Community Information Exchange

(CIE) Advisory Board Meeting

November 15, 2022

CIE Advisory Board Meeting
AGENDA
November 15• 8:30-9:30 AM

Time	Agenda Item	Presenter
8:30-8:35 am	Welcome & Agenda Overview	Jack Dailey Chair 2-1-1 Advisory Board Arnulfo Manriquez Vice Chair 2-1-1 Advisory Board
8:35-8:45 am	CIE Updates • ASMCI State Opportunity • DxF: Planned Outreach with HIE	Karis Grounds Camey Christenson
8:45- 8:55 am	CIE Membership Workgroup • Review of updated charter language	Jack Dailey Chair 2-1-1 Advisory Board Arnulfo Manriquez Vice Chair 2-1-1 Advisory Board
8:55-9:25 am	• Overview/History of CIE as Backbone Agency • Exercise: Input on Strategic/Operational Information	Karis Grounds Camey Christenson
9:25-9:30	Action Items & Meeting Adjournment	Jack Dailey Chair 2-1-1 Advisory Board Arnulfo Manriquez Vice Chair 2-1-1 Advisory Board
Pre/Post Read	Appendix: • CIE Trends • CalAIM Workgroup	

CIE Updates

ASCMI Opportunity

DxF Outreach

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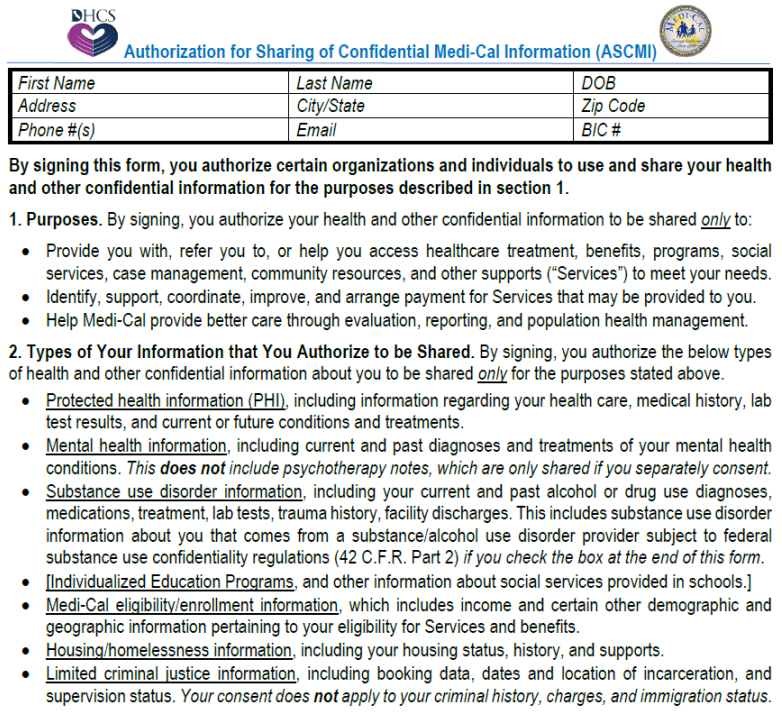
ASCMI Project Overview

Purpose: DHCS issues this Request for Information (RFI) to pilot the Authorization to Share Confidential Medi-Cal Information (ASCMI) Form and consent management service (collectively referred to as the "Pilot" hereafter). The ASCMI Form is a universal release of information form designed to facilitate sharing of an individual's physical, mental, and social health information through a standardized consent process. A consent management service is to be used to store and manage Medi-Cal member consent and can be accessed and amended by members and service providers via website and/or their existing electronic health record (EHR) system.

Primary Collaborators: CIE, HIE, County of San Diego, pilot MCP



DHCS

Authorization for Sharing of Confidential Medi-Cal Information (ASCMI)

First Name	*Last Name*	*DOB*
Address	*City/State*	*Zip Code*
Phone #(s)	*Email*	*BIC #*

By signing this form, you authorize certain organizations and individuals to use and share your health and other confidential information for the purposes described in section 1.

