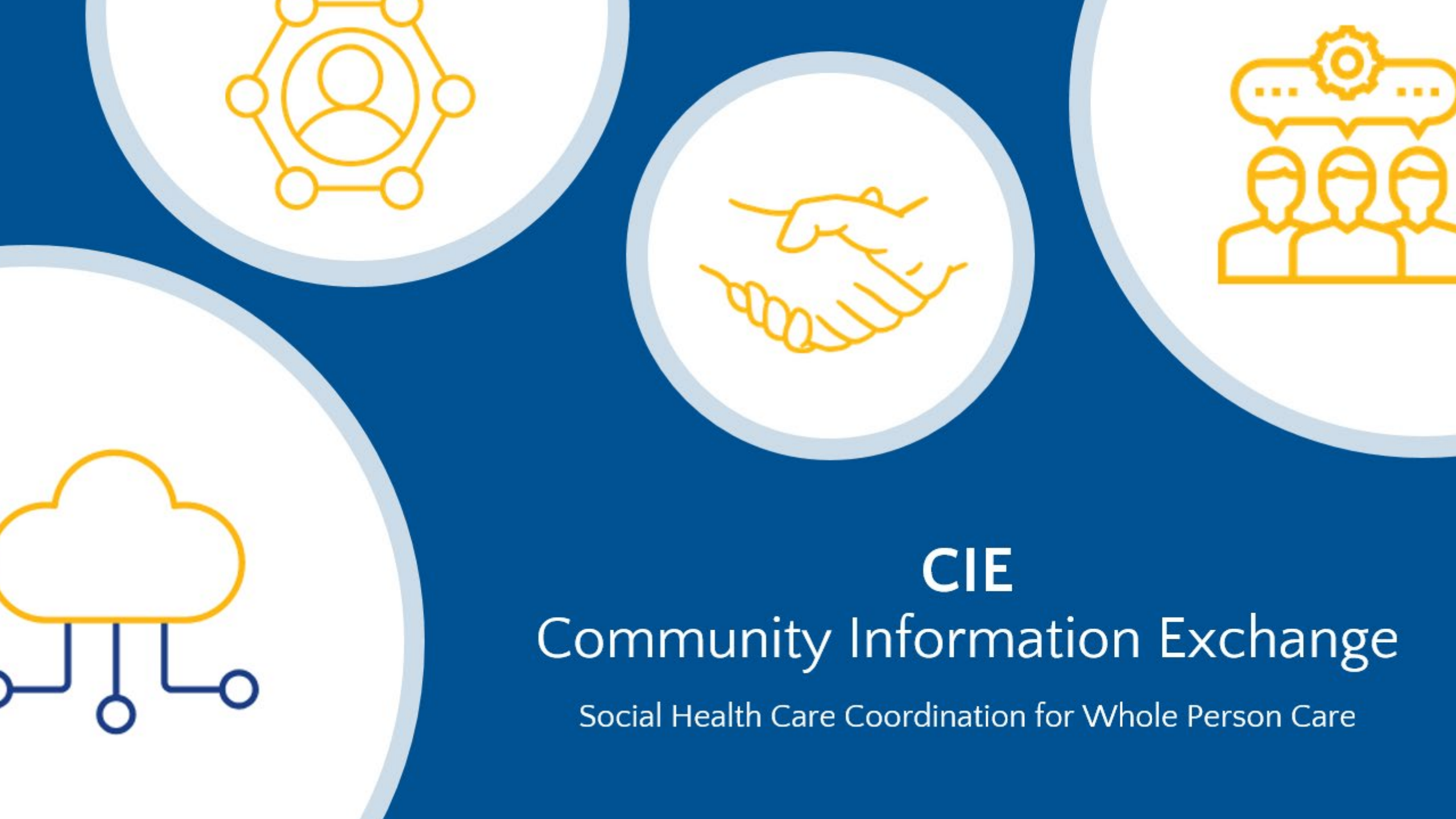
CIE
Community Information Exchange
Social Health Care Coordination for Whole Person Care

South Dakota CIE Project Overview

- Program of the SD Department of Health
  - Funded by CDC Health Disparities Grant
- Merative (formerly IBM Watson Health) has been selected as the technology solution to host the SD CIE
- We are working with their team to configure the system and bringing in the partners who will test and use the system.
- The Helpline Center community resource directory will feed the CIE platform

SOUTH DAKOTA DEPARTMENT OF HEALTH

helpline center

CHWSD
Community Health Worker Collaborative of South Dakota

SOUTH DAKOTA Health Link
Exchanging information. Changing lives.

