Priority 1: Coordinating Infrastructure for Community and Clinical Connections

BluePath HEALTH

ORANGE COUNTY NETWORK OF CARE

Objectives

To address Priority 1, today we will:

1. Review outcomes from our February meeting
2. Explore the relationship between the California Data Exchange Framework and Closed-Loop Referrals
3. Hear updates from use case centered workgroups
4. Map the system of Closed-Loop Referrals in Orange County

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 through convening a Data Exchange Framework Collaborative with Orange County partners to prevent duplication of efforts, drive implementation and uptake of CalAIM services, and deliver faster, better service outcomes to all Orange County residents.

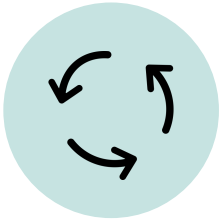
OC Network of Care Priority 1:
Coordinating Infrastructure for Community and Clinical Connections

2025 pillars of the OC DxF Collaborative

Vision	Education	Execution
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 two workgroups, focused on Housing and Child Development, to identify opportunities for low-lift integrations and implement new data exchange workflows

The DxF and Closed-Loop Referrals

Data Exchange to Enhance Care Delivery



Facilitates Referrals and Service Coordination

Ensure not only **connections** are **made to needed health and social services**, but adequately **tracked and completed**

Promotes Continuity of Care

Ensure all providers have **up-to-date information** to **reduce gaps** and promote **seamless transitions** across care team

Enables Timely and Informed Care Decisions

Provide **real-time access to client data** to **respond to changing client needs**

Data sharing is critical to improve and integrate care delivery ensuring coordinated, timely, and long-term support.

Data Sharing 101 | What is Data Sharing?

Data sharing allows patients and the organizations that provide or pay for patients' care to appropriately access and securely share a patient's vital medical and social information electronically.

Common legal obligations

Defined technical specifications

Optimal participant directory within catchment area

Three key forms of data sharing

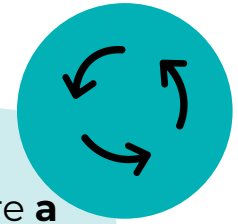
Directed Exchange
Sending/receiving secure information to a known care provider for care coordination

Query-based Exchange
Sending secure information in response to a request, typically for unplanned care

Consumer Mediated Exchange
Patients manage and share their own data among providers

Understanding the DxF and Closed-Loop Referrals

The **Data Exchange Framework** consists of a **Data Sharing Agreement** and **a set of policies and procedures** that regulate secure exchange of health and social services information. It is a set of data exchange **rules of the road** that some entities are required to follow.



Closed-Loop Referrals (CLR) are **a process** for health and social services entities to send and receive referrals for clients and patients to outside providers and to access updates about whether that service was delivered. While there are multiple methods and purposes for which organizations engage in CLR, currently, **ECM and Community Supports are the only Medi-Cal services for which CLR is required** statewide.

About the California DxF

What the DxF is

- ❑ The DxF provides the **rules of the road** to bring existing standalone health systems, providers, and social services together
- ❑ The DxF is a **technology-agnostic** collection of organizations that are required to share health information using national standards and a common set of policies
- ❑ The DxF includes a **strategy for unique, secure digital identities** capable of supporting master patient indices
- ❑ **Signing the DSA is the first step of the DxF implementation process**.

What the DxF *isn't*

- ❑ The DxF **is not a technology system for a single repository of data.**

Data Sharing Agreement and Rules of the Road

AB 133 required the establishment of a **single data sharing agreement** and a **common set of policies and procedures** that **govern and require the exchange of health information**.

DxF Data Sharing Agreement (DSA)

A legal agreement that a broad spectrum of health organizations were required to execute by January 31, 2024

- ❏ Streamlined document that focuses on the key legal requirements

Policies & Procedures (P&Ps)

Rules and guidance to support "on the ground" implementation

- ❏ Detailed implementation requirements
- ❏ Will evolve and be refined over time through a participatory governance process involving stakeholders

The DSA & P&Ps were developed to **align with an build upon existing state and federal data exchange laws, regulations, and initiative**s where possible (e.g., HIPAA, 21st Century Cures Act, etc.).

