California Health & Human Services Agency
Center for Data Insights and Innovation
Data Exchange Framework Stakeholder Advisory Group
Meeting 4 Transcript (10:00AM – 12:30PM PT, December 14, 2021)

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

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Technical difficulties during this session, please type your question into the q&a section located at the bottom of your zoom webinar viewer, and a producer will respond.
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During today's event, live closed captioning will be available.
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Please click cc on the bottom of your zoom window to enable or disable.
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I just want to cover the meeting participation options, Alice you know how the floor.
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Thanks joining Next slide please.
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There are a few ways attendees may participate today. First participants may submit written comments and questions for the zoom q amp a box, all comments will be recorded and reviewed by advisory group staff, participants may also submit comments and
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questions as well as request to receive data exchange framework updates to cdii@chhs.ca.gov. Next slide please.
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Designated times spoken comment will be permitted participants and advisory group members must raise their hand for zoom facilitators to unmute them to share comments, the chair will notify participants and members of the appropriate time to volunteer
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feedback.
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If you logged in via phone, only press star nine on your phone to raise your hand and listen for your phone number to be called if selected to share your comment, please ensure you're unmuted on your phone by pressing star six.

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If you logged on via zoom interface. Press raise hand in the reaction buttons button on your screen. If selected to share your comment, you will receive requests to unmute.
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please ensure you accept before speaking.
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Next slide please.
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Public comment will be taken during the meeting at designated times and will be limited to the total amount of time allocated individuals will be called on in the order in which their hands were raised and will be given two minutes.
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Please state your name and organizational affiliation when you begin.
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Participants are also encouraged to use the q amp a to ensure all feedback is captured or again you may email comments to cdi@chhs.ca, cats, but that I would like to introduce john Oh honey and chief data officer at California Health and Human Services.
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Thank you so much, Alice.
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Thank you, Julian. Thank you, our team, and welcome everyone. Thank you for joining us today we have a terrific agenda and as per usual, much to cover in our limited time together.
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I yesterday, little late. We shared materials with the advisory group which will reference in today's conversation. And we. It should also be posted online for public reference, if you're on the advisory group and did not receive distribution, please
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contact Kevin and still make sure you received them.
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Today we're going to start with a few remarks by Secretary galley.
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And before we move to more open discussion with this group around potential opportunities to address several of the hit capacity gaps confirmed in our previous meeting.
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Excuse me.
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In solution in the discussion we're going to offer possible strategies for private and public stakeholders to address specific program policy and system gaps, building on the significant system transformation efforts underway, and both nationally and
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in California to advance the vision of av 133.
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Today we start to dig into the core ask of this advisory group to advise the development and implementation of our data exchange framework, identifying gaps proposing solutions to gaps in the life cycle of health information in California.
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I appreciate you all rolling up your sleeves. I asked that you enter each of these conversations with an open mind and that you listen to one another productively offer specific and concrete alternatives to draft options presented, and that we always
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keep the health and well being, Californians as our horizon, focusing as we work together to improve our often invisible but invaluable system of health information exchange.
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We will be seeking additional ideas from this group stemming from today's discussion through next Tuesday, as you take your today's discussion back to your team's give you a little extra time.
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Following our open discussion which Jonah's kindly do agree to steer us through. Thank you, Jonah will be sharing more about our digital identity strict strategy plans and providing an update on our data sharing agreement subcommittee.
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Please note a few changes to our agenda. We've moved our update on the principles to the close of today's discussion, though I'd like to thank you all for the terrific feedback we've received, and it's been reviewed and many of the suggestions were incorporated.
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And Dr. Catherine has been called to civic duty as juror today. So Jennifer Schwartz and Kevin KB will be presenting on digital identity strategy and instead.
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Thanks in advance to go Jennifer and Kevin.
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With that, I'd like to do a quick roll call.
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You can just please let us know you're here, and I begin with Bay Area service. Community Services Jamiel Monza
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California Association of Health Plans Charles Bochy morning.
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Going Kaiser Permanente Andrew Bindman.
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Good morning john.
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Good morning.
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County Behavioral Health Directors Association of California Michelle diaper Clara,
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California Hospital Association Carmela coil.

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Good morning everyone.
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That point management problem with the one.
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Good morning. Thank you for having me.
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California Association of Health Facilities Joe DS.
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California Medical Association, David Ford.
00:06:09.000 --> 00:06:11.000
Good morning.
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Partnership health plan of California Liz given a morning john. Good morning.
00:06:17.000 --> 00:06:22.000
County Health Executives Association of California Michelle Givens your morning.
00:06:22.000 --> 00:06:29.000
Morning, California Association of health information exchanges Lori hack.
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Service Employees International, you know john, Laura raised her hand she may not be able to.
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Got it. Good morning. Excellent. Laura give us a big the morning SEIU that leech
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regular California Healthcare Foundation Sandra Fernandez.
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Morning john.
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Good morning, county of San Diego.
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Cameron Kaiser.
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Good morning.
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Morning hometown of San Diego Blue Shield of California, Andrew keeper.
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Good morning.
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Good morning.
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local health plans of California.
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Good morning.
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Good morning.
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You see center for Information Technology Research and the interest of society, David lemon.
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Good morning, Halifax California, Amanda McAllister one.
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California Primary Care Association Dan McAllen.
00:07:34.000 --> 00:07:35.000
Morning.
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Morning.
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Los Angeles network for enhanced services, ali matter se morning.
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California Association of public hospitals and health systems Erica Murray.
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Hi everybody.
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Oh California Labor Federation Janice O'Malley.
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Warning.
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Mark Savage, I know he said he might be late.
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But I am here. Thanks.
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Excellent, made it. Welcome, California pan Ethnic Health Network. Karen savage penguin hasn't California Welfare Directors Association Kathy Sunderland McDonald's
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manifest medics Claudia Williams, running, and San Diego Community information exchange William York. Good morning.
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Morning.
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And I'd like to acknowledge our representatives appointed from our State Department's the California Health Benefit exchange as reef Amara Amada commodity.
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Morning john one, Department of Developmental Services, Nancy Bartman.
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Yes, good morning.
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Department of Aging Mark Beckley.
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Good morning.
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Department of Health Care Access and information about Crispin morning john green California public employee retirement system David Kalin.

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Department of Insurance, Katie Fisher.
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Good morning.
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Does this consumer services and housing agency Julie low barbell public health Dana more
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department and Managed Health Care Nathan now.
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Good morning.
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Morning. Department of Health Care Services, Dr Lynette Scott.
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I know she's dialing in she might be a few minutes out from calling in and then Department of Corrections and Rehabilitation. They can attach.
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Who is represented today by Sheryl US
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Department of Social Services Giuliana, being a lot of money. Morning, and Emergency Medical Services Authority Leslie Whitney, and Morning.
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Good morning.
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Well thank you everyone.
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Just want to.
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I've done, Amanda McAllister Wallner sorry could get off mute earlier. Oh, great, thank you so much. Welcome, and good morning, Mark and john Michelle Cabrera also joined to this message.
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Excellent. Great participation Thank you everyone for your patience. Thank you for being here today.
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And I would now like to introduce Secretary galley for some introductory remarks discussion of our vision and meeting objectives, the morning boss.
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Great, thanks john and good morning, everyone. Thanks again for the tremendous turnout.
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And the ongoing work together. Really appreciate it I know we've been on an aggressive timeline since July, as we have with every meeting just want to highlight the vision, and you're all becoming more familiar with this vision statement around data exchange
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in California, highlight a few words, the very beginning that this is really about every California and we're not just talking about safety net programs or the ones administered by the state but that touched the lives of every California and we want to
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We want to focus on the word usable, we've highlighted that we want this to be actually usable implementable meaningful for providers and others serving individuals but the individual themselves and then a phrase that has even greater meaning, meaning
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throughout this pandemic and has been part of the fabric and California is really just focusing on equitable and equitable services, the delivery of those services and frankly, as some of the colleagues in this on this framework through advisory group.
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Remind me really that think about how we use data and information to help shift some of the power dynamic that drives certain disparities and inequities in our system so all very powerful part of why we're gathered and really taking asked you to take
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time to come together and help the state. In this important work for you go to the next slide and just remind people before I turn it over to Jonah and john you did a really tremendous job I think of talking a bit about what we want to get done today
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but by way of also reminder, what we've done so far beyond just bringing this group together and now having regular monthly meetings where certainly it feels like we're beginning to gel and have that important open constructive conversation.
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We have also been able to establish the team in the process for developing the data sharing agreement, which I know took quite some time within health and human services to establish but we're on the fast track to do that with all of you.
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We've began to identify and confirm the key challenges to data exchange across Health and Human Services, and today really having a conversation about looking at those challenges and talking about solutions and approaches to get through those challenges.
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And then lastly establish the principles to guide us in developing those solutions and challenges to those challenges and I would be remiss if I didn't just thank you all for your candid and commitment candid commitment to helping us to do the most that
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we can on these issues on a tight timeframe.
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Also just want to focus quickly on what I hope we get out of today, today is going to be about looking at some of those challenges and barriers and looking at some of the gaps and potential ways to fill those gaps, I hope, as you've reviewed the slides
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previously and come to today's conversation that we continue to get your best thinking about what the real practical implementable solutions might be whether we have the gaps right all together, what exists today that we might leverage and build upon
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and what other new investments might be required so that we can take today's conversation and incorporate it in just some real thinking around next steps I know that will also have some time to do a couple of other things to talk about having an update
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from the data sharing agreement subcommittee, and then having some other conversation about those important principles around data exchange framework that that stakeholder advisory groups feedback has been vital around so those two.
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Towards the end or however john you describe the rejiggering of the agenda given some of people's presence and absence from the conversation today.
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So with that I'll turn it over to Jonah but just as we kind of are in this period of giving thanks and counting our blessings during this holiday season I just want to thank you all personally for taking on yet another commitment this year I think
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many of you spend time with me on other commissions and other venues, doing the work. And I know this is another, another thing, added to your plates this year, and I am really pleased with the progress we've made on a pretty aggressive timeline to really
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deliver on three teams so with that Jonah, I'll turn it over to you to run the rest of the meeting but these hear loud and clear my gratitude to each of you.
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Thanks.
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Thank you Dr galley, and if you wouldn't mind advancing another slide to the development process.
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I think Dr Galle very nicely articulated where we've been. We are now in this gaps and opportunities phase and for today, we're going to focus over an hour on the potential opportunities for the first set of gaps were identified around IT infrastructure,
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and so on the next slide, what we're proposing here is to review what those opportunities hard, and specifically what areas for private and public investment including policy development may be needed to address the specific gaps that have been identified
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and advance the vision of at 133 on a recognize that these opportunities may require a braiding of existing resources, federal state private fund tropic and other commercial funding across sectors to support all the health and human service organizations,
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and their implementation of at 133.

