Manifest MEDEX

Evolution CA 2025: Southern Inland

Bridging Clinical, Claims, and Social Data to Accelerate Whole Community Care

September 9, 2025

Welcome Remarks

Erica Galvez
Chief Executive Officer,
Manifest MedEx

Driving Health Care Strategy Through Data

Elizabeth Landsberg
Director,
California Department of Healthcare Access and Information

Manifest MEDEX

HCAi
Department of Health Care Access and Information

Driving Health Care Strategy Through Data

September 9, 2025

HCAI Director Elizabeth Landsberg

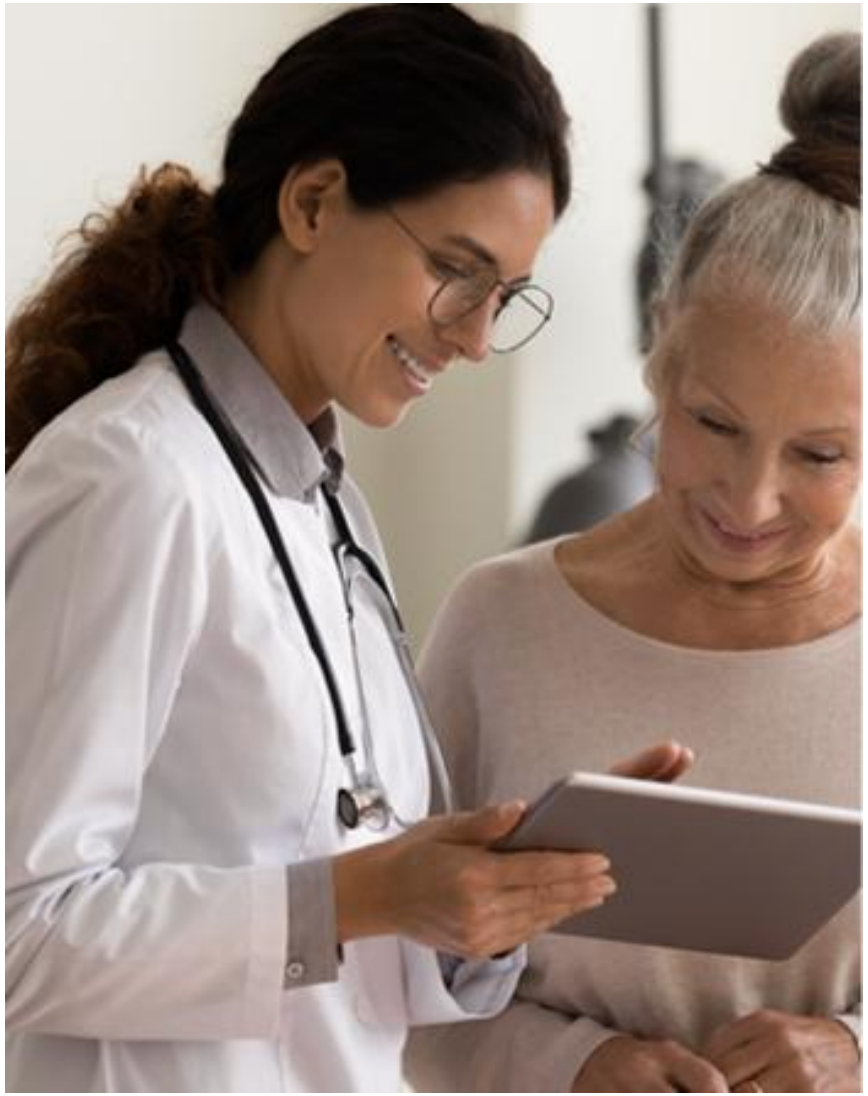
Our Mission

HCAI expands equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs.

HCAI Overview

- Established in 1978 as the Office of Statewide Health Planning and Development (**OSHPD)** to ensure health care accessibility within California.

- Transitioned to the Department of Health Care Access and Information (**HCAI**) in 2021 to reflect a growing portfolio and a more descriptive name.



HCAI Program Areas

- **Facilities**: Monitor the construction, renovation, and seismic safety of California's hospitals and skilled nursing facilities.
- **Financing**: Provide loan insurance for non-profit healthcare facilities to develop or expand services.
- **Workforce**: Expand and diversify California's health workforce for underserved areas and populations.
- **Data**: Collect, manage, analyze, and report actionable information about California's healthcare landscape.
- **Affordability:** Improve health care affordability through data analysis, spending targets, and measures to advance value. Enforce hospital billing protections, and provide generic drugs at a low, transparent price.

Rural Health Transformation Program

- The **Rural Health Transformation Program (RHTP)** is a federal funding program to strengthen health care in rural communities, where access, workforce shortages, and infrastructure gaps create unique challenges.
- Established through **H.R.1** and signed into law in July 2025, the program created the Rural Health Transformation Fund — a $50 billion investment over five years, available to all 50 states that apply. This program provides states resources to reimagine how rural health care is delivered and financed.
- HCAI is compiling California's application for the Rural Health Transformation Program

- Contact: State Office of Rural Health: CalSORH@hcai.ca.gov
- Sign Up for our Rural Health Mailing List: https://hcai.ca.gov/mailing-list/
  - When subscribing, select "Rural Health" under the *Healthcare Workforce* category to ensure you receive updates directly from SORH.

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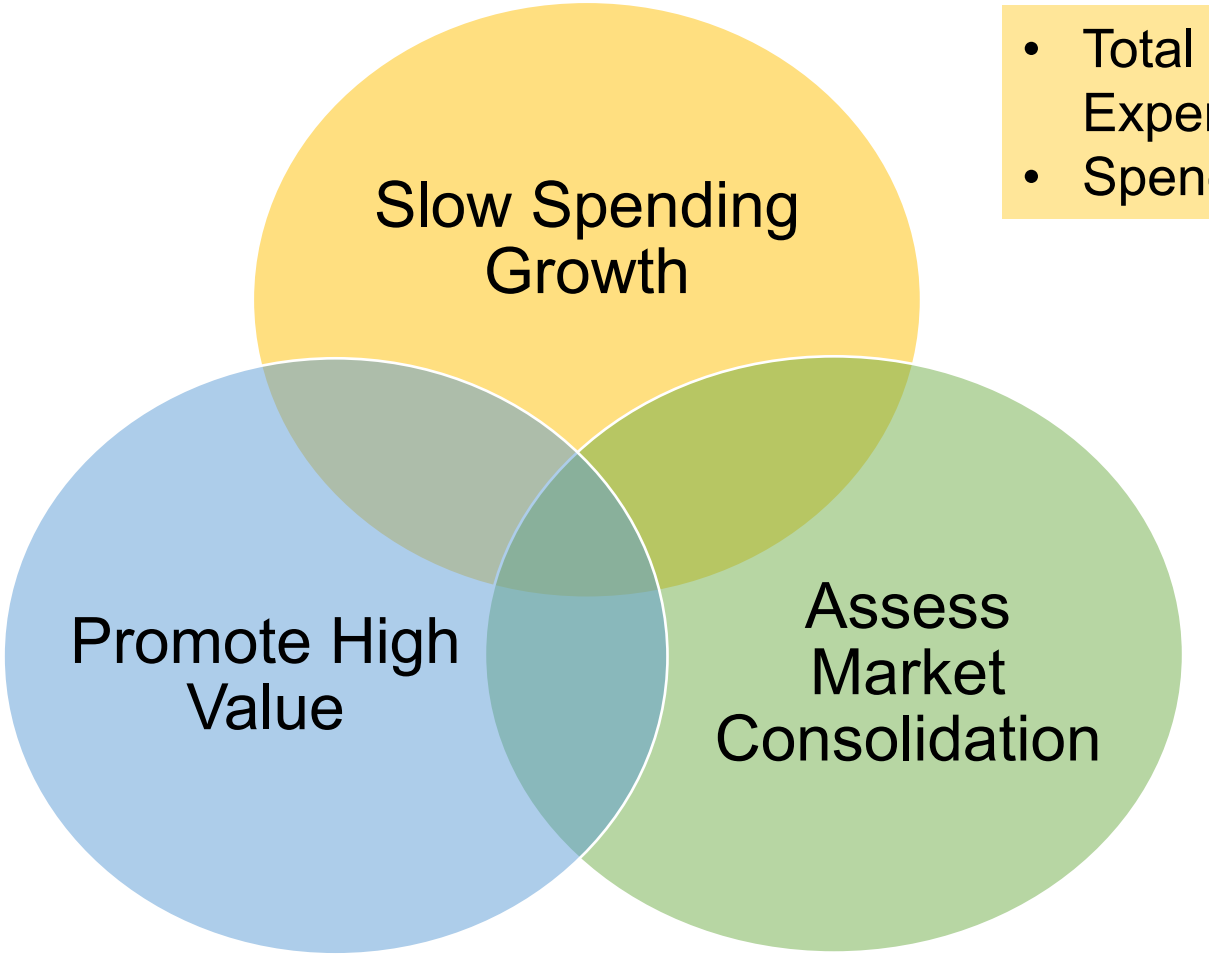
Office of Health Care Affordability (OHCA)

OHCA – Key Components



- Total Health Care Expenditures (THCE)
- Spending Targets

- Alternative Payment Models
- Primary Care
- Behavioral Health
- Workforce Stability
- Equity & Quality Measures

- Material Change Notices
- Cost and Market Impact Reviews

Spending Targets

WHAT A SPENDING TARGET IS	WHAT A SPENDING TARGET IS NOT
A **target** to track and evaluate the growth of health care spending.	A **price cap** or price reduction. A spending target looks forward, toward managing growth. It cannot roll back or cut prices.
A **measure of per capita growth in total medical expenses or total health care expenditures** (TME/THCE). When reported statewide, THCE is the annual sum of all health care expenditures on behalf of residents for health care services covered by public and private health coverage.	A measure of **internal costs or operating expenses** of health care entities.
A **long-term framework** for industry action. Health care entities have the flexibility to manage growth in prices, volume, or both; meaning they are challenged to engage in efforts to improve affordability of health care.	A **single solution** to addressing health care affordability challenges within California. The spending target provides critical information and data to inform other OHCA policy or state initiatives to improve affordability and access.

Total medical expenses (TME) measures all payments from payers to providers for reimbursement of the cost of health care, including medical claims, pharmacy claims, and non-claims payments. Total health care expenditures (THCE) includes total medical expense plus administrative costs and profits of health insurers and health plans.

Per Capita Health Care Spending Target

On April 24, 2024, the California Health Care Affordability Board established a base 3% statewide spending target for performance year 2029, based on the average annual rate of change in historical median household income growth from 2002-2022, ***signaling that health care spending should not grow faster than the income of California families***.

Performance Year	Per Capita Spending Growth Target
2025	3.5%
2026	3.5%
2027	3.2%
2028	3.2%
2029	3.0%

Identifying High-Cost Hospitals

OHCA identified disproportionately high-cost hospitals as those that are **repeat outliers on both unit and relative price measures**. Repeat outliers are defined as being above the 85th percentile for 3 out of the past 5 years.

- **Commercial Unit Price:** Price per standard unit for Commercial inpatient care. Represents dollar amounts and accounts for the amount and intensity of inpatient care delivered.
- **Relative Commercial to Medicare Price:** Ratio contextualizes commercial payments based on standard, national benchmark. Includes inpatient and outpatient revenue.

Note: The 85th percentile approximates one standard deviation above the mean

Commercial Unit Price for Repeat Outliers

Key: above 85%

Hospital	2018	2019	2020	2021	2022	Pooled Avg 2018-22
All Other Comparable Hospitals	$20.1K	$19.8K	$20.2K	$20.4K	$21.1K	$20.3K
7 High-Cost Hospitals	$36.3K	$39.7K	$40.1K	$42.1K	$43.8K	$40.4K
Community Hospital of The Monterey Peninsula	$32,729	$41,866	$42,292	$43,655	$38,891	$39.9K
Doctors Medical Center – Modesto	$27,288	$40,915	$35,947	$36,831	$39,679	$36.0K
Dominican Hospital	$37,237	$33,720	$33,201	$34,923	$33,291	$34.5K
Salinas Valley Memorial Hospital	$46,937	$43,061	$44,748	$50,400	$48,784	$46.7K
Santa Barbara Cottage Hospital	$31,185	$30,325	$36,617	$32,636	$33,596	$32.8K
Stanford Health Care	$47,705	$47,374	$49,091	$53,366	$58,873	$51.5K
Washington Hospital – Fremont	$32,200	$33,404	$30,929	$33,082	$35,432	$32.9K

Relative Commercial to Medicare Price for Repeat Outlier Hospitals, 2018-2022

Key: above 85%

Hospital	2018	2019	2020	2021	2022	Pooled Avg 2018-22
All Other Comparable Hospitals	203%	200%	201%	191%	198%	198%
7 High-Cost Hospitals	323%	365%	350%	355%	362%	351%
Community Hospital of The Monterey Peninsula	238%	437%	353%	363%	369%	354%
Doctors Medical Center - Modesto	326%	372%	343%	325%	372%	348%
Dominican Hospital	355%	314%	336%	316%	334%	331%
Salinas Valley Memorial Hospital	405%	457%	461%	556%	501%	475%
Santa Barbara Cottage Hospital	293%	300%	310%	310%	311%	305%
Stanford Health Care	326%	335%	339%	351%	340%	338%
Washington Hospital – Fremont	347%	392%	352%	328%	363%	358%

Hospital Sector Spending Target

At the April 2025 Health Care Affordability Board meeting, the Board voted unanimously set a lower target for high-cost hospitals

- Most hospitals are subject to the statewide spending target.
- For seven high-cost hospitals, and the Board set the spending target at 1.8% in 2026, 1.7% in 2027 and 2028, and 1.6% in 2029.
- Each year, the Office will provide the Board with an updated list of hospitals which meet the high-cost criteria and an updated list of factors to be considered in identifying high-cost hospitals.

OHCA Primary Care Investment Benchmark

Performance Years	Annual Improvement Benchmark
2025-2033	0.5 - 1% per year for each payer and product*
Performance Year	**Investment Benchmark**
2034	**15% statewide for all payers and products**

Rationale and Considerations:

- Received strong stakeholder support from Workgroup and public commenters
- Gives all payers reasonable opportunity to demonstrate immediate progress and long-term success
- Emphasizes demonstrating annual progress
- Offers gradual glidepath to ambitious but achievable 15% goal
- Offers some flexibility since OHCA does not have exact measures of current spend using its definition

*Payers at or above 15% of total medical expense may refrain from continued increases if not aligned with care delivery or affordability goals.

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Workforce Development

Health Workforce Approach and Strategy

HCAI enables the expansion and development of a **health workforce that reflects California's diversity in order to address supply shortages and inequities**, by administering programs and funding and generating actionable data.

Focus Our Programs in Four Areas

Develop, support and expand a health workforce that:

- Serves medically underserved areas
- Serves Medi-Cal members
- Represents the California it serves through racial and language diversity

Offer programs that provide financial support for:

- Organizations building the workforce pipeline
- Organizations expanding educational capacity
- Individuals pursuing health careers
- Organizations supporting providers and addressing retention

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A data-driven strategy to workforce gaps

Purpose

Enable HCAI and partners to understand and equitably solve the supply/demand gap in services & better serve Californians

Approach

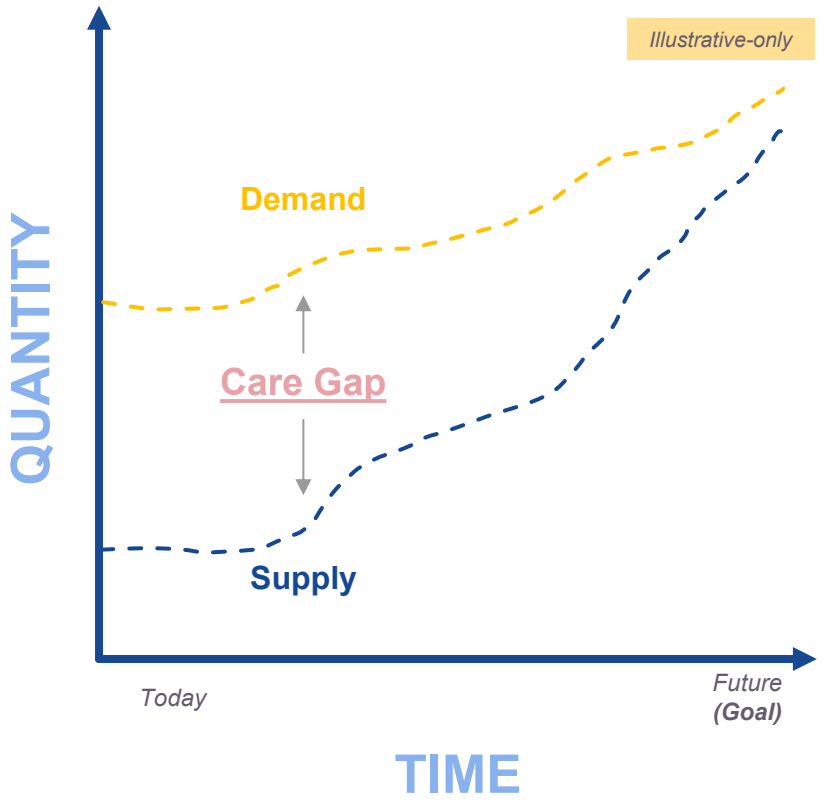
Supply, demand & pipeline modeling: Modeling tools enable a **granular** (by role & geography) **and quantitative view** of current state workforce shortages and projected future needs (shortages & training supply). Model outputs can be used by many departments, agencies and actors to guide their decision making.

Strategic planning: A **data-driven** strategy that identifies **innovative and tested best practices** to resolve persistent workforce gaps and inequities and creates **tailored intervention bundles** to target specific challenge and opportunities.

Stakeholder engagement: Significant stakeholder consultation and **collaboration with experts inside and outside of government, including health workers;** ongoing validation and refinement of our strategy, shaped by evidence and experience.

The right care to the right people

Supply currently lags demand in today's complex healthcare labor market …



… with this care gap being driven by key interrelated factors:

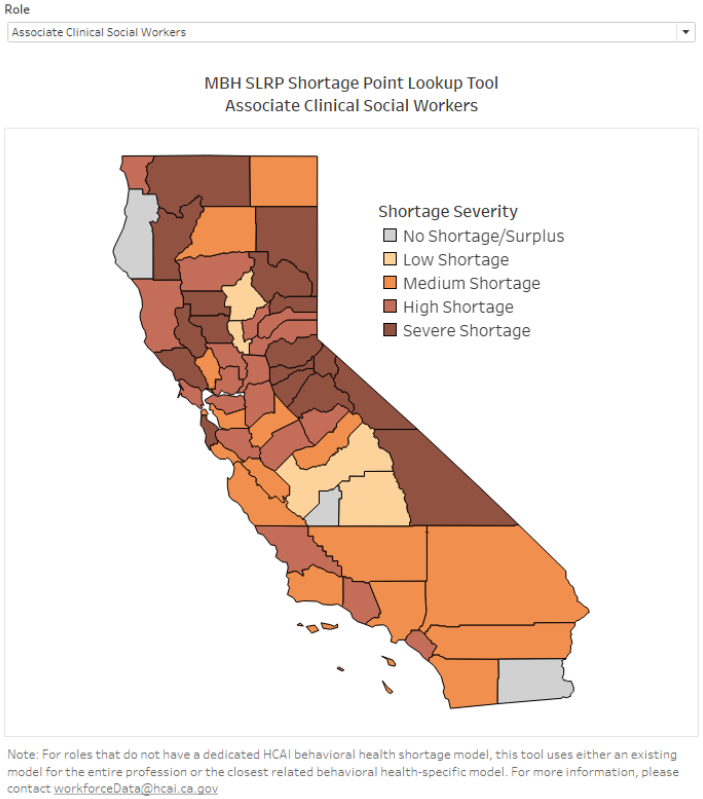
- **Total roles staffed / needed by specialty**
- **Geographic distribution of professionals & disease burden**
- **Utilization patterns**
  (based on delivery channels available & care-seeking behavior)
- **Importance of culturally competent care**
- **Insurance coverage**
- **Education pipeline & licensure**
- **Attrition rates**
  (e.g., migration, retirement, burnout)

Creating a detailed Health workforce model enables HCAI to **develop a targeted set of interventions to close the care gap** & focus on **investment avenues** with the **greatest lasting impact**

Additionally, it provides a replicable model for leverage across other use cases

BH Model Use Case | Program Scoring

HCAI has adapted our Behavioral Health and Nursing Program Scoring methodologies to use more data-driven approaches using the results from our models in a variety of ways:



Nursing & Behavioral Health shortage areas for the **Medi-Cal Behavioral Health Student Loan Repayment Program**

Create custom scoring for each applicant based on **the area they will serve** and their **role type**.

- *Allows for over 21 different roles to be scored individually by county.*
- *Includes results from the Nursing and Behavioral Health models for licensed professionals, as well as results from our Behavioral Health Supplemental Tool for many certified professions.*
- *Publicly available MBH SLRP Shortage Designation Lookup Tool*

Policy Impact:

- Awarding of providers targeted to areas in need for those roles
- Improved retention of providers leading to slowing of attrition
- Incentivizes providers to seek employment in these shortage areas, decreasing severity with the goal of eliminating shortages

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Data Programs

HCAI Healthcare Data Programs

Healthcare Utilization

- Patient: Inpatient, emergency dept., ambulatory surgery encounters
- Facility: Hospital, long-term care, clinic, home health and hospice utilization

Healthcare Quality

- Risk-adjusted outcomes studies
- Quality indicators including safety, readmissions, pediatrics, prevention

Cost Transparency

- Hospital: financials, Chargemasters, community benefit, discount policies, supplier diversity
- Long-Term Care: financial statements and ownership information
- Prescription Drug: price increases, price of new drugs introduced to market
- Healthcare Payments: claims and encounters submitted by payers

Healthcare Facility Attributes

- Geographic, ownership, license, and other information

Healthcare Workforce

- Workforce capacity, supply & demand
- Shortage areas designations

Maternity Care Honor Roll

94 hospitals met or surpassed the statewide target aimed at reducing births via Cesarean (C-Section) in first-time mothers with low-risk pregnancies.

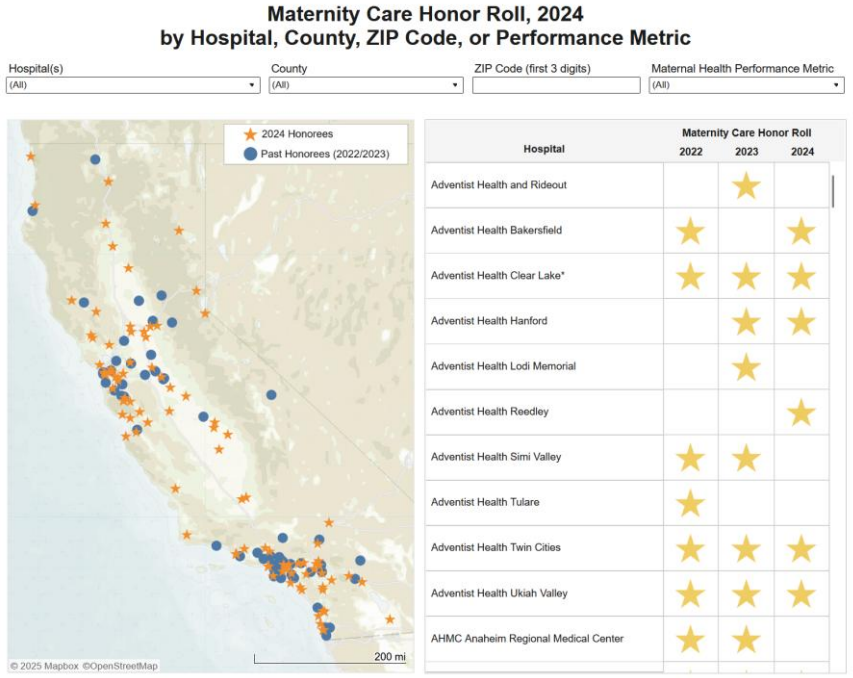
Recognizing Improvements in Quality Care

Of the 94 hospitals recognized in 2024, 57 have made the Honor Roll the last three years, and 19 have achieved Honor Roll status nine years running.

The hospitals earning Honor Roll status have met or surpassed the target of reducing C-section rates for low-risk, first-births to 23.6 percent.

Evidence suggests that the chance of having a C-section delivery largely depends on aspects such as where a delivering occurs and the practice patterns of the obstetric care team. Even for low-risk, first-birth pregnancies, huge variations are noted in rates of C-sections at individual hospitals.

Overuse of C-sections can result in higher rates of complications like hemorrhage, transfusions, infection, and blood clots. The surgery also brings risks for babies, including higher rates of infection, respiratory complications, neonatal intensive care unit stays, and lower breastfeeding rates.



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Variation in Potentially Avoidable ED Visits

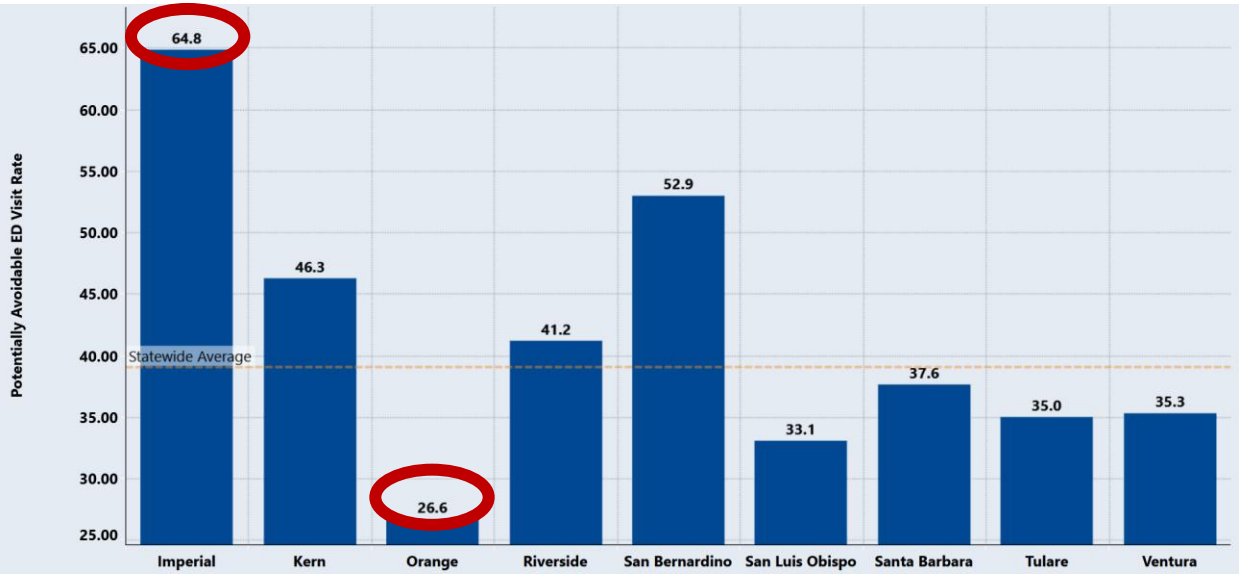
Comparing Regions to Identify Improvement Opportunity

Emergency department (ED) visits are designated as potentially avoidable when the visit could have been prevented with access to high-quality outpatient care.

