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:

The undersigned are providers, health plans, health information organizations (HIOs), labor, and health equity voices who provide or support care for Californians across the state. While all our organizations subject to the first signing deadline have executed the DSA, we view the Agreement as more than just a compliance obligation. We are CalHHS' local partners in CalAIM and other Healthy California for All initiatives. We are thus invested in shaping and advancing DSA policies that directly *improve* our ability to share and use information in providing more collaborative and equitable whole-person care.

For example, many of us 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. As a real-world consequence, many of these safety-net providers do not receive the Admit, Discharge, Transfer (ADT) notifications they need today.

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.

<u>QHIOs will expand and streamline ADT access—but only if hospitals contribute</u>

We fully expect and will advocate that QHIOs be required to (1) collectively handle a statewide volume of 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.

Through these capabilities, QHIOs will reduce the burden on ambulatory practices, health plans, and other DSA signatories to locate and manage the ADTs they receive, by guaranteeing these signatories can (but not are not mandated to) receive them from a consolidated and streamlined source rather than having to seek multiple notification services through different individual hospitals. These criteria will also help QHIOs ensure that ADTs only reach DSA signatories who are permitted to receive them, introducing more security for patient data.

However, failing to require hospitals to send ADTs to at least one QHIO deprives them of these signature capabilities. It defeats the QHIO Program's guiding principle of equity to "create opportunities for many signatories to successfully participate in the DxF."

<u>**Arguments to withdraw hospital ADT-to-QHIO requirement do not hold up**</u>

Below we address various claims against requiring hospitals to send ADTs to at least one QHIO.

<u>"Many commenters identified that the requirement might conflict with HSC § 130290 language allowing Participants to use 'any health information exchange network, health information organization, or technology'…"</u> The full statutory citation reads: "The [DxF] will be designed to *enable and require real-time access to, or exchange of, health information* among health care providers and payers through any health information exchange network, health information organization, or technology *that adheres to specified standards and policies* [emphases added]." This language does not preclude, **and in fact supports**, a requirement for hospitals to send ADTs to at least one QHIO.

Indeed, through the Technical Requirements P&P, CDII has *specified a policy to require real-time access to health information*—that every hospital "must communicate ADT events electronically"—as well as a *standard* (i.e., HL7 messages). The P&P also defines <u>Requested Notifications</u> as being tied to "specified persons (e.g., patients, members, or clients)." From there, it is important to clarify the policy context and intent. ADTs are widely understood to have their most critical applications when a patient requires emergency hospitalization outside of their residing region, alerting their primary care teams to follow up as necessary. ADTs are also most urgently needed by care teams least able to acquire multiple connection points and notifications services stipulated by hospitals. Again, these are the low-resourced safety-net providers whose patients are at the greatest risk for readmissions and ED bounce backs.

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*.

There is no additional mandate for hospitals to adopt QHIOs as a "technology" or "vendor" for DxF requirements they can otherwise meet through their own preferred methods. Nothing in the P&P compels a hospital to purchase or use any other service a QHIO may offer. Moreover, we endorse several policies to minimize hospitals' burden in sending ADTs to at least one QHIO. For instance, a hospital that is already sending ADTs to a non-QHIO intermediary should be able to direct that intermediary to forward the ADT to the QHIO. CDII should also require QHIOs to accept ADTs from any hospital with minimal contract requirements and without initial or ongoing fees greater than what DxF Signatory Grants will cover.

<u>"Comments against requiring Hospitals send ADTs to a QHIO outnumbered comments in favor."</u> We implore CDII to weigh the real-life burdens and implications for stakeholders arrayed on either side of this issue. You have heard from Medi-Cal plans and clinics responsible for transitional care management, small practices participating in Accountable Care Organizations, and local public health nurses supporting pregnant women in high-risk situations. Absent a QHIO to manage their ADT needs, all of them would face the technical and operational lift of setting up point-to-point connections, multiplied across different hospitals wishing to employ different customized methods. The upshot in many cases is that ADTs simply do not reach the care teams that need them most.

In the other camp are those opposed to connecting or 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.

CDII should also assess its own potential capacity to oversee hundreds of California hospitals sending ADTs to at least one QHIO—versus verifying their claims to provide point-to-point connections with thousands of DSA signatories who may request ADTs for their patients.

<u>Other arguments.</u> Some have questioned how a QHIO receiving ADTs for patients not on its rosters will be able to divert the notification to the appropriate QHIO that does maintain records for those individuals. We agree it is imperative to arrive at a QHIO-to-QHIO solution for sharing ADTs, via rules of the road or a central forwarding service. We also emphasize this has been accomplished in Pennsylvania and other states with multiple HIOs. CDII should compare the opportunity to learn from and adapt these successful models, against the harm of allowing gaps in ADT notifications to persist.

A suggestion to require hospitals to send ADTs to a "HIO" versus QHIO is a veiled attempt to perpetuate the status quo. Not all HIOs (a wide-ranging term which may be used to include the enterprise systems or expensive platforms inaccessible to many DSA Participants today) will meet the robust criteria tied to the fundamental purpose of fulfilling ADT requests on a statewide, person-centered basis. The proposal is also moot since the QHIO Program will launch over the next several months, with the first set of designated intermediaries to be selected within the year.

Guaranteeing ADTs can reach <u>all</u> care teams that request them is a collective action problem. It cannot be met without a modest requirement for hospitals to send notifications to at least one QHIO as part of a digital health data safety net. CDII must reinstate this requirement to align with the first DxF Guiding Principle: "*Advancing health equity requires filling gaps in data completeness and quality for historically underserved and underrepresented populations*."

Sincerely,

America's Physician Groups	L.A. Care
Anthem Blue Cross	Local Health Plans of California
Bella Vista Medical Group IPA	Los Angeles Network for Enhanced Services
Blue Shield of California	Manifest MedEx
Connecting for Better Health	MedPOINT Management
Health Care LA, IPA	San Diego Health Connect
Health Plan of San Joaquin	Santa Cruz Health Information Organization
Hill Physicians	Service Employees International Union California
Inland Empire Health Plan	Synclarity Consulting

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