Technology as a Tool, Not a Solution

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Who We Are

Partners in helping our Neighbors Thrive

WHO WE ARE

- United Way and 211 are trusted community partners.
- Understanding the intersection between social service/nonprofits, health care, and government services is our core competency.
- Connected to the social service ecosystem needed to address individual/family needs.

WHAT WE HAVE

- Vital resources available 24/7 through 211, accessed by millions each year.
- Connections with national, state and community partners within the SDOH sphere. Statewide database of more than 30,000 services.
- 211 staff members are highly trained and follow national standards.
- We foster and maintain robust partner networks, with a national network that is hyperlocal.

211 Wisconsin at a Glance

2022 Summary

Minutes Serving Clients

362,166

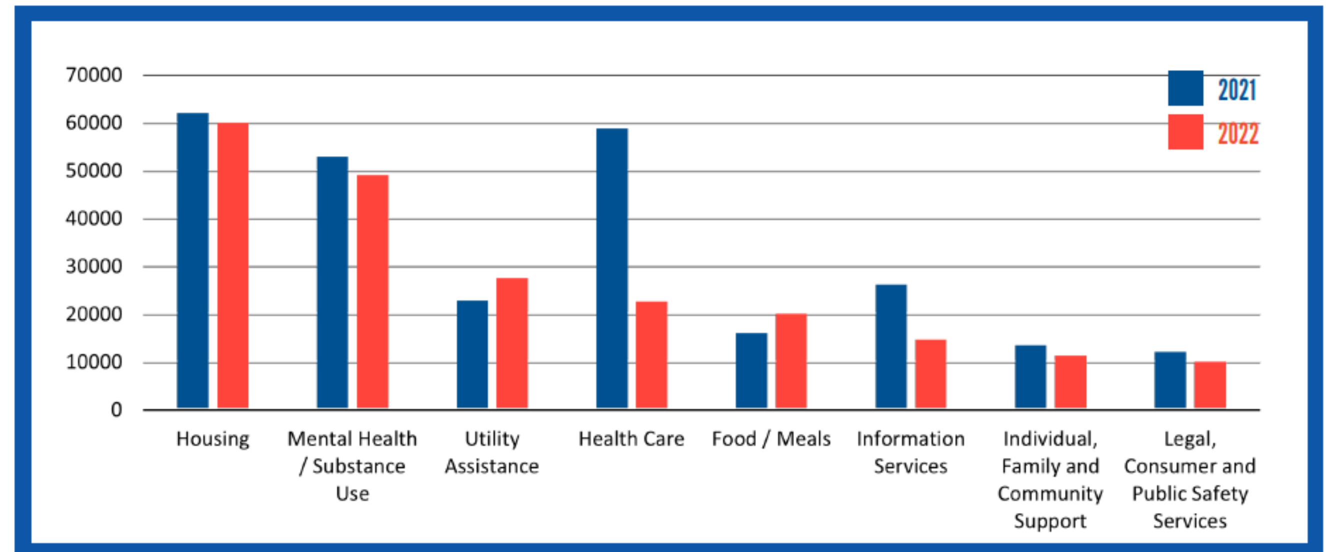
Total Contacts

410,000

Total Referrals

Total Website Searches

Requests by Category - 2021 vs. 2022

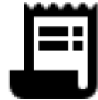


211 Wisconsin at a Glance

Top Requests by Category - 2022

Housing
59,964

Mental Health / Substance Use
49,049


Utility Assistance
27,544

Health Care
22,701

Food / Meals
20,116

Information Services
17,676

Individual, Family, and Community Supports
11,387

Legal, Consumer, and Public Safety
10,129

TOP 10 WEB SEARCHES

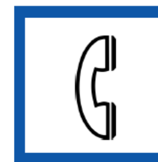
1.) COVID-19 Immunization Clinics
2.) COVID-19 Vaccine Information
3.) Food Pantries
4.) Rental Payment Assistance
5.) COVID-19 Diagnostic Tests
6.) Low-Income / Subsidized Rental Assistance
7.) Rental Deposit Assistance
8.) Water Service Payment Assistance
9.) Automotive Repair and Maintenance
10.) Electric Service Payment Assistance

Available 24/7/365

CHAT on 211Wisconsin.org

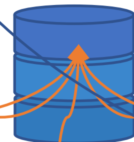
TEXT your zipcode to 898211

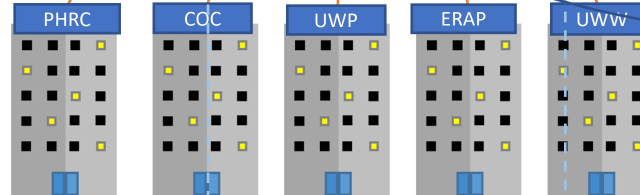
SEARCH on 211Wisconsin.org


CALL 211 or (877) 947-2211

Assessment, Referral, Follow-up (closed-loop) Workflow

- AIRs standards
- Assessment of presenting need, secondary and root needs.
- Brief Intervention
- Referral or Warm Transfer
- Assurance of next step
- Follow-up with caller or agencies
- **Local Implementation and cross-market scaling**





Coalition Building, Planning and System Capacity

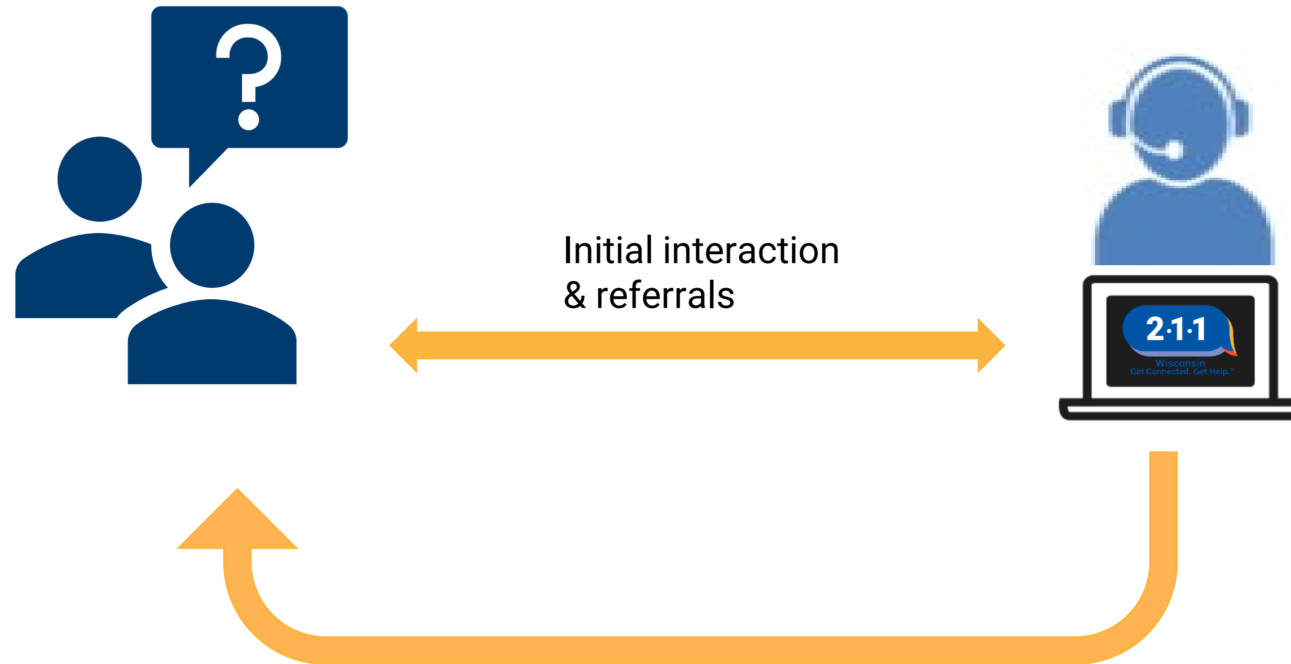
- Collective Impact with a backbone organization
- Public/private partnership
- Hyperlocal design based on community priorities
- **Scaled through state and national partnerships**

Community Resource Curation Workflow

- Partnership development
- Agency, Site, and Service identification
- Data coding
- Verification and regular updates
- AIRs standards
- **National Database Platform today**

How We Work

211 Wisconsin Follows Up with Patients



Follow up:

- Previous Referrals & Services reached/received
- Additional referrals as needed
- Assistance in overcoming barriers to reaching services
- Offer additional follow up as needed

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Public Health Region

All values (5)

Western | Southeastern | Southern | Northern | Northeastern

Call Center Site

All values (11)

Brown County | Great Rivers | Impact | Marathon | Center Not Recorded | Fox Cities | Dane County | Inner Wisconsin | St. Croix | Frontline | Statewide

Public Health Domains

All values (9)

Other | Housing | Hunger | Mental Health | Transportation | Income/Jobs | Health Care | Education | Substance Use

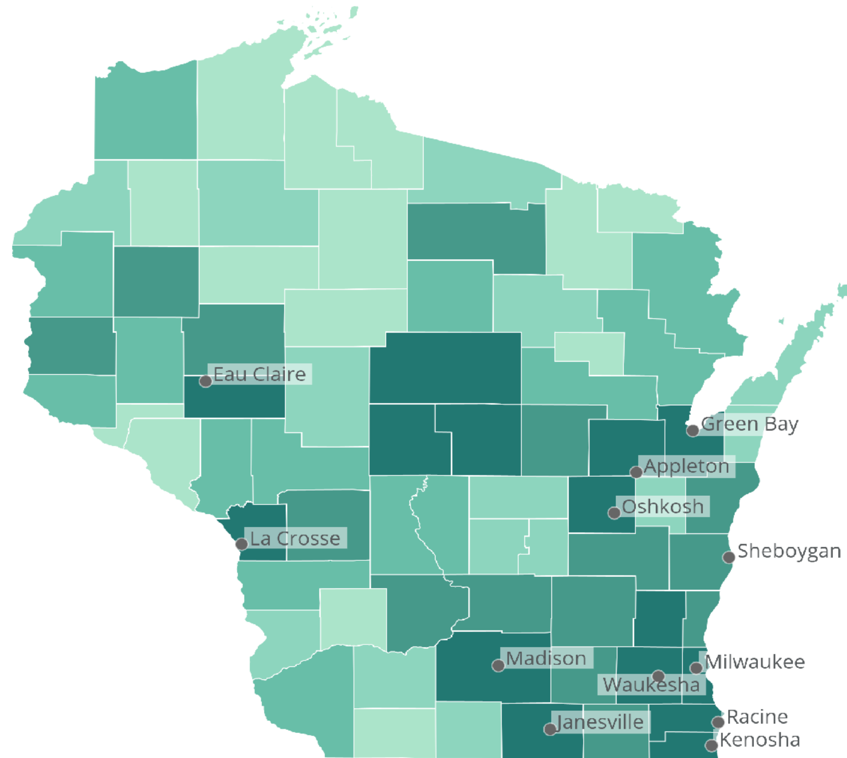
211 Problem/Needs

All values (21)

