Glossary of Terms for Collaborative Planning and Implementation (CPI)

Definitions Related to Population Health Management and CalAIM

Accountable Community for Health (ACH) *(see also* 'Community Care Hub/Multisector Collaborative'): An Accountable Community for Health (ACH) is a community-driven collaborative dedicated to making lasting and transformational change in the health of a community and forwarding the goal of health equity. ACHs provide residents and key partners from diverse sectors an infrastructure for working together to change systems, advance equity and build stronger, more cohesive communities prepared to address both existing and emerging health challenges over the long term. The ACH's key roles—elevating community voices, facilitating multi-sector dialogues and aligning organizations and systems—fuels powerful and sustainable changes that reflect the needs of the community.

California Accountable Communities for Health Initiative (CACHI): The California Accountable Communities for Health Initiative (CACHI) was established to lead efforts to modernize our health system and build a healthier California. CACHI aims to transform the health of entire communities, not just individual patients. By bringing together valuable community institutions—hospitals, public health, schools, public safety agencies, parks, and local businesses—along with residents, CACHI is creating a new vision for our health system: a health system capable of fundamentally changing health outcomes by aligning interventions for maximum impact, promoting prevention, and organizing resources to focus on the most effective strategies.

California Health Information Exchange (HIE) Systems: The Health Information Exchange (HIE) landscape in California consists primarily of two types of Health Information Organizations (HIOs):

- **Community**: Local or community-based initiative, supported by a number of unaffiliated health care organizations, often within a geographic medical service area
- **Enterprise**: Supported by a single hospital, health system, or integrated delivery network.

Like enterprises, community HIOs establish the policies for data sharing, as well as the access to the technology and services that moves data. More importantly perhaps, community HIOs also convene a diverse set of stakeholders to solve data sharing problems, and establish collaboration and trust among them.[4]

Community Supports: Community Supports are new services provided by Medi-Cal managed care plans as cost effective alternatives to traditional medical services or settings. Community Supports are designed to address social drivers of health. All Medi-Cal managed care plans are encouraged to offer as many of the 14 pre-approved Community Supports as possible and are available to eligible Medi-Cal members regardless of whether they qualify for Enhanced Care Management services.

Community Care Hub/Multisector Collaborative: A Community Care Hub (CCH) is a community-centered entity that organizes and supports a network of community-based organizations providing services to address health-related social needs. It centralizes administrative functions and operational infrastructure including, but not limited to, contracting with health care organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting. Examples of Community Care Hubs or Multisector Collaborations include Accountable Communities for Health (ACHs), Pathways Community HUB, Community Information Exchange, Wellness Collaborative, and Connected Community Network (CCN).

Department of Health Care Services (DHCS): The California Department of Health Care Services (DHCS) is the state agency charged with administering the Medicaid program for the federal government.

Enhanced Care Management: Enhanced Care Management (ECM) is the whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

Social Drivers [Determinants] of Health: Social drivers of health are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Systems Coordination: A desired goal of PATH CPI participants in Northern California counties who make up the local *Complex Care Ecosystem* in their area is to achieve systems coordination through community engagement supported by facilitator expertise and technical assistance.[1]

Definitions Related to Provision of Services

Care Coordination: Care coordination is the deliberate organization of consumer care activities between two or more providers, caregivers, or other individuals involved in a consumer's care, in order to facilitate the effective delivery of health and social care services.

Complex Care Coordination: A person-centered approach to address the needs of people who experience combinations of medical, behavioral health, and social challenges that result in extreme patterns of healthcare utilization and cost. (*Baseline definition for ECM Designation)

Complex Care Ecosystem: The local network of organizations from different sectors, fields, and professions that collaborate to serve individuals with complex health and social needs.

Consumer: A consumer is anyone who accesses and uses healthcare services. Consumers are sometimes referred to as patients, clients, or participants in other care settings.

Consumer Engagement: Consumer engagement is the act of empowering the consumer (i.e., the patient, client, or participant) to be an equal and active member of the care team.

Cross-Sector Collaboration: An alliance between organizations from two or more sectors with the intention to share responsibility for a project, product, process, or other activities. E.g., Care Coordination, Enhanced Care Management, or provision of Community Supports for consumers with complex health and social needs.

Cross-Sector Data Sharing: Individuals with complex health and social needs often cycle through various systems, including healthcare, social services, and criminal justice, without cross-sector communication or coordination. Cross-sector data sharing agreements allow for data from multiple systems to be combined in order to gain a broader understanding of the gaps that exist across systems and to pinpoint process improvements to create systems better able to serve people with complex health and social needs.

ECM Provider: ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM

Integrated Care: Integrated care most often refers to the integration of behavioral health into the primary care setting and vice-versa. Integrated care aims to better treat the whole person, reduce the stigma often associated with substance use and mental healthcare, and improve coordination of care for consumers. Integrated care can also more broadly refer to cross-disciplinary models that address behavioral and social needs of consumers alongside medical needs.[4]

Interdisciplinary Care Teams: Interdisciplinary care is an approach in which a diverse group of individuals works interdependently to effectively address multiple aspects of an individual's wellbeing. Members of a team may include, for example, educators, physicians, social workers, nurses, lawyers, occupational and physical therapists, psychologists, and pharmacists.

Lead Care Manager: A Member's designated care manager for ECM. The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

Person-Centered Care: An approach to care delivery that prioritizes the needs and goals of the individual and their family or support network.

Social Services: Social services are the delivery of items, resources, and/or services to address social drivers of health, including but not limited to housing, foster care, nutrition, access to food, transportation, employment, and other social needs.

Definitions Related to Data Systems and Sharing

Center for Data Insights and Innovation (CDii): CDii provides an infrastructure for data sharing that helps Californians access, use, and understand data from the CA Health & Human Services Agency (CalHHS). CDii works with state agencies and partners to develop products and services to improve data sharing and analysis.

Health Information Exchange (HIE): A system that electronically links medical records across healthcare systems and organizations. HIEs can give providers a more complete picture of consumers' medical history and healthcare utilization, facilitate coordination of care across multiple systems, and assist in population health monitoring and data gathering. HIEs must abide by the Health Insurance Portability and Accountability Act (HIPAA) and other laws that protect patient privacy.

Health Information Organization (HIO): A health information organization is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

Community Information Exchange (CIE): A CIE® is an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning. Care planning tools enable partners to integrate data from multiple sources and make bi-directional referrals to create a shared longitudinal record. By focusing on these core components, a CIE enables communities to shift away from a reactive approach to providing care toward proactive, holistic, person-centered care.

Data Sharing Agreement (DSA): The DSA is a mandated agreement between hospitals, physician organizations and medical groups, skilled nursing facilities, health plans and disability insurers, clinical laboratories, and acute psychiatric hospitals to share patient information safely. CalHHS and the California State Association of Counties encourage as many county health, public health, and social services providers to connect to the Data Exchange Framework—with all state and local public health agencies exchanging health information in real time with participating health care entities.

Data Exchange Framework (DxF): The data exchange framework is a statewide data sharing agreement that will accelerate and expand the exchange of health information among health care entities, government agencies, and social service programs beginning in 2024. It is not a new technology or centralized data repository;

instead, it's an agreement across health and human services systems and providers to share information safely.

Electronic Data Systems (EDS): EDS is the Medi-Cal Fiscal Intermediary responsible for processing claims submitted by Medi-Cal providers through a contract with the Department of Health Care Services (DHCS). EDS also provides a variety of support services to Medi-Cal providers.

Fee-for-Service (FFS): The traditional method of billing for health services under which a health care provider charges separately for each patient encounter or service rendered.

Qualified Health Information Organization (QHIO): a state-designated data exchange Intermediary that facilitates the exchange of Health and Social Services Information between Participants.

National Provider Identifier (NPI) —Unique national 10-digit provider identification number that is Health Insurance Portability and Accountability Act (HIPAA) compliant.

For more definitions related to data and the DxF: https://www.cdii.ca.gov/wp-content/uploads/2023/07/CalHHS-DxF-Glossary_Final_v1_7.12.23.pdf

References

1. Agency for Healthcare Research and Quality. (n.d.). *What is Integrated Behavioral Health?* The Academy. https://integrationacademy.ahrq.gov/about/integrated-behavioral-health
2. CACHI. (n.d.). *The Fundamentals*. California Accountable Communities for Health Initiative (CACHI). Retrieved July 25, 2023, from https://www.cachi.org/fundamentals
3. CAHIE. (n.d.). *HIE Landscape – California Association of Health Information Exchanges*. https://www.ca-hie.org/initiatives/hie-in-ca/
4. California Department of Health Care Services. (2023, January). *CRCS Instructions and Information*. https://www.dhcs.ca.gov/provgovpart/Documents/FY-2018-19-CRCS-Instructions.pdf
5. CDC. (2022). *Social Determinants of Health*. Centers for Disease Control and Prevention. https://www.cdc.gov/about/sdoh/index.html
6. Center for Data Insights and Innovation. (2022, November 15). *Data Exchange Framework*. Data Exchange Framework. https://www.cdii.ca.gov/committees-and-advisory-groups/data-exchange-framework/
7. Community Information Exchange. (n.d.). *What is CIE?* CIE San Diego. https://ciesandiego.org/what-is-cie/
8. Department of Health Care Services. (n.d.). *Enhanced Care Management and In Lieu of Services*. Www.dhcs.ca.gov. https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices
9. Department of Health Care Services. (2023). *LEA Program Glossary of Terms*. Ca.gov. https://www.dhcs.ca.gov/provgovpart/Pages/LEAGlossary.aspx
10. HealthIT.gov. (2020, July 24). *What is HIE? | healthit.gov*. Healthit.gov. https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie
11. HHS - OCR. (2008). *The HIPAA Privacy Rule and Electronic Health Information Exchange in a Networked Environment*. https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/healthit/introduction.pdf
12. Humowiecki M, Kuruna T, Sax R, Hawthorne M, Hamblin A, Turner S, Mate K, Sevin C, Cullen K. Blueprint for complex care: advancing the field of care for individuals with complex health and social needs. www.nationalcomplex.care/blueprint .
13. Kuluski, K., Ho, J. W., Hans, P. K., & Nelson, M. L. (2017). Community Care for People with Complex Care Needs: Bridging the Gap between Health and

Social Care. *International Journal of Integrated Care*, *17*(4). https://doi.org/10.5334/ijic.2944
14. Medi-Cal. (2021a). *Claims Follow-Up* . https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/modules/bb/workbook_claimfollow_bb.pdf
15. Medi-Cal. (2021b, December). *CIF Completion*. https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/cifco.pdf
16. National Academies of Sciences, E., Division, H. and M., Services, B. on H. C., & Health, C. on I. S. N. C. into the D. of H. C. to I. the N. (2019). A Workforce to Integrate Social Care into Health Care Delivery. In *www.ncbi.nlm.nih.gov*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK552605/
17. Partnership to Align Social Care. (n.d.). *Resources*. Partnership to Align Social Care. Retrieved July 25, 2023, from https://www.partnership2asc.org/resources/
18. Population Health Innovation Lab. (2023, May). *Improving Population Health Through Multisector Collaboration: Brief Series*. Population Health Innovation Lab. https://pophealthinnovationlab.org/aligning-brief-series/
19. The National Center for Complex Health and Social Needs. (2018). *Building Trust for Cross-Sector Data Collaboration*. National Center for Complex Health and Social Needs. https://camdenhealth.org/wp-content/uploads/2019/05/Building-Trust-for-Cross-Sector-Data-Collaboration-2.pdf