Healthify

The Northeast Kansas Community Network

Pathways Learning Session:
Coordinated Resource Referral Network

Friday, April 30, 2021

Healthify

Agenda

Introductions

The SDoH Challenge

Introduction to the [Market] Community Network

Use Cases / Demo

Partnership Requirements & Next Steps

Discussion

JANEL **SIA**

DIRECTOR, NETWORK DEVELOPMENT

Responsible for building and maintaining the metro Detroit Community Network

OLIVIA **TALMAN**

PARTNERSHIP LEAD

Primary executive point of contact. Leads teams supporting partnership. Responsible for partnership alignment, impact, and value.

Who we are

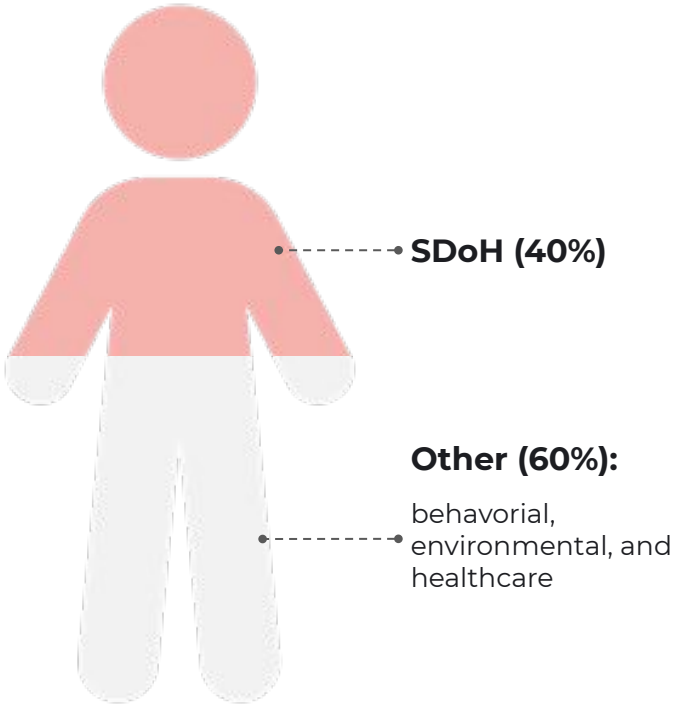
Healthify improves the health of populations by building the ***infrastructure*** that integrates the social determinants of health into the era of value based healthcare.

The SDoH Challenge

Addressing social needs at scale

We widely recognize that health is influenced by social factors

In aggregate, social determinants of health (SDoH) are known to contribute to **40%** of an individual's health outcomes[1]



[1]American Hospital Association Report, *Addressing Social Determinants of Health*

But health ecosystem does not adequately address SDoH, creating significant burden on CBOs and individuals

OECD Spend <> Rankings out of 37

1 In healthcare spending (**17%** of our total GDP)

36 In social spending for families (**0.6%** of our total GDP)

Shawnee County Statistics

19% of people under the age of 5 who are living below the federal poverty level (*in the 2nd worst quartile based on data from 105 counties*)

