

Welcome to the ASCMI Pilot Training

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Training Outline

Today we'll review:

- Overall Pilot Objectives and workflow
- How to access resources and materials
 - ASCMI Authorization Form
 - Frequently Asked Questions (FAQs resources)
 - QR Link
- Recommended verbiage
- How to submit evaluation documentation



Training Outcomes

By the end of this training, you'll be ready to:

- Share a high-level description of the ASCMI form and why we're doing this pilot.
- Demonstrate the ASCMI Authorization form
- Answer participants' questions as needed
- Gather and submit evaluation documents
- Ask the client to submit their responses using the QR link



Real-world Considerations

Resources needed:

- Tablet or device with Wi-Fi to submit the ASCMI forms & Evaluation component
- Bookmark: <https://ciesandiego.org/ascmi-pilot-resources/>
 - ASCMI Authorization Form
 - Frequently Asked Questions (FAQs resources)
 - QR Link

Overall Pilot- Why we're here

The California Department of Health Care Services drafted a 42CFR Authorization form. DHCS wants feedback from providers like you, and from clients like the ones you work with.

Facts:

- San Diego is one of 3 CA counties doing this pilot.
- In San Diego, MAAC, PATH, and McAlister Institute are the 3 organizations getting feedback directly with clients.
- The feedback we gather is an opportunity to shape how a state-wide 42CFR form is finalized and implemented.



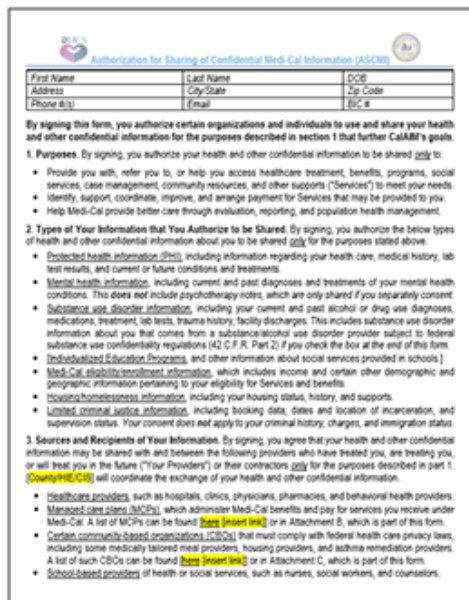
ASCM Form Overview

The ASCMI Form is a universal release of information (ROI) Form designed to facilitate sharing of an Medi-Cal member's physical, mental, and social health information through a standardized consent process.

Purposes of ASCMI Form

By signing this form, you authorize certain organizations and individuals to use and share your health and other confidential information for the following purposes:

- » 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 to enrollees through evaluation, reporting, and population health management.



The image shows a sample of the ASCMI Form. At the top, it has the title "ASCM Form: Authorization for Sharing of Confidential Medi-Cal Information (ASCM Form)". Below the title is a table with fields for personal information:

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

Below the table, there is a paragraph explaining the purpose of the form and a list of purposes. The purposes are:

1. **Purposes.** By signing, you authorize certain organizations and individuals to use and share your health and other confidential information for the purposes described in section 1 that further CAAMI's goals:
 - 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:
 - **Physical 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 (IEPs),** 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.
3. **Sources and Recipients of Your Information.** By signing, you agree that your health and other confidential information may be shared with and between the following providers who have treated you, are treating you, or will treat you in the future ("Your Providers") or their contractors only for the purposes described in part 1. **(Source: Medi-Cal)** only will coordinate the exchange of your health and other confidential information:
 - **Healthcare providers,** such as hospitals, clinics, physicians, pharmacies, and behavioral health providers.
 - **Managed care plans (MCPs),** which administer Medi-Cal benefits and pay for services you receive under Medi-Cal. A list of MCPs can be found [here \(insert link\)](#) or in Attachment B, which is part of this form.
 - **Certain community-based organizations (CBOs)** that must comply with federal health care privacy laws, including some medically tailored meal providers, housing providers, and asthma remediation providers. A list of such CBOs can be found [here \(insert link\)](#) or in Attachment C, which is part of this form.
 - **School-based providers** of health or social services, such as nurses, social workers, and counselors.