ED visits are challenging for patients and costly for both payers and patients; high rates of preventable visits indicate opportunity for improvement.

Results shown are for the commercial market, 2018-2023, by select county; HEDIS measure, rate is visits per 1,000 member years.

Potentially avoidable ED rates in the commercial market are nearly 2.5x higher in Imperial County than in Orange County.



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Monitoring Mental Health

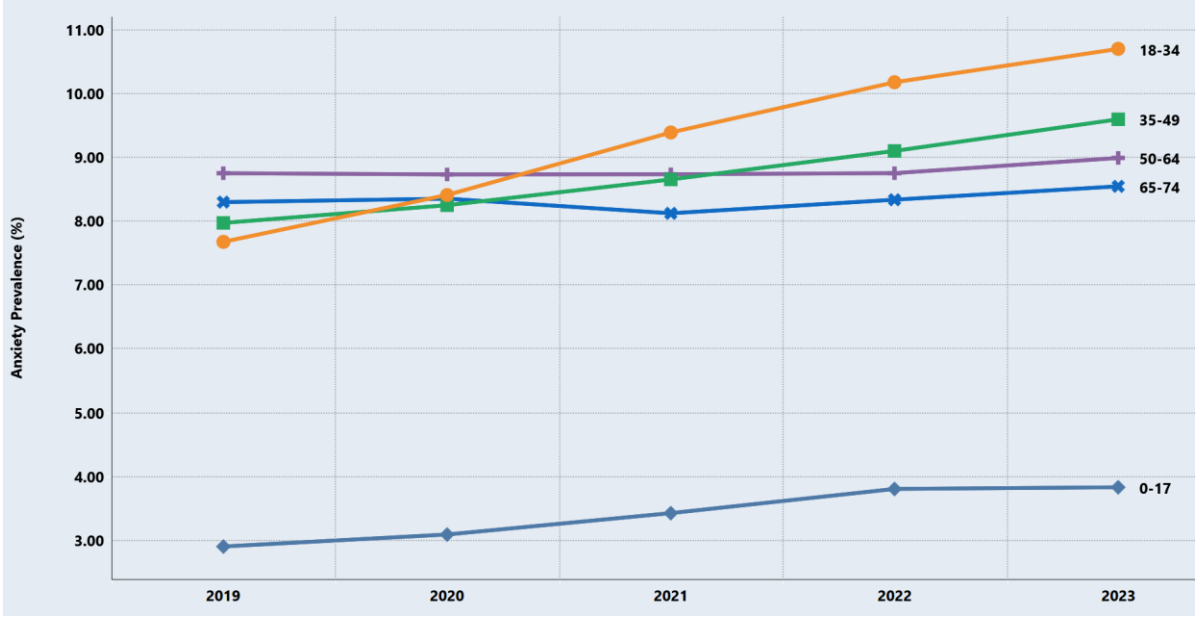
Understanding Trends and Tailoring Interventions

Anxiety disorders can interfere with daily activities such as employment, school, and relationships. Prevalence of anxiety has increased over the last several years, including among children.

Understanding the impact on populations can support development of interventions.

Results shown for the commercial market, 2019-2023, Orange County; excludes age 65+.

In Orange County, anxiety is on the rise for all age groups, with the largest increase in the 18 to 34-year range.



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Data Exchange Framework (DxF)

Data Exchange Framework

- As of August 1, 2025, administration of the California Data Exchange Framework moved from the California Health and Human Services Agency to HCAI.
- The Data Exchange Framework comprises a single Data Sharing Agreement and common set of Policies and Procedures that govern the exchange of health and social services information among health care entities and government agencies.
- HCAI is proud to take on this important initiative.
- This program aligns well with HCAI's mission and portfolio of programs, focused on advancing equitable access to care and by using data to improve outcomes.
- HCAI has launched a statewide listening tour to gather stakeholder feedback on the Data Exchange Framework (DxF) user experience and identify opportunities to further advance data exchange in California.

Sign Up to our Newsletter!

https://hcai.ca.gov/mailing-list/

Contact Us!

Phone (916) 326-3600

#WeAreHCAI #HCAI #HealthWorkforce
#HealthFacilities #HealthInformation

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Questions?

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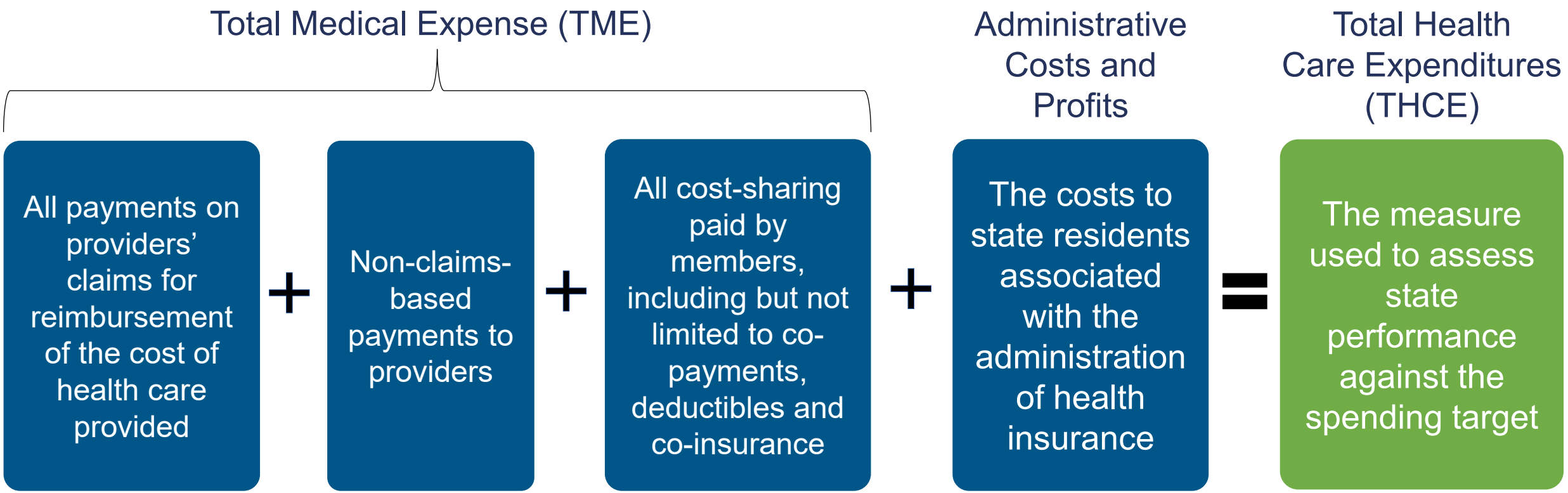
Appendix

Total Health Care Expenditures Calculation



Coffee Talk with Jarrod McNaughton, CEO, Inland Empire Health Plan (IEHP)

Erica Galvez (moderator)
Chief Executive Officer
Manifest MedEx

Jarrod McNaughton
Chief Executive Officer
Inland Empire Health Plan, and
Chairman of the Board, Manifest MedEx

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MISSION ~~IM~~POSSIBLE: A Manifest to Exchange Social and Health Information to Improve Whole Person Outcomes

Vikram Kumar, MD, MBA, FAAP
Chief Executive Officer,
Ventura County Ambulatory Care

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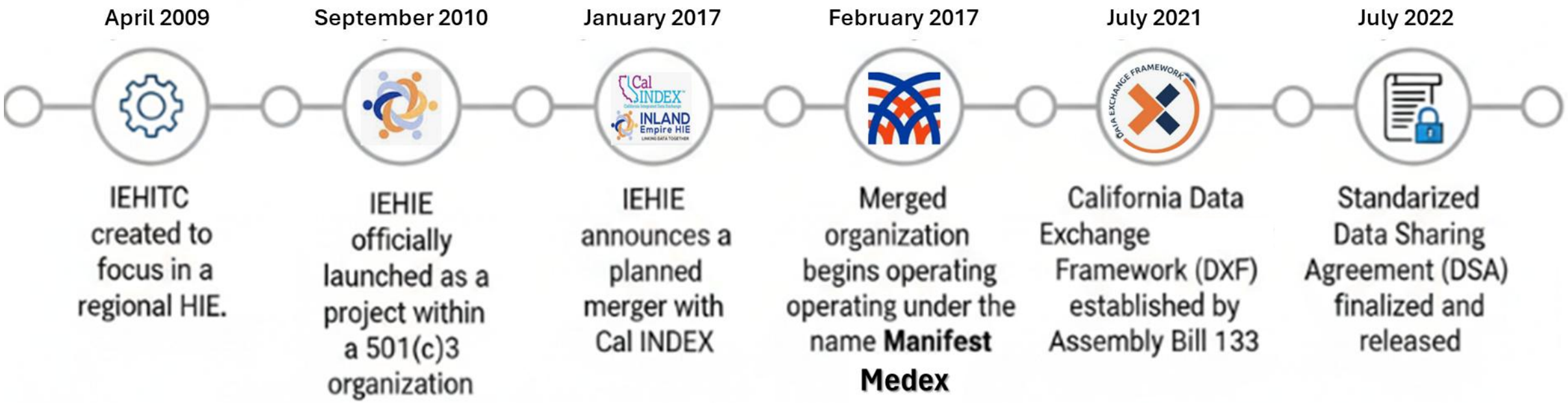
VENTURA COUNTY
AMBULATORY CARE
A Department of Ventura County Health Care Agency

MISSION ~~IM~~POSSIBLE!

A MANIFEST TO EXCHANGE SOCIAL AND HEALTH INFORMATION TO IMPROVE WHOLE PERSON OUTCOMES

September 9th, 2025

The story so far...



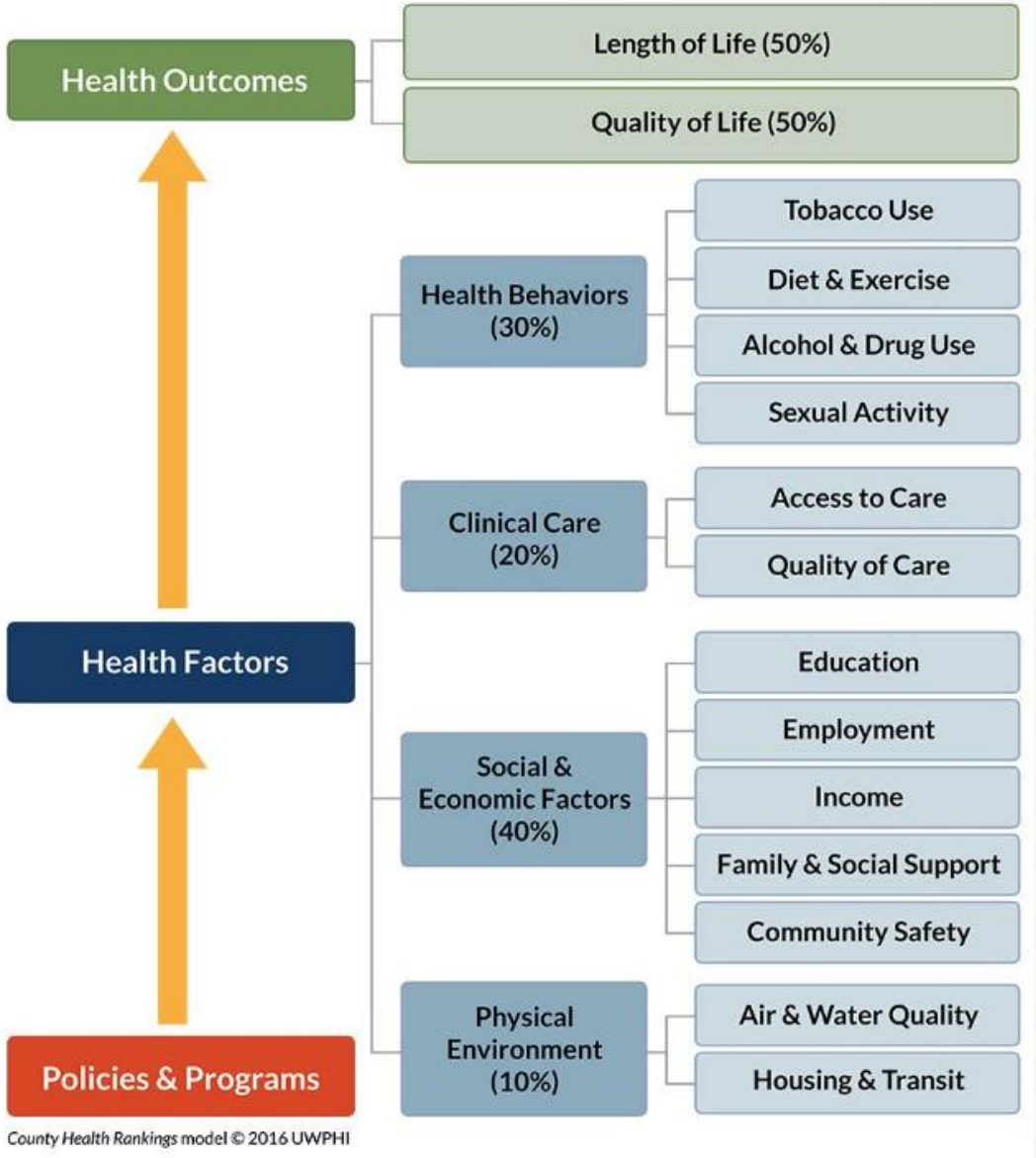
Life Happens!

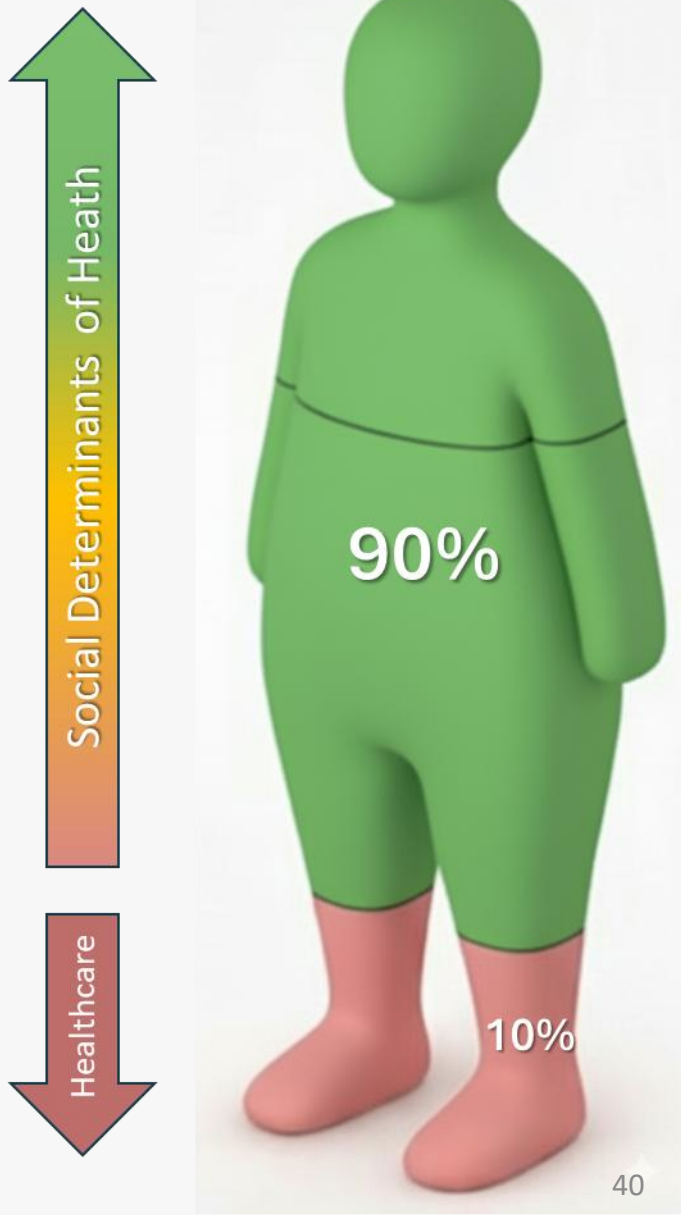
(continuum)

What we see in healthcare

(fragmented)

Distribution of Factors influencing Health Outcomes





News, but not new…

FOR IF MEDICINE IS REALLY TO ACCOMPLISH ITS GREAT TASK, IT MUST INTERVENE IN POLITICAL AND SOCIAL LIFE. IT MUST POINT OUT THE HINDRANCES THAT IMPEDE THE NORMAL SOCIAL FUNCTIONING OF VITAL PROCESSES, AND EFFECT THEIR REMOVAL.

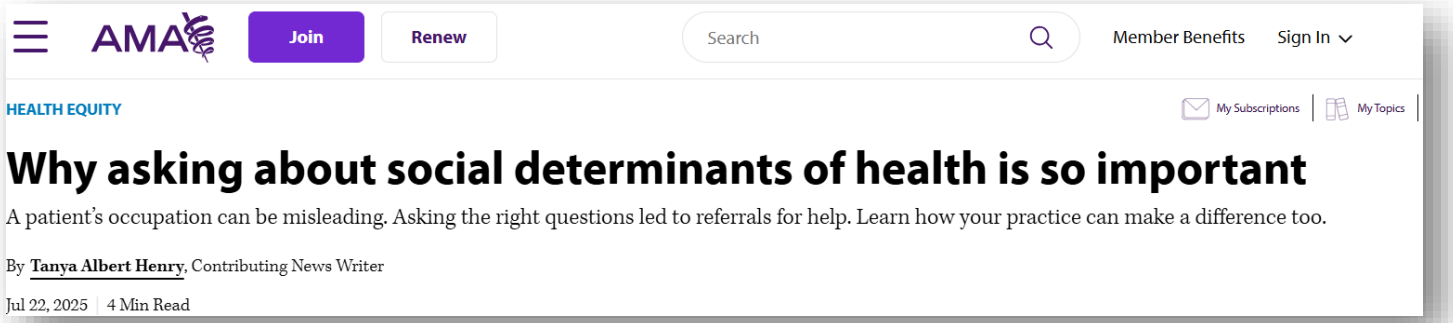
- RUDOLF VIRCHOW - 1851


The Washington Post
Democracy Dies in Darkness

The doctor will see you now. So will the lawyer.

Legal aid organizations are helping doctors address social barriers to patients' health.

July 9, 2025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HEALTH EQUITY My Subscriptions My Topics

Why asking about social determinants of health is so important

A patient's occupation can be misleading. Asking the right questions led to referrals for help. Learn how your practice can make a difference too.

By Tanya Albert Henry, Contributing News Writer

Jul 22, 2025 | 4 Min Read


AJMC News Video Podcasts Conferences Journals Events

News | Article | July 21, 2025

Social Determinants of Health Linked to Congestive Heart Failure Deaths

~~Im~~possible

Inspire Possible

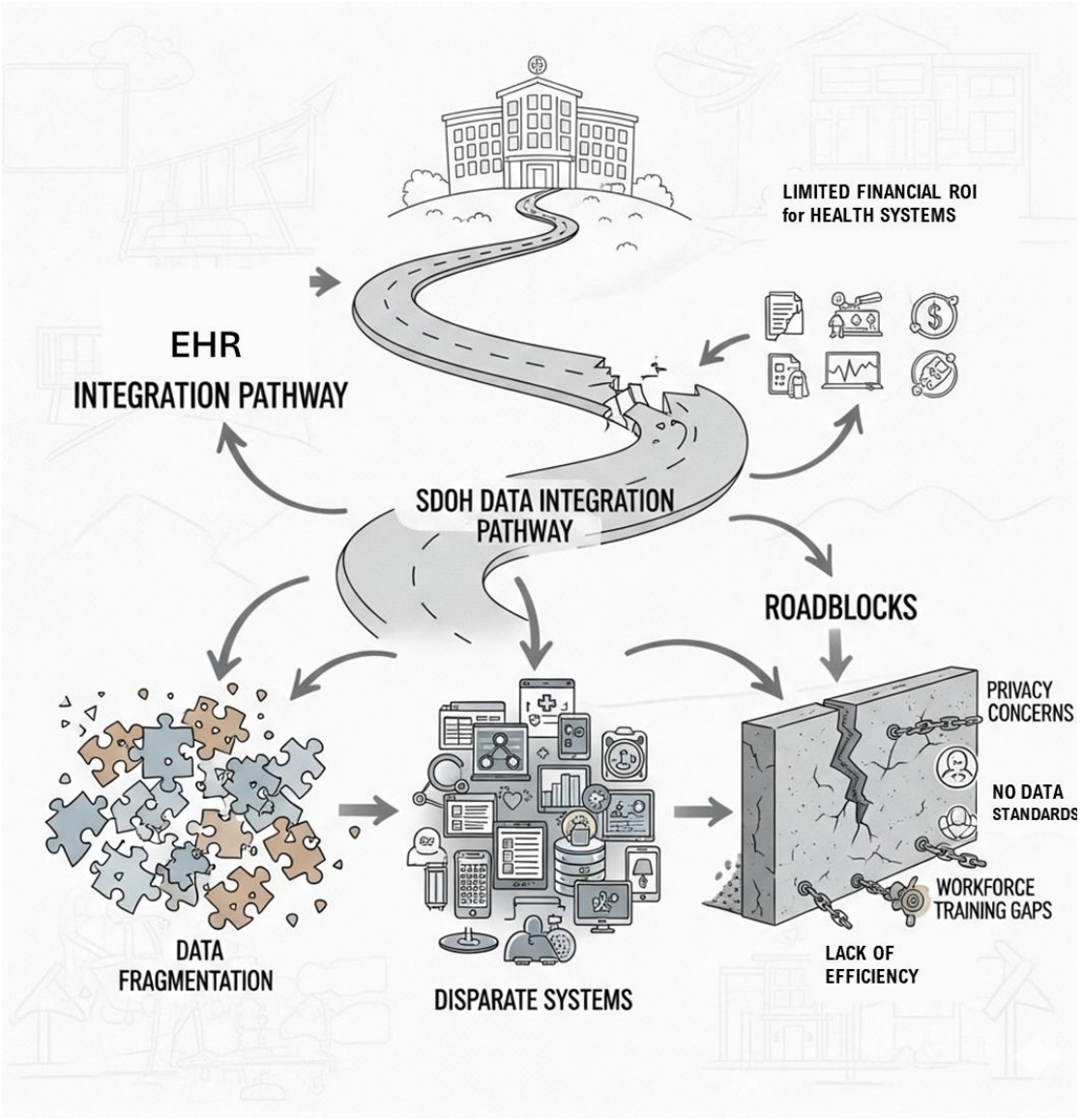
Any sufficiently advanced technology is indistinguishable from magic.

