Connecting for Better Health Meeting

September 26, 2024

Connecting for Better Health

Advancing data sharing to improve the health of all Californians

Agenda

No.	Item	Minutes
1	Welcome and Introductions	5 minutes
2	Closed-Loop Referral Pilot with WIC Agencies and FQHCs ● Ali Modaressi, CEO, LANES Health Information Organization	20 minutes
3	Collaborative Partnerships and Data Sharing Innovations to Address Housing Insecurity and Homelessness ● Camey Christenson, Chief Business Development Officer, 211/CIE San Diego ● Tamera Kohler, CEO, Regional Taskforce on Homelessness	20 minutes
4	California State Legislation Tracking	5 minutes
5	Implementation Advisory Committee Recap: Data Exchange Framework Roadmap Preview	5 minutes
6	News, Events, and Announcements	5 minutes

About The Coalition

Our Vision: Every Californian and their care teams have the information and insights they need to make care seamless, high quality and affordable

Policy Priorities

- **DSA Education & Implementation:** Promote awareness of the DSA and support data exchange implementation to realize the promise of AB 133
- **Funding:** Advocate for the state to dedicate continued funding for health and social services data sharing and encourage state agencies to seek federal match when and where appropriate
- **Integration of social services data:** Develop and communicate case studies and policy recommendations that support cross-sector data sharing, consent, and authorization
- **Advance DxF Governance, Enforcement, and Accountability:** Work towards the passage of DxF legislation, monitor state legislation and budgetary actions related to data sharing, and provide critical feedback to CDII and other state agencies to resolve challenges

Closed-Loop Referral Pilot with WIC Agencies and FQHCs

Ali Modaressi
CEO
Los Angeles Network for Enhanced Services (LANES)

LANES

Connecting for Better Health

Closed-Loop Referral Pilot with WIC Agencies and FQHCs

Fall 2024

Who is Lanes?

Los Angeles Network for Enhanced Services (LANES)

- LANES is a nonprofit, community driven Qualified Health Information Organization (QHIO)
- We enable health data exchange, clinical data insights at the point of care, and population health capabilities
- Empowering providers across the health and social service ecosystem to deliver more effective, coordinated care more efficiently

- **10 M Patients** in Our Network
- **4 Health Plans** (L.A. Care, Health Net, Molina Health, Blue Shield Promise)
- **42 Acute Care Hospitals**
- **52 FQHCs and Health Centers** (250 sites)
- **26 Mental and Behavioral Health**
- **350+ Ambulatory Practices**
- **23 IPAs/MSOs**
- **4 LTC/Post-Acute** (10 sites)
- **11 Social Services/CBOs**

What Does LANES Do?

Data

Sorted Data

Visual Data

Data Turned
Into Information

Actionable
Information

ECM Support Services

Current Services:

- Tracking eligible and enrolled ECM patients
- On-Location Indicator for Patient Engagement
- ADT Notifications to Care Teams
- Service Utilization Reports
- Community Care Coordination Notes
- Closed-Loop Referral System

Roadmap:

- County jail health records
- Substance use data
- Social determinants of health data

Objectives

Simplify the WIC referral and enrollment process and more holistically coordinate care for WIC families.

- **Stakeholder:** California WIC Association (CWA)
- **Funding:** The National WIC Association (NWA), Kaiser National Community Benefit Fund

WIC Closed-Loop Referral

Goal

Enhance coordination between WIC agencies and healthcare providers to improve access to WIC services.

- Simplify the WIC referral and enrollment process for both participants and providers.
- Establish a sustainable model for healthcare-WIC collaboration using Health Information Exchange (HIE) technology.
- Implement pilots in two Los Angeles locations—Northeast Valley Health Corporation (NEVHC) and Watts Healthcare—to test and refine this collaboration.

Stakeholders Profile

Northeast Valley Clinic

- 19 Locations
- 181 Providers
- 83,000 Patients/yr

Watts Clinic

- 6 Locations
- 50 Providers
- 20,000 Patients/yr

Northeast Valley WIC

- 9 Centers
- 40,210 participants
- San Fernando & Santa Clarita Valleys

Watts WIC

- 5 Centers
- 11,270 participants
- South LA, Compton, Huntington Park

Pilot Resources & Timeline

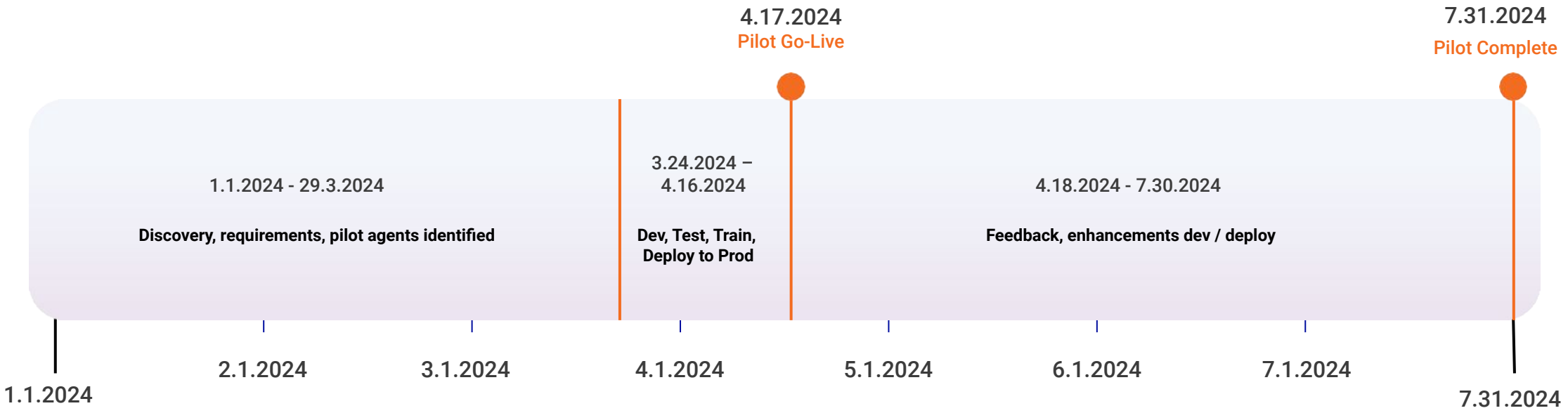
Project Team

CWA: Project Lead

LANES: Operations, IT, Compliance

Health Centers: Admin, Clinical, IT

WIC Agencies: Managers, Admin Staff



WIC Referral Implementation

Discovery

- WIC MIS is a closed system
- WIC needs health data for nutrition assessment and certification
- Adapt to clinic workflow
- Two groups to work with
  - Pediatric referral
  - Women's health referral

WIC Eligible Population:

Women

Pregnant, postpartum, and breastfeeding women

Infants

Children up to their first birthday

Children

Children from 1 year up to fifth birthday

Referral Delivery Method:

- Via Roster from referral originator based on standing orders
- Derived by receipt of a well child visit encounter, any pre-natal visit, a failure to thrive diagnosis of any child 0-18 months

Referral Workflow

FQHC

- IT staff generates a roster of patients seen at prenatal & well child visits
- Send roster to LANES weekly

LANES

- Matches patients and validate and add visit encounters
- Creates a worklist for WIC staff
- Populates “WIC View” with health data necessary for enrollment, assessment, and certification

WIC Agency

- WIC Staff access LANES Portal daily and use the worklist, to contact the family
- Update status codes and number of contact attempts, etc.
- For the new and reenrolling participants, staff retrieve health data needed for certification in the “WIC view”

Referral System - Worklist

Welcome, NEVHC test

View Participants Sharing Data

WIC

WIC Patient Search

Start Typing to search. Grid will load all roster patients.

