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

The following comments were made in the Zoom chat log by Stakeholder Advisory Group Members and the public during the October 7th virtual meeting:

10:06:59 From Jill DeGraff to Hosts and panelists:

    Hey Jonah, glad to see you.

10:10:14 From Bryan Johnson - DDS (CISO) to Everyone:

    Bryan Johnson - present for DDS (standing in for Jim Switzgable.

10:12:33 From Kevin McAvey to Everyone:

    CHHS Data Exchange Framework background material can always be found at our website: https://www.chhs.ca.gov/data-exchange-framework/

10:13:14 From Kevin McAvey to Everyone:

    To receive updates on the development of the Data Exchange Framework, email CDII@chhs.ca.gov.

10:13:37 From Kevin McAvey to Everyone:

    We will add you to our growing community. Thank you all for joining.

10:14:36 From Claudia Guzman to Hosts and panelists:

    Thank you Kevin!

10:17:18 From Le Ondra Clark Harvey to Everyone:

    Love Dr. Ghaly's honesty about current challenges and focus on building better models

10:20:19 From Kevin McAvey to Hosts and panelists:

    Stakeholder Advisory Group Members - please raise your hand if you have any comments (please no more than two minutes). We should have time for one more comment before opening to Public Comment.

10:22:03 From DeeAnne McCallin (CPCA) to Everyone:

    We presented Erica Murray. Thank you.

10:23:03 From Andrew Bindman to Hosts and panelists:

    I support idea of having ONC of coming to address this group so we can hear directly from them about what the federal standards will look like so we can act in a complimentary way.

10:23:16 From Cathy Senderling-McDonald to Everyone:

    Hearing from the national organization would be great. It sounds like there has been a lot of work done there and it would be really good to understand how what we are working towards can both inform, and be informed by, that national work.

10:23:31 From Liz Gibboney to Hosts and panelists:

I second David's suggestion. Thanks

10:23:54 From DeeAnne McCallin (CPCA) to Everyone:

Ditto, support and agree with David Ford's suggestion re ONC

10:23:56 From Kevin McAvey to Hosts and panelists:

Please also document your comments in the chat box throughout today's meeting. We will be reviewing all feedback. Thank you so much.

10:24:25 From Bill Barcellona to Everyone:

Excellent point by David Ford to invite the Office of the National Coordinator

10:25:57 From Le Ondra Clark Harvey to Everyone:

Agree w/current speaker. This is long overdue and I'm pleased that this is a priority for this Administration.

10:26:40 From Claudia Guzman to Hosts and panelists:

👏👏👏👏 Yes, thank you all including you Marty!

10:27:43 From Lisa Chan-Sawin/Transform Health to Everyone:

Agree with David Ford's comments on ONC - it may also be useful to look at the experiences of other states, like NY and CO who have gone through the journey of developing statewide and regional models (including connecting regional models into a state model)

10:28:06 From John Helvey | SacValley MedShare to Everyone:

who was that from Philips?

10:28:55 From Jeff Dillavou to Everyone:

Ben Stover

10:29:51 From Troy Kaji to Hosts and panelists:

At Contra Costa, since we have included WIC in our County Health EHR, we are able to communicate requests back and forth. Agree this is crucial for our prenatal patients, who often only have insurance during their pregnancy

10:31:02 From Lane, Steven MD MPH to Everyone:

The standards-based exchange of full DICOM diagnostic imaging files is soon to go live with the first participating imaging vendors utilizing the existing Carequality national interoperability framework. This technical standard, developed with RSNA, will allow federated exchange without the need to store copies of these large data files in a central repository.

10:32:39 From Lane, Steven MD MPH to Everyone:

An upcoming edition of the Journal of Digital Imaging will be largely dedicated to this work in Carequality

10:32:56 From Ali Modaressi to Everyone:

I affirm David Ford's comment on inviting ONC

10:35:55 From Bill Barcellona to Everyone:

Excellent identification of issues by Carmela Coyle. Couldn't agree more.

10:36:05 From DeeAnne McCallin (CPCA) to Everyone:

@Carmela Coyle et al. Great list but it sounds like 4 not 3: Collection, Exchange, Receiving, and Use. COVID vaccine immunization records are a key indicator of the value of the "Receiving" component

10:36:58 From Jennifer Inden (she/her), RCHC to Everyone:

Thank you @Carmela for acknowledging these challenges-receiving and use also involves EMR vendors (functionality and cost of these connections w/in the EMR).

10:38:17 From Lane, Steven MD MPH to Everyone:

ONC can represent the current and evolving state of nationwide health information exchange and the supporting standards and regulations. ONC, The Sequoia Project and Carequality are partnering in the development of the national Trusted Exchange Framework and Common Agreement (TEFCA), which will serve the needs of all Californians. In addition it would be helpful for the committee to hear from the leaders of the major national networks which are currently supporting exchange across our state, including eHealth Exchange, CommonWell and DirectTrust.

10:38:44 From John Helvey | SacValley MedShare to Everyone:

There is another need for wireless infrastructure for EMS Transport agencies in the rural parts of the state. This lack of wireless data access in rural CA significantly hinders the EMS personnel from having access to the HIE's and create workflow with receiving hospitals.

10:39:19 From Andrew Bindman to Hosts and panelists:

Was it a typo or intentional that quote on prior slide said "consent" rather than "content"? The statute I believe says content not consent.

10:40:42 From Kevin McAvey to Hosts and panelists:

Andrew, welcome and thanks for joining. Yes. The word in the brackets should read "content".

10:41:10 From John Ohanian to Hosts and panelists:

Please raise you hand if you'd like to follow Lori with any comments.

10:42:36 From Charles Bacchi to Everyone:

Thanks for putting together the calendar. Very helpful.

10:43:34 From Kevin McAvey to Everyone:

Thank you all for joining us for the second meeting of the CHHS Data Exchange Framework (DxF) Stakeholder Advisory Group. CHHS DxF background material can always be found at our website: https://www.chhs.ca.gov/data-exchange-framework/.

10:43:45 From Kevin McAvey to Everyone:

To receive updates on DxF development and join our community, please email CDII@chhs.ca.gov.

10:43:51 From Pavel Budilo to Everyone:

Lori, represented the concerns of the Regional HIEs well and I would add that HIE participants are not supportive of an HIE operated or dominated by a Payer

10:44:17 From Michael Marchant (UC Davis Health) to Hosts and panelists:
    role based access could accolade this issue
10:44:36 From Michael Marchant (UC Davis Health) to Hosts and panelists:
    *accomadate
10:46:49 From DeeAnne McCallin (CPCA) to Michael Marchant (UC Davis Health) and all panelists:
    @Michael Marchant, great technical suggestion, role based access
10:47:07 From Scott MacDonald to Everyone:
    I'd like to emphasize Dr Lane's comments.
10:47:43 From John Ohanian to Hosts and panelists:
    please keep your comments to under 2 minutes - thank you
10:47:55 From Scott MacDonald to Everyone:
    Current national networks are supporting robust exchange (though not universally) and California should harmonize with those infrastructures and efforts and standards.
10:48:19 From David Ford, CA Medical Assn. to Hosts and panelists:
    I support Dr. Lane's comments, above. Along with inviting the ONC, it might be good to bring in the Sequoia Project.
10:48:32 From DeeAnne McCallin (CPCA) to Everyone:
    @Michael Marchant, great technical suggestion, role based access
10:48:37 From Lisa Chan-Sawin/Transform Health to Everyone:
    can't agree with @Michelle Cabrera more - the definition of providers and who is included varies significantly when we are talking about BH and social determinants, and the use cases need to be based on what we are building for the future, not what have built in the past
10:48:59 From DeeAnne McCallin (CPCA) to Everyone:
    @Scott MacDonald, agree!
10:49:13 From tien@eff.org to Hosts and panelists:
    I'd just like to mention that over the pandemic, consumer and privacy advocates have been fairly confused about the legal regime over privacy and security for personal health data once it enters a public health agency, it's very confusing to consumers (esp. sharing with large business entities that use data in many ways that patients may not expect or know about
10:49:32 From Linnea Koopmans to Hosts and panelists:
    To my earlier question on subcommittees, I do think there would be benefit in developing additional subcommittees or at least dedicated sessions on specific topics with groups of technical experts. Good to know that CHHS is looking to the workgroup to identify where we believe those conversations are needed.
10:50:55 From Lane, Steven MD MPH to Everyone:

