

Data Exchange Framework Stakeholder Advisory Group Meeting #4

California Health & Human Services Agency

Tuesday, December 14, 2021
10:00 a.m. to 12:30 pm



Meeting Participation Options

Written Comments

- Participants may submit comments and questions through the **Zoom Q&A box**; all comments will be recorded and reviewed by Advisory Group staff.
- Participants may also submit comments and questions – as well as requests to receive Data Exchange Framework updates – to CDII@chhs.ca.gov.

Meeting Participation Options

Spoken Comments

- *Participants and Advisory Group Members* must “raise their hand” for Zoom facilitators to unmute them to share comments; the Chair will notify participants/Members of appropriate time to volunteer feedback.

If you logged on via phone-only

Press “*9” on your phone to “raise your hand”

Listen for your phone number to be called by moderator

If selected to share your comment, please ensure you are “unmuted” on your phone by pressing “*6”

If you logged on via Zoom interface

Press “Raise Hand” in the “Reactions” button on the screen

If selected to share your comment, you will receive a request to “unmute;” please ensure you accept before speaking

Public Comment Opportunities

- Public comment will be taken during the meeting at designated times.
- Public comment will be limited to the total amount of time allocated for public comment on particular issues.
- The Chair will call on individuals in the order in which their hands were raised.
- Individuals will be recognized for up to two minutes and are asked to state their name and organizational affiliation at the top of their statements.
- Participants are encouraged to use the comment box to ensure all feedback is captured or email their comments to CDII@chhs.ca.gov.

Agenda

10:00 AM	Welcome and Roll Call <ul style="list-style-type: none"><i>John Ohanian, Chief Data Officer, California Health and Human Services</i>
10:10 AM	Vision and Meeting Objectives <ul style="list-style-type: none"><i>Dr. Mark Ghaly, Secretary, California Health and Human Services</i>
10:15 AM	Technical Infrastructure Opportunities: Addressing HIT Capacity Gaps <ul style="list-style-type: none"><i>Jonah Frohlich, Managing Director, Manatt Health Strategies</i>
11:30 AM	<u>Public Comment</u>
11:45 AM	Digital Identity Strategy Considerations <ul style="list-style-type: none"><i>Dr. Rim Cothren, Independent HIE Consultant to CDII</i>
12:05 PM	Data Sharing Agreement Subcommittee Update <ul style="list-style-type: none"><i>Jennifer Schwartz, Chief Counsel, CalHHS CDII</i>
12:15 AM	Updated Principles of Data Exchange in California <ul style="list-style-type: none"><i>John Ohanian</i>
12:25 PM	Closing Remarks <ul style="list-style-type: none"><i>Dr. Mark Ghaly</i>

Welcome and Roll Call



Advisory Group Members

Stakeholder Organizations (1 of 3)

Name	Title	Organization
Mark Ghaly (Chair)	Secretary	California Health and Human Services Agency
Jamie Almanza	CEO	Bay Area Community Services
Charles Bacchi	President and CEO	California Association of Health Plans
Andrew Bindman <i>designated by Greg A. Adams</i>	Executive Vice President; Chief Medical Officer	Kaiser Permanente
Michelle Doty Cabrera	Executive Director	County Behavioral Health Directors Association of California
Carmela Coyle	President and CEO	California Hospital Association
Rahul Dhawan <i>designated by Don Crane</i>	Associate Medical Director	MedPoint Management (representing America's Physician Groups)
Joe Diaz <i>designated by Craig Cornett</i>	Senior Policy Director and Regional Director	California Association of Health Facilities
David Ford <i>designated by Dustin Corcoran</i>	Vice President, Health Information Technology	California Medical Association
Liz Gibboney	CEO	Partnership HealthPlan of California

Note: Complete bios for each member are available in a publicly posted biography listing; updated on Sept. 30th at 5pm PT

Advisory Group Members

Stakeholder Organizations (2 of 3)

