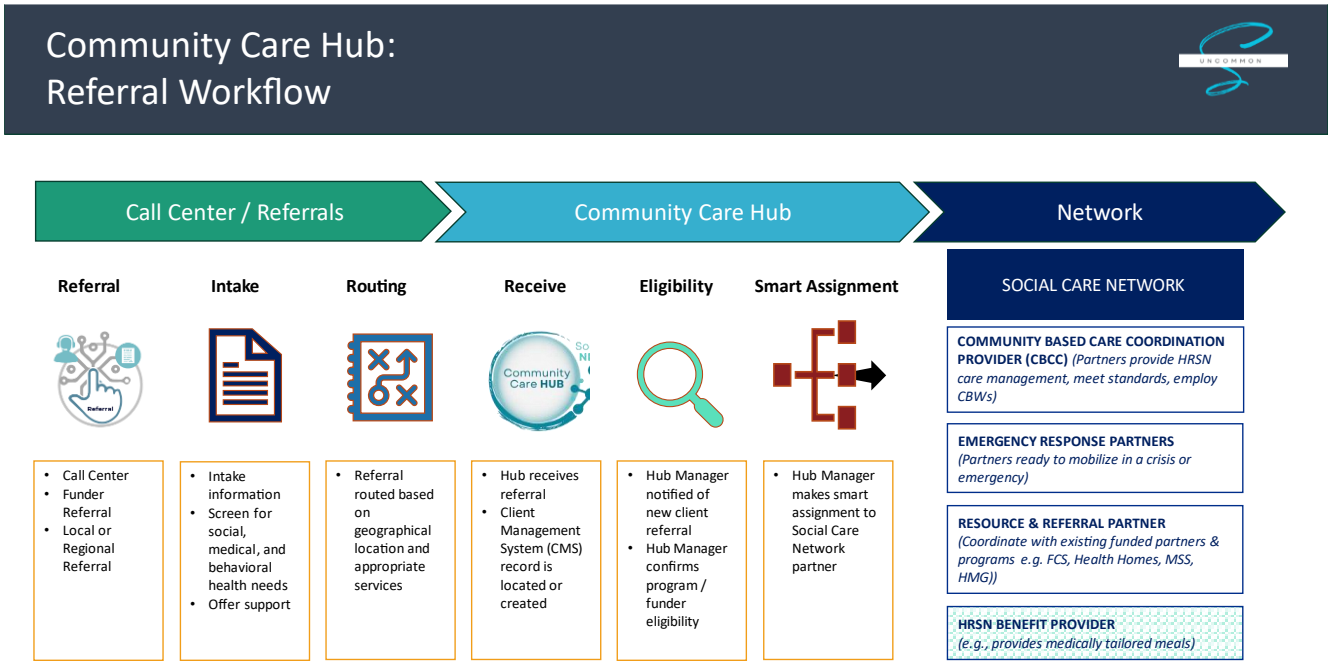
Referral Workflow & Community-Based Care Coordination

Purpose: this document serves as end-to-end guidance for the Community Care Hub (CCH) referral and care coordination workflows. The referral workflow includes the roles of the Call Center, CCH, and Social Care Network (Network). The Community-Based Care Coordination Standards included below are an integral part of this workflow. These standards and processes support ongoing community-based care coordination to assist people who have complex social, medical and/or behavioral health needs to improve their health.

Guiding Principles

To address whole person care, show population health outcomes, optimize resource use, and deliver less fragmented services, CCH and their Network partners abide by the guiding principles described below. CCHs and their Networks:

- Build trust and relationships in the community which is required to meet individual's social and health needs.
- Ensure equitable access for eligible individuals who face barriers to meeting their social, medical, and behavioral health needs.
- Ensure services are culturally and linguistically responsive, easy to access including for people with disabilities and other access and functional needs and make individual needs and preferences central in all aspects of care.
- Provide technical assistance and infrastructure support to a diverse Network of partners who provide community-based care coordination in each of the nine regions.



REFERRALS

Referrals to the CCH
Requests for community-based care coordination services can be completed by any referring entity. Referral management is a shared effort between the state and the CCHs.

State Supports: Department of Health provides statewide call center support to screen and refer individuals to CCHs when a client requests care coordination. Statewide Call Centers, including self-referrals, include 988, 211, and 911.