1. Purposes. By signing, you authorize your health and other confidential information to be shared *only* to:

- Provide you with, refer you to, or help you access healthcare treatment, benefits, programs, social services, case management, community resources, and other supports ("Services") to meet your needs.
- Identify, support, coordinate, improve, and arrange payment for Services that may be provided to you.
- Help Medi-Cal provide better care through evaluation, reporting, and population health management.

2. Types of Your Information that You Authorize to be Shared. By signing, you authorize the below types of health and other confidential information about you to be shared *only* for the purposes stated above.

- Protected health information (PHI), including information regarding your health care, medical history, lab test results, and current or future conditions and treatments.
- Mental health information, including current and past diagnoses and treatments of your mental health conditions. *This **does not** include psychotherapy notes, which are only shared if you separately consent.*
- Substance use disorder information, including your current and past alcohol or drug use diagnoses, medications, treatment, lab tests, trauma history, facility discharges. This includes substance use disorder information about you that comes from a substance/alcohol use disorder provider subject to federal substance use confidentiality regulations (42 C.F.R. Part 2) *if you check the box at the end of this form.*
- [Individualized Education Programs, and other information about social services provided in schools.]
- Medi-Cal eligibility/enrollment information, which includes income and certain other demographic and geographic information pertaining to your eligibility for Services and benefits.
- Housing/homelessness information, including your housing status, history, and supports.
- Limited criminal justice information, including booking data, dates and location of incarceration, and supervision status. *Your consent does **not** apply to your criminal history, charges, and immigration status.*

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CIE Membership Workgroup

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Review of Updated Charter Language

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Topic: 211 as Backbone Organization

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History of CIE

2011: Alliance Healthcare Foundation funds Community Information Exchange, a collaboration of public and private organizations. 2-1-1 San Diego UCSD Beacon Community Program/HIE Father Joe's Villages Regional Task Force on the Homeless Rural/Metro of San Diego (City Paramedic) San Diego Fire-Rescue Department. Operated as own 501c3.

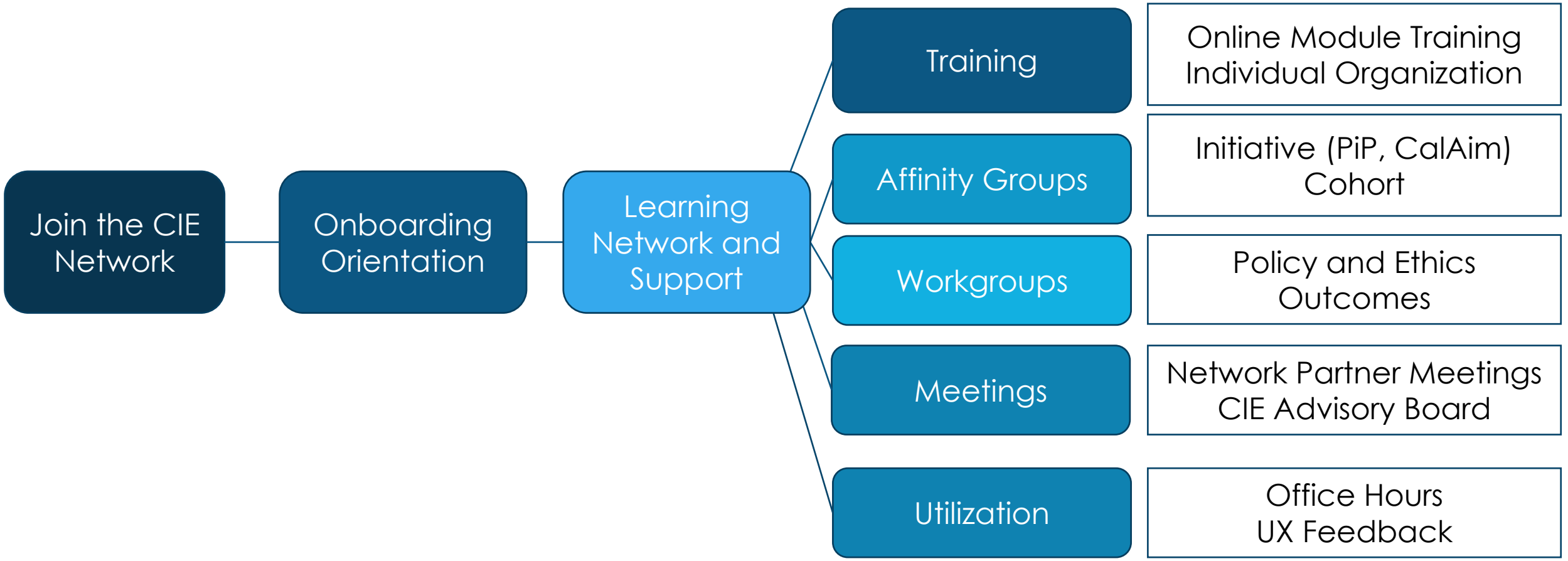
2014: CIE launches pilot cohort of homeless services providers sharing basic client demographic data.

