Community Information Exchange (CIE) Advisory Board Meeting

November 17, 2020
CIE Advisory Board Meeting  
AGENDA  
November 17, 2020 • 8:30 AM – 9:30 AM

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter</th>
</tr>
</thead>
</table>
| 8:30 – 8:35am | Welcome and Introductions & Agenda Overview                                 | Mathew Packard  
Chair 2-1-1 Advisory Board                                               |
| 8:35 – 8:55am | CIE Utilization Update & Initiatives  
• AHRQ Update  
• RWJF: CIE as Public Health Transformation  
• Other Initiatives and Updates | Karis Grounds  
VP of Health and Community Impact  
Camey Christenson  
Chief Business Development Officer                                           |
| 8:55 – 9:00 am | Affinity Groups                                                            | Karis Grounds  
VP of Health and Community Impact                                           |
| 9:00-9:25 am  | Workgroups Update  
• Membership  
• Outcomes  
• Sustainability                                                           | Karis Grounds  
VP of Health and Community Impact  
Mathew Packard  
Chair 2-1-1 Advisory Board  
Camey Christenson  
Chief Business Development Officer                                           |
| 9:25-9:30 am  | Other Updates & Meeting Adjournment                                         | Mathew Packard  
Chair 2-1-1 Advisory Board                                                  |
WELCOME & INTRODUCTIONS
CIE UTILIZATION UPDATE
CIE TRENDS AND METRICS DASHBOARD - Fiscal Year: July 1, 2020 - June 30, 2021

The trends dashboard highlights the established fiscal year metric goals for the CIE. These goals are specific to utilization, including how many partners and clients are in the network and how partners use the network to view clients, refer them to appropriate resources and share data to enhance records. This utilization allows us to better assess and understand the overall impact the CIE has on client outcomes.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Current Numbers</th>
<th>% to Goal</th>
<th>Monthly Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>105 Partners</td>
<td>97 Partners</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Adoption Metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30,000 Logins</td>
<td>7,697 Logins</td>
<td>26%</td>
<td>2,122 Jul, 1,806 Aug, 1,829 Sep, 1,940 Oct</td>
</tr>
<tr>
<td>205,000 Consents</td>
<td>170,459 Consents</td>
<td>83%</td>
<td>5,382 Jul, 6,679 Aug, 5,056 Sep, 4,851 Oct</td>
</tr>
<tr>
<td>40,000 Searches</td>
<td>7,809 Searches</td>
<td>20%</td>
<td>2,206 Jul, 1,956 Aug, 1,727 Sep, 2,321 Oct</td>
</tr>
<tr>
<td>Engagement Metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100,000 Records with Shared Data</td>
<td>79,715 Records with Shared Data</td>
<td>80%</td>
<td>5,019 Jul, 5,218 Aug, 4,369 Sep, 3,675 Oct</td>
</tr>
<tr>
<td>30,000 Profile Views</td>
<td>7,815 Profile Views</td>
<td>26%</td>
<td>1,790 Jul, 1,624 Aug, 2,506 Sep, 1,895 Oct</td>
</tr>
<tr>
<td>Intervention Metrics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25,000 Direct Referrals</td>
<td>6,110 Direct Referrals</td>
<td>24%</td>
<td>1,627 Jul, 1,544 Aug, 1,436 Sep, 1,503 Oct</td>
</tr>
</tbody>
</table>

Data Source: 211/CIE Information Systems | Reporting Period: 7/1/2020 - 10/31/2020
## Data Sharing Metrics

