Better Health Together Landscape Scan, Roadmap, and Recommendations

For community-based care coordination in Eastern Washington

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Executive Summary

Care coordination is foundation to providing whole-person care that integrates health and social services. Since 2013, Better Health Together has partnered with communities throughout Eastern Washington—especially those it serves as the Accountable Community of Health for Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties; the Confederated Tribes of the Colville and Kalispel Tribe of Indians; Spokane Tribe of Indians; and The NATIVE Project—to work towards an integrated health system accountable for improving health by delivering quality whole-person care and addressing health inequities.

In 2022, Better Health Together commissioned Mathematica and Comagine Health to conduct a landscape scan of Eastern Washington to identify the current state of care coordination and opportunities for transforming to an improved, whole-person care coordination model that better meets the needs of residents. The landscape scan combined data from three sources: (1) a web-based survey of staff at organizations that provide care coordination services; (2) interviews and focus groups with community-based service providers, clinical providers, and adult and youth consumers; and (3) an iterative review of publicly-available documents. Mathematica and Comagine Health also convened a Data and Survey Advisory Board with representatives from organizations in the Better Health Together service areas and staff from Better Health Together to inform the design and interpretation of the landscape analysis.

Four themes emerged about the current state of care coordination in Eastern Washington (see below). The landscape scan also identified five promising care coordination models being used in other regions that could be adapted or used to inform improvements in Eastern Washington.

Landscape scan themes

There are diverse needs and considerations for providing whole-person care in Eastern Washington, and providers lack sufficient resources to support and facilitate effective care coordination.

Organizations are already connected and collaborating but lack the systems, tools and processes to effectively coordinate care.

The bidirectional information sharing foundational to coordinating care doesn't occur consistently, due in part to limits in technology and infrastructure constraints.

Strong relationships, along with self reflection, are critical elements in providing whole-person centered care.

Based on these findings, Mathematica and Comagine Health suggest a roadmap for improving and transforming care coordination in Eastern Washington by encouraging change at the systems, organizational, and individual levels and taking action both upstream and downstream using an adapted version of the Public Health Impact Pyramid. Organizations and communities across Eastern Washington can work individually and collectively to apply the lessons from this landscape analysis and create solutions that improve care coordination, foster whole-person care, and advance equity in Eastern Washington.

Introduction

Providing whole-person care that integrates health and social services is key to advancing equity (NASEM 2019). Care coordination is a crucial part of delivering whole-person care. Eastern Washington has an opportunity to build a system that works for everyone by transforming existing fragmented care processes into a single, streamlined community-based care coordination model that addresses individuals' lived experiences and health-related social needs (such as food insecurity, housing instability, transportation constraints, poverty, and threats to safety).

Care coordination

Deliberately organizing care activities and sharing information among all the people concerned with an individual's care so that care is provided at the right time, by the right people, in the right place, and in a way that reflects the individual's needs and preferences. *(Adapted from AHRQ 2018)*◢

Better Health Together is a trusted partner for cross-sector collaboration in Eastern Washington. Better Health Together aims to improve the health in the region by partnering with communities to pursue the vision of an integrated health system that is accountable for improving health through the delivery of quality whole-person care and addressing health inequities. It leads regional efforts toward bidirectional integration of care, community-based workforce to help support and facilitate care coordination, opioid crisis response, and chronic disease management and support (Better Health Together 2022). Better Health Together is one of nine Accountable Communities of Health in Washington, which were created by the Washington Health Care Authority (HCA) to drive health improvements by convening local clinical and community partners and implementing delivery system transformations (HCA 2022).[1]

Since 2013, Better Health Together and its partners have made substantial progress by contributing to a 6-percent decrease in the region's uninsured rate through their initiatives supporting care coordination and community health care workers. Since becoming an Accountable Community of Health in 2017, Better Health Together has continued to advance its mission by serving the residents of Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties, in addition to the Confederated Tribes of the Colville and Kalispel Tribe of Indians, Spokane Tribe of Indians, and The NATIVE Project. These communities have unique needs and considerations for partner engagement across multiple counties and states, rural and urban communities, tribal nations, and immigrant populations.

In 2022, Better Health Together hired a team comprised of researchers at Mathematica and Comagine Health to assess care coordination in Eastern Washington and its opportunities for improvement. This report represents the culmination of this effort and includes two components: (1) a landscape analysis that describes the current state of care coordination in the Eastern Washington region served by Better Health Together, which draws on the perspectives of care coordination providers across sectors and community

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[1] Accountable Communities of Health were key drivers in Washington's State Innovation Model, a Center for Medicare & Medicaid Innovation award to test health care delivery and payment transformation (HCA 2014). Today, Accountable Communities of Health continue to drive regional care transformation through Washington's Medicaid section 1115 waiver, the Medicaid Transformation Project.

members who access such services (who we refer to as consumers); and (2) a roadmap to chart a course that Better Health Together and its partners can follow in their pursuit of whole-person, community-based care coordination. The roadmap includes opportunities for affecting change at systems, organizational, and individual levels and the expected impacts at each level of the intervention.

Landscape Analysis Methodology

Our landscape analysis included three data sources: a review of existing documents, a survey, and interviews and focus groups. Better Health Together and its partners contributed to designing the data collection methods and interpreting results through a Data and Survey Advisory Board. The Health Media Lab institutional review board approved this study prior to initiation of data collection activities. (See Appendix A for Institutional Review Board approval documents.)

A. Data sources

1. **Document review.** We conducted an iterative review of publicly available resources between March and July 2022 to understand (1) the population health context in Better Health Together's service area, and (2) models of care coordination previously or currently implemented elsewhere in the country. Appendix F details the databases, search terms, and processes for the document review.

2. **Survey.** To solicit feedback from Better Health Together's partners on organizational capacity for care coordination and opportunities for improvement, we developed a web-based survey. We administered the 15–20-minute survey in July 2022 to partners serving Adams, Lincoln, Ferry, Stevens, Pend Oreille, and Spokane counties. More than one person from each organization could complete the survey, so that the perspectives would reflect a diversity of roles in care coordination. Those who completed the survey and provided an email address received a $10 electronic Amazon gift card. A total of 209 participants took part in the survey, including 152 complete responses and 57 partial responses. Appendix E further describes the survey methodology. The survey instrument is in Appendix E.

