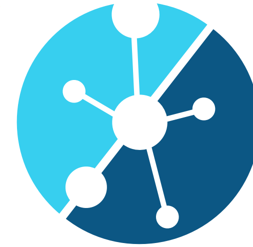


Community Information Exchange

Community Information Exchange (CIE) Advisory Board Meeting

July 19, 2022

CIE Advisory Board Meeting
AGENDA
July 19, 2022 • 8:30 AM – 9:30 AM

Time	Agenda Item	Presenter
8:30 – 8:35 am	Welcome & Agenda Overview	Mathew Packard Chair 2-1-1 Advisory Board
8:35-8:40	CIE Highlights	Camey Christenson Karis Grounds
8:40-9:25 am	• Overview/History of Referrals • Exercise: Input on Strategic/Operational Information	Mathew Packard Karis Grounds Alana Kalinowski
9:25-9:30 am	Action Items & Meeting Adjournment	Mathew Packard Chair 2-1-1 Advisory Board
Pre/Post Read	Appendix: • CIE Utilization Highlights • CalAIM Workgroup	

CIE Highlights

- **Center for Healthcare Strategies (CHCS) Partnerships for Action: California Health Care & Homelessness Learning Collaborative**

The objectives of *Partnerships for Action* are to:

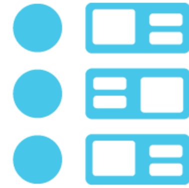
- **Build the capacity of the participating teams** — composed of health care organizations, managed care plans, community-based organizations, homeless service organizations, and other stakeholders — to collaborate on the creation of a more robust support network for people experiencing homelessness;
- **Foster peer-to-peer learning** through virtual and in-person learning sessions, convenings, site visits, and affinity groups; and
- **Spread best practices** related to health care and homelessness across California and nationally.

Participating Teams	Focus	Region
Alameda County Health Care for the Homeless, **Alameda Health System-Bridge Program**, and **Bay Area Community Services**	Reduce the risk of overdose among people experiencing homelessness who use drugs and/or with substance use disorder through the creation of a peer harm reduction program, expanded access to buprenorphine in street and shelter settings, and the development of a Contingency Management program.	**Bay Area** (Alameda County)
Gardner Health Services and **Catholic Charities of Santa Clara County**	Create a system that guides people experiencing homelessness through Medi-Cal enrollment and eligibility issues, coordinates care for those qualified for Enhanced Managed Care, and helps address housing insecurity.	**Bay Area** (Santa Clara County)
Marian Regional Medical Center, **5 Cities Homeless Coalition**, **Community Action Partnership of San Luis Obispo County**, **Good Samaritan Shelter**, and **CenCal Health**	Employ a homeless health coordinator to provide Enhanced Care Management to people experiencing or at risk of homelessness discharged from the hospital and facilitate cross-sector partnerships to strengthen the care continuum for those receiving care management services.	**Central Coast** (Santa Barbara and San Luis Obispo Counties)
Kings Tulare Homeless Alliance and **Anthem Blue Cross**	Strengthen partnerships between the local Continuum of Care, health plan, and community partners to better serve people experiencing homelessness through integration of health and homeless services, including the implementation of CalAIM, alignment of the Coordinated Entry System, and improved data sharing across sectors.	**Central Valley** (Kings and Tulare Counties)
Resiliency Village and **Mathiesen Memorial Health Clinic**	Collaborate with the community to develop a program that offers on-site health, dental, mental health, and substance use services for people in emergency shelter or supportive housing and design a mobile outreach and service delivery program for community members currently experiencing unsheltered homelessness.	**Central Valley** (Tuolumne County)
211 San Diego, **People Assisting the Homeless**, **Health Net**, **YMCA**, **San Diego State University's Social Policy Institute**, **McAlister Institute**, **San Diego Wellness Collaborative**, and **Legal Aid Society of San Diego County**	Enhance data exchange between health care, homeless services, and other community organizations to improve health and housing outcomes for people experiencing homelessness.	**Southern California** (San Diego County)
Akido Labs and **Homeless Outreach Program Integrated Care System (HOPICS)**	Explore new approaches to care coordination between health care and homeless service providers by piloting new approaches to patient engagement to strengthen continuity of care when practicing street medicine.	**Southern California** (Los Angeles County)
Illumination Foundation, **CalOptima**, and **Orange County Health Care Agency**	Develop workflows, in collaboration with local partners, to create a robust continuum of care for people experiencing homelessness to seamlessly transition from the hospital to medical respite care, and ultimately to permanent housing.	**Southern California** (Orange County)