Great comments by Michelle Doty. The scenarios attempt to paint a very bleak picture of the current tremendously robust and mature state of standards-based data exchange at play today across our state. There are many opportunities to extend current exchange capabilities to additional stakeholders, to address new use cases, and to address last mile connectivity issues for small, rural and/or poorly-funded stakeholders. Let's urgently address these gaps with the resources at our disposal.

10:52:01 From Cathy Senderling-McDonald to Hosts and panelists:

Also so sorry just letting you know that I'm having some bandwidth issues as well, so I'm going to have to keep my camera off a good bit of the time. I'm here!

10:52:14 From Michael Marchant (UC Davis Health) to Hosts and panelists:

@steven lane - agreed - millions of exchanges happen in ÇA today on a monthly basis with our existing infrastructure

10:53:40 From Le Ondra Clark Harvey to Everyone:

Great comments- there is certainly a spectrum of access to EHR's with the majority of the behavioral health providers CBHA represents having an EHR. Good to focus on who doesn't and more importantly, why they don't have access and how systems and protocols can be created to ensure consistency across systems.

10:57:33 From Lane, Steven MD MPH to Everyone:

An EHR is not a requirement for providers to access the existing national exchange networks. Anyone who has the technical capabilities to use email and the Internet can inexpensively engage with health IT service providers to gain access to Direct Secure Messaging and Carequality query-based document exchange.

10:58:06 From Kristine Santoro to Everyone:

Thank you all for this group is doing! And thank you, Michelle, for your comment on behalf of behavioral health. I'm writing on behalf of Didi Hirsch Mental Health Services, one of the largest community mental health centers in Los Angles, and also the largest suicide prevention crisis line in California. We are taking the lead on behalf of the state, at DHCS's request, for the 988 implementation planning. This may already be part of your consideration, but I would like to encourage us to consider the crisis care continuum as part of this HIE to make processes as seamless as possible when callers and those in crisis are most in need. We take the majority of the Lifeline calls across California, and would find, for example, it helpful to see live-time what resources the callers are currently receiving so we can link them to the best services possible, or for example, to know which callers have already been hospitalized for suicide attempts (among other use cases). Thanks for your consideration!

10:59:19 From Lisa Chan-Sawin/Transform Health to Everyone:

Beyond EHRs and HIE, will these scenarios consider other aspects of data exchange needed to support CalAIM? I'm thinking about the care management platforms, community resource referral databases, county systems, roster management, eligibility systems, alerting systems, etc. many that are being considered or being

implemented now. What we need for social care coordination is less about EHRs and more about care and service planning.

11:00:20 From Kevin McAvey to Everyone:

Pre-read materials may be found on our website: https://www.chhs.ca.gov/data-exchange-framework/

11:00:53 From Lisa Chan-Sawin/Transform Health to Everyone:

@Kevin - thanks for sharing the materials

11:02:47 From Lane, Steven MD MPH to Everyone:

If we could leverage state resources to build and incentivize the population and use of a statewide provider directory this would advance multi-stakeholder interoperability tremendously, to the benefit of all parties. A comprehensive up-to-date listing of clinical and social service providers, their contact information, technical capabilities and use case-specific communication preferences would support a multitude of value added services, including attribution of patients to providers and payers, care team management, record location services, potentially subscription-based alert management, care coordination, transitions of care, etc.. Such a directory would also allow us to identify those stakeholders lacking robust connectivity so that gaps can be closed.

11:02:52 From Michelle Doty Cabrera to Everyone:

Don't mean to overemphasize the positives, but really felt that the BH scenario was overly primary care centric in ways that don't line up with our experience of engagement with primary care. Would be great if BH plans and providers could be more engaged in offering up what we want/need out of these efforts - based on what our perception of challenges are. Happy to take that offline as offered.

11:03:27 From Scott MacDonald to Everyone:

Lisa- EHRs are increasingly able to capture social influencers of health, and link patients to community resources. This forum might really improve collaboration and communication possibilities!

11:04:18 From Claudia Guzman to Everyone:

That GI scenario is exactly one of my issues!

11:04:56 From Lori Hack to Hosts and panelists:

For Scenario 1 the specialists have an EHR but don't know how to get the CCD from the PCP to them. They may not be part of an HIE. Also, the data is being uploaded to the MSO for authorization/referral. After that it is faxed 99% of the time.

11:05:19 From Andrew Bindman to Hosts and panelists:

I am unclear in these scenarios whether the depiction of HIE entity is meant to denote a single entity or a capability for different hubs of information to interact together. I am trying to understand whether the assumption is a single entity which doesn't feel like it should be a given.

11:05:54 From Zhen Lin to Hosts and panelists:

Zoom settings question- ok to leave users to decide if to turn on captions? (So they don't block a big trunk of view on smaller devices) Thanks!

11:06:15 From Lori Hack to Hosts and panelists:

@andrewbindman, in tiny print it says that the HIE is a variety of solutions

11:07:06 From DeeAnne McCallin (CPCA) to Everyone:

re "Challenges with patient and provider identity matching". Provider Directory (falls under Cures Act Interoperabilty rule I believe) and a unique patient identifier used throughout the continuum sure would be nice.

11:07:18 From Jonah Frohlich (he/him) to Everyone:

@Michelle - thank you and we greatly appreciate and welcome input to the relevant scenario to make it more reflective and to better articulate the challenges and barriers that exist between behavioral, physical and social service providers and agencies.

11:07:22 From Michael Marchant (UC Davis Health) to Everyone:

EHR Incentive program and RHIOs did do that education in the programs early years

11:07:58 From Amanda McAllister-Wallner to Everyone:

You mentioned one of the challenges to overcome is the patient being able manage their medications and any potential interactions. However, I don't see consumer access to their own records anywhere in the mapped scenario. I think we need to answer how consumers interact with their records and the data that is being recorded/shared about their health.

11:08:04 From Lisa Chan-Sawin/Transform Health to Everyone:

@Scott MacDonald - thanks for sharing and that's great to hear. That's great for clinical providers and could certainly improve workflows. One consideration I have though is for the non-clinical providers engaging with health plans and clinical providers to address SDOH and the data exchange between these non-clinical providers with health care providers. Those CBO type providers don't usually use EHRs (think housing providers or meals on wheels); many are on paper or use case management software. The linkage and connection of that data in appropriate ways to broader clinical data sets and vice versa has been something we've been working on in our WPC pilot. That's where some of the rubber hits the roads with small local CBOs providing what we consider Community Supports (ILOS) services, and is an important aspect.

