OeHI Care Coordination:

Executive Summary of Lessons Learned

November 2020

CORHIO and Mile High United Way partnered between June and September 2020 to complete an environmental scan as a part of the planning for a statewide Community Resource Inventory (CRI) using the current 2-1-1 Colorado CRI to support social-health information exchange (S-HIE) infrastructure. This project was funded by the Colorado's Office of eHealth Innovation (OeHI) using funds sourced from the Centers for Medicaid and Medicare Services. This work was focused on determining the value and planning a business model and technology platform for a statewide CRI aimed to facilitate the workflow and data exchange for entities interested in referring for social needs. There were several important lessons learned in this project, many of which create opportunities for future iterations for a statewide CRI. In this document, we will outline those lessons learned and identify the work that guides the next phase.

To meet OeHI's requirements for this effort, CORHIO interviewed key stakeholders across Colorado. These stakeholders included health systems, community services providers, community-based organizations (CBOs), community resource referral platforms, Regional Accountable Entities (RAEs), and payers/health plans. Below is a summary of lessons learned through this work. The landscape associated with exchange of social-health information data is complex and being approached in a variety of ways across Colorado and the nation. Flexibility will be a key pillar of future progress.

Opportunities for 2-1-1 Colorado to create a broad-based, affordable referral structure for Community Based Organizations

CORHIO's interviews with clinical partners indicate they want community resource content available in the 2-1-1 Colorado CRI. CORHIO's research indicated most entities already utilize the 2-1-1 Colorado website for referrals today. This familiarity positions 2-1-1 Colorado to be a central component of a S-HIE infrastructure. In the long road ahead to a statewide S-HIE infrastructure, the first step is to establish an aggregated, curated, and complete statewide CRI. During this process, it will be key to establish data sharing and data governance structures that use current data exchange standards, such as Open Referral. With these standards in place, we would next establish the statewide CRI with access that meets the needs of organizations. Options for allowing near real-time CRI updates are via an Application Program Interface (API) or web services, depending on the organization's technology capabilities and preference.

In CORHIO's market research interviews, we learned that all market segments broadly support the concept of one statewide CRI. One notable challenge identified is due to the way in which these organizations consume the data and their business model that brings technical, financial, and workflow challenges with a larger statewide S-HIE implementation that will require additional funding and technical assistance.

Revenue opportunities

CORHIO is proposing a revenue model that recovers the cost of exchanging data across the ecosystem. This revenue model includes a licensing fee, appropriate implementation costs, and custom data delivery subscription fees. While the fee schedule has not yet been determined, CORHIO is confident that a system can be built that meets the needs of all S-HIE participants across the state of Colorado.

Today, 2-1-1 Colorado is highly dependent on charitable giving, and any revenue generated from statewide CRI license fees will be positively accretive. Many organizations expressed support for 2-1-1 Colorado CRI sustainability and the concept of a reasonable license fee.

Additional Challenges in Today's Colorado's Care Coordination Ecosystem:

In Colorado, community resource referral platform vendors, such as Unite Us, Aunt Bertha, and Boulder Connect are actively and successfully promoting their platform to health systems and are reaching out to onboard CBOs to participate in their networks as referring organizations. Consequently, CBOs are being asked to participate in and adopt a variety of community resource referral platforms, creating data silos in referring networks that will impact downstream data sharing. This is resulting in potential CBO fatigue as they are being asked to align with multiple systems while also having significant limitations in technology and resources to implement and maintain these complex systems. Additionally, there is a wide range and disparity in the way CBOs can participate because they may lack the necessary technology tools and resources, further creating gaps in CBO participation. These referring entities simply do not have the ability to share outside their current community resource referral platform networks.

As an example, if a health care provider from a referring entity is using a community resource referral platform (such as Unite Us, Aunt Bertha, or Boulder Connect) to access community-based services, such as a food bank, each referral platform may vary in the food bank resources available in the provider's referral network. There may be a scenario where a patient may have a food bank in their neighborhood, but they would not be referred to that specific food bank if it is not in the community resource network of the referral platform. As such, the food bank is *out-of-network,* and if the patient in need takes their referral to this unconnected food bank, both the provider and CBO providing services are left to manage the referral in a manual workflow. The individual's care provider will be unaware of the status of the client's visit to the food bank as out-of-network referrals do not provide a status update. There are two issues, first is of in-network vs

out-of-network, and second is that each referral platform may not have the same comprehensive set of available services, regardless of whether or not they are in-network or out-of-network.

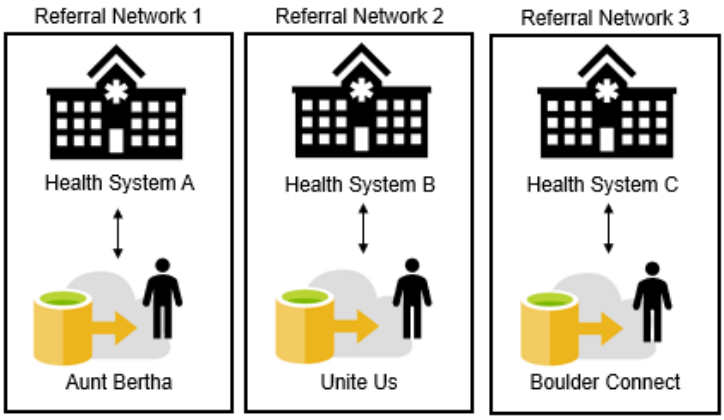

Figure 1. Current state that shows how organizations adopting community resource referral platforms have isolated systems with different CBO referral networks that do not communicate between each other.