3. **Interviews and focus groups.** We conducted 12 interviews and 4 focus groups to gather detailed, nuanced, qualitative insights about facilitators, gaps, and challenges in current care coordination processes, including those related to making and communicating about referrals. Each interview and focus group lasted between 45 minutes and one hour and was facilitated by a member of our team with experience in qualitative research. A second member of our team took notes during each interview and focus group, and we used the webinar software (Zoom) to produce a recording and an automated transcript. Consumers each received $50 for their participation. A youth organization, which assisted with recruiting and convening a focus group of youth, was given $100 honoraria for supporting data collection activities. We gathered data from a total of 39 individuals, including community-based service providers, clinical providers, and both adult and youth consumers. We used the single protocol for interviews and focus groups, included in Appendix D.

   Across three of the interviews and focus groups, we asked participants to describe a hypothetical consumer's experiences when being referred to and accessing needed services. We used this description to create consumer experience flow charts that visually depicts the steps in the process, as well as barriers and facilitators of successfully receiving services. The protocol in Appendix D describes the activity.

B. Data and survey advisory board

To inform the design and interpretation of the landscape analysis, we convened a Data and Survey Advisory Board comprised of members across eight organizations in the Better Health Together service areas and staff from Better Health Together. Advisory Board members also contributed to data collection activities and strategies. Each organization received $500 for their participation in two 90-minute virtual meetings and to review and provide feedback on data collection instruments.

1. **Co-design workshop.** We held the first virtual meeting in April 2022 to inform the design of the landscape analysis. We provided an overview of the project (including the approach and timeline), asked what Advisory Board members wanted to know about care coordination, and solicited ideas about information-gathering priorities and strategies. See Appendix B for the detailed co-design workshop agenda.

2. **Feedback on data collection instruments.** In May 2022, we shared drafts of the survey instrument and interview and focus group protocol with the Advisory Board via email. Members were invited to give feedback by commenting in the documents or by attending one of two drop-in office hours.

3. **Co-interpretation workshop.** We held the second virtual meeting in July 2022 after completing data collection activities. In this session, we presented preliminary findings from the landscape analysis and solicited Advisory Board member reactions. See Appendix C for the slides from this co-interpretation session.

C. Data analysis

After data collection activities, we conducted analyzes across each data collection method and present cross-cutting themes in our landscape scan. For journey maps, we summarized barriers and roadmaps across three focus groups to create a visual representation of the barriers and facilitators of care coordination.

Exhibit 1. Example journey map
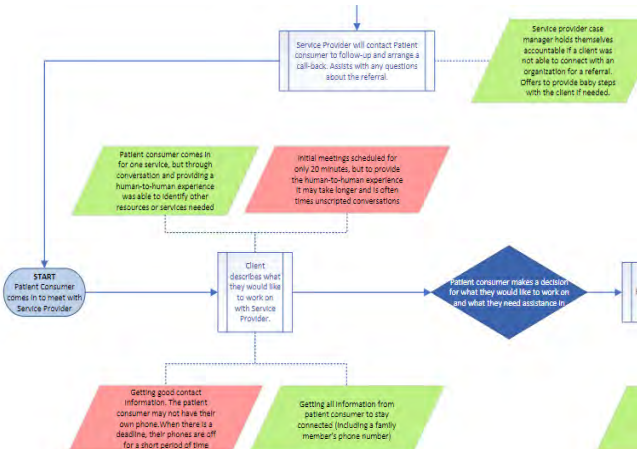
Appendix E contains detailed survey results and additional graphs. Appendix D further describes interview and focus group findings. Appendix D provides visual depictions of the patient journey maps created.

D. Limitations

There were several limitations to this project. First, we were operating under a tight timeline and limited resources. Our sample is not representative because our data collection respondents reflect organizations and/or individuals who had existing relationships with Better Health Together and cannot speak to the general population. Despite data collection across seven different countries, due to sample sizes we were unable to disaggregate data by geography, and none of the interview and focus group participants referred to which county they work with. Finally, our virtual data collection methods may have been biased against those who do not engage with media technology as consistently and/or as frequently, such as rural populations.

Landscape Analysis Findings

As our landscape analysis illustrates, Eastern Washington has a large and multifaceted care coordination system that already strives to provide whole-person care to the region's diverse population. This diverse population includes representatives from Black, Indigenous, and people of color (BIPOC)-impacted communities, those with limited English proficiency, gender and sexual minorities, elderly and disabled communities, and rural communities, among others. Clinical and social service providers are very knowledgeable about the kinds of care these diverse populations need and the pathways that exist to help consumers access and coordinate their care. Consumers know and can articulate what works for them when it comes to receiving care and care coordination services, as well as what their communities need to thrive.

"It takes a gambit of things. I guess the best way to describe it is wraparound services. Whatever someone is struggling with or where the gaps are. This community is impactful at pulling in different organizations and resources in helping the whole-person care ideal come to fruition and help the person meet their goals."

~ Representative from organization providing aging and long-term care

Unfortunately, many barriers impede effective care coordination. Consumers and care coordination providers are navigating imperfect and disjointed systems, with complicated, duplicative, and inconsistent application and eligibility processes, long wait times, and capacity constraints. Their experiences navigating and coordinating care depend heavily on the strength of relationships (for instance, between consumers and care coordination providers, and between providers in different sectors) and the degree of alignment between service providers and sectors. Organizations that provide care coordination services don't consistently have sufficient resources to meet the needs of the communities they serve, and the existing care coordination workforce doesn't have all of the skills and experiences necessary to provide effective and empathic care to the diverse communities they serve. Although many organizations already have partnerships and communication channels in place, they don't have tools that foster bidirectional communication about referrals and other aspects of care coordination or processes. Fortunately, there are existing care coordination and navigation models and community information exchange tools that are being used in other areas of the United States that could be adapted or used to design new solutions to address the challenges.

This section begins with cross-cutting themes on the current state of care coordination in Eastern Washington, combining survey results, qualitative findings from interview and focus groups, and relevant information from the document review. In our summaries of these themes, we highlight respondents' suggestions for improving care coordination with a lightbulb icon (see example on the right).

The section ends with a summary of the key characteristics of promising care coordination models in use in other areas of the United States, which could inform approaches for improving or transforming care coordination in Eastern Washington.

