Better Health Together Landscape Scan, Roadmap, and Recommendations

For community-based care coordination in Eastern Washington

August 2022

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Better Together Report Appendices

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Appendix A. IRB Application and approval forms

Better Health Together Care Coordination Landscape Analysis

Admin	
Study ID	2038
Panel	No Panel Assigned
PI	Vanessa Quince
PI Type	General User
Department	
PI Institution	Mathematica
Research Coordinators	Alyssa Crawford 05/09/2022
Other Staff	Lisa Packard, MS, Executive Director, Comagine Health
Review Type	Expedited Review
Approval Status	Expedited Approved (6) Collection of data from voice, video, digital, or image recordings made for research purposes. (7) Research on individual or group characteristics or behavior
Submitted By	Alyssa Crawford
Date Received	05/12/2022
Date of Completion	05/17/2022
Date Approved	05/17/2022
Final Approval Date	05/17/2022
Approval Expires	05/16/2023
Proposed Start Date	05/17/2022
Proposed End Date	08/31/2022
Date Closed	
Risk Category	Minimal Risk Only
Study Country	USA
Data Collection Types	Survey questionnaire Subject interview Focus group discussion (FGD) Document review
US Federally Funded?	No
Funding Source	Better Health Together
Billing Name/Email	Amelia Forman, AForman@mathematica-mpr.com
Billing Number/Code	Project task#: 51401.BY.T02.200.000; Org: 1.MPR.HLT.24
Vulnerable Subjects	• Children • Disadvantaged • Have Health Risks
Other Subjects Type	Health care and social service care coordinators, providers, and program administrators
Total Number of Subjects	175

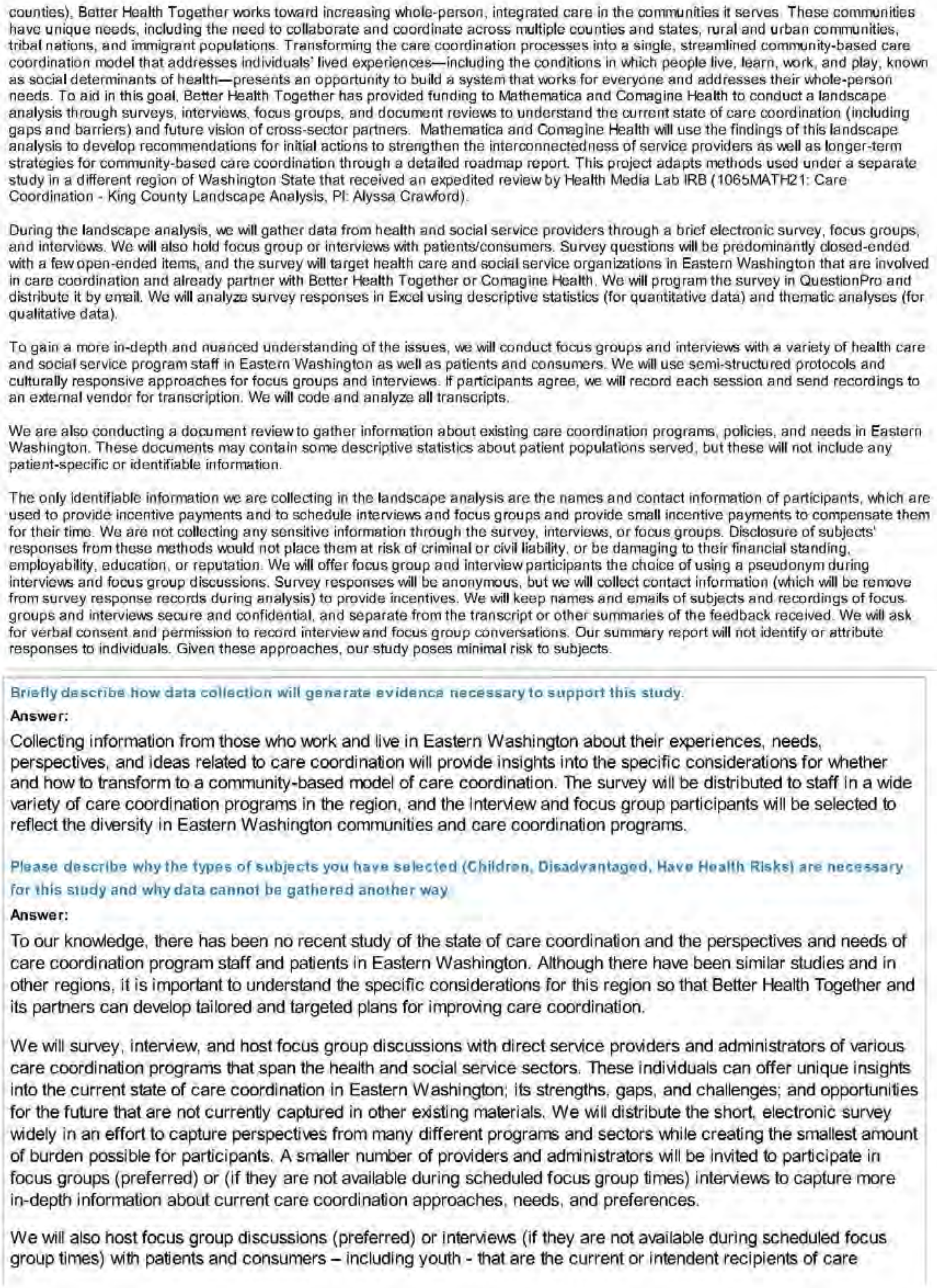
Consent Form	05/12/2022 Informed consent language for all data collection ...
Assent Form	05/12/2022 BHT Care Coordination Landscape Analysis Informed ... 05/16/2022 Revised IC language_all data sources.docx
Interview Data Collection Tool	05/12/2022 BHT Interview and Focus Group Protocol.docx 05/16/2022 Revised protocols_tailored for patients and youth....
Survey Data Collection Tool	05/12/2022 BHT Survey Protocol.docx 05/16/2022 Revised Survey Protocol_Updated IC language.docx
Focus Group Data Collection Tool	05/12/2022 BHT Interview and Focus Group Slides.pptx 05/16/2022 Revised protocols_tailored for patients and youth....
Notifications	05/16/2022 Revisions Required: IRB #2038.pdf 05/17/2022 Expedited Review Approved: IRB #2038.pdf
Approved Application Sections	05/17/2022 Approved Application Sections.pdf
Approved Consent Form	05/17/2022 Revised IC language_all data sources.pdf

Research Design

Please provide a summary of your research design: Abstract plus 1000 to 1500 words.
(describe your study's background, rationale, & methodology)

Answer:

As the Accountable Community of Health (ACH) for Eastern Washington (Adams, Ferry, Lincoln, Pend Oreille, Spokane and Stevens



counties). Better Health Together works toward increasing whole-person, integrated care in the communities it serves. These communities have unique needs, including the need to collaborate and coordinate across multiple counties and states, rural and urban communities, tribal nations, and immigrant populations. Transforming the care coordination processes into a single, streamlined community-based care coordination model that addresses individuals' lived experiences—including the conditions in which people live, learn, work, and play, known as social determinants of health—presents an opportunity to build a system that works for everyone and addresses their whole-person needs. To aid in this goal, Better Health Together has provided funding to Mathematica and Comagine Health to conduct a landscape analysis through surveys, interviews, focus groups, and document reviews to understand the current state of care coordination (including gaps and barriers) and future vision of cross-sector partners. Mathematica and Comagine Health will use the findings of this landscape analysis to develop recommendations for initial actions to strengthen the interconnectedness of service providers as well as longer-term strategies for community-based care coordination through a detailed roadmap report. This project adapts methods used under a separate study in a different region of Washington State that received an expedited review by Health Media Lab IRB (1065MATH21: Care Coordination - King County Landscape Analysis, PI: Alyssa Crawford).

During the landscape analysis, we will gather data from health and social service providers through a brief electronic survey, focus groups, and interviews. We will also hold focus group or interviews with patients/consumers. Survey questions will be predominantly closed-ended with a few open-ended items, and the survey will target health care and social service organizations in Eastern Washington that are involved in care coordination and already partner with Better Health Together or Comagine Health. We will program the survey in QuestionPro and distribute it by email. We will analyze survey responses in Excel using descriptive statistics (for quantitative data) and thematic analyses (for qualitative data).

To gain a more in-depth and nuanced understanding of the issues, we will conduct focus groups and interviews with a variety of health care and social service program staff in Eastern Washington as well as patients and consumers. We will use semi-structured protocols and culturally responsive approaches for focus groups and interviews. If participants agree, we will record each session and send recordings to an external vendor for transcription. We will code and analyze all transcripts.

We are also conducting a document review to gather information about existing care coordination programs, policies, and needs in Eastern Washington. These documents may contain some descriptive statistics about patient populations served, but these will not include any patient-specific or identifiable information.

The only identifiable information we are collecting in the landscape analysis are the names and contact information of participants, which are used to provide incentive payments and to schedule interviews and focus groups and provide small incentive payments to compensate them for their time. We are not collecting any sensitive information through the survey, interviews, or focus groups. Disclosure of subjects' responses from these methods would not place them at risk of criminal or civil liability, or be damaging to their financial standing, employability, education, or reputation. We will offer focus group and interview participants the choice of using a pseudonym during interviews and focus group discussions. Survey responses will be anonymous, but we will collect contact information (which will be remove from survey response records during analysis) to provide incentives. We will keep names and emails of subjects and recordings of focus groups and interviews secure and confidential, and separate from the transcript or other summaries of the feedback received. We will ask for verbal consent and permission to record interview and focus group conversations. Our summary report will not identify or attribute responses to individuals. Given these approaches, our study poses minimal risk to subjects.

Briefly describe how data collection will generate evidence necessary to support this study.

Answer:

Collecting information from those who work and live in Eastern Washington about their experiences, needs, perspectives, and ideas related to care coordination will provide insights into the specific considerations for whether and how to transform to a community-based model of care coordination. The survey will be distributed to staff in a wide variety of care coordination programs in the region, and the interview and focus group participants will be selected to reflect the diversity in Eastern Washington communities and care coordination programs.

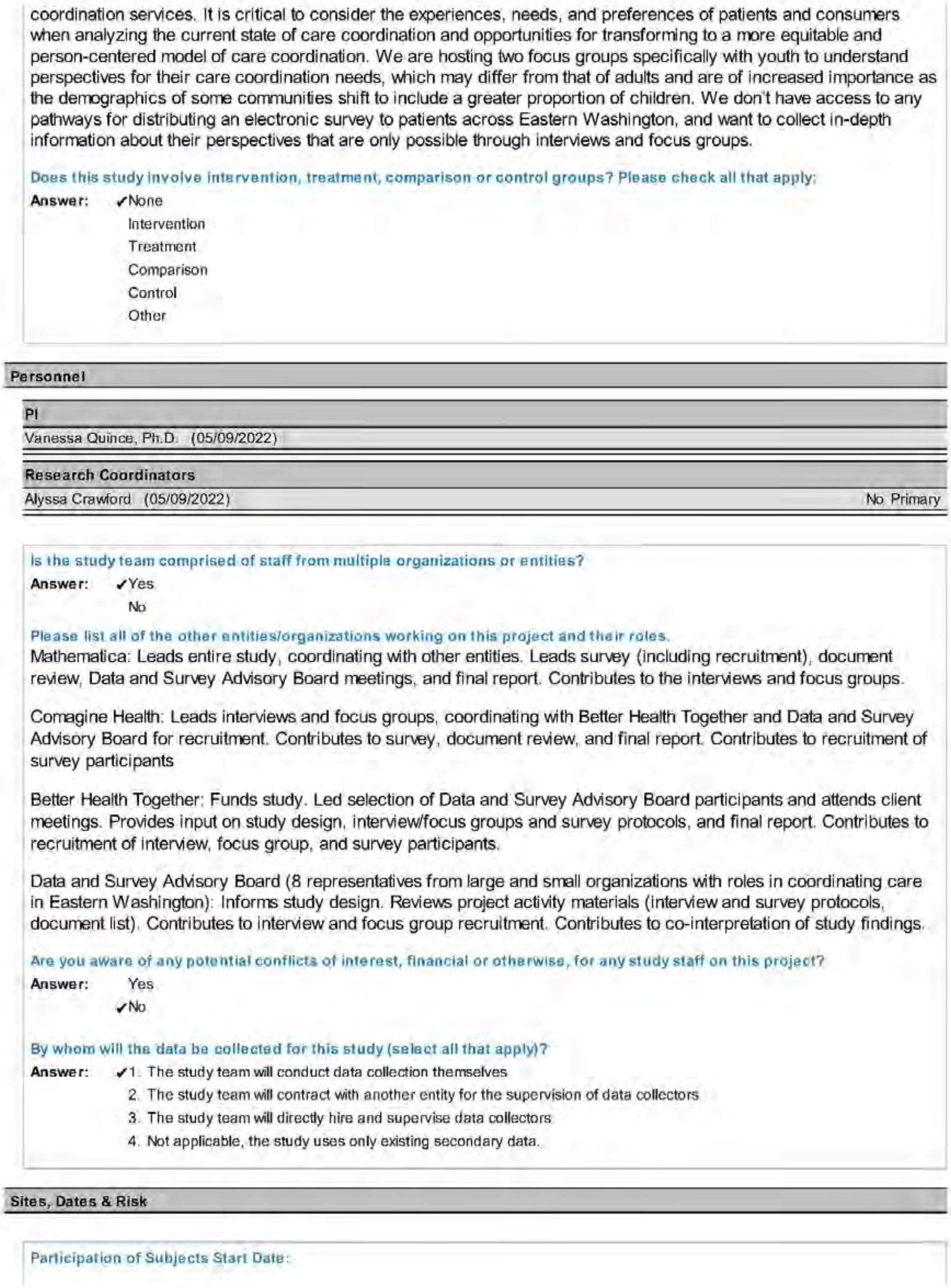
Please describe why the types of subjects you have selected (Children, Disadvantaged, Have Health Risks) are necessary for this study and why data cannot be gathered another way

Answer:

To our knowledge, there has been no recent study of the state of care coordination and the perspectives and needs of care coordination program staff and patients in Eastern Washington. Although there have been similar studies and in other regions, it is important to understand the specific considerations for this region so that Better Health Together and its partners can develop tailored and targeted plans for improving care coordination.

We will survey, interview, and host focus group discussions with direct service providers and administrators of various care coordination programs that span the health and social service sectors. These individuals can offer unique insights into the current state of care coordination in Eastern Washington; its strengths, gaps, and challenges; and opportunities for the future that are not currently captured in other existing materials. We will distribute the short, electronic survey widely in an effort to capture perspectives from many different programs and sectors while creating the smallest amount of burden possible for participants. A smaller number of providers and administrators will be invited to participate in focus groups (preferred) or (if they are not available during scheduled focus group times) interviews to capture more in-depth information about current care coordination approaches, needs, and preferences.

We will also host focus group discussions (preferred) or interviews (if they are not available during scheduled focus group times) with patients and consumers – including youth - that are the current or intendent recipients of care



coordination services. It is critical to consider the experiences, needs, and preferences of patients and consumers when analyzing the current state of care coordination and opportunities for transforming to a more equitable and person-centered model of care coordination. We are hosting two focus groups specifically with youth to understand perspectives for their care coordination needs, which may differ from that of adults and are of increased importance as the demographics of some communities shift to include a greater proportion of children. We don't have access to any pathways for distributing an electronic survey to patients across Eastern Washington, and want to collect in-depth information about their perspectives that are only possible through interviews and focus groups.

Does this study involve intervention, treatment, comparison or control groups? Please check all that apply:

Answer: ✓None
Intervention
Treatment
Comparison
Control
Other

Personnel

PI

Vanessa Quince, Ph.D. (05/09/2022)

Research Coordinators

Alyssa Crawford (05/09/2022)	No Primary

Is the study team comprised of staff from multiple organizations or entities?

Answer: ✓Yes
No

Please list all of the other entities/organizations working on this project and their roles.

Mathematica: Leads entire study, coordinating with other entities. Leads survey (including recruitment), document review, Data and Survey Advisory Board meetings, and final report. Contributes to the interviews and focus groups.

Comagine Health: Leads interviews and focus groups, coordinating with Better Health Together and Data and Survey Advisory Board for recruitment. Contributes to survey, document review, and final report. Contributes to recruitment of survey participants

Better Health Together: Funds study. Led selection of Data and Survey Advisory Board participants and attends client meetings. Provides input on study design, interview/focus groups and survey protocols, and final report. Contributes to recruitment of interview, focus group, and survey participants.

Data and Survey Advisory Board (8 representatives from large and small organizations with roles in coordinating care in Eastern Washington): Informs study design. Reviews project activity materials (interview and survey protocols, document list). Contributes to interview and focus group recruitment. Contributes to co-interpretation of study findings.

Are you aware of any potential conflicts of interest, financial or otherwise, for any study staff on this project?

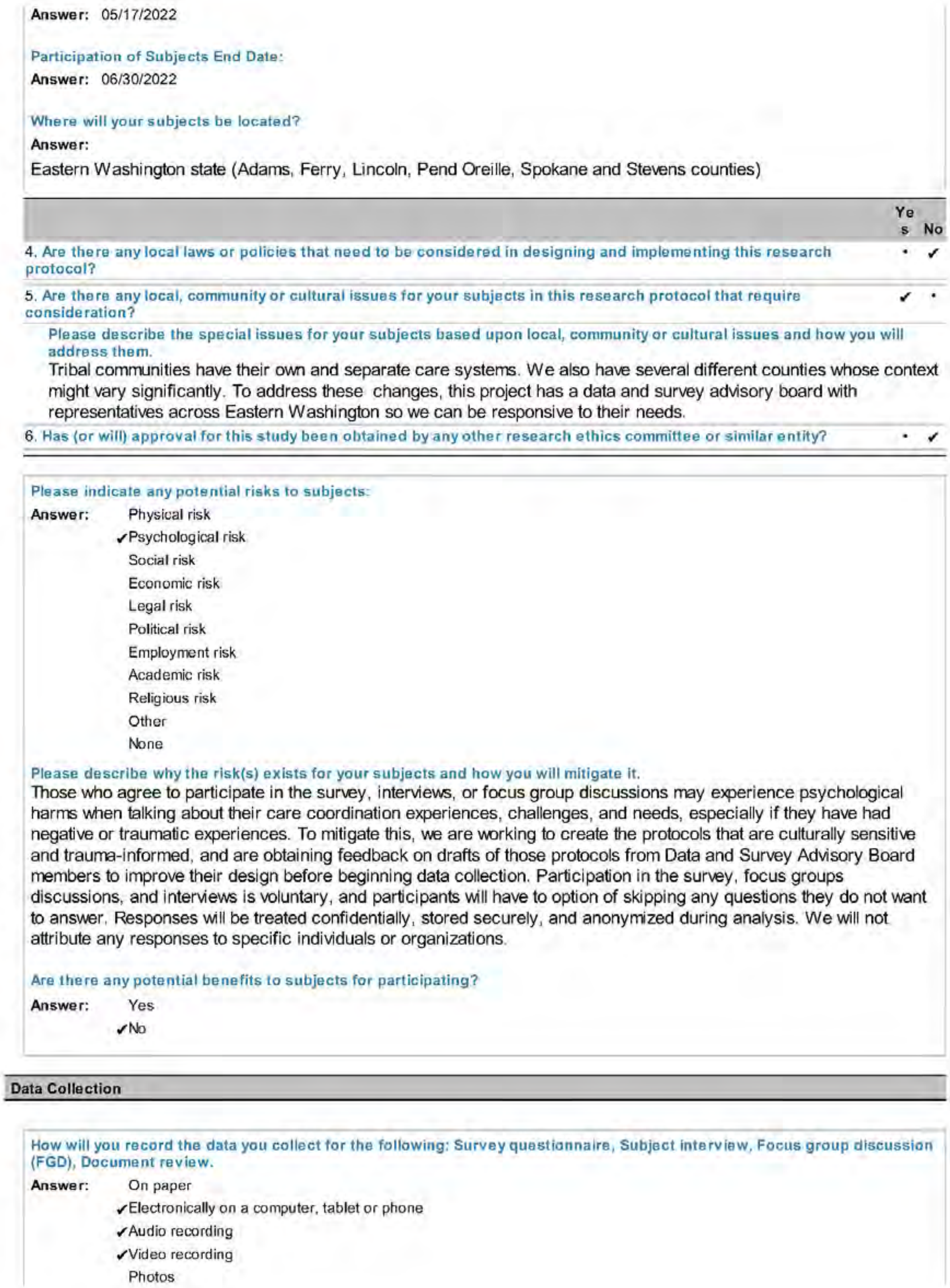
Answer: Yes
✓No

By whom will the data be collected for this study (select all that apply)?

Answer: ✓1. The study team will conduct data collection themselves
2. The study team will contract with another entity for the supervision of data collectors
3. The study team will directly hire and supervise data collectors
4. Not applicable, the study uses only existing secondary data.

Sites, Dates & Risk

Participation of Subjects Start Date:



Answer: 05/17/2022

Participation of Subjects End Date:

Answer: 06/30/2022

Where will your subjects be located?

Answer:

Eastern Washington state (Adams, Ferry, Lincoln, Pend Oreille, Spokane and Stevens counties)

	Yes	No
4. Are there any local laws or policies that need to be considered in designing and implementing this research protocol?	•	✓
5. Are there any local, community or cultural issues for your subjects in this research protocol that require consideration?	✓	•
Please describe the special issues for your subjects based upon local, community or cultural issues and how you will address them. Tribal communities have their own and separate care systems. We also have several different counties whose context might vary significantly. To address these changes, this project has a data and survey advisory board with representatives across Eastern Washington state so we can be responsive to their needs.		
6. Has (or will) approval for this study been obtained by any other research ethics committee or similar entity?	•	✓

Please indicate any potential risks to subjects:

Answer:
Physical risk
✓Psychological risk
Social risk
Economic risk
Legal risk
Political risk
Employment risk
Academic risk
Religious risk
Other
None

Please describe why the risk(s) exists for your subjects and how you will mitigate it.

Those who agree to participate in the survey, interviews, or focus group discussions may experience psychological harms when talking about their care coordination experiences, challenges, and needs, especially if they have had negative or traumatic experiences. To mitigate this, we are working to create the protocols that are culturally sensitive and trauma-informed, and are obtaining feedback on drafts of those protocols from Data and Survey Advisory Board members to improve their design before beginning data collection. Participation in the survey, focus groups discussions, and interviews is voluntary, and participants will have to option of skipping any questions they do not want to answer. Responses will be treated confidentially, stored securely, and anonymized during analysis. We will not attribute any responses to specific individuals or organizations.

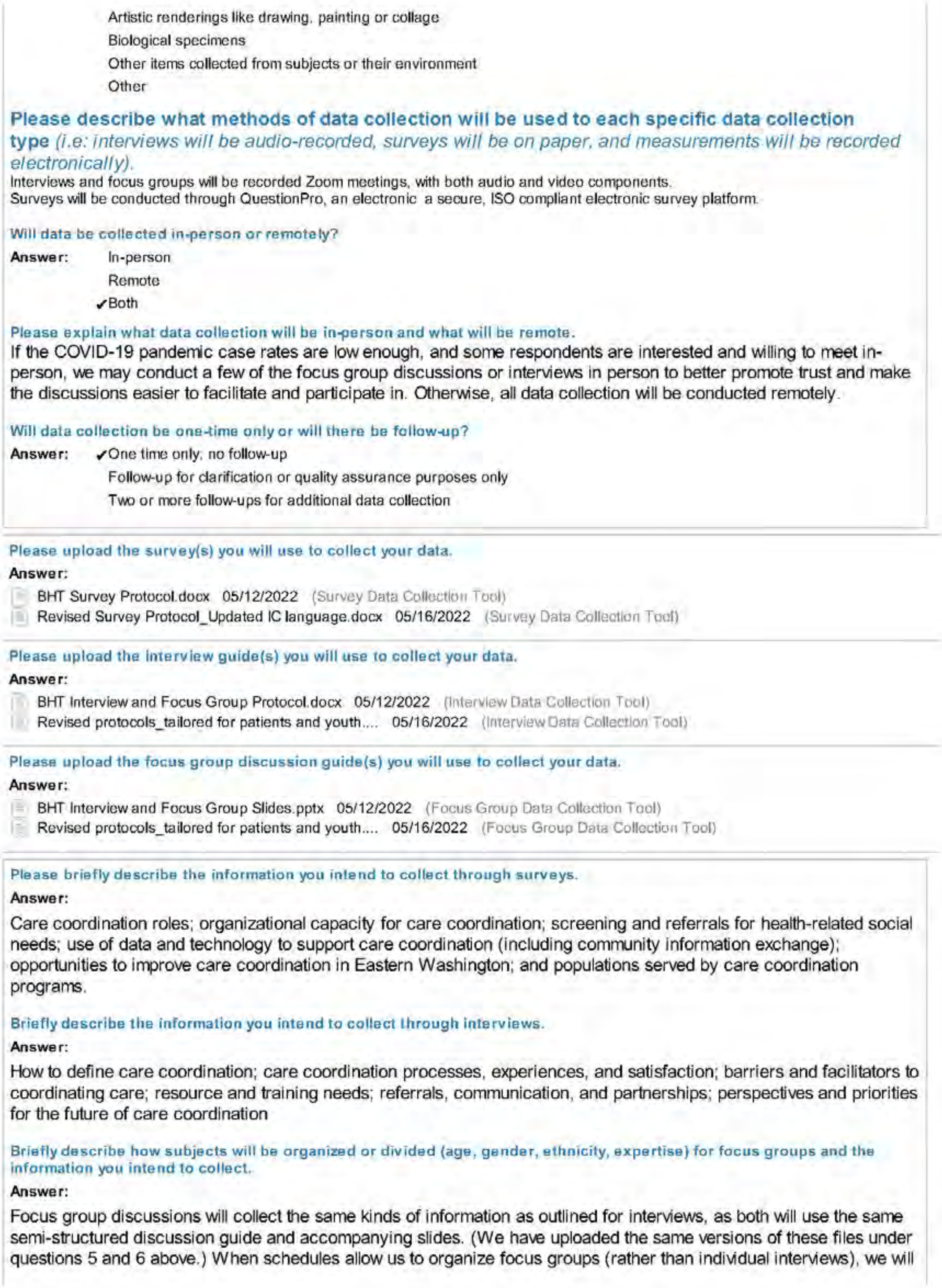
Are there any potential benefits to subjects for participating?

Answer:
Yes
✓No

Data Collection

How will you record the data you collect for the following: Survey questionnaire, Subject interview, Focus group discussion (FGD), Document review.

Answer:
On paper
✓Electronically on a computer, tablet or phone
✓Audio recording
✓Video recording
Photos



Artistic renderings like drawing, painting or collage
Biological specimens
Other items collected from subjects or their environment
Other

Please describe what methods of data collection will be used to each specific data collection type *(i.e: interviews will be audio-recorded, surveys will be on paper, and measurements will be recorded electronically).*

Interviews and focus groups will be recorded Zoom meetings, with both audio and video components.
Surveys will be conducted through QuestionPro, an electronic a secure, ISO compliant electronic survey platform.

Will data be collected in-person or remotely?

Answer:
In-person
Remote
✓Both

Please explain what data collection will be in-person and what will be remote.

If the COVID-19 pandemic case rates are low enough, and some respondents are interested and willing to meet in-person, we may conduct a few of the focus group discussions or interviews in person to better promote trust and make the discussions easier to facilitate and participate in. Otherwise, all data collection will be conducted remotely.

Will data collection be one-time only or will there be follow-up?

Answer:
✓One time only; no follow-up
Follow-up for clarification or quality assurance purposes only
Two or more follow-ups for additional data collection

Please upload the survey(s) you will use to collect your data.

Answer:
BHT Survey Protocol.docx 05/12/2022 (Survey Data Collection Tool)
Revised Survey Protocol_Updated IC language.docx 05/16/2022 (Survey Data Collection Tool)

Please upload the interview guide(s) you will use to collect your data.

Answer:
BHT Interview and Focus Group Protocol.docx 05/12/2022 (Interview Data Collection Tool)
Revised protocols_tailored for patients and youth.... 05/16/2022 (Interview Data Collection Tool)

Please upload the focus group discussion guide(s) you will use to collect your data.

Answer:
BHT Interview and Focus Group Slides.pptx 05/12/2022 (Focus Group Data Collection Tool)
Revised protocols_tailored for patients and youth.... 05/16/2022 (Focus Group Data Collection Tool)

Please briefly describe the information you intend to collect through surveys.

Answer:

Care coordination roles; organizational capacity for care coordination; screening and referrals for health-related social needs; use of data and technology to support care coordination (including community information exchange); opportunities to improve care coordination in Eastern Washington; and populations served by care coordination programs.

Briefly describe the information you intend to collect through interviews.

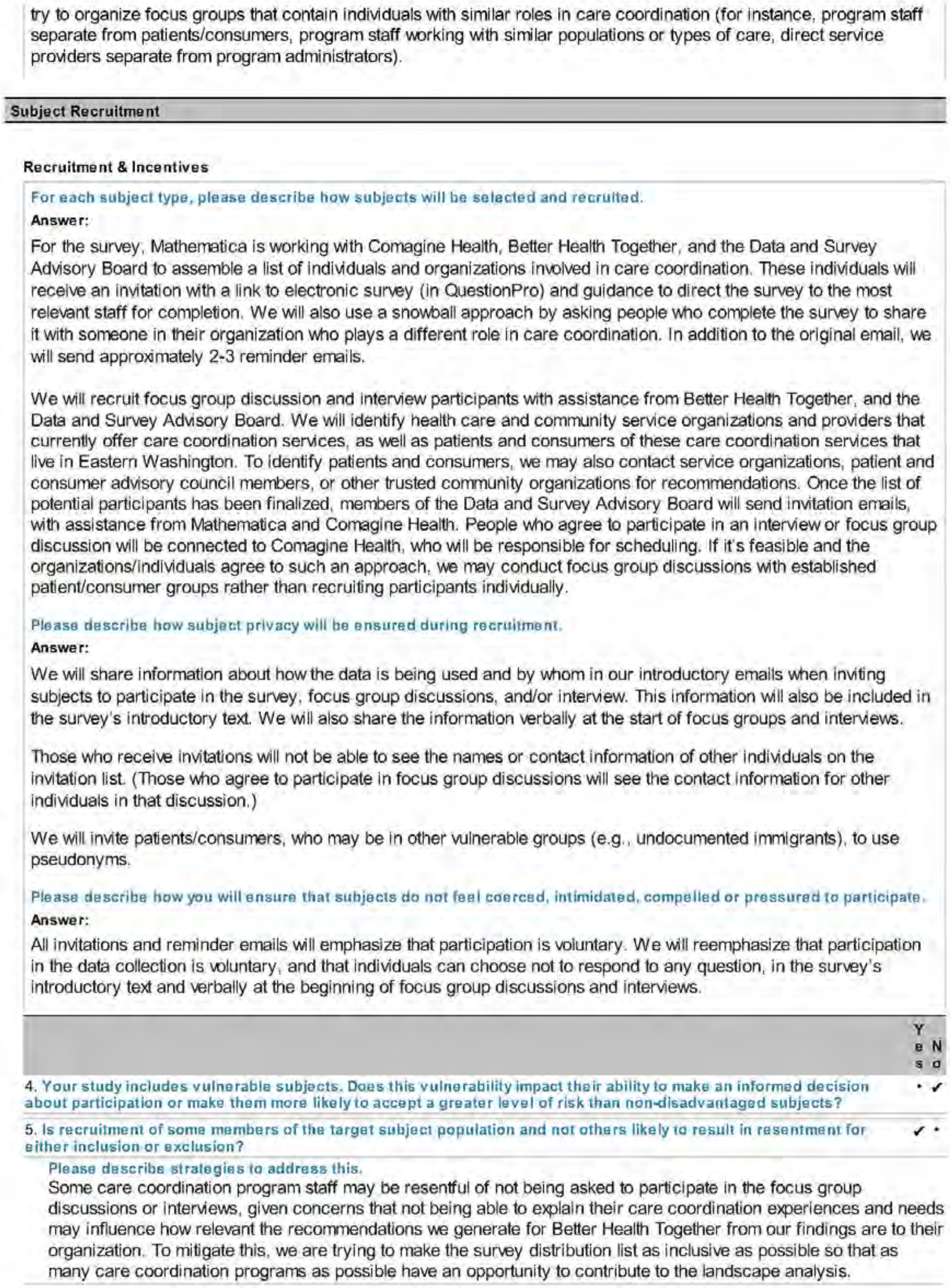
Answer:

How to define care coordination; care coordination processes, experiences, and satisfaction; barriers and facilitators to coordinating care; resource and training needs; referrals, communication, and partnerships; perspectives and priorities for the future of care coordination

Briefly describe how subjects will be organized or divided (age, gender, ethnicity, expertise) for focus groups and the information you intend to collect.

Answer:

Focus group discussions will collect the same kinds of information as outlined for interviews, as both will use the same semi-structured discussion guide and accompanying slides. (We have uploaded the same versions of these files under questions 5 and 6 above.) When schedules allow us to organize focus groups (rather than individual interviews), we will



try to organize focus groups that contain individuals with similar roles in care coordination (for instance, program staff separate from patients/consumers, program staff working with similar populations or types of care, direct service providers separate from program administrators).

Subject Recruitment

Recruitment & Incentives

For each subject type, please describe how subjects will be selected and recruited.

Answer:

For the survey, Mathematica is working with Comagine Health, Better Health Together, and the Data and Survey Advisory Board to assemble a list of individuals and organizations involved in care coordination. These individuals will receive an invitation with a link to electronic survey (in QuestionPro) and guidance to direct the survey to the most relevant staff for completion. We will also use a snowball approach by asking people who complete the survey to share it with someone in their organization who plays a different role in care coordination. In addition to the original email, we will send approximately 2-3 reminder emails.

We will recruit focus group discussion and interview participants with assistance from Better Health Together, and the Data and Survey Advisory Board. We will identify health care and community service organizations and providers that currently offer care coordination services, as well as patients and consumers of these care coordination services that live in Eastern Washington. To identify patients and consumers, we may also contact service organizations, patient and consumer advisory council members, or other trusted community organizations for recommendations. Once the list of potential participants has been finalized, members of the Data and Survey Advisory Board will send invitation emails, with assistance from Mathematica and Comagine Health. People who agree to participate in an interview or focus group discussion will be connected to Comagine Health, who will be responsible for scheduling. If it's feasible and the organizations/individuals agree to such an approach, we may conduct focus group discussions with established patient/consumer groups rather than recruiting participants individually.

Please describe how subject privacy will be ensured during recruitment.

Answer:

We will share information about how the data is being used and by whom in our introductory emails when inviting subjects to participate in the survey, focus group discussions, and/or interview. This information will also be included in the survey's introductory text. We will also share the information verbally at the start of focus groups and interviews.

Those who receive invitations will not be able to see the names or contact information of other individuals on the invitation list. (Those who agree to participate in focus group discussions will see the contact information for other individuals in that discussion.)

We will invite patients/consumers, who may be in other vulnerable groups (e.g., undocumented immigrants), to use pseudonyms.

Please describe how you will ensure that subjects do not feel coerced, intimidated, compelled or pressured to participate.

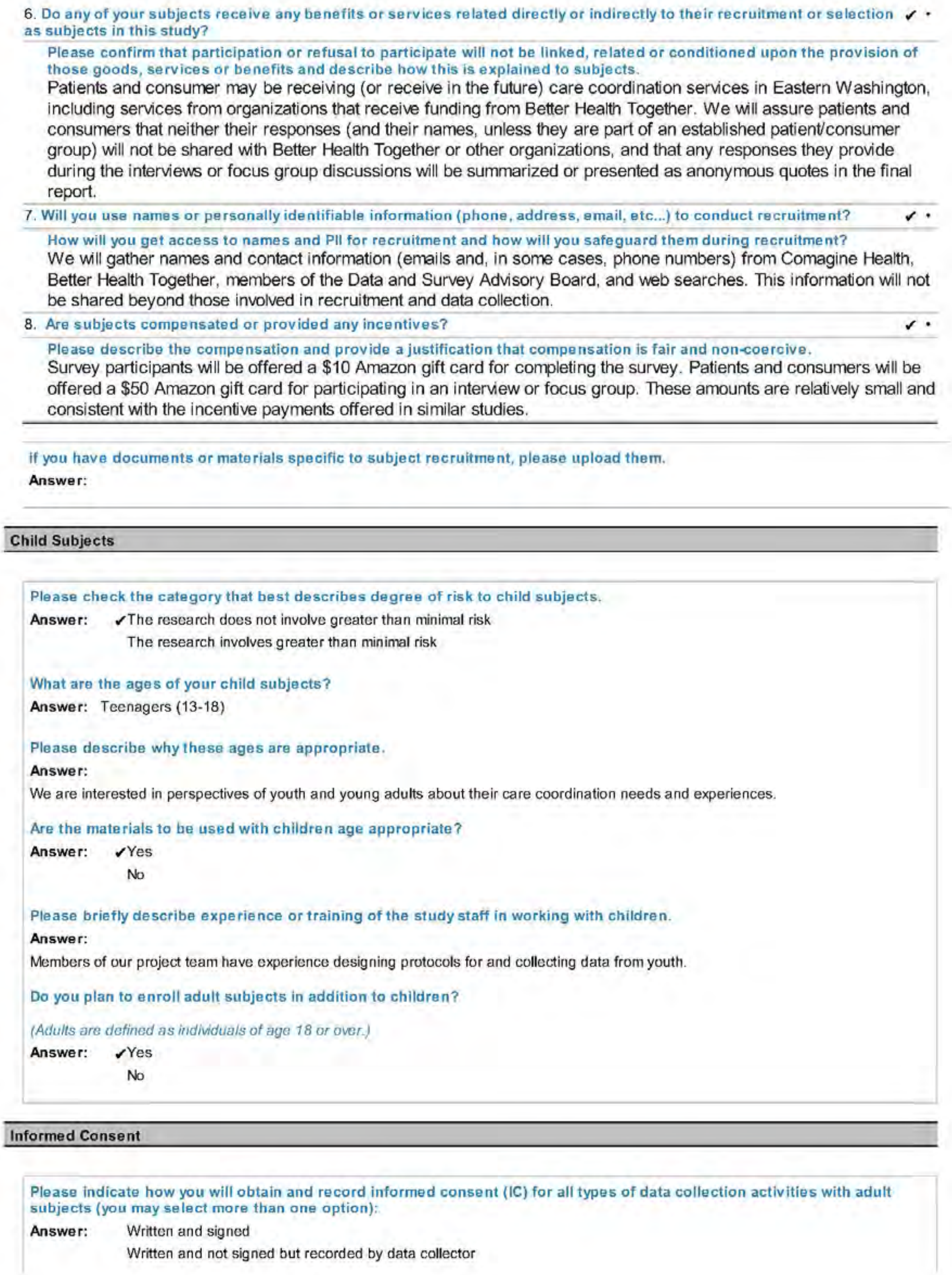
Answer:

All invitations and reminder emails will emphasize that participation is voluntary. We will reemphasize that participation in the data collection is voluntary, and that individuals can choose not to respond to any question, in the survey's introductory text and verbally at the beginning of focus group discussions and interviews.

	Yes	No
4. Your study includes vulnerable subjects. Does this vulnerability impact their ability to make an informed decision about participation or make them more likely to accept a greater level of risk than non-disadvantaged subjects?	•	✓
5. Is recruitment of some members of the target subject population and not others likely to result in resentment for either inclusion or exclusion?	✓	•

Please describe strategies to address this.

Some care coordination program staff may be resentful of not being asked to participate in the focus group discussions or interviews, given concerns that not being able to explain their care coordination experiences and needs may influence how relevant the recommendations we generate for Better Health Together from our findings are to their organization. To mitigate this, we are trying to make the survey distribution list as inclusive as possible so that as many care coordination programs as possible have an opportunity to contribute to the landscape analysis.



6. Do any of your subjects receive any benefits or services related directly or indirectly to their recruitment or selection as subjects in this study? ✔ •

Please confirm that participation or refusal to participate will not be linked, related or conditioned upon the provision of those goods, services or benefits and describe how this is explained to subjects.

Patients and consumer may be receiving (or receive in the future) care coordination services in Eastern Washington, including services from organizations that receive funding from Better Health Together. We will assure patients and consumers that neither their responses (and their names, unless they are part of an established patient/consumer group) will not be shared with Better Health Together or other organizations, and that any responses they provide during the interviews or focus group discussions will be summarized or presented as anonymous quotes in the final report.

7. Will you use names or personally identifiable information (phone, address, email, etc...) to conduct recruitment? ✔ •

How will you get access to names and PII for recruitment and how will you safeguard them during recruitment?

We will gather names and contact information (emails and, in some cases, phone numbers) from Comagine Health, Better Health Together, members of the Data and Survey Advisory Board, and web searches. This information will not be shared beyond those involved in recruitment and data collection.

8. Are subjects compensated or provided any incentives? ✔ •

Please describe the compensation and provide a justification that compensation is fair and non-coercive.

Survey participants will be offered a $10 Amazon gift card for completing the survey. Patients and consumers will be offered a $50 Amazon gift card for participating in an interview or focus group. These amounts are relatively small and consistent with the incentive payments offered in similar studies.

If you have documents or materials specific to subject recruitment, please upload them.

Answer:

Child Subjects

Please check the category that best describes degree of risk to child subjects.

Answer: ✔The research does not involve greater than minimal risk

The research involves greater than minimal risk

What are the ages of your child subjects?

Answer: Teenagers (13-18)

Please describe why these ages are appropriate.

Answer:

We are interested in perspectives of youth and young adults about their care coordination needs and experiences.

Are the materials to be used with children age appropriate?

Answer: ✔Yes

No

Please briefly describe experience or training of the study staff in working with children.

Answer:

Members of our project team have experience designing protocols for and collecting data from youth.

Do you plan to enroll adult subjects in addition to children?

(Adults are defined as individuals of age 18 or over.)