Role of the Statewide Call Centers

- **Referral**: referral may originate as a call to a Call Center, via funder referral, via local or regional referral, or by a 211-resource specialist. Clients may also be transitioned from another CCH program.
- **Intake**: ensure complete intake information (final version will have Appendix with minimum standards for intake information). Screen for individual social, medical and/or behavioral health needs and barriers to meeting those needs. Offer ongoing care coordination support.
- **Routing**: route referrals to CCHs for individuals who request care coordination support. Follow protocols for sharing screening results appropriately while protecting individual privacy and avoiding duplicate screening. Refer individuals who do not need or are not interested in care coordination to appropriate services.

CCH Supports: Direct referrals may come to Community Care Hubs via Funder referrals and local/regional referrals, including self-referrals and transitions from other CCH programs.

COMMUNITY CARE HUB

No Wrong Door
The CCH maintains a no wrong door for entry approach. The CCH ensures any individual with a social or health barrier is successfully connected to a Network partner.

Role of the CCH

- **Receive**: CCH receives referral. Client Management System (CMS) record is located or created. CCH is responsible for Referral Management of all received referrals.
- **Eligibility**: CCH Manager screen clients for eligibility and best program, if offering multiple care coordination models.
- **Smart Assignment**: CCH Manager makes smart assignment, routing client to appropriate Network partner.

Eligibility for Services
The CCH manages processes and staff to confirm individuals referred are eligible for services. Eligibility is determined by the CCH program and funder requirements (e.g., Medicaid Transformation Project (MTP), Impacted by Covid, etc.)

NEW: HRSN Eligibility: HRSN screening, Medicaid status and previous engagement with other Medicaid services trigger a person's eligibility to be served via HRSN benefits under MTP 2.0. CCHs are waiting for guidance on what tools ACHs/CCHs will be able access to confirm Medicaid status and member engagement in other services with ease.

Client Management System

Each CCH supports a client management system (CMS) and provides access to a resource directory to support documentation, reporting, and connection to community resources. CCHs are responsible for providing reports, assuring data quality, and providing feedback on improvements to the CMS, workflow, and documentation. Additionally, CCHs support Network partners, supervisors and workforce with training and documentation needs. See the 'Infrastructure & Documentation' and 'Training & Resource Directory' Sections below for more information.

