California Health & Human Services Agency
Center for Data Insights and Innovation
Data Exchange Framework (DxF) Information is Power Webinar Series: How the DxF Supports CalAIM & Other DxF Program Updates
Webinar #7 Transcript (9:30 AM – 10:30 AM PT, March 23, 2023)

The following text is a transcript of the March 23 Data Exchange Framework Information is Power Webinar Series: *How the DxF Supports CalAIM & Other DxF Program Updates*. The transcript was produced using Zoom's transcription feature. It should be reviewed concurrently with the recording – which may be found on the CalHHS Data Exchange Framework website to ensure accuracy.

1
00:00:06.870 --> 00:00:15.430
DeeAnne McCallin: Good morning. Thank you for joining us today. My name is Dia Mcallen. I'm. With Cdi, the deputy director for the Data Exchange framework.

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00:00:15.450 --> 00:00:20.810
DeeAnne McCallin: Today is our Webinar Number 7 in the information is Power Webinar Series.

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00:00:21.330 --> 00:00:37.940
DeeAnne McCallin: For those of you who are joining us for the first time. This series is set of informational webinars. What that we are hosting to discuss data, California's Data exchange, framework which we'll refer to, or at least I will, as D. Except throughout this presentation

4
00:00:37.970 --> 00:00:48.930
DeeAnne McCallin: the Dxf's data sharing agreement and its policies and procedures. the programs that we are developing to help support the implementation of the framework

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00:00:49.270 --> 00:00:54.350
DeeAnne McCallin: for your ongoing reference. Each Webinar is recorded and posted to our website

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00:00:54.520 --> 00:01:05.600
DeeAnne McCallin: along with the presentation slides. So today's the session is being recorded, and there's 6 other sessions that are available to download and access the slide decks and or

7
00:01:05.620 --> 00:01:10.440
DeeAnne McCallin: transcripts and copies of, and recordings of this session.

8
00:01:15.050 --> 00:01:24.900
DeeAnne McCallin: we will hold a question and answer session at the end. The procedure is, please submit. Submit your questions through the zoom. Q. A. Function.

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00:01:25.060 --> 00:01:34.240
DeeAnne McCallin: Cdi. I will select answers to be answered. Live as time allows, and if your question is not answered and would like to follow up with us, please submit

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00:01:34.320 --> 00:01:43.390
DeeAnne McCallin: in via email to CD. I. i@chs.ca.g o V,

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00:01:43.570 --> 00:01:48.860
DeeAnne McCallin: and I think we probably have that throughout, and we'll share it again near the end.

12
00:01:51.710 --> 00:01:59.550
DeeAnne McCallin: Today I've been introduced myself. Dean Mcallen, and joining me is Dr. Paula Barbaria, who is with the Department of

13
00:01:59.620 --> 00:02:16.370
DeeAnne McCallin: Health Care Services, how love is the chief quality Officer and Medical Officer, Deputy Director, Quality and Population Health Management, with Dhcs. So Paula will be leading the second half of this presentation cited to have her join us today.

14

00:02:19.830 --> 00:02:25.110
DeeAnne McCallin: Today's agenda vision for the review of the vision, for the Data Exchange framework.

15
00:02:25.360 --> 00:02:30.510
DeeAnne McCallin: the Data Exchange framework program updates and some frequently asked questions.

16
00:02:30.920 --> 00:02:39.820
DeeAnne McCallin: The part that Pelv will be presenting on is the Calend Data Exchange initiatives, and we will be wrapping up with the question and answer session.

17
00:02:40.930 --> 00:02:41.520
DeeAnne McCallin: That's it.

18
00:02:42.940 --> 00:02:46.920
DeeAnne McCallin: Review of the of the vision for the data exchange framework

19
00:02:48.190 --> 00:02:58.770
DeeAnne McCallin: Once implemented across California, the data exchange framework will create new connections and efficiencies between health and social service providers improving whole-person care.

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00:02:58.880 --> 00:03:11.860
DeeAnne McCallin: It's the first ever statewide data sharing agreement that required California that requires the secure and appropriate exchange of health and human services information to enable providers to work together

21
00:03:11.920 --> 00:03:15.370
DeeAnne McCallin: to improve individuals. Health and well-being.

22
00:03:21.460 --> 00:03:31.690

DeeAnne McCallin: Since our last information is power webinar in February, Cdi. And stakeholders have continued to advance the implementation of the data Exchange framework

23
00:03:31.690 --> 00:03:50.950
DeeAnne McCallin: so broad strokes of the buckets that we work on in the domains. Our government's governance where the other day we held a joint implementation, advisory committee meeting and a data sharing agreement, policy and procedure subcommittee meeting. During those meetings we review adjustments to

24
00:03:50.950 --> 00:04:07.460
DeeAnne McCallin: drafts in the policies and procedures and updates to a qualified health information exchange pro organization program and the Dsa signatory grants. Again, Dsa: When I say it is the data side data sharing agreement.

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00:04:07.650 --> 00:04:10.760
DeeAnne McCallin: Then, under the policies and procedures

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00:04:10.840 --> 00:04:18.209
DeeAnne McCallin: we have reviewed stakeholder input that was due up through. We accept a public comment through February fourteenth.

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00:04:18.339 --> 00:04:26.330
DeeAnne McCallin: on 5 draft and amended policies and procedures that are are needed to help. With the implementation of the framework.

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00:04:26.670 --> 00:04:35.080
DeeAnne McCallin: We reviewed a summary of the public comments received and have proposed responses, and we expect that next month that the

29
00:04:35.140 --> 00:04:45.400
DeeAnne McCallin: Iac. Meeting the Implementation Advisory Committee group that will be presenting the final copies of the policies of the new policies and procedures.

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00:04:46.120 --> 00:04:58.940
DeeAnne McCallin: We're launching the data, exchange framework Brands program, finalizing eligibility and funding for 2 different domains. One is a qualified Health Information organization on Boarding

31
00:04:59.060 --> 00:05:06.860
DeeAnne McCallin: Grant opportunity and technical assistance grants for signatories of the data sharing agreement.

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00:05:07.030 --> 00:05:07.990
DeeAnne McCallin: And then.

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00:05:08.350 --> 00:05:21.570
DeeAnne McCallin: as a sub part of that is what is a. Q. H. I. A qualified health information organization. So we are standing up a program. We've been working on that over the past month, if not past 6 months, and looking ahead, or these are

34
00:05:21.740 --> 00:05:22.560
DeeAnne McCallin: Ford.

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00:05:23.240 --> 00:05:31.210
DeeAnne McCallin: different domains, of which Cdi I. And our data exchange framework, part partners and stakeholders have been working on

36
00:05:35.710 --> 00:05:39.590
DeeAnne McCallin: diving into the frequently asked questions.

