AB 133 Discussion: <u>Striking the Balance of the Alignment of Public Health, Aging, and the Underserved Population in the Area of Data Standardization of SDOH - Background Information</u>

For questions or further discussion please contact Katy Weber, MPH at kweber@pophealthsolutions.com

Part 1: Feedback from various types of stakeholders

Incentives for Health Plans and Healthcare Providers

If the intent of AB 133 is to coordinate across public health, department of aging, healthcare, behavioral health and social service agencies including community-based organizations, it is critical to include discussion around and SDOH framework as part of the primary discussion.

Having the ability to exchange medical, behavioral, and social service data through a digital exchange framework provides you the ability to provide a patient centered view for more effective enhanced care management enabling the ability to compile/exchange data across various types of providers(medical, behavioral health, and community based organizations).

By incorporating a SDOH framework into the standards would provide the ability at the individual level to see what social services were provided under CalAIM and what additional services are being provided under other social service programs including IHSS, CalFresh, California Department of Aging(Meals on Wheels and other CDA programs), and other social service programs. This will especially help in coordinating supportive services in the community for CalAIM Enhanced Care Management for those individuals at risk of institutionalization or are currently institutionalized transition back to the community.

This will also provide a framework for MCPs and community-based organizations to build out their technical infrastructure under the various funding opportunities for CBOs including the CalAIM IPP Incentive Funding, PATH, and HHIP funding. The AB 133 framework could provide a framework for CBOs to exchange SDOH data with MCPs as the population health strategy, enhanced care management, and community support initiative is rolled out. This will help CBOs coordinate across multiple health plans and align vendor platforms across medical and non-medical providers.

Funding Initiatives for Community Based Organizations

We also have several funding opportunities for community-based organizations/social service organizations to access to build out their technical architecture of over $4 billion dollars including CalAIM IPP, PATH funding, and HHIP funding. If there are SDOH data exchange standards like Gravity incorporated into AB 133 for social service organizations to exchange data

with healthcare providers, the social service agencies can utilize these standards with their software vendors to align the data exchange standards with the interfaces with healthcare providers. This will help avoid the scenario of a community based providers having to create different interfaces with different healthcare providers to exchange SDOH data.

CalAIM Incentive Payment Program (IPP)- Infrastructure & Capacity Building Funding for CBOs:

The Governor's Budget FY 2021-22 allocated $300 million for plan incentives from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024. Incentive Funding will phase out in FY 2024-25.

This funding is intended to complement and expand ECM and Community Supports in the following ways:

- Build appropriate and sustainable capacity

- Drive MCP investment in necessary delivery system infrastructure

- Bridge current silos across physical and behavioral health care service delivery

- Reduce health disparities and promote health equity

- Achieve improvements in quality support

- Incentivize MCP take-up of Community Supports

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Providing Access and Transforming Health (PATH) Funding

Reminder: What is "Providing Access and Transforming Health" (PATH)?

California has received targeted expenditure authority as part of its section 1115 demonstration renewal for the "Providing Access and Transforming Health" (PATH) program to take the State's system transformation to the next phase, refocusing its uses to achieve the CalAIM vision. DHCS received authorization for $1.44 billion total computable funding to support for PATH to maintain, build, and scale the capacity necessary to ensure successful implementation of CalAIM.

Reference: https://www.dhcs.ca.gov/CalAIM/Documents/PATH-Jan-28-All-Comer-Webinar.pdf

Housing & Homelessness Incentive Program

HHIP Overview: HHIP is a voluntary incentive program that will enable Medi-Cal Managed Care Plans (MCPs) **to earn incentive funds for making progress in addressing homelesness and housing insecurity** as SDOH. MCPs must collaborate with local Continuums of Care to identify gaps in services. **Goal is to ensure MCPs have the necessary capacity and partnerships to connect their members to needed housing services.**

HHIP Program Design: DHCS is designing HHIP with input from Stakeholders, including MCPs, cities, counties, local Continuums of Care, providers, nonprofits, county behavioral health and social services, local housing departments and CBOs.

Total Incentive Funding: $1.288 billion one-time funds - ($644 million in state ARPA + $644 million in matching Federal funding)

Funding Timeline: Funding available through March 21, 2024; Letters of Interest from MCPs to DHCS are due 3.25.22; MCPs submit Local Homelessness Plan by 6.30.22; Initial payment issued September 2022

Source: American Rescue Plan Act (ARPA) HCBS Spending Plan

California Department of Aging Initiatives

If the Data Exchange Framework incorporates exchange standards for medical, behavioral health, and social services, the framework could be utilized to align the California Department

of Aging(CDAS) customer relationship system(CRM) being implemented over the next couple of years to exchange data with DHCS, Public Health, and other agencies. This will be critical to coordinate social services across dual-eligibles with other social service programs for older adults including Meals on Wheels. This will also avoid duplication of services.

This will be critical for the CDA to accomplish the initiatives set forth by the Master Plan on Aging. Here are some from the California Master Plan on Aging

- · Goal 2: Health Reimaged:
    - o Strategy A: Bridging Health Care with Home
        - Initiative 34: Plan and develop innovative models to increase access to long-term services and supports for people receiving Medicare only. (Lead Agency: CHHS)
        - Initiative 35 Plan and develop innovative models to increase access to long-term services and supports and integrated health care for people receiving both Medicare & Medi-Cal ("duals"): by implementing statewide Managed Long-Term Services and Supports (MLTSS) and Dual Eligible Special Needs Plan (D-SNP) structure, in partnership with stakeholders. (Lead Agency: CHHS)
        - Initiative 36: Expand access to home and community-based services for people receiving Medi-Cal: via CalAIM, by implementing "In Lieu of Services" (including: Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, Short-term Post Hospitalization Housing, Recuperative Care, Respite, Day Habilitation Programs, Nursing Facility Transition/Diversion to Assisted Living Facilities of Home, Personal Care and Homemaker Services, Home Modifications, Medically Tailored Meals, Sobering Centers, and Asthma Remediation) and "Enhanced Care Management." (Lead Agency: CHHS)
        - Initiative 37 Consider home and community alternatives to short-term nursing home stays for participants in Medi-Cal managed care through utilization of combination of the home health benefit, in lieu of services, and proposed expanded telehealth benefit, including remote patient monitoring. (Lead Agency: CHHS)
        - Initiative 38 Explore options within existing authority and new state plan authority for community health workers to conduct isolation checks/home visits for older and other adults, to meet need and as funds available. (Lead Agency: CHHS)