Arthur C. Clarke

Why this needs to be done right…

‘Any sufficiently advanced garbage is indistinguishable from magic’

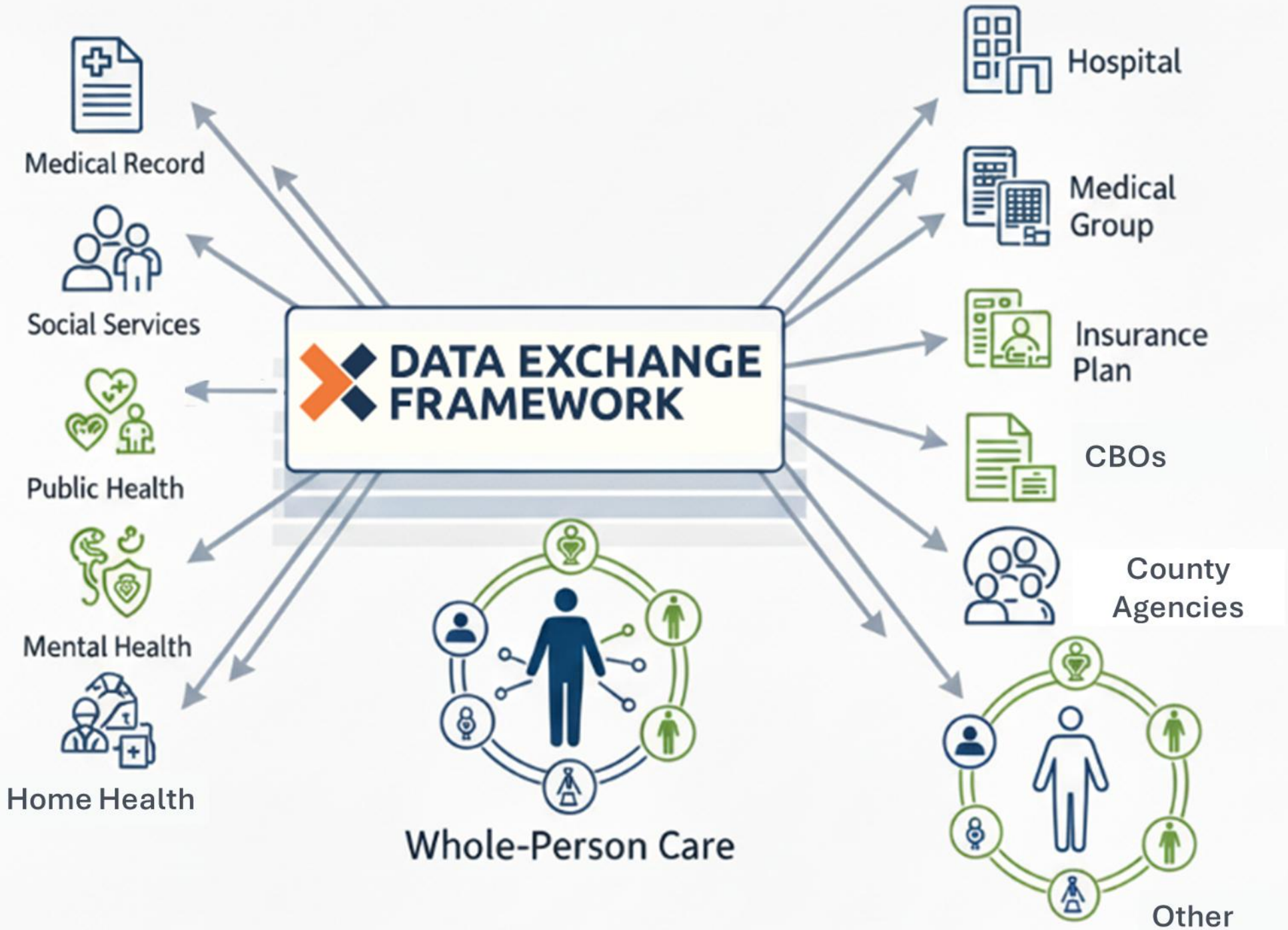
Sterling's Corollary to Clarke's Law

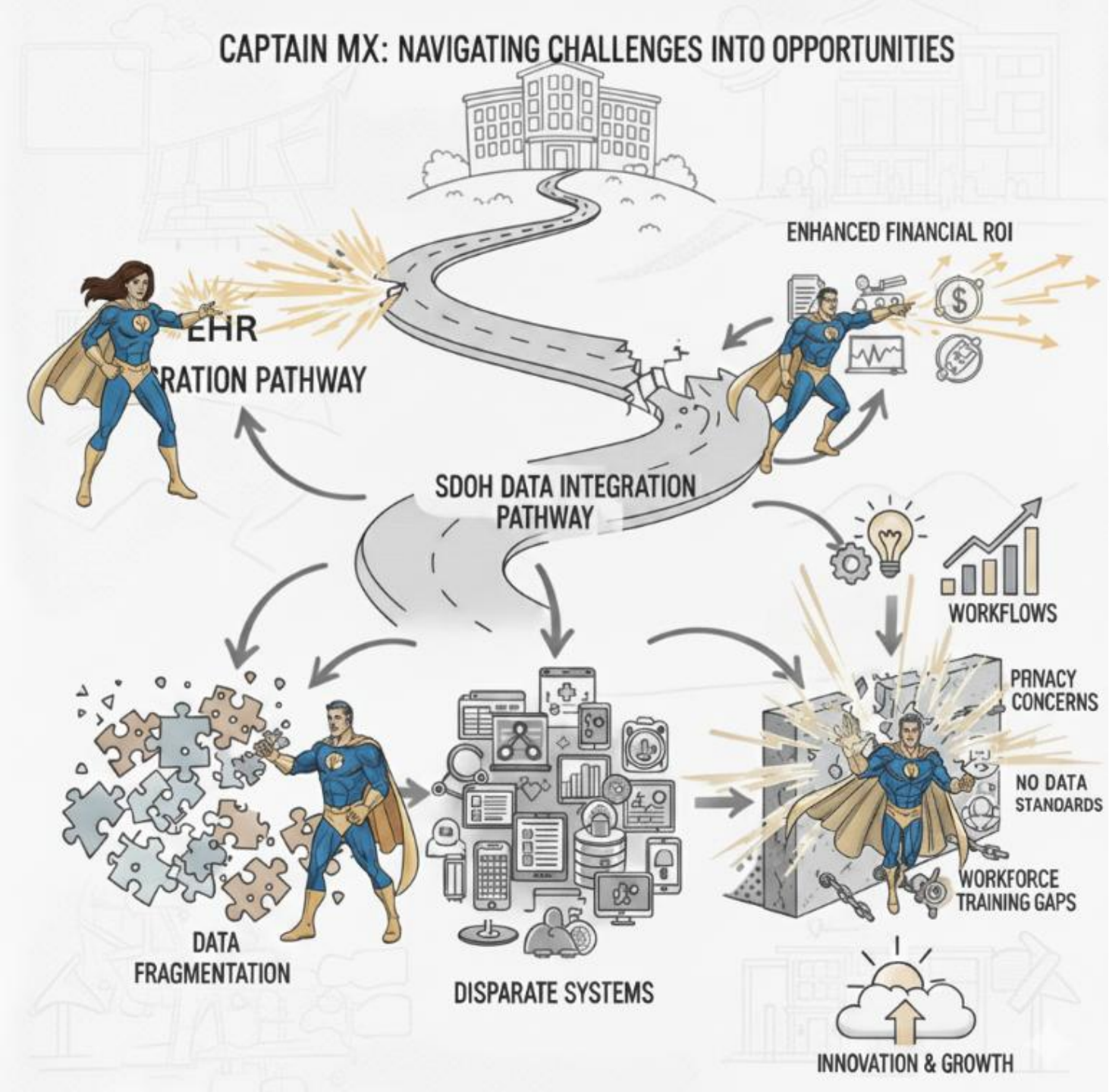

LIMITED FINANCIAL ROI
for HEALTH SYSTEMS
EHR
INTEGRATION PATHWAY
SDOH DATA INTEGRATION
PATHWAY
ROADBLOCKS
PRIVACY
CONCERNS
NO DATA
STANDARDS
WORKFORCE
TRAINING GAPS
LACK OF
EFFICIENCY
DATA
FRAGMENTATION
DISPARATE SYSTEMS


Challenges
Opportunities
Obstacles
Potential

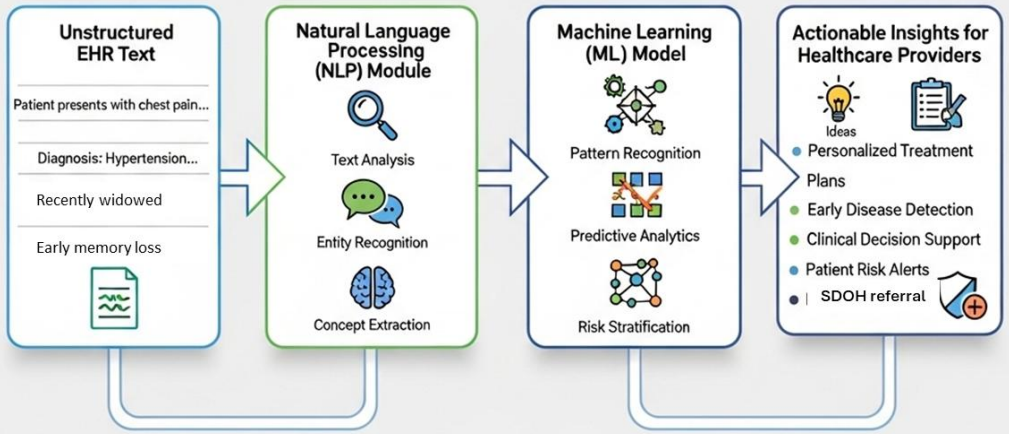
Data sharing constructs

Initiative	Description	Inclusions	Considerations
CalAIM Data Sharing	Information sharing under state law to implement CalAIM components (for example, Community Support)	Medi-Cal managed care	PHI protections governed by HIPAA
HIPAA Health Care Operations	Allows hybrid entities (such as Counties) to share information amongst its agencies and covered entities	PHI	Other state & federal laws
Social Services Administration	Data sharing permissible amongst public agencies for administration of public social services (for example, housing)	Social Services' data	
Medi-Cal/SNAP	Data sharing from SNAP to other federal and federally assisted state programs	Medi-Cal /SNAP	Limited for purposes of administration of some programs


Medical Record
Social Services
Public Health
Mental Health
Home Health
DATA EXCHANGE FRAMEWORK
Whole-Person Care
Hospital
Medical Group
Insurance Plan
CBOs
County Agencies
Other



- Data quality
- Privacy concerns
- Algorithmic bias
- Standardize SDOH data collection
- Continued investigation
- Interdisciplinary collaboration
- Innovative data capture solutions



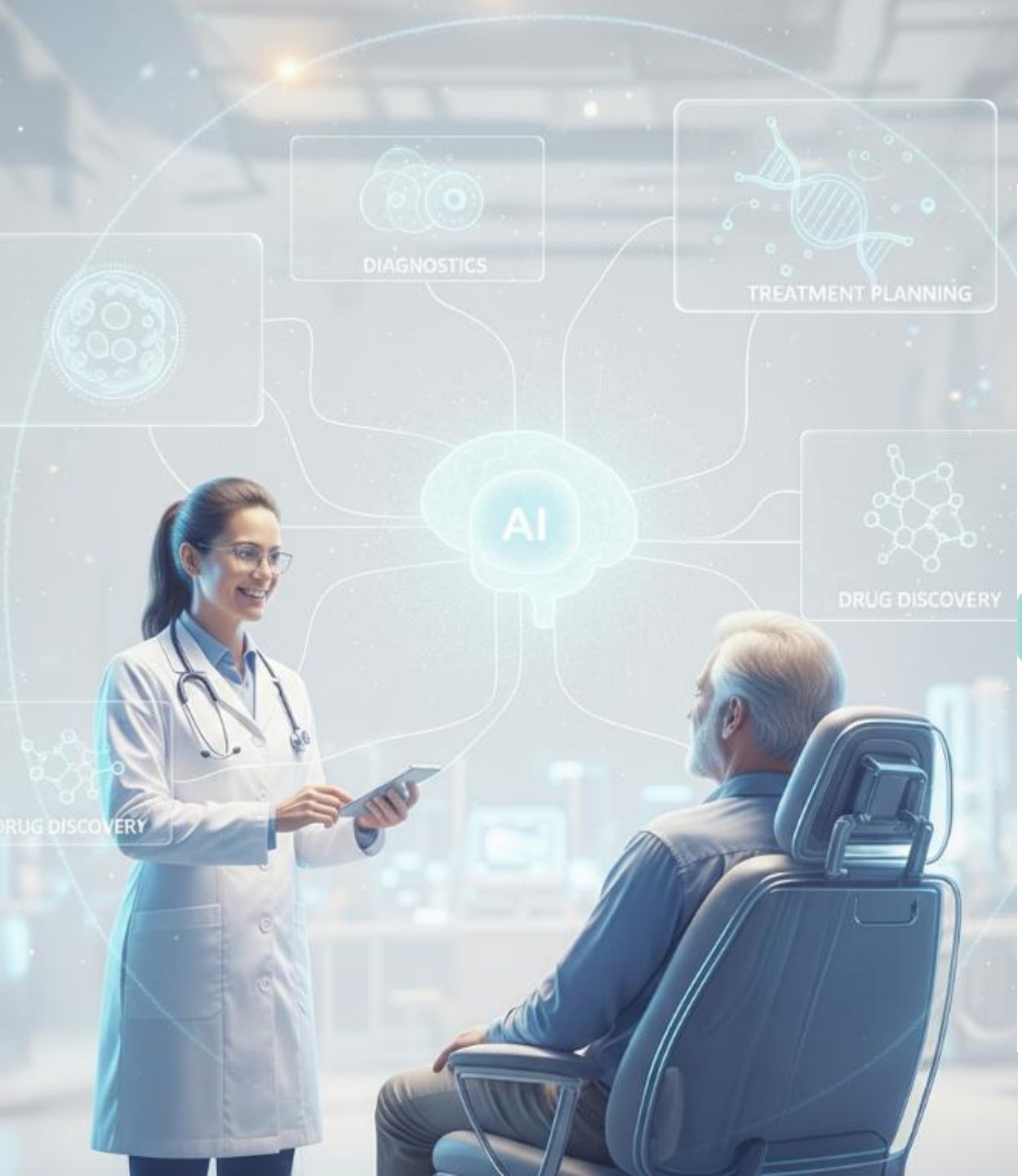
AI-Data

- Data Aggregation & Interoperability via HIEs
  - Bridge SDOH interoperability gap
  - Aggregate data: healthcare entities & CBOs
  - Comprehensive patient view
  - Integrate data into EHR workflow
  - Minimize external navigation
  - SDOH often scattered/unstructured in EHRs
  - Integrate geodemographic & external data
- AI/ML for SDOH Extraction, Modeling, & Predictive Analytics
  - Natural Language Processing (NLP)
  - Large Language Models (LLMs)
  - Machine Learning (ML)
- Prescriptive Analysis for Effective Care Solutions
  - Suggest specific actions/interventions
  - Care Adjustment Activities
  - Targeted Interventions & Referrals
- Comprehensive Data Integration
- Benefits in Physician Workflows
- Challenges & Future Directions
- AI & HIEs for Whole Person Care

Evolving to prescribe wellness

Physician Workflows

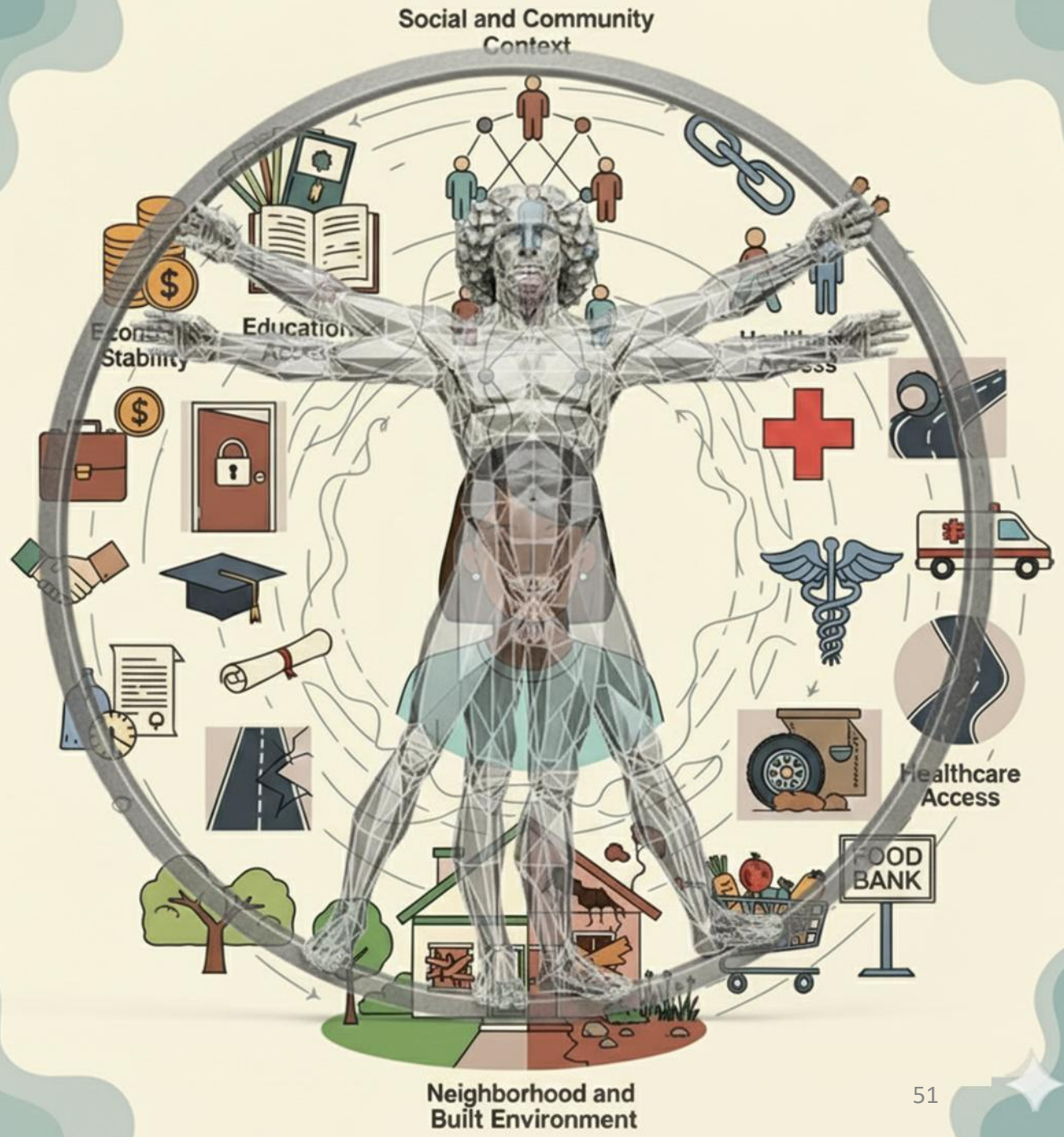
2. Whole Person Care → 1. Physician Efficiency → 3. Health and Social Referrals



- Physician Efficiency <
  - Reduced burden (AI-assisted data capture)
  - NLP/LLMs automate SDOH extraction
  - Streamlined access (HIEs deliver data to EHR)
  - No extra clicks (e.g., PDMP data)
  - More time for patient care
  - Proactive identification of social needs
  - Reduced reactive responses
  - Team-based communication via EHR enhancements

Caring for the Whole Person

- Screening for SDOH
- Holistic hierarchy of needs
- Predictive/Prescriptive Analytics
- Referrals
  - Proactive (AI) vs. Reactive (human)
- Referral loop closure/CHW role
  - Connect to Community Resources
- Accommodate Social Needs
  - Contextualized Care
- Education, Navigation, Advocacy
- Outcomes improvement measurement
- Tangible ROI
  - Decreased Readmissions,
  - Care gaps closed
  - Decreased pmpm utilization
  - Quality Adjusted Life Years, etc.



AI Driven Health & Social Referrals

- Informed Stratification (ML)
- High risk patients needing intensive support
- Automated pathways (z-codes + order sets)
- Facilitate handoffs
- AI generated community resource info
- Closed loop (with data & ML)
- HIE advances SDOH interoperability with CBOs

Some use cases – Current

- **RivCo-ONE** – EHRs, Manifest Medex, ConnectIE
- **Ventura County Community Information Exchange**
- Contact tracing during the pandemic with MX
- **Intermountain Health's Utah Alliance for Determinants of Health** – digital platforms & CHWs
- **Lurie Children's Hospital of Chicago** uses HIE for resource coordination in underserved areas to reduce emergency department (ED) visits and inpatient stays.
- **Healthy Alliance in New York** operates as a social care network utilizing a closed-loop referral platform to connect healthcare and social service providers, ensuring “no wrong door”.
- **Arkansas's HIE (SHARE)** integrates social determinants data from communities directly into patient charts, providing a more complete picture of a person's health and well-being.
- **Medicaid Section 1115 Waivers** have been approved in 18 states to address health-related social needs.

Envision the possibilities (future state examples)

- **Flag patients with potential future health-related social needs**
  - **changes in patient insurance status** (suggesting employment shifts)
  - **constantly changing residential history** (indicating housing instability)
  - **referrals to social services like SNAP and WIC** (suggesting food insecurity)
  - **critical social factors affecting care**, such as an endocrinologist being notified if a diabetic patient lacks electricity to refrigerate insulin
- **Machine Learning (ML) models with HIE & EHR data**
  - have shown to outperform traditional screening questionnaires. This model is being trialed with a HIE in Indianapolis.
- **Geospatial Risk Mapping and Service Expansion**
- **Proactive Public Health Interventions**
- **Streamlined Reimbursement for SDOH Services**
- **Value-Based Care Integration**
  - CMS is increasingly incorporating SDOH data into **risk adjustment models and quality measures.**

VENTURA COUNTY AMBULATORY CARE

Thank you!

QR Code for List of References
https://docs.google.com/document/d/1rkHklSEmj-eDLwvelrNNc9S3Z-3A4npetH-fr8M7ql0/edit?tab=t.0

VENTURA COUNTY
AMBULATORY CARE
A Department of Ventura County Health Care Agency

Vikram Kumar, MD MBA
vikram.kumar@venturacounty.gov
CEO, Ventura County Ambulatory Care

Break: **10:30 a.m. – 10:45 a.m.**

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42 CFR Part 2, Behavioral Health Data, and Privacy: Navigating the Rules and Regulations for Data Sharing

Jason Buckner
Chief Information Officer
Manifest MedEx

Elizabeth Killingsworth
Chief Privacy Officer and
General Counsel
Manifest MedEx

Manifest MEDEX

42 CFR Part 2, Behavioral Health Data, and Privacy: Navigating the Rules and Regulations for Data Sharing

KEY REGULATORY REQUIREMENTS

HIPAA

- Health Insurance Portability and Accountability Act and its implementing regulations (collectively, "HIPAA") establishes a set of national standards for the protection of certain health information

CMIA

- Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) ("CMIA") is a California law that augments HIPAA to protect the confidentiality of individually identifiable medical information obtained by health care providers, health insurers, and their contractors

Part 2

- Updated federal regulations governing the confidentiality of substance use disorder ("SUD") records at 42 C.F.R. part 2 ("Part 2") impose stringent requirements with respect to disclosing certain SUD-related information

Section 11845.5

- Cal. Health & Safety Code § 11845.5 ("Section 11845.5") creates California-specific requirements applicable to SUD records maintained by alcohol and drug abuse treatment or prevention programs conducted, regulated, or directly or indirectly assisted by DHCS. While many SUD programs in California are subject to both Part 2 and Section 11845.5, because Section 11845.5 is more expansive in its definition of included programs, it applies to some private service providers that may not be subject to Part 2

LPS Act

- The Lanterman-Petris-Short Act ("LPS Act") governs records obtained in the course of providing mental health treatment in an institutional setting or through a state- or county-sponsored program

PARTICIPANT POLICY UPDATES

- **Ability to Send and Receive SUD Data**. Creating an option to contribute and/or receive SUD data. This will require the Participant to meet additional legal requirements, such as: attesting to status as a Part 2 entity (if applicable), only submitting data that may be redisclosed for TPO, notifying MX in the event of any withdrawal of patient consent, and/or making relevant consents available to MX.
- **Expectation of Additional Technical Requirements**. Provides groundwork for new technical requirements specific to the exchange of SUD and other sensitive data.
- **AB352**. Outlines limitations on the exchange of data protected by AB352, including acknowledgement of the prohibition of out-of-state sharing and requirements for Participants to access such data.

PART 2 DATA CLASSIFICATION & ACCESS

Sensitive Data Classification

- Part 2 facilities identified by a “location” (entire data source, facility, unit, etc.)
- **All** data from that facility will be tagged as sensitive

Sensitive Data Access: MX Access Portal

- Specific role required for access
- Attestation required
- Sensitive data is *hidden* until user requests it to be displayed
- Sensitive data *highlighted* for ease of view

Sensitive Data Access: Data Feeds

- Participants will be required to sign an amendment to account for attestation
- Data incorporated into existing data feeds (not a separate feed)
- Sensitive source location list provided to participants

AB352 APPROACH

Approach

- Identify and remove AB352 related data and place a notice indicating data may have been removed per California law.
- Phase I – Identify data for removal via a code list generated by clinical informaticists
  - Code systems: CPT, SNOMED, ICD-Diagnosis & Procedure, LOINC, RxNORM, NDC
  - Contraception: 4k+ codes
  - Abortion and Abortion Related Care: 25k+ codes
  - Gender Affirming Care: 5k+ codes
- Phase II – Potential AI approach
  - Identify data using AI to close the gap of local/non-standard codes and textual data

Spotlights: Expanding the Data Sharing Ecosystem

Rudy Valdez
Program Director
Inland Empire Health Information Organization (IEHIO)

Geoffrey Leung, MD, EdM
Public Health Physician
Riverside University Health System

Brit Steele
Director, Healthcare Innovation
Inland Housing Solutions

ConnectIE: A Tool for Everyday Patient Challenges

Rudy Valdez
Program Director
Inland Empire Health Information Organization

Manifest MEDEX

ConnectIE:

A Tool for Everyday Patient Challenges

Rudy Valdez
Program Director
Inland Empire Health Information Organization

INLAND Empire HIO
LINKING PEOPLE WITH DATA

Who is IEHIO?

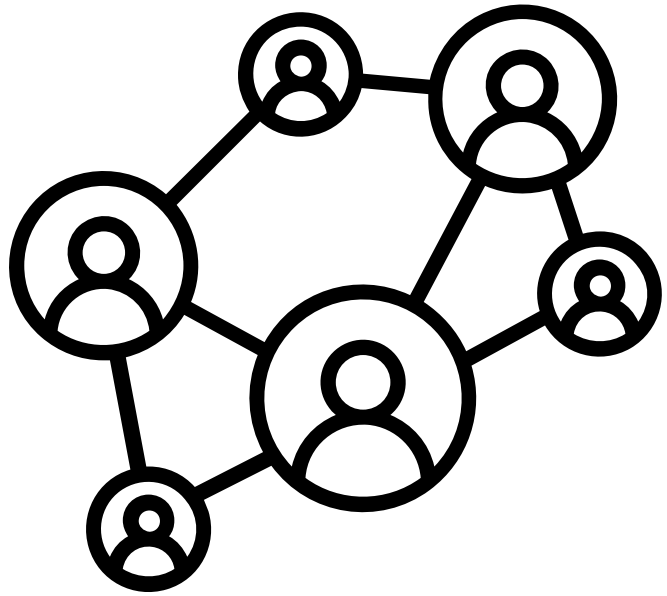
Formerly Inland Empire Health Information Exchange (IEHIE)

INLAND Empire HIO

LINKING PEOPLE WITH DATA

We Link People to Data

- **IEHIO** is a non-profit organization supporting interoperability for healthcare and the community.
- **IEHIO**'s purpose is to connect people with data by coordinating data sharing services not only to improve treatment at the point of care, but also to address the psycho-social determinants of health to support whole-person care efforts that improve the health of all residents in the Inland Empire.