Answer: ✔Yes

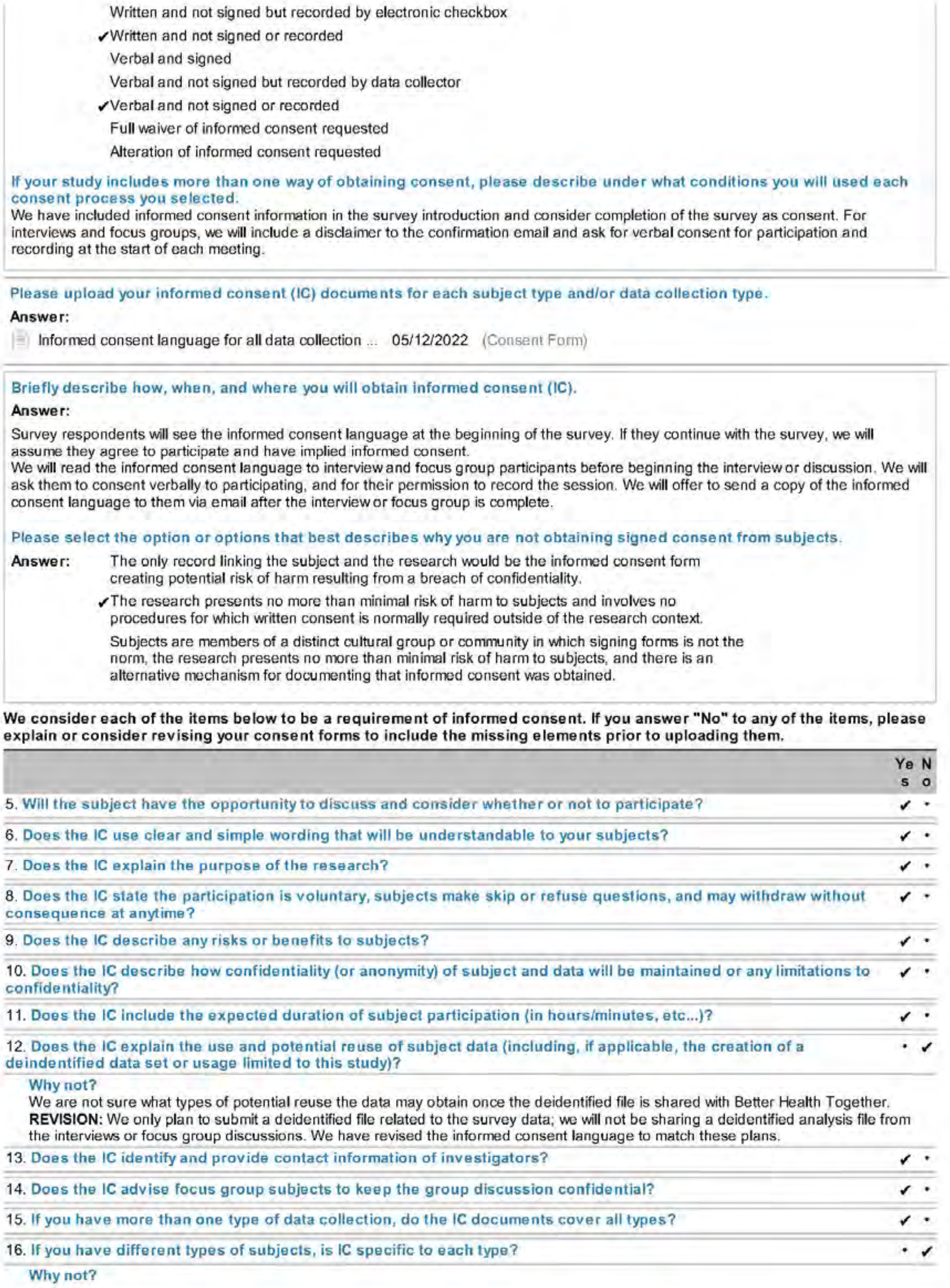
No

Informed Consent

Please indicate how you will obtain and record informed consent (IC) for all types of data collection activities with adult subjects (you may select more than one option):

Answer: Written and signed

Written and not signed but recorded by data collector



Written and not signed but recorded by electronic checkbox
✓Written and not signed or recorded
Verbal and signed
Verbal and not signed but recorded by data collector
✓Verbal and not signed or recorded
Full waiver of informed consent requested
Alteration of informed consent requested

If your study includes more than one way of obtaining consent, please describe under what conditions you will used each consent process you selected.

We have included informed consent information in the survey introduction and consider completion of the survey as consent. For interviews and focus groups, we will include a disclaimer to the confirmation email and ask for verbal consent for participation and recording at the start of each meeting.

Please upload your informed consent (IC) documents for each subject type and/or data collection type.

Answer:

Informed consent language for all data collection ... 05/12/2022 (Consent Form)

Briefly describe how, when, and where you will obtain informed consent (IC).

Answer:

Survey respondents will see the informed consent language at the beginning of the survey. If they continue with the survey, we will assume they agree to participate and have implied informed consent.
We will read the informed consent language to interview and focus group participants before beginning the interview or discussion. We will ask them to consent verbally to participating, and for their permission to record the session. We will offer to send a copy of the informed consent language to them via email after the interview or focus group is complete.

Please select the option or options that best describes why you are not obtaining signed consent from subjects.

Answer: The only record linking the subject and the research would be the informed consent form creating potential risk of harm resulting from a breach of confidentiality.

✓The research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

Subjects are members of a distinct cultural group or community in which signing forms is not the norm, the research presents no more than minimal risk of harm to subjects, and there is an alternative mechanism for documenting that informed consent was obtained.

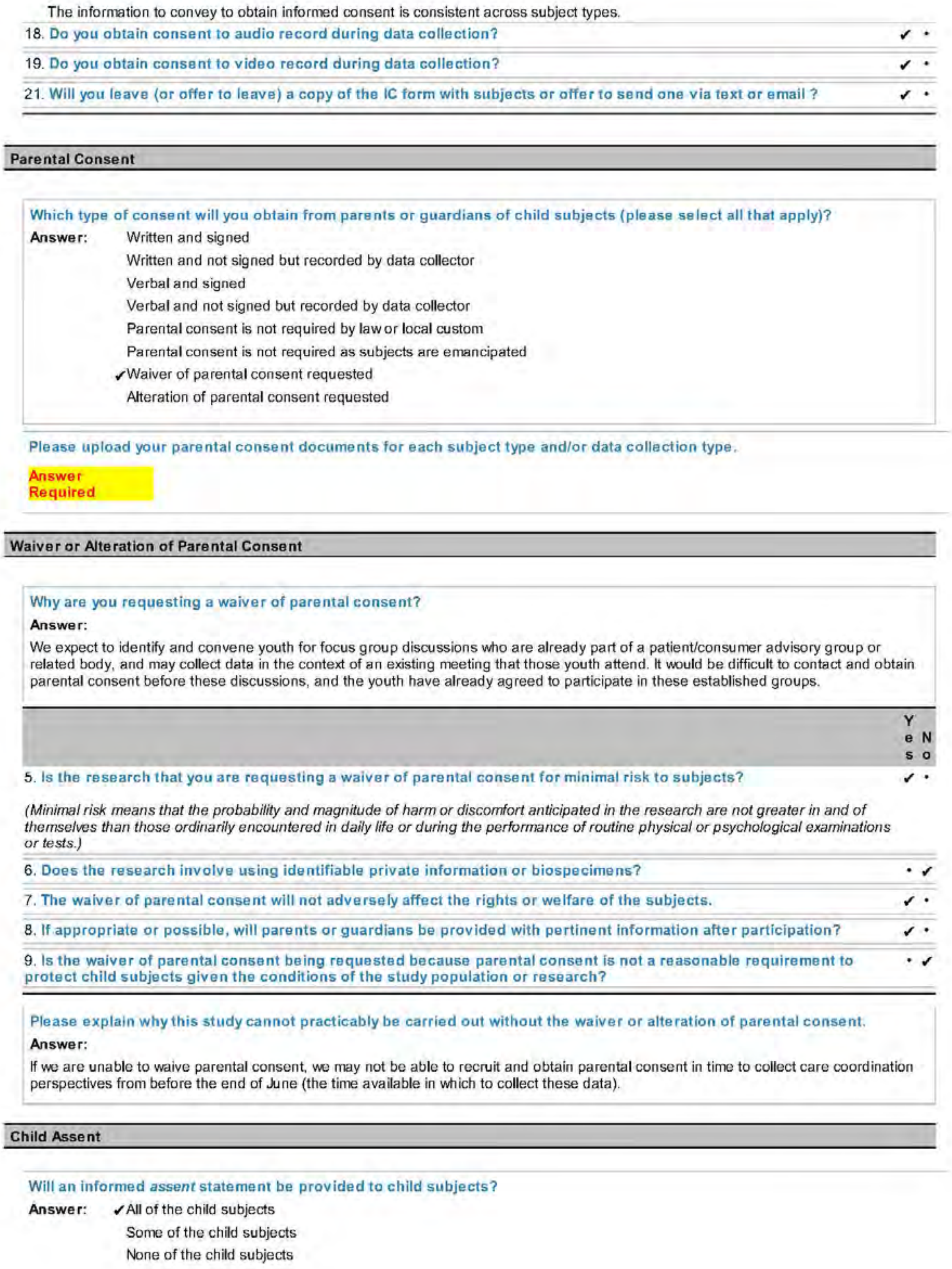
We consider each of the items below to be a requirement of informed consent. If you answer "No" to any of the items, please explain or consider revising your consent forms to include the missing elements prior to uploading them.

	Yes	No
5. Will the subject have the opportunity to discuss and consider whether or not to participate?	✓	•
6. Does the IC use clear and simple wording that will be understandable to your subjects?	✓	•
7. Does the IC explain the purpose of the research?	✓	•
8. Does the IC state the participation is voluntary, subjects make skip or refuse questions, and may withdraw without consequence at anytime?	✓	•
9. Does the IC describe any risks or benefits to subjects?	✓	•
10. Does the IC describe how confidentiality (or anonymity) of subject and data will be maintained or any limitations to confidentiality?	✓	•
11. Does the IC include the expected duration of subject participation (in hours/minutes, etc...)?	✓	•
12. Does the IC explain the use and potential reuse of subject data (including, if applicable, the creation of a deindentified data set or usage limited to this study)?	•	✓

Why not?
We are not sure what types of potential reuse the data may obtain once the deidentified file is shared with Better Health Together. **REVISION:** We only plan to submit a deidentified file related to the survey data; we will not be sharing a deidentified analysis file from the interviews or focus group discussions. We have revised the informed consent language to match these plans.

	Yes	No
13. Does the IC identify and provide contact information of investigators?	✓	•
14. Does the IC advise focus group subjects to keep the group discussion confidential?	✓	•
15. If you have more than one type of data collection, do the IC documents cover all types?	✓	•
16. If you have different types of subjects, is IC specific to each type?	•	✓

Why not?



The information to convey to obtain informed consent is consistent across subject types.

18. Do you obtain consent to audio record during data collection?	✓	•
19. Do you obtain consent to video record during data collection?	✓	•
21. Will you leave (or offer to leave) a copy of the IC form with subjects or offer to send one via text or email ?	✓	•

Parental Consent

Which type of consent will you obtain from parents or guardians of child subjects (please select all that apply)?

Answer:
Written and signed
Written and not signed but recorded by data collector
Verbal and signed
Verbal and not signed but recorded by data collector
Parental consent is not required by law or local custom
Parental consent is not required as subjects are emancipated
✓Waiver of parental consent requested
Alteration of parental consent requested

Please upload your parental consent documents for each subject type and/or data collection type.

Answer Required

Waiver or Alteration of Parental Consent

Why are you requesting a waiver of parental consent?

Answer:

We expect to identify and convene youth for focus group discussions who are already part of a patient/consumer advisory group or related body, and may collect data in the context of an existing meeting that those youth attend. It would be difficult to contact and obtain parental consent before these discussions, and the youth have already agreed to participate in these established groups.

	Yes	No
5. Is the research that you are requesting a waiver of parental consent for minimal risk to subjects? *(Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.)*	✓	•
6. Does the research involve using identifiable private information or biospecimens?	•	✓
7. The waiver of parental consent will not adversely affect the rights or welfare of the subjects.	✓	•
8. If appropriate or possible, will parents or guardians be provided with pertinent information after participation?	✓	•
9. Is the waiver of parental consent being requested because parental consent is not a reasonable requirement to protect child subjects given the conditions of the study population or research?	•	✓

Please explain why this study cannot practicably be carried out without the waiver or alteration of parental consent.

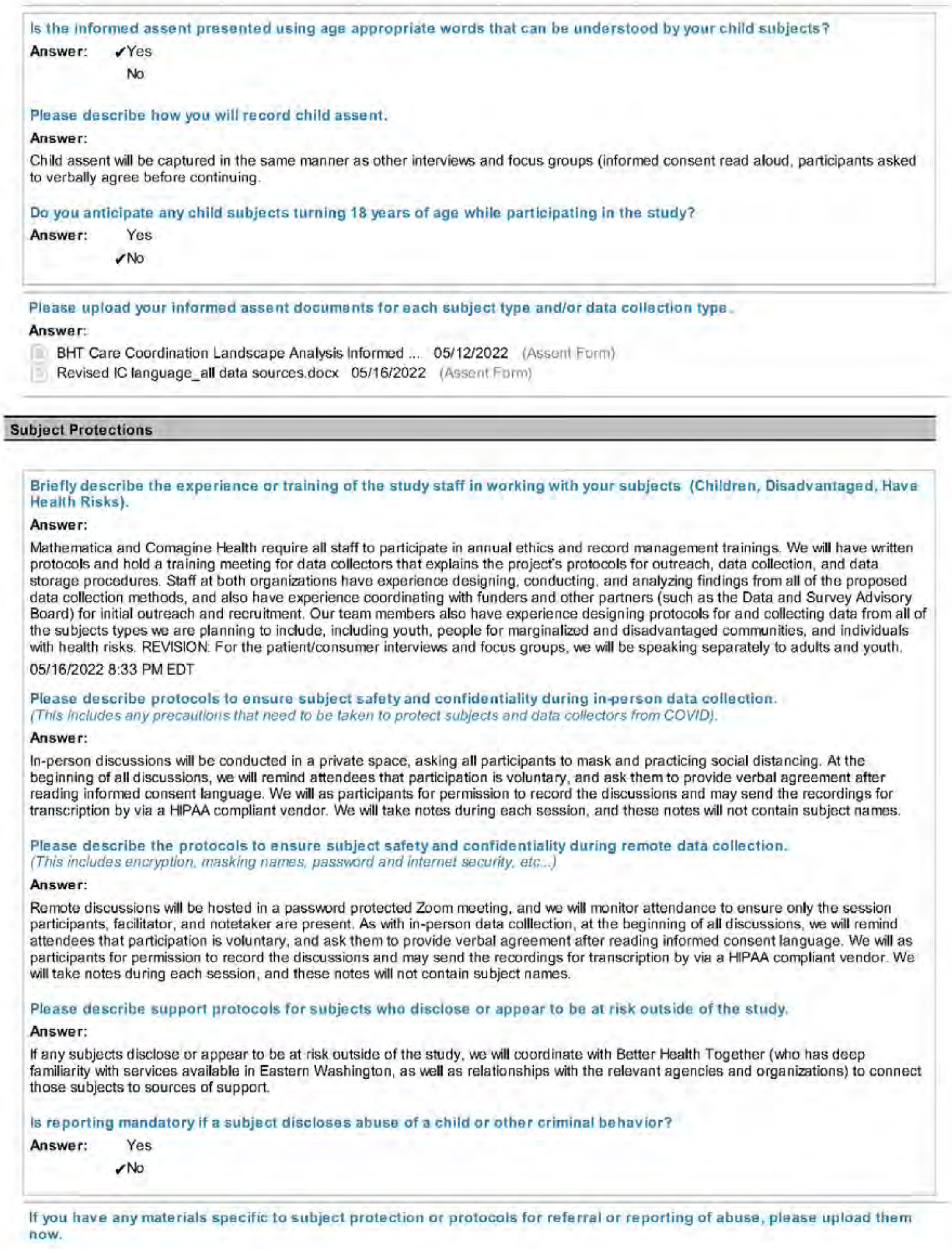
Answer:

If we are unable to waive parental consent, we may not be able to recruit and obtain parental consent in time to collect care coordination perspectives from before the end of June (the time available in which to collect these data).

Child Assent

Will an informed *assent* statement be provided to child subjects?

Answer:
✓All of the child subjects
Some of the child subjects
None of the child subjects



Is the informed assent presented using age appropriate words that can be understood by your child subjects?

Answer: ✓Yes
No

Please describe how you will record child assent.

Answer:

Child assent will be captured in the same manner as other interviews and focus groups (informed consent read aloud, participants asked to verbally agree before continuing.

Do you anticipate any child subjects turning 18 years of age while participating in the study?

Answer: Yes
✓No

Please upload your informed assent documents for each subject type and/or data collection type.

Answer:

BHT Care Coordination Landscape Analysis Informed ... 05/12/2022 (Assent Form)
Revised IC language_all data sources.docx 05/16/2022 (Assent Form)

Subject Protections

Briefly describe the experience or training of the study staff in working with your subjects (Children, Disadvantaged, Have Health Risks).

Answer:

Mathematica and Comagine Health require all staff to participate in annual ethics and record management trainings. We will have written protocols and hold a training meeting for data collectors that explains the project's protocols for outreach, data collection, and data storage procedures. Staff at both organizations have experience designing, conducting, and analyzing findings from all of the proposed data collection methods, and also have experience coordinating with funders and other partners (such as the Data and Survey Advisory Board) for initial outreach and recruitment. Our team members also have experience designing protocols for and collecting data from all of the subjects types we are planning to include, including youth, people for marginalized and disadvantaged communities, and individuals with health risks. REVISION: For the patient/consumer interviews and focus groups, we will be speaking separately to adults and youth.

05/16/2022 8:33 PM EDT

Please describe protocols to ensure subject safety and confidentiality during in-person data collection.
(This includes any precautions that need to be taken to protect subjects and data collectors from COVID).

Answer:

In-person discussions will be conducted in a private space, asking all participants to mask and practicing social distancing. At the beginning of all discussions, we will remind attendees that participation is voluntary, and ask them to provide verbal agreement after reading informed consent language. We will as participants for permission to record the discussions and may send the recordings for transcription by via a HIPAA compliant vendor. We will take notes during each session, and these notes will not contain subject names.

Please describe the protocols to ensure subject safety and confidentiality during remote data collection.
(This includes encryption, masking names, password and internet security, etc...)

Answer:

Remote discussions will be hosted in a password protected Zoom meeting, and we will monitor attendance to ensure only the session participants, facilitator, and notetaker are present. As with in-person data colllection, at the beginning of all discussions, we will remind attendees that participation is voluntary, and ask them to provide verbal agreement after reading informed consent language. We will as participants for permission to record the discussions and may send the recordings for transcription by via a HIPAA compliant vendor. We will take notes during each session, and these notes will not contain subject names.

Please describe support protocols for subjects who disclose or appear to be at risk outside of the study.

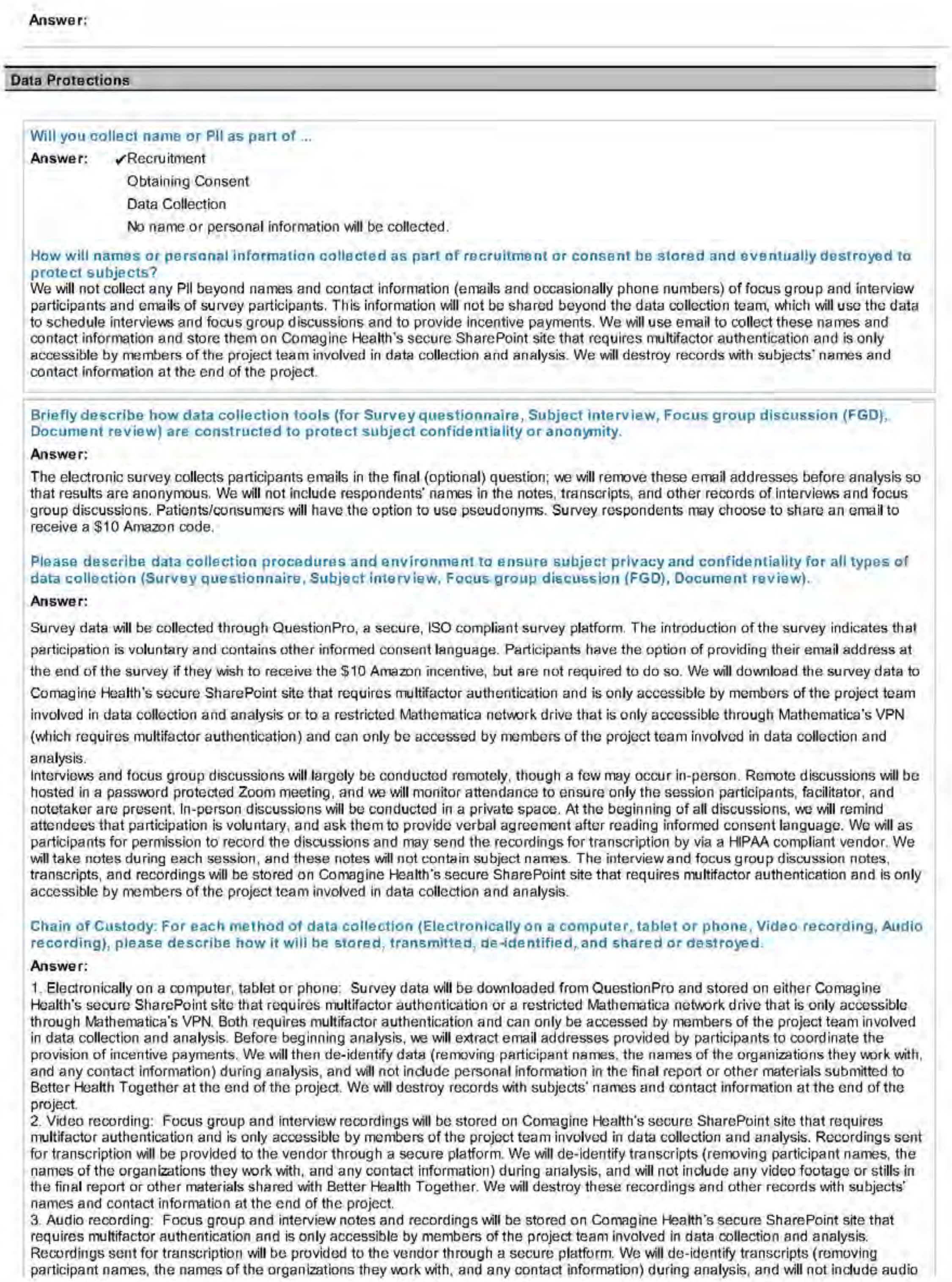
Answer:

If any subjects disclose or appear to be at risk outside of the study, we will coordinate with Better Health Together (who has deep familiarity with services available in Eastern Washington, as well as relationships with the relevant agencies and organizations) to connect those subjects to sources of support.

Is reporting mandatory if a subject discloses abuse of a child or other criminal behavior?

Answer: Yes
✓No

If you have any materials specific to subject protection or protocols for referral or reporting of abuse, please upload them now.



Answer:

Data Protections

Will you collect name or PII as part of ...

Answer: ✓Recruitment
Obtaining Consent
Data Collection
No name or personal information will be collected.

How will names or personal information collected as part of recruitment or consent be stored and eventually destroyed to protect subjects?

We will not collect any PII beyond names and contact information (emails and occasionally phone numbers) of focus group and interview participants and emails of survey participants. This information will not be shared beyond the data collection team, which will use the data to schedule interviews and focus group discussions and to provide incentive payments. We will use email to collect these names and contact information and store them on Comagine Health's secure SharePoint site that requires multifactor authentication and is only accessible by members of the project team involved in data collection and analysis. We will destroy records with subjects' names and contact information at the end of the project.

Briefly describe how data collection tools (for Survey questionnaire, Subject interview, Focus group discussion (FGD), Document review) are constructed to protect subject confidentiality or anonymity.

Answer:

The electronic survey collects participants emails in the final (optional) question; we will remove these email addresses before analysis so that results are anonymous. We will not include respondents' names in the notes, transcripts, and other records of interviews and focus group discussions. Patients/consumers will have the option to use pseudonyms. Survey respondents may choose to share an email to receive a $10 Amazon code.

Please describe data collection procedures and environment to ensure subject privacy and confidentiality for all types of data collection (Survey questionnaire, Subject interview, Focus group discussion (FGD), Document review).

Answer:

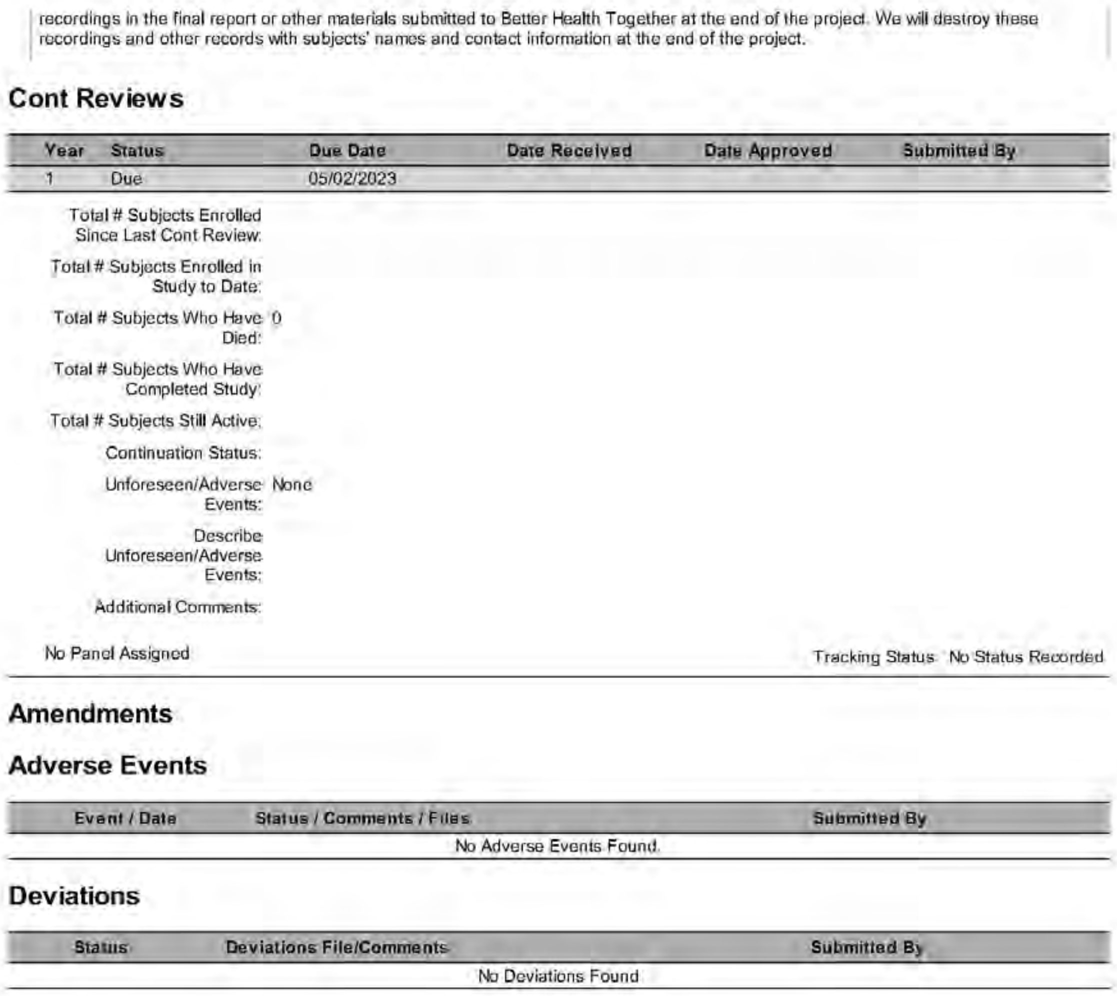
Survey data will be collected through QuestionPro, a secure, ISO compliant survey platform. The introduction of the survey indicates that participation is voluntary and contains other informed consent language. Participants have the option of providing their email address at the end of the survey if they wish to receive the $10 Amazon incentive, but are not required to do so. We will download the survey data to Comagine Health's secure SharePoint site that requires multifactor authentication and is only accessible by members of the project team involved in data collection and analysis or to a restricted Mathematica network drive that is only accessible through Mathematica's VPN (which requires multifactor authentication) and can only be accessed by members of the project team involved in data collection and analysis.

Interviews and focus group discussions will largely be conducted remotely, though a few may occur in-person. Remote discussions will be hosted in a password protected Zoom meeting, and we will monitor attendance to ensure only the session participants, facilitator, and notetaker are present. In-person discussions will be conducted in a private space. At the beginning of all discussions, we will remind attendees that participation is voluntary, and ask them to provide verbal agreement after reading informed consent language. We will as participants for permission to record the discussions and may send the recordings for transcription by via a HIPAA compliant vendor. We will take notes during each session, and these notes will not contain subject names. The interview and focus group discussion notes, transcripts, and recordings will be stored on Comagine Health's secure SharePoint site that requires multifactor authentication and is only accessible by members of the project team involved in data collection and analysis.

Chain of Custody: For each method of data collection (Electronically on a computer, tablet or phone, Video recording, Audio recording), please describe how it will be stored, transmitted, de-identified, and shared or destroyed.

Answer:

1. Electronically on a computer, tablet or phone: Survey data will be downloaded from QuestionPro and stored on either Comagine Health's secure SharePoint site that requires multifactor authentication or a restricted Mathematica network drive that is only accessible through Mathematica's VPN. Both requires multifactor authentication and can only be accessed by members of the project team involved in data collection and analysis. Before beginning analysis, we will extract email addresses provided by participants to coordinate the provision of incentive payments. We will then de-identify data (removing participant names, the names of the organizations they work with, and any contact information) during analysis, and will not include personal information in the final report or other materials submitted to Better Health Together at the end of the project. We will destroy records with subjects' names and contact information at the end of the project.
2. Video recording: Focus group and interview recordings will be stored on Comagine Health's secure SharePoint site that requires multifactor authentication and is only accessible by members of the project team involved in data collection and analysis. Recordings sent for transcription will be provided to the vendor through a secure platform. We will de-identify transcripts (removing participant names, the names of the organizations they work with, and any contact information) during analysis, and will not include any video footage or stills in the final report or other materials shared with Better Health Together. We will destroy these recordings and other records with subjects' names and contact information at the end of the project.
3. Audio recording: Focus group and interview notes and recordings will be stored on Comagine Health's secure SharePoint site that requires multifactor authentication and is only accessible by members of the project team involved in data collection and analysis. Recordings sent for transcription will be provided to the vendor through a secure platform. We will de-identify transcripts (removing participant names, the names of the organizations they work with, and any contact information) during analysis, and will not include audio



recordings in the final report or other materials submitted to Better Health Together at the end of the project. We will destroy these recordings and other records with subjects' names and contact information at the end of the project.

Cont Reviews

Year	Status	Due Date	Date Received	Date Approved	Submitted By
1	Due	05/02/2023			

Total # Subjects Enrolled Since Last Cont Review:

Total # Subjects Enrolled in Study to Date:

Total # Subjects Who Have Died: 0

Total # Subjects Who Have Completed Study:

Total # Subjects Still Active:

Continuation Status:

Unforeseen/Adverse Events: None

Describe Unforeseen/Adverse Events:

Additional Comments:

No Panel Assigned

Tracking Status: No Status Recorded

Amendments

Adverse Events

Event / Date	Status / Comments / Files	Submitted By
	No Adverse Events Found.	

Deviations

Status	Deviations File/Comments	Submitted By
	No Deviations Found	

Appendix B. Co-design Workshop Agenda

Better Health Together Landscape Analysis Co-Design Workshop

Tuesday, April 12, 2022, 10:30 AM -12:00 PM

B.1. Central tenets of our approach

Problem-solve and make decisions through collaboration

To target and tailor data collection and to inform interpretation

Consider cultural and social contexts that impact equitable practices

To build and reinforce trust and align with Better Health Together's established approach

Include workstreams that allow for repeated reflection, review, and refinement

To gather insights quickly, learn from them, and refine our approach

B.2. Partner roles

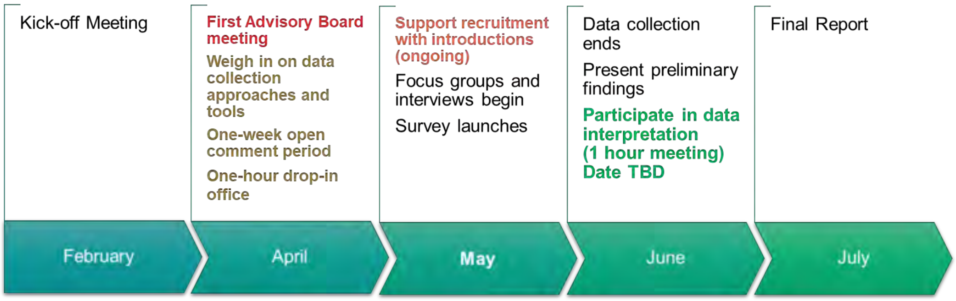
Organization	Responsibilities
Better Health Together	• ▪Set the budget and timeline for our project • ▪Oversee project scope and objectives • ▪Lead and guide recruitment efforts
Mathematica	• ▪Facilitate co-design workshop, document review, surveys, and reporting • ▪Support interviews and focus groups • ▪Manage and coordinate project activities and resources
Comagine Health	• ▪Lead interviews and focus group discussions • ▪Contribute to design and reporting • ▪Advise on document review and surveys
Data and Survey Advisory Board	• ▪Share experiences and expertise about care coordination in their communities • ▪Set and guide project expectations and goals. • ▪Review project activity materials (interview and survey protocols, document list) • ▪Support data collection recruitment

A. Data and Survey Advisory Board Organizations

- Rural Resources
- Frontier Behavioral Health
- CHAS
- AICC
- Latinos en Spokane
- Spectrum
- VOA

- Northeast Community Center

B.3. Data and Survey Advisory Board roles and timeline[1]



1. Breakout activity 1: Meet the team

You will randomly be assigned to a buddy. You have 2 minutes to find 5 things you have in common.

- Get creative:
  - Prompts:
    - Go-to comfort food
    - Pandemic hobby (we all had at least 1!)
    - Favorite animal
    - Favorite vegetable

2. Breakout Activity 2: Defining what we know and want to know about care coordination

1. Let’s start with a chat question:
   - What are your hopes, dreams, and wishes for health equity to be fully realized and implemented?
2. Keeping your responses in mind, think about what you:
   - Currently know about care coordination in your community
   - Want to learn about care coordination through our research that will help with getting closer to your goals.

What you currently know about care coordination in your community	What you want to learn about care coordination through our research that will help with getting closer to your goals

3. Breakout activity 3: Planning future information sharing

1. Who should we gather feedback from?

---

[1] Note: this reflects our original timeline. We changed the project timeline to August 2022 after the co-design workshop to be responsive to the needs across interested parties.

2. What method should we use for each group of participants (e.g., interviews for beneficiaries vs. surveys for organization directors)?
3. How should we share feedback and collaborate on findings among our group?
   - What has worked for you in the past?
   - What has not worked?

Data Collection Audience	Most Appropriate for Which Group of Participant?	Explain Rationale
Surveys		
Interviews/ Focus Groups		
Something Else?		

Appendix C. Co-interpretation Workshop agenda

C.1. Co-interpretation Workshop summary

Main topic/theme	Key Highlights from Breakout Room Discussions
CIE	• There is no 1 CIE that all organizations use. Because of this, there is no management or clear oversight of data collection, structure, or rules for entering data and tracking whether there is capacity for helping the client/patient. • Can get overwhelming for the client and the provider in filling out all the forms for different programs and organizations to get services. • No one is responsible for the follow-up and closing the loop—need better two-way communication between medical providers and non-profit community-based organizations. Currently there is no feedback. • Sharing Quality Info between organizations: same information that is often asked by both organizations can be completed once and then shared with referred to partner organization to reduce duplicate work. • CIE(s) should include a feature for all places client has been referred to by all organizations. *CCS is being used. High percentage of interest of why responses to the CIE are "not interested."* • Are there more data that reflects the reason for "not interested in a CIE"? • Does it show there is a need for education related to this? • Difference between how info is exchanged and what is most effective – why is this as it is? What are the barriers, etc.? • Privacy Concerns regarding CIE: Challenges/Barriers: **1.** Moving away from paper (HIPAA) and fear of electronic PHI. o Once this challenge is removed, then a CIE could be useful to share info and use same apps. **2.** Lack of Education – proper education will decrease barriers and prove the safety and effectiveness of CIE. • Pilot project (include Education) – successful results will help to swing those who are "not interested" and "do not know." • BHT asking: How do we move past what we already know? o What are the themes that are already known? o What does the data show us that is outside of that? • Understanding the limitations and overlap of the work that different organizations do. Based on focus groups where someone shared concerns on the CIE –Would it help to provide an example of a particular case for when a phone or other methods are most appropriate? For example, is there a platform out there that has successfully married SDOH with medical information and other provider information? • Lack of resources holds many organizations back from providing care coordination. • Broadband issues proved to be a major blocker as shown during the COVID response. • Need an accountable party responsible for the follow-up and closing the loop with a CIE • A feature is needed for if an organization receiving the referral does not have the capacity or has a barrier/challenge in providing the service to the client. • There is worry about a negative impact to the organization for the client if they referred them and the referral was not successful. The organization that is impacted is the first organization and not the second.
Motivational Interviewing (MI)	Motivational Interviewing is already being used for community health workers and case managers (direct frontline staff) • MI does not abide by the non-violent compliance guidelines.

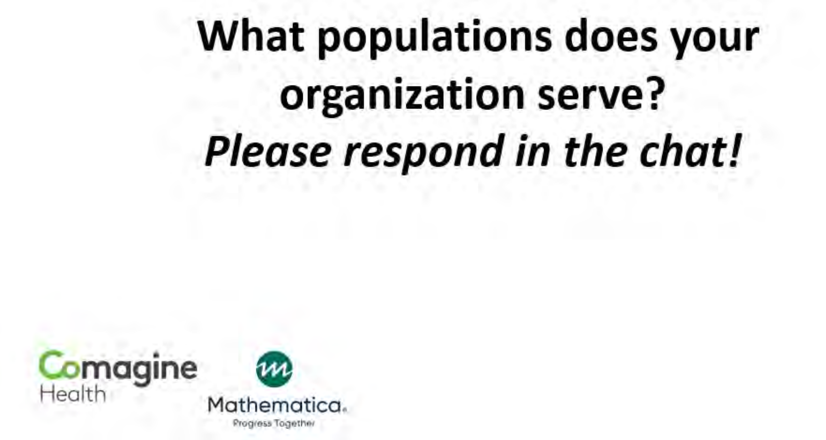
Main topic/theme	Key Highlights from Breakout Room Discussions
	- MI should be complimentary to the training that already is in place. - There is a need to provide more training that ties in cultural competency/cultural humility to address the unique needs of all communities that we serve.
Trainings for Providers	- Trainings are needed to help with language and increase patient centered care. - There is a need to include more Language, Behavioral and Communication training that ties in cultural humility for providers and their staff. - There are many languages underrepresented.
Closed-Loop Referral System	- For Social Service programs and Medical providers – they send out referrals and receive referrals, but there is no follow-up communication from the social service programs or medical providers to close the loop. - Opportunity to create a shared Care Coordination Collaborative Space to bring the community-based organization and the social service program or medical provider to the same table like an ECHO to discuss any shared clients and care coordination.
Staffing	Provide increased quality Staffing - working with higher ed, high schools, re: engagement into programs.

Appendix D. Interviews and Focus Groups

A. Interview and focus groups protocol

Thank you for joining us today. While we wait for folks to join, we'd like to understand the populations your organization serves.

Exhibit D.1. Slide 1



What populations does your organization serve?

Please respond in the chat!

Exhibit D.2. Slide 2

Better Health Together operates in the following counties:

1. Ferry County
2. Stevens County
3. Pend Oreille County
4. Lincoln County
5. Spokane County
6. Adams County

1. Introduction Script

Hello, thank you for joining us today. My name is [*INSERT FACILITATOR/INTERVIEWER'S NAME*] and I am a [*INSERT POSITION*] at [*MATHEMATICA OR COMAGINE HEALTH*]. I am joined by *[INTRODUCE NOTETAKER].* We are conducting a study for Better Health Together to assess community perspectives on care coordination in Ferry, Stevens, Pend Orielle, Lincoln, Spokane and Adams Counties.

The purpose of our call today is to gather nuanced perspectives from people with unique roles in coordinating health care and community social services to meet residents' needs. Your insights and participation will directly feed into a roadmap, or plan, that will chart the course ahead to help us collectively achieve a meaningful, community-based care coordination system. To respect participants' confidentiality, please do not share information we discuss with people outside the group.

2. Time Commitment

We'll spend about [*ONE HOUR/THIRTY MINUTES*] together for this [*FOCUS GROUP/INTERVIEW*].

3. Voluntary Participation

Your participation in this [*FOCUS GROUP/INTERVIEW*] is voluntary. If you don't want to participate, it is OK. If you agree to participate, you can decide not to answer any question and can stop at any time. Your decision about whether to participate in this study or to answer any specific questions will in no way affect your job or any services that you receive. If you do choose to participate, please answer the questions honestly and openly, so that we can understand your experience and find out what you really think.

4. Confidentiality

The information you provide will be strictly confidential and never connected to you. Other people will not know if you participated in the interview or focus group or what you have said.

5. Uses of the Data

Only the researchers from the Mathematica-Comagine Health team will have access to the information you provide. We will share the combined information we gather with Better Health Together in a summary report but will never use your name and no one will ever know what answers you gave. All the information we gather will be stored securely under the care of the lead researcher. We will destroy the information at the end of the study.

6. Risks & Benefits

Your participation in this [*FOCUS GROUP/INTERVIEW]* may not benefit you directly, but it may benefit others, as your responses may help improve care coordination in Eastern Washington. We do not see any risks from your participation.

7. Recording

We would like to record this discussion as a backup to our notes. The recording will not be shared with anyone beyond the researchers conducting this study and will be destroyed after we complete our summary report.

Is it okay with you if we record?

8. Verbal Consent and Contact Information

We're happy to answer any questions you have about participating in this [*FOCUS GROUP/INTERVIEW*]. You can ask questions at any time [*FOR FOCUS GROUPS:* by private chat] during this discussion.

Do you have any questions now?

Do you understand everything I have explained?

Do you agree to participate in this [*FOCUS GROUP/INTERVIEW*]?

[*FOR FOCUS GROUPS ONLY]* Please indicate your agreement with a thumbs up or down, in chat or verbally by taking yourself off mute

You may also contact easternwacarecoord@mathematica-mpr.com if you have any questions or concerns after our discussion.

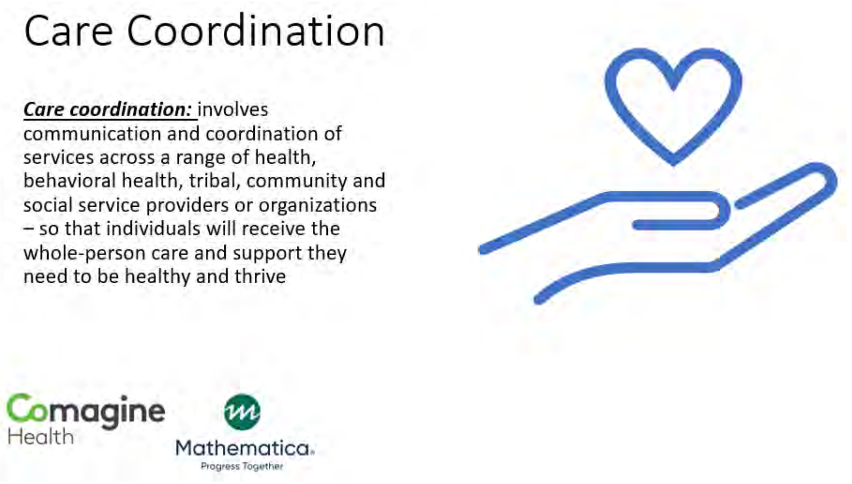
We will share a copy of this information by email following our meeting.

