Mobilizing a Community for Transformational Change: Creating a Community-Level, Person-Centered System of Care

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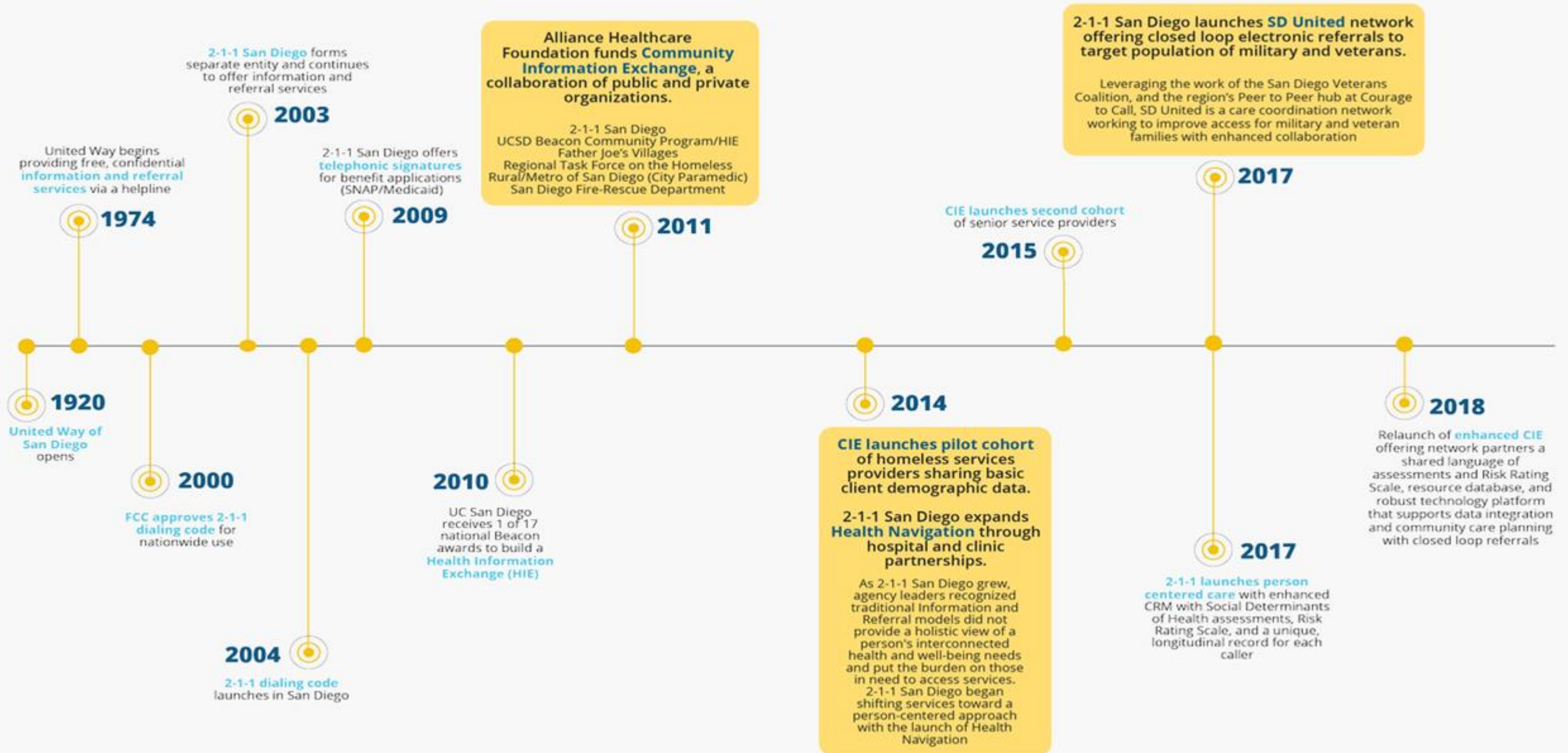United Way of Mid-South
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History of 2-1-1 San Diego & CIE