South Dakota CIE

South Dakota's Community Information Exchange (SD CIE) is a statewide collaboration of health care, human and social service providers sharing information using an integrated technology platform and referral system to coordinate whole-person care.

Vision: To streamline connection between health care, human and social service providers to address social needs and advance health improvement among populations at higher risk and that are underserved.

SOUTH DAKOTA DEPARTMENT OF HEALTH

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The Pathway to Meeting Social Needs

Seems simple!

In reality connections may be missed at many points along the way

What's the Problem?

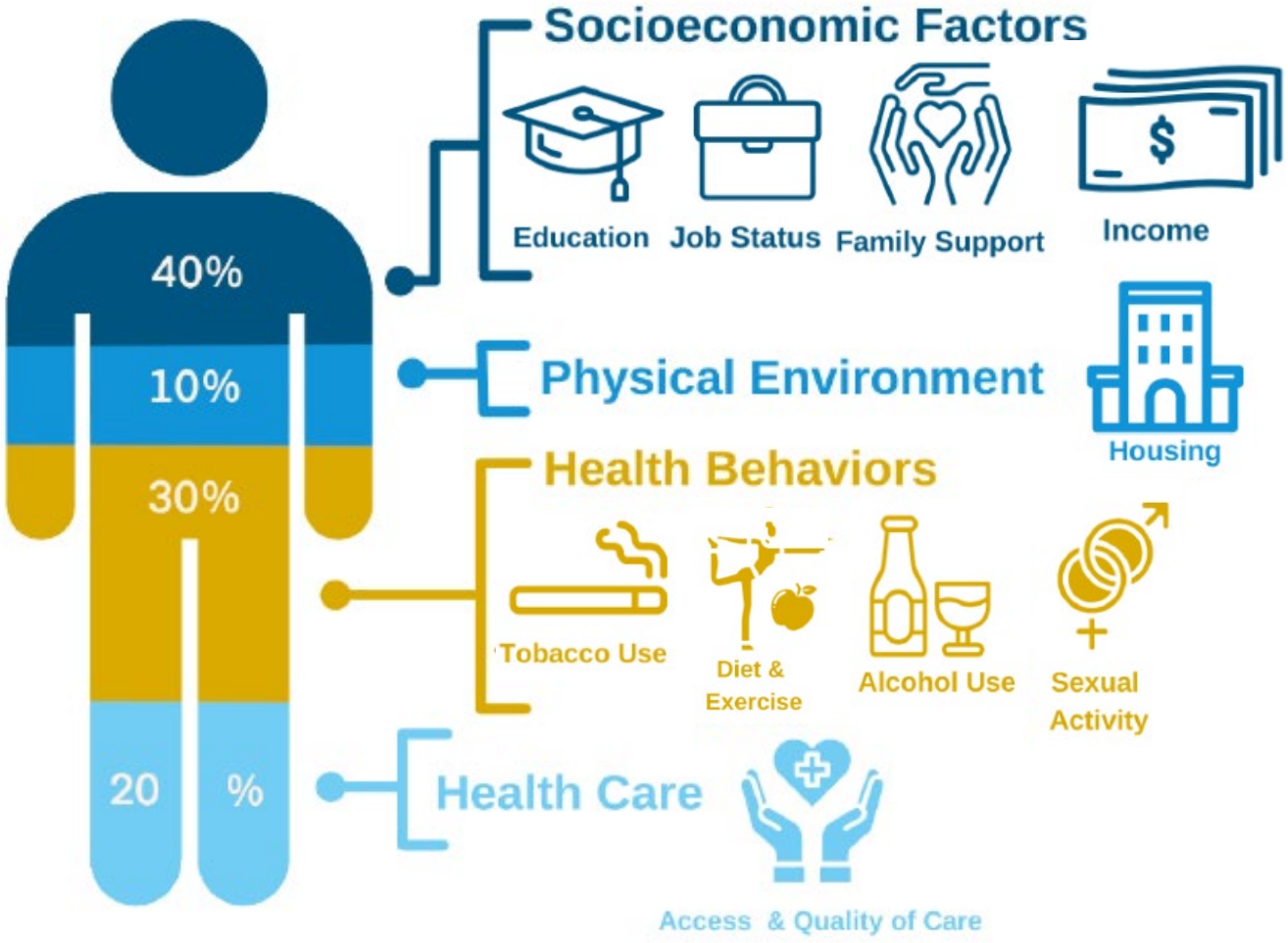
1. Navigating systems

- Difficult for community members
- Organizations are not integrated to one another
- Siloed data systems result in duplicated processes for individuals and providers
- Leaders have limited visibility into the barriers and gaps in service delivery

2. Difficulty accessing care

- Stigma
- Language barriers
- Shame
- Lack of trust
- Overwhelmed
- Lack of transportation
- Social services not convenient
- Social risk is not a social need
- Free services still cost something

Navigating Social Care to Support Social Determinants of Health



