CIVITAS
Networks for Health

Collaboratives in Action: *Community Information Exchange and Comprehensive Data Sharing to Create the Whole Picture*

Thursday, August 10, 2023

Housekeeping Reminders

- This is a Zoom webinar
- All webinar participants are automatically muted, and your video is not displayed
- If you would like to ask the presenters a question, please use the **Q&A** function on the task bar
- Use the **chat** feature to introduce yourself – name, organization, and location; share resources, etc.
- If you have any questions following the webinar, please reach out to contact@civitasforhealth.org

Agenda

- **Welcome** – Jolie Ritzo, Civitas Networks for Health
- **Debunking Myths: Social Service Partnerships Leading Interoperability**
  - Alana Kalinowski, Director of Interoperability & Collective Impact, MSW, San Diego 211/CIE
- **A Practical Approach to Implementing FHIR Standards for Behavioral Health Providers Participating in CIEs**
  - Brian Dillon, Consultant, Technology Strategy, Intrepid Ascent
  - Danielle Carter, Vice President Community Change, Intrepid Ascent
- **Moderated Discussion/Q&A**

Introduction to Civitas Networks for Health

Regional innovation, national impact.

Our vision: Communities across the country are thriving and healthy, realizing the full potential of data-driven, multi-stakeholder, and cross-sector approaches to health information exchange and health improvement.

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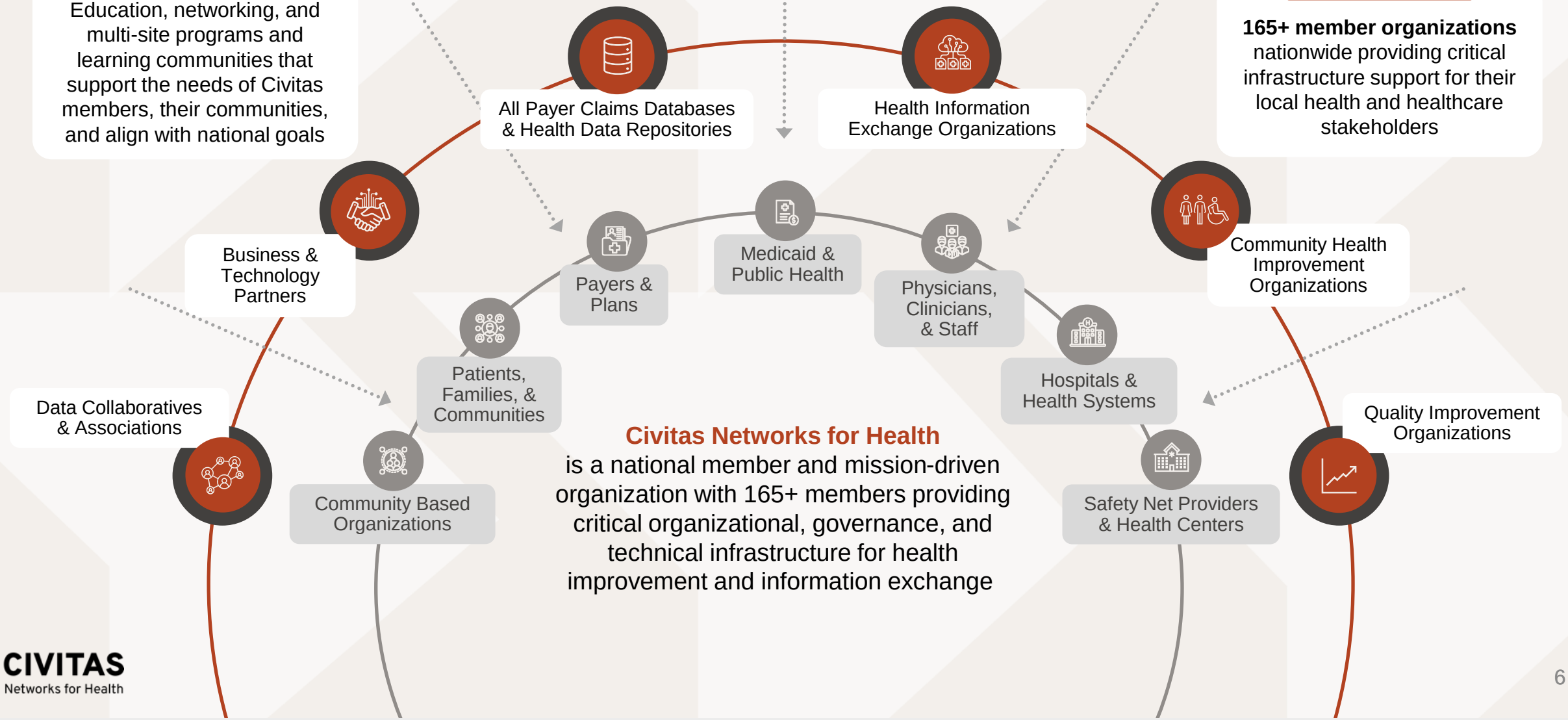
Who We Serve

Programs

Education, networking, and multi-site programs and learning communities that support the needs of Civitas members, their communities, and align with national goals

Members

165+ member organizations nationwide providing critical infrastructure support for their local health and healthcare stakeholders



Civitas Networks for Health is a national member and mission-driven organization with 165+ members providing critical organizational, governance, and technical infrastructure for health improvement and information exchange

Debunking Myths: Social Service Partnerships Leading Interoperability

Alana Kalinowski, MSW
211 San Diego/Community Information Exchange (CIE)

Meet the Presenter

Alana Kalinowski, MSW

Director of Interoperability & Collective Impact

211 San Diego / CIE

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• Learning Objectives

1. Understand San Diego's Community Information Exchange (CIE)
2. Importance of Interoperability of a CIE
3. The essential role of Social Service Providers
4. Myths about social services
5. Systemwide Impacts

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Services

GENERAL LINE

- 24/7 contact center
- 10-minute information and referral
- 300+ languages
- Use CIE to document all interactions with callers and consent into CIE
- CRM integrated with CIE platform

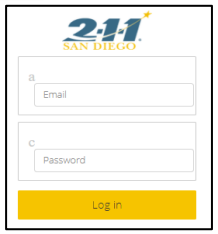
CARE COORDINATION

- Specialty line with case management
- Contracted partnerships with Managed Care Plans (MCPs)
- In-depth assessment and coordinated referrals via the CIE
- CRM integrated with CIE platform

Community Information Exchange

Connect to 133+ organizations through direct system access and leveraging data integration between systems

CIE Network Partners



Individual User Access

- Secure login
- Individual level PII & CIE profile, Screenings, Assessments, Comprehensive Social Continuum Assessment (CSCA)
- Electronic Referrals

System to System Integration

- Secure member matching
- API connections
- Eligibility prioritization

Community Information Exchange

A CIE is an **ecosystem** comprised of multidisciplinary network partners that use a shared language, a resource database, and an **interoperable** technology platform to **deliver enhanced community care planning**. Care planning tools enable partners to integrate key SDOH data from multiple sources, make bi-directional referrals, and create a **shared, longitudinal record** that enables informed care. By focusing on these core components, a CIE enables communities to shift away from a reactive approach to providing care toward proactive, holistic, person-centered care.

Network Partners

Collective approach with standard Participation Agreement, Business Associates Agreement and participant consent with shared partner governance, ongoing engagement, and support.

Shared Language (SDoH)

Setting a Framework of shared measures and outcomes through 14 Social Drivers of Health Assessments and a Risk Rating Scale: Crisis, Critical, Vulnerable, Stable, Safe Thriving

Bidirectional Closed Loop Referrals

Updated resource database of community, health, and social service providers. Ability to accept/return referrals and to provide outcomes and program enrollment.

Technology Platform and Data Integration

Technology software that integrates with other platforms to populate an individual record and shapes the care plan. System features include care team communication feeds, status change alerts, data source auto-history and predictive analytics.

Community Care Planning

Longitudinal record with a unified community care plan that promotes cross-sector collaboration and a holistic approach.

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What's the difference between a CIE and HIE?

PHI by **source** not because of content (data coming from a covered entity); authorization converts PHI to PII

CIE: Care Coordination

Comprised of social data and when it is medica, for the purposes of eligibility/care coordination (e.g. Where is your medical home or # of hospitalizations in the last 12 months [don't really need to know specifics of hospitalization])

The Healthcare component is related to:

1. Who are the specific care providers? (Health plan, PCP, Medical home, Health Navigator, etc.)
2. Health Information as it impacts social needs and access (that you are disabled or have cancer, but not medical information like what's person's cancer treatment plan or tests that have been run)

PHI by **content** (medically-related information)

HIE: Continuity of Medical Care

Comprised of Medical data for medical providers to use to inform diagnosis and treatment. Moving towards also having some social data that shapes treatment plans (e.g. do you have transportation to get to your post-op follow up?)

Needs to include data captured by a Dr. or other healthcare provider s(diagnosis, medications, test, blood work, etc.).