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And then consider opportunities to incorporate other system transformation underway nationally and in California.
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Calcium is one example but there are many others, to ensure that we're leveraging every potential opportunity and resource and aligning them as we implement and Support Division of 33.
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Maybe 133.
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We are requesting that in terms of the feedback that as we go through the first four set of gaps and opportunities that we consider the feasibility and effectiveness of each of the opportunities presented and consider, consider those potential others
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that may arise from, from this process.
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Consider what existing programs incentives initiatives and policies may be built upon to modify or address the gaps.
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And then what philanthropic and private, public and other funding may be available to support implementation.
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So we're going to cover on the next slide. For gaps and opportunities today. The first gap was with respect to EHR adoption.
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And in this case, as we discussed on our last session, we're really want to focus on the limited adoption amongst young healthcare organizations, particularly those that are required to meet everyone 33 requirements around data exchange.
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So there are a number of different types of institutions that for example were left behind in high tech. We're not funded federally through that program and considerations about how those institutions, organizations might be supported.
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Second is with respect to that exchange capacity, and many organizations that we are including in the framework, have limited capacity today, technical process, etc to electronically share information.
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So we want to address that gap in opportunities we identify third round event notifications, there's been significant advancement in federal policy around event notification with policy guidance and rules, and we want to completely aligned behind those,
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and consider what other types of policies might be important for California to whine about around at 133 in its goals. And then the fourth is around inter and intra that sector data exchange.
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And by that we mean the ability for public health, social service healthcare and other organizations in the human service space to be able to share information effectively to support all California and make division.
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So those are the four gaps, we're going to address today. And we're going to look at the opportunities around.
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On slide 20, the opportunities around a multiplayer EHR Incentive Program to address the HR adoption around data exchange capacity.
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Consider an HIV onboarding program and then process for qualifying information exchange intermediaries in New Year's and data sharing policies, again really want to consider what's being done at the federal level, not duplicate it.
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But consider what needs to potentially be enhanced in California to address any additional requirements or needs that extend beyond federal requirements and are specific to state needs or requirements around event notifications and these are again policies
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around expanding event notification and similarly to number two, to be specifically what other types of event notifications might be germane and supportive of at 133 goals.
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And then the fourth is around this internet data exchange capabilities.
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And there are two areas here one's around capacity building for public health.
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Human Service and other organizations, ability to exchange data, and then around policy and contractual and other requirements that may help bolster and support data exchange.
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before I turned to slide 21 and the first of these policies I want to just underscore the process here, we had of course intended to get materials, more advanced to all the stakeholders and recognize that the 24 hour turnaround is not sufficient for you
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to have time to review and adjust with your teams were definitely very sorry that we weren't able to get those in advance, want to use this opportunity to get your initial reactions to these to these opportunities, and then provide a week for you to bring
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these back to your teams will obviously incorporate any of your considerations that we identified today and that you offer, but want to give you all another week opportunity to preview these with your teams, and to provide additional feedback.
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So again, sorry for the late delivery. We're going to accommodate as best we can, by giving you another week with your chance to review these.
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Okay.
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Why don't we go to the first gap and opportunity at slides of this is EHR adoption gap that we've identified.
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And here the gap is we've described as the limited adoption amongst certain organizations that did not have access to high tech funding.
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And, and the provision and a B 133 that's important is to identify gaps and propose solutions, specifically around things like storage maintenance and management of health information, and the ability to link and share data across those systems so we're
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going to consider specifically around.
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We're going to consider opportunities specifically to address that gap.
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And there are few opportunities here and then we'll go to the next slide and open it up for comments.
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So the first would be an EHR Incentive Program is basically a state version of an incentive program that would build upon investments that have been made through high tech and through public and private institutions already there would incentive incentivize
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the HR adoption.
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Whether it's certified EHR is is a good question, but we'd like to pose to you and get some feedback but would, in our view needs to be adoption of technology that would support collection exchange and use of electronic information.
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pursuant to at 133 and subsequent guidance from the state.
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So their number of models including high tech there are a number of state models that have been implemented, specifically to North Carolina for example to address behavioral health providers adoption and New Jersey has a similar type of program.
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So there's certain models that we might be able to learn from and, and, and incorporate if you think that's relevant.
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The second is around a training and technical assistance program.
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These would be some sort of a program incentives or funding a subtype, that might provide technical assistance to support organizations to adopt the HR we have examples here.
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Many of the participants on this advisory group participated in Cal hips oh and other Regional Extension Center efforts under high tech. There's been technical assistance program that has been funded by the state around adoption as well, called the RC
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cap.
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And then the third is around promoting requirements to adopt certified EHR technology and other programs, and specifically is there a mechanism by which through contractually obligating
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providers and qualified networks with plans to adopt these types of technologies and incentivize their adoption and use for data exchange.
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So those are the opportunities that we want to consider and so in terms of what this incentive program might look like on the next slide, and how we might craft a recommendation or the opportunity.
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The proposal here is to consider a multiplayer EHR Incentive Program.
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This would create incentives for healthcare organizations to adopt technology to collect exchange in use information again pursuant they do 133.
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It would as a proposal to include organizations require baby 133 to execute the day exchange framework, and specifically for those who weren't previously eligible for high tech funding those essentially who are not covered their number of psychiatric
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hospitals, certain behavioral health providers that weren't psychiatry practices that potentially could qualify for this, just so that there's awareness of current activities and programs the state's making significant investments over the next three
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years.
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In this priority area.
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One avenues to Kaleem.
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There are specifically to incentive programs and then one waiver programs, instead of payment program behavior health quality incentive program, both of which launched next year, and path which also launched launches next year which is still awaiting
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approval from CMS but it's the new waiver, all three of those have significant investments in adoption of EHR clinical documentation system and data exchange including between behavioral health, physical health, and other providers that are serving medical
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members. So it's important to recognize that there will be state investments, general fund investments federal match to incentivize adoption of VHS and data exchange.
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So this proposal would leverage those consider that other opportunities across Covered California Medical helpers commercial managed care plans and others to establish similar types of Value Based Payment arrangements that align with these requirements
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advance the use of interoperability hrs.
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And potentially coupling those efforts with other policy we'd want to advance, there are potentially funding sources, including in the support Act, which authorized BMI, to test the EHR incentive payment for behavioral health providers, they haven't yet
00:27:04.000 --> 00:27:24.000
implemented this. But if we were to come to them with a proposal that's leveraging commercial, medical, and other investments, we may be able to seek additional funding today so want to put this on a table first as an opportunity and a proposal.
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do we need. And should we require certified EHR technology if this type of incentive program is adopted, or at least recommended incorporated into the framework. And can the sources also establish technical assistance programs to support the HR adoption.
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So I would like to pause for a moment, to see if we have questions from members, please feel free to raise hands which you're getting very used to Erica, you're up first.
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Thanks for raising this, I think there is an opportunity for policy alignment here with Kaleem and IPP and path. At the same time, that the state has made significant investments to encourage data sharing and EHR adoption.
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They are finite dollars. And, I think, public health care systems would be concerned about a potential dilution of those dollars that are needed for so many different purposes.
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You know, across Kaleem to ensure that patients, continue to receive holistic comprehensive services that if we start drawing from existing funds first, as we contemplate.
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You know, there's such a need out there and I worry that if we go we dip into this well.
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We could end up end up inadvertently undermining the policy goals of counting.
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Got it.
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So what I take away is that just relying on this for public systems alone and saying job done may not be sufficient. we need to make sure that there is sufficient resources that are allocated to all public systems to participate in that.
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And will need just much more than, than the dollars that exist in these indeed through Kalyan funding sources, it's a need a far exceeds what's in those what what will likely be approved in those programs over the next five years.
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Got it.
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Okay, thank you.
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Amanda.
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Thank you. I'm so agree in terms of some of the
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concerns identified with this specific gap and opportunity.
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I wanted to also just, you know, bring up some other opportunities and gaps that I see with EHR adoption, that, you know, I don't see reflected in these the opportunities in gaps that you have listed here.
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You know, I think, you know, a big one is around.
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You know, consistency and compatibility with, you know, EHR is that, that are in use today. There is a lot of variety in what's used and I think especially for an advisory group that has stated that health equity is the top goal, and the top value
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of this work. There's a huge equity opportunity here, because we know that each cars that are in us. Currently, already in us today are not consistently, you know, collecting sexual orientation and gender identity data.
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For a lot of, you know, a lot of the different data modules that we're interested in are optional and individual
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folks within the whole system have to specifically request that those be built out for for their EHR is and so I think we need to, you know, as we're talking about gaps and especially as we're talking about opportunities and opportunities to advance our
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number one priority as a, you know, as, as a group, we should take a look at what are the what are the equity opportunities here as well. And I imagine there are other data measures that similarly, you know are very inconsistently collected within the
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existing EHR is and and as we move to support greater adoption of EHR hours, you know, in other places in the system.
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We should be addressing that at the very beginning.
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Yeah, that's a good point I think Amanda what I'm hearing you say is that if this kind of program is implemented there are certain functions that that that EHR like collection and use and sharing of demographics so g other data that specifically addresses
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the goal and a principle around health equity need to be incorporated into that kind of incentive program, which sounds very like a very effective use of that program.
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Great.
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Thank you, Michelle Please go ahead.
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Hi, Michelle have a data with the County Behavioral Health Directors Association and I mostly want to echo some of the concerns raised by Erica Murray with the public hospitals in that I think that what I'm hearing here is sort of suggesting that we would
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pull from the existing Behavioral Health Quality incentive program to try to add additional.
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You know, potential funded activities. And that just is by way of a little bit of context County Behavioral Health Plans, who are implementing Cal aim and drawing from the bH quip are really implementing a wide range of Cali massive transfer system transformations
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including payment reform, a transition from hc pick codes to CPT codes, as well as changes in eligibility and documentation requirements. There's a massive workload sitting on the bH quip already related to Kelly for County Behavioral Health, and we at
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the same time are limited in terms of how we build medical for how we can sort of invest in these sorts of, you know, it and technical infrastructure components we, because we use a certified public expenditure we have to document services to, you know,
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along the lines of what the cost of those services are, and we don't have any built in opportunity for reserves or margins, like health plans do we really have to go out and hustle for grants and try to find, you know, money between the couch cushion
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so to speak to fund these sorts of things and so I think if there's an interest in using the bH quip as an as a vehicle will need to expand the bhi bH equipped to account for these goals, which, I think, again, our folks would be really supportive of
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counties are interested in innovating around this space, but we need to make sure that we're not just sort of trying to double dip into what is already I think a pretty well overloaded pot the funding.
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Thank you.
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Yep. Thank you. Very good. Very appropriate considerations.
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The pH quit Scott three different domains, what you know there's an aspect around this billing component which is absolutely critical moving to CPT and then there's this piece around data, and I think we've heard that there needs to be real attention
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to the resource need for adoption of these types of programs so definitely appreciate those Lori Please go ahead.
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I think you would agree with both Andrea Michelle on some of those key issues. My two concerns about the certified EHR approaches in working under the sea tab program as you mentioned, we had experience with many different providers.
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And they, you know, even if you have a certified EHR. That doesn't mean you can share data with anybody, or you can find a patient in the system so i i think some attention needs to be paid on focus support on requirements on workflow on training the
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folks who haven't had the opportunity to have technical assistance, and really focus on what I call training in the trenches, on how to optimize the technology and in use it for care delivery and an information exchange.
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Thank you, Lori. My Thank you, we experienced this early on in high tech with the certification program adoption of these dh ours. And then, not necessarily implementation of these of HIV capabilities that these EHR said to have had sometimes they weren't
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actually implemented. And I think what I hear you saying is we really need to be clear that it's not just about the systems that are implemented but it's the data sharing and the ability that to do that, and the capabilities and they needed to incorporate
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that into workflows so but I hear that systems not enough. We've got to make it a requirement to have incentive programs to support, not just adoption but actual data exchange and quitting workflow changes that are that are difficult.
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Thank you. Great. Thank you, David. Please go ahead. We have about three minutes I know there's a lot of comments if we don't get to everybody will will love to get your comments in chat and we'll take it.
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After as well. Please go ahead.
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David you're if you're on mute.
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Sorry. Okay, indifference my fellow committee members I'll try to run through this very quickly as a bunch of just disparate thoughts on this. I'm just as a on the question of certified EHR.
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I think I'll sort of agree with Lori they're necessary but not sufficient.
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It's not an end all be all and at the same time we do want some requirements on the hrs because as we saw in the early days of high tech.
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There are a lot of EHR is out there that are not great, and providers adopt them and that can't do what they need to do for bH, I just want to underscore with appear on the screen about the funding from the support act.
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I know CMI has been sort of dragging their feet about getting information out there but if we could do it that's just a huge opportunity to draw down federal funding to support bH.
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And then as we start talking about multi payers and the private payers I, I do believe there are some other states that have done that in fact, I don't know if Carmela Klaus on but I believe, Maryland was one of them.
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And I think Minnesota may offend the other that actually did create sort of almost reflections of the high tech act in state law or sort of state level Meaningful Use program so there might be some other states we can look out for models.
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Excellent.
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I think, I think that's totally appropriate we've also seen some support like this in North Carolina so we, I think being able to describe models and other states, how they've been supported through the various different purchasing channels and, and ways
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that we can actually align sounds totally appropriate.
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Please go ahead.
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Thank you so much for recognizing people that weren't able to benefit from the high tech I really appreciate that and you're amazing you're doing that, you know, there's a lot of people weren't eligible for the program.
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As far as, as a practicing physician for these patients.
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As far as, as a practicing physician for these patients, as you mentioned, I take care of all types of California state sponsored and private funding 500 patients and, really, that I took I didn't provide for financial resources for physician organizations
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and resources necessary because without that as a physician organization very hard for us to get data usable data, actionable data that really impacts quality so I just wanted to make sure to recognize your recognition of that and also the fact that it's
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really important for physician organizations to be at the forefront because ultimately we're the first responders were the ones going into skilled nursing homes and getting records from the ER that's like multiple pages of notes that are not usable, and
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the one most important details are not available to us that impacts quality impacts care and delays care, unfortunately.
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You've raised some great points I think some so many people have raised great points here so having that forum, really is, is why we're here and really echoes with Dr Valley started a software.
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so I really wanted to say that thank you for allowing me to speak, towards the end of this.
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Thank you.
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I'm going to I'm going to see if we can get a couple of more minutes here. Mark and Lana if you can be brief. I'm sorry that you can obviously, add more to it but just that we can get to all the opportunities that marketplace.
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Go ahead.
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Thanks, I totally appreciate the attention to broadening EHR adoption.
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At the same time, that is a clinical side of things, it's a piece of the he ecosystem and want to suggest that we think about this as in balance with other pieces so for example, the gravity project on which I work building connections to community and
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social service agencies to social insurance with health data, looking at an end to end approach.
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We, we are trying to build fire based exchange using Tor to those organizations that do not have EHR using smartphone applications. So I just want to raise up the issue of thinking about solutions overall solutions.
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That might not use EHR, but my give us better HIV in California.
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Overall, it's not that. It's not binary it's not get rid of one thing or and lift up only another but just to think about the balance between those. The other thing I want to say is, I appreciate the Avi 133 provisions for identifying gaps EHR doctrine
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is, is just one of the things that helps address those gaps and I think the variety of digital divide issues that do need attention, like to be talking about those two.
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Thank you.
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Thank you, Mark.
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It strikes me your comments and I'm going to Jamie's hit the fan from the chat, get this specific policy requirement that would then have things like fire standards, and using gravity project as a, as a point where we can support that exchange with those
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who don't have them a lot of human service organizations, etc.
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It feels like we potentially could work on policies that would enable that and require it, either in this program but also more broadly and other and other programs that California Dobson will be talking to in a few minutes.
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It's great. Okay. when I messed up. Please go ahead.
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Hey, great linear equipment with the local health plans and Yes, I will. I'll be brief, but I think I just when looking at a couple of five they wanted to note that for the local plans and Medicare managed care plans I feel like what I've heard is one
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of the biggest gaps in terms of their providers who may not have hrs today are really the small individual mental health providers lm s keys or LCS W, which may not necessarily be the core Kaleem providers that these funding sources are intended to support
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so I think that's one consideration in terms of where we look to help fill the gap. And then, I think, not all Kalyan providers of course would necessarily have the capability nor would it be, you know, appropriate for them necessarily to have any
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HR and I'm thinking specifically are some of the human services organizations like housing navigators which I think you kind of get to later in the slide deck about having data exchange capabilities, but it wouldn't necessarily be through an EHR.
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So I think, you know, there's some opportunity I think through these programs that I can give others have pointed out there really intended to support a much broader range of activities and capacity and infrastructure needs group.
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Yeah, I think that's, that's totally appropriate when I agree, they're going to be some entities that don't, and won't necessarily not necessarily should adopt the chores, but they are part of the ecosystem.
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So we need to think about how to support them and as we go into the next requirement or the next opportunity and then the fourth one, we should think about how that might be incorporated into those suggestions to, and I just want to call out Jamie Thank
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you. Just one call Jamie, Amanda you're, and thank you for documenting learn your hand.
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There requirements around interoperability when working in a bay area or other place where there are multiple counties serving, where institutions or organizations multiple counties you've got lots of different institutions that many different systems
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and seeing some type of policy or rule or regulation that California might promulgate to define some basic requirements around data sharing with organizations like their community services CBS and others.
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It sounds like it's a very sound suggestion here. So we'll incorporate that into the policy considerations here to.
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Excellent. Thank you. We're gonna move on to this second opportunity this is specifically around data exchange capacity.
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And here the gap, as we've identified is that there still remain many institutions that have limited capacity to share information.
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Those beholden to at 133 included.
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And that relevant provision is excerpted here that we need to identify what health information as well might be shared pursuant to at 133.
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That may be in addition to what is defined in federal policy so we need to be careful about this, we want to make sure we're 100% aligned behind us CDI and other sections of the Federal code that already specified data exchange and consider what else
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might be necessary in California.
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So first is to opportunities to consider one is an onboarding program that would establish funding and incentives and technical assistance to help.
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Helping human service organizations securely exchange information I think this goes to a number of comments that may mark.
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Jamie noted in particular about making sure that they can't exchange data.
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The second is related to what we call a data sharing intermediary like a qualification process so the federal policies already heading in the direction with Kafka, and with the subway of project, many efforts are underway right now to sort of qualify
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this new framework organizations that are certified and meet certain federal requirements and what we are considering here and want to get your input on here is with this data sharing agreement and requirements to share data going into effect, less than
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two years for many institutions, a lot of providers are going to be asking questions like if I sign up with this local h i o or if I sign up with this national network.
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Do I meet the requirements of maybe 133, and my public enjoy meet my obligations at least two to share information or connect to an intermediary And so thinking about can, should there be a process by which we leverage the federal programs around qualification
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and have in California.
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Any additional qualification requirements that align with at 133, without layering on or being at all contradictory to the federal program.
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So what we would propose then for consideration of this group is the following.
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One is this hi onboarding program. And what we would consider here, is that health and human service organizations that are required to participate in HIV, pray the 133, including but not limited to connecting that they would connect to qualified information
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organizations and intermediaries and others, federal or direct connects, and that the state commitment to support this type of information exchange just important to note is also being incentivized through the HR.
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The, the, Kaleem Incentive Payment Program path, and based to repeat again, that's focusing on the talent program and medical.
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So it does not apply to the entire market.
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So, we would consider this as an opportunity to build on those programs, and on board, others who may not be subject to those funding, those those funding streams.
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The second consideration here under to a would be to create some sort of a Technical Assistance Center of Excellence, they would provide support for implementation and and assistance with onboarding considering philanthropic investments and other private
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investments from other private and public player payers, we have a lot of experience getting those on this call who supported this type of initiative.
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And I think could provide some good guidance for us here. The second consideration is having a qualified information exchange intermediary and data sharing policy.
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Again, this will be adopting this national programs that are qualifying health networks to acquire project, and a true Stefka this the reason coordinating any, and that would specify additional California data exchange framework requirements for qualified
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And that would specify additional California data exchange framework requirements for qualified intermediaries. And so that's the second consideration again, we'd want to further specify how those exchange requirements under federal rules that are noted
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here, and any additional specify data sharing requirements would be incorporated into that qualification process.
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So I'm going to pause and then would love to get reactions from the group, and start to get to some questions got some hands up. So I'm going to start with Claudia, please.
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Yeah, you're already putting.
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I love the whole package so very supportive.
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I on this number to a, I think there are three distinct things that need to be funded.
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One is incentives that would go to the provider, similar to what HP for instance has today which motivates folks to move and create the data connections.
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The second is the, the money the effort needed to make a data connection. And in our experience at least at MX we bear the full cost of that, because we're trying to offload the costs from the providers so it's about, you know, eight to $10,000 per practice.
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And, and I think the approach chicken to cow hop, which I think worked is to is to direct that to the, to the, to the entity that's doing the data integration, but the third is the cost and effort to actually make the data usable right to collect an aggregate
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and distill insights from it. And that's the piece that all of these state programs have never funded because if you look at the answer program you look at Co Op.
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which in other states is paid for through high tech and Micah, so I think we need to just get very crisp about, I would argue, we need to solve all three.
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But if we solve one and don't solve to solve one and two and don't sell three we're going to end up in a painful place.
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And then on the deeming I love the idea of deeming, I would just be careful about assuming that tough because the right starting point, because tech tasks as a pipe it's not a destination.
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Right. And so if we think part of what we're trying to build is this kind of data. Insight generation and cleaning of data. Then, we're not, then there's a big chunk that's not covered by TEPCO.
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Also I would just say, we've been told very clearly by Sequoia that each of us are really not part of tough cut as a, as one of the nodes, we're going to be like, way down the pipe.
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So they're, they built their requirements to be the very largest kinds of organizations like sure scripts that are operating at national scope so I just, I think there's a lot of questions about 1010 how it's going to operate and when it's going to actually
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actually be in place. So I think it's a good to not replicate it. But I actually think the cow hop qualifying process might be more relevant for California event Africa.
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So anyway, that would just I think there's just a lot more thinking about what the right, what are we actually trying to do there and what are the right competitors.
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Looks great. I mean we were thinking cow hop was one of the models we were thinking about I think the incentive for providers and getting a better understanding of the landscape HP you mentioned already is doing something like this but how might that
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be expanded to all other payers, and specifically what would they incentivize that we're really aligned behind this feels like a very appropriate and a good suggestion that we'd like to incorporate here.
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And I think the deeming issue is also really important I don't think that just by saying, I'm connecting to one of these and these would deem someone compliant they actually have to do something once they're connected.
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And so we want to be able to demonstrate, I'm not going to say Meaningful Use, I just said, but we're actually actively shared data that's usable, which is really important.
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Thank you, Michelle Please go ahead.
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Thank you. I'm going to try to keep up after the the more technical comments that I'm not familiar with what I would say is as I'm thinking about kind of the onboarding program like from a public health perspective there's so much data that public health
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departments touch. Some of it is the need to be able to get data from each ours and then some jurisdictions depending on what what other parts of infrastructure they have in terms of health systems and clinics and so forth may have EHR is already, but
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I think there's a number of health departments where there's a lot of data and there's no repository for that so we're working in a million different systems and it would be great to know a little better.
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and the technical assistance, even having some like direct outreach and start like hey here's how you might qualify for this. And if applicable, and in all of the ways that it might be beneficial would be really helpful for for health departments and
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thinking about, like, even if they're coated with green tea extract some data around like immunizations and you know what healthcare providers have done, they didn't really have a way to do that that was that connects through kind of an electronic means
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so I just wanted to throw that out there and like technical assistance like the onboarding liking, having this kind of, I forget what you call it, but like kind of the mindmeld of all the good things that can help support somebody with better HR that
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on boards with the HR, I think that they're the one aspect that I would just ask that you is how to get ready to raise their hand, even want to kind of take on that task, and that role, and knowing and getting information about how this looks for them
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and, and how it can benefit them.
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Great.
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Excellent. Okay. Thank you Michelle, that makes sense, that feels. We need a marketing plan, we need a communication plan need to make it clear what this is and how it's necessarily going to support a variety of different initiatives so.
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Got it.
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Ali. Thank you, Ali.
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Thank you, fully support. What you stated here this is, this is great it's kind of demonstrates how well informed.
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You all are in in recognizing the, the serious issues that are, we are challenged with in the, in the field.
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Totally support the, the incentive programs as well as the technical assistance and technical assistance something that I want to kind of elaborate on in the count hub obviously was, was a success.
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It was, had a short run of 18 months, but they can be retrieved a lot through that program and it was a successful program, which we had the technical assistant piece to that, because some of the smaller doctors offices, they just don't have the means
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and this is not just about technical means but what we ran into during the cow health program and the solo practices of small doctor practices was that, as simple things like that we have to do as part of the high trust certified, we have to do security
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risk assessment. And this is small doctor offices, I just don't have the.
00:58:03.000 --> 00:58:19.000
The means you know from increase options to solve the other basic things that they need to have at their practice so I want to emphasize on the tech meme that when we talking about technical assistance, other than the incentives.
00:58:19.000 --> 00:58:38.000
They need it needs to be really full support throughout that entire implementation and covering the cost of some of the additional tools that they need to deploy, just to connect with health information exchange.
00:58:38.000 --> 00:58:49.000
So that's one and the other point I have is that about the tough guy King that's that's that's too early for California Lois Lois Lois walk before we run.
00:58:49.000 --> 00:59:07.000
So, totally agree with that, you know, quiet qualify health information exchange program similar to the what Cal have offered that again doubt that would be a good basis start, but also want to mention that, you know, as part of the HIV AIDS and health
00:59:07.000 --> 00:59:24.000
information organization. One of our value proposition is that the quality of data that we receive and enhance on. And this is something that is not recognized that at many levels.
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But, you know, I consider ourselves as a data refinery where we get the raw data, and we kind of cleanse it, and standardize it and share it across so so that's something that I want to scope to take into consideration and and communicate that.
00:59:43.000 --> 00:59:55.000
Thank you. Great. Thank you all. I appreciate the support and comment, and I think the need, around Tia it's been reinforced by a number of other products we've heard as well.
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So those are definitely appreciate it. Cameron Please go ahead.
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Thank you This is sort of a follow up to a miss Givens was saying about local health departments and I'll come out from the technical side.
01:00:13.000 --> 01:00:29.000
on hi ease. But for many of our health jurisdictions, they don't really reside in such an area and one is easily serviced, nor do they have the technical ability or the resources to maintain any kind of internal repository epidemiology resources have

