Public Comment
Community Information Exchange (CIE) Workgroup Meeting
March 15, 2022

March 2022 CIE Workgroup Public Comment Handout

Public Comment 1

Date: 12/16/2021

RE: Community Information Exchange

I want to voice my concern that I don't see a lot of community-based non-medical organizations on the slate. These are the organizations that have to receive the referrals and are less likely to have access to an EHR; especially those providing services related to SDOH (Housing, Nutrition, Transportation, Homecare workers, community-based care coordination, etc).

Lavinia Goto

MAC Board Member

Public Comment
CIE Workgroup Meeting
April 19, 2022

Project Access NOW
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4-19-22

Health Information Technology Oversight Council

Communication Information Exchange Workgroup

Good afternoon committee members, for the record my name is Linda Lang, Chair of Project Access NOW Advocacy Committee – or PANOW – a non-profit in the tri-county area. I am also the Director of Quality and Population Health at Samaritan Health Plans.

Project Access NOW fills the gaps in Portland's regional healthcare and social safety net systems. Working with major health systems, clinics, and community partners, PANOW improves access to health care services and coverage, provides culturally-appropriate health information and resource navigation, and advocates statewide to improve community wellbeing. Over the past 14 years, PANOW has become a critical resource point, especially for underserved communities.

We believe adequate funding is key to not only adopt the technology and integrate it with the existing platforms, but to **staff accordingly** through the transition. Integrating new platforms comes at enormous cost to organizations financially for many reasons amongst of which include technical equipment, software, etc. it is unacceptable to expect organizations continue to perform the same level of service to the community uninterrupted through such an integration without adding more staff.

- Given our positioning between these partners, we stand to gain a lot from a unified health information technology system that supports the navigation our team makes for hundreds of clients each day.

- Community-based organizations (CBOs) are often the first point of contact for communities experiencing poverty; we ask a series of questions to better understand our clients and make sure that the information that's getting collected at the point of entry to the CIE is information that is useful and workable for CBOs. For example, standardizing how Race and Ethnicity demographics are collected or date of birth formats etc.
- We believe that clients should have access to their data , and should not have to go through undue stress of accessing their information. It is also critical to get feedback from CBOs specifically on how data is handled in a tool like this.
- Without Community Based Organization engagement, this work will not take root; we all need to do our part to ensure adequate resources are provided in increasing efficiency and communication between entities with the adoption of a CIE, if it works as we want it to, will mean a much higher volume of referrals and clients for CBOs and we need to help them be prepared for that with whatever resources they need to scale up.

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- Community Based Organizations have a lot to offer because of the relationship with their communities. Their perspective matters on how high-level policy reaches those impacted – our collective voice should be present in decision-making.
- We are passionate about health equity and improving community by addressing the biggest factors that drive health: the non-medical ones. CBOs are frequently addressing many of those non-medical determinants of health, often even more than the health systems, as they have a closer cultural connection to clients, so they stand to gain a lot from a resource like this if it works properly, but also have a lot to lose if it doesn't. Making sure this resource isn't just effective strictly in the healthcare space but also social services, housing, and beyond will benefit CBOs greatly.

Thank you for your time.

Public Comment
CIE Workgroup Meeting
May 17, 2022

April 19, 2022

Dear members of the HITOC Community Information Exchange Workgroup,

Findhelp appreciates the opportunity to provide public comment on the CIE Workgroup's progress towards supporting and improving community information exchange across Oregon. We share your commitment to creating a more equitable, culturally, and linguistically responsive health care system. A CIE or social care e-referral approach that advances the state's goal to eliminate health inequities by 2030 must be truly interoperable, built on agreed upon data standards, and integrated into the existing record systems used by health care and social care providers. In addition, a health-equity driven approach must facilitate participation by a broad array of community-based organizations (CBOs), and ensure consumer-directed privacy of social care referral information.

In recent years, some states have adopted models that mandate health care plans and providers exclusively use a single vendor, and require community-based organizations to sign exclusivity contracts as a condition of funding. This type of single vendor approach is a shortcut around building interoperable technology solutions, and has not been successful in practice. By intentionally narrowing networks that CBOs can engage in, the entire community is disadvantaged by limiting the number of services people can access. We believe it is imperative for CBO's to have their choice of CIE vendor to ensure a more sustainable and equity-driven path forward.

As OHA expands upon the current infrastructure for facilitating referrals from healthcare providers to CBOs, it will be imperative that the protection of privacy is at the center of this conversation. We believe that individual consumers must maintain control over their personal information. While HIPAA dictates how health information is shared between HIPAA-covered entities, in the social care context, data sharing must be driven by the individual, and can only be shared with appropriate consent and permissions. Within these growing social care referral networks, many participating entities are not governed by HIPAA. Using a one-time all-in consent in this context, to allow a broad network of service providers to access information in a centralized database, compromises the privacy of an individual's most personal information. We believe that best practices build upon a per-referral consent model, where individuals opt-in to share their information for each referral and network members' access to referral history is permission based.

Again, we appreciate the CIE Workgroup's efforts in this important area, as we are at a pivotal moment that will set the course for how Oregon stakeholders construct coordinated systems of care. Our hope is that the direction set by the Workgroup's recommendations shapes a truly interoperable approach that prioritizes the individual seeking assistance, and maintains the privacy of their personal referral information. We welcome the opportunity for further discussion of the critical policy issues outlined in our comment.

Submitted on behalf of findhelp, a Public Benefit Corporation.

May 17, 2022

Good afternoon members of the HITOC Community Information Exchange Workgroup. Thank you for the opportunity to speak with you today.

My name is Erine Gray, and my company findhelp, formerly Aunt Bertha, runs the largest social care electronic referral network in the United States, with over 11 million users. We are a Public Benefit Corporation based in Austin, Texas and we are proud to say we have earned the trust of more than 400 clients – from state and local governments to health and social service organizations, including a number that do business here in Oregon.

I am here today to share from our experience as a trusted technology partner, with a national perspective on the activities that this Workgroup has been tasked with guiding for Oregon. Through the recommendations that you provide to the legislature, you have the opportunity to thoughtfully drive the way that Oregon strengthens connections between health care and social care providers to ensure the holistic care of people in this state. A CIE can allow for electronic referrals to social care providers within an integrated system, closing the loop on those referrals to ensure that important services are received, and provide important data to assess whether better health outcomes are reached.

This opportunity to improve outcomes and potentially lower costs, however, relies on the collection, storing, and sharing of some of the most private and personal information about the people of Oregon. Your Workgroup **must** address critical questions of how the privacy of individuals' social care data will be protected and the governance structures required to ensure consumer-directed privacy of an individual's most personal information, about the services they access during a time of need.

Many people are aware of the privacy protections that guide **medical information** under HIPAA – but do not **realize** that federal privacy protections for **an individual's** interactions with **social services** are unclear and ambiguous. A closed-loop or electronic referral system is one designed to enhance care coordination by connecting clients to services through managed referrals and, upon informed consent, sharing their personal information through a database of networked providers. A number of these providers, however, can be social service organizations that will

have access to an individual's referral history. This can include requests for help from a non-profit or non-medical provider.

As you know, most social service providers are small, community based organizations. They provide needed social services but they typically are not "covered entities'' under the federal HIPAA law. **Thus, they are not guided by the same privacy protections and policies that govern traditional health care providers.**

More importantly, there is often a **stigma** that comes with needing social services, so it is **important** that we all recognize that this stigma **exists** and respect the right to privacy.

Social services exist to help people during their **time** of need. We've all been there — these are some of our most **vulnerable** moments. Many people needing these services are newly unemployed, survivors of trauma, ex-offenders trying to make their way back into society, or parents helping their struggling teenagers.

People **expect** this deeply personal information, which is housed in closed-loop referral systems like ours, to only be visible to the people they trust — people they **know**.

One approach used in our industry is an open-access consent model. An open-access model is common in healthcare. If I go into a clinic I'll usually sign something in the waiting room that allows **any** member entity of a network to look me up and find my records. This is useful in healthcare because if I show up to an emergency room **unconscious**, I want the ER doctor to be able to look me up to know about my medical conditions.

In the open-access model **any** user with a valid login and password may have access to a centralized database — even someone in another town that you've never met, or never talked to, can look you up and see your information if you've received social services in the state.

But to govern access to **deeply personal** social services information the same way? It's a lot riskier as this database contains information about people's most vulnerable moments. And you may be alarmed to know that this open-access model is being used in Oregon today.

While an open-access consent model may allow for convenience — we strongly believe that people won't seek the help they need if they **fear** their information will be seen by the wrong people. Our organization has helped millions of people using a model that is driven by informed consent at each instance of a referral. It has **not** hindered care coordination and most

importantly it respects the right to privacy of the individual.