2015: Older Adult Cohort

2017: Military and Veterans Cohort

2017-2018: 211 merged with CIE and launched enhanced CIE platform with data sharing and closed-loop referrals; expanded to all populations

CIE Infrastructure/Journey



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Team Support: Local Learning and Collaboration

Engagement:
- Onboarding of Partners
- Orientation
- Building Trust with Community Stakeholders

Integration:
- Hosting and connecting partners into learning and using CIE (affinity groups)
- All user experience (setting up accounts, helpdesk support to training, implementation plans, etc.)
- Development of new features in Salesforce based on feedback from CIE partners and use cases
- Data Integrating and Data Sharing Efforts

Communication:
- Partner Utilization Reports
- Newsletter
- Calendar of Events

Other Key Elements:
- Strategic/Stakeholder Relationships
- Partnership Opportunities
- Sustainability/Funding
- Governance Management

CIE SAN DIEGO TEAM

Angie Esparza-Banuelos

CIE NETWORK SPECIALIST

Camey Christenson

CHIEF BUSINESS DEVELOPMENT OFFICER

Karis Grounds

VICE PRESIDENT OF HEALTH AND COMMUNITY IMPACT

Tanissha Harrell

DIRECTOR OF ENGAGEMENT

Nakisha Jones

PROGRAM ASSISTANT

Alana Kalinowski

DIRECTOR OF PARTNER INTEGRATION

Aidee Roman

COMMUNITY PARTNERSHIP MANAGER

Roxanne Suarez

DIRECTOR OF PARTNER INTEGRATION

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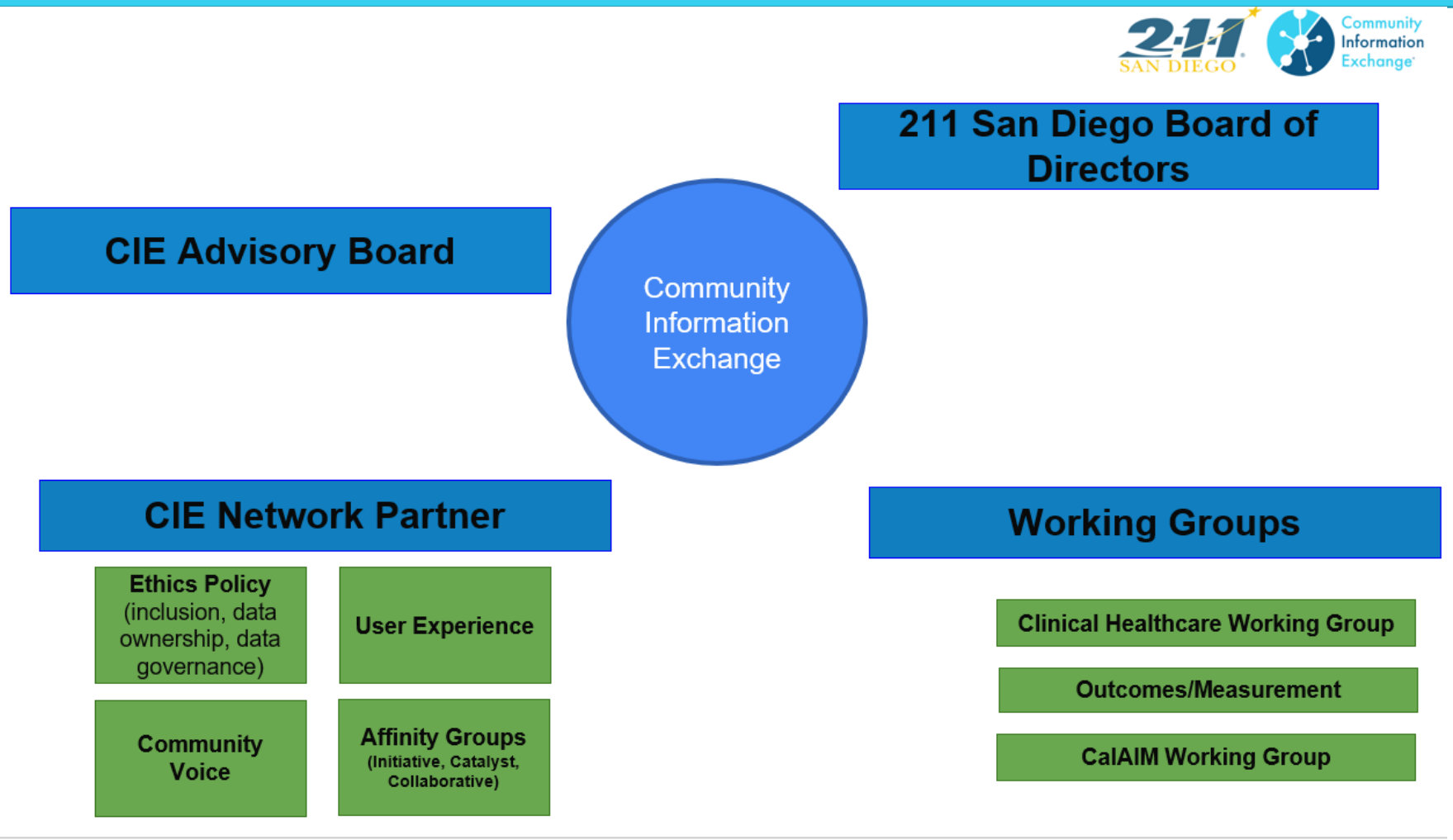
CIE Stewardship Framework

Community Voice-Community Members



211/CIE Backbone Insights

Successes	Challenges
Building Better Relationships with prospective partners via trust	Ensuring CIE is a larger community initiative
Leveraging 211 infrastructure, reputation and use of CIE to support use cases and value	Separating 211 from CIE
Expanding the team to support changing needs and requests of community	Managing needs of the community vs. funding requirements and needs
Being agile, responsive and flexible to community needs	Being seen as a neutral convener
	Ensuring our communication highlights value the value of CIE partners not just CIE

Other insights or feedback we are missing?

