

# CalAIM Consent Management Pilot Webinar

November 2, 2022

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 1	Julian – 00:10	Hello and welcome. My name is Julian, and I'll be in the background answering any Zoom technical questions. If you experience difficulties during this session, please type your question into the Q&A field, which is located on the bottom Zoom panel at the bottom of your screen. We encourage you to submit written questions at any time using the Q&A. Finally, during today's event, live closed captioning will be available in English and Spanish. You can find the link in the chat field. With that, I'd like to introduce Dr. Linette Scott, Deputy Director and Chief Data Officer. Linette, you now have the floor.
Slide 2	Dr. Linette Scott – 00:44	Great. Thank you so much and welcome. It looks like, at last count, we understood that there were perhaps on the order of 600 people registered, and as I watched the ticker, there's over 280 going on 300 people that have logged in so far today, so welcome. As was mentioned, my name's Linette Scott. I'm the Deputy Director and Chief Data Officer in our Enterprise Data and Information Management Program at Health Care Services. I've been with the department for about 10 years, and working with probably many of you through the High Tech Act and various work around interoperability and data sharing here in California. We can go to the next slide.
Slide 3	Dr. Linette Scott – 01:28	Today, we're going to cover a variety of topics. For some of you, this may be new, for others, you may have been following along with us as we've been going through this process over the last many months. But we'll talk specifically about the authorization to share confidential Medi-Cal information, or the ASCMI form. We'll do a brief overview of that, and then we'll dive into the pilot design related to the use of that form and the concept around a consent management service. Then, we'll talk specifically about the request for information and the criteria that we're considering related to selecting pilots to use the form and to put it into a consent management service.

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Slides 3-4	Dr. Linette Scott – 02:13	Then finally, milestones, looking ahead and question and answer. As you can see, we're looking to leave a good chunk of time for question and answer. As we dive into this, just to cover a couple of logistics upfront, we will be sharing out the slide deck. We will also be making sure the form is posted on the public website, and so this information will be available. As many of you have probably been in the world of sharing data and supporting data exchange to provide services to our Medi-Cal members and to people throughout California, one of the things that we often talk about is the need to make sure that we have the appropriate consent from patients, from the people we take care of to share the data. There are some very specific types of data that absolutely under state and federal law require consent to be able to be shared.
Slide 5	Dr. Linette Scott – 03:10	What we are hoping to do with this program is to be able to learn and assess the best ways to address this need as we move forward in the context of our CalAIM program. CalAIM is California Advancing and Innovating Medi-Cal to transform and strengthen our Medi-Cal program, offering our Californians and our Medi-Cal members equitable, coordinated and person-centered approaches to their health and life trajectories. As part of this, we have a number of different programs that are providing support services.
Slide 5	Dr. Linette Scott – 03:44	One in particular is our enhanced care management program that are providing services to individuals with many needs for both their health and social support requirements in order to obtain a healthy and well-being that we're trying to help them achieve. In order to support that, we need to share data across different types of providers that are providing those services. Under CalAIM, one of the key components is appropriate data sharing both securely and in accordance with both federal and state law. We go to the next slide.

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 6	Dr. Linette Scott – 04:21	<p>In order to support this process, there are a number of things that the department has done to help support our provider's plans and others that are working with our members and our beneficiaries to support appropriate data sharing. In March of '22, we released the CalAIM data sharing authorization guidance to help provide that support, and we also provided a repository of sample data sharing forms and agreements that are in use by counties and health plans to exchange data. Out of that work, we moved into this idea of having a universal form, which we are calling the ASCMI form in terms of being a model that can be used for data sharing and could potentially be adopted on a broader scale to support consent for data sharing as part of our program across CalAIM and across the Medi-Cal program. This webinar is to talk about our goals around having a pilot and the request for information that we're using to request support in that process. Going to the next slide.</p>
Slide 7	Dr. Linette Scott – 05:33	<p>To provide a brief overview of the form itself, and again, this will be posted, we do not expect you to read the small image that you see there, but highlighting some key components of the form. As part of signing the form, we are clear as to the purposes that the data can be used for when it is shared under consent with this form. Providing the individual with services and those that are providing those services, the ability to support, coordinate, and improve those services that are being provided. As I mentioned, there's a lot of words on these slides. We're not going to read through all of them, they will be available, but we want to give you a high level context of both the content of the form, which again, built off of what many of you are using in your program areas across our counties and our plans to be able to put this together. Going to the next slide.</p>