- Initiative 41Assess need and opportunities to expand community-based aging and disability networks' "business acumen" for health partnerships. (Lead Agency: CHHS)
  o Strategy B: Health Care as We Age
    - Initiative 49 Highlight to Medi-Cal plans and providers the value of palliative care to improve patient outcomes and support patient and family choices for care. (Lead Agency: CHHS)
- Goal 3: Inclusion & Equity, Not Isolation
    - Strategy F: California Leaders
      - Initiative 98 Build out No Wrong Door/"One Door" statewide for public information and assistance on aging, disability, and dementia, via upgraded web portal, statewide network of local ADRCs with shared training, tools, and technology, and continually improving cultural competency and language access. (Lead Agency: CHHS)
- Goal 5: Affordable Aging
    - Strategy A: End Homelessness for Older Adults
      - Initiative 117: Building on the success of Homekey, further develop the network of housing needed to end homelessness, prevent older and other at-risk individuals from falling into homelessness, and provide expanded supports at housing placements. (Leading Agencies: CHHS & BCSHA)
    - Initiative 119: Assess IHSS Plus Housing models. (Leading Agency: CHHS)

Population Health

With regards to the CalAIM Population Health Strategy, and Enhanced Care Management and Community Supports a social identifier would be needed to be used to link both medical and social services to an individual provided under CalAIM and other social service programs to provide effective care coordination and population health. By linking the individuals with medical and social services before de identifying would improve the population health strategy since often SDOH intervention coordinated with a medical intervention is more effective than a medical intervention alone. This is the reason why SDOH has gotten more focus over the years. With the population health strategy rolling out through CalAIM, the data exchange framework/digital identities utilizing de-identified data could be used at the population health data to identify needs and evaluate the combination of medical and social interventions at the population level at a county, region, and state level if utilizing population health data across health plans, community based organizations, and other agencies. Here is an example from the Gravity Project that integrates SDOH with healthcare data. This approach promotes cross agency collaboration. Here is a screenshot of how this is being implemented through the Gravity Project.

Accelerating Adoption Using Nationally Recognized Standards
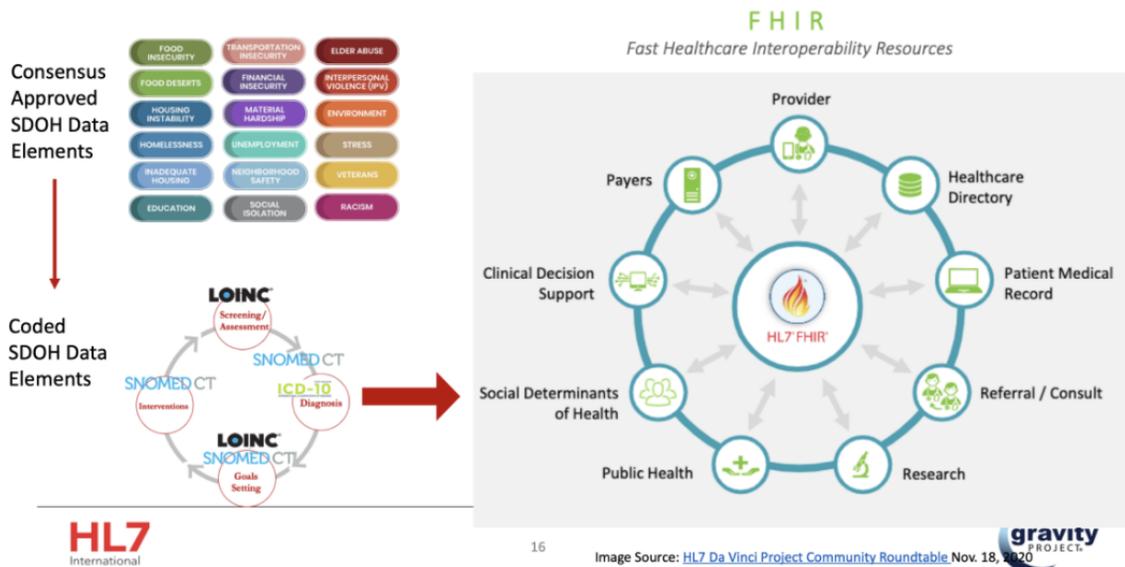
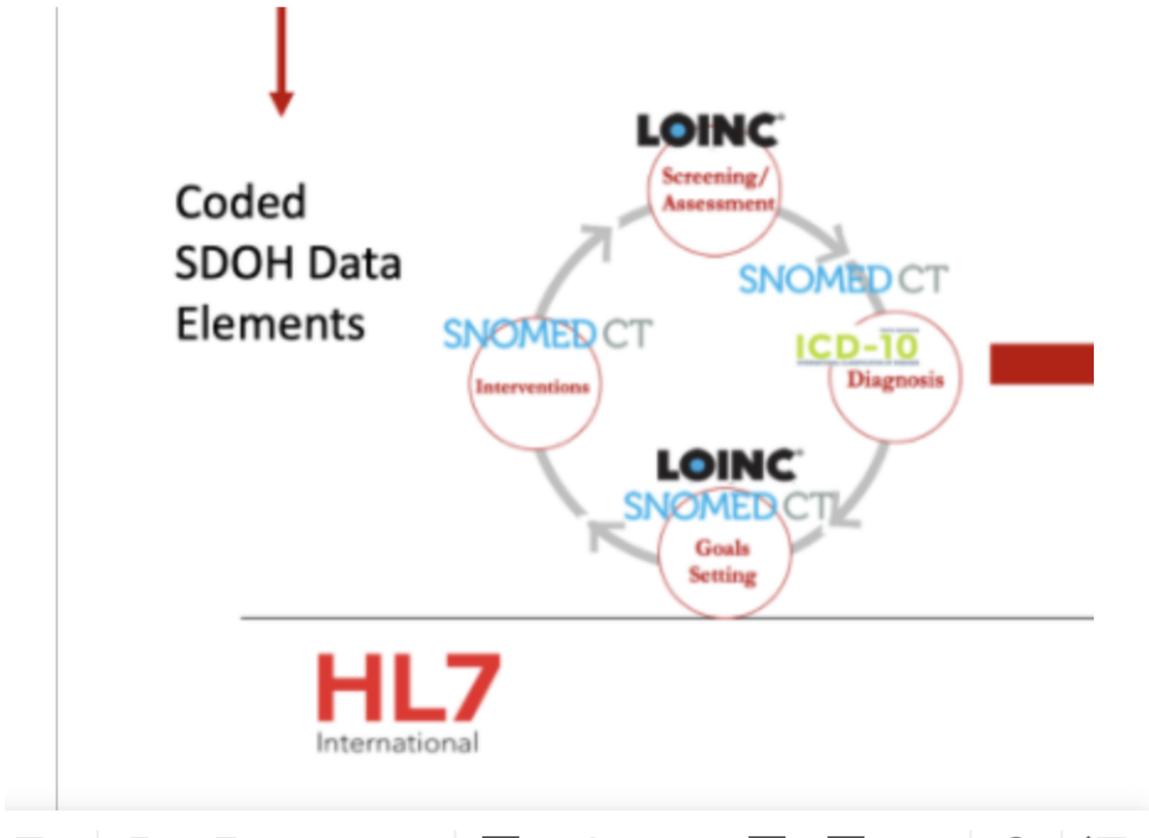Reference: https://www.healthit.gov/sites/default/files/facas/2021-04-08_Gravity_Project_Presentation.pdf