Agenda

What ConnectIE is

Why it was created

Current utilization

Looking ahead (MX + ConnectIE)

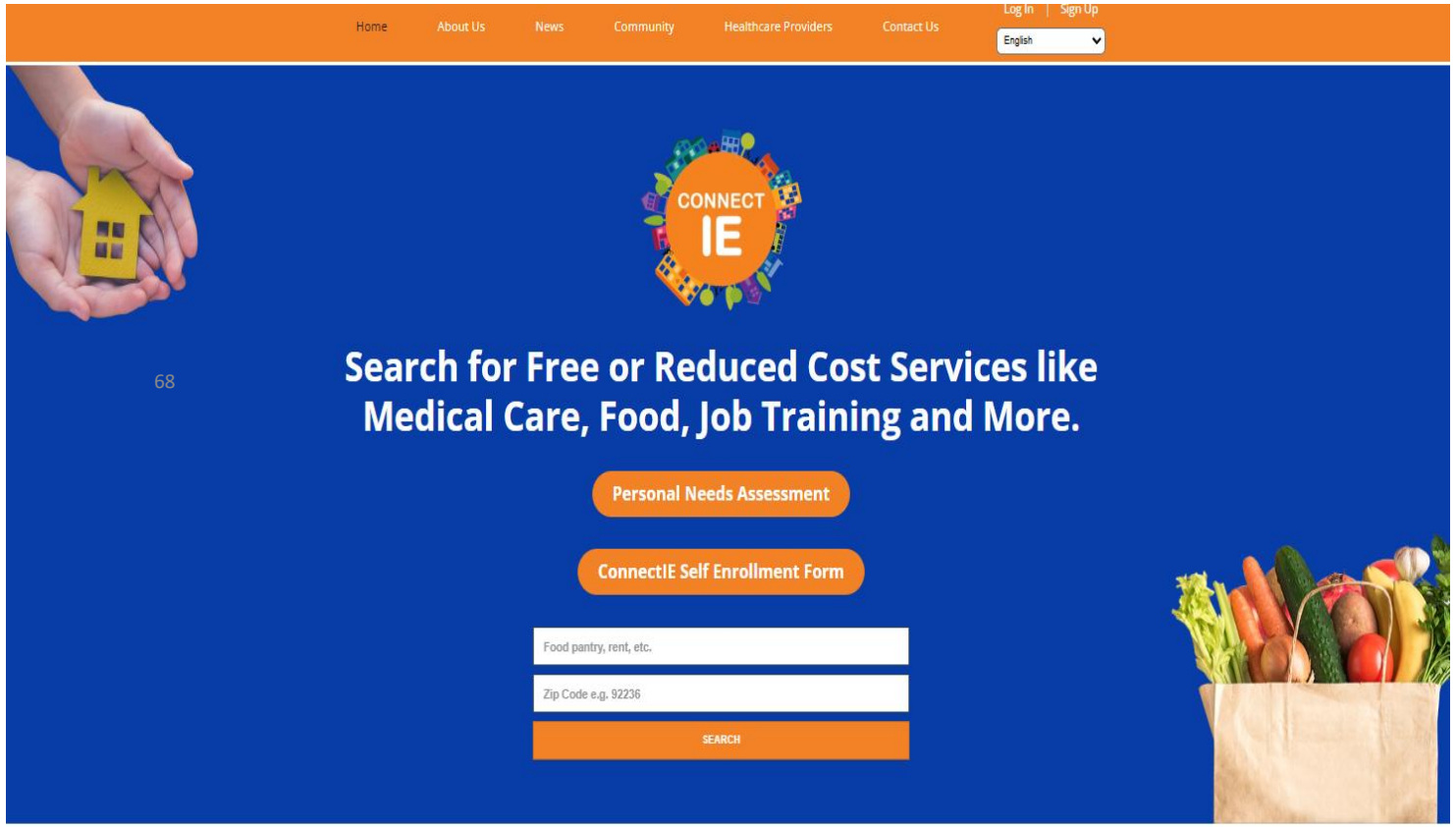
Q&A + Conclusion

ConnectIE

- ConnectIE is a user-friendly resource platform powered by Findhelp.
- Connects community members to food, housing, and other social services.
- Designed to bridge healthcare, the community and community-based organizations together.

Simple to use:

- Navigate to www.connectie.org
- Enter Need
- Enter ZIP code
- Find Resource
- Connect



www.connectie.org

When and Why ConnectIE Was Started

- In 2018/2019 the Free, one-stop interactive website for care providers and the public within the Inland Empire was launched to help address the growing social needs of the community.

- ConnectIE is a partnership between Inland Empire Health Plan, Desert Health Care District, Inland SoCal United Way 211+ Riverside/San Bernardino, and Inland Empire Health Information Organization.

Focuses on critical resources:

- Health
- Housing
- Transportation
- Income Related challenges
- And many more

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CONNECT IE

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IE HP
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Inland Southern California UNITED WAY

211 Inland Southern California 211+

DESERT HEALTHCARE DISTRICT & FOUNDATION

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www.connectie.org

ConnectIE Strategy

Introduce ConnectIE

All partners promoted ConnectIE and provided training and demos to their target audience

Engage With Community Based Organizations (CBO)

ISCUW 211 and Desert Healthcare District were contracted to have CBO engage with the platform and receive referrals.

Healthcare Organizations

IEHIO and Desert Healthcare District were contracted to promote ConnectIE to healthcare organizations, provide training, and have healthcare organizations adopt search boxes.

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Create Community Utilization

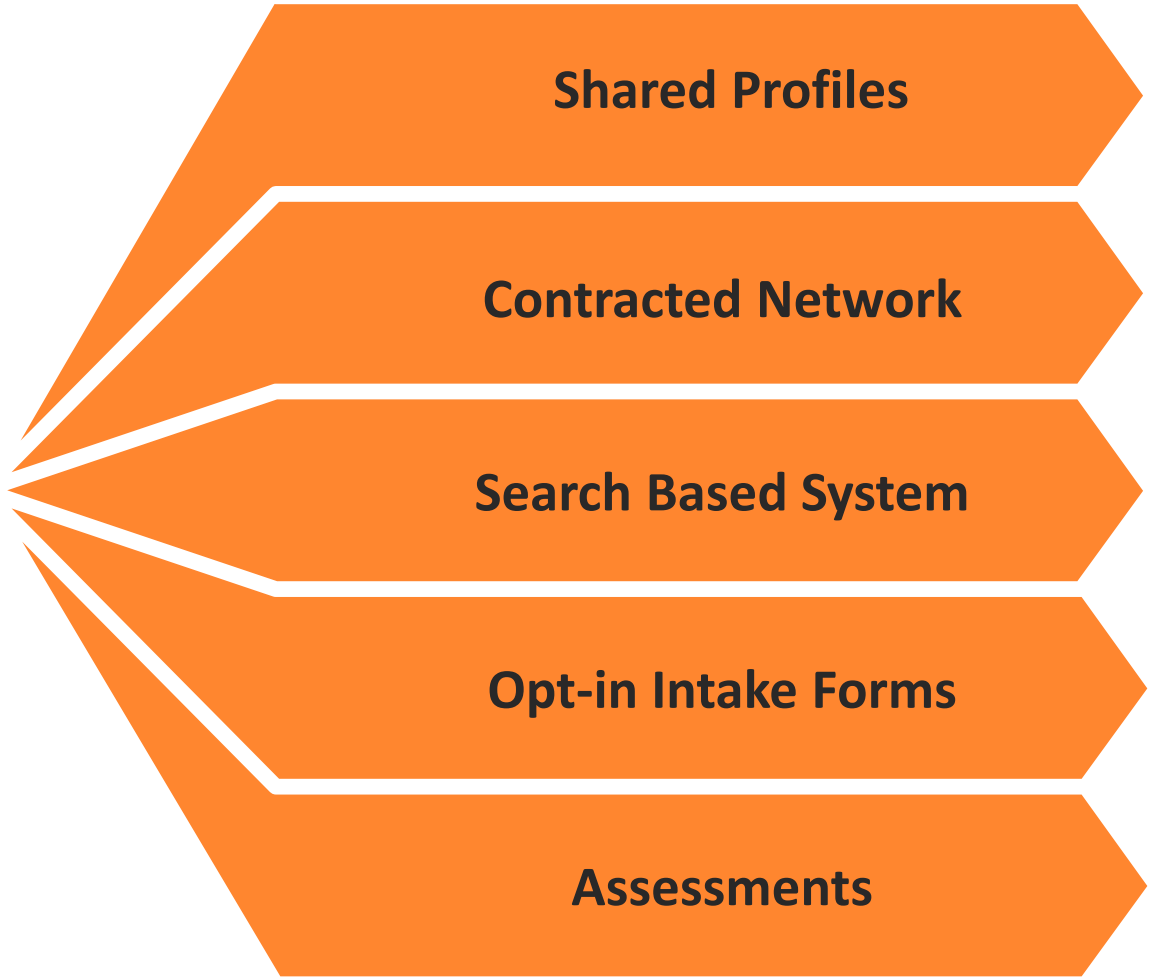
ISCUW 211 and Desert Healthcare District were contracted to promote ConnectIE to the community.

ConnectIE CIN

Utilizing the Findhelp technology, in 2022, we launched the Community Information Network (CIN) providing shared seeker profiles, seeker history and social assessments etc.

ConnectIE transformed into a **tool for agencies to manage client relationships** and **a system for healthcare providers** to facilitate cross-sector sharing of information to **streamline and improve outcomes for people needing assistance.**

It's also a place where **people are enrolled into** and where **people can self "opt in" to participate** in a network for accessing resources.



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CIN Network Participants

- Clinics
- Hospitals
- Health plan
- Community Based Organizations

CIN Enrollments

- Enrolled by CIN Network Participants
  - Healthcare and CBOs
- Self-Enrollments
  - On www.connectie.org

Enrollments to the CIN

73

Call to 211

211 manages calls for both Riverside and San Bernardino Counties

Provided Resources

All calls address the initial need for the call

Screened CIN

Each caller is educated on the ConnectIE CIN and asked if they would like to enroll

Enrolled CIN

Callers conduct the intake form which includes SOGI questions

Shared Profile

Once the intake form is completed the individual's profile is accessible by the CIN network partner

How We Support Basic Needs Through Partnerships

- Coordinate ConnectIE powered by Findhelp.
- Continued efforts to engage healthcare providers and CBOs via outreach and shared workflows.
- Build and sustain the coalition with healthcare and CBOs.
- Offer training, implementation support, and workflow design for healthcare organizations and CBOs.
- Monitor referral outcomes.

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ConnectIE Metrics

Searches

Number of Searches for specific needs

Users

Unique sign-ins to the ConnectIE platform

Referrals

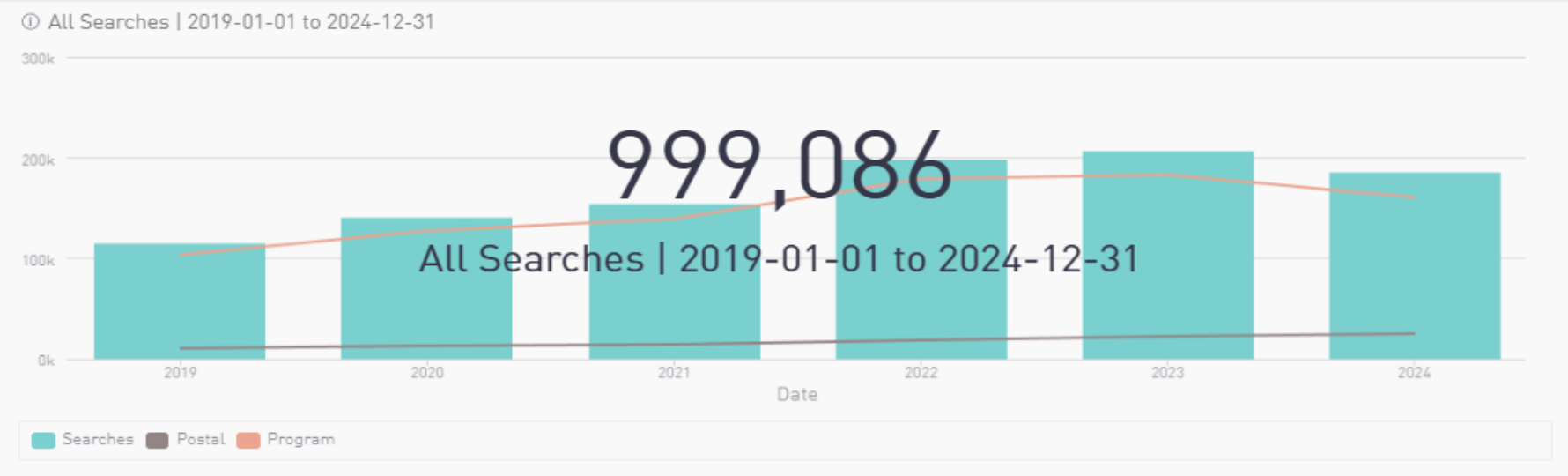
Number of Referrals into the platform

Assessments

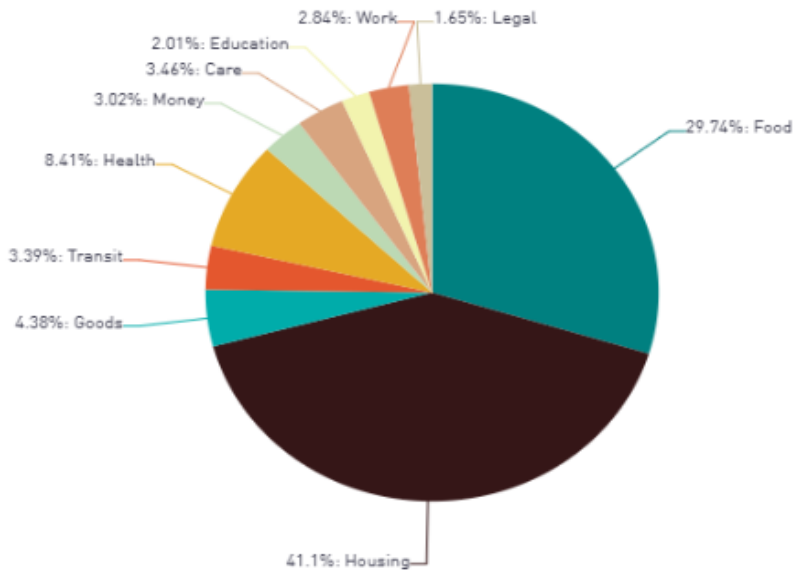
Number of Assessments into the platform

75

Searches 2019 - 2024



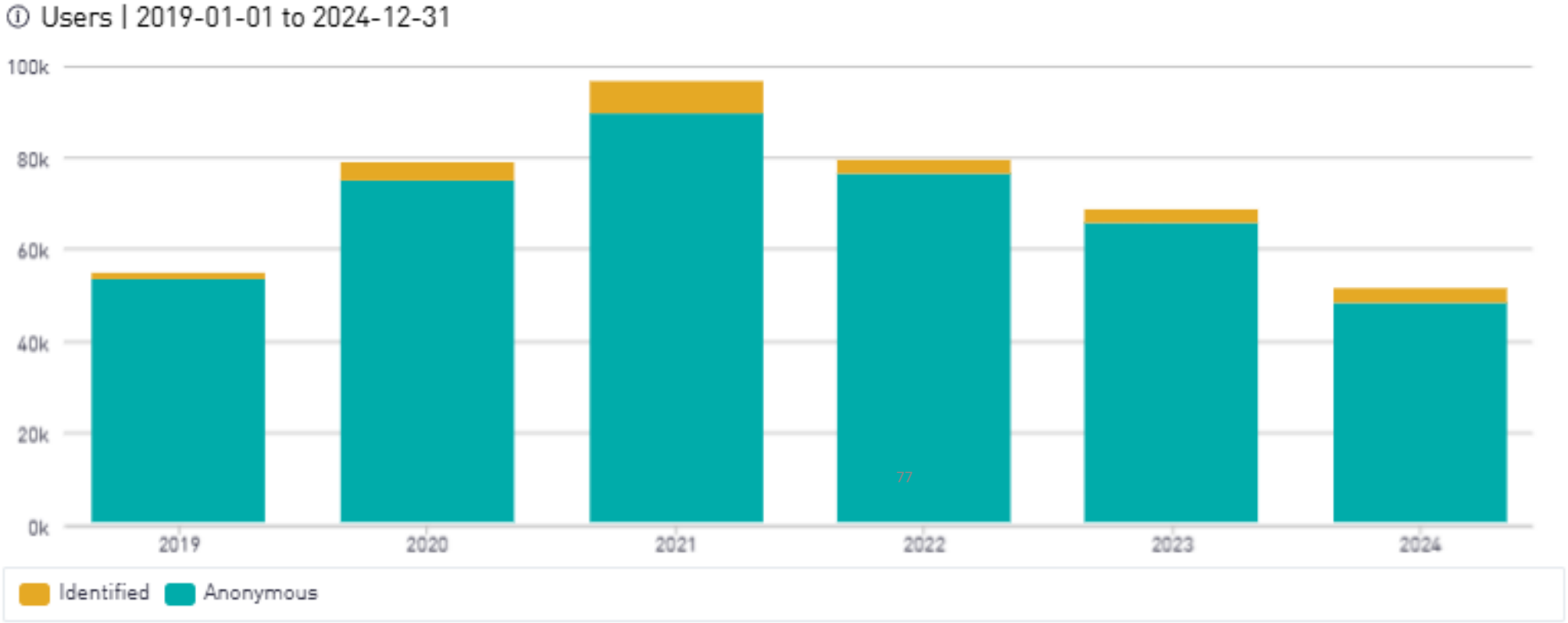
Searches by Category | 2019-01-01 to 2024-12-31



Most Common Search Terms | 2019-01-01 to 2024-12-31

TERM	DOMAIN	SEARCHES
food pantry	food	60,877
housing	housing	41,400
food	food	37,159
rent	housing	31,605
help find housing	housing	18,090
help pay for housing	housing	16,002
free food	food	14,367
free food box		11,086
free food boxes		11,044
rental assistance	housing	10,401
temporary shelter	housing	9,685
emergency food	food	8,841
food delivery	food	7,016
help pay for utilities	housing	6,404
transportation	transit	5,638

Users 2019 - 2024



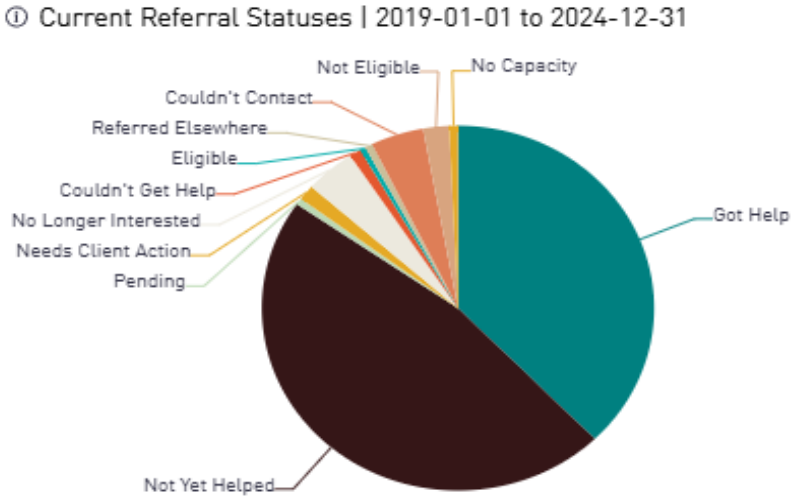
18,216

Distinct Identified Users

396,621

Distinct Anonymous Users

Referrals 2019 - 2024



78

58,230

Seekers Referred

91,677

Referrals with Responses

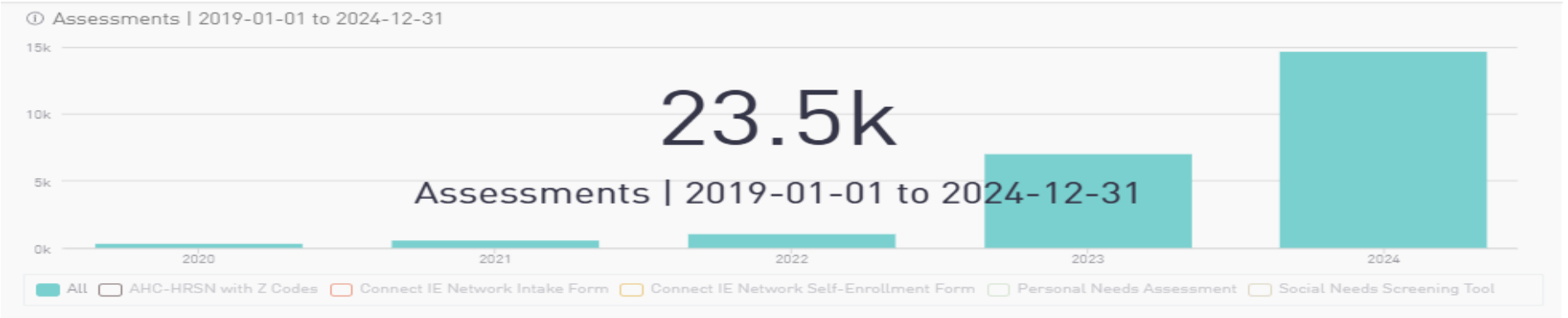
87,538

Closed Loop Referrals

25,246

Seekers that Got Help

Assessments 2019 - 2024



06:38:55

Average time to Complete Assessment

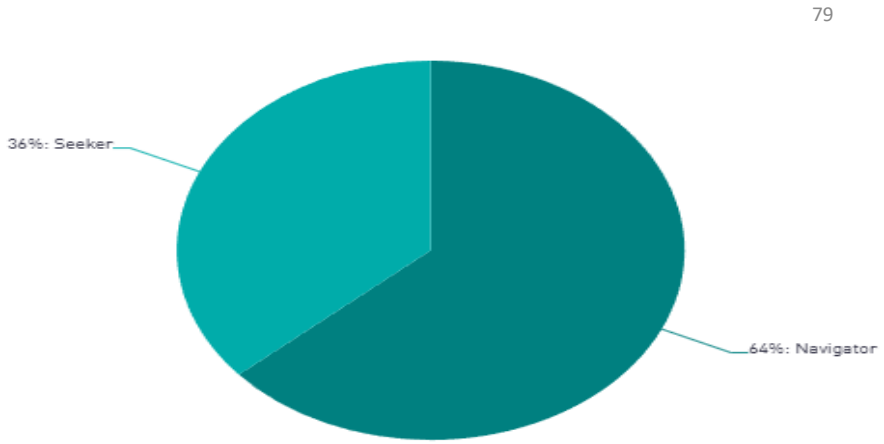
20,615

Seekers Assessed

35%

Seekers with a Need

Submissions by Source | 2019-01-01 to 2024-12-31



Identified Needs | 2019-01-01 to 2024-12-31

CATEGORY	SEEKERS	PERCENT	OPEN NEEDS
Housing	4,977	24.1%	4,972
Mental Health	4,043	19.6%	4,043
Work	3,748	18.2%	3,745
Food	3,642	17.7%	3,639
Utilities	3,279	15.9%	3,274
Transportation	3,049	14.8%	3,047
Safety	2,826	13.7%	2,824
Goods	2,768	13.4%	2,768
Family/Community Support	2,137	10.4%	2,137
Medical	1,913	9.3%	1,911
Education	1,383	6.7%	1,378
Care	1,110	5.4%	1,104
Financial	472	2.3%	469
Home Maintenance	30	0.1%	30
Other	11	0.1%	11

Looking Ahead

A partnership between Findhelp and Manifest MedEx will bring:

- Value to providers!
- ConnectIE → social needs data
- MX → clinical/claims data
- Together → a more complete longitudinal patient record at the point of care

Outcomes Expected

- Better care coordination (providers see social + medical needs together)
- Improved patient outcomes (closing gaps like food, housing, transportation).
- System-level insights such population health strategies

Data that currently lives in ConnectIE that can help providers at the point of care is:

- Demographics, Race & Ethnicity, SOGI Data
- Social Screening Assessments
- Social Resource Referrals

Ultimately, interoperability between social health data and healthcare data will lead to improved community outcomes.

Q&A

ConnectIE FAQs

What are some key features of *Connect IE?*

- You'll gain access to FREE tools to help you help others, including:
  - Making referrals and tracking the outcome
  - Sharing favorite resources with your team
  - And more!

Is *Connect IE* mobile-friendly?

- Yes. You can save the website to your favorites on your smartphone and view it when you're on the go!

Is the site available in other languages?

- Yes. You can toggle through many different languages (including Spanish) and even print the handouts in other languages.

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CONNECT IE

Thank you!

