COMMUNITY INFORMATION EXCHANGE LANDSCAPE IN WASHINGTON

SEPTEMBER 2022

Washington State Health Care Authority

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1. Executive summary

The Washington State Health Care Authority (HCA) is proposing the implementation of a statewide Community Information Exchange (CIE) to improve health outcomes and reduce health disparities; this is consistent with the objectives of the Medicaid Transformation Project (MTP).[1] As the first step in this direction, HCA has been directed by a 2022 Supplemental Budget proviso[2] to work with various stakeholders and partners (e.g., health plans, Accountable Communities of Health, tribes, Community-Based Organizations) to build a perspective on existing CIE capabilities and forward-looking expectations from a statewide CIE solution.

To fulfill the proviso requirements, HCA has designed an approach that includes three phases – CIE landscape review, CIE strategic options development, and ongoing planning.

CIE landscape review	Interviewing/surveying stakeholders and partners to gather a fact base on current CIE investments, pain points, implementation challenges and expectations from HCA in implementing a statewide CIE solution; fact-based overview of select CIE market solutions
CIE strategic options	Outlining potential design choices that HCA could consider when planning the implementation of the statewide solution in Washington
Ongoing planning	Engaging stakeholders and partners on a continuous basis in the design and implementation of the statewide CIE solution

Current state in Washington: As part of the landscape review, HCA conducted 19 interviews (nine ACHs, five Managed Care Organizations, three HHS Coalition Agencies – Department of Health, Department of Children, Youth and Families and Department of Social and Health Services, two CBO sessions arranged with partner ACHs), two information sharing webinars with participation across different stakeholder and partner groups, and two Tribal Partner listening sessions.[3] Additionally, HCA received 81 completed survey responses by the close date of August 16, 2022 to collect feedback from CBOs, Safety Net Providers, Professional Organizations, and Tribes. The following is a summary of findings and insights based on the input received across these sessions and surveys:

CIE investments: Statewide stakeholders and partners have adopted different strategies and solutions to support community-based care coordination around Health-Related Social Needs (HRSN). At least four ACHs, five MCOs, and one HHS coalition agency (DOH) have invested in a CIE solution. Among organizations that have not invested in CIE platforms, organizations have conducted landscape reviews, run pilots, and invested in building a strong community-based workforce to help coordinate care.[4]

Pain points: Information on ACH and MCO pain points was collected using interviews. Eleven key themes emerged when stakeholders were asked about CIE related pain points during these interviews:[5]

[1] HCA MTP renewal application: https://www.hca.wa.gov/assets/program/wa-mtp-renewal-application-draft.pdf
[2] 2022 supplemental budget proviso language (CIE)
[3] A Tribal listening session is a meeting including Tribal representatives and representatives from State or Federal agencies with the purpose of sharing and gathering information between parties. (source: https://www.bia.gov/service/tribal-consultations/what-tribal-listening-session#:~:text=A%20Tribal%20listening%20session%20is,formal%20than%20Tribal%20consultation%20sessions.)
[4] Source: ACH, MCO and HHS Coalition Agency interviews. Please refer to Section 3 for additional information on data gathering methodology
[5] Source: ACH and MCO interviews. Please refer to Section 3 for additional information on data gathering methodology

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Barriers to connecting patients to appropriate care resources as expressed by statewide stakeholders and partners:

- Availability of care resources in local community
- Access to information on currently available local resources
- Prioritizing care for the highest need groups
- Access to information about care received from other providers
- Compliance with data sharing regulations and standards
- Availability of up-to-date data on population health and needs

Barriers to implementing new community-based care coordination systems as expressed by statewide stakeholders and partners:

- Technological and logistical barriers to creating a CIE system
- Buy-in from key stakeholders and partners
- Community-based care coordination processes creating resource and capacity burden for partner organizations
- Securing sustainable, long-term funding for community-based care coordination
- Prioritizing patient experience and relationships during the community-based care coordination process

Across these 11 themes, more than 50% of ACHs and MCOs noted access to information on currently available local resources, compliance with data sharing regulations and standards, and added burden on partner organizations from community-based care coordination systems (e.g., multiple data entry) as pain points. Additionally, more than 50% of ACHs highlighted availability of care resources, technology barriers, and stakeholder/ partner buy-in as pain points. More than 50% of MCOs also noted access to information about care received from other providers as a pain point. In interviews, MCOs did not mention technological barriers or funding as potential pain points (Exhibit 1).

Exhibit 1: Pain points described by ACHs and MCOs, ordered by frequency of mentions in interviews

Response frequency: >50% of respondents; 26-50% of respondents; 1-25% of respondents; 0% of respondents

"Pain points" described by ACHs and MCOs	ACHs (9 interviews)	MCOs (5 interviews)
IX. Resource and capacity burden from running community-based care coordination processes	7	5
II. Access to information on currently available local resources	7	3
V. Compliance with data-sharing regulations and standards	7	3
VIII. Buy-in from key stakeholders and partners	8	2
I. Availability of care resources in local community	5	2
IV. Access to information about care received from other organizations	4	3
VII. Technological and logistical barriers to creating a CIE system	6	0
XI. Prioritizing patient experience and relationships	4	2
III. Prioritizing care for the highest need groups	3	2
VI. Availability of up-to-date data on population health and needs	3	1
X. Securing sustainable, long-term funding for community-based care coordination	4	0

Source methodology: ACH and MCO interviews as of August 22, 2022. "Pain points" were assessed based on interviews with representatives from each stakeholder group and include all "Pain points" mentioned at least once. The "Pain points" are not listed in order of priority.

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Input on pain points for Tribes and Indian Health Care Providers (IHCPs) was collected through two listening sessions held on August 10 and 17, 2022. The pain points discussed during those open forums aligned with the 11 pain point themes from the ACH and MCO interviews discussed above. Four of those pain point themes emerged in both listening sessions: availability of care resources in local communities, access to population-level HRSN data, technological and logistical barriers to implementing community-based care coordination platforms, and resource and capacity burden on partner organizations from participating in community-based care coordination ecosystems. Nine of the eleven pain points were discussed in at least one tribal listening session; the two exceptions were prioritizing care for the highest need groups and prioritizing patient experience and relationships in a community-based care coordination system.

Information on pain points for CBOs, Safety Net Providers, professional organizations, and other organizations (e.g., local and regional health departments, universities and research institutions, hospitals, resource directories and call centers, law enforcement, not-for-profit care centers, CIE technology vendors, etc.) was collected through a CIE survey, supplemented by other input methods including webinars and two CBO group interviews. The survey asked two questions around pain points: (a) What pain points do you currently face around connecting patients to appropriate health and social services? and (b) Which of the below do you anticipate will be challenges in implementing and using a CIE solution? There was a wide variance in responses for the first question; lack of closed-loop referral, lack of a consistent system/process for connecting patients to appropriate care, and ineffective data sharing capabilities were stated as the most frequent pain points by survey participants. For the second question, all four options were seen as being important implementation challenges for HCA to consider (Exhibit 2).

Exhibit 2: Pain points described by surveyed stakeholders, organized by response frequency

Response frequency: >50% of respondents; 26-50% of respondents; 1-25% of respondents; 0% of respondents

Survey question	"Pain points" described by surveyed stakeholders	CBOs (30 responses)	Professional organizations (18)	Safety net providers (14)	Other (19)
Current barriers to connecting patients with appropriate care (top 3)	Lack of closed-loop referral	14	9	5	12
	Lack of a consistent system / process for connecting patients to appropriate care	12	11	6	8
	Ineffective data sharing capabilities across the health and social services ecosystem	12	11	4	8
	Limited number of community-based health and social services available	13	8	5	8
	Health disparities for vulnerable populations	11	3	2	4
	Lack of awareness of resources available	8	3	1	2
	Other "pain points"	4	2	3	6
	Ineffective matching to community resources based on identified needs	2	3	1	3
Anticipated barriers to implementing CIE	Resources to support a CIE	18	14	7	15
	Adequate and consistent funding to support a CIE implementation	18	13	6	15
	Organizational adoption of a CIE in the local community	16	8	4	15
	Privacy or security concerns for patient data sharing	12	9	5	9
	Other implementation barriers	4	1	2	0

Role of HCA: Across all the interviews conducted, stakeholders were asked about the role HCA could play in implementing a statewide CIE solution in support of the Medicaid Transformation Project (MTP). Respondents stated the following as potential roles for HCA to play:

- Provide sustainable funding support to build and maintain a CIE solution
- Provide funding to build and develop a strong community-based workforce at the local level
- Set and disseminate statewide standards on data security, data capture, and reporting in compliance with all key regulations (e.g., HIPAA, FERPA, 42 CFR Part 2)

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- Analyze statewide data to identify care gaps based on a co-designed strategy with local stakeholders and partners (e.g., state vs. local ownership of data, frequency of data share)
- Build statewide data sharing agreements to help reduce the expense and effort of local organizations negotiating individual contracts
- Act as a convener across the ecosystem to actively engage stakeholders and partners, set a shared language around CIE, and create opportunities for cross-sector interaction (e.g., sharing of best practices)
- Invest in inter-CIE interoperability as a key feature of community-based care coordination given the current ecosystem of multiple CIE systems in use across different stakeholder and partner groups
- Provide statewide guidance and standards on HRSN screening to promote consistency in case management and referrals

Market scan of select vendors: Separately, to provide an overview of currently available market solutions, the CIE planning team interviewed external industry experts and conducted a search of publicly available information. To date, the market scan identified four CIE solutions, namely Unite Us, Findhelp (formerly Aunt Bertha), WellSky Social Care Coordination (formerly Healthify), and Care Coordination Systems (CCS).[6] Additionally, select potential alternatives to CIE were identified, including resource directories, case management platforms, data analytics solutions, and CIE solution as an extension of an existing Health Information Exchange (HIE).

2. Context and objectives: Planning statewide CIE in Washington

2.1 What is the background on the HCA CIE planning project and how is it linked to Washington's Medicaid Transformation Project (MTP)?

The Washington State Health Care Authority (HCA) recently submitted Washington's Medicaid Transformation Project (MTP) waiver renewal application to the Centers for Medicare & Medicaid Services (CMS). With the proposed MTP 2.0, the focus is on continuing to improve health outcomes and reducing health disparities through three key goals[7]:

1. **Expanding coverage and access to care** through strategic expansion of Medicaid coverage across life stages and for high-risk and historically marginalized populations
2. **Advancing whole-person primary, preventive, and home and community-based care** beyond the clinical setting through innovative policy and funding mechanisms
3. **Accelerating care delivery and payment innovation focused on Health-Related Social Needs (HRSNs)** like nutrition, housing, transportation, education, and social supports

In relation to goal 3, HCA is proposing the implementation of a statewide Community Information Exchange (CIE) solution which can effectively address growing needs for services supporting communities and patients requiring food assistance, job assistance, housing, transportation, and other social supports. Prior to issuing a request for proposals (RFP) or beginning a CIE implementation, a proviso in the 2022 Supplemental Budget[8] appropriates funding and directs HCA to accurately assess the impact of cost and implementation, as well as cross-CIE data interoperability needs of a statewide CIE, informed by consultation with various partners and stakeholders (e.g., HHS Coalition, CBOs, health plans, ACHs, and safety net providers).

[6] This is not an exhaustive list and solutions were identified through publicly available research and experts in the area
[7] HCA MTP renewal application: https://www.hca.wa.gov/assets/program/wa-mtp-renewal-application-draft.pdf
[8] 2022 supplemental budget proviso language (CIE)

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Exhibit 3: 2022 supplemental budget proviso language (CIE)

2022 supplemental budget proviso language (CIE)

Section 211 (113)

(a) $500,000 of the general fund—state appropriation for fiscal year 2023 and $1,500,000 of the general fund—federal appropriation are provided solely for the authority, in consultation with the health and human services enterprise coalition, community-based organizations, health plans, accountable communities of health, and safety net providers, to determine the cost and implementation impacts of a statewide community information exchange (CIE). A CIE platform must serve as a tool for addressing the social determinants of health, defined as nonclinical community and social factors such as housing, food security, transportation, financial strain, and interpersonal safety, that affect health, functioning, and quality of-life outcomes.

(b) Prior to issuing a request for proposals or beginning this project, the authority must work with stakeholders in (a) of this subsection to determine which platforms already exist within the Washington public and private health care system to determine interoperability needs and fiscal impacts to both the state and impacted providers and organizations that will be using a single statewide community information exchange platform.

(c) This subsection is subject to the conditions, limitations, and review requirements of section 701 of this act.

One definition of CIE, from HealthierHere ACH, "is a network of cross-sector partners – social service, community, tribal, government, physical and behavioral health organizations – who commit to coordinating care so that patients have better access to the care and supports they need to improve their health. Partners access a shared network database where they contribute to a single longitudinal client record, share information, and make bi-directional closed-loop referrals."[9] The process of developing and refining a shared CIE definition is ongoing, and one objective of this landscape review is to gather input to help inform shared language and terminology.

A CIE platform may include functionalities such as a resource directory, closed-loop referral, community health records, event notification, and user-based access. Using these capabilities, the CIE solution will be used to:

- Help aid the coordination of and connection to necessary community resources
- Provide a network of partners to identify and screen for HRSN, share data, and close referrals
- Assist with data analytics of health-related services

2.2 What is the overall CIE planning approach?

To advance the CIE planning effort, HCA has identified an approach that includes the following 3 stages: CIE landscape review, strategic options development, and ongoing planning. Each of these stages include several discrete activities to support the CIE strategy development.

The first stage is to **scan the current CIE landscape in Washington** by gathering a fact base on the partners and stakeholders impacted by a statewide CIE solution. As part of this landscape review, there will be an assessment of existing CIE investments within Washington. The landscape review will summarize stakeholder and partner input on pain points and future expectations from a statewide CIE solution. In addition, it will provide information on select CIE vendor solutions available in the market with a view of their capabilities, licensing options, and case examples from past implementations. Perspectives will be gathered via 20+ interviews and a survey across various stakeholder groups (e.g., HHS Coalition representatives, ACHs, MCOs, CBOs, Professional Organizations, and Safety Net Providers) and Tribal partners.

[9] https://www.healthierhere.org/cie/

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The second stage is to **identify strategic options on a statewide CIE strategy**. This stage will serve to highlight key design choices impacting the rollout and implementation of a statewide solution in Washington. For each design choice, there will be multiple alternatives with information on pros and cons along evaluation criteria (e.g., ability to meet objectives and vision for CIE; adoption from key statewide partners; and cost, technological feasibility, and governance feasibility).

The last stage is **ongoing planning,** during which phase HCA will continue to engage in a collaborative, cross-functional dialogue with stakeholders and partners in the state to inform the CIE planning effort.

2.3 Who are the core stakeholders and partners as identified by HCA?

The 2022 Supplemental Budget proviso identified different stakeholders and statewide partners that could potentially be impacted by a statewide CIE implementation.[10] The approach to collecting perspectives from these groups is split into three stages: input and review, planning and strategy, and authority and funding.[11]

Input and review: In this stage, HCA has identified stakeholders such as ACHs, MCOs, HHS Coalition agencies, professional organizations (e.g., Washington Academy of Family Physicians (WAFP), Washington State Medical Association (WSMA), Washington State Hospital Association (WSHA), etc.), CBOs, and safety net providers (e.g., Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs)), along with statewide partners including Tribes and Indian Health Care Providers (IHCPs). Each of these partner and stakeholder groups were engaged through interviews or surveys to gather input as part of the Landscape Review. Additionally, the partners and stakeholders will be consulted for input and review of identified CIE strategic options and recommendations.

Planning and strategy: As part of the CIE planning effort, HCA will collaborate with the HHS Coalition CIE Advisory Groups (e.g., DOH, DSHS, DCYF), CIE Planning Steering Committee, and CIE Health Services Consultant to coordinate the statewide planning and outreach to all stakeholders and partners.

Authority and funding: HCA will engage agency leadership, legislative staff, the Office of Financial Management (OFM), funding sources, and the Office of the Chief Information Officer (OCIO) to review the statewide CIE strategy, including fiscal impacts to the identified stakeholders and partners.

[10] 2022 supplemental budget proviso language (CIE)
[11] Source: Exhibit 2.

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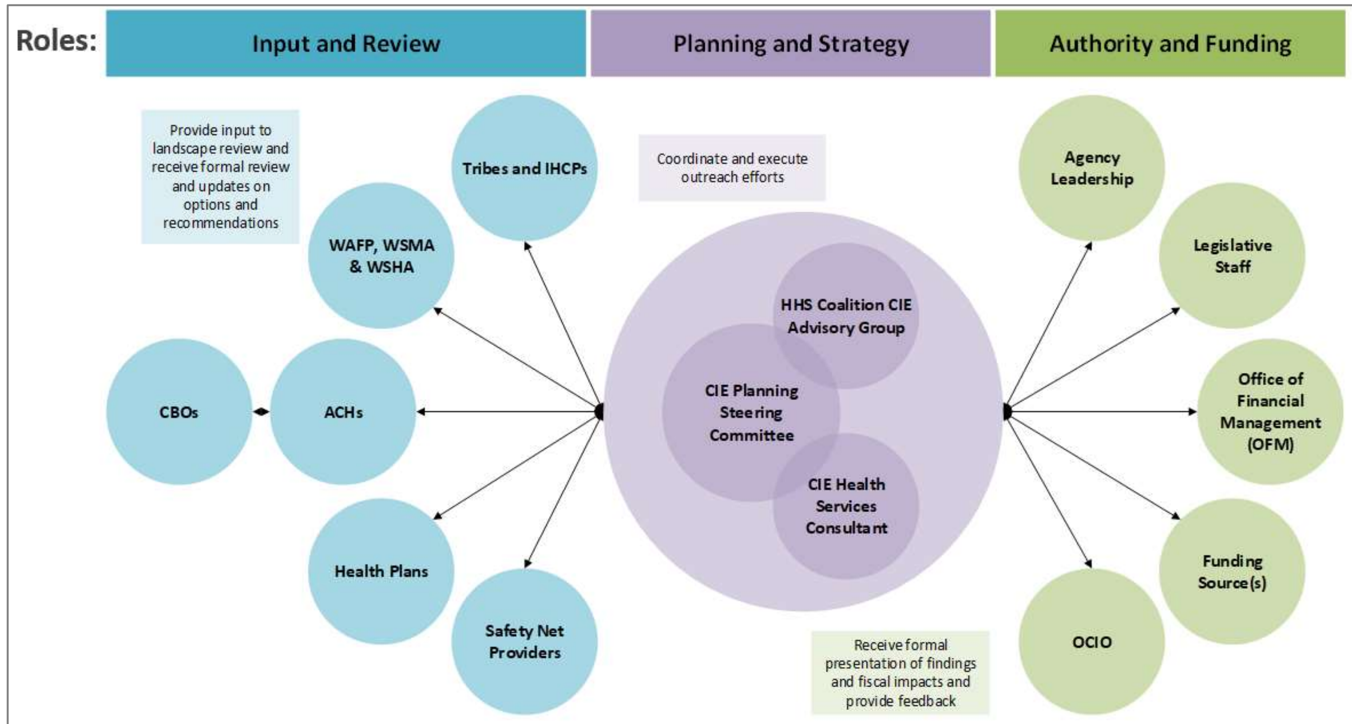
Exhibit 4: Key stakeholders and partners identified as part of HCA CIE planning project[12]



3. Landscape assessment methodology

3.1 Approaches for information gathering

Information on the CIE landscape was collected both internally from statewide partners and stakeholder groups using interviews, surveys, listening sessions, and webinars and externally through interviews with external experts and searches of publicly available materials on CIE solutions.

Interviews: One-hour interviews were conducted with representatives from each of the ACHs, MCOs, and HHS Coalition agencies. The goal of the interviews was to gather input regarding: current investments in and implementation of CIE systems; pain points in connecting patients to appropriate care; and perspectives on the desired future implementation of a state-level CIE solution, including HCA's role in that ecosystem. Additionally, ACHs had the opportunity to convene representatives from CBOs operating in their region as part of a second interview. The CBO interviews had the same overall goals, with an emphasis on pain points and desired future state for a CIE solution. A list of interviews completed along with sample interview questions is included in the appendix (exact questions differed based on the context of each interview).

Survey: A CIE survey was distributed to stakeholders throughout Washington to gather responses from members of CBOs, professional organizations, and safety net providers (including RHCs, FQHCs, and other providers), among other groups. The five-question survey used a combination of multiple choice and open text questions to collect structured input on: current pain points in community-based care coordination; specific desired features from a state-level CIE solution; anticipated challenges in implementing CIE; any existing investment in CIE; and any other considerations on CIE. The full CIE survey is included in the appendix.

[12] Source: HCA CIE Planning Team

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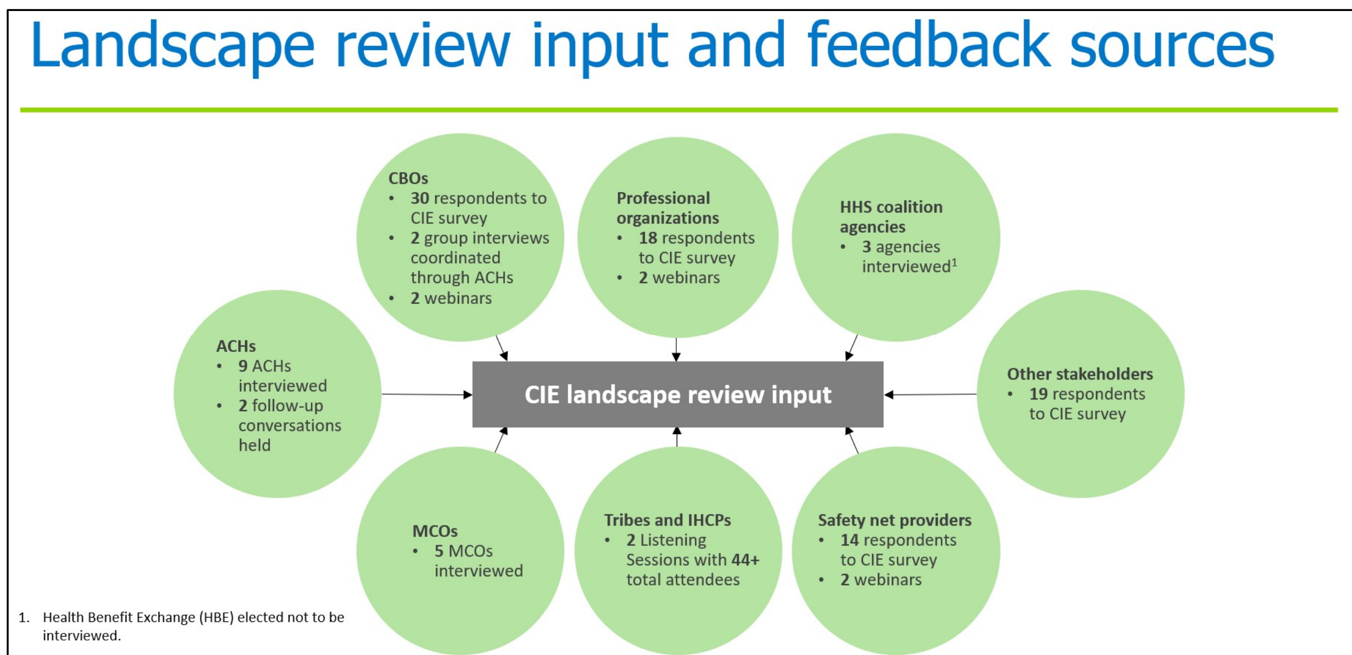
Tribal Listening Sessions: Two Tribal listening sessions were organized to share information on the HCA CIE planning project and to gather input from Tribe members around CIE implementation in Washington. A list of interview questions used during the listening sessions is included in the appendix

Webinars: Two webinars were held to disseminate information on the CIE planning effort and to gather additional feedback from the stakeholders (e.g., CBOs, safety net providers and advocates) in attendance.

