

# Data Exchange Framework

# **INFORMATION IS POWER**

## Webinar Series

### **WEBINAR 1**

What is the Data Exchange Framework?

**September 13, 2022**

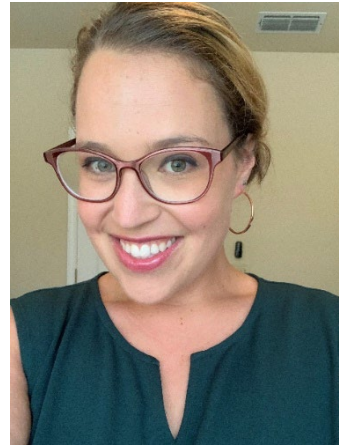
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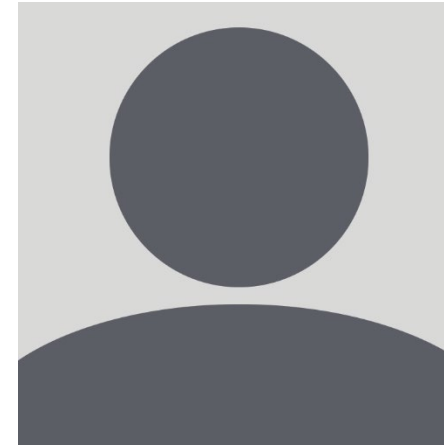
# Speaker Introductions



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# Agenda

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- Vision For Data Exchange in California
- CalHHS Data Exchange Framework (“DxF”)
- DxF Data Sharing Agreement + Policies & Procedures
- Digital Identities Strategy
- What’s Next
  - *DxF Grant Program*
  - *DxF Data Exchange Intermediary Qualification (“QHIO”) Program*
  - *DxF Governance*
- Questions & Answers



# Vision for Data Exchange in California

# The Vision for Data Exchange in California

Every Californian, and the health and human service providers and organizations that care for them, will have timely and secure access to usable 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.



# THE PROBLEM WE ARE TRYING TO SOLVE:

## AN EXAMPLE - SERVING SOMEONE WITH COMPLEX NEEDS

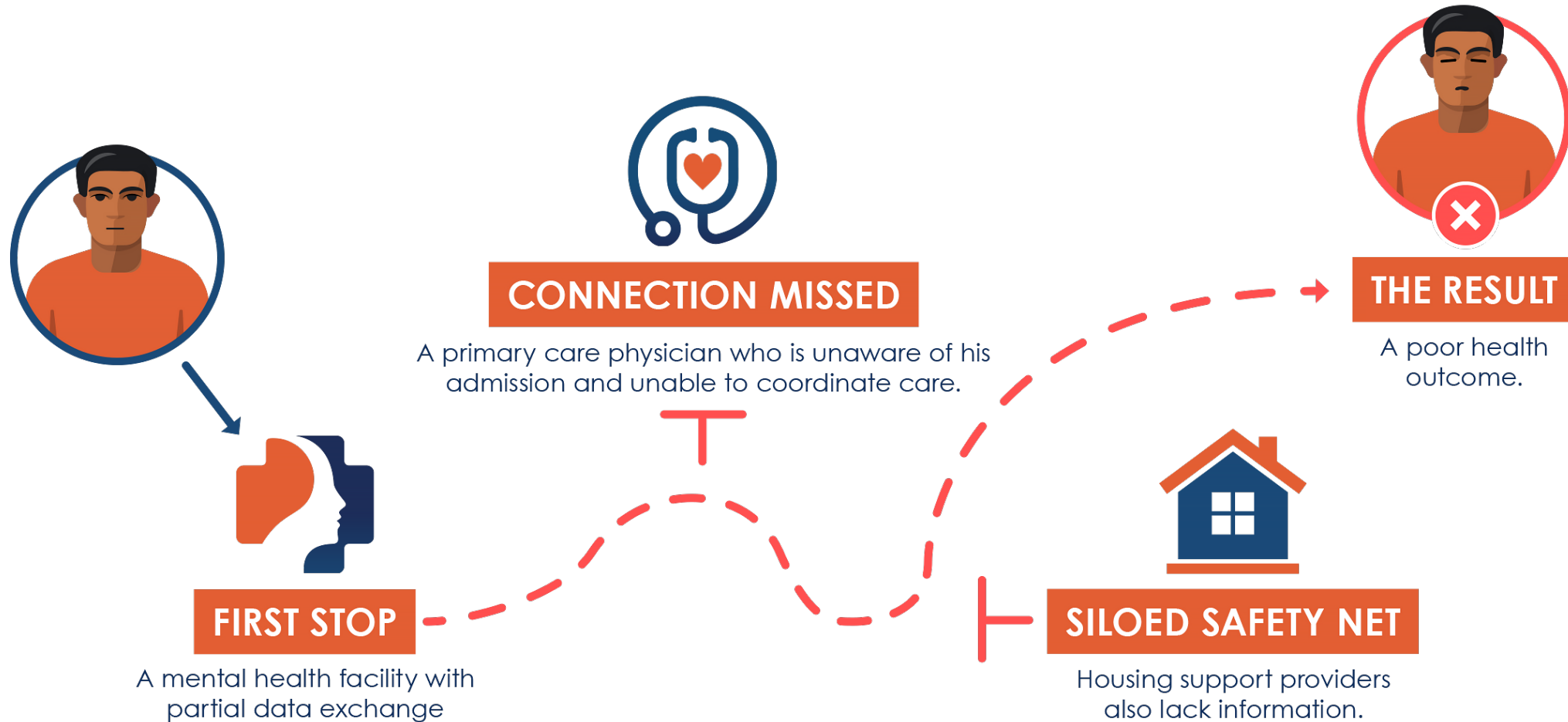
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### WHO