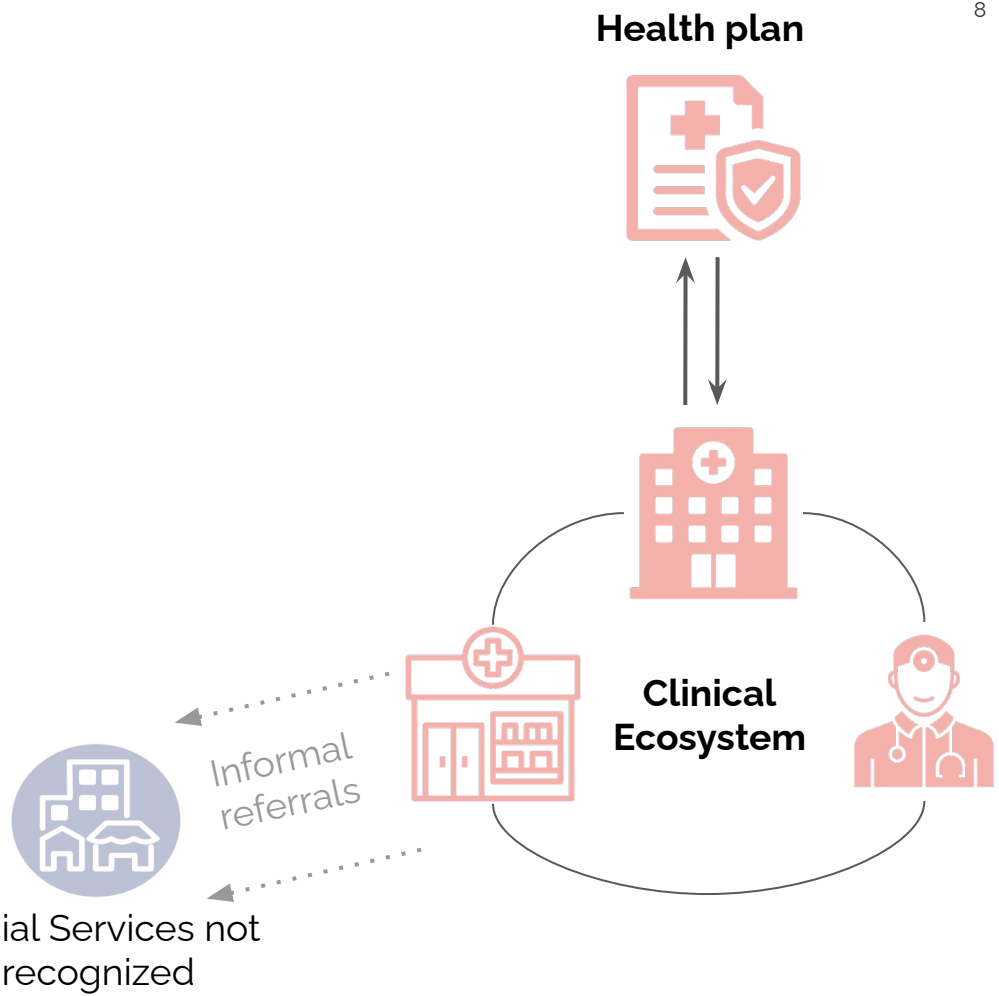
Source: American Community Survey
Measurement Period: 2015-2019

13% of households with at least one of the following four housing problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities.

Source: County Health Rankings
Measurement Period: 2012-2016

This challenge is exacerbated by the lack of integration of SDoH in the healthcare ecosystem

CBOs are not recognized or reimbursed for many of the non-clinical services that contribute to better health outcomes



Introduction to the Northeast Kansas Community Network

Purpose-built to support social services integration

The Northeast Kansas Community Network

We are a network of healthcare and social service organizations committed to transforming the current system of care and dramatically improving health outcomes in Kansas.

The network is built through engagement of multiple critical stakeholders, including:

- Community organizations - direct service providers
- Conveners (e.g., United Way)
- Clinical providers/ health systems
- Health Plan
- Public Agencies

The Northeast Kansas Community Network enables integration by supporting in three critical areas:

1. Access to Data & Coordination
2. Increased Exposure to Community and Healthcare Stakeholders
3. Building Healthcare Relationships

1 Access to Data & Coordination

Access to reporting and data

- Referrals and service utilization
- Patient health outcomes*

Increased referral outcomes transparency

- CBOs can improve clinical impact of their services
- Health plans can use data to inform investments

Process Metrics:

- Referrals by sender, status, service type

Relevant Outcomes metrics:

- Cost of care reduction, target clinical metrics*

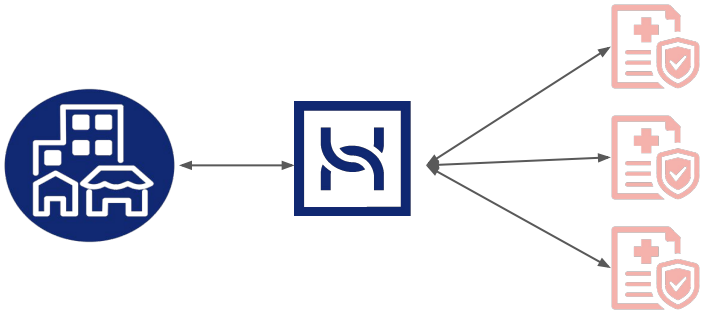
* Contingent on availability of health plan data

2 Increased Exposure to Community & Healthcare Stakeholders

Increased visibility among community & healthcare stakeholders

- Visible to all network stakeholders
- Join multi-stakeholder convening meetings with health plan representatives

Leverage a single letter agreement to formalize partnerships with multiple stakeholders

