Preparing for SDOH DAP 2025: Milestones and Next Steps

September 12, 2024

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Today's presenters:

Kristina Belinte

SDOH Senior Advisor

Sebastian Blackwell

Customer Success Executive

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Overview

- SDOH DAP 2025 Milestone Review
- Quarterly Meeting Requirements and Staying on Track
- Screening Leads to Success
- CommunityCares Data & Insights
- CommunityCares Platform Demonstration
- Next Steps & Questions and Answers

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SDOH DAP 2025 Milestones – Cohort 1

Cohort 1: Participated in CYE 2023 and/or 2024

Milestone #1 – Sign & Submit

- Sign and submit HIE SOW and CommunityCares Agreement

Milestone #2 – Define & Review Goals

- Meet with SDOH Advisor to complete Post-Live Meeting to discuss training needs, screening and referral workflows, implementation of screening tool, and define monthly goal.

Milestone #3 – Screenings & Referrals

- Utilize CommunityCares Platform by a combination of screenings and/or in-network referrals.
- Showing a 5% improvement from CYE 2024 and no less than 10/month

Milestone #4 – Quarterly Touchbase

- Meet with your SDOH Advisor quarterly to review progress, and if needed, complete an Improvement Plan.

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SDOH DAP 2025 Milestones – Cohort 2

Cohort 2: Have not participated in CYE 2023 or 2024

Milestone #1 – Sign & Submit

- Sign and submit HIE SOW and CommunityCares Agreement

Milestone #2 – Onboard & Utilize

- Complete CommunityCares onboarding with your SDOH Advisor by Jan. 1, 2025.
- Utilize CommunityCares Platform with a combination of screenings and/or in network referrals no less than 10/month.

Milestone #3 – Quarterly Touchbase

- Meet with your SDOH Advisor quarterly to review progress, and if needed, complete an Improvement Plan.

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Quarterly Meetings and Staying on Track

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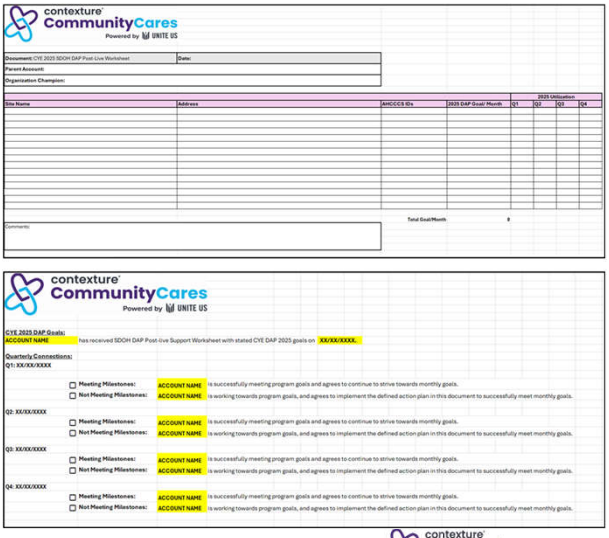
Quarterly Meetings

- Depending on your progress towards your goals meetings can range from email check-in to 1:1 meeting with your Advisor.
- Opportunity to review your monthly progress towards goals and SDOH DAP Post-Live Support Worksheet.
- Provide support on training, workflow, and program implementation issues.
- Implement Improvement Plan if needed.
- Each organization should track their monthly numbers.

SDOH DAP Post-Live Support Worksheet



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Screening Leads to Success

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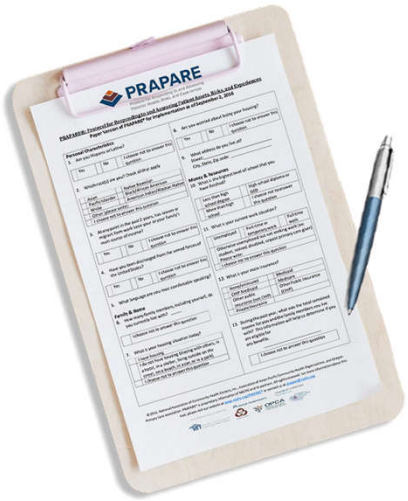
Screening Leads to Success



- Better understanding of your patients/clients.
- PREPARE Screening already available
- Custom screenings can be added (free of cost)
- Integration – Screening Ingest
  - Cerner
  - Epic

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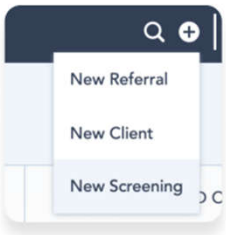
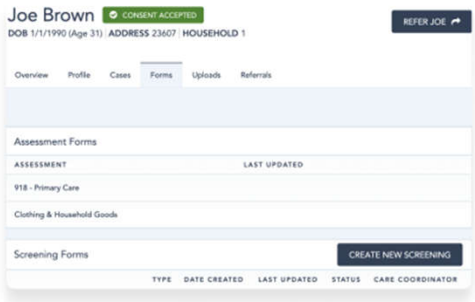
Unite Us Makes It Easy to Screen Patients for HRSN Across Care Settings

The Unite Us Platform supports custom and standard HRSN screenings.





