



Community
Information
Exchange

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

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.

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.

Shared Language

14 Domains: Risk Rating Scale



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



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)

The shared client record integrates data from multiple partners into a user-friendly display:

Individual and demographic Information

Individual Information

Client Name: John Doe

Mobile: (858) 465-1234

Birth Date: 04/12/1942

Birth Month/Year: 04/1942

Last 4 of SSN or PIN: 6789

Address Information

Home Street: 1200 DEPOT RD APT 2

Home City: SAN DIEGO

Home State/Province: CA

Home Zip/Postal Code: 92101

Home Country: United States

Demographics

Primary Language: English

Age: 72

Gender Identity: Man

Race: Bi-Racial/ Multi-Racial

Ethnicity: Hispanic

Marital Status: Widower

Income & Benefits

Employment Status: Disabled

Monthly Income Amount: \$ 900.00

Sources of Income: Supplemental Security Income (SSI)

Percent of ABE: 30% or less

New Cash Benefits: N/A

Percent of PPL: 43.03%

Highest Level of School Completed: Associates Degree

CalFresh Renewal Date:

Notifications of significant events, such as when a client is transported by ambulance or booked in jail

Privacy Records (1)

PRIVACY	PRIVACY TYPE	PRIVACY METHOD	CREATED BY
P-253992	Authorization	E-mail	John Doe II

Client Data Sources (3)

SOURCE RECORD	SERVICE	SOURCE ID
CD5-999000	PATH San Diego	ServicePoint
CD5-999001	Alpha Project	ServicePoint
BBB-888888	Outreach Outreach	OutreachPoint

Alerts (1)

ALERT NAME	TOTAL # OF RECURRING	LAST INCIDENT
BMS	2	2/15/2018 2:02 AM

Domains (5+)

DOMAIN	RISK	ACTIONS	REFERRALS
Health Management	Vulnerable	2	3
Transportation	Critical	1	2
Housing	Critical	1	2
Insurance	Critical	2	5

Core Teams (3)

CARE RECORD	CARE MANAGER	AGENCY	DATE ASSIGNED
CT-00000044	Thomas Lescote	Jewish Family Services	10/05/2018
CT-00000046	Jen Hernandez	SDRC (Southern Calif...	10/09/2018
CT-00000047	Archie Munoz	Access to Independence	10/09/2018

Program Enrollments (3)

ENROLLMENT RECORD	SERVICE	STATUS	ENROLLMENT DATE
PE-00000199	PATH Connectors	Active	8/07/2018
PE-00000197	Outreach Team	Active	8/30/2018
PE-00000194	Enrollment Center	Closed	7/24/2018

Referrals to programs

Information on the client's care team

Current and prior program participation

Client Record Sample Highlights

Presumed Eligibility
(WPW, SSI/CF)

Data Integration
(HMIS, C-STAR, Oasis)

Sadie Blue

[Refer to 2-1-1](#)[Request an Update](#)[Edit](#)[Find Referral](#)Age
25Phone
(858) 000-0000Email
andrew.barnhart@gmail.comGender Identity
Woman[DETAILS](#) [REFERRALS](#) [FEED](#) [SDOH](#)

Individual Information

Privacy Status Icon

Client Name
Sadie BlueEmail
andrew.barnhart@gmail.comLast 4 of SSN or PIN
1233Client Phone
(858) 000-0000Mobile
(770) 402-5191Birthdate
01/01/1994Birth Month/Year
01/1994

Address Information

Home Street
7733 OTHELLO AVEHome City
SAN DIEGOHome State/Province
California

Address Line 2

Home Zip/Postal Code
92111-3624Home Country
United States

Demographics

Primary Language
EnglishAge
25Gender Identity
WomanSexual Orientation
Pansexual

Household

Head of Household
YesNumber in Household
2

Income & Benefits

Employment Status
UnemployedSources of Income
No IncomePercent of FPL
70.96%Race
Bi-Racial/ Multi-RacialEthnicity
Non-Hispanic/Non-LatinoMarital Status
SingleLives Alone
NoNumber of Children in the Household
No ChildrenMonthly Income Amount
1000Percent of AMI
30% or LessHighest Level of School Completed
Some College No Degree

Privacy Records (2)

PRIVACY...	CONSENTI...	PRIVACY M...	PRIVACY T...
P.106387	2-1-1 San Diego	Telephonic S...	Authorization
P.092157	2-1-1 San Diego	Telephonic S...	Authorization

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Digibilities (2)

ELIGIBILITY N...	SERVICE	TAXONOMY
E000000	Whole Person Welin...	Homeless People
E000002	Whole Person Welin...	