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been really limited for many health departments and, and I want to boil the ocean with this particular initiative by making a gated on that.
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But I think the impact of something like this is going to be muted for many of the smaller health departments that don't either have the technical resources to set up something of their own, or don't have the epidemiology resources to do any kind of analysis
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that makes sense to them, especially for those health care providers.
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For those who operate HIV clinics, which is specifically part of at 133, those facilities that run public health nursing operations, things like that.
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I think they also would fall under some sense but again we're going to be relying on whatever resources their parent organizations can come to bear. And for some of our smaller jurist things that will be somewhat of a tough ass, even with funding, especially
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since some of this will incur some ongoing costs.
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Yeah.
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Yeah, I think Cameron you, you bring up some really important points about local health department, other providers who and other entities that are implicated here and there, there really needs to be a full consideration of where we can.
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How and where we can support them.
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It.
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And, including investigating potential federal federal funding that would be required because it's it's a pretty broad swath of institutions.
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And we need to be thoughtful about how they can be supported.
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Great.
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Laura, if you don't mind, I'm going to ask if Carmela and Lynette can comment and then we'll. We should have time to come back to you and then we'll close out the section.
01:02:11.000 --> 01:02:14.000
Not forgetting you just want to make sure we get to them.
01:02:14.000 --> 01:02:21.000
Carmela Can you go ahead please.
01:02:21.000 --> 01:02:26.000
Camilla you there.

