

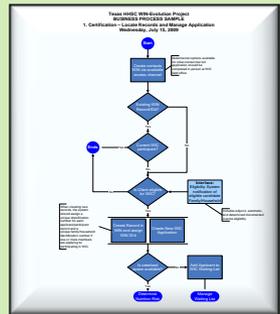
## Conceptual HHSIE To-Be scenarios

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Complete  
In Process

# High Level Approach to Requirements Gathering Process

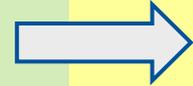
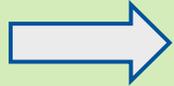
## LoC Process Flows



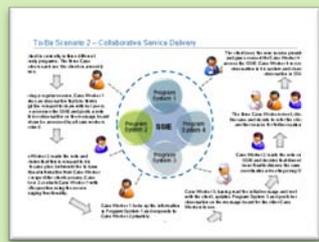
## Opportunities

Opportunity	Description	Impact	Priority	Timeline
1	Improving the current system's performance and reliability.	High	High	Q3 2024
2	Integrating the current system with other systems to improve data flow.	Medium	Medium	Q4 2024
3	Enhancing the user interface to improve user experience.	Low	Low	Q1 2025
4	Implementing new features to meet changing business requirements.	High	High	Q2 2025
5	Optimizing the system's architecture for better scalability.	Medium	Medium	Q3 2025
6	Improving the system's security to protect sensitive data.	High	High	Q4 2025
7	Enhancing the system's reporting capabilities to provide better insights.	Low	Low	Q1 2026
8	Implementing a new data source to improve data accuracy.	Medium	Medium	Q2 2026
9	Improving the system's integration with external systems.	High	High	Q3 2026
10	Enhancing the system's performance on mobile devices.	Low	Low	Q4 2026

## Use Cases



## Person Centric Scenarios



## Requirements Matrix

Category	Requirement #	Description	Priority	Timeline	Owner
Access	R1	Users can access the system from any device.	High	Q3 2024	John Doe
	R2	System is available 24/7.	High	Q3 2024	Jane Smith
	R3	System is secure and protected from unauthorized access.	High	Q3 2024	John Doe
Quality	Q1	System is easy to use and intuitive.	Medium	Q4 2024	Jane Smith
	Q2	System is reliable and stable.	High	Q3 2024	John Doe
	Q3	System is scalable and can handle increasing data volume.	Medium	Q4 2024	Jane Smith
Costs	C1	System is cost-effective and provides good value for money.	Low	Q1 2025	John Doe
	C2	System is easy to integrate with existing systems.	Medium	Q2 2025	Jane Smith
	C3	System is easy to maintain and update.	Low	Q3 2025	John Doe

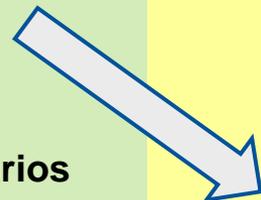
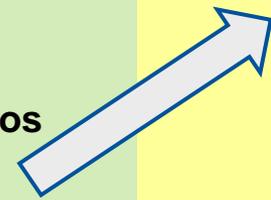
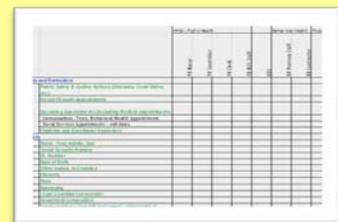
## Program Measures

Type	Measure
Access	LHAP: Time to first appointment, days wait time for LHAP eligibility requirement, client's who only use medical home services AB 100: wait time to get treatment
Quality	LHAP: All measures are tracked (collected and reported by the ADO), MHPIH integrated care-related metrics AB 100: TED
Outcome	LHAP: Retention, Client Profile, increased use of MH services, reduction of ED/ED discharges, environment level AB 100: The outcomes (by type of case), recidivism, employment, program retention, program completion, addresses of AD 100 patients with Foster Children
Costs	LHAP: Cost as known by patient, hospital, specialty etc. from ED, administrative costs (costs up to 50% by the State), offset of CHS costs, Ryan White cost AB 100: How much is this unfunded program costing the County? cost of service, disproportionately impacting budget by region, program etc. goal of serving and integrating AD 100.

## Shared Analytics Scenarios

Scenario	Description
AD 100 Prevalence	All children has successfully completed his term in state prison. He is due to be released in 30 days. The program sends the courts a 30-day notice and packet to the County Probation Office. The data are captured and entered into the Probation Case Management System (PCMS). The County Screening team review the offender's packet and makes a determination of the offender's status. They are able to tag the PCMS to monitor information as well as any other relevant dependencies or for additional information about the offender, and it is an informed determination. If the offender passes the initial screening, he is referred back to his home where the team is able to use information PCMS and other systems to review and verify information about the client given them and send relevant questions.

## Data Model



## Purpose of the To-Be scenarios

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- Based on the opportunities identified in the workflows and the measures around key program priorities identified, To-Be Scenarios have been developed to provide context for the use cases and solution requirements
- The To-Be scenarios are hypothetical descriptions that illustrate how a future user of the HHSIE would benefit from the access to additional information, the capability to share information and collaborate across program boundaries, to access analytics. and create electronic referrals
- The To-Be scenarios and storyboards also serve as catalysts to highlight non-technology related issues that HHSIA will need to take into account to ensure a successful implementation of the HHSIE, such as:
  - Confidentiality, consent and use management and referral readiness
  - Changes to the current Model of Practice including cross-program case coordination and case management
  - Changes to organization design within HHSIA
- The To-Be scenarios are grouped in two categories
  - Five conceptual HHSIE To-Be scenarios that show the core capabilities (access to client record, cross-program collaboration, manage referrals, view notifications/alert and access shared analytics)
  - Eleven scenarios based on specific examples of how the HHSIE will work in practice

# Scenario Notation

Providers, Case Workers, Health Services Specialists and other users of the HHSIE are represented as figures.

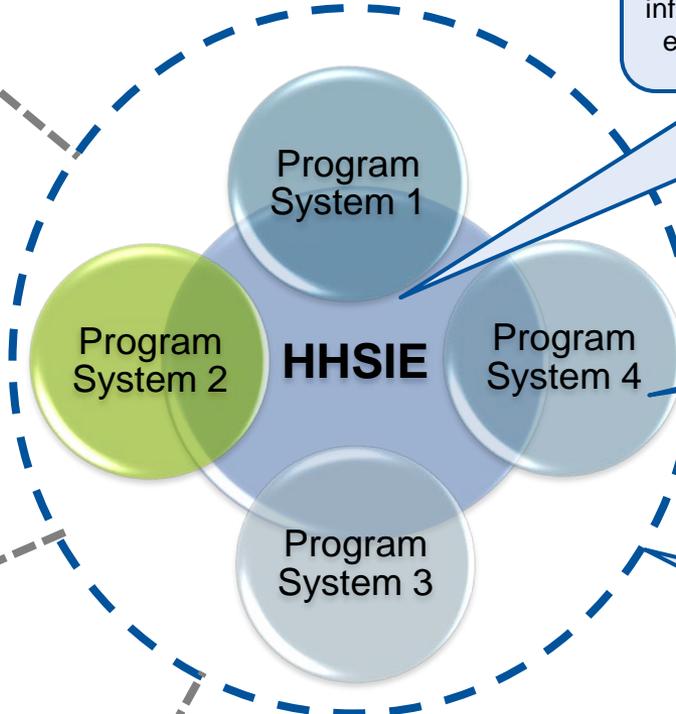


During a regular session with a client, Case Worker 1 makes an observation that she thinks might be relevant to share with others working with the client and where case coordination can produce better outcomes. She solicits Informed Consent from the client and notifies other through secure messaging capabilities of the HHSIE.

The narrative describes how users will interact with the HHSIE and how the HHSIE will support their work in the context of a specific scenario. The text also identifies where client consent is required and describes high level HHSIE capabilities.



The large circle labeled HHSIE shows the Health and Human Services Information Exchange that contains the shared client information and analytics. This information can either reside in the HHSIE itself or be pulled from the Program Systems.