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 8	Dr. Linette Scott – 06:36	Again, key components of the form include the purpose, the types of information that are being authorized to share the sources, so who is going to receive your information and where is it coming from, expiration revocation or changes to the form, which means changes to your consent in terms of data sharing, the rights of the individuals who are signing it, and then what data can be shared confidentially without specific consent, and finally, the authorization or the signature aspect of it. Going to the next slide.
Slide 9	Dr. Linette Scott – 07:11	Again, the types of information that we are having authorized to be shared by using this form includes protective health information, mental health information, excluding psychotherapy notes, substance use disorder information, individualized education programs, eligibility and enrollment information, housing and homeless information, and very limited criminal justice information. We do want to highlight that the substance use disorder information is only then shared by having the specific box checked related to that information that is protected under the 42 CFR confidentiality regulations for federal substance use data and services provided thereunder. Again, highlighting those components. Going to the next slide.
Slide 10	Dr. Linette Scott – 08:05	In terms of where the data is coming from and to, sources and recipients of the information, healthcare providers, managed care plans, certain community-based organizations, school-based providers, state health agencies, county agencies, providers and case managers at correctional facilities, these are the providers that are providing services and for those that are providing direct services, then data can be shared among them. This does not, again, highlighting this last item, this does not consent data related to jails, prisons, and youth correctional facilities, does not consent the use of that information with respect to criminal investigations or prosecutions, sentencing, parole or probation monitoring, immigration enforcement or family court proceedings. We are trying to be very specific about what it does not include as well as what it does include. Going to the next slide.

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 12	Dr. Linette Scott – 09:05	<p>This takes us to the pilot. As we've been thinking about this pilot, we are planning for this to occur primarily January through June of this coming year, 2023. The idea around piloting this form is to understand what are the complexities in terms of using this form, what would we need to consider to have a broader rollout and how do we incorporate that into planning for those purposes? Some of the areas in particular, understanding market adoption. The idea around a user base and how the information is collected and used on the form. Does the form work? Does the form have challenges? What are the challenges you have in using this particular form? Again, we've had a great deal of stakeholder feedback in developing it, but that's not the same as testing it. We want to understand and hear how that goes.</p>
Slide 12	Dr. Linette Scott – 10:11	<p>A second key component of this is around care coordination. Care coordination is really the driving factor and as I mentioned in particular around our population that are receiving enhanced care management and community supports, we know that this population and these teams in particular have had challenges, questions and concerns around data sharing, and the goal of this form is to help support that. Some of you have already worked on this and we look forward to hearing further input in that process, so specifically looking at care coordination and for those that participate in the pilot, we want to make sure that we have inclusion of beneficiaries or members as well as providers that are specifically working around enhanced care management and community supports, as well as with our behavioral health systems, recognizing that these are two of the areas that folks have raised concerns and questions.</p>

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 12	Dr. Linette Scott – 11:09	<p>Then, the third piece is around infrastructure. What does it mean to have a centralized consent management service? How does that work? Is it useful? What are the things that we need to think about? What kinds of gaps or technical assistance would need to be addressed if we were to move towards having a centralized consent management service? What does that mean as we think about it across different parts of the California state geography around particular health information exchange or community information exchange organizations? How would this work as we roll out and we think about this more broadly? These are the three key areas of information that we are hoping to learn from this pilot. For those that participate, we'll be asking you to help us understand these areas. Going to the next slide.</p>
Slide 13	Dr. Linette Scott – 12:07	<p>In terms of, again, overarching long-term goals beyond the pilot, initially, we're focused on using the pilot and learning from it, but longer term, can we use this form for all of our Medi-Cal beneficiaries? Can this be used more broadly and support Medi-Cal services across the organization and across our populations? What is the infrastructure that we need to support providers, plans, counties and other organizations that need to know what an individual has consented for to be shared and with whom? Then, another aspect is in the context of our population health management service and our population health management program, how can we leverage consent management services in that context as well recognizing that that will be an important part of that activity? Going to the next slide.</p>
Slide 14	Dr. Linette Scott – 13:09	<p>An apology, the last piece on that, that previous slide was again, this also supports the data exchange framework that our colleagues at the Center for Data Insight and Innovation have been leading over the past year. So excited to see how this can help inform their process as well. In terms of the pilot design, the base model, the idea is that we have service providers, so county behavioral health, enhanced care management, community supports, primary care hospitals and others that may need to provide information about a member and they may need to receive and obtain that consent.</p>

