A Guide to Referral Platforms

The Metro Area Health Alliances developed a list of questions for referral platforms and vendors that are active in Colorado. In this document, you will find responses from the following platforms:

Aunt Bertha	aunt bertha	**Mile High United Way 211 & CRISPeR**	2-1-1 Get Connected. Get Help.™
Activate Care	ActivateCare	**Now Pow**	NOWPOW
Boulder County Connect	Boulder County Connect	**Quality Health Network**	QUALITY HEALTH NETWORK
Julota	Julota	**Unite Us**	UNITE US

About Each Platform

Aunt Bertha is a nationwide community resource platform based in Austin, TX. Aunt Bertha offers a social care network that connects people in need to programs related to food, housing, financial and legal help, health services, and more. Tens of thousands of nonprofits and social care providers have adopted Aunt Bertha to send and receive referrals, track and manage care, implement reporting tools, and improve intake and scheduling, all for free.

Activate Care is a nationwide community information exchange platform headquartered in Boston, MA. Activate Care offers services, technology, and data analytics engagement with healthcare and social services stakeholders in 42 states through its integration with 2-1-1 Helplines, community-based organizations, healthcare systems and ACOs, and government agencies to better help communities collaborate and achieve better health outcomes.

Boulder County Connect is a Boulder County-specific platform launched by Boulder County Department of Housing and Human Services in 2016. It links individuals and families directly to available supports, including information about SNAP, WIC, TANF, health insurance options, the Child Care Assistance Program, and Housing Choice Vouchers, so they are able to get the help they need, when and where they need it. The platform allows members of the public to manage existing benefits and supports, learn about additional services they may qualify for, and connect with county staff via online chat for assistance. Additionally, it serves as a coordinated case management and referral system for over 12 Community Based Organizations and Family Resource Centers.

Julota is a patented HIPAA, 42 CFR Part 2, CJIS, and FERPA compliant interoperability platform based in Colorado Springs, CO that transforms the disconnected patchwork of local service providers into a well-coordinated network that can proactively manage and support individuals. Julota's cloud-based SaaS platform manages the consent and multidirectional sharing of Personal Identity Information (PII) and Personal Health Information (PHI) between software systems for healthcare, EMS, law enforcement, behavioral health, and social services organizations. Julota manages and organizes an individual's records into one holistic longitudinal record that operates standalone or between each organization's existing systems.

Mile High United Way 211 is a statewide community resource connecting individuals and families to critical resources including food, shelter, rental assistance, childcare, and more. In addition to being able to access and search a statewide online database, individuals can also call, text, or live chat someone at the 211 Help Center to learn about available services and supports. MHUW 211 is partnering with CORHIO and Denver Health to develop a closed loop referral and care coordination platform called CRISPeR (Community Resource Inventory Service for Patient e-Referral). CRISPeR was initially piloted as an eReferral tool embedded in an electronic health record to assist with diabetes management.

Now Pow, a nationwide self care referral platform based in Chicago, IL, was acquired by Unite Us in September 2021. This combination creates the nation's leading integrated health and social care network connecting people to the resources they need — from food and housing assistance to counseling, caregiver support and more. The companies are combining NowPow's high quality, whole person approach, and research-validated condition-based algorithms with Unite Us' proven end-to-end solutions and scale. By adding NowPow's tools and community partners to the Unite Us system, customers will now be able to support the changing needs of all people and all care teams.

Quality Health Network is a health information exchange in western Colorado that allows medical and behavioral health providers to securely share patient data to enhance care coordination and reduce duplication of services. The HIE is used by hospitals, providers, post-acute care facilities, home care agencies, and other service providers. In addition, QHN recently launched their Community Resource Network, which is a person-centered community information exchange integrated with the HIE focused on addressing Social Determinants of Health. The CIE centralizes social, behavioral, and medical data to fill gaps in care and improve the well-being of people in western Colorado communities.

Unite Us is a nationwide technology company based in New York City that builds coordinated care networks of health and social service providers, including community-based organizations, with the aim of addressing people's social needs and improving health across communities. With Unite Us, participating organizations across sectors can send and receive secure electronic referrals, track every person's total health journey, and report on tangible outcomes across a full range of services in a centralized, cohesive, and collaborative ecosystem. Unite Us' dedicated team builds authentic, lasting partnerships with local organizations to ensure their networks have a solid foundation, launch successfully, and continue to grow and thrive. Joining the network is free for community-based organizations and many organizations that are considered part of the safety net. Unite Colorado launched in the Denver Metro area in fall 2020 and plans to expand statewide by early 2023.

We asked each platform the following questions:

Responses

1. Which organizations have you been in conversation with that offer similar platforms or are involved in creating a regional Social Health Information Exchange in the Denver metro area? How has this informed your approach? How are you avoiding duplication of existing efforts?

    a. How and to what extent are you coordinating with the Metro Denver Partnership for Health's S-HIE-related efforts?

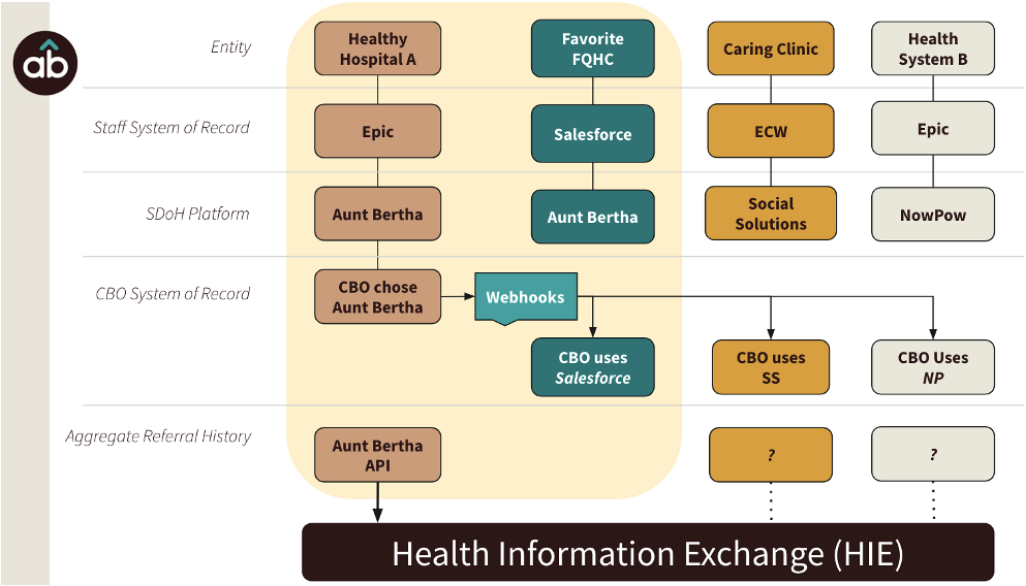
Aunt Bertha

Aunt Bertha is a national network for social care, including the program network and care coordination network. Aunt Bertha works with more than 340 customers as well as 70,000+ in-network CBOs. The concept of a CIE or S-HIE is a concept modeled after the Health Information Exchange (HIE) framework in the U.S. HIEs are heavily regulated and have primarily supported medical data for the purposes of care coordination, analytics, and research. There are many considerations when adding social care data into an existing HIE framework, primarily privacy and data access considerations, as social data has more privacy implications than medical data and is less regulated.

Please see our recent webinar and major considerations of CIE structures here: https://auntbertha-2.wistia.com/medias/9131lnvkqm

Aunt Bertha is a CIE in that we support functionality including care coordination across entities, privacy for the person to control who has access to their social care information (per organization), and coalition sharing, where organizations can choose to build data sharing sub-networks for care coordination purposes with transparency to the person being helped. We have found that this approach provides the highest level of security, accountability, and ease of use.

Other CIEs treat private information as a one time "all-in" approach without a permission-based access framework. This is a lesser standard than existing HIEs, and doesn't go far enough to protect the private information of people seeking help during their most vulnerable moments.



In the above diagram, regardless of the system the care coordinator is using, the referrals can be forwarded to the chosen system of the CBO. The CBO may use one of many vendors, including Salesforce or other CRMs.

We believe CBOs should be able to choose their preferred system of record, and network vendors should provide the integration to those systems for receiving the referral and outcome data. This approach is extremely beneficial and is the standard interoperability approach in healthcare as well.

The benefits of this approach include:

- Customers do not need to purchase more than one vendor;
- Customers can use the vendor they prefer for the network;
- CBOs can choose the system of record they prefer to use (for their mission and data sharing values);
- No middleware is necessary;
- No third party mapping or data aggregation is needed;
- Integration with EHRs can be direct by the vendors, and no third party is needed; and
- All vendors will be required to use FHIR integration standards set forth by the ONC and Gravity project.

We provide the network of social care resources and referral platform to Colorado Community Managed Care Network (CCMCN)'s S-HIE project via integration with Salesforce.

We are meeting with CORHIO/CRISPeR and Quality Health Network/CRN to discuss interoperability with their S-HIE projects. By working together, we hope to advance care coordination and reduce the double documentation being asked of the nonprofit community.

On a national level, we have discussed interoperability with Salesforce, Social Solutions, NowPow, Unite Us, CIVI, Apricot 360, and more. Most if not all of these vendors have agreed to the FHIR interoperability principles and many participate in the Gravity project. UniteUs is the only vendor with an "all-in" approach to consent and data access. We believe this creates significant barriers to trust in the community and blocks interoperability with the others.

We are also in conversation with the Mile High United Way/2-1-1 on how we can partner together and provide 211 resources in addition to our 5,113 human verified Aunt Bertha resources that serve the state of Colorado.

We use modern APIs to support data exchange with HIEs. We use SMART on FHIR protocols, as well as native EHR application tools for imports, API transactions, and data exchange. We also provide an external REST API that gives programmatic access to Aunt Bertha program and referral data. We are strong advocates of interoperability standards for the exchange of assessment and referral data. It allows patients, service providers, and other organizations to share documentation regardless of which system of record they use, in the same way that people can make a phone call to anybody with a valid phone number, regardless of which mobile phone provider the receiving party uses. We make this possible via web hooks that allow organizations who are helping the same patients to inform each other of the information they've agreed to share. Through APIs, organizations can query each other for assessment results, referral data, and care plans.

By placing an emphasis on interoperability and working together, we respect the choices that customers and nonprofits make. We don't force organizations into closed networks, and therefore avoid duplicated work. Single-sourced and/or closed networks discourage innovation

and drive up the price on social care for Coloradans. Colorado agencies should be able to choose the system of record and network that works for them.

Aunt Bertha has participated in alignment conversations with Colorado Health Institute, Mile High Health Alliance, OeHI, and Prime Health's Social Innovation Summit on what a successful social care network and social health information exchange would look like.

We have also had extensive conversations with the team at CORHIO, the CRN team at Quality Health Network, and CCMCN (our customer) about how social care referral platforms can work with S-HIEs to create an interoperable network (as outlined above) — avoiding duplication and advancing care coordination.

We are very happy to participate in any conversations on advancing care coordination for Colorado. These conversations can set the "rules of the road" around:

- Reducing nonprofit/Community-Based Organization (CBO) fatigue and respecting their choice in System of Record (SoR);
- Ensuring the privacy of the Seeker (and the dangers of all-in consent); and
- Advancing care coordination through interoperability.

We can provide insights to the governance group from our nationwide experience with Health Information Exchanges as we pave the way for interoperability.

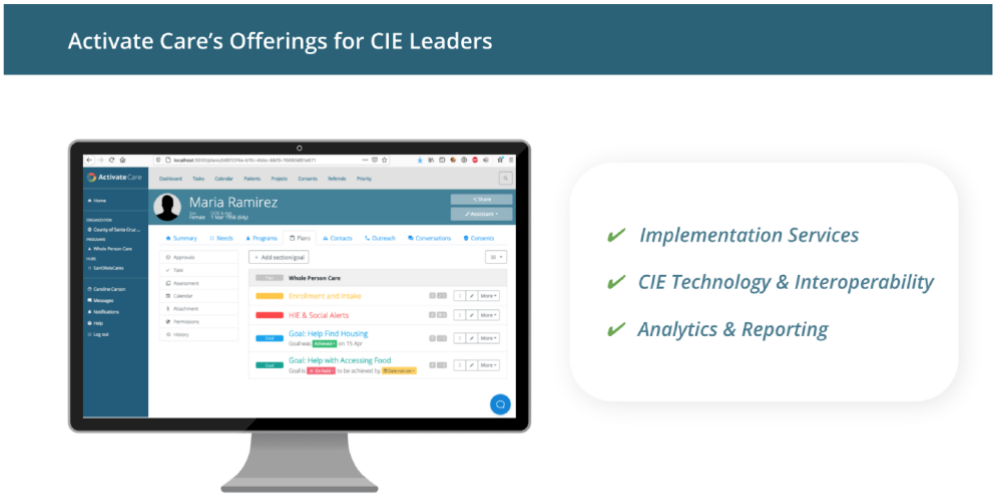
Activate Care

Activate Care has had numerous discussions with Colorado community leaders, government agencies, and the 2-1-1 Colorado operation over the past several years. We also have relationships with Unite Us and Aunt Bertha who have been entering the State to build community directories and networks - these and other vendors are essentially competing with each other and complicating efforts across Colorado. As a true community information exchange/social health information exchange platform, Activate Care offers an open referral infrastructure which can both manage referrals that originate from any vendor, as well as originate referrals directly in our own platform while integrating with all other referral management platforms. We would also be open to integration with Julota and other similar systems that may be in place.

Our approach is fundamentally different. We believe that organizations like 2-1-1 Colorado have been working in the State for decades to assemble directories and networks of community service providers to meet the needs of individuals and families. Such organizations have been working to build a S-HIE for quite some time and need additional support and technology to extend their capabilities. Our approach always starts by integrating with these existing networks (e.g., 2-1-1 Colorado) and helping them with technology and services to extend the impact of their efforts. Our expertise complements a 2-1-1 directory, network, and local governance model, with a platform for community coordination, closed loop coordination, and outcomes/impact analytics. In our experience these community partners are looking for simple applications that can integrate into existing systems to provide broader coordination experiences.

It is well known that community networks and services are highly localized and existing investments from government and community partners can yield significant value if stakeholders augment their existing infrastructure with value-added services and technology. This has been Activate Care's approach, and it has significantly reduced duplication of efforts in the journey to a Social Health Information Exchange.

In 1999, community leaders across the state of Colorado began working together to develop an integrated system of independent information and referral call centers. In 2002, the Public Utilities Commission approved the plan, and the 2-1-1 dial code was officially active in the state of Colorado. Today, 2-1-1 Colorado provides border-to-border coverage of Colorado, serving all 64 counties. This represents foundational building blockers within the State of Colorado to build a S-HIE.



We start our work in communities with the local 211s who have been building the components of a S-HIE for many years. As required, we also work with other open standard applications to connect with the private competitive networks being built in parallel (for example, we can integrate with Unite Us or Aunt Bertha if needed). However, we would encourage the Metro Denver Partnership for Health to look at the existing work that has been underway for decades and believe the state should not compromise these networks, relationships, and trained professionals. We want to extend these efforts with complementary services and technology. For example, many of these organizations have technology to capture a directory of providers, some assessment capabilities, and analytics to track call volumes or referral types. With our partners we're seeing that S-HIE operations want to extend their capabilities in areas such as:

1. The ability to develop a longitudinal community shared plan of care for individuals and families working with community providers.
2. The ability to share data on individuals and work with community providers around a plan of care with healthcare, payers, and government agencies.
3. The ability to integrate interventions across health care systems and payers to better meet the needs of their patients and members.
4. The ability to get better data on outcomes and service delivery to see the impact of their efforts.
5. The ability to integrate with the range of systems already operating in various care sectors (e.g., EHR, HMIS, Jail systems, HIE, I&R, 211, etc.).

The Activate Care Services team has extensive experience helping communities stand up their S-HIE care models. Our team of professionals works with our partners to help define program models, community networks, program workflows, and teams. Our work is informed by the many engagements we have across the country with similar programs and community initiatives.

Our CareHub platform provides the essential functionality needed to enable true health and social sector collaboration. Our S-HIE technology platform offers robust integration capabilities, supports the creation of a longitudinal care record, surfaces critical health and social events and alerts, and enables care coordination and care planning between all network partners. Our advanced analytics provide real-time operational insights at the point of care, and allows teams to demonstrate the long-term impact of their work.

Activate Care has invested significant resources to help our partners meet their reporting and improvement requirements. Measuring the impact and outcomes of our partners is central to our work. We have over 100 standard reports used by our partners. These reports help our partners understand program operations, network and individual engagement, and opportunities to improve and refine workflows and referral networks. We also provide additional capabilities with custom reporting based on the evolving needs of the program. All program data is stored on a reporting database, which can be accessed and downloaded for any additional needs or data analysis requirements of the program.

We are confident that our experience, expertise, interoperable technology, and our passion for this work position us uniquely to help the Metro Denver Partnership for Health succeed with Social Health Information Exchange and all future community health transformation efforts. Supporting communities standing up CIE models of care is our singular focus.

Boulder County Connect

We have conversations with Mile High United Way 211, CORHIO, QHN, Unite Us, Now Pow, Colorado Health Institute, Office of eHealth Innovation, MDPH, HD Consult, and others.

We participate in all 3 MDPH/CHI S-HIE workgroups as well as the Care Coordination Task Force that was recently spun up by Stephanie Bennett. We are very committed to helping find paths towards cooperation and integration between the many resource and referrals systems that are popping up.

Julota

To be clear, we don't look at ourselves nor position ourselves as a referral platform. We're typically brought in and viewed under two lenses: Data-sharing and Program operations. At a data-sharing level we're viewed as a Community Information Exchange due to our compliances and interoperability capabilities. This infrastructure is necessary to administer the programs operated by community organizations.

Yes, we allow referrals, and we give our hubs the option to allow community partners and resources to be able to submit referrals into their program. Referrals are the keys to the ignition for administering programs and helping individuals within the community. We prefer to partner with a UW211, Aunt Bertha, or Unite Us platform who are placing people on the ground into each and every community, constantly checking on the status of social services organizations to update their services offered profiles and remove them from the available list if they've closed their doors. That's not where we put our efforts as a company. Through the partnership and Advanced Programming Interfaces (API) however, we will have the visibility they've earned in the referral market to deliver to our hubs and community partner organizations.

Yes, we're involved with CHI though they've yet to set up a meeting with vendors, which Julota will be a participant.

We've connected CHI to El Paso County as that county is working with Julota on a Community Navigation pilot which is directly related to the S-HIE efforts outlined to me by CHI. EPCPH's medical director, Dr. Robin Johnson, will be a participant for CHI's initiatives.

Mile High United Way 211

We use the Salesforce Service Cloud platform for our 211 client intake and to hold the 211 Community Resource Inventory (211-CRI). We're in our 3rd year of funding with CDPHE towards a e-referral closed loop referral/ care coordination platform (aka CRISPeR), leveraging ICD-10 diagnosis codes as search terms to find appropriate resources. This is a partnership with 211, Denver Health and CORHIO.

We've received OeHI grant funding and are working with CORHIO towards 211-CRI distribution and towards creating the comprehensive, one source of truth 211-CRI which will aggregate other databases, e.g. we will be aggregating the Hunger Free Colorado database with the 211 database to eliminate duplication of efforts.

This OeHI work is in connection with the work of CCMCN and QHN, towards statewide interoperability.

The OeHI work is also leveraging our CRISPeR work.

211-CRI under OeHI grant:

- One Source of Truth
- Standardization of Unique ID Assignment
- Aggregation / Curation of Databases
- Mtce Owner Assignment to Reduce Burden on CBOs
- Identify Access Preference
- (View, Fax or e-Referral, Closed Loop)
- Platform Location of CBO
- Distribution through CORHIO to Provide or Enhance existing CRIs Sets

We at 211 are participating in the various Collaborations and Workgroups such as MDPH and are in conversations with the parties mentioned above.