11:08:05 From Cathy Senderling-McDonald to Zhen Lin and all panelists:

Hi Zhen, in the lower right hand corner of the menu on the bottom of your screen, there should be a "CC" symbol - click on that, and you can turn off your closed captioning.

11:08:11 From Lori Hack to Hosts and panelists:

Absolutely David!

11:08:53 From Bill Barcellona to Everyone:

Fragmented adoption of EHRs by small practice providers is an impediment. For example, IEHP discovered that their physician network utilized over 400 separate EHRs. Organizing providers around a smaller number of EHR systems that are maintained by a sponsoring organization, like a medical group, health plan,, IPA,, clinic or hospital makes it far easier to service, train and maintain connectivity for the individual providers.

11:10:12 From Le Ondra Clark Harvey to Everyone:

Yes, agree with Bill, his comments speak to my earlier point about consistency across EHRs.

11:10:18 From Andrew Kiefer to Hosts and panelists:

couldn't agree more w/ Dr. Hernandez' comments.

11:10:23 From Lisa Chan-Sawin/Transform Health to Everyone:

@DeeAnne - your comment about a universal unique patient identifier would be dreamy and so useful!

11:11:16 From Scott MacDonald to Everyone:

@Lisa Chan-Sawin- good point, EHR vendors have some tools for external service providers to access EHR data, but could be a lot more robust; giving the ability to coordinate across community services would enable them to be more effective / efficient. Great point.

11:12:10 From Carmela Coyle to Bill Barcellona and all panelists:

To address Michelle's concern, perhaps the scenarios should be reframed as "use cases" - what we want to achieve (usually how these issues are framed) - rather than "failure scenarios"

11:12:39 From Cathy Senderling-McDonald to Everyone:

@Lisa Chan-Sawin, I'm also thinking about the services provided not through CBO but through government, particularly IHSS in this scenario.

11:14:11 From Lisa Chan-Sawin/Transform Health to Everyone:

Yes! and care planning across various complex scenarios is key. In our WPC pilot, we built into our cloud based shared care planning platform separate portions for our housing providers, the CHWs doing field based work, and our FQHCs so they can document the clinical, social services and housing care plans, which each are distinct

11:14:20 From David Ford, CA Medical Assn. to Hosts and panelists:

I'm documenting my request for a working group on provider technical assistance here in the chat box. I would add, of course, that CMA would love to participate.

11:14:49 From Kevin McAvey to Hosts and panelists:

Please record your feedback here - suggested additions, additional considerations, etc - all comments welcome and appreciated as we identify the cross-cutting issues we aim to address.

11:14:55 From Bill Barcellona to Everyone:

A key barrier to care coordination that impacts patients in a post-discharge setting is the lack of connectivity between the discharging hospital and the patient's primary care provider. Transmittal of the discharge plan in near-real time to the PCP can GREATLY decrease avoidable readmissions. Putting the discharge plan into the hands of the PCP allows for medication reconciliation, warm handoffs, and avoidance of complications.

11:15:07 From DeeAnne McCallin (CPCA) to Everyone:

agree and support David Ford's request for a TA Work Group

11:15:24 From Melissa Cannon to Everyone:

Seconding Lisa Chan-Sawin's comment. The reality is that for the majority of Californians with acute and chronic health care needs there will be a need to connect with non-traditional providers of care, including those who help address SDOH. In this specific scenario for example there might be a benefit in incorporating meals on wheels providers or medically tailored meal providers as actors. In which case, another key challenge is worth calling out: the fact that those entities are treated differently under California's COMIA privacy laws compared to health providers and that federal laws related to those programs (e.g., older americans act) will complicate the exchange of information exchange back to the health provider.

11:15:56 From tien@eff.org to Hosts and panelists:

As we see the role of anti-vaccine or vaccine hesitancy in influencing US health — is the group looking at misinformation on health, or education for patients/workers?

11:16:32 From Amanda McAllister-Wallner to Everyone:

Want to support the comments of Mark and Sandra around individuals having that direct access to their records. It's crucial that we put consumers at the heart of how we design the data systems. How will consumers access this data, both to update/provide info, and to get information that this crucial for their managing their health.

11:17:06 From Andrew Kiefer to Hosts and panelists:

Agree w/ Amanda's point seconding Mark and Dr. Hernandez.

11:17:26 From Kiran Savage-Sangwan to Hosts and panelists:

My comment echoes Mark. The consumer is included in this scenario (and I think all the scenarios) as only a recipient of treatment, not as an active participant in their own health. In scenario 1, the individual cannot recall her treatment plan/medications but we should be talking about how to overcome the barrier to her being able to access her own medical information. Also, to the earlier points about data collection, there should be scenario to address consumer concerns about data collection and how those can be alleviated in order to have robust inputs (including privacy, consumer-inputted data, language access). Scenario 3 talks about a child who has been self-managing their asthma - can we talk about how the child/family can contribute information about this? Thanks.

11:17:31 From Cathy Senderling-McDonald to Everyone:

The first scenario got me thinking about how to think about the work of this group within the broader context of our existing systems, structures, and plans. For example, the state recently submitted its HCBS spending plan to the federal government. Home and Community Based Services are likely needed here. This could include In Home Supportive Services which are coordinated through county human services agencies and public authorities. However, neither HCBS (in general) nor IHSS (specifically) are mentioned in this scenario - or, I would note, the document as a whole. I'm happy to help think through this issue and how it could fit into the scenarios, and therefore be included in the discussion.

11:18:39 From Lane, Steven MD MPH to Everyone:

Accessing longitudinal data for individuals and populations does NOT require the assembly of a centralized hackable longitudinal record, which may contain old, incomplete or erroneous data. Evolving standards-based tools allow a user in need to access the latest data in real time when and where it is needed.

11:18:39 From Lisa Chan-Sawin/Transform Health to Everyone:

@Cathy Senderling - totally agree. the counties have oversight of so many critical programs for coordination when we are talking about stabilization of patients with complex needs that must be coordinated with their health care. They also have an important role when it comes to integration and coordination across programs and services in a community. What we needed to build under WPC gave us a lens on what that looks like, and a key learning is the important of linking county and county data systems to support development of a delivery system that can really address SDOH. A good example is Alameda - they build a social HIE that allowed them to track COVID patients, including those in project roomkey. As a result, they did not have any deaths in their project roomkey program and were able to enroll eligible but not enrolled Roomkey patients into Medi-Cal from project roomkey in under 100 days. It's just highlights the importance of county's role

11:19:05 From David Ford, CA Medical Assn. to Hosts and panelists:

Re the conversation about individuals having access to their own records. This underscores the need to follow the federal context. Under the 21st Century Cures Act final rule and the Patient Access and Interoperability Final Rule, patients have an absolute right to all of the data that providers have on them (within the bounds of HIPAA and State Law). But the rules are new, and patients may not know their rights.