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 14	Dr. Linette Scott – 13:51	<p>A second part is then, where is this consent form stored and is there a way to have that shared? We know, again, many of you have already been doing work in this space and have fantastic lessons learned to share, and we hope that some of you'll consider being part of this pilot. With the idea being that that consent, while obtained in one location, can be shared across the different team members that are providing services to the Medi-Cal member and that it can be shared electronically in a seamless way, recognizing that there are many team members that provide support to our Medi-Cal members. Going to the next slide.</p>
Slide 15	Dr. Linette Scott – 14:33	<p>As we've thought about this pilot, we're looking for there to be a primary respondent to the request for information that would be a lead agency and we expect that that will be a health information exchange or community information exchange that's based in California and is open to participation by any healthcare enterprise that serves Medi-Cal patients regardless of their business affiliation or health IT vendors. That would be the primary respondent. We then are looking for the primary respondent to have agreements and subcontracts as appropriate with the providers that they will be moving data for. County agencies and providers, again, we specifically are looking to see behavioral health represented and also looking to see in particular primary care providers and providers that are supporting enhanced care management and community supports with data exchange, moving through these health information exchange or community information exchanges to support the delivery of services. Going to the next slide.</p>

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 16	Dr. Linette Scott – 15:41	In terms of our design, again, outcomes that we're looking for. We're hoping to improve the ability of care managers to effectively identify and coordinate the right services at the right time. Treating people holistically is a key underpinning of our initiatives through the CalAIM initiatives and CalAIM program. We want to empower members to control how their information is shared and help them understand what it means to share data about their services and how that helps them improve their outcomes. A key component of the pilot will include education for members as they sign this document. We also are looking to standardize processes around obtaining consent, recognizing that one of the challenges right now is that often people are providing consent across or for different organizations and the forms may vary, the instructions may vary and it can be very confusing understanding what you've provided consent for.
Slide 16	Dr. Linette Scott – 16:47	Standardizing this process will help our beneficiaries and our members by simplifying and keeping the messaging more consistent, and that's one of the things we want to learn from the pilot as well. We also are looking to help address and overcome some of the interoperability challenges that we have specifically talked about for years and decades related to sharing data specifically around the 42 CFR Part 2 data associated with substance use disorder services. Then, how do we also streamline our investments across the data sharing infrastructure, so recognizing this is an issue that many people are working on. Going to the next slide.
Slide 17	Dr. Linette Scott – 17:32	Again, basic features in terms of talking about the participants. Key participants, again, DHCS would be overseeing this program and distributing the funds. We'll look to an HIE/CIE being the primary and be the lead around establishing and operating a consent management service. Then, they will be collaborating with county's plans and other providers to help provide these services and provide the consent. Going to the next slide.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 18	Dr. Linette Scott – 18:04	<p>In terms of funding, we are estimating about up to \$300,000 per pilot, and we're looking to do three pilots, where the funding can be used for a number of different things depending on each pilot team's readiness and maturity. The CIE/HIE may use this to help build and operate the consent management service, provide technical assistance and support to county agencies, plans and providers. The county may end up, so the CIE/HIE may be able to share money with the county, again, to implement and train in terms of using both the form and also using the service in terms of the consent management service similarly with the managed care plans and then also with the service providers and understanding that some providers may need assistance in terms of connecting to the health information exchange or the community information exchange redesigning workflow to incorporate the form or providing education directly to members. The funding can be used for any of these things and when you respond to the request for information, we'd ask you to give us a high-level perspective in terms of how you would be doing that. Going to the next slide.</p>
Slide 19	Dr. Linette Scott – 19:20	<p>Roles and responsibilities. DHCS will, as we discussed, be issuing the contracts and grant funding providing program management oversight and technical assistance. The HIE/CIE is the lead entity in applying for the pilot, and will build and operate the consent service, consent management service, and then collaborate with the other team members to support this pilot and this process. The HIE/CIE will be responsible for submitting periodic implementation outcome reports, as well as providing training on the use of the service. Then, the other participants, counties, managed care plans and service providers would be doing similar things, providing training, using the service, and then also providing information back to the HIE/CIE, so that they can provide reports back to DHCS. Going to the next slide.</p>