A.   Current state of care coordination in Eastern Washington

Four primary themes emerged related to the current state of care coordination in Eastern Washington:

1. There are diverse needs and considerations for providing whole-person care in Eastern Washington, and providers lack sufficient resources to support and facilitate effective care coordination.

2. Organizations are already connected and collaborating but lack the systems, tools, and processes to effectively coordinate care.

3. The bidirectional information sharing foundational to coordinating care doesn't occur consistently, due in part to limits in technology and infrastructure constraints.

4. Strong relationships, along with self-reflection, are critical elements in providing whole-person care.

Below, we elaborate on and summarize the evidence that supports each theme.

1. **There are diverse needs and considerations for providing whole-person care in Eastern Washington, and providers lack sufficient resources to support and facilitate effective care coordination.**

The community members and service providers interviewed identified a broad spectrum of needs to consider when providing whole-person care. Participants consistently emphasized the need for mental health supports, a large care coordination gap in the community, as well as assistance with health-related social needs (such as transportation, housing, and financial instability). Respondents also noted dental, spiritual, and emotional needs. Most survey respondents (85 percent of all types of providers) are screening consumers for health-related social need, but only 68 percent of social service providers are screening individuals for health care needs (including mental and behavioral health needs), suggesting there is still work to be done to identify and meet each person's overall needs.

"The first priority is mental health. A lot of misconceptions and stereotypes lead to substance use—[comments like] they are homeless because it's a choice or because they are addicted—but there is a trauma has led to homelessness…We really need to make it known that mental health is normal."

~Representative from community organization serving urban, BIPOC, and youth populations

Diverse, population-specific needs. Whole-person care requires recognizing that different populations have different needs. Many interview and focus group participants highlighted the unique needs of particular populations. One participant noted that the definition of care coordination should include cultural relevance to recognize the interconnectedness with communities and how the one-size-fits-all approach doesn't necessarily meet the needs of everyone. For example, participants identified specific

needs of the increasingly aging population, such as safe and supportive long-term housing for people living with dementia. LGBTQIA+ youth may need supports for gender-affirming care and, more generally, feeling safe to openly share and express their true identity when receiving and coordinating care. Residents of rural communities have less access to broadband Internet, which limits their options for accessing virtual services and other online supports. Participants highlighted the importance of language considerations for BIPOC and tribal communities. Similarly, nearly two-thirds (62 percent) of survey respondents recommended using culturally responsive approaches to reach individuals underserved by health and social services, making it the third most frequently selected option for improving care coordination in Eastern Washington.
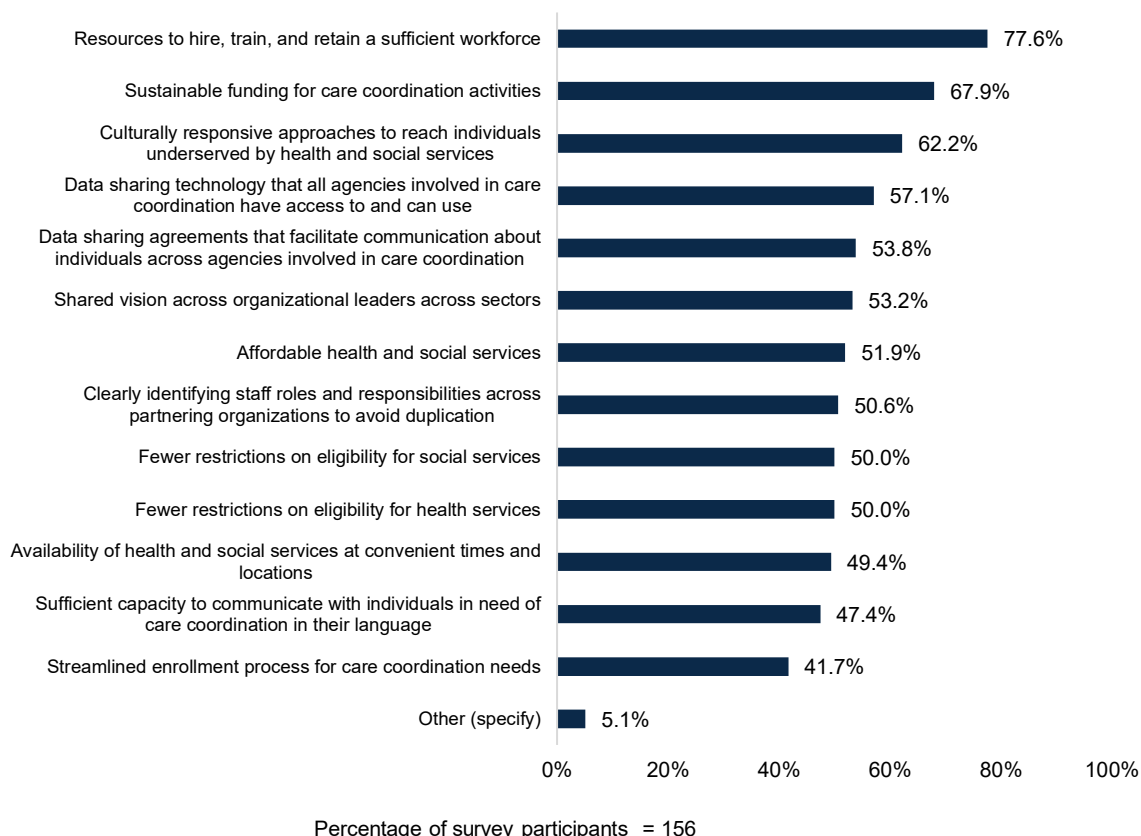
Limited workforce and funding. Organizations in Eastern Washington lack the staff capacity to sustain care coordination activities. Results from the survey highlighted the extent of this challenge. High proportions of respondents agreed that "We often go through periods when we are not able to meet demand for services" (80 percent) and "We often go through periods when we do not have adequate staffing to support care coordination activities" (81 percent). Nearly two-thirds (64 percent) agreed that "We often go through periods when we do not have adequate funding to support care coordination activities." While over half (57 percent) agreed that "We are able to retain a qualified workforce to support care coordination," only 13 percent strongly agreed with the statement. When asked how to improve care coordination, the top two needs survey respondents most frequently selected were (1) resources to hire, train, and retain a sufficient workforce (78 percent); and (2) sustainable funding for care coordination activities (68 percent). Exhibit 2 lists other top needs for improving care coordination in Eastern Washington, in order of how frequently they were selected by survey respondents.

