



CalAIM Authorization to Share Confidential Medi-Cal Information (ASCFI) Pilot



211 San Diego's Community Information Exchange Final Evaluation Report

San Diego Pilot Overview

The San Diego Pilot Partnership is a diverse and collaborative group of health and social service provider organizations, data intermediaries, local public governmental departments, professional consortiums and advisors, and a Medi-Cal Managed Care Plan. The group often worked together before the ASCFI RFP and came together in response to DHCS's ASCFI Pilot opportunity. Pilot Partners include:

1. **211 San Diego / Community Information Exchange (CIE)**
2. **County of San Diego's Health and Human Services Agency**
 - a. Behavioral Health Services
 - b. Medical Care Services
 - c. San Diego Advancing and Innovating Medi-Cal Unit (SDAIM)
3. **Health Net (MCP)**
4. **McAlister Institute** (Community Supports Provider, DMC/DMC-ODS Provider)
5. **Metropolitan Area Advisory Committee on Anti-Poverty (MAAC)** (SMHS Provider)
6. **People Assisting the Homeless (PATH)** (Community Supports Provider and SMHS Provider, previous Whole Person Care and Enhanced Care Management provider)
7. **Integrated Health Partners** (Local consortium of community-based health centers)
8. **San Diego Health Connect** (Health Information Exchange HIE)
9. **San Ysidro Health Center** (ECM Provider)

The original ASCFI pilot had a very robust initial use case. Partners planned to inform individuals transitioning from incarceration or inpatient psychiatric stays about the Community Information Exchange and offer the opportunity to consent to share their information using the ASCFI form. The ASCFI form would have been signed by willing participants and uploaded into CIE's consent management system. The participating managed care plan would have received an alert and electronic referral for their members to then determine eligibility and make an electronic, closed looped referral to their contracted service provider. The consent management and referral processes were designed to be hosted on the CIE portal to allow for further coordination of care among and between the collaborative pilot partners.

San Diego Pilot Adjustment

The ASCFI pilot, as designed, had two separate focuses – the ASCFI consent form itself, and the local consent management system and processes. In late March the final pilot draft ASCFI Form was released and the managed care partner Health Net's legal and compliance team shared "strong concerns" and written feedback on the ASCFI form. *Please see Attachment #1 for the MCP feedback on the ASCFI Form provided.* There was discussion locally, with the other two pilot sites who had received similar feedback, and with DHCS. Changes to the ASCFI form approved by DHCS were not an available option. Collectively, the pilot sites agreed to adjust the pilot to 'test' the ASCFI form and consent management but not to utilize the form to authorize data sharing.

Table 1 – Individual Provider Data Report

During the pilot, providers recorded the information in Table 1 Individual Provider Data Report at every encounter when the individual was presented with the ASCMI form. Completed forms were sent electronically to CIE at the end of each encounter.

Table 2 – Pilot Outcomes Aggregate Data Report

See Attachment #2 for the DHCS Excel template.

Table 2. Pilot Outcomes Aggregate Data Report⁴ Source: HIE/CIE Recipient: DHCS	
Column	Data Element
A.	Pilot Site 211/CIE San Diego
B.	Pilot Start Date 5/24/2023
C.	Pilot End Date 6/23/2023 Ended ASCMI Form Survey (6/30/23 Ended Pilot)
D.	HIE/CIE Name San Diego Community Information Exchange (CIE)
E.	All County Agency Names County Health and Human Services Agency; Behavioral Health Services; Medical Care Services; San Diego Advancing and Innovating Medi-Cal Unit
F.	All County Agency Network Providers Using ASCMI Form Names McAlister Institute; Metropolitan Area Advisory Committee on Anti-Poverty (MAAC); People Assisting the Homeless (PATH)
G.	All MCP Names Health Net
H.	All MCP Network Providers Using ASCMI Form Names McAlister Institute; People Assisting the Homeless (PATH); San Ysidro Health

I.	Total Number of Unique Members Asked to Sign ASCMI Form 187
J.	Total Number of Unique Members Who Signed the ASCMI Form 153 (82%)
K.	Total Number of Unique Members Who Signed the ASCMI Form and checked the box in <u>ASCFI Form Section 7 "Authorization,"</u> authorizing the disclosure of their substance use disorder information from Providers subject to 42 C.F.R. Part 2 118 (77%)
L.	<p>Based on your current consent management process, how often do unique members sign into the process then revoke their consent?</p> <ul style="list-style-type: none"> • Less than 10% • 10-25% • 26%-50% • 50+ <p>Based on your current consent management process, what are the reasons why members revoke consent?</p> <ul style="list-style-type: none"> • 60% of individuals revoking their CIE consent reported privacy concerns as the reason. • 27% of individuals choose reasons other than options listed. • 6% of individuals revoking consent reported they are no longer interested in sharing information. • 4% of Individuals reported they did not understand the value/need. • 3% of individuals did not provide a response in their request to revoke.