- **AHRQ: Final evaluation phase of AHRQ research project, initial concept accepted for 3 conferences in 2023 in collaboration with UCSF (NAPCRG, AMIA, Academy Health)**

Referrals

How Referrals Work? Direct and Informational Referrals

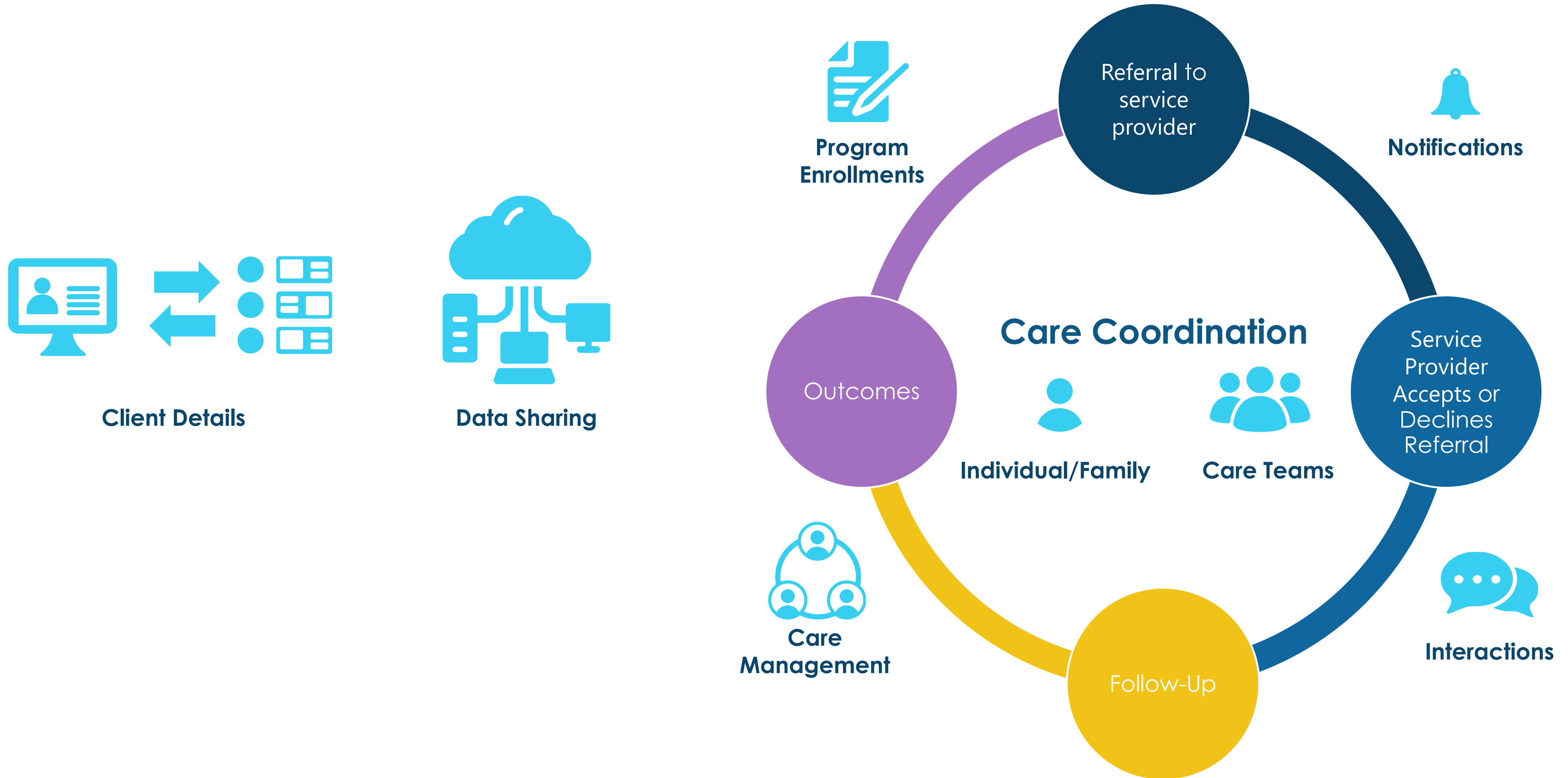
Direct Referral	 Informational Referral
An electronic warm-handoff between service providers using the Community Information Exchange.	**A referral given to a client in which he/she is responsible to follow-up with on their own.**
• Closed loop referral • Access to 2-1-1 San Diego directory of services • Detailed information about the client • Ability to provide updates to status and outcomes of referrals (closed loop referral • Ability to track where you are referring your clients • Track where your client has been referred to over time. • Better connection and coordination of programs and services • Benefit from Opportunities that are offered by CIE(example Lyft Rides, and Food deliveries)	• Access to 2-1-1 San Diego directory of services • Track where your client has been referred to over time • Client follows up with the service they were referred to.