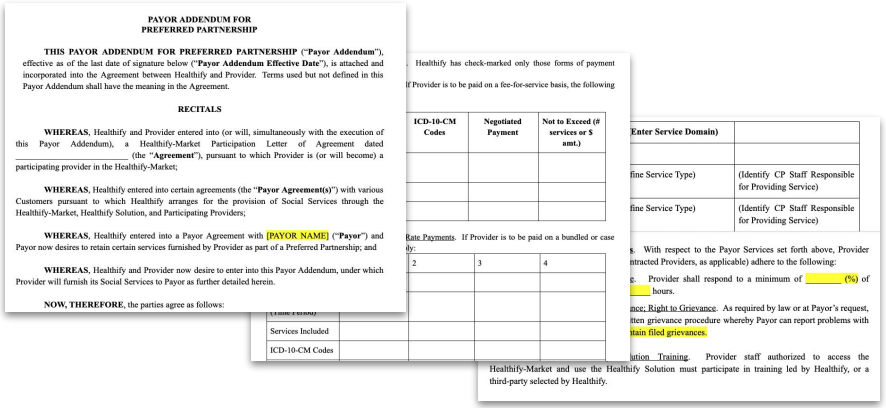


3 Building Healthcare Relationships

Establish partnerships with health plans and/or providers

- Leverage our contract
- Templatized agreement
- Dedicated negotiation support from Healthify
- Expedite the contracting process

Template Documents and Processes



PAYOR ADDENDUM FOR PREFERRED PARTNERSHIP

THIS PAYOR ADDENDUM FOR PREFERRED PARTNERSHIP ("**Payor Addendum**"), effective as of the last date of signature below ("**Payor Addendum Effective Date**"), is attached and incorporated into the Agreement between Healthify and Provider. Terms used but not defined in this Payor Addendum shall have the meaning in the Agreement.

RECITALS

WHEREAS, Healthify and Provider entered into (or will, simultaneously with the execution of this Payor Addendum), a Healthify-Market Participation Letter of Agreement dated _____ (the "**Agreement**"), pursuant to which Provider is (or will become) a participating provider in the Healthify-Market;

WHEREAS, Healthify entered into certain agreements (the "**Payor Agreement(s)**") with various Customers pursuant to which Healthify arranges for the provision of Social Services through the Healthify-Market, Healthify Solution, and Participating Providers;

WHEREAS, Healthify entered into a Payor Agreement with [PAYOR NAME] ("**Payor**") and Payor now desires to retain certain services furnished by Provider as part of a Preferred Partnership; and

WHEREAS, Healthify and Provider now desire to enter into this Payor Addendum, under which Provider will furnish its Social Services to Payor as further detailed herein.

NOW, THEREFORE, the parties agree as follows:

Healthify has check-marked only those forms of payment

If Provider is to be paid on a fee-for-service basis, the following

ICD-10-CM Codes	Negotiated Payment	Not to Exceed (# services or $ amt.)

Rate Payments. If Provider is to be paid on a bundled or case

	2	3	4
Services Included			
ICD-10-CM Codes			

Enter Service Domain)	
fine Service Type)	(Identify CP Staff Responsible for Providing Service)
fine Service Type)	(Identify CP Staff Responsible for Providing Service)

s. With respect to the Payor Services set forth above, Provider ntracted Providers, as applicable) adhere to the following:

e. Provider shall respond to a minimum of _____ (%) of ___ hours.

nce; Right to Grievance. As required by law or at Payor's request, tten grievance procedure whereby Payor can report problems with tain filed grievances.

ution Training. Provider staff authorized to access the Healthify-Market and use the Healthify Solution must participate in training led by Healthify, or a third-party selected by Healthify.

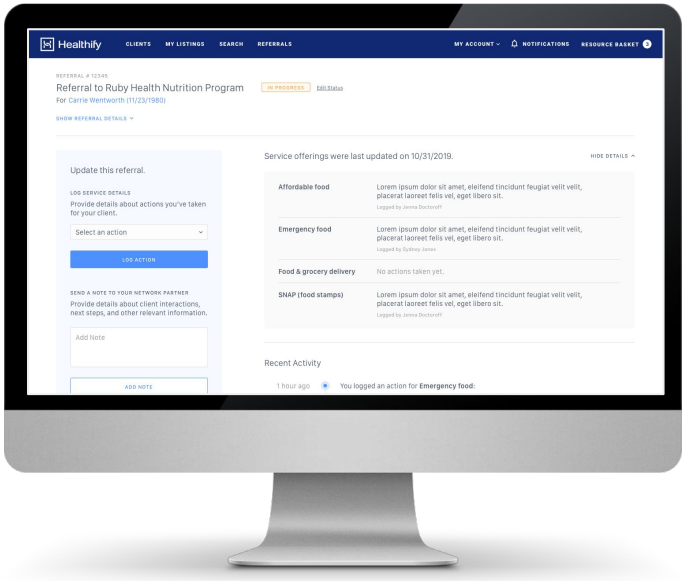
Hear from our Partners

Reading Community Network

Reading, PA

This network sits on top of Healthify's user-friendly, lightweight referral management platform

1. Enables central source of truth for network referral activity
2. User control of your resource page
3. Fosters collaboration across CBOs, clinical providers, and payors
4. Opportunity for internal referral coordination
5. Potential for system/ platform integration[1]



[1]Dependent on type of platform and desired integration

Network Use Cases

Collective Impact

SUMMARY

In Spring of 2020, as COVID-19 took hold around the country, Healthify's community partners in Topeka, KS identified housing and utilities support as an urgent and critical need in their region.