Other | Utility Assistance | Information Services | Food/Meals | Clothing/Personal/Household Needs | Mental Health / Substance Use | Arts, Culture and Recreation

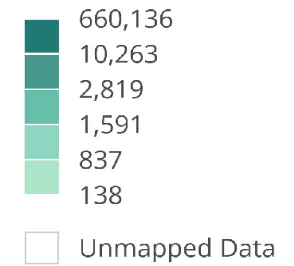
Interactions by County

1M Distinct Interactions



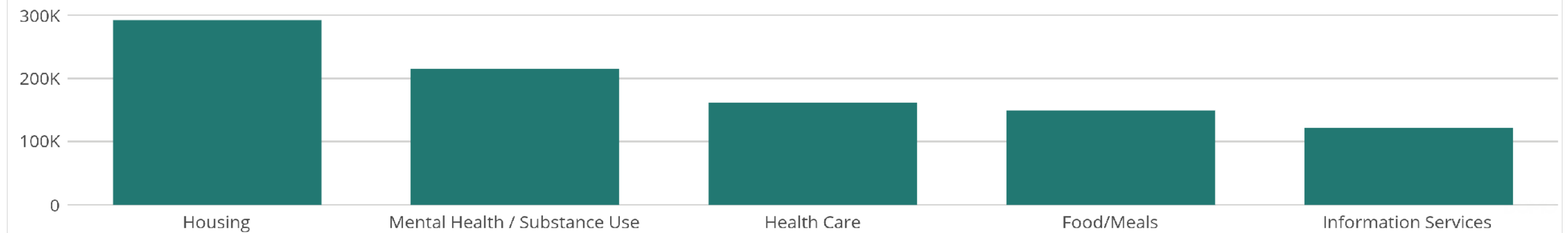
Total

1,271,615



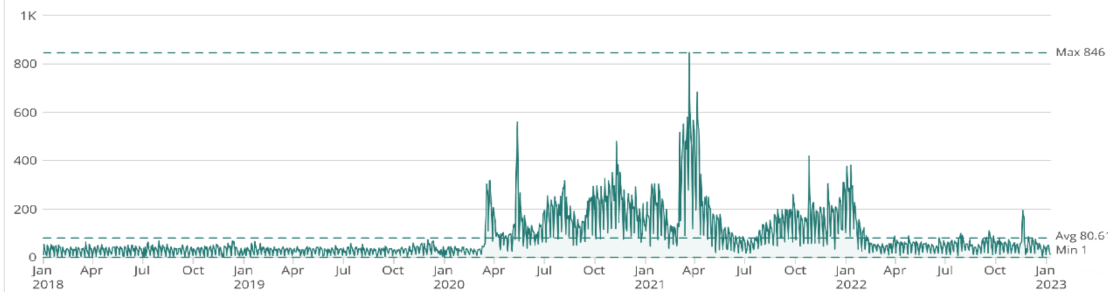
Top 5 Problem/Needs by Interactions

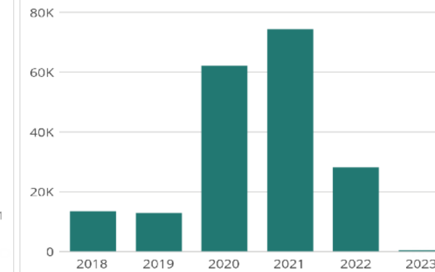
2M Distinct Referrals

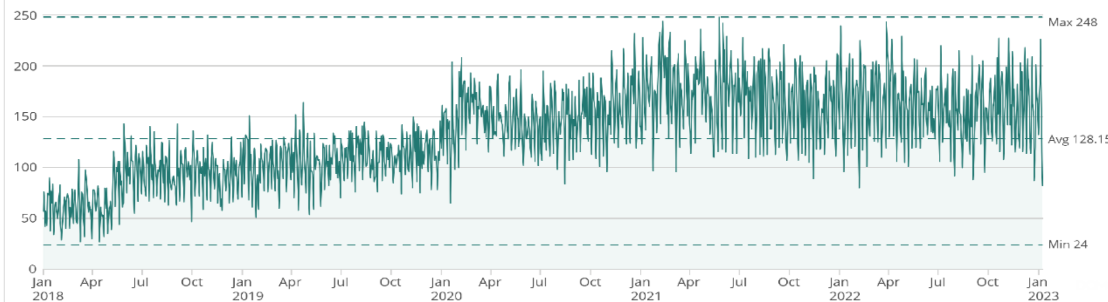


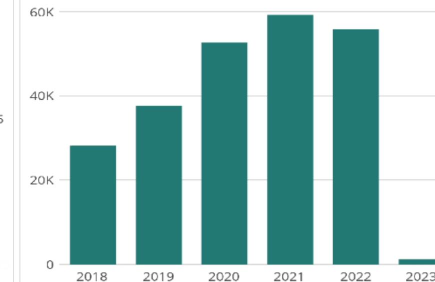
Access to Health & Clinical Care

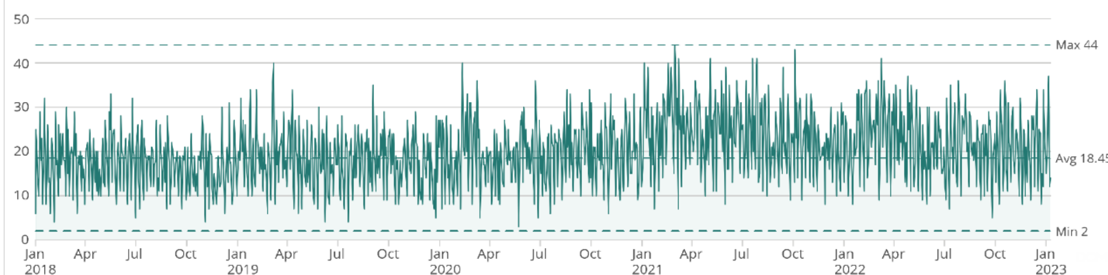
The below graphs focus on trends related to access to health & clinical care.
Please note: certain filters exclude the referral data the graphs below use and may cause these graphs to display no values.

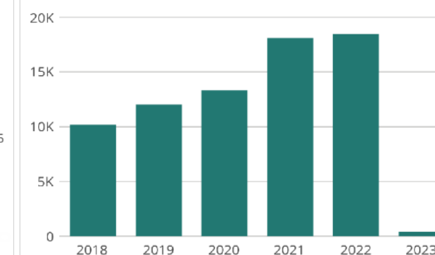










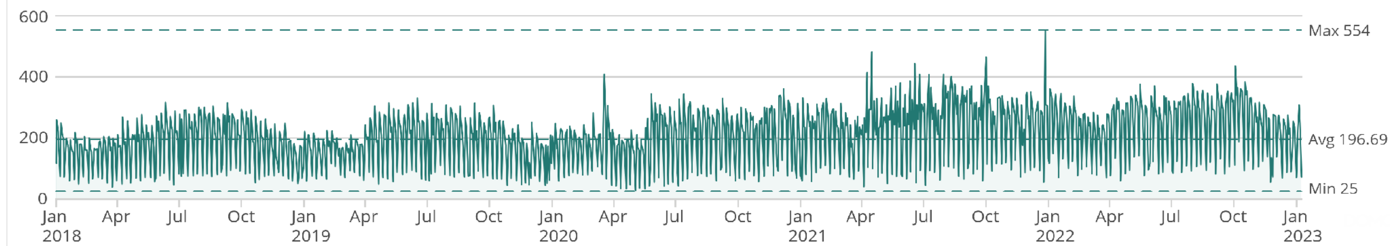


Access to Social Determinant of Health (SDOH) Care

The below graphs focus on trends related to social determinants of health and access to care for these determinants.
Please note: certain filters exclude the referral data the graphs below use and may cause these graphs to display no values.

