# Emerging Insights: CalAIM Implementation in San Diego

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Community Information Exchange
California Forum
2022

# Overview: 211SD and CIE

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## GENERAL LINE

- 24/7 contact center
- 10 minute information and referral
- 300+ languages
- Use CIE to document all interactions with callers and consent into CIE (85% of callers)
- CRM integrated with CIE platform

## NAVIGATION SERVICES

- Specialty line with case management
- Contracted partnership
- Health Homes, Direct ECM, CS Service Provider
- In-depth assessment and coordinated referrals via CIE
- CRM integrated with CIE platform

Community Information Exchange

Connect to 122+ organizations through direct system access or leveraging data integration between systems

## CIE Network Partners


## Individual User Access

- Secure login
- Individual level PII & CIE profile Screenings, Assessments, CSCA
- Electronic Referrals

## System to System Integration

- Secure member matching
- API connections
- Eligibility prioritization

# What is a Community Information Exchange?

*"A Community Information Exchange (CIE) is 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****."*

# Overview: Community Information Exchange

- Network of 122+ health, social and government organizations coordinating care through shared platform and data integration
- 300,000+ consented San Diegans (shared authorization form)
- Shared Governance structure, aligned with local infrastructure, initiatives and leadership
- Supports system coordination and comprehensive communitywide care management
- Local to San Diego for over 10 years, being replicated as a state and national model

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# Objectives & Goals

*A locally built and led infrastructure that supports initiatives, collective efforts, and coordination across our community to improve health and wellness outcomes for people.*

- *Care Management*
- *Single Communitywide Client Record via data integration*
- *Bi-directional and Closed-Loop Referrals*
- *Data Insights and Analytics*

# CIE CALAIM SAN DIEGO COUNTY PANEL

*August 25, 2022*

LIVE WELL SAN DIEGO

# SAN DIEGO ADVANCING AND INNOVATING MEDI-CAL (SDAIM)

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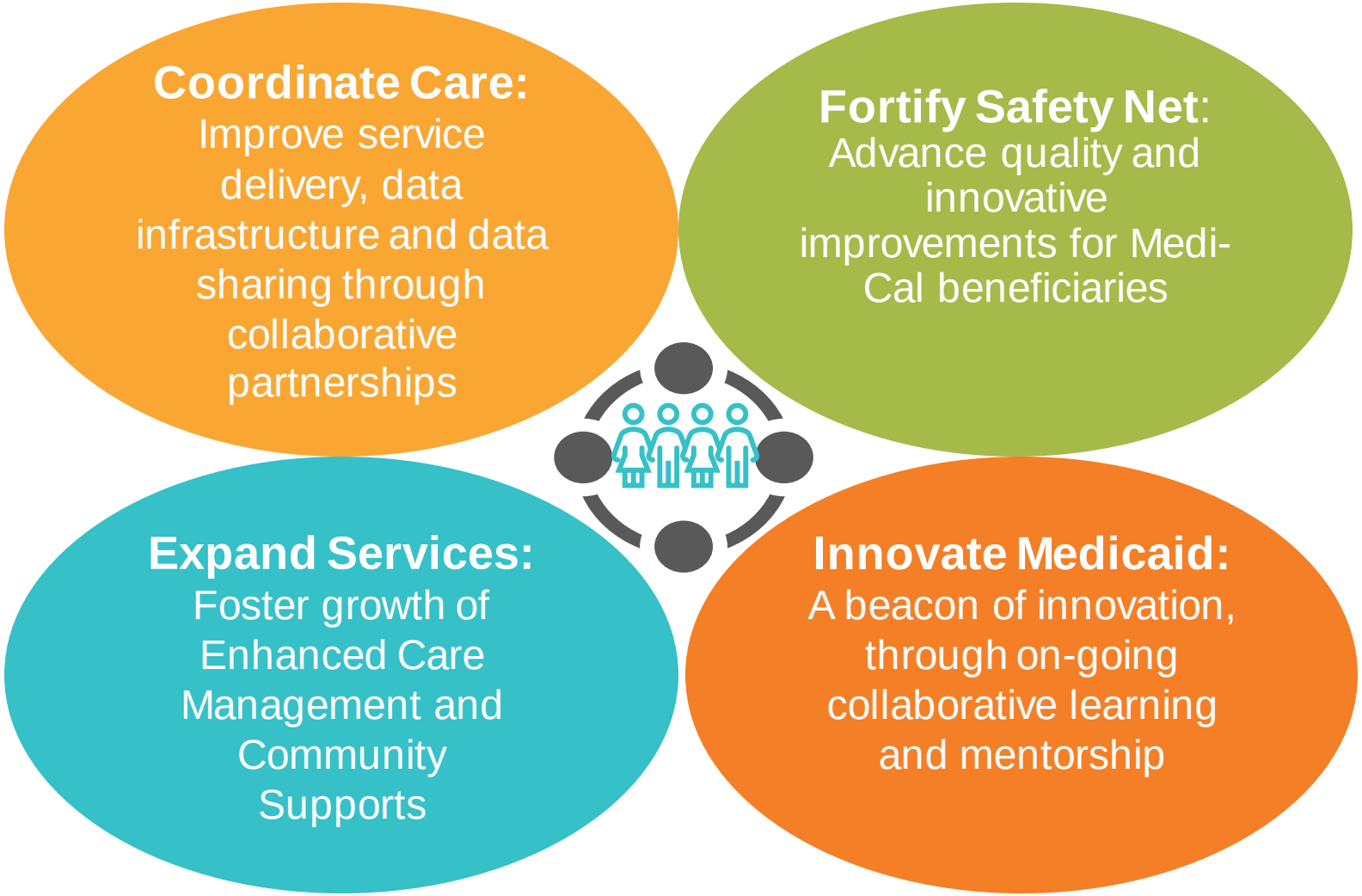

