Health Homes Analysis

Using 2-1-1 data to assist local planning efforts

April 2019

2-1-1 Overview

2-1-1 San Diego

- Information and Referral Services
- Navigation Services
- Resource Database: **1,300** agencies and over **6,000** services

Food

Benefits and Enrollment

Veterans

Courage to Call

Health

Health Navigation

Housing

Housing Navigation

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Community Information Exchange (CIE) Overview

Community Information Exchange (CIE):

An ecosystem comprised of multidisciplinary network partners that use a shared language, resource database, and integrated technology platform to deliver enhanced community planning.

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Community Information Exchange (CIE) 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.

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Shared Language

14 Domains: Risk Rating Scale


Housing Stability


Health Management


Nutrition & Food Security


Financial Wellness and Benefits


Activities of Daily Living


Social & Community Connection


Legal & Criminal Justice


Primary Care and Prevention


Safety & Disaster


Utility & Technology


Transportation


Education & Human Development


Personal Care & Household Goods


Employment Development

CRISIS **CRITICAL** **VULNERABLE** **STABLE** **SAFE** **THRIVING**

IMMEDIACY

KNOWLEDGE AND UTILIZATION

BARRIERS AND SUPPORTS

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Community Information Exchange Network Partners

Client Record

Client Profile

- Demographic and important information about the client

Domains

- Examples like Housing, Food & Nutrition,
- Categorization of Needs (SDOH) & Risk Level
- Shared Assessments and Values across agencies

Care Team

- Case Managers working with client across agencies
- Contact Information

Referrals & Program Enrollment

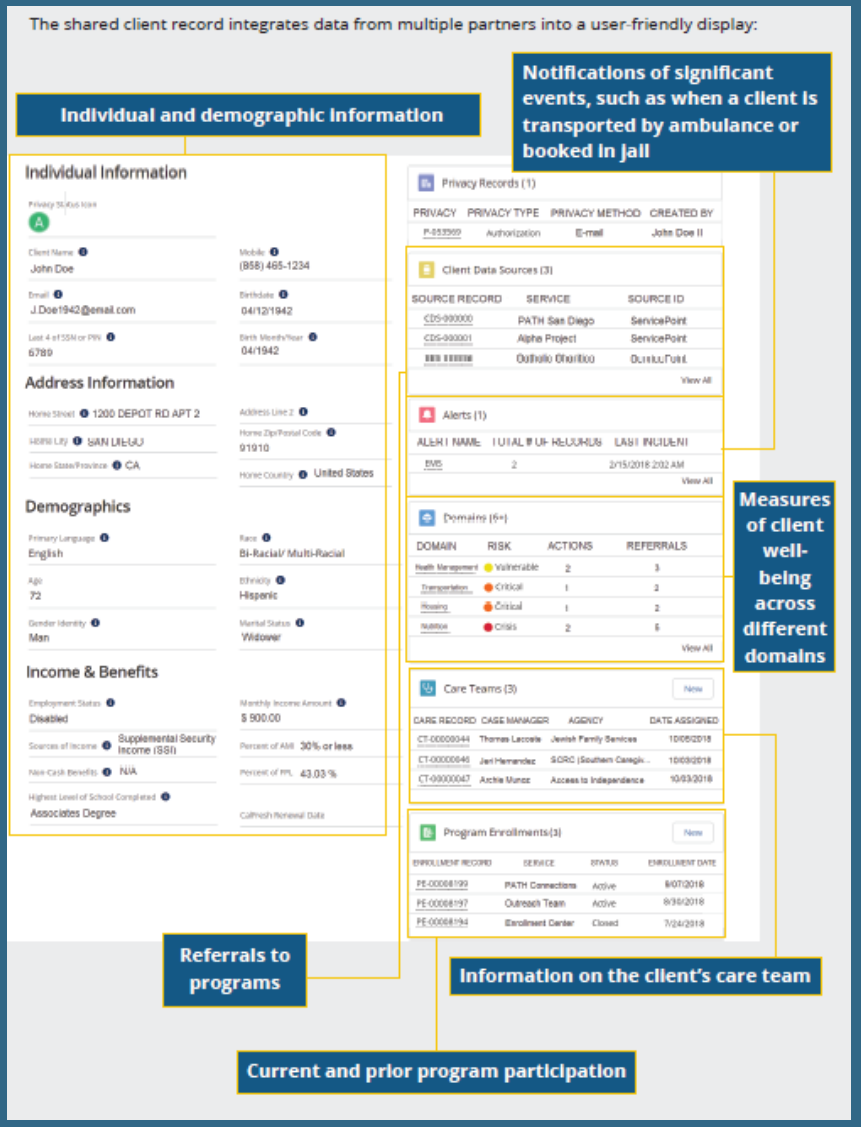
- Referral History
- Connection to Services

