California Health and Human Services

Data Exchange Framework Stakeholder Advisory Group

Meeting #2

Thursday, October 7, 2021
10:00 a.m. to 12:30 pm

Meeting Participation Options
Written Comments

Written Comments

- Participants may submit comments and questions through the **Zoom Q&A box;** all comments will be recorded and reviewed by Advisory Group staff.
- Participants may also submit comments and questions - as well as requests to receive Data Exchange Framework updates - to **CDII@chhs.ca.gov**.

Meeting Participation Options
Spoken Comments

Spoken Comments

Participants and *Advisory Group Members* must "raise their hand" for Zoom facilitators to unmute them to share comments; the Chair will notify participants/Members of appropriate time to volunteer feedback.

If you logged on via phone-only

- Press "*9" on your phone to "raise your hand"
- Listen for your phone number to be called by moderator
- If selected to share your comment, please ensure you are "unmuted' on your phone by pressing "*6"

If you logged on via Zoom interface

- Press "Raise Hand" in the "Reactions" button on the screen
- If selected to share your comment, you will receive a request to "unmute;" please ensure you accept before speaking

Public Comment Opportunities

- Public comment will be taken during the meeting at designated times.
- Public comment will be limited to the total amount of time allocated for public comment on particular issues.
- The Chair will call on individuals in the order in which their hands were raised.
- Individuals will be recognized for up to two minutes and are asked to state their name and organizational affiliation at the top of their statements.
- Participants are encouraged to use the comment box to ensure all feedback is captured or email their comments to CDII@chhs.ca.gov.

Agenda

10:00 AM **Welcome and Roll Call**
- *John Ohanian, Chief Data Officer, California Health and Human Services*

10:10 AM **Meeting Objectives**
- *Dr. Mark Ghaly, Secretary, California Health and Human Services*

10:25 AM **Public Comment**

10:40 AM **Data Exchange Framework Development Overview**
- *John Ohanian*

11:00 AM **Break**

11:05 AM **Data Exchange Framework Scenario Discussion**
- *Jonah Frohlich, Managing Director, Manatt Health Strategies*

12:15 PM **Data Sharing Agreement Subcommittee Charter and Nomination Update**
- *John Ohanian*

12:25 PM **Closing Remarks**
- *Dr. Mark Ghaly*

Welcome and Roll Call

Advisory Group Members

Stakeholder Organizations (1 of 3)

Name	Title	Organization
Mark Ghaly *(Chair)*	Secretary	California Health and Human Services Agency
Jamie Almanza	CEO	Bay Area Community Services
Charles Bacchi	President and CEO	California Association of Health Plans
Andrew Bindman *designated by Greg A. Adams*	Executive Vice President; Chief Medical Officer	Kaiser Permanente
Michelle Doty Cabrera	Executive Director	County Behavioral Health Directors Association of California
Carmela Coyle	President and CEO	California Hospital Association
Rahul Dhawan *designated by Don Crane*	Associate Medical Director	MedPoint Management (representing America's Physician Groups)
Joe Diaz *designated by Craig Cornett*	Regional Director	California Association of Health Facilities
David Ford *designated by Dustin Corcoran*	Vice President, Health Information Technology	California Medical Association
Liz Gibboney	CEO	Partnership HealthPlan of California

Note: Complete bios for each member will be included in a publicly posted biography listing; updated on Sept. 30th at 5pm PT

Advisory Group Members

Stakeholder Organizations (2 of 3)

Name	Title	Organization
Michelle Gibbons *designated by Colleen Chawla*	Executive Director	County Health Executives Association of California
Lori Hack	Interim Executive Director	California Association of Health Information Exchanges
Alma Hernández	Executive Director	Service Employees International Union California
Sandra Hernández	President and CEO	California Health Care Foundation
Cameron Kaiser *designated by Karen Relucio*	Deputy Public Health Officer	County of San Diego (representing the California Conference of Local Health Officers)
Andrew Kiefer *designated by Paul Markovich*	Vice President, State Government Affairs	Blue Shield of California
Linnea Koopmans	CEO	Local Health Plans of California
David Lindeman	Director, CITRIS Health	UC Center for Information Technology Research in the Interest of Society
Amanda McAllister-Wallner *designated by Anthony E. Wright*	Deputy Director	Health Access California

Advisory Group Members

Stakeholder Organizations (3 of 3)

Name	Title	Organization
DeeAnne McCallin *designated by Robert Beaudry*	Director of Health Information Technology	California Primary Care Association
Ali Modaressi	CEO	Los Angeles Network for Enhanced Services
Erica Murray	President and CEO	California Association of Public Hospitals & Health Systems
Janice O'Malley *designated by Art Pulaski*	Legislative Advocate	California Labor Federation
Mark Savage	Managing Director, Digital Health Strategy and Policy	Savage & Savage LLC
Kiran Savage-Sangwan	Executive Director	California Pan-Ethnic Health Network
Cathy Senderling-McDonald	Executive Director	County Welfare Directors Association
Claudia Williams	CEO	Manifest MedEx
William York	President and CEO	San Diego Community Information Exchange

Advisory Group Members
State Departments (1 of 2)

Name	Title	Organization
Ashrith Amarnath	Medical Director	California Health Benefit Exchange
Nancy Bargmann	Director	Department of Developmental Services
Mark Beckley	Chief Deputy Director	Department of Aging
Scott Christman	Chief Deputy Director	Department of Health Care Access and Information
David Cowling	Chief, Center for Information	California Public Employees' Retirement System
Kayte Fisher	Attorney	Department of Insurance
Julie Lo	Executive Officer	Business, Consumer Services & Housing Agency

Advisory Group Members
State Departments (2 of 2)

Name	Title	Organization
Dana E. Moore	Acting Deputy Director	Department of Public Health
Nathan Nau	Deputy Director, Office of Plan Monitoring	Department of Managed Health Care
Linette Scott	Chief Data Officer	Department of Health Care Services
Diana Toche	Undersecretary, Health Services	Department of Corrections and Rehabilitation
Julianna Vignalats	Assistant Deputy Director	Department of Social Services
Leslie Witten-Rood	Chief, Office of Health Information Exchange	Emergency Medical Services Authority

Vision & Meeting Objectives

Vision for Data Exchange in CA

Every Californian, and the health and human service providers and organizations that care for them, will have timely and secure access to usable electronic information that is needed to address their health and social needs and enable the effective and equitable delivery of services to improve their lives and wellbeing.

