California Health & Human Services Agency
Center for Data Insights and Innovation
Data Exchange Framework Implementation Advisory Committee and Data Sharing Agreement Policies & Procedures Subcommittee
Meeting Q&A Log (12:00PM – 2:30PM PT, March 21, 2023)

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

Count	Name	Comment	Response
1	Beverly Ntagu	Can you loop current signatories that have already signed under an umbrella organization?	live answered
2	Paul Matthews (He/Him/His)	Thanks for commenting on OCHIN, we will review this option, but expect that limits on a single EHR instance and the limit number of interfaces could limit the value of this option.	Thanks Paul. I thought your organization might be a potential example, although it sounds like this is still in the "thinking" stage?
3	Jessica Nunez de Ybarra	All signatories are required to have compliance with the DxF Policies and Procedures by January 31, 2024. How will this be measured? Will organizations attest that they are in compliance or will the process be verified by some third party entity (CDII)?	
4	Paul Matthews (He/Him/His)	Has CDII had any discussions to date with Nationwide Networks and Frameworks on support of DxF exchange requirements? If discussion has occurred will CDII share the findings in an FAQ or in a communication about QHIO selection in the next couple of months? This feeds to TA Grant application or Umbrella Organization grant submission.	
5	Rachel Goldberg	In addition to the $50 million for grant funding, there is also $200 million set aside in the state budget “for grants and TA to allow small physician practices to upgrade their clinical infrastructure, such as EHR systems, data	live answered

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		collection and reporting capabilities, implementation of care management systems, and other activities that will allow the adoption of value-based and other payment models that improve health care quality while reducing costs." What is the status of this $200 million for small physician practices?	
6	Rachel Goldberg	In addition to the $50 million for grant funding, there is also $200 million set aside in the state budget "for grants and TA to allow small physician practices to upgrade their clinical infrastructure, such as EHR systems, data collection and reporting capabilities, implementation of care management systems, and other activities that will allow the adoption of value-based and other payment models that improve health care quality while reducing costs." What is the status of this $200 million for small physician practices?	Can you specify where this is coming from? Is it a specific department?
7	Jennifer Inden (she/her)# Aliados Health (formerly RCHC)	Federally Qualifies Health Centers, Rural Health Centers and Tribal Health Centers are still not specifically mandated to sign the DSA/participate per the current language. Will this be clarified prior to the grants opening?	Federally Qualifies Health Centers, Rural Health Centers and Tribal Health Centers and others that may not be explicitly called out as mandatory signatories should consult with their counsels to determine whether they believe they are mandatory signatories before applying. CDII at this time does not have authority to further specify whether these

Count	Name	Comment	Response
			organizations are mandatory signatories.
8	Jennifer Inden (she/her)# Aliados Health (formerly RCHC)	Federally Qualifies Health Centers, Rural Health Centers and Tribal Health Centers are still not specifically mandated to sign the DSA/participate per the current language. Will this be clarified prior to the grants opening?	Hi Jonah, I think this is different than the information we have received from CDII.
9	Jennifer Inden (she/her)# Aliados Health (formerly RCHC)	Federally Qualifies Health Centers, Rural Health Centers and Tribal Health Centers are still not specifically mandated to sign the DSA/participate per the current language. Will this be clarified prior to the grants opening?	So if CDII does not recognize them as mandatory signatories does this mean they aren't eligible for grants?
9	Viru Nagathan	Quick clarification - Anybody under CAHIE network,need not have to sign individual DSA?	live answered
10	Viru Nagathan	Quick clarification - Anybody under CAHIE network,need not have to sign individual DSA?	The grant will require a signed DSA prior to application.
11	Rachel Goldberg	Lori, my question came from the CalHHS DxF Executive Summary - https://www.chhs.ca.gov/wp-content/uploads/2022/07/Executive-Summary_DxF_7.1.22.pdf	Great question! I will follow up Rachel.
12	Jennifer Inden (she/her)# Aliados Health (formerly RCHC)	Thanks @Jonah I appreciate your response, but this doesnt actually support the work we're all trying to accomplish. All other language indicates they are mandated (see January 2026 data sharing deadline for 'clinics' with 10 or less providers. They also are the providers for the patients this iniative is trying to target. Not having this specificity potentially will exlude them from accessing any grants which then may prohibit many of them from actually participating in the DxF. If CDII does not hae authority to specify what is CDII doing to remedy this?	