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00:05:42.140 --> 00:05:53.480
DeeAnne McCallin: So i'll. I'll be reading. And then speaking to some of these, there are approximately 20 at the queues on the link that is shared in the slide deck on our website.

38

00:05:53.480 --> 00:06:12.180
DeeAnne McCallin: We did just migrate to a new website this week, so if anybody's having any challenges, it's up. It's running. It's working, but it might look and feel a little different if you're accustomed to it. But if anybody has any challenges accessing it, please let us know, but you are. It should be able to find our frequently asked questions out there.

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00:06:12.410 --> 00:06:22.200
DeeAnne McCallin: So these are some of the highlights of the ones that are in our longer document. What skilled nursing facilities are required to sign the data, sharing agreement.

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00:06:23.030 --> 00:06:36.820
DeeAnne McCallin: skilled nursing facilities as defined in section 1,250 of the California Health and Safety code that maintain electronic records or electronic health information as defined in section and I cannot see all that

41
00:06:36.900 --> 00:06:41.420
DeeAnne McCallin: 171 dot, 102 of title 45. So

42
00:06:41.730 --> 00:06:58.290
DeeAnne McCallin: hopefully that helps. And if if you're a skilled nursing facility, also known as a snip citing these sections might be helpful for you to be able to determine if you are required mandatory to sign the data sharing agreement.

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00:06:59.030 --> 00:07:11.520
DeeAnne McCallin: Our solo practices, a practice owned by a single position considered physician organizations and medical groups that are required to sign the data sharing agreement. Yes, they are

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00:07:11.570 --> 00:07:17.440
DeeAnne McCallin: the d data sharing agreement does have the condition that

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00:07:18.090 --> 00:07:21.780

DeeAnne McCallin: physician practices fewer than 25 positions

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00:07:21.970 --> 00:07:40.210
DeeAnne McCallin: are not required to implement the the actual exchange of data until January 30 first 2,026. That's 2 years after many of the entities that are required to sign must begin exchange in 2,024, but small

47
00:07:40.510 --> 00:07:51.050
DeeAnne McCallin: fewer than 25 clinicians have, until 2,026. Any position, organization, or medical group, with one or more physicians is required to sign the Dsa.

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00:07:51.240 --> 00:08:06.710
DeeAnne McCallin: The signing deadline was January 30, first of 2,023, no matter which bucket you your entity might fall into, whether it's the 2,024 folks who are required to begin exchange for the 2,026,

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00:08:06.740 --> 00:08:13.320
DeeAnne McCallin: and even though January 30 first 2,023, has a spot has gone by, you're still able to sign.

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00:08:19.860 --> 00:08:30.770
DeeAnne McCallin: If my organization is a covered entity under Hipaa, how can I share protected health information with a non-covered entity like a social service organization under the Dsa.

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00:08:31.520 --> 00:08:40.760
DeeAnne McCallin: The Dsa. Does not require your organization to share protected health information with non-covered entities such as so social service organizations.

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00:08:40.830 --> 00:08:54.580
DeeAnne McCallin: It is sharing between it does permit sharing between a covered entity and a non-covered entity. When you have valid authorization from the patient or patients representative, and then we cite the section code

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00:08:54.580 --> 00:09:07.930
DeeAnne McCallin: for more information on how covered entities can share protected health information with non-covered entities. Please see the State health Information Guidance, also known as the shig, especially volume, one dot, one

54
00:09:07.960 --> 00:09:12.860
DeeAnne McCallin: sharing behavioral health information in California. That's typically one of the

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00:09:13.070 --> 00:09:17.120
arenas of data and information that people have a lot of

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00:09:17.720 --> 00:09:33.470
DeeAnne McCallin: need for clarity on and scenario, for in the shigs by you to sharing health and in information, to address food and nutrition in security. So i'm putting you directly to a couple of places that should be good resources for you.

57
00:09:38.950 --> 00:09:55.470
DeeAnne McCallin: How will patients say to be secured? The Data Exchange framework is not a technology. It's not a single repository, but it is instead, rules of the road for how organizations will provide access to and exchange health and social services. Information.

58
00:09:55.580 --> 00:10:04.530
DeeAnne McCallin: patient data will not reside on any State data exchange framework system. So, therefore, Cdi in the State is not

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00:10:05.340 --> 00:10:21.910
DeeAnne McCallin: holding patient data under the framework, the permitted required and prohibited purposes, Policy and procedure of the data Exchange framework describes the purposes for which participants are required or permitted to exchange health and information, social service.

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00:10:21.940 --> 00:10:35.100
DeeAnne McCallin: social services, information. And we also have a privacy and security, safeguards, policy and procedure which describes the minimum privacy and security safeguards for all participants under the data exchange framework.

61
00:10:35.770 --> 00:10:51.180
DeeAnne McCallin: How will data exchange be operationalized? So let me actually back up a moment for this particular slide and go back a second to the other. So the previous 2 slides, where fa cues, pages, one and 2 frequently asked questions.

62
00:10:51.260 --> 00:11:15.380
DeeAnne McCallin: and then these are are trending new questions that we have not put in the FAQ. So if you, after this Webinar, if you navigate to our Ffaq document, you will not see these here so little bit of caveat and background to that, so they they will likely be coming and added to the FAQ. But they are not there yet.

63
00:11:15.530 --> 00:11:29.880
DeeAnne McCallin: So back to this new question, how will data exchange be operationalized? It lays out the rules for the road the framework does on how organizations will provide access to an exchange. It's not a specific technology.

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00:11:29.920 --> 00:11:31.680
DeeAnne McCallin: and

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00:11:32.280 --> 00:11:37.540
DeeAnne McCallin: they're kind of similar to the the first question here about securing it.

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00:11:37.630 --> 00:11:54.540
DeeAnne McCallin: Cdi. I anticipates that many participants will choose to use a nationwide network or one of California's health information organizations to meet some or all of their data sharing agreement obligations to exchange data. So that third bullet

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00:11:54.540 --> 00:12:00.690

DeeAnne McCallin: starts to get hold in a bit more on. How how is this actually operationalized?

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00:12:06.780 --> 00:12:23.330
DeeAnne McCallin: So throughout the last few minutes I've mentioned signers of the data, sharing agreement mandated or required participants at the actual statute and H. This health and Safety Code Section 1,250,

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00:12:23.330 --> 00:12:35.220
DeeAnne McCallin: 1 302 9, which is where the data exchange framework is, lists out. These required signatory types to the data, exchange framework.

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00:12:35.240 --> 00:12:45.140
DeeAnne McCallin: general to care, hospitals, physician organizations and medical groups, skilled nursing facilities that currently maintain electronic records.