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I'll come back to Carmel in a moment, but do you wanna go ahead please.
01:02:30.000 --> 01:02:32.000
Good morning. Thank you so much.
01:02:32.000 --> 01:02:47.000
I just wanted to echo a couple of comments one. Thank you to our partners who have worked with Cal hop and appreciate the positive comments. I know it was a short span with the 18 months but I do think we made tremendous progress.
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One of the lessons learned, though I would flag especially as we think about additional programs, is the time it takes, and it's not just about the time to get a program approved it's about the time to implement.
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When you're changing, you know workflow processes etc and practices is their ability to move and change as much as it is the ability of the technical assistance and the support pieces to move and change.
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So just to reinforce timing. As we think about these things will be aligning to the AV 133 timelines, but also to think about what these assistance programs need to look like.
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Over time, I mean when we look back over 10 years ago now for high tech right.
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We initially were supposed to be working on HIV and people didn't have a chart.
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So things didn't time out quite right in terms of when the resources were needed for some of these different pieces.
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The other thing that I just wanted to fly for clarification a little bit is appreciate the call out to the support from the state in relation to the incentive payment program path and Behavioral Health Quality incentive program.
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But, but also just want to flag that those those programs are not paying for HIV onboarding what's been incentivize there is the importance of data exchange to do whole person care to treat people holistically to connect the different services.
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And to do that, that piece, as opposed to onboarding.
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So looking at what is the value of data exchange and then how do we pay for that value of data exchange.
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So just, I just want to call out that clarification. And then also I mean I think you could arguably also list. The patient access interoperability rule and that list because, as part of the patient access interoperability rules.
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It has requirements related to using data standards around the US CDI using the fire API's and and those are requirements. Now from CMS for medicare medicaid plans providers, etc.
01:04:52.000 --> 01:05:06.000
So, that is definitely a driver and they're there obviously are going to be financial investments that go along with that as well so I think that could also be in this list as the way that the state is committed to and supporting information exchange.
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Thank you, rich.
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Thank you, Anna.
01:05:10.000 --> 01:05:14.000
Yeah, am I unmuted.
01:05:14.000 --> 01:05:28.000
Yes you are.
01:05:28.000 --> 01:05:42.000
So we'll need to sort of balance that with like the timing of the implementation of the agreement and data exchange requirements for a new 133, and consider how we can ensure that all those who need support can can get it.
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Come out, please go ahead and then we'll go with Lori and then we'll go to the next one.
01:05:47.000 --> 01:05:55.000
Thank you and apologies for the interruption. A couple of general comments and then I want to build a little bit off with Claudia Williams comments.
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The first thank you for the recognition that we want to be 100% aligned with what's going on at the federal level, I think our tremendous opportunity here is to build off of that around what's unique in California, and of course our public health infrastructure,
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you know really stands out. We're a very unique state in terms of our public health capabilities.
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Many of those riding at the county level so that was one second, I just wanted to also underscore the notion of supplementing rather than supplanting funding from other sources.
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And if I could build on Claudia Williams, breaking out of this issue. I think one of the challenges is these gaps are identified at a very high level.
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And when I look at the onboarding piece in particular, we're talking about providers and human service agencies, and in that big group we I think are in very very different places.
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We might benefit from really breaking out.
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Not just providers from human service agencies, but within providers, we may have some provider types who are much further along and onboarding Of course, perhaps less important.
01:07:17.000 --> 01:07:31.000
When I think of the human service agencies and again a very unique piece of this we're trying to achieve in California. We've got some very important legal privacy and security issues for these HIPAA non covered entities that need to be addressed first
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before, perhaps the onboarding piece. So just a recognition that may be breaking this down and making it more granular will also help us best target some of the limited funds.
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Thank you.
01:07:44.000 --> 01:08:01.000
Yeah, yeah, I totally agree Carmela, and I were part of the work that will continue to do through June and then it's going to go beyond. And the next phase is this landscape, sort of this ecosystem of who is adopting technology to the exchanging data
01:08:01.000 --> 01:08:14.000
connected and who isn't and where those gaps very specifically so that we can target this. I agree with you it's, it's completely necessary. I know we're looking for some data that's going to be coming in in February March with some landscape assessments,
01:08:14.000 --> 01:08:31.000
and even lane has also provided a number of really good documents about data sharing today in California, it's going to be helpful to deepen sort of that landscape analysis and and get into the more detailed analysis of where the support needed appreciate
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this last one, Lori, please go ahead,
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sir thank you just briefly to sort of support a couple of the points that the others made to rapidly get to this interoperability that one that pointed out takes a long time.
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I think we need to leverage some of the programs and policies that are already in place for qualifying HIE s for setting up these intermediate or intermediaries to be made available.
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This see 10 for example has done a lot of this work of identifying the technical side for data exchange and calculate the course that program had a qualifying event as well.
01:09:20.000 --> 01:09:39.000
So I think we, we definitely to support Carmela statement we really do need to develop this roadmap to meet each of the entities where they are, so that we get beyond just the IT department, setting up an interface and and then, calling it a day.
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So I really like that idea of that roadmap to really get to where folks need to be and deliver this, the focused and targeted support to get them to the end line.
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Yeah, I think those are good points.
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Yeah, see can Cal hop test their multiple different aspects of qualifying, and we don't want to start again from scratch. We want to just add whatever is necessary to me.
01:10:08.000 --> 01:10:19.000
Also to come out point the requirements that make us unique in California and, and make sure that they don't, They're not contraindicated against federal requirements.
01:10:19.000 --> 01:10:35.000
So I think to embrace that. And I just want to recognize David thanks for your, your chat comment GMA supportive and it's suggesting that there be a committee that actually underscore that supports the development of like a TV program so just acknowledge
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that. Thank you.
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Great. Let's go to the third item.
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So this item represents the gap identified around event notifications.
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And that, in much of the ecosystem event notifications are still limited without much is changing, especially as the patient interoperability patient access final rule has gone into a place earlier this year that actually requires event notification from
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happening with acute care hospital. So those are our rapidly we understand really being put into place. There are other types of notifications that potentially could also be implemented supported.
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There are many life stage transitions, whether it's through incarceration, whether it's housing status, and even things like food security were being able to understand that a beneficiary and a health plan a client of a program has these incredibly important
01:11:39.000 --> 01:11:46.000
life changing events to be able to notify care team members of that status change so that they can be acted upon.
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That's really the consideration here, not to replicate what's being done under the interoperability patient access final rule we absolutely need to, and are going to align behind it.
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But consider what other types of notifications, and event notifications might we want to try to embrace and then extend.
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There's some examples in Florida, with some contracting requirements around pre booking sites so that's like for justice involved individuals are for behavioral health assessment and Arizona Medicaid also has some examples around justice system connections.
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There is work happening as well and counting on this part of path which is again still seeking CMS approval.
01:12:30.000 --> 01:12:51.000
We expect that shortly but would have data exchange between justice involved entities including state state prisons and county jails and your correctional facilities, to be able to share information with health plans with eligibility offices with providers
01:12:51.000 --> 01:13:05.000
in the community, and that could include things like notifications when like booking and release information is important to understand, to notify turkey members managed care plans and others who are supporting care.
01:13:05.000 --> 01:13:23.000
So if you go to the next page to consideration here, the opportunity want to review with you is around notification requirements that might be specified in a policy and hear what we suggest is that we'd build upon as I've noted, federal rule.
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Those that went into effect. This year, I believe this May, and expand the scope of those to support what is envisioned at 133 so it might include and this is where we really need your input event notifications that would that would expand to additional
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entities.
01:13:42.000 --> 01:13:57.000
Human Service Providers housing agencies justice facility so that there would be a mechanism by which they can communicate any kind of status change in an individual, and an individual's status for things like housing, potentially establishing state licensing
01:13:57.000 --> 01:14:08.000
requirements for other organizations that aren't beholden to the interoperability rule to provide those event notifications, potentially to establish contracting requirements.
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now these might be with commercial medic cow. Covered California California calipers other plans that support the various.
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The various programs that would create incentives or requirements that as part of their network there be notification that notification that is taking place in certain settings and for for very certain event transitions.
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So what we want to ask you is one.
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Does this seem like the appropriate and appropriate opportunity and a recommendation that we want to advance in defining different policies that the state might support to expand the alert notification and or the sort of the right tools that we might
01:14:57.000 --> 01:15:01.000
bring to bear to do that. Is there anything else that needs to be considered.
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I'd like to pause now open it up for for questions.
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I know this, this may not be in everyone's real house.
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There are a number of the advisory committee members where this is really important and others that this might be fairly new so
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let's start with, let's start quality is good.
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And I'm going to start with ADT requirements because I think while the federal requirements helped. They were a long ways from having the data sharing we need and I, I'd love to see us build into whatever approach we take to deeming or qualifying a requirement
01:15:40.000 --> 01:15:56.000
that we actually share at data across different networks so the problem I flagged in the, in the chat is we have a bunch of PCP, they want a DT no notifications, they want it through MX the hospitals don't want to participate in MX, so they can't get
01:15:56.000 --> 01:16:02.000
it through us so there's this problem.
01:16:02.000 --> 01:16:19.000
No, I think we lock. Okay, I'm going to channel quality because I think what I heard her say and I would even potentially consider one up is that there are certain entities that are being notified under the rule, others that would really like need, and
01:16:19.000 --> 01:16:35.000
should have access to, to, to an alert notification at ADP transfer information. I would include plans in that these managed care plan, they've got their members and hospital to being admitted discharged and the federal rule doesn't actually speak to
01:16:35.000 --> 01:16:50.000
that that's communication between the acute care facility, and the community provider. So one possibility is to potentially expand that to a broader set of stakeholders who had received those notification hope I didn't speak at a term for Claudia I'm
01:16:50.000 --> 01:16:57.000
sure she'll come back in and provide some additional considerations.
01:16:57.000 --> 01:17:06.000
I'm going to keep going, and I'm sure it will join us back, back in a moment and David Please go ahead.
01:17:06.000 --> 01:17:15.000
We'll see. Yes. Okay. Um, so it's not even California alert notification requirements. Yes, I think the other thing we should look at.
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In the patient access interoperability rules, is the requirements for open API's.
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The there's, I believe there's six and potentially seven required API's of the federally regulated plans that they have to turn on for their federal federally funded clients medic Medicare Advantage and Medicaid managed care in this state, and we should
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look at potentially expanding those requirements to make those available to the commercial and individual markets.

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Right.
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Thank you. Very good. David, that does that make sense.
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There are other.
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There are others who are not party to that rule. Qualified Health Plans on state sponsored marketplaces. So there's a gap, a federal marketplaces Qualified Health Plans, and they're like, Okay, Excellent.
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I think we got.
01:18:11.000 --> 01:18:14.000
Michelle Please go ahead.
01:18:14.000 --> 01:18:22.000
Thank you, um, just to kind of build on your earlier comment, Jonah, and you know I think it's important to note that today.
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County Behavioral Health things are not always notified when a client is in an emergency department, and we understand that this may be true for managed care plans as well.
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And so, if we're going to improve coordination and follow up care, after an emergency department visit it California under Medicaid. We really need some basic information and so wanted to flag that that is not always happening or hospital today.
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And then the other issue I wanted to flag as it relates to the slide here is we are really excited at CVH da about the opportunity to also improve transitions and assessments coordination warm handoff with individuals who are incarcerated both in county
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jail as well as with with CDC are we, you know, understand that under Kelly, we're going to be making progress in that space.
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We would ask that we include the California state hospitals, as another entity to consider for some of this event notification and fortunately, there, there is room for improvement there as well with very vulnerable population.
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Yeah.
01:19:40.000 --> 01:19:51.000
Thank you, Michelle noted inclusion, California state hospitals and the need for kind of behavioral health, to receive notification so definitely appreciate that.
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Amanda you're up I think Rahul you were there and I thought text and then we can go back to Claudia about let's see Amanda, who inequality.
01:19:59.000 --> 01:20:00.000
Thank you.