CRISPeR

The CRISPeR team participates in several statewide meetings and workgroups, while also coordinating weekly calls with MHUW, CORHIO and Boulder County Connect. Through consistent and regular communication with the partners listed below, we strive to avoid duplication of efforts, learn from best practices and work to identify complementary roles for those involved with CRISPeR and other S-HIE efforts throughout Colorado.

- MHUW- participates in weekly meetings with CRISPeR, encouraged to become the universal community resource list provider (OeHI)
- CORHIO- participates in weekly meetings with CRISPeR, referral system exchange
- BCC- participates in weekly meetings with CRISPeR, CORHIO and MHUW
- HFC- encouragement and collaboration to be a data steward and e-referral recipient
- QHN- preliminary conversations have taken place

- MDPH – CRISPeR team members attend the Governance and User meetings, as well as the Technical Implementation Workgroup
- CCMCN- partnering to better understand the role in population health data aggregation, are key in NE Colorado and Boulder
- OeHi- CRISPeR team members participate in State Health Information Governance Group and Care Coordination Governance Taskforce
- Gravity (HL7)- CRISPeR is working to align with national standards for social determinants of health and health information exchange

Now Pow

NowPow reached out to Mile High United Way to learn more about the Mile High United Way and CORHIO partnership. In follow up of introductory meetings, NowPow provided an overview and demo of the platform for United Way Denver, CORHIO, Boulder County Department of Housing and Human Services, Denver Public Health and Boulder County Connect to explore synergies and support collaboration. NowPow has also connected with the Denver Regional Council of Governments in separate conversations around how we can best support their work through our seamless workflows and robust data and reporting capabilities.

NowPow is partnered with Telligen Community Initiative (TCI) to release a Special Funding Opportunity Request for Proposal (RFP) in Colorado, with NowPow as the technology partner. This special funding opportunity will select 7 – 8 organizations focused on innovative projects to make social determinants of health data and information more usable and actionable – to truly benefit the clients or patients they are serving. The funding opportunity is focused on FQHC, Critical Access Hospitals, Rural Health Clinics, and Critical Care Hospitals in Colorado. We welcome the opportunity to work with any of the Mile High Health Alliance members and partners through this unique opportunity.

Additionally, NowPow is currently supporting a Boulder County project, which is implementing a county-wide behavioral health co-responder intervention.

NowPow has connected with other platforms in this space, if provided the opportunity we would welcome conversations around interoperability to support collaborative efforts.

In any partnership opportunity, we seek out to understand the existing efforts in supporting the community, and aim to add value and sustainability while ensuring community stakeholders and members remain central to the support we provide.

For the S-HIE effort, NowPow has taken a two-pronged approach for support.

As of now, NowPow's Community Engagement team is heavily involved in the community on behalf of our partners in Boulder, Colorado. The Community Engagement Team manages identification, recruitment, and onboarding efforts to develop a strong set of community referral partners to support the targeted interventions and promote intervention success.

Aligning to the intervention performance standards is a key part of this work as well as getting referral partners well-versed in self-monitoring and receiving feedback on their performance. Our team is dedicated to doing and supporting a lot of the work that our partners are currently

taking on in the early stages of their project. Our team brings this level of expertise in community engagement and dedication to standing up a community network to every partnership we work with, including any efforts that S-HIE may have. We would love the opportunity to work alongside any efforts that S-HIE or its partners may have in developing a comprehensive and sustainable community engagement network.

For the existing S-HIE efforts, NowPow welcomes opportunities for interoperability so that connections in the community and data that is generated from these engagements are not siloed but rather used to inform improved community connections. This can take the form of leveraging our interoperability partner to facilitate seamless bi-directional integrations or data that can be de-identified and shared with all stakeholders to guide actions. Our robust data offerings can be leveraged to

- Understand prevalence and distribution of social needs in communities
- Drive successful resource connection, including referral outcomes and barriers to care
- Optimize referral networks that effectively support the needs of the population served
- Support data driven resource investment and policy development with deepened understanding of resource supply & demand

Quality Health Network

Quality Health Network (QHN) is actively engaged in conversations with State partners, especially the Office of eHealth Innovation and the Colorado Department of Health Care Policy & Financing, and other organizations such as Colorado Regional Health Connectors, CORHIO, CCMCN, and Aunt Bertha. QHN is currently focusing on implementation in Western Slope communities of Colorado and has partnered with Western Colorado 211 with our Community Resource Network (CRN) application.

In addition, QHN partners with Rocky Mountain Health Plans to assist with the CMS pilot project, Accountable Health Communities Model (AHCM), which includes an SDOH screener. Rocky Mountain Health Plans and QHN launched a social needs screening platform for use by

primary care, behavioral health, and hospital partners in 2018. As of early 2021, more than 50,000 screeners had been completed.

QHN staff are active participants in statewide conversations about S-HIE efforts including the eHealth Commission and OeHI efforts and participate in national conversations, such as the Gravity Project and the National CIE Advisory Committee.

Unite Us

Unite Us sees it as our role to not only connect network partners through our technology, but also to bring together key users, community organizations and Unite Colorado stakeholders to collaborate in ways that stimulate best practices, new learnings and ultimately help push the industry forward together.

We have talked with all of the organizations listed above and are actively exploring opportunities for partnership and integration capabilities based on the guidance provided to avoid duplication of efforts and leveraging the resources and infrastructure already in place in Colorado. We recognize the state has taken the position of being vendor neutral, allowing each entity to select a platform that will best meet their needs. We are dedicated to working with each entity to understand their current workflows and any identified gaps.

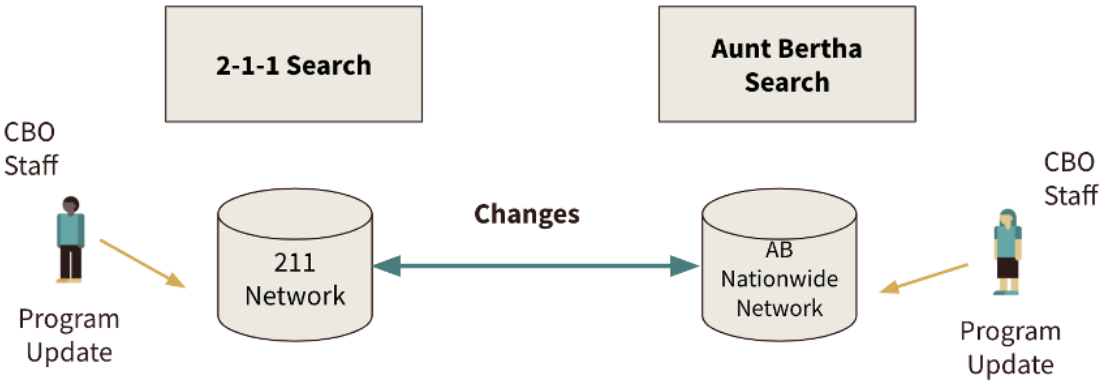
We have been actively participating in conversations with Metro Denver Partnership for Health/CHI around our capabilities, integrations, legal compliance and our work with CORHIO and the S-HIE.

2. How are you integrating or communicating with other systems? For example, how are you sharing resource information across platforms so that service organizations only have to update their information once?
    a. Do you plan to integrate into EHRs used by all healthcare providers in CO?
    b. What would this look like/how would it operate?

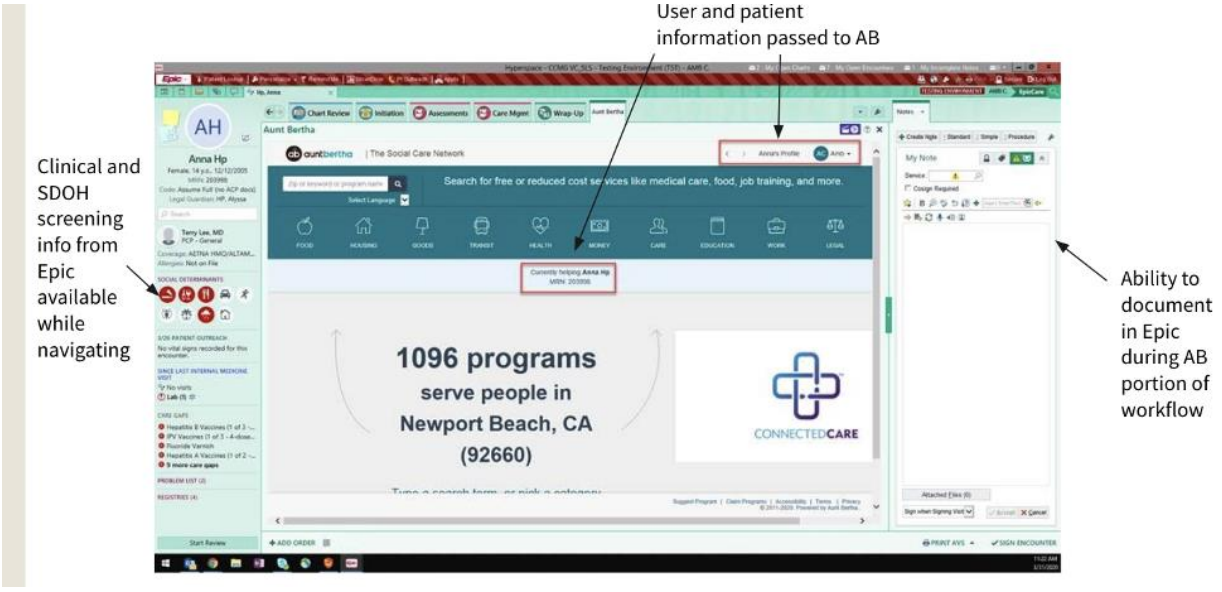
Aunt Bertha

Aunt Bertha has an in-house integration team for customer platform integrations, CBO integrations, CRM integrations, care platform integrations, EHR integrations, and more. To the right are some of those integrations that are live along with those that are being developed.

Aunt Bertha also has program data partnerships in California, Wisconsin, West Virginia, and other states. In California, we have APIs that connect to iCarol and directly exchange program data with Aunt Bertha and 211 so that real-time program updates are only made one time in either system and communicated to the other. This is possible at scale and we are the only vendor in CO to have successfully completed this in large volume.



Changes made in one system will be reflected in the other.



Aunt Bertha also supports EHR integrations, similar to what's pictured above, reducing the need to login to other applications.

We already work directly with providers of these systems, including athenahealth, Epic, and Cerner eCW, *(and more in development)* so that the record of care follows patients from inside clinical walls out into the community. We support both native and launch search and referral workflows with the understanding that program Seekers may originate from the community prior to landing in a traditional care setting.

In addition to our many EHR integrations, we also integrate with care/case management like Innovaccer, CRMs like Salesforce, and other systems of record that our customers use to bring smooth workflows to all coordinators of care regardless of business sector.

We plan to or have integrated with all EHRs in Colorado.

We support Launch integration so that staff can dynamically launch into Aunt Bertha's platform from within their EHR or system of record. Credentials are passed via Single Sign-On (SSO) so there are no interruptions to the workflow and staff can focus on caring for the patient.

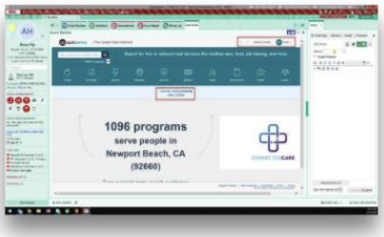
We support Native integration so that Aunt Bertha's program data is embedded within EHRs (like Epic) so that our data can be incorporated into the history section of patient charts, Plan of Care module, resource lookup, and more.

We support integration into Patient Portals, like Epic MyChart, so that Coloradans have access to the Aunt Bertha network and can self navigate to social care providers in their community.

Please see visuals of all integration types in our recorded webinar below: https://auntbertha-2.wistia.com/medias/8kxnfsgrei

SMART Launch Integration

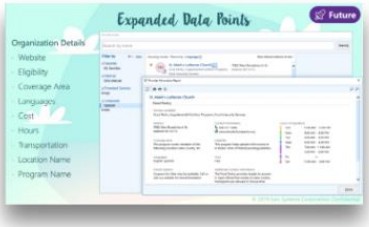
Released and Live



Closed Loop Workflow

Healthy Planet Native Search

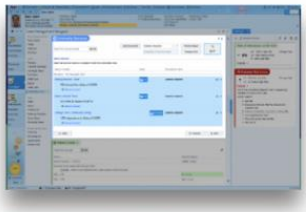
Released and Live



AVS Workflow

CoCM Referrals

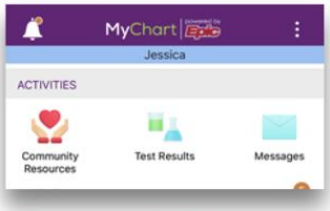
(unreleased)



Closed-Loop Workflow

MyChart

Released and Live



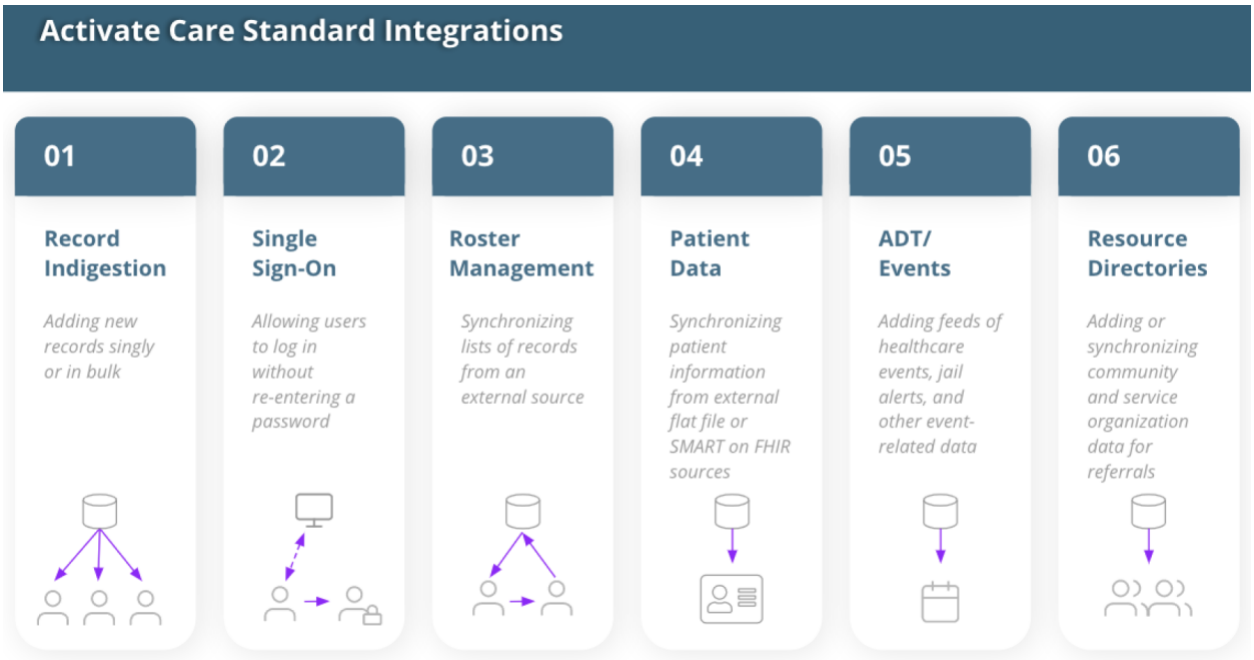
Self-navigation Workflow

Activate Care

In order for a S-HIE to be effective it must integrate with the existing data systems (public and private) of the various stakeholders central to network success. We start by understanding existing systems operating in the region and then integrate with those systems into a shared record. There are a number of public and private networks identified by Metro Denver Partnership for Health in Colorado and our application can integrate the existing database (211, Aunt Bertha, Unite Us, etc.) and well as the other key systems of data central to a successful S-HIE. For example, the value of a S-HIE is enhanced with data integrated from HIE, EHRs, HMIS, Jail alert systems, etc. This is the core capabilities of the Activate CareHub S-HIE platform.

Activate Care believes that data integration is key to the success of bridging the gap across physical health, behavioral health, public health, and community based organizations. We believe in Open interoperability. In fact, one of our founders, Dr. Ken Mandl, leads the SMART on FHIR project - a project that lays the groundwork for a more flexible approach to sourcing

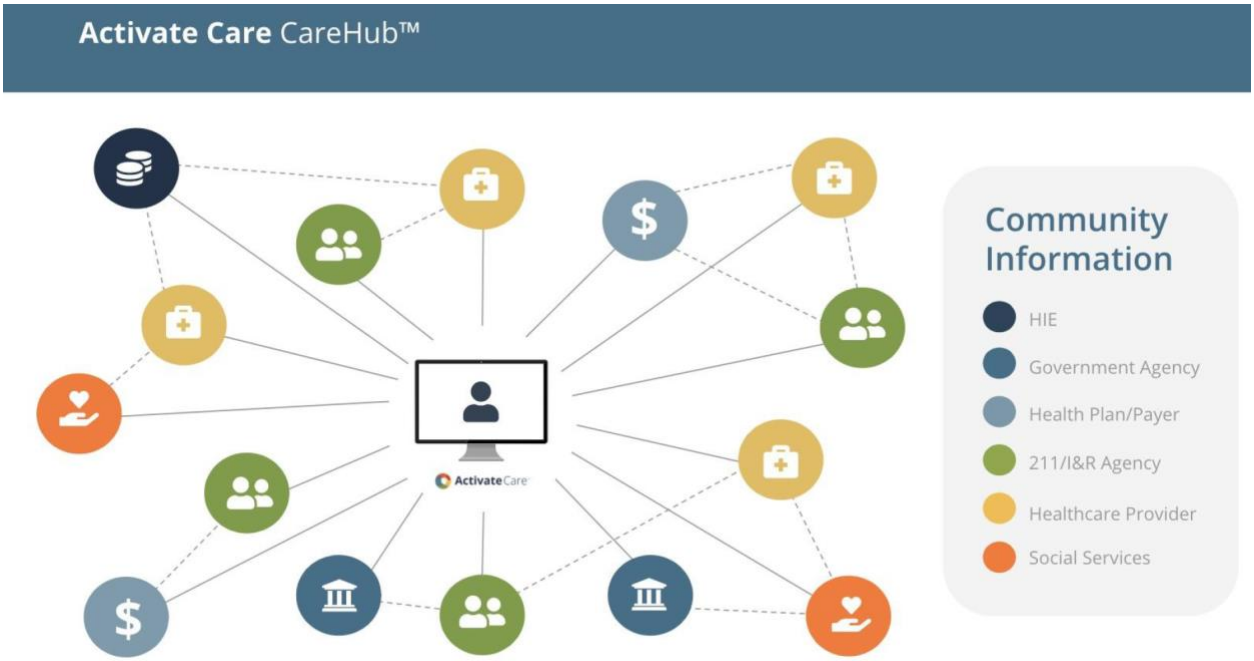
health information technology tools. We have designed the platform to be able to integrate with and ingest from a broad range of systems.



One of Activate Care's differentiated sources of value to clients is sharing appropriate data across health and community organizations, so that they can have the appropriate information to support prioritizing work, and inform care. We support making appropriate elements of clinical information (such as hospital discharges, condition lists, or medication lists) and community derived information (community developed behavioral health assessments, a member's actual compliance to a care plan) available to appropriate members of the care team - both clinical and community based. Our methods include, but are not limited to, those mentioned above: We have a number of approaches to support this data-friendly technology approach: FHIR, SSO, HL7, Flat file imports, OpenReferral, and more.

- FHIR - Activate Care has a FHIR API to integrate and exchange data with Electronic Health Records like Epic, Cerner, and NextGen.
- SSO - We can launch Activate Care, in member context, from other applications, so users do not need to reauthenticate and search for a member to access a record.
- HL7 - We can ingest member cohorts, including demographic and other key EHR information, such as medication lists, problem lists, diagnoses, etc. that clients use to inform the work of care coordinators.
- Flat file imports - Activate Care customers use a range of data from health technology platforms, and other community resources, such as Homeless Management Information systems (HMIS), criminal justice systems, population health tools, etc.
- OpenReferral - Open Referral https://openreferral.org/ is an emerging standard that makes it easier to share, find and use information about health, human, and social services. This integration makes it easy for Activate Care to leverage information in existing resource directories, such as state and county 211 systems, UniteUs, Aunt Bertha, and NowPow. Greg Bloom, the chief organizing officer of Open Referral, is on Activate Care's board of advisors.