11:19:08 From Dan Chavez to Everyone:

Identity matching and consent management are also barriers in Scenario 2

11:20:13 From DeeAnne McCallin (CPCA) to Everyone:

Re "Not all providers with CEHRT are connected to an HIO", per Dr. Lane's earlier comment, there are current technical approaches to use that exist and are safe

exchange that are not restricted to having to be connected to an HIO (organization) that does HIE (exchange)

11:20:20 From Heather Readhead, MD to Everyone:

There are states that already have universal unique patient identifiers via an Master Patient Index (MPI) that ensures patient privacy and data accuracy. Utah provides a particularly good example. The State of Indiana and Indiana University/Regenstrief Institute (https://www.regenstrief.org/) has now 40-50 years of doing health information exchange, provides open source code for critical tools, and they used to do a lot of helpful teaching on this topic at the CDC Informatics Conference. CA can learn a lot from other states!

11:20:28 From Cathy Senderling-McDonald to Everyone:

@bill barcellona, knowing that most in-patient systems have (likely overworked) discharge planning staff, thinking about the ways in which they access information and services now, and what could be possible, would be a potentially important and helpful part of our discussion.

11:20:31 From Michael Marchant (UC Davis Health) to Everyone:

adding a patient consent model that allows them to be aware of and consent to those non-HIPAA entities could help alleviate some concerns around improper sharing

11:21:12 From Hector Ramirez (they/them) to Everyone:

Maybe eliminating ways in which data contribute to stigma could facilitate data exchanges which can ultimately increase positive health outcomes for all people. Particularly people with disabilities, BIPOC, LGBTQIA2S+, and in communities in extreme poverty.

11:21:23 From DeeAnne McCallin (CPCA) to Everyone:

@ Dr. Readhead, great info from Utah and Indiana! thank you

11:21:52 From Claudia Williams to Everyone:

I agree Michael that consent to share with CBOs is a good route. Also OCR has clarified that sharing data with CBOs, to support patient care coordination, does not necessarily require consent

11:22:54 From Bill Barcellona to Everyone:

Agree with Dr. Readhead on need for master patient index. We also need an accurate provider registry in California as well. People can't find the doctors in their networks.

11:23:05 From Mark Savage to Everyone:

John and Jonah asked about resources. I'm happy to share a range of resources on integrating social determinants of care. I'm both policy lead for the Gravity Project, building standardized terminology and exchange for SDOH data, and also sit on the ONC's USCDI Task Force, which recommended and the National Coordinator agreed that SDOH data elements be included in USCDI version 2 for nationwide interoperability. Also sexual orientation and gender identity, finally.

11:23:34 From Claudia Williams to Everyone:

Once HHS SAMSHA releases their final regulations for simpler consent (expected in October), California (or regions) have big opportunities to develop and deploy an electronic consent registry to support 42 CFR part two data sharing

11:23:55 From Lisa Chan-Sawin/Transform Health to Everyone:

@Mike Marchant - love the idea! that would also help with the issue of trust across provider types and across industry. I keep remembering our early convos with Medi-Cal plans about concerns of sharing data with housing providers who didn't have HIPAA compliant systems at the time

11:23:55 From DeeAnne McCallin (CPCA) to Everyone:

a starting place, NPPES: Add Digital Contact Information, https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2021-10-07-mlnc#_Toc84424561

11:23:56 From Carmela Coyle to Bill Barcellona and all panelists:

Would like to ask staff to reconsider the flow charts and labeling for each of the scenarios. Nearly all of the scenarios include a "Data Exchange Entity." This assumes an entity - a physical place - into which data is deposited and retrieved. That is one of other models for exchange and we should not assume that is implicit in each scenario. A data exchange entity is not necessarily consistent with national standards.

11:24:16 From Mary-Sara Jones (AWS, HHS) to Everyone:

It is not essential that all organizations adopt the same standards. What matters is making sure the data can be understood. Without standards that is more complicated - but it is possible. Need to meet the organizations where they are today.

11:24:35 From Kevin McAvey to Everyone:

Thank you all for the terrific comments. Please feel free to echo prior comments or offer your support for statements/suggestions so we can continue to get a sense of consensus from our diverse AG.

11:24:55 From DeeAnne McCallin (CPCA) to Hosts and panelists:

Agree with Carmela Coyle re labeling

11:25:01 From Andrew Bindman to Hosts and panelists:

Agree with Carmela and what I was trying to call out in all of the scenarios.

11:25:53 From Claudia Williams to Everyone:

Would be great to have a scenario around ECM providers and what they need to do to create, manage, update and share a shared care plan

11:25:56 From David Lindeman to Everyone:

Support Williams point about creating a platform that will flex to include data from emerging social service technologies and need to include social determinants of health data

11:25:59 From Melissa Cannon to Everyone:

It would be helpful to integrate into this scenario the challenges associated with the resource and referral networks popping up throughout California. CBOs addressing food insecurity are increasingly being asked to interact with a multitude of resource and referral platforms (e.g., UniteUs, OneDegree). But those platforms aren't interoperable with one another. Its burdensome for CBOs to have to log in and out of multiple platforms that don't communicate.

11:26:08 From Erica Murray to Everyone:

Agree with Carmela re the Data Entity

11:26:41 From Hector Ramirez (they/them) to Everyone:

The overreaching concern with "consent" is the lack of control of our data, the way it can be weaponize against us, and the way data contributes to stigma in the places in which we use it and when it comes out into the public space.

11:26:59 From ana to Hosts and panelists:

Really good conversation on scenario 2. How do we do data integration for true service coordination including with CBOs who are providing critical social programs.

11:27:58 From Bill Barcellona to Everyone:

I agree with Claudia Williams' request for an ECM provider needs scenario. It's a great concept, but very difficult to execute given the several barriers under discussion.

11:29:04 From Cathy Senderling-McDonald to Everyone:

As I represent agencies with robust existing eligibility and data systems that primarily focus on the social services end of the equation, I would agree with Carmela's comment as well that we not presuppose the outcome of the workgroup on how data may be accessed, utilized and housed.

11:29:56 From jessica ross to Hosts and panelists:

Short-doyle billing rules in California for Specialty Mental Health severely limit which EHRs BH can use to bill the state. It CA aligned their Specialty mental health billing with Federal Medicaid billing used in almost all other states, this would expand SMH groups ability to choose EHRs that are already highly interoperable, as opposed to niche SMH EHRs that focus on CA Short-dolye billing but have extremely limited interoperability and other capabilities, including the agile response time when faced with new state or federal regulations.

11:30:06 From Claudia Williams to Everyone:

+100% agree with @ali on need to examine blockers to sharing behavioral health data. Many times it is a business or cultural blocker, not a technical or legal one

11:30:22 From Lisa Chan-Sawin/Transform Health to Everyone:

@Melissa Cannon - there was a social IT company that I spoke to who was interested in solving that specific issue for CBOs. I agree it is burdensome the many different referral databases. Having a meta database that pushes info out when CBOs update their info would be helpful

11:30:25 From Heather Readhead, MD to Everyone:

RE: concern about data standards. ONC has done so much work in this area and has created the USCDI: US Core Data for Interoperability. For public health, we will likely need to align our systems to be able to exchange these standardized data elements - simply leverage that work that has already been done. After all, most of our data does currently come from health care delivery. However, for this time when public health (and other organizations) do NOT have systems that can exchange the USCDI elements, my understanding is that an HIN or an HIE can provide a "flat file" (this Excel spreadsheet) or report of data on an individual or a population of patients - identified or de-identified, as is appropriate.