Exhibit 2. Top ranked needs for improving care coordination in Eastern Washington

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

Category	Percentage
Resources to hire, train, and retain a sufficient workforce	77.6%
Sustainable funding for care coordination activities	67.9%
Culturally responsive approaches to reach individuals underserved by health and social services	62.2%
Data sharing technology that all agencies involved in care coordination have access to and can use	57.1%
Data sharing agreements that facilitate communication about individuals across agencies involved in care coordination	53.8%
Shared vision across organizational leaders across sectors	53.2%
Affordable health and social services	51.9%
Clearly identifying staff roles and responsibilities across partnering organizations to avoid duplication	50.6%
Fewer restrictions on eligibility for social services	50.0%
Fewer restrictions on eligibility for health services	50.0%
Availability of health and social services at convenient times and locations	49.4%
Sufficient capacity to communicate with individuals in need of care coordination in their language	47.4%
Streamlined enrollment process for care coordination needs	41.7%
Other (specify)	5.1%

Percentage of survey participants = 156

Staff with cultural sensitivity and lived experiences. During interviews and focus groups, participants expressed the need to hire staff across all sectors of the care coordination system, including frontline workers, such as community health workers and care coordinators. These workers can help consumers navigate their care. Participants also noted the importance of training providers in cultural competency and addressing stigma and hiring qualified staff with lived experiences to provide care with an empathetic lens. Consumers further supported this perspective and stated that empathy was important to them when seeking care and empowering themselves to self-advocate.

Interview and focus groups participants identified solutions to expanding capacity requires investments across the individual, organizational, and systems levels. These include cultural humility training for staff, livable and competitive wages for care coordination staff and reinvestment in community-based ownership, and safe and affordable housing for the broader population.

2. **Organizations are already connected and collaborating but lack the systems, tools, and processes to effectively coordinate care.**

Survey respondents indicated their organizations generally had the right partnerships to support care coordination. Survey respondents had high levels of agreement with statements about leadership being committed to working across organizations to coordinate care for people underserved by health and social

services (92 percent) and developing or maintain relationships with other key organizations to coordinate care (89 percent), though a higher proportion of health providers agreed with these statements than social service providers. Most also agreed that their organization consistently communicates and coordinates with a range of health and social service providers to deliver whole-person care (84 percent), commits sufficient resources to coordinate care for people underserved by health and social services (83 percent), and has the right partnerships to address whole-person care needs (82 percent). While 77 percent of respondents agreed their organization's key external care coordination partners effectively collaborated with them to address whole-person care needs, only 26 percent strongly agreed with this statement—a substantially smaller proportion than other statements, suggesting room for agreement.

Most (83 percent) respondents indicated that, 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, though fewer social service providers agreed with this statement than health providers (78 percent versus 87 percent, respectively). Also, although 70 percent of respondents agreed that direct service providers know which external organizations or providers to refer individuals to in order to meet their needs, only 11 percent strongly agreed with this statement, suggesting room to improve connections and collaborations. There is also substantial room for improvement in other aspects of direct service providers' experience, especially among social service providers.

While three-quarters (76 percent) of providers agreed that providers within their organization use a consistent process to refer individuals to appropriate health care providers, only 54 percent of social service providers agreed with this

- Only 43 percent of providers overall agreed that 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 (42 percent of social service providers and 60 percent of health providers).

- Only 53 percent of providers overall agreed that 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 (49 percent of social service providers and 57 percent of health providers).

- Only 58 percent of providers overall agreed that direct service providers have clear roles and responsibilities when collaborating with providers from other organizations or sectors (54 percent of social service providers and 64 percent of health providers).

statement, compared to 85 percent of health providers. Providers working with youth expressed identified a common pain of lack of awareness of resources for youth populations and referrals for youth organizations (Appendix X).

Both survey respondents and interview and focus group participants described barriers that interfere with effective care coordination processes, including the following:

We describe each of these barriers below. There are also barriers related to information sharing and relationship-building, which are described under Themes 3 and 4, respectively.

Administrative burdens around completing applications. Interview and focus group participants identified the toll the application processes can place on those seeking care. For example, online applications may be inaccessible and confusing for specific populations, such as elderly clients or those with limited digital literacy. Having to complete multiple applications which ask the same questions may have the effect of repeatedly retraumatizing those who are seeking care. Also, when faced with limited in-service capacity, some providers have instituted approaches to prioritize who receives care—a process that effectively makes consumers compete to demonstrate who is most traumatized.

"My understanding is that agencies are only accepting individuals who are super high risk. I have gotten advice from these agencies to tell my client to call and act like it is the worst day of their life in order get seen. That is not trauma-informed care."

~Representative from community organization serving urban, BIPOC, and youth populations

Delays in receiving services. Administrative hurdles and capacity constraints (described in Theme 1) create delays in providing services to clients. Consumers expressed frustration in the length of time it took to receive resources they applied for, and providers shared those same frustrations over the prolonged delays after referrals were made. Both described waiting lists that were almost three months long.

"I got a high trauma score and still had to wait a long time for a voucher. Then you still need to search for housing that works with the voucher amount."

~ Consumer

To address the administrative burdens of care coordination, participants suggested streamlining the referral and application process. For example, one participant advocated for creating a phone system where a community member can call and be transferred to a service directly. A consumer suggested a community-based doctor model, where medical teams go directly to a consumer's home to perform regular check-ins and preventative care.