Housing Referral Trend

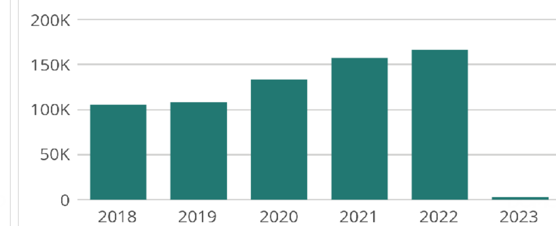
674K Distinct Referrals



Housing Referrals by Year

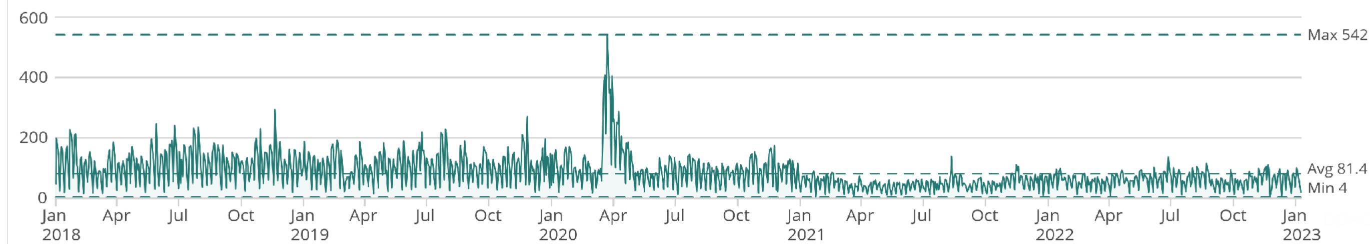
by Year

674K Distinct Referrals



Hunger Referral Trend

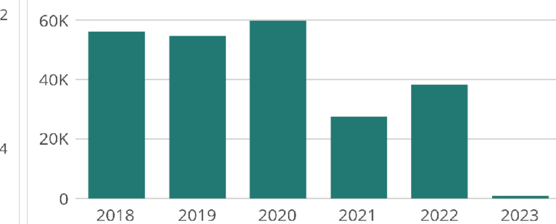
238K Distinct Referrals



Hunger Referrals by Year

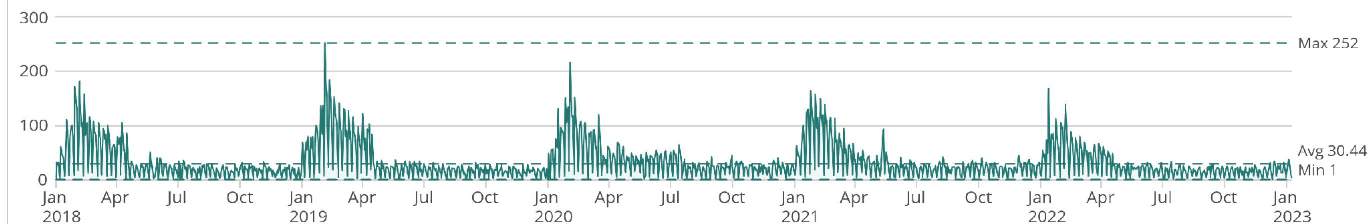
by Year

238K Distinct Referrals



Income & Jobs Referral Trend

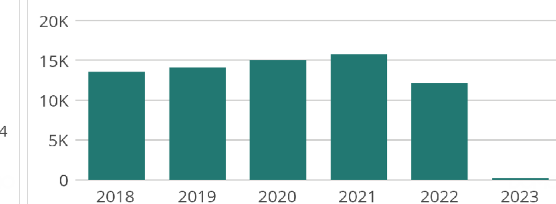
71K Distinct Referrals



Income & Jobs Referrals by Year

by Year

71K Distinct Referrals



Transportation Referral Trend

37K Distinct Referrals

Transportation Referrals by Year

by Year

37K Distinct Referrals

Results and Persisting Barriers

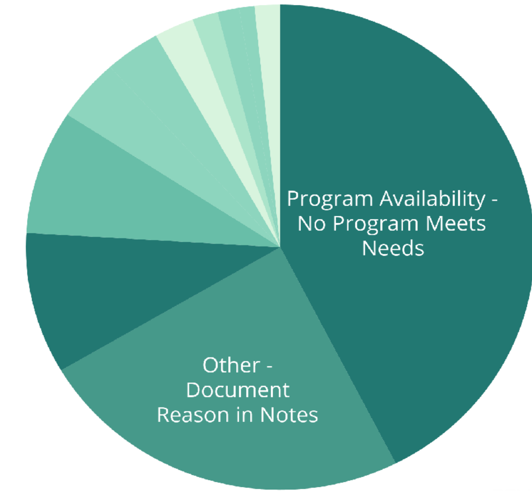
Community members can experience many barriers that limit their access to resources around them. 211 Information and Referral Specialists seek to identify and record specific unmet needs as well as the barrier that prevented the need from being met. Each unmet need is directly correlated to a problem need. *Users are encouraged to explore problem need specific unmet needs by using the filters at the top of the page.*

To further support the unmet needs data and continue to identify barriers that clients encounter, 211 offers a follow up call to those who receive referrals on our network. These follow up calls identify any previously unrecorded unmet needs as well as unforeseen barriers in contacting an organization and receiving service.

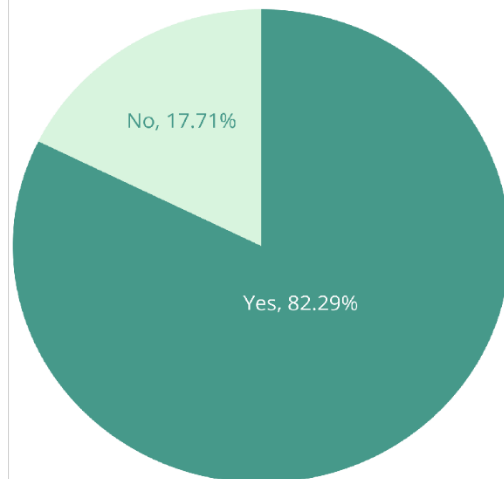
Unmet Needs

87K Distinct Interactions with Unmet Needs

Unmet Need	Count
Program Availability - No Program M...	38,998
Other - Document Reason in Notes	22,045
Program Availability - Program Not Ac...	8,642
Caller Refused Referral - Document R...	7,591
Ineligible - Already Served	3,780
Ineligible - Does Not Fit Program Crite...	3,242
Service Delivery - Delay in Service	2,324
Funding - Program Out of Funds	1,492
Ineligible - Household Structure Does ...	1,261
Transportation	892
Other	1,490



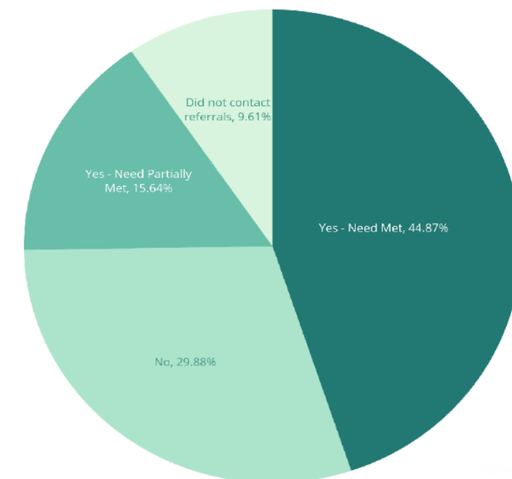
Did you contact the referrals given to you by 211?



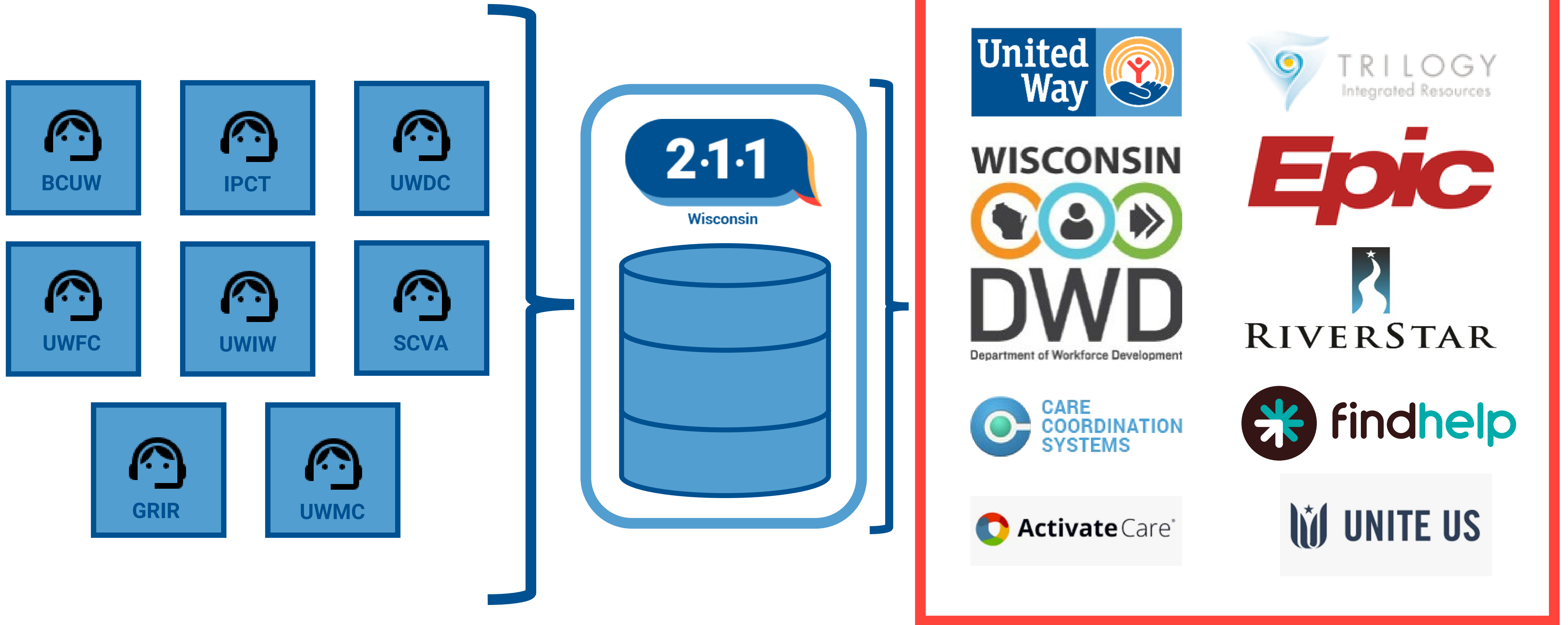
Response	Count
Yes,	10,025
No,	2,158

Was one of your referrals able to help?

Response	Count
Yes - Need Met,	5,226
No,	3,480
Yes - Need Partially Met,	1,822
Did not contact referrals,	1,119