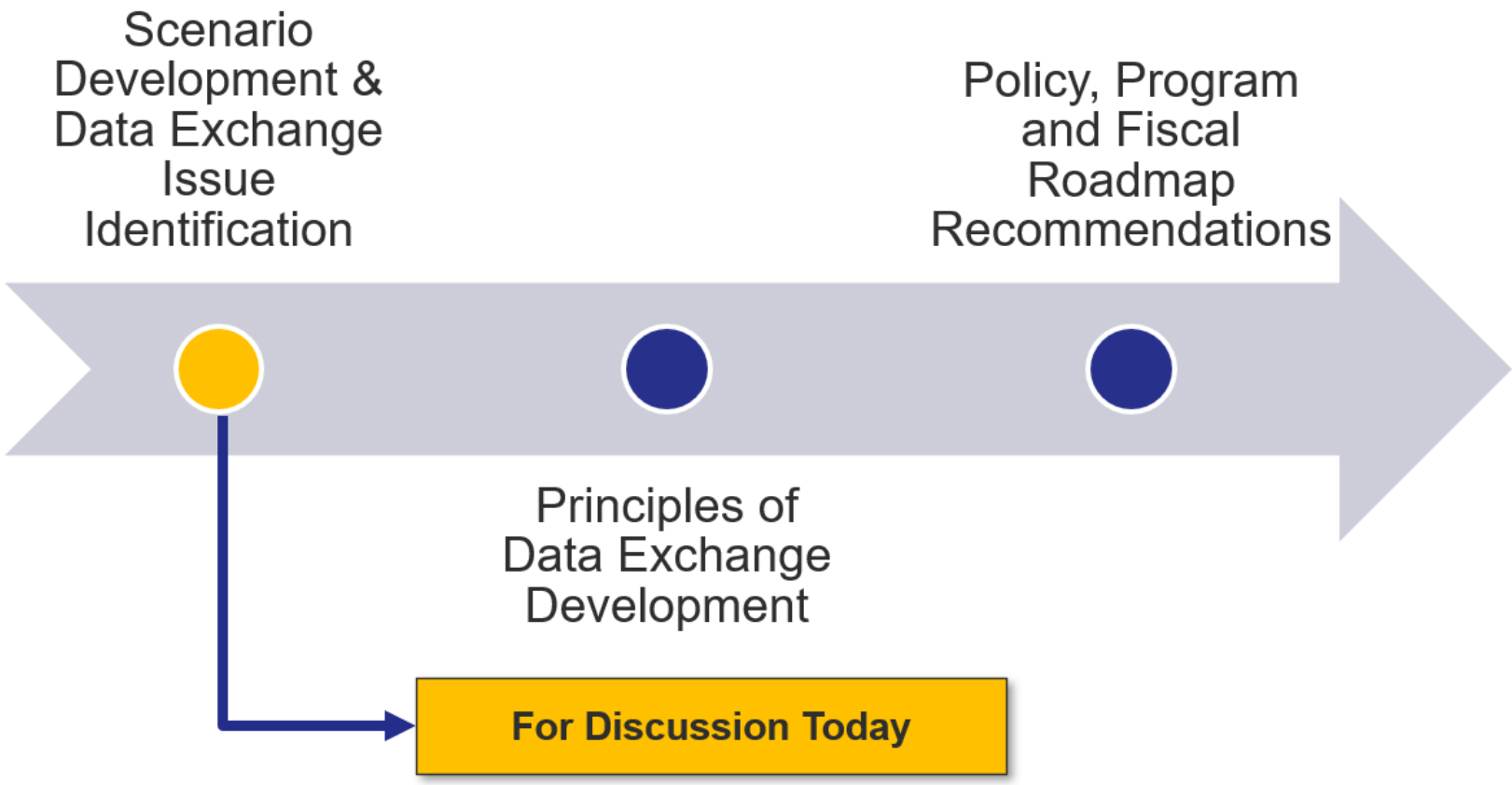
Meeting #2 Objectives

- Confirm a structure and roadmap for the development of the Data Exchange Framework
- Discuss examples of six data exchange “scenarios” and identify data exchange barriers
- Discuss the Data Sharing Agreement Subcommittee charge and response update

