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Submitted via HealthIT.gov

Micky Tripathi, Ph.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street SW
Washington, DC 20201

RE: Draft 2024-2030 Federal Health IT Strategic Plan

Dear National Coordinator Tripathi:

I write on behalf of Unite Us in response to the draft Federal Health IT Strategic Plan (“Plan”) issued by the Office of the National Coordinator for Health Information Technology (“ONC”) within the U.S. Department of Health and Human Services (“HHS”). Unite Us brings sectors together through technology to ensure peoples’ needs are met—driving collaboration to identify, deliver, and pay for services that impact whole-person health.

Unite Us’ mission is aligned with ONC’s vision for Federal Health IT: improving the “health and well-being of individuals and communities using technology and health information that is accessible when and where it matters most.” Plan, p. IV. Like ONC, Unite Us strives to improve whole-person care; health equity, research, and care delivery; and public health—all while prioritizing individual rights, data privacy, and security. See Plan, p. 3. We applaud ONC’s development of a strategic plan that prioritizes health equity and the need to integrate social care needs with health care.

We submit this comment to express our strong support for the Federal Health IT Strategic Plan as drafted and respond to several of the Plan’s specific goals, objectives, and strategies. In particular, we encourage ONC and other federal agencies to look to successful, consensus-driven private sector efforts that address the goals and objectives in the Plan, and to incorporate the perspective of community-based organizations working to help advance community and industry standards.

I. Building Healthy Communities

Founded in 2013, Unite Us implements the core federal health IT principles as it powers care coordination to eliminate silos between health and social care teams, reduce the burden placed on individuals seeking care, and improve health outcomes. Plan, pp. 2, 6. Unite Us’ intuitive platform enables health and social service organizations to coordinate and manage services for their clients, track referrals and outcomes together, and securely share information to facilitate care coordination. Plan, p. 6. For example, if an individual arrives at a clinic for a health checkup, a case

manager at the clinic may screen them and identify that they have additional social needs—like transportation challenges, food insecurity, or housing instability. The case manager may then use Unite Us to obtain consent from the client and electronically refer them to multiple community partners. Through the platform, the case manager can seamlessly communicate with other providers in real time and securely share the client’s information. As the client receives care, the care manager receives real-time updates and tracks the client’s total health journey.

A. Promoting Health and Wellness

Unite Us supports ONC’s first goal to “promote health and wellness,” Plan, p. 1, and specifically the strategy of enabling “EHI sharing between health care providers and organizations serving communities.” Plan, p. 11. In this way, our platform helps “health care, public health, and human services professionals securely exchange data to improve care and effectively administer social programs.” Plan, p. 11; see *also id.* at 14 (recommending promotion of “health IT that supports greater integration of health care and human services [so that] patients experience more seamless support across their health and human services interactions, including appropriate information flowing effortlessly among their care teams”). Like ONC, our goal is to ensure every individual, no matter who they are or where they live, can access the critical services they need to live happy and healthy lives.

Over the past decade, Unite Us has grown nationally to power coordinated care networks across the country. We have facilitated more than 24.6 million screenings, referrals, and resource shares, and we enable access to more than 1.5 million services across the country, including housing, mental and behavioral health, transportation, education, employment, legal, food, and benefits assistance. We support Medicaid beneficiaries throughout the country and provide the technology infrastructure for North Carolina’s Healthy Opportunities Pilot and other key initiatives, including In Lieu of Services (ILOS) work in California. The growth of care coordination between health and social care organizations since the pandemic has been exponential, illustrating the need to continue supporting this integrated work.

We encourage ONC to continue to support and prioritize efforts to facilitate exchange of health data between health care providers and social care providers and collaborate with and learn from experience across these sectors. We look forward to engaging with ONC and other federal agencies to provide the experience and knowledge we have gained regarding social care needs, community-based organizations, and integration with health care services to address inequities in health and improvements in access to all types of care for individuals.

B. Enhancing the Delivery and Experience of Care & Accelerating Research and Innovation

Unite Us further supports ONC’s second and third goals to “enhance the delivery and experience of care” and “accelerate research and innovation.” Plan, p. 1. Not only does Unite Us provide a

platform to connect health care and social care providers; we are an active partner to the communities we serve. Unite Us builds comprehensive care networks and change management processes in order to increase access to services and empower the community to improve health outcomes. We support our partners “with using health IT as part of their workflows” so that they have an “improved experience with health IT throughout the cycle of implementation, go-live, upgrades, and ongoing use.” Plan, p. 17. For example, in 2023, in one state alone, Unite Us team members held over 600 meetings with organizations in the network, and our user education team held more than 200 live user education training sessions.

Unite Us also agrees with ONC that in order to “[i]ncrease health equity across all populations,” we must “[a]dvance the use of data to represent social needs and the conditions in which people live, learn, work, and play.” Plan, p. 6. We work to “[p]romote the use of health IT interventions that address health disparities” so that “[r]esearchers, technology developers, and other health IT users can generate insights on how to support care needs across socioeconomic, environmental, and system-level landscapes.” Plan, p. 21. In partnership with external researchers, our Research and Evaluation team has evaluated “the impact and effectiveness of health IT development and implementation on care, safety, health, and other types of outcomes” in use cases across the country. Plan, p. 20. These evaluations demonstrate the incredible impact our work has had on our customers and the communities they serve, allowing providers to deliver safe, equitable, high-quality, and improved care and expanding access to care while eliminating health disparities.

In Florida, new mothers referred to services through Unite Us experienced a statistically significant reduction in all-cause hospital readmissions. Specifically, findings from a retrospective, matched case-control study at one of our provider partner hospitals showed that new mothers referred to services through Unite Us experienced a statistically significant reduction in all-cause hospital readmissions at 1, 3, 6 and 12 months compared to matched controls. Of particular note, Medicaid patients experienced a 79% reduction in odds of postpartum-related readmissions at 30 days ($p < 0.05$) (defined as postpartum-specific ICD-10 codes, e.g., maternal mental health, labor and delivery complications, gestational diabetes, and Type II diabetes), and a 70% reduction in odds of all-cause readmissions at 30 days ($p < 0.05$).

New mothers in Florida also reported a 54% reduction in perceived stress ($p < 0.05$) and improvement in the number of mentally healthy days per month: before receiving assistance, moms reported, on average, 9.9 unhealthy mental health days per month. Thirty days after receiving assistance, that number had fallen to 7.2 days per month; after 60 days, the number had fallen to 6 days per month. An increase in healthy days per month reflects an improved quality of life for new moms, and it may also reduce healthcare utilization and generate associated cost savings. In particular, the increase of 4 healthy days per month reported in this study translates to an estimated

\$32 lower medical costs per member per month.¹ Additionally, parents reported 89% improvement in protective factors like knowledge and awareness of social and concrete supports, and 35% improvement in perceived access to social support in times of need, demonstrating the potential for long-term impacts on well-being and quality of life.

Similarly, in Kentucky, individuals participating in a Louisville housing pilot powered by our technology reported a 63% reduction in physically unhealthy days and a 62% reduction in mentally unhealthy days, both of which are associated with increased hospital admissions and medical costs. In New Jersey, a pilot led by community health workers using our technology to screen for and address social needs—including by referring individuals to local community organizations—documented a 25% reduction in total cost of care for patients successfully connected to services. The individuals served through our technology experienced a 24% reduction in emergency department utilization and a 60% increase in behavioral health care utilization.

In Oregon, a study conducted in partnership with researchers at UCSF SIREN sought to assess client perspectives on using Unite Us' self-referral form (known as an "Assistance Request Form"), which enables clients to ask for assistance for the services they need. The vast majority of respondents agreed that the Assistance Request Form was easy to fill out (89%), with 76% strongly agreeing, and that someone had followed up with them quickly after submitting the form (93%), with 82% strongly agreeing. Further, the vast majority of respondents reported that they were likely to use the Assistance Request Form again (87%), with 65% saying they were extremely likely to do so, and that they would recommend the form to a friend or family member (93%), with 81% stating that they were extremely likely to do so. The significance of these results indicates increased self-efficacy among individuals seeking care through our self-referral options and improved knowledge and awareness of resources in their community for recurring needs.

Our research also demonstrates that "health care, public health, and human service providers experience better efficiency, convenience, and outcomes in workflows supported by health IT." Plan, p. 17. In a cross-sectional survey of 391 Unite Us end users, the majority reported saving 1 to 4 hours per week using Unite Us for care coordination. Similarly, a longitudinal survey of 101 Unite Us end users documenting time spent on social care coordination activities prior to and after the implementation of Unite Us demonstrated an efficiency gain of more than 85,000 hours in 2023 alone across all Unite Us networks. Corroborating these findings, one Florida health system conducted its own study of how our technology impacted staff efficiency, concluding that it saved 3.97 hours per week per case manager. In these ways, Unite Us has helped health and social care providers work more efficiently by decreasing documentation burden, administrative inefficiencies, and provider burnout.

¹ Dana Drzayich Antol et al., "Change in Self Reported Health: A Signal for Early Intervention in a Medicare Population," *Healthcare* (Vol. 10, Issue 1) (Mar. 2022) (finding that for every reported unhealthy day, healthcare costs increased by \$8 per member per month).

We encourage **ONC and other federal agencies to engage Unite Us to understand areas of focus and opportunity to “advance health equity by using health data that includes underrepresented groups” and to ensure “patients experience expanded access to quality care and reduced or eliminated health disparities” across health and social care services, considering issues related to social determinants of health (SDOH).** Plan, pp. 12, 18. We also encourage federal agencies to continue to support policies and invest in studies that support the coordination between health and social care.

C. Enabling Social Care Payments

Unite Us further agrees that health IT should be used “to support payment for high-quality, value-based care,” which we have seen work to reduce health disparities. Plan, p. 13. In 2022, North Carolina launched the Healthy Opportunities Pilots (HOP), the nation’s first comprehensive program to provide evidence-based interventions—including housing, food, transportation, interpersonal safety, and toxic stress support services—to high-needs Medicaid enrollees.² Through an 1115 waiver, the federal government has authorized up to \$650 million in Medicaid funding to reimburse providers in North Carolina for these non-medical interventions over five years. This program will ensure that Medicaid members have timely access to critical social care services to improve their health.

Unite Us is proud to serve as the technology backbone connecting health plans, network leads, providers, and public entities engaged in HOP. With Unite Us’ Social Care Payments product, providers can manage eligibility and authorization, send referrals to contracted providers, securely track outcomes and document services, generate invoices, and efficiently manage reimbursement of social care services. By “us[ing] health IT to support payment for high-quality, value-based care,” providers that use Unite Us’ Social Care Payments product are able to “deliver high-quality care in a transparent, modern, and competitive market.” Plan, p. 13.