Alerts

- Notification of emergency services & jail
- Ability to notify Care Team Members of changes

Feed

- Ability to communicate with Care Team members (twitter-like feed)



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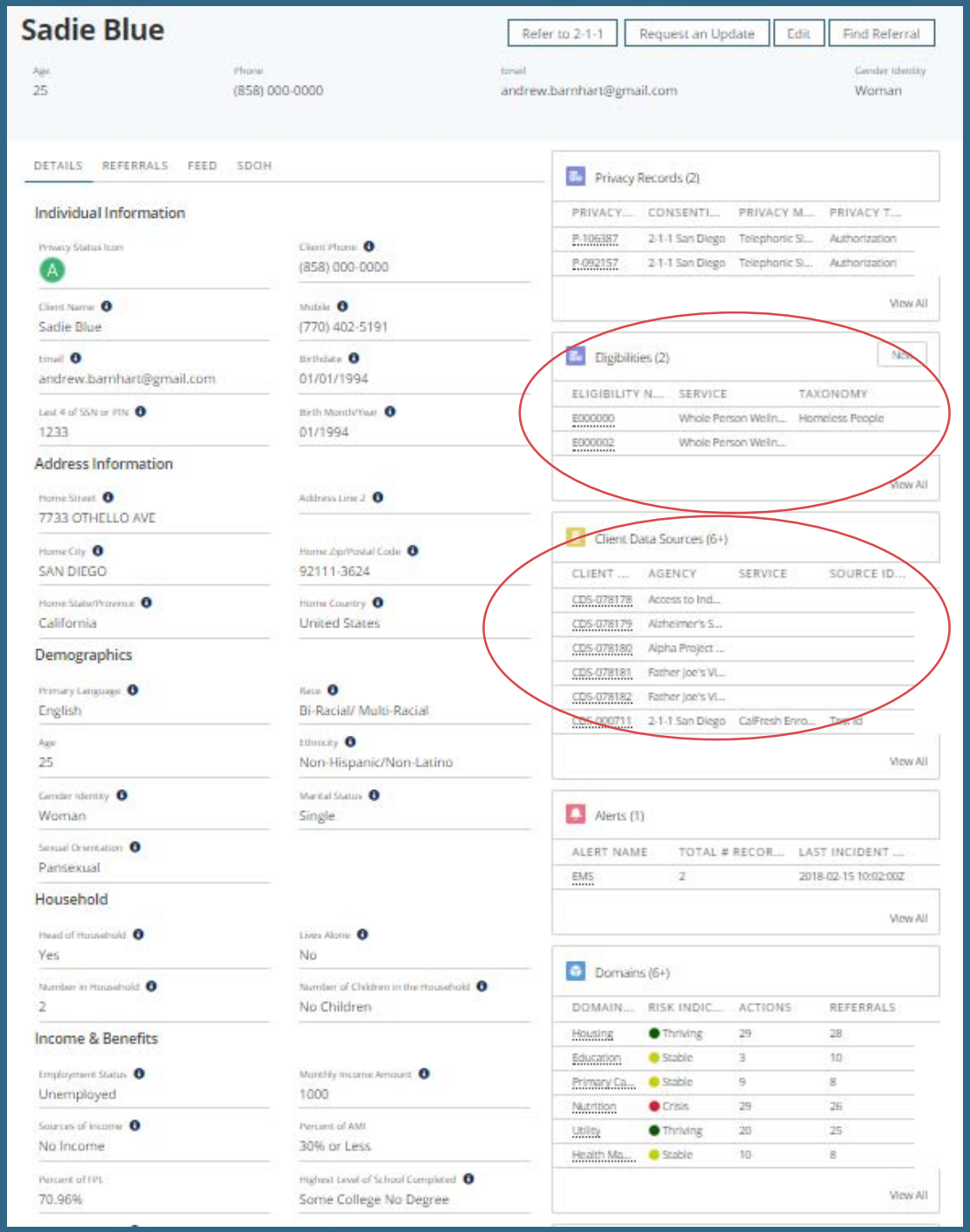
Client Record Sample Highlights

Presumed Eligibility
(WPW, SSI/CF)

Data Integration
(HMIS, C-STAR,Oasis)



