# Smashing Successes and Fast Failures: The Highs and Lows of Building CIE Partnerships

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# Session Reminders

COMMUNITY INFORMATION EXCHANGE VIRTUAL SUMMIT

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COMMUNITY INFORMATION EXCHANGE
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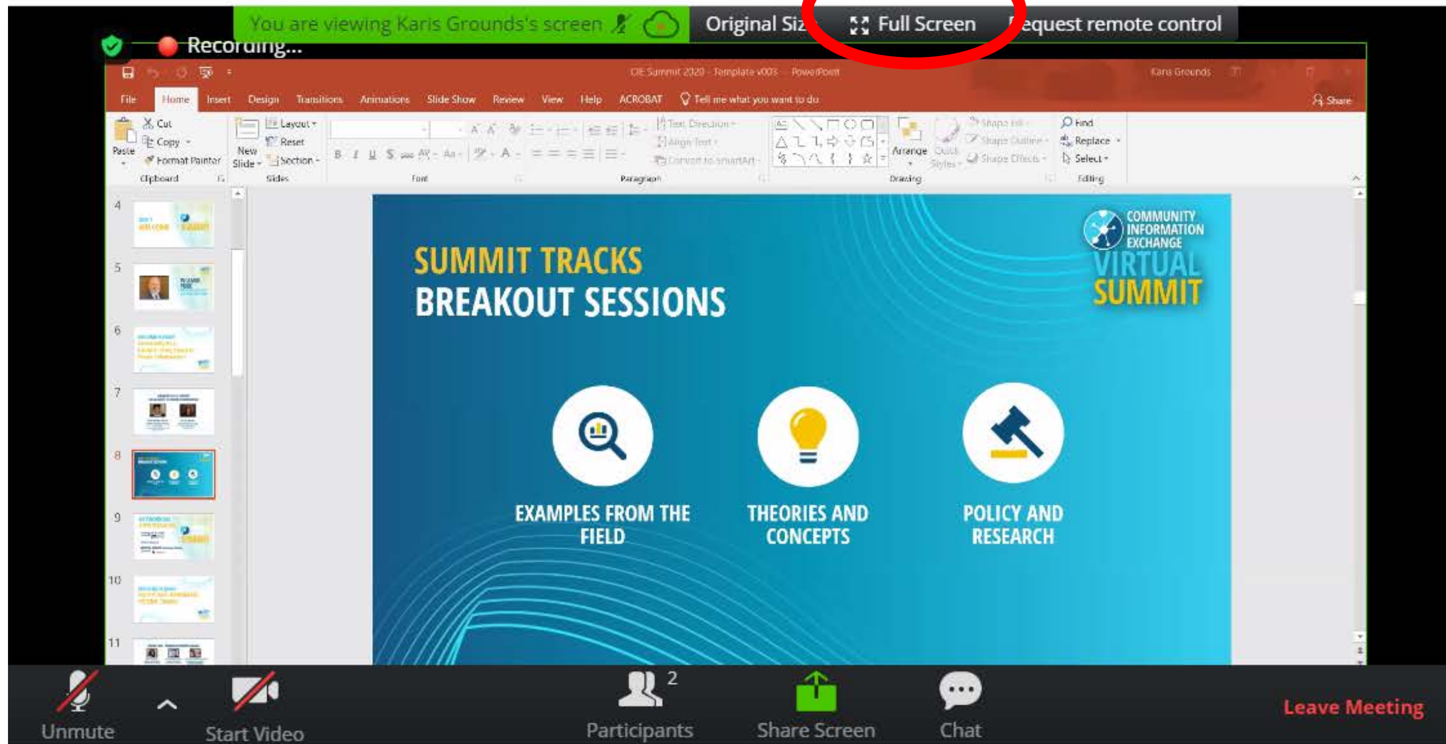
Show Agenda




Session Q&A | Chat | Community

Back to question list

Edit question

Will these slides be shared?

Asked by Karis Grounds

There are no replies yet

Health Leads

## WHO WE ARE

Health Leads is an innovation hub that unearths and addresses the deep societal roots of racial inequity that impact health.

## OUR MISSION

We partner with communities and health systems to address systemic causes of inequity and disease. We do this by removing barriers that keep people from identifying, accessing and choosing the resources everyone needs to be healthy.

## OUR VISION

Health, well-being and dignity for every person, in every community.