ASCM Form

ASCMI Form Types of Information Covered

2. Types of Your Information that You Authorize to be Shared¹

- Protected health information (PHI).
- Mental health information, This **does not** include psychotherapy notes, which are only shared if you separately consent.
- Substance use disorder (SUD) information; 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 initial 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.
- Housing/homelessness information.
- 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.

7. Authorization

☐ By checking this box, I also authorize the disclosure of substance use disorder information about me that comes from providers subject to federal substance use confidentiality regulations (42 C.F.R. Part 2).

» *While signature of the Form would imply the individual opted into having enumerated types of information be shared, an additional check-box was added for SUD information given its sensitive nature and ensure compliance with 42 C.F.R. Part 2.*

1. The text shown here has been abbreviated. The complete ASCMI Form will be shared with meeting participants

ASCMI Form: Sources & recipients

3. Sources and Recipients of Your Information

By signing, you agree to allow a health information exchange or community information exchange ("HIE/CIE") facilitate the exchange of your health and other confidential information with and between your care partners from which you have received, are receiving, or will receive benefits, treatment, or services ("Your Care Partners"). Information may be shared only for the purposes in part 1. Your Care Partners may include the following:

- (a) Healthcare providers, such as hospitals, clinics, physicians, pharmacies, and behavioral health providers.
- (b) Managed care plans (MCPs), which administer Medi-Cal benefits and pay for services you receive under Medi-Cal.
- (c) Certain community-based organizations (CBOs) that must comply with federal health care privacy laws, including some medically tailored meal providers, housing providers, and asthma remediation providers.
- (d) School-based providers of health or social services, such as nurses, social workers, and counselors.
- (e) State health agencies, specifically, the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services.
- (f) County agencies, including mental health plans, human/social services or welfare departments, drug Medi-Cal organized delivery systems, and health and public health departments.
- (g) Providers & case managers at correctional facilities, such as those at jails, prisons, and youth correctional facilities, only for the purposes in part 1 of this form. You do not consent to the use of your information for criminal investigations or prosecutions, sentencing, parole or probation monitoring, immigration enforcement, or family court proceedings.