A number of states are advancing legislation in this area, which may be of interest to this Workgroup. The legislation establishes two important guardrails to protect personal information about referrals to social services that fall outside the bounds of HIPAA. First, establishing the need to consent on **each instance of referral**, empowering the consumer to direct where their information is shared. Second, requiring that any organization or individual with access to the referral database receives the consent of the individual before their sensitive and personal referral information can be looked at. With technology, a per-referral consent is a way to appropriately **limit** access to parties that **shouldn't have** access.

If an individual wants to share his records with people he trusts, perhaps a social worker at a local nonprofit, he can do that in a per-referral consent model. This is about **access** and ensuring that the **right** people have access to the **right** information at the **right** time.

To close, I want to commend this Workgroup on the critical work you are undertaking and encourage you to meaningfully address the unique privacy issues specific to a social care referral network in your recommendations. I would be happy to answer any questions.

Public Comment
CIE Workgroup Meeting
June 21, 2022

June 20, 2022

Dear members of the HITOC Community Information Exchange (CIE) Workgroup,

We appreciate the opportunity to comment on the CIE Workgroup's preliminary recommendations related to the role of the Oregon Health Authority (OHA) and the Oregon Department of Human Services (ODHS) in the state's CIE and support for community-based organizations (CBOs) to participate in the CIE.

We share your commitment to creating a more equitable, culturally, and linguistically responsive health care system. A CIE or social care e-referral approach that advances the state's goal to eliminate health inequities by 2030 must be truly interoperable, built on agreed upon data standards, and integrated into the existing record systems used by all of the entities needed to facilitate the outlined vision: health care plans and providers, community-based organizations (CBOs), government agencies, and others. In addition, a health-equity driven approach must facilitate participation by a broad array of CBOs and ensure consumer-directed privacy of social care referral information.

To this end, we would like to highlight a few areas pertaining to the role of state agencies and support for CBOs for more in-depth consideration by the CIE Workgroup.

OHA & ODHS Use of CIE

The CIE Workgroup highlighted the importance of ensuring OHA and ODHS case managers and staff are trained and able to use the CIE, however, there is no discussion of the vision for how CIE will be integrated into the existing case management and data systems that currently support agency workflows and data reporting. In our work across the country, we have partnered with government agencies and programs with unique needs, workflows, and reporting requirements related to managing social care referrals.

Based on our extensive experience supporting different social care referral work streams across the country, we know that successful adoption and implementation depends on allowing organizations to select the vendor that best integrates with their existing workflows and that meets their specific organizational needs. The needs of the Oregon Health Plan are vastly different from the needs of the Child Welfare Division at ODHS, which employs thousands of navigators providing direct services to families. We are concerned that there has not been significant engagement of the other critical agencies cited in the recommendations, such as the Department of Education and Housing and Community Services, to ensure a holistic approach to CIE.

A top-down approach that requires use of a specific CIE technology will meet major adoption challenges within government agencies and programs, and more broadly. We encourage the Workgroup to:

1) Develop more specific recommendations addressing the type of stakeholder engagement needed to inform a CIE design that meets the needs of all agencies;
2) Recommend a CIE approach founded on maintaining organizations' choice of technology vendor; and
3) Recommend that the designated governance body establish data standards and certify vendors, allowing agencies and programs to select the CIE vendor that best meets their needs through competitive procurement.

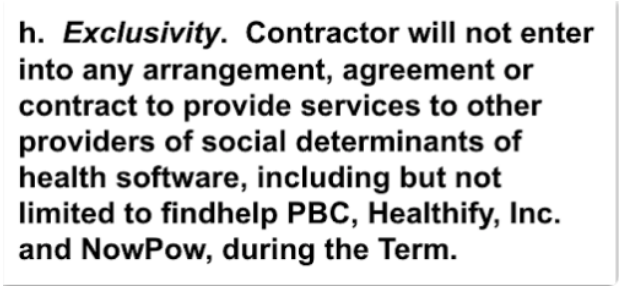
We believe there is a significant amount of government stakeholder engagement work that remains to be done before Oregon will be well situated to implement the CIE vision outlined in the recommendations.

Leveraging Policy and Contractual Levers to Support CIE Adoption and Use

As currently drafted, the recommendations indicate that OHA and ODHS may require participation in CIE through legislation, contracting, and grant mechanisms. It is unclear as currently written if the state is entertaining the possibility of requiring use of a specific technology vendor to support CIE or if the requirement would be for contracted organizations to select and use the technology vendor of their choice, with requirements for interoperability, reporting to OHA and other agencies, and data exchange. It is critical that the Workgroup clarifies this vision prior to submitting recommendations to the legislature and explicitly commits to an approach that maintains organizations' choice of technology platform to support CIE. Further, the Workgroup must consider the differential impact of technology costs on CBOs and smaller health care providers. A sustainable funding approach is also dependent on organizational choice of vendor.

We have serious concerns about a CIE approach that relies upon a state mandate to use a specific technology, which will not only limit adoption and use, but also raises legal and ethical issues that the Workgroup and legislature must directly address. For example, there is currently a CIE technology vendor operating in Oregon that requires CBOs sign exclusivity contracts as a condition of platform use and receipt of funding. The CIE Workgroup has given significant time to discussion of the Connect Oregon platform, supported by Unite Us, but has not addressed the significant issues with the vendor's approach to requiring CBO exclusivity.

Unite Us Contract Clause H,
Prohibiting CBOs from Receiving Referrals from Other Vendors


h. *Exclusivity*. Contractor will not enter into any arrangement, agreement or contract to provide services to other providers of social determinants of health software, including but not limited to findhelp PBC, Healthify, Inc. and NowPow, during the Term.

This type of anti-competitive practice is deeply harmful to the mission of CBOs to serve those most in need and leads to service silos, in which organizations are incentivized to serve individuals based on a

relationship with a technology vendor. This is an approach that is designed to advance the vendor's business interests and is in direct conflict with Oregon's stated commitment to health equity.

Technical Assistance on Privacy and Data Integration

In the preliminary recommendations to support CBOs in CIE, the issues discussed related to privacy and data integration fall short of addressing the most critical privacy issue in the space, which is ensuring consumer-directed privacy of social care information. Incorporating referrals to social care into our healthcare infrastructure relies on the collection, storing, and sharing of some of the most private and personal information. As you expand upon the current infrastructure for facilitating referrals between healthcare providers and CBOs, the CIE Workgroup must address critical questions of who will own the data, who will be able to view and analyze the data, and how the data will be protected from unauthorized access and cyber attacks. With the inclusion of more CBOs that are not HIPAA-covered entities, it will be imperative that the protection of privacy is at the center of this conversation, with individuals maintaining control over their personal information.

One data-sharing approach used in this industry utilizes a one-time consent model that grants open look-up data access to a broad network of organizations and their staff. A one-time consent model is common in healthcare, where data sharing between covered entities is governed by HIPAA. If I go into a healthcare clinic, I will sign something in the waiting room that allows other providers in the network to access my health record. However, applying the same one-time consent model to grant access to a broad network of social care providers is not appropriate, violates individuals' fundamental right to privacy, and raises significant issues related to safety and trust. In the final recommendations to the legislature, the CIE Workgroup needs to provide direct recommendations for how social care data will be governed.

Best practices for governing social care data privacy include:

- Allowing staff generated referrals (from a covered entity), shared pursuant to existing data sharing or network agreements with a Health Information Exchange or other covered entity, to follow existing paths for care coordination.
- Requiring a per-referral consent model, in which individuals are asked to *opt-in* to share their information for each referral and network members' access to referral history is permission-based.
- Maintaining the individual's right to obtain help without conditioning referrals on consent to share personal information.
- Requiring that individuals seeking help maintain the right to opt-out of sharing their information at any time, and that revoking network access to personal information is simple for the individual.
- Establishing provisions governing the length of time non-health identifiable information will be maintained in a database, and;
- Prohibiting the sale of personal information without explicit individual consent.

We thank the CIE Workgroup for your consideration of these issues, which must be addressed in your final recommendations to the legislature. We welcome the opportunity to connect with interested members of the Workgroup to share more about any of the topics discussed here.

Submitted on behalf of findhelp, a Public Benefit Corporation.

June 21, 2022

Oregon Community Information Exchange Workgroup

To the members of the CIE Workgroup:

My name is Linda and I am writing as a Board member of Project Access NOW, a community-based nonprofit organization providing access to health care and health-related resources for un-and under-insured communities in the tri-county area. As such, a state-wide Community Information Exchange has the potential to change the way we do our work significantly, hopefully for the better! We have been very pleased to see what the CIE workgroup has developed so far, especially the most recent concept papers on support for CBO participation in CIE and the recommended role of OHA and ODHS in CIE.