Phase VIII:
Community
Care Planning

Phase VI:
System
Integrated
Record

Phase VII:
Shared Care Plan

Phase IV: Referrals &
Data Sharing

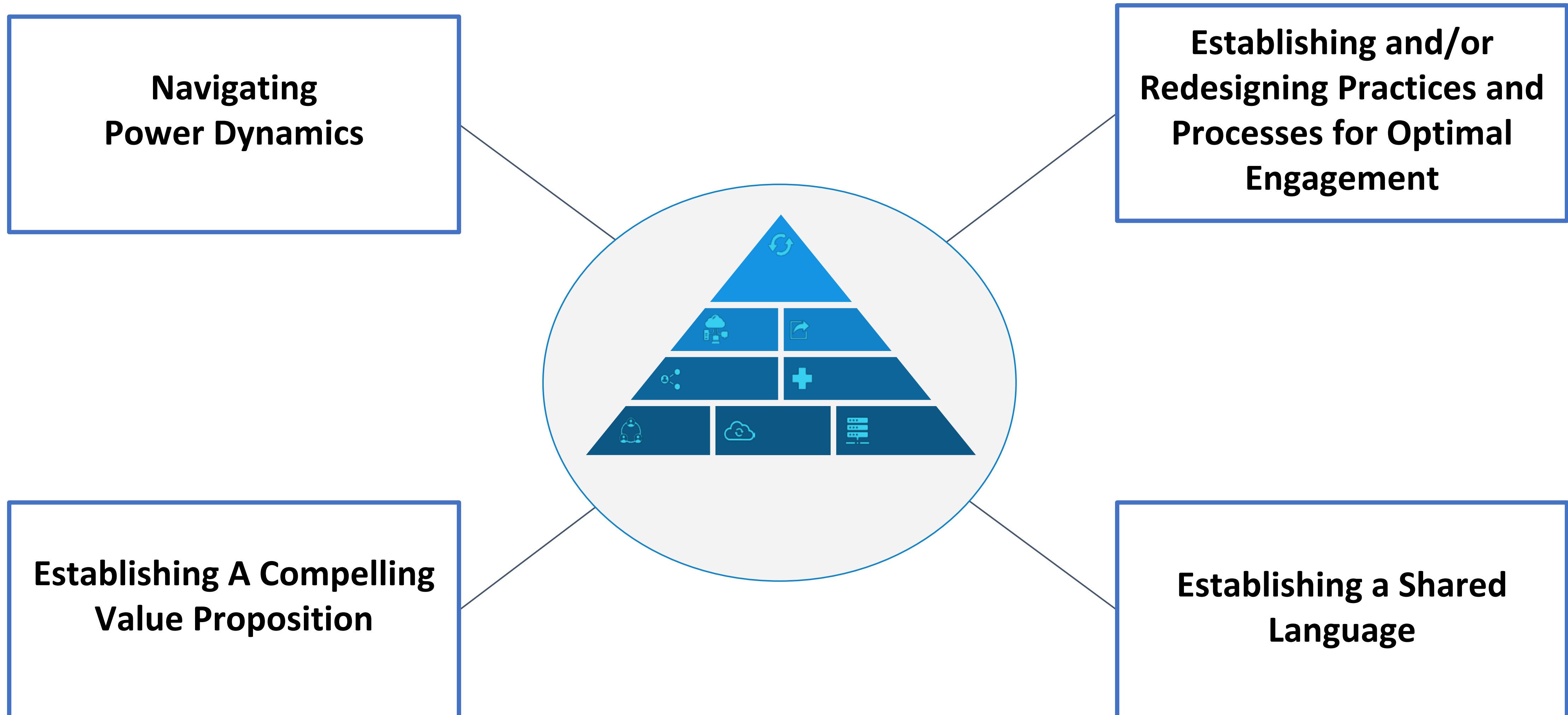
Phase V: Shared Language

Phase I: Buy-in &
Community
Engagement

Phase II: Shared
Record

Phase III: Data
Standards &
Governance

# Common Challenges Every Step of the Way



# Community Information Exchange

**2-1-1 San Diego / Imperial**

- Free, 24/7 service, 3-digit dialing code
- Access to community, health, social and disaster services
- Tailored programs take the client beyond just a referral—movement towards Navigation

**Community Information Exchange**

- Systems change that fosters true collaboration across networks
- Moving towards person-centered interventions and interactions across healthcare and human services
- Goal is to improve health and wellness for individuals and populations

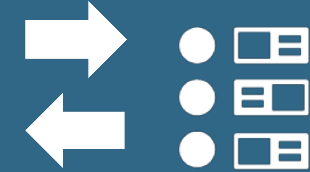
# Community Information Exchange Core Components

### 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.

# Person-Centered Care

# Community-Driven Approach to Care

- Community Stewardship
  - Led by shared governance structure (Leadership at all levels)
  - Informed by community needs
- Community Ownership
  - Input from the community and orgs representing community
  - Opt-in
  - Community Access and Input (Advisory Board)
- Tailored by Community
  - Based on community needs and customized by users
  - Ongoing development, led by users
- Integrated
  - One size does not fit all
  - Goal is not to use one system, but integrated from multiple systems and data structures

**Power Dynamics**

# Comprehensive Social Assessment Continuum

## HOUSING STABILITY

Long-term safe and adequate housing that meets all needs with access to multiple resources and ability to access supports for long-term housing sustainability

| | CRISIS | CRITICAL | VULNERABLE | STABLE | SAFE | THRIVING |
|---|---|---|---|---|---|---|
| IMMEDIACY | Place Not Meant for Habitation | Housing Application Submitted<br>Eviction Notice | Temporary Housing (less than 3 months) | Housing (at least 6 months) | Adequate Housing to Meet Most Needs | Knowledge and Utilization of Multiple Resources |
| KNOWLEDGE AND UTILIZATION | Not Knowledgeable<br>Not Sought Any Services | Limited Knowledge<br>Attempted Some Services<br>(e.g. VI-SPDAT, CAHP, Section 8, Rapid-Housing) | | Knowledge of a Few Resources<br>Has Access to and Some Support from Resources<br>(e.g. Social Networks, Family) | | Adequate Housing to Meet All Needs |
| BARRIERS AND SUPPORTS | No Finances<br>Credit Issues<br>Incarceration | Violence<br>Substance Abuse<br>Immigration Status | Limited Finances<br>Foreclosure<br>Increased Rent | | Home Repair<br>In-Home Support<br>Adequate Finances | |