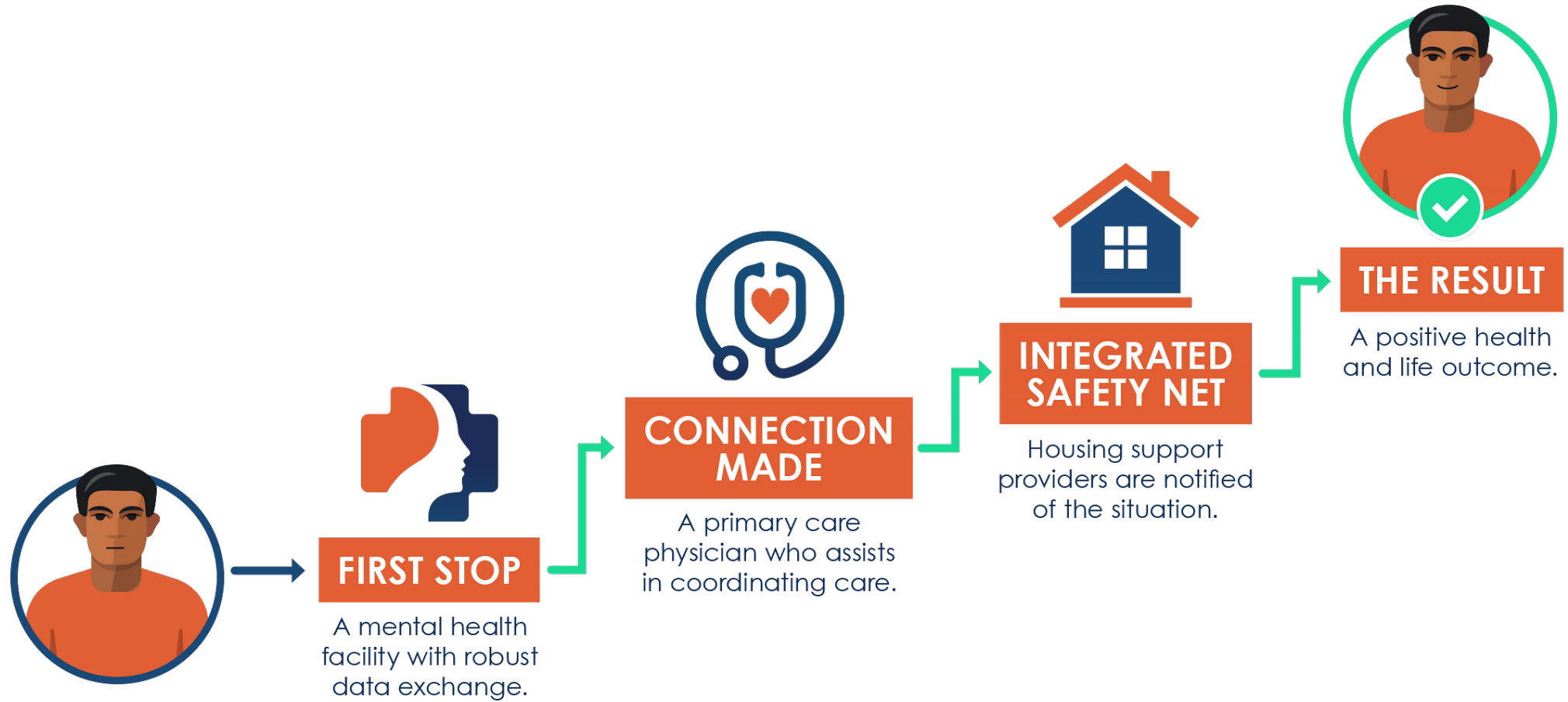
A 40-year-old Latino male with a diagnosis of schizophrenia and diabetes who is also experiencing housing instability. He is admitted to a mental health facility following an acute episode of schizophrenia.