Activate Care uses the SMART on FHIR standard to integrate and exchange data with Electronic Health Records like Epic, Cerner, Meditech and NextGen. Not all EHR vendors have completed required work around this standard, so we have an integration engine designed to push/pull data into such environments. Activate Care will integrate with any Colorado EHR that Mile High Health Alliance needs. The EHR is not only one data source often required to integrate such information central to a S-HIE. In our efforts we've integrated with other technologies such as HIE, HMIS, Jail systems, I&R systems, and other actionable data sets.



Activate Care validated an app inside Epic that shows the member's community care record goals, service needs, SDOH-related information including the dynamic care team. We prefer SMART on FHIR as a standard for integration into the clinical setting, but would want to work with your stakeholders to understand the appropriate integrations. Our goal is to integrate the community plans of care and appropriate events & alerts to inform a clinical team of activities happening around individuals when present for care.

Boulder County Connect

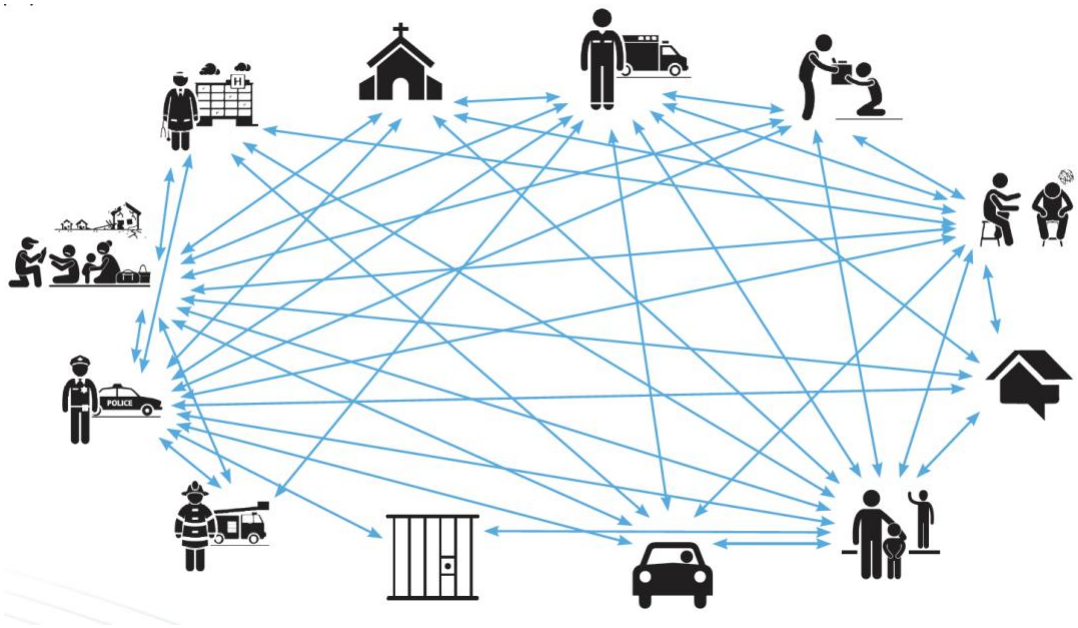
As part of the Integrating for Equity project that included Boulder County Public Health, Clinica Family Health, Mental Health Partners, and CORHIO, CBOs in Boulder County are now able to receive referrals directly from Clinica's EHR. Work is ongoing to receive referrals from Mental Health Partners, which uses a different EHR than Clinica. I believe this puts us firmly on the path to receive referrals from even more EHR systems as CORHIO expands their closed loop referral/CRISPeR architecture.

It makes sense to us for CORHIO to continue to be a/the leader in terms of providing the architectural hub for an S-HIE.

Julota

We share this information via APIs. Two-direction APIs allow service organizations to intake patient information, then through a strict confidence match between Julota and other connected

systems, Julota will update their patient records accordingly. We then can take this a step further as Julota understands each organization's compliance and consent requirements delivering the necessary “documentation” if you will, for each unique organization. The goal here is to eliminate duplicate entry while creating data-transparency across the state.



Yes, we are integrating with EHRs today. For those organizations operating on paper, Julota provides a web-based EHR platform to foster community data-transparency. Julota allows organizations to choose using their current EHR, and we’ll connect that EHR to community partners so they’re community-present, or they can choose to use Julota’s user-interface as their EHR.

Mile High United Way 211

We at 211 are creating pathways to provide the 211-CRI to care coordination platforms, to EHRs, such as EPIC Healthy Planet, to nonprofits, government agencies, to anyone needing a database of community services, government programs, etc. locally, statewide, nationwide, with the goal to provide the same comprehensive set of community resources to all entities so that wherever a patient/client enters, they are provided with the same set of resources available.

As mentioned above, under the work of OeHI we will be developing the process and procedures to enable CBOs themselves or those who collect and manage a database of resources, e.g. Hunger Free Colorado, to provide those resources in the 211-CRI as the source of truth.

We are currently beta testing the functionality for a CBO to manage and maintain their own service information on the 211Colorado.org website. Future work will include receiving CBO service information that is maintained on various platforms, e.g. Unite Us, to also feed into the 211-CRI.

CRISPeR

CRISPeR integrates into health system electronic health records through obtaining a dataset from MHUW or through utilization of a query and response tool managed by CORHIO.

At this time, funding is primarily dedicated to support FQHC's, however the design for CRISPeR is not uniquely suited to one type of health system. The CRISPeR team is open to and interested in other opportunities to collaborate with health systems statewide and would like to expand to more rural areas, including the western slope.

CRISPeR will continue to partner with MHUW, who offers statewide services, as well as CORHIO and QHN, who together support exchange of health information statewide. As noted above, we have had preliminary conversations with QHN and are working to establish a stronger partnership.

Now Pow

NowPow has experience integrating data from 211s/resource directory partners to maximize mutual benefits, leveraging 211's deep local knowledge and NowPow's deeply indexed information to support personalized referral matching. This helps to eliminate duplicate efforts as NowPow offers flexibility with these relationships including the ability to auto-update their resource data when our in-house team does the validation process; reducing the burden on CBOs to update their information for more than one organization.

NowPow understands the importance of meeting our stakeholders where they are at while providing them with an efficient workflow. We can integrate with any data source of truth, such as an EMR, HIE, or CRM, and recommend expanding our integration partnerships across all healthcare providers, payors, and government entities in Colorado.

NowPow is a champion of seamless integrations which can take various forms. We are currently supporting projects with a bi-directional integrated version of our platform through FHIR API, HL7, and web services. If your EHR or CRM operates within those modalities, then we can integrate using standard methods. Further consultations would be needed to determine the work needed to integrate with your system and set it up for your specific intervention needs. As our

team works to integrate with your system, we will make clear the expectation and asks from your team, but the NowPow integrations will lead the project.

All integration projects include these main components: federated authentication or SSO, person data exchange, screening synchronization, referral generation, and optional curation, document write back (HealtheRx and Screening/Referral Summary documents filed to person records for a quick review), and optionally raw data package delivery (for business intelligence and analytics systems). This seamless integration allows for all users to view the work being done for the individual, keeping all members of the care team on the same page, and preventing duplicity of work.

Quality Health Network

QHN's Community Resource Network (CRN) is built on the understanding that interoperability and workflow are critical for medical, behavioral and social service providers. With this in mind, CRN is currently interoperable with multiple systems and can connect with additional systems as opportunities emerge. CRN connects with systems using Application Program Interfaces (APIs) for real-time data sharing and can also receive information in flat files.

CRN data is managed from a central data storage repository; however, the Client View of participant data is federated to users. The central repository, backed by the health information exchange's master patient index, can be queried to identify existing member records. This query is performed with a high degree of attention to the protection of personally identifiable information but encourages use of common participant registry identities to avoid duplication of entry and proliferation of incongruent client records. Agencies are permitted to use CRN as their case management record. The system supports an agency focused view of the engagement with the member, with no implied data sharing required. Once the individual has consented to a care team engagement the whole-person, 360 profile is made available to the user. This view presents a summarized view of need and case activity as well as access to shared care coordination and case management tools.

Currently, the CRN platform is interoperable with the Mirth suite of health information exchange tools as well as the 211 platform VisionLink. The connections with Mirth allow medical and behavioral health providers utilizing QHN's HIE to single sign on from Mirth into the CRN platform. This can be performed as a proxy for signing in manually or can be accessed from a specific patient's longitudinal record to allow sign in with client context. In addition, we ingest HL7 ADT messages from the Mirth HIE as well as send AHCM screener results to populate the screener record in CRN. The interface with 211 allows for updates to the CRN Resource Directory from the local 211 system. The platform as a whole can be viewed at the services layer via REST APIs. All of the core capabilities of the program have documented APIs which would allow an external third-party system to connect and exchange data or capabilities with CRN.

a. Yes, we plan to integrate into EHRs used by all healthcare providers in Colorado.
b. The details of an interface would be scoped with the entity who is requesting it. Likely, messages that would move back and forth would include referrals and team messages. The Accountable Communities Health Model (AHCM) screener is already pulled from the HIE into CRN and would be available to move into an EHR, as well.

Unite Us

Unite Us supports modern application programming interfaces (APIs), data extract products, an enterprise master person index (EMPI), relevant open security frameworks (OAuth 2.0, SAML, SCIM, SMART), industry data exchange standards (HL7 FHIR), OpenReferral-based resource directory exchange, and custom APIs as appropriate. In 2022, Unite Us continues to expand its library of bidirectional data flows, with heavy focus on FHIR and population data products, and its library of standard out-of-the-box integrations with vendors that support standard space interoperability (Epic, Cerner, eClinicalWorks, with more in the pipeline).

Unite Us works with entities to connect with Unite Us' Electronic Master Patient Index (EMPI), so that the social care record can contribute and query regional systems and facilitate the matching of people across platforms. Unite Us views its EMPI and ability to match and store external identifiers as an important foundation for advanced interoperability.

We have an internal team dedicated to evaluation of integration opportunities, responding to both community and customer requests.

The Future of Interoperability:

Unite Us believes that the greatest opportunities for advancing interoperability and standards-based exist at the state and regional level. For example, Unite Us recently co-facilitated a discussion in July 2020 with the State of NC Department of Health and Human Services (NCDHHS), Foundational for Health Leadership and Innovation, Duke University Health, WakeMed Health, more than a dozen major health systems across the state of North Carolina, and their EHR vendor, Epic. The agenda included care best practices, state IT vision, and a forward-looking discussion on future SDOH interoperability.

Ultimately, interoperability is an enabler for facilitating better care. Unite Us sees the most promise in opportunities that contemplate both innovative models of care and payment with technology as an enabling tool.

Unite Us has been a vital partner in these demonstration opportunities, bringing all of its technical and non-technical capabilities to bear to meet the goals of the program. Some examples include participation in grant applications and implementation of Innovative Care for Kids (InCK), providing underlying technology for NC Healthy Opportunities Payment Pilots, and implementing its first integration with a school information system in Kentucky to better enable the use of wrap-around community services for children and families.

These programs contemplate the overall holistic care model, the systemic outcomes they are seeking to address, and the underlying use of technology as a means to achieve these goals. As we partner with state and local agencies on new models of payment, care, and community collaboration, the Unite Us Interoperability team will be the technology partner to build the connectivity needed to reach Colorado's long-term goals.

EHR Integration:

EHR integration is not required, but if it is desired the Unite Us platform offers a number of interfaces of different types that are used for integrations with external systems.

Today, Unite Us maintains an EHR agnostic position and supports standards-based interoperability. We have several standard Smart on FHIR integrations available out of the box with leading EHR platforms (Epic, Cerner, eClinicalWorks, with more in the pipeline).

In 2020, we deployed this application to 25+ leading health organizations, including Kaiser Permanente, University of North Carolina Healthcare, Intermountain Healthcare, and Santa Cruz Health Information Organization, across Epic, Cerner, eClinicalWorks, and NextGen HIE platforms.

Through our SMART on FHIR application, Unite Us can be embedded into an intuitive launch point within the EHR end user's workflow, typically from care planning tools or patient summary screens. Through the course of an implementation, we work with your project team to review specifications, set up and test the necessary connectivity, consult on workflow best practices, and partner on strategies for training end users.

- Single Sign on for users from within the EHR
- Leverage a FHIR resource to get patient demographics from the EHR, jumping the user into a patient context if a match is identified and reducing double entry
- Sending social care referrals electronically
- Gather consent from an intuitive point in the workflow, or view that consent has already been acquired elsewhere in the network
- See patient's social care history including a longitudinal view that can also include service episodes that were initiated for that patient by other facilities
- See up-to-date statuses for social care service episodes
- See the outcomes of all the social care service episodes sent by the hospital
- A dashboard view that shows a list of all the social care referrals and cases of patients of the hospital
- Access screening tools for SDOH needs, including values entered by external users

3. How are you prioritizing equity? How can your platform advance equity or reduce disparities?

Aunt Bertha

Our customers used the data generated on their unique sites to support all types of initiatives, including advancing equity and reducing disparities. **The Aunt Bertha platform**

can be used to compare search activity in Colorado communities with available resources to identify potential coverage gaps or areas of opportunity. These reports break down searches on the Aunt Bertha Platform by program type, comparing the percentage of each category searched against the percentage of programs that are actually available in the region.

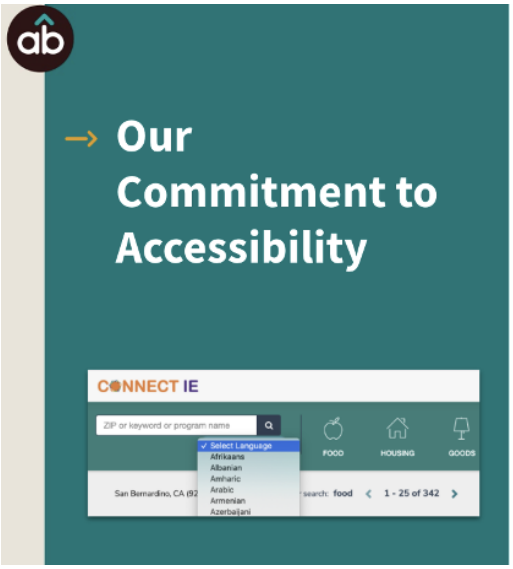
One of our Colorado customer partners used our assessment and analytics tools to gather data on immigrant populations looking for assistance enrolling in health insurance. In comparing primary language and the availability of trusted and qualified interpreters, they identified that the immigrant population was disproportionately affected by COVID-19 and required additional support to enroll. Their analysis led them to take fast action in finding interpreters, and supported them with documentation to seek enrollment extensions that they and the immigrants desperately needed.

Aunt Bertha's unique database of hundreds of thousands of social service programs and nationwide search data provides an opportunity to obtain important insights regarding individuals seeking help. Another example of the insight our data has, is our collaboration with Stanford Immigration Policy Lab.

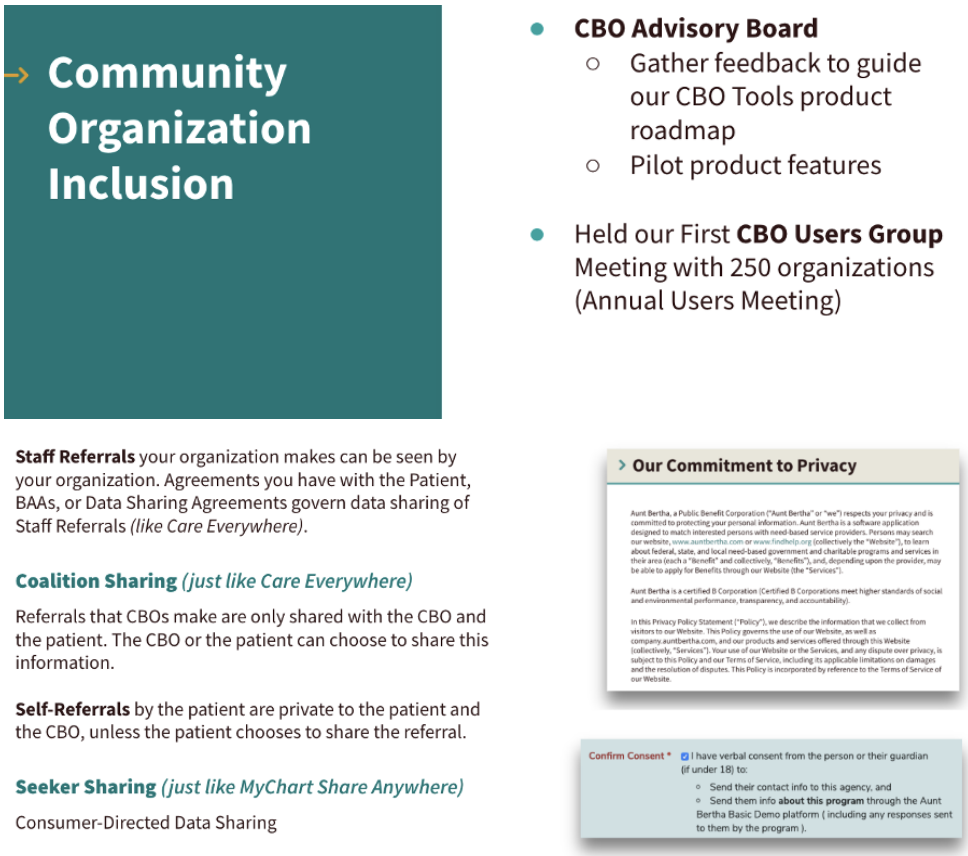
We remain WCAG compliant for accessibility to all through our public facing customer sites.

We have a nonprofit user group that provides feedback on equity of resources and services.

And finally, we keep private referrals private (unlike most other vendors) which reduces stigma and barriers to receiving help.



- Our customer sites are fully **WCAG 2AA compliant**, and we continually monitor existing pages and test new features as they come out to maintain accessibility going forward.
- We perform an **accessibility audit** using WAVE, safari & voiceover, and keyboard navigation for all browsers. We actively seek feedback on our product from disabled users.
- Our accessibility efforts also include **translating key features** of our site, such as email and text notifications, and CBO screeners as well as capturing language preference on referrals.



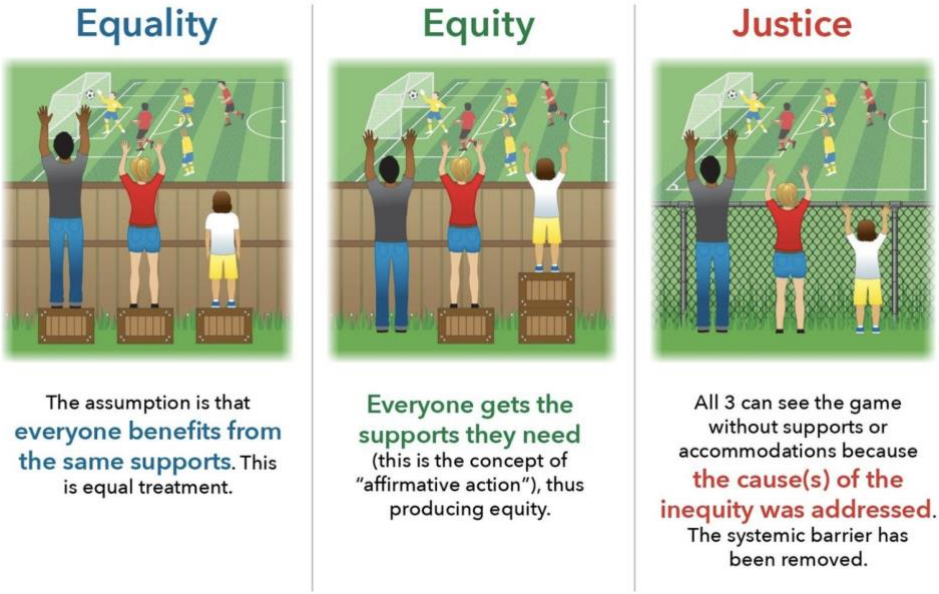
Activate Care

Activate Care has centered equity from our founding by recognizing the need to give voice, agency, and access to community care partners and their individual clients in any community-based system of care. Our programs incorporate existing 2-1-1 resources rather than attempting to replicate and replace these invaluable resources. We take a similar, methodical approach to community engagement with all network partner organizations.

