California Health & Human Services Agency
Center for Data Insights and Innovation
Data Exchange Framework Stakeholder Advisory Group
Meeting 5 Transcript (10:00AM – 12:30PM PT, January 25, 2022)

The following text is a transcript of the January 25th 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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Hello and welcome. My name is Mario and I'll be in the background answering any zoom technical questions.
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If experienced difficulties, please type your question into the q amp a and a producer will respond.
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During today's event live closed captioning will be available please click on the CC button at the bottom of your zoom window to enable or disable mo will now cover that meeting participation options.
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Right. There are a few ways, attendees may participate today. First participants may submit written comments and questions through the zoom q amp a all comments will be recorded and reviewed by staff.
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Participants by also submit comments and questions as well as request to receive updates to cdi@chhs.ca.gov at designated time spoken comment will be permitted participants and group members must raise their hand for zoom facilitators to unmute them to
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share comments, the chair will notify participants have appropriate times to volunteer feedback. If you logged on by a phone, only press star nine on your phone to raise your hand.
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Listen for your phone number to be called and if selected to share your comment please ensure you are unmuted on your phone by pressing star six. If you logged on via zoom, press raise hand and the reactions area.
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And if selected to share your comment, you'll receive a request to unmute.
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Please ensure you accept before speaking comments will be taken during the meeting at designated times 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
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two minutes, please state your name and organizational affiliation when you begin participants are also encouraged to use the q amp a to ensure all feedback is captured or again, you can email comments to cdi@chhs.ca, Dhaka.
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And with that I will hand it off to john onion.
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Great, thank you so much, and thank you everyone for joining us. Per usual is looking at our agenda we have much to cover our limited time together but this is meeting five and we're all in sync and we know how to get this done.
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So thank you again for joining us before we turn it over to Secretary golly for some opening remarks, I'm going to just give you a couple of highlights of the meeting, as well as go through roll call.
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Today we're going to turn our attention to the opportunities to address identified data standards and consumer data access gaps. As always I asked you to enter this conversation with an open mind, that you listen to one another, productively offers specific
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and concrete alternatives to the draft options presented, and that we always keep the health and well being of California, as our horizon.
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Focusing us all on the work together to improve the often invisible, but very valuable system of health information exchange will be moving quickly by necessity, but don't worry if you don't have a chance to have your voice, your comment today.
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You're always welcome to put your comments in the chat, and we will be seeking additional written comments stemming from today's conversation through next Tuesday, as you take this information back to your teams, we will close with updates on our digital
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identity strategy work and data sharing agreement subcommittees deliberations.
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We're going to briefly reflect on changes we made to the guiding principles and hit capacity gaps and opportunities, and based on last meeting the comments that we subsequently received all this information, all the comments are also posted on our website.
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Before starting today I also want to make. Take a minute to acknowledge, an exciting development on many of our minds. Last week the ONC release Stefka were reviewing the new guidance put forward by the LNZ to ensure our principles and ultimately our
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framework aligns to the greatest extent possible with these federal requirements. We will keep the stakeholder advisory group appraised on those efforts.
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So let's start with a quick. Roll Call.
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We go to the next slide please. I call your name if you can just let us know you're there.
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Jamie all Monza.
00:04:15.000 --> 00:04:16.000
I'm here.
00:04:16.000 --> 00:04:18.000
Great, Charles budget.
00:04:18.000 --> 00:04:19.000
Good morning.
00:04:19.000 --> 00:04:22.000
Andrew Bindman.
00:04:22.000 --> 00:04:27.000
Good morning. Michelle daddy cupboard.
00:04:27.000 --> 00:04:28.000
Okay.
00:04:28.000 --> 00:04:30.000
Carmel coil.
00:04:30.000 --> 00:04:31.000
Good morning.
00:04:31.000 --> 00:04:37.000
Right, hold the one
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show the apologize our new President. Thank you so much. Thank you. Good morning.
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God is.
00:04:46.000 --> 00:04:50.000
Okay, David Ford president.
00:04:50.000 --> 00:04:51.000
Let's give me.
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Good morning. Morning.
00:04:54.000 --> 00:04:58.000
Michelle Gibbens Lori.
00:04:58.000 --> 00:05:00.000
Lori hack.
00:05:00.000 --> 00:05:04.000
Well, morning badly morning.
00:05:04.000 --> 00:05:08.000
My name is Sandra Fernandez morning everybody.