Support for CBOs concept paper:

The value of this concept paper cannot be overstated. CBOs are absolutely critical to reaching the most vulnerable populations in Oregon. Without them, a CIE won't be effective, and it certainly won't maintain the standards of health equity we know the state strives to achieve. In order to accomplish robust CBO participation in a CIE, CBOs need to be provided with the appropriate resources to be successful. That's why we would like to express full support for all four preliminary recommendations set forth by the workgroup in this concept paper, with special focus placed on "Ongoing Sustainable Funding and Grants." While other recommendations like Technical Assistance, Coordination and Convening, and Education are all critical pieces of this puzzle, they will be essentially meaningless if CBOs don't have the funding to support the following:

1. Adequate staffing capacity to support the transition from existing technology and workflows to a CIE. Maintaining staff morale and expertise is integral to the success of a CIE rollout.
2. The purchase and integration of new and updated IT equipment with existing infrastructure. We have not been part of federally supported movement towards better IT infrastructure, like our health system counterparts. This will be key for our own success.
3. An increased volume of referrals for services and resources that will come with a CIE.
4. Diversification of new services and resources offered to support increased need from CIE.

We also would like to urge the workgroup to support an upstream funding model for CBOs. Making supportive investments in CBOs on a general operations level outside of a per-referral (or similar) payment model will guarantee that CBOs are successful in CIE participation, even in the face of a potentially challenging transition.

OHA and ODHS roles in CIE concept paper:

As noted in this concept paper, the Oregon Health Authority (OHA) and Oregon Department of Human Services (ODHS) are critical partners offering both a safety net of public programs that support those in

need, and coordination across systems at a state level. We are grateful to see the workgroup supporting the notion that they are included in any successful CIE as we agree wholeheartedly.

Specifically, we believe state agency program participation in use of the CIE would support better access to public programs that health systems and other CBOs are currently referring to the State for such as WIC, SNAP, TANF, etc.

We also believe there is an important role for OHA and/or ODHS to play in coordinating efforts and potentially even aligning our governing model at a state level. To date, there are no non-vendor associated statewide CIE convenings or opportunities to discuss how we want this to look in Oregon and how we want stakeholders to drive our priorities, data sharing/safety recommendations, and community uptake. A non-partial entity developing the structure for decision making and discussion, one without a preferred population of focus, business model incentive, or set of individual organization priorities, would help ensure greatest reach, uptake, and impact. Some combination of state partners, beholden to our state leadership could be a great governing entity to ensure ongoing, Oregon-centered alignment.

Finally, we also agree that while OHA and ODHS are the current state entities engaged, we believe there are many others who should be included who offer a lot of power, knowledge and expertise not currently incorporated in CIE discussions.

Thanks for the opportunity to comment,

Linda Lang
PANOW Board Advocacy Chair
Director Quality and Population Health (Samaritan Health Plans)

Public Comment
CIE Workgroup Meeting
July 19, 2022

Comments Submitted by the Connect Oregon Network to the HITOC Workgroup on Community Information Exchange

Date: July 11, 2022

Dear members of the HITOC CIE Workgroup:

Thank you for the opportunity to submit these comments in response to the draft proposal titled: "Support for community-based organizations to participate in CIE". The Connect Oregon network, powered by Unite Us, is a network of health and social service organizations, including CBOs, that work together, using a common technology platform, to address the social needs of all people in Oregon. Our shared experience – plus individual organizations' experiences predating Connect Oregon work – informs these comments.

First and foremost: We applaud the proposed document and want to recognize the incredible amount of work that went into the draft. This document clearly recognizes the centrality of CBOs and thus the CBO voice in a health (not just a healthcare) system.

Below we offer recommendations to improve the draft as it is prepared for inclusion in a broader statewide strategy. Our recommendations relate both to the current content of the document and also to broader best practices and lessons learned on the topics of sustainable funding, technical assistance, education, and coordination/convening.

Relating to current content:

1. Page 2 outlines a couple overarching principles. We suggest two more:
    - **A CIE platform should be trusted by CBOs;** and,
    - **A CIE platform should make CBO's lives easier, not harder.**

    The first principle points to the importance of privacy and security protections being not only in place but understood by CIE users; indeed we believe privacy and security can be expanded on and elevated elsewhere in the document such as in the Problem Statement and within each section of recommendations.

    The second principle pertains to user-experience and design of the CIE platform. CBOs use many systems in their day-to-day work of providing services to their clients, and CIE risks being "another system" they have to incorporate. However, a system designed with CBOs at the center will result in natural adoption of that system by the CBOs: The value of using the CIE platform will be inherent. Further, it's important to note that while in the short-term CIE may be a new system for CBOs to adopt, a mature CIE system has deeper integrations with other systems and may even reduce the total number of technologies used by CBOs, thus simplifying their workflows.

2. Page 3 begins a discussion on sustainable funding and grants. We suggest language is added that recognizes that CBOs are funded by existing and recurring funding streams administered by the State and others, and that these existing fundings streams can be leveraged via CIE-specific capacity building. For example: In April of this year, 147 organizations were granted a collective $30M of OHA funding. Meanwhile, OHA's 1115 draft waiver renewal proposal suggests that new entities known as Community Investment Collaboratives will play a critical role in facilitating CBO funding. Aligning these types of CBO investment mechanisms with the statewide CIE framework will help point all efforts in the same direction while simplifying technology procurement and reporting requirements for the CBOs.

3. Page 4 notes that certain CBOs should be prioritized, specifically that "Initially the Workgroup believes CBOs that focus on housing and food accessibility and availability should be prioritized." Data from the Connect Oregon network supports the prioritization of these two service types. That same data also makes a very strong argument for the inclusion of two more: Utilities support & Benefits Navigation. We recommend these two are added to the list of priority CBO programs and services.

4. Page 4 also requests "Data support for funding." We recommend an emphasis not only on the ability for CBOs to generate their own reports and conduct their own analysis but also on the broader aim of data literacy. A CIE solution will indeed make certain data available to CBOs for their own analysis; however, and via a proper governance and best-practices framework, aggregate data, analysis, and insights will be brought to and shared with groups of organizations for the purpose of driving data-driven discussions. In those cases, the ability to read and interpret data and to ask questions about the data is the key skill to be gained.

5. Page 5 mentions the topic of "privacy and data integrations". We recommend modifying that paragraph in full as follows:

    4. **Privacy and Security:** TA support and training in rules and regulation compliance, especially around the frameworks of HIPAA, FERPA, 42 CFR Part 2, HITRUST and other relevant privacy and security principles, frameworks, and regulations as pertinent to utilizing a CIE platform.

    5. **Integrations and Interoperability:** TA support and training on how different systems can (and sometimes cannot) achieve interoperability or integration. This support includes education on the distinctions between "workflow integrations" and "technical integrations" and provides a cost-benefit framework analysis for individual organizations to use when navigating interoperability discussions. This will support CBO work overall, and connections between social service providers and other types of partners, while increasing knowledge around key information sharing rules and regulations.

Relating to Best Practices, Lessons Learned, and CBO Feedback

The below recommendations are sourced from feedback provided and captured by CBOs participating in Connect Oregon. A June 2022 Statewide Network Advisory Board (SNAB) meeting included time for SNAB members to provide feedback via jamboards on the CIE Workgroup document in question. The themes and sentiment are reflected below. Specific quotes are also provided.

1. **Ongoing Sustainable Funding and Grants**

   Connect Oregon partners conduct ongoing outreach to and listening sessions with CBOs. A central theme in those discussions is the importance of sustainable, reliable funding for the community partners. CBOs are often living grant-to-grant. While grants and philanthropic donations can play a role in funding special initiatives, these funding streams do not make up a sustainable funding model.

   CBOs are able to join Connect Oregon and leverage closed loop referral technology for free. However, as they accept referrals and provide services, sustainable financing for those services is necessary. As one member of the Connect Oregon Statewide Network Advisory Board (SNAB) member shared out:

   "Getting referrals from health systems that don't pay for the services themselves disincentivizes an organization to participate in this."

   Multiple CCOs and CBOs are now in active discussions to reimburse CBOs through health-related services (HRS) and in lieu of services (ILOS) workflows. While HRS has been an available mechanism for a few years, a barrier to HRS uptake has been the lack of shared infrastructure to send referrals to CBOs and to support those CBOs invoicing for their services. The Connect Oregon network has simplified the conversations, enabling more deliberate and systematic efforts.

   HRS and ILOS, as well as the Transition Services proposed in the state's proposed 1115 demonstration waiver currently in discussion with CMS, offer new, sustainable pathways to shift funding from health care into the community. In addition, incentivizing the use of CIE through hospital and health system community benefit or other mechanisms would further drive adoption of CIE and provide CBOs with impact data to report back to funders. The Connect Oregon partners are excited about the work ahead to make this possibility a reality.