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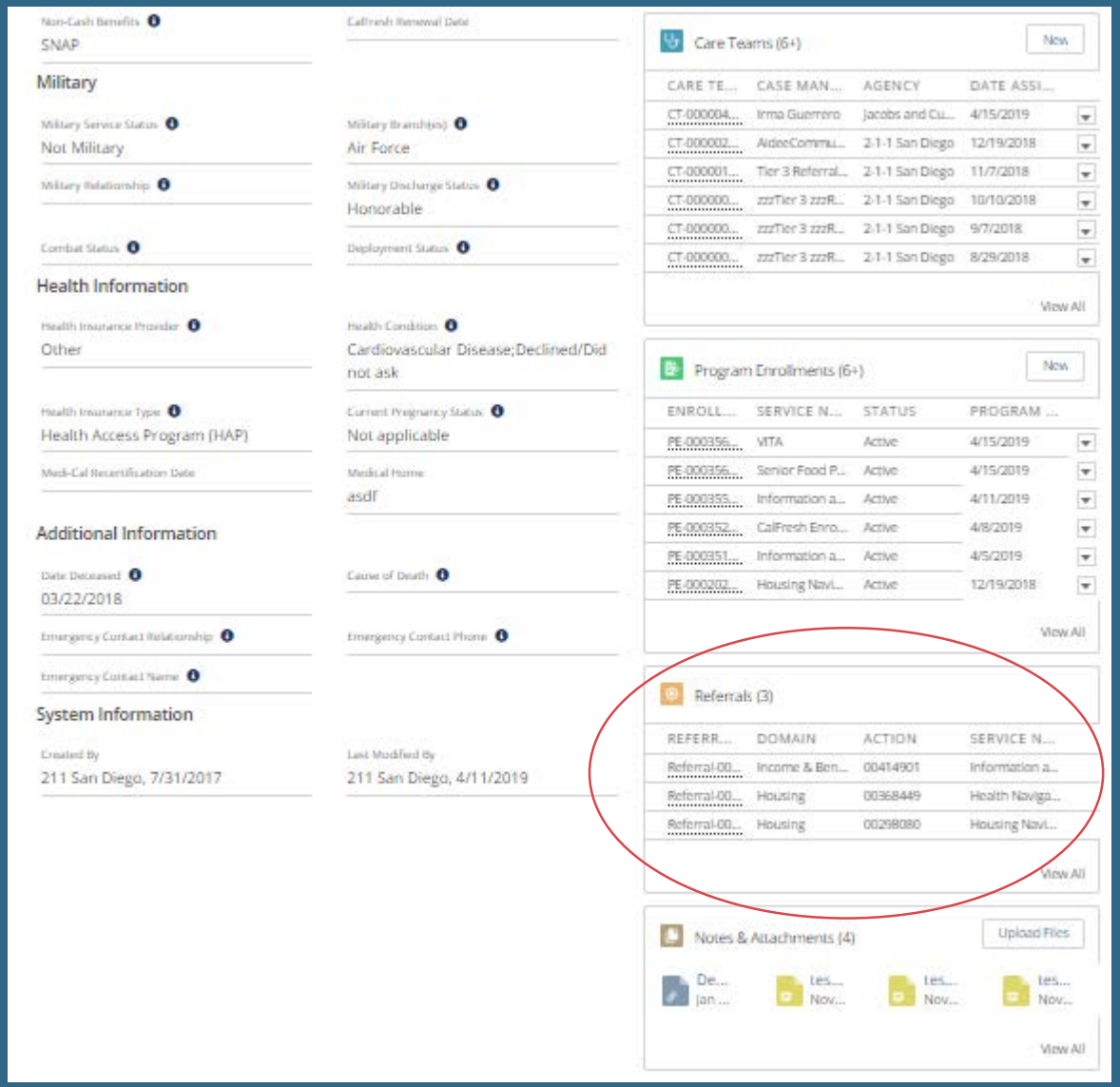
Client Record Sample Highlights

History of Referrals



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2-1-1 San Diego/CIE Summary Numbers

2-1-1 San Diego

Over **138,000** clients served annually

Over **450,000** interactions with clients via phone, chat or text annually

Over **300,000** referrals sent addressing roughly **500,000** needs annually

CIE

61 network partners

89,000 actively consented clients in CIE

88,000 assessments completed for consented clients

3,800 direct referrals sent to network partners

CIE data all-time as of Apr 12, 2019

Health Homes Analysis Purpose

Use 2-1-1 San Diego data to help local planning efforts for Health Homes implementation

1. Gain deeper insight into "who" the prospective Health Homes population is
2. Gain better understanding of the population's potential service needs
3. Gain better understanding of current services the population may be utilizing
4. Make recommendations to Health Homes planning group to take into consideration for implementation