Public Comment Period

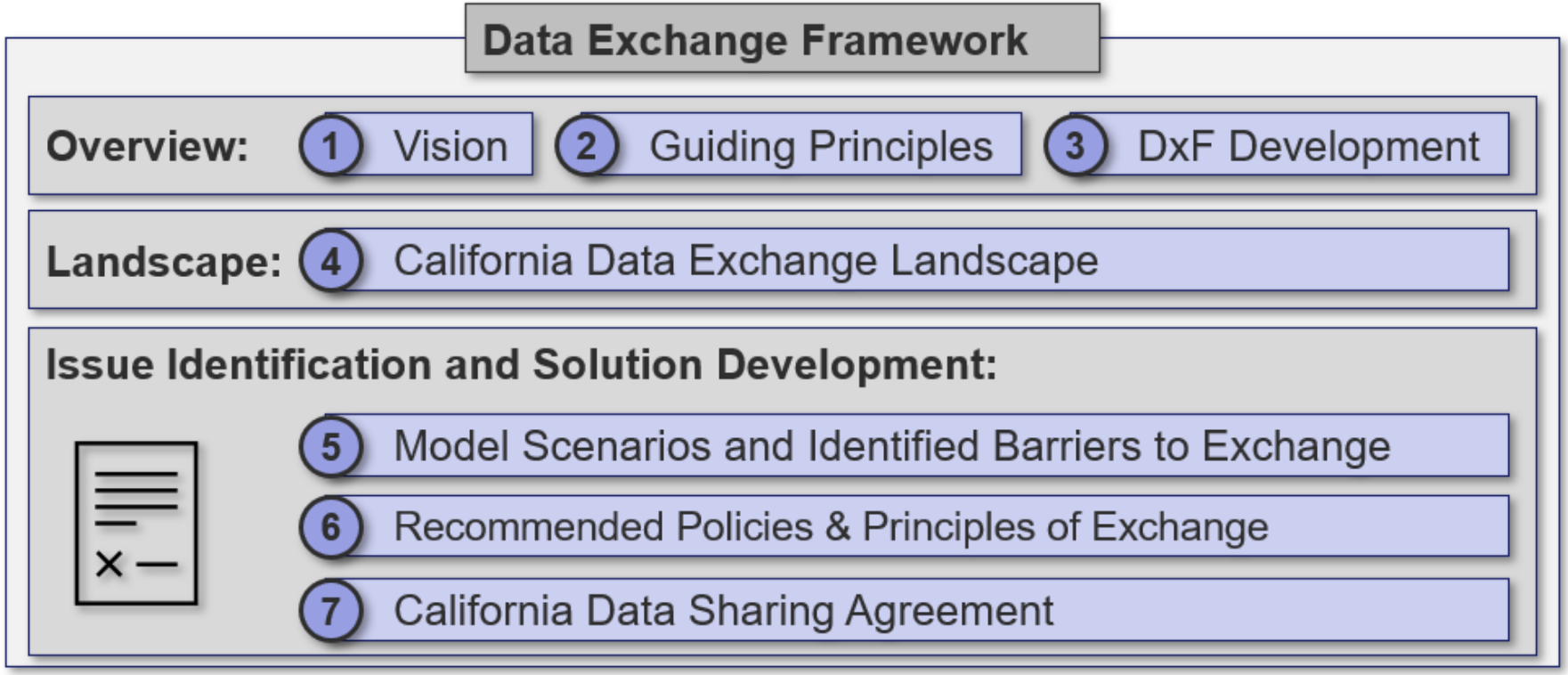
Data Exchange Framework Development Overview

Data Exchange Framework (DxF) Development Process



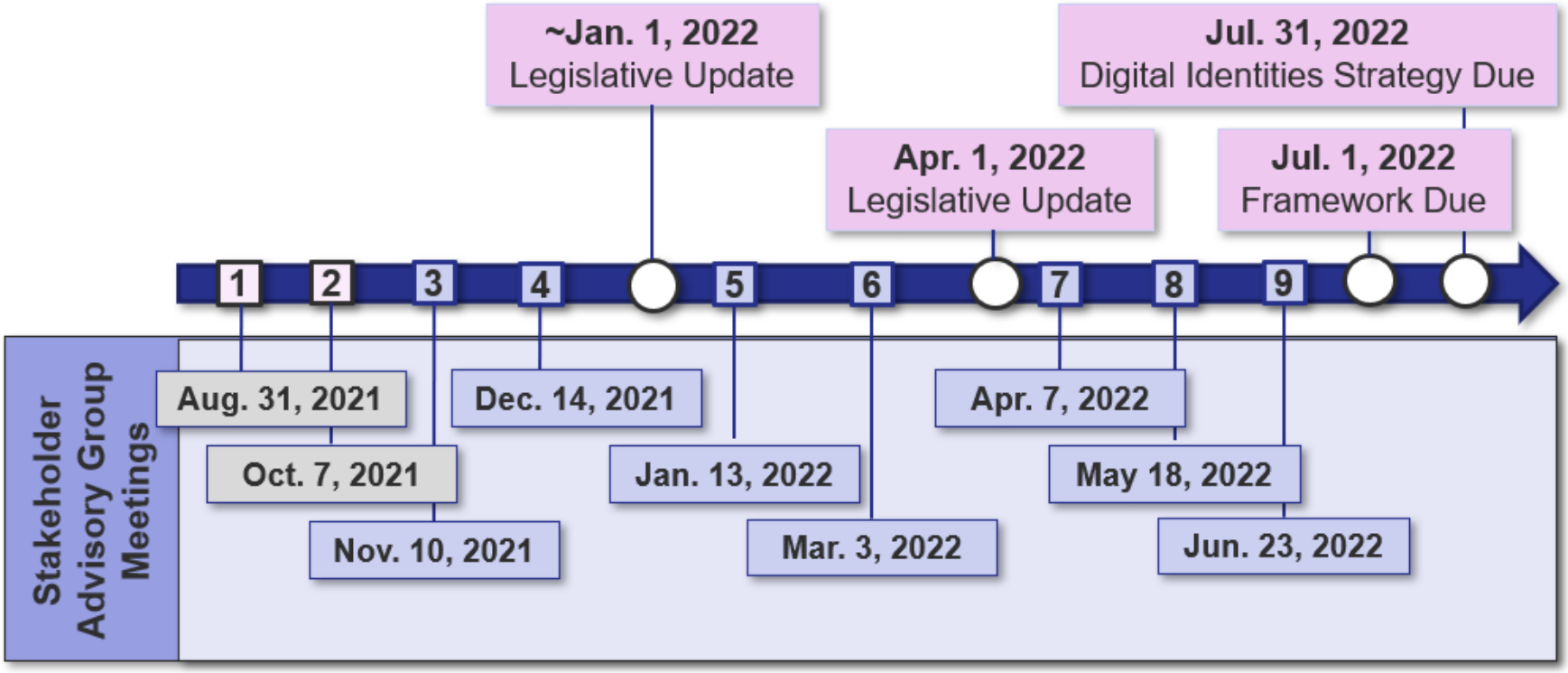
Data Exchange Framework
End-Product(s)