00:05:08.000 --> 00:05:11.000
Cameron Kaiser, and morning.
00:05:11.000 --> 00:05:13.000
Andrew keeper.
00:05:13.000 --> 00:05:15.000
Good morning.
00:05:15.000 --> 00:05:17.000
Lenny equipments.
00:05:17.000 --> 00:05:18.000
Morning.
00:05:18.000 --> 00:05:21.000
David Lindemann. Good morning.
00:05:21.000 --> 00:05:23.000
Amanda McAllister Wallner.
00:05:23.000 --> 00:05:25.000
Good morning.
00:05:25.000 --> 00:05:29.000
Again McAllen, I am here Good morning.
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Good morning. ali Materazzi.
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Good morning. Good morning.
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Erica Marie there. Janice O'Malley, The morning, Mark Savage.
00:05:43.000 --> 00:05:44.000
Good morning.
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Morning, Karen savage thing one morning.
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Kathy center link McDonald.
00:05:51.000 --> 00:05:53.000
I'm here Good morning.
00:05:53.000 --> 00:05:55.000
Morning Claudia Williams.
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Warning.
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William your morning present.
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Morning. I'd like to also take a moment to acknowledge our stakeholder representatives from our state departments Ashley's are not.
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Hi. Good morning.
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Morning, Nancy Bartman.
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Yes Good morning, Mark Beckley morning.
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Scott Crispin.
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Okay, David callin.
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The morning thing.
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Katie Fisher. Good morning.
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Dana more.
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Nathan now.
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Good morning. Morning.
00:06:54.000 --> 00:06:56.000
Giuliana big highlights.
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Good morning. Morning. Leslie wouldn't.
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Okay. Excellent. I'm going to now pass to Secretary golly for discussion of our vision objectives for the meeting today morning sir.
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Really thanks john and our team our consultant team and all of our advisory group members appreciate the ongoing work that everyone is leaning in on.
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Just take a take a moment and acknowledge that we're in another yet another difficult coven period, or our state.
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I think that what we've experienced over the last six weeks.
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So many including people here. We're hoping expecting not to have to go through again as a state but I think the resolve of California and that continued hard work of so many people in Health and Human Services broadly, continue to make a difference.
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Good news is cases it's certainly started to stabilize and come down a bit in our hospital impact although tremendous and extreme, the moment with the case, case number starting to slow down and come down a bit.
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There is hope on that horizon front as well. So I just want to take a moment as I often do to just thank all of you for your hard work, pushing on issues of equity and access and concern for communities, often overlooked.
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Throughout the pandemic.
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Keeping them front of mind and no different than some of the tenants that are following this conversation so just want to start with that and remind people of where we are, and a little bit of hope of where we'll be covering.
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Next slide.
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So as we have spent a minute every time kind of going over what our vision is, and I often highlight in this statement that we want to make sure that people stay at the center.
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Whether you call them patients are consumers.
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Members, that its people in California is at the center of this important work that we want it to not just be information to be usable and accessible, and timely for ourselves as leaders and organizations that produce and and use the data but also for
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those members to improve their lives and overall well being and focus on a phrase that has had such deep meaning throughout the pandemic, and is increasingly important as we think about health policy and Health and Human Services broadly which is equity.
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So focusing on opportunities to close gaps and lift all boats, but some a little more than others. Next slide.
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I also just take a moment right now to focus on the exciting time that we're in, I talked a bit about covered, and the constant focus there but also want to just take a moment and acknowledge what happened at the end of last year, California, was successful
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in negotiating our Kalyan waiver with CMS and the federal government. I think this is an incredible feat, was not easy, grateful for partners like Michelle boss and JC Cooper, who led the way with their tremendous teams negotiating fine details with our
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federal partners to make sure California could do all we can, in the next series of years through both our health plans our communities and our provider networks to really deliver improved care that addresses not just integration and quality, but also
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the upstream social determinants, which I think our broad view of health information exchange that this group has adopted and endorse and lifted up really brings together.
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Also, the governor's proposed budget was announced since we last met and just take a moment because so many of you have been fighting tooth and nail for so long to see how for all.
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Get, get it today, it is in the budget proposed, going to the legislature for consideration.
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But a really tremendous effort to further close the gap on who has access to coverage, who has access to upstream preventative primary care services so we don't see some of the tragic delays and cares that so many of us witnessed start to get better with
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things like the passage of the ACA, and recent augmentation to providing support for people under 26 and last year, over 50. Now all Californians regardless of where you live your age, your immigration status, if you meet Medicaid eligibility, that you
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would, if this passes in the budget, be provided the care that I think so many of us depend on. And then also the proposed budget, raise some other very important.
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Well, linked topics to our conversation the Office of healthcare affordability.
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Some proposed disruptions to how we pursue and procure pharmaceuticals focused on cost and affordability for so many, so many California and so I think a lot of important connected work, a lot of disruptions and innovations that the governor is pushing
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forward with so many in his administration and I'm grateful every day to have a chance to work on, on that team.
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The last thing I'll mention, because it is timely and our focus on a piece of work that I have certainly spent time, a significant amount of time helping move forward.
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Dr. Hernandez, a member of this advisory group also a member of the California for all commission, and so many others, working on looking at how unified financing becomes a real possibility and California, not asking the question Should we, but how do
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we pursue pursue such an approach. And I mentioned that, as the last piece because so much of what I've already talked about is sort of built into that conversation.
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And what we are doing today talking about health information exchange, making it accessible real time equity focused rod in consideration is going to make those efforts possible.
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So, if you don't get enough of a reminder of how important the work that you're doing in this advisory group is, it is linked to so many other efforts, and we can't move forward as a state, without us really producing a thoughtful collaborative work product
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from this advisory group to guide, not just the rules of the road for the future, but also the investments that California needs to make to get us to this improved broad Health and Human Services delivery system that I know we all want to see.
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So, I just again.
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Thank you for taking this job so seriously, I've seen the level of engagement, the communications, the thoughtful recommendations suggestions input that so many people are providing in the meetings but also directly and other venues to really push forward
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something I think we can all be proud of. So, with that john I'll turn it back to you excited to hear how today's session goes, and, and, and as we continue our pursuit to our goal later this summer.
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Excellent. Thank you, Secretary I'm now going to hand it over to john and take us through our next part of the agenda.
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Right. Thank you.
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Forgive me for the next 10 minutes I'm going to sort of lay out the context, objectives, the barriers are the gaps we've identified and then begin to introduce some of this, the potential opportunities for your consideration so it'll be about 10 minutes,
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and then dive right into your feedback and make this more interactive.
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I think as we will run through today, we want to discuss opportunities and spend about the next hour and a half on addressing the gaps and data exchange standards identity management and consumer data access will have a public comment period and then
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we'll go through a digital identity management strategy where we're at with that an update on the data sharing agreement subcommittee, and guiding principles which we are at the tail end of finalizing and really appreciate everyone's good input throughout
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that process.
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Okay, so those are the objectives for the meeting, and we're going to go to the next slide.
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In order for us to keep going through in order for us to dress, we want to make sure we know where we are in a roadmap here and our timeline and just for discussion today we're going to go through these gaps.
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So, Just to level set on slide 18.
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The next slide are potential opportunities we want to remind everyone.
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These are areas that we want to consider as an advisory group where public and private stakeholders can address specific program policy or system gaps.
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And these were identified through this earlier process with scenarios that we went through these opportunities may require blending braiding of all sorts of resources federal state private philanthropic and other other sources and activities that are
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maybe necessary to implement some of these opportunities or recommendations.
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And we have to consider significant transformation efforts underway. Secretary galley already mentioned Kelly and that's a big one, but there are others.
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And we want to make sure that we're really considering all of those in the context of these of these opportunities and gaps. So what we're requesting as you wherever possible when we're raising some of these recommendations are opportunities.
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Are they feasible effective do they address the specific gaps or are there some modifications or adjustments we should consider or other opportunities.
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Second, what other programs incentives policies initiatives, should we incorporate or consider as we develop those opportunities and, and integrate them into the framework that will be published, and finalized in July, and then Claire, what far this resources,
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and funding across the spectrum of public private philanthropic federal, state, etc. that we can bring to bear to support implementation so please consider those in your responses.
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So what are we going to review today in terms of our gaps.
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There were four slide 19.
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One is around. Human Service data exchange standards and capacity. And this gap is we identified, is that there are recognized national federal and state data exchange standards, but they're nascent, and they're not complete.
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So the standardized collection exchange of use of things like SDLH information remains somewhat limited, and many national networks, including electronic health records have some limited capabilities to structure store and share information with others.
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This information specifically that's kept number one.
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Number two, related is around demographic data collection.
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And here specifically race ethnicity languages so G and other demographic information is necessary, not just for pop health that to identify and dress disparities in an equities.
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Often it's missing it's incomplete, we have more nascent standards in place, and some standardized terminologies multiple in some cases will say for her.
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So, for example, yesterday I are in conflict at times.
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And so that remains the gap.
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We're going to structure a set of recommendations to focus on these two gaps together. There are a number of them will see on the next slide in a moment.
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So those are two gaps, we will address today. Third is around provider identity management, and here will address the gap identified around provider care team and social service organization directories that aren't complete aren't aren't available to
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all who need to access them to be able to share information about clients patients California State collectively support and then the last is around consumer data access.
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Like a robust discussion here. A number of opportunities to in fact we will discuss.
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And this is going to address the gap around individuals who currently face multiple challenges accessing all of their health and human service information all and be ability to actually access us update share bi directionally with partners in a matter
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timely and in alignment alignment with federal standards, there's this other depth around personal identity management, so we'll give you a brief update on where that is how we're moving forward with that in the digital dentistry strategy update the book
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The digital identity strategy update that will be provided to you.
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Those are the gaps and now in terms of some of the opportunities, three of them will consider in the context of those first two gaps the human service, and demographic data exchange.
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So one will be focused on social determinants health data collection and standards. A second on demographic data collection new standards, and the third around cross agency data sharing efforts, actually deploy there's a fourth.
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And the fourth is around recommendations around advocating for federal agencies to improve or create certain standards that we feel are important but haven't been promulgated yet.
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Second, on the provider identity management gaps, to opportunities will consider one is expanding on provider API directory requirements and CMS interoperability and patient access final rule, are the things we can do in California to expand it in alignment
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Are there things we can do in California to expand it in alignment with federal rules but make it broader. A second is requiring qualifying he chose to participate in a federated provider provider identity management service, and I'll bring back last
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month.
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Last month recommendations around quality qualifying HIO recommendation, because that's important context for this obviously. Last one consumer data, two opportunities.
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One is around policies to ensure that consumers have meaningful access to longitudinal health information across all the organizations that are subject to a b 133 mandates and requirements.
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And the second is around policy to ensure consumers understand how their health information they may be used and trusted and how they can better support bi directional access including potentially updating information, and not going into two.
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Okay, so that those are the gaps. These are the opportunities, and to remind folks of the first two gaps in detail.
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The first one is around standards around social determinants health information and relevant provision is that we need to identify ways to incorporate these data, data related to SEO he says housing, food insecurity and just into some Shared Health Information
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Exchange processes.
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So just considerations for everyone to come to think through these SEO efforts efforts for data collection are fairly nascent. And, as most of you all know, they're hugely important social determinants of health.
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Really account for by some about 80% of health outcomes.
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So being able to understand what those underlying social determinants are is critical. And we can collect them directly with interactions from individuals and families through screenings and other mechanisms.
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And then indirectly from changes in an individual's engagement with human services organization so like, where they are or stopped receiving SNAP CalFresh.
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Have they been released from jail so they have a history of incarceration.
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These data can also be collected from individuals for interactions with individuals, and they're recorded on things like screenings, whether you're enrolling in meta cow or your screen once you're incarcerated, and then claims and encounters also have
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a series of codes that can collect this information they're set to the codes that Hix pix codes that also can serve to help identify SDLH underlying issues.
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And then there are indirect ways to collect them from individual engagement between individuals and families and Health and Human Service Organizations, but they're not always accessible, or structured in a way that can allow for easy sharing.
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So that's the first step synopsis. Then the second gap synopsis is really focused on data exchange standards around race, ethnicity, language, so G, and other demographic data necessary to help identify and address disparity.
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So, what are the key considerations here. There's some variation and how some of these data are collected, gender, for example, Is it universally collected against a consistent and almost universally collected against the consistent outdated male female
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classification schema.
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That's a challenge when it comes to actually addressing issues for non binary and, and, and individuals who do not consider themselves male female sexual orientation and gender identity or rarely collected at all.
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And there are a variety of different standards by which they are, they are stored race ethnicity and language are almost always universally voluntarily solicited, and sometimes again don't conform to any of the standards that are emerging from use us
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CGI for example.
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VI, for example, and you can see from this there are massive disparities in California is not the only place where clearly this happens, but when we are able to collect information you see much higher rates of death, and our ability from cancer for African
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Americans and other communities of color, you see LGBT q youth are seriously considered attempting suicide 42% of them.
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So you have massive disparities and inequities. Not just around race but around gender identity and social and sexual orientation demographic data, ideally collected from individuals against standardized definitions, but often there's a fear of discrimination.
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And so you don't really get an accurate complete picture.
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And then last, is that demographic data collection and curation will benefit from standards and protocols. But, as I mentioned her son your CD I have some differences.
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but they have reports in her so that are have different standards for for demographic data.
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Those are the two gaps and let's focus first on this opportunity. So this is the first of four, and I'll read through this and then I'd love to get your comments So raise your hand if you have anything you want to contribute to this, we got this right.
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What might we change this going to address the core challenges are part of the core gaps that we've identified.
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So, the, the option here the opportunity here is to consider establishing sth data collection and new standards requirements and incentives so what would that, what does that mean.
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So what we're suggesting is that, first we adopt and follow us course CDI version two.
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And those standards, be used to facilitate collection of consumer sth data collection. In addition to race, ethnicity, language, and others which we'll talk about in a minute.
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Now just nothing we're going to adopt it doesn't really do a whole lot so we feel that it's important to adopt other other standards around functional and communist status that are not in USA VI, because we believe that's important for us to collect and,
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and use that to identify disparities there.
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And we believe we need to pair these with common collection reporting requirements, including things like quality performance measures and incentives to support system change.
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And we also believe that there may need to be some technical assistance and training, about how what the standards are and how you would code for them.
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So that, so this is the recommendation or the opportunity. Adopt us CDI consider additional factors like Social and Behavioral Risk information I'm sorry, like functional and cognitive status and pair them with measures and incentives across public and
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private payers to incentivize good collection and use of these standards.
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There's a number of opportunities where, or number of issues where this has happened to programs.
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Columns building on whole person care that's prioritize care coordination, physical behavior and social and their incentive Incentive Payment Program is actually being used to better collect information on this.
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There were a number of pilots in previous whole person care programs that actually helped collect some of this information I listed here.
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And they included new data sharing protocols to support collection of this information.
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And then finally CMS is encouraging state Medicaid and CHIP programs to adopt strategies to address social determinants of health, including new requirements around collection reporting investing in new capabilities, system capabilities.
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So that's where we were concerned going with this first recommendation would love to get initial reaction to this feedback. Does this feel appropriate I saw a comment about UFC I version three.
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And if Mark if you'd like to speak to that or if not the comments line on its own, that's great, but please raise your hand if you have any thoughts, comments about this, about this.
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Mark.
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I'll just lift up early that the draft of the CDI version three does include three separate data elements for functional cognitive and mental status, that's being considered by both the public and a work group of, you know, MC, and said come out in July,
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so it's it's also helpful to illustrate that this is an annual process where we keep trying to build in the important elements, if you've got any questions happy to answer them.
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Okay.
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Okay. Awesome.
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Thank you, that would make our life a little easier. If there were actually a national standards here that we wouldn't have to develop the network. So I appreciate that.
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Charles Go ahead, please.
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Thanks.
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Yeah, I'm just curious.
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I'm thinking about our charge as a group and obviously.
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What we're doing here today, and I'm looking at some of these recommendations or discussion questions.
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And I'm just curious I mean, these require a state law to be passed me Are you asking the is the question before this group to make recommendations to the legislature on on specific bills that need to be enacted in order to require people to adopt certain
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things, or we. Because it seems like it's a little bit outside of the data sharing framework, responsibility, and I noticed that through a lot of these different talking points I'm just just want to kind of make sure I know what I'm voting yes on before
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I vote yes.
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So, so Charles.
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We are charged to develop a data exchange framework, and specifically for AB 133. We need to identify, or advanced recommendation to identify ways to incorporate data related to social determinants of health, like housing and food insecurity into shared
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health information, and the second provision is we need to identify ways to incorporate data related to underserved and underrepresented populations including not limited data regarding sexual orientation, gender identity racial and ethnic minority so
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those are the two provisions maybe you want 33 we're trying to address here and address, specifically the gaps we identified that we have a positive use data in a structured standard way right now.
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So we haven't said, for example, the tactical mechanism by which we're going to do that specifically we're going to advance new legislation that may be an outcome, what we're suggesting here is that it's important for us in the framework to embrace us
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CDI version two. I think we're looking at we need to look at version three and does it address the functional cognitive status issues that were raised.
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And specifically, should we create some sort of an approach, or a policy about how we might try to incentivize the collection of these data in a standardized way according to us CDI that we haven't said in here, necessarily, that there would be new law
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passed, but that we do need to try to reinforce us CDI with things like incentives and reporting standards that help.
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Thank you very, very helpful. Appreciate it.
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Okay.
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Karen Go ahead, please.
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Yeah, thanks Jenna, I really appreciate the work on this I think we are struggling supportive of adopting the version two standards, or the version three standards, I will just say, and maybe this is getting ahead a little bit but the version two standards
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do allow us to collect race, ethnicity, language data with the level of granularity that we believe is needed in the state of California.
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And it also does have to your point about sexual orientation and gender identity data does have those questions separate from sex assigned at birth and maybe they don't have exactly the categories we would list if we were designing this but I think it
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definitely keeps a step farther. And then on the disability status, I would just notice my understanding that the version three uses the same six part census question that's pretty standard, so that shouldn't be a huge leap for folks to be incorporating
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that and that that data is really important because there's a huge body of evidence that shows we don't provide clinically appropriate or physically accessible care to people living with disabilities so that's going to be incredibly important data for
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us to capture it even though it's not in the version two standards on the social determinants I think the version two standards are a good place to start and then one thing I would notice I believe our Department of Public Health submitted comment on
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to that that includes a couple of additional suggested elements to that that I don't know that all of them are incorporated so to the extent we may want to go slightly beyond the version to standards that may be a good place to start in terms of what
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the state of California has already recommended to the federal government but really just want to say we're strongly supportive and appreciative of the inclusion of the version two series.
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Thank you Karen will also per year in March, comments, look at the three, and we can follow up with this group about whether that inclusion is appropriate as well.
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Right Hello Please go ahead.
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Russell Jenna thank you so much for setting up this forum for us to be able to talk and communicate. It's really necessary for us to appreciate what's been done already.
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You know the social drummer physician, practicing physician and an IPA and muscle world we really look at the social determinants of health very closely because they really impact compliance and cares you all can appreciate especially during the pandemic
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that was highlighted even more using integrated platforms like Symphony is not used by every medical group but we shouldn't really create new ones and said, Let's create minimum standards through state resources.
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In other words, instead of starting fresh from scratch, we, we don't want to, like, do that we want to use what we have and build on that so I think, let's learn from our experiences and grow together as a result of the challenges that we bought in the
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barriers we've already broken, so I appreciate everything that's been done I think that when my colleagues Alex, Kerry really works to use this data and actionable way and really helps people get identified homelessness specifically so I think it's using
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this data and actionable way that's really going to move the needle and improve compliance and care delivery for our needy patient population, and that doesn't apply to just medical but all lines of business to be honest all Californians.
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Thank you so much on what you do, so appreciate about all of us here.
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Thank you, appreciate that and we'll talk about some of the work related to provider. Identity Management shortly to which is your destiny or comments.
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Thank you.
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Andrew, find that please go ahead.
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Yeah Hi, thanks.
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First you know thank thanks for calling out this important issue of data collection I think all of us probably on the committee, recognize, just how important this is for you know the contributions to help, which we're all trying to support the state
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of California.
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I do think there is a tension here for us to kind of think about as a committee which is, you know, our. I guess I think of our job in many ways that you kind of recalled the stat, the work that we're working under the stat to work under that we're in
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a lot of ways, I think involved in laying down the tracks of how information will be shared.
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And while we want to have tracks that are capable of moving the information that you talk about here.
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I wonder if we are getting into a little bit of a potential risk area, if we take on the responsibility also of trying to define the data elements and how that can be moved along those cracks, I mean I do think that we have really want to bring alignment