Since the program’s launch, we have reimbursed community-based organizations for more than \$69 million of services. To date, 95 percent of individuals identified by a care manager as eligible for the pilot were successfully enrolled in the program. After a service has been approved, providers accept the referral within two days on average. Only 2% of claims are rejected by the payer once submitted, compared to a national clinical rejection rate of 18%—reflecting the high-quality eligibility and invoicing process facilitated by Unite Us and its partners in North Carolina. Like ONC, Unite Us believes that by “leverag[ing] health IT to standardize data and processes related to electronic prior authorizations to allow for increased automation,” providers can “experience reduced administrative burden and improved timeliness of prior authorization decisions.” Plan, p. 16.

² “Healthy Opportunities Pilots,” North Carolina Department of Health and Human Services (NCDHHS) (last modified April 24, 2024), <https://www.ncdhhs.gov/about/departments-initiatives/healthy-opportunities/healthy-opportunities-pilots>.

Just last month, the North Carolina Department of Health and Human Services reported that “preliminary research from the program’s independent evaluation shows the state is spending about \$85 less in medical costs per Healthy Opportunities Pilots beneficiary per month,” and that “participants avoided a significant number of emergency department visits” and “have a reduced risk of food insecurity, housing instability and lack of access to transportation.”³ Our work supporting communities across North Carolina has also been recognized by the White House in its North Carolina Institute of Medicine⁴; the Center for American Progress⁵; Princeton School of Public and International Affairs⁶; and Politico.⁷ This year, Unite Us is on track to surpass more than \$100 million in social reimbursements across our Unite Us payments initiatives.

This successful approach to address social care needs and reduce disparities is one that we encourage the federal government to promote in more states and communities.

II. Connecting Systems and Data

Further, Unite Us supports ONC’s fourth goal to “connect health systems with health data,” Plan, p. 1, including by “[d]evelop[ing], align[ing], test[ing], and implement[ing] data standards to increase interoperability across the public health data systems” and by “[a]dvanc[ing] the use of forecasting and predictive analytics,” Plan, p.27.

A. Promoting Data Standardization and Interoperability

We commend ONC for prioritizing social care data collection and standardization in the Plan. We agree with ONC in the importance of “[a]dvanc[ing] standardization and interoperability of social determinants of health data” so that “[p]atients and health care providers benefit from data that

³ Healthy Opportunities Pilots Celebrate Two-Year Anniversary, NCDHHS (Apr. 2, 2024), <https://www.ncdhhs.gov/news/press-releases/2024/04/02/healthy-opportunities-pilots-celebrate-two-year-anniversary>.

⁴ North Carolina Institute of Medicine, “Lessons Learned Thus Far From North Carolina’s Healthy Opportunities Pilots” (Aug. 15, 2022), <https://nciom.org/lessons-learned-thus-far-from-north-carolinas-healthy-opportunities-pilots/>.

⁵ Center for American Progress, “How North Carolina Is Using Medicaid To Address Social Determinants of Health” (Feb. 3, 2022), <https://www.americanprogress.org/article/how-north-carolina-is-using-medicaid-to-address-social-determinants-of-health/>.

⁶ Princeton School of Public and International Affairs, “Advancing Health Equity in North Carolina: Recommendations for Improving Sickle Cell Disease and Maternal Health Care Among Medicaid Enrollees” (Feb. 2022), https://issuu.com/woodrowwilsonschool/docs/aca_report_final_3-20-2022.

⁷ Joanne Kenen, “Why North Carolina Might Be the Most Innovative Health Care State in America,” Politico (Oct. 24, 2019), <https://www.politico.com/agenda/story/2019/10/24/north-carolina-health-care-001291/>.

provides a more complete view of a person’s health”; that “interoperable and secure health information sharing through nationally adopted standards” will help ensure that “individuals’ health information is available across care settings for use in their care”; and that “[a]dvanc[ing] the collection and use of standardized social determinants of health data” will help “reduce health and health care inequities and disparities” and ensure that “[p]atients experience ethical and consistent high-quality care.” Plan, pp. 13–14; see *also id.* pp. 19, 23, 24, 27. Indeed, we recently submitted a comment letter (attached hereto) in support of ONC’s recent “Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing (HTI-1)” rule, which was aimed at enhancing interoperability of EHI, including through adoption of version 3 of the United States Core Data for Interoperability (USCDI v.3).

In our work across the country, we have seen the impact that standardized SDOH data and interoperability have on health outcomes. Our platform features more than one million services, with more than 170 standardized service types and more than 1,500 standardized and structured outcomes—helping to power networks of government, health care, and social care organizations coordinating care throughout the country. We enable data collection in alignment with USCDI v.3 standards in addition to myriad other industry standards, including HL7 FHIR (for information exchange); HL7 MDM and ORU messages (for screenings and status updates); ASC X12 837 file format (for claims); and Human Services Data Specifications and AIRS (for resource directories).

The Unite Us Platform also enables collection of structured data beyond these industry standards, including a robust range of additional SDOH-related data fields. We have developed standardized and structured data fields based on community-driven feedback over the last decade to describe the services they provide and individual outcomes in a consistent way across sectors. For example, with coordinated care networks powered by Unite Us, food pantries that receive requests for food boxes receive the same structured service type requests no matter where they are located—a food pantry in Florida will receive the same structured service type request as will a food pantry in Illinois or Rhode Island. The structured service types are also specific enough to ensure that granular distinctions in services are reflected. Similarly, government partners can meaningfully compare the impact of their investments in social care through structured outcomes data that are adopted by organizations using Unite Us throughout the country. **We encourage ONC to continue to look to successful, consensus-driven private sector efforts to improve SDOH data standardization such as the Gravity Project to support the definition and adoption of SDOH data standards across industries.**

Unite Us participates in several industry groups advancing interoperability and data standards, including the Sync for Social Needs Coalition, an industry-wide effort to pilot HL7 FHIR-based approaches for the collection and sharing of social needs screening results; Connecting for Better Health, a coalition advancing information exchange-related policies and programs in California; the National Association for the Social Determinants of Health, a multi-sector coalition of stakeholders working to advance effective policies and programs to address HRSNs and the broader SDOH; and

the Gravity Project, a national public collaborative that develops consensus-based data standards to improve how we share information on SDOH. Unite Us serves on the steering committee of the Gravity Project, and is co-leading two Gravity Project initiatives this year to standardize social needs service types as well as HRSN reimbursement processes and exchange standards.

In addition to data standardization, Unite Us has successfully interoperated using FHIR and other standards with EHR systems such as Epic, Cerner, and eCW; care management systems such as Virtual Health; and case management tools like Salesforce, which are commonly used by community-based organizations. This includes workflow integrations that enable users to launch our platform within their existing systems of record; APIs that enable easy searches for programs based on parameters including location, eligibility, language, and payment options; and APIs under development that enable users to receive back information into their system of record on referrals, cases, and structured outcomes that have been routed through our platform. We have also completed data integrations with state government partners—including state agencies, MCOs, and HIEs—and resource directory integrations with regional partners including United Ways and 211s throughout the country.

We applaud ONC’s efforts to promote the design and adoption of standardized data across partners and sectors, and have seen in our own work the value of standardized data sets—including that such data sets can help researchers assess the impact of multisectoral interventions. The collective action of community partners engaged in care coordination around individuals, generates community-driven data grounded in a unique community context. Unlike national datasets or even local datasets that are often lagging by years, data generated in the Unite Us Platform offers a robust locally-reflective, social care dataset that most importantly is updated in real-time. As ONC notes, “leverag[ing] individual, population, and public health data to inform action at local, state, Tribal, territorial, and federal levels” ensures that “[p]ublic health professionals can foster greater assessment, transparency, inclusion, resilience, and learning within and across the health system and the communities and populations they serve,” and “streamlin[ing] the secure access, exchange, and use of linked health and human services datasets” means “[r]esearchers, technology developers, and other health IT users can conduct enhanced population health planning, analysis of quality and patient outcomes across settings and programs, and clinical research.” Plan, pp. 11, 19. Indeed, locally-generated Unite Us data enables community organizations to gain more power and agency to be at the table to inform shared evidence-based decision making, and to demonstrate their need for sustained investment. This is an important strategy for dismantling structural and institutional barriers to health equity and de-siloing the way community investment decisions are reached. **We would welcome the opportunity to engage with ONC on how to promote the design and adoption of standardized data across partners and sectors based on our experience supporting cross-sector collaboration and research on the outcomes of these interventions.**

B. Advancing the Use of Forecasting and Predictive Analytics

In addition, to systematically measure the impact of SDOH challenges across a variety of demographics, geographies, and health outcomes definitions, Unite Us has developed an innovative analytics approach that defines and measures social and economic vulnerability. As the Plan notes, “[a]dvancing the use of forecasting and predictive analytics” will help ensure that “[e]fficient and effective decisions can be made to respond to outbreaks, emerging threats, and exposures.” Plan, p. 27. Informed by our expertise in designing and supporting structured data sharing across sectors to improve outcomes, Unite Us’ Social Needs System (SNS) classifies and organizes SDOH to help the healthcare industry understand, identify, measure, and quantify the specific social barriers and circumstances in which people live. In the 2023 Medicare Advantage Announcement, CMS included the Unite Us Social Needs System among other key SDOH data assets to consider in Medicare Advantage Star Ratings and risk adjustment.⁸

SDOH challenges vary from one population and individual to the next. Food insecurity and loneliness might represent the greatest influences on the health of an individual with diabetes living alone in rural Mississippi, while financial insecurity and health illiteracy might be the driving factors for a person with diabetes living with a spouse and children in a suburb of Atlanta. While Z-codes, surveys, and geographically-aggregated data provide helpful social and economic indicators, they all have limitations. Z-codes are rarely collected in connection with SDOH and therefore have limited use⁹; surveys are challenged by selection bias, response bias, and high administration costs; and geographically-aggregated data are mostly outdated and make broad assumptions about a large group of people living in a similar geography. For example, on average eleven thousand people live in a single zip code. Taking the average score and applying it to thousands of people living in diverse, heterogeneous communities dilutes the value of social needs data and undermines the importance of addressing social needs in a meaningful way.

The SNS score developed by Unite Us addresses these important factors to provide a comprehensive and precise measure of social need to advance health equity. Controlling for age, gender, and other attributes, a 10-point increase in the SNS score equates to a 13-percent increase in total cost of care, a 2021 internal analysis showed. This is because underlying social and economic challenges accelerate disease progression and lead to intensified use of the healthcare system (specifically emergency department and hospital services), as well as higher rates of adverse health events.

Social needs data and analytics provided through the SNS support a more data-driven approach to care management and integration of health and social care—ultimately leading to better health outcomes and experiences for individuals, especially in underrepresented groups. The SNS

⁸ See CMS, “Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies,” (Apr. 4, 2022), <https://www.cms.gov/files/document/2023-announcement.pdf>.