New: 759 | In Process: 393 | In Process - New to WIC – invite sent: 566 | In Process - Previous – message sent: 525 | Pending Enrollment: 4

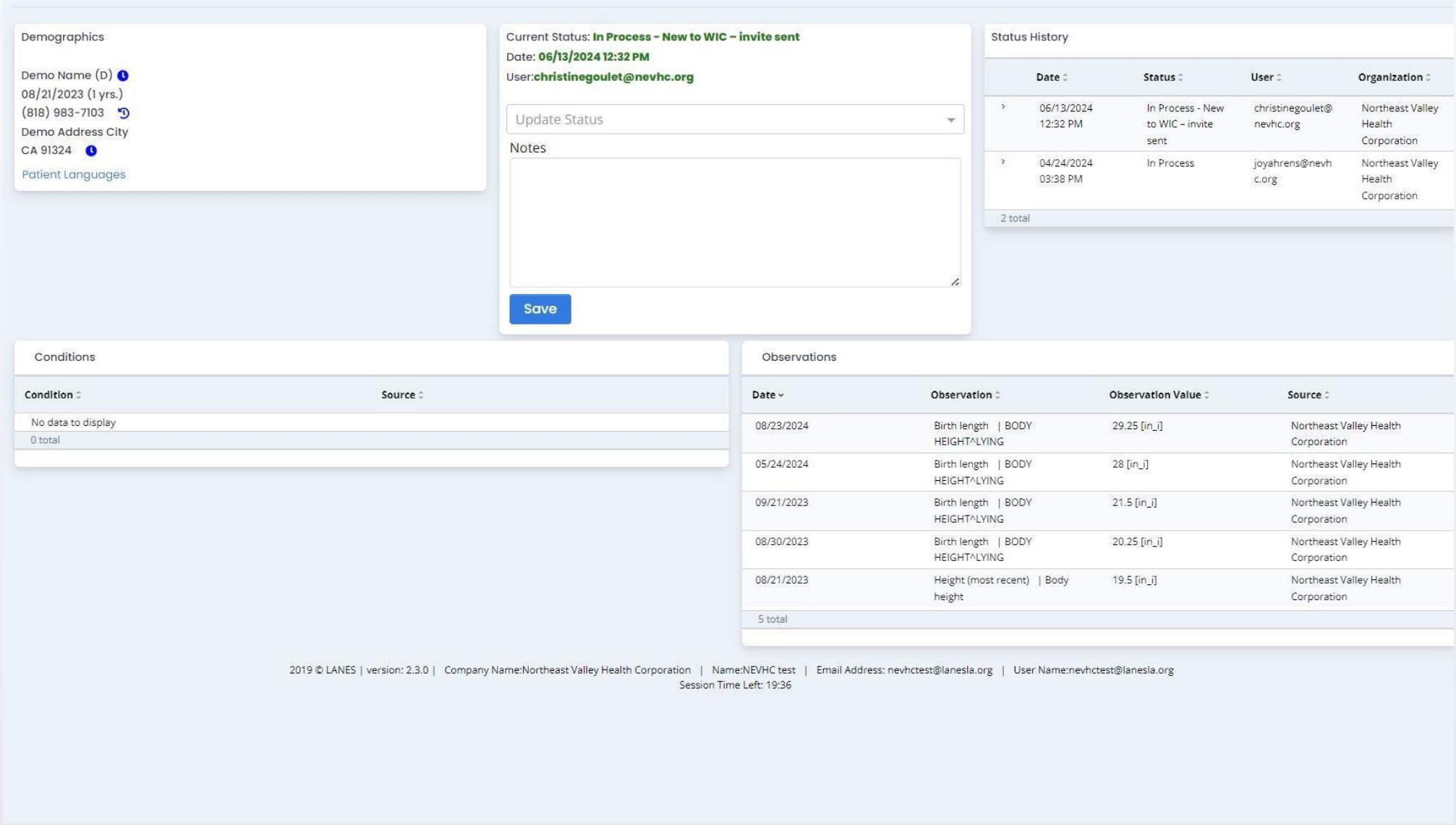
Already on NEVHC WIC: 4401 | Already on WIC elsewhere: 455 | Enrolled: 196 | Not eligible – income: 14 | Not eligible – moved: 5 | Not eligible - other: 389

Declined: 36 | Unable to Reach: 478 | Other: 0

First Name | Last Name | Date Of Birth | × New

View Patient	First Name	Middle Name	Last Name	Birth Date	Age	Gender	Address	Latest Status
Patient Synopsis	Demo First Name	CARLOS	Demo Last Name	Demo DOB	Demo DOB	M	815 S KALISHER ST SAN FERNANDO CA 91340	New
Patient Synopsis	Demo First Name		Demo Last Name	Demo DOB	Demo DOB	M	27042 LANGSIDE AVE CANYON COUNTRY CA 91351	New
Patient Synopsis	Demo First Name	MAGALY	Demo Last Name	Demo DOB	Demo DOB	F	15201 VICTORY BLVD APT 13 VAN NUYS CA 91411	New
Patient Synopsis	Demo First Name	TERESA	Demo Last Name	Demo DOB	Demo DOB	F	18540 SOLEDAD CYN RD SPC 65 CANYON COUNTRY CA 91351	New
Patient Synopsis	Demo First Name	JUAN	Demo Last Name	Demo DOB	Demo DOB	M	13350 CORNELIUS ST PACOIMA CA 91331	New
Patient Synopsis	Demo First Name	GRACE	Demo Last Name	Demo DOB	Demo DOB	F	6337 MIDDLETON ST. APT.302 HUNTINGTON PARK CA 90255	New
Patient Synopsis	Demo First Name	JULIETTE	Demo Last Name	Demo DOB	Demo DOB	F	13101 1/2 CARL ST 1/2 PACOIMA CA 91331	New
Patient Synopsis	Demo First Name	ERZA	Demo Last Name	Demo DOB	Demo DOB	M	9044 LEDGE AVE SUN VALLEY CA 91352	New

Referral System – WIC Clinical View



LANES Portal WIC View

Customized WIC View:

Simplifying Data Access for Enrollment

- WIC View: A tailored user interface in LANES showing Health data necessary for WIC enrollment and certification
- Data Fields Available:
  - Contact information, demographics, height, weight, hemoglobin levels, relevant medical diagnoses, provider notes relevant dietary need, nutrition, or breastfeeding
  - Reduce the burden on providers and patients by eliminating the need to gather and submit these records.

Impact Measurement

Initial Observations:

- Three months look back
- Replaced manual referral at the clinics with standing order.
- Reduced burden on the providers to send health information to WIC.
- Potential to reduce the lag time between provider visits and WIC outreach.
- Health information helps nutritionist make informed decision and recommendation.
- **Participant Feedback:** Families appreciated the proactive contact initiated by their healthcare providers.

NEVHC:

- 6,471 referrals made through LANES.
- 30% were eligible but not enrolled.
- Streamlined access to clinical data reduced participant burden, especially in remote scenarios.

Watts Healthcare:

- 3,100 referrals made.
- The use of LANES helped re-engage children aged 1-5 who had missed appointments
- Improved early prenatal outreach.

Lessons Learned

- Align data policies with regulatory requirements.
- Patient consent is necessary for WIC to share services with referring entity.
- The standing order approach is effective for one-to-one referrals.
- The CWA’s leadership and expertise were essential for the project's successful implementation.
- Community base QHIOs can solve local problems and bridge gaps in the workflow.

WIC is a program that's adjunct to health care, so the closer we can get WIC working with health care providers, the better. […] the goal is to use this huge nutrition and lactation force more effectively with healthcare.

