Transforming Community Care through Shared Client Records:

San Diego Region Data Infrastructure Asset Map

2-1-1 SAN DIEGO

Community Information Exchange

Contents

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Advisory Group

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Executive Summary

Medi-Cal stakeholders across the San Diego region have been collaboratively planning for a number of Medi-Cal Transformation initiatives, including Enhanced Care Management (ECM) and Community Supports (CS) to address both the clinical and non-clinical needs that contribute to high-need members' health outcomes.[1] In the past few years, these initiatives have increased the demand on the region's existing data exchange infrastructure and created new opportunities for cross-sector partnership. To address regional demand, 2-1-1/CIE San Diego requested funding from the DHCS CalAIM Incentive Payment Program (IPP) to create a point-in-time asset map of the region's current data infrastructure and a roadmap to guide stakeholders' efforts to effectively—and appropriately—leverage exchange healthcare and social services data within the ecosystem to support improved care coordination.[2]

Existing Data Infrastructure

San Diego is home to robust, local data infrastructure, including the Community Information Exchange (CIE) and San Diego Health Connect, the local health information exchange (HIE). Both were established over a decade ago to support data sharing among health and social services providers. San Diego also has Health Center Partners, a consortium of FQHCs that are working toward improving population health. Innovation partners like the Regional Taskforce on Homelessness have established data sharing with CIE. Additionally, the County of San Diego Health and Human Services Agency (HHSA), the Hospital Association of San Diego & Imperial Counties and other key stakeholders are working collaboratively to improve the larger system of care.

San Diego's Community Information Exchange (CIE) began in 2011 as a collaborative approach to sharing basic client-level data between service providers in San Diego. Over time, the CIE has become a catalyst for the community-based movement to understand, value and share social determinants of health data and use technology to bridge sector divides. The CIE facilitates closed loop referrals and the creation of a single, unduplicated, person-centered record and community-wide care plan. Today, San Diego's CIE is an ever-growing network of 137 health care, human and social service organizations delivering person-centered care using a cloud-based platform that allows individuals to share information about their progress toward health and wellness goals across providers through an individual, identifiable, longitudinal record.

San Diego Health Connect is a 501(c)(3) community collaborative that started in 2010 when San Diego County was awarded a Beacon Community Program grant from the Office of the National Coordinator for Health Information Technology (ONC). This developmental grant established a health information exchange (HIE), which allows the electronic interchange of patient medical care information, including test results, imaging data, demographic data, allergies, medications prescribed and medical care summaries for individuals from San Diego & Imperial County. Exchange occurs at the point of care between hospitals, physicians, clinics and other care settings to support care activities. Health organizations contribute annual subscription fees to sustain SDHC. With over 65 participating organizations, San Diego Health Connect is also a Qualified Health Information Organization (QHIO) and a state Data Exchange Framework (DxF) designated intermediary supporting the development of data sharing capabilities across California.

With the launch and implementation of the Medi-Cal Transformation Initiative, the number of organizations that will need to enhance their data sharing capacity while also protecting individual data privacy has grown significantly.[3] San Diego's data infrastructure will need to be poised to expand to meet the opportunity to welcome new and diverse data sharing partners, align informed patient/client consent practices, and delineate appropriate access to individuals' varied social and health data.

Current State of Data Sharing

From January through June 2024, stakeholders representing critical sources of Medi-Cal member data participated in Advisory Group meetings, surveys and interviews to identify barriers to data exchange and opportunities to enhance the ecosystem's data sharing capacity related to ECM/CS.

Two key challenges the Advisory Group identified were interpreting changes to state and federal policy and the need to rapidly integrate a variety of previously disconnected data systems.

Stakeholders also acknowledged the complexity involved in fostering collaboration among organizations and systems with different values, operating models, terminology and measures of success. Specific challenges stakeholders identified include:

- Use of multiple systems often necessary to record and report on members' care needs, service provision and outcomes
- Lack of transparency around contact and utilization data
- Potential for duplicative outreach efforts
- Variability in the forms and documentation required to obtain service authorization
- Limited insight into provider capacity for services
- Delays in confirmation of eligibility and authorizations for CS services
- Variable access to care plan tools and information among team members

Collectively, these challenges create an administrative burden for all entities, cause confusion among providers navigating multiple systems, increase the potential for duplication of services, and delay member access to critical care.

Recommendations

To address the challenges they identified, Advisory Group participants engaged in the collaborative development of the following recommendations, which are intended to be used as a road map for future regional data exchange initiatives:

Enhance capacity to share an individual's contact and utilization information to streamline member outreach and increase Medi-Cal benefits access.

Increase transparency of Medi-Cal related program enrollment status to eliminate duplicative outreach.

Leverage existing data sets to identify Medi-Cal Transformation potentially-eligible individuals for ECM enrollment.

Establish a standardized, streamlined practice for community referrals to connect Medi-Cal Transformation eligible individuals to MCPs and CS providers.

Establish a mechanism for ensuring warm handoffs (care transitions) from discharge planning to ECM/CS providers prior to members leaving the hospital.

Streamline authorization for Community Supports related to housing and medically tailored meals.

Enable all care team providers and the member to access the care plan and enable providers to refer to each other to provide holistic care and ensure continuity of care.

Leverage existing data sets to provide insights for process improvement, outcomes and impact of CalAIM services on clients.

The Advisory Group also identified several general recommendations such as creating a contracted provider directory, establishing a minimum data set for exchange, collaborating on a shared interpretation of federal and state laws, developing a universal consent management service, and supporting agencies in adopting real-time, bidirectional data exchange. Several Advisory Group participants also recommended ensuring that providers and community-based organizations were aware of funding and technical assistance resources to support data exchange for ECM/CS implementation through the PATH Technical Assistance Marketplace and Data Exchange Framework grants program.

Next steps include developing a work plan, expanding the ecosystem's capacity to convene an ongoing forum to guide future data exchange, advocating for policy change to ensure small- and mid-size providers with access to target populations can fully participate in the ecosystem, connecting providers and community-based organizations with funding and technical assistance, and exploring additional funding sources.

Introduction

Medi-Cal Transformation is a five-year California Department of Healthcare Services initiative to improve quality of life and health outcomes for Medi-Cal members, especially individuals with complex care needs, by integrating the health care and social services systems. Also known as CalAIM, Medi-Cal Transformation includes Enhanced Care Management (ECM) for high-need members and Community Supports (CS) to address both clinical and non-clinical needs that contribute to members' health outcomes.[4] These initiatives—supported through federal waivers from the Centers for Medicare & Medicaid Services (CMS)—have dramatically altered the already complex landscape of stakeholders, legislation and regulations governing data and have highlighted the need to further expand the San Diego region's capacity for more robust data exchange.[5]

To better support data exchange within San Diego County, 2-1-1/CIE San Diego requested funding from the DHCS CalAIM Incentive Payment Program to facilitate a San Diego Regional Data Infrastructure Asset Mapping Technical Advisory Group (Advisory Group) focused on providing a point-in-time snapshot of the current data exchange infrastructure and a roadmap for expanding that infrastructure and stakeholders' capacity to use healthcare and social services data to support improved care coordination.[6] Key elements of the project included clarifying stakeholders' roles and responsibilities, mapping the technology platforms different entities are using to collect and share data, identifying barriers to data exchange, and establishing a shared vision with high-level action steps to guide prioritization of data exchange initiatives.

Enhanced Care Management is a critical component of population health management that provides a whole-person interdisciplinary approach to comprehensive care that assigns a lead care manager to coordinate all the health and health-related social services for an individual whose complex health needs meet the criteria for one or more Populations of Focus.

Community Supports are health-related social services (e.g., housing, medically tailored meals) that are provided to help individuals avoid higher, costlier levels of care or discharge delays.

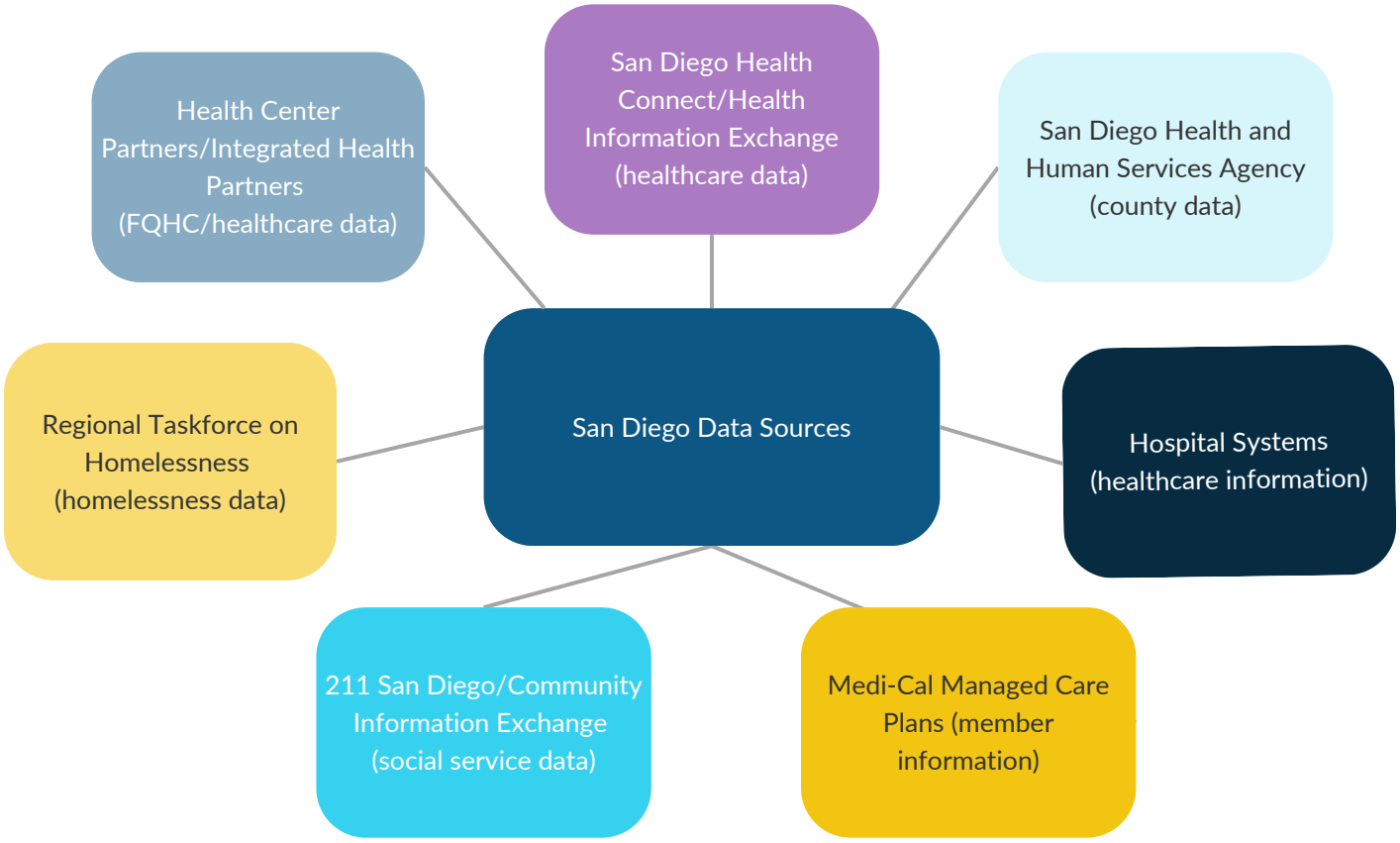
A **Population of Focus** is a group of individuals with one or more shared chronic or complex conditions or social factors that put them at elevated risk for poor health outcomes. Current guidance identifies nine Populations of Focus that each meet specific and distinct criteria to qualify for ECM services.