⁹ Unite Us has mapped ICD-10 Z-Codes to standard SDOH measures collected within our platform to enable organizations interested in advancing data standardization across existing measures.

provides the ability to measure the effectiveness of our healthcare and social care system over time, evaluating corresponding impacts on health, economic mobility, social well-being, and more. For example, one veterans services organization in North Carolina was able to use SNS to more deeply understand the needs and preferences of veterans in its community, learning that the population it served was four times more likely to be uninsured than the nation and more than twice as likely to have childcare needs than the general population in the state. By gaining these insights into the community it served, the organization could better tailor outreach to more efficiently and effectively reach those in need. Unite Us would welcome the opportunity to engage with ONC to help explore how forecasting and predictive analytics can help ensure that “[e]fficient and effective decisions can be made to respond to outbreaks, emerging threats, and exposures.” Plan, p. 27.

III. Prioritizing Privacy, Security, and Individual Rights

Throughout all this important work, trust and transparency remain the cornerstones of the Unite Us Platform. We agree with ONC that data collection should involve “consent for and understanding of secure sharing and use,” Plan, p. 21, and have implemented a robust, client-centered, and equitable process that requires each person seeking services to consent to share their information before any referrals can be sent on their behalf via our platform. No referral can be shared without the individual’s documented consent, which is visible to the organization coordinating care for that individual at all times. If an individual has revoked their consent, our technology does not permit a user to share that individual’s information with any other organization or user. We designed this process to protect individual privacy, while simultaneously removing barriers individuals face when seeking services and alleviating the challenges faced by health and social service providers when coordinating care.

Unite Us agrees that it is of critical importance to “implement appropriate mechanisms for privacy and security to protect EHI” and to “mitigate individual health information security and privacy risks,” Plan, p. 26, particularly as it relates to sensitive health and social care data. As described above, Unite Us takes this very seriously and encourages ONC and other federal agencies to encourage greater privacy protections to ensure “individuals can trust that their EHI is protected from unauthorized access, use, and disclosure,” Plan, p. 26.

Across the country, Unite Us—joined by state Medicaid directors, county health departments, veterans agencies, universities and local school board associations, non-profit community-based organizations, and community members (whose testimony is attached hereto)—has fought to protect people seeking care from legislation that runs counter to the principles, mission, vision, and policies advanced by ONC, including through the Plan. In Kansas, one such bill would have imposed unreasonable burdens on individuals seeking care—requiring them to re-tell their story to each provider they seek services from, even after they have signed a consent to share their information with their providers. Numerous health and social service organizations submitted testimony opposing the bill, including several county and local health departments, multiple child

advocacy organizations, the state’s association of school boards, the local United Way, and the state University’s Center for Public Partnerships and Research. One of the child advocacy organizations shared that it opposed the bill because it would “impact the ability of [individuals] to be referred to and access critical services like child care” and that “if families can no longer find child care because another barrier is in the way, the crisis will only worsen.” A county health department explained, “we are not sure what this bill is trying to solve.” When a similar bill was introduced in Rhode Island, the RI Office of Veterans Services testified against it, explaining that it was “likely to impose [an] extensive burden on community non-profits and Veteran-serving organizations.” Similar bills have also been opposed and defeated in Nebraska, Utah, Oklahoma, and West Virginia.

We ask that ONC consider addressing legislative activities that directly interfere with the goals and objectives set forth in the Plan, whether through its rulemaking or enforcement powers. We note that such legislation not only promotes information blocking, but it also runs counter to the latest guidance from HHS on the Confidentiality of Substance Use Disorder (SUD) Patient Records regulations at 42 CFR part 2 (“Part 2”), which aims to help increase coordination among providers treating patients for SUDs and improve patient health outcomes. The final rule permits the use and disclosure of Part 2 records based on a single patient consent given once for all future uses and disclosures for treatment, payment, and health care operations. By contrast, the proposed legislation requires that an individual consents to each additional organization that receives their information—a consent structure that ONC and HHS deemed too strict for even the most sensitive information.

Indeed, Unite Us recently wrote a comment letter in support of HHS’s modifications to the Part 2, attached hereto, applauding the agency’s efforts to “increase[] coordination among providers in treatment for substance use challenges,” while remaining sensitive to patient privacy concerns “to avoid discrimination in treatment.”¹⁰ As the market leader in empowering care coordination across the country, we have witnessed many of the challenges that individuals face when seeking services across siloed providers, as well as the difficulties that Part 2 providers manage when working to coordinate care with their partners. In our comment letter, we wrote: “Individuals with SUDs deserve equal access to coordinated networks of care to improve their health and well-being. Integrated whole-person care, which is critical for an individual’s health and well-being, requires that providers be able to share clinical information about the client’s treatment and their healthcare condition.”

Unite Us further agrees with ONC in the importance of “[s]upport[ing] individuals in accessing and using their EHI securely, privately, and without special effort” so that they “have usable EHI to understand and inform their health decisions, and can engage with their own health information in their preferred ways.” Plan, p. 9. When individuals have an “understanding of and control over their

¹⁰ HHS Proposes New Protections to Increase Care Coordination and Confidentiality for Patients With Substance Use Challenges (Nov. 28, 2022), <https://www.hhs.gov/about/news/2022/11/28/hhs-proposes-new-protections-increase-care-coordination-confidentiality-patients-substance-use-challenges.html>.

EHI,” they know “how to access and use their EHI, are aware of potential secondary uses of their data, and can make informed decisions concerning consent and data exchange.” Plan, p. 26. For these reasons, when accessing services through providers coordinating through our platform, individuals have the right to know what information is collected from their providers, the right to consent to the sharing of their information, the right to correct their information, the right to revoke consent to sharing their information, and the right to delete their information.

In addition to these fundamental rights, individuals seeking care should trust that their information will be protected and secure. At Unite Us, we protect all social care information as though it were protected health information, employing the same security measures required by HIPAA for all data on our platform, regardless of where it originates. Individuals can therefore “expect that their health information is safeguarded no matter where and how it is used” and “can trust that their EHI is protected from unauthorized access, use, and disclosure.” Plan, pp. 9, 26.

We also provide heightened protections for information subject to 42 CFR Part 2 and other federal and state protections, enabling providers that have historically been siloed to collaborate with their partners and improve outcomes. See Plan, p. 21 (“Researchers and other health IT users are protecting sensitive health information, while accessing a greater range of datasets.”). Our partners have welcomed this opportunity to securely connect across sectors:

“Normally, we are not able to use any other platforms because they could jeopardize the safety of survivors of gender-based violence. Not being able to receive and make referrals through other platforms kept us siloed. This is the first community-based referral connector system that we’ve ever seen that would meet our qualifications and ensure survivor safety. Unite Us worked closely with us to ensure that this platform could work for our population. This partnership creates more referral pathways for healthcare and other community-based organizations to connect survivors to our services that might not have otherwise been referred.” – *Executive Director of a Community Provider Serving Survivors of Domestic and Interpersonal Violence in Oregon*

By providing the technology and resources to support secure coordination across sectors, we alleviate the burdens imposed on resource-constrained providers serving our communities. As an organization certified under NIST 800-53, we help health and social care providers “integrate high-impact cybersecurity practices”—including those CBOs that have historically used less technically secure solutions due to resource constraints—so that they may “strengthen cyber preparedness, improve cyber resiliency, and ultimately protect patient health information and safety, and individual- and population-level data are protected from cybersecurity attacks, fraud, misuse, and other harms.” Plan, p. 26. **We encourage ONC to support direct funding opportunities for community-based organizations, safety net providers, and state and local governments to adopt the digital infrastructure required to support the initiatives set forth in the Plan and advance privacy and security across health and social care providers.**

When we develop new features for our solutions, we always take into account community feedback to ensure that the individuals in need of care and community partners serving them are heard. We listen to our community partners to reflect our shared vision to promote seamless access to care that centers the individual. As one community partner shared:

“Unite Us has successfully and easily linked families with whom I work and resources specific for their needs. I recently had a family with a variety of needs. The mother and her two children were living in a car but were able to get a home through a community program. Unfortunately, they did not have any furniture, lighting, clothing, or household goods. The mother was also interested in assistance in obtaining childcare and a job. The mother agreed to me entering her information into the Unite Us Platform. It took about five minutes or so. The mother was sent a text message from the program, where she had to give electronic permission for Unite Us to disseminate her information to the resources I had chosen. Within 24 hours, she was linked to a potential employer, financial resources, and community resources to meet their concrete needs. The mother has been so grateful for the resources and assistance.” – *Social Worker in West Virginia*

We encourage ONC to incorporate the perspectives of community based organizations as it refines the Plan, and we would be happy to help connect the agency with community partners working to help advance industry standards.

Conclusion

Unite Us sincerely appreciates the opportunity to provide feedback on this draft strategic plan and share our perspective. We look forward to working with you to address this important issue and to serve as a resource to support data sharing between health care and social care providers to improve health outcomes. If you have any questions or if there is any additional information Unite Us can provide, feel free to contact me.

Sincerely,

Esther Farkas

Esther Farkas
Chief Operating Officer
[Unite Us](#)

ATTACHMENTS

Unite Us HTI-1 Comment Letter



June 20, 2023

Submitted via Regulations.gov

Micky Tripathi, Ph.D., M.P.P.
National Coordinator for Health Information Technology
U.S. Department of Health and Human Services
330 C Street SW
Washington, DC 20201

RE: Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing, RIN 0955-AA03

Dear National Coordinator Tripathi:

I write on behalf of Unite Us, the nation's leading software company bringing sectors together to improve the health and well-being of communities. Thank you for the opportunity to respond to the proposed rule entitled "Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing," 88 Fed. Reg. 23,746 (Apr. 18, 2023), issued by the Office of the National Coordinator for Health Information Technology ("ONC") within the U.S. Department of Health and Human Services ("HHS"). We submit this comment to express our support for ONC's proposed policies that would improve interoperability of electronic health information ("EHI"), including adoption of version 3 of the United States Core Data for Interoperability ("USCDI v.3"). We also encourage ONC to consider and leverage existing data exchange infrastructures for care coordination and information exchange between providers and community-based organizations in developing its policies.

Background on Unite Us

Founded in 2013, Unite Us powers care coordination to eliminate silos between health and social care teams, reduce the burden placed on individuals seeking care, and improve health outcomes. Unite Us' intuitive platform enables health and social service organizations to coordinate and manage services for their clients, track referrals and outcomes together, and securely share information to facilitate care coordination. Our goal is to ensure every individual, no matter who they are or where they live, can access the critical services they need to live happy and healthy lives.