   CBOs within the Connect Oregon network share these additional themes and reactions as feedback on the Ongoing Sustainable Funding and Grants section:

   - The capacity and training concerns presented in the document resonate with Connect Oregon members
   - Ensure delineation of one-time, implementation funding verses on-going capacity building and support funding
   - "Referral systems tend to increase demand and yet does not increase the supply"
   - "Funded, trained, designated T/CHWs might be the solution to training/capacity challenges"

- Support with grant writing by providing sample language to use with funders to support staff training / implementation
- Flexible funding to use for the programs/services needed or for CBOs to be reimbursed for services or as part of contracts.
- “Definitely best to rely on data from within the CIE for reporting rather than burdening CBOs with that.”

2. Technical Assistance

Technical Assistance for Connect Oregon CBO partners is currently provided by Unite Us in partnership with CCOs and other network funders. Built into the Unite Us model is a local team of community engagement managers; their job is to connect with CBOs, train them on the Unite Us platform, and to be available for questions. This is often done in one-on-one settings as well as in regularly scheduled group Lunch and Learn webinars.

Beyond this local team, Unite Us has centralized technical support via a chat feature available on the platform. Unite Us also has subject matter experts to provide deeper technical trainings when appropriate. Technical Assistance is currently provided to Connect Oregon partners on each of the items listed in the draft report: New and Advanced user training; Data support; Workflow; Privacy and Data integration (as amended above).

Connect Oregon supports ready availability of technical help and through multiple channels and partners to ensure cases are processed and individuals receive care as efficiently and effectively as possible. Additional support for CBO technical assistance delivered in various settings is welcome.

CBOs within the Connect Oregon network share these additional themes and reactions as feedback on the Technical Assistance section:

- Many aspects of this section resonate with Connect Oregon CBOs, in particular: The role of super users; tying funding to technical assistance training; and the recognition of the workflow challenges that may come with centralizing use of CIE
- CIE may be a new system for many and thus come with adoption barriers, especially when you consider log-in fatigue and duplication of entry into other systems. Workflow integrations and data sharing across required systems, such as with HMIS, should be discussed with the CBO experience front and center.
- Importance of providing training in multiple formats (videos, 1:1 trainings, asynchronous options, regional learning communities, visual representations of referral process) to accommodate different learning styles, language needs, and time availability
- Importance of centering training on organizational workflows and how to adapt to CIE systems
- Page 4 clarifications are needed: “What, exactly, is an impacted community?” “What TA options are a higher priority?”
- Power dynamics between large and smaller CBOs were also shared, with concerns that smaller CBOs would be prioritized below larger CBOs

- "Will the TA support/training in HIPAA actually train on HIPAA or just how it relates to the CIE? As a CBO I see an opportunity to use the CIE resource to train staff on HIPAA."

3. Education

Broader education as to the value of the Connect Oregon network is a shared task among Connect Oregon partners. Unite Us and its community engagement team play a central role. So do leaders, funders, and early adopters across the state. Often communications are shared by Unite Us and local organizations. Personal and direct communication is best. Sharing success stories from Connect Oregon partners has proven, not surprisingly, an effective strategy.

Education is of course an ongoing effort and must be sustained as CIE efforts evolve and grow, including efforts to engage individuals directly in self-referrals into CIE systems, i.e., "help when you need it or are ready". Connect Oregon partners welcome additional support in this area.

CBOs within the Connect Oregon network share these additional themes and reactions as feedback on the Education section:

- Public education relating to how sensitive information is securely stored and protected within platforms to promote confidentiality and enable organizations to meet all legal obligations while efficiently connecting individuals to services in a manner that is person-centered and trauma-informed is key to advancing user adoption.
- Recognition that adoption of CIE may involve a process of change management in how referrals are received and sent.
- Incorporating CIE training as a specific module into existing OHA THW certification would help in addressing turnover/retraining in CBOs
- As also shared in the TA section: Offering educational materials in multiple ways, including in pre-recorded webinars and videos, and access to 1:1 training as needed is important.

4. Coordination and Convening

Governance. Connect Oregon currently has a governance model in line with the principles and details communicated in the draft document. This governance model centers the CBO voice. There are two primary places where CBOs gather and make decisions. Those are:

- **The Statewide Network Advisory Board (SNAB)**
  - Centers the *community* voice at the *statewide* level
  - Provides network-level network health & sustainability guidance
  - Shares best practices between communities within a state or region
  - Supports network growth and adoption through subject matter expertise, and relationship building
- **Community Network Advisory Boards (CNABs)**
  - Centers the *community*-voice at *regional level*
  - Ensures network health & success within its region
  - Provides input on network standards and participation expectations
  - Communicates quality or performance issues of platform partners

These two bodies exist in conjunction with these other governance groups:

- **The Statewide Funders Advisory Committee (SFAC)**
    - Coordinates network-related decisions across *funding partners* at the *statewide* level
    - Co-convened by the Oregon Health Leadership Council (OHLC)
    - Reviews recommendations of the Network Workgroup and Community Network Advisory Group (if applicable)
    - Assesses network health and identifies and invests in available opportunities to strengthen the network
    - Promotes the network within the community and with partners to encourage utilization and improve network health
    - Engages with community members to identify strengths of the network and opportunities for growth
- **Network Workgroups**
    - Responds to data and trends to support network growth at the *regional level*
    - Incorporates health care and SDOH initiatives into Connect Oregon
    - Aligns communication and resources among regional funding partners
    - Champions use of Connect Oregon across health care and public health systems

Connect Oregon partners are in active discussions about how to mature this governance model as the work of the network itself matures.

Coordination Center. 211info currently operates as Connect Oregon's coordination center in multiple counties. In addition to that formal role within the network, Unite Us and 211info have built out an integration to enable the full 211info resource directory to present within the Unite Us platform, updating weekly. Further investments in 211info to expand the coordination center statewide would support the broader vision of a no wrong door and truly whole-person approach embraced by all Connect Oregon partners.

Best Practice Sharing. Creating space for cross-organizational discussions has been an important tactic for the adoption, growth, and maturation of the Connect Oregon network. The above-mentioned SNAB and CNABs provide space for sharing of best practices and providing mentorship opportunities among Connect Oregon CBO partners. Other spaces are also created, either as one-off topical discussions or through more deliberate avenues such as regularly scheduled "Lunch and Learns".

Research and Evaluation. OHLC is currently leading an engagement with the Social Interventions Research and Evaluation Network (SIREN), an initiative out of UC San Francisco, to create and implement a short- and long-term research and evaluation of Connect Oregon. Given the implications for the state and Oregon tax-payers, in particular as it pertains to overall Medicaid expenditure and OHA's goal of eliminating health inequities by 2030, further investments in research and evaluation efforts are certainly welcome and needed.

CBOs within the Connect Oregon network share these additional themes and reactions as feedback on the Coordination and Convening section:

- There are *many* existing bodies across the state that can be and are already leveraged for CIE conversations (e.g., CCO tables/committees, Education Service Districts)
- With that said, most of those are local/regional bodies: More spaces for statewide discussion are needed
- Piloting is the best way to learn and share best practices: Start small with engaged and interested partners across agency programs to develop case studies before expanding throughout the state
- Collaborate across sectors, such as using CIE in housing navigation centers
- One individual suggested funding "CBO Coordinator" positions at ODHS and OHA. These individuals would serve as point persons to work directly with CBOs to enable better best practice sharing and coordination.
- In addition to virtual spaces, physical spaces are important. How does the virtual world of CIE integrate with the physical world we live in?

Thank you again for the opportunity to share these reactions to the released draft document on CBO participation in CIE. We, the network of Connect Oregon partners, are happy to engage further in these topics and others. Do not hesitate to reach out.

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Connect Oregon is a coordinated care network of health and social service providers serving Oregon. Partners in the network are connected through Unite Us' shared technology platform, which enables them to send and receive electronic referrals, address people's social needs, and improve health across communities.

Connect Oregon has been growing organically since 2018 when Samaritan Health Services/IHN CCO partnered with Unite Us to launch a closed-loop referral network with health and social service providers in the Valley region of our State. Kaiser Permanente followed with an expansion to the network in 2019. As growing awareness of social needs accelerated and at the request of its members, the Oregon Health Leadership Council (OHLC) facilitated a process to review, vet, and select a technology vendor to implement closed-loop referrals for interested OHLC member and partner organizations.

Since that time, Coordinated Care Organizations (CCOs) have engaged and contracted with Unite Us to build and advance the Connect Oregon network. The CCO contracts cover the licensing costs for their contracted providers. CBOs are able to join Connect Oregon and thus utilize the Unite Us platform at no cost.

When joining Connect Oregon and accessing the Unite Us Platform for the first time, CBOs review and accept standard platform terms. CBO partners choose to join the network and use the Unite Us Platform. They are and always have been free to use other tools, including Unite Us competitors.