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Datasets and Limitations

Datasets

- Data extracted as of January 2019, which includes clients calling 211, shared through the CIE, or transferred from legacy 211 client information sources.
- Most data was collected through self-reported Social Determinants of Health (SDoH) assessments
- Data through CIE was also used in analysis
- All percentages are out of total known responses. %'s may add up to over 100% for some responses since a client can select more than one response

Limitations

- Response rates vary by question
- Most data is self-reported
- Data used to determine proxy population criteria does not align perfectly with official Health Homes criteria

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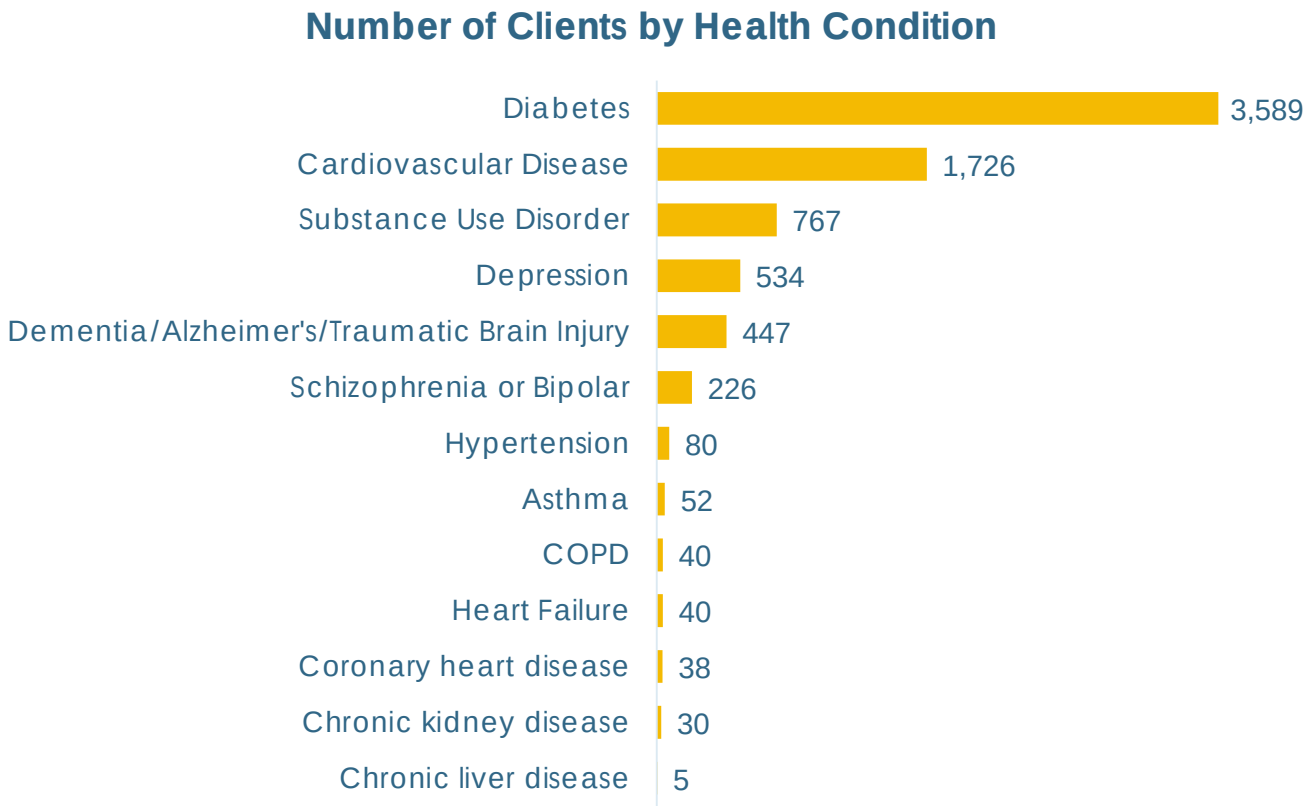
Methodology: Identifying the Population

Used Health Homes eligibility criteria to select similar population within 2-1-1 San Diego's database

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in <u>at least one</u> of the following categories: • **At least two of the following**: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

Methodology: Chronic Condition Criteria

- A client must have a condition in at least one of the health conditions below.
- This data represents clients who self-reported during a SDoH assessment, program intake or throughout a call if they had a health condition.
- Clients can have more than one health condition.



