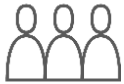
Community Information Exchange (CIE) in Oregon

CCO Health-Related Services Convening 2021

May 25, 2021

“Working” Vision for CIE in Oregon

Patients and Families: **Reliable referrals** to organizations for patients’ pressing social needs, **assistance with system navigation**, and overall improved health and well-being.



Communities: **More effective and efficient referrals among CBOs**, and community-wide social needs data to inform policy, advocacy and investment.

Health care systems: **Improved patient health, provider satisfaction**, metrics and performance on health outcomes and well-being. **Reduced utilization and cost**, engagement of community health partners to address patients’ social needs and demonstrate community benefit investment.

Policymakers: **Alignment with state health care transformation goals**, CCO 2.0 policy recommendations, and the HB 3076 Community Benefits spending floor. Leverage the work of the HIT Commons to coordinate investments in HIT, funding opportunities, and advance HIE across the state. Provide data on regional social and resource needs, and outcomes to inform policy changes and resource allocation.

*working definition/visual developed by HIT Commons CIE Advisory Group. See: http://www.orhealthleadershipcouncil.org/oregon-community-information-exchange-ocie/

OREGON HEALTH LEADERSHIP COUNCIL

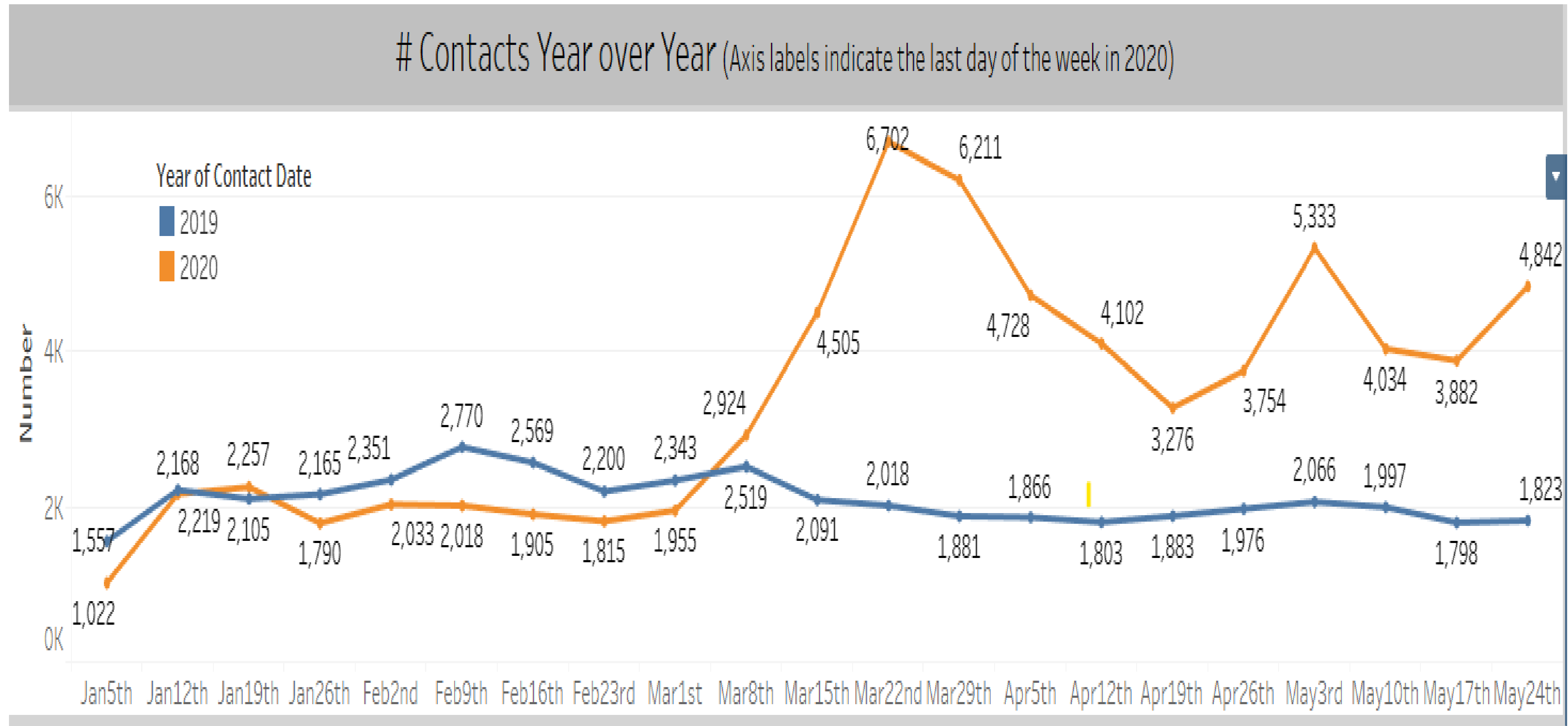
CIE Vendors in Oregon

- **Aunt Bertha**

- **Unite Us**
  - In 2019, OHLC engaged with Unite Us at the request of our stakeholder partners:
    - Coordinated demos/whiteboard sessions
    - Statewide pricing model
    - Statewide governance model
  - Announced “Connect Oregon” in October 2020. Implementation underway.

Additional CIE Vendor Details:
https://www.oregon.gov/oha/HPA/OHIT/Meeting%20Documents/20210429_CIE_Webinar_Slides_Final.pdf

COVID 19: Highlighted Critical Need for CIE



Data shared with permission of 211info.

Connect Oregon (Unite Us platform)