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

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

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

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

2011

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

CIE launches second cohort of senior service providers
2015

1920
United Way of San Diego opens

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

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

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

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

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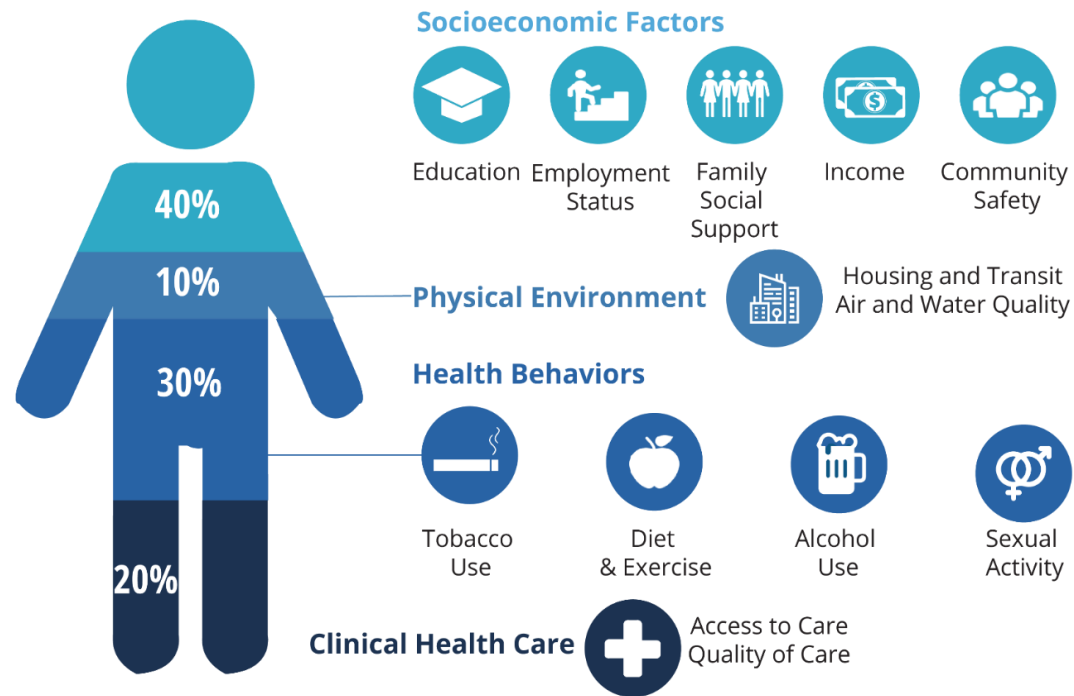
2004
2-1-1 dialing code launches in San Diego

San Diego- Health and Social Service Landscape

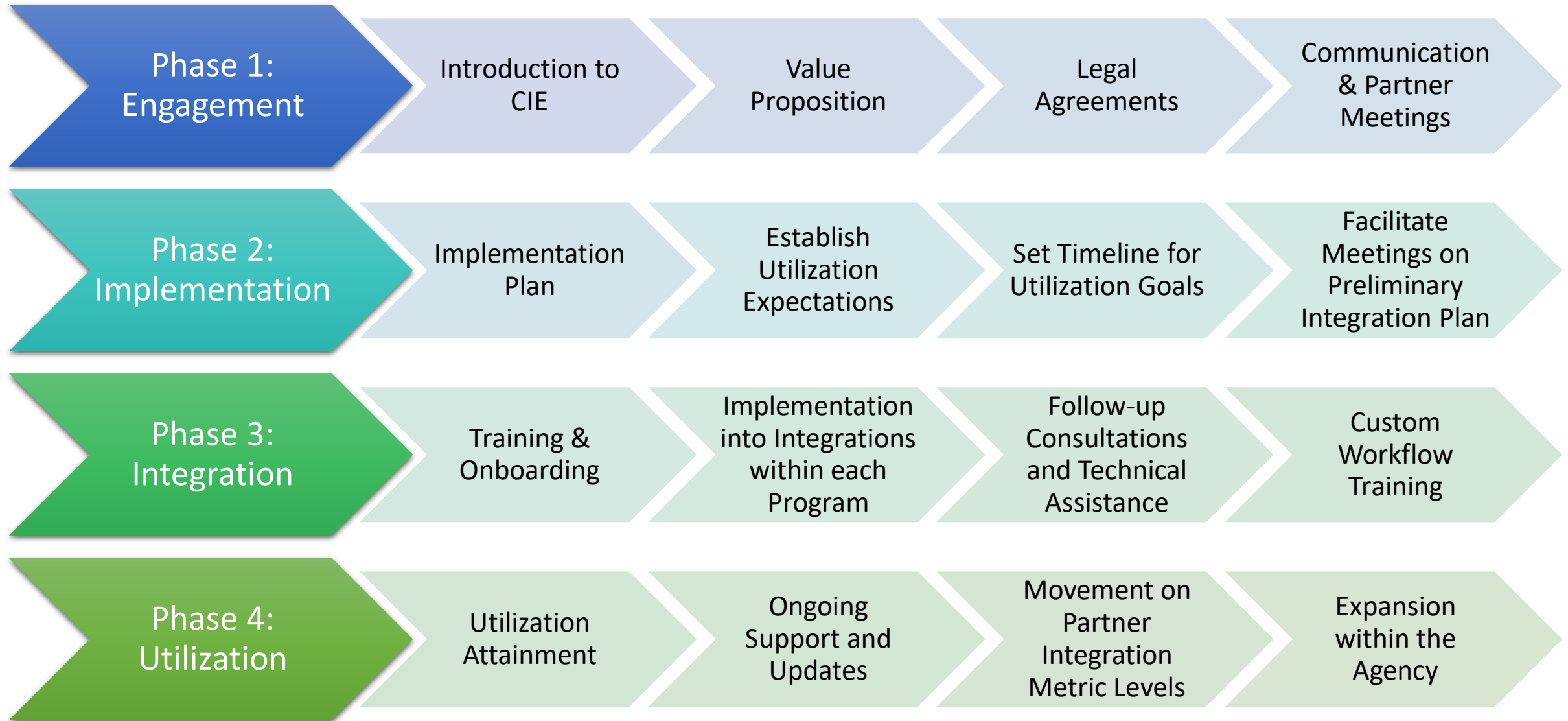## Growing public awareness of the social influences and how they greatly impact health