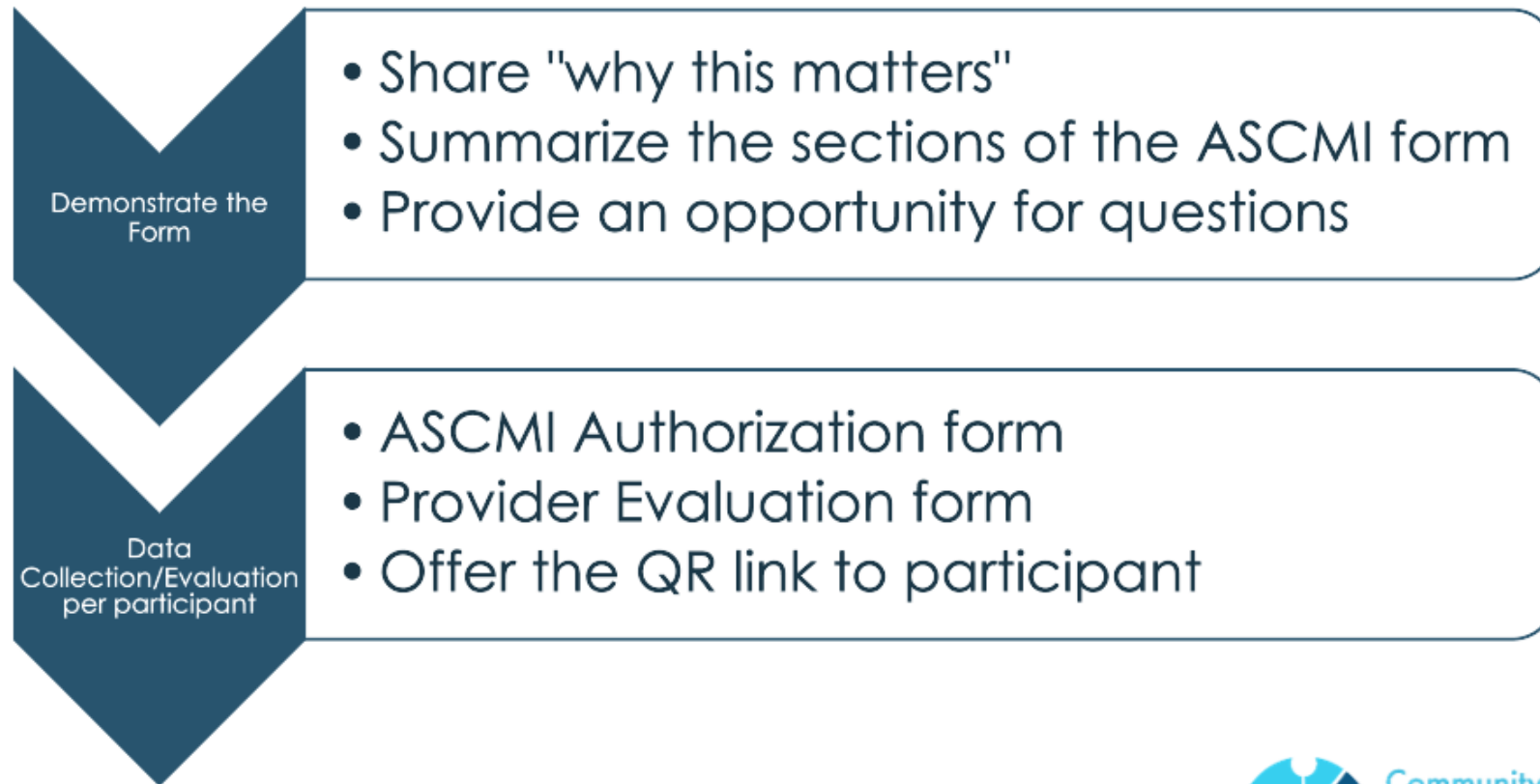


CIE Partner List: 131

Account Name	Type of Services Offered
2-1-1 San Diego	Other
A Positive Choice Resource & Referral Services, LLC	Activities of Daily Living
Access to Independence of San Diego	Activities of Daily Living
Access, Inc.	Education and Human Development; Employment
Adjoin	Social Service
Aetna	Healthcare Management
Alpha Project for the Homeless	Housing
American Red Cross of San Diego and Imperial Counties	Safety and Disaster
ARCC Center Foundation, Inc.	Primary Care
Bayside Community Center	Social Service
Blue Shield of California Promise Health Plan	Healthcare Management
Catholic Charities Diocese of San Diego	Social Service, Criminal Justice/Legal Services
Champions for Health	Healthcare Management
Charitable Adult Rides and Services	Social and Community Connection, Transportation
Chicano Federation of San Diego County	Education and Human Development
Child Development Associates, Inc.	Social Service
Childcare Resource Service, YMCA of San Diego County	Social Service
Chula Vista Community Collaborative	Healthcare Management; Safety and Disaster; Social and Community Connection
City Heights Community Development Corporation	Housing











Workflow- What you'll be doing











ASCMi Pilot Resources




▼ Electronic Client Consent (8 Languages)

-  English Form  Spanish Form
-  Arabic Form  Chinese Form
-  Tagalog Form  Vietnamese Form
-  Russian Form  Farsi Form


▼ Download Paper Client Consent Form (8 Languages)

-  English Form  Spanish Form
-  Arabic Form  Chinese Form
-  Tagalog Form  Vietnamese Form
-  Russian Form  Farsi Form

▼ FAQ's & Training Resources

-  Training
-  FAQ's
-  List of CIF Providers

▼ Provider Evaluation

-  Electronic Provider Submission Form

▼ QR Code & Link

Share this QR Code with participants. They can choose to provide feedback on the ASCMI form.



