California Health & Human Services Agency
Center for Data Insights and Innovation
Data Exchange Framework Implementation Advisory Committee
Meeting 1 Q&A Log (10:00AM – 12:30PM PT, Septemebr 21, 2022)

The following table shows comments that were entered into the Zoom Q&A by public attendees during the September 21st meeting:

Count	Name	Comment	Response
1	Lane# Steven MD MPH	Very excited to be a part of this next phase of the evolution of our statewide data exchange framework.	
2	Lane# Steven MD MPH	It seems that one of the biggest mistakes we could make in CA would be to try to design a local solution set from scratch. SO MUCH progress has been made in health data interoperability nationwide with great examples of regional success with the use of standardized exchange (push and query) as well as the evolving use of Health Data Utilities. The challenge in our large diverse state is to help connect underserved stakeholders with the existing tools and support their use of those tools, and THEN see where there are gaps that we can close to meet specific unmet needs.	
3	Lane# Steven MD MPH	Yes @ Jonathan! We have so many opportunities to connedt social and human service providers to existing standards-based interoperability solutions, e.g., Direct Secure Messaging and query-based document exchange via the Carequality framework today and the federal TEFCA in the future. This access is readily accessible at nominal cost and new Information Blocking prohibitions on providers require them to support this exchange using their installed base of health IT solutions.	
4	Wes Rishel	How does a QHIO compare to a TEFCA QHIN?	That is what we are going to have to define. It is the work of the committee

Count	Name	Comment	Response
			to develop. Would love your thoughts Wes. Thank you for attending this!
5	Lane# Steven MD MPH	There is also a need for communications regarding the specific marginal requirements of the DxF, especially for providers across the state who are already exchanging millions of clinical data transactions monthly via existing standardized exchange (CDA push/pull and FHIR queries) with multiple stakeholders via existing networks and data exchange frameworks. Providers are fully enabled to exchange health data with additional stakeholders for additional use cases leveraging existing technology with only modest additional requirements/burden.	
6	Lane# Steven MD MPH	'@Wes - I anticipate that the QHIO definition will be more similar to the federal definition of a HIN as opposed to a QHIN. We anticipate a relatively small number of QHINS (~ a dozen in time?) that will provide connectivity services to their participants and subparticipants, which will include HINs. https://rce.sequoiaproject.org/tefca/	I think that's right Steven. CDII recently met with the Sequoia project leadership to discuss QHIO and QHIN alignment. Those discussions will continue as CDII develops QHIO criteria
7	ljohns	CA is big state, so it needs to *lead* in intergration with prior and ongoing federal initiatives. That hasn't been mentioned as a guideline yet at this meeting, hope to hear that said. ;-)	
8	Kristan DeGraeve	Is there an opportunity for Health IT vendors with several CA customers/partners to participate as an IAC member or subcommittee member?	
9	Lane# Steven MD MPH	California stakeholders will absolutely want to connect up to the evolving TEFCA framework via a QHIN. We will therefore want all QHIOs to have develop plan for TEFCA connectivity via a QHIN. Note that no QHINs have been designated to date. We anticipate the first group of applicant/candidate QHINs to be identified by January and hope to see live voluntary data exchange over the TEFCA framework next year. One of our challenges in CA is to forge ahead on our own interoperabiility	

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		journey now with a clear awareness that this will need to integrate/merge into TEFCA exchange over the coming years.	
10	ljohns	"Transaction patterns"…please explain what this means, refers to?	
11	Lane# Steven MD MPH	It is helpful to point out the the federal Common Agreement for Nationwide Health Information Interoperability published in January (https://rce.sequoiaproject.org/wp-content/uploads/2022/01/Common-Agreement-for-Nationwide-Health-Information-Interoperability-Version-1.pdf), is an agreement signed by QHINs to support their role in TEFCA exchange. This is quite different than the Flowdown Agreements to which QHINs' participants and subparticipants will be required to agree, typically through contract ammendments.	
12	Karen Ostrowski	Consent management should absolutely be prioritized both to resolve conflicts in laws and regulations, but also because it is, in many ways, central to the alignment issue that was discussed at the beginning of the meeting.	
13	Karen Ostrowski	Thank you Lori! Agree about QHIO being a top priority (as well as consent)…we are getting more and more questions from communities about what that means and how it applies to work they are already doing.	
14	Karen Ostrowski	'+1 to DeeAnne about alignment with PHM!	
15	Lane# Steven MD MPH	Many of these P&Ps will be able to point to established national processes/requirements which are updated on a rolling basis as technology, standards, and adoption evolve. We will want to avoid establishing duplicative regional standards/requirements for California stakeholders who also participate in established transaction patterns. To do otherwise would add unreasonable burden to participants, including providers.	