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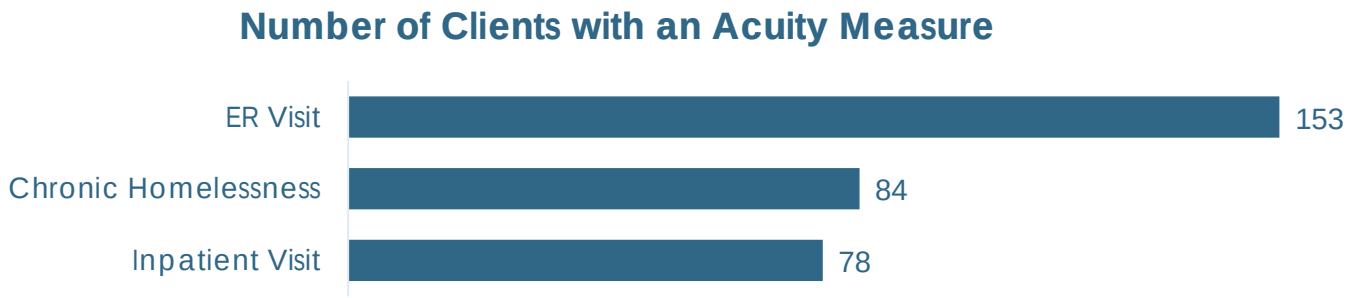
Methodology: Acuity/Complexity Criteria

- The chronic condition criteria must be paired with at least one of the acuity/ complexity criteria.
- Acuity/complexity data is collected in the Housing or Heath related SDoH assessments.
- Data is only reported for clients who completed a Housing or Health assessment and answered one of the specific questions.

Health Homes Program Definitions	2-1-1 Proxy Definitions
Three or more emergency department visits in the last year	Clients have been to the ER recently or are seeking care at the ER
Chronic homelessness	Clients met the length of time/episodes of homelessness criteria in HUD's Chronic Homeless definition.
At least one inpatient hospital stay in the last year	Clients have been to the hospital recently or are seeking inpatient care



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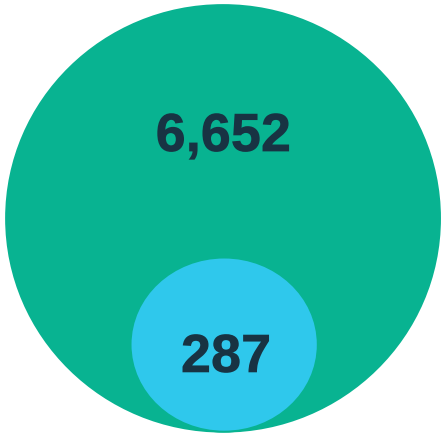
Methodology: Creation of Proxy Groups

Based on the HHP eligibility criteria, two Proxy Groups were created to define the population in the 2-1-1/CIE information systems.



Chronic Condition Group: Person had at least one of the HHP health conditions

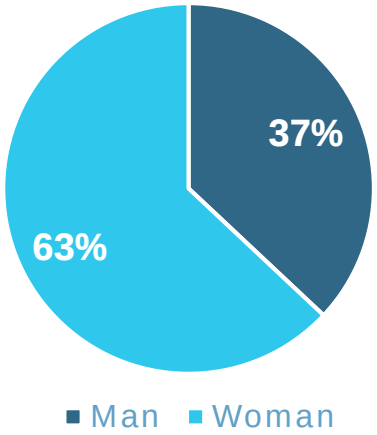
Condition and Acuity Group: Person had at least one of the health conditions AND at least one acuity/complexity criteria outlined

Since the Condition and Acuity Group was relatively small, the focus of this analysis is on the Chronic Condition Group, with specific call-outs on Condition and Acuity Group as needed.

