Learning from Innovation & Success in San Diego

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Community Information Exchange

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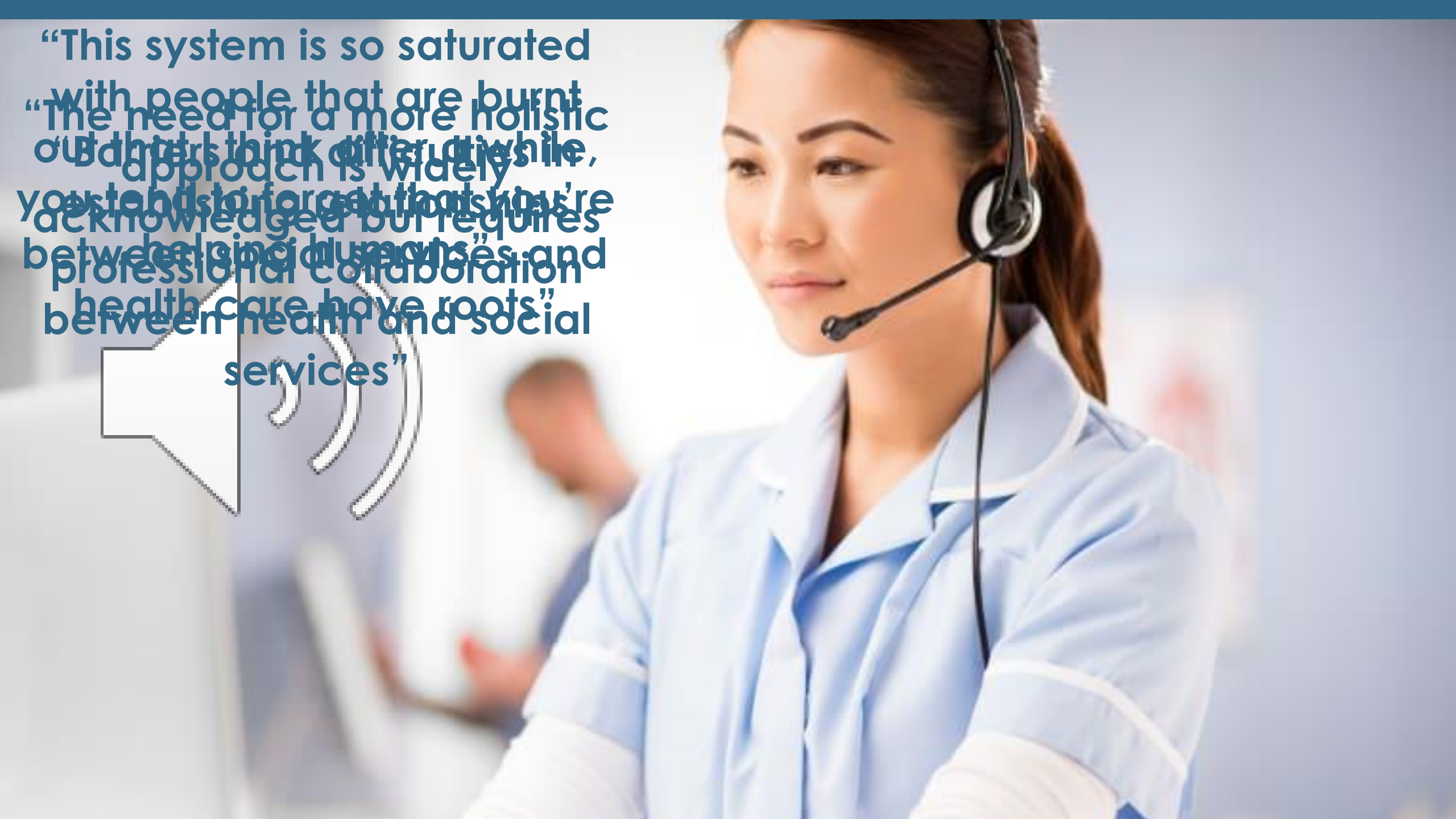
“This system is so saturated with people that are burnt out, that I think after a while, you tend to forget that you’re between human beings and health care have roots”
“The need for a more holistic approach is widely acknowledged but requires professional collaboration between health and social services”

211 History

Information and Referral (I&R) is the art, science and practice of bringing people and services together.

When individuals and families don't know where to turn, I&R is there for them.

1970

A program of United Way

1997

Atlanta launched the first 211

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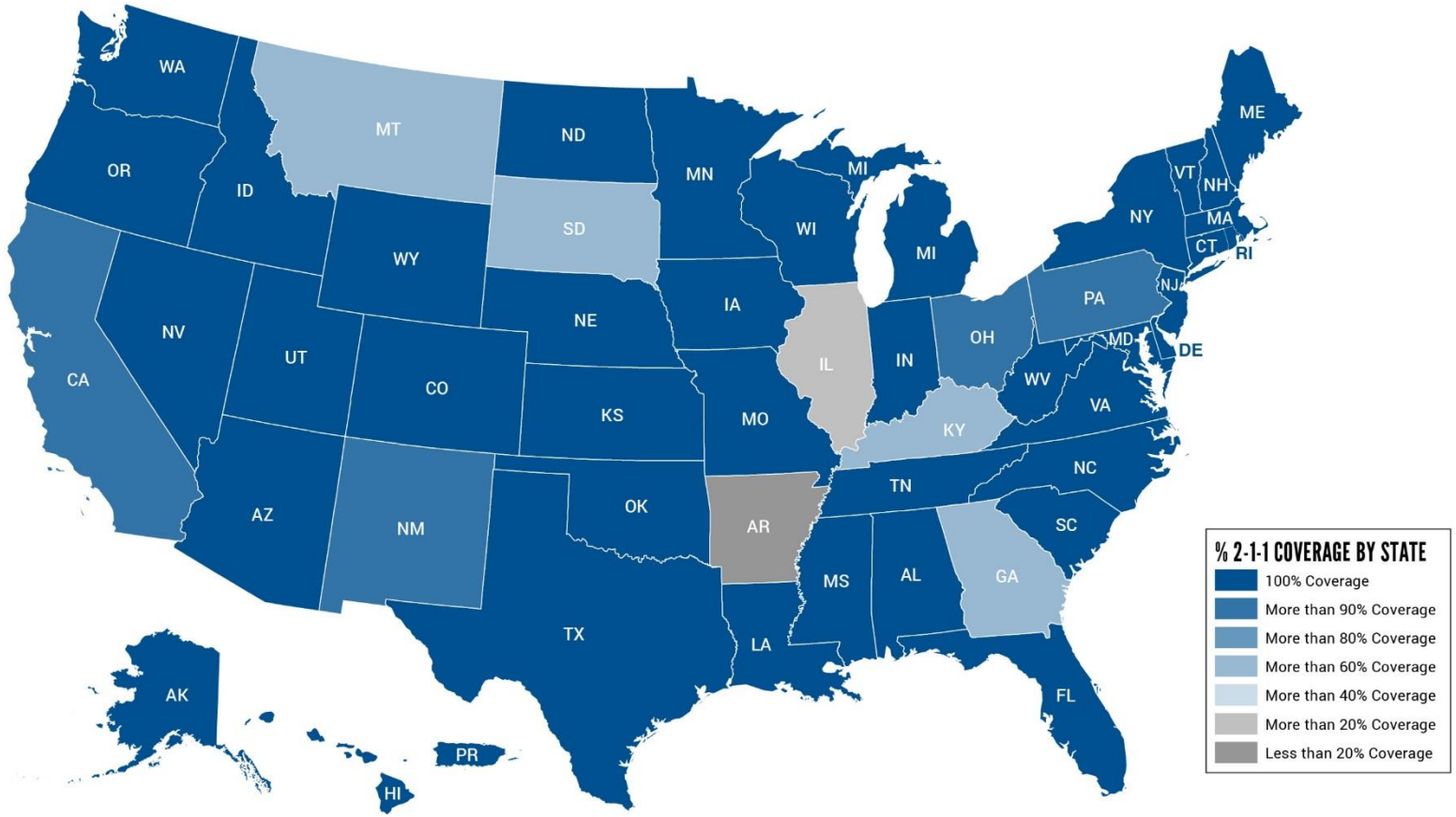
94.2% OVERALL COVERAGE