Socioeconomic Factors

Education | Employment Status | Family Social Support | Income | Community Safety

40%
10%
30%
20%

Physical Environment — Housing and Transit Air and Water Quality

Health Behaviors

Tobacco Use | Diet & Exercise | Alcohol Use | Sexual Activity

Clinical Health Care — Access to Care Quality of Care

Hood, CM, Gennuso, KP, Swain, GR, & Catlin, BB. (2015). County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine.*

Person-Centered Care

A Phased Approach

Phase 1: Engagement
- Introduction to CIE
- Value Proposition
- Legal Agreements
- Communication & Partner Meetings

Phase 2: Implementation
- Implementation Plan
- Establish Utilization Expectations
- Set Timeline for Utilization Goals
- Facilitate Meetings on Preliminary Integration Plan

Phase 3: Integration
- Training & Onboarding
- Implementation into Integrations within each Program
- Follow-up Consultations and Technical Assistance
- Custom Workflow Training

Phase 4: Utilization
- Utilization Attainment
- Ongoing Support and Updates
- Movement on Partner Integration Metric Levels
- Expansion within the Agency

- Engagement Approach

- Onboarding Options

Value Propositions

Community (Macro)

Agency (Mezzo)

Individual
and Family (Micro)

Community
Information
Exchange

2-1-1
SAN DIEGO/IMPERIAL

IMPACT
DRIVING THE DREAM
Out of Poverty

POVERTY { Education Financial Stability Health }

United Way of the Mid-South
UWMIDSOUTH.ORG

OUR WHY
THE
PROBLEM
The key to improving this area's
economic prosperity for all is
POVERTY REDUCTION.

OUR SOLUTION
Driving The Dream

DRIVING THE DREAM
Out of Poverty

Our Method

Start with the UWMS Network of Partner Agencies

Add **…**

- ***Driving The Dream*** Partners
- **Transition to Success** *(operating model)*
- **Map of My Dreams** *(defines "life of my choosing")*
- **Arizona Self-Sufficiency Inventory** *(common assessment)*
- **CoactionNet** *(shared database)*

=

…And we get a
"No Wrong Door"
evidence-based collaboration
to move
DRIVING THE DREAM
BENEFICIARIES
out of poverty
to greater
economic self-sufficiency and
the life of their dreams!

Our Journey

Truth mixed with hope.