# RIGHT NOW ... CALIFORNIA DOESN'T HAVE ALL THE DATA EXCHANGE PATIENTS NEED



# WITH DATA EXCHANGE ... THE RIGHT CONNECTIONS CAN BE MADE, FOR EVERY CALIFORNIAN





# CalHHS Data Exchange Framework (“DxF”)

# IT STARTED WITH... AB-133

**AB-133 put California on the path to building a Health and Human Services Data Exchange Framework that will advance and govern the exchange of electronic health information across the state.**

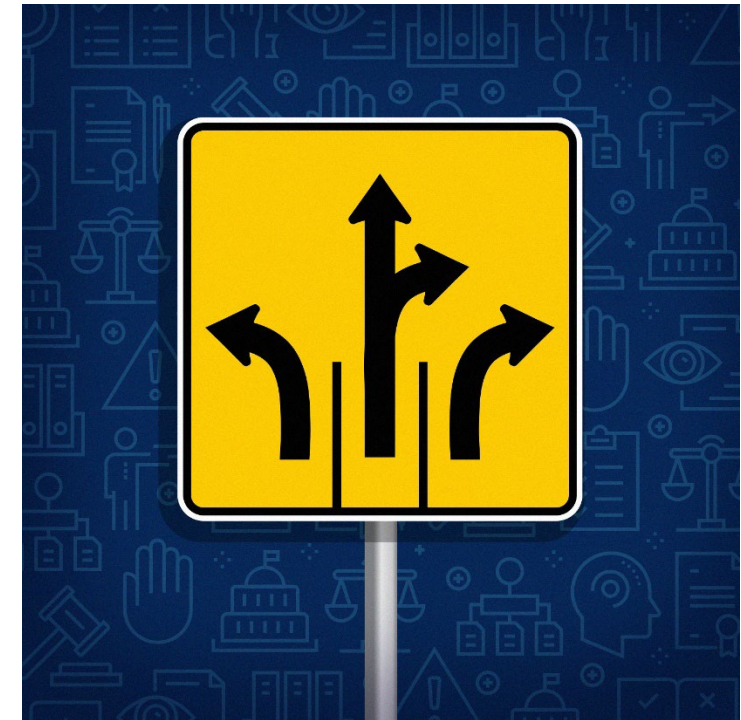
- In 2021, with the passage of AB 133, the Governor and Legislature agreed it was time to disrupt our health and human service information silos —by resolving the numerous information exchange barriers that make it difficult for millions of Californians to receive inform and effective care.
- The legislation directed CalHHS to develop a Data Exchange Framework (DxF) that would govern the seamless and secure exchange of health and human service data between healthcare entities across California, and to convene a Stakeholder Advisory Group to advise on the development and implementation of the DxF.