### Top 25 Data Sharing Partners*

<table>
<thead>
<tr>
<th>Organization</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father Joe's Villages</td>
<td>18,462</td>
</tr>
<tr>
<td>County of San Diego</td>
<td>14,354</td>
</tr>
<tr>
<td>San Diego Workforce Partnership</td>
<td>13,572</td>
</tr>
<tr>
<td>Regional Task Force on the Homeless</td>
<td>13,115</td>
</tr>
<tr>
<td>Molina Healthcare, Inc.</td>
<td>9,990</td>
</tr>
<tr>
<td>Jacobs and Cushman San Diego Food Bank</td>
<td>5,429</td>
</tr>
<tr>
<td>Legal Aid Society of San Diego, Inc.</td>
<td>4,446</td>
</tr>
<tr>
<td>Alpha Project for the Homeless</td>
<td>4,285</td>
</tr>
<tr>
<td>EMS Alerts</td>
<td>3,198</td>
</tr>
<tr>
<td>San Ysidro Health</td>
<td>1,992</td>
</tr>
<tr>
<td>Jewish Family Service (JFS) of San Diego</td>
<td>1,815</td>
</tr>
<tr>
<td>Metropolitan Area Advisory Committee (MAAC)</td>
<td>1,643</td>
</tr>
<tr>
<td>San Diego Housing Commission</td>
<td>1,523</td>
</tr>
<tr>
<td>Interfaith Community Services</td>
<td>1,460</td>
</tr>
<tr>
<td>PATH San Diego</td>
<td>1,388</td>
</tr>
<tr>
<td>City of Chula Vista</td>
<td>1,268</td>
</tr>
<tr>
<td>Family Health Centers of San Diego</td>
<td>1,224</td>
</tr>
<tr>
<td>Veterans Village of San Diego</td>
<td>984</td>
</tr>
<tr>
<td>The Salvation Army San Diego Regional Office</td>
<td>913</td>
</tr>
<tr>
<td>Childcare Resource Service, YMCA of San Diego County</td>
<td>760</td>
</tr>
<tr>
<td>Community Catalysts of California</td>
<td>722</td>
</tr>
<tr>
<td>Mental Health Systems, Inc.</td>
<td>690</td>
</tr>
<tr>
<td>Catholic Charities Diocese of San Diego</td>
<td>584</td>
</tr>
<tr>
<td>Meals on Wheels San Diego County</td>
<td>548</td>
</tr>
<tr>
<td>Episcopal Community Services</td>
<td>529</td>
</tr>
<tr>
<td>San Diego Rescue Mission, Inc.</td>
<td>468</td>
</tr>
<tr>
<td>McAllister Institute for Treatment and Education</td>
<td>458</td>
</tr>
<tr>
<td>Home Start</td>
<td>442</td>
</tr>
<tr>
<td>South Bay Community Services</td>
<td>264</td>
</tr>
<tr>
<td>Operation Hope North County</td>
<td>234</td>
</tr>
</tbody>
</table>

*This is a unique count of clients who have at least one source of data shared from another partner, besides 2-1-1 San Diego.

### Shared Data Trends

Graph represents the number of new sources of data each month on a client record. For example, a client is counted in January for FJV consenting them, but SDFB enrolls them into a program in March, therefore also counting them in March as a record with a new source.

<table>
<thead>
<tr>
<th>Month</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5,019</td>
<td>5,218</td>
<td>4,369</td>
<td>3,575</td>
</tr>
</tbody>
</table>

### Alert Breakdown by Incident Month

<table>
<thead>
<tr>
<th>Month</th>
<th>Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>590</td>
</tr>
<tr>
<td>August</td>
<td>706</td>
</tr>
<tr>
<td>September</td>
<td>681</td>
</tr>
<tr>
<td>October</td>
<td>565</td>
</tr>
</tbody>
</table>
CIE INITIATIVE UPDATE
AHRQ: Dashboards
AHRQ Purpose

- AHRQ in collaboration with University of California, San Francisco

- **What health and social information would be useful to change your intervention care with the goal of improving health outcomes?**
  - Dashboards-Individual, Panel & Aggregate
  - 35+ interviews, FQHCs,
  - 40+ survey CIE Network
10. What do you use this social needs information for? (check all that apply)

- Intake: 36
- Eligibility determination: 34
- Prioritization for services: 26
- Referrals: 48
- Care planning/case management: 37
- Tailoring services or care: 22
- Program planning: 14
- Monitoring or evaluation: 15
- Fundraising: 4
- I don’t use social needs information: 5
- Other: 2