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Thank you.
01:20:02.000 --> 01:20:08.000
So I wanted to, I wanted to
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echo what you had recommended on on ensuring that plans are included in the event notification ecosystem. I think also for, you know, looking at making changes or expanding event notification alert notification requirements.
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You know, I would want to make sure that consumers are a part of that thought process as well. I think consumers can really benefit from, you know, from this, this infrastructure for things like you know preoperative or care or after care notifications
01:20:52.000 --> 01:21:05.000
immunizations prescriptions. Open Enrollment notifications about their health care rights and opportunities to file grievances. You know there are
01:21:05.000 --> 01:21:26.000
uh, you know if we're going to be looking at building this out and and expanding what this looks like. We should also include the consumer as a user of the, you know, of this platform and be thinking as well about, you know, how can they benefit from
01:21:26.000 --> 01:21:33.000
an expansion of the alert notification requirements.
01:21:33.000 --> 01:21:41.000
Greatly Amanda registered that the consumer, we do have a principal will get to around the consumer.
01:21:41.000 --> 01:21:49.000
Being critically important to all of this, and I think like, like all the suggestions we're getting.
01:21:49.000 --> 01:22:04.000
These are very wise, ideas, we're going to need to like all of them, put them on paper and begin to go through a process of how we how we really start to prioritize and elevate certain aspects of this and including that one so I appreciate that role do
01:22:04.000 --> 01:22:06.000
you want to go ahead please.
01:22:06.000 --> 01:22:21.000
Thanks Jonah. So, essentially this topic is so important that worked in justice involve facilities LA County Jail work in nursing homes regularly. And it's so complicated for us is practicing physicians, not only for Medicaid beneficiaries are all beneficiaries
01:22:21.000 --> 01:22:39.000
when we have received these patients that despite nursing efforts and hospital efforts is just not translated. So, obviously very much looking forward to working more with lanes than my role with the med point, but also as a directly treating these patients.
01:22:39.000 --> 01:22:54.000
This event notification really needs to go broadly because patients are coming from all walks of life, and a lot of cares rendered and very much different places and the usability of that data back into what Dr galley said is so key, and having actionable
01:22:54.000 --> 01:23:11.000

data is so important. So I think that having these event notifications is just the beginning. But it's so critical to the infrastructure so I'm so glad that it's an opportunity number three, and it should be definitely evaluated as we should find opportunities
01:23:11.000 --> 01:23:17.000
to address this huge gap that we face is practicing position so thank you.
01:23:17.000 --> 01:23:22.000
Thank you. I, it also has come up in Kalyan a lot.
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Given the focus on whole person care, and the true notify teams about housing status so it's and and adjust this involved settings to it continues to be something that feels very critical to address.
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We have two more comments I want to make sure we move us forward we have one more opportunity to discuss, and then the rest of the agenda, Claudia, any additional comments.
01:23:44.000 --> 01:24:03.000
Sorry, I missed your interpretation of where you're gone but I guess I guess just maybe an idea. So let's imagine we have a process for deeming networks that qualify as being a way to like if a provider joins in certain network insurance data, they have
01:24:03.000 --> 01:24:04.000
met the requirements.
01:24:04.000 --> 01:24:20.000
I think if we then require those networks to not just share things like CCD as through let's say national networks, but also share at TT, we will resolve the issue I identify which is that a doctor picks one network of hospital picks another and then
01:24:20.000 --> 01:24:33.000
you have a fragmentation. So I think we need to figure out a way to share att data more broadly so that you don't have let's say there's collective medical and there's MX and there's lanes and and basically each of those is a closed ADT network that doesn't
01:24:33.000 --> 01:24:48.000
actually resolve the issues that we're trying to solve. So I don't think the national networks deal with that really at all. But if if we had a demon process I think we could build that in is like, if every hospital shared with one of those and then the
01:24:48.000 --> 01:24:57.000
entities that node shared with each other I think we would resolve but of course for for patients that are shared you wouldn't just share all data, necessarily.
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So sorry to get into the technical options but I think we, like there's so much more work to do on a DT sharing and are even though hospitals, say they're meeting their requirements that doesn't mean that PCB gets the notification.
01:25:11.000 --> 01:25:25.000
It just means that they have the technical option to do it if they happen to ask like if it comes up right so I would just love to see us do more work on that before we in parallel to moving on to some of these other areas.
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Yeah.

01:25:26.000 --> 01:25:35.000
Got it. Yeah, I think that is broadly being supported from all these comments, both in the chat and and speaking so thank you.
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Cathy to Good.
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Great hi everybody chatting center lane McDonald's to wda. I am this is just such a really interesting conversation and I do think there's a lot of potentially very helpful things that additional notifications can allow thinking about people getting services
01:25:53.000 --> 01:26:09.000
to the programs that my members run or that we may be then contract with others children. One of the things that I think about is making sure that you have informed consent on the part of the person whose information would be shared i mean i i know that
01:26:09.000 --> 01:26:26.000
goes without saying, but I think we've seen heightened requirements for example with online entities to collect your data there's existing California law now related to that so I think we'd want to both look at what might there be in the specific to Health
01:26:26.000 --> 01:26:41.000
and Human Services space, but I think you also want to think about some of these other more recent initiatives like that online information and then how do we make sure that people, you know, it can get complicated if somebody, either.
01:26:41.000 --> 01:26:56.000
If it's not an in out but it's in for some things out for others and just how do we sort of think about structuring that just wanted to put a little marker in to make sure to think through those issues because it obviously could help to more robustly
01:26:56.000 --> 01:27:00.000
serve someone, but you also want to make sure that you're following all of those areas.
01:27:00.000 --> 01:27:13.000
So, thanks. yep, yep, yep understood I think content management is definitely a reputation for granted, especially when it comes to notifications about behavior health status.
01:27:13.000 --> 01:27:24.000
If that's going to be a notification process you can't do that without having some sort of informed consent policy and mechanism to document and communicate that.
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So, can't go without saying, really important.
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Great, we're going to move on want to recognize Janice she's like don't leave the MS merge serious fires behind so making sure that they are part of the solution.
01:27:37.000 --> 01:27:48.000
And just want to make sure I recognize that and a lot of supportive comments about engaging with with county and human service organizations on it.
01:27:48.000 --> 01:27:50.000
Okay, last one.

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We're going to focus now on opportunity number four. And this is around inter and intra data sharing capabilities. And we're really focusing here on state, County and other local government.
01:28:04.000 --> 01:28:23.000
Government agencies and their ability to electronically exchange timely information and linking to this relevant provision in AB 133. It's noted here on slide 27 that we develop processes around data sharing and support.
01:28:23.000 --> 01:28:39.000
Working with see stack, for example, and encourage inclusion of all these various health and social and human service entities in those in the counties and in the cities to be supported through the implementation of the day exchange framework.
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So putting that forth, that's the relevant AV one through three provision we need to address here, couple of different opportunities to consider upgrades to County Health IT infrastructure I think being able to support, things like federally funded programs,
01:28:54.000 --> 01:29:04.000
especially on public health with endemic has supported but understanding where the limits are to that and what additional opportunity maybe to support that infrastructure development.
01:29:04.000 --> 01:29:09.000
And there are a couple of examples here but the CDC monetization so this is just one.
01:29:09.000 --> 01:29:15.000
And then the other is around, considering public agency.
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Excuse me data exchange policy and contracting requirements, both through things like, Can there be additional contracting levers that consumer care organizations have with respect to HMIS and coordinating with HUD and how data exchange is supported and
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we we've seen in recent state policy.
01:29:33.000 --> 01:29:47.000
Really good policy about how information can be shared between an HDMI s and the state's new homeless data integration system. Maybe 977 basically stating you receive state funds that you will share and contribute data to the system and and using that
01:29:47.000 --> 01:29:52.000
kind of a lever and creating additional policies like that to support this kind of work.
01:29:52.000 --> 01:30:00.000
That's the opportunity we're considering here in in terms of what the considerations are on slide 28.
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One is to consider developing a public health and human service state exchange capacity building program that leverages and aligns with federally funded modernization efforts.
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So this would include public health, healthcare, Justice involved housing and others to support their needs and as we've heard there's.
01:30:20.000 --> 01:30:29.000
In many respects, some of them are just far along in terms of capacity to share data as hospitals and clinics and practices that had high tech funding.
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Second is around the policies that would expand data reporting requirements. These can be contractual requirements. These can be state policy, kinda like 977, that would allow and require some sort of data exchange.
01:30:42.000 --> 01:30:54.000
And so what we want to consider is what sort of the scope of these programs that might work, where this might be supported CalFresh co works, they're just examples of other programs, whereby data is often needed.
01:30:54.000 --> 01:31:07.000
As always needed, but could potentially be provided through data exchange to support things like more automated applications and better access to data to accelerate the application process CalFresh with a really good examples but I'm actually in the first
01:31:07.000 --> 01:31:23.000
group on the first advisor group meeting, and then should there be other policies developed to incorporate HIE requirements into state applicable state or local procurements for things like county county jails procuring or updating any HR should there
01:31:23.000 --> 01:31:32.000
be certain provisions that will require that these procurements include data sharing for the new EHR vendor that comes on board that's just one example.
01:31:32.000 --> 01:31:45.000
So I'd love to open this up again to questions for our last for this last program and Erica you are fastest on the button. So, please go ahead and be so good at jeopardy.
01:31:45.000 --> 01:31:55.000
And I am wondering if I could answer the question with a question.
01:31:55.000 --> 01:32:05.000
What is the relationship between what what's being proposed here as an opportunity with the
01:32:05.000 --> 01:32:26.000
database that we are here that the department is developing to synthesize and aggregate data across Medicare beneficiaries and other other.
01:32:26.000 --> 01:32:38.000
Yes, I could not think of its name thank you Jonah, I'm curious what's, how, how are you thinking about the relationship between those two things, what you're proposing here in that.
01:32:38.000 --> 01:32:49.000
That's a, that's a really good question Erica so for those who don't know that department health care services is planning the development of a service.
01:32:49.000 --> 01:33:08.000

That would be an aggregator of data, administrative data like claims program information flags that indicate is an individual, that's in medical for example, do they receive CalFresh how works or other benefits, and ultimately clinical data from the field
01:33:08.000 --> 01:33:22.000
so that as a locus, the department can provide that information to plans and counties and providers can support things like risk stratification can pre populate assessments so the, I think the link is one.
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The in order to access data from some of these county institutions, those institutions need to have systems in place that can actually store manage and share that information and that's one of the gaps that we're really focusing on here.
01:33:38.000 --> 01:33:52.000
What health management service would do is like right it's an aggregator almost like an HIE in some respects, but has to get the data in the first place and, and many institutions, which is the gap that we're trying to address at the county or city level
01:33:52.000 --> 01:33:58.000
for example, don't have the capabilities to do that today.
01:33:58.000 --> 01:34:01.000
Okay, that's very helpful.
01:34:01.000 --> 01:34:20.000
I this, we would want to take this back and really think about it with our county colleagues and, and sort of chew on the into the particular implications opportunities issues here so appreciate you raising it and we'll, we'll get back to you.
01:34:20.000 --> 01:34:21.000
Thank you.
01:34:21.000 --> 01:34:24.000
Ok. Michelle.
01:34:24.000 --> 01:34:45.000
Hi, Michelle fab data again from County Behavioral Health Directors Association and I also want to sort of take this back to our folks but simply out of curiosity, trying to understand if what the thinking or rationale is behind developing this as a programmer
01:34:45.000 --> 01:34:51.000
initiative that covers all County, HHS, except for County Behavioral Health.
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Just hearing a bit more about what the thinking was there would be helpful, so that I can bet this appropriately.
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Right.
01:35:00.000 --> 01:35:07.000
I think, well the thinking and we may be wrong here but the thinking is that County Behavioral Health.
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When we're, when we consider that infrastructure and capacity to store and share data would be covered in the opportunity number one and number two, as a provider of behavior health services.
01:35:21.000 --> 01:35:24.000

So that kind of infrastructure capacity and support would be covered in those others.
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This opportunity would be for those who are in this example, they're not subject to at 133 day sharing requirements and that first go live in 2023 and 24.
01:35:36.000 --> 01:35:59.000
But that are subject to a previous slide that provision at 133 that extends to other institutions, so I think that's where that's where at least we're proposing to sort of to create some guardrails but contours of this, of this proposal.
01:35:59.000 --> 01:36:03.000
Okay, well, we'll follow up with more offline. Thank you.
01:36:03.000 --> 01:36:07.000
Great. Thank you, Karen.
01:36:07.000 --> 01:36:24.000
Thanks Donna, Karen savage at Penn, I wanted to follow up on Amanda's earlier points and just ask the question of, is there a future discussion planned about technical infrastructure from the consumer standpoint, or for consumers to be able to interface
01:36:24.000 --> 01:36:36.000
and access their health information through the HIE, is that a future discussion or is that just missing from this conversation at this point.
01:36:36.000 --> 01:36:50.000
I get the sense from your question that perhaps it needs to be conversation, and not not assumed to be incorporated into this.
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Is that correct.
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Yeah, absolutely. Because I just, you know, there's nothing in here about making sure that we have a way for limited English proficient consumers to access their having there's nothing that sort of addresses the central issue we have today that you can
01:37:03.000 --> 01:37:15.000
can access your health information if you are well resourced well educated and connected to a provider who will help you right and other than that you're not going to have access to your own health information and so I think there's, you know really significant
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considerations here around how we build and utilize technology that's equally accessible to all Californians, and how we ensure there's some kind of affirmative obligation for providers to assist their patients with understanding how to access their own
01:37:30.000 --> 01:37:35.000
health information and how to use it as well.
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Very good points Karen and will obviously be taking that back.
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As we consider future iterations and additional opportunities.
01:37:47.000 --> 01:37:59.000

