What is CIE? Developing Community Information Exchange in California and Beyond

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Community Information Exchange (CIE)[i] networks develop shared governance and technology to support cross-sector collaboration addressing social determinants of health. They bring together diverse partners from health and behavioral health care, social services, education, the legal system, tribal entities, and other organizations to build relationships, goals, and agreements. By delivering core infrastructure and methods for active planning and collaboration across organizations and programs, CIEs serve as critical hubs in communities integrating systems of care to improve services and outcomes, especially for their most vulnerable residents.

Many related initiatives have advanced integration within systems of care. For example, Health Information Exchange (HIE) efforts aggregate medical data in one record that clinicians across health systems can access, while housing Continuums of Care have come together to build coordinated entry services and shared documentation in homeless management information systems. CIEs, in contrast, knit together these partners through tools and data that span sectors to provide more

holistic and actionable views of community needs and the complexity of individuals. My colleague Mark Elson provides more information on the distinctions between HIE and CIE in a companion post.

There are many types of processes that CIE networks try to improve through shared goals, agreements, and technology. These often include:

- **Assessments** of individuals' needs
- **Eligibility and enrollment** in appropriate programs and services
- Building an **individual care record** and a holistic **care plan**
- Facilitating **referrals for services** across organizations and sectors linked to a community resource directory
- **Communications and workflows** among distributed care teams
- **Individual consent** for data sharing and **participation** in organizing one's care
- **Reporting and analytics** to illuminate inequities and upstream causes of health and social issues, and to identify gaps in service supply

Policy Drivers

Many programs and funding streams across the country are driving cross-sector collaboration. These include Accountable Communities for Health, Medicaid transformation projects, issue-focused funding (such as Adverse Childhood Experiences (ACEs) Aware), and state legislation that all push for collaboration between health care providers and community-based organizations. Each has a slightly different focus, but all are pushing communities to build connections across sectors to improve services, experiences, and outcomes for vulnerable populations. Below we describe a few programs that have allowed innovative communities and CIE pioneers to start building capacity, infrastructure, and sustainable collaborative practices.

Federal programs: Center for Medicaid Services (CMS)

Starting in 2015 to advance the triple aim, CMS began funding some states to implement Accountable Communities for Health. These began as regional public private partnerships that are designed to be conveners, coordinating bodies, and investment hubs to better connect health care delivery systems to community service providers. In 2016, CMS funded additional five-year **Accountable Health Community** pilots in 28 communities, which focused on connecting eligible residents with community services to address five core health related social needs: housing, food security, utility assistance, transportation problems, and interpersonal violence. Services focus on s**creening, referral, and navigation**, with most screening occurring in hospital settings. The first evaluation report indicated that most communities built upon existing infrastructure and relationships, but that AHC

funding allowed for the formalization of processes for screening and referrals, and expanding capacity for navigation services. California funded 8 regional ACH communities through these State Innovation Model funds. In the years since then, many other California Medicaid innovation projects have continued to drive cross-sector collaboration.

In 2016, California matched CMS funding with state general funds and local sources to test new cross-sector collaboration approaches with DHCS's Whole Person Care pilots. This program funded 25, 5-year pilot programs to develop new wrap-around case management services to better serve clients with complex needs. These funds allowed lead entities,

> *to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities will identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.*

This program funding continued regional pressure in California to knit together health, behavioral health, and social service systems of care with improved agreements and collaboration processes or tools. Rather than just focusing on referrals from hospitals, many WPC pilots required the development of a shared care plan across organizations providing care within 30 days of enrollment. This pushed many counties towards identifying cross-sector care teams, developing more sophisticated data sharing frameworks, and implementing secure collaboration tools. Some counties built upon assessment and referral infrastructure. Others focused on implementing tools that would allow for more in-depth data sharing for long-term case management and collaboration.

State Initiatives

Two other initiatives continued to push collaboration for specific populations. In 2018 the State passed Senate Bill 1152 (Health and Safety Code § 1262.5) which requires hospitals to have a written plan for coordinating services for patients experiencing homelessness. This bill increased pressures on hospital systems to have an efficient way to refer patients to community-based services and has led many regional efforts to implement directory and referral networks. In 2020 California also announced funding for the Adverse Childhood Experiences (ACEs) Aware initiative. This program provides grant funding to communities across California to build

networks and strategies to address Adverse Childhood Experiences and toxic stress. Grants support provider engagement and training, but also *building a network for care planning and care implementation,* creating new opportunities and new challenges for existing networks and service providers.