Equipped with an $82k grant, we partnered closely with United Way of Greater Topeka to identify five community partners serving clients with housing and utilities needs.

Given the pressures of COVID-19 on the already dwindling administrative capacity at each organization, this program was structured with this limitation top of mind in order to reduce pressure on each partner's human resources.

One of the funded community partners self identified as having sufficient capacity to process all the required paperwork for the funds as they were distributed to community members in need.

As a result, all other funded partners leveraged Healthify's network to send referrals to the identified partner processing the funds, reducing the need for a dedicated staff member at their organization.

OBJECTIVE

The objectives of this project were two-fold:

1. Support community members who were in need of financial support in order to maintain housing and/or pay for utilities and
2. To execute this support in an efficient and in the least administratively burdensome manner for resource and time strapped community-based organizations.

IMPACT

- Project structure allowed several partners to participate without extreme disruptions to their workflow
- 79 families were able to receive housing and utilities support with an average amount of $886

Collective Impact Workflow

Community member(s) visits one of four funded social service organizations with needs surrounding housing, rental and utilities assistance.

catholic charities OF NORTHEAST KANSAS

DOORSTEP Neighbors Helping Neighbors

Let's Help Building a Better Community

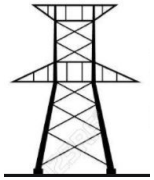
Work for Success Developing Dads Building Relationships

Community partner assesses eligibility and sends referral to Community Action to access pool of housing, rental and utilities assistance funds

Helping People. Changing Lives. community Action PARTNERSHIP COMMUNITY ACTION, INC.

Collective Impact Workflow

Helping People. Changing Lives.
community Action
PARTNERSHIP
COMMUNITY ACTION, INC.



Community Action processes checks to families and remits payments to energy company and landlords. .

Clinical and Social Service Coordination

SUMMARY

In November 2020, Healthify and Stormont Vail Health completed their EPIC integration work. This integration enabled case managers and social workers from SVH's Inpatient and Ambulatory Care teams to assess patient needs and send referrals to an accountable set of social service organizations.

OBJECTIVE

The objectives of this project were three-fold:

1. Connect SVH patients with identified social needs to community based organizations with capacity to serve

2. Improve coordination and collaboration between a clinical provider, SVH, and 10+ community based organizations

3. Gather baseline quantifiable data on where there are gaps in resources within our community

IMPACT

- 130 referrals have been sent from SVH's Inpatient and Ambulatory Care teams since end of November 2020
- 37 (28.5%) referrals from SVH have been completed, indicating 37 instances of programs/services provided to community members in need
- Needed services have ranged from prescription assistance, utility assistance, infant or child supplies, medical bill assistance, emergency food, job counseling, job search assistance, rental assistance, activities of daily living (ADLs), case management, Emergency financial assistance, meal programs, food pantries, more
- 44 referrals were sent originating from one social service organization to another social service organization
- 29 (66%) of CBO originated referrals have been completed, indicated 29 more instances of services provided to community members in need of assistance

Clinical and Social Service Coordination Workflow

SVH case manager or social workers identifies social need(s) and uses Healthify to find accountable social service organizations to send needed referrals to

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DOORSTEP Neighbors Helping Neighbors

East Topeka Senior Center

JAYHAWK AREA AGENCY ON AGING, INC.

SCMS HealthAccess

Let's Help Building a Better Community

MIDLAND CARE Meals on Wheels

Work for Success Developing Dads Building Relationships

Topeka Habitat for Humanity®

TRM MINISTRIES TOPEKA RESCUE MISSION MINISTRIES

Topeka Youth Project

Clinical and Social Service Coordination Workflow

Helping People. Changing Lives. community Action PARTNERSHIP COMMUNITY ACTION, INC.

JAYHAWK AREA AGENCY ON AGING, INC.

Social service organization anticipates patient to enroll in services or outreaches patient directly. Services are rendered.

Stormont Vail Health

Referral status and updates provided to SVH.

Client Journey

Example Care Coordination Workflow

Meet Jose

He is a diabetic senior living in Shawnee County. Blue Cross of Kansas has enrolled him in their diabetes management program to help keep his medical costs in control. In a recent discussion, Jose mentions that he is struggling to buy and eat the healthy food options he needs.

Example Care Coordination Workflow

Jose meets with Health Plan Care Mgr

Care Manager conducts regular monthly assessment

Conducts a social needs screening and identifies a need for food assistance.