Inequitable eligibility criteria. Interview and focus participants also expressed frustrations in payments available for services. Providers mentioned the limitations of Medicaid, where the provision of certain services, such as transportation, are not available for reimbursement despite transportation being a high need for the communities, and certain providers turning down Medicaid because they are unable to match the fees that private insurance companies are able to pay.
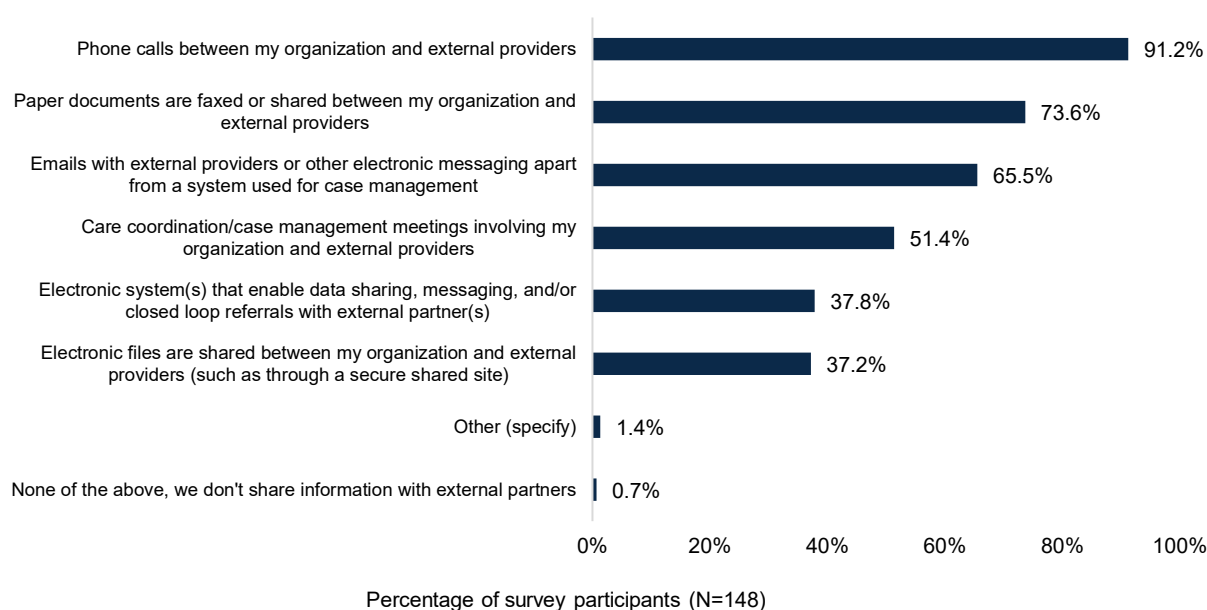
3. The bidirectional information sharing foundational to coordinating care does not occur consistently, due in part to limits in technology and infrastructure constraints.

Service providers and care coordinators in Eastern Washington are using many communication channels to coordinate care (Exhibit 3). Nearly all (91 percent) of survey respondents use phone calls to share or communicate information with external providers, almost three-quarters (74 percent) share paper documents, and two-thirds (66 percent) use email or electronic messages outside of a case management system.

- Social service providers are much more likely to use email than health providers (77 percent versus 65 percent), and they are less likely to use paper documents (44 percent versus 87 percent) and phone calls (85 percent versus 93 percent).

- Most survey respondents reported phone calls (71 percent of those who use them) and emails (66 percent of those who use them) enable them to coordinate care most effectively, though social service providers preferred emails while health providers preferred phone calls.

- Among those who use them, some of the less frequently used communication methods were also rated as effective for coordinating care, including electronic systems that enable data sharing, messaging, and/or closed loop referrals (79 percent of those who use them) and care coordination and case management meetings (71 percent of those who use them).

Exhibit 3. Processes that enable organizations to share and communicate for care coordination

B12. Which of the following does your organization use to share or communicate information with external providers for the purpose of care coordination? (select all that apply)

Category	Percentage
Phone calls between my organization and external providers	91.2%
Paper documents are faxed or shared between my organization and external providers	73.6%
Emails with external providers or other electronic messaging apart from a system used for case management	65.5%
Care coordination/case management meetings involving my organization and external providers	51.4%
Electronic system(s) that enable data sharing, messaging, and/or closed loop referrals with external partner(s)	37.8%
Electronic files are shared between my organization and external providers (such as through a secure shared site)	37.2%
Other (specify)	1.4%
None of the above, we don't share information with external partners	0.7%

Percentage of survey participants (N=148)

Survey respondents did not perceive current information sharing systems and processes as sufficient for care coordination. Fewer than half (43 percent) agreed that direct service providers receive feedback about resolution or required next steps for addressing the individual's needs after making a referral (13 percent strongly agreed and 30 percent somewhat agreed). Shared referral platforms and community information exchanges can enable secure information sharing about clients' needs across sectors and, in some cases, bidirectional communication to close the referral loop; yet, fewer than half of respondents felt that they have sufficient technology system(s) direct service providers to deliver whole-person (13 percent strongly agreed and 35 percent somewhat agreed). Only 32 percent of respondents reported their organizations used an electronic system that enables data sharing, messaging, and/or closed loop referrals, but 79 percent of those who do use such systems felt it was the most effective coordination method.
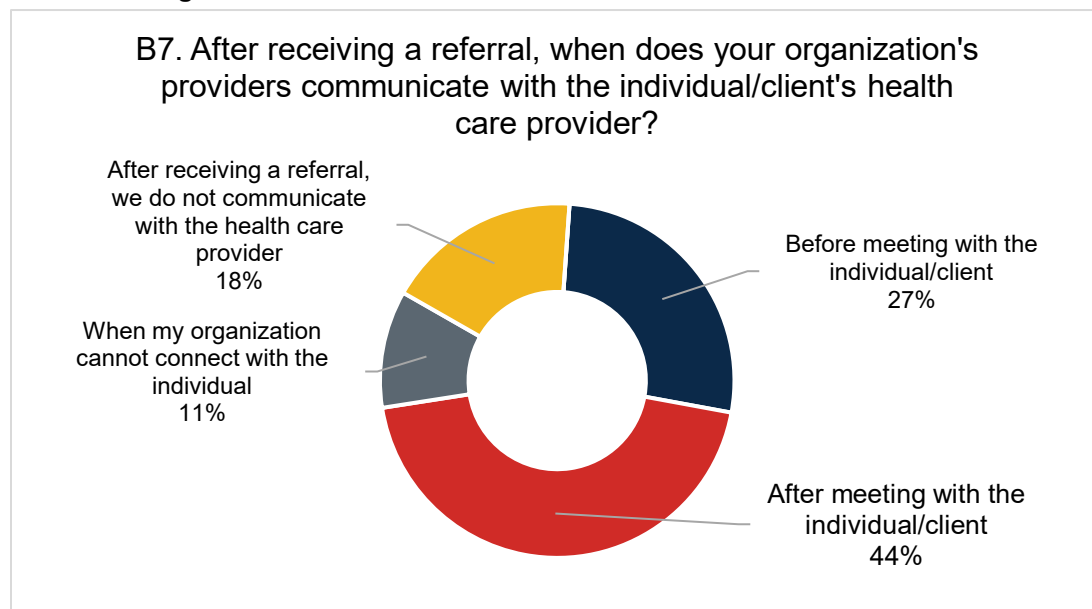
Interview and focus groups participants shared sentiments that current information-sharing systems are sufficient for coordinating care, often citing lack of communication between organizations, no closed loop

communication after referrals, and little coordination between clinical and social providers as their primary challenges.