Additional materials: Select stakeholders shared materials with the CIE planning team that provided additional context on current use of CIE regionally, frameworks for defining and creating shared language for CIE, and challenges around CIE implementation. These materials were reviewed and synthesized into the overall landscape findings.

Exhibit 5: Information gathering methods and response levels by stakeholder and partner group[13]



Additionally, a market scan was conducted to identify current CIE vendor solutions. This scan involved a press-search[14] of publicly available online materials and interviews with external experts. For each solution, information was gathered on core capabilities and past implementations. Interview topics covered only publicly available product information and outward-facing perspectives on CIE products.

3.2 Methods for analysis

In developing the landscape review, information was analyzed and synthesized as follows:

On current CIE investment in Washington, responses from interviews with ACHs, MCOs, and HHS coalition agencies were synthesized into sections describing each organization's current approach to community-based care coordination. The interview responses were supplemented, where applicable, by additional information provided offline by select interviewees and publicly available information (e.g., organization's website, website of the CIE vendors being used by the organization, etc.).

For analysis of pain points, open-ended responses across all information sources (e.g., interviews, open-text survey responses, listening session comments, etc.) were analyzed in aggregate by partner or stakeholder group.

[13] Source: Exhibit 21 (interview schedule).

[14] Press search refers to research of secondary materials that are publicly available

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For expectations for the HCA role in future CIE implementation, open-ended responses were analyzed in aggregate across all partners and stakeholders. Survey responses were analyzed separately.

For the market scan of CIE vendor solutions, information was synthesized from publicly available sources (including vendor websites, customer websites, etc.) and supplemented with information from interviews with external experts.

4. Current investment in CIE in Washington

Washington's nine ACHs, five MCOs, and three of the five HHS coalition agencies have taken a wide array of strategies toward coordinating care for their patients and constituents. At least three ACHs, five MCOs, and one HHS coalition agency have invested in a CIE vendor solution to enable community-based care coordination, based on interviews with representatives from each group.[15] Among organizations that have not invested in CIE platforms, at least three ACHs have conducted landscape reviews within their regions to understand current use of CIE and the needs of their communities.[16] The following sections document current implementation of CIE for each ACH, MCO, and HHS coalition agency in Washington.

Exhibit 6: Summary of current CIE platform investments in Washington by stakeholder group[17]

	Category of investment	ACHs	MCOs	HHS coalition agencies
Investments in CIE technology platforms	Unite Us	1	1	
	Findhelp		4	
	Care Coordination Systems (CCS)	2		1
	Innovaccer	1		
	Help Me Grow			1[18]
Investments in community-based care coordination among groups without a CIE technology investment[19]	Investment in network of community-based workers to coordinate care	4		
	CIE exploratory phase (e.g., landscape conducted, roadmap established, etc.)	3		
	No formal investment in CIE			1

4.1 Current implementation of CIE: ACHs

4.1.1 Better Health Together (BHT)

Better Health Together has invested in building infrastructure for community-based care coordination, with roughly one third of waiver funding from the original MTP waiver going toward regional care infrastructure. The organization has emphasized screening for HRSNs, especially from primary care providers, of whom 80-85% are currently screening patients for HRSN considerations. Rather than using a single technology platform for

[15] See section 3 for additional details on information gathering approaches.
[16] Source: Interviews with ACH, MCO, and HHS coalition agency representatives.
[17] The investments may be at different levels of maturity across the set of stakeholders and partners interviewed (e.g., two organizations that have invested in CIE technology platforms may not have developed the same community-based care coordination capabilities or reached the same targets for adoption of their CIE solutions).
[18] Based on interview with DCYF representatives, the organization uses Help me Grow as a resource directory tool but has not implemented a broader CIE platform
[19] The totals in these rows include only the investments discussed during interviews with representatives from the ACHs, MCOs, and HHS coalition agencies. Investments not discussed in the interviews may not be reflected in this summary table or the following descriptions. Note also that the categories in this section are not mutually exclusive

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screenings, BHT has implemented a bottom-up approach, supporting partner organizations in developing their own screening and partnership systems. BHT is also conducting a comprehensive landscape review in partnership with Mathematica to understand community-based care coordination needs in the region. An ongoing goal is to improve care equity by building capacity and understanding needs in Black, Indigenous, and people of color (BIPOC) communities.[20]

4.1.2 Cascade Pacific

Cascade Pacific has explored multiple systems and platforms for implementing CIE in the region. First, the ACH partnered with Washington 2-1-1[21] and local organizations in a program to ensure that the data in regional resource directories was up to date, with funding partially provided through United Way to gather and update information on available resources. Both Cascade Pacific and United Way then migrated to Unite Us,[22] which had a growing presence in the region through the vendor's partnership with Kaiser Permanente. The Unite Us tool is currently available at no cost to many partner organizations in the community, with advocates bringing information on the platform to local forums to help onboard new CBOs and articulate the value of CIE.[23] Many groups in the region currently rely on staff members at providers and CBOs to identify available services to update internal resource directories and make referrals directly to their contacts at trusted partner organizations.[24]

Cascade Pacific is also a Pathways Hub,[25] using Care Coordination Systems (CCS)[26] as an implementation platform. The Hub is often used as a platform to give trainings for community members to support community-based care coordination capabilities (e.g., regarding HIPAA compliance for data sharing). The tool also uses a directory provided by the DOH listing COVID-19 care resources and provides a tool to screen for eligibility for care and for financial benefits related to the pandemic.[27]

4.1.3 Elevate Health

Elevate Health is a Pathways Hub, using an Innovaccer platform to support community-based care coordination (although previously the Hub has used other tools, including CCS and SpectraMedix). Elevate Health has worked with Innovaccer to customize and expand its Pathways system to include a closed-loop referral tool available to all partner organizations.[28] The closed-loop referral requires partners to use the Innovaccer platform, with back-end data interoperability available for other elements of the community-based care coordination tool, which also allows partner organizations to share patient notes, updates on care received, and current needs.[29]

The ACH has recently undertaken an effort to create a shared data resource, making population-level data on care and resources available to the public. Elevate Health is exploring multiple implementation pathways for the nascent program. The organization has also laid the groundwork for future data sharing agreements, working

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[20] Source: Better Health Together interview, July 26, 2022
[21] 2-1-1 Washington is a statewide resource directory with over 30,000 listings and a call center that can direct patients to care resources. (source: https://wa211.org/)
[22] See section 6 of the review for more details on the Unite Us platform.
[23] Source: Cascade Pacific interview, August 4, 2022
[24] Source: Cascade Pacific interview, August 4, 2022
[25] Pathways Community HUB is a model for community-based care coordination involving functionality to centrally track individual patient progress, monitor performance for Hub workers, improve health for historically underserved populations, and track organizational performance. (source: https://www.ahrq.gov/sites/default/files/wysiwyg/innovations/CommunityHubManual.pdf)
[26] See section 6 of the review for more details on CCS' CIE technology platform.
[27] Source: Cascade Pacific interview, August 4, 2022
[28] Source: Elevate Health interview, August 4, 2022
[29] Source: Elevate Health interview, August 4, 2022

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with a legal consultant experienced in CIE to develop templates and frameworks for legal documents and Data Use Agreements (DUAs).[30] [31]

4.1.4 Greater Health Now

Greater Health Now is developing a strategy for establishing a community-based care coordination hub. The ACH is one of two in Washington that does not operate as a Care Connect Washington Hub administrator;[32] the Hub for the region's nine counties is currently administered by Providence St. Mary Medical Center, which implements CCS as the Hub platform. Multiple other CIE technologies are currently active in the region, with one group implementing Unite Us in multiple counties and Yakima County employing its own community-based care coordination platform and referral system. To coordinate care for patient HRSNs, Greater Health Now works with seven Local Health Improvement Networks (LHINs), which are formalized groups of community-based workers who interface and collaborate with CBOs to address local HRSN needs.[33] [34]

4.1.5 Healthier Here

HealthierHere ACH has established a CIE system called Connect2 Community Network. Priorities for the initial functionality of the CIE include enabling data integration and interoperability across partner organizations, supporting bi-directional closed-loop referrals, and creating a shared resource directory. HealthierHere partnered with Unite Us in 2020 to implement the CIE technology platform, with an initial focus on bidirectional referral capability. The ACH initially supported onboarding to Unite Us by sharing information on the platform with community partners. In 2021, HealthierHere established the Catalyst Fund, which offered funding to partner organizations to support adoption of the Unite Us platform. The Fund provided financial support to partner organizations in two cohorts, with 49 funded organizations onboarding to Unite Us by July 2021. By October 2021, at least 41 of the organizations had sent or received at least one referral through the Unite Us platform.

HealthierHere's roadmap for CIE implementation has been informed by input from partner organizations on their community-based care coordination needs. The ACH governs the CIE and monitors and manages the network for King County Unite Us users, and co-leads partner outreach with Unite Us. The vendor also provides technical support for users in King County. In 2022, HealthierHere has focused on building its unified network infrastructure, which includes a client index, resource database, tools for coordinating care teams, and longitudinal patient records. A future implementation priority is to connect additional technology platforms to the infrastructure.

The ACH has gathered feedback from partner organizations throughout the CIE technology rollout to understand both the benefits of the system and challenges to implementation. The ACH has also established milestones and metrics for platform adoption by partner organizations. Organizations reach the first milestone, called "Engage", by registering as a partner with Unite Us and attending trainings and onboarding with both Unite Us and HealthierHere. The second milestone, "Use", occurs when, in a 3-month period, organizations send or receive 20 unique referrals, update their profile information in a shared resource directory, and attend a review with

[30] Source: Elevate Health Data Work Excerpts
[31] Source: Elevate Health interview, August 4, 2022
[32] Care Connect Washington is a program governed by DOH to provide regional support for COVID-19 relief. As part of that program, Hubs were established across nine regions to coordinate care for COVID-19 infection, with the capability to support a range of HRSN services. For more details, see section 4.3.2 of the landscape review. (source: https://doh.wa.gov/emergencies/covid-19/care-connect-washington)
[33] Greater Health Now interview, August 17, 2022
[34] https://greaterhealthnow.org/impact/local-health-improvement-networks

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HealthierHere. The last milestone, "Optimize", happens when organizations continue meeting the "Use" benchmarks, set and reach annual performance goals, and join CIE working groups.[35] [36] [37]

4.1.6 North Central

North Central ACH is in an exploratory phase to gather information on the current state of CIE in the region and build a shared language and set of goals around community-based care coordination. The ACH has established two working groups, with one focused on resource directories and the other on community-based care coordination tools, to gather community input and identify implementation considerations. Multiple resource directories are in use in the region, including 2-1-1 and several specialized directories (e.g., ParentHelp123, Informing Families, etc.). The care coordination working group, primarily led by case managers, has a focus on identifying strategies to support interoperability between existing systems. North Central was a Pathways Hub for roughly 18 months, contracting administration of the Hub to a CBO partner, with CCS providing the technical platform. The Pathways program is now discontinued in the region as the ACH considers alternative approaches to connecting patients to appropriate care.[38]

4.1.7 North Sound

Over the past three years, North Sound has invested in strategies to build the workforce and capacity of the community-based workers in the region to enable them to connect patients to appropriate care through direct referrals to partner organizations. The ACH sees this community network as core both to community-based care coordination today and to a potential tech-enabled CIE solution in the future. In addition, Whatcom County has developed a CIE pilot program, the Whatcom Research Information Collaborative (WRIC), to consolidate listings from current resource directories, build data interoperability between those directories, and establish a governance system to enable frequent updates of information on availability and listings. A goal of the WRIC is to establish a sustainable, accurate resource directory data infrastructure with the potential to expand into other counties or to integrate with other CIE tools in the community.[39]

4.1.8 Olympic Community of Health

In 2021, Olympic Community of Health conducted a landscape assessment to identify community-based care coordination needs in the region across a wide range of stakeholders and gather input on CIE implementation. The outreach process has included providers and CBOs, but also organizations that may not be typically included in CIE networks (e.g., library systems, dentists, etc.), finding enthusiasm for community-based care coordination across a wide range of groups. The ACH is currently working with the Open Referral Initiative to develop a strategic plan on the steps needed to implement a closed-loop referral system that accounts for existing care relationships in the region.

4.1.9 Southwest Washington Accountable Community of Health (SWACH)

SWACH's HealthConnect Hub integrates community-based care coordination efforts across seven care services, including a Pathways program, Care Connect Washington, and other, more targeted programs (Access to Health, Health Homes, Humana Care Coordination, Community Paramedicine, and Evidence-Based Self-Management Programs). The Hub implements CCS as a client master index which can store patient data in a standard format across care services and provides a platform for sharing data and updates between partner organizations. In this

[35] HealthierHere interview, August 22, 2022

[36] "Catalyst Fund Pre-read Materials", shared by HealthierHere in August 2022

[37] "Care Coordination Landscape Analysis Report", shared by HealthierHere in August 2022

[38] North Central ACH interview, August 5, 2022

[39] North Sound interview, August 3, 2022; Whatcom Resource Information Collaborative charter, shared by North Sound in
August 2022

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no wrong doors system of care,[40] a patient who signs up for any of the integrated services can elect to join the Hub system. At that point, the patient is assigned a case manager who is trained across multiple services. The case manager works with them to identify HRSNs through informal conversations and can send referrals to Hub partner organizations, using the CCS platform to share relevant data and establishing a shared social care plan. To date, more than 65% of patients referred to HealthConnect are connected with a Community-Based Worker (CBW) and receive full support. SWACH emphasizes Pathways as a foundational element of community-based care coordination because the program can braid funding from multiple sources into one initiative, and it standardizes outcomes for social care in a way that gives partner organizations a shared language (e.g., defining a successfully housed patient as having consistent housing for 60 days).

HealthConnect is also a referral partner of Unite Us, which deployed its CIE platform in the region in 2020 through a partnership with Kaiser Permanente. Organizations in the Unite Us ecosystem can refer their patients to the HealthConnect Hub, although most referrals to HealthConnect happen directly from partner organizations. Many referrals also reach HealthConnect through a call center jointly administered between 2-1-1 and Unite Us. The ACH utilizes multiple intersecting resource directories, including those from 2-1-1 and Unite Us, as well as a network of trained CBWs to identify treatment options for patients.[41]

4.2 Current implementation of CIE: MCOs

4.2.1 Amerigroup

Amerigroup and its parent company, Elevance Health, have implemented Findhelp at a national level as a resource directory.[42] The tool is available to the public through the Amerigroup website, giving users the ability to search for care resources by zip code. Case managers also use the Findhelp platform to identify care resources based on the results of their health screenings. A nationwide effort is also underway to establish an internal system for closed-loop referrals, with teams in multiple states piloting programs to address the specific needs of their communities.[43]

In Washington, a targeted closed-loop referral pilot program has focused on identifying priority HRSNs and connecting CBOs that serve those needs to existing networks of health providers. An assessment using input from case managers identified three priority HRSNs concerns in the pilot region as housing, food security, and employment; Amerigroup is in the process of onboarding 10+ Washington CBOs aligned to each need category onto a platform to allow closed-loop referrals.

The company has also implemented a community-based care coordination tool, PreManage, to share relevant patient notes between providers (e.g., adding a note that a patient should not be prescribed opioids due to history of addiction). Using the PreManage tool, Amerigroup has also enabled automatic Admission-Discharge-Transfer (ADT) event notification for primary care and can access reports on population-level health and HRSN trends which inform new initiatives and regional policy. A network of on-the-ground CBWs helps onboard new users onto the platform by setting up 'field stations' at local gathering points (e.g., grocery stores, churches, etc.), providing on-the-spot screenings and directing community members to care resources.

[40] No wrong doors refers to a system of care in which patients who enter a care system for one type of service can access other types of care and be connected to a broader community-based care coordination system. (Source: https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/no-wrong-door-system-and-medicaid-administrative-claiming-reimbursement-guidance/index.html
[41] SWACH interviews, August 1 and August 9, 2022
[42] See section 6 of the landscape review for more details on Findhelp.
[43] Amerigroup interview, August 8, 2022

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4.2.2 Community Health Plan of Washington (CHPW)

CHPW partnered with Unite Us in 2020 to build a social network hub using Unite Us' CIE platform. The rollout process began with a pilot program in select counties and has since expanded to 9 counties in Washington. Target counties for the rollout were selected based on input from case managers and CBWs regarding areas with high concentrations of referrals and HRSNs. The hub uses CIE to connect CHPW's health workers and case management teams to social services and CBOs across the state. A longer-term goal is to connect the Unite Us tool to other CHPW systems (including, e.g., a population health system which incorporates clinical information from community health centers) and combine existing data centers with new social data from the CIE. Before migrating to the Unite Us platform, CHPW had implemented Findhelp as a resource directory to support community-based care coordination.

Patients are often onboarded into the hub through a referral to CHPW's community support services team, which then connects patients to a community assessment team member for HRSN screening. Based on that assessment, the support services team searches for relevant organizations in the Unite Us network using the company's resource directory. If no resources are available in the network to meet the patient's specific needs, the team makes referrals to other organizations. The care team then uses the Unite Us platform to receive closed-loop updates on those referrals and provide a platform for workers across providers and CBOs to share care notes.[44]

4.2.3 Coordinated Care Health (CCH)

CCH has implemented Findhelp for care teams based in Washington, and its parent company, Centene, has invested in systems integrations with both Findhelp and Unite Us at a national level. Centene has also implemented a version of Findhelp nationwide through a partnership with Collective Medical Technology (CMT). In addition to Findhelp, CCH utilizes other communications channels for providers and health workers, including Availity, which provides automatic notifications following ADT events and drives community-based care coordination work for providers in the region. The company has also deployed CMT to provide bidirectional integration of the ADT information between providers, enabling providers to act in real time to provide support to patients based on medication compliance information.

To track health outcomes, CCH uses a proprietary system for monitoring referrals, screening data, and care requests from members. Using that data, the company has developed new programs to address HRSN; in one region, CCH identified a gap in current services for food insecurity and used that information to develop a new food security program built into the benefits plan.[45]

4.2.4 Molina Healthcare

Molina has contracted with Findhelp at a national level to develop a national CIE, Molina Help Finder, which it uses to provide community-based care coordination and data exchange between providers and CBOs. The Help Finder rollout in Washington began in 2021 in two phases; the first phase made the tool available to Molina staff members, and the second expanded access for members and providers, including search engine access through member and provider portals. Today, Molina operates with the solution in every county in Washington. Molina's Findhelp tool has some level of integration with major EHR players, including Epic, with emerging partnerships with multiple additional EHR providers to increase data access.

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[44] CHPW interview, August 9, 2022

[45] CCH interview, August 3, 2022

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Molina has established a range of reporting metrics to track outcomes among its approximately 4,000 internal CIE users, including the number of searches in the directory, number of referrals sent and accepted, responsiveness of partner organizations, engagement by zip code, and mapping of need areas.

4.2.5 United Health Care (UHC)

To enable connection of patients to appropriate care, UHC has implemented Findhelp. Case managers working with end-patients in the region are very familiar with the tool and use it to identify resources available. An on-the-ground network of case managers is in place currently to maintain an updated perspective on available resources in the area. The case managers follow up manually with CBOs and providers to determine their availability and scheduling on a given day (e.g., to find out the number of available beds in a homeless shelter) and fill in gaps in information available in the resource directories. To close the loop on referrals, UHC has an auto-trigger in its documentation platform (which uses a separate community tool from Findhelp) which reminds partner organizations who sent referrals to follow up manually (often via phone or email) with the organization that accepted the referrals and/ or the patient receiving care. UHC has reported high response rates with this system for following up on referrals and emphasizes the value of the relationship-focused approach, which encourages direct conversations between patients and partner organizations.