Here is link to an article "Integrating Social and Medical Data to Improve Population Health: Opportunities and Barriers (https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0723). Here is an example of patient and population-level data collection tools and uses for data on social determinants of health: case study on food security.

Exhibit 1 Patient- and population-level data collection tools and uses for data on social determinants of health: case study on food security
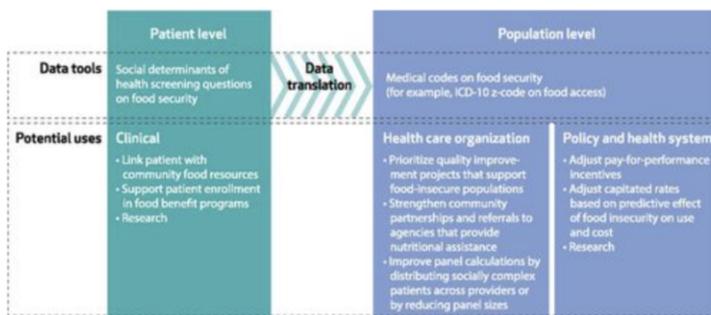

SOURCE Authors' examples of individual- and population-level data collection tools and uses for data on food security. NOTES ICD-10 is the *International Statistical Classification of Diseases and Related Health Problems* , Tenth Revision. Z-codes include codes for social determinants of health that reflect a patient's social characteristics.