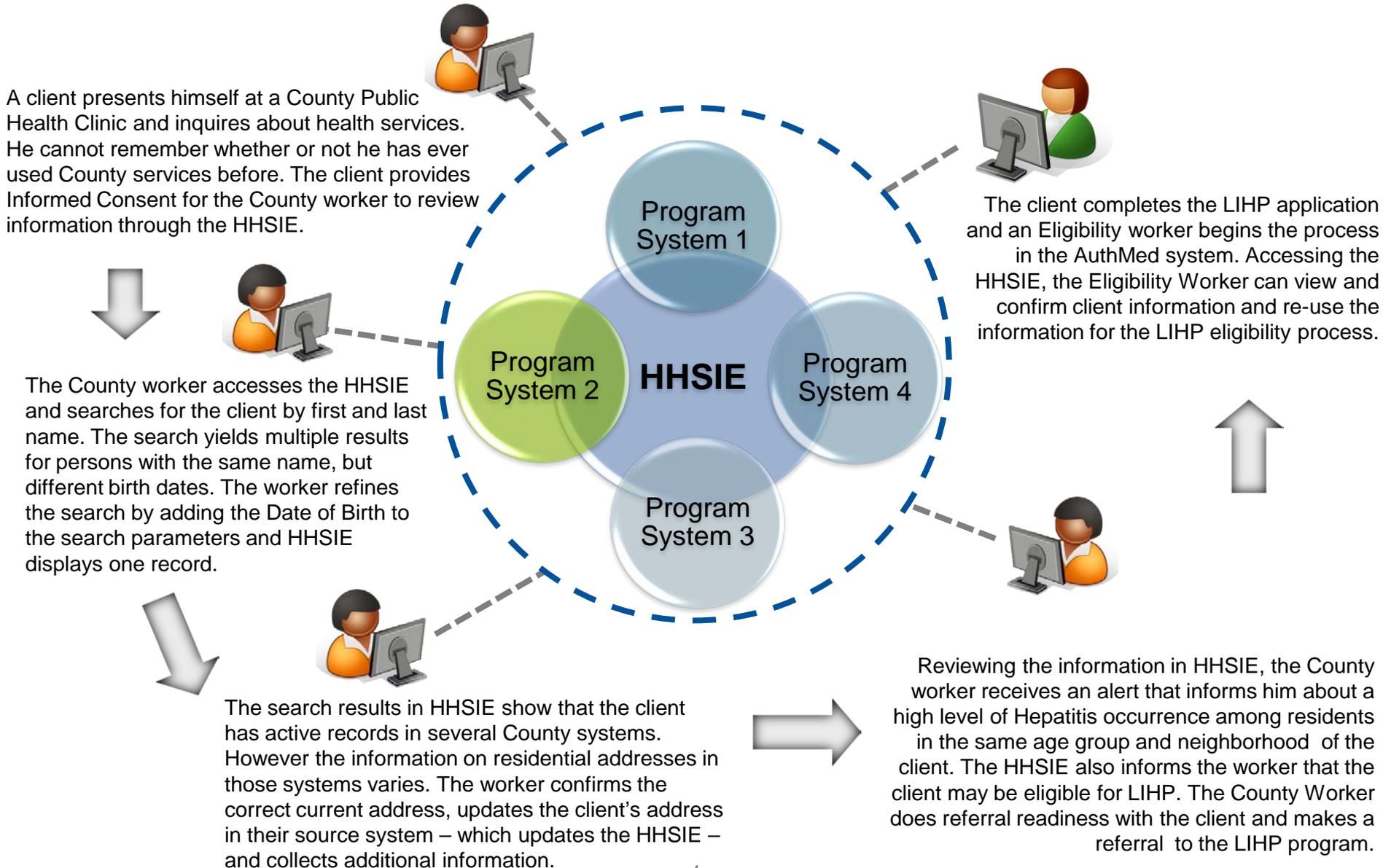


The Program Systems represent existing, program specific case management systems from which the HHSIE will pull information.

The blue dotted line around the systems represents the scope of the systems being part of the initial scope of the HHSIE.

The grey dotted line represents a user accessing the HHSIE or their program specific case management system. Initially, users will likely access the HHSIE portal and their case management system separately. Over time, all systems will be accessed through the HHSIE portal.

# To Be Scenario 1 – Search and View Query Results



## To-Be Scenario 2 – Collaborative Service Delivery

A client is currently in three different County programs meeting with three different Case Workers weekly. One of the case workers has obtained Informed Consent (Consent Registry) identifying the other providers and the scope and focus of the information to be shared to support collaborative case management services on behalf of the client.



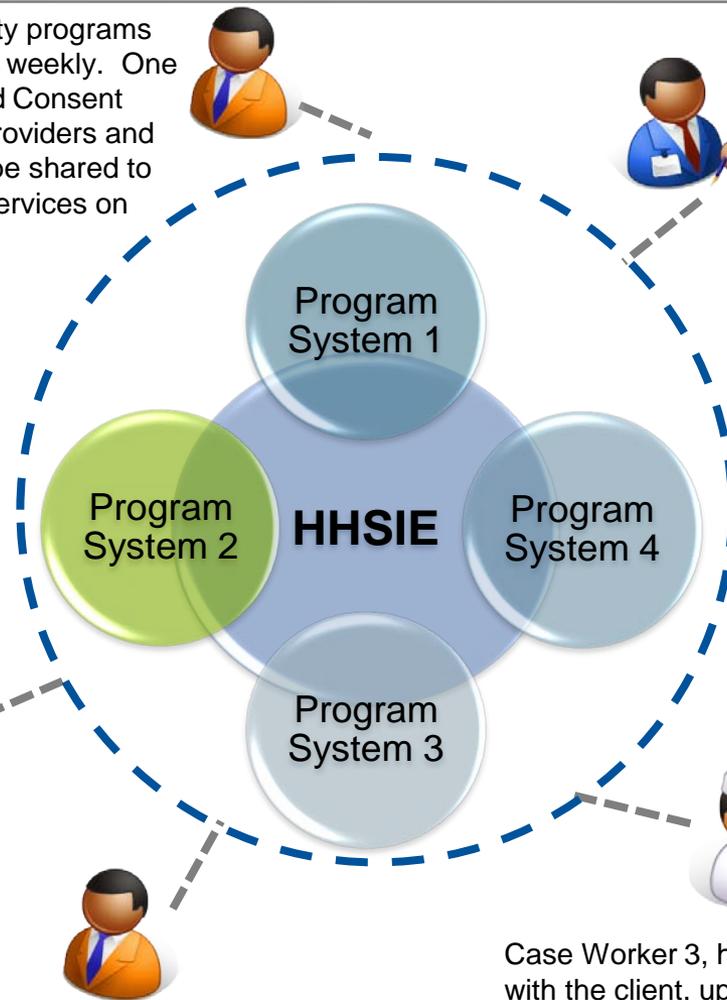
During a regular session, Case Worker 1 makes an observation that she thinks might be relevant to share with her peers. She accesses the HHSIE through secure messaging she submits a note with her observation on the HHSIE that can be accessed by all case workers involved with the client.



Case Workers 2 and 3 read the note and concludes that this is relevant to his clients case plan, but would like to have additional information from Case Worker 1. Case Worker 2 contacts Case Worker 1 with specific questions using the secure messaging functionality.



Case Worker 1 looks up the information in Program System 1 and responds to Case Worker 2.



The client sees the new service provider and provides Informed Consent for Case Worker 4 to participate in the Case Coordination effort through the HHSIE. Case Worker 4 records observation in his system and shares observation in HHSIE for all providers to see.



The three Case Workers meet, discuss the case and Case Worker 2 takes responsibility to conduct a referral readiness session and refer the client to another service for further evaluation.



Case Worker 2 reads the note on the HHSIE and decides that it would be beneficial to discuss the case and coordinates a meeting using HHSIE.



Case Worker 3, having read the initial message and met with the client, updates Program System 3 and accesses the HHSIE and through secure messaging she submits a note with her observation on the HHSIE that can be accessed by all case workers involved with the client.



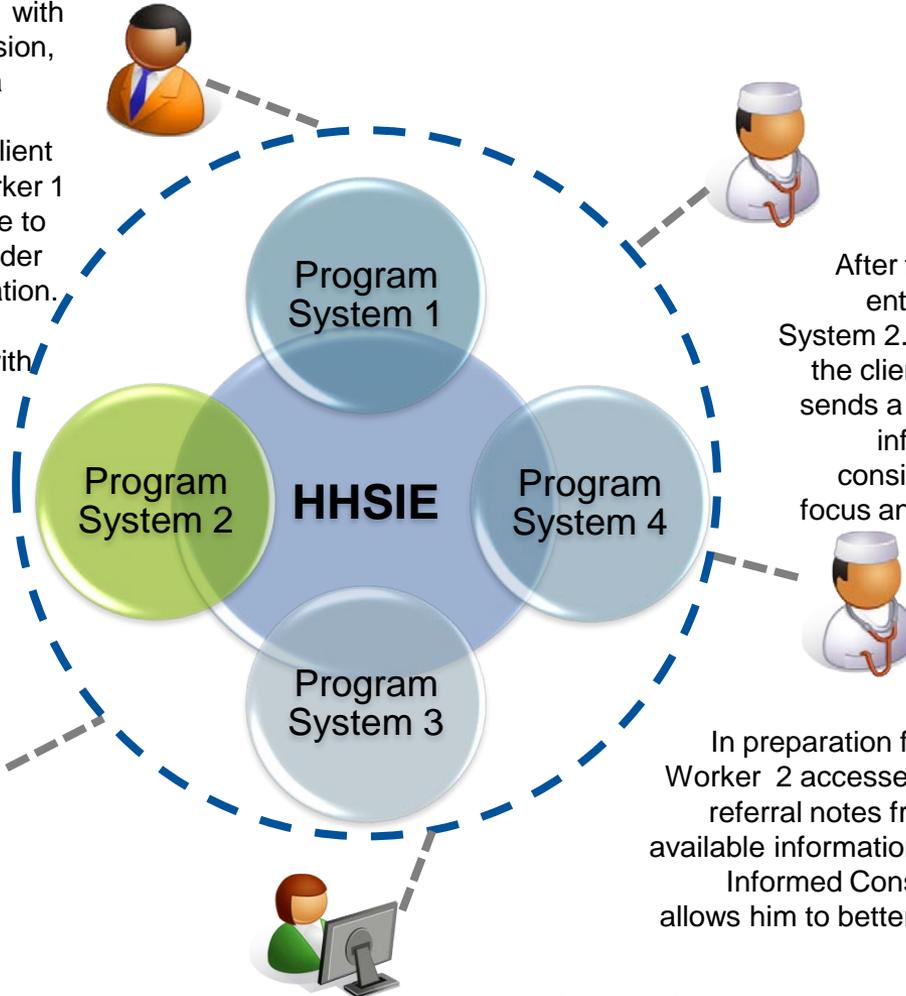
## To-Be Scenario 3 – Manage Referrals

A client presents himself to a weekly session with Case Worker 1. During the course of the session, Case Worker 1 decides to refer the client to a specific service need. He looks up service providers in the client's neighborhood. The client depends on Public Transportation. Case Worker 1 reviews the resource directory (can be linkage to San Diego 2-1-1) and selects a service provider (Provider 2) – accessible by public transportation.

