

**California Health & Human Services Agency  
Center for Data Insights and Innovation  
Data Exchange Framework Stakeholder Advisory Group  
Meeting 2 Transcript (10:00AM – 12:30PM PT, October 7, 2021)**

The following text is a transcript of California Health & Human Services Agency and Center for Data Insights and Innovation Data Exchange Framework Stakeholder Advisory Group Meeting 2. The transcript was produced using Zoom's transcription feature. It should be reviewed concurrently with the recording – which may be found on the CHHS Data Exchange Framework [website](#) – to ensure accuracy.

00:00:14.490 --> 00:00:16.949

Mario S., Manatt Events: Thank you for joining today's program will begin shortly.

00:01:18.840 --> 00:01:24.810

Mario S., Manatt Events: hello, and welcome to today's program my name is Mario and I'll be in the background answering any technical questions.

00:01:25.260 --> 00:01:36.180

Mario S., Manatt Events: If you experienced technical difficulties during this session, please type your question into the Q amp a section located at the bottom of your zoom webinar viewer and a producer will respond.

00:01:36.870 --> 00:01:44.970

Mario S., Manatt Events: During today's event like closed captioning will be available, please click on the CC button at the bottom of your zoom window to enable or disable.

00:01:46.020 --> 00:01:49.470

Mario S., Manatt Events: mo will now cover the meeting participation options.

00:01:52.350 --> 00:02:04.650

Emma P., Manatt Events: Right, there are a few ways attendees may participate today's first participants may submit written comments and questions through the zoom Q amp a box and all comments will be recorded and reviewed by advisory group staff.

00:02:05.190 --> 00:02:15.960

Emma P., Manatt Events: Participants may also submit comments and questions, as well as request to receive data exchange framework updates to [cdi@hhs.ca](mailto:cdi@hhs.ca) CA let's go to the next slide please.

00:02:20.010 --> 00:02:20.400

Great.

00:02:21.990 --> 00:02:31.560

Emma P., Manatt Events: designated time spoken comment will be permitted, and to offer comment, you must raise your hand if you logged in via phone only press star nine on your phone to raise your hand.

00:02:31.860 --> 00:02:42.960

Emma P., Manatt Events: Listen, for your phone number to be called and if selected please ensure you're unmuted on your phone by pressing star six if you logged in on the zoom interface press raise hand and the reactions button.

00:02:43.320 --> 00:02:49.170

Emma P., Manatt Events: And if selected to share your comment you'll receive a request to unmute please ensure you accept before speaking.

00:02:50.220 --> 00:02:51.030

Emma P., Manatt Events: Next slide.

00:02:52.320 --> 00:02:58.080

Emma P., Manatt Events: Public comment will be taken during the meeting at designated times and will be limited to the total amount of time allocated.

00:02:58.560 --> 00:03:06.720

Emma P., Manatt Events: Individuals will be called on in the order in which their hands were raised and will be given two minutes, please state your name and organizational affiliation, when you begin.

00:03:07.200 --> 00:03:22.050

Emma P., Manatt Events: participants are also encouraged to use the Q amp a to ensure all feedback is captured or, again, you may email comments to CDI and see [hhs.ca.gov](http://hhs.ca.gov) and with that I'd like to introduce CHF just chief data officer john have you been.

00:03:34.860 --> 00:03:35.580

Jonah Frohlich (he/him): able to hear up.

00:03:41.760 --> 00:03:49.080

Jonah Frohlich (he/him): Okay, well, I think we may have temporary last john what I will go for a roll call, and I think when we get back we'll.

00:03:50.460 --> 00:03:55.890

Jonah Frohlich (he/him): we'll we'll have him join the roll call if you can advance the next slide to jenna.

00:03:57.090 --> 00:04:05.970

Jonah Frohlich (he/him): Thank you, everybody appreciate everyone's time here we'll do a brief roll call and then we'll get right to some opening remarks trigger we go.

00:04:07.980 --> 00:04:08.700

Dr. Mark Ghaly: Oh, there we go john.

00:04:09.390 --> 00:04:11.160

John Ohanian: Right at the moment you're gonna talk.

00:04:13.080 --> 00:04:21.420

John Ohanian: Well, good morning everyone, as you probably saw from our agenda and the volume of materials we developed over the past few weeks, we have much to go over today, so I will be again.

00:04:21.900 --> 00:04:24.300

John Ohanian: To try to move as quickly as we can, through the agenda.

00:04:24.960 --> 00:04:40.860

John Ohanian: and get to the point of the meeting, the major point of the meeting, which is going through these scenarios so i'm going to quick least start with a roll call like we did last time, if you can just please say President after I call your name we're going to start with Jamie all Monza.

00:04:42.360 --> 00:04:42.750

Jamie Almanza, BACS: As a.

00:04:44.160 --> 00:04:45.060

John Ohanian: Charles paki.

00:04:45.300 --> 00:04:47.490

John Ohanian: Here Andrew bindman.

00:04:55.050 --> 00:04:57.120

John Ohanian: OK, Michelle Cobra.

00:05:00.660 --> 00:05:02.550

Michelle Doty Cabrera: Good morning morning.

00:05:04.800 --> 00:05:05.310

Carmela Coyle: Good morning.

00:05:07.140 --> 00:05:09.660

John Ohanian: I knew designee ravel go on.

00:05:10.620 --> 00:05:13.230

Ali Modaressi: Good morning, thanks for having me that's.

00:05:13.650 --> 00:05:16.170

John Ohanian: Another new designee to do, yes.

00:05:16.590 --> 00:05:18.960

Joe Diaz: Present good morning morning.

00:05:19.320 --> 00:05:20.250

John Ohanian: David forward.

00:05:21.090 --> 00:05:21.540

here.

00:05:23.610 --> 00:05:24.330

John Ohanian: Let us give any.

00:05:26.520 --> 00:05:27.150

Liz Gibboney: Good morning.

00:05:29.040 --> 00:05:29.970

John Ohanian: Michelle Gibbons.

00:05:36.420 --> 00:05:38.280

John Ohanian: Okay laurie hack.

00:05:41.340 --> 00:05:42.390

John Ohanian: Alma Hernandez.

00:05:47.310 --> 00:05:48.300

John Ohanian: Sandra Hernandez.

00:05:49.020 --> 00:05:49.650

Good morning.

00:05:50.790 --> 00:05:53.310

John Ohanian: that's one and then designate Cameron Kaiser.

00:06:04.620 --> 00:06:08.760

Kevin McAvey: down, I think we lost you Andrew kieffer but maybe jonah would you take over.

00:06:11.190 --> 00:06:12.720

Jonah Frohlich (he/him): Sure yeah Andrew gave her.

00:06:13.980 --> 00:06:15.750

Andrew Kiefer: presence great Thank you.

00:06:16.470 --> 00:06:17.160

Jonah Frohlich (he/him): For the equipment.

00:06:18.480 --> 00:06:18.990

Jonah Frohlich (he/him): Good morning.

00:06:21.330 --> 00:06:22.050

Jonah Frohlich (he/him): David Lindemann.

00:06:23.340 --> 00:06:23.880

David Lindeman: President.

00:06:25.710 --> 00:06:27.120

amanda mcallister wallner.

00:06:36.840 --> 00:06:38.370

Jonah Frohlich (he/him): colon present.

00:06:40.410 --> 00:06:41.250

Joe Diaz: i'll be mother se.

00:06:41.310 --> 00:06:41.760

Welcome

00:06:43.290 --> 00:06:43.890

Ali Modaressi: Thank you.

00:06:45.000 --> 00:06:49.050

Jonah Frohlich (he/him): Great I always remember part advisor group Erica Murray.

00:06:50.190 --> 00:06:50.730

Erica Murray: Everybody.

00:06:52.410 --> 00:06:56.970

Jonah Frohlich (he/him): morning janice o'malley new designate my art philosophy.

00:06:58.260 --> 00:06:58.770

Janice O'Malley: morning.

00:07:00.000 --> 00:07:01.380

Jonah Frohlich (he/him): morning mark savage.  
00:07:02.430 --> 00:07:02.880  
Jonah Frohlich (he/him): The morning.  
00:07:04.860 --> 00:07:06.030  
Mark Savage: Karen savage San Juan.  
00:07:09.240 --> 00:07:12.180  
Jonah Frohlich (he/him): capistrano Lee McDonald hi i'm here thanks.  
00:07:14.160 --> 00:07:14.970  
Jonah Frohlich (he/him): Claudia William.  
00:07:20.100 --> 00:07:22.440  
Jonah Frohlich (he/him): And William York present.  
00:07:22.560 --> 00:07:23.070  
morning.  
00:07:24.510 --> 00:07:24.780  
Jonah Frohlich (he/him): Great.  
00:07:26.130 --> 00:07:31.320  
Jonah Frohlich (he/him): we're almost there a larger group Ashraf amaranth and we're  
not excuse me.  
00:07:32.610 --> 00:07:33.210  
I present.  
00:07:36.060 --> 00:07:36.780  
Jonah Frohlich (he/him): At the bartman.  
00:07:42.630 --> 00:07:43.470  
Jonah Frohlich (he/him): Mark beckley.  
00:07:47.730 --> 00:07:49.440  
Jonah Frohlich (he/him): got chrisman good morning.  
00:07:50.940 --> 00:07:51.210  
Jonah Frohlich (he/him): morning.  
00:07:54.240 --> 00:07:54.720  
Good morning.  
00:07:56.310 --> 00:07:57.660  
Jonah Frohlich (he/him): morning katie Fisher.  
00:08:00.690 --> 00:08:01.440  
Kayte Fisher: Good morning.  
00:08:02.700 --> 00:08:04.380  
Jonah Frohlich (he/him): morning Julie low.  
00:08:08.280 --> 00:08:08.610  
Julie Lo, HCFC: morning.  
00:08:10.410 --> 00:08:13.320  
Jonah Frohlich (he/him): Good morning, and then data more.

00:08:19.140 --> 00:08:19.920

Jonah Frohlich (he/him): Later now.

00:08:23.850 --> 00:08:24.240

Jonah Frohlich (he/him): gone.

00:08:25.500 --> 00:08:26.130

Jonah Frohlich (he/him): Oh come on morning.

00:08:27.570 --> 00:08:28.410

Jonah Frohlich (he/him): Great mission.

00:08:33.600 --> 00:08:34.800

Jonah Frohlich (he/him): For today.

00:08:34.860 --> 00:08:35.250

Lisa Heintz for Diana Toche: Thank you.

00:08:38.400 --> 00:08:39.000

Jonah Frohlich (he/him): Joanna.

00:08:40.050 --> 00:08:42.510

Jonah Frohlich (he/him): signal up, please forgive my pronunciation.

00:08:44.130 --> 00:08:45.000

Good morning.

00:08:48.480 --> 00:08:49.140

Jonah Frohlich (he/him): Good morning.

00:08:50.880 --> 00:08:51.300

Joe Diaz: Okay.

00:08:51.840 --> 00:08:54.030

Jonah Frohlich (he/him): john do we have you back on audio.

00:08:55.410 --> 00:09:11.850

John Ohanian: For the moment, you do I don't know what to cut off again, so thank you for thanks for pointing and I would like to then Secretary galley I know is having some Internet connection issues as well, let me just check and see if he's been able to dial in Secretary, are you there.

00:09:12.270 --> 00:09:20.520

Dr. Mark Ghaly: yeah i'm not sure the audio cameras probably not going to work for the moment but i'm gonna if you can hear the audio.

00:09:22.050 --> 00:09:24.030

Dr. Mark Ghaly: Let me know, and I can keep going.

00:09:24.600 --> 00:09:25.560

John Ohanian: We can hear you loud and.

00:09:25.590 --> 00:09:26.670

John Ohanian: Clear, thank you very much.

00:09:26.670 --> 00:09:27.930

John Ohanian: Please go right ahead, thank you.

00:09:28.050 --> 00:09:35.280

Dr. Mark Ghaly: All right, well apologies to everyone for the technical glitches on john in my part but.

00:09:36.330 --> 00:09:45.150

Dr. Mark Ghaly: we'll get through it again just want to give a warm welcome to our second meeting of this data exchange framework stakeholder advisory group.

00:09:45.630 --> 00:09:52.620

Dr. Mark Ghaly: I know as john said, while we were waiting to go live has meant a lot of work over the last couple of weeks and.

00:09:53.190 --> 00:09:59.370

Dr. Mark Ghaly: I appreciate it from all of you, because I know we're asking you do many of you to do many other things.

00:09:59.730 --> 00:10:11.640

Dr. Mark Ghaly: And so, taking the time to be thoughtful on this topic and issue, I think, is foundational for us in the work group moving forward so just want to take a moment to thank the public who's.

00:10:12.030 --> 00:10:19.680

Dr. Mark Ghaly: Joining see over 180 participants total to our meeting today and then special.

00:10:20.250 --> 00:10:33.420

Dr. Mark Ghaly: acknowledgement new members and designees of the work group we took the communication, the feedback seriously to broaden our group and invite some others who were mentioned in our last meeting to make sure we cast a net.

00:10:33.900 --> 00:10:51.300

Dr. Mark Ghaly: That California deserves to do this work, as well as we can also want to call your attention to our website that is been developed john i'm not sure if that's on the next slide if that link is, if not okay well.

00:10:52.110 --> 00:10:57.060

Dr. Mark Ghaly: chat yeah but uh for those who want to track our work both on on the.

00:10:58.050 --> 00:11:08.700

Dr. Mark Ghaly: advisory group members, but also the public there's check the chat out, we have a site going with all of the good materials that we're talking through today and other.

00:11:09.270 --> 00:11:19.440

Dr. Mark Ghaly: pieces of information to help us move forward effectively so as I want to do in every one of our meetings, I want to start and remind us with.

00:11:19.980 --> 00:11:26.520

Dr. Mark Ghaly: Why, we are doing this and what an effort we worked on together was the vision for data exchange in California.

00:11:27.180 --> 00:11:34.470

Dr. Mark Ghaly: And this idea that every California and the health and human services providers and organizations, they care for them.

00:11:34.830 --> 00:11:51.030

Dr. Mark Ghaly: will have timely and secure access to usable electronic information underscore usable that is needed to address their health and social needs and enable the effective and equitable delivery of services to improve their lives and well being put a sort of different way.

00:11:52.230 --> 00:12:06.690

Dr. Mark Ghaly: We want to really work to ensure that real time usable information being available is no longer a barrier to people getting the care and services that really changed the arc of their life.

00:12:07.290 --> 00:12:22.950

Dr. Mark Ghaly: And today we're going to have a chance to dig into six really the you know can never be comprehensive, with vignettes and and scenarios, but I think the six that the team shows really do help us think through.

00:12:23.490 --> 00:12:32.910

Dr. Mark Ghaly: A broad array of examples and important efforts to bring information together in a usable and life altering way.

00:12:33.660 --> 00:12:40.680

Dr. Mark Ghaly: So today's meeting objectives are three we want to confirm a structure and roadmap for the development of the data exchange framework.

00:12:41.040 --> 00:12:48.240

Dr. Mark Ghaly: This will then be coupled with other steps in future meetings to actually bring that exchange framework together.

00:12:48.930 --> 00:12:59.340

Dr. Mark Ghaly: And and really advanced the overall mission of this group discuss today we're going to discuss these six data exchange scenarios.

00:12:59.670 --> 00:13:15.330

Dr. Mark Ghaly: That the team has put together, I think many of you have already had a chance to review them what I like about them, is it starts with what I would say is some of the more bread and butter opportunities to exchange information to link.

00:13:16.560 --> 00:13:26.430

Dr. Mark Ghaly: providers that may all be in the healthcare space, but really aren't connected or linked in any other way, all the way to scenarios where.

00:13:27.750 --> 00:13:39.690

Dr. Mark Ghaly: Both fortunately unfortunately they've been real life for me and my role, whether it's in the disaster services space and supporting people during power shut offs to.

00:13:40.170 --> 00:13:45.840

Dr. Mark Ghaly: Ensure that they have access to medications and food at those critical times two.

00:13:46.470 --> 00:13:56.310

Dr. Mark Ghaly: Conditions around incarceration and re entry and transitions to covert in the public health response that the state has been facing so all of these scenarios.

00:13:56.820 --> 00:14:04.080

Dr. Mark Ghaly: May resonate some more than others with each of you, but I think we'll have an important place in this conversation.

00:14:04.680 --> 00:14:10.890

Dr. Mark Ghaly: And then, lastly, want to talk about the data sharing agreement subcommittee that charge and.

00:14:11.700 --> 00:14:18.000

Dr. Mark Ghaly: A bit of an update I know we've had some conversation in our last meeting about this subcommittee and I know john and team are going to.

00:14:18.990 --> 00:14:34.830

Dr. Mark Ghaly: be able to share more there, I wanted to take a moment and just acknowledge a few points of both clarification and punctuation, we know that this committee is not the first we hope.

00:14:35.760 --> 00:14:42.510

Dr. Mark Ghaly: Last isn't the right word but, honestly, build upon the work that this committee will do over the next many months.

00:14:43.080 --> 00:14:49.290

Dr. Mark Ghaly: But I see this now because I want to acknowledge the important work that many people have participated in.

00:14:50.040 --> 00:14:59.940

Dr. Mark Ghaly: And we want to acknowledge that work throughout these conversations and the history of this conversation across the state and the important expertise each of you bring.

00:15:00.390 --> 00:15:10.860

Dr. Mark Ghaly: But I also want to at the same time, acknowledge that, where we are today doesn't work that we continue to fail our.

00:15:11.400 --> 00:15:20.730

Dr. Mark Ghaly: communities in our populations, because of the lack of consolidate and information around specific individuals.

00:15:21.270 --> 00:15:33.960

Dr. Mark Ghaly: Specific populations and communities, and this is an ongoing opportunity in this advisory group to begin to bring together that information for each of us.

00:15:34.380 --> 00:15:43.710

Dr. Mark Ghaly: And i'm sure, as we did in the last meeting, we will continue to keep the people, our patients our clients, the communities, we serve.

00:15:44.280 --> 00:15:55.080

Dr. Mark Ghaly: front and Center in these conversations and I think that that is going to carry the day and help us get get to the end point i'll also remind you that the.

00:15:55.440 --> 00:16:07.200

Dr. Mark Ghaly: framework that we will advance will not in any way mandate, the creation of a single statewide data repository it is technology agnostic as well we're not pushing a specific.

00:16:07.830 --> 00:16:21.210

Dr. Mark Ghaly: type of HIV, for example, but hope to develop the framework that allows us to find in every nook and cranny of California for each person that we are.

00:16:21.720 --> 00:16:34.260

Dr. Mark Ghaly: We we build something that we can all be proud of, so with that john I want to turn it back over to you, I think we want to TEE up some of our committee members to.

00:16:35.100 --> 00:16:44.070

Dr. Mark Ghaly: Help help give their own context to these conversations and then go into a public comment period and again just looking forward to this conversation with all of you today.

00:16:46.380 --> 00:16:52.230

John Ohanian: Thank you, Secretary Eric Murray, with the California association of public hospitals and health systems.

00:16:53.130 --> 00:16:54.630

Erica Murray: Thanks john and thank you Secretary.

00:16:54.630 --> 00:16:55.710

Erica Murray: galley for.

00:16:56.730 --> 00:17:02.730

Erica Murray: for putting in context, this really, really important conversation I.

00:17:03.600 --> 00:17:13.410

Erica Murray: represent the California association of public hospitals and health systems 21 systems across California that serve primarily medical and uninsured patients.

00:17:13.830 --> 00:17:18.300

Erica Murray: Along with Community health centers and and other safety net providers really.

00:17:18.900 --> 00:17:35.370

Erica Murray: Service, the core of the safety net in California and, needless to say, like many people representing communities across the state really have been on the front lines of the pandemic response and as a result, have seen the importance of.

00:17:36.360 --> 00:17:49.170

Erica Murray: health information exchange and data exchange in true life and death situations, I think, also in terms of public health care systems so often as county.

00:17:49.920 --> 00:18:01.680

Erica Murray: county healthcare systems we really serve as the intersection of health, public health behavioral health, social services eligibility so many of the needs.

00:18:02.310 --> 00:18:21.660

Erica Murray: Often of low income communities across California, so the the opportunity to think about a framework that addresses those needs in a in a in grounded in a patient's whole experience and whole life, I think, is is really important.