With roll-out of the CalAIM population health strategy incorporating screening or assessment data and available social data records, with incorporating SDOH standards like the Gravity Project already has several of the assessments with the questions coded. With the codes you are able to connect the SDOH to the assessment data to drive population health with healthcare providers and enable the ability for risk stratification and risk tiering. Having SDOH standards will also help collaboration across multi-plan MCP counties. See the slide to below as a reference to population health and coding as it relates to the Gravity Project. The Gravity project has coded SDOH elements where the screening/assessment is linked the Screener/Assessment with Diagnosis, Goals Setting, and Intervention.
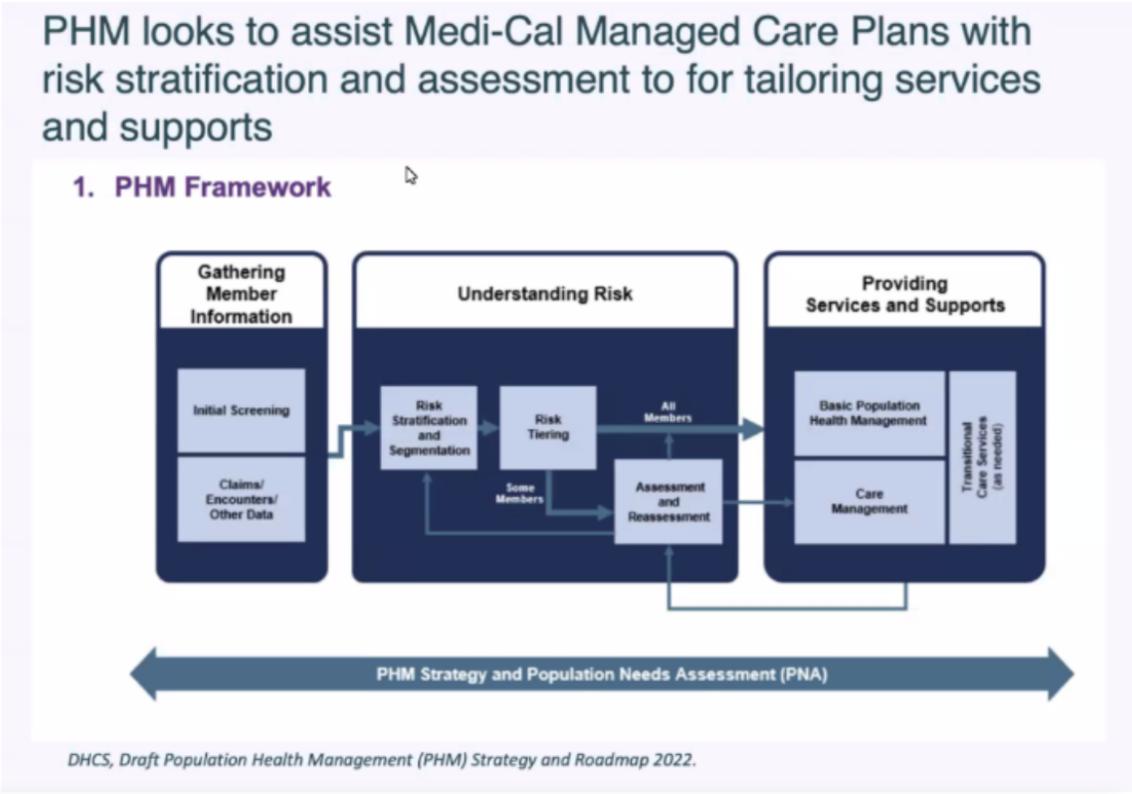
Reference:https://www.healthit.gov/sites/default/files/facas/2021-04-08_Gravity_Project_Presentation.pdf
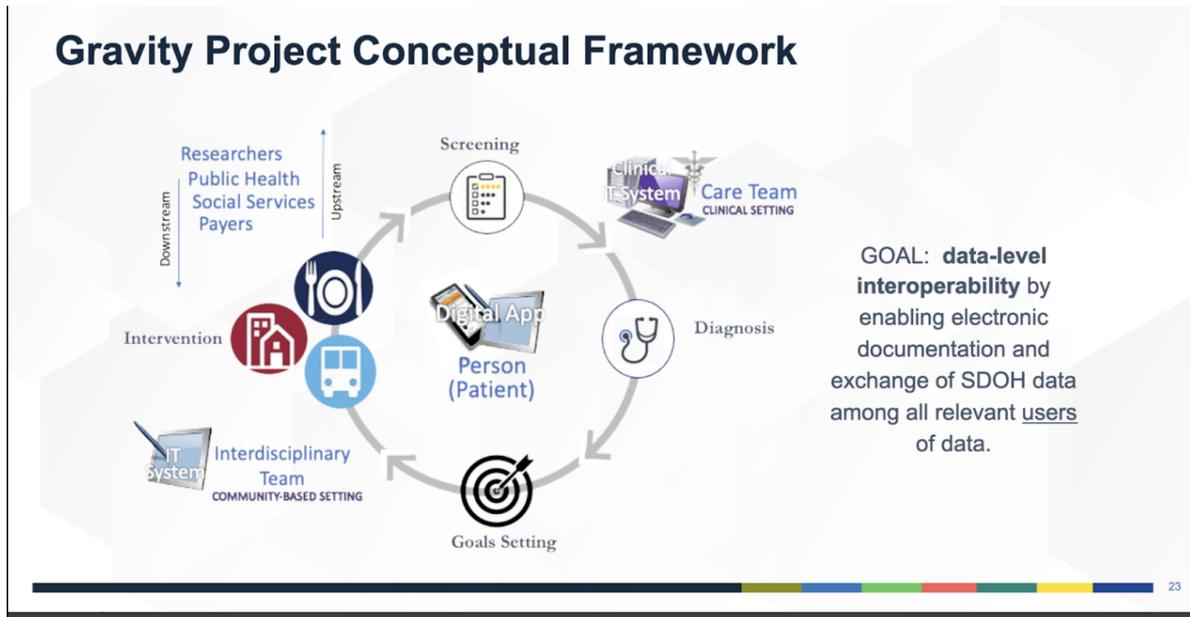
Reference: https://confluence.hl7.org/display/GRAV/Public+Health+Use+Case+Workgroup+for+Chronic+Disease+Prevention+Home?preview=/90342101/94663897/CDC%20NCCDPHP%20SDOH%20Data%20Exchange%20Workgroup%20Kickoff_20-04-2022%20FINAL.pdf

Here are a couple slides that represent the proposed CalAIM Population Health Medi-Cal Strategy

PHM looks to assist Medi-Cal Managed Care Plans with risk stratification and assessment to for tailoring services and supports

1. PHM Framework

DHCS, Draft Population Health Management (PHM) Strategy and Roadmap 2022.

MCPs-–and DHCS—expected to gather extensive data beyond administrative claims

Leveraging Existing Member Data

As part of initial information gathering, MCPs are expected to access and use data to inform whole-person care approaches.

- Screening or assessment data;
- Claims and encounter data, including fee-for-service data;
- Available social needs data;
- Electronic health records;
- Referral data;
- Behavioral Health data (including SBIRT and other SUD data);
- Pharmacy data;

- Utilization data;
- Disengaged Member reports;
- Lab results data;
- Admissions, discharge and transfer (ADT) data;
- Race/ethnicity data; and
- Sexual orientation and gender identity (SOGI) data.
- For Members under 21, information on developmental and ACEs screenings.

Level-Setting Timing Expectations

- DHCS acknowledges that while the PHM Service is coming online, MCPs have imperfect access to some of the required data sources.

- **MCPs are expected to make a good faith effort to use these data sources to the greatest extent possible** prior to the PHM Service being available.

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DHCS, Population Health Management Advisory Group Kick-Off, March 2022

- Reference: https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Advisory-Group-Kickoff-11y.pdf

Public Health Emergencies

With a digital identifier and SDOH data structure as part of the data exchange standards, you are able to collect critical SDOH data for the vulnerable population that can be utilized in the case of a public health emergency to provide life saving interventions.   For example, Patient Unified Lookup System for Emergencies(PULSE) provides access to health information during a disaster.   With the PULSE, the data is masked/secured when collected. When a public health emergency including power outages, you would be able to unmask the data during the public health emergency and prioritize the services needed by the individual residents and coordinate staff and volunteers to services these needs. These could include battery packs to those that need power for emergency equipment to getting older adults to cooling centers for those that do not have transportation, or evacuating form a fire. We should include a process to get the consent of the individual to utilize the information during a public health emergency.   After the public health emergency is over, the data is masked again.