I'm getting the getting the message, we've got about 12 minutes. And so I want to make sure that we get to as many comments as we can I see at least for their to their will try to get up to all for the next 12 minutes so marketplace that.
01:37:59.000 --> 01:38:00.000
Thanks Jenna.
01:38:00.000 --> 01:38:16.000
I'm going to make exactly the same point that Karen did thinking the four things that are here, these are these are not opportunities or gaps, you're really talking about what it is for the patient the individual family caregiver.
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And I go back to the vision statement, which is that every California should have access. And so, yes we do need to, we do need to be thinking from that perspective to.
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I very much look forward to that future conversation.
01:38:34.000 --> 01:38:48.000
That also would embrace the digital divide questions that people have been mentioning as well just on some, some of the more technological friends. Thank you.
01:38:48.000 --> 01:38:49.000
Great.
01:38:49.000 --> 01:38:52.000
Catholic Please go ahead.
01:38:52.000 --> 01:39:12.000
Oh, sure. Hi. So, Kathy semolina CTV. I think it's kind of mostly a what they said on Erica and Michelle's comments. I, you know, we're my programs, at least the big three cow works CalFresh a medical eligibility pieces come at this from a perspective
01:39:12.000 --> 01:39:21.000
that might be a little different from some of the other programs that we talked about here and I think I've said this before but it's been a while so it's probably worth repeating.
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For those who don't know, we do have a really robust eligibility system. We're in the process. In fact, of merging eligibility systems from a couple of systems that together, 58 counties use across three systems, we've just gone from three to two, we're
01:39:42.000 --> 01:39:57.000
going from two to one over the next year so year or two, I guess I'd say by 2024 that will be completed. So I think, I think that keep in mind when you think about those three major programs is number one.
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I mean, we do have data for people. I mean, we're talking 10s of millions of people really we have you know 14 million people as sort of the high points on medical, but they're not always the same people.
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So we've got so many you know people in our systems that you, you want to think about, you know, both that's a robust and rich source of data, a lot of that information isn't.
01:40:23.000 --> 01:40:35.000

In addition to I'm receiving CalFresh or I'm on that account. It's your income, your immigration status, these are things that are pretty you know private.
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And so, I think, how we think about together. Once we're done with the migration and the merger because we can't possibly Connect I think into new things until then, what pieces is it that we really do need to share that wouldn't already be obtained through
01:40:53.000 --> 01:41:10.000
other sources, through some kind of an interface, and you know to what end, are they being used, I I don't know that you need us to plug in the income information for example or how much somebody spends on their utilities, which is an aspect of figuring
01:41:10.000 --> 01:41:20.000
out if they're eligible for CalFresh and for how much. And so it's a, it is again an interesting conversation, it's one that could bear a lot of fruit.
01:41:20.000 --> 01:41:35.000
It also, it's a little different. I think when you're talking in particular about the big three programs that are in the Cal sauce system is what it's ultimately going to be called because the data that are in there are somewhat different than I think
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we typically think of it, we've been talking in these meetings, and then give us a couple years, but then we also have so many people in those systems, we've got historical data as well as people coming in new.
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So there's a few considerations and we'll think about some other things and, like, the other said from counties, go back and talk together as well kind of from a county perspective generally if we're able to do so in addition to probably some individual
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comments based on each of our different kind of memberships.
01:42:03.000 --> 01:42:24.000
Great. Yeah, Kathy that's great and particularly the process of migrating towards a single Cal sauce which is awesome, which I know has been on the books for many years and is incredibly welcome, they're identifying opportunities by which that can be
01:42:24.000 --> 01:42:27.000
that can support,
01:42:27.000 --> 01:42:41.000
sharing of information and particularly around some of the comments we got around consumer engagement and consumer information about when, where my benefit status would win industry determination happening you know being able to actually have an advanced
01:42:41.000 --> 01:42:53.000
view on certain things like that, and sharing that with Medicare plans and others so that they can and providers so they can have access to that information, know who their managed care plan is who the provider is, who's your care manager is.
01:42:53.000 --> 01:43:04.000

I think there's a lot that could be incorporated. Not all necessarily through calculus but any any input, you can have from the counties around that integration would be really welcome.
01:43:04.000 --> 01:43:07.000
Yes.
01:43:07.000 --> 01:43:10.000
Thank you. To mark Lynette.
01:43:10.000 --> 01:43:19.000
Hi, this is Scott from department health care services and I just want to echo on some of the conversation around consumer patient engagement.
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Just to acknowledge and make sure we track to the requirements again on the patient access and interoperability role one of the aspects of the patient access and in our role is that for Medicare and Medicaid providers that we, and that health plan providers,
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etc.
01:43:36.000 --> 01:43:48.000
Have have data exposed to a fire API so that a third party application that is patient focused can then interface with it and provide patient patients, their information.
01:43:48.000 --> 01:44:08.000
The requirement is around having the data available in that fire API is not that we have to have an application to connect to it. And so being able to understand how that fits into this conversation and what does it mean to have that usable application
01:44:08.000 --> 01:44:13.000
for a patient and having language and and using language that's understandable.
01:44:13.000 --> 01:44:26.000
So it's something that should be part of that conversation and part of that mix piggybacking on some of what Kathy was talking about as well. One of the things that comes up frequently as having high quality.
01:44:26.000 --> 01:44:42.000
Identify or demographic information so that we may start talking about identifiers and making it linking across or connecting people across different systems to her point around some of the work in the sauce is around having that that information so there
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may be a piece to take into account there just to draw that connection. Certainly as we think about patient consumer access broadband connectivity comes into play.
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So I don't know if that would pick your into the conversation here. And then the final thing in terms of the backing on the original question relates to the population health management service that Jonah talked about so as we think about that as an aggregator
01:45:09.000 --> 01:45:12.000
for the medical population.
01:45:12.000 --> 01:45:28.000

Because typically it is focused on the medical population. It could be thought of as a third party app that connects to our underlying data and the MediCal program to make that available to beneficiaries, also to provide our sense of plans, so it will
01:45:28.000 --> 01:45:43.000
be a phased approach. We won't have everything all at once. It will be an ongoing piece, but it is simply not an HIE, so it's a aggregator around, being able to to Population Health Management Services.
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When it was first announced last spring that was one of the questions came up. So I just want to make sure that we clarify that here as well. Thank you so much.
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Thank you, Anna.
01:45:53.000 --> 01:46:00.000
And I do want to just reinforce the patient equity interoperability rule in terms of what you see in the future from us.
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Just to preview that because we were intending that rule is really important for and it implicates certain segments of plans for example but not qualified plans on California marketplace.
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And so making sure that it's extended to those, potentially, that it goes beyond just to communicate with the, with the beneficiary or with other plans, or the state Medicaid agency for example but it also extends to providers who are delivering services
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to that member so we're going to come back to this in a future meeting, and just want to recognize that that rule, and the consumer patient access issue that have been brought up by Karen and Mark, Cathy and others.
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Okay, we have two more minutes.
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If we can do this, Michelle, and so forth.
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Yeah, thank you. I'm struggling on this concept a little bit because it's not quite clear to me which direction the data is flowing and what data from public health we're talking about.
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I feel like a lot of the discussion is centered on like what you can extract from, I'll just use public health as an example that supports kind of healthcare decision making in the healthcare field.
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And in reality that that there might be some there that's more of a population focus but then there's also data that healthcare providers have that we need in terms of, you know, immunizations or other, other things so I'm struggling conceptually on that
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one a bit and public health is so broad like are we talking about specific public hope health programs like CCS or home visiting are we talking about.

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Sorry, I just lost your audio of me
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know we lost it. Okay.
01:47:51.000 --> 01:47:54.000
I thought it was okay. So Michele.
01:47:54.000 --> 01:48:01.000
Yeah, Michelle, what I heard is what's the scope of this, and making, making it more clear.
01:48:01.000 --> 01:48:10.000
I think we lost her make it more clear what the scope is and the direction of the sharing of data center, which makes important Okay, well you're, you're up last one.
01:48:10.000 --> 01:48:25.000
Yeah, mines quick just a quick comment on the requiring, or you know, creating policies around some of the vendors like each is vendors and you know software like that, that has invaluable data that I think that could be used and if there were there if
01:48:25.000 --> 01:48:38.000
they were required because they really don't do anything unless it's required, and it's so disparate across counties, you know, or the hub, you know, the hub regions so they you know they're creating a policy, creating that standard that you know the
01:48:38.000 --> 01:48:50.000
Amy even you know Michelle's comment around immunization data is often found in there, so much of the demographic data, other data that housing providers need, and it's such a wide swath of from housing providers so I just think that you have an incredible
01:48:50.000 --> 01:49:01.000
opportunity with that policy, requiring them to again have some type of API or data exchange, so it's just an easy win.
01:49:01.000 --> 01:49:02.000
Right.
01:49:02.000 --> 01:49:06.000
I don't know what it's easy.
01:49:06.000 --> 01:49:09.000
Easy.
01:49:09.000 --> 01:49:27.000
You know, I think that what you're raising here is we've got, and others have raised here we've got federal policy. It specifies a type, like an API buyer, in this case, to share data effectively interoperability rule and others, and one is the consideration,
01:49:27.000 --> 01:49:38.000
would that be something that might be policy that extends to all different, and additional public institutions, county, state and others.
01:49:38.000 --> 01:49:48.000
And, but they would also need to ensure that they have the capabilities to be able to do that and we know already, it's difficult fire is not sort of turn on the light switch.
01:49:48.000 --> 01:50:03.000

Kind of points so there's I think I need to do that and then to also for those organizations, county, city and other health and human service agencies to be able to also be consumers of the data, not just like we've got data and we're going to share it,
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but there's got to be some by directionality here.
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And I know your organization San Diego is actually practice open quite widely with two on one, and you've been able to do that to some great extent so there's some good learnings I think from there I mean account and a few others who've done some good
01:50:20.000 --> 01:50:21.000
work here.
01:50:21.000 --> 01:50:26.000
All right, thank you for all this incredible comment and discussion.
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We are going to obviously summarize what we took away from this.
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What's going to happen is as we build out these we're going to we're going to develop this.
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These essentially as sort of chapters in the framework.
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We're going to give all the advisor group members and other week five business days one week from today to provide additional comment, certainly welcome additional thoughts, especially from a couple of you noted, I think Michelle Erica, really important
01:50:56.000 --> 01:51:11.000
to take some of these back to your constituencies but all the advisory group members will come here additional thoughts here. And the last thing I would say is you know there's the first the first opportunity a lot of issues and comment came up about
01:51:11.000 --> 01:51:12.000
funding.
01:51:12.000 --> 01:51:25.000
And we have to be very mindful of the fact that this is, this is not just to Secretary always point, this is not just about safety net programs, this is not just about medical.
01:51:25.000 --> 01:51:37.000
This is not just about public health, this is broad for every California, there are private, there are public payers there's all sorts there's the federal government there's philanthropy we really need to braid funding.
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We know that we cannot just rely and ask the state government to continue to fund these initiatives on their own. It's got to be a consolidated multi stakeholder braided aligned funding initiative and so when you think about responding to additional comments,
01:51:54.000 --> 01:51:58.000
we'd love your thoughts about how that can be done effectively.
01:51:58.000 --> 01:52:00.000
Okay.

