Leveraging a Community’s 2-1-1 System to Build on Information Exchange

- Peter Battistel, 2-1-1 San Diego
- Camey Christenson, 2-1-1 San Diego
- Alana Kalinowski, 2-1-1 San Diego
Camey Christenson  
Senior Vice President  
211 San Diego/Imperial

Peter Battistell  
Chief Technology Officer  
211 San Diego/Imperial

Alana Kalinowski  
Director of Partner Engagement  
211 San Diego/Imperial
Topics

**WHY 2-1-1**

**WHAT is CIE - Community Information Exchange**

**HOW we built the CIE Together**
211 Industry
Built for Connection

- **Accessible:** 3 digit dialing code, multilingual, 7/24/365
- **Resource Database**
- **All sit at the intersection** of supply & demand; client need & service providers
- **Many moving** towards deeper level of navigation & care coordination
About AIRS Standards - Core Areas

- Service Delivery
- Resource Database & Taxonomy
- Reports and Measures
- Cooperative Relationships
- Disaster Preparedness
- Organizational Effectiveness
211 Coverage

overall coverage

90%

<39%

79% - 40%

99% - 80%

100%
Traditional Information & Referral Limitations

Anonymous Client Records:

• Limit holistic understanding or whole person view

• Relies solely on client self report, clients in crisis may not be great historians

• Helpers can’t view client history or status changes

• Limits ability to establish case plans, goals or prevention work

• Limits understanding of interconnected needs
Traditional Information & Referral Limitations

Referral Process:

• Client bears all the weight of next steps and access

• Not trauma-informed: Client must describe their situation repeatedly to different people

• Lack of ownership: Client fall through the cracks

• Agencies accepting referrals start from scratch without benefit from the info just captured by 2-1-1 to identify best resource
211 San Diego

Today

- 500,000 connections/year
- 1,200+ service providers
- 200+ languages offered
- 150+ highly trained staff
- Deeper level of service: Navigation, Person-centric
2-1-1 San Diego leads statewide collaboration to electronically submit applications with a legally valid, telephonic signature.

Benefits include:
- SNAP (CalFresh)
- Medicaid (Medi-Cal)
- EITC/CalEITC
- WIC
- ACA (Covered CA)

Strategies Activities include:
- Outreach (mail, email, text, outbound calls, in-reach)
- Education
- Application submission, follow-up
- Advocacy
- Navigation services
- Data analytics

Services are unique to each area served: San Diego, Imperial, and San Francisco.

Special Projects: Medi-Cal Renewal, Benefit programs enrollment comparison.

In the last year, 2-1-1 San Diego connected over 7,000 families to CalFresh benefits.

Approved applications provide an average $185 in monthly benefits or $1.9M in total annual benefits.

Navigation Services pilot resulted in 35% of previously denied applicants being approved for benefits.

CalFresh benefits stimulate the economy, bringing total impact to $25.5M in economic stimulus to San Diego.
Courage to Call is a program funded by County Mental Health Prevention and Early Intervention, in collaboration with Mental Health Systems, Veterans Village of San Diego and 2-1-1 San Diego.

Courage to Call is the single access point for information, referrals, navigation, and ongoing care coordination for active duty military, veterans, and their families.

Supported by strengths-based case management and care coordination services offered through masters-level Veteran social workers.

In the last year, about 3,500 military and veteran clients connected to a Courage to Call peer-to-peer support specialist.

73% of clients were empowered by 2-1-1 San Diego to contact the referral they were provided.

90% or more of clients report they are better able to handle their situation and know where to get help.
Serves as a single access point for anyone in need of health services, addressing the health and social needs of the whole person by better connecting, empowering, educating, and advocating for clients with health needs.

Address risk factors and social determinants of health to help clients achieve a better quality of life and health outcomes.

Complete an in-depth holistic assessment and establish a care plan to address the needs of each client.

In the last year, Health Navigation provided in-depth services to about 2,700 clients.

Health Navigators assisted nearly 200 vulnerable senior clients, empowering 80% to feel more secure in their home and enabling 86% to feel more able to manage their care.

Successfully enrolled 81% of prenatal women in Medi-Cal and 98% of clients were connected to prenatal care.
HEALTH NAVIGATION:
Care Transitions Intervention (CTI)

Partners:
- Feeding America
- Grossmont Hospital Foundation
- Sharp Healthcare
- Sharp Grossmont Hospital
- 2-1-1 San Diego

Shared Goal: Assist in the transition from hospital discharge to medical home and connection to social services.