Community Partnerships



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Wisconsin Lifeline

Family Services of Northeast WI

NATIONAL SUICIDE PREVENTION LIFELINE™

1-800-273-TALK

www.suicidepreventionlifeline.org

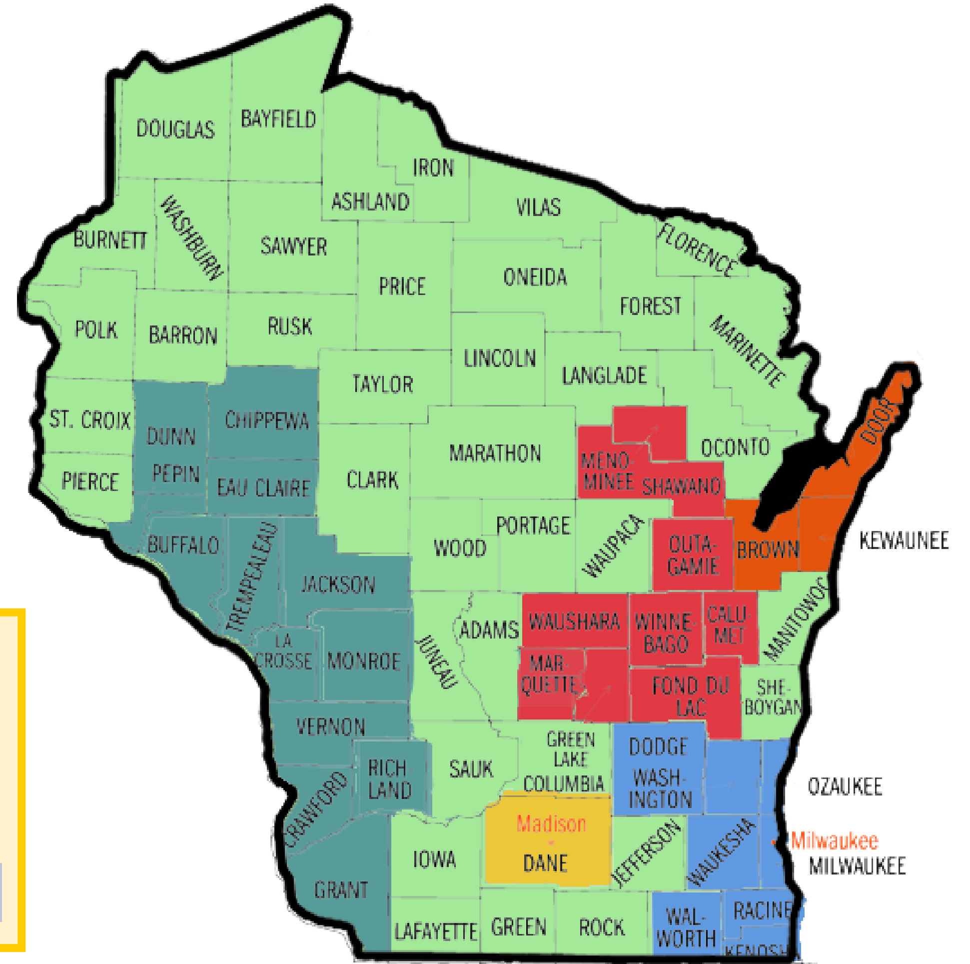
STATEWIDE

GUNDERSEN HEALTH SYSTEM®

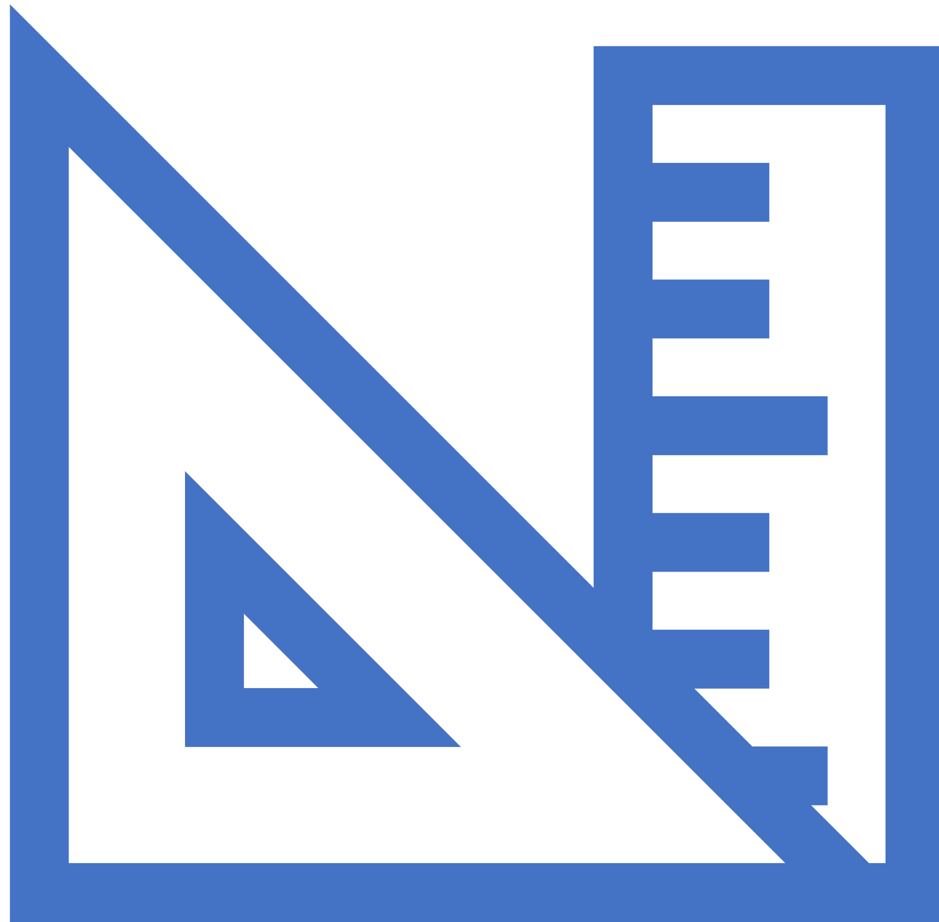
Door County Partnership for Children

IMPACT Connect is a collaborative partnership of agencies combining efforts to make social services assessable and navigable to the people who need them. IC is led by IMPACT – the regional provider of 211 services and the go-to source for social service referrals in SE WI. UniteUs provides the technology platform.

MILWAUKEE HEALTH CARE PARTNERSHIP

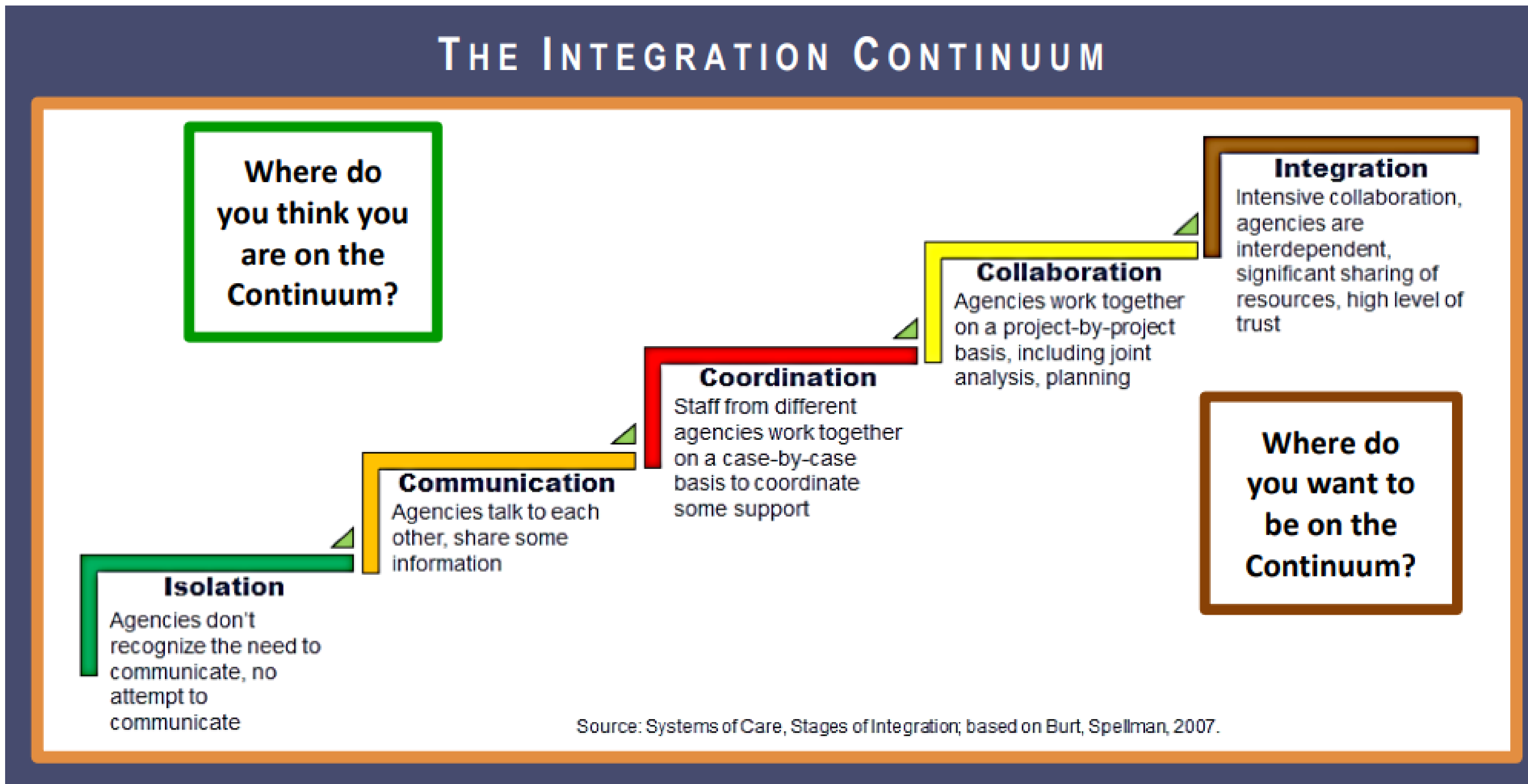


211 WI INTEGRATIONS & PROJECTS



Setting the Stage

Figure 1: The Integration Continuum



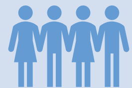
White House: Office of Science and Technology Policy

COMMUNITY CONNECTED HEALTH STAKEHOLDER ENGAGEMENT SUMMARY REPORT

May 2022

Background

From January through April 2022, the Office of Science and Technology Policy (OSTP), in partnership with the Health Resources & Services Administration (HRSA), **solicited stakeholder input on the proposed vision for Community Connected Health through a Request for Information (RFI) and three formal roundtables**.



In May of 2022 they posted their summary of inquiries addressing how communities view and wish to use new technological solutions to providing community care.

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Respondent Information

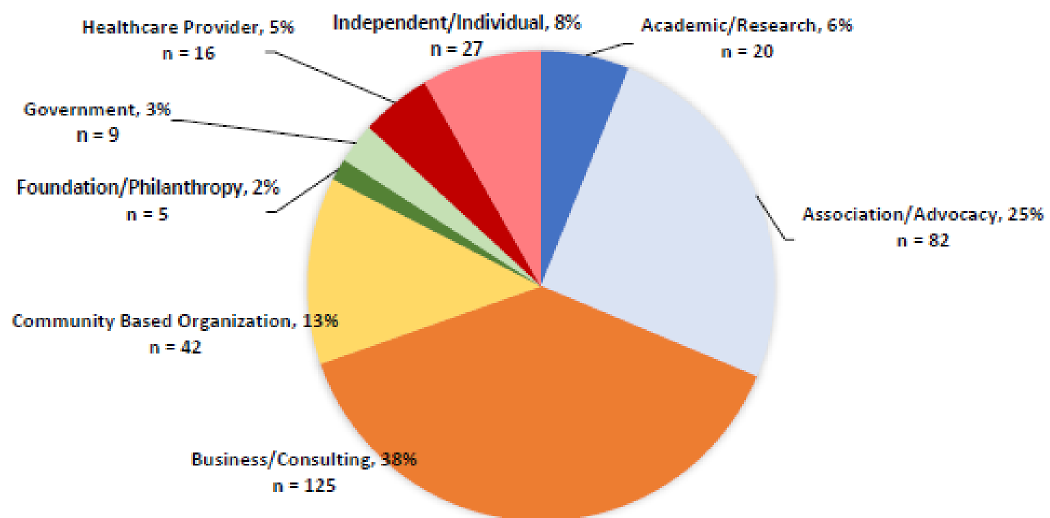

FIGURE 1: RFI RESPONDENTS BY STAKEHOLDER CATEGORY

This graph depicts the types of stakeholders that responded to the RFI by March 30, 2022. There were 326 total responses.