Table 3 – Pilot Evaluation: Provider

<h2 style="margin: 0;">Table 3. Pilot Evaluation: Provider</h2> <p style="margin: 0;">Source: Provider Recipient: CIE/HIE</p>	
Number	Question
1.	<p>Prior to the ASCMI Pilot, how did your organization document consent to share a Medi-Cal Member’s information?</p> <ul style="list-style-type: none"> a. Hard copy of signed consent form - 17% b. Digital copy of signed consent form – 25% c. Both A and B – 17% d. Other – 41%
2.	<p>Prior to the ASCMI Pilot, when did your organization document consent to share a Medi-Cal Member’s information?</p> <ul style="list-style-type: none"> a. At intake of any new patient – 67% b. At the request of the patient – 100% c. When required for referral and/or care coordination – 92% d. Other
3.	<p>Prior to the ASCMI Pilot, how often did your organization require a Member to “renew” their consent?</p> <ul style="list-style-type: none"> a. Every year – 17% b. Somewhere between every 2 and every 5 years c. Never – 17% d. Other – 66%
4.	<p>Prior to the ASCMI Pilot, how did your organization most commonly communicate consent to share a Medi-Cal Member’s information with the Member’s other care partners?</p> <ul style="list-style-type: none"> a. Fax (or other transmittal involving hard copy) – 25% b. Electronically via secure messaging (e.g., encrypted email) – 50% c. Electronically via shared digital platform (e.g., HIE/CIE) -17% d. Other – 8%

<p>5.</p>	<p>Prior to the ASCMI Pilot, what was the primary challenge your organization experience with obtaining and documenting consent to share a Medi-Cal Member’s information? (Select all that apply.)</p> <ul style="list-style-type: none"> (a) Confusion with legal requirements (for information sharing consent) – 92% (b) Lack of standard tools (e.g., consent form used) between organizations – 83% (c) Lack of standard practices (e.g., documentation methodology) between organizations – 33% (d) Other – 25%
<p>6.</p>	<p>As a Provider, using the ASCMI Form was helpful and improved my organization’s consent management process.</p> <ul style="list-style-type: none"> • Strongly Agree – 17% • Agree – 25% • Neutral – 58% • Disagree • Strongly Disagree
<p>7.</p>	<p>As a Provider, using the consent management service was helpful and improved my organization’s consent management process</p> <ul style="list-style-type: none"> • Strongly Agree – 17% • Agree – 25% • Neutral – 58% • Disagree • Strongly Disagree
<p>8.</p>	<p>As a provider, I believe having a standardized universal consent form would improve my ability to coordinate care for my patients.</p> <ul style="list-style-type: none"> • Strongly Agree – 65% • Agree – 29% • Neutral – 6% • Disagree • Strongly Disagree <p>Please explain your response.</p> <p>The overwhelming majority (94%) strongly agreed or agreed having a standardized universal consent form would improve care coordination. A few respondents shared concerns about the administrative burden another consent form would require if it would not replace the many existing consenting forms already required.</p>

9.	<p>As a Provider, I felt equipped with the appropriate knowledge, training, and tools to understand how to use the ASCMI Form.</p> <ul style="list-style-type: none"> • Strongly Agree – 79% • Agree – 21% • Neutral • Disagree • Strongly Disagree
10.	<p>As a Provider, I felt equipped with the appropriate knowledge, training, and tools to communicate the purpose of the ASCMI Form to my patients.</p> <ul style="list-style-type: none"> • Strongly Agree – 79% • Agree – 21% • Neutral • Disagree • Strongly Disagree
11.	<p>As a Provider, I felt equipped with the appropriate knowledge, training, and tools to understand how to use the consent management service.</p> <ul style="list-style-type: none"> • Strongly Agree – 74% • Agree – 26% • Neutral • Disagree • Strongly Disagree
12.	<p>As a Provider, I felt equipped with the appropriate knowledge, training, and tools to communicate the purpose of the consent management service and to provide instructions on using the consent management service to my patients.</p> <ul style="list-style-type: none"> • Strongly Agree – 76% • Agree – 24% • Neutral • Disagree • Strongly Disagree