# DATA SHARING VISION

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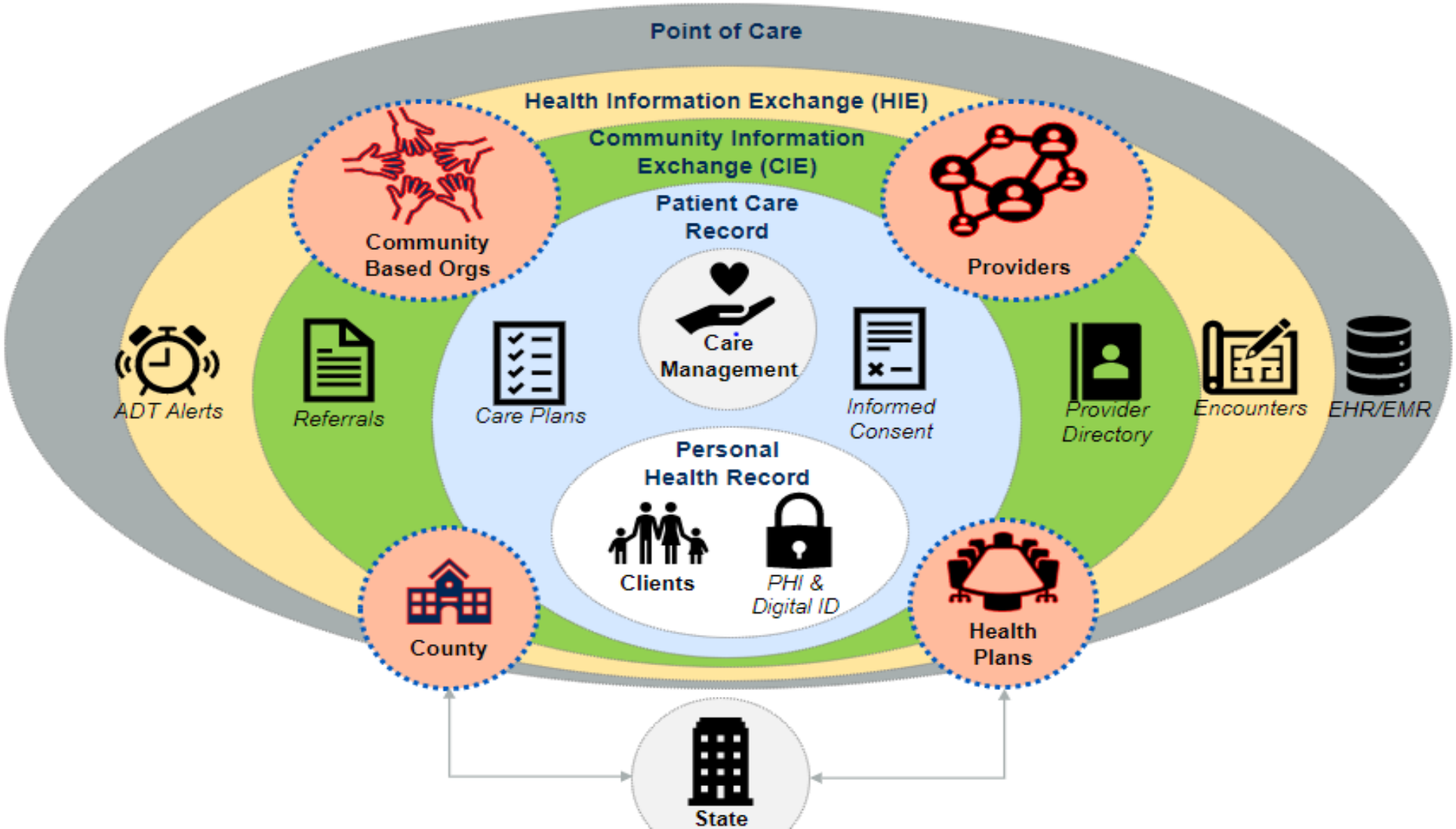

# MANAGED CARE PLAN RELATIONSHIPS

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# MANAGED CARE PLAN COORDINATION

- Memorandum of Understanding
- Letters of Support
- Monthly Meetings

Successful Waiver Implementation:

- Whole Person Wellness (WPW)

GEOGRAPHIC MANAGED CARE PLAN COORDINATION SINCE 1994

Healthy San Diego

# San Diego Governance & CalAIM Pilots

211 SAN DIEGO Community Information Exchange

Community Information Exchange

**211 San Diego Board of Directors**

**CIE Advisory Board**

- **Clinical Healthcare Working Group**
- **Outcomes/Measurement**
- **CalAIM Working Group**
- **CalAIM Provider**
- **CalAIM Pilot**

**CIE Partner Network**

- **Ethics Policy** (inclusion, data ownership, data governance)
- **User** Experience
- **Community Voice**
- **Affinity Groups** (Initiative, Catalyst, Collaborative)