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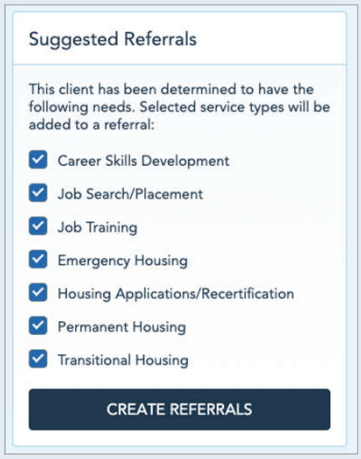
Once a Patient Is Identified as at Social Risk, Now What?

Unite Us Screenings: Easily Identify and Make Referrals for Social Care Needs

Our screening tools use **national core measures** to identify the risk factors and needs of community members: **You no longer have to guess which types of organizations or programs patients should be referred to.**

The Unite Us Platform will **automatically suggest a referral based on screening answers**, so you can rest assured knowing you're sending patients and clients to organizations that are the best fit for their unique needs.



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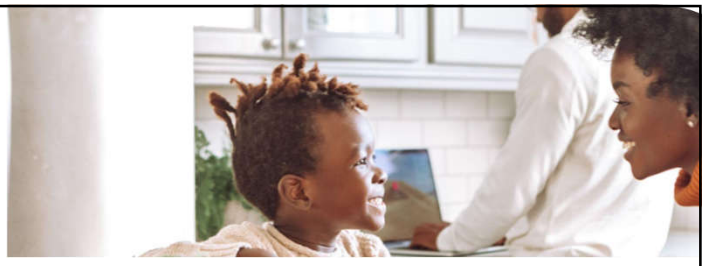
Seamlessly Integrating Screenings and Referrals into Existing Workflows



Entry

Katie shows up at Hospital to receive services

Screening

At discharge, Sue, an ED social worker, screens Katie and identifies that she has social needs:

- Food insecurity
- Child care
- Transportation

Referral

Sue uses Unite Us to **gain digital consent** and electronically refers Katie to multiple community partners.

Through the platform, she can securely share Katie's information and seamlessly **communicate with the other community providers** in real-time.

Resolution

Feedback

As Katie receives care, Sue receives real-time updates and tracks Katie's total health journey.

Referral status and **structured outcomes data** is delivered to the Hospital to see how needs have been met.

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CommunityCares Data & Insights

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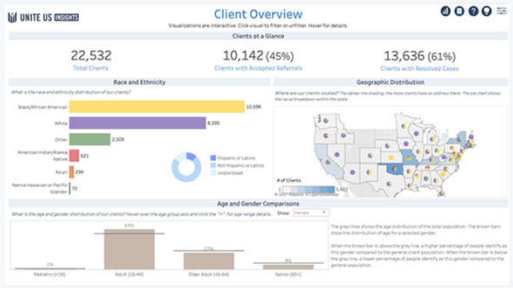
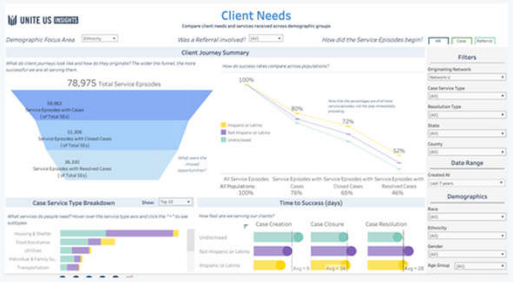
It's your story. Tell it.

Demonstrate your organization's outcomes and drive community change.

- **Track** your organizational activity
- **Measure** your impact through data
- **Inform** community reinvestment decisions





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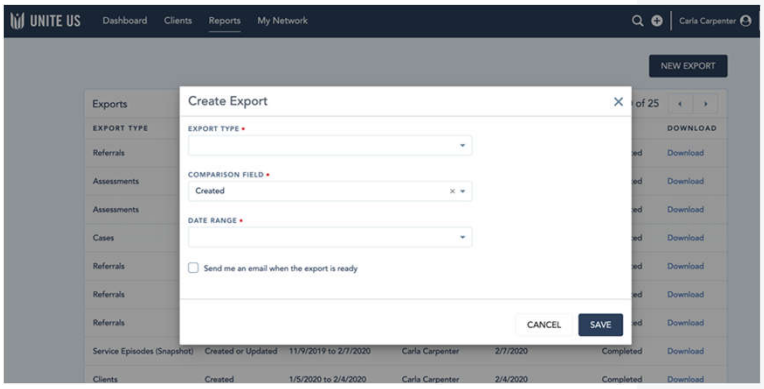
In-Application Exports



Each organization in Unite Us can export data specific to the clients they work with. Exports can be downloaded as CSV files. These exports include data regarding:

- Clients
- Cases
- Notes
- Referral
- Assessments
- **Screenings**
- Users

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Network Activity Dashboard

With this Dashboard, you can:

1. **Evaluate network coverage** as well as network trends
2. **Understand** who your clients are, what services they seek, whether they have received their requested services, and how organizations within your network can serve client needs
3. **Deep dive into network service events** (service episodes, cases and referrals)
4. **Assess performance** in specified geographies, timeframes, organizations and by client demographic profiles

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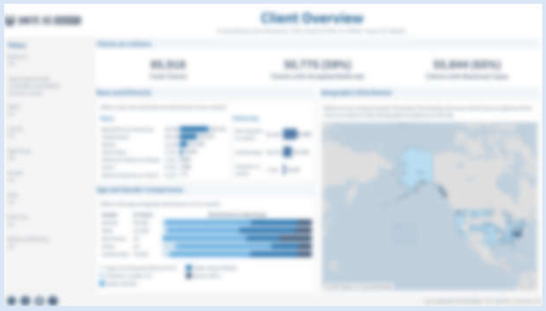
Health Equity Dashboard

With this Dashboard, you can:

1. **Establish a baseline understanding** of clients served and their care journeys
2. **Deep dive into demographic factors** impacting health disparities
3. **Analyze areas for further improvement**, such as organizational workflow optimization, community service gaps, or opportunities for additional navigation support
4. **Explore methods to bridge health and social care** in locations where gaps persist
5. **Drive positive outcomes** for the community by testing and deploying new interventions



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Data Model Definitions

CASE	An overarching concept that represents **a client's need and their care journey** to address the need in the platform. All stages of a client's care journey are tracked under a case, including referrals (when applicable).
REFERRAL	**Individual attempts to connect** a client or case to a specific in-network organization that might be able to serve the client's need. Cases can have multiple referrals.
REFERRED CASE	A **case with at least one associated referral**, meaning the client's need was referred into the network.
MANAGED CASE	A case that has reached an **in-network organization with the capacity to serve the client** (e.g., when an associated referral has been accepted).
OUT OF NETWORK CASE	A case that ultimately ended in a traditional referral **made to an out-of-network organization**, but documented in Unite Us.

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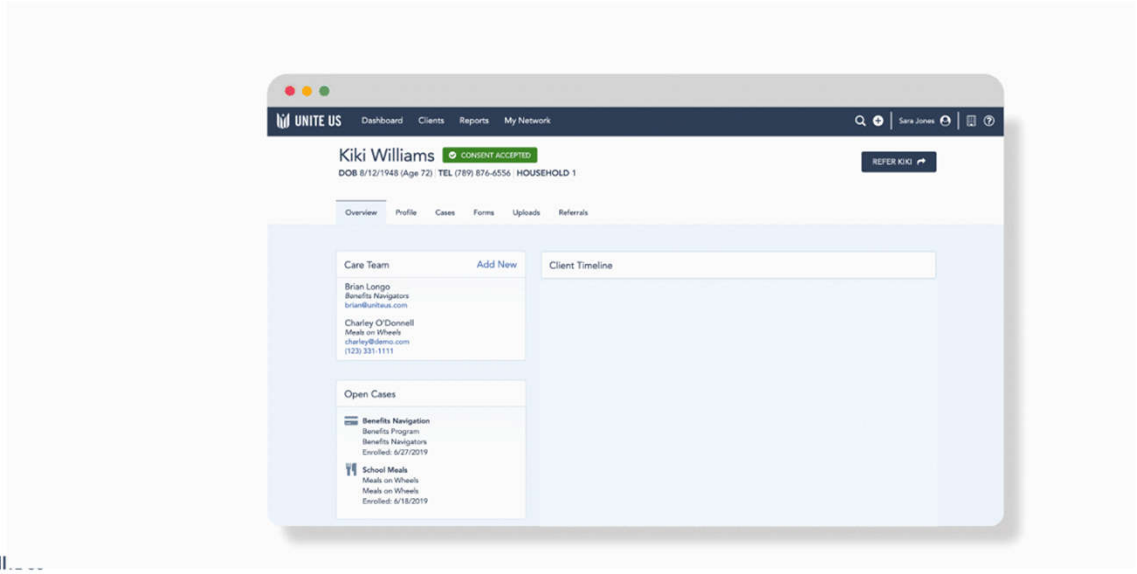
Platform Demonstration



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Next Steps & Questions & Answers

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What Happens Next

1. Look out for an email from your SDOH Advisor with your Post-Live Support Worksheet listing your 2025 goals (by September 30th).

2. Reach out to your SDOH Advisor if you have questions or would like to set up a meeting.

3. Connect with your SDOH Advisor quarterly to monitor progress towards monthly goals.

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Questions?

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Your Arizona CommunityCares Team

Thank You

Kelly McGann

Contexture Director of Social Determinants of Health

Arielle Stearns

Contexture SDOH Manager

Kristina Belinte

Contexture SDOH Senior Advisor

Alicia Munoz

Contexture SDOH Advisor

Carey Ann Smith

Contexture SDOH Advisor

Stacey Van Emst

Contexture SDOH Advisor

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