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Moving Care Upstream

CIE Community Directory Search

- Government Programs
- Non-profit Programs
- Civic Programs
- For Profit Programs
- Volunteer-Run Programs
- HealthCare Programs

Medicaid
SNAP
TANF
Employment Support
Housing Funding/ HUD
Homeless Prevention
Rent Payment Assistance
Utilities Payment Assistance
Medical Bills Assistance
Transportation
Car Repairs
Tuition Assistance
Food Pantries
Personal Care Items
Holiday Items
Children and Family
Clothing and Household
Work Clothing
School-Based Supports
Police Resource Officers
Alcoholics Anonymous
Homeownership Education
Tenant-Landlord Mediation
Nutrition Education
Smoking Cessation
Exercise Programs

Data Sharing of Client Info and Service Outcomes Across Providers

Requirements to Access SDOH Supports Varies Program by Program

Eligibility:
Gender
Veteran Status
Income Limits (Varies)
Household Size
Have Children?
Current Employment
ID, SS Card Required
Disability Status
Diagnoses

Frequent Personal Requirements:
Internet Access
Vehicle or Transportation
Phone

Did the person get the help?
If so, is it working?
If not, why not?

Is SDOH support leading to health improvement and lower costs?

Streamlining Communication and Closing the Loop!

helpline center

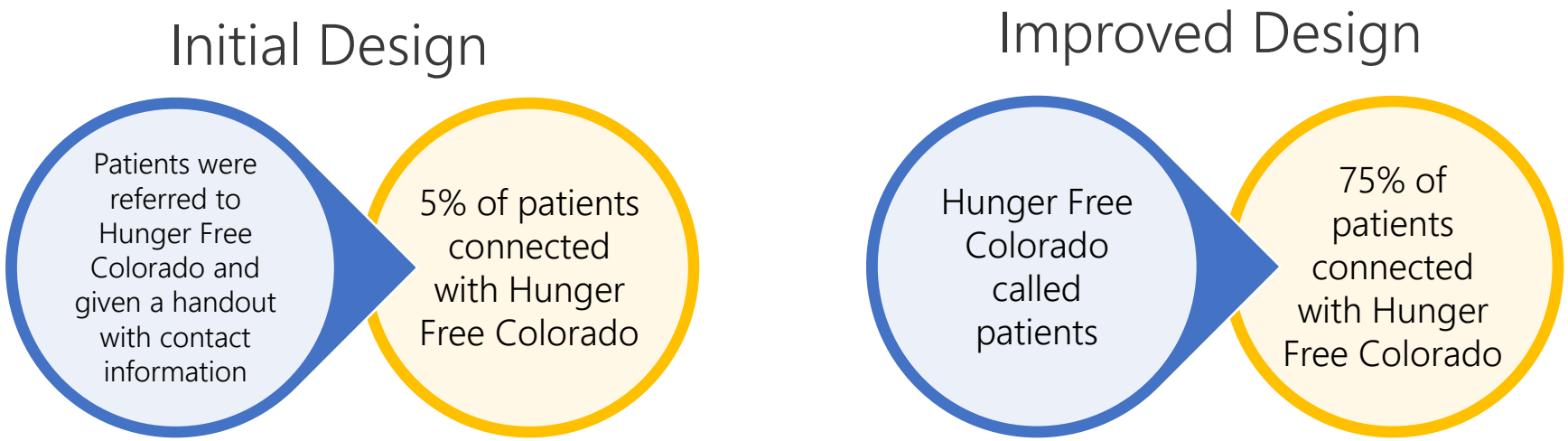
Why does a closed-loop referral matter?