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Client Data Sources (6+)

CLIENT ...	AGENCY	SERVICE	SOURCE ID ...
CDS-078178	Access to Ind...		
CDS-078179	Alzheimer's S...		
CDS-078180	Alpha Project ...		
CDS-078181	Father Joe's VL...		
CDS-078182	Father Joe's VL...		
CDS-000711	2-1-1 San Diego	CalFresh Enro...	Task ID

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Alerts (1)

ALERT NAME	TOTAL # RECOR...	LAST INCIDENT ...
EMS	2	2018-02-15 10:02:00Z

[View All](#)

Domains (6+)

DOMAIN...	RISK INDIC...	ACTIONS	REFERRALS
Housing	Thrivin...	29	28
Education	Stable	3	10
Primary Ca...	Stable	9	8
Nutrition	Crisis	29	26
Utility	Thrivin...	20	25
Health Ma...	Stable	10	8

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Client Record Sample Highlights

History of Referrals

Non-Cash Benefits 1

SNAP

Military

Military Service Status 1

Not Military

Military Relationship 1

Combat Status 1

Health Information

Health Insurance Provider 1

Other

Health Insurance Type 1

Health Access Program (HAP)

Medi-Cal Recertification Date

Additional Information

Date Deceased 1

03/22/2018

Emergency Contact Relationship 1

Emergency Contact Name 1

System Information

Created By

211 San Diego, 7/31/2017

CalFresh Renewal Date

Military Branch(es) 1

Air Force

Military Discharge Status 1

Honorable

Deployment Status 1

Health Condition 1

Cardiovascular Disease; Declined/Did not ask

Current Pregnancy Status 1

Not applicable

Medical Home

asdf

Cause of Death 1

Emergency Contact Phone 1

Last Modified By

211 San Diego, 4/11/2019

Care Teams (6+)

New

CARE TE...	CASE MAN...	AGENCY	DATE ASSI...
CT-000004...	Irma Guerrero	Jacobs and Cu...	4/15/2019
CT-000002...	AldiceCommu...	2-1-1 San Diego	12/19/2018
CT-000001...	Tier 3 Referral...	2-1-1 San Diego	11/7/2018
CT-000000...	zzzTier 3 zzzR...	2-1-1 San Diego	10/10/2018
CT-000000...	zzzTier 3 zzzR...	2-1-1 San Diego	9/7/2018
CT-000000...	zzzTier 3 zzzR...	2-1-1 San Diego	8/29/2018

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Program Enrollments (6+)

New

ENROLL...	SERVICE N...	STATUS	PROGRAM ...
PE-000356...	VITA	Active	4/15/2019
PE-000356...	Senior Food P...	Active	4/15/2019
PE-000355...	Information a...	Active	4/11/2019
PE-000352...	CalFresh Enro...	Active	4/8/2019
PE-000351...	Information a...	Active	4/5/2019
PE-000302...	Housing Navl...	Active	12/19/2018

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Referrals (3)

New

REFERR...	DOMAIN	ACTION	SERVICE N...
Referral-00...	Income & Ben...	00414901	Information a...
Referral-00...	Housing	00368449	Health Naviga...
Referral-00...	Housing	00298080	Housing Navl...

View All

Notes & Attachments (4)