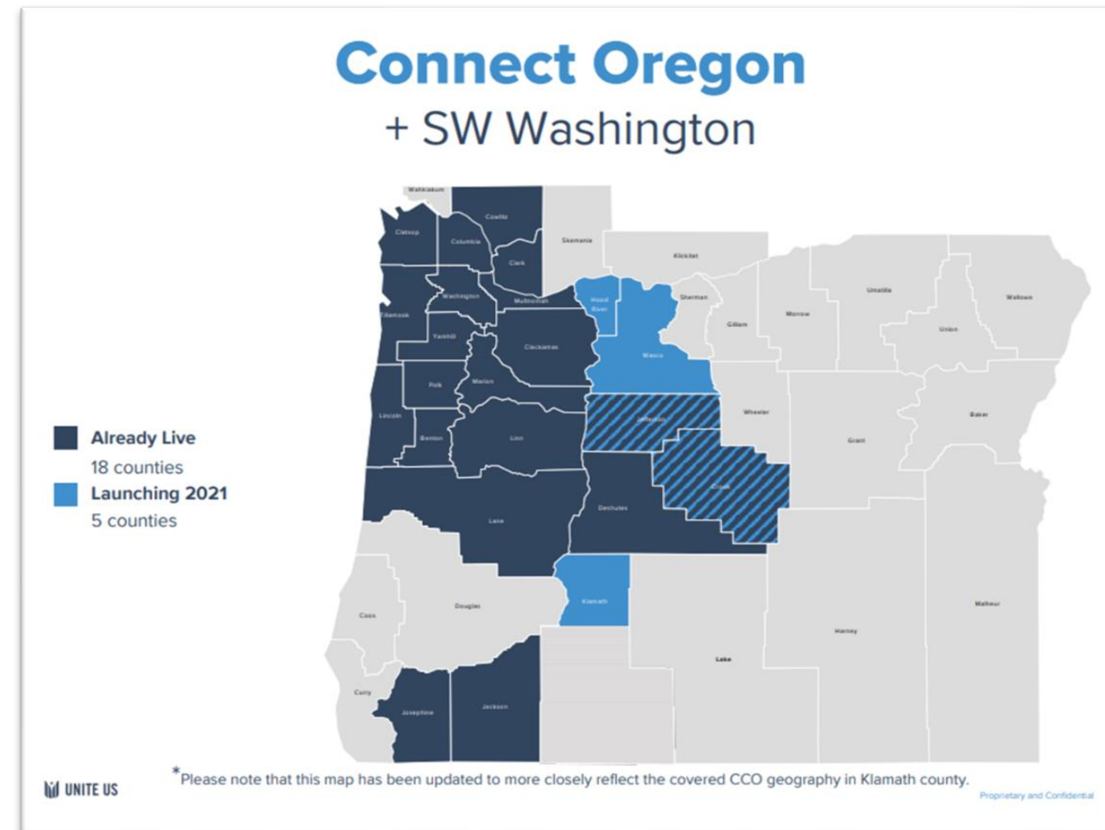
Unite Us: https://uniteus.com/

Connect Oregon: https://oregon.uniteus.com/

Footprint: 21/36 counties live by end of 2021

Currently contracted with:

- AllCare Health
- Central Oregon Health Council
- Columbia Pacific CCO
- Health Share of Oregon
- InterCommunity Health Network/Samaritan
- Jackson Care Connect
- Kaiser Permanente
- PacificSource