Per Health and Safety Code § 130290, the DxF "shall include a single data sharing agreement and common set of policies and procedures that will leverage and advance national standards for…[data exchange and consent], and that will govern and require the exchange of health information among health care entities and government agencies in California."



Data Exchange Framework
Roadmap

The Stakeholder Advisory Group will meet up to nine times through July 2022 to advise on DxF development.



Potential agenda topics will be raised at the close of each preceding meeting.

California Health & Human Services Agency

CENTER FOR DATA INSIGHTS AND INNOVATION
CALIFORNIA HEALTH & HUMAN SERVICES AGENCY

Break (5 min.)

Agenda - Remaining

~~10:00 AM~~ ~~Welcome and Roll Call~~
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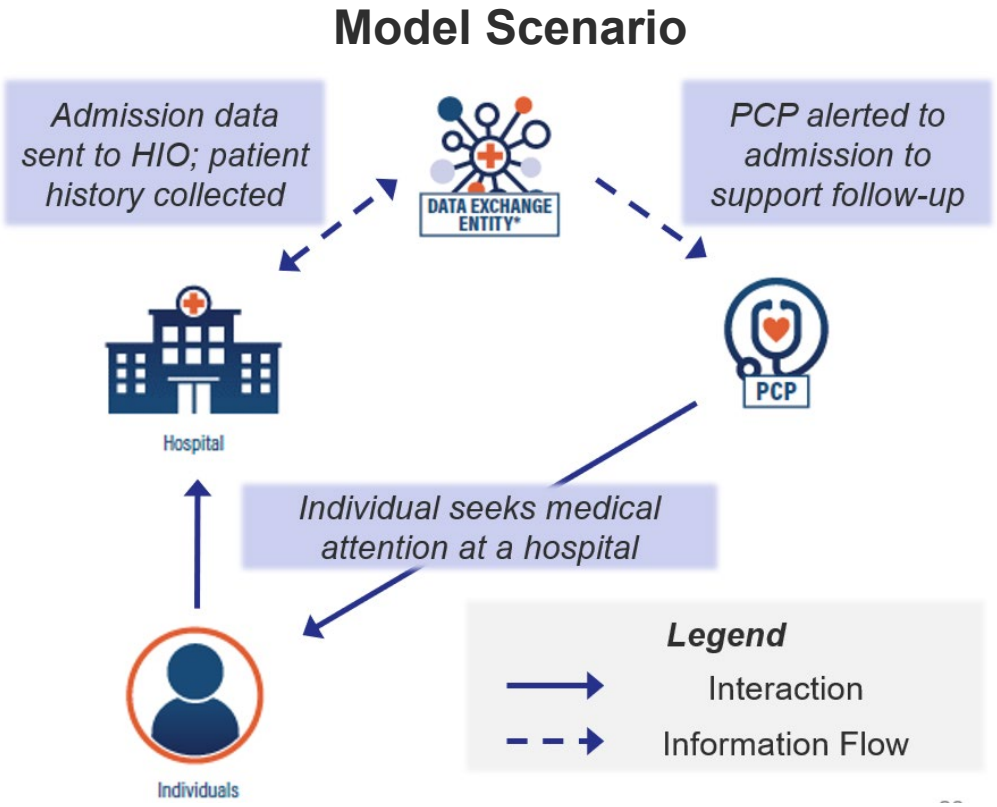
Data Exchange Framework Scenario Discussion

Purpose of Proposed Scenarios

Scenario: a triggering event, followed by a set of activities and actions that require the exchange of health and human service information between actors to support the individual's health and wellbeing

Examining **scenarios** through the DxF development process will allow us to:

- **Identify shortcomings** of our current system of electronic information exchange; and,
- **Develop** policy, program, and fiscal recommendations and actions that can be incorporated into the Data Exchange Framework to overcome barriers.



*Data Exchange Entity (e.g., HIO, national network, EHR vendor network, or other data exchange entity)

Overview of Proposed Scenarios

Six scenarios have been developed for discussion today.

1. **Acute or Chronic Health Needs:** Addressing the health and social needs of individuals with acute or chronic care needs.
2. **Complex Health & Social Needs:** Addressing the health and social needs of individuals with complex medical and behavioral health conditions and social needs.
3. **Population Health & Value-Based Care:** Addressing the health and social needs of individuals and populations across the continuum of care using data driven risk stratification, predictive analytics, identifying gaps in care and standardized assessment processes.
4. **Emergency Response:** Addressing the health and social needs of individuals and populations by ensuring that emergency response providers and disaster healthcare volunteers have access to patients' clinical records and other relevant information during emergencies.
5. **Public Health Response:** Addressing the health and social needs of Californians by strengthening public health surveillance, research, preparedness, and response to public health emergencies.
6. **Coordinating Reentry Health Services:** Addressing the health and social needs of individuals as they transition from incarceration back into their communities.