13.	<p>Please describe your organization’s current experience with consent management your members. In your response, please describe best practices, pain points and potential impacts on operations.</p> <p>Because there is not currently a widely-used, single, universal consent, providers are required to complete many individual releases of information or multiparty agreements. This is not a person-centered approach and delays care coordination, especially across sectors of care. The current CIE authorization form is the closest thing we have in San Diego but it currently does not include sensitive data under 42 CFR Part 2 and only allows sharing to organizations within the CIE Partner Network. The current CIE consent management is user friendly for different levels of sophistication but needs additional refinement for increased participant controls.</p> <p style="text-align: center;">***</p> <p>Currently, most consents are collected at admission during the intake process. Any additional consents are collected throughout the treatment process. Most clients understand the need for signing the consents or just go along to get along; others require a little more explanation especially concerning limits of disclosure. The consent portion of the intake process is the longest and most laborious because of all the different consents that have to be collected. I like to anticipate additional needs early on, so during intake, if I am doing the admit, I get others signed at that time. Not everyone thinks like that. A pain point is a situation where a counselor/case manager is working to resolve an issue or coordinate care for a client and we need a consent for additional organizations. When the client isn't present due to being out on an appointment, the entire process stops until the client returns and the consent is signed. A universal consent would 1) be better for our planet, and 2) would facilitate more efficiency in client care and coordination of services.</p> <p style="text-align: center;">***</p> <p>Any release of information paperwork is explained and offered at intake and then as clients’ needs present, we will do more to coordinate client with new resources.</p> <p style="text-align: center;">***</p> <p>We explain each consent. In the case they do not have a primary care physician, staff completes a consent for our partner health center, or one of the other health providers. Rarely have issues getting them signed by the client.</p> <p style="text-align: center;">***</p> <p>The problem is when an outside agency or service partner calls for information and we don't have consent. We then have to track down the client for information and signature if they're willing to give it. Without it there are vital missed opportunities. Sometimes to the detriment of the client or their children.</p>
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	<p style="text-align: center;">***</p> <p>Individual Releases of Information (ROIs) are collected at the time of intake and throughout the course of a client's treatment, as needed. The main issues we encounter is client accuracy in providing information, or that they forget where they have received services in the county.</p> <p style="text-align: center;">***</p> <p>Consents are collected during intake and throughout treatment episode as needed.</p> <p style="text-align: center;">***</p> <p>We keep client consents electronically which are good for 1 year. It is easy for us to access client's files to ensure confidentiality at all times. Meeting with clients for each individualized care coordination helps the client's build the therapeutic alliance and helps the clients be more accountable in their recovery. Personally, I have concerns and would like to have gatekeeping in place and at the same time would like treatment to be seamless to help client's needs be met.</p> <p style="text-align: center;">***</p> <p>Most client concerns I hear are about confidentiality and how the data will be protected.</p> <p style="text-align: center;">***</p> <p>Upon intake of our program is when our clients sign most of their releases. Clients are encouraged at that time to sign a release of information not only for their support team (personal) but for their medical providers. If clients come into the program without a medical provider, we have them sign an ROI for the medical provider that we work with, a local health clinic. We also will have them sign for other providers that we work closely with so that the consent will always be available. At any time when a client would like to add a new consent or medical provider the counselor or case manager will enter the consent to release and place it in the file.</p> <p style="text-align: center;">***</p> <p>First, with a universal consent time spent signing consents would be reduced freeing up the staff person to engage in more direct services for clients. Secondly, it would make coordination of care smoother and more efficient - which is better for clients and providers.</p> <p style="text-align: center;">***</p> <p>Consent management has been established in San Diego. We use the CIE San Diego and have to get individual ROIs for individuals or agencies not on CIE or to share data not stored in CIE.</p>
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14.	<p>Describe your organization's experience utilizing the consent management service. In your response, describe best practices, pain points, and impacts on operations.</p> <p>The ASCMI pilot consent management was a bit confusing because of the added complexity of the different evaluation form and client survey links. I find the regular CIE consenting process from the provider perspective is much easier.</p> <p style="text-align: center;">***</p> <p>Consents management is a pain point. There are many types of consents to manage and access to them and the sharing of patient data is limited - meaning we cannot serve beneficiaries as well as we could and are operating in silos. San Diego received very good results from beneficiaries with the initial ASCMI pilot, which means they are also anxious for a better process. Having a standard universal consent form that can be accessed on a single platform by both providers and beneficiaries will provide a more integrated system and is a gold standard that we should continue to strive for in San Diego. We appreciate DHCS' continued support in this area.</p> <p style="text-align: center;">***</p> <p>As a provider we need to figure out a way to have less consents to obtain. The administrative burden is problematic and our residents are eager to get connected to services that require eligibility information and because of the scarce resources it's heart-breaking when paperwork gets in the way of getting people the help they need.</p> <p style="text-align: center;">***</p> <p>Substance use disorder (SUD) providers obtain multiple authorizations during intake. This is a time-consuming exercise, which requires staff to have good communication skills, so clients understand the forms they are signing. It would be ideal to have a single uniform consent document addressing confidential sharing within a network of community providers. Every time our clients must provide another authorization is one more hurdle to ever accessing those services. The San Diego Community Information Exchange (CIE) was created to address this systemic issue - to coordinate community-based organizations efforts to assist individuals who not only have the great needs and are the most vulnerable but for whom society spends the most yet achieves the least. For this remarkable concept to function, there must be a climate of TRUST. To accomplish this, the benefits and risks of consent, particularly to share 42CFR confidential data, need to be explained in culturally appropriate, trauma-informed language. If we put enough effort into building TRUST, the single consent can succeed.</p>
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<p>15.</p>	<p>Are there any other updates or changes to the ASCMI Form that your organization would recommend?</p> <p>The form needs to be easier for clients with all education levels to understand, especially not native English speakers.</p> <p style="text-align: center;">***</p> <p>Preference would be for expiration date should be based on signature date – not date last enrolled in Medi-Cal. DHCS guidance on required data sharing for Medi-Cal enrollment changes must accompany the form as written to facilitate.</p> <p>Include language specific to all care – not just health care. Housing/Meals/Asthma is included (because of the CalAIM focus) but other real-world social care examples would be helpful (transportation, financial assistance, child care, etc.).</p> <p style="text-align: center;">***</p> <p>Better explain the “arrange payment for services” portion of the form. Causes confusion, and potentially unnecessary concerns, thinking it’s collections-related activity.</p> <p style="text-align: center;">***</p> <p>Incarceration-related language could be cleaner.</p> <p style="text-align: center;">***</p> <p>More clearly include revocation options and processes as a required addendum to form for wider deployment. Explain the word “revoke.”</p> <p style="text-align: center;">***</p> <p>The form should be expanded to all people, not just Medi-Cal recipients.</p> <p style="text-align: center;">***</p> <p>Larger font size.</p> <p style="text-align: center;">***</p> <p><i>Please see Attachment #1 for redlines and comments on the ASCMI Form from our MCP partner.</i></p>
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16.	<p>Are there any other updates or changes to the consent management service that your organization would recommend?</p> <p>Several CIE partners have integrated the current CIE Authorization form into their CRMs and EHRs. Once approved for wide use, an electronic version of the ASCMI form that is easy to integrate into source systems with direct connection to regional consent management services like CIE and HIE or other data intermediaries would be very helpful.</p> <p style="text-align: center;">***</p> <p>Being allowed to obtain verbal consent until the person can provide the signature when the need is time constrained would be very helpful, or, yes, having that standardized universal consent would be VERY helpful.</p> <p style="text-align: center;">***</p> <p>Our organization recently adopted a behavioral health electronic record. We would need to integrate the uniform consent once it's activated into the Intake Counselor's intake process. Ideally, there would be a standardized video orientation for clients to watch prior to the discussion about signing the consent where FAQ could be addressed. We would need to have a readily available means to inform clients about organizations that choose to join (or leave) the CIE after their original consent was obtained. Client access to their own CIE portal would provide clients easy access to review and adjust their sharing status. To address the fact that some clients may wish to share with some but not all CIE participants, the ability to opt out of sharing with certain organizations would address the concerns of some clients. All of this will require a very comprehensive education to all providers in the CIE network, from physicians and administrators to drug counselors and key client confidants.</p> <p style="text-align: center;">***</p> <p>Linking a consent management service to available resources is critical next step. Having record of available services/resources is needed. Most often mental health services have a 3 to 6 month wait and there is no long-term housing available after they leave sober living. Having these services available could help clients realize benefits of data sharing and access services to remain abstinent for longer periods of time.</p> <p style="text-align: center;">***</p> <p>The consumer/patient/client/member need to have more acute control and oversight into who specifically can or has accessed their information. The consent management system of the future should let the individual be in the driver's seat.</p>
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<p>17.</p>	<p>Is there any other guidance or technical assistance on the ASCMI Form and/or the consent management service that would be helpful? In your response, specify who should provide the guidance or technical assistance (DHCS, HIE/CIE, county, or MCP).</p> <p>90% of Pilot partner respondents strongly agreed (75%) or agreed (15%) that DHCS is ‘critical to the development of a standardized universal consent.’ The remaining respondents were neutral – none disagreed.</p> <p style="text-align: center;">***</p> <p>Pilot partners remain committed to assisting in the implementation of a standardized universal consent that include sensitive behavioral health and substance use information. 80% stated their organization remains eager to assist in the implementation of a standardized universal consent form addressing sensitive data and are willing to continue the work of this pilot. The remaining respondents were neutral - none disagreed.</p> <p style="text-align: center;">***</p> <p>Having a standardized consent and standardized process approved at the State level for use and access would decrease administrative burden and improve timely access across the continuum of care as well as the overall satisfaction rate in Medi-Cal. We can focus more on meeting the needs and overall health and well-being of the beneficiaries versus the "paperwork" - especially if we can put the consent in a centralized trusted location like CIE and shared with San Diego Health Connect.</p>
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Table 4 – Pilot Evaluation: MCP and County