OREGON HEALTH LEADERSHIP COUNCIL

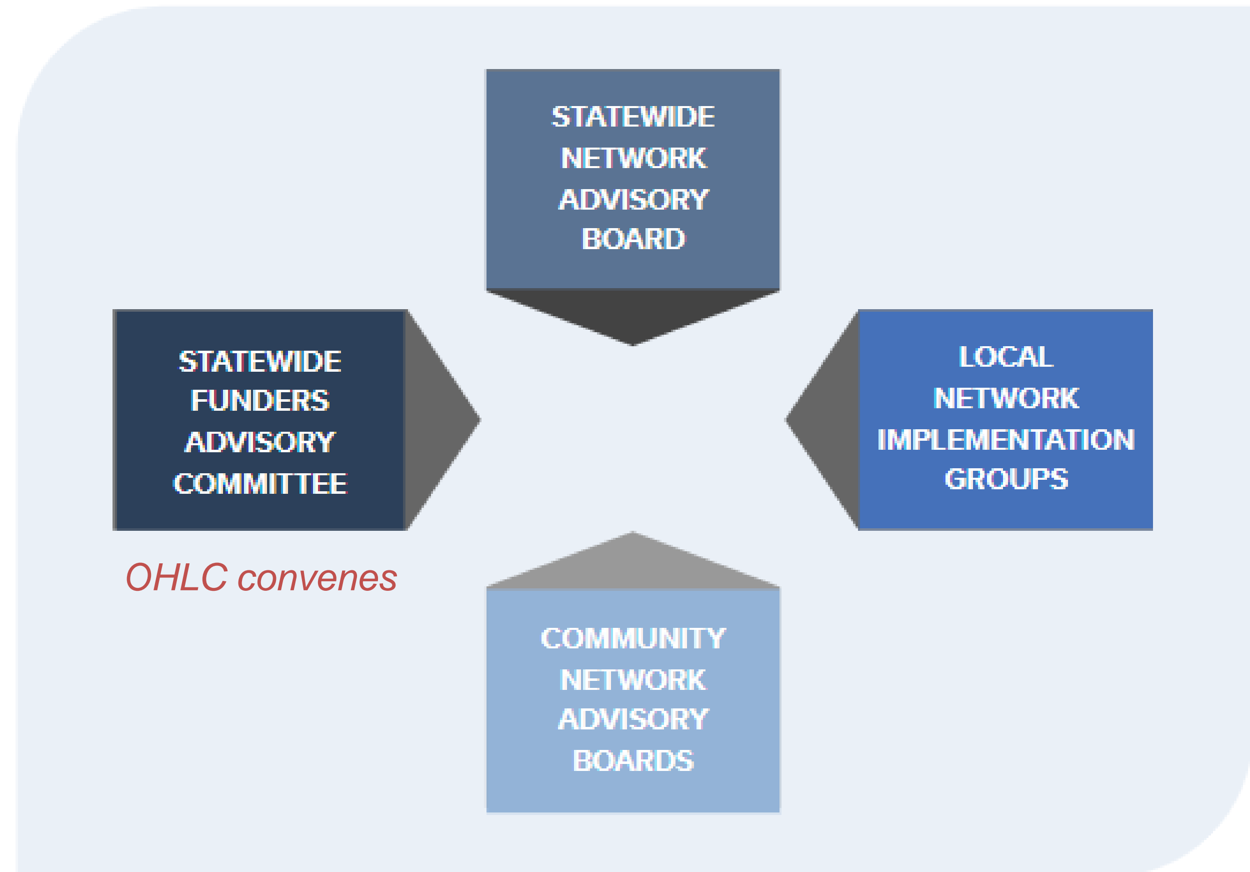
Connect Oregon Governance Model

Function

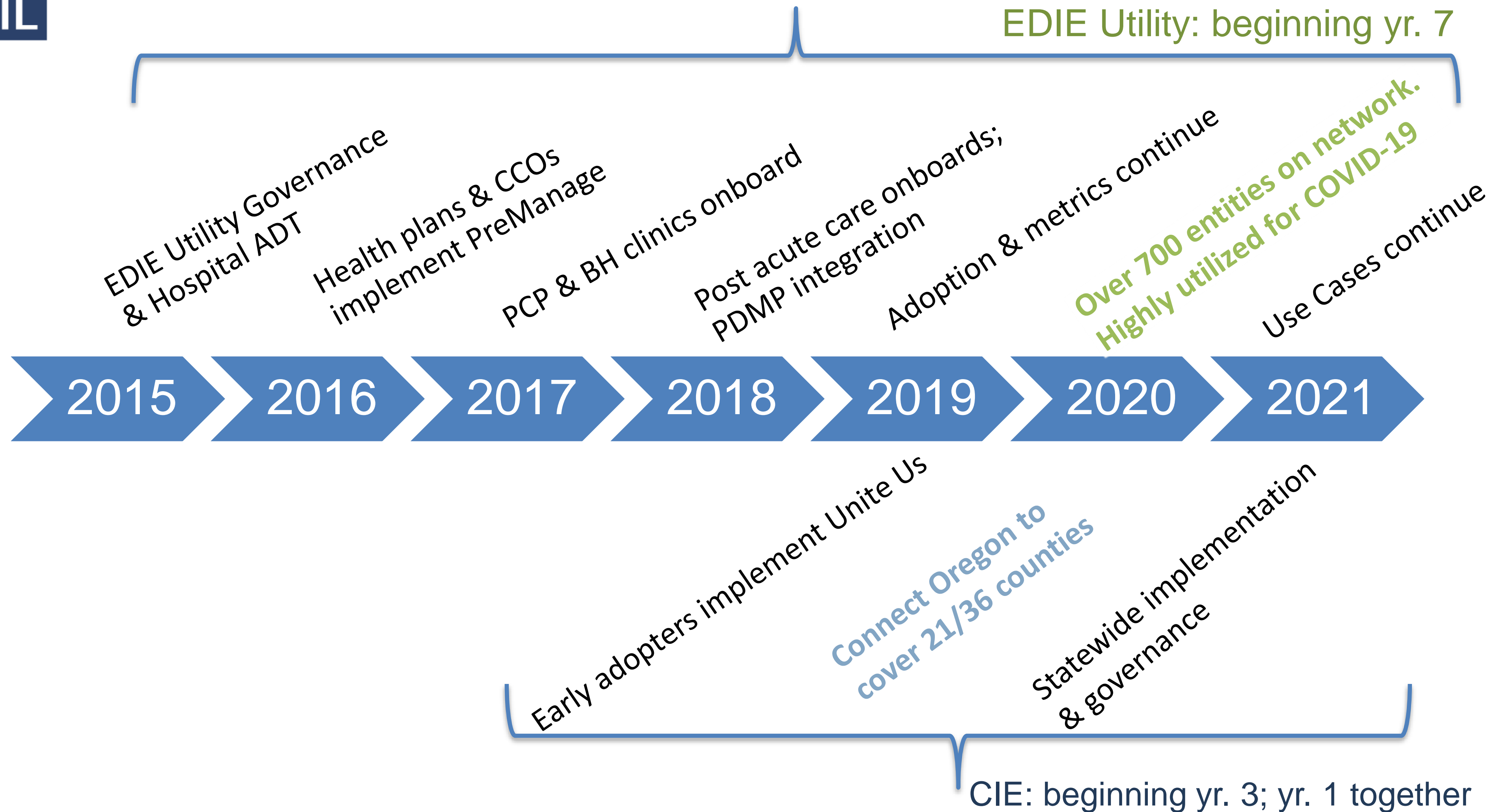
- Inform and/or facilitate strategic decisions
- Support initial network launch and ongoing growth and maintenance

Framework

- The structure is geography-based; not tied to a particular customer
- The advisory groups are two-tier, organized at the regional and statewide/network-wide levels
- One Statewide Funders Advisory Committee due to natural convening of statewide entities with OHLC



CIE: Setting expectations from prior experience…



Key Opportunities for Alignments

(not exhaustive; there are many!)

- **Federal policy/priorities—American Rescue Plan, HIPAA changes, etc.**
- **State policy/priorities**
  - Oregon's SHIP
  - Oregon Health Policy Board Priorities/1115 Medicaid Waiver Renewal
  - OHA HITOC Strategic Plan
  - Proposed legislation: HB 3039 CIE/HIE planning bill
- **Integrations with other CIEs/systems**
- **Adoption & spread—both clinical and CBO focused**

Thank you and contacts

- Michael Pope, Program Consultant, michael@orhealthleadershipcouncil.org
- Liz Whitworth, Managing Director, liz@orhealthleadershipcouncil.org

Health Related Services:

Centering Equity and Community Engagement

CCO Health-Related Services Convening 2021

Christine Bernsten, Peg King, Maria Tafolla

Agenda

For today:

- Welcome-introduction activity
- COVID Impact Support Funds
- Partner Highlights
- Reflection/Discussion

health share

Mission, Vision, Values

Our Mission

We partner with communities to achieve ongoing transformation, health equity and the best possible health for each individual.

Our Vision

A healthy community for all.

Our Values

At Health Share, we believe:

- Member voice and experience are at the center of what we do
- Health equity is achievable and requires deliberate action on our part
- In honoring our commitments
- Using continuous improvement is vital to our efforts
- In operating transparently and using data to guide our work
- In working in partnership to maximize our resources

Introduction Activity

Participants can join
at **slido.com** with **#684525**
or scan the QR code below

COVID Impact Support Fund

$4.8 million

How can we do things differently in a pandemic, especially for our most impacted communities?

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Our Process

Funding decision - Quality Committee of the Board

Internal cross sector teams developed process

Community Impact Committee, Community Advisory Council

Health Share's Racial Equity Tool

GOAL: Low-barrier approach to get funds out to community-based organizations working with communities of color in response to COVID

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Health Share of Oregon

Reset Form

Please fill form out completely

Purpose: To eliminate racial i
toolkit has been developed to r
In addition, the toolkit will out
and evaluation of budgets, poli
on racial and health equity.

Application of a Racial Equit
equity as we focus on informat
revision of strategy or approac

When Do I Use This Tool?

Early: Apply the toolkit early
and desired outcomes.

How Do I Use This Tool?

With Inclusion: The analysis s
perspectives.