BACKBONE INPUT

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Opportunities

- **What can 211/CIE do to create share ownership among community partners?**
- **How can we do better at supporting the community as a backbone?**
- **How can we show-up better or differently in spaces to support the mission of CIE?**
- **Other recommendations/insights to share**

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OTHER UPDATES & NEXT MEETING

December 20, 8:30-9:30 AM

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Appendix

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CIE Trends and Utilization

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CIE Dashboard

	FY Goal	Current	% of Goal	Monthly Trends	All-Time Total
Partners	15	2	13%	Jul 1, Aug, Sep 1	123
Adoption Metrics					
Logins	50,000	12,056	24%	Jul 2,835, Aug 3,351, Sep 3,137, Oct 2,733	119,462
Consents	106,000	20,735	20%	Jul 5,341, Aug 5,853, Sep 4,886, Oct 4,655	290,825
Successful Searches	50%	29%	58%	Jul 31%, Aug 29%, Sep 27%, Oct 30%	25%
Engagement Metrics					
Records with Shared Data	175,000	68,490	39%	Jul 29,706, Aug 33,786, Sep 31,957, Oct 31,897	68,490
Profile Views	45,000	9,631	21%	Jul 2,757, Aug 2,577, Sep 2,263, Oct 2,034	82,358
Program Enrollments	150,000	31,334	21%	Jul 6,527, Aug 6,721, Sep 7,757, Oct 10,329	169,763
Care Teams	3,500	636	18%	Jul 143, Aug 117, Sep 266, Oct 110	9,238

Data Source: 211/CIE Information Systems | Reporting Period: 7/1/2022 - 10/31/2022

Intervention Metrics					
Direct Referrals	40,000	8,620	22%	Jul 2,168, Aug 2,287, Sep 2,104, Oct 2,061	105,723
SDoH Screenings	N/A	321	N/A	Jul 164, Aug 101, Sep 37, Oct 19	3,319
SDoH Assessments	N/A	15	N/A	Jul 3, Aug 6, Sep 2, Oct 4	81

CIE CalAIM Workgroup

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Provider Workgroup Update

Top Priorities:

- ECM payment structures and type of encounter to generate payment (successful vs unsuccessful encounter; not paid for unsuccessful encounters; not paid for outreach and engagement efforts)
- Lack of TELs, inconsistency in timing and size of TELs, lack of communication regarding TELs; difficult to plan and staff appropriately
- Restrictions/caps on services – challenges with authorization/reauthorization requirements and processes; payment and cap on services not sufficient to meet client needs
- Documentation requirements – medical necessity documentation; duplicate documentation requests
- Transportation challenges – requesting updated materials from each plan, summarize updated transportation information based on new APL

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Provider Workgroup Update

Goal: Improve awareness, access, and utilization of recuperative care and short-term post hospitalization housing

Partners:
- PATH
- ICS
- Father Joes
- HASDIC
- CIE San Diego
- San Diego Wellness Collaborative

Approach:
Short Term:
- Provide draft of eligibility and contracted health plans, considerations, referral pathway and contacts for ICS, PATH, and Father Joes (attached)
- Develop sample shared bed availability tool to support coordination and bed availability between ICS, PATH and Father Joes (thank you Glen!)

Long Term:
- Streamline intake and referral process among recuperative care and STPHH services
- Create shared real-time bed availability tool in shared technology system available to other key stakeholders
- Identify training opportunities to increase utilization with hospitals, health plans, ECM and CS providers

We plan to spend the next six months planning our long-term approach and want input from other key stakeholders referring to or supporting these services.

If you are interested in participating in these meetings, please identify 1-2 representative(s) from each organization and use this form to sign up: https://forms.office.com/r/kLmmDwbWC5