Notetaker: responsible for interview recording if consent = yes

a.. Community-based care coordination definition

Before we get started, I want to acknowledge that the concept of care coordination is not new; it has long been practiced in Indigenous and Asian communities. And today, as I mentioned, we're trying to learn more and identify potential ways to improve care coordination on a county and cross-county level.

Exhibit D.3. Slide 3



Care Coordination

Care coordination: involves communication and coordination of services across a range of health, behavioral health, tribal, community and social service providers or organizations – so that individuals will receive the whole-person care and support they need to be healthy and thrive

Comagine Health

Mathematica

Progress Together

I'd like to start by asking what words or phrases come to mind when you hear the term whole-person care?

We want to make sure we have a common understanding of care coordination that reflects the perspectives of the community.

"Care coordination involves communication and coordination of services across a range of health, behavioral health, tribal, community, and social service providers or organizations -- so that individuals will receive the whole-person care and support they need to be healthy and thrive."[2]

I recognized that this definition may or may not be the same for counties in Eastern WA. Does this definition resonate with you? Why or why not?

---

[2] Connect2 Community Network. https://www.healthierhere.org/cie/

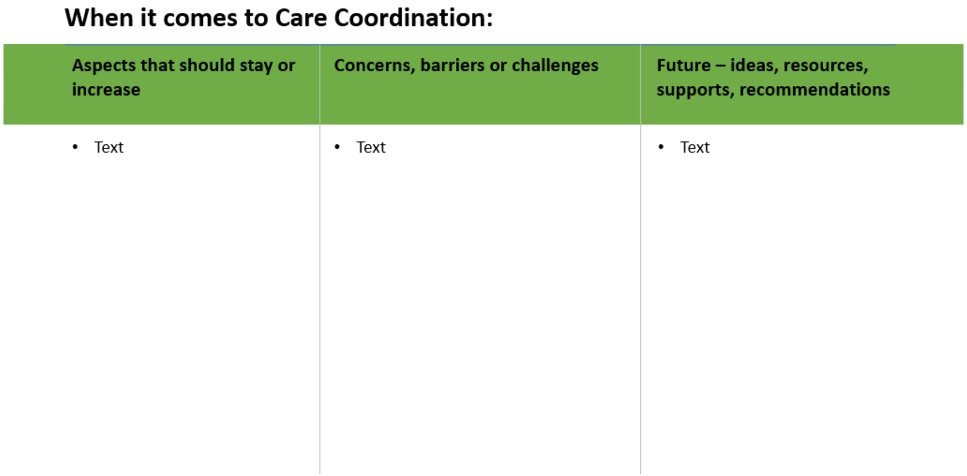
9. Providers' perspectives on care coordination in and around Eastern WA

[The table format activity and the journey mapping activity are options to do in place of question/answer format. Selection will depend on the interviewee organization(s) and amount of time scheduled.]

Exhibit D.4. Suggested use of Activity 1 Table Format vs. Journey Map Activity

Activity 1 Table Format	Journey Map Activity	Question & Answer Format
Best suited for small group or focus group setting with organizations of different types or specialization. Can be used for interviews less than 60 minutes.	Best used for small group or individual (same organization or 2 organizations that work together for referrals or care coordination of client). Recommend at least 60 minutes for this activity.	Best used for small group or focus group interviews; more than one organization is attending. Recommend 45 – 60 minutes. Customize & prioritize questions according to the organizations interviewed.

Slide 4 [Optional Activity 1, table format]



When it comes to Care Coordination:

Aspects that should stay or increase	Concerns, barriers or challenges	Future – ideas, resources, supports, recommendations
• Text	• Text	• Text

Keeping in mind the definition we discussed earlier, what does care coordination look like within the communities you serve?

Could you please describe your experiences with care coordination?

What care coordination processes currently work well for your organization?

Can you describe an experience or current process that you consider a strength in the current care coordination landscape?

- What resources or support systems are currently in place that help with care coordination?

Will you please describe any barriers or challenges you experience when trying to facilitate care coordination for your client (or patient)?

- Are there additional resources or training that would be helpful in coordinating care for people underserved by health and supportive services?
- Does your organization have enough staff to support care coordination activities?

Do the service providers you make referrals to understand what is needed to make successful referrals that meet individual’s needs? What obstacles do you encounter when making referrals to other organizations?

After making a referral, does your organization follow-up with individuals to confirm they connected with the relevant services?

- If not, why not?
- If yes, what areas could improve the process or better support your role in care coordination?

After making a referral, is there someone who communicates with the receiving organization to coordinate next steps for the individual?

Does your organization have the right partnerships to address whole-person care needs?

- If yes, can you please describe these partnerships? What makes these partnerships “right”?
- If not, which partners are missing?

10. Patient Perspectives with care coordination in and around Eastern WA

Slides 5, 6, 7, 8 [Optional Activity 2, patient journey mapping]

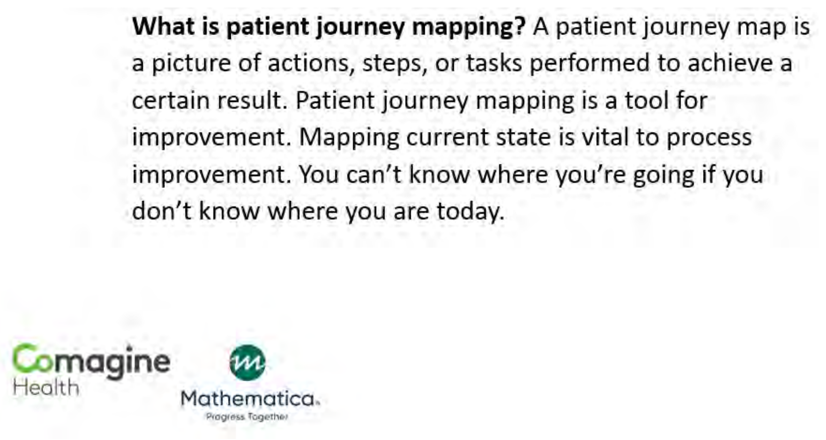
Identifying current state care coordination workflow - “Patient Journey Mapping” (Providers)

a. Slide 5: What is a patient journey map?
[Share a brief overview of journey mapping and describe how the following questions and discussion will help create a similar journey map and help to identify gaps in coordination and service.]

[Script] A patient journey map is a visual aid to help us capture all the different steps, challenges, and nuances patients face. The map will reveal what coordinators need to consider when coordinating care and opportunities for improvement.

[Script] Let’s shift to discussing a patient’s journey with care coordination with your organization. We’ve discussed some processes that currently work for you, now let’s take a deeper dive into what that process looks like from the patient’s perspective.

Exhibit D.5. Patient Journey Mapping

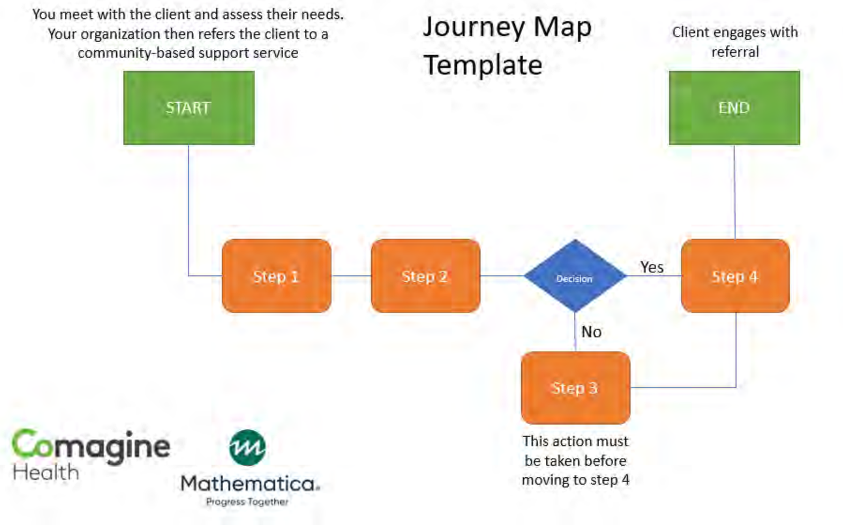


What is patient journey mapping? A patient journey map is a picture of actions, steps, or tasks performed to achieve a certain result. Patient journey mapping is a tool for improvement. Mapping current state is vital to process improvement. You can’t know where you’re going if you don’t know where you are today.

Comagine Health

Mathematica
Progress Together

Exhibit D.6: Review sample process flow mapping



b. Slide 7, 8: Table to Identify Steps, Decisions, and Barriers

[Script] Think of a recent experience you've had with someone who represents the population your organization typically serves. Now what happens once this individual gets a referral from your organization and how do they reach the end goal?

Request a volunteer to discuss a common scenario or client referral that is made with their organization.

[Facilitator or notetaker types in notes as the participants identify steps after a referral is made for a patient/client.]

[Script] Walk me through how your agency would address this patient's needs. Start from the beginning when initial contact is made.

- What are the potential services that you are aware of in Eastern Washington that are available to help this person?
- Which role or staff member is responsible for initiating a referral?
- Which role or staff member is responsible for receiving a referral?
- Is this program-specific?

How are referrals created and received? On paper, EHR, other reporting system?

- What are the facilitators and barriers to your and/or your organization's methods?

Is this the ideal method for your organization?

- If no, what is the first thing you would address?

What components of your workflow or processes are specific to the community you serve?

- What considerations would help you better serve your community?

Exhibit D.7. Slide 7. Table to Identify Steps

START	Your Organization meets with the client and identifies a [need]	
	Step Description	Decisions/Barriers
Step 1		
Step 2		
Step 3		
Step 4		
Step 5		
Step 6		
Step 7		
Step 8		
Step 9		
END	YAY! Client reaches their referral	

Exhibit D.8. Slide 8. Decisions and Barriers

END	After the client reaches the referral appointment	
	Step Description	Decisions/Barriers
Step 1		
Step 2		
Step 3		
Step 4		
Step 5		
Step 6		
Step 7		
Step 8		
Step 9		

11. Personal Experiences

Please think about an experience that you had seeking out services in your community for yourself or a friend or family member. I'd like you to think about your last process receiving a referral, examples include - medical/health, community-based, social service referral, or any process you would feel comfortable sharing. Think about how you used the agency you were referred to. As you speak to this experience, think back on your definition of whole person care. [*Allow person to share their experiences.]*

What went well?

What were some of your areas of frustration about the care coordination and referral processes?

What was missing?

On a scale of 1-5, how would you rate the referral process you experienced, with 1 being very easy and 5 being very challenging? Explain your rating.

12. Communications between organizations and considerations for the Community Information Exchange (CIE)

How do you currently share or communicate with a partner organization during and after a referral is made?

- Does this vary based on the partner organization? If so, how?
- What is the most common pathway you use to share or communicate with a partner organization during and after making a referral?
- What current barriers do you experience when communicating with a partner organization or the individual receiving the care coordination?
- What current processes work for you?
- Would a shared portal like a Community Information Exchange (CIE) help improve communication process between you and partner organizations?

13. Perspectives and priorities for future, community-based care coordination

What are the priorities for the future of care coordination in the communities you serve?

What are the top 3 most pressing concerns/priorities for the future of care coordination in those communities?

How do you imagine the future of care coordination for your community?

Are there aspects of the current care coordination landscape that should stay?

What are some recommendations to improve care coordination in the communities you serve?

- What improvements can your organization contribute to?
- How can partners improve the care coordination process?

What additional support does the community need to improve care coordination?

- Are there any specific institutions or entities that can provide this support? If so, what are they?

14. Closing

Is there anything else you would like to add about care coordination in Eastern Washington?

Thank you so much again for your time. We really appreciate your insight.

Our team is going to take the feedback that you and others provided and use it to create our roadmap and recommendations. We hope to share our findings with you in the future. In the meantime, please feel free to reach out if you have any questions.

B. Interviews and Focus Groups Analysis Summary Write-Up

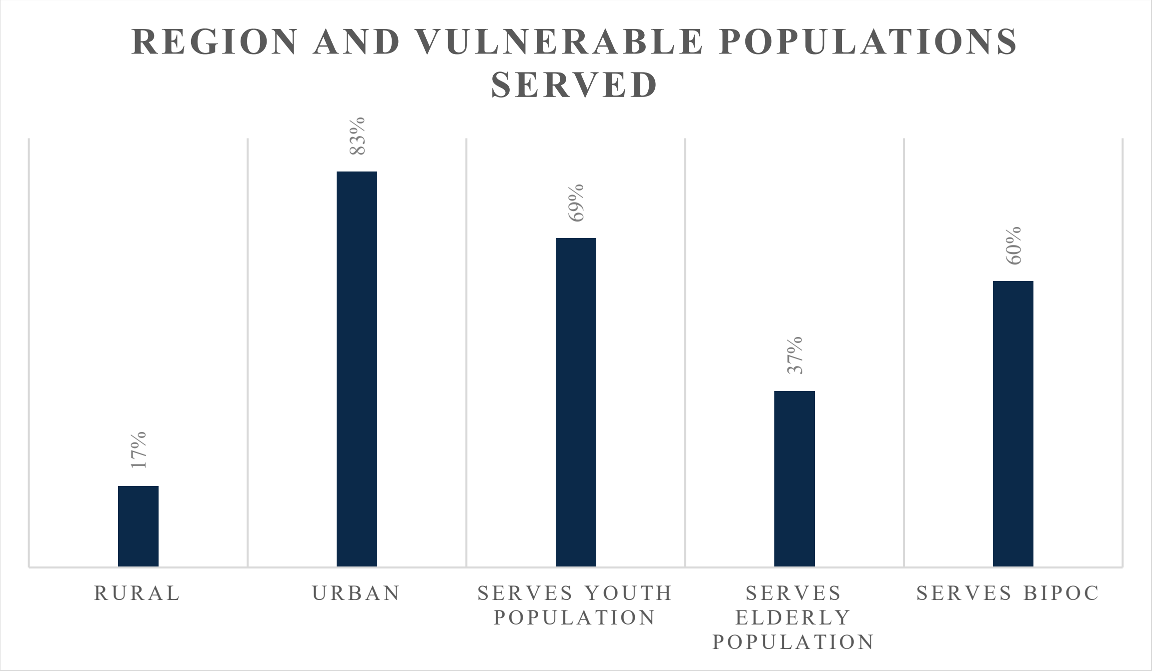
a. Data cleaning methodology

- For each discussion we had a note taker, a recording, and an automated transcript created by our recording software, Zoom.
- We exported notes and transcripts from each interview and focus group into post-it notes on Mural. Each post-it represents a summarization of the discussion and distinct quotes from the respondents taken from the transcript.
- On the Mural board, the research team first organized data by the interview protocol questions.
- The team then used deductive reasoning to code the data into broad categories.
- The team then shared these categories with the Data and Survey Advisory Board and Better Health together for a co-interpretation of data.
- The team then used an inductive approach to identify additional themes that emerged within the broad categories. Click here to access the final Mural board.
- In this summary, the team focused on identifying patterns based on organization type and populations served.

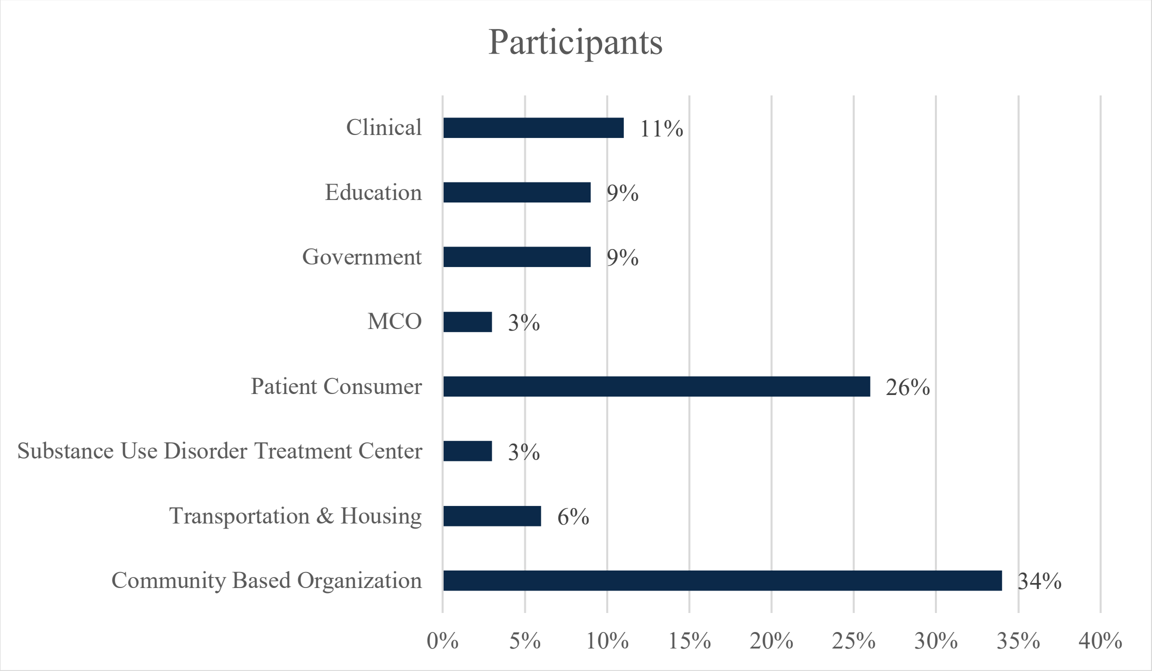
b. High-level findings

Participants interviewed varied from patients to service providers at the community and county levels throughout Adams, Lincoln, Ferry, Stevens, Pend Oreille, and Spokane counties. The sample size included a total of 39 participants from 4 Focus Groups & 12 Individual Interviews (single organization or patient consumer). The participants provided perspectives specific to rural (6) and urban (29) parts of Eastern Washington. We heard from 24 organizations and consumers that represented youth and 13 that represented elderly populations. Among the participants, 20 served or were part of the BIPOC population of Eastern Washington and one participant represented a Tribal specific organization. See Exhibit D.9 for more information.

Exhibit D.9. Participant demographics



Note: some participants are counted more than once for serving multiple groups



Note: some participants are counted more than once for serving multiple groups

Through the co-interpretation we identified 5 key findings into which we further aggregated our data. These five findings included both community needs and solutions that are currently in place to address identified needs.

Community Needs. Participants identified the wide scope and range of service delivery methods required to provide care coordination to deliver whole-person centered care. Participants emphasized the barriers that consumers face in getting care due to duplicative application processes, income thresholds, and long wait times for services.

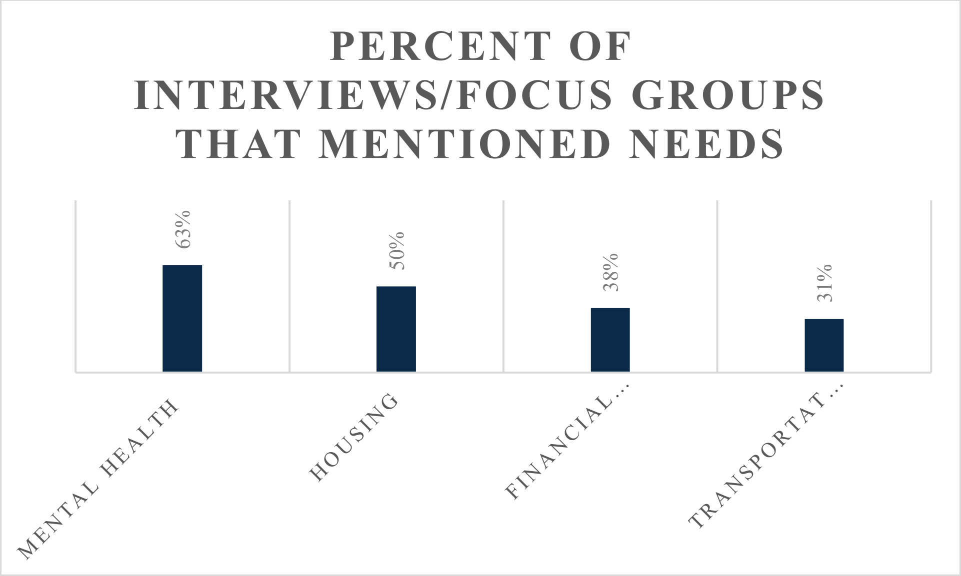
Participants identified the lack of staff capacity, in terms of skills needed to address community needs, and quantity as a barrier to providing whole-person centered care.

Recommendations shared by participants. Participants identified the expanding role of technology in care coordination and how it can either improve or limit the ability for communities to receive care. Participants identified relationship building as an asset to getting needed support and resources and a major barrier when partnerships and trust are lacking.

Finding 1: Participants identified the wide scope and range of services required to provide care coordination to deliver whole-person centered care.

All participants felt whole person care is required to provide appropriate care coordination. Participants stressed the need to provide support to individuals beyond physical care as a means of creating a sustainable and “person-centered” approach to care coordination. Across all conversations, participants mentioned mental health support, housing, and financial stability as community needs frequently requested in care coordination. To ensure equitable access to these outcomes, participants also stressed the importance of providing means to transportation for consumers that needed assistance reaching services and appointments. Exhibit D.10 shows the frequency that certain community needs were mentioned in the discussions.

Exhibit D.10. Frequency of community needs



Addressing mental health needs was the most common need that participants discussed (10 out of 16 discussions). This was followed by access to housing (mentioned in 8 out of the 16 discussions) and financial independence (5 out of 16 discussions).

"The first priority is mental health- there is always trauma that has led to homelessness. There are a lot of people who are leaving domestic violence. We really need to make it known that mental health is normal." ~Representative from community organization serving urban, BIPOC, and youth populations
"People entering homelessness should be able to exit in a quick amount of time. they need places to exit to - so more housing." ~Youth, urban
"Working with seniors in long term care, it's more focused on long term care planning. What needs to happen to keep people in their home as long as possible. Also depends on resources at your disposal." ~ Representative from a community organization serving elderly populations in rural and urban areas
"Add financial status or aspects in a person's life. I have to help this part of them[consumer] as well and not just the health and social services." ~ Representative from tribal serving organization

While the goals of care coordination were similar across populations, organizations, and consumers, delivery methods and barriers varied. Geography, mental health, age, and past criminal records presented a challenge in finding housing, healthcare, and other social services. For example, the conversations with youth consumers revealed the challenges in using criteria such as trauma scores to determine housing program eligibility and income thresholds under Medicaid to determine eligibility for mental health services.

"The scoring system should be changed so we're not comparing the trauma score of a 15-year-old who's recently entered homelessness to an adult with many years of homelessness and a much higher trauma score." ~Youth, urban, LGBTQIA consumer discussing their application for housing
"How much money you make or income you have – someone with low income could not get the support they needed. Example: suicide attempt with pills – person could not get the care they needed because they did not meet the income criteria." ~ Youth, rural consumer

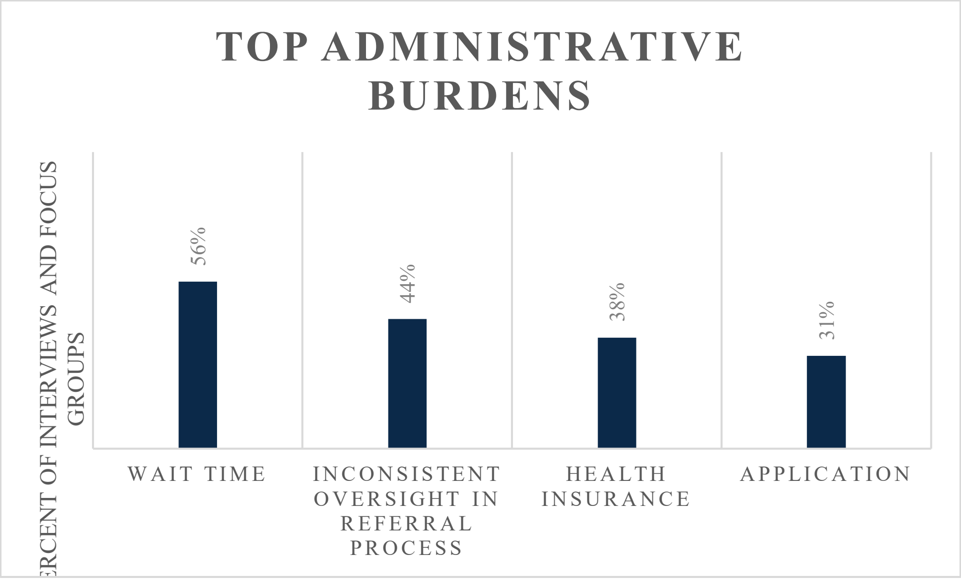
On the other hand, communities working with aging populations identified that more serious health needs, such as dementia, created a barrier due to a shortage of services that address the consumer's needs. The lack of services became more disparate if the aging consumer has a criminal record and needs nursing care.

"The other thing was for the homeless population and the sex offenders. Facilities that can manage those patients that need nursing care. We really don't have facilities that will accept those patients." ~ Representative from a clinic serving BIPOC populations in rural and urban settings

Finding 2: Participants emphasized the barriers that consumers face in getting care due to duplicative application processes, income thresholds, and long wait times for services.

All 16 conversations included a discussion around barriers to access. There were several themes that surfaced when it came to administrative burdens around applications, inconsistent referral oversight, delays in service delivery and inequitable eligibility criteria. The most common challenge to care delivery mentioned was the wait time between initial outreach and service delivery (9 out of 16 discussions). Exhibit D.11

Exhibit D.11. Frequency of barriers to accessing services



Wait Time. Consumers described frustrations in the length of time it took to receive resources they applied for. Meanwhile, providers expressed frustration over the delays in response time after referrals were made.

> *"Access to mental healthcare has a long waiting period, almost 3 month or longer."*
> ~Rural youth consumer

Inconsistent oversight in referral process. On the provider side, the challenge with so many applications meant more tracking work, oftentimes having to look across multiple data systems or connecting with various organizations. Due to having to work across organizations, there was a lack of oversight. In other words, there is no standardized communication loop system and no one person or agency managing all referrals across organizations. This resulted in service delivery stalling and distrust in the system from--both the consumer and provider side.

> *"Most providers operate within silos, and there's no accountability. The people dropping through those huge crevices are the ones we're catching. I don't think there is a care coordination happening in our community. If there is, it's impacted by nepotism, gatekeeping, because it's led by white-led agencies that are trying to support a diverse network but doing so in a manner that creates divisiveness on the ground because of favoritism or nepotism. The white entity is of value."*
> ~ Representative from community organization serving BIPOC, youth, and tribal communities

"A community member can call and be transferred to the service that exists in their community. It can take weeks for a community member to make calls to several agencies to find the service they need and qualify for."
~Representative from community organization serving youth, elderly, BIPOC populations

Health insurance. One of the most common barriers discussed was health insurance limitations around the lack of reimbursement options for services outside of basic physical health. For organizations providing whole-person care models, this was challenging because services such as transportation, nutrition, feminine hygiene products, dental and non-traditional therapeutic interventions were not reimbursable.

Income eligibility under Medicaid, Medicare coverage, and assessment risk scores presented a barrier for consumers to access care unless they were in a crisis, creating an unsustainable model for maintaining a long-term solution for the consumer. As a result, consumers who did not meet eligibility criteria were disadvantaged.

"Access to non-traditional therapeutic interventions, e.g., nature or food as therapy. These don't exist in a billing system for Medicare or Medicaid. Not sure we want this anyway because of the restrictions that come with that. Looking at ways the organization can be sustainable and continue the work we're already doing."
~ Representative from community organization serving youth and tribal communities

"There's a need for a lot of political advocacy. For instance, Medicare doesn't have a whole person concept (don't cover dental and mental). There are smaller barriers, like not having chore volunteers, but the big ones really take time to dig through. With [dental non-profit], a lot of barriers are political (for instance, fluoride, health equity). Lack of providers (e.g., dental), especially willing to take certain insurance."
~Representative from community organization serving elderly populations in rural and urban settings

Applications. The application process presented two challenges for service providers and consumers. For consumers, the challenge was in having to fill out multiple applications to apply for service eligibility. In some cases, such as the needs assessments, these applications would be retraumatizing for the consumer filling it out. During two focus groups, participants explained they experienced this when applying for services where level of trauma score determines eligibility.

"Clients have to call and act like it is the worst day of their life just to get seen. That is not trauma-informed."
~ Representative from community organization serving urban, BIPOC, youth

Finding 3: Participants identified the lack of staff capacity, in terms of the experience and skills needed to empathetically address community needs and quantity of staff as a barrier to providing whole-person centered care.

During 11 of the conversations, participants identified staff capacity as a need for continuing their work and improving their services. It was either presented as an issue with hiring and retaining staff (6 discussions), staffing training (6 discussions), or both (one discussion). Participants expressed the need to hire staff across all sectors of the care coordination system, in particular front line workers and care coordinators. Participants identified limits of funding and difficulty finding qualified staff with relevant lived experiences as barriers for hiring more staff. Participants stressed the importance in staffing systems of care with personnel that had lived experience and the ability to provide care with an empathetic lens. Consumer interviews aligned in this mindset in stating that empathy was important to them when seeking care and empowering them to self-advocate.

> *"Have a team of people who have lived experience, have navigated multiple systems, have an understanding of needs and barriers. Instead of putting the burden on the individual to heal themselves, which is a volatile system (education, healthcare, etc.). Making sure they have advocacy within those spaces, but can also self-advocate."*
> ~ Representative from community organization serving urban, youth, BIPOC populations

Several interviews mentioned that language played an important role in gaining consumer and community buy-in.

> *"We need more specific language (e.g., disabilities, bipoc, lgbtq+) that's mentioned rather than implied -the intentionality around changing those things is what's important, but a starting place is making sure its reflected in language."*
> ~Youth, urban

Additionally, participants felt training in cultural competence and addressing stigma around mental health, incarceration, sexual orientation and identity, and homelessness was needed across all levels of care, from delivery to administrative and policy levels. Two conversations offered suggestions on how using a strength-based model and motivational interviewing helped make the care provider focus on consumers' personal goals.

When discussing service delivery with a tribal organization, they expressed the need to work together with the consumer to beyond the initial ask. One example that was mentioned was the situation in which a couple reached out to the tribal organization to seek help with housing. The participant explained that in the process of helping them get housing, it was also a best practice in their care coordination to discuss other factors that would help them thrive in the community.

Finding 4: Participants identified the expanding role of technology in care coordination and how it can either improve or limit the ability for communities to receive care.

When discussing technology, participants discussed the integration of communication technologies, such as Zoom, email, and phone calls in the care delivery process (9 out of 16). Communication technology was typically used for following up with organizations, providers, and consumers after the initial contact with the consumer. Phone calls were the most common form of communication overall.

> *"People rely on oral communication (even in the social media age) and are more comfortable with personal connections. What works best is listening to people to find out who the best person is to connect to rather than sending them to an 800 number (people don't like feeling stupid, talking to an 800 number)."*
> ~ Representative from community organization serving urban, youth, elderly and BIPOC populations

However, the reliance on phones still presented a barrier for some consumers. Even if a client had access to a phone, it sometimes took weeks to connect with different agencies to find the service they needed and are qualified for. This can also occur when an organization is seeking additional services to support a community member.

> *"A community member can call and be transferred to the service that exists in their community. It can take weeks for a community member to make calls to several agencies to find the service they need and qualify for."*
> ~ Representative from community organization serving urban, youth, elderly, and BIPOC populations

The use of online communication (Zoom, online training) revealed an apparent divide between rural and urban care delivery services. While urban communities (2 organizations) were able to transition to more online platforms during the pandemic, rural communities struggled. For organizations serving rural and tribal communities, broadband limitations prevented providers from accessing online training, telehealth services, and other services requiring online applications (3 organizations).

> *"We need to find solutions unique to rural areas. In larger cities people just need to know who to call; in rural areas, it's not just a phone call, there's a huge divide. In rural populations, libraries should get funding because that's where people go. They're really good at focusing on information and how to find it. They provided telehealth kits with laptops during the pandemic, so people did telehealth visits from their cars."*
> ~ Representative from organization serving urban and rural populations

That said, many people were not used to using online services, particularly recently incarcerated individuals.

> *"Education and Technology. Most people don't know how to navigate technology when they are released from prison. Even with something as simple as completing an application online."*
> ~ Representative from community organization serving urban, rural, and BIPOC populations

Several providers discussed the need to improve broadband access and make online services more available, particularly after COVID moved many services online. One organization started to provide creative solutions during the COVID-19 pandemic such as providing telehealth kits with laptops to clients in a rural region for telehealth visits from their cars.

In addition to communication technology, participants discussed the use of shared databases like a Community Information Exchange (CIE). As mentioned above, referral oversight was one of the common frustrations among participants. While some participants felt a CIE would be effective in closing knowledge and communication gaps in the referral process (2 discussions), others expressed concern over the lack of a consistent tracking referral processes (2 discussions). Organizations were worried that privacy issues would create access issues such as firewalls and data sharing policies that make it hard to share certain consumer information (2 organizations).

> *"After the pandemic, email became really important. Maybe there is more detail that can be conveyed, but they may not want to record that information in the chart. They work really hard to protect client confidentiality."*
> ~ Representative from community organization serving rural and urban elderly populations

On the consumer side, consumer participants expressed the desire to have access to their data and be able to update it. During a discussion with youth consumers, the participants expressed the desire to have access to update data in the chance that they moved or change their phone number.

> *"Make sure that databases across the board can actually be accessed - have outreach workers and case managers be able to access the data. If we have one main system, people [patients] should have the ability to update their data… I just remember getting an email address – if they don't have that email anymore, how am I going get a hold of them?"*
> ~ Youth, urban

Finding 5: Participants identified relationship building as an asset to getting needed support and resources and a major barrier when partnerships and trust are lacking.

During the discussions, we asked participants to share what they felt the areas of strength were in the current care coordination systems in their communities. In all discussions, there was a common consensus over the importance of fostering positive interpersonal skills (relationship with other people) and intrapersonal skills (personal thoughts and perceptions of others). Participants also shared barriers that presented obstacles to building strong partnerships and relations that would enable more effective systems of care. Exhibit D.12 below summarizes findings that were shared during the discussions. It is organized by the relationship skills mentioned by consumers and providers as important in ensuring high quality care coordination services.

Exhibit D.12. Interpersonal and intrapersonal skills and barriers, with common themes shared by consumers and providers in bold.

	Interpersonal skills (person-person behaviors and mindsets to guide care coordination)	Intrapersonal skills (self-perceptions/behaviors needed in care coordination)	Barriers
Consumer	• Trust in providers • **Sense of support by community**	• **Self-efficacy** • **Motivated**	• Stigma from community • **Feelings of hopelessness** • **Distrust in system from past/current experiences**
Provider	• Empathy when working with consumers • Cultural awareness • Trauma-informed • Trust within organization and with other agencies • **Sense of support by community** and policymakers.	• **Motivated** • **Self-efficacy** • Awareness of cognitive bias	• Limited training in understanding population needs (particularly limited learned experience) • Emerging/nascent awareness of cognitive bias • **Feelings of hopelessness and being overwhelmed** • **Distrust in system from past/current experiences** • Siloed system structures.

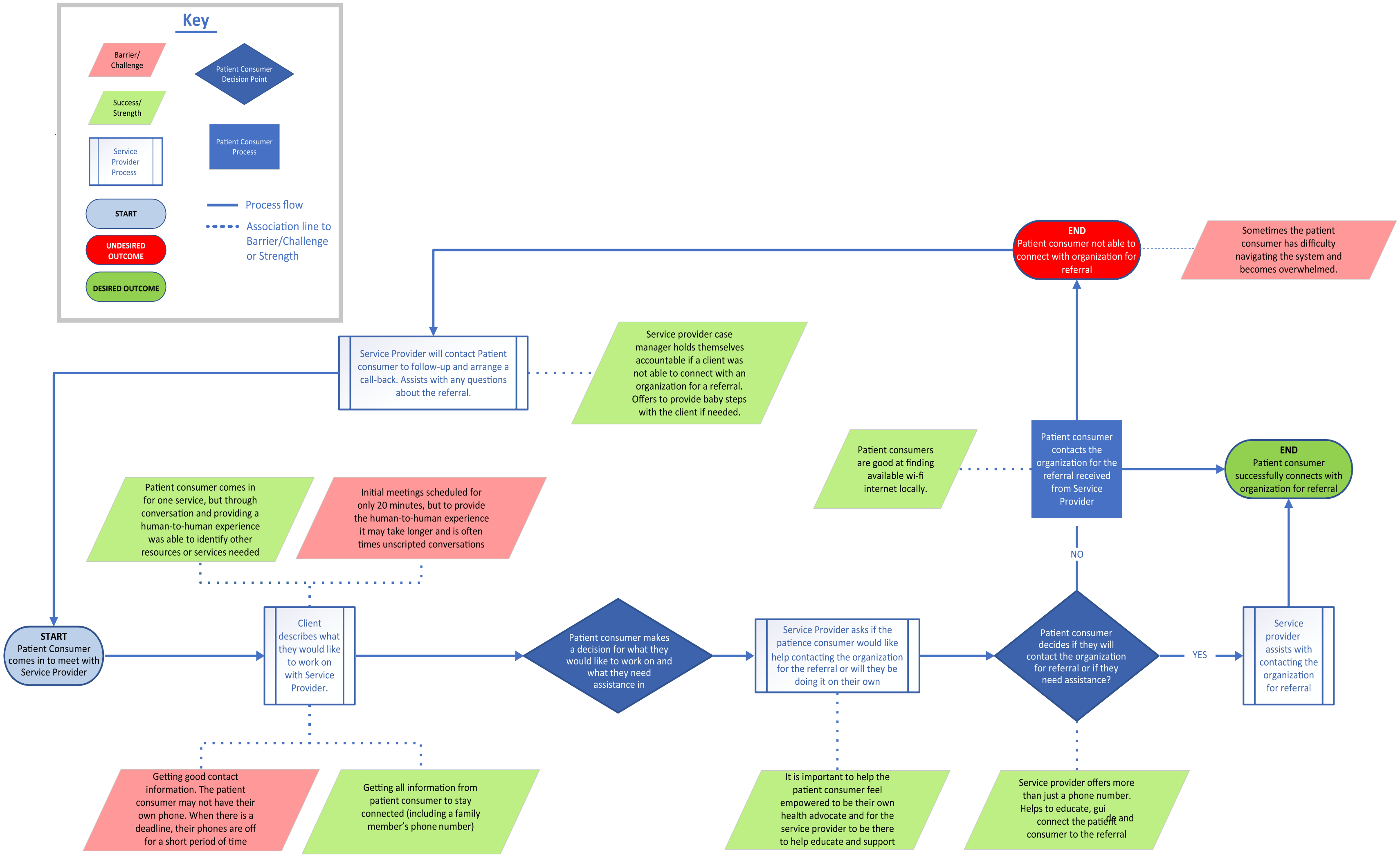
Participants offered suggestions for how both providers and consumers could foster the skills mentioned above. For example, all discussions mentioned a need to improve how providers empathize and support consumers. The most common approach to improving support was to make care coordination more accessible and personalized. Examples included home visits, providing day care options for parents, intergenerational counseling, peer support, community outreach, and counseling methods such as motivational interviewing.

> *"We start with the member. I always start personally. One of the biggest challenges is to acknowledge bias. For example, when professionals call people drug seekers. It is implying we have a bias toward individuals. One of the barriers is a provider with biases. For me, it's hard to believe you can provide quality care to someone you are biased against. Some clients will not follow the treatment plans but then you need to do interventions you have to have providers in place that are well interventions. Provider bias can really get in the way."*
> ~Representative from community organization serving urban youth, elderly, and BIPOC populations

C. Patient Journey Maps

D.13. Community Based Organization Patient Consumer Journey Map

This patient consumer journey map combines data from an interview from a community based organization and includes strengths, barriers and challenges discussed. The recommended way to review this visual is by beginning at the Start oval and following the patient consumers journey to the end, or detours that are possible in the process showing as a challenge or barrier.



START Patient Consumer comes in to meet with Service Provider

Client describes what they would like to work on with Service Provider.

Patient consumer comes in for one service, but through conversation and providing a human-to-human experience was able to identify other resources or services needed

Initial meetings scheduled for only 20 minutes, but to provide the human-to-human experience it may take longer and is often times unscripted conversations

Getting good contact information. The patient consumer may not have their own phone. When there is a deadline, their phones are off for a short period of time

Getting all information from patient consumer to stay connected (including a family member's phone number)

Patient consumer makes a decision for what they would like to work on and what they need assistance in

Service Provider asks if the patience consumer would like help contacting the organization for the referral or will they be doing it on their own

It is important to help the patient consumer feel empowered to be their own health advocate and for the service provider to be there to help educate and support

Patient consumer decides if they will contact the organization for referral or if they need assistance?

Service provider offers more than just a phone number. Helps to educate, guide and connect the patient consumer to the referral

Service provider assists with contacting the organization for referral

END Patient consumer successfully connects with organization for referral

Patient consumer contacts the organization for the referral received from Service Provider

Patient consumers are good at finding available wi-fi internet locally.

END Patient consumer not able to connect with organization for referral

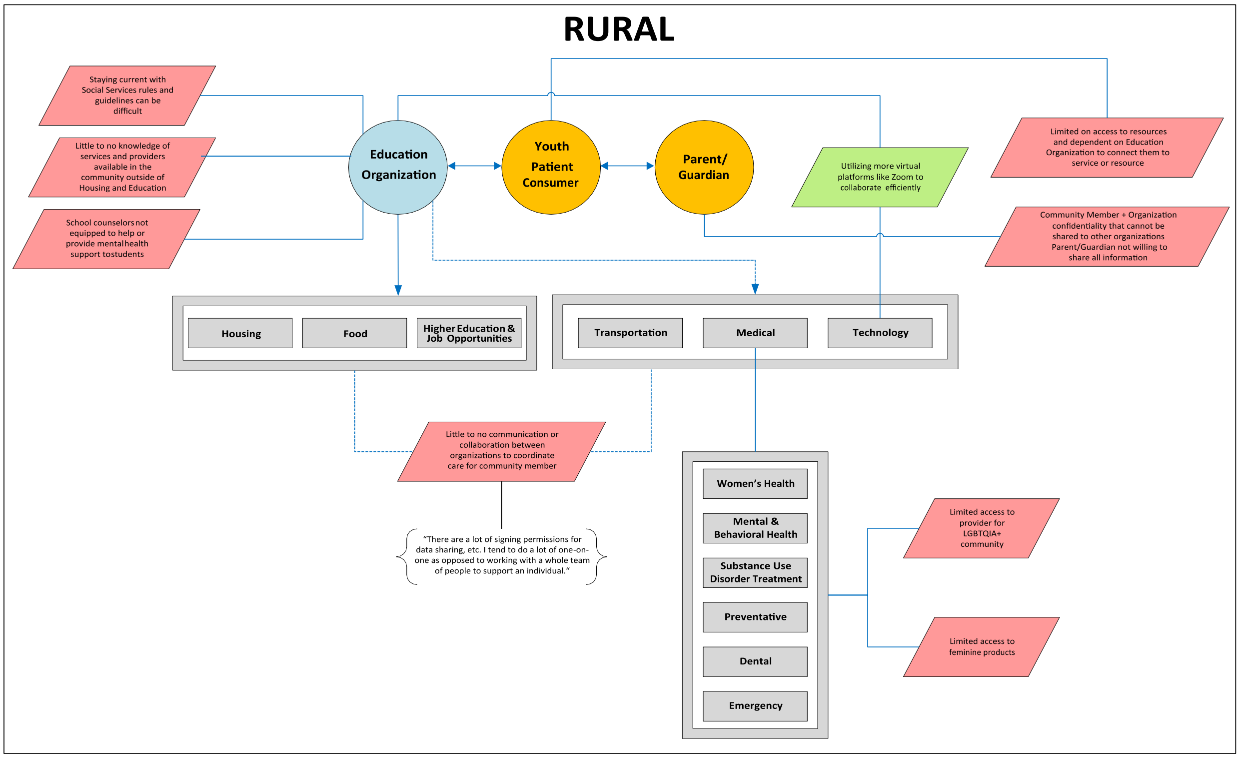
Sometimes the patient consumer has difficulty navigating the system and becomes overwhelmed.