Launch of Initial DTD Pilot

DTD Pilot Evaluation Report

Reboot of DTD Pilot (Collaborative Design)

DTD Pilot Reboot Launch

One Year of Operations

Jul – Sep 2016

Jan 2017

May – Sep 2017

Mar 2018

Mar 2019

Staff up and training

Staffing and infrastructure enhancements
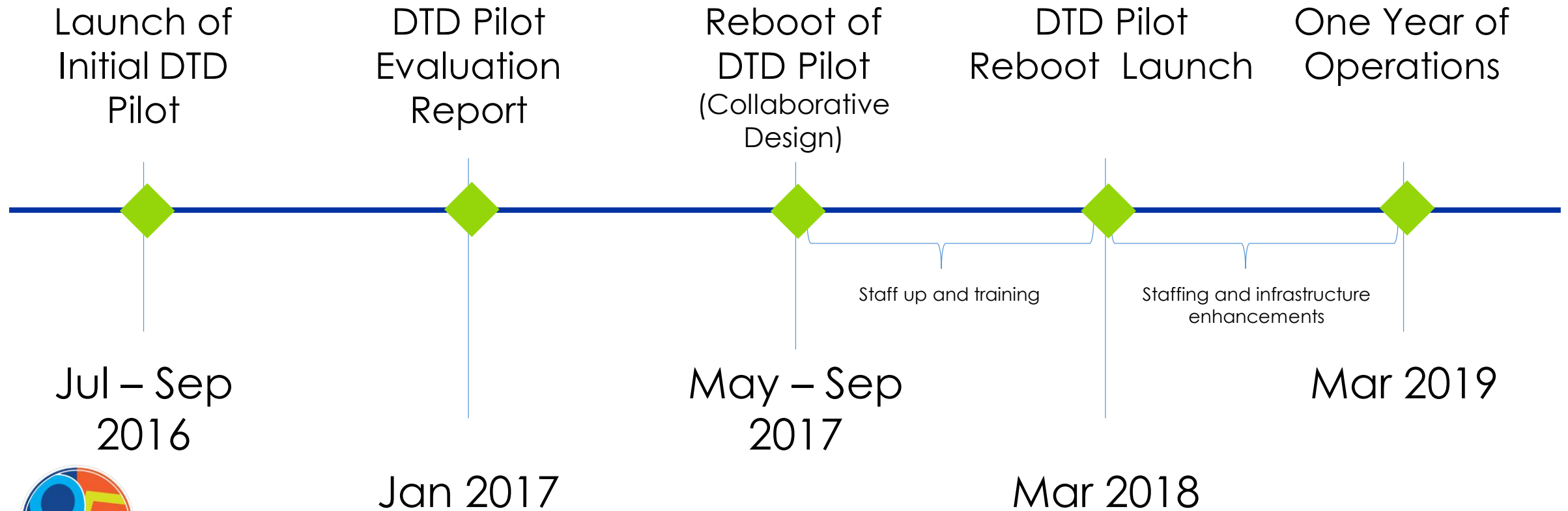
How Driving The Dream Works

United Way partners with agencies to create accessible resource networks.

- **United Way** Provides Leadership, Strategy, Data and Relationship Support

- **Coordinated Service Referrals** Create Seamless Partnerships Between Agencies