Rudy Valdez

Program Director

Inland Empire Health Information Organization

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INLAND Empire HIO

LINKING PEOPLE WITH DATA

CONNECT IE

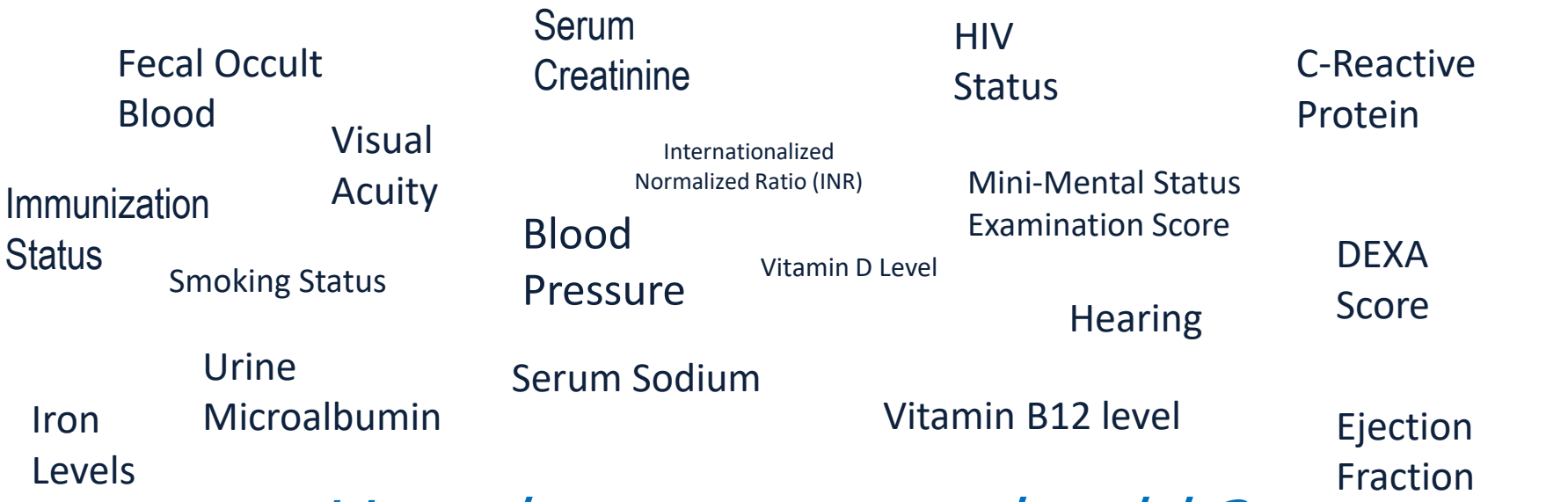
Whole Person Health Score: Catalyzing Cross-System Collaboration with a Universal Holistic Health Assessment Tool

Geoffrey Leung, M.D., EdM
Public Health Physician
Riverside University Health System

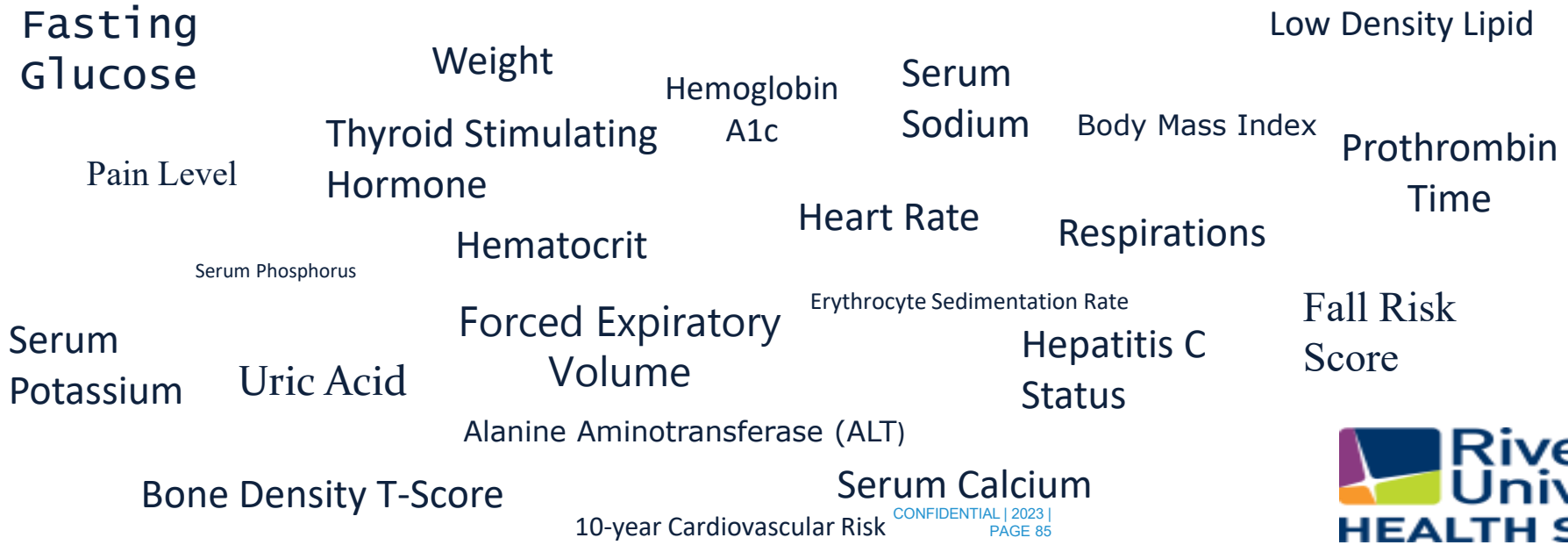
Manifest MEDEX

Whole Person Health Score: Catalyzing Cross-System Collaboration with a Universal Holistic Health Assessment Tool

Geoffrey Leung, M.D., Ed.M.
Riverside University Health System Public Health
Riverside County
Manifest MedEx Inland SoCal Conference
September 9th, 2025



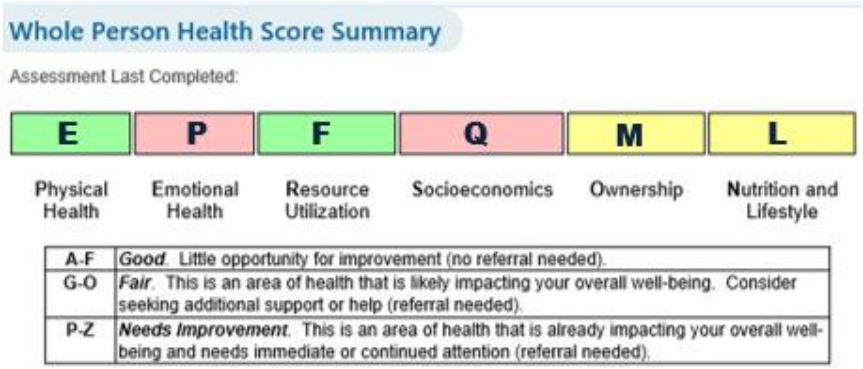
How do we measure health?



Riverside University HEALTH SYSTEM

Whole Person Health Score Overview

- **6-letter score** that provides a **snapshot of health** (each letter representing a different dimension):
  - **P**hysical Health
  - **E**motional Health
  - **R**esource Utilization
  - **S**ocioeconomics
  - **O**wnership & Activation
  - **N**utrition & Lifestyle
- **Letters range from A to Z** for each dimension ("A" being the best and "Z" being the worst)
- Based on a **28-question assessment**
- **Patient preference for letters** over numbers



Whole Person Health Score Summary

Assessment Last Completed:

E	P	F	Q	M	L
Physical Health	Emotional Health	Resource Utilization	Socioeconomics	Ownership	Nutrition and Lifestyle

A-F	*Good*. Little opportunity for improvement (no referral needed).
G-O	*Fair*. This is an area of health that is likely impacting your overall well-being. Consider seeking additional support or help (referral needed).
P-Z	***Needs Improvement***. This is an area of health that is already impacting your overall well-being and needs immediate or continued attention (referral needed).

Riverside University HEALTH SYSTEM

Whole Person Health Score Assessment: Summary of Elements

Physical
- Blood Pressure
- Body Mass Index
- Chronic Condition Load
- Functional Activity

Emotional
- Depression
- Anxiety
- Social Support
- Prayer / Meditation / Relaxation
- Meaning / Purpose

Resource Utilization
- Emergency Room / Hospital Visits
- Outpatient Visits
- Prescription Medications
- (Zip Code)

Socioeconomics

Finances

Housing

Education, Employment

Food Access, Transportation

Ownership and Activation

Self-Rating

Knowledge

Self-Efficacy

Self-Management

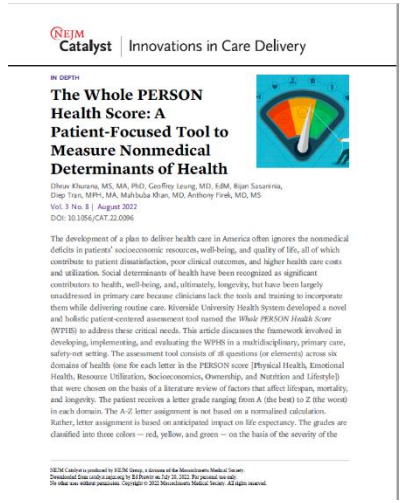
Nutrition and Lifestyle

Diet, Physical Activity

Sleep

Smoking

Alcohol, Substance Use


NEJM Catalyst | Innovations in Care Delivery

IN DEPTH

The Whole PERSON Health Score: A Patient-Focused Tool to Measure Nonmedical Determinants of Health

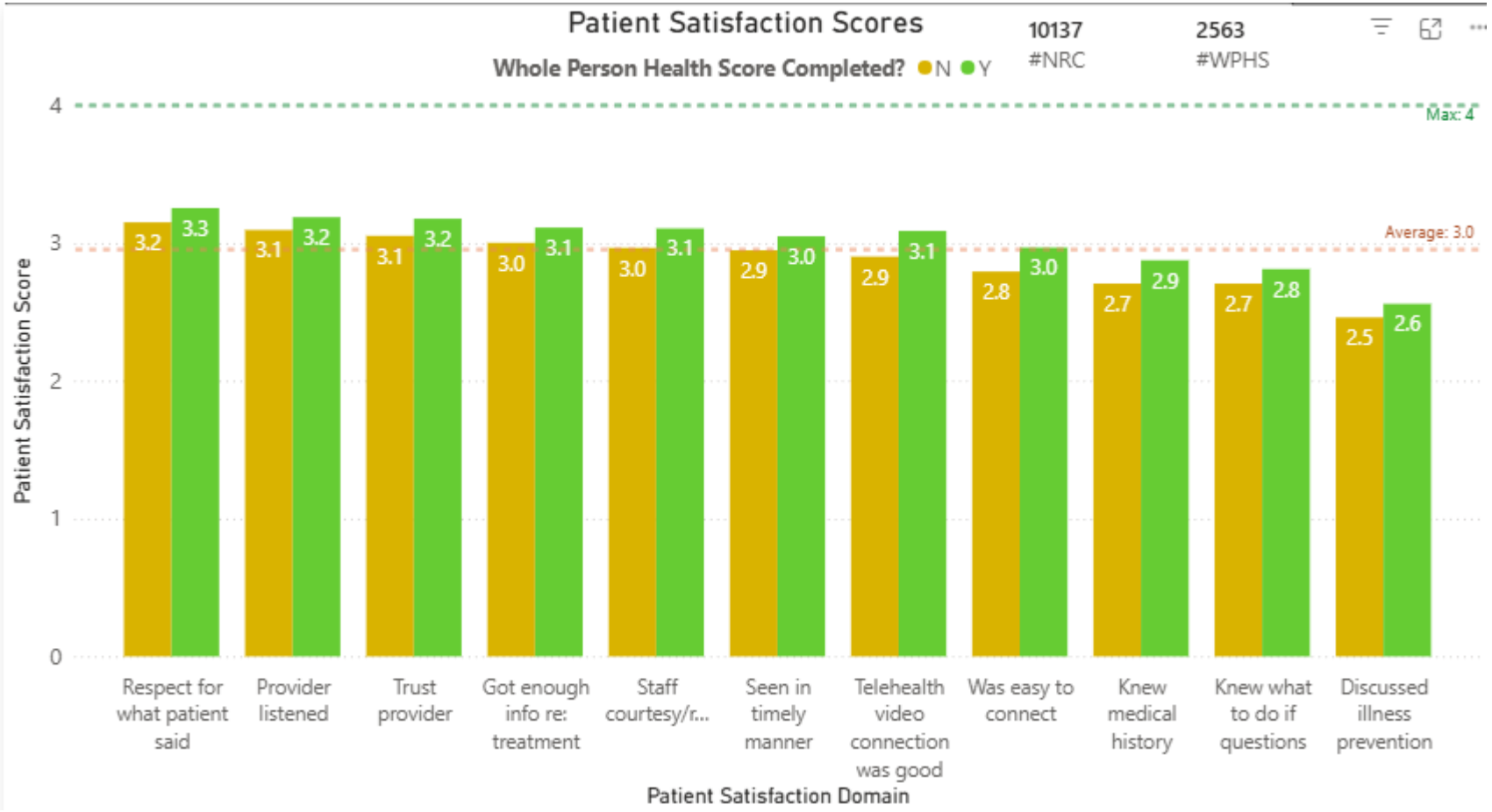

SCIENCE-IN-BRIEF

TURNING SCIENCE INTO ACTION

The Whole PERSON Health Score: A Patient-Focused Tool to Measure Nonmedical Determinants of Health

Riverside University HEALTH SYSTEM

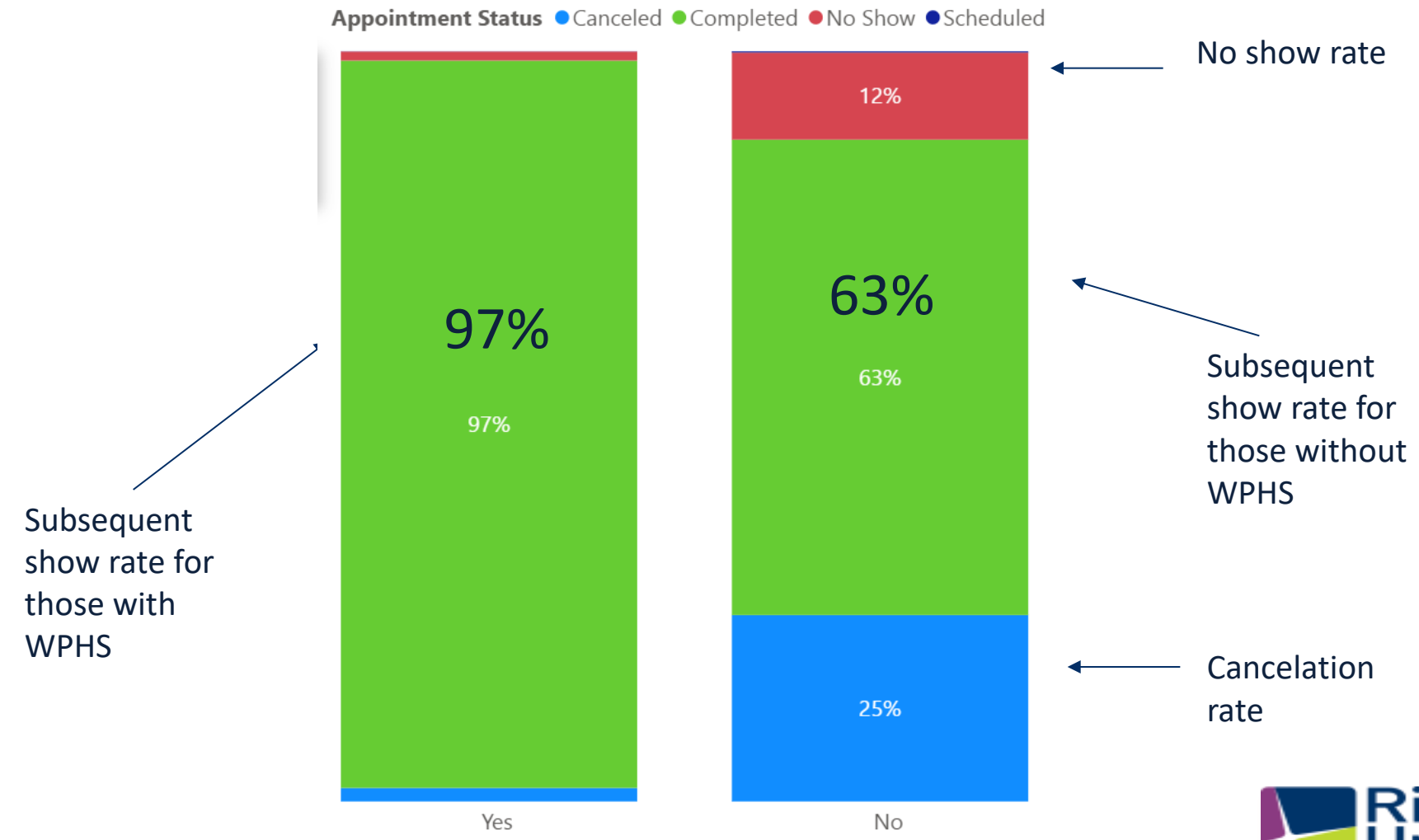
Whole Person Health Score Use Associated with Higher Patient Satisfaction



NRC WPHS. Power BI. January 1st, 2023 – December 31st, 2023. All RUHS CHC Sites. Accessed August 31st, 2025.

Riverside University HEALTH SYSTEM

Whole Person Health Score Use Associated with Improved Follow Up Rate



RUHS Power BI Dashboard: Clinic Appointment Status by Whole Person Health Score. January 1st, 2025 through August 31st, 2025 (n= 25,516). Accessed September 1st, 2025.

Riverside University HEALTH SYSTEM

RUHS Clinic Patient WPHS Needs

(2025 calendar year, n= 37,221)

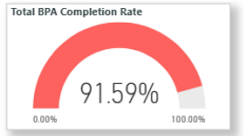
- Overweight or obese: 84.3%
- Chronic condition: 50.9%
- **Functional capacity: 18.5%**
- Depressed mood most or all days: 10.5%
- Anxious most or all days: 12.3%
- **Poor social support: 11.8%**
- **No meaning or purpose: 4.9%**
- ER or hospital visit past year: 39.2%
- Poor finances: 16.9%
- Poor living situation: 3.0%
- **Not working but wants to work: 18.8%**
- Difficulty **transportation: 8.4%**
- Difficulty access to **food: 11.8%**
- Fair or poor self-rated health: 36.0%
- Fair or poor nutrition: 47.3%
- **Sedentary activity: 33.5%**
- Difficulty sleeping: 32.3%
- Smoker: 10.4%
- **Substance use: 12.7%**

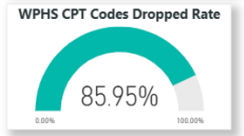
RUHS Power BI Dashboard: Whole Person Health Score 2025. Data from January 1st, 2025 through August 31st, 2025. Accessed September 1st, 2025.

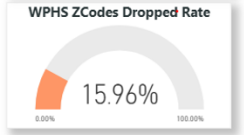
Riverside University HEALTH SYSTEM

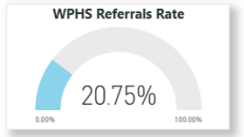
Holistic Health Assessment Prompts Multidisciplinary Referrals

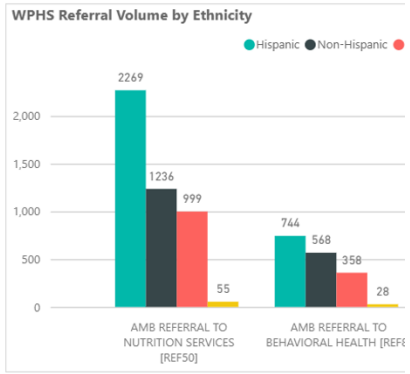
January 2025 - August 2025

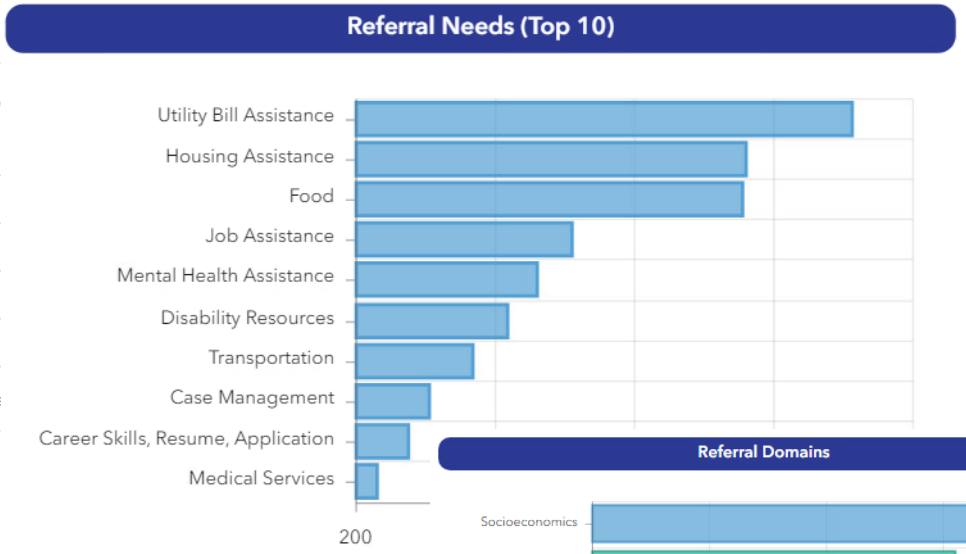


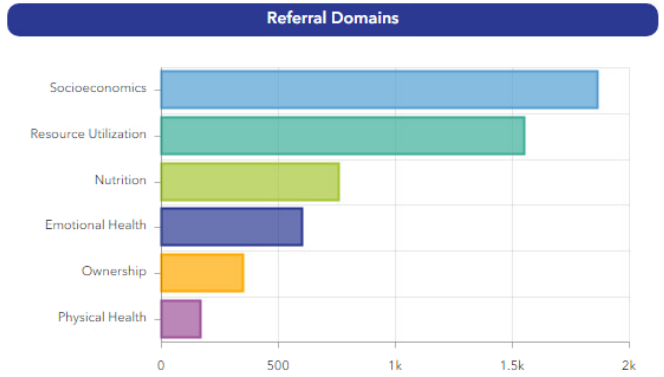






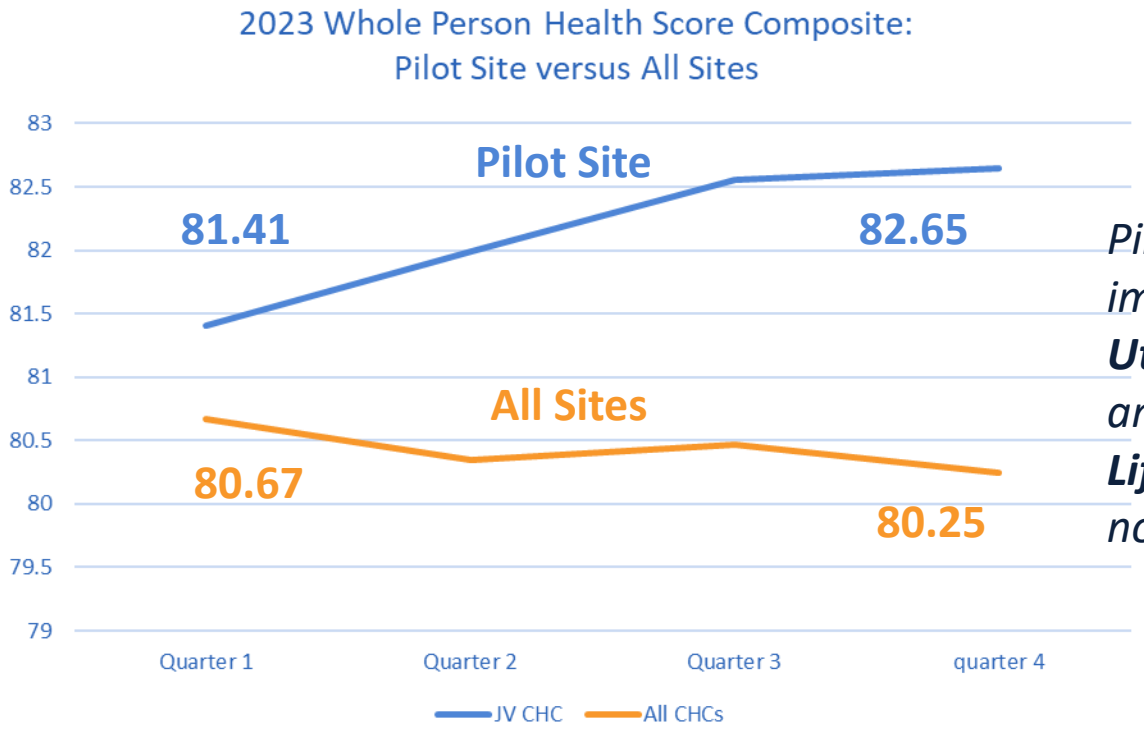






Riverside University HEALTH SYSTEM

Whole Person Health Score Composite Improves at Integrated Service Delivery Pilot Site



*Pilot Site saw significant improvement in **Resource Utilization**, **Ownership**, and **Nutrition and Lifestyle** compared to non-pilot sites*

Pilot Site Clinic: # WPHS = 5,625
(# of unique patients = 5,241)

All Clinics: # WPHS = 35,828
(# of unique patients = 33,869)

RivCoONE
Coordinating Services. Connecting People.

Riverside University HEALTH SYSTEM

"Whole Person Health Score Composite." Power BI Dashboard: WPHS. Based on February 4th, 2024 RUHS Whole Person Health Score Data Set. Accessed February 4th, 2024.

Riverside County Integrated Service Delivery

Integrated Service Delivery

- Program-centered → **person-centered service**
- Reactive and fragmented → **proactive** and integrated
- ***Universal registration***
- ***Information sharing*** (release of information)
- ***Whole Person Health Score*** (holistic assessment)
- ***Navigation and Coordination***

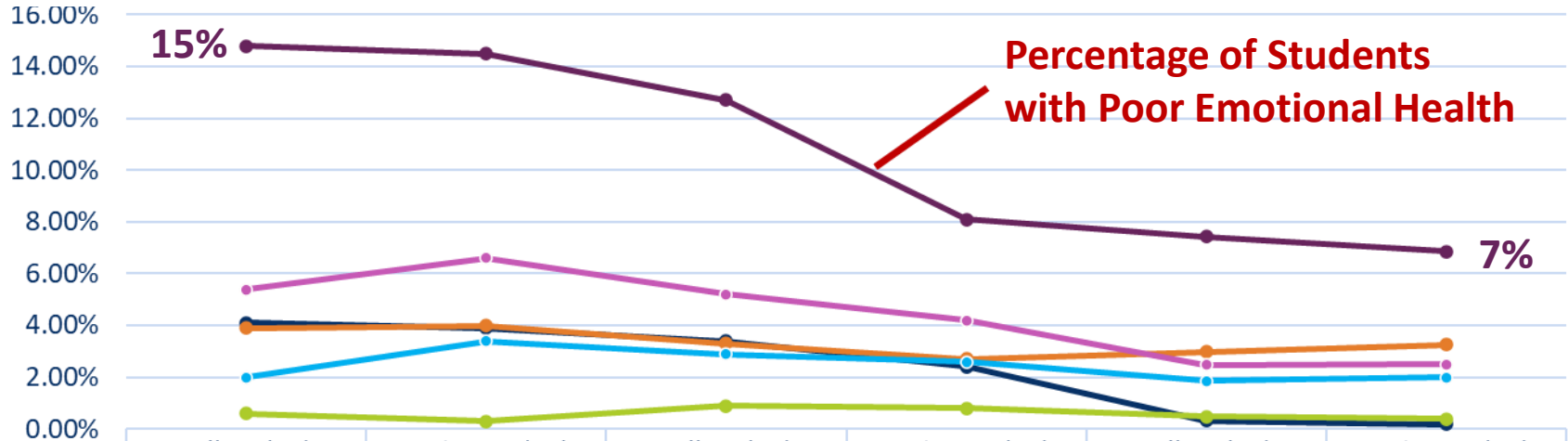
RivCoONE
Coordinating Services. Connecting People.