This model used by community resource referral platforms with their own networks of CBOs limits services available for referral and may result in patient burden depending on resource availability. However, community resource referral platform vendors have expressed willingness to exchange data in three ways:

- Bi-directionally share CBO resource data they curate and receive statewide CRI aggregate data,
- Referrals to CBOs outside of their network, and
- Share initiating referral, ongoing status, and final outcomes via a report.

This requires a significant change in both the referral ecosystem, and processes in place today. A limiting factor in the achieving the above goals is the lack of data standards that exist today that promote interoperability. Today, conversations are underway to understand the data sharing models and the business model necessary to facilitate these three efforts toward developing a statewide social-health information exchange infrastructure. There is a broad spectrum of readiness and/or ability to provide interoperable solutions among community resource referral platform vendors, referring entities, and CBOs. In most cases, providing interoperable solutions remains on their roadmap and is not part of their current product offering.

Additionally, we have learned that Electronic Health Record (EHR) systems, such as Epic, are building social determinants of health and care coordination into their platform, creating seamless workflows with specific community resource referral platforms. Other EHRs, such as NextGen and eClinicalWorks, are working to integrate seamless workflows between the EHR and other community resource referral platforms. While these solutions may work well for referring providers, they create another data silo because the information is not necessarily shared in an interoperable way.

Lastly, funding continues to be a significant challenge to community-based organizations to meet increase in service demands, and further compounded with the need for technology upgrades and growing the required skillset in their resource pool to manage a social referral system. These costs come before building a system that enables sharing beyond the individual CBOs.

Conclusion

This is a complex space. Stakeholders across the ecosystem are actively evaluating and adopting a variety of technology solutions to support this work that are creating workflow challenges as well as exacerbating resource disparities among CBOs and healthcare providers/systems. We strive to create our vision for a statewide S-HIE into a reality that would remove the silos and allow for interoperability between different referral networks across community resource referral platforms.

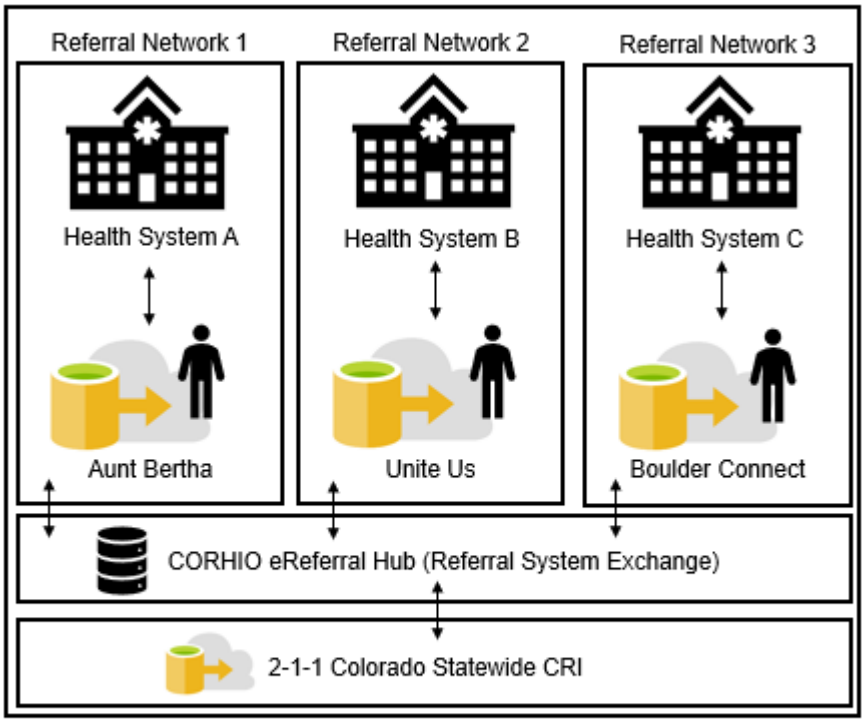

Figure 2. This future state diagram shows the S-HIE ecosystem including 2-1-1 Colorado would be the Statewide CRI, CORHIO as the Referral System Exchange that allow interoperability within the workflow that referring entities have with their community resource referral platforms.

This work requires agreed upon leadership, governance, and initial financial support to ensure long-term and widespread adoption and success. Leveraging existing competencies of both CORHIO and 2-1-1 Colorado to create a statewide CRI and distribution channels that allow for the most efficient and sustainable approach, making it a sensible next step in the long process of developing a statewide S-HIE infrastructure.