Name	Title	Organization
Michelle Gibbons <i>designated by Colleen Chawla</i>	Executive Director	County Health Executives Association of California
Lori Hack	Interim Executive Director	California Association of Health Information Exchanges
Matt Legé <i>delegate for Tia Orr</i>	Government Relations Advocate	Service Employees International Union California
Sandra Hernández	President and CEO	California Health Care Foundation
Cameron Kaiser <i>designated by Karen Relucio</i>	Deputy Public Health Officer	County of San Diego (representing the California Conference of Local Health Officers)
Andrew Kiefer <i>designated by Paul Markovich</i>	Vice President, State Government Affairs	Blue Shield of California
Linnea Koopmans	CEO	Local Health Plans of California
David Lindeman	Director, CITRIS Health	UC Center for Information Technology Research in the Interest of Society
Amanda McAllister-Wallner <i>designated by Anthony E. Wright</i>	Deputy Director	Health Access California

Advisory Group Members

Stakeholder Organizations (3 of 3)

Name	Title	Organization
DeeAnne McCallin <i>designated by Robert Beaudry</i>	Director of Health Information Technology	California Primary Care Association
Ali Modaressi	CEO	Los Angeles Network for Enhanced Services
Erica Murray	President and CEO	California Association of Public Hospitals & Health Systems
Janice O'Malley <i>designated by Art Pulaski</i>	Legislative Advocate	California Labor Federation
Mark Savage	Managing Director, Digital Health Strategy and Policy	Savage & Savage LLC
Kiran Savage-Sangwan	Executive Director	California Pan-Ethnic Health Network
Cathy Senderling-McDonald	Executive Director	County Welfare Directors Association
Claudia Williams	CEO	Manifest MedEx
William York	President and CEO	San Diego Community Information Exchange

Advisory Group Members

State Departments (1 of 2)

Name	Title	Organization
Ashrith Amarnath	Medical Director	California Health Benefit Exchange
Nancy Bargmann	Director	Department of Developmental Services
Mark Beckley	Chief Deputy Director	Department of Aging
Scott Christman	Chief Deputy Director	Department of Health Care Access and Information
David Cowling	Chief, Center for Information	California Public Employees' Retirement System
Kayte Fisher	Attorney	Department of Insurance
Julie Lo	Executive Officer	Business, Consumer Services & Housing Agency

Advisory Group Members

State Departments (2 of 2)

Name	Title	Organization
Dana E. Moore	Acting Deputy Director	Department of Public Health
Nathan Nau	Deputy Director, Office of Plan Monitoring	Department of Managed Health Care
Linette Scott	Chief Data Officer	Department of Health Care Services
Diana Toche	Undersecretary, Health Services	Department of Corrections and Rehabilitation
Julianna Vignalats	Assistant Deputy Director	Department of Social Services
Leslie Witten-Rood	Chief, Office of Health Information Exchange	Emergency Medical Services Authority

Vision & Meeting Objectives



Vision for Data Exchange in CA

Every Californian, and the health and human service providers and organizations that care for them, will have timely and secure access to usable electronic information that is needed to address their health and social needs and enable the effective and equitable delivery of services to improve their lives and wellbeing.

Progress and Next Steps

Status	Step
✓	Convene DxF Stakeholder Advisory Group (AG)
✓	Convene AG Data Sharing Agreement Subcommittee
✓	Identify key gaps to data exchange across technical infrastructure and standards, financing and business operations, and regulatory and policy domains
✓	Establish guiding principles for health and human services data exchange in California
Today	Provide feedback on options for resolving infrastructure gaps (HIT)
1/13	Provide feedback on options for resolving infrastructure gaps (data standards)
3/3	Provide feedback on options for resolving business operations gaps
4/7	Provide feedback on options for resolving regulatory and policy gaps
5/18	Provide feedback on options for establishing governance*
6/23	Provide feedback on the draft DxF