Connect Oregon is not a website and thus cannot easily be "turned on" in a region or county. The Connect Oregon network is the result of contracts and relationships that have been cultivated and that are now in place to facilitate an accountable care coordination network. At the time of writing, Unite Us is contracted with 13 of the 15 CCOs – most recently, Eastern Oregon CCO and Trillium Community Health Plans have contracted with Unite Us to invest in Connect Oregon. There are currently over 400 active and accountable CBOs representing over 600 social care programs in the Connect Oregon network. Each month, the number of support services increases as new organizations and programs are onboarded.

Connect Oregon has served CBOs, healthcare partners, and government agencies for more than three year and continues to mature as the need for social care grows and evolves. Indeed: Transformation, as the saying goes, is hard and slow work. We anticipate continued growth and are excited to support the next phase of work that lies ahead.

CONNECT OREGON

Recommended OHA and ODHS roles in CIE

Comments Submitted by the Connect Oregon Network of Partners to the HITOC Workgroup on Community Information Exchange

Date: July 18, 2022

Dear members of the HITOC CIE Workgroup:

Thank you for the opportunity to submit these comments in response to the draft "Recommended OHA and ODHS roles in CIE". As many CIE Workgroup members are aware, Connect Oregon, powered by Unite Us, is a network of health and social service organizations. Partners in the network are connected through a shared technology platform which enables them to send and receive electronic referrals, address people's social needs, and improve health across communities. It is through our shared experience of the last two years – plus individual organizations' experiences pre-dating the Connect Oregon work – that informs these comments.

First and foremost: As with the previously released document pertaining to CBO participation in CIE, we applaud this draft and appreciate the amount of work that went into it. The draft document appropriately recognizes the critical role that government can and should play in the development, maturation, and long-term sustainability of CIE.

Below we offer recommendations to improve the draft as it is prepared for inclusion in a broader statewide strategy. Our recommendations relate both to the current content of the document and also to broader best practices and lessons learned. These comments reflect verbal and written input received from Connect Oregon partners.

In brief, we recommend:

1. Taking a whole-of-government approach to CIE.
2. Explicitly stating that CIE can drive efficiencies and accountability in government.
3. Contracting with a third-party for governance design.
4. Ensuring alignment with OHA's 1115 waiver and its proposed role for CIE.
5. Building off of past and current ODHS and OHA efforts pertaining to CIE.
6. Using data to drive government adoption of CIE.

These recommendations are further described below.

1. Take a whole-of-government approach to CIE. On Page 1, the draft notes that "While the scope of the Workgroup is OHA and ODHS, the Workgroup recognizes the significant benefit of future engagement by additional state agencies beyond OHA and ODHS." We strongly support this point: A whole-of-government approach is needed.

2. Explicitly state that CIE can drive efficiencies and accountability in government. On Page 3, we suggest adding a new Overarching Principle in the form of the below or comparable:

- Statewide CIE has the potential to drive efficiencies and effectiveness across ODHS- and OHA-led programs, and indeed for programs across many state agencies.

The missions of ODHS and OHA are stated on Page 1 of this document; it should be stated that CIE can help these agencies better carry out these missions. Further, the goal of eliminating health inequities by 2030 is also mentioned on Page 1; it should be stated that CIE can play a foundational role in helping the state achieve this goal.

3. Contract with a neutral third-party to run a process to determine the best governance model(s). Governance, a critical non-technical component of CIE, has a number of components: The document names the need for "a governance convener" for CIE, suggesting that a single entity be responsible for the whole of it. However mature governance likely entails multiple conveners with ownership of various components. For example, there may be statewide as well as local bodies; technical as well as non-technical groups; policy as well as program convenings.

In comments submitted on a previous topic, pertaining to CBO engagement in CIE, we delineated the current governance structure of Connect Oregon. This interim governance structure was created as an early iteration for the purpose of creating spaces to onboard partners and for shared learning. The next version of governance may and indeed should look quite different.

To determine what the next-phase of governance could look like, we encourage hiring a trusted, neutal third-party entity with experience in cross-agency, multi-sector, public-private efforts like CIE. The recommendation is to hire this entity not to run the governance, but to run the process to determine what governance should look like. Given the complexity and criticality of CIE to the future of how health (and not just healthcare) is delivered in Oregon, and the importance Governance plays in the long-term viability and efficacy of CIE in Oregon, investment in an expert to run a proper process is warranted.

4. Ensure alignment with OHA's 1115 waiver and its proposed role for CIE. OHA has, via its 1115 proposal currently in discussion with CMS, communicated the central role CIE will play in the next phase Medicaid transformation in the state. Those proposed efforts, and the framework provided by that proposal– that CIE can be infrastructure upon which should be referenced.

5. Build off of past and current ODHS and OHA CIE-related efforts. The draft document states that "[t]he CIE Workgroup recommends that OHA and ODHS leverage policy and contractual opportunities to support, accelerate, and improve successful statewide CIE." (Page 7) Its message is one of looking forward and imagining what government involvement could look like. We encourage this forward looking. We also encourage moving beyond the conceptual to recognizing the role that OHA and ODHS have already played and are currently playing as it pertains to CIE.

ODHS is the central agency for administering Self-Sufficiency programs, Aging and People with Disabilities services, Child Welfare programs, and other programs. These programs require, by their design, care coordination across sectors. This sets the stage and the need for CIE and care coordination technologies.

Meanwhile OHA, in their role in driving Medicaid transformation writ large, has long played an important role in CIE. Key OHA policies–including global budgets, Health Related Services, and SDOH-related quality metrics–created the market conditions which incentivized health system–and in particular: CCO–investments into CIE. This history is important to recognize.

And today, many ODHS and OHA programs are using CIE. Listed below are the ODHS and OHA programs and initiatives that are, at least in certain parts of the state, currently leveraging Connect Oregon.

ODHS & OHA non-clinical programs currently leveraging Connect Oregon
Benefit Application Assistance Programs, many
Food Assistance: WIC, Meals on Wheels, and several of the Food Banks
Domestic Violence Services
COVID Wraparound Services: Deschuttes, Marion, Clackamas Counties
Court Appointed Special Advocate (CASA) Programs
Area Agencies on Aging
Eastern Oregon Center for Independent Living
Office of Resilience and Emergency Management (contracted with Unite Us)

The above list does not include health care partners that are funded and/or regulated by OHA. For example: CCOs, Health Systems, Behavioral Health clinics, and County-based clinics and programs leverage the Connect Oregon network but are not shown.

This history and current experience with CIE should be recognized in the document that is to be sent to legislature. Indeed these experiences provide a foundation for learnings that can further propel use of CIE by OHA, ODHS, and other agencies.

4. Use Data to Drive Use of CIE. Onboarding of programs to CIE is the product of deliberate discussions. Participation in Connect Oregon, for example, is a deliberate opt-in step for the program staff.

Important to our work in Oregon is the simple recognition that different programs may be in a different seasons of their work: Not all programs are necessarily ready to join Connect Oregon. For various reasons, it may be appropriate for some organizations to join sooner and others later.

As the State considers how ODHS, OHA, and other agencies can utilize CIE in the future, we encourage those discussions to be informed by data, both quantitative and qualitative. As data pertaining to the value of CIE utilization grows, so should the incentives and encouragements for its use.

—

Thank you again for the opportunity to share these reactions to the released draft document on OHA and ODHS roles in CIE. We, the network of Connect Oregon partners, are happy to engage further in these topics and others. Do not hesitate to reach out.

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In January of this year, Unite Us submitted comments to OHA in response to the draft 1115 waiver proposal released for public comment.

The focus of those Unite Us submitted comments pertained to OHA's role in "CIE". In brief, the recommendations in those submitted comments were that OHA should:

- Recognize the CIE Workgroup established by OHA in December of 2021;
- Recognize CIE as the central infrastructure required to advance the equity agenda;
- Consider the overlaps of ongoing CIE work in Oregon with those proposed in this waiver, including existing CIE governance structures and the Community Investment Collaboratives; and
- Use this Waiver opportunity, coupled with administrative claiming opportunities, to communicate intent to build long-term sustainable financing of the CIE.

We now share these comments as comments to CIE Workgroup Concept #2 which also pertains to OHAs roles in "CIE". Our aim is simply to continue to support the integration of "CIE" and medicaid transformation efforts.

UNITE US

January 7, 2022

Health Policy and Analytics Medicaid Waiver Renewal Team
Attn: Michelle Hatfield
500 Summer St. NE, E65
Salem, OR 97301

Subject: Support for Oregon's Draft Medicaid Section 1115 Demonstration Five-Year Renewal and Amendment Application

Dear Director Allen:

Unite Us writes in strong support of Oregon Health Authority's draft 1115 Waiver Renewal and Amendment application.