Required Data Collection: From you

ASCEM Pilot: Individual Provider Data Report

This form is to be completed by the provider (e.g. Case Manager) for every ASCEM demonstration interaction. This form should be completed during or directly at the end of the interaction with the participant.

* Required

1. Clinic Name *

- ☐ MAAC- Casa De Milagros
- ☐ MAAC- Nosotros
- ☐ PATH- Community Supports
- ☐ PATH- Interim Housing
- ☐ PATH- Homeless Outreach
- ☐ PATH- C3 Program
- ☐ McAlister Institute- North County Women's Recovery Center

Example of ASCEM Authorization


Source: Provider
Recipient: HIE/CIE

7. Authorization

By signing this form, I authorize certain organizations and individuals to use and share my health and other confidential information for purposes described in part 1 of this form. Also, if I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my information may be shared (standard message and data rates may apply).

☒ By checking this box, I also authorize the disclosure of substance use disorder information about me that comes from providers subject to federal substance use confidentiality regulations (42 C.F.R. Part 2).

If you are signing on your own behalf, fill out the 1st line. If you are signing on behalf of someone else, fill out the 2nd line. If you are signing on behalf of a minor aged 12-18, the minor should fill out the 1st line and you should fill out the 2nd line.

Beneficiary's Name	Beneficiary's Signature	Date (mm/dd/yyyy)
	 <small>x (May 17, 2023)</small>	May 17, 2023
Representative's Name	Representative's Signature	Date (mm/dd/yyyy)
		May 17, 2023

By signing, I agree to this agreement, the [Consumer Disclosure](#) and to do business electronically with CIE San Diego.

Click to Sign

Additional Data Collection: From the resident

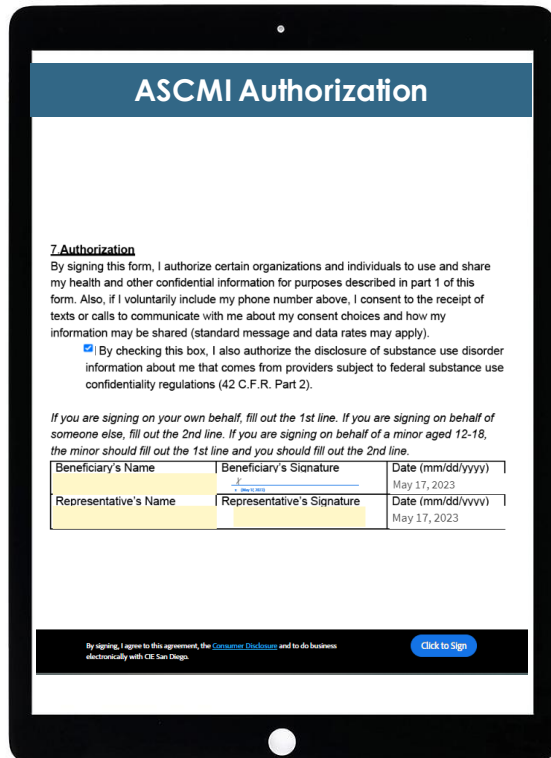
- **QR Code & Link**

Share this QR Code with participants. They can choose to provide feedback on the ASCMI form.