*May also address Governance as part of earlier Advisory Group meetings

Meeting #4 Objectives

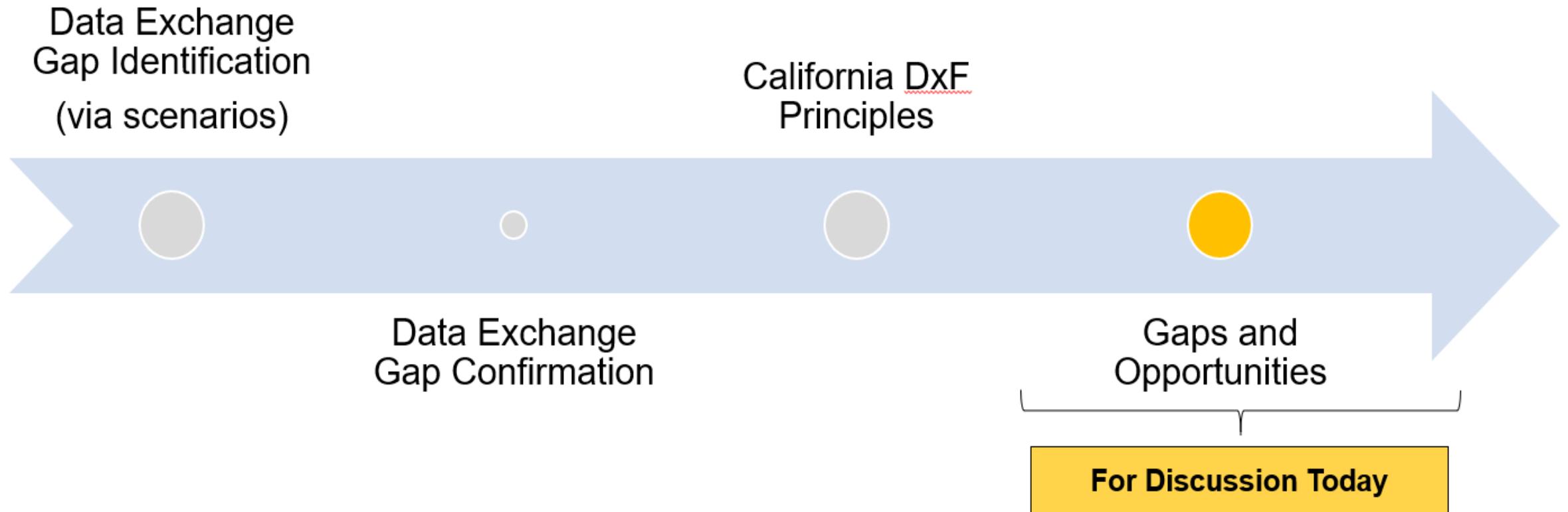


1. Discuss potential **technical infrastructure opportunities to address HIT capacity gaps.**
2. Discuss the **considerations** for developing a **digital identity strategy.**
3. Provide a **Data Sharing Agreement Subcommittee update.**
4. Review the **updates to the DxF principles** that were made based on Stakeholder Advisory Group feedback.

Potential Opportunities **Addressing Health Information Technology Capacity Gaps**



Data Exchange Framework (DxF) Development Process



Potential Opportunities

Potential Opportunities

- Opportunities presented here represent areas for private and public stakeholders to address specific program, policy, and system gaps to advancing the vision of AB 133.
- Opportunities may require the blending and braiding of existing resources across various sectors to support health and human service organizations to in the implementation of AB 133.
- Opportunities must consider and incorporate significant system transformation efforts underway nationally and in California – and opportunities to build from those efforts to advance the vision of AB 133.

Feedback Requested

CDII requests Stakeholder Advisory Group feedback on:

- Opportunity feasibility and effectiveness to address the specified gap
- Existing programs, incentives, and initiatives that may be built-upon and modified to address gap
- What philanthropic, private sector, and public sector funding may be already available to support the implementation of the opportunity

Gaps: Technical Infrastructure - HIT

- 1. EHR Adoption.** EHR adoption is limited among some health care organizations, particularly those without access to HITECH and other federal and state modernization funding opportunities (e.g., behavioral health, long term care facilities, correctional facility health providers); not all EHRs are certified or have capacity to share data using national standards.
- 2. Data Exchange Capacity at Many Health Care and Human Service Organizations.** Many human service organizations have limited technological capacity to store, electronically share, and use health and human service information.
- 3. Event Notifications.** Alerts and notifications today are mostly limited to transitions from acute care facilities and are not widespread for housing, incarceration status and other important events.
- 4. Intra- & Inter- Sector Data Exchange.** Some state, county, and other local government public health and human service organization information systems have limited capabilities to electronically exchange timely and usable health information with health care organizations.