PULSE was developed to provide disaster healthcare volunteers with access to electronic health information during times of large-scale emergency or disaster. It is intended to support five primary use cases, which are retrieving health information for:

1. Patients evacuated from healthcare facilities in the effected area
2. Injured victims transported by first responders
3. Injured victims transported by themselves, family members, or neighbors
4. Walking wounded presenting with minor injuries requiring treatment
5. Evacuees seeking primary care for chronic conditions or health issues unrelated to the disaster

Users of PULSE are granted access through the California Disaster Healthcare Volunteers (DHV) database, which provides a vetted registry for individuals who have volunteered to serve during an emergency or disaster. Currently, DHV authorizes licensed physicians, pharmacists, nurses, nurse practitioners, physician assistants, paramedics, and EMTs to access health information for treatment purposes.
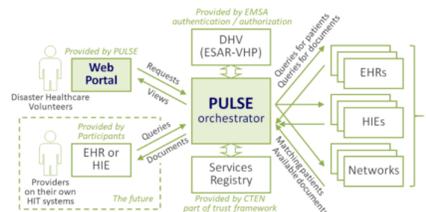
- Reference: https://www.ca-hie.org/initiatives/pulse/

Improved Equity and Data Transparency

With a SDOH data exchange standards, you are able to be able to drive equity within both medical and social interventions. It also provides better data transparency through data modernization.

Here are some slides from the Social Determinants of Health Data Exchange for Chronic Disease Prevention through the Gravity Project. Initiative(https://confluence.hl7.org/display/GRAV/Public+Health+Use+Case+Workgroup+for+Chronic+Disease+Prevention+Home?preview=/90342101/94663897/CDC%20NCCDPHP%20SDOH%20Data%20Exchange%20Workgroup%20Kickoff_20-04-2022%20FINAL.pdf)

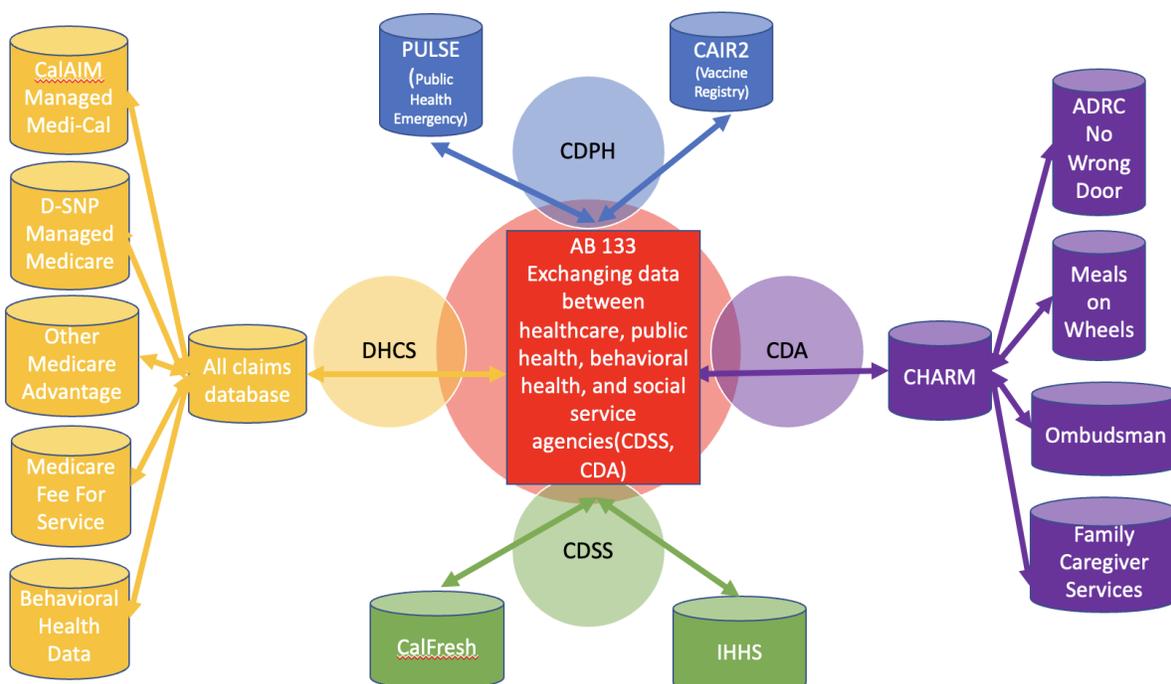High-Level SDOH Measurement Roadmap
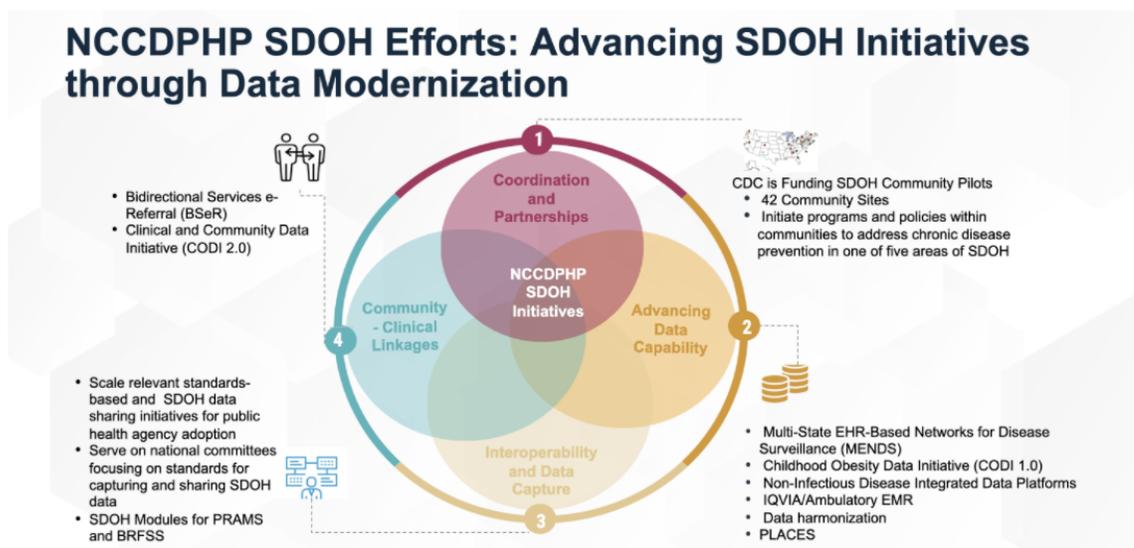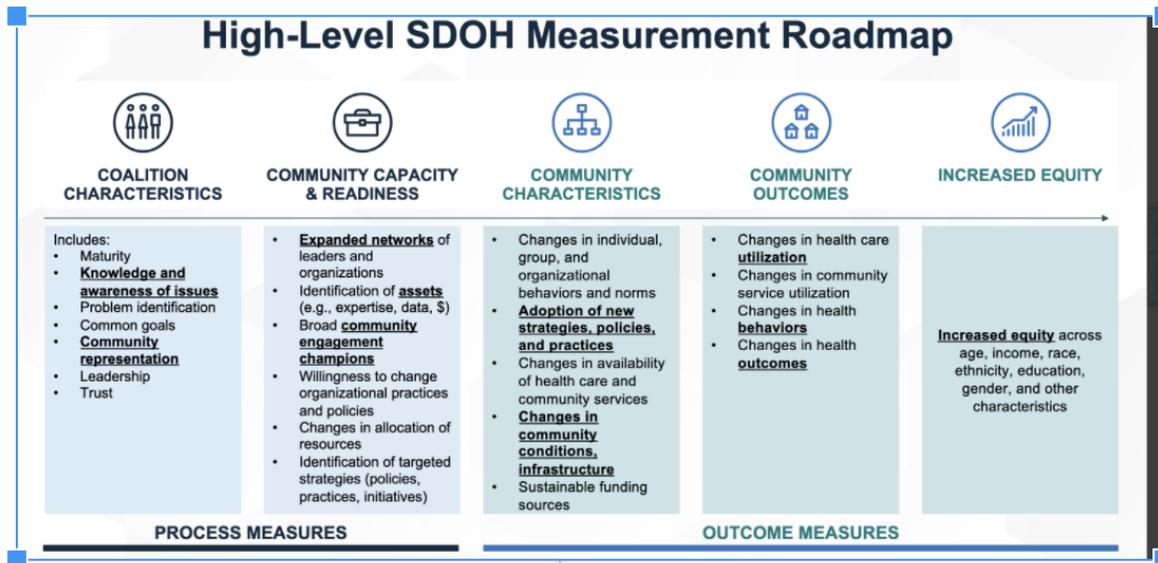
In conclusion there are several reasons to include SDOH standards as part of the AB 133 data exchange standards recommendations. It is critical both for CalAIM and California Department of Aging to provide patient centered care for older adults and people with disabilities.