A **member** is an individual who receives low- or no-cost insurance through Medi-Cal.

Methodology

This roadmap was developed collaboratively by an Advisory Group representing 15 organizations, including 2-1-1 San Diego/CIE, that each manage one or more sources of Medi-Cal member data critical to Enhanced Care Management (ECM) and Community Supports (CS). Several community-based organizations and Intrepid Ascent, the designated facilitator for ECM and CS collaborative planning and implementation, also provided valuable insights.

Figure 1: Medi-Cal Transformation Data Sources



Activities used to gather input on the current state of data exchange and proposed recommendations include:

1. **Utilization of Existing Workgroups:** Engaged representatives of different data sources from the PATH CPI Data Standardization Workgroup and CIE CalAIM and Provider workgroups to participate in six advisory group meetings.

2. **ECM and CS Eligibility Criteria Review:** Analyzed ECM eligibility criteria for the nine Populations of Focus to inform opportunities to streamline member outreach and eligibility, authorization and enrollment, and care coordination and referrals to Community Supports.[7] Also reviewed CS eligibility and provider service requirements.[8]

3. **Medi-Cal Transformation Workflow and Use Case:** Reviewed the Medi-Cal Transformation workflow through the lens of a use case to gather insights on how an eligible individual currently experiences the system and points in time where data exchange could improve patient outcomes.

4. **Identification of Data Exchange Opportunities:** Reviewed what types of data would be needed to enable stakeholders to streamline processes and enhance the member experience.

5. **Data Infrastructure Survey:** Surveyed Advisory Group participants to understand what data systems they or the organizations they represent are using, data management roles and responsibilities, data exchange capacity and constraints, and planned system upgrades or procurements.

6. **Stakeholder Interviews:** Conducted in-depth interviews with representatives of 11 stakeholder organizations to elicit insights into the existing barriers and challenges related to accessing essential information crucial for effective care coordination.[9]

7. **Analysis of Data Interoperability and Scoping Plans:** Reviewed the scope and limitations of current and planned data interoperability initiatives and identified a roadmap with actionable opportunities for community-wide data exchange.

8. **Listening/Feedback Sessions:** Gathered input from representatives of each sector who reviewed and provided feedback on the proposed roadmap during the final two advisory group meetings and via written comment.

Current State of Data Exchange

Throughout California, Medi-Cal Transformation aims to improve population health outcomes by adopting a person-centered approach designed to ensure that all Californians have equitable access to physical and mental health care and social services that enhance their well-being and quality of life. As part of this effort, DHCS has shifted the administration of Enhanced Care Management and Community Supports (ECM/CS) from the counties to Managed Care Plans (MCPs) and developed an array of initiatives that present both technical and adaptive challenges for health care and social services providers. The technical challenges include building on and maintaining existing data sharing infrastructure and adapting to state and federal policy changes. The more complex, adaptive challenge requires organizations and systems with different values, measures of success and operating models to contribute to the ecosystem's capacity to nimbly respond to data sharing challenges and opportunities.

Infrastructure Development and Maintenance

To better understand the current state of data sharing and technologies, interviews and a data Infrastructure survey were conducted with Advisory Group participants and key stakeholders to supplement the insights shared during meetings.

- Stakeholders use a wide variety of off-the-shelf and custom-built platforms, including legacy systems, to document members' service utilization and health and well-being outcomes.
  - Hospitals primarily use EPIC to manage electronic health records (EHR).
  - Several County programs will migrate to Streamline SmartCare in September 2024.

- Several Advisory Group members agreed that shared learning is necessary to establish common definitions for data elements to support data exchange.

- Advisory Group members have been proactive in evaluating and addressing their current platform's capacity to meet Medi-Cal transformation requirements for data exchange.
  - Several expressed concern about maintaining their systems' data integrity while also wanting to automate systems and reduce duplicative data entry.
  - Some want to automate data exchange so that staff using their platforms could remain in their organizational workflow rather than accessing multiple systems.

- More than three quarters of the 20 survey respondents currently share data with other entities.
  - Frequently named data sharing partners were the MCPs, CIE/HIE and various State and County departments that oversee specific programs.
  - Healthcare organizations reported that they continue to use manual, scheduled reports via email or Secure File Transfer Protocol (SFTP) to exchange data rather than using real-time, bidirectional data exchange or Application Programming Interface (API).
  - The majority of Advisory Group participants expressed interest in closed loop referrals.

- Stakeholders agreed that all data exchange decisions should be centered around a use case with a clearly defined problem, an understanding of the pain points in each stakeholder group's workflow and a shared list of data elements that would be necessary to solve the problem.

- One interviewee reported that many organizations within the broader ecosystem have only recently realized the workflow and budget impacts of adapting their technology platforms to meet Medi-Cal requirements.
  - These organizations have expressed interest in funding and technical assistance for new integrations, ongoing infrastructure maintenance and associated costs.
  - The interviewee described several instances where available funding did not align with the level of effort required to complete the scope of work.

Areas of potential focus that were mentioned less frequently by Advisory Group participants included the capacity to aggregate data at scale for reporting on population health outcomes and the effort required to engage new partners and scale system integrations.

State and Federal Policy and Implementation

In meetings, surveys and interviews, Advisory Group participants directed the bulk of their feedback to concerns about how different legal interpretations of federal and state law—and the risks associated with violating them—have constrained data exchange.

- A number of laws and regulations define how organizations obtain a person's consent to share their Health and Social Services Information (HSSI) with a system, organization, or multiple entities and what types of safeguards and agreements organizations need to have in place to protect how they collect, use and share HSSI.
  - The most frequently cited federal legal barriers included the Health Insurance Portability and Accountability Act and public health (Title 42) and public welfare (Title 45) sections of the U.S. Code of Federal Regulations.
  - State level legal barriers include the California Welfare and Institutions Code covering social services, the California Penal Code and the California Confidentiality of Medical Information Act.
  - Two organizations and four County departments reported that the systems they used were required by state or federal agencies.[10]
  - At least four federal agencies, four state agencies and one County department govern how Advisory Group participants use and share data.[11]

- Advisory Group participants shared that each entity has its own requirements for Medi-Cal member consent and data sharing agreements.
  - Some use an opt-in approach that requires individuals to actively give written or verbal consent, others use an opt-out model, and some non-voluntary programs do not require consent.
  - Advisory Group discussions focused on obtaining consent from adults; only one participant proposed placing greater emphasis on specific populations (e.g., minors, legal guardians of youth in foster care and individuals with disabilities).

- Each organization has developed its own data sharing agreements, such as a release of information (ROI), business associate agreement and provider participation agreements.
  - In 2023, several San Diego organizations participated in the DHCS Authorization to Share Confidential Medi-Cal Information Form (ASCMI) Pilot, which tested the use of a universal, electronic consent form. The evaluation report found that participating Medi-Cal members broadly agreed to share HSSI, including substance use disorder (SUD) information, for the purpose of care coordination.
  - One Advisory Group participant suggested that a future pilot test the implementation of the tools as part of a consent management service.

- On multiple occasions, Advisory Group participants expressed a need for more widespread training and technical assistance.
  - Potential training and technical assistance topics included related to federal and state laws and policy, forecasted trends, Medi-Cal Transformation goals, ECM/CS eligibility and authorization documentation, consent management and funding opportunities.
  - MCPs reported limited uptake on existing training, which may require analysis to inform future training plans.
  - Several Advisory Group participants identified a need for cross-sector education on how stakeholders' different organizational goals inform their approaches to care and measures of success. For example, the approach to curing a disease or illness differs from treating a chronic condition, such as diabetes, or providing ongoing support and guidance on well-being for an individual with a developmental disability.

- Participants also underscored the importance of clear, concise Medi-Cal member education.

- During the last few Advisory Group meetings, participants discussed the current emphasis on implementing policy changes and standardizing tools and processes rather than measuring population health outcomes.
  - Several suggested drawing upon current data sharing guidance to begin identifying the data elements and reports that will be required to analyze progress on population health outcomes.

ASCMI Universal Consent Pilot

In 2023, DHCS piloted their universal consent form Authorization to Share Confidential Medi-Cal Information Form (ASCMI) in three communities including San Diego. 211 San Diego/CIE led the project and partners included:

- 211 San Diego - Community Information Exchange (CIE)
- County Health and Human Services Agency
  - Behavioral Health Services
  - Medical Care Services
  - San Diego Advancing and Innovating Medi-Cal Unit
- Health Net
- Integrated Health Partners
- McAlister Institute
- Metropolitan Area Advisory Committee on Anti-Poverty (MAAC)
- San Diego Health Connect (HIE)
- San Ysidro Health
- People Assisting the Homeless (PATH)

CIE has long had a local, universal authorization form for sharing data but it is not inclusive of 42 CFR Part 2: Confidentiality of Substance Use Disorder Patient Records covered data. The San Diego region was eager to participate in the pilot to pioneer the "last frontier" of sharing the most sensitive behavioral health and substance use data.

The ASCMI Form is a voluntary standard release of information intended to inform Medi-Cal Members of their rights and expressed preferences to share sensitive physical, social, and behavioral health information. The ASCMI forms were designed to be securely stored and managed by contracted health and community information exchange organizations and accessible by the Member, their providers, health plans, county agencies, and others.

San Diego's original ASCMI 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 ASCMI form. The ASCMI form signed by willing participants and uploaded into CIE's consent management system would trigger an alert to the participating managed care plan to 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.

After a few implementation adjustments, the ASCMI form was piloted at 8 different sites across San Diego including outpatient and residential substance abuse treatment programs, street outreach programs and short-term shelters for adults experiencing homelessness, wrap-around services for justice-involved adults with a serious mental illness, and CalAIM contracted ECM and various Community Support providers.

