Aligning California: Enacting Policies for Systems Change

Plenary Panel

August 25, 2022

Community Information Exchange
California Forum
2022

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Community Information Exchange
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CIE California Forum

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Three years ago, Governor Newsom laid out a vision for a California for All

Governor Newsom set a path to simultaneously create effective, culturally competent, and efficient safety-net programs that address the whole-person needs of vulnerable Californians while also creating policies and practices that support the creation of inclusive communities where all Californians from diverse backgrounds and with diverse resources and opportunities can be healthy and thrive.

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CalHHS Guiding Principles and Strategic Priorities

Focus on Equity by creating programs that address persistent and systemic inequities.

Actively Listen to individuals and communities to better understand their conditions and formulate better policies, programs and services that meet their needs.

Use Data to Drive Action to help advance social and economic mobility, and improve the health and well-being of children, families and individuals.

See the Whole Person by focusing on the needs of the people we serve, not on the siloed structures of government and its programs.

Put the Person Back in Person-Centered with programs that are informed and structured to meet the diverse and unique needs of each community and person.

Cultivate a Culture of Innovation to catalyze our improvement efforts and solve intractable problems.

Deliver on Outcomes by continuously evaluating and adapting our programs to better address our clients' unmet needs while furthering our goal of delivering positive outcomes.

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The California Data Exchange Framework (DxF)

In 2021 Governor Newsom signed AB 133, putting California on a path to building a single data sharing agreement to govern health information exchange

- ✓ The law mandates that a broad spectrum of health care organizations execute the Framework's Data Sharing Agreement (DSA) by January 31, 2023, and exchange health information with other mandated organizations by January 31, 2024.
- ✓ The Framework identifies infrastructure and capacity gaps, and opportunities that could be undertaken to address them including:*
  - ✓ Developing a technical assistance and HIE onboarding program
  - ✓ Establishing a data exchange intermediary qualification process
  - ✓ Expanding federal event notification requirements
  - ✓ Upgrading public health and county health IT infrastructure
  - ✓ Improving standardized demographic, SDOH and SOGI data collection
  - ✓ Improving individual data access
  - ✓ Establishing provider directory and digital identity capabilities

*https://www.chhs.ca.gov/wp-content/uploads/2022/07/6_CalHHS_DxF_Gaps-and-Opportunities_Final_v1_07-01-2022.pdf

Department of Health Care Services (DHCS): CalAIM

Two years ago, DHCS launched "CalAIM" a long-term commitment to transform and strengthen Medi-Cal

CalAIM represents a significant investment and sustained commitment to collaboration with partners to provide more equitable, coordinated, and person-centered care. CalAIM initiatives include:

- ✓ **Enhanced Care Management** benefits to deliver person-centered care management to the highest-need Medi-Cal enrollees through in-person engagement where enrollees live, seek care, and choose to access services.
- ✓ **Community Supports** services such as housing supports and medically tailored meals, that play a fundamental role in meeting enrollees' needs for heath and health-related services that address social drivers of health.
- ✓ **Population Health Management** requirements for managed care plans (MCPs) to implement whole-system, person-centered strategies that includes enrollee assessments, care management and care transition services.
- ✓ **PATH** capacity and infrastructure funding for community-based organizations (CBOs), public hospitals, county agencies, tribes, and others to successfully participate in the Medi-Cal delivery system.
- ✓ **Incentives** to support the implementation and expansion of ECM and Community Supports by incentivizing MCP investment in provider capacity and delivery system capacity and infrastructure.

CalAIM Incentive Payment Program (IPP)

The Incentive Payment Program is intended to support the implementation and expansion of ECM and Community Supports

The 2021-22 California State Budget allocated $1.5 billion in funding over 2.5 years for the Incentive Payment Program.