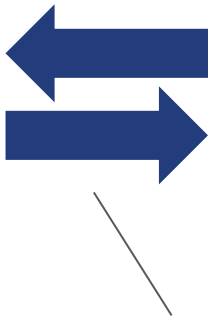
Example Care Coordination Workflow

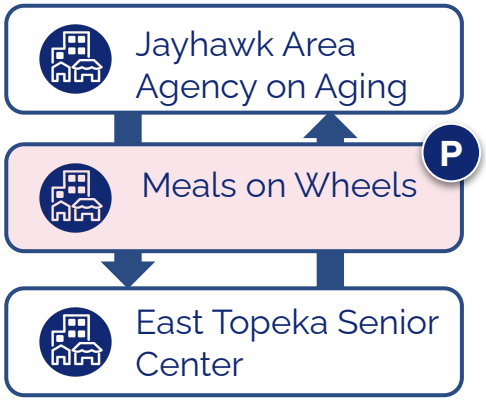
Care Manager accesses Network

- Jayhawk Area Agency on Aging
- Meals on Wheels (P)
- East Topeka Senior Center

Example Care Coordination Workflow

And refers to [Name of Org]





[Resource 2] acknowledges the referral:

- coordinates directly with Care Mgr
- Updates and resolves referral
- Makes secondary referrals if applicable

Example Care Coordination Workflow

Data is shared with health plan

- Referral data aligned to member
- Downstream clinical/ cost impact assessed
- Data can be shared with network partners

Jayhawk Area Agency on Aging

Meals on Wheels

P

East Topeka Senior Center

Partnership Requirements and Next Steps

Here's what to expect next.

	Exploration	Partnership	Onboarding	Engagement
Key Activities	• Introductory Discussions as requested • Walk through services • Referral workflow • Address outstanding questions	• Signed Letter of Agreement (LOA) • Optional Business Associate Agreement (BAA)*	• Confirm/ Complete Resource Page • User Identification • End User Training	• Quarterly Convening Sessions • Ongoing Reporting • Service Expansion
Timeline	**As needed**	**As needed** **(e-signature for LOA)**	**~ 2 weeks**	**Ongoing**

* for those intending to have direct services contracts with health plans

Network Participation Requirements

Each CBO network partner is required to do the following activities...

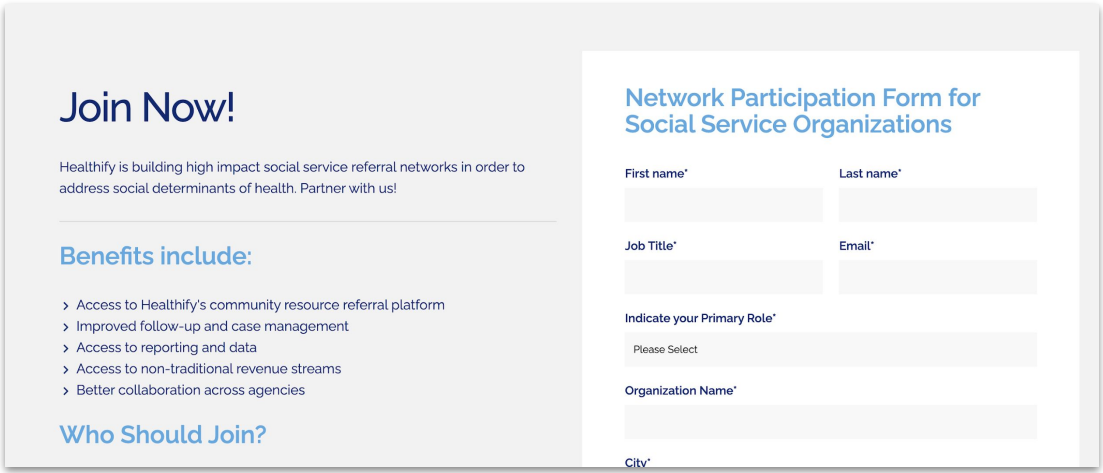
- ❑ Acknowledge every referral you receive from the network in a timely manner
- ❑ Resolve every referral you receive from the network - even if it means you need to cancel the referral

... but is encouraged to do the following as well, as capacity allows

- ❑ Provide services in response to referrals received
- ❑ Send referrals to other community resources within the network as client needs are identified
- ❑ Attend network governance and other convenings
- ❑ Participate in opportunities for best practice sharing and networking
- ❑ Maintain ongoing communication with Healthify

Want to Get Involved?

CBOs and Conveners can complete the Network Interest form HERE



Join Now!

Healthify is building high impact social service referral networks in order to address social determinants of health. Partner with us!

Benefits include:

- Access to Healthify's community resource referral platform
- Improved follow-up and case management
- Access to reporting and data
- Access to non-traditional revenue streams
- Better collaboration across agencies

Who Should Join?