Part 2: AB133 Comments in Use Case of a Older Adult Across Multiple Agencies

The intent of AB 133 is to coordinate across public health, department of aging, healthcare, behavioral health and social service agencies including community-based organizations for the underserved population.

Figure: 1 Intent of AB 133 - Provide a data exchange network across public health, healthcare, and social service organizations including Department of Health Care Services(DHCS), California Department of Public Health(CDPH), California Department of Aging(CDA), and California Department of Social Services.

CalAIM Managed Medi-Cal

D-SNP Managed Medicare

Other Medicare Advantage

Medicare Fee For Service

Behavioral Health Data

All claims database

DHCS

PULSE (Public Health Emergency)

CAIR2 (Vaccine Registry)

CDPH

AB 133 Exchanging data between healthcare, public health, behavioral health, and social service agencies(CDSS, CDA)

CDA

CDSS

CalFresh

IHHS

CHARM

ADRC No Wrong Door

Meals on Wheels

Ombudsman

Family Caregiver Services

The eight CalHHS Data Exchange Framework Guiding Principles include: 1: Advance Health Equity. 2:Make Data Available to Drive Decisions and Outcomes. 3:Support Whole Person Care. 4: Promote Individual Data Access. 5: Reinforce Individual Data Privacy & Security. 6: Establish Clear & Transparent Terms and Conditions for Data Collection, Exchange, and Use. 7: Adhere to Data Exchange Standards. 8: Accountability. See Appendix A for a more comprehensive description of the CalHHS Data Exchange Framework Principles.

Here is an example of a use case where you have Ms. Smith, an older black women, receiving services from multiple agencies including DHCS(dual-eligible), CDPH(lives alone, homebound, ADRC coordinating her services), CDA(care coordination from ADRC, Meals on Wheels and family caregiver services), and CDSS(gets IHSS).

Figure 2: Use Case: Ms. Smith, older black adult, receiving services from DHCS, CDPH, CDA, and CDSS.
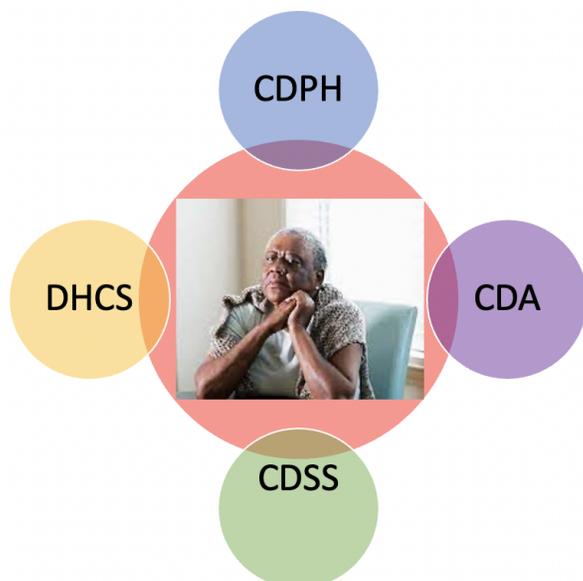

In order to achieve CalHHS Data Exchange Principles, it is important to consider the **Statewide Person Index** along with the **Statewide Consent Registry** to ensure that data can be exchange between different types of agencies with different data authorization/sharing requirements and at the same time ensuring that an individual's data is accessible to the individual and secure. Also, with the ability to connect an individual's data to a statewide data index and consent registry you will have the ability to evaluate equity across the state to align and evaluate interventions from an equity population health perspective.