HOMELESS — HOUSED

**Legend**

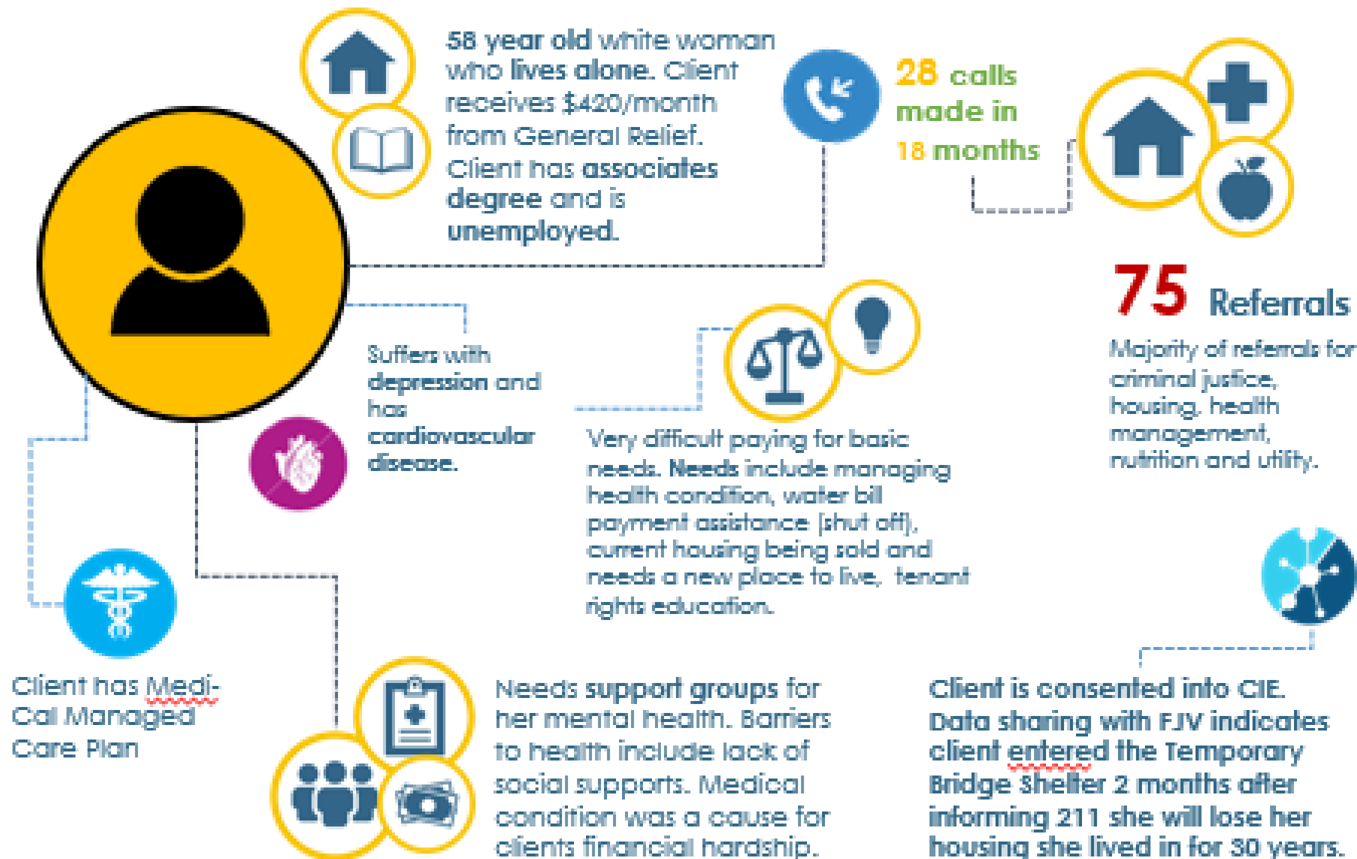
- **Crisis:** Intense difficulty, trouble or danger
- **Critical:** Severe concern
- **Vulnerable:** At-risk
- **Stable:** Satisfactory state of being
- **Safe:** Secure and able to manage to difficulty
- **Thriving:** Ability to flourish

**Shared Language**

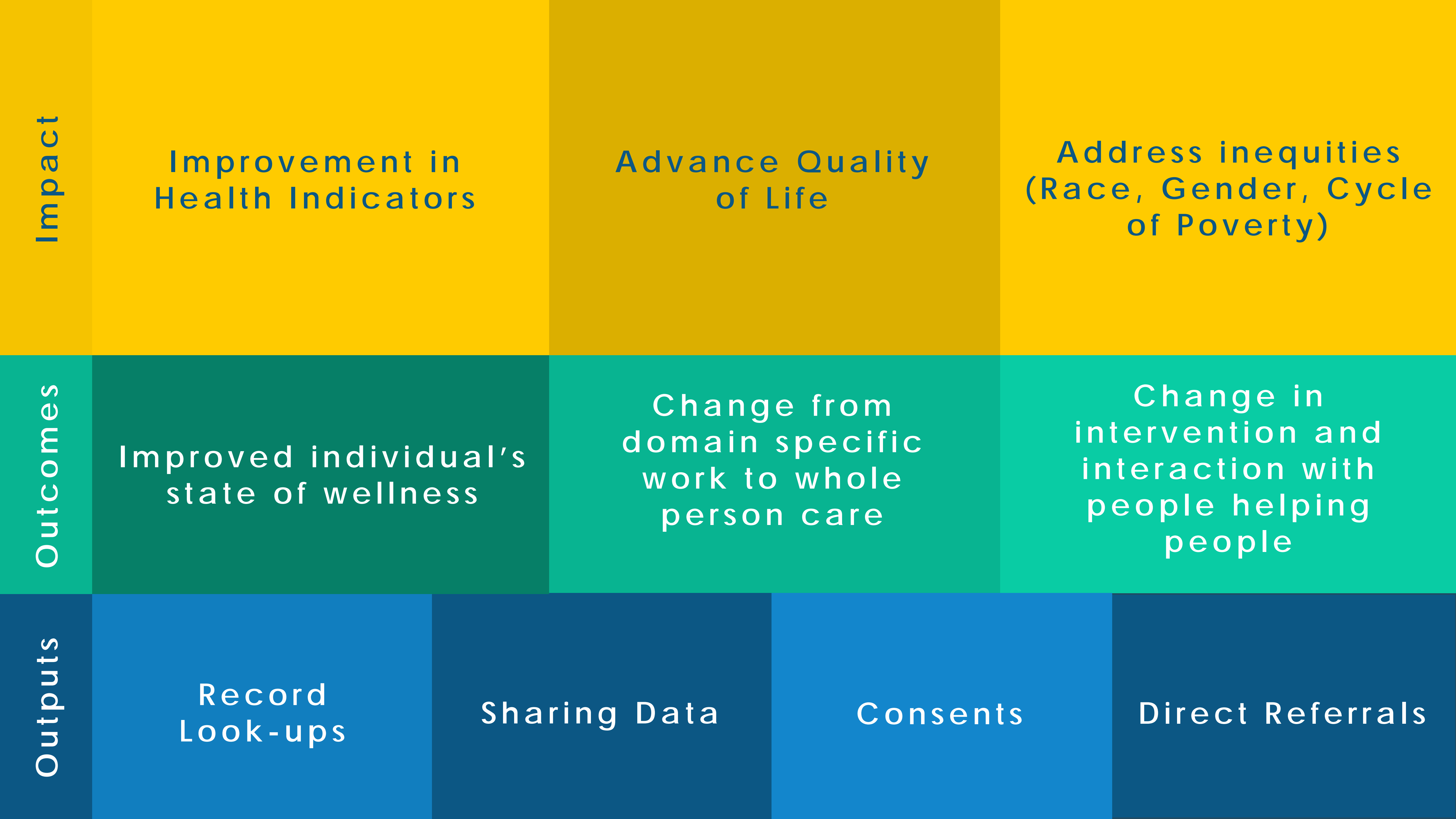
2-1-1 SAN DIEGO

IN COLLABORATION WITH: University of San Diego SCHOOL OF LEADERSHIP AND EDUCATION SCIENCES, CASTER FAMILY CENTER FOR NONPROFIT AND PHILANTHROPIC RESEARCH

2-1-1 SAN DIEGO IMPERIAL




**Value Proposition**


Impact
Improvement in Health Indicators
Advance Quality of Life
Address inequities (Race, Gender, Cycle of Poverty)
Outcomes
Improved individual's state of wellness
Change from domain specific work to whole person care
Change in intervention and interaction with people helping people
Outputs
Record Look-ups
Sharing Data
Consents
Direct Referrals

# Value and Return on Investment

CHCS Center for Health Care Strategies, Inc.

