WHOLE PERSON CARE

Data Sharing Convening

May 22, 2018

Today's Focus

Why?

- Varying perceptions of what's allowable
- Bring different roles together

Who?

- WPC Leads
- Data Leads
- BH/SUD Leads
- Privacy/Compliance Officers
- Legal Counsel

What?

- Protected under 42 CFR Part 2
- Eligibility
- Jail
- HMIS

Welcome & Opening Remarks

Giovanna Giuliani

California Association of Public Health Systems / California Health Care Safety Net Institute (CAPH/SNI)

Michelle Gibbons

County Health Executives Association of California (CHEAC)

Farrah McDaid Ting

California State Association of Counties (CSAC)

Mary Adèr

County Behavioral Health Directors Association of California (CBHDA)

Catherine Teare

California Health Care Foundation (CHCF)

Today's Agenda

8:30	*Coffee and Networking*
9:30	Welcome and Opening Remarks
9:40	Navigating Federal and State Data Sharing Regulations (Part A)
11:00	*Stretch Break*
11:05	Navigating Federal and State Data Sharing Regulations (Part B)
12:30	*Lunch*
1:15	WPC Technical Models Assessment – Survey Results Overview
1:25	*Transition to Breakout Session*
1:30	Technology and Workflow Design for Appropriate Data Sharing ➢ Shared Care Planning ➢ Patient Consent Management ➢ WPC and Health Information Exchange (HIE)
2:30	*Snack Break*
2:40	Regroup
2:55	Pilot Spotlight: Success Stories in Teamwork and Data Integration
4:00	*Adjourn*

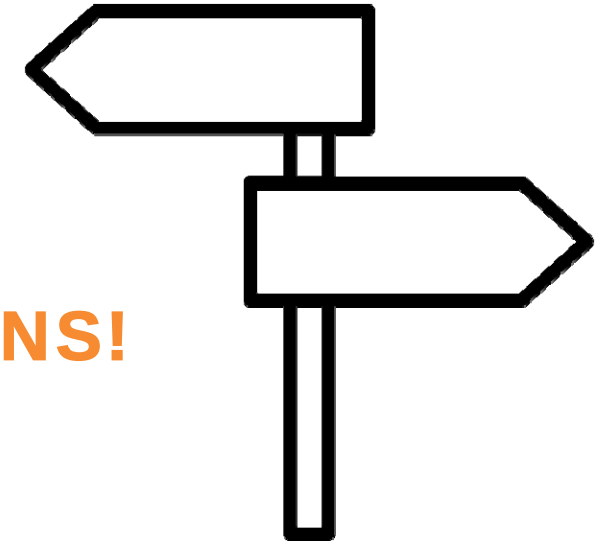
Today's Goals

Participants will…

- ✓ Increase their knowledge of **what data can be shared** under state and federal law.
- ✓ Identify **new opportunities and technical approaches to share data** across WPC partners.
- ✓ Learn **strategies to address organization dynamics** and develop a stronger culture of data sharing.

Odds & Ends

- Materials posted on CAPH website
- Index cards
- Restrooms
- WiFi
- Validate parking
- Please complete **EVALUATIONS!**



NAVIGATING FEDERAL AND STATE DATA SHARING REGULATIONS (PART A)

Anil Shankar, Senior Counsel
Adam Hepworth, Associate
Foley and Lardner LLP

Laura Rosas, Ethics and Compliance Officer
Santa Clara Valley Health System

FOLEY

FOLEY & LARDNER LLP

Approaches to Information Sharing for Whole Person Care Pilots

Anil Shankar and Adam Hepworth

May 22, 2018

Information Sharing Overview

- WPC Pilots need to share information among different organizations to achieve Pilot goals
  - Screen individuals for eligibility and make referrals
  - Develop comprehensive care plans
  - Connect clients to care and other resources
  - Program evaluation and improvement
- Successful information sharing is critical to the success of WPC Pilots and will inform future efforts

Information Sharing Overview

- WPC client information can be very sensitive

  SAMHSA: disclosure has the potential to lead to a "host of negative consequence, including: loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest, prosecution, and incarceration."

Information Sharing Overview

- Develop an information sharing system that:
  - Meets clinical and operational needs to achieve the promise of the WPC Pilots
  - Respects client confidentiality and consent
  - Meets legal requirements

Information Sharing Overview

- No standard model for all Pilots
  - Decisions will be impacted by Pilot structure, types of organizations and information being shared, and long-term goals
- Will there be a centralized database?
- What County programs/initiatives will share information?
- What information is essential to the program?

Information Sharing Overview

- Best Practices:
  - WPC Pilot Information Sharing Team, including leadership, legal, and clinical expertise
  - Unified, consistent approach to promoting information sharing while protecting confidentiality
  - Documentation of approach in policies, training
  - Follow through on implications for contracting, software purchases, ability to serve enrollees

Confidentiality Laws

	Personal Health Information	Mental Health Info	SUDS Treatment Program Info	HIV Test Result Info
Federal Laws	HIPAA		42 C.F.R. Part 2	
State Laws	CMIA § 56.10 *et seq.*	LPS Act, W&I § 5328	H&S §§ 11812, 11845.5	H&S §§120980, 121010

If relevant to Pilot information sharing, consider laws and/or County policies with regard to information about participation in public social services programs, educational records, law enforcement records, records of immigration status, sexual orientation/gender identification; HIPAA requires separate treatment of psychotherapy notes

Counties also subject to requirements related to maintenance and disclosure of personally identifiable information

California Constitution guarantees a right to privacy.

Laws that promote data sharing

WPC Statute, W&I § 14184.60(c)(5)	Overrides state law confidentiality provisions to allow for "the sharing of health information, records, and other data with and among WPC lead entities and WPC participating entities… to the extent necessary for the activities and purposes set forth in this section."
Homelessness (AB 210, W&I § 18999.8)	Includes provisions authorizing data sharing among members of a homeless adult & family multidisciplinary team that provides identification, assessment, and linkage to housing and supportive services. Requires County data sharing protocols.
Amendments to LPS Act (AB 1119)	Allows LPS data to be shared for operations purposes and with Business Associates, in accordance with HIPAA
Federal legislation re: 42 CFR Part 2	If enacted, federal legislation currently under discussion in Congress would allow Part 2 programs to share information with HIPAA Covered Entities, under HIPAA rules

WHOLE PERSON CARE AND SUBSTANCE USE TREATMENT CONSIDERATIONS FOR DATA SHARING

Laura E. Rosas
Ethics and Compliance Officer
Santa Clara Valley Health and Hospital System

Better Health for All

- **42 CFR PART 2 IMPLEMENTS 42 U.S.C §290DD-2:**
  - Protects the confidentiality of the records containing:
    - the identity, diagnosis, prognosis, or treatment
    - of any patient that are maintained in connection with the performance
    - federally assisted program or activity
    - relating to substance abuse (now referred to as substance use disorder) education, prevention, training, treatment, rehabilitation, or research.
  - First promulgated in 1975 and last substantively updated in 1987

- **Congress recognized patients feared prosecution and this acted as a significant disincentive to enter treatment**

- **Unlike HIPAA, patient information cannot be shared for treatment, payment or operations without an authorization or an applicable exception**

REASONS FOR REVISION OF 42 CFR PART 2

- **Recognition of increase in electronic health records and health information exchange (HITECH ACT/ARRA)**
- **New models of integrated care to support coordination across providers**
- **Recognition that improved research is needed to identify new evidence-based treatment for substance abuse disorders**
- **New focus on performance measurement**

WHO AND WHAT IS A PART 2 COVERED PROGRAM (APPLICABILITY)

- **A FEDERALLY ASSISTED FACILITY (includes management by a federal agency, receipt of federal funding, or registered to dispense controlled substances for treatment of substance abuse)**

- **THAT HOLDS ITSELF OUT AS PROVIDING AND PROVIDES DIAGNOSIS, TREATMENT OR REFERRAL FOR SUBSTANCE ABUSE DISORDER**

- **MEDICAL PERSONNEL OR OTHER STAFF IN A MEDICAL FACILITY WHOSE PRIMARY FUNCTION IS THE DIAGNOSE, TREATMENT OR REFERRAL OF SUDS**

NOTE: "LAWFUL HOLDER" IS DEFINED AS AN INDIVIDUAL OR ENTITY WHO HAS RECEIVED PART 2 COVERED INFORMATION AS THE RESULT OF A PART 2-COMPLIANT CONSENT OR THROUGH AN EXCEPTION

HOW 42 CFR PART 2 WORKS – CONSENT REQUIREMENTS

- Name or general designation of the program or person permitted to make the disclosure
- Name or title of the individual or name of the organization to which disclosure is to be made
- Name of the patient
- Purpose of the disclosure
- How much and what kind of information is to be disclosed
- Signature of patient or personal representative
- Date on which consent is signed;
- Statement that the consent is subject to revocation at any time except to the extent that the program has already acted on it
- Date, event, or condition upon which consent will expire if not previously revoked
- For General Designation, right to request a List of Disclosures

42 CFR PART 2 CONSENT REQUIREMENTS

- **REQUIRES AN EXPLICIT DESCRIPTION OF THE "AMOUNT AND KIND" OF SUBSTANCE USE DISORDER TREATMENT INFORMATION THAT WILL BE RELEASED**

- **DISCLOSURES MUST BE ACCOMPANIED BY A PROHIBITION ON RE-DISCLOSURE. THE FINAL RULE CLARIFIED THAT THIS PROHIBITION ONLY APPLIES TO INFORMATION THAT WOULD:**
  - identify, directly or indirectly an individual as having been diagnosed, treated, or referred to treatment for a substance abuse disorder
  - such as medical codes, descriptive language, or both and allows other health-related information shared by the Part 2 program to be re-disclosed, if permissible under other applicable laws
  - For example, a patient's vaccine record would not identify the patient as receiving substance use treatment

- **SUPPLEMENTAL FINAL RULE RELEASED IN JANUARY 2018 ALLOWED FOR ALTERNATIVE LANGUAGE**

NOTICE OF PROHIBITION ON REDISCLOSURE

Santa Clara Valley Health & Hospital System

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65

OR

42 CFR Part 2 prohibits unauthorized disclosure of these records.

You choose.

