Elements & Functions of a Mature Community Care Hub Crosswalk

Purpose: To compare national strategies that define the operational functions of a Community Care Hub (Hub). This tool can be used to inform statewide strategies toward common functions. Community Care Hubs (CCHs) are identified as a key strategy to address social determinants of health (Biden Administration, 2023). The following crosswalk compares national white papers and frameworks used by national partnerships and government agencies with the framework to inform functions of a Community Care Hub.

Care Connect WA / Uncommon Framework	Partnership to Align Social Care (2023)	Manatt SDoH Playbook (2022)	ACL (2020)	HHS (2023)
Community Voice & Engagement				
• Function 1: Establishes community buy-in and partnership to co-create CCH vision, goals & priorities	X	X	X	X
• Function 2: Implements a community advisory & governance structure that defines priority populations and community needs/gaps, includes strong community voice & engagement	X	X	X	X
Comments	• All white papers and frameworks put emphasis on partnership with community organizations and partners to address social and health related needs; All see need to engage with community partners to build trust and buy-in. • The Partnership, Manatt, and Administration on Community Living have a health-care centric focus, prioritizing collaboration between payers, health care delivery systems and CHC's to build trust and buy-in with CBOs. The ACH Hub framework looks at community trust and buy-in more broadly.			
Sustainability & Business Operations				
• Function 1: Establishes a strategic and sustainability plan that includes CCH value proposition	X	X	X	X
• Function 2: Strategic Measurement & Reporting – evaluation and measurement to further community health improvement	X	X	X	X
• Function 3: Establishes an organizational structure, staffing model and fund development plan to achieve strategic goals	X	X	X	X
• Function 4: Maintains healthy business functions that supports a Network of partners (includes policies, processes & tools)	X	X	X	X

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Comments	• All frameworks and white papers align on leadership engagement, accountability, and sustainability as foundational to a hub; all align on a hub needing sustainable business functions to support a network of community-based organizations. • The ACL, Manatt and Partnership place an emphasis on multi-payer contracts with a Hub or hub-like entity serving as the backbone for a network of Community-Based Organizations; whereas Washington is focused on a broader braided approach to funding to ensure government and federal grants are also supported via the Hub as a key sustainability strategy for CBOs.			
Care Coordination Operations & Reporting				
• Function 1: Establishes Care Coordination Standards that help people get the services they need to improve health.	**X**	**X**	**X**	**X**
• Function 2: Client Management Systems – IT for data collection of service coordination, billing & invoicing, and reporting	**X**	**X**	**X**	**X**
• Function 3: Intake & Referral Processes - the CCH manages referrals and coordinates with existing care coordination services	**X**	**X**	**X**	**X**
• Function 4: Protection of Client Information - The CCH maintains the protection of client information in compliance with HIPAA or other federal rules/regulations.	**X**	**X**	**X**	**X**
• Function 5: Programmatic Measures, Reporting & Improvement - Tracks, monitors and reports on care coordination services and operations to sustain Network	**X**	**X**	**X**	**X**
Comments	• The national frameworks and white papers focus on a broader Network integration strategy between payers, health care and community-based organizations with a focus on general standardized processes per specific contracts. • Washington's approach focuses on the Hub, in collaboration with community, to define a community-based care coordination approach to support a network; The hub also negotiates terms with payers and funders to provide nimble funding. • For a crosswalk on CareConnect/ACH Hubs *standards for care coordination*, see Community Based Care Coordination Standards Crosswalk in the Appendix below.			
Network Management & Capacity Building				