Of the San Diegans who were presented the ASCMI form, 82% signed the ASCMI form and 77% of those who signed agreed to share their substance use information.

Initial ASCMI Pilot results show participants with substance use and behavioral health needs consent to share their information at about the same rate as the general CIE population and found the average length of time discussing and processing the consent across sites was about 5 minutes.

Across all pilot sites, DHCS's evaluation report found that participating Medi-Cal members broadly agreed to share information, including substance use disorder (SUD) information, for the purpose of care coordination.[12]

Ecosystem Capacity Development

Throughout the research process, the majority of Advisory Group participants reported concerns about the pace of change required to align policies, programs, practices and staffing plans with new requirements following the Medi-Cal Transformation rollout in January 2022.

- In larger organizations, responsibility for Medi-Cal Transformation implementation has been diffused across departments and organizations, resulting in a lack of clarity about who can provide what information to resolve challenges that arise.
- Small providers with limited staff capacity and resources to advance expenditures had difficulty adapting their business models, staffing and technology to a claims-based model.
- Providers reported challenges staffing to accommodate the transition from the initial volume of MCP-initiated referrals to the slower, more time intensive community referral process.
- Several organizations also reported that funding does not fully cover the time required to hire and train staff or to proactively engage and serve members.
- Even those stakeholders most involved in the transition have had limited time to master new ways of doing business before the next phase of implementation begins.
- Several stakeholders noted that their primary focus has been on implementation and enrollment without measuring effectiveness.
    - Increasing the amount of time dedicated to rapid feedback cycles and iteration could potentially increase the effectiveness of Medi-Cal Transformation initiatives.
    - In the short- to medium-term, Medi-Cal Transformation partners should expect to experience inefficiencies coordinating among different entities and higher costs of service provision.
- Multiple Advisory Group participants identified a need for an ongoing forum—beyond the support currently provided by PATH CPI—to support cross-sector planning and implementation.

Insights: How Constraints on Data Exchange Affect Client Care

The following scenarios illustrate how current constraints on data exchange limit how quickly Medi-Cal Transformation eligible individuals are identified and connected with services based on the experience of one client, Arthur.

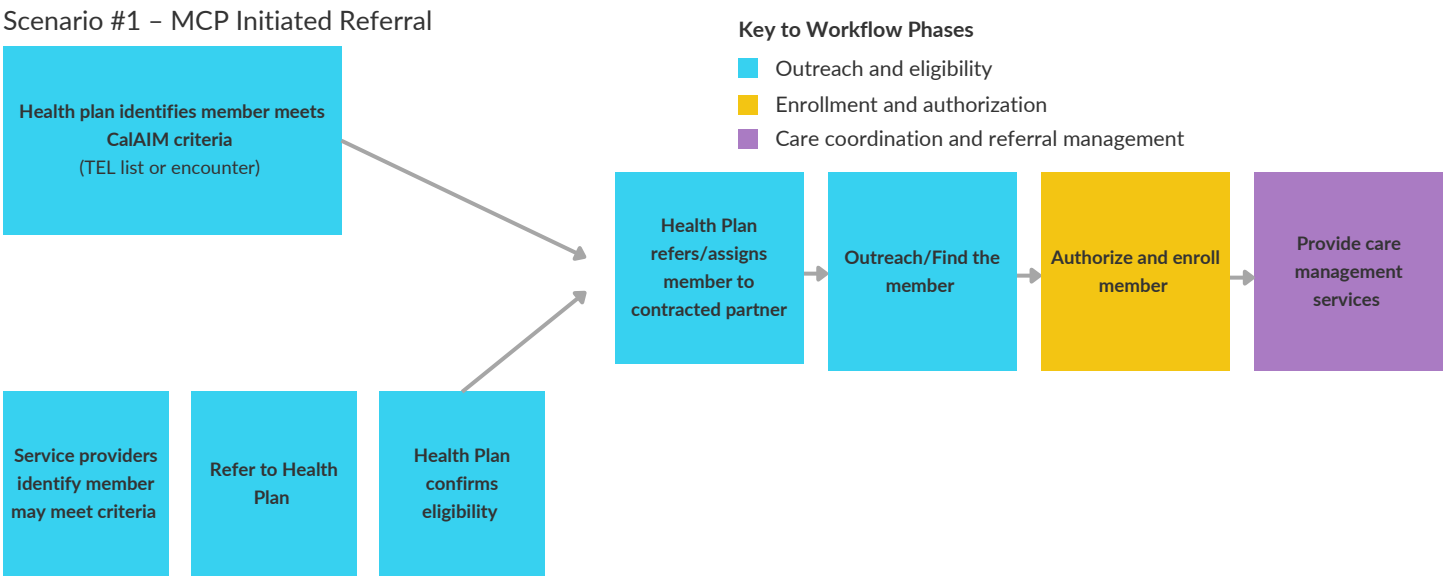
Meet Arthur:

Arthur, 56, has been living in and around a local park for 10 years. Two weeks ago, he broke his wrist in a fall. He was transported to the emergency department with a severely infected wrist and high blood alcohol level. While at the hospital, Arthur shared that he used alcohol to manage his severe depression and anxiety.

The following scenarios provide a snapshot of a client's experience at different points in the Medi-Cal Transformation workflow (Figure 2), which the Advisory Group organized into three phases: (1) outreach and eligibility; (2) enrollment and authorization; and (3) care coordination and referral management.

The report also includes several scenarios that highlight broader challenges constraining data sharing. Each scenario is followed by a table summarizing Advisory Group participants' insights on pain points in Medi-Cal Transformation implementation that could be addressed through more robust data sharing policies, processes and infrastructure.

Figure 2: Medi-Cal Transformation Workflow



Outreach and Eligibility

The following scenarios are related to identifying and connecting with potentially eligible members to determine whether they meet program criteria.

MCP-Initiated Referrals

Arthur has already selected a Managed Care Plan following a prior emergency department visit. The MCP identified him as meeting the criteria for two ECM Populations of Focus:

- *Adults and their families experiencing homelessness.*
- *Adults with serious mental health and/or substance use disorder.*

The MCP assigned Arthur to an ECM provider for outreach. The ECM provider looked Arthur up in the plan portal but gets a message that voicemail is full when they call. The ECM provider did not know Arthur had recently stayed at an emergency shelter.

What the Advisory Group Shared:	
Managed Care Plans	• MCPs only need the referral form to verify eligibility. • MCPs do not receive real-time information on how ECM/CS providers are progressing with outreach.
Community Health Centers (CHCs)/FQHCs	• CHCs receive hospital Admission, Discharge, Transfer (ADT) reports from some plans, but may not know which hospital the member was discharged from or where they were assigned or discharged. • CHCs may not receive clinical data that could inform ECM care planning or CS eligibility.
ECM/CS Providers	• Community referrals are the primary source of outreach to potential members, rather than lists of potential members. • ECM/CS providers use MCP portals as the primary source of member information (e.g., contact information, date of birth, demographics, population, diagnoses codes) and may need to research to confirm data is current and accurate. • Members' medical history and service utilization data are dispersed across multiple systems. • ECM/CS providers often cannot access utilization data so that they can locate and timely outreach to them. • Some ECM/CS providers attribute the gap between elevated levels of unmet community needs and ECM enrollment to the time intensiveness of outreach. • ECM/CS providers have to use different processes (e.g., Secure File Transfer Protocol) to provide outreach and encounter data to MCPs at regular intervals (e.g., monthly).

Identifying ECM-Eligible Populations

If the ECM provider had identified Arthur through their day-to-day work, they could have obtained Arthur's consent to refer him to ECM. They could access the CIE to look Arthur up and learn he received his mail at a local nonprofit distribution site and that he had recently stayed at an emergency shelter and visited a food pantry. The provider could use these data to identify Arthur as ECM-eligible.

What the Advisory Group Shared:	
Managed Care Plans	• MCPs follow DHCS guidance to prioritize sourcing ECM/CS referrals from the community. • MCPs are working to identify members that are eligible for ECM/CS based on enrollment in one or more County programs.
County	• The County is mapping existing ECM/CS providers' geographic coverage to ensure that eligible Medi-Cal members can access services near where they live.
Community Health Centers (CHCs)/FQHCs	• Some CHCs have built in data mining capacity to flag patient records and provide notification when a member meets specific criteria. • CHCs want enrollment data from County programs, including mental health, which include ECM-eligible populations.
ECM/CS Providers	• Some ECM/CS providers have leveraged existing data sharing infrastructure (e.g., CIE/HIE) to research MCP members, but usage is not consistent across providers.

Community Referrals of Potentially Eligible Members

Arthur is known to several other community-based organizations who work with unhoused individuals with substance use disorders, but they did not know when or how to refer Arthur for ECM or CS services.

What the Advisory Group Shared:	
Managed Care Plans	• ECM only requires a referral form indicating Population of Focus criteria the member meets. • Each MCP has its own referral forms and completion guidance. A universal referral form is being piloted.
ECM/CS Providers	• ECM providers experience administrative burden working in multiple systems to identify, authorize and enroll Medi-Cal Transformation-eligible individuals. • ECM/CS providers rely heavily on member self-report when conducting eligibility screens, but do not have access to diagnoses or utilization data to streamline eligibility verification. • Some ECM/CS providers reported that the language used in the universal ECM enrollment form was a barrier to organizations not familiar with medical terminology. • Some ECM/CS providers want primary care to provide diagnoses to complete referral forms and inform care planning. • An ECM/CS provider contracted with an MCP can submit a referral form through the MCP's portal. • Providers need ongoing training to keep up with changes to processes and documentation and to navigate staff turnover.
Non-Contracted Entities (NCEs)	• NCEs do not have access to the MCP portal to confirm an individual's health plan or see if the member is already enrolled in ECM or CS. • NCEs can submit either a plan-specific enrollment form or the pilot universal form via secure email. Guidance for completion and documentation varies by plan.
Self-Referrals	• Individuals who are not enrolled in Medi-Cal receive information on how and where to apply but only providers approved to offer enrollment assistance can help them complete the application, which can delay enrollment.

Hospital Discharge Planning and Referrals

Now that Arthur is in the hospital, the discharge planner or social worker emails or faxes a referral for ECM and recuperative care to the MCP.