- ✓ IPP is designed to drive MCP investment in provider capacity and delivery system infrastructure to integrate physical and behavioral health services, reduce health disparities, promote health equity, achieve improvements in quality performance, and encourage take-up of Community Supports

Providing Access and Transforming Health (PATH)

PATH is a $1.85 billion initiative supporting justice-involved, ECM and Community
Supports capacity building through five distinct initiatives

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	PATH	IPP
Eligibility Criteria	**Counties, providers, community-based organizations, Tribes, and others** • MCPs are not permitted to receive PATH funding for infrastructure, capacity or services	**MCPs** that elect to participate and meet requirements to qualify • MCPs are expected to maximize investment and flow of incentive funding to ECM and Community Support providers to support capacity and infrastructure
Funds Flow & Uses	Funding will flow from DHCS to eligible entities, *sample uses include:* • Hiring and training staff that will have ECM and Community Supports responsibilities • Providing technical assistance to support billing processes and contracting with MCPs • Establishing collaborative planning groups • Supporting health information exchange	Funds will flow to MCPs upon meeting milestones, *sample uses include:* • Purchasing or upgrading IT systems for billing, data exchange and care management documentation systems for ECM and Community Supports providers • Expanding ECM and Community Supports capacity • Developing program compliance and oversight capabilities

Program Alignment

- ✓ **Transparency.** MCP IPP Needs Assessments and Gap-Filling Plans are publicly posted to ensure transparency. DHCS will make information on PATH funding awards publicly available and require applicants to attest that funding requests are coordinated with MCPs.
- ✓ **Collaboration.** PATH is facilitating collaborative planning efforts across eligible entities. MCPs are expected to collaborate with providers, CBOs, and others to support a coordinated effort to invest in ECM and Community Supports infrastructure and capacity.
- ✓ **Reporting.** DHCS will review PATH funding application requests against MCPs' IPP Needs Assessments and Gap-Filling Plans.

Thank you!

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Aligning California: Enacting Policies for Systems Change

Leveraging National & California Policy Drivers for Community Information Exchange

211 San Diego's CIE California Forum August 25, 2022

Mark Savage Managing Director, Digital Health Strategy & Policy

Topics

- California's new Data Exchange Framework
- U.S. Core Data for Interoperability

California Health and Human Services Data Exchange Framework: Overview

- **AB 133 requires the California Health and Human Services Agency to establish a statewide data exchange framework by July 1, 2022:**
  - **Requires and governs exchange of health information among health care entities and government agencies across California**; a statewide minimum which does not preclude more extensive data exchange and services
  - Single data sharing agreement and common set of policies and procedures
  - **Leverages national standards for exchange and data content**
  - **Leverages and aligns with federal and state privacy standards, including HIPAA and CMIA**
  - A framework, not a single information technology system or data repository
- **Requires all hospitals, physicians, skilled nursing facilities, health plans, laboratories and psychiatric hospitals (with limited exceptions):**
  - Execute the data sharing agreement by January 31, 2023
  - Exchange or provide access to health information in real time for treatment, payment, or health care operations by January 31, 2024
  - Defines "health information" at a minimum as USCDI v1 before October 6, 2022, and all EHI thereafter
  - Intends that all state and local public health agencies will also exchange data as part of the Framework
- **Requires a 25-member Stakeholder Advisory Group to make recommendations on numerous issues, including:**
  - Which data beyond "health information" should also be shared for specified purposes
  - **Ways to incorporate SDOH data**
  - **Ways to incorporate data related to underserved or underrepresented populations**
  - Ways to incorporate data on behavioral health and substance abuse conditions
  - How payers should provide enrollees with electronic access to their health information

Legislative findings

- **SECTION 1. The Legislature finds and declares . . . :**
  - (a) While parts of California's health care system rely on coordinated, interoperable electronic systems, other parts rely on decentralized, manual, and siloed systems of clinical and administrative data exchange that is voluntary in many situations. This **voluntary patchwork imposes burdens on providers and patients**, **limits the health care ecosystem from making material advances in equity and quality**, and functionally **inhibits patient access to personalized, longitudinal health records**. Further, a lack of clear policies and requirements to share data between payers, providers, hospitals, and public health systems is a **significant hindrance to addressing public health crises**, as demonstrated by challenges inherent to the **COVID-19** pandemic.
  - (b) . . . .
  - (c) **Social and economic factors** distinct from medical care are powerful predictors of health outcomes and disease burden throughout a person's life. From a population health perspective, this means that evidence-based policies that affect the broader conditions in which people are born, grow, and live can exert a powerful influence on health and well-being. From an operational perspective, **data-driven efforts to better coordinate human and social supports with the medical and health care sectors provide opportunities** to deliver services that are more client centered, efficient, effective, and tailored.