DxF Participants & What Data will be Shared

Who are the Participants?

- **Mandatory signatories**, which are mostly **health services organizations**
- **Non-mandatory signatories**, such as **community-based organizations, county agencies, and technology companies**

What is Health and Social Services Information (HSSI)?

- "...any and all **individually identifiable information** received, stored, processed, generated, used, transferred, disclosed, made accessible, or shared pursuant to the DSA **including but not limited to**:

(a) **data elements** as set forth **in the applicable Policy and Procedure**

(b) **information related to the provision of health care services**, including but not limited to PHI; and

(c) **information related to the provision of social services**. HSSI may include PHI, PII, and digital identities"

PHI = Protected Health Information, PII = Personally Identifiable Information
For more information on DxF Terms, please refer to the following: Data Exchange Framework Glossary of Defined Terms

DxF Mediated Exchange

For now, the only data exchange transactions that the DxF enables are:

Request for Information	Information Delivery	Notification of Admit, Discharge, Transfer (ADT) Events	Person Matching
Request by a Participant for HSSI regarding a specific Individual from one or more Participant(s) and the associated responses of Participant(s) to that request.	The **delivery of HSSI** regarding a specific Individual to a specific Participant in conjunction with an Order or Referral.	The **communication of ADT Events** sent by a sending Participant to a receiving Participant for specified Individuals requested by the receiving Participant.	Process by with a Participant ensures that **exchanged HSSI is appropriately linked** to the correct real person.

Closed-Loop Referrals: Definition

Closed-Loop Referrals (CLR) are a process for sending and receiving referrals that allow the referring entity to access updates on whether the service was delivered.

There are **numerous technology platforms** that can be used to enable CLRs, among other functionalities, including:

CalAIM Closed-Loop Referral Definition

Closed-Loop Referral (CLR) is a referral initiated on behalf of a Medi-Cal Managed Care Member that is tracked, supported, monitored and results in a Known Closure.

Known Closures are the final result of a referral loop closure, which include:

1. Services Received
2. Service Provider Declined
3. Unable to Reach Member
4. Member No Longer Eligible for Services
5. Member No Longer Needs Services or Declines Services
6. Other
7. Authorization Denied

CalAIM Closed-Loop Referral Requirements

- The latest CLR guidance from the California Department of Health Care Services details requirements for Medi-Cal Managed Care Plans (MCPs) to collect data to track the status of referrals and serve as a resource for others involved, including providers, CBOs, and Members

- MCPs are required to implement CLR requirements by **July 1, 2025** for **ECM and Community Supports referrals.** So far, CLR is not required for any other Medi-Cal services

- The State does not mandate that MCPs use CLR technology to implement CLR policy. Some MCPs might use CLR platforms while others may rely on existing data sharing mechanisms, including the MIF and RTF.

The Relationship between the DxF and CLR

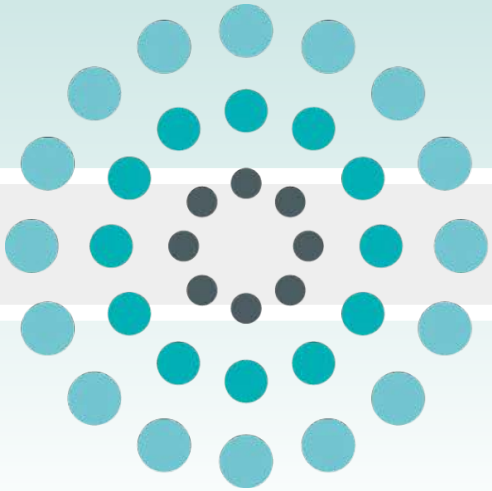
Data Exchange Framework
A common set of rules to govern exchange of health and social services information between entities

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



Questions?