00:18:22.920 --> 00:18:31.590

Erica Murray: As as I was contemplating the the importance of this of the charge, we really have before us, I.

00:18:32.730 --> 00:18:39.570

Erica Murray: Have a raises more questions than perhaps answers and I thought I would posit for to this group.

00:18:40.290 --> 00:18:50.940

Erica Murray: For our art important discussion today, the first is, you know what does the Statute call us to do and sort of what is our charge and i'm I really appreciate.

00:18:51.630 --> 00:19:02.610

Erica Murray: The that in the slide deck we're reminded of what that language says, and especially that it reminds us that it's important to leverage existing and.

00:19:03.030 --> 00:19:23.700

Erica Murray: Advanced national standards which, which relates to a second question of how can we best do that leveraging, how do we take when what when those national standards become available, how do we make sure we're doing the most appropriate work and not reinventing the wheel.

00:19:25.080 --> 00:19:27.300

Erica Murray: The third, I would say is how do we.

00:19:28.650 --> 00:19:34.410

Erica Murray: understand the connection between the adoption of health information exchange.

00:19:35.220 --> 00:19:46.320

Erica Murray: And, and many of the scenarios identify the the lack of adoption of HIV, for various reasons, as a significant barrier and it surely is.

00:19:46.590 --> 00:20:02.070

Erica Murray: And how do we, how do we contemplate the distinction between adoption of HIV and the actual rules of the road, because both both are just related but distinct concepts and then, finally, how do we.

00:20:03.210 --> 00:20:13.020

Erica Murray: work together to identify and develop a framework that not only acknowledges and identify specific barriers that currently exist.

00:20:13.890 --> 00:20:29.970

Erica Murray: But also raise up what's working across California and where are their local HIV ease and and other instances where patients needs truly are being met, and how can we find that balance between.

00:20:30.780 --> 00:20:37.770

Erica Murray: identifying and addressing barriers and also raising up best practices so i'll turn it back over to you john.

00:20:40.980 --> 00:20:46.890

John Ohanian: Excellent I think David for how to stand up, but Emily Emily you've been watching it for you can let me know, thank you.

00:20:52.470 --> 00:20:53.070

Kevin McAvey: We can't hear you.

00:20:53.700 --> 00:20:54.540

you're muted David.

00:20:57.480 --> 00:20:58.350

David Ford, CA Medical Assn.: sorry about that.

00:20:58.410 --> 00:20:59.280

Jonah Frohlich (he/him): David you're muted.

00:21:00.840 --> 00:21:07.020

David Ford, CA Medical Assn.: sorry about that um so somebody came up this weekend conversation with some other folks on the committee.

00:21:08.010 --> 00:21:17.580

David Ford, CA Medical Assn.: And I was, I was trying to figure out when to bring this up in the agenda but Eric actually teamed up really nicely, which is to make just a quick suggestion, which is for one of the upcoming.

00:21:18.810 --> 00:21:23.970

David Ford, CA Medical Assn.: Meetings of this committee, it would be really helpful, I think, to invite the officers and national coordinator.

00:21:24.900 --> 00:21:38.190

David Ford, CA Medical Assn.: To come and be part of the meeting, and to address us two reasons, one is Eric talked about the governing statute that we're operating under by design as California to Hugh very close to federal standards.

00:21:39.120 --> 00:21:47.040

David Ford, CA Medical Assn.: So be good to just for everyone to get a better education on what the federal standards are and how that that process is rolling out at their level.

00:21:47.610 --> 00:21:56.070

David Ford, CA Medical Assn.: The other reason, I think that would be important is the very likely scenario where we're all going to go looking for federal money to pay for some of the work we're going to set up here.

00:21:57.180 --> 00:22:04.680

David Ford, CA Medical Assn.: You know I think the earlier, we can engage our federal partners and have that conversation, the better our chances of success when we go to them, hand in hand.

00:22:07.590 --> 00:22:15.450

John Ohanian: Thank you for that David actually a little update that i'll be sharing a little layer we were on with me yesterday, so thank you for that i'm gonna do we have time for one more.

00:22:18.660 --> 00:22:19.080

Emma P., Manatt Events: We do.

00:22:23.340 --> 00:22:24.630

John Ohanian: Someone watching whose hands up.

00:22:25.110 --> 00:22:26.880

Emma P., Manatt Events: I don't see any other hands raised at this.

00:22:26.880 --> 00:22:27.180

Time.

00:22:29.790 --> 00:22:41.490

John Ohanian: Okay, then what i'm going to do is move us into public comment period if you are a member of the public that would like to speak, if you can please raise your hand during.

00:22:42.000 --> 00:22:55.260

John Ohanian: Using the zoom teleconferencing options and you'll be called an order that your hand was raised, if you can please state your name and organization affiliation and keep your comments respectful and brief and will recognize your individuals and take you off mute that that.

00:22:59.100 --> 00:23:01.230

Emma P., Manatt Events: is like the first call on Marty and modal.

00:23:01.320 --> 00:23:02.190

Emma P., Manatt Events: I will go ahead.

00:23:02.280 --> 00:23:03.990

Emma P., Manatt Events: and give you permission to speak well.

00:23:05.190 --> 00:23:18.570

Marty Omoto - CDCAN: Thank you, my name is Marty and moto i'm a family member of a sister who passed away with developmental disabilities and also currently an extended family member unpaid caregiver to a 29 year old.

00:23:20.010 --> 00:23:31.770

Marty Omoto - CDCAN: An adult with the down syndrome and also on the autism spectrum and executive director see can California disability senior Community Action Network member of the developmental services Task Force.

00:23:32.340 --> 00:23:38.700

Marty Omoto - CDCAN: And served on the master plan for aging subcommittees and and other committees with the state, but I just want to just.

00:23:39.660 --> 00:23:48.240

Marty Omoto - CDCAN: offer my thanks and deep appreciation for all of you, and some of you i've known for many years i'm looking at mark savage there.

00:23:48.780 --> 00:24:00.210

Marty Omoto - CDCAN: i've worked with many years ago, but I just want to offer my support to the work that you all, are doing i'm trying to translate out to other advocates and other people in California.

00:24:00.720 --> 00:24:07.650

Marty Omoto - CDCAN: The critical importance of everything you're doing and everything that the state is trying to move in this direction.

00:24:08.040 --> 00:24:12.840

Marty Omoto - CDCAN: So foundational and if it's done right, it can be transformative to all of us.

00:24:13.170 --> 00:24:23.010

Marty Omoto - CDCAN: Looking at the whole person and tying outcomes that are person centered that can make a difference in everyone's lives and not everybody understands the work you're doing.

00:24:23.550 --> 00:24:34.140

Marty Omoto - CDCAN: And so anything I can do an all of us as Elvis can you support what you are doing, please let us know, and I just want to basically just say a shout out to all of you.

00:24:34.980 --> 00:24:49.920

Marty Omoto - CDCAN: The work you're doing is so important, and I appreciate the direction that the health and human Services Agency under Dr galley is looking at the whole person and looking at person centered outcomes and this framework is so critical, so thank you very much.

00:24:55.380 --> 00:24:58.590

Emma P., Manatt Events: Be next i'll call on Ben stover.

00:25:03.810 --> 00:25:08.220

Ben Stover: hello, my name is Ben stover I work for a healthcare technology leader.

00:25:08.280 --> 00:25:12.960

Ben Stover: known as Philips my role here is to lead our health information.

00:25:12.960 --> 00:25:22.260

Ben Stover: exchange market division for North America, so through that I have the opportunity to work with many of our HR leaders, as well as the Member organizations that.

00:25:23.220 --> 00:25:40.980

Ben Stover: That belong to those organizations so very happy to see the progress it's going on in California and excited to see all this coming together as it's done in other states would certainly love to understand the scope of.

00:25:42.240 --> 00:25:57.210

Ben Stover: clinical data that will be under review here, from our perspective, one of the most rich data sets in healthcare is full full resolution imaging data, and that is traditionally very under utilized didn't need a PhD level so.

00:25:58.260 --> 00:26:03.900

Ben Stover: we'll certainly put that up for comment and happy to hear feedback from the rest of, thank you for the time.

00:26:09.690 --> 00:26:13.260

Emma P., Manatt Events: Thank you next will call on Melissa cannon.

00:26:17.610 --> 00:26:26.730

Melissa Cannon: hi everyone, this is Melissa cannon with nourished California I just were a statewide nonprofit that works on increasing access to food for low income Californians.

00:26:27.060 --> 00:26:39.180

Melissa Cannon: really appreciate the work of this working group focused on helping connect individuals to all the resources that they need, as work begins on the scenarios, I just wanted to lift up.

00:26:39.690 --> 00:26:49.170

Melissa Cannon: One one program to everyone's attention that I hope we can incorporate into scenarios and that's the WIC program which serves over.

00:26:49.470 --> 00:26:56.760

Melissa Cannon: About 1 million Californians it's a critical support for our pregnant women and our youngest children.

00:26:57.360 --> 00:27:05.520

Melissa Cannon: it's also a program that requires medical documentation to be eligible for WIC services with participants have to provide.

00:27:05.850 --> 00:27:12.270

Melissa Cannon: Proof of pregnancy height and weight measurements blood work and medical documentation for formula.

00:27:12.690 --> 00:27:27.210

Melissa Cannon: yep there's no pathway for exchange of information to the WIC program from medical to provider So although there is the need for this information to come from health providers WIC is there's no pathway for electronic exchange.

00:27:27.750 --> 00:27:34.590

Melissa Cannon: there's also a difference in terms of how the WIC program is treated under California privacy laws.

00:27:34.890 --> 00:27:46.620

Melissa Cannon: We have a real need to set up some connections to this program and i'm a little concerned that the scenarios won't allow for some deep consideration around this really important program for California.

00:27:46.920 --> 00:27:55.080

Melissa Cannon: Since those scenarios don't include pregnant women or young children, so I hope we can give that program some special attention as work goes on, thank you.

00:28:00.090 --> 00:28:04.110

Emma P., Manatt Events: Thank you next will call on Mario dia's.

00:28:06.750 --> 00:28:14.310

Mario Diaz: Good morning, everybody Mario do is with an empire health plan a medical plan which serves over 1.4 million members in San Bernardino riverside counties.

00:28:14.730 --> 00:28:18.420

Mario Diaz: We want to thank you all for these important discussions, and we want to express our support.

00:28:18.900 --> 00:28:28.980

Mario Diaz: A white health and human services data exchange framework which we have also submitted by way of a joint letter of support with riverside county Medical Association and San Bernardino county medical society.

00:28:29.460 --> 00:28:34.980

Mario Diaz: We want to echo the gratitude probably work you all continue to do in the space, thank you very much.

00:28:39.810 --> 00:28:40.470

Emma P., Manatt Events: Thank you.

00:28:41.580 --> 00:28:44.070

Emma P., Manatt Events: Next, will call on hector ramirez.

00:28:48.000 --> 00:28:58.410

Hector Ramirez (they/them): Good morning windows, yes, everybody, my name is JEREMY it is i'm medicare medicare beneficiary from Los Angeles county in the unseeded territory of the tundra to tyrion.

00:28:59.070 --> 00:29:05.160

Hector Ramirez (they/them): mission band of Indians, I want to thank you, each and every one of you for the work that you're doing, and once again.

00:29:05.820 --> 00:29:15.030

Hector Ramirez (they/them): really ask you to consider new scenarios, the role that people with disabilities have including all the various different types of disabilities.

00:29:15.690 --> 00:29:21.090

Hector Ramirez (they/them): Including our new subset of people living with post covered conditions and also.

00:29:21.810 --> 00:29:28.320

Hector Ramirez (they/them): really asking to focus on individuals with psychiatric disabilities who are oftentimes to classified as being.

00:29:28.680 --> 00:29:36.990

Hector Ramirez (they/them): severely mentally ill and mentally ill and really oftentimes don't get categorized properly, as you embark on this particular models and.

00:29:37.320 --> 00:29:46.680

Hector Ramirez (they/them): we're to we infidelity with the Federal standards, a really awesome to Have you considered those those considerations as a beneficiary, I really.

00:29:47.190 --> 00:29:58.560

Hector Ramirez (they/them): hope that this particular group really engages other folks like myself and have access to plain language, information, so that we could have an equitable role in this particular process.

00:29:58.950 --> 00:30:08.910

Hector Ramirez (they/them): As a person of color I know how like of this information and and visibility significantly impact black Latino and indigenous communities here in the city, called for you.

00:30:09.210 --> 00:30:19.020

Hector Ramirez (they/them): and hope that all of you embark on this call, that is the primary call to take equity focusing on those individuals who are significantly impacted and those of us who.

00:30:19.380 --> 00:30:26.400

Hector Ramirez (they/them): Come for communities who have been marginally forgotten oftentimes Thank you once again and looking forward to recognition one of you.

00:30:30.600 --> 00:30:38.250

Emma P., Manatt Events: Thank you next call on Lisa chin so in politics for butchering your last name.

00:30:43.680 --> 00:30:46.050

Lisa Chan-Sawin/Transform Health: Can you hear me now, am I unmuted.

00:30:48.660 --> 00:30:57.390

Lisa Chan-Sawin/Transform Health: Thank you Lisa Thompson i'm the CEO and founder of transform health and we have the pleasure of supporting the city of sacramento and implementing their whole person care pilot.

00:30:58.140 --> 00:31:14.700

Lisa Chan-Sawin/Transform Health: One of the key lessons we learned, as we work and looked at data exchange across, health and housing was the issue of different privacy and data standards between healthcare and other industries, for example.

00:31:15.510 --> 00:31:26.670

Lisa Chan-Sawin/Transform Health: The housing providers that we work with the housing community and housing industry are up are not operating on hipaa and for us to work with them once data is shared between.

00:31:27.630 --> 00:31:41.820

Lisa Chan-Sawin/Transform Health: Our clinical providers at the you know the nature of that data changes, and so I wanted to flag this as a potential issue, especially when we're talking about addressing social determinants of health and thinking about how to connect.

00:31:42.420 --> 00:31:51.570

Lisa Chan-Sawin/Transform Health: data systems, I really appreciate the comment from the the woman earlier about work and how do you connect you know.

00:31:52.110 --> 00:31:58.200

Lisa Chan-Sawin/Transform Health: An address the social determinants close the loop on the types of referrals that are made.

00:31:58.590 --> 00:32:11.670

Lisa Chan-Sawin/Transform Health: And I just wanted to flag that as a potential issue this issue of varying data standards across industries is a significant challenge that all the whole person care pilots have had to grapple with.

00:32:11.940 --> 00:32:25.050

Lisa Chan-Sawin/Transform Health: And it has been a significant barrier for us to coordinate better care and in so we've had to do a lot of training, a lot of crosswalks definitions to address this issue, thank you.

00:32:29.400 --> 00:32:30.000

Emma P., Manatt Events: Thank you.

00:32:32.880 --> 00:32:37.710

Emma P., Manatt Events: don't see any other hands raised from our attendees today.

00:32:41.520 --> 00:32:45.600

Kevin McAvey: let's go to carmela, thank you for raising your your hand.

00:32:47.220 --> 00:32:50.940

Carmela Coyle: hey thanks so very much and just a quick comment listening to.

00:32:51.660 --> 00:32:54.600

Carmela Coyle: members of the public, and thank you all for participating.

00:32:56.010 --> 00:33:03.600

Carmela Coyle: It makes me think as we think about our framework, and I was thinking about this as I read the scenarios, how can we carefully.

00:33:04.200 --> 00:33:13.590

Carmela Coyle: Separate what are some really important issues here, and I think, as we enter the discussion about the scenarios, there are issues of health information collection.

00:33:14.520 --> 00:33:25.410

Carmela Coyle: information and data health equity things we don't know about race, ethnicity, gender and some other things, but health information collection being a set of issues.

00:33:25.950 --> 00:33:40.050

Carmela Coyle: health information exchange, being a second set of issues, whether issues around sending data, whether that's access to broadband data sharing agreement state exchange standards and issues around receiving data.

00:33:41.130 --> 00:33:48.210

Carmela Coyle: Public health infrastructure investments state investments and more and what i'm hearing from our public commenters is a third bucket.

00:33:48.720 --> 00:33:58.350

Carmela Coyle: And that is health information use where again investments in state infrastructure state program infrastructure privacy issues.

00:33:58.650 --> 00:34:05.760

Carmela Coyle: program connectedness I think there's a lot, thank you to the last comment or a lot we can learn from the whole person care models so.

00:34:06.030 --> 00:34:17.250

Carmela Coyle: I think it'll be important as we look at the scenarios to think about health information collection exchange and use and for us as an advisory board to slot those items, thank you.

00:34:25.500 --> 00:34:26.160

Jonah Frohlich (he/him): Thank you very much.

00:34:32.040 --> 00:34:32.490

Jonah Frohlich (he/him): graduates.

00:34:34.590 --> 00:34:48.630

John Ohanian: Look, we don't have any more comments i'm going to move us into the work, but I will say that all these comments are very heartfelt the public comments definitely remind us all about how critical this work is and just.

00:34:49.770 --> 00:34:52.590

John Ohanian: proud to be working with all of you to to move this work forward.

00:34:53.610 --> 00:35:00.540

John Ohanian: So let's let's go to the than the next slide on our data exchange framework works for everyone.

00:35:03.630 --> 00:35:06.840

John Ohanian: So the body of work that we're trying to get done when we envisioned.

00:35:07.980 --> 00:35:14.940

John Ohanian: Developing the data exchange framework we think about it in a three step process if you can go to the next slide please.

00:35:15.330 --> 00:35:27.270

John Ohanian: Our focus today is to introduce and refine six drafts model scenarios through these scenarios we're going to identify key barriers to data exchange in California today and as was mentioned, there may be things that.

00:35:27.720 --> 00:35:33.960

John Ohanian: models that need to be added, and we really appreciate all the feedback and we'll get on that.

00:35:34.800 --> 00:35:42.030

John Ohanian: We will then so that'll be purpose for today, we will then work on developing a set of data sharing principles that are typically.

00:35:42.390 --> 00:35:56.760

John Ohanian: In alignment with Federal and State policies and frameworks, the type of compact that we're hoping to make for California and during this process, we will then use those principles to guide the development of more specific policy Program.

00:35:57.930 --> 00:36:05.610

John Ohanian: and fiscal roadmap recommendations, what do we need to do to realize the principles for all of our participants and.

00:36:08.340 --> 00:36:15.330

John Ohanian: So the code outline the required components of the data exchange framework but it's really up to all of us to shape its structure and details.

00:36:15.690 --> 00:36:24.180

John Ohanian: We envision that the data exchange framework will document this advisory groups considerations and recommendations of the codes components three three major sections.

00:36:25.230 --> 00:36:35.760

John Ohanian: an overview section that establishes our vision, it lays out the guiding principles and provides an overview of the process that we use to develop the data exchange framework.

00:36:36.330 --> 00:36:42.330

John Ohanian: The next section will will describe the data exchange landscape in California today.

00:36:43.320 --> 00:36:58.980

John Ohanian: And the final section will be the primary focus of our efforts in the coming months, it will include our assessment of the model scenarios and the key barriers to data exchange, as they surface the principles to propose the govern the type of data exchanged by the code.

00:37:00.270 --> 00:37:18.420

John Ohanian: Recommendations for policies and procedures sorry policies and principles to address those barriers and a single common California data sharing agreement which will be used the documents that compact among I truly expansive and diverse group of stakeholders across California.

00:37:20.430 --> 00:37:21.660

John Ohanian: We go to the next slide.

00:37:22.860 --> 00:37:30.660

John Ohanian: With we do have a lot to cover and not a lot of time to do it in, so I imagine that many of our future meetings will be packed with this one is.

00:37:31.050 --> 00:37:35.760

John Ohanian: And we're going to be leaning on you, more than ever, for your expertise and feedback to drive our discussion.

00:37:36.390 --> 00:37:43.770

John Ohanian: As shown here in the pink box is at the top of the slide, we can see key deadlines for the data exchange framework established by the code.

00:37:44.310 --> 00:37:56.430

John Ohanian: Most eminently we're expecting to share updates with our legislature on our progress in January, April and with our final data exchange framework due on July 1 2020 to mark your calendars.

00:37:57.210 --> 00:38:02.760

John Ohanian: On the bottom of the slide, we can see the cadence of currently scheduled data our stakeholder advisory group meetings.