Case Worker 1 conducts referral readiness with the client and secures Informed Consent to make the referral and to share information with Provider 2 and makes the referral through HHSIE and documents the referral in his Program System (Program System 1)



The Intake Worker at Provider 2 receives an electronic notification that a referral has been made. She accesses the HHSIE and reviews the referral, then assigns it to Case Worker 2. An automated message is sent to Case Worker 1 that the referral has been viewed.



After the first session, Case Worker 2 enters his observations in Program System 2. HHSIE receives an update that the client has attended the session and sends a notification to Case Worker 1 to inform him of the first appointment consistent with the Informed Consent focus and scope of the consent to share information.



In preparation for the first appointment Case Worker 2 accesses the HHSIE and reviews the referral notes from Case Worker 1 and other available information on the client – including the Informed Consent (Consent Registry). This allows him to better prepare for the first session.

When the client contacts Provider 2, the Intake Worker opens the record in HHSIE and schedules an initial appointment for the client with assigned Case Worker 2. An automated message is sent to Case Worker 1 that the referral has been scheduled.



## To-Be Scenario 4 – View notifications and alerts in HHSIE

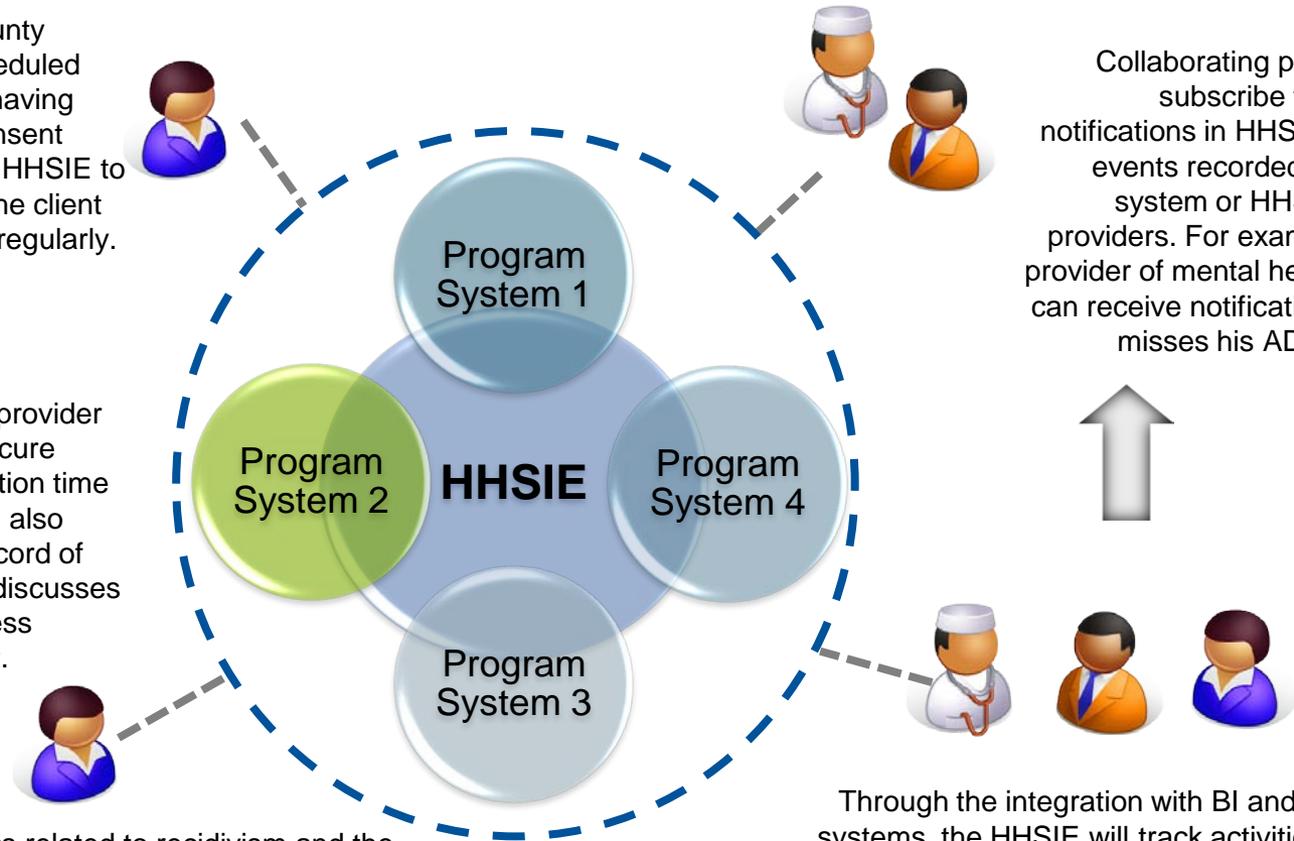
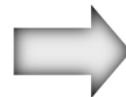
A client presents himself at a County service center for a regularly scheduled therapy session. The provider – having previously obtained Informed Consent (Consent Registry) – is using the HHSIE to collaborate with other providers the client is seeing and access the HHSIE regularly.



When accessing the HHSIE, the provider receives a notification through secure messaging that the client's probation time will be ending in a few weeks. He also sees that the client has a prior record of domestic violence. The provider discusses the transition– discharge readiness planning process – with the client.



The provider then reviews analytics related to recidivism and the relationship to continued therapy. He explains to the client that – while no longer obligated – it would be beneficial for him to continue regular counseling sessions as they significantly reduce the risk of relapse and anger management (Referral Readiness) The client agrees to continue counseling , Informed Consent is updated or executed and the provider makes a referral in the HHSIE (See Manage Referrals and Collaborative Service Delivery scenarios).



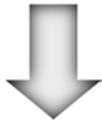
Collaborating providers can subscribe to alerts and notifications in HHSIE based on events recorded in a source system or HHSIE by other providers. For example, the the provider of mental health therapy can receive notification if a client misses his ADS sessions.



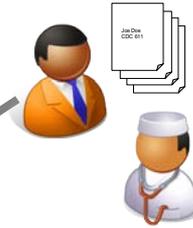
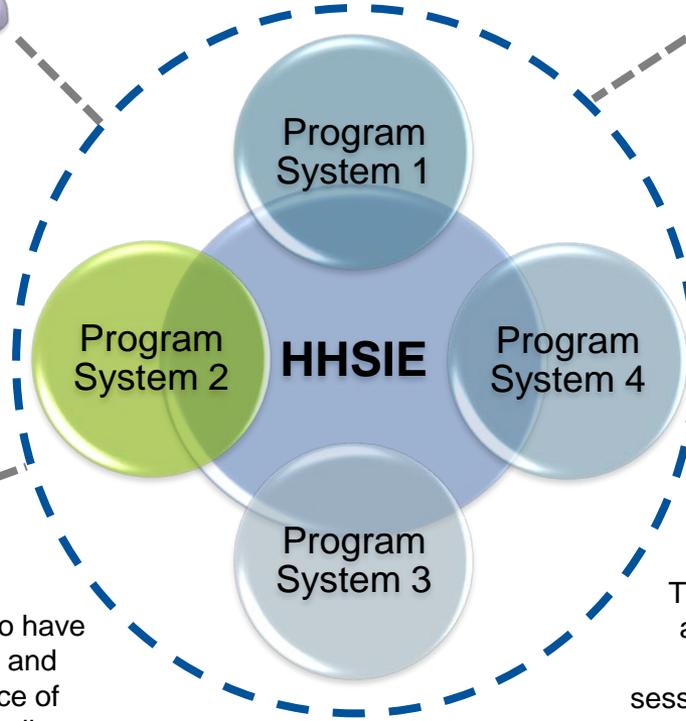
Through the integration with BI and reporting systems, the HHSIE will track activities related to populations and individuals and provide users of the HHSIE with updated reports on an ongoing basis. Other users will benefit from the aggregate knowledge gained by tracking the activities and outcomes related to services and client populations.

# To-Be Scenario 5 – Access population based shared analytics in HHSIE

A client attends a regularly scheduled session with the Public Health nurse. During the appointment, the client mentions that he has moved to a new neighborhood that he is not familiar with. The Public Health Nurse updates his system with the new address.



HHSIE displays a new alert showing that the neighborhood the client has moved in tends to have high chronic illness rates, especially diabetes and obesity. The provider discusses the importance of physical activity and healthy nutrition with the client. To illustrate the point, the nurse accesses some dashboard reports in the HHSIE that show statistics related to the client's demographics as well as a map with parks and access to fresh food markets.



The Public Health Nurse records in HHSIE the resources shared with the client. This will allow to assess the impact or early orientation and pro-active education on risks and issues related to the clients personal profile.



The nurse educates the client and can access additional reports that present cross-program information and statistics. At the end of the session, the nurse prints out relevant reports and maps for the client with listings of resources such as access to medical care, parks, farmers markets and other resources. This will allow the client to better orient himself in the new neighborhood.