Workgroup Updates

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

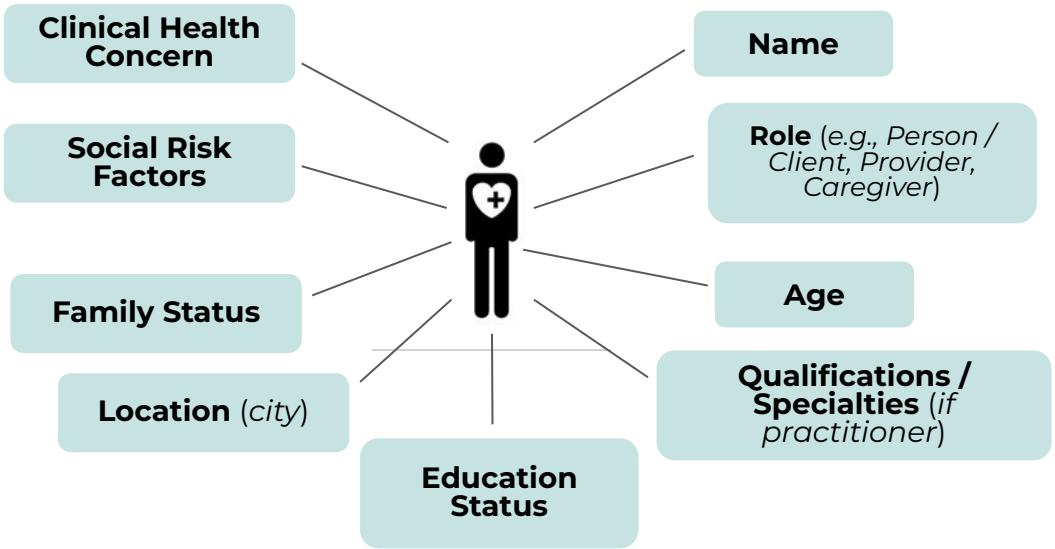
Child Development Workgroup

- 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

Developing a User Persona



- **About Persona:** Brief description of persona. What is their profession? What is their history with health and social risk factors identified? What is their household status (how many children?) What are their preferences?
- **Typical Routine & Interactions:** What does a regular day look like?
- **Challenges & Goals:** What are the primary challenges faced at the most recent point in time? What are the short-term and long-term goals?
- **What Persona wants from the Orange County Network of Care**

Housing 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

Child Development 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

Activity:
Mapping the CLR System

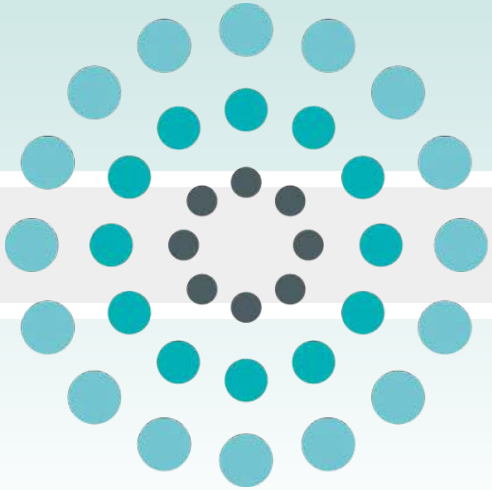
Mapping the CLR System

Objective: Map the CLR systems our network utilizes, who uses them, and for what purpose so that we can identify opportunities for increased integration and collaboration.

Process:

1. Using sticky notes, **add additional detail** about the systems listed on the wall.
2. Include your **questions** about these systems.
3. **Add systems** that are missing and update information as needed.

Next steps: You are invited to a working session this summer to review the outcomes.