<h2 style="margin: 0;">Table 4. Pilot Evaluation: MCP and County</h2> <p style="margin: 0;">Source: MCP and County Recipient: CIE/HIE</p>	
Number	Question
1.	<p>The ASCFI Pilot provided a clear and efficient process for obtaining consent information.</p> <ul style="list-style-type: none"> • Strongly Agree – 20% • Agree – 20% • Neutral – 60% • Disagree • Strongly Disagree
2.	<p>Our current consent management process has improved the exchange of information between MCP and SMHS as well as between MCP and DMC/DMC-ODS.</p> <ul style="list-style-type: none"> • Strongly Agree – 20% • Agree – 20% • Neutral – 60% • Disagree • Strongly Disagree <p>Please explain your response.</p>
3.	<p>Please describe what changes to your current consent management process would improve care coordination for members by facilitating the exchange of patient information.</p> <p>I'm not on the front line, but the current process for Part 2 data seems to require asking the individual to sign a consent at each point of care. No county-wide CoSD platform to view and manage consents across departments (PHS and BHS) and agencies (HHSA and PSG) is available for this type of data.</p> <p style="text-align: center;">***</p> <p>An IT platform to assist with verifying consent, or lack of, and releasing or sequestering information accordingly is needed.</p> <p style="text-align: center;">***</p>