01:52:00.000 --> 01:52:03.000
I think at this point we're going to public comment.
01:52:03.000 --> 01:52:10.000
So I'm going to turn it back to our facilitators to take us through that process. Thank you.
01:52:10.000 --> 01:52:12.000
You want me to take.
01:52:12.000 --> 01:52:26.000
I'll take that. I think you're ready to go so we're going to go into public comment. Please note, they individuals in the public audience who have comment be inserted in the q amp a or otherwise, please raise your hand, using the zoom teleconferencing
01:52:26.000 --> 01:52:34.000
options, as we previously discussed then you'll be called an order that your hand was raised, state your name and organizational affiliation.
01:52:34.000 --> 01:52:37.000
And please keep comments, respectful and brief.
01:52:37.000 --> 01:52:43.000
We're going to have, I believe it's going to be Alex who's going to be recognizing individuals and taking them off mute.
01:52:43.000 --> 01:52:50.000
And I'm going to hand it over to Alex.
01:52:50.000 --> 01:52:58.000
Thank you, Michael merchant Michael you should be able to unmute and speak.
01:52:58.000 --> 01:53:11.000
Thank you very much as the michael moore shot I'm with UC Davis. So just a couple of quick comments, quite a lot in the q amp a so if you read through the q amp a, you'll get most of it but just to highlight is the language around point one around EHR,
01:53:11.000 --> 01:53:24.000
the technology stack and the people that are going to be exchanged organizations may or may not be on an EHR so we may want to look at changing that language, like the PC ours and pre MS and there's some others that I call the appointed dollar bill pointed
01:53:24.000 --> 01:53:26.000
out in, in the chat.
01:53:26.000 --> 01:53:41.000
The other piece is just really again making sure that we increase our create some additional work groups to deal with some of the Messier issues around identity and consent that we talked about today, and some of the other pieces I know we have one subgroup
01:53:41.000 --> 01:53:56.000
but I think this organization, the based on the regulations we need to move quicker and be can be active and doing these things on a more regular cadence and so I would encourage the Advisory Council to commission additional work groups, and to try to
01:53:56.000 --> 01:54:10.000
move things along a little bit quicker, just feels like we're going to get to next year when we need to have something done and we're going to have way too many spaces are holes and what we're trying to do, and again just continue to leverage the existing

01:54:10.000 --> 01:54:22.000
work I know Dr. Lane done a great job of putting a lot of things that exist out in the chat or in the q amp a and I would just encourage the Advisory Council to leverage as much of that as possible as we move this forward.
01:54:22.000 --> 01:54:25.000
Thank you.
01:54:25.000 --> 01:54:27.000
Thank you.
01:54:27.000 --> 01:54:56.000
We do not currently have any other hands raised, give it a minute to see if anyone else would like to raise their hand.
01:54:56.000 --> 01:55:20.000
Can if any members of the public would like to make a verbal comment please raise your hand and we will give you access to unmute.
01:55:20.000 --> 01:55:27.000
All right. No hands raised, I will pass it over to Jennifer.
01:55:27.000 --> 01:55:31.000
Great, thank you very much can you go to the next slide please.
01:55:31.000 --> 01:55:34.000
Thank you.
01:55:34.000 --> 01:55:44.000
So, as Tom mentioned earlier Robert coffin is unable to join us today, he's serving in jury duty So Kevin McCarthy and I will be taking the section instead of him.
01:55:44.000 --> 01:55:48.000
So thank you for your patience. Next slide please.
01:55:48.000 --> 01:55:57.000
We'll be discussing two pieces for this part of the agenda, the statutory requirements and our development plan. I'll present the statutory requirements and previous slide, please.
01:55:57.000 --> 01:56:13.000
And Kevin will delve into the development plan. So we'll stay on 32. As you can see from the statutes language ab 133 requires a strategy for a unique secure digital identity that can support master patient indices and be implemented by the public and
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private sectors. Next slide please.
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So what does the statute mean by a strategy.
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We see this as a collection of recommendations or a high level plan that explains and discusses issues such as what additional stakeholder engagement should occur.
01:56:31.000 --> 01:56:48.000
Who the stakeholders may be the options for approaching digital identities, which may include risks and benefits for those approaches identity validation, who can access digital identities, whether a Golden Record or a master record to be created for
01:56:48.000 --> 01:56:49.000
each person.

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01:56:54.000 --> 01:57:09.000
The strategy would also define what a digital identity is and what it's not. We don't see a digital identity as being a unique identifier or a unique number assigned to each individual like a social security number, rather a digital identity is really
01:57:09.000 --> 01:57:19.000
a collection of various identifiers that establishes an individual's profile. So for example, my name my birthdate and address could be a digital identity.
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01:57:23.000 --> 01:57:38.000
The identity also needs to be unique and secure what unique means in this context, needs discussion because there are different identities for various purposes, what information you may need on an individual for financial purposes is very is likely very
01:57:38.000 --> 01:57:53.000
different from what you might need for treatment purposes. In addition, this identity needs to be secure and consider the privacy of individuals. So digital identity could be the minimum information necessary to validate an individual, for example of
01:57:53.000 --> 01:57:58.000
a very common first and last name, Jennifer Schwartz, so many people have that name.
01:57:58.000 --> 01:58:08.000
We need to make sure that, Jennifer shorts me is the Jennifer shorts were actually talking about rather than someone else that isn't particularly important for treatment purposes.
01:58:08.000 --> 01:58:12.000
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01:58:12.000 --> 01:58:22.000
This digital identity needs to be implemented by both private and state and local government entities. The goal is to consider how counties and states departments, as well as industries can use this.
01:58:22.000 --> 01:58:37.000
We do need to ensure that we fulfill the purposes of the statute. So we do need to focus on the entities listed by a b 133, such as providers plans and labs, but we should also consider other entities that will want to use these identities.
01:58:37.000 --> 01:58:53.000
So just health information organization state departments community based organizations, counties, and others. So the strategy should identify possible gaps in implementing digital identities that would need to be addressed in future work on this topic.
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Lastly, the strategy needs to support master patient indices master patient indices are necessary to assist organizations and accurately identify patients across different systems entities and context.
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Again we don't see this as a unique identifier or, you know, unique number, but rather a collection of information that can be used to link records together, or to validate the identity of an individual.
01:59:22.000 --> 01:59:37.000
The strategy needs to identify how different entities develop and use digital identities, which will help prevent negative impacts on existing business processes, but also allow future work on digital identities to enhance what is already done been done
01:59:37.000 --> 01:59:38.000
in this area.
01:59:38.000 --> 01:59:50.000
The strategy may have an impact on the data sharing agreement, and that there needs to be some level of reciprocal sharing and the information that as part of an identity such as that name address and birthdate.
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01:59:56.000 --> 02:00:18.000
So, I'm going to go ahead and hand it off to Kevin and I think maybe we can take questions at the end Kevin, unless you want to stop for a moment and take questions now know that sounds great, thank you so much Dan and so nice to be able to chat with
02:00:18.000 --> 02:00:27.000
I know our solution in our discussion about the opportunities around a little bit long, but I think it was, it was well worth it.
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So, standing in for him is always a hard thing to do but I think he would agree with the statement that the promise of interoperability really requires us to have more than just capable technology in place.
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It requires a willingness and institutions to share data common adoption of effective standards and interfaces for facilitating health information transmission processes protocols infrastructure to, to protect individual and patient data.
02:00:55.000 --> 02:01:11.000
And of course as Jen spoke to the capacity to accurately and reliably match health and increasingly human service records to a single individual AB 133 requires us to develop a strategy for unique Secure Digital identities.
02:01:11.000 --> 02:01:21.000
Ik by digital identity strategy capable of supporting master patient indices, to be implemented by both private and public organizations in California.
02:01:21.000 --> 02:01:28.000
It's not a small task or an easy one, a digital identity strategy in the public and private sectors.
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Currently, are managed, and how they're managed varies widely, as does their success, reminding us of the real risks, and and and benefits.
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As we think about balancing individual privacy and health as Jen mentioned understanding the current landscape and how we must consider and balance the needs for privacy against security in our development of a strategy moving forward, bringing our all
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of our stakeholders along with us is going to be of the utmost importance. And so as we get underway with our opportunities development. We didn't want to leave aside our really important work to fulfill the promise of at 133 and developing a digital
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identity strategy on the slide right now you'll, you'll see our proposed approach for for building out the strategy between now and its delivery in July, 2022.
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Today we're hoping to get some targeted feedback from this group, on, on a few areas including different stakeholder groups we'd like to engage and the topics we'd like to cover with those with those stakeholders, come January, and I think this is already
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underway with our at our team, we're assessing current consumer privacy data exchange framework participant needs, and really exploring overall approaches for for what should comprise could comprise digital identity strategy in California.
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February will refine these needs and explore different strategy components, March, will continue to refine those components with an emphasis on this balance of privacy and security.
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We're hoping to have a draft strategy ready by April, and we'll be working to refine that strategy and align requirements with final recommend final recommendations and opportunities identified by the advisor group, through the data exchange framework,
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and through its subcommittee, and the data sharing agreement in May 2022 will finalize the strategy for delivery to the legislature, June and July.
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One point that I want to make and just want to make sure we're really clear on is throughout this process we want to make sure that this advisory group is kept well up to speed with our development of the digital identity strategy.
02:03:54.000 --> 02:04:09.000
So similar to our data sharing agreement subcommittee updates that will have at the end of each meeting and generally following me up and in a couple minutes with some latest updates there will lean to have regular updates for you all every time we get
02:04:09.000 --> 02:04:14.000
together. Next slide please.
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So stakeholder engagement, engaging in the development of a robust and effective digital identity strategy requires deep technical Council.

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David, I think I just saw your a couple of comments that you mentioned in the advisor group reiterating this for for several aspects of our data exchange framework and I think it's certainly true here.
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Engaging focus groups are coming from a similar perspective, will allow Cal HHS to tap into additional expertise on the topics of digital identity and patient matching while making sure again all of you are involved, and in the loop.
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The focus groups that we are planning to reach out to include the fall into organizations and individuals working every day in the following sectors, health information exchanges providers, health plans, consumer privacy representatives state health and
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human service departments and others that you might suggest some of these meetings will be held a one off all will be subject to public meeting laws and everyone will be invited to attend.
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And I'll talk a little bit about some of the topics we're hoping to cover, but one of the questions I'd love to come back to in just a minute here is, are there other groups, we should be thinking about engaging, listening to through these through these
02:05:50.000 --> 02:06:01.000
sessions over the coming months to identify both the current state of play as it relates to digital identities, the needs in the market and testing potential effective ways forward.
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So, with within each of these focus groups or listening sessions that we're presently planning on facilitating Kelly chest and CDC CDI will seek to get additional information on on topics including the technology and service components that should and
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can and should comprise the strategy for for arriving at a digital identity. What data should comprise a digital identity. And how should that be documented ultimately in our data exchange framework, how organizations presently and could potentially contribute
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to and use a digital identity and permit permitted uses of a digital identity, under the data sharing agreement or any a company policy to the data exchange framework.
02:07:00.000 --> 02:07:15.000
If there are other topics that this group thing so that you would like us to test, as we engage the stakeholders in these listening sessions over the course of January, February, We very much love to hear about them.
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So please feel free again in a moment or over chat over email at any time to let us know what questions you feel will be important for us to be posing to any of these

groups given your previous experience successfully or diary or previous challenges and
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working to implement a digital identity strategy yourselves.
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Again, over the course of the next few months will be holding two to three listening sessions with each of the focus groups. I mentioned before, where it makes sense we might consolidate several stakeholders in a single focus group.
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But we do aim to wrap up this work by March.
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All these meetings will be posted as public meetings for Begley keen requirements will have high level agendas and a few likely high level discussion questions around which will have facilitated conversation, everyone on this group should be, that should
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getting updates and notifications of future sessions in case you are members, your peers would like to join agendas meeting notes and all other meeting materials we posted to the next website as these meetings and notes and and artifacts are presently
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posted.
02:08:36.000 --> 02:08:52.000
Again, this group will remain posted on all progress, and where there are key decision points, strategic decisions that need to be made. Though we will use these sessions as much time during the sessions as we can to raise those decision points for your
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consideration, and always for written feedback offline.
02:08:57.000 --> 02:09:03.000
So I think we have a couple of questions as I'm glancing over this side of my eye here.
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I'll open up. Claudia, I think you might have had a question that came up during Jen's went through the statutory requirements.
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I think this is a fabulous focus.
02:09:21.000 --> 02:09:42.000
And I would just urge us to distinguish between an operational Identity Service and policies that we might want to promulgate or promote and my kind of premature but still strongly held recommendation is to focus a service on government needs.
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Because I don't know that it's going to be possible in the short run to develop a service that meets, everyone's needs. And I think the lack of robust, I density management within government affects all of us and I'll give an example.
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We recently started receiving data from CD pH from the care from their snowflake storage of covert data. We submitted 23 million patient records and received 6 million records back we would have expected to receive 20 million, and primarily that's because