OTHER CHANGES IN JANUARY 2018 RULE

- **With this new final rule (January 2018) if a patient consents to disclosure for payment and/or health care operations, the lawful holders may disclose those records as necessary for payment and health care activities but not for treatment. There are 17 examples, which include payment and health care operations.**
- **Lawful holders that contract with 3rd Parties must have contractual language that addresses compliance with 42 CFR Part 2.**
- **Contract language should state that any disclosure must be limited to that information which is necessary to carry out the purpose of the disclosure (similar to the minimum necessary standard under HIPAA).**
- **Lawful holders should ensure that the purpose section of the patient consent form is consistent with the role of services provided by the 3rd Party.**

QUALIFIED SERVICE ORGANIZATION AGREEMENTS (QSOAS) AND AUDIT AND EVALUATION

- **Similar to the business associate agreement arrangement under HIPAA**

- **QSOAs: Disclosures are permitted to an entity that provides services (data, processing, bill collecting, dose preparation, lab analysis, legal, accounting, population health management etc.) to a Part 2 program that has entered into a written agreement with the program.**

- **Audit and Evaluation: Disclosures are permitted to any entity or individual for the purpose of conducting a Medicare, Medicaid or CHIP audit or evaluation, including one necessary to meet the requirements of a CMS-regulated Accountable Care Organization ("ACO") or a CMS-regulated Qualified Entity (an entity permitted to receive Medicare claims data to evaluate provider performance**

RESEARCH: Disclosures are permitted to qualified personnel for purposes of conducting scientific research if the researcher meets certain regulatory requirements related to existing protections for human research (for example, the researcher is subject to patient authorization and/or the privacy protections under the HIPAA Privacy Rule or the Common Rule)

DATA SHARING CONSIDERATIONS

- **PATIENTS AND CLIENTS STILL FEAR BEING IDENTIFIED AS RECEIVING SUBSTANCE USE TREATMENT:**
  - Arrest, prosecution, incarceration
  - job loss
  - loss of child custody
  - loss of employment
  - loss of housing/eviction
  - Discrimination by medical professional and insurers

- **42 CFR PART 2 HAS BEEN A PART OF TREATMENT PROGRAMS FOR DECADES, AND THIS CONFIDENTIALITY LAW HAS BECOME PART OF THE TREATMENT CULTURE.**
- **WORKFLOW REDESIGN, TRAINING AND COMMUNICATION ARE ESSENTIAL FOR SUCCESS**
- **UNDERSTAND THE DATA FLOW. WHO IS THE LAWFUL HOLDERS, IS THE INFORMATION VIA CONSENT OR EXCEPTION AND WHO HAS THE RIGHT TO SEE IT?**
- **BE HONEST AND TRANSPARENT WITH PATIENTS.**

Managing Client Authorizations

- Information sharing is always permitted with a valid authorization
- Authorizations give clients control over disclosures of information and are strongly preferred by privacy laws
- May help reduce future conflicts about information sharing with clients

Managing Client Authorizations

- Key Requirements:
  - Plain language that clearly communicates the parameters of information sharing
  - What information? For what purposes? Who can share it? Whom can they share it with? For how long?
  - Clients should specifically authorizing sharing of certain sensitive information (SUDS, mental health, HIV test results, etc.)
  - Signed and dated by the patient or an authorized individual

Client Authorization to Share Information

	HIPAA (45 C.F.R.)	Part 2 (42 C.F.R.)	CMIA (Civ. Code)
Plain Language	§ 164.508(c)(3)	N/A	N/A
Description	§ 164.508(c)(1)(i)	§ 2.31(a)(3)	§ 56.11
From Whom	§ 164.508(c)(1)(ii)	§ 2.31(a)(2)	§ 56.11(e)
To Whom	§ 164.508(c)(1)(iii)	§ 2.31(a)(4)	§ 56.11(f)
Purpose	§ 164.508(c)(1)(iv)	§ 2.31(a)(5)	§ 56.11(d)
Expiration	§ 164.508(c)(1)(v)	§ 2.31(a)(7)	§ 56.11(h)
Signature & Date	§ 164.508(c)(1)(vi)	§ 2.31(a)(8), (9)	§ 56.11(c)
Separate Form	§ 164.508(b)(3)	N/A	§ 56.11(b)
Right to Revoke	§ 164.508(c)(2)(i)	§ 2.31(a)(6)	N/A

Client Authorization to Share Information

- The Part 2 Problem
  - Much stricter requirements around the “to whom” portion of the authorization
  - In many cases, must identify the recipient individual by name
  - Additional flexibility when there is a “treating provider relationship”

Client Authorization to Share Information

- Other key challenges
  - "Universal authorization" versus more limited and specific notice to clients
  - Fluid panels of care team providers, participating entities
  - Ability to provide services to patients that decline consent
  - Retaking consents that expire, or if terms change
  - Managing revocations
  - Requests to limit disclosures

Sharing Information without Authorization

- Sharing confidential information without client authorization requires the disclosure to meet a legal exception
- Requires navigating the varied exceptions across different privacy laws
- Exceptions were not crafted with WPC Pilot activities in mind
- Exceptions are limited for sensitive information (SUDS and mental health)

Privacy Law	Treatment Exception
HIPAA	Covered entities “may disclose protected health information for treatment activities of a health care provider.”
CMIA	Health care providers may disclose medical information “to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient.”
LPS Act	Information may be disclosed “[i]n communications between qualified professional persons in the provision of services or appropriate referrals” if the recipient of the information has “the medical or psychological responsibility for the patient’s care.”
Part 2	Information may be communicated with other personnel in the Part 2 program who need it “in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of patients with substance use disorders.”
State SUDS (H&S 11845.5)	The content of the record may be disclosed “[i]n communications between qualified professional persons employed by the treatment or prevention program in the provision of service.”

Scope of Applicable Exceptions

	HIPAA	Part 2	CMIA	LPS Act / H&S 11812	H&S 11845.5
Treatment	Broad	Extremely Narrow	Broad	Limited	Extremely Narrow
Health Care Operations	Broad	Broad with QSOA	Broad	Broad	N/A
Payment	Broad	N/A	Broad	Broad	N/A
Audits & Evaluations	Broad	Broad	Limited	Broad	Broad
Emergency	Limited	Broad	Broad	Broad	Broad
Law Enforcement	Limited	Extremely Narrow	Limited	Limited	Extremely Narrow

Putting it all together

- Key elements
  - Effective consent process
  - Segregation of sensitive data
  - Parameters around disclosures to ensure compliance
  - Contracting and implementation
  - Training and oversight
- Laws are technical and nuanced, but serve broader goals: protect confidentiality and limit surprises
- Getting it right can be leveraged for future efforts

Template – When Is Information Sharable?

User/Purpose	General PHI	LPS Data	Part 2/SUD Data
Medical Treating Provider	Authorization *or* HIPAA Treatment Exception	Authorization *or* LPS Treatment Exception	Authorization
Unlicensed Case Worker (for care coordination)			
Eligibility/Intake worker			
Housing Provider (non-treatment)			
Pilot Admin staff – Payment			
Pilot Admin – QI			

Contact Information

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NAVIGATING FEDERAL AND STATE DATA SHARING REGULATIONS (PART B)

Pilot Activity

Navigating Regulations: Case Study #1

With your Pilot Team (25 mins)

- Maria has been homeless for the past 5 years. She has uncontrolled Type 2 diabetes and severe alcohol dependency. In the past year, Maria has been treated in a local hospital's emergency room eight times and had ongoing encounters with a substance use treatment program that participates in WPC. She is eligible for placement in supportive housing but does not have transportation.

- Maria recently slipped and fractured her leg, making it difficult for her to get around on her own. She was placed in a temporary shelter, where she was enrolled in her county's WPC pilot program. Maria may need follow-up care for her fracture, as well as diabetes and detox.

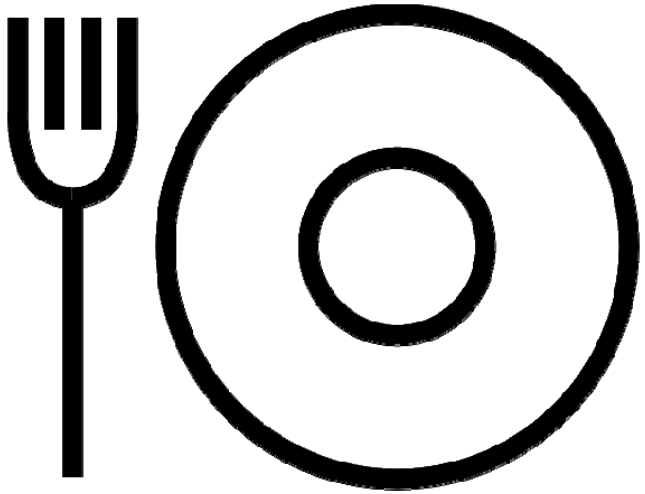
- Maria's assigned Medi-Cal PCP is participating in WPC, and a care manager at the PCP's clinic has Maria on her panel of WPC enrollees for proactive services coordination. The care manager needs to develop a comprehensive care plan and arrange for supporting housing services. The county's WPC pilot program does not have a central data hub.

Navigating Regulations: Case Study #2

With your Pilot Team (25 mins)

- Joseph is being discharged from an inpatient psychiatric facility after a crisis episode during which he was admitted involuntarily because he was determined to be a danger to himself. He will be temporarily residing at a supervised community residential facility upon release. Joseph has an anxiety disorder, depression, asthma and high blood pressure. He is participating in a community support group, but has no friends or relatives to provide assistance.

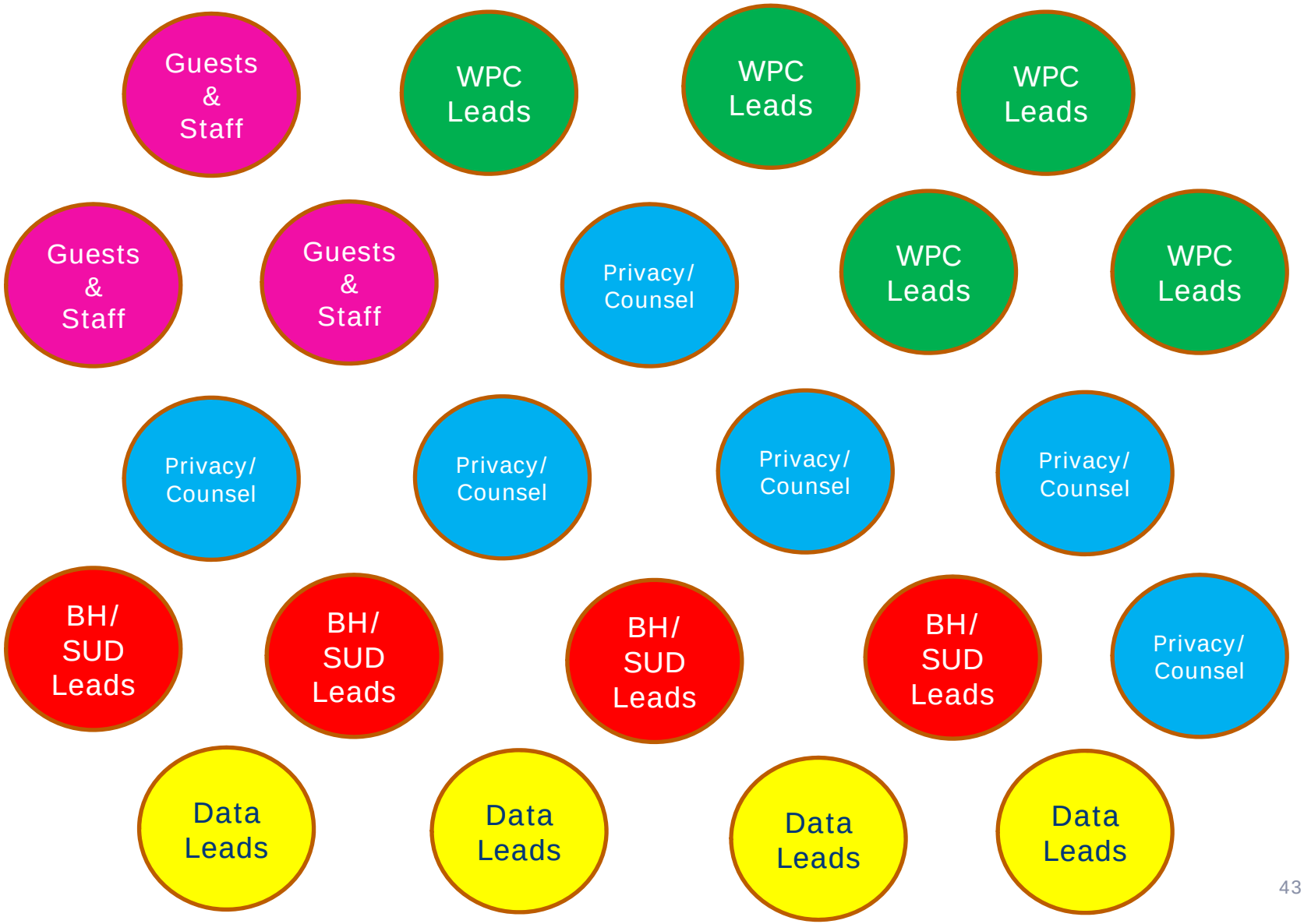
- Prior to treatment at the inpatient facility, Joseph received routine care at a local FQHC, which is now participating in the WPC Pilot. When Joseph returns to the FQHC, he is interviewed by a Community Health Worker (CHW) employed by the local WPC program, who believes he may be a good candidate for the Pilot. The county operates a centralized data hub that facilitates information sharing between participating entities of the WPC Pilot.



