inconsistent use in 2021 and 2022, CHA intends to standardize workflows and enhance staff training during 2023. CHA is also working on revamping HRAs to get enhanced information about 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 834 data files, authorizations, and manually entered Case Management assessments) will be utilized to help enhance the member profile in [redacted]. The 834 data files are member eligibility files which include member demographics data.
- **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 2022, HKC continued to receive financial and technical support via CHA. As of February 2023, there are over 150 local community-based organizations offering services in Klamath County in the online platform offering over 200 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.

Strategy 1 title: Care coordination and care management of individual members

Brief description: Enhance care coordination and connecting members to needed services within a closed loop referral system. (In 2022 HIT Roadmap submission, this strategy was titled "SDOH Screening and Referring Strategy 1: Care Coordination".)

Progress (including previous year accomplishments/successes and challenges with this strategy): To further identify and close social needs gaps, CHA has a multidisciplinary team focused on improving social determinates of health (SDOH) screening and referrals (through HKC) to improve identification of social needs to decrease health disparities for all members, including members who may not have received culturally and linguistically responsive services previously. This work is tracked through the Establish SDOH Screening and Referral Process performance improvement project (PIP) which is currently focused on infrastructure building for SDOH screening and referrals. Through the PIP, CHA is evaluating, testing, and updating current processes for social needs screening, data capture, data sharing, and closed-loop referrals. During the process to update CHA's internal infrastructure, CHA will collaborate with local organizations and providers who are already screening members to limit duplicative efforts, establish data-sharing protocols, and increase usage of HKC for referring members to resources. CHA also utilized Social Determinants of Health (SDOH) data from other sources to identify both member level and community level needs. These data sources include, but are not limited, to Health Risk Assessments (HRAs), Klamath County Community Health Assessment, and Well-Being data through BlueZones RealAge Test. In 2022, CHA made limited progress on the HIT Roadmap activities themselves; however, CHA made great achievement in laying the foundation for work in 2023 and 2024. CHA spent 2022 focused on enhancing CHA's infrastructure and doing an initial high level environmental scan of work being done in the community. CHA's health equity department is the primary team responsible for moving SDOH screening and referral efforts forward. CHA's quality management department is the primary team responsible for incentive metrics, PIPs, and TQS, including the SDOH Screening and Referral Incentive Metric and PIP. On August 29th, 2022, CHA moved its health equity department from the member services department to the quality department. The increasing alignment between health equity and quality efforts and deliverables guided CHA's decision. Then, on January 26th, 2023, CHA moved its quality and equity department to Operations, previously it was in medical management. These moves allowed CHA to more easily operationalize health equity while enhancing alignment for optimum performance and success. After taking a deeper dive into the SDOH Screening & Referral Incentive Metric, CHA updated SDOH Screening and Referral plans and timelines as well as PIP target and benchmark dates to better align with the metric. This update affects the milestones of HIT as well. Activities are adjusted accordingly.

Planned Activities	**Planned Milestones**
1. Standardize internal workflows to ensure Healthy Klamath Connect (HKC) is the primary tool for closed-loop referrals and data captured in HKC is integrated with other data.	1. By Q4 2023, new process is established.

Strategy 2 title: Use data to identify individual members' SDOH experiences and social needs

Brief description: Integrate and utilize assessments within platforms for a holistic view of a member to guide person-centered care plans (In 2022 HIT Roadmap submission, this strategy was titled "SDOH Screening and Referring Strategy 2: SDOH Screening and Data Capture".)

Progress (including previous year accomplishments/successes and challenges with this strategy): All HIT to Support SDOH Needs strategies are intertwined and depend on one another. Since CHA is still in the development and implementation phases of enhancing SDOH work, the progress is similar for all strategies. Specifically related to this strategy and in alignment with OHA Project #61, Closed-loop Grievance System, TQS project, CHA created a member profile enhancement plan. The enhanced member profile will include SDOH, REALD, SOGI, and other types of quality data. Refer to "Support SDOH Needs Strategy 1 Care coordination and care management of individual members" for more details.