Unite Us is more than just a technology company—we are an active partner to the communities we serve, building comprehensive care networks and change management processes in order to increase access to services and empower the community to improve health outcomes. Over the past decade, Unite Us has grown nationally to power coordinated care networks in 44 states. We have facilitated over 17 million connections to care and enable access to more than one million services across the country, including housing, mental and behavioral health, transportation, education, employment, legal, food, and benefits assistance. We support Medicaid beneficiaries

throughout the country and provide the technology infrastructure for North Carolina's Healthy Opportunities Pilot and other key initiatives, including In Lieu of Services (ILOS) work in California. The growth of care coordination between health and social care organizations since the pandemic has been exponential, illustrating the need to continue supporting this integrated work.

Trust and transparency are the cornerstones of the Unite Us Platform. We have implemented a robust, client-centered, and equitable process that requires each person seeking services to consent to share their information before any referrals can be sent on their behalf via our platform. No referral can be shared without the individual's documented consent, which is visible at all times to the organizations coordinating care for that individual. If an individual does not consent to share their information with other providers, the organization supporting that individual can still securely share information about resources directly with the individual through our platform. In addition, individuals seeking care always control the information they provide to the organizations supporting their care journey—the only information required to send a referral is first name, last name, and date of birth, and individuals can revoke their consent at any time. We designed this process to protect individual privacy, while simultaneously removing barriers individuals face when seeking services and alleviating the challenges faced by health and social service providers when coordinating care.

Unite Us protects social care information under the same strict security standards required for protected health information under HIPAA and is HITRUST and SOC-2 certified. In addition to strict user and organization-level permissions to protect data access, Unite Us has developed an innovative technological solution that features heightened protections for organizations that provide sensitive services or serve sensitive populations. Referrals sent by a sensitive organization are only visible to recipient organizations. These referrals are never viewable by other organizations within the network. Unite Us' industry-leading approach prioritizes client privacy while ensuring that organizations providing sensitive services can access and benefit from a coordinated care network to meet their clients' needs.

Comments

Unite Us agrees with ONC that “[t]ransparency regarding healthcare information and activities—as well as the interoperability and electronic exchange of health information—are all in the best interest of the patient and are central to the efforts of [HHS] to enhance and protect the health and well-being of all Americans.” 88 Fed. Reg. at 23,748. We write in support of ONC's efforts to enhance interoperability of EHI, including its proposal to adopt USCDI v.3, which would update the USCDI standard to include SDOH data elements.

In our work across the country, we have seen the impact that standardized SDOH data and interoperability have on health outcomes. Our platform features more than one million services,

with more than 170 standardized service types and more than 1,500 standardized and structured outcomes—helping to power networks of government, health care, and social care organizations coordinating care throughout the country. We enable data collection in alignment with USCDI v.3 standards in addition to myriad other industry standards, including HL7 FHIR (for information exchange); HL7 MDM and ORU messages (for screenings and status updates); ASC X12 837 file format (for claims); and Human Services Data Specifications and AIRS (for resource directories).

The Unite Us Platform also enables collection of structured data beyond these industry standards, including a robust range of additional SDOH-related data fields. We have developed standardized and structured data fields based on community-driven feedback over the last decade to describe the services they provide and individual outcomes in a consistent way across sectors. For example, with coordinated care networks powered by Unite Us, food pantries that receive requests for food boxes receive the same structured service type requests no matter where they are located—a food pantry in Florida will receive the same structured service type request as will a food pantry in Illinois or Rhode Island. The structured service types are also specific enough to ensure that granular distinctions in services are reflected. Similarly, government partners can meaningfully compare the impact of their investments in social care through structured outcomes data that are adopted by organizations using Unite Us throughout the country. We encourage ONC to continue to look to successful private sector efforts to improve SDOH data standardization.

In addition to data standardization, Unite Us has successfully interoperated using FHIR and other standards with EHR systems such as Epic, Cerner, and eCW; care management systems such as Virtual Health; and case management tools like Salesforce, which are commonly used by community-based organizations. This includes workflow integrations that enable users to launch our platform within their existing systems of record; APIs that enable easy searches for programs based on parameters including location, eligibility, language, and payment options; and APIs under development that enable users to receive back information into their system of record on referrals, cases, and structured outcomes that have been routed through our platform.

We have also completed data integrations with state government partners—including state agencies, MCOs, and HIEs—and resource directory integrations with regional partners including United Ways and 211s throughout the country. We participate in several industry groups advancing interoperability and data standards, including the Sync for Social Needs Coalition, an industry-wide effort to pilot HL7 FHIR-based approaches for the collection and sharing of social needs screening results; Civitas, a national member-organization advancing data-sharing policies and collaborations; and the Gravity Project, a national public collaborative that develops consensus-based data standards to improve how we share information on social determinants of health.

We applaud ONC's efforts to promote the design and adoption of standardized data across partners and sectors as they work to standardize their data sets to improve health equity. In our

own work we have seen the enormous impact that data standardization and interoperability can have on health outcomes. For example:

- In Florida, new mothers referred to services through Unite Us experienced a statistically significant reduction in all-cause hospital (re)admissions. Specifically, findings from a retrospective, matched case-control study at one of our provider partner hospitals showed that new mothers referred to services through Unite Us experienced a greater than 50% reduction in odds of all-cause hospital admission at three months as compared to those not referred for services through Unite Us.
- In Kentucky, individuals participating in a Louisville housing pilot powered by our technology 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.
- In New Jersey, a pilot led by community health workers using our technology to screen for and address social needs—including by referring individuals to local community organizations—documented a 25% reduction in total cost of care. The individuals served through our technology experienced a 24% reduction in emergency department utilization and a 60% increase in behavioral health care utilization.

These improved outcomes would not be possible without our focus on SDOH data standardization and cross-sector interoperability efforts, and they emphasize the importance of updating the USCDI standard to include SDOH data elements.

Conclusion

Unite Us sincerely appreciates the opportunity to provide feedback on this proposed rulemaking and share our perspective. We look forward to working with you to address this important issue and to serve as a resource to support data sharing between health care and social care providers to improve health outcomes. If you have any questions or if there is any additional information Unite Us can provide, feel free to contact me.

Sincerely,



Esther Farkas
Chief Operating Officer
[Unite Us](https://www.uniteus.com)

Testimony from State Legislatures



March 21, 2023

Daniel Klaassen, Education Policy Advisor
Kansas Action for Children
Opponent Written Testimony on SB 234
Senate Committee on Public Health and Welfare

Chairperson Gossage and members of the Committee,

Thank you for the opportunity to provide testimony in opposition to SB 234, which prevents the sharing of information with closed-loop referral systems. Kansas Action for Children is a nonprofit, nonpartisan advocacy organization working to make Kansas a place where every child has the opportunity to grow up healthy and thrive.

Kansans rely on a variety of different services to meet their needs. From health care and transportation to education and child care, every resident benefits from these public services in some way. We agree that individuals' personal information should be greatly protected. However, when agencies are allowed to share information, the application process is simplified and Kansans can receive the benefits of those services more quickly.

While the intent of the bill seems to be to protect personal information, in reality, it will impact the ability of Kansans to be referred to and access critical services like child care. Requiring an individual to consent at each instance of a referral is a high bar that could take a significant portion of an individual's or organization's time. While this may protect some information, the impact of more barriers to learning about resources could be greater. For instance, if families can no longer find child care because another barrier is in the way, the crisis will only worsen.

Proponents of this bill give the following scenario. A woman enters a domestic violence shelter and also picks up food from a food pantry. She shares information with the shelter, but the shelter cannot share any information with partners in their network. Seemingly, it would be beneficial to protect her private information. However, if we examine the impact more closely, we find that further help for someone in such a situation would be difficult to provide. This woman could benefit from services provided by in-network partners that she qualifies for, but without her documented consent, they are unable to refer her to another organization.

With much uncertainty around the implications and unintended consequences, it would be imprudent to advance this bill out of committee. Kansas Action for Children stands in opposition to SB 234.

Thank you for the opportunity to share information with you today. Feel free to reach me if you have any questions at daniel@kac.org



Kansas Children's Service League

Stronger families start here.

Senate Committee on Health and Public Welfare

SB 234

Written Neutral Testimony

March 21, 2023

Thank you Chair Gossage, Vice Chair Erickson, Ranking Minority Member Pettey and Committee Members for the opportunity to provide written neutral testimony of SB 234. Kansas Children's Service League (KCSL) is a statewide private, non-profit, 501(c)3 serving children and their families. We are the Kansas Chapter for Prevent Child Abuse America.

Childhood adversity includes abuse and neglect as well as other household dysfunctions. The childhood trauma stemming from adversity can have a profound impact on social connections, school readiness, and an increased likelihood of developing negative coping mechanisms. BUT we also know children and adults who have experienced adversity have great capacity to also build resiliency. **Ensuring parents have access to concrete supports and services has been shown to reduce household stressors which can contribute to child abuse and neglect.**

One of the primary roles KCSL has as a part of the chapter network for Prevent Child Abuse America, is a 24/7 parent helpline which is available to parents 365 days a year. This parent helpline allows parents to seek out resources in their community. Over the past four years KCSL has worked with state departments, including KDHE, DCF, KSDE, KDOC and CCTF to promote awareness and utilization of 1-800-CHILDREN. During this time, we entered a formal partnership with FindHelp. 1-800-CHILDREN call line, website, and mobile app is a closed loop referral system. All searches and calls are anonymous UNLESS a parent chooses to provide their information for the purpose of KCSL sending a referral to an organization. KCSL also works with other resources and referral systems, including IRIS, based on local partner requests.

KCSL would recommend the following amendments to SB 237, to ensure parents and ultimately children are able to continue to access the necessary services they need without an undue financial burden on local non-profit providers.

- Ensure that the proposed law does not disrupt established childcare, mental health, public health, family support, and prevention services referral networks.
- Allow a grace period for existing closed-loop referral networks to review the law and make needed changes to come into compliance.
- Encourage coordination between referral platforms for the investments local communities have already made for existing practices to continue.

Thank you for your consideration.

Gail Cozadd, CEO

785-215-6401

gcozadd@kcsl.org



United Way of Kaw Valley

To: Senate Committee on Public Health & Welfare
From: Jessica Lehnherr, CEO, United Way of Kaw Valley
Date: March 20, 2023
RE: Opposition to SB 234

Dear Chair Gossage and Committee Members,

United Way of Kaw Valley (UWKV) brings together people, companies, and nonprofits to help individuals and families not just survive but thrive. We work to solve issues no single donor, charity or government agency can handle alone. We work with residents, and public and private partners to co-create solutions that ensure everyone has the resources, support, opportunities, and networks they need to thrive.