Inconsistent referral oversight. When referrals to external organizations do happen, there are few processes for follow-up to ensure that client needs are met. Social service providers also commonly reported receiving referrals from health providers, including mental or behavioral health providers (79 percent). However, as shown in Exhibit 4, communication between health and social service providers about these referrals was less common. Fewer than half (44 percent) of social service providers reported communicating with the individual's health care provider after meeting with the client, and an additional 27 percent communicated before the social service provider met with the individual. Providers overall noted that they are often required to look across multiple data systems to connect with various organizations for a status update on one referral.

Exhibit 4. Whether and when social service providers communicate with health care providers after receiving a referral

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

- After receiving a referral, we do not communicate with the health care provider 18%
- When my organization cannot connect with the individual 11%
- Before meeting with the individual/client 27%
- After meeting with the individual/client 44%

Source: Responses from 56 survey participants (the 76 percent of social service providers that receive direct referrals from health care providers).

"Most providers operate within silos that are very self-protective, and there's no accountability. The people dropping through those huge crevices are the ones we're [our organization] catching. I don't think there is care coordination happening in our community…"

~ Community organization serving youth and tribal communities

Interview and focus group 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. For some providers, regularly convening virtually, created opportunities for collaboration across sectors to identify gaps in services. However, the growing use of online communication tools revealed an apparent divide between rural and urban care delivery services. While community service providers in urban settings were more

able to transition using online platforms during the COVID-19 pandemic, rural service providers struggled to provide coordinate care virtually. For organizations serving rural and tribal communities, broadband limitations prevented providers from accessing online training, telehealth services, and other services requiring online applications. In addition, many residents had no experience with using online services or were not trained on how to navigate and utilize these tools effectively.

Several providers discussed the need to improve broadband access and make online services more available, particularly after the COVID-19 pandemic moved many services online. For example, one organization used creative solutions during the COVID-19 pandemic, such as partnering with local libraries to provide telehealth kits with laptops to clients in a rural region; the clients could participate in their telehealth visits from their parked cars within the library's Wi-Fi reach.

Community information exchanges. Despite the growing importance of community information exchanges (CIEs), respondents across the sample were not aware or did not use a CIE. Over half of survey respondents (52 percent) did not know whether their organization participates in a CIE. Of those who were able to answer the question (79 respondents), only 29 percent reported that they do participate in a CIE. Among those whose organizations do not currently participate in a CIE, half are exploring or interested in exploring participation in the future; an additional one-third were unsure (Exhibit 5).

Exhibit 5. Degree of interest in potential CIE participation among organizations not currently using a CIE

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

- We are not interested in participating in a CIE — 17%
- We are interested in exploring participation in a CIE — 44%
- We are currently exploring participation in a CIE — 6%
- Don't know — 33%

Source: Responses from 54 survey participants (those who reported their organization does not participate in a CIE). CIE = community information exchange.

Interview and focus group participants thought a CIE could be effective in closing knowledge and communication gaps in referral processes, but others were concerned about the lack of a consistent platform for tracking referrals. Organizations were also worried that privacy issues would create access issues, such as firewalls, and that existing data-sharing policies would make it hard to share certain consumer information.

Common barriers identified by consumers and providers

✓ Feelings of hopelessness
✓ Distrust in system from past or current experiences

4. **Strong relationships, along with self-reflection, are critical elements in providing whole-person care.**

While hiring staff with cultural sensitivity and lived experience (explored in Theme 1) was identified as a solution to capacity constraints for care coordination, interview and focus groups participants also emphasized the *how*—that is, how relationships and empowering the consumer are at the core for providing care. Consumers often expressed frustration in the lack of personalized care and the trauma they experienced from engaging in current health care systems. These include doctors not treating patients with care, lacking interpersonal skills, being discriminatory towards disproportionately impacted groups (such as the LGBTQIA+ community), and treating patients through a deficit-based lens. Youth participants expressed frustrations about often being dismissed and not taken seriously when seeking care. Providers expressed dissatisfaction from operating in silos, lack of awareness of the community resources, and limited training in understanding community needs.

Interview and focus group participants offered suggestions for how relationships could improve in the future. These relationships include those between providers and those between providers and consumers. Both processes would require providers and consumers across social services and health care to engage in self-reflection to address their own stigma and biases. Other approaches identified include making care coordination more accessible, personalized, and legible. Examples include listening, educating, and advising the consumer using trauma-informed language, as well as community outreach and home visits to meet the consumer where they live in a comfortable environment that is free from judgement.

*"People in this community rely on oral communication. Even though we have social media, people are still going to trust their aunt for information and not rely on social media or read the newspaper. So, keeping connections to people and keeping personal connections is difficult…What works best for me is listening to what people are asking for and thinking about **who** in the organization is the best person to talk to rather than sending them to an 800 number."*

~ Representative from organization supporting rural communities

Facilitators for care coordination

✓ Empathy when working with consumers
✓ Cultural awareness
✓ Trauma-informed
✓ Trust within organization and with other agencies
✓ Sense of support by community and policymakers

Through implementing and promoting support for consumers to better navigate their own care and addressing personal biased, it aims to place accountability on the health systems rather than placing all the onus on individuals to change their behavior.

We work with the individual to get them the life skills needed and also to help them identify the triggers and trauma that would be the catalyst for de-escalating or hindering the whole-person restoration…We have a great team of people who have lived experience who have a deeper understanding of what the needs are and the barriers that individuals come up against instead of putting the burden on the individual to heal themselves, which I consider to be a volatile space (education, health care, primary care etc.) for the people we serve. Making sure they have advocacy within those spaces [social services], but also, they are learning to self-advocate in a manner that doesn't feed into the idea of socialized niceness but more in a way that puts the accountability on the systems of care."