LUNCH WITH PEERS

STAGE

= Multiple Roles/Other



WPC TECHNICAL MODELS ASSESSMENT: SURVEY RESULTS OVERVIEW

Mark Elson, Principal, Intrepid Ascent

John Weir, Senior Consultant, Intrepid Ascent

Data Sharing Models

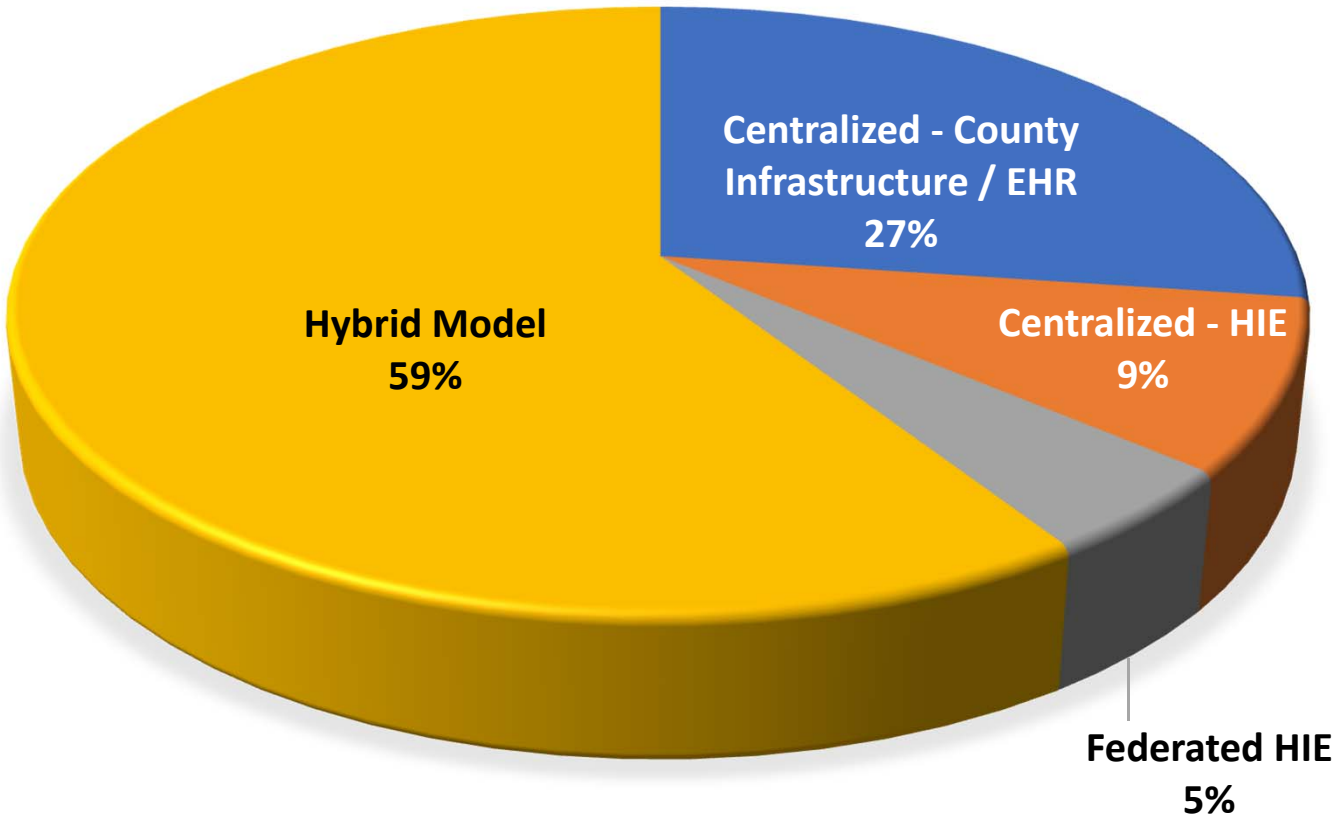
John Weir
Intrepid Ascent
May 22, 2018

California Health Care Foundation

Survey Purpose and Methods

- California Health Care Foundation-funded assessment of technology models and data sharing approaches undertaken by WPC Pilots
- Online survey with all 25 Pilot communities, to be followed by interviews with over half of Pilots (so these are provisional findings!)
- Goal to understand IT models and functions, cross-walk them with program needs and identify vendors used
- Determine how Pilots are addressing data sharing for clinical data; plus housing, social determinants of health, law enforcement, and other data

Data Sharing Infrastructure Models



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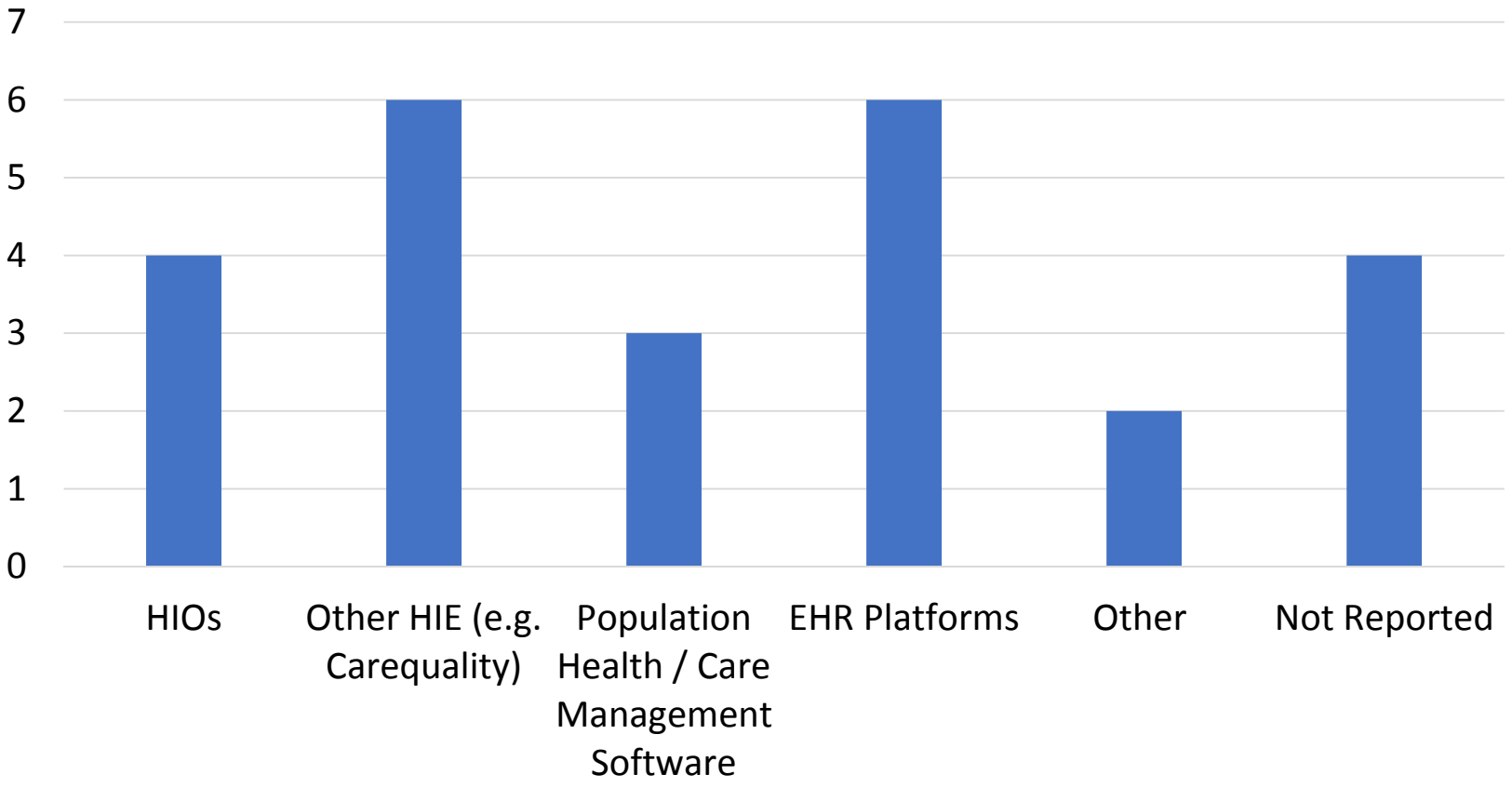
Methods of Data Sharing



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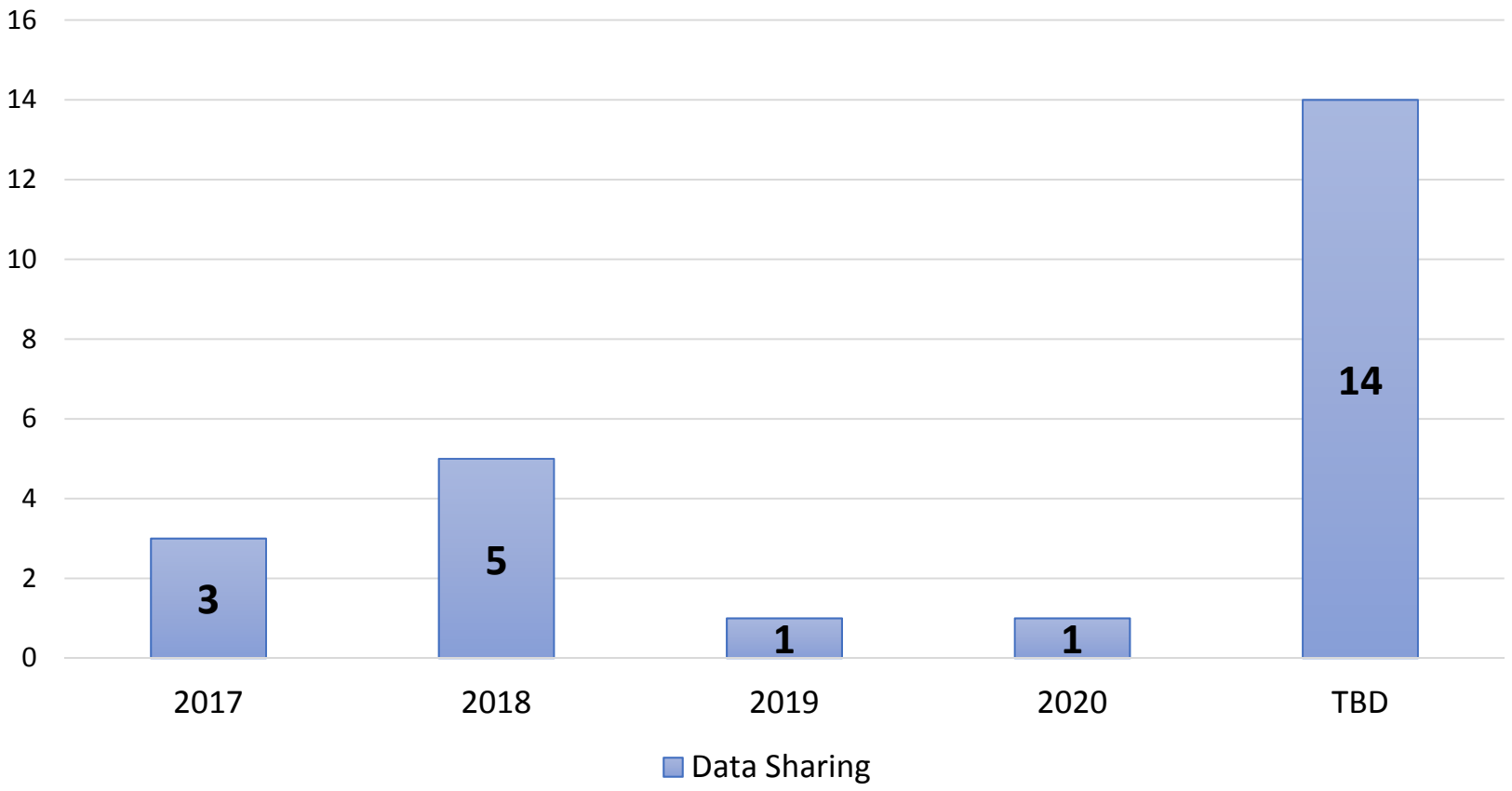
Timing for Data Sharing – Pilot Communities