11:30:41 From Liz Gibboney to Hosts and panelists:

Health plans are missing as an "actor" in scenario 2 (and a few other scenarios) in that we have claims and encounter data, but also Initial Health Assessment and Case Management notes collected by our own staff, and will eventually have more social determinants data under CalAIM/ECM. We also can't forget the pharmacy data that will be managed by the state (rather than plans) after 1/1/22 under MediCal Rx.

11:30:50 From John Helvey | SacValley MedShare to Everyone:

Thank you Ali. Legal creates as many if not more barriers for us to connect and share data.

11:30:57 From Carmela Coyle to Bill Barcellona and all panelists:

Would ask the Advisory Group and staff to consider discussion of four subcommittees, each which addresses particularly technical content. We may benefit from engaging experts. They are:

1) Data Sharing
2) Privacy
3) Consistency with National Standards
4) Data Use Experiences, Barriers and Opportunities

11:31:04 From Andrew Kiefer to Hosts and panelists:

Agree with Liz's point on the plan role

11:32:05 From Janice O'Malley to Everyone:

Something that's largely missing from these scenarios that when serving individuals with complex health and social needs, there may be emergency services involvement– particularly if the fire department implements a community paramedicine or triage to alternate destination program. When a fire department responds to a 911 patient that is described here, whatever is disclosed during dispatch or contained in an electronic health record may likely include dispatch of a triage paramedic or community paramedic that may triage that patient to a mental health crisis facility.

11:32:11 From Claudia Williams to Everyone:

Agree with @Liz that we need a health plan actor for scenario two. And important to note that health plans cannot access national networks to query for clinical data for

care coordination. Only treatment queries require a response. Care coordination is an operations use case under HIPAA

11:34:36 From Claudia Williams to Everyone:

@Janice - good point. I believe that scenario is addressed under the emergency/SAFR example. SAFR allows emergency responders to query for patients' records, and forwards the summary from responders to EDs.

11:34:45 From Josh Morgan to Everyone:

This isn't, in my mind, true pop health, as it's still focused on an individual, rather than a population. It's a very legitimate scenario, of course, but I think there needs to be considerations on truly identifying the overall trends, gaps, etc. in a pop health way. More aggregate info. There's different sections of the privacy laws that allow for that kind of work, too, which is important to consider.

11:35:00 From Janice O'Malley to Everyone:

In many of the scenarios listed, a 911 call may be involved and reviewing what data can be made available in the field to inform care and transport is important to getting the services the patient is in most need of. It would be important to get the perspective of Community Paramedics/those working in emergency response on the data that is needed to support the sharing that critical information.

11:36:05 From Sandra Hernandez to Josh Morgan and all panelists:

Agree with Josh this isn't really a true pop health scenario

11:36:43 From Zhen Lin to Everyone:

Agree

11:36:44 From Bill Barcellona to Everyone:

Scenario 3: Most organized physician groups have population health systems that flag patients with conditions such as asthma. This scenario points out that the PCP needs to be informed of the hospital admit, and the discharge. Entities like Manifest Medex and Lanes enable this kind of data exchange to help prevent an avoidable readmission.

11:36:51 From Jennifer Inden (she/her), RCHC to Everyone:

@josh morgan-i agree. This isn't pophealth. This work is being done at FQHC's which are struggling with these scenarios

11:37:23 From Michael Marchant (UC Davis Health) to Everyone:

I've been working with SacMIH for a few years - EPCR technology has challenged that exchange process - Nemsis vs HL7 standard exchange and terminology as well as query based exchange have been impediments there as well

11:37:51 From Jennifer Inden (she/her), RCHC to Everyone:

How is this work aligning with other indicatives (CalAIM, Population Health Management CPCA/KP/CDPH)? Is anyone connecting the dots amongst all of these?

11:38:00 From DeeAnne McCallin (CPCA) to Everyone:

agree with Josh Morgan. Recently I have been seeing the use of "Pop Health" with the focus on individuals not that which Pop Health has historically meant.
11:38:02 From Claudia Williams to Everyone:

Agree @bill that many organizations have population health systems. But they are often missing the clinical and claims data they need to make this system effective.
11:39:10 From Jennifer Inden (she/her), RCHC to Everyone:

@claudia-i think the focus would be on ADT alerts/feed. Claim data is too late.
11:40:12 From DeeAnne McCallin (CPCA) to Everyone:

Good point Jennifer Inden, claim data is too late
11:40:23 From Josh Morgan to Everyone:

I also really like the way KP and others have framed these ideas in terms of Community and Social Health rather than Pop Health. The latter has gotten some odd definitions, especially when focused too much on healthcare. There's definite agreement across all of us there's a clear importance of non-health insights in this.
11:40:24 From Claudia Williams to Everyone:

@jennifer - I think it depends on the pop health use case. If the question is identifying which patients are high risk and need a third covid booster, ADTs wont help. The needed data will be CCDAs, IZ data, lab data, etc
11:40:33 From Heather Readhead, MD to Everyone:

PROSPECTIVE POP HEALTH EXAMPLE: A local public health dept example might have been good here, with health info exchange allowing the health dept to see multiple COVID cases (all tested at different labs) in a neighborhood or at a workplace or at a clinic or food distribution center or showers serving homeless - which then allows the public health nurse to go out an start an outbreak investigation and mitigation/containment efforts.
11:40:52 From Cathy Senderling-McDonald to Everyone:

@Jennifer Inden agree here is another area where we might wish to ensure we are discussing these scenarios in the context of other efforts going on.
11:41:09 From Josh Morgan to Everyone:

And to the discussion of risk stratification, that's key to pop health and value based care, as well as to others' comments here. That's the kind of scenario we need here in my opinion. FWIW, here's a paper I wrote on this topic: https://www.sas.com/content/dam/SAS/en_us/doc/solutionbrief/analytics-improve-community-health-109792.pdf
11:41:45 From Michael Marchant (UC Davis Health) to Everyone:

maybe more of a longitudinal record of activity and entity by person that provides a directory of how to electronically navigate and exchange with each individually with those engaged in providing services and needing information
11:41:46 From Lisa Chan-Sawin/Transform Health to Everyone:

Agree with all the comments re: pop health. I would expect a pop health/VBC model to engage and integrate all populations. The other challenge here is not all school based clinics are run like health clinics with EHRs and there are two school based health models in CA, one where the schools hire school nurses not affiliated with delivery systems and may not have the infrastructure to connect to this type of model

11:42:15 From Lane, Steven MD MPH to Everyone:

Each of these scenarios should consider bidirectional exchange. The school-based clinic should not only be able to share their data with other providers/stakeholders. That nurse should also be able to access current data, when appropriate, from payers, providers, public health, etc. AND be enabled with ssecure communications capabilities (e.g., Direct Secure Messaging) to be able to inform and coordinate care.

11:42:34 From Josh Morgan to Everyone:

Many folks have referenced WPC, which does provide some good foundations for this scenario. Here's a sample of work I did in San Bernardino County on this topic, including risk stratification across health and non-health:

https://www.sas.com/en_be/customers/san-bernardino-county-health.html

Riverside's work doing similar things, focused more on VBC is relevant:

https://www.sas.com/en_us/customers/riverside-county.html

It's also relevant to note that pop health and VBC are related, but not necessarily the same thing.