Gaps and Opportunities

1. EHR Adoption

- **Opportunity 1:** Consider a Multi-Payer EHR Incentive Program

2. Data Exchange Capacity at Many Health Care and Human Service Organizations

- **Opportunity 2a:** Consider a HIE On-Boarding Program
- **Opportunity 2b:** Consider Qualifying Information Exchange Intermediary and Data Sharing Policies

3. Event Notifications

- **Opportunity 3a:** Consider Policies that Expands Event Notification Requirements

4. Intra- & Inter-Sector Data Exchange Capabilities

- **Opportunity 4a:** Consider Developing a Public Health and Human Services Data Exchange Capacity Building Program
- **Opportunity 4b:** Consider Policies that Expand Human Service Data Reporting Requirements

Gaps and Opportunities: EHR Adoption

Gap #1: EHR adoption is limited among some health care organizations, particularly those that did not have access to HITECH and other federal/state modernization funding (e.g., behavioral health, long term care facilities, correctional facility health, and small physical health providers); not all EHRs are certified or have capacity to exchange data using national standards.

Relevant AB 133 Provision(s): *Identify gaps, and propose solutions to gaps, in the life cycle of health information, incl. gaps in the:*

- *Storage, maintenance, and management of health information. [§130290(c)(3)(B)(iii)]*
- *Linking, sharing, exchanging, and providing access to health information. [§130290(c)(3)(B)(iv)]*

Opportunities:

A. Consider EHR Incentive Program: Build on investments being made by the state to private payers to incentivize adoption of interoperable EHR technology to support the collection, exchange, and use of electronic health information.

- **Models:** U.S. HHS HITECH, NC [EHR Incentive Program for BH/IDD Providers](#), NJ [Substance Use Disorder Promoting Interoperability Program](#)

B. Consider EHR Implementation Training & Technical Assistance: Incentive programs can be coupled with technical assistance to support health care organizations adoption of EHRs.

- **Models:** HITECH [Regional Extension Centers](#), DHCS CA [Technical Assistance Program](#)

C. Consider Promoting Certified EHR Requirements in State Programs: [Certified](#) EHR technology requirements can be incorporated into state contracting (e.g., Covered California, DHCS managed care, CalPERS QHP contracts); may be particularly important for advancing integrated behavioral health (see MACPAC June 2021 [reporting](#)).

- **Models:** Medicare [Quality Payment Program](#) (QPP)

Opportunity #1: Multi-Payer EHR Incentive Program

(1a) Consider a Multi-Payer EHR Incentive Program that incentivizes health care organizations to adopt EHR technology capable of collecting, exchanging, and using electronic health information pursuant to AB-133. The scope of the incentive program would include health care organizations required by AB-133 to execute the DxF Data Sharing Agreement that were not previously eligible for HITECH funding, and who have a demonstrated financial need – including acute psychiatric hospitals and certain behavioral health providers.

The state is making significant investments over the next three years in this priority area, including through CalAIM, which will provide funding through the [Incentive Payment Program](#), [PATH](#) and the [Behavioral Health Quality Incentive Program](#) that support adoption of interoperable electronic health records and care management documentation systems.

Other purchasers including Covered California, Medi-Cal, and CalPERS, and commercial managed care plans should establish value-based payment arrangements that align with these public requirements and advance use of interoperable EHRs that support information exchange. The program should be coupled with efforts to advance federal policy to provide funding to providers that were ineligible for incentive payments under the HITECH Act. It can be further reinforced through proposals leveraging the federal SUPPORT Act (P.L. 115-271) which authorized the Center for Medicare and Medicaid Innovation (CMMI) to test EHR incentive payments for behavioral health providers that contract with state Medicaid plans (*note: CMMI has yet to implement this demonstration*).