Scenario Pre-Read Material

Pre-Read Material has been shared in advance of today's discussion that provides an example of how a given scenario may unfold. Each example includes:

- A case example or "story" of the circumstance
- An illustration of how organizations ("Actors") in the example may interact to support the individual's health and wellbeing, including what information should be exchanged to support the care of the individual
- A summary of the key data exchange challenges Actors confront when striving to meet the individual's needs.

Note: Scenario examples are being shared for discussion purposes and are not intended to be exhaustive or fully representative of all the circumstances a given scenario may comprise.

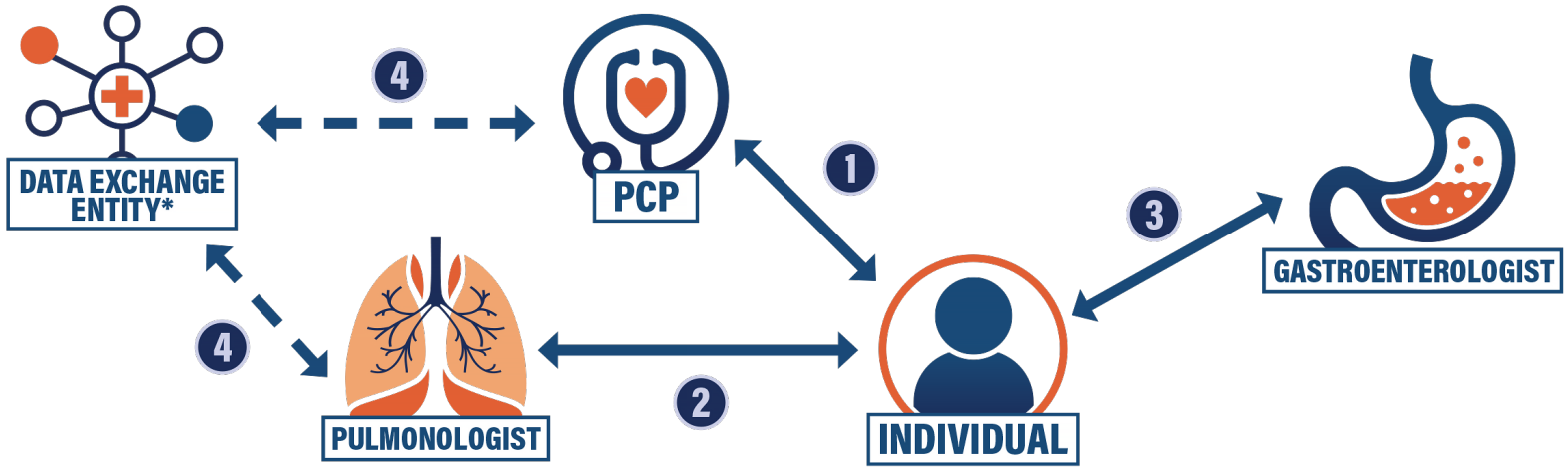
Proposed Scenario Feedback

We are seeking Stakeholder Advisory Group feedback in the following areas:

1. Are these the most salient scenarios to test through our process?
2. For each scenario-example, would you highlight other critical:
   - ❑ Actors or data types that are (or should be) involved in supporting or informing care delivery?
   - ❑ Pressing data exchange barriers or challenges that we should be considering through DxF development?

Scenario 1: Acute or Chronic Health Needs

A 60-year-old woman receives care from multiple unaffiliated providers resulting in care coordination challenges. Despite widespread adoption of electronic health records, there remain barriers to data exchange to coordinate care.



**Data Exchange Entity may include a HIO, national network, EHR vendor network, or other data exchange entity*

Data Exchange & Process Steps

1. Individual engages primary care provider (PCP) for treatment of hypertension and general health needs
2. Individual engages pulmonologist (specialist) for treatment of COPD
3. Individual engages gastroenterologist (specialist) for treatment of newly diagnosed IBD
4. Select health providers engage in data sharing with a data exchange entity

Please see Scenario Pre-Read on the CHHS website for more information. https://www.chhs.ca.gov/data-exchange-framework/

Scenario 1 Barriers: Acute or Chronic Health Needs

Infrastructure Gaps

- Lagging EHR adoption at some smaller independent and safety-net practices
- Low EHR adoption at behavioral health, long term and post-acute care providers
- Uneven health information exchange presence across California

Data Exchange Barriers

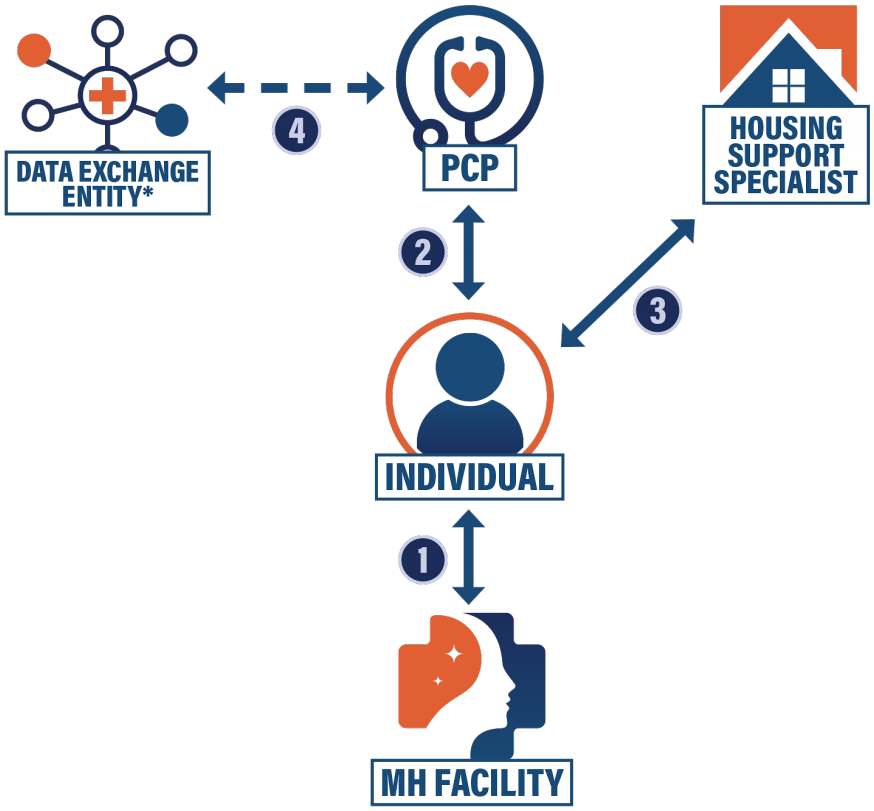
- Lack of interoperability between existing EHRs (particularly among providers using non-certified EHR technologies)
- Challenges with patient and provider identity matching
- Absence of key data types

