Community Information Exchange (CIE) Advisory Board Meeting

November 17, 2020

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

Time	Agenda Item	Presenter
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

Community Information Exchange

2-1-1 SAN DIEGO

CIE UTILIZATION UPDATE

CIE TRENDS AND METRICS DASHBOARD - Fiscal Year: July 1, 2020 - June 30, 2021

The trends dashboard highlights the established fiscal year metrtic 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.

Goal	Current Numbers	% to Goal	Monthly Trends
105 Partners	**97** Partners	**92%** of Goal	
Adoption Metrics			
30,000 Logins	**7,697** Logins	**26%** of Goal	Jul 2,122 · Aug 1,806 · Sep 1,829 · Oct 1,940
205,000 Consents	**170,459** Consents	**83%** of Goal	Jul 5,382 · Aug 6,679 · Sep 5,056 · Oct 4,851
40,000 Searches	**7,809** Searches	**20%** of Goal	Jul 2,205 · Aug 1,556 · Sep 1,727 · Oct 2,321
Engagement Metrics			
100,000 Records with Shared Data	**79,715** Records with Shared Data	**80%** to Goal	Jul 5,019 · Aug 5,218 · Sep 4,369 · Oct 3,675
30,000 Profile Views	**7,815** Profile Views	**26%** of Goal	Jul 1,790 · Aug 1,624 · Sep 2,506 · Oct 1,895
Intervention Metrics			
25,000 Direct Referrals	**6,110** Direct Referrals	**24%** of Goal	Jul 1,627 · Aug 1,544 · Sep 1,436 · Oct 1,503

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

Dreams for Change

Community Information Exchange

211 SAN DIEGO/IMPERIAL

Data Sharing Metrics

Top 25 Data Sharing Partners*

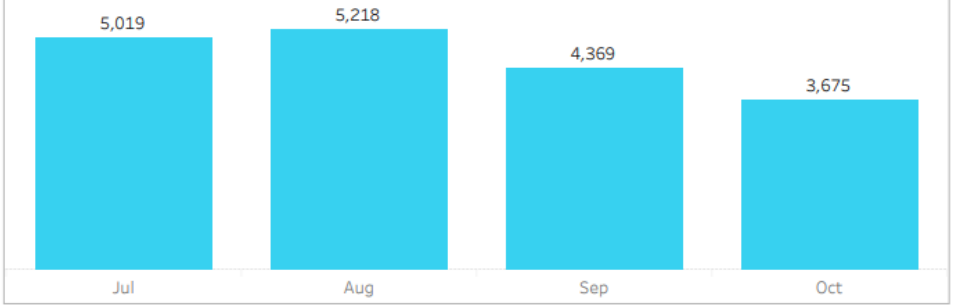
Father Joe's Villages	18,462
County of San Diego	14,354
San Diego Workforce Partnership	13,572
Regional Task Force on the Homeless	13,115
Molina Healthcare, Inc.	9,990
Jacobs and Cushman San Diego Food Bank	5,429
Legal Aid Society of San Diego, Inc.	4,446
Alpha Project for the Homeless	4,289
EMS Alerts	3,198
San Ysidro Health	1,991
Jewish Family Service (JFS) of San Diego	1,815
Metropolitan Area Advisory Committee (MAAC)	1,643
San Diego Housing Commission	1,523
Interfaith Community Services	1,460
PATH San Diego	1,388
City of Chula Vista	1,268
Family Health Centers of San Diego	1,224
Veterans Village of San Diego	984
The Salvation Army San Diego Regional Office	913
Childcare Resource Service, YMCA of San Diego County	760
Community Catalysts of California	722
Mental Health Systems, Inc.	690
Catholic Charities Diocese of San Diego	584
Meals on Wheels San Diego County	548
Episcopal Community Services	529
San Diego Rescue Mission, Inc.	468
McAlister Institute for Treatment and Education	458
Home Start	442
South Bay Community Services	264
Operation Hope North County	234

Client Records with Shared Data*: 79,715

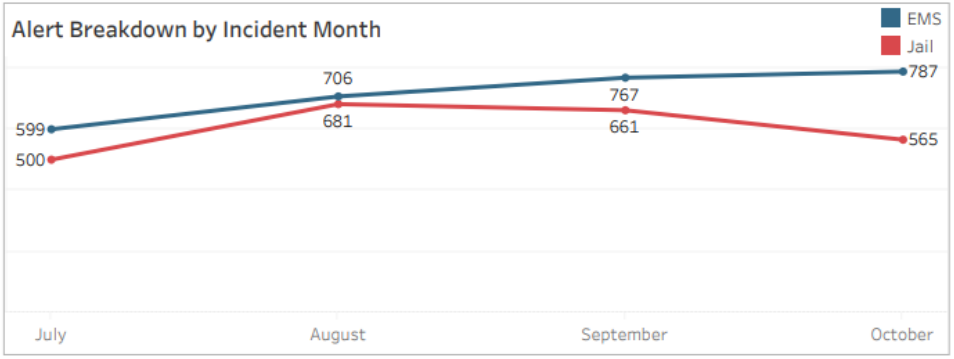
This is a unique count of clients who have at least one source of data shared from another partner, besides 2-1-1 San Diego.