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13	Robby Franceschini	Thank you, Mark. I was going to ask the same question as whether the IAS P&P will be changed since the info blocking rules also ostensibly apply to IAS.	
14	Robby Franceschini	The CA Info Blocking draft P&P also references individuals, personal representatives and the IAS	
15	Sean Folweiler	Information Blocking at Federal level is only with hipaa defined covered entities. This draft proposal states we would have to share with non hipaa covered entities (social services). This will create an administrative burden of always having to send letters stating the social entity request is a privacy exception.	This isn't quite accurate - info blocking applies to all providers who meet the Medicare definition of provider (most of whom are covered entities, but some of whom are not), as well as certified HIT vendors (most of which are business associates) and health information exchanges (same). So the bubble of entities covered by the info blocking rules is not a complete overlap to the HIPAA coverage bubble.
16	L. Johns	Any way for this speaker to speak directly into the mic? Hard to understand her (at least here)	Thanks. We've moved the microphone closer to the speaker.
17	Michael Ciabatti	Agree with the previous comment, this audio can be difficult to discern.	
18	Paul Matthews (He/Him/His)	Techincal implementation should also allow for workflow change, training and adoption when thinking about Early Exchange	great point!
19	Davis# Adam# M.D.	The biggest concern of Sutter is that the breadth of data required to be exchanged is poorly defined and makes it very hard to comply with. HSSI is not clearly defined and I don't believe many	

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		organizations have the technical capabilities to exchange this broad swath of data in a useful manner at this time. Orders for services is also not defined, is it simply for referral or also for lab, imaging, DME, etc. There are no standards for how to do order exchange and no plausible scenario for where we would be able to accept electronic orders and respond to them with all comers across California by January 2024. We really need to narrow the ask to demonstrate that exchange can happen with organizations left outside the federal CURES act and then expand the scope of sharing. Is there an opportunity to partner with the vendors to understand better what is technically feasible in this year so we can take appropriately sized steps?	
20	David O. Duke# M.D.	I think she is asking, what is the penalty for causing a programatic delay	
21	Paul Matthews (He/Him/His)	The question is what's the penalty for non-compliance at the state level?	Thank you yes, that was my question. To further clarify, I think that those working with QHIOs aren't likely to be in this situation, but those who're not able to or willing to do so for whatever reason, might not be able to meet the real-time requirements though they are mandatory signers/exchangers under the law. Some providers/organizations may just be doing the best they can - but it's not within that 24

Count	Name	Comment	Response
			hour rule, so I was just wondering, are they subject to some kind of penalty?
22	Paul Matthews (He/Him/His)	'@Adam Davis, 100% agree with your comment.	
23	Ray Duncan	'@Adam Davis - Exactly right.	
24	Viru Nagathan	Slide#36 - Real time exchange definition - 24 hours of delay is a significant. Is it in the event of disconnection of EHR system with network?	
25	Zach Gillen (KP)	Completely agree with Dr. Davis' comments above regarding HSSI not clearly defined. In the technical specifications, USCDI v2 is called out, but Info Blocking P&P calls out the expansiveness of EHI. I understand the inclusivity and alignment of EHI with Federal info blocking requirements, but needs to be really clear what the expectations are for technically implementing exchange. Also agree with the 'orders for services' is not clearly defined.	
26	Paul Matthews (He/Him/His)	If two signatories cannot agree on a query-based exchange provider, what is the arbitration process to meet the requirement to exchange. Will all QHIO's be required to participate in nationwide frameworks to close this gap?	Yes, we have discussed and published in draft crtiera the potential requirement for QHIOs to participate nationwide networks/frameworks.
27	Jennifer Inden (she/her)# Aliados Health (formerly RCHC)	'+ to Dr. Davis. in order for entities to determine what system/connections they choose to deploy for compliance/participation; understanding exactly what information they will need to digest is important as not all interfaces have the ability to transmit it.	