# To-Be Scenario 1 – Search and View Query Results

## High Level HHSIE Capabilities

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- The HHSIE will contain an actual summary index of client information or basic demographics (i.e. HHSIE will have its own repository)
  - The HHSIE will include a Master Patient Index (MPI) – or “client phonebook” – and some subset of client information (not including external health data)
  - If a client is a member of one of the initial HHSIE target populations (AB 109 or LIHP), then a summary record in the HHSIE exists – focusing on Need to Know core information to support Case Collaboration as well as supporting shared analytics for additional performance metrics for these two populations
  - The HHSIE will be able to make calls to other systems to retrieve additional information (i.e. case information that will remain in source systems) and display this information to users in the HHSIE
- Any authorized user in a program that is part of the HHSIE will have access to the information in the HHSIE. The amount and type of information accessible by a user will be managed through role based access control and will be dependent on:
  - Their program
  - Their role
  - Informed Consent provided by the client
  - Any other regulatory or policy based restrictions

# To-Be Scenario 1 – Search and View Query Results

## High Level HHSIE Capabilities (cont'd)

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- The HHSIE will include two types of Consent:
  - a registry for Informed Consent between clients and providers
  - a registry for Qualified Service Agreements (QSAs) between services and providers
    - The QSA registry must identify the services covered as well as any exceptions taken by the client
- The HHSIE Informed Consent Registry will record for each client:
  - Who recorded consent and date of consent
  - What consent was provided, to what program/service/individual, the focus and scope of the consent and duration of the consent
  - The HHSIE will need to distinguish between consent for referral only and consent for cross-program purposes (look-up of information only of client's participation in other programs or Coordinated Case Management across programs/services)
- The HHSIE will include a security policy engine that will manage – among other things – access control based on the consent registry and user profile
- The HHSIE will include a user registry, including individual identifiers and user roles
- Data in the HHSIE repository can be updated in one of two ways:
  - Users will be able to enter/update data directly in the HHSIE
  - The HHSIE will be updated automatically through integration with source systems

## To-Be Scenario 2 – Collaborative Service Delivery

### High Level HHSIE Capabilities (con't)

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- Collaborating Case Workers will communicate through the HHSIE. The HHSIE will contain a record consistent with the parameters in the informed consent, that will remain in place for the duration the consent has been obtained.
  - Consent is time limited (either a specific period of time or until case is closed)
  - Once a case is closed or consent has expired, information can no longer be accessed
- The HHSIE record will only contain program specific information that is relevant to others during the coordination of care (“need to know”)
  - The HHSIE record of program information exists only for the duration of a case collaboration
  - Program specific data will reside in the source system, e.g. for a treatment plan with dates, the HHSIE record will include basic information to be displayed to users from other programs
- The HHSIE will include secure messaging (including attachment of electronic files)
- The HHSIE will have the capability to store notes between collaborating case managers (e.g. as a message board as part of a virtual record)
- Case managers in programs and services will manage their cases using their own systems. They will use information available to them in the HHSIE. The HHSIE will not have case management such as coordination workflow or escalation processes

# To-Be Scenario 1 – Search and View Query Results

Operational questions to be addressed

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- Updates to the HHSIE repository can be propagated to other systems through use of the information exchange engine
  - The HHSIE will not be the tool to actually update information in the source system of record
  - Programs and services will have complete discretion of what changes are propagated from the HHSIE to their systems
- Where is informed consent required?
  - Is client consent required to search and view a basic record in the HHSIE?
- What are the key components of informed consent and use management?
- Will there be a standardized consent form/process for all ACC related information?
- Where would a Qualified Service Agreement be the right vehicle for sharing information to enhance coordination of services?
- Who gets to see what types of information when a client has provided / not provided consent?
- Consider whether a user will have the authorization to update client information directly in the MDM environment.

## To-Be Scenario 2 – Collaborative Service Delivery

Operational questions to be addressed

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- What are the responsibilities of participants in cross-program case collaboration?
- Will there be an overall case coordinator for interdisciplinary case management?
- How will consent be governed – can a worker from one program obtain consent from a client for information related to another program?
- Will there be interdisciplinary teaming on program development?
- What policies and guidelines will be required for cross-program case collaboration?
- Develop guidelines of
  - when people "should" and when people "must" share information across program and role boundaries
  - how they should act upon the information provided
  - what kind of cross-program metrics there should be (for individuals as well as teams)
  - what kind of cross-program analytics should be developed and presented

# To-Be Scenario 3 – Manage Referrals

## High Level HHSIE Capabilities

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### ■ High Level HHSIE Capabilities

- Referrals will occur through secure messaging within the HHSIE and not go from one program specific system to another program specific system (In the long run, referrals may flow end-to-end without the users interacting with the HHSIE portal)
- The HHSIE will have the capability to view the status of a referral
- Recipients of referrals will be able to acknowledge referrals
- Capability to track outcomes and metrics of referrals (including analysis by type of referral)

## To-Be Scenario 3 – Manage Referrals

Operational questions to be addressed

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### ■ Operational questions to be addressed by HHSA

- What is the impact on the model of practice and policy implications for each program/service domain related to referrals?
- What are the responsibilities of a program/service at the receiving end of a referral? Is there an obligation to act? Do referrals have to be acknowledged? What are the workload implications?
- Can any program make referrals for any program/service?
- What are the responsibilities of a referring program, if any, after a referral has been recorded in the system? Will they have to monitor status?
- What is the responsibility of the receiving entity? Should they provide information on when the referral was received, when the follow-up was made, if the first appointment was kept, if any appointments are missed, and if the program is completed (all as appropriate)?
- What are the requirements for documenting referral readiness? Should HHSIE include a checklist?
- What metrics should be tracked related to referral (outcomes, source of referral)
  - linkage to “Live Well, San Diego!” metrics

## To-Be Scenario 4 – View notifications and alerts in HHSIE

High Level HHSIE Capabilities and operational questions to be addressed

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### ■ High Level HHSIE Capabilities

- The HHSIE will push notifications to users based on pre-defined parameters (e.g. when a referral has been acknowledged, when a security alert has been entered in a source system, when a new report is available)

### ■ Operational questions to be addressed by HHSA

- TBD

# To-Be Scenario 5 – Access population based shared analytics in HHSIE

High Level HHSIE Capabilities and operational questions to be addressed

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## ■ High Level HHSIE Capabilities

- The HHSIE will provide access to existing and new reports and analytics that are developed outside of the HHSIE in the BI and reporting environments
- The HHSIE contains reporting capability on information that is stored within the HHSIE

## ■ Operational questions to be addressed by HHSA

- Will contractors and external service providers have access to shared analytics?

## Detailed HHSIE To-Be scenarios/storyboards

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## Overview of Example To-Be scenarios

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■ The following person centric scenarios have been developed:

- Scenario 5 – AB 109 Pre-Release
- Scenario 6 – AB 109 Post-Release
- Scenario 7 – LIHP Enrollment
- Scenario 8 – LIHP Re-Enrollment (*to be further developed*)
- Scenario 9 – Initial Contact with Medical Home
- Scenario 10 – Service Delivery
- Scenario 11 – Service Delivery (HIV/AIDS Primary Care)
- Scenario 12 – AB 109 Treatment Agency Assessment
- Scenario 13 – Manage Referrals

■ The following shared analytics scenarios have been developed:

- Scenario 14 – Response to Incident
- Scenario 15 – Emergency Situation and Executive Update

# To-Be Scenario Notation

Providers, Case Workers, Health Services Specialists and other users of the HHSIE are represented as figures.



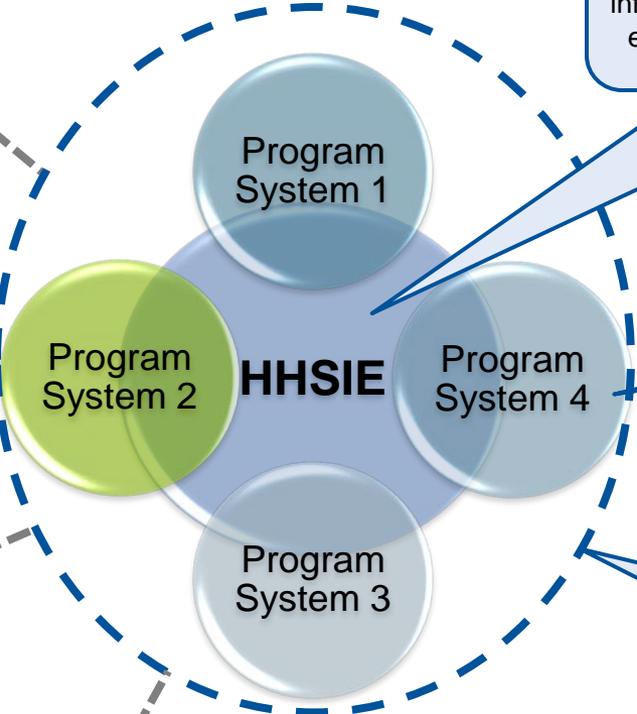
During a regular session, Case Worker 1 makes an observation that she thinks might be relevant to share with her peers. **She accesses the HHSIE and posts a note with her observation on the message board that can be accessed by all case workers involved.**



The narrative describes how users will interact with the HHSIE and how the HHSIE will support their work in the context of a specific scenario. The text also identifies where client consent is required and describes high level HHSIE capabilities. Sections in **bold** indicate HHSIE benefits and capabilities.



The large circle labeled HHSIE shows the Health and Human Services Information Exchange that contains the shared client information and analytics. This information can either reside in the HHSIE itself or be pulled from the Program Systems.



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The blue dotted line around the systems represents the scope of the systems being part of the initial scope of the HHSIE.