Upload Files

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View All

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

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

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

Methodology: Identifying the Population

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

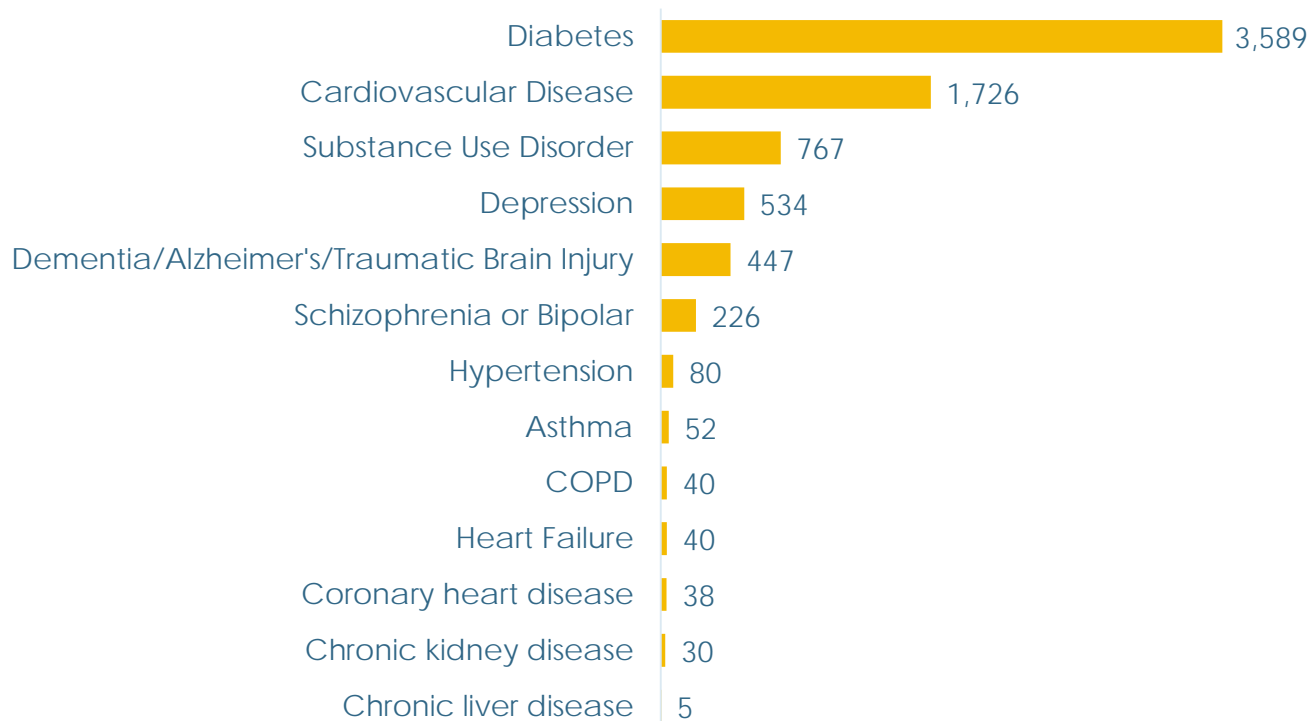


Eligibility Requirement	Criteria Details
1. Chronic condition criteria	<p>Has a chronic condition in <u>at least one</u> of the following categories:</p> <ul style="list-style-type: none">• At least two of the following: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic 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	<ul style="list-style-type: none">• 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.

Number of Clients by Health Condition



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 Health related SDoH assessments.
- Data is only reported for clients who completed a Housing or Health assessment and answered one of the specific questions.

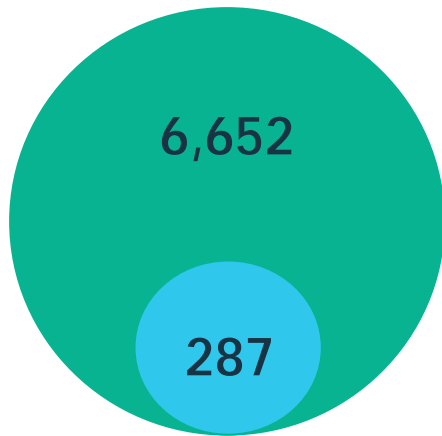
Health Homes Program Definitions	2-1-1 Proxy Definitions
Three or more emergency department visits in the last year	Clients have been to the ER recently or are seeking care at the ER
Chronic homelessness	Clients met the length of time/episodes of homelessness criteria in HUD's Chronic Homeless definition.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

Number of Clients with an Acuity Measure



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

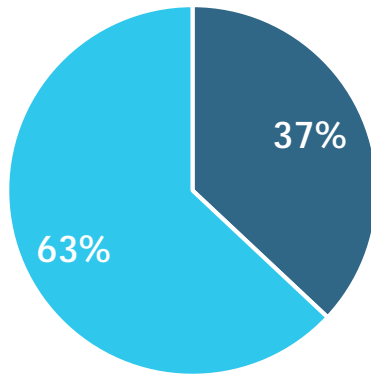
Condition and Acuity Group: Person had at least one of the health conditions AND at least one acuity/complexity criteria outlined