# CIE CalAIM Workgroups

| Workgroup Name | Primary Goals | Members | |
|---|---|---|---|
| **CIE CalAIM Workgroup** | Identify ways CIE can be leveraged to support CIE Network (CBOs, health plans, healthcare providers, etc.) in CalAIM efforts and operations<br><br>Provide recommendations and support implementation for **strategic** and **collective** data use and coordination between key stakeholders (i.e. health plans, CBOs, FQHCs, County, health care providers)<br><br>Advocate or highlight challenges and opportunity within the community, impacting community CIE Network | Key stakeholders of all sectors, focused on system level impact<br>• Alliance Healthcare Foundation<br>• Blue Shield Health Plan<br>• County of San Diego Health and Human Services Agency Father Joes Villages HASDIC<br>• Health Net<br>• Interfaith Community Services<br>• Legal Aid Society of San Diego<br>• McAlister Institute<br>• PATH Sharp Healthcare<br>• San Diego State University Social Policy Institute<br>• San Diego Wellness Collaborative<br>• Veterans Village of San Diego<br>• YMCA of San Diego | Began October 2021<br><br>Monthly, First Wednesday of each month |
| **CIE CalAIM Provider Workgroup in partnership with San Diego Wellness Collaborative** | Highlight challenges among provider network, identify potential solutions and capacity building needs, identify opportunities and recommendations to advocate for improvement or leverage CIE technical infrastructure | Individual providers, sharing challenges and offering potential tangible solutions<br>• San Diego Wellness (chair)<br>• Exodus<br>• PATH<br>• 211 San Diego<br>• Father Joes<br>• Interfaith<br>• Family Heath Centers | Began February 2022<br><br>Monthly, Third Wednesday |
| **CIE CalAIM Provider Pilot** | 3 month pilot of 5 meetings to support adoption of CIE to enhance each organizations use of CalAIM<br><br>Focus on adopting use cases that make sense of organization and learning network to support use | Contracted providers interested in being part of the pilot, supervisors and managers | Began April 2022 |

# Initial Opportunities with CIE for CalAIM

***Overarching Opportunity:*** *To leverage CIE to support efficiency and coordination across our local San Diego community*

*CIE answers the following field level questions:*

**Who is (potentially) eligible, enrolled, where and in what service?**

**How do I get my clients/members connected to CalAIM services?**

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# Opportunities to think about:

| Step on Process | Value/Impact | What you do in CIE? | Challenges for Implementation |
|---|---|---|---|
| Outreach | • Finding members updated contact information and more information | • Looking up in CIE | • Another system to login<br>• Not everyone is in CIE |
| Enrollment | • Receive proactive notifications on significant events<br>• List your information so clients can be connected back to you | • Consent<br>• Looking up in CIE<br>• List in CIE your program and care team person | • Learning consent<br>• Requires dual-documentation<br>• Need to create process on what to do with alerts |
| Care/Case Management | • Tracking and closed-loop referrals<br>• Leveraging existing screeners and assessments | • Consent<br>• Make referrals in CIE<br>• Use assessment/screening tools in CIE (ex. CalAIM, SDoH, Housing Assessments) | • Learning consent<br>• Training on new referral process<br>• Data outside of your system (but we can send you via excel) |

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# Call to Action by Sector

| Sector | CIE Membership | Specific CIE Utilization* |
|---|---|---|
| **County HHSA** | Enhance CIE/Connect Well data integration<br><br>Encourage/Require CIE Membership for County-funded partners and MCPs | • Consent individuals into CIE[1]<br>• Document Medi-Cal Eligibility[1]<br>• Document program enrollment of similar services (IHSS, etc.)[2]<br>• Receive referrals for ECM/CS[3] |
| **Managed Care Health Plans** | Formally join CIE as integrated partner w/Data Use Agreement | • Consent members into CIE[1]<br>• By-name member matching[4]<br>• Document program enrollment for ECM/CS[2]<br>• Send/Receive referrals for ECM/CS[3]<br>• Document contracted service provider for ECM/CS[3] |
| **Hospitals** | Formally join CIE | • Consent patients into CIE[1]<br>• Document health plan[4]<br>• Look up care team[2]<br>• Send referrals for ECM/CS[3] |
| **Community Based Organizations** | Formally join CIE as integrated partner w/Data Use Agreement | • Consent clients into CIE[1]<br>• Document health plan[4]<br>• Document program enrollment of similar services and ECM/CS services[2]<br>• Send/Receive referrals for ECM/CS[3]<br>• Document staff member to care team[3] |

**CIE Utilization Impacts for Cal AIM Community Coordination*

[1] ***Person Identification*** *(who's eligible/enrolled)*

[2] ***Service Identification*** *(what specific service a person is eligible/enrolled)*

[3] ***Service Access*** *(process to facilitate access to services)*

[4] ***Plan Identification*** *(assigned managed care health plan)*

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CIE CA Forum Panel Discussion

August 25, 2022

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# Challenge: Systems Alignment

Effective implementation of Community Supports requires:

- Breaking down silos between and among sectors
- Creating a common vision
- Aligning multiple systems
- Creating shared workflows, data, etc.