63 respondents
Needing the Insights, Not Just the Information

- There was an underlying, less stated desire to know the insights from the data, not just the data element itself (e.g. having A1c levels too high, vs. just the number).
- For example, knowing someone’s employment status coupled with their behavioral health or substance use disorders could highlight employment risks or needs.
- External datasets to help interpret meanings, for example having transportation data to know if a patient/client has access to a program.
Next Steps

• Adding clinical data into the CIE

• Expanding alert functionality to include additional
  • Homeless + Chronic Condition
  • Missed Appointments
  • Food Insecurity + Diabetes, Pre-diabetes, hypertension
  • Housing Insecure + Medications
  • New eligibility

• Enhancing search for referrals

• Panel Management Sessions in December
### Examples of Clinical and Social data paired

<table>
<thead>
<tr>
<th>Social Data</th>
<th>Clinical Data</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any (especially multiple cumulative)</td>
<td>Medications No show appts.</td>
<td>Instead of increasing medications, first focusing on addressing barriers to attending appts (e.g., counseling).</td>
</tr>
<tr>
<td>Housing quality / mold</td>
<td>Diagnosis (asthma) Inhaler (medication)</td>
<td>Mold in housing could trigger and exacerbate asthma. Addressing social risk could result in less medication use/need.</td>
</tr>
</tbody>
</table>
Examples of Clinical and Social data paired

<table>
<thead>
<tr>
<th>Social Data</th>
<th>Clinical Data</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food insecurity</td>
<td>Diagnoses (e.g., diabetes)</td>
<td>Let social service CBO know to ensure food provided is appropriate.</td>
</tr>
<tr>
<td>Food insecurity</td>
<td>Diagnoses (e.g., diabetes, hypertension)</td>
<td>PCP will tailor/change approach to lifestyle changes (e.g., diet recommendations) as well as overall increased understanding of “non adherence”</td>
</tr>
<tr>
<td>Housing quality</td>
<td>Diagnoses (e.g., diabetes) and ventilator use</td>
<td>Working on specific housing quality resources where impact on health is greatest (e.g., air conditioning)</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Medications (e.g., insulin)</td>
<td>Information would facilitate housing placement (e.g., hotel room or immediate shelter placement) as medication requires refrigeration.</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Diagnoses (e.g., diabetes, schizophrenia)</td>
<td>Combined information will inform medications prescribed as well as specific social referrals.</td>
</tr>
<tr>
<td>Any</td>
<td>Diagnoses (e.g., cognitive such as TBI)</td>
<td>Utilize clinical diagnoses or conditions to correctly pair with best social referral and/or support that referral to be successful.</td>
</tr>
</tbody>
</table>
Robert Wood Johnson Foundation: Public Health Transformation

- **CIE Case Study (April 2021):** Create an understanding of the value, impact, and equitable approach that CIEs can bring to the public health data models

  Leveraging the [CDC’s New World of Public Health Data infographic](#), 2-1-1 San Diego, will produce a case study that introduces the important elements of a CIE, including the CIE definition, community value, impact, and short-term and long-term outcomes with the goal of advancing health equity. We will provide insights on system design, interoperability and data infrastructure, as well as share key needs, challenges, gaps and resiliency factors that communities are experiencing that create opportunities for proactive and strengths-based investment vs. need-based, using the COVID-19 pandemic as a use case.

- **Community Profiles (April 2021):** Explore strategies for and examples of meaningful engagement of community members in the development and maintenance of community data systems like a CIE

  Community members are the most critical element to the successful design and implementation of a CIE. 2-1-1 will compile profiles of three communities (including San Diego and at least one rural community) to detail approaches for community member engagement in developing and maintaining community data systems. Each profile will detail how community voice is embedded in their local CIE and will include strategies, lessons learned, and opportunities for growth.

- **CIE Data Equity Framework (April 2021):** Identify challenges and promote opportunities to build data systems that are not structurally racist, using CIEs as the example

  The CIE systems change work requires a community to adopt an anti-racist framework. 2-1-1, in collaboration with the CIE National Community Council and 2-1-1’s Chief Medical Officer, Dr. Rhea Boyd, will develop a CIE Data Equity Framework that ensures diversity, equity, and inclusion is built into each stage of CIE planning, including: shared governance structure, power dynamics, data ownership, monetization, and other key aspects.