Step by step: The Racial Equity
completion:

Adopted from Government Alliance on Race and Equi
http://www.racialequityalliance.org/resources/racial-eq

Title of budget, initiative, policy, p

Description:

Department:

Budget ◯ Initiative (

1. What is the budget, initiative,
2. What group(s) experience disp
decision? Are they at the table
3. How might the budget, initiati
perceived by the group(s)?
4. Does the budget, initiative, po
existing disparities? Please ela
institutional racism?
5. Does the budget, initiative, po
unintended consequences for
6. Does the budget, division strat
needs?
7. Based on the above responses
program, or decision under rev
8. What next step is recommend

Glossary of Terms

Accountability: Dependability is demonstrated and carries an expectation of account-giving. It is about being answerable to others. Accountability means making clear agreements about what is expected and about what happens because of actions we do or do not take. Within these agreements:

- Behavioral expectations need to be well defined and specific.
- People must have adequate resources and skills to accomplish what is desired or required of them.
- Definitions and measures of success must relate to the thing we say we are trying to do.
- Consequences, positive ones when we meet agreements and others when we fall short, are needed to ensure credibility and follow-through.

http://www.alynconsulting.com/diversity-blog/key-concepts-conversations/from-inclusion-to-accountability/

Equity: The absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. (World Health Organization)

Equity Lens: An approach to ensure policies, programs, and decisions result in equitable outcomes for historically oppressed and marginalized populations. An equity lens requires analyzing the impact of internal and external processes, as well as foundational assumptions and interpersonal engagement, on marginalized and underserved individuals and communities.

Individual racism: Pre-judgment, bias, stereotypes about an individual or group based on race. The impacts of racism on individuals including white people internalizing privilege and people of color internalizing oppression.

Individual Racism: Can include face-to-face or covert actions toward a person that intentionally expresses prejudice, hate or bias.

Institutional Racism: The policies and practices within and across institutions that, intentionally or not, produce outcomes that chronically favor, or put a racial group at a disadvantage. Examples can easily be found in school disciplinary policies in which students of color are punished and excluded at much higher rates than their white counterparts (for same behaviors), racial bias and discrepancy in treatment within the criminal justice system, maternal child health outcomes/mortality rates for African American women, etc.

Racial Equity: The condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, how one fares.
When we use the term, we are thinking about racial equity as one part of racial justice. This means we also include work to address root causes of inequities and not just their manifestation. This includes the elimination of policies, practices, procedures, attitudes, and cultural messages that reinforce differential outcomes by race or fail to eliminate them. www.racialequitytools.org/glossary

Our Process

Initial application review – staff worked in teams to review applications and cross-checked partner's assessment. Review criteria:

- Organization was invited to apply
- Request for funds support organization's response to COVID
- Funds are focused on supporting communities of color
- Provides services in the Portland tri-county region
- Request is less than 30% of annual operating budget

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Invitation - COVID-19 Im

Dear Community Partner:

You are invited to apply for Health Share of Oregon's new
offering 4.5 million dollars in **one-time funding** to support
communities disproportionately impacted by COVID-19, w
serve communities of color. The funds are intended to aid
current public health and economic crises. This **one-time** f
30% of your current operating budget.

We are prioritizing this funding for the following organizat
1. Culturally specific/BIPOC (Black, Indigenous, Peop
2. Organizations receiving funds from OHA for conta
using these funds for infrastructure development
3. Organizations receiving funds from counties for C
for infrastructure development
4. Organizations and Coalitions with a priority focus

The COVID-19 Impact Support Fund focus areas include, b
- Community-based mental health and wellness ser
including recovery services, traditional health wor
- Essential resources including housing or rent assis
economic/employment services, technology.
- Enhancing organizational emergency capacity incl
support for employee assistance funds, replaceme
- New COVID-19 specific programs or services to su

When are applications due?
- Applications are due October 2, 2020. Funds will b
to covidsupportfunds@healthshareoregon.org.

- **Here is the application portal:** COVID Impact Sup
We have also attached a PDF of the application fo

How much funding will be awarded?
Funding awards will range from $25,000 - $250,000. Orga
current operating budget. This money is intended to meet
18 months of receiving the funds. At the end of the fundir
submit a brief narrative report describing how they used t
they serve, including specific stories about individuals and

Thank you for the work you do to support our community

Application - COVID-19 Impact Support Fund

You are invited to apply for Health Share of Oregon's
offering 4.5 million dollars in **one-time funding** to sup
communities disproportionately impacted by COVID-1
that serve communities of color. The funds are intend
by our current public health and economic crises. This
to exceed 30% of your current operating budget.

Here is the application portal: COVID Impact Support

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ORGANIZATION INFORMATION

Organization Name:

Street Address:

Contact Name & Title:

Phone:

Organization's Mission:

For this funding request, which counties and zip codes would your organization serve?

❑ Clackamas ❑ Multnomah ❑ Washington

Zip codes (if available):

PROGRAM DETAILS

1. How does your organization engage communities most impacted by health inequities, and specifically communities of color?
2. What services does your organization provide to Oregon Health Plan members and/or individuals in our community with limited income?
3. What is your organization's annual operating budget?
4. How much funding is your organization requesting at this time?
5. Briefly describe what the funding will be used for.
6. When do you expect the funding to be spent and project complete (needs to be spent within 18 months of receipt of funds)?
7. How will you know the funds have helped the communities you serve?
8. Describe how this funding aligns with Health Share's Mission of partnering with communities to achieve on-going transformation, health equity, and the best possible health for each individual.
9. Is there anything else you would like to share with Health Share?

Review Criteria.
Funding requests will be reviewed based on the following criteria:
1. The organization meets one of the four criteria of organizations these funds are prioritized for.
2. The organization will use funds to support response to COVID-19.