Count	Name	Comment	Response
28	Ray Duncan	“Discouraging” broadcast queries is not sufficient. Instead, the policy should itemize exactly under what circumstances they are allowed, if they are allowed at all.	
29	Paul Matthews (He/Him/His)	The risk of broadcast query is that small providers may be overwhelmed from a capacity level. Limiting to the QHIO is a good solution.	
30	Sean Folweiler	It is seems counter intuitive to restrict any type of health exchange when the intent of data excahnge agreement is to share health data.	
31	Neal Cox	Some mics are very low and CC is not capturing the conversation.	live answered
32	Neal Cox	Some mics are very low and CC is not capturing the conversation.	Noted, will try to remediate.
33	L. Johns	What if a patient who is conscious does not want query for information about her broadcast all over the place, only to providers she specifies?	
34	Paul Matthews (He/Him/His)	Are you suggesting that an ORU/MDM or DSM requirement is being expected by DSA signatories by 1/31/24?	
35	Zach Gillen (KP)	How, technically, is it being proposed that organizations implement these Information Delivery triggers for an order for diagnostic services? To my knowledge, while Direct or XDR push based messaging is implemented across a variety of organizations supporting transitions of care use cases today, I'm not sure how organizations will be able to receive external orders and subsequently trigger a Direct message (or MDM, ORU).	
36	L. Johns	Cc is mostly useless. When speaker doesn’tn speak clearly,	

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		nonsense. When speaker does, not needed. ;-)	
37	Jennifer Inden (she/her)# Aliados Health (formerly RCHC)	'+1 Zach. requiring a reponse electornically when the order didnt/not required come in electronically thats a human intervention in most systems. this puts organization at risk of non-compliance.	
38	Paul Matthews (He/Him/His)	Will a DSM be allowed rather than a ADT for event notification?	The P&P out for public comment allowed for event notifications via standards other than HL7 v2 ADT messages. So yes, Direct secure messaging might be an option.
39	Neal Cox	Have you looked at other states who have successfully implimented similar requirements/programs like NJHIN? This way you can learn from their success and failures.	
40	L. Johns	hard to understand this speaker, just say'in	
41	Paul Matthews (He/Him/His)	Is the ADT requirement limited to Hospitals only (the language seems to say this)? If, so is the only requirement for ambulatory providers to support query exchange?	Per the language in the P&P out for public comment, yes, the event notification requirement is lmited to hosptials (and EDs). All participants must support query-based exchange. Specialists and anscillary services may be required to push results.
42	Ray Duncan	I would be interested to see whether the committee has done a thorough job of discovery on what volume of "realtime" ADT transactions the QHIOs will be expected to process from all their participants. Just looking at the	

Count	Name	Comment	Response
		volumes on our own ADT interface and expecting other large organizations will have similar volumes, i suspect this will be quite a large processing burden on the QHIOs.	
43	Arnulfo Reynoso - ALTURA CHC	Our patient members of our provider community have greatly benefitted from being able to receive property matched ADTs for our patient panels. Our patients experience is much better with follow-up care and overall health improvements as a result. This is possible as our community hospitals regualry contributing ADT to local HIO. Otherwise, we would be left to try to locate and manage ADT feeds on our own. which is virtually impossible for a small practice.	
44	Mohit Ghose	'+1 to comments made so far on the importance of verified, clean data being able to transmit without specific queries per interaction - ADT should be required as part of QHIO submissions since that could be the best way to get clean data to the PCP or IPA upon discharge, without having specific plan and hospital data submissions set up.	
45	Paul Matthews (He/Him/His)	If a Hospital send ADT to EDIE (Collective) in CA, will this meet the ADT requirement? This goes to scaling the system. Second will event notification be allowed via Direct Secure Messaging?	If EDIE is able to and in practice transmits those notificaitons to all signatories that desire to receive them (and it's permissible to send b/c there's a relationship) then it should fulfilll the requirement.
46	Neal Cox	Is this only applicable to acute care and clinics, and will post acute care be brought into this as well?	

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47	Mohit Ghose	Could we please consider a further discussion of real-time data? what if it is outside an ADT situation - what are the responsibilities of all stakeholders and definitions?	
48	Paul Matthews (He/Him/His)	'@ RIM - Agreed	
49	Paul Matthews (He/Him/His)	'@Rim - The Team at eHealth Exchange has been impleemnting a solution for this and would be able a good partner to help.	Thanks, Matt. We have been talking with the folks at eHX and will continue to draw on their experience.

Total Count of Zoom Q&A comments: 49