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00:12:45.290 --> 00:13:00.210
DeeAnne McCallin: health care service plans and ensures I'm. Abbreviating some of this and clinical laboratories under used in section 1,265, and that are regulated by the Department of Public Health and acute Psychiatric Hospitals

72
00:13:00.250 --> 00:13:03.180
DeeAnne McCallin: and Hsc. Section 1,250,

73
00:13:03.440 --> 00:13:20.500
DeeAnne McCallin: so regardless as to whether, as I stated, whether these are entities have to begin exchange in 2,024 or 2,026 they all still must sign, must have signed by January 30, first, 2,023

74
00:13:24.860 --> 00:13:36.940
DeeAnne McCallin: so in the event you have not yet signed. You should sign mandatory signature signatories we're required to sign. We encourage those who have not signed to sign as soon as possible.

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00:13:36.980 --> 00:13:51.380
DeeAnne McCallin: We do have a signing portal. There's links to it on our website, and once you get in there you click register to start, and it walks you through on the home page of the signing portal

76
00:13:51.380 --> 00:14:07.010
DeeAnne McCallin: there is up to the top right a help button that gives you some guidance, almost the equivalent of an FAQ document. It's not super long, but it is helpful, and I do recommend folks go to that help button up at the top right of the signing portal.

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00:14:07.020 --> 00:14:25.470
DeeAnne McCallin: You can also review the actual data sharing agreement. It's on our website. You can link to a Pdf. And download the document to read. So that's where the right hand side has more information on our website for what you can look at and see if

78
00:14:25.580 --> 00:14:42.240
DeeAnne McCallin: you're a little hesitant to go straight, jump right into a button that says, register to start. There is a final data sharing agreement on our website, the policies and procedures, the Fa Cues additional meeting recordings, a list of who has signed.

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00:14:42.240 --> 00:14:51.210
DeeAnne McCallin: And so there's a lot and and more. There's tons of information out there, and our our email i'll speak it again in case folks have joined late.

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00:14:51.490 --> 00:15:01.460
DeeAnne McCallin: and or are not on visual today. CD. I. i@chs.ca.g O. V.

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00:15:06.220 --> 00:15:13.090
DeeAnne McCallin: Here's a summary very broad strokes of who has signed the data, sharing agreements to date

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00:15:14.640 --> 00:15:30.700
DeeAnne McCallin: it over 800 ambulatory care facilities and practices over 150 hospitals and other acute care settings over 90 long term care facilities, and over 80 health plans, and insurers

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00:15:30.700 --> 00:15:43.580
DeeAnne McCallin: additionally there's a wide variety of other health care entities, community-based organizations, and voluntary signers who were not on that list of mandated signatories. So

84
00:15:43.580 --> 00:16:12.080
DeeAnne McCallin: the data share signing portal does allow entities to list subordinate organizations or facilities, so that if you, if you're an umbrella organization, your your apparent organization, and the data sharing agreement, and then you can list all of your sites or different facilities as subordinates, and that is why we report 1,400 entities with over 1,000 signatories.

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00:16:12.080 --> 00:16:21.910
DeeAnne McCallin: There may only be 1,000 data sharing agreements signed to date, but they represent over 1,400 different health care organizations.

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00:16:26.810 --> 00:16:28.900
DeeAnne McCallin: all Righty. And with that

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00:16:29.090 --> 00:16:42.940
DeeAnne McCallin: we I do thank everyone who has signed the data sharing agreement, and again we encourage everyone who is especially a required signatory to to sign as soon as possible. And

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00:16:43.390 --> 00:16:55.980
DeeAnne McCallin: with that I'm. Now going to pass to my colleague, Paula, Dr. Paula Barbaria, who is going to talk to us about howling and data exchange, and if initiatives that fall under that

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00:16:58.320 --> 00:17:18.300
Palav Babaria: mit Ctl. And thank you so much, Dan. Hi. Everyone, Paula Bavaria, from the Department of Health Care services so excited to be here today, because I think we at Dhcs are really anticipating leveraging the data exchange framework to really accelerate the incredible transformation that is happening across the Medicare program. 250

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00:17:18.300 --> 00:17:32.700
Palav Babaria: currently and over the next few years. So just gonna walk through at a high level where some of the major touch points are between the data exchange framework and calend, but happy to dig into any details, depending on what questions you all have.

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00:17:32.770 --> 00:17:53.060
Palav Babaria: So I think you know, for those of you who haven't met me before my day. Job is obviously at Dhcs, overseeing all of our quality, health, equity, and Population health management work. I'm also an internal medicine position by training, and still see patients at half day a week. And so, from my own personal experience as a primary care provider as well as through my state role.

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00:17:53.060 --> 00:18:06.270
Palav Babaria: I think we can all agree that health care today is fragmented right. And if we want to achieve our vision for whole person care as described in Calais. We need to get to the the data to be whole person data as well, and it is not helpful

93
00:18:06.270 --> 00:18:25.480
Palav Babaria: to patient care or to our members when you know pieces of their data are in the dental system. Pieces of their data are in, You know, the vision system. Pieces are with behavioral health pieces are with managed care, plans, and the physical system, and when those silos are not connected, clinicians and our health care delivery system cannot provide the care that they need and want.

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00:18:25.830 --> 00:18:27.110
Palav Babaria: You can go to the next slide.

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00:18:35.440 --> 00:18:45.580

Palav Babaria: So most of you are probably familiar with Kelly. But just for those of you who may be newcomers to this conversation. Cal AIM is our multi year bold.

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00:18:45.580 --> 00:19:15.480
Palav Babaria: you know, really wholesale transformation of the medical program, and what the traditional notion of a health care system is so we are really trying to break out of healthcare for walls. We know most of the drivers of people's health does not happen in your clinicians office or in the hospital. It really happens in your homes and communities, and especially for the medic health population addressing those community, paced and upstream. Social drivers of health is critical to getting the health quality and equity outcomes that we want. And so

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00:19:15.630 --> 00:19:22.090
Palav Babaria: calim is a series of interconnected but synergistic initiatives that are really designed to provide

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00:19:22.090 --> 00:19:49.780
Palav Babaria: whole person care to really make sure that health care providers are trusted and relatable, and really meeting the needs of our members. There's an entire suite of initiatives around. Community supports enhanced care management and really upstream services that help bridge the silos not just within healthcare and between health care delivery systems, but also with key partners in the social services, public health and community based sectors who are also serving our members.

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00:19:49.780 --> 00:19:59.250
Palav Babaria: We really want to make sure that we are, you know, leveraging the strength of our communities across California for health and wellness, and making the best use of partners and resources one.

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00:19:59.490 --> 00:20:00.750
Palav Babaria: and go to the next slide.