Figure 3: Statewide Person Index and Statewide Consent Registry
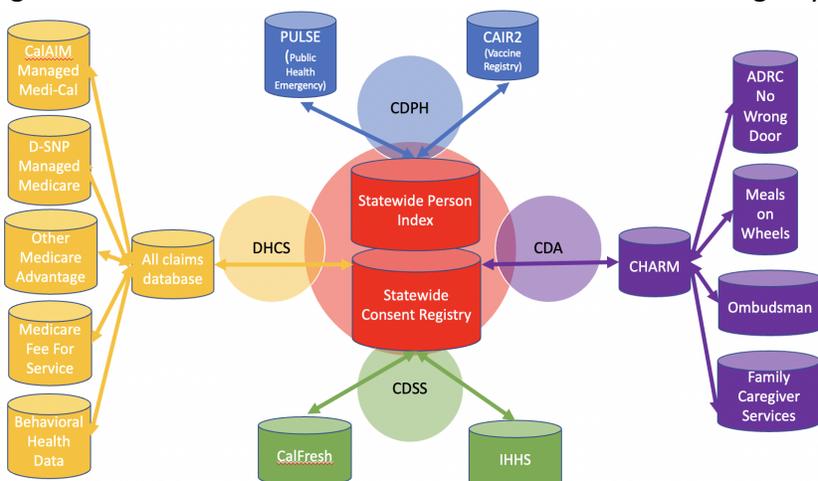
Looking at the use case of Ms. Smith from the DHCS side of integrating social services into healthcare, there are multiple levels of data that have to be considered. With Ms. Smith being dual eligible, there is a need to connect the social services being delivered through the supplemental benefits on the Medicare Advantage Side (D-SNP) and on the CalAIM Enhanced Care Management/Community Supports.   This could be accomplished utilizing a statewide person index and statewide consent registry. There is also a need to connect the SDOH data with the healthcare at the individual level to evaluate equity and outcomes of an intervention and identify gaps in the community.
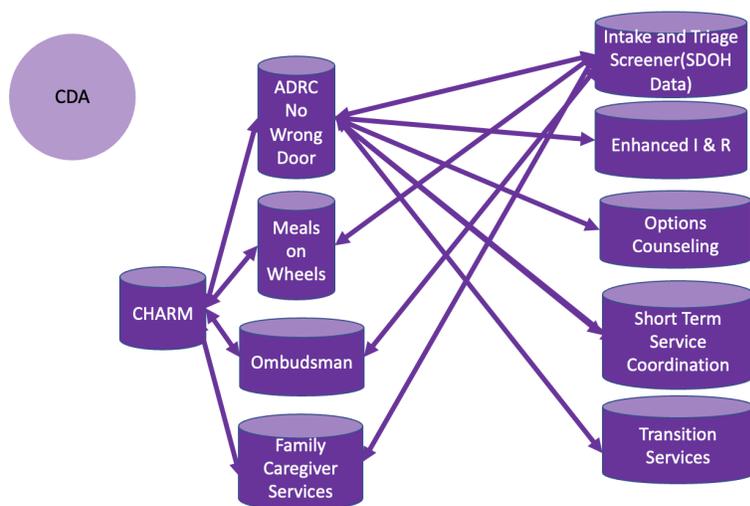
Figure 4: DHCS Data Connection Scenarios
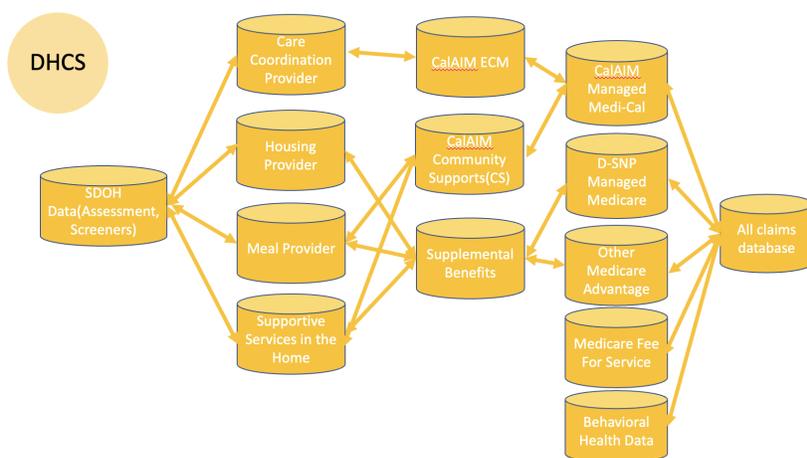
This is one of the critical reasons to include an approach to a data exchange SDOH framework as part of the AB 133 Data Exchange Framework. By incorporating a SDOH Data Exchange Framework along with a Statewide Person Index and Statewide Consent Registry into the overall data exchange framework will provide the ability for other agencies to exchange healthcare,

behavioral health, social service, and public health data across agencies. There is **over $4 billion dollars** in funding going to community based organizations aligning around CalAIM(IPP and PATH) and Homelessness(HHIP) to build out their technical infrastructure. With a SDOH Data Exchange standard as part of the data exchange standards, the underlying data architecture of the SDOH would be compatible across organizations to exchange both healthcare and social service data for CalAIM and the coordination of services across agencies. Without SDOH data exchange standards as part of the data exchange framework, would create barriers for organizations to be able to exchange SDOH data similar to what happened when the incentive to implement medical records was rolled out without any data exchange standards.

In addition, Ms. Smith is also receiving services from CDA including care navigation from the ADRC, Meals on Wheels, and Family Caregiver Services. From the No Wrong Door being developed under the ADRC, it will be critical for the ADRC to be able to exchange data with DHCS to see what enhanced care management, community support services are being delivered through CalAIM, exchange the data with CDSS for other social service programs like CalFresh an IHSS services, and CHARM to identify the services being delivered through CDA.

Figure 5: CDA Programs

Note, the CDA is currently aligning their data across the various CDA programs with the implementation of CHARM which is a customer relationship management to coordinate the data structure across the CDA departments. This is one of the critical reasons to include an approach to a data exchange SDOH framework as part of the AB 133 Data Exchange Framework. By incorporating SDOH Data Exchange Framework along with a Statewide Person Index and Statewide Consent Registry into the Data Exchange Framework, would provide a data structure and data consent workflow for the CDA to align the data within CHARM to be able to exchange the data with other agencies.