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between what we're trying to do with the federal government I think you call that out there. But if we start to deviate from that and then those federal standards evolved we run the risk of what's happened in other measurement spaces, particularly the
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quality measurement space where suddenly there's multiple masters and difficulty I think for providers and others to a sort of a line on a common set of goals.
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So I guess I would really hope that we a will focus on the, how are we going to share this information, and allow the great work that's been going on the federal government about figuring out you know the standards related to that, so that we have the
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tracks in place to move that but if we get ahead of defining some of those data elements I think we've run the risk of as the federal standards evolve, that we could be out of alignment and suddenly creating a lot of chaos, for I work so I hope we can
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really focus on the sharing part, and how we do that, as opposed to the the the con, the defining the standards which I think is really well set up through the work of the federal government.
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I, those are really good comments what I would suggest is we especially in light of version three, the fact that we have members here that are very engaged and other individuals as part of this process with federal government activities around standards,
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we modify this so that we aren't really focusing as much on the state developing those but that we are advocating for pushing and investing time in some of those federal activities.
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To get to the kind of definition around these data standards that are necessary to me California is global so instead of us, creating them and then creating potential discordance with new federal standards that come later.
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That instead we actually just continue to push and through federal channels to develop standards that we think are necessary. We don't have. So I think that gets to your point, and it feels like a better, more It feels like a good modification to this
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to this proposal.
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Thank you. Okay, thank you.
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Carmela Please go ahead.
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Thank you, you might have just made my point.
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Last week was a big week, not only because of Tesco but we because we have this us CDI version three now out for comment. I guess I'd like to split the recommendation

versus the incentive, as you just said Jonah, I think from a recommendation perspective.
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Our greatest impact as California will be to contribute to the national discussion. And as you were just suggesting, I think we have important ways to do that.
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First of all, by defining what is unique to California.
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Some of that appears to already be in US CDI three second to make certain that we have more California involved, whether it's this group or others in the national discussion and debate.
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And third by contributing California specific use cases. But to the previous commenter and to your thoughts, there is a significant movement what we don't want to do is to duplicate or, as was suggested deviate from those federal standards but we could
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accelerate that federal work by contributing what is unique to California.
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On the incentive side.
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I guess I'd like to hear more before I'm comfortable there. I think about incentives, and what we really need to understand to set incentives that are meaningful is one of the barriers, and I'm not certain that we're quite there yet, understanding what
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those barriers will be to then understand what kind of incentives might be helpful, are we talking about positive incentives negative incentives are we talking about financial incentives.
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So unless comfortable on the incentive side of this, but in terms of moving ahead with California really jumping in and helping to lead the national efforts, all for it.
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Thank you.
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Okay. So two things you mentioned I think two good amendments one is to contribute to the dialogue, and the use cases what makes us unique It feels like and this is what we can talk about in March.
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There's there should be a role in governance that set up here to define what those priorities are, what the needs are where there's missing, whether it's standards or policy or something else.
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And for governance to facilitate that and then to advance those to the federal government so what I would recommend is that we consider that particular point when we review governance next month, and it would be directly tied to this.
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I think the second point is around incentives, is it sounds like there's a feeling we need to better understand the gaps and I think I saw a comment. It's hard for me to see all this but I think I saw a comment from Claudia about how or maybe more maybe
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both of you about some of the challenges or some of the, the need to better understand how we're going to do this.
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So what I might suggest here is that we investigate the feasibility of of creating this type of a, of a of an incentive arrangement. I was thinking more I think we're thinking more like positive incentives and not sticks, but that we actually investigated
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as opposed to advancing it as we're going to do this, but that does not address, your comments.
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Yes, Thank you. Okay.
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Last one dr Amanda speak good.
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Thanks john appreciate all the good work here and the conversation as well. I sort of see this conversation we're having as both and we certainly should be nudging and pushing the feds as others have mentioned, but we also should move really aggressively
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on version two in my view of really starting to get at the social determinants. We've got a lot of experience in that through whole person care and all these counties that worked on data exchange elements and it seems to me we really shouldn't drag our
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feet on that piece. And the last thing I would just say is that, maybe wearing a little bit of Covered California had here for a moment but all three of our public purchasers.
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So Kalin and Covered California and calipers, all have contracts that we should be looking at those agencies or sister agencies across the state to put their heads together to really understand how to use incentives.
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Both carrots and sticks if necessary, but that's 40% of our enrollees across the state and I think that using those agencies and their contracting capabilities, is something that will significantly accelerate this work.
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Okay.
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I totally agree. I think we can pair that amendment about investigating incentives and particularly focused on those that the public tears.
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I know there's, and you know this week. Most folks here do there's been a lot of attention and effort in recent months and years really to try to align some of those contracting requirements and including incentives, and it feels like it's right opportunity

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here and I know Covered California and Canada, and DHS under Kalyan with re procurement etc. They're, they're really both lining up to try to make sure that they're addressing disparities and an equity.
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It feels like it's the right time for this to be more deeply considered and align.
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What 40% of the purchase healthcare in California public purchasers actually do.
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That's great.
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Okay, I'm going to move on, there's some other comments, I think around the gravity project and let's go to opportunity number two and might want to speak to that briefly could also addresses, it's relevant I think to this other other area to.
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Okay, so, I think we've covered some of this and we may actually be able to go through this a little more quickly.
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So one is consider establishing demographic data collection standards requirements and incentives. So, this would be paired with opportunity one a what we put here is that we may work with private health organizations to establish require demographic
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data collection and reporting.
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This is focusing on the demographic race ethnicity so g gender up disability status etc against federal standards like us CDI version two and pair them with reporting requirements, like these Performance Reporting as incentives, and obviously we use those
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to identify things like disparities. I think we mostly covered this and what I'm going to what I'm going to paraphrase here from the last conversation is one we should clearly work with the republic purchasers on opportunities to align and create incentives
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around this data collection reporting to I think we need to do that in unison with private private payers, in a way that's going to advance potential recommendations around incentive programs for this kind of data collection.
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So that's number one.
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I don't think, as I just heard, embracing a standards, outside of the federal government. Once we would develop our out is, is of interest here but instead we would advocate for what standards may be needed that don't exist.
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So, I'm going to pause there and see if that aligns with what we just heard, and if there are other comments about about this opportunity. I think Claudia has her hand raised.
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Yeah.
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I really appreciate the conversation we just had and I just really want to point out that defining a standard is step one in a very very long journey to actually get people to share data using that standard.
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And an example of that as we receive clinical summaries CCD aids from probably thousands of sources and about half of those these CDs don't include all the needed data.
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So I think it's going to be as we point to standards, I think it'll be very smart to use incentives to highlight, make sure we're getting complete and high quality data for the most important, and data fields, and then you build that incrementally.
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And I just want to point to the experience we've had in the Inland Empire, Arizona, Wisconsin, Michigan, where data sharing incentives from payers Medicaid or from private payers are incentivize the sharing of high quality data, and those quality metrics
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shift over time. Right. So I don't think a standard sadly creates the kind of completeness and quality that we want it defines what that could look like.
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And I, I just very I'm very bullish about incentives. If they build in the quality metrics, and I don't think those incentives have to be focused just on this kind of data.
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I think they can be incentives around sharing clinical data that includes these critical fields.
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So I think there's some great examples to look to both within California and outside California of how those data sharing incentives where there are quality metrics have dramatically improved the quality of the data.
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And I just want to encourage us to be fairly pragmatic or not too optimistic about what what is accomplished when we name a standard.
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It's probably not what we want. So I think we need other other tools to get there.
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Okay, I agree. I think that's right.
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And it seems to align fairly well with what we've where we're going with this recommendation.
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Lori, please go ahead.
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Thanks. Yeah, I think just to add on to what Claudia was mentioning, we want to make sure that these sort of gold standards of v2 or even v3, I think we should put that on the table as well, that we don't somehow penalize those organizations that currently

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don't even have a certified system that is collecting even the basic information so you know we've got a number of organizations counties that don't have these types of systems yet on the corrections department some dental systems don't have don't meet
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the standards so we really want to make sure that these incentives are matched to help lift up those folks that don't have the basic tools yet to be able to create and meet those other standards as well.
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Yeah.
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So I guess Lori with that suggest to me as we, as you said we need to account for where the market that and the different segments of the market or at.
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We know that there are jails that there are that use non certified EHR is there other providers that don't have certified EHR is at all.
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And instead of penalizing them for not reporting in a structured way we want to try to create some capacity for them to structure the data in the first place.
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So it feels to me that we need to consider what a differentiated kind of an incentive program would look like. That accounts for different stakeholder types and where they might be.
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So if that if that is responsive to your comment. I think we would want to define that in this recommendation or in this opportunity and specify that we need to really account for the different places at various different entities are starting from, and
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Does that seem to address that adjust your comment.
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Indeed, it sort of the the tides, raise all boats.
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Thank you.
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Okay. All right, guarantees good.
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Thanks Jonah I think just want to chime in on the incentives piece I mean I I don't take issue with exploring the best, best practices and best ways to do that.
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But I do think it would be helpful in our recommendations to be clear about what we are trying to incentivize because I don't think it's just collection of the data I think it's making sure that the data is collected in a way that we get quality data
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and so the standard being self reported data for demographic data collection so I think we should be clear in our recommendations at what we're trying to incentivize both self reported on data, but also actual use particularly of demographic data because