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00:20:06.180 --> 00:20:22.430
Palav Babaria: So this is sort of our vision for the future of health care that you know to really get to health and wellness. It has to be much broader than just our narrow health

care, delivery system, and really encompass collaboration, coordination, and communication across all the different sectors you see here

102
00:20:22.430 --> 00:20:37.120
Palav Babaria: mit ctl and and data really underpins each and every one of these pieces. And so we, for those of you who Don't know as a part of our Cali and population health management program. We are currently in the design process to launch a statewide population, health management service, 150

103
00:20:37.120 --> 00:20:46.940
Palav Babaria: mit ctl. And many people ask us, is this in place of the Data exchange framework? Is this a health information exchange? And so just clearly outlining that our population Health Management service is not 150.

104
00:20:46.940 --> 00:21:03.070
Palav Babaria: The Health Information Exchange. It is not the data exchange framework, but it will leverage both of these scaffoldings and infrastructures to really make data much more accessible, and bring together those multiple sources of information, so that anyone who is

105
00:21:03.070 --> 00:21:20.900
Palav Babaria: supporting or interacting with the Medicare member really has all the information they need at their fingertips to serve that member in a whole person oriented way. And so the service itself will sort of sit on top of these various pieces of infrastructure. Sit on top of our data warehouse that we have at Dhcs that has

106
00:21:20.900 --> 00:21:33.830
Palav Babaria: an incredible amount of data even today, and really link and aggregate and make that usable data for everyone in our ecosystem, for our managed care plans for providers and for our numbers themselves.

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00:21:34.070 --> 00:21:35.350
Palav Babaria: we can go to the next slide.

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00:21:37.790 --> 00:21:44.180
Palav Babaria: So, as we think about launching the population Health Management Service and really leveraging the data exchange framework.

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00:21:44.180 --> 00:22:14.140
Palav Babaria: We really want this Ph. M. Service to allow integrated access for all of the various parts of the healthcare delivery system that are currently siloed. So right now, you know, we know there are data silos at the State level with the Department of Health care services, with other state departments and agencies, with our managed care, plans with providers, with social services, providers and local county partners as well. And so in phase one of the population Health Management Service. We will really be looking at data that we already have today. And already in current state.

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00:22:14.140 --> 00:22:44.000
Palav Babaria: there is data that we successfully share with data, sharing agreements with state departments and agencies. But the real promise of the Phm. Service is once the data exchange framework really has been implemented, and there is more robust local data exchange happening. We hope that the Phm service can leverage that data and really improve the quality and timeliness of data that we are able to share with anyone who is touching a Meta cow number. So right now we Dhcs we get.

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00:22:44.000 --> 00:23:07.850
Palav Babaria: that is, you know, usually 6 to 9 months old through claims, data, and we can do a lot of analysis on that. But if we are really talking about real time, care, coordination for those of you who follow our Pop health journey. We often talk about Linda, who is one of our medical members who have a new diagnosis and really needed care, coordination between her high risk.

112
00:23:07.850 --> 00:23:18.770
Palav Babaria: obey specialist between social services that we're trying to connect her to Wic and Cal fresh benefits, and with her deal of benefits that she was now able to access through the medical program.

113
00:23:18.770 --> 00:23:33.760
Palav Babaria: We Dhcs usually get all of those pieces of information 9 months down the road Shouldn't surprise any of you that if we're trying to serve Linda 9 months down

the road, we have missed her entire pregnancy and the ability to intervene and change her health outcomes

114
00:23:33.760 --> 00:23:51.120
Palav Babaria: for not just her, but her family and her child. And so we really want to be able to leverage real time data exchange, so that anyone who is trying to serve our members can do so in real time and meet their needs before those needs become much more severe or non interveneable.

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00:23:51.610 --> 00:23:52.870
Palav Babaria: and go to the next slide.

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00:23:56.340 --> 00:24:07.010
Palav Babaria: Another just key piece that I want to emphasize while i'm. Here is a big part of our population health management service. And just our data approach is really how we empower our members.

117
00:24:07.010 --> 00:24:36.990
Palav Babaria: give them ownership of over their data and really use that to drive equity. And so in current state, I think any of us can agree. If you've ever tried to access your own healthcare data, it can be challenging, to say the least. And so we really intend to leverage the Ph. M. Service so that any medical member can log in see their data that they are entitled to see edit key pieces of information on this platform, such as contact information, demographic information really own, where they have control over who they want that data shared

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00:24:36.990 --> 00:24:45.600
with. And how so our members are really in the driver's seat and making those decisions, and really having trust in that data, and who has access to it

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00:24:45.920 --> 00:24:47.160
Palav Babaria: and go to the next slide.

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00:24:49.920 --> 00:24:59.290

Palav Babaria: So I know you know those are all lofty, high, high goals about data share sharing and how we're going to make things in for, you know, available. But why is this so important?

121
00:24:59.300 --> 00:25:14.790
Palav Babaria: So I think it should also not be a surprise to any of us that we have some ways to go when it comes to quality and equity in health care in our state and in the medical programs. Specifically, many of you may have seen. We launched our bold goals 50 by 2,025

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00:25:14.790 --> 00:25:44.570
Palav Babaria: campaign last year and we've said some pretty ambitious targets that by the end of 2,025. We really want to close rate shown ethnic disparities in key children's preventative care and maternity outcomes by 50, and we want to improve key quality measures related to mental health screening and follow up for mental health and substance. Use disorders by 50, and then we also want to make sure that each and every single one of our health plans is meeting our minimum performance levels. For all children's

123
00:25:44.570 --> 00:25:50.530
care measures because we know that access to that quality. Care is really uneven across our state.

124
00:25:50.580 --> 00:26:19.040
Palav Babaria: and the only way to achieve these goals is to really work collaboratively as an entire ecosystem. These goals cannot be met by Dhcs alone. They cannot be met by a single hospital or provider alone. It is only we are only going to be able to meet the needle, move the needle on these on a statewide basis, with close communication and collaboration between health care providers, managed care, plans, the state, social services, agencies, public health departments, community based organizations.

125
00:26:19.040 --> 00:26:39.630
and in current state. It is so hard for any of those entities to know which one of them are serving which members where they have overlap, and what opportunities they have for closer collaboration and synergy. And so that is really the vision that we have for both the data exchange framework and our population health management program. As these initiatives are implemented.

126
00:26:39.750 --> 00:26:41.030
Palav Babaria: we can go to the next slide.

127
00:26:43.860 --> 00:26:59.280
Palav Babaria: So I referenced Linda a little bit before. So I just want to give you a brief snapshot of how we see this actually working to bring it. You know a real life example, into play, and so on the right. This is our population, health management, framework of how we Dhcs envision.

128
00:26:59.280 --> 00:27:17.350
Palav Babaria: population, health management working at our managed care plan levels and these requirements as a part of Kelly went into effect in January of 2,023 so just a few months ago. So in our future State scenario when we all have amazing robust local data exchange and the Population Health Management Service in play.