Network Participation Form for Social Service Organizations

First name* Last name*

Job Title* Email*

Indicate your Primary Role*

Please Select

Organization Name*

City*

Or contact us at:
networks@healthify.us

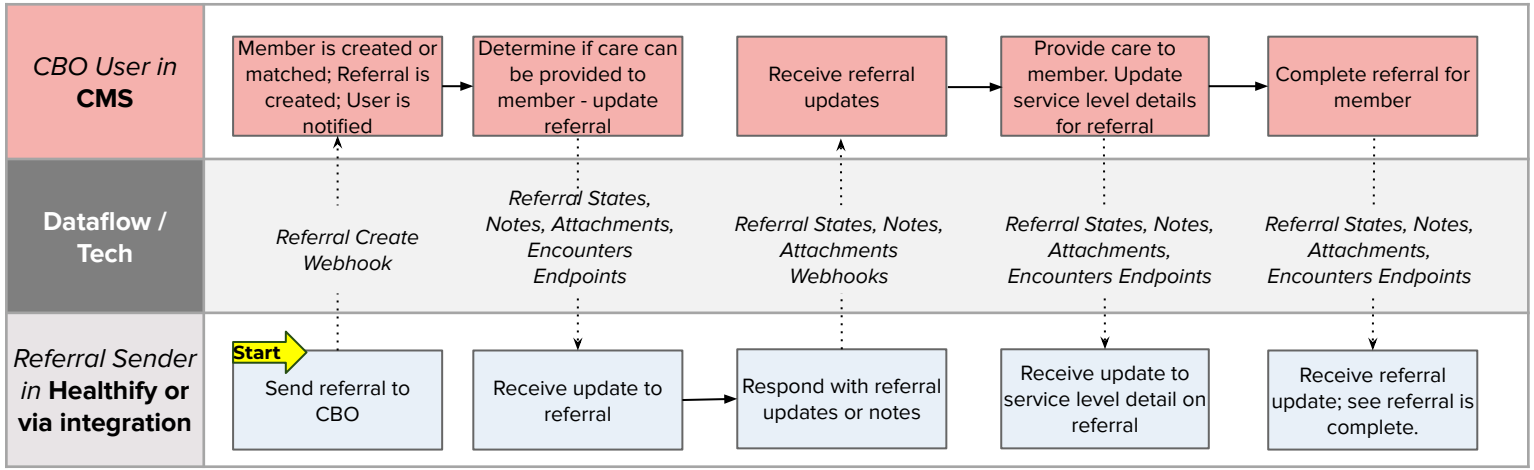
Discussion


Healthify
Our mission is to build a world where
no one's health is hindered by their need.