There is also a need to connect public health data with other agencies. One of the most important use cases is in the case of a public health emergency and PULSE. If you have the ability to collect critical SDOH data(example during a IHSS annual assessment) like homebound, live alone, need power for life saving medical equipment as example for our vulnerable population and mask the data to access during a public health emergency, the data can be unmasked during a public health emergency and the first responders can utilize the data to quickly prioritize resources and evacuations if necessary that could be life saving.   For example, if there was a wildfire, the first responders would be able to unmask the data and see that Ms. Smith is homebound and lives alone. The first responders would know to check her house to evacuate her first since she is not able to leave on her own.

Figure 6: CDPH Data
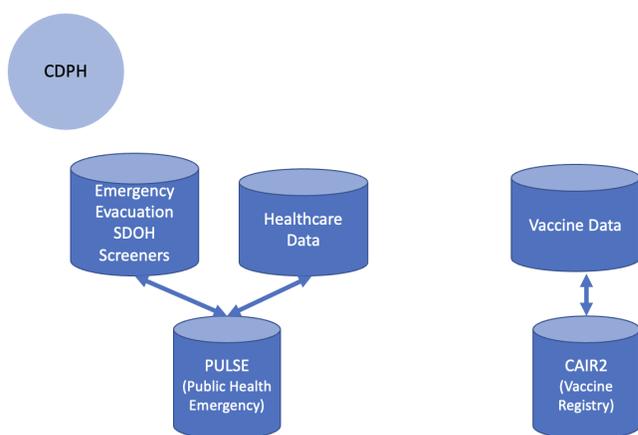
Last, Ms. Smith is receiving services through CDSS including CalFresh and IHSS. As part of coordinating care it is important to exchange data with DHCS and CDA to see what additional social service programs Ms. Smith is already receiving to avoid duplication of services. In addition, it can help support care planning on discussing with Ms. Smith what services are working for her and if an alternative intervention should be considered that would be more appropriate.

Figure 7: CDSS Data
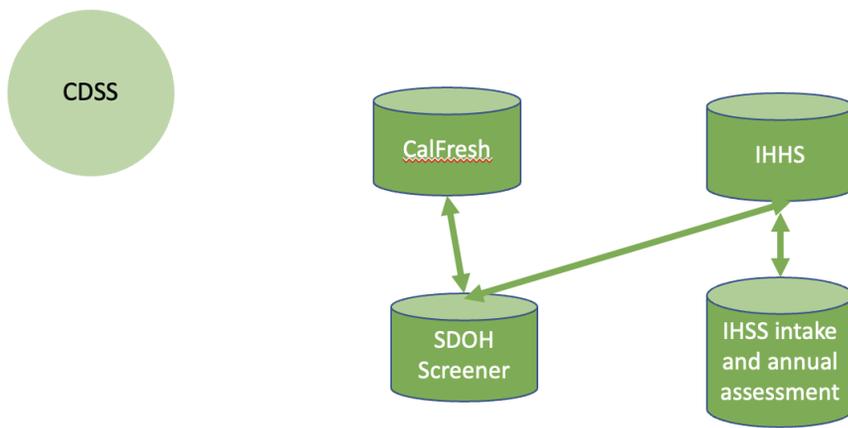
The use case about Ms. Smith shows the need to incorporate SDOH data exchange standards along with a Statewide Person Index and Statewide Consent Registry. It is critical to incorporate this structure today versus waiting due to the implementation of CHARM including ADRC No Wrong Door and coordinating care for vulnerable individuals, the rolling out of incorporating enhanced care management and community supports under CalAIM and the data that will be generated, and the need to have real-time critical SDOH and healthcare data accessible during a public health emergency including a wildfire for life saving initiatives.

Appendix A:

Reference:
https://www.chhs.ca.gov/wp-content/uploads/2022/02/CalHHS-DxF-Guiding-Principles_Final.pdf

Principle 1: Advance Health Equity: We must develop and implement data exchange policies, processes and programs to better understand and address health inequities and disparities among all Californians. Advancing health equity requires filling gaps in data completeness and quality for historically underserved and underrepresented populations and information sharing infrastructure capable of consolidating and curating individual demographic and health information.

•Principle 2: Make Data Available to Drive Decisions and Outcomes: We must collect, exchange, and use actionable and timely information within and across health and human service sectors, to the greatest extent allowable by law, to: better understand and manage health needs and manage conditions at the level of the individual, within our communities, and across our populations;, assess the impact of our programs, operations, and payment arrangements so that we may identify opportunities and implement new strategies to improve 1 quality, experience and outcomes of care and services and advance new payment models that support population health improvement and the delivery of value-based care.

•Principle 3: Support Whole Person Care: We must promote and improve data collection, exchange, and use across health and human services organizations so that we may gain greater insight into the needs of the people we serve and can better meet individuals' whole person care needs, to the greatest extent allowable by law and in alignment with federal and state standards.

•Principle 4: Promote Individual Data Access: We must ensure that all Californians and their caregivers have access to their electronic health and human services information.

•Principle 5: Reinforce Individual Data Privacy & Security: We must collect, exchange, and use health and human service information in a secure manner that promotes trust, ensures data integrity and patient safety, and adheres to federal and state privacy law and policy.

•Principle 6: Establish Clear & Transparent Terms and Conditions for Data Collection, Exchange, and Use: We must conduct all exchange and operations openly and transparently, and communicate clear policies and procedures so that all Californians and the organizations that serve them can understand the purpose of data collection, exchange, and use.

•Principle 7: Adhere to Data Exchange Standards: We must adhere to federal, state and industry recognized standards, policies, best practices, and procedures in order to advance interoperability and usability.

•Principle 8: Accountability: All entities participating in the collection, exchange, and use of health and human service information must act as responsible stewards of that information and be held accountable for any use or misuse of information other than for authorized purposes in accordance with state and federal law and California's Data Sharing Agreement and Data Exchange Framework policies.