We strongly oppose SB 234 as it makes it more difficult for our partners, like our local health departments, to participate in our network. Many of the information privacy provisions of this bill already exist within our network, and our local health department carries out key programs which are vital to our network. We need fewer barriers to their participation not more.

For more than four years, we have worked with cross-sector partners to build a community coordinated resource and referral network across Shawnee County to improve outcomes for individuals and families across our community. Through this network of partners with our largest hospital system, largest school district, and nonprofits large and small, we are working to provide more opportunities for individuals and families to remove barriers to access and find the resources they need to live healthy lives. This system of partners will:

- Reduce costs through upstream approaches to care that ensure people have the resources they need to avoid crisis situations;
- Improve systems of care delivery through key partnerships that ultimately drive down health care costs as hospital systems rely on the expertise of community based organizations;
- Improve the health of Kansans so that more individuals can provide for their families and go beyond meeting just their most basic needs.

Thank you for your service on behalf of our State.

Sincerely,

A handwritten signature in black ink that reads "Jessica Lehnherr".

Jessica Lehnherr
President and CEO, United Way of Kaw Valley

UNTIL THE FIGHT IS WON

Creating and cultivating an unbreakable network of support
for a strong, healthy and equitable community

Leave a legacy of impact.

United Way of Kaw Valley
Topeka Office
1527 SW Fairlawn Rd
Topeka, KS 66604

**SALINE COUNTY
HEALTH DEPARTMENT**



We are good for your health!

Administration
785-826-6600
Fax: 785-826-6605

Child Care Services
785-826-6600
Fax: 785-826-6605

Clinic Services
785-826-6602
Fax: 785-826-6619

Home Health Agency
785-826-6606
Fax: 785-826-6652

MCH
785-826-6600
Fax: 785-826-6605

WIC
785-826-6603
Fax: 785-826-6619

Saline County Health Department
125 W. Elm
Salina, KS 67401

Testimony by Jason Tiller with the Saline County Health Department to

Senate Committee on Public Health and Welfare

Written Opponent for SB 234 • March 21, 2023

Chair Gossage and Members of the Committee,

Thank you for the opportunity to provide written testimony in opposition to Senate Bill 234 prohibiting governmental entities from sharing or transmitting social care information into a closed loop referral system.

SB 234, if passed, would have serious negative consequences on providing and coordinating social care services to our populations. Closed loop referral systems have several layers of built-in security and segmenting of information to prevent others from seeing client information they are not privileged to see. Over the course of one encounter with a client, multiple referrals may need to be generated which would cause the client to sign multiple consent forms. This would create a burdensome level of resource use on the health department, but more importantly, would create a burdensome level of resource use on the client to sign each consent. Furthermore, referrals may be rejected because of capacity issues or several other reasons causing the client further issues such as trying to find a ride, taking time off work or missing school to simply come back to the health department to sign another consent. This scenario would only accomplish prolonging clients from receiving the services they need. Clients are informed throughout their care of what agencies they will be referred to and adding another layer of bureaucracy does nothing to serve their best interest.

Privacy Laws protecting health information (i.e. HIPAA) already exist. Care coordination across multiple agencies is necessary to ensure the right care at the right places through efficient referral processes such as those offered through closed loop referral systems that help ensure clients do not fall between the cracks in their care.

I ask that you do not recommend the passage of SB 234 out of committee.

Respectfully,

A handwritten signature in cursive script that reads "Jason K. Tiller".

Jason K. Tiller, Director
Saline County Health Department



Opponent Testimony for SB 234
Committee on Public Health and Welfare
March 19, 2023

Chair and Members of the Committee,

I am submitting this testimony in opposition of SB 234 in my role as director of the University of Kansas, Center for Public Partnerships and Research (CPPR). We strongly support data privacy and protection standards and the intent of the bill. As proposed, the legislation's specificity and restrictions, however, will make it challenging for communities to continue to use IRIS and other systems. We offer recommendations under which we could support this bill.

CPPR builds and implements tools and resources that help children and families have better access to services designed to support their health and well-being. In 2017, we built IRIS – a web-based closed-loop referral tool designed to support bi-directional referrals for services (e.g., healthcare, public health, social supports, education, early childhood, housing, transportation) between providers within a community catchment area. IRIS has been active in Kansas for seven years. IRIS is supported by an evidence-informed implementation framework that leads community champions and partners through adaptive processes, policies, and procedures to better coordinate services and ensure individuals have equitable access.

Families recognize and experience high quality coordination among partners in a community, including when staff communicate across agencies and organizations and depend on organizations to know when to refer and understand services across the community (Ervin, 2004). Individuals and families who have positive experiences with coordination are more likely to participate in services and perceive them as useful. IRIS was built on the premise of family choice and the protection of data.

There are currently nine IRIS networks in Kansas, spanning 21 counties and 542 partner organizations. These cross-sector community networks include health systems, community based early childhood service providers, mental and behavioral health organizations, and public health departments. With support from Kansas state agencies, these robust and engaged community networks have connected more than 15,000 Kansas families to services through more than 23,000 referrals.

The IRIS referral workflow contains multiple checkpoints to ensure that client consent has been obtained. IRIS users are required to affirm that they have received appropriate consent from the individual being referred. First, prior to entering any personally identifying information (PII), staff must affirm that the individual provided consent for their PII (name, date of birth, phone number) to be shared through IRIS. Additionally, staff must affirm that they received appropriate consent for each referral. IRIS provides resources to guide the development of consent practices that align both with IRIS best practices and any applicable privacy laws and/or confidentiality regulations.



The IRIS community-driven networks matter for Kansas because:

- Through local control and collaboration, communities have addressed client consent and data privacy through MOUs, mutual client consent forms and practice, data use agreements, local governance, and referral tool consent check.
- Local communities are best suited to determine how and what data is valuable for them and how to apply client consent protocols and data privacy protections that address applicable privacy laws and/or confidentiality regulations specific to each organization.
- Communities achieve better health and well-being outcomes for their members when they know and understand the array of services received by individuals and the multiple touchpoints within their referral network.
- Kansas communities use this community-level data to make decisions about how to engage families and improve services and access.

Before exchanging a single referral, IRIS community partners establish community-driven and community specific standards for how they will implement the platform, including how they will address client consent, data ownership, and data governance. Some communities develop a shared written client consent document, others agree to minimum expectations for client consent while allowing individual organizations to follow consent protocols that meet their specific regulatory standards.

We respectfully propose that the bill be amended to:

- Ensure that the proposed law does not disrupt established child care, mental health, public health, family support, and prevention services referral networks.
- Allow a grace period for existing closed-loop referral networks to review the law and make needed changes to get into compliance.
- Encourage coordination between referral platforms (IRIS, findhelp, Unite Us, Community CareLink, 1-800-CHILDREN) and using Application Programming Interfaces (APIs) to maintain community investments in existing practices.

Thank you for the opportunity to provide written testimony on SB 234. We have included a description of the IRIS network and our data privacy standards. Again, we strongly support data privacy and protection standards and would like to be part of a cohesive strategy that honors the community work and state investments that have already established a strong referral system. We look forward to partnering with other developers and community partners to develop these standards.

Sincerely,



Jackie Counts
Director



Growing a Connected Network Around a Family

A simple, data-driven communication tool paired with community generated solutions.



14,707
KANSAS FAMILIES

Unduplicated number of individuals who were the subject of at least one referral in IRIS.



23,259
REFERRALS

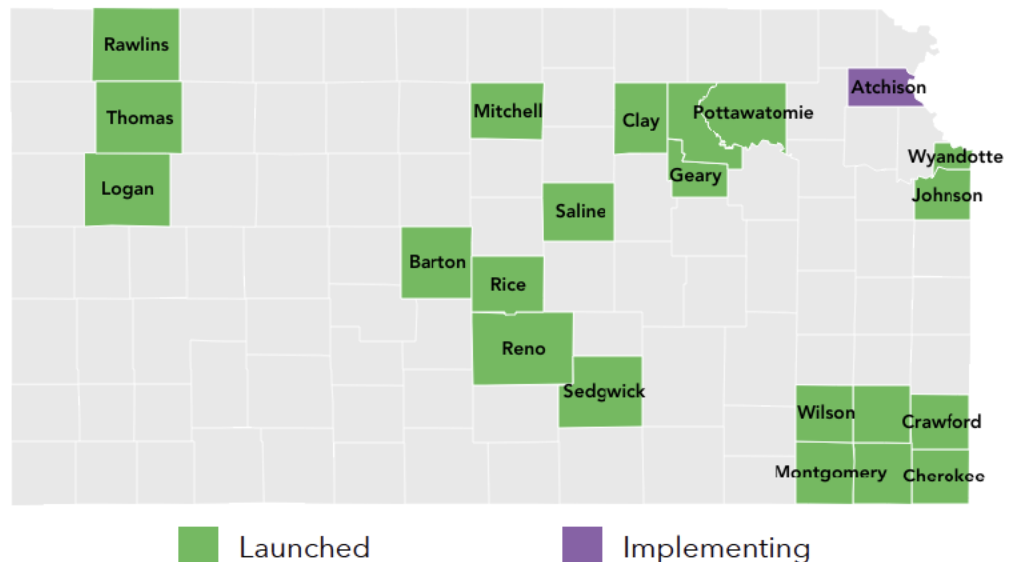
Many families were involved in multiple referrals.



42.6%
ENROLLED IN SERVICES

Families connected with needed services in IRIS communities.

COMMUNITIES	LAUNCH	CHAMPION
Atchison County	Implementing	Atchison County Housing Authority
Barton & Rice Counties	6/3/19	Barton County Health Department
Cherokee, Crawford, Labette, Montgomery, Neosho, & Wilson Counties	12/11/17	Four County Mental Health & My Family-Cherokee County
Clay, Geary, Riley, & Pottawatomie Counties	5/27/22	Clay, Riley, & Pottawatomie County Health Departments, Delivering Change
Jackson (MO), Johnson, & Wyandotte Counties	3/11/22	Jackson County Health Department, Johnson County Department of Health & Environment, Community Health Council of Wyandotte, Connections
Mitchell County	11/15/19	Mitchell County Regional Medical Foundation
Reno County	10/1/18	Hutchinson Community Foundation
Saline County	9/30/19	Saline County Health Department
Sedgwick County	3/4/19	Sedgwick County Health Department
Thomas, Logan, & Rawlins Counties	10/20/21	Northwest Kansas Educational Service Center



The Clay County IRIS Community merged into the Geary, Riley, & Pottawatomie Counties' Community on February 15, 2023.



IRIS Data Privacy Standards

WHAT IS IRIS?

The Integrated Referral and Intake System (IRIS) is a web-based communication tool used for sending, receiving, and updating information about referrals. IRIS is managed by the Center for Public Partnerships and Research at the University of Kansas. Each IRIS network is made up of a group of organizations and their staff (users) who send and receive referrals to one another. Each network is supported by one or more local user(s) with access to all referral information, known as the Data Manager.