Case Study | August 2018

## 2-1-1 San Diego: Connecting Partners through the Community Information Exchange

Connecting patients to needed social services can be challenging for health care providers, who are generally focused on clinical care. Additionally, they are often neither aware of the full range of community services nor have the capacity to refer and follow up with patients. Recognizing that social factors significantly impact health outcomes and spending, 2-1-1 San Diego developed the Community Information Exchange (CIE), a cloud-based platform that enables participating providers to better understand a client's interactions with health and community services. The CIE includes a social risk assessment tool, provides alerts, and facilitates connections across multiple agencies and providers. The rich client information collected through the CIE is also used to monitor community trends and address local challenges. 2-1-1 San Diego is actively engaging community partners to participate in the CIE in the hopes of improving care coordination and health outcomes for at-risk patients throughout San Diego.

**Program At-A-Glance:** Community Information Exchange (CIE) is an interactive data platform developed by San Diego 2-1-1 designed to allow multiple health and social service providers see a patient's interaction across systems, agencies, and community services.

**Partners:** San Diego 2-1-1 and 34 social service and health care providers, including federally qualified health care centers, and government agencies.

**Goals:** Improve care coordination for vulnerable patients through an online platform.

**Partnership Model:** Coordinated service.

**Scope of Services:** Referral support; secure, cloud-based platform; shared measures for social determinants of health; capacity for organizations to accept and return referrals.

**Funding:** Grants.

**Impact:** Among clients enrolled in the CIE, reduced number of emergency medical services trips and increased stable housing rates.

### Background

2-1-1 San Diego, launched in 1997 by the United Way, is a free, confidential information and referral helpline

**Advancing Community-Based Organization and Health Care Partnerships to Address Social Determinants of Health**

Health care and community-based organizations (CBOs) across the country are increasingly working together to better address the root causes of poor health among low-income and vulnerable populations. To assist these efforts, there is a need to identify the financial, operational, and strategic considerations necessary to make these partnerships a win-win for all parties: consumers, the communities being served, health care providers, and CBOs. Through support from Kaiser Permanente Community Health, the Center for Health Care Strategies and Nonprofit Finance Fund collaborated to identify new strategies for advancing effective health care-CBO partnerships, building on work done under the *Partnership for Healthy Outcomes* project funded by the Robert Wood Johnson Foundation. This case study is part of a series highlighting diverse partnerships between CBOs and health care organizations.

*Made possible through support from Kaiser Permanente Community Health.*

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

## Community Information Exchange
## Using Data to Coordinate Care for People Experiencing Homelessness: Addressing COVID-19 and Beyond

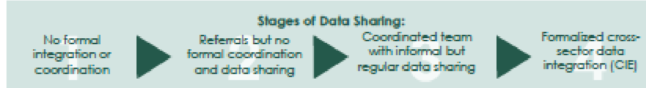
April 2020

### WHAT IS CIE?

Community Information Exchanges (CIEs) are care coordination tools that bring together providers and data from the health and social services sector.[1]

While Health Information Exchanges (HIEs) focus on bringing health care providers from across a community together, this model builds on the idea for HIEs to incorporate cross-system partners.

Partners in a CIE can include hospitals, health centers, other primary care providers, social service providers, housing providers, and schools, among other community resources.[2]



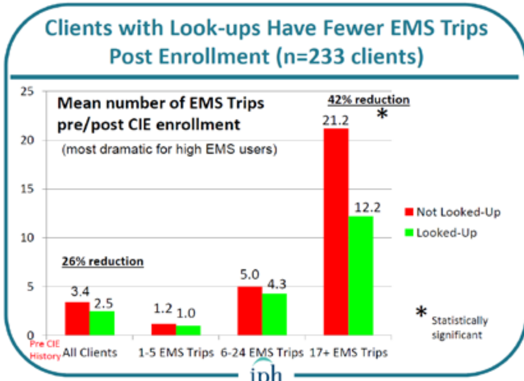

### HOW IS CIE USED?

CIE a response to growing awareness of the Social Determinants of Health (SDOH). After a health center provider screens for SDOH related needs, the community wide data system can be used to identify and connect individuals to other community resources.[3]

An integrated CIE allows for coordination with other health care providers, like an HIE would, but also connects to social service providers. This allows health center staff to identify where an individual is accessing other services and who could be considered part of the care team.

Data integration tools can be incorporated and linked to fields in the electronic health record (EHR), following HIPAA considerations, to help seamlessly sync health center workflow as part of the SDOH strategy.