00:38:03.120 --> 00:38:18.630

John Ohanian: Potential topics will be raised at the close of each proceeding them meeting, allowing us both methodical in our preparations to ensure not only compliance with principles but also get your feedback in between those meetings as well.

00:38:19.830 --> 00:38:29.010

John Ohanian: During our next meeting on November 10 we're presently planning subjected today's discussion to begin discussing ways to incorporate data related to underserved.

00:38:29.370 --> 00:38:39.060

John Ohanian: underrepresented populations, including but not limited to data regarding sexual orientation, gender identity and racial and ethnic classifications.

00:38:39.510 --> 00:38:54.420

John Ohanian: The importance of being able to do so, and the barriers to presently doing so in California, so if you have any materials or thoughts to share with us in advance, please let me or Kevin know and i'd like to now open it up to thoughts from the advisory group, starting with lori hat.

00:38:57.420 --> 00:39:05.190

Lori Hack: I think thanks john I think the comments today, I think, have been really just wealth, well thought through.

00:39:06.240 --> 00:39:19.890

Lori Hack: As a representative of the California association of HIV ease, we have a variety of technologies, stakeholders and processes that we're developing over the past.

00:39:20.520 --> 00:39:32.460

Lori Hack: Really 20 years we've been working with local providers, both from the private sector and public sector within our region's and what we've found really.

00:39:32.880 --> 00:39:46.020

Lori Hack: Is that the Community membership is not only concerned about as Carmela put out their health information data collection process, but how the data is being used.

00:39:46.410 --> 00:39:55.470

Lori Hack: So part of what I'm hoping to see in the framework that we're developing are some principles around how the data is protected.

00:39:56.070 --> 00:40:06.810

Lori Hack: How the stakeholders are using that data and what framework is being developed with the policies that can instill the confidence that the providers of.

00:40:07.650 --> 00:40:24.690

Lori Hack: Data are sharing it at an appropriate level with providers that are using it for care of the patients in the Community, but that that's all they are sharing so there's sort of a balance between the use of data for.

00:40:25.950 --> 00:40:37.200

Lori Hack: Purposes within a Community and then extending that to data exchange among public health measures for safeguards for the public.

00:40:38.100 --> 00:40:48.810

Lori Hack: So one of a couple thoughts about the components and principles that they think are going to be critical comes from our work in the past 20 years in the regions where.

00:40:49.380 --> 00:40:59.340

Lori Hack: We have established sort of the circle of trust within the Community, where we're sharing data from one provider to another, from one hospital to another.

00:40:59.760 --> 00:41:12.810

Lori Hack: And then that's been rapidly expanding to be able to provide data to public health departments to other services in the Community for social service purposes.

00:41:13.350 --> 00:41:19.530

Lori Hack: So some of the key components that we found to help make that trust in the Community.

00:41:19.950 --> 00:41:32.610

Lori Hack: Are accountability transparent policies really helping that the patient or member of the Community understand who the data steward is.

00:41:33.180 --> 00:41:40.740

Lori Hack: Not just controlling their data, but really managing their data and ensuring that that data is being shared appropriately.

00:41:41.190 --> 00:41:51.000

Lori Hack: With consent, with the proper controls and and that it's well understood in the Community by the data contributors and the data users.

00:41:51.510 --> 00:42:07.320

Lori Hack: So really a couple principles number one accountability number two consent number three oversight and enforcement, that the policies and technical requirements are being followed.

00:42:07.950 --> 00:42:20.370

Lori Hack: And then finally Lisa pointed this out from their experience with whole person care there really needs to be some education and training of the stakeholders who are accessing data.

00:42:21.150 --> 00:42:35.160

Lori Hack: Looking at protected health information to make sure that they're doing it properly and that we're all following the same policies and procedures in a consistent manner, from a statewide as well as the federal perspective.

00:42:40.830 --> 00:42:41.430

John Ohanian: Thank you for that.

00:42:42.960 --> 00:42:44.310

John Ohanian: Other other Members that have.

00:42:49.590 --> 00:42:51.600

Jonah Frohlich (he/him): Raised your hand and then we have Michelle.

00:42:53.820 --> 00:42:54.150

Jonah Frohlich (he/him): yeah.

00:42:54.180 --> 00:43:01.890

Linnea Koopmans: hi good morning Linda equipments with the local health plans of California, I have a process question when looking at the roadmap and timeline.

00:43:03.060 --> 00:43:13.830

Linnea Koopmans: A lot of work to be done in the next eight or so months and my questions around the subcommittee's I know later in the agenda we're talking about the data sharing agreement subcommittee.

00:43:14.280 --> 00:43:28.530

Linnea Koopmans: That, I believe there was also discussion about forming a number of other subcommittees so it'd be helpful to understand kind of what the process and timeline will be for forming those and identifying which are the appropriate subcommittees to form.

00:43:36.660 --> 00:43:41.700

Jonah Frohlich (he/him): I can take that john, if you like, but I think the the approach is if there's if there's.

00:43:42.990 --> 00:43:51.900

Jonah Frohlich (he/him): If this group deems that it's critical to form a subcommittee on very specific topic to explore content and a set of recommendations that would be adapted to the advisory group.

00:43:52.440 --> 00:44:02.640

Jonah Frohlich (he/him): That would be taken under advisement at this point or hasn't been identified the need for another subcommittee right as we go there may be um so the process really is.

00:44:03.630 --> 00:44:15.360

Jonah Frohlich (he/him): If the if the content of the type of recommendations to advance to this advisor group really need necessitate the subcommittee than advisory group members should.

00:44:16.650 --> 00:44:20.940

Jonah Frohlich (he/him): Should advanced that proposition for consideration.

00:44:26.190 --> 00:44:28.140

John Ohanian: Thank you john and Michelle.

00:44:30.120 --> 00:44:31.350

John Ohanian: hi I hope you.

00:44:31.350 --> 00:44:45.840

Michelle Doty Cabrera: All have a humor me I have kind of a content issue that comes up later in the agenda, but unfortunately have another meeting with the state that I need to be in so i'm going to try to frame it as a process question.

00:44:46.920 --> 00:44:55.230

Michelle Doty Cabrera: In looking at some of the use case scenarios, you know it, the example that was provided for behavioral health integration.

00:44:56.790 --> 00:45:06.300

Michelle Doty Cabrera: To be completely transparent was a little it felt a little stigmatizing in that it talks about a mental health facility without an ehr.

00:45:06.570 --> 00:45:18.330

Michelle Doty Cabrera: That sort of stumbles and it's not able to plug into the primary care physicians desire to understand that their patient has now had an admission in a mental health facility.

00:45:19.500 --> 00:45:28.320

Michelle Doty Cabrera: Most of not all but most of our providers in specialty behavioral health do have ehr they may not be certified.

00:45:29.250 --> 00:45:35.310

Michelle Doty Cabrera: But it just doesn't seem to reflect the current state of playing, in fact, not only are we sharing data.

00:45:35.700 --> 00:45:43.920

Michelle Doty Cabrera: Across behavioral health, we also share data with our child welfare partners our justice partners and there's some really progressive things happening.

00:45:44.370 --> 00:45:55.110

Michelle Doty Cabrera: And and just sort of the whole orientation of this being about the PCP who's left out, we often do case management care coordination trying to plug into.

00:45:56.340 --> 00:46:08.850

Michelle Doty Cabrera: Our clients and into primary care oftentimes they're not connected to primary care, not because we're not working to try to get them in but because of other structural barriers and so.

00:46:09.300 --> 00:46:17.040

Michelle Doty Cabrera: I think it's important to understand if we're going to try to tackle behavioral health as an important key sort of realm of data.

00:46:17.430 --> 00:46:27.270

Michelle Doty Cabrera: Information Exchange, we need to understand the ways in which all of our systems are really falling short and connecting with each other we've tried, for example, to get hospital data about.

00:46:27.630 --> 00:46:31.500

Michelle Doty Cabrera: psychiatric team ED visits and been told that you know.

00:46:31.950 --> 00:46:46.020

Michelle Doty Cabrera: That that's something that may not be available to us today or for some time, or that those psychiatric codes are buried, and so I just want to sort of call out from a process standpoint that it's going to be really important to.

00:46:46.500 --> 00:46:56.640

Michelle Doty Cabrera: connect with those groups that are sort of at the core of some of the use case scenarios that you want to develop in bringing those forward and and urge that kind of engagement.

00:46:58.860 --> 00:47:10.740

John Ohanian: Thank you so much, I appreciate that and I know you have to leave early, but we can definitely take some of this offline as well and have a deeper conversation rebuild, thank you, Michelle journalists judging.

00:47:10.860 --> 00:47:13.950

Janice O'Malley: panel, yes, thank you janice o'malley with the.

00:47:13.980 --> 00:47:15.690

California Labor federation.

00:47:16.770 --> 00:47:18.300

Janice O'Malley: I just wanted to.

00:47:18.360 --> 00:47:19.800

Janice O'Malley: Really emphasize.

00:47:20.880 --> 00:47:26.460

Janice O'Malley: The need to ensure that the data exchange framework can be used by appropriate stakeholders.

00:47:27.540 --> 00:47:47.790

Janice O'Malley: To address the systematic inequalities in our healthcare system and really appreciate the comments and Mr ramirez on accessing that information, especially as a consumer lori has had briefly mentioned the need for consent and it being of importance and.

00:47:51.030 --> 00:48:07.380

Janice O'Malley: And when we talk about equality, you know system in equality, you know for a consumer to be able to access that information to consent consent to having that information shared How does that help, not on there and and.

00:48:08.520 --> 00:48:13.560

Janice O'Malley: You know, it will there be language accessibility connected, not as well, so just something to point.

00:48:13.560 --> 00:48:14.130

out.

00:48:17.940 --> 00:48:18.900

John Ohanian: Thank you very much.

00:48:21.780 --> 00:48:22.830

John Ohanian: Do we have next sorry.

00:48:24.750 --> 00:48:26.460

Kevin McAvey: We have lives next.

00:48:26.700 --> 00:48:27.300

Jonah Frohlich (he/him): Oh, oh.

00:48:29.340 --> 00:48:29.880

Cathy Senderling-McDonald: Oh OK.

00:48:30.510 --> 00:48:31.140

Cathy Senderling-McDonald: I can.

00:48:32.310 --> 00:48:37.950

John Ohanian: see that bba and thank you so much hi everybody, I also wanted to comment on the.

00:48:38.010 --> 00:48:46.770

Cathy Senderling-McDonald: On the use cases I thought they were really interesting I also thought and maybe that sort of speaks to some of the comments that Michelle was making they could benefit from.

00:48:47.310 --> 00:48:54.600

Cathy Senderling-McDonald: Some conversation maybe offline with some of the experts in some of the other fields that are not quite as host.

00:48:54.960 --> 00:49:00.990

Cathy Senderling-McDonald: focused on the social services aspects of some of these are things that I might have some thoughts to share an offer.

00:49:01.950 --> 00:49:11.850

Cathy Senderling-McDonald: I I also I mean, I know that we're trying to fill gaps here, but I was struck a little bit about how they talked about only the weaknesses and they were sort of set out in that way.

00:49:12.300 --> 00:49:16.650

Cathy Senderling-McDonald: And I know that we have some strengths, too, and so I thought it might be an interesting.

00:49:17.520 --> 00:49:30.360

Cathy Senderling-McDonald: Part of the conversation or important to be thinking about areas where there could be connections already that could be strengthened through this process versus just the thing is hopeless and we're starting from scratch, because I don't think it's always.

00:49:30.360 --> 00:49:31.020

John Ohanian: That case.

00:49:31.320 --> 00:49:33.990

Cathy Senderling-McDonald: I do think that in talking about equity.

00:49:34.440 --> 00:49:35.820

John Ohanian: At disproportionality.

00:49:35.970 --> 00:49:43.620

Cathy Senderling-McDonald: impacts on people of color LGBT Q plus and people in extreme poverty, you probably.

00:49:43.800 --> 00:49:47.040

Cathy Senderling-McDonald: are in a place where you could be starting you know more from scratch.

00:49:47.220 --> 00:49:48.690

Cathy Senderling-McDonald: So I think, ensuring that we have.

00:49:48.690 --> 00:49:50.400

Cathy Senderling-McDonald: That lens applied is important.

00:49:50.670 --> 00:49:52.020

Cathy Senderling-McDonald: It just seemed like making them.

00:49:52.050 --> 00:49:54.360

Cathy Senderling-McDonald: A bit more robust together might help.

00:49:54.390 --> 00:49:55.260

John Ohanian: US kind of.

00:49:55.290 --> 00:49:57.990

Cathy Senderling-McDonald: move forward to kind of you know, think about those.

00:49:57.990 --> 00:49:58.560

Cathy Senderling-McDonald: strengths.

00:49:58.710 --> 00:50:00.120

John Ohanian: As well as there's gaps.

00:50:00.330 --> 00:50:03.960

Cathy Senderling-McDonald: And you know a little bit more diversity in that.

00:50:04.170 --> 00:50:05.850

Cathy Senderling-McDonald: In the scenarios themselves.

00:50:06.270 --> 00:50:07.140

happy to help us out.

00:50:08.520 --> 00:50:18.090

John Ohanian: Thank you so much Kathy and sounds like there's gonna be a lot of great discussion when we get into the scenarios as well excellent feedback live sorry, can you please go ahead.

00:50:18.510 --> 00:50:19.530

Liz Gibboney: Oh no worries thanks.

00:50:20.190 --> 00:50:21.180

John Ohanian: And it makes.

00:50:22.110 --> 00:50:25.920

Liz Gibboney: handling this later on, but my question, and thank you for reminding us of.

00:50:25.920 --> 00:50:43.620

Liz Gibboney: These key dates is there going to be a work plan that is shared with the advisory committee that kind of spells out in much greater detail what's behind these dates and like I said, if you're going to talk about this later that's that's fine I can meet.

00:50:44.730 --> 00:50:46.110

John Ohanian: Thanks thanks.

00:50:49.860 --> 00:50:52.650

John Ohanian: yeah we'll probably be covering that just shortly after.

00:50:56.310 --> 00:50:57.450

John Ohanian: anyone else, what they're.

00:50:58.770 --> 00:51:02.430

John Ohanian: Missing anyone have jonah did you want to comment on that last comment or.

00:51:05.670 --> 00:51:09.090

Jonah Frohlich (he/him): The the last comment about the what's behind these key dates.

00:51:13.320 --> 00:51:29.700

Jonah Frohlich (he/him): yeah I mean, these are the new dates are defined in and that's huge in our work plan in terms of the legislative update their only defined as in milestone and not and they don't really specify what needs to be included in that legislative update.

00:51:30.780 --> 00:51:34.380

Jonah Frohlich (he/him): What what we need to do, and I think what you're suggesting was this, we need to.

00:51:35.940 --> 00:51:44.820

Jonah Frohlich (he/him): Help us define sort of what the shape of some of these milestones should be and what we're recommending maybe in order for us to provide.

00:51:45.900 --> 00:51:52.080

Jonah Frohlich (he/him): So you may help guide the development of these milestones we anticipate, for example, the legislative update on January.

00:51:52.710 --> 00:51:58.020

Jonah Frohlich (he/him): is going to need to provide some guidance about where this advisory group record where the recommendations are starting to shape.

00:51:58.710 --> 00:52:14.040

Jonah Frohlich (he/him): To take shape and what might be requested in any kind of a policy or a budgetary request in the next fiscal year so right now what's behind them is just legislatively mandated dates that need to work a deliverable needs to be.

00:52:15.990 --> 00:52:30.060

Jonah Frohlich (he/him): Actually executed and and and redo out to you to provide some some structure tool how those might be shaped so that we can deliver the packages that are necessary, based on the legislative mandate, a timeline is that helpless.

00:52:32.970 --> 00:52:33.750

Liz Gibboney: It does, thank you.

00:52:36.180 --> 00:52:36.570

Jonah Frohlich (he/him): Excellent.

00:52:36.600 --> 00:52:47.250

John Ohanian: Well, since you have the MIC jonah i'm going to hand it to you and we can either survey the Group for a quick break because we're a couple minutes ahead unless there was any other comments that he saw.

00:52:48.690 --> 00:52:50.760

Jonah Frohlich (he/him): yeah i'm gonna recommend.

00:52:50.760 --> 00:52:58.890

Jonah Frohlich (he/him): That we keep going, given that we have a great deal to move through but isn't it has anyone have any strong suggestions just taking a five minute break.

00:53:03.030 --> 00:53:03.360

Jonah Frohlich (he/him): Okay.

00:53:04.410 --> 00:53:09.810

Jonah Frohlich (he/him): Why don't we move forward, then, and we can we can get into this scenario, development, so if you could please.

00:53:10.560 --> 00:53:11.820

John Ohanian: move towards.

00:53:12.150 --> 00:53:13.830

Jonah Frohlich (he/him): glide 23.

00:53:16.320 --> 00:53:23.730

Jonah Frohlich (he/him): there been a number of comments in the chat and actually were sent in advance and it's it's really important to sort of set up what is the purpose of the proposed scenarios.

00:53:24.990 --> 00:53:34.620

Jonah Frohlich (he/him): The the purpose, first and foremost, is this uniting impact that the lack of this data exchange, infrastructure and capacity has on on the lives of some individuals or.

00:53:34.920 --> 00:53:51.810

Jonah Frohlich (he/him): needing to access care and services under set of these real life circumstances it's not meant to depict what happened, every time it's not meant to be comprehensive, of every type of scenario that may actually occur and it's interesting that.

00:53:53.220 --> 00:53:54.210

Claudia Williams: A lot of the reaction and.

00:53:54.240 --> 00:54:00.000

Jonah Frohlich (he/him): For good reason and totally understandable is that well there's a lot of good exchange happening in the state, we should leverage that.

00:54:00.510 --> 00:54:13.560

Jonah Frohlich (he/him): I don't think anyone on this advisory committee would disagree with that we absolutely do need to highlight what what exists today it's part of the landscape that needs to be developed, what is working and what we need to build upon.

00:54:14.760 --> 00:54:22.320

Jonah Frohlich (he/him): What these landscape what these scenarios really do need to depict us where they're still shortcomings we've heard a number of issues today.

00:54:23.340 --> 00:54:28.200

Jonah Frohlich (he/him): We heard from the public, for example, that over a million California has access Wick.

00:54:28.800 --> 00:54:40.800

Jonah Frohlich (he/him): And they need access to better health information clinical data from the hrs, for example, that would help them more readily access those you saw in comments that in contra Costa that's actually has been done in some part because of the integration, the HR with the Program.

00:54:41.730 --> 00:54:48.090

Jonah Frohlich (he/him): So it's great when that happens in pockets that's a really good example of where something works and in one community.

00:54:48.600 --> 00:54:58.740

Jonah Frohlich (he/him): And could be spread to others, but that isn't necessarily something that is widespread and, as we heard from from the public comment in fact it's not and it's a real shortcomings that we'd like to try to overcome.

00:54:59.670 --> 00:55:05.970

Jonah Frohlich (he/him): So the purpose of these scenarios is to try to identify where there are meaningful gaps, whether it's an emergency response in the fact.

00:55:06.750 --> 00:55:16.710

Jonah Frohlich (he/him): That a public comment that there is not predominant wi fi in some rural and frontier communities in California or broadband that really hamper emergency response, we need to surface those.

00:55:17.520 --> 00:55:26.160

Jonah Frohlich (he/him): We need to call out that there is, in some cases there's broadband there's connectivity, but there are certain services that and we'll get into those like pulse that actually work.

00:55:26.970 --> 00:55:33.690

Jonah Frohlich (he/him): And that are used in some cases, but not others, so the purpose isn't to paint the picture it's really to surface that there are still gaps.

00:55:34.140 --> 00:55:41.280

Jonah Frohlich (he/him): There are gaps that we need to address as part of our recommendations, so we need to identify what those barriers are those gaps are.

00:55:41.760 --> 00:55:49.890

Jonah Frohlich (he/him): and part of the charges this group is to develop a set of policy recommendations and actions that that this group can advance to the Secretary.

00:55:50.310 --> 00:55:57.360

Jonah Frohlich (he/him): And for incorporation into a framework and then, when those policies and those recommendations or events they will come with.

00:55:57.870 --> 00:56:12.390

Jonah Frohlich (he/him): Things like how are we going to develop programs policies governance and funding options to be able to close the gaps, to be able to address and it's like the the gaps that we find either in rural communities or the fact that we have.