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16	Wes Rishel	Lori thanks for your response. Listening to a seminar yesterday and reading between the lines it seems clear that at least CommonWell and probably Epic are angling to be QHINs with a vision of national scope. While the theory is that multiple state specific QHIOs can operate as equals with the national QHINs one wonders if healthcare providers and other customers of EHR-like products will meet their interop obligation through the two I mentioned. At least CommonWell is also chasing payers. The upshot of that is that state-specific QHIOs may have difficulty adding enough value to charge sufficient fees to sustain their operation.	
17	Karen Ostrowski	It seems disjointed to address information blocking and monitoring and auditing before enforcement. Shouldn't the who/what/when/how of enforcement be described first?	
18	Lane# Steven MD MPH	Yes, Courtney! One of our real opportunities in California is to extend the existing HIPAA privacy and security, Information Sharing, and other federal standards, e.g., the US COre Data for Interoperability, to additional stakeholders not covered by these requirements today.	
19	Ray Duncan	'@StevenLane Thank you for continuing to emphasize the need for harmonization with efforts by TEFCA, Carequality, and eHealth Exchange	
20	ljohns	Does legislation allow for consumer/pt opt out? If so, there needs to be a P&P about that.	
21	Ray Duncan	What we don't need is a bunch of similar but slightly different requirements by multiple organizations and agencies - nightmare for provider organizations and vendors, also makes it more difficult to get EMR vendors to commit effort to each different set of requirements.	

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22	ljohns	So, query. What about push? And bi-lateral? Included in your concept?	yes those re other types of transaction patterns
23	Karen Ostrowski	While I don't disagree that privacy and security standards should apply to all participants, including those that are not subject to HIPAA, there is a misconception that CBOs and non-health care entities are less sophisticated when it comes to privacy and/or are more lax. Even HIPAA CEs are not good at adhering to HIPAA, so I would encourage the committee to really consider the application of HIPAA standards without thinking through the unintended consequences of making organizations subject to HIPAA when they aren't currently or otherwise.	
24	Lane# Steven MD MPH	In addition to Data Quality, we should consider embracing standards of Data Usability. Specifically, the Sequoia Project has recently published the first version of our Data Usability WOrkgroup.s Implementation Guide: https://sequoiaproject.org/interoperability-matters/data-usability-workgroup/data-usability-workgroup-implementation-guide/	
25	Lane# Steven MD MPH	'+1 Karen Ostrowski	
26	Lane# Steven MD MPH	We want to assure that we are including the large established federated exchange networks within the definition of QHIOs - eHealth Exchange, CommonWell Health Alliance, Epic Care Everywhere, DirectTrust. These are the "organizations" that are managing the lion's share of health data interoperability today. Not all of these are "organizations" per se, but need to be included as these networks already meet these capability requirements.	
27	Ray Duncan	'+1 StevenLane - this is so important. Ca based QHIOs should not be the only ones considered.	
28	Dan Chavez	Does the State of CA plan to participate in TEFCA?	

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29	ljohns	Thanks to whoever is talking this minute! This effort has to add value to huge amount already done.	
30	Michelle Lewis	What with the California DxF achieve that TEFCA will not? Why not wait for TEFCA to become effective? The 2024 timeline for CA DxF is ambitious since so many P&Ps have yet to be developed. EHR vendors cannot begin work until P&Ps are finalized. Also, has anyone engaged the Electronic Health Record Association (EHRA) to see if they would like to participate on the CA DxF committees? The EHRA is an excellent resource to engage numerous EHR vendors. The success of CA DxF will rely heavily on EHR vendors.	CDII very recently met with the EHRA, had an excellent conversation about engagement with them and their members. They are aware of this proess and the various committees, have been invited to participate as members of the public and are committed to meet with CDII on an ongoing basis to discuss issues and opportunities.
31	Lane# Steven MD MPH	If we are to designate regional QHIOs, as a supplement to all of the existing nationwide networks, an absolute requirement should be that they are able to connect bidirectionally with the national networks noted above and the Carequality Interoperability Framework, so that all CA participants are able to participate in nationwide exchange and not be limited to local exchange.	
32	Karen Ostrowski	'+1 David Ford. Some of those established networks are vendor-based and/or “closed” networks and don’t currently meet the requirements of AB133 and the DxF. While they can’t be ignored and need to be part of the conversation, the existing community HIOs in California are much more ready to support the rollout of the DxF and are already working at the local level, something that was stressed at the top of the meeting.	
33	ljohns	QHIOs look a lot like HISPs. HISPs require an authoritative Directory to enable “transaction patterns.” Where is a Directory in this conversation?	