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 Q4 2023, 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 2023, new process is established.
3. Add SDOH data to member profile in [redacted] [new activity]	3. By Q2 2024, gap analysis completed to show differences between current member profile and Health Equity Dashboard 4. By Q4 2024, enhanced member profile completed
4. Explore pilot project with Collective Medical for SDOH Insights	5. By Q4 2023, have meeting with Collective Medical to scope project
Strategy 3 title: Collaboration with network partners Brief description: Enhance data sharing related to SDOH needs, screening, and referring data to better meet member needs and to decrease duplication. (In 2022 HIT Roadmap submission, this strategy was titled "SDOH Screening and Referring Strategy 3: SDOH Data Sharing [external]".)	
Progress (including previous year accomplishments/successes and challenges with this strategy): Data sharing is one of the more difficult SDOH items to accomplish. There is not clear guidance on how to share SDOH data in HIPPA rules. Additionally, both organizations and some members consider SDOH to be private information. Prior to establishing a path to share SDOH data, CHA needs to evaluate current agreements with network providers and community benefit organizations. If these agreements do not include SDOH data sharing, CHA will work with partners to update them. Additionally, if CHA finds additional partners to form agreements with, this will be done as well. Refer to Support SDOH Needs Strategy 1 Care coordination and care management of individual members for more details.	
Planned Activities	**Planned Milestones**
1. Review current SDOH data sharing agreements with network providers and community providers and, if needed, update current agreements, or create new agreements	1. By Q2 2023, review current agreements and identify if additional agreements are needed. 2. By Q4 2023, update 100% of current agreements (if needed). 3. By Q4 2023, 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. 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 Q4 2024, data is consistently shared amongst all applicable organizations.
Strategy 4 title: CCO metrics support Brief description: Utilize Healthy Klamath Connect, Reliance eHealth Collaborative, [redacted], [redacted], and other platforms to help meet the annual requirements of the SDOH Screening and Referral OHA Incentive Metric. Efforts are documented and project managed through the Establish SDOH Screening and Referral Process Performance Improvement Project (PIP).	
Progress (including previous year accomplishments/successes and challenges with this strategy): N/A (This is a new HIT Roadmap strategy; however, work has been occurring through other efforts. Refer to "Support SDOH Needs Strategy 1 Care coordination and care management of individual members" and "Support SDOH Needs Strategy 3 Collaboration with network partners" for more details.)	
Planned Activities	**Planned Milestones**
1. Establish SDOH Screening and Referral Process Performance Improvement Project (PIP)	1. In 2023 and 2024, submit quarterly report to OHA
2. Meet requirements for SDOH Screening and Referral OHA Incentive Metric	2. Q4 2023, CHA can attest to all Measurement Year (MY) 1 Must-Pass elements.

	3. Q4, 2024, CHA can attest to all MY2 Must-Pass elements AND report on sample population.
Strategy 5 title: Use data for risk stratification Brief description: Utilize SDOH data in the Health Equity Dashboard. The Health Equity 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 Health Equity 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.	
Progress (including previous year accomplishments/successes and challenges with this strategy): N/A (This is a new HIT Roadmap strategy; however, work has been occurring through other efforts. Specifically related to this strategy and in alignment with OHA Project #61, Closed-loop Grievance System, TQS project, CHA created a Health Equity Dashboard implementation plan. Refer to "Support SDOH Needs Strategy 1 Care coordination and care management of individual members")	
Planned Activities	**Planned Milestones**
1. Health Equity Dashboard implemented	1. Q4 2023
2. One project based on health disparity identified from Health Equity Dashboard completed	2. Q4 2023

2. Please describe your 2022 progress and 2023-24 plans for supporting contracted physical, oral, and behavioral health providers with using HIT 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 HIT in your community. In the spaces below, (in the relevant sections), please:
    1. Select the boxes that represent strategies pertaining to your 2022 progress and 2023-24 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. Provide a title and description of each strategy CCO implemented in 2022 and/or will implement in 2023-24 to support contracted physical, oral, and behavioral health providers, as well as social services and CBOs with using HIT to support social needs, including but not limited to social needs screening and referrals.
    4. Describe the 2022 progress of each strategy in the appropriate narrative sections. In the descriptions, include:
        a. accomplishments and successes (including the number of organizations of each provider type that gained access to HIT to support SDOH needs as a result of your support, as applicable), and
        b. challenges related to each strategy, as applicable.
    5. Describe activities and milestones related to each strategy CCO plans to implement in 2023-24.