Legal and Policy Issues

- Certain data types (e.g., mental health, SUD, HIV/AIDS test results) are governed by specific federal & state rules/regs and require consent, complicating automated exchange
- Lack of systems/ processes for managing patient consent (data sharing authorization) for sensitive data

Scenario 2: Complex Health & Social Needs

A 40-year-old Latino man with complex health and social needs receives care from a broad spectrum of unaffiliated physical health, behavioral health, and social service providers, each addressing specific needs of the individual.



Data Exchange & Process Steps

1. Individual is admitted to a mental health (MH) facility to receive treatment for psychiatric symptoms
2. Individual engages PCP for treatment of diabetes
3. Individual engages housing support specialist to secure safe, affordable housing
4. Select health providers are engaged in data sharing with a data exchange entity

**Data Exchange Entity may include a HIO, national network, EHR vendor network, or other data exchange entity*

Please see Scenario Pre-Read on the CHHS website for more information. https://www.chhs.ca.gov/data-exchange-framework/

Scenario 2 Barriers: Complex Health & Social Needs

Infrastructure Gaps

- Behavioral health and many small, rural, and under-resourced providers often lack EHRs and other HIT capable of exchanging clinical data.
- Not all providers with certified EHR technology are connected to an HIO.
- CBOs often do not have technologies or platforms to share and receive social or health information with other providers.

Data Exchange Barriers

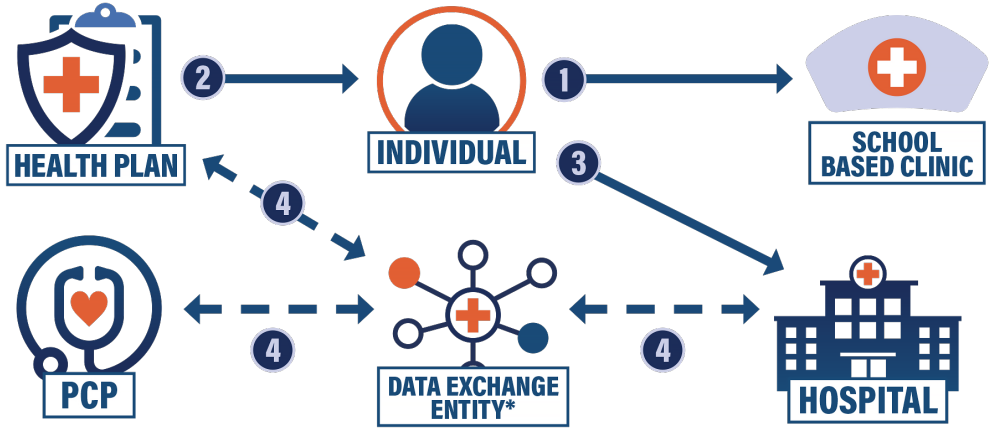
- National networks, HIOs, and EHRs generally have limited capabilities to exchange SDOH data.

Legal and Policy Issues

- Federal and state laws, regulations and policies that govern the exchange of health and social services data are complex, confusing, and open to varying interpretations, creating hesitancy to share data.
- Federal and state laws also require a variety of consent processes and timeframes, complicating automated exchange.

Scenario 3: Population Health and Value-based Care

An African American non-binary teenage child with undiagnosed asthma experiences an exacerbation of their underlying condition during a wildfire.



Data Exchange & Process Steps

1. Child engages school nurse due to asthma exacerbation; child referred to PCP, but does not go due to distance and discrimination concerns (not shown)
2. Health plan's population health management system identifies individuals with asthma in the child's neighborhood as being at risk, but plan is not aware of child's symptoms or recent school-based clinic visit
3. Child admitted to local emergency department after symptoms worsen
4. Select health providers are engaged in data sharing with a data exchange entity

**Data Exchange Entity may include a HIO, national network, EHR vendor network, or other data exchange entity*

Please see Scenario Pre-Read on the CHHS website for more information. https://www.chhs.ca.gov/data-exchange-framework/

Scenario 3 Barriers: Population Health and Value-based Care

Infrastructure Gaps

- Many school-based health providers (among other ambulatory care providers in settings outside of traditional practices and clinics) lack certified EHRs or systems capable of electronically recording, storing, and sharing health information with other providers.

Data Exchange Barriers

- Demographic data, particularly race, ethnicity, language, sexual orientation, and gender identity, that could inform population health equity efforts are challenging to acquire.
- Many non-traditional health care providers may not be connected to health information exchanges.
- Most payers can't access clinical, behavioral and social data needed to support population health management efforts.