UHC has held a focus on understanding HRSNs at both a national and regional level. The company has created approximately 200 Z codes[46] based on HRSN categories using community data accessed through the PreManage platform it has implemented. The HRSN data is used to compare needs across regions and is overlayed against external data to identify gaps in the company's data visibility. UHC also uses the PreManage platform as a tool to store and share provider documentation, care plans, ADT information, and patient status. The tool has been especially effective in certain at-risk populations, including frequent emergency department visitors.[47]

4.3 Current implementations of CIE: HHS Coalition Agencies

4.3.1 Department of Children, Youth and Families (DCYF)

DCYF uses the Help Me Grow platform to support families in finding resources for early childhood services. Help Me Grow is a national network with affiliates in at least 28 states using the system to provide care resources to their communities.[48] In Washington, WithinReach is the coordinated access point for Help Me Grow, implementing the model as a tool to increase parents' access to information about available care resources in their communities.[49]

When people contact Help Me Grow Washington over the phone, they are connected with a Family Resource Navigator who conducts an HRSN screening and then identifies local resources in the Help Me Grow database (e.g., pregnancy and parenthood resources, free or low-cost health insurance, food resources, child development tracking, etc.). The Family Resource Navigator follows up with the patient directly to ensure quality treatment was received.[50]

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[46] Z codes are diagnosis codes indicating factors that influence health status, including Health Related Social Needs (HRSNs). (Source: https://www.cms.gov/files/document/zcodes-infographic.pdf

[47] UHC interview, August 8, 2022

[48] https://helpmegrownational.org/who-we-are/history/

[49] https://withinreachwa.org/our-programs

[50] https://helpmegrowwa.org/what-is-help-me-grow

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DCYF case managers also make direct referrals to partner organizations that are not routed through Help Me Grow. Efforts are underway to link the agency's current care resource tools, including Help Me Grow, with integrated eligibility platforms to consolidate information about which resources are available to patients.[51]

4.3.2 Department of Health (DOH)

DOH has invested in a license for HealthBridge, a care coordination platform from CCS, to make the tool available to Care Connect Washington regional hubs, with the license allowing an unlimited number of users across the state.[52] Seven of the nine ACHs serve as the Care Connect hubs for their regions, and in two other regions, other entities are contracted to operate the hubs and coordinate with their ACHs.[53] The initial investment in the CCS system was funded by multiple federal grants for COVID-19 care support, but the platform can be used to enable community-based care coordination for a wider range of HRSN programs and services.[54] The platform's features include tools for making/ following up on patient referrals and for exchanging patient data and care updates between partner organizations. The CCS platform also has a built-in tool for logging verbal consent for data sharing at the time of referral. [55]

In the past 18 months, CCS has provided support to connect its platform to other groups in Washington that offer resource directories (e.g., 2-1-1, Crisis Connection, WithinReach, etc.), with the goal to build agreements to support resource identification, referral, and information sharing across platforms. Maintenance and operations for the CCS license currently cost ~$1.3M per year, and are expected to increase to ~1.6M per year in FY2026. Statewide, the platform has been used to serve almost 100,000 patients, including over 55,000 referrals for social services and nearly 5,000 for medical services.[56]

4.3.3 Department of Social and Health Services (DSHS)

DSHS maintains an internal directory of resources used by operators at the agency's statewide Community Services call center, which can offer information on available resources and send referrals for a range of services. The resource database includes both general social services resources and listings for specific providers (e.g., psychologists) who are typically contracted to accept referrals. Staff members in regional and local offices manually edit listings in the directory when they receive updated information through local contacts or community partnership meetings.[57]

The agency also works with organizations such as Community Living Connections and the Brain Injury Alliance of Washington, which have their own call centers to provide specialized support including information on available resources, referral management, and case resource management. They have made no other formal investment in a CIE technology platform.[58]

5. Pain points and expectations for future CIE

5.1 Pain points: Overview and common themes

The landscape assessment revealed a list of eleven pain points around community-based care coordination, reported below. The listed pain points outline current challenges to connecting patients to appropriate care

[51] DCYF interview, August 9, 2022
[52] DOH interview, August 9, 2022
[53] https://doh.wa.gov/emergencies/covid-19/care-connect-washington
[54] DOH interview, August 9, 2022
[55] DOH interview, August 9, 2022
[56] DOH interview, August 9, 2022
[57] DSHS interview, August 10, 2022
[58] DSHS interview, August 10, 2022

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(pain points I-VI) and barriers to implementing new community-based care coordination systems, including CIE (pain points VII-XI).[59] The reported pain points include:

Exhibit 7: Summary of common pain point themes expressed by statewide stakeholders and partners

Barriers expressed by statewide stakeholders and partners around connecting patients to appropriate care today	I. **Availability of care resources in local community:** [60] limited care resources to meet communities' care needs II. **Access to information on currently available local resources:** [61] challenges in identifying care resources, and their specific available services, in an area at a given time III. **Prioritizing care for the highest need groups:** [62] challenges due to lack of standard processes to prioritize care based on need and/or challenges in implementing set priorities due to gaps in services for certain vulnerable populations IV. **Access to information about care received from other organizations:** [63] challenges in determining if referrals were accepted or care was provided (i.e., "closing the loop"), and coordinating ongoing care with health workers from other organizations V. **Compliance with data sharing regulations and standards:** [64] difficulties in attempting to access and share patient data in a complex regulation and compliance landscape VI. **Availability of up-to-date data on population health and needs:** limited visibility into local population-level Health-Related Social Needs (HRSNs)
Barriers expressed by statewide stakeholders and partners around implementing CIE or other community-based care coordination systems	VII. **Technological and logistical barriers to creating a CIE system:** [65] challenges around platform development and integration that may hinder the creation of systems that improve community-based care coordination VIII. **Buy-in from key stakeholders and partners:** low adoption rates from both community members and organizations that may limit the effectiveness of community-based care coordination systems IX. **Community-based care coordination processes creating resource and capacity burden for partner organizations:** [66] potential administrative strain to

[59] See Section 3 for detailed methodology

[60] This pain point was highlighted in the document "Care Coordination Landscape Analysis Report" shared by HealthierHere, August 3, 2022

[61] This pain point was highlighted in the document "Community Resource Referral Guide" shared by SWACH, August 2, 2022

[62] This pain point was highlighted in the document "Who has the power CIE follow up" shared by Olympic Community of Health,August 2, 2022

[63] This pain point was highlighted in select documents shared offline by stakeholders and partners including - "OCH Needs Assessment 2021" shared by Olympic Community of Health on August 2, 2022; "CCS Overview and Infrastructure" shared by DOH on August 9, 2022; "ACH Joint Policy Statement" shared by Elevate Health on August 5, 2022; "Catalyst Fund Pre-read materials" shared by HealthierHere on August 3, 2022; "Community Resource Platform Referral Guide" shared by SWACH on August 2, 2022; "Care Coordination Landscape Analysis Report" shared by HealthierHere on August 3, 2022

[64] This pain point was highlighted in select documents shared offline by stakeholders and partners including - "ACH Joint Policy Statement" shared by Elevate Health on August 5, 2022; "OCH Needs Assessment 2021" shared by Olympic Community of Health on August 2, 2022; "Who has the power CIE follow up" shared by Olympic Community of Health on August 2, 2022

[65] This pain point was also highlighted in the document "Who has the power CIE follow up" shared by Olympic Community of Health on August 2, 2022

[66] This pain point was also highlighted in the document "Charter—Whatcom County" shared by North Sound on August 3, 2022

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	organizations from opting into community-based care coordination efforts, taking time and resources away from providing care X. **Securing sustainable, long-term funding for community-based care coordination:**[67] uncertainty around long-term funding pathways for CIE can create barriers to implementation XI. **Prioritizing patient experience and relationships:** [68] difficulty creating a streamlined, whole-person-focused patient experience may limit the effectiveness of care

Among stakeholder groups interviewed (ACHs and MCOs) and surveyed (CBOs, Professional Organizations, Safety Net Providers, and other groups), responses were aggregated in order to analyze which pain points were most frequently mentioned.[69] The most common pain points mentioned in the interviews were (IX) community-based care coordination processes creating resource and capacity burden for partner organizations, (II) access to information on currently available local resources, (V) compliance with data sharing regulations and standards, and (VIII) buy-in from key stakeholders and partners (Source: Exhibit 8)

Exhibit 8: Pain points for ACHs and MCOs by response frequency (n=14)

Response frequency
>50% of respondents 26-50% of respondents 1-25% of respondents 0% of respondents

"Pain points" described by ACHs and MCOs	ACHs (9 interviews)	MCOs (5 interviews)
IX. Resource and capacity burden from running community-based care coordination processes	7	5
II. Access to information on currently available local resources	7	3
V. Compliance with data-sharing regulations and standards	7	3
VIII. Buy-in from key stakeholders and partners	8	2
I. Availability of care resources in local community	5	2
IV. Access to information about care received from other organizations	4	3
VII. Technological and logistical barriers to creating a CIE system	6	0
XI. Prioritizing patient experience and relationships	4	2
III. Prioritizing care for the highest need groups	3	2
VI. Availability of up-to-date data on population health and needs	3	1
X. Securing sustainable, long-term funding for community-based care coordination	4	0

Source methodology: ACH and MCO interviews as of August 22, 2022. "Pain points" were assessed based on interviews with representatives from each stakeholder group and include all "Pain points" mentioned at least once. The "Pain points" are not listed in order of priority.

[67] This pain point was also highlighted in select documents shared offline by stakeholders and partners including - "ACH Joint Policy Statement" shared by Elevate Health on August 5, 2022; "Care Coordination Landscape Analysis Report" shared by HealthierHere on August 3, 2022

[68] This pain point was also highlighted in the document "Catalyst Fund Pre-read materials" shared by HealthierHere on August 3, 2022

[69] Pain points for Tribes were not analyzed by frequency of mentions due to the format of the input (Listening Sessions with many representatives from Tribes present, rather than discrete interviews). Pain points for HHS coalition agencies were also not analyzed by frequency because of the relatively small number of stakeholders (3 interviews conducted). Pain points for those groups are described in the following sections of the landscape review.

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Among stakeholder groups surveyed, the most common current pain points were lack of closed-loop referral, lack of consistent systems for connecting patients to care, and ineffective data sharing capabilities; the most mentioned implementation barriers were resources to support CIE, funding for CIE, and organizational adoption. (Source: Exhibit 9).

Exhibit 9: Pain points for surveyed groups by response frequency (n=81)

Response frequency: >50% of respondents; 26-50% of respondents; 1-25% of respondents; 0% of respondents

Survey question	"Pain points" described by surveyed stakeholders	CBOs (30 responses)	Professional organizations (18)	Safety net providers (14)	Other (19)
Current barriers to connecting patients with appropriate care (top 3)	Lack of closed-loop referral	14	9	5	12
	Lack of a consistent system / process for connecting patients to appropriate care	12	11	6	8
	Ineffective data sharing capabilities across the health and social services ecosystem	12	11	4	8
	Limited number of community-based health and social services available	13	8	5	8
	Health disparities for vulnerable populations	11	3	2	4
	Lack of awareness of resources available	8	3	1	2
	Other "pain points"	4	2	3	6
	Ineffective matching to community resources based on identified needs	2	3	1	3
Anticipated barriers to implementing CIE	Resources to support a CIE	18	14	7	15
	Adequate and consistent funding to support a CIE implementation	18	13	6	15
	Organizational adoption of a CIE in the local community	16	8	4	15
	Privacy or security concerns for patient data sharing	12	9	5	9
	Other implementation barriers	4	1	2	0

5.2 Pain points by stakeholder and partner group

While representatives of various statewide partners and stakeholder groups described similar barriers to connecting patients to appropriate care in their communities, different groups also had unique perspectives on the ways in which those pain points presented for them. The following account details pain points heard from each group.

5.2.1 Pain points: Accountable Communities of Health (ACHs):

During the interviews, multiple ACH representatives highlighted each of the eleven common pain points as barriers to community-based care coordination in their region, sharing evidence and anecdotes around how the pain points manifested in their regions. Details around pain points for ACHs are below.

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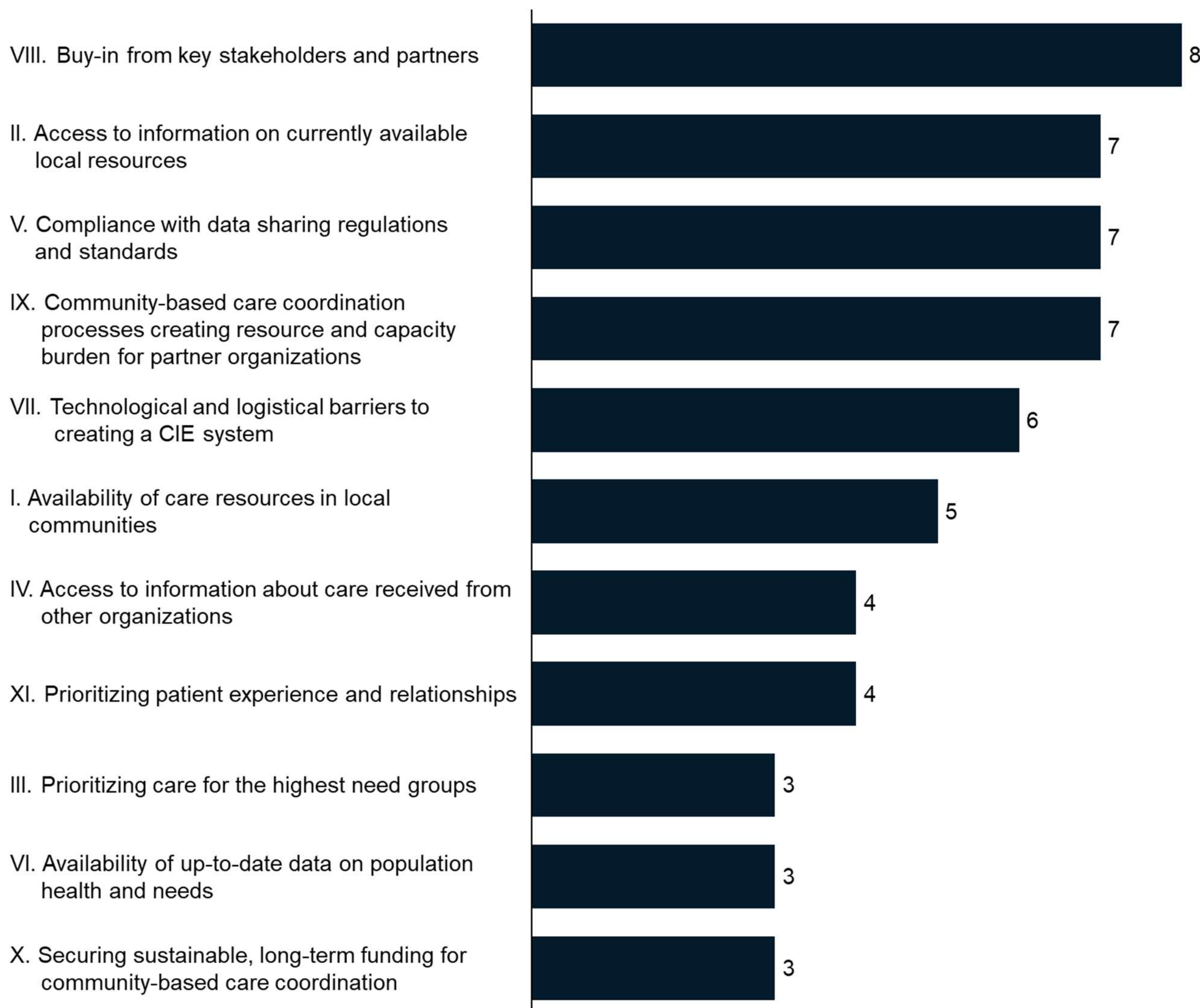
Exhibit 10: ACH pain points by frequency of mentions in interviews (n=9) [70]



I. Availability of care resources in local community (mentioned in 5 ACH interviews): Interviewees noted that gaps in available care in some communities, especially rural areas without specialized services, can be a barrier. Some respondents expressed concern that lack of available housing, healthy food, and medical infrastructure pose challenges that may not be solved by a CIE platform, because the community-based care coordination tool can only be effective when there are organizations to connect patients to care.

II. Access to information on currently available local resources (mentioned in 7 ACH interviews): While many regions utilize resource directories, these tools often have some outdated information, and community members face challenges verifying the quality of information without reaching out directly to the organization. This challenge becomes more immediate in crisis cases (e.g., suicide prevention interventions), where it may become critical that a referral can be accepted within a window as short as 20 minutes.

[70] Source: ACH interviews. Data to be updated based on additional interviews.

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Many regions have multiple, partially overlapping resource directories which each show only a subset of available organizations in an area, and some organizations are not listed on any directories. This is true especially for rural areas with small, localized CBOs. One interviewee discussed a call center in their region that was partnered with a resource directory; operators in the call center would sometimes direct patients to care resources in cities that were hours away because the local organizations were not registered. Many organizations fill gaps in resource information by developing their own internal databases, with staff members regularly contacting resources directly to get updates on availability.

III. Prioritizing care for the highest need groups (mentioned in 3 ACH interviews): ACHs noted that the lack of a consistent system to prioritize care based on need can leave some groups underserved. Given a lack of public access to quality information on resource availability, care is sometimes more readily available to the patients who know best how to navigate systems, rather than those who most need care. For example, someone who knows which days a charity receives donations may be more likely to access that charity's resources. Without a standardized framework for prioritizing care based on need, interviewees said that decisions around allocating care often come down to the judgement of individual case managers, making those decisions more susceptible to factors like implicit bias. Additionally, respondents expressed concern that some providers can fill their contractual obligations without serving the highest need groups, removing the incentive to provide services for those populations.

Further, some vulnerable populations may lack targeted support to connect them with care coordination systems, potentially making community-based care coordination less effective at treating those groups. As an example, populations with limited English proficiency can face additional challenges navigating publicly available tools for accessing care information and self-referrals. Sometimes there are challenges translating web pages from English, and even when translation is possible, HRSN screening forms and referral requests often need to be submitted in English. Without dedicated translation support, these historically underserved populations may be discouraged from seeking care.

IV. Access to information about care received from other organizations (mentioned in 4 ACH interviews)*:* Several ACH interviewees commented that without an automatic closed-loop referral system, organizations that send referrals face difficulties following up with patients because they lack visibility regarding timing for referrals being accepted or care being provided. In some cases, interviewees noted that a patient may be receiving similar care from multiple organizations that are not communicating with each other, so none of the organizations involved can determine whether the patient's needs are being met. This lack of community-based care coordination may then create difficulties in tracking health outcomes because no organization has a complete picture of a patient's journey.

Even when closed-loop referrals are implemented, there may be challenges in ensuring the quality of referral. For instance, an organization may be able to see whether patient referral to an employment security organization has been accepted but can still lack visibility into whether that patient's long-term care needs have been met or what follow-up is required.

V. Compliance with data sharing regulations and standards (mentioned in 7 ACH interviews)*:* Many ACH interviewees expressed concerns about the use of data needed to create an effective CIE. First, groups noted that differences in data standards across organizations create barriers to sharing information. Some types of organizations, including behavioral health providers and jail reentry support organizations, have strict

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regulations around sharing sensitive patient data, limiting their ability to share data with other organizations that have softer standards.

Respondents also noted that, given the complex regulatory landscape for data access, some organizations may not fully understand policies, and some solutions for obtaining patient consent and sharing data may fall short of compliance standards, at least for some partners in a potential ecosystem. While certain regions are working to address this pain point by negotiating data sharing agreements (e.g., Business Associate Agreements (BAAs), DUAs, etc.), the process of developing those contracts can be time-consuming and complicated.

Interviewees also expressed concern around ownership and stewardship of data in a CIE. Some groups, especially those in rural populations, may be resistant to sharing data with any large, conglomerated ecosystem. This includes not only systems led by large companies (with concerns magnified if the companies take ownership of patient data), but also those led by the state, or even a regional ACH. There were also logistical concerns around stewardship, with interviewees raising questions about data handling in a non-standardized environment (e.g., ensuring that data is protected when a partner organization shuts down).

VI. Availability of up-to-date data on population health and needs (mentioned in 3 ACH interviews):
Historically, some regions have experienced challenges in working with state-level agencies to access health information about their communities. For example, Medicaid data is sometimes not available to the ACHs for 18-24 months, at which point, interviewees commented, the data is too old for ACHs to use to make informed health policy decisions.

In addition, regions sometimes lack visibility regarding which areas have enough health and social services resources to meet population needs for specific HRSNs and where there may be gaps in those services. Without comprehensive, population-level HRSN data for their communities, ACHs may not be able to identify where more resources are needed.

VII. Technological and logistical barriers to creating a CIE system (mentioned in 6 ACH interviews)**:** Some interviewees said that many of the available tools on the market for community-based care coordination may not have all the desired features and capabilities (e.g., no closed-loop referral systems, limited integration with current systems, etc.). Some regions have worked with vendors to create customized solutions to meet their specific needs, but this approach can then make platform maintenance and system updates more expensive.

Some ACHs also noted the logistical and technological challenges of integrating with current systems, especially CBO interfaces, which are often non-standardized and may lack APIs or other pre-built tools to support the integration process. Integrations can also face collaboration issues. For example, one ACH noted that their CIE vendor was resistant to integrating with another CIE platform currently used in the region because the two companies were competitors.

Web accessibility is another challenge, especially in rural areas with limited broadband access. In these areas, patients may be less able to navigate care resources independently, and CBWs face additional challenges to conducting mobile, on-the-ground outreach in their communities.

Interviewees also noted that the lack of standardization of information in the listings across resource directories can be a barrier to creating shared, up-to-date databases of available care resources. Since many resource directories have their own data systems for storing organization listings, it can be difficult to consolidate information from multiple directories into a central location or enable collaboration between directories to

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ensure that they all have the most up-to-date information. Without this ability to share listing information across directories, implementing solutions to address gaps in awareness of currently available care resources may become more challenging.

VIII. Buy-in from key stakeholders and partners (mentioned in 8 ACH interviews)*:* Multiple ACHs noted that building consensus around any one CIE platform and convincing partners and communities to join a platform has been a challenge in their efforts to improve community-based care coordination systems. Low adoption can be a product of distrust, both toward the organizing group or toward other partners in the coalition, or can result from groups not believing in the value proposition of CIE.

In some regions, experience with previous efforts to implement community-based care coordination tools may cause some organizations and communities to be hesitant to join a CIE partnership. Interviewees also mentioned community distrust toward corporations offering CIE tools to responsibly steward sensitive patient data. Some groups similarly may distrust state agencies to lead community-based care coordination ecosystems, with the concern that regional and community-level HRSN and values may be lost in a large-scale system. Some communities that have been historically underserved for healthcare may be especially skeptical that a large-scale or statewide solution will prioritize their health.

In addition, many ACHs noted that organizations may not be convinced that the value added from CIE is worth the resource and capacity cost. For CBOs that have already developed informal care networks with their partner organizations and have functioning systems to follow up on referrals, a new platform for community-based care coordination may seem unnecessary. Additionally, many providers have invested in new data systems and EHR platforms within the last 10 years; these providers may be resistant to switching systems if their current platforms are incompatible with a new CIE tool, given the resources already spent on data systems and the time needed to retrain employees in a new system.

IX. Community-based care coordination processes creating resource and capacity burden for partner organizations (mentioned in 7 ACH interviews)**:** ACHs noted that many current approaches to community-based care coordination create additional work for the organizations that use them, limiting those groups' ability to provide quality care. First, due to gaps in up-to-date information on care resources described above, some organizations employ staff members to manually maintain internal logs of availability by calling partner organizations daily to get updates on capacity. In some organizations, this is a full-time role. Interviewees also commented that this system can make partner organizations less resilient, potentially risking their relationship-driven information network if a single employee leaves the organization.

In addition, the use of care coordination tools that do not integrate into existing interfaces creates additional work for partners who then need to work in multiple systems at once. For instance, many CBOs use grant management systems which may not be compatible with some HRSN data systems and closed-loop referral platforms. Without integration, the CBOs need to enter patient data and log updates into multiple systems. The problem can be compounded in regions where multiple groups, including MCOs, ACHs, and providers, each ask CBOs to enter data into a different system. Providers face similar challenges when CIE platforms are not integrated with existing EHR tools.