11:43:10 From DeeAnne McCallin (CPCA) to Everyone:

@Claudia Williams Probably only need IZ data and patient matching re completing COVID vx series, eligibility for third mRNA, eligibility for booster. Part of the earlier mention of "Receiving" the data back at the provider level. Which yes, can happen via an HIE. But can also happen with bi-directional functionality between IIS and provider

11:44:09 From Jim Sullivan   to Everyone:

Responding to Andrew Bindman's comments... could any existing public health IT network/infrastructure be leveraged by repurposing and expanding it's use? ie could schools/universities that may be connected to public health registries (immunization?) be further leveraged within this environment?.. understanding that the original purpose may not have been for data management beyond a narrow specific scope? This is an approach that is being studied in other states.

11:44:45 From Sandra Hernandez to Everyone:

Agree that health plans have a key role in CalAIM and thus are a critical actor in both collection and sharing of timely data

11:44:57 From Melissa Cannon to Everyone:

When it comes to population health, health care providers are increasingly partnering with non-traditional health providers to keep their patients healthy outside of health care visits. For example, some health plans have been conducting in-reach to members to inform them that they may be eligible for WIC and CalFresh. There are many issues with the ideal exchange of that information that would benefit from this group discussing under this population health scenario.

11:45:18 From Claudia Williams to Everyone:

@DeeAnne - DHCS is now providing incentives to health plans for their vaccination of high risk and homebound members. We are working with plans to identify these member but it requires all the data I mentioned: IZ data, CCDAs, lab data AND claims

11:46:42 From David Ford, CA Medical Assn. to Hosts and panelists:

One thing to consider re the role of the health plans - the federal Patient Access and Interoperability Rule only applies to federally-regulated plans (Medicaid, Medicare Advantage, and federally-facilitated exchanges) and only for patients covered by those plans. As California doesn't use the federal exchange, the effect of the rule in California is limited to MA and MCMC.

11:47:41 From Jonathon Feit to Everyone:

FYI -- Jonathon Feit here representing the California Fire Chiefs Assn.

11:47:46 From Lane, Steven MD MPH to Everyone:

The existing ONC Cures Final Rule (https://www.healthit.gov/curesrule/) requires that both Providers and Health Information Networks/Exchanges make electronic health information available to patients/individuals. Today this applies to the subset of data included in the USCDI Version 1 (https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi). In less than a year these Information Sharing "Actors" will be required to make available All Electronic Health Information, unless a specific limited exception applies.

11:47:48 From Amanda McAllister-Wallner to Hosts and panelists:

This scenario underscores the need for record availability and integration across health delivery systems. For instance, connecting school based clinics - or another provider that this young person might be using, a CBO-led hormone clinic. These are not necessarily connected to an EHR, but have crucial information about a patient's health.

11:47:55 From Andrew Kiefer to Hosts and panelists:

it's a requirement through Attachment 7 at Covered CA too.

11:47:56 From Amanda McAllister-Wallner to Hosts and panelists:

Sorry, previous scenario.

11:48:28 From David Ford, CA Medical Assn. to Hosts and panelists:

Re my previous comment -

MA = Medicare Advantage

MCMC = Medi-Cal Managed Care

11:49:10 From Lane, Steven MD MPH to Everyone:

HIEs could be penalized $1M / occurrence for blocking individuals' access to their own health information under the ONC rules. We do not need to re-legislate this. It is already federal law.

11:49:19 From Claudia Williams to Everyone:

@David I thought the "providing data through FHIR APIs" applied to Medicaid, Medicare and state exchange plans?

11:49:23 From DeeAnne McCallin (CPCA) to Everyone:

@Claudia. A sizeable task I'm sure. As each HP member should have a PCP (not always the case, I know), hopefully there is a tie into the PCP in the effort

11:49:45 From Jonathon Feit to Everyone:

Should we have a conversation about why PULSE and SAFR aren't being used?

11:50:19 From Heather Readhead, MD to Everyone:

To Steven Lane's comment above - bidirectional exchange for some public health uses cases is valuable for all. It would be much better our systems could "ping" the primary care/urgent care/ER or mental health provider that is caring for someone known to be TB or COVID exposed (which the patient may not know themselves). There was a great CDC-funded BEACON grant-funded project that spoke to this use case in New Orleans with complex care for HIV patients. There are also tragic tuberculosis cases in the US (where providers are not as familiar with TB care) that led to multi-drug resistant TB and poor outcomes for patients that could have been avoided if the public health TB physician specialist had been able to better follow and guide the care of the patient.

11:50:57 From DeeAnne McCallin (CPCA) to Hosts and panelists:

Do you share the chat log with the AG? Or would it be advised for us each to save it individually?

11:51:28 From David Ford, CA Medical Assn. to Hosts and panelists:

@Claudia From the CMS website:

The Interoperability and Patient Access final rule (CMS-9115-F) put patients first by giving them access to their health information when they need it most, and in a way they can best use it. This final rule focused on driving interoperability and patient access to health information by liberating patient data using CMS authority to regulate Medicare Advantage (MA), Medicaid, Children's Health Insurance Program (CHIP), and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs).

11:51:37 From David Ford, CA Medical Assn. to Hosts and panelists:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index#CMS-Interoperability-and-Patient-Access-Final-Rule

11:51:38 From Kevin McAvey to Hosts and panelists:

   @deeanne - Like with our last meeting, the complete chat log will be posted on our website

11:51:43 From Kevin McAvey to Hosts and panelists:

   great question

11:51:44 From Mark Savage to Everyone:

   Lifting up Stephen Lane's comments about bidirectional--even multi-directional--information flows. Individuals are often sharing, not just receiving, information, including PROs, PGHD, device data from remote monitoring. Referrals to community and social service providers are not uni-directional. Community and social service providers may actually have the initial, critical assessments that providers also need. Etc.

11:51:53 From Lane, Steven MD MPH to Everyone:

   SAFR has thus far been deployed only via regional HIE/HIOs with their limited geographic coverage. It is now being deployed based on FHIR-based exchange and will hopefully be leveraging the Carequality framework (working on this now). This will allow all providers with certified health information technology to be able to quickly implement SAFR.

11:52:18 From Lisa Chan-Sawin/Transform Health to Everyone:

   @Steven Lane - does the $1M penalty apply to consumers trying to access their records from providers? I don't know how many patients would know to go to an HIE....

11:52:31 From Andrew Bindman to Hosts and panelists:

   I agree with role of health plan as supporting care. In essence a health plan can use the information collected from across providers of different type to integrate a record helpful for an individual provider. What didn't work in the example is that there is not much in the way of useful information that the plan would have had in this case. The main information the health plan would have contributed to the school based clinic is the information on gender identity . The student seemed to have little prior experience with the plan so would have offered little to the school based clinic provider. A better scenario would be based on which there was an experience of care that the plan could have supplied to support a decision in real time for the nurse in the school based clinic. This would have included who the PCP was, assessment of diseases severity, what meds have been used, etc etc.

11:53:19 From Claudia Williams to Everyone:

   @steven - love that! The complexity and heavy lift is integrating with all the ambulance EPCRs. Would love to hear how that is or can be addressed.

11:53:53 From Lisa Chan-Sawin/Transform Health to Everyone:

   @Mark Savage - you are correct, and so much info comes up in the intake process when we are trying to determine program eligibility for patients. In our WPC pilot, we designed an intake process that included capturing this data and feeding it directly into a preliminary care plan for the patient. When they go in to see the provider,

the provider already has that initial information shared by the patient, including their care goals

11:54:38 From Lane, Steven MD MPH to Everyone:

"Health care providers are treated differently under the law. A health care provider who engages in information blocking may be subject to "appropriate disincentives," as set forth by the HHS Secretary. Regulations (not yet issued) are required to implement HHS' approach to these disincentives." - https://www.healthit.gov/buzz-blog/information-blocking/pssst-information-blocking-practices-your-days-are-numberedpass-it-on

11:54:38 From Melissa Cannon to Everyone:

Most federal nutrition programs do permit the exchange of a participants data, but only with an individuals' consent to share. There is an infrastructure gap to collect that consent and a data exchange barrier with exchanging that information with the individuals a participant authorizes to receive it.