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 2022, note 'N/A' in Planned Activities and Planed milestones sections.
- If CCO is implementing a strategy beginning in 2023, 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 checkboxes

Using the boxes below, please select which strategies you employed during 2022 and plan to implement during 2023-24. Elaborate on each strategy and your progress/plans in the sections below.

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

HIT tools supported or provided by CCO that support SDOH needs, including but not limited to screening and referrals

List and briefly describe tools:

- Refer to "HIT tools used by CCO for Support of SDOH needs" section for list of tools.

Strategy 1 title: Sponsor CIE for the community
Brief description: Sponsor Healthy Klamath Connect for the community to use as a SDOH search tool and referral platform. (In 2022 HIT Roadmap submission, this strategy was included in the strategy titled "SDOH Screening and Referring Strategy 1: Care Coordination [external]".)

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).

Planned Activities	Planned Milestones
1. Sponsor Healthy Klamath Connect	1. 2023-2024

Strategy 2 title: Training and/or technical assistance
Brief description: 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. (In 2022 HIT Roadmap submission, this strategy was included in the strategy titled "SDOH Screening and Referring Strategy 1: Care Coordination [external]".)

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 2022, 22% (51 of 230) of local programs are claimed. With increased training and awareness efforts in 2022, 19 new local programs were claimed in 2022 compared to 4 claimed in 2021 and 25 claimed in 2020. Of note, the implementation of Healthy Klamath Connect was in 2020. In partnership with FindHelp, CHA hosted four HKC trainings for community partners during 2022. 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. For the Intro to Healthy Klamath Connect 101 training held on April 4, 2022, 33 community partners completed the training. For the Intro to

Healthy Klamath Connect 201 training held on April 25, 2022, 18 community partners completed the training. For the Intro to Healthy Klamath Connect 101 + 201 training held on September 26, 2022, 5 community partners completed the training. And, for the Intro to Healthy Klamath Connect 101 + 201 training held on December 7, 2022, 21 community partners completed the training.

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 local programs are claimed.
2. CHA offer scheduled trainings and technical assistance to community partners. Topics include how to claim program, how to use platform once program is claimed, how to help community members use platform as a search tool and self-referral platform, reporting capabilities, and closed-loop referral capabilities.	2. By Q4 2023, at least two community trainings completed outside of regularly scheduled meetings. 3. By Q4 2023, review and update Healthy Klamath Connect training that is included with annual Provider Network Training. 4. 2023-2024, provide technical assistance as needed

Strategy 3 title: Assessment/tracking of adoption and use
Brief description: Integrate and utilize assessments within platforms including Healthy Klamath Connect and [redacted]. (In 2022 HIT Roadmap submission, this strategy was included in the strategy titled "SDOH Screening and Referring Strategy 2: SDOH Screening and Data Capture [external]".)

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): After initial, high-level environmental scan, CHA identified multiple primary care clinics, care management departments, social service organizations, and CBOs complete various types of SDOH screening. A couple organizations were starting to develop and implement new methods to capture the data for better tracking and reporting. In alignment with the SDOH Screening and Referral OHA Incentive Metric, CHA will do a full environmental scan in 2023 to better identify how screenings are captured in the various platforms Healthy Klamath Connect and [redacted]. This environmental scan will help guide future work. In 2022, 52% (86 of 165) of referrals within Healthy Klamath Connect were closed loop referrals. The remaining referrals had been responded to outside of HKC, so data is not available.

Planned Activities	**Planned Milestones**
1. Work with clinic and community partners to ensure their screenings are captured within a platform that has reporting capabilities	1. By Q4 2023, complete environmental scan 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 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
Brief description: 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. (In 2022 HIT Roadmap submission, this strategy was included in the strategy titled "SDOH Screening and Referring Strategy 1: Care Coordination [external]".)

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 2022, CHA brought awareness to social services and CBOs through training opportunities and direct outreach. CHA made sure clinical providers and community members were aware of Healthy Klamath Connect during meetings and the annual provider network training. All new member packets include a Healthy Klamath Connect flyer. CHA passed out flyers at community events. Both the Healthy Klamath website and CHA

website have links to the Healthy Klamath Connect page. CHA is leading activities related to Healthy Klamath Connect are included in the health promotion: access to care focus area of the 2022 Klamath County Community Health Improvement Plan (CHIP). During the 2022 calendar year, the Klamath Falls community used HKC for 3,811 searches for social needs services to aid in a variety of searched topics. Health, housing, and food were the top three categories for searches. CHA intends to continue ramping up outreach efforts in 2023.