United Way • AIRS 2-1-1
Get Connected. Get Answers.

% of Population Covered* by 2-1-1 in Each State



Data produced by UWW and AIRS: June 2018

*Coverage is calculated by U.S. Census data.

SAN DIEGO

- **5th largest U.S. County**
- **18 municipalities**
- **18 tribal nations**
- **42 school districts**
- **Region is very diverse:**
  - Over 100 languages
  - Large military presence
  - Largest refugee resettlement site in CA
  - Busiest international border crossing in the world

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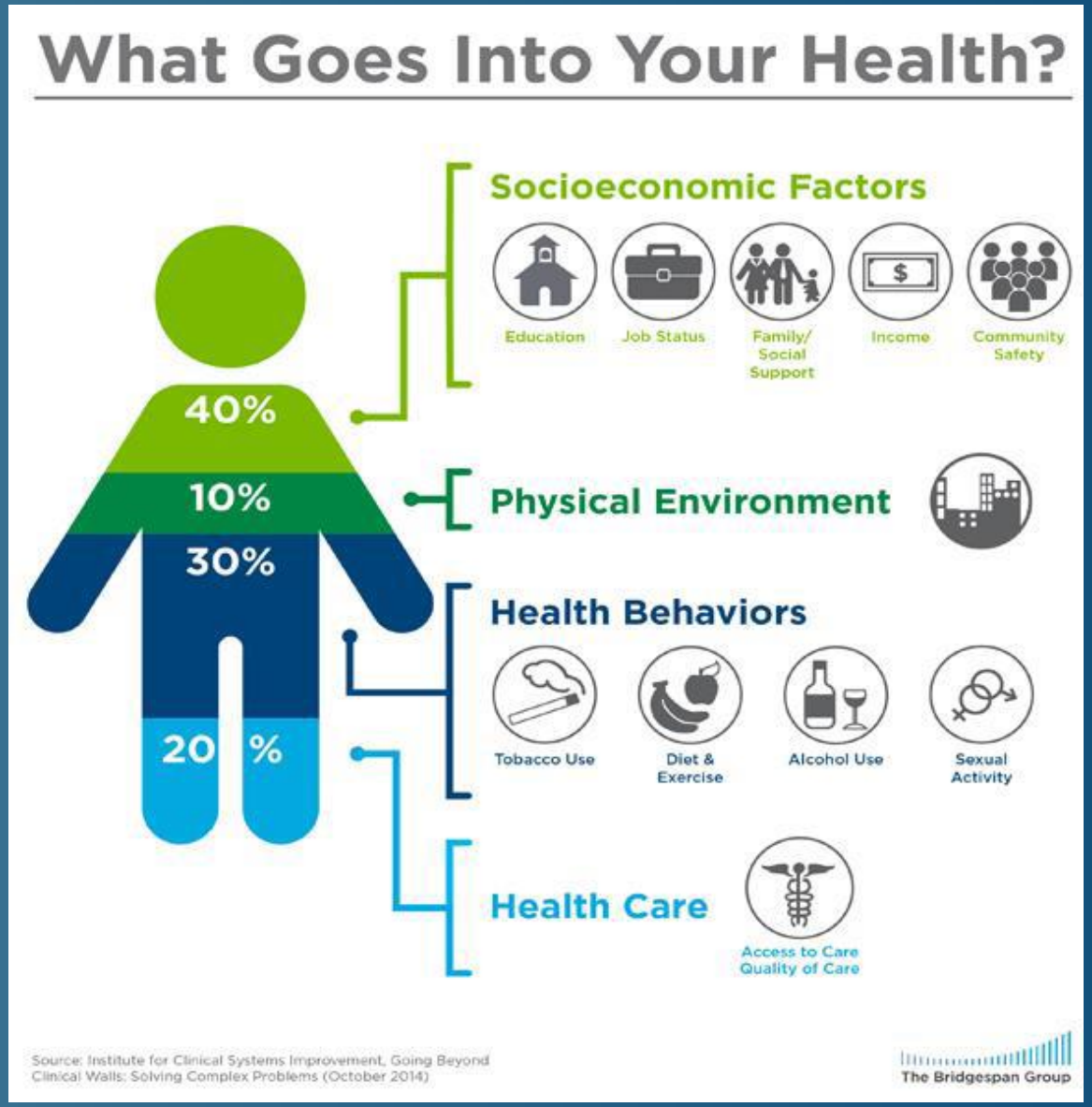
LIVE WELL
SAN DIEGO


Building Better Health
Living Safely
Thriving

What We Know

Social influences greatly impact health



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Person Centered Model

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Regional Information Exchange

CIE Timeline

1920 — United Way of San Diego opens

1974 — United Way begins providing free, confidential information and referral services via a helpline

2000 — FCC approves 2-1-1 dialing code for nationwide use

2003 — 2-1-1 San Diego forms separate entity and continues to offer information and referral services

2004 — 2-1-1 dialing code launches in San Diego

2009 — 2-1-1 San Diego offers telephonic signatures for benefit applications (SNAP/Medicaid)

2010 — UC San Diego receives 1 of 17 national Beacon awards to build a Health Information Exchange (HIE)

2-1-1 San Diego joins Live Well San Diego

2011 — Alliance Healthcare Foundation funds **Community Information Exchange**, a collaboration of public and private organizations.