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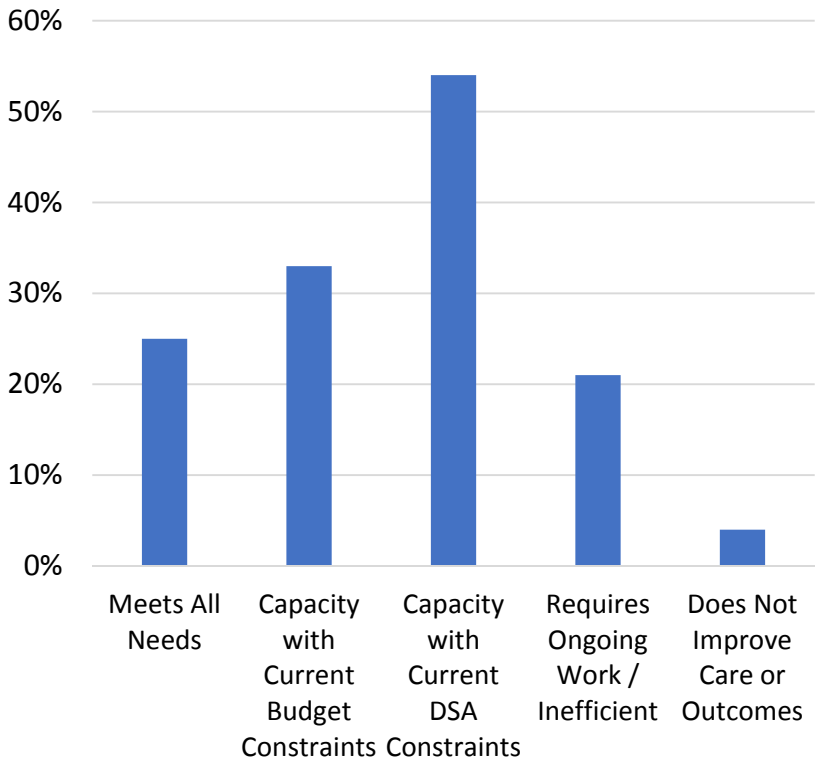
Data Sharing Architecture Strengths and Limitations

Pilot Feedback on Current Approaches



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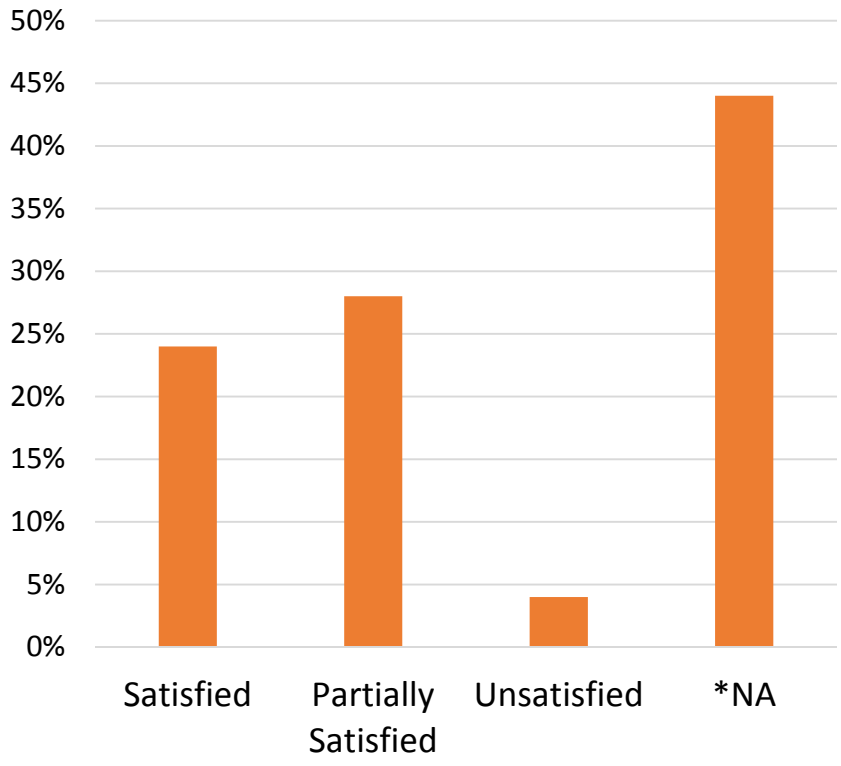
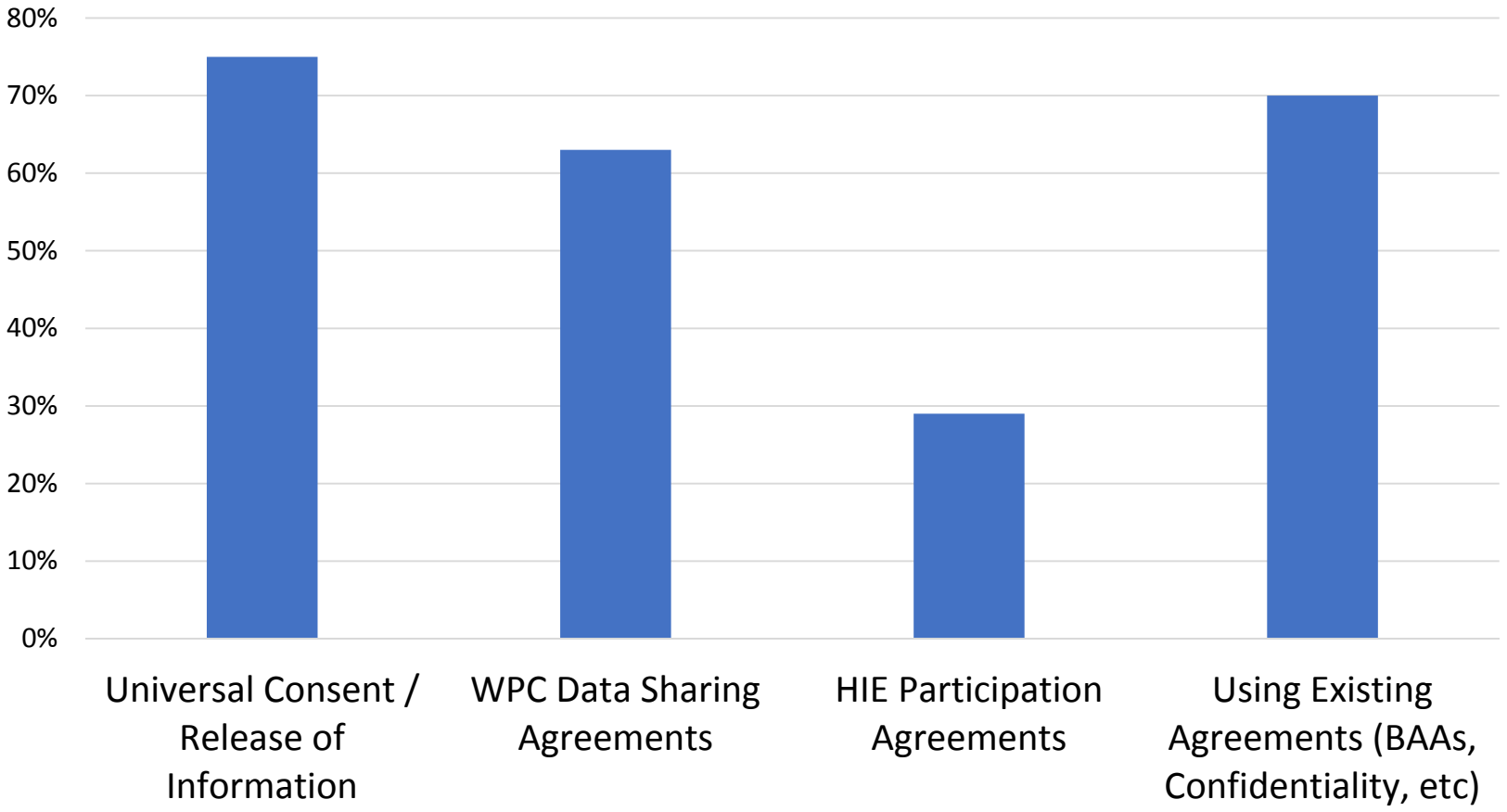
Pilot Satisfaction With Current Approaches



* In process of implementation

Data Governance Framework Components



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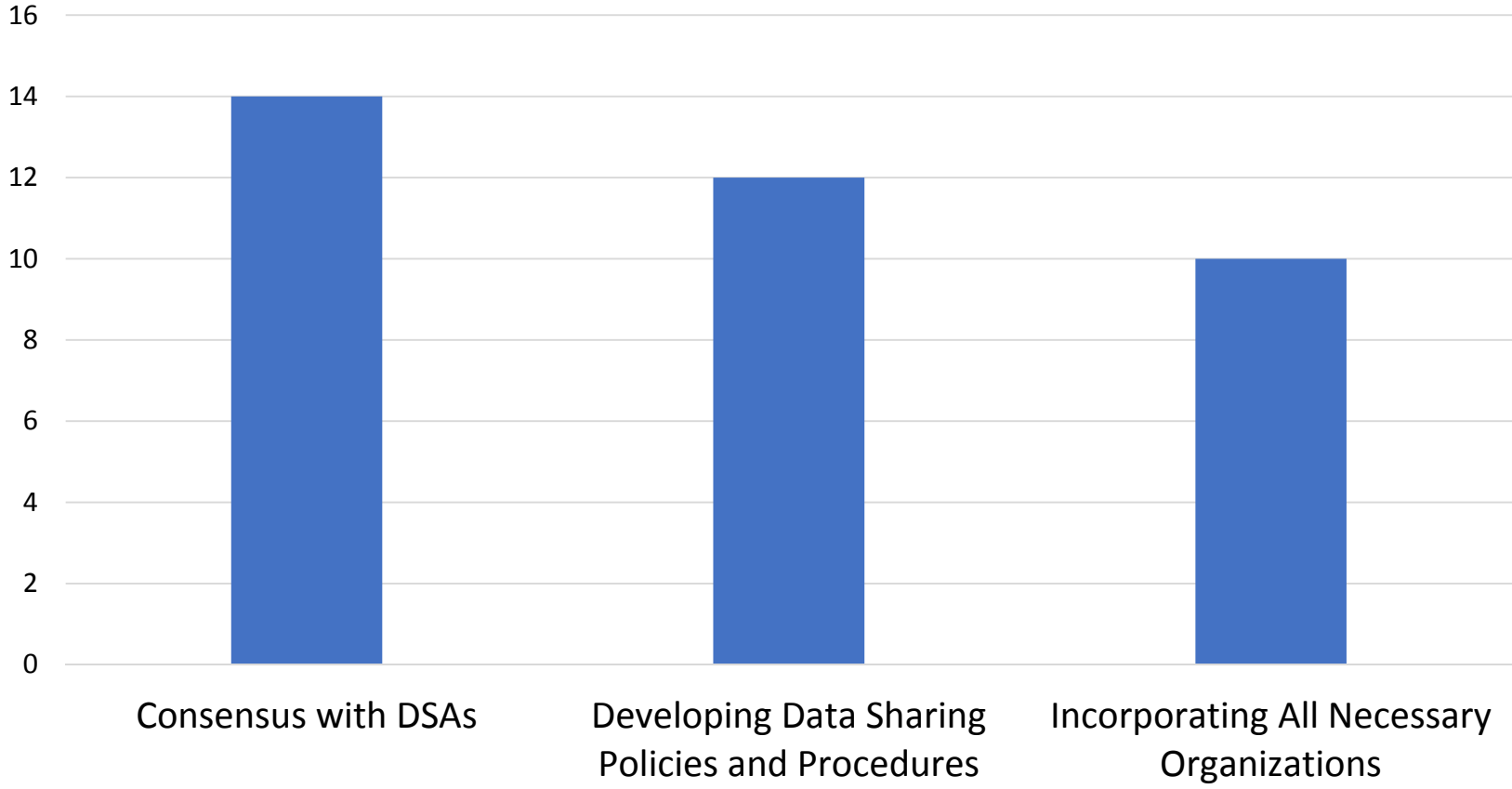
Top 3 Challenges for Data Sharing Framework