X. Securing sustainable, long-term funding for community-based care coordination (mentioned in 4 ACH interviews): Multiple interviewees commented that uncertainty around long-term funding for regional CIE solutions may hinder their ability to invest in a sustainable solution. Some of the funding for CIE at the regional level today is for exploratory programs and pilots, and ACHs worried that even if they secured funding to

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implement a platform, the ongoing maintenance and upkeep costs may be more difficult to fund. Vendors may also be less willing to sign long-term contracts unless customers can demonstrate a secure funding channel.

XI. Prioritizing patient experience and relationships (mentioned in 4 ACH interviews): Respondents noted difficulties in maintaining a patient-friendly experience throughout the care journey. One interviewee commented that administering any formal HRSN screening can hinder patient experience, especially in cases where patients have sensitive histories that they may be less willing to share on formal screenings without having relationships with the screeners. More generally, interviewees expressed that care coordination tools can be difficult for patients to navigate themselves and can create barriers to entry unless an infrastructure of CBWs is in place to provide a face-to-face introduction into the data sharing ecosystem, guide patients throughout the process, and serve as a resource for patients' questions.

5.2.2 Pain points: Managed Care Organizations (MCOs)

MCO interviewees mentioned at least nine of the eleven common pain points across five interviews. The ways in which those pain points manifested for MCOs as a group are described below.

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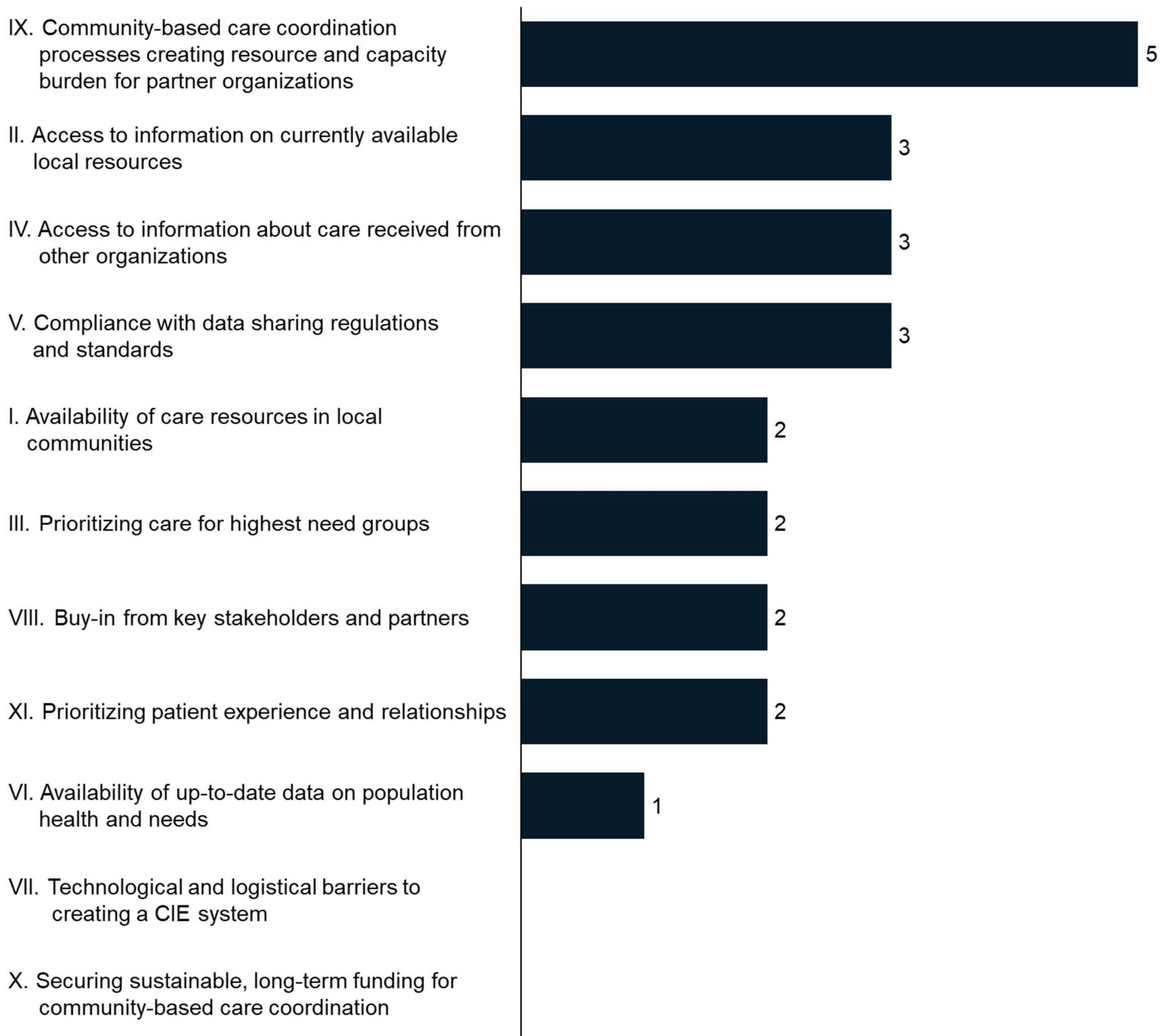
Exhibit 11: MCO pain points by frequency of mentions in interviews (n=5) [71]



I. Availability of care resources in local community (mentioned in 2 MCO interviews)*:* MCOs mentioned that some of their partner CBOs may experience staffing shortages. These challenges can limit the CBOs' ability to impact health outcomes in their regions. Interviewees also observed gaps in available care in some regions; using population-level HRSN data, multiple MCOs identified insecurity around housing, food, and employment as areas with gaps in available care for the population need. Interviewees also noted that challenges around low resource capacity can be exacerbated when new community-based care coordination systems increase the number of referrals being sent to partner organizations.

II. Access to information on currently available local resources (mentioned in 3 MCO interviews)*:* MCOs identified challenges in keeping care resource information up to date. While many MCOs have implemented resource directories, they note that there is often no guarantee of the reliability of information in the listings.

[71] Source: MCO interviews.

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Some resource directories rely on crowdsourcing to keep information accurate, with anyone being able to recommend updates to information. However, it is not always easy to determine how recently a listing has been updated.

MCOs also expressed concern about the lack of transparency into day-to-day scheduling availability for the organizations in many resource directories (e.g., whether a food bank is currently stocked with supplies that can support patients with specific dietary needs). Without this information, organizations sending referrals may have difficulty ensuring that their referrals will be able to meet a patient's needs in a timely manner that meets patient needs.

***III. Prioritizing care for the highest need groups (mentioned in 2 MCO interviews)**:* Several MCO community-based care coordination systems reported a lack of standardized processes for prioritizing care based on the needs of patients. While many MCOs have systems for risk stratification based on HRSN screening data, individual case managers often make decisions around care allocation; some interviewees noted that case managers may resist a transition into a system which automatically prioritizes care.

Further, MCOs expressed difficulties in providing culturally sensitive care for some vulnerable populations. One interviewee noted that many of the available resource directories in the state today have few listings for tribal organizations, creating challenges matching patients affiliated with tribes to appropriate care. Additionally, some of the current care matching systems may not have mechanisms in place to search for resources aligned to cultural groups, (e.g., faith-based groups, LGBT-affiliated organizations, etc.). Gaps in targeted care for these groups may worsen existing health disparities among some historically disenfranchised populations.

***IV. Access to information about care received from other organizations (mentioned in 3 MCO interviews)**:* MCOs commented that accessing records from correctional facilities about care for jail reentry populations has been challenging due to complex regulations and lack of coordination with state and federal agencies including the Department of Corrections.

Interviewees also noted difficulties sharing care updates between organizations across different regions, especially given the emergence of regional-level CIE solutions. They noted that without a statewide standard for sharing information on patient care, organizations in different regional community-based care coordination ecosystems may face challenges serving patients who live near regional borders or need to travel for specialized care not available locally.

***V. Compliance with data sharing regulations and standards (mentioned in 3 MCO interviews)**:* MCOs noted the challenges in negotiating BAAs for data sharing, especially when those contracts involve a range of stakeholders that have different data compliance standards. In particular, interviewees noted that establishing data agreements for certain protected populations (e.g., minors) can become a barrier due to the sensitivity of the data and the resulting complexity of the negotiations across parties. Interviewees also noted that establishing data sharing agreements with ACHs has been difficult due to HIPAA restrictions and internal MCO data policies.

Without those agreements in place, the process of sharing data within the community-based care coordination ecosystem can become more time-consuming and limit the amount of information that partner organizations can share – in some cases data sharing may be restricted to only referral details and contact information.

***VI. Availability of up-to-date data on population health and needs (mentioned in 1 MCO interview)**:* Interviewees identified a challenge in tracking population social needs due to a gap in HRSN screenings. One

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MCO noted that only 50% of its members are screened for HRSN, limiting the resulting view of overall member needs in Washington.

VIII. Buy-in from key stakeholders and partners (mentioned in 2 MCO interviews): MCOs noted that, due to the burden of using multiple platforms for community-based care coordination (see section on resource/ capacity burden for more details), some case managers may choose not to enter data into a separate community-based care coordination platform, limiting the effectiveness of those tools. Interviewees also mentioned that some organizations that already face resource constraints, including some CBOs, may be less willing to opt into new community-based care coordination systems that require additional capacity from their workers.

IX. Community-based care coordination processes creating resource and capacity burden for partner organizations (mentioned in 5 MCO interviews): MCO interviewees emphasized the strain that participation in community-based care coordination ecosystems can cause for partner CBOs. Many CBOs use grant management systems that are often non-standardized and difficult to integrate with new CIE platforms, requiring CBOs to perform multiple data entry into two or more systems. They noted that the strain can increase when multiple CIE platforms are in use in a region because each platform may require the CBO to work in a separate data system.

Interviewees also noted that the process of adopting a new platform can be capacity-intensive for partners due to the need to retrain staff members on a new interface and set organization-wide standards on using the new system. Ongoing training may be necessary both to ensure that new practices are engrained and to account for the high turnover rate at some CBOs.

XI. Prioritizing patient experience and relationships (mentioned in 2 MCO interviews): Interviewees expressed concern that some community-based care coordination systems today may create additional strain for patients or lack processes to support the relational element of care. For example, at least one MCO commented that when different groups use unique HRSN screening tools, a patient may need to complete similar screenings multiple times. This process can be a burden on patients' time and can create unnecessary stress in the onboarding process (e.g., in cases where a patient's HRSNs involve past trauma).

Further, some interviewees noted that in some current community-based care coordination systems, partner organizations do not regularly connect with patients directly following care to understand their experience and ongoing needs. If partner organizations do not follow up with patients directly, they may face challenges determining whether a patient is likely to seek care again, or if they were satisfied with the quality of care received.

5.2.3 Pain points: HHS Coalition Agencies

Interviews were conducted with representatives from the Department of Health (DOH); Department of Children, Youth, and Families (DCYF); and Department of Social and Health Services (DSHS). Interviewees identified pain points around accessing information on available care resources in local communities. Several interviewees noted that when multiple call centers and directories are active in an area, they may each have incomplete lists of available services and inconsistent standards for keeping information updated. Further, directory users may have difficulty determining whether a given directory has up-to-date entries. Interviewees also commented that the amount of staffing capacity required to keep a resource directory up-to-date may be unsustainable, especially for a statewide directory, because so much information about partner organizations' capacity changes every day.

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HHS coalition agency representatives also discussed difficulties around sharing patient data to improve community-based care coordination. One agency experienced challenges around accessing data from another state agency about which people were eligible for support services because of pre-existing agreements between the agencies around protecting patient privacy.

5.2.4 Pain points: Community-Based Organizations (CBOs)

When asked to list their top three current barriers to community-based care coordination, CBO survey respondents selected lack of closed-loop referral systems (47% of respondents) and limited local health and social resources (43% of respondents) as the most common pain points. However, responses indicated a wide range of challenges across organizations, with at least 30% of CBOs flagging all but one of the listed options as a pain point. The only exception was ineffective matching based on need (7% of respondents).

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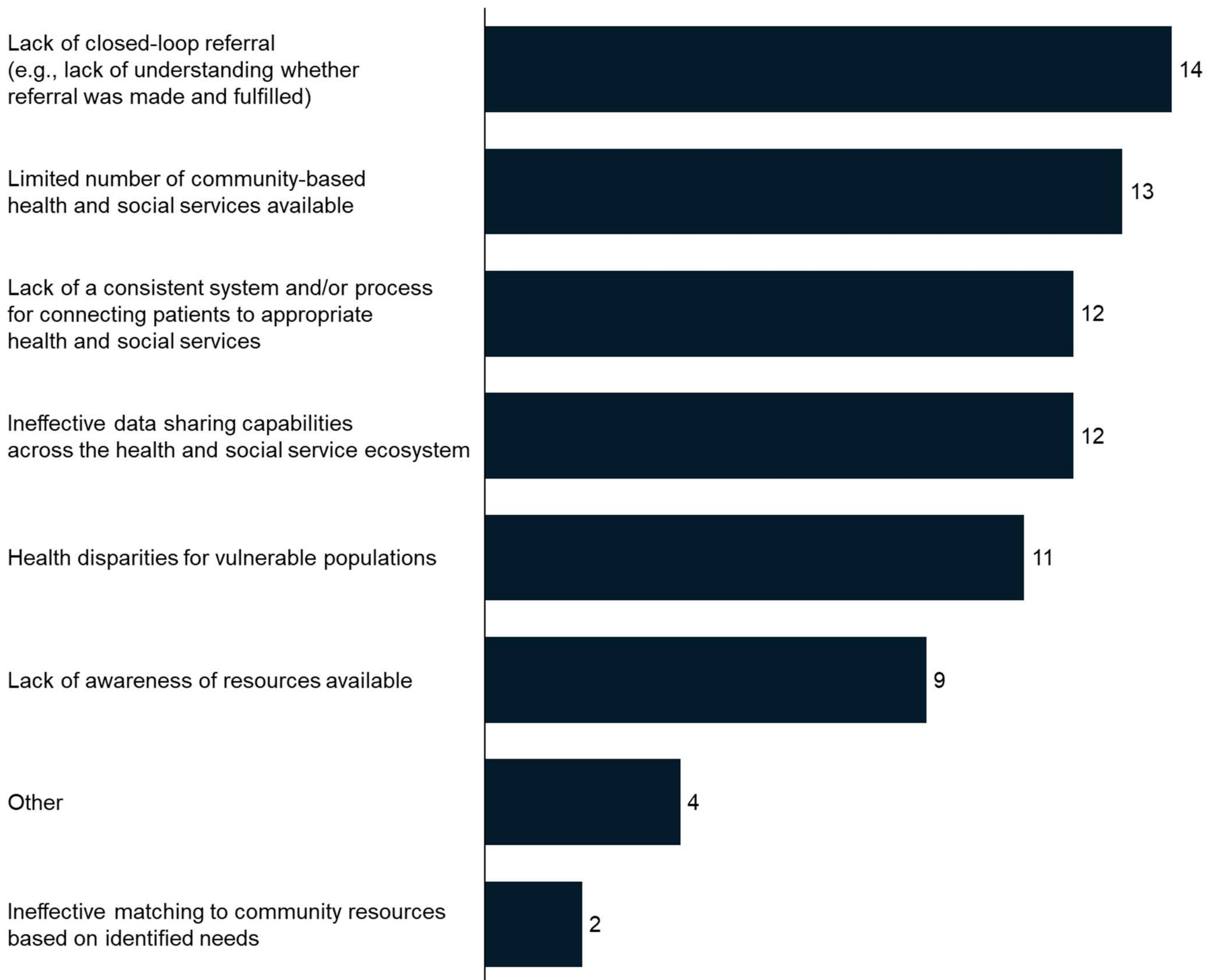
Exhibit 12: Current barriers to community-based care coordination for CBOs (n=30) [72]



In their responses regarding implementation barriers for CIE, CBOs expressed that each of the four listed factors could pose challenges to future implementation, with at least 40% of respondents anticipating each as a barrier.

[72] Source: CIE survey question: "What pain points do you currently face around connecting patients to appropriate health and social services (select top 3)?"

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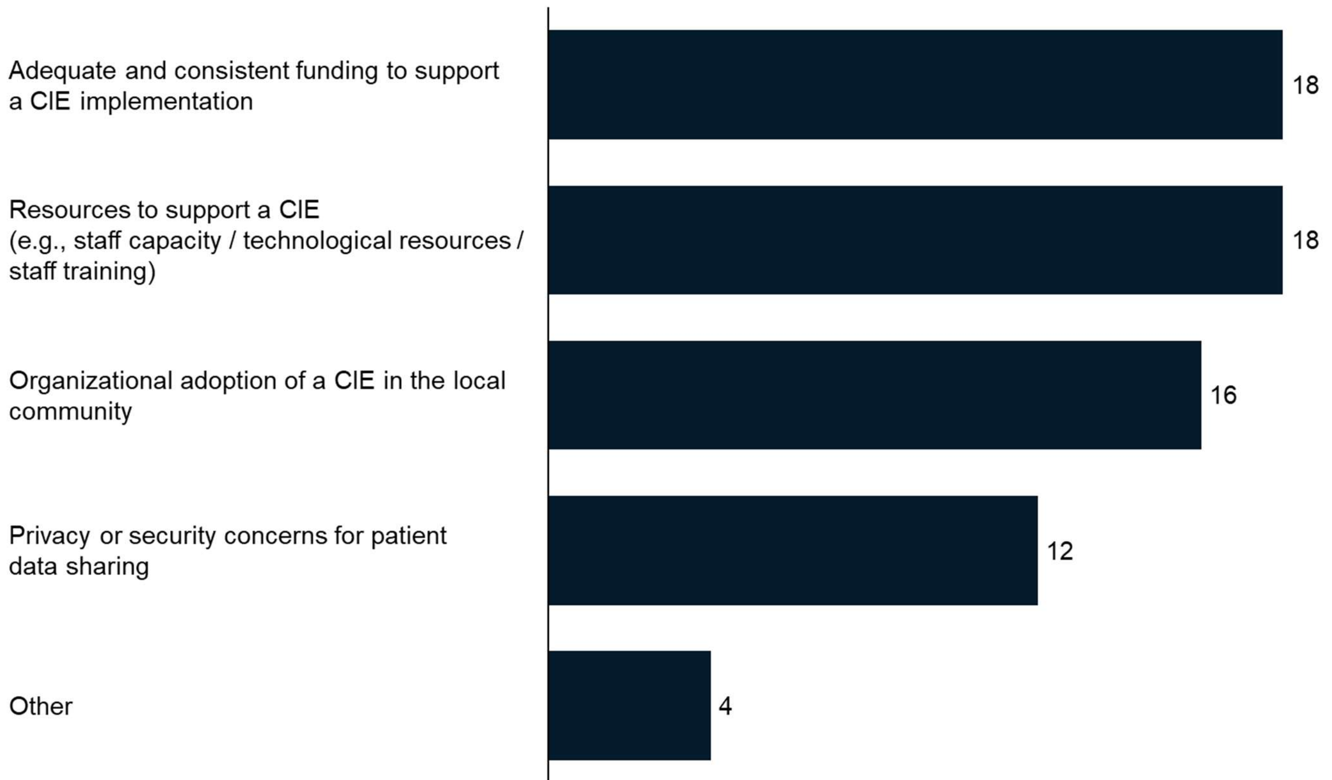
Exhibit 13: Anticipated barriers to CIE implementation for CBOs (n=30) [73]



Beyond the structured survey results, additional input was gathered from several CBOs through open text survey questions, two webinars, and two interviews with select CBOs coordinated through their respective ACHs. Those additional comments were categorized based on the eleven shared pain point themes and are described below:

- ***II. Access to information on currently available local resources:*** Respondents expressed concern that regional or statewide resource directories may not have strategies for keeping all listings up to date. Some CBOs preferred to use their own internal directories, updated manually by employees, due to the guarantee of reliable information.

- ***IV. Access to information about care received from other organizations:*** Lack of visibility into the resources patients are already connected to can create challenges for CBOs in identifying where to shore up existing relationships and add additional care.

- ***V. Compliance with data sharing regulations and standards:*** CBOs described challenges in navigating patient consent for data sharing. When patients are discharged from hospitals or other long-term treatment facilities, if the discharging organizations do not collect patient consent for connecting to community-based care coordination services, it can become more difficult to follow up with those patients later to get consent and track wellbeing.

- ***IX. Community-based care coordination processes creating resource and capacity burden for partner organizations:*** While CBOs noted that multiple data entry adds capacity strain for their employees, several

[73] Source: CIE survey question: "Which of the below do you anticipate will be challenges in implementing and using a CIE solution?"

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interviewees expressed that the benefits of a successful CIE platform could outweigh the operational burden on their organizations.

- ***X. Securing sustainable, long-term funding for community-based care coordination:*** CBOs noted several areas where funding may be needed for effective CIE implementation. First, financial and technical assistance for integrating existing CBO interfaces with new platforms could reduce capacity strain on organizations. Second, funding for CBOs to hire additional CBWs could help offset the additional work required for multiple data entry and manual updating of internal resource directories

5.2.5 Pain points: Tribal partners

Representatives from Washington's tribes and IHCPs were consulted through two open Tribal Listening Sessions[74] and a survey distributed to members of tribes. Participants in both listening sessions discussed (I) availability of care resources in local communities, (VI) availability of up-to-date data on population health and needs, (VII) technological and logistical barriers to creating a CIE system, and (IX) community-based care coordination processes creating resource and capacity burden for partner organizations. All but two of the eleven pain points were discussed in at least one of the listening sessions. The two barriers not directly mentioned were prioritizing care for the highest need groups and emphasizing a strong patient experience in a community-based care coordination system. The following list describes the pain points heard during the two listening sessions, categorized into the shared pain point themes:

- ***I. Availability of care resources in local community (mentioned in both listening sessions):*** Respondents noted that federal funding may not be sufficient to cover social service needs for tribes, adding that in some cases, tribal programs may only receive funding for 40% of their annual operating budget from federal funding. That gap in support for tribal resources, they commented, may contribute to unmet care needs across multiple systems of care. One tribal representative noted that the lack of available housing on reservations has been a particular challenge.
- ***II. Access to information on currently available local resources (mentioned in 1 listening session)*****:** Listening session participants commented that some current resource directories do not have recently updated information on the availability and capacity of individual organizations. One respondent voiced concerns that, due to this lack of up-to-date information, they may not be able to match patients in need with same-day treatment and therefore may have patients who elect not to receive care at all.
- ***IV. Access to information about care received from other organizations (mentioned in 1 listening session):*** Participants discussed challenges caused by the use of multiple systems for tracking patient data and care information. Several EHRs, including the Resource and Patient Management System (RPMS) administered by Indian Health Services (IHS) and used by many tribes, have limited interoperability with other data systems used by partners. Additionally, respondents said some social services organizations track care information manually using spreadsheets, adding to difficulties around sharing information about care received across partner organizations.
- ***V. Compliance with data sharing regulations and standards (mentioned in 1 listening session):*** Respondents commented that managing multiple data sharing agreements with different partner organizations can be logistically challenging. Further, multiple representatives from tribes expressed their concerns about protecting patient data that is shared as part of a CIE ecosystem. At least one participant said that their tribe chose not to adopt a certain EHR platform due to concerns that the vendor would have ownership over patient data.