- Karen Farley, California WIC Association Project Director

Thank you!

lanesla.org

Collaborative Partnerships and Data Sharing Innovations to Address Housing Insecurity and Homelessness

Tamera Kohler
CEO
Regional Taskforce on Homelessness

Camey Christenson
Chief Business Development Officer
211/CIE San Diego

CIE SUMMIT 2024

Emerging Models of Community-Led Care Infrastructure

Collaborative Partnerships and Data Sharing Innovations to Address Housing Insecurity and Homelessness

Tamera Kohler
Regional Taskforce on Homelessness
CEO

Camey Christenson
211/CIE San Diego
Chief Business Development Officer

Meet the Presenters

CIE SUMMIT 2024
Emerging Models of Community-Led Care Infrastructure

Tamera Kohler

Regional Taskforce on Homelessness
CEO

Camey Christenson

211/CIE San Diego
Chief Business Development Officer

Regional Task Force on Homelessness

RTFH

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure

Both the CoC Lead and HMIS Lead agency for city and county of San Diego

- Conduct annual Point-In-Time Count
- Administer Homeless Management Information Systems (HMIS)
- Promote best practices, trainings, and standards for assistance
- Operate Coordinated Entry Systems (CES)
- Policy, advocacy, and research
- Fund homeless services
- Collaborative Applicant for HUD CoC funds
- Monitor system and program performance

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure

RTFH/CoC/HMIS – By The Numbers

- CoC covers 18 cities with total population about 3.28 million
- 2024 Annual PIT: 10,605 (6,110 unsheltered & 4,495 sheltered)
- Calendar Year 2023 Annual HMIS client count is over 46,000
- About 1,500 HMIS active users
- Over 143 HMIS participating agencies
- Over 600 HMIS programs

211 San Diego and CIE

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure

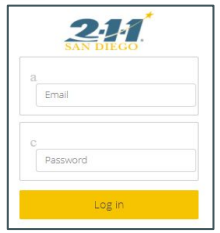
- 24/7 contact center
- 10-minute information and referral
- 300+ languages
- Use CIE to document all interactions with callers and consent into CIE
- CRM integrated with CIE platform

CARE COORDINATION

- Specialty line with case management
- Contracted partnerships with Managed Care Plans (MCPs)
- In-depth assessment and coordinated referrals via the CIE
- CRM integrated with CIE platform

Community Information Exchange

Connect to 137+ organizations through direct system access and leveraging data integration between systems



Individual User Access

- Secure login – 1,500 individual users
- Individual level PII & CIE profile, Screenings, Assessments, Comprehensive Social Continuum Assessment (CSCA)
- Electronic, closed-loop Referrals

System to System Integration

- Secure member matching
- API connections
- Eligibility prioritization

Community Information Exchange (CIE)

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure

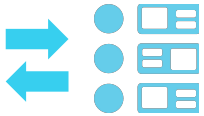
A CIE® is a **community-governed infrastructure** that enables information to be effectively and responsibly shared among many organizations, using different, **interoperable technologies**, in support of **holistic coordination of care** and **equitable systems change**. Specifically, a CIE enables the **sharing of data** among multiple kinds of stakeholders – such as providers who need to share data to provide more holistic care, people in need who must navigate complex systems of care, and researchers and decision-makers. As **critical infrastructure** that supports many stakeholders, using many different technologies, a CIE can enhance understanding of individuals' and communities' needs, improving service accessibility, service outcomes, and the health and well-being of a community.

Network Partners

Collective approach with standard Participation Agreement, Business Associates Agreement and participant consent with shared partner governance, ongoing engagement, and support.

Shared Language (SDoH)

Setting a Framework of shared measures and outcomes through 14 Social Drivers of Health Assessments and a Risk Rating Scale: Crisis, Critical, Vulnerable, Stable, Safe Thriving



Bidirectional Closed Loop Referrals

Updated resource database of community, health, and social service providers. Ability to accept/return referrals and to provide outcomes and program enrollment.

Technology Platform and Data Integration

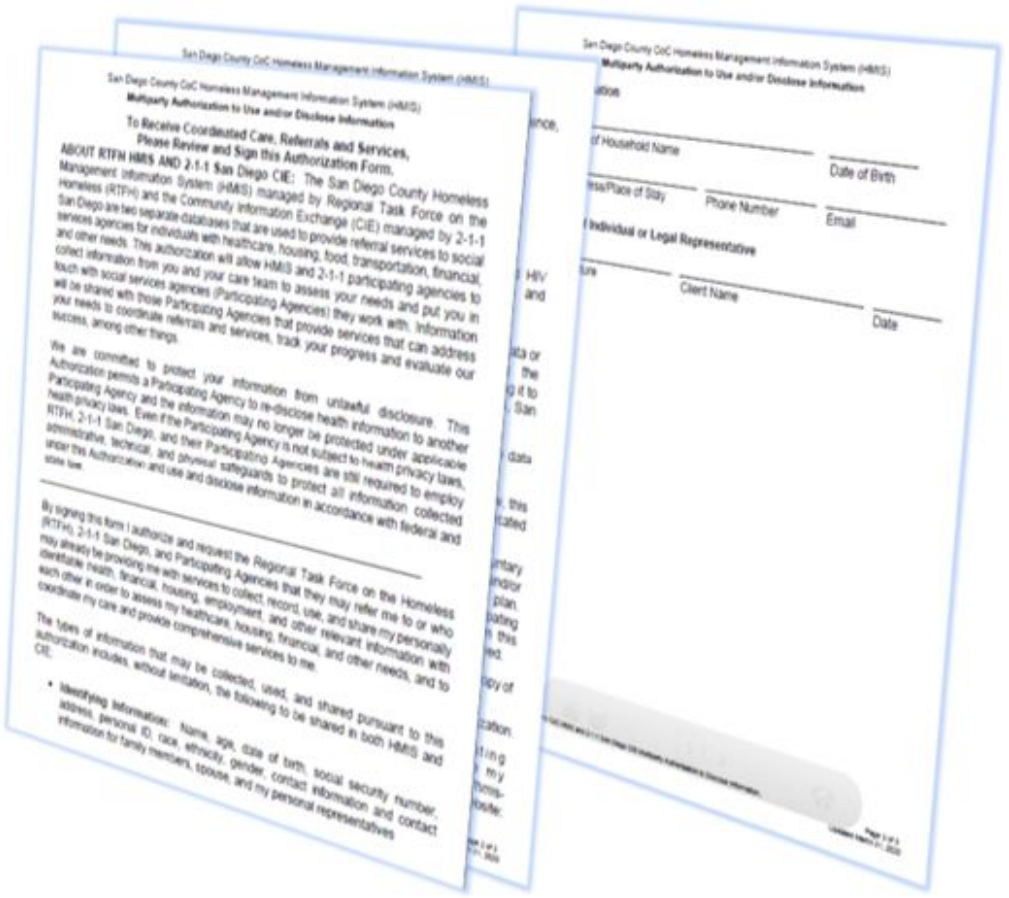
Technology software that integrates with other platforms to populate an individual record and shapes the care plan. System features include care team communication feeds, status change alerts, data source auto-history and predictive analytics.

Community Care Planning

Longitudinal record with a unified community care plan that promotes cross-sector collaboration and a holistic approach.

Why combine the Multi-Party Agreement with CIE Authorization?