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I think there's a very fair concern about collecting the data, which can be very sensitive for consumers and not using it in a way that actually advances equity or reduces disparity so I think we need to make sure that our incentives however they're designed
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are clear about the goals and I do think that should be part of the recommendations.
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Any comment on specifically use that.
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Easier to imagine incentivizing collection status using standards, because you can more easily measure it right you can see well 85% of population that you're reporting on has the standards adopted and, and, and used any thoughts about how the recommendation
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might be tailored to the use aspect, you mentioned.
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Sorry. So I think tailoring incentives for use both on an individual clinical level and on a population health level so thinking about when we have accurate demographic data for individuals, for example, health systems should be more proactive about coordinating
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interpreter services there's things like that that we can measure and track and track against the data that's now available to ensure that we are utilizing it, and then I think on the population health bubble it's going to be really important to look
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to, to the extent the data is now available to health systems, how are they utilizing it to target programs to advance equity and reduce disparities. Got it. So we want a couple of these your suggestions you couple of the collection with specific actions
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you would expect systems to take when they have this information and you've got these disparities you've now identified.
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There's a set of actions you would expect those systems to take to address those disparities and so you want it, we want to try to centralize both collection and then actions.
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Yeah incentivize both it doesn't have to be together could be separately but I think those should both be goals of the incentives that are provided.
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Okay. Great.
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Thank you, Mark.
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Thanks said, I totally agree with Karen on the importance of use as well as his collection. When even basic way to do that is to is to require quality measures that show how those, those demographic variables are playing out in a particular cared but
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individual and population level so you can stratify quality measures by demographic variables and and that's a way you would actually identify and address health disparities. So there's a lot more you can do too, but that's already been in places and
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certified EHR they have their clinical quality measures ratifiers.
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EHR they have their clinical quality measures ratifiers. I want to add on to the some of the previous points about
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having systems in place usually refer to a certified EHR is, in order to do this and for sharing a little bit of the work that I do with the gravity project.
00:57:06.000 --> 00:57:19.000
We recognize that the, not all of the important stakeholders have certified EHR is in the, in the house, and yet they are providing critical care so community based organization social service organizations.
00:57:19.000 --> 00:57:38.000
So, even now this year we are we are working on pilots and and reference implementations to make sure that fire AP eyes can be used without the need for a certified EHR to do the, do the exchange and creating smartphone applications that can carry that
00:57:38.000 --> 00:57:53.000
out, even for organizations that don't have certified EHR themselves so things in place. Now, which, given that this framework goes you know signed in, in 2023 and goes into an effect in 2024 will be available.
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Thank you.
00:57:56.000 --> 00:57:57.000
Thank you, Mark.
00:57:57.000 --> 00:58:11.000
Okay, I'm going to move us forward I'm actually going to ask Can we go to slide 26 because I actually think we've addressed this addressed, one day, so we're going to pass 25, we'll come back to it.
00:58:11.000 --> 00:58:18.000
This opportunity is around improving data collection and use to identify and address health disparities.
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What I would, would say here is that we have already, we've already covered this.
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These data are unevenly collected, they're still the sort of, there's still some to discordance between her side and us CDI.
00:58:33.000 --> 00:58:50.000
And it means that some entities need to support both what our recommendation that we've just discussed is that we need a process which we're going to advance through governance that our next meeting is to actually identify what those issues are an advanced
00:58:50.000 --> 00:59:07.000

remedies with the federal government, I think, as opposed to us developing our own standards in California going on their own, is to work with in with the federal apparatus to address that the issues that we've identified in our framework.
00:59:07.000 --> 00:59:24.000
So I don't think this really requires any discussion lest anyone has any comments. And if not, I'm going to go back to my 25, which is different to slide 25 is really focusing on the work that is starting.
00:59:24.000 --> 00:59:36.000
And is ongoing between various departments and Cal HHS and recommendations are opportunities to enhance it and continue its good work.
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So there are interagency in our department data sharing efforts.
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And we would recommend that those continue in accordance with the framework course in compliance with law, and that there be an intentional design of efforts to share Health and Human Service data across the various departments, and make those data more
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accessible not just between the departments, but to the client and the providers who work with these agencies.
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Examples include department healthcare service and meta cow, including enrollment, and then find social needs that might be captured in claims or encounters to the enrollment process.
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Social Services and CalFresh, so that we can identify enrollment and food and security indicators and share those across departments, working with the state's new homeless data integration system which is pulling information from hm is to include information
01:00:42.000 --> 01:00:44.000
about housing stability.
01:00:44.000 --> 01:00:59.000
Working with the Department of Justice, CDC er to include justice involvement and probation events including possibly things like alerts that might be sent when somebody is transitioning out of the facility, child welfare systems including and taking
01:00:59.000 --> 01:01:06.000
screening, and then Covered California and calipers include enrollment identified social needs.
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So what we're asking for comment here in terms of recommendation is that this that in our framework.
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We specifically address some of these interagency data sharing efforts, and that there be continued focus on investment to enhance that inner agency data sharing so that public health can have access to information for medical and social services when
01:01:32.000 --> 01:01:53.000

responding to a public health emergency for an individual who is identified as having some, some need, and can identify what programs they are enrolled in and how they might be able to receive delivery of services and a different expedited way.
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The fields noncontroversial to us.
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It really is like for us I think an imprimatur on, on a recommendation to get to continue to support interagency and inner department data sharing.
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I'd love to get an initial responses and it looks like David you may have a comment here.
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David, do you have a comment or yeah sorry I got sick myself off mute of China.
01:02:20.000 --> 01:02:25.000
So, yes, again, David for the California Medical Association, just real quickly.
01:02:25.000 --> 01:02:37.000
Yes, I think this is not time to reverse the all the internet agency data sharing is important for doing whole person care, but on the second question you asked on this on this slide.
01:02:37.000 --> 01:02:43.000
Just want to play well be great to get a lot more of this information out in the field where it could be actionable by providers.
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And at that point, you know, we're still struggling with some of the blocking and tackling type stuff where the state is concerned.
01:02:51.000 --> 01:02:55.000
Data CD pH immunization registry.
01:02:55.000 --> 01:03:06.000
Cal ready you know we've had horrible problems all through the pandemic with both of those. When you reference DOJ they of course also managed security database and their problems getting that information out into the field.
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So it's great to collect this data, but we need to also start thinking about how we actually make this data actionable at the point of care.
01:03:18.000 --> 01:03:37.000
Okay, so what that suggests, I guess, to me, David is the need to not just support this interagency data sharing but to also consider ways that some of these data can be made more readily available and used by providers by agencies that are caring for
01:03:37.000 --> 01:03:47.000
individuals that have, especially that have multiple names that span different like health and human service agencies.
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Okay, great. Thank you.
01:03:49.000 --> 01:03:51.000
Lynette Please go ahead.
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Yeah. Thanks and I'll be brief because I think my common.
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Pretty, pretty much aligned with what David was just outlining. I think it agree that this is this would be fantastic. It will be wonderful to have all of this data, I think in terms of the opportunity and potential recommendation, there really should
01:04:12.000 --> 01:04:28.000
be a focus on then how does that make it to plans providers and other organizations will lose the data so I think just supporting that comment, but that this would be wonderful to ultimately be able to have all this data in a centralized place and then
01:04:28.000 --> 01:04:31.000
to be used for care. Thanks.
01:04:31.000 --> 01:04:44.000
Okay, great. So that's two votes for enhanced to expanding this to not just data sharing within departments, but also to make those data available to others who are involved in care
01:04:44.000 --> 01:04:50.000
for members, or clients or California. Right.
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Thank you. Claudia, please go ahead.
01:04:53.000 --> 01:05:11.000
Yeah, I guess I'm feeling maybe I'm a lumber not a splitter but I'm feeling a need to see these things brought together. I know we've strongly recommended using leveraging Medicaid enhanced match for the opportunities and gaps that we identified last
01:05:11.000 --> 01:05:20.000
time and I agree that there's also an opportunity to do it here, but I'd love to see these things laid out in a more holistic way.
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That shows kind of how where we see the opportunities to leverage that, you know, many, many other states are leveraging Medicaid enhance match for both the clinical data infrastructure issues we identified last time.
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And for these things. And in both cases leveraging qualified Ohio's to help with that. And so it just feels a little bit like we're dealing with these in a little bit of a fragmented way that doesn't allow us to understand the kind of bigger picture and
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how these things come together, and I don't want us to be trading off advancements and clinical data sharing for advancements in social data sharing we need to do both.
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So I guess that's just an ask, maybe not for this meeting to help us understand how these pieces fit together and what the overall strategy might look like.
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You want to see the framework is that, Claudia.
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I just feel like I guess I feel, maybe that's what I'm looking for but it feels like we're taking these a little bit one off, and I think they fit together.
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And I, I don't want to feel like we have to choose between filling the extraordinary gaps we have in clinical data sharing and making progress and social and I think we can do them in a coordinated and integrated way anyway.
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No, that's a good comment i mean i think what you're basically saying is we're going through this exercise. We need a, we need a way to kind of prioritize what we're going to do, because this, there's a ton in here that we're charged to do by it up because
01:06:54.000 --> 01:07:09.000
at 133 says we need to do it, we have to we have to chunk the work we have to prioritize. We can't do it all at once. I think that's what you're saying you want to see how it works, how it fits together and how we can basically not give up one for another.
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And maybe say this is what we're going to tackle first, second and third that fair.
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Yeah, and it just felt a little bit like at least didn't very prior conversations that we felt like the clinical data sharing was hard, and we don't know how to make progress so now we move on to social and that's going to be even harder, and I, so I
01:07:31.000 --> 01:07:42.000
guess I would agree that like, let's be pragmatic about what we can accomplish, and not just expand things to a set of things that we really will be able to get to for a decade.
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So, I'm a pragmatic operational person and I just love to see agree with you Yes What are we going to actually accomplish and get done in the first five years.
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And let's have that be really all the policies and all the funding you really lined up for that.
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Okay, that makes sense.
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And I also just note in the comments about making sure we specifically call out mental health and county mental health.
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Got to prioritize that as well so we'll also add that to this.
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Okay.
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I'm going to move forward to the second set of barriers or gaps, I should say, and opportunities, this is around provider identity management.
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There are two opportunities to discuss here so we should advance the slide 28.
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For those following in the public.
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So, slide 28, actually I should start backup slides my seven, what's the gap. Let's start with that.