2-1-1’s Role: 2-1-1 Health Navigators receive referrals from Sharp health educators and social workers to assess and address risks of social determinants of health by connecting to resources in the community.

Measures: Percent of individuals readmitted into hospital; number of individuals who improve on shared risk rating scale; Client Satisfaction of Sharp referral program; Percent of patients who felt care was better coordinated.
CY 2016-2017:
- 71 CTI patients referred to 2-1-1 San Diego
- 92% decreased vulnerability

**Patient Needs (n = 71)**

- Activities of Daily Living: 2%
- Disaster and Safety: 1%
- Legal: 4%
- Employment: 7%
- Human Dev & Education: 7%
- Personal Hygiene HH Goods: 2%
- Primary Care: 4%
- Health Condition Management: 4%
- Financial Wellness: 8%
- Social Community Connection: 7%
- Transportation: 10%
- Utility and Technology: 4%
- Food and Nutrition: 18%
- Housing: 22%

**Hospital Readmission Rates**
- 9.6%: 211 Patients
- 30.0%: Comparison Group

**DATA SAMPLE:**
YEAR 1: SDOH Outcomes, 2-1-1 San Diego
DATA SAMPLE:
SDOH Outcomes, 2-1-1 San Diego

Percent of Clients Decreasing Vulnerability by Domain

- Income Employment: 42%
- Ambulance: 38%
- Nutrition: 37%
- Social Support: 37%
- Transportation: 36%
- Health Management: 35%
- Activities of Daily Living: 29%
- Housing: 28%
- Utilities: 27%
- Primary Care: 27%
- Safety: 18%
- Personal Hygiene & Household Goods: 15%

91% of clients decreased vulnerability in at least one domain

Decreasing Vulnerability between Year 1 and Year 2

- Nutrition: Y1 29% Y2 57%
- Housing: Y1 24% Y2 46%
- Safety: Y1 17% Y2 25%
HEALTHCARE - What we know:

Social influences greatly impact health

What Goes Into Your Health?

- Socioeconomic Factors
  - Education
  - Job Status
  - Family/Social Support
  - Income
  - Community Safety

- Physical Environment

- Health Behaviors
  - Tobacco Use
  - Diet & Exercise
  - Alcohol Use
  - Sexual Activity

- Health Care

Source: Institute for Clinical Systems Improvement, Going Beyond Clinic Walls: Solving Complex Problems (October 2016)
What we know:

Traditional models of care aren’t working

Exhibit 9. Select Population Health Outcomes and Risk Factors

<table>
<thead>
<tr>
<th>Country</th>
<th>Life exp. at birth, 2019*</th>
<th>Infant mortality, per 1,000 live births, 2019*</th>
<th>Percent of pop. age 65+ with two or more chronic conditions, 2014d</th>
<th>Obesity rate (BMI&gt;30), 2019c</th>
<th>Percent of pop. age 15+ who are daily smokers, 2019b</th>
<th>Percent of pop. age 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>82.2</td>
<td>3.6</td>
<td>54</td>
<td>28.3a</td>
<td>12.8</td>
<td>14.4</td>
</tr>
<tr>
<td>Canada</td>
<td>81.5d</td>
<td>4.8a</td>
<td>56</td>
<td>25.8</td>
<td>14.9</td>
<td>15.2</td>
</tr>
<tr>
<td>Denmark</td>
<td>80.4</td>
<td>3.5</td>
<td>–</td>
<td>14.2</td>
<td>17.0</td>
<td>17.8</td>
</tr>
<tr>
<td>France</td>
<td>82.3</td>
<td>3.6</td>
<td>43</td>
<td>14.5d</td>
<td>24.1d</td>
<td>17.7</td>
</tr>
<tr>
<td>Germany</td>
<td>80.9</td>
<td>3.3</td>
<td>49</td>
<td>23.6</td>
<td>20.9</td>
<td>21.1</td>
</tr>
<tr>
<td>Japan</td>
<td>83.4</td>
<td>2.1</td>
<td>–</td>
<td>3.7</td>
<td>19.3</td>
<td>25.1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>81.4</td>
<td>3.8</td>
<td>46</td>
<td>11.8</td>
<td>18.5</td>
<td>16.8</td>
</tr>
<tr>
<td>New Zealand</td>
<td>81.4</td>
<td>5.2a</td>
<td>37</td>
<td>30.6</td>
<td>15.5</td>
<td>14.2</td>
</tr>
<tr>
<td>Norway</td>
<td>81.8</td>
<td>2.4</td>
<td>43</td>
<td>10.0d</td>
<td>15.0</td>
<td>15.6</td>
</tr>
<tr>
<td>Sweden</td>
<td>82.0</td>
<td>2.7</td>
<td>42</td>
<td>11.7</td>
<td>10.7</td>
<td>19.0</td>
</tr>
<tr>
<td>Switzerland</td>
<td>82.9</td>
<td>3.9</td>
<td>44</td>
<td>10.3d</td>
<td>20.4d</td>
<td>17.3</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>81.1</td>
<td>3.8</td>
<td>33</td>
<td>24.9</td>
<td>20.0d</td>
<td>17.1</td>
</tr>
<tr>
<td>United States</td>
<td>78.8</td>
<td>6.1a</td>
<td>68</td>
<td>35.3d</td>
<td>13.7</td>
<td>14.1</td>
</tr>
</tbody>
</table>