11:55:30 From Heather Readhead, MD to Everyone:

To Jonathon Feit's comment above, can we talk about why POLST is not well understood by public health? Most of the time, local health departments were greatly hindered by lack of access to any information about cases without trying to speak to them on the phone. Why was POLST or POLST-COVID not used to help local health departments to get contact information and other demographic info for cases? Why was it not used to better understand the morbidity and mortality of COVID cases, particularly those in jail, shelter and workplace outbreaks?

11:56:18 From Jonathon Feit to Everyone:

@Heather -- California has no POLST registry that is field-accessible.

11:56:51 From Jonathon Feit to Everyone:

What Leslie is describing is theory, not actually happening.

11:57:09 From Jonathon Feit to Everyone:

Is the context here to talk about what's really happening, or are we dealing only in the ideal "theory" setting?

11:57:45 From Jonathon Feit to Everyone:

They didn't work.

11:57:47 From Jonathon Feit to Everyone:

@Leslie

11:57:58 From Jonathon Feit to Everyone:

Oh come on.

11:58:33 From Claudia Williams to Everyone:

Given similar names good to clarify that POLST and PULSE are different. PULSE is a way for patients' records to be queried in an emergency, like wildfires. POLST is the patients' advance directives

11:58:35 From Lane, Steven MD MPH to Everyone:

CHHS
California Health & Human Services Agency

CENTER FOR
DATA INSIGHTS
AND INNOVATION
CALIFORNIA HEALTH & HUMAN
SERVICES AGENCY

@Claudia - eso.com is building out SAFR on FHIR and connecting with Carequality.

11:58:56 From Jonathon Feit to Everyone:

@Steven that has never been deployed.

11:59:08 From Mary-Sara Jones (AWS, HHS) to Everyone:

@Kiran +1

11:59:09 From Claudia Williams to Everyone:

@steven Is it also addressing the EPCR data to ED data flow?

11:59:15 From Jonathon Feit to Everyone:

No.

11:59:18 From Jonathon Feit to Everyone:

@Claudia

11:59:24 From Lane, Steven MD MPH to Everyone:

Right. Still being built. It is the natural next step in the evolution of this critical connectivity.

11:59:34 From Cathy Senderling-McDonald to Everyone:

Hi all, as we've unfortunately had a lot of experience with wildfires and similar disasters in the past several years, county hhs is well-engaged in our local OES. there are other databases that we have access to that would potentially result in our county staff being a point of contact for rescuers so they would know that they have been evacuated. I'll reach out to Jonah's team to talk about some suggested refinements on this scenario as it relates to CalFresh receipt. The person doesn't lose their eligibility if they forget their EBT card, for example. The need would be for them to ensure they can access a new card, which can be done pretty quickly and CalOES as well as county OES includes social services (state and county depending on the level) for these communications to be clear.

11:59:40 From Lisa Chan-Sawin/Transform Health to Everyone:

+1 on Kiran's comments!

11:59:50 From Jonathon Feit to Everyone:

@Steven -- as you know, much in that workflow you modeled is already deployed inside your own hospitals.

12:00:09 From tien@eff.org to Hosts and panelists:

+1 to Kieran's comments on privacy and trust

12:00:10 From Janice O'Malley to Everyone:

Thank you, @Kiran. So important to identify issues with language accessibility in care and disparities in care.

12:00:22 From Jonathon Feit to Everyone:

@Sutter's POLST lead described the lack of EMS access as resulting in a "50% of value" in California.

12:00:36 From Jonathon Feit to Everyone:

(Thumbs up to Sutter Health) @Steven

12:00:47 From Cathy Senderling-McDonald to Everyone:

Sorry hit return too soon - in a case where someone had been evacuated and been completely missed by all of the possible points where he would have connected with the county social services department, or been connected via a hospital social worker/discharge planner, happy to think about those aspects together.

12:01:23 From Amanda McAllister-Wallner to Everyone:

+1 to Kiran's comments. Additionally around flagging trauma and potential needs within social services systems, to allow those care providers to get ahead of these issues and connect patients with care that they may not even know to ask for or know that they're eligible for.

12:01:26 From Liz Gibboney to Lane, Steven MD MPH and all panelists:

For Scenario 4, some other key and time-sensitive functions that health plans hold is to authorize emergency "overrides" of medication authorizations, to replace durable medical equipment that may be left at home in an emergency evacuation, etc…thanks

12:05:43 From Lane, Steven MD MPH to Everyone:

Lots of work being done nationally to modernized public health data systems: https://www.cdc.gov/surveillance/surveillance-data-strategies/data-IT-transformation.html.

12:06:12 From Lane, Steven MD MPH to Everyone:

Many specific suggestions came out of our ONC Taskforce on this topic: https://www.healthit.gov/sites/default/files/facas/2021-07-14_PHDS_TF_2021_Recommendations_Report_0.pdf

12:08:03 From Lori Hack to Everyone:

@Dana yes need to have capabilities to share with HIEs rapidly and in batch form the data already collected

12:08:15 From DeeAnne McCallin (CPCA) to Everyone:

COVID Vaccine approved providers are required to report to IIS (Immunization Information Systems- CAIR2, Healthy Futures, SDIR) within 24 hours. There should be a requirement of bidirectionality from IIS back to any electronic system talking to IIS of a recorded COVID vaccine. i.e. resident is a patient of health center and is a member of HealthPlan A. Resident received first dose at a mass vaccine site run by a county health dept, resident received second dose at CVS. Both the County and CVS had to report the doses to IIS. IIS should have to feed that data back to the health center (provider) and the HP.

12:08:49 From Lane, Steven MD MPH to Everyone:

New CMS rules incentivize hospitals to exchange data with public health using modern technical standards: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms

12:09:42 From drodda to Everyone:

Thank you for bringing up the Federal Gov and their role in this. They have a ton of data we should be using,

12:09:48 From Jonathon Feit to Everyone:

@DeeAnne -- I tested the system myself....my own data was not found by the state system. After I got two shots at the same CVS.

12:09:52 From Claudia Guzman to Everyone:

In regards to the current scenario, if the individual was nonverbal and had maybe slight other disabilities, a family member, parent, caretaker has to be allowed to be with the recipient for the communication and understanding the health history. Sometimes there are medical personal who would do unnecessary testing. My apologies but it has happened.

12:09:54 From Jonathon Feit to Everyone:

(Bummer)

12:10:40 From Cameron Kaiser to Hosts and panelists:

Completely disagree.

12:11:18 From Lane, Steven MD MPH to Everyone:

The current Electronic Case Reporting standard supports bidirectional exchange between providers and public health. https://www.cdc.gov/ecr/index.html; https://ecr.aimsplatform.org/

12:11:25 From David Ford, CA Medical Assn. to Hosts and panelists:

Re the Feds - I would point everyone to the American Rescue Plan (HR 1319), Section 2401

12:11:41 From David Ford, CA Medical Assn. to Hosts and panelists:

https://www.congress.gov/bill/117th-congress/house-bill/1319/text

12:12:34 From Claudia Williams to Everyone:

@cameron - are you disagreeing with my comments, or something else? Can you say more about your views?