Sector and Cross-Sector Collaboration

Increase in cross-sector collaboration to break down silos and foster clinic-community linkages to better understand and serve the needs of people who overlap systems of care.

Community Information Exchange

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Client Record Sample

Client Profile
- Demographic and important information about the client

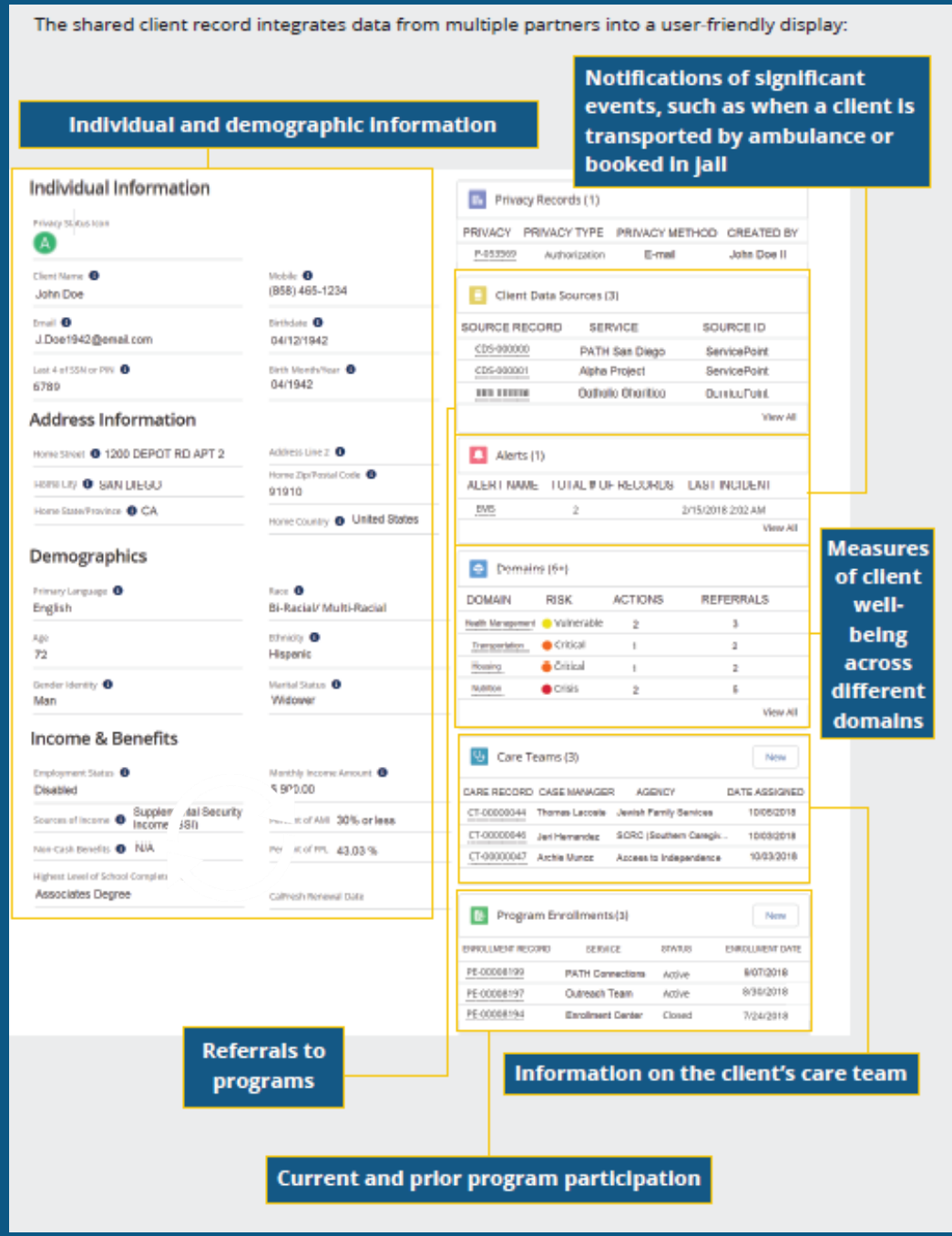
Domains
- Examples like Housing, Food & Nutrition,
- Categorization of Needs (SDOH) & Risk Level
- Shared Assessments and Values across agencies

Care Team
- Case Managers working with client across agencies
- Contact Information

Referrals & Program Enrollment
- Agencies or programs client is referred
- Connection to Services

Alerts
- Notification of emergency services & jail
- Ability to notify Care Team Members of changes

Feed
- Ability to communicate with Care Team members (twitter-like feed)



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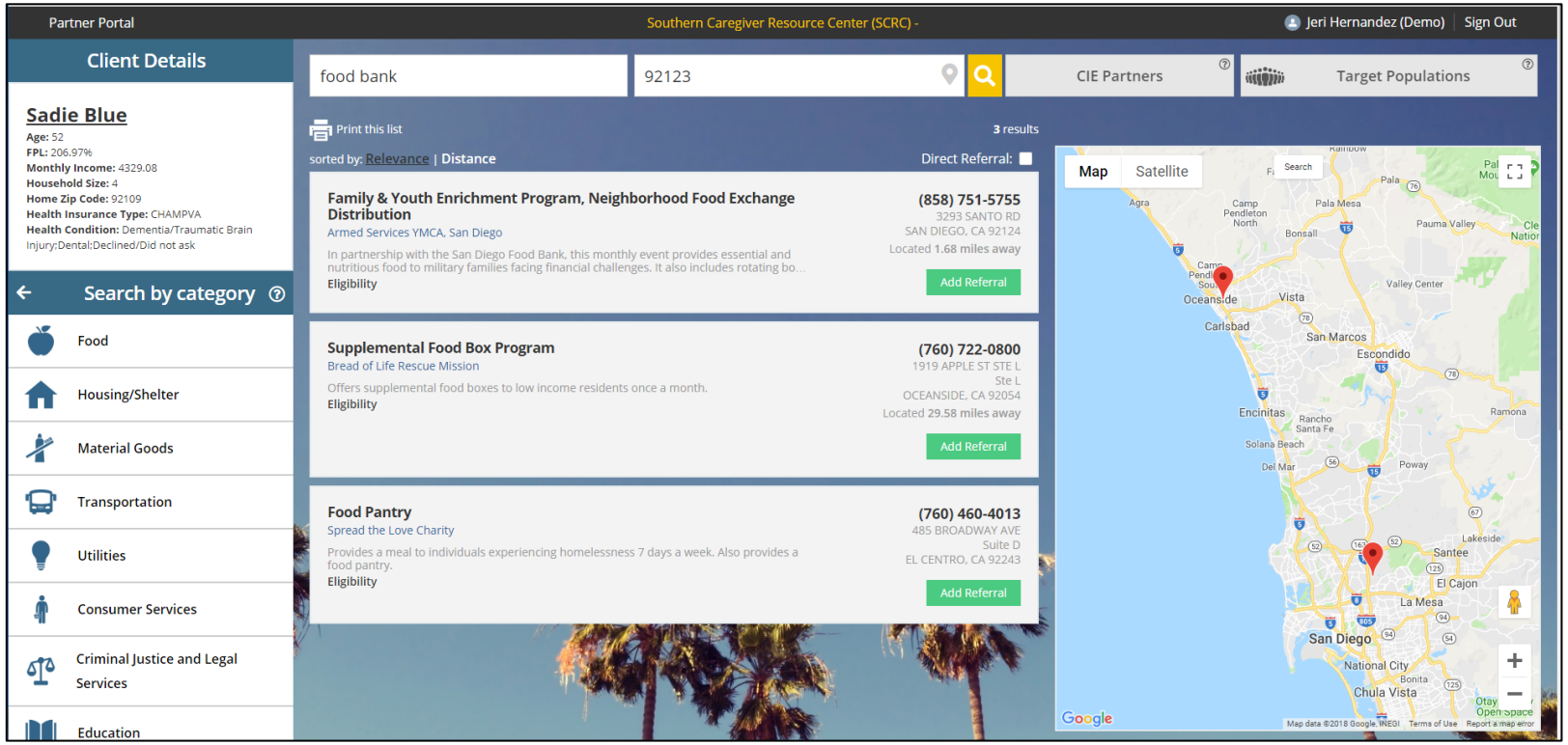
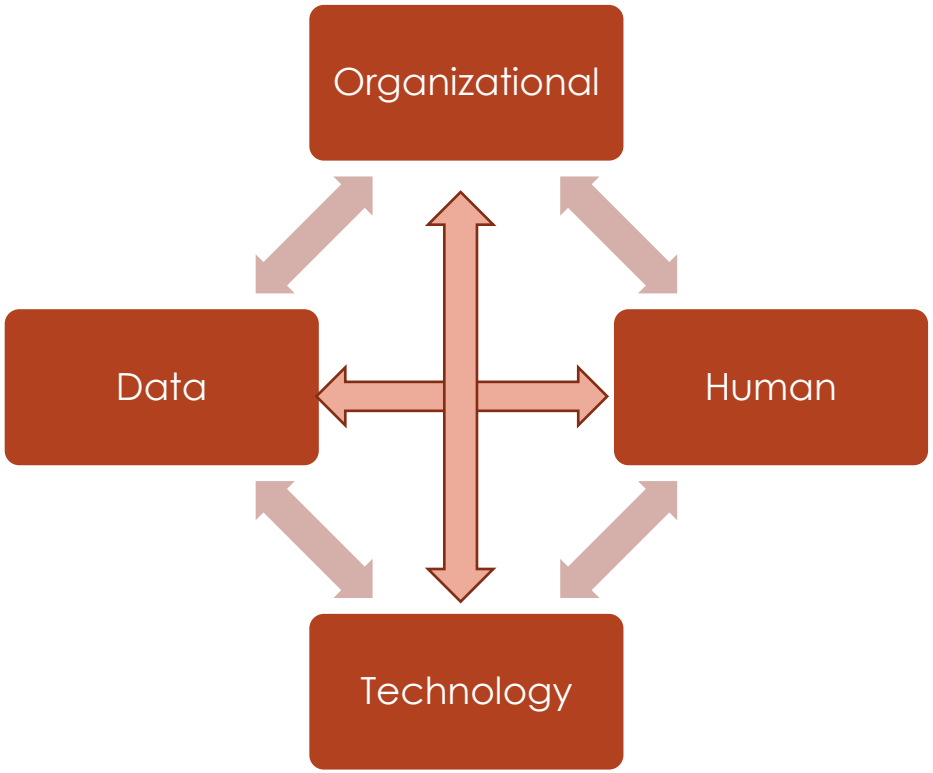
Community Information Exchange®