- *If Arthur is discharged before the referral is processed, the ECM provider may not have up-to-date contact information to locate him.*
- *In some cases, Arthur's discharge from acute care may be delayed waiting for authorization.*

What the Advisory Group Shared:	
Managed Care Plans	• MCPs prefer to receive faxed referrals for certain community supports. • MCPs typically do not maintain 24/7 business hours (e.g., nights, weekends) to respond to authorizations for post-acute care.
Hospital Systems	• Hospitals discharge patients 24/7, and not having 24/7 authorizations often delays transitioning patients out of acute care settings beyond 72 hours. • Hospitals find it easier to submit referrals for ECM and CS services, such as recuperative care, to MCPs via efax rather than going outside their workflows to use the portals. Some MCPs prefer faxed referrals. One MCP has a toll-free transition of care number. • Hospitals do not know if patients are enrolled in ECM or if the patient is already receiving services through CS. • Hospitals must send referrals individually, not batched. • Hospitals are required to get pre-acceptance of recuperative care but do not have real-time data on provider capacity. Some recuperative care providers are reluctant to accept referrals that require frequent reauthorization. • Hospitals do not have real-time data on shelter capacity or ability to directly connect members to shelter on discharge. • Hospital discharge planners often struggle to coordinate between MCP utilization and CalAIM staff to coordinate post-acute care transitions. • Hospitals can send clinical notes and check the approval status of County mental health plan referrals inside the County portal (typically 3 days), but facility coordination (e.g., bed availability, wait list status) is done by phone. • Hospitals have responded to delayed authorizations from MCPs by referring patients to services that are available upon discharge rather than trying to access CalAIM benefits, such as ECM and recuperative care. • Processes do not currently exist to screen for presumptive/retroactive authorization of recuperative care for hospitals and providers meeting specified criteria.
San Diego Health Connect	• HIE currently has capacity for (near) real-time exchange of discharge data, but it is not fully utilized.
ECM/CS Providers	• ECM providers are not alerted to pending hospital discharges to trigger follow-up. • Referrals ECM providers receive from MCPs may not include the member's current phone number or address.

Duplicate Referral of an ECM-Enrolled Member

Arthur has now had multiple emergency room visits. An ECM provider identifies Arthur as being Medi-Cal Transformation eligible but does not know whether Arthur is already assigned to or enrolled with another ECM provider.

What the Advisory Group Shared:	
Managed Care Plans	• MCPs report frequent duplicate referrals to ECM, which result in inefficiencies related to timely billing and claims. • Not all MCPs make the name of the rendering provider available so that other providers can check where the individual is already assigned or enrolled.
Hospitals	• Some hospitals can attach a referral to client record but cannot see if they have been assigned. If hospital staff call, they are often connected with MCP staff whose role may not be to respond to questions about whether a member is enrolled in ECM. Hospitals want MCPs to provide a contact list to increase timely connections with appropriate MCP staff.
ECM/CS Providers	• A provider can search authorizations to check assignment/enrollment status when they are contracted with the plan but may require research to determine rendering provider and reconnect the person or arrange reassignment.
Non-Contracted Entities (NCEs)	• An NCE that refers an individual has no insight into whether they are assigned or enrolled with an ECM/CS provider.

Authorization and Enrollment

Authorization Process

A new team member for an ECM provider submits the universal referral form for Arthur but is not clear on what documentation the MCP needs, delaying authorization.

What the Advisory Group Shared:	
County Health and Human Services	• Some County contracts previously allowed eligible clients to enroll in a program while they waited for Medi-Cal MCP or County Behavioral Health Plan authorization (pre-authorization/presumptive eligibility), which allowed community-based providers to help individuals quickly access services while minimizing gaps in service, the cost of outreach, and the financial risks associated with the provision of care under a fee-for-service contract.
ECM/CS Providers	• ECM/CS providers confirm the member meets criteria for at least one population of focus, assesses for program duplication and submits either the plan-specific or universal form using the plan portal. • ECM/CS providers working with multiple MCPs create and update "how to" guides to address differences between what documentation MCPs require for authorization. • Providers are piloting a universal referral form. • Some ECM/CS providers have created a simplified form NCEs can use to submit referrals to them, acting as an intermediary between MCPs and NCEs. • Processes do not currently exist to screen for presumptive/retroactive authorization of ECM for hospitals and providers meeting specified criteria.
Non-Contracted Entities (NCEs)	• Not all MCP forms offer guidance to NCEs on what happens after the form is submitted or how to follow up. • Some MCP forms reference additional documentation without specifying what is required. • NCEs that submit forms directly to MCPs have no insight into authorization.
Self-Referral	• Individuals who self-refer for housing insecurity can leverage CIE to document their eligibility and provide a screenshot to the MCP portal.

Consent

Arthur is unhoused with a substance use disorder. He wants to share his housing status and other demographic and social service information with his primary care provider and managed care plan so that he can be authorized to access Community Supports housing services.
Federal and State law mandates that all partners obtain members' approval before sharing sensitive data. Many systems have different consent models that create challenges facilitating holistic care coordination.

What the Advisory Group Shared:	
Managed Care Plans	• MCP consent requirements vary by plan and portal.
County of San Diego	• Consent for County departments varies by program; many require consent at intake.
2-1-1 San Diego/CIE	• CIE has an existing universal consent that is used to opt-in to CIE, with over 350,000 currently consented within San Diego. Individuals are being consented in at point of care for many organizations. • The CIE and several local organizations that piloted a consent management process (ASCMI) learned that the majority of members are willing to share data for care coordination and require provider training and technical assistance on how to communicate the value to members.
San Diego Health Connect	• San Diego Health Connect uses opt-out model for consent. • Data Exchange Framework is expected to provide a legal pathway (e.g., role-based licensing) to allow data to flow between organizations where traditionally there were constraints on data sharing between covered and non-covered entities. • Consent hinges on having mechanisms to determine where data should and should not flow, including "break the glass" exceptions that allow disclosure in clearly defined emergency situations.
Regional Task Force on Homelessness	• HMIS requires informed consent before clients are entered into the system. Use of a multiparty consent form allows information to be shared in HMIS and with CIE.
ECM/CS Providers	• Federal and state laws to protect patient privacy represent risk, constrain data exchange.
All Stakeholders	• High opt-in requires ongoing education and training for organizational staff, an understanding of where in the organization's workflow to seek consent, easy-to-use materials and the ability to communicate the benefits of consent to members in a clear, compelling manner.

Care Coordination and Referral Management

Care Coordination

Arthur receives care from multiple providers, but only the ones contracted with his MCP can access the care plan. Care team members also cannot refer Arthur to other providers.

DHCS requires all providers be able to use the member's care plan, but tools vary across MCPs and are not shared. Providers are required to log into multiple different systems to coordinate referral status and outcomes.

What the Advisory Group Shared:	
Managed Care Plans	• Each MCP has its own transition of care plan tool to collect member data. • MCPs do not receive real-time information on progress related to care planning.
County of San Diego HHSA	• County BHS currently operates separate electronic health records for mental health and substance use disorder services, with plans to launch an integrated system for providers in September 2024.
Hospitals	• Some hospitals use CIE to send closed loop referrals.
Regional Task Force on Homelessness	• HMIS is primarily used for reporting purposes to HUD, not for care coordination outside of those who are experiencing homelessness, and federal regulations do not allow HMIS to ingest additional data elements from CIE.
ECM/CS Providers	• ECM/CS providers only have access to care plans in MCP portals where they are contracted. • DHCS requires contracted ECM/CS providers to share care plans with a medical home or primary care provider. • ECM/CS providers do not have a pathway to coordinate referrals directly with other providers offering different services. • When patients/beneficiaries change MCPs, ECM/CS providers are no longer able to access information about the client contained in the MCP portal. ECM/CS providers maintain their own systems and client records to ensure access to data over time.
Non-Contracted Entities (NCEs)	• NCEs cannot access care plan tools in the MCP portals; they share information on printed forms.

Referrals to Community Supports and Other Supportive Services

Arthur is eligible for housing supports and medically tailored meals, but each plan has a different form and requires different documentation from providers. Providers want a streamlined referral and process.

Through Medi-Cal Transformation, MCPs can offer up to 14 different Community Supports that allow Medi-Cal members to address health-related social needs and ideally prevent the need for more intensive, costly care.

What the Advisory Group Shared:	
Managed Care Plans	• Each MCP interprets Community Supports eligibility criteria differently, resulting in different documentation requirements for authorization (e.g., housing, meals). • Some MCPs require an itemized budget to accompany the lease to approve housing expenditures. • Some MCPs reduce wait times to access services through direct connections with community-based service providers via CIE in advance of closed loop referral requirements going into effect in January 2025.
ECM/CS Providers	• Providers are required to submit a separate CS referral for each of three housing services—the "housing trio"—even though they are often delivered together. • Providers currently use plan-specific CS referral forms and workflows rather than universal tools. • ECM/CS providers frequently call MCPs to get authorization for transportation.

Summary of Key Challenges

The key challenges stakeholders experienced are summarized below:

- Use of multiple systems often necessary to complete tasks
- Lack of transparency around contact and utilization data
- Potential for duplicative outreach efforts
- Variability in the forms and documentation required to obtain service authorization
- Limited insight into provider capacity for services
- Delays in confirmation of eligibility and authorizations for CS services
- Variable access to care plan tools and information among team members

Future State of Data Exchange

In the future state, key stakeholders expressed a need for greater accuracy, transparency and timeliness in accessing member information relevant to their roles. These needs can be met through policy changes, process improvements and enhanced data collection and aggregation.

Clear Policy and Infrastructure Guidance

Critical policy changes include the adoption of a minimum data set, community-based electronic consent management and greater interoperability and streamlined data exchange between MCPs, CIE/HIE, the County, electronic health record systems and other data sources.

Establishing a Minimum Data Set

One way CalAIM aims to improve member care is through standardized information exchange, which can reduce administrative burden and minimize the number of times a member needs to recall and document their health histories and needs. Starting in 2021, DHCS began issuing data sharing and reporting guidance to support stakeholders in preparing for more robust data exchange requirements.

The San Diego PATH (Providing Access & Transforming Health) CPI (Collaborative Planning & Implementation) collaborative identified data-related barriers to the implementation of Enhanced Care Management (ECM) and Community Supports, such as non-standardized duplicative data entry requirements and gaps in data collection/availability across the county.

The Data Standardization Workgroup formed in Q3 2023 to identify and address data-related obstacles in the implementation of Enhanced Care Management and Community Supports throughout the county. The workgroup focuses on enhancing client-level or client-related data sharing across participants.

Stakeholders in the San Diego region have been collaborating on a standard minimum dataset for exchange between health care and social services providers. This dataset first focused on 8 stakeholder categories (See Recommendation #B below) to catalog the data elements to be exchanged and most probable data source for the data. The group then spent time prioritizing data to focus on the identification of a minimum dataset along with the identification of value propositions for data sender and receiver in each stakeholder category.