COVID-19 Impact Support Funds

103 – invited to apply

72 – applications received

60 – funded organizations

COVID-19 Impact Support Funds

$11,635,121 - requested

$4,844,309 - awarded

COVID-19 Impact Support Funds

Of the 60 organizations we funded:

- **100%** focused on **serving communities of color**
- **33%** focused on **children and families**
- **30%** focused on **housing, utilities and food**
- **26%** focused on **Community Health Workers**

The 60 COVID Support Fund Award Recipients

Adelante Mujeres
African Family Holistic Health Organization
African Youth and Community Organization
Albina Head Start, Inc
Angolan Community Organization of Oregon
Ant Farm
APANO Communities United Fund
Bienestar
Black Parent Initiative
Boys & Girls Club of Portland
Bradley Angle
Brown Hope
Catholic Charities of Oregon
Center for African Immigrants and Refugees Organization
Center for Intercultural Organizing (dba Unite Oregon)
Central City Concern
Chinese Friendship Association of Portland
Clackamas Women's Services
Coalition of Community Health Clinics
Community Action
Community Development Corporation of Oregon
East Washington Co Shelter Partnership Council (dba Good Neighbor Center)
Ecumenical Ministries of Oregon
El Programa Hispano Catolico
Familias en Accion
Hacienda Community Development Corporation
Holistic Health
Immigrant and Refugee Community Organization
Kairos PDX
Latino Network
Lutheran Community Services NW
Mercy Connections
Metropolitan Family Services
NARA
National Alliance for Filipino Concerns
Native American Youth and Family Center
Native Wellness Institute
Neighborhood Health Center
North by Northeast
Northwest Family Services
Open School, Inc.
Oregon Chinese Coalition
Oregon Latino Health Coalition
Oregon Marshallese Community Association
Portland Opportunities Industrialization Center, Inc. + Rosemary Anderson High School (POIC+RAHS)
Reach Out and Read Oregon
Slavic Community Center of NW
Social Venture Partners (on behalf of Early Childhood Equity Collaborative)
Straightway Services
The Giving Tree
The Miracles Club
The Northwest Catholic Counseling Center
The Rosewood Initiative
Together We Are Greater Than
Torus
Tryon Creek Watershed Council (on behalf of HAKI Community Org)
United Way of the Columbia Willamette (on behalf of Early Learning Washington Co)
UTOPIA PDX
Virginia Garcia Memorial Health Center
Young People Dreamers & Achievers

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Community Partner Highlight

Let's hear from one of our community partners:

Dioscelin Sánchez,
TierrAgua Community Navigator

- Washington County Community Action

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What's next?

Tracking impact of funding

Deepening relationships with culturally specific CBOs

Expanding Community Engagement processes

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Reflections & Discussion

Based on what you've heard, what ideas do you have about how we can engage with community in HRS funding decisions?

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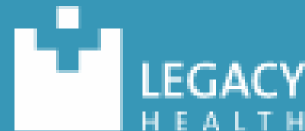
Our Partners

ADVENTIST HEALTH
PORTLAND



Community Information Exchange

Community Integration Goals

COLLABORATIVE PARTNERSHIP

MAXIMIZE RESOURCES

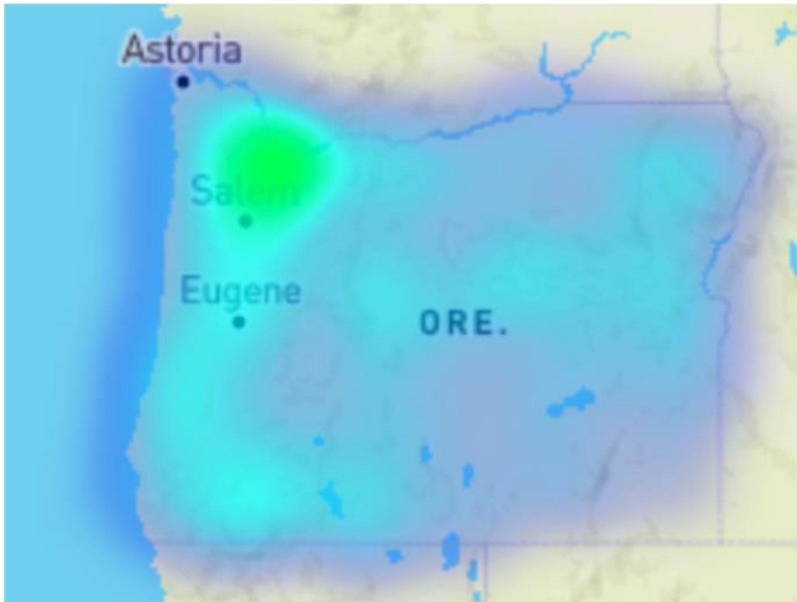
COMMUNITY INTEGRATION

SUSTAINABLE NETWORK

Statewide Social Care Referral Network

Aunt Bertha social care network in **Oregon**, by the numbers:

- **45,000+** users; **269,000+** searches, **11,000+** connections
- **29** customers serving Oregon residents
- **454** in-network CBOs serving residents of Oregon in need on our platform.
- **4,274** available programs to residents of Oregon.



Aunt Bertha Customers serving Oregon:

Community Information Exchange

Healthy Klamath Connect
Connecting People Locally

HealthyKlamathConnect.com

The Healthy Klamath Coalition is here to help connect you with the resource you need, like food, job training, child care, medical care and more.

ZIP 97601 Search

Our vision: To create direct connections to local services and assistance for the residents of Klamath County.

This resource is brought to you by:

Cascade Health Alliance, LLC - A Better Health For a Better Future.

ZIP or keyword or program name

Select Language

The Healthy Klamath Coalition is here to help connect you with the resource you need, like food, job training, child care, medical care and more.