	<p>Having a universal consent form on file, in an easily accessible way is the goal we should strive for.</p> <p style="text-align: center;">***</p> <p>Our needs are simple and were not yet realized through this pilot for behavioral health information. We need 1) A single consent form – done via ASCFI but we couldn’t get agreement on actually activating it – which is the first step and requires DHCS support IMO. 2) A County-wide platform to view and manage consents. We currently have the CIE but that is an all or nothing consent and does not yet include behavioral health data. 3) Ability to share info across County departments and agencies to truly allow patient-centered care and coordination of physical, behavioral, and social services.</p>
<p>4.</p>	<p>The ASCFI Form and consent management service should be rolled out more broadly</p> <ul style="list-style-type: none"> • Strongly Agree – 80% • Agree – 20% • Neutral • Disagree • Strongly Disagree
<p>5.</p>	<p>How did your organization use the ASCFI Form? In your response, list each use case and describe its pros and cons.</p> <p>The County and MCP partners did not use the ASCFI Form during the adjusted pilot because of concerns with the ASCFI forms and/or the complexity of presenting the form while not actually sharing data. Both groups reviewed the ASCFI form and provided comments, redlines and compliance concerns that are included in this report.</p>
<p>6.</p>	<p>How did your organization use the consent management service? In your response, describe how it changed workflows.</p> <p>The County and MCP partners did not use the ASCFI consent management service during the adjusted pilot.</p>
<p>7.</p>	<p>What was your organization’s Provider onboarding and training process? In your response, include your organization’s specific role and lessons learned in designing the training program and conducting the trainings.</p> <p>The County and MCP partners reviewed the onboarding and training process and materials and encouraged their contracted partners to attend but the County and MCP did not directly participate or conduct the trainings.</p>