• Function 1: Engage and assess community-based organizations – assesses populations, services, partner types, and network capacity to develop the Social Care Network	X	X	X	X
• Function 2: Manages a network of intake & referral partners - ensures people with identified needs are connected to resources (no-wrong door)	X	X	X	X
• Function 3: Manages, contracts, and onboards a Network of partners - provides community-based care coordination and additional supports for Network partners	X	X	X	X
• Function 4: Capacity building and technical assistance – provides assistance for potential partners not contracted with CCH	X	X	X	X
Comments	• All national frameworks and white papers focus on a Network strategy whereby community-based organizations are in a deeper administrative or contractual relationship with a Community Care Hub or hub-like entity. • All frameworks and white papers place emphasis on the Hub's role in supporting a Network via administrative and business functions as well as onboarding and technical assistance support. • Washington's approach places additional emphasis on capacity building of non-traditional partners who have long-standing trust and relationships in community; this serves as an equity as well as population health strategy to ensure the Hub and its Network reflect community-priorities and needs.			
Community-Based Workforce				
• Function 1: Lived-Experience Workforce – develops strategy for recruiting, training, retaining, and growing a diverse peer-based workforce.	X	X	X	X
• Function 2: Workforce Voice – create shared learning and feedback loops to improve CCH services and identify gaps in services	X	X	X	X
Comments	• All national frameworks and white papers focus on the need for diverse workforce within the Network and plan for workforce capacity within the Hub.			

	• Washington places additional emphasis on the hubs role in convening the voices of the community-based workforce broadly to address systemic challenges in workforce growth, retention, and recruitment; the hub provides a direct role in facilitating or providing culturally responsive training to its Network and community partners; the hubs can also facilitate a policy and advocacy.

Appendix: Community Based Care Coordination Standard Crosswalk

Goal: To compare ACH Hubs care coordination standards with MTP 2.0 (HCA) proposed case management protocols.
Crosswalk conducted by Uncommon Solutions in January 2024. HCA's final protocols may be revised.

Process	MTP 2.0 – HCA Proposed Protocols	Care Connect WA -DOH Standards (Meets National Standards)
Eligibility Criteria	• Title XIX or XXI mandatory prerequisite. • Medical appropriateness. • Screen positive for: food, housing, or financial insecurity; OR screen positive for other HRSN; OR would benefit from navigation assistance, such as benefit application or referral to programs. • Any qualifying individual in WA may access community-based care coordination services through any of the 10 regional and Native Hubs.	• Determined by Care Connect WA (I&Q, COVID Recovery) • Individual must be impacted by COVID 19 to include any of the following: ○ Positive COVID19 test ○ Exposure to COVID19 ○ Complication to COVID19 including long-COVID symptoms ○ Financial or economic impact from COVID19 impacting social & health needs
Funding	• Waiver funded services for both fee-for-service and managed care populations. • ILOS for managed care population. • Parallel ILOS authority for waiver funded HRSN services when appropriate.	• Care Connect WA grant funded to support individuals and families impacted by COVID 19
Engage: Reach and engage people in communities who need support to connect to social & health services	• Services may be initiated/provided in community and clinical settings: ○ Physical/Behavioral Health Care ○ Tribal Clinics ○ CBOs ○ Social Service Organizations ○ Food Banks/Farmers Markets ○ Day Habilitation Settings ○ Stabilization Centers ○ Prisons/Jails ○ Housing Agencies ○ Others approved by the state.	• **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 including access to services and resources to address HRSN. • **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 economic, social, and health factors that significantly compromise health and collaborate with client to make a plan to address identified needs	• Initial TBD screening process using evidence-based screening tool to identify individuals eligible for health-related social needs. • Unified screening approach TBD with approved screening tool(s) that will interface with statewide community information exchange. • Confidentiality	• **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. 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. • **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.	**Shared care plan documents:** • HRSN/SDoH screening results. • Medicaid eligibility/enrollment status • Utilization data to prevent duplication • Scope clinical vs community-based care coordination to avoid duplication • Person centered planning process. • Shared decision making • Reviewed annually & revised at client's needs change • Culturally appropriate & trauma informed care as established by CDC, ORR, SAMHSA • Conflict resolution, grievance, appeals process. • Confidentiality	• **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.	• Services to address HRSN, physical, and BH • HRSN needs tailored to client needs. • Dialogue/referrals between individual & care team • Closed loop referrals to community-based services and workforce (via current information exchange systems until statewide CIE established). • Continuity of care • Conflict resolution, grievance, appeals process. • Confidentiality	• **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.