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The gap was around robots provider care team, social service organization directories, they're not available accessible to all health and human service organizations or consumers.
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And this is addressing specific 133 where the gaps solutions aren't my cycle of health information including linking sharing exchange in providing access to health information so that's what we're linking to an 8133.
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What are the key considerations here.
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There's a different number different ways provider identity management can be improved, and made more bi directional So, consider individual to provider relationships, how can I do that as a consumer find a provider that I need for some care that is necessary
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from a diversity provider to provider. Information is data exchange will help support care coordination as necessary to identify refer to, and then support care coordination, and then route information to the right provider, whether it's physical behavioral
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social or other.
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And then this provider to plan and again this is all bi directional so it goes both ways, the ability for for this data exchange that provider directories, not just for plans to post but also for information to be shared about the discharge of a patient
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from an acute care facility that, the plan is responsible for managing their care so that there is identification of who that provider is and information from the plan about where that person has been discharged to or that the plan actually has a complete
01:10:29.000 --> 01:10:33.000
listing of the providers in their networks.
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There's been a lot of work done to date on provider to plan, data exchange through it a symphony project.
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There are also other National Provider directors like direct trust and antennas is federal registry basically that's, that's where you get your MPs from.
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If you're providing services for Medicare.
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And then there's recent interoperability patient access final rule. And that's the 137 that stipulates more rigorous requirements around plan certain types of plans maintaining up to date consumer facing provider directories.
01:11:09.000 --> 01:11:15.000
So those are some of the issues, some of the challenges include.
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There are many widely used identifiers, and API's are not perfect.
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You know, worked with them, their group and individual multiple API's, it can be difficult to track them and it doesn't necessarily give you a digital address doesn't give you that provider clinical system affiliation and technical issues, often address
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information often changes requiring updates to organization information.
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So there are a number of other issues including like social service providers don't really have many don't have any kind of robust identity management processes, and the same kind of a process for things or rules or laws like St 137.
01:12:02.000 --> 01:12:12.000
So those are some of the challenges now in terms of the opportunities there to that we've identified and would appreciate your comment on one.
01:12:12.000 --> 01:12:27.000
Starting on slide where we slide 2828 Yep, is that we consider expanding upon provider directory API requirements and CMS is interoperability and patient access finding a rule.
01:12:27.000 --> 01:12:37.000
So we are California can require that all signatories today exchange framework that are listed at 133, maintain and update identity credentials.
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So the requirement, and the interoperability and patient access final rule specifies that payers offer public facing provider directly API's and use fire based API's.
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Specifically, it's the PBX care network implementation guide.
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It could be expanded to include all players in California.
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If you know this final rule with basically limited to certain payers, medical payers and others but it excludes, it does not include Qualified Health Plans on state based marketplaces just on the national marketplace.
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Don't know why they did that they didn't say, Some of you may know better.
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Second, is that the day exchange framework signatories and to remind everybody by the middle of 23.
01:13:22.000 --> 01:13:31.000
It's an expectation that the signatories listen AB, are the those lists may be one through three will be signatories today sharing agreement.
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And that is part of that process that providers will update their credentials to payers and others, and make them available to qualify to any like qualifying health information exchange so that there is a digital address and the ability to share information.
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And it's maintained by the signatories so that it gets it allows for a process for those to be updated routinely
01:14:03.000 --> 01:14:19.000
would love to get some comments I have not looked at the chat so I haven't seen what's been posted here but if there's any initial comments about expanding on this federal rule to apply it to a broader set of stakeholders as noted here we definitely welcome
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those thoughts.
01:14:41.000 --> 01:14:52.000
Why did you want to speak to the comment that you made about the problem we're trying to solve the problem I what I would say is the problem we're not trying to solve is
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health plans, updating their public facing provider directors which are typically used for. And by consumers and by other providers to access services, it's really focused on electronic identities that can be used to share information electronically with
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other entities health plan providers, and other organizations.
01:15:14.000 --> 01:15:32.000
Yeah, again, I'll be I'll take my like pragmatic on the ground. Like, if we could get type one and type two and P eyes and all the clinical records shared, we would be ecstatic type one is one refers to the organizational one refers to the individual
01:15:32.000 --> 01:15:44.000
provider. So that is a really amazing starting place those fields are already defined and all the standards, they're just almost very rarely populated.
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So that would be a very simple way to be able to track things like who ordered something and, who's the treating provider as distinguished from, who's the organizational provider.
01:15:54.000 --> 01:16:09.000
I think the identifiers that are things like direct addresses will depend on what our assumptions are about how we're sharing data, whether we're doing it through networks or not and whether we're doing it directly so I would defer that till a moment
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where we have more definition around the sharing modalities because it'll differ a lot but honestly type one type two, if we could have that in all the records that are shared I would be, I would be over the moon, so quiet Can you just, if you were to
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refine what this is saying, what is the recommendation around type one and type two NPI, what would we be saying is required, or recommended here.
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I mean, to me it would be simple so saying that the clinical data or the data is shared through. Maybe 130 to meet, if you want 33 requirements has to identify both the organizational, and the individual providers involved in the care so for instance
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when we share data for, he just reporting. Often, the individual provider isn't indicated, so it makes it impossible to track the quality measure app, or to track whether that follow up occurred after a clinical encounter so it sounds so simple, it is
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very simple, but often when we receive data we do not receive the both MPs.
01:17:20.000 --> 01:17:40.000
Right. Okay. And I think I mean that this suggests a pretty significant. I'm not saying this is a bad thing at all but just understand the issue on the ground support for providers to enter both type one and two and identifiers in things like claims,
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when they're when they're submitting them so that both are captured that right.
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Yep, that's right.
01:17:53.000 --> 01:17:55.000
Okay.
01:17:55.000 --> 01:17:59.000
David please God. Thank you.
01:17:59.000 --> 01:18:04.000
Thank you, Jonah and I'll make this very quick because it's something of a tangential comment.
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But, the short answer to the question is yes we believe that the provider directory API's, you know we should be looking at how that applies outside of what the, the effect of the interoperability and patient patient access final rule which is actually
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somewhat muted in California applies to MediCal managed care and Medicare Advantage but because we run our own exchange doesn't apply the exchange in the state doesn't apply to the employer individual market.
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So we should look at how that could apply to those markets.
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And I see we're going to talk about the provider directory API and the patient access API and a little bit here is actually seven API is listed in the rule.
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We think all of them weren't to look the pair two pair the provider access prior off support all data and I think I forgetting one.
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But I think they all actually could be potentially applicable outside of the markets that are covered by the federal rule.
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Okay.
01:19:03.000 --> 01:19:04.000
Good point.
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So well I think we'll go back and expand sort of what those other API requirements are and whether or not those should be included in this in this recommendation.

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Great, I should do you have a question or comment. Yeah Hey john is ash from are not Covered California.
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As you know, we've spoken about this gap that we found in patient in the interoperability final rule where a state based exchanges are exempt and how Covered California can even their contract reinforced filling that gap so happy to see this come up in
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this discussion. I would just like to pick your brain in this group's brain a little bit more on how this is related tie Symphony participation, which is a requirement we're proposing in our in our 23 contract.
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And if this would enhance like build upon the synchronous if you will, with the ij requirement. In addition to this patient, or this fire based API.
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Excellent. Very good question, and I know DMHC and Nathan you may or may not feel like your position to answer this, but I think what might.
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I think there could be benefits to enhancing what is required, and through this 157 and then through that you're proposing with using Symphony.
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What it may require is that there's an additional rule advanced about those two fields that Claudia mentioned for example that NPI types one and two are also updated.
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As part of this process of posting and updating provider directory information. That's one potential others may have, that may be wrong. I think that's one option and Nathan if you can comment love to hear it.
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If not, we can follow up with you after.
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Yeah, Jenna thank you and I think this came up a little bit earlier but we do have an open letter out for sb 137 and it brings standards to provider directories and submission requirements to the department, and we're in support of this effort and don't
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have a problem with updating the API but there may be a need for potential law changes.
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If there's not authority or conflicts with what's in current law, but we're, like I mentioned, we're in support of this effort and I think that that's probably part of the discussion for next steps and timelines, but we land on recommendations.
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Okay.
01:21:53.000 --> 01:21:54.000
Okay.

01:21:54.000 --> 01:22:02.000
So it feels like this is worth integrating the consideration that at 137 potential promulgation of rules.
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Or if needed new law to enhance things like product provided directory postings and add information.
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That should be considered and investigated as part of this proposal.
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Right, Carmela. Please go ahead.
01:22:22.000 --> 01:22:32.000
Thank you, Jonah just a general comment, and I may be the only one that's probably the case, you don't some of the things that we're talking about are on different levels.
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This is one that is on a much more technical level. We're happy to get back to you. But as we move ahead anything we can do to provide a little bit more background, I think.
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And I know everybody's working hard right everybody's flat out, but more background and a little bit more in advance, we can make certain that we are collecting that feedback and and and putting it into this process I think this is one we'd like to get
01:22:57.000 --> 01:23:03.000
back to you on in terms of some of the technical aspects. Thanks.
01:23:03.000 --> 01:23:07.000
Thank you. Good point. I should have pointed this out earlier we do.
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We were really very thankful that many of you responded and followed up with comments about December's recommendation and really help enhance what we had initially drafted and post meeting.
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We got comments all the way through middle of January, and we want to give the same opportunity here so I should have said this uptrend.
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We definitely want to give you all two weeks to I think we said the 14th, if I'm not mistaken, but will will specifically say date and then follow up with you to get any additional comments.
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And sorry, one week. Okay.
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Let's start with one week, additional comments and feedback, especially on the technical, it's those like this require a little bit more understanding of the technical issues.
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So I want to make sure that we give you all an opportunity for follow up post meeting, especially because other issues will come up that you may not have considered when you're reviewing the materials as well in this meeting.
01:24:08.000 --> 01:24:10.000

Thanks so much.
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Thank you.
01:24:12.000 --> 01:24:19.000
All right, last set of opportunities are focusing on consumer data access.
01:24:19.000 --> 01:24:21.000
And we have.
01:24:21.000 --> 01:24:24.000
We're doing okay.
01:24:24.000 --> 01:24:25.000
In terms of time.
01:24:25.000 --> 01:24:42.000
Okay, so the, so the gap, first of all, this is on slide 30, a gap that we've identified is individuals consistently face challenges accessing their information, either directly or through third parties and matter that's timely convenient compliant with
01:24:42.000 --> 01:24:45.000
federal access requirement usable.
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And in terms of the provisions we're trying to resolve here and develop resolutions for identify gaps and proposed solutions in the life cycle specifically around Lincoln sharing and exchanging providing access to health information and how pairs will
01:25:00.000 --> 01:25:11.000
be required to provide enrollee with electronic access to the health information, consistent with rules applicable to federal pair programs we just mentioned one of those in the last discussion in the last recommendation.
01:25:11.000 --> 01:25:27.000
So what are some of the considerations. One consumer data access and HIPAA under HIPAA, as we all know, we've lived with this for 20 years and it's been evolving patients have legal enforceable right to access their health records that are maintained
01:25:27.000 --> 01:25:33.000
by covered entities, but there's information that's maintained by non covered entities and HIPPA doesn't apply there.
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And there are numerous barriers that exist for accessing health information, and some complex assets access requirements.
01:25:41.000 --> 01:25:48.000
Sometimes portals may be difficult to navigate they may not be in the right language, and language that the individual speaks.
01:25:48.000 --> 01:25:57.000
So there are issues around, you know, sort of cultural competence in terms of accessing information and there can be financial costs to this PR HIPAA.
01:25:57.000 --> 01:26:12.000
Now there are recent regulations and frameworks we've talked about some of them already. The Cures Act, and final rule provides provides provisions that support consumer data access, including curtailing, the blocking and interoperability and patient