- **Strategic Agenda and Alignment (On-going):** Establish a strategic agenda to support communities building Community Information Exchanges

  In collaboration with Health Leads, 2-1-1 launched a National Advisory Board and a community of practice advancing the CIE Movement through collaborating on resources, tools, and policy recommendations. The project team will utilize the completed work to develop and advance a national CIE strategic agenda that would promote alignment and cultivate a culture of health equity through meaningful systems change.
Date and Time: November 17th 10-11:30 AM

Listening Session: How Might CIE Support Community Responses to ACEs
Please join this discussion to consider how CIE might be an additional resource in responding to needs related to adverse childhood experiences (ACEs). The guided discussion will explore opportunities to leverage CIE to document and share information relevant to referrals and coordinated support. We look forward to hearing your ideas, perspectives and considerations as our community aligns around pathways to support those who have experienced ACEs.

Registration Link: https://211sandiego.zoom.us/meeting/register/tJApf-yrpzkvEtXyaT-Eb-1ThuRUbexkR4-I
CIE Affinity Groups
Affinity Groups

• Establishing “affinity groups” for the 97+ partner organizations to help drive utilization, collaborative alignment and outcomes for the community

• **Goal:** Create peer learning opportunities to share best practices and opportunities among similar initiatives or target populations using the CIE

• **Structure:**
  • @ first meeting identify meeting structure
    • Working goals, timelines (shared ownership of content)
    • Frequency (monthly, quarterly or period of time)

• **Examples of Affinity Groups:**
  • **Initiative (closed groups/invite only)**
    • Partners in Prevention
    • 2Gen
    • Neighborhood Networks
    • HEAP
  • **Target Population**
  • **Cross-Sector Collaboration**
  • **Functions**
Workgroup Updates
Workgroups

- Membership Workgroup Meeting
  - Second Monday of the Month

- Sustainability Workgroup Meeting
  - Second Tuesday of the Month

- Outcomes Workgroup Meeting
  - 1st Tuesday of the Month
Outcomes Workgroup
Next Steps Matrix

- **Breakout by focus areas & create separate matrix**

- **Hold smaller group discussions on each matrix**
  - Housing- RTFH, others?
  - Food Insecurity-CACHI, others?
  - Family Health and Wellness- YMCA, others?

- Share with larger group proposed outcome measures
How to measure: Efficiency/Collaboration

- Efficiency:
  - I can develop a synopsis of a patient's social needs faster
  - It takes less effort to gain an understanding of a patient's needs
  - I am able to find more resources to meet the patients needs
  - The CIE helps me give better overall care
  - The CIE has increased patient satisfaction
  - I have an increased awareness of community resources available to patients

- Collaboration/Coordination:
  - I use CIE to work better with other organizations
  - I feel more informed about my clients/patients due to CIE
  - I know more about my clients/patients needs outside of my organization due to CIE

- Effectiveness
- Equity-Disparities
Survey: Informed Interventions

• Change in intervention and interaction with individuals

• **Example Intervention Questions:**
  • Do you help a person differently because of information in CIE?
  • The information in CIE changes the way you help a client

• **Example Quantitative Assessments**
  • Viewed CIE record and made a referral
  • Post-encounter survey
Membership Workgroup
Membership

CIE Advisory Board Membership
Working Group Agenda
Monday 10/12/20 9:00 a.m.