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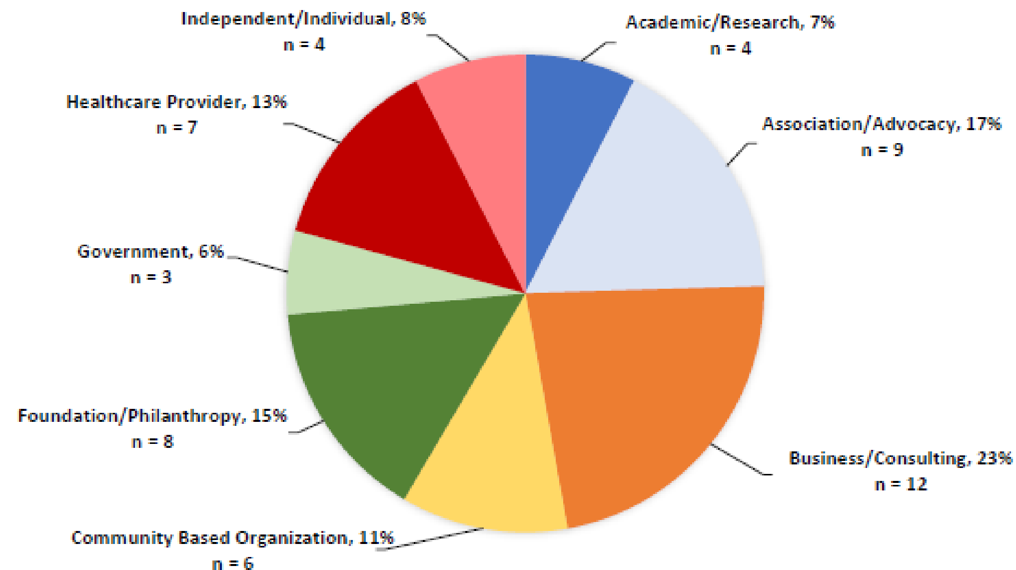

FIGURE 2: ROUNDTABLE PARTICIPANTS BY STAKEHOLDER CATEGORY

The makeup of roundtable participants is collated from across all three roundtables. There were 53 total participants, not including the Federal stakeholders who attended either in moderating or listening capacity. The public webinar portions of the roundtables were livestreamed and collectively amassed 1,129 viewers on HHS.TV.

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Key Insights

- Even well-designed technology will never replace a trusted health care worker or provider.
  - Technology should serve as a connector to these trusted individuals. Tools should be designed to enhance effectiveness of workers, and can help facilitate the bridge between community and clinic. Community health workers empowered with digital tools can improve health outcomes, but their **lived experience and trust within the communities in which they work are their most valuable asset.** Digital health tools should be designed to reduce burden of this workforce and where possible be co-designed with the community.

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Key Insights

- Steady and sustainable funding sources for the community health workforce are critical to their success.
  - As outlined above, technology or digital solutions are an important tool for enabling and empowering community health workers, but they are **not a panacea.** These tools need to be complemented by long-term, sustainable funding for the workforce. One-time or limited term funding makes program continuity difficult and diminishes the quality of their work. While integration into existing healthcare systems is possible, it **needs to be designed intentionally** from the start to ensure success.

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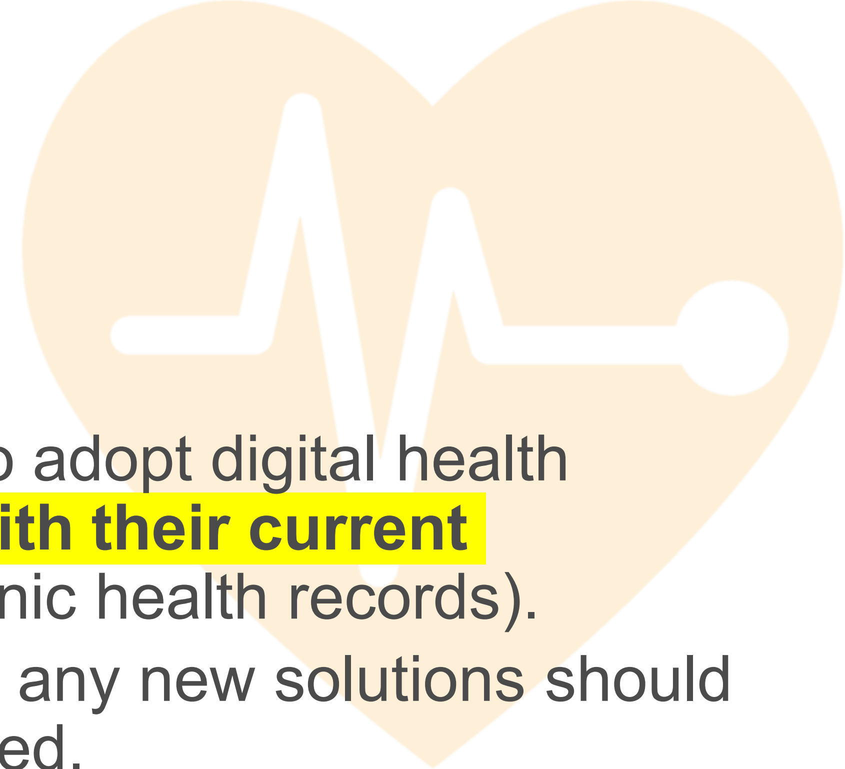
Key Insights



- Community-based providers would be more likely to adopt digital health technologies **if there was seamless integration with their current technologies**, workflows, and systems (like electronic health records).
  - Providers are already stretched very thin and so any new solutions should be easy to learn, integrate, and change as needed.

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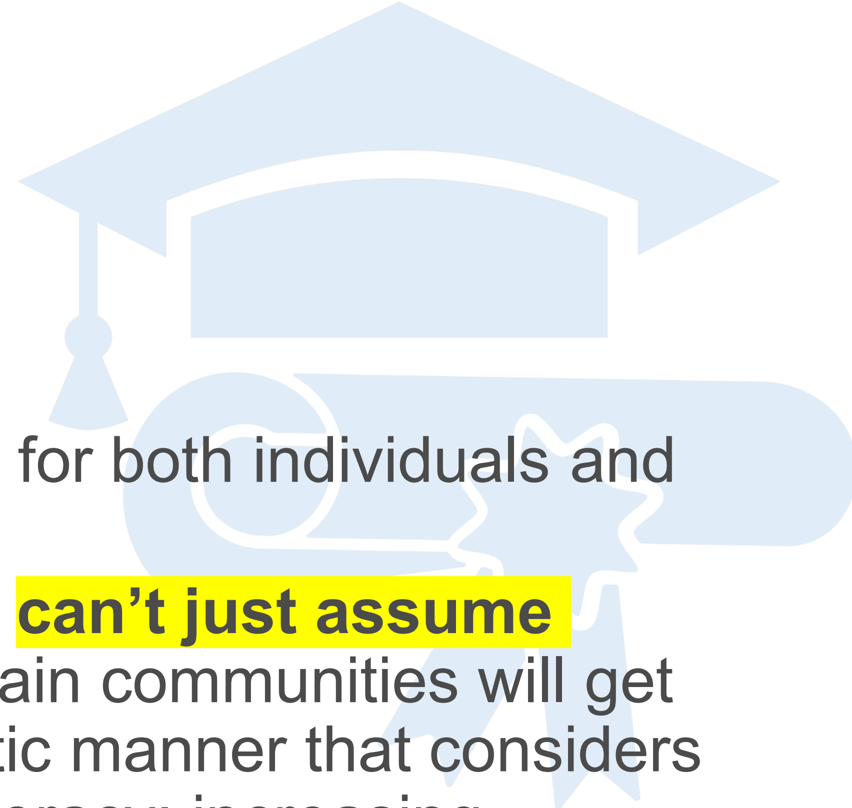
Key Insights



- Digital literacy is a real, but addressable, challenge for both individuals and health workers and providers.
  - The COVID-19 pandemic has taught us that we **can't just assume comfort or fluency with digital systems.** Certain communities will get left behind. This should be addressed in a holistic manner that considers multiple critical touchpoints to increase digital literacy: increasing accessibility of digital tools to all digital literacy levels and increasing levels of end-user digital literacy through education and training in targeted communities.

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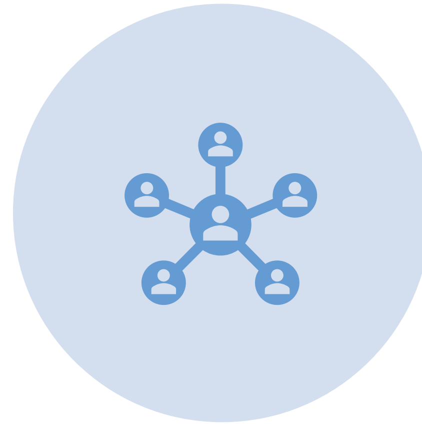
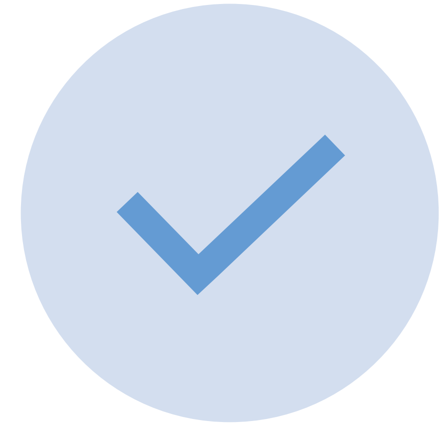
Keys to Success

ENGAGEMENT (OUTREACH)



CONNECTION (RELATIONSHIP AND TRUST)



INTEGRATION (EXISTING AND ADDITIONAL TECHNICAL SOLUTIONS)

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System Integration Steps

- Assess your organization readiness
- Study the landscape
- Identify potential partners
- Develop a coalition defined by a shared priority
- Understand existing networks (housing, food, older adult services, young family services)
- Do no harm – what is the current community organization capacity; are there already workflows in place to support this work
- Establish indicators of success
- Pilot and test
- Evaluate existing infrastructure and assess gaps
- Identify technical platforms that will enhance your plan and support interoperability with existing infrastructure

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With the people around you please discuss the following.