01:26:12.000 --> 01:26:28.000
final rule requires that CMS regulated payers make information patient data available including claims and counter and other information accessible via via standard API's, and then tech counts, easy access to electronic health information for for individuals
01:26:28.000 --> 01:26:33.000
and their caregivers as one of the principles of his trust exchange framework.
01:26:33.000 --> 01:26:36.000
When it's seven I think it is.
01:26:36.000 --> 01:26:57.000
So, what we want to really consider is improving data access, it really needs more of an industry wide effort to get individuals information more than just from HIPAA covered entities and and more readily accessible and usable and have them engage in
01:26:57.000 --> 01:27:07.000
things like correcting information that may be incorrect or using it in ways it's going to improve help them improve their or their families care.
01:27:07.000 --> 01:27:14.000
So, two opportunities here to consider, and starting on slide 31.
01:27:14.000 --> 01:27:29.000
So, the opportunity here is to ensure consumer access to their health information so what we would consider is adopting policies to ensure that consumers have meaningful access to the longitudinal health information across all healthcare organizations
01:27:29.000 --> 01:27:33.000
subject to at 133 at 133 mandate.
01:27:33.000 --> 01:27:41.000
So to help them make informed decisions so potential policies are requirements may include the following.
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So one is to expand the information blocking and patient access API, rules to all healthcare organizations, subject to the data exchange framework. So if you look at maybe 133.
01:27:52.000 --> 01:28:00.000
There are six different categories license plan helped organizations clinics practice hospitals.
01:28:00.000 --> 01:28:19.000
That would be subject to this so it would expand what's in the information blocking rule and patient access API to apply to all of those, and requiring that they use standards like fire API's to allow a patient access to that information.
01:28:19.000 --> 01:28:24.000
Second is to provide consumers with bi directional access to their health information.
01:28:24.000 --> 01:28:37.000
That is, including self reported data, and the ability, for example, to correct inaccurate information in a matter that accommodates their language readability disability access etc.
01:28:37.000 --> 01:28:45.000

and including a bridging digital divide. So, supporting individuals who have unlimited technology abroad capabilities.
01:28:45.000 --> 01:28:59.000
And then third is that there's going to be a need for consumers to have education and supported by healthcare organizations, how they can access health information use it to inform decision making, update their health information already thinking about,
01:28:59.000 --> 01:29:02.000
well, this we're going to broaden this.
01:29:02.000 --> 01:29:14.000
There are a whole host of organizations, listed in subdivision f one through six that like we're going to also need support in making sure their systems can do this.
01:29:14.000 --> 01:29:21.000
So we would need to think about what kind of supports do those types of providers, can't do this today need.
01:29:21.000 --> 01:29:28.000
So really want to get your your your comments here about these gaps.
01:29:28.000 --> 01:29:45.000
Does this help address the gaps and any considerations about API, using the API's that are noted in the federal rules, or if there is a different approach by which these information can be shared and accessible to consumers.
01:29:45.000 --> 01:29:50.000
I'll take a look at the chat which I've not looked at, but if anyone has any initial thoughts would love to hear them.
01:29:50.000 --> 01:29:59.000
I'd love to hear them.
01:29:59.000 --> 01:30:02.000
Mark, please go ahead.
01:30:02.000 --> 01:30:21.000
So, I totally support this opportunity and approach to closing the gap The, the access to longitudinal health information is a key friction point for care and shared care planning across, not just California but uh but across the nation, trying to connect
01:30:21.000 --> 01:30:31.000
to all these different sources of information but never having it woven together in a longitudinal way. So, this is huge. It's important.
01:30:31.000 --> 01:30:37.000
It's the kind of thing that patients in California to have been trying to do for decades and decades and decades.
01:30:37.000 --> 01:30:54.000
And we really ought to help them this is the perfect opportunity to do it. Likewise on bidirectional access Cove, it has shown this to us so much that we need from the patient and the patient's home or in other other providers that are in the community
01:30:54.000 --> 01:31:11.000
helping the patient so patient generated health data patient reported outcomes, remote monitoring data, and other things that are coming quite soon device data from work with the FDA is doing so that focus on, also in bullet to on bi directional access
01:31:11.000 --> 01:31:18.000

is is will make a major contribution to improve to improve and care and value for California.
01:31:18.000 --> 01:31:20.000
Thank you.
01:31:20.000 --> 01:31:23.000
Great.
01:31:23.000 --> 01:31:24.000
Thank you, Mark.
01:31:24.000 --> 01:31:28.000
Rahul.
01:31:28.000 --> 01:31:44.000
Thank you, you know a lot of Mr. Mark savages said really resonated with me as a patient reported outcomes are so critical and just in general that goes back to the principle that the physicians and nurse practitioners that social workers, the whole continuum
01:31:44.000 --> 01:31:57.000
of care really needs to have access to their own databases. But not only that, ultimately this is patient data. This is data that ultimately the patients are the owners of the more we empower our patients, the more they'll be able to be their best advocate
01:31:57.000 --> 01:32:12.000
for themselves so when they show up to clinic when I see them, the more they have access to themselves, regardless of whether I have access to it or not, if they have access to it, it'll make them more accountable for their own care and we want, California
01:32:12.000 --> 01:32:27.000
and I'm born, raised California. I want my colleagues, there are patients that are Medicaid or commercial or Medicare for all of them I want them to be their best advocate because I've seen health outcomes, improved tremendously.
01:32:27.000 --> 01:32:40.000
When the patients are aware of their disease process, they're able to speak to it in their own language in terms of their own reading level their own as much as they can be their own advocate, the better it is for them and they want to be so let's give
01:32:40.000 --> 01:32:54.000
them that's empower our car fellow Californians and I know that that that's so important for them to be compliant. And I think the consumer literacy is something that really is something very important to address in the situation we want to make sure
01:32:54.000 --> 01:33:00.000
that they have access to data and they understand.
01:33:00.000 --> 01:33:01.000
Right.
01:33:01.000 --> 01:33:06.000
Okay, Thank you. Excellent.
01:33:06.000 --> 01:33:19.000
Claudia Was there anything in your comment about what we can do about OCR, I mean, does this go back to the state through its governance process and use case development and advocacy efforts.

01:33:19.000 --> 01:33:33.000
Is there something that we can do to advance the challenge that you feel you can front, when it comes to your ability to collect but then be beholden to OCR rules that prohibit sharing even with a BA in place.
01:33:33.000 --> 01:33:44.000
Yeah, I mean, I think it would if if others, if we feel like this is a blocker which I think it is. I think it would be smart to go back to OCR and ask if they have guidance coming out.
01:33:44.000 --> 01:33:59.000
My suspicion is that there's debates within government about the authority of OCR, and about what essentially this is a discordance between to federal laws and regulations.
01:33:59.000 --> 01:34:14.000
And so it's a little in the weeds but it just means that many many Chinese across the country are not really sharing data through API's with patients because we're essentially blocked from doing it by HIPAA, even though we're told to do it by information
01:34:14.000 --> 01:34:28.000
blocking. So I do think it would be smart for you, us to go back to OCR and ask them if they have in pen, you know they can provide guidance, they may just be silent as they have been with us but doesn't hurt to ask.
01:34:28.000 --> 01:34:30.000
Okay.
01:34:30.000 --> 01:34:46.000
So I would put this back in the category of, we have, we're going to establish governance, we're going to develop use case priorities advocacy for certain needs that we feel are necessary to advance, then this case, consumer better consumer access bi
01:34:46.000 --> 01:34:53.000
directionally AM, as, as part of that process but link it to hear.
01:34:53.000 --> 01:34:57.000
Great. Lori, please go ahead.
01:34:57.000 --> 01:35:05.000
Yeah, I just wanted to emphasize, In addition to having access to data for consumers.
01:35:05.000 --> 01:35:08.000
Totally agree with that second bullet.
01:35:08.000 --> 01:35:22.000
I recently had a phone calls from just as my role is Kate hi someone called me a patient who said she needed access to her data for a practice that had been closed in the state.
01:35:22.000 --> 01:35:34.000
She was calling couldn't, no one answers the phone, and she raised a really good question. If that if that organization, the provider group had been participating in HIV.
01:35:34.000 --> 01:35:52.000
For her records to be somewhere, so. So there seems to be, I would think we need to have some sort of standard for what happens to practices that clothes clothes.

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And then on the front end.
01:35:54.000 --> 01:36:00.000
How can we get practices to really as part of their intake.
01:36:00.000 --> 01:36:08.000
Ensure that the patient understands that they've got access to the patient portal, train them on how to use it.
01:36:08.000 --> 01:36:24.000
Make sure that that it's a continued source of of access for the patient. But it just was an interesting interaction, and I don't even know where to tell this word patient to go to find her records now that the practice is closed.
01:36:24.000 --> 01:36:25.000
Right.
01:36:25.000 --> 01:36:32.000
So, that's the two things that struck me about that. I think one is back to.
01:36:32.000 --> 01:36:40.000
That sounds like a particular use case that we want to try to further assess, like what can we do, because I don't think we have a very good answer.
01:36:40.000 --> 01:36:52.000
The second that sort of comes to mind is that there are this sort of came about one of the five things the campfire and there was a really good story written.
01:36:52.000 --> 01:37:01.000
I think it was fact I mentioned there were one of the facilities that a patient, the patient's were seeing was burned to the ground.
01:37:01.000 --> 01:37:18.000
And the HIO was able to actually had some of the information for some of the individuals who are leaving the community they're fleeing the wildfires and were able to compile portions of their records and so what that suggests to me is, why don't we have.
01:37:18.000 --> 01:37:39.000
Similarly, have a Chios be to qualify, because we're gonna have this qualifying process ratios. Also, be able to provide and beholden to this provided access to information, just as a provider would just as a plan would under federal law.
01:37:39.000 --> 01:37:58.000
Okay, great. Thank you. Great comments, Andrew Bindman Please go ahead. Yeah. So again I like others I think this is, you know, a terrific goal. This is how we want to empower individuals to be able to have their information in ways that is meaningful
01:37:58.000 --> 01:38:17.000
and actionable for them to be able to make choices about health care, and their health, where I was struggling to fully understand is in your second bullet toward the bottom under discussion questions.
01:38:17.000 --> 01:38:33.000
The last phrase is should the state consider a centralized service, coupled with digital identities and this brought to mind that there are different solutions to how to do what you're talking about here and I don't know, I guess I've been envisioned
01:38:33.000 --> 01:38:52.000

that this group would be discussing those different solutions whether that is using an approach where one could imagine all the data is kind of dumped in one place and kind of centralized is sorted through and kind of created these longitudinal records
01:38:52.000 --> 01:38:54.000
that are pushed back out to people.
01:38:54.000 --> 01:39:06.000
There are other solutions that basically, you know, leave the data where they are and then basically in a federated way bring it together as needed.
01:39:06.000 --> 01:39:16.000
And it's kind of like our banking system right people don't put all their money in their bank and then it's pooled together it's kind of the information is shared and used as needed.
01:39:16.000 --> 01:39:22.000
I guess I'm just calling you know is the word centralized here meant to be something specific.
01:39:22.000 --> 01:39:40.000
How are we thinking about the potential solutions out there. To accomplish this, because I think that devil in the details is really important in terms of being able to execute on this in a way that also doesn't create a different burden and what's also
01:39:40.000 --> 01:39:46.000
being driven at the at the federal level so love to know where we are in that conversation.
01:39:46.000 --> 01:39:59.000
Very good. And probably shouldn't have had this question here it should have gone into later section because Graham is going to come and give a brief update I believe today on identity management digital identities, we actually do have is an A B one through
01:39:59.000 --> 01:40:09.000
three requirement a digital identity strategy for that needs to be considered as part of the framework.
01:40:09.000 --> 01:40:25.000
What that means is, there is effort going on now to begin to outline what those that strategy might be including whether it's centralized federated pros and cons, things of that nature, probably the wrong question to ask here, as you're asking the right
01:40:25.000 --> 01:40:41.000
question. I don't think we'll position to answer it in this context. I'm going to suggest we scrap it here and address it in the digital identities discussion which you will see later in the program, not, you're going to get a quick update today.
01:40:41.000 --> 01:40:48.000
But we have a responsibility to bring back what our proposed set of strategies are around digital identities.
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That will give you the opportunity to think about what are the potential mechanism so it's a really good point.
01:40:53.000 --> 01:40:59.000