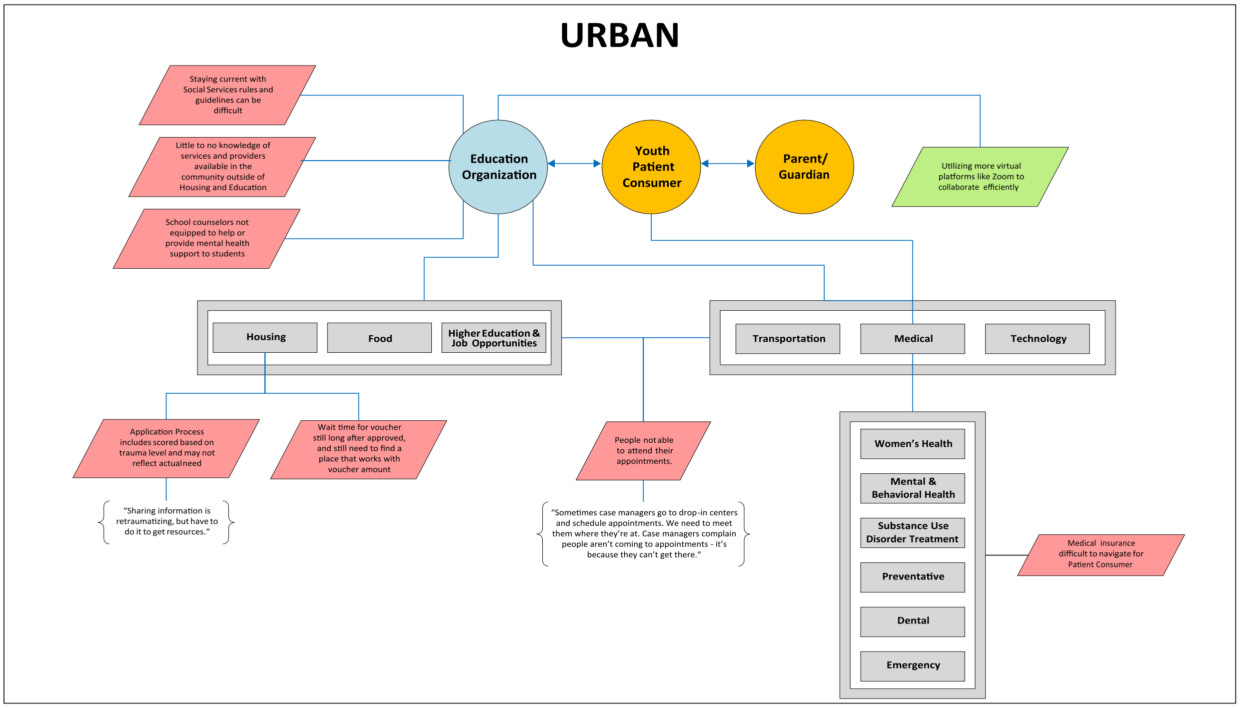
Service Provider will contact Patient consumer to follow-up and arrange a call-back. Assists with any questions about the referral.

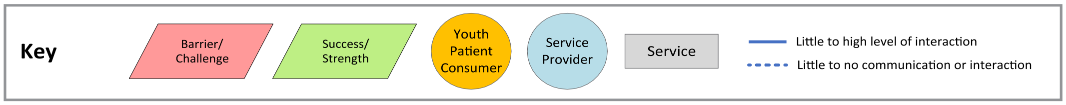
Service provider case manager holds themselves accountable if a client was not able to connect with an organization for a referral. Offers to provide baby steps with the client if needed.

D.14. Education Organization and Youth Patient Consumer Network Map

This network map combines data from interviews with education providers and youth patient consumers from both rural and urban regions. It is different from a patient journey map where it shows the connections, barriers/challenges and strengths between the different people, places and things.







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Appendix E. Survey

A. Survey instrument

Eastern Washington Care Coordination Survey

This survey is sponsored by Better Health Together and will be used to learn more about your perspectives on organizational capacity for care coordination and opportunities for improvement. Survey findings will play an important role in helping develop a roadmap report to inform short- and long-term strategies for community-based care coordination.

The survey will take about **15-20 minutes** to complete. Please complete this survey if your service area includes any of the following counties: **Adams, Lincoln, Ferry, Stevens, Pend Oreille, or Spokane.** Please answer each question to the best of your knowledge.

You will also have the option to select "Save and Continue Later," which will ask for your email and send you a unique link to the survey. Please check your junk/spam folders if it does not go directly into your mailbox.

Survey responses are confidential, secure and anonymous. We will not attribute them to specific individuals or organizations. The data will only be reported in an aggregated form. Participation is voluntary and will not affect your job.

All the information we gather will be stored securely under the care of the lead researcher. We will destroy the information at the end of the study.

While your participation in this survey may not benefit you directly, it may benefit others by improving care coordination in Eastern Washington. We do not see any risks from your participation.

As a thank you for participating, you will receive a **$10 Amazon gift code** sent via email. We will not share your email address with third parties.

If you have questions about the survey, please contact the Mathematica-Comagine Health team at easternwacarecoord@mathematica-mpr.com or Amelia Forman at (617) 715-9928.

SECTION A

ALL

A Intro. These first two questions are about your role in Eastern Washington care coordination. This includes the following counties: Adams, Lincoln, Ferry, Stevens, Pend Oreille, and Spokane.

A1. Which describes the sector(s) that you work in?

Select all that apply

☐ Health care	1
☐ Mental health or behavioral health	2
☐ Tribal health or traditional medicine	3
☐ Managed care	4
☐ Housing	5
☐ Criminal justice	6
☐ Education or schools	7
☐ Public health	8
☐ Other social/human services	9
☐ Local government	10
☐ Tribal government	11
☐ Policy or advocacy	12
☐ Other *(specify)*	99

Specify ☐ (STRING 150)

ALL

A2. What role(s) do you hold?

Select all that apply

☐	Care coordinator, case manager, or navigator (health or community services)	1
☐	Cultural navigator	2
☐	Peer	3
☐	Community health worker	4
☐	Community comadre	5
☐	Patient or consumer advocate	6
☐	Social or human service provider	7
☐	Health care provider or clinician	8
☐	Behavioral health clinician	9
☐	Policymaker	10
☐	Health care payer	11
☐	Administrator or manager	12
☐	Other (specify)	99

Specify ☐ (STRING 150)

SECTION B

ALL

B Intro. The next questions are about your perspectives on the capacity for care coordination within your organization.

Care coordination involves communication and coordination of services across a range of external health, behavioral health, tribal, community, and social service providers or organizations -- so that individuals will receive the whole-person care and support they need to be healthy and thrive.

ALL

B1. Please indicate your level of agreement with each statement about <u>your organization's</u> leadership and partnerships for care coordination in Eastern Washington.

Care coordination involves communication and coordination of services across a range of external health, behavioral health, tribal, community, and social service providers or organizations -- so that individuals will receive the whole-person care and support they need to be healthy and thrive.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
a. Our leaders are committed to working across organizations to coordinate care for people underserved by health and social services	1 ○	2 ○	3 ○	4 ○
b. Our leaders develop or maintain relationships with other key organizations to coordinate care	1 ○	2 ○	3 ○	4 ○
c. My organization commits sufficient resources to coordinate care for people underserved by health and social services	1 ○	2 ○	3 ○	4 ○
d. My organization has the right partnerships to address whole-person care needs	1 ○	2 ○	3 ○	4 ○
e. My organization's key external care coordination partners effectively collaborate with my organization to address whole-person care needs	1 ○	2 ○	3 ○	4 ○
f. My organization consistently communicates and coordinates with a range of health and social service providers to deliver whole-person care	1 ○	2 ○	3 ○	4 ○

ALL

B2. Please indicate how often the following statements apply to how direct service providers from your organization work with providers at other organizations in Eastern Washington to coordinate care.

Direct service providers are those who interact with individuals to provide health care, social services, or patient navigation support. They include clinicians, care coordinators, care managers, case managers, patient navigators, peer navigators, and community health workers.

Care coordination involves communication and coordination of services across a range of external health, behavioral health, tribal, community, and social service providers or organizations -- so that individuals will receive the whole-person care and support they need to be healthy and thrive.

	Always	Often	Sometimes	Rarely	Never
a. Direct service providers know which external organizations or providers to refer individuals to in order to meet their needs	1 ○	2 ○	3 ○	4 ○	5 ○
b. When direct service providers do not know where to make a referral, they reach out to a trusted person(s) to determine an appropriate referral	1 ○	2 ○	3 ○	4 ○	5 ○
c. Direct service providers help individuals make appointments with external providers	1 ○	2 ○	3 ○	4 ○	5 ○
d. After making a referral to an external provider, direct service providers follow up with individuals to confirm they connected with the relevant services	1 ○	2 ○	3 ○	4 ○	5 ○
e. After making a referral to an external provider, direct service providers receive feedback about resolution or required next steps for addressing the individual’s needs	1 ○	2 ○	3 ○	4 ○	5 ○
f. Direct service providers have clear roles and responsibilities when collaborating with providers from other organizations or sectors	1 ○	2 ○	3 ○	4 ○	5 ○
g. Direct service providers have access to up-to-date information about external providers to coordinate care, such as eligibility criteria, service hours, and language and access capabilities	1 ○	2 ○	3 ○	4 ○	5 ○
h. The technology system(s) direct service providers use to share information with external providers are sufficient to deliver whole-person care	1 ○	2 ○	3 ○	4 ○	5 ○
i. Direct service providers have adequate support to use technology to share information with external providers	1 ○	2 ○	3 ○	4 ○	5 ○

ALL

B3. The following questions are about care coordination in Eastern Washington to specifically address health-related social needs.

Do providers from your organization routinely screen patients for health-related social needs, such as housing stability, transportation, or food security?

○	Yes	1
○	No	0

A1 = 1-4 (health providers)

B4. Please indicate your level of agreement with the following statements about how direct service providers from your organization refer to <u>other organizations</u> to address health-related social needs.

Direct service providers are those who interact with individuals to provide health care, social services, or patient navigation support. They include clinicians, care coordinators, care managers, case managers, patient navigators, peer navigators, and community health workers.

		Always	Often	Sometimes	Rarely	Never
a.	Providers from my organization use a consistent process to refer individuals <u>to community resources to address health-related social needs</u>	1 ○	2 ○	3 ○	4 ○	5 ○
b.	Providers from my organization consult a directory to identify appropriate community resources to address health-related social needs	1 ○	2 ○	3 ○	4 ○	5 ○

B4b=1-4

B5. What directory or directories are you using?

☐ (STRING 500)

A1 = 5-9 (social service providers)

B6. Does your organization receive direct referrals from health care providers, including mental or behavioral health providers?

○	Yes	1
○	No	0

B6 = 1

B7. After receiving a referral, when does your organization's providers communicate with the individual/client's health care provider?

Select all that apply

☐ Before meeting with the individual/client	1
☐ After meeting with the individual/client	2
☐ When my organization cannot connect with the individual	3
○ After receiving a referral, we do not communicate with the health care provider	4

A1 = 1-9 (health and social service providers)

B8. Do providers from your organization routinely screen individuals for health care needs, including mental or behavioral health needs?

○ Yes	1
○ No	0

A1 = 1-9 (health and social service providers)

B9. Please indicate how often the following statement is true for direct service providers who refer from your organization to <u>other organizations</u>.

Direct service providers are those who interact with individuals to provide health care, social services, or patient navigation support. They include clinicians, care coordinators, care managers, case managers, patient navigators, peer navigators, and community health workers.

		Always	Often	Sometimes	Rarely	Never
a.	Providers from my organization use a consistent process to refer individuals <u>to appropriate health care providers, including mental and behavioral health</u>.	1 ○	2 ○	3 ○	4 ○	5 ○
b.	Providers from my organization consider an individual's <u>sexual orientation or gender identity</u> when determining where to make a referral.	1 ○	2 ○	3 ○	4 ○	5 ○
c.	Providers from my organization consider an individual's <u>race or ethnicity</u> when determining where to make a referral.	1 ○	2 ○	3 ○	4 ○	5 ○

ALL

B10. Please indicate your level of agreement with each statement about your organization's resources for care coordination.

Care coordination involves communication and coordination of services across a range of external health, behavioral health, tribal, community, and social service providers or organizations -- so that individuals will receive the whole-person care and support they need to be healthy and thrive.

		Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
a.	We often go through periods when we do not have adequate funding to support care coordination activities	1 ○	2 ○	3 ○	4 ○
b.	We often go through periods when we do not have adequate staffing to support care coordination activities	1 ○	2 ○	3 ○	4 ○
c.	We often go through periods when we are not able to meet demand for services	1 ○	2 ○	3 ○	4 ○
d.	We are able to retain a qualified workforce to support care coordination	1 ○	2 ○	3 ○	4 ○

ALL

B11. The next questions are about your organization’s use of data and technology for care coordination in Eastern Washington.

If you are not able to answer these questions, please select “Don’t know” or “Not applicable.”

ALL

B12. Which of the following processes does your organization use to <u>share or communicate</u> information with <u>external</u> providers for the purpose of care coordination?

Select all that apply

☐ Electronic system(s) that enable data sharing, messaging, and/or closed loop referrals with external partner(s)	1
☐ Electronic files are shared between my organization and external providers (such as through a secure shared site)	2
☐ Paper documents are faxed or shared between my organization and external providers	3
☐ Care coordination/case management meetings involving my organization and external providers	4
☐ Emails with external providers or other electronic messaging apart from a system used for case management	5
☐ Phone calls between my organization and external providers	6
☐ Other (specify)	99

Specify ☐ (STRING 150)

○.. None of the above, we don’t share information with external providers 7

IF B12 = 1-6 OR 99

B13. Which process(es) enable you to most effectively coordinate care?

Select all that apply

SHOW RESPONSES FROM B12 1-6, 99 IF SELECTED

A1 = 1-9 (health and social service providers)

B14. Is your organization listed in a shared directory of community resources?

○ Yes 1

○ No 0

ALL

B15. A community information exchange (CIE) is a care coordination tool that partners across sectors use to share resource directory information, contribute to a single longitudinal client record, share care team information, and make bi-directional closed-loop referrals.

Does your organization participate in a CIE?

○ Yes 1

○ No 0

B15 = 0

B16. Which best describes your organization's interest in participating in a CIE?

○ We are not interested in participating in a CIE	1
○ We are interested in exploring participation in a CIE	2
○ We are currently exploring participation in a CIE	3
○ Other (specify)	99

Specify ☐ (STRING 150)

SECTION C

C Intro. The following questions are about your perspectives on opportunities to improve care coordination in Eastern Washington.

Care coordination involves communication and coordination of services across a range of external health, behavioral health, tribal, community, and social service providers or organizations -- so that individuals will receive the whole-person care and support they need to be healthy and thrive.

ALL

C1. What does Eastern Washington need to improve care coordination?

Select all that apply

☐	Shared vision among organizational leaders across sectors	1
☐	Clearly identified staff roles and responsibilities across partnering organizations to avoid duplication	2
☐	Resources to hire, train, and retain a sufficient workforce	3
☐	Culturally responsive approaches to reach individuals underserved by health and social services	4
☐	Sufficient capacity to communicate with individuals in need of care coordination in their language	5
☐	Streamlined enrollment process for care coordination needs	6
☐	Fewer restrictions on eligibility for health services	7
☐	Fewer restrictions on eligibility for social services	8
☐	Availability of health and social services at convenient times and locations	9
☐	Affordable health and social services	10
☐	Sustainable funding for care coordination activities	11
☐	Data sharing technology that all agencies involved in care coordination have access to and can use	12
☐	Data sharing agreements that facilitate communication about individuals across agencies involved in care coordination	13
☐	Other *(specify)*	99

Specify ☐ (STRING 250)

ALL

C2. Please rank the top three improvements that would have the greatest impact on improving care coordination in Eastern Washington.

Rank up to 3, with "1" having the greatest impact

SHOW RESPONSES FROM C1 IF SELECTED

☐ Other *(specify)* 99

Specify ☐ (STRING 250)

ALL

C3. What would it take to ensure seamless care coordination across Eastern Washington so that individuals will receive the whole-person care and support they need to be healthy and thrive?

☐ (STRING 500)

ALL

SECTION D

These last questions are about the populations your organization serves.

ALL
SHOW D1 AND D2 ON SAME PAGE

D1. What are the population(s) of focus for your organization?

Select all that apply

☐ Older adults.	1
☐ Children aged 12 and under	2
☐ Adolescents	3
☐ Individuals with a disability	4
☐ Individuals with lower incomes	5
☐ Individuals with multiple chronic health conditions	6
☐ Individuals with a mental health diagnosis	7
☐ Individuals with a substance use disorder	8
☐ Individuals experiencing homelessness	9
☐ Incarcerated/Formerly incarcerated individuals	10
☐ Immigrants and refugees	11
☐ LGBTQ+ individuals	12
☐ Other *(specify)*	99

Specify ☐ (STRING 150)

○ We do not focus on specific populations and serve the community in general	13

ALL

D2. If your organization aims to serve primarily people who identify as Black, Indigenous, or People of Color (BIPOC), please indicate which groups below.

Select all that apply

☐	Black or African American	1
☐	Asian	2
☐	American Indian/Alaska Native/Indigenous/Native American	3
☐	Native Hawaiian or Other Pacific Islander	4
☐	Hispanic or Latino	5
☐	Other *(specify)*	99

Specify

(STRING 150)

○	We do not focus specifically on people who identify as BIPOC and serve the community in general	6

SECTION E

ALL

E1. Thank you for taking part in the Eastern Washington care coordination survey!

Please provide the email address where we can send a $10 Amazon gift code as a thank you.

Email Address: ☐

Your email address will only be used to send the gift code. It will not be associated with any of your responses in the report from this survey.

ALL

E Close. Thank you for completing the survey! We would also like to hear different perspectives on care coordination within your organization. **Would you be willing to forward the survey link to one other person in your organization involved in care coordination serving any of the following counties: Adams, Lincoln, Ferry, Stevens, Pend Oreille, or Spokane?** Ideally, this will be someone who has a different role than yours.

Below is some text that you can copy and paste into an email explaining the purpose of the survey:

Would you be willing to take a 15-20-minute survey about care coordination in Eastern Washington?

https://surveys.questionprogov.com/a/TakeSurvey?tt=Sp%2BnmU5uBVM%3D&cu=14

Better Health Together wants to learn more about your perspectives on organizational capacity for care coordination and opportunities for improvement. Survey findings will play an important role in helping develop a roadmap report to inform short- and long-term strategies for community-based care coordination.

A team from Mathematica-Comagine Health is conducting the survey. Survey responses will not be attributed to specific individuals or organizations. The data will only be reported in an aggregated form.

As a thank you for participating, you will receive a **$10 Amazon gift code** sent via email.

B. Detailed survey results

1. Organizational leadership and partnerships for care coordination (B1)

- Generally high levels of agreement with statements about leadership and having the right partnerships (77-99% strongly or somewhat agree). The lowest level of agreement was for “My organization's key external care coordination partners effectively collaborate with my organization to address whole-person care needs,” with only 26% strongly agreeing and 51% somewhat agreeing with this statement.

2. How direct service providers work with providers from other organizations to coordinate care (B2)

- Similar to feedback above (from B1) about effective collaboration, respondents agreed less with statements about direct service providers having clear roles, information, and processes to coordinate care (43-83% strongly or somewhat agree).
- Respondents were least likely to agree that they have sufficient technology systems to deliver whole-person care (13% strongly agree and 35% somewhat agree), and that direct service providers receive feedback about resolution or required next steps for addressing the individual’s needs (13% strongly agree and 30% somewhat agree).
- While 70% of respondents agreed that direct service providers “know which external organizations or providers to refer individuals to in order to meet their needs,” notably only 11% strongly agreed with this statement. Agreement was slightly lower among social service providers (63% agreed) than those who worked in a health sector (72% agreed) or both health and social services sector (75% agreed).
- Social service providers least commonly agreed with the statement, “After making a referral to an external provider, direct service providers follow up with individuals to confirm they connected with the relevant services” (42% agreed) than those who worked in a health sector (60% agreed) or both health and social services sector (57% agreed).

3. Screening and addressing SDOH (B3-B9, B14)

- B3. Screening patients or clients for health-related social needs was a common practice reported among respondents (85%).
  - B4. 69% strongly or somewhat agreed that “Providers from my organization use a consistent process to refer individuals to community resources to address health-related social needs”
  - B4. 56% strongly or somewhat agreed that “Providers from my organization consult a directory to identify appropriate community resources to address health-related social needs.”
  - B5. The most common directories respondents reported using were those created for internal/in-house use (24 out of 71 responses), followed by Fig Tree (13), 211 (12), and those created by payers such as the Washington State Health Care Authority (10). Others included directories produced by Washington State DOH or DSHS, the county, or for rural resources. Some respondents reported using multiple directories to identify appropriate community resources.
  - B14. Over a third of survey respondents (36%) did not know whether their organization was listed in a shared directory of community resources. However, among those who could answer this question (n=100), 95% reported that they were in a shared directory.

- B8. Screening patients or clients for health care needs was also a common practice among respondents (90%).
    - B9. 76% agreed that “Providers from my organization use a consistent process to refer individuals to appropriate health care providers, including mental and behavioral health.”
    - B9. Similar proportions agreed that providers consider SOGI (67%) or race/ethnicity to make a referral (64%). Notably, however, about 20% of those who answered the question about using a consistent process to refer individuals did not answer the questions about considering these characteristics when making referrals.
- B6. Social service providers also commonly reported receiving referrals from health providers, including mental or behavioral health providers (79%). However, communication between health and social service providers was less common:
    - B7. 44% of these social service providers reported communicating with the individual’s health care provider after meeting with the client, and 27% communicated before the social service provider met with the individual. 18% of these social service providers reported not communicating with the health care provider after receiving a referral, and 11% only communicated when they could not connect with the individual
    - Respondents could select multiple responses for items above about communicating with health providers (B7)

4. **Resources for care coordination (B10)**
    - B10. Insufficient resources, both funding and staffing, were commonly reported challenges. Similarly high proportions of respondents agreed that “We often go through periods when we are not able to meet demand for services” (80%) and “We often go through periods when we do not have adequate staffing to support care coordination activities” (81%). 64% agreed that “We often go through periods when we do not have adequate funding to support care coordination activities.” Only 57% agreed that “We are able to retain a qualified workforce to support care coordination,” of whom only 13% strongly agreed with the statement.

5. **Information sharing and CIE (B12, B13, B15, B16)**
    - B12. Phone calls were the most common means of sharing information with external providers, among survey respondents (91%), followed by paper documents (74%) and emails (66%).
        - B13. However, when asked about which of the processes enabled them to most effectively coordinate care, respondents indicated that phone calls (71% of those who use phone calls); care coordination/case management meetings (71% of those who use meetings); and electronic systems that enable data sharing, messaging, and/or closed loop referrals (79% of those who use electronic systems) were most effective.
    - B15. Over half of survey respondents (52%) did not know the answer to whether their organization participates in a CIE. Of those who could answer this question (n=79), 29% reported that they do participate.
        - B16. Those who reported their organization does not participate in a CIE were asked about interest in future participation. 50% indicated they were exploring participation (6%) or interested in exploring participation (44%). 33% did not know how to answer this question, and 17% were not interested in participating in a CIE.

6. What Eastern WA needs to improve care coordination (C1-C2)

- C1. Respondents were presented with a list of potential ways to improve care coordination and asked to select all that they thought apply to Eastern WA. The four needs respondents most frequently selected were 1) resources to hire, train, and retain a sufficient workforce (78%), 2) sustainable funding for care coordination activities (68%), 3) culturally responsive approaches to reach individuals underserved by health and social services (62%), and 4) data sharing technology that all agencies involved in care coordination have access to and can use.
    - When looking at responses by sector, “resources to hire, train, and retain a sufficient workforce” and “sustainable funding” remained the most frequently indicated needs among those categorized as working in health, social service, or both sectors.
- C2. Among the needs they marked, respondents were then asked to rank up to 3 that they thought would have the greatest impact on Eastern WA.
    - The needs most often ranked #1 were 1) resources to hire, train, and retain a sufficient workforce (51.3%), 2) sustainable funding for care coordination activities (35.7%), 3) shared vision across organizational leaders across sectors (33.8%), and 4) data sharing technology that all agencies involved in care coordination have access to and can use (26.0%).
    - Since respondents could rank up to 3 priority needs, we also created a composite score that weighted their selections, with the need they ranked first having the greatest weight, and the need they ranked third having the smallest weight. While this did not change the top-ranked needs, it raised slightly the priority on data sharing technology. Based on this composite score, the top-ranked needs were:

      1) resources to hire, train, and retain a sufficient workforce

      2) sustainable funding for care coordination activities

        - C3. One philanthropic administrator/manager hoped for: “By/for community based organizations supported and sustainably/adequately funded to serve their community members, including any necessary training on how to navigate relevant systems/institutions and high quality capacity building support to deliver new lines of service.”
        - C3. A social service sector administrator/manager hoped for: “Funding, including for organizations that fill a gap within the community but are not traditional service providers of a particular issue. For example, providing funding for trauma-related supports through social service providers that improve care coordination and mental/behavioral health outcomes, even though the service provider is not explicitly a mental/behavioral health agency.”

      3) Data sharing technology that all agencies involved in care coordination have access to and can use

        - C3. A few respondents noted that any tool should be free.
        - C3. A social service community health worker acknowledged that “This will be difficult given the investments that have already been made in the community with individual agency driven tools.”

      4) Shared vision across organizational leaders across sectors

- C3. Several respondents gave feedback about the need for systems change to provide client-centered care.
  - One health care administrator/manager provided their perspective on how this reduces services available in a rural service area: "Not sure there is a clear answer or single solution because of the mix of very large private corporations, small to medium private providers, for-profit and not-for-profit providers, small social service organizations, many organizations which do not have the resources of very large medical and mental health care corporations, and lastly the financial inability or unwillingness of medical, mental, and social service providers to operate in the rural areas and counties of Eastern Washington. Most rural people in Eastern Washington have to drive longer distances to get to providers than those who live in the larger communities in the area, if the services are available in those communities. Larger medical organizations say they serve these areas but are regularly closing small community hospitals or clinics because of inadequate revenue and ROI leaving rural communities without services. This is a trend and reality in many western states."
  - Another health care administrator/manager elaborated on how existing structures are not conducive to client-centered care: "Knowing who is doing the work and what work they are doing is key, but that does not exist like it should because it is not a sustainable model because there is no real way to measure the overall impact. VBC and population health initiatives help but larger health systems are still in a fee-for-service model."

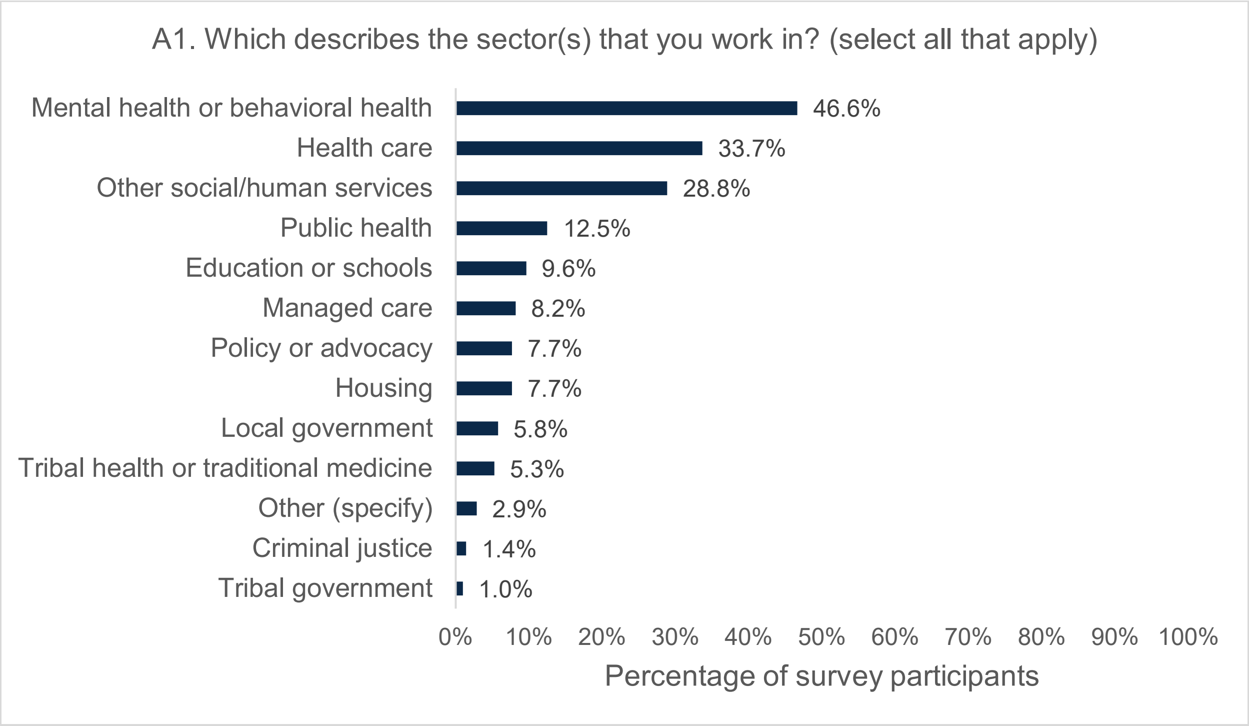
7. **Organization characteristics and service population (A1, A2, D1, D2)**

- A1. Respondents typically worked in health services (50%), and less commonly social services (25%). 20% of respondents reported working in both health and social services, and the remaining 5% did not work in health or social services.
- A2. The largest proportion of respondents indicated that they held a role as administrator or manager (48%), followed by care coordinator, case manager, or navigator (29%). Similar proportions identified their role as a social or human service provider, community health worker, health care provider, or behavioral health clinician (9-14%).
- D1. We asked respondents about the population of focus for their organizations, including age groups as well as various groups that may be underserved by health and social services. Respondents reported focusing on a wide variety of groups, but the most common were those with lower incomes (59%) and those with a mental health diagnosis (48%).
- D2. We also asked respondents whether their organization primarily serves people who identify as BIPOC. In general, they reported serving the community at large (78%) more commonly than specific populations.

Survey Methods

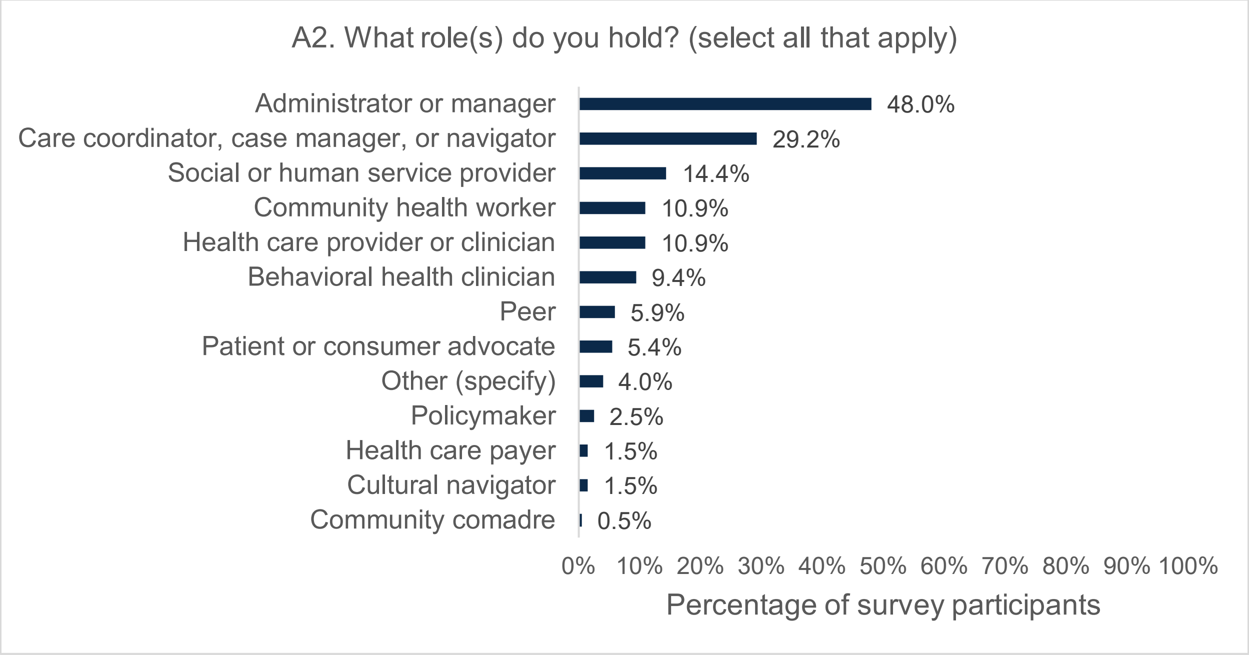
- The purpose of the Eastern Washington Care Coordination survey was to solicit feedback from Better Health Together's partners on organizational capacity for care coordination and opportunities for improvement. These 916 partners reflected a broad array of sectors, such as health care, mental and behavioral health, social services, state/local/tribal government, and others. More than one person from an organization could complete the survey, so that the perspectives would reflect a diversity of roles in care coordination. The web-based survey was administered in June 2022 to partners serving Adams, Lincoln, Ferry, Stevens, Pend Oreille, and Spokane counties, and took approximately 15-20 minutes to complete. Better Health Together sent an advance email on June 1 alerting them to the upcoming survey, and sent out an invitation including the web survey link the following week. Mathematica then sent a weekly reminder email for the remainder of the month. Those who completed the survey instrument and provided an email address received an $10 electronic Amazon gift card as a thank you.
- The survey results shown in this report represent the 209 participants who took part in the survey, including 152 complete responses and 57 partial responses. Since the survey was intentionally structured to allow anyone with the web link to enter feedback, we retained only responses that could reasonably be considered to have come from unique individuals. For example, we reviewed individual item responses that came from the same IP address and dropped partial cases if the item responses duplicated those of a completed case. We also dropped cases from individuals who only provided responses on their organization type (A1) and job role (A2), since these limited data could not be used in the survey analysis.
- Given the diversity of roles and knowledge about aspects of care coordination represented among survey participants, each question allowed participants to mark "don't know" if they could not answer. Additionally, the instrument included skip logic so that some questions were not asked of all survey participants. Therefore, the number of responses for each question is noted below each figure showing survey responses and may be fewer than the number of total survey participants.

E.1. Survey figures, all respondents



208 survey participants

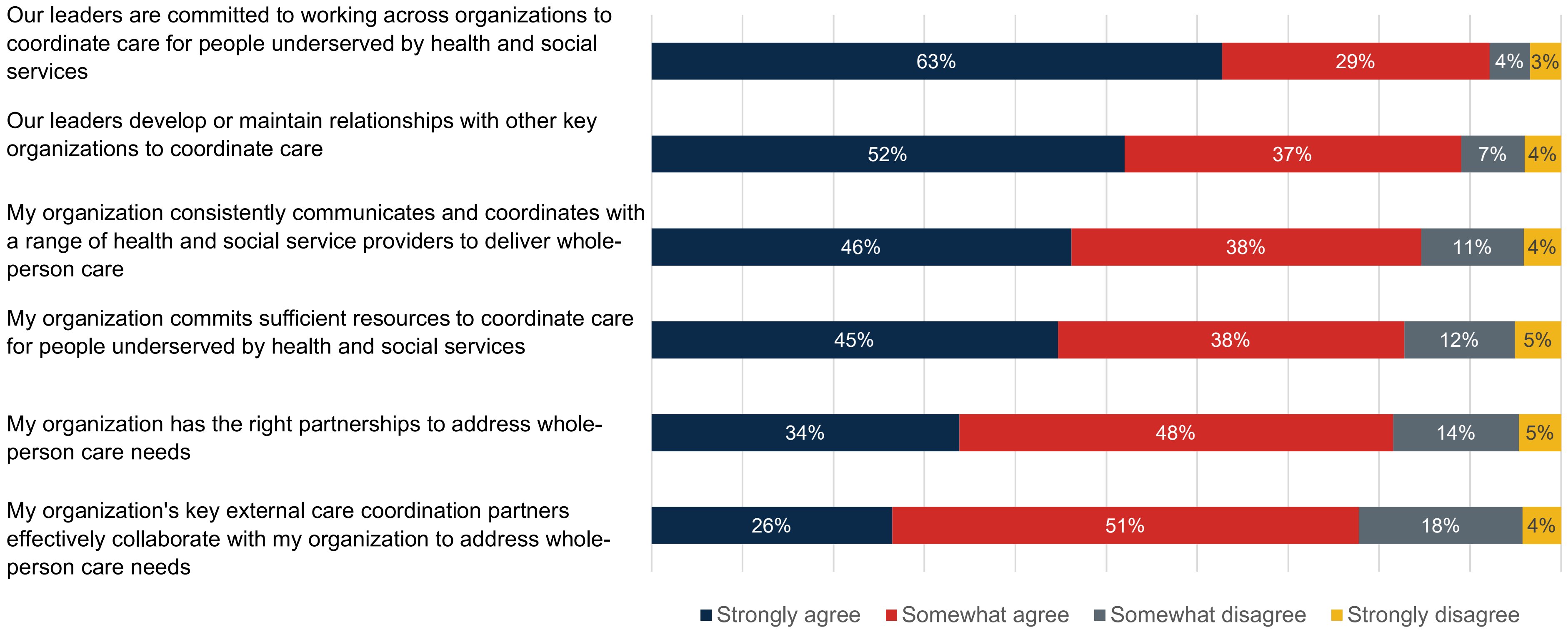
E.2. Table Title



202 survey participants

E.3.

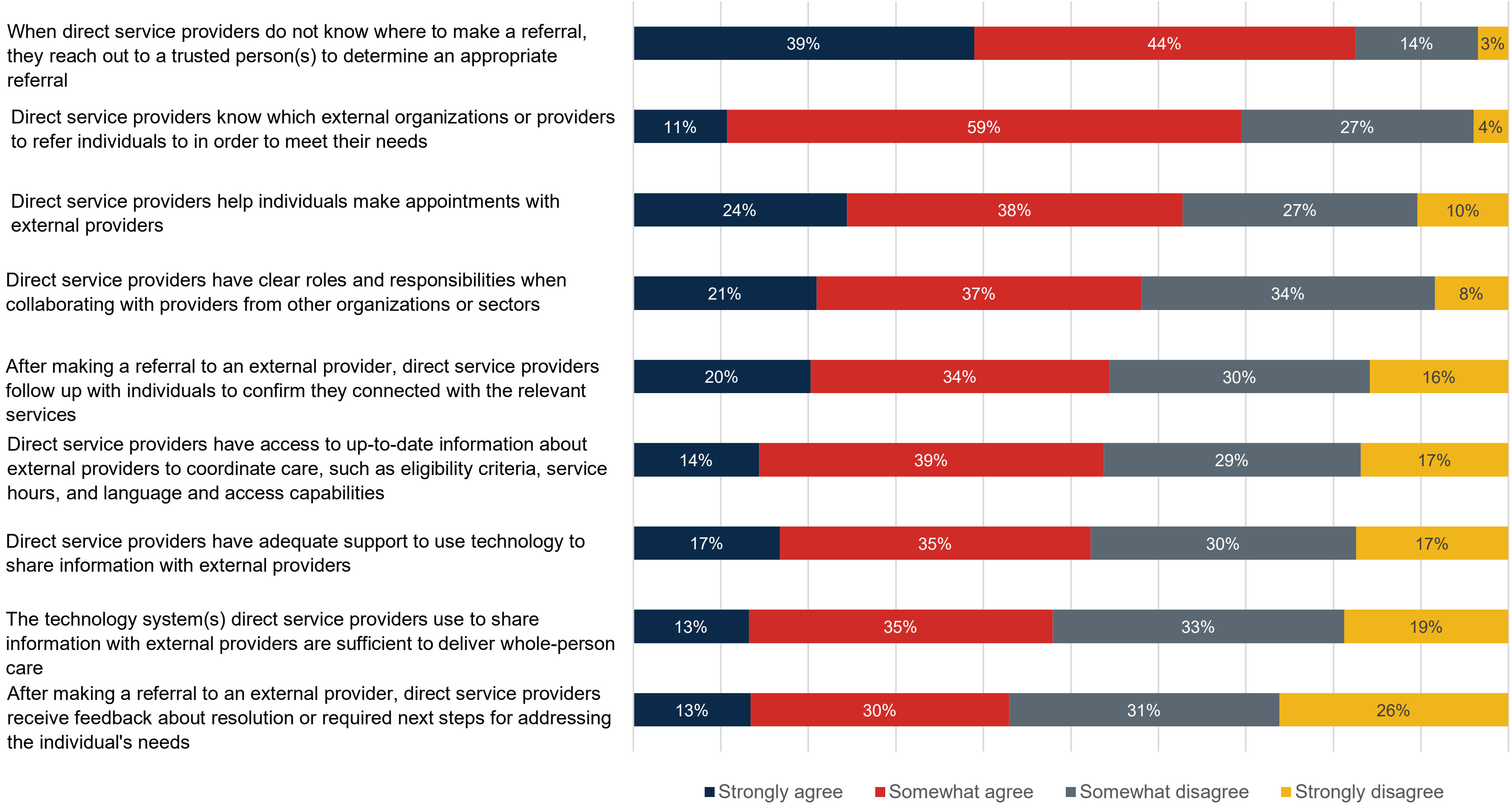
B1. Please indicate your level of agreement with each statement about your organization's leadership and partnerships for care coordination in Eastern Washington.