2-1-1 San Diego
UCSD Beacon Community Program/HIE
Father Joe's Villages
Regional Task Force on the Homeless
Rural/Metro of San Diego (City Paramedic)
San Diego Fire-Rescue Department

2014 — **CIE launches pilot cohort** of homeless services providers sharing basic client demographic data.

2-1-1 San Diego expands **Health Navigation** through hospital and clinic partnerships.

As 2-1-1 San Diego grew, agency leaders recognized traditional Information and Referral models did not provide a holistic view of a person's interconnected health and well-being needs and put the burden on those in need to access services. 2-1-1 San Diego began shifting services toward a person-centered approach with the launch of Health Navigation

2015 — CIE launches second cohort of senior service providers

2017 — 2-1-1 San Diego launches **SD United** network offering closed loop electronic referrals to target population of military and veterans.

Leveraging the work of the San Diego Veterans Coalition, and the region's Peer to Peer hub at Courage to Call, SD United is a care coordination network working to improve access for military and veteran families with enhanced collaboration

2017 — 2-1-1 launches person centered care with enhanced CRM with Social Determinants of Health assessments, Risk Rating Scale, and a unique, longitudinal record for each caller

2018 — Relaunch of enhanced CIE offering network partners a shared language of assessments and Risk Rating Scale, resource database, and robust technology platform that supports data integration and community care planning with closed loop referrals

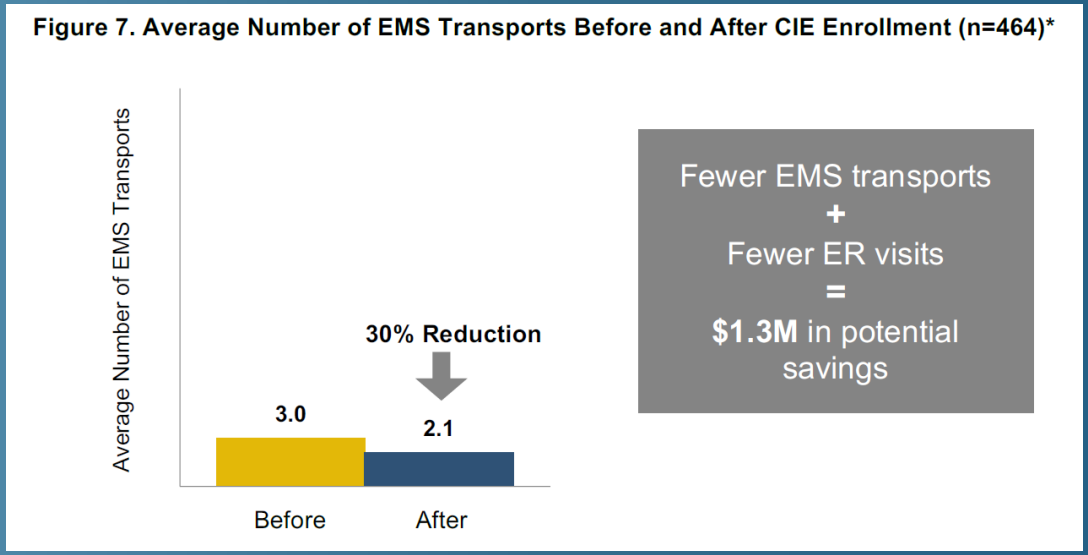
CIE: ROI

Year 1: Homeless Cohort Analysis

26% reduction — EMS Transports Post CIE enrollment

44% improvement — Remained in housing

Year 2: Senior Cohort Analysis



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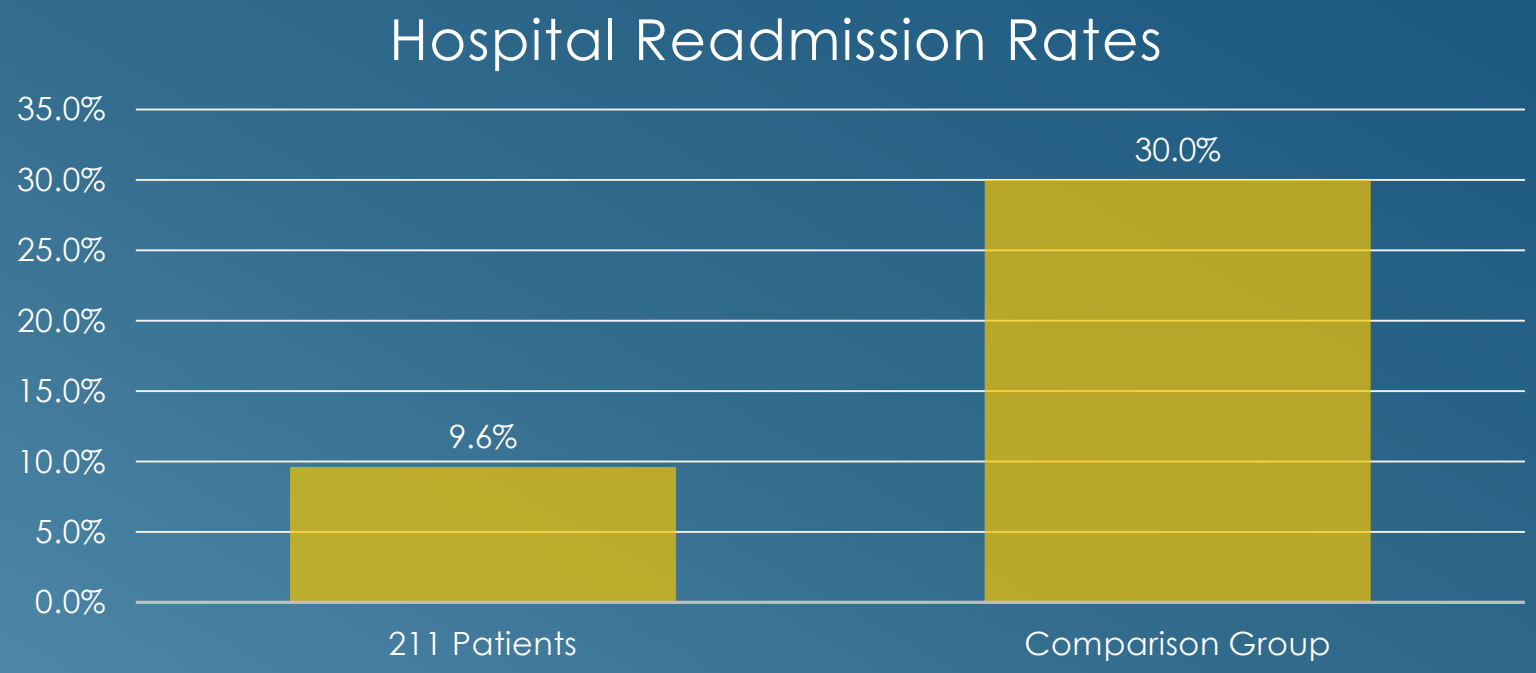
CIE: Social Navigation