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 21	Dr. Linette Scott – 20:20	Okay. Moving to this next topic area, the RFI and selection process. We expect to release the request for information later this week or the latest early next week, and we'll talk about that a little bit more. It's just about ready to be released. This is a program that does not require specific federal approval, so it is a state-funded program. In terms of the pilot site form, each pilot site will be a collaborative consisting of the HIE/CIE as the primary respondent and then looking for them to be able to identify who they will be working with at the county managed care plan and provider levels. Next slide.
Slide 22	Dr. Linette Scott – 21:08	In terms of the selection process, the HIE/CIE will submit an RFI response to DHCS for review and we will be looking at these components, so documentation qualifications at a station of collaboration agreements with the county managed care plans, proposed approach for building this consent management service, a preliminary timeline and work plan, and a non-binding budgetary pricing. Based on your RFI responses, we would select up to three pilots and then execute contracts and grant agreements based on that. Going to the next slide.
Slide 23	Dr. Linette Scott – 21:50	Again, as we move forward then with this, the HIE/CIEs will need to, as they move forward, those that are chosen will need to establish a data sharing agreement with the county managed care plan and other participants. This can be accomplished by all parties signing the CalHHS data sharing agreement, or you can use other agreements that you may already have in place such as the CalDURSA or an agreement that you already have. If you don't have a data sharing agreement yet, we would certainly suggest that it would be advantageous to move forward with the CalHHS data sharing agreement. But again, that's not necessarily required for the pilot. Going to the next slide.

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 24	Dr. Linette Scott – 22:37	In terms of the qualification criteria, what we'll be looking at as we review the RFI responses. With respect to the HIE/CIE, as we mentioned, we expect that to be a California-based HIE/CIE that is open to participation by any of the healthcare enterprises that serve Medi-Cal patients regardless of business affiliations or health IT vendors. We expect that the HIE/CIE will be a signatory to the California Health and Human Services data sharing agreement and that the organization is financially viable and sustainable to launch the pilots using the funding that would be provided.
Slide 24	Dr. Linette Scott – 23:18	In terms of technical capabilities, we'll obviously need to agree to develop a consent management service since that is what the pilot is, that you have the IT infrastructure to build and operate that service and to safeguard sensitive information in accordance with the 42 CFR Part 2 data, and also with all applicable state and federal laws that the organization has the technical workforce expertise to build and operate the service and that the organization has the ability and is committed to providing the technical assistance to county plans and providers. We know that's going to be a key component. Going to the next slide.
Slide 25	Dr. Linette Scott – 23:59	Things that we'll be looking for in terms of the counties and the managed care plans that that HIE/CIE is working with. Again, at the county level, assurance that the local authority requirements will be met for use of the form. Depending on the county, there may be other entities that need to provide approval, and so we would look for assurance that that will occur. We'd like to see each pilot have at least one county provider, including specialty mental health services and Drug Medi-Cal Organized Delivery System that will use the form and demonstrate that it is supported by their providers and their patients. The county will need to have the capacity to provide training and technical assistance, again, to the providers that use this form.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 25	Dr. Linette Scott – 24:48	<p>Similarly, for the managed care plan, we'd like to make sure at least one enhanced care management, community supports and our other contracted provider related to primary care is committed to using the form as their data sharing authorization consent form, and that the plan has the capacity to provide training and technical assistance. One of the questions that we received in developing this was, do all of my patients have to use this form? The answer is no. If you already have data sharing in place for some of your patients, you don't necessarily have to change that. But as you have new patients coming on board, we would ask you to use the form and then be able to provide the feedback that we're looking for in terms of the success or changes that need to occur to make that form viable. Again, it's not an all or nothing, but we do want this much use at a minimum to occur. Let's see. All right, and going to the next slide.</p>
Slide 27	Dr. Linette Scott – 25:51	<p>Again, in terms of the milestones and looking ahead. Going to the next slide. We have three milestones in terms of this pilot. The first milestone would be in January, when the pilots are selected and the contracts are executed. The second milestone would be in April, where the pilot launches related to the use of the form and the consent management service. The third milestone is when the pilot completes and the report is submitted to DHCS. This would be an evaluation report that would tell us how it went, what are the things that worked, what didn't work, what are gaps, what's the other information that we need to know. All funds will be dispersed within fiscal year '22-'23. By June 2023, each milestone will include a payment to the pilot sites. The dollar value is still being determined and will depend on the number of pilot sites and some of the information that's submitted related to the estimated budgets. Payments will be frontloaded with milestone one, so that there is initial implementation funding available. Going to the next slide.</p>