Guiding Principles

- Principle 1: Advance Health Equity
- Principle 2: Make Data Available to Drive Decisions and Outcomes
- Principle 3: Support Whole Person Care
- Principle 4: Promote Individual Data Access
- Principle 5: Reinforce Individual Data Privacy & Security
- Principle 6: Establish Clear and Transparent Terms and Conditions for Data Collection, Exchange, and Use
- Principle 7: Adhere to Data Exchange Standards
- Principle 8: Ensure Accountability

- Core principles to guide design and implementation of the Framework and electronic health and human services information exchange in California
- Draw heavily from the "Consumer and Patient Principles for Electronic Health Information Exchange in California"

Who: A broad ecosystem

- **Effective January 31, 2024:**
  - **Health Care Providers:** General acute care hospitals, physician organizations & medical groups, skilled nursing facilities, health plans & disability insurers, Medi-Cal managed care plans, clinical laboratories, and acute psychiatric hospitals must share data by January 31, 2024
  - **Payers:** Health Plans & disability insurers, Medi-Cal managed care plans
  - **Individuals** requesting access or contribution of PGHD
- **Effective January 1, 2026:**
  - Physician practices of <25 physicians, rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with <100 acute care beds, state-run acute psychiatric hospitals, and nonprofit clinics with <10 providers must share data by January 31, 2026
  - **Governmental participants**, including state public health agencies, county health facilities
  - **Social services organizations** and community-based organizations
- **Voluntary signatories**
  - Intermediaries, e.g. HIE networks, HIOs
  - HIT developers

What: Data elements to be exchanged

To the extent a participant collects and maintains such data:

- **Health Care Providers, public health agencies, county health facilities:**
  - Before October 6, 2022, US Core Data for Interoperability **(USCDI) v1**
  - Beginning October 6, 2022, **USCDI v2** + all Electronic Health Information (**EHI**) in the designated record set
- **Health Plans:**
  - Adjudicated claims, encounter data, and clinical data in USCDI v1 / v2
  - For Individual Access, also cost information, including provider remittances and enrollee cost-sharing
- **Intermediaries, e.g. HIEs and HIOs, that are signatories:**
  - Where providing exchange services to health care providers, public health agencies, county health facilities, or health plans, the data elements above respectively for each

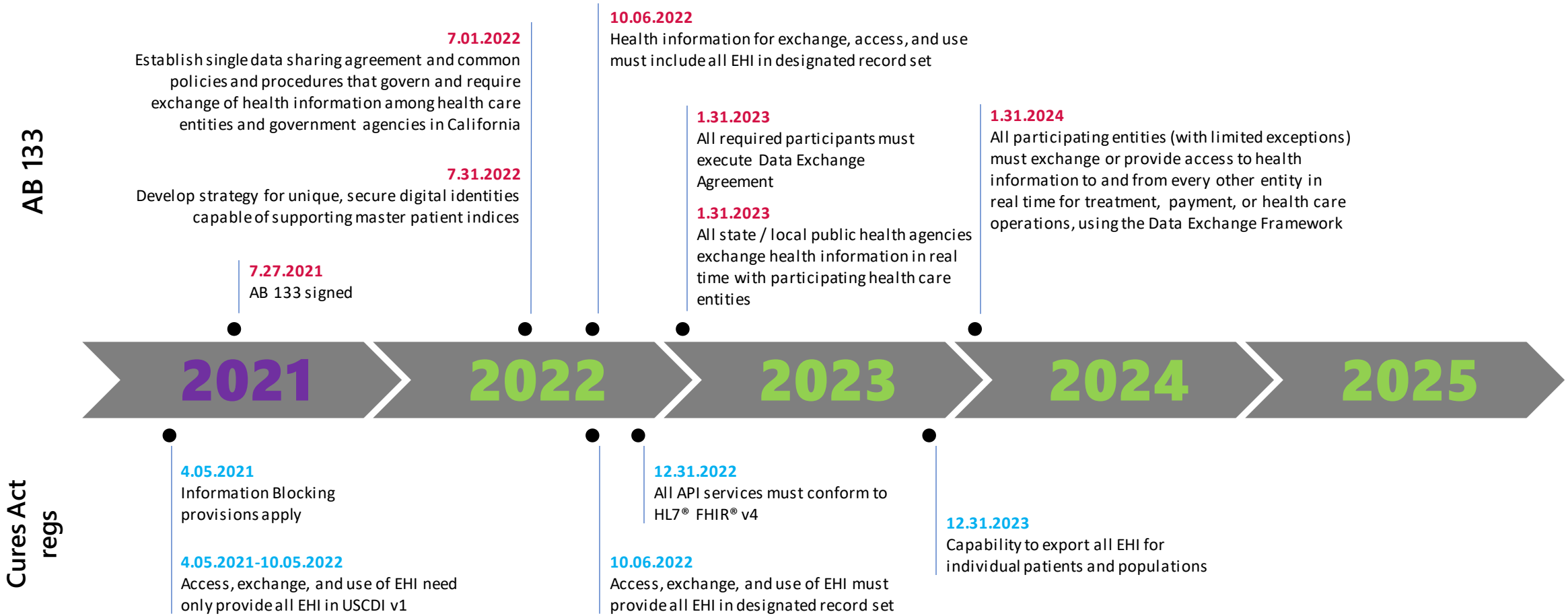
Why: Required, permitted & prohibited uses