Discussion Questions:

- Should these programs require the implementation of federally Certified EHR Technologies (CEHRT)?
- Can these sources be used to establish technical assistance programs to support EHR adoption?

Gaps & Opportunities: Data Exchange Capacity at Many Health Care and Human Service Organizations

Gap #2: Many health care and human service organizations have limited technological capacity to store, electronically share, and use health and human service information.

Relevant AB 133 Provision(s): *Identify which data beyond health information as defined in paragraph (4) of subdivision (a), at a minimum, should be shared for specified purposes between the entities outlined in this subdivision and subdivision (f).*

[§130290(c)(3)(A)] Minimum “health information” sharing requirements in AB-133 are defined for specific health care organization, but broadly include provider sharing of USCDI and “electronic health information” per Section 171.102 of Title 45 of Code of Federal Regulations, and payer sharing of data per federal Interoperability regulations.

Opportunities:

- A. **Consider a Health and Human Service Organization HIE Onboarding and Technical Assistance Program.** A program can be established to provide funding, incentives, and technical assistance to help health and human service organizations securely exchange electronic health information to support data collection, exchange, and use in accordance with AB 133, DxF priorities and state requirements.
 - **Models:** CA DHCS [California HIE Onboarding Program \(Cal-HOP\)](#), TNC Tailored Care Management Capacity Building Program
- B. **Consider a Data Sharing Intermediary and Data Sharing Requirements Policy.** Policy can be established that leverages national programs that define data sharing intermediary qualifications and further specify additional state data sharing requirements pursuant to AB-133 that should be incorporated into the DxF Data Sharing Agreement.

Opportunity #2: HIE On-Boarding Program, Qualified Networks and State Data Sharing Requirements

(2a) Consider an HIE Onboarding Program that provides incentives to health and human service organizations to participate in information exchange in accordance with AB-133, including but not limited to connections to qualified information exchange intermediaries. The state's commitment to support information exchange through the [Incentive Payment Program](#), [PATH](#), and the [Behavioral Health Quality Incentive Program](#) should be coupled with private sector investments that support HIE onboarding.

The program should include establishing a technical assistance “Center of Excellence” to provide support for implementation, potentially through a statewide program funded by philanthropic investments and/or private and public payers.

(2b) Consider Qualifying Information Exchange Intermediary and Data Sharing Policies that adopt national programs that qualify health information networks (i.e., Sequoia Project Regional Coordinating Entity and TEFCA), and specify additional California DxF requirements that Qualified Intermediaries must meet to participate in state-sponsored data sharing programs. State policies would further specify how federal data exchange requirements (CMS-9115-F, 85 FR 25510) and additional state-specified data sharing requirements and use cases should be incorporated into the DxF Data Sharing Agreement.

Discussion Questions:

- Are policies/programs to qualify information exchange intermediaries necessary?

Gaps and Opportunities: Event Notifications

Gap #3: Event notifications today are mostly limited to transitions from acute care facilities and are not widespread for housing, incarceration status and other important events.

Relevant AB 133 Provision(s): *Identify gaps, and propose solutions to gaps, in the life cycle of health information, incl. gaps in:*

- *Linking, sharing, exchanging, and providing access to health information. [§130290(c)(3)(B)(iv)]*

Opportunities:

A. **Consider Expanding Federal Alert Notification Requirements:** State policy and contracting requirements can be developed, extending the scope and scale of federal Interoperability and Patient Access Final Rule ([CMS-9115-F](#)) notification requirements to additional health and human service organizations.

- **Models:** FL Medicaid managed care plan [contracts](#) with required linkages to pre-booking sites for behavioral health assessments and potential diversion; AZ Medicaid managed care plan/justice system data [connections](#) and Medicaid requirements to support transitions; MI Medicaid [pilot](#) to identify homeless individuals by HMIS matching; CA WPC Pilot program [lessons learned](#)

Opportunity #3: Expand California Alert Notification Requirements

(3a) Consider Policies that Expand Event Notification Requirements, specifying how the DxF Data Sharing Agreement should build on federal data exchange requirements (CMS-9115-F, 85 FR 25510) to expand the scope of event notification requirements in California and envisioned by AB-133. Policies may:

- Expand event notification requirements described in [CMS-9115-F](#) to additional entities (e.g., human service providers, housing agencies, justice facilities, etc.).
- Establish state licensing requirements for entities required to provide event notifications.
- Establish contracting requirements for entities required to provide event notifications through public and privately financed coverage programs.