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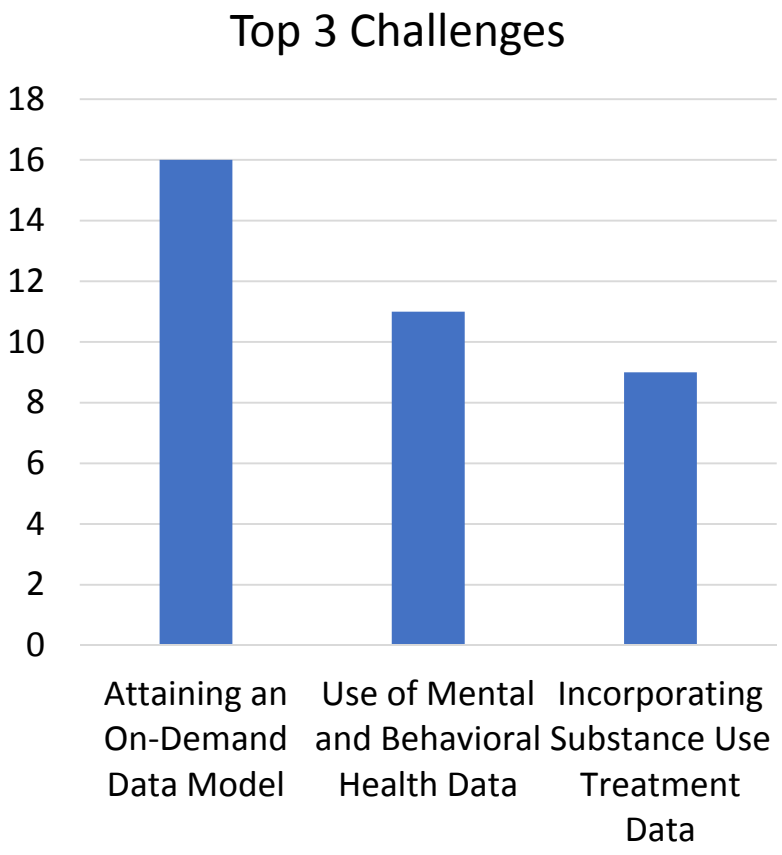
Top Challenges with Data



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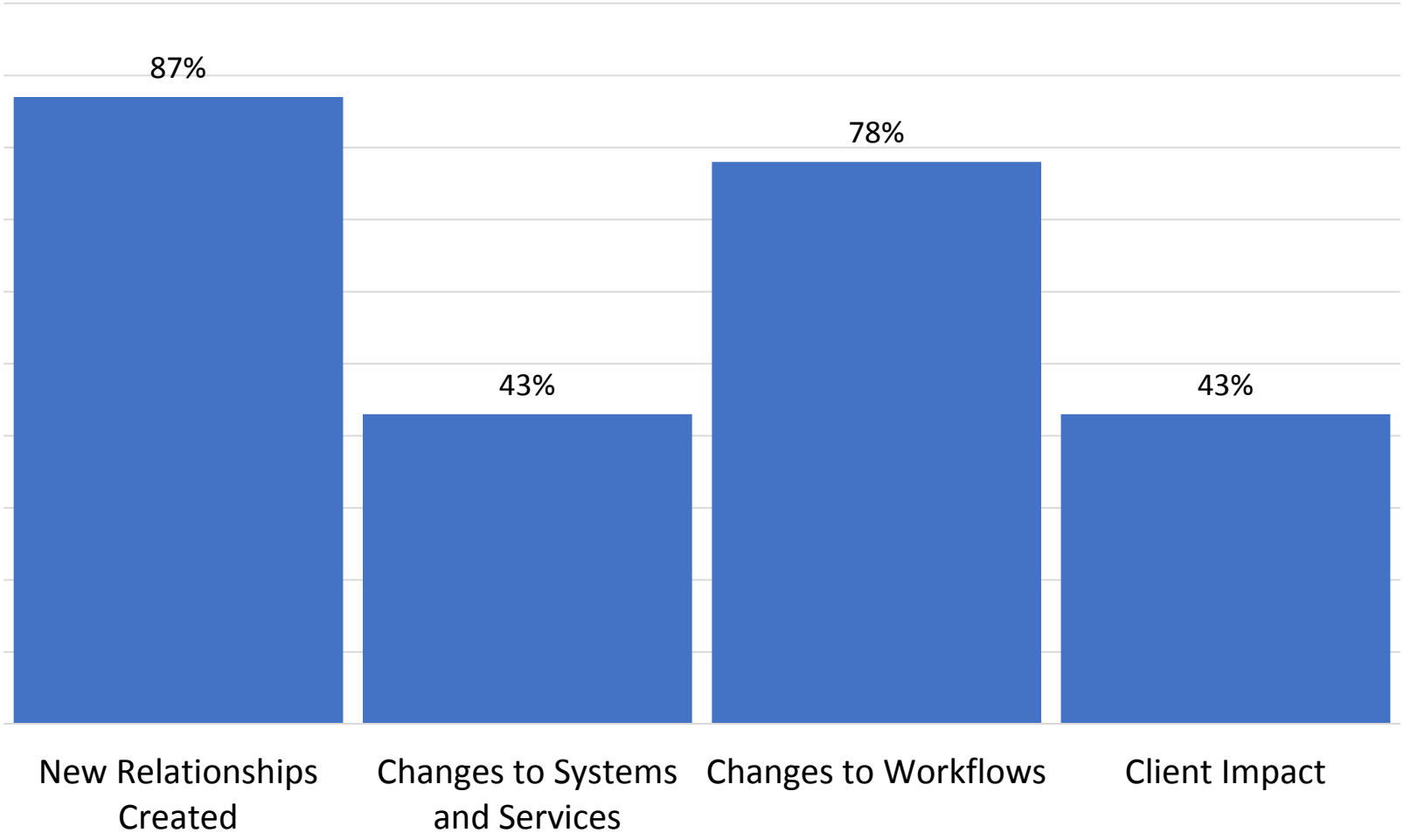
Additional Challenges:

- Philosophical tension between “more is better” and “curated data”.
- Addressing data quality issues.
- Data matching across systems.
- Support and buy-in from data partners.
- Finding the right software(s) that meet Pilot needs, Addresses risk and falls within budgetary requirements.
- Data privacy concerns.

Early Successes with Data Sharing



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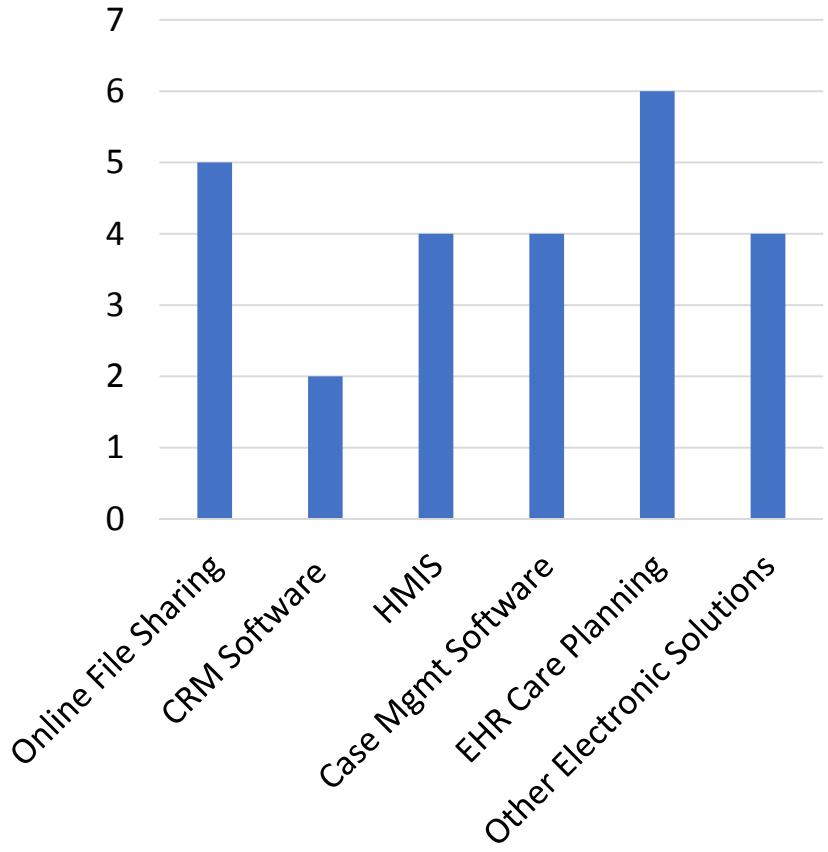
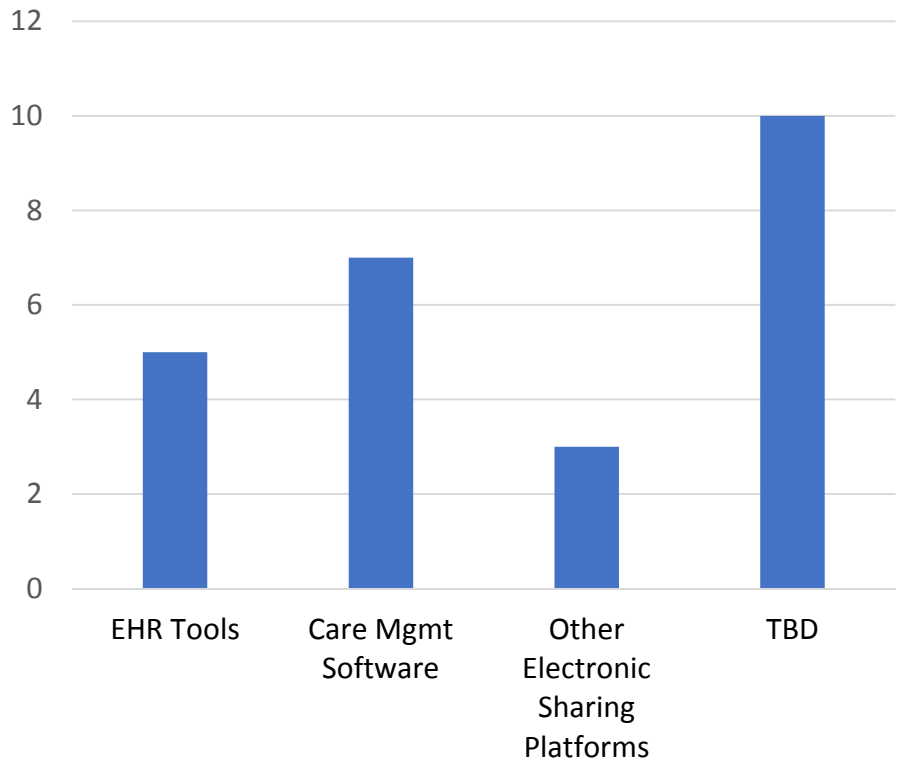
Data Sharing: Case Management