00:56:13.920 --> 00:56:26.910

Jonah Frohlich (he/him): A lack of perfect information around social determinants of health around race, ethnicity gender identity orientation information that would really create a.

00:56:28.590 --> 00:56:45.090

Jonah Frohlich (he/him): Better bigger full picture of an individual, so that they are able to be more responsible more able to access the information themselves and be able to work with the whole host of providers, whether the physical patient or social providers to provide their care.

00:56:46.140 --> 00:56:50.550

Jonah Frohlich (he/him): So again, the purpose of these scenarios isn't to paint a bleak picture that things aren't happening.

00:56:51.030 --> 00:56:58.920

Jonah Frohlich (he/him): it's to define where there still are, in some cases barriers that exist and so they're not perfect part of what we want to do today, if you go to the next slide please.

00:56:59.880 --> 00:57:09.210

Jonah Frohlich (he/him): is to is to define what the six scenarios what they are, and then to have some input from the advisory committee about how that can be made better.

00:57:09.660 --> 00:57:19.110

Jonah Frohlich (he/him): And from Michelle your perspective, the point and I were obviously very sorry if it if it if it if it stigmatize the Community the point wasn't to say that every.

00:57:19.710 --> 00:57:28.260

Jonah Frohlich (he/him): psychiatric hospital and facility doesn't have any ehr the point is to emphasize in some cases that exchange doesn't happen, we have the same issue in the acute care.

00:57:29.700 --> 00:57:36.060

Jonah Frohlich (he/him): scenario where we have a primary care of we have a group of physicians and one of them doesn't have a system that can.

00:57:36.540 --> 00:57:50.850

Jonah Frohlich (he/him): exchange information we recognize that with high tech many providers actually have now certified ehr and exchange data but they're still gaps and part of what we need to do is to identify what the scale and the magnitude of those steps to address them.

00:57:51.930 --> 00:57:58.740

Jonah Frohlich (he/him): So the six areas we're going to cover today will have about 10 minutes to go through each i'll spend just a couple of minutes describing what those scenarios are.

00:57:59.310 --> 00:58:09.690

Jonah Frohlich (he/him): And then open it up to comment from all of you about how we can strengthen them make them better make them more realistic reduce the stigma, if that is if it feels like that that is.

00:58:10.260 --> 00:58:19.710

Jonah Frohlich (he/him): If those are unfortunately depicted in these so that we can identify what those barriers are and then address them with with policy recommendations.

00:58:20.400 --> 00:58:29.610

Jonah Frohlich (he/him): With six around first around acute and chronic health needs, the second is a complex, health and social needs third is around population health and value based care.

00:58:30.300 --> 00:58:39.150

Jonah Frohlich (he/him): Fourth, is around emergency response if it's public health response at a sixes around coordinating reentry and health services and it's Secretary value mentioned.

00:58:39.810 --> 00:58:47.010

Jonah Frohlich (he/him): Those are for individuals who are an injustice and goal setting and we're transitioning into the Community so we're going to focus on those.

00:58:47.850 --> 00:58:54.360

Jonah Frohlich (he/him): Just so you are so you and members of the public or where we have to go to the next slide please the pre reading materials.

00:58:54.840 --> 00:59:01.140

Jonah Frohlich (he/him): were shared in advance that give an example of these scenarios to describe a story we're really trying to humanize the impact.

00:59:01.740 --> 00:59:07.020

Jonah Frohlich (he/him): that the lack of infrastructure has and illustrate how different organizations are actors.

00:59:08.010 --> 00:59:12.360

Jonah Frohlich (he/him): Are may be impacted by a lack of some the infrastructure and the ability to exchange data have.

00:59:12.960 --> 00:59:20.220

Jonah Frohlich (he/him): and have some some reason, the key data challenges are So these are these are really being shared for discussion purposes they're not intended to be exhausted.

00:59:20.910 --> 00:59:29.820

Jonah Frohlich (he/him): So what we're hoping to do, and the next slide please is really for every scenario, the highlight are we missing other actors and data types that are really important to highlight here.

00:59:30.960 --> 00:59:37.410

Jonah Frohlich (he/him): Are there other pressing data exchange berries or challenges that we should be considered him should add to these are the modify those that exists and then.

00:59:37.950 --> 00:59:42.300

Jonah Frohlich (he/him): Towards the end we can we can address any of the most salient areas that we might be missing.

00:59:42.990 --> 00:59:48.810

Jonah Frohlich (he/him): Again, this is not every single use case we tried to bring it up from a level of a use case because there could be hundreds of them.

00:59:49.350 --> 00:59:59.040

Jonah Frohlich (he/him): were really trying to just pick scenarios that try to that would capture multiple different use cases so in in some of these you may want to, for example against the public comment.

00:59:59.430 --> 01:00:06.540

Jonah Frohlich (he/him): Because we don't have a snare that involves a pregnant woman or a young mother or a mother, with a young child.

01:00:07.410 --> 01:00:22.410

Jonah Frohlich (he/him): We still want to incorporate things like access to WIC food stamps cow works and other kinds of social programs or social services, where we need integration with physical behavioral programs and providers.

01:00:24.270 --> 01:00:33.030

Jonah Frohlich (he/him): So, having said that i'd like to turn to scenario one and, and then we can get right into.

01:00:35.730 --> 01:00:36.900

Jonah Frohlich (he/him): We can get right into the description.

01:00:38.970 --> 01:00:39.270

Okay.

01:00:41.010 --> 01:00:42.900

Jonah Frohlich (he/him): So in scenario in scenario one.

01:00:45.000 --> 01:00:50.640

Jonah Frohlich (he/him): scenario one we're addressing acute and chronic health and social needs in this scenario.

01:00:51.180 --> 01:00:57.300

Jonah Frohlich (he/him): From the pre read the scenario illustrates a seven year old woman she's undergoing treatment for hypertension and chronic and COPD.

01:00:57.840 --> 01:01:04.650

Jonah Frohlich (he/him): she's referred to a specialist following persistent GI distress she was diagnosed with inflammatory bowel disease.

01:01:05.400 --> 01:01:15.060

Jonah Frohlich (he/him): To begin to receive treatment from a gastroenterologist in addition to the care she's receiving from a pre existing conditions, well, none of the three providers are in the same practice or health system.

01:01:17.220 --> 01:01:24.780

Jonah Frohlich (he/him): The primary care physician and the pulmonologist use the common ehr they'll offer some data exchange and share participation that network allows them to.

01:01:25.260 --> 01:01:28.470

Jonah Frohlich (he/him): provide access to share information and things like progress notes and medication.

01:01:29.430 --> 01:01:37.020

Jonah Frohlich (he/him): But the gastroenterologist solo practitioner she didn't participate in the network or any of the other health information organizations or national networks, so they.

01:01:37.830 --> 01:01:44.190

Jonah Frohlich (he/him): So, instead, the gastroenterologist shares information on the providers primarily using tax documents or phone conversations and there's.

01:01:44.460 --> 01:01:48.690

Jonah Frohlich (he/him): And, as a result, there may be some incomplete information they're not able to share the complete record.

01:01:49.380 --> 01:01:55.290

Jonah Frohlich (he/him): With the patients PCP or pulmonologist so the patient spends large portions of their time relaying information back and forth.

01:01:56.190 --> 01:02:02.970

Jonah Frohlich (he/him): But the patient also has trouble recalling your treatment plan prescribed medications and that could result potentially in an adverse reaction.

01:02:03.420 --> 01:02:12.120

Jonah Frohlich (he/him): So, again it's a it's a general basic scenario, but we want to highlight our next page, where some of the on the on the next slide where some of the barriers are.

01:02:15.060 --> 01:02:22.680

Jonah Frohlich (he/him): First, is around the infrastructure gaps so high tech has been has had an immense influence the adoption of the hrs and interoperability.

01:02:24.090 --> 01:02:30.390

Jonah Frohlich (he/him): But there's still lagging HR adoption and some smaller so low in independence and safety net practices and other settings.

01:02:31.380 --> 01:02:46.410

Jonah Frohlich (he/him): That really do hamper for some who use those and this this can be more common in rural areas, until underserved communities, so that lower HR adoption and in some behavioral health settings as well, I know, Michelle you've commented about this.

01:02:47.610 --> 01:03:06.330

Jonah Frohlich (he/him): Not just behavioral health but physical health practices is is is a barrier for those who are accessing the patients were accessing us and then there's uneven health information exchange across California and not all counties have access to either an H I O or may use a national network.

01:03:07.470 --> 01:03:18.840

Jonah Frohlich (he/him): Because the infrastructure gaps on data exchange barriers, there may be some lack of interoperability between certain types of ehr there are some national standards which are really helping immensely around the.

01:03:19.950 --> 01:03:28.620

Jonah Frohlich (he/him): corner care document that can be exchanged but there's still can be challenges to with patient identifiers and some key data types that may not be transmitted restructured.

01:03:29.670 --> 01:03:35.880

Jonah Frohlich (he/him): And then there are legal and policy challenges that may evolve in some of these cases certain data types are subject to other.

01:03:36.570 --> 01:03:45.360

Jonah Frohlich (he/him): rules and laws both state and federal that require things like a consent or an authorization document to exchange them.

01:03:46.140 --> 01:03:57.810

Jonah Frohlich (he/him): And and generally there's a lack of really robust systems or processes for managing that kind of consent, which can make it very challenging for individual infer it really important information to be shared.

01:04:00.300 --> 01:04:02.460

Jonah Frohlich (he/him): So I think at this point what I.

01:04:03.750 --> 01:04:09.270

Jonah Frohlich (he/him): What I'd have that we do is is turn it over to David forward if you wouldn't mind.

01:04:10.920 --> 01:04:14.670

Jonah Frohlich (he/him): Providing sort of your thoughts on this and then I'd like to ask other members of the way.

01:04:16.890 --> 01:04:25.950

David Ford, CA Medical Assn.: Perfect Thank you John and I'll just I'll just give a couple moments on this again David for that the California Medical Association and.

01:04:27.360 --> 01:04:37.140

David Ford, CA Medical Assn.: In your your first column you reference lagging HR adoption and there's no doubt that continues to be a problem smaller Indian smaller independent practices.

01:04:38.280 --> 01:04:42.090

David Ford, CA Medical Assn.: Even you know after high tech funds have kind of played out.

01:04:43.410 --> 01:04:45.810

David Ford, CA Medical Assn.: ehr systems are very expensive and.

01:04:47.370 --> 01:05:01.770

David Ford, CA Medical Assn.: What happens in small practices, a lot of time because of systems can be very expensive as they move to smaller, less robust ehr systems that may not have access to the national type data exchange networks.

01:05:02.940 --> 01:05:05.370

David Ford, CA Medical Assn.: And because they're smaller systems.

01:05:06.870 --> 01:05:15.570

David Ford, CA Medical Assn.: If they go to try to get on board to a health information organization it oftentimes requires a custom interface, which can be prohibitively expensive.

01:05:16.590 --> 01:05:23.760

David Ford, CA Medical Assn.: But cost is actually only sort of one impediment and sometimes actually not the biggest one and so i'll mention a couple of others.

01:05:24.480 --> 01:05:43.680

David Ford, CA Medical Assn.: But related to cost, I think, collective we have not always done a very good job at it's talking to small practices about the return on investment if they do invest the money into doing health information exchange, we tend to think of it and talk about it in terms of.

01:05:45.210 --> 01:05:51.570

David Ford, CA Medical Assn.: impact on the market and not so much how it benefits to practice that we're asking to put up.

01:05:52.200 --> 01:06:07.080

David Ford, CA Medical Assn.: money out of their own pocket to do this, and so I think we need to reorient our thinking about how does this benefit the individual practitioner in the smaller safety net practice and then one final and I think very, very important point.

01:06:08.880 --> 01:06:20.520

David Ford, CA Medical Assn.: Is that small and safety net practices they don't have it departments, they don't even have an IT director, even if they do get an ehr system and even a very good certified ehr system.

01:06:21.120 --> 01:06:32.070

David Ford, CA Medical Assn.: they're going to need help at the elbow often in you know in office assistant that's why actually the governing statute and i'll keep going back to that.

01:06:33.120 --> 01:06:40.440

David Ford, CA Medical Assn.: Does discuss the state and stakeholders, working together on technical assistance for small and safety net practices.

01:06:40.920 --> 01:06:45.330

David Ford, CA Medical Assn.: And I will just make what but to end my comments i'll make one quick plug.

01:06:46.110 --> 01:06:52.560

David Ford, CA Medical Assn.: jonah and john that, because that is in the Statute is one of the things this working group is asked to work on.

01:06:52.920 --> 01:07:06.630

David Ford, CA Medical Assn.: I believe that provider technical assistance would be a really good working group for us to form and actually to do it sooner rather than later, so

that, in theory, if we needed to do something in the state budget next year, we can start to build that now.

01:07:08.580 --> 01:07:09.000

David Ford, CA Medical Assn.: Thank you.

01:07:10.230 --> 01:07:15.360

Jonah Frohlich (he/him): Thank you very much, David i'm going to ask Senator Hernandez could try to come up with.

01:07:16.710 --> 01:07:35.280

Sandra Hernandez: Sure, thank you jonah john really appreciate all the work on these scenarios I guess you know this first scenario is a good example of seems like there are some infrastructure gaps and data exchange barriers that actually apply across most all of these scenarios.

01:07:36.390 --> 01:07:46.680

Sandra Hernandez: So just to name a couple here, for example, and then to sort of think about how we might extract those and sort of, say, these are prevalent across all these use cases.

01:07:47.160 --> 01:07:57.060

Sandra Hernandez: A good example would be just the challenges with you know identity matching, which is a big issue, and you know, there have been efforts at working at this.

01:07:57.750 --> 01:08:05.970

Sandra Hernandez: But, but that seems to be to be one key example that really cuts across all of these scenarios, the other courses that we do have an even.

01:08:06.780 --> 01:08:16.530

Sandra Hernandez: health information exchanges across the state so it's not unique to this particular scenario, and I think if we get a little crisper at the thing was that.

01:08:17.460 --> 01:08:28.650

Sandra Hernandez: apply to all these use cases and the ones that we haven't yet worked up that will then allow us to sort of hone in a little bit more on the specifics of the scenarios and I think would make them a little bit more useful.

01:08:29.130 --> 01:08:38.820

Sandra Hernandez: And then the last thing I just wanted to comment on with regard to public comment is you know our charge starts with California and Shell half.

01:08:39.570 --> 01:08:53.850

Sandra Hernandez: And so, a use case that really looks at a consumer perspective of them being able to have access to all of their data sets seems to me to be worth us giving some thought to so thank you for that.

01:08:55.050 --> 01:09:09.240

Jonah Frohlich (he/him): Thank you Sandra really a quick comment, there was not by accident that some of these are you familiar barriers come up in multiple different

scenarios we we we We definitely want to highlight those and identify them and see the themes across each.

01:09:10.290 --> 01:09:14.580

Jonah Frohlich (he/him): It will emphasize the need and will help in many cases that may help prioritize what we do.

01:09:15.930 --> 01:09:16.230

Jonah Frohlich (he/him): Thank you.

01:09:17.250 --> 01:09:18.600

Jonah Frohlich (he/him): Mark Please go ahead.

01:09:19.890 --> 01:09:22.920

Mark Savage: Thank you, and can we go back to the previous slide please.

01:09:24.660 --> 01:09:25.230

Mark Savage: I wanted to.

01:09:25.410 --> 01:09:34.290

Mark Savage: pick up on something actually builds on what Sandra was saying and it's an observation about this scenario, but it actually cuts across all of them.

01:09:36.240 --> 01:09:44.640

Mark Savage: with one exception, the scenarios do not have any information flows with the individual at the Center and care, but they are actors.

01:09:45.510 --> 01:09:51.960

Mark Savage: But the information flow is in there, I know this is not supposed to be exhaustive, but because I was seeing this across.

01:09:52.770 --> 01:10:07.470

Mark Savage: The scenarios, except for scenario five where there's a curvy test result delivered to the to the individual sort of tends to have a pattern or or an opportunity, because in the in the real world, the information is providing information.

01:10:08.970 --> 01:10:14.700

Mark Savage: across the board and the individual has a great need to pour information to.

01:10:17.010 --> 01:10:36.480

Mark Savage: So I wanted to suggest that we go back and look at these data NAPs throwing in an information flow that brings the individual, the information she or he needs and reflect square sure he may be contributing information such as a patient reported outcome, did I get better or worse.

01:10:38.490 --> 01:10:40.380

Mark Savage: Family medical history that kind of.

01:10:41.850 --> 01:10:42.630

Mark Savage: kind of thing.

01:10:43.770 --> 01:10:46.770

Mark Savage: And and it's suggested to me with.

01:10:48.090 --> 01:10:50.760

Mark Savage: A southern scenario, I know, one of the questions was.

01:10:52.500 --> 01:11:01.380

Mark Savage: Are these the most salient scenarios I think something around shared care planning which tries to connect all these different actors.

01:11:02.160 --> 01:11:14.460

Mark Savage: might be a good a good useful scenario for us to consider I i've done some work with that and the fire fast fire fast on Task Force at the national level.

01:11:15.060 --> 01:11:22.980

Mark Savage: Trying to build a shared care planning use case that we connect the different entities and provide a an update to a longitudinal.

01:11:23.910 --> 01:11:36.360

Mark Savage: Dynamic care plan in in real time, I think that might be a scenario that helps us week together some of these different pieces that show up more as silos on these data mass because, as you say.

01:11:37.410 --> 01:11:40.440

Mark Savage: That may be the state of play the state of play at the moment.

01:11:41.460 --> 01:11:48.480

Mark Savage: So, and actually the last thing i'll say is again for that individual and the access to to information.

01:11:50.280 --> 01:11:53.430

Mark Savage: A dotted line with the data exchange entity.

01:11:54.750 --> 01:11:59.490

Mark Savage: would be a huge opportunity for access to a longitudinal.

01:12:00.840 --> 01:12:08.490

Mark Savage: Health record when it goes across the different providers, which is such a hard thing now but it's so important for better care and value based care.

01:12:09.990 --> 01:12:10.350

Mark Savage: Thanks.

01:12:11.580 --> 01:12:20.040

Jonah Frohlich (he/him): Thank you, mark i'm going to ask that we have one additional comment, and I know we've got a lot of hands up, so what I suggest, because you have five other scenarios.

01:12:20.580 --> 01:12:32.100

Jonah Frohlich (he/him): I think, Claudia is next for those who still have some comments, if you could please send them to us, you can send them to us in the chat or following the meeting, but in the chat we can document them and make sure that we're.

01:12:32.580 --> 01:12:36.900

Jonah Frohlich (he/him): integrating them into the summaries and into the follow up steps that we're going to have.

01:12:38.100 --> 01:12:40.350

Jonah Frohlich (he/him): That will make note of i'm Claudia.

01:12:41.640 --> 01:12:49.380

Claudia Williams: Sure thanks and i'm one of those folks in a rural area sitting outside at a CAFE so if there's background noise, I apologize.

01:12:50.970 --> 01:13:01.920

Claudia Williams: I think this is a cross cutting issue I wanted to raise that relates to this scenario, and also builds off comments that both Sandra and mark made.

01:13:02.460 --> 01:13:12.180

Claudia Williams: I really you know I think all of these use cases will require creating longitudinal records from multiple providers or multiple sources.

01:13:12.960 --> 01:13:24.390

Claudia Williams: For scenario, one that would be needed to know if the patient was vaccinated because you don't necessarily know that from your own records for two and three, you need to be able to query.

01:13:24.780 --> 01:13:35.940

Claudia Williams: For population health insights which patients are missing vaccinations for, for we need to link, public health and clinical data for five, we need to not just spit out.

01:13:37.140 --> 01:13:46.980

Claudia Williams: But actually have an integrated record available in an emergency, and so I feel like there's a cross cutting infrastructure gap, which is the ability.

01:13:47.310 --> 01:14:04.410

Claudia Williams: To bring in data from multiple sources integrate those data using the matching that Sander described clean the data and then make them available for these sources and today there are a few large integrated delivery systems that who can do this.

01:14:05.610 --> 01:14:12.450

Claudia Williams: And there are some other providers who rely on a Chios to do this for each of those that are able to do that kind of work.

01:14:12.900 --> 01:14:21.570

Claudia Williams: But it's it's such a core infrastructure piece, and I think i'd like to see that called out as a cross cutting gap that we choose.