Planned Activities	**Planned Milestones**
1. Expand member awareness and education about Healthy Klamath Connect	1. By Q4 2023, CHA will add a link to Healthy Klamath Connect on CHA's homepage for quicker access to it. 2. By Q2 2023, all new member calls include information about Healthy Klamath Connect 3. By Q4 2023, an annual CHA staff training is implemented 4. By Q4 2024, members will receive two text messages a year that include a link to Healthy Klamath Connect.
2. Expand community partner awareness and education about Healthy Klamath Connect	1. By Q4 2023, an annual CareTalk, provider newsletter, Health Klamath Connect article is written 2. By Q4 2023, review and update Healthy Klamath Connect training that is included with annual Provider Network Training. 3. By Q4 2024, Healthy Klamath Connect is discussed at least annually during the following external CHA lead meetings: metrics workgroup (primary care representatives), behavioral health meeting, and oral health provider check-ins 4. By Q4 2023, attend at least one regularly scheduled community meeting per quarter to provide information about
3. Expand community awareness about Healthy Klamath Connect	1. At community events during 2023 and 2024, continue to hand out Healthy Klamath Connect flyers and provide a live demo of the platform 2. By Q4 2024, Healthy Klamath Connect banner is displayed across Main St. at least annually 3. By Q4 2024, Healthy Klamath Connect article is included in at least two community publications annually (like LivingWell and ActiveSeniors) 4. By Q4 2024, complete CHIP activities 5. By Q4, 2024, a local digital billboard regularly has information about Health Klamath Connect

Strategy 5 title: Enhancements to CIE tools (e.g., adding new functionality, health-related services funds forms, screenings, data sources)
Brief description: Explore the addition of SDOH screenings in Healthy Klamath Connect as a tool to collect and share screening data

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): N/A

Planned Activities	**Planned Milestones**
1. Explore utilization of Healthy Klamath Connect for screenings	1. Q4 2023

Strategy 6 title: Integration or interoperability of HIT systems that support SDOH with other tools

Brief description: Explore the interoperability of Healthy Klamath Connect with HIT systems already utilized in Klamath, including but not limited to [redacted], Reliance, [redacted], and Collective Medical
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): N/A

Planned Activities	**Planned Milestones**
1. Explore the interoperability of Healthy Klamath Connect with [redacted], Reliance, [redacted], and Collective Medical	1. Q4 2023

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 HIT to support SDOH needs, including but not limited to screening and referrals.
Increasing requirements, staffing changes and bandwidth limited the amount of engagement, awareness, and TA CHA could provide in 2022. Additionally, HIT system limitations as well as limited agreements in place for SDOH data sharing slowed efforts.

B. Optional Question

How can OHA support your efforts in using and supporting the use of HIT to support SDOH needs, including **social needs screening and referrals?**
Continue to provide guidance or best practices related to sharing SDOH data across organizations. Support from OHA on other CIE platforms utilized in Oregon. It appears that UniteUs/Connect Oregon is the only CIE platform recognized by OHA. Is OHA's strategy to support one CIE platform and have all CCO's using it?

6. Other HIT Questions (Optional)

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

A. Describe CCO HIT tools and efforts that support **metrics**, both within the CCO and with contracted providers. Include CCO challenges and priorities in this work.
One of the challenges with HIT related to metric support, is the change in metrics yearly that leads to additional technical administration support needed to build new reporting.
B. Describe CCO HIT tools and efforts that **patient engagement**, both within the CCO and with contracted providers.
C. How can **OHA support** your efforts in accomplishing your HIT Roadmap goals?
D. What have been your organization's **biggest challenges** in pursuing HIT strategies? What can OHA do to better support you?
Challenges with FHIR implementation has been a major challenge in pursuing HIT strategies. With increasing OHA Deliverable and contractual requirements, recommend consolidating deliverables and audit activities as much as possible.
E. How have your organization's HIT strategies supported **reducing health inequities**? What can OHA do to better support you?