Shared Goal:
Assist in the transition from hospital discharge to home by assessing and connecting to social determinants of health resources through electronic referrals from EHR to 2-1-1 Health Navigators

Measures:
- Percent of individuals readmitted into hospital
- Improvement on shared Risk Rating Scale
- Patient Satisfaction
- Self-Efficacy

Year 1 Outcomes: 2016-2017



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State of the Field

Proliferation of Technology

Awareness of the Social Determinants of Health

Evolving Funding Environment

Person-Centered Care

Cross-Sector Collaboration

Research and Policy Advocacy

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Network Partners

Collective approach with standard Participation Agreement, Business Associates Agreement and participant consent with shared partner governance, ongoing engagement, and support.

Shared Language (SDoH)

Setting a Framework of shared measures and outcomes through 14 Social Determinants of Health Assessments and a Risk Rating Scale: Crisis, Critical, Vulnerable, Stable, Safe Thriving

Bidirectional Closed Loop Referrals

Updated resource database of community, health, and social service providers. Ability to accept/return referrals and to provide outcomes and program enrollment.

Technology Platform and Data Integration

Technology software that integrates with other platforms to populate an individual record and shapes the care plan. Partners access the system. System features include care team communication feeds, status change alerts, data source auto-history and predictive analytics.

Community Care Planning

Longitudinal record with a unified community care plan that promotes cross-sector collaboration and a holistic approach.

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Shared Language (SDoH)

14 Domains of Social Determinants of Health

Housing Stability

Primary Care and Prevention

Health Management

Nutrition & Food Security

Financial Wellness and Benefits

Activities of Daily Living

Social & Community Connection

Legal & Criminal Justice

Safety & Disaster

Utility & Technology

Transportation

Education & Human Development

Personal Care & Household Goods

Employment Development

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Domains/Social Need Domains	HealthyPeople2020 (CDC)	2-1-1 San Diego	Henry J. Kaiser Family Foundation	SIREN	Health Leads	PRAPARE	Self-Sufficiency Matrix
Housing		x		x Quality & Stability	x (Housing Stability)	x(Status & Stability	X (Housing and Household Management)
Primary Care	X (Health & Healthcare)	x	X (Primary Care and Access)		x(Health Behaviors)	x (Insurance)	X (Access to Services)
Health Condition Management	X (Health & Healthcare)	x			x (Behavioral/Mental Health)	(Stress)	X (Mental, Physical Health, Substance Abuse)
Food & Nutrition	x	x	X (Hunger and Food Insecurity)	x	x (Food Insecurity)		X (Food)
Social & Community Connection	x (Social & Community Context)	x	x	x	x (Social Isolation & Support)	x (Social Integration & Support)	X (Support System)
Activities of Daily Living	x	x			x (Social Isolation)		X (Functional Ability)
Employment	x (Economic Stability)	x	X (Economic Stability)	x (Economic Stability)	x	x	x (Career Resiliency/Training, Employment Stability, English Second Language)
Criminal Justice & Legal	x	x				X (Incarceration History)	X (Legal)
Financial Wellness & Benefits	x	x	X (Economic Stability)	x (Public Benefits)	x (Financial Resource Strain)	x	X (Financial Matters and Income Area Median and FPL)
Transportation	x	x			x	x	X
Personal Hygiene & Household Goods	x	x				x (Material Security)	X (Clothing)
Utility & Technology	x	x			x (Utility Needs)		
Safety & Disaster	x	x		X (Violence/Safety)	x (Exposure to Violence)	x (Safety & DV)	X (Safety)
Human Development & Education	x (Education)	x	x	X (Education & Childcare)	X (Childcare)	x	X (Childcare & Education, Life Skills (human relations and setting goals), Parenting
Neighborhood & Built Environment	X (Access Healthy Food, Housing Quality, Crime & Violence, Environmental Conditions)		X (Housing, Transportation, Park Safety, Walkability)				

Screening vs. Assessment

Healthcare Provider

Priority: Providing Medical Care

Secondary: Screening for Specific Social Risks

Tools: Positive or Negative

Example:

- **Within the past 12 months, we worried whether our food would run out before we got money to buy more.**
- **Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.**

Social Service Provider

Priority: Address bio-psycho-social of individual and family

Secondary: Connection between health and social

Tools: Target population focused and tailored

Example:

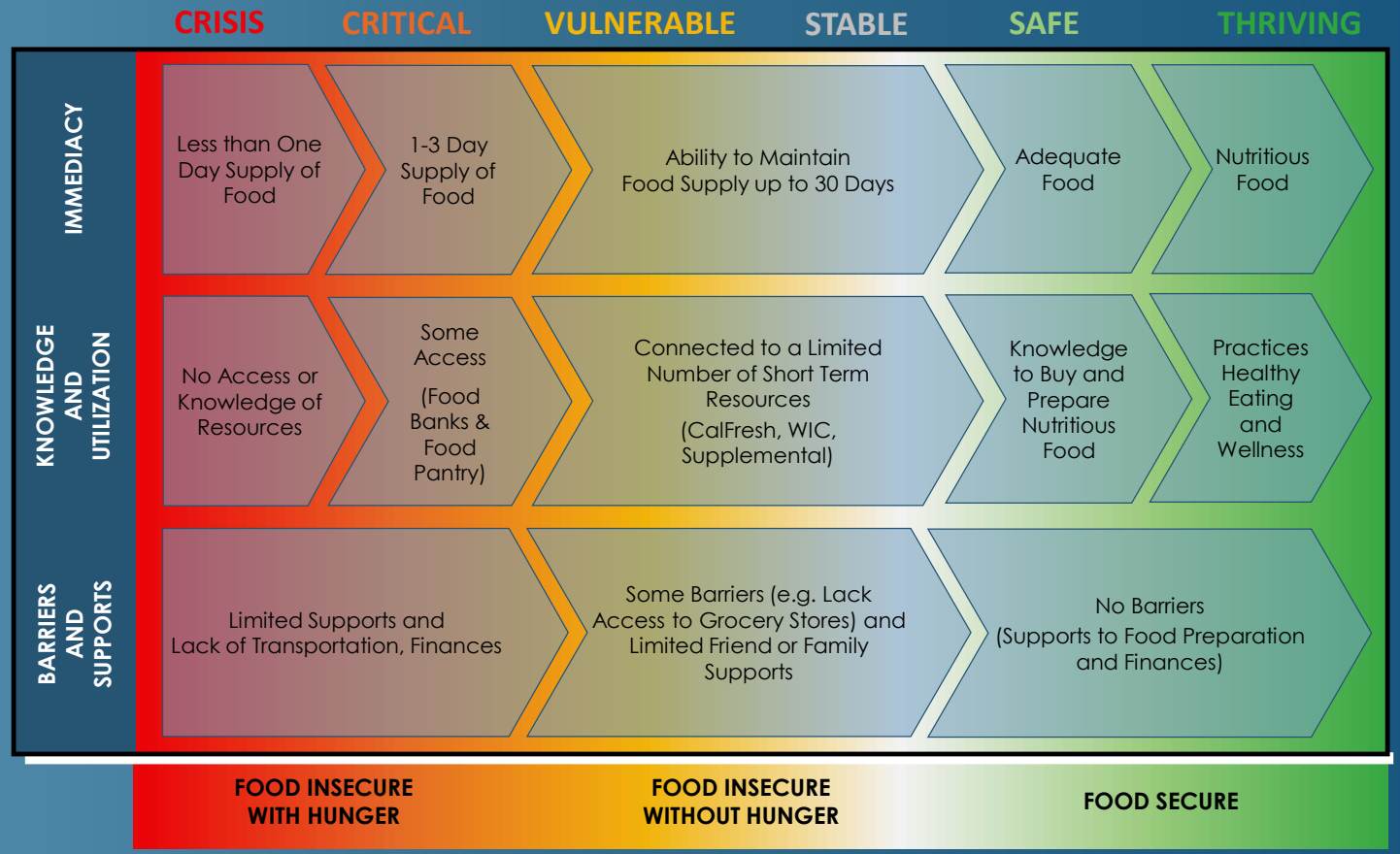
- **What is your current health situation?**
  - Open ended (Physical, Mental/Behavioral, Substance Abuse, Dental)
- **Are you experiencing any barriers to managing your health condition?**
  - Transportation, Prescription Costs, Health Insurance Issues, knowledge health condition, procedure costs, timeline for care, medical equipment
- **What types of services are you hoping access to help you?**
  - Medical home, Sobriety Services, Inpatient, Medical Access, Financial Assistance Programs, Medical Home

CIE Risk Rating Scale

Shared Language (SDoH)

FOOD & NUTRITION

Long-term and sustainable access to nutritious foods and to support services to maintain access



IN COLLABORATION WITH:

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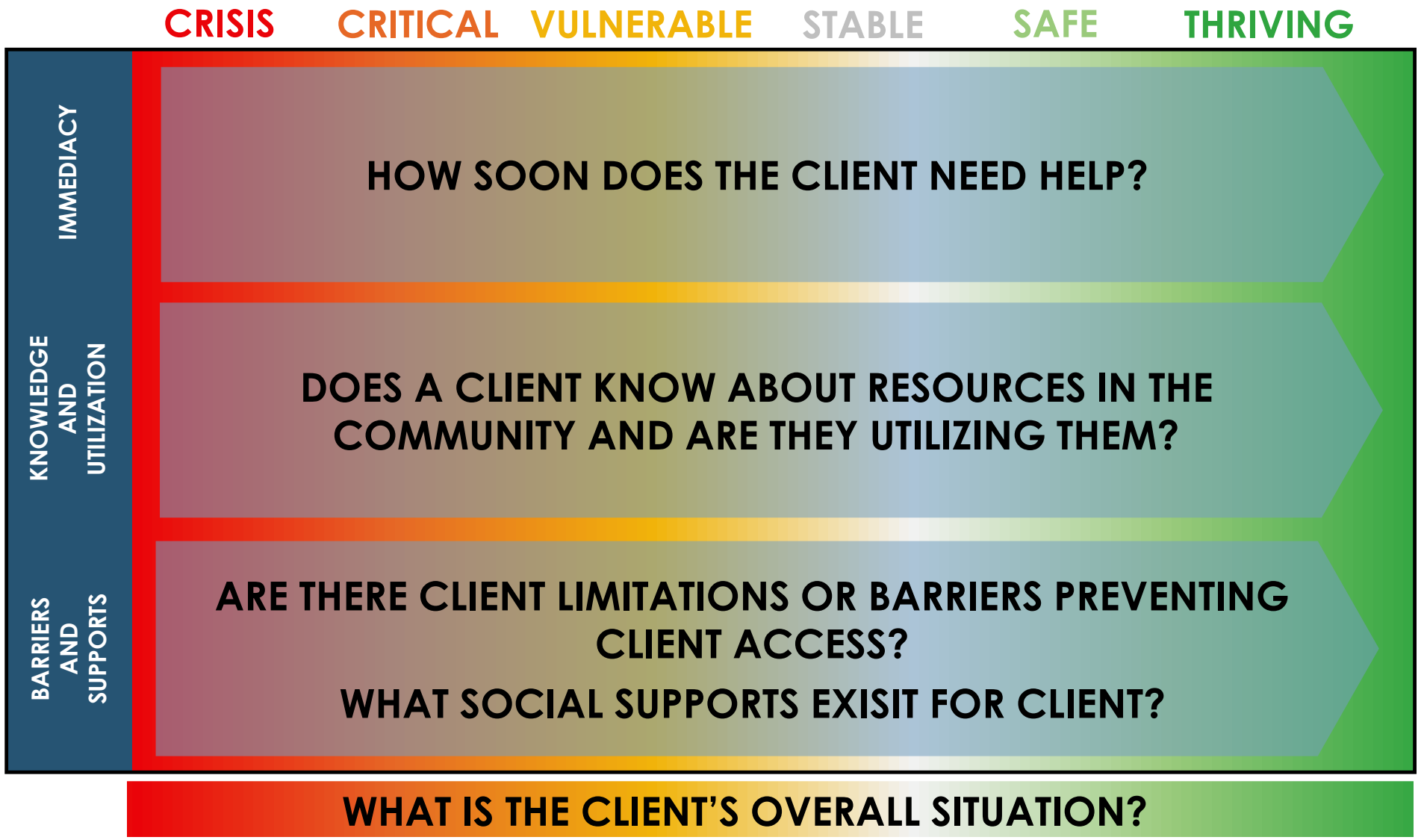
Framework


CRISIS
CRITICAL
VULNERABLE
STABLE
SAFE
THRIVING
IMMEDIACY
KNOWLEDGE AND UTILIZATION
BARRIERS AND SUPPORTS
HOW SOON DOES THE CLIENT NEED HELP?
DOES A CLIENT KNOW ABOUT RESOURCES IN THE COMMUNITY AND ARE THEY UTILIZING THEM?
ARE THERE CLIENT LIMITATIONS OR BARRIERS PREVENTING CLIENT ACCESS?
WHAT SOCIAL SUPPORTS EXISIT FOR CLIENT?
WHAT IS THE CLIENT'S OVERALL SITUATION?