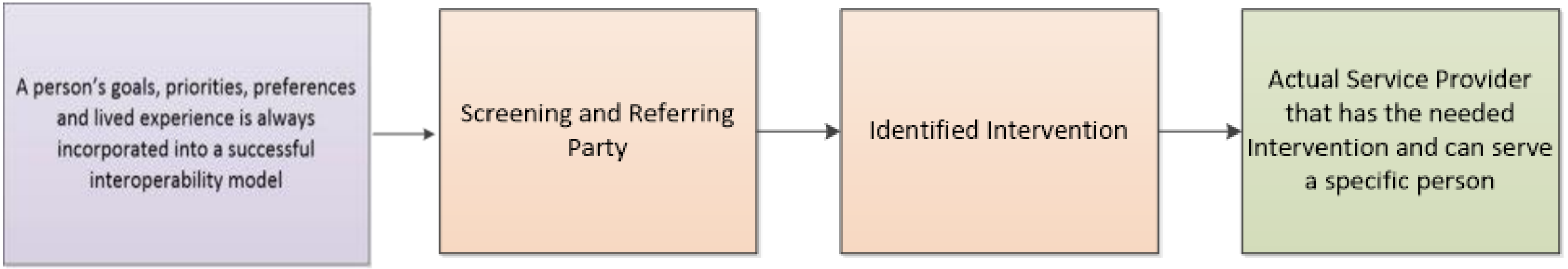
- Shared taxonomy language for referrals (AIRS)
- Dedicated resource staff
- Standards to listings and requirements
- Inclusion/Exclusion Criteria
- Linked to health conditions
- Tracks resource availability and unmet needs



The ability for different systems, devices, applications or products to connect and communicate in a coordinated way, without effort from people.

Data standards make interoperability scalable and provide a consistent definition and means of representing or measuring something.

Technical Interoperability is downstream and informed by organizational and human processes and goals.



Referrals (6+)

Referral #	Domain	Created Date	Referred By Ag...
Referral-02296...	Safety & Disaster	4/21/2023 8:47 ...	2-1-1 San Diego
Referral-02296...	Safety & Disaster	4/20/2023 5:02 ...	2-1-1 San Diego
Referral-02285...	Social/Commun...	4/10/2023 3:44 ...	2-1-1 San Diego
Referral-02285...	Personal Hygien...	4/10/2023 2:57 ...	2-1-1 San Diego
Referral-02080...	Activities of Dail...	10/4/2022 11:43...	Kaiser Permane...
Referral-01783...	Housing	1/25/2022 10:04...	SAY San Diego

View All

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ABOUT CONTACT SIGN IN SEARCH

2-1-1 San Diego

Enhanced Care Management (ECM)

Not ADA Accessible

2-1-1

Intake Hours of Operation
7:30 am-5:30 pm, Monday-Friday

Intake Procedure
Referral, Call

Documents Required
No Documents Required

Description
Enhanced Care Management ECM provides a whole-person approach to care. Addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries.

Offers Comprehensive Assessment and Care Management Plan, Enhanced Coordination of Care, health promotion, Comprehensive Transitional Care, member and family supports, and Coordination of Referral to Community and Social Support services.

Eligibility
Members must be enrolled in a Medi-Cal Health Net or Blue Shield Promise managed care health plan and meet criteria for at least one of the Populations of Focus
• Individuals who are experiencing homelessness and have at least one complex physical, behavioral, or developmental health need.
• Individuals who are considered high utilizers of care, including those who have had 5+ emergency department visits or 3+ unplanned hospital or short-term skilled nursing facility says in the last 6 months, or those who have been identified by their health plan as having a pattern of high utilization that could have been avoided.

Integrating with FHIR

Technology Platform and Data Integration

CIE: Local data intermediary

- Risk indicators/risk populations coded to related to corollary resources provided by CBOs
- Allows for CBO customizability to align with FHIR data standards

ETL (Intelligent Informatica Cloud)

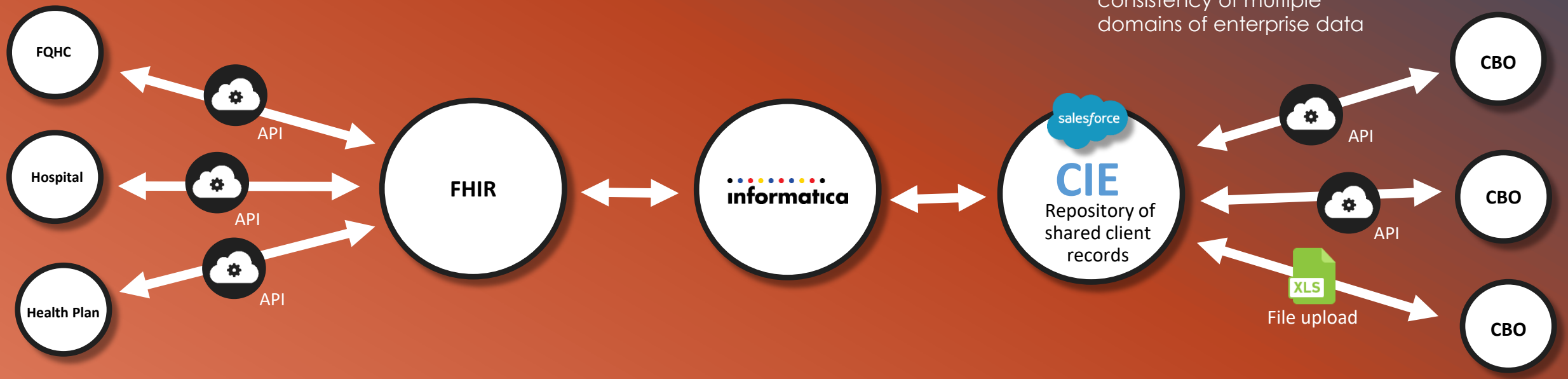
Extract Transform Load

1. Reads data from a database
2. Converts the data for the new database
3. Loads into the new database

MDM – Installed on top of SalesForce (created by Informatica)

Master Data Management

- Detects and merges duplicate records
- Ensures the accuracy, completeness, and consistency of multiple domains of enterprise data



Community Information Exchange

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Integrated Data Types:

Technology Platform and Data Integration

- **Personal Identifiable Information (PII)**
- **Demographic Data**
- **Social Drivers of Health Data (SDoH) and Assessments**

Housing	Education	Activities of Daily Living
Nutrition	Criminal Justice & Legal Services	Personal Hygiene & Household Goods
Income & Benefits	Health Management	Safety & Disaster
Transportation	Primary Care	Social & Community
Employment		

- **Family and Household Data**
- **Screening Tools and Program Intake Forms**
- **Alerts**
- **Program Enrollment and Referral Data**
- **Care Teams**

Community Information Exchange

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Social Influences of Health


Housing Stability


Health Management


Nutrition & Food Security


Financial Wellness & Benefits


Activities of Daily Living


Social & Community Connection


Legal & Criminal Justice


Primary Care & Prevention


Safety & Disaster


Utility & Technology


Transportation


Education & Human Development


Personal Care & Household Goods


Employment Development

CRISIS CRITICAL VULNERABLE STABLE SAFE THRIVING

IMMEDIACY

KNOWLEDGE AND UTILIZATION

BARRIERS AND SUPPORTS

Screening vs Assessment

Healthcare Provider

Priority: Providing Medical Care

Secondary: Screening for Specific Social Risks

Example:

- **What is your housing situation?**
  - Have housing, I don't have housing, I choose not to answer
- **What is the highest level of school that you have finished?**
  - Less than high school degree, High school diploma, more than high school, I choose not to answer

Social Service Provider

Priority: Addressing complex and interrelated social dynamics

Secondary: Accounts for relationship between health and social

Example:

- **What is your current housing situation?**
  - Emergency Shelter, Long-Term Nursing Home, Motel/hotel, Place not meant for human habitation, Habitable RV/boat (connected to electricity/water), Safe Haven, Couch Surfing, Mobile Home, Affordable Housing, Staying with family or friends, Own, Rent, Single room occupancy
- **What are your barriers to receiving housing?**
  - Eviction, Credit History, Cost, Household Size, Issues with Landlord, Home Repair, Incarceration, Unable to live independently, No prior rental history
- **What resources have you access in the past?**
  - Emergency Shelters, Section 8 Housing, VI-SPDAT/CES, Rapid Re-housing, HUD/VASH Voucher

Strength-based and Trauma Informed Data

* Which assessment is this?
Baseline

Screening Date
Aug 9, 2023

I tend to bounce back quickly after hard times
Strongly agree

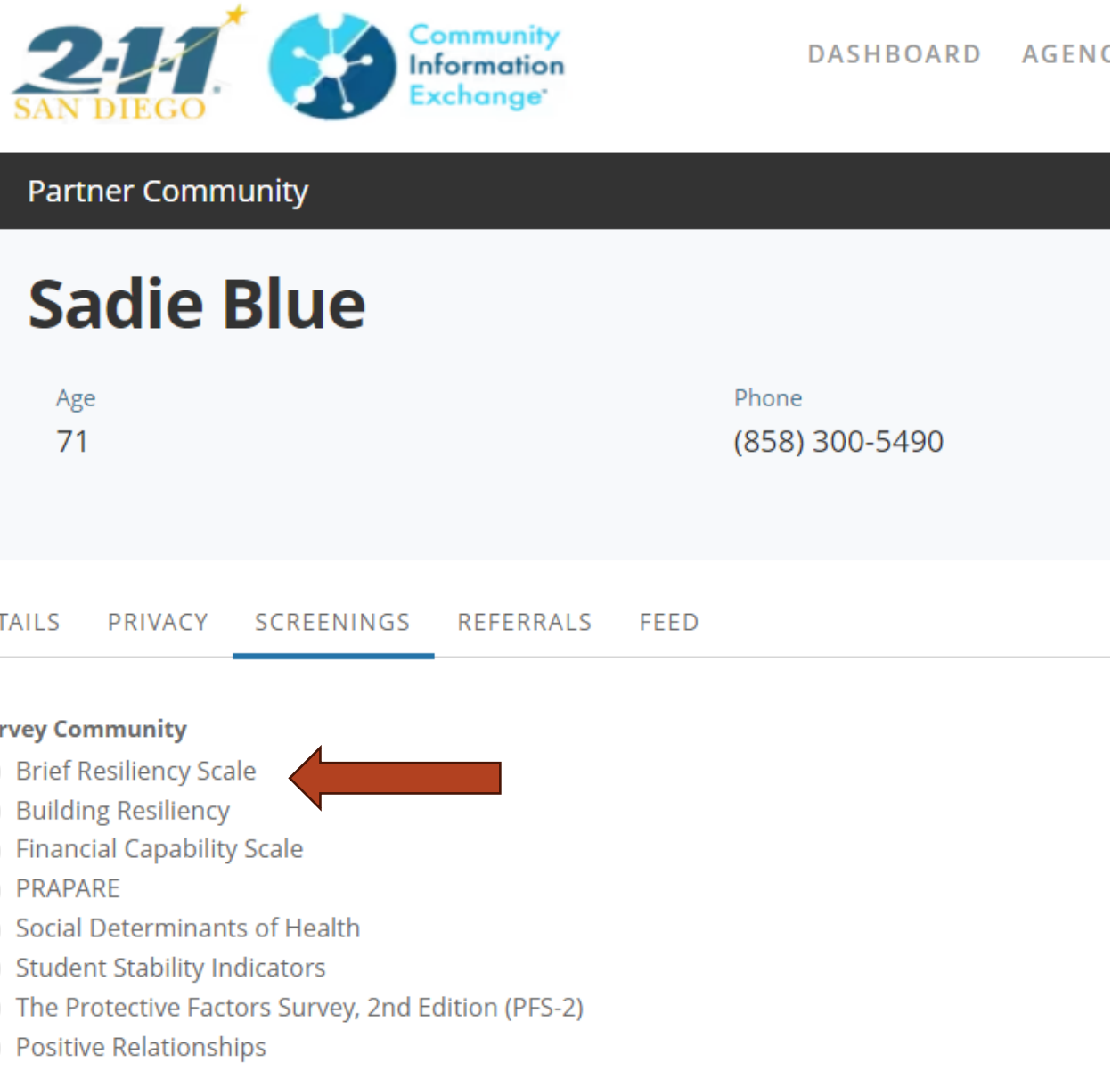
I have a hard time making it through stressful events
Agree

It does not take me long to recover from a stressful event
Agree

It is hard for me to snap back when something bad happens
Disagree

I usually come through difficult times with little trouble
Agree

I tend to take a long time to get over set-backs in my life
Disagree



Myths about Social Services

- Low/no technology and unsophisticated = unable to be interoperable
- Not HIPAA compliant/Unable to be HIPAA Compliant
- Don’t use standardized data sets
- Don’t have sophisticated EHRs/CRMs
- Don’t understand or are unable to do billing
- Don’t use or interact with health information
- (False) line of demarcation between health and social services

Social Services Leading the Way

- The interdependence of social services has meant that collaboration and care coordination is already embedded in workflows and culture
- Social Services carry out the majority of care coordination activities in the system of care
- Due to the nature of grant and contract funding, social services are ever tailoring their services – interventions are an intersection of a what for a specific group (often groups historically oppressed and discriminated against)
- Focus of Intervention: strides towards data and interventions oriented to a person in their environment
- Social service data sets capture more nuanced information relevant for effective care coordination
- CBOs have access to biopsychosocial-spiritual assessments and information not captured by traditional screening tools
- CBOs have knowledge of how holistic record types should and could work (When and how intersectional identity is meaningfully taken into account)

Systemwide Impact

Within emerging systems of interoperability and data sets that capture social needs, standards are being created that will impact our entire system of care. A medical-centered framework will directly affect the understanding of population needs and approaches to providing quality, person-centered care.

- Individual v. Household, Formal v. Informal Networks
- Further institutionalizing a "diagnostic" model rather than a persons' goals, ordering of priorities, stage of change, impact of trauma, trust of the system of care, Self-identified strengths, etc.
- Intersectional data and interventions
- Screened risk does not = Current situation (ex. ACEs)
- Policy, disparities, allocation of resources, and addressing structural oppression
- An over-emphasis on a closed-loop referral (a tool for increasing access to the needed intervention, it is **not** the intervention)
- Need to access of services in tandem – Care Coordination v. referral activities