129
00:27:17.350 --> 00:27:28.580
Palav Babaria: Linda, our medical member, you know. We'll have her first prenatal appointment. She just goes in routine check up, and her provider diagnoses her with gestational diabetes in current state.

130
00:27:28.580 --> 00:27:48.190
Palav Babaria: Many of our plans don't even know that Linda is pregnant until that claim hits their claims. Warehouse, you know, 3 to 6 months down the road. They also likely don't know that she is this new diagnosis of gestational diabetes again until 3 to 6 months down the road in our amazing data exchange supported future state.

131
00:27:48.190 --> 00:27:51.930
Palav Babaria: using local data, exchange and health information exchanges.

132
00:27:51.930 --> 00:28:18.490
Palav Babaria: The plan actually receives that information 8 as close to real time as possible. That information triggers, our risk, stratification and segmentation algorithm that eventually will be done by Dhcs at the State level is currently being done by our plans and creates a flag for that plan that, hey? This member has a new diagnosis, not

only of pregnancy, but also gestational diabetes increasing her risk for poor outcomes down the road.

133
00:28:18.490 --> 00:28:33.700
Palav Babaria: A care coordinator from Linda's health plan then reaches out to Linda, understand what's going on, and understands that Linda has a hard time accessing fresh, healthy food. Linda has no idea that she's eligible for wicked services, and a doula under the new medical benefit

134
00:28:33.700 --> 00:28:48.420
Palav Babaria: mit

135
00:28:48.420 --> 00:29:02.990
Palav Babaria: our population. That's eligible, and often people are not being connected to these services until months and months into their pregnancy, or in the post-partum period, and this early notification helps us get real life changing services to this member sooner.

136
00:29:03.090 --> 00:29:14.800
Palav Babaria: So Linda is well supported by her plan and her provider. Unfortunately, at 28 weeks she's diagnosed with high blood pressure and depression, and at this point is referred to a high risk pregnancy Specialist.

137
00:29:14.800 --> 00:29:28.550
Palav Babaria: This change in condition also re-triggers Her risk stratification, and she's moved into a higher risk tier, and is now eligible for her Health plans complex care management program, and is assigned a dedicated care manager

138
00:29:28.790 --> 00:29:46.270
Palav Babaria: at 37 weeks linda is unfortunately diagnosed with pre eclampsia and admitted for labor. Induction. But she's supported by her doula, who has been supporting her throughout her entire birthing journey, and she delivers a healthy son, Jacob, her complex care manager, who has also been supporting her since 28 weeks. 2

139

00:29:46.270 --> 00:29:57.630
Palav Babaria: helps her with the transitions from the hospital, making sure that she is access to a breast pump, and all of the needed equipment at home. Once she is discharged, and also helping coordinate her, follow up appointments.

140
00:29:58.070 --> 00:30:14.920
Palav Babaria: Few weeks postpartum. Linda's health conditions have resolved, and Linda and her son Jacob are receiving dyadic services, which is also a new medical benefit to really address her depression and make sure that she is well supported in her role as a new mother, and her plan

141
00:30:14.920 --> 00:30:27.130
Palav Babaria: that you know, based off of these improvements. She no longer needs the complex care management program. And so it's discharged from that program. But it is continued to be monitored through the plans basic population, health management program.

142
00:30:27.140 --> 00:30:27.760
Yeah.

143
00:30:27.890 --> 00:30:41.970
Palav Babaria: And so hopefully, it's clear along this journey. You know at how many points early data, early notification to the people who are responsible for Linda's Care really help us move the needle and get resources to the people who need them

144
00:30:41.970 --> 00:31:00.510
Palav Babaria: sooner faster and a more member-centered way. And I think all of us who work in the health care sector. When you think about how we do this in the current state, using paper and facts and phone calls and asking patients where they've been, and who they saw and what their conditions are, know that this is a much better way. We can go to the next slide.

145
00:31:02.910 --> 00:31:17.350
Palav Babaria: and so I think there's a lot of slides, and I have to give credit to my our chief deed officer, Dhcs Lynette Scott, who put this together. There is a lot happening around data, exchange and consent and interoperability. And so this just sort of lays out

146
00:31:17.350 --> 00:31:46.780
Palav Babaria: all of the pieces that are currently moving at Dhcs. And so you'll see the data exchange framework. Bubble is sort of on the right. We are also leveraging sort of in this ecosystem the h chi healthcare payments database that will become an all-payer database. We have specific requirements and initiatives for our county behavioral health quality improvement program

147
00:31:46.780 --> 00:32:02.400
mit ctl. And we are also running pilots for a calling consent management pilot with the ask me for, which is a standardized universal consent form to really lower the barrier of multiple entities, trying to individually and separately obtain. Member, consent, 150,

148
00:32:02.400 --> 00:32:19.730
Palav Babaria: to share some of those data types that are protected and require consent, and especially as we think about whole person care, and breaking down some of those barriers to be able to truly meet People's mental health and substance use needs. This is a critical pilot that we hope to scale. Once we've worked out all of the kinks.

149
00:32:19.730 --> 00:32:47.700
Palav Babaria: the population, health management program and service I just went through in detail, but that is clearly a part of this puzzle. We also have numerous initiatives through calim, enhanced care management, community support and our incentive payment program, which are really working on bringing in some of those non traditional medical providers, community based organizations, local health jurisdictions, social service departments, to become medical providers, and to be able to help again get to that whole person care.

150
00:32:47.700 --> 00:33:08.660
Palav Babaria: And then, obviously underlying all of this, there is a Cms interoperability and patient access rule that we are in the process of implementing and then building on over a decade of other Federal initiatives created through high tech. So I know there is a lot happening in this space. But this slide is here to reassure you that we are tracking all of these pieces.

151
00:33:08.660 --> 00:33:22.390

Palav Babaria: and making sure that there is synergy and alignment, as you all in the sector experience these initiatives. If you see missing pieces or lack of alignment anywhere, please feel free to reach out to me Personally, we definitely want to fix that.

152
00:33:22.710 --> 00:33:23.930
Palav Babaria: We can go to the next slide.

153
00:33:25.610 --> 00:33:36.070
Palav Babaria: So these slides, i'm sure will go out. So we've just listed all the references where you can do a deep dive into any and all of these programs, and there's a lot more information available on our website.

154
00:33:37.350 --> 00:33:42.580
Palav Babaria: I think that was our last formal slide, but happy to go in to detail wherever it is helpful

155
00:33:43.740 --> 00:33:46.040
DeeAnne McCallin: great. Thank you so much.

156
00:33:46.150 --> 00:34:05.090
DeeAnne McCallin: I'm sure a lot of the attendees especially repeat attendees to this Webinar series are seeing the interplay, hearing some of the same words, some of the needs for the data exchange framework to crosswalk and work together across agency.