* Source: OECD Health Data 2015

† Includes: hypertension or high blood pressure; heart disease; diabetes; lung problems; mental health problems; cancer; and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014

‡ DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.

What we know:

Quantity v. Quality
- Changes in policy will change revenue
  - Value-based models change incentives to focus on value by rewarding better outcomes and lower spending.
  - Most medical treatment services are fee-for-service reimbursement, driving volume over value.
- Transition to Value-based Healthcare is Slow: only 3% of health systems provide more than one-half of all care under value-based contracts

Social Determinants of Health Considerations
- Intersection of social service and health care
- How will change in social status be measured?
- How can data exchanges help?
Community Information Exchange
Community Information Exchange (CIE):

A network of multidisciplinary providers collectively sharing and contributing to a single longitudinal individual client record. The CIE captures change over time in 14 domains of wellness, using shared language and outcome measurements.
Person Centered Model

- Housing Provider
- Transportation Provider
- Healthcare Provider
- Food Provider
- Income and Benefits Provider
**Data Hubs**

**Housing Services**
Homeless Management Information System HMIS (San Diego Systems: ServicePoint & CSTAR)

**Food Services**
Local food banks & meal programs (San Diego System: OASIS)

**Healthcare Services**
Ambulance transport, Healthcare systems, Hospitals, Community Clinics, Health Plans (San Diego Systems: WATER, HIE, Individual EHRs)

**Income & Benefit Programs**
CalFresh, Medi-Cal, CalWorks, General Relief (San Diego Systems: CalWin, ConnectWell)
2010
Community Initiative around frequent fliers

2011
Community Exchange Created through Alliance Healthcare Foundation i-2 grant to 2-1-1

Cohort 1
Homeless Providers

Cohort 2
Senior Providers

2016
CIE returns to 2-1-1 San Diego

2017
Launch referral network for veterans, UniteUS platform

2018
Launch of CIE within new Salesforce platform with bi-directional referrals

Expanded to all agencies and target populations
CIE: Pilot Evaluation Results

Clients with Look-ups Have Fewer EMS Trips Post Enrollment

Mean number of EMS Trips

- Pre-CIE: 3, 2, 1, 0 for 1-5 EMS Trips, 6-24 EMS Trips, 0 EMS Trips respectively.
- Post-CIE: 1, 0, 0, 0 for 1-5 EMS Trips, 6-24 EMS Trips, 0 EMS Trips respectively.

- 26% reduction in mean number of EMS trips pre and post CIE enrollment for 233 CIE enrolled clients with a history of EMS use. Largest percent reduction (42%) for clients with highest EMS risk.

Housed Clients with Look-ups Are Less Likely to Exit to Street

- Pre-CIE: 24% exited housing compared to 15% post-CIE.
- Largest effect seen among clients with EMS history (62% reduction).

Percent Exitine to the Street

- Pre-CIE: 24%, 15%, 10% for All Clients, No EMS Trips, EMS Trips respectively.
- Post-CIE: 14%, 10%, 6% for All Clients, No EMS Trips, EMS Trips respectively.