WHAT INFORMATION IS SHARED IN IRIS?

Information entered and stored in IRIS includes client contact information (first and last name, birth date, phone number, and/or e-mail address), other details needed to make a referral, and referral results. Client contact information can be seen by all users in the IRIS network. Details about each referral can only be seen by the Data Manager(s) and the users at the organization sending or receiving the referral.

HOW IS DATA PRIVACY MANAGED?

Before joining an IRIS network, each partner organization must affirm that families will be given the choice to consent for their personally identifying information to be shared. All IRIS users must treat personal data in IRIS as private and clients must consent before their personal information is entered and before every referral. While procedures for gaining consent lie outside of IRIS and are the responsibility of each organization, IRIS provides resources to guide the development of consent practices that align both with IRIS minimum standards and any applicable privacy laws and/or confidentiality regulations.

The IRIS tool meets applicable law to reasonably maintain the privacy and security of personal information. Safety measures include regular audits, mandatory IRIS staff training, policies requiring appropriate handling of secure information, encrypting data while at rest and during transmission, housing data on HIPAA-compliant cloud storage solution, and single-user logins.

**Testimony of D. Charles Hunt, M.P.H.
To the Senate Committee on Public Health and Welfare
Opponent for Senate Bill 234
March 21, 2023**

Chair Gossage and Members of the Committee:

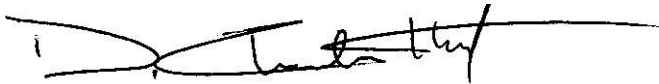
Thank you for the opportunity to provide written testimony in opposition to Senate Bill 234 regarding closed loop referral systems. Johnson County acknowledges the importance of safeguarding the social care information of individuals who entrust us to provide services to them. However, I would like to highlight several concerns we have about this bill:

- The requirement in SB 234 to obtain consent for each instance of referral is overly burdensome. We take great care to explain the referral process for our clients and patients, and we obtain their general consent to share their information with other providers for the purpose of coordinating care and services. However, it is not practical to obtain and document consent for each instance.
- We also are concerned about the broad and vague nature of the definition of “closed loop referral system” and the full potential implications of the bill.

Our Department and other departments in Johnson County have stringent policies and procedures in place to protect the privacy and confidentiality of our clients and patients, and we comply with applicable federal and state privacy laws. If enacted, this bill would create special privacy procedures for specific services and would cause additional burden and confusion for our clients and patients.

Thank you for your consideration.

Sincerely,



D. Charles Hunt, M.P.H.
Deputy Director/Interim Director



Kansas Association of Local Health Departments
715 SW 10th Avenue
Topeka, KS 66612
Phone: 785-271-8391
www.kalhd.org

Healthy People Build Strong Communities

Testimony by Dennis Kriesel with the Kansas Association of Local Health Departments (KALHD) to

Senate Committee on Public Health and Welfare

Written Opponent for SB 234 • March 21, 2023

Chair Gossage and Members of the Committee,

Thank you for the opportunity to provide written testimony in opposition to Senate Bill 234 prohibiting governmental entities from sharing or transmitting social care information into a closed loop referral system. KALHD is a nonprofit association dedicated to strengthening local health departments for the purpose of improving and protecting the health of all Kansans.

KALHD has a couple of concerns with SB 234 and the negative impacts it could have:

- SB 234 specifies a requirement that individuals provide consent on each instance of a referral. Our concern is this could be very burdensome for both clients and local health department staff as a client would need to be re-contacted to submit yet another consent form when trying to initially get them referred to a social care provider (as potential providers might decline the referral for capacity reasons, for instance, requiring multiple entities to be approached to assist the client). This is our primary concern with the bill.
- SB 234 also has language impacting participating organizations requiring they restrict/prohibit access to individual social care information with any employee not necessary for the provision of services. We are concerned that this may have an impact on tangential employees who might not provide services to the individual but are critical to maintaining the closed-loop system or related software that communicates with it. Existing requirements on keeping such information confidential appear to be sufficient as-is and we worry SB 234 might cause some unforeseen issues with its strict mandates relating to restricted access.

Reading through SB 234 we are not sure what this bill is trying to solve. Personal, health-related data already has a lot of legal protections (e.g., HIPAA).

KALHD believes SB 234 would put in place unnecessary barriers to connecting clients to social care services they may need. As KALHD believes coordinated solutions are necessary to address gaps in social determinants of health, we think SB 234 would put up roadblocks to this important work. As such, we ask the committee to not recommend SB 234 favorably for passage.

Thank you.

Sincerely,

Dennis Kriesel

Executive Director, Kansas Association of Local Health Departments



SEDGWICK COUNTY
Health Department

Adrienne Byrne
Health Director

**Testimony by Adrienne Byrne, Sedgwick County Health Director to
Senate Committee on Public Health and Welfare
Written Opponent for SB 234 • March 21, 2023**

Chair Gossage and Members of the Committee,

Thank you for the opportunity to provide written testimony in opposition to Senate Bill 234 prohibiting governmental entities from sharing or transmitting social care information into a closed loop referral system. Sedgwick County Health Department's mission is *'To improve the health of our residents by preventing disease, promoting wellness and protecting the public from health threats.'*

Sedgwick County Health Department has a couple of concerns with SB 234 and the negative impacts it could have:

- SB 234 specifies a requirement that individuals provide consent on each instance of a referral. Our concern is this could be very burdensome for both clients and local health department staff as a client would need to be re-contacted to submit yet another consent form when trying to initially get them referred to a social care provider (as potential providers might decline the referral for capacity reasons, for instance, requiring multiple entities to be approached to assist the client). This is our primary concern with the bill.
- SB 234 also has language impacting participating organizations requiring they restrict/prohibit access to individual social care information with any employee not necessary for the provision of services. We are concerned that this may have an impact on tangential employees who might not provide services to the individual but are critical to maintaining the closed-loop system or related software that communicates with it. Existing requirements on keeping such information confidential appear to be sufficient as-is and we worry SB 234 might cause some unforeseen issues with its strict mandates relating to restricted access.

Reading through SB 234 we are not sure what this bill is trying to solve. Personal, health-related data already has a lot of legal protections (e.g., HIPAA).

Sedgwick County Health Department believes SB 234 would put in place unnecessary barriers to connecting clients to social care services they may need. As Sedgwick County Health Department believes coordinated solutions are necessary to address gaps in social determinants of health, we think SB 234 would put up roadblocks to this important work. As such, we ask the committee to not recommend SB 234 favorably for passage.

Thank you.

Sincerely,

Adrienne Byrne, Health Director
Sedgwick County Health Department





**Written opponent testimony on
SB 234,
Relating to public health and welfare
In
Senate Public Health and Welfare Committee
By
Leah Fliter, Assistant Executive Director of Advocacy
Kansas Association of School Boards
Lfliter@kasb.org**

March 21, 2023

Madam Chair and Members of the Committee,

KASB appears today in opposition to SB 234. Our legal staff believes SB 234 could prohibit school personnel from providing information about a student who is in crisis, in the event a parent or guardian can't be reached to provide consent.

Thank you.

PREPARED BY: Mikayla Findlay
 DATE PREPARED: January 18, 2023
 PHONE: 402-471-0062

LB 592

Revision: 00

FISCAL NOTE
LEGISLATIVE FISCAL ANALYST ESTIMATE

ESTIMATE OF FISCAL IMPACT – STATE AGENCIES (See narrative for political subdivision estimates)				
	FY 2023-24		FY 2024-25	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	\$3,243,840			
CASH FUNDS				
FEDERAL FUNDS	\$701,760			
OTHER FUNDS				
TOTAL FUNDS	\$3,945,600			

Any Fiscal Notes received from state agencies and political subdivisions are attached following the Legislative Fiscal Analyst Estimate.

The Department of Health and Human Services (DHHS) indicates many systems would be impacted by provisions of the bill restricting close-loop systems collecting social care information by government entities. DHHS lists costs to the Children Have A Right To Support (CHARTS) System, the Behavioral Health Central Database System (CDS), the Level 1 Screen System, the Medicaid Management Information System (MMIS), and the Nebraska Family Online Client User System (N-FOCUS) as databases that would need substantial changes. There is no basis to disagree with the estimated total cost of \$3,945,600 in FY24 however ongoing costs to maintain updates performed to obtain compliance should be minimal. DHHS indicates the bill has a potential impact to federal funding: if an individual refuses consent for information sharing they would not be able to send referrals thus jeopardizing federal funding in that case.

ADMINISTRATIVE SERVICES STATE BUDGET DIVISION: REVIEW OF AGENCY & POLT. SUB. RESPONSE			
LB:	592	AM:	AGENCY/POLT. SUB: Nebraska Department of Health & Human Services
REVIEWED BY:	Ann Linneman	DATE:	2-14-2023
		PHONE:	(402) 471-4180
COMMENTS: The Nebraska Department of Health and Human Services' analysis and estimate of fiscal impact to the department appears reasonable.			

ESTIMATE PROVIDED BY STATE AGENCY OR POLITICAL SUBDIVISION

State Agency or Political Subdivision Name:(2) Department of Health and Human Services

Prepared by: (3) John Meals

Date Prepared 2-13-2023

Phone: (5) 471-6719

	<u>FY 2023-2024</u>		<u>FY 2024-2025</u>	
	<u>EXPENDITURES</u>	<u>REVENUE</u>	<u>EXPENDITURES</u>	<u>REVENUE</u>
GENERAL FUNDS	\$3,243,840		\$3,243,840	
CASH FUNDS				
FEDERAL FUNDS	\$701,760		\$701,760	
OTHER FUNDS				
TOTAL FUNDS	\$3,945,600	\$0	\$3,945,600	\$0

Return by date specified or 72 hours prior to public hearing, whichever is earlier.

Explanation of Estimate:

LB592 places restrictions on close-loop systems collecting social care information provided by governmental entities.

An individual's personally identifiable information or social care information may be added to a closed-loop referral system only if: (1) The individual consents to its inclusion on each instance of a referral for services; and (2) The individual retains the right to revoke consent to be in the closed-loop referral system at any time. Sec. 8. (1) No participating organization utilizing a closed-loop referral system shall have access to an individual's personally identifiable information or social care information unless: (a) The individual has been referred to that participating organization for services; and (b) The individual has consented for that participating organization to access such information. (2) A participating organization shall have policies and controls in place defining staff roles necessary for the referral and provision of services and for the purpose of providing care coordination.

LB592 would impact multiple eligibility and enrollment systems and databases within the department. This fiscal impact is extremely difficult to project. The department consulted with the IT teams for our various systems and databases to create a projected fiscal impact.