Many S-HIE models emerging across the country are perpetuating a model of inequity in community care. In the traditional model of healthcare, care plans are developed by clinical teams or case management teams as directives based on a set of clinical tests (e.g., exams, labs, medications, etc.). In the emerging S-HIE models, the hospital or payers are the purchasers of referral management platforms - which only reinforces the power disparity. This imbalance translates into community based organizations and the individuals they serve not getting access or input into plans.

Additional challenges to local organizations are now present in the referral networks that are being built. Many organizations are becoming overwhelmed or disrupted by the scale of the need for help in their communities. When we build a S-HIE with a focus on integrating interventions, rather than merely enabling referrals, we can take a more logical and less disruptive approach to implementing S-HIE.

Our mission is to recognize and give voice to the community service providers doing the difficult work of serving individuals and families in need. Our mission is to give voice to the goals and objectives of the individuals and families being served.



We believe in shared plans of care which are developed across the community, with community care providers with the individual and aligned to their goals is critical for equity. We hope to outline service needs, accommodations, and remove systemic barriers. This requires visibility and accountability for all community partners and their clients.

Boulder County Connect

Equity is a high-priority topic in our department and we are still figuring out the best ways in which to ensure that all projects and systems, including Boulder County Connect, can advance equity and reduce disparities. In other words, it's an evolving work in progress.

Julota

This requires involvement from state leaders and frankly by community leaders at the community level on the types of information they're wanting to collect and information needing to be shared. Julota strongly recommends not labeling or identifying individuals in a manner that would cause disparity for each individual program administered by a hub.
We also encourage anonymous surveys for community organizations and participants which are a place for individuals experiencing inequity to have a voice. We prefer this information be automatically delivered to an individual focused on disparity mitigation allowing an appropriate response for the participant's shared experience.

Mile High United Way 211

N/A

CRISPeR

CRISPeR is prioritizing equity through collaboration with FQHCs and by connecting patients with culturally and geographically relevant resources. Services referred to are in response to the patients place of residence, as well as a personal assessment that helps to understand the needs of that patient. CRISPeR strives to establish partnerships that

are geographically dispersed, and with organizations who offer resources in other languages.

A few partnerships include Vuela, the Center for African American Health, YMCA, etc.

Now Pow

NowPow can be leveraged to address inequities / disparities in the following ways:

Partnership

- NowPow actively seeks partnership with policy and research centers and knowledge experts to inform execution and evaluation of client initiatives designed to effect policy level change with disparate populations
- NowPow encourages governance between payers, providers, community partners, and technology solutions committed to outcomes improvement and health equity
- Empowers underserved communities and pathways toward health equity by facilitating education, relationships/partnerships, resources, and tools geared toward prioritizing infrastructure and programs using evidence-based standard plans

Integration to Support Standardization of Workflows

- The platform facilitates structures and processes that support equity (i.e., platform integrates with HIE/EHR/Care management solutions) to help providers and payers funnel dedicated resources to address community and social support, through existing risk stratification and screening tools designed for their specific population
- Through its customer success team, NowPow harnesses the power of community and client base to integrate workflows tailored to unique population health needs and focused on patient outcomes

High-Fidelity Service Directory

- Robust filtering options that screen to remove common access barriers and offer resource recommendations informed by individual eligibility criteria. These filters include the ability to narrow search options by resources that cater to specific populations such Immigrants, Asian Americans, Refugees and Asylees, Black or African American, Hispanic or Latino Americans, Middle Eastern Americans and more
- Ability for users to make well-informed resource recommendations based on business ownership status of the service provider such as being a Minority-owned or Women-owned business

Data and Analytics

- Analyze prevalence of needs and rate of need identification in populations based on key demographics such as race/ethnicity, age, ZIP code. Data captured by NowPow also allows insight into any target populations that may have needs identified but no referrals shared (process gaps)
- NowPow's raw data package offering includes a wealth of information to understand – on the individual patient – which communities are being engaged, where they are being referred, the outcomes of those referrals, etc.
- The resource directory data in and of itself is well-suited to support analyses to understand supply/demand of resources in various community areas. An example use case with one of our current partners – the NowPow resource data is being used to understand the association of COVID-19 shelter in place orders with police reporting and

availability of domestic violence resources in Chicago community areas. Geospatial analyses are being leveraged to understand differences in rates of domestic violence crime and resource availability in majority White-identifying vs. majority Black-identifying communities. This is an example of how external data combined with NowPow generated insights can inform discussion, impact, and policy for racially disparate populations.

Vaccine Rollout Strategy

- A "Connect & Protect™" approach to support COVID-19 vaccination rollout to improve health equity and access for vulnerable populations. Engaging community partners as trusted voices to address vaccine hesitancy, with the ability to leverage NowPow's free tool to text/email/print resources for community members and support vaccination education, advocacy, and administration.

For additional reference, I have linked some recent news articles around our work in Health Equity and reducing disparities.

NowPow founder Dr. Stacy Lindau on Reducing Racial Disparities in Maternal Health
Link: US Health Insurer Announces New Plan To Reduce Racial Disparities In Maternal Health By 50% In Five Years
Presbyterian Healthcare Services Partners with NowPow to Improve Health Equity and Address Social Needs in New Mexico
Link: To improve health equity, address social needs |
Dominican University uses NowPow to Connect Students with Community Resources to Overcome Barriers to Success
Link: Attention to social mobility, students fuels Dominican U. success |
What COVID revealed about Healthcare Disparities
Link: What COVID Revealed About Healthcare Disparities
Platforms Like NowPow Help Reduce Disparities in Care
Link: Forbes Covid-19, Subway Stops And Health Equity: How Digital Health Platforms Help Reduce Disparities In Care
RWJBarnabus Health Partners with NowPow to Link Community-Based Care to Value- Based Care
Link: RWJBarnabas Health Launches Health Beyond the Hospital
How NYC Health + Hospitals is teaming with a startup to tackle food and housing insecurities
Link: How NYC Health + Hospitals is teaming with a startup to tackle food and housing insecurities
You can find our most up to date news articles on the work we are supporting in the community. posted on the website, linked here: https://www.nowpow.com/engineering-self-care/#section-6

Quality Health Network

QHN regularly participates in trainings and dialogues about health equity, especially in technology. A primary concept of our CRN platform is showing whole person information and utilizing a very visual profile page so that users connect to the person they are serving, even virtually. CRN was recognized by the Robert Wood Johnson Foundation in 2019 for innovation in SDoH solutions because of the platform's collaborative approach. CRN's analytics will

provide insight into referral response and outcomes, service deserts, and identify if interventions vary based on demographics.

Unite Us

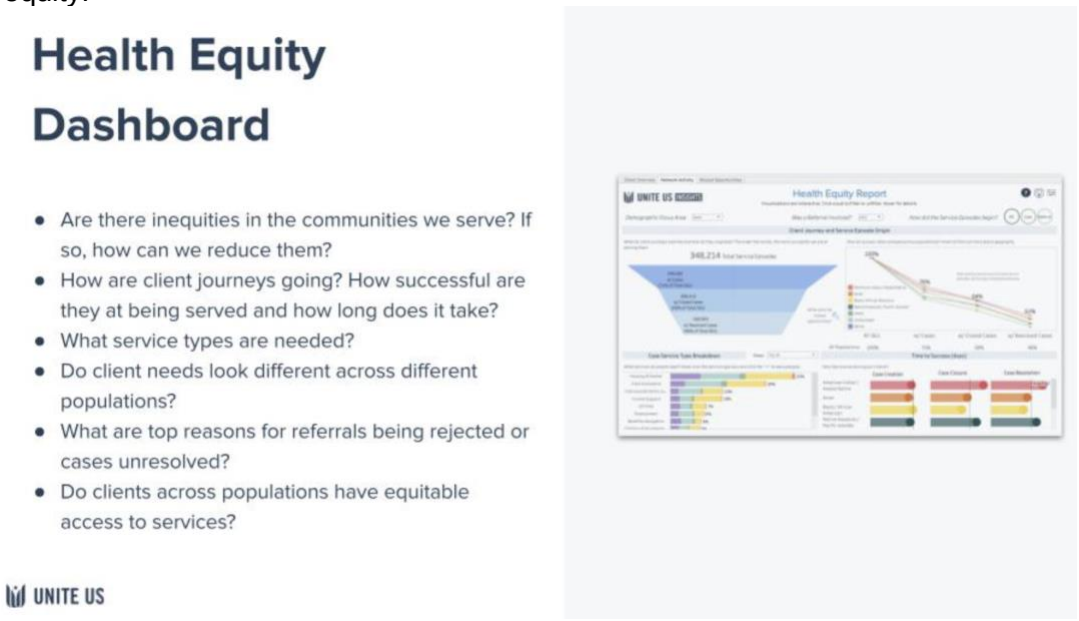
Advancing health equity is a guiding priority of Unite Us' mission and work. Health disparities in marginalized communities are symptoms of the social, environmental and/or economic realities born of historical and systemic discrimination across race/ethnicity, socioeconomic status, age, location, gender, ability, and sexual orientation, as these communities have not been cared for, protected, or invested in the same ways as others. We partner with communities through an intersectional approach to build a network that provides people a fair opportunity to access the resources they need to not only survive but thrive – leading to health equity.

First, the Unite Us platform plays a crucial role in advancing equity by enabling communities to better address health disparities and to shift investments upstream. With the infrastructure in place to address individuals' social determinants of health, which often reflect systemic inequities, our platform seamlessly connects those seeking support to the care they need, in the communities where they live and work through a no-wrong door approach. This shared, community-wide technology infrastructure ultimately increases access to health and human services for underserved populations, addresses the fragmentation of services that makes our health system challenging to navigate, and confronts institutionalized barriers to health equity such as poverty, racism, and discrimination. Crucially, the Unite Us platform is free for any community-based organization or provider that constitutes the safety net system. That means that regardless of whether a client discloses a need to a barber or a primary care physician, they will have access to the same set of resources and referral system.

Second, our community engagement approach ensures that our platform provides individuals with access to a network of high-quality, culturally relevant, and inclusive providers. In order to achieve this vision, we employ an asset-based community engagement strategy that identifies, uplifts, and onboards local community leaders, existing collaboratives and coalitions, and other trusted community assets like barber shops, churches, and community centers. For example, in the Metro Denver area, our engagement team conducted over 30 community context interviews to deepen understanding of local needs and disparities. From this context, we invited key organizations to inform our implementation and serve on the Community Advisory Committee. Organizations such as Center for African American Health, Servicios de la Raza and Denver Indian Family Health Services are guiding our approach in Colorado and ensuring the network can benefit populations with the greatest need. This community engagement approach ultimately strives to lay a foundation for community members' strengthened trust in the health system, especially for those who have felt the harms of racist and discriminatory care in the past.

In addition to our engagement strategy, our Data and Analytics team's health equity strategy is centered around ensuring that local community-level insights around disparities and inequities are captured, filling a gap in many healthcare data systems that can leave out or miss lower-income and minority populations that do not interact as regularly with the traditional healthcare system. The team is working to identify the key metrics and data points that are critical for measuring health disparities in the communities we serve, identify the existing gaps in empirical evidence detailing health inequities and address them, analyze collected data to accurately measure our impact in reducing inequities, and use data to provide actionable insights for partners to reduce health inequities.

Ultimately, the Unite Us platform, engagement strategy, and data capacity work in tandem to help move investments upstream, transform our current inequitable health system, and change laws that perpetuate inequities and discriminatory practices. For instance, our coordinated networks support the Health in All Policies approach, a collaborative strategy that seeks to ensure decision-makers are informed about the health, equity, and sustainability consequences of various policies and pushes conversations to consider factors beyond traditional healthcare such as the social determinants of health. Our Unite Us platform powers networks that naturally are multi sector as we connect communities to a range of health and social services, and with our data and community engagement process we can support a wide range of root cause policy initiatives to promote health in all policies, to support systems transformation, and to achieve health equity.



4. Who do you see as your stakeholders and which organizations are you seeking to recruit? What gaps in services (or for specific populations) you have identified in your care coordination network?

Aunt Bertha

Aunt Bertha is a public benefit corporation and **our first and foremost stakeholders are people seeking services**, or "Seekers" as well call them. Our free search and referral tool (findhelp.org) is an open and focused, easy-to-use network that is 100% free to the public and to nonprofits. Our mission and product direction is created with the *Seeker at the Center,* making it easier to find and connect to help.

Nonprofit providers, or Community-Based Organizations (CBOs), are also our stakeholders. In Colorado, we list **over 5,000 nonprofit programs serving the state of Colorado** *(network data here)*. **Over 1,130 are active ("claimed") programs on our network**, meaning they have claimed their listing and can take advantage of our free suite of CBO intake tools.

Our Customer stakeholders come from all business sectors including healthcare, government, education, health plans, and many other community-serving functions. We work with local Colorado organizations like **UCHealth, Children's Colorado, Jefferson**

County Public Health, along with national customers like **Cigna, Anthem, and Mercy Housing** to serve Coloradans.

Gaps:

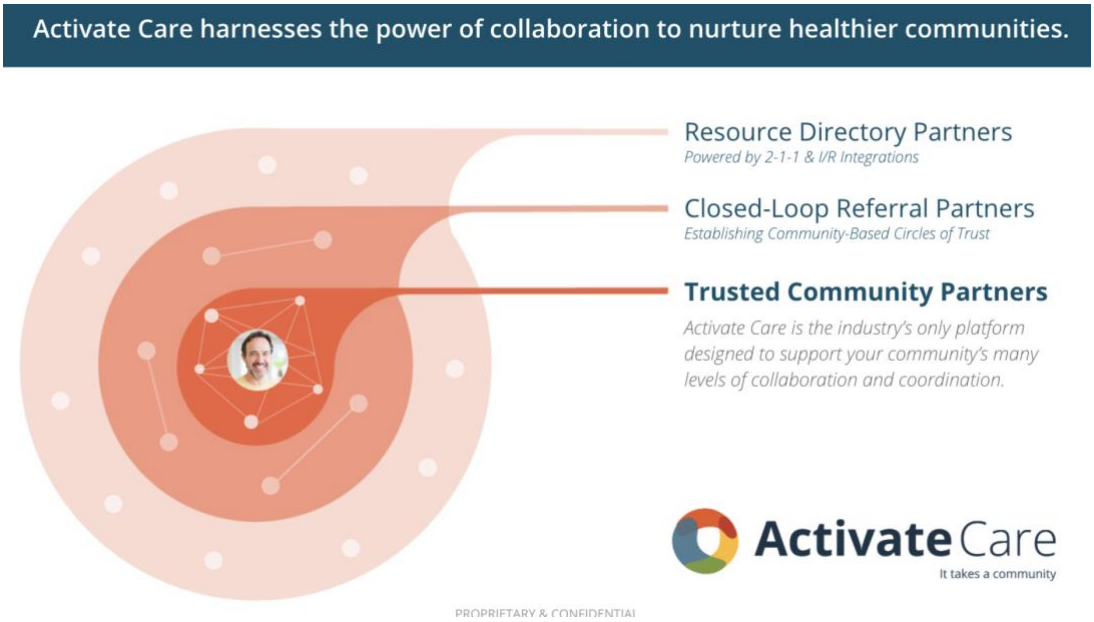
As mentioned above, analytics can inform the strategic outreach we need to complete in order to close resource deserts. We partner with our customers to identify gaps in care by looking at search activity in their region. We then help close these gaps by determining the available resources (or lack thereof) in the community and partner on outreach.

Activate Care

Typically our primary stakeholders are the conveners and builders of S-HIE models of care. Typical conveners include government agencies, community service conveners, community-based organizations, HIE operators, hospital systems, and payers. The organizations identified as part of the Mile High Health Alliance questionnaire would be typical stakeholders that we see within our implementations. We currently support networks of dozens and hundreds of diverse local community-based organizations.

The first question we help our partners answer is, “What are the key care services and needs of our population?” From this, we help to prioritize these service needs as the starting point for expanding to new community partners and service providers. These trusted partners serve as the core network of community partners focused on delivering the desired outcomes and services through integrated interventions in addition to referrals.

Over time, the network of community partners grows as more trusted partners are invited to the S-HIE. There are additional tiers of partners that serve as closed-loop referral partners or resource directory partners in the S-HIE.



Many S-HIE partner networks experience different challenges with services gaps. The gaps are often tied to specific community needs (e.g., Behavioral Health providers or permanent housing inventory), but varies widely if you introduce variables such as urban vs. rural, ethnicity, and other social variables of the community. One mission of the S-HIE should be to assemble the data needed to highlight such gaps and target investments to address these service need gaps.

Boulder County Connect

As a human services agency, we see all of the people in our community and the agencies that serve them as our stakeholders. Put simply, our goal is to fill the gap and make connections between people who need help and the agencies who can help them.

Julota

We seek any organization who is serving anyone within their operating service area. The largest gaps we've encountered are around behavioral health organizations as companies haven't learned how to properly navigate 42 CFR Part 2 or CJIS compliant workflows. Addressing 100% of the population demographic within a region is critical to holistically prove outcomes and collect comprehensive actionable data.

Mile High United Way 211

The CRISPeR work today is geared toward those with Cardiovascular disease (CVD), with expansion for food and housing resources for e-referral closed loop care coordination. Currently Denver Health is the partner in this initiative that is working closely with the end-user CBOs.

CRISPeR

CRISPeR is in the process of recruiting additional health systems and community based organizations, with a primary focus on resources related to chronic disease prevention and management (i.e. DPP, DSME, CVD), as well as food insecurity and housing. CRISPeR is also working with data stewards, such as Hunger Free Colorado (HFC), Family Resource Center Association (FRCA), Boulder County Connect, Colorado Department of Human Services (CDHS) and Emergency Family Assistance Association (EFAA).

We have identified a gap within clinical and public programs related to food insecurity (i.e. SNAP, WIC) and are engaging with HFC and other relevant partners, to work together on improvements for connecting to these services.

To reach a state of interoperability, other essential stakeholders will include vendor platforms such as Aunt Bertha and Unite Us.

Now Pow

NowPow has launched successfully with various stakeholders, of all sizes and sectors. We understand that whole person care and caring for the community extends beyond the healthcare setting; from low population rural communities to cities serving millions to complex state-wide projects. We understand that addressing SDOH needs is critical across every community, and there are many avenues to support this work such as health providers government agencies, behavioral and physical health organizations and MCOs, child welfare organizations, schools, community centers, universities, corrections and jails, police departments, first responders, Federally Qualified Health Centers (FQHCs), community-led governances, non-profit organizations, research labs and institutions, community partners, and many more. NowPow views everyone as an equal stakeholder, and we are committed to supporting a whole community effort that aligns the healthcare and non-healthcare stakeholders doing this work. Regardless of the stakeholders, our approach is focused to drive a successful outcome that is tailored to that population, their needs, and resource availability which is prone to vary across a geography.

For any partnerships we pursue in Colorado, we plan to expand on our current work in multi-state health systems, government agencies, behavioral and physical health organizations and MCOs, child welfare organizations, Federally Qualified Health Centers (FQHCs), community-led governances, non-profit organizations, research labs and institutions, community partners, and many more.