- 38% reduction in the percentage of housed clients who exited housing and went back to the street (24% vs 15%) between those that were not looked up compared to those that were looked up. Largest effect seen among clients with EMS history (62% reduction).

Percent Exitine to the Street (continued)

- Pre-CIE: 38%, 15% for All Clients, No Look-up respectively.
- Post-CIE: 24%, 10% for All Clients, Look-up respectively.

- 44% improvement in the percentage of housed clients who remained in current housing placement between those who were not looked-up and those who were looked up. Largest effect (77% improvement) seen among clients with EMS history.
Community Information Exchange Today

Technology Platform
Salesforce software with MDM middleware Informatica to Integrate with other technology platforms.

Social Determinants of Health
14 Domains Risk Rating Continuum
Crisis, Critical, Vulnerable, Stable, Safe Thriving.

Bidirectional Information Sharing
Ability to Accept and Return Referrals
Ability to provide outcomes and Program Enrollment.

Network Partners
Collective approach with shared Participation Agreement, Business Associates Agreement and Consent/Authorization

Resource Database
Updated resource database of community, health and social service providers.

Community Care Coordination
Communication Feed with Care Team, Alerts, Program Enrollment, and Shared Goals
Resource Database

- Shared taxonomy language for referrals (AIRS)
- Regular updates made to resources
- Standards to listings and requirements
- Inclusion/Exclusion Criteria
- Linked to health conditions and the Risk Rating Scale
- Allows foundation for bi-directional referrals
Technology Platform

**MDM**

Master Data Management
- Detects and merges duplicate records
- Ensures the accuracy, completeness, and consistency of multiple domains of enterprise data

**ETL**

Extract Transform Load
1. Reads data from a database
2. Converts the data for the new database
3. Loads into the new database

**CIE**

shared client record
Social Determinants of Health
Shared Measures Across Social Needs
14 Domains

- Housing Stability
- Primary Care and Prevention
- Health Management
- Nutrition & Food Security
- Financial Wellness and Benefits
- Activities of Daily Living
- Social & Community Connection
- Legal & Criminal Justice
- Safety & Disaster
- Utility & Technology
- Transportation
- Education & Human Development
- Personal Care & Household Goods
- Employment Development
- Financial Wellness and Benefits
# Methodology

## Identify Existing Models for SDoH
- Researched existing SDoH tools: World Health Organization (WHO), HealthyPeople2020, Live Well San Diego, Center for Disease Control, Kaiser Family Foundation, Alliance for Information and Referral Taxonomy (AIRS)

## Outline Impact on Community Level
- Identified micro and macro factors that impact San Diego community
  - Individuals’ Demographics, Behavior & Choices, Access to, Environment, Policy
  - Laid foundation for 2-1-1 San Diego’s 14 domains of health and wellness

## Measure Impact (Risk Rating Scale)
- Developed model to assess client’s change over time (adapted from Jewish Family Service’s Self-Sufficiency Model)
  - Plots clients within six levels of vulnerability: Crisis, Critical, Vulnerable, Stable, Safe, and Thriving

## Identify Shared Measures through Assessments & Domain Standards
- Developed domain-specific assessments, driven by evidence based tools, existing social service intakes, and practical application
  - Risk is defined by Immediacy, Knowledge & Utilization, Barriers & Support
  - Analytics also include situational factors such as demographics, socioeconomic status, health conditions, and place (geography)

## Weighted Assessment Rubric
- Weighted constructs that aligns specific responses to risk level
  - Values and point allocation driven by literature
  - Objective risk determination via standardized scoring
  - Establishes baseline risk to calculate change over time