Discussion Questions:

- Does the opportunity address the identified gap?
- How broadly should event notification requirements extend (e.g., housing agencies, justice-involved facilities, SNFs)?

Gaps & Opportunities: Intra- & Inter-Sector Data Exchange Capabilities

Gap #4: Some state, county and other local government public health and human service organization information systems have limited capabilities to electronically exchange timely and usable health information with health care organizations.

Relevant AB 133 Provision(s): *Identify gaps, and propose solutions to gaps, in the life cycle of health information, incl. gaps in...Linking, sharing, exchanging, and providing access to health information. [§130290(c)(3)(B)(iv)]*

[By] January 31, 2023, [CalHHS] shall work with the [CA] State Association of Counties to encourage the inclusion of county health, public health, and social services, to the extent possible, as part of the [DxF] in order to assist both public and private entities to connect through uniform standards and policies. It is the intent of the Legislature that all state and local public health agencies will exchange electronic health information in real time with participating health care entities... [§130290(c)(5)(E)]

Opportunities:

- A. **Consider Upgrades to California County Health IT Infrastructure:** Leverage and expand federally funded programs to upgrade state and local public health IT infrastructure and to provide a glidepath for county health, public health, and social service entities to participate in information exchange.
 - **Models:** CDC [Data Modernization Initiative](#) nationally and CA's ~\$300m allocation for public health modernization
- B. **Consider Developing Public Agency Data Exchange Policy and Contracting Requirements.** Through policy (e.g., statewide HMIS reporting to centralized Homeless Data Integration System [[HDIS](#)] via [AB977](#)), procurement processes and contract amendments, public agencies could contractually obligate vendors to share information with health and human service organizations to advance goals envisioned by AB-133.
 - **Models:** Merced and San Joaquin County [contracts](#) with EHR vendors serving their county jails

Opportunity #4: Public Data Exchange Capacity Building Program

(4a) Consider Developing a Public Health and Human Services Data Exchange Capacity Building Program that leverages and aligns with federally-funded modernization efforts to support local health, public health, justice-involved, housing, and social service organization data exchange capacity to advance priority health data exchange use cases envisioned by AB-133 and outlined by the DxF. The program would seek funding from federal sources to support upgrades to technology that can support data sharing with stakeholder groups referenced in AB-133.

(4b) Consider Policies that Expands Human Service Data Reporting Requirements. Establish policies requiring public funded programs to incorporate data sharing requirements into procurements and vendor contracts. Policies would apply to use cases defined pursuant to the DxF and include flow-down requirements for vendor contracting (e.g., HMIS vendors, prison/jail EHR vendors).

Discussion Questions:

- Are there other programs/data (e.g., CalFRESH, CalWORKS) that should be incorporated into these opportunities?
- Should policies be developed to incorporate HIE into requirements into applicable state/local procurements?

Public Comment Period



Digital Identities Strategy Considerations



Digital Identities Strategy

Agenda

- Statutory Requirements
- Development Plan



Digital Identities Strategy

Statutory Requirement

AB133 requires that, by July 31, 2022, CalHHS in consultation with the Stakeholder Advisory Group, develop:

“a strategy for unique, secure digital identities capable of supporting master patient indices to be implemented by both private and public organizations in California.”

Digital Identities Strategy

Statutory Requirement: Breaking it Down (1 of 5)

“a *strategy* for unique, secure digital identities capable of supporting master patient indices to be implemented by both private and public organizations in California.”

Strategy: a plan for defining, creating, and deploying the components necessary to establish and use digital identities to the benefit of patients and Data Exchange Framework participants

A strategy will define what is and is not part of DxF digital identities and options for approaches, including advantages and disadvantages. It may also address:

- Whether and when Master Data Management or a “golden record” is part of the strategy
- Whether and when identity proofing and access authorization is part of the strategy

The strategy will likely include a roadmap (likely extending beyond July 2022) and rough timeline.