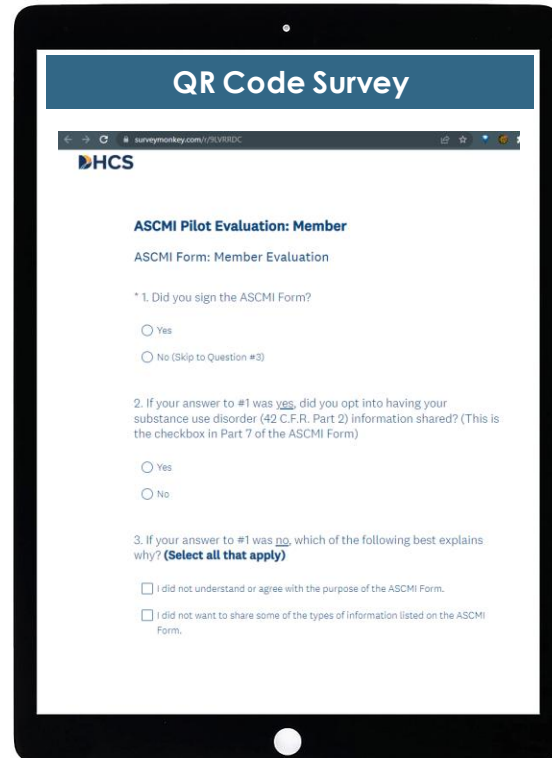
In Practice- Digital Copies

Resident sees/fills out:



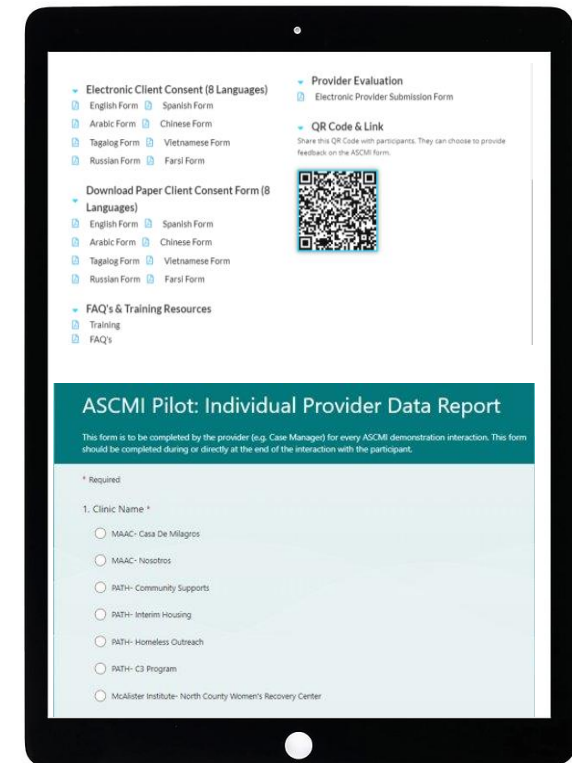
The tablet displays the 'ASCMI Authorization' form. The title 'ASCMI Authorization' is at the top in a blue header. Below it, the section '7. Authorization' is followed by a paragraph explaining the purpose of the form. A checkbox is checked, indicating authorization. Below this, there is a section for signing the form, with instructions for signing on behalf of someone else. A table with four rows and two columns is present, with the first two rows filled out. The first row contains 'Beneficiary's Name', 'Beneficiary's Signature', and 'Date (mm/dd/yyyy)'. The second row contains 'Representative's Name', 'Representative's Signature', and 'Date (mm/dd/yyyy)'. At the bottom, there is a 'Click to Sign' button.

Beneficiary's Name	Beneficiary's Signature	Date (mm/dd/yyyy)
		May 17, 2023
Representative's Name	Representative's Signature	Date (mm/dd/yyyy)
		May 17, 2023



The tablet displays the 'QR Code Survey' form. The title 'QR Code Survey' is at the top in a blue header. Below it, the section 'ASCMI Pilot Evaluation: Member' is followed by 'ASCMI Form: Member Evaluation'. A survey question is displayed with two radio button options: 'Yes' and 'No (Skip to Question #3)'. Below this, another question is displayed with two radio button options: 'Yes' and 'No'. A third question is displayed with three checkbox options: 'I did not understand or agree with the purpose of the ASCMI Form.', 'I did not want to share some of the types of information listed on the ASCMI Form.', and an unlabeled checkbox.