Participating Departments

- Behavioral Health
- Child Support Services
- Community Action Partnership
- Community Health Centers
- Emergency Management
- Fire
- First Five
- Housing and Workforce
- In-Home Support Services
- Nonprofits
- Office on Aging
- Probation
- Self Sufficiency
- Women Infant and Children
- Medical Center
- Veterans

Riverside University HEALTH SYSTEM

Percentage of High School Students with Poor Emotional Health Scores Decreased Significantly with Integrated Behavioral Health Program



	Fall 20 (T1)	Spring 21 (T2)	Fall 21 (T3)	Spring 22 (T4)	Fall 22 (T5)	Spring 23 (T6)
P-Domain	4.10%	3.90%	3.40%	2.40%	0.33%	0.18%
E-Domain	14.80%	14.50%	12.70%	8.10%	7.43%	6.86%
R-Domain	0.60%	0.30%	0.90%	0.80%	0.49%	0.40%
S-Domain	3.90%	4%	3.30%	2.70%	2.98%	3.25%
O-Domain	5.40%	6.60%	5.20%	4.20%	2.48%	2.49%
N-Domain	2.00%	3.40%	2.90%	2.60%	1.86%	2%

P-Domain E-Domain R-Domain S-Domain O-Domain N-Domain

Riverside University HEALTH SYSTEM

Unhoused Individuals by WPHS Element

(n=754)

WPHS Item	Unhoused (n=754)	RUHS (n=85,508)	Gap
Hospitilzaton/ER**	3.45	2.17	-1.28
Prescription Medication**	3.16	2.04	-1.12
Smoking**	2.06	1.01	-1.05
Living Situation **	2.91	1.94	-0.97
Depression**	2.42	1.57	-0.85
Finances**	4.20	3.35	-0.85
Employment**	2.27	1.54	-0.73
Social Support**	3.49	2.83	-0.66
Self-Rating**	5.09	4.43	-0.66
Transportation**	0.90	0.34	-0.56
Food Access**	0.93	0.41	-0.52
Chronic Condition Load**	1.27	0.75	-0.52
Anxiety**	1.39	0.97	-0.42
Diet**	4.82	4.41	-0.41
Funcional Capacity**	1.42	1.01	-0.41
Outpatient Visits**	1.68	1.30	-0.38
Alcohol Substance Use**	0.70	0.33	-0.37
Self-Efficacy**	2.13	1.81	-0.32
Purpose**	1.15	0.83	-0.32
Sleep**	1.41	1.14	-0.27
Knowledge**	2.24	2.03	-0.21
BMI**	1.60	1.43	-0.17
Self-Management*	1.44	1.29	-0.15
Physical Activity*	4.20	4.07	-0.13
Relaxation/Meditation/Prayer	1.87	1.83	-0.04
Education	1.79	1.78	-0.01
Blood Pressure	3.51	3.52	0.01

Top 5 Potential Need

Hospitalization/ER
Prescription Medication
Smoking
Living Situation
Depression

Welch's T-Test, CI= 95%, alpha=0.05
*=p-value <.05
**=p-value <.001
No asterisk = not statistically significant

Note: In the 'Unhoused' and 'RUHS' columns, higher values represent worse outcomes, while lower values indicate better outcomes. In the 'Gap' column, negative differences reflect worse outcomes, while positive differences signify better outcomes

RUHS CHC WPHS Data Set, 2023-2024.

Riverside University HEALTH SYSTEM

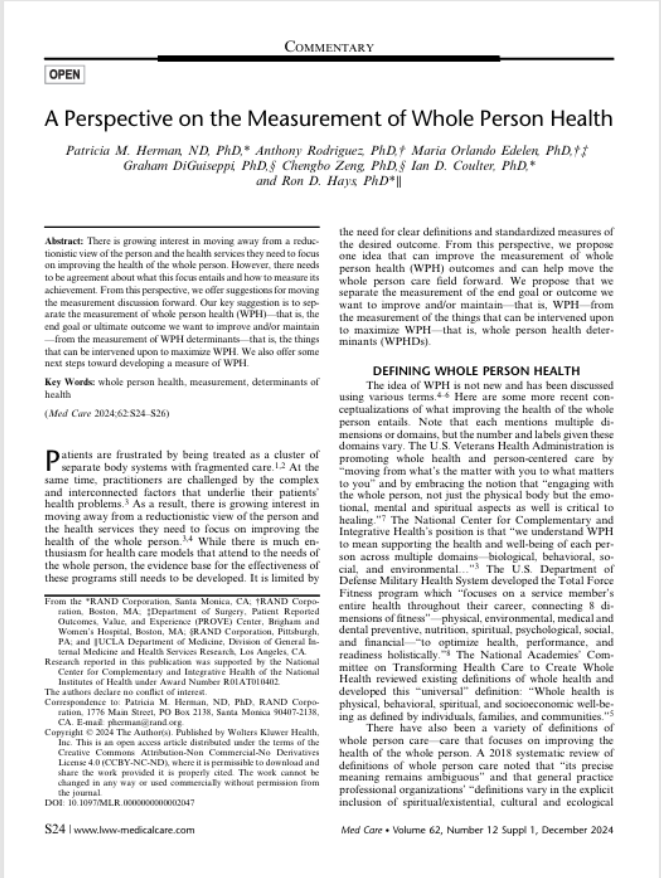
Using WPHS Composite to Measure Quality of Life and Estimate Life Expectancy

- Daily Smoker **69.2**
  - Occasional Smoker: 74.2
  - Former Smoker: 81.5
  - Never Smoker: **84.6**
- Uncontrolled Blood Pressure (SBP > 140): **72.8**
  - BP 120-140: 81.6
  - BP 120 or less: **84.1**
- Diabetes: **74.5**
- Heart disease / failure: **68.3**
- Chronic Pain: **65.4**
- Asthma / COPD: **69.3**

- RUHS population: **80.3**
- Disabled: **63.1**
  - Unemployed but wanting to work: 77.5
  - Working part-time: 82.7
  - Working full-time, not working by choice, or homemaker: **87.1**
- 4 or more visits to ED / hospital in past 12 months: **56.8**
  - 3 visits: 64.1
  - 2 visits: 71.6
  - 1 visit: 79.7
  - No visits: **85.5**

Riverside University HEALTH SYSTEM

How do you address Social Determinants of Health?



COMMENTARY

OPEN

A Perspective on the Measurement of Whole Person Health

Patricia M. Herman, ND, PhD, Anthony Rodriguez, PhD,† Maria Orlando Edelen, PhD,†‡ Graham DiGuiseppi, PhD,§ Chengbo Zeng, PhD,§ Ian D. Coulter, PhD,* and Ron D. Hays, PhD*‖*

Abstract: There is growing interest in moving away from a reductionistic view of the person and the health services they need to focus on improving the health of the whole person. However, there needs to be agreement about what this focus entails and how to measure its achievement. From this perspective, we offer suggestions for moving the measurement discussion forward. Our key suggestion is to separate the measurement of whole person health (WPH)—that is, the end goal or ultimate outcome we want to improve and/or maintain—from the measurement of WPH determinants—that is, the things that can be intervened upon to maximize WPH. We also offer some next steps toward developing a measure of WPH.

Key Words: whole person health, measurement, determinants of health

(*Med Care* 2024;62:S24–S26)

Patients are frustrated by being treated as a cluster of separate body systems with fragmented care.[1,2] At the same time, practitioners are challenged by the complex and interconnected factors that underlie their patients' health problems.[3] As a result, there is growing interest in moving away from a reductionistic view of the person and the health services they need to focus on improving the health of the whole person.[3,4] While there is much enthusiasm for health care models that attend to the needs of the whole person, the evidence base for the effectiveness of these programs still needs to be developed. It is limited by the need for clear definitions and standardized measures of the desired outcome. From this perspective, we propose one idea that can improve the measurement of whole person health (WPH) outcomes and can help move the whole person care field forward. We propose that we separate the measurement of the end goal or outcome we want to improve and/or maintain—that is, WPH—from the measurement of the things that can be intervened upon to maximize WPH—that is, whole person health determinants (WPHDs).

DEFINING WHOLE PERSON HEALTH

The idea of WPH is not new and has been discussed using various terms.[4–6] Here are some more recent conceptualizations of what improving the health of the whole person entails. Note that each mentions multiple dimensions or domains, but the number and labels given these domains vary. The U.S. Veterans Health Administration is promoting whole health and person-centered care by "moving from what's the matter with you to what matters to you" and by embracing the notion that "engaging with the whole person, not just the physical body but the emotional, mental and spiritual aspects as well is critical to healing."[7] The National Center for Complementary and Integrative Health's position is that "we understand WPH to mean supporting the health and well-being of each person across multiple domains—biological, behavioral, social, and environmental…"[3] The U.S. Department of Defense Military Health System developed the Total Force Fitness program which "focuses on a service member's entire health throughout their career, connecting 8 dimensions of fitness"—physical, environmental, medical and dental preventive, nutrition, spiritual, psychological, social, and financial—"to optimize health, performance, and readiness holistically."[8] The National Academies' Committee on Transforming Health Care to Create Whole Health reviewed existing definitions of whole health and developed this "universal" definition: "Whole health is physical, behavioral, spiritual, and socioeconomic well-being as defined by individuals, families, and communities."[5]

There have also been a variety of definitions of whole person care—care that focuses on improving the health of the whole person. A 2018 systematic review of definitions of whole person care noted that "its precise meaning remains ambiguous" and that general practice professional organizations' "definitions vary in the explicit inclusion of spiritual/existential, cultural and ecological

From the *RAND Corporation, Santa Monica, CA; †RAND Corporation, Boston, MA; ‡Department of Surgery, Patient Reported Outcomes, Value, and Experience (PROVE) Center, Brigham and Women's Hospital, Boston, MA; §RAND Corporation, Pittsburgh, PA; and ‖UCLA Department of Medicine, Division of General Internal Medicine and Health Services Research, Los Angeles, CA.

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The authors declare no conflict of interest.

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DOI: 10.1097/MLR.0000000000002047

- Assess baseline
- Prioritize needs
- Connect with resources
- Measure change
- Compare interventions
- Standardize and systematize approach

Riverside University HEALTH SYSTEM

Questions?

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Geoffrey Leung
Riverside University Health System
g.leung@ruhealth.org
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Riverside University HEALTH SYSTEM

Bridging Healthcare and Social Services: A Social Service Organization's Journey with Health Data Exchange

Brit Steele
Director, Healthcare Innovation
Inland Housing Solutions

Manifest MEDEX

SSO SPOTLIGHT

Bridging Healthcare and Social Services:

A Social Service Organization's Journey with Health Data Exchange

PRESENTED BY

Brit Steele, MBA

Director of Healthcare Innovations

Data = Communication

Health Care + Social Care = **One Story**

Inland Housing Solutions

From Housing Crisis Response to Health System Partner

1988 — Women's Shelter

2008 — Housing First

2016 — Housing Navigation

2018 — Whole Person Care Pilot

2022 — Community Supports

2024 — Enhanced Care Management

Why Interoperability?

1. **Health** + **Housing** Are Inseparable
2. Improve Our **Continuum of Care**
3. **Meet Partners** Where They're At
4. Drive **Accountability** and **Equity**
5. Members deserve **Whole-Person Care**

ADTs + DxF = **Missing Puzzle Pieces**

The Quadruple Challenge

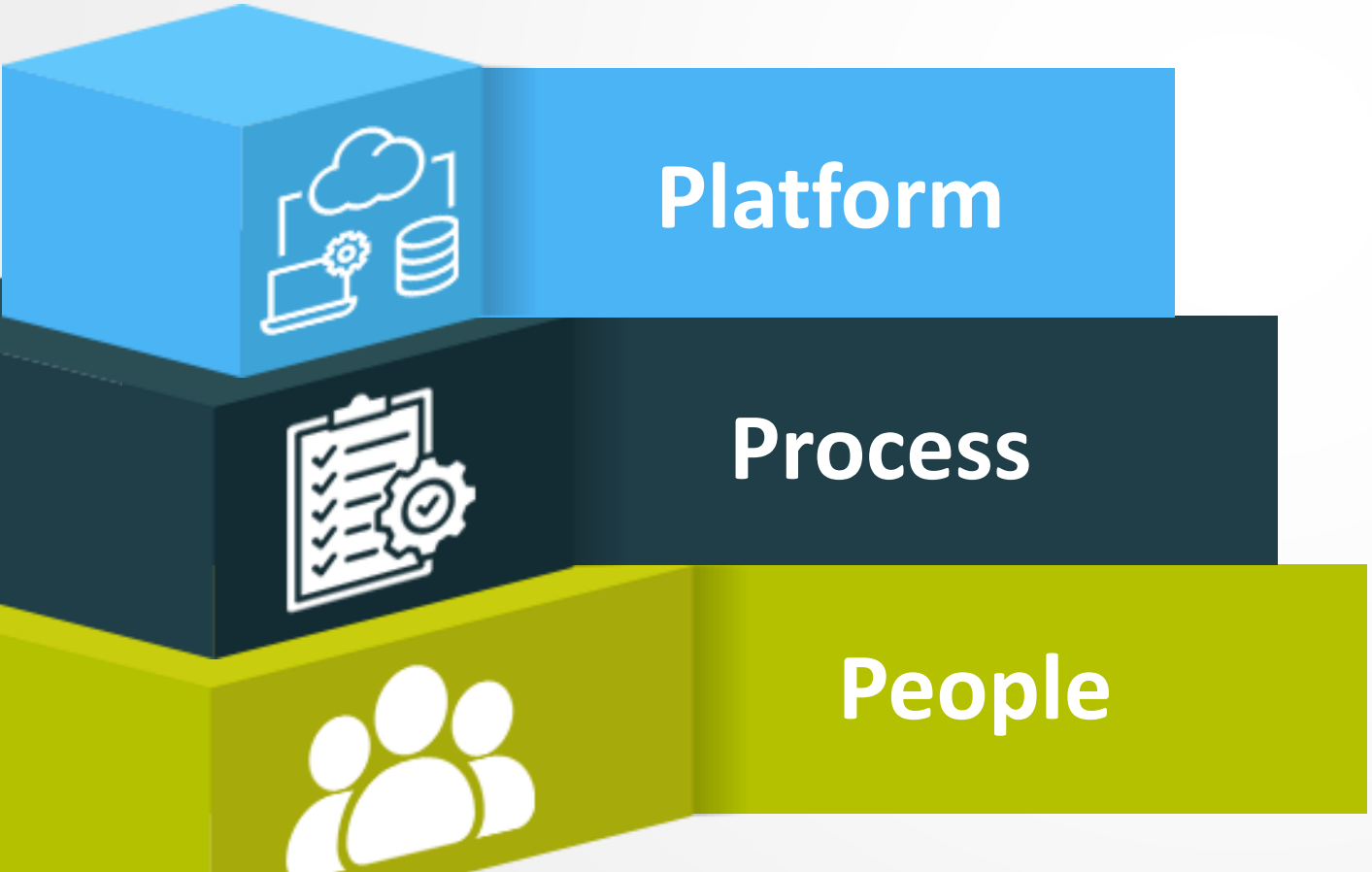
1. **Financial**
   Funding

2. **Technical**
   Integration

3. **Expertise**
   Capacity

4. **Policy**
   Alignment

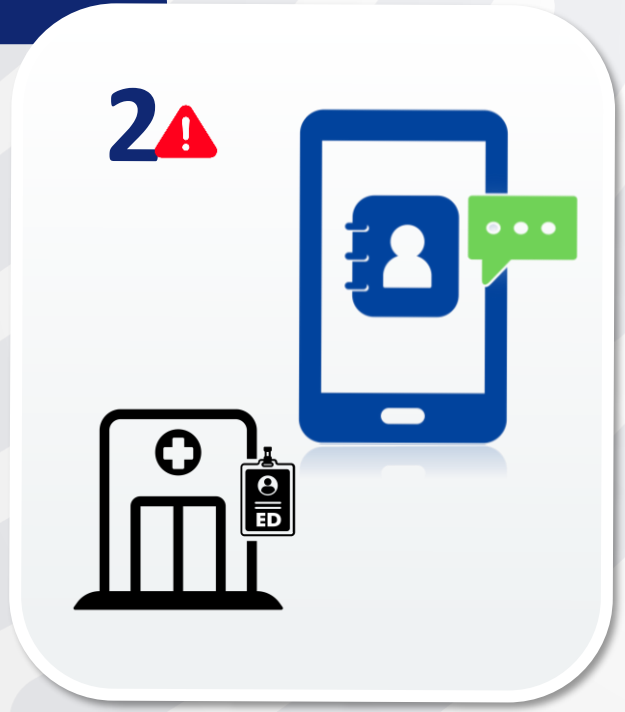
What We Built



2 On The Ground Moments

Oxygen & Housing Safety

2 On The Ground Moments



Oxygen & Housing Safety

Critical Contact Windows

1 STORY

CalAIM
In Action

Hope in Bridging the Gap

Questions?

Break: **12:00 p.m. – 1:00 p.m.**

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UNITE US

Spotlights: Expanding the Data Sharing Ecosystem

Megan Esparza
Executive Director
California WIC Association

Mike Ciancio
Fire Chief
Northshore Fire Protection District

Tim Polsinelli
Senior Director, Health Informatics
Manifest MedEx

Peeling the Onion: Electronic Data Linkages for WIC

Megan Esparza
Executive Director
California WIC Association

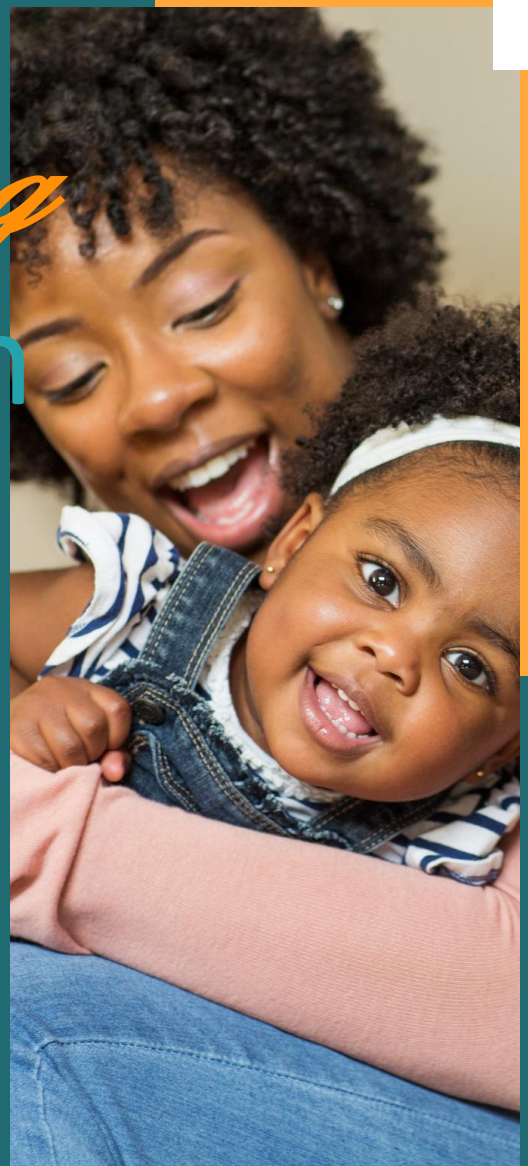
Manifest MEDEX

Peeling the Onion

ELECTRONIC DATA LINKAGES FOR WIC

Manifest MedEx Regional Forum
September 9th, 2025

California WIC ASSOCIATION



Images: Canva

MEGAN ESPARZA, MAS, RDN, CLC

I have no conflicts of interest or disclosures.

Image: Canva

What we will talk about today...

01 Why pursue electronic data linkages for WIC local agencies.

02 Establishing working partnerships.

03 Workflow for WIC staff.

04 Participant and health care provider experiences.

05 Tips, strategies, and caveats from WIC staff.

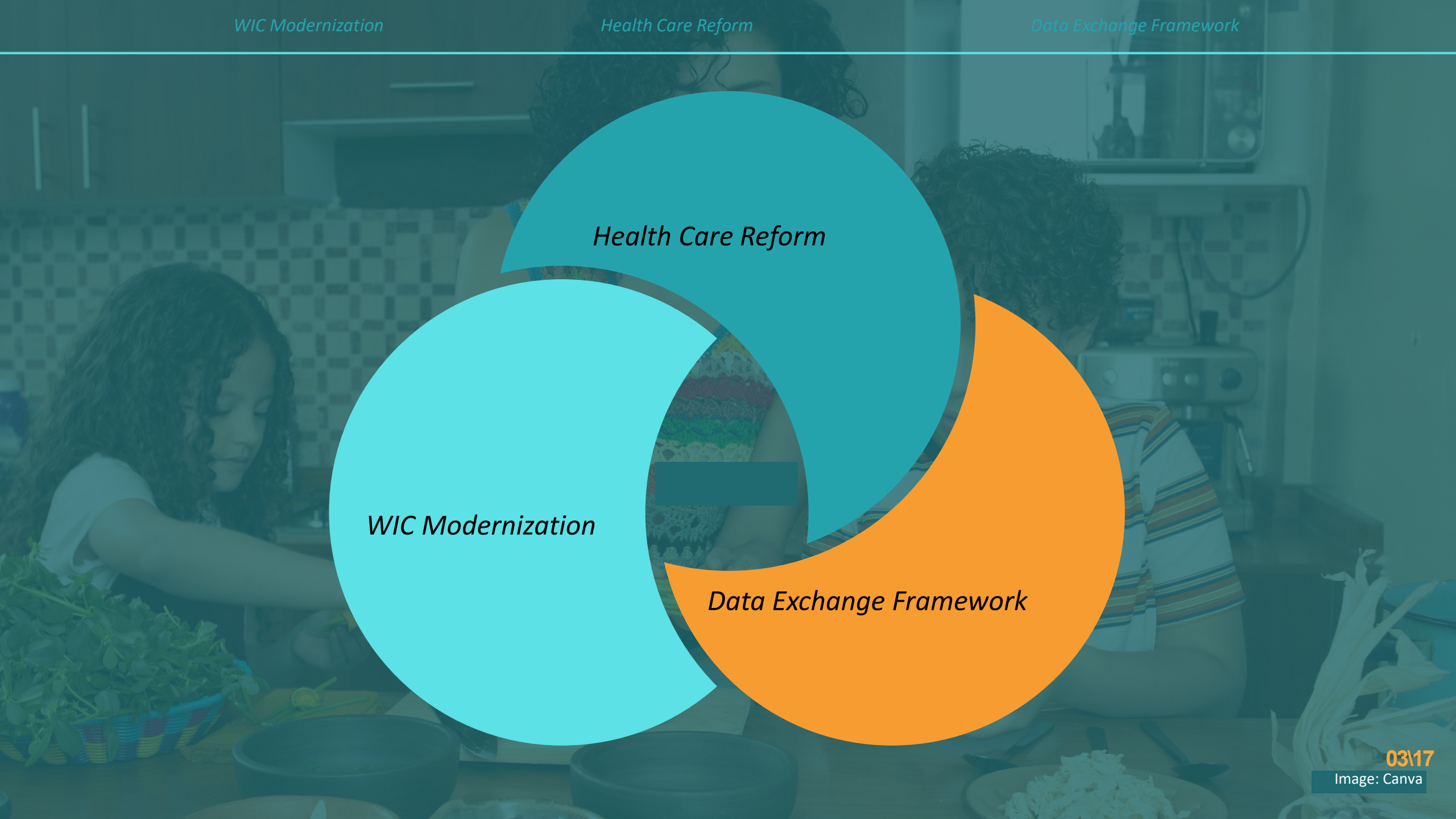

Health Care Reform
WIC Modernization
Data Exchange Framework

Image: Canva

Partners

- Health Information Exchanges
- Electronic Health Records
- Community Information Exchanges
- Health Care Providers
- WIC Local Agencies

Linking WIC to health care providers is the goal. From an earlier project with WIC and Neighborhood Health Care in San Diego.

WIC Staff say...

Images: Canva

> Involve key stakeholders from the beginning. Our Director of Women's Health & Chief Medical Office of Pediatrics and Chief Information Officer were extremely important in our early discussions regarding what was feasible.

> Having both the HIE & WIC agency IT staff together to brainstorm brought us to the process we now have in place.

WIC Staff

1. Health Care Providers send rosters of prenatal, postpartum, and well child visits to the HIE.
2. Data populates in the referral dashboard and in the 'WIC View' in the HIE.
3. WIC staff log into the HIE to use the dashboard & WIC view
4. WIC staff:
    - compare information to WIC MIS
    - use relevant data
5. WIC staff reach out to eligible and participating individuals for enrollment and certification.

Image: Canva

Partnerships & Connections

Image: Canva

WIC Staff say....

Initially, we were concerned that staff might be hesitant to log into yet another system and would not use it consistently. However, as they became more comfortable, it's clear they now cannot imagine working without it.

Lesson learned: If a tool genuinely adds value to the team's workflow-even if it's not perfect-they will embrace it. All new staff is trained on EPIC even before they start WW training- its now embedded into the workflow.

One practical tip: providing staff with dual monitors has made it significantly easier to navigate between the HIE and WIC MIS. This small change has had a big impact on usability.

WIC Staff say….