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure

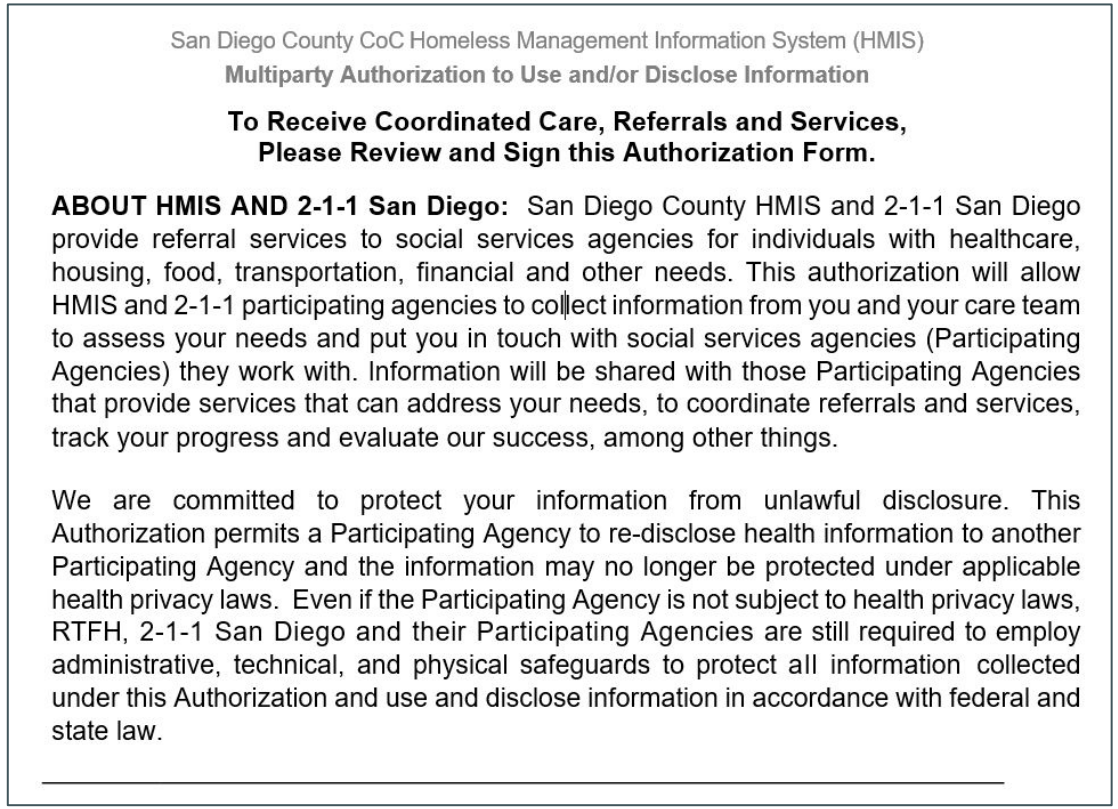


Recognizing unhoused individuals and families experience co-related hardships and can benefit from holistic care, in October 2019, the RTFH Board voted to approve a joint HMIS-CIE Client Authorization form.

As of April 1st, 2020, clients who opt-in to HMIS/Clarity are given the opportunity to opt-in to CIE as well.

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure

HMIS Integration and Single Joint Consent



San Diego County CoC Homeless Management Information System (HMIS)

Multiparty Authorization to Use and/or Disclose Information

To Receive Coordinated Care, Referrals and Services, Please Review and Sign this Authorization Form.

ABOUT HMIS AND 2-1-1 San Diego: San Diego County HMIS and 2-1-1 San Diego provide referral services to social services agencies for individuals with healthcare, housing, food, transportation, financial and other needs. This authorization will allow HMIS and 2-1-1 participating agencies to collect information from you and your care team to assess your needs and put you in touch with social services agencies (Participating Agencies) they work with. Information will be shared with those Participating Agencies that provide services that can address your needs, to coordinate referrals and services, track your progress and evaluate our success, among other things.

We are committed to protect your information from unlawful disclosure. This Authorization permits a Participating Agency to re-disclose health information to another Participating Agency and the information may no longer be protected under applicable health privacy laws. Even if the Participating Agency is not subject to health privacy laws, RTFH, 2-1-1 San Diego and their Participating Agencies are still required to employ administrative, technical, and physical safeguards to protect all information collected under this Authorization and use and disclose information in accordance with federal and state law.

Contact/PII Information:

- First Name
- Last Name
- Middle Name
- Email
- Mobile
- Home Phone
- Home Address
- Physical Address Line 2
- Other City
- Other State
- Other Postal/Zip Code
- Mailing Address
- Mailing Address Line 2
- Mailing City
- Mailing State
- Mailing Postal/Zip Code

Demographics: 14 fields

- Ethnicity
- Gender Identity
- Race
- Language
- Military Branches
- Military Discharge Status
- Military Service Status
- Head of Household
- Number of Children in the Household
- Household Size
- Monthly Income Amount / FPL
- Sources of Income
- Non-Cash Benefits
- Accessed Supplemental Benefits

Housing/Enrollment Data:

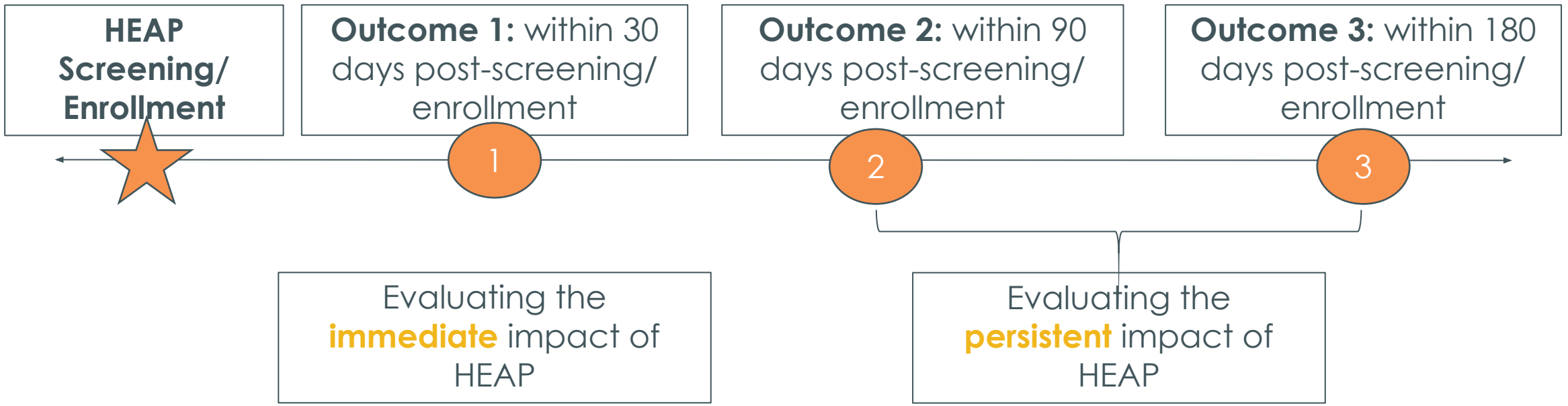
- Chronic Homelessness
- HMIS Assessment Name, Date, Score
- Program Enrollment Name, Entry, Exit, Destination

Outcomes – Robust Data Examples: Homeless Emergency Aid Program (HEAP)

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure

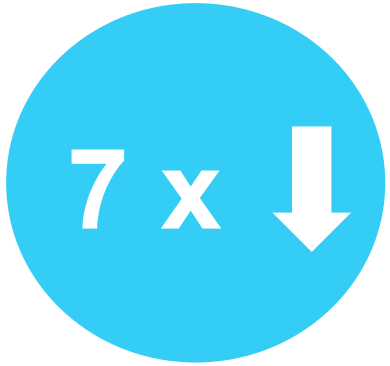
The Homeless Emergency Aid Program (HEAP) was a one-time funding opportunity intended to provide immediate emergency assistance to people who were at imminent risk of homelessness in San Diego County.

Partnership included 11 community partners across the region, leveraging CIE to centralize screening/intake and document outcomes, from July 2019 to July 2021.