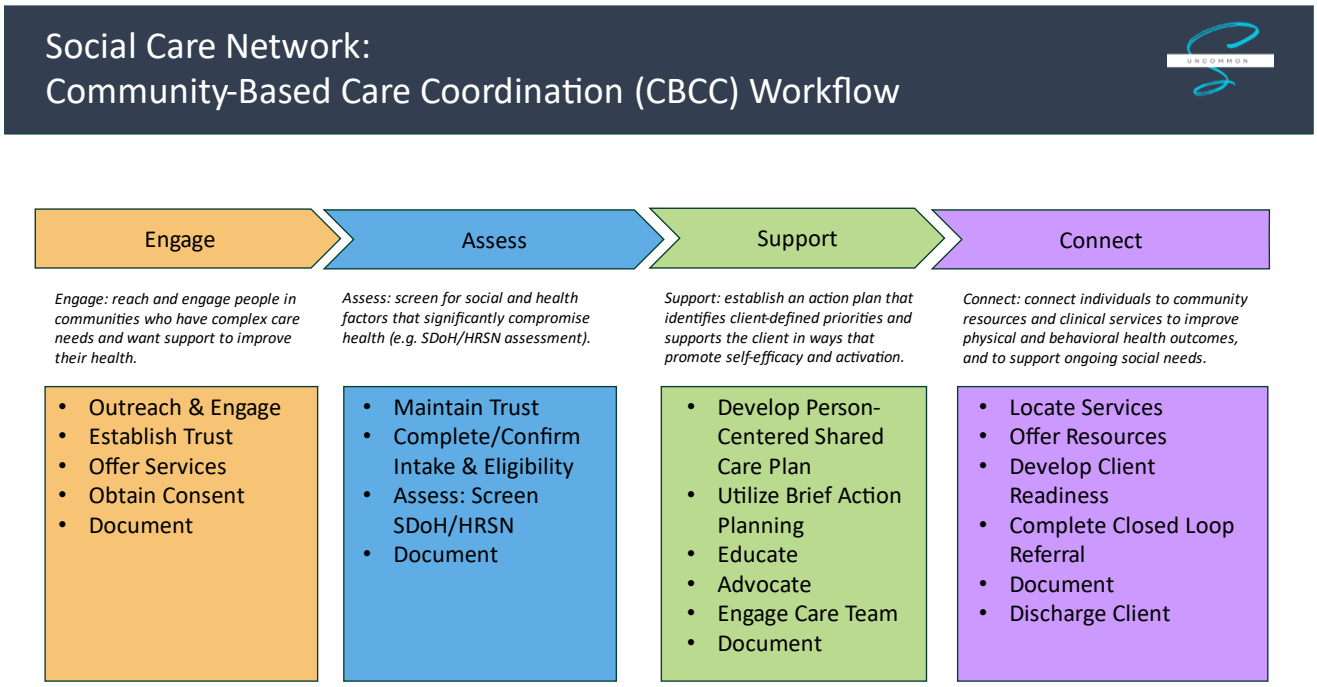
SOCIAL CARE NETWORK

The Social Care Network

CCHs ensure their Networks include Community Based Organizations (CBO) with diverse cross-sector representation (e.g., housing organizations, community health centers, BIPOC/Grassroots organizations) who employ community-based care coordinators that share lived experience with the clients they serve. The CCH is responsible for ensuring its Network provides community-based care coordination that addresses individual needs, follows evidence-based care coordination standards, and includes documentation and tracking of activities.

Community-Based Care Coordination Standards

The CCH supports its Network partners to implement care coordination standards that align with the four key process of community-based care coordination:



Engage: reach and engage people in communities who have complex care needs and want support to improve their health.

- **Steps to Engage**:
  - **Outreach & Engage**: minimum of three attempts to connect with a referred client; attempt at different times of day a couple of days apart and/or via different contact methods such as text, email, etc.
  - **Establish Trust:** establish trust and rapport with the client by understanding their needs, offering a human connection, being open, and sharing similar experiences.
  - **Offer Services**: describe the organization they work for and the community-based care coordination they can offer.
  - **Obtain Consent:** obtain and document client consent prior to enrolling in services or gathering additional client information in the client management system (CMS).
  - **Document**: document engagement steps in the Client Management System (CMS).

Assess: screen for social and health factors that significantly compromise health.

- **Steps to Assess**:
  - **Maintain Trust:** maintain trust and support prior to asking for personal information, use multiple phone calls or visits as needed to complete the full assessment.
  - **Complete/Confirm Intake & Eligibility:** including demographics and documentation of initial social and health barriers for minimum intake standards. Confirm eligibility for programs/services as appropriate.
  - **Assess: Screen SDoH/HRSN:** screen for social and health factors, including SDoH/HRSN screening and other funder requirements (final version will have Appendix with SDoH/HRSN checklist).
  - **Document**: document intake and assessment in the Client Management System (CMS).

Support: establish an action plan that identifies client-defined priorities and supports the client in ways that promote self-efficacy and activation.

- **Steps to Support:**
  - **Develop Person-Centered Shared Care Plan**: focus on the client, utilize culturally responsive and trauma-informed practices, and remain accessible and open to their needs, while establishing a person-centered shared care plan that supports utilization of health, behavioral health, and social services. Review shared care plan at least every 6 months.
  - **Utilize Brief Action Planning**: utilize brief action planning to support client progress with client-directed goal setting and self-efficacy.
  - **Educate:** provide education to support health promotion, empowerment, and service navigation.
  - **Advocate**: advocate for clients as they navigate through social service and health care organizations.
  - **Engage Care Team**: engage with members of the client's care team (e.g., doctors, case managers, housing specialists) as needed to coordinate. *Complete a Release of Information* with the client for each social service and health care organization with which you will be sharing client information.
  - **Document**: document support provided in the Client Management System (CMS).

Connect: connect individuals to community resources and clinical services to improve physical and behavioral health outcomes, and to support ongoing social needs.