Short-Term Solutions



Long-Term Solutions

14 Pilots have a long-term solution



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Technology Design for Appropriate Data Sharing and Use: Breakout Sessions

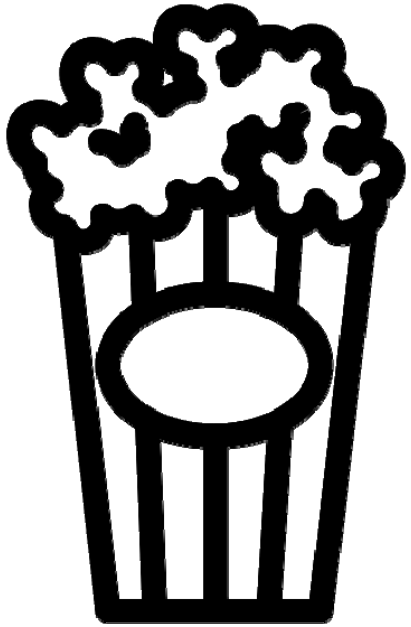
- **Shared Care Planning: California Room**
  - Pilots will discuss how they are implementing a shared care plan, including care team models and workflows, care management technology, and user access levels

- **Patient Consent Management: Pacific Room**
  - Pilots will share approaches to the consent process, including electronic storage and access to consent status across WPC partners

- **WPC and HIE: International Ballroom**
  - Overview of HIE models, including examples from Sacramento, Marin, and San Joaquin. Participants will have the opportunity to ask questions and discuss their Pilot's approach to HIE with peers

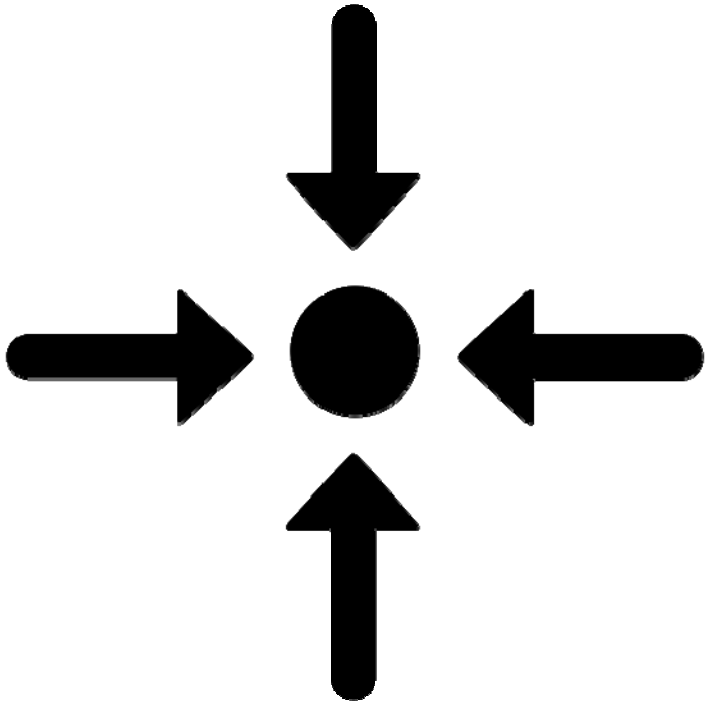
SNACK BREAK

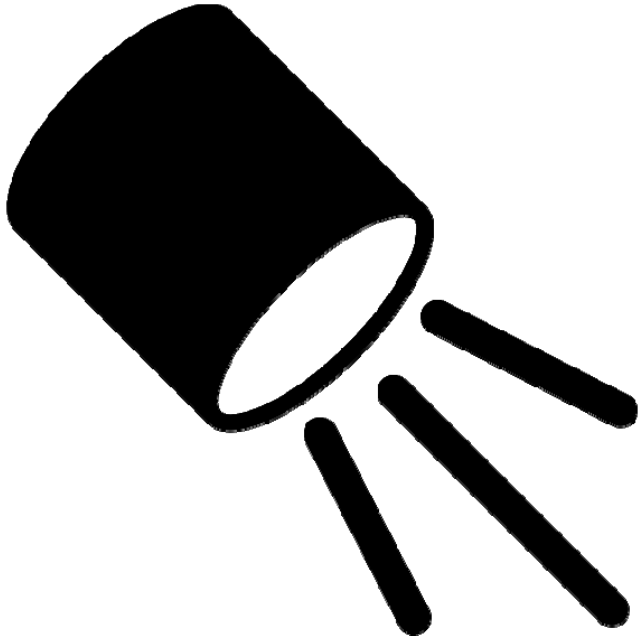
10 MINUTES



Regroup

- Share what you learned at your breakout session
  - New ideas
  - Follow-up questions
- Write down 2-3 action steps for after the meeting





PILOT SPOTLIGHT

SUCCESS STORIES IN TEAMWORK AND DATA INTEGRATION

Data Sharing Best Practices

Mark Elson

Intrepid Ascent

May 22, 2018

Getting to Yes… for Appropriate Data Sharing

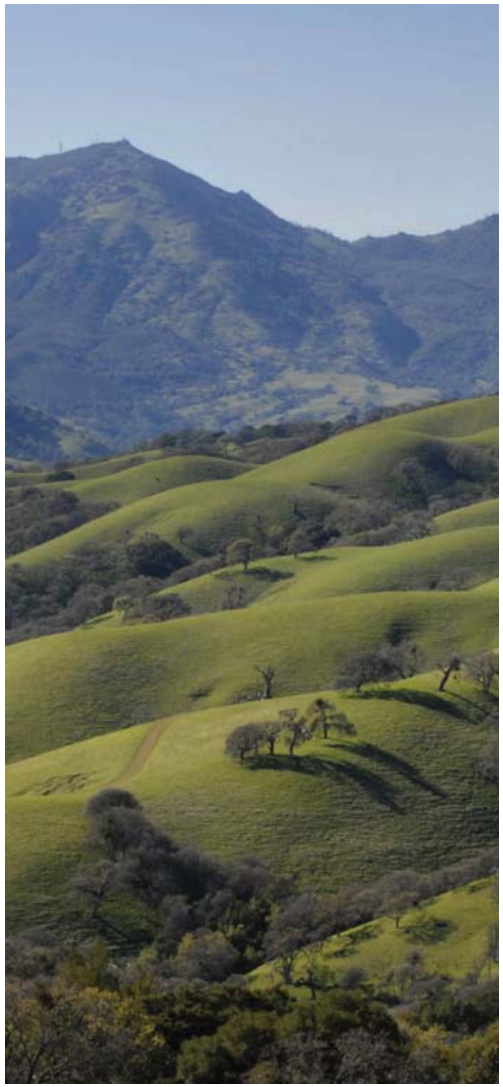
- Defining goals **+** terms **=** **a foundation for alignment**
- Culture of data protection **+** spirit of innovation **=** **dynamic balance of values**
- Stakeholder inclusion **+** transparent governance **=** **trust**
- Data sharing effort **-** leadership commitment **=** **no chance**
- Carrots **+** sticks **=** **pragmatic motivation**
- **Data stewardship** **>** data ownership
- Collective value **+** distributed costs **=** **sustainability**

Getting it Done… Implementing Data Sharing

- Customized IT products **+** vendor lock-in **=** **a sinking island**
- Technology standards **+** data standards **=** **interoperability**
- Multi-party agreements **+** hub-and-spoke networks **=** **efficient exchange**
- Measurement **+** honesty **+** drive **=** **effective PDSAs (fail often!) and improvement**

It's Been Done Before: Community HIOs

- More than 15 in CA
  - Collectively receive more than 20m ADT messages/month
  - Collectively have more than 22 million entries in their master person indices
    - > 56% of CA population