# The DxF... What it is vs. What it isn't

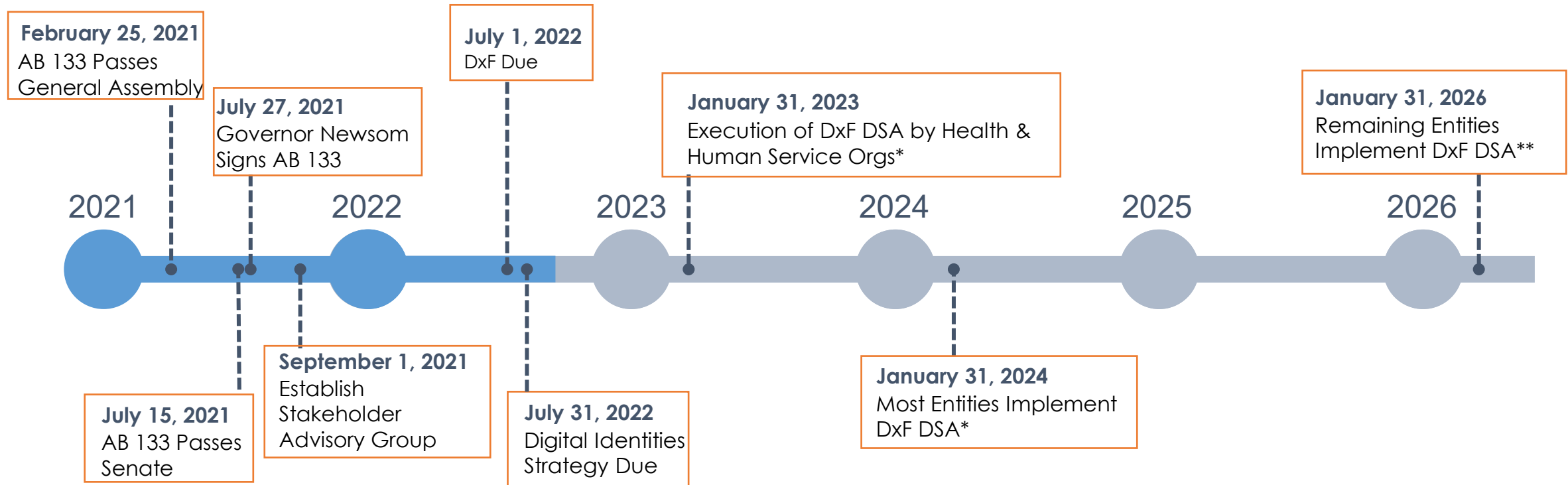
IS NOT TECHNOLOGY



IS RULES OF THE ROAD



# AB-133 Requirements & Timelines



\*General acute care hospitals, physician organizations and medical groups, skilled nursing facilities, health service plans and disability insurers, Medi-Cal managed care plans, clinical laboratories, and acute psychiatric hospitals. County health, public health, and social services providers are encouraged to connect to the DxF.

\*\*Physician practices of <25 physicians, rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with <100 acute care beds, state-run acute psychiatric hospitals, and nonprofit clinics with <10 providers

# Step 1... Identify the Issues We Want to Fix

While parts of California's health care system rely on coordinated, interoperable electronic systems to exchange data, other parts rely on decentralized, manual, and siloed systems of data exchange that is voluntary in many situations.

## Gaps

- ① Electronic Health Record (EHR) Adoption
- ② Data Exchange Capacity at Many Health Care and Human Service Organizations
- ③ Digital Identity
- ④ Health and Human Service Data Exchange Governance
- [Among many... for a longer listing, see our [Gaps and Opportunities](#) analysis]

# Step 1 – Gap 1... EHR Adoption

Many health and human service organizations do not have digital record systems, which are required for the electronic collection and exchange of health information to support effective service delivery. Incomplete adoption leaves critical data siloed, limiting care coordination.