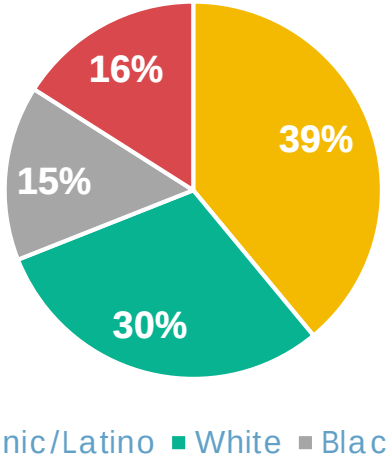
Demographics of Chronic Condition Group

6,652 clients | **71%** Consented CIE Clients

Gender



Race/Ethnicity



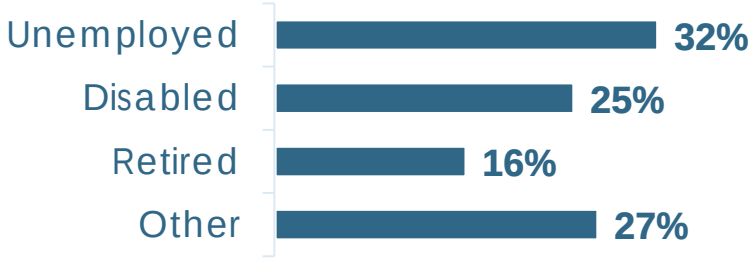
47% 50 to 69 year old

52% Single Household

87% Insured

54% Medi-Cal

Employment



The condition and acuity group tend to be younger, men, **40%** white, **22%** black, **69%** single households, higher enrollments into Medi-Cal, higher disabled employment status (**37%**).

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Chronic Condition Group: Client Story

58 year old white woman who **lives alone.** Client receives $420/month from General Relief. Client has **associates degree** and is **unemployed.**

28 calls made in 18 months

75 Referrals

Majority of referrals for criminal justice, housing, health management, nutrition and utility.

Suffers with **depression** and has **cardiovascular disease.**

Very difficult paying for basic needs. **Needs** include managing health condition, water bill payment assistance (shut off), current housing being sold and needs a new place to live, tenant rights education.

Client has Molina through Medi-Cal.

Needs **support groups** for her mental health. Barriers to health include lack of social supports. Medical condition was a cause for clients financial hardship.

Client is consented into CIE. Data sharing with FJV indicates client entered the Temporary Bridge Shelter 2 months after informing 211 she will lose her housing she lived in for 30 years.

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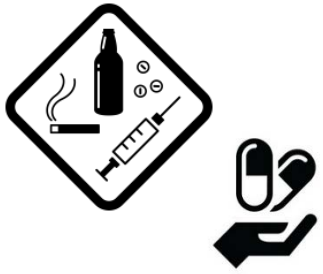
Condition and Acuity Group: Client Story



Suffers from **substance use disorder** (alcohol and illicit drugs) and is **not accessing care** for his conditions.

15 calls made
in the past 11 months

35
Referrals for housing, nutrition, health management, criminal justice and hygiene.

26 of those referrals were in housing and nutrition.

54 year old
Hispanic male who is **chronically homeless.**

Barriers to managing health for the client include lack of a health management plan and navigating system

Client has Health Net through Medi-cal.

During this time, client worked with Legal Aid as a result of a direct referral. Client also has shared data from PATH San Diego.

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Service Needs of Groups

What needs are Health Homes proxy group calling about?

(Needs data is collected by 2-1-1 staff during every call)

- The Condition and Acuity Group requested assistance with **residential treatment for substance use** and **emergency housing**.

- The Chronic Condition group requested assistance with **utility payment assistance**, which aligns with the 2-1-1 general population.

- But we also know that both groups have nutrition and benefit related needs.

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Referrals for Groups

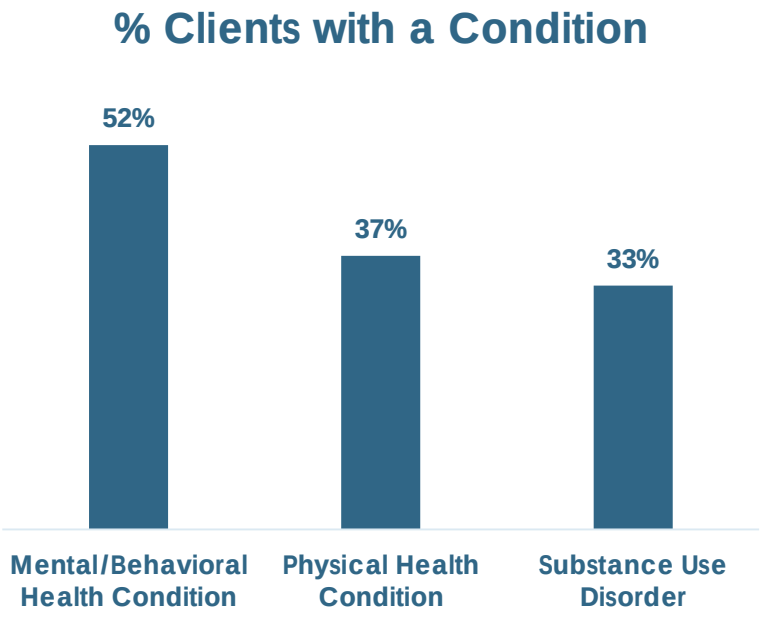
What services are Health Homes proxy group being referred to?

