Orange County Data Exchange Framework Collaborative Update

August 21, 2025

BluePath HEALTH

DATA EXCHANGE FRAMEWORK

Orange County UNITED WAY

Orange County DxF Collaborative

Vision

Health and social data exchange enables person-centered, equitable, and coordinated care for all Orange County residents.

Mission

Advance health and social data sharing in Orange County through education, collaboration, and implementation.

2025 Pillars of the OC DxF Collaborative

Vision	Education	Implementation
Goal: Build consensus on future of health and social data sharing in Orange County	**Goal:** Increase Orange County's understanding of the DxF and opportunities in health data exchange	**Goal:** Build new integrations that tangibly improve service delivery for populations of focus
Strategy: Convene the OC Network of Care Quarterly to discuss strategies, progress, and successes pertaining to *Priority 1- Coordinating Infrastructure for Community and Clinical Connections*	**Strategy:** Host quarterly all-comer education sessions on the DxF designed specifically for Orange County providers and CBOs working at the intersection of health and social services	**Strategy:** Facilitate small use-case centered working groups to identify and test opportunities for low-lift integrations and implement new data exchange workflows

Vision: May Discussion Recap

The Relationship between the Data Exchange Framework and Closed Loop Referrals

Data Exchange Framework
A common set of rules to govern exchange of health and social services information between entities

Access to the data needed to provide quality care

Closed Loop Referrals
A process to send and receive referrals for services to other health and social services organizations

Client-centered process to connect people to services

A **coordinated system of care** for all OC residents, where providers have access to the information they need to best serve their patients and clients

Mapping Closed-Loop Referral Systems

Key Takeaways:

- Many referral sources and navigators
- Few CLR platforms
- Education and stakeholder engagement is needed across systems
- Participants desire integration between CLR platforms

Next Steps:

- Participants in workgroups are exploring tangible integration options for CLR platforms
- Education on data exchange and referral pathways is ongoing through OC Network of Care and Education Sessions

Education: DxF Education Sessions

Empowering Data Sharing Through Privacy & Security

Thursday, September 18 | 2:00-3:30pm
Join us on Zoom
Hosted by OC United Way
Facilitated by BluePath Health

<u>Participants will learn about:</u>

- How to navigate DxF privacy and security requirements
- How to access and share data for care coordination while maintaining regulatory compliance

Register now:

Implementation: Workgroups

Workgroup Goals

The goal is to **build a low lift, high impact data integration, using existing technology, that solves a real problem for front line, client facing teams working to serve children and individuals experiencing homelessness in Orange County.**

We use **human-centered design** methodology to gain a deep understanding of the problems best solved with data integrations, and do so with a **clear understanding of existing technical infrastructure.**

Participants

Child Development Workgroup

- 2-1-1 OC
- First 5 Orange County
- CHOC

Housing Workgroup

- 2-1-1 OC
- HOPE Center
- Housing for Health OC
- The Coalition of Community Health Centers of Orange County

Child Development Workgroup
User Persona: Sonny

Age: 3 yr. Old male

Health Concerns: Cerebral Palsy

Social Needs: low-income, food-insecure, transportation-insecure, unhoused

Location: Santa Ana, CA

About Sonny

- Experiencing homelessness with his mother and grandmother
- Family is Spanish speaking, minimal English
- Recently diagnosed with Cerebral Palsy
- Struggles with mobility and speech delays
- Sonny, his mother, and his grandmother are Medi-Cal members

Typical Routine & Interactions

- Spends most of his time at home with his mother or grandmother
- Struggles with access to food since his mother works during food pantry hours
- Often misses medical appointments because of transportation or work schedule challenges
- Sonny often plays with stuffed animals with his neighbor's 4-year-old daughter

Challenges and Goals

- Does not have a treatment plan due to missing medical appointments
- Not yet accessing behavioral, social, and educational supports
- Family is stressed about meeting his caregiving needs
- Language barrier
- Lack of connection with families who are experiencing the same thing

What Sonny's Family Wants From System

- Guidance navigating various appointments and administrative processes in English
- Support with Caregiver respite services for his mother and grandmother
- Assistance with applying to food assistance programs (CalFresh)
- Transportation assistance for Sonny's medical visits
- Housing support for the whole family

Child Development Workgroup
Summary of Recommended Solutions

Options outlined:

1. Develop a redesigned **process map for social services referrals** for CHOC patients based on user needs
2. Build a **bi-directional interface between CLR platforms** to support increased interoperability.
3. Develop a **standardized set of intake questions** and workflows for sharing answers to those questions between referral partners

Housing Workgroup
User Persona: Marta

Age: 60 yr. old female

Health Concerns: high blood pressure, weight management, recent fall, behavioral health (depression)

Social Needs: Unhoused, Unemployed

Location: Santa Ana, CA

About Marta

- Marta was previously housed and evicted due to inability to pay rent when her partner passed away earlier this year.
- Currently living in an encampment.
- Fell and has lacerations on her right leg that are not healing well.
- Grief has exacerbated her behavioral health symptoms.
- Has Medi-Cal plan through CalOptima

Typical Routine & Interactions

- Calls 211 seeking assistance for housing
- Contact with Hope Center outreach workers to help connect with shelter options
- Occasionally receiving services from an FQHC to treat her leg and her chronic conditions
- Lacks transportation access for medical appointments, social services access, her church, and job interviews

Challenges and Goals

- Marta would like to find secure, stable housing and consistent medical care.
- Feels socially isolated with no family in the area.
- Compliance with treatment plan recommendations is limited due to impact of worsening health symptoms and lack of housing, transportation, and nutritional food.

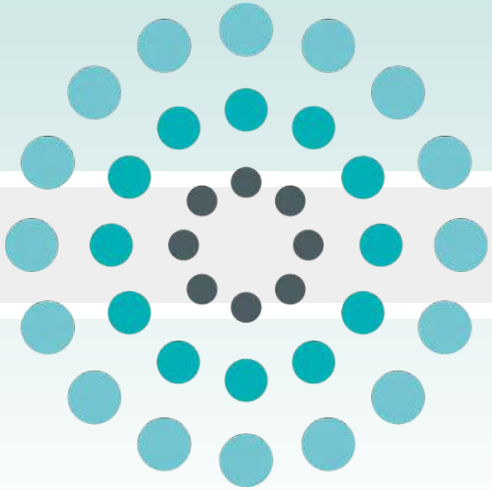
What Marta Wants From System

- Information and assistance with finding affordable, stable housing
- Access to a consistent source of medical care to manage chronic conditions and behavioral health
- Ability to not have to share her story with each new provider she meets
- Expand mental health support to include grief counseling and/or a support group

Housing Workgroup
Summary of Recommended Solutions

Options outlined:

1. Surface **real time bed availability** upon request for housing care navigators and ECM providers.
2. Establish an operational framework for ECM and Community Supports provider **access to health information** for their clients.
3. Develop workflows that **limit delays due to duplication of authorization requests.**



Questions?