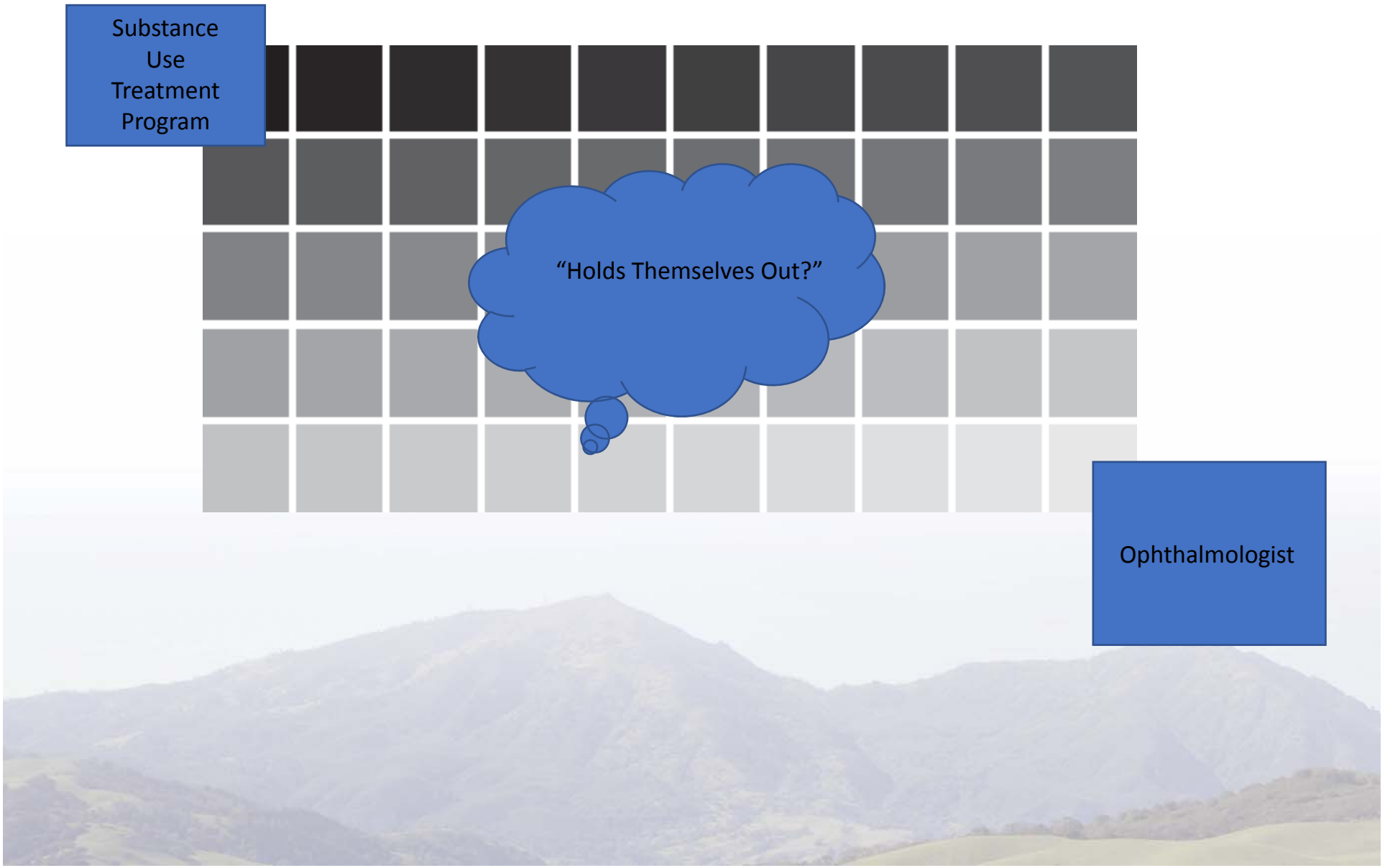
42 CFR Part 2

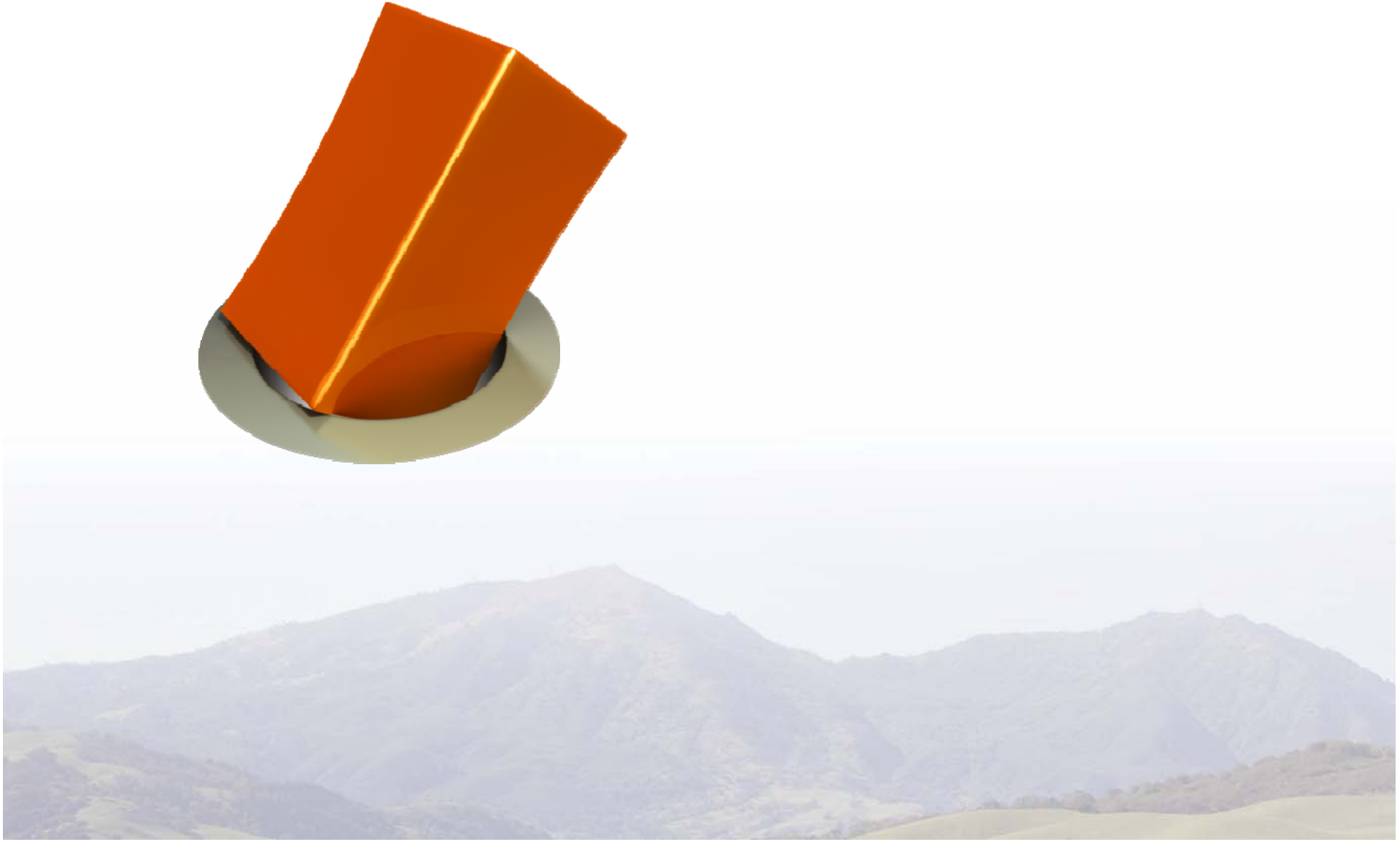
A Journey Toward Compliance

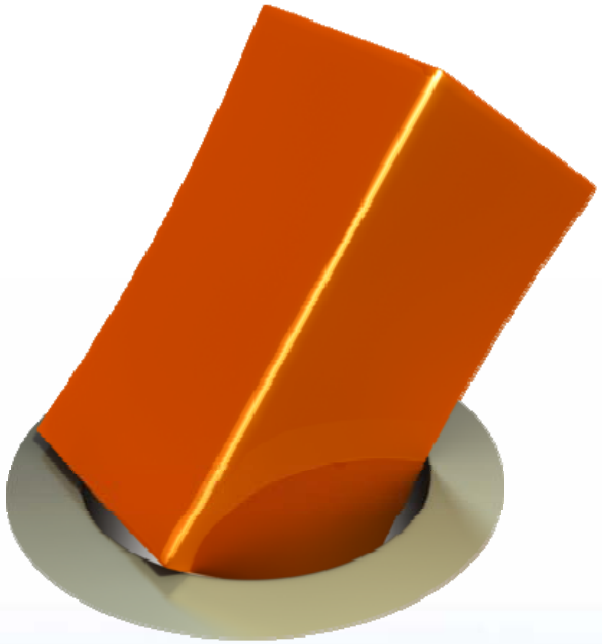
Jennifer Tong, M.D.
Chief Medical Informatics Officer
Contra Costa County Health System

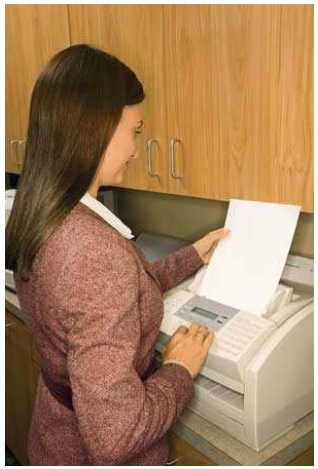
Substance Use Treatment Program


Substance Use Treatment Program
Ophthalmologist


Substance Use Treatment Program
"Holds Themselves Out?"
Ophthalmologist



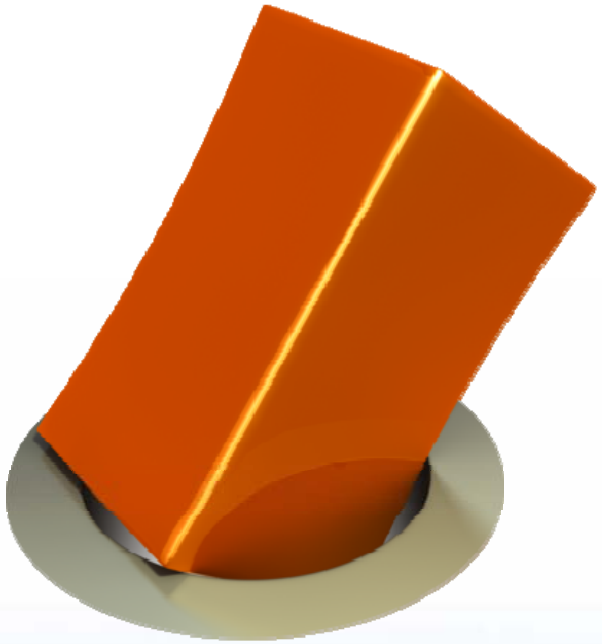


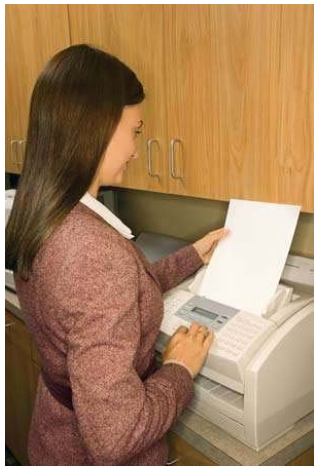


The following portions of my Behavioral Health chart:

☐ **Diagnosis** ☐ **Chemical Dependency history & treatment Information**

☐ **Treatment Plan** ☐ **Medication** ☐ **Other**_____





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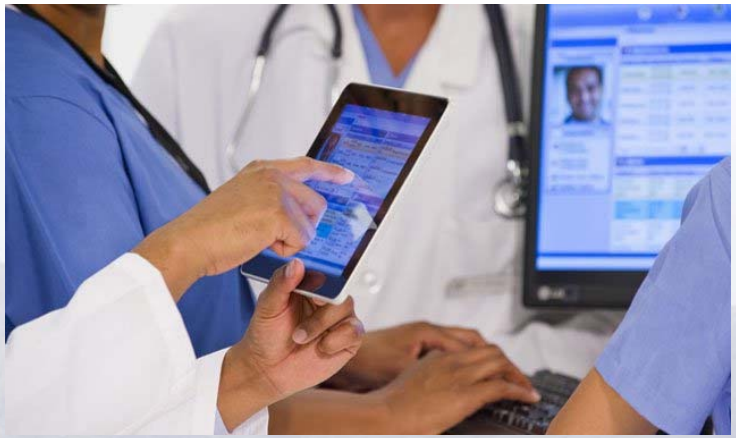
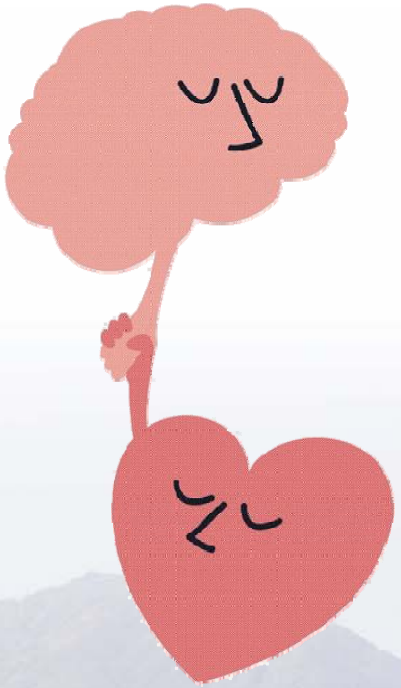




Contra Costa Health Services (CCHS) is asking your permission to share substance use treatment information with members of the care team for coordination of your health care needs. You may grant us permission by choosing one of the following choices.

☐ Share all health information related to substance use treatment with care team members that I have a treating provider relationship with, including past, present and future providers. This information includes substance use provider notes and counselor notes, health history, orders, study results, diagnoses and medication. By checking this box, I understand that my information would be available to anyone with lawful authority to look at my chart.

☐ Exclude substance use provider and counselor notes and share only limited health information related to substance use treatment including health history, orders, study results, diagnoses and medication with care team member that I have a treating provider relationship with, including past, present and future providers.

☐ Share nothing that would identify me as a patient receiving substance use treatment information in this program. I understand that this may limit my ability to receive care in this program.

Important Notes:

- Still in draft form! This is an excerpt from the form.
- Limited check boxes and no blank lines
- Separated into two sections: Sharing within our system (shown here) and sharing beyond our system (HIE)
- 3 checkboxes map to 3 distinct technical workflows for which staff will be thoroughly trained

Critical Members to Bring Together:

- Legal and Compliance Expertise
- Clinical Expertise
- EHR Technical Configuration Expertise
- HIE Technical Configuration Expertise
- Health Information Management Expertise

Take Home Points

- **Identify Gray Areas**. Document them for later attention but first focus on the Black and White.
- **Identify your Square Pegs**. Older processes that required humans and fax machines for exchange of information must be reworked. Consider starting with a blank page when redesigning your authorization forms. Beware of options you can't accommodate and blank lines.
- Be a **Champion of Facts and Expertise**. Limit an emotional approach.
- **Simulate being a patient** who feels strongly that their information should be available to all people involved in their care. Simulate being a patient who feels strongly that their information cannot be available to anyone outside of their drug/alcohol treatment program. Are you options clear to the patient? Where might your process not meet the patient's expectations?