- **Care Coordination Hubs** Offer Extensive Support
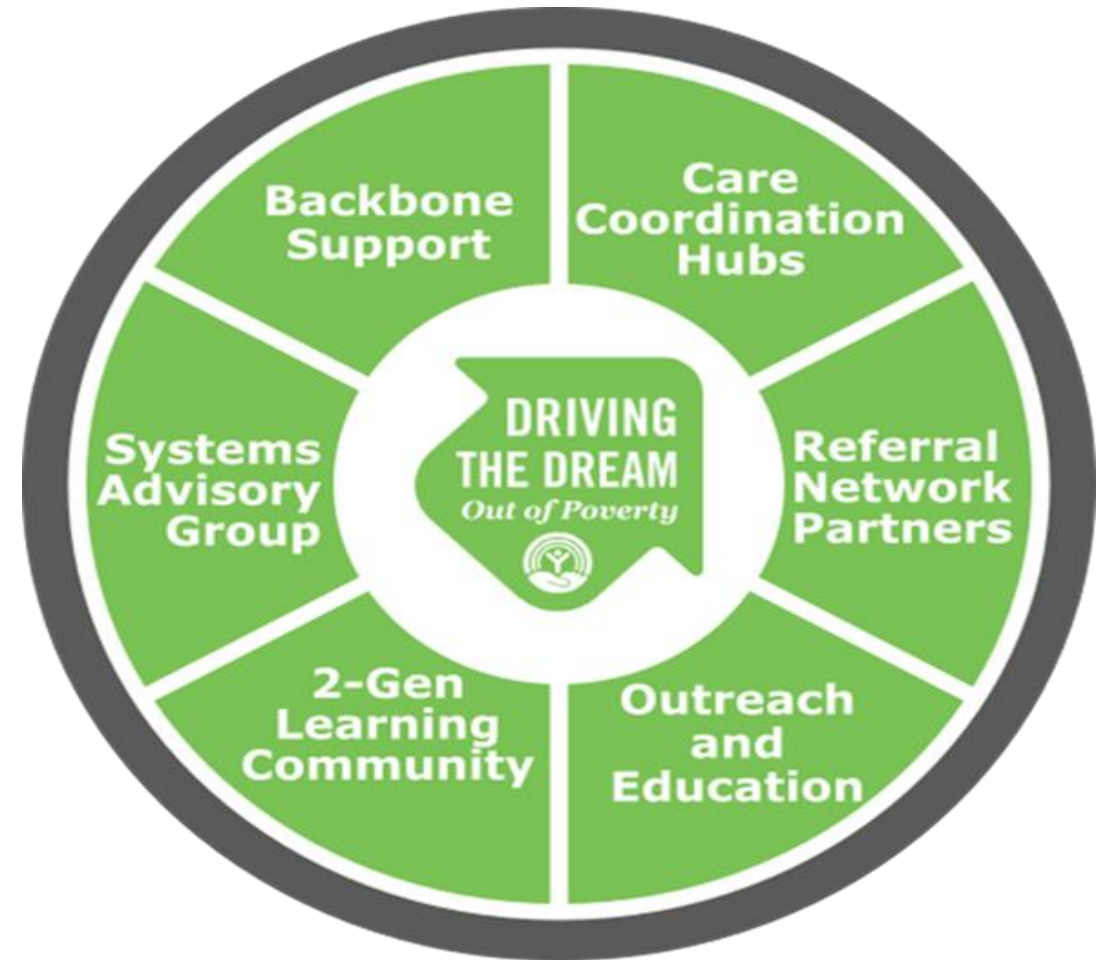
The Arizona Self-Sufficiency Matrix

19 health and human services domains.

DOMAIN	1 – In Crisis	2 - Vulnerable	3 - Safe	4 – Building Capacity	5 – Empowered
1. Shelter/ Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.	Household is safe, adequate, unsubsidized housing.
2. Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.	Maintains permanent employment with adequate income and benefits.
3. Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.	Income is sufficient, well managed; has discretionary income and is able to save.
4. Food and Nutrition	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household receives SNAP benefits.	Can meet basic food needs, but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires. [Makes healthy choices.]
5. Childcare	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available.	Affordable subsidized childcare is available, but limited.	Reliable, affordable childcare is available, no need for subsidies.	Able to select quality childcare of choice.
6. Children's Education	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.	All school-aged children enrolled and attending on a regular basis.
7. Adult Education	Literacy problems and/or no high school diploma/GED are serious barriers to employment.	Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.	Has high school diploma/GED.	Needs additional education to improve employment and/or to resolve literacy problems to where they are able to function effectively in society.	Has completed education/training needed to become employable. No literacy problems.

The Value of Driving The Dream

A combination of technology, social work best practices & collaborative relationships help families climb out of poverty.

- Clients receive **integrated services** and a **supportive experience.**

- Easy **documentation** of client progress and client history.

- **Improved outcomes** for individuals and families over time

- **Opportunities** for professional development and staff training.

- **Accurate and reportable client data**.

- Clients have **easy access** to referral resources.

- **Better accountability** of staff time and efforts.

DRIVING THE DREAM *Out of Poverty*

YEAR 1 GOALS

March 2018 – February 2019

- **Sector Integration**

- **Cultural Transformation**

- **Improved Coordination of Services**

- **Expanded Services for Families**

YEAR 1 ACHIEVEMENTS

March 2018 – February 2019

Established 18 *Driving The Dream* partnerships – MOUs and DSAs - and launched **4 Hubs**

- Secured **$4.8 million** in private and state government funding

- Launched **shared data & measurement platform** with 143 users

- Documented that **94%** of surveyed Care Coordination clients report progress in one or more ASSI domains

- Served **500+** unduplicated clients

YEAR 2 GOALS

March 2019 – February 2020

- **Increase data platform usage.**

  ○ Expand existing agency partnerships with schools, county government, and healthcare providers.

  ○ Launch Outreach and Education partnerships with faith communities.

- **Increase access to data.**

  ○ Establish a 24-hour client intake and referral portal.

  ○ Establish interoperability

- **Secure 3-5 years of scale up operating support.**