In Fall 2024, the County of San Diego Behavioral Health Services will launch Streamline SmartCare, which will support the integration of behavioral health information from disparate systems that County-funded programs currently utilize into a single EHR. Stakeholders engaged in the PATH CPI Data Standardization Workgroup, led by Intrepid Ascent, are already working to finalize a minimum data set that could be shared across organizations through the CIE or HIE. Entities that participated in the ASCMI pilot are awaiting feedback from DHCS on next steps to refine the tools and secure funding to implement electronic consent management among all stakeholders. In addition, several stakeholders proposed a "no wrong door" policy coupled with enrollment assistance when needed for self-referrals.

By January 2025, MCPs will be required to support closed loop referrals to ECM/CS providers and other local community organizations. The implementation of these requirements will necessitate more stakeholders developing the capacity for bidirectional data exchange.

Each of these initiatives will require state and/or federal funding, such as Center for Medicaid and Medicare Services 90/10 funding or DxF technical assistance grants, to support onboarding, training and ongoing technical assistance for stakeholders to help them fulfill Medi-Cal Transformation program requirements.

Data Exchange Infrastructure Grants and Technical Assistance

Organizations that need to develop their capacity to support data exchange can access funding and technical assistance through several sources to help cover their costs.

The Providing Access and Transforming Health (PATH) Technical Assistance Marketplace provides funding to organizations to work with approved vendors to establish the data infrastructure necessary to implement ECM/CS services. For example, 2-1-1 San Diego/CIE is approved to provide technical assistance on community-wide data sharing, which covers shared governance, data integration, and legal frameworks and consent management. 2-1-1 also has the capacity to develop asset maps, use cases, and data interoperability and scoping plans to support a community-wide data sharing infrastructure.

Similarly, health care providers and intermediaries that sign on to the Data Exchange Framework (DxF) must meet certain secure, real-time data exchange requirements as part of their commitment to providing safe, effective, whole-person care. DxF signatories are eligible for several grant programs. San Diego Health Connect is one of the nine approved QHIOs in the State. Several health and community based organizations and San Diego Health Connect received funding to connect data and meet DxF requirements. QHIO Onboarding Grants, which cover costs associated with connecting the QHIO to the signatory's electronic record system. Technical Assistance Grants offer signatories a more customized, flexible option to address technical and operational barriers to DxF implementation.

Streamlined Access through Process Improvements

Advisory Group participants and interviewees also identified process improvements at each stage of the Medi-Cal Transformation workflow, which if implemented, could support a more robust data exchange infrastructure.

Two significant process improvements related to eligibility and outreach include establishing partnerships between MCPs and programs serving populations of focus. Specifically, non-contracted partners can help identify eligible populations through their current services and work on screening and referring to contracted organizations to increase the flow of referrals to contracted providers. These organizations could also enhance existing population health tools to populate member assignment/enrollment status, medical history and service utilization to support eligibility screening and ongoing care coordination. To improve authorization and enrollment, the Advisory Group proposed further streamlining the universal ECM referral form to reduce terminology barriers and establishing a mechanism to support warm hand-offs as part of hospital discharge planning to post-acute care settings. Stakeholders also proposed creating dashboards to provide real-time capacity data and establishing presumptive authorization processes to streamline and accelerate authorizations across the provider network.

In addition, stakeholders generated a number of ideas for process improvements related to care coordination and community supports. To meet DHCS requirements, several stakeholders identified the need to standardize care plan tools and make them accessible to all members of the care plan team, whether or not the provider is contracted by the specific MCP. And because housing services are often provided jointly, stakeholders expressed a need for a single, streamlined referral form and authorization workflow for housing transition navigation services, housing deposits and housing tenancy sustaining services, as well as an itemized budget for housing costs. Future priorities include streamlining the authorization process for home modifications for older adults and people with disabilities, medically-tailored meals and transportation services.

Data Aggregation

Finally, Advisory Group participants identified a variety of data elements that could be incorporated into a minimum data set and aggregated in a shared data system. For example, MCPs are interested in real-time compliance data related to outreach, assessment and care planning timeframes. Community-based ECM/CS providers specifically expressed a need for up-to-date client contact information, service utilization history and medical diagnosis data to streamline outreach, reduce reliance on member self-report during eligibility screening, and track member medical appointments, visits and progress toward care plan goals. Providers also want to know where MCPs have assigned and enrolled members to avoid duplicating outreach efforts with other providers. Further analysis is needed to clarify which of these data points may already be integrated into the statewide data exchange framework, which facilitates the exchange of a defined data set of healthcare information through local Qualified Health Information Organizations and data intermediaries, such as San Diego Health Connect 2-1-1 San Diego/CIE.

Roadmap of Medi-Cal Transformation Data Sharing Recommendations

The following roadmap highlights the recommendations, action steps and policy and regulatory drivers that the advisory group identified during future state discussions and informational interviews, as well as by other local stakeholders with insight on the current data infrastructure. The first set of recommendations is specific to Medi-Cal Transformation whereas the second set applies to broader concepts related to data sharing.

- *Recommendations* address the pain points and inefficiencies Advisory Group participants experience relative to data sharing. These recommendations reflect feedback provided in the "Current State of Data Exchange" section but are not weighted in order of importance or sequenced in terms of which recommendations must be addressed first.
- *Action steps* provide a high-level overview of the sequence of tasks and decisions that are necessary to address the recommendation, including steps that are already planned or underway.
- *Data contributions* represent the types of data, and in some cases data elements, that data sources could contribute to address the recommendation.
- *Policy drivers* are the new and existing laws and regulations, documents and initiatives that inform the action steps and data contributions.

Medi-Cal Transformation Data Sharing

Recommendation	Action Steps	Data Contributions	Policy and Regulatory Drivers
Recommendation #1: Enhance capacity to share contact and utilization information to streamline member outreach and increase Medi-Cal benefits access.	• Develop use case(s) and workflow diagrams common pain points in the outreach process. • Identify processes and data elements necessary to timely and effectively reach the member. • Establish avenues and recommended use among providers to access contact and utilization data for outreach, including the possibility of creating authorization check tools in CIE/HIE. • Establish avenues for providers to document outreach efforts in real-time.	• Contact Information (e.g., current and alternate phone, email and mailing address) • Client Data (e.g., change in coverage, demographics) • Utilization Data (e.g., last contact, current program enrollment)	• Data privacy and security • AB 133 and other laws and regulations governing data sharing, CalAIM Data Sharing Authorization Guidance (October 2023)

Recommendation	Action Steps	Data Contributions	Policy and Regulatory Drivers
Recommendation #2: Increase transparency of Medi-Cal related program enrollment status to eliminate duplicative outreach.	• Identify data elements necessary to confirm whether an individual is enrolled with another provider. • Establish universal avenues to verify or check assign or enrolled status outside of individual portals, that referring providers can use to determine whether an individual is already enrolled and notify provider and member of option to retain or switch providers	• Current Plan & Contact Information • Confirmation of Enrollment • Current ECM/CS Provider Assigned or Enrolled & Contact Information • Last Contact Date	• Data Exchange Framework USCDI v2-recommended data sets or national standards • Data privacy and security • Data quality/integrity standards
Recommendation #3: Leverage existing data sets to identify Medi-Cal Transformation eligible individuals for ECM enrollment	• Review existing ECM policy guidance to determine eligibility for each Population of Focus • Develop informational campaign to educate organizations working with Populations of Focus about ECM/CS benefits. • Establish partnerships with non-contracted providers and target populations to identify eligible members and leverage universal referrals • Identify existing data sets for each Population of Focus • Review existing data sets to determine what data is already captured relative to additional data required by the Data Exchange Framework or national standards and recommendation from Intrepid Ascent Data Standardization Workgroup document (see Appendix X) • Prioritize Populations of Focus for ECM enrollment based on volume of community referrals and infrastructure capacity. Use and leverage existing technology (CIE/HIE) or build data integration with existing electronic health records or case management systems to populate ECM eligibility data based on diagnosis codes. • Further refine tools to incorporate additional filters (e.g., potential to improve health outcomes, decreased use of high-cost services, access to relevant data sources)	• CoC HMIS • ADT Feeds • ACES Screening Data • Justice-Involved Pre-Release Eligibility • Adult Protective Services and Home and Community-Based Services Data • Skilled Nursing Facility Minimum Data Set Assessment • California Children's Services and Whole Child Model Enrollment Data • Specialty Care Center Data • Adoption Assistance Program or Family Maintenance Eligibility and Enrollment Data • California Wraparound Plan Data • Maternity Care Programs	• CalAIM Enhanced Care Management Policy Guide (February 2024) • Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiatives (October 2023) • Data Exchange Framework USCDI v2-recommended data sets or national standards • Consent management

Recommendation	Action Steps	Data Contributions	Policy and Regulatory Drivers
Recommendation #4: Establish a standardized, streamlined practice for community referrals to connect Medi-Cal Transformation eligible individuals to MCPs and CS providers.	• Convene group on data governance. • Review Medi-Cal Community Supports Policy Guide and the Data Exchange Framework USCDI v2-recommended data sets to confirm what data is needed to confirm eligibility for each type of service. • Prioritize populations of focus for CS enrollment based on volume of community referrals, potential to improve health outcomes and/or decreased use of high-cost services and access to relevant data sources. • Leverage existing technology (CIE/HIE) or build data integration with existing electronic health records or case management systems to populate eligibility data. • Conduct engagement and training on why to share data and how to make data sharing more approachable. • Share data appropriately	• Contact Information (e.g., current and alternate phone, email and mailing address) • Client Data (e.g., change in coverage, demographics) • Utilization Data (e.g., last contact, current program enrollment)	• Medi-Cal Community Supports or In Lieu of Services Policy Guide • Data Exchange Framework USCDI v2 or national standards • Member/patient privacy • AB 133 and other laws and regulations governing data sharing, CalAIM Data Sharing Authorization Guidance (October 2023)
Recommendation #5: Establish a mechanism for ensuring warm handoffs (care transitions) from discharge planning to ECM/CS providers prior to members leaving the hospital.	• Engage MCPs, hospitals, PCPs and ECM/CS providers in a workgroup to identify workflow bottlenecks (e.g., operating hours, communication methods) to warm handoffs to short-term post-hospitalization housing, recuperative care and medically tailored meals. • Build on existing workflows (e.g., EPIC) and explore alternative avenues to verify and make direct connections (e.g., CIE) to increase access to qualified providers. • Establish standard practice for engaging ECM lead care managers to obtain consent, conduct assessments and develop care plans. • Create simultaneous notification from hospital to MCP and a prioritized list of providers to streamline intake. • Celebrate wins and conduct ongoing training for providers responsible for warm handoffs to maintain knowledge of policies and practices.	• Provider capacity	• Presumptive/retroactive authorization or maximum turnaround time, CalAIM Enhanced Care Management Policy Guide (Updated February 2024) • DHCS Guidance on Closed Loop Referrals, CalAIM Population Health Management Policy Guide (August 2023)