Staff sees/fills out:



The tablet displays the 'ASCMI Pilot: Individual Provider Data Report' form. The title 'ASCMI Pilot: Individual Provider Data Report' is at the top in a blue header. Below it, there is a section for 'Electronic Client Consent (8 Languages)' with links to various language forms. A 'QR Code & Link' section is also present. Below this, there is a section for 'FAQ's & Training Resources'. The main body of the form is a table with a header row and several data rows. The header row contains '1. Clinic Name *'. The data rows contain various clinic names, including 'MAAC- Casa De Milagros', 'MAAC- Nosotros', 'PATH- Community Supports', 'PATH- Interim Housing', 'PATH- Homeless Outreach', 'PATH- C3 Program', and 'McAlister Institute- North County Women's Recovery Center'.

Recommended Verbiage

Sample "Why" Verbiage

"Would you say it's hard to access services? As a [case manager], it's also challenging. If you need support that our program can't offer, we're going to try to find you a program that can. The tricky part is finding the right program for you, and submitting the documentation needed to show that you qualify. This is extra challenging when it comes to programs that will need information about substance abuse history.

What if I said that the State Department of Health has drafted a consent form that in theory, could make it easier to connect you to outside programs? Would you see value in that?

Since having this form could help people in similar circumstances gain quicker access to services in the future, I'd like to get your feedback on it."



Real talk

Another way..

You know how ____? That was a pain right? Part of what makes the process so long is that programs like ours are limited in what information I can disclose when we're trying to connect you to those kinds of programs. Especially if we're a substance use program. The reason I wanted to meet with you is because the State's Dept of Health Services wants to get feedback from people like you, who have seen first-hand what it's like trying to get into a SUD program.

No need to sound like someone else, so make it your own.

Let's roleplay. Explain the "Why" to a peer. How would you share the big picture and tee up a resident to give their feedback on the ASCMI form?



Recommended Transition Verbiage

"Here's the plan.

- I'll show you a draft of the form.
- I'll answer any questions the best I can.
- At the end, I'll ask you to:
 - Mark an X in the signature box if you would, hypothetically, sign the form.
 - Check the box if you would, hypothetically, agree to share Substance Use information.
 - Lastly, I'll share a QR code with you so that you can share your own feedback on how this went."



Recommended Demonstration

"This is the ASCMI Authorization form. The top portion is where you would fill in your own information. Followed by the 3 reasons that providers would be allowed to share your information. Then the types of information that could possibly be shared. Then a list of which providers that could possibly receive this information. The last page covers your rights, and a section for signature if you agree for your information to be shared. You can take time to look it over and let me know if you have any questions.

Remember to mark the checkbox and type an “X” in the signature box if you would agree to sign the form."

- If a client has questions about the ASCMI form, refer to the FAQs.
- Separately, complete the Provider Evaluation Form.
- Have the QR code printed out and ready to share.