Legal and Policy Issues

- Federal and state laws, regulations and policies as they pertain to minors can be complex and may create hesitancy to share data.

Scenario 4: Emergency Response

A 50-year-old adult male with a diagnosis of chronic heart disease who receives Supplemental Nutrition Assistance Program benefits through CalFresh and is eligible for medically tailored meals through their managed care plan is evacuated from a wildfire.

Data Exchange & Process Steps

1. Individual is disoriented and seeks care from disaster healthcare volunteer
2. Disaster healthcare volunteer queries PULSE and SAFR (not shown) to view individual's available clinical summaries
3. Individual is transferred to a hospital emergency department (ED) for further assessment
4. Individual engages with ED physician to receive treatment for chronic heart condition
5. Some actors are potentially disconnected from information exchange

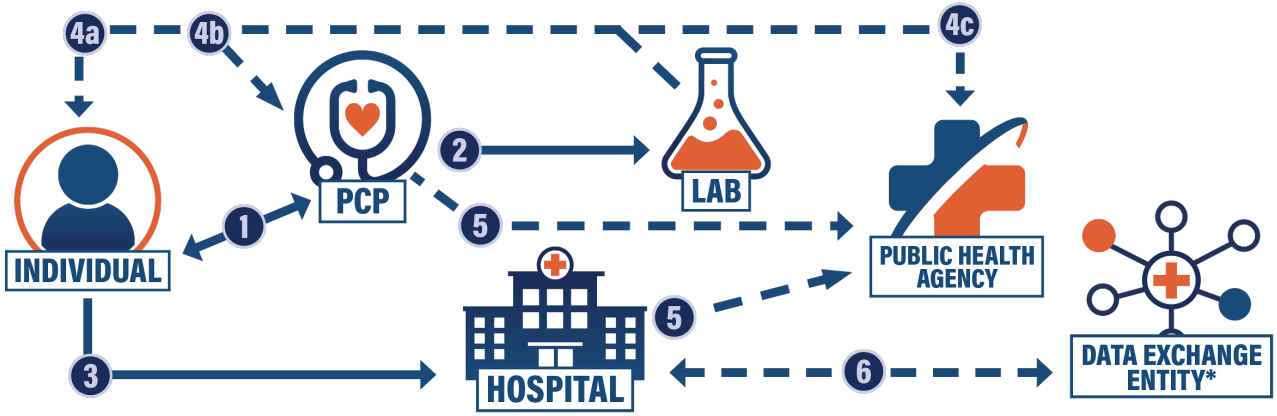
Please see Scenario Pre-Read on the CHHS website for more information. https://www.chhs.ca.gov/data-exchange-framework/

Scenario 4 Barriers: Emergency Response

Infrastructure Gaps	Data Exchange Barriers	Legal and Policy Issues
• PULSE and SAFR have data and coverage gaps, limiting providers' access to critical physical health records during emergency response and disaster responses (e.g., some hospitals don't connect to PULSE, SAFR is active in only 29 of California's 58 counties)	• Neither PULSE nor SAFR currently collect or exchange non-clinical SDOH data	• Federal and state law in some instances may prohibit the exchange of SDOH data (e.g., USDA rules may not allow Member information to be disclosed). • Complex federal/state consent requirements can be prohibitively difficult to sort through during an emergency.

Scenario 5: Public Health Response

A 35-year-old Asian-American woman who works as a housecleaner and lives in a multi-generational setting contracts COVID-19, is instructed to self-quarantine by her PCP as she awaits test results, and is admitted to hospital after condition worsens.



Data Exchange & Process Steps

1. Individual engages primary care provider (PCP) for diagnosis and COVID testing
2. PCP directs individual to get tested at a local testing site/lab
3. While awaiting test results, the individual's condition worsens and she is brought to the nearest hospital, admitted, and diagnosed with COVID-19
4. Lab transmits results to the (a) individual, (b) provider, & (c) applicable public health agencies
5. Providers transmit reportable disease reports to applicable public health agencies; public health agency to follow-up for contact tracing
6. Individual's admission data is transmitted to the Data Exchange Entity (PCP may not be connected)

**Data Exchange Entity may include a HIO, national network, EHR vendor network, or other data exchange entity*

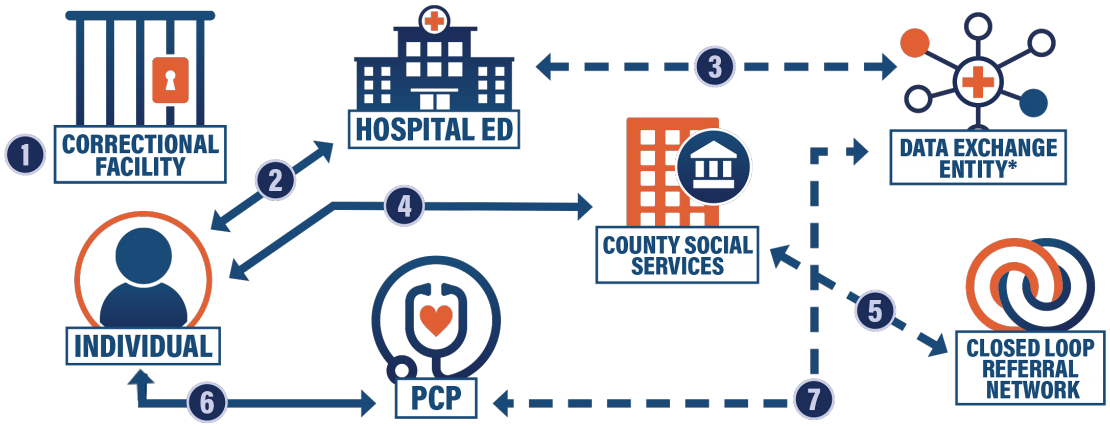
Please see Scenario Pre-Read on the CHHS website for more information. https://www.chhs.ca.gov/data-exchange-framework/