Stay In Touch

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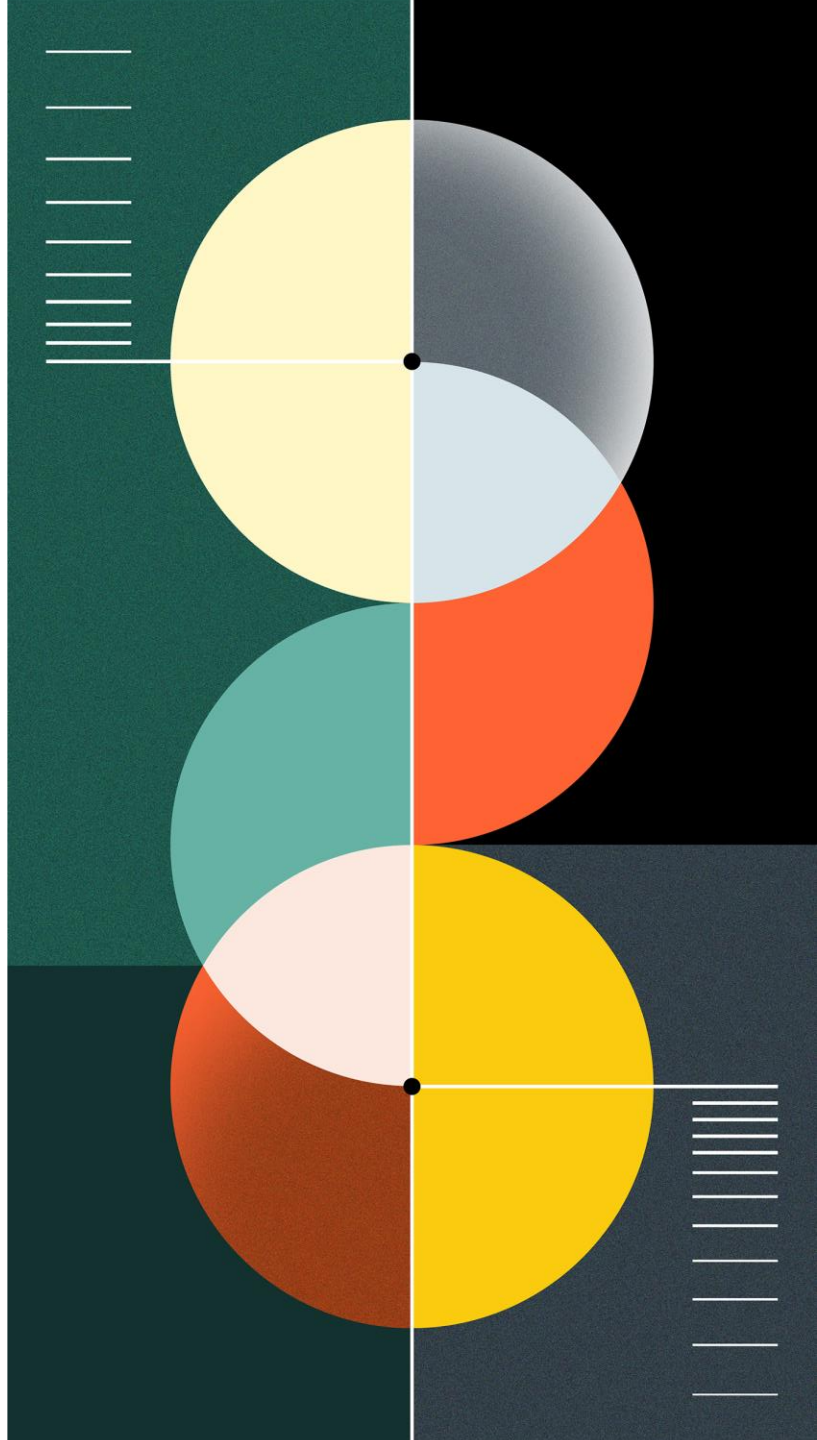
Community Information Exchange

Intrepid Ascent

A Practical Approach to Implementing FHIR Standards for Behavioral Health Providers Participating in CIEs

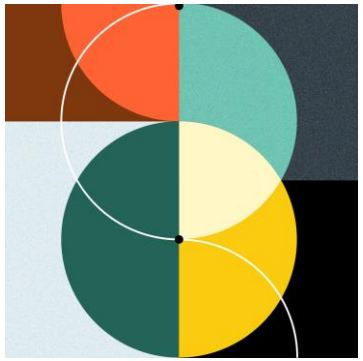
August 10, 2023



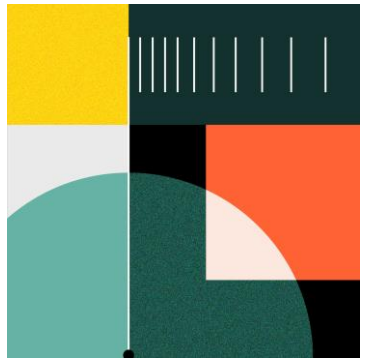
Intrepid Ascent *Who We Are*

Intrepid Ascent partners with clients in a collaborative ecosystem approach that intersects policy innovation, technology strategy, and change management for lasting progress. We guide whole person care initiatives across the country with our population health and cross-sector expertise, promoting the adoption of scalable technologies with a human-centered focus.

Technology
Strategy



Community
Change



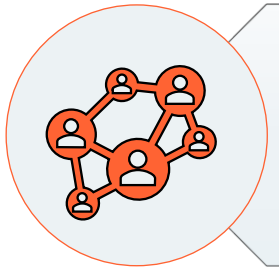
Policy
Innovation

Intrepid Ascent *Who We Are*

Danielle Carter, MPH
Vice President, Community Change

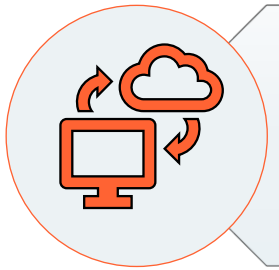
Brian Dillon, MBA
Senior Consultant, Technology Strategy

Objectives



Explore how behavioral health is a key component in community collaboration

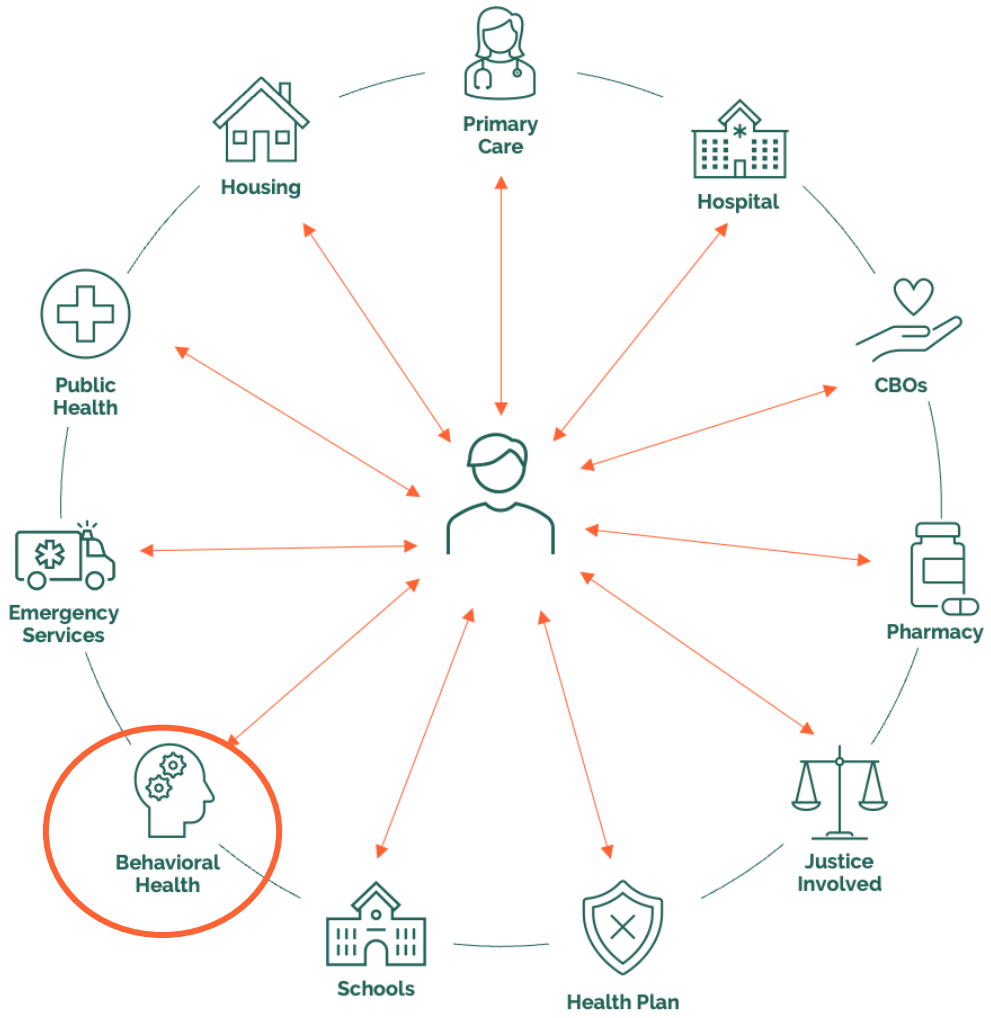
Review core concepts of data governance and consent for Behavioral Health (BH) Data Sharing



Conceptualize FHIR as a tool for relevant CIE use cases, including for Behavioral Health

Behavioral Health, Whole Person Care, and Community Information Exchange

Behavioral Health and Whole Person Care



Behavioral Health Data Sharing: CIE & HIE

Health Information Organization (HIO)

- HIOs facilitate health information exchange (HIE) among health care providers and plans, typically **storing data centrally** and sending appropriate data to other systems, both of which allows access to individuals' clinical records.