## Key Data Exchange Gaps in California

Health Plans	Hospitals	Nursing Facilities	Physician Orgs	SUD Providers
Less than half (42%) of CA's HIOs report that private health plans contribute data, view, or receive data, or pay to participate.	EHR adoption among smaller hospitals (~70%) remains lower than among medium-size and large hospitals (~90%). <sup>1</sup>	Only 10% of surveyed SNFs in CA reported that their EHR was fully interoperable with hospital EHRs and less than half reported being fully electronic for many critical care functions.	While overall EHR adoption among physicians is high, those who have not yet adopted EHRs are more likely to be in a rural, independent, or solo practice.	Only 36% of surveyed SUD treatment facilities in CA reported using only electronic methods for treatment plan documentation and issuing and receiving lab results.

# Step 1 – Gap 2... Data Exchange Capacity

Effective health and human service information exchange requires investment in tech capable of supporting data exchange and the ability to connect and share information with other participants. However, many health and human service organizations confront technical, operational, and financial barriers to making those connections.

- CA health information organizations (HIOs) exchange data with only about half of the state's hospitals.
- Where connections to HIOs, national networks, or data exchange intermediaries are possible, **providers may not be connected due to:**
  - **Lack of understanding of the value** that data exchange can bring to patient care, and potentially to their practices through payer and provider incentives;
  - Expected **challenges with integrating information into tech or workflows;**
  - **Legal concerns;** and
  - The **costs** of addressing concerns and paying data exchange on-board + participation fees.

# Step 1 – Gap 3... Identity

**California has no robust or systematic coordination of digital identities, person resolution, or data linking across organizational boundaries, limiting the efficacy of cross-organizational data access and exchange**

- Organizations often fail to locate existing health records for individuals they serve that might exist at other organizations to support care coordination and management, because the organizations' health information systems fail to agree on a single personal "identity."
- California stakeholders have significant experience in person resolution, person matching, and record linking

**AB-133**

CalHHS "shall develop... a strategy for unique, secure digital identities capable of supporting master patient indices to be implemented by both private and public organizations."



# Step 1 – Gap 4... Governance

California currently lacks a governing entity to develop, implement, and oversee policies that will advance the meaningful exchange and use of health and human services data throughout the state.

## AB-133

California's "voluntary patchwork [of health information data exchange] imposes burdens on providers and patients, limits the health care ecosystem from making material advances in equity and quality, and functionally inhibits patient access to personalized, longitudinal health records. Further, a lack of clear policies and requirements to share data between payers, providers, hospitals, and public health systems is a significant hindrance to addressing public health crises, as demonstrated by challenges inherent to the COVID-19 pandemic."

# Step 2... Engage Stakeholders in Solutioning

## DxF Stakeholder Advisory Group

### Consumer Organizations

- Health Access CA
- CA Pan Ethnic Health Network

### Health IT

- CA Association of Health Information Exchanges
- Manifest Medix
- Savage & Savage LLC
- UC Center for IT Research in the Interest of Society

### Health Plans

- Blue Shield of California
- CA Association of Health Plans
- Kaiser Permanente
- Local Health Plans of CA
- Partnership HealthPlan of CA

### Labor

- CA Labor Federation
- SEIU California

### Local Government

- County Behavioral Health Directors Assoc
- County Health Executives Assoc of California
- Conference of Local Health Officers
- Assoc of Public Hospitals and Health Systems
- County Welfare Directors Association

### Local Networks

- 211 San Diego/Community Information Exchange
- Bay Area Community Services
- Los Angeles Network for Advanced Services

### Philanthropy

- CA Health Care Foundation

### Provider Organizations

- America's Physician Group
- CA Medical Association
- Primary Care Association
- CA Hospital Association
- CA Association of Health Facilities