FOOD

HOUSING

GOODS

TRANSIT

HEALTH

MONEY

CARE

EDUCATION

WORK

LEGAL

1,400 programs

serve people in Klamath Falls, OR 97601

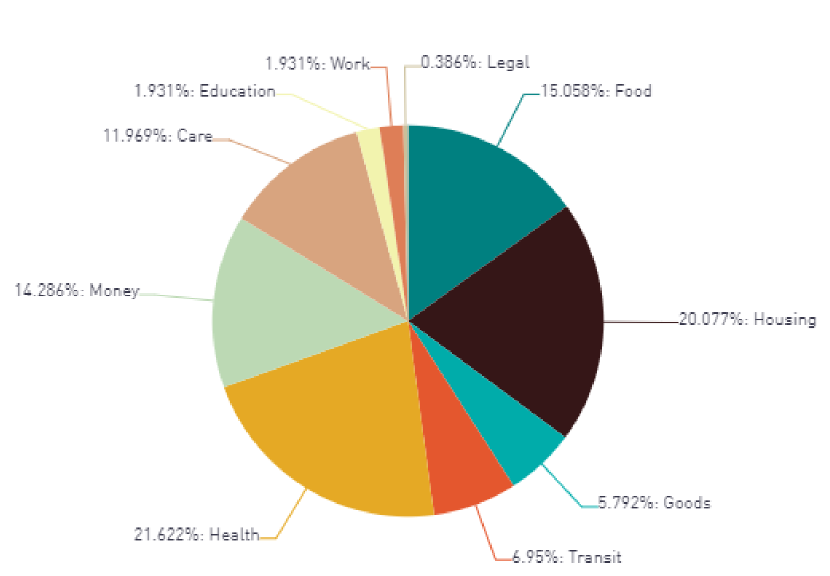
Type a search term, or pick a category

Search Activity Reports

FILTERS (2) ▾ Aggregation Weekly DateRange 90 Days

ⓘ All Searches | 90 Days

ⓘ Searches by Category | 90 Days



ⓘ Most Common Search Terms | 90 Days

TERM	DOMAIN	SEARCHES
translink		43
care management	care	19
financial assistance, covid19, female, individuals, home re...	money	15
help find housing	housing	12
help pay for utilities	housing	11
dental care	health	10
community uplift		9
emergency food	food	9
help pay for housing	housing	8
food delivery	food	6
bus passes	transit	6
nutrition education	food	6
food pantry	food	6
transportation	transit	6

- ***Objectives***

➢ Enhance communication and service delivery across systems.
  - Mobilize Healthy Klamath Coalition service groups
    - Local Governments, Public Health, Klamath Tribes, Healthcare Provider, Community-Based Organizations, and CHIP Workgroups
  - Engage System of Care Network
  - Implement in K-12 Education Districts
  - Quality Metrics and Care Coordinator

Successes vs. Challenges

- Successes
  - ➢ Cross-Sector Collaboration
  - ➢ Community Plan
  - ➢ 25 local users managing 62 programs
  - ➢ Klamath Tribal Health Pilot
    - ▪ Foster clinic-community linkages

- Challenges
  - ➢ Community-Based Organizational Capacity
  - ➢ Limiting groups settings
  - ➢ Competing community efforts trying to accomplish connecting SDOH needs

Thrive Local

CIE Panel: May 25, 2021

Tracy Dannen-Grace, MBA
Director, Community Partnerships & Philanthropy

The Case for Social Health

Being healthy isn't just a result of high-quality medical care. In fact, what influences our health the most is often not found within a hospital or doctor's office.

Kaiser Permanente is fast-tracking efforts to broaden the scope of our care and services to address all the factors that affect people's health, including having a safe place to live, enough money, healthy meals, and meaningful social connections.

Now is a time when our commitment to health and our values compel us to do all we can to create more healthy years for everyone.

Health is interconnected

TOTAL HEALTH

Physical

Health of our bodies

Mental

Health of our minds

Social

Health of our personal situations

KAISER PERMANENTE®

UNMET SOCIAL NEEDS ARE A BARRIER TO HEALTH

Even before COVID-19, people struggled with unmet social needs

68%

Had at least one social factor they needed help with in the past year.

People reporting unmet social needs are

2x

as likely to rate their health as fair or poor.

97%

Of respondents want medical providers to ask about social factors during care visits.

1 in 4 Americans

Had a social factor they say was a barrier to health in the past year.

2019 Social Needs in America Study (national data)

KAISER PERMANENTE®

Addressing pervasive and emerging inequities
among Kaiser Permanente members

5x

Hispanic KP members were nearly **5x** more likely to want help buying food than white members

42%

of members struggled to buy food and pay bills and 35% experienced social isolation

UNMET SOCIAL NEEDS ARE A BARRIER TO HEALTH

3 in 5 members

have had at least 1 social factor they need help with

2020 Kaiser Permanente Social Needs Survey (KP member data)

Kaiser Permanente National Social Needs Survey

Social Health in KP's Enterprise Strategy

Goal

Deliver superior quality, drive equitable health outcomes for our members, and improve conditions for health in our communities

Key Actions

Outcomes | Equity | **Social factors** | Research | Lead the national dialogue

Execution Plan

- Identify, predict, and incorporate into members' care paths social factors that impact health and contribute to inequities
- Incorporate social factors into quality-performance reporting
- Develop and implement evidence-based strategies to address social factors

Social Health Practice

Identify

Connect

Support and Follow up

KAISER PERMANENTE®

Thrive Local: A Tool to Connect People to Community Resources

Identify

- Standard screening questions/tools in KPHC
- Workflow design and job aids for integrating screening in care delivery (WIP)
- Chatbot for social needs screening (WIP)
- Social risk models to target outreach (WIP)

Connect

- Resource sharing and referrals using Thrive Local
- Thrive Local Connections call center for members
- Member self-access to Thrive Local on kp.org (WIP)
- KP-funded resources, including for food, housing, social isolation, financial wellness* (*WIP)

Support and Follow Up

- Social health practice as part of enterprise care-coordination approach (WIP)
- Tracking closed/resolved cases in Thrive Local (WIP)