[74] Tribal Listening Session 1, 41 participants, August 10, 2022; Tribal Listening Session 2, 3 participants, August 17, 2022 DOH interview, August 9, 2022

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- ***VI. Availability of up-to-date data on population health and needs (mentioned in both listening sessions):*** Multiple tribal representatives discussed the challenges in keeping track of members who are experiencing homelessness or in need of housing assistance support.
- ***VII: Technological and logistical barriers to creating a CIE system (mentioned in both listening sessions):*** Respondents described multiple challenges around using the Resource and Patient Management System (RPMS), the EHR administered by IHS. Some listening session participants expressed dissatisfaction with current billing systems in use, but also noted that finding a separate billing system that could link to RPMS may be expensive and logistically challenging. Although one respondent said that efforts may be in place for IHS to replace RPMS with a new EHR, they noted that the rollout to tribal health nations may not occur until 2027.
- ***VIII. Buy-in from key stakeholders and partners (mentioned in 1 listening session):*** Listening session participants commented that many tribes and tribal care providers have already invested in their own data systems, which may increase hesitation about switching to a statewide CIE solution. They added that if a statewide solution does not work similarly to current systems or provide new functionality, some organizations may prefer to continue using their current platforms.
- ***IX. Community-based care coordination processes creating resource and capacity burden for partner organizations (mentioned in both listening sessions):*** At least one respondent during the listening sessions expressed concern that investment in a new community-based care coordination system could require double data entry for staff members at partner organizations.
- ***X. Securing sustainable, long-term funding for community-based care coordination (mentioned in 1 listening session):*** Tribal representatives noted that initiatives to connect multiple Tribal services with a community solution have not historically been funded. One challenge is that funding for different health and social services can be siloed without clear funding pathways for intersectional support programs. At least one respondent observed that tribes in other states have adopted software platforms such as OneTribe to connect services, but tribes may often need to self-fund these investments.

5.2.6 Pain points: Professional organizations

Two of the most mentioned pain points (>60% of respondents) facing community-based care coordination today for respondents from professional organizations were (a) ineffective data sharing capabilities between organizations and (b) lack of a consistent system for connecting patients to appropriate care resources. As per survey results, respondents placed less emphasis (<20% of respondents) on pain points such as current health disparities, ineffective need-based matching to resources, and lack of awareness of available resources.

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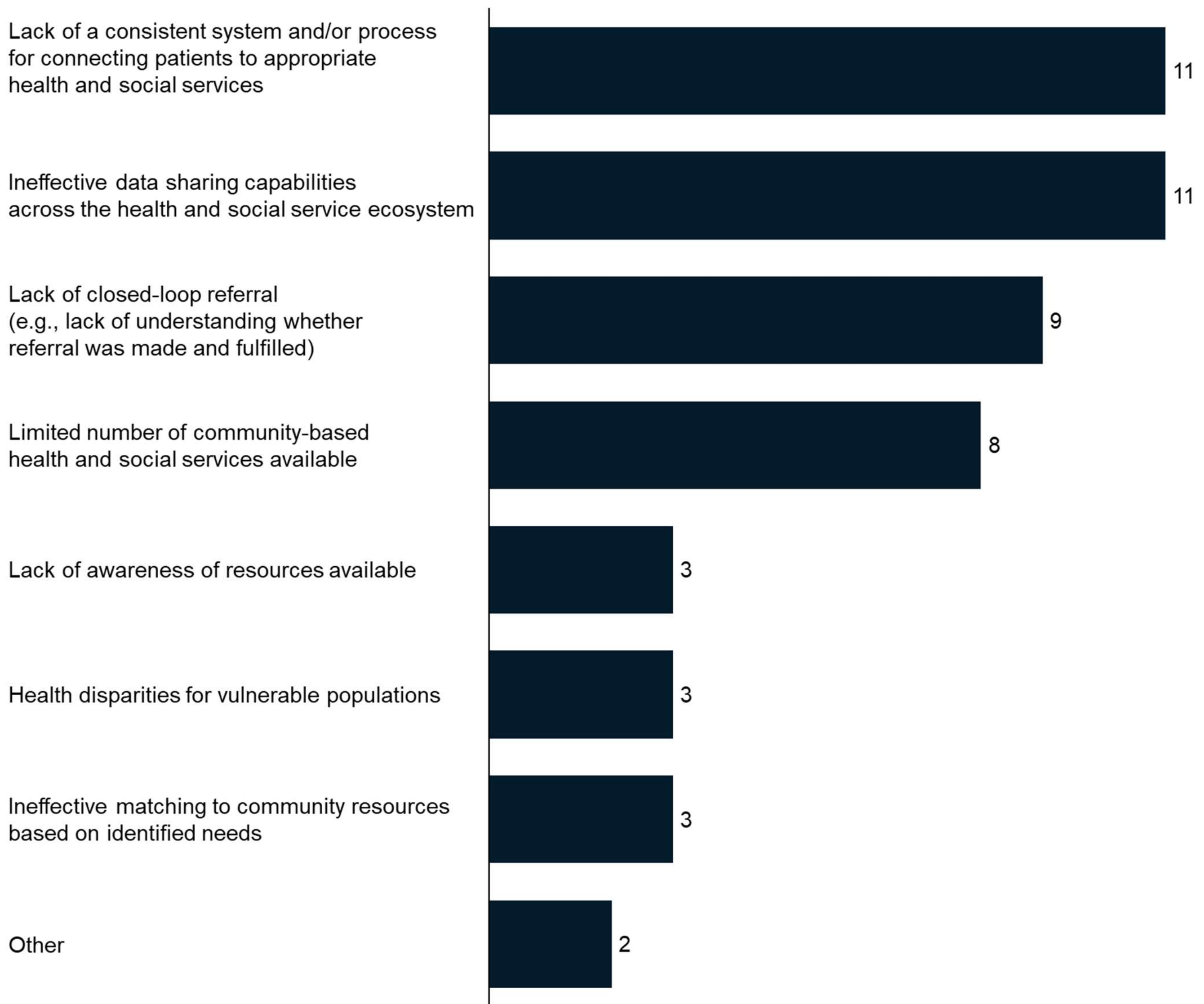
Exhibit 14: Current barriers to community-based care coordination for Professional Organizations (n=18) [75]



In terms of implementation, more than 70% of professional organization members surveyed responded that securing operational resources to support a CIE and funding for a CIE investment were anticipated barriers to creating CIE networks.

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[75] Source: CIE survey question: "What pain points do you currently face around connecting patients to appropriate health and social services (select top 3)?"

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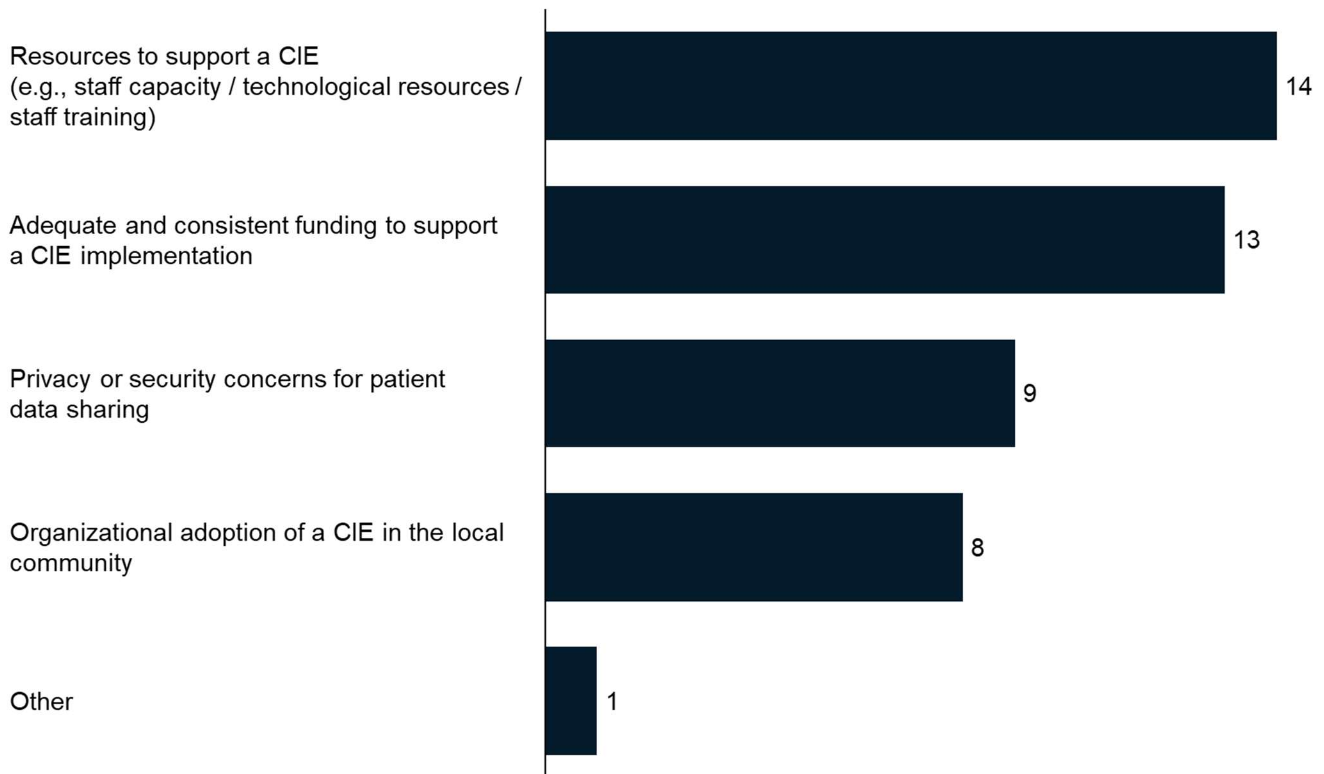
Exhibit 15: Anticipated barriers to CIE implementation for Professional Organizations (n=18) [76]



5.2.7 Pain points: Safety Net Providers

Representatives from safety net provider organizations (including FQHCs, RHCs, and other providers) were surveyed on pain points around connecting patients to appropriate care. Based on the CIE survey, the most common current pain points facing safety net providers for community-based care coordination today (>30% of respondents) are (a) the lack of a consistent system for connecting patients to care (43%), (b) limited number of available care resources (36%), and (c) lack of a closed-loop referral system (36%). No pain points were selected by more than 50% of respondents, indicating a wide range of experiences and challenges across safety net providers.

[76] Source: CIE survey question: "Which of the below do you anticipate will be challenges in implementing and using a CIE solution?"

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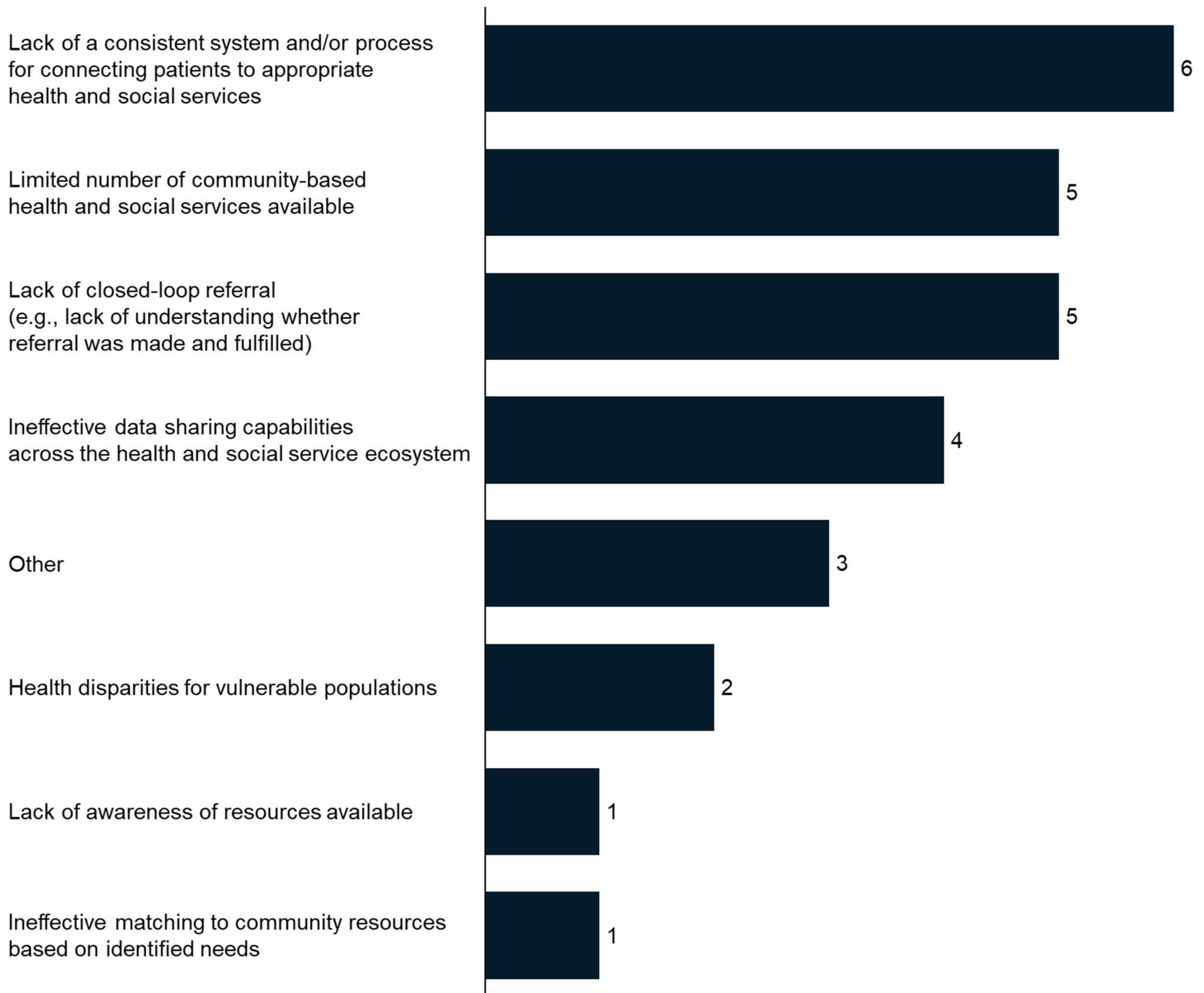
Exhibit 16: Current barriers to community-based care coordination for Safety Net Providers (n=14) [77]



When asked about anticipated future barriers to CIE implementation, safety net providers in the survey were most likely to identify resources to support a CIE as a challenge (50% of respondents). The least selected barrier was organizational adoption, with less than 30% of respondents identifying it as a barrier.

[77] Source: CIE survey question: "What pain points do you currently face around connecting patients to appropriate health and social services (select top 3)?"

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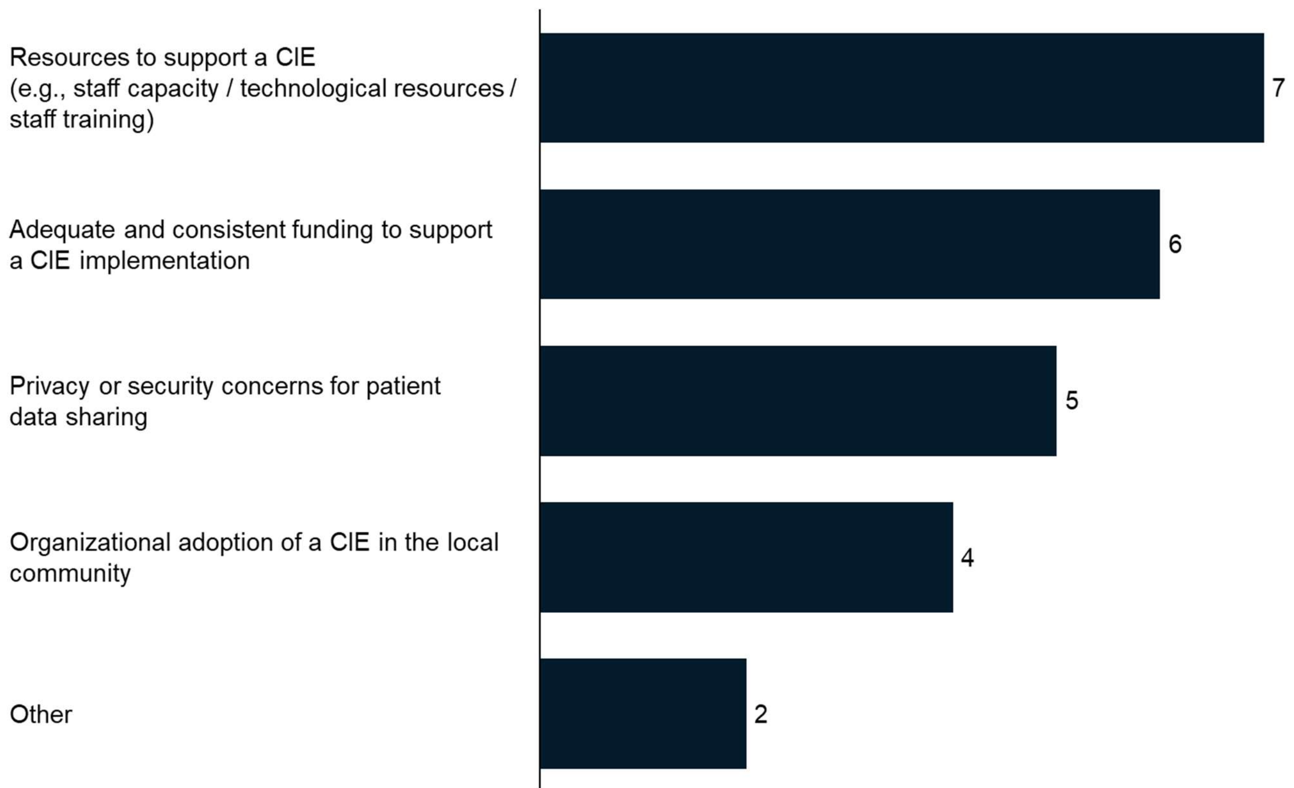
Exhibit 17: Anticipated barriers to CIE implementation for Safety Net Providers (n=14) [78]



5.2.8 Pain points: Other stakeholders

Stakeholders who listed their organization type as 'other' on the survey represented a range of organizations, including local and regional health departments, universities and research institutions, hospitals, resource directories and call centers, law enforcement, not-for-profit care centers, and CIE technology vendors, among others.

Among these stakeholders, the only pain point identified by a majority was lack of a closed-loop referral system (63% of respondents). Respondents were least likely (<25% of respondents) to select health disparities (21%), ineffective matching (16%), and lack of awareness of resources (11%) as pain points.

[78] Source: CIE survey question: "Which of the below do you anticipate will be challenges in implementing and using a CIE solution?"

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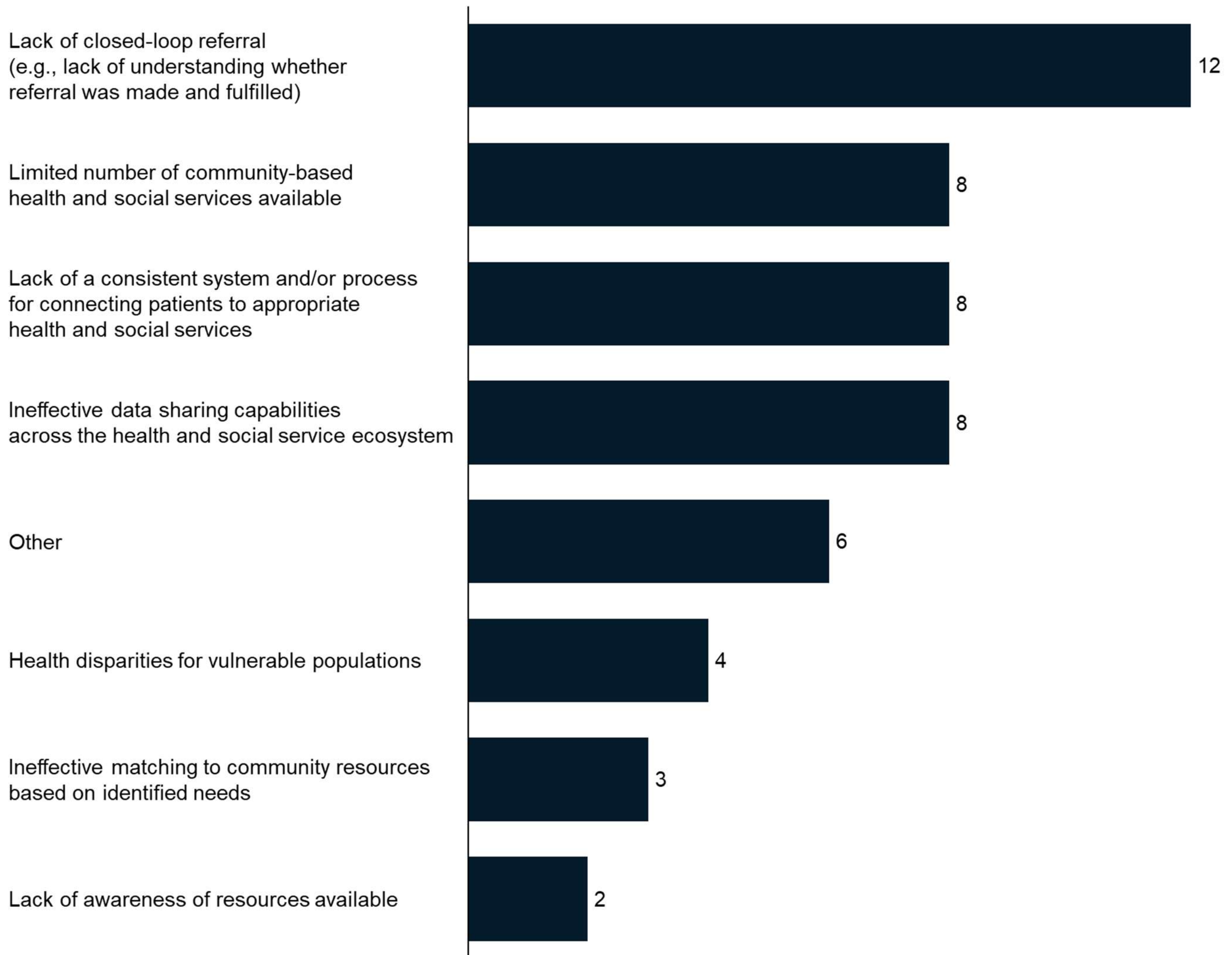
Exhibit 18: Current barriers to community-based care coordination for other stakeholders (n=19) [79]



In terms of anticipated barriers to future CIE adoption, three of the four listed options were each selected by 75% of respondents: funding for CIE, resources to support CIE, and organizational adoption. The only barrier identified by less than 50% of respondents was privacy and security of patient data (47%).