189-204 survey participants

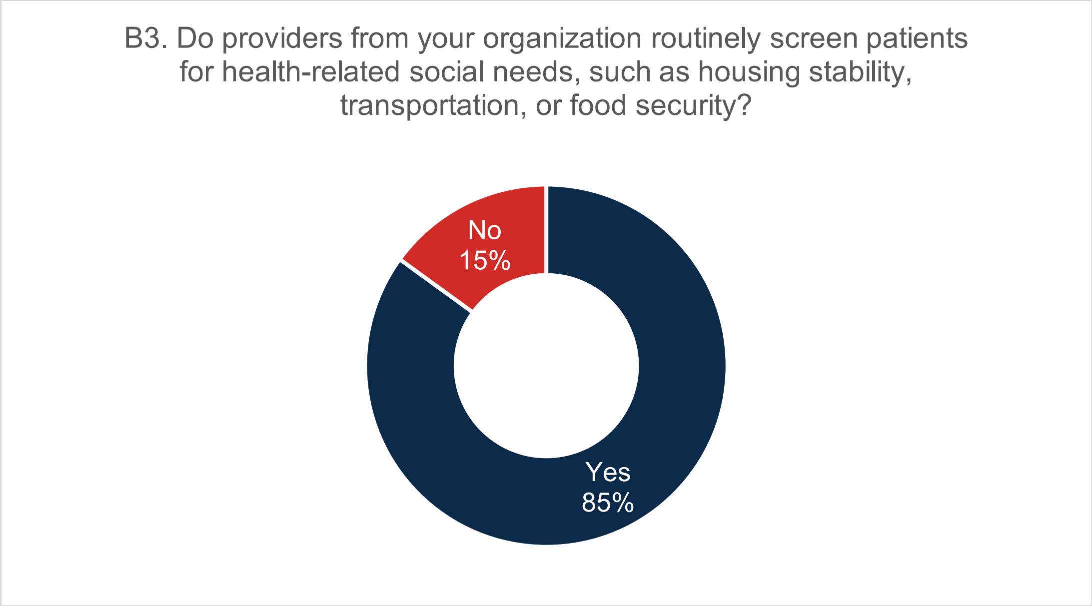
E.4.

B2. Please indicate how often the following statements apply to how direct service providers from your organization work with providers at other organizations in Eastern Washington to coordinate care.



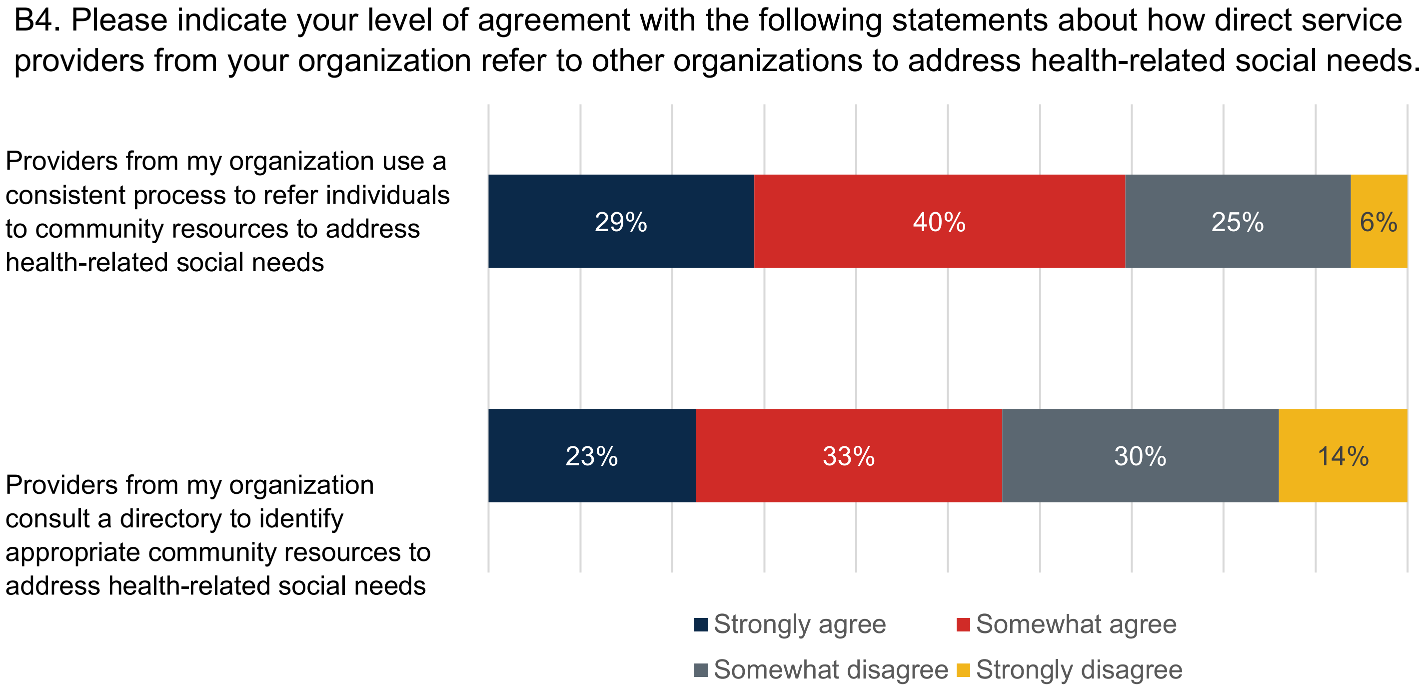
144-177 survey participants

Table E.5.



160 survey participants

Table E.6.



93-114 survey participants. Question asked of health providers.

B5. What directory or directories are you using?

Table E.7.

Type of directory	Count of responses
Internal/in-house directory	24
Fig Tree Community Resources Directory	13
211	12
Provider- or payer-created directory (including Washington State Health Care Authority [HCA])	10
Better Health Together (BHT) (e.g., Spokane Collaborative Directory, Capacity Connect)	4
Washington State Department of Health (WA DOH) (e.g., Care Connect Washington)	3
Substance Abuse and Mental Health Services Administration (SAMHSA)	3
Find Help	3
Word of mouth or networking	3
Washington State Department of Social and Health Services (DSHS) (e.g., Spokane Area Resource List, Aging and Long-Term Support Administration)	3
Other*	24

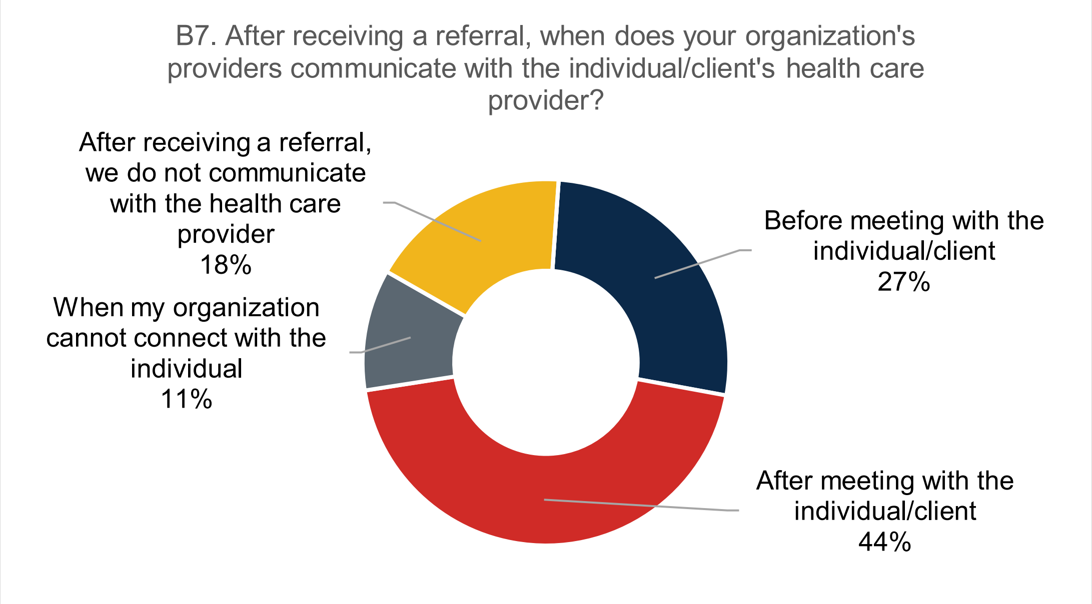
Notes: 71 survey participants. Respondents may have reported more than one resource directory. Question asked of health providers that reported using a directory in B4.

*The “Other” category includes directories such as those produced by the county and for rural resources, as well as those that could not clearly be identified as belonging to a more specific source like DSHS due to generic naming of the directory.

Table E.8.

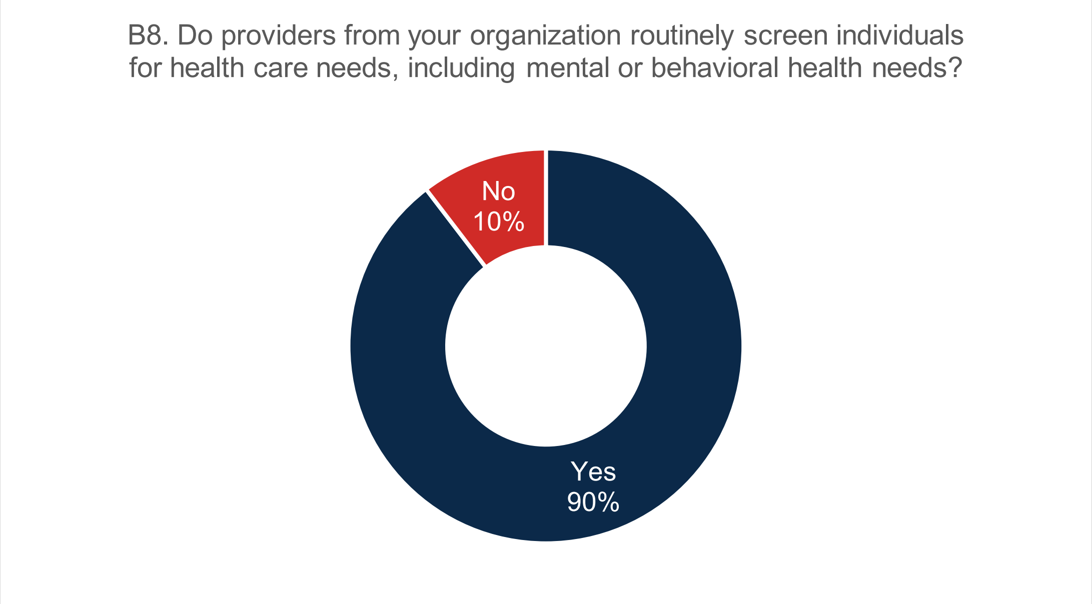
73 survey participants. Question asked of social service providers.

Table E.9.



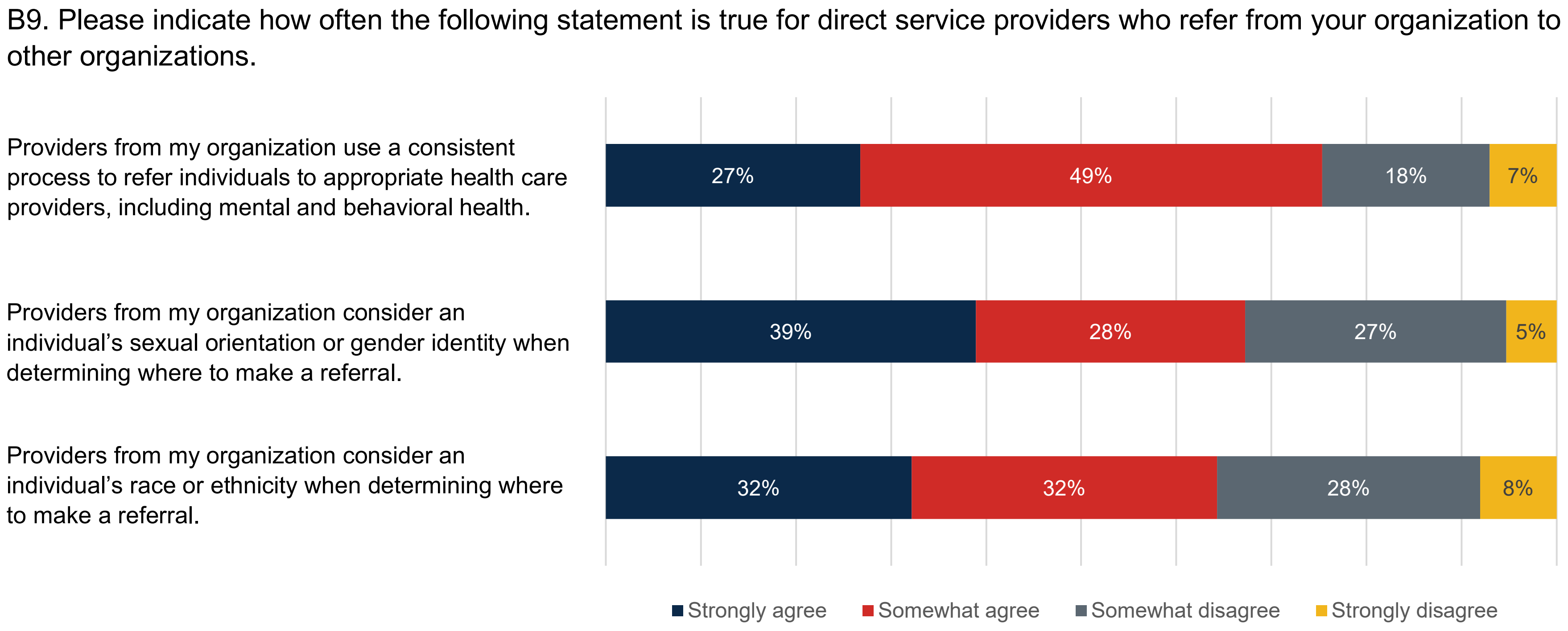
56 survey participants. Question asked of social service providers that receive direct referrals from health care providers.

Table E.10.



154 survey participants. Question asked of health and social service providers.

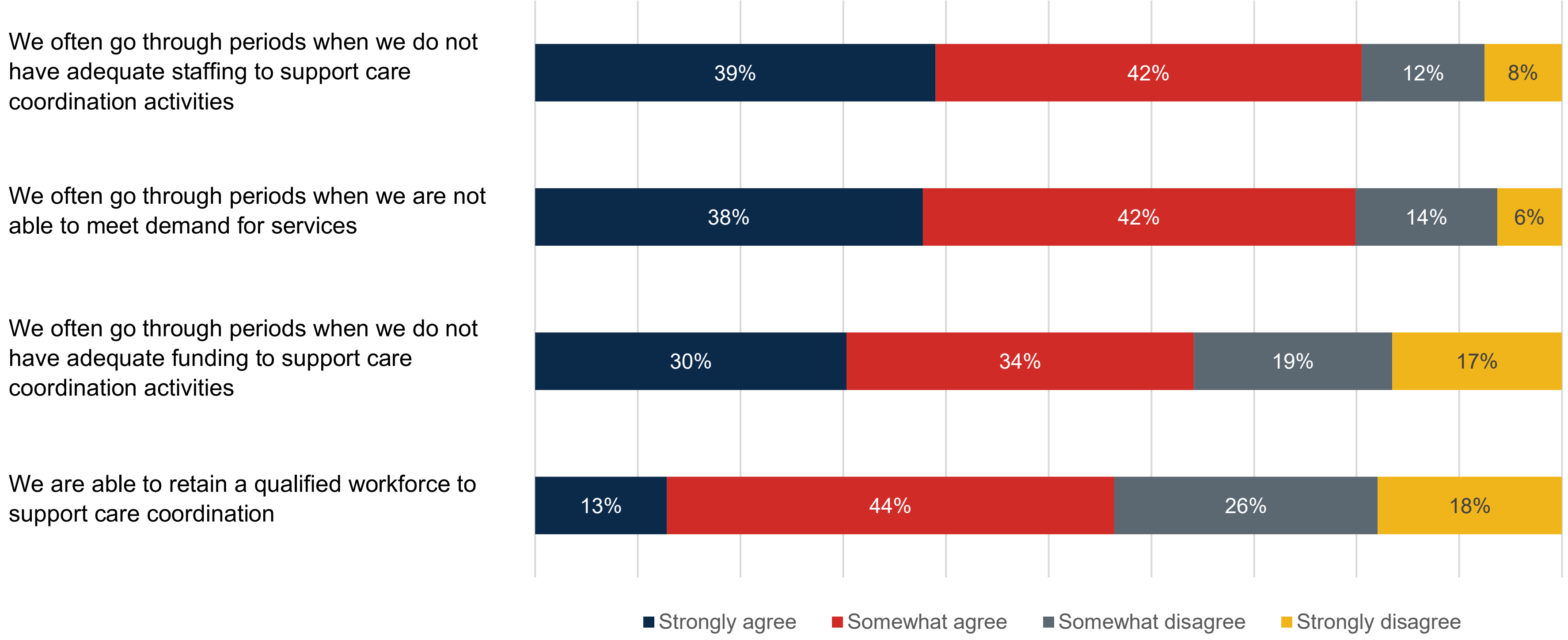
Table E.11.



112-142 survey participants. Question asked of health and social service providers.

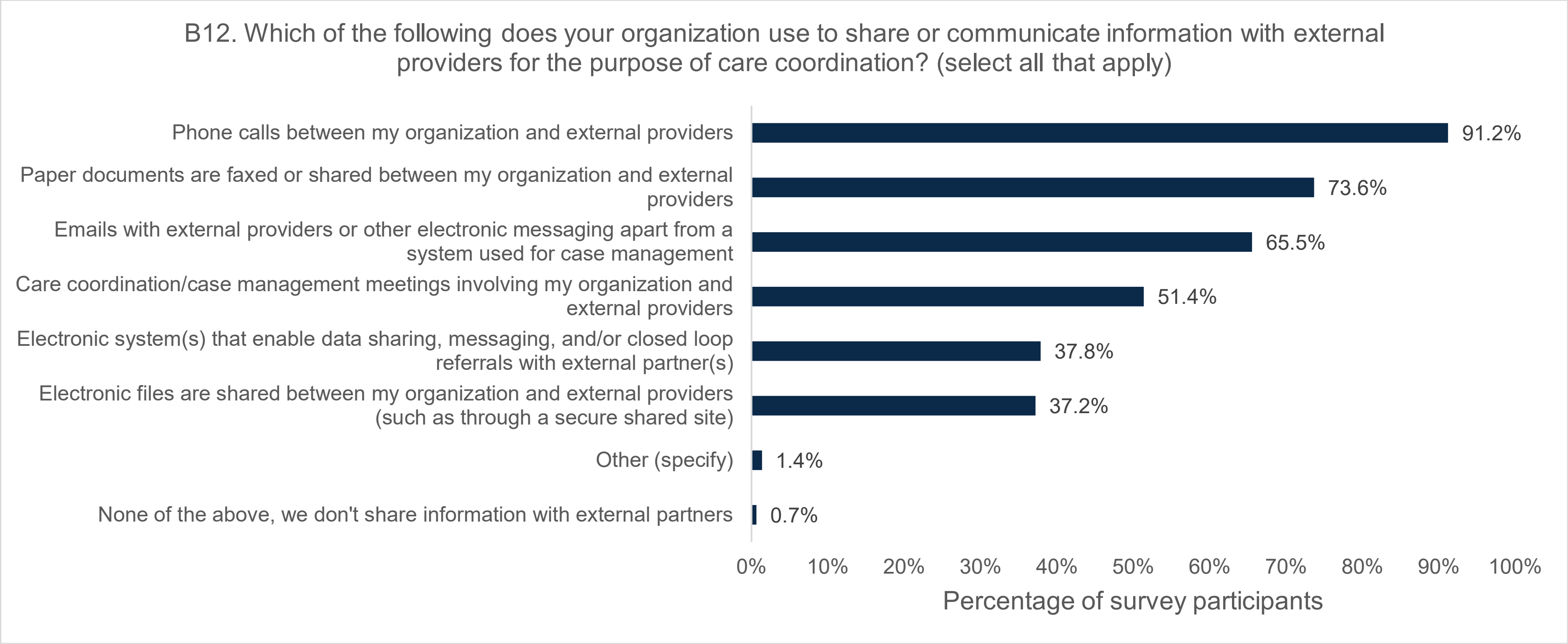
Table E.12.

B10. Please indicate your level of agreement with each statement about your organization's resources for care coordination.



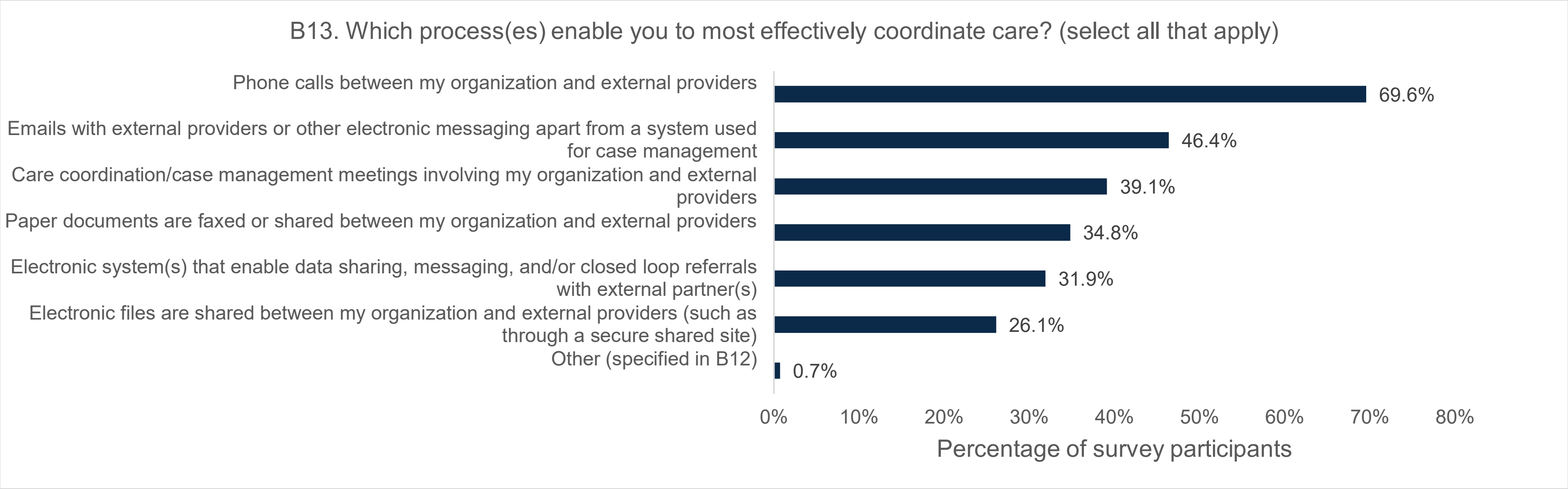
145-159 survey participants

Table E.13.



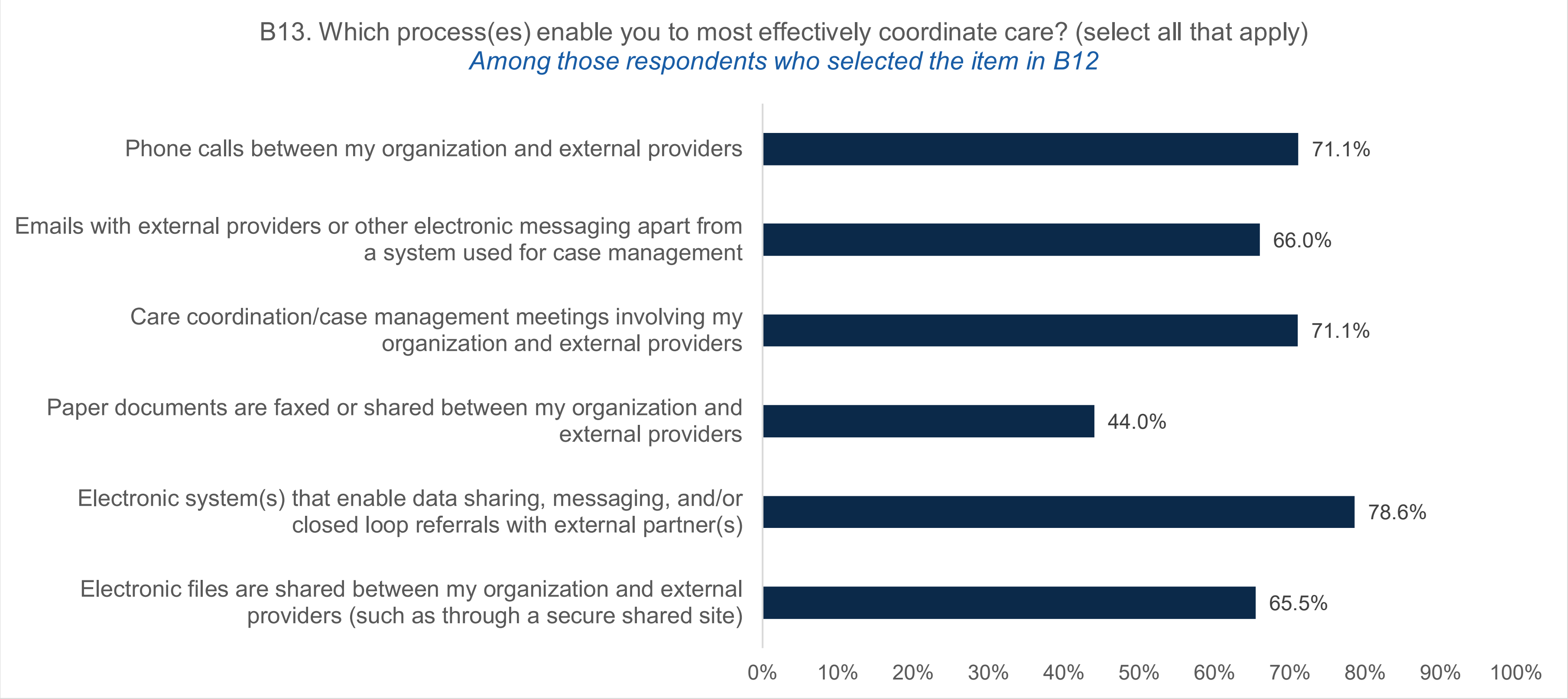
148 survey participants

Table E.14.



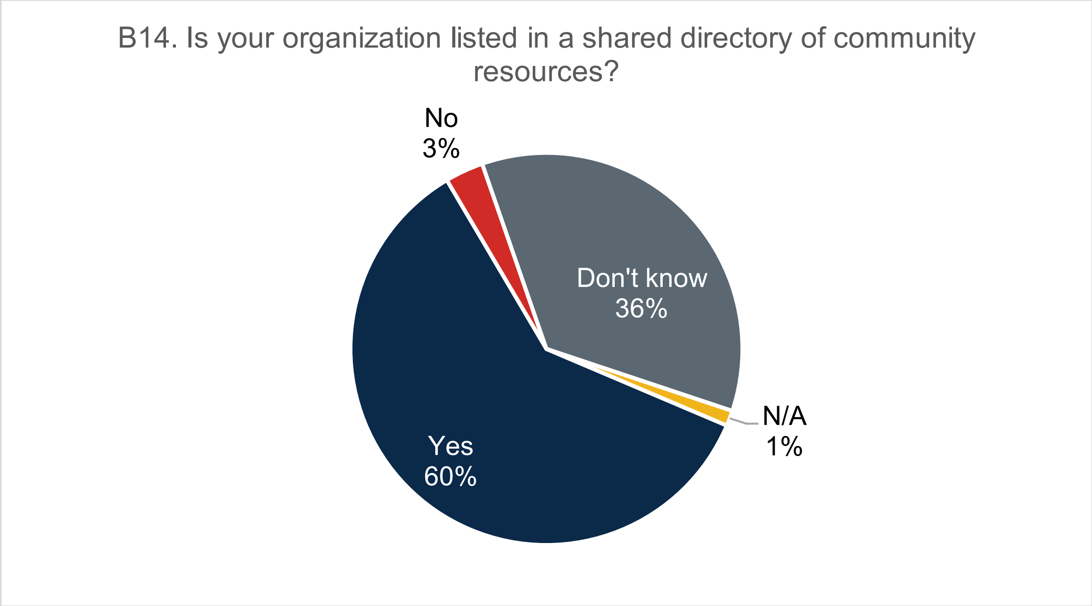
138 survey participants. Question asked of those who reported sharing or communicating information with external providers in B12.

Table E.15.



138 survey participants. Question asked of those who reported sharing or communicating information with external providers in B12.

Table E.16.

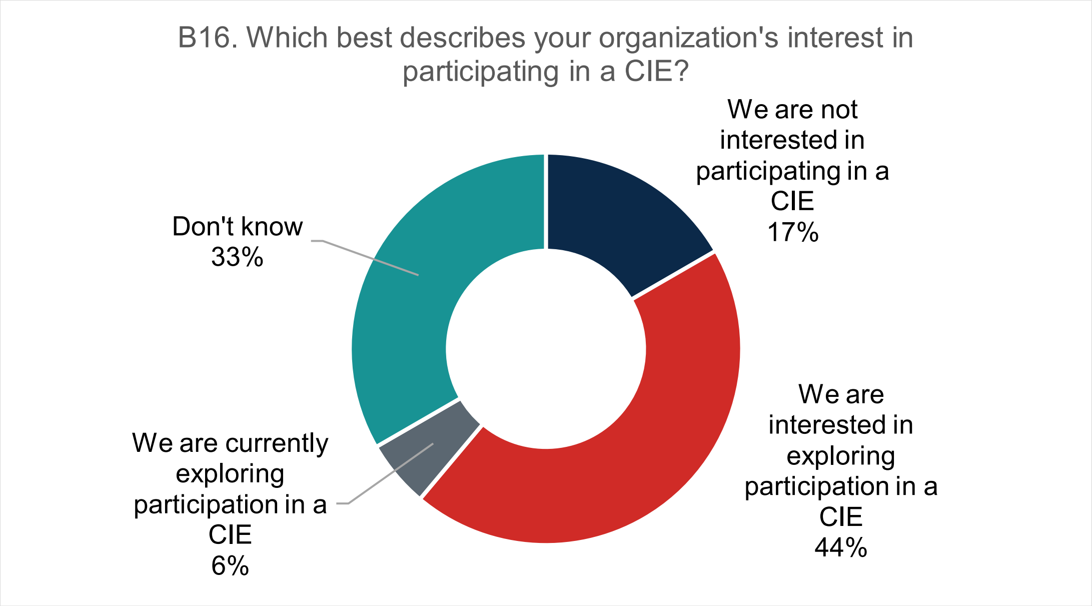


158 survey participants. Question asked of health and social service providers.

Table E.17.

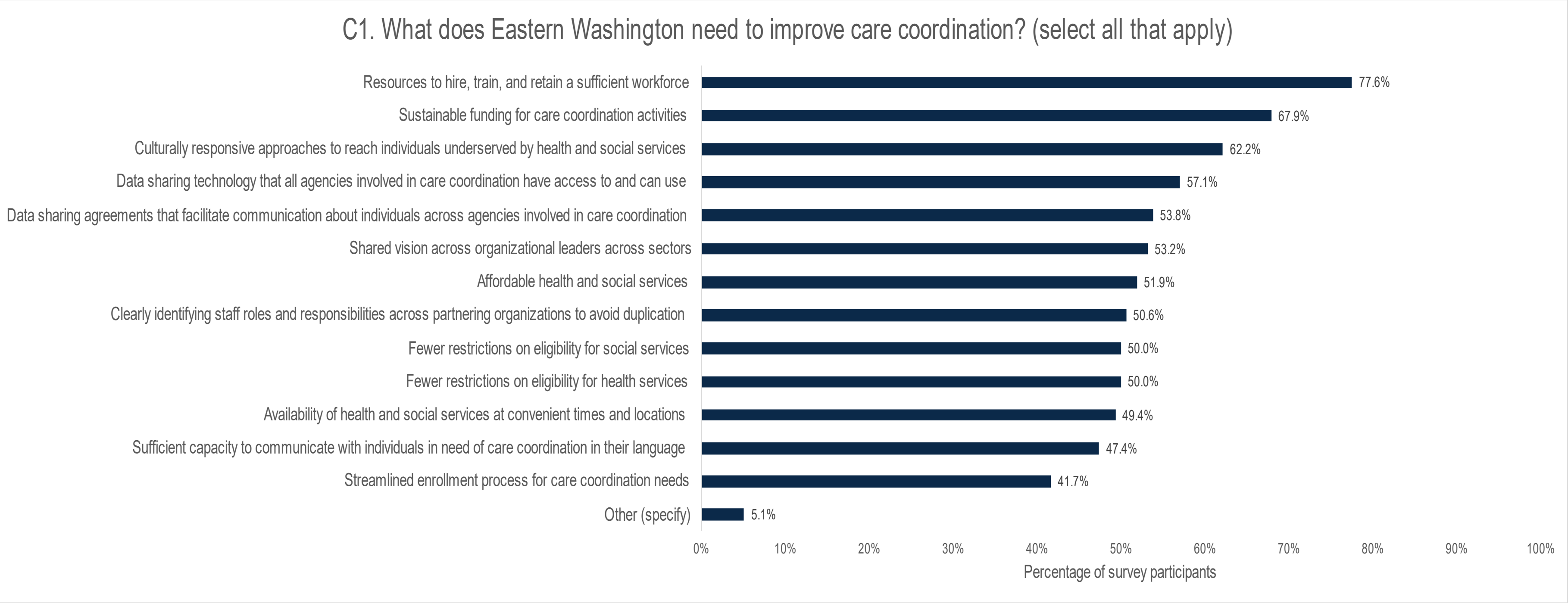
170 survey participants

Table E.18.



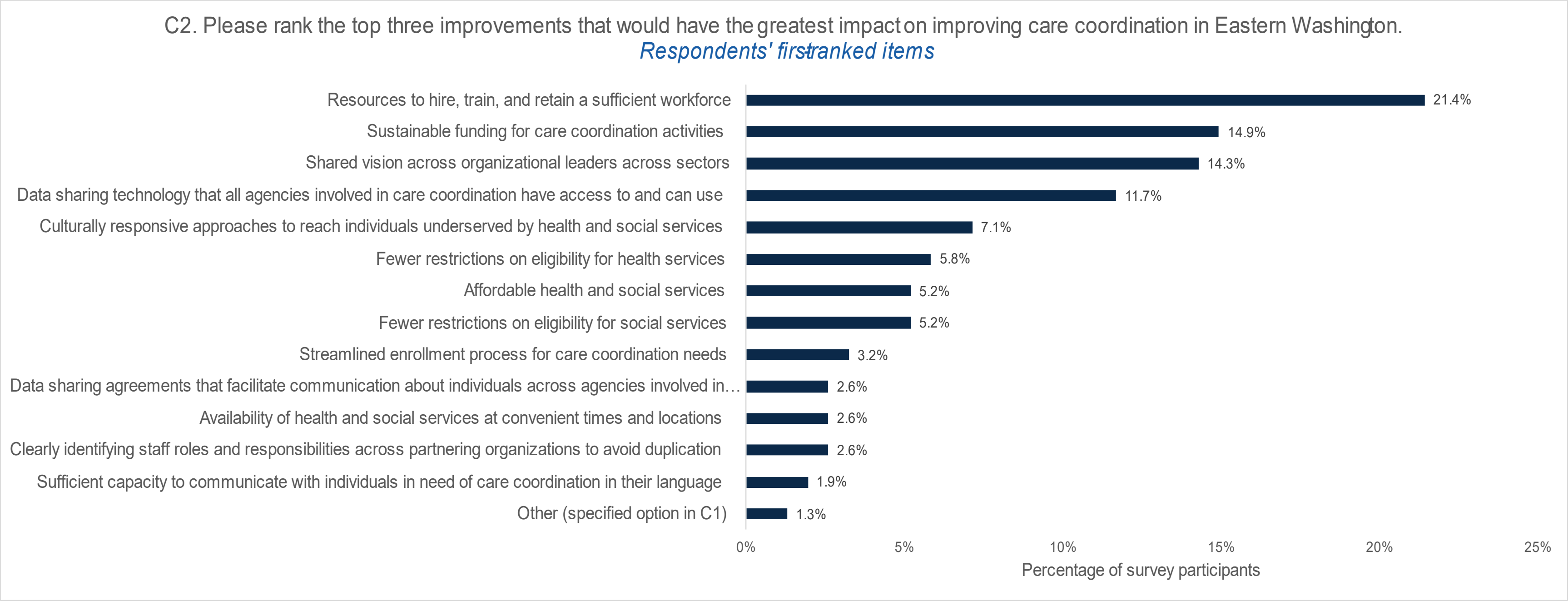
54 survey participants. Question asked of those who reported their organization does not participate in a CIE in B15.

Table E.19.



156 survey participants

Table E.20.



154 survey participants

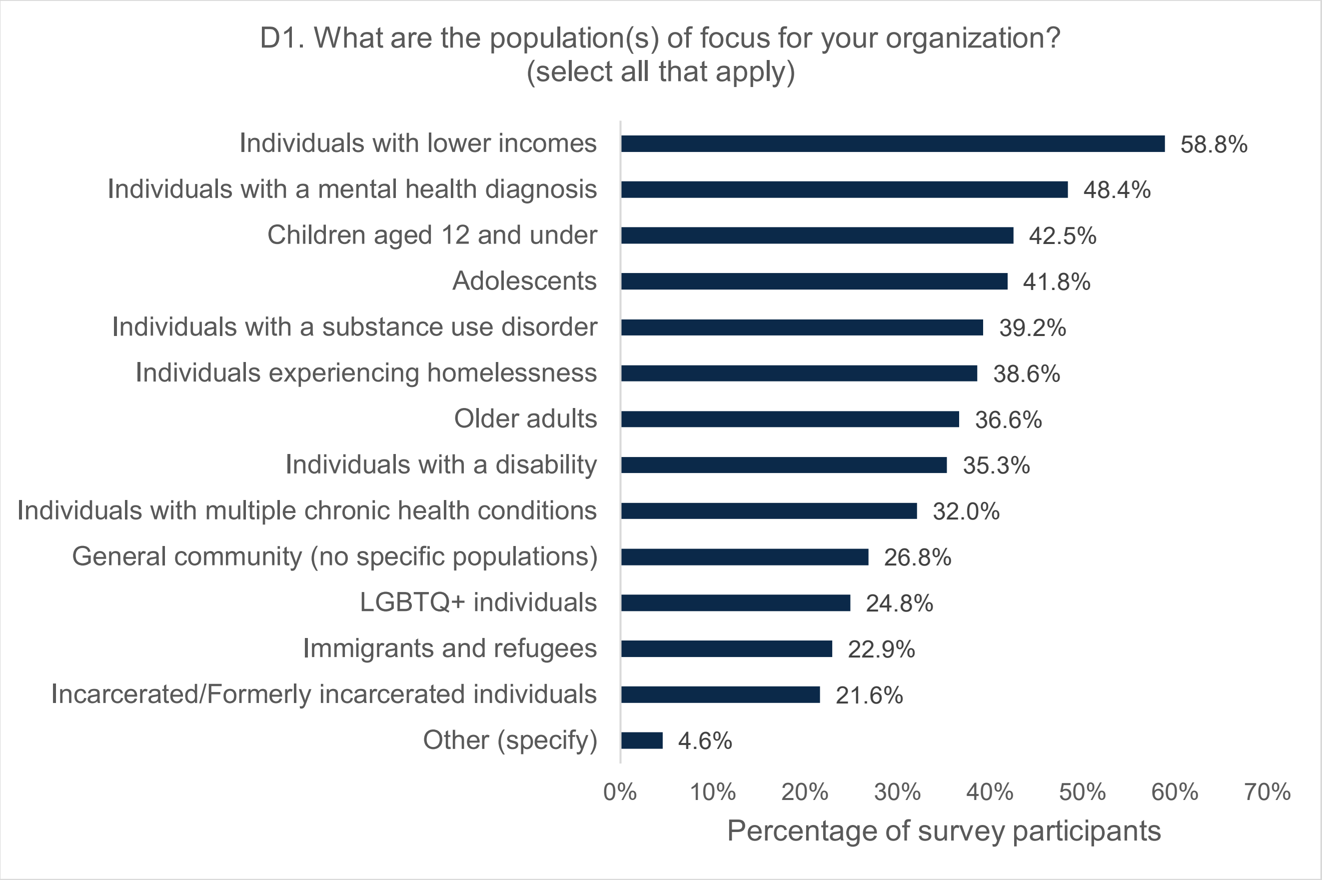
C3. What would it take to ensure seamless care coordination across Eastern Washington so that individuals will receive the whole-person care and support they need to be healthy and thrive?

Table E.21.

Identified need	Count of responses
Funding	27
Coordinated referrals/communication/delivery	26
Data sharing system	24
Sufficient workforce	17
Systems change/client-centered mentality	15
Access to services	9
Shared vision	4
Resource directory	4
Culturally appropriate care	4
Affordable care	3
Data sharing agreements	1
Other	17

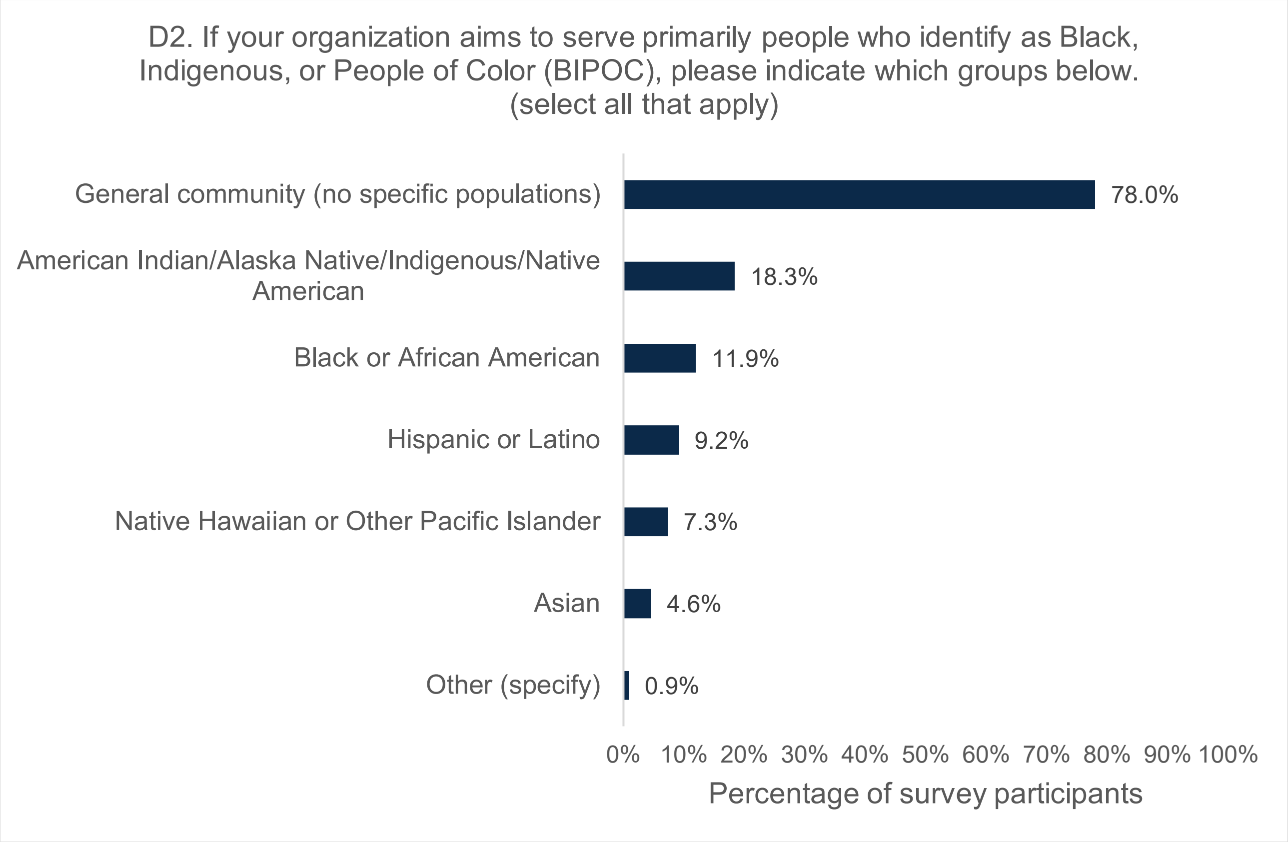
Note: 107 survey participants. Respondents may have reported more than one care coordination need.

