March 23, 2023

John Ohanian
CalHHS Chief Data Officer
Director, Center for Data Insights and Innovation (CDII)

RE: Requiring Hospitals to Send ADTs to at Least One Qualified Health Information Organization (QHIO)

Dear John:

On behalf of the Health Information Exchange Organizations in California, many of which represent Medi-Cal-focused physician organizations that are independent of hospital affiliation. These practices face dual dilemmas: they are not part of hospitals' larger EHR integrated system networks, and they do not possess the bandwidth to locate, negotiate, pay for, and implement hospital connections and notification services.

Most of these safety-net providers do not receive the ADTs they need today. Further, the data exchange feeds necessary to support our social services, behavioral health and county health services, and unaffiliated Critical Access Hospitals and Rural Health providers are currently supported through our HIOs.

National "intermediaries" do not provide, real-time ADT feeds to the community stakeholders that need them. The only form of delivery currently is occurring between hospital's and their affiliated provider groups. This process leaves out the core CalAIM stakeholders including MCPs, CAHs, FQHCs, RHCs, County Health Services, Social Services and the like. While the hospitals are not the only target for ADT feeds, they are currently an important partner that are not participating in the real process of data sharing in the community.

We urge CDII to restore its Technical Requirements for Exchange provision for hospitals to send ADTs to at least one QHIO. Undoing this requirement will deepen the digital divide rather than bridge it, leaving behind care teams responsible for the most vulnerable and frequently hospitalized Californians. QHIOs will expand and streamline ADT access—but only if hospitals contribute their information to the QHIOs directly to support the ADT feeds we are already managing with our participants. ADT message sharing is the best way to promote the real-time, bi-directional exchange of healthcare information and:

- Certified EHRs can support ADT feeds out of the box
- ADT message sharing provides a vehicle to onboard non-traditional exchange partners such as behavioral health and public health
- ADT messaging is cost effective automated mechanism for maintaining the integrity of identity and consent information
- ADT messaging provides a very flexible automated platform for additional programming, customization and enhancement in data sharing
- ADT feeds need to be sent to the patient Health Plan for care coordination

We fully expect and will advocate that QHIOs be required to (1) collectively handle all of their participant's ADTs transactions, (2) be capable of serving *all DSA signatories* regardless of which EHR system they use (or whether they have an EHR), (3) manage dynamic patient rosters and alert subscriptions on behalf of providers and health plans, and (4) securely and reliably attribute, filter, and deliver ADTs to the appropriate care teams based on these rosters.

The original policy appears to focus on hospitals, but we encourage this requirement for all members of the health data exchange eco-system. Hospitals provide necessary information and allowing them to continue the practice of nebulous data sharing to occur "via an intermediary" allows the status quo which does not work for the aforementioned stakeholders.

CDII therefore is on firm ground to require hospital ADTs to *adhere to a policy* that *enables* these messages to have the highest chance of reaching any DSA Participant that (1) has a relationship with the subject of the ADT, and (2) requests to be notified of these events for permitted purposes—especially when the Participant lacks the wherewithal or even awareness to directly connect to those individual hospitals.

The only mechanism for this is **a common infrastructure that can receive, match, and forward ADTs to any DSA Participant.** CDII is on track to demand these capabilities from QHIOs to serve as a **digital health data safety net**. The corresponding duty should be on hospitals to *contribute ADTs to least one node of this digital safety-net infrastructure*.

While some hospitals are opposed to forwarding an ADT feed to just *one additional* intermediary in service of breaking this logjam. Again, we have recommended reasonable approaches for CDII to minimize hospitals' costs for sending ADTs to a single QHIO.

We fully support the original language presented and respectfully request that it is restored as a requirement to achieve the goals of data sharing for the most vulnerable of our members in California.

"*Advancing health equity requires filling gaps in data completeness and quality for historically underserved and underrepresented populations*."

Sincerely,

Lori L. Hack

Digitally signed by Lori L. Hack
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Lori L. Hack
Interim CEO

CC: Rim Cothren, Independent HIE Consultant to CDII
Jonah Frohlich, Senior Managing Director, Manatt Health Solutions