<p>8.</p>	<p>What ongoing technical assistance did your organization provide? In your response, include what types of technical assistance were most helpful for Providers.</p> <p>The County and MCP partners provided review of the adjusted pilot design, the initial training plans and documents, and provided assistance during recurring pilot partner meetings.</p>
<p>9.</p>	<p>What lessons have you learned from the Pilot that would inform how your organization would do a broader rollout? In your response, describe Pilot implementation challenges, resource gaps, and any considerations for scaling the ASCFI Form and consent management service.</p> <p>Local survey included additional questions including:</p> <p>100% of MCP and County survey respondents strongly agreed or agreed that having a standardized universal consent form would improve the ability to coordinate care.</p> <p>80% of MCP and County survey respondents strongly agreed or agreed that they are eager to continue the ASCFI Pilot.</p> <p style="text-align: center;">***</p> <p>Expanding the training done with the CBO's to ensure it can be expanded to other "like groups" and is applicable to County departments. Implementing the form at the County could take some time. Business agreements / MOA's / contracts may need to be altered/changed/adjusted to implement at a County level. Future aspirations: The ability to use a single consent to share information is positive and will reduce burdens on the patient/customer to not complete multiple forms. Identifying one business group/department/unit to implement the form in the County would be a good initial step.</p> <p style="text-align: center;">***</p> <p>Current process varies by Legal Entity. Goal is to have a standardized form and process and an IT platform to assist with verifying consent, or lack of, and releasing or sequestering information accordingly.</p> <p style="text-align: center;">***</p> <p>In my current role, I am outside of those processes, so I can't speak to them in detail. A challenge remains - the need for clear and concise consent forms that accounts for all state and federal patient protections. Having an approved form that captures all of this is the first step to beginning that process.</p>

Table 5 – Pilot Evaluation: HIE/CIE

<h2 style="margin: 0;">Table 5. Pilot Evaluation: HIE/CIE</h2>	
<p>Source: HIE/CIE Recipient: DHCS</p>	
Number	Question
<p>#1 – 4 are open-ended questions. Respond to each question in 1,000 words or less.</p>	
1.	<p>What was your organization’s Provider onboarding and training process? In your response, include your organization’s specific role and lessons learned in designing the training program and conducting the trainings.</p>
<p>211 San Diego’s Community Information Exchange was responsible for the creation and implementation of the ASCFI Pilot’s on-boarding and training process. We originally recruited diverse partner organizations to join the pilot including direct service providers that met the RFP requirements (DMC/DMC-ODS Providers, CalAIM contracted Providers) and were also mindful to include partners with varying levels of current San Diego Community Information Exchange utilization and consenting activities. We included behavioral health service provider partners that have been eagerly awaiting the opportunity to address the sharing of sensitive data for purposes of care coordination. We also included partners that were not direct service providers but whom would serve as training and scalability advisors like San Diego Health Connect (HIE) and Integrated Health Partners.</p> <p>The adjusted scope of the pilot (i.e. not actually sharing participant data using the ASCFI form), coupled with the very short project timeline, impacted some partners’ ability and willingness to simply ‘demo’ the ASCFI form without actionable results for their clients. The County and MCP partners choose not to participate in the survey of participants.</p> <p>The adjusted scope of the pilot added complexity to the provider training, requiring information about ‘hypothetically’ signing the form as opposed to participants actually signing the form and receiving the potential benefits of sharing data. This adjustment, or ‘pilot pivot’ as it was called locally, also required the San Diego CIE team to create new processes and tools outside the existing CIE consent management infrastructure.</p> <p>While the adjusted scope impacted the training development and rollout, it was the condensed timeline that was most impactful and burdensome. The delayed statewide materials including the FAQs and translated forms shortened an already tight timeline.</p> <p>The CIE team met with the full project partners several times to outline the pivot from the</p>	

original use case to the adjusted “ASCMCI Demonstration” rather than full deployment with data sharing, and asked each partner how their planned project participation would need to shift. Three provider partner organizations identified eight diverse program sites from across San Diego County to test the ASCMCI consent form with participants and utilize a pilot-specific consent management process.

The eight pilot program sites included:

- Residential substance abuse treatment program for Latinx women;
- Two adult outpatient treatment recovery centers;
- Residential substance abuse treatment program for adult men;
- Short-term housing program for adults experiencing homelessness;
- Coordinated Street Outreach program for individuals and families living unsheltered;
- Community Care Coordination (C3) wrap-around services for justice-involved adults with a serious mental illness referred from the sheriff’s department or the public defender; and
- CalAIM ECM and various Community Supports services.