In response to SDOH needs, health care providers, case managers and other enabling services staff then have access to information on available community resources, what resources someone has accessed, and can track follow-up on referrals to improve care planning incorporating SDOH.[1]



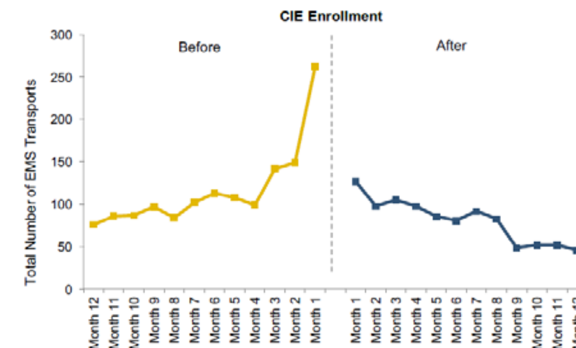
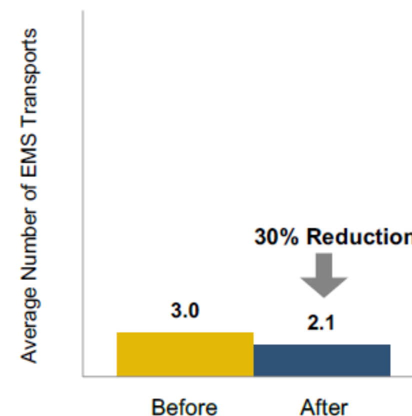




**Figure 7. Average Number of EMS Transports Before and After CIE Enrollment (n=464)***




*Statistically significant difference (p<.05)*

Fewer EMS transports
+
Fewer ER visits
=
**$1.3M** in potential savings

Attachment A
With CIE: Clinical Workflow: Diabetes/Pre-Diabetes & Heart Disease/Stroke

PCP identifies patients who is pre-diabetic

PCP identifies patients who has diabetes

Reduces risk with PCP

Pre-Diabetes (patient is independently engaging in lifestyle change activities

Pre-Diabetes (patient is not independently engaging in any lifestyle change activities)

Patient with diabetes

Refer to lifestyle change programs and/or other SDoH services via CIE
AND/OR
Use CIE to refer to community based DPP programs like Skinny Gene or Multi-Cultural if a better fit for the patient

Refer to lifestyle change programs and/or other SDoH services via CIE

Diabetes Clinic

Refers to clinical providers: dental, eye exam, podiatrist, etc. (internal) and to West Coast Optometry of San Diego (external → no referral outcomes)

Refers to other community resources, like lifestyle change programs, SDOH resources, etc.

Patient is seen by either:
Primary Care Physician or Nurse Practitioner

**Health Education Department**
(high BP/overweight/nutrition edu, high cholesteral.)
Types of Services:
Nutrition classes on site
Medication management
Lab results – goal numbers
Routine Care – vaccines
Portion Control
Exercise
Stress
PHQ9 – Depression screening (point of intake screening)
SDOH: screen for housing, utility, clothing
Refer to Paradise Valley for a Registered Dietician

Patients with high cholesterol, high blood pressure, or are overweight are referred to the Health Edu. Dept.

Patients who have a history of or are at risk of heart disease and/or stroke

PCP identifies patients with/at risk of heart disease and/or stroke

Cardiologist (External)

No referral outcomes to external providers, including what a patient is referred to

# Engagement

# Recommendations

- Understand the worth and value of community partners and the unique perspectives

- Strategic Partnerships are critical to Community Coordination/ Multi-Sector Implementation is Important

- Understand your audience and tailor the values to the values of the organizations

- Take an agile process, things change over time

# Building CIE Partnerships

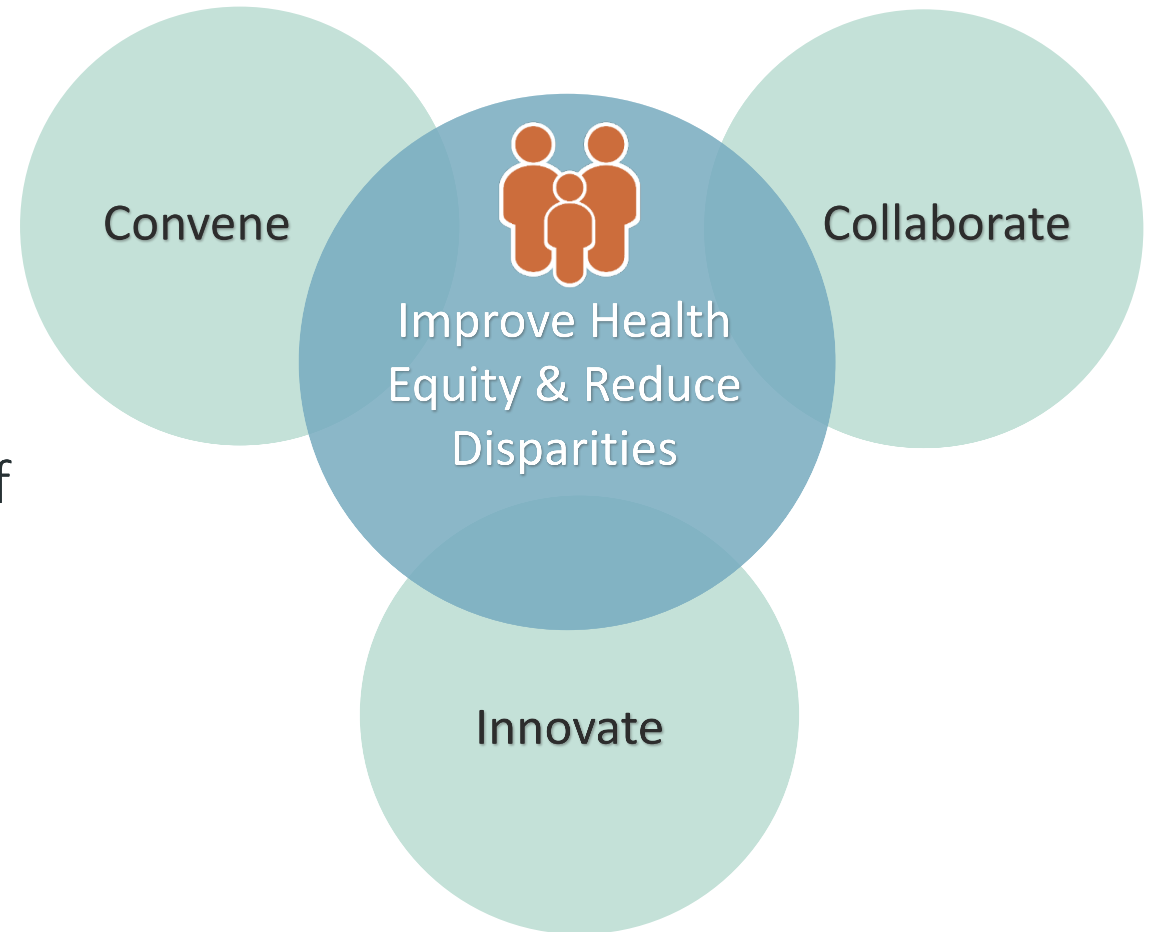
Community Information Exchange Summit 2020 • August 12, 2020