The grey dotted line represents a user accessing the HHSIE or their program specific case management system. Initially, users will likely access the HHSIE portal and their case management system separately. Over time, all systems will be accessed through the HHSIE portal.

## Actors and HHSIE Users

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- Offender / Probationer



- Residents or Clients

- Probation Officer (PO)



- County Supervisor

- Behavioral Health Screening Team (BHST)



- Office of Media and Public Affairs

- A Provider or Counselor



- Data Analysts and Epidemiologists

- Staff Supervisor



- County Office Staff or Eligibility Worker



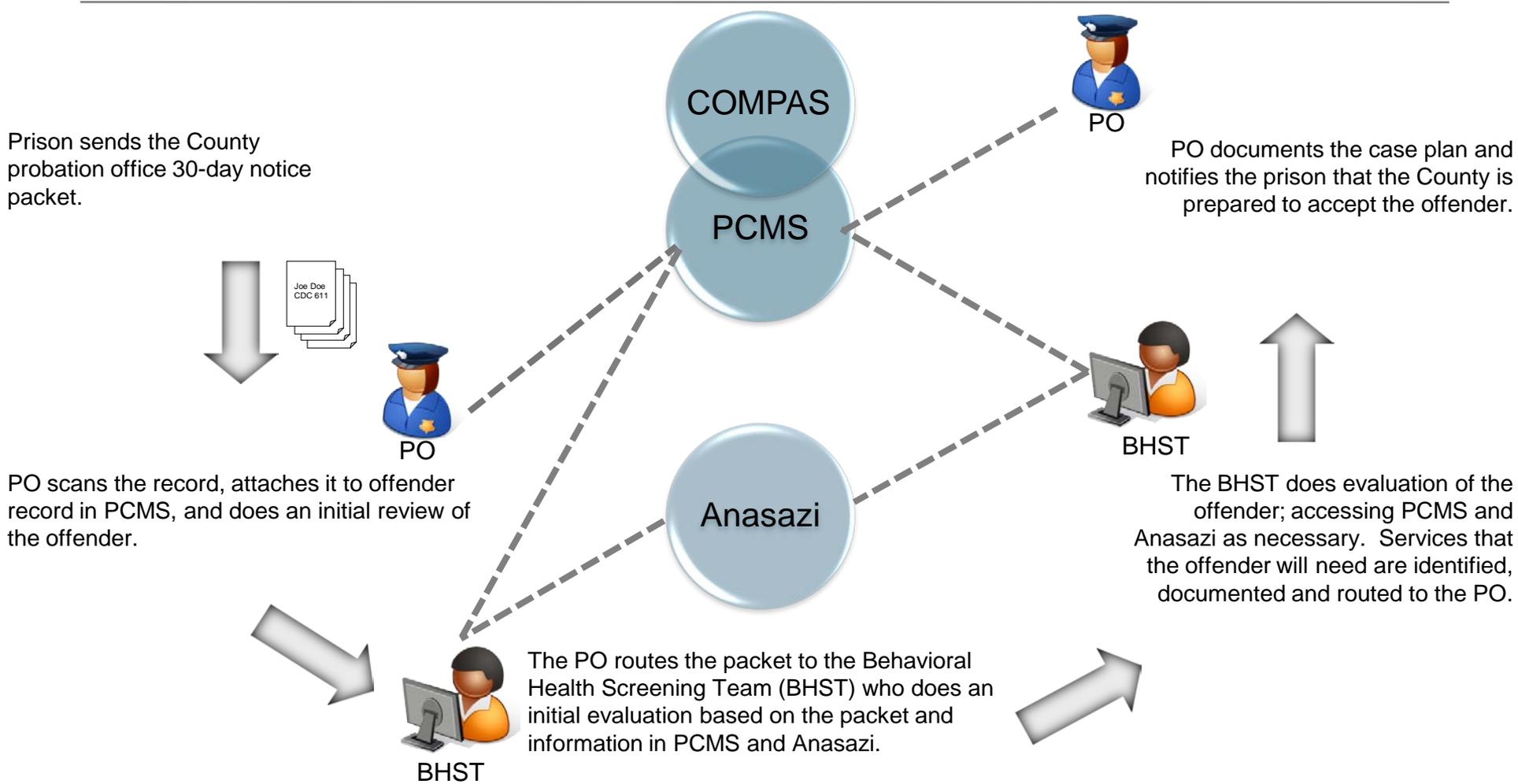
## To-Be Scenario 5 – AB 109 Pre-Release Screening

- An offender has been identified for release from state prison. He is due to be released in 30 days.
- The prison sends the county a 30-day notice and packet to the County Probation Office. The files are scanned and entered into the Probation Case Management System (PCMS). While the Probation Officer (PO) updates PCMS, he may also access HHSIE to see if the offender is already known to the County. He then routes the packet to the Behavioral Health Screening Team (BHST).
- The BHST reviews the offender's packet and makes a determination of his mental state, substance abuse issues and physical health. They are able to log directly into PCMS and HHSIE to review information as well as any other system connected to HHSIE to find additional information about the offender.
- By accessing HHSIE, the BHST is able to ascertain that the offender was previously receiving substance abuse treatment from the County, including the providers he has seen and the therapy he received. HHSIE also presents a notification that the male offenders in the same age group, living in the same zip code area have a very high occurrence of a certain chronic disease. The BHST specialist drills down further by clicking on the notification to see the entire notification and information about it to assist in more accurately determining the offender's risk level. The BHST specialist approves the offender for the County's AB 109 program.
- The BHST specialist identifies services as necessary for the offender, routes the packet back to the PO who documents the Probationer's case plan, requirements for informed consent and the agreement to actively participate in the treatment plan.

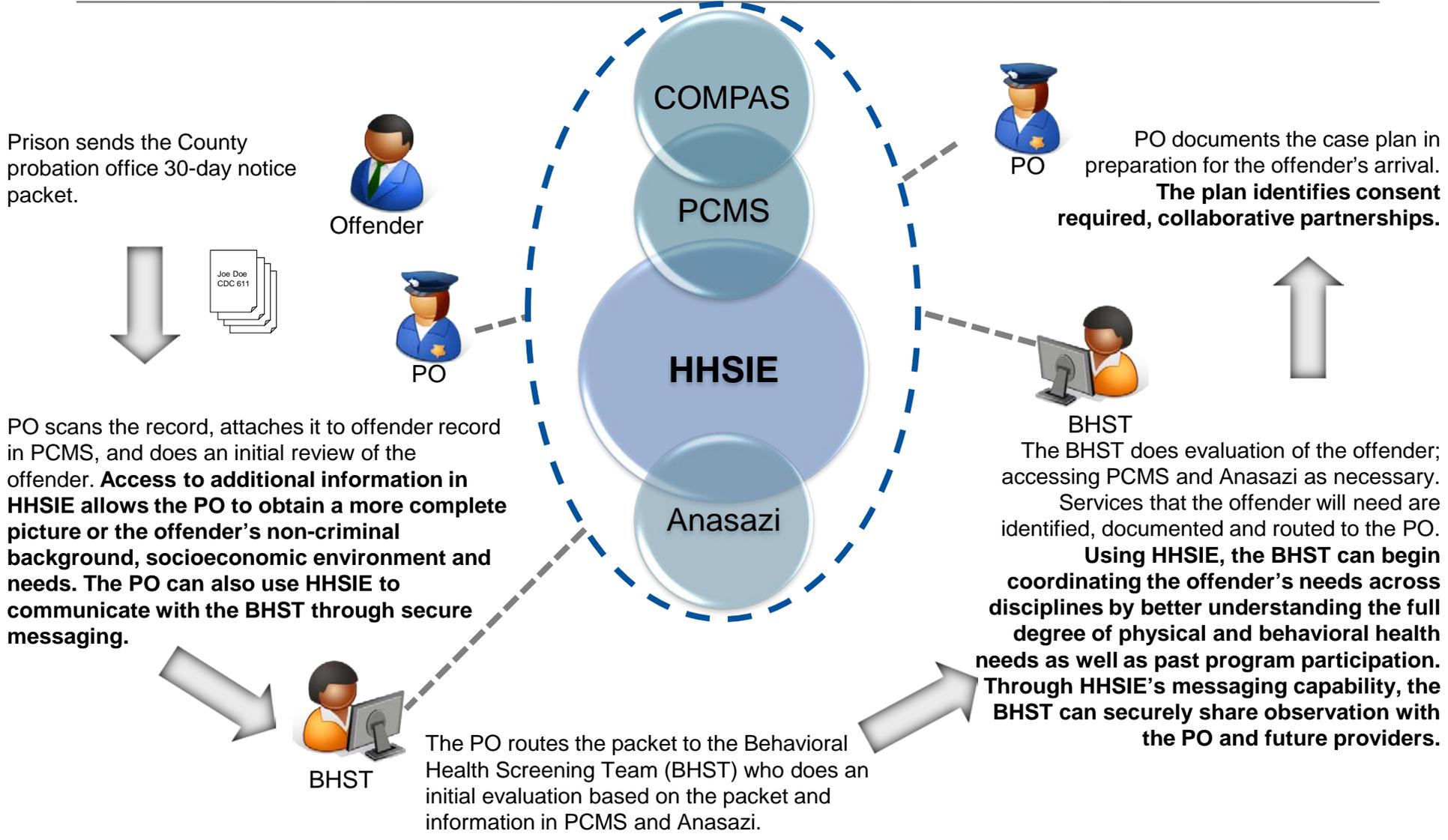
### **HHSIE Analytics supporting this scenario:**