- Required
  - Treatment
  - Payment
  - Health Care Operations: quality assessment and improvement; population-based activities such as case management, care coordination, reducing health care costs
  - **Public Health Activities**
- Permitted
  - **Social Services Activities:** Social Service Organizations' services to address social drivers of health
  - Research
  - Any other permissible purpose
- Prohibited
  - Sale of health information
  - Unlawful discrimination
  - Unlawful denial or limitation of access to medical services
  - Adverse action against an individual who accesses medical services
- Individual Access
  - Allow individuals to view, download, direct transmission to a third party
  - **Respond to individuals' requests to add patient-generated health data**
  - Provide process to correct errors submitted by individuals and reconcile discrepancies

Privacy and security

- Covered entities must comply with the HIPAA regulations
- Business associates must comply with their business associate agreements
- Participants who are not covered entities or business associates must still comply with subparts C (security standards) and E (privacy standards) of the HIPAA regulations
- Behavioral health information must also comply with 42 C.F.R. Part 2 and the California Lanterman-Petris-Short Act

Timeline: AB 133 & ONC's Cures Act regulations



Allergies and Intolerances
- Substance (Medication)
- Substance (Drug Class)
- Reaction

Assessment and Plan of Treatment
- Assessment and Plan of Treatment
- SDOH Assessment

Care Team Member(s)
- Care Team Member Name
- Care Team Member Identifier
- Care Team Member Role
- Care Team Member Location
- Care Team Member Telecom

Clinical Notes
- Consultation Note
- Discharge Summary Note
- History & Physical
- Procedure Note
- Progress Note

Clinical Tests
- Clinical Test
- Clinical Test Result/Report

Diagnostic Imaging
- Diagnostic Imaging Test
- Diagnostic Imaging Report

Encounter Information
- Encounter Type
- Encounter Diagnosis
- Encounter Time
- Encounter Location
- Encounter Disposition

Goals
- Patient Goals
- SDOH Goals

Health Insurance Information
- Coverage Status
- Coverage Type
- Relationship to Subscriber
- Member Identifier
- Subscriber Identifier
- Group Number
- Payer Identifier

Health Status/Assessments
- Health Concerns
- Functional Status
- Disability Status
- Mental/Cognitive Status
- Pregnancy Status
- Smoking Status

Immunizations
- Immunizations

Laboratory
- Tests
- Values/Results
- Specimen Type
- Result Status

Medications
- Medications
- Dose
- Dose Unit of Measure
- Indication
- Fill Status

Problems
- Problems
- SDOH Problems/Health Concerns
- Date of Diagnosis
- Date of Resolution