The CIE team met several times with the Provider agency staff to develop site-specific workflows. The CIE team developed a pilot-specific website to host all training materials and resources. The training materials developed were presented to the full project team for review. The trainings were deployed to 34 individual staff members across the three provider organizations at separate, organization-specific, training sessions.

The ASCMCI Pilot training curriculum included:

- Pilot Overview – Why This Matters
- Overall Pilot Objectives and Workflows
- Consent Management: How to Access Resources and Materials
- Materials Overview: ASCMCI Authorization Form; FAQs; QR Link
- Talking Points: Conversation Starters/Real Talk
- How to Submit Evaluation Documentation
- Post-Training Survey

Each pilot site completed one virtual training session with all their own team members who would be deploying the ASCMCI form. One partner organization chose to use a train-the-trainer model because of the condensed project timeline.

We learned many lessons in designing the training program and conducting the trainings and comparing this project training to our usual CIE onboarding and training processes around consent and consent management.

Context:

- There is high value in dedicated training content to contextual information, big picture understanding, and the ‘why’ behind data sharing. Also, walking through the

<p>INFORMED portion of consenting processes when designing workflows and training is critical.</p> <p>Timeline:</p> <ul style="list-style-type: none"> • The short timeline did not allow for thorough review by pilot and community partners or those with lived experience. More time is needed for appropriate review and feedback from diverse groups. <p>Learning Settings:</p> <ul style="list-style-type: none"> • Comprehension tests at the end of each training proved helpful to discern competency of each participant for follow up individual instruction. • Train-the-trainer model proved less effective. • In-person, monitored individual learning training is most effective. <p>Resources:</p> <ul style="list-style-type: none"> • We had to provide one pilot site mobile electronic devices to facilitate a streamlined process and avoid creation of an additional, paper-dependent workflow. • Additional funding for partner agency staff training time would have been appropriate. 	
2.	<p>What lessons did you learn from the Provider onboarding and training process? In your response, discuss any consistent feedback received from Providers and what parts of your onboarding and training process you would keep and what parts you would modify.</p>
<p>We learned many lessons from the Providers onboarding and training process from their survey and comments. Post-training survey results showed:</p> <ul style="list-style-type: none"> • 79% of trained providers reported feeling “very confident” in presenting the ASCFI form to participants and 21% felt “somewhat” confident.” • 74% of providers felt confident they would be able to answer participant questions about the ASCFI form and 26% felt “somewhat confident.” • 76% of providers felt “very confident” <p>Partners appreciated the contextual overview, the talking points and conversational guides, and walking through the ASCFI form in close detail to understand intent in order to provide guidance to their clients. They felt confident about the overall explanation of the form and benefits to sharing data and the consent management process. They were most nervous about the different pilot-specific reporting processes (i.e. the Provider Evaluation Form</p>	

documentation with each encounter, and ensuring clients has access to QR code to submit the survey directly to DHCS).

Each organization and each program worked through the appropriate timing to present the ASCFI form. When talking through workflow, one provider training attendee decided they were going to first introduce the ASCFI form at intake but allow their client time to process before deciding whether they would sign it because of all the other ‘required consents’ done at intake.

The diversity of the programs and services at the eight partnering sites allows for continued analysis. Are consent rate different at program intake versus program discharge? Are consent rates for unhoused clients enrolled in residential programs different from clients in a street outreach program? Does an established relationship with the helper presenting the form impact consent rates? How do consent rates or reasons for declining differ among various target populations or demographics?

The CIE Consent Management infrastructure had to be adapted because the ASCFI form was not activated for sharing data resulting in a pilot-specific proxy process with different links and workflows that was confusing at times and was not as streamlined as the current CIE Authorization.

The very short pilot timeline and the fact that the form was not used for data sharing did not allow for our typical CIE authorization training process that includes an e-learning module followed by an in-person training session with role play and real-time discussion. Given more time for the pilot or if the ASCFI form was actually activate to share data, we would have included additional contextual resources and required our standard privacy/security e-learning modules and other foundational learnings.