- **Steps to Connect:**

- **Locate Services**: locate available services, where the client lives, that address their social and health needs. Services may include primary care, housing services, transportation services, Apple Health / Medicaid, Health Homes, SNAP, WIC, and others.
- **Offer Resources**: offer education and information to the client about available community resources.
- **Develop Client Readiness**: prepare the client to connect to social and health services.
- **Complete Closed Loop Referral:** coordinate with social service and health care organizations to schedule available appointments, complete paperwork, and prepare client and support resources for warm handoff. Provide additional support as the client requests. Complete a Release of Information with the client for each social service and health care organization with which you will be sharing client information.
- **Document:** document the social service and health related referrals in the CMS, including complete and incomplete referrals, to meet closed-loop referral requirements.
- **Discharge Client:** document warm hand-off and any additional referrals as part of Client Discharge.

Caseload
A full caseload of clients will be 20-30 clients per full-time Care Coordinator, depending on the complexity of the client's needs.

Duration of Care Coordination Services
The duration of time the client is supported varies by the client's individual needs, typically 3-6 months depending on the complexity of an individual's social and health needs.

The CCHs can work with supervisors and care coordinators to determine if an extension of services is advisable. If service extension is needed, the CCH should determine availability of funding or other services the client may be eligible for.

A workgroup, hosted by the Learning Collaborative, will identify documentation, workflow, and training that supports these standards. Their products will be available to the CCHs, and to the CBW workforce representatives.

Care Models that Align with the Community-Based Care Coordination Standards:
Care Coordination can be completed using a variety of care models that align with the Care Coordination Standards (i.e., Engage, Assess, Support, and Connect). Evidence-based community-based care coordination models (Pathways Community Hub model, etc.), that address the social drivers of health may be used, allowing CCHs flexibility to secure multiple CCH funding opportunities.

Responsibilities of Network Staff
At each Network partner, the Supervisor and Care Coordinator have specific responsibilities within the Community-Based Care Coordination workflow.

- Supervisor
  - Review and assign cases to Care Coordinators, confirming eligibility as appropriate
  - Support Care Coordinator in navigating resources and accurate documentation
  - Provide supportive supervision
  - Document resolutions as a result of conflict, grievances, or appeals
  - Case closure and coordination with the Regional CCH for additional resource coordination

- Care Coordinator:
  - Implement Care Coordination Standards
    - ✓ **Engage**

- ✓ **Assess**
- ✓ **Support**
- ✓ **Connect**

- Regular follow up and review of cases with supervisor
- Assessment and recommendation for case closure / graduation from program for each client

Consent Management, HIPAA and Protection of Personal Identifiable and Health Information (PPI/PHI)
CCHs have integrated robust HIPAA security policies across all operational domains, including IT, HR, and Client Services, ensuring compliance with regulations and ethical handling of personal information. CCHs prioritize transparency by clearly communicating practices to clients, safeguarding ePHI using strong encryption and secure access controls, and conducting annual audits to validate security measures. CCHs emphasize the minimization of data use and retention, only collecting and retaining information as necessary for specified, lawful purposes.

Mandatory security training is tailored to staff roles, enhancing accountability and awareness. The risk assessment process identifies and mitigates potential security threats effectively, with particular care for vulnerable populations and sensitive data. CCHs align with CMS vendors' IT security policies and participate actively in the Learning Collaborative HIPAA workgroup to continually enhance security practices.

CCHs and Network partners use client management systems (CMS) to store and manage both personal identification information and protected health information. It is important to protect client information, including not asking for client information without consent or sharing client information (e.g., name, DOB, address, health insurance) without the client authorization.

All CMS systems must meet standards for security and compliance including: robust encryption and security protocols; compliance with international data protection regulations (e.g., SOC-II, Hi-Trust, HIPAA); and regular security audits and compliance checks.

The following forms must be provided and be part of regular quality assurance review by a CCH and the care coordinator's supervisor.

- Client Consent: must be documented prior to enrollment in the program
- Release of Information: client authorization to share information with other health care providers

Organizations like a doctor's office may request the client complete another authorization to share client information with the care coordinator.

CCHs and their Network partners have specific practices and requirements related to health information and are responsible for managing HIPAA and/or 42 CFR Part 2 requirements and training. Care coordinators must comply with these practices.

INFRASTRUCTURE & DOCUMENTATION

Call Center Infrastructure
Call Center is responsible for hosting IT infrastructure that can document and close loops on referral. Closed-Loop Referral will be coded as: Referral Status-Referred, Referral Status-Accepted, Referral Status-Provided, or Referral Status-Declined.