Our team utilizes local demographics, publicly available data on population health, proprietary models based on existing local and national resource directories as well as NowPow referral data. We use this information to identify resource gaps and the saturation level of resources that is necessary to power any intervention. This modeling is used to prospect new data sources in addition to identifying gaps (by area or service). NowPow then works to enhance the directory to fill any void. If the services do not exist in the community, NowPow alerts community stakeholders of the structural service void so that long term action may be taken to fill. Typically, we find the most common service gaps are for resources to address food insecurity, transportation needs, and mental health resources, all with low barriers to access.

To better understand our stakeholders and target market, please refer to our current clients who range from community collaborators, hospitals, health systems and large IDNs to payors and clients outside of healthcare including child welfare, education, and partnerships with community-based organizations.

We regularly highlight partnerships we are powering up in various communities on our website. This is a great resource to better understand the ways in which our platform is used to meet program objectives and intervention goals and to view a variety of our stakeholders.

Link: https://www.nowpow.com/powering-networks/#section-3

Quality Health Network

QHN considers our stakeholders in this effort to be the State of Colorado, payers, community leaders, and entities that provide medical, social, and behavioral health interventions. Current Network Partners in CRN include medical agencies, behavioral health agencies and social agencies.

QHN utilizes the CRN platform to connect Eligible Providers to other Medicaid providers including behavioral health, Substance abuse treatment, home health, pharmacies, laboratories, correctional health, emergency medical, public health, and other community-based Medicaid providers to improve care coordination for Medicaid members.

The highest needs identified for clients in CRN are 1) housing, 2) food, and 3) social isolation. As use of our platform grows, QHN will be able to analyze identified needs and the availability of resources in their service area.

Unite Us

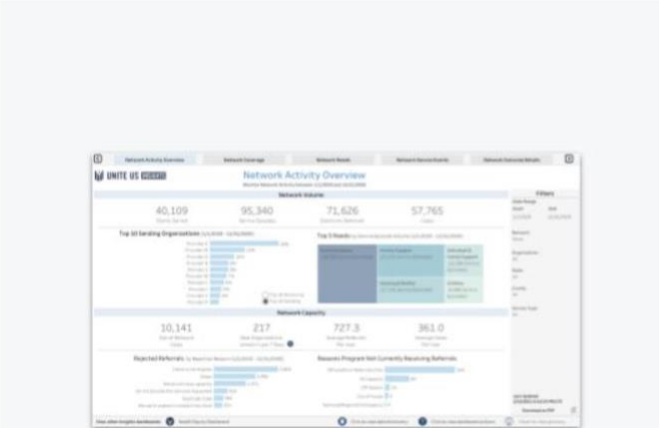
Unite Us works directly with community based organizations (“CBOs”) in communities that provide services that address an array of Social Determinants of Health, including housing, employment, food assistance, benefits, utilities, behavioral health/MAT, transportation, plus 150 other service categories. We built the network to ensure we can address the whole persons health, which means we require onboarding of both healthcare and social service providers who both interact with individuals and need to send referrals (ranging from clinical providers to brick and mortar social services), to a robust network of services that can provide direct service for a specific health, behavioral or social need. We do not limit CBO participation based on non-profit status, size, funding or any other specific criteria. Rather, in each network region, we facilitate a

Community Advisory Committee to identify any specific vetting criteria for that region and to vote for the inclusion or exclusion of network organizations based on compliance to network SLAs.

With our recent network launches we currently have over 200 organizations that have agreed to participate in our network and agree to our network standards on closed-loop referrals, covering 14 counties.

Network Activity Overview

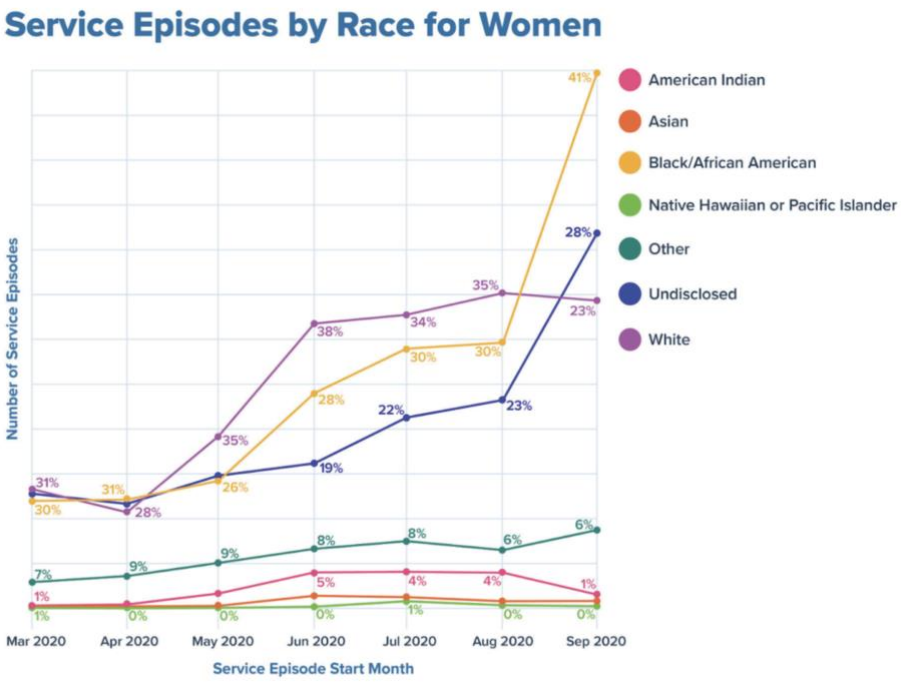
- How many clients have been served by the network?
- How many referrals have been made?
- What are the common needs of the community?



Unite Colorado has just recently launched (on Nov. 17th) so we will need to monitor performance to truly identify gaps. Each network is unique. Unite Us' robust platform not only enables organizations to see their own data about their organization and the clients they have served (and referred outside), but they can also see the entire care journey (minus legal permissions) of each individual being served in the community. Additionally, Unite Us provides aggregated data of outcomes, service delivery, network access points, performance of the network, efficiency gains, and demand/supply across the network. This also allows the community to see gaps in services and the improved outcomes they have all contributed to across their community.

For example: Louisville, Kentucky is the center of the United Community network, powered by Unite Us and sponsored by Metro United Way and Aetna/CVS. Since April of 2019, United Community has been connecting people to the services they need and providing insights to the network on how to better serve the community. With this foundation in place and Unite Us' community engagement team on the ground, Louisville was able to assess the immediate need for housing and shelter and use its CARES Act funding to directly address the housing needs of its community. In partnership with Louisville's Southwest Community Ministries and the local 2-1-1, United Community established an Eviction Coordination Center, which connects individuals to rental assistance, utility assistance, and legal aid should concerns about eviction with a landlord arise. You can read more on how our network is responding to the Eviction Crisis in our Blog link.

Another Example: The COVID-19 pandemic has had a disproportionate impact on women, particularly Black women. With over **860,000** women leaving the workforce in September and a staggering job loss number of **5.8 million** since February, the economic fallout of COVID-19 may be causing equality setbacks that won't easily be rectified and could be felt for generations to come.



The data on the Unite Us Platform show us that women and marginalized populations are struggling. Data from spring 2020, the beginning of the pandemic, show a marked increase in the number of women requesting services, surpassing men for the first time since 2013 when Unite Us was founded. Further, service episodes initiated by Black women are not only increasing but surging as compared to those initiated by white women. This is indicative of overall current trends that Black and Hispanic women are experiencing nearly two times the unemployment rate that white women experience (11.1%, 11%, and 6.9% respectively). Read more about the Impact of Covid-19 by Gender and Race in our Blog link.

5. What incentives would there be for a primary care practice (for example) to use the platform?

Aunt Bertha

Our healthcare customers use our platform to advance their Social Determinants of Health (SDoH) workflows.

- Through **EHR integration** they are able to seamlessly access our robust network of social care providers and connect their patients directly to them.
- The data generated in their workflows helps inform strategic insight into the social care of their patients and drives strategies to proactively intervene.
- We support our customers by providing **dedicated customer success managers** who leverage national best practices that will advance the unique SDoH strategies of healthcare providers in Colorado.

Our Colorado healthcare customers are choosing to partner in an active strong network, including over **1,130 active nonprofit providers, 18+ customers across various business sectors, and a dedicated Aunt Bertha team**. Collaboration between our customers, nonprofits, and everyone at Aunt Bertha has already made it even easier for Coloradans to connect to the help they need.

Incentives for providers include risk identification, accountable health community grants, ACO grants, marketplace service ordering partnerships with payers, and improved outcomes with wellness registries that are tracked with coordination partners.

Activate Care

Over the past decade primary care practices have been taxed with the additional burden of technology, reporting, and charting. They have very little interest in more work or work that takes them away from providing care for their patients. The critical incentives for these clinical teams are streamlined workflow, integration with existing systems, and possible incentives for additional patient services.

Streamlined workflow: Screening for SDOH does not need to be administered by a physician, and it can be performed upon check in or while rooming so that it does not disrupt the flow of the visit while promoting more comprehensive care. Activate Care offers capabilities for the screening tool to be self-administered or given via a remote interview.

Integration with existing systems: Activate Care offers the most comprehensive set of 9 interoperability features in the S-HIE vendor landscape. This is critical for primary care and family physicians who want to engage with patient-level screening data about social risk factors in their existing systems, and apply that information to decisions about medications, referrals, lifestyle recommendations, and other treatment plan components, from within those same existing systems. Activate Care is designed to support this streamlined workflow through our integrations.

Possible incentives: The movement toward value-based payment models is structured around health outcomes rather than processes. Under these models, physicians are paid based on those health outcomes. Empowering primary care and family physicians to address SDOH allows them to discuss behaviors and social factors that influence those health outcomes.

Boulder County Connect

I think a big incentive would be the ability to refer directly into a collaborative network of SDOH providers.

Julota

Aside from improved patient experiences, PCPs can now see how an individual has previously navigated the community and what other programs/services the individual is accessing. Additionally, for this example, the PCP would have comprehensive transparency on previous care given to the individual through not only healthcare but all industries allowing the physician to make better decisions and deliver a smarter solution. Further, the PCP could now identify a need that their office cannot meet and, using Julota, can see what eligible programs are available with the individual's living radius to refer that person.

Mile High United Way 211

N/A, we are not looking to the goal of usage of one platform, but our work is building toward interoperability of platforms so that hospitals and CBOs can choose their platform of choice but allows the ability for a CBO to receive an e-referral from any platform e.g. Unite Us, Aunt Bertha, etc.

CRISPeR

CRISPeR offers many workflow focused incentives, including the ability to integrate into an electronic health record and establish a closed feedback loop, where providers receive progress note reporting for patients referred to chronic disease prevention services. In addition, we are working toward interoperability across platforms and are encouraging one universal list of resources.

Now Pow

There are many benefits and incentives for a primary care practice to use NowPow. In this response I am speaking to the specific use case in a primary care practice, but these points can be applied to any stakeholder in provider, payor, government sector and beyond. What sets NowPow apart from other referral platforms is the ability to support all needs, all people and organizations of all sizes and sectors. From the beginning, we took a total population health approach to building our platform. This is a value for primary care practices because they are able to care for the entire population they serve from the low risk, rising risk to high risk by utilizing our platform.

We support primary care practices in caring for their whole population by:

Going beyond basic needs: We care for the Whole Person, across all of life's ages and stages and for all the roles they play, whether member, parent, or caregiver. With a taxonomy of 20 service categories and over 200 service types, our referrals go beyond basic needs to address a wide array of chronic health and social conditions. Our filters and custom algorithms comprehend a wide array of personal information as well as multiple conditions to match and prioritize services.

Supporting prevention to target critical care: With multiple products on the NowPow platform and three types of referrals (Shared, Tracked and Coordinated), we can tailor care from helping people stay well to preventing a rise in risk. By ensuring higher acuity, people get the support they need to connect to community care. We help all people - the most complex and vulnerable as well as the rising risk and keeping the low risk well to improve the health of the entire community.

Being sensitive to all stakeholders: One size does not fit all. With organizations of all sizes and sectors across a community, we allow ample workflow and outcome configuration being mindful to support the care professionals at the primary care practice in implementing seamless workflows. Organizations can choose light touch workflows if staffing is a constraint to deeply detailed ones if working on compensated interventions.

Having data guide decisions: Guided by a founder who is still a clinician and a scientist, we built the NowPow platform on top of a powerful analytics architecture to provide deep process and outcome information and referral partner performance on interventions. NowPow goes beyond this to provide many levels of data aggregation to understand resource supply and demand all the way up to the community view helping primary care practices connect to vital resources to better serve their community beyond the clinical setting.

Our data offerings can provide insight into performance on various dimensions of care such as HEDIS measures and quality metrics. Addressing individuals' social needs and tracking long term outcomes can show the impact of SDOH on the effectiveness of care, access to care, individual's experience and utilization. Care beyond the healthcare setting allows for better health outcomes by reducing barriers. Redirecting individuals to resources within their

community brings down emergency department utilization while creating a community support system for the individual.

They find value in our offering because it helps them to meet the quadruple aim:

- Improved experience of care for their patients: personalized, high quality referrals to build trust and engagement
- Improved overall population health: 3 types of referrals to tailor care based on how much connection support a patient needs and access to a robust, hyper-local directory with over 200 service types
- Clear value translated in per capita cost: the platform is evidence based, data-driven and intervention outcome focused to power evaluations
- Implementations designed to protect care team wellbeing: integrations, configurations, and automated workflows to minimize burden

Quality Health Network

CRN is currently used by medical providers in western Colorado. Ultimately, the goal of CRN is to provide a streamlined whole-person picture to people providing services. That includes information about the client/patient's needs and risks, what is already being done, and who else is involved. Having that information at a glance allows PCP providers and their teams to quickly and easily find meaningful resources and expedite getting services to the person, which ultimately improves outcomes. This also minimizes duplication of effort since providers can see what each other are doing and eliminates the need for multiple phone calls, faxes, and emails to set up services. CRN's referral system is closed loop, so the person sending the referral will receive real-time updates on the status and know whether services were provided.

Unite Us

The Primary Care First (PCF) model rewards value and quality by offering an innovative payment structure to support delivery of advanced primary care and outlines two tracks - General and Seriously Ill Population. PCF not only tests whether delivery of advanced primary care can reduce total cost of care, but also focuses on advanced primary care practices ready to assume accountability for patient outcomes and financial risk, and is oriented around comprehensive primary care functions, listed on the next page.

Comprehensive Primary Care Requirements	UNITE US Features
Access and Continuity: Care Teams	Our platform designates established care teams that can be multi-disciplinary and inclusive of the community partners.
Care Management: Comprehensive Care Plans	Our platform allows for the documentation of progress concerning referrals made to assist with the care plan, which will include those who require care management support to address their social needs. All activity is date and time-stamped.
Comprehensiveness and Coordination: Psychosocial Needs Assessment and Inventory Resources	Our platform can configure any social needs screening tool within the platform. Patient and/or provider-facing algorithmic screenings stratify social risk and identify specific co-occurring needs, which our platform will match to a suitable community partner within the coordinated care network. The network can be searched and filtered by service category, eligibility criteria, location, accessibility, language, and more. Additionally, our platform supports the management, tracking, and follow-up of social care referrals, which closes gaps in care that can exacerbate disparities.
Patient and Caregiver Engagement: Support Patients' Self-Management of High-Risk Conditions	Our coordinated care networks connect organizations along the entire continuum of care – from the healthcare setting to community-based chronic disease or treatment programs (e.g. palliative care, falls prevention, diabetes prevention), Area Agencies on Aging, food and housing resources, transportation, and more. Our platform is also able to send status updates and notifications to the patient or caregiver via SMS or email.
Planned Care and Population Health: Review of Population Health Data	Unite Us adds social needs data to the population health dataset, providing a more comprehensive and holistic representation of your attributed patients.

6. How will you ensure community and other partners are not overtapped by attending meetings for your platform and other platforms simultaneously? How will you address limited capacity barriers for small organizations, including working to ensure that they are not expected to update multiple platforms?

Aunt Bertha

One of our core values at Aunt Bertha is to **meet the nonprofit community where they are**. We respect the choices CBO's make in choosing a network and system of record. We also understand and respect that CBO's may not have the ability to take on a new tool, at all.

To respect CBO capacity, we have made it easy to engage with us at varying levels of participation. Our most advanced CBO users set up our **free suite of CBO intake tools** as their system of record and partner with our Community Engagement team to make the most of the tools. However, since we understand that CBOs may not have the capacity to take more tools, we made it easy for them to simply claim their listing and update their availability on their own time. And, if they want to be listed on our platform but not use our tools, **inbound referrals can be updated through email** without even logging in to the Aunt Bertha platform.

We respect the decisions CBOs make on how they want to document their service to the community. That includes using another network or system of record like Salesforce, NowPow, QHN's CRN, or CORHIO's CRISPeR. To decrease duplicative efforts and break down data silos, we develop **referral webhooks** to bring Aunt Bertha referrals into other systems of record. **CBO's will not** be forced into contracts to use our platform nor will they have to manage multiple listings.

Activate Care

Different communities and states around the county face a difficult task. Cities, counties, community organizations, hospitals, and payers have contracted with different resource directory or referral management platforms. These various offerings are making competing demands and overlapping requests of small organizations, with the imposition of multiple requirements to update and share information. This is replicating the same issue seen in hospitals in the early 2000s wherein different electronic health records (EHR) were purchased by different hospitals that didn't integrate, exchange information, or share resources. This is completely avoidable.

Activate Care is agnostic to the directory or referral platform deployed in a community, and is built with standardization and integration at its core. We have the ability to integrate the various information and referral (I&R) offerings into our community-based application. The existing 2-1-1 Colorado has been doing this work since 1999, working to identify, update, and validate service providers across the 64 counties of the State. This is difficult work, but presents validated work that should be integrated and supported to enhance and build the S-HIE.

At an operational level, community and other partners have the ability to accept or decline any referral. A response can include the reason for declining including: service no longer available, at capacity and does not meet eligibility criteria. Referrals can be waitlisted until there is availability. This allows our partners to control their capacity. Ultimately, Activate Care's implementation strategy seeks to limit these negative impacts to local organizations. We achieve this by prioritizing the integration of interventions, rather than the accumulation of referrals - our approach is one of quality over quantity, which we have found to be a more scalable and sustainable strategy.

Boulder County Connect

We regularly communicate with our community partners about the expanding landscape of resource/referral platforms and our involvement in alignment/integration efforts. We by no means encourage them to choose any one system over another, but do try to minimize the amount of confusion they might experience as a result of hearing about or being approached by potentially duplicative or redundant or overlapping platforms.

Julota

Most importantly, community and other partners should not be expected to update multiple platforms. Those platforms should operate on standard data metrics outlined by each unique organization and Julota would allow those systems to operate as one. Additionally, a COO from a local social service organization shared with me that they have over 700 volunteers that work at their company and they cannot learn yet another software system. No problem, this is why we're highly interoperable. As long as their current EHR vendor is willing to play ball, we will connect via API and allow all of these FTE and volunteer employees to continue using the platform they've been using, while Julota connects them to their community.

Mile High United Way 211

N/A, the CRISPeR platform today is geared toward a small subset of CBOs that support CVD as we continue to assess the usability and value gain for end-user CBOs and the healthcare entities.

CRISPeR

The model and intention for CRISPeR it to have a single, universal community resource inventory. Through partnerships with large health information exchange organizations, we also promote an infrastructure that will be less burdensome to community based organizations.

Now Pow

A key factor in successful network management when working with community partners is balancing the need for active user engagement and aiming to not overburden community-based organizations. NowPow believes "one size" does not fit all. Our partners run a full range of capacity, from being willing and able to bring in a new technology to not even having the capacity to verify listed information in a directory. To that end, NowPow builds in-house data management and collection procedures, allowing Community partners into the resource directory without needing their active participation in the process; we additionally have multiple levels at which a community partner can participate in the referral process, allowing us to meet them where they are. NowPow's platform can be tailored to allow each community partner to adjust workflows to meet their ability to engage in the work.