3.	What ongoing technical assistance did your organization provide? In your response, discuss what types of technical assistance were most helpful for Providers.
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The CIE staff routinely checked in with the providers after their training sessions and throughout the open survey. We provided all trained providers with CIE staff cell phones, direct email addresses, and also scheduled drop-in office hours. The only technical assistance needed was process-related (“did I submit the evaluation form properly?”) and none were related to the ASCFI form or client questions they were unprepared for.

4.	<p>What lessons have you learned from the Pilot that would inform how your organization would do a broader rollout? In your response, describe Pilot implementation challenges, resource gaps, and any considerations for scaling the ASCMI Form and consent management service.</p>
<p>Initial ASCMI Pilot results show that people seeking assistance are willing and eager to share their personal information, even their sensitive behavioral health information. We found participants with substance use and behavioral health needs consent to share their information at about the same rate as the general CIE population.</p> <p>The greatest challenge for this project was the short timeline. All three pilot sites continuously raised concerns about the timeline necessary for adequate preparation and to deepen the pilot’s reach and impact. The local roll-out of pilot activities were delayed waiting for contracting and sharing of approved State documents.</p> <p>The challenge that had the largest impact on this pilot were the concerns about the ASCMI form itself. The concerns were raised by the Managed Care Plan partner and DHCS’s inability to address concerns within the term of this pilot greatly impacted the depth of pilot activities. This disconnection limited all pilot projects and underscores the need for thoughtful sector engagement, honest conversations about power structures, and what role data intermediaries like CIE and HIEs can and should play.</p> <p>The authentic community engagement and feedback on the ASCMI form is critical first step to communities effectively being able to share data. We had high aspirations for this pilot but our initial CalAIM use case was dependent upon deep involvement from our MCP partner, as is so much of CalAIM implementation efforts. DHCS is critical to the facilitation of conversations needed around consent forms and processes and all perspectives including MCPs, front line staff, local government, and end user/community voice should be collected and shared.</p> <p>CIE has a local, universal authorization form for sharing of data, not currently inclusive of 42 CFR Part 2 covered data. It has taken years and thousands of conversations with compliance officers, and legal counsels from diverse sectors, to get our community to agree to the shared language we use today. We have behavioral health providers eager to utilize CIE’s resources to aid in care coordination. We have very strong local support, but many organizations extend beyond one region and the burden to get different, regional versions of forms agreed to and implemented is a hurdle for local communities. With DHCS’s guidance and support for a universal consent form, we can leverage local insights and trusted relationships to expedite progress.</p> <p>Along with the many challenges comes great opportunities. San Diego’s CIE has been driving local data sharing efforts across health and social care sectors for years. The interest and</p>	

momentum for cross sector data sharing has never been greater than it is today. In San Diego we have the infrastructure of technology with both a CIE and HIE and the trusted cross sector partnerships, but we need DHCS to support efforts for the initial step of an agreed upon universal form partners can agree to. Manage care plans are at the center of CalAIM reform and are responsible for social care like never before. They, like the County and community-based organizations, are reengineering business processes to facilitate seamless care coordination. The first step is developing a universal consent form that all partners are comfortable with and compelled to use.

Pilot results show there is resounding acknowledgement of the need for a universal consent form. Member survey results show participants are open to being informed about care coordination tools and are willing consent to share their sensitive information. There are limits to what can be accomplished locally, especially by a CIE or HIE.

Resources are needed for continued planning for strategic local deployments. In San Diego, pilot partners are ready to get back to work on our original use case for the justice involved population of focus.

Resource gaps also include financial support for comprehensive staff training and technical infrastructure. The beginning phases of ‘meaningful use’ over a decade ago may serve as an example of the depth and breadth of need support – even more so for data sharing beyond one own’s organization and single sector.

Resource gaps exist for funding of CIE/HIE system improvements as the consent landscape changes and requires additional refinement. Funding for partner technology integrations is also an identified gap we heard from our partners.

This initial demonstration of the ASCMI form has brought the critical local partners to the table who are eager to continue this work. The three pilot sites from across the State have become a learning cohort and continued activities to share local learnings and offer feedback from the field and practical applications back to the State would be beneficial.

The ASCMI Project itself has garnered so much interest. We had several inquiries for ASCMI insights/outcomes from outside groups (foundations, consultants, etc.) even before we launched the pilot. We are eager and excited for a broader roll out of a universal consent form and consent management.

5.	The HIE/CIE must develop and issue a Provider survey after conducting consent management service trainings and attach those survey results as part of their Pilot evaluation submission. The survey results should inform the response to questions #1 – 2.
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Please see Attachment #3 for the Post Training Survey form and results.