- **Traditional Linear Referral:** We provide the resource information to the client.
  - The responsibility is the on the client to go to that resource.

- **Closed-Loop Referral:** Through technology, we send e-referrals to resource partners to connect the client. The resource partner reports back to the system about the outcome of the service.
  - The responsibility is on the resource partners and technology processes to connect the client and track outcomes.

What Research Shows

- Kaiser Permanente Colorado Study:



When the Provider reached out to the client, they were **15x more successful** in connecting!

(Permanente, Kaiser, 2018)

SD CIE Levels of Impact

Individual Benefits:

Quicker connection to appropriate services
Telling story only once
Screening identifies additional needs

Partner Benefits:

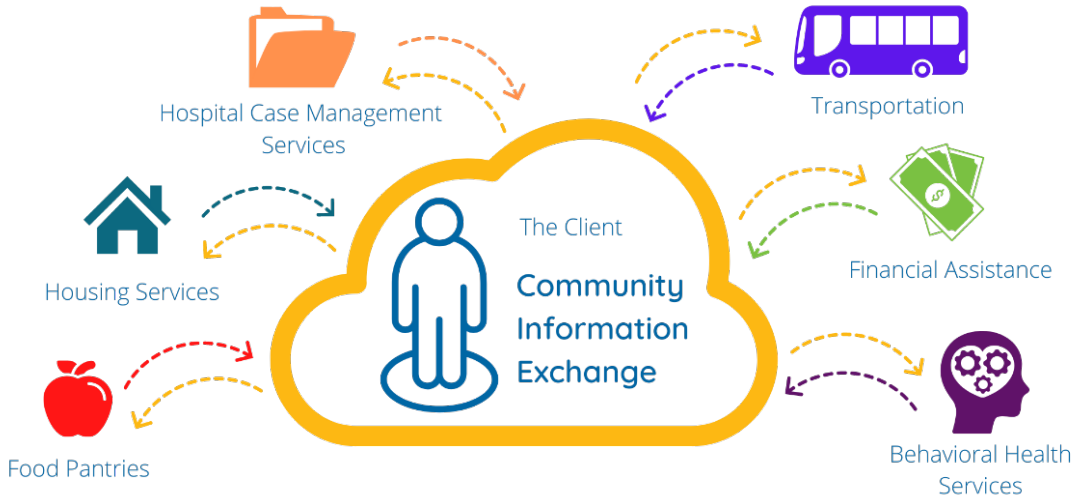
Access to comprehensive resource database
Streamlined referrals and communication between providers
Shared client story promotes rapid identification of social needs
Organizations can more effectively serve community members
Access to outcome data for measuring impact

Community Benefits:

Community data to inform policy, planning, and investment
Identification of unmet needs and barriers to access services
Infrastructure more effectively serves community members

What SD CIE Offers

- Longitudinal Client Record
  - Look up & creation
- Closed-loop referral system
  - Electronic referrals on behalf of client
  - Visibility to referral/service outcomes
- Data sharing capabilities
  - Agency to agency
  - Community wide data collection and analysis
- Social Determinants of Health (SDOH) assessment tools
  - Helps guide care manager actions based on social needs and risks



Thank you!!