### State Departments

- CA Health Benefit Exchange
- Aging
- Health Care Access and Information
- Public Employees Retirement System
- Insurance
- State Hospitals
- Corrections and Rehabilitation
- Business, Consumer Services and Housing Agency
- Public Health
- Managed Health Care
- Health Care Services
- Developmental Services
- Social Services
- Emergency Medical Services Authority

# Step 3... Establish Principles to Guide Solutioning



## DxF Guiding Principles\*

1. Advance Health Equity
2. Make Data Available to Drive Decisions and Outcomes
3. Support Whole Person Care
4. Promote Individual Data Access
5. Reinforce Individual Data Privacy & Security
6. Establish Clear & Transparent Terms and Conditions for Data Collection, Exchange, and Use
7. Adhere to Data Exchange Standards
8. Accountability

# Step 4... Develop Strategies to Address the Issues

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## Data Exchange Framework Components

1. **Data Exchange Framework**, that includes a landscape assessment, gaps and opportunities analysis, and a first-ever, statewide data sharing agreement that will accelerate and expand the exchange of health information among health care organizations beginning in 2024.
2. **Data Sharing Agreement and Common Set of Policies and Procedures** that spell out the standards for and governance of information exchange.
3. **Digital Identity Strategy** that enables providers and public organizations to match shared clients while keeping identities secure.

# DxF Data Sharing Agreement + Policies & Procedures



# The DxF Data Sharing Agreement

AB 133 requires the establishment of a single data sharing agreement and a common set of policies and procedures that govern and require the exchange of health information.

## The DxF Data Sharing Agreement (DSA) is:

- A legal agreement that a broad spectrum of health organizations will be required to execute by January 31, 2023.
- Intended to facilitate data exchange between Participants in compliance with applicable federal, state, and local laws, regulations and policies.
- Sets forth a common set of terms, conditions, and obligations to support secure real-time access to, or exchange of, Health and Social Services Information between and among Participants.

**The DSA is not** intended to replace or supersede any existing or future agreement between or among Participants that provides for more extensive data exchange than it requires.

# Who has to sign the DxF's DSA?

#	Required Signatory Type
1	<b>General acute care hospitals</b> , as defined by Section 1250.
2	<b>Physician organizations and medical groups.*</b>
3	<b>Skilled nursing facilities</b> , as defined by Section 1250, that currently maintain electronic records.
4	<b>Health care service plans and disability insurers that provide hospital, medical, or surgical coverage</b> that are regulated by the Department of Managed Health Care or the Department of Insurance. This section shall also apply to a <u>Medi-Cal managed care plan under a comprehensive risk contract</u> with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code that is not regulated by the Department of Managed Health Care or the Department of Insurance.
5	<b>Clinical laboratories</b> , as that term is used in Section 1265 of the Business and Professions Code, and that are regulated by the State Department of Public Health.
6	<b>Acute psychiatric hospitals</b> , as defined by Section 1250.

\*Additional guidance and rulemaking will be needed to more precisely define what entities in this Signatory Type are subject to the mandate, and whether they are regulated by a state agency.

\*\*Note: Some entities have until January 31, 2026 to begin exchanging data. These entities are: physician practices of <25 physicians, rehabilitation hospitals, long-term acute care hospitals, acute psychiatric hospitals, critical access hospitals, and rural general acute care hospitals with <100 acute care beds, state-run acute psychiatric hospitals, and nonprofit clinics with <10 providers.

# DSA Policies and Procedures (P&Ps) Overview

The DSA's P&Ps provide rules and guidance to support “on the ground” implementation.

**The first set of DSA P&Ps, released in July 2022, included:**

1. Process for Amending the DSA
2. Development of and Modifications to Policies & Procedures
3. Breach Notification
4. Permitted, Required, and Prohibited Purposes
5. Requirement to Exchange Health & Social Services Information
6. Privacy and Security Safeguards
7. Individual Access Services
8. Data Elements to be Exchanged



# Digital Identities Strategy

# Key Questions and Principles

## Question / Issue

**How do health care and social services providers find information on their patients and clients?**

**How are patients assured their identity is secure?**

## Approach

- Define standards for attributes of a digital identity.
- Create a master person index that matches certain pieces of information to confirm a unique identity, even if names don't exactly match.
- Doesn't collect sensitive information.
- Treat identities with the same care afforded to health information.