- Access to Client Record including notifications and alerts
- Access to dashboard report on information specific to the offender's population
- Capability to generate parameter based standard report

## AB 109 Pre-Release Screening – Current State



To-Be Scenario 5 – AB 109 Pre-Release Screening



## Questions / Assumptions related to the implementation and use of the HHSIE

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- As a condition of the release, offender agrees to Informed Consent that allows the screeners to access any information necessary to conduct the Pre-Screening planning.
- BHST can access additional information on a client without explicit consent in Anazasi, SanWITS and HHSIE without consent

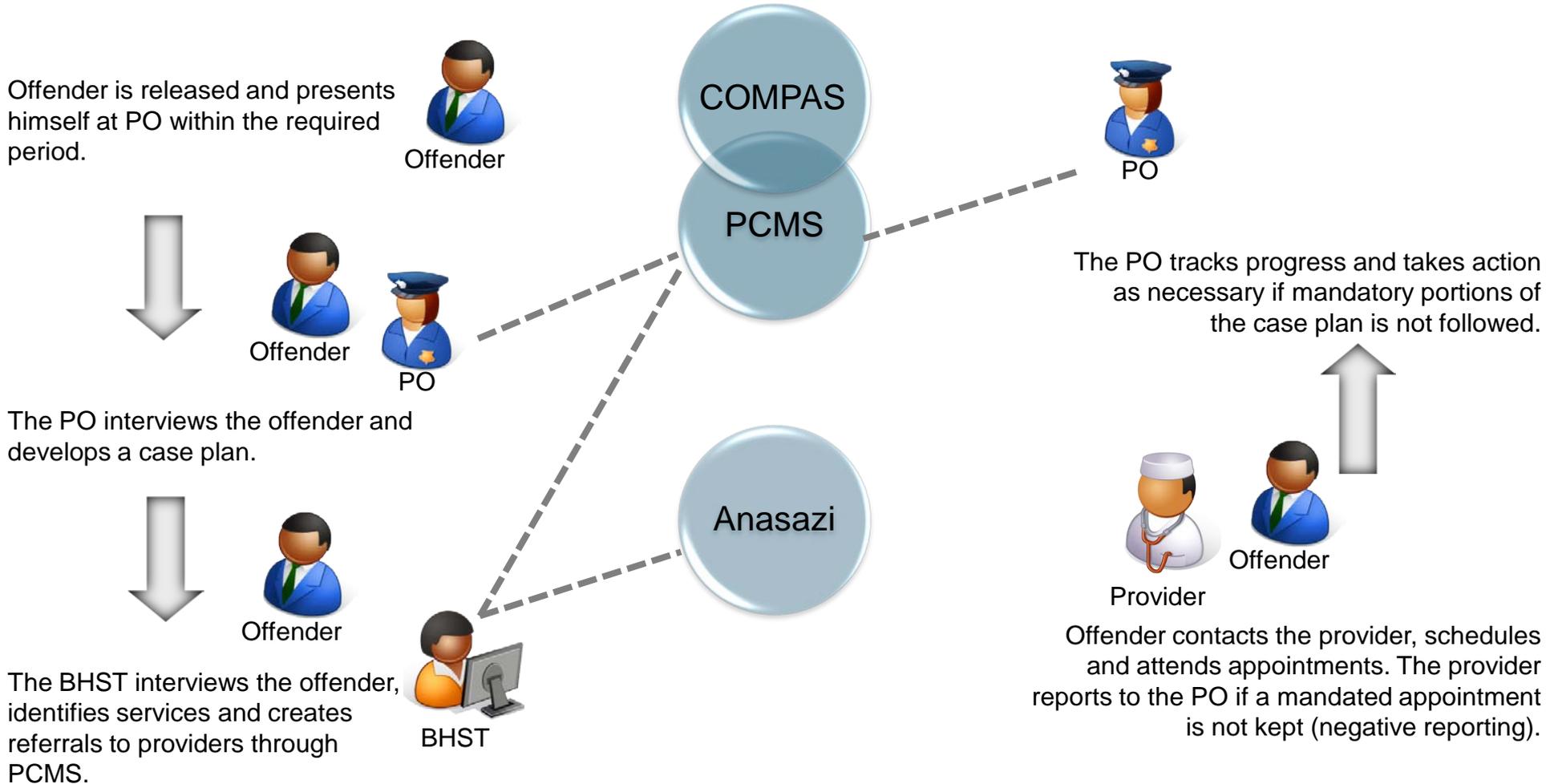
## To-Be Scenario 6 – AB 109 Post-Release

- After the offender is released, he presents himself within 2 days or 48 hours, as required, at a Community Reception Center (CRC) or at the Probation office. He is interviewed by a Probation Officer who is able to use PCMS and HHSIE to create his probation plan. The offender is also interviewed by the BHST who may identify additional probation-approved services by using directories accessible via PCMS and HHSIE such as Community Resource Directory and 211. The PO can use HHSIE to record information he thinks is relevant for future providers who do not have access to PCMS through posts and notes. This additional information will facilitate the coordination of care during the delivery of services.
- HHSIE provides information such as housing, access to transportation and languages read and spoken. The directories allow the BHST to identify services that are readily accessible to the offender by geography, language and other preferences, thereby increasing the accessibility of the services to the offender. HHSIE will allow the BHST to see relevant analytics to the offenders population and provide.
- The BHST creates an electronic referral (including referral readiness and collecting Informed Consent) which is sent to the providers that are identified in the case plan. The referrals indicate whether a requested service is mandatory or optional, including what was required as a condition of his release. The referrals include all appropriate information for the referred provider. In addition, the BHST can record brief observations in the form of posts or notification to future providers. The provider acknowledges the referral through HHSIE.
- The offender calls the provider for the required service and attends his first two appointments but misses his next 3 appointments. The provider notifies the PO via HHSIE that the offender made first contact, that he attended his first two appointments, and missed appointments thereafter. Through HHSIE, the Provider can also access shared analytics, receive notification and alerts or post observation on the client for the PO or other providers to see. Since this was a required service, alerts are also emailed directly to the PO and are sent to PCMS for notation in his PCMS record.
- When the PO attempts to contact the offender, he is unable to locate him at the address he has in his record. He is able to query other known addresses obtained by other providers through HHSIE and meets the offender at his new address. The PO verifies and then adds the new address to PCMS. PCMS notifies HHSIE of the new address, which notifies other current providers of the new address. PO includes BHTS in ongoing case management as required.

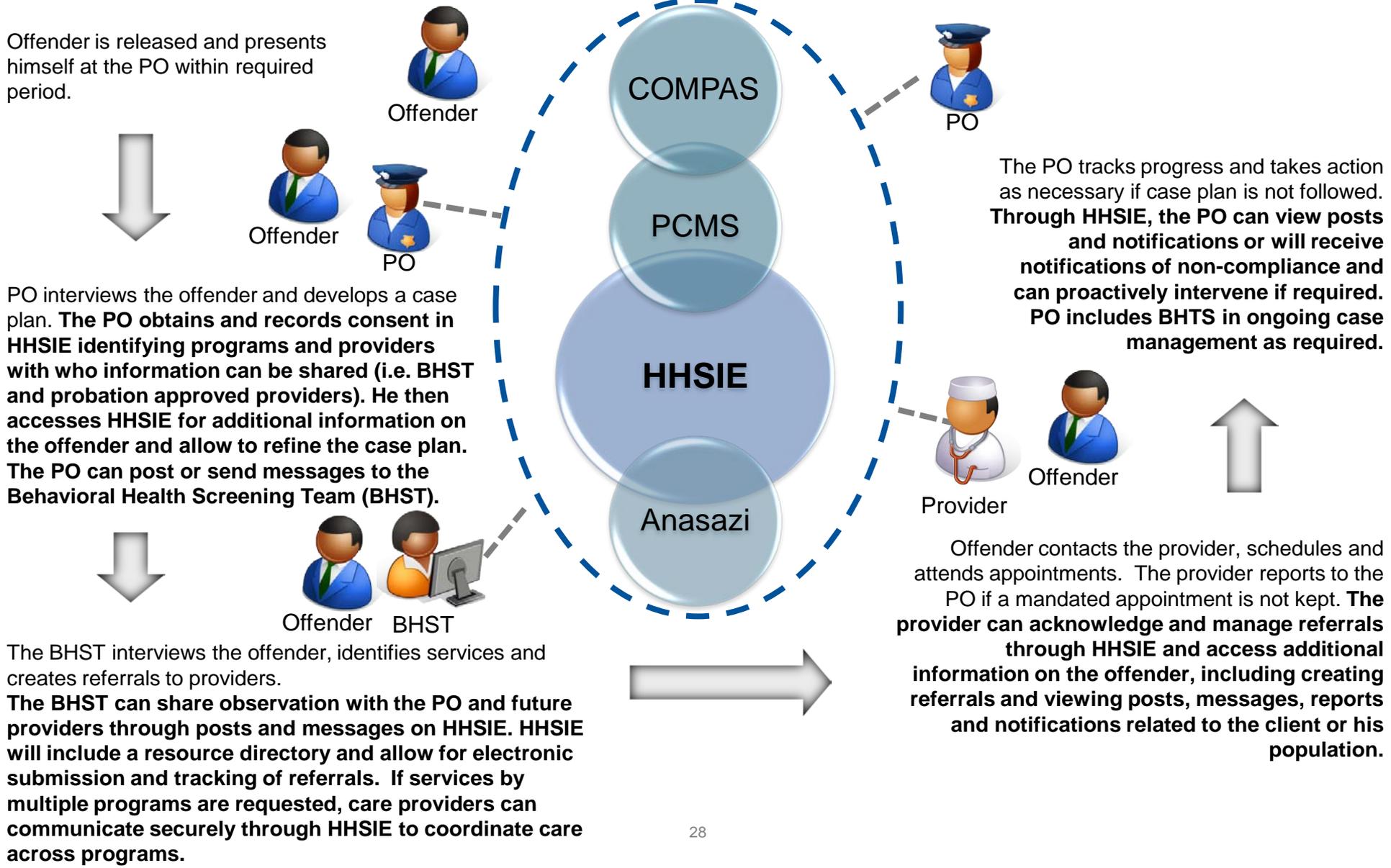
### **HHSIE Analytics supporting this scenario:**