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 28	Dr. Linette Scott – 27:06	<p>Again, in terms of selecting pilots, pilots will be asked to submit detailed implementation plans, those that are selected, and that will need to include a final budget and work plan for building the consent management service and establishing interfaces with EHR systems, as well as providing training and technical assistance. Again, we know that many of you may already be using a consent management process or may have a consent management service, in which case you may be able to incorporate this form into that to provide the testing and the pilot and the use of this during the pilot. All of those things will be considered and are options. For the counties and the managed care plans, again, the HIE/CIE will be responsible for submitting this, but we'll be looking for final implementation plans for piloting the form with the provider networks, as well as providing technical assistance for providers that will be actually obtaining signatures from members. Going to the next slide.</p>
Slide 29	Dr. Linette Scott – 28:14	<p>For milestone two, this is the launching of the ASCMI form and consent management service. Requirements for the HIE/CIE, we would look to have a demonstrated ability to upload the form signatures, collecting those signatures, demonstrating the ability for members to consent and to access that consent for data sharing as part of your query response poll mechanisms. As you share data, make sure you're using the consent information to guide whether data is shared or not through the HIE/CIE. Demonstrated ability to modify a member's consent, so if somebody does change their mind and wants to update what they are consenting for, showing that that can be done, and documentation of trainings and technical assistance on the use of the service.</p>

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 29	Dr. Linette Scott – 29:04	<p>For the counties and managed care plans, again, similarly, documentation of training and technical assistance provided to service providers at a station of the readiness to launch the form demonstrating or documenting that the consent management service is connected to EHRs when possible. We know this is not always possible, and then in some cases, the consent management service may provide the consent form through a portal, so that service providers can upload, amend, inquiry a member's consent either through the EHR or through a separate portal that is hosted by the HIE/CIE. Again, demonstrating that members can amend inquiry their consent in real time. The requirements for the counties and managed care plans would be reported to the HIE/CIEs, and then the HIE/CIEs would be submitting that to DHCS. Going to the next slide.</p>
Slide 30	Dr. Linette Scott – 30:02	<p>Milestone three. Pilot completes initial, and this would be the initial evaluation report. I realize it says initial evaluation report, it's also the final evaluation report. At the end of the pilot, we would look for the HIE/CIE to submit an evaluation report. We will develop a template to support that, so that will be coming in 2023, but it will capture the same kinds of things we've been talking about throughout this presentation. Counties and managed care plans will need to provide the data required for that reporting to the HIE/CIE, so that they can provide that information onto DHCS. Examples of things that we might be asking, How many members used the form? What percentage of enrollees asked to sign the form? So these are some of the measures that we might consider and again, we'll look forward to having further conversation and input around some of the exact evaluation components, and those will become available then in 2023. Okay. The slides went the wrong way.</p>

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 31	Dr. Linette Scott – 31:16	All right. Again, high-level timeline. For the past several months, we've been defining the pilot scope and selection criteria. We've been working with a stakeholder group to help provide feedback. We're now at the point of identifying pilot participants over the next couple of months. Again, we will be posting all of this information. The request for information is going to include the same information that is in the slide deck and this will be available. This is when we would look to you to think about whether you want to participate or not, and if so, for the HIE/CIEs to work with those counties and plans and providers in their networks or their service areas to be able to participate. Then again, January through March, preparing for implementation, April to June, launching and monitoring. We are at this point now of being able to post and then receive the RFI responses.
Slide 31	Dr. Linette Scott – 32:19	At the end of this webinar, we will have a post webinar survey. We have asked a few questions regarding who you are, those of you that participated today, as well as some high-level information. One question being, do you think you might participate in the pilot? We will use this as a way to help send out the link for the RFI when it is officially posted. We'll thank you in advance for any information you provide there. Next slide.
Slide 32	Dr. Linette Scott – 32:51	Okay, so we're to the Q&A, and so we have a good amount of time for that. One of the questions I think that may have already come in was related to whether this pilot could then expand even broader than Medi-Cal. I'm going to not actually answer that question because I think that's looking at it a little bit too far. Certainly, at this point in time for the Medi-Cal population and in particular for our enhanced care management and convening supports, that's an area of focus for us right now.

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 32	Dr. Linette Scott – 33:28	Based on what we learned from the pilot, we will use that information to make decisions in terms of next steps. But certainly, we know that in the context of the data exchange framework, this has also been a key area of conversation and we are working closely with our partners, John Ohanian and his team at CDII in terms of making sure we're sharing lessons learned and being able to coordinate on this and that we are able to share that information and inform in both directions, both to the data exchange framework as well as to the Medi-Cal program. All right. I think we're open to additional questions.
Slide 32	Zoe Barnard – 34:11	Linette, we have a couple of questions about EHRs and EMRs. One person asked whether EHR vendors are eligible to pilot for our customers and counties we interop with. Another person said, we are a provider organization that implements EMR and other IT consulting services, wanting to know would we only be eligible if an HIE county and us responded to the RFI or could we partner with an HIE and be eligible to apply if we had agreements with one or more counties?
Slide 32	Dr. Linette Scott – 34:45	Great, thank you Zoe. We are looking at this as a structure where an HIE/CIE is the lead. I realized the definition around what is an HIE/CIE is not super-specific, we kept it pretty high-level, but again, the key is that we have that organization that would provide the service and then that service is going to be shared with managed care plans with county behavioral health and then that is used with providers who are delivering services.

