UNITE US

RI HIT Committee Presentation

February 15, 2024

UNITE US

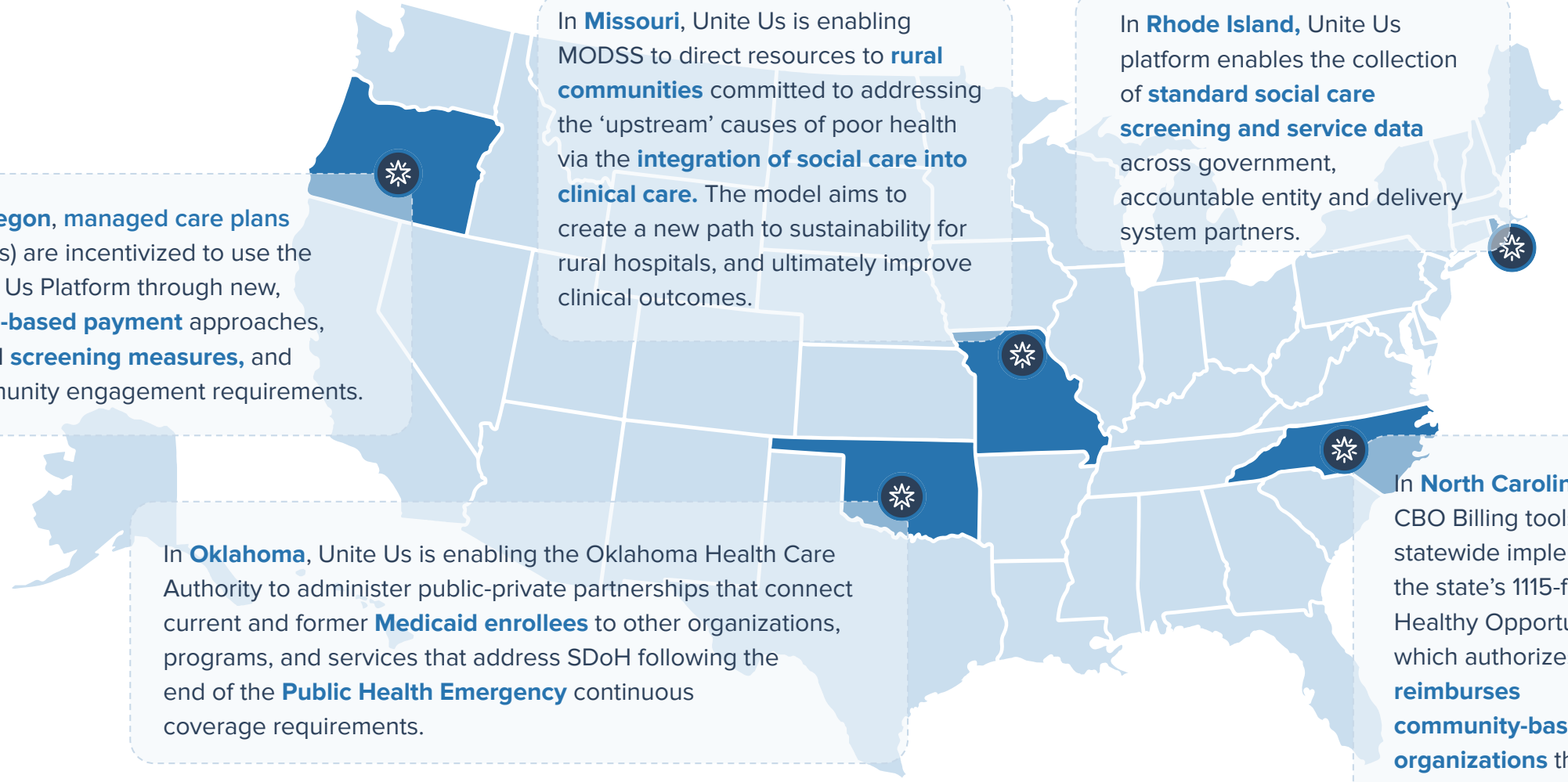
Your partner for **social care.**

We help communities work better together.

- Community-level social care insights
- Cross-sector care coordination infrastructure
- Community provider invoicing tools

Where We **Do It**

Across the Medicaid Delivery System



In **Oregon**, **managed care plans** (CCOs) are incentivized to use the Unite Us Platform through new, **value-based payment** approaches, SDoH **screening measures,** and community engagement requirements.

In **Missouri**, Unite Us is enabling MODSS to direct resources to **rural communities** committed to addressing the 'upstream' causes of poor health via the **integration of social care into clinical care.** The model aims to create a new path to sustainability for rural hospitals, and ultimately improve clinical outcomes.

In **Rhode Island,** Unite Us platform enables the collection of **standard social care screening and service data** across government, accountable entity and delivery system partners.

In **Oklahoma**, Unite Us is enabling the Oklahoma Health Care Authority to administer public-private partnerships that connect current and former **Medicaid enrollees** to other organizations, programs, and services that address SDoH following the end of the **Public Health Emergency** continuous coverage requirements.