~ Representative from community organization serving urban, youth, BIPOC populations

The remainder of the report includes recommendations for the future state of care coordination. The next section provides a brief overview of the common features of existing care coordination models from across the country. We complete the section with our roadmap recommendations, which illustrate information at the individual, organizational, and systemic levels.

B.   Care coordination models

Our web search exploring care coordination models yielded five unique programs. These programs range from previously implemented Center for Medicare & Medicaid Innovation (CMMI) models to recently announced state-driven initiatives. Previously implemented initiatives, such as Accountable Health Communities and COMPASS (Care of Mental, Physical and Substance-use Syndromes), are valuable to organizations seeking to improve care coordination due to the volume of documentation. Models and awards operated by CMMI have substantial documentation on implementation, case studies, and formal evaluations, which organizations can use to inform implementation decisions. While recently implemented initiatives, such as CommunityCares and Healthy Opportunity Pilots, do not yet have this evidence base, these models are likelier to be based on more recent technology and knowledge of best practices and include some novel, yet unproven, approaches.

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"With doing referrals if they [consumer] didn't call back, I think to myself that maybe I gave them too much information at one time. I never put the blame on them. I tell them ok, maybe we just need to do this step by step. I ask them if they want me to call with them or be in the room with them when they call again to make sure they get the connection. Go back and bring it back to baby steps."

~Representative from community organization serving urban youth, elderly and BIPOC populations

All five programs use either case management/navigation or CIE, or both. Case management/navigation provides clients with advocates, personalized care plans, and dedicated assistance navigating health and community care systems. CIEs enable data sharing among a network of clinical and community service providers and allow clients to be entered into the network through the organization with which they feel most comfortable. The programs that combine these approaches, Healthy Opportunities Pilots and Connected Communities for Health, benefit from both a

dedicated referral network and a dedicated client champion, who advocates for the needs of the consumer to ensure referral success.

Four of the five programs screen clients for health-related social needs. Two programs, the Accountable Health Communities Model and CommunityCares, screen clients in face-to- face settings with the provider. CommunityCares screens clients in both clinical and community service settings, enabling clients to enter the system through various types of organizations (Health Current 2020). However, without a navigator, the responsibility for a successful referral falls on the referring organization, which increases burden and risk to the organization and impacts the ability of clients to be served. Two additional programs screen clients for health-related social needs through care management/navigation teams. The Connected Communities for Health program screens clients either by phone when clients call their managed care organization, by phone for clients referred by their clinical providers, or in-person by community health workers who visit a homeless shelter multiple times per week (Daniel-Robinson and Moore 2019). While phone and in-person contact align with rural communication preferences indicated in our survey and interviews, the limited screening settings do not allow for the widest reach. Healthy Opportunities Pilots' care management entities receive referrals from their own network, clinical and community service providers, managed care organizations, and self/family referrals (North Carolina Department of Health and Human Services 2022c). Having a care manager/navigator screen clients reduces the burden of new workflows and referral accountability on service providers, but it requires additional staffing and partnerships outside the provider network. Another advantage of this model are the unique mechanisms for Medicaid coverage of nonmedical services.

Care coordination programs may seek to address whole-person care through health and social service referrals without ensuring their communities have the capacity to address identified needs (Kreuter et al. 2020). To avoid this misalignment, **two programs integrated quality improvement and needs alignment into their care coordination approach.** The Accountable Health Communities Model's Alignment Track coupled screening and navigation components with quality improvement efforts. Alignment Track awardees convened advisory boards to identify gaps in community service capacity and created quality improvement plans to address those gaps (Armstrong Brown et al. 2020). However, initial evaluation showed that early Alignment Track quality improvement activities focused primarily on implementation rather than capacity alignment and were limited due to advisory group members' competing priorities and staff turnover (Armstrong Brown et al. 2020). COMPASS also integrated quality improvement into its model. The program's technical partners worked with awardees to develop quality improvement methods and created monthly summary reports for each of the awardees' clinical partners (Ireys et al. 2017). Each organization's goals were developed in partnership with patients to achieve targeted outcomes. These reports were reviewed at both the national level by program leaders and awardees and at the local level by awardees and their clinical partners to discuss the reports and brainstorm ideas for improvement (Coleman et al. 2016).

Using these models can inform how Better Health Together and its partners could address barriers to support care coordination. For more detailed information on each of these programs, including entities involved, lessons learned, funding, and implementation dates, see Appendix F.

Roadmap

There are opportunities at the system, organizational, and individual levels to improve and transform care coordination in Eastern Washington.

System. System level considers the broader factors that may help to support care coordination. This may include addressing health, economic, educational, and social policies that promote or hinder the ability to provide whole-person care.

Organizational. This level explores way to improve the environment in settings where care is received or coordinated, such as community-based organizations, health care facilities, and other institutions, and refines the processes used in those settings to better provide whole-person care.

Individual. Each person who acts within the organizations or systems represented in the two levels above, including service and care coordination providers as well as consumers, influences care coordination experiences and its impact on whole-person care. The first level identifies individual opportunities to drive change. Strategies at this level can include training on how to navigate the health care system.

Fostering and supporting sustainable, whole-person care coordination in Eastern Washington will require action at all levels. Exhibit 6 provides illustrative examples of potential solutions, organized around the themes that emerged from our landscape analysis at the systems, organizational, and individual levels. Selecting, designing, and implementing any policies, practices, or changes should be tailored to—and done in partnership with—the communities for which they are intended, taking context into account to ensure that the intervention is meaningful, relevant, culturally responsive, and trauma informed, will benefit impacted communities and has the potential to improve community health.