01:14:21.960 --> 01:14:31.830

Claudia Williams: To mark's point that we really need to fill and we need to build a defined exchange to include that kind of data management to make it useful piece thanks so much.

01:14:33.210 --> 01:14:43.980

Jonah Frohlich (he/him): Great Thank you my comments Claudia we're going to move to the second scenario, I hope that rule and you can submit comments to us through the chat that we can incorporate those.

01:14:45.120 --> 01:14:52.110

Jonah Frohlich (he/him): In the second scenario we have this is the scenario around individual complex, health and social needs.

01:14:53.520 --> 01:15:01.140

Jonah Frohlich (he/him): And in this scenario, you have a four year old Latino male diagnosed with schizophrenia diabetes experiencing housing instability.

01:15:01.770 --> 01:15:11.520

Jonah Frohlich (he/him): he's admitted to a mental health facility I falling an acute episode of schizophrenia that's silly does not have a certified ehr most connected to an information exchange network.

01:15:12.420 --> 01:15:22.740

Jonah Frohlich (he/him): As a result of providers the mental health facility aren't aren't able to view the individual records, from primary care or from other providers to understand their their conditioning and fitting diabetes.

01:15:23.640 --> 01:15:29.160

Jonah Frohlich (he/him): Individuals primary care physician as a certified ehr but he's unaware of the individual submission to mental health facility.

01:15:30.090 --> 01:15:42.000

Jonah Frohlich (he/him): So that there's also a housing support specialist in this scenario at a Community based organization they support the individual and finding and maintaining housing supports temporary housing needs, etc.

01:15:43.830 --> 01:15:51.600

Jonah Frohlich (he/him): there's a break and communication after the individual was admitted to the facility and the housing support specialist in this scenario.

01:15:52.650 --> 01:15:59.640

Jonah Frohlich (he/him): is unable to contact them and they and they lose their source of housing, and you know the result in this scenario.

01:16:00.750 --> 01:16:01.500

Jonah Frohlich (he/him): would have.

01:16:02.670 --> 01:16:14.850

Jonah Frohlich (he/him): The individual who is discharged from the facility and may lose their housing supports and actual housing their temporary housing and required moving into a temporary shelter.

01:16:16.500 --> 01:16:23.400

Jonah Frohlich (he/him): And there are issues there that may include not having refrigeration to store insulin which would create complications from diabetes.

01:16:25.020 --> 01:16:30.120

Jonah Frohlich (he/him): On the next slide a few of the issues that for identified in this.  
01:16:30.660 --> 01:16:43.200

Jonah Frohlich (he/him): Are around again same very that we saw on the first one there certain types of providers small solo rural some rural some safety net and behavioral health providers and not have any HR or at least a system that is interoperable with other.

01:16:44.370 --> 01:16:45.300

Jonah Frohlich (he/him): with other hr.

01:16:46.650 --> 01:16:50.640

Jonah Frohlich (he/him): Back being not being connected to an information exchange organization or national network.

01:16:52.380 --> 01:16:59.730

Jonah Frohlich (he/him): Often Community based organizations don't have technologies that can share receive social other information from other providers.

01:17:00.690 --> 01:17:07.800

Jonah Frohlich (he/him): The homeless management information systems that that are funded and supported through federal grants, for example.

01:17:08.520 --> 01:17:13.290

Jonah Frohlich (he/him): Do have like order entry and ability to share information with each other, but not not readily shareable.

01:17:13.830 --> 01:17:26.640

Jonah Frohlich (he/him): with other providers physical behavior on other providers we've seen some pilots in person care that have been very successful and, in doing that and La county, for example, but it's not yet widespread and Lisa attention that from for public comment to.

01:17:28.620 --> 01:17:41.010

Jonah Frohlich (he/him): So there are there still some gaps with respect to both national and local networks, being able to and have capacity to share some social and social data and some cases behavioral health data to.

01:17:41.790 --> 01:17:51.900

Jonah Frohlich (he/him): And of course I think most folks on this advisory group know that there are federal laws that require for two CFR, for example, that require.

01:17:52.380 --> 01:18:11.790

Jonah Frohlich (he/him): A patient's documented authorization to share certain types of information that are implicated under 42 CFR, part two, and and that can can be difficult to implement, so that those data can be shared with a with a variety of other providers that are joining the Managing your care.

01:18:13.290 --> 01:18:16.050

Jonah Frohlich (he/him): I asked, I think if if we can.

01:18:17.220 --> 01:18:27.120

Jonah Frohlich (he/him): love to get some comments from from individuals, I think it's really in New York, and now you have experienced the San Diego two on one with us get any initial reactions that you might have here.

01:18:28.200 --> 01:18:33.930

William York: yeah Thank you and I really appreciate the insights and the feedback from all of the.

01:18:33.960 --> 01:18:35.700

William York: Committee, and so I you know.

01:18:35.880 --> 01:18:44.760

William York: With Michelle and kathy's comments talking about specifically I think Kenyan the CEO part of that scenario, but it rings through many of the scenarios.

01:18:45.510 --> 01:18:51.510

William York: that there are some common things that you know, not only in San Diego, but I think being exposed to programs across California.

01:18:51.750 --> 01:18:59.880

William York: In different domains, whether that's housing or utility or broadband and all of the things that people need to bring services together.

01:19:00.300 --> 01:19:09.000

William York: That there's sort of three buckets for actually a buckets that I think that CEOs experience nonprofit services that do amazing work so it's not because.

01:19:09.390 --> 01:19:21.660

William York: And so the technology or the funding the technology or the absence of data, you know exchange standards and even kind of that consent management and the additional part 242 CFR.

01:19:21.990 --> 01:19:31.140

William York: They still do great work, so this isn't a knock on the quality of services, but it is, I think, limited to the the funding the technology and again those standards so.

01:19:31.920 --> 01:19:39.990

William York: You know, we have seen this you know, time and time again, where you know technology might not even be is an admin costs that's not allowed, we see that in programs.

01:19:40.620 --> 01:19:45.930

William York: That the GA or the administrative costs they want more see more indirect services so technology.

01:19:46.200 --> 01:19:57.990

William York: And I think someone mentioned the infrastructure to support that so, and this can be all sizes of organizations right they could be large organizations that the program specifically is is smaller but doing great work but there's not.

01:19:58.650 --> 01:20:07.800

William York: necessarily a software integration there that can work and plus the long term support of that so a cost, and again it might not be allowable expenses, so not that they don't realize and value it.

01:20:08.040 --> 01:20:18.720

William York: But it's It really is the cost of the funding mechanism we've seen that you know you know excel work access, where we know great people doing case management is still working on binders.

01:20:19.470 --> 01:20:27.600

William York: So, so there definitely is you know some disparate you know ways to get this data have a much needed, you know social network provider.

01:20:28.560 --> 01:20:36.330

William York: I think that also be the standards right, so I think someone mentioned, you know the hud that there are some there, but we don't have cross sector data standards.

01:20:36.990 --> 01:20:44.670

William York: You know I so admire healthcare, because you have some standardization, you have something to fall back on, you know that you all know and consistency.

01:20:44.940 --> 01:20:51.120

William York: We don't have that in a lot of most programs programs, not all I don't want to speak generally that everything.

01:20:51.360 --> 01:21:02.550

William York: But a lot of them and the further you go out to services and even talking about the refrigerator the diabetes that it gets it gets more and more complicated with standards taxonomy is coding, and all those types of things.

01:21:03.750 --> 01:21:14.940

William York: So I think that you know again finding the technology and then the last part of 42 CFR I am excited about you know there's lots of things moving technology and social services, but then, a lot of investment, private and government.

01:21:15.150 --> 01:21:17.610

William York: into looking at ways to accomplish that there is movement.

01:21:17.970 --> 01:21:28.590

William York: You know I don't know if you know it has been many reports that nonprofit social service providers or 20 years behind the technology, I wanted to mention that up front, so we knew this we know this to be true we've seen in practice but.

01:21:28.980 --> 01:21:34.980

William York: I think we didn't 42 CFR there's also some other promising practices of getting that part to consent and how that can be done.

01:21:35.250 --> 01:21:40.260

William York: In systems, you know workarounds that we're having some legal tests, you know there's many going on.

01:21:40.530 --> 01:21:50.700

William York: about how that can work so appreciate allowed to give them feedback this did speak to us and me about you know things that we've experienced real time with with many different sizes and scales of organizations.

01:21:51.840 --> 01:22:00.660

Jonah Frohlich (he/him): Thank you, great comment i'm wondering if Jamie you might just be able to comment from the perspective of a housing provider on the experience, where you identify gaps.

01:22:02.460 --> 01:22:09.180

Jamie Almanza, BACS: yeah Thank you absolutely hi everyone Jamie alonzo from back so we're kind of unique in that we're both behavioral health.

01:22:09.270 --> 01:22:20.160

Jamie Almanza, BACS: and housing and homelessness kind of under one umbrella as an agency, and I just want to lift up all the comments that were made, particularly from William and Michelle and mark around kind of centralized care planning.

01:22:20.340 --> 01:22:24.360

Jamie Almanza, BACS: Even with that in our organization i'd say we're a fairly large organization and.

01:22:24.600 --> 01:22:34.740

Jamie Almanza, BACS: We have you know we're in seven counties which means seven different age of my systems, and it also means seven different county ehr is and the dilemma we have is.

01:22:34.950 --> 01:22:46.080

Jamie Almanza, BACS: You know I want to buy an ehr for our organization that's fully integrated and interoperable and it's just not possible so i'm constantly waiting kind of the cost benefit of.

01:22:46.380 --> 01:22:53.700

Jamie Almanza, BACS: That and kind of frankly waiting waiting the counties out and waiting this process out as an organization this use case.

01:22:54.330 --> 01:23:01.350

Jamie Almanza, BACS: Really spoke to me it's what we live, every day, and we have privileged to work in alameda county and they definitely with.

01:23:02.340 --> 01:23:11.250

Jamie Almanza, BACS: whole person care they implemented the Community health record so in alameda county I can hop on and see the primary care doc's diabetes diagnosis.

01:23:11.460 --> 01:23:21.780

Jamie Almanza, BACS: We again we're an hmo as provider, so I can hop on to a trump is and see that interim housing opportunity and then certainly we're behavioral health provider, so we can certainly see that.

01:23:22.290 --> 01:23:34.350

Jamie Almanza, BACS: The the stay in the short term crisis crisis or mental health facility, but but that's all kind of privilege for us because we just happened to be so widespread and in our scope of work, which I know is.

01:23:34.860 --> 01:23:43.920

Jamie Almanza, BACS: Not the case for different organizations that just work in the housing space just work in the behavioral health space, so I think, for me, you know the shared care plan and like.

01:23:44.250 --> 01:23:56.760

Jamie Almanza, BACS: I said this before, but you know we write 12 care plans for one individual because we have to fit it into that funders source so hmm is there's a care plan around housing and behavioral health there's a care plan.

01:23:57.000 --> 01:24:06.510

Jamie Almanza, BACS: Around behavioral health there's you know the physical health care plan all those things, so I think a goal for us, as a committee, is really looking at getting rid of the multiple.

01:24:07.110 --> 01:24:12.210

Jamie Almanza, BACS: Care plans and then really and again what speaks to me as an organization that does work with.

01:24:12.450 --> 01:24:26.010

Jamie Almanza, BACS: It and all the systems we still have to go 10 different places to get 10 different pieces of information for for this gentleman who you know will not get that housing opportunity because because of the challenges that we all face.

01:24:28.800 --> 01:24:36.090

Jonah Frohlich (he/him): Great Thank you Thank you Jamie we really appreciate your perspective as a provider in this scenario, and your experience here.

01:24:36.720 --> 01:24:47.640

Jonah Frohlich (he/him): i'm going to ask if if I know rebel and then our you didn't have a chance to speak last time, if we can just go through YouTube if we have time we'll do one more, but I think where it might just be too and we'll move on.

01:24:49.470 --> 01:24:49.920

Rahul Dhawan: Thank you.

01:24:50.970 --> 01:24:52.530

Rahul Dhawan: really appreciate the opportunity, my name is.

01:24:52.530 --> 01:25:00.840

Rahul Dhawan: rahul one of a working with medication management is the primary care doctor, as well as specialist transplant nephrologists working medically underserved area.

01:25:01.230 --> 01:25:08.010

Rahul Dhawan: where he was mad point a large so we take care predominately medical homeless patient and homeless patients patients with behavioral health issues.

01:25:08.430 --> 01:25:16.890

Rahul Dhawan: Through the field of challenge of not being able to locate our patients, Ms offers a great data repository for us as primary care doctors and specialists and serves as a.

01:25:17.640 --> 01:25:23.460

Rahul Dhawan: Somewhat of the local HIV, because of the portal that they offer, but I know colleagues of mine that don't have.

01:25:24.090 --> 01:25:28.140

Rahul Dhawan: Access to an organization like midpoint really don't get the same.

01:25:28.560 --> 01:25:35.490

Rahul Dhawan: benefits, because a lot of our doctors still on paper charts authorizations are submitted on paper there's coding and documentation.

01:25:35.760 --> 01:25:42.510

Rahul Dhawan: Due to error errors dude aging physicians and i'm part of the succession planning for a lot of these doctors So these are the challenges we face.

01:25:43.470 --> 01:25:49.560

Rahul Dhawan: not getting discharge summaries for discharge payment patients timely in additional risks or readmissions, a result.

01:25:50.190 --> 01:26:00.510

Rahul Dhawan: really want to emphasize along those lines and echo the comments made before, but the timeliness of data and decision making that's important as a result of that, and the good patient outcomes that come as a result of.

01:26:01.140 --> 01:26:07.770

Rahul Dhawan: timeliness of data and locating this patient such a challenge for us and really we should look at the root cause of why this is happening.

01:26:08.040 --> 01:26:20.190

Rahul Dhawan: Why this information is wrong and unreliable I sit on health plan committee meetings and is something that comes up amongst all health plans were found tremendous success utilizing different ancillary such as pharmacy dialysis centers and others.

01:26:20.190 --> 01:26:21.270

Rahul Dhawan: To find patients.

01:26:21.900 --> 01:26:30.720

Rahul Dhawan: So I think that we should focus on how we could find these patients, a lot of these scenarios offer the demographics, as a core foundation provider to decision making.

01:26:31.050 --> 01:26:39.060

Rahul Dhawan: we're not really in a rural area but still a medically underserved area we still suffer a lot of the barriers that some of the rural colleagues of ours here face.

01:26:39.900 --> 01:26:50.820

Rahul Dhawan: So just want to say thank you for listening and really appreciate this forum and opportunity to discuss these very vital issues are so valuable to a patient safety and patient care and high quality care, so thank you.

01:26:52.110 --> 01:27:03.510

Jonah Frohlich (he/him): Great Thank you all right, one more comment from our way and then i'm sorry we'll move on and if with Jonathan others if you can add people to the chat Thank you.

01:27:05.520 --> 01:27:05.760

Ali Modaressi: Thank you.

01:27:07.650 --> 01:27:14.250

Ali Modaressi: Thank you jonah hi everyone alley mother is see with lanes health information exchange in Los Angeles in this.

01:27:15.390 --> 01:27:22.440

Ali Modaressi: scenario and most of them, the last three the huge gaps in the care coordination across different care settings.

01:27:23.160 --> 01:27:39.570

Ali Modaressi: And the challenges that the health information organizations across California, we are experiencing experiencing these on on a daily basis, I think there's opportunity here for this advisory committee and most likely subcommittees to.

01:27:40.710 --> 01:27:46.560

Ali Modaressi: To bring out discuss bringing in the US, all of the administrative policies.

01:27:47.310 --> 01:28:02.760

Ali Modaressi: That may be can be relaxed whether it's state or local agencies that can be relaxed on help in this particular area, especially when we're talking about behavior health and social determinants of health data, so I kind of look forward to.

01:28:03.960 --> 01:28:12.450

Ali Modaressi: What comes out of the subcommittee's through later to relaxing these all of these policies that is preventive right now.

01:28:13.230 --> 01:28:22.740

Ali Modaressi: The in the recent version of the task of framework, there is a language and provision is kind of interesting is kind of transitions from the user.

01:28:23.130 --> 01:28:34.410

Ali Modaressi: and sharing of their permitted purposes or permissible us to exchange purposes, and I think that may be an opportunity to use that in the.

01:28:35.160 --> 01:28:41.940

Ali Modaressi: legal framework that we are from that we are tasked with to develop in a few months.

01:28:42.540 --> 01:28:58.380

Ali Modaressi: I also want to mention that or echo what David said earlier, because I didn't get a chance to comment on that is that is independent small practices that are catering, to the medicare population safety net population, they are.

01:28:59.460 --> 01:29:08.760

Ali Modaressi: They don't have the means to connect they have an emr systems, but they don't have a means to connect securely to an hie we experienced that.

01:29:09.030 --> 01:29:25.830

Ali Modaressi: firsthand during the cow hub some small practices interested in joining, but they just couldn't pass the privacy security assessment that we have to have in place to establish a secure connection with the small practices so they need that.

01:29:27.180 --> 01:29:35.820

Ali Modaressi: Technical assistance as David also mention and and not just short term but long term technical assistance and incentives.

01:29:36.900 --> 01:29:40.230

Ali Modaressi: For them to be able to connect and share data, thank you.

01:29:43.110 --> 01:29:43.650

Jonah Frohlich (he/him): Thank you, I.

01:29:45.540 --> 01:29:48.240

Jonah Frohlich (he/him): appreciate it we'll move on to the third barrier there's been a lot of.

01:29:49.200 --> 01:30:00.780

Jonah Frohlich (he/him): comments about the labeling and creating a data exchange entity in some of these, and I think I think criminal just started with you and and it's a really good point we we don't we're not trying to presuppose and we shouldn't try to presuppose.

01:30:02.160 --> 01:30:11.610

Jonah Frohlich (he/him): mechanism or method, and we want to make it really clear that that's not we're not trying to get to the to the results here we're trying to define where their potential gaps, I think there's.

01:30:12.600 --> 01:30:20.520

Jonah Frohlich (he/him): I think we probably need to make some adjustments to this that this entity this not physical place it's more we're talking about a mechanism for exchanging.

01:30:21.060 --> 01:30:29.550

Jonah Frohlich (he/him): So I think we do need to make some adjustments to our scenarios to reflect that that concern that you raised that others so clearly indicated as well.

01:30:31.050 --> 01:30:38.820

Jonah Frohlich (he/him): So let's move to the third scenario, this is the population, health and value based care scenario that the illustration, here is my hope is really focused on population health.

01:30:40.050 --> 01:30:51.570

Jonah Frohlich (he/him): it's difficult to do an individual scenario, one for this population health focus, so it may not have quite hit the mark in terms of what we're trying to achieve and population health, but this is the scenario we we drafted.

01:30:52.710 --> 01:31:01.890

Jonah Frohlich (he/him): In this example, you have an African American changer non binary child undiagnosed asthma health coverage through a commercial plan don't have a primary care provider.

01:31:03.330 --> 01:31:08.820

Jonah Frohlich (he/him): This individual has largely been able to manage their asthma through lifestyle changes.

01:31:09.360 --> 01:31:19.530

Jonah Frohlich (he/him): And it's not requiring you for medical intervention, so the health plan doesn't have any medical claims on file that would document that they have a chronic condition, so when they're creating registries and pop health Program.

01:31:20.190 --> 01:31:28.920

Jonah Frohlich (he/him): Using those that the claims, for example, or any clinical data they might access there's nothing there didn't kick that individual has underlying as a condition.

01:31:29.790 --> 01:31:36.690

Jonah Frohlich (he/him): or during a recent wildfire ambien smoke persists there's a local power outage which we've experienced given us wildfires.

01:31:37.320 --> 01:31:42.840

Jonah Frohlich (he/him): And access, therefore, to indirect conditioning is available, and it worsens there as a sentence.

01:31:43.740 --> 01:31:50.490

Jonah Frohlich (he/him): While at a school the visit the nurse and that's where they're really getting their care with documents systems and surfers them to primary care provider.

01:31:51.150 --> 01:32:05.700

Jonah Frohlich (he/him): Their health plan is not connected to that nurse they don't they're not aware of the symptoms, and so the POP health management program that the health plan has might signal that any individual in these neighborhoods.

01:32:06.720 --> 01:32:15.510

Jonah Frohlich (he/him): With asthma condition and it might try to alert them to to the shelter or two or to follow a set of other activities that would help them.