Procedures
- Procedures
- SDOH Interventions
- Reason for Referral

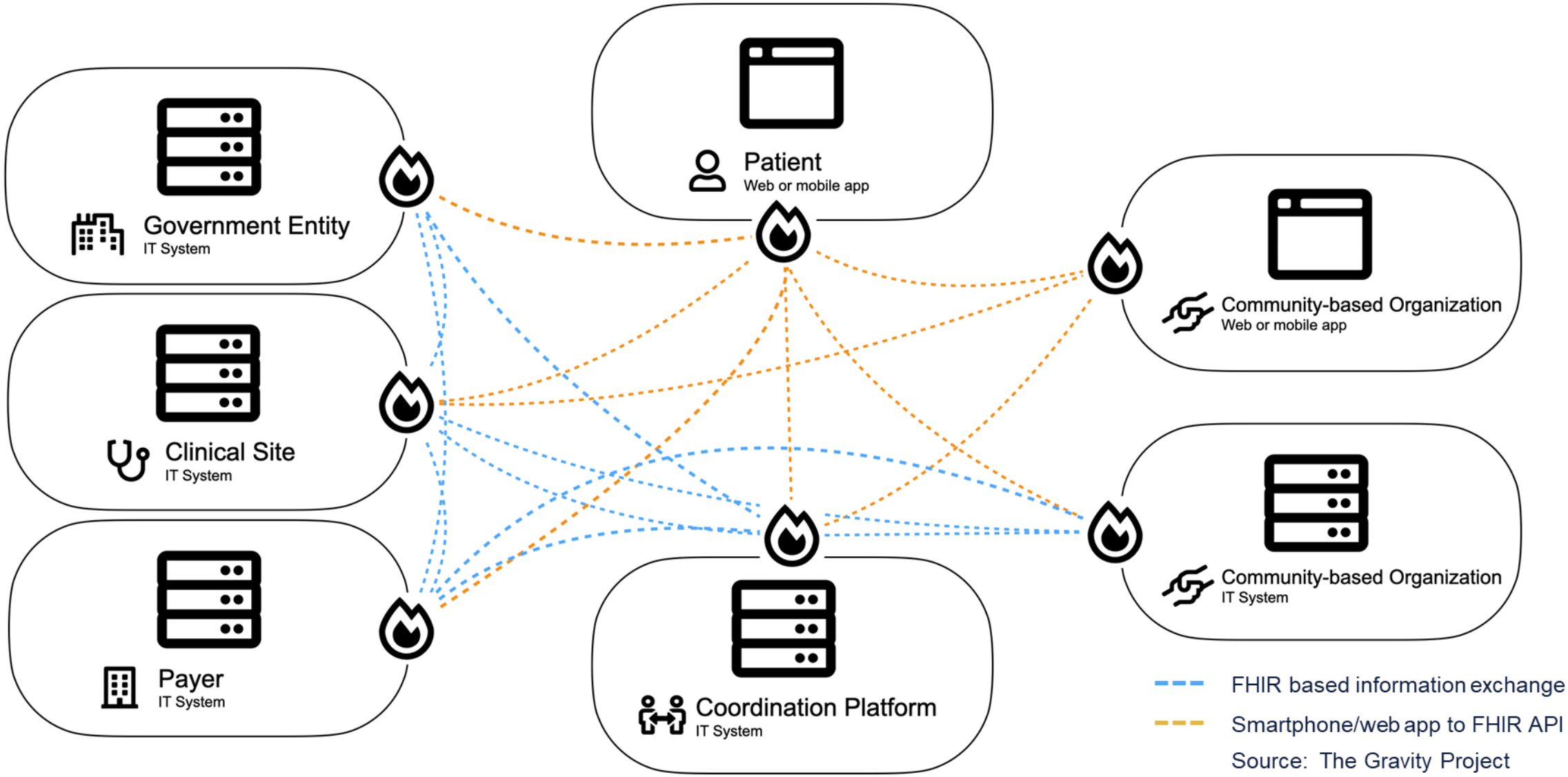
Provenance
- Author Organization
- Author Time Stamp