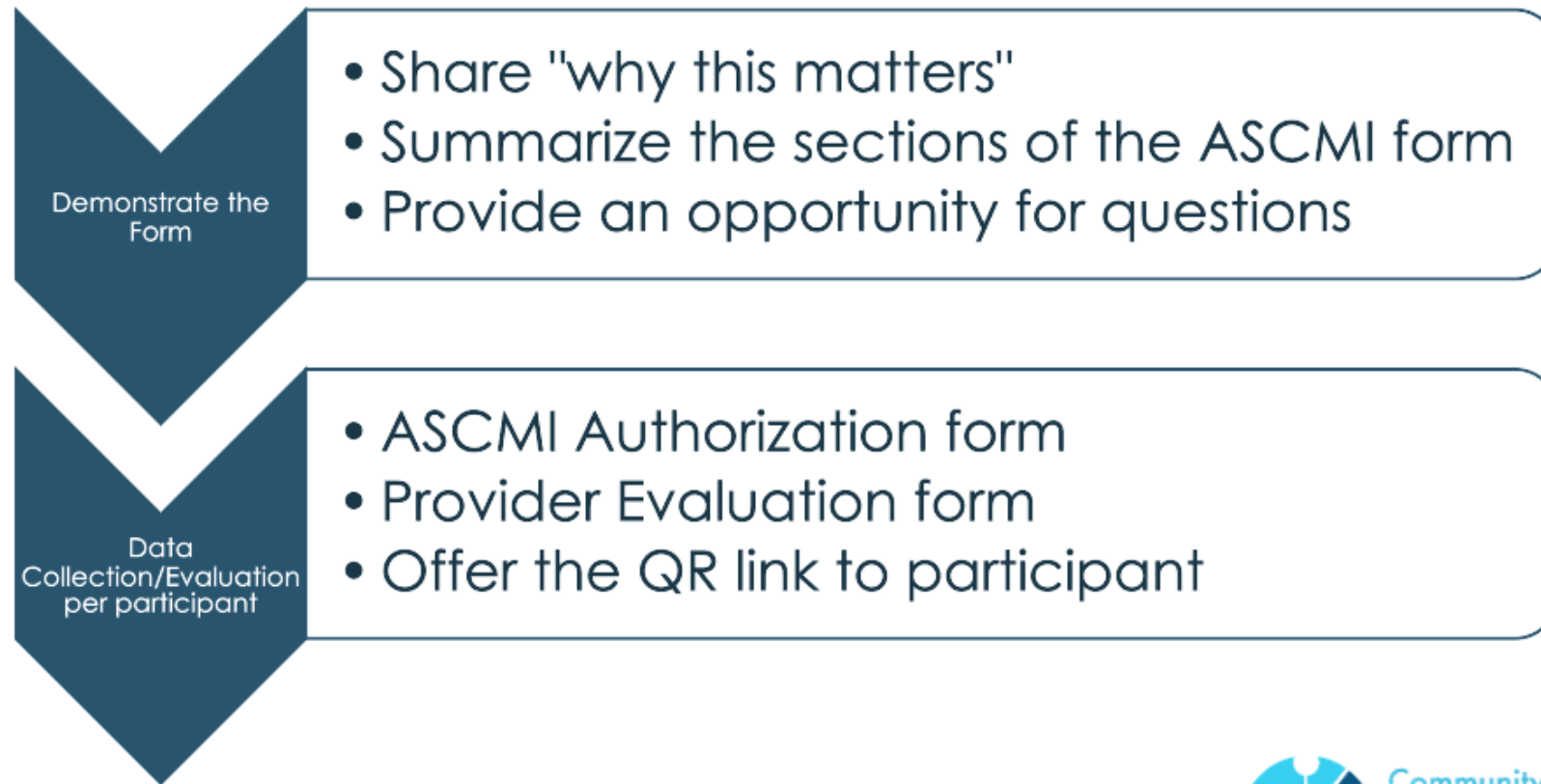


Submitting evaluation documentation

After the participant, decides...

1. Scroll to the top of the form (page 1) and delete identifying information about the participant
2. Scroll to the bottom of the form (page 4).
3. Take note of whether the participant marked the 42CFR check box and/or marked an X on the Adobesign.
4. If the participant left the Beneficiary Signature box blank, enter in "N/A,"
5. Select "Apply," "Finish," "Tap to Sign."
6. Enter **ciehelpdesk@211sandiego.org** in the pop-up.
7. Disregard the message that says to check your email for confirmation.
8. Based on what the participant marked, respond in your [Provider Evaluation](#) form.
9. Share the [QR code](#) with the participant to fill out.
10. If the participant does not have their own device, pass the tablet to them for completion.

Recap of the Workflow



Next Steps

- Today: Complete the [Post-training Survey](#)
- Go-live: 5/30
- Complete demonstrations: 5/30 – 6/23

Thank you!

<https://forms.office.com/r/jDFuW2j6Di>



**Please complete
this survey!**