Summary changes to these systems/databases and estimated impacts are as follows:

Children Have A Right To Support (CHARTS)

- Change to My Account web application to support electronic signature
- New document for the client to sign and return giving permission (or not) for the referral and monitoring
- Edits to existing referral process
- Updates to CHARTS security

Resource	Rate	Hours	Cost
Technical Analyst	\$100 per hour	2000	\$200,000
Business Analyst	\$80 per hour	2400	\$192,000
Total			\$392,000

Behavioral Health Central Database System (CDS)

Assumptions

- New consent screens
- New Revoke screens
- Database changes
- New reports

Work Involved

- Attend working meetings, gather requirement
- Development of screens
- Database changes
- Testing

Resource	Rate	Hours	Cost
Technical Analyst (4)	\$200 per hour	7040	\$1,408,000
Business Analyst (2)	\$120 per hour	1920	\$230,400
Total			\$1,638,400

Level 1 Screen System

Assumptions

- New Consent screens
- New Revoke screens
- Database changes
- New reports

Work Involved

- Attend working meetings, gather requirement
- Development of screens
- Database changes
- Testing

Resource	Rate	Hours	Cost
Technical Analyst (4)	\$100 per hour	7040	\$704,000
Business Analyst (2)	\$80 per hour	1920	\$153,600
Total			\$857,600

MMIS

Assumptions:

- The following MMIS interfaces would require consent
 - Managed Care Enrollment Broker
 - Managed Care Organizations
- Not included in our estimate
 - NF interfaces (PASRR / LOC / Casemix) – These are all inbound interfaces and would be estimated under the sending system if applicable
 - Therap – Eligibility information is coming from NFOCUS, they will just be sending MMIS auths and claims
 - Magellan FFS Pharmacy Benefits
- Consent would be tracked on the NFOCUS / iServe side, and would be checked at the point of application for Medicaid
- Consent not found would mean no managed care enrollment; we would simply cover FFS

Resource	Rate	Hours	Cost
Technical Analyst	\$100 per hour	1200	\$120,000
Business Analyst	\$80 per hour	1000	\$80,000
Total			\$200,000

NFOCUS

Assumptions

- New Consent screens
- New Revoke screens
- Database changes
- New reports

Work Involved

- Attend working meetings, gather requirement

- Development of screens
- Database changes
- Testing

(NFOCUS had a very difficult projection so a mid baseline matching the level one screening was used)

Resource	Rate	Hours	Cost
Technical Analyst (4)	\$100 per hour	7040	\$704,000
Business Analyst (2)	\$80 per hour	1920	\$153,600
Total			\$857,600

Summary by Fund Type

System	Total Funds	Federal	State
CHARTS	392,000	258,720	133,280
CDS	1,638,400		1,638,400
Lvl 1 Screen System	857,600		857,600
MMIS	200,000	100,000	100,000
NFOCUS	857,600	343,040	514,560
Total	3,945,600	701,760	3,243,840

Other Potential Impacts Not Included in the Fiscal Note Tables:

Child & Family Services (CFS)

There is a potential for this bill to require a system re-write as well as operational staff to support the re-write for the NFOCUS system. If this is required, the fiscal impact will be greatly increased.

LB592 has a possible impact on federal funding CFS receives. If an individual does not consent for their information to be shared, CFS would not be able to send referrals for programs that would be required for client participation. An individual would then **not be eligible for federally funded programs**. Fewer people participating in these programs would mean less Federal funding.

Developmental Disabilities (DD)

The fiscal impact of this bill is dependent on how the solution for tracking consent information is implemented. Costs associated with creation of a consent form and development of a procedure to utilize the consent form will occur regardless of how the solution is created. However, creating a robust solution that fully utilizes the IT systems used by DD will add more costs for the analysis and development of a solution.

Operations (OPS)

If a closed loop referral system were to be procured by the agency, IT and Procurement would need to be closely involved. Any agreements stemming from participation in a platform owned or operated by an outside entity would need to be reviewed by Legal and the Chief Data Strategist. The bill does not require participation in a closed loop system, it just sets out requirements if there is participation. To the extent that agency personnel participate in a closed loop referral system, the agency would need to draft consents and policies and procedures to ensure compliance.

MAJOR OBJECTS OF EXPENDITURE

PERSONAL SERVICES:				
POSITION TITLE	23-24	24-25	2023-2024 EXPENDITURES	2024-2025 EXPENDITURES
Benefits.....				
Operating.....			\$3,945,600	\$3,945,600
Travel.....				
Capital Outlay.....				
Aid.....				
Capital Improvements.....				
TOTAL.....			\$3,945,600	\$3,945,600



March 24, 2022

The Honorable Evan P. Shanley
Chair, House Committee on State Government and Elections
Rhode Island State House
82 Smith Street
Providence, RI 02903
via email: Rep-Shanley@rilegislature.gov
via email: HouseStateGovernmentandElections@rilegislature.gov

RE: H-7994 – Relating to State Affairs and Government – Office of Health and Human Services

Dear Chairman Shanley:

I write today regarding H-7994 – Relating to State Affairs and Government – Office of Health and Human Services (establishing privacy and security protections for closed-loop referral systems). The Office of Veterans Services acts as the statewide hub of the RIServes network, offering coordinated services to support our Veterans, service members, and their families, ensuring they have the opportunity to succeed in the civilian community. RIServes was the first integrated, no-wrong-door social services network launched in Rhode Island in 2017, and based upon that success, our partners at EOHHS expanded upon our partnership with UniteUs, the RIServes and EOHHS Community Resource Platform (CRP) platform provider.

Since the launch of RIServes, we have serviced over 2,000 cases and referrals; while that number is impressive, the most important part of RIServes is that every service member, Veteran and their family can easily access the full range of comprehensive services required – and the design of the network brings the formerly dispersed array of resources into a single location where providers are vetted and verified. RIServes has allowed warm hand-offs from one provider or referral entity to another, so we can make sure that a client is getting the services they've earned, deserve, and need – and most importantly, they don't slip through the cracks.

The RIServes platform uses the same strict privacy protocols as the EOHHS CRP, which implemented with best-practice privacy and consent policies, including the following:

- Consent is obtained from each individual before a referral is sent; the system will prompt the user to indicate whether consent was obtained.
- Out of an abundance of caution, all information in the CRP is treated as protected health information (PHI) covered under HIPAA. Unite Us is a signed Business Associate of EOHHS and of

each Medicaid provider entity using the system. This is a legal agreement that ensures privacy and security protections are in place for all PHI.

- The EOHHS Business Associate Agreement includes provisions that PHI will not be used or further disclosed except as permitted or required by law; that safeguards will be in place to prevent other use or disclosure; that any breaches or security incidents be reported within 48 hours; and that any known harmful effects due to use or disclosure of PHI be mitigated to the extent possible. All subcontractors and agents are subject to the same requirements.
- Integrations with Electronic Health Records (EHRs) improve provider workflows and are a high priority for busy medical offices. CRP integrations with EHRs are implemented to the highest current technical standard available (SMART on FHIR). The EOHHS contract for CRP requires that, as an EOHHS Business Associate subject to HIPAA, the minimum necessary patient information is received from the EHR to facilitate referrals for social needs.
- Information received from behavioral health programs and providers are held apart as sensitive information with additional security protocols.
- All of the entities in Rhode Island that use the CRP through their own contracts, including Lifespan, the Office of Veterans Services, and individual Accountable Entities, use these same strict privacy protocols. We carry out shared governance meetings, where we are able to review any updated privacy and security plans with Unite Us.

Several provisions of H7994, if enacted, raise concerns about the continued success of the RIServes network in Rhode Island:

- Requiring individual consent before information can be input into the system is likely to impose extensive burden on community non-profits and Veteran-serving organizations. It could discourage Veterans, service members, and their families from asking for help, since they would be asked for consent before there could be any conversation with the nonprofit organization.
- The bill as written would require substantial revision of participating organizations' existing workflows. Presently, consent is obtained in order to send each referral, which is common practice and does not introduce an additional administrative burden. The appropriate staff members are trained in meaningful consent and can carry it out during their interaction with the person receiving services. However, adding new, duplicative consent processes require specialized training, and every additional staff person obtaining consent would need to be fully trained on the details and nuances of the state law and closed-loop referral system. This introduces a staffing demand at a time when there are severe point-of-care staffing shortages and could deter providers and Veteran-serving organizations from offering referrals for social services at all.
- The legislation as written may also be seen to prohibit providers from integrating a closed loop referral system into their EHR systems at all. Ultimately, this means referrals will remain a time-consuming, manual process, and is likely to result in fewer Rhode Islanders receiving needed and timely referrals for social services.

RHODE ISLAND OFFICE OF VETERANS SERVICES

In addition, the provision to require “express consent” before any person or entity providing services related to a referral may access that individual’s records creates a difficult standard. Providers and Veteran-serving organizations typically form close working relationships over time between individual staff members, and the free flow of information as appropriate under HIPAA is critical to ensure the success of these relationships. Many service programs have eligibility criteria that require review of an individual’s records, and introducing additional steps into the referral review process will create unnecessary delays for individuals seeking services at what is often a crisis point in their lives. We welcome the opportunity to sit with the sponsor of the legislation, to discuss these issues, and we are happy to provide any additional information you might need.

As always, I thank you for your partnership and consideration of this letter. Your leadership and advocacy for Rhode Island’s Veterans and their families is appreciated.

Regards,



Kasim J. Yarn
Director

cc: The Honorable Members of the House State Government and Elections Committee
The Honorable Patricia Serpa
Nicole McCarty, Legal Counsel to the Speaker of the House

Unite Us Part 2 Comment Letter



January 31, 2023

Submitted via Regulations.gov

U.S. Department of Health and Human Services
Office for Civil Rights
Attn.: SUD Patient Records
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: Unite Us Comments to NPRM on Confidentiality of Substance Use Disorder Patient Records, Docket No. HHS-OCR-0945-AA16

Dear Secretary Becerra:

I write on behalf of Unite Us, a technology company that works to address social determinants of health by building coordinated care networks of health and social service providers.¹ Thank you for the opportunity to respond to the Notice of Proposed Rulemaking on Confidentiality of Substance Use Disorder (“SUD”) Patient Records (“NPRM”), 87 Fed. Reg. 74,216 (Dec. 2, 2022), issued by the Office for Civil Rights (“OCR”) and Substance Abuse and Mental Health Services Administration (“SAMHSA”) within the U.S. Department of Health and Human Services (“HHS”).

Unite Us supports HHS’s efforts to “increase[] coordination among providers in treatment for substance use challenges,” while remaining sensitive to patient privacy concerns “to avoid discrimination in treatment.”² Integrated whole person care—which is critical for an individual’s health and well being—requires that providers be able to share clinical information about a client’s treatment and their healthcare conditions. We submit this comment to express our support for the proposed rule and respond to several of HHS’s specific requests for comment.