Presented by Gena Morgan, Chief Operating Officer

HealthierHere

# Nonprofit Dedicated to Health Equity

- Cross-sector partnership
- Multi-stakeholder Governing Board
- Contracted Accountable Community of Health (ACH) for King County, WA



HealthierHere

# Our Shared Vision

## A Connected, Coordinated System of Whole-Person Care Designed by the Community

HealthierHere

# What We are Working Toward

Meaningful community and consumer involvement and voice

Multi-disciplinary, culturally competent care teams and coordination

Payment models that incorporate and compensate social services

**Inter-connected information systems to support collaboration and coordination** between health care and social service providers

HealthierHere

# Sharing Power & Creating Buy-in

## Bring Everyone Together to an Equitable, Evenly Set Table

HealthierHere

# Sharing Power & Creating Buy-in

## Build a Shared Vision… and Stick to It

HealthierHere

# Sharing Power & Creating Buy-in

## Build a Shared Vision… and Stick to It

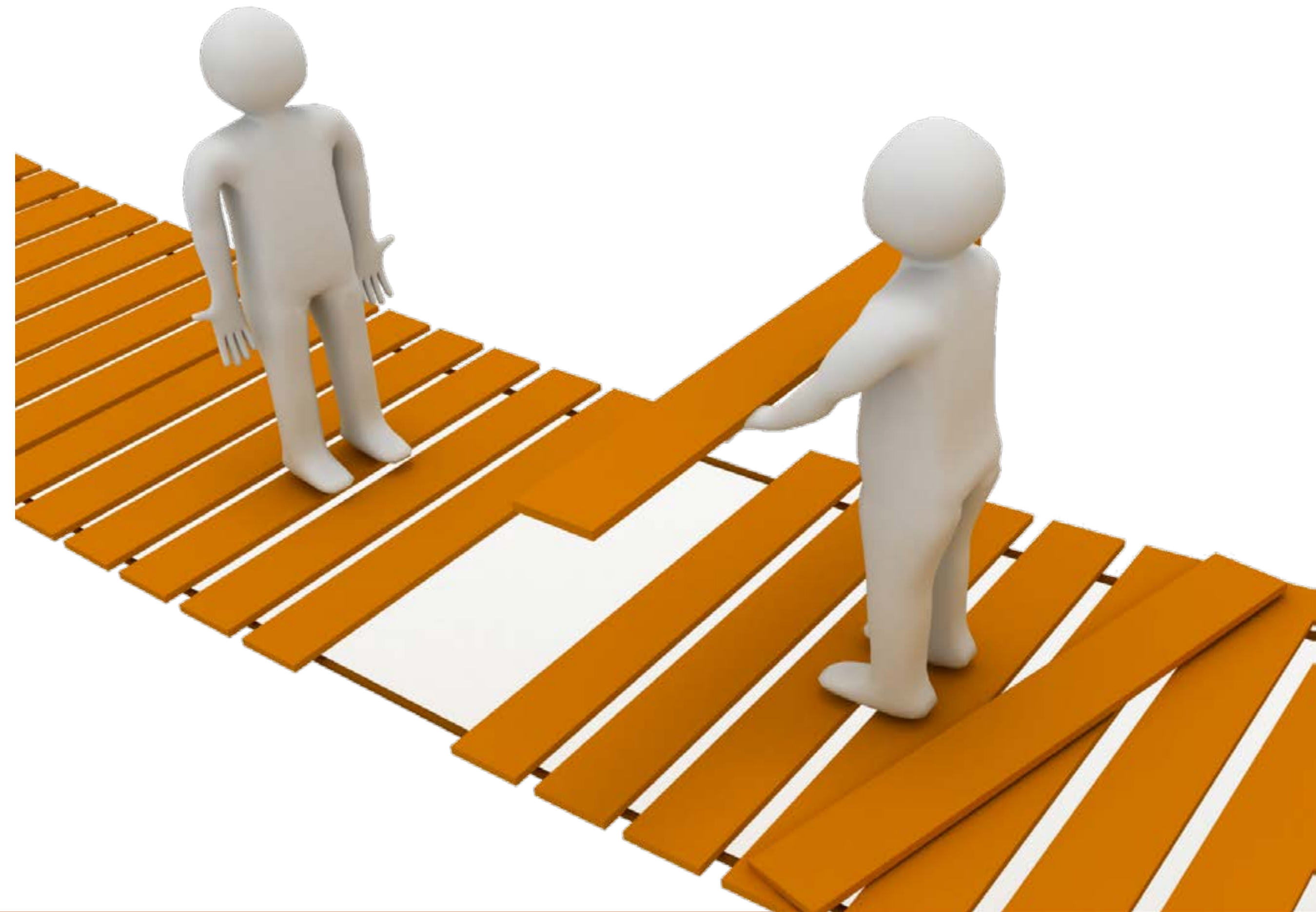
# Building a Resource That Brings Community Together