What tool(s) do you use to track client information?

What tool(s) do you use to navigate resources for your clients?

Are you required to use a specific tool/system for your work?

- Who requires you use this system? E.g., federal, state, coalition, etc...

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Discussion Cont...

What aspects of your tool(s) contribute to your success in serving clients?

What aspects of your tool(s) are missing to best serve your clients.

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Activity Break

What's Most Important to you in Creating Referral Pathways?

Instructions

- Please rate the following items in terms of importance to you on a scale of low, medium, or high importance.
- Tally under the small, medium, or high bar on the chart paper that coincides with each question.
- Example:

1: Health Related Social Needs Screening Tools.

II

IIII

IIIII

Referral Infrastructure Features

1. Health Related Social Need screening tools
2. Screening tool integrated with your current technical system
3. Receive and Send event notification data,
   Notify members of the care team, navigators, CHWs or third party vendor that there is a screened need
4. Risk stratification
   Some systems have additional features that indicate risk factors Some communities have established their own risk stratification system
5. Centralized service directory
   Listing of in a community can be claimed, in network or out of network
6. Closed-loop referral capabilities (outcome data collected)
   Agency agrees to provide information about whether or not they served the patient
7. Creation of a community patient health record
   System creates a community patient record that contains information about SDOH referrals, outcomes and patient needs.
8. Navigator access to the system (directory, patient SDOH record, analytics)
   Navigators, CHWs and other health support staff have access to the patient community record, can navigate services and make referrals and view closed loop information.

Referral Infrastructure Features

9. Patient access to the system (directory, patient SDOH record, analytics)
   Patients have access to their own data and history of service provision.
10. CBO access to the system (directory, patient SDOH record, analytics)
    Community based organizations have access to the patient record and can use all system functions to screen, refer and access data.
11. Ability to create a shared care plan
    Clinicians, navigators can create a SDOH care plan and share it with participating community organizations.
12. Care coordination workflow and/or case management services
    System can track care team members and workflows that are specific to certain pathways or patient needs.
13. View/Extract Health Related Social Need (HRSN) analytics
14. Health Related Social Need data exchange between system and related tools/services
    System is interoperable with EHRs as well as community based organization referral systems. A workable data governance plan needs to exist in order for a system to be effective. Interoperability is bi-directional.

16. Call center for patients to identify community resources
17. Public/patient facing navigation services
    Self-service through mobile friendly device. Searchable website and referral system.

Results?

- What was most important?
- What was least important?

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Questions, Comments, Themes?

Now, imagine your community partners doing this same exercise

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Our Collective Challenge

Early Wins

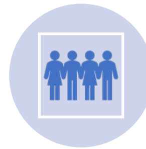
Widespread understanding of SDOH (prevention)

Understanding and partner agreement that people benefit from system coordinating efforts

Multiple vendors to support workflows

Interest and adoption from many sectors including health care

Understanding of the importance of humans in the workflow

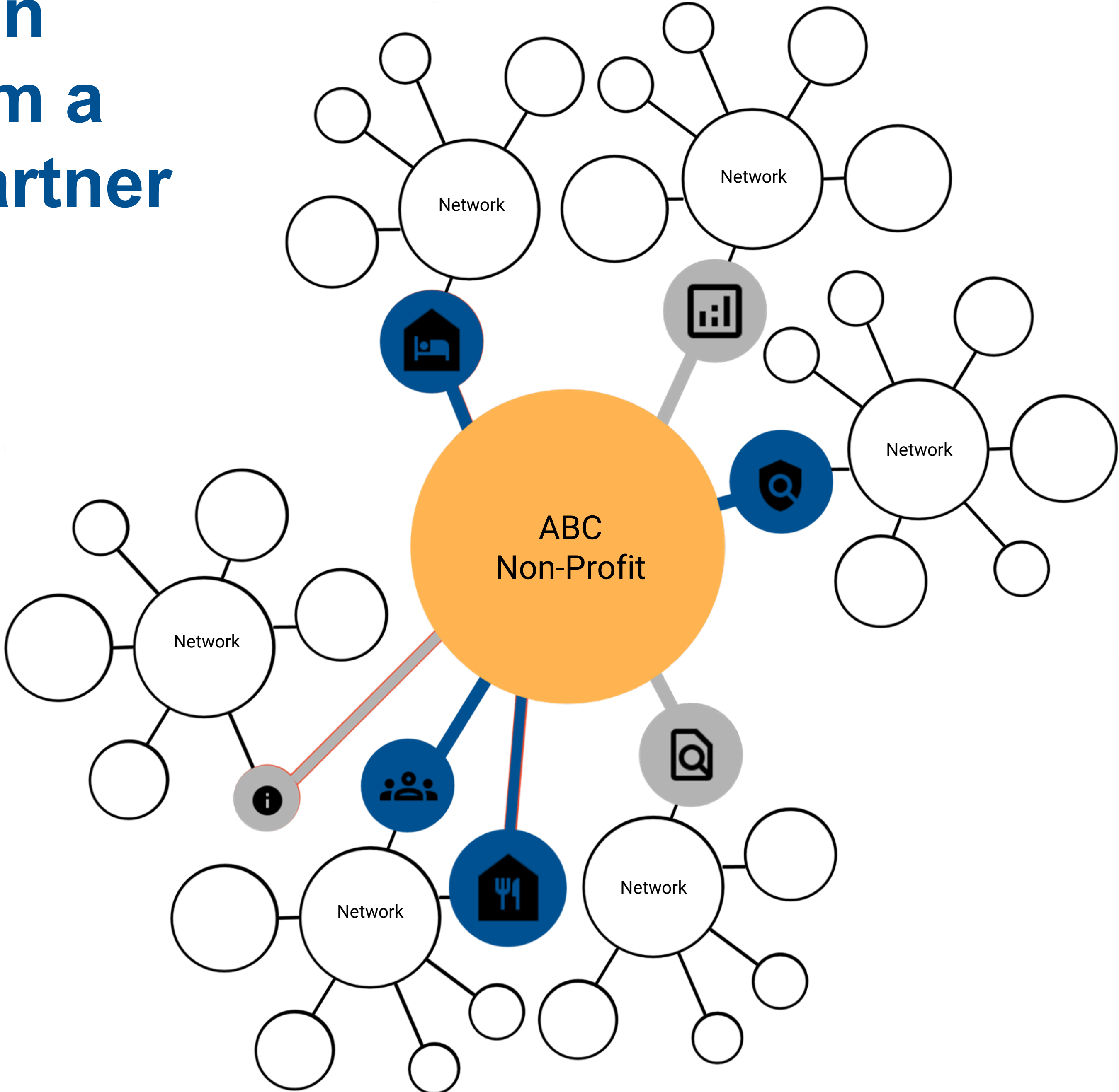


Increased understanding of the need for continuity in social care

Emerging Challenges and Roadblocks

- Vendors require enrollment on THEIR system.
- Multiple vendors building statewide networks
- CBO's forced to manage multiple system or risk creating silos and increase disparities.
- Limited consideration of nonprofit capacity.
- Potential for families to be "served" by multiple networks.
- Sustainability and risk medicalization of CBO services.
- Motivators/drivers of workflow is not the same for all partners resulting in cross-purpose solutions.
- Uncoordinated, redundant investment in core elements of the eco-system.
- Disruption of existing successful workflows in order to conform with vendor pre-defined processes.

Current State in Wisconsin from a Community Partner Perspective



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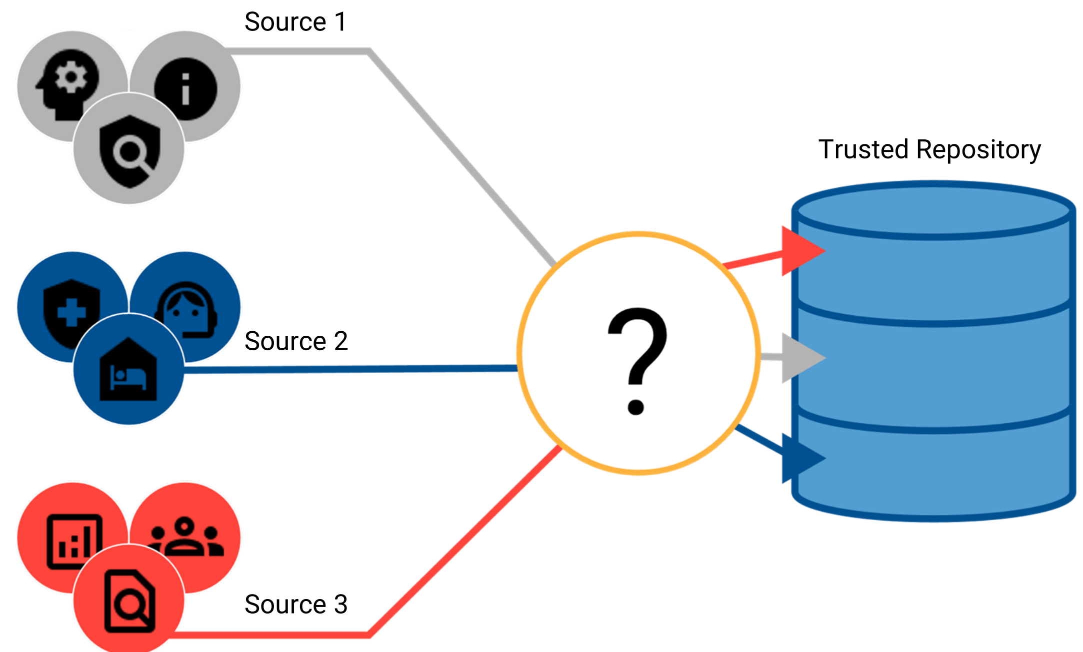
Current Regional SDOH Landscape

Organization Type	Health System A	Health SYstem B	FQHC	CBO (Food pantry)	CBO (Coordinated Entry)	CBO (Employement)	211
Staff Member	SW, RN, PA	CHW		Volunteer	CE Team, Housing Navigator	Placement Specialist	Community Resource Specialist
Client/ patient System of Record	EHR	EHR	EHR	Excel	HMIS	Unite Us	VisionLink
SDoH navigation platform	Unite Us	Find Help	Unite Us	Find Help / Unite Us	Find Help / Unite Us	Find Help / Unite Us	VisionLink
Resource Directory	211	211	211	211	211	211	211
Closed Loop Outcomes	Unite Us	Find Help	Unite Us		Find Help / Unite Us	Find Help / Unite Us	VisionLink

The Data Problem

- multiple directories
- multiple vendors
- proprietary formats
- non-standardized content
- multiple ways used to transmit data
- no universally accepted schema
- no authoritative “aggregator”
- no easy way for users to consume data



Private and Confidential

San Diego CIE

What is a CIE?