- Access to Client Record including Notifications and Alerts
- Access to Dashboard report on information specific to the offender's population
- Capability to generate parameter based ad-hoc report

AB 109 Post Release – Current State



To-Be Scenario 6 – AB 109 Post Release



## Questions related to the implementation and use of the HHSIE

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- During the first personal meeting, what should the process be for the PO to ask and document client consent?
  - High need cases may come with a consent
  - Consent will likely be collected at Intake by the PO
- How much program specific information is the PO allowed to see?
- Resource Directory in HHSIE – will it include CRD and 2-1-1?
  - If yes, will need to have a flag for “Probation approved Service Providers”
- If the BHST screener comes across information in HHSIE that may be important for the case plan, but not known to the PO (offender has a HIV, has a record with CWS, addresses with active eligibility case, etc.), what are the responsibilities of the BHST screener or the collaborative team in regards to that information?
  - level of information will need to be managed (“medical condition” vs. detailed description)
- What criteria should be used for establishing a collaborative case plan? How will this collaboration work?
  - Capability to post notes and send secure messages through HHSIE either to one specific provider or all participants in the case

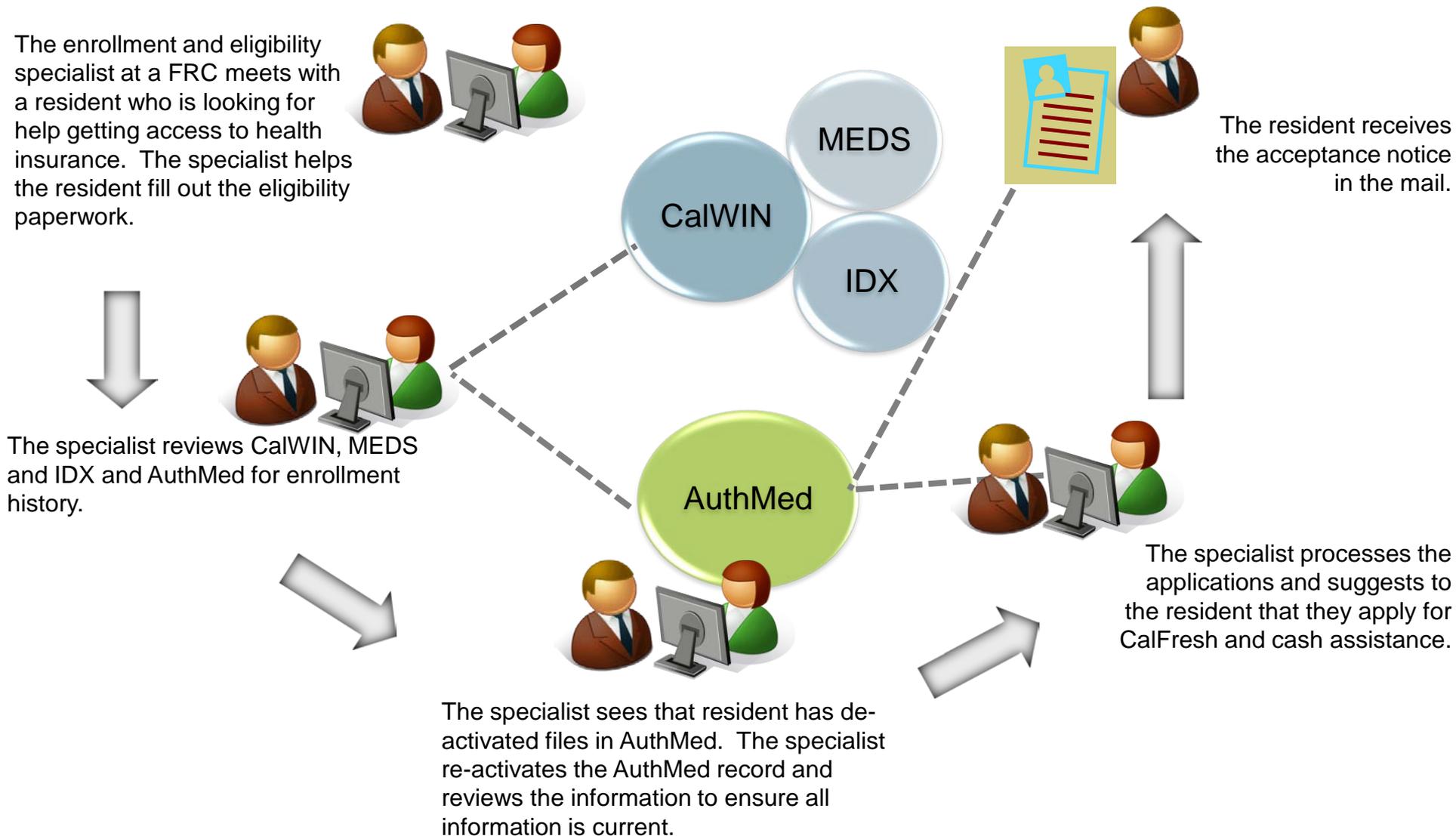
## To-Be Scenario 7 – LIHP Enrollment

- A resident without health insurance walks into a Family Resource Center and asks for assistance getting access to health care services. An enrollment and eligibility specialist, with consent from the resident, accesses all current and past applications and eligibility assessments in CalWIN and reviews the resident's record in HHSIE. Through the inclusion of shared analytics, HHSIE provides the specialist with suggestions for other applicable programs which are discussed with the client. The specialist also reviews alerts related to public safety specifically for that client that are displayed in HHSIE.
- After determining that the resident has past files in AuthMed, the specialist re-activates the AuthMed record. The specialist and the resident discusses the information and the specialist helps the resident fill out the LIHP application while verifying the information is current and accurate in HHSIE.
- The specialist is able to confirm eligibility for LIHP, but is also prompted to check eligibility for CalFresh, cash assistance and other programs and services based on information provided by the resident. In order to coordinate services for the client, the specialist requests and receives Informed Consent from the resident. With the resident's consent, the specialist applies for all programs for the resident, and directs the resident to more services that may be of assistance to them.
- Using HHSIE, the specialist updates the resident's information and sends an alert to the coordinating providers. The ASO acts on the alerts and updates the enrollment information and sends a secure email to the clinics serving the resident.

### **HHSIE Analytics supporting this scenario:**

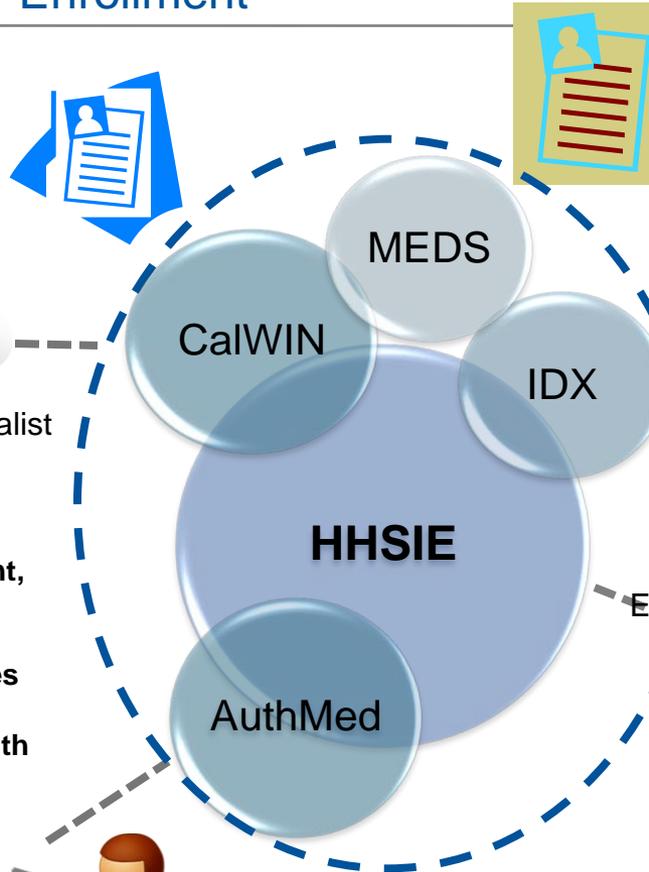
- Access to Client Record including Notifications and Alerts
- Access to Dashboard report on information specific to the offender's population

# LIHP Enrollment – Current State



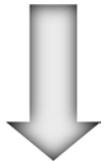
## To-Be Scenario 7 – LIHP Enrollment

The enrollment and eligibility specialist at a FRC meets with a resident who is looking for help getting access to health insurance.