## Connect Existing Networks and Expand the Tent

HealthierHere

# Creating Value for Our Community

## Go Beyond Connections…
## Build Relationships
## to Enable Coordination

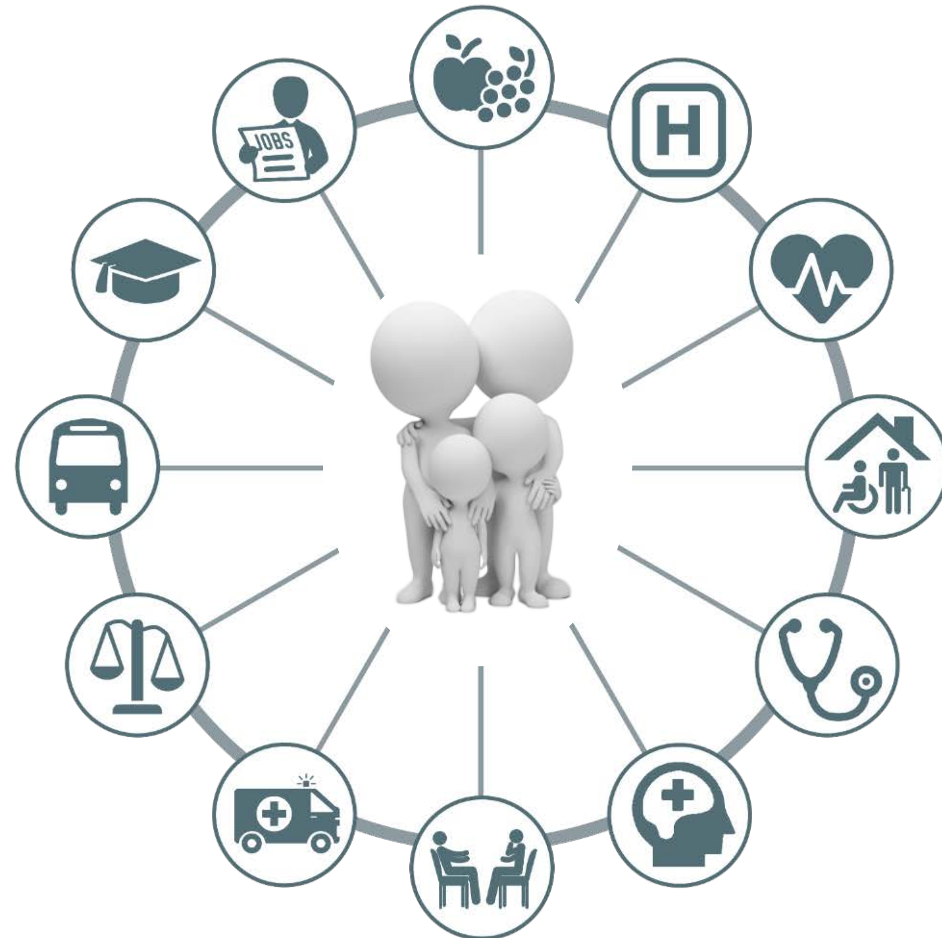


# Creating Value for our Community

## Engage and Ensure Community Ownership and Governance

# Navigating Through the Currents

## Always Keep the People We Serve at the Center



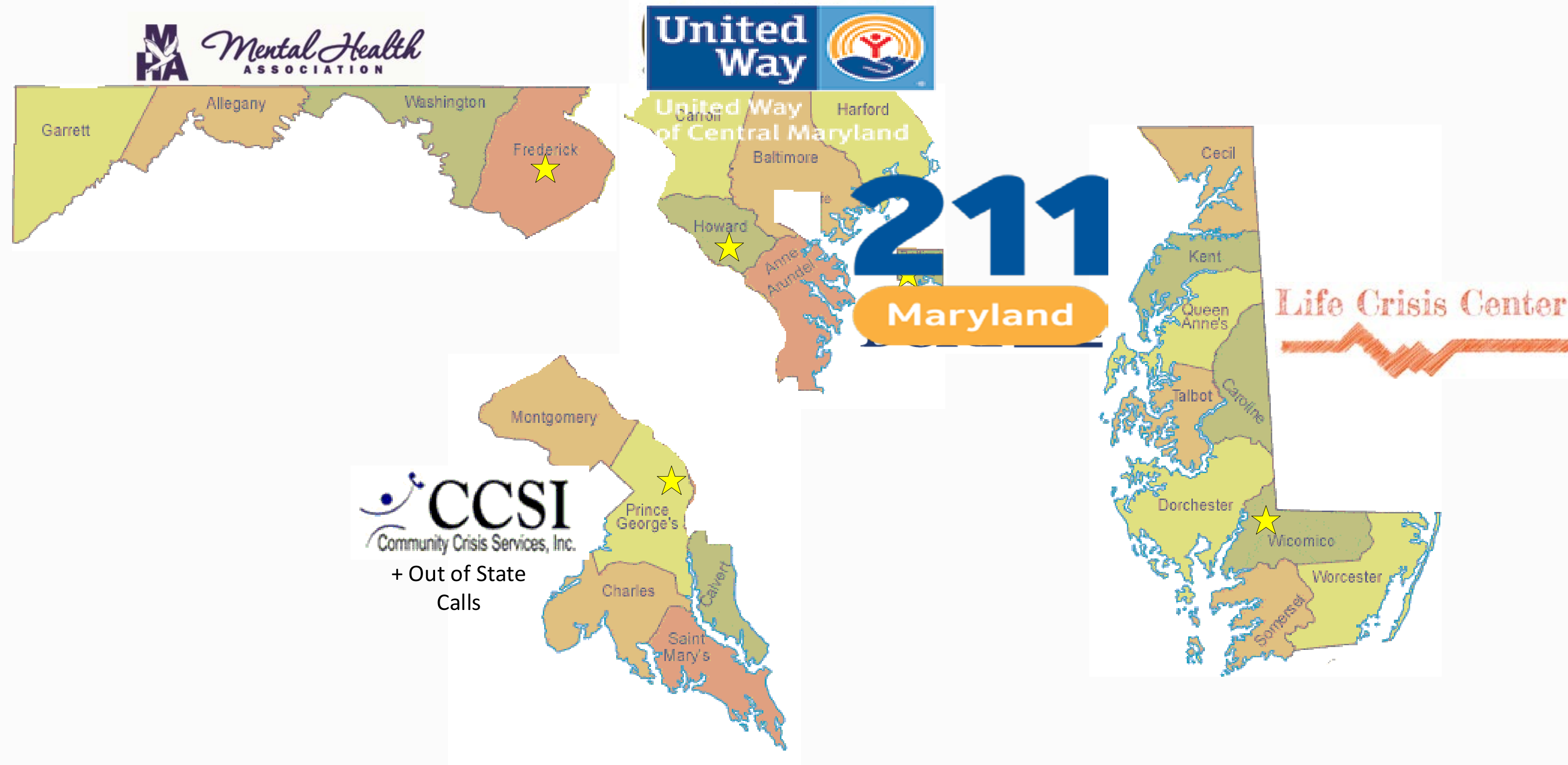
211

Maryland

- 211 pilot launched in Maryland in 2006. In 2010, legislation was passed enabling 211 to become a permanent system in Maryland.