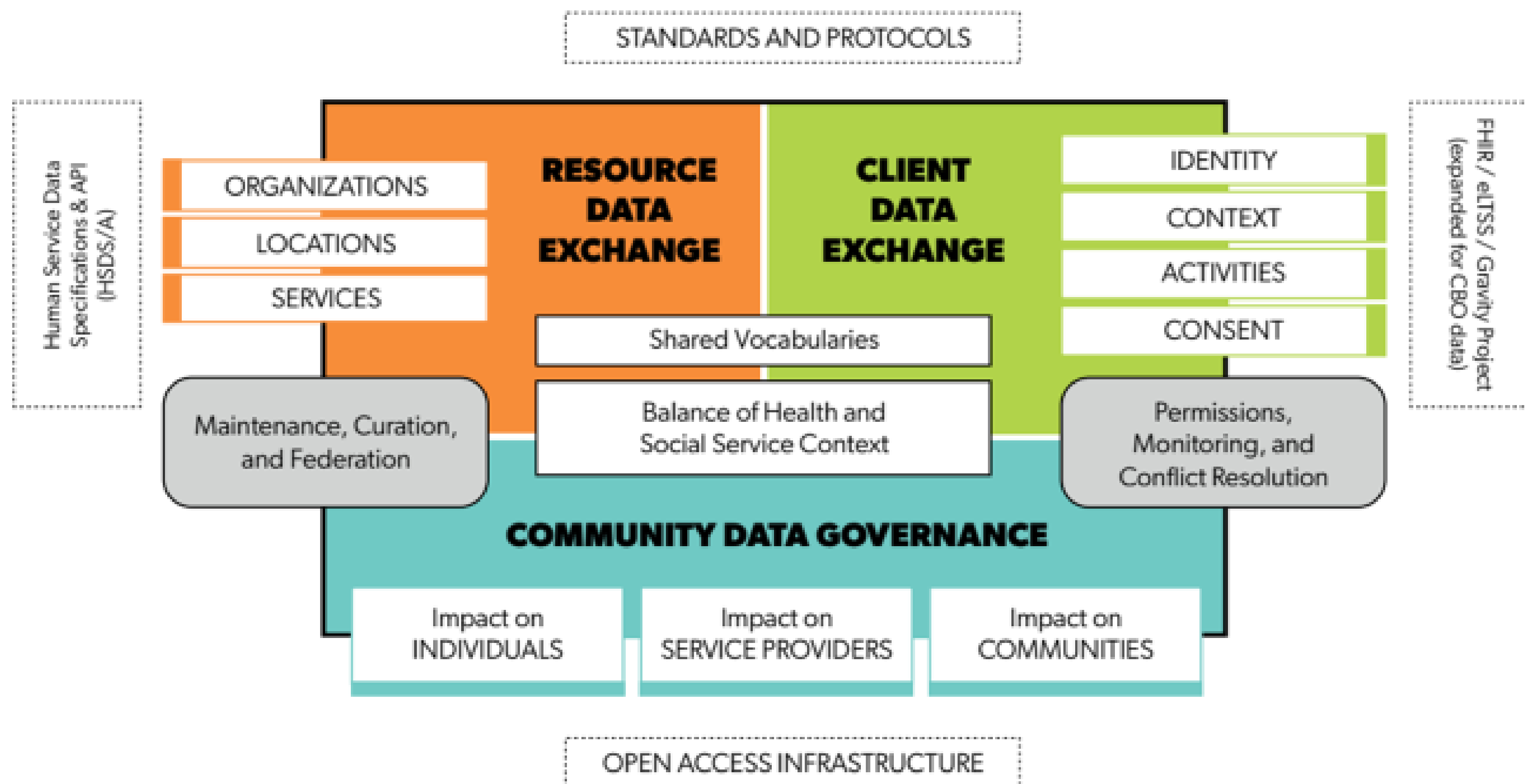
- Cultivates trust and capacity within the community
- Enables individual agency and understand root cause
- Drives systems change
- Community-led collaborative
- Designed to uplift and assist in providing agency to communities that experience disparities and inequities

What a CIE is NOT.

- A specific technology or platform, nor is it dependent solely on tech to connect
- Generic one-size fits all solution that does not address capacity, readiness or infrastructure
- Intended to solve one issue
- Led by one organization, nor driven by one sectors needs
- Centered around institutional goals or interests

Role of United Way of Wisconsin

- Collective Impact backbone
- Guide the development of a shared vision and strategy
- Maintain a shared identity
- Expand the network of partners and funders
- Understand partner needs and workflows
- Establish shared outcomes and measurement practices
- Manage the CIE including technical development with partners
- Support aligned ongoing learning and best practice sharing (WPHCA & WPHA)

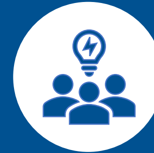

Primary Components of
"Community Information Exchange"
STANDARDS AND PROTOCOLS
Human Service Data Specifications & API (HSDS/A)
ORGANIZATIONS
LOCATIONS
SERVICES
RESOURCE DATA EXCHANGE
CLIENT DATA EXCHANGE
IDENTITY
CONTEXT
ACTIVITIES
CONSENT
FHIR / eLTSS / Gravity Project (expanded for CBO data)
Shared Vocabularies
Balance of Health and Social Service Context
Maintenance, Curation, and Federation
Permissions, Monitoring, and Conflict Resolution
COMMUNITY DATA GOVERNANCE
Impact on INDIVIDUALS
Impact on SERVICE PROVIDERS
Impact on COMMUNITIES
OPEN ACCESS INFRASTRUCTURE

Incorporating Insights Into Our Work

Guiding Principles

People First/Maintain Trust

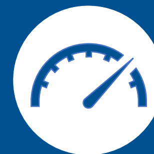
Value all Partners Equally



Invest in a shared vision

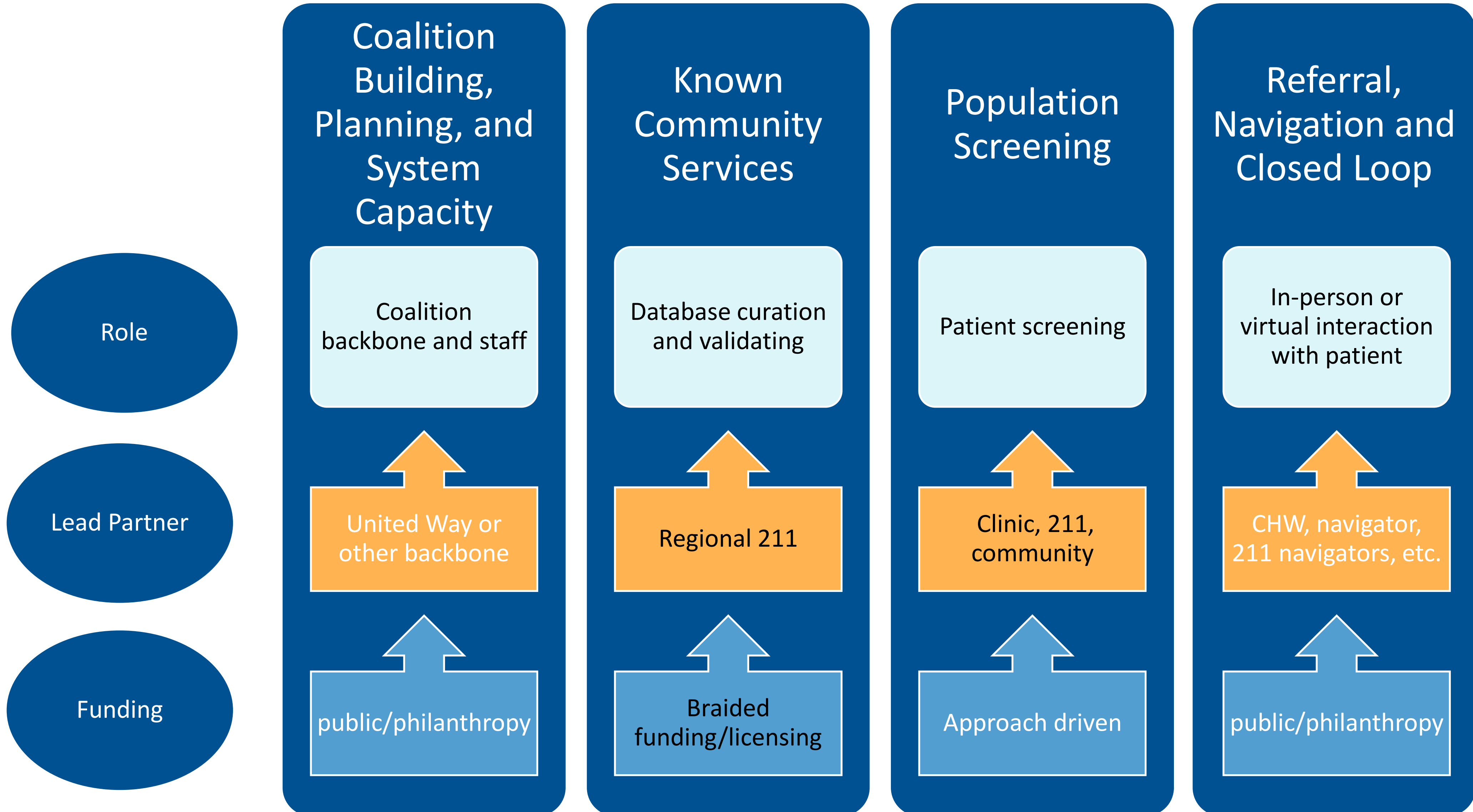
Technology is a tool, not the driver

Design with sustainability in mind



Adaptable and scalable

Scope of United Way/211 Engagement



Wisconsin Information and Referral Exchange (WIRE) Approach

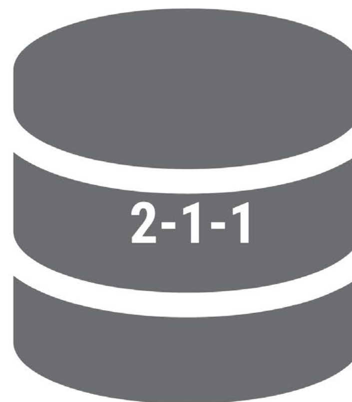
Physical, Mental, Behavioral, and Social Needs