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the matching only occurred on exact matches of name and date of birth.
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And so, I guess I would just urge that we identify the exact use cases we're trying to solve for. And to me, the lack of being able to match across state programs and match records with private organized, you know with organizations in the community that
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needs to receive data from the public is such a huge and show stopping issue that my recommendation is to start there and then examine To what extent that service can be opened up to other private sector organizations, but I don't think we can achieve
02:10:57.000 --> 02:11:14.000
like the population health management services the HDD sharing covert data with health plans or with a Chinese, none of that can be done unless there's a robust cross government service that allows for matching of records, and that service isn't just
02:11:14.000 --> 02:11:20.000
the technology show. It's also the actual data that would populate it.
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So I just get a little nervous about us thinking that we can create one thing for everyone to use.
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I would recommend we focus a bit more narrowly but actually solve a very concrete use case that would help all of us.
02:11:35.000 --> 02:11:49.000
Thank you, Claudia points very well taken and also reminds me and I'll channel room here about what we can do with the time that we have, I mean July is seven months around the corner and you have to really think about what we can scope, what we can what
02:11:49.000 --> 02:11:53.000
we can accomplish for the time and the scope we have.
02:11:53.000 --> 02:12:08.000
Lori, I think what we'll close up with you on this topic, others for stakeholders and topics to cover with those stakeholders, please feel free to enter them in the chat, but Lori you want to close this up on this topic here before we move to Jen, the
02:12:08.000 --> 02:12:26.000
subcommittee, sure, for sure. Thank you. First of all, I think it's important that we are following I really appreciate the recommendation that we do sort of deep dive with focus groups, rather than a subcommittee because this is such a complex issue.
02:12:26.000 --> 02:12:42.000
It has a technology issue a policy, obviously a patient issue as well. So I really appreciate this process of trying to tease out best practices from each of these focus groups.
02:12:42.000 --> 02:12:49.000
I would recommend additional folks is participants beyond providers and so forth.
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A Hema has addressed this issue with a national look at MPI.
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The California Health Informatics Association has also spent about a year developing an MPI tool kit.
02:13:06.000 --> 02:13:16.000
So it gets out some of those issues of workflow and data that that could be used some best practices across health systems.
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So I think those participants would be really valuable in this. And I would also recommend that folks reach out to their colleagues across the country, to see if we can have some, some learnings from other areas that have worked to try to address specific
02:13:34.000 --> 02:13:47.000
use cases as Claudia said, rather than trying to come up with some sort of, you know, Master patient index single centralized repository.
02:13:47.000 --> 02:13:57.000
I think pretty far beyond that. So, I'm just really encouraged by this process and I think this is going to be really beneficial.
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Thank you.
02:13:58.000 --> 02:14:16.000
Hema California Health metrics Association. I will also add to the list for consideration. I also think you bring up a key component or activity that's going to be undertaken or it actually brings fall under way with really looking beyond our borders
02:14:16.000 --> 02:14:28.000
to what's worked effectively elsewhere. Other states and regions. And I think that'll be a key ingredient to our success and developing an effective digital identity strategy plan to move forward by July.
02:14:28.000 --> 02:14:42.000
So thank you all for for your your your consideration comments here again we wanted to make sure that you were briefed and aware of what we are required setting out to do and our approach to do so methodically.
02:14:42.000 --> 02:14:57.000
We will keep this group of prize that are developments over the course of the next few months together. So with that I'll pass it back to Jen. For a brief data sharing agreement subcommittee update, and then we'll, we'll talk about principles before we
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close. Thank you.
02:15:00.000 --> 02:15:09.000
Thank you, Kevin, we go to the next slide please.
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Thank you. The data sharing agreements and important part of the framework and, as everyone knows, has very tight timelines, to meet the such trade deadline.
02:15:18.000 --> 02:15:24.000
So the DSA committee met for the first time then discuss the charter and goals for the subcommittee.
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Our second meeting will be Wednesday December 20 seconds.

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definitions such as exchange purposes and public health, to sort of help sort of define all these different elements.
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And based on the discussion at the next meeting draft language will be developed. And the subcommittee will start to look at draft sections of the data sharing agreement and discuss topics, including technology such as how to address different levels
02:15:59.000 --> 02:16:14.000
of technological readiness for exchange without a negative business impact, whether certain types of exchange should be required, such as treatment or patient access and privacy and security, such as breach and breach notification will be posting these
02:16:14.000 --> 02:16:26.000
draft pieces of the data sharing agreement and invite folks to provide written comments and feedback for folks who are not so committee members, you can still attend the meetings and voice your feedback during the public comment period.
02:16:26.000 --> 02:16:28.000
Thank you very much.
02:16:28.000 --> 02:16:42.000
And I believe I'm handing it on to john. Thanks, gentlemen. Thank you very much Thank you everyone great conversation today. It's been very fun to watch the chat and it's been fabulous to watch all he contributes so thanks for your time.
02:16:42.000 --> 02:16:46.000
We have one more topic and then we're going to close out the meeting.
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As we discussed if we can go to the next slide please. As we discussed in our last meeting moving forward, as we move forward on the guiding principles.
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We were looking at the federal state data exchange principles were possible know that these guiding principles that were presenting were based on the onz Stefka principles for trusted exchange with additions from Cali jjs guiding principles and the consumer
02:17:10.000 --> 02:17:22.000
and Patient Protection principles for electronic health information exchange in California to align with the vision of a view 133. Next slide please.
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During our November meeting, while the advisory group, generally agreed with the guiding principles put forth, you also requested a more detailed principles, more detailed principles that would better lend themselves to opera operational ization.
02:17:36.000 --> 02:17:52.000
We heard from you. And we followed up, and we, we received an expanded number of service, a number of comments from all of you significantly expanded the principles, sharing them in advance of the holiday and requesting any additional feedback you might
02:17:52.000 --> 02:17:53.000
have.
02:17:53.000 --> 02:18:06.000

And you responded, we had 10 of you respond with 11 detailed comments about the principles, and we received a lot of other feedback as well.
02:18:06.000 --> 02:18:18.000
It was very constructive, it was well taken. And while we don't see complete always have full agreement with each other. The feedback you provided allowed us to further refine the principles of shared.
02:18:18.000 --> 02:18:27.000
So ultimately we incorporated many of your suggestions. And you can see some of the highlighted on this slide here.
02:18:27.000 --> 02:18:36.000
And I'm just checking on time. Kevin Do we have time for comments and Do we have any comments coming in.
02:18:36.000 --> 02:18:51.000
I have about four or five minutes if there are any questions comments. This is the first time we've had the opportunity to raise the guiding principles and receiving feedback last time.
02:18:51.000 --> 02:19:02.000
to feedback or receive last time was was essential so if any advisory members do have a comment at this point, please raise your hand and we'll take a few minutes to to discuss.
02:19:02.000 --> 02:19:09.000
While you're doing that photo
02:19:09.000 --> 02:19:11.000
sharing us.
02:19:11.000 --> 02:19:27.000
Yes, thank you. So I appreciate you making a couple of minutes to discuss this, I want to say that we're moving principle eight on accountability is a huge concern for me and I think I probably speak for all the consumer advocates because I know that
02:19:27.000 --> 02:19:36.000
we had really voice the need to add that principle. And while I recognize that you got a number of comments from providers objecting to that principle.
02:19:36.000 --> 02:19:48.000
I just want to emphasize again that from a consumer standpoint not explicitly including both accountability for misuse of data, but also accountability for actually using the data that providers will have access to.
02:19:48.000 --> 02:19:59.000
And I've previously given the example of language when a provider knows what is the preferred language if a patient, they have an affirmative duty to coordinate language services.
02:19:59.000 --> 02:20:11.000
And there's many other examples of why this is important so we will be sending a letter with lots of consumer advocates and Jonah did receive a preview of the letter which really emphasizes the importance of accountability.
02:20:11.000 --> 02:20:22.000

But again, we do have deep concern with the removal of that principle. I say we have a few other concerns to with this final draft and things that have been changed or not included from a consumer perspective.
02:20:22.000 --> 02:20:35.000
And those include making sure that there's bidirectional access for consumers. Another point that's been raised repeatedly by consumer advocates on this committee and making sure that we address some of the accessibility and digital divide issues so I
02:20:35.000 --> 02:20:49.000
recognize you're presenting this as a final but do you want to put that on the record. Thanks.
02:20:49.000 --> 02:20:59.000
I'm reminded of a expression that nothing's final until we say it is so I appreciate it and definitely will will hear your comments.
02:20:59.000 --> 02:21:01.000
Thank you very much for speaking out.
02:21:01.000 --> 02:21:05.000
Do we have anyone, anyone else.
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Mark and then Saturday.
02:21:07.000 --> 02:21:11.000
Okay.
02:21:11.000 --> 02:21:18.000
So. Second thing what Karen said and I'll just follow up with the question why was accountability dropped.
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It was clearly added because you under, because we articulated there's a, there was a stakeholder advisory group wide discussion about its importance, I was quite surprised to see it removes to ask the question why this fall under the same comments that
02:21:38.000 --> 02:21:43.000
Karen made and I'd love to hear Marc's question and thank you.
02:21:43.000 --> 02:21:44.000
Yeah.
02:21:44.000 --> 02:22:01.000
So in response to a number of comments, that, that, that the accountability principle was duplicative of some of the parameters that were in the other principles that was, that was removed.
02:22:01.000 --> 02:22:16.000
It sounds like no Karen you'd shared an event copy, at least with me about some of your considerations that there are concerns from, especially on the consumer side about removing it even if that the tenants of that principle were incorporated into the
02:22:16.000 --> 02:22:18.000
other seven.
02:22:18.000 --> 02:22:24.000
And so I think as john had noted, look forward to sharing with those comments are.
02:22:24.000 --> 02:22:27.000

And considering how we might incorporate them.
02:22:27.000 --> 02:22:36.000
I know there's been a thought of how we can incorporate accountability and every single one of our principles. I think that was another thought that was brought up I don't know if that way.
02:22:36.000 --> 02:22:41.000
But,
02:22:41.000 --> 02:22:50.000
which I think we endeavor to do but it sounds like even, even with that incorporation. It's not sufficient. And as the advisory board members.
02:22:50.000 --> 02:23:05.000
So we're not calling these final we are calling this draft. We are continuing our dialogue. We think it's great that we bring it back as we've been able to iterate on it and we have some more work to do and get my word that will bring it back next meeting
02:23:05.000 --> 02:23:17.000
and engage with all of you on how to make this better. So I appreciate all of that. I do want to be quiet for a moment because I think there was someone else that had a comment
02:23:17.000 --> 02:23:29.000
that Maven Sandra Hernandez from th CF who is adding to the concerns that bookmarking and Karen had raised.
02:23:29.000 --> 02:23:35.000
I'll just say thank you john thank you john I appreciate appreciate the consideration.
02:23:35.000 --> 02:23:40.000
Oh, this is, this is why all of you are here.
02:23:40.000 --> 02:23:49.000
I mean I would say that's a big whoops, and I you know I would say a lot of things right now but it's all on me and so I just want you to know that that's, you know, never.
02:23:49.000 --> 02:24:02.000
Maybe too many things going on at once. But yeah, I mean, we're doing it so we'll get in, and I'm looking forward to the conversation. This is very interesting and welcome.
02:24:02.000 --> 02:24:09.000
So I'm going to have it real quick so we can close this on time if that's okay Johnny was it, or was there any way to go ahead.
02:24:09.000 --> 02:24:23.000
Thank you, everyone, and thanks for conversations like this I think that as we work together in this new environment that I always feel like one arm behind my back doing this work with all of you versus being in a room.
02:24:23.000 --> 02:24:36.000
I think we're doing really well. And I want to congratulate all of you, I also want all the, all the folks out there that are on our stakeholder advisory group are so good at raising their hands to all raise their hands up once and appreciation to our
02:24:36.000 --> 02:24:43.000
team with with Jonah facilitating Jan and Kevin who who planted today, in place of rim.
02:24:43.000 --> 02:24:54.000

Secretary gala who was here and had to run off to a press conference. I want you to know that this team is hustling in between meetings, and we are hearing you.
02:24:54.000 --> 02:25:05.000
The destination is undefined we're not, we don't have an end in mind that we're leading you to we're doing it all together is really what I would say that's the spirit of how we come to these groups as well.
02:25:05.000 --> 02:25:18.000
So, in closing remarks to get to that next slide, I want you to know that we're going to be sharing summary of notes, doing, doing that work, we definitely are going to get you pre read materials, we're all working on how we can get this, get the work
02:25:18.000 --> 02:25:23.000
done get quality materials but get it ahead of time, like Jonah said and.
02:25:23.000 --> 02:25:30.000
Next, next session working session is going to be focused on the infrastructure barriers data standards.
02:25:30.000 --> 02:25:40.000
And so please share any additional feedback you might have on the opportunities to to address our most pressing each it capacity.
02:25:40.000 --> 02:25:52.000
Ideally by next Tuesday, email me Jonah Kevin with any suggestions, we can jump on a call at any time with any of you, so please let us know. And our next meeting January 13th at 10am.
02:25:52.000 --> 02:25:59.000
And I'm just going to pause and see if there's any other comments before I wish you a good day.
02:25:59.000 --> 02:26:01.000
Okay.
02:26:01.000 --> 02:26:04.000
Oh, and there you go. Sorry.
02:26:04.000 --> 02:26:09.000
Excellent, everyone. Thank you very much. No, you did great work and have a great day.
02:26:09.000 --> 02:26:24.000
Thank you. All right.