Resource Database and Bi-directional Referrals

Hub for social and health sites and providers

- Shared taxonomy language for referrals
- 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

Bi-directional Closed Loop Referrals

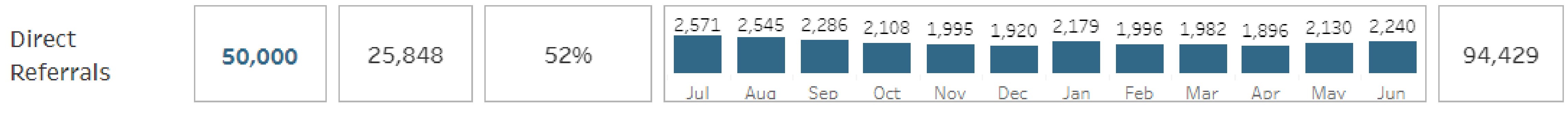


Referral Process: Sending

25% of agencies have sent referrals (most are below 10)

Top Agencies sending referrals:

- 211 San Diego
- YMCA
- San Ysidro Health
- County of San Diego
- Kaiser Permanente
- Sharp Healthcare



Referral Process: Accepting

# of services accepting referrals: 438

- Significant # of services available from FQHCs

Top Referral Partners:

- Legal Aid Society
- San Diego Food Bank
- 211 San Diego

Organization	Count
Family Health Centers of San Diego	64
Jacobs and Cushman San Diego Food Bank	64
San Ysidro Health	54
Planned Parenthood of the Pacific Southwest	39
Legal Aid Society of San Diego, Inc.	30
TrueCare	28
Vista Community Clinic	16
Neighborhood Healthcare	15
2-1-1 San Diego	14
Southern Caregiver Resource Center (SCRC)	11
Jewish Family Service (JFS) of San Diego	10
Interfaith Community Services	9
Goodwill Industries of San Diego County	8
Elder Law and Advocacy	7
Home Start	7
Chula Vista Community Collaborative	5
Adjoin	4
Meals on Wheels San Diego County	4
The Salvation Army San Diego Regional Office	4
National Veterans Transition Services, Inc, aka REBOOT	3
PATH San Diego	3
Rock Church	3
SBCS	3
St Paul's Senior Services	3
Vets' Community Connections	3
Childcare Resource Service, YMCA of San Diego County	2
Facilitating Access to Coordinated Transportation (FACT)	2
Fraternity House, Inc.	2
San Diego Housing Commission	2
Veterans Village of San Diego	2
A Positive Choice Resource & Referral Services, LLC	1
Access, Inc.	1
Blue Shield of California Promise Health Plan	1
Downtown San Diego Partnership	1
Easterseals Southern California	1
ElderHelp of San Diego	1
Exodus Recovery, Inc.	1
Gary and Mary West PACE	1
Kick it California	1
Mental Health Systems, Inc.	1
Metropolitan Area Advisory Committee (MAAC)	1
Molina Healthcare, Inc.	1
National Conflict Resolution Center	1
San Diego LGBT Community Center	1
San Diego Rescue Mission, Inc.	1
Skinny Gene Project	1
TransFamily Support Services	1