- 211 MD consists of 4 regional call centers: UWCM-Central Maryland; CCSi-Southern Maryland; MHAFC-Western Maryland, and LCC-Eastern Shore

- **2018** Maryland Department of Health Maryland Crisis Hotline (MCH) Merge w/211



# 211Maryland Website Visits in FY'20=157,664

*Top THREE Needs: MENTAL HEALTH • FOOD • HOUSIN

**479,365**

CALLS TO 211 DURING FY'20

**10** YEARS OF 211... **3,247,740** CALLS

- FY'11 — **271,684**
- ▼ FY'12 — **266,281**
- ▲ FY'13 — **274,273**
- ▲ FY'14 — **292,924**
- ▲ FY'15 — **321,817**
- ▼ FY'16 — **278,359**
- ▲ FY'17 — **317,000**
- ▲ FY'18 — **359,000**
- ▲ FY'19 — **387,037**

## HIGHLIGHTS

- March through July: **COVID19-related calls surpassed 40,000** (top three jurisdictions: Baltimore City, Baltimore County and Prince George's County.
- Developed text subscription **MDReady** in partnership with MEMA to inform Marylander's about emergency COVID-related testing/services. Over 20,000 subscribers joined text platform.
- Partnered with the **Department of Human Services** to be the access point for COVID-related food distribution.
- Partnered with **Maryland Office on Aging** to be the access point for the Caregiver Program.
- Partnered with **CareFirst** and **DHHS** to provide medical information and COVID testing to Baltimore City residents.


© 2

# Our Future Work: CIE MODEL

- 2-1-1 Maryland was awarded a grant through the DASH Mentor Program, within the All In Network to support communities in advancing efforts to share and use multi-sector data to improve community health.

2-1-1 SAN DIEGO

# CIE Buy-In

✓What's my (211MD) role?

✓What's our organizational perception?

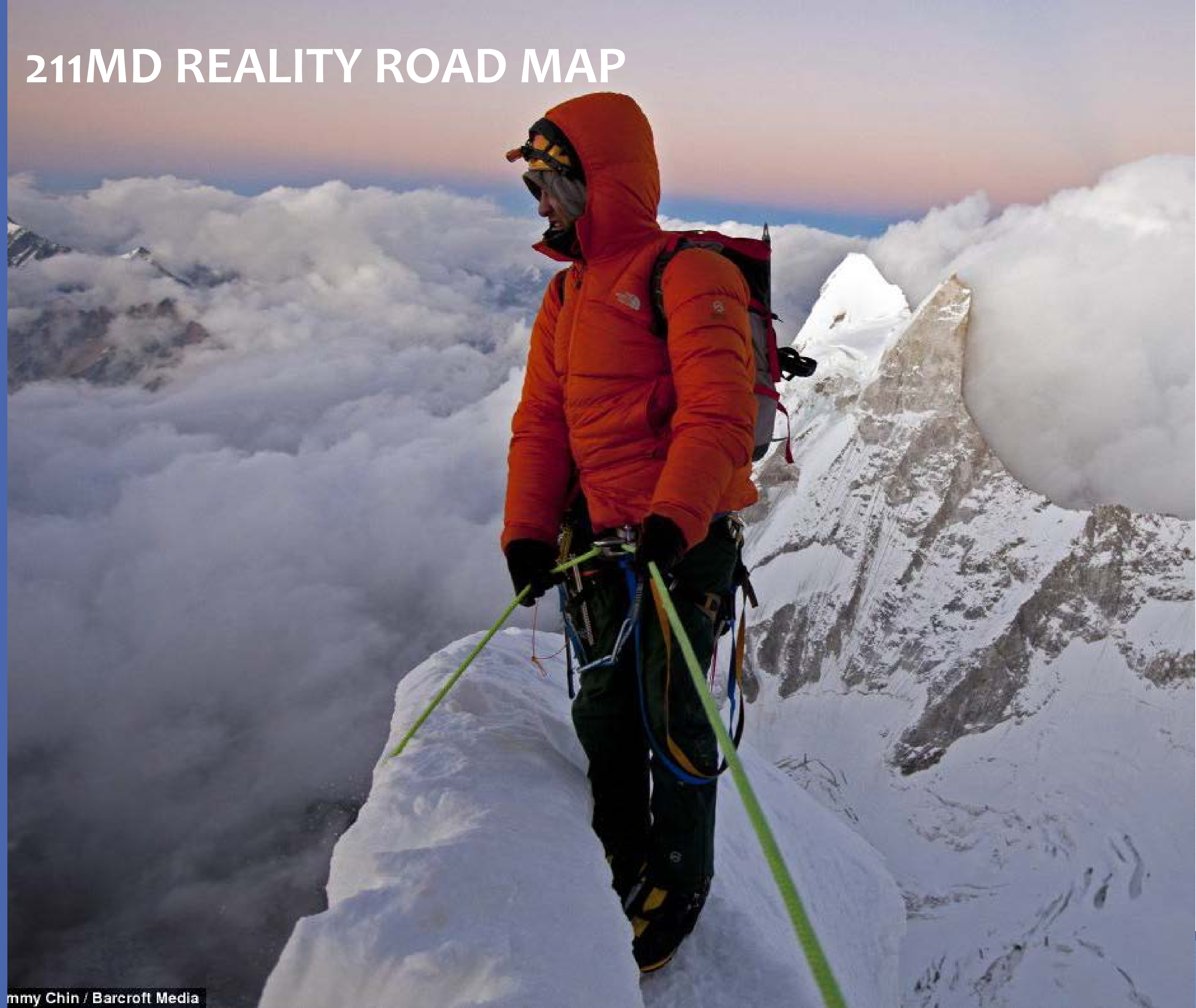
- Leverage power relationships

✓Top & Bottom Process

- (State/Local Conversations)

✓Environmental Scan –

- Internally & Externally



# Lessons Learned

- ✓Be Bilingual
- ✓There are many issues, which one are you solving?
- ✓It's ok to start small

*Our 211MD United Way Call Center is in the beginning stage of creating an ecosystem for older adults with funding from Kaiser Permanente*

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# Questions?

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Twitter: @211Maryland

# THANK YOU!

What's Next:

2:30pm - 3:30pm

Meet the Experts: Disruption Dialogue

Sponsored by Union Bank