This comprehensive Waiver application appropriately recognizes that working upstream is the path of the equity agenda. The Waiver builds on Oregon's innovative efforts made possible through previous Waivers and furthers Oregon's commitment to health equity through important reforms, which include expanding covered benefits to include services that address social determinants, incentivizing CCOs to address upstream drivers of health through equity-focused quality metrics, and driving community-centric health investments and governance structures.

Unite Us believes the Waiver application could be further strengthened by recognizing and incorporating the ongoing and planned work of OHA, the CCOs, and community-based partners across the state to build the infrastructure required for community information exchange (CIE).

Over the last 2 years, significant statewide advancement has been made on CIE. These include smarter, more precise definitions of the term and greater awareness as to core components of CIE: shared statewide technology, community-driven governance across diverse sets of network partners, and data and reporting to support network maturation, population health initiatives, and policy and government budgeting decisions. CIE in Oregon, sustained with new long-term financing that maximizes federal drawdown, is now primed to be the shared infrastructure upon which many of the efforts outlined in this Waiver should be built.

In particular, Unite Us encourages OHA to:

- Recognize the CIE Workgroup established by OHA in December of 2021;
- Recognize CIE as the central infrastructure required to advance the equity agenda;
- Consider the overlaps of ongoing CIE work in Oregon with those proposed in this waiver, including existing CIE governance structures and the Community Investment Collaboratives; and
- Use this Waiver opportunity, coupled with administrative claiming opportunities, to communicate intent to build long-term sustainable financing of the CIE.

Background on Unite Us and Connect Oregon
Since 2013, Unite Us has been the national leader in deploying community-wide care coordination infrastructure to meaningfully connect health and social care providers in a common ecosystem and to help address social determinants of health. Our goal is to ensure every individual, no matter who they are or where they live, can access the critical services they need to live happy and healthy lives.

We help community partners – payers and providers, private and public, large and small – work together in new ways to identify and address unmet social needs. To support these network partners, we have deployed our community engagement process in more than 42 states. Our coordinated care networks demonstrate that a robust, collaborative, and holistic community-wide approach to identifying and addressing unmet social needs not only improves individual health and quality of life, but also improves community health, reduces healthcare costs and utilization, and promotes health equity. Network partners leverage the Unite Us platform to securely share information required to coordinate care through closed-loop referrals. If enabled, partners are also able to streamline the billing and invoicing of services from CBOs to payers. A suite of data as well as centralized care coordination services make up the end-to-end solution available to network partners.

In Oregon, Connect Oregon is the network, powered by Unite Us, of organizations participating in community information exchange. Unite Us is currently contracted by 12 of the 16 CCOs to serve 35 of the 36 Oregon counties. In addition to the CCOs, health providers (including large systems and FQHCs), CACs, CBOs, and county-based programs are partners. Further, Oregon Health Leadership Council serves as statewide convener of the CCOs, and 211info operates as a coordination center for the network. OHA currently recognizes Connect Oregon as a Community Information Exchange (CIE).

Given these partnerships in place, the history and the trajectory of this work, and an expansive overlap in values and mission, Unite Us respectfully submits the following comments as a committed partner and advocate for the impact envisioned through OHA's waiver proposal.

Unite Us is excited to support OHA's 1115 Waiver renewal and amendment which critically expands policy levers to incentivize and enable upstream health approaches focused on equity. Among the provisions applauded, we highlight the following:

1. The Waiver supports individuals experiencing life transitions and disruptions through comprehensive SDOH-related benefits.
Unite Us applauds OHA's expenditure authority requests for 1) CCOs, to provide covered SDOH services for populations experiencing transitional events, such as reentry from the criminal justice system or the impacts of extreme climate change, and for 2) community-based organizations (CBOs), to support their implementation capacity through infrastructure and capacity-building spending flexibility. These requests will lay the foundation for critical health reforms that emphasize and reward preventative, upstream approaches to care delivery.

Covered SDOH transition services will importantly help individuals more easily access expanded health-related services that meet their basic needs in areas such as housing, food, and employment assistance.

These SDOH benefits will help OHA standardize and streamline the delivery of services that address SDOH, which often reflect and reinforce entrenched health inequities. These benefits can ultimately be offered to additional populations beyond those experiencing life transitions and disruptions.

Importantly, this strategy will drive healthcare dollars to CBOs and community providers who have historically supported the whole-person health of Medicaid members without receiving reimbursement for their services. These dollars will drive sustainable funding and capacity for CBOs, targeting resources toward prevention and directly into communities where the most vulnerable and marginalized individuals often receive their care.

Unite Us works with CBOs on a daily basis. We applaud that this waiver acknowledges the disruption and change management that will be required of CBOs; this initiative presents a massive change to their normal workflows with the added benefit of Medicaid reimbursement. The implementation capacity funds for CBOs and aligned Community Investment Collaboratives (CICs) will be critical for supporting CBOs through this transition. These funds are essential for setting up the necessary infrastructure system that allows for tracking the delivery of services, payment and billing, reporting, and monitoring outcomes.

To further strengthen this proposal, Unite Us recommends:

Early CBO/Payer Alignment. We encourage OHA to ensure close collaboration with CBOs and community leaders when developing requirements for CBO participation, reimbursement, and reporting. This can help prevent undue administrative burden for community providers and to ensure the reimbursement process is not over-medicalized for CBOs that are not resourced to process and submit traditional medical claims. For example, OHA should ensure that their state reporting requirements for CCOs do not undermine the ability of CBOs to easily submit invoices for reimbursement. For example, California requires health plans to submit all data on Community Supports in standard encounter format, which forces plans to require traditional medical claims from CBOs so they can properly report back to the state. It's important to acknowledge that this transition will be difficult for CBOs operating with limited overhead spending, and so OHA's requirements should ensure that the transition to billing for social services is as simple and efficient as possible. CCOs should allow CBO providers to submit reimbursement requests in invoice form if that is the best process for them, and encourage use of an invoice portal as an alternative to traditional claims reporting.

In addition, OHA should ensure that vetting processes for CBO providers is distinct from the vetting process in place of medical providers. Background checks on CBO staff and other aspects of the traditional credentialing process may preclude important and trusted CBOs from participating in the initiative, and OHA should explore alternatives that are uniquely suited to vet CBOs.

Clear Standards to Drive Quality. In order to reduce duplicative efforts and minimize the number of systems and solutions that providers need to learn and adopt, SDOH transition services payments and infrastructure investments should build upon existing CIE efforts across the state, which include social needs screenings, closed-loop referrals, social care outcomes data collection and reporting functions.

OHA can ensure that all CIE solutions meet the same single set of standards to allow for standardized data collection and streamlined care coordination efforts across the state. Just as OHA has encouraged MMIS and APCD to align with REALD regulations as required by statute, so should that be encouraged with a CIE solution.

Establishing appropriate privacy, security and billing compliance requirements SDOH referral and reimbursement technology must also be emphasized here. Information exchange between partners must occur in order to ensure care coordination and the adoption of trauma-informed approaches to addressing health-related social needs; but this information sharing must occur pursuant to HITRUST Certification and compliance with HIPAA, 42 CFR Part 2, FERPA, and other pertinent regulations. The assurance of privacy and compliance enables the trust upon which any integrated solution is built and upon which equity is achieved.

Shared, Publicly-Sponsored, CBO Billing Systems. Billing systems adopted and/or procured by and/or for CBOs participating in reimbursement arrangements with CCOs should be seen as shared infrastructure. The burden should not be placed on CBOs nor community investment collaboratives that lack technical capacity to build and/or procure their own billing systems. Further, it is important for CBO payments to be linked to closed loop referral infrastructure in order to link outcomes with reimbursement and monitor population outcomes.

If viewed as shared infrastructure, OHA may consider an Advanced Planning Document (APD) as a mechanism for securing federal match funding (75-90%) for statewide CBO referral and reimbursement technology, while continuing to finance SDOH payments to CBOs via waiver requests. Continued federal investment in SDOH services combined with a publicly-privately funded foundational referral technology presents a sustainable strategy for financing such systems in the long-term – ensuring that individuals' upstream needs are being met and that CBOs are being paid for their valuable services.

2. The Waiver aligns financial incentives in the healthcare delivery system to drive community health and health equity improvements.

Unite Us celebrates OHA's commitments in this waiver around redesigning financial incentives in the healthcare system to shift resources towards and reward prevention and population health. We applaud the regulatory and policy levers outlined, including a) value-based global budgets for CCOs, b) 3% allocation of CCO population health budgets towards health equity investments with 30% designated for community investment collaboratives, and c) flexibility around CCO's ability to count health-related spending as part of their medical load when calculating MLR.

As described by OHA, Unite Us believes that these requirements/levers will "flip" financial incentives in Oregon's healthcare delivery system – CCOs will be accountable for and rewarded by improvements in whole-person health outcomes, health equity, prevention, and care

coordination rather than being financially rewarded when members are sick and access more care.