01:32:16.320 --> 01:32:22.620

Jonah Frohlich (he/him): find a safer environment for them it doesn't notify that that miners family because they don't have historical information about them.

01:32:23.610 --> 01:32:32.910

Jonah Frohlich (he/him): They also don't know that that that the health plan doesn't know that the indigenous African American which may put them in higher risk for asthma medication, excuse me, asthma complications according to evidence.

01:32:33.690 --> 01:32:45.600

Jonah Frohlich (he/him): Of the individual does not end up going to the primary care provider, in addition, because their office it's far and they're concerned that the primary care provider may not be accepting of the gender identity so without those medication needs, there are there's.

01:32:46.800 --> 01:32:51.960

Jonah Frohlich (he/him): No real potential that individual condition condition and the taken to an emergency department.

01:32:53.250 --> 01:32:59.880

Jonah Frohlich (he/him): So, in terms of barriers on the next page that we've identified and again the comment from everyone.

01:33:00.900 --> 01:33:08.010

Jonah Frohlich (he/him): One is there there's some scenarios and settings like school based health providers that may not have access to.

01:33:08.730 --> 01:33:28.050

Jonah Frohlich (he/him): electronic health record some nurses don't use one, and so the linkage with a health plan or other providers, maybe, maybe sub optimal and does not enable sharing of electronic information in near real time or the communication with the with the individual health plan.

01:33:29.070 --> 01:33:38.640

Jonah Frohlich (he/him): There are some demographic exchange berries, who really wanted to highlight here and that have been mentioned in comments, one is that demographic data race, ethnicity.

01:33:39.660 --> 01:33:47.490

Jonah Frohlich (he/him): Sexual orientation gender identity could help inform population health management programs and address health equity by understanding.

01:33:48.300 --> 01:33:58.020

Jonah Frohlich (he/him): background demographics and support culturally competent care and without that information it's very hard for a health plan or provider to be able to address those and understand those underlying issues.

01:33:59.070 --> 01:34:05.370

Jonah Frohlich (he/him): Many non traditional healthcare providers may not be connected to information exchange, services or capabilities.

01:34:05.880 --> 01:34:12.960

Jonah Frohlich (he/him): And most peers today can't really access clinical behavior of social data and needed to support their own population health management efforts to drive things like.

01:34:13.680 --> 01:34:25.140

Jonah Frohlich (he/him): Risk stratification and identification issues and, again, there are some in terms of policy issues in this particular case, there are some issues related to sharing of data related to minors.

01:34:26.310 --> 01:34:31.620

Jonah Frohlich (he/him): And again, that goes into another set of conversations that are happening in the chat around around consent.

01:34:33.240 --> 01:34:46.500

Jonah Frohlich (he/him): And i'd like to ask if we can have a couple of comments I think Andy be great to hear your perspective from Kaiser about this scenario, and things that we can do to surface barriers for issues and make this more relevant.

01:34:48.240 --> 01:35:02.190

Andrew Bindman: Thanks yep hi everyone i'm Andrew bindman my primary care physician, and also the chief medical officer at kp yeah I think this example was a hard one action to try to shoehorn into population health it didn't quite.

01:35:02.280 --> 01:35:02.970

Andrew Kiefer: match up.

01:35:03.000 --> 01:35:06.450

Andrew Bindman: In my mind and, in all honesty, for several reasons, one is.

01:35:07.290 --> 01:35:19.950

Andrew Bindman: Population health often does begin with like an identification of people who have certain conditions or risk factors and so forth, and as you sort of speak doing this scenario is someone who's being identified for the first time.

01:35:19.950 --> 01:35:24.930

Andrew Bindman: As possibly having asthma so it's hard to imagine how the health plan would have had population health.

01:35:25.470 --> 01:35:31.260

Andrew Bindman: plan in place related to the individual other than the sort of Community data that you sort of alluded to.

01:35:32.100 --> 01:35:38.250

Andrew Bindman: But that's not in my experience, quite how we organize population health information, I mean.

01:35:39.060 --> 01:35:51.660

Andrew Bindman: The experience of the person ultimately going to the hospital and perhaps being identified at that location with asthma might be information that we would, in a future plan related to population health take account for but.

01:35:52.710 --> 01:36:00.420

Andrew Bindman: it's hard to imagine how that would have happened in the prospective way that is laid out in this scenario, I mean to me the biggest defect.

01:36:00.930 --> 01:36:13.860

Andrew Bindman: In your gap in a way, in this case that you lay out is that school based clinics seem to be not tied into the relationship with the health plan and.

01:36:15.150 --> 01:36:21.870

Andrew Bindman: You know it's a it's in a way, I guess, I sort of feel like this is a true scenario and a problem that you're identifying.

01:36:22.380 --> 01:36:28.560

Andrew Bindman: But it's not quite clear to me how information exchange, would have necessarily changed.

01:36:29.250 --> 01:36:45.600

Andrew Bindman: You know the outcome in this particular case, that the nurse at a clinic is kind of making a new diagnosis potentially have asthma, but doesn't feel empowered actually manage it so makes a referral and kind of a loose way I guess to primary care.

01:36:46.800 --> 01:36:54.450

Andrew Bindman: And you know there's something that's broken potentially between the health plan and primary care that the provider doesn't feel that the.

01:36:55.020 --> 01:37:03.780

Andrew Bindman: Particular individual you're calling out doesn't feel comfortable to go to that primary care provider hasn't sort of formed a relationship that I helped plan and a primary care provider.

01:37:04.230 --> 01:37:14.880

Andrew Bindman: should have already provided to the Members so i'm struggling a little bit to understand how information exchange, would have made up for other very significant problems.

01:37:15.210 --> 01:37:30.660

Andrew Bindman: That are identified in this particular case population health is really the capacity to on a population level learn from information exchange, to try to prevent.

01:37:31.110 --> 01:37:42.480

Andrew Bindman: Future problems, this one is sort of setup is kind of a real time issue that I don't think the correct historical information would have been there, that would have resulted in.

01:37:43.080 --> 01:37:46.890

Andrew Bindman: necessarily a different outcome, the most important thing in this case, would have been for the.

01:37:47.400 --> 01:37:57.990

Andrew Bindman: School perhaps a school based clinic to have you know either called up the health plan or reached out to the primary care provider directly if they're already was a relationship or something It just seems.

01:37:59.010 --> 01:38:00.630

Andrew Bindman: like this one doesn't quite.

01:38:01.650 --> 01:38:09.930

Andrew Bindman: Online in my mind, so the biggest solution, I would have offered from this is how do we create a mechanism for school based clinics to become.

01:38:10.470 --> 01:38:22.950

Andrew Bindman: connected to the ecosystem that we're talking about in a similar way to how other providers that you've talked about in other scenarios are not connected to the ecosystem, but I probably would want to.

01:38:23.010 --> 01:38:24.210

Jonah Frohlich (he/him): work with you and others to.

01:38:24.210 --> 01:38:25.650

Jonah Frohlich (he/him): rethink this.

01:38:25.710 --> 01:38:44.670

Andrew Bindman: doesn't quite match my idea of how population health would have been supportive of solving this problem, or, in fact, been enhanced by what you're talking about other than feeding back information if it was out of network to inform future plans for population health so anyway.

01:38:45.090 --> 01:38:46.560

Andrew Bindman: that's my struggle with it a little bit.

01:38:47.670 --> 01:38:47.970

Jonah Frohlich (he/him): Okay.

01:38:48.270 --> 01:38:53.580

Jonah Frohlich (he/him): I think Andy we definitely appreciate refinement here and and take your point.

01:38:54.750 --> 01:39:07.410

Jonah Frohlich (he/him): I think what we need to take in your comments need to specify here is the need for plans and providers to be able to aggregate and collect information from a variety of different sources, including school based clinics, but also.

01:39:08.040 --> 01:39:15.030

Jonah Frohlich (he/him): The individual from other providers and, of course, so so clinical social and and, of course, encounter data to drive.

01:39:15.720 --> 01:39:20.850

Jonah Frohlich (he/him): The pop health management programs the stratification algorithms so that so that.

01:39:21.720 --> 01:39:30.540

Jonah Frohlich (he/him): Those programs can actually operate efficiently, so I think if we certainly welcome so ways that we can reframe this to more accurately reflect those programs.

01:39:31.260 --> 01:39:40.680

Jonah Frohlich (he/him): And I so we very much welcome that net and put a man asked if Andrew if you can provide your perspective from Blue Shield and then we can.

01:39:42.060 --> 01:39:43.530

Jonah Frohlich (he/him): Take a couple more comments, please.

01:39:45.060 --> 01:39:46.620

Andrew Kiefer: yeah Thank you jonah and.

01:39:46.920 --> 01:40:00.120

Andrew Kiefer: Secretary galley and he just team, and I just really appreciate the opportunity to be here today to offer some comments and the robust chat that i'm witnessing has sparked many, many thoughts.

01:40:01.350 --> 01:40:12.510

Andrew Kiefer: i'm actually in the context, this slide actually going to lift up an issue that I think is applicable across all these scenarios and many of the others that we could all envision.

01:40:14.190 --> 01:40:22.800

Andrew Kiefer: And i'm putting it in the context of the major State initiatives that are underway, that many of our organizations have supported and look forward to.

01:40:23.610 --> 01:40:30.750

Andrew Kiefer: Getting up off the ground and really realizing their potential to improve health outcomes for every California.

01:40:31.590 --> 01:40:45.180

Andrew Kiefer: i'm sitting on the contact with colleen and the the role at it it's invoking for health plans to coordinate care, not just medical care, but social services as well, and many, many other components.

01:40:46.410 --> 01:40:53.490

Andrew Kiefer: The the role that health plans play and managing chronic care chronic disease management of our membership.

01:40:54.660 --> 01:40:59.130

Andrew Kiefer: As, including the development of products that coordinate and incentivize.

01:41:00.360 --> 01:41:03.840

Andrew Kiefer: Greater attention to these individuals with our provider partners.

01:41:04.890 --> 01:41:20.520

Andrew Kiefer: The new and incredibly important regulations that are going to be developed, pursuant to the state budgets for health and equity standards and health plans central for us and our ability to both assess our quality and our equity.

01:41:22.050 --> 01:41:32.070

Andrew Kiefer: Our position and our advancement and achieving those goals is having access to clinical information for our Members, and I can continue on there's.

01:41:32.940 --> 01:41:37.230

Andrew Kiefer: A longer list, and when you look at through the lens of those major state programs.

01:41:37.950 --> 01:41:45.810

Andrew Kiefer: And and apply it to these scenarios, I think that the big missing element here, and this is the role the health plan is fine.

01:41:46.620 --> 01:41:55.440

Andrew Kiefer: it's noted on one slide this slide, in particular, but I have specific instances with the rule that my plan was playing each one of these that.

01:41:56.160 --> 01:42:06.750

Andrew Kiefer: are not mentioned, I don't think that's anything more than sort of an oversight and a offer to sort of put this through the lens of the of the the Member that's.

01:42:07.110 --> 01:42:15.000

Andrew Kiefer: The we're all trying to help here, but that is I think an overarching comment on that we can apply that.

01:42:17.580 --> 01:42:18.540

Andrew Kiefer: As much as.

01:42:20.130 --> 01:42:37.740

Andrew Kiefer: All the other elements of the care delivery system, the health plan needs to have access to that information and in near real time as possible, and I would be remiss if I didn't just belabor the point about the individual health records, this is central to.

01:42:38.910 --> 01:42:44.850

Andrew Kiefer: This working and believe that that is in and of itself critical.

01:42:46.080 --> 01:42:47.490

Jonah Frohlich (he/him): objective that will.

01:42:47.550 --> 01:42:56.070

Andrew Kiefer: empower individuals and the care continuum to deliver better care and others have mentioned that and I would would hardly second that that.

01:42:56.700 --> 01:43:05.280

Andrew Kiefer: We need the ability for every person in California, to have access to their log into the new patient record also the health plan are obliged to provide this information.

01:43:05.880 --> 01:43:09.600

Andrew Kiefer: Today, but it's only to the extent that information is available that's incomplete.

01:43:10.530 --> 01:43:29.220

Andrew Kiefer: Often, because the lack of data flow so we'll just pause there and just really appreciate again the Secretary and team for their just outstanding work on this so far and really look forward to rolling up my sleeves and dig in on this to realize the vision of it.

01:43:31.320 --> 01:43:44.580

Jonah Frohlich (he/him): Great Thank you Andrew and I think will take to heart and incorporate sort of the role that matched her plans, as you mentioned, and these other scenarios play an important role that they do, and not just in the sun one more one more time for one more comment.

01:43:46.020 --> 01:43:47.760

Jonah Frohlich (he/him): So when, if you could please provide them.

01:43:51.030 --> 01:43:55.350

Linnea Koopmans: yeah Linda Goodman school local health plans and i'll be brief, some of my comments.

01:43:55.770 --> 01:44:05.550

Linnea Koopmans: we're going to be similar to those that Andrew just made in terms of the role of the health plans, I will reiterate those that would I would agree with them and and those that have been shared by Liz in the chat but.

01:44:05.940 --> 01:44:11.550

Linnea Koopmans: I think a couple of comments specific to this scenario, I do think and to Dr environment point I think said.

01:44:11.910 --> 01:44:24.840

Linnea Koopmans: The gap and information between the plan and the school really resonated I think you know when looking through these scenarios, there was you know full agreement that that's the linkage that isn't occurring to be that that should be or needs to be in the future.

01:44:25.980 --> 01:44:35.940

Linnea Koopmans: We were a little puzzled by the assumption that the plan did not have race or ethnicity data and that did that we didn't know that this patient with African American.

01:44:36.390 --> 01:44:50.070

Linnea Koopmans: And we've been medical and we have race, ethnicity data it's not complete i've heard you know around 75 to 80% is generally the percentage of data that we have for our Members.

01:44:51.510 --> 01:44:59.250

Linnea Koopmans: And then I wanted to make one kind of overarching in very brief comment because I do have to hop off the call a little bit early.

01:44:59.790 --> 01:45:16.950

Linnea Koopmans: Which is in terms of a scenario that I think might be missing, I think all of all of these scenarios are really complex, which I know was intentional to illustrate

the various systems and entities involved in any given person's life when trying to receive care.

01:45:17.970 --> 01:45:23.310

Linnea Koopmans: But I do think we need a much simpler scenario, one that highlights.

01:45:24.630 --> 01:45:34.140

Linnea Koopmans: A patient's need for preventive care, for example, I think, even in that case they're often barriers or challenges that exist today.

01:45:34.590 --> 01:45:44.520

Linnea Koopmans: So well I think these are really great scenarios I don't think they're exhausted, and I do think it would be helpful to have one that is much more basic Thank you good Thank you again.

01:45:46.470 --> 01:45:49.590

Jonah Frohlich (he/him): Okay, so we'll move to the fourth scenario.

01:45:50.700 --> 01:45:54.960

Jonah Frohlich (he/him): The fourth scenario focuses on supporting emergency response.

01:45:56.610 --> 01:46:07.800

Jonah Frohlich (he/him): we've highlighted a couple of different systems that have been put into place pulse and safer and wants to sort of go through the scenario and get another scenarios comments from the group.

01:46:09.270 --> 01:46:13.800

Jonah Frohlich (he/him): So in this scenario, we have the illustration as a 50 year old male.

01:46:15.360 --> 01:46:24.930

Jonah Frohlich (he/him): That individual as underlying health conditions receives snap benefits or calfresh eligible for medical tailored neil's through the managed care plan.

01:46:25.890 --> 01:46:32.340

Jonah Frohlich (he/him): they're evacuating from a wildfire the individual is disoriented care from a disaster healthcare volunteer.

01:46:32.880 --> 01:46:47.430

Jonah Frohlich (he/him): And alternative care facility near the evacuation Center it's a temporary site that's been set up and it tastes evacuated was unable to bring medications as Catholics benefit card and other medical insurance card, since the local clinic reduce moses's carers close down and.

01:46:48.540 --> 01:46:55.050

Jonah Frohlich (he/him): Access to healthcare volunteer doesn't have access to their medical records, so the responders have to rely on the individual explain their condition.

01:46:56.130 --> 01:47:08.400

Jonah Frohlich (he/him): Patient mentioned that it takes medication, but doesn't know remember the name the dosage last time you took it may have forgotten that he

received these medically catered meals, to help manage its heart disease, and since he didn't have his insurance card.

01:47:09.450 --> 01:47:18.390

Jonah Frohlich (he/him): doesn't have any way of knowing how to restart their meal plan the volunteer consults with emergency response provider and queries safer.

01:47:19.620 --> 01:47:23.220

Jonah Frohlich (he/him): wasn't able to find records given to the patient received medication from a clinic.

01:47:24.630 --> 01:47:35.100

Jonah Frohlich (he/him): they're unsure of the severity of the patient's symptoms he's transported and transport to kind of world local emergency department visits the caution and patients diagnosed and he starts to medication during the.

01:47:36.930 --> 01:47:49.950

Jonah Frohlich (he/him): Crop this experience the providers don't have access to the social service information and they're not aware that they were calfresh beneficiary, so there are several opportunities to reconnect the individual services may be missed in this case.

01:47:52.110 --> 01:47:52.680

Jonah Frohlich (he/him): So in.

01:47:52.770 --> 01:47:59.130

Jonah Frohlich (he/him): In this illustration, if we can just go to the barriers, a few that have emerged.

01:48:00.240 --> 01:48:02.340

Jonah Frohlich (he/him): pulse unsafe for both have.

01:48:03.420 --> 01:48:05.640

Jonah Frohlich (he/him): have emerged recently and are are highly.

01:48:07.170 --> 01:48:12.030

Jonah Frohlich (he/him): relied upon when they're being when they are connected to various providers in the state.

01:48:13.380 --> 01:48:20.760

Jonah Frohlich (he/him): to connect it to organizations for people who are impacted by by us naturally disasters.

01:48:21.570 --> 01:48:34.500

Jonah Frohlich (he/him): There are some coverage gaps, where organizations aren't connected to them, and so that does not allow for those systems to connect to every institution that provider may have that the patient may have thought care from.

01:48:36.990 --> 01:48:41.700

Jonah Frohlich (he/him): Neither pulsar safe for currently collect or exchange non clinical social data.

01:48:42.930 --> 01:48:53.520

Jonah Frohlich (he/him): source in terms of health data, and there are some issues related that that that identified around instances where there may be some prohibitions in at least.

01:48:53.970 --> 01:49:00.960

Jonah Frohlich (he/him): In the state around sharing certain data that under usga rules, or at least California interpretation of them.

01:49:01.860 --> 01:49:13.590

Jonah Frohlich (he/him): which may require again consent to share that information in certain circumstances, between a provider who delivers that benefit and those who are treating the patient at the individual sites.

01:49:14.850 --> 01:49:33.990

Jonah Frohlich (he/him): I guess if I, if I may, if Leslie if you're available would love to hear from you and then back here, and if you have comments you to do so comments in this case, see your hand raised i'd love to hear from you so Karen are you are you here i'm sorry let's say, are you oh yeah hi.

01:49:34.320 --> 01:49:47.250

Leslie Witten-Rood: Thank you, I appreciate the opportunity to share what we've been working on, so the pathway for Poles and safer have been about I would say, a five year process starting off with pilots from the.

01:49:47.250 --> 01:49:51.000

Leslie Witten-Rood: nc and we just currently i'm going to start with.

01:49:51.000 --> 01:50:01.710

Leslie Witten-Rood: polls so it's a patient unified look up system for disaster, so this is enabled us to be able to have our kill matt and i'll help core teams now with the pandemic.

01:50:02.070 --> 01:50:22.800

Leslie Witten-Rood: be able to have access to patient information and austere conditions in an alternative care environment so we've already seen many benefits of this and our expansion has been from using the California Agios through the sea 10 process.

01:50:24.420 --> 01:50:33.270

Leslie Witten-Rood: to moving forward to just five days ago we've just completed our implementation with some of the high times funding to.

01:50:33.540 --> 01:50:51.300

Leslie Witten-Rood: connect to eat health exchange care, quality and source scripts along with the California, he knows so we've gone from having patient records of about 65% of California records with match to 85% of the nation's records.

01:50:51.660 --> 01:51:04.740

Leslie Witten-Rood: This system, though, was developed to be a view only system to be used by prevented disaster healthcare workers that we check their licenses every 24 hours within the state.