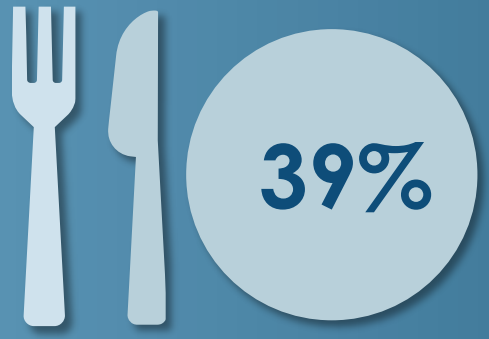
Shared Language (SDoH)

Food & Nutrition

Concern about Food Supply

During the last 30 days, how often are clients concerned about their food supply? How often do they actually run out of food?

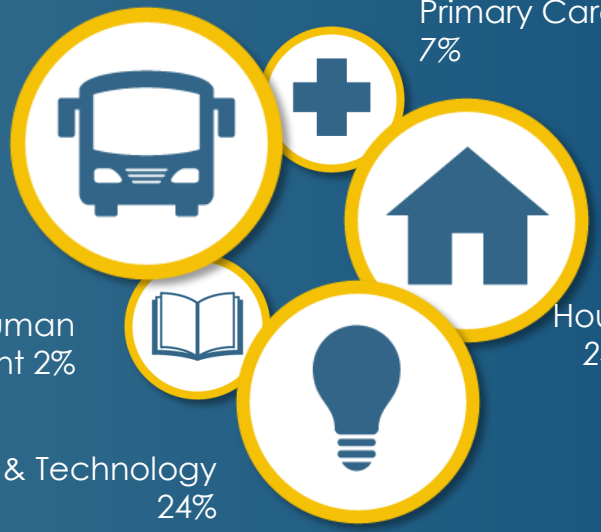
45% of clients are often **worried** their food supply will run out



of clients often **actually** run out of food during the month

Decisions over Nutrition

What other basic needs do clients need to meet before they can address their nutrition needs?



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Preliminary Findings in Change Over Time

What does decreased vulnerability mean for clients?

- Reduced the rate of clients often concerned with food supply from 45% to 33%.
- Increased access to resources by 49%.
  - Connected clients to SNAP applications, food banks and other emergency food options, WIC, and congregate meals.

6% of clients initially in a Safe or Thriving risk level decreased vulnerability

37% of clients initially in a Vulnerable or Stable risk level decreased vulnerability

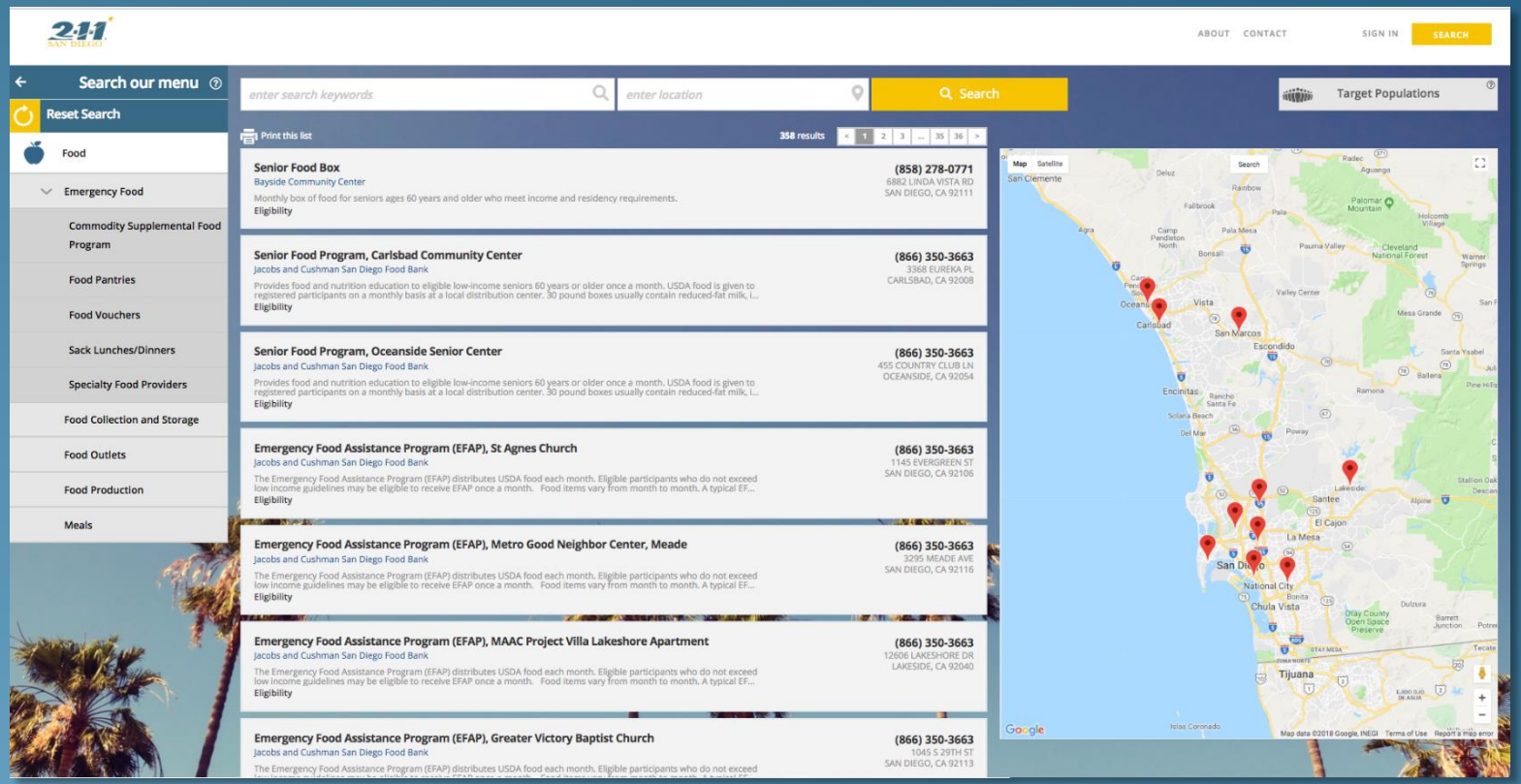
71% of clients initially in a Crisis or Critical risk level decreased vulnerability