Exhibit 6. Examples of potential solutions and recommendations for care coordination

Level of action	Theme #1: There are diverse needs and considerations for providing whole-person care in Eastern Washington, and providers lack sufficient resources to support and facilitate effective care coordination.	Theme #2: Organizations are already connected and collaborating but lack the systems, tools, and processes to effectively coordinate care.	Theme #3: The bidirectional information sharing foundational to coordinating care doesn't occur consistently, due in part to limits in technology and infrastructure constraints.	Theme #4: Strong relationships, along with self-reflection, are critical elements in providing whole-person care.
Systems	Expand policies and increase funding for social supports, particularly for sectors related to housing and poverty reduction. (**Example(s):** social determinants of health trust fund at the regional level, reconsider services that are billable – vouchers for transportation, non-western approaches to mental health)	Increase awareness and adoption of a statewide phone system where community members can call a number and be transferred to a service that exists within the community immediately.	Create the infrastructure to successfully implement community information exchange(s) that enable data sharing among a network of clinical and community service providers and help consumers find and access services that align with their needs and preferences.	Expand definitions and requirements for care coordination providers to allow for greater use of a community-based workforce – including community health workers, peer navigators, and other types of care coordinators (such as care navigators) who have lived experiences in impacted communities.
Organizational	Ensure access to livable wages and equitable pay; take steps to support providers and prevent burnout.	Implement initiatives to identify gaps in services such as convening community advisory boards for quality improvement and alignment of capacity with community needs.	Create a partner learning community to ensure consumer and provider needs are being met, highlight, and amplify successful approaches, and create solutions to commonly encountered challenges, with an eye toward closing referral loops.	Strengthen the pipeline for recruiting and retaining a strong care coordination workforce that reflects the communities it serves and has the skills and experience necessary to provide empathic care
Individual	Center the human interactions between consumers and providers. Encourage patient self-maintenance, while allowing flexibility in timing for differing levels of need.	Share your experiences, ideas, and skills to inform and aid transformation efforts	Draw on the power of libraries to build digital literacy in communities and provide support for accessing telehealth and broadband services. (**Example:** Partner with libraries to train librarians on the CIE portal to support consumers to access service network)	Both providers and consumers can reflect on how they interact with others and their potential biases to identify opportunities for personal growth and to establish new or strengthen existing interpersonal relationships. (**Example:** patient navigation, health coaching, motivational interviewing)

The framework below, adapted from the Public Health Impact Pyramid, illustrates types of solutions with differing degrees of impact and individual autonomy. All types of solutions are relevant to improving care coordination and the delivery of whole-person care, but it is important to recognize and make informed decisions about the tradeoffs they entail. For instance, strategies that move upstream to address socioeconomic factors and root causes of inequities have the greatest potential for wide-reaching and long-term population-level impacts.[2] These interventions, which are at the base of the pyramid, are most often achieved through systems-level change, however, which require consensus, coordination, and alignment across many sectors and institutions. On the flipside, interventions at the top of the pyramid are more within the control of individuals but will only impact the people who directly receive those interventions or services—which can be constrained by resources and capacity for delivering such services.

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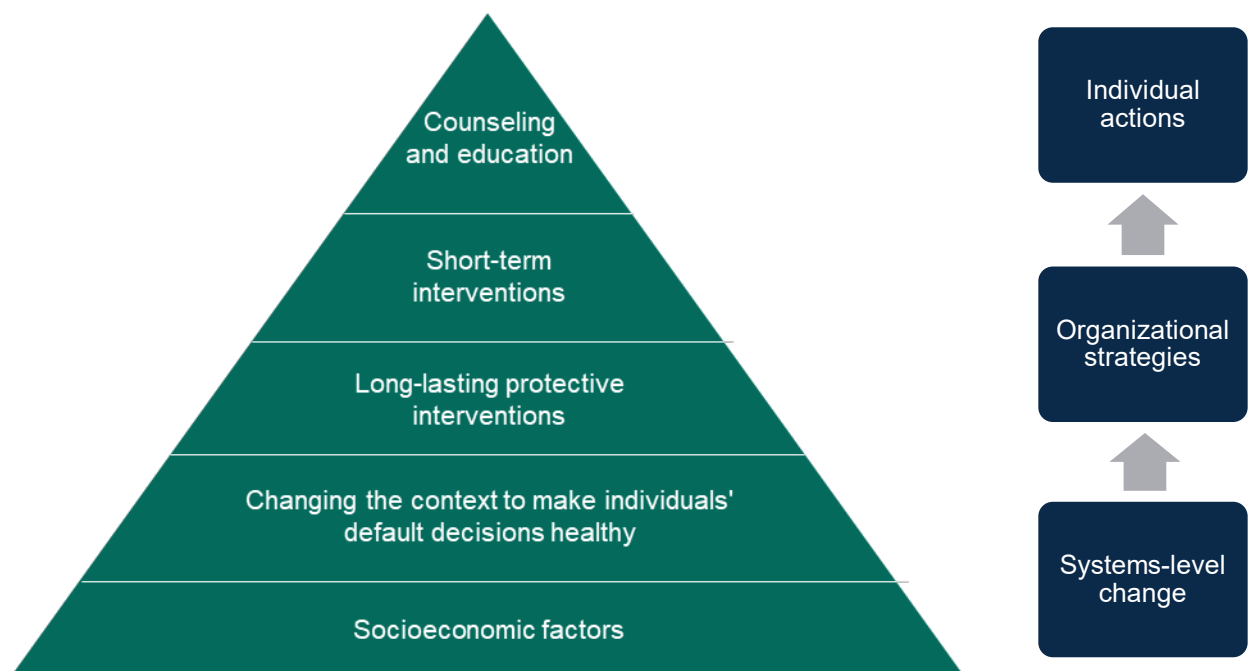
[2] The Public Health Impact Model.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/#:~:text=The%20health%20impact%20pyramid%2C%20a,greatest%20potential%20to%20improve%20health.

Conclusion

Eastern Washington is full of passionate people working diligently to provide high-quality care coordination for the diverse populations they serve. There are strengths of the current care coordination network, including the widespread commitment to coordinating and collaborating across organizations, but care coordination organizations lack sufficient resources to meet the demand for their services and to hire and retain a sufficient workforce with the skills and experiences necessary to provide effective and empathetic care. Consumers and care coordination providers are navigating siloed and unaligned systems, do not have tools for bidirectional communication, and need to build more trust with one another.

Better Health Together and its partners across Eastern Washington have an opportunity to work collectively towards systems-level and upstream changes to transform the care coordination ecosystem and context in which it operates. In the meantime, each individual and organization can apply the insights gained from this landscape analysis, and consider some of the potential solutions it identifies, to improve care coordination in Eastern Washington so that it promotes whole-person care, betters the health and well-being of individuals and communities, and advances equity.