157
00:34:05.130 --> 00:34:11.270
DeeAnne McCallin: so we'll now take some time for questions and answers.

158
00:34:11.510 --> 00:34:16.400
DeeAnne McCallin: and I can't remember. Is there another slide on that already?

159
00:34:16.690 --> 00:34:25.650
DeeAnne McCallin: So i'm going to be looking. Don't mind me as I jump around going through some of the questions and answers here.

160
00:34:26.530 --> 00:34:39.260
DeeAnne McCallin: someone, and for folks that are not visually watching and are listening. What are some broad ideas to consider for the Data Exchange frame Framework Grant funding

161
00:34:39.560 --> 00:34:57.780
DeeAnne McCallin: to look at. So our website has especially Webinar Number 6 today's Webinar 7. So back in February, Number 6, we covered some good information on the Data Exchange Framework Signatory Grant program where the recording and slide is there.

162
00:34:57.780 --> 00:35:06.200
DeeAnne McCallin: The slide deck from today's presentation will be posted on the Data Exchange framework website. So you'll be able to access it through that.

163
00:35:06.510 --> 00:35:26.240
DeeAnne McCallin: Someone asked if there's a penalty for providers or entities who have not yet signed the data sharing agreement, even though they might have been required to on January 30 first. There is not, which is why we are able to comfortably encourage folks to come and sign past the deadline. There, there's no penalty to do that.

164
00:35:26.290 --> 00:35:31.550
DeeAnne McCallin: but we do highly recommend that you you go and sign.

165
00:35:31.850 --> 00:35:59.260
DeeAnne McCallin: Inform yourself, of course, first a little bit more, and then sign with through the portal another great question that does tie into our grants program. Is there any way for for Cdi to provide consultation or Webinars to specific medical societies or others specific groups, especially that crosswalk to those 6 required mandate required entity types. So

166
00:35:59.260 --> 00:36:09.990
DeeAnne McCallin: we do have in our frequently asked questions. I think it's somewhere in the teens around 17 or 18 or so

167
00:36:10.310 --> 00:36:20.990
DeeAnne McCallin: 8 entities that are working on data, exchange framework, their provider associations, associations, a a multi stakeholder group that

168
00:36:20.990 --> 00:36:39.670
DeeAnne McCallin: are contracted with Cdi. They're working closely with the Cdi team on the data Exchange framework who have funding to support education and outreach to specific entity types that are entity types that they're very familiar with, and have a a good working experience with.

169
00:36:39.670 --> 00:36:49.900
DeeAnne McCallin: So we do recommend that you look in our FAQ. Where there is a list of who the entities are and their contact information for data, exchange framework.

170
00:36:51.040 --> 00:37:02.100
DeeAnne McCallin: All Righty. Continuing on data exchange framework, we have, we have a lot of time. We both covered a lot of content on some slides, but we went fast, so we do have some time for questions.

171
00:37:02.280 --> 00:37:04.470
DeeAnne McCallin: Let's see

172
00:37:05.790 --> 00:37:09.120
DeeAnne McCallin: who let's see

173
00:37:10.720 --> 00:37:29.800
DeeAnne McCallin: who should sign the lists most. The the list that we're on earlier slides about required entities are indeed mostly health care providers. So the person asked, what about entities that are in that are into the human services, so, especially across government departments

174
00:37:29.800 --> 00:37:38.430

DeeAnne McCallin: in the State. They're highly encouraged, and it was the intent of the legislature in the statute to encourage

175
00:37:38.440 --> 00:37:57.050
DeeAnne McCallin: and have government agencies join the data sharing agreement, and then that filters down to also a community based organization. So we are working with those types of entities and encouraging participation. And there are what are we call voluntary

176
00:37:57.080 --> 00:38:11.400
DeeAnne McCallin: or optional participants in the data sharing agreement? If they sign they're bound to the same terms and conditions as everyone else. And that's where it dub tells into the covered entities and the non-covered entities in that FAQ. That I highlighted earlier.

177
00:38:13.930 --> 00:38:19.320
DeeAnne McCallin: looking to see some other questions. And then

178
00:38:20.090 --> 00:38:24.320
DeeAnne McCallin: we must have crossed over into

179
00:38:25.850 --> 00:38:29.750
DeeAnne McCallin: the Pop Health Management and Kelly

180
00:38:30.680 --> 00:38:34.200
DeeAnne McCallin: section, because i'm seeing a lot of questions there.

181
00:38:36.390 --> 00:39:05.890
DeeAnne McCallin: So and Pelv, Are you able to see any question, Jen? Or would you like me to read any I Can I have a few, which i'll start with, and then, Dean, that maybe you can keep me honest to make sure if I skip any, that we come back to it, so i'll just read them out. So we have a great question on HD. Limits access to the Hmis database to those within the continuum of care. Dhcs has advised, managed care, plans to

access Hms. And mine. The data for Ecm. Which is in conflict with current HUD regulations.

182
00:39:06.050 --> 00:39:08.000
Palav Babaria: M. Cps

183
00:39:08.500 --> 00:39:26.840
Palav Babaria: want to put Phi into Hmis, which is not an Ehr. How do we resolve these conflicts between HD. And Dhcs regulations? So whoever asked that question, please feel free to send me a direct email with details. It is our understanding that with the appropriate data sharing agreements.

184
00:39:26.840 --> 00:39:46.670
Palav Babaria: there are ways locally to share that data. I will say at the State level. We are definitely exploring ways to get broader access via the State. But that will take some time, and we know that Our incentive program related to housing obviously is on a sort of a faster trajectory, but happy to help dig into that and get resolution as soon as possible for all of you.

185
00:39:47.730 --> 00:40:07.530
Palav Babaria: And then I see a few great questions just about the Phm. Service and some of what I mentioned, and if it's statewide, so i'll read 2 of them because they answer to both is sort of the same. Does the Dhcs. P. Hms. Include a statewide e mpi master patient index. And then there's another one that is related.

186
00:40:12.580 --> 00:40:24.970
Palav Babaria: Do you foresee deployment of a California wide, longitudinal, patient record of which is aggregation of all visit information of a patient to all care, settings into a single repository to deliver Ph. Of services.

187
00:40:24.970 --> 00:40:54.490
Palav Babaria: The so the short answer to both of those is at this time. The Ph. M. Service is medical, specific, so both of those functions will exist within the service for medical members. So we will have an Mpi within the service, because we obviously need to match data across multiple systems that are coming into it as well as have a longitudinal patient record for medical members. At this time I can't speak to a larger

vision that is statewide, so I will defer that to Dn or others, if they have more context on those.