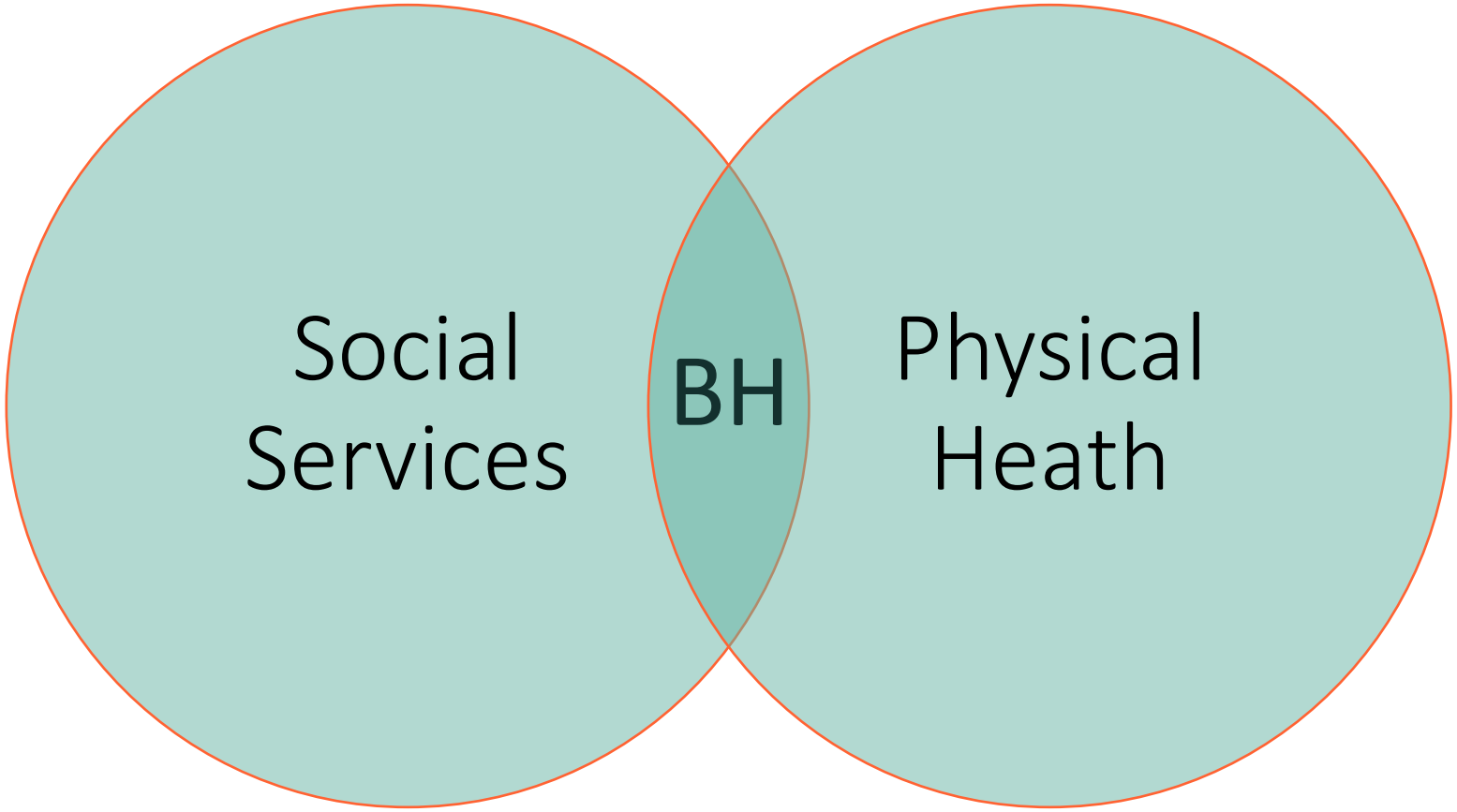
Community Information Exchange (CIE)

- CIEs serve as hubs for integrating systems of care, providing technology tools and governance for cross-sector **collaboration and care management** addressing social determinants of health and health equity.

Behavioral Health Services:

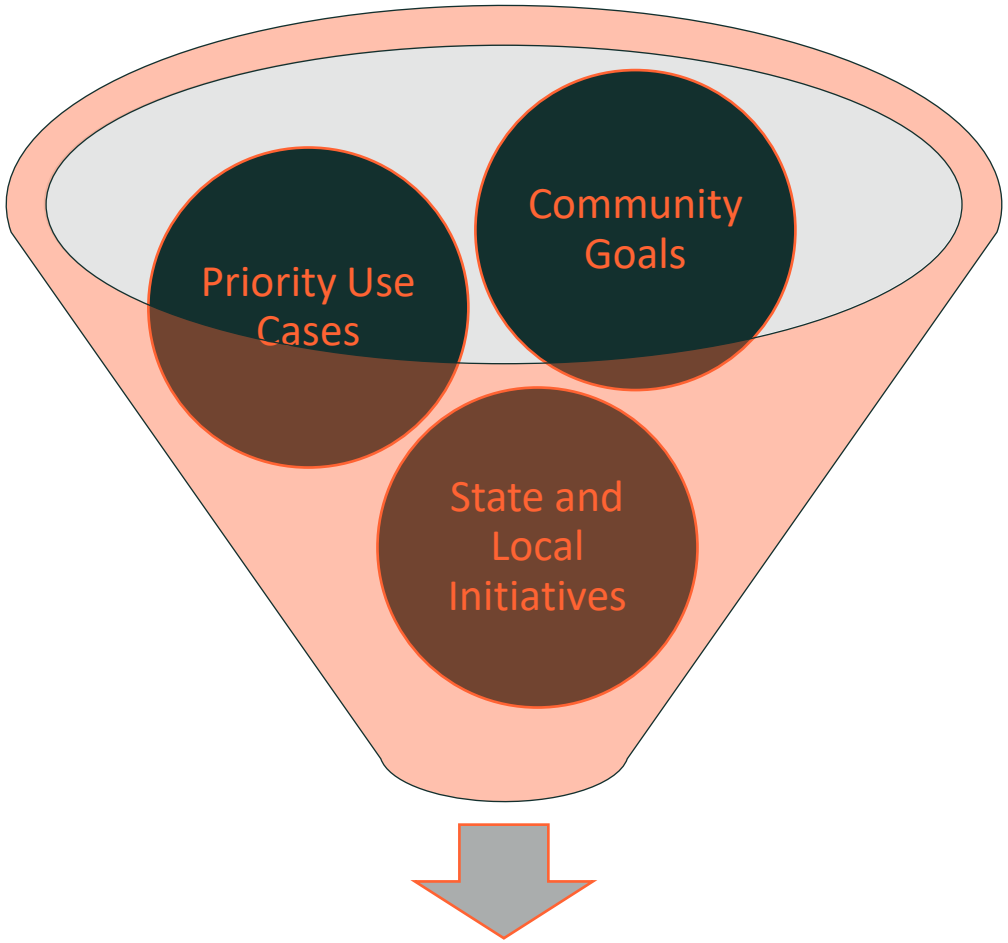
Where Do They Live?

Behavioral Health often sits at the intersection of Physical Health and Social Services.



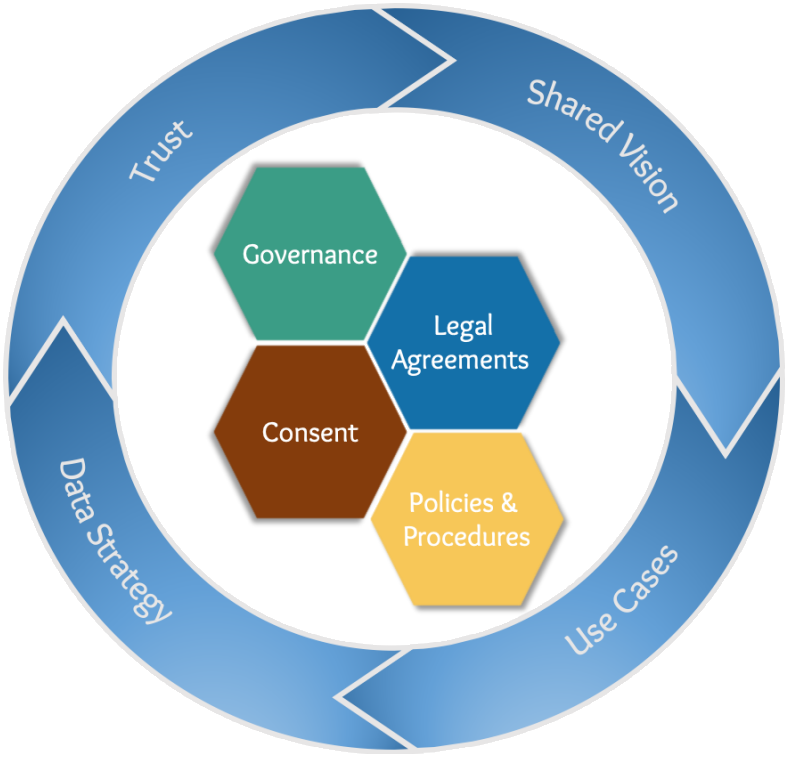
Behavioral Health and CIE:

Local Drivers



Behavioral Health and CIE:

Data Governance



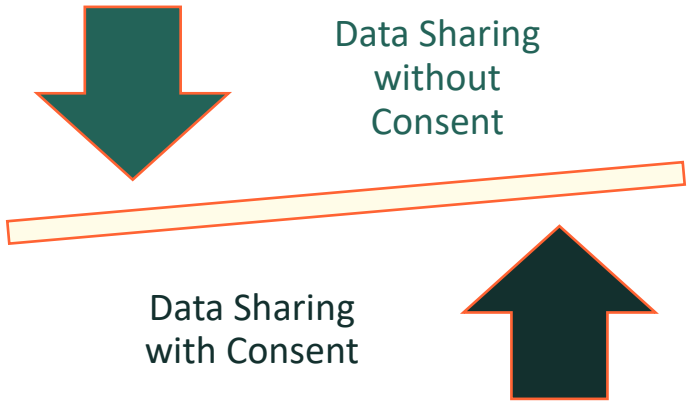
Data Travels at the Speed of Trust

- Sharing data among multiple partners requires:
  - A solid legal framework and protocols that comply with federal and state laws and regulations, as well as local and organizational policies
  - All partners understand complex legal and privacy issues related to what data may be shared and for what purposes
- In the absence of clear guidelines, policies, and procedures, partners may be reluctant to share data
- **Data Governance** ensures consistent and proper management of data across the network, shared understanding among users, and confidence in the information being used to make decisions.