Unite Us agrees with and celebrates OHA's recognition that entrenched inequities, power imbalances, and systemic racism in and resulting from the health system cannot be undone unless financial incentives link market power to health equity and community health improvements. At Unite Us, we're working with communities and our funded healthcare partners to shift investments upstream and into community health through community health infrastructure – we will continue supporting and elevating the efforts of OHA alongside our work in communities.

3. The Waiver holds CCOs accountable for health equity through quality metrics.
Unite Us supports OHA's proposal to redesign the Oregon Health Plan Quality Incentive Program with dedicated upstream metrics focused on equity as well as to better integrate community member decision-making power through the new Health Equity Quality Metrics Committee (HEQMC).

In particular, Unite Us celebrates the new health equity upstream metric titled "Social Determinants of Health: Social Needs Screening and Referral," which incentivizes more CCO members having their social needs acknowledged and addressed.

With this metric in place, OHA is building a comprehensive healthcare delivery system that seeks to address members' social determinants of health through population health and prevention strategies, which include connecting members to services that address their social needs.

The new upstream metrics, coupled with the new HEQMC, will enable OHA to iterate and improve its social determinant strategy in the long term.

OHA and the HEQMC should also consider the role of analytical tools to identify opportunities where proactive outreach could drive social care service delivery. Supported as a shared service and run out of OHA, risk scoring mechanisms and proactive human services outreach can be essential components of a forward-looking strategy to achieve health equity.

Conclusion & Unite Us Support for Oregon's Waiver
This 1115 waiver will allow OR to implement innovative and long-lasting equity initiatives within the healthcare delivery system.

These proposals will drive sustainability for the CBO provider network, financially reward CCOs for delivering holistic care that keeps members healthy and in their communities, and incentivize more equitable outcomes with new quality standards.

We recommend that OHA continue to build upon efforts already underway across the state, including the CIE efforts and its governance approaches, to avoid conflicting solutions when possible.

If you have any questions or if there is any additional information Unite Us can provide, please do not hesitate to contact me at read@uniteus.com.

Thank you for the opportunity to submit comments, and for your continued leadership and support to provide more holistic and equitable care in Oregon and nationally.

Sincerely,

/s/ Read Holman

Read Holman
Policy Director, Government and Regulatory Affairs
Unite Us
read@uniteus.com

Public Comment
CIE Workgroup Meeting
August 16, 2022

CONNECT OREGON

Support for Additional Partners to participate in CIE

Comments Submitted by the Connect Oregon Network to the HITOC Workgroup on Community Information Exchange

Date: August 10, 2022

Dear members of the HITOC CIE Workgroup:

Thank you for the opportunity to submit these comments in response to the draft proposal titled: "Support for Additional Partners to Participate in CIE", where additional partners are defined as the following organization types: Behavioral health organizations, Oral health organizations, Physical health organizations, safety net clinics, Coordinated care organizations (CCOs), City or county government, and others. The Connect Oregon network, powered by Unite Us, is a network of health and social service organizations, including CCOs, safety net clinics, local government partners, health organizations, and CBOs, that work together, using a common technology platform, to address the social needs of all people in Oregon. Our shared experience – plus individual organizations' experiences predating Connect Oregon work – informs these comments.

The integration of health and social care requires support not only for the Community-Based Organizations (CBOs) delivering the bulk of social care services, but also for the broad spectrum of providers serving the community. Whole-person care requires coordination across behavioral, physical, and oral care providers and in coordination with local government. Statewide CIE must be able to support this wider ecosystem of service and care providers.

Indeed, this observation is at the heart of Oregon's Medicaid transformation efforts: In 2012, the CCOs were created by a new 1115 Waiver Demonstration. They were designed to support the integration of physical, behavioral, and oral health. And as described on page 319 of the current 1115 Waiver Application currently being negotiated with CMS, the CCO model highlights community advisory councils (CACs) as a part of their governance model. CACs include local government partners.

The incentives created by the policy levers within the 1115 Demonstration Waivers planted the seeds for Connect Oregon. Building off of the experiences of IHN-CCO/Samaritan Health Services and Kaiser Permanente who were early adopters of Unite Us, the CCOs have been–each on their own accord–contracting and partnering with Unite Us to expand the Connect Oregon footprint. They have purchased user licenses for more than just their care management teams: They covered the core costs of their contracted providers, including their contracted physical, behavioral, oral, and government partners. Doing so allows these partners to use the Connect Oregon network.

Thus, from the beginning the Connect Oregon network has cast a wide net. And today the Connect Oregon network, even as it seeks further growth and maturation, includes partners from all of the organizational types delineated.

The draft document released by the CIE Workgroup for comment organizes its recommendations into these four sections:

1. Sustainable funding, grants, and offsetting costs
2. Technical Assistance
3. Coordination and Convening
4. Education

This organizing structure and the recommendations herein mirror a previous concept document released by the CIE Workgroup, specifically: The Workgroup document titled “Support for community-based organizations to participate in CIE”. Our comments thus do as well: Please reference the Connect Oregon-submitted comments dated July 11 for additional context.

Beyond pointing to previous comments submitted and noting alignment with the 1115 Medicaid Waiver, we share these examples of how “additional partners” are currently leveraging the Connect Oregon network:

- **Local Government Partners:** Three Local Public Health departments, Marion County, Clackamas County and Deschutes County are using Connect Oregon as the infrastructure to send and receive COVID wrap-around referrals. This has allowed Local Public Health Departments and CBOs to have a safe and secure way to send and receive referrals, coordinate care and track outcomes. A brief case study can be found here.
- **CCOs**: 13 of the 15 CCOs currently leverage the Connect Oregon network to support their SDOH strategies. Care managers and panel coordinators from these CCOs, as well as their contracted care providers, use Connect Oregon to connect their members with social care providers throughout the State that can address their social needs, improve health outcomes, and reduce costs.
- **Physical Health Providers**: Health systems and health clinics throughout the state are leveraging the Connect Oregon network to connect their patients and families to vital wraparound social needs, including but not limited to, utility bill assistance, housing, individual and family support services, including early childhood intervention services, nurse home visiting programs, mental/behavioral health support services, and more. Some health providers are utilizing Unite Us through EHR integrations to allow for greater ease in provider workflows and are also looking for opportunities to implement formal SDoH screenings during their standard patient encounters. In addition, health providers are looking to leverage Unite Us data from these patient encounters to assess the impacts of social factors on their patient populations to improve health outcomes for patients.
- **Safety Net Providers**: In addition to large health systems across the state, there are currently 22 FQHCs on the Connect Oregon network. These providers leverage the Unite Us core platform to support social needs screening and referrals for their patients. Many of them use OCHIN as their EHR; the Unite Us platform integrates with OCHIN to ease workflow and data sharing.
- **Behavioral Health Providers**: Multiple behavioral health providers and workflows are currently being supported on the Connect Oregon network. For one example, Kaiser Permanente has piloted their Enhanced Behavioral Health Referral program to refer to community mental health partners in the Portland area, including in southern Washington. The goal of the program has been

to gain better reporting and visibility into what happens with these patients and whether they got the services they needed.

- **Oral Health Payers and Providers**: Dental Care Organizations (DCOs) throughout the state are adopting Unite Us and leveraging the Connect Oregon network to connect their members and patients with vital social care. Some DCOs are piloting Unite Us as a way to connect dental case managers with behavioral health and physical health case managers, a communication gap currently filled by clunky email systems and phone tag. Additionally, several DCOs plan on rolling out Unite Us to all of their clinics statewide near the end of 2022, assuring the patients they see day to day can be connected to these services as well. Additionally, implementing Unite Us grants our DCO partners helpful data insights, streamlining processes for meeting quality metrics across the board.

Thank you again for the opportunity to share these reactions to the released draft document on OHA and ODHS roles in CIE. We, the network of Connect Oregon partners, are happy to engage further in these topics and others. Do not hesitate to reach out.

Signed by the two statewide governing bodies of the Connect Oregon network:

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Carrie Copeland, representing Food for Lane County
Christian Moller-Andersen, representing A Smile for Kids
Dan Herman & Cara Kangas,, representing 211*info*
Franni Filzen, representing Catholic Community Services
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Background: Connect Oregon

Connect Oregon is a coordinated care network of health and social service providers serving Oregon. Partners in the network are connected through Unite Us' shared technology platform, which enables them to send and receive electronic referrals, address people's social needs, and improve health across communities.

Connect Oregon has been growing organically since 2018 when Samaritan Health Services/IHN CCO partnered with Unite Us to launch a closed-loop referral network with health and social service providers in the Valley region of our State. Kaiser Permanente followed with an expansion to the network in 2019. As growing awareness of social needs accelerated and at the request of its members, the Oregon Health Leadership Council (OHLC) facilitated a process to review, vet, and select a technology vendor to implement closed-loop referrals for interested OHLC member and partner organizations.