Background on Unite Us

Founded in 2013, Unite Us powers data-driven care coordination to eliminate silos between health and social care teams, reduce the burden placed on individuals seeking care, and improve health outcomes. Originally created to serve veterans and military families, Unite Us has grown into a national movement to connect anyone seeking health or social care with the services they need. Unite Us’ intuitive platform enables health and social service organizations to coordinate and

¹ Unite Us is joined in these comments by numerous partners, including Accessible Pharmacy Services for the Blind, ChristianaCare, EveryMind, La Clinica, Pinetree Institute, and Public Health Solutions.

² HHS Proposes New Protections to Increase Care Coordination and Confidentiality for Patients With Substance Use Challenges (Nov. 28, 2022), <https://www.hhs.gov/about/news/2022/11/28/hhs-proposes-new-protections-increase-care-coordination-confidentiality-patients-substance-use-challenges.html>.

manage services for their clients, track referrals and outcomes together, and securely share information to facilitate care coordination. Our goal is to ensure every individual, no matter who they are or where they live, can access the critical services they need to live happy and healthy lives.

Unite Us is more than just a technology company—we are an active partner to the communities we serve, building comprehensive care networks and change management processes in order to increase access to services and empower the community to improve health outcomes. Over the past decade, Unite Us has grown nationally to power coordinated care networks in 44 states. We have facilitated over 10.4 million connections to care and enabled access to over 700,000 types of services, including housing, mental and behavioral health, transportation, education, employment, legal, food, and benefits assistance. The growth of care coordination between health and social care organizations since the pandemic has been exponential, illustrating the need to continue supporting this integrated work.

Trust and transparency are the cornerstones of the Unite Us Platform. We have implemented a robust, client-centered, and health equity–driven process that requires each person seeking services to consent to share their information before any referrals can be sent on their behalf via our platform. Unite Us also adheres to strict data privacy standards and is HITRUST and SOC-2 certified. In addition to strict user and organization-level permissions to protect data access, Unite Us provides heightened protections for sensitive data, including data subject to 42 CFR Part 2 and other data subject to additional federal and state protections. We take pride in our culture of compliance, which combines cross-team collaboration and training with industry-leading security practices and certifications.

General Comments

Unite Us applauds HHS’s efforts to facilitate greater integration of SUD treatment information within other PHI in order to “improve communication and care coordination between providers and others in the health care system,” thus enhancing their “ability to comprehensively diagnose and treat the whole patient.” 87 Fed. Reg. at 74,242. As the national leader in deploying community-wide coordinated care networks of health and social services, we believe our perspective and experience will benefit HHS as it considers these potential needs.

Unite Us also strongly believes in the importance of individual privacy. If individuals do not trust that their information will be kept confidential, they may choose not to seek SUD treatment. We believe that the proposed rule appropriately balances these important privacy concerns with the value of

information sharing,³ including by expanding prohibitions on the use and disclosure of Part 2 records in civil, criminal, administrative, and legislative proceedings. See, e.g., 87 Fed. Reg. at 74,232. Unite Us also acknowledges that HHS is currently developing a CARES Act antidiscrimination rule, *id.* at 74,217, and strongly supports enactment of the antidiscrimination rule.

As to the benefits of the proposed rule, Unite Us agrees with the nearly 50 organizations in the Partnership to Amend 42 CFR Part 2 that aligning Part 2 with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) helps ameliorate “the confusing requirements of Part 2, how Part 2 hinders access to medication-assisted treatment, and the stigma of SUDs.”⁴ Individuals with SUDs deserve equal access to coordinated networks of care to improve their health and well being, which HHS’s proposed modifications to Part 2 would help provide.

In an article cited by HHS,⁵ the medical director of one health system’s Division of Substance Abuse explains in concrete terms the harms Part 2 in its current form imposes. Because Part 2 “prevents programs and doctors who treat patients with substance use disorders from sharing any information about that treatment without explicit permission from the patient,” many doctors and other care team members “are treating patients with opioid and other substance use disorders without knowing about this diagnosis.”⁶ This means that individuals with opioid use disorder could be prescribed medications that negatively interact with those substances, or inadvertently placed in situations that put them at risk of relapse. Further, “[h]iding addiction disorders like this sends the message that they are somehow different from other brain diseases and inadvertently supports the stigma that surrounds them.”⁷

Similarly, in a 2014 public comment, Oregon’s largest coordinated care organization (“CCO”) explains that Part 2 prevents the behavioral health systems under its umbrella from coordinating care for patients with SUDs who see providers in multiple counties or across private health care

³ In a public comment, an organization that provides addiction treatment services in Illinois explains that while they “strongly support confidentiality protections for patients,” having “separate health information privacy requirements for substance abuse treatment patients does more harm to the patient, harm to their families and harm to their communities by necessitating a separate and unequal health data sharing environment that prevents the full inclusion of substance abuse treatment patients into integrated health settings and systems.” Published Comments - Request for Public Comment on the Confidentiality of Alcohol and Drug Abuse Patient Records, 79 Fed. Reg. 26,929 (May 2014), at PDF p.22, https://www.samhsa.gov/sites/default/files/about_us/who_we_are/comments-100-120.pdf (cited at 87 Fed. Reg. at 74,217 n.10).

⁴ Ltr. from Partnership to Amend 42 CFR Part 2 to Secretary Becerra (Jan. 8, 2021), https://aahd.us/wp-content/uploads/2021/01/PartnershipRecommendationsforNextPart2-uleLtrtoNomineeBecerra_01082021.pdf (cited at 87 Fed. Reg. at 74,217 n.9).

⁵ “Privacy Laws Are Hurting the Care of Patients with Addiction” (July 2018), <https://www.statnews.com/2018/07/13/privacy-laws-patients-addiction/> (cited at 87 Fed. Reg. at 74,217 n.10).

⁶ *Id.*

⁷ *Id.*

systems.⁸ Specifically, the CCO explains, providers' inability to share information about diagnoses impedes the integration of behavioral health with primary care. These barriers to care coordination imposed by Part 2 affect the 20% of the CCO's adult population that have SUDs, thus "undermining the State's ability to achieve the health transformation in which our state and federal governments have invested so heavily."⁹

The proposed modifications to Part 2 would help remedy these harms. The rule provides more flexibility for how Part 2 information may be shared after consent is obtained, and does not require that all potential recipients be listed in the consent, requiring instead a description of the classes of recipients who might receive the information. In these ways, the proposed rule helps align Part 2 with HIPAA and prevent unnecessary siloing of SUD information.¹⁰

Specific Comments

- 1. HHS requests comment on "the benefits and burdens of creating ... additional privacy protection for SUD counseling notes that are maintained primarily for use by the originator of the notes, similar to psychotherapy notes as defined in the Privacy Rule." 87 Fed. Reg. at 74,230.**

Unite Us understands the importance of maintaining the confidentiality of counseling sessions and supports maintaining strict protections for counseling session notes. We note that the Unite Us Platform's functionality enables providers to maintain these notes as strictly confidential, and we would defer to the experts who provide direct services to individuals with SUDs on the appropriate

⁸ Published Comments, *supra* n.3, at PDF p.20.

⁹ *Id.*

¹⁰ Some analysts have noted that "the proposed rule leaves in place the requirement that Part 2 programs ... generally must obtain patient consent prior to disclosing Part 2 information for [TPO] purposes." *HHS Proposes New Rule to Align "Part 2" SUD Provider Confidentiality with HIPAA Privacy Standards*, Manatt Health (Jan. 3, 2023), <https://www.manatt.com/insights/newsletters/health-highlights/hhs-proposes-new-rule-to-align-part-2-sud-provider>. In this manner, the rule departs from HIPAA, which does not require authorization when information is shared for TPO purposes. See, e.g., HHS HIPAA Guidance #3008, <https://www.hhs.gov/hipaa/for-professionals/faq/3008/does-hipaa-permit-health-care-providers-share-phi-individual-mental-illness-third-party-not-health-care-provider-continuity-care-purposes/index.html> ("[H]ealth care providers who believe that disclosures to certain social service entities are a necessary component of, or may help further, the individual's health or mental health care may disclose the minimum necessary PHI to such entities without the individual's authorization.")

Unite Us's standard consent model—which requires client consent before any information may be shared—is consistent with the proposed rule. We note that providers updating their processes and forms may face challenges in connection with the proposed rule's inclusion of a one-time consent specific to Part 2 information. Although the rule aims to bring Part 2 in alignment with HIPAA, it maintains this difference between HIPAA and Part 2—which may cause confusion for organizations accustomed to the standard TPO exceptions, which do not require authorization prior to disclosing information.

treatment of SUD counseling session notes. When using our product, providers can coordinate care and exchange information about a shared patient within a care team while maintaining private notes that are not disclosed to any other providers within the care team.

2. HHS requests comment on “[w]ays to make the proposed notices more easily understandable.” 87 Fed. Reg. at 74,248.

As part of our commitment to health equity, Unite Us has standardized and streamlined an intake process for health and social care providers that includes a consent form that is accessible to the average person. To be more easily understandable, our consent form does not use any specialized language, and is as short as possible while still conveying all the necessary information. Our consent form can be shared in multiple formats (e.g., via secure text, email, print, via in-person display, and other methods) and is translated into over forty-five languages (with additional translations available upon request). A social worker at a West Virginia community service provider explains how the Unite Us intake process works for her:

Unite Us has successfully and easily linked families with whom I work and resources specific for their needs. I recently had a family with a variety of needs. The mother and her two children were living in a car but were able to get a home through a community program. Unfortunately, they did not have any furniture, lighting, clothing, or household goods. The mother was also interested in assistance in obtaining childcare and a job. The mother agreed to me entering her information into the Unite Us Platform. It took about five minutes or so. **The mother was sent a text message from the program, where she had to give electronic permission for Unite Us to disseminate her information to the resources I had chosen. Within 24 hours, she was linked to a potential employer, financial resources, and community resources to meet their concrete needs.** The mother has been so grateful for the resources and assistance.

We designed our intake process to protect client privacy, while simultaneously removing barriers individuals face when seeking services and alleviating the challenges faced by health and social service providers when coordinating care. As the above example makes clear, the ease and accessibility of this process helps providers connect their clients to the services they need.

Conclusion

Unite Us sincerely appreciates the opportunity to comment on this NPRM and share our perspective on the importance of care coordination between health and social care entities, which is vastly improved by greater integration of SUD treatment info within other PHI. We look forward to

working with you to address this important issue. If you have any questions or if there is any additional information Unite Us can provide, feel free to contact me.

Sincerely,

Esther Farkas

Esther Farkas
Chief Strategy Officer
[Unite Us](#)