01:51:05.190 --> 01:51:14.040

Leslie Witten-Rood: So, with the pandemic MCI has gone from doing care in shelters that have been limited to under about a 24 hour period.

01:51:14.340 --> 01:51:19.410

Leslie Witten-Rood: two instances with the pandemic now we've gone from paper patient care reports.

01:51:19.740 --> 01:51:27.420

Leslie Witten-Rood: Have maybe a page and a half of care till they're transferred to a hospital or different environment or, at least from our care.

01:51:27.720 --> 01:51:36.030

Leslie Witten-Rood: To treating patients up to 30 days and some of the facilities and some of our paper PC ours are over 200 pages now.

01:51:36.510 --> 01:51:44.460

Leslie Witten-Rood: So with meeting the need one of our things that we're looking at right now and we've just graciously received through a trailer bill.

01:51:44.790 --> 01:51:56.040

Leslie Witten-Rood: And some general funds is to expand what we're doing with our data be able to expand our systems capabilities and be able to share that with our stakeholders.

01:51:56.250 --> 01:52:09.570

Leslie Witten-Rood: Our state and our federal partners in real time, so our hopes for this is to be able to establish a quasi PCR slash ehr system where we're able to search the patient's record.

01:52:09.810 --> 01:52:21.930

Leslie Witten-Rood: we're able to document the patient's care we're also able to act other systems, so when we're discharging that patient from one of our alternate care facilities, we can connect them with other.

01:52:22.290 --> 01:52:41.460

Leslie Witten-Rood: services and social determinants of care and share this data and have it documented safer, which is our daily use, because for him set everything's an emergency with us and everything starts with the first responder and first point of care we've made advances with safer.

01:52:42.480 --> 01:52:51.840

Leslie Witten-Rood: Also, just ending September 30 with some high temp funding we've been able to expand it from four counties in California.

01:52:52.170 --> 01:53:00.840

Leslie Witten-Rood: To I believe will end up with about 26 counties, we had hoped, with 29 but the impacts of the pandemic has reduced out a little bit.

01:53:01.770 --> 01:53:12.780

Leslie Witten-Rood: The vision of this is the first responder responds in the field to the patient's home or wherever they're at the paramedic is able to.

01:53:13.380 --> 01:53:25.230

Leslie Witten-Rood: search the patient record it pulls back and renders care we're able to have it pre populates using some software data that's a federal requirement but we've also.

01:53:25.470 --> 01:53:32.940

Leslie Witten-Rood: Put in there other elements for core measures so that we're able to look at collecting additional data on that patient.

01:53:33.150 --> 01:53:44.190

Leslie Witten-Rood: As well as looking at the core measures of what we're doing in emergency response and efficiency of patient care we're then able to transfer that information.

01:53:44.460 --> 01:53:54.480

Leslie Witten-Rood: To the receiving hospital, it also helps us coordinate with receiving hospitals in the field, the appropriate place so, for instance, if we have a patient.

01:53:54.750 --> 01:54:01.560

Leslie Witten-Rood: They might be able to go to an alternate destination to receive care at a stroke stem Center if that's what.

01:54:02.070 --> 01:54:16.530

Leslie Witten-Rood: The primary impression of the paramedic is once that information is transferred upon arrival which we've seen that also a lot of efficiencies, not just in cost savings of the hospital but also being able to redirect.

01:54:17.040 --> 01:54:28.500

Leslie Witten-Rood: nurses, which we have a shorter have to patient care versus having to re enter information from a paper PCR from emergency services that's brought that patient in.

01:54:29.070 --> 01:54:38.370

Leslie Witten-Rood: Additionally, the goal of this was reconcile that's one of the key components and I think one of the best things we can provide to others.

01:54:38.640 --> 01:54:50.070

Leslie Witten-Rood: And that's for when the patient is admitted discharge are transferred, we have that information go back to the continuity of care document and documented through the H I o

01:54:50.310 --> 01:54:55.470

Leslie Witten-Rood: From the H I O that information is shared within the county to our local Ms agencies.

01:54:55.680 --> 01:55:10.440

Leslie Witten-Rood: It goes back to the SMS provider as well, and we have the opportunity to also share that with our other partners as well the outcomes of the patient or other needs they have so that's right now we're we're looking building and expanding.

01:55:11.160 --> 01:55:22.440

Leslie Witten-Rood: we're also looking at adding connections to special registries such as immunization registries so we're able to share with all the partners with vaccines if they receive.

01:55:22.470 --> 01:55:26.970

Leslie Witten-Rood: covert vaccines flu immunizations as well as tetanus shots.

01:55:27.210 --> 01:55:39.600

Leslie Witten-Rood: there's unlimited abilities, with the difference of special registries that we can connect to share and provide information so we're still doing baby steps, but our goal.

01:55:39.930 --> 01:55:52.710

Leslie Witten-Rood: is to be able to connect all of our data and have it in real time but also be able to be a partner and connect and share that data or the outcome of that patient for the whole care of the patient.

01:55:54.150 --> 01:55:55.230

Jonah Frohlich (he/him): Thank you that's.

01:55:56.790 --> 01:56:10.110

Jonah Frohlich (he/him): helpful to helpful to get all of that context, and I think what what we're seeing in a number of these posts, is that there are some opportunities to really expand access to services, I think we've also seen a lot of post post about.

01:56:10.890 --> 01:56:20.400

Jonah Frohlich (he/him): paul's letters for licensing treatment and the need to try to integrate and create some sort of establish that registry and connections to write.

01:56:21.030 --> 01:56:21.720

Jonah Frohlich (he/him): Things I just.

01:56:23.700 --> 01:56:25.530

Jonah Frohlich (he/him): responded to this and trying to keep my.

01:56:25.770 --> 01:56:40.710

Leslie Witten-Rood: Comments concise and consolidated, but one of the things that we did with the safer program that we just ended is, we were able to do a small pilot with physicians order for life, sustaining treatment using our safer model.

01:56:40.830 --> 01:56:45.480

Leslie Witten-Rood: to connect pulse forms as an alert so they'd be available in the field to.

01:56:45.480 --> 01:56:46.530

Jonah Frohlich (he/him): The aromatics.

01:56:46.740 --> 01:56:48.570

Leslie Witten-Rood: And we actually have also been.

01:56:48.570 --> 01:56:54.210

Leslie Witten-Rood: given time to start working on a statewide pulse registry to expand that.

01:56:55.830 --> 01:57:00.480

Jonah Frohlich (he/him): Thank you Karen did you have one additional comment on this before I move on.

01:57:01.050 --> 01:57:03.480

Kiran Savage-Sangwan: Thank you, I do have a comment Thank you jonah and.

01:57:03.690 --> 01:57:13.440

Kiran Savage-Sangwan: So I want to sort of reiterate the points that have been made about the importance of having that consumer be central, and all of these scenarios and I think a couple things to add one is.

01:57:13.860 --> 01:57:18.270

Kiran Savage-Sangwan: You know it's not only about having the person be able to see their own record.

01:57:18.600 --> 01:57:26.880

Kiran Savage-Sangwan: But it's also important that the person be able to input information into it, so in your previous scenario you're talking about the child who is self managing their asthma.

01:57:27.270 --> 01:57:33.300

Kiran Savage-Sangwan: There should be a way that they can put information about how that's working into their record because that's going to be important for providers to know.

01:57:33.540 --> 01:57:41.280

Kiran Savage-Sangwan: I think in this, and some of the other scenarios it's also important to recognize that not everything that a provider puts in is accurate right, and so there has to be a way.

01:57:41.520 --> 01:57:46.770

Kiran Savage-Sangwan: that a patient can access their record and can correct their records, so that there is accurate information in there.

01:57:47.250 --> 01:57:53.520

Kiran Savage-Sangwan: I think, on the point that you had made on the last slide about demographic data collection, I also want to really highlight.

01:57:53.730 --> 01:57:58.320

Kiran Savage-Sangwan: You know in this scenario would have been really important that there be information that's accurate.

01:57:58.530 --> 01:58:10.590

Kiran Savage-Sangwan: In the link in the record about language and the patient's language, we have all sorts of issues where the provider isn't communicating with the patient in their primary language, and we have mistakes, some of which are great happen right.

01:58:11.610 --> 01:58:22.020

Kiran Savage-Sangwan: And I think that, on the collection of demographic data, I hope that at some point we actually talked about the barriers to collection because they're not all about technology right there also about.

01:58:22.740 --> 01:58:24.210

Kiran Savage-Sangwan: Their about privacy.

01:58:24.630 --> 01:58:34.470

Kiran Savage-Sangwan: All of those things come into play, and so I hope that that's somewhere in this and then the other thing i'm going to add one more thing, just because I haven't done called on any of the other scenarios.

01:58:34.650 --> 01:58:36.360

Jonah Frohlich (he/him): Is that.

01:58:36.390 --> 01:58:41.790

Kiran Savage-Sangwan: You know, for this and other scenarios, we also need to be thinking of the bi directional with the social services of the.

01:58:41.790 --> 01:58:51.450

Kiran Savage-Sangwan: Community based organizations, because in this one there's nothing about what's going to happen to this person after they're discharged from the hospital and who's going to pick that up and who's going to get that information.

01:58:51.660 --> 01:59:01.920

Kiran Savage-Sangwan: Both their medical care, but also, this is a person who's now been through a trauma they might have lost their house, so that information needs to be going to the right entity, who can help with that and that may not be a writer.

01:59:03.150 --> 01:59:16.680

Jonah Frohlich (he/him): got it Thank you excellent comment and to your point about data collection and I think there's a bi directional exchange, which makes different lens than making a number of comments, and also because wide agreement, but that needs to be well.

01:59:18.390 --> 01:59:29.400

Jonah Frohlich (he/him): defined here in these scenarios, so you mentioned various data collection, which you think is real, we need to define that as a real barrier here and add language to the list of others race.

01:59:30.330 --> 01:59:33.900

Jonah Frohlich (he/him): ethnicity, demographic and other information that needs to be collected here.

01:59:34.740 --> 01:59:42.930

Jonah Frohlich (he/him): Excellent, thank you for those comments we're going to turn to the fifth scenario Now this is supporting public health response in this scenario.

01:59:43.680 --> 01:59:53.220

Jonah Frohlich (he/him): 35 year old Asian American woman in Los Angeles works as a House cleaner lives in a multi generational setting with her family three generations.

01:59:53.880 --> 02:00:00.570

Jonah Frohlich (he/him): She begins to exhibit symptoms associated with the onset of code 19 she actually contacted primary care provider.

02:00:01.020 --> 02:00:07.080

Jonah Frohlich (he/him): director to a code 19 test site recommends yourself quarantine monitor conditions, she gets tested.

02:00:07.590 --> 02:00:19.920

Jonah Frohlich (he/him): restricts your activities section can what she needs to be apartment get food, etc, while waiting test results are conditioned declined with the worsening fever, she she's admitted to a hospital.

02:00:21.060 --> 02:00:29.940

Jonah Frohlich (he/him): The rapid test the hospital because she does have coven 19 she's kept in a temporary isolating waiting area where when she's waiting for an icu bet to be freed up because the the.

02:00:30.420 --> 02:00:48.900

Jonah Frohlich (he/him): hospital is as currently Max out maxed out on its capacity doesn't have an available bed when she stabilized that public health investigator contact her but it's been some time since since she's she's exhibited symptoms and it's difficult to trace all the potential contacts that she's.

02:00:50.160 --> 02:00:52.920

Jonah Frohlich (he/him): That she's experienced over the course of of her exposure.

02:00:54.150 --> 02:00:56.970

Jonah Frohlich (he/him): In terms of the barriers on the next slide.

02:00:58.770 --> 02:01:04.050

Jonah Frohlich (he/him): I think what we would note here and we would ask for some comments about other barriers here.

02:01:05.640 --> 02:01:09.990

Jonah Frohlich (he/him): We note that there's still many types of public health data that are being transmitted not.

02:01:10.440 --> 02:01:19.410

Jonah Frohlich (he/him): electronically in real time there's been a lot of improvements made in the last year and heroic efforts there's still some that are coming by on paper and facts.

02:01:20.100 --> 02:01:30.690

Jonah Frohlich (he/him): Not machine readable format, the system is that were set up already and care we're not established to deal with the scale of a global pandemic and again more investments have been made to.

02:01:31.230 --> 02:01:42.150

Jonah Frohlich (he/him): to bolster and reinforce those systems, but creating the kind of real time connectivity as many i'm sure carmela you can attest your hospitals, having to report on daily basis.

02:01:43.230 --> 02:01:53.190

Jonah Frohlich (he/him): capacity I see you pee pee ventilators etc difficult to do when you don't have an automated system again the anticipation of this kind of event.

02:01:53.670 --> 02:01:58.350

Jonah Frohlich (he/him): Nobody foresaw but it became you know it's clear that that having.

02:01:58.830 --> 02:02:04.920

Jonah Frohlich (he/him): Being able to create those electronic linkages both at the hospital and the various local and state public health agencies.

02:02:05.250 --> 02:02:14.250

Jonah Frohlich (he/him): is necessary in the future so that you've got real time information that can convey things like capacity to individuals to emergency responders and transport agencies.

02:02:14.850 --> 02:02:22.050

Jonah Frohlich (he/him): That are bringing on patients to a hospital or facility, and then there are there are additional complex rules around public health data.

02:02:22.440 --> 02:02:30.210

Jonah Frohlich (he/him): that we need to understand and we, we need to address in these cases, so that that information can be made that information can be made available to address.

02:02:30.810 --> 02:02:43.920

Jonah Frohlich (he/him): Not just the initial response but follow up for people who are isolated and who need care and services, this individual, for example, in many cases they might need they may have been on WIC or snap or other things that.

02:02:44.940 --> 02:02:56.880

Jonah Frohlich (he/him): That unless there's information that can be shared across agencies is not apparent to whoever is working with them that they might be eligible, and be able to access other services while they're isolating.

02:02:58.350 --> 02:03:09.720

Jonah Frohlich (he/him): I if Dana if you were here from the Department of public health, would really appreciate any comments that you might have about barriers and the scenario and then we'll open it up to other other comments here.

02:03:10.530 --> 02:03:11.880

Dana Moore: Absolutely I.

02:03:12.000 --> 02:03:18.180

Dana Moore: Good afternoon as well before and it's great to hear from all of our stakeholders throughout this process.

02:03:19.980 --> 02:03:39.090

Dana Moore: they're just some some food for thought, so you brought this up, that there are different laws and statutes that differently govern each type of program or type of data, how infectious disease data is different than how and maybe our Center.

02:03:39.090 --> 02:03:40.140

Andrew Bindman: role in.

02:03:40.320 --> 02:03:46.350

Dana Moore: felicity data is collected, which is different than vital records and vital statistics data.

02:03:47.400 --> 02:04:01.230

Dana Moore: You have some some inconsistencies and overlap From that perspective, but also thinking about the end users across different data systems and and day to day use.

02:04:01.710 --> 02:04:06.990

Dana Moore: versus emergency use and our systems, as you mentioned, with cow ready.

02:04:07.680 --> 02:04:19.890

Dana Moore: They were built for day to day, use and not the intention of you know, emergency preparedness and response and that's also when we think about our different counties and their capacities.

02:04:20.430 --> 02:04:29.820

Dana Moore: You know, some counties might have a very simple platform some counties might have very calm bucks problems because they got more money and preparedness and response.

02:04:31.140 --> 02:04:46.080

Dana Moore: or they just have more staffing resources or access to workforce when we think about pipelines, and you know how are we thinking about using that help break down some of these barriers and also thinking about.

02:04:47.340 --> 02:04:57.630

Dana Moore: Different data sets so there's different types of data collected so there's different data fields and and different data dictionaries.

02:04:58.380 --> 02:05:09.600

Dana Moore: And so, even though you might have you know something like gender there might be slight differences and how that's collected and so when you put it into a system, it just might.

02:05:10.200 --> 02:05:17.850

Dana Moore: appear different differently, and you can't immediately reconcile it but that's something that's important, so I think from.

02:05:18.420 --> 02:05:28.950

Dana Moore: Now, not just looking at barriers but there's a huge opportunity to come together to look at not just data standardization, but data normalization.

02:05:29.460 --> 02:05:46.560

Dana Moore: In addition to being able to catalog what are all the different platforms that are out there, I mean there's there's a huge list of different whole technological platforms, as well as the systems summer proprietary some are private some are public.

02:05:47.700 --> 02:05:54.660

Dana Moore: Some are meant to be interdependent and interact summer meant to be standalone, so I think it's a.

02:05:55.440 --> 02:06:02.880

Dana Moore: This is a really great launch pad to start this conversation that I know has been happening for years in different pockets and groups.

02:06:03.600 --> 02:06:09.510

Dana Moore: But I think this is really opening the gate to the path to allow us to really come together and talk about.

02:06:10.140 --> 02:06:17.970

Dana Moore: How are we going to start standardizing what we have and then, how do we think about that from a day to day business use.

02:06:18.750 --> 02:06:37.320

Dana Moore: that's not just a day to day business use, but can easily translate to response and potentially even provide sort of a syndrome IQ or real time surveillance that helps us bridge the data data response I in a faster way so that's sort of our perspective.

02:06:39.660 --> 02:06:41.580

Jonah Frohlich (he/him): Thank you Dana excellent.

02:06:42.600 --> 02:06:48.600

Jonah Frohlich (he/him): David you have your hand up, you have a comment on other barriers here things that we want to address.

02:06:50.070 --> 02:06:51.780

David Ford, CA Medical Assn.: yeah Thank you um.

02:06:52.860 --> 02:06:54.690

David Ford, CA Medical Assn.: i'll try to do this real quickly.

02:06:56.160 --> 02:07:02.220

David Ford, CA Medical Assn.: I feel like where where public health is concerned, we can solve a lot of our problems.

02:07:03.240 --> 02:07:15.450

David Ford, CA Medical Assn.: With a couple of actually pretty simple fixes one is there really should just be one interface for state data kind of where cta test and trying to go with with HIV gateway.

02:07:16.500 --> 02:07:24.570

David Ford, CA Medical Assn.: But we need to expand the HIV gateway to incorporate more sources of data So yes, care cow ready are important.

02:07:26.460 --> 02:07:38.370

David Ford, CA Medical Assn.: But also things like the carrier's database should be accessible through just one interface to the providers aren't providers or HIV aren't having to build multiple interfaces to interact with multiple states or.

02:07:39.480 --> 02:07:44.130

David Ford, CA Medical Assn.: Data The other thing I will notice we're at this point where the federal government.

02:07:44.730 --> 02:07:50.490

David Ford, CA Medical Assn.: referencing something I said earlier in the meeting federal government's very, very focused on modernizing public health data infrastructure.

02:07:51.420 --> 02:08:02.190

David Ford, CA Medical Assn.: And I think there's huge opportunities in funding, both in the cares act in the American rescue plan and what is being discussed right now in Congress.

02:08:02.760 --> 02:08:08.610

David Ford, CA Medical Assn.: For the state to actually go and have Uncle Sam foot the bill for a lot of what we might need to do here to really.

02:08:09.060 --> 02:08:22.650

David Ford, CA Medical Assn.: make this modernize the system so it's not only more easy to use, but also, as many have said in the chat box bi directional so that data providers aren't just sending data in, but they can also figure out, you know data coming out.

02:08:28.620 --> 02:08:36.300

Jonah Frohlich (he/him): Okay, thank you, thank you, David i'm in some really good comments in the chat to about some how this is being addressed or has been in you know and see.

02:08:36.720 --> 02:08:45.300

Jonah Frohlich (he/him): With a task force that I think we want to want to consider too and Claudia if you have a comment go ahead and then we'll move on to the last one.

02:08:46.560 --> 02:08:53.910

Claudia Williams: yeah Thank you so much um the scenario kind of alluded to this need to link clinical and public health data.

02:08:54.540 --> 02:09:08.370

Claudia Williams: And I would say today California has almost no ability to do that if you I mean it has the reporting requirements, but not really an ability to track what's happening over time longitudinally and one sort of.

02:09:09.390 --> 02:09:19.500

Claudia Williams: Normal thought would be to share a bunch of clinical data with public health, and I think that is probably not a good idea I don't think we want to have massive amounts of pH I.

02:09:19.860 --> 02:09:28.500

Claudia Williams: being shared with public health, so I think one rather big thought experiment is what is the way we could build an insight system that would allow.