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Provider Workgroup Update

Provider	Services	Contracted Health Plan	Agency Considerations	Referral Process	Contact
PATH	STPHH	United Healthcare Blue Shield Aetna	• *low barrier (able to accommodate SUD)* • *no PC290, arson* • *must be homeless* • *able to perform ADLs* • *Refrain from use of illicit drugs or alcohol onsite* • *Onsite Federally Qualified Health Center (FQHC) - FHC*	Completion of Intake Packet including Homelessness Cert, TB test; Proof of Income required within 24 hours of arrival Packet can be obtained by emailing us.	Email: SDCalAIM@epath.org or KamiahT@epath.org
	Recup	Molina Blue Shield Aetna			
Father Joe's Villages	Recup	Aetna Blue Shield Community Health Group Health Net Kaiser Permanente Molina United Healthcare	• *low barrier (able to accommodate SUD)* • *no PC290, arson* • *must be homeless* • *able to perform ADLs* • *Refrain from use of illicit drugs or alcohol onsite* • *Onsite Federally Qualified Health Center (FQHC)* • *Pets Allowed (Including animals that are not ESA/SA)* • *Individuals who are currently debarred (excluded) from services at Father Joe's Village due to prior safety issues are not eligible.*	Link to Referral Form and Process on our website Email address monitored 7 days per week.	Website: https://my.neighbor.org/recuperativecare/ Email: Recuperative.Care@neighbor.org
Interfaith	STPHH	Aetna Blue Shield United Healthcare Health Net Community Health Group Kaiser (Pending)	• *low barrier (able to accommodate SUD)* • *no PC290, arson* • *must be homeless* • *able to perform ADLs* • *Onsite Federally Qualified Health Center (FQHC)* • *(SA/ESA) Pets Allowed* • *Refrain from use of illicit drugs or alcohol onsite* • *Individuals who are currently debarred from services at Interfaith Community Services due to prior behavioral issues are not eligible.*	Completion of Referral Packet including: Patient information form, Release of Information, Homelessness Cert, TB/communicable Disease Packet can be obtained by emailing us.	Email: rcpreferral@interfaithservices.org or jrector@interfaithservices.org
	Recup	Aetna Blue Shield United Healthcare Health Net Community Health Group Molina Kaiser Permanente			

Note: Other For-Profit Agencies include: Lightbridge, HOLA Recup Care and Serene Health

Resource Guide for CalAIM Recuperative Care and Short-Term Post Hospitalization Community Supports

Recuperative Care

- Length of time can vary, but is dependent on need to recuperate from acute exacerbation of a condition
- Intended to support individuals who do not meet SNF level for recuperation, but still need a stable environment to heal
- Can be used numerous times, and length of stay extended, at health plan discretion
- Can be used to avoid hospitalization (does not need to be discharging from hospital)

Eligibility:

- Must have a managed Medi-Cal plan in San Diego.
- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification.
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals;
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be
                - terminated within 21 days after the date of application for assistance;
                - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
                - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

OCTOBER 2022: This document is subject to change

- Presented HSD CalAIM Workgroup
- HASDIC presented to social work departments for input
- Group continues to meet

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CHCS Workplan

Overall Project Goals: *List the project goals determined by your team.*	1. Increase Community Information Exchange (CIE) utilization by Health Care partners (hospitals, health plans, contracted providers). 2. Increase the rate of ECM and CS enrollments through workflow improvements such as eligibility identification, community referrals resulting in authorizations, and program enrollment documentation. 3. Streamline closed looped referral process for Enhanced Care Management and housing-related Community Supports (with initial focus on the Recuperative Care Community Support).

Strategy Goal 1:
1: Develop and implement Recuperative Care Pilot to address the 50% reduction in referrals since CalAIM launch.
2: Develop shared intake and screening tool, resource guide and minimal viable product for real time recuperative bed availability and care coordination.
3: Train project partners and key stakeholders

Strategy Goal 2:
1: Identify expanded data needed to aid local CalAIM implementation
2: Identify costs, willingness, and funding sources for data expansion and technical integration improvements.
3: Build integrations and educate/train CIE network of new available data and benefits for CalAIM implementation.

Strategy Goal 3:
1: Gather and share CalAIM provider feedback with key local and State stakeholders.
2: Client engagement and community voice
3: Collect CalAIM contracted provider information, program and service eligibility, and other systemwide information.

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