Image: From an earlier project linking WIC to health care, Contra Costa WIC staff access the county EHRs.

> My team and I are impressed that such a massive universe of data could be distilled into a straightforward platform that a user could learn to navigate in under 10 minutes.

08\17

WIC Staff say….

Image: Megan Esparza, CWA, Priti Rane, San Francisco WIC, Christine Goulet, Northeast Health Corp WIC, Dr. Leong, Riverside County, share lessons and insights at the California Data Exchange Framework Summit, March 2025.

> While this has and continues to take a lot of time, overall, this has been a very positive experience. Working directly with the program developers has helped move this project from an idea to the development of the initial WIC Referral interface (WIC View).
>
> Lessons: Brushing up on programming lingo a bit beforehand,
>
> i.e., understanding data formats would have been helpful.

Image: Coordinating with healthcare providers at Communicare, Yolo county, in an earlier project.

Healthcare Provider Experience

- Learn about the health care providers workflows and use of technology
- Share about WIC needs and workflow
- Streamline health care providers workflow and/or decrease administrative burden
- Plan together
- Continue to engage with health care providers for WIC outreach, referrals and care coordination. E.g. lactation support, therapeutic formula

Participant Experience

- Expect modern business practices
- Do not need to provide height and weight and other data if WIC staff can retrieve the data from the HIE/EHR

Image: Merced WIC

- Eliminates multiple steps of sending screenshots or bringing paper information into the WIC clinic
- Electronic data linkages support virtual and in-person WIC appointments
- Ongoing working relationships with WIC reminds health care providers to mention the importance of WIC with patients

WIC Staff say….

Image: Shasta County WIC

“We are:

- capturing our prenatal eligible individuals earlier in their pregnancy since they are referred to us as soon as they find out they are pregnant. This gives us the opportunity to provide more education for a healthy pregnancy and promote the importance of breastfeeding.
- re-engaging families whose children were on WIC when they were infants but have fallen off the program.

While we can’t tie it directly to the HIE referrals, our caseload has increased a bit.”




Recomendations

Closed loop referrals:

- The most immediate, high-impact ask is to allow closed-loop referrals that are not so burdensome to local staff
- Inability to close the referral – It would be great to inform providers that their patients are receiving help from WIC

Consent:

Access to a broader patient pool via Universal consent.

Image: Grethel Pallaviccini, San Francisco WIC, presents lessons and recommendations at NWA in 2024

Recommendations

Interoperability:

- Develop a system that can integrate with any EHR, allowing referrals to be accessed directly through WIC MIS
- This process is burdensome since it is a one-to-one matching process – the HIEs referral against our WIC MIS system
- Exportable referral lists for faster case-matching against WIC MIS reports

And more!

Care Coordination:

- Providers would like to know how WIC is helping their patients, e.g., breastfeeding challenges and support, infant weight gain/loss, therapeutic formula, nutrition recommendations, and concerns. Having interoperable systems to share this type of information would be ideal

- Increased care coordination between HCPs and WIC, especially for breastfeeding dyads

Image: Canva

Thank you to staff who provided comments

Christine Cho, Watts Healthcare

Christine Goulet, Northeast Valley Health Corporation

Priti Rane, San Franciso WIC

Image: Grethel Pallaviccini, San Francisco WIC, presents lessons and recommendations at NWA in 2024

Questions

THANK YOU

For more information:

***Megan Esparza**, MAS, RDN, CLC*

Executive Director

California WIC Association

mesparza@calwic.org

Image: Merced WIC

Integrating Fire and EMS into the Data Sharing Ecosystem

Mike Ciancio
Fire Chief
Northshore Fire Protection District

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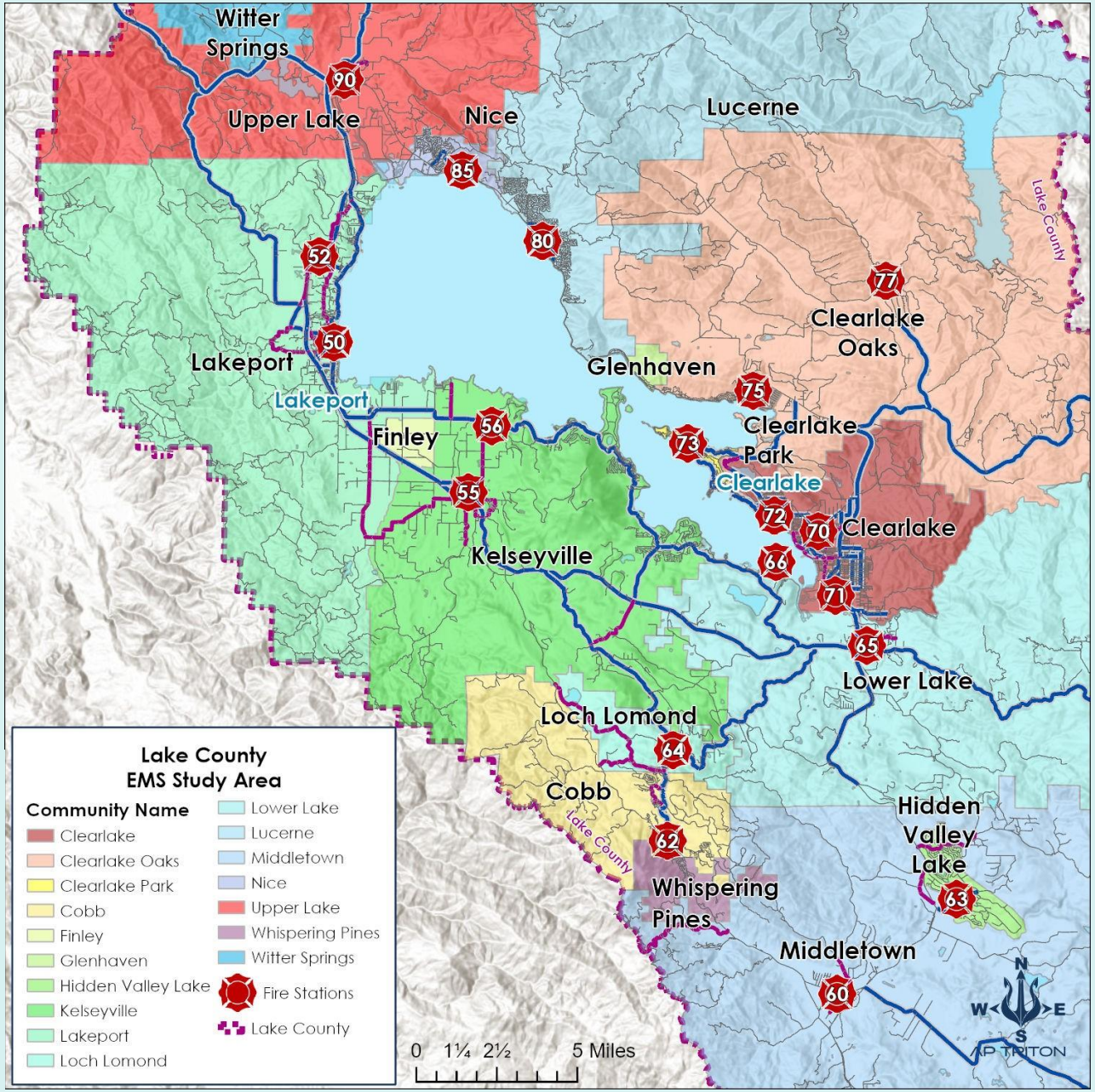
Witter Springs
Upper Lake
Nice
Lucerne
Lake County
Clearlake Oaks
Glenhaven
Lakeport
Lakeport
Finley
Clearlake Park
Clearlake
Kelseyville
Clearlake
Lower Lake
Loch Lomond
Cobb
Lake County
Hidden Valley Lake
Whispering Pines
Middletown
90
85
80
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Lake County
EMS Study Area
Community Name
Clearlake
Clearlake Oaks
Clearlake Park
Cobb
Finley
Glenhaven
Hidden Valley Lake
Kelseyville
Lakeport
Loch Lomond
Lower Lake
Lucerne
Middletown
Nice
Upper Lake
Whispering Pines
Witter Springs
Fire Stations
Lake County
0 1¼ 2½ 5 Miles
N
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S
TRITON

Questions?

Mike Ciancio

Northshore Fire Protection Dist.

Chief800@northshorefpd.com

Innovations in County Connectivity

Tim Polsinelli
Senior Director, Health Informatics
Manifest MedEx

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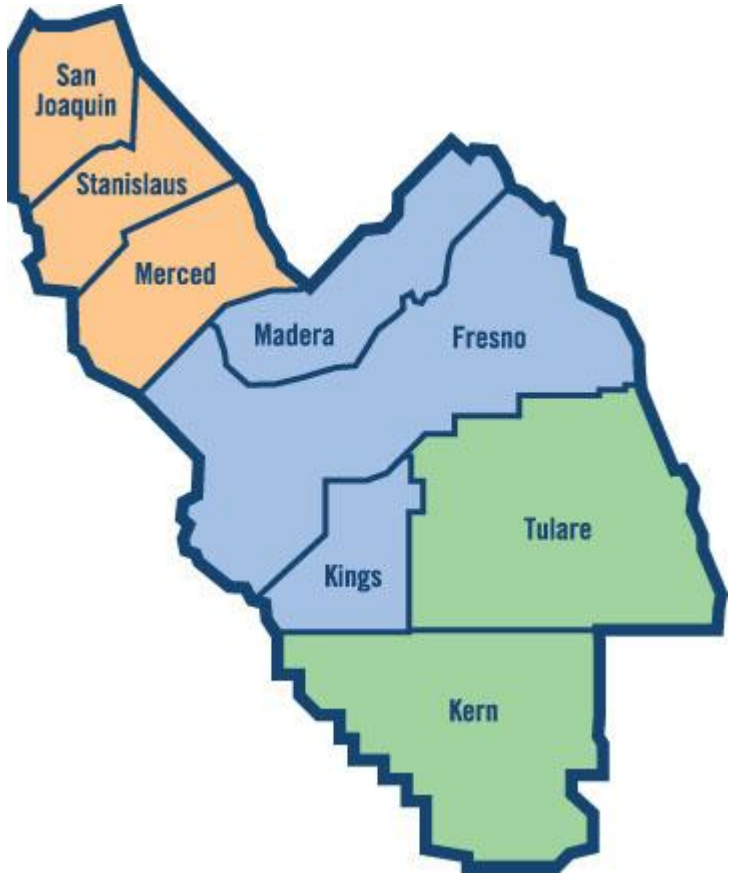
Innovations in County Connectivity

September 9, 2025

MX COUNTY INNOVATION

- DHCS Memo of Understanding (MOU) work with MCPs and Counties
  - Standardizing Data Exchange across County Agencies and MCPs
- Fresno County Information Exchange
  - County-wide Social Health Information Exchange with 2 pilot use cases



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DHCS MOU DATA SHARING

BACKGROUND

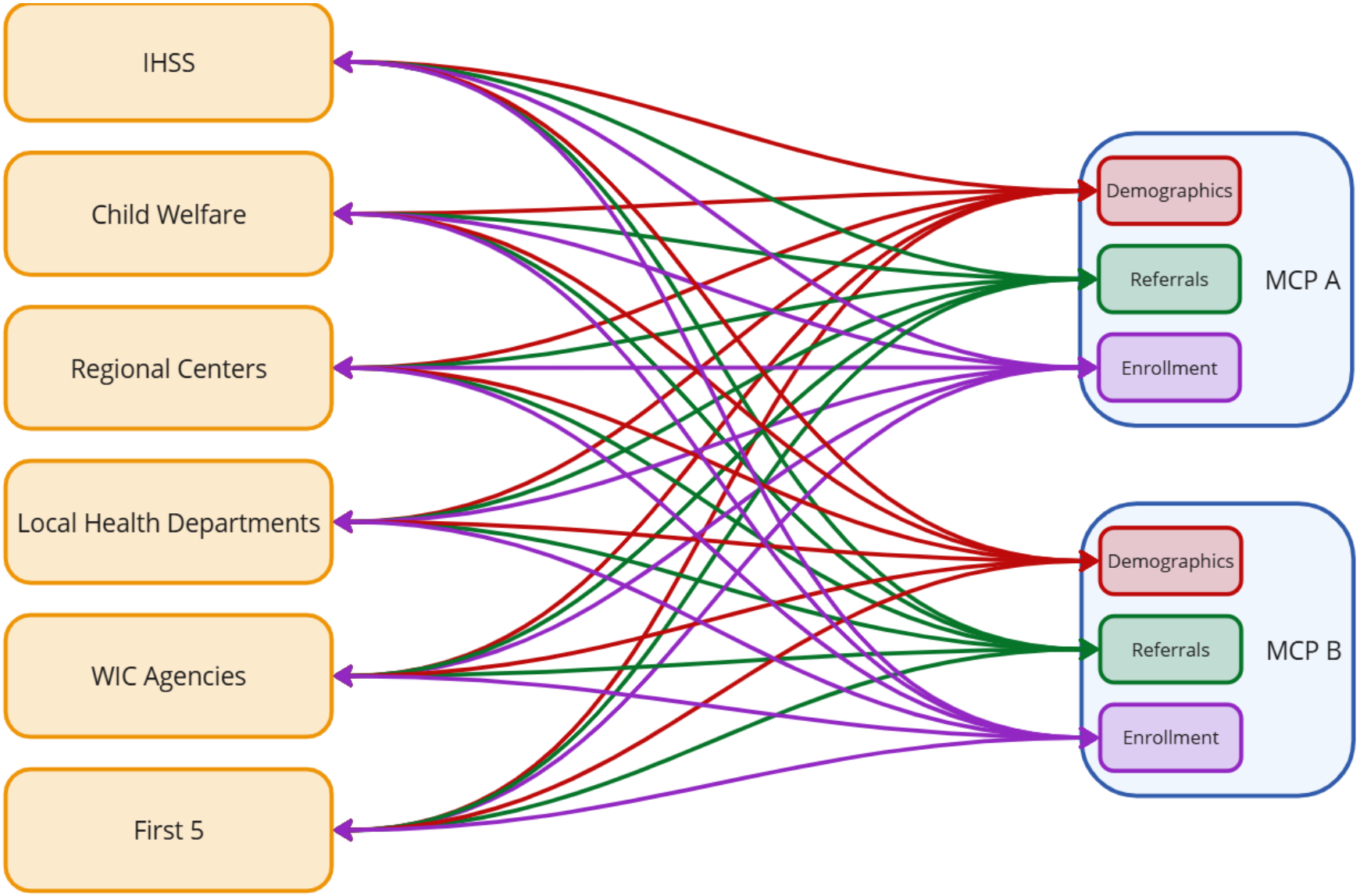
- DHCS requires MCPs to build partnerships with "Third-Party" entities, ensuring:
  - Member care is coordinated
  - Members have access to community-based services to support whole-person care
- "Third-Party" entities are typically county agencies and include:
  - Local Health Departments
  - County Education Agencies
  - County Government Agencies
  - Social Services
  - Child Welfare
  - Women, Infant and Children (WIC)
  - County Correctional Agencies

CHALLENGES

- DHCS requires data exchange but allows the MCPs to define the means to exchange.
- With multiple MCPs per county, county agencies may be required to support multiple exchange mechanisms
  - No shared data formats or structures
  - Users in county agencies may need different workflows or access to different systems to share data.
- Many county agencies are constrained by:
  - Resources
  - Funding
  - Technology

DECENTRALIZED INTEGRATION MODEL

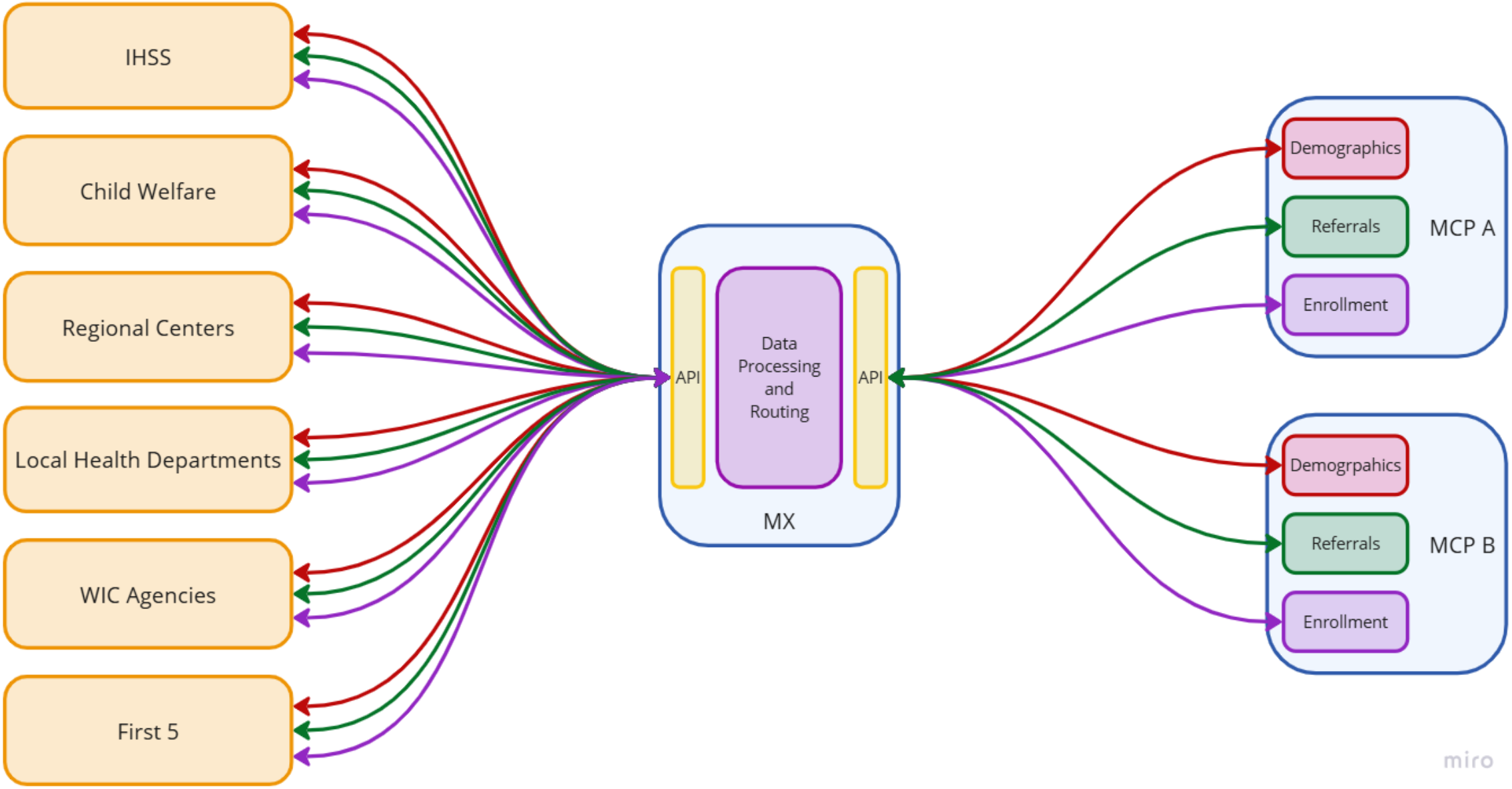
- What a mess! This model illustrates the administrative and technical complexity:



A BETTER APPROACH IN THE CENTRAL VALLEY

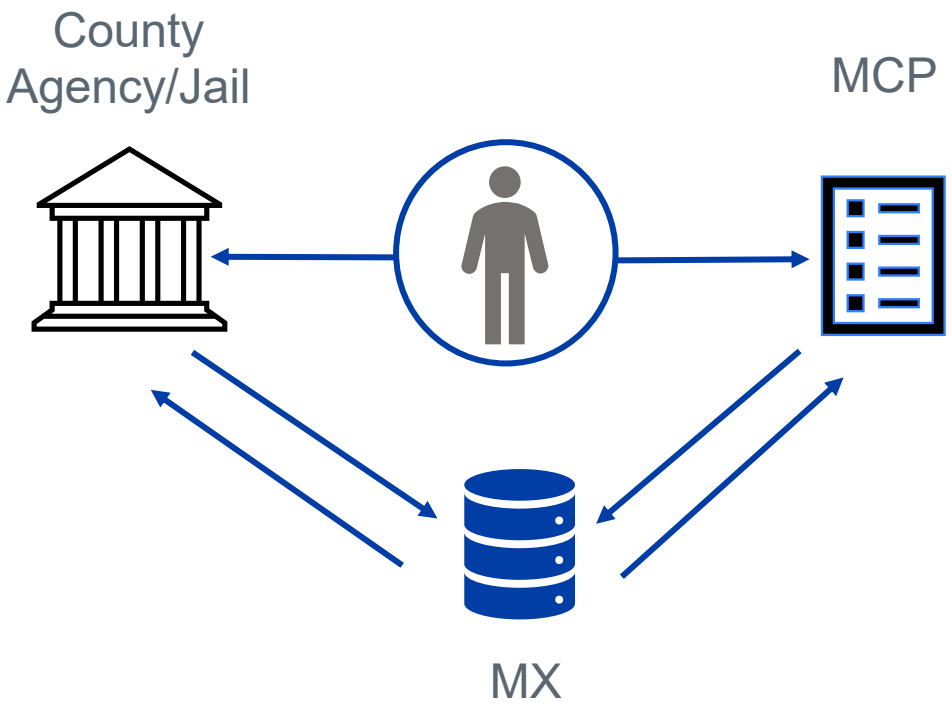
- Collaborating with 2 MCPs, MX designed a HUB model, allowing agencies and MCPs to exchange a standard set of data in a known format through MX.
- With this model:
  - County Agencies can receive MCPs' data in a standard format
  - County Agencies can provide MX with a data stream of all members
    - MX will route a member's data to the correct MCP
  - Repeatable, Reproducible
    - Initial target service area provides a learning bed/pilot for future expansion to other counties.

THE SOLUTION: MX HUB MODEL



OUTCOMES

- Prior to DHCS MOU implementation, county agencies, jails, and MCPs were not required to share data with one another.
- The significant overlap between Medi-Cal members and individuals accessing county services results in poorly coordinated care and potential duplication of efforts.
- Leveraging streamlined data exchange, counties and managed care plans are better equipped to coordinate care for vulnerable populations.
- Jails can inform managed care plans of pending releases and assign ECM providers for qualified members.



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FRESNO COUNTY INFORMATION EXCHANGE

OVERVIEW - FCIE

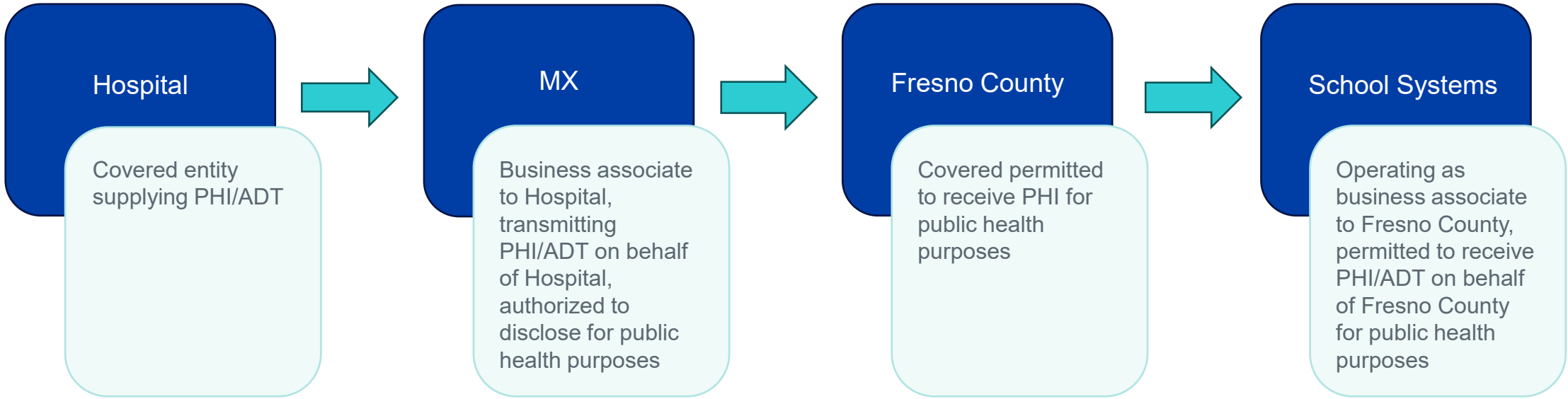
- Vision
  - To create a data-driven, interconnected community in Fresno County where timely and effective support is provided to those in need.
- Mission
  - Expedite data sharing across sectors to allow for improved communication and coordinated services for students and families in Fresno County.
- Objectives
  - Develop initial FCIE partnerships, governance, legal framework, and technical infrastructure to set the stage for ongoing development.
  - Enhance care coordination and expand accessibility to services for Fresno County residents.
  - Streamline service delivery and improve outcomes in key areas.
  - Foster trust among stakeholders through clear and effective data governance.

USE CASE: YOUTH SUICIDE PREVENTION (YSP)

- The Youth Suicide Prevention (YSP) pilot will test the initial feasibility of leveraging real-time admit, discharge, transfer (ADT) data to alert school district support staff when a student is in crisis.
- Real-time alerts will enable appropriate school district staff to support the student as quickly as possible.
- Partners in the pilot include:
  - Central Unified School District
  - Sanger Unified School District
  - Manifest MedEx Health Information Exchange (MX)
  - Fresno County Department of Public Health (FCDPH)
  - Fresno County Hospital Partners
- Pre-cursors to pilot launch included:
  - Development of a legal framework to allow for the secure exchange of data
  - Collaboration efforts to design the technical solution

YSP: LEGAL FRAMEWORK

- Through business associate agreements (BAAs) between participating school districts and FCDPH, the use and disclosure of PHI for public health purposes is permissible under HIPAA.
  - **School district staff who receive ADT alerts will be required to complete HIPAA training.**
- FERPA: For patient matching purposes, the schools will provide only demographic data not protected by FERPA (directory data). Schools are required to inform parents (or eligible students) what will be disclosed and give them an opportunity to submit an opt-out form.