Healthify Integration

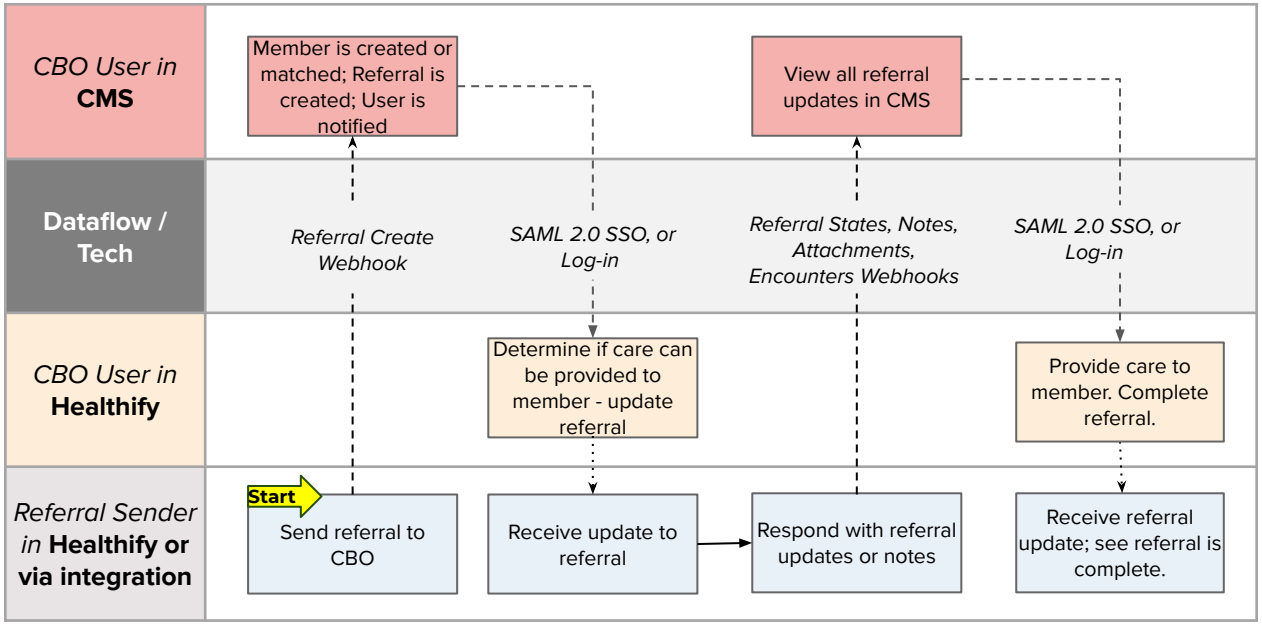
Workflow Examples

Integration - Receiving Referrals Example Workflow



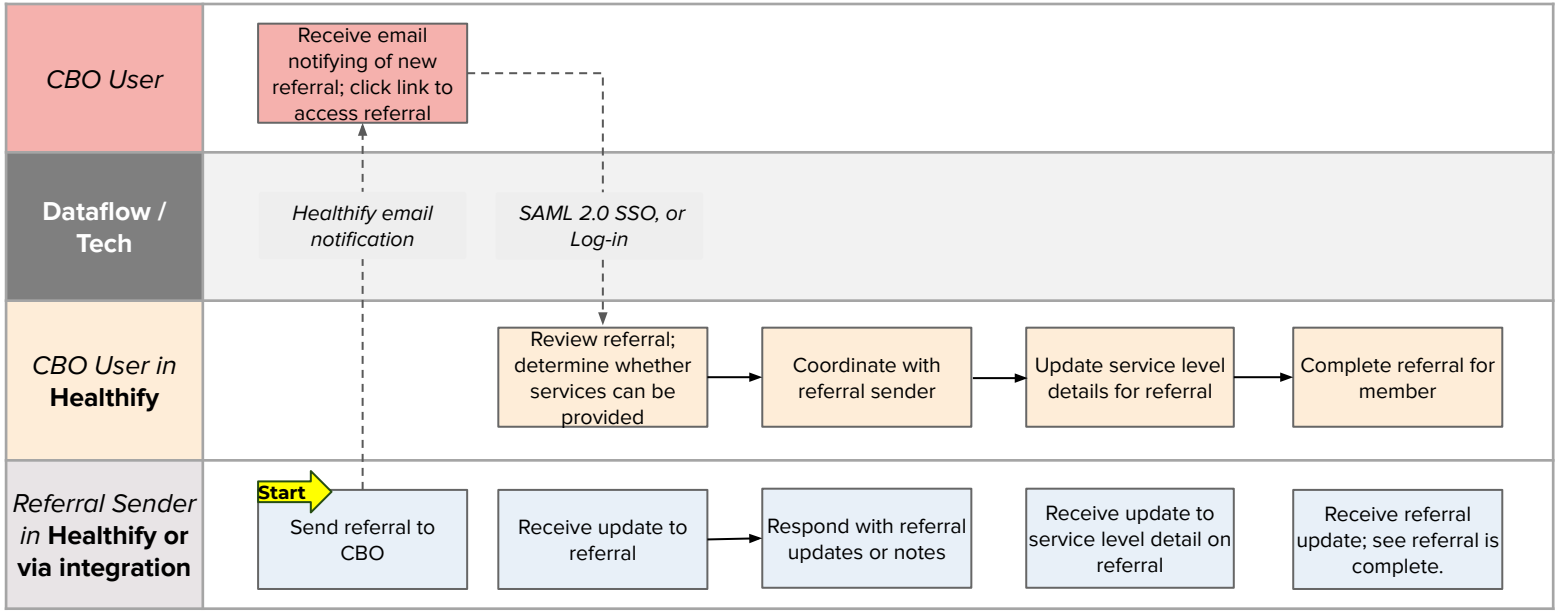
Detailed referral data, status updates, notes, attachments, and encounter details passed between CMS and Healthify