The outcome of many of CMS's pilot projects is the creation of a new a Medicaid benefit for vulnerable California residents. This year, Whole Person Care pilots are transitioning many services into Medicaid benefits offered by Managed Care Organizations (MCOs) under California Advancing and Innovating Medi-Cal (CalAIM). The program is focusing on building capacity to implement population health management strategies, and offering integrated services to key populations of interest, starting with Medi-Cal members with complex medical needs (Enhanced Care Management) or who are experiencing homelessness or require other community services to support health like medically tailored meals (Community Supports). Future waves of implementation will include better access to behavioral health services and re-entry services for justice involved adults and youth. While important for long-term sustainability of critical case management and community services, transition of the program to MCOs is challenging the systems set up under WPC pilots.

CIEs as Multi-Purpose Infrastructure

What all of these examples illustrate is that there are often short-term initiatives that drive innovation; however, each of these efforts has its specific program requirements and target populations. Building a CIE requires stepping back from each individual program's specific needs, to consider the broader long-term goals of a community. CIE development must start with those broader goals to build a system that centers the experience and rights of community residents, that does not over-burden community-based service providers, and does not continue to build and re-build with every program transition. Braiding together program funding can bring new providers into the network of stakeholders, or could allow the network to serve new groups of residents, but the goals should be to build a resilient, multi-purpose system of care and collaboration that will outlast any one programmatic funding stream. This requires the lead local entities on specific programs to work through a broader community framework, an approach that at times generates resistance from program managers whose jobs require them to deliver on their specific program needs, often on short timelines from state or federal funders.

One CIE pioneer, the 211/CIE San Diego, has harnessed programmatic funding opportunities over the past two decades to establish and expand their network of service providers, build a community governance framework, and implement multi-purpose technology solutions. CIE San Diego defines CIE as

> *"a community-led ecosystem comprised of multidisciplinary network partners using a shared language, a resource database, and integrated technology platforms to deliver enhanced community care planning. A CIE enables communities to have multi-level impacts by shifting away from a reactive approach towards proactive, holistic, person-centered care. At its core, CIE centers the community to support anti-racism and health equity."*

In a presentation at the California Primary Care Association meeting in 2019 entitled, "Community Information Exchanges (CIE): Changing the Landscape – Coordinating Social Determinants of Health," they present a timeline that shows how they have harnessed opportunities to grow, test, and iterate their service offerings over time (Slide 9). These have included initiatives like the ONC's Beacon Community grants that supported HIE expansion after the passage of the HITECH act, partnership and funding from Managed Care Health Plan partners for health navigation services, and California Whole Person Care funding that helped expand structured approaches to assessment, risk ratings, and developing a longitudinal care record in a shared technology platform. They expand upon some of the influences shaping CIE in the opening sections of their CIE Toolkit, which they offer to other communities engaged in this work.

211/CIE San Diego has produced and shared many practical resources designed to help communities build beyond individual program requirements. 211/CIE San Diego's CIE toolkit and the Data Equity Framework (Collaboratively developed with Dr. Rhea Boyd and Health Leads) provide tools that center community vision, goals, and control of information and data. They offer both written materials and a series of sessions from the 2021 CIE Summit called "Leading with Community to Drive Systems Change." In addition to sharing lessons learned on broad CIE implementation they offer many materials to help CIE communities put equity theory into practice through their series on Leveraging CIEs for Equitable and Inclusive Data. This includes the data equity framework, a vision for the future, and examples of CIE work in communities around the country. In 2022, they are focusing their convening efforts on a conference called Aligning California, Maximizing Opportunities to Advance Local Community-Led Networks. The need for this type of convening stems from both the opportunities and challenges communities feel as CalAIM and other pressures push regional networks to adapt to new programmatic demands.

Conclusion

CIEs are ideally positioned to power cross-sector collaboration and data sharing to address community needs across programs. Many communities developing CIE services are sharing learnings and tools to build policy and technology frameworks

that center on clients, support front-line service providers, build local control of data, and unify systems of care. We will explore how large-scale initiatives such as CalAIM can support broad systems planning and collaboration rather than building new program silos, and how some communities are doing this work, in future posts.

[i] CIE(R) is a registered trademark of 211 San Diego. For more information about the trademark, see the following webpages on the legal status and brand guidelines for the term.