YSP: TECHNICAL CONSIDERATIONS – ICD-10 CODES

Initial List of ICD-10 Codes

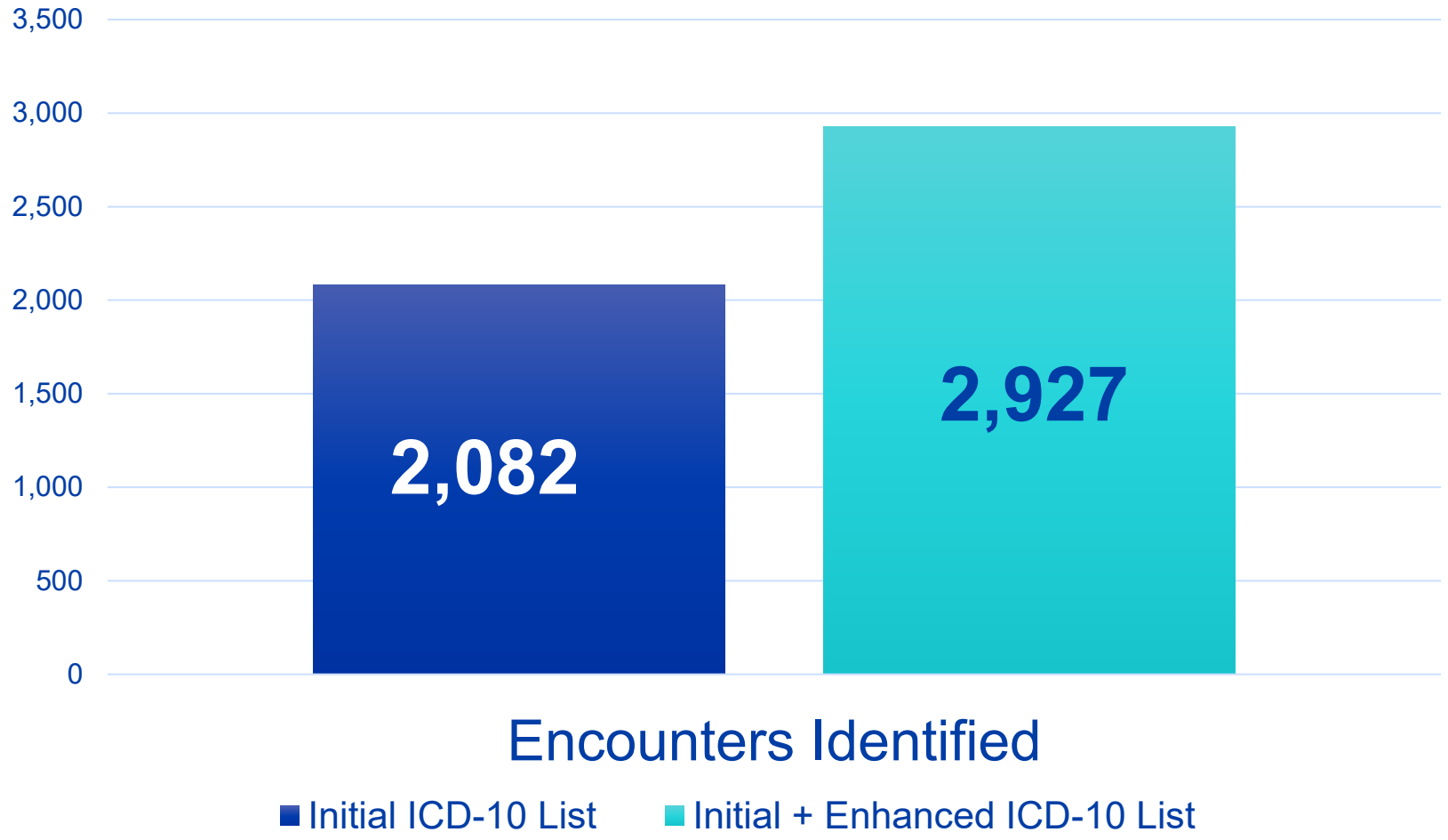
ICD-10	Description
T14. 91	Suicide attempts and interrupted attempts
Z91.5	Personal history of a suicide attempt(s)
R45.851	Suicidal ideation

Enhanced List of ICD-10 Codes

ICD-10	Description	Modifiers
X71-X83	Intentional Self-Harm Codes	
T36-T50	Poisoning	Intentional Self-Harm
T51-T65	Toxic Affects of Substances	Intentional Self-Harm
T71	Asphyxiation, suffocation, hanging	Intentional Self-Harm

TECHNICAL COLLABORATION: IMPROVEMENT IN ENCOUNTER IDENTIFICATION

Hospital encounters in 2024 for patients up to 18 years old with indication of suicide or self-harm attempt



LESSONS LEARNED

- FERPA considerations
  - FERPA protects student IDs. Schools needed to generate another unique ID for purpose of sharing data with MX.
  - The student's association with the school district will be blinded to the MX network and in outgoing data feeds.
  - School districts must inform parents of directory data disclosures and provide an opportunity to opt-out; pilot school districts have decided to include the YSP disclosures in their annual student handbook distribution.
- Schools want to minimize exposure to PHI. Minimal details about their hospital encounter are shared.
- School districts have existing workflows to receive crisis alerts and perform "wellness" check-ins with students. Our solution needed to feed into those processes.

USE CASE: HOME VISITATION

- What is Home Visitation?
  - The California Home Visiting Program (CHVP) is designed for overburdened families who are at risk for Adverse Childhood Experiences (ACEs), including child maltreatment, domestic violence, substance use disorder and mental health related challenges. Home visiting gives parents the tools and know-how to independently raise their children.[1]
- The Challenge:
  - Fresno County's Home Visitation programs are delivered by public health nurses and multiple community-based organizations (CBOs) providing community health worker (CHW) services.
  - The systems used by the PHN team and CBOs are siloed, nurses and CHWs do not have insight into the full scope of services provided to families.
  - Services may be duplicated or poorly coordinated resulting in unmet social needs.

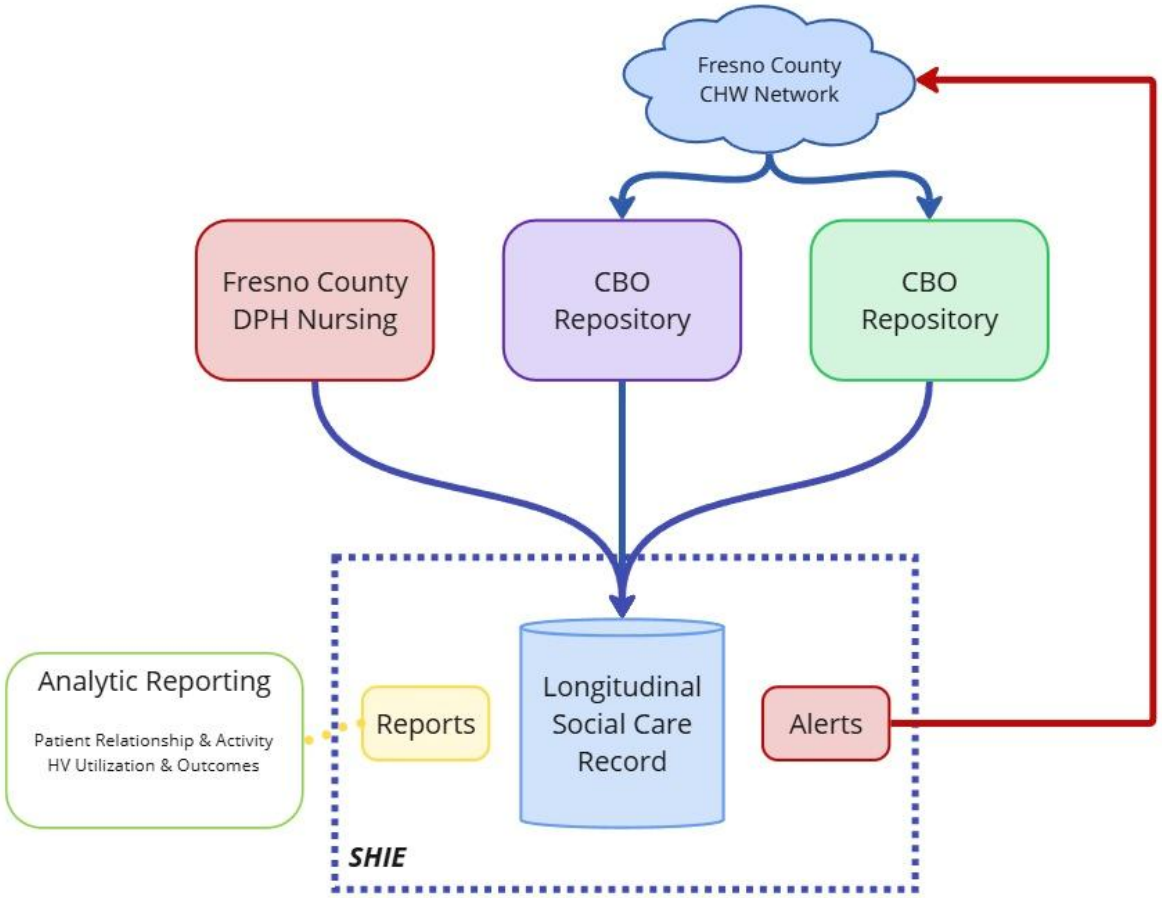
[1] https://www.cdph.ca.gov/Programs/CFH/DMCAH/CHVP/Pages/default.aspx

HOME VISITATION GOALS

- The Home Visitation pilot aims to improve the overall efficiency and impact of vital services in Fresno County.
- Pilot Scope:
  - Integrate data from 3 systems into a central repository (SHIE)
  - Provide a real-time, consolidated social record to home visitation workers in the field
- Initial partners will include Fresno County Department of Public Health, Fresno County CHW Network, Select CBOs and Fresno County Superintendent of Schools.

USE CASE: HOME VISITATION

- Initial scope will integrate data from 3 systems.
- Data will include:
  - Social needs & assessments
  - Demographics
  - Referrals
- Incoming records will be combined and consolidated into a single unified social care record.



HOME VISITATION GOALS

- The longitudinal social care record will enable:
  - Visibility into a client's care team creates opportunities for collaboration.
  - Reductions in service duplication
  - Streamlined client intake processes and community referrals.
- Analytics will enable the county to understand how families are served under county contracts.

LOOKING AHEAD

- Future Use Cases look to take advantage of the SHIE's centralized repository, which will improve the overall efficiency and impact of vital services in Fresno County.
- An up-to-date person-centric longitudinal social record is the foundation for the seamless delivery of new and novel data into case records, enriching available data with the potential to optimize service delivery.

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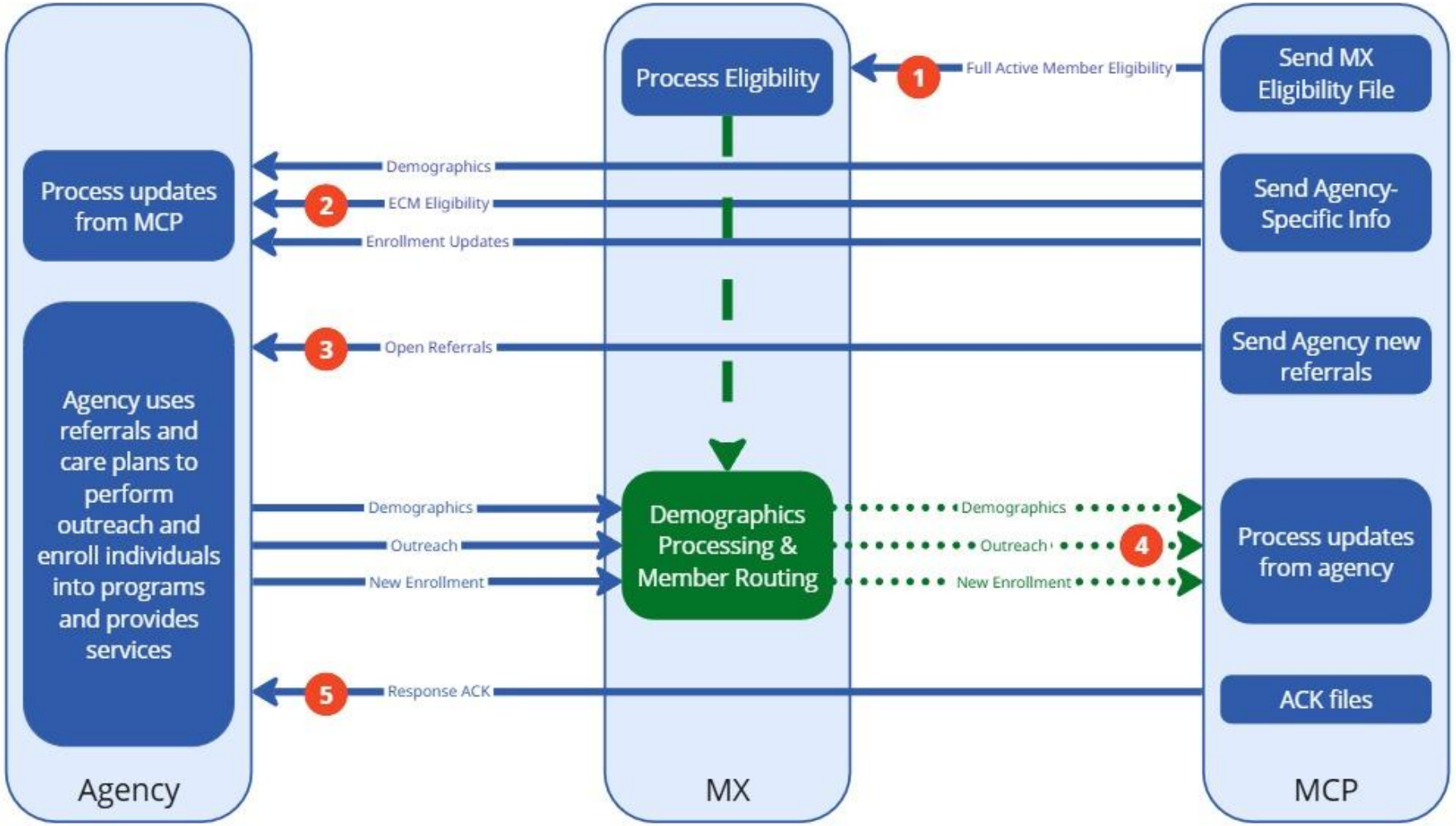
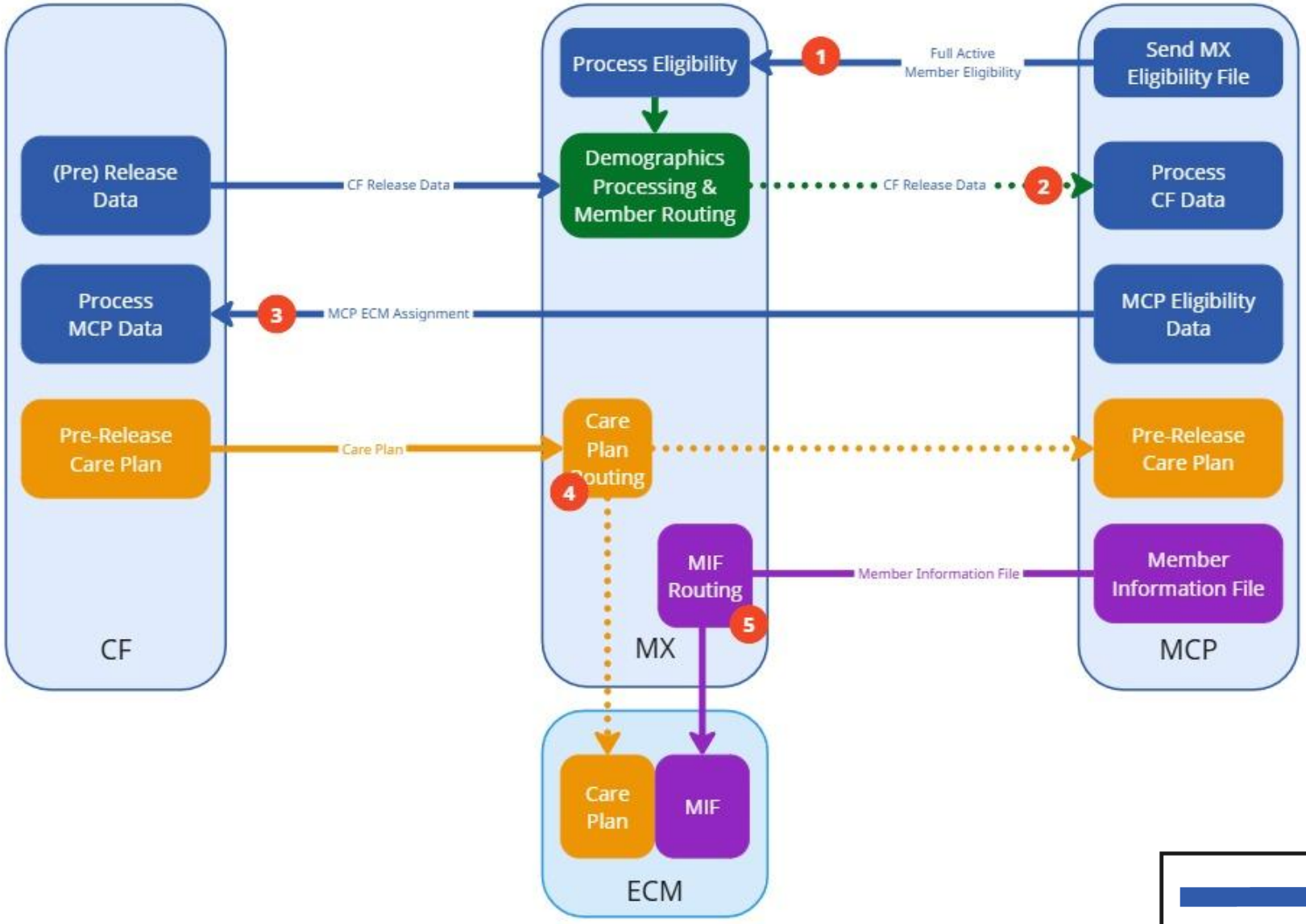
QUESTIONS?

REFERENCE

COUNTY AGENCY WORKFLOW



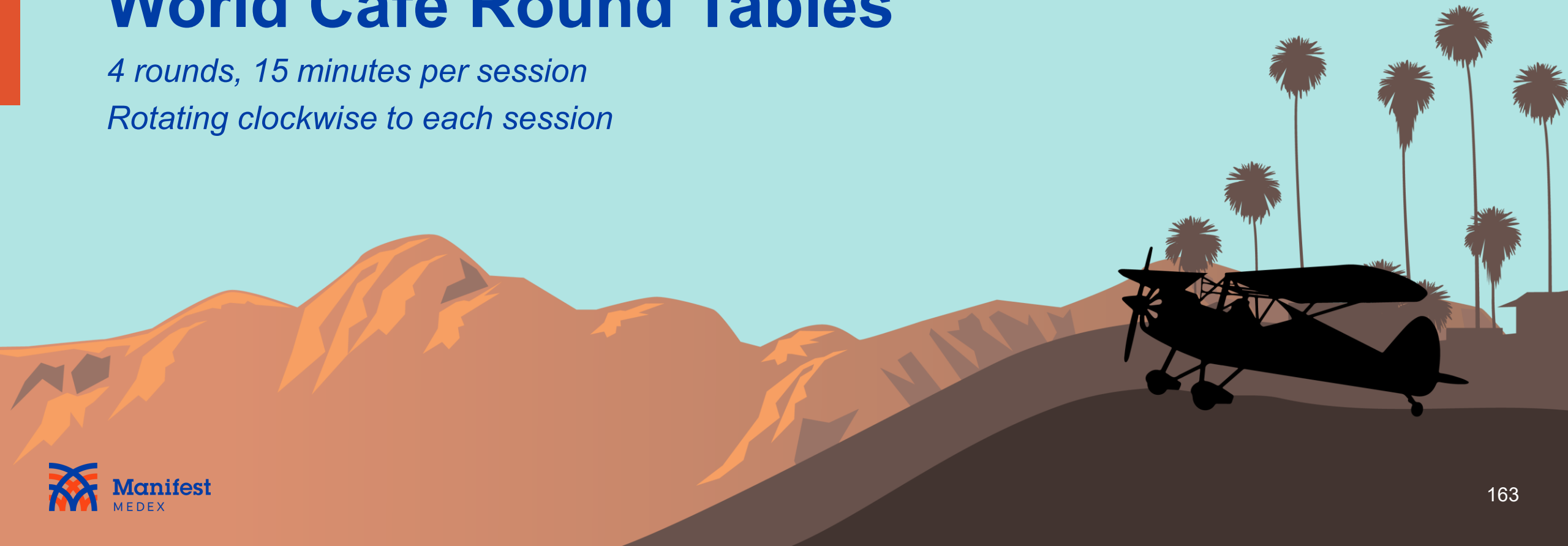
CORRECTIONAL HEALTH FLOW



World Café Round Tables

4 rounds, 15 minutes per session

Rotating clockwise to each session



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BEGIN AT YOUR DOT AND MOVE CLOCKWISE EVERY 15 MINS

Exchanging Behavioral Health and Part 2 Data

Location: Hangar 2 Patio

Jason Buckner
Chief Information Officer
Manifest MedEx

Ednann Naz, M.D., M.P.H, M.B.A
Executive Director, Central and Northern Regions
Manifest MedEx

Meeting Housing Needs with Data

Location: Back left of Hanger 2

Tim Polsinelli
Senior Director, Health Informatics
Manifest MedEx

Eva Williams, Ph.D.
Executive Director, Southern Inland
Manifest MedEx

DxF Listening Tour: We Want to Hear From You

Location: Hangar 2 Conference Room

Kia Gaines
Healthcare Management Consultant
Freed Associates

Michael Haynes
Healthcare Operations Senior Consultant
Freed Associates

Shanti Wilson
Vice President, Client Solutions
Freed Associates

Assessing Social Drivers of Health with Data

Location: Back right of Hanger 2

Brittany Weppler
Chief of Staff
Manifest MedEx

Leslie Goodyear-Moya
Senior Advisor, Strategic Initiatives
Manifest MedEx

Manifest MEDEX

World Café Round Tables

Report Out

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Break: **3:15 p.m. – 3:30 p.m.**

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UNITE US

A Conversation on AI and Data Interoperability: Shaping the Future of Health and Connectivity

Erica Galvez (moderator)
Chief Executive Officer
Manifest MedEx

Jason Buckner
Chief Information Officer
Manifest MedEx

Bill Howard
Strategic Consultant; past Board Chair, eHealth Exchange

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Mosaic Award Presentation

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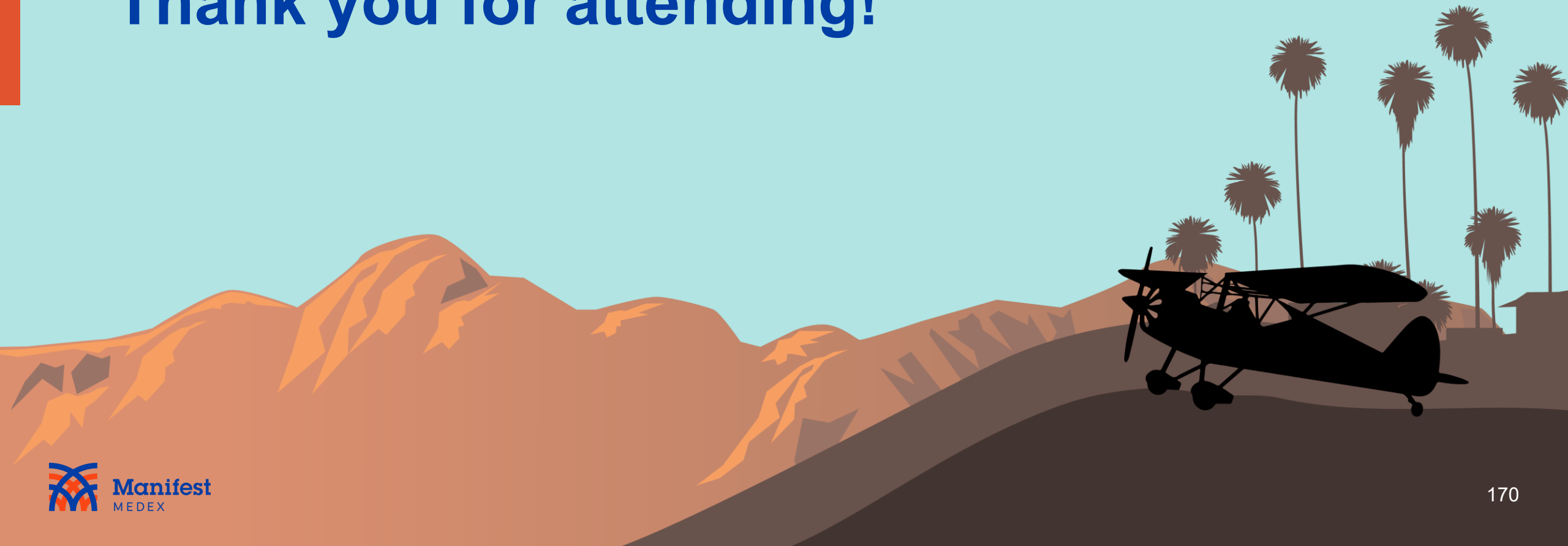
Mosaic Award Recipient

Dolores L. Green, MBA

Executive Director, Riverside County Medical Association
CEO, Inland Empire Foundation for Medical Care
CEO, Inland Empire Health Information Organization

Thank you for attending!



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Join us for our Cocktail Reception!

4:15 pm – 5:30 pm

Hangar 2 Patio

Manifest MEDEX

Evolution CA 2025: Southern Inland

Bridging Clinical, Claims, and Social Data to Accelerate Whole Community Care

September 9, 2025

Exchanging Behavioral Health and Part 2 Data

Location: Hangar 2 Patio

Jason Buckner
Chief Information Officer
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