NUTRITION ASSESSMENT

Resource Database

Bidirectional Closed Loop Referrals

Hub for social and health sites and providers



- Shared taxonomy language for referrals (AIRS)
- Dedicated resource staff
- Regular updates made to resources
- Standards to listings and requirements
- Inclusion/Exclusion Criteria
- Linked to health conditions
- Tracks resource availability and unmet needs

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Referral Network between all providers

Bidirectional Information Sharing

Closed loop referrals and outcomes

CIE Network Partner

- Creates client profile
- Authorization to share information

Agency

Declines

Accepts

Evaluating

Did Not Receive Services

Receiving/Received Service

Care Team

Program Enrollment

Closed Referral

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CIE Shared Record

Community Care Planning

Client Profile

- Demographic and important information about the client

Domains

- Examples like Housing, Food & Nutrition,
- Categorization of Needs (SDOH) & Risk Level
- Shared Assessments and Values across agencies

Care Team

- Case Managers working with client across agencies
- Contact Information

Referrals & Program Enrollment

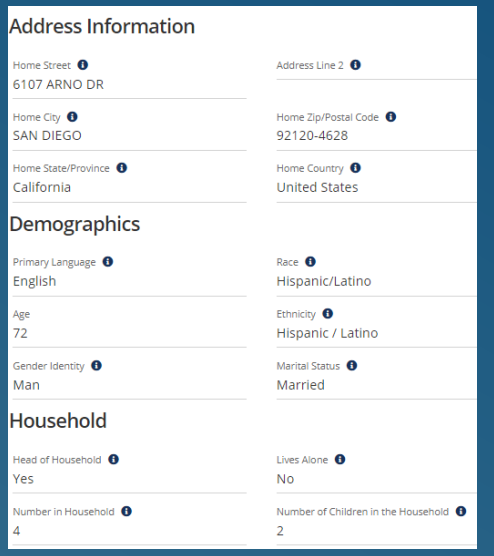
- Agencies or programs client is referred
- Connection to Services

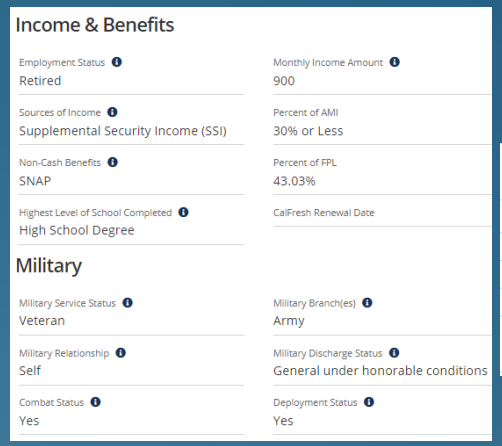
Alerts

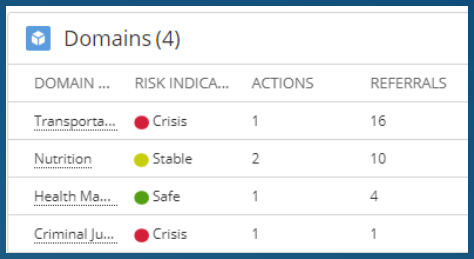
- Notification of emergency services & jail
- Ability to notify Care Team Members of changes

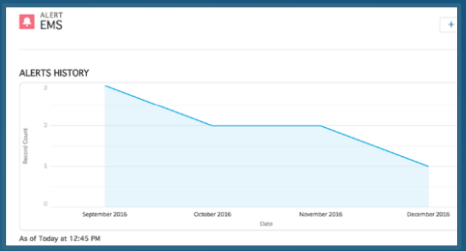
Feed

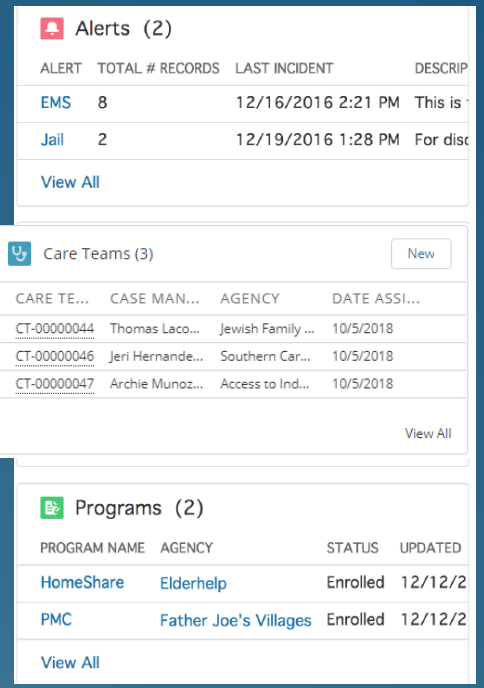
- Ability to communicate like Twitter to other Care Team members











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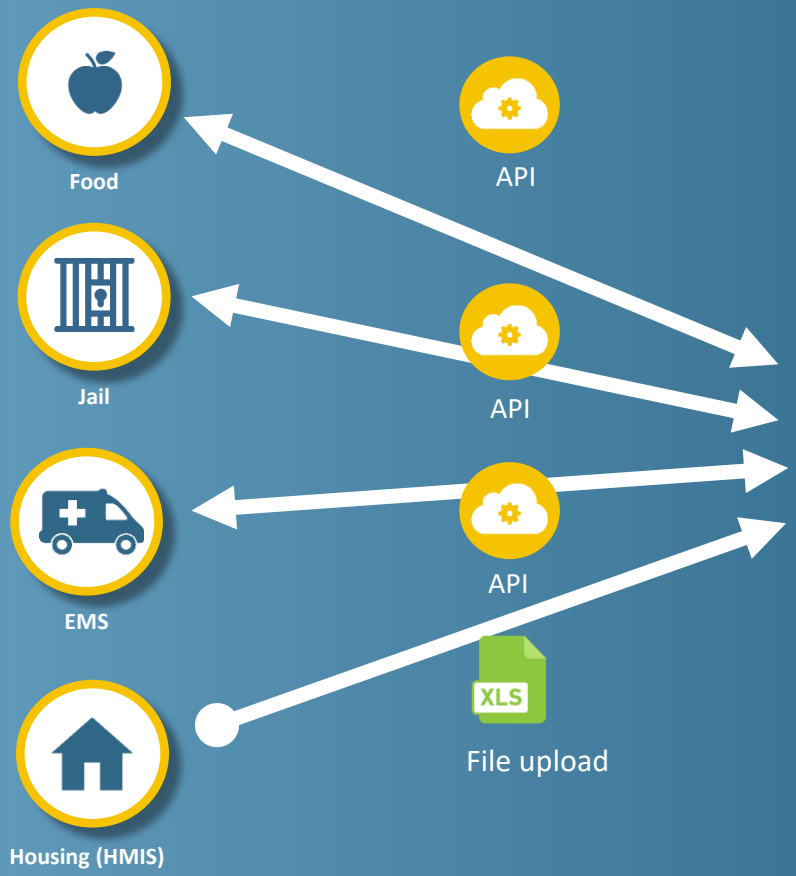
Technology Platform