Next Steps

Join our next working session

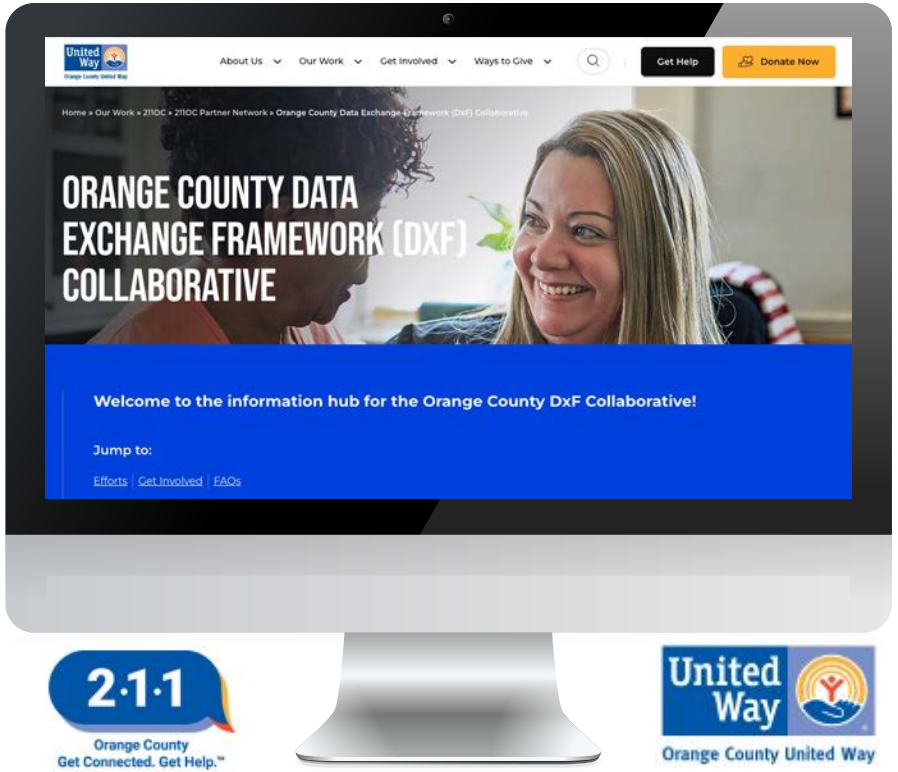
Interested in being part of the process as we take the next steps in this system mapping? Join us for a working session this summer (date TBD)!

Register to stay involved:

Check out the OC DxF Collaborative Webpage

Visit the information hub for the OC DxF Collaborative to:

- **Learn more** about the DxF
- **Get involved** in data sharing in a way that makes sense for your organization
- **Review materials** from past meetings and education sessions
- **Reach out** with questions



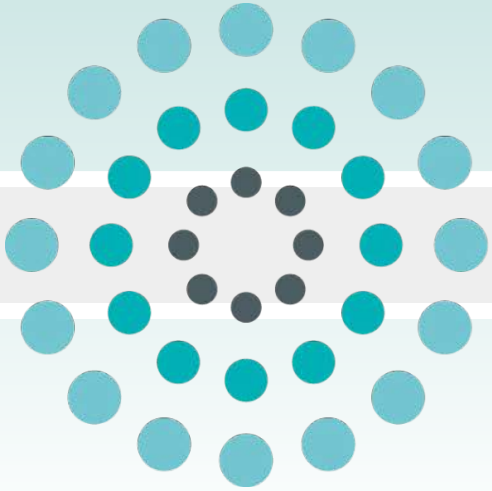
Accessing Data Sharing Networks to Enable DxF Participation for CBOs

Tuesday, June 17 | 1:30 - 2:30pm
Join us on Zoom
Hosted by OC United Way
Facilitated by BluePath Health

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

- First steps to take to begin sharing data under the DxF
- Role of data sharing networks in supporting CBOs with DxF participation

Register now:



Thank you!