Integration - Receiving Referrals Example Workflow



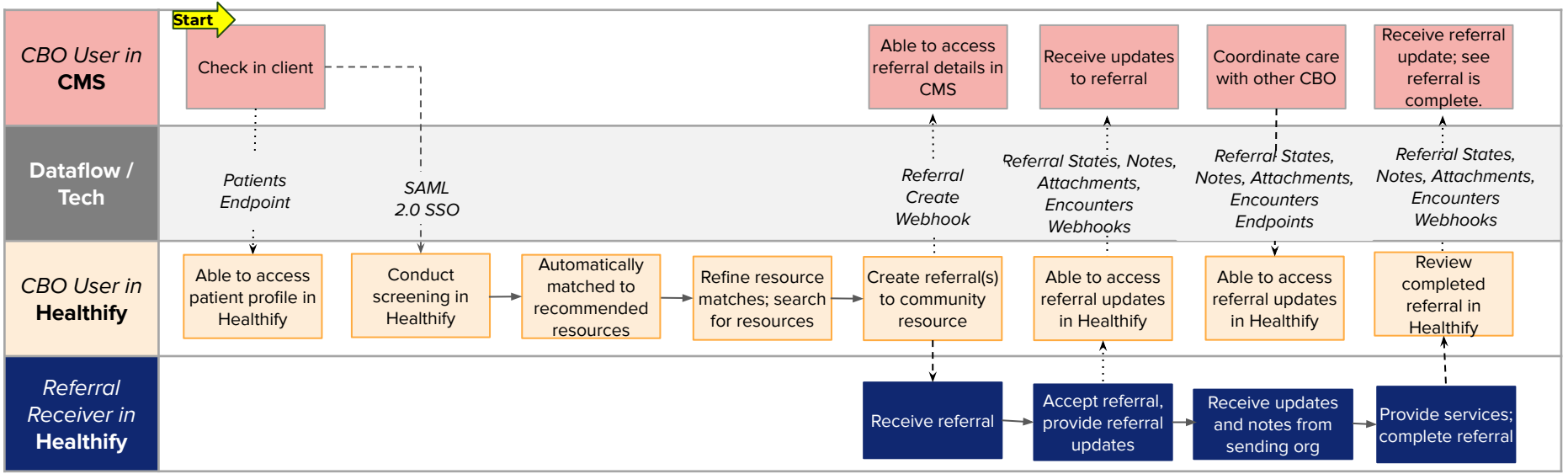
Detailed referral data, status updates, notes, attachments, and encounter details passed from Healthify to CMS; user updates referral in Healthify

Manual Access - Receiving Referrals Example Workflow



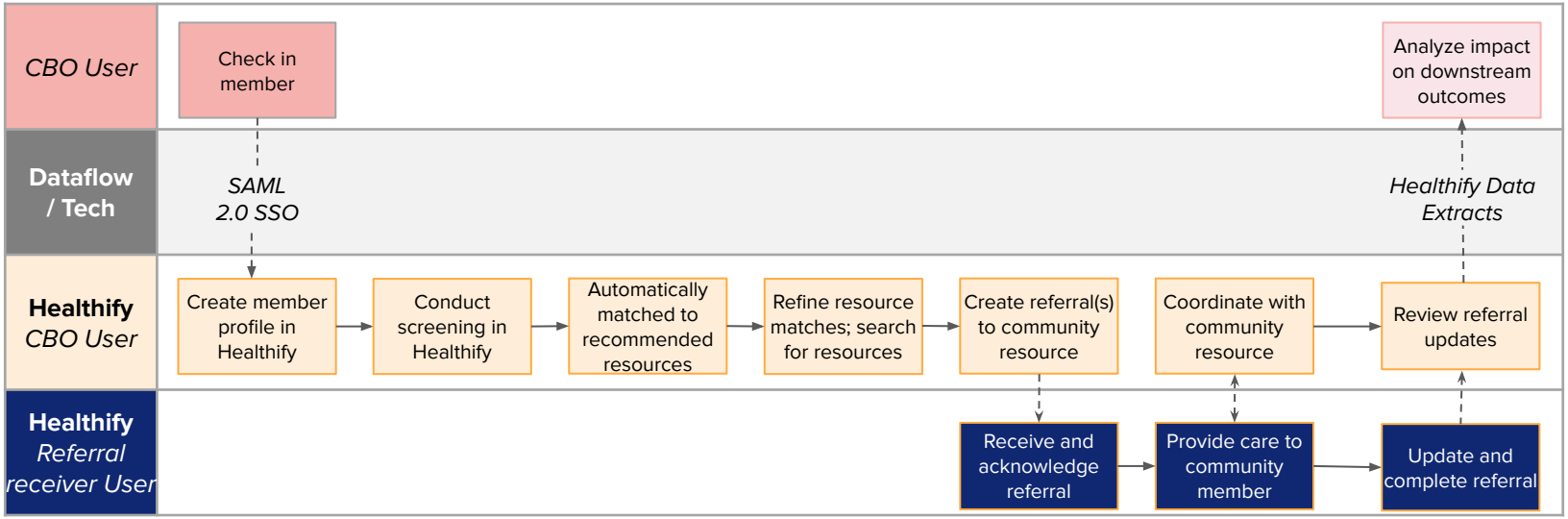
Detailed referral data, status updates, notes, attachments, and encounter details passed between CMS and Healthify

Integration - Sending Referrals Example Workflow



Healthify

Manual Access - Sending Referral Example Workflow



Manual member creation, Screening in Healthify, Optional Single Sign-On