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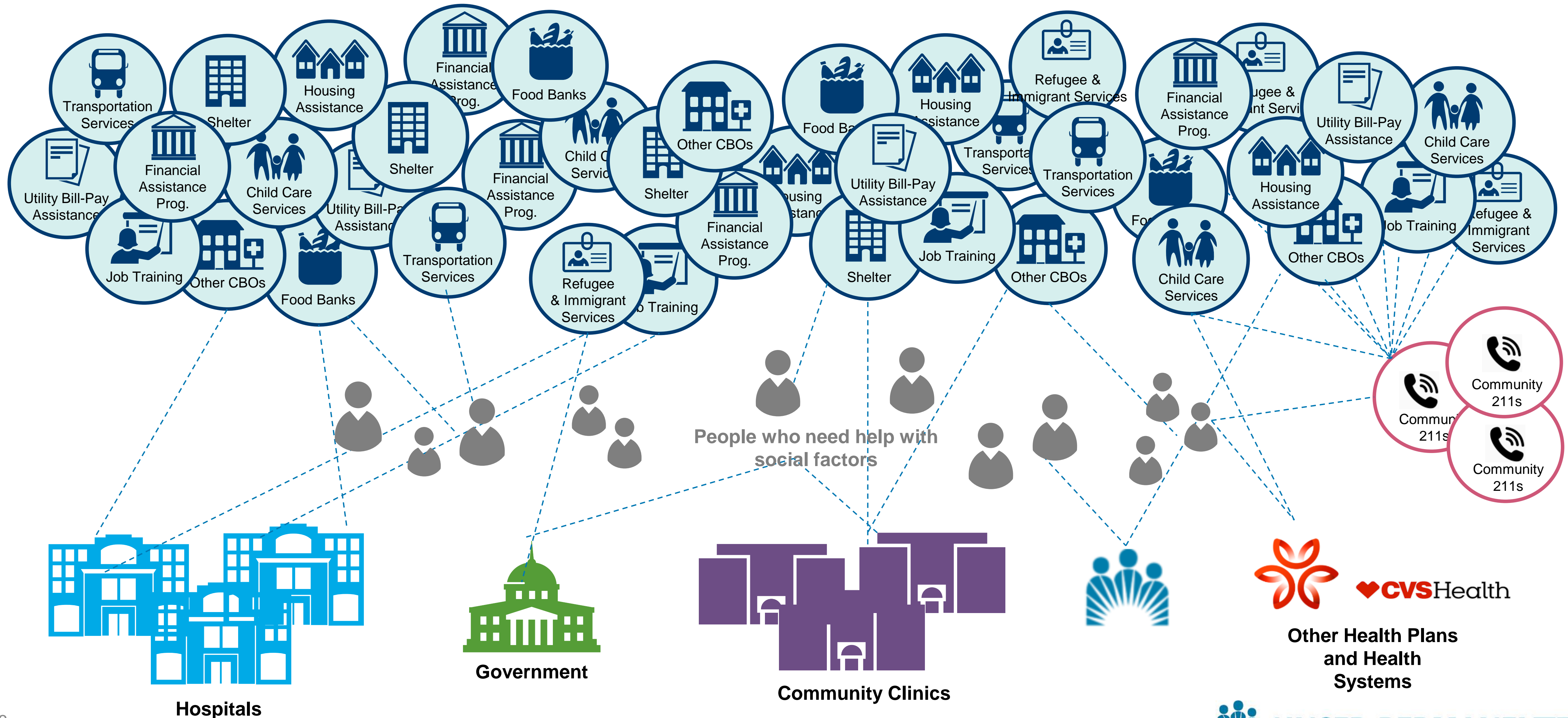
Updated as of 08.13.2020

Fragmented Approach to Social Health

Health care providers, health plans and community organizations are not connected to one another, creating lack of visibility, limited coordination, patchwork solutions for people, missed opportunities, and inconsistent outcomes.



Confidential | For Internal Use Only

Thrive Local
Connecting People to Community Resources

Thrive Local is Kaiser Permanente's **tool for connecting members to community-based programs and services**.

The platform (powered by Unite Us) includes:

Resource Directory

Online directory of local community organizations and social service providers. Includes eligibility criteria, hours of operation, location, and other key information. Search and filter functions help narrow choices to appropriate resources.

Community Network

Many organizations in Thrive Local participate with KP in the **community network,** where we can coordinate care by making electronic social referrals with each other and track the outcomes.

KP end-users either **refer members electronically** to organizations in the community network or **share information** about organizations with members by print, email, or text.

THRIVE LOCAL

COMMUNITY NETWORK
Community organizations participate in network and use Unite Us platform to make and track electronic social referrals with KP and each other

RESOURCE DIRECTORY
Online platform allows users to search for local community resources to share with members

UNITE US

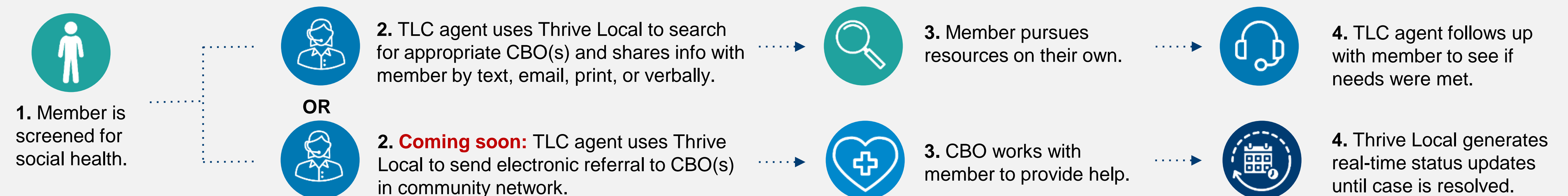
Thrive Local Member Touch Points

Care Delivery

Member interacts with KP care team (in-person or virtually).

Call Center

Member calls Thrive Local Connections (TLC) call center or is transferred from another KP call center/ program.



KP.org (Coming Soon)

Members use Thrive Local resource directory on kp.org to look up info on local social services and pursues resources themselves.

Key Benefits

For Patients

- Reliable referrals to helpful organizations
- Help navigating complex systems
- Improved care experience
- Improved health and well-being

For Communities

- Free to most community health centers and community organizations
- Community-wide analysis to inform policy, investment decisions, and community advocacy
- Improved coordination, collaboration, and efficiency for community organizations

For Health Care Systems

- Improved satisfaction among front-line providers
- Improved performance on health outcomes
- Reduced utilization and total cost of care

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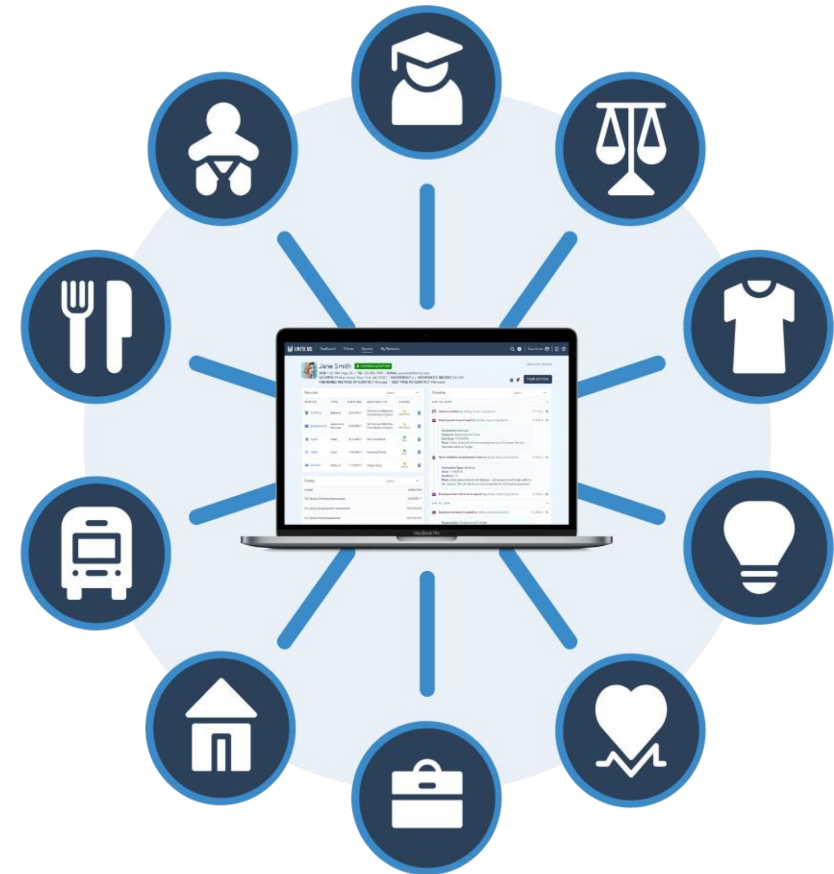
Partnerships