## Feedback & Integration
- Review & feedback session with agency subject matter experts across multiple domains
  - Integrated assessments with existing intakes, including shared measures, aligning values and eligibility criteria across agencies
  - External validity through partnership with University of San Diego Caster Center for Non-Profit and Philanthropic Research
<table>
<thead>
<tr>
<th>Domains/Social Need Domains</th>
<th>HealthyPeople2020 (CDC)</th>
<th>2-1-1 San Diego</th>
<th>Henry J. Kaiser Family Foundation</th>
<th>SIREN</th>
<th>Health Leads</th>
<th>PRAPARE</th>
<th>Self-Sufficiency Matrix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x Quality &amp; Stability</td>
<td>x (Housing Stability)</td>
<td>x (Status &amp; Stability)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>X (Health &amp; Healthcare)</td>
<td>x</td>
<td>X (Primary Care and Access)</td>
<td>x</td>
<td></td>
<td>(Health Behaviors)</td>
<td>x (Insurance)</td>
</tr>
<tr>
<td>Health Condition Management</td>
<td>X (Health &amp; Healthcare)</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>(Behavioral/Mental Health)</td>
<td>x (Stress)</td>
</tr>
<tr>
<td>Food &amp; Nutrition</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>(Hunger and Food Insecurity)</td>
<td>x (Food)</td>
</tr>
<tr>
<td>Social &amp; Community Connection</td>
<td>x (Social &amp; Community Context)</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x (Social Isolation &amp; Support)</td>
<td>x (Social Integration &amp; Support)</td>
<td>x (Support System)</td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>(Social Isolation)</td>
<td>x (Functional Ability)</td>
</tr>
<tr>
<td>Employment</td>
<td>x (Economic Stability)</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>(Economic Stability)</td>
<td>x (Career Resiliency/Training, Employment Stability, English Second Language)</td>
</tr>
<tr>
<td>Criminal Justice &amp; Legal</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>(Incarceration History)</td>
<td></td>
</tr>
<tr>
<td>Financial Wellness &amp; Benefits</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>(Economic Stability)</td>
<td>x (Public Benefits)</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x (Material Security)</td>
</tr>
<tr>
<td>Personal Hygiene &amp; Household Goods</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>(Utility Needs)</td>
<td></td>
</tr>
<tr>
<td>Utility &amp; Technology</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety &amp; Disaster</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>(Violence/Safety)</td>
<td>x (Exposure to Violence)</td>
</tr>
<tr>
<td>Human Development &amp; Education</td>
<td>x (Education)</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>(Education &amp; Childcare)</td>
<td>x (Childcare)</td>
</tr>
<tr>
<td>Neighborhood &amp; Built Environment</td>
<td>x (Access Healthy Food, Housing Quality, Crime &amp; Violence, Environmental Conditions)</td>
<td>x (Housing, Transportation, Park Safety, Walkability)</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Housing Assessment Snapshot

- Each assessment is built to as an algorithm to plot clients on a crisis to thriving scale
- Shared across all agencies and can be updated by agency data through integration
- Shows a history of client change and by which agency to move up on the continuum
- Examine client need by domain accounting for the follow factors:
  1. The nature, severity, & immediacy of the need
  2. The barriers and supports available to client in meeting that need
  3. The client’s knowledge and capacity to utilize resources to meet that need
Objective: Creation of universal assessment tool to understand complexity of social influences
  • Clinical screenings exist, but lack comprehensive guide to capture holistic view

Designed to:

1. Understand client situation, nature and severity of the need
   • Standardized categories across domains

2. Establish baseline risk to objectively measure change over time
   • Built framework for shared measures

3. Provide a roadmap for care planning
   • Utilize continuum to move clients towards thriving

4. Align resources with client need and risk
   • Resources are tagged through standardized classification system
What is the client's overall situation?

Does a client know about resources in the community and are they utilizing them?

How soon does the client need help?

Are there client limitations or barriers preventing client access?

What social supports exist for the client?
HOUSING STABILITY

Long-term safe and adequate housing that meets all needs with access to multiple resources and ability to access supports for long-term housing sustainability

CRISES

CRITICAL

VULNERABLE

STABLE

SAFE

THRIVING

IMMEDIACY

Place Not Meant for Habitation

Housing Application Submitted

Temporary Housing (less than 3 months)

Housing (at least 6 months)

Adequate Housing to Meet Most Needs

Knowledge and Utilization of Multiple Resources

LIMITED KNOWLEDGE AND UTILIZATION

Not Knowledgeable

Limited Knowledge

Knowledge of a Few Resources

Adequate Housing to Meet All Needs

Not Sought Any Services

Attempted Some Services (e.g. VI-SPDAT, CAHP, Section 8, Rapid-Housing)

Has Access to and Some Support from Resources (e.g. Social Networks, Family)