In **North Carolina,** Unite Us' CBO Billing tools enable statewide implementation of the state's 1115-funded Healthy Opportunities Pilot, which authorizes and **reimburses community-based organizations** that deliver HRSN benefits to members

How We **Do It**

- Healthcare Providers and Plans
- Public Health Agencies
- Community-based Organizations
- Corrections Agencies
- United Ways & 211
- Workforce Boards
- Self Referral
- Benefits Agencies

Unite Us Closed-Loop Referral Tool → **Referral Accepted** → **Outcomes Documented** → **Network-Wide Insights** → **Program Improvement**

One accountable network with many entry points powers health, social, and economic programs to realize efficiencies and better outcomes.

Unite Rhode Island
by the numbers

Since network launch:

1,087
Programs

29,094
Referred cases

68%
Of Engaged RI Adults with 1+ Resolved Case(s)

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Top 4 Needs Among Served RI Adults Residents

Food Assistance
2,072 individuals received service
4,071 total cases
3,257 resolved cases

Individual & Family Support
1,054 individuals received service
3,853 total cases
3,189 resolved cases

Physical Health
1,079 individuals received service
3,208 total cases
2,525 resolved cases

Housing & Shelter
1,276 individuals received service
2,575 total cases
1,656 resolved cases

Our Approach to Interoperability

Gain critical insight into a client's total health journey.

Create a meaningful, comprehensive perspective for care team members through easy access to a unified social care record.

Simplify workflows for efficient care coordination.

Put fewer clicks between care team members and closed-loop social care referrals for their clients.

Connect clients to a powerful network in the community.

Access a network of community-based organizations that are ready to meet clients' social care needs.

Resource Directory

Workflow Integration

Data Feed

Member Roster Ingestion

The Future We See

Automated eligibility and enrollment processes ensure that clients are enrolled in the best fit, reimbursable programs.

Solutions: Member Eligibility Roster Ingestion; API; X12 EDI 270/271, Gravity Project 2024 Workgroup

Capturing and reporting discrete services and claims is necessary to facilitate reimbursement.

Solutions: X12 EDI 837/835, HCPCS, Gravity Project 2024 Workgroup

A client-centered journey requires standard client data.

Solutions: USCDI v4, EMPI

Discrete, standardized outcomes allow closing the loop and data analysis to drive ongoing program iteration.

Solutions: Unite Us outcomes, Gravity Project 2024 Workgroup (Unite Us leading social care data standards initiatives)

Screening standardization allows for a no wrong door approach to care and prompt reimbursement.

Solutions: Gravity Project implementation guide (FHIR observations)

Referral exchange keeps users in their system of record.

Solutions: Epic CRN, Gravity Project implementation guide, non-FHIR solutions to meet CBOs and other stakeholders where they are

A robust directory powers connections to care.

Solutions: OpenReferral, REST APIs

Medicaid Considerations: Social Care Integration

A Single Record

Use of an **Enterprise Master Person Index** establishes a single social care record and shared workspace for cross-sector care teams, promoting real-time collaboration, streamlining screenings and enabling outcome tracking and evaluation over time.

Flexible Delivery System Deployment

Use of **industry standards** and customer-specific best practices (SSO, HL7, APIs) should enable all cross-sector partners with the right solutions to integrate data and workflows seamlessly without additional administrative burden.

Sustainability

MES & MITA principles associated with business need and modularity are adopted to **enhance whole person care**, reduce redundancies, streamline workflows, reflect real-time eligibility, authorize community benefit access, and maximize federal participation over time.

Data Enabled Care

Robust **service type and outcomes data** provides community & population-level dashboards to identify understand needs, capacity and network activity. Multiple data delivery modes and visualizations enable all cross-sector partners to manage performance and evaluate outcomes.

Why it Matters

63% reduction in unhealthy days

Individuals participating in a Louisville housing pilot reported a 63% reduction in physically unhealthy days and a 62% reduction in mentally unhealthy days. Unhealthy days are associated with increased hospital admissions and medical costs.

3.97 hours saved per case manager per week

A Florida health system conducted its own study of how our technology impacted staff efficiency. They found it saved 3.97 hours per week per case manager.

Reduced odds of readmission at 3, 6, 12 months for new moms

Compared to matched controls, patients receiving care coordination through Unite Us experienced a statistically significant reduction in all-cause hospital readmissions at 3, 6, and 12 months following labor and delivery discharge. Patients also experienced reduced odds in postpartum-specific ED, readmission, and inpatient visits at 3 months.

The Positive Impact of Sarasota Memorial and First 1,000 Days Initiative

30-day readmission results, stratified by insurance

79% ↓ Reduction in odds of postpartum* related readmissions for Medicaid patients

70% ↓ Reduction in odds of all-cause readmissions for Medicaid patients

67% ↓ **Reduction in odds of postpartum related readmissions for patients with private insurance

*Postpartum-specific ICD-10 codes (e.g. maternal mental health, labor and delivery complications, gestational diabetes, and Type II Diabetes

**Not statistically significant

UNITE US | SARASOTA MEMORIAL HEALTH CARE SYSTEM | FIRST 1,000 DAYS SUNCOAST

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Get in touch.

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