I. Confirm targeted number of Advisory Board seats
   a. Proposed 15 seats 10 – sectors 5 – at large

I. Update on AB member biographies

II. Making a meaningful contribution to address social/racial equity issues through CIE AB membership
   a. Outreach to Partner Network meeting
   b. Targeted outreach to individual members
   c. Opportunities for further outreach

I. Further discussion of sector representation
   a. Some possible sectors

• Education
• Healthcare
• Criminal Justice
• Social Services
• Faith-based
• Chamber-Business
• Law Enforcement
• Community Member
• Government
• Youth/Children
• Veterans
• Seniors
Sustainability Workgroup
CIE Sustainability Workgroup Planning Meetings

**Workgroup Session 1: Intro & Level Set**
- Review and approve Work Group Goals / Objectives / Agenda
- Brief CIE History
- FY21 Goals Overview

**Workgroup Session 2: Best Practices**
- CIE’s Shared Governance Model
- Overview of Historical Documents / Past Strategies
- Deep Dive into FY21 Strategies, Membership Model, & Revenue Expectations
- Identify Other Financial Models for backbone/technology/network sustainability

**Workgroup Session 3: Brainstorming Strategies**
- Review existing metrics, ROI, and value propositions
- Compare value propositions to current audience and marketplace
- Identify Opportunities to Diversify Funding Streams / Monetize

**Workgroup Session 4: Compare Updates from Outcomes Committee with Sustainability Plans**
- Review work of Outcomes Workgroup and any potential changes to metrics, ROI, and value propositions

**Workgroup Session 5: Recommendations**
- Establish Recommendations for Future Sustainability Models
- Identify Roles and Responsibilities
Last Meeting Follow Up:

- Consulting detail
- Affinity Groups - Health Care
- Examine language: Who is opting in?
Primary CIE Uses

• Searching patients/members to see historical use of social services
  • Tailor services accordingly
  • Reach out to existing care team member or agency for support
• Make referrals to external community and healthcare organizations
  • Ability to track referrals to partners
  • Send client profile directly to agency (outcomes of referral)
• Shared screening or prioritization of resources
  • Example--Homeless Prevention resources
  • Prioritize access to services (history or acuity)
• Receive alerts to be proactive or response
  • Join as care team member and receive alerts
## Sustainability Opportunities

### Healthcare
- **Opportunity**: Without addressing whole person, health outcomes will not completely improve for all.
- **Target**: Health Plans, Hospitals, Health Centers/Clinics
- **Impact**: Improve Patient Health Outcomes
- **Value**: Revenue structure to support approach and intervention (readmission, value based care, healthier members)

### Education
- **Opportunity**: Lack of early intervention and wrap-around services for children, families and students
- **Target**: Adverse Childhood Effects, Violence, Foster Youth, Colleges
- **Impact**: Early intervention can prevent arrests and support post-incarceration with whole person care
- **Value**: Reduction in government spending by decreasing all recidivism

### Justice-Involved
- **Opportunity**: Poor prevention, release and racial inequities
- **Target**: Parole, Reentry, Recidivism
- **Impact**: Early connections can prevent arrests and support reintegration with whole person care
- **Value**: Reduction in government spending by decreasing all recidivism

### Public Safety
- **Opportunity**: Increasing incidences of violence and disconnected prevention and support resources
- **Target**: IPV, Gun Violence, Neighborhood Safety
- **Impact**: Early intervention resources to link individuals and families in crisis
- **Value**: Local capacity to prevent violence and support communities

### Employment
- **Opportunity**: EAP programs, to support personnel, family and workplace
- **Target**: Workforce Development, Government
- **Impact**: Ability to access resources and supports to be successful in work
- **Value**: Healthy, happy and productive workforce

### Utility and Technology
- **Opportunity**: Technology divide
- **Target**: Cell Phone Carriers/Plans, Apps
- **Impact**: Improve access to resources and information
- **Value**: Communication and connected to needs to target markets
Value Propositions

Member Retention  Social Determinants of Health  Case Management Tools  Community Wellness  Referrals  Care Coordination  Data

Collective Impact  One Stop Shop for SDoH Information  Stakeholder Value & Grant Writing  Patients Healthier  Readmission Reduction & Utilization  Patient-Centered Care  Efficiency

Care Beyond Hospitals
Brainstorming Discussion:

• Membership Model
• Revenue Diversification
• Monetization Ideas
OTHER UPDATES & NEXT MEETING

December 15th, 2020 8:30-9:30 AM