BARRIERS AND SUPPORTS

No Finances

Violence

Limited Finances

Home Repair

Credit Issues

Substance Abuse

Foreclosure

In-Home Support

Incarceration

Immigration Status

Increased Rent

Adequate Finances

Limited Finances

Immigration Status

Increased Rent

Knowledge and Utilization of Multiple Resources

IN COLLABORATION WITH:

211 SAN DIEGO
FOOD & NUTRITION

Long-term and sustainable access to nutritious foods and to support services to maintain access

CIE Risk Rating Scale

CRISIS
1. Less than One Day Supply of Food
2. No Access or Knowledge of Resources
3. Limited Supports and Lack of Transportation, Finances

CRITICAL
1. 1-3 Day Supply of Food
2. Some Access (Food Banks & Food Pantry)
3. Some Barriers (e.g. Lack Access to Grocery Stores) and Limited Friend or Family Supports

VULNERABLE
1. Ability to Maintain Food Supply up to 30 Days
2. Connected to a Limited Number of Short Term Resources (CalFresh, WIC, Supplemental)
3. No Barriers (Supports to Food Preparation and Finances)

STABLE
1. Adequate Food
2. Knowledge to Buy and Prepare Nutritious Food
3. No Barriers

SAFE
1. Nutritious Food
2. Practices Healthy Eating and Wellness
3. No Barriers

THRIVING

FOOD INSECURE WITH HUNGER
FOOD INSECURE WITHOUT HUNGER
FOOD SECURE
Bidirectional Information Sharing

Referral Network between providers with closed loop/outcomes
- **Declines**
- **Accepts**
- **Evaluating**
- **Program Enrollment**
  - Creates client profile
  - Authorization to share information
- **Did Not Receive Services**
- **Care Team**
- **Receiving/Received Service**
- **Closed Referral**
- **CIE Network Partner**
- **Agency**
  - Evaluating
Search Client

First Name

Last Name

Social Security Number

Last 4 of SSN

###

Birthdate

Birth Month/Year

MM/YYYY

Phone Number

Email

Search
**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**
- Agencies or programs client is referred
- Ability to note barriers to accessing referral
**CIE Shared Client Record**

**Program Enrollment**
- Agencies or programs client is receiving services
- Status of service or program

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

**Feed**
- Ability to communicate like Twitter to other Care Team members
**Benefits of CIE**

**Clients**
- Not having to share their story to multiple agencies
- More informed and tailored services
- More proactive and successful connection to services

**Agency**
- Bridges different sectors and systems
- Efficiencies through client service history
- Shared language, outcomes and measurements

**Community**
- Data that Speaks
- Real-time Integrative Insights.
- Identify and track unmet needs by services
- Identify and track barriers for clients and populations
<table>
<thead>
<tr>
<th>Tier 1 Referral Partner</th>
<th>Tier 2 Connected Partner</th>
<th>Tier 3 Integrated Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Agency listed in the searchable 2-1-1 database</td>
<td>• Direct client referral from 2-1-1 call staff, sharing basic client information</td>
<td>• Ability to access CIE client record</td>
</tr>
<tr>
<td>• Login access to update community profiles and add services</td>
<td>• Agency ability to accept or return referral (set expectations)</td>
<td>• 2-1-1 sends client referral and agency access to client profile</td>
</tr>
<tr>
<td>• Agency information provided by 2-1-1 staff to clients</td>
<td>• Option to provide additional feedback on client outcome</td>
<td>• Access to client profile and updates from a multi-agency network</td>
</tr>
<tr>
<td>• Request reports on referrals to your agency</td>
<td>• No access to the full CIE client record</td>
<td>• Agency ability to accept or return referral and provide feedback and outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Agency can also consent clients into the CIE CRM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CIE CRM can integrate with agency CRM for shared clients, view only options</td>
</tr>
</tbody>
</table>
Tier 2
- Basic client info – no access to client profile
- Ability to accept or decline electronic referrals from 2-1-1

Tier 3
- Integrated View-Only
- Full client profile
- Health or No Health info

CIE Partner Decision Tree
- View Health or No Health Info
- Accepts or declines electronic referrals
- Consents client into CIE
- Care Team Program Enrollment Alerts
- Client Data Sharing
Thank you!

Camey Christenson
cchristenson@211sandiego.org

Peter Battistel
pbattistel@211sandiego.org

Alana Kalinowski
akaalinowski@211sandiego.org
Leveraging a Community’s 2-1-1 System to Build on Information Exchange