- We are partnering with Unite Us to launch Thrive Local. Unite Us provides the technology that connects health care and social service providers with each other, and it's also helping create community networks in every Kaiser Permanente service area across the country.
- Hundreds of organizations are joining the Thrive Local partnership by becoming part of a community network. And we are collaborating with other health systems, public agencies, and organizations to ensure the community networks remain robust and permanent public resources in our communities.



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Kaiser Permanente's Promise as a Sponsor

Total health requires more than great medical care.

That's why we are partnering with Unite Us to build and expand networks of health and social service providers working together to address social factors that impact people's health and well-being: having healthy meals, a safe place to live, meaningful social connections, and myriad other daily essentials.

Engaging with our communities for more than 75 years has taught us that every community is unique and the most impactful community health solutions are almost always local.

We're committed to working with you and all our community partners to create a social health asset that works for each community and serves everyone – especially our most vulnerable and underrepresented neighbors.

Together, we can build stronger, more equitable communities.

Success Stories & Animated Video

Social Health Stories from the Field

Helping a COVID-19 Patient Avoid Crisis

Phillip* -- Portland, Oregon

Phillip and his family were unable to pay rent and utilities for several months *because COVID-19 kept his daughter – the primary income earner for the family of 8 – out of work. Financial strain was the most prevalent social factor impacting KP members, according to the KP 2020 National Social Needs Member Survey. Some 43% of Asian Pacific Islander members surveyed experienced financial strain.*

With a little creative thinking and Thrive Local, his KP community health navigator was able to help.
As Micronesians, Phillip and his daughter were ineligible for KP's Medicaid-dependent resources. But when his KP community health navigator, Rykken Grancher, learned his grandkids had Medicaid through another plan, she facilitated a connection with a case manager there who helped the family pay rent. Rykken also used Thrive Local to refer Phillip to the Society of St. Vincent de Paul, which, within a matter of days, got the family's overdue water bill paid.

> "Phillip was practically in tears he was so grateful."
>
> —**Rykken Grancher**, KP Northwest Community Health Navigator

Social Health Stories from the Field

Thrive Local Champion Testimony

"Thrive Local provides members a connection to community resources with one click. I became a navigator to assist people as a whole and to help them get the resources and information they need to make their lives better. This is my ***why****."*

Maki Akiyama, Northwest
Community Health Navigator

Social Health Stories from the Field

A hot meal when it’s needed most

A COVID-19 patient was without power for 2 days because of a local storm and was very low on food – Food insecurity is among the most prevalent social factors impacting KP members, according to the KP 2020 National Social Needs Member Survey.

North Valley Senior Patient Assistance Representative **Sharan Cheema used Thrive Local** to refer the patient to Self Awareness and Recovery in Sacramento, which provided her a freshly cooked meal from a nearby restaurant.

> “The member was so appreciative for the help when I called to follow up.”
>
> —**Sharan Cheema**, Senior Patient Assistance Representative, KP North Valley

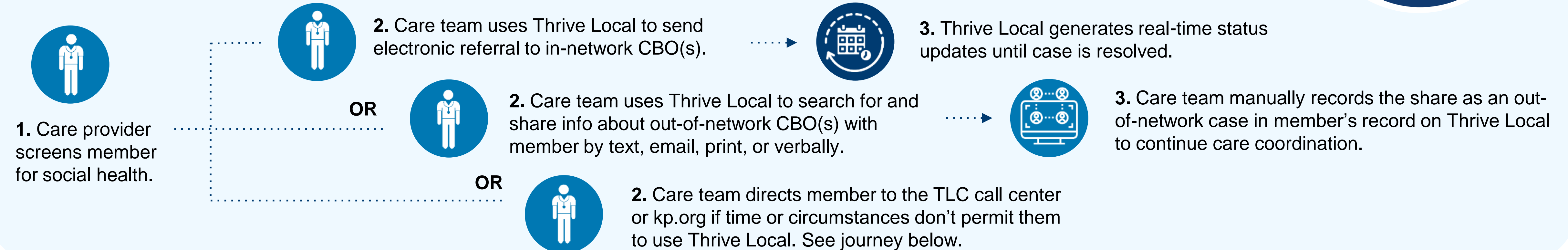
Social Health

Thrive Local Supports Social Health

Thrive Local End-User Touch Points

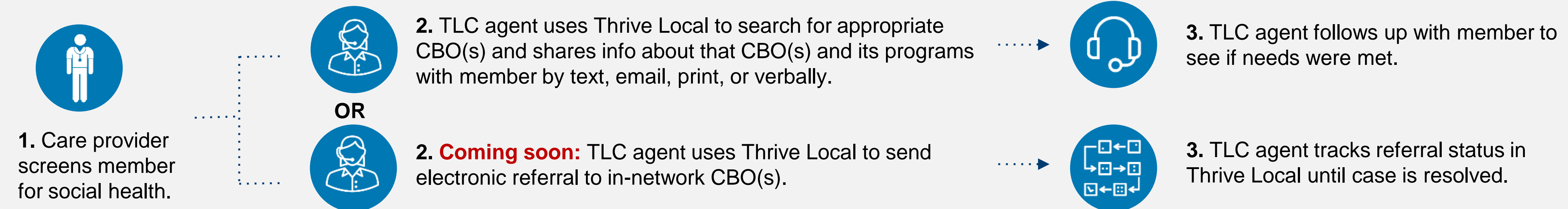
Care Delivery

Member interacts with KP care team (in-person or virtually).



Call Center

Member calls Thrive Local Connections (TLC) call center or is transferred from another KP call center/ program.



KP.org (Coming Soon)

Members use Thrive Local resource directory on kp.org to look up info on local social services and pursues resources themselves.

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