

Providing Access & Transforming Health



PATH Collaborative Office Hours: CalAIM and Data Sharing Use Cases

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May 22, 2024

Agenda



- ITUP Issue Brief Overview
- Enhanced Care Management Scenario
- Open Q&A

ITUP's Latest Issue Brief: Leveraging Data to Advance Health Equity and Success in CalAIM

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Leveraging Data to **Advance** Health **Equity and** Success in **CalAIM**



>>> Issue Brief Leveraging Data to Advance Health Equity and Success in CalAlM

EXECUTIVE SUMMARY

Data exchange is integral to identifying and connecting populations to health and social services, modernizing delivery systems, and improving quality of care for all Medi-Cal patients. This issue brief explores how improved health and social services information exchange through the California Health and Human Services (CalHHS) Data Exchange Framework (DxF) is essential for the foundational success of California's Advancing and Innovating Medi-Cal (CalAIM) Initiative, Data sharing through the DxF directly supports CalAIM's goals to improve whole person care by addressing social determinants of health (SDOH), improving systems of care for Medi-Cal members, generating better health outcomes and advancing health equity. Data sharing is a vital element to measure the impact on health care access and health outcomes for Medi-Cal members.² This brief further examines data sharing needs for five major CalAIM Initiatives:



Medi-Cal Members to Community Supports



Dual-Eligibles to Managed Care



Transform Behavioral Health Services



Identify and Address Health and Social Needs of Justice-Involved Medi-Cal Members



ACRONYMS 101: Lingo To Know

BIPOC = Black, Indigenous, and Other People of Color

CalAIM = California Advancing and Innovating Medi-Cal

CIE = Community Information Exchange

CBO = Community-Based Organization DxF = Data Exchange Framework

DSA = Data Sharing Agreement

EHR = Electronic Health Record

ECM = Enhanced Care Management

HIE = Health Information Exchange HIO = Health Information Organization

HSSI = Health and Social Services Information

MCP = Medi-Cal Managed Care Plan QHIO = Qualified Health Information

SOGI = Sexual Orientation and Gender Identity

SDOH = Social Determinants of Health

Organization

CalAIM & DxF TIMELINE

O January 2022

Enhanced Care Management (ECM) and Community Supports Initiative launches; Mandatory Managed Care Enrollment for dual-eligibles launches.

JULY 2022

CalHHS establishes Data Sharing Agreement (DSA) and Data Exchange Framework (DxF) as mandated by AB 133, and releases a final version of the DSA and an initial set of policies and procedures to govern the DxF.

O July 2022

Behavioral Health No Wrong Door Policy goes live.

November 2022

DSA signing begins.

January 2023

Deadline for DSA to be signed by required signatories in California.

January 2023

Justice-Involved Initiative launches, releasing applications for county jail and youth correctional facilities.

January 2023

Population Health Management (PHM) Initiative launches, Full statewide launch of PHM is still being determined.

January 2024

Most required DXF signatories must begin to exchange health information for treatment, payment, health care operations, and public health activities.

January 2024

Qualified Health Information Organizations (OHIOs) for the DxF are announced.

April 2024

Beginning of 24-month phase-in period for Justice-Involved pre-release Medi-Cal services.

O January 2026

All required DxF signatories must begin sharing health information.



Equity in Data and Data Sharing is Foundational for CalAIM's Success





- Access to Health and Social Services Information is Foundational
- Equity-Focused
 Statewide Data
 Policy is Necessary
- Opportunity is Now

The Opportunity the DxF Has in Supporting the CalAIM Initiative





Medi-Cal Members to

Community Supports





TransitionDual-Eligibles to Managed Care

TransformBehavioral Health Services





Identify and Address
Health and Social Needs of
Justice-Involved Medi-Cal Members



EstablishStatewide
Population Health Management

 Vital to Measure Impact on Health Care Access & Health Outcomes for Medi-Cal Members

Data Sharing Advances Equity & **Efficiency in CalAIM Initiatives**



The care manager ensures member receives

culturally relevant care in SNF, and coordinates with

community supports to install home modifications to

prevent future falls. With established data exchange

and coordination, the MCP provides a longer care

transition process across the episode of care. Once

member is discharged home, the care manager

coordinates routine checks to ensure she is following

her treatment plan and healing in place.