Recommendation	Action Steps	Data Contributions	Policy and Regulatory Drivers
Recommendation #6: Streamline authorization for Community Supports related to housing and medically tailored meals.	• Engage MCPs, the PATH CPI Provider workgroup and other identified stakeholders to determine what data is needed to develop a streamlined universal referral form and authorization documentation for the three CS housing services, including current efforts to standardize housing deposits. • Identify and address bottlenecks in the existing workflow. • Leverage existing CIE/HIE infrastructure. • Obtain approvals for the universal housing form and required documentation. • Educate and enlist contracted and non-contracted housing providers to pilot the process. • Document lessons learned to revise the form and workflow based on MCP and provider feedback. • Replicate the process with service-specific workgroups to develop similar tools for medically tailored meals and other Community Supports.	N/A	• Joint authorization for housing supports • Multi-party consent

Recommendation	Action Steps	Data Contributions	Policy and Regulatory Drivers
Recommendation #7: Enable all care team providers and the member to access the care plan and enable providers to refer to each other to provide holistic care and ensure continuity of care.	• Convene cross-section of health and social services providers, including EMC providers, to map current workflows and use case(s) for shared care plan tool, building on existing workflows (e.g., EPIC) and connection points whenever possible. • Determine what level of information (e.g., referral, diagnoses, case notes) authorized providers need and when to deliver effective care. • Develop processes for data reconciliation between care plans. • Utilize existing infrastructure (e.g., CIE, HIE) to develop and pilot a tool accessible to all authorized providers. • Use lessons learned from the provider pilot to enable members to access their own care plans.	• Referring provider • Receiving provider • Diagnoses code	• Establish and implement policy to enable care plan sharing among all authorized providers. • DHCS Guidance on Closed Loop Referrals, CalAIM Population Health Management Policy Guide (August 2023)

Recommendation #8: Leverage existing data sets to provide insights for process improvement, outcomes and impact of CalAIM services on clients.	• Identify common data elements across IPP measures, DHCS evaluation and MCP scorecard data.
	• Develop dashboard tools to aggregate and display outcomes data from across region.
		• Claims and encounter data
		• Number/percent of assessments completed in 45 days
		• Completion of care plans
		• Number/percent fulfill care plan goals
		• Number/percent of ECM-enrolled members engaged once a month
			• CalAIM Data Sharing Authorization Guidance (October 2023)
			  ◦ DHCS CalAIM Section 1115(a) Demonstration
			  ◦ Revised Evaluation Design (February 2024)
			• CalAIM Incentive Payment Program Progress Report Submission 5
			• MCP scorecards w/ provider incentives
			• ECM and Community Supports HSPCS Coding Guidance (Updated June 2024)

General Data Exchange Priorities

Recommendation	Action Steps	Data Contributions	Policy Drivers
Recommendation #A: Create a contracted provider directory	• Establish mechanism for monthly export of contracted providers or direct connection between MCP databases and CIE	• Provider organization name, website and contact information	• DHCS public resource database and transparency requirements

Recommendation #B: Establish a minimum data set shared among MCPs, healthcare and social services providers and data exchange intermediaries.
 	
Draft/final data set approved by stakeholders Fall 2024.
	• Continue to convene the PATH CPI Data Standardization Workgroup
	• Identify top data elements to share by stakeholder group based on the value proposition to sender and receiver (e.g., reporting and regulatory requirements, frequency of data exchange, volume of referrals)
	• Create a data dictionary with a standard definition for each data element.
	• Seek feedback from MCPs, ECM/CS providers
		• County Health and Human Services Agency
		• San Diego County Public Safety Group
		• Medi-Cal Managed Care Plans
		• CalAIM Contracted Providers (ECM and Community Supports)
		• Homeless Management Information System (HUD-funded homeless service providers)
		• Federally Qualified Health Centers
		• Ambulatory Care Clinical Providers
		• San Diego Health Connect (HIE)
			• Data Exchange Framework or national standards
			• CalAIM Data Sharing Authorization Guidance (October 2023)
			  ◦ Data Elements to be Exchanged
			  ◦ Requirement to Exchange Health and Social Services Information
			• Gravity/Civitas SDOH Standards

Recommendation #C: Establish shared interpretation of federal and state law, and opportunities to eliminate barriers to data exchange.	• Develop use cases to identify barriers to data exchange in federal and state law by sector. • Convene legal compliance professionals from different sectors to clarify whether the barrier is real or whether it can be addressed through policy, education and training, infrastructure, or incentives. • Identify and develop solutions, as well as key metrics for success. • Conduct education and training to encourage adoption of solutions.	N/A	• AB 133 and other laws and regulations governing data sharing, CalAIM Data Sharing Authorization Guidance (October 2023) • Health Insurance Portability and Accountability Act • Public Health (Title 42) and Public Welfare (Title 45) sections of the U.S. Code of Federal Regulations • California Welfare and Institutions Code covering social services. • California Penal Code • California Confidentiality of Medical Information Act

Recommendation	Action Steps	Data Contributions	Policy Drivers
Recommendation #D: Collaborate to integrate and expand patient consent processes to share personal data for purposes of care coordination.	• Engage legal compliance professionals in analyzing lessons learned from DHCS Authorization to Share Confidential Medi-Cal Information (ASCMI) pilot. • Develop use cases to analyze the different problems that need to be solved by population and service type and the purpose for giving consent (e.g., upload, share with specific entity, share with data hub, aggregate). • Identify appropriate stakeholders to translate between different entities to define pain points in stakeholder workflows and develop regional consent management service. • Gain approval/adoption of universal consent form established by DHCS and align consent models (e.g., CIE, HIE, QHIOs). Ensure language is accessible to users. • Develop and deliver training, education, technical assistance and incentives to providers to ensure informed consent adoption. • Providers prioritize member consent.	N/A	• Data privacy and security • Universal adoption of community-based electronic consent management policy • Incentives for adoption
Recommendation #E: Have agencies adopt internal processes to move toward real-time, bi-directional data exchange or APIs	• Survey providers to assess capacity and readiness for secure bi-directional data exchange. • Determine how to prioritize and accommodate providers using a range of technologies, including no technology. • Conduct education and training to build support for data exchange among providers based on capacity and readiness. • Develop integrations for committed data exchange partners.	N/A	• Data privacy/security • DHCS closed loop referrals

Conclusion and Next Steps

San Diego has a unique opportunity to build on its robust data exchange infrastructure by connecting more partners into the CIE/HIE to fulfill Medi-Cal's vision for more coordinated, equitable, person-centered care. To effectively respond to the scenarios and recommendations outlined in this report, however, the ecosystem would benefit from taking the following next steps:

Develop a Shared Work Plan

Use this report to create a work plan that identifies the stakeholder commitments, timelines and detailed action steps for each recommendation.

Expand Ecosystem Capacity

Identify an ongoing forum anchored by a core group of stakeholders to guide the work plan, as well as ongoing and ad hoc workgroups to respond to specific recommendations. Ensure that each workgroup grounds its work in clearly defined use cases and includes representatives who have direct experience with the problem that needs to be solved and can communicate both barriers and solutions to a diverse audience.

Advocate for Policy Change

The rapid pace at which Medi-Cal initiatives have been rolled out risks losing sight of efforts to achieve equitable access. Larger entities typically have both the staff time and resources to accommodate transitions, and longer rollout periods may be needed to effectively educate, onboard and integrate smaller providers working with target populations of focus into the broader ecosystem.

Explore Additional Funding Sources

To continue to enhance the ecosystem's capacity to integrate new organizations and provide more accessible pathways for self-referral and records access, stakeholders will need funding for a collaborative planning forum to work through policies, processes and required data elements and tools by population and service type. Funding will also be needed to support both one-time and ongoing infrastructure development, training and technical assistance to onboard new partners, refresher training for existing partners and capacity building related to legal compliance. Stakeholders would benefit from jointly exploring and prioritizing needs to align with upcoming CalAIM funding opportunities, as well as opportunities for federal funding.

Appendix A: Data Infrastructure Asset Map

The following tables provide a snapshot of Advisory Group participants' responses to a survey inquiring about their existing data infrastructure, current data sharing capacity and future technology and data sharing priorities.

Organization	Integrated Health Partners of Southern California (IHP)	Regional Task Force on Homelessness San Diego
Current Data System	IHP uses multiple custom and off-the-shelf technology platforms to manage the health records of contracted, non-contracted, self-pay and sliding scale patients for nine health centers. Their primary system, Arcadia Analytics, is a population health tool that supports IHP's Clinically Integrated Network (CIN) as it adopts best practices for patient care and performance in value-based payment models/contracts with our health plans. System users include informatics and operational staff, as well as clinical teams at both the network and individual health center levels. IHP also receives clinical and patient enrollment data from external feeds (e.g., SD HIE, Quest, CAIR, claims) and has direct access to various third-party web portals and SFTP file sharing locations. Limited staff have front-end, read only access to CHC EHR platforms. IHP's technology platform is required to adhere to U.S. Health Resources and Services Administration and National Committee for Quality Assurance Standards.	The Homeless Management Information System (HMIS) of record is Clarity Human Services, an off-the-shelf, web-based system provided by Bitfocus. Homeless services providers who are part of the San Diego Continuum of Care use the system to collect data on individuals and families who are unhoused or at risk of homelessness, as well as the housing and services provided to them. Staff at each organization enter data on the clients they serve.
Current State of Data Sharing	Patients are added to the system through enrollment and claims feeds, which are refreshed monthly. Clinical connectors refresh relevant patient information every 24-48 hours. IHP follows best practices for data security and complies with regulatory requirements for the sharing/transfer of PHI related data. Data use and sharing is governed by a network-level Data Governance Committee and Compliance Committee, each comprised of member health center representatives and subject matter experts. An internal IT Steering Committee works to develop policies and procedures pertaining to the safe and compliant use of data, data systems and technologies used to house and transmit data. Consent and data use agreements, including Business Associate Agreements and MSAs. IHP SoCal shares data with member health centers based on permissions and patient assignment, and with health plans to support quality measure performance. IHP's system does not have the capacity for bi-directional data sharing.	Providers give clients a verbal explanation and use a consent poster before they are entered into HMIS and are asked to sign a consent form once they are in the system. Clients that sign the Multiparty Authorization to Use and/or Disclose Information agree to share specific information with 2-1-1/CIE and participating social services agencies. HMIS data is also shared with the State of California Homeless Data Integration System (HDIS) and the four MCPs. Data is shared manually or via scheduled reports. Data sharing is restricted by federal and state laws and regulations governing data sharing (e.g., HIPAA) as well as by funders such as the U.S. Department of Housing and Urban Development and the Substance Abuse and Mental Health Services Administration. Criteria for data sharing and sample agreements are included in the San Diego County Continuum of Care Homeless Management Information Systems Policies and Procedures. Closed loop referrals among participating agencies are currently handled within HMIS.