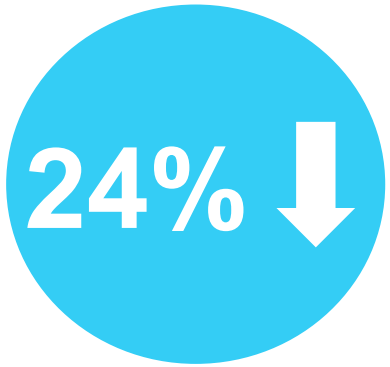


Outcomes – Robust Data Examples: Homeless Emergency Aid Program (HEAP)

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure



Eligible clients enrolled in HEAP were nearly **7 times less likely to experience homelessness** compared to eligible clients who were never enrolled



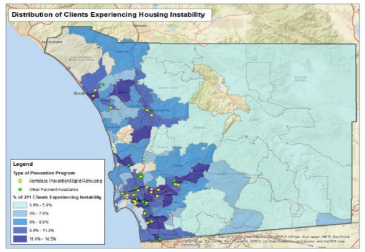
Preventing homelessness costs 24% less than providing services to serve clients experiencing chronic homelessness

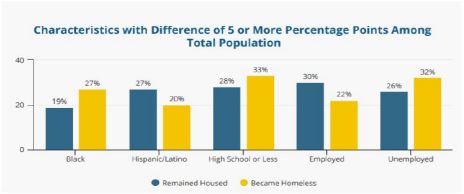
* Based on available data for amounts received by clients enrolled in HEAP (from 51% of eligible and enrolled clients)
** Based on estimated service costs of $35,578 per individual experiencing chronic homelessness per year (NAEH, 2015)

Outcomes – Robust Data Examples:
Leveraging Robust Social Determinant Datasets to Drive Policy

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure

Macro (Community)

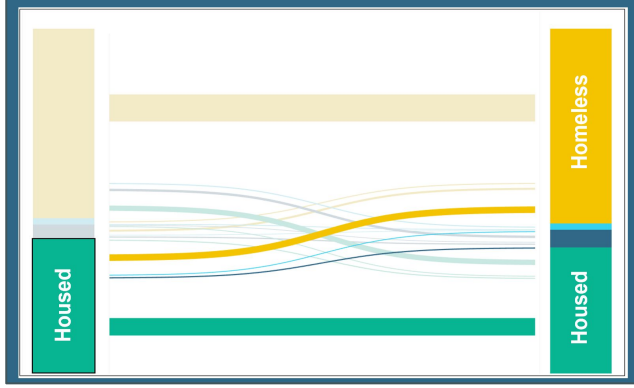




- **Root cause of racial inequities:** Identify & address upstream barriers
- **Distribution of Resources:** movement away from first come first serve and creates accountability to ensure equitable services
- **Co-Occurring Associated Needs:** Identification of multiple social and health indicators

Identify Populations for Targeted Interventions

Identifying populations of individuals who move from housed to homeless provide opportunities to understand barriers or factors that led to homelessness.



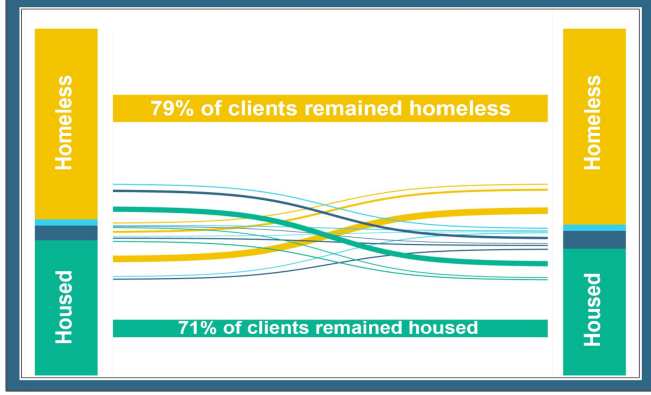
However, 25% of **housed** clients became **homeless** by their second interaction.

1 in 4

persons facing housing instability **became homeless within 4 months**

Better Understanding of Pathways

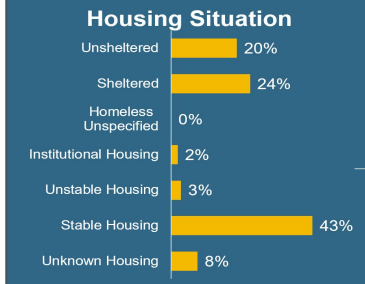
Data shared through 2-1-1 San Diego and the Community Information Exchange provide insights into housing situations at first and second interaction.



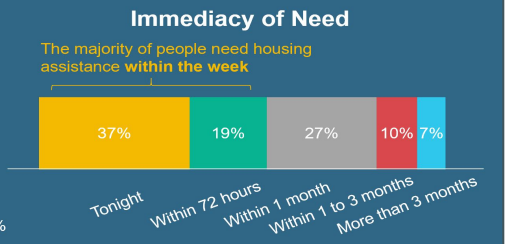
The majority of clients who were homeless remained homeless, and those who were housed remained housed.

Housing Insights

Social determinant assessments provide comprehensive information about what individuals are experiencing.



42% of individuals have **no social supports**



Top 5 Barriers to Accessing Housing

1. Rental costs
2. Move-in costs
3. Eviction
4. Violence or safety concerns
5. Credit or prior tenant history

Reminder: Strong & Healthy Partnerships take work

CIE SUMMIT 2024 Emerging Models of Community-Led Care Infrastructure

- Value and build the partnership
- Give each other credit
- Have each other's back
- Lead together
- Build community trust
- Work towards what’s next

CIE SUMMIT 2024
Emerging Models of Community-Led Care Infrastructure

Thank you!

Tamera Kohler
Tamera.kohler@rtfhsd.org
www.rtfhsd.org
Twitter @RFTHSD

Camey Christenson
cchristenson@211sandiego.org
www.211sandiego.org
www.ciesandiego.org
Twitter @211SD

California State Legislation Tracking

California Legislation Tracking

No./Author	Summary	Recent Developments
SB 957 **(Wiener)**	Requires the CDPH to collect sexual orientation, gender identity, and variations in sex characteristics/intersex status (SOGISC) data from third-party entities, including local health jurisdictions, on any forms or electronic data systems unless prohibited by federal or state law. This bill would only require health care providers to disclose SOGISC information that is voluntarily self-identified and prohibit disclosures for individuals under 18 years of age.	Presented to the Governor (9/9)
SB 1016 **(Gonzalez)**	Requires CDPH by 2028 to use OMB demographic categories for Hispanic and Latino groups, additional categories for each major Latino group and Mesoamerican Indigenous nation, and specified language categories when collecting language preference	Presented to the Governor (9/3)
AB 2198 **(Flora)**	Requires departments to require health care service plans and health insurers to establish and maintain federal API requirements and authorize departments to issue guidance relating to these provisions by 2027 or when final federal rules are implemented, whichever occurs later.	**Signed by the Governor (9/22)**
AB 2250 **(Weber)**	Establishes SDOH screeners as a covered benefit for Medi-Cal beneficiaries and require health plans and insurers to cover SDOH screenings. Additionally, requires providers to use specified tools or protocols to document patient responses and require health plans and insurers to provide PCPs access to peer support specialists, lay health workers, social workers, or CHWs.	**Vetoed by the Governor (9/22)**
AB 2058 **(Weber)**	Requires legible disclosures on devices that collect or analyze medical or physiology information regarding effectiveness limitations for the device's intended population considering patient characteristics, including age, color, disability, ethnicity, gender, or race. Infractions are considered to be criminal by 2027.	Presented to the Governor (9/11)