Level 1 engagement: be a candidate to receive shared referrals.

By being visible in NowPow's high-fidelity, deeply indexed resource directory, the community partner can be matched to customers/clients that are in need of their services. Whether working with NowPow directly or through a local resource directory effort that has a data sharing relationship with NowPow, the community-based organization would only be required to engage in information validation at least 2 times per year. They can also contact NowPow directly to update their information through a digital process at any time.

Level 2 engagement: participate in shared referral making across the community.

Any community-based organization in a NowPow community can access CommRx free for up to 20 users. This allows an organization to make shared referrals on behalf of their customers. All a community partner needs to do is sign a simple user agreement and access NowPow via a web browser on a computer, laptop, tablet, or phone.

Level 3 engagement: participate in single closed loop referrals as a referral partner.

To manage specific interventions with other referral sending organizations, community partners step up to free CommRx Plus which includes functionality to accept and manage single closed loop referrals. Here, community-based organizations can tailor their workflows to be very light touch or deeply detailed. A light touch workflow might include just the basic referral milestone capture like acceptance, closure, and success. More detailed workflows would include reasons for declining a referral, wait-listing, appointment scheduling and details on contacting the customer and customized outcome details that can be used for evidence-based reporting and documenting service compliance for reimbursement. Based on their preferences, community partners can choose to leverage NowPow in-app and external notifications and other care management functionality.

Level 4 engagement: participate as a coordinated closed loop referral partner in a coordinated closed network.

To support this level, community-based organizations need to be on PowRx, a paid license of NowPow given the data sharing infrastructure required to support the coordinated network. This approach allows co-management of care for customers/clients by allowing everyone within a network to gain access to a certain level of customer information so they may collaboratively coordinate to support the customer throughout their longitudinal care. Coordinated referrals support the ability to share and view longitudinal referral history with organizations in the coordinated network, and community partners can convert a referral into a client record in NowPow, allowing them to make secondary single closed loop and shared referrals.

With onboarded referral receivers, each organization will have the ability to generate a robust array of reports on referral data, including service providers accepting referrals, referral outcomes, time to service fulfillment, service types, and more.

NowPow supports integration into CBO operating systems in both Level 3 and Level 4 engagement which can provide a more seamless experience for them. They can set up external email notifications in the platform, so they do not have to actively monitor the tool to be notified of a new referral. Lastly, as was mentioned above, NowPow often partners with local United Ways/211s to jointly validate the resource data to not overburden CBOs with having to update their information multiple times.

Quality Health Network

QHN has a history of working with a variety of size and types of organizations in a way that is meaningful for them. We prioritize having relationships with our customers and can tailor communications and trainings to fit their needs. CRN was built with an 'enter once' philosophy so we pull in as much information from the HIE as we can. If an entity chooses to interface CRN with whatever platform they are using, we can eliminate further duplication.

Unite Us

We understand that many organizations are facing unprecedented challenges to their capacity due to COVID-19 and related factors. And, at the same time, the COVID-19 pandemic has accelerated the need to establish a stronger social care infrastructure and is causing many organizations to look for new and innovative ways to make electronic referrals and connect community members to services. We invite organizations to learn about the Unite Colorado initiative, but always respect their realities and timelines. We work with each organization who is expressing interest 1:1 to develop a workflow that fits their organizational needs. In many cases the Unite Us network is not adding something new, but simply replacing an existing process taking place via phone, email or fax and offers a more secure and efficient way of making referrals. Our engagement and network health team is able to provide hands-on technical assistance and support around how to use their network data to demonstrate the impact of their navigation and care coordination work.

We understand the concern about organizations updating information in multiple places and have identified a potential integration opportunity that we are working toward in partnership with key stakeholders.

Finally, we have heard from many network partners in active networks across the country that the time saved in using Unite Us to send and receive referrals outweighs the potential

challenges. For example, the Pittsburgh Housing and Utilities shared, "Unite Us has removed over 85% of our administrative work and spend. That's saving 15 hours per week per person."

7. How often is information updated in your database? Through what mechanism(s)?

Aunt Bertha

Aunt Bertha program data is updated by **human verification** — over one third of Aunt Bertha's employees are dedicated to updating and verifying program information on the database so resources are accurate.

Prior to publishing in the Aunt Bertha network, all programs go through a four step human verification process to ensure they are **100% accurate**.

We know program information changes rapidly. Our Service Length Agreement (SLA) with our customers is to review at least **95% of these programs every six months**. We do this to ensure that information is maintained and sustainable. We often exceed this SLA by updating program data in 48 hours if we do identify a change.

Activate Care

Through our integration with the 2-1-1 Colorado or other private networks, we are able to update and post changes in real time with their updates. Typically these are done on a monthly or semi-annually basis. We prefer to tie into the system and operating practices of the local 2-1-1 and present those updates according to their cadence. The updates are accomplished via our integration framework (described above) around established standards and best practices.

Boulder County Connect

Our data warehouse pulls data from a variety of sources, some of which are updated every 10-15 minutes and some of which are updated once per day.

Julota

As often as multiple times per second. The delay is typically from other vendors; we've not interfaced with a system that updates more frequently than Julota.

Mile High United Way 211

2-1-1 is Well-Established in Local Communities and Has Fostered and Developed Partnerships with the Agencies Around the State That Are Listed Within the 2-1-1 Resource Directory. *Curated by Colorado for Colorado.*

- Services available in all 64 counties, including national services
- Every service and resource listed has a signed agreement with 2-1-1 to be in their resource directory
- Holds details such as hours of operation, eligibility criteria, necessary documents, fees and more
- Continually updated and personally vetted with the agencies
- Simple process for agencies to provide real-time updates & availability
- Adherence to Nationally Recognized Information & Referral Best Practices (AIRS)

CRISPeR

CRISPeR leverages an existing process through MHUW, who outreaches monthly to organizations for up to date information on community programs. MHUW is also

in the process of building a self-administration portal, so that organizations can keep information up to date on their own.

Now Pow

At the heart of NowPow is a credible and searchable community resource directory that meets the needs and standards of care professionals. NowPow has developed a rigorous validation process and understands the information necessary to make high-quality referrals to meet the basic, economic, behavioral, and other self-care needs of people.

Resources in NowPow's directory are organized according to NowPow's service type taxonomy and are highly indexed to drive NowPow's powerful matching logic. This includes capturing information on eligibility requirements, service restrictions, special population focuses, accessibility, fee structure, insurance accepted, languages supported, and intake process.

In building each resource directory our team utilizes a population-based model to find resources to meet the needs of the community and interventions planned. This includes vetting and validation of resources by our in-house Community Resource team. Our team confirms service level details with the community-based organizations at least bi-annually, more frequently for highly utilized services. Community based organizations can update their service via our website or through the platform with a request for update. In addition, we employ an ongoing QA process of resources across all geographies. Lastly, in addition to our regular updates, we provide COVID-19 Operational Status of services to ensure a successful referral can be achieved determined by operational status of the community-based organization alongside the status needed by the customer, for example virtual, pick-up, delivery, or regular hours.

The Community Resources auditors review all research team work to ensure that the quality of resource information remains consistently high and in compliance with our standards over time. To ensure the credibility of the information in our resource directory, we publish the most recent verification date on each resource's page in the platform. This way all users, including community partners on our free CommRx offering, know exactly when the resource was last updated.

Data analysts on the Community Resources team also leverage our Resource Saturation Predictive Model that combines machine learning, data science, and database partnership to right-size directories. Since this model allows us to predict the appropriate number of resources or services necessary in any geography based on nearly a dozen data sets, we use it to fine-tune or fill gaps in databases we have created from scratch. We also use it to advise our customers on where their databases are over/underbuilt, to better utilize resources and pinpoint where extra effort is needed.

NowPow's "Request an Update" and "Request a New Service" functionality is available to all users. All users, whether at a health system, payer, public health, or a community-based organization- can request for information to be added or modified in the directory. We respond to all requests within two business days. After responding, we confirm the change requested with the organization to verify it before publishing.

NowPow will be launching additional community-based organization facing technology to support in 2021. However, in our research into resource directory development and launch processes, we are cognizant of not over-burdening CBOs in the update process and continue to update listings in-house at this time.

Quality Health Network

Resources are updated via Western Colorado 211 in real time via an API. Network Partners also have the ability to update their listing at any time.

Client information is also updated in real time as CRN users update information in the system. CRN is also designed to accept batch data for one-time or ongoing uses.

Unite Us

Unite Us coordinates closely with each provider, beginning when the organization is first registered, onboarded and trained within Unite Us and continuing on an ongoing basis as new staff or new workflows are added over time. Partners are able to provide updates or suggestions directly to our staff via real-time chat and Unite Us will manage the information and updates from there. Indeed, 99.6% of network providers update their profiles every month. Any time that thirty days elapse with no updates to an organization's profile or details, our account management team reaches out to that organization directly to ensure no changes are necessary, resulting in profiles that are consistently up to date. Our Customer Success team also maintains documentation of each change and update made by network organizations in case they are ever needed for quality control.

8. Who tracks referrals to ensure that people are not getting lost between organizations? How does this work?

    a. Do you evaluate the quality of referrals? (Where referrals are sent, how many are completed, is it resolved well, etc.)

    b. How do you track who has access to referrals? If an employee leaves an organization, how does their access get disabled, and does this impact any of their past referrals?

Aunt Bertha

With Aunt Bertha, three parties can update the status of the referral with the outcome achieved (or closed the loop):

1. Our customer **staff** users who generate referrals on behalf of those in need. These staff are managing the care of their patients, members, and community members on a regular basis and tracking the follow up is just part of the job.
2. The **nonprofit/CBO user** can update the status of the referral when they provide the care.
3. The **referred person** may also update the status of the referral and take control of their social care navigation.

Any of these methods generates a notification/update in the platform that is visible to all parties on the referral so that they know when a follow up is needed.

Each customer has a different set of staff and responsibilities for follow up. Some staff assign follow up coordinators, or include this responsibility with existing care managers. Other customers make referrals and remind the person to do self-follow up. As the nation’s largest closed-loop referral network, we work with more than 20 coalitions around the country where customers work together for follow up. Engaged customers, nonprofits, and Aunt Bertha staff all do their part to activate their network and move towards proactive social care intervention.

Yes, we evaluate the quality of referrals — we report on and manage quality through our Community Engagement team. It is important that customers play a role in partnership building with the community.

We offer multiple ways to measure the efficacy of service providers on our platform, including reporting on usage and engagement, user ratings, and referral outcomes tracking. We work with our customers to define a set of criteria that are used to demonstrate the quality of the referrals. In working with thousands of service providers, we have found that partnerships built on trust (rather than a set of criteria) result in stronger usage, better engagement, and high service quality.

We foster deep, long-term relationships between our customers and the social care providers that receive referrals. With this approach, we grow a sustainable social care network that thrives beyond the onboarding period. Senior Community Engagement Manager, **Alex Turnaclifff**, is a Colorado native focused on building these relationships with social care providers and training them to use the platform to update referrals. He advances the unique partnerships with providers in Colorado to create an active network and ensure direct connections to those in need.

Access rights on Aunt Bertha are determined through user roles, group memberships, and Single Sign-On provisioning. These are all directly connected to active staff members at each organization. When the person is deactivated by the customer, they are deactivated for access to their Aunt Bertha customer sites. There are defined roles:

1) **Worker**: defined in relation to the organization in which they work (a client organization or a community-based resource provider); and

2) **Administrator:** someone who manages a particular customer's users and groups. Users with no defined role (i.e. community users) can access the platform's core search and referral functionality, but are restricted from accessing functionality and reporting that requires role-based access.

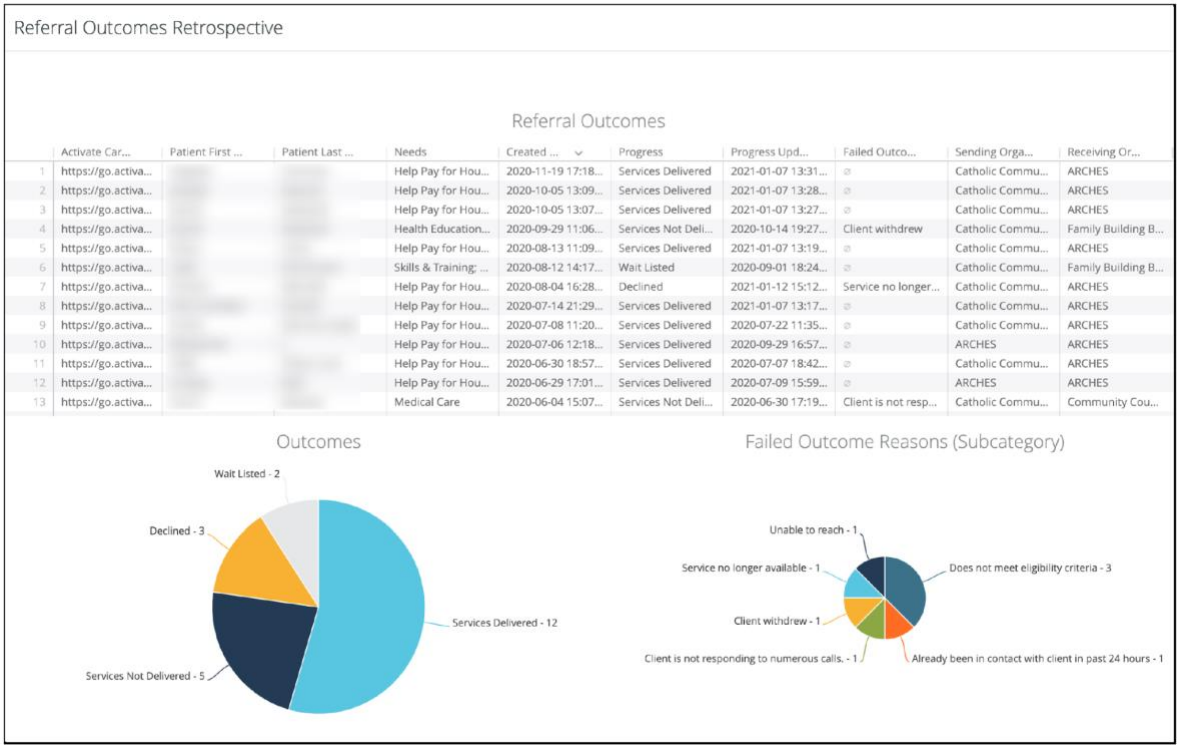
Permissions are provisioned at the group and organization level so that users in social service agencies receive access to the screening tool and resource directory with a username/password provided by their organization. Our reports meet federal and state requirements, including search and referral activity reports. Anyone who is not authorized to see detailed information will only receive aggregate level data.

The person seeking services will never lose their past referrals or history.

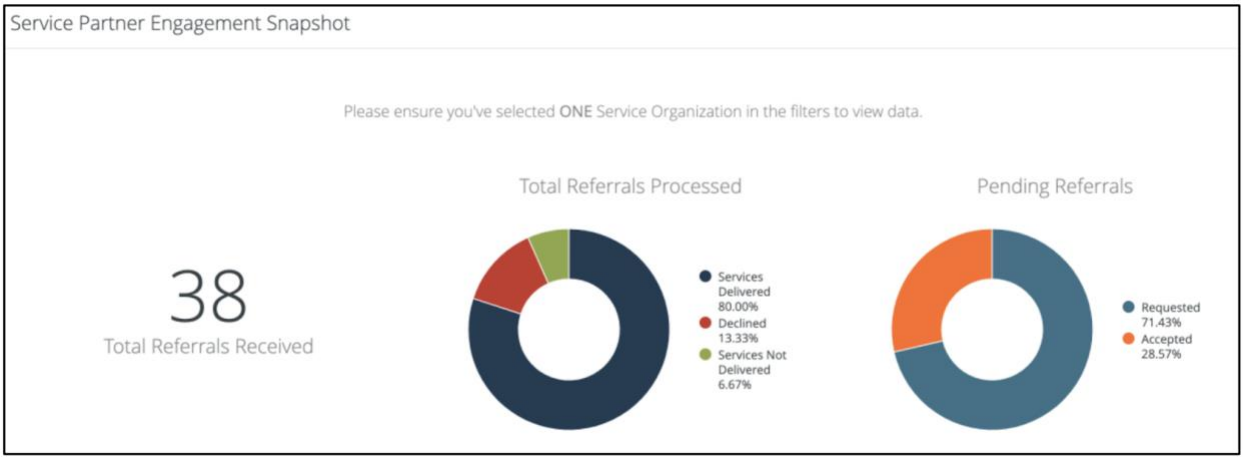
Activate Care

Administrators and community partners all have access to the status and state-of-play of any given care plan or referral. All community partners and the individuals they serve can quickly see the status of the plan, what open tasks are incomplete/complete, and the next steps in the intervention.

In addition to easily accessible analytics around community demographics, needs, and health outcomes, Activate Care offers a full array of operational and outcomes metrics reports related to referral management, closing the loop, and delivering interventions.



At a higher level, Activate Care provides insights into population health, accessibility, equity, and other valuable indicators of social health. Your S-HIE will sit at the intersection of healthcare, social services, public programs, and more. We believe your S-HIE's data should be used to support community health needs assessments, trend analysis, asset mapping, and service gap analysis, among other critical tasks. Our Analytics team will support your efforts to make your S-HIE data readily accessible to the community.



Boulder County Connect

Patient/client advocates at agencies receiving referrals conduct proactive outreach to try to get folks to come in to receive services for which they were referred.

Julota

This is an excellent question. Julota understands for each program that receives referrals, people get sick, are fired, go on vacation, etc. We work with each organization to deliver an automated workflow for incoming referrals. No referral is allowed to “just sit” in our system, it must be either rejected or accepted and have action done upon it. We also close the feedback loop eliminating what we call “fire and forget referrals”. Those are a death-knell for community partnerships and programs. Julota will follow the outlined protocols for that organization passing the referral to multiple individuals and flagging the program administrator if it’s not acted upon. We’ll then escalate to additional individuals if the parameters for action are still not met. We have many failsafes in place to ensure nobody ever falls through the cracks.

Julota is a Hub and Spoke system where Hubs can interconnect with other Hubs across a larger, statewide network of Organizations. A Hub is an entity that can receive and send referrals across a large network, whereas an Organization is an entity that can receive and send referrals to only the Hubs they are connected to or within a Hubs network. Hubs are designed to be responsible, accountable entities for the populations they serve, whereas Organizations are often partners or resources assisting the Hub in providing their services. Users are assigned to one or more Hubs and are unique to the statewide networks. The Hub Administrators then assign Users to one or more Organizations within that Hub’s network. The Hub’s Administrators are responsible for creating, assigning, and managing their Users, which includes the assignment of access roles to Users, such as access to referrals and the ability to accept or reject referrals on behalf of their Organizations. Referrals are not tied to Users, but instead Hubs and Organizations. Any User that is no longer active on a Hub, will no longer have access to any referrals belonging to the Hub. The referrals will still be owned by the source and destination Organizations that are involved. The Hub’s Administrators are responsible for deactivating their Users when they no longer have access, or using SSO or Active Directory to manage their Users.

Mile High United Way 211

When 211 Staff leave, their access to all our 211 program platforms are closed (phone, client intake, text, email, etc.).

As for the CRISPeR platform, Ken Scott is the partner in this initiative that is working closely with the end-user CBO.

CRISPeR

CORHIO provides a weekly QA report to the CRISPeR team, who completes manually review to ensure referrals process correctly. This involves communication between health systems and community based organizations, to understand where referral failures may have occurred.