02:09:28.860 --> 02:09:35.880

Claudia Williams: Public health and clinical data to be linked using intermediaries, a Chinese are one of them, but there might be others.

02:09:36.630 --> 02:09:46.050

Claudia Williams: That don't require massive amounts of PhD being shared with public health when it's not needed, so I think that's a huge opportunity CDC is building out a new.

02:09:46.650 --> 02:09:54.060

Claudia Williams: surveillance and modeling team that's looking at that same question FDA just asked us to share PhD with them, we said no.

02:09:54.390 --> 02:10:05.010

Claudia Williams: So I know this is a little bit more blue sky but it's a huge opportunity for the state, but I don't think we can use our traditional models that thinking about public health to address it thanks.

02:10:05.520 --> 02:10:05.730

Okay.

02:10:06.810 --> 02:10:18.690

Jonah Frohlich (he/him): Thank you, I sense we will get some different opinions on that I totally get the perspective, Claudia don't disagree or agree with you, necessarily I I think there, we certainly need to contemplate the.

02:10:19.950 --> 02:10:23.130

Jonah Frohlich (he/him): sort of like minimum necessary what's needed in order for exchange.

02:10:23.850 --> 02:10:32.010

Jonah Frohlich (he/him): So what what I would suggest is that we contemplate like what the but the barrier is and what's needed for public health, response and consider that.

02:10:32.490 --> 02:10:41.910

Jonah Frohlich (he/him): As we define what are the things that need to happen and what kind of policies, we might need to establish but I definitely appreciate your comments.

02:10:42.720 --> 02:10:51.870

Jonah Frohlich (he/him): We have about 10 minutes left for this for this last scenario we're going to move on to coordinating re entry health services and this scenario, we have.

02:10:52.380 --> 02:10:58.590

Jonah Frohlich (he/him): A 25 year old white male even a county jail and he prepares for his relief and transition back to the Community.

02:10:59.310 --> 02:11:06.480

Jonah Frohlich (he/him): Prior to incarceration he's diagnosed with hypertension and all depression upon this release he's provided with medication to dresses hypertension depression, but.

02:11:06.930 --> 02:11:17.400

Jonah Frohlich (he/him): lacks health coverage he's unable to schedule an appointment and get his hero health conditions and behavioral and physical health needs met prior to a doctor's appointment, he did you feel stressed paying goes to move.

02:11:18.780 --> 02:11:31.320

Jonah Frohlich (he/him): And while they're in the hospital, they will obtain medical records from the from a child, but they don't have access to medical history, diagnosis and treatment and what he's incarcerated so they don't have that information, while he was in the county jail.

02:11:32.970 --> 02:11:43.320

Jonah Frohlich (he/him): Upon release he was also contacts a county social worker to help them enroll and insurance and locate I needed social services, the social worker consults a directory of any based organization.

02:11:44.010 --> 02:11:47.700

Jonah Frohlich (he/him): For some to an organization that can help address it, housing, employment, transportation and food.

02:11:49.200 --> 02:11:56.730

Jonah Frohlich (he/him): The stress of his recent hospitalization exasperate with depression, the contact the primary care provider gets referred to a psychiatrist.

02:11:57.390 --> 02:12:11.700

Jonah Frohlich (he/him): primary care providers also connects to regional a child, but they do not have access to all the information during incarceration so there's critical information that that could be used, that would help informed decision making and treatment patterns.

02:12:12.990 --> 02:12:14.730

Jonah Frohlich (he/him): In terms of some of these barriers.

02:12:16.080 --> 02:12:18.030

Jonah Frohlich (he/him): We we want to note, first that.

02:12:19.980 --> 02:12:31.380

Jonah Frohlich (he/him): linkages between justice involves setting within Community setting don't exist in terms of care coordination that's part of what calcium is is intending to address and an ECM program for medical at least.

02:12:32.190 --> 02:12:36.810

Jonah Frohlich (he/him): it's not widespread and it's and it's it's going to be launched in the next year, so.

02:12:38.190 --> 02:12:45.660

Jonah Frohlich (he/him): In some sense settings correctional facilities don't have a certified ehr technology, sometimes they do sometimes they'll work with the county health department that does.

02:12:46.620 --> 02:12:58.170

Jonah Frohlich (he/him): But often they don't which prohibits or at least makes it difficult to share complete information about what happened clinically or from behavioral health specialist while the individual was incarcerated.

02:12:59.580 --> 02:13:08.940

Jonah Frohlich (he/him): There are again barriers are on data exchange there's still some barriers around behavioral health physical health sometimes but social alternative health data.

02:13:09.390 --> 02:13:20.190

Jonah Frohlich (he/him): They would support re entry into the Community, and then there are some legal issues around criminal data being governed by different set of federal state and privacy laws, I think, for the most part.

02:13:21.240 --> 02:13:30.960

Jonah Frohlich (he/him): Those can be overcome, just in terms of the ability to identify an individual and be able to link information but it's important to note that was those do exist in some contexts.

02:13:31.590 --> 02:13:47.340

Jonah Frohlich (he/him): i'd asked if Lisa is available from CDC are just to comment about the scenario and about other whether their specific barriers that we might need to identify here or this or this narrow general we'd really appreciate it and take comments for about the next six minutes.

02:13:48.870 --> 02:13:56.940

Lisa Heintz for Diana Toche: Yes, thank you, I just think it's essential and I know I see some of our other stakeholders and partners that are participating in this so of course thank everybody.

02:13:57.660 --> 02:14:07.950

Lisa Heintz for Diana Toche: it's just essential that our data innovations focus on the significantly underserved population just prior to and, at the time of rant rave we are working with the calcium initiative as well.

02:14:08.460 --> 02:14:26.070

Lisa Heintz for Diana Toche: With some of our estate partners and just need to stress that incarcerated individuals they have the significantly higher rates of diseases than the non incarcerated individuals and in our prison system we have 34 presidents and we have about 3000 patients that leave.

02:14:27.390 --> 02:14:38.460

Lisa Heintz for Diana Toche: Every month to all 58 counties generally and we have a robust behavior health mental health delivery system medical supports and substance use disorder treatment.

02:14:38.790 --> 02:14:47.790

Lisa Heintz for Diana Toche: Including medicated system treatment while they're incarcerated However, our patients do compensate within the first two weeks of release from prison.

02:14:48.120 --> 02:15:00.450

Lisa Heintz for Diana Toche: At extraordinary rates and so all the good work with that our partners in the present and some of our Community partners that come into the presence as well do, while our population isn't incarcerated.

02:15:01.230 --> 02:15:18.420

Lisa Heintz for Diana Toche: We just see a significant amount of the compensation, so I would just really support this initiative and hope that, prior to release we can link the participants to their appropriate county Community supports and also share the data and the information.

02:15:19.590 --> 02:15:24.930

Lisa Heintz for Diana Toche: I've heard all the right things today with 42 CFR being a concern standardized.

02:15:25.980 --> 02:15:33.600

Lisa Heintz for Diana Toche: Data sharing processes, so I would just hope that we can really focus and not not leave this population behind.

02:15:34.440 --> 02:15:49.800

Lisa Heintz for Diana Toche: They are kind of the ones that we see just continuously recycled through our criminal justice system as a whole, so it impacts, a lot of people that ERS and any of our specialty clinics and as well as our jails.

02:15:52.020 --> 02:16:02.280

Jonah Frohlich (he/him): Great Thank you, I think I think we should also, as you suggest in the legal policy here, we did know behavioral health, though it we recognize that there.

02:16:03.360 --> 02:16:13.920

Jonah Frohlich (he/him): it's it's fairly common amongst incarcerated population to have a behavioral health condition or substance use disorder, some of which is treated through mat or other therapies.

02:16:14.520 --> 02:16:22.410

Jonah Frohlich (he/him): In the jail, so we should or or the state prison or in the juvenile justice system, so we should note that, here in this person under Hernandez.

02:16:23.340 --> 02:16:33.480

Jonah Frohlich (he/him): initial comments we really should make sure that we're linking it to other and just reinforcing that it exists in this scenario, as well as others I really appreciate this spot.

02:16:35.640 --> 02:16:49.230

Jonah Frohlich (he/him): Also, just want to point out some of the comments Steve lane you continue to know in the comments from the public about the fire standards and this goes back to it to other discussions and comments that have been had about leveraging and and using.

02:16:49.770 --> 02:16:52.620

Jonah Frohlich (he/him): national standards and rules that with with.

02:16:53.730 --> 02:16:58.770

Jonah Frohlich (he/him): With the cures and interoperability rules that are have are coming into effect that.

02:16:59.880 --> 02:17:08.850

Jonah Frohlich (he/him): Adoption of those standards is something that that the State obviously really should get behind and try to reinforce and understand where there are.

02:17:09.360 --> 02:17:11.160

John Ohanian: gaps in capabilities certain.

02:17:11.160 --> 02:17:18.240

Jonah Frohlich (he/him): types of entities, a lot of Community based organizations don't have the capability to implement something like a fire API and.

02:17:18.810 --> 02:17:19.920

John Ohanian: The extent that we might.

02:17:20.730 --> 02:17:31.560

Jonah Frohlich (he/him): Create policies or programs, to enable that so that they can participate in bi directional exchange, I think, is really important, I mean it feels like it's something we need to really consider, as part of our recommendations in this advisory group.

02:17:33.000 --> 02:17:36.540

Jonah Frohlich (he/him): I think, unless there any other comments I may.

02:17:36.630 --> 02:17:37.320

Jonah Frohlich (he/him): This point.

02:17:38.280 --> 02:17:40.500

Jonah Frohlich (he/him): turn it over I don't see any other raised hand.

02:17:41.100 --> 02:17:42.270

Jonah Frohlich (he/him): may return over back to.

02:17:42.270 --> 02:17:47.010

Jonah Frohlich (he/him): john to go over the process for subcommittee around the.

02:17:49.230 --> 02:17:52.710

Jonah Frohlich (he/him): Data sharing agreement so john are you there and able to pick it up from here.

02:17:54.000 --> 02:18:06.090

John Ohanian: I am, thank you very much Thank you everyone out there for sharing the data sharing agreement statement of interest form with your networks.

02:18:06.570 --> 02:18:16.440

John Ohanian: We did receive an incredible response with well over 50 individuals voluntary insert from over 45 organizations from all across California.

02:18:17.010 --> 02:18:31.170

John Ohanian: And with that a wealth of really smart technical and legal subject matter experts are willing to roll up their sleeves and advise us cj jazz and our stakeholder advisory group in the development of a single data sharing agreement.

02:18:32.040 --> 02:18:42.690

John Ohanian: And a common set of policies and procedures, the data sharing agreement as we previously discussed and the Secretary reiterated will build upon national information exchange.

02:18:43.590 --> 02:19:01.830

John Ohanian: Among healthcare entities and government agencies in California, as I, as I mentioned earlier, where we just spoke yesterday with the rnc and we're working together with them to align any Federal and State data sharing laws policies frameworks like there's a calendar and TEPCO.

02:19:03.120 --> 02:19:05.880

John Ohanian: With that, if you can go to the next slide sorry at job.

02:19:07.560 --> 02:19:08.010

John Ohanian: And one.

02:19:09.510 --> 02:19:09.780

John Ohanian: That.

02:19:10.830 --> 02:19:20.760

John Ohanian: We are proposing asleep technical and legal experts as we mentioned for consideration will be sending that out over email in the next coming days, and we appreciate any.

02:19:20.820 --> 02:19:31.800

John Ohanian: comments that you have in the timetable that we're going to present we're really looking to keep this this group to a manageable group of 10 to 15 members and have identified those.

02:19:32.970 --> 02:19:37.200

John Ohanian: By mid October, so we can begin working in November.

02:19:38.430 --> 02:19:54.240

John Ohanian: They will be about seven times, between now and June in response to needs and things of that nature as it comes up like the stakeholder advisory group the subcommittee will not have decision making authority, but obviously will heavily advise our process here.

02:19:55.410 --> 02:20:01.020

John Ohanian: john can you pick them like for one second and then i'm going to do, you can hand it back to me just need to do one quick thing.

02:20:02.100 --> 02:20:05.400

Jonah Frohlich (he/him): Sure, I guess, I would, the one thing I would notice that.

02:20:06.540 --> 02:20:13.860

Jonah Frohlich (he/him): On the data sharing agreement is, if you refer to every 133 statute, this agreement isn't like.

02:20:14.100 --> 02:20:17.640

Jonah Frohlich (he/him): A calendar set in some respects this in one respect.

02:20:18.840 --> 02:20:20.790

Jonah Frohlich (he/him): The law requires that.

02:20:22.740 --> 02:20:24.570

Jonah Frohlich (he/him): Every provider organization as.

02:20:24.570 --> 02:20:25.770

Jonah Frohlich (he/him): specified in the law.

02:20:26.790 --> 02:20:29.400

Jonah Frohlich (he/him): Hospitals clinics and practices.

02:20:29.880 --> 02:20:44.190

Jonah Frohlich (he/him): And a variety of other actors are going to be required to sign this agreement we're talking about 10s of thousands of institutions in California will be required to sign it, if we consider that premise.

02:20:45.210 --> 02:20:54.420

Jonah Frohlich (he/him): Having a 30 page document that space, then legal ease with long list of terms and conditions just seems like it's not the right approach for what this agreement really needs to specify.

02:20:55.260 --> 02:21:04.860

Jonah Frohlich (he/him): And this is where we're going to need to the subcommittee to really weigh in on like what is this what is this day share agreement really need to say, and we also need to be very mindful of Tesco.

02:21:05.880 --> 02:21:12.660

Jonah Frohlich (he/him): Tesco two parts and one is the common agreement and what we need to be very mindful of is we don't want to replicate.

02:21:13.110 --> 02:21:21.210

Jonah Frohlich (he/him): We don't want to overrule we can't, we have to make sure that what we developed as part of the subcommittee is perfectly aligned to the extent.

02:21:21.750 --> 02:21:36.600

Jonah Frohlich (he/him): That we possibly can, with Tesco, and with the common agreement again a common agreement is a different different animal it's it's you know, overseen by the square project it's not meant necessarily for every individual provider organization California to sign.

02:21:37.170 --> 02:21:42.330

Jonah Frohlich (he/him): But we do need to line behind tech both the trust exchange framework and the common agreement.

02:21:43.110 --> 02:21:53.490

Jonah Frohlich (he/him): So when we're developing this data sharing agreement, we need to keep those things very much in mind, what can we do that's going to be meaningful for this data sharing agreement to be signed by thousands of institutions.

02:21:54.000 --> 02:22:01.530

Jonah Frohlich (he/him): And then subsequently for these organizations to to actively share data in real time, which is also part of the Statute, while also aligning.

02:22:02.130 --> 02:22:14.340

Jonah Frohlich (he/him): Behind and with Tesco, and the things like the cures act and interoperability rules that have been promulgated and will be in the future if I just wanted to provide that that background for this group.

02:22:15.840 --> 02:22:18.240

Jonah Frohlich (he/him): And before we move forward.

02:22:19.350 --> 02:22:19.830

Jonah Frohlich (he/him): john.

02:22:20.640 --> 02:22:21.180

Jonah Frohlich (he/him): Thank you.

02:22:22.920 --> 02:22:39.540

John Ohanian: Thank you very much for that jonah i'm I know that Secretary is having a little bit of technical issues, but he is on the phones bill, and I wanted to turn it over to him for some closing comments and then i'll close the meeting like okay yeah.

02:22:39.840 --> 02:22:51.420

Dr. Mark Ghaly: john thanks in jonah Thank you terrific facilitation of really engaged conversation by so many, I just want to thank participants for their comments, it was.

02:22:52.740 --> 02:23:02.130

Dr. Mark Ghaly: terrific to hear the conversation and the coalescence around the importance of the work, and even the divergence of views on on.

02:23:02.820 --> 02:23:15.180

Dr. Mark Ghaly: How how we get far this done some of this work, I think these are going to be important struggles for this group to continue when I it's hard to summarize the entirety of the conversation, but one of the.

02:23:16.290 --> 02:23:27.510

Dr. Mark Ghaly: topics that keeps coming to mind, and I think a number of you raised it, including mark and sondra early that one of the agencies core principles is to.

02:23:28.140 --> 02:23:37.020

Dr. Mark Ghaly: Put and keep the individuals Californians in the middle of all of our work and the opportunity here with.

02:23:37.680 --> 02:23:44.490

Dr. Mark Ghaly: Information data exchange think is really a critical one to advance that point.

02:23:45.210 --> 02:23:56.550

Dr. Mark Ghaly: That this isn't just about the service providers doing their work more seamlessly efficiently and better by really providing each California and opportunity to.

02:23:56.940 --> 02:24:06.450

Dr. Mark Ghaly: sort of drive the services and the connection of those services in a certain way that really empowers Californians to be in charge of.

02:24:07.140 --> 02:24:15.450

Dr. Mark Ghaly: components of their health and well being that we often aren't because the data and information is in knit together, I heard a lot about.

02:24:16.080 --> 02:24:26.760

Dr. Mark Ghaly: What we should do and how we need to roll up our sleeves and I think they were terrific suggestions about the scenarios and how they identified some important gaps, but that we have to elevate certain.

02:24:27.300 --> 02:24:33.240

Dr. Mark Ghaly: Things that are already working i'll be pushing our team to be thinking about how we highlight those.

02:24:34.050 --> 02:24:39.690

Dr. Mark Ghaly: Good except those experiences that have developed organically whether they're in the locally tie us or.

02:24:40.410 --> 02:24:48.030

Dr. Mark Ghaly: In projects like the whole person care pilots that we heard a little bit about today, I think there's a number of really terrific examples.

02:24:48.390 --> 02:24:57.690

Dr. Mark Ghaly: on how your efforts, whether it's an elevator or sacramento to Los Angeles have really come together to bring information in a powerful way to support.

02:24:58.230 --> 02:25:07.080

Dr. Mark Ghaly: The care and services for individuals, the work of and being aligned with the Federal direction inviting and engaging and aligning.

02:25:07.920 --> 02:25:18.780

Dr. Mark Ghaly: open seas work in this space and anticipating what's coming forward continues to be a theme that I hear raised up and we will certainly continue to be attentive.

02:25:19.980 --> 02:25:30.540

Dr. Mark Ghaly: You know, without pulling the specifics i'll just say that what I heard was the ongoing willingness to quote roll up the sleeves and do this work, I think that.

02:25:31.080 --> 02:25:40.680

Dr. Mark Ghaly: It is now time to actually get those sleeves rolled up dig in this this last piece on the subcommittee I think is a specific example of the work.

02:25:41.070 --> 02:25:54.780

Dr. Mark Ghaly: and get down to business tasks that we have to get on to now to meet that very important timeline that john shared early on, so with that john i'll turn it to you and just thank everybody for their engagement their thoughtful.

02:25:56.460 --> 02:26:04.200

Dr. Mark Ghaly: insights to how we get not not just get this work done, but how we get it done in a way that really represents that equity.

02:26:05.790 --> 02:26:09.330

Dr. Mark Ghaly: Quality access focus that I think many of us bring to the work.

02:26:11.010 --> 02:26:14.490

John Ohanian: Thank you so much Secretary, and we know that you have a very full plate.

02:26:15.570 --> 02:26:23.370

John Ohanian: Many plates, and the fact that you spent the time here with us today and and the last meeting fall along this process is really.

02:26:24.060 --> 02:26:30.600

John Ohanian: important to all of us, thank you for sharing the vision and I know we all feel motivated so let's get to work.

02:26:31.260 --> 02:26:38.520

John Ohanian: We will be hearing the notes from this meeting in the coming weeks, as well as our data subcommittee data sharing agreement subcommittee.

02:26:39.330 --> 02:26:46.560

John Ohanian: slate please give us additional comments documentation for our consideration, you can email jonah Kevin myself.

02:26:47.040 --> 02:27:01.320

John Ohanian: We will keep those and we will use those as well, our next meeting is November 10 at 10am followed by a pre holiday December 14 meeting, I want to thank you all again for joining and have a great rest of your day.

02:27:03.600 --> 02:27:03.840

Carmela Coyle: Thank.

02:27:04.260 --> 02:27:04.590

You.

02:27:07.650 --> 02:27:08.130

David Ford, CA Medical Assn.: Thank you.

02:27:10.500 --> 02:27:10.860  
Ashrith Amarnath: Thank you.