California Legislation Tracking - Artificial Intelligence

No./Author	Summary	Recent Developments
SB 892 **(Padilla)**	Requires the Department of Technology to establish an automated decision systems procurement standard, which would include risk and equity assessments for automated decision systems.	**Vetoed by the Governor**; In Senate for Consideration (9/20)
SB 896 **(Dodd)**	Requires the Office of Emergency Services to perform a risk analysis of potential threats posed by the use of generative artificial intelligence to California's critical infrastructure.	Presented to the Governor (9/4)
SB 1047 **(Weiner)**	Requires AI developers to implement safety and security protocol, use third-party auditors to perform and submit annual compliance certifications, and prohibit AI use if unreasonable risk could cause harm. Establishes a governing board and division, whistleblower protections, and civil action for unlawful acts.	Presented to the Governor (9/9)
SB 1120 **(Becker)**	Establishes requirements for health plans and disability insurers using AI, algorithm, or software tools for utilization review or management decisions, including that tool bases determinations on specified information and is fairly and equitably applied. Violations are considered to be a crime.	Presented to the Governor (9/11)
AB 3030 **(Calderon)**	Requires health providers using AI for clinical communications to include AI disclaimers with clear instructions to connect with a human provider, exempting communications read and reviewed by a licensed or certified provider. Violations are subject of state medical boards, as appropriate.	Presented to the Governor (9/13)
AB 2013 **(Irwin)**	Requires AI developers by 2026 to publicly post high-level summaries of AI training datasets with exceptions for AI with certain purposes and AI developed.	Presented to the Governor (9/5)

Implementation Advisory Committee Recap: Data Exchange Framework Roadmap Preview

Development of DxF Roadmap

CDII is developing a three-year DxF Roadmap to detail critical DxF implementation priorities in 2025 – 2027.

Roadmap Purpose

To identify DxF design and implementation priorities to advance nation-leading health and social service data exchange in California over the next three years (2025-2027).

Roadmap Structure

The Roadmap will comprise six "Priority Areas" for advancing health and social service data exchange in California (see right sidebar), and for each, describe the:

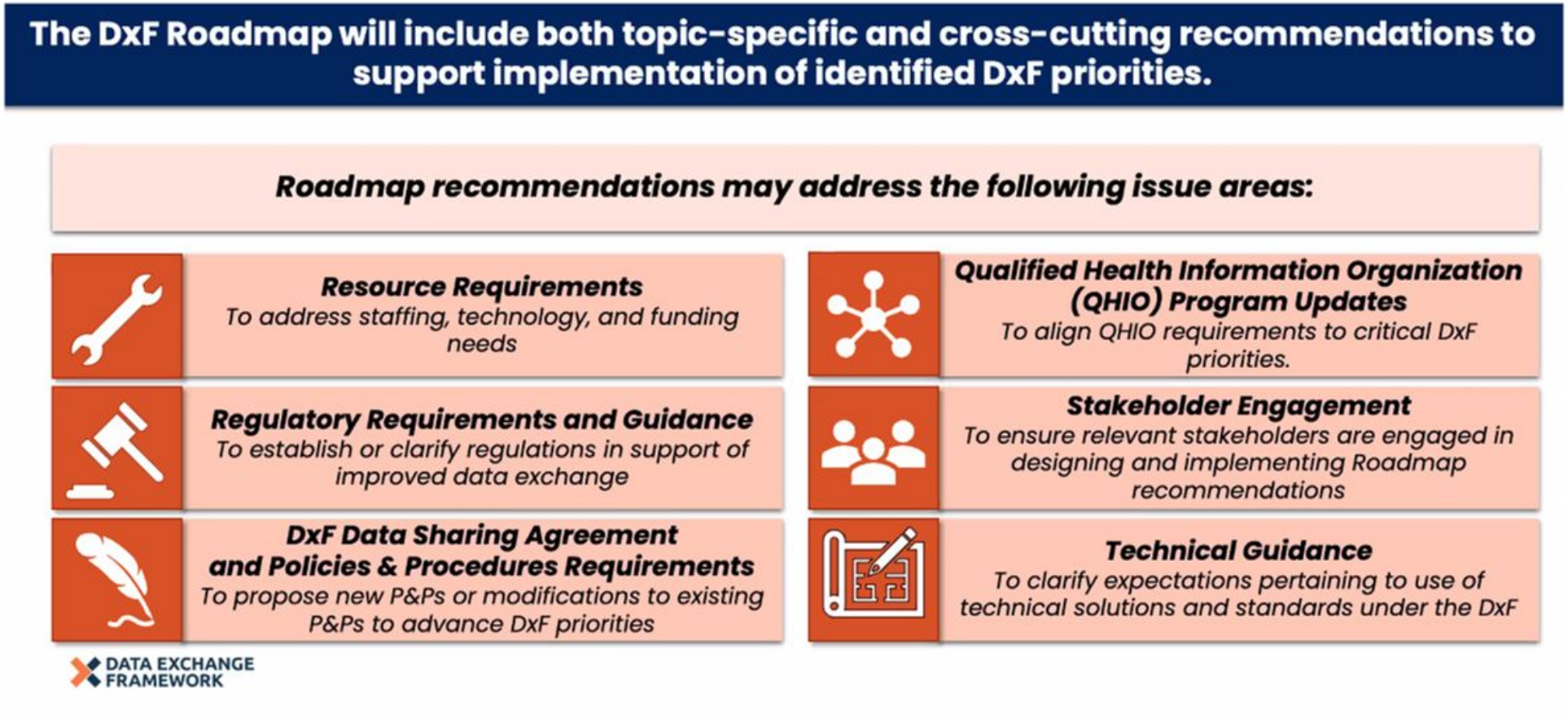
- Issues to be addressed;
- Goals and tenets guiding resolution strategy development;
- Recommendations to address issues and advance DxF in California.

The DxF Roadmap will be structured as a narrative document.