[79] Source: CIE survey question: "What pain points do you currently face around connecting patients to appropriate health and social services (select top 3)?"

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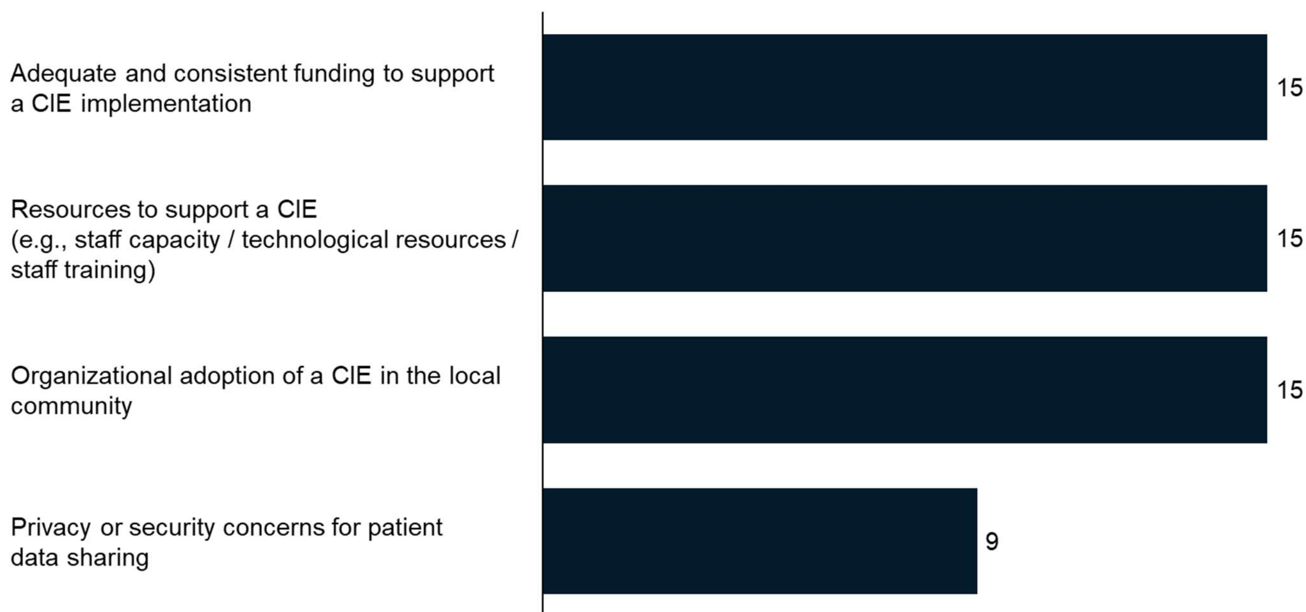
Exhibit 19: Anticipated barriers to CIE implementation for other stakeholders (n=19)[80]



5.3 Expected roles for HCA in implementing a statewide CIE solution

Across all the interviews conducted, stakeholders and partners were asked about the role HCA could play in implementing a statewide CIE solution. The following key themes were identified and aggregated into a single list to represent suggestions obtained across the various stakeholder and partner groups:[81]

- **Provide sustainable funding support to build and maintain a CIE solution:** Historically, organizations have received limited funding for shorter durations to run pilot programs – this has limited their ability to deploy community-based care coordination tools in a sustainable way. Additionally, lack of consistent funding has been cited as one of the challenges around building adoption with local CBOs who may not be willing to shift to a new technology with no defined long-term funding plan. To bridge these gaps, stakeholders and partners would like to see consistent HCA funding support for CIE deployment, including both implementation and ongoing maintenance costs.
- **Provide funding to build and develop a strong community-based workforce at the local level:** In interviews conducted, stakeholders and partners shared that a statewide CIE solution will need to be complemented by well-trained, on the ground CBWs. CBWs act as trusted navigation liaisons in communities, and they regularly use their relationships at the local level to provide timely community-based care coordination for patients. Unfortunately, there is a shortage across majority of regions which is made worse by the lack of adequate resources to develop and train even the existing set of CBWs. Stakeholders and partners requested HCA play a bigger role in helping individual regions with funding for hiring, training, and ongoing development of CBWs.
- **Set standards for data:** Stakeholders and partners see HCA as being uniquely positioned to act as the statewide data steward for a CIE system. In this role, HCA can set and disseminate standards on data security in compliance with all key regulations (e.g., HIPAA, FERPA, 42 CFR Part 2). Furthermore, HCA can provide guidelines on data capture and outcome reporting (e.g., data to be shared as part of a referral, data

[80] Source: CIE survey question: "Which of the below do you anticipate will be challenges in implementing and using a CIE solution?"
[81] Please see Section 3 for detailed methodology

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to be reported for MCO billing, guideline on what qualifies as a successful housing referral). This could help drive consistency and coordination across various organizations that need to work together to provide care for an individual patient. As HCA builds data standards, stakeholders and partners would like HCA to maintain close alignment with other state agencies (e.g., DOH, DCYF, Dept. of Corrections) to provide singular state level guidance to on-the-ground organizations.

- **Analyze statewide data to identify care gaps:** Stakeholders and partners would like HCA to analyze cross-regional data to identify care gaps that can then inform development of new service delivery options and/or programmatic improvements. Stakeholders and partners would like for HCA to co-design this strategy with them, with some degree of local data ownership maintained to allow for easy and timely access to data. With this approach, organizations could potentially more effectively respond to immediate patient needs while also proactively addressing care gaps through longer-term investments.
- **Set and disseminate standards for HSRN screening:** At present, organizations across the state use different tools for screening patients for HRSNs and have varying degrees of success with correctly identifying holistic patient needs. Some respondents suggested that HCA can help by providing statewide guidance and standards on HSRN screening to promote consistency in case management and referrals across all members of a patient care team.
- **Act as a convener across the ecosystem:** A successful CIE implementation will likely need consistent input and engagement from various stakeholders and partners both at the state and regional level. HCA can help enable this through active outreach to partner organizations along every step of the CIE planning and implementation process. A second challenge that has come up in interviews is the lack of a consistent definition for CIE combined with varying levels of understanding about what a CIE solution hopes to achieve. As a convener, HCA can promote shared language around CIE that bridges clinical care and community services to enable effective and accurate communication. Finally, organizations stated the lack of an appropriate forum for cross-section communication and sharing of learnings. HCA can help plug the gap by collecting and sharing best practices from different parts of the ecosystem and by creating better opportunities for cross-sector interaction (e.g., hosting CIE learning collaborative calls with interested parties)
- **Invest in interoperability as a key feature of community-based care coordination**: Many consulted partners and stakeholders reported interoperability as a critical function of a statewide solution that HCA could support. At present, there are multiple community-based care coordination systems in use across different groups – providers often use over 10 different EHRs, CBOs document and report data on multiple grant systems, care coordinators utilize several case management tools, MCOs and ACHs have invested in different CIE solutions, and multiple resource directories exist at any given time. Stakeholders and partners noted a preference to drive towards better data interoperability. Integrating across all these platforms is a highly complex effort that can be more efficiently coordinated and funded on a state level with HCA leading the effort as part of their strategy on a statewide CIE solution.
- **Build statewide data sharing agreements:** In the current ecosystem, data sharing is often a time consuming and expensive effort to undertake as organizations are required to negotiate and sign data sharing agreements at a 1:1 level. For example, CBOs report often having to sign individual data sharing agreements across multiple MCOs, ACHs, and providers. HCA can help reduce this burden by developing a single data sharing template in compliance with state and local regulations (e.g., HIPAA, FERPA, 42 CFR Part 2) that could be used by all parties in the CIE ecosystem. Additionally, a standardized data sharing template could help promote better patient data privacy with appropriate guardrails on data being gathered and shared

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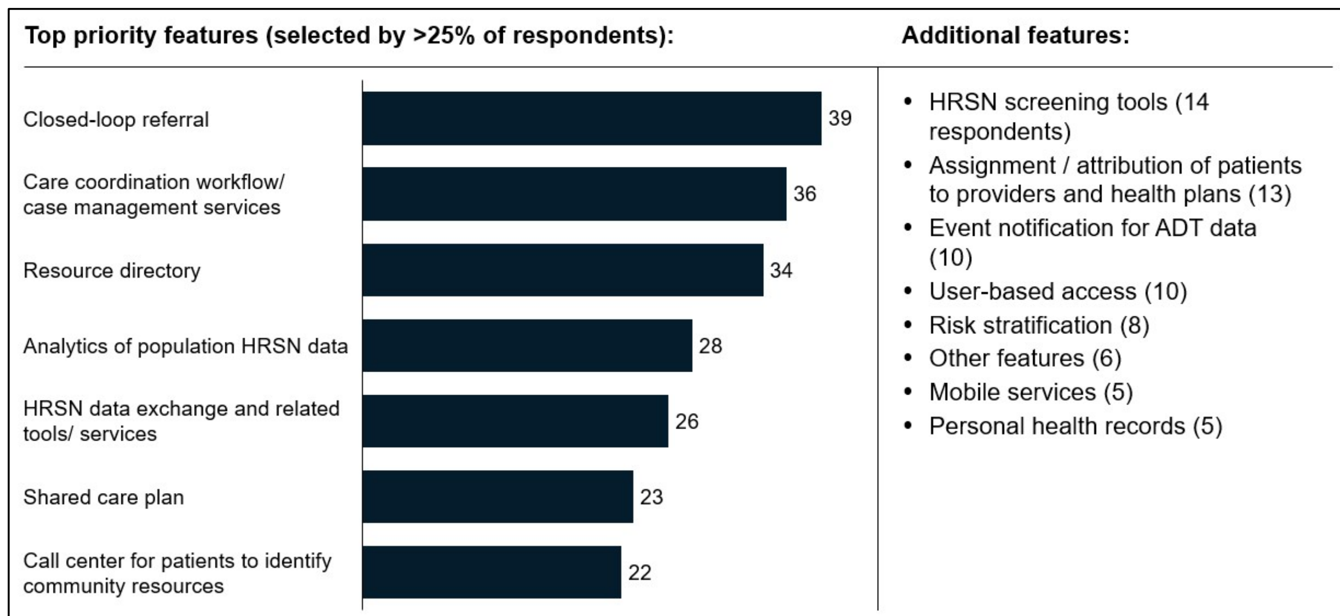
within the ecosystem. HCA could consider co-developing this template with representatives and lawyers from across different stakeholder and partner groups to ensure better adoption of the standardized data sharing agreements in the future.

5.4 Desired features in a statewide CIE solution

Stakeholders and partners were consulted during the CIE survey about the features they would find most helpful in a future statewide CIE solution. More than 40% of respondents across organization types selected a closed-loop referral system, care coordination workflow / case management tool, or a shared directory of available resources in their top five priority features for a future statewide CIE platform.

Exhibit 20: Desired functions and capabilities in a statewide CIE solution (n=81) [82] [83]



During interviews and other live input sessions, stakeholders and partners were not specifically asked to name the features that would be most helpful to have in a statewide CIE solution. However, in their discussion of other topics, including pain points and expected HCA role in a future solution, multiple respondents provided input on valued CIE features.

At least five interviewees noted that they would want access to a shared statewide resource directory. Several of those commenters emphasized that they would want a shared directory to have a reliable system for updating listings and to include information about day-to-day scheduling availability of partner organizations. They also added that a useful directory might consolidate information from the current partial directories in use in the state today.

At least three interviewees said that they would prioritize a closed-loop referral system in a statewide CIE solution. One ACH representative said that, in a recent care coordination landscape assessment, closed-loop referral was among the top priorities identified by their community members, especially among partner organizations. Some interviewees added that they would want a closed-loop referral system to be automatically bidirectional, giving senders an electronic notification of care received rather than requiring manual follow-up.

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[82] Source: CIE survey question: "What specific functions or capabilities do you envision will be most helpful to have in a statewide CIE solution (select top 5 choices)?"

[83] Responses in the 'other' category included funding, participation incentives for CBOs, consolidation of current resource directories, a statewide data sharing standard, and support for interoperability.

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6. Market Scan of CIE vendors

The following section provides publicly available information on select CIE vendor solutions that have been identified to date in the market. This scan involved a press-search and interviews with external experts. HCA should independently verify information shared in this section before making any decisions on products or vendor solutions. For each technology solution, there is information provided on capabilities, licensing options, and case examples from past implementations. To date, this market scan has identified four CIE solutions,[84] namely Care Coordination Systems (CCS), Findhelp (formerly Aunt Bertha), Unite Us and WellSky Social Care Coordination (formerly Healthify) – additional information on these solutions is provided below. Solutions and the underlying capabilities for each solution (e.g., closed-loop referral, resource directory, etc.) have been listed in an alphabetical order. Additionally, the market scan includes details on current alternatives that are being used across the region such as resource directories, case management platforms, data analytics platforms, and CIE capabilities as an extension of an existing HIE. For each solution, information was gathered on core capabilities and past implementations.[85]

6.1 Coordinated Care Solutions (CCS)

6.1.1 Overview and capabilities:

Care Coordination Systems (CCS) is a healthcare IT company that provides interconnectivity products for community-based care coordination. CCS offerings include – a resource directory solution called HealthBridge, closed-loop referral capability, user-based access, data analytics, a patient social data solution called Community Health Records (CHR), and a training solution called Care Transitions Intervention (CTI). Below is a brief description of its core capabilities:

<u>Care Transitions Intervention</u>: CCS provides a services solution for training and developing Care Transition Intervention® (CTI) Coaches, Transition Coaches®, and CHW.[86] CTI® is a model developed by Dr. Eric Coleman at University of Colorado – with the help of Transition Coaches, CTI® strives to teach self-management skills to patients with complex care needs who are transitioning from hospital to home.[87]

<u>Closed-loop referral:</u> CCS offers a closed-loop referral system that requires a CHW to make manual referral status updates based on patient feedback.[88] At present, patient health or social records are typically not shared as part of the referral.
Referrals can be made in two ways – the patient can make a self-referral, or a referral can be made on behalf of the patient (e.g., by a CHW). To make a self-referral, a patient can search for resources and request an appointment with any organization using HealthBridge. The organization receives an email alert and can log in to HealthBridge to view the request. Then, the organization and the patient can coordinate on an appointment time and hold any additional communication through a messaging feature available as part of HealthBridge. Information on the referral is tracked on CHR and can be accessed by the CHW assigned to the patient.
An example of a referral being made on behalf of the patient is when a CHW logs in to the CCS CHR portal and requests an appointment for the patient. This request shows up for the receiving organization on HealthBridge, where they can accept/reject the referral and schedule an appointment accordingly.

[84] This is not an exhaustive list and solutions were identified through publicly available research and experts in the area.
[85] See Section 3 for additional information on the landscape assessment methodology and sourcing.
[86] https://caretransitions.health/about
[87] https://caretransitions.org/about-the-care-transitions-intervention/
[88] https://community.healthbridge.care/#!/Explainer

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Community Health Record (CHR): CCS offers a Community Health Record (CHR) tool that is an online portal.[89] Community Health Workers (CHWs) use CHR to document care-related notes and support patients in scheduling and tracking of appointments.[90]

Data analytics: CCS offers a set of dashboards and reports that pertain to users' monthly activities. Examples of metrics analyzed include patient engagement, discharge status from an assigned CHW, and number of patients by zip code.[91]

Data interoperability: CCS shares information with others via multiple channels including – (a) CSV files extracted from reports and transmitted to secure FTP locations, (b) Direct secure messaging to EMR systems, providers, pharmacies, and anyone with a valid HISP/Direct message account, (c) point-to-point secure encrypted, and (d) Application Program Interface with a library of 70+ APIs for connection to organizations and other systems.[92]

Data security: Outside of basic information related to a patient's name and referral history, CCS does not record sensitive data. The platform follows NIST cybersecurity standards and is compliant with HIPAA, SOC1, and SOC2.[93]

Resource directory: HealthBridge is an online interface with a search engine functionality (akin to Google) that connects people with information on local community resources (i.e., foodbanks).[94] Specifically, HealthBridge collects information on an organization's logistical capabilities (i.e., address, operating hours, services provided).

6.1.2 Licensing options

CCS offers a tiered monthly subscription model that charges a flat fee which scales based on an organizations' headcount.[95]

6.1.3 Case examples from past implementations:

Case example #1 –partnership with Lake County, CA[96]

Lake County, CA partnered with CCS in 2020 to determine community needs and potential community resources to create a community-wide resource and referral system. Additionally, CCS was contracted to plan and implement the CHR system with support for activities such as identifying need for and number of CHR licenses, conducting community engagement, and educating organizations on CHR use.

6.2 Findhelp[97]

6.2.1 Overview and capabilities:

Findhelp is a social care technology platform with nationwide presence and a network of over 200 provider and payer organizations.[98] To coordinate care across organizations, Findhelp's solution offers several features

[89] "CCS Overview and Infrastructure", shared by DOH on August 9, 2022
[90] https://www.youtube.com/watch?v=Fv3G4nj7ku0
[91] "CCS Overview and Infrastructure", shared by DOH on August 9, 2022
[92] http://crhn.org/pages/wp-content/uploads/2017/02/CCSPathways-Presentation-BOB-HARNACH-20170315.pdf
[93] http://crhn.org/pages/wp-content/uploads/2017/02/CCSPathways-Presentation-BOB-HARNACH-20170315.pdf
[94] healthbridge.care
[95] https://centralhealthcollaborative.files.wordpress.com/2018/08/pathways-and-the-hub-bob-harnach-8-7-18.pdf
[96] http://www.lakecountyca.gov/Assets/Departments/Mental+Health_AODS/docs/QI+and+Comp/Contracts/FY20-21/Pathways+HUB+FY+20-21.pdf
[97] https://company.findhelp.com/
[98] https://go.findhelp.com/bestinklas2022

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including a resource directory, closed-loop referral system, HRSN screening tools, user-based access, data analytics, mobile/offline services, and a community engagement team. Below is a brief description of its core capabilities:

Closed-loop referral: Organizations have the option to utilize a closed-loop electronic referral system within the Findhelp platform. Patient name, preferred contact method, and consent for sharing information with involved parties is must-have information for the referral.[99] Additionally, organizations have access to assessment history for the patient seeking help.[100] When a referral is sent or accepted through the platform, both the referrers (staff worker and/or patient) and the partner organization are notified via email, even if one of them does not have an active Findhelp account. [101] Referral information and social records are stored and tracked on the Findhelp platform.[102]

Community engagement team: Findhelp provides an on-the-ground Community Engagement Team that provides free resources and monthly trainings to CBOs.[103] The engagement process starts by working with customers to identify key CBO partners within the community. The Community Engagement Team then educates CBOs on the free toolkit that Findhelp offers and how CBOs can best meet patients' needs through the platform.[104] CBOs are encouraged by the Community Engagement Team to take ownership of their Findhelp listing and respond to referrals.[105]

Data analytics: Findhelp reserves the right to utilize data collected in aggregate and anonymized for statistical information analyses – the aggregated statistics is owned by Findhelp. Through the platform, a suite of data analytics that update daily is available to inform customers on various outcome and care metrics.[106] Dashboards (e.g., recent activity and area information) and reports (e.g., search history, gap reporting) provide organizations with additional insights that can help them better provide care for patients.[107] Organizations can also customize the Findhelp tool (e.g., color scheme, logo, pop-ups) to meet its needs.[108]

Data interoperability: Findhelp has adopted FHIR standards for data exchange. Findhelp partners with care management systems (e.g., Innovaccer and naviHealth) and EHRs (e.g., Epic, Cerner, Athenahealth, eClincialWorks) to allow for interoperability.[109] APIs support data exchange between EHRs and care platforms.[110] As an example, Findhelp's partnership with Innovaccer allows care managers who use InNote and InCare to search for community resources and make referrals that are tracked in member charts.[111]

A sample list of Findhelp's partners includes: Epic, Cerner, eClinicalWorks, Innovaccer, Salesforce, Altruista Health, Vlocity, CareIQ, CareEvolution, REDCap, Care Compass Network, Family Connects, iCarol, Navvis, Arcadia, ZeOmega, naviHealth, Optum, VirtualHealth, Casenet, MHK, The Garage.[112]

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[99] https://auntbertha-2.wistia.com/medias/pdimqjhfcp
[100] https://organizations.findhelp.com/about/#1632811196910-8f9492e3-65c9
[101] https://auntbertha-2.wistia.com/medias/pdimqjhfcp
[102] https://company.findhelp.com/our-solutions/network/#1632213553878-7da9e359-8487
[103] https://company.findhelp.com/proposal/
[104] https://auntbertha-2.wistia.com/medias/pdimqjhfcp
[105] https://company.findhelp.com/closing-the-loop/
[106] https://support.findhelp.com/hc/en-us/articles/360051658932-Analytics-Overview
[107] https://support.findhelp.com/hc/en-us/articles/4407904536219-Program-Tools-Dashboard
[108] https://auntbertha-2.wistia.com/medias/pdimqjhfcp
[109] https://company.findhelp.com/partnerships/
[110] https://company.findhelp.com/implementation/
[111] https://company.findhelp.com/partnerships/
[112] https://company.findhelp.com/partnerships/

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Data security: Customers of Findhelp retain ownership over their data that is shared on the platform.[113] If a self-referral is made, only that person will be able to see the referral, besides the referred organization. Findhelp is compliant with HIPAA and FERPA and uses encrypted communication in its integrations.[114] Findhelp also has HITRUST CSF Certification and HITRUST Certification of the NIST Cybersecurity Framework.[115] Audit logs within Findhelp track who is searching a patient's history to ensure that the searcher is in a care coordination relationship with the patient.[116] In addition, patients can view and edit permissions for organizations that have access to their referral history.[117]