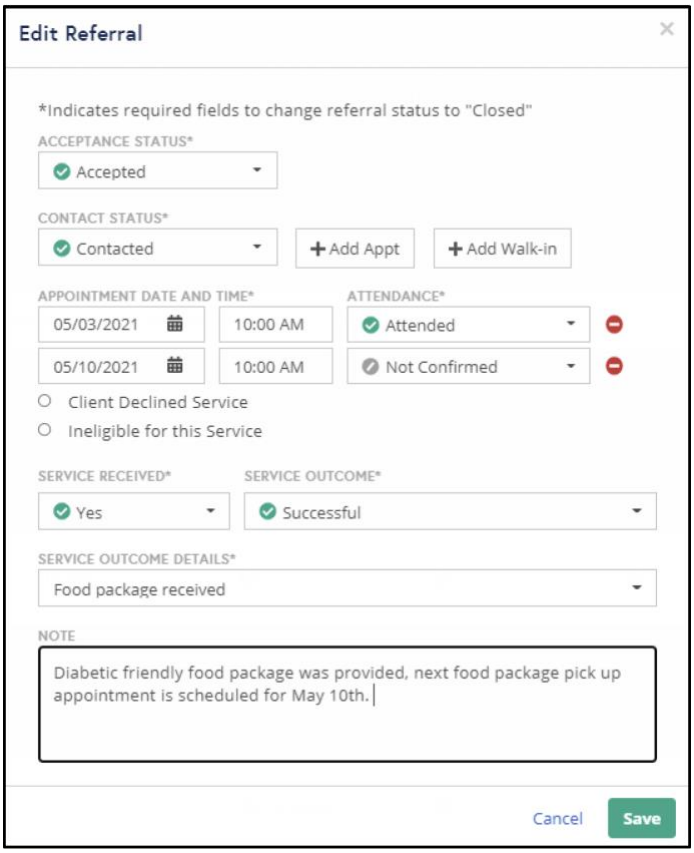
CRISPeR tracks both aggregate level and individual referral level information. This includes the number and location of referrals sent, as well as any bugs that have been identified and need to be troubleshooted. CRISPeR also enables progress notes to be sent back to referring providers.

We are interested in leveraging integration with electronic health records, for outcomes-oriented evaluation in the future.

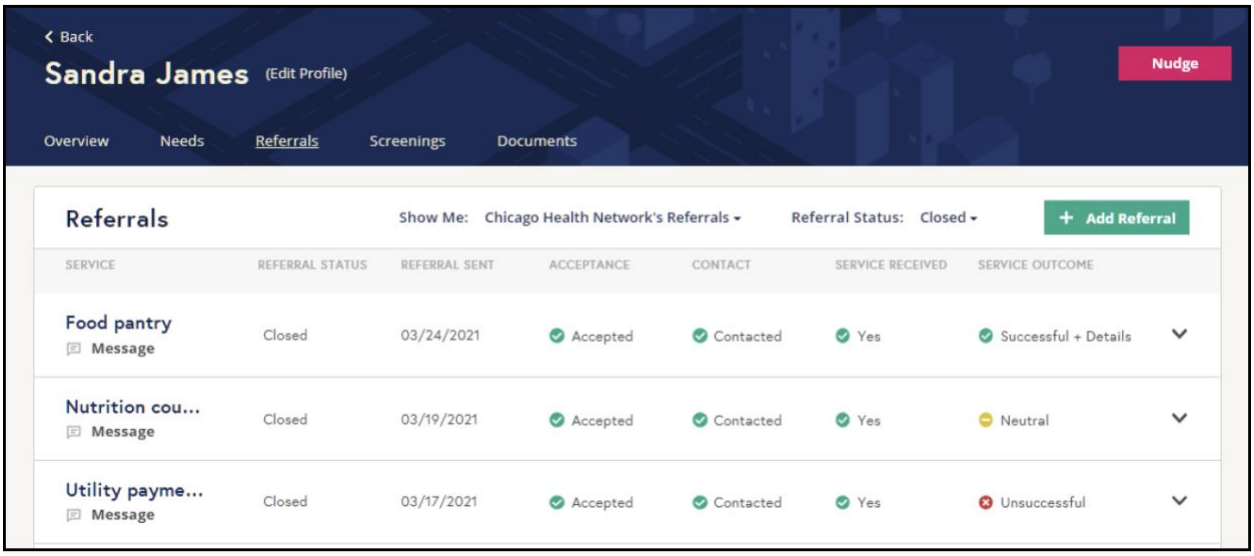
Access to referrals is restricted based on internal policies for electronic health records at all sites.

Now Pow

The NowPow platform focuses on referral coordination and management and provides the necessary infrastructure so referral senders and receivers may coordinate services, share information, track progress, share notes, and upload customer documents. Referral senders are also able to establish, track and document customizable goals for individuals, obtain and record customer consent to share information with multiple providers as well as track and report individual progress towards the goals. With a Tracked closed loop referral, the care professional sends the member's information to a community-based organization through a secure interface. Network partner referral receiving organizations receive in-app and email notifications of new referrals and can update acceptance/waitlist/deny status, document referral progress and referral outcomes, including use of service and outcome details.



These updates are shared in real time with the referral sending organization. Care professionals and Community Based Organization users can communicate with referred individuals to let them know the referral has been received and discuss appointment scheduling.



NowPow's in-app messaging platform also allows users in the referral sending and receiving organizations to communicate with one another about the referral. NowPow is currently working

on enhancements for this year that will include the ability for patients themselves to manage and track the referral process directly.

Referral success can be interpreted in several ways: by customer-driven metrics for success that are determined at the start of the intervention; by referral acceptance and attendance rates; or, more strictly, by the referral receiver's determination of appointment success after the referral has been completed. Each of these metrics are reported on regardless of interpretation. At the start of any project launch, the client project team defines metrics for success, including outbound referral rate, referral acceptance percentage, and success outcomes. However, in the strictest interpretation of referral success, NowPow has a clear "Referral Outcome" data point that is determined once a referred member has been accepted and has received services from the recipient organization. At this point, the referral receiving user, or referral sending user depending on the workflow, indicates whether the service outcome was Successful, Neutral, or Unsuccessful, and supplements this determination with free text notes. Community based organizations also have the ability to create custom service outcome details. For example, for English as a Second Language (ESL) classes, they may configure for a successful outcome to mean the member completed the lessons and passed the exam whereas a neutral outcome may mean the member has begun lessons but has not yet taken or passed the exam. With customized service outcome details, they must be manually indicated for a referral to be considered closed in support of ensuring transparency for all users involved in managing the member's care.

While these are all the data-driven approaches to determining referral success, the actual experience of referral success varies from program to program. Generally speaking, NowPow has interpreted success as whether a member was referred to a program that was appropriate for them, provided them with services, and addressed their identified needs to some degree. While a single referral may not be able to fully solve a need such as housing instability, a referral that helps a member make progress towards a stable future can be a successful one.

Additionally, understanding referral quality provides valuable insight into network quality. Utilizing our interactive dashboards allows systems to quickly derive insights and highlight areas for improvement within their network. They provide insight on intervention management, CBO uptake and engagement, service supply and demand, user engagement, etc. and have been used to set and monitor goals and easily identify longitudinal trends. This allows stakeholders to evaluate how networks are performing against the goals and metrics that were drawn at the start of the project.

Quality Health Network

CRN has built-in analysis tools for tracking of referrals. This allows us to track specific items such as the referring agency, the accepting agency, and the current status of the referral. The closed-loop aspect of CRN is automatic, so the sender of the referral receives real-time updates.

CRN’s robust analysis tools track all information required to analyze the quality of referrals including, but not limited to, how many are sent, to whom they are sent, who sent them, time it takes to receive and the current status of the referral.

Each Network Partner has an Agency Administrator who adds or inactivates users. Once a user has been disabled in the system, CRN transfers any outstanding referrals to the agency administrator who can then distribute them to the proper user. Agency administrators can view reports on who is working with clients and readjust any caseloads accordingly. Every

action in CRN is auditable and QHN has a suite of audit reports that are reviewed regularly. Audit and user reports are sent to Network Partners on a regular basis.

Unite Us

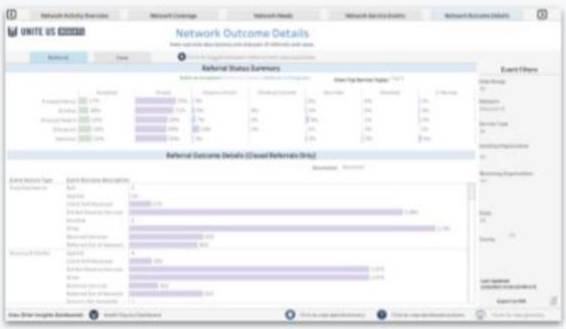
The Unite Us platform is proven to have a community-driven approach where all providers in the network can work together around a shared client and track every outcome delivered (not just healthcare providers referring to CBOs). The Unite Us platform, at the very least, tracks the following activities and sends real-time notifications to the community care team when these activities occur on the platform. These activities are contained in the client record and viewable by users who has permission to access the client's record:

- Generate and send electronic referrals with configured assessments for each service type
- Alert whether the referral was accepted or rejected.
- If the referral is rejected, you will see the rejection reason code and have the ability to send the same transaction out to another organization from the same screen. The rejecting organization no longer sees the referral in their queue.
- If the referral is accepted, users will see the name of the organization that accepted the referral, the primary worker at the receiving organization who is responsible for working the referral to resolution, the current status, all notes, documentation, and a timeline of activity is viewable. Users will receive alerts for all audited transactions by the external organization, including a final outcome after services are delivered.
- The specific services rendered during the case (after a referral is accepted), and the final outcome (structured outcome all organizations agree on by each service type).
- Unite Us also provides a 360-degree view so not only would CBOs know exactly who and when a referral was picked up, but other referrals that have been generated and worked on for that client by other agencies (and the ability to communicate with them securely in the platform).

Therefore, there is 100% accountability for all users working with that client to know exactly what is happening with that client at external organizations and goes beyond if a CBO has picked up the referral. We also provide robust notifications/alerts within the application and to the user's email to ensure all organizations are kept up to date on progress occurring by external organizations.

Network Outcomes Detail

- How many referrals currently need action taken?
- What percentage of referrals are accepted?
- What outcomes are we seeing?



Not only can you see the real-time status of the referral you can also see the detailed service delivery transactions and the final care outcome (structured) of that service (along with notes, interactions, and encounters). Users also get robust real-time alerts of those statuses and updates to their email and phone to keep them up to date on all interactions and outcomes provided in the community.

System capacity, data by county, outcomes from each partner organization, breakdowns by service category, and information including time to service, can all be viewed, spliced and diced through our Insights suite.

Unite Us Insights are our data services, including access to robust social data, reporting, and analysis to equip cross-sector network partners to match, prove, and improve performance standards. Insights empower coordinated care networks to optimize service delivery for better health outcomes. With Unite Us Insights, you can:

- Generate robust social care data to inform decision-making and prove the impact of services being delivered throughout the community.
- Understand network performance, services delivered, and impact across all patients and clients.
- Access real-time social care data on your patients, members, and clients to better support and measure impact and return on investment.
- Proactively identify individuals at risk, and their likely needs, to drive positive outcomes.

In addition, each of our networks is supported by a Network Health Manager whose sole focus is on analyzing the network utilization, key performance indicators and trend data in order to drive usage, engagement and strategic capacity of the network over time.

Network Hub Support (NHS) is an added service we can provide to ensure clients receive the services they need, no matter the complexity of the case or the size of the network. NHS supports the referral process for care navigators to ensure individuals are being connected to services. It’s accountable at the network level, providing the proper support to community partners so networks run efficiently and decreasing unnecessary time due to inappropriate or misaligned referrals. NHS may also be contracted to perform proactive client outreach for screenings, assessments, or other virtual engagement services.

- NHS talks to and supports clients directly
- NHS manages outside of a coordination center
- Provider-to-provider (P2P) referrals and can accept Assistance Requests as an added entry point
- NHS guides partner organizations to follow network standards

An employee's access to referrals is controlled through technical user permissions. Our organization onboarding process first seeks to understand an employee's connection to organization programs and locations. Then, a Unite Us team member ensures each user is appropriately provisioned to the correct program(s) and location(s) in the platform. In addition, the Unite Us Platform has user roles that define what information a user can access and what actions they can take, like viewing and taking action on referrals, updating organization information, and more. When an employee leaves, their user account is made inactive so they can no longer log in to the platform. Their past referrals and cases are still visible to other users and can be transferred to another user at the same organization for continued work.

9. When and how often are policies related to HIPAA and security of referrals updated? Do you have legal disclaimers? What information is collected for referrals, and where is it stored? What is the process for selecting what fields to include in the referral template?

    a. How is authorization or permission from clients to share their information being collected (verbal, written, how often, etc.)?

Aunt Bertha

We're HITRUST certified and have solutions for role-based privacy, vulnerability management, and system maintenance, as well as an Incident Response Program as part of our broader written information security policy. We're proud to be among a small group of organizations around the world who have received both the HITRUST CSF Certification and HITRUST Certification of the NIST Cybersecurity Framework for our site, endpoints, and supporting infrastructure. HITRUST certification incorporates HIPAA as well as NIST 800-53 security controls and validates that we're committed to meeting key regulations and protecting sensitive information.

A HITRUST CSF Certified status demonstrates that we've met key regulatory and industry-defined requirements and that we're appropriately managing risk. This achievement places us in an elite group of organizations worldwide that have received this certification. By including federal and state regulations, standards, frameworks, and incorporating a risk-based approach, our HITRUST CSF Certification benefits our partners through a comprehensive and flexible framework of prescriptive and scalable security controls. Our vendors (specifically our data storage host, Google Cloud) have also completed thorough ISO certifications. These can be found here: (https://cloud.google.com/security/compliance/).

Person Data	
Demographics	☑
First Name	☑
Last Name	☑
Phone	☑
Email	☑
Address	☑
DOB	☑
Zip Code	☑
Race	☑
Ethnicity	☑
Members in household	☑
Monthly income	☑
Housing Status	☑
Employment Status	☑
Education	☑
Marital status	☑

When new users sign up for the platform, they need to give consent to both our Privacy Statement and our Terms of Service, which detail what data we collect and what we do with it.

Policies are updated weekly or as needed, and at least as regularly to recertify for all regulations including HITRUST certification ongoing.

Customers choose what demographic data is collected. People can search and get help for free without ever providing personal information, which is an equitable approach in social care.

The example to the right shows what is possible to capture with referrals and customer information about a person. Only name and contact email or phone is required for a referral.

Any person or organization making a referral must confirm that they have received the patient's consent before submitting the referral. The level of consent required will vary by user based on their organization's policies. At a minimum, the person making the referral must confirm verbal consent of the Seeker to share their contact information with the receiving agency. A referral cannot be sent without confirmation of consent, and the confirmation is stored with the referral record.

A per referral consent is a far superior approach than an “all-in” consent, which gives far overreaching access to a vendor to misuse data.

Boulder County Connect

Thorough legal analyses were conducted by all involved agencies to ensure that all data being exchanged during the referral process is done so in a compliant manner. A minimal amount of information is exchanged during the referral process: client name, contact information, and a few other very basic demographic fields…. Just enough information for the receiving agency to contact the patient and start trying to serve them.

Mile High United Way 211

In the case of 211, verbally. In cases where a client needs advocacy assistance to the referrals we’ve provided, we offer two options, we stay on the line with the client and call into the agency together and can help communicate the situation and needs, other times we may call on behalf of the client to gather more information and set a path forward for and with the client.

CRISPeR

CRISPeR engages with health systems during the onboarding process, and then health systems manage internal policies moving forward. This includes written consent for treatment within a health system prior to providing services.

CRISPeR e-referrals use the minimum amount of information necessary to make an effective referral for a social determinant of health.

Julota

Our policies are reviewed and updated annually alongside our annual external HIPAA/HITECH security audit. Since Julota is not open to the public and is a Hub and Spoke network, Julota does not provide or require legal disclaimers on behalf of the Organizations on the system. Any legal agreements or requirements are the Hubs’ responsibility for the Users and Organizations they add as part of their network. Hub or network-specific disclaimers can be added to Julota as requested by the Hub. Each Hub joining Julota undergoes a SaaS agreement and signs a BAA directly with Julota. All data is treated at the minimum security and compliance standards of HIPAA, regardless if the Hubs or Organizations are bound to or adhere to HIPAA. Security and compliances are added additionally for each Hub that needs to meet different levels of compliances, such as 42 CFR Part 2 and CJIS.

All information collected is stored in the Cloud and never on-premises. Julota provides some default referral templates that can be used in various use cases, however the Hub has the ability of customizing each referral either per Organization or per use case. At Julota, we have found that most often Organizations need customized referrals in order to prevent additional work, bounce backs, and the population served from falling through the cracks. Julota does not provide a basic set of fields on each referral for a type of Organization (i.e. Food Insecurity), but instead uses a starting point for customization of the referrals to support Hub and Spoke networks with the highest possible levels of success from referrals.

Authorization or permission from individuals being served is the Hub’s responsibility and is collected as per the Hub’s requirements, which is most often by a digital signature bi-annually. Julota supports multiple methods, versions, and types of authorization, permission, or disclosures that can be collected and managed within the platform for services provided to the

populations served. Julota is not only a platform used for referrals, we spend our energy on the next step which is operationalizing the referrals for the provision of services across a network to prove outcomes and deliver actionable data.

Quality Health Network

CRN's consent and authorization is HIPAA compliant and gives the client choice about how agencies are authorized to see their information. The client's profile page has a consent status with expiration date clearly visible and the platform will prompt users to renew consent when the expiration date is near. If a consent expires, all users will lose access to the information until it is renewed. The client may deauthorize entities or revoke consent at any time.

The standard information sent in a referral includes the sender information and contact information for the client including name, preferred contact method and detail, and address. Additional information may include urgency, client expectations for a return call, and a summary from the sender. Entities have the option to attach referral forms or collateral material to a referral to reduce burden on the client in providing information. The referral detail is maintained in the client profile and the sender will receive real-time updates when the referral is picked up and worked by the receiving entity.

Client consent is obtained from agencies working with the client and can be captured in written, electronic (text and email) and verbal forms and is valid for 2 years. The authorized consent is stored within the platform and clients may request changes of authorization or revocation at any time. All versions of the consent are maintained and auditable.

NowPow

NowPow is following the latest regulations and working with our customers to best support their compliance process. As regulations change, we will be adjusting support where desired to better support compliance processes. A great historical example is our work with a 42-CFR part 2 to help inform our workflow aids for providers subject to this federal regulation. For information regarding our most up-to-date privacy and security policies please see attached Privacy & Security one-pager.

Legal disclaimers are managed by the customer in their custom consent forms if they choose to use signature consent. For further reference please see our privacy policy linked here https://nowpow.com/privacy-policy.

Within the NowPow platform, user permissions utilize a Role Based Access Control system. NowPow Admin users can further secure PII/PHI data by applying user level permissions that grant only designated users the ability to see a person's PHI/PII and separately, to see reports with PHI/PII included. Users without these permissions cannot access PHI/PII information or reporting. Viewing and conducting screenings and closed-loop referrals are also held to the same Role Based Access Control.

NowPow offers the ability to configure the consent workflow to meet the needs of the wide array of referral partners and interventions across an enterprise or community.

- External system consent where NowPow customers obtain consent within an external system or are not required to obtain consent based on the regulations that apply to them.

- Consent confirmation where NowPow prompts a user to confirm consent has been obtained verbally or in another method, and a checkbox is required prior to sending the referral.
- Signature consent where NowPow supports consent via document upload, or in-app signature and digital e-signature (via text or email) using a custom template. With signature consent, NowPow also supports rigorous management including the ability to revoke consent at any time, see days to expiration and expiration date and leverage workflow hard stops to prompt consent if expired or not yet obtained.

Unite Us

We conduct HIPAA compliance audits with a third-party auditor at least annually to ensure that all systems, processes, procedures, and structures comply with best practices. If an area of improvement is identified during a regular audit, remediation measures would be pursued to correct the matter. Unite Us will provide a copy of the most recent HIPAA security assessment upon request. All policies and procedures are reviewed and updated at least annually or more frequently in the event of a major change.

All users are required to sign an End User License Agreement prior to using the platform for the first time, and all organizations must sign a Network Participation Terms Agreement prior to using the platform. Where appropriate, business associate agreements are also signed. They legal agreements set expectations and responsibilities for the use of the platform and access to client data.