Table E.22.



153 survey participants

Table E.23.



109 survey participants

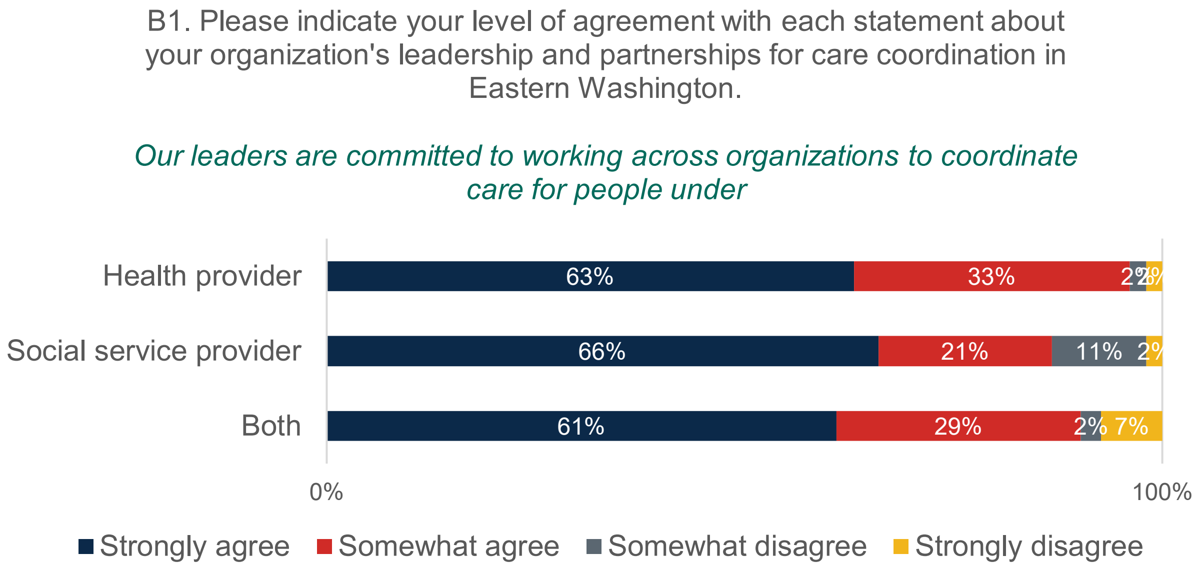
Survey figures, by sector

The figures below show responses by 1) health provider, 2) social service provider or 3) both, based on responses to question A1. Given the small number of responses in the "Neither" category, data for this group are not presented in the figures.

Table E.24.

Category	Criteria	Number of respondents
Health	Response to A1 of any below: Health care Mental health or behavioral health Tribal health or traditional medicine Managed care	104
Social service	Response to A1 of any below: Housing Criminal justice Education or schools Public health Other social/human services	53
Both	Response to A1 in both the "Health" and "Social service" category	42
Neither	All other responses that do not meet criteria for "Health," "Social service," or "Both" categories	10

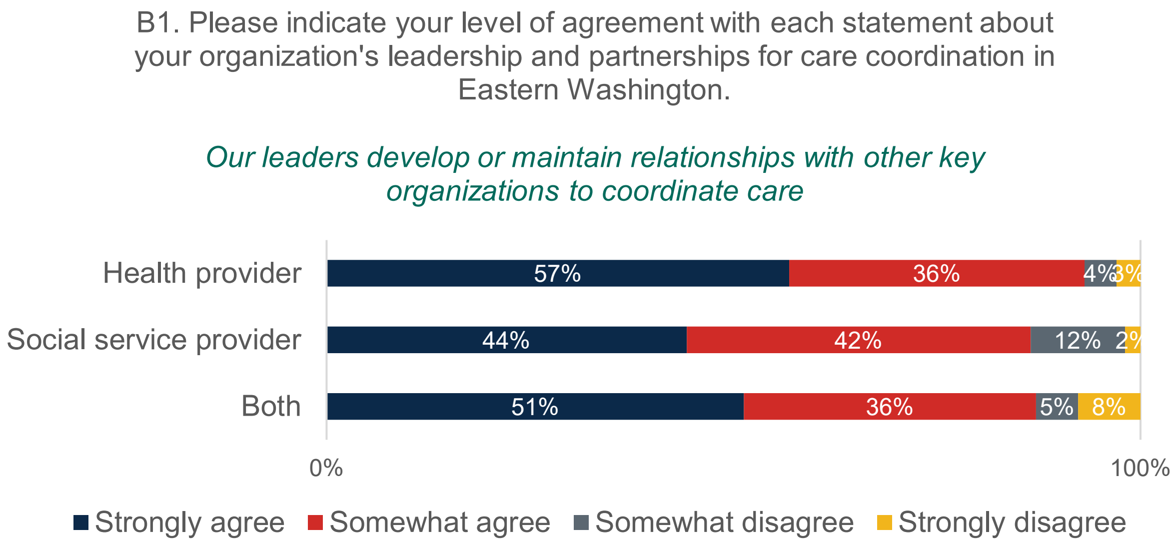
Table E.25.


B1. Please indicate your level of agreement with each statement about your organization's leadership and partnerships for care coordination in Eastern Washington.

Our leaders are committed to working across organizations to coordinate care for people under

197 survey participants

Table E.26.

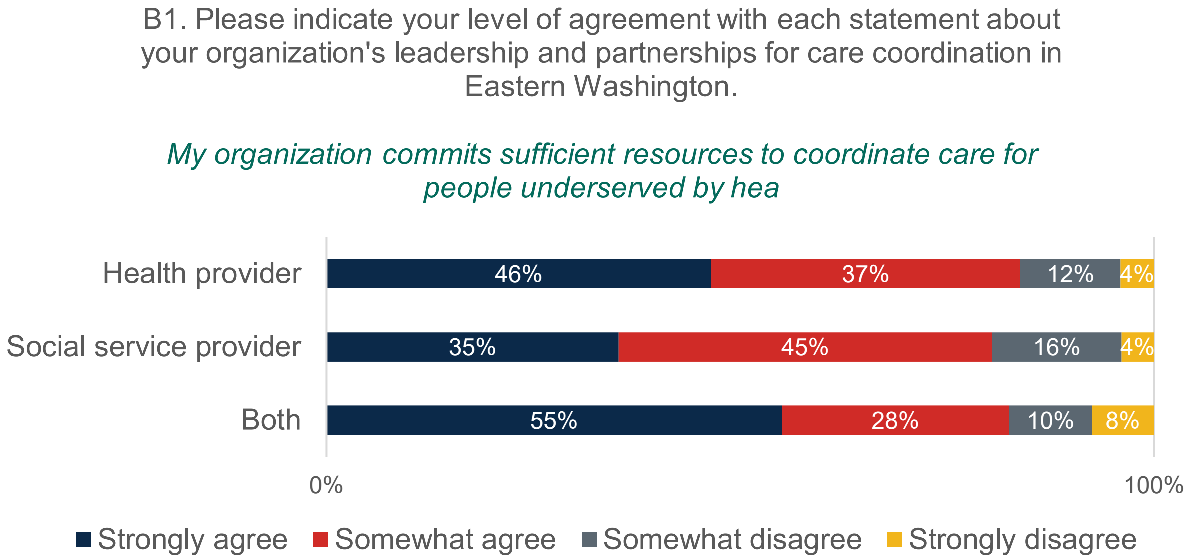


B1. Please indicate your level of agreement with each statement about your organization's leadership and partnerships for care coordination in Eastern Washington.

Our leaders develop or maintain relationships with other key organizations to coordinate care

193 survey participants

Table E.27.



B1. Please indicate your level of agreement with each statement about your organization's leadership and partnerships for care coordination in Eastern Washington.

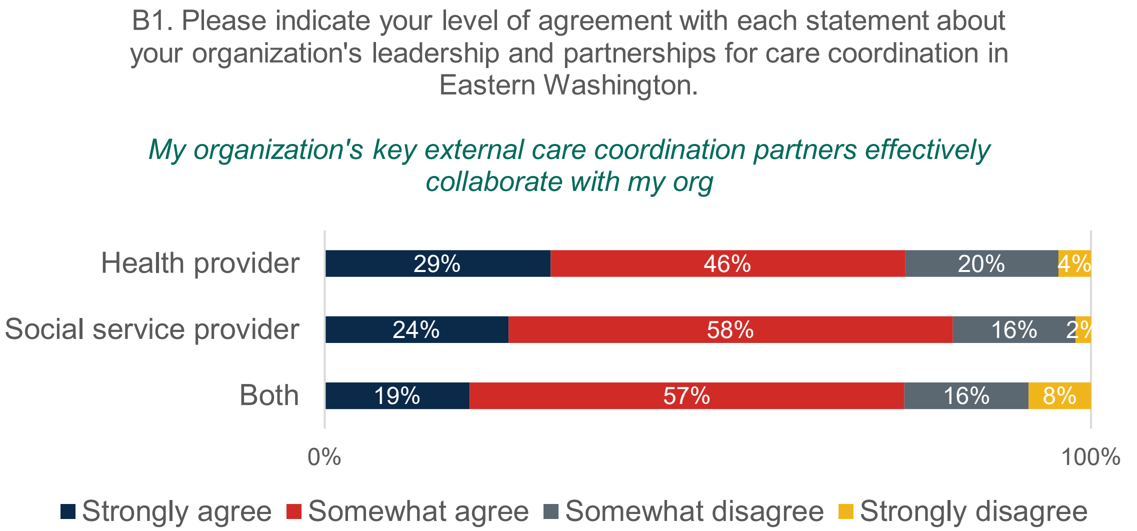
My organization commits sufficient resources to coordinate care for people underserved by hea

190 survey participants

Table E.28.

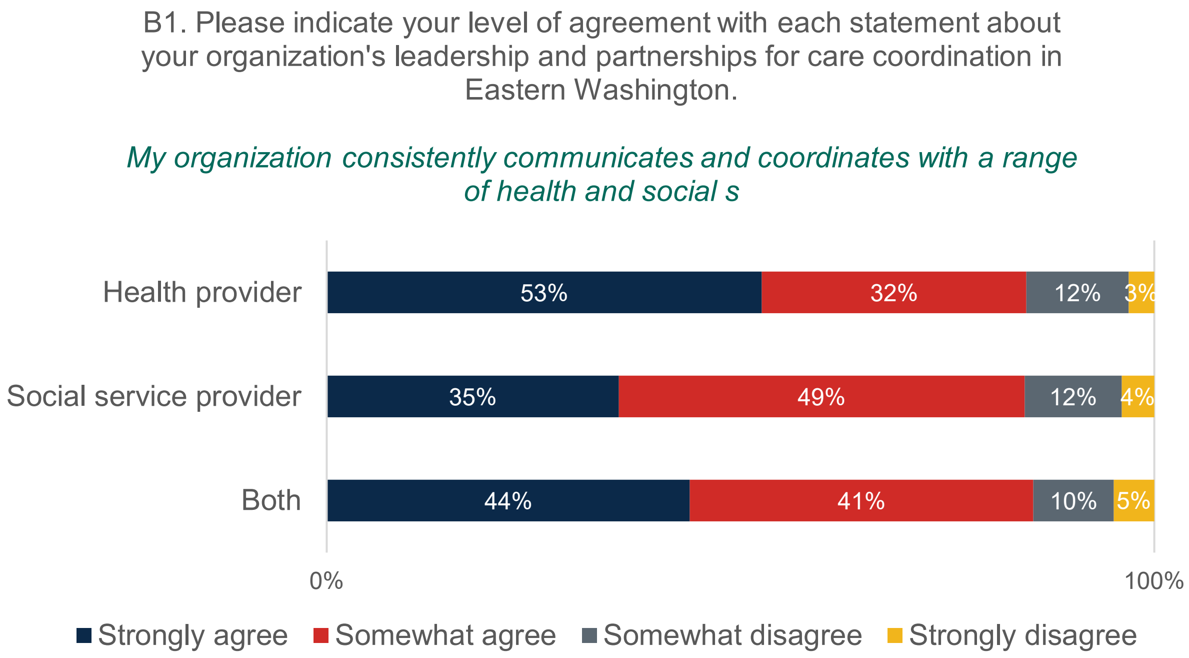
189 survey participants

Table E.29.



182 survey participants

Table E.30.

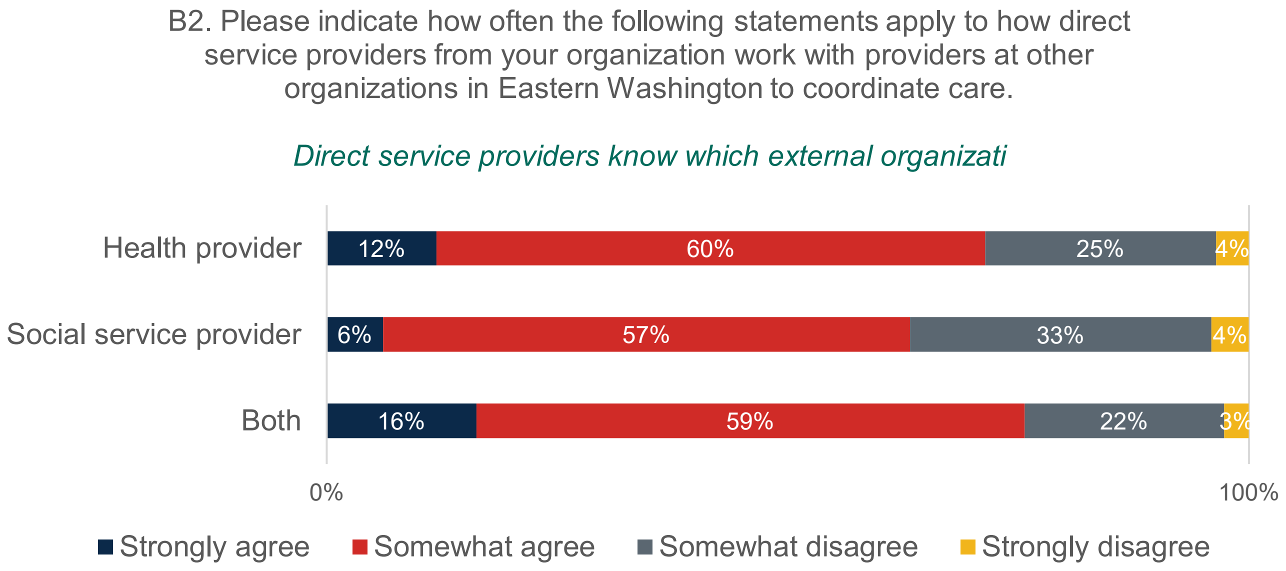


B1. Please indicate your level of agreement with each statement about your organization's leadership and partnerships for care coordination in Eastern Washington.

My organization consistently communicates and coordinates with a range of health and social s

189 survey participants

Table E.31.

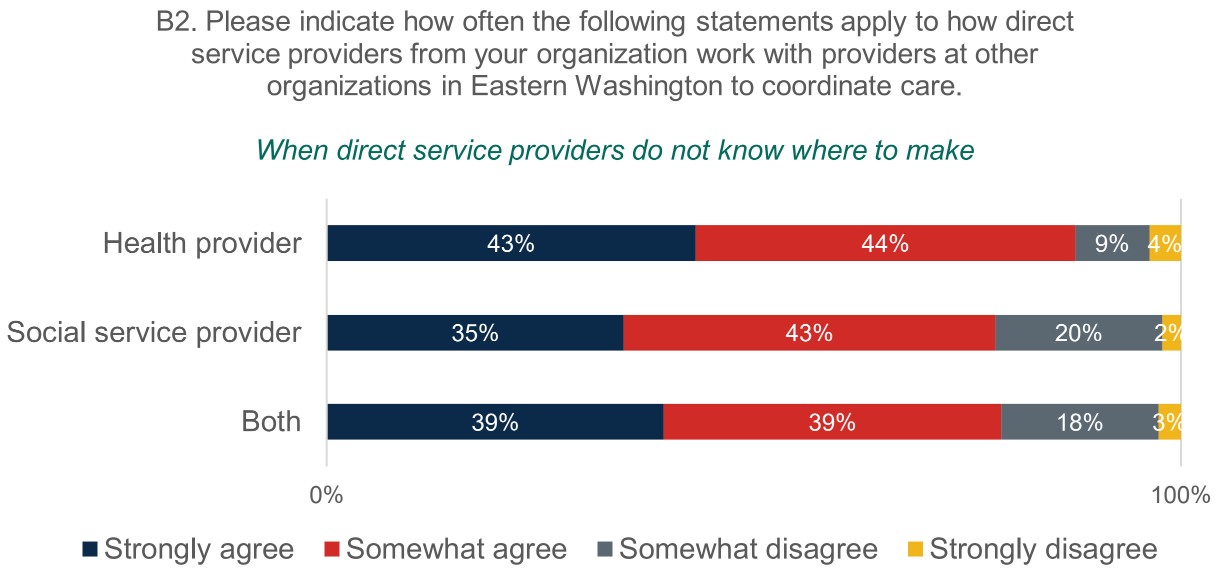


B2. Please indicate how often the following statements apply to how direct service providers from your organization work with providers at other organizations in Eastern Washington to coordinate care.

Direct service providers know which external organizati

170 survey participants

Table E.32.

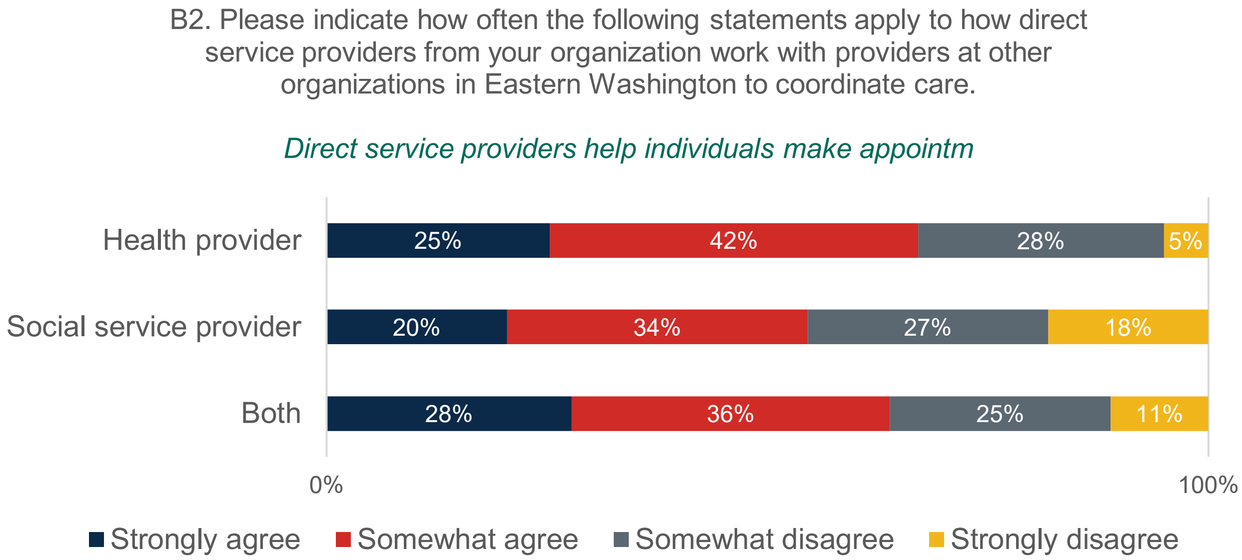


B2. Please indicate how often the following statements apply to how direct service providers from your organization work with providers at other organizations in Eastern Washington to coordinate care.

When direct service providers do not know where to make

165 survey participants

Table E.33.

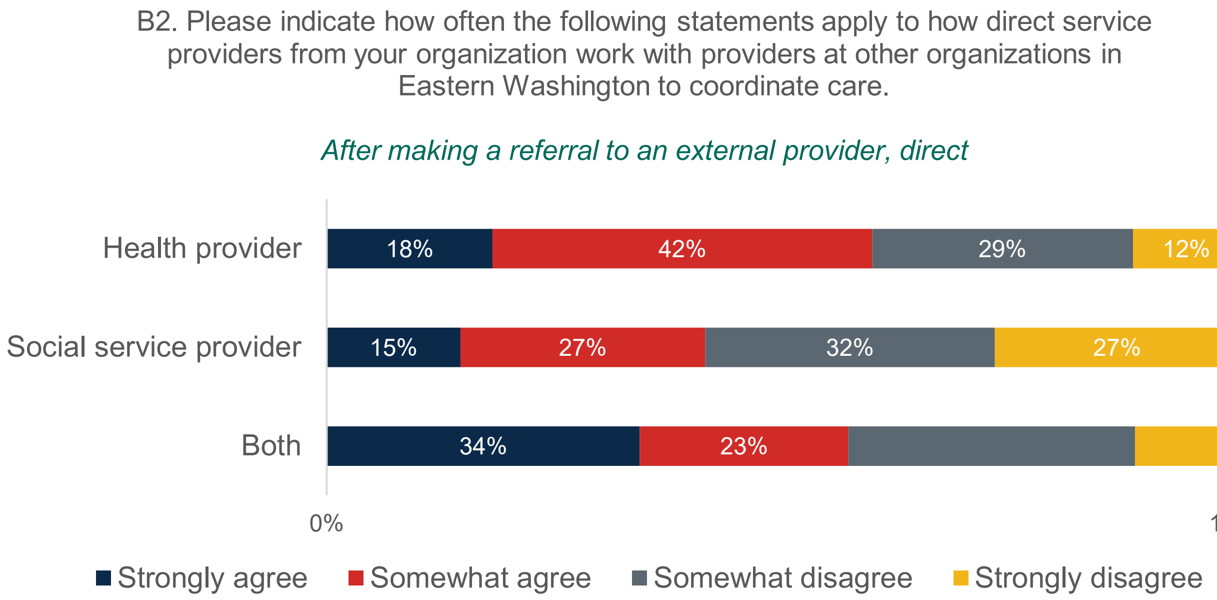


B2. Please indicate how often the following statements apply to how direct service providers from your organization work with providers at other organizations in Eastern Washington to coordinate care.

Direct service providers help individuals make appointm

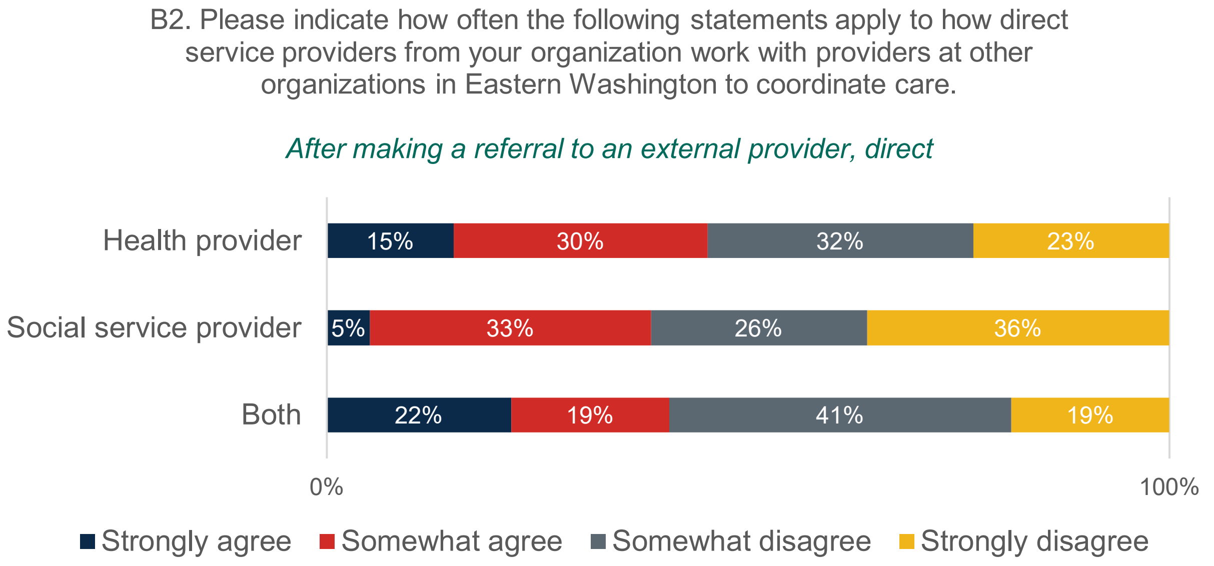
159 survey participants

Table E.34.



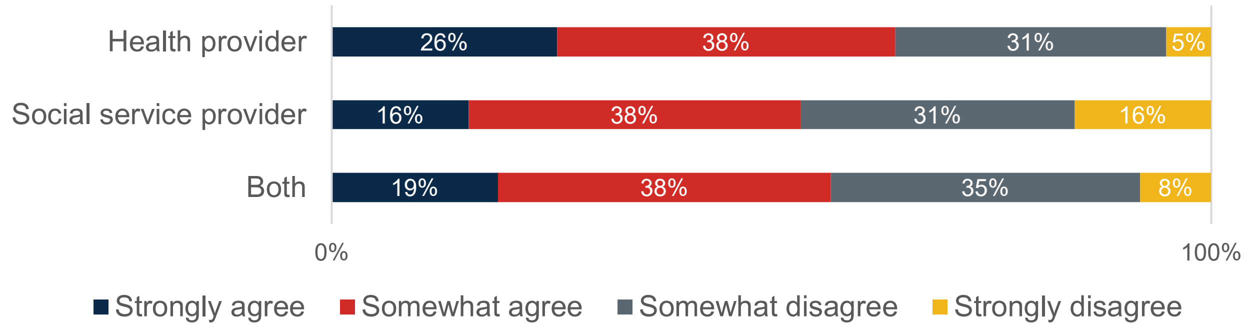
153 survey participants

Table E.35.



144 survey participants

Table E.36.

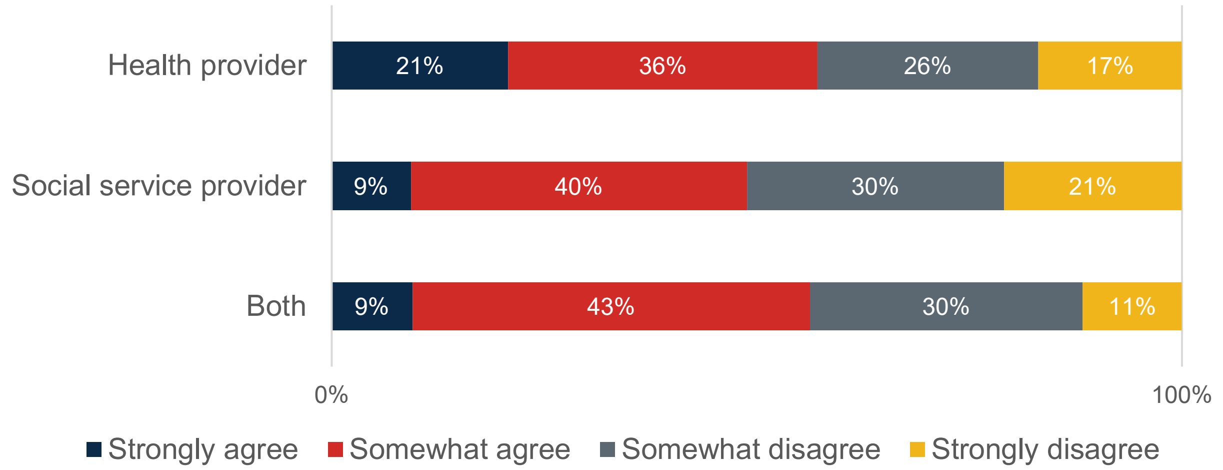


B2. Please indicate how often the following statements apply to how direct service providers from your organization work with providers at other organizations in Eastern Washington to coordinate care.

Direct service providers have clear roles and responsib

160 survey participants

Table E.37.

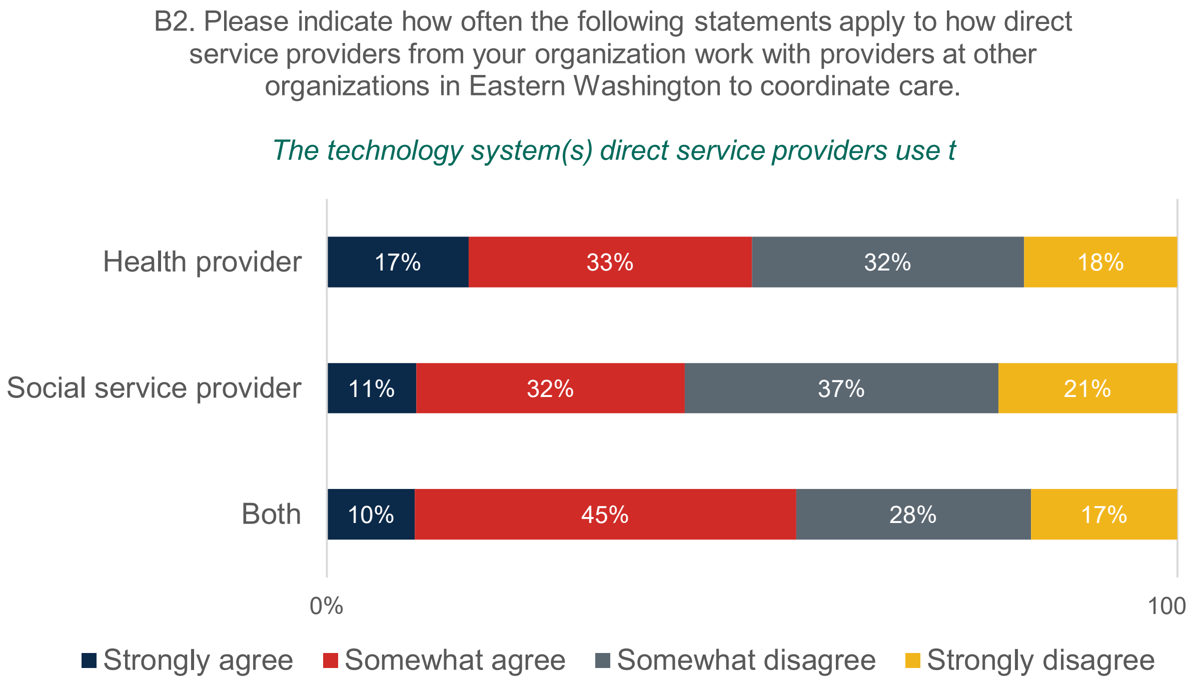


B2. Please indicate how often the following statements apply to how direct service providers from your organization work with providers at other organizations in Eastern Washington to coordinate care.

Direct service providers have access to up-to-date info

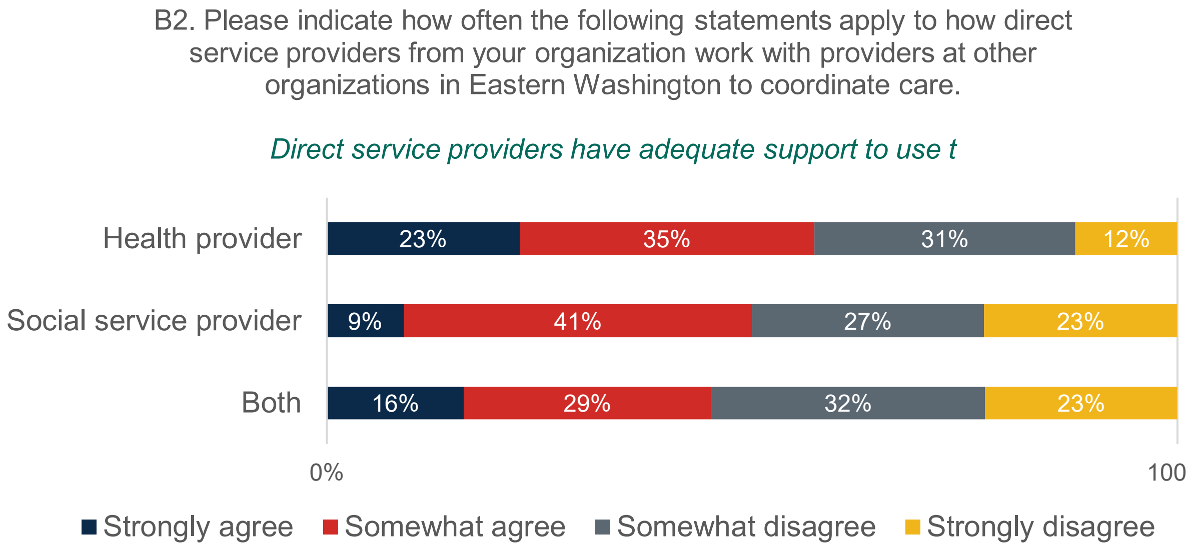
154 survey participants

Table E.38.



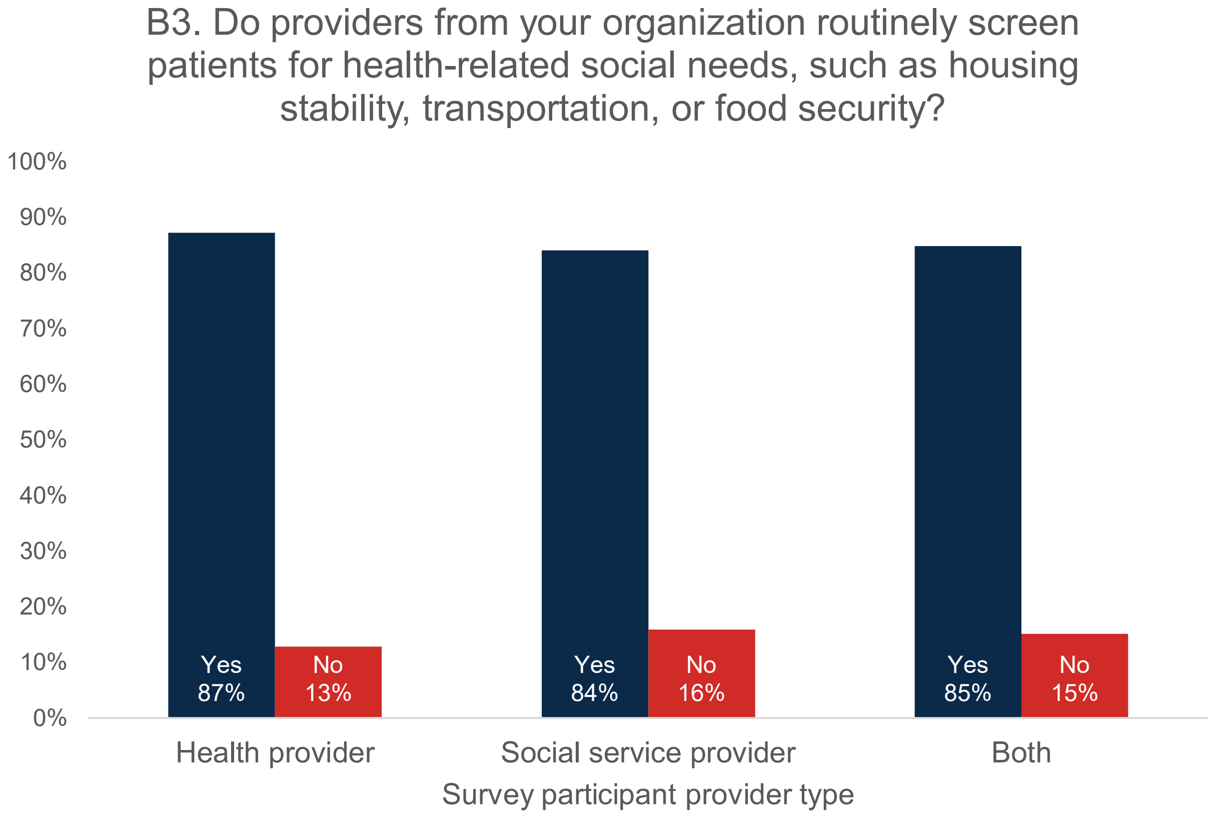
139 survey participants

Table E.39.



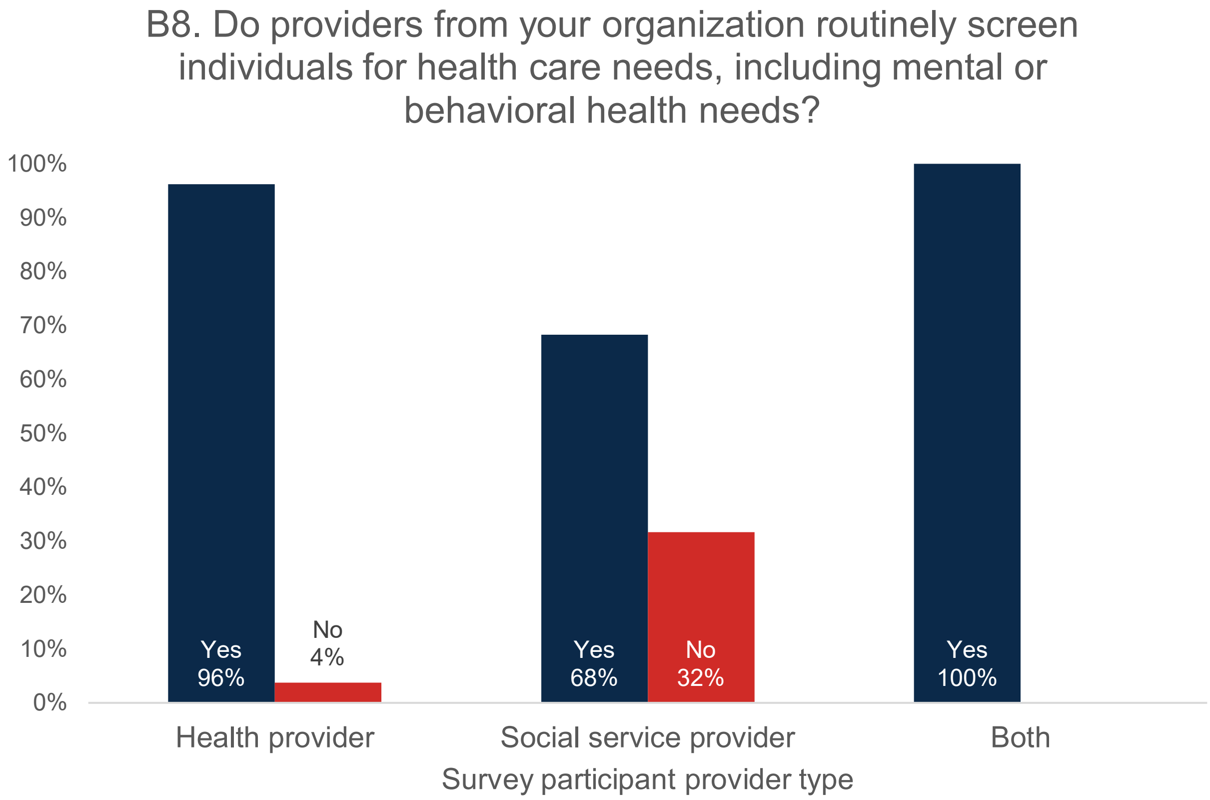
150 survey participants

Table E.40.



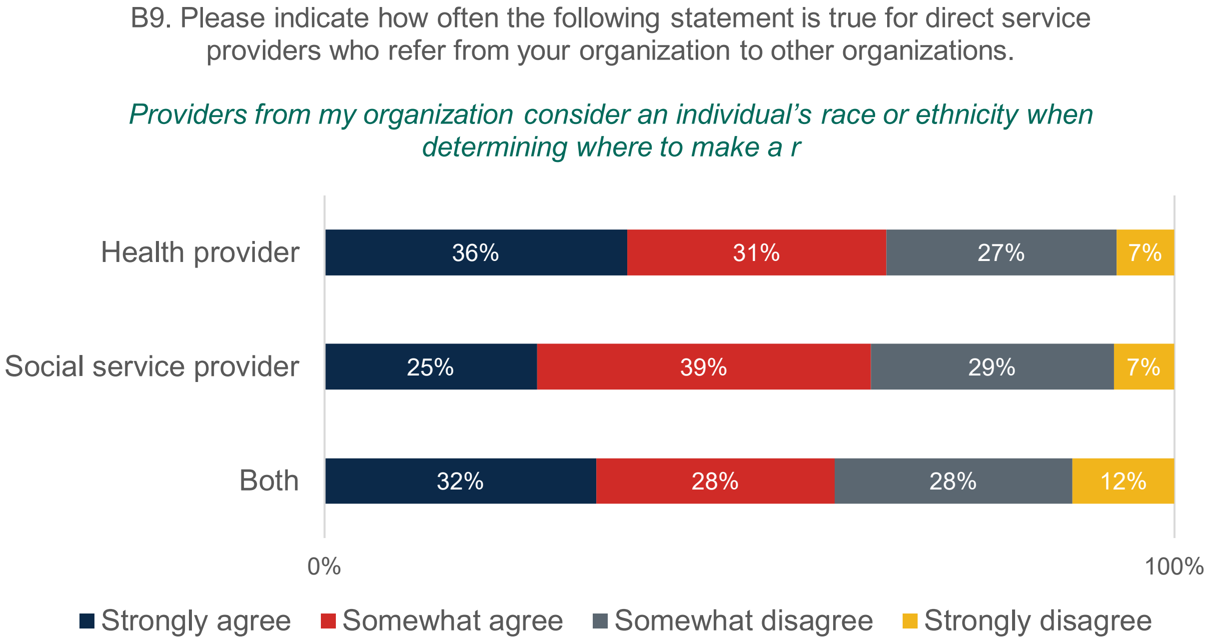
155 survey participants

Table E.41.