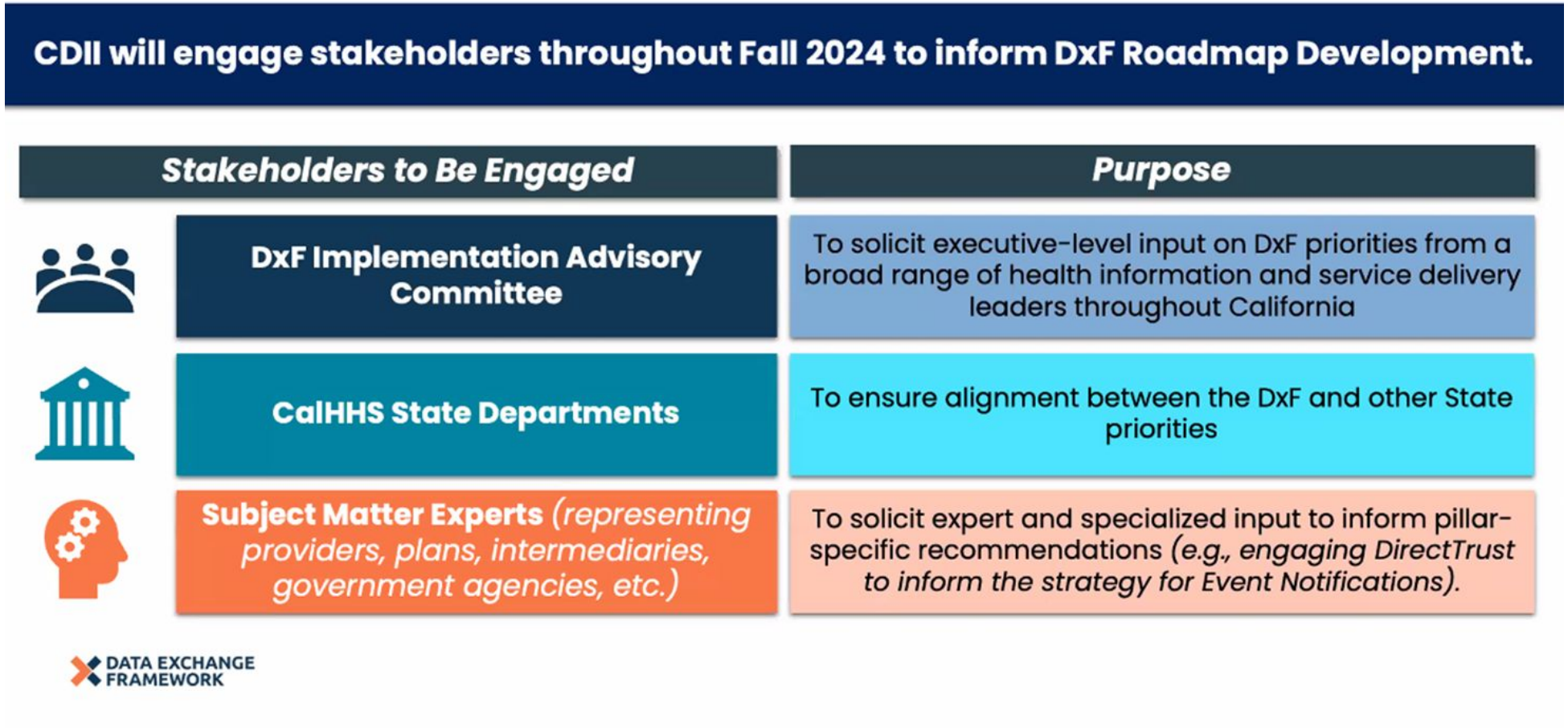
Identified Priority Areas

1. Event Notifications
2. Social Services Data
3. Consent Management
4. Public Health Data
5. Impact Measurement
6. DxF Signatory Campaign Strategy

DxF Roadmap Expected Outputs

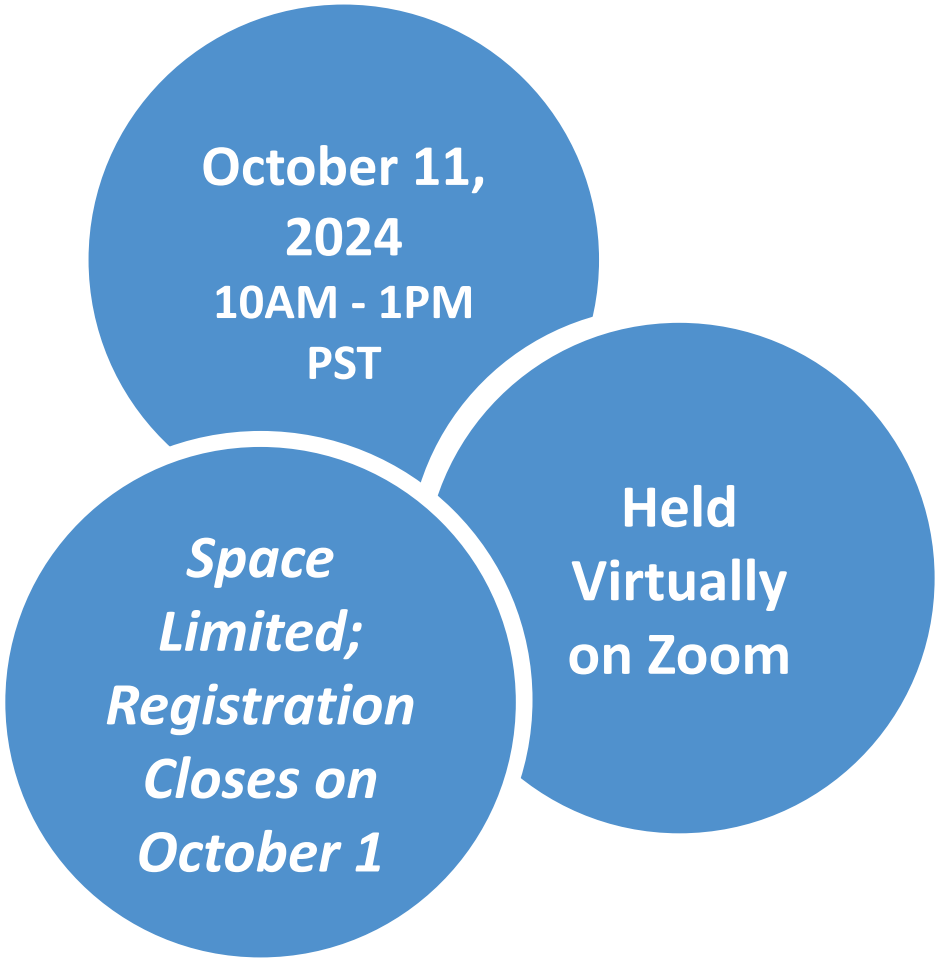


DxF Roadmap Stakeholder Engagement



News, Events, and Announcements

Final 2024 DxF Bootcamp for All-Comers



RSVP TODAY:

Connecting for Better Health
Advancing data sharing to improve the health of all Californians

Monthly C4BH Office Hours

C4BH is launching monthly office hours to engage with coalition partners on their priorities and answer data exchange policy questions

The first session is open to the entire coalition, but office hours will be exclusive to C4BH sponsors and supporters moving forward

October 2, 2024
9:30-10:30AM PST

JOIN US:

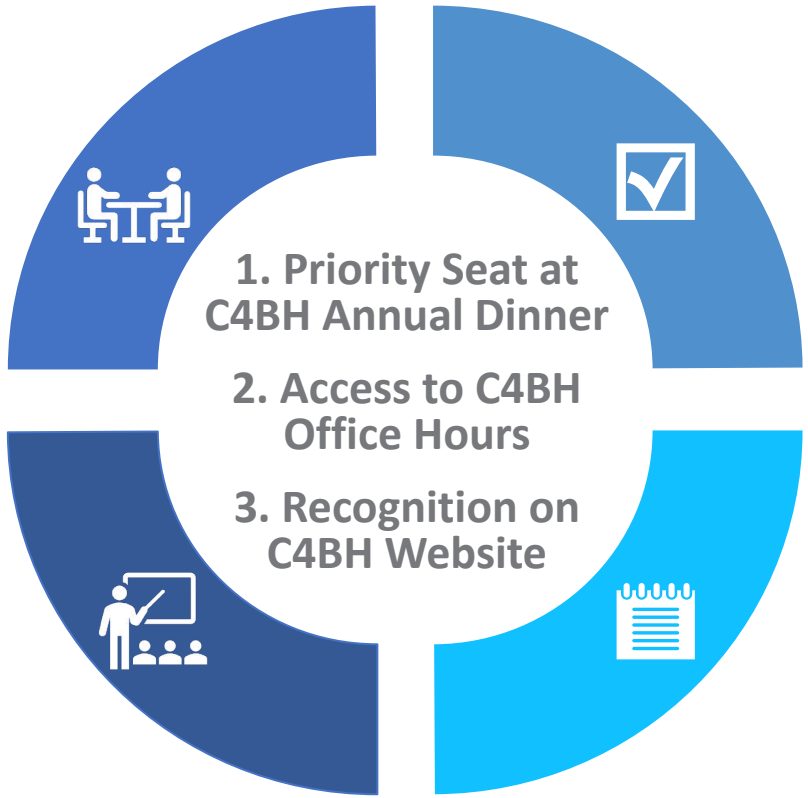
Connecting for Better Health
Advancing data sharing to improve the health of all Californians

Call for C4BH Supporters

Join C4BH as a Supporter

$500 contribution

Supporter Benefits



Why Become a Supporter?