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

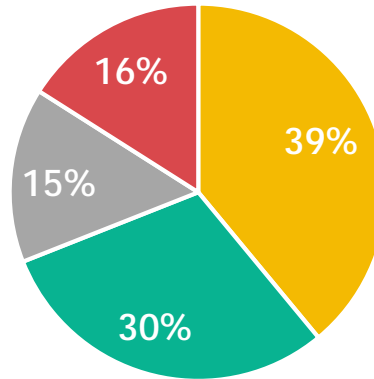
6,652 clients | 71% Consented CIE Clients

Gender



■ Man ■ Woman

Race/Ethnicity



■ Hispanic/Latino ■ White ■ Black ■ Other

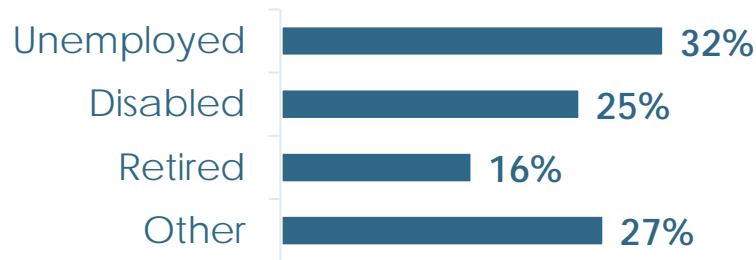
47% 50 to 69 year old

52% Single Household

87% Insured

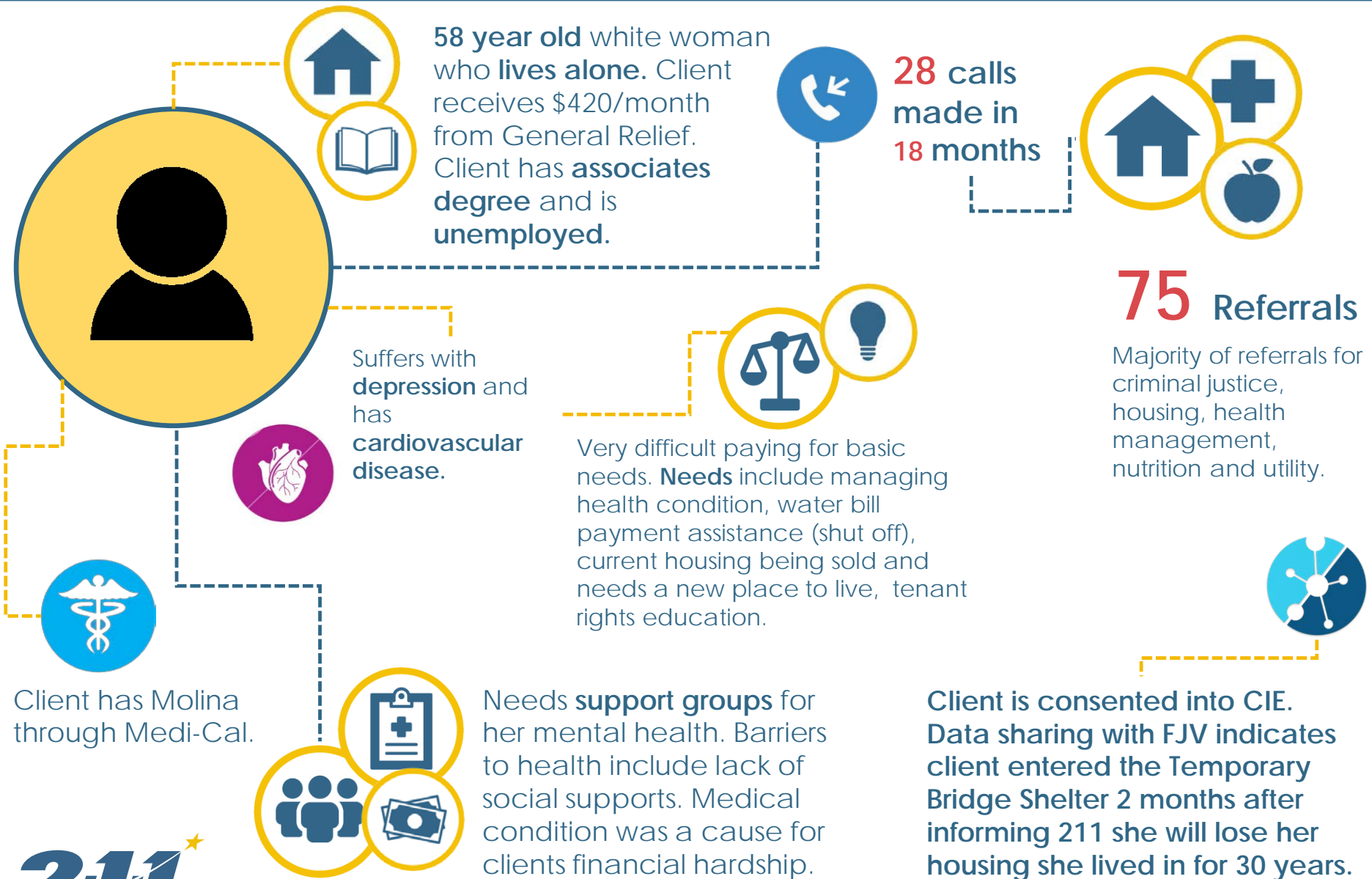
54% Medi-Cal

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%**).

Chronic Condition Group: Client Story