Client

The resident receives the eligibility notice in the mail. **Using HHSIE, the specialist updates the resident's information and sends an alert to the coordinating providers. The ASO acts on the alerts and updates the enrollment information and sends a secure email to the clinics**



Client



Eligibility Specialist

The specialist reviews CalWIN, MEDS and IDX and AuthMed for enrollment history. **The specialist, with consent from the resident, accesses HHSIE and reviews the past enrollment in other programs. Through inclusion of shared analytics, HHSIE provides the specialist with suggestions for other applicable programs which are discussed with the client. The specialist also reviews alerts related to public safety specifically for that client that are displayed in HHSIE.**



Client



Eligibility Specialist

The specialist sees that resident has past files in AuthMed. The Specialist re-activates the AuthMed record and reviews the information to ensure all information is current. **The specialist is able to confirm eligibility for LIHP, but is also prompted to check eligibility for CalFresh, cash assistance and other programs and services based on information provided by the resident.**

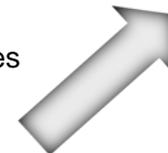


Eligibility Specialist



Client

In order to coordinate services for the client, the specialist requests and receives Informed Consent from the resident. **With the resident's consent, the specialist applies for all appropriate programs, and the resident is informed of other services that may be of assistance.**



## Questions related to the implementation and use of HHSIE

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- What are the consent requirements for a client when applying for LIHP?
  - Most likely a non-issue as this only pertains to eligibility determination
- What are the consequences if the Enrollment Specialists ignores the HHSIE recommendations?
- Will the specialist have to confirm that the client was informed of other programs?
  - In most cases, this is not the role of the eligibility specialist
- If the client requests to see additional information, information can be accessed as this implies client consent.
  - Part of roles and responsibilities

## To-Be Scenario 8 – LIHP Re-Certification

- A resident visits his FRC, and gives the provider Informed Consent (which is entered into the Consent Registry) to review the client's enrollment in other County programs by using HHSIE. The provider sees an alert in HHSIE that two weeks ago the FQHC sent the resident a notice that her LIHP certification (valid for one year) will soon expire. The provider asks if the resident has begun the recertification process. The resident responds that she has not started it, but would like to get recertified. The provider explains why continued coverage is important and arranges for the resident to meet with the FRC eligibility specialist.
- The specialist sees that the resident gave Informed Consent, which allows the specialist to search the systems. The specialist locates the past applications and any current information from HHSIE and verifies information with the resident. Eligibility is confirmed and the resident is re-enrolled.

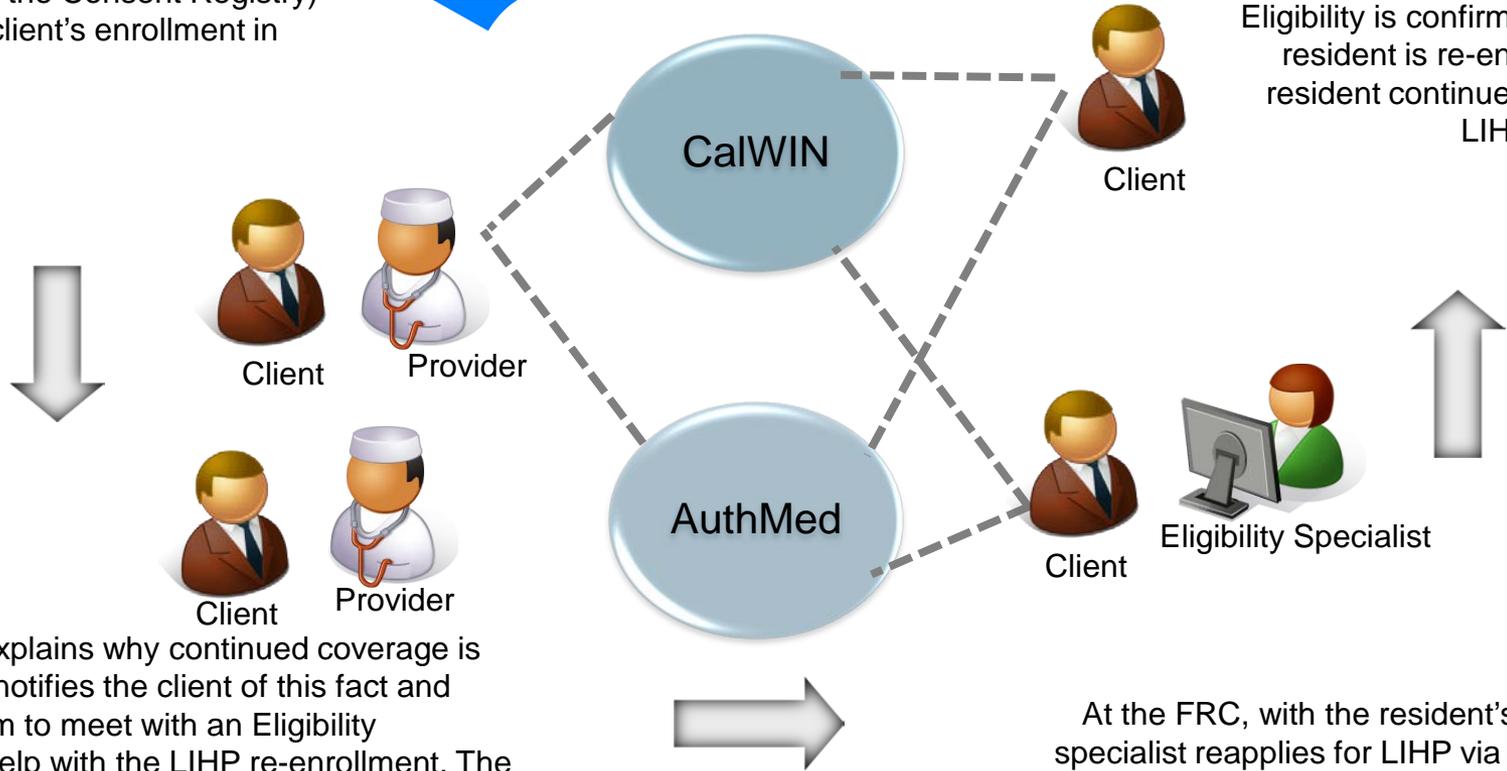
### **HHSIE Analytics supporting this scenario:**

- Access to Client Record including Notifications and Alerts
- Access to Dashboard report on information specific to the offender's population

# LIHP Re-Certification – Current State



A resident visits his FRC, and gives the provider Informed Consent (which is entered into the Consent Registry) to review the client's enrollment in LIHP.

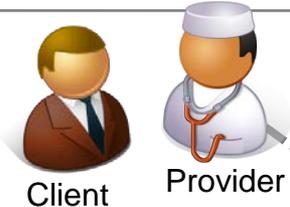


Eligibility is confirmed and the resident is re-enrolled. The resident continues receiving LIHP benefits.

The provider explains why continued coverage is important and notifies the client of this fact and encourages him to meet with an Eligibility Specialist for help with the LIHP re-enrollment. The resident visits the FRC to re-enroll in LIHP.

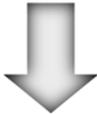
At the FRC, with the resident's consent, the specialist reapplies for LIHP via AuthMed and CalWIN.

To-Be Scenario 8 – LIHP Re-Certification



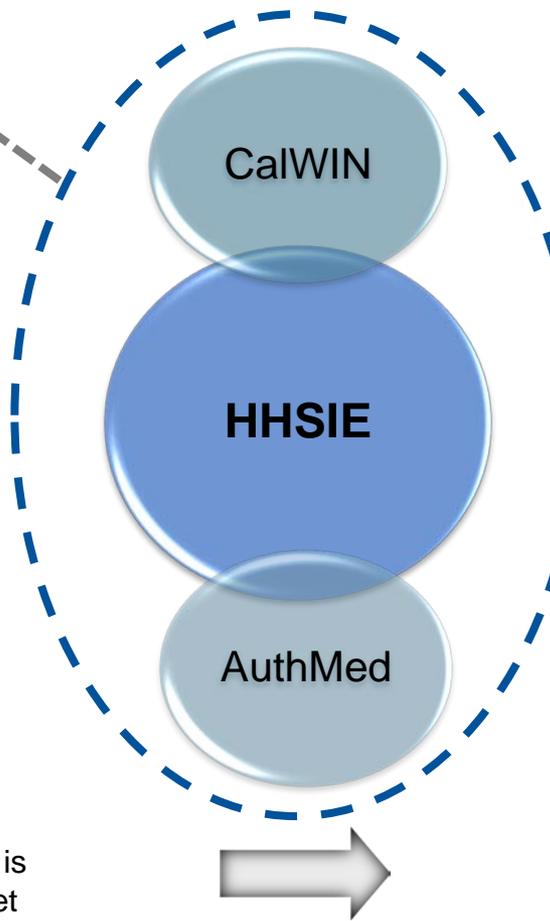
Client Provider

A resident visits his FRC, and gives the provider Informed Consent (which is entered into the Consent Registry) **to review the client's enrollment in other County programs by using HHSIE. The provider sees an alert in HHSIE that two weeks ago the FQHC sent the resident a notice that her LIHP certification (valid for one year) will soon expire.** The provider asks if the resident has begun the recertification process. The Resident responds that she has not started it, but would like to get recertified.



Client Provider

The provider explains why continued coverage is important and arranges for the Resident to meet with the FRC eligibility specialist.



Client

Eligibility is confirmed and the resident is re-enrolled. The resident continues receiving LIHP benefits.



Client

Eligibility Specialist



The specialist sees that the resident gave Informed Consent, which allows the specialist to search the systems. The specialist locates the past applications and any current information from HHSIE and verifies information with the resident.