Shared Data Trends

Graph represents 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.



Alert Breakdown by Incident Month



Community Information Exchange

2-1-1 SAN DIEGO/IMPERIAL

CIE INITIATIVE UPDATE

AHRQ: Dashboards

AHRQ Purpose

- AHRQ in collaboration with University of California, San Francisco

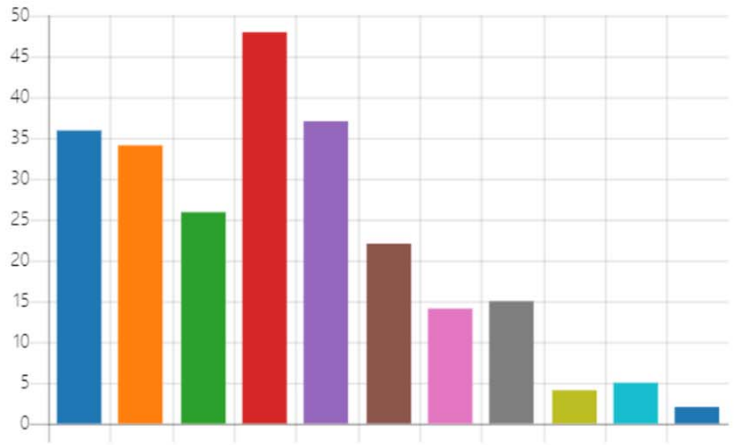
- **What health and social information would be useful to change your intervention care with the goal of improving health outcomes?**
  - Dashboards-Individual, Panel & Aggregate
  - 35+ interviews, FQHCs,
  - 40+ survey CIE Network

What do you use CIE for?

10. What do you use this social needs information for? (check all that apply)

More Details

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



63 respondents

211 SAN DIEGO/IMPERIAL

Functional Themes

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

Social Data	Clinical Data	Use
Any (especially multiple cumulative)	**Medications** **No show appts.**	Instead of increasing medications, first focusing on addressing barriers to attending appts (e.g., counseling).
Housing quality / mold	**Diagnosis (asthma)** **Inhaler (medication)**	Mold in housing could trigger and exacerbate asthma. Addressing social risk could result in less medication use/need.
Any (especially multiple cumulative)	**No show appts.** **Medication taking concerns**	Bring information to HC Provider to increase and seek to deepen or modify intervention.
Any (especially multiple cumulative)	**Diagnoses** **Symptoms/ exacerbations (e.g., breathing difficulty)**	Additional / heavier follow-up with individual to support (e.g., to keep on Medical, maintain social resource linkages)
Homelessness **Transportation** **Insurance**	**Medication taking** **Medication refills** **No show appts.**	Prioritize social resource referrals / linkages for social factors to improve health (vs. change in medications).
Transportation **Financial insecurity** **Homelessness**	**Disabilities**	Offer tailored social resources (e.g, discuss SSDI, look for appropriate transportation options).

Examples of Clinical and Social data paired

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

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.

2-1-1 SAN DIEGO/IMPERIAL

ACEs: White Paper

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-l

CIE Affinity Groups

Community Information Exchange

2-1-1 SAN DIEGO

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**

211 SAN DIEGO/IMPERIAL

Workgroup Updates

Community Information Exchange

2-1-1 SAN DIEGO

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

Community Information Exchange

2-1-1 SAN DIEGO/IMPERIAL

Outcomes Workgroup

Community Information Exchange

2-1-1 SAN DIEGO

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

Community Information Exchange

2-1-1 SAN DIEGO

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

211 SAN DIEGO/IMPERIAL

Sustainability Workgroup

Community Information Exchange

2-1-1 SAN DIEGO

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

Community Information Exchange

211 SAN DIEGO

Last Meeting Follow Up:

- Consulting detail
- Affinity Groups – Health Care
- Examine language: Who is opting in?

Community Information Exchange

2-1-1 SAN DIEGO

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

211 SAN DIEGO/IMPERIAL

Sustainability Opportunities

211 SAN DIEGO/IMPERIAL

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

Community Information Exchange

2-1-1 SAN DIEGO

OTHER UPDATES & NEXT MEETING

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

Community Information Exchange

2-1-1 SAN DIEGO