Scenario 5 Barriers: Public Health Response

Infrastructure Gaps	Data Exchange Barriers	Legal and Policy Issues
• Many types of public health data are collected and transmitted via paper-based, phone, fax, or other non-machine-readable formats. • CalREDIE and the CAIR systems were not designed to connect, consume, & incorporate health information from HIOs or EHRs at scale.	• Basic clinical data, hospital/ED alerts, emergency department capacity, acute care beds, ICUs, protective personal equipment, demographic information, and social information are stored in disparate systems that are not easily accessible to public health departments.	• Navigating complex public health data exchange rules and consent requirements can be difficult to manage, particularly during a pandemic which necessitates rapid responses to contain and manage outbreaks and toxic exposures.

Scenario 6: Coordinating Reentry Health Services

A 25-year-old white male with hypertension and mild depression is released from a county jail but lacks coverage. He experiences complications and interacts with providers with incomplete information as he seeks access to needed care in the community.



Data Exchange & Process Steps

1. Individual is released from the correctional facility
2. After the individual is released from the correctional facility, his condition worsens and he visits the hospital emergency department (ED) for treatment
3. Hospital ED queries regional data exchange entity for available health data (correctional facility's health information not available)
4. Individual engages county social service department for help accessing insurance and SDOH services
5. County social service representative queries CBO directory to identify support services for individual
6. Individual engages a new PCP to discuss worsening behavioral health condition
7. PCP queries regional data exchange entity for recent information on individual's health service utilization (correctional facility's health information not available)

**Data exchange entity may include a HIO, national network, EHR vendor network, or other data exchange entity*

Please see Scenario Pre-Read on the CHHS website for more information. https://www.chhs.ca.gov/data-exchange-framework/

Scenario 6 Barriers: Coordinating Reentry Health Services

Infrastructure Gaps

- Data on justice-involved individuals is highly siloed across settings which creates barriers to collaboration and effective care coordination.
- Correctional facilities often lack certified EHR technology capable of electronically sharing data with other health care providers.

Data Exchange Barriers

- National networks, HIOs, and EHRs generally have limited capabilities to exchange mental health and SDOH data that would help individuals reentering their communities to identify, obtain and utilize mental health and SDOH-related services.

Legal and Policy Issues

- Criminal data are governed by a different set of federal and state privacy laws that must be navigated to get access to information and may limit type of information able to be shared.

Data Sharing Agreement Subcommittee Update

Data Sharing Agreement Subcommittee
Purpose and Focus

Subcommittee Purpose

The CHHS DxF Data Sharing Agreement (DSA) Subcommittee will advise CHHS and the Stakeholder Advisory Group in the development of a "*single data sharing agreement and common set of policies and procedures*" that build on national information exchange and data content standards to govern health information exchange among health care entities and government agencies in California.

Subcommittee Focus

- Technical and operational issues related to the development of a single statewide data sharing agreement, potentially including, but not limited to: data standards and specifications; data exchange and transmission protocols; privacy and security requirements; and disclosure requirements.
- Supporting alignment with existing federal and state data sharing laws, policies, and frameworks (e.g., DURSA, CalDURSA, TEFCA).
- Refining principles and addressing questions raised by the Stakeholder Advisory Group.

Data Sharing Agreement Subcommittee
Membership

Membership

The DSA Subcommittee will comprise between 10 and 15 individuals representing a diverse set of public and private health care stakeholders with expertise and experience relevant to the design, development, and implementation of health and cross-sector data sharing agreements. DSA Subcommittee will be appointed by mid-October.

The DSA Subcommittee will advise and advance recommendations to the Stakeholder Advisory Group. The DSA Subcommittee does not have decision-making authority.

The DSA Subcommittee will meet up to seven times from October 2021 through June 2022. It will conduct its business through discussion and consensus-building.

As of Friday, October 1st, over 50 individuals from over 40 organizations have completed a Statement of Interest form to serve on the DxF DSA Subcommittee.

Closing Remarks

Next Steps

CHHS will:

- Summarize meeting notes and circulate for review over email in advance of next meeting.
- Advance Data Sharing Agreement (DSA) Subcommittee candidates, charter, and proposed meeting schedule to the Stakeholder Advisory Group for comment and consideration.

Members will:

- Review meeting notes and provide feedback to CHHS staff.
- Provide feedback on proposed Scenarios with a focus on identifying barriers and gaps in data exchange.
- Provide feedback on DSA Subcommittee candidates, charter, and proposed meeting schedule.

Advisory Group Meeting Schedule

Meeting	Date
Advisory Group Meeting #3	**November 10, 2021, 10:00 AM to 12:30 PM**
Advisory Group Meeting #4	December 14, 2021, 10:00 AM to 12:30 PM
Advisory Group Meeting #5	January 13, 2022, 10:00 AM to 12:30 PM
Advisory Group Meeting #6	March 3, 2022, 10:00 AM to 12:30 PM
Advisory Group Meeting #7*	April 7, 2022, 10:00 AM to 12:30 PM
Advisory Group Meeting #8*	May 18, 2022, 10:00 AM to 12:30 PM
Advisory Group Meeting #9*	June 23, 2022, 10:00 AM to 12:30 PM

Dates Tentative for Meetings #7-9

For more information or questions on Advisory Group meeting scheduling and logistics, please email Kevin McAvey (Kmcavey@manatt.com).

Thank You!