Digital Identities Strategy

Statutory Requirement: Breaking it Down (2 of 5)

“a strategy for unique, secure digital identities capable of supporting master patient indices to be implemented by both private and public organizations in California.”

Digital Identities: a collection of data that establish the identity associated with a real person, in this context a person with health information

“Digital identities” is not necessarily a call for to establish a digital identifier. It will likely include a definition of the data used to establish an identity and the standards and quality requirements for representing that data. Digital identities are dynamic and change as the data they comprise them change.

Digital Identities Strategy

Statutory Requirement: Breaking it Down (3 of 5)

“a strategy for unique, secure digital identities capable of supporting master patient indices to be implemented by both private and public organizations in California.”

Unique, secure digital identities: key qualities of the digital identity for the Data Exchange Framework are that they must be unique and secure.

- “Unique” likely entails discussion of whether there will be a single digital identity to be used for all DxF purposes. Individuals may have multiple digital identities used for different purposes.
- “Security” likely includes not only protection against unauthorized disclosure, access, or use, but also protection against unintended modification, corruption or loss.

The strategy must consider - and balance - the needs for consumer privacy and patient safety.

Digital Identities Strategy

Statutory Requirement: Breaking it Down (4 of 5)

“a strategy for unique, secure digital identities capable of supporting master patient indices to be implemented by both private and public organizations in California.”

Implemented by both private and public organizations: a strategy for digital identity appropriate for state departments as well as private-sector signatories.

The digital identity strategy must meet both public and private needs. Contributors to and users of digital identities will likely include:

- Required signatories to the DSA under AB-133 (e.g., providers, plans, labs)
- Potential signatories to the DSA (e.g., HIOs, human service organizations, state depts)

Should identify regulatory Gaps to implementation and use that would need to be addressed.

Digital Identities Strategy

Statutory Requirement: Breaking it Down (5 of 5)

“a strategy for unique, secure digital identities capable of supporting master patient indices to be implemented by both private and public organizations in California.”

Supporting Master Patient Indices: an enterprise master person/patient index (EMPI) is a technology system to aid in identifying "patients" across different organizations, systems, and contexts

- Not necessarily a call for a single statewide EMPI, but may be recommended by the strategy
- Should identify how various organizations (providers, plans, HIOs, state Departments, and social services) contribute to and use digital identities

May have impacts on the DSA such as reciprocity and permitted purpose for use of data comprising digital identities.

Digital Identities Strategy

Development Plan: Approach + Timeline

- DxF AG request for focus group recommendations (Today)
- Assess consumer privacy and DxF participant needs; explore overarching approaches (January 2022)
- Refine needs and explore strategy components (February 2022)
- Refine strategy components with emphasis on privacy, security (March 2022)
- Complete a draft strategy (April 2022)
- Refine strategy with AG; align potential requirements with DxF and DSA (May 2022)
- Finalize strategy for delivery to legislature (June, July 2022)

CDII will keep the Stakeholder Advisory Group apprised of progress at each meeting, elevating key issues raised by focus groups for discussion.



Digital Identities Strategy

Plan for Development: Stakeholder Engagement (1/2)

The development of a robust and effective Digital Identities Strategy will require expert counsel. CalHHS will convene several expert focus groups to inform our understanding of the need and project approach.

Rationale

Engaging focus groups will allow CalHHS to tap into additional expertise on the topics of digital identities and patient matching while engaging Stakeholder Advisory Group Members as needed to obtain targeted input.

Focus Groups

CalHHS will engage experts in several focus groups representing various health industry sectors, including:

- Health information exchanges
- Providers
- Health plans
- Consumer privacy representatives
- State health and human service departments
- Others as suggested by the Stakeholder Advisory Group



Digital Identities Strategy

Plan for Development: Stakeholder Engagement (2/2)

Topics

CalHHS will seek focus group input on topics including, but not limited to:

- Technology and service components that comprise the strategy for digital identity
- Data that comprises digital identity for the Data Exchange Framework
- How organizations contribute to and use digital identity
- Permitted uses of digital identity under the DSA or accompanying policy
- Others as suggested by the AG

Process

CalHHS anticipates scheduling two to three listening sessions with each focus group through March.

