**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 #6 Public Comment Log (10:30AM – 12:30PM PT, April 24, 2023)**

The table below shows public comments that were made verbally during the April 24 meeting. Additional public comments can be found in the meeting's "Q&A Log" posted on the CalHHS Data Exchange Framework website.

| Count | Name | Comment |
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| 1 | L. Johns | Thank you. Can you hear me? This is Lucy Johns. Great. Thank you. This has been a fascinating discussion. I only want to comment as a consumer patient on one very important point. Namely, the comment by Matt Eisenberg for this group to please take some time to consider the possibility that patients may decline ADT sharing. Someone else, Morgan Stains, termed this consent management and I really support both of these individuals and look forward to this esteemed group really starting to look at all these rules from the patient consumer point of view. Thank you. |
| 2 | Mohit Ghose | Thank you very much. This is Mohit Ghose with Anthem and just want to echo some of the comments that were made earlier, especially when it comes to items like ADT completely respect the patient privacy aspects of it. If folks do not want their data to be transmitted, that is obviously something we want to be very careful with. But at the same time there are myriad rules now on health plans to do follow up care, ensure that patients are being seen in the right setting within a certain number of days after they are discharged from the hospital. And the idea that we would have to go to each individual hospital and figure out whether or not we have the right feed, whether we have the right patient panel being presented at that hospital depending on treating physicians and admission capabilities of those physicians, rather than having a push feed coming out of the hospital that goes to an |

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| | | entity that can tell anthem very directly, by the way, your patient, who you may not have known was in the hospital, has just been discharged today, allowing us to then do the follow up care immediately and ensure the PCP and care team can engage. I just, you know, in terms of workflow, that's something I hope the panel will consider. And then the other piece is very similar on real time. When you think about real time, you know, you have the ADT issue there as well. Having ADTs appear in a fax four or five days later doesn't allow us to do our job, number one. Number two, in terms of real time, is it a query or is it a push? Under what circumstances should it be a query or push? And so, really as we get to the point of trying to have interoperability looking at the Federal rules also becomes very, very important, because inconsistencies only set people up for failure. At this point, if we are behind on some of TEFCA or FHIR, or any of those items, we should try to align as closely as possible, because, as you recognize, hospital systems, health plans have to build significant change through the CDII process. So those are three areas of comments. Thank you. |
| 3 | Dan Chavez | Good afternoon. Thank you. Dan Chavez, CEO serving Communities Health Information Organization, formerly the Santa Cruz HIO. The oldest HIO in the state of California. I'd ask the committee to really think through at some point in time unintended consequences. That some of these policies could have a dramatic impact on the state of interoperability in California. If that HITRUST requirement stands as is, I think it's easy to foresee the consolidation of HIEs in the state. What is HITRUST say, when a HITRUST certified entity merges with one or two other noncertified entities? Does that HITRUST certification remain in place? I'm not sure it does. So I would really ask that we look hard at some unintended consequences of policies. With respect to security, I believe HIOs in the state should be given consideration for passing security assessments with our larger health systems, like Kaiser, like Common Spirit, like the Department of Defense, like VA. We do this cyclically today, and a HITRUST certification does |

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| | | not alleviate our time, energy, and efforts in going through these assessments with these major health systems. Next, I would ask that the committee review last week's published health data utility maturity model. It's a fine piece of work of which our sister HIO, Manifest Medex, contributed to. And then finally, with regards to the ADT conversation, it's a tough one. Lots of considerations have to be made, but I believe that we're not really addressing some of the key elements of the concern, as it relates to ADTs. Which, in my view, seems like unfettered aggregation of data. I think we need to put more explicit business rules in place as to who can ask for an ADT and perhaps change these policies and procedures to have a little bit more teeth as it relates to who is entitled to an ADT, like an existing patient provider relationship. Thank you. |
| 4 | Olivia Bundschuh | Hi! Good afternoon, everyone. My name is Olivia Bundschuh and I am calling on behalf of the Connecting for Better Health Coalition. We are calling to express concern regarding the latest proposal for the technical requirements policy and procedure, and the omission of the requirements for hospitals to share ADT messages with the QHIO. We strongly urge CDII to reconsider this position requiring the sharing of ADTs with the QHIO, or through a central statewide ADT hub, will ensure that this critical data gets shared with community providers, community organizations, and care coordinators, which is particularly important to advance CalAIM. We also called to express support for the proposed trailer billing, which was proposed by CDII. We support the effort to establish a formal data exchange board, and also urge CDII to make critical amendments to the Health and Safety Code to clarify which entities are required to sign the DSA. Thank you very much. |

**Total Count of public comments: 4**