Technology Platform and Data Integration



MDM

Master Data Management

- Detects and merges duplicate records
- Ensures the accuracy, completeness, and consistency of multiple domains of enterprise data

informatica

CIE
shared client record
salesforce

ETL

Extract Transform Load

1. Reads data from a database
2. Converts the data for the new database
3. Loads into the new database

Alerts

Single Sign on

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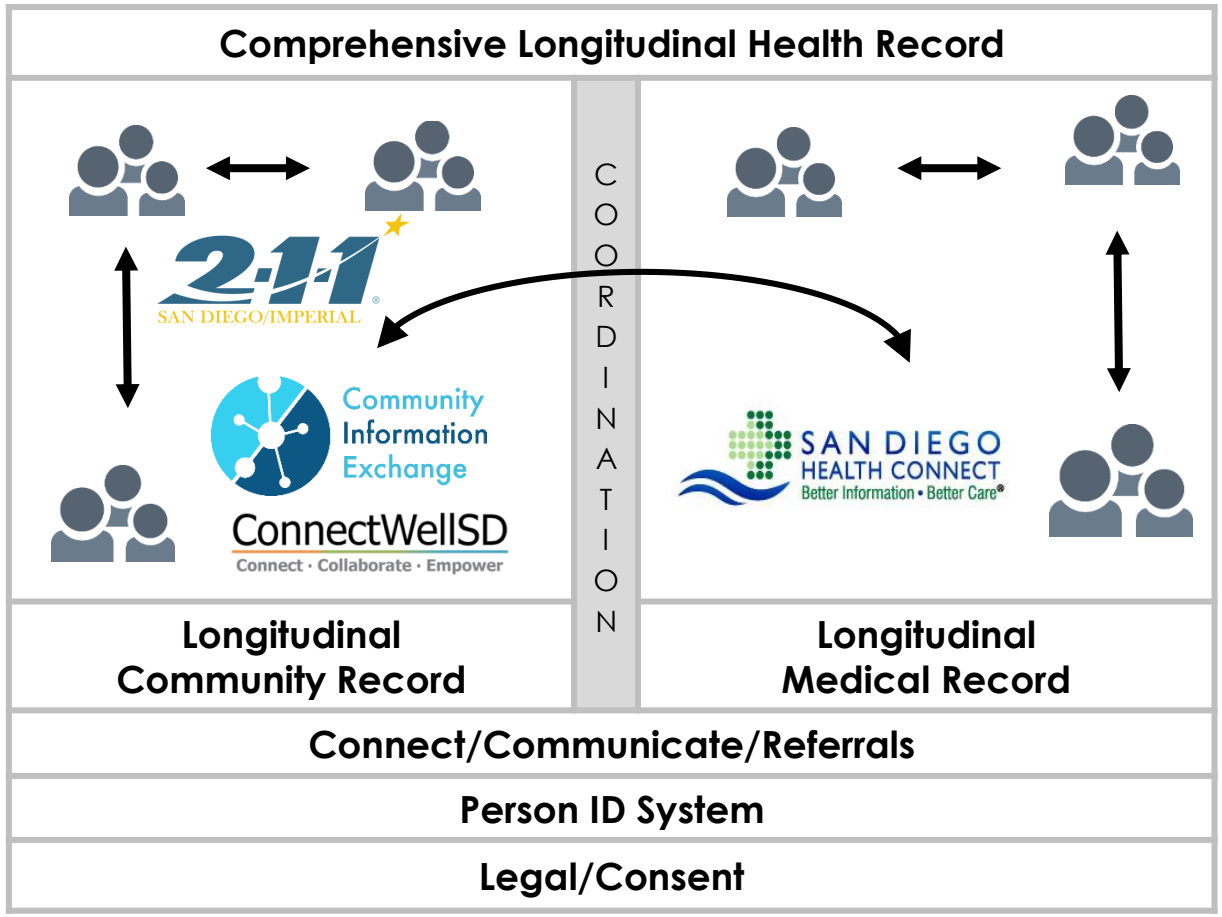
Fully Integrated Information Exchange

Public Health + Social + Behavioral + Medical



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Partnership with County of San Diego Health and Human Services

Bridge between CIE and ConnectWell

- Connect each other systems for following purposes:
  - Resource Database
  - Risk Rating Scale
  - Identify-Proofing
  - Referrals

Partnerships and Engagement with CBOs

ConnectWellSD
Connect · Collaborate · Empower

LIVE WELL SAN DIEGO

Building Better Health | Living Safely | Thriving

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Partnership with Health Information Exchange

Short Term Goals:

- Present CIE data into the HIE
- Single sign-on for platforms (CIE & HIE)
- Research
  - Healthcare utilization and outcomes & social determinants of health

Long Term Goals:

- Present HIE data into the CIE
- Explore bi-directional referrals & Master Patient Index
- Create standards and best practices between HIE & CIE

Community Information Exchange Partners

Network Partners

Community Information Exchange

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CIE Toolkit Launch

The CIE Toolkit is designed to assist communities interested in learning how to harness the value of cross-sector collaboration and data sharing to develop a Community Information Exchange (CIE) that enables a network of health, human, and social service providers to deliver coordinated, person-centered care to address social determinants of health to improve population health.

Download via PDF at
www.ciesandiego.org

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CIE Toolkit Webinars

2-1-1 San Diego is offering a five-part webinar series providing an overview and a deep dive into CIE Toolkit:

- Introduction to CIE and Toolkit Overview
- Identify CIE Vision and Governance
- Mobilize the Community Network
- Prepare a Legally Compliant Framework & Adopt an Interoperable Technology
- Cultivate Sustainability & Evolve and Shape the Movement / CIE Summit Overview

Register for Toolkit Webinars at
www.ciesandiego.org

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