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



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



35

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

26

of those referrals
were in housing
and nutrition.



**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.

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.

Referrals for Groups

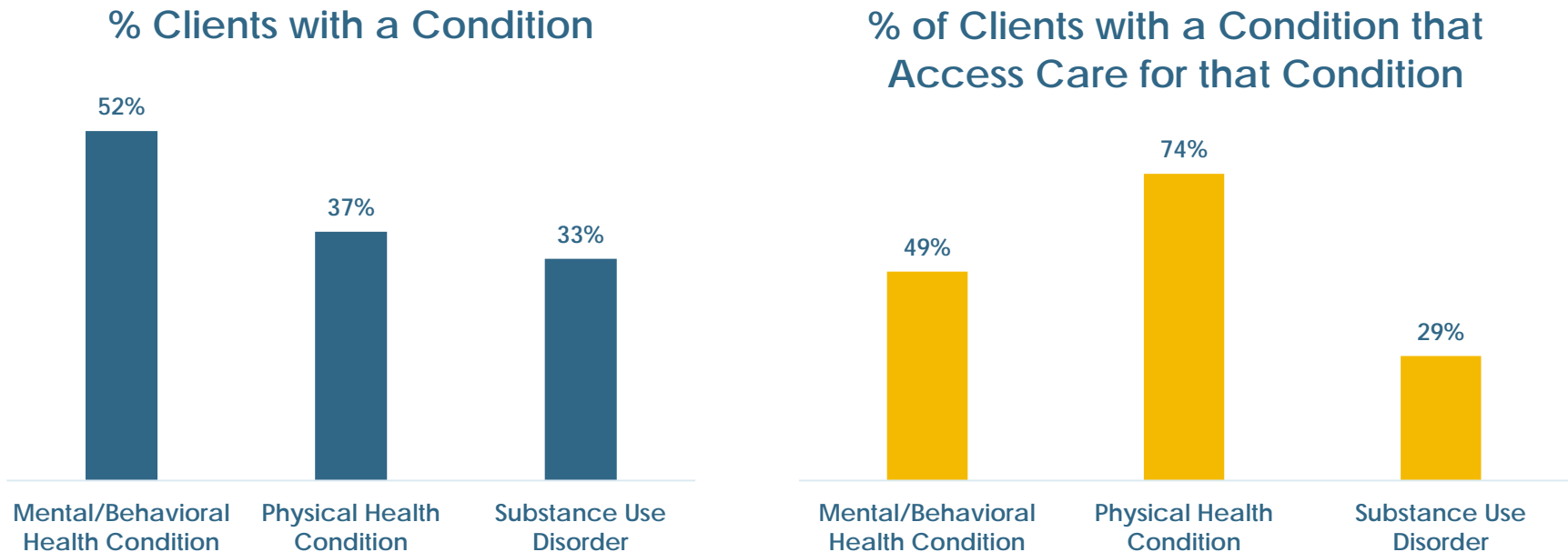
What services are Health Homes proxy group being referred to?