The Unite Us platform is role and permission-based and runs on a strict permissions engine. All software users on the platform are configured with individual user credentials which links to a defined set of permissions and accessibility capabilities based on that user's role and responsibilities, and only for clients to whom they are directly providing services. Aside from standard permissions, enhanced permissions are integrated for the access of sensitive information, such as PHI, substance use information, or information of survivors of domestic or sexual violence.

Unite Us has incorporated workflows for referrals from feedback of thousands of health and social service providers. As stated above, Unite Us manages participation agreements that are mandatory by each organization before accessing the network which manages data sharing, compliance, and service level agreements between all organizations. Unite Us also has a specific intake feature typically used by call centers that helps gather relevant information before referrals are sent out. The only information required from a client is first name, last name, date of birth. However, Unite Us encourages users to capture the additional demographic information contained in the client profile, such as address, phone, household data, insurance ID (if enabled), military background information, ethnicity etc. This data is also pulled via FHIR API for healthcare providers who use our EHR integration. PHI and PII may be shared relevant to the referral or case. Within the platform, Unite Us includes disclaimer guidance about minimum necessary disclosures per HIPAA, as well as guidance around 42 CFR Part 2 Redisclosures.

Referrals are also accompanied by an assessment/care plan for the service, which are logic based and agreed upon supplemental questions, unique to the service category, that can further identify eligibility criteria and ensure receiving organizations have the proper information to serve the client. When you receive a referral, you will be able to view the contents of the referral, any attachments, and any accompanying assessments.

Below are the steps to creating a referral in just a few minutes:

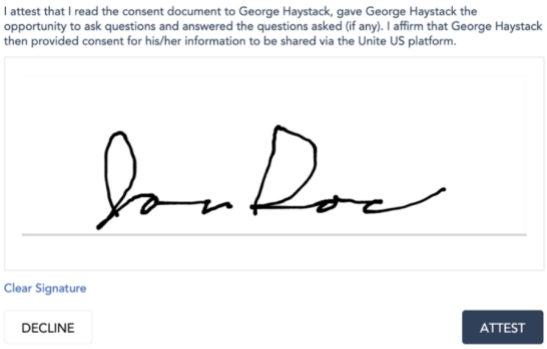
1. Enter client’s First Name, Last Name, and DOB to ensure matching or use the

workflow dashboard or clients index to go to the client face sheet
2. Provide demographic and contact information for the client (or review if existing client)
3. Complete the Supplemental Information section to enter the client's Medicaid ID (if applicable)
4. Select the service type(s) and a referral description to describe the client's request for service
5. Choose which network organization to send the referral to, or send to the Coordination Center, if available in your network
6. Provide additional information about the client's need through the assessment
7. Review the information you've added, and press Submit
8. Collect the client's Informed Consent using one of six options (if this is the first referral made through the Unite Us platform- the system will automatically alert the user if needed).

Data is archived and stored in two data centers: one primary and one backup. Primary: Northern Virginia; Backup: Oregon. Backups are made hourly with a daily snapshot and rotated weekly.

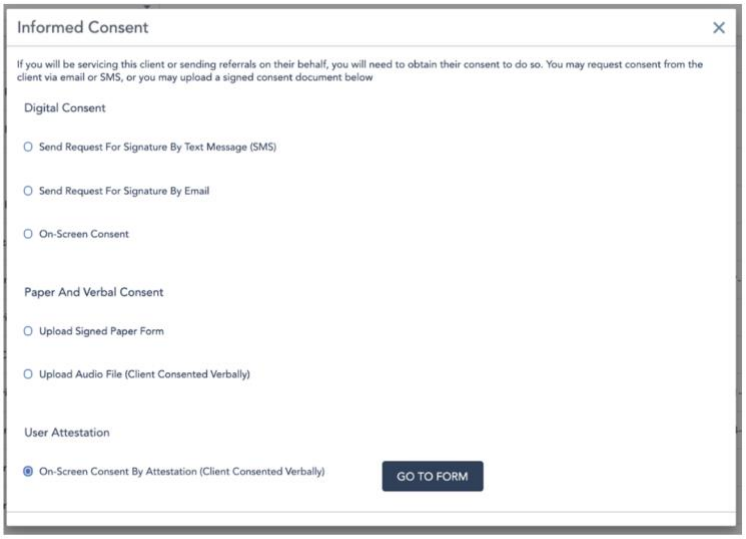
The Unite Us consent allows clients to understand and acknowledge how their information will be shared across the Unite Us network in order to connect them with services. The consent is written with health equity, literacy, and accessibility considerations in mind, and links to a publicly available privacy policy, which provides transparency into an individual's might be shared in order to get the individual the care they need. Capturing the Unite Us consent is an automated workflow which occurs once, prior to the first referral being sent. Unite Us offers six various methods to capture client consent.

1. E-mail (Secure link to the consent form is received in Client's email)
2. SMS (Secure link to the consent form is received as a text message)
3. On Screen (Client signs the consent form on the computer, laptop, tablet, etc.)
4. Verbal Consent (Staff reads through the verbal consent script with Client, and the audio file of a client verbally consenting is uploaded to the Unite Us platform.
5. By Attestation (User attests within Unite Us that they read the script, allowed the client to ask questions, and verbally received client's consent).



6. Hard Copy (consent form is downloaded, printed, signed, scanned, and uploaded into the Unite Us platform)

If an organization requires an additional subject matter specific consent or authorization, such as a HIPAA authorization or 42 CFR Pt. 2 ROI, those authorizations can be obtained outside the platform, then easily uploaded, attached to the client record, and stored safely within the Unite Us platform.



A client may revoke their consent at any time by either informing the user they are working with or contacting Unite Us via the method outlined in the Unite Us Consent.

Access Control

One of the Unite Us technical safeguards that is continuously exercised are access controls for all users based on what information they should or should not be able to access. After the consent is captured and stored at the client record, Unite Us' robust permissions engine controls what information can be accessed by each user and organization serving a client.

During the onboarding process, organizations submit a registration form that identifies their specific services and aids the Unite Us Customer Success team in creating users with the appropriate roles and permissions. Additional time and attention are taken for any organization that is a covered entity, a business associate under HIPAA, or provides sensitive services such as domestic violence/sexual violence support, 42 CFR Pt. 2 covered services, or HIV+/AIDS treatment. Each user of the Unite Us platform is provisioned with their own login credentials and permission settings to ensure the minimum necessary information is shared.

10. What is the onboarding process for organizations that agree to participate in the platform and what ongoing support will you provide to partner organizations?

Aunt Bertha

Nonprofit Organizations: At Aunt Bertha, we are committed to supporting Nonprofit organizations. We provide a set of free (forever) suite of CBO intake tools and have an entire team of regionalized Community Engagement managers focused on training and empowering nonprofits to use the platform, in whatever way that works for them. *Alex Turnacliff, our local Senior Community Engagement Manager,* creates a customized onboarding experience for CBOs dependent on their capacity. We have 101, 102, and 103 training courses available. Our support is ongoing in this shared service model — we are embedded in the community and create lasting relationships with the CBOs that will stand the test of time.

Customer Organizations: Our methodical approach to planning, configuration, third-party integration, deployment, and support paves the way for customers to hit the ground running with our software. Most of our projects go live within one month of kickoff; projects with more complexity or customization may require a lengthier timeline.

Beyond implementation, our Customer Success team provides ongoing support and partnership to our customers. We dedicate a Customer Success Manager to every account to determine and implement the unique visions of each customer. They help the customer leverage best practices to advance their social care reach. Through these partnerships, we collaborate on studies, program additions, targeted outreach and training, success stories, and ongoing promotion of opportunities to support communities.

Activate Care

Our core belief is that it takes a community to achieve this vision of S-HIE. Rather than starting with the development of a referral network, which quickly overwhelms local service providers with demand from people in need, we start by integrating interventions across organizations, which directly matches service capacity to community needs. Our solution enables these smart networks to enroll individuals, assess and build shared plans of care, and jointly intervene with visibility into processes and accountability built into workflows. Where referrals are happening, they can be easily plugged into the interventions enabled through Activate Care's S-HIE platform.

Some organizations need additional support to become ready for participation in a S-HIE. We work hand-in-hand with network leaders to support efforts to engage, update, and invest in the capabilities of their partner organizations. We also leverage the investments in network development of private conveners or private I&R networks. The Activate Care Community Connect team works with communities building a S-HIE, helping to identify trusted partners to participate in the network.

Boulder County Connect

There is a vetting process that includes approval from existing BCC agencies, legal agreements on both agency and individual user levels, training… there are several steps involved that I can specify in more detail if desired. We provide ongoing support as needed to all BCC agencies.

Julota

Especially during the first years while gaining adoption on this type of methodology is mission critical, we'd deliver our white-glove Elite Support services. Each hub has a dedicated line with a 24/7 available phone rep where any organization affiliated with that hub, or any individual, can call the dedicated line. Julota will help onboarding those organizations and deliver the necessary training/support for their future personnel changes.

Mile High United Way 211

CRISPeR

CRISPeR has developed explicit and thorough onboarding guides for health systems and community based organizations.

Consistent with organizational training practices and existing processes in place for educating staff and providers, the health system provides internal training for CRISPeR users. The CRISPeR team provides ongoing support as well (email, check-in's, meetings, etc.).

Now Pow

NowPow offers a flexible onboarding process, with implementation, technical, training, and ongoing support throughout the partnership. NowPow works with you to define product

configurations and align on an approach that supports initial project launch and future expansion. The implementation process is broken out into three phases, which is supported by project team meetings: plan, develop, launch and assess.

Community referral partner onboarding is also an ongoing process. NowPow's Community Engagement Manager will work with all stakeholders for the duration of the partnership, leveraging data to identify gaps and optimize the referral network, provide ongoing support to partners, and continue to engage community organizations whenever they are ready to participate in the network at any and all levels.

NowPow's customer support offering includes:

- 24/7 Product Support
  - Support portal available 24/7 with tutorial videos and FAQs
  - Specific support requests monitored during business hours (American Central Time). Extended hours available with Premium Support Package.
  - Engineers available 24/7 to address system issues
- Regular Webinar-Based Trainings & Customized In-Person Trainings
  - Live webinars available for tools and platform to support large-scale rollout and adoption
- Implementation Support
  - Dedicated project manager and technical project manager
- Customer Success Support
  - High touch account management model to support all organizational needs
- Community Engagement Team
  - Engagement team conducts strategy planning, outreach, onboarding, and ongoing support for community network partners, including all referral-receiving organizations within the community
- Ongoing Referral Network Support
  - Monitoring of network health to increase referral success and ensure that network partners are able to effectively address patients and community members' needs

Quality Health Network

Once an agency has agreed to participate in CRN, there is a scoping process to learn more about the agency, the services they provide and who will be involved in the implementation. At that point, the agency's profile is created or updated in CRN and the initial user is created by QHN. The agency administrator is trained in the application and they set up the additional users in CRN. QHN provides initial training for all users and ongoing support. Each community that is using CRN also has a Steering Committee and user group that meet regularly, and entities are able to attend if they choose.

Unite Us

Unite Us approaches our implementation plans with an agile methodology and provides a suite of project management tools to support the successful completion of implementation. This includes the creation of a high-level critical path, detailed project plan, formal status reports, and risk management tools that are used to provide consistent project tracking, mitigate risks, and adapt as needed. A normal implementation for a clinical team occurs across a 16-week time span, following a fundamental five-week discovery period. Key activities include (1) project kick-off, (2) prep for community outreach and internal user socialization, (3) engagement and communications targeted to prospective users, (4) training and onboarding of users prior to go-live. An additional technical implementation plan will be provided as needed for integrations; timing can vary and requires a technical design session to appropriately scope the project and define the workload across Unite Us and the customer.

The onboarding process for organizations requires them to complete a Partner Registration Form in which they detail their organization profile, programs accepting referrals and staff who will be using the platform. Unite Us uses this information to build the organizations in the software and provides organization users with multiple training options including weekly live webinars, on-demand eLearning, written guides and customized individual organization training when needed. Ongoing support includes the following: Once users log in to the network, they have access to on-demand live help through user support. Average response time is less than 5 minutes. The local Unite Colorado team is also offering weekly office hours for support, on-demand technical assistance for help with using the data, monthly newsletters, bi-monthly meet & greet opportunities to build relationships and collaboration and continued engagement to expand the network.

11. What is your long-term financial plan or business model?

Aunt Bertha

Aunt Bertha was founded in 2010. Over the next 10 years, we built a network of social care providers in every ZIP Code across America, representing over 450,000 program locations. We work with more than 340 paying customers from a diverse set of industries, including leading healthcare providers and insurers, well-known nonprofits (like AARP and Red Cross), state and local governments, and community college systems.

Our business model is to remain as a certified Public Benefit Corporation with a subscription model that incentivizes customers to continue to invest in their communities. Our goal is to keep the costs for customers as low as possible.

With 180 employees, we are the largest social services network in the U.S., and have more closed-loop referrals than all other social networks combined. We've developed strong partnerships with our customers across a variety of sectors and they rely on us to help their communities. We are confident that we will be around for decades to come, serving customers, CBOs, and people in need.

Activate Care

Since 2012, Activate Care has worked with our partners to build a full-service Community Information Exchange (CIE) Solution for community-based care teams, focused on addressing health and social needs. Such platforms are also referred to as Social Health Information Exchanges (S-HIE). Our software-as-a-service (SaaS) platform, the Activate CareHub,

integrates data and systems across government and local stakeholders, healthcare organizations, health plans, and community-based social services.

We actively seek partnerships with like-minded communities and community-based organizations that recognize the importance of community information exchange to realizing the health and wellness outcomes we seek for individuals and families. We work with our partners to build networks of community and clinical care providers who share this vision of whole person care, united through interventions, rather than referrals.

Activate Care S-HIE implementations are typically funded by public and private organizations that are responsible for improving outcomes among specific populations within the community, and we work within local governance structures to support the delivery of their programs with the services, technology, and data/analytics needed to realize impact and scale interventions.

Boulder County Connect

I'm not able to provide an informed answer to this question at the moment.

Julota

There's a myriad of questions I need to ask before answering this question, however, in its simplistic form: sustainability. Different hubs have different programs and those programs typically have different goals. Whether it's an incarceration mitigation program, a 911-overuse reduction program, or increasing access to healthcare to mitigate costs. Julota efforts to understand each state-level, county-level, community-level, organizational-level, and program-level goals to prove outcomes. This is how we've identified sustainability outside of grants for these types of programs.

Mile High United Way 211

The CRISPeR team – under the funding and partnership of CDPHE are currently assessing the future of the CRISPeR platform.

CRISPeR

We believe payors and RAE's should ultimately support this process, and would like to see a national focus that balances health care treatment and services for social needs.

Now Pow

Our business model is designed to help organizations and communities sustain the important work in driving health equity and the goals of the quadruple aim by linking to value-based care initiatives and other mandated quality-related activities. As a result, our model includes four offerings: our NowPow SaaS Technology Platform, NowPow Network Management, NowPow Analytics and NowPow Resource Directory Management. We have revenue streams in each offering.

NowPow Technology Platform: our recurring subscription-based technology platform offers four products including an API to support the full spectrum of risk in a population and extend care broadly through a community.

NowPow Network Management: Our network management offering provides network building and maintenance to support closed loop referral interventions. We are also standing-up multi-site intake (often known as "no wrong door") compensated networks where groups of organizations are paid to provide coordinated care.

NowPow Analytics: Our analytics offering is designed to understand needs, process gaps and outcomes to assess impact. Our offering includes access to our portal for standard templated on-demand reports, access to interactive dashboards and raw data packages if purchased. For an additional fee, we also provide custom reports and other customized services to support large scale evaluations or research programs.

NowPow Resource Directory Management: While our high-fidelity up-to-date resource directories are included in any product on the NowPow Technology Platform, for an additional fee, we also offer communities the ability to leverage NowPow to co-parent local resource directories, leveraging NowPow's expertise in this area.

We have carefully constructed our business model to help customers and entire communities at any place on their journey to a financially and operationally self-sustaining approach that ensures everyone has access to the care they need to get well, stay well, manage with disease and care for others.

Quality Health Network

QHN meets its partner communities and organizations where they are. This means working with each community to develop an implementation timeline and approach that helps meet their community's unique needs and priorities.

Network partners will be charged reasonable subscription costs based on the size of their organization and overall number of users to ensure that the platform is affordable to the agencies that will benefit and who will create value by participating. QHN will assist Network Partners with seeking funding to cover these costs, as needed, which may mean assisting agencies with writing grants or QHN seeking grant funds directly to share with Network Partners.

Building interfaces between CRN and other systems that Network Partners use is a fee-for-service cost and based on the complexity of the interface. QHN will actively seek grant funds to assist organizations with the costs of these interfaces to improve interoperability and use. In establishing a high-quality, broadly connected HIE across western Colorado, QHN worked with partners from state agencies, including the Office of eHealth Innovation (OeHI), Colorado Department of Health Care Policy and Finance (HCPF) and the Colorado Department Public Health and Environment (CDPHE) among others as well as federal agencies and regional and statewide foundations. QHN is also discussing opportunities to partner with payers and providers and others involved in the broad ecosystem that might benefit directly or indirectly from CRN. Already, CRN has been recognized by the Robert Wood Johnson Foundation for innovation in addressing social determinants of health (SDoH) challenges. Potential funders include government grant opportunities, as well as philanthropic organizations. Rocky Mountain Health Plans has expressed interest in CRN as a coordinated effort toward screening and addressing SDoH needs.

Unite Us

Unite Us is building a national infrastructure to support whole person care by connecting healthcare, government, and social service providers. Our technology is able to scale from navigating referrals for a city to an entire state. We enable our technology by deploying people into the community – network management – who cultivate healthy relationships amongst the community stakeholders to better utilize our technology and to create a robust network of care. Unite Us has focused on tracking outcomes since 2013 and over the last 7 years we have scaled to over 40 states. Our long-term focus is to continue to build products and offerings to

enable and accelerate the emphasis on whole person care. This includes developing solutions for facilitating new payment models between healthcare and social service providers, leveraging insights from networks to drive preventative outcomes in care, and to ensure the social services sector is funded and has the necessary capacity to address the needs of each community. Unite Us has raised $195M in private equity since inception, most recently a $150M in Series C financing in March of 2021. The Company has adequate capital to fund its operations well beyond profitability.

Additional Resources

Community Resource Referral Platforms: A Guide for Healthcare Organizations

This comprehensive guide was created in 2019 by SIREN (Social Interventions Research and Evaluation Network) at UCSF to help health care organizations understand what these new technologies offer. It reviews nine commonly used platforms (including Aunt Bertha, Now Pow, and Unite Us) and distills information gleaned from interviews with 39 organizations in the process of selecting or implementing a platform to share lessons learned.

Advancing a Coordinated Ecosystem for a Social Health Information Exchange in Colorado

Colorado's Office of eHealth Innovation published a white paper in January 2021 to offer an overview of what a social health information exchange (S-HIE) is, the benefits S-HIE confers, and how a coordinated S-HIE can be created in Colorado. Unlike states such as Nebraska and North Carolina, which have a single system for information exchange between social, human, and healthcare services, there are multiple concurrent local and regional efforts underway to build S-HIE infrastructure in Colorado. The goal is to align and integrate these efforts so they complement and strengthen one another.

San Diego 211 Community Information Exchange Toolkit

This toolkit was published in 2018 by San Diego 211's CIE to provide guidance for communities interested in building a Community Information Exchange, which coordinates the care delivery and services offered by a network of health, human, and social service providers with the ultimate goal of improving population health. San Diego's CIE began in 2011 and has since developed into a robust and continually growing network. The toolkit explains what a CIE is and outlines the process of developing an effective CIE.

Acknowledgement

We extend our sincere gratitude to the numerous individuals who made this referral platform guide possible by providing responses on behalf of the organizations they represent.