HRSN screening and risk stratification: Organizations can administer an HRSN prescreening tool (either from a list of 80 pre-made questions or customized) on the Findhelp platform to determine a patient's eligibility and need for programs when making referrals.[118] The screening tool automatically risk stratifies a patient.[119]

Mobile services: In addition to desktop, the platform is available on mobile through an app.[120] For offline access, some customers print program information in bulk and mail available resources to patients.[121]

Resource directory: Findhelp offers two types of resource directories – (a) a free, publicly available directory in of nationwide care resources (translated in 100+ languages) which anyone can access anonymously. Organizations added to this list may or may not belong to the Findhelp referral network. and (b) a focused resource directory that organizations can create with selected programs — including their internal programs.[122] Organizations can also rank and score programs which provides their staff with reliable information to help patients.[123]

Across both types of directories, Findhelp categorizes resource listings based on social need (e.g., food, housing, good, transit, etc.).[124] Additional filters are also available to conduct a more tailored search – e.g., "Help Pay For Food" under the broader category of "Food", insured vs uninsured, and resources for infants vs Seniors (55+ age).[125] Although not required, some organizations also provide capacity and scheduling availability as part of their profile listing.[126] Additional information shown can include contact information, directions, eligibility, services offered, languages translated, costs, and time of last update to profile information.[127]

6.2.2 Licensing options

Findhelp licenses its solution using a tiered monthly or annual subscription model that includes unlimited users and $0 network setup fees.[128] They offer different subscription tiers with varying levels of features – for example, the "Basic" model includes a reporting suite, team collaboration options, and dedicated account

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[113] https://company.findhelp.com/customerterms/
[114] https://www.findhelp.org/claims
[115] https://company.findhelp.com/about/?__hstc=4845100.c4a577029c49e44b73bd3bee6fa38565.1636156800124.1636156800125.1636156800126.1&__hssc=4845100.1.1636156800127&__hsfp=2774523568
[116] https://camdenhealth.org/integrating-data-and-building-trust-in-south-jersey/
[117] https://company.findhelp.com/privacy-model
[118] https://company.findhelp.com/blog/2019/01/29/our-screening-form-has-arrived/
[119] https://cdn2.hubspot.net/hubfs/455700/Aunt%20Bertha%20for%20AHCs%20%5BPublic%5D.pdf
[120] https://play.google.com/store/apps/details?id=com.auntbertha.webapp.ab&hl=en_US&gl=US
[121] https://company.findhelp.com/proposal/
[122] https://auntbertha-2.wistia.com/medias/pdimqjhfcp
[123] https://auntbertha-2.wistia.com/medias/pdimqjhfcp
[124] https://auntbertha-2.wistia.com/medias/pdimqjhfcp
[125] https://www.findhelp.org/
[126] https://auntbertha-2.wistia.com/medias/pdimqjhfcp
[127] https://www.findhelp.org/
[128] https://company.findhelp.com/our-solutions/

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support while their “Enterprise” model includes EHR and care platform integration, API integration, and configurable search results in addition to offerings from the Basic tier model. [129]

Different subscription pricing plans are also available depending on the organization type, e.g., government or Federally Qualified Health Centers (FQHC). For FQHCs, three monthly subscription options are available based on the number of clinicians.[130] Subscriptions include a dedicated community and staff sites, team collaboration features, a reporting and analytics solution, a Single sign on authentication (SSO), and integration with the health center’s system. For governments (e.g., city, county, state), three annual pricing tiers are offered based on population size.[131]

6.2.3 Case examples from past implementations

Findhelp has existing partnerships with health plans, health systems, educational institutions, government entities, and other types of organizations.

Case example #1 – Oregon case study:
The state of Oregon’s CIE strategy is overseen by the Oregon Health Authority (OHA). [132] As of 2020, two main CIE vendors are being used across the state: Unite Us and Findhelp. Findhelp is available for free to CBOs, Licensed Practitioners of the Healing Arts (LPHAs), and Tribes within Oregon – with voluntary participation and the freedom to choose how they engage with the Findhelp platform without any requirements to adhere to network norms.[133,134] In addition, Findhelp also works with Medicaid CCOs and Health Plans, including Cascade Health Alliance and Trillium Community Health Plan in 5 counties: Clackamas, Lane, Washington, Klamath, and Multnomah. The platform is used as a shared resource directory, closed-loop referral system, HRSN screening tool.[135]

Case example #2 – Camden Coalition case study
The Camden Coalition of Healthcare Providers is a nonprofit working to improve care for people with complex health and social needs in Camden, New Jersey. They develop, test and redesign care management models in partnership with various organizations (e.g., health systems, CBOs, government agencies, payers, etc.).[136]

In 2016, Camden Coalition partnered with Findhelp (Aunt Bertha at the time) to provide a social services search tool for Camden County called My Resource Pal. Prior to using Findhelp, Camden Coalition created a shared resource library on Google Drive that it mentioned was difficult to navigate and keep up to date.[137] Camden Coalition switched to Findhelp when it realized that the knowledge on local resources was not readily accessible or easily useable. When My Resource Pal launched, Camden Coalition sent Americorps health coaches to train partner health providers to use the tool. Currently, My Resource Pal includes information on over 7,000 programs in the state of New Jersey.[138]

[129] https://company.findhelp.com/our-solutions/
[130] https://company.findhelp.com/fqhc/
[131]https://go.findhelp.com/government/
[132] https://www.oregon.gov/oha/HPA/OHIT/Pages/CIE-Overview.aspx
[133] https://www.oregon.gov/oha/PH/ABOUT/CETDocuments/Community-Information-Exchange-Flyer.pdf
[134] http://www.orhealthleadershipcouncil.org/wp-content/uploads/2020/12/HIT-Commons-CIE-Advisory-Group-Report-Final-Report-December-2020.pdf
[135] https://www.oregon.gov/oha/PH/ABOUT/CETDocuments/Community-Information-Exchange-Flyer.pdf
[136] https://camdenhealth.org/about/
[137] https://camdenhealth.org/aunt-bertha-social-services-search/
[138] https://camdenhealth.org/integrating-data-and-building-trust-in-south-jersey/

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With Findhelp's ability to allow user suggestions to directory listings, Camden Coalition utilized My Resource Pal as a crowdsourced database. Additionally, clinical providers also use the tool for HRSN screening and closed-loop referrals.[139] Patients who screen positive for at least one HRSN (housing instability, food instability, utility needs, interpersonal violence, transportation) receive a referral summary and a printout from My Resource Pal of community service providers that can address their needs.[140] In 2021, Camden Coalition was working with Findhelp to integrate My Resource Pal into the organization's HIE system so that providers can access social needs information and refer patients within the HIE platform.[141]

6.3 Unite Us[142]

6.3.1 Overview and capabilities:

Unite Us is a technology company that builds coordinated care networks of health and social service providers.[143] As part of its solution suite, the Unite Us platform provides a resource directory, closed-loop referral capability, HRSN screening tools, user-based access, analytics, risk stratification, and care coordination workflow/case management services. Additionally, in 2021, Unite Us acquired NowPow, a referral platform that aims to support whole person care in communities.[144]

Unite Us also recently launched its Social Care Payments solution to support the implementation and management of paid social scare programs for healthcare funders.[145] Through the platform, health plans can access a contracted network of CBOs, facilitate eligibility and authorization processes, simplify invoicing and billing to reimburse community partners for services, and measure the effectiveness of social care funding.[146]

Below is a brief description of the Unite Us care coordination solution's core capabilities:

<u>Care coordination workflow/case management services:</u> The Unite Us platform can be leveraged to create a virtual care team involving members of partner organizations, case managers, or social workers, who can share information and updates on patient treatment.[147] The platform tracks patients' health journeys and allows staff of partner organizations to add case notes or documents associate with each patient.[148]

<u>Closed-loop referral:</u> Unite Us allows partner organizations to send electronic referrals after receiving digital consent from patients.[149] As part of the referral, organizations can add configurable assessments by service type to share more detailed information on the specific needs of each patient.[150] As part of resolution tracking, the Unite Us tracks every referral, interaction, and outcome on the platform. Additionally, the platform allows for real-time updates to be shared between different members of the care team helping a particular patient.[151] Unite Us offers a Sensitive Organizations feature that provides privacy protections for organizations

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[139] https://camdenhealth.org/our-online-social-service-finder-expands-beyond-camden-county/
[140]
[141] https://camdenhealth.org/integrating-data-and-building-trust-in-south-jersey/
[142] https://uniteus.com
[143] https://www.csctulsa.org/wp-content/uploads/2021/03/Unite-Us-FAQ-for-Network-Partners.pdf
[144] https://uniteus.com/nowpow
[145] https://uniteus.com/unite-us-drives-funding-into-communities-with-launch-of-social-care-payments-technology/
[146] https://uniteus.com/unite-us-drives-funding-into-communities-with-launch-of-social-care-payments-technology/
[147] https://vimeo.com/showcase/7014662
[148] https://www.csctulsa.org/wp-content/uploads/2021/03/Unite-Us-FAQ-for-Network-Partners.pdf
[149] https://uniteus.com/how-it-works/
[150] https://uniteus.com/serve/
[151] https://uniteus.com/how-it-works/

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administering services to vulnerable patients. Any organization that is subject to 42 CFR Part 2, offers HIV/AIDS support, services survivors of domestic violence or sexual violence, or provides legal services is classified as sensitive. Referrals and associated records sent to or from a Sensitive Organization are only visible to the sender and recipient organizations that are directly involved in care service for the patient (e.g., information on domestic abuse is shared only if the referrals are being made from or to an abuse survivor organization).[152]

Community engagement team: Unite Us provides a community engagement team that works directly with local organizations and supports them through onboarding and training.[153] Unite Us provides in-person and virtual training prior to network launch, ongoing webinar trainings, reference materials, and a learning hub to all network partners.[154] A Network Hub Support (NHS) team is available to provide administrative support for referral requests from partner organizations, identify community members that have high social needs using a proprietary Social Opportunity Index score (SOI), and direct self-referrals from an online Assistance Request form to the appropriate social care[155].

Data analytics: Tailored reports and dashboards illustrate standardized outcome data specified at the individual, partner organization (e.g., CBO, health plan), or regional level. [156] Unite Us can monitor metrics such as network activity, service demand and delivery, co-occurring and re-occurring needs, and network efficiency and impact to provide insights for in-network organizations.[157] In addition, a Community Needs Map that visualizes social care needs for patients via a calculated Community Needs Index is publicly available on the platform.[158] Also, In 2020, Unite Us acquired social-determinants-focused analytics company Staple Health (tracks detailed data on how social factors are impacting acute care, behavioral health, substance use and other key patient outcomes).[159]

Data security: Unite Us is a HIPAA, FERPA, and 42 CFR Part 2-compliant platform that also has certifications aligned with privacy and security frameworks such as HITRUST and SOC 2 Type 2.[160] Partner organizations can only view information on the patients they serve.[161] Unite Us signs Business Associate Agreements (BAAs) with partners in its network that provide health-related services and are considered Covered Entities under HIPAA.[162] All network information is dually protected by secure technology and user procedures, and the network is routinely audited for digital security.[163]

EHR/ care management interoperability: The Unite Us platform is built on APIs and can integrate with several EHRs (e.g., Epic, Cerner, eClinicalWorks, VirtualHealth, KaiserPermanente)[164] and care management tools (e.g., OCHIN, iCarol).[165]

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[152] https://blog.uniteus.com/sensitive-organizations
[153] https://vimeo.com/showcase/7014662
[154] https://www.csctulsa.org/wp-content/uploads/2021/03/Unite-Us-FAQ-for-Network-Partners.pdf
[155] https://uniteus.com/enroll/
[156] https://uniteus.com/serve
[157] https://uniteus.com/measure/
[158] https://uniteus.com/community-map/
[159] https://uniteus.com/unite-us-acquires-sdoh-analytics-company-staple-health/
[160] https://uniteus.com/how-it-works/
[161] https://uniteus.com/protect/
[162] https://www.unitedwaynsv.org/sites/unitedwaynsv.org/files/Unite%20Us%20FAQ%20for%20Network%20Partners%202.0.pdf
[163] https://uniteus.com/how-it-works/
[164] https://blog.uniteus.com/ehr-integration
[165] https://www.csctulsa.org/wp-content/uploads/2021/03/Unite-Us-FAQ-for-Network-Partners.pdf

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HRSN screening and risk stratification: Unite Us lists itself as screening tool agnostic, such that it can take any set of questions from a partner organization and run proprietary algorithms to predict risk and co-occurring patient needs.[166] Unite Us evaluates patients across 12 factors, coming up with a composite Social Needs Score (SNS) Score of 0-100 that predicts the level of overall social need[167]

Resource directory: Unite Us allows a real-time search of care resources where a user can filter organizations based on the patient's specific need (e.g., food assistance, housing & shelter, transportation, etc.).[168] Users can request updates to the resource directory listings via an online request form – organization information is then edited based on publicly available information.[169]

User login: Unite Us provides secure logins for each network partner with configurable access and permission settings at the organization and individual user levels.

6.3.2 Licensing options

Unite Us charges a one-time fee for configuration and setup and recurring annual fees for network access, network maintenance, and third-party integrations.[170]

6.3.3 Case examples from past implementations

Case example #1 – NCCARE360[171]

Unite Us has implemented its platform for state governments using a range of implementation methods. One example is in North Carolina as a partner of NCCARE360.

NCCARE360 is a statewide coordinated care network with a focus on connecting patients to local services and resources. It is based on a public-private partnership between the North Carolina Department of Health and Human services (DHHS) and the Foundation for Health Leadership & Innovation (FHLI). The roll-out of NCCARE360 began in early 2019 and was launched statewide in June 2020, where it became active in all 100 counties across the state.[172]

The implementation team for NCCARE360 includes United Way of NC/2-1-1, Expound Decision Systems, and Unite Us. NC/2-1-1 provides a statewide resource directory and runs a call center. A community repository powered by Expound pulls information from multiple resources directories across the state and allows data sharing. Unite Us acts as the shared technology platform that enables health and human services providers to send and receive electronic referrals, communicate in real-time, share client information, and track outcomes. A community engagement team from Unite Us also works with community-based organizations, social service agencies, health systems, independent providers, community members, and more to create a statewide coordinated care network.[173]

[166] https://uniteus.com/serve/
[167] Unite Us solutions brochure at https://uniteus.com/knowledge-hub/#downloads
[168] https://nccare360.resources.uniteus.io/
[169] https://uniteus.com/directory-requests/
[170] https://www.patchwiselabs.com/wiki/uniteus
[171] https://nccare360.org/
[172] https://northcarolina.uniteus.com/
[173] https://nccare360.org/team/

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6.4 WellSky Social Care Coordination (formerly known as Healthify)[174]

6.4.1 Overview and capabilities

WellSky is a technology company that offers multiple software solutions and services across the continuum of health and social care. In terms of feature set, in addition to acute, post-acute, and community care technology solutions, WellSky expanded its portfolio to include a HRSN care coordination solution with the acquisition of Healthify in 2021. Following the acquisition, Healthify was renamed WellSky Social Care Coordination. [175]

As part of the HRSN care coordination solution, WellSky provides a closed-loop referral capability, a resource directory, HRSN screening tool, user-based access, analytics, and risk stratification (enabled through a third party). Below is a brief description of its core capabilities:

Closed-loop referral: Patient screening information and basic demographics are shared with relevant in-network organizations identified as part of the patient's care team. At present, the closed-loop capability is used primarily to document an acceptance of the referral from the receiving organization. Both clinical and nonclinical organizations can send and receive referrals.

Data analytics: WellSky collects social records data through the platform, with customers retaining ownership over the data. WellSky reserves the rights to utilize the data collected in aggregate for population health analytics[176] – for instance, a reporting suite that tracks HRSN trends and referral outcomes is offered through the platform. Additionally, select measures (e.g., number of referrals) are tracked to determine usage and outcomes at the local level.[177]

Data interoperability: Regarding interoperability, WellSky Social Care Coordination has integration capabilities with health plan care management software (e.g., GuidingCare platform) and major provider EHRs (e.g., Epic). It also supports HL7 and API integrations into several healthcare and Business Intelligence (BI) systems. Additionally, as part of the acquisition, WellSky wants to integrate Healthify's HRSN referral platform and community networks with their existing human and social services network.[178]

HRSN screening and risk stratification: Health plans and providers can choose from standard screening tool available on the WellSky platform or create a custom screening tool that meets their needs.[179] Based on results of the screening, risk levels can be assigned via analytics.[180]

Network of CBOs: Another feature of WellSky Social Care Coordination is its network of social services and CBOs. WellSky works closely with health plans to continuously develop the network through proactive outreach and onboarding support for potential partners.[181]

Resource directory: WellSky has a national directory which is made available as a default to any partner organization. Additionally, they provide an incremental service where a partner organization (e.g., health plans, provider organizations) can request a curated resource directory that best meets its unique requirements and HRSN priorities. This curated list is managed by a dedicated resource network team that updates directory profile information as per individual contract requirements – one customer, Reading Hospital, noted that the

[174] https://wellsky.com/social-care-coordination/
[175] https://wellsky.com/healthify-is-now-wellsky-social-care-coordination/#:~:text=WellSky%20acquired%20Healthify%20in%202021,evolving%20at%20an%20unprecedented%20pace.
[176] https://wellsky.com/wp-content/uploads/2021/05/WellSky-Master-License-Agmt-online-12.17.2020.pdf
[177] https://www.healthify.us/solutions#Platform
[178] https://wellsky.com/wellsky-to-acquire-healthify-to-enhance-social-services-care-coordination/
[179] https://www.healthify.us/solutions#Platform
[180] https://wellsky.com/social-care-coordination/#performance-insights
[181] https://wellsky.com/social-care-coordination/#community-partnership

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directory profiles are updated every 90 days.[182] Partner organizations included as part of the directory also have an option to self-update their profiles, including any information on capacity for accepting referrals.[183]

6.4.2 Licensing options

WellSky Social Care Coordination offers two licensing solutions: user licensing and per member per month (PMPM).[184] For user licensing, costs vary depending on the size and breadth of the deployment and are cheaper when at scale beyond 50 users. For PMPM model, the rate depends on the features selected (e.g., assessments, member access, referral tracking, and electronic referrals for closed-loop system).

6.4.3 Case examples from past implementations

Case example #1 – partnership with Reading Hospital, PA[185]

Healthify (prior to the acquisition by WellSky) partnered with Reading Hospital, Pennsylvania in 2017 to establish a hub for bridging the gap between health and social services care for local Medicare and Medicaid patients. The health system received a $4.5 million federal grant from CMS for this project. At the time, Reading Health was one of 32 organizations across the U.S. to receive federal funding for piloting CMS's Accountable Health Communities (AHC) care model, which aims to address HRSN of Medicare and Medicaid patients through enhanced clinical-community linkages.[186]

As part of the pilot, Reading Hospital leaders noted that the Healthify closed-loop referral system empowered increased care coordination with the CBO network.[187] After one year of the AHC pilot program, Reading Hospital reported a 15% decrease in unnecessary emergency department (ED) visits and savings of almost $1 million. [188]

Case example #2 – partnership with Coordinated Behavioral Care Independent Practice Association (CBC IPA)

CBC IPA is a member-led IPA focused on improving behavioral health with a network including over 50 health and human services organizations across New York City.[189] In 2018, CBC IPA faced administrative challenges with locating, reviewing, and referring patients to appropriate services.[190] To build an effective community-based referral network among its organizations, CBC IPA partnered with Healthify (prior to the acquisition by WellSky) to create an online community resource directory and referral system. For the resource directory, Healthify mapped out CBC IPA's community-based behavioral services which included over 55 organizations running approximately 1,500 programs across five boroughs of New York City. Network organizations could then use Healthify to search through an online resource directory of in-network and out-of-network social service and behavioral health programs, including mental health services, primary care sites, housing, substance use disorder services, education services, employment programs, domestic violence recovery programs, and art therapy. Healthify worked with CBC IPA to update contact information every 90 days. For closed-loop referral capabilities, a pilot program was launched in 2019 to onboard network organizations, with the intent to electronically refer patients and track referrals through Healthify.[191]

6.5 CIE alternative market solutions

Alongside the CIE vendor solutions discussed above, multiple alternative platforms exist in the market today which address some elements of a CIE solution or community-based care coordination. These alternatives

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[182] https://www.chcf.org/cin-case-study-coordinated-behavioral-care-independent-practice-association/#three
[183] https://www.healthcareitnews.com/news/reading-hospital-extracts-powerful-results-sdoh-techepic-ehr-combo
[184] https://www.healthify.us/pricing
[185] https://www.healthify.us/healthify-insights/the-roi-associated-with-addressing-sdoh
[186] https://www.hcinnovationgroup.com/population-health-management/social-determinants-of-health/article/21143318/at-reading-hospital-addressing-sdoh-becomes-a-top-priority
[187] https://www.youtube.com/watch?v=OZ5D7Y9aRBs
[188] https://towerhealth.org/articles/reading-hospital-saved-1-million-emergency-department-costs-medicare-and-medicaid-patients
[189] https://cbcare.org/ipa/what-is-an-ipa/
[190] https://www.healthify.us/healthify-insights/leveraging-sdoh-technology-to-address-social-needs
[191] https://www.chcf.org/cin-case-study-coordinated-behavioral-care-independent-practice-association/

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include dedicated resource directories, case management platforms, data analytics platforms, and CIE capabilities within an HIE. Each category of alternative is outlined in more detail in the following sections.

6.5.1 Resource directory

At present, solutions centered around a single CIE feature, a resource directory, are being used as an alternative to a CIE solution. A directory-centered solution offers listings of community resources for health and social care but may not provide closed-loop referral or data analytics capabilities.

Example solutions include:

- 2-1-1 is a network of nonprofit agencies across the U.S. – agencies maintain directories of community resources and connect patients in need to local services such as utility assistance, food, housing, health, childcare, etc.[192]
- Help Me Grow is a national nonprofit that maintains resource directories of available services and connects parents and caregivers to community resources.[193]

Available market solutions vary in how they source directory information and how they connect patients to listed resources. For example, for information sourcing – some solutions use a basic web scraping technique to get information available on search engines (e.g., Google), while others use an advanced scraping technique to pull information from websites of different CBOs, health plans, and provider organizations. For user access, 2-1-1 agencies across the U.S. operate both a 24/7 call center and an online directory, while Help Me Grow connects patients primarily using a call center[194].