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# CalAIM ECM/CS Provider Workgroup

- Forum for individual providers to share challenges and offer potential tangible solutions
- Primary goals include:
  - Highlight challenges among provider network
  - Identify potential solutions and capacity building needs
  - Identify opportunities and recommendations to advocate for improvement or leverage CIE technical infrastructure
- Mix of ECM/CS providers; mainly community-based organizations (non-clinical)
- Coordinating with similar FQHC ECM/CS Provider Workgroup

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# Implementation Challenge Categories

- Outreach/Referrals into ECM/CS - directing eligible clients to their assigned provider
- Enrollment/Eligibility process
- ECM service limits/requirements
- Community Support service limits/requirements
- Funding levels/requirements not sustainable
- Electronic Claims Submission/Invoicing
- MCP Portals/Reporting/Data Entry Requirements
- Communication with MCPs
- Provider Training & Education
- Data Sharing to Support Care Coordination

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# Categories of Potential Solutions

| Category | Description |
|---|---|
| Provider Capacity Building | a resource or change to build/enhance capacity at the provider level (e.g., provider orientation, provider training, provider workflow change) |
| MCP Policy | a change in policy or practice at the MCP level; could apply to one or more MCPs (e.g., standard referral form outlining documentation needs for CS, clarification on reauthorization process, additional information available to providers with referral, additional information available to providers regarding claims status and reason for denial) |
| Community Infrastructure/System Change | a resource or change with the potential to impact all providers (e.g., provider directory aggregated by CIE, medical necessity documentation for CS available in CIE) |

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# Top 3 Areas for Action

- ECM Sustainability – Enrollment/Reimbursement
- CS Enrollment
  - Housing Services
  - Recuperative Care Services

- Convening focused, small groups of providers to develop and test solutions

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# CalAIM Provider Pilot

| CIE CalAIM Provider Pilot Workgroup | |
|---|---|
| **What?** | **3-month pilot** with **5 meetings** supporting adoption of CIE to enhance **your CalAIM services** |
| **Why/Value?** | • **Outreach:** Increase number of people enrolled in CalAIM services for successful client outcomes<br>• **Efficiency:** Increases access to additional information about members for more informed care (less time)<br>• **Coordination:** Increase encounters, by coordinating enrolled members back to your organization<br>• **Documentation:** Tracking of closed-loop referrals to health, social and community based resources |

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# CalAIM Provider Pilot

| | Meeting Content/Agenda/Dates |
|---|---|
| **Kick-Off** | **Define the Value & Impact on CalAIM:**<br>• What can CIE help with?<br>• Share draft and customize workflow of CIE use for your organization |
| **Workflow Review** | **Share out Workflow and Identify Pilot Group:**<br>• Identifying the right pilot group<br>• Plan for Launch and Training Support |
| **Pilot Check-In** | **Share out on Pilots:**<br>• What worked<br>• What didn't work<br>• Lessons learned and needed resources |
| **Iterate & Scale** | **Evaluate the success of the pilot.**<br>• Update your processes as needed.<br>• Look at outcomes and value add<br>• Develop business case to expand |
| **Check-in Progress** | **Check-in:** How is it going? What changes/needs/supports? |