Behavioral Health and CIE: Consent

- Privacy laws related to mental health and/or substance use disorders often require explicit permission from the individual prior to sharing
- CIEs by nature operate outside of the ”HIPAA tent” and therefore often have strict opt-in consent approaches due to the variability of data types and applicable laws

- “Traditional” HIE consent management is opt-in vs. opt-out – a reasonable and acceptable approach when data is shared for purposes of TPO
- This promotes and accelerates data sharing between health care providers, but does not support exchange of data that requires consent or with CBOs/non covered entities
- CIEs demonstrate that opt-in consent is not a barrier to data exchange



- **Myth**: Opt-in consent is administratively burdensome, reduces and slows data sharing, and individuals are reluctant to share BH data
- **Fact**: Typically, when given the choice, over 95% of clients give permission to share their BH data. Implementing options for capturing consent and providing tools that integrate with existing workflows greatly improves consent management, enabling more data sharing than ever before.

Technical Application: Leveraging FHIR for Behavioral Health Coordination via CIE

Common Approaches and Challenges

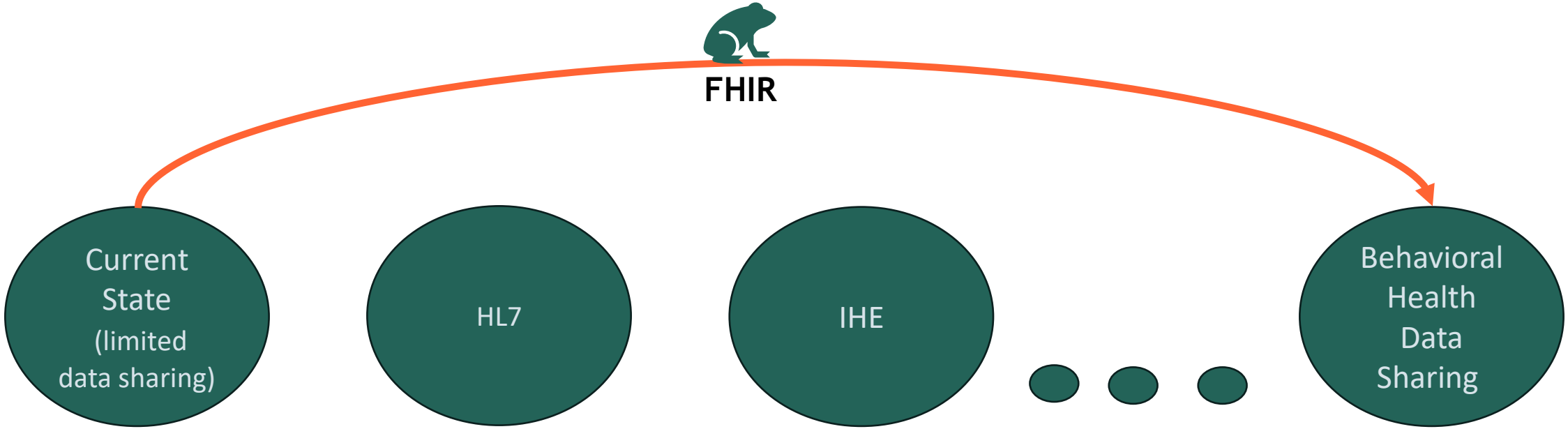
Domain	Approach	Challenges
CIE	Vendor-centric	Collaboration workflows are built in a technology that may not directly map to community goals or be interoperable with other systems.
	HIE + SDOH HIE + Referrals	HIE integrates some social needs data, likely quite limited to date based on the consent structure and system interoperability. Adding collaboration tools (read/write) such as referrals to historical data access (read only) is a profound step requiring organizational transformation.
FHIR	Modernization	An organization attempts to convert all previous exchange modalities to FHIR, creating redundancy and excessive cost.
	Phased Adoption	An organization makes any new integration a FHIR API, which may create issues with internal systems and other organizations that are not FHIR-ready.
Behavioral Health	No Integration	Generally a default approach for BH EHR systems, results in email and phone communication with community partners which is less auditable and harder to track quality measures.
	Query Only	Connecting to a national network that enables patient lookup queries has variable utility based on the EHR and limited to no social data.

How might we...

Jump-start data sharing to support behavioral health participation in CIE for cross sector collaboration?

Concept to Explore: Leveraging FHIR

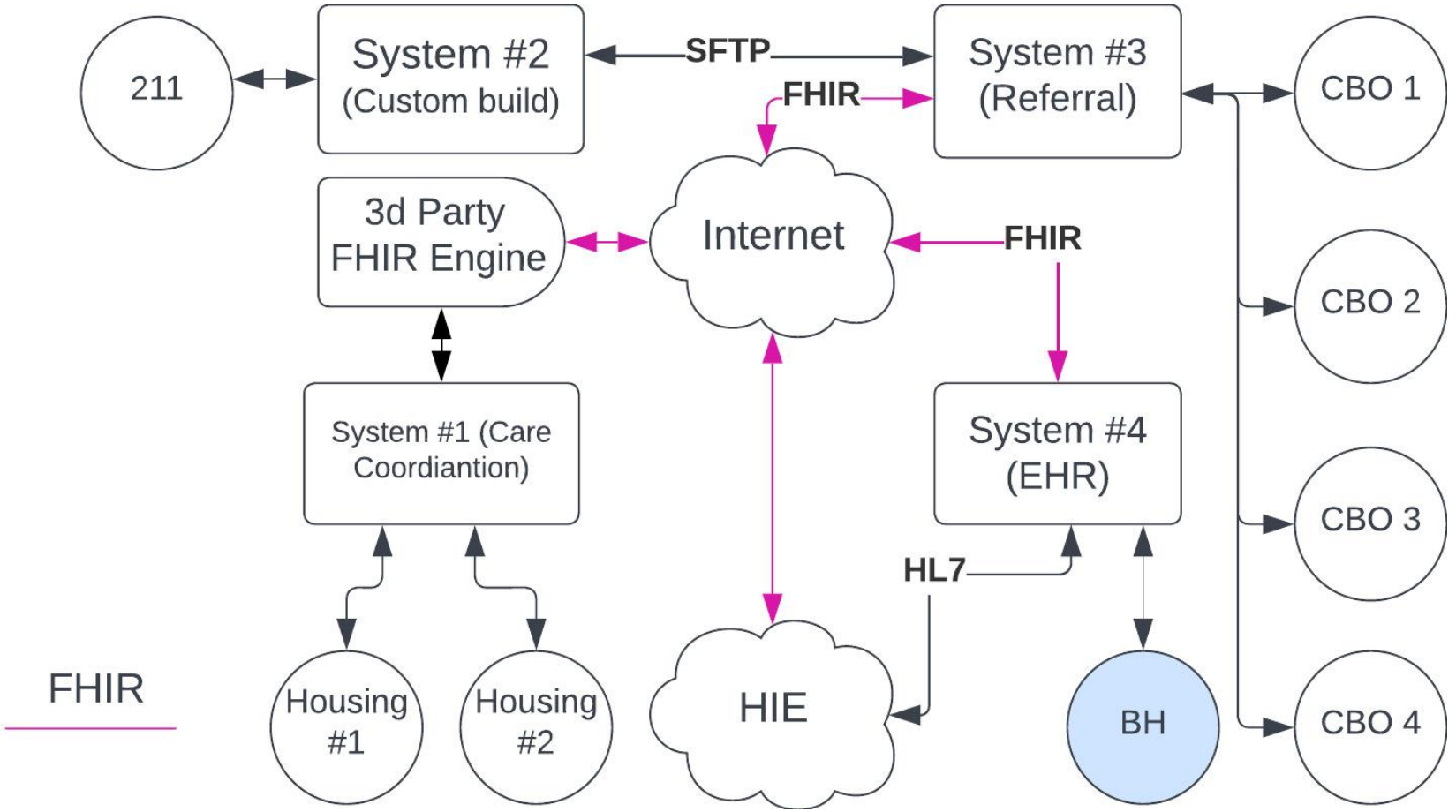
FHIR could be a 'leapfrog' standard given limited exchange today.