A standalone resource directory solution has been utilized by some states in the past – for example, 2-1-1 is being utilized under NCCARE360 in North Carolina[195]. In another case, 2-1-1-San Diego partnered with the City of San Diego to create aCIE solution.[196]

6.5.2 Case management platforms

A case management platform offers a subset of features from a CIE solution that are focused on data exchange between members of a care team – it usually does not include a resource directory.

Example solutions include:

- Collective Medical, a PointClickCare company, provides features like ADT event notification, patient health records, and care coordination workflow to facilitate a care team for patients in post-acute and acute settings.[197]
- HealthEC's solution, CareConnect, also helps care managers provide coordination by offering HRSN screening tools, risk stratification, interoperability, care coordination workflow/case management services, and data analytics.[198]
- Innovaccer, a healthcare data platform company, offers closed-loop referrals, HRSN screenings, risk stratification, data analytics, patient health records, and interoperability[199].

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[192] https://www.211.org/about-us
[193] https://helpmegrownational.org/hmg-system-model/
[194] https://helpmegrowwa.org/
[195] https://nccare360.org/about/
[196] https://www.chcs.org/media/2-1-1-San-Diego-Case-Study_080918.pdf
[197] https://collectivemedical.com/
[198] https://www.healthec.com/careconnect.php
[199] https://innovaccer.com/

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- Julota has bidirectional sharing of sensitive information among EMRs, ePCRs, and other software platforms used by organizations (including law enforcement and behavioral health) – the solution is interoperable and tracks historical patient records.[200]

6.5.3 Data analytics platform

Data analytics solutions focused on aggregation and analysis of health and social data from multiple systems are another alternative to a CIE solution. Additional features that support analytics capabilities for these solutions may include multi-system interoperability, risk stratification, and secure documentation of patient health records.

Example solutions include:

- Arcadia is a population health software that curates data based on normalized clinical EHR data, adjudicated claims-based data, HRSN, pharmacy data, ADTs, and other sources.[201] Coupled with machine learning algorithms, Arcadia uses the curated data to provide prescriptive analytics (e.g., patient identification for HRSN and risk stratification).[202]
- Lightbeam Health Solutions, a healthcare analytics company which recently acquired Jvion's AI-enabled prescriptive intelligence and HRSN solutions,[203] can generate data-based HRSN insights from screening assessments within the platform.[204]

6.5.4 CIE capabilities within a Health Information Exchange (HIE)

Some Health Information Exchange (HIE) vendors currently offer or are in the process of building out capabilities to address HRSN as an extension of their existing solutions. HIE is a technology solution that enables healthcare providers and organizations to access and share clinical patient information electronically.[205] Features of an HIE that support the facilitation of coordinated patient care can include interoperability with EHR systems, patient medical records, referrals, and ADT summaries.[206]

Example solutions include:

- Amadeus by Orion Health can aggregate health and social data from traditional (e.g., claims, clinical) and nontraditional (behavioral, medical devices, social, etc.) sources.[207]
- Cerner is another vendor that provides an HIE solution. It has built extensions like the Determinants of Health, a dashboard integrated into Cerner's EHR that helps providers identify social risk factors and screen for HRSN among patients.[208]

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[200] https://www.julota.com/
[201] https://arcadia.io/
[202] https://arcadia.io/platform/analyze-your-data/
[203] https://lightbeamhealth.com/news/lightbeam-acquires-jvion-ai-and-sdoh-solutions/
[204] https://lightbeamhealth.com/social-determinants-of-health/
[205] https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/health-information-exchange
[206] https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie
[207] https://orionhealth.com/us/products/amadeus/
[208] https://www.cerner.com/solutions/determinants-of-health

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7. Appendix

7.1 Interview schedule

Exhibit 21: Interview schedule

Meeting type	Organization Name	Date	Time
ACH interview	BHT	7/26/2022	9:00 AM
ACH interview	SWACH	8/1/2022	12:00 PM
ACH interview	Olympic Community of Health	8/2/2022	1:00 PM
MCO interview	Coordinated Care Health	8/3/2022	8:00 AM
ACH interview	North Sound	8/3/2022	10:00 AM
ACH interview	Elevate Health	8/4/2022	8:00 AM
ACH interview	Cascade Pacific	8/4/2022	9:00 AM
ACH and CBOs interview	BHT CBOs	8/4/2022	11:00 AM
ACH interview	North Central	8/5/2022	1:00 PM
MCO interview	Amerigroup	8/8/2022	8:00 AM
MCO interview	United Healthcare	8/8/2022	10:00 AM
CIE planning information sharing webinar - 1/2	CBO, Professional organizations, Safety Net Providers	8/8/2022	11:00 AM
HHS Coalition interview	DCYF	8/9/2022	2:45 PM
CIE planning information sharing webinar - 2/2	CBO, Professional organizations, Safety Net Providers	8/9/2022	9:00 AM
MCO interview	Molina Health	8/9/2022	10:00 AM
ACH interview	CHPW	8/9/2022	11:00 AM
HHS Coalition interview	DOH	8/9/2022	5:00 PM
Tribes & ICHPs (Listening Session 1)	Tribes & ICHPs	8/10/2022	4:00 PM
HHS Coalition interview	DSHS	8/10/2022	5:00 PM
ACH interview	Greater Health Now	8/17/2022	12:00 PM
Tribes & ICHPs (Listening Session 2)	Tribes & ICHPs	8/17/2022	4:00 PM
CBO interview (follow-up from information sharing webinar)	Area Agency on Aging & Disabilities of Southwest Washington	8/19/2022	9:00 AM
ACH interview	HealthierHere	8/22/2022	11:00 AM
ACH and CBOs interview	HealthierHere CBOs	8/22/2022	2:00 PM

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7.2 ACH interview questions

Exhibit 22: ACH interview questions

1

ACH Survey on CIE

The Washington State Health Care Authority (HCA) is conducting a landscape review to understand current Community Information Exchange (CIE) usage within the state by consulting each ACH.

Please note these questions are illustrative of the types of questions that may be asked during an interview or official survey and is not intended to be an exhaustive list.

If your ACH currently uses a CIE, please see below:

Questions on the CIE technology/solution

1. What is your definition of CIE?
2. When was CIE implemented?
3. What vendor or technology is deployed?
4. Who is using the CIE solution? How many users are there?
5. Which populations (patients) are currently being served by CIE?
6. What systems, if any, are currently integrated with CIE?
7. What is CIE being used for (e.g., SDoH screening, care coordination, closed loop referral, community improvements, resource directory)?
8. What data is being collected and shared through the CIE platform?
9. What Community Based Organizations (CBOs) are involved in sharing data across the CIE network (e.g., providers, tribal, social service, etc.)?
10. Which health/social services are being provided through the CIE (e.g., referrals for SDoH factors such as food security, housing, transportation, financial strain, interpersonal safety, etc.)?
11. What accessibility considerations does the CIE take into account (e.g., offered in multiple languages, accessible to those with disabilities, etc.)?
12. What is the roadmap for the current CIE solution?
13. Is the current CIE solution meeting the ACH's needs? If not, what is missing?

Questions on the CIE process

1. Do patients need to give consent to be included in the CIE system?
2. Are there any metrics being used to track the "success" of using the CIE system? If so, what are they and what have the results and impacts been?
3. What are the challenges or pain points of the current CIE platform?
4. What does current funding look like for the CIE solution?
5. What investments have already been made, including any additional tools and resources that were necessary to complement the CIE?

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Washington State
Health Care Authority

<u>Questions on CIE governance</u>

1. Who (which agency) holds the contract for the vendor?
2. What does the governance look like for your CIE solution?
3. Who owns the decision-making for your CIE solution?
4. Who is involved in planning, implementing, and maintaining the CIE solution?
5. Who has access to data shared on the CIE network?
6. What considerations for the below are there for the existing CIE?
    a. Privacy
    b. Security
    c. Policy/legal

If your ACH does not currently have a CIE solution but has existing plans for future implementation, please see below:

1. Are there any alternatives to CIE that are currently being used, such as HIE?
2. How does your existing system and/or process work for connecting patients to appropriate health and social services?
3. What plans are there for implementing a CIE solution, including anticipated investments or funding, timeline, resources required, etc.?
4. Who is currently involved in planning a CIE?
5. What additional investments must be made for tools and resources that are necessary to complement a CIE solution?
6. What existing systems are there in place that need to be integrated with a CIE solution?
7. Which health and social service providers are expected to participate in the CIE network?
8. What is the anticipated level of FTE support for deployment of a CIE system?

For all ACHs regardless of current CIE status, please see below:

1. What do you hope to get out of a statewide CIE solution/what does a successful CIE look like to you?
2. What pain points would you like addressed via a statewide CIE solution?
3. What services providers do you want to be included in the CIE network?
4. What do you think will be the most challenging part of implementing and using a statewide CIE?
5. Are there any major constraints (financial, legal, technical, etc.) for your ACH that should be considered when considering a statewide CIE solution?

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7.3 MCO interview questions

Exhibit 23: MCO interview questions

Washington State Health Care Authority

1

MCOs Interview Questions on CIE

The Washington State Health Care Authority (HCA) is conducting a landscape review to understand current Community Information Exchange (CIE) usage within the state by consulting MCOs.

Please note these questions are illustrative of the types of questions that may be asked during an interview or official survey and is not intended to be an exhaustive list.

If your MCO currently uses a CIE, please see below:

Questions on the CIE technology/solution

1. What is your definition of CIE?
2. When was the CIE solution implemented?
3. What vendor or technology is deployed?
4. Who is using the CIE solution? How many users are there?
5. Which populations (patients) are currently being served by CIE?
6. What systems, if any, are currently integrated with CIE?
7. What is CIE being used for (e.g., SDoH screening, care coordination, closed loop referral, community improvements, resource directory)?
8. What data is being collected and shared through the CIE platform?
9. What organizations are involved in sharing data across the CIE network (e.g., providers, tribal, social service, etc.)?
10. Which health/social services are being provided through the CIE (e.g., referrals for SDoH factors such as food security, housing, transportation, financial strain, interpersonal safety, etc.)?
11. What accessibility considerations does the CIE take into account (e.g., offered in multiple languages, accessible to those with disabilities, etc.)?
12. What is the roadmap for the current CIE solution?
13. Is the current CIE solution meeting your needs? If not, what is missing?

Questions on the CIE process

1. Do patients need to give consent to be included in the CIE system?
2. Are there any metrics being used to track the "success" of using the CIE solution? If so, what are they and what have the results and impacts been?
3. What are the challenges or pain points of the current CIE solution?
4. If comfortable sharing, what does current funding look like for the CIE solution?
5. If comfortable sharing, what investments have already been made, including any additional tools and resources that were necessary to complement the CIE?

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Washington State Health Care Authority

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Questions on CIE governance

1. What does the governance look like for your CIE solution?
2. Who owns the decision-making for your CIE solution?
3. Who is involved in planning, implementing, and maintaining the CIE solution?
4. Who has access to data shared on the CIE network?
5. What considerations for the below are there for the existing CIE?
    a. Privacy
    b. Security
    c. Policy/legal

If your MCO does not currently have a CIE solution but has existing plans for future implementation, please see below:

1. Are there any alternatives to CIE that are currently being used, such as HIE?
2. How does your existing system and/or process work for connecting patients to appropriate health and social services?
3. How effective do you think your current care coordination system is? Do you use any metrics to measure effectiveness?
4. If comfortable sharing, what plans are there for implementing a CIE solution (e.g., anticipated investments or funding, timeline, resources required, etc.)?
5. What additional investments must be made for tools and resources that are necessary to complement a CIE solution?
6. What existing systems are there in place that need to be integrated with a CIE solution?
7. Which health and social service providers are expected to participate in the CIE network?
8. If comfortable sharing, what is the anticipated level of staff support for deployment of a CIE system?

For all MCOs regardless of current CIE status, please see below:

1. What does a successful CIE look like to you?
2. What pain points do you believe could be addressed via a statewide CIE solution?
3. What specific functions or capabilities do you envision will be most helpful to have in a CIE solution?
4. What health and social services providers do you want included in the CIE network?
5. What do you think will be the most challenging part of implementing and using a statewide CIE?
6. Are there any major constraints (financial, legal, technical, etc.) for your MCO that should be considered when considering a statewide CIE solution?
7. Are there any circumstances that would prevent you from leveraging a statewide CIE?

7.4 HHS Coalition Agency interview questions

The following questions were used in the interviews with HHS Coalition agencies (DCYF, DOH, DSHS)

- What current investments have you made in a CIE solution? What is your existing system for connecting patients to appropriate health and social services?

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- How do these existing systems and/or processes work?
- What pain points do you currently face around coordinating care for individuals?
- What specific functions or capabilities do you envision would be most helpful to have in a CIE solution?
- How is data currently shared, and are there any concerns or challenges?
- What do you see as the major challenges of implementing and using a statewide CIE?
- What role do you envision HCA has in a statewide CIE solution?

7.5 Washington HCA CIE survey questions

- What type of organization are you affiliated with?
    a. Safety Net Provider – FQ
    b. Safety Net Provider – RHC
    c. Safety Net Provider – others
    d. Professional Organization
    e. Community Based Organization (CBO)
    f. Other (open text)
- What pain points do you currently face around connecting patients to appropriate health and social services (select top 3)?
    a. Ineffective data sharing capabilities across the health and social service ecosystem
    b. Ineffective matching to community resources based on identified needs
    c. Health disparities for vulnerable populations
    d. Lack of a consistent system and/or process for connecting patients to appropriate health and social services
    e. Lack of closed-loop referral (e.g. lack of understanding whether referral was made and fulfilled)
    f. Limited number of community-based health and social services available
    g. Lack of awareness of resources available
    h. Other pain points (open text)
- What specific functions or capabilities do you envision will be most helpful to have in a statewide CIE solution (select top 5 choices)?
    a. Resource directory
    b. Event notification for Admission-Discharge-Transfer (ADT) data
    c. Closed-loop referral
    d. User-based access
    e. Analytics - population based data around Social Determinants of Health (SDOH)
    f. Personal health record
    g. Shared care plan
    h. Assignment/Attribution of patients to providers and health plans
    i. SDOH data exchange and related tools/services
    j. SDOH screening tools
    k. Risk stratification
    l. Call center for patients to identify community resources
    m. Care coordination workflow and/or case management services
    n. Mobile services
    o. Other functions or capabilities (open text)

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- What data or information do you believe would be most useful for you to access from a CIE network to better coordinate care for your members/clients (select top three choices)?
  a. Information on any past and/or ongoing interactions with community-based organizations
  b. Information on patient care team (e.g. primary care provider)
  c. Patient demographics
  d. SDOH screening data (e.g. housing status or employment status)
  e. Updated information on health plan coverage
  f. Other (open text)
- Which of the below do you anticipate will be challenges in implementing and using a CIE solution?
  a. Adequate and consistent funding to support a CIE implementation
  b. Resources to support a CIE (e.g. staff capacity/technological resources/staff training)
  c. Privacy or security concerns for patient data sharing
  d. Organizational adoption of a CIE in the local community
  e. Other (open text)

The following questions are optional. If you feel comfortable sharing:

- Describe any investment you have made in a CIE for your organization.
- Are there any other concerns around a statewide CIE solution that you would like to share with the planning team?

7.6 Tribal listening session questions

The following questions were distributed to the Tribes by HCA in a Dear Tribal Leader letter and were used in the listening sessions.

- What is your existing system for connecting patients to appropriate health and social services?

- What pain points do you think could be addressed via a statewide CIE solution? What do you think could be the benefits of a statewide CIE solution?

- What specific functions or capabilities do you envision would be most helpful to have in a CIE solution?

- What data or information would be most useful for you to access from a CIE network to better coordinate care for your tribal members or IHCP clients? What data or information would you not be comfortable sharing with the CIE network?

- What do you see as the major challenges of implementing and using a statewide CIE?

7.7 National trends in SDOH data standards for health IT

What is the current landscape for health IT standards?

The FHIR (Fast Healthcare Interoperability Resources) standard for health data was developed by Health Level Seven International (HL7) as a flexible standards system that enables users to implement, document and share specific use cases.[209] The standard defines how healthcare information can be exchanged between different computer systems regardless of how the data is stored in those systems. It allows healthcare information in the form of clinical and administrative data to be available securely to patients and healthcare workers. FHIR's

[209]https://ecqi.healthit.gov/fhir#:~:text=FHIR%20combines%20the%20best%20features,technologies%20to%20aid%20rapid%20adoption.

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development began in 2012 in response to market needs for faster and more effective methods to exchange the rapidly growing amount health data. Individual pieces of data from FHIR are known as resources, which are composed of a common set of metadata, a standardized way to interpret its data, and the personalized data itself.[210]

FHIR is widely used today as a standard for health IT systems, with increasing levels of adoption in recent years.[211] Multiple Federal organizations, including notably the Office of the National Coordinator (ONC), have supported use of the FHIR standard by providing funding for implementing the standard or requiring adoption from partner organizations as a prerequisite for certification programs. First, the ONC's Leading Edge Acceleration Projects (LEAP) in Health IT initiative provides funding to organizations that use FHIR (e.g., Chesapeake Regional Information System, MedStar Health, etc.).[212] Second, with the passage of the Cures Act in 2020, ONC added adoption of FHIR to the USCDI data standards as a criterion for its Health IT Certification Program, which includes an evolving set of data standards used by many organizations that deploy health IT systems. Certification is voluntary, but may be encouraged or required for participation in certain federal, state, and private programs.[213] For example, the Centers for Medicare & Medicaid Services (CMS) Promoting Interoperability Programs requires certification for participating health IT systems. Over 50 projects of the Centers for Disease Control (CDC) are utilizing FHIR standards; these projects include the National Healthcare Safety Network (NHSN) and electronic case reporting (eCR), which use FHIR to connect to the EHR systems of healthcare facilities and collect data.[214]

How are health IT standards being adopted for SDOH data?

The FHIR standard has been increasingly implemented to document SDOH data, with implementation support from organizations in the FHIR accelerator community.[215] One prominent organization in this space is the Gravity Project, founded by the University of California San Francisco Social Interventions Research and Evaluation Network (SIREN) in 2018 to develop, test, and validate standardized SDOH data for use across care activities, including screening, clinical assessment/ diagnosis, goal setting, and the planning and performing of interventions.[216]

Consisting of over 1,000 healthcare stakeholder participants, the Gravity Project's activities include supporting implementation guides for documentation of SDOH data in the FHIR standard, and working with other health standards organizations to develop and standardize Z-codes for SDOH needs.[217] In December 2018, the project published a FHIR implementation and recommendation guide for SDOH data and terminology, with a strong focus on food insecurity, housing instability and homelessness, and transportation access.[218] [219] The organization has since expanded its focus to include FHIR implementation guides for additional SDOH needs, including financial strain, education, unemployment and Veteran status.[220] The Gravity Project's implementation guides are publicly available and can be used by other organizations to support FHIR documentation of SDOH data.

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[210] https://www.healthit.gov/sites/default/files/2019-08/ONCFHIRFSWhatIsFHIR.pdf
[211] https://blog.hl7.org/u.s.-federal-health-data-solutions-in-the-era-of-interoperability
[212] https://www.healthcareitnews.com/news/onc-awards-27m-new-funding-interoperability-innovation-initiatives
[213] https://www.healthit.gov/sites/default/files/PUBLICHealthITCertificationProgramOverview.pdf
[214] https://www.cdc.gov/csels/phio/exchanging-data-efficiently.html
[215] https://ainq.com/social-determinants-health-healthcare-it-standards/
[216] https://www.healthit.gov/sites/default/files/facas/2021-04-08_Gravity_Project_Presentation.pdf
[217] https://www.hcinnovationgroup.com/population-health-management/social-determinants-of-hea[…]-sdoh-standardization-gravity-projects-pull-creates-hope
[218] https://www.hcinnovationgroup.com/population-health-management/social-determinants-of-health/article/21211225/for-sdoh-standardization-gravity-projects-pull-creates-hope
[219] https://ainq.com/social-determinants-health-healthcare-it-standards/
[220] Ibid.

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Additionally, the Gravity Project is working with the other standards development organizations such as WHO (for ICD-10), LOINC, and SNOMED, and U.S.-based terminologies such as CPT (diagnosis), HCPCS (billing), and RXnorm (medications), to standardize vocabulary to support the exchange of SDOH data and HL7 FHIR SDOH Clinical Care Implementation Guide.[221]

How are patient data standards being adopted among CBOs and other social services organizations outside of healthcare providers?[222]

While organizations like the Gravity Project have made headway in adapting the current FHIR health IT standard for SDOH data documentation, data standards may not yet be widely adopted among CBOs community-based care coordination partner organizations in CIE ecosystems, due to potential barriers around lack of regulation or funding support for implementation.[223] First, there may be less funding available to CBOs and other non-provider partner organizations to update their patient data systems to comply with standards such as FHIR. They may also face additional technological barriers; whereas many providers deploy EHR platforms from national vendors as their health IT systems, many CBOs and other partner organizations may implement either customized systems tailored to their grant management platforms or manual patient databases (e.g., maintaining patient information in a regularly updated spreadsheet). The relatively small scale of these solutions may create additional challenges to ensuring widespread adoption of a single standard. Second, there may be less regulation to enforce participation in a data standard for CBOs than for providers. Certifications like the ONC Health IT Certification Program may not apply to CBOs, and without those programs to incentivize adoption, organizations may be less likely to implement changes to their data systems.

In the absence of a widely adopted national data standard for CBOs, some current CIE ecosystems and vendors may be developing their own internal standards for SDOH data among their partner organizations, creating a more fractured landscape for data standards in CIE environments than in health information exchange.[224] However, because many of the organizations in a future CIE ecosystem may have already adopted FHIR standards, including many provider EMR systems and the systems that interface with those EMRs, FHIR may also be a useful standard to consider in the development of statewide norms around patient data storage.[225] At least, FHIR can provide a case study for the ways in which adoption of a data standard can be supported at scale through funding for implementation, regulatory enforcement of certification criteria, and support from partner organizations to develop use-cases.

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[221] https://ainq.com/social-determinants-health-healthcare-it-standards/
[222] See section 5 of the report for more details.
[223] Yoon, A, Copeland, A. Toward community-inclusive data ecosystems: Challenges and opportunities of open data for community-based organizations. *J Assoc Inf Sci Technol*. 2020; 71: 1439– 1454. https://doi.org/10.1002/asi.24346
[224] Expert interview
[225] https://www.hcinnovationgroup.com/population-health-management/social-determinants-of-health/news/21273196/community-information-exchange-called-a-gamechanger-for-st-louis

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