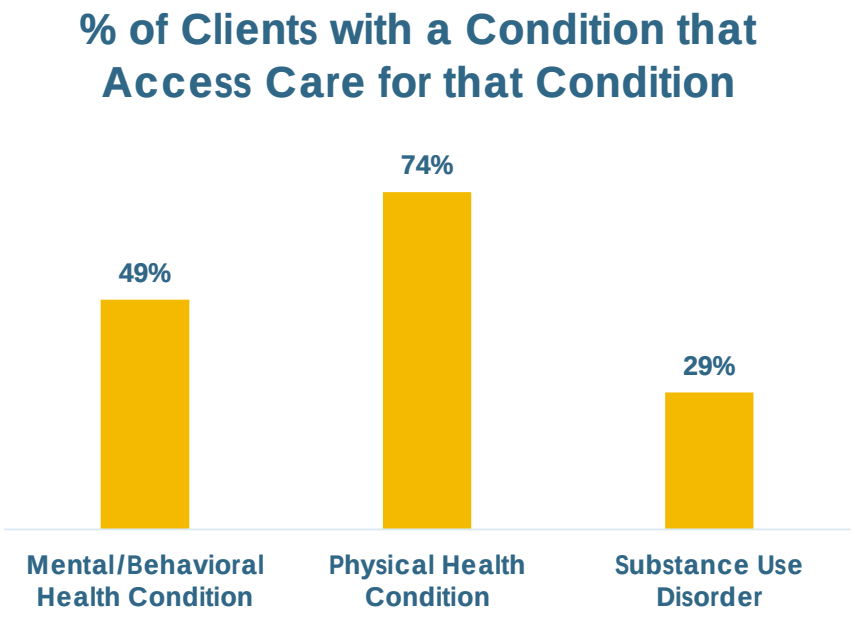
(Referrals are provided to callers based on their presented needs)

- The Condition and Acuity group had more referrals given for health related referrals. Examples include:
  - Access and Crisis Line
  - In-home Supportive Services (IHSS)
  - Consumer Center For Health Education and Advocacy (CCHEA)
  - Residential Detox
- The Chronic Condition group had more referrals given for utility payment assistance and housing search assistance, which aligns with the general 2-1-1 population. Examples include:
  - SDG&E CARE Program
  - Neighbor to Neighbor Utility Assistance
  - The County's and City's Housing Guides

Healthcare Access: Chronic Condition Group

Accessing Care for Conditions: Clients were asked what type of health concerns they have and if they are accessing care for those conditions.





Less than one-third of clients are accessing care for their substance use disorders. The Condition and Acuity Group is less likely to access care, regardless of health condition type.

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Healthcare: Chronic Condition Group

Primary Care Physician and Appointments:

66% of clients have a primary care physician (PCP)

75% of clients saw their provider less than 3 months ago

55% of clients needed to see their provider within 1 week

Where Care is Usually Sought:

54% Primary Care Provider

34% Community Clinic

10% ER

9% do not seek care

57% of clients in the Condition and Acuity Group regularly seek care in the ER

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911/EMS and Jail Use

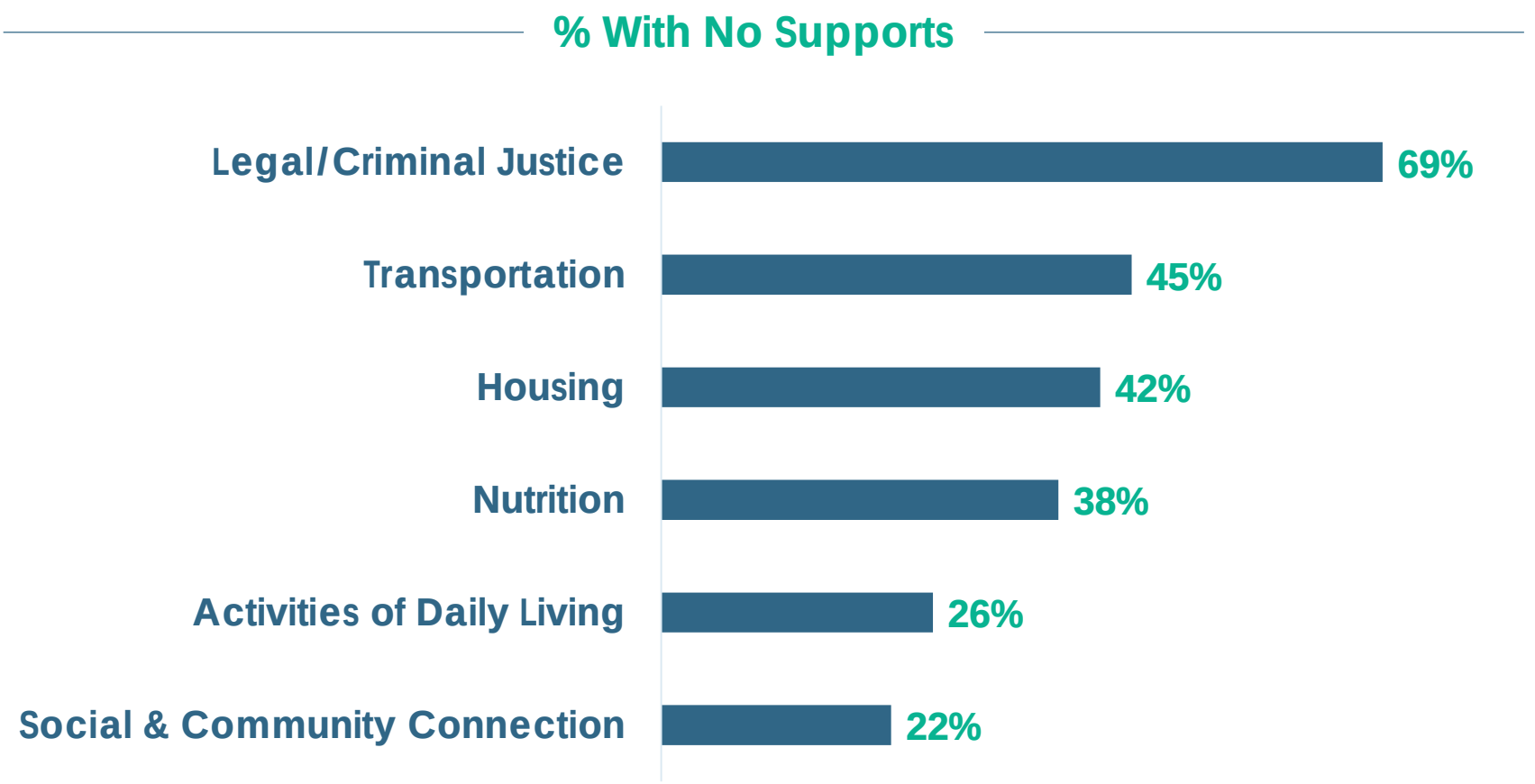
- **71%** of the population is consented into CIE
- **149** clients (**2%** of the health homes population) had 385 alerts
  - 2 clients had both a jail and EMS alert (1 from acuity group)

- **102** clients had jail alerts (8 from acuity group)
- **8** clients accounted for **22%** of jail alerts (1 from acuity group)
- **92%** of Jail alerts were in the condition proxy group

- **49** clients had EMS alerts (17 from acuity group)
- **6** clients accounted for **47%** of EMS alerts (5 from acuity group)
- **35%** of EMS alerts were for the acuity proxy group

Services Needs: Chronic Condition Group

Supports: clients were asked across multiple SDoH assessments whether they feel they have supports in that domain



Summary of Key Findings

- Population is not homogenous. Within 211 data there were two distinct groups that differed across demographics, needs, referrals and utilization of services.
  - Chronic Condition group appeared to have lower severity of need compared to other group
- Both groups relatively older, disproportionately people of color compared to general population, disabled/retired, and unemployed
- Chronic Condition and Acuity group called for residential SUD treatment, temporary shelter while Chronic Condition Group called for permanent housing, and utility assistance
- Identified having mental health and substance use issues but reported less utilization of services to assist with those issues
- Many are currently accessing primary care services
- Reported having family or friends that could assist them with some activities
- Legal services, transportation, and housing identified as largest unmet needs

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Recommendations

Understanding resources and what populations need

- CB-CME's to have knowledge of resources for older adults and cultural competence training
- CB-CME's to tap into persons social network; support ongoing building of social support system
- Need strategies for helping people obtain income

Leverage partnerships across social and health providers

- **CB-CME's to coordinate network of partnerships, services and referrals across SDoH resources**
- Housing resources both temporary and permanent will be needed
- Partnerships with mental health programs in psychiatry, peer support, counseling
- Partnerships with legal services (eviction support, warrants, tickets, etc.)
- Partnerships with hospitals, jails critical for discharge coordination
- Partnerships with SUD treatment programs
- Ensuring transportation is readily available will be critical (bus pass, agency car/van, health transport, RideShare)

Service delivery model

- Tiered model of service delivery; payment structure needs to reflect this

Leverage technology

- Technology tools like CIE to coordinate services, and communicate among cross-sector care team

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Questions?

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