Emerging Data Sets for Coordination

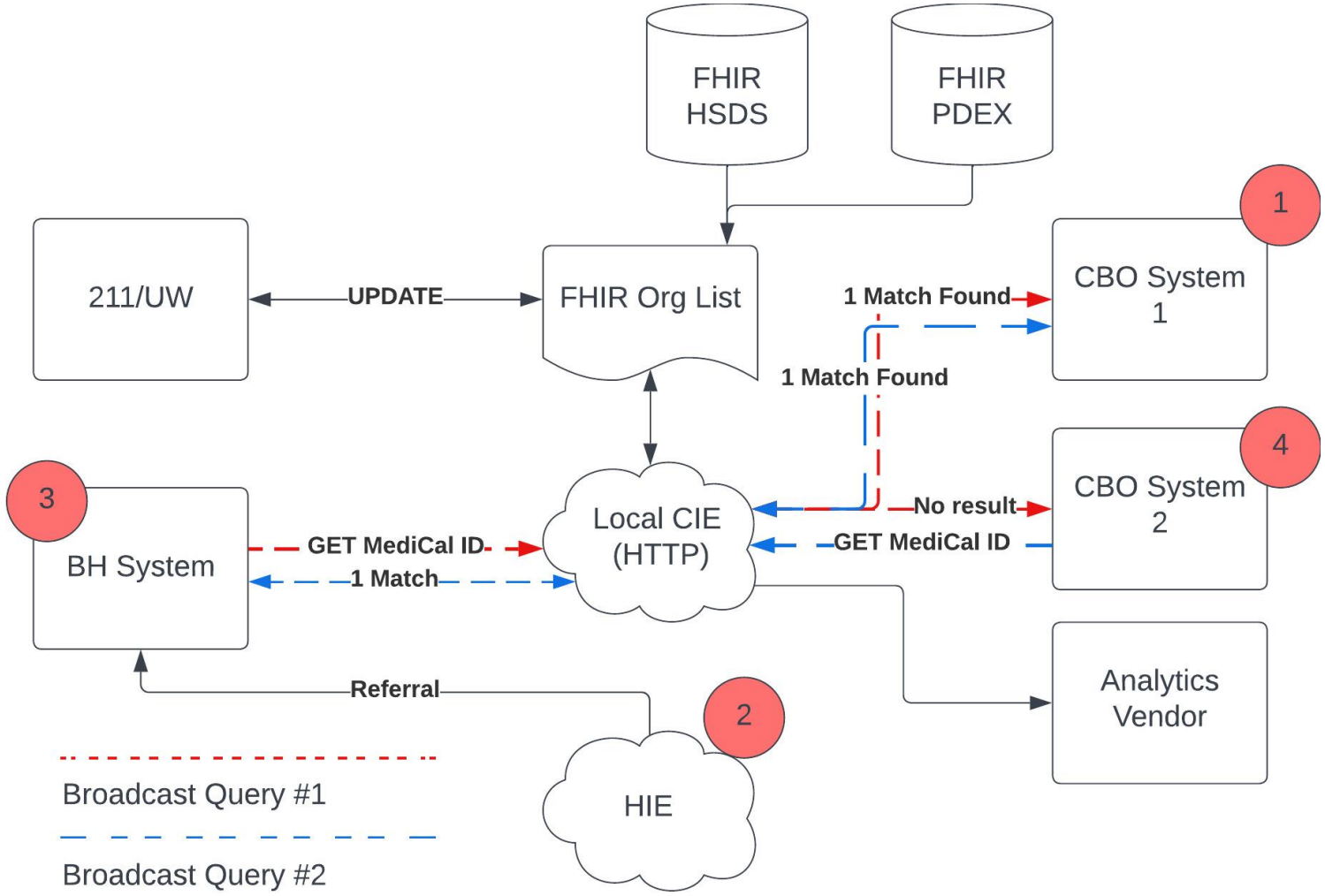
In a CIE setting, new data sets become important, including for BH providers, such as **Contact Information** and **Program Attribution**.

Open System CIE with BH



Key Takeaway: FHIR provides alternatives for meaningful CIE in the absence of a single community-level care management / referrals system

Sample CIE FHIR Workflow



1. CBO 1 adds a new client to its organization and assigns a case manager.
2. A referral is sent to BH from a healthcare provider.
3. BH queries CIE for client and receives care team data from one organization and subsequently assigns a member from their team.
4. CBO 2 conducts a broadcast query and now can see two care team linkages.

CIE Pilot Approach

Phase 1

- Identify pilot CIE organizations
- Assign business identifiers and token scopes
- Determine pilot population
- Build FHIR APIs

Phase 2

- Build onboarding and training process
- Map organizations to social data standards
- Develop analytics dashboard

Phase 3

- Map organizations to payor codes
- Integrate other vendor systems
- Role based access support
- HIE integration

Questions? Reach Out!

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Discussion

Moderated Discussion

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Staying engaged with Civitas

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THE CIVITAS NETWORKS FOR HEALTH 2023 ANNUAL CONFERENCE

C '23

Public-Private Partnerships that Inspire Health Transformation

In Partnership with Chesapeake Bay Region Members

August 20-23 | National Harbor, MD

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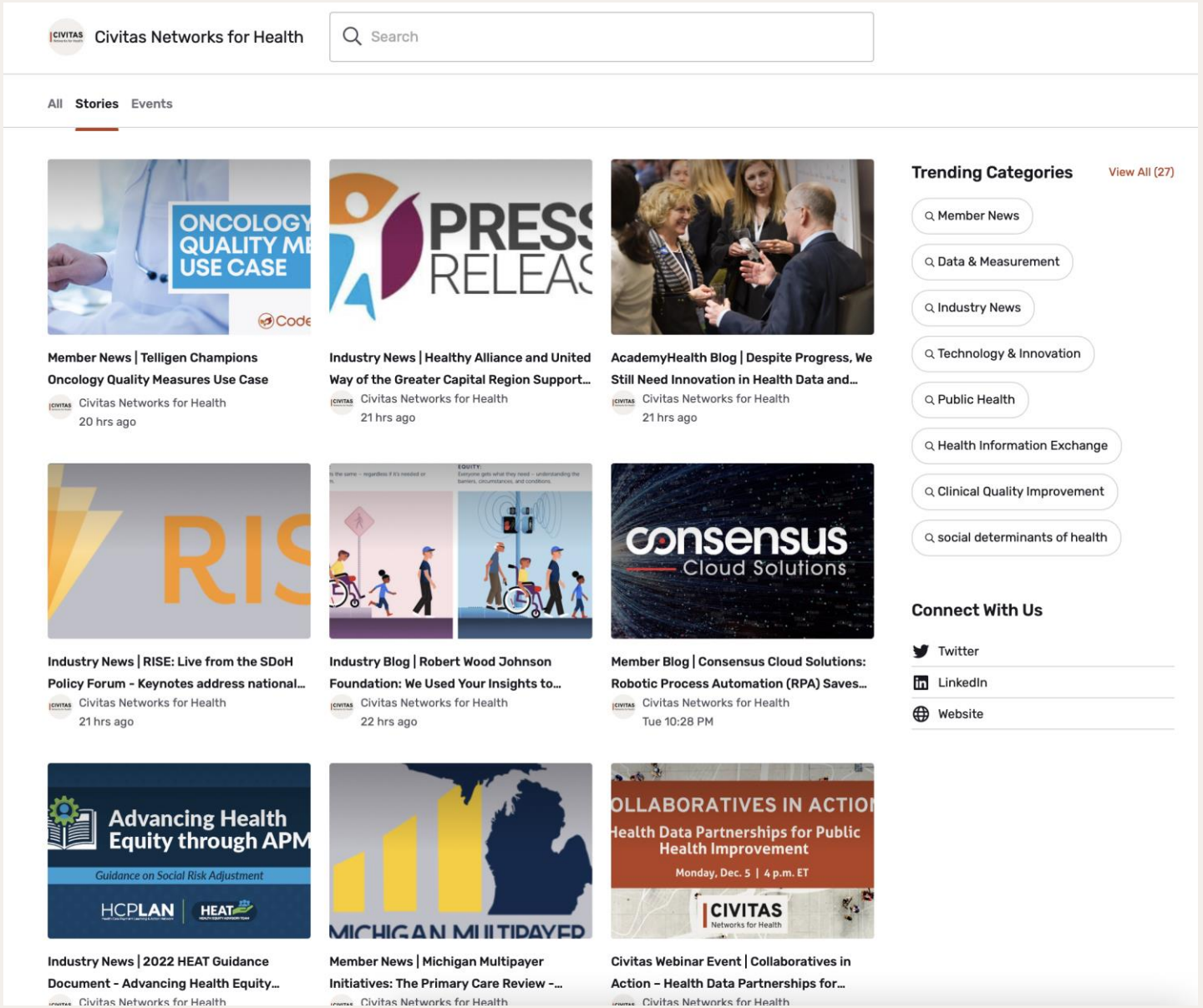

Poll: Did you learn something valuable or new, make a new connection, and/or was this a valuable use of your time?

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