12:12:44 From tien@eff.org to Hosts and panelists:

One of the big Qs is the protection of data in the hands of public health, e.g. the privacy and security rules for city and county public health departments, since the state IPA only governs state entities.

12:14:22 From Lane, Steven MD MPH to Everyone:

One of the many benefits of the new FHIR (https://www.healthit.gov/sites/default/files/2019-08/ONCFHIRFSWhatIsFHIR.pdf) interoperability standard is that it allows directed requests for and transmission of the Minimum Necessary data elements to meet the current need. No need to expose/share a longitudinal record or even a Continuity of Care Document (CCD) which may contain extraneous/unnecessary information and impact patient privacy.

12:18:14 From Jonathon Feit to Everyone:

Please be advised that FHIR, NFIRS, and NEMSIS are not naturally interoperable.

12:18:23 From Cathy Senderling-McDonald to Everyone:

@Jonah, there are a few things with the writeup on the re-entry scenario that aren't correct on how things would occur for this individual in their interaction with the county human services department. Happy to work with your team on this.

12:18:27 From Jonathon Feit to Everyone:

but are all relevant at the federal level.

12:18:37 From Mark Savage to Everyone:

Again, lift up adding a "Shared Care Planning/Coordination" scenario, with individual and family caregivers and community caregivers integrated, per my suggestions @ scenario 1.

12:19:22 From Lane, Steven MD MPH to Everyone:

Every modern cell phone (and certified EHR and payer data system) has the technical capabilities to exchange clinical data using FHIR APIs.

12:19:37 From Jonathon Feit to Everyone:

That's not EMS and Fire data.

12:19:54 From Jonah Frohlich (he/him) to Everyone:

Mark Savage: right! shared care plan should be elevated in the scenarios, including the need to establish process/standards for care plans and the sharing of them

12:19:56 From Claudia Williams to Everyone:

@Jonah @john thank you for your preparation and guidance to create a terrific conversation. Much ground covered

12:19:58 From Mark Savage to Everyone:

@Jonah, Gravity Project is working on reference implementation and smartphone apps for FHIR API connection in the community and with individuals, as a bridge for now and going forward.

12:20:00 From Jonathon Feit to Everyone:

doesn't matter what Apple does, EMS & Fire can't naturally use them

12:20:12 From Lisa Chan-Sawin/Transform Health to Everyone:

@Jonah, it would be good to hear more about the corrections HIE built under Clark Kelso, if that's still operational and can that be leveraged?

12:20:19 From Jonathon Feit to Everyone:

i'm working on a white paper about this as we speak, Steven -- I'll be sure to send a copy ot you.

12:20:23 From Jonathon Feit to Everyone:

*to

12:20:48 From Lane, Steven MD MPH to Everyone:

Thanks @JonathonFeit

12:20:51 From Cathy Senderling-McDonald to Everyone:

Appreciate the very robust discussion/chat on these scenarios! I have a better understanding of some of the ins-and-outs of these various issues through reading all of your comments.

12:21:28 From Jonathon Feit to Everyone:

@Steven -- it's problematic: Consider...if your phone tells someone "I've fallen and I can't get up," EMS CANNOT SEE IT.

12:21:35 From DeeAnne McCallin (CPCA) to Everyone:

Will DSA Subcommittee, and any other Subcommittees if created, report out during this forum each meeting?

12:21:39 From Jonathon Feit to Everyone:

PSAPs can. EMS can't.

12:22:11 From Lane, Steven MD MPH to Everyone:

We should determine what unique needs we have in California for a data sharing agreement that goes beyond what will be included in the federal Common Agreement, that will be published as part of TEFCA.

12:22:14 From David Ford, CA Medical Assn. to Hosts and panelists:

I have the same question as DeeAnne.

12:22:25 From Andrew Bindman to Hosts and panelists:

From a process perspective shouldn't our committee agree on principles before the sub-committee picks up the pen?

12:22:39 From Lane, Steven MD MPH to Everyone:

https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement

12:22:41 From Amanda McAllister-Wallner to Everyone:

As we move on from the presented scenarios, I want to just put one additional thought that wasn't in any of the six scenarios presented. It's an extremely common scenario - a consumer who ends up at an out of network emergency room/trauma center, which may or may not have access to their EHR. We've discussed communication between health care systems and other stakeholders such as public health or social service providers, but this example also underscores the gaps that exist currently even within health care systems. I know we've covered a lot, but wanted to mention the challenge with out-of-network providers.

12:23:07 From Jonathon Feit to Everyone:

@Amanda -- you've made a strong argument for an interoperable POLST Registry.

12:23:42 From Karen Ostrowski to Everyone:

To Dana's and others points about variations in data laws and standards…Many of the communities we work with are raising serious questions about the disconnect in the State's posture on data sharing and how is becoming a problem. As one individual

noted to me recently, CalAIM is doubling down on holistic and data-driven approaches for the most vulnerable populations, but persistent lack of clarity on laws (e.g., LPS) as well as myriad privacy and security standards attached to specific data sets that must flow with the data. For example, we are seeing real issues with Counties needing to shore up their contracts and policies related to uses and disclosures of Medi-Cal data, but the underlying standards are not consistent and/or not grounded in reality. This is causing significant confusion as County agencies are procuring tools and need to flowdown privacy and security requirements into vendor contracts that address DHCS BAA standards, protections for SSA data, etc.

12:23:46 From Jonathon Feit to Everyone:

(Without forgetting that hospitals don't go to the patient during stress -- Fire & EMS agencies do, and they can't access EHR data naturally.)

12:24:11 From Kevin McAvey to Hosts and panelists:

This has been a phenomenal exchange - and we truly appreciate the engaged chat conversation.

12:24:14 From Lori Hack to Everyone:

Many organizations have already signed a "DURSA" through a number of initiatives. We should catalogue who has already signed.

12:24:39 From Karen Ostrowski to Everyone:

We are hopeful this effort will also help bring alignment among those standards and provide greater clarity to both the organizations that are rolling out programs such as CalAIM, as well as to the technology vendors that are entering this space that may not understand the complex delivery system in CA.

12:24:55 From Lane, Steven MD MPH to Everyone:

https://ehealthexchange.org/dursa/

12:25:17 From Lane, Steven MD MPH to Everyone:

https://www.ca-hie.org/initiatives/cten/caldursa/

12:25:57 From tien@eff.org to Hosts and panelists:

I am perhaps a broken record, but if the laws around privacy and security aren't clear to the folks in health care, it's even harder for ordinary folks to understand or trust

12:26:06 From Claudia Williams to Everyone:

@lori - I agree that we should consider the existing DURSA, in addition to the TEFCA common agreement. TEFCA is still so new and its future is a little unclear given that it is voluntary

12:27:43 From Lane, Steven MD MPH to Everyone:

The TEFCA Common Agreement is likely to include a lot of the details in the Carequality Connected Agreement: https://carequality.org/wp-content/uploads/2019/08/Carequality-Connected-Agreement-CCA-v2.0-FINAL-7-29-2019-Agreement-Only.pdf

12:28:02 From Lori Hack to Everyone:

@claudia indeed!