Referral Feedback

CIE Participants

Pro	Cons
Does not require them to reach out, agencies proactively reach out	Unable to reach a common outcome (lost phones, different phone numbers)
Don’t have to share full story again	Call back 211 or service provider because no contact by agency

CIE Partners

Pro	Cons
Streamline intake processes	Workflow Adoption
Less falling through the cracks	Multiple systems for tracking, receiving referrals
Quality Control- line of sight into appropriate and inappropriate referrals	Inappropriate referrals result in extra administrative time

REFERRAL INPUT

Opportunities

- **Where is there value for CBOs to accept referrals?**
- **Where is there value for agencies to send referrals?**
- **How do we embed into program design, intake processes and workflows?**
- **How do we support expectations of providers sending referrals?**
- **How can we support shift in care towards proactive (facilitated) vs. client-initiated intakes?**
- **How can we leverage this opportunity (funding) to create system level change?**

Current CIE Profile Needs

Need	%
Housing	37%
Nutrition	28%
Utility	19%
Income & Benefits	5%
Criminal Justice/Legal	3%
Health Management	2%
Primary Care	2%
Education	2%
Transportation	1%
Employment	1%

Community Information Exchange

OTHER UPDATES & NEXT MEETING

August 16, 8:30-9:30 AM

Appendix

CIE Trends and Utilization

CIE Dashboard

Successes:

- Increase utilization with highest logins in history
- Exceeded records with shared data

Challenges:

- Lower utilization metrics than anticipated (reduction of use with COVID-19 stabilization.
- Additional funding needed for partners to directly integrate.

CIE TRENDS AND METRICS DASHBOARD Fiscal Year: July 1, 2021 - June 30, 2022

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.

	FY Goal	Current	% of Goal	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	All-Time ..
Partners	20	14	70%	1	1		1		3	3	1			2	2	120
Adoption Metrics																
Logins	45,000	33,210	74%	2,701	3,279	2,634	2,698	2,407	2,129	2,142	2,017	2,688	3,606	2,917	3,992	107,275
Consents	90,000	85,262	95%	7,267	8,500	7,537	6,725	7,651	9,977	10,913	5,501	5,790	5,459	5,036	4,906	294,178
Searches	35,000	18,683	53%	1,236	1,996	1,574	1,490	1,356	1,045	994	1,270	1,600	2,121	2,170	1,831	72,826
Engagement Metrics																
Records with Shared Data	80,000	125,004	156%	20,848	22,688	22,417	22,497	25,630	30,994	29,012	24,268	28,222	27,676	26,222	33,048	257,375
Profile Views	35,000	29,355	84%	2,466	2,925	2,356	2,363	2,218	2,259	2,067	1,936	2,383	2,522	2,795	3,065	80,208
Panel Management Users	N/A	117	N/A				31	16	7	31	6	7	9	10	18	117
Intervention Metrics																
Direct Referrals	50,000	25,799	52%	2,568	2,543	2,283	2,106	1,992	1,915	2,175	1,994	1,981	1,893	2,122	2,227	94,350
SDoH Screenings	N/A	1,480	N/A	92	118	69	71	50	285	28	82	111	48	450	76	2,998
SDoH Assessments	N/A	66	N/A		26	9	3		2		1		1	16	8	66

Data Source: 211/CIE Information Systems | Reporting Period: 7/1/2021 - 6/30/2022