Organization	Integrated Health Partners of Southern California (IHP)	Regional Task Force on Homelessness San Diego
Future Technology and Data Sharing Priorities	IHP is currently focused on platform stabilization and medical and prescription claims ingestion. They would like to expand their capacity to share data that supports improved patient care and ECM/CCM initiatives with entities that meet requirements and are exploring a solution that would allow for closed loop referrals to improve care efficiency. They are also interested in claims data from payers and hospital discharge data populated with standard diagnoses.	HMIS set up and design along with the HUD HMIS standards do not allow HMIS to ingest information from other systems.

Organization	San Diego Health Connect (SDHC)	San Diego Wellness Collaborative (SDWC)
Current Data System	SDHC uses several off-the-shelf data systems to support its clinical data warehouse, patient matching, clinical query portal and data integration for patients across San Diego and Imperial County patients. Systems include a Health Information Exchange (HIE)-focused solution called Outcome Healthcare, 4Medica to improve patient matching and health data quality and Mirth Connect for data interoperability. Current system users include clinicians, case managers, paramedics and health plans.	SDWC uses HealConnect, developed by Sagitec) to support care coordination for populations eligible for Enhanced Care Management, Housing Community Supports and Community Health Worker services, as well as the documentation of community-based workforce activities for reporting and billing. Users include the Neighborhood Networks hub team and a community-based workforce that includes ECM Lead Care Managers, CS Housing Navigators, Community Health Workers and their supervisors.
Current State of Data Sharing	SDHC was awarded Qualified Health Information Organization (QHIO) status in October 2023 based on its demonstrated ability to meet state data exchange requirements. SDHC currently shares information with at least 60 other organizations, and patients are automatically added to the system unless they choose to opt out. Data sharing is governed by the SDHC Participant Policies and Procedures established by its Board of Directors with support from workgroups that provide input on patient consent requirements, privacy and security and subscription fees. Mechanisms for data sharing include a Business Associate Agreement and Participation Agreement. Other government and regulatory bodies, as well as specific laws and policies, may influence how data is used and shared.	Members come from both MCPs and community referrals and are added to the system through consent, opt-in and intake and enrollment process that include a release of information form. SDWC uses both the CIE/HIE and MCP portals to look up information to support care coordination. Decisions about Medi-Cal services are governed by DHCS, and HIPAA governs how health information is shared. Currently, data is shared with MCPs and the community-based workforce using a manual process through secure email or SFTP. SDWC is working with the CIE/HIE on future bi-directional process.
Future Technology and Data Sharing Priorities	SDHC recently migrated to the Outcome platform, and they plan to configure it to allow for closed loop referrals by the end of 2024.	SDWC is interested in greater interoperability and streamlined data exchange with the CIE/HIE and MCP portals and is currently planning to integrate its case management system with the CIE/HIE to better support the community-based workforce and improve care coordination for enrolled members.

Organization	Health and Human Services Agency Aging and Independence Services In Home Supportive Services (IHSS)	Health and Human Services Agency - Aging & Independence Services - Multipurpose Senior Services Program (MSSP)
Current Data System	IHSS uses a custom-built system called Case Management, Information and Payrolling System (CMIPS) to manage applicant, client and service provider data, reporting and customer support. System users include IHSS direct staff, such as social workers, supervisors and management and administrative support staff.	MSSP uses an off-the-shelf tool called MSSPCare Online (MCO) to support case management record keeping and billing for older adult clients over the age of 65. Users include clinical, social services, fiscal and administrative staff.
Current State of Data Sharing	Users manually enter clients into the system, which does not require consent and automatically interfaces with Medi-Cal information. Disaggregated data and information can be shared through contract agreements or during a public health emergency and/or severe weather threat. Data sharing is regulated by the California Department of Social Services the County of San Diego Business Accuracy and Compliance Department, as well as HIPAA regulations. Mechanisms to support data sharing include a Release of Information (ROI), a Memorandum of Understanding, a Memorandum of Agreement and a Data Use Agreement. IHSS currently shares data with partners such as SDG&E, CalEOS, Senior Nutrition Programs, Home Safe and cities. IHSS has the capacity for bidirectional data sharing with the state SAFE server at which point data is de-identified per HIPAA standards.	The program adheres to HIPAA regulations, and clients must consent to be entered into the system. Program data is shared with the California Department of Aging.
Future Technology and Data Sharing Priorities	IHSS is not currently exploring system upgrades or enhanced data sharing.	MSSP is not currently exploring system upgrades or enhanced data sharing.

Organization	Health and Human Services Agency Aging and Independence Services Adult Protective Services	Health and Human Services Agency Behavioral Health Services San Diego County Psychiatric Hospital
Current Data System	Adult Protective Services uses an off-the-shelf system called LEAPS provided by Jump Technology for case management, referrals to other programs and identity and access management related to serving older adults, adults with disabilities and callers inquiring about services. Users include social services staff, call center staff, administrative staff, managers and supervisors.	The San Diego County Psychiatric Hospital (SDCPH) uses an application called Cerner Millennium, serviced by Oracle Health Millennium Platform. The off-the-shelf electronic health record product has been highly localized to meet the patient population and hospital clinical practice needs. The product allows for clinical and administrative staff to document and track health care related treatment, care and services on all patients admitted to the hospital.
Current State of Data Sharing	Anyone can make a referral that gets entered into the system without client consent, and all data that is shared with the department is protected by HIPAA and the Welfare and Institutions Code. Adult Protective Services obtains client verbal consent before sharing personally identifiable information (PII) with community-based organizations and certain investigative agencies. Some PII data can be shared without client consent. Non-PII data is shared with the California Department of Social Services. Data is also aggregated with other counties and shared publicly and with the federal government.	Staff review and obtain patient consent for services at intake. The Hospital has the capability to view and import information from external pharmacies' history utilizing Sure Script. DHCS oversees data sharing decisions, which are governed by HIPAA and the California Confidentiality of Medical Information Act. HHSA also consults with Business Assurance and Compliance and with County Counsel. Mechanisms to support data sharing include agreements with the County Public Safety Group and the Office of Evaluation, Performance and Analytics. The County also has contracts that allow data sharing with Optum Administrative Services Organization and UCSD Research & Evaluation.
Future Technology and Data Sharing Priorities	Adult Protective Services does not currently have a system to support closed loop referrals. They are currently acquiring access to the State Homeless Management Information System (HMIS), which will enable them to share data about clients who are experiencing homelessness.	The Psychiatric Hospital is interested in increased interoperability with Managed Care Plans, FQHCs, Hospitals and other HHSA Departments such as Eligibility and Housing. They are exploring an Immunization Hub through the California Immunization Registry (CAIR 2) and the Cerner HealtheIntent population health management platform to support care coordination and referral management, including closed loop referrals and predictive analysis. They are also interested in a data warehouse solution, a portal to access other systems and real-time data and alerts from Emergency Departments.

Organization	Health and Human Services Agency Behavioral Health Services Outpatient Mental Health Services	Health and Human Services Agency Behavioral Health Services Substance Use Disorder Services
Current Data System	Cerner Community Behavioral Health (CCBH) is a customizable electronic health record solution used by clinical and administrative staff in providing specialty mental health services. The department also uses Panasoft to manage conservatorship records and the Mental Health Outcomes Management System (MHOMS), a UCSD outcomes database.	County of San Diego Substance Use Disorder Services uses the modular FEi Systems Web Infrastructure for Treatment Services, known locally as SANWITS, to maintain an electronic health record for individuals who have received Drug Medi-Cal services. Users include clinical and administrative staff.
Current State of Data Sharing	Consent for services is reviewed at intake, and information is shared within the provider network according to role-based access rules. The system does not ingest information from other sources. DHCS oversees data sharing decisions, which are governed by HIPAA and the California Confidentiality of Medical Information Act. The CARE Act (2022) also includes some data sharing requirements. HHSA also consults with Business Assurance and Compliance and with County Counsel. They also have agreements with the Optum Administrative Services Organization, UCSD Research & Evaluation and the County Office of Evaluation, Performance and Analytics.	Consent for services is reviewed at intake, and data can be shared manually with proper releases. The system does not ingest information from other sources. DHCS oversees data sharing decisions, which are governed by Section 42 of the Code of Federal Regulations. HHSA also consults with Business Assurance and Compliance and with County Counsel. They also have agreements with the Optum Administrative Services Organization, UCSD Research & Evaluation and the County of San Diego's Office of Evaluation, Performance and Analytics.
Future Technology and Data Sharing Priorities	The department will be transitioning to Streamline SmartCare, a new EHR with closed loop referral functionality, in September 2024. They are also implementing Cerner HealtheIntent for potential care management and predictive analysis. They are interested in greater interoperability with Managed Care Plans, FQHCs, Hospitals and other HHSA Departments such as Eligibility and Housing or the Public Safety Group. Other needs include a data warehouse solution, a referral management system, a portal to access other systems and real-time data and alerts from Emergency Departments.	The department will be transitioning to Streamline SmartCare, a new EHR with closed loop referral functionality, in September 2024. They are interested in greater interoperability with Managed Care Plans, FQHCs, Hospitals and other HHSA Departments such as Eligibility and Housing or the Public Safety Group. Any data sharing initiatives would need to meet Code of Federal Regulations, Section 42, Part 2 requirements. Other needs include a data warehouse solution, a referral management system, a portal to access other systems and real-time data and alerts from Emergency Departments.

Organization	Health and Human Services Agency Child and Family Well-Being Foster Youth	Health and Human Services Agency Child and Family Well-Being First5 Healthy Development Services
Current Data System	The Child Welfare Services/Case Management System (CWS/CMS) is California's version of the federal Statewide Automated Child Welfare Information System (SACWIS) and the platform required by the California Department of Social Services. The system is used by child welfare services staff to provide immediate access to child, family and case-specific information necessary to inform appropriate and timely case decisions.	First 5 uses CMEDS, a custom platform, used to gather information on children birth to 5 years old with mild to moderate developmental and social/emotional needs. The system is used by clinical and direct services staff for data collection and reporting to the First 5 Commission and funders, contract monitoring, and program improvement.
Current State of Data Sharing	SB 370 (1989) mandated a single statewide-automated child welfare services information system to consolidate the collection and reporting of CWS program information. Data sharing is governed by the State CWS/CMS Oversight Committee. Data is currently shared with the San Diego County Office of Education Foster Youth Services Coordinating Program (SDCOE FYSCP) through a relationship between the California Department of Social Services and the California Department of Education.	Data sharing is governed by HIPAA and must be approved by the First 5 San Diego Commission. Currently, clients consent to share data with First 5, and that data is not shared with entities outside of HHSA except on approval in an aggregated format.
Future Technology and Data Sharing Priorities	Planning for technology upgrades and data sharing are managed by the California Department of Social Services.	None identified.