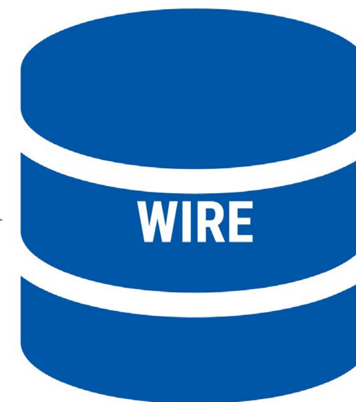
Regional SDoH Programs

IMPACT Connect (MKE)
Achieve Brown County
Connect Rx (MSN)
Fox Valley
Pathways Hub Gundersen

State Agencies

Specific Populations



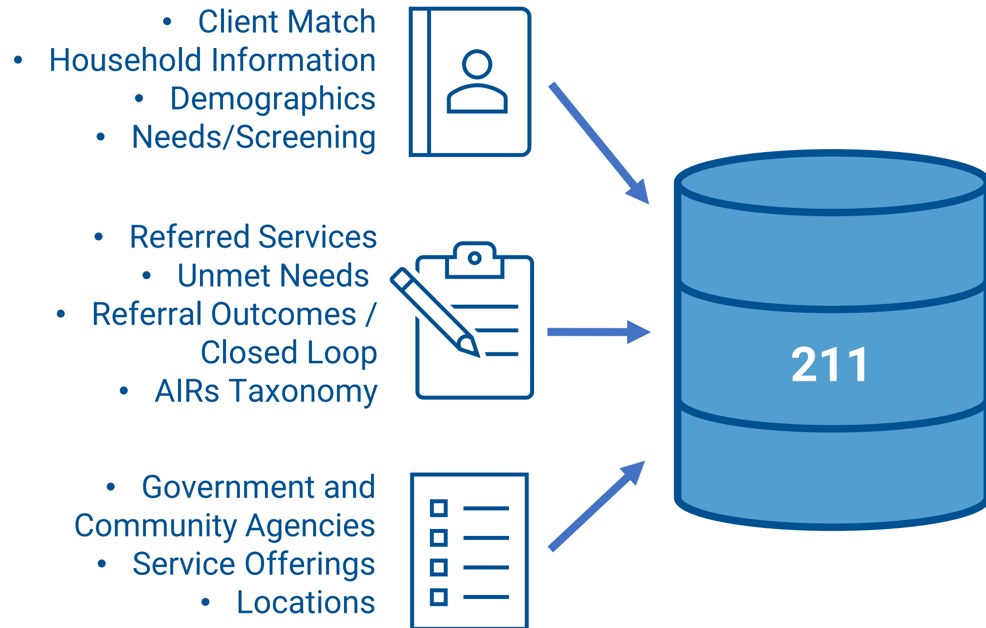


Standardized Resource Database

Longitudinal Personal Record

Referral & Outcome Data

Leverage Existing Infrastructure



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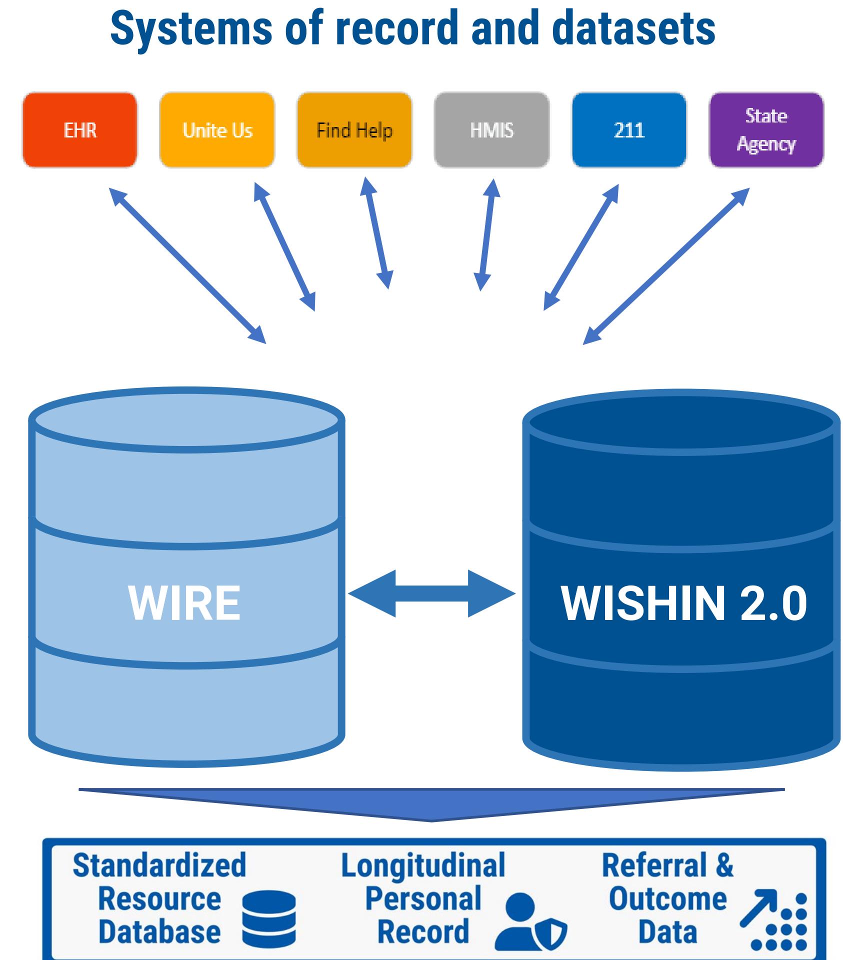
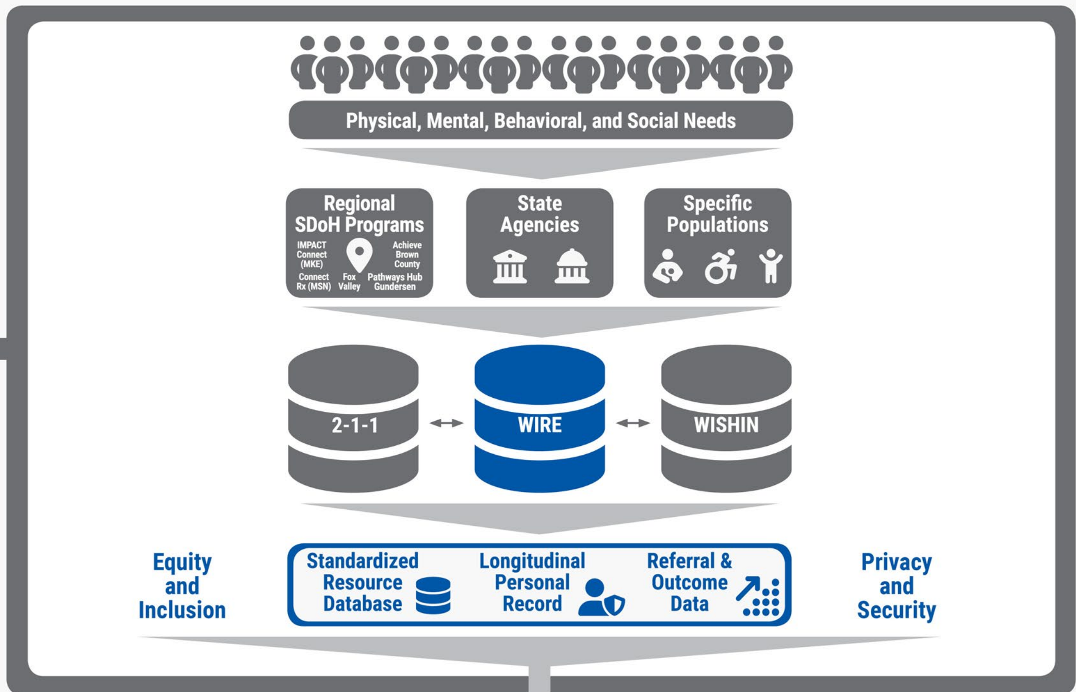
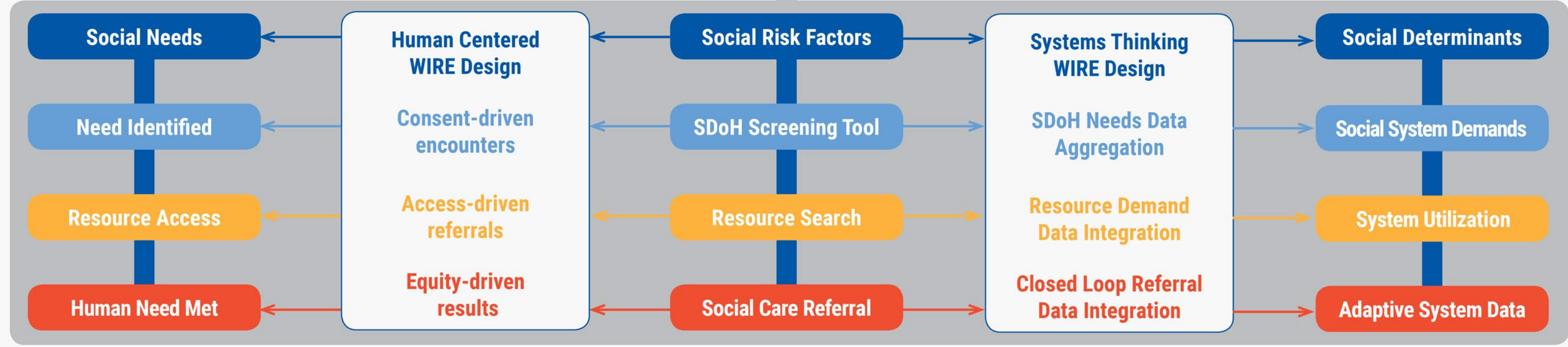


Wisconsin Information and Referral Exchange (WIRE) Interoperable Systems Approach Framework

Interoperability Governance

WIRE Approach





Human-Centered Systems Design

Questions, Comments, Themes?

References