CIE CalAIM Workgroup

Challenges, Opportunities and Potential Outcomes

CalAIM Challenge	CIE Opportunity	Potential Outcomes/Results
Identification of new members eligible for ECM services	(Outreach) Search CIE profile for historical information (ex. HMIS) to identify new eligibility for current patients/members	Example: Increase in enrollment for ECM/CS services
Impact of ECM/CS services (social interventions) on health condition outcomes for members	(Case Management/Reporting) Use CIE for assessments, social needs screening or referrals to measure health and social outcomes (can request exports of members data)	Example: Decrease vulnerability for one social need
Engagement with potential members via information within CIE	(Outreach) Look in CIE to view past referrals, program enrollments and care teams to see how services might be helpful to members situation	Example: Reduce volume of those not interested in ECM services
Evidence for homeless documentation for eligibility for ECM/CS services	(Enrollment) Using information within CIE HMIS/homeless data to share housing status with health plan in request for ECM/CS services	Example: Increase efficiency in identifying housing status
Documentation of enrollment in services with other providers—Coordination	(Case Management) Coordinating services by using referrals, program enrollments and care team to better coordinate across other service providers and receive proactive alerts	Example: Reduce time (efficiency and effectiveness) for ECM services
Documentation/Administration of information for various MCPs	(Case Management) Request export of CIE data for individual members to leverage data collected or shared in CIE for health plan reporting	Example: Reduce time (efficiency and effectiveness) for ECM services

Provider Workgroup Update

Current Challenges from Providers:

- Outreach strategies/enrollment rate
  - Volume of lists from health plans
  - Harder to reach or not interested?
  - Impact on staffing – keeping full caseloads
- Reassessment/reauthorization processes
- Transition to in-person outreach/encounters
- Other successes or challenges to share?

Insights:

- Significant drop in enrollment—down to 2-5% compared to 13-15%
- What is different about this population?
  - Qualifications more complex

    Requested Providers to provide data on health plan lists:
    - Ineligible
    - Were not able to get a hold of member
    - Did not want to enroll

Monthly Meeting: June 22nd (3-4 PM)

Next Meeting: June 27th (3-4 PM)

Category	Description
Community Infrastructure/System Change	a resource or change with the potential to impact all providers (e.g., provider directory aggregated by CIE, medical necessity documentation for CS available in CIE)

Implementation Challenges identified by Contracted Providers	Potential Solutions based on input from Contracted Providers
Outreach/Referrals into ECM/CS - directing eligible clients to their assigned provider	
Lack of detailed patient information with MCP referral including patient contact information/incorrect contact information	Request more patient information with referral from MCP; ability to access updated contact information in CIE/HIE
No streamlined referral process, particularly for CS, identified among the MCPs	Request at least one universal referral pathway and requirement across MCPs (potentially through CIE); identify universal approach to coordinate with hospitals
Lack of information about provider network and how to refer to CS services; can't refer to CS services without knowing providers	Access to centralized ECM and CS Provider Directory across all MCPs; host directory on County website, 211 or CIE to host directory; use Care Team and alerts in CIE
Enrollment/Eligibility process	
Eligibility verification – time consuming to verify Medi-Cal MCP at the client level, no bulk process, second step of confirming eligibility criteria based on population of focus	Reduce duplicative work, access to centralized eligibility information and reports, access to eligibility information with CIE/HIE; leveraged alerts in CIE
ECM/CS clients on in CIE – lack of consent	Implement joint consent for ECM/CS and CIE
Clients transitioning from one MCP to another MCP	Ability to see MCP history in CIE; use Care Team and alerts in CIE
Community Support service limits/requirements	
Documentation for medical necessity for CS services including PCP signature	Access to centralized information on service utilization across all MCPs and service providers; use Care Team and alerts in CIE; access medical necessity information in CIE/HIE; request MCP play a greater role in medical necessity documentation, particularly in areas where they already have access to requested information such as behavioral health records

How can we support outreach efforts for CalAIM?

- **Some example opportunities:**
  - Standard referral form within CIE to send CalAIM potentially eligible members to health plans or to CalAIM providers
  - Request health plans for potentially eligible lists (not only enrolled members)
  - Request health plans to use CIE social need data to help identify potentially eligible members

New Opportunities

- Initiating Data Sharing Conversations with all Health Plans
  - Active
    - United Healthcare
    - Health Net
  - In Conversation
    - Molina
    - Blue Shield of California

- Process for Health Plan Bidirectional Data-Sharing
  - Member Match those with Health Plan and Active Consent in CIE
    - For Health Plans: Send all social need data (ex. HMIS) and closed-loop referral information
    - For CIE: All Health Plan Members in CIE & ECM enrollment & CalAIM Provider