I asked the wrong question where you're asking your question here because you're not really an answer it.
01:40:59.000 --> 01:41:10.000
But it does queue up the future discussion that we're going to have. So, I'm sorry it's not very satisfying answer but we'll get there.
01:41:10.000 --> 01:41:13.000
Last one David and then we got one more to go.
01:41:13.000 --> 01:41:26.000
Okay, that will make a note in the chat box about this, just as we're looking at all this through the lens of the information blocking role. It's important to remember that the information blocking rules the first two state law.
01:41:26.000 --> 01:41:33.000
The state law around patient access to medical information is pretty carefully negotiated in California.
01:41:33.000 --> 01:41:42.000
To protect certain types of information. So as we're thinking of all of this, we just can't. This is one place where as we're thinking about the federal context.
01:41:42.000 --> 01:41:49.000
They actually defer to us and the state context is really really really important.
01:41:49.000 --> 01:41:50.000
Yeah.
01:41:50.000 --> 01:41:52.000
Good point.
01:41:52.000 --> 01:42:08.000
Okay, so we'll need to ensure that when we go what will need to add to this is that specific provision and the rule, where there may be state laws specifically that govern data sharing that may prohibit certain types of information to be shared.
01:42:08.000 --> 01:42:17.000
So we can't simply open everything up we need to be obviously respectful, we need to identify where there may be some,
01:42:17.000 --> 01:42:25.000
some protections to maintain and some that we may want to adjust with future policy.
01:42:25.000 --> 01:42:29.000
Okay, Let's go to the last one.
01:42:29.000 --> 01:42:32.000
Same barrier, same gap.
01:42:32.000 --> 01:42:39.000
This is focused now on ensuring consumer access to their health information so we should be on slide.
01:42:39.000 --> 01:42:55.000
32 and specifically three be considered adopting policies to ensure that consumers understand how their health information may be used and trusting the system in place to governance you so what we're saying here is there a number of different potential
01:42:55.000 --> 01:43:01.000
policies and requirements that we would like to consider here and get your feedback on.

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First is that we review our current fair Information Practices which we understand are actually pretty rigorous rigorous, when you're looking at other states.
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So we need to we need to consider whether their updates needed to develop stronger guidelines that can be linked with the state's data sharing agreement, which is in development with our subcommittee and future state policy guidance that would be issued
01:43:24.000 --> 01:43:27.000
as part of our governance process.
01:43:27.000 --> 01:43:38.000
What are those guidelines, what might they include transparency about data policies limitations on collection use and disclosure consent data quality integrity and security.
01:43:38.000 --> 01:43:42.000
Accountability through appropriate audience audit trails.
01:43:42.000 --> 01:43:47.000
We know that guidelines need to be clear enough for the, for the consumers actually understand them.
01:43:47.000 --> 01:44:05.000
And it gives them the ability to understand it so that they can provide meaningful consent, where it's necessary because in some cases it is for information to be shared, particularly around substance use disorder conditions but that's not the only example,
01:44:05.000 --> 01:44:20.000
second set of considerations. The California developed practices and policies, specifically around those that plan today sharing agreement, hold them accountable for participating in the appropriate exchange and use the consumer health information that
01:44:20.000 --> 01:44:36.000
would include monitoring evaluating participation adherence the policies, writing data sharing safeguarding and use integrating explicit protections against misuse supporting healthcare organizations training and consumer access and support and consumer
01:44:36.000 --> 01:44:41.000
feedback mechanisms to improve data access.
01:44:41.000 --> 01:44:45.000
So this is their last set of considerations for today.
01:44:45.000 --> 01:44:55.000
Love to get final comments, or comments from this group again will give everyone an additional week to do any follow up, especially if you need to brush up on our fair Information Practices.
01:44:55.000 --> 01:45:13.000
but would welcome any comments that you have here.
01:45:13.000 --> 01:45:21.000
It may be that 90 minutes of this in a row is too much to go through so this is
01:45:21.000 --> 01:45:28.000
compress this into more digestible bites but mark your hand, go ahead.
01:45:28.000 --> 01:45:39.000

Sure, so totally appreciate the listing here and these are all the good important things to be considering the ideas.
01:45:39.000 --> 01:45:50.000
Putting it a little differently. Trust means, try not to surprise. So, getting ahead of the curve, letting, helping people understand beforehand.
01:45:50.000 --> 01:45:56.000
What, what is routine. Then means that they're, they're prepared for it and not and not surprised.
01:45:56.000 --> 01:46:14.000
And I think that's what we've found with, with Exchange under HIPAA so far, most of those exchanges and just permitted disclosures for treatment. Payment healthcare operations, patients expecting the patients actually want their data to be with the specialist,
01:46:14.000 --> 01:46:18.000
before they get there so they can actually have a useful appointment.
01:46:18.000 --> 01:46:34.000
You asked about successful programs, I don't know if you consider this a program but i i did work on the consumer engagement work group and I wouldn't see where we were trying to put together a disclosure form to answer questions that would be useful
01:46:34.000 --> 01:46:39.000
to consumers in language that they would expect to use.
01:46:39.000 --> 01:47:00.000
Even in languages other than 10 English and that that is not the only program, but it is one way that may be able to help get information out ahead of time, rather than just dropping, say a Notice of Privacy Practices or something like that.
01:47:00.000 --> 01:47:09.000
Force, you know, eight pages for signature at the time that you're actually trying to get in to the emergency room for care.
01:47:09.000 --> 01:47:14.000
Okay. Pretty, pretty common sense but still needs to be done.
01:47:14.000 --> 01:47:15.000
Thank you. Right.
01:47:15.000 --> 01:47:35.000
Okay, noting Karen your comment that we probably should be cross referencing some of the earlier discussion around accountability or around. Quality Measures incentive etc that we would consider an into investigate as part of this process and developing
01:47:35.000 --> 01:47:40.000
for the recommendations so I want to make sure we're, we're capturing that.
01:47:40.000 --> 01:47:57.000
Okay, great. We made it through these really appreciate excellent discussion, everyone's going to have another week to digest these consider this discussion send us any additional feedback or comments, brush up on the technical side.
01:47:57.000 --> 01:48:08.000
And we'll make revisions to these wherever we can. And bring this back, just for the final look through at our next meeting.
01:48:08.000 --> 01:48:14.000

But next week we're going to focus primarily on governance, and that's going to be a really interesting conversation.
01:48:14.000 --> 01:48:22.000
Okay, I think we are ready to go to public comment so john, I'm going to turn this over to you please.
01:48:22.000 --> 01:48:37.000
Thank you, Jonas take a breath. Thank you very much. Great job. Great job, everyone. We're now at the agenda point for public comment. Please note that individuals in the public audience who have a comment be inserted in the q amp a or otherwise you can
01:48:37.000 --> 01:48:45.000
raise your hand using the zoom teleconferencing options, but and you'll be called in the order that your hand was raised, state your name and organization affiliation.
01:48:45.000 --> 01:48:54.000
If you can please keep your comments, respectful and brief. Oh, and I'll turn it over to Emma.
01:48:54.000 --> 01:49:05.000
Great. At the moment we do not have any hands raised.
01:49:05.000 --> 01:49:11.000
I've got one hand here john healthy I'm going to go ahead and give you permission to unmute.
01:49:11.000 --> 01:49:29.000
Well, I've been participating in john Lv from sac Valley med chair in Northern California and I've been participating as an observer on these meetings so far and I really liked the momentum and the content that's getting
01:49:29.000 --> 01:49:41.000
momentum is moving forward, and I just appreciate all the hard work that each one of you are putting into this and just wanted to say thank you.
01:49:41.000 --> 01:49:44.000
Thank you.
01:49:44.000 --> 01:49:49.000
thank you for your comment.
01:49:49.000 --> 01:49:57.000
Next up we've got Boosie John's Lucy I'll go ahead and unmute you now.
01:49:57.000 --> 01:49:59.000
Thank you.
01:49:59.000 --> 01:50:09.000
I also appreciate the breadth and depth of this discussion, it's the task before this group is monumental.
01:50:09.000 --> 01:50:30.000
And I think Jonah's leadership has created at least a set of slides that starts to organize it in a very understandable way. So thank you for that. I just wanted to make a comment on the second bullet and one of the slides that Jonah said really shouldn't
01:50:30.000 --> 01:50:51.000
have been there, but I'm just going to say that there is a pilot starting right now. Under federal HHS auspices called the XMS pilot, which is addressing the Federated versus the centralized digital identity issue.

01:50:51.000 --> 01:51:09.000
And anything that we do in California should certainly be aware of that and comments throughout this meeting, have referred constantly to the dynamic between federal and state policy making.
01:51:09.000 --> 01:51:23.000
So I just want to be sure that everyone on the call knows that the issue of federated versus centralized digital identity is a debate that is not going to be settled soon.
01:51:23.000 --> 01:51:49.000
And it's not going to be settled by this project. So please start to inform yourselves about it. It's really, it really evokes how digital identity should be governed whether there should be a government function or not.
01:51:49.000 --> 01:51:58.000
So this is really complicated really controversial and really interesting. Thank you.
01:51:58.000 --> 01:52:01.000
Thank you for your comment.
01:52:01.000 --> 01:52:07.000
Next we've got Cheryl Esther's surely you should be able to unmute now.
01:52:07.000 --> 01:52:21.000
I just want to thank you for all the work that you're doing on this it's been a big challenge for all of us at the county's trying to figure out the direction that we should be going and so I just want to offer my appreciation for allowing us to be part
01:52:21.000 --> 01:52:27.000
of these conversations.
01:52:27.000 --> 01:52:32.000
Continue. Next week at Devon Devon you should be able to unmute.
01:52:32.000 --> 01:52:34.000
Yeah, great. Thank you very much.
01:52:34.000 --> 01:52:50.000
I'm also a member of the data of your subcommittee working on the data sharing framework agreement. And I want to applaud the committee for embracing individual access as an important component of the data sharing framework for my day job.
01:52:50.000 --> 01:52:52.000
I hope patients gather their records from all the places where they've been seen.
01:52:52.000 --> 01:53:08.000
gather their records from all the places where they've been seen. And that can be very difficult for them to accomplish, particularly if they need to set up ways to do this at each and every provider versus being able to potentially take advantage of a kind of a
01:53:08.000 --> 01:53:23.000
a kind of a networked approach to gathering data from multiple places through a single request, which might be something we can accomplish if we get everyone connected together through this data sharing activity so I'm going to thank the members of the
01:53:23.000 --> 01:53:32.000
committee and all the staff, because I agree this is definitely heading in a positive direction. Thank you.
01:53:32.000 --> 01:53:35.000
Thank you for your comment.