Whole Person Care Data Sharing Convening: Success (and Failure) Stories in Teamwork and Data Integration

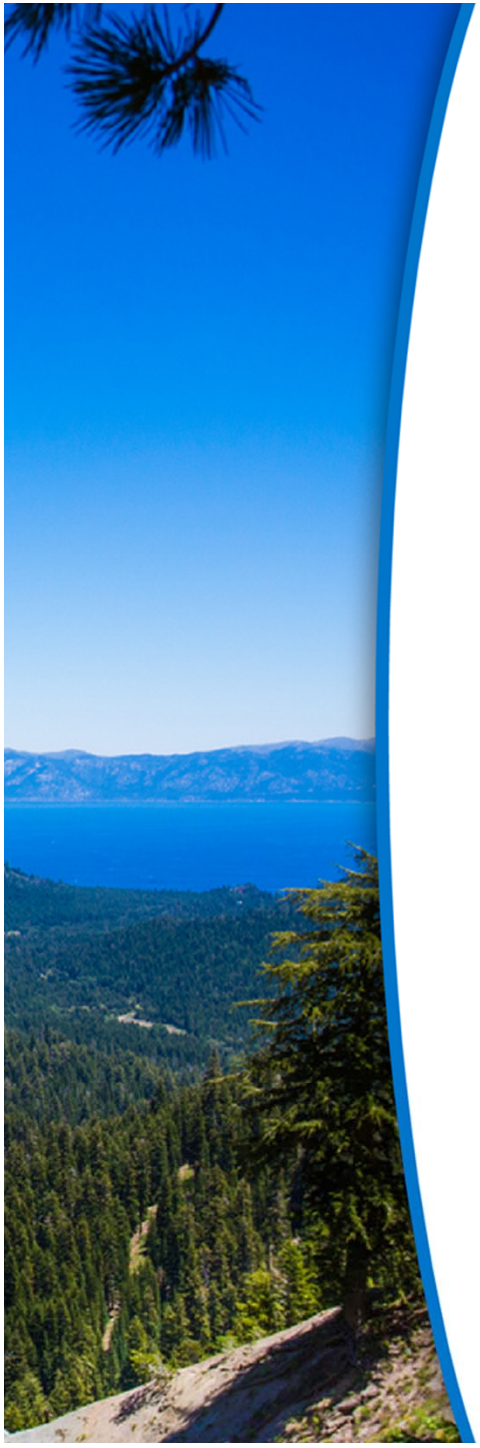
Geoff Smith, LMFT
Program Manager, Placer WPC

May 22, 2018

Placer County Background

- Placer County:
  - Formerly small, rural county
  - Now ~380,000 residents and rapidly growing
  - ~60,000 Medi-Cal beneficiaries
  - No public hospital or County-operated primary care clinics
  - No centralized BH Department
  - Small CBOs with limited capacity
- HHS consists of:
  - Adult System of Care
  - Children System of Care
  - Public Health
  - Human Services (includes Housing Authority)

COUNTY OF Placer



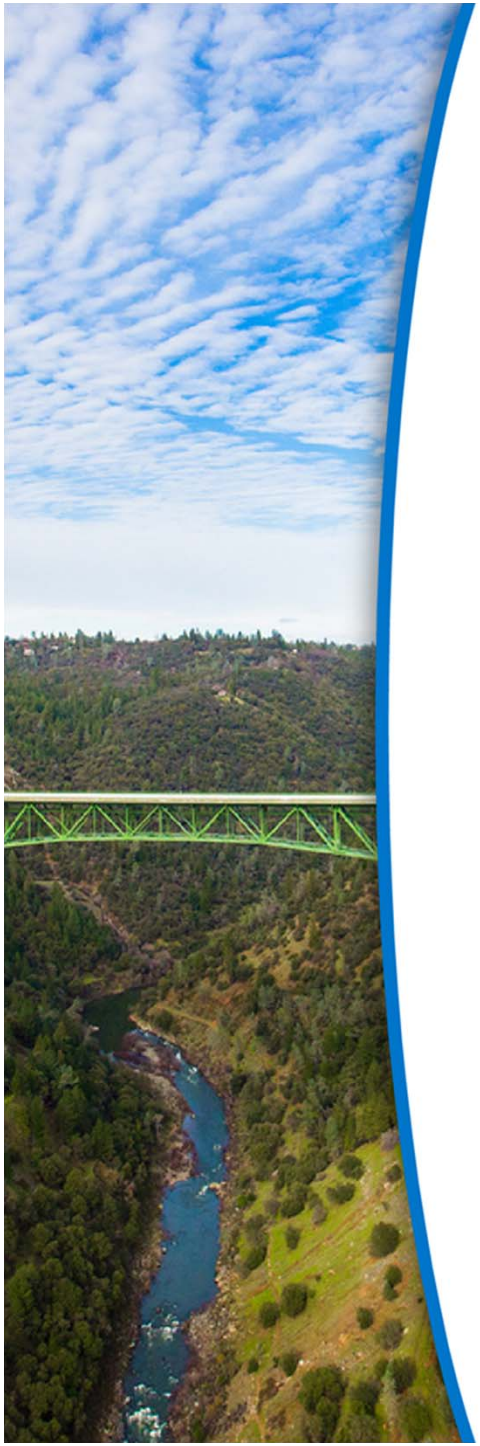
Placer Data Sharing Background

- Legacy of integrated services ("Placer Model")
- But health IT not a recent Senior Management Priority
- Recent underinvestment in health IT/ data sharing:
  - strategic planning
  - governance
  - infrastructure

Strengths

- WPC is a Board, HHS, and community priority
- HHS-dedicated Counsel who is engaged and thoughtful
- Integrated agency with generally collaborative culture
- Only a few Medi-Cal healthcare partners
- Low numbers of WPC members

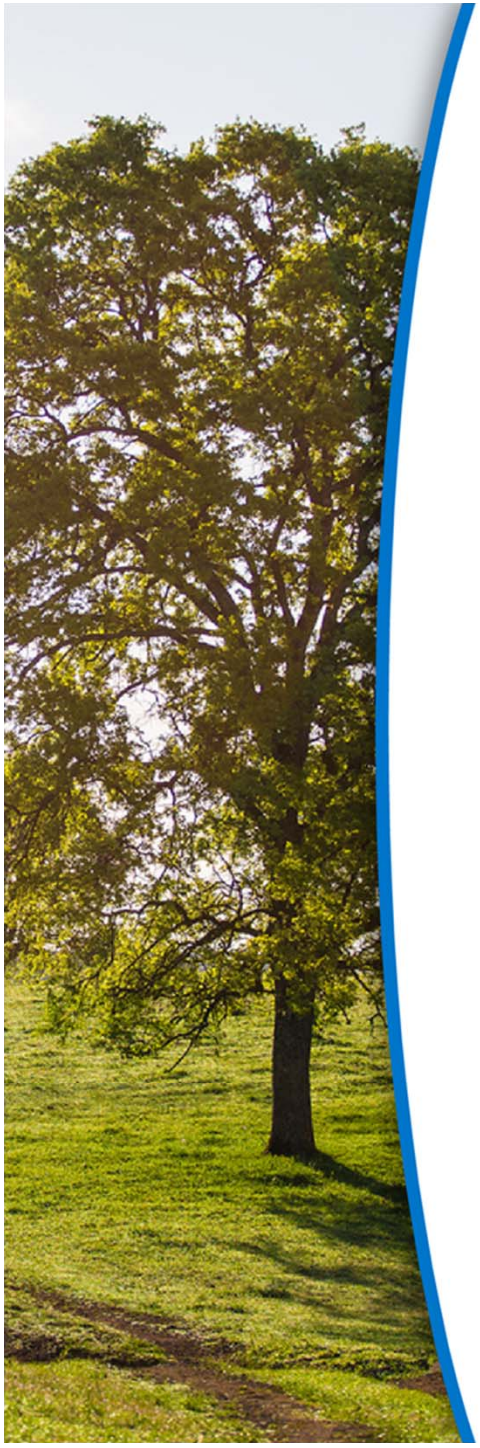
County of Placer



Challenges

- Unclear health IT decision-making processes
- Limited health IT expertise, especially among senior management
- Health IT and compliance under-resourced and disconnected from program/patient experience
- E.H.R. far from optimized
- “Legacy” systems and workarounds

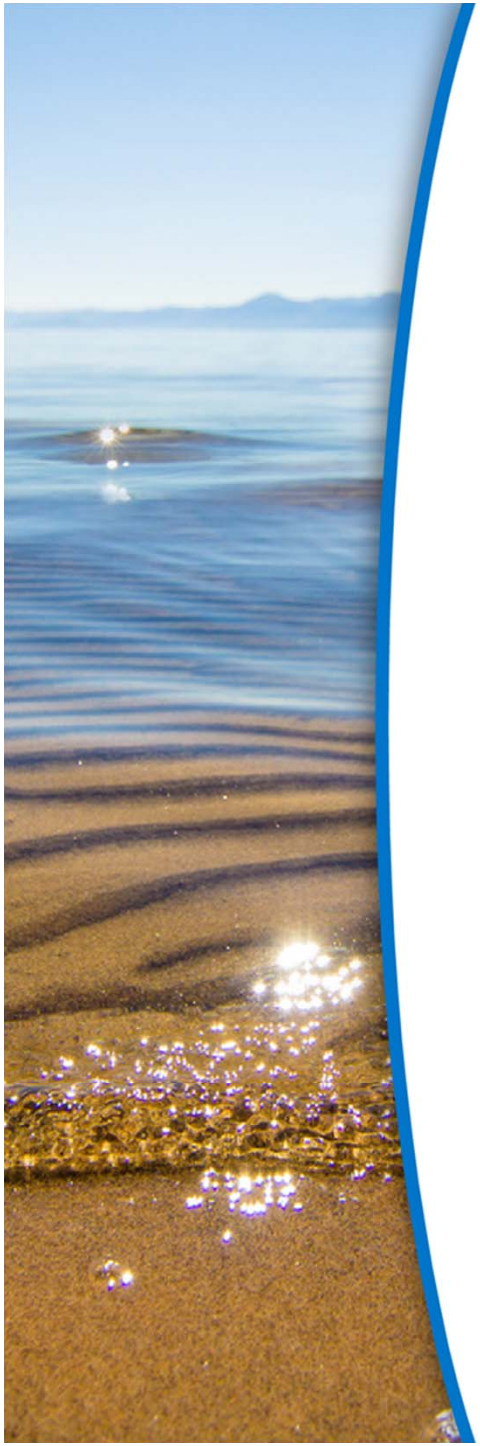
County of Placer



Early Successes

- Implementation of PreManage in June 2017
- Improved management engagement with respect to health IT and data-sharing
- More streamlined health IT decision-making process
- Recent read-only access to hospital system records

County of Placer



Ongoing Efforts

- Increase utilization of PreManage
- WPC IT and Data Management Needs Assessment
- Advocacy for participation in a regional HIE
- Revisiting HIPAA “hybrid-entity”
- Revamping data sharing policies and training
- Senior management engagement around Health IT and Data Management

COUNTY OF Placer

Questions?

THANK YOU!

DON’T FORGET TO COMPLETE YOUR EVALUATION