(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.

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

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

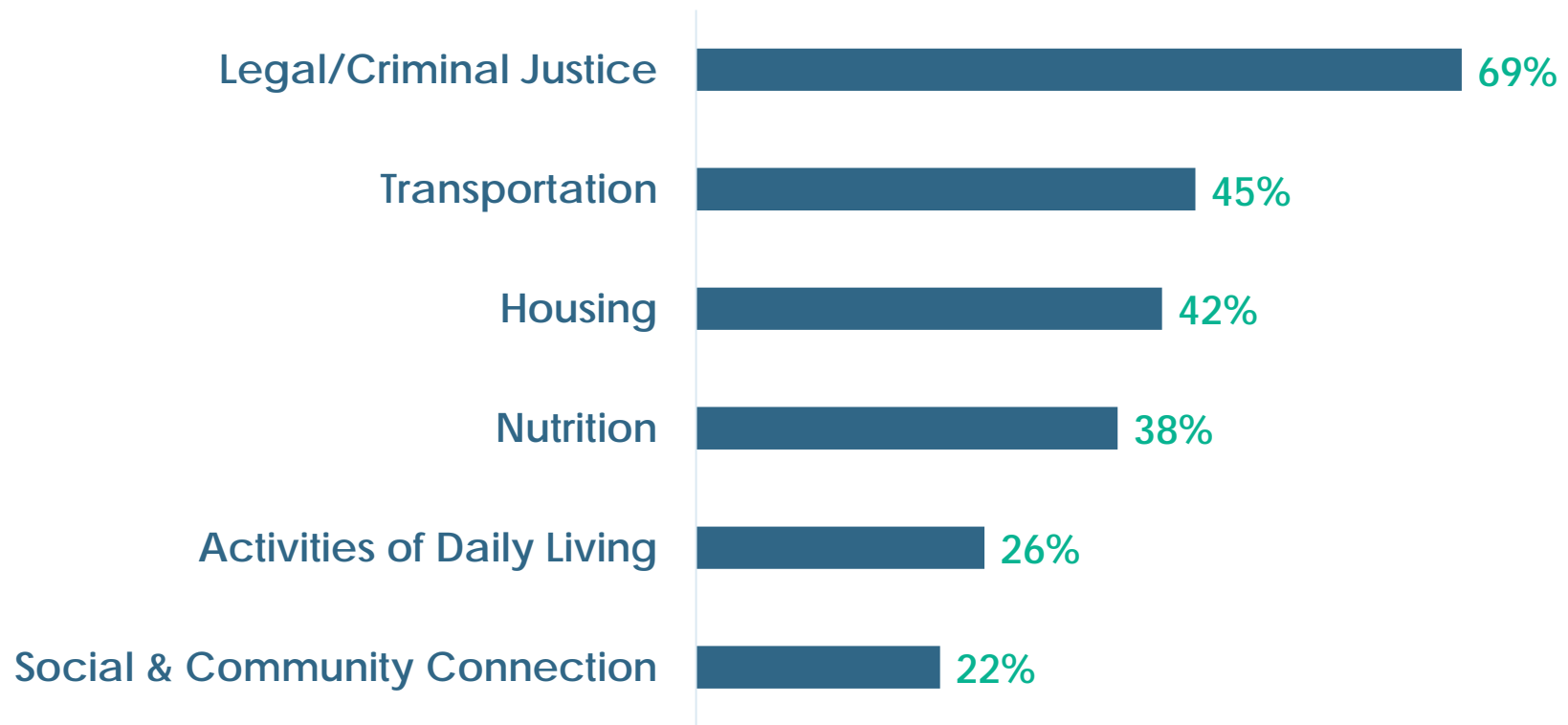


- 49 clients had EMS alerts (17 from acuity group)
- 6 clients accounted for 47% of EMS alerts (5 from acuity group)
- 35% of EMS alerts were for the acuity proxy group

Services Needs: Chronic Condition Group

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

% With No Supports



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

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





Questions?

Camey Christenson

Sr. VP, 211SD/CIE

cchristenson@211sandiego.org

Rebecca Dandrea

Resource & Data Analyst, 211SD/CIE

rdandrea@211sandiego.org