01:53:35.000 --> 01:53:48.000
do not see any other hands raised at this time.
01:53:48.000 --> 01:53:49.000
Okay.
01:53:49.000 --> 01:53:51.000
Thank you, everyone.
01:53:51.000 --> 01:54:01.000
I'm gonna hand it over to Bram to give us an update on digital identity strategy, thank you john Can you hear me all right.
01:54:01.000 --> 01:54:02.000
Yes we can.
01:54:02.000 --> 01:54:16.000
Thank you. So if we want to go on to the next slide please. I just want to remind people of what our charges under at 133 and that's develop a strategy for unique Secure Digital identities.
01:54:16.000 --> 01:54:32.000
There are some very important words in this statement, even though it's a very brief statement in the legislation that we need to keep in mind that this is a strategy that we're developing that identities need to be unique and secure, and that we're looking
01:54:32.000 --> 01:54:48.000
for something that can be implemented both in the private and public organizations that are participants in the data exchange framework. So the work is large, even though the statement is small and we discussed this at some detail in our last advisory
01:54:48.000 --> 01:54:51.000
group meeting.
01:54:51.000 --> 01:55:11.000
We want to move on to the next slide, a little bit more about our approach, and the timeline for developing this strategy. In December, here we're going to start assessing the needs for digital identities across the number of our different stakeholder
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groups who will be participating.
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And
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that is going to begin with our first focus group meetings that are actually scheduled for this week.
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In February and March will refine the needs and explore strategy components, and our target is to complete a draft strategy in April. It is that draft strategy that will be bringing back to this advisory group to talk about based on information that we
01:55:41.000 --> 01:55:43.000
get from our focus groups.
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So part of my charge in particular, but CDI and pick in general will be keeping the advisor group earlier praise from our progress during those meetings and to also bring some important questions that arise during those focus group meetings back to you

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for consideration, as well as bringing some of the important discussions that you are having to those focus groups. For instance, today we talked about incorporation of us CDI be two or v3.
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We talked about identity proofing we talked about authorization. We talked about SXMSX MS Project, those types of things will make it into the focus groups as well.
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For move on to the next slide really are used to the focus group comes from the need to make sure that we bring the right expertise to bear on creating this strategy.
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And so they are really designed to make sure that we gain specific input from specific stakeholder perspectives on that strategy, and therefore we have a number of different focus groups that we are creating that will be meeting individually to get us
01:56:52.000 --> 01:57:08.000
that information, our first meeting objectives are relatively broad and a high level, and that is to get insight into the potential components that might make up a strategy for digital identities and to understand how these different stakeholder groups
01:57:08.000 --> 01:57:17.000
can both contribute to digital identities, but also make use of those digital identities to make sure that we're actually getting value from this.
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Let's go on to the next slide please.
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And we've talked a little bit before also about the focus groups that that we are convenient.
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The first is, comprising a Chios, both in the state, and some input from outside state of California and our first focus group meeting is on Friday of this week.
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I've reached out to a number of people here in the Ag and elsewhere for recommendations for consumer representation largely around privacy. And we're putting that work that focus group together, and on providers, both large and small organizations, urban
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and rural organizations to get a provider perspective as well.
01:58:05.000 --> 01:58:23.000
We'll also be putting together, focus groups are representing health plans and social service organizations, and Kelly ths continues to meet with its department representatives to discuss digital identities within those meetings as well, and how they
01:58:23.000 --> 01:58:30.000
can be used and would impact the ongoing operations of those departments.
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If we move on to the next slide.
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This is a brief snapshot of the types of discussions that we envision for the first focus group meetings.
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That will be talking about what components might be part of that strategy for example does the strategy need to include a statewide MPI what data elements might comprise your digital identity and input from this group for instance on consideration for
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v2 v3 updates to us CDI will be part of that discussion potentially specific terminologies that might be used, etc. Also, is there a need for a consensus version of truth associated with the digital identity.
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When we're talking about those.
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Those demographics a concept. Often people think of as Master Data Management Do we need to identify what is the correct representation of my address or my ethnicity or his personality if that data is still valuable and more useful importantly though
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we will also be talking about how organization should engage here How might participants in the data exchange frame framework contribute data elements, how would the quality of those data elements be maintained and how might they use those data elements,
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you can imagine that this is not only a technical discussion, it's also an operation on a low. It's a policy discussion and has privacy considerations written all over it.
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We need to make sure that we continue to to to consider, move on to the next slide please.
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Just a real quick snapshot of the draft participants in the HIO focus group that is again scheduled for this Friday. So I say this is a draft.
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Tim Fletcher who was listed here has decided to recuse himself from these discussions as his organization might be interested in a procurement that might or might not come out of this activity.
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And we've reached out to a couple other. He goes to potentially participate as well.
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If there are other thoughts from the advisory group here on good representative representatives to be included in the HIO focus group.
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I would like to hear those. And as I said before, we're continuing to put together the membership for consumer privacy provider plan and social service focus groups as well, so please send me or anybody on the CDI team.
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Information recommendations that you have about who might participate in those groups.

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And the final slide then just in what the next steps are again if you have thoughts about some of the topics that we should be discussing in the focus groups, but also about the membership to the focus groups please pass that on.
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And then at each one of our upcoming meetings we will continue to update you on the progress we're making and those focus groups the discussions that are happening there any rising questions that we'd like to bring to you for comment.
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And then in the April timeframe, you should start to see a draft of that strategy, come to you for consideration.
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That is the end of my section.
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john if it's all right we might pause for a minute or two to see if there are questions.
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Absolutely.
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Are there questions for him.
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JOHN.
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Do you want from Dr. Hernandez.
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Please go ahead.
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Yeah, just curious me thank you for the update super helpful I'm wondering, kind of what your strategy is going to be on the focus group for the social service organizations, it's a very big universe of organizations and very important input to the process
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I wonder what you're thinking is on that. So that's a very good question, and I'm not sure that I have a very good answer for you as you point out to very large universe, it's also a universe that doesn't necessarily think about the technical implications,
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or technical potential technical solutions around digital identity. And I think that that getting good representation on a focus group there is going to have some present some very specific challenges so first of all I'm interested in anybody's thought
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about how they would recommend we approach that one.
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However, there are initiatives, both here in California and outside of the state of California that are focused on social determinants of health. And I think that there is, there are some organizations and some leadership within those organizations that
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can help us with that, but I would hate to rely solely on those types of initiatives, without any input from specific organizations here within California, So I'm really interested in people's thoughts along those lines.
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And Dr. Hernandez that's both from you but from the rest of the advisory group as well.
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Thank you Dr. Hernandez, I think we have time for one more question for him move on.
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We have time for one more question for him move on. Okay, great job, Graham, I'm going to hand it over to Jennifer to give a data sharing agreement subcommittee update, Jennifer. Thank you very much john.
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Next slide please.
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So the data sharing agreement subcommittee had a really great discussion on some additional threshold questions. The first was around individual or patient and proxy our patient representative access to health information.
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So, we're sort of hitting that subject in multiple different forum.
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In addition, we also discussed this threshold issue of how to ensure health care provider confidence and sharing health information, while also not labeling social services organizations as business associates when they don't necessarily meet that definition
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subcommittee also reviewed a high level draft outline of the elements of the data sharing agreement, which is going to assist in providing them with some context on what that agreement might look like.
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It's very much a draft and very much will change, but it does provide that sort of overview look as to what it might seem might be sort of an ending piece on which is helpful when you think about how this all fits together.
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Lastly, the subcommittee provided feedback on some draft language on privacy and security breach permitted uses of information required responses to certain requests for information, and how to address the various levels of technological readiness to
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share information.
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The group had a lot of great ideas around how to streamline the draft language, and we've received some written feedback as well on that draft language, the subcommittee will continue to discuss threshold questions in our next meeting around data quality
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and application of HIPAA particularly since many organizations were hoping will join that data sharing agreement will not necessarily be covered by HIPAA and addition will continue to discuss draft language and refine that draft language.
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You can find the draft language on the website and we absolutely welcome your feedback. Please keep in mind that this language will be changed regularly as a subcommittee in this group progresses, so.
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Please expect that that language will continually change and will not look the same. So, when you go there, you might see new versions popping up.
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Thank you very much. And I'd like to deliver it back over to john unless there are any questions.
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Any questions from the group for Jennifer,
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Trying to get them all tired out for you.
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Thank you very much, Jennifer.
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We're now going to go to the updated on principles did it change in California.
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So that all of you know we've definitely received a lot of thoughtful feedback on our principles first presented back in November, as well as in December, when we reviewed the hit capacity opportunities, every opportunity has been made to consider all
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comments as well as making changes to the latest edition, so hopefully everyone sees their comments being considered and in these latest additions that we go to the next slide please.
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So I'm going to take you through a little bit of this following the feedback received during our December meeting, we added an explicit principle on accountability, emphasizing the importance that all entities, participating in the collection exchange
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and the use of Health and Human Service information must act as responsible stewards of that information and be held accountable for any abuse or use or misuse of information other than for authorized purposes in accordance with state and federal law
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in California is data sharing agreement and data exchange framework policies.
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We also made modifications to principle for promote individual data access acknowledging the need to address the digital divide to support equal access to health and human service information, noting that consumers should have bidirectional access to

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their longitudinal Health and Human Service information to correct possible errors, to the extent allowed by state and federal law.
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They also updated principle five reinforce individual data privacy and security.
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Adding a sub principle to establish procedures for sharing electronic consent between entities, exchanging Health and Human Service data and compliance with state and federal data sharing rules.
02:08:36.000 --> 02:08:45.000
All stakeholder comments and the red line data exchange framework principles are available on the data exchange framework website.
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we can go to the next slide please.
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We also requested additional feedback on the potential hit capacity opportunities we reviewed during our last meeting. The feedback he shared broadly supported the potential opportunities and suggested thoughtful remind five minutes and additions to advance
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their objectives. A few of the key revisions and clarifications made based on your feedback, where opportunity number one multiplayer EHR Incentive Programs, adding additional flexibility for the allowable uses a potential EHR incentive program funds,
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such as for the electronic documentation technologies for non HIPAA covered entities and to provide.
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Sorry to upgrade providers existing EHR clarifying that for HIPAA covered entities funds should be directed to investments in the certified electronic health record technologies.
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And we also recognize that guidance should be developed to support provider selection of technologies and services that meet state data sharing requirements.
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Going to go on to opportunity to on the HIE onboarding program qualified networks and state data sharing requirements at 133 requires that the data exchange framework be technology agnostic.
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So potential HIV onboarding programs should support onboarding to any net network slash data sharing intermediary that meets the state's qualification requirements.
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It's also important to clarify that this would be an onboarding program and funds would not be intended to use to would not be used to defray ongoing costs associated with maintaining