Discharge from

Post-Hospitalization

Care and Aging

in Place

Member is discharged to a non-preferred SNF and

misses therapy and recovery milestones. She is

not provided culturally relevant meals and care,

and her health and happiness decline. She is

discharged weaker than before the fall, without

services and supports to assist her in aging in

place. She experiences another fall and

is readmitted to the ED.

- Includes 3 Detailed Scenarios:
 - Community Supports
 - Dual-Eligible Members
 - Justice-Involved **Population**
- Barriers to Success: **Policy Considerations**

The member's MCP care manager coordinates Because of existing data exchange between the skilled-nursing facilities (SNF) placement, according MCP and the ED, the ED has information on the to the patient's pre-specified SNF preferences. The patient's preferred language, care preferences, care manager locates a SNF that practices culturally and other demographic information. The ED informed care for the Hmong community, updates providers are able to provide affirming, seamless, the member's family throughout the process, and timely care. and ensures the member is discharged in a timely manner to progress to the next level of care. **Transition into Patient Care Culturally Relevant** in the ED **Post-Hospitalization** Care After receiving surgery for her fractured hip, While in the FD, member does not have access to her member transitions to post-operative care. The insurance card. The ED does not have data on the hospital attempts to coordinate between the MCP, patient and cannot communicate with her, causing the member's D-SNP, and available SNFs. Due to delays in care and treatment. The member is left dementia and language barriers, the hospital relies feeling confused and disoriented. Her preferences on a family member to discuss SNFs. While the are not met, and her questions unanswered. hospital and SNFs coordinate, the member faces

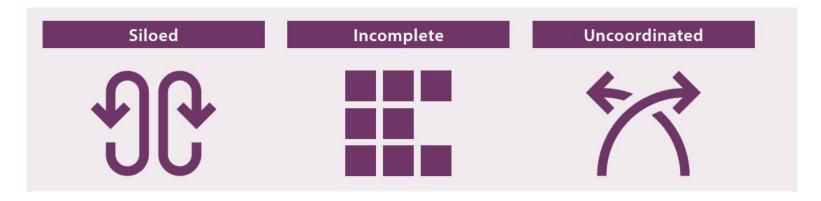
delays in discharge and deteriorates in the hospital.

Adoption of DxF is Essential for Advancing Health Equity



- Disproportionately Impacts
 Low-Income BIPOC Communities
- Equity-Focused Data Policy is Essential in Addressing Whole-Person Care

- Establishes Common Data Exchange Procedures
- Collects and Integrates
 SDOH Data



Enhanced Care Management (ECM) Scenario¹⁸

A 40-year-old Latino male on Medi-Cal with schizophrenia, diabetes, and experiencing housing instability is admitted to a mental health facility following an acute episode of schizophrenia.

The MCP contacts ECM housing ECM providers continue to exchange DATA Upon admission to the mental health supports of admission to ensure data with the MCP after member's facility, the facility sees the member's services are maintained and connects ECM providers and MCP develop an discharge and coordinate services the facility with the member. The MCP integrated, coordinated care plan to social needs and their diabetes to manage his care. MCP and ECM diagnosis. The facility communicates engages a behavioral health provider address housing stability, diabetes, and providers use data exchanged to refer with the Primary Care Physician (PCP) behavioral health care upon release. and PCP to coordinate care once member to other community services and MCP on the member's status. discharged and ensures temporary offered as needed. housing includes safe insulin storage. **ECM Member ECM Care Plan ECM Care ECM Assignment** Identification, Development, Coordination and Member Review, and Sharing, and Referral **Engagement** and Use **Authorization Management** DATA Providers at mental health facility Housing support specialists housing the discharge patient without housing or Member is unable to find stable housing The member's PCP is unaware of his member are unaware of his admission. coordination with a behavioral health and manage diabetes due to the WITHOUT admission, and the providers at the After failing to reach the member provider or PCP, disrupting his care. disruption in care services. The member mental health facility are unaware of is ultimately readmitted to the ED with to renew his temporary housing Member resides at homeless shelter his diabetes diagnosis. placement, he loses his housing. with no access to insulin storage until complications from diabetes. renewal for housing is approved.



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Questions?