Since that time, Coordinated Care Organizations (CCOs) have engaged and contracted with Unite Us to build and advance the Connect Oregon network. The CCO contracts cover the licensing costs for their contracted providers. CBOs are able to join Connect Oregon and thus utilize the Unite Us platform at no cost.

When joining Connect Oregon and accessing the Unite Us Platform for the first time, CBOs review and accept standard platform terms. CBO partners choose to join the network and use the Unite Us Platform. They are and always have been free to use other tools, including Unite Us competitors.

Connect Oregon is not a website and thus cannot easily be "turned on" in a region or county. The Connect Oregon network is the result of contracts and relationships that have been cultivated and that are now in place to facilitate an accountable care coordination network. At the time of writing, Unite Us is contracted with 13 of the 15 CCOs – most recently, Eastern Oregon CCO and Trillium Community Health Plans have contracted with Unite Us to invest in Connect Oregon. There are currently over 400 active and accountable CBOs representing over 600 social care programs in the Connect Oregon network. Each month, the number of support services increases as new organizations and programs are onboarded.

Connect Oregon has served CBOs, healthcare partners, and government agencies for more than three year and continues to mature as the need for social care grows and evolves. Indeed: Transformation, as the saying goes, is hard and slow work. We anticipate continued growth and are excited to support the next phase of work that lies ahead.

CONNECT OREGON

Statewide CIE Data Program

Comments Submitted by the Connect Oregon Network to the HITOC Workgroup on Community Information Exchange

Date: August 10, 2022

Dear members of the HITOC CIE Workgroup:

Thank you for the opportunity to submit these comments in response to the draft proposal titled: "Statewide CIE Data Program". The Connect Oregon network, powered by Unite Us, is a network of health and social service organizations, including CBOs, that work together, using a common technology platform, to address the social needs of all people in Oregon. Our shared experience – plus individual organizations' experiences predating Connect Oregon work – informs these comments.

The future of health and social care is data-driven. To achieve the goal of eliminating health inequities by 2030, we must have visibility into what works and what doesn't. A mature CIE can play a central role. The draft document released by the CIE Workgoup recognizes the importance of data in decision-making, and we support the creation of a statewide CIE data program to formalize that work.

As the draft properly and thoroughly notes, data can be used to 1) Understanding needs and resource gaps within the social care system; 2) Measure the outcomes of people accessing or attempting to access services and resources throughout the state; 3) Guide policy and investment decisions in services and programs; 4) Support efficiencies in the social care system; 5) drive process improvements in the CIE itself; and 6) Support upstream CCO quality measures.

Connect Oregon, for example, has data at the center of its continuous improvement process. Aggregate, anonymized data dashboards showing trend lines and progress are brought to both statewide- and community-level discussions. These dashboards highlight network performance, referral quality, and referral outcomes trended across time. They fuel reflections and discussions on how to improve the ability of the network to identify individuals with social needs and ensure they receive high quality care.

The data efforts of Connect Oregon are in line with and are positioned to directly support a statewide data program as proposed by this draft.

We also recommend:

1. **Delineating key CIE performance metrics and reporting capabilities**
2. **Ensuring alignment with existing Oregon data programs**
3. **Recognizing and supporting SDOH-related standards development processes occurring nationally**

1. Delineate key CIE performance metrics and reporting capabilities

Closed-loop referral systems that include robust referral-outcomes reporting provide new insights into social care delivery. More than just performance metrics, outcome metrics are captured and reported. CIE network partners of all types are thus able to not only demonstrate activity but impact. Below are specific metrics for consideration.

Key performance metrics of a CIE system:

- # of unique individuals served
- % of cases closed with resolved outcomes
- % of accepted referrals accepted in 4 or fewer days
- % of licensed providers sending or receiving at least one referral within the last 3 months

Additional reporting capabilities by a CIE system include:

- Demographic breakdown of individuals served, with emphasis on race, age, gender and other key equity variables
- Service type breakdown of cases and referrals (e.g., food, transportation, housing services)
- Ability to share, as appropriate, de-identified member-level data for the purposes of 3rd party aggregation, evaluation, and analysis
- Ability to share with community partners anonymized, aggregate data in the form of dashboards
- Ability to drive performance across integrated health and social care networks such that impact evaluations can be conducted on:
    - Progress towards health equity
    - Time to acceptance of referrals
    - Resolution rates for referrals
    - Gap and overlaps in social care service coverage
    - Referral rejection rates and structured fields stating why client referrals are rejected from programs
    - Comparative workforce performance at organization and program levels
    - Growth in workforce user performance over time
    - Cross-sector referrals / Relational Map analyses
    - Emergency department usage, overall health expenditure, and other total system cost metrics
    - Care delivery efficiencies and patient / member satisfaction scores
    - Healthcare quality, per quality metrics and standards as defined by NCQA, NQF, and other national organizations as well as the State

Regular reporting on key metrics provides transparency and accountability for any CIE system; this generates trust. Similarly, reporting by government programs to agencies and the legislature can provide transparency and accountability for those programs; furthering trust in the overall system.

2. Ensure alignment with existing Oregon data programs
There are a number of data and analytics programs across OHA, ODHS, and other parts of the state. A legislative recommendation for a new social care / CIE data program should note these existing programs and how the new data program aligns with and complements these existing programs.

Some of the data programs already surfaced by the CIE Workgroup and users of existing CIE systems include OHA's REALD-SOGI data initiative, OHA Public Health's universal nurse home visiting program, ODHS data programs such as those involving 211*info*, OHCS' HMIS statewide repository initiative, Oregon's Data Strategy as owned by the CIO, and others.

3. Recognize and support SDOH-related standards development processes occurring nationally
While data from a single CIE system can provide unique insights on its own, the power of data is amplified when connected with other datasets. For example, studying the relationship between social care service utilization and emergency department usage requires data from multiple systems and sources. Further, true information exchange across sectors means that data from a CIE flows into other systems. For example, data captured by a CIE system will also present within an HMIS system.

This vision is captured by the draft document released. However, the path to enable this vision is not as clear: We recommend the document recognize the role of data standards to enable the future of information exchange and social care delivery in Oregon.

Industry-wide health data standards, historically anchored in the clinical space, have begun to incorporate SDOH elements. Version 3 of the US Core Data Set for Interoperability (USCDI) owned by the Office of the National Coordinator for Health IT (ONC) within the US Department of Human Services (HHS) includes a number of SDOH-related elements. Related to this are the efforts of the Gravity Project and the evolution and increased adoption of HL7 FHIR.

Recognition of the role of standards in this space is necessary to set the stage for the long-term vision to be realized. Partners within Connect Oregon are leading efforts to align on national standards to support interoperability and social care transformation at the national and local level.

Thank you again for the opportunity to share these reactions to the released draft document on OHA and ODHS roles in CIE. We, the network of Connect Oregon partners, are happy to engage further in these topics as is helpful.

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Public Comment
CIE Workgroup Meeting
September 20, 2022

ATTN: CIE Workgroup

Thank you for the great work you are doing. I am serving on the Connect Oregon Network State Advisory Board, representing Tillamook County as both a partner organization through my role as Well-Being Director at Adventist Health Tillamook (AHTM) as well as our county wellness coalition, which is a program of Tillamook County Public Health. We are actively supporting implementation of the Connect Oregon Network throughout our region.

We were asked to provide input regarding the workgroup's concept papers. I do have concerns about these statements from concept paper #2 and am interested in understanding the rationale for consideration that large health systems are lower priority.

The Workgroup had more nuanced thoughts on additional partners' funding support needs, which is explained in the first section.

The group was split on this need for physical health and city/county government. Funding support was perceived as a lower priority for CCOs and large health systems.

Here are some considerations that may not be widely understood:

- Volume: Large health systems see the vast majority of patients in general. In Tillamook County, AHTM is the largest provider of care (including primary care) for Medicaid and Medicare patients. One would assume that volume factors into prioritization.
- Financial Stability: There seems to be a perception that large health systems have stable financial footing and can easily adapt workflows and staff capacity to implementing CIE. This is, unfortunately, not the case. The industry is struggling financially and our state is no exception, with severe staff shortages, chronic lack of skilled candidates in the workforce to meet existing demand and paying exorbitant rates for contract labor. Furthermore, there are no existing funding incentives to drive the necessary changes in workflow.
- ROI: Lack of intentional support for large health systems ultimately undermines the intent of CIE. Any care system must operate efficiently. Implementation of CIE requires that we have the same workflows for all patients, regardless of payor type. Ideally policies from state and federal payors would support extending care delivery to all populations to leverage economies of scale.

Please accept these as my observations as an independent voice on our advisory board. I would be happy to convene a meeting or have further conversations around this topic if it would be helpful.

Thank you,

Michelle Jenck, M Ed | Director | Well-Being
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Tillamook County Wellness Coordinator