Organization	Health and Human Services Agency Child and Family Well-Being First5 Home Visiting	Health and Human Services Agency Homeless Solutions and Equitable Communities Office of Homeless Solutions (OHS)
Current Data System	First 5 uses CMEDS, a custom platform, to gather information on specific high-risk target populations, including pregnant and parenting teens, military, refugee/immigrant and low-income families and Cal WORKs recipients. The system is used by paraprofessional and administrative staff for data collection and reporting to the First 5 Commission and funders, contract monitoring and program improvement.	OHS uses Clarity Human Services, the San Diego County Continuum of Care system of record as required by federal and state regulations to gather information on the services provided to individuals experiencing or at risk of homelessness. The system is used by direct services staff, data analysts and program managers to enter information related to programs that serve people experiencing homelessness and to complete assessments and match people with permanent housing resources.
Current State of Data Sharing	Data sharing is governed by HIPAA and must be approved by the First 5 San Diego Commission. Currently, clients consent to share data with First 5, and that data is not shared with entities outside of HHSA except on approval in an aggregated format.	Clients consent to sharing data with HHSA and can also opt to sign a multiparty consent form that allows for data sharing with 211/CIE and HMIS. Data sharing decisions are governed by the federal HMIS and state Homeless Data Integration System. Both OHS and the Regional Task Force on Homelessness produce public facing dashboards with aggregated data. OHS also consults with County Business Assurance and Compliance and County Counsel.
Future Technology and Data Sharing Priorities	N/A	HSEC-OHS is developing a system for Homeless Disability Advocacy Program reporting and managing case flow, and the County Office of Evaluation, Performance and Analytics is working on a cloud-based system to support data collection and analysis.

Organization	Health and Human Services Agency Homeless Solutions and Equitable Communities Community Health Workers	Health and Human Services Agency Medical Care Services Home Visiting Program
Current Data System	Community Health Workers uses Smartsheet, a customizable off-the-shelf solution to collect data and provide aggregated outcomes reports on the people and geographies reached through the program as required by funding sources. Specific data points include populations and Zip codes reached, types of health education provided, and the number and languages of the materials disbursed. Users include the Community Health Engagement Team, primarily community health workers.	The Home Visiting Program uses Persimmony to document referrals, assessments and home visits for individuals served through the Nurse Family Partnership and Maternal Child Health programs. System users include clinical staff and social services providers.
Current State of Data Sharing	Community health workers do not collect any identifiable information, and consent is not required. If grants and contracts require data collection, the department consults with County Business Assurance and Compliance and County Counsel.	Data sharing decisions are governed by the federal Maternal, Infant and Early Childhood Home Visiting program and the California Home Visiting Program. All data agreements are included in contract language as required by Department of General Services standards. Clients sign a consent for home visiting services, and information is shared with the U.S. Health Resources and Services Administration, the State of California and the Nurse Family Partnership.
Future Technology and Data Sharing Priorities	The department is currently exploring updates and/or changes to its systems and is specifically interested in a tool to collect individual information that complies with all security and privacy requirements and that will support system navigation efforts that align with ECM and CS data tracking.	HVP is exploring using Persimmony to share data with CIE, MCPs, ECM/CS providers, Family Support Connection and other community-based organizations. Data sharing will require a Memorandum of Understanding/ Agreement. HVP is interested in greater ease pulling reports and validating data.

Organization	Health and Human Services Agency Public Health Services California Children's Services (CCS)	Public Safety Group Probation Probation Case Management System (PCMS)
Current Data System	CCS case managers use CMS.net, a platform custom-developed by DHCS, to receive and manage referrals from the Provider Electronic Data Interchange (PEDI). Case managers use the system to review and authorize services and care coordination for children ages birth to 21 with a CCS-eligible medical condition. CMS.net is only accessible to County CCS staff; medical providers use PEDI to make the referrals and look up certain information. CCS also uses MTU Online and an electronic records management system to store client charts and service notes for the CCS Medical Therapy Program that provides direct Occupational/Physical Therapy services at clinic sites throughout San Diego.	PCMS uses a custom-developed solution to manage information related to Adult and Juvenile Probation client cases. The system specifically tracks court information, legal information, probation supervision status, assessments, court reports, etc., and is used by probation staff, counselors, revenue and recovery staff and contractors. PCMS also uses SCRAM for pretrial clients and a Community Resource Directory.

Organization	Health and Human Services Agency Public Health Services California Children's Services (CCS)	Public Safety Group Probation Probation Case Management System (PCMS)
Current State of Data Sharing	Data sharing decisions are under the jurisdiction of DHCS and governed by HIPAA. CCS does not currently share data with third-party organizations and would typically direct requests from non-County entities to DHCS. CCS has pulled and shared reports with the County's Office of Business Intelligence department on request. Medical providers or CCS staff can enter clients into the referral system and potentially eligible clients do not need to consent. CCS clients that do not have Medi-Cal need to fill out a CCS application or Program Services Agreement (PSA) to receive services. Medical providers and health plans registered with PEDI can view the status of submitted referrals, but those who are not registered need to call the CCS office to check on referral status.	Data sharing is governed by the following federal and state regulations: FBI CJIS Security Policy State of California Penal Code (PC) 11105: State Summary Criminal History Information & PC 13300: Local Summary Criminal History Information California Government Code 15150-15167: California Law Enforcement Telecommunications System (CLETS) Code of Federal Regulations Title 45 Part 64: Health Insurance Portability and Accountability Act (HIPAA) Code of Federal Regulations Title 42 Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) California's Welfare and Institutions Code 10850: Public Social Services Records WELFARE AND INSTITUTIONS CODE SECTION 827 Users manually enter data into the system, and consent is not required. The system has a bi-directional interface with the District Attorney CMS, Courts CMS, Community Resource Directory, COMPAS Assessment Tool and JELS. The system also has a one-way interface to PCMS with Drug Interface and DOJ SRF. Prior to granting access to any CJIS data, data sharing agreements and CORI/CLETS rules must be adhered to, including background checks conducted by Probation. Internal group prepares data sharing agreement in consultation with County Counsel.
Future Technology and Data Sharing Priorities	San Diego CCS is active in multi-County workgroup meetings, providing input on system enhancements to DHCS CMS IT staff and supporting UAT testing. CCS would like to share data with families through a parent/patient portal that would allow them to check status on referrals, similar to other insurance programs that authorize care.	PCMS conducts ongoing software/technology upgrades and is interested in resolving barriers related to CJIS and HIPAA requirements to allow for data exchange between HHSA and Probation for matched/shared clients, including juvenile records.

Organization	Public Safety Group Probation Electronic Health Record	Public Safety Group Emergency Medical Services
Current Data System	The Public Safety Group is in the process of procuring TechCare, an off-the-shelf solution that may include some customization. The platform would allow probation medical providers and clinical staff to manage the health/medical records, including assessments and treatment, for youth in custody and adults in the work furlough program. Sworn officers are not allowed access to medical records by law.	The County of San Diego EMS contracts with ImageTrend, an off-the-shelf platform with user customization option. This platform enables users to document EMS patient care, including 911 medical calls and both emergency and nonemergency ambulance transports. System users include paramedics, EMTs, base hospital nurses and Critical Care Transport (CCT) nurses from numerous agencies throughout San Diego County to accurately record and submit statutorily required quality improvement data to the County and the State. Use of the County of San Diego EMS system is voluntary, and a number of other EMS patient care recordation systems are also in use in the county.
Current State of Data Sharing	Clients are added to the system when they receive a medical assessment and/or treatment by Probation, and consent is not required. Currently, medical records are shared in certain circumstances for youth with significant medical needs with consent, which is a manual process.	Consent is not required to enter individuals into the system, although data sharing is governed by HIPAA and California's Emergency Medical Services Authority. County of San Diego EMS currently has data sharing agreements with specific EMS agencies. Emergency Departments have access to patient data through a portal, and data is shared through the local Health Information Exchange (HIE) through the Search, Alert, File and Reconcile (SAFR) program.
Future Technology and Data Sharing Priorities	The procurement process is part of an initiative to meet Medi-Cal Transformation bi-directional data sharing requirements with entities including PCMS, pharmacy, lab, x-ray, etc. Consent to share information will align with HIPAA regulations, and both consent and ROI will be collected and stored in system. The department does not currently have data sharing agreements but plans to enter into MOUs with Managed Care Plans, Enhanced Care Management Providers, Behavioral Health, etc., with the new system.	County of San Diego EMS does not currently have capacity for closed-loop referrals but is interested in exploring opportunities to better meet patient needs. In addition, sharing additional Alert Discharge Transfer (ADT) data with or through the HIE or other connections could offer value to system users.

Footnotes

1. ECM and CS are separate initiatives, and members may qualify for only one or both
2. The DHCS CalAIM Incentive Payment Program supports the implementation and expansion of CalAIM by incentivizing managed care plans (MCPs) to build capacity, bridge existing silos across physical and behavioral health care service delivery, and encourage take-up of Community Supports, among others.
3. DHCS CalAIM Data Sharing Authorization Guidance. (October 2023).
4. ECM and CS are separate initiatives, and members may qualify for only one or both.
5. DHCS received federal approval authorizing the CalAIM Section 1115 demonstration and CalAIM Section 1915(b) waivers.
6. The DHCS CalAIM Incentive Payment Program supports the implementation and expansion of CalAIM by incentivizing managed care plans (MCPs) to build capacity, bridge existing silos across physical and behavioral health care service delivery, and encourage take-up of Community Supports, among others.
7. CalAIM Enhanced Care Management Policy Guide. (February 2024).
8. Medi-Cal Community Supports or In-Lieu of Services Policy Guide. (July 2023).
9. Interview participants included two Managed Care Plans, the regional hospital association, the homelessness Continuum of Care, a federally qualified health center, the health information exchange, and five community-based organizations.
10. Federal and state agencies with specific data system requirements include the U.S. Department of Housing and Urban Development, U.S. Health Resources and Services Administration, California Department of Healthcare Services, California Department of Social Services, and the National Committee for Quality Assurance.
11. U.S. Departments of Agriculture, Health and Human Services, Housing and Urban Development, and Justice; California Departments of Healthcare Services, Public Health, and Social Services, and the California Emergency Medical Services Authority, and the County of San Diego Business Accuracy and Compliance Department
12. Department of Health Care Services. Authorization to Share Confidential Medi-Cal Information: Pilot Evaluation Report. (January 2024).
13. CalAIM: Population Health Management Policy Guide. (May 2024).