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34	Ray Duncan	I find it worrisome that community HIOs would be viewed as a preferred solution to national networks with a track record of robustness and ability to handle huge volumes of traffic.	
35	Lane# Steven MD MPH	The national networks are NOT "closed". They are all connected to and can exchange with one another through the Carequality Framework. This is the whole point of having a national interoperability framework and the goal of TEFCA. We need to stop looking in the rearview mirror, attempting to require the use of 20th century HIE technology to solve our evolving 21st century interoperability challenges. Grant funding should be spent helping underserved stakeholders to connect to existing tools, be they regional HIEs providing access to standardized interoperabilty solutions, or directly to the existing networks.	very good point Steven - we should consider how these grants can positioned to help signatories (with particular attention to entities that serve underesources communities and populations that experience disparities more acutely) to use a variety of tools to help them meet the mandate
36	Ray Duncan	California's track record with survival of RHIOs has been pretty dismal.	
37	Maria Lourdes Cate #01115497/Scripps Health Plan Services	With entities that may have multiple signatories (i.e., hospitals, labs, health plan, provider groups/IPA, etc,), do "each" signatory entity have to apply separately for the grant? Can entities apply for multiple grants (i.e., educational, technical assistant, and HIO onboarding)?	
38	Erica Galvez	Looks like lots of support here for national networks, which are very important enablers of large health system exchange for the DxF, but we also need to recognize that many small provider EHRs do not connect to those networks today, those networks do not currently support broad-based CBO participation, nor do they broadly support exchange of claims data by health plans today. Nat'l networks are important to acknowledge as *components* of the infrastructure that will help us realize the promise of the DxF, but are unsufficient alone	

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39	Wes Rishel	Will existing HIOs be eligible for grants to adapt to DxF requirements, onboard with CTEN, etc?	To be determined Wes, CDII would welcome input here. The purpose of the grant funding is to support entities enumerated in AB 133 to meet DxF requirements, we need to consider how best to do that with these resources.
40	Erica Galvez	*insufficient :-)	
41	Rachel McLean	Will there be sessions for local public health departments?	
42	Karen Ostrowski	Erica - thank you, that was the point I was trying to make but you articulated it much better. That was one of the main points of our recent CHCF paper, that the national networks, when compared against the goals and requirements of AB133, have many gaps and are not sufficient on their own.	
43	Erica Galvez	Completely agree @Karen O. The ambitions (and promise!) of AB133/DxF extend far beyond what national networks enable	
44	Ray Duncan	The current community RIOs also have many gaps compared to the requirements of AB133 so that's that argument is not valid.	
45	Karen Ostrowski	That is a true and valid point - most organizations and networks today are not able to meet the requirements of AB133 which is why more guidance and discussion is so critical.	Yes, need to clarify how to enable these requirements in the best way possible.
46	Ray Duncan	We have to confront the idea that many requirements of AB133 may not be achievable in the mandated timeframe regardless of the QHIO issue. A great deal of technical development would be required as well as establishing connectivity to many (hundreds? thousands?) of participants that are unconnected or only minimally connected today.	
47	Lane# Steven MD MPH	We continue to revisit the same discussion - whether we will address and advance CA needs in alignment with and leveraging evolving technology, standards, networks,	

Count	Name	Comment	Response
		frameworks, and implementations, or whether we allow ourselves to be convinced by entrenched interests that the historic lack of use of existing tools means that they can/will not meet our needs in the future. We have the technology and now we have some money and focus to help bring everyone forward together, leveraging the latest technology to allow CA to be a leader, rather than a follower, in health data interoperability.	
48	Lane# Steven MD MPH	https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index	
49	Rachel McLean	Has CalHHS considered creating a visual showing how DxF and DHCS population health management, PATH, behavioral health efforts, grants, etc. do and don't overlap?	
50	Lane# Steven MD MPH	Critical point Dr. Scott! FHIR API access will be required soon to support health data interoperability, and all certified EHRs are required to support this capability this year. Any HIOs designated as part of the DxF should have or be on the path to supporting this new health data/interoperability standard.	
51	Wes Rishel	'@Steven Lane -- can you give a reference for the flowdown requirements? I have only heard the term in relationship to HIPAA	
52	Lisa Rodriguez	Can you send more information about the upcoming grants?	
53	Karen Ostrowski	Onboarding to an HIO and adopting FHIR APIs is a key requirement under the BHQIP, so HIOs are already working on that in support of counties.	
54	Lane# Steven MD MPH	Can members of the public sign-up for informational emails for this phase of the project as they were able to in the prior phase? If so, perhaps mention how to do that.	
55	Wes Rishel	Will you publish the chat and q*a? Can't be copied from Zoom	
56	Lane# Steven MD MPH	'@Wes Rishel: https://rce.sequoiaproject.org/summary-of-required-flow-down-provisions/	

Count	Name	Comment	Response
57	Diane Van Maren	A discussion on how behavioral health providers can participate more actively would be useful at some point.	

Total Count of Zoom Q&A comments: 57