188
00:40:56.580 --> 00:41:21.630
Palav Babaria: and then we might do. Alright, and then, timing wise, we are working through our implementation plan for the phm service. So more updates to come on timing in the upcoming months in the links. If you go to our Kellyn website, there is a population health management page, so you can just sign up to get updates and alerts and join our advisory groups, where we will be sharing publicly sharing that information

189
00:41:21.630 --> 00:41:22.940
Palav Babaria: when it's available.

190
00:41:23.290 --> 00:41:44.880
Palav Babaria: We also have a great question of. If you're going to promote, follow-up care to a substance, use diagnosis and an LED department Will those services become billable under State Plan drug medical so I can take that back for our finance experts to confirm. But in current state substance use treatment is actually reimbursable through both the physical health

191
00:41:44.880 --> 00:42:13.920
Palav Babaria: manage care side, as well as through drug medica depending on the service codes that are used, and we do have a lot of models of sort of integrated substance. Use treatment on the physical health side, which are a covered benefit. I will also lift up that for those of you familiar with the California Bridge program which has funded and scaled substance use navigators in emergency rooms. There's a lot of great data. It's an incredibly successful program, and through our new medical community health worker benefit.

192
00:42:13.960 --> 00:42:25.110
Palav Babaria: Those substance use navigator services are now billable services that are covered under Medicare under the Chw. Benefit, which is a really exciting opportunity to scale that program.

193
00:42:26.120 --> 00:42:55.780

Palav Babaria: And then another great question on sort of is there a work group, considering the confidentiality issues for teams in the Population health management program, who would have access to Linda's pregnancy and mental health information if she is 16 years old, and does not consent to sharing confidential information with her parents.

194
00:42:55.780 --> 00:43:11.070
Palav Babaria: think, through and launch this project on security, consent, and confidentiality that is well aware of sort of the nuances and intricacies, especially for our adolescent members that will be working through all of those privacy regulations. So lots more to come on that.

195
00:43:12.920 --> 00:43:14.900
Palav Babaria: And then

196
00:43:16.920 --> 00:43:28.520
Palav Babaria: for there's another question. Is there a data exchange agreement specific to the Bhq. IP program. So you know, wonderful example of State alignment. We actually have pointed to the data exchange framework

197
00:43:28.520 --> 00:43:50.750
Palav Babaria: as the agreement that we want entities to sign for the data exchange between managed care, plans and behavioral health plans in the State as a part of behavioral health. Qip. There are some other sort of ways that plans on the behavioral health and managed care side can exchange data. But our preferences that everyone leverages the data exchange framework where possible.

198
00:43:53.330 --> 00:43:56.320
Palav Babaria: Tan. Do you see any other key? Questions that I missed?

199
00:43:56.990 --> 00:44:10.150
DeeAnne McCallin: I think it's like harder than playing chess going through the the question log to see. One other person did did share that. They're interested in the HUD, the hed response.

200
00:44:10.150 --> 00:44:23.490
DeeAnne McCallin: So i'm wondering if you hear from anyone if you're able to share with me, and then I could post or share in our next Webinar, or promote it somehow, just a little bit more more information.

201
00:44:23.830 --> 00:44:37.250
Palav Babaria: and and it will say globally, You know, I think sort of housing and education or areas where there's so much potential for closer collaboration and need for breaking down those silos, and we're still working through what some of those

202
00:44:37.250 --> 00:44:47.840
Palav Babaria: mit ctl and look like at the state level. And then one other question that I think is really great. Has there been any thought around developing a screener, assessment or functional, cognitive and social drivers of health? 250

203
00:44:47.840 --> 00:45:17.400
Palav Babaria: to be deployed through the population, health framework to not only drive population, health, but streamline. The process of utilizing the data to identify individuals for Ecm. And community supports connecting them to the right services at the right time, plus drive equity of access to medical and social services across all populations. So i'm so glad you asked that question, because the the brief answer is, Yes, we've definitely thought about it for those of you who've been on the Caliim journey since the beginning, You may remember there initially was appropriate

204
00:45:17.400 --> 00:45:19.380
to have a standardized

205
00:45:19.380 --> 00:45:48.680
Palav Babaria: universal screening tool exactly as described here, that would be implemented, statewide and standardized. Once the Population Health Management service was conceived. We sort of went back to the drawing board, because we have learned through other Dhcs initiatives, such as the staying, healthy assessment that having you know a paper based screening tool that's deployed at scale, but isn't interoperable isn't captured digitally, you know, has its disadvantages, and so, as we build out the Ph. M. Service we are interested in.

206
00:45:48.680 --> 00:46:18.240
Palav Babaria: Where can we leverage data that is already captured? We know our medical members have screening fatigue because they may be asked about their housing status 18 times, with all the different entities that they visit, and we would much rather leverage existing data and make that data available than to add additional screening burden. That being said, we are exploring, you know. Where does it make sense to maybe standardize some of those elements and leverage the service for a more standardized approach. So more to come on that as we

207
00:46:18.240 --> 00:46:20.150
develop and launch the service.

208
00:46:20.740 --> 00:46:26.990
DeeAnne McCallin: did you answer a question about the behavioral health. Qip Program.

209
00:46:27.540 --> 00:46:45.290
Palav Babaria: Yeah. Mostly that the requirements in Behavioral Hall. Q. I. P. Those are also available publicly. I think they're also linked through a Cal name website, or you can just Google, the Hq. IP. But we are encouraging everyone to use the Data Exchange framework agreement as the agreement for that data Exchange in Vhq. I.

210
00:46:47.610 --> 00:46:48.440
DeeAnne McCallin: Great

211
00:46:48.780 --> 00:46:53.890
DeeAnne McCallin: I'm. Scrolling through the questions

212
00:46:57.550 --> 00:47:03.210
DeeAnne McCallin: i'm not sure if you were able to touch upon whether your department

213
00:47:03.230 --> 00:47:13.110

DeeAnne McCallin: has looked at any additional funding sources beyond high tech, which, were, we were by text over right

214
00:47:14.090 --> 00:47:33.820
Palav Babaria: and the and you may have more details on this on that one we may have to take back to our cheap data officer. But I know there there are conversations, obviously, you know, with agency and and other State partners about what are the gaps across the State as we really try to achieve this vision? And where are there areas where maybe the State needs to support filling some of those gaps.

215
00:47:33.860 --> 00:47:38.370
DeeAnne McCallin: Yes, yes, and and say we are looking that's where

216
00:47:38.680 --> 00:48:00.950
DeeAnne McCallin: launching the Pop Health Management service during 2,023 is, it is, you know it priority a standing up the data exchange framework Grants program priority a happening right now. But we have other things in thoughts and a avenues that we're exploring collectively, individually.

217
00:48:01.810 --> 00:48:07.970
DeeAnne McCallin: connecting the dust between us on that that other types of needs and

218
00:48:08.050 --> 00:48:10.710
DeeAnne McCallin: possible possibilities for how to fund

219
00:48:16.910 --> 00:48:23.180
DeeAnne McCallin: looking at a couple of different other questions to see if there's things we are able to answer.