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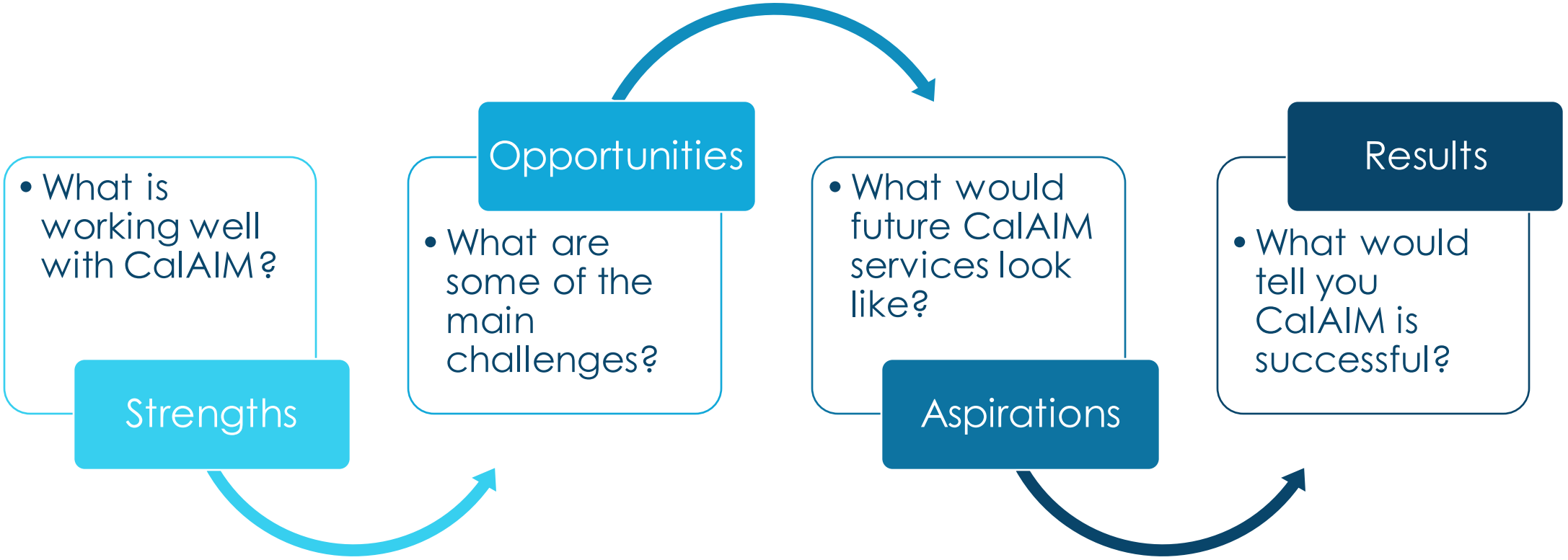
# CalAIM Provider Pilot - SOAR Analysis



# Challenges, Opportunities and Potential Outcomes

| CalAIM Challenge | CIE Opportunity | Potential Outcomes/Results |
|---|---|---|
| Identification of new members eligible for ECM services | (Outreach) Search CIE profile for historical information (ex. HMIS) to identify new eligibility for current patients/members | Example: Increase in enrollment for ECM/CS services |
| Impact of ECM/CS services (social interventions) on health condition outcomes for members | (Case Management/Reporting) Use CIE for assessments, social needs screening or referrals to measure health and social outcomes (can request exports of members data) | Example: Decrease vulnerability for one social need |
| Engagement with potential members via information within CIE | (Outreach) Look in CIE to view past referrals, program enrollments and care teams to see how services might be helpful to members situation | Example: Reduce volume of those not interested in ECM services |
| Evidence for homeless documentation for eligibility for ECM/CS services | (Enrollment) Using information within CIE HMIS/homeless data to share housing status with health plan in request for ECM/CS services | Example: Increase efficiency in identifying housing status |
| Documentation of enrollment in services with other providers—Coordination | (Case Management) Coordinating services by using referrals, program enrollments and care team to better coordinate across other service providers and receive proactive alerts | Example: Reduce time (efficiency and effectiveness) for ECM services |
| Documentation/Administration of information for various MCPs | (Case Management) Request export of CIE data for individual members to leverage data collected or shared in CIE for health plan reporting | Example: Reduce time (efficiency and effectiveness) for ECM services |

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## *Question and Answer Panel Discussion*

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