- **Impact:** Be on the Leading Edge of Policy and Research
- **Impact:** Contribute to California's Meaningful Transformation
- **Opportunity:** Network with Industry Leaders over Shared Mission
- **Recognition:** Showcase Your Commitment to Health Improvement

Connecting for Better Health
Advancing data sharing to improve the health of all Californians

C4BH On The Road - Upcoming Conferences

- **October 2-4:** CHEAC Annual Meeting | Sonoma, CA | Register here
- **October 15-17:** Civitas Annual Conference | Detroit, MI | Register here
  Coalition Meetup: October 15 at 7:30PM, Located at FUELL (Detroit Marriott)
- **October 20-23:** HLTH 2024 | Las Vegas, NV
- **October 21-23:** CAHP Annual Conference | Palm Desert, CA | Register here
  After Hours Meetup: October 22 at 8PM, Located at Aquifer65 (JW Marriott Desert Springs)
- **December 4-5:** ASTP/ONC | 2024 Annual Meeting | Washington D.C. | Register here

Find the full C4BH calendar of events here

Upcoming Meetings & Webinars

- **September 27, 1-2PM PT:** CalHHS CDII | 2024 DxF Standards Committee Meeting #1 | Register here
- **September 27:** Community Clinic Association of Los Angeles County Health IT Summit | Los Angeles, CA | Register here
- **October 3, 11-12PM PT:** ASTP/ONC | Ask Us About Information Sharing Webinar | Register here
- **October 17, 1:30-3PM PT:** ITUP | Justice-Involved and Behavioral Health Policy Forum | Register here
- **October 18, 1-2PM PT:** CalHHS CDII | 2024 DxF Standards Committee Meeting #2 | Register here
- **October 29, 1:30-3PM PT:** ITUP | 2024 Election Policy Forum | Register here
- **November 7, 12:30-3PM PT:** CalHHS CDII | DxF Implementation Advisory Committee Meeting | Register here

What We're Reading – Check Out C4BH's Newsletter!

Secretary Ghaly on the DxF

As Dr. Mark Ghaly departs as Secretary of CalHHS, he reflects on the tremendous effort and progress of the DxF, shines light on the work still to come to achieve compliance, and highlights the transformative impact of sharing health and social service information. Read More

ASTP/ONC 2024 LEAP in Health IT Grant Awardees

ASTP/ONC announced the grant awardees for the Leading Edge Acceleration Projects in Health IT (LEAP in Health IT), which seek to advance AI data quality and health IT adoption in behavioral health. Read More

Epic And Oracle Health Improve VA Interoperability

The U.S. Department of Veteran Affairs (VA) now has the ability to connect to Epic and Oracle Health EHRs through open APIs, allowing health care providers to view information about veterans receiving care outside VA facilities. This connection is part of a pledge among 13 health systems to improve data sharing with the VA, allowing providers to identify veterans receiving private care, connect them with resources, and coordinate care for shared patients. Read More

C4BH Storytelling Continues - Reach Out!

DATA SHARING TO ASSIST CARE MANAGERS

Anwar Zoueihid
Vice President Long Term Services & Supports, Partners in Care Foundation

DATA SHARING TO PROVIDE LIFE-SAVING NUTRITION

Michelle Kuppich
Executive Director
California Food is Medicine Coalition

SAVING LIVES WITH INFORMED EMERGENCY CARE

Jonathon Feit
Jonathon Feit, Co-Founder & CEO, Beyond Lucid Technologies

Jonathon's Vision
To transform pre-hospital care systems through enhanced data sharing, eliminating inefficiencies and ensuring seamless, effective emergency medical services.

EMPOWERING HEALTH WITH INTEGRATED SOCIAL AND HEALTH CARE DATA

Bill York
President & CEO, 211 San Diego

Bill's Vision
My vision is an integrated system of social and health care data that empowers decision-making so individuals can build and sustain healthy lives.

CENTERING COMMUNITY CARE

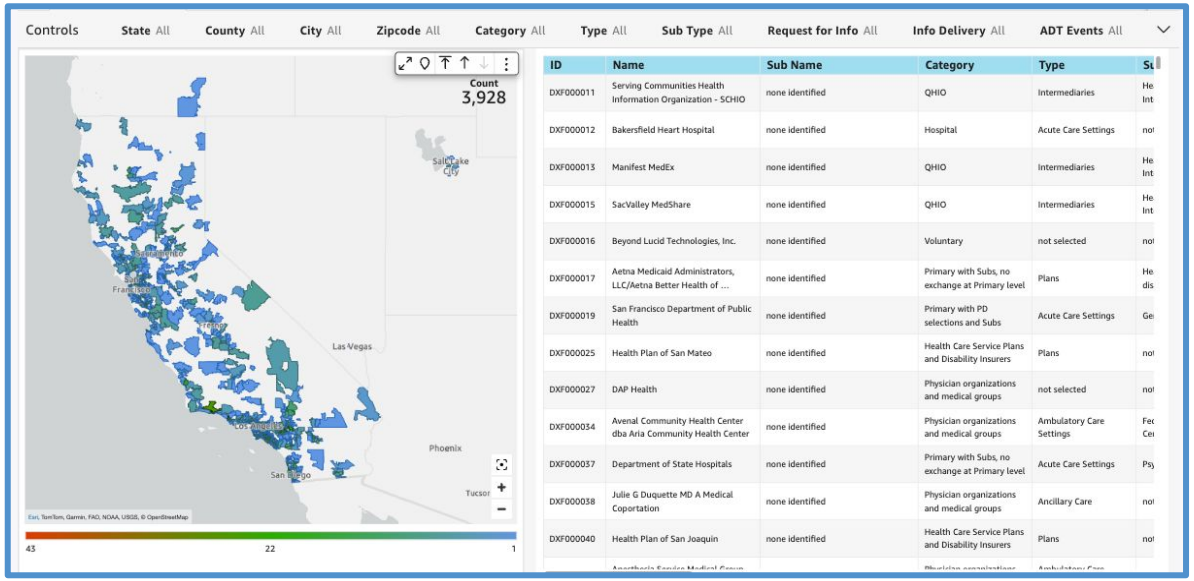
Scott Perryman
Battalion Chief, Paramedic, PA-C, Sacramento Metropolitan Fire District

Scott's Vision
My vision is for Sacramento's Mobile Integrated Health (MIH) to use data sharing to optimize coordinated care for better community health and well-being.

Appendix

Now Live: DxF Community Sandbox Platform

Find and Filter DxF Participants in your Region



Access the Sandbox Platform

The Sandbox enables DxF Participants to

- **Use visualization tools** to identify neighboring organizations and learn how they are sharing data
- **Explore available use cases** to further your organization's data sharing practices - with more coming soon!
- **Simulate data exchange and test use cases** with organizations that have onboarded to the Sandbox

Available Technical Assistance

	Level of DxF Readiness	C4BH Supports	What it is	Outputs
1	Planning	DxF Bootcamp	Half day education of what the DxF is, overview of Policies and Procedures, and help with identifying priority use cases	Develop a DxF Roadmap and Identify Priority Use Cases
2	Assessment	DxF Community Design Studio	6-8 weekly sprints to design real-world community use cases	Technical and Functional data exchange workflows, test data and reports
3	Ready to Connect!	DxF Community Sandbox	Real-world testing environment for DxF priority use cases.	Test and Validate Use Case to Establish Workflows

C4BH Annual Sponsor Tiers

Annual Sponsor Tiers *See next slide for exclusive sponsor benefits*	Platinum *$100,000+*	Gold *$50,000*	Silver *$25,000*	Supporters *$500*
End-of-Year Dinner	Table of 8-10 seats with recognition	4 seats with recognition	2 seats with recognition	Priority Invitation
Add Logo to Website and Sign-On Letters with Opt-Out Approach	✓	✓	✓	✓
Access to Office Hours	✓	✓	✓	✓
Advisory Group Representatives	1+	1	1	
Access to DxF Sandbox Community Studio	Priority Access	✓	✓	
Access to DxF Bootcamps	Priority Access	✓		
First Right to Engage in New C4BH Projects	✓			
White-Labeled DxF Implementation Toolkit	✓			

Do Your Priorities Differ From The Annual Sponsor Tiers? Reach Out To Us!

Additional Sponsor Opportunities Available For Our Annual Dinner