- Listening sessions will be conducted as public meetings per Bagley-Keene requirements
- Agendas, meeting notes and all other meeting materials will be posted to the public CalHHS website
- The AG will be regularly updated on progress and engaged around key decision-points



Data Sharing Agreement (DSA) Subcommittee Update

DSA Subcommittee Status Update

Purpose

Support the CalHHS's Data Exchange Framework Stakeholder Advisory Group's development of recommendations for the creation of California's Data Sharing Agreement ("DxF DSA") as required by AB133.

Status Update

At its first meeting on Nov 8th, the DSA Subcommittee discussed parameters for the DxF DSA, compared characteristics of existing data sharing agreements, and reflected on survey results that showcased a range of perspectives on what topics should be addressed by the DxF DSA.

Key takeaways from the meeting included:

- The DSA should leverage existing data sharing agreements when possible and reference them as appropriate.
- Certain topics (e.g., standards, technical specifications) should not be included in the DxF DSA, but addressed in policies & procedures documents.

DSA Subcommittee Meeting #2 (Dec. 22nd)

- I. Welcome and Roll Call
- II. Meeting Objectives
- III. DSA Subcommittee Charter
- IV. DxF Guiding Principles and the DxF DSA
- V. Key Considerations for the DxF DSA
- VI. Threshold Questions for the DxF DSA
- VII. Developing the DxF DSA
- VIII. Closing Remarks

Updated Principles of Data Exchange in California



DxF Guiding Principles: Development

How the Principles Were Developed

The DxF Guiding Principles were informed by the CalHHS Guiding Principles¹, Consumer and Patient Protection Principles for Electronic HIE in CA², and the ONC's TEFCA Principles for Trusted Exchange³ in alignment with the requirements of AB 133.



1. CalHHS Guiding Principles. <https://www.chhs.ca.gov/guiding-principles-strategic-priorities/>

2. Consumer and Patient Protection Principles for Electronic HIE in CA. <https://advocacy.consumerreports.org/wp-content/uploads/2013/02/HIE-Principles-6-10.pdf>

3. ONC's TEFCA Principles for Trusted Exchange. <https://www.healthit.gov/sites/default/files/page/2019-04/FINALTEFCAQTF41719508version.pdf>

Updated DxF Guiding Principles: Key Revisions

Stakeholder feedback on the updated DxF Guiding Principles was congruous in some areas and divergent in others.

Key revisions to the updated DxF Guiding Principles based on stakeholder input included, but were not limited to:

- Explicitly acknowledging that data collection, exchange, and use should be conducted in accordance with federal and state law.
- Consistently referring to “health and human service data and information”.
- In *Principle 1: Advance Equity*, elevating the need to fill existing data gaps and prioritize analytics.
- Removing *Principle 8: Accountability*.

The revised data exchange principles that incorporate stakeholder feedback are available on the [DxF website](#).



Closing Remarks



Next Steps

CHHS will:

- Summarize and post meeting notes in advance of next meeting.
- Finalize the DxF Guiding Principles
- Develop materials to support our next Opportunities working session focused on Infrastructure Gaps: Data Standards.

Members will:

- Provide additional feedback on Infrastructure Gaps: HIT Capacity opportunities

Advisory Group Workplan & Meeting Schedule

#	Date	Proposed Topics
5	January 13, 2022	<i>Topic Area:</i> Data Standards
6	March 3, 2022	<i>Topic Area:</i> Business Operations
7	April 7, 2022	<i>Topic Area:</i> Regulatory & Policy
8	May 18, 2022	<i>Topic Area:</i> Governance*
9	June 23, 2022	Framework review

For more information or questions on Stakeholder Advisory Group meeting scheduling and logistics, please email Kevin McAvey (Kmcavey@manatt.com).



*May also address Governance as part of earlier Advisory Group meetings