Documentation of Intake and Assessment

To understand social and health risk factors impacting client health, Community Based Care Coordinators are required to complete a social and health assessment and intake. Minimum data requirements for intake and assessment must be integrated into the CCH's client management system (final version will have Appendix with minimum data requirements). The Call Center will begin Intake and Assessment. The community-based care coordinator will complete/confirm Intake and continue the Assessment process. CCHs may have additional assessment and screening tools.

CCH and Network Partner Documentation

Accurate and complete documentation is necessary to show impact, identify resource needs, and promote quality assurance/improvement. To support reporting requirements, CCHs have specific documentation requirements. All CMS systems must meet the minimum data requirements needed to support regular reporting and evaluation (final version will have Appendix with CMS minimum functionality requirements).

Reporting Requirements

All CCHs have minimum data requirements reflect a common set of strategic and programmatic measures. The strategic measures enable the statewide system of CCHs and individual CCHs to demonstrate their value to communities, policy makers, health systems and other key partners. This data is generated from the CCH's CMS system as well as primary sources. The programmatic measures are used by CCHs to monitor their performance and outcomes. The data will be generated from documentation in the CMS. (final version will have Appendix with strategic and programmatic measure sets).

TRAINING & RESOURCE DIRECTORY

Resource Directory: Community Based Resources and Services

Connection to community resources is often built on relationships. Community Based Care Coordination depends on the care coordinators' knowledge of local community resources. The CCHs should provide training and learning opportunities to care coordinators about new resources and services in the community.

DOH will provide a statewide resource directory powered by WA211 and SiteSavy. This resource directory is available for Care Coordinators to search for resources. Care Coordinators and CCHs can also add new resources by clicking the Feedback tab. Additional training and support on use of this resource directory can be coordinated through DOH.

Training Support

DOH will provide CCHs with three training opportunities each of which can be taught virtually, as synchronous or asynchronous courses and include mixed media, links to research, practitioner stories, reflection and discussion questions, and team activities to apply the training content to each CCH's specific context and population. CCH staff will be responsible for facilitating all trainings. The three training opportunities include:

- A basic training for community-based care coordinators and supervisors on meeting care coordination standards and documenting the work in a CMS system. CCHs will need to tailor this training to reflect how to document the work in their CMS system.
- A basic training on supervising community-based workers who share lived experience with the clients they serve including supporting them to accurately document their work.
- Access to Camden Coalition's Complex Care Certificate. This online training teaches the skills and knowledge necessary to effectively serve individuals with complex health and social needs working across sectors. Nine courses address a set of thirty competencies. (final version will have Appendix with Camden Complex Care Certificate information).

CCHs are responsible for providing additional training to grow the skills of the care coordinators and CCHs. For example, CCHs may want their community-based care coordinators to attend DOH's CHW Core Competencies training, be trained in brief action planning, etc.

DEFINITIONS

Community Care Hub (CCH): A community centered organization that organizes and supports a network of community-based organizations into a comprehensive Social Care Network and provides its Network partners operational, administrative and infrastructure support.

Social Care Network (Network): Diverse Community Based Organizations who deliver services that address the social drivers of health and employ a community-based workforce to provide community-based care coordination services.

Community-Based Care Coordination: A care process which involves deliberately organizing activities and sharing information among all the participants concerned with an individual to achieve health outcomes; this is a client-driven process done in the community setting. Care coordination includes coordinating and connecting clients to care and social services.

Community Based Workforce: The community-based workforce includes trained and trusted community- based professionals such as care coordinators, peer specialists, recovery coaches, community health workers, Promotoras de Salud; community-based, nongovernmental nonprofit staff and human services providers. http://communitybasedworkforce.org

Community resources: Assets in the community that help improve clients' quality of life by addressing health and social needs

Health: The World Health Organization and Center for Disease Control and Prevention defines health as a state of "complete physical, mental and social well-being and not merely the absence of disease or infirmity**."**

Ongoing Care Coordination needs: lasting social or medical needs requiring additional support in the form of connection to services, application assistance, etc.

Whole person care: Whole person care is the delivery of physical, behavioral, emotional, and social services required to improve health outcomes while respecting individual's choices. All factors that significantly contribute to poor health outcomes are addressed including social conditions such as economic instability.