220
00:48:25.800 --> 00:48:34.230
DeeAnne McCallin: Were you? Did you touch upon what types of clinical data the Pop Health Management service may ingest.

221
00:48:34.540 --> 00:48:43.810
DeeAnne McCallin: Will it? Will it come from the clinician level, or is it the plan? And therefore maybe a step a degree away from clinical?

222
00:48:44.130 --> 00:49:14.080
Palav Babaria: So at the onset. It will likely mostly just include data that we already have at the Department of Health Care services. And so that is largely claims and encounter data. There are some additions to that. Obviously, with the pharmacy carve out. We now also have all of the pharmacy data that is timely and accessible to the State. We have data sharing agreements with some of our State partners to get, for example, immunization registries from our public health colleagues. So there are some additional pieces of information, but

223
00:49:14.260 --> 00:49:39.780
Palav Babaria: most of it is claims and encounter data which you know we know is, it's limited, not. Everything is in there that we would want, and there is claims leg. I think the ultimate vision is again, as the data Exchange framework is rolled out across the State that ultimately the service would ingest information from health information exchanges, so that we can get more of that clinical data that we know is really critical to population health management.

224
00:49:40.370 --> 00:49:52.750
DeeAnne McCallin: Great. Thank you. I can pivot to a data exchange framework question to give you a break. How will data, exchange, framework, protect ultra sensitive mental health and alcohol and drug.

225
00:49:52.750 --> 00:50:14.410
DeeAnne McCallin: Phi that is kept in Ehrs. There was also even similar questions under the Pop Health management or Cal name space about like team clinical or social work, personal information that all of these initiatives adhere to Federal and State regulations and rules rules.

226
00:50:14.410 --> 00:50:22.990
DeeAnne McCallin: The data. Exchange framework is a set of rules. It's not a centralized repository, and

227
00:50:23.560 --> 00:50:38.830
DeeAnne McCallin: any of the sensitive mental health or S. Ud. Information. The exchange of such an information is subject to the protections of Federal and State, even though it's under the data sharing agreement, the our privacy and security and the data elements

228
00:50:38.830 --> 00:50:47.250
DeeAnne McCallin: So good question it's. It's definitely a key area of the data that that is in all of this. Let's see.

229
00:50:47.990 --> 00:50:51.540
DeeAnne McCallin: looking to see if there's any other questions.

230
00:50:56.190 --> 00:50:57.430
DeeAnne McCallin: all right.

231
00:51:00.910 --> 00:51:19.820
DeeAnne McCallin: recognizing that there are some questions that we're not going to be able to answer on the fly. But Cdi does look at these, and and we do encourage questions follow up. But I I can see a few that we're. I'm not going to be able to get into the devilish details today.

232
00:51:19.820 --> 00:51:26.910
DeeAnne McCallin: We'll cross, walk to any of our epic queues as well, and help direct you there. Hmm.

233
00:51:28.120 --> 00:51:41.870
DeeAnne McCallin: I'm: reading one right now to see it's about like the care and the Covid vaccine data duplicate records and misspellings and patient matching hyphens and non high things. How will the data exchange framework

234
00:51:41.870 --> 00:51:51.860

DeeAnne McCallin: work to reduce the potential for duplicate charts, and that so part of the data Exchange framework said to to establish a

235
00:51:52.040 --> 00:52:04.180
DeeAnne McCallin: digital identity. And then we're looking into a participant registry for the folks who have signed the data sharing agreement. And that's where we definitely look into like

236
00:52:04.530 --> 00:52:18.150
DeeAnne McCallin: not to leaning upon what we have built, such as Care registry, the California Immunization registry to try to avoid duplications, but we we do know it'll be there

237
00:52:18.240 --> 00:52:20.230
DeeAnne McCallin: but and

238
00:52:20.510 --> 00:52:31.780
DeeAnne McCallin: get the data exchanging, and then we can work towards the data clean. But we we hope that the page patient matching works well.

239
00:52:31.980 --> 00:52:36.090
DeeAnne McCallin: and it's through the different technologies which is not under the framework.

240
00:52:38.290 --> 00:52:53.840
DeeAnne McCallin: All right. So with that i'm going to start to wrap us up. And again apologies for any questions that I haven't been able to address right now. Today i'll work with my colleagues, and we'll see what we can get back out to the question folks.

241
00:52:53.840 --> 00:53:21.330
DeeAnne McCallin: A number of the questions that have been asked that I haven't touched on. We are already working on, so we we appreciate it and acknowledge and see that they are still questions, and that we need to answer to to them. Thank you for joining us today. Stay involved. These are the let me get the questions out of my way.

Our next how information is power? Webinar is on April eighteenth, from 10 am. To 11 am. Pacific time, and we have

242
00:53:21.430 --> 00:53:33.110
DeeAnne McCallin: Oh, is it the same day? April Eighteenth is our next policy and procedure subcommittee meeting and an implementation advisory committee meeting on April 20 fourth.

243
00:53:33.220 --> 00:54:03.220
DeeAnne McCallin: The one. The meeting that we held this week was a combined meeting, and people really seem to like it. So some of these meetings are potentially subject to change, but we don't know what April looks like right now and again we encourage folks to join our mailing list, so that oh, Paul, if I did think of one question, do you? Are there any Dhcs led either Kelly or Pop health management, specific webinars that are also public facing and open to like, not internal stakeholders.

244
00:54:03.220 --> 00:54:03.680
Yeah.

245
00:54:03.680 --> 00:54:33.410
Palav Babaria: yes, lots. So if you go to the Kelling website that is linked to my slides, which we can definitely send out and and share and post. Or, if you just, you know, look up the Dhcs calling website, there's multiple links for population, health management advisory group that meets every other month, and it's an open chat. And so we do have an advisory group that's sort of named, and our experts on there, but we really encourage broad participation. So for any of you who have any inkling of interest in, pop pop up. Please

246
00:54:33.410 --> 00:54:35.370
please come, join us and share your thoughts.

247
00:54:35.390 --> 00:54:54.340
DeeAnne McCallin: Great. Thank you. Thank you so much for your time Today we we know you're extremely busy and doing a lot of work. The the tie into your actual clinical experience is is meaningful, and resonates with many, and we look forward to further collaboration with your department.

248
00:54:54.460 --> 00:55:11.900
Palav Babaria: Thanks so much for having us. The data is the underpinning of everything we are trying to do. So we are. We are on this journey with you.

249
00:55:11.900 --> 00:55:27.530
DeeAnne McCallin: Check out our website, and we will be back in talking to you soon, and before our internal team logs off, we'll be collecting any of the questions that we did not answer. And we're working daily to try to get responses to you all. Have a great day, everyone. Thank you.