Bi-directional Referrals in San Diego: Assessing, Developing, and Piloting

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REACH Grantee Meeting
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SAN DIEGO COUNTY

- 4,261 square miles
  (larger than 21 U.S. States; same size as Connecticut)
- 5th largest U.S. County, 2nd largest in CA
- 18 municipalities; 36 unincorporated towns
- 18 tribal nations
- 42 school districts
- 2016 Estimates - 3.2 million population
  - 46% White
  - 33% Latino
  - 11% Asian/PI
  - 4.8% African American
  - 0.4% American Indian
- Region is very diverse

- Over 100 languages
- Large military presence
- Largest refugee resettlement site in CA
- Busiest international border crossing in the world (San Ysidro/MX)
Implement bi-directional referral systems for lifestyle change programs

Goals

- Develop pilot National Diabetes Prevention Program (DPP) referrals for clinics and health systems and explore regional opportunities for implementation
**PROBLEM**

**Program Providers:** Want to help more patients and have bi-directional communication with healthcare.

**Insurance:** Want members to get connected to programs but don’t know how to get their members to program providers.

**Healthcare:** Know about medication but do not know where to refer for diabetes prevention.

**Patients:** Don’t know the programs exist or where to access them.

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*Image*
Bi-directional Referrals/Community-Clinical Linkages

- Conducted assessment of bi-directional referral options including current capacity and existing infrastructure such as clinical decision support tools that could support bidirectional referrals
- Surveyed health system partners to determine barriers to bi-directional referral
- Piloted internal referral process at a large health system

THEN

- Developed two linked pilots to explore potential mechanisms for bi-directional referral and assess how to integrate referral within existing workflows
HIPAA and CMIA

- Reviewed existing processes to determine organizational and infrastructure changes needed for medical data sharing
- Develop internal policies to support HIPAA compliance
- Provided HIPAA training for all 2-1-1 staff involved in providing services and information related to confidential medical information
- Updated technology to support new requirements
- Created and posted Notice of Privacy Practices for individuals accessing 2-1-1 services
- Developed Business Associates Agreements with clinic partners
WHAT WE DID…

2-1-1/CIE Pilot Project
Review: existing resources in database

Trained: 2-1-1 Health Navigators on heart disease, stroke, and diabetes prevention

Assess: selected a few healthcare systems (FQHCs) for readiness assessment

Coordinated: Develop partnerships with other community resources to explore pathways for referral
COMMUNITY INFORMATION EXCHANGE

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

**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.

**Technology Platform**
Salesforce software with MDM middleware
Informatica to integrate with other technology platforms. Access to community, health and social service providers

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

**Community Care Coordination**
Communication Feed with Care Team, Relationships, Program Enrollment, Referrals and Goals
Dr. Smith or Care Team logs into CIE Network

- Finds patient within the Network or creates a profile

- Makes a referral to 2-1-1

- 2-1-1 accepts referral from healthcare provider

DPP Provider receive e-mail alert for new referral

- Make a referral within CIE to DPP Provider

2-1-1 staff use DPP Network database to find best DPP program based on patient needs

- Calls the patient and gathers eligibility information

DPP referral accepts or declines referral and contact patient

Referring healthcare provider is notified of program enrollment

Option for healthcare providers to have access to Skinny Gene platform for progress on care plan

DPP = National DPP
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
NEXT STEPS…
REACH/1817 Development Plan
Work with 2-1-1/CIE to expand programs and increase partnerships to facilitate bi-directional referrals between health systems and community resources, including new lifestyle change programs.

**Phase 1:** Recruit additional FQHCs for referral to lifestyle change program providers and expand menu of lifestyle change programs

**Phase 2:** Develop additional infrastructure within 2-1-1/CIE to facilitate fully electronic referrals

**Phase 3:** Pilot health coach-assisted referrals and compare outcomes to the fully electronic process (evaluation project)
Initial Referral Process

**Phase 1:**
- Healthcare Provider
  - Referral
  - CIE (Community Information Exchange)
    - Electronic Bi-directional Referral
  - Call Center
  - Weight Watchers Reimagined
  - Diabetes Prevention Program

**Phase 2:**
- Patient
  - Referral
On May 17, 2016, the County of San Diego Health and Human Services Agency Division of Public Health Services received accreditation from the Public Health Accreditation Board.