# Digital Identity Overview

**AB 133 requires CalHHS to develop a strategy for unique, secure digital identities capable of supporting master patient indices to be implemented by private & public CA organizations.**

The **purpose and use case** proposed for digital identities is to associate accessed or exchanged health and social services information with the correct real person.

## Digital Identity Strategy recommendations included:

- Utilizing selected attributes from the United States Core Data for Interoperability (USCDI) V2 useful to person matching: name, date of birth, gender (but only if required by a technical standard/regulation), address(es), phone number(s), email address(es).
- Including identifiers that are uniquely associated with one and only one real person, but only if related to health care services delivery (e.g., EHR medical record numbers, health plan member identifiers).
- Adopting standard formats and datasets for person demographics specified in USCDI V2.
- Adopting standard formats and datasets other than USCDI promoted by federal initiatives and identified for use by the Data Exchange Framework (e.g., US@ Project).

# Digital Identity Moving Forward

## Approach

- ① Explore creating a statewide person index
- ② Understand and leverage the person resolution activities across state government
- ③ Determine if and how to engage consumers, support consumer access
- ④ Explore shared consent, which is related to person identity
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# What's Next

# What's Next...DxF Grant Program

CDII will administer \$50 million in funding over two years to provide education, technical assistance, and HIO onboarding support for DxF signatories to implement the DxF.

## Key Program Goals



Support DxF implementation among DxF signatories in under-resourced geographies and/or serving historically marginalized populations and underserved communities



Address significant barriers to DxF implementation (operational, technical, or other) for DxF signatories



Align across other grant programs and promote activities ineligible for funding by other grant programs (past or present).

CDII will gather stakeholder input in the design of the DxF Grant Program through Listening Sessions in September and October.

# What's Next...DxF QHIO Program

**The DxF Stakeholder Advisory Group recommended the development of a formal process for qualifying data exchange intermediaries that meet CalHHS DxF requirements**

The qualification process will align on federal and state models, including the federal Trusted Exchange Framework and Common Agreement's (TEFCA) of a Qualified Health Information Network (QHIN).

QHIOs will be expected to demonstrate corporate stability, technical capability, effective data privacy and security measures, and service accountability.

## **Upcoming topics for discussion will include:**

- Extent of alignment with QHIN requirements
- Initial design of QHIO application submission and assessment process

**CDII will gather additional stakeholder input in the design of the QHIO Program through IAC Meetings starting in September.**

# What's Next...DxF Governance

**CDII has established an Implementation Advisory Committee (IAC) to advising it on a range of topics related to DxF implementation.**

CDII will engage the IAC for advisory support until a HHS Data Exchange Board is established in 2023. The Board may then choose to establish new advisory committees to support its work.

The IAC will:

- Be Chaired by the CDII Director.
- Advise CDII on implementation issues. It is not a decision-making body.
- Be open to the public (always check the CDII website for meeting log-in information).
- Be comprised of 19 industry representatives from consumer, CBO, provider, health system, and health plans, in addition to health IT, data privacy, and data security experts.
- Have a Data Sharing Agreement Policies and Procedures (DSA P&P) Subcommittee, which will convene between IAC meetings.
- Meet approximately every six weeks starting on **September 21<sup>st</sup> from 10:00 am – 12:30 pm.**



# Questions + Answers

# Stay Involved

## (1) Participate in upcoming IAC or DSA P&P Subcommittee meetings:

- **IAC Meeting #1:** Sept. 21, 2022, 10:00 am–12:30pm
- **DSA P&P Subcommittee Meeting #1:** Sept. 23, 2022, 9:30 am–12:00pm

Meeting materials, participation information, and recordings will be posted on the [CalHHS DxF website](#).

## (2) Join our DxF Community mailing list by emailing [CDII@chhs.ca.gov](mailto:CDII@chhs.ca.gov).