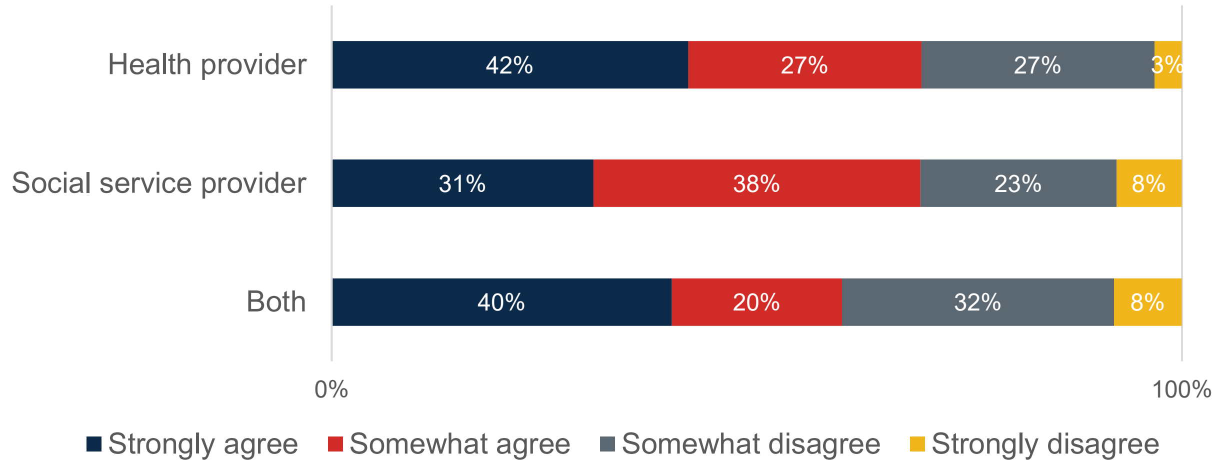
154 survey participants

Table E.42.



112 survey participants

Table E.43.

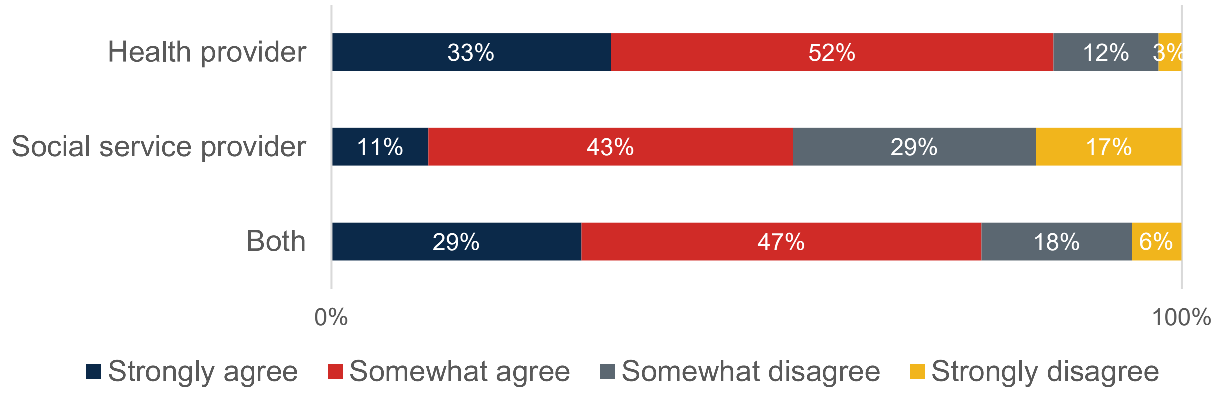


B9. Please indicate how often the following statement is true for direct service providers who refer from your organization to other organizations.

Providers from my organization consider an individual's sexual orientation or gender identity when determini

113 survey participants

Table E.44.

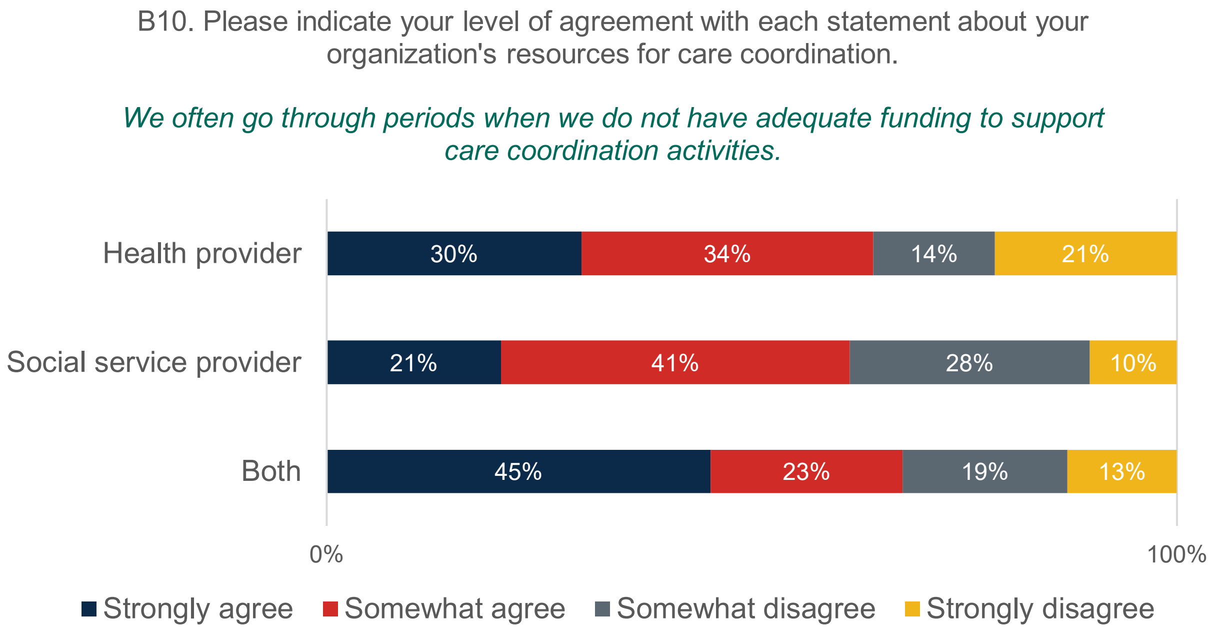


B9. Please indicate how often the following statement is true for direct service providers who refer from your organization to other organizations.

Providers from my organization use a consistent process to refer individuals to appropriate health care prov

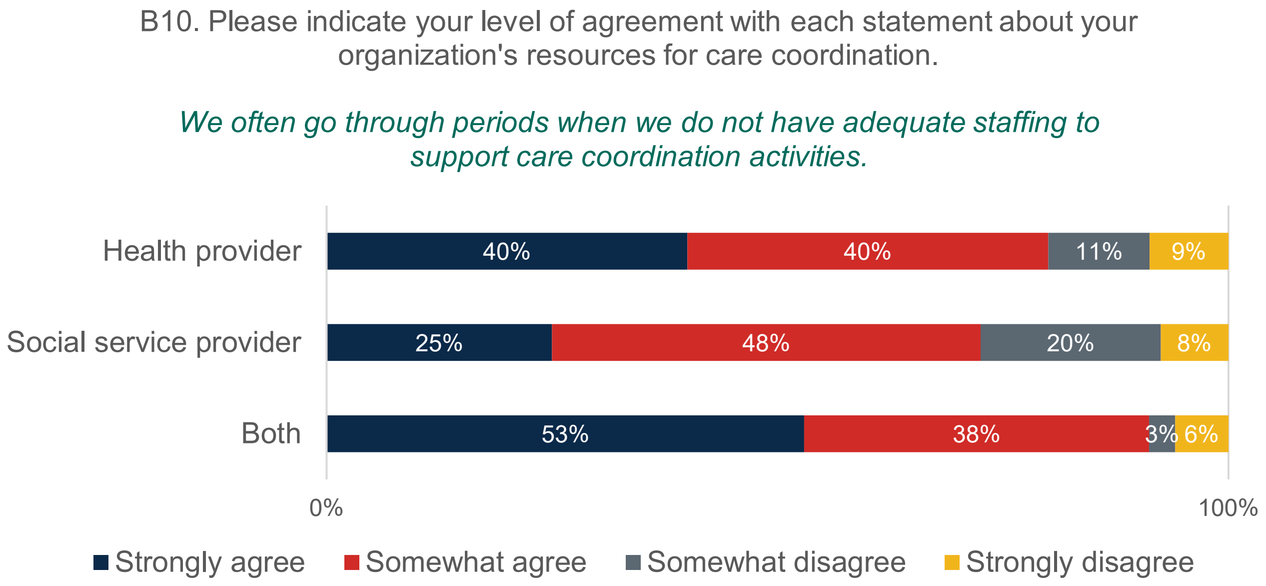
142 survey participants

Table E.45.



140 survey participants

Table E.46.

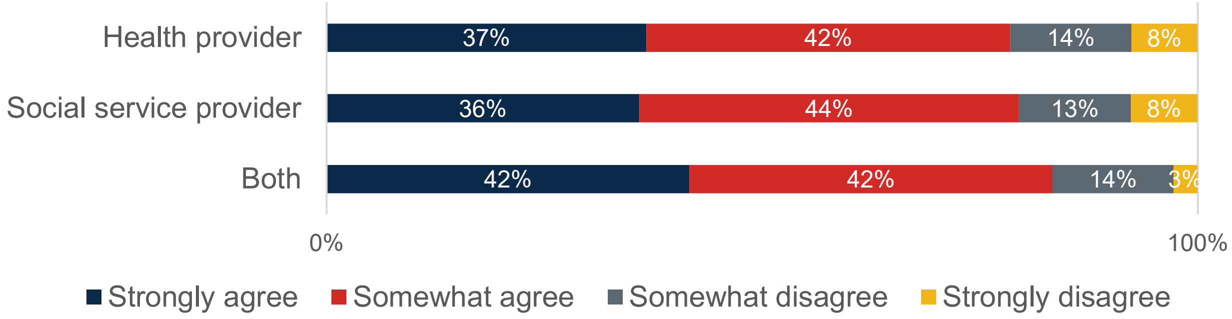


154 survey participants

Table E.47.

B10. Please indicate your level of agreement with each statement about your organization's resources for care coordination.

We often go through periods when we are not able to meet demand for services.

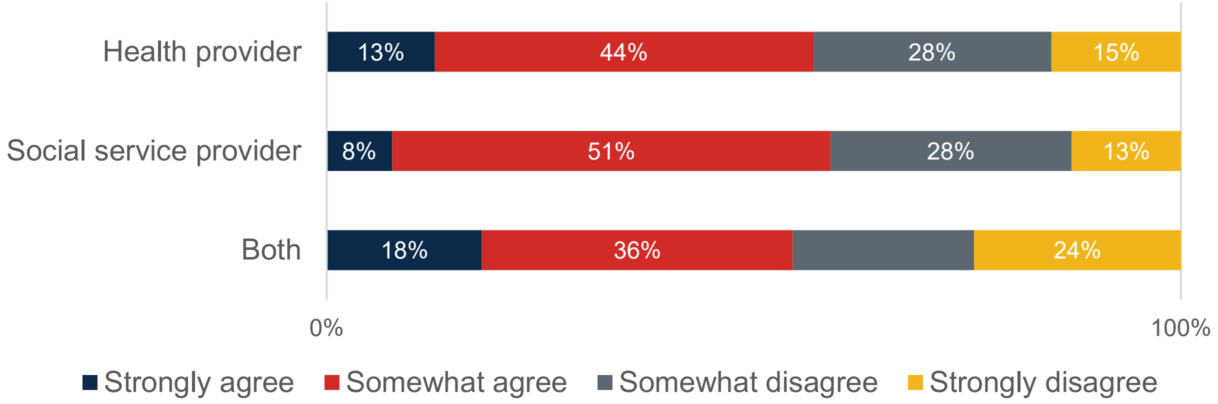


154 survey participants

Table E.48.

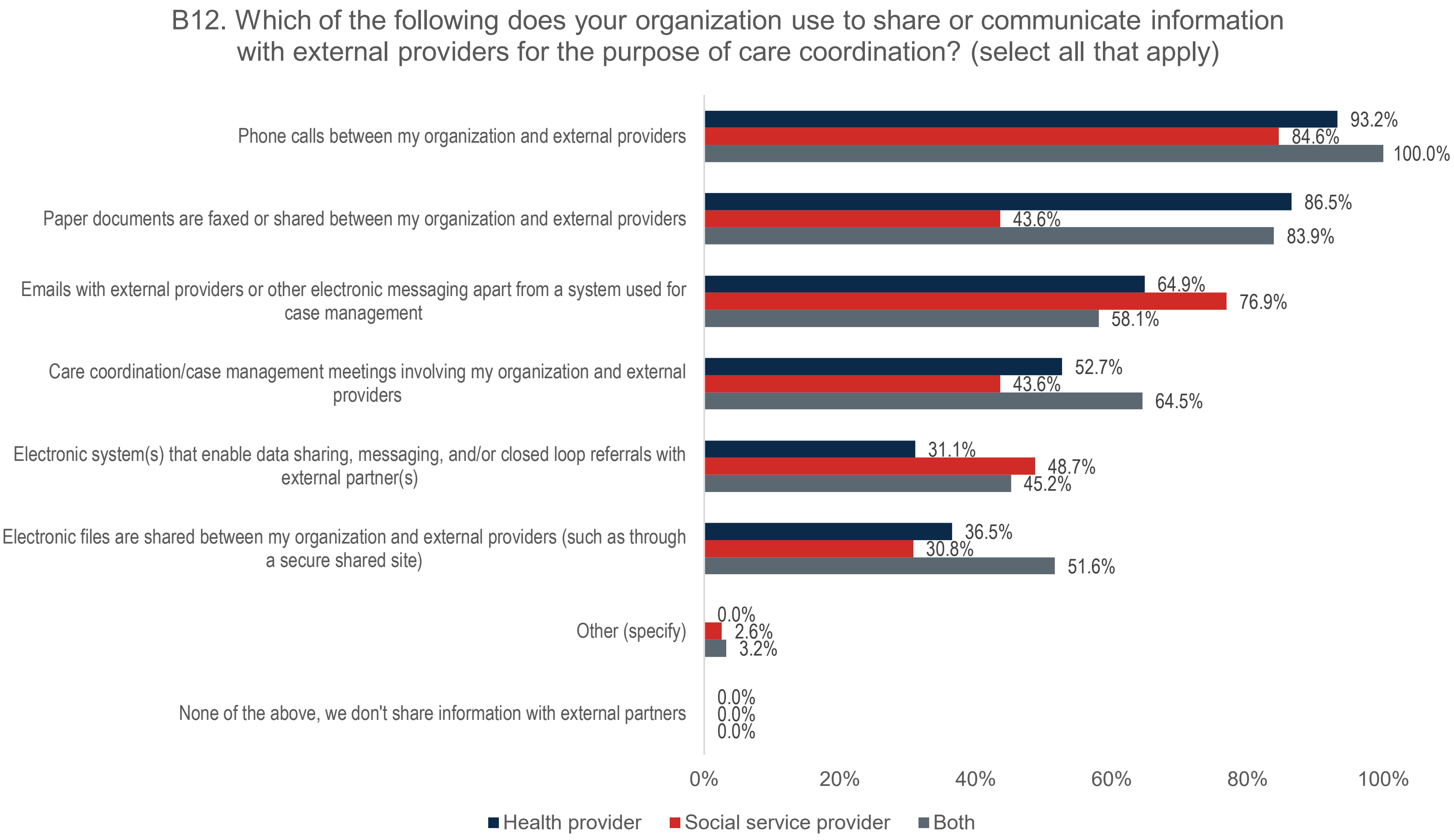
B10. Please indicate your level of agreement with each statement about your organization's resources for care coordination.

We are able to retain a qualified workforce to support care coordination.



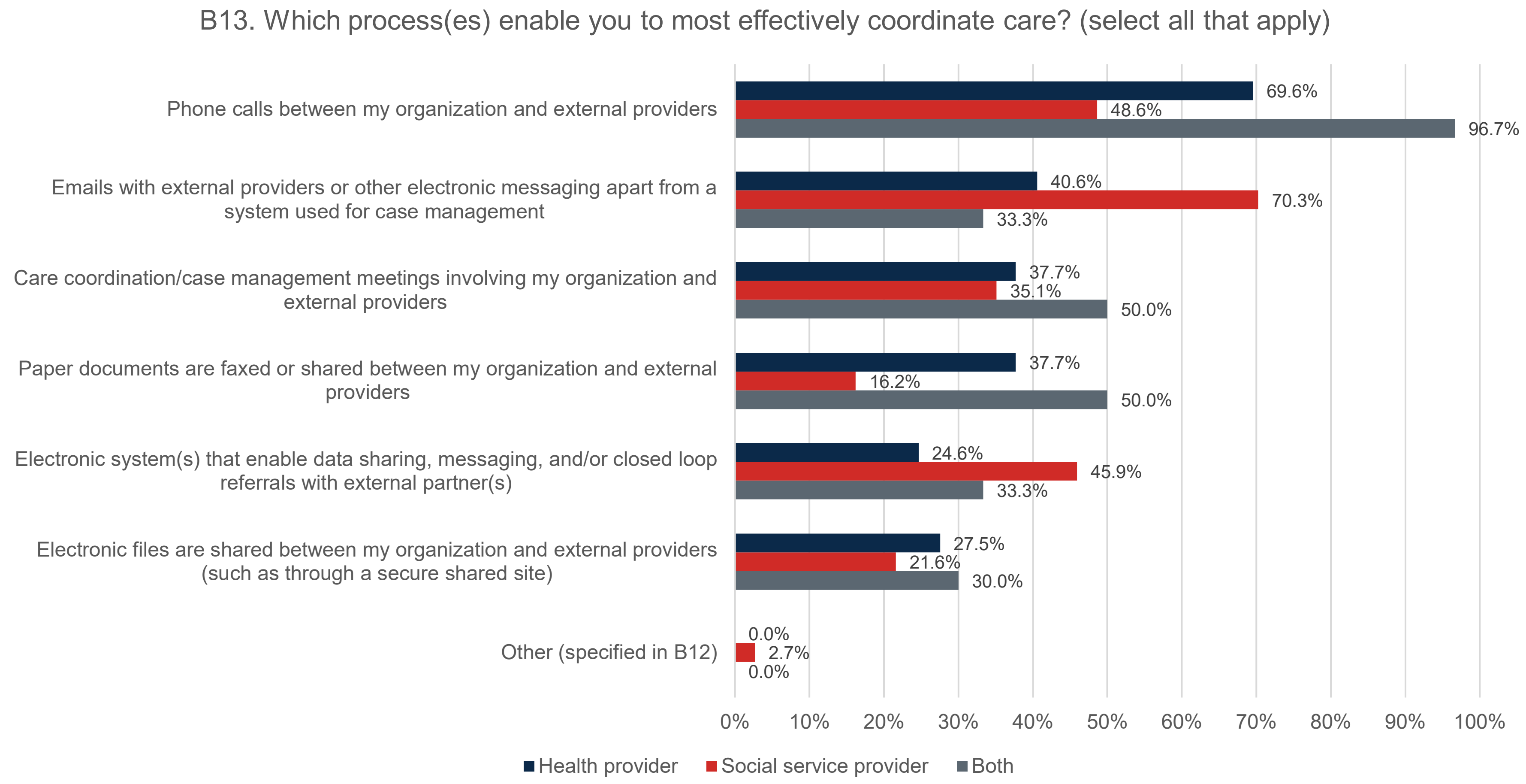
151 survey participants

Table E.49.



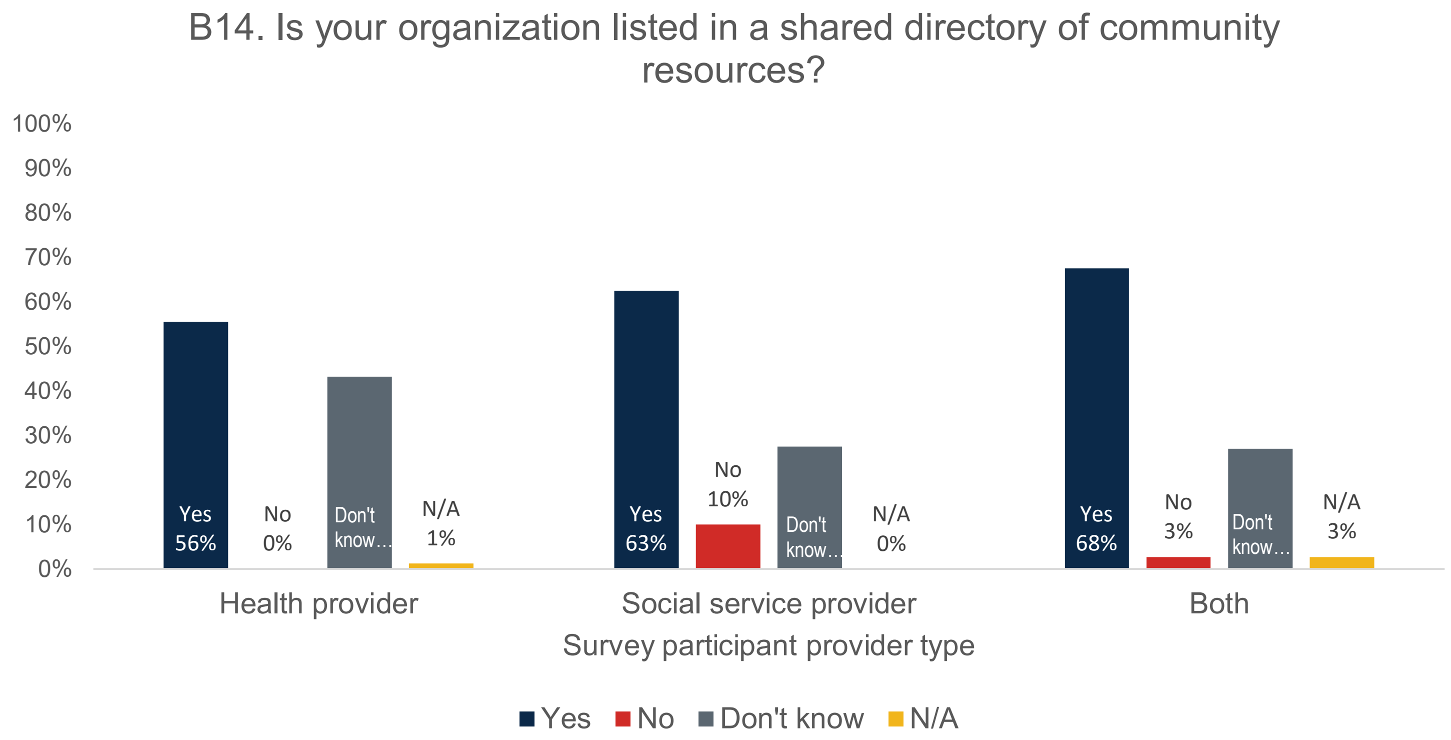
144 survey participants

Table E.50.



136 survey participants

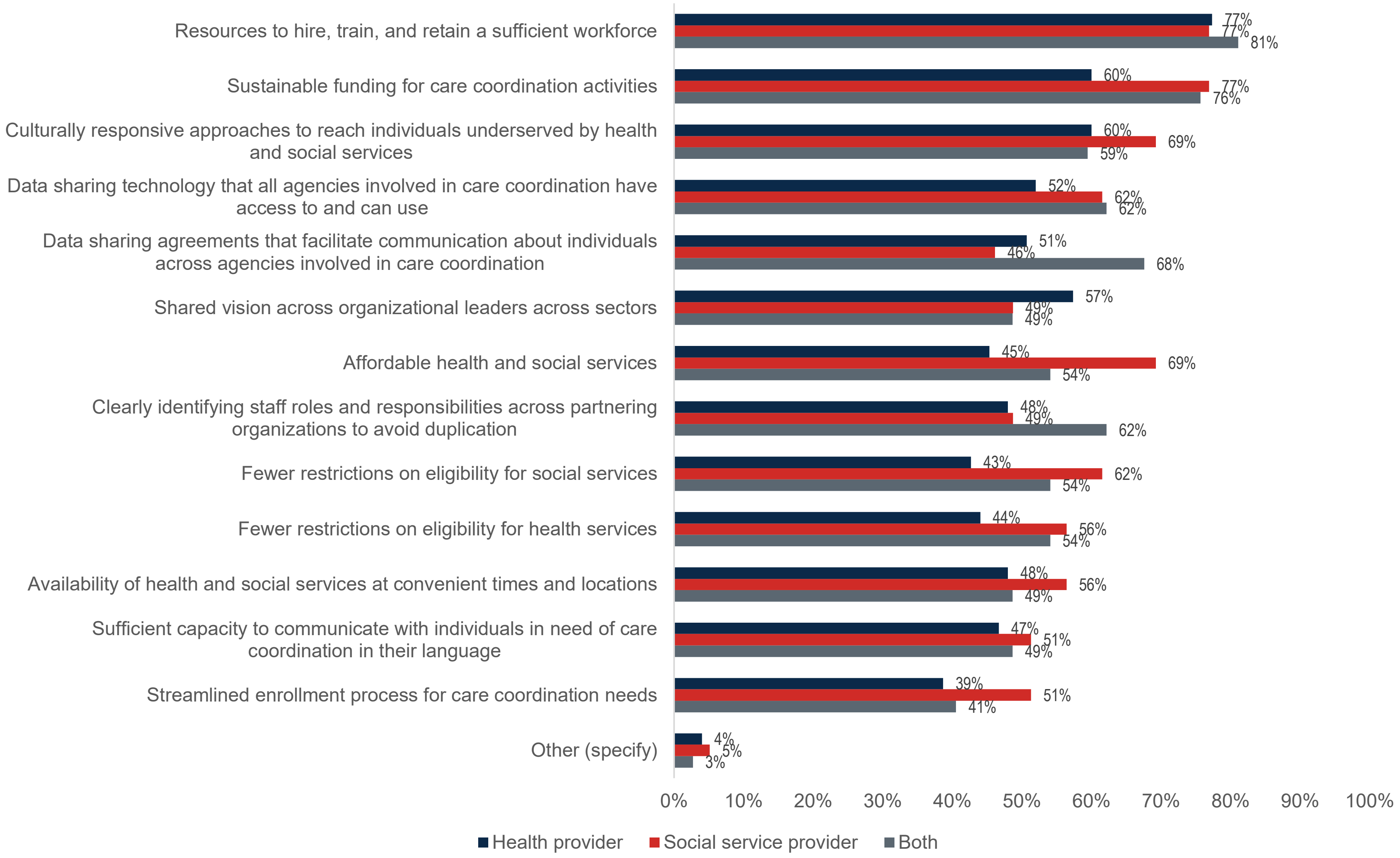
Table E.51.



158 survey participants

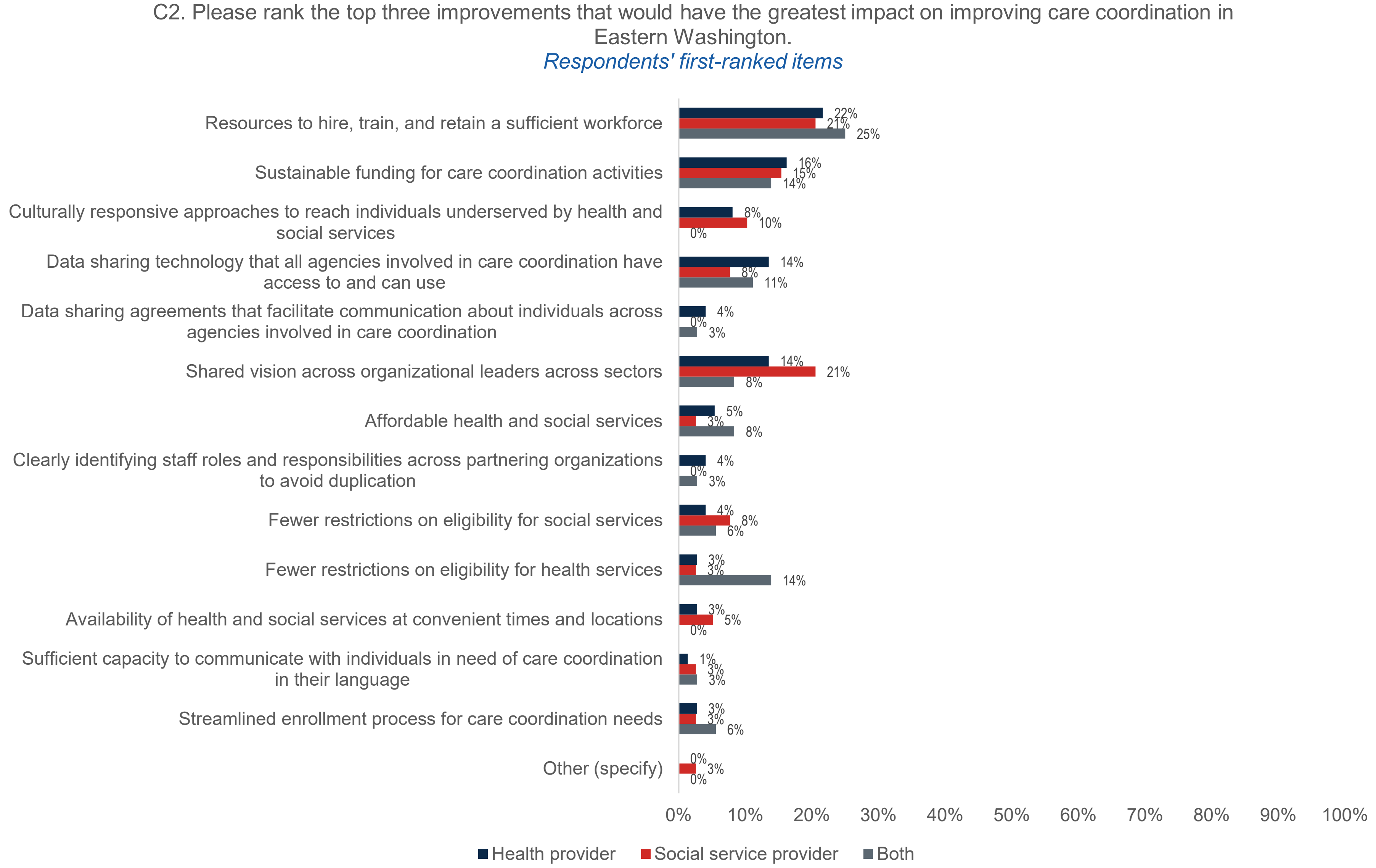
Table E.52.

C1. What does Eastern Washington need to improve care coordination? (select all that apply)



151 survey participants

Table E.53.


C2. Please rank the top three improvements that would have the greatest impact on improving care coordination in Eastern Washington.

Respondents' first-ranked items

149 survey participants

Appendix F. Document Review

A. Care Coordination Models

1. Document Review Methods

We conducted a document review to understand (1) the context surrounding population health in Better Health Together's service area, and (2) models of care coordination previously or currently implemented elsewhere in the country. We began by compiling a list of metrics to understand the population health context of each county in the region. The final 23 metrics were divided into the following categories: population demographics, health access, health outcomes, and economic indicators. To identify sources, we scanned publicly available data from government agencies and large-scale surveys including the American Community Survey, Behavioral Risk Factor Surveillance System, and United States Census (see below for the final set of metrics and sources). We then developed an extraction and synthesis tool to organize and present the population health data by category. We extracted the data from the sources above for each county Better Health Together serves, as well as for Washington overall to create a comparison. We used this information to provide context to our survey, interview, and focus group findings, and inform our final report.

To understand models of care coordination, we conducted a web search of currently or previously implemented care coordination programs. We first developed a data extraction and synthesis tool to organize the findings from our search, including programs' implementation dates, populations served, care coordination models used, and equity considerations. We identified care coordination programs through a targeted web search of thought leaders on care coordination, the Centers for Medicare and Medicaid website, and systematic reviews and evaluations. We prioritized programs that had sufficient available information and integrated important components of care coordination identified in our interviews, focus groups, and co-interpretation meeting. These components included health and social services integration, data sharing, patient navigation, and oversight of referrals.

Our web search yielded five programs. We analyzed program data to identify multiple pros and cons of each program. We summarized this information in the matrix below.

B. Additional information on Better Health Together's service area

F.3. Population health metrics and sources

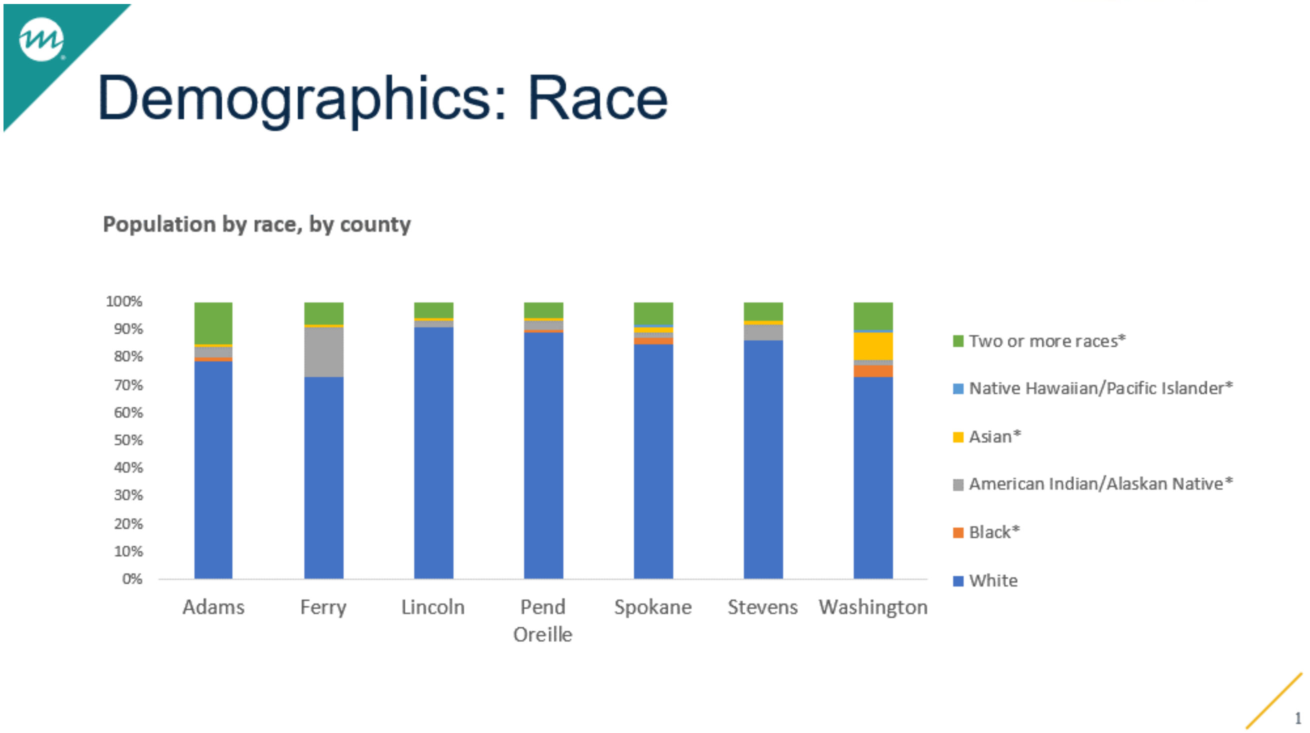
Metric	Unit of observation	Measure	Data year	Source	Link
Population demographics					
Age					
Population by age group (0-19, 20-44,45-64, 65+)	County - All	Share of county population	2019	American Community Survey	https://www.census.gov/data/tables/time-series/demo/popest/2010s-counties-detail.html https://data.census.gov/cedsci/table?q=age%20by%20state%202019&g=0400000US53
Race/ Ethnicity					
Population by race/ ethnicity	County - All	Share of county population	2020	United States Census	https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin
Hispanic population	County - All	Share of county population	2020	United States Census	https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin
Race/Ethnicity					
Limited English proficiency	County - All	Share of county population	2015	United States Department of Justice	https://www.lep.gov/maps/lma2015/Final_508
Health					
Access to Care					
Uninsured rate	County - All	Share of total population	2019	American Community Survey	https://www.census.gov/data-tools/demo/sahie/#/?s_statefips=53&s_year=2019&s_searchtype=sc&s_agecat=0
Uninsured by age group	County -All	Share of total population & number	2019	United States Census	https://www.census.gov/data-tools/demo/sahie/#/?s_statefips=53&s_year=2019&s_searchtype=sc&s_agecat=0
Uninsured by income	County -All	Share of total population & number	2019	United States Census	https://www.census.gov/data-tools/demo/sahie/#/?s_statefips=53&s_year=2019&s_searchtype=sc&s_agecat=0
Primary care physicians	County - All	Count, Ratio	2018	Area Health Resource Files	https://www.countyhealthrankings.org/app/washington/2021/measure/factors/4/data

Metric	Unit of observation	Measure	Data year	Source	Link
Mental health providers	County - All	Count, Ratio	2020	National Plan and Provider Enumeration System	https://www.countyhealthrankings.org/app/washington/2021/measure/factors/62/data
Flu vaccination rates	County - All	Share of population	2019	American Community Survey	https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population-prevalence-key-demographic-features
Mammography rates	County - All	Share of population	2019	American Community Survey	https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population-prevalence-key-demographic-features
Behavioral health					
Drug overdose deaths	County - All	Count	2015-2019	Washington State Department of Health	https://doh.wa.gov/sites/default/files/2022-02/wa_lhj_quarterly_report_18_1_2_pub.html#132_Mortality_Tables_By_Geography,_Drug_Type,_and_Year_from_2000_to_2019
Frequent mental distress	County - All	Share of population	2018	Behavioral Risk Factor Surveillance System	https://www.countyhealthrankings.org/app/washington/2021/measure/outcomes/145/datasource?sort=sc-2
Physical health					
Adult diabetes	County - All	Share of population	2019	Centers for Disease Control and Prevention	https://experience.arcgis.com/experience/dc15b033b88e423d85808ce04bd7a497/page/Health-Outcomes/?views=Diabetes; BRFSS, 2019. https://www.americashealthrankings.org/explore/annual/measure/Diabetes/state/WA?edition-year=2019
Adult heart disease	County - All	Share of population	2018	Centers for Disease Control and Prevention	https://experience.arcgis.com/experience/dc15b033b88e423d85808ce04bd7a497/page/Health-Outcomes/?views=Heart-Disease https://www.americashealthrankings.org/explore/annual/measure/CVD/state/WA
Adult obesity	County - All	Share of population	2019	Behavioral Risk Factor Surveillance System	https://experience.arcgis.com/experience/dc15b033b88e423d85808ce04bd7a497/page/Health-Outcomes/?views=Obesity https://www.americashealthrankings.org/explore/annual/measure/Obesity/state/WA
Economic					
Income					
Median household income	County - All	Number	2019	United States Department of Agriculture	https://data.ers.usda.gov/reports.aspx?ID=17828

Metric	Unit of observation	Measure	Data year	Source	Link
Population in poverty	County - All	Share of total population	2019	United States Department of Agriculture	https://data.ers.usda.gov/reports.aspx?ID=17826
Children 0-17 in poverty	County - All	Share of total population	2019	United States Department of Agriculture	https://data.ers.usda.gov/reports.aspx?ID=17827
Employment					
Unemployment rate	County - All	Share of total population	2020	United States Department of Agriculture	https://data.ers.usda.gov/reports.aspx?ID=17828
Food insecurity					
Participation in SNAP	County - All	Share of households	2018	United States Department of Agriculture	https://www.census.gov/data/datasets/time-series/demo/saipe/model-tables.html
Food insecurity	County - All	Share of total population	2018	Feeding America	https://www.countyhealthrankings.org/app/washington/2021/measure/factors/139/data
Housing					
Households spending 50+% of income on housing	County - All	Share of households	2015-2019	American Community Survey	https://www.countyhealthrankings.org/app/washington/2021/measure/factors/154/data
Broadband access	County - All	Share of households	2015-2019	American Community Survey	https://www.countyhealthrankings.org/app/washington/2021/measure/factors/166/data https://data.census.gov/cedsci/table?q=S2801&g=0400000US53&d=ACS%205-Year%20Estimates%20Subject%20Tables&tid=ACSST5Y2019.S2801

BHT’s service area

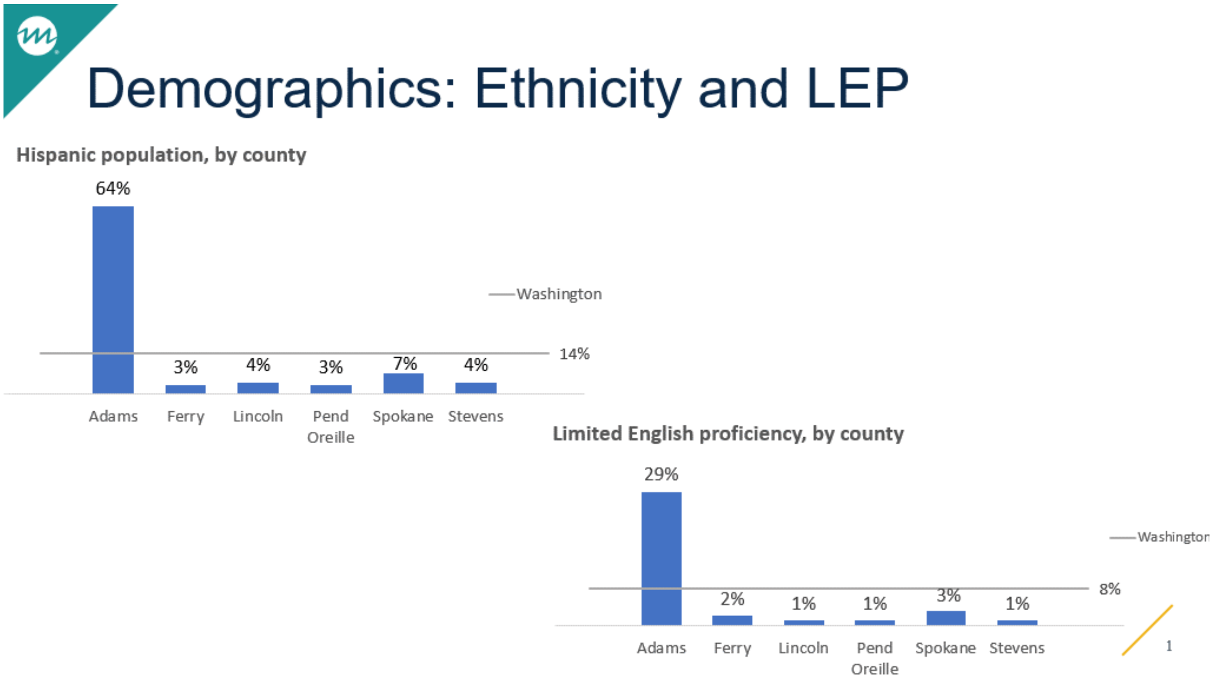
- **Counties:** Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens
- **Metrics:**
  - Demographics
  - Health access
  - Health outcomes
  - Economic indicators



Demographics: Race

Population by race, by county

*Includes Hispanic populations.
Source: United States Census, 2020. https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin



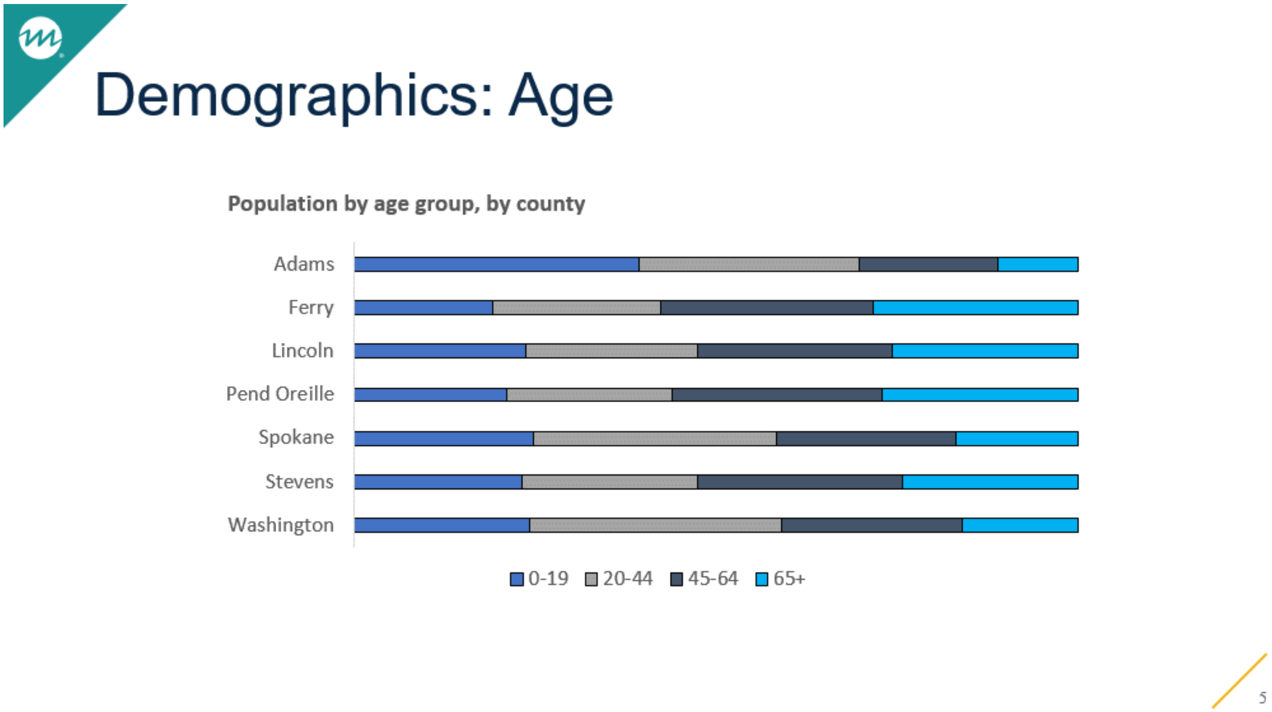
Demographics: Ethnicity and LEP

Hispanic population, by county

Limited English proficiency, by county

Source: United States Department of Justice, 2015. https://www.lep.gov/maps/lma2015/Final_508

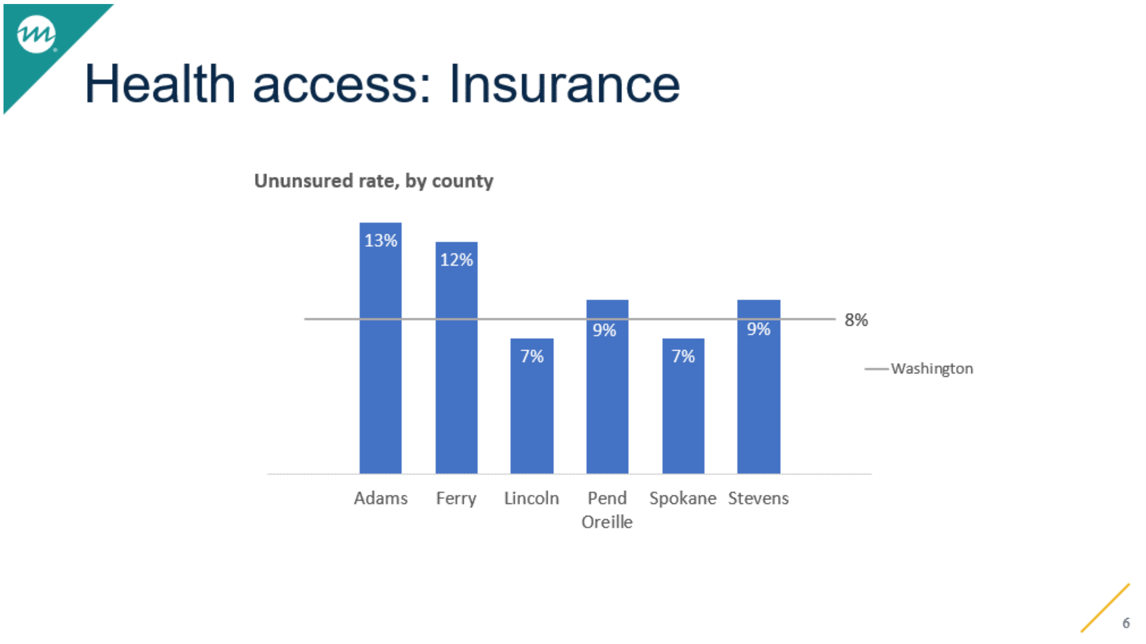
*Includes Hispanic populations.
Source: United States Census, 2020. https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin



Demographics: Age

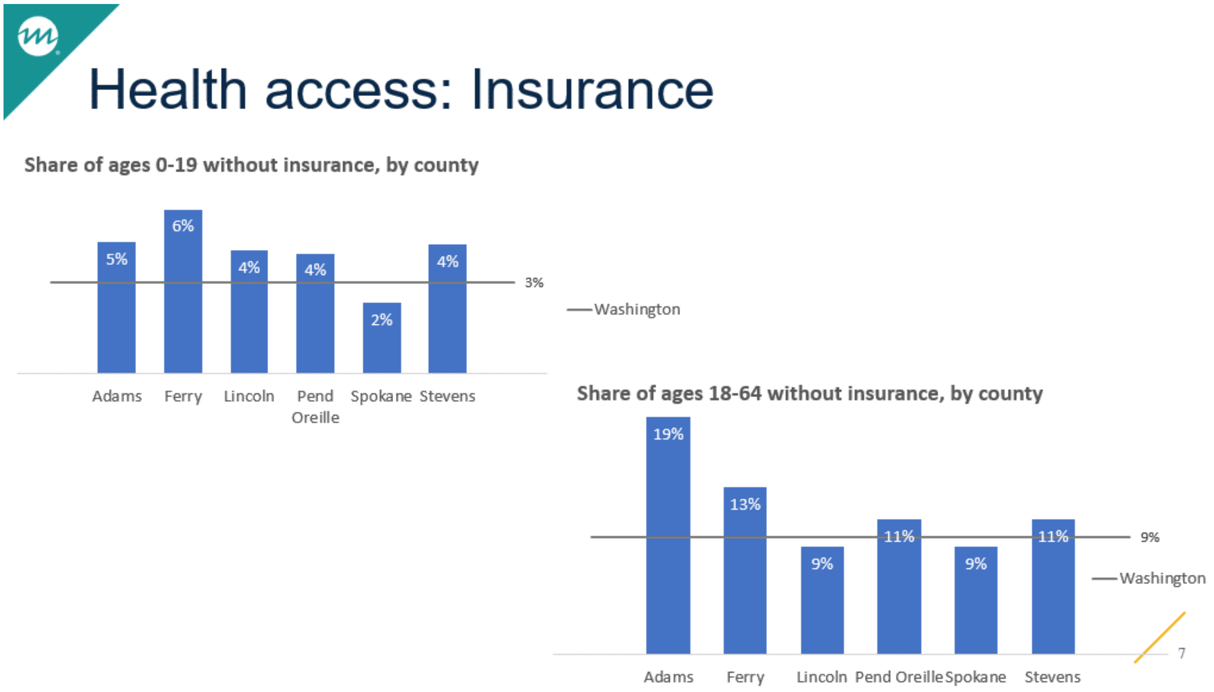
Population by age group, by county

Source: American Community Survey, 2019. https://www.census.gov/data/tables/time-series/demo/popest/2010s-counties-detail.html



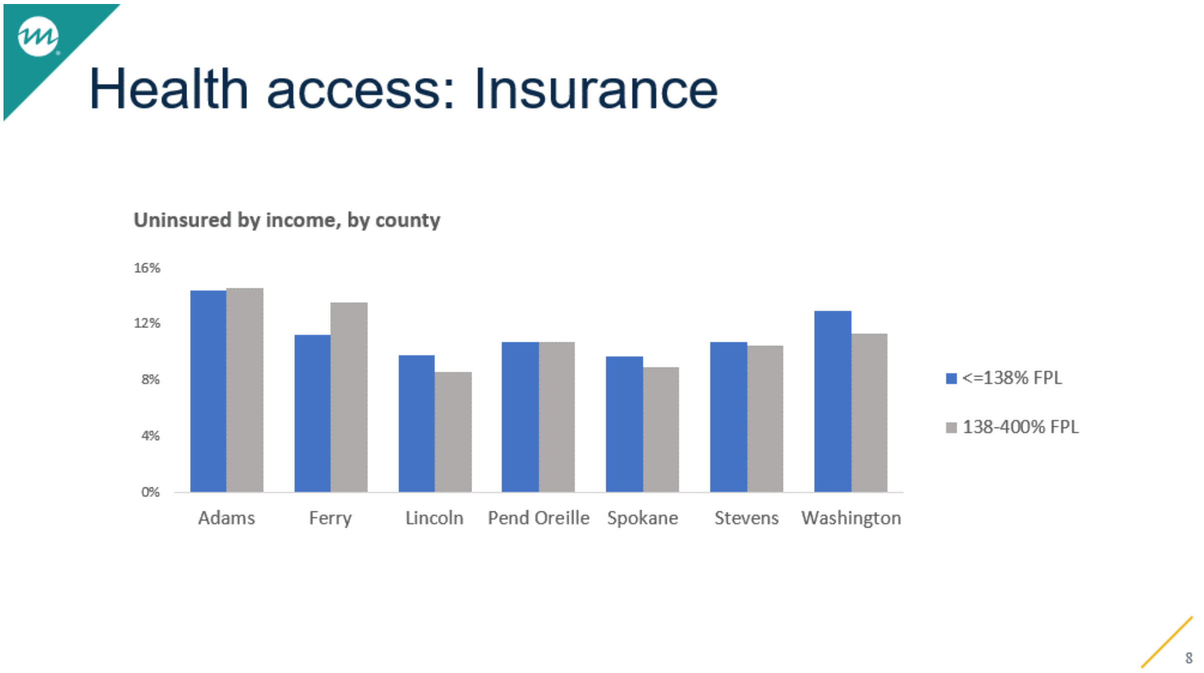
Health access: Insurance

Source: American Community Survey, 2019. https://www.census.gov/data-tools/demo/sahie/#/?s_statefips=53&s_year=2019&s_searchtype=sc&s_agecat=0



Health access: Insurance

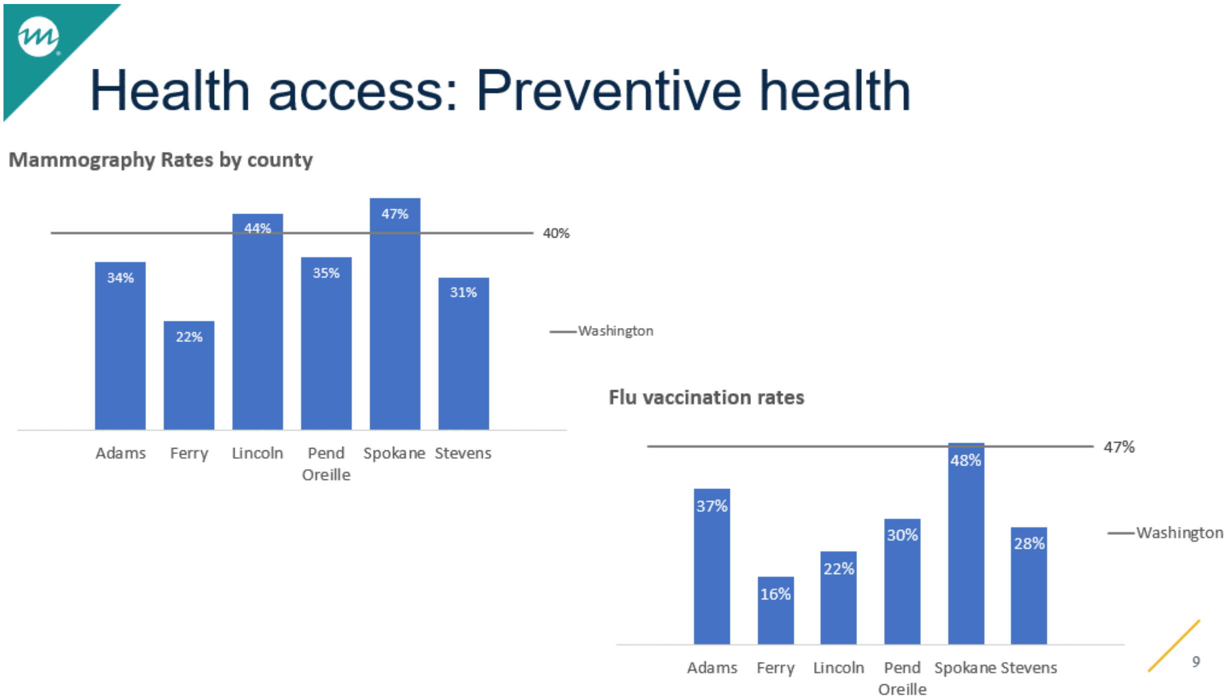
Source: United States Census, 2019. https://www.census.gov/data-tools/demo/sahie/#/?s_statefips=53&s_year=2019&s_searchtype=sc&s_agecat=0



Health access: Insurance

Uninsured by income, by county

Source: United States Census, 2019. https://www.census.gov/data-tools/demo/sahie/#/?s_statefips=53&s_year=2019&s_searchtype=sc&s_agecat=0



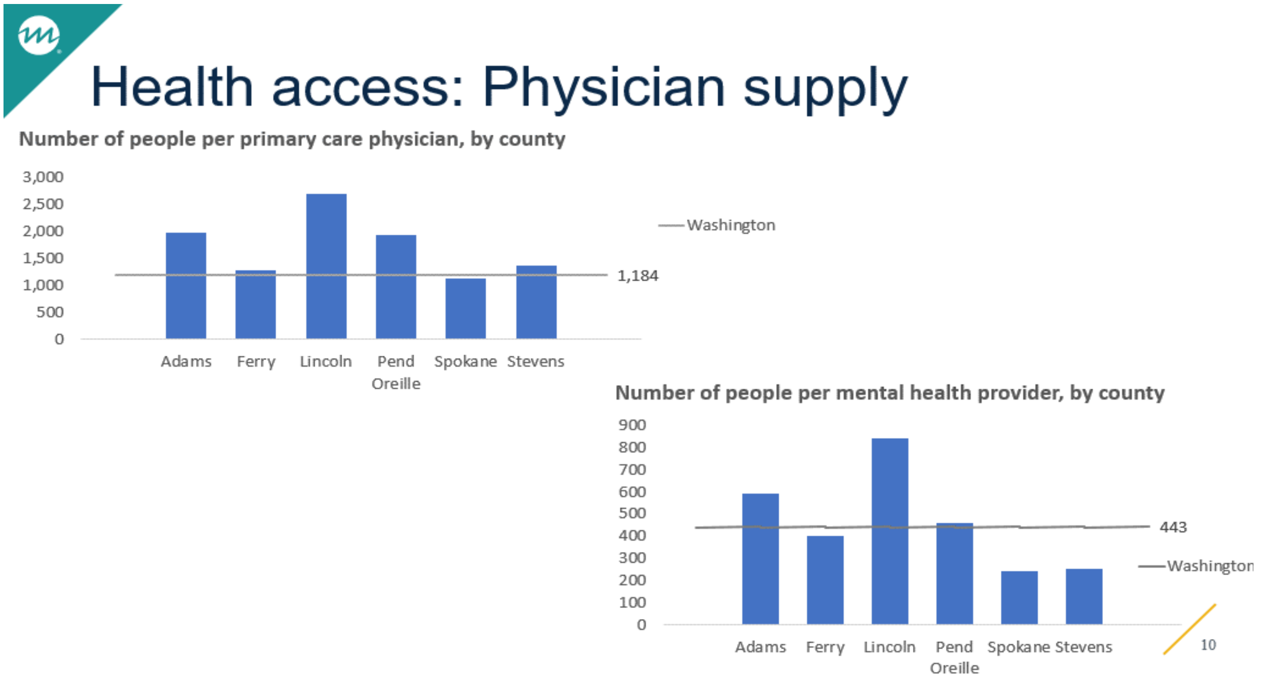
Health access: Preventive health

Mammography Rates by county

Flu vaccination rates

Source: American Community Survey, 2019. https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population-prevalence-key-demographic-features

Source: American Community Survey, 2019. https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population-prevalence-key-demographic-features



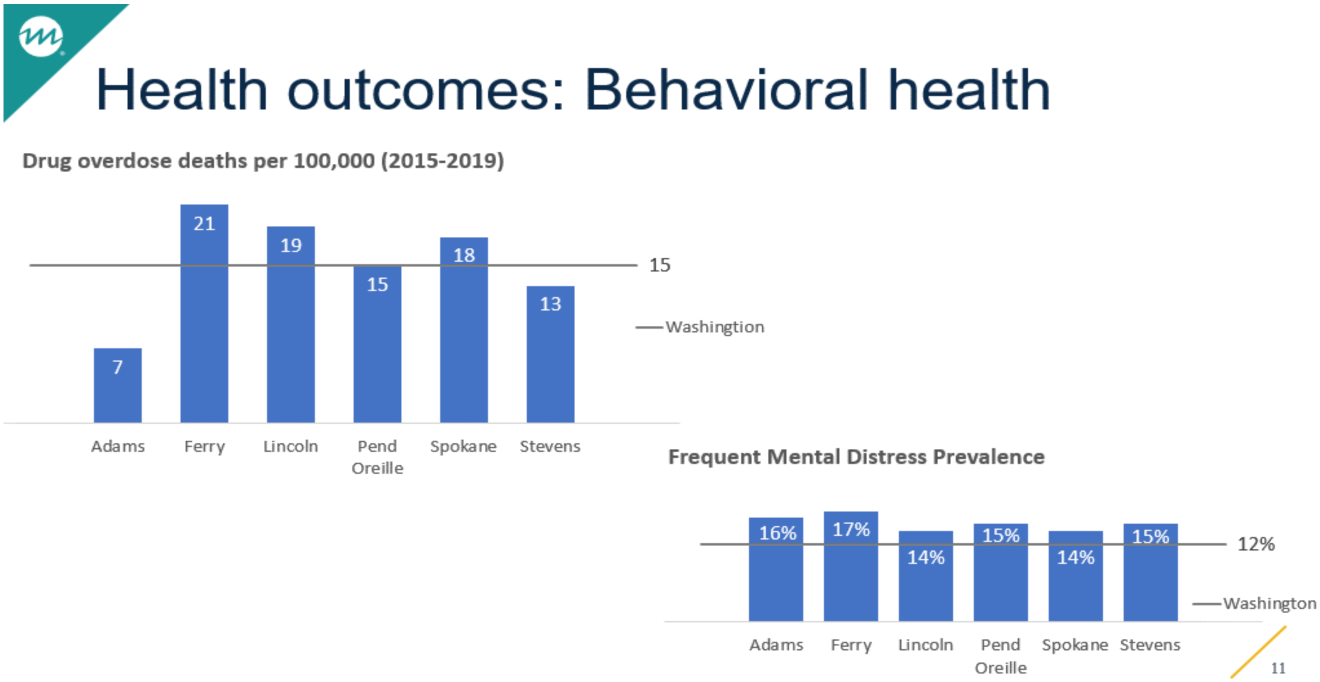
Health access: Physician supply

Number of people per primary care physician, by county

Number of people per mental health provider, by county

Source: Area Health Resource File, 2018. https://www.countyhealthrankings.org/app/washington/2021/measure/factors/4/data

Source: National Plan and Provider Enumeration System, 2020. https://www.countyhealthrankings.org/app/washington/2021/measure/factors/62/data

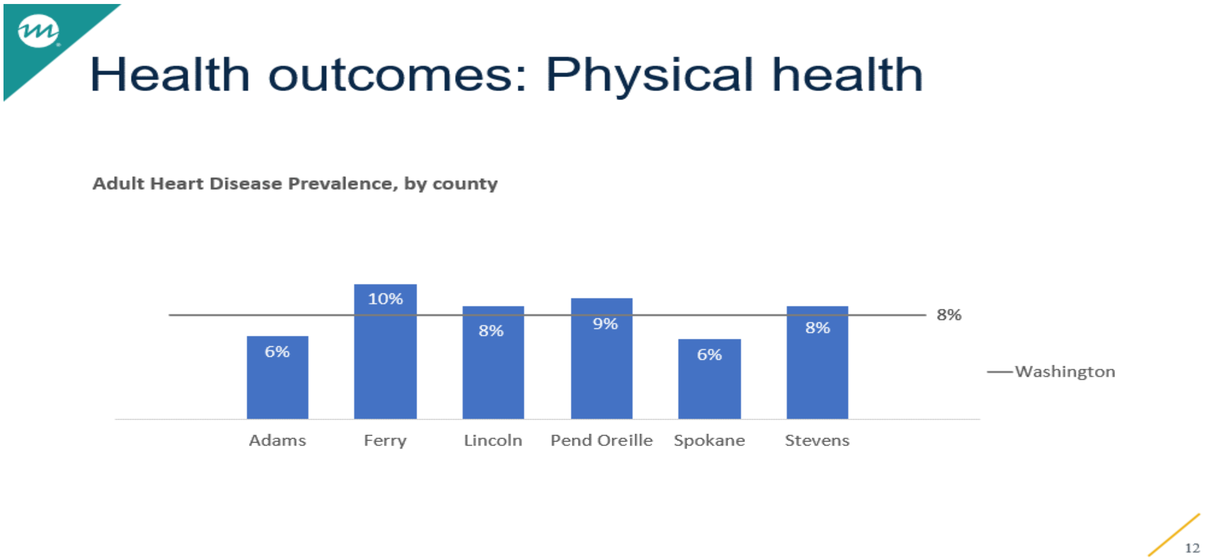


Health outcomes: Behavioral health

Drug overdose deaths per 100,000 (2015-2019)

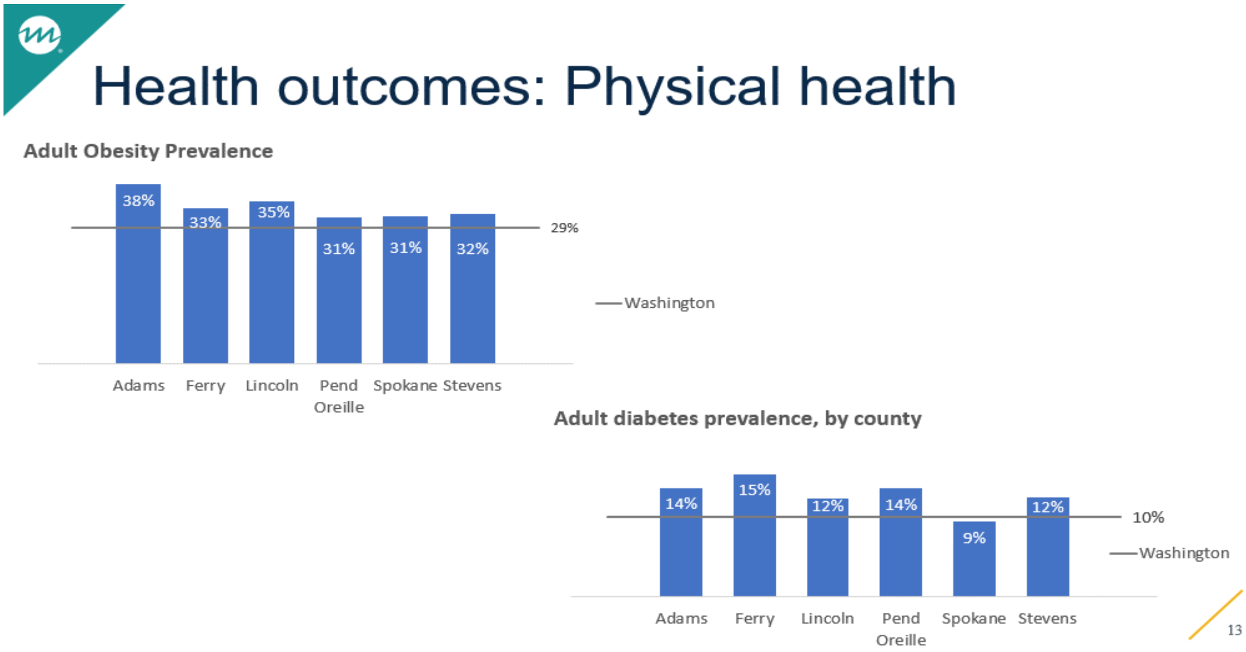
Frequent Mental Distress Prevalence

Source: Washington State Department of Health, 2022. https://doh.wa.gov/sites/default/files/2022-02/wa_lhj_quarterly_report_18_1_2_pub.html#132_Mortality_Tables_By_Geography,_Drug_Type,_and_Year_from_2000_to_2019



Health outcomes: Physical health

Source: Behavioral Risk Factor Surveillance System, 2018. https://www.countyhealthrankings.org/app/washington/2021/measure/outcomes/145/datasource?sort=sc-2

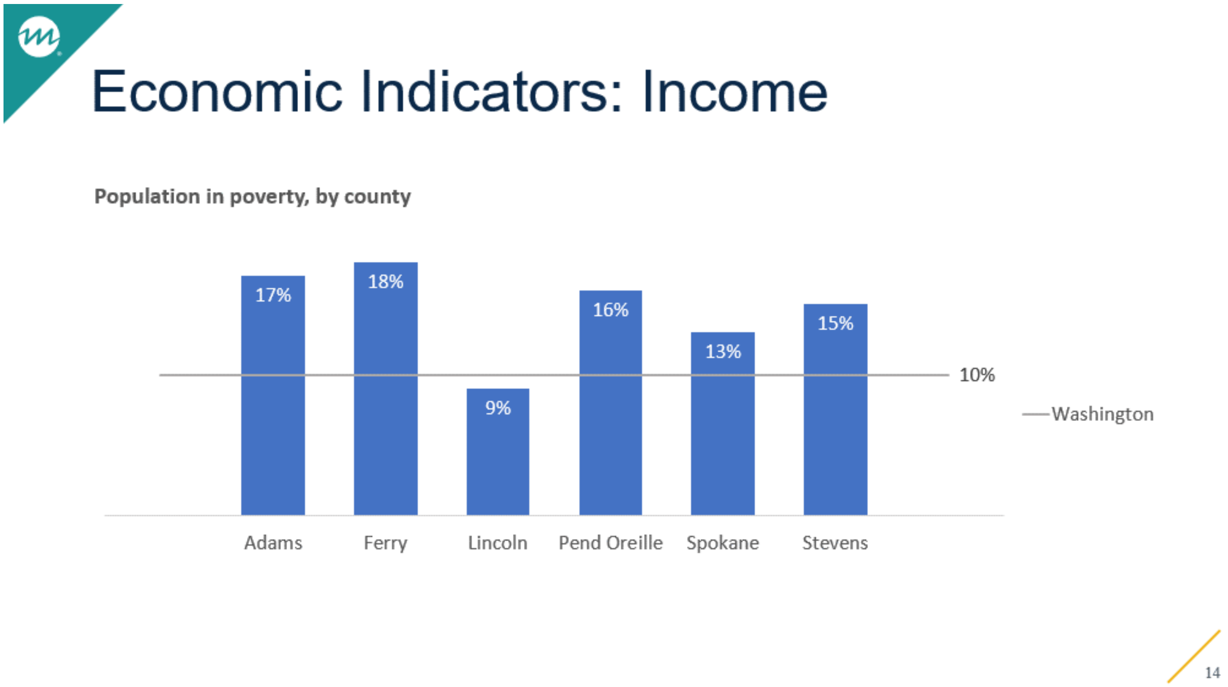


Health outcomes: Physical health

Source: Behavioral Risk Factor Surveillance System, 2019. https://experience.arcgis.com/experience/dc15b033b88e423d85808ce04bd7a497/page/Health-Outcomes/?views=Obesity
https://www.americashealthrankings.org/explore/annual/measure/Obesity/state/WA

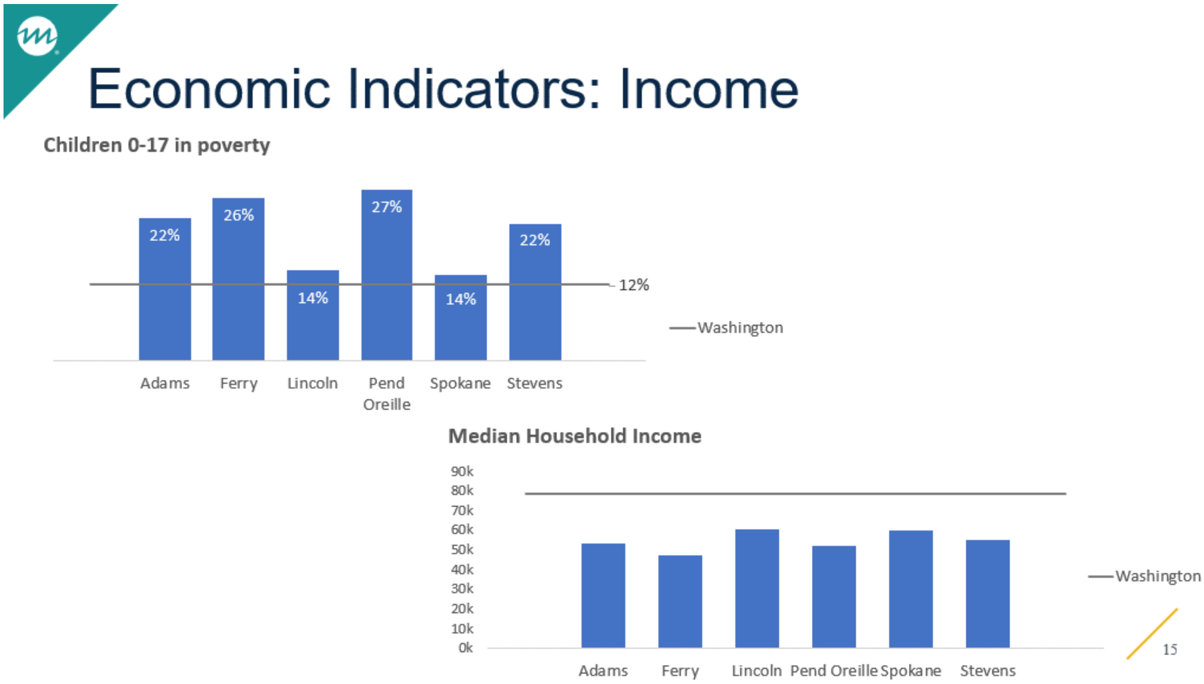
Sources: CDC PLACES, 2019. https://experience.arcgis.com/experience/dc15b033b88e423d85808ce04bd7a497/page/Health-Outcomes/?views=Diabetes; BRFSS, 2019.

https://www.americashealthrankings.org/explore/annual/measure/Diabetes/state/WA?edition-year=2019



Economic Indicators: Income

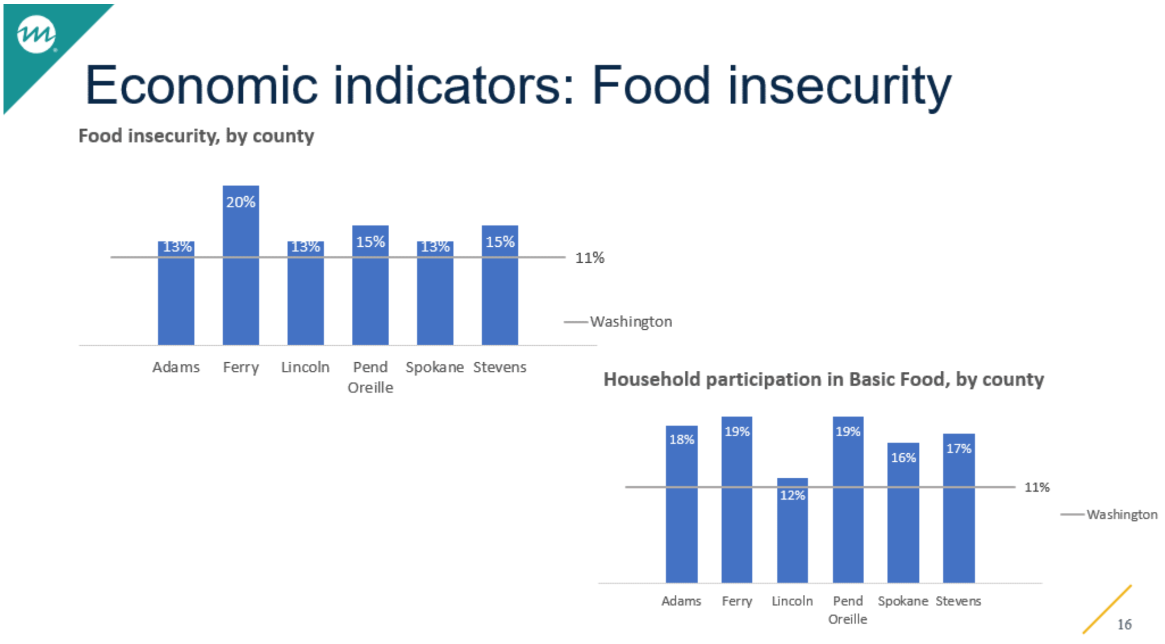
Source: United States Department of Agriculture, 2019. https://data.ers.usda.gov/reports.aspx?ID=17828



Economic Indicators: Income

Source: United States Department of Agriculture, 2019. https://data.ers.usda.gov/reports.aspx?ID=17827

Source: United States Department of Agriculture, 2019. https://data.ers.usda.gov/reports.aspx?ID=17828

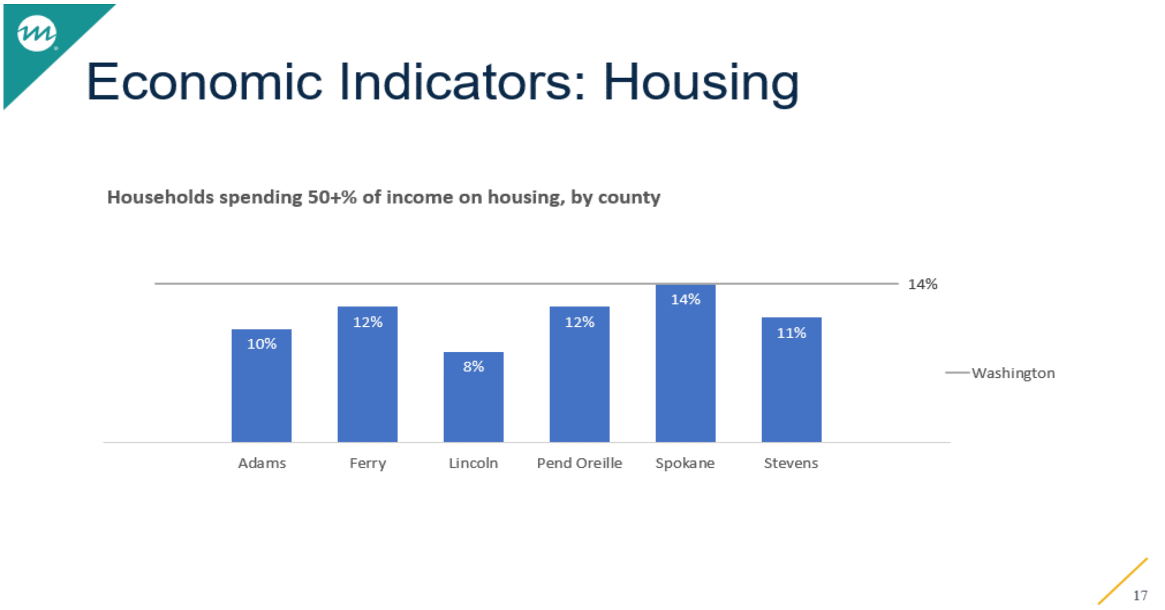


Economic indicators: Food insecurity

Food insecurity, by county

Household participation in Basic Food, by county

Source: Feeding America, 2018.
https://www.countyhealthrankings.org/app/washington/2021/measure/factors/139/data



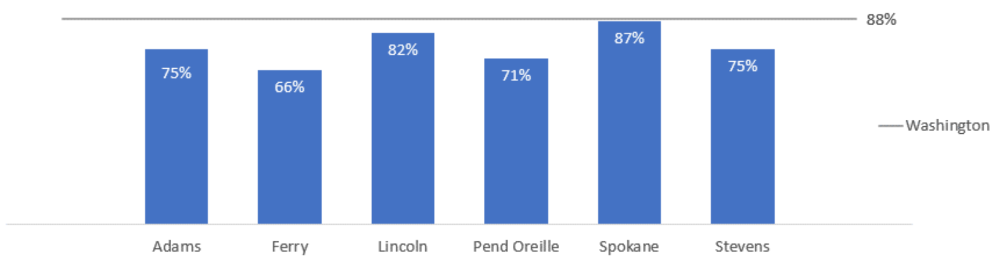
Economic Indicators: Housing

Households spending 50+% of income on housing, by county

Source: American Community Survey, 2015-2019.
https://www.countyhealthrankings.org/app/washington/2021/measure/factors/154/data

Economic indicators: Broadband access

Households with broadband access, by county



Source: American Community Survey, 2015-2019.
https://www.countyhealthrankings.org/app/washington/2021/measure/factors/166/data

https://data.census.gov/cedsci/table?q=S2801&g=0400000US53&d=ACS%205-Year%20Estimates%20Subject%20Tables&tid=ACSST5Y2019.S2801

Table F.1. Care Coordination Program Matrix

Program name	Accountable Health Communities Model [a, b, c]	CommunityCares [d, e, f, g]	Healthy Opportunities Pilots [h, i, j, k, l]	Connected Communities for Health [m, n]	COMPASS (Care of Mental, Physical and Substance-use Syndromes) [o, p]
Location	Nationwide	Arizona - Statewide	North Carolina - 3 regions	Michigan - Upper Peninsula	Nationwide
Summary	Accountable Health Communities was a CMMI model that screened beneficiaries for unmet social needs in clinical settings. Eligible beneficiaries were offered navigation to address needs.	Community Cares is a state-wide closed-loop referral system for clinical and community service providers led by Arizona's Medicaid program.	Healthy Opportunities Pilots is a Medicaid section 1115 waiver-funded initiative. Beneficiaries are screened for health and social risks and referred to community services by care management teams.	Connected Communities for Health is a call center operated by Upper Peninsula Health Plan, an MCO, to screen, refer, and follow-up with members regarding social needs.	COMPASS was funded through the Health Care Innovations Awards. Patients were connected by physicians to care managers, who worked on health goals and target outcomes. The model used team-based care to review patients.
Implementation dates	2017-2022	2021-present	2022-present	2016-present	2012-2015
Focus population	Medicaid and Medicare beneficiaries	Medicaid beneficiaries, general patient population	Medicaid beneficiaries	Rural Medicaid beneficiaries	Medicare and Medicaid beneficiaries with depression and diabetes or cardiovascular disease
Funding (Sources and funded activities)	CMMI (Infrastructure and bridge organization staffing needs - no funding for community service provision		CMS - Medicaid section 1115 waiver (Capacity building, administration, provision of non-medical services, value-based payment incentives)		CMMI - Health Care Innovation Award
Care coordination model	Case management/navigation	CIE	Case management/navigation with CIE	Call center with CIE	Case management/navigation
Care coordination process	Beneficiaries are screened for health-related social needs in clinical settings. Those eligible are assigned to	Organizations screen beneficiaries for needs. The platform generates a tailored referral, sent to organizations and beneficiaries. Providers	Care management screens MCO enrollees for risk factors and enters data and recommendations into	Members who the MCO are screened for social needs and transferred to the Connected	After a primary care appointment, send patients to care managers, who review the care plan, and

Program name	Accountable Health Communities Model [a, b, c]	CommunityCares [d, e, f, g]	Healthy Opportunities Pilots [h, i, j, k, l]	Connected Communities for Health [m, n]	COMPASS (Care of Mental, Physical and Substance-use Syndromes) [o, p]
	navigators. Navigators are required to connect with beneficiaries monthly for 12 months.	indicate referral success in the platform, which notifies the referring organization.	NCCARE360. The MCO authorizes eligibility determinations and recommendations. Care management monitors NCCARE360 to ensure referrals are accepted and verifies services are meeting enrollees' needs.	Communities for Health desk. Community health workers refer members to services. Community health workers also conduct outreach 3 days per week. Successful referrals can be indicated in the Community Referral Network platform.	discuss goals. A Systematic Case Review Team meets weekly to discuss care plans for patients not meeting goals or transitioning from the program. The team relays recommendations to the patients' physician.
Whether and how community voices are incorporated in the design and/or governance of the program, or program alignment to community needs	The Model's Alignment Track requires bridge organizations use data to identify gaps in community service capacity. Bridge organizations and advisory groups use data to create quality improvement plans.		The North Carolina Department of Health and Human Services convened an advisory group that selected the social needs to address and reviewed the screening questions. The North Carolina Department of Health and Human Services also created a map of social determinants of health to inform funding and policy decisions.	Local organizations were involved in creating the resource database.	COMPASS included a needs and assets assessment component, which involved clinical outcomes, quality improvement infrastructure, current programs and local resources, change readiness, prevalence of focus conditions, and payer interest.
Pros	• Substantial documentation, formal evaluations, and case studies from awardees • Early evaluation showed success in	• Beneficiaries can be screened at any organization • Each organization's landing page on the CIE can include eligibility	• Federal funding covers a range of activities including direct service provision, administration, and capacity-building	• Phone and in-person contact align with rural communication preferences • Members can search resources	• Implementation flexibility enables tailoring to local context • Program phases encourage patient self-maintenance with

Program name	Accountable Health Communities Model [a, b, c]	CommunityCares [d, e, f, g]	Healthy Opportunities Pilots [h, i, j, k, l]	Connected Communities for Health [m, n]	COMPASS (Care of Mental, Physical and Substance-use Syndromes) [o, p]
	identifying high-need beneficiaries, reducing ED visits, and a higher rate of navigation uptake than expected	criteria, capacity, and required documents		online by cost, income cap, and opening hours, and see organizations' locations, contact information, and hours • The program has dedicated patient navigators/ coordinators to ensure referral success	flexibility for differing needs • Evaluation showed improvements in clinical outcomes and patient satisfaction • Evaluation showed care management improved patient self-efficacy and efficiency of providers' time with patients
Cons	• •Screening only reached beneficiaries engaged with clinical settings • Navigation cases closed after 12 months, which may not be enough time to meet beneficiaries' needs. • Early evaluation showed < 20% of navigated beneficiaries connected to services or resolved a social need	• There is no dedicated patient navigator or coordinator. Responsibility for ensuring referrals are complete falls on the referring organization	• Program enrollment and referrals cannot occur until they are authorized by MCOs		• Care Management Tracking System was not compatible with other EMRs • Evaluation noted difficulty in sustaining the care manager after the award period • Flexibility led to variations in outcomes, making impacts harder to determine • Team-based care requires restructuring workflows • COMPASS did not directly involve community service providers

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