Patient Demographics/ Information
- First Name
- Last Name
- Middle Name (Including middle initial)
- Name Suffix
- Previous Name
- Date of Birth
- Date of Death
- Race
- Ethnicity
- Tribal Affiliation
- Sex
- Sexual Orientation
- Gender Identity
- Preferred Language
- Current Address
- Previous Address
- Phone Number
- Phone Number Type
- Email Address
- Related Person's Name
- Related Person's Relationship
- Occupation
- Occupation Industry

Unique Device Identifier(s) for a Patient's Implantable Device(s)
- Unique Device Identifier(s) for a patient's implantable device(s)

Vital Signs
- Systolic Blood Pressure
- Diastolic Blood Pressure
- Heart Rate
- Respiratory Rate
- Body Temperature
- Body Height
- Body Weight
- Pulse Oximetry
- Inhaled Oxygen Concentration
- BMI Percentile (2 - 20 years)
- Weight-for-length Percentile (Birth - 24 Months)
- Head Occipital-frontal Circumference Percentile (Birth - 36 Months)

USCDI v2 adds SDOH
USCDI v2 adds more
USCDI v3 additions


Patient
Web or mobile app
Government Entity
IT System
Clinical Site
IT System
Payer
IT System
Coordination Platform
IT System
Community-based Organization
Web or mobile app
Community-based Organization
IT System
FHIR based information exchange
Smartphone/web app to FHIR API
Source: The Gravity Project

Contact us

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HIE, CIE, and CalAIM

August 25, 2022

HIE and CIE

HIE and CIE are multi-purpose, multi-organization, and (especially CIEs) multi-sector infrastructure

Are HIE and CIE multi-program infrastructure too?

And if one of these programs is California Advancing and Innovating Medi-Cal (Cal-AIM)?

See our recent posts:

What is CIE? Developing Community Information Exchange in California and Beyond, by Keira Armstrong

Understanding HIE and CIE Alignment, by Mark Elson

intrepidascent.com/our-thinking

Intrepid ascent

HIE vs. CIE

HIE provides historical patient data to improve health care (read only)

CIE provides a platform for community collaboration and distributed care teams

Users constantly add new information (read and write)

Intrepid ascent

What is CIE?

Community Information Exchange (CIE) networks develop shared technology and governance to support cross-sector collaboration addressing social determinants of health.

There are many types of processes that CIE networks try to improve. These often include:

- **Assessments** of individuals' needs
- **Eligibility and enrollment** in appropriate programs and services
- Building an actionable **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, reducing duplicate data entry and documentation
- **Individual consent** for data sharing and **participation** in organizing one's care
- Addressing methods for community partners to **bill for services**
- **Reporting and analytics** to illuminate inequities and upstream causes of health and social issues

CIE as Multi-Program Infrastructure?

How effectively does CIE support multiple programs?

Does it become more complex for a technology service (and for a group of stakeholders) to support multiple programs across a community the deeper they go into care management and analytics, into PHM?

Yes, but communities and vendors are navigating these challenges given the tremendous value, including between CalAIM and other programs.

Leveraging CalAIM to Advance HIE and CIE

How can CalAIM funding and program structure be leveraged by communities to establish multi-purpose, multi-organization, multi-sector technology infrastructure like HIE and CIE?

- Incentive Payment Program (IPP) - for Managed Care Organizations (MCOs)
- Providing Access and Transforming Health (PATH) - for everyone else
  - Collaborative Planning and Implementation Initiative
  - Capacity and Infrastructure Transition, Expansion and Development (CITED)
  - TA Marketplace

CalAIM Population Health Management Initiative

The Population Health Management Program and Service are coming in 2023

Expands CalAIM to the entire Medi-Cal managed care population

The PHM Service will offer CIE-like functions
to communities across the state

Final Population Health Management Strategy and Roadmap

dhcs.ca.gov/calaim/pages/populationhealthmanagement.aspx

Intrepid ascent

Envision Community Success

If CalAIM were to be successfully implemented in my community, how would services for Medi-Cal beneficiaries be delivered differently? Would that approach spill over to services provided to the rest of the population?

How would HIE, CIE, and/or similar shared technology infrastructure such as the PHM Service support the foundation for this transformation, not only of the Medi-Cal delivery system but of the delivery system overall?

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