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Slide 32	Dr. Linette Scott – 35:19	It's a matter of having all of those touchpoints, and then if you have a very specific question, we can certainly follow-up separately, but those are the key components of the pilot that we're looking at, because those are the areas we've heard challenges. Again, the key thing here is how can we address the challenges that we know exist, in particular, around sharing across these different kinds of organizations that are providing services dealing with consent that is perhaps more challenging, in particular around the 42 CFR Part 2, the related substance use disorder treatment. We really want to address the challenges. In your proposal, those are things that we're going to be looking for in order to maximize the lessons learned from this pilot.
Slide 32	Zoe Barnard – 36:18	Thank you. We had a follow-up for that question. If counties are already contracted with an HIE or HIO, how will it be envisioned that all of this will work together, if at all?
Slide 32	Dr. Linette Scott – 36:33	Actually, that's ideal, that the county is already contracted with an HIO. That puts that team, I think, in an ideal situation to then look at using this form, using a consent management service and testing it out. Ideally, there's going to be probably several sets of organizations or teams, and I'm using team to describe that HIE/CIE county behavioral health, managed care plan and their associated providers that would be able to do this. As you can tell, based on our timeline, this is a pretty quick pilot. If you're starting completely from scratch, you probably don't have enough time unless you're really inspired and you have a really inspired team. If you already have agreements, if you already have contracts, that is wonderful. Again, that's why in the slide deck and in the RFI, we talked about the fact that if you already have a data sharing agreement, you don't have to change that. If you don't already have a data sharing agreement, we would strongly encourage the use of the agency data exchange framework data sharing agreement because many providers and entities will need to be signing that by January of 2023 anyway. Great.

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Slide 32	Zoe Barnard – 37:55	Linette, one person said thank you for the presentation. Is there a concept of the PHM service being the repository for the consent management form? In other words, do we have or do you have a presentation format or a PHM service format that you have in mind?
Slide 32	Dr. Linette Scott – 38:15	We know that for the population health management service as it matures over time, understanding consent around data sharing will be important in that context, but we do not have a specific approach in terms of how that will work in terms of a consent management service that could perhaps be broader than the population health management service or one that's used by the population health management service. We do look to the pilots to help inform and support some of those questions and considerations, but we don't have answers yet. It's part of the goal of the pilot.
Slide 32	Zoe Barnard – 38:58	How do you see the ASCMI form fitting in with the current BAAs, an established privacy practice notifications that CBOs and hospitals have with MCPs regarding release of protected health information?
Slide 32	Dr. Linette Scott – 39:10	That's a pretty complex question.
Slide 32	Zoe Barnard – 39:17	That's a lot. That's an extensive question.
Slide 32	Dr. Linette Scott – 39:21	That's a good question, yeah. I'm going to go back to the piece where, again, to the extent that you already have your data sharing agreements, your business associate agreements, that covers you organizationally for sharing. As is described in the form itself, there is information that can be shared without consent, and so this form specifically addresses when consent is needed. Your business associate agreements, even if you have a business associate agreement, if there's specific information that needs consent, you still have to do that. The idea would be that you would use this form to help capture that consent and then be able to incorporate that into your workflow around how you share data to make sure that that data that does require consent has consent for sharing, and then can support the delivery of services.

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Slide 32	Zoe Barnard – 40:22	Now, we have a specific question for you, Linette. In Alameda, the HIE uses DocuSign as an option for consumers to execute a consent. Is DocuSign an acceptable tool to use with this pilot?
Slide 32	Dr. Linette Scott – 40:39	I'm going to answer and not answer the question. DocuSign is a wonderful tool for signing documents. Many of us have used it for loan agreements, bank agreements, other kinds of things when we all went to virtual in the context of COVID. In terms of how you capture the signature from the patient, the member, the beneficiary, how you capture the signature on the form is something that we're looking for the pilot to work with. The signature is just one piece of it. The other part of it is how do you understand that, again, that consent management service sharing, the fact that the form has been signed and consent has been delivered. Certainly, DocuSign could be a way of doing an electronic signature. There's also other ways. We would look to the pilots help inform that and share what works well and what doesn't work well. Thank you for the question.
Slide 32	Zoe Barnard – 41:41	Regarding the percentage of ECM enrollees asked to sign the ASCMI, is verbal consent acceptable? Does DHCS expect participating ECM providers to ask currently enrolled ECM members to re-consent or only newly enrolled ECM members?
Slide 32	Dr. Linette Scott – 42:00	I'm going to go backwards through that question. As I mentioned earlier, if you have somebody, if you already have an ECM participant that has already consented, you do not need to have them re-consent. It is perfectly okay to use the form to support new consents that you're receiving. We know people are enrolling into ECM on an ongoing basis to receive those services, and so it is perfectly acceptable to use it just for your new members as they come on board as opposed to having somebody re-consent. I'm going on reverse there.

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VISUAL	SPEAKER – TIME	AUDIO
Slide 32	Dr. Linette Scott – 42:41	In terms of how you receive the consent, whether verbal or written or electronic signature, I'm going to defer on that at the moment unless any of my friends behind the scenes want to jump in. Standard consent process that you use now for things that need a written signature consent versus verbal consent depending on the information is going to apply. Again, we're not changing federal or state statute, we're using a particular form to help document the consent as needed. Then, in particular, making the fact that the consent has been obtained available across all of the providers on the team taking care of that person, so that they don't have to sign a separate consent for each of their 10 different providers.
Slide 32	Zoe Barnard – 43:34	Going along with that theme, we have a couple of behavioral health questions. The first one is behavioral health substance use/42 CFR consent expected to be supported by the form and the consent management service or other privacy or consent laws outside of HIPAA.
Slide 32 (return to Slide 9)	Dr. Linette Scott – 43:55	Again, the form, we will have the form posted, so that you'll be able to review it in detail. But yes, the intention is that this form will support the 42 CFR. Actually, if we want to go back to, why don't we go ahead and just pull up one of those earlier slides because we spoke to that specifically on slide nine. Maybe if we just go back to slide nine. Again, we address this in specific ways. In particular, with respect to the federal substance use confidentiality regulations, the 42 CFR Part 2. This is currently structured as a two-page form. Obviously, when you make it electronic it will flow in different kinds of ways, but the step 7 includes the authorization that says by signing this form, I authorize certain organization/individuals to use and share my health and other confidential information for purposes described in part one, and if I voluntarily include my phone number, I consent to the receipt of text and calls.

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Slide 9	Dr. Linette Scott – 45:10	Then, there's this specific checkbox that folks will need to check in order to then share the substance use confidentiality regulations or substance use data. We had a lot of conversation about that and our feeling was really to be compliant with that. We needed members to take an active action of checking the box to agree that they are consenting to that information being shared.
Slide 9	Zoe Barnard – 45:36	Another behavioral health question. Is this limited to ECM & CS or would other elements of CalAIM such as No Wrong Door apply as well?
Slide 9	Dr. Linette Scott – 45:47	While we have highlighted ECM & CS as a specific area we want to test this in, this absolutely would apply across all of our CalAIM programs, including the No Wrong Door, and that could be done for the pilot as well.
Slide 9	Zoe Barnard – 46:07	One of our folks asked, is it expected that there will be no hard copies of the current consent and this will all be electronic?
Slide 9	Dr. Linette Scott – 46:18	The intent is that it will be electronic in terms of being able to make the information available. The idea around a consent management service is that that service that allows for different providers to interact and check it, whether it's through a portal or whether it's through integration with their electronic health record or some other similar mechanism. We do not expect paper to be traveling around as part of this, so the consent management service is specifically looking at an electronic process. That being said, when people go to implement the signature process itself, when the provider's office is working with the patient beneficiary member to obtain the signature, they may find that it's easier to provide information, have the conversation, obtain the signature using paper, and then that gets turned into an electronic format, so that the result of the signature, the result of the consent is shared electronically.

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Slide 9	Dr. Linette Scott – 47:26	We would like to find out and learn what works well. Again, understanding that a key part of this is the education piece associated with providing consent and what are providers doing to provide that education, whether it's the provider or the plan or the county, depending on where that consent is obtained from the beneficiary, what works well, what do people understand and what are the differences in different type of people and what their experiences. We certainly know that some folks much prefer electronically on an iPhone or a cellphone of some sort. Other people, you go to the restaurant, how many people say, "No, give me the piece of paper. I want to see my menu on paper," and the others are like, "I'll scan the Q code." That's something we want you to learn from in the pilot and provide information. Does it help to have it both ways? That would be a great thing to learn.
Slide 9	Zoe Barnard – 48:27	Here's one that I'm going to broaden slightly from the question. The question is, should the health plans make the decision about participating in the pilot as opposed to the providers? I'm going to ask you to speak to the collaboration and how an HIE, MCP and county would choose to participate together.
Slide 9	Dr. Linette Scott – 48:48	Thank you and appreciate the broadening. Certainly, this is a collaboration. Providing services is a team effort and is a collaboration effort from every single part of the way. We document that collaboration with things like contracts and formal agreements. Certainly, there's an aspect of accountability that's driven through that process with contracts and agreements. That being said, when we create a care team to take care of an individual, there's a lot of collaboration between those different providers that are providing those services. As we think about this, it probably will not work well if a plan says we commit and they haven't talked to their providers that they expect to participate.

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Slide 9	Dr. Linette Scott – 49:41	Again, depending on your relationship and the entities that are involved, you all will know your relationships and how they work, but we would hope and we would suspect that the most successful effort will be when people have the ability to agree upfront, which is one of the things we know about consent as well. People are often willing to have data shared as long as they know that it's going to be shared. This was one of the lessons learned from another consent pilot we did back in 2013, 2014 time period. Again, same thing goes for the people that you expect to participate in the pilot from a provider and a plan perspective.
Slide 9	Zoe Barnard – 50:26	Linette, if the organization's authorization or consent form is broader than the ASCMI form, can the ASCMI form be modified to allow an individual to include more personal info?
Slide 9	Dr. Linette Scott – 50:39	Really good question. I think the thing I would say is, our goal is to have a single form that we can use broadly, partly because every time we do that one off and that variation, it then limits to that particular scope that it's used. For example, if somebody signs a consent form in Southern California, they come up to Tahoe to go skiing, they get injured, they need to have care, they need data shared. If we are using a different consent form in Southern California to Northern California, that may end up being a blockade for having data moving, so the idea is to have a single form.
Slide 9	Dr. Linette Scott – 51:28	What we will want to hear from you is if you find that when you go to implement this, you're getting pushback or that there's limitations or that there's things that you think that, "Well, we've been using this, we tried to use your form and it had challenges for reasons A, B, and C." That's exactly what we want to hear both throughout the pilot and in particular in the final report that gets submitted, and then that will inform us as to whether we need to make changes to this form before it rolls out more broadly. That's the reason this is a pilot. As part of the pilot, we would expect the form to be implemented as it is, but a key thing that we want to learn from you is if there are specific things that need to happen to make the form more successful.

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 9	Zoe Barnard – 52:16	Just to say, there are a lot of questions that have come in, and I know we're not going to get to all of them. Here in a couple of minutes, we're going to drop the survey into the chat and if you did not get your question answered, you can answer a question via that path, but we have time for a couple of additional questions I think. What about sustainability? What are thoughts about how the consent management service could be funded or be provided long term?
Slide 9	Dr. Linette Scott – 52:52	Well, we are definitely thinking about lots of options in that respect and some of the key lessons learned from the pilot will inform that, so thank you.
Slide 9	Zoe Barnard – 53:03	Can you remind folks what you said about the timeline please?
Slide 9 (move to Slide 31)	Dr. Linette Scott – 53:07	Absolutely. Why don't we go ahead and pull that up? Let's see, maybe slide 31 to pop in there. That's probably a good thing to finish on. Again, we're in this timeline now, so we again expect to have the RFI posted. We're expecting to have it posted by the end of this week, if that gets delayed, by early next week. But again, all of the information in the RFI is consistent with the information in the slide deck, so they are aligned. You can use the information in the slide deck to start having conversations and thinking about this. As Zoe mentioned, that post-webinar survey is another way to submit questions that you have. We will capture all the questions that were submitted in the Q&A, and so we'll take those back and work on putting together responses that we can add to the website where we have the RFI when that goes out as well. We'll work on getting as many questions answered as we can in writing that we can put alongside of this.

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<b>VISUAL</b>	<b>SPEAKER – TIME</b>	<b>AUDIO</b>
Slide 33	Dr. Linette Scott – 54:22	Really appreciate everybody's participation today, and again, for being interested and willing to think about this with us. We are hoping to have three pilots that we can learn from and that will inform next steps both for us with the Medi-Cal program and also for the agency in the context of the data exchange framework. Again, really appreciate everybody's time. Huge thank you to the team for helping to host this webinar. We will be going through your questions and helping to provide as many answers as we can. Some answers may not exist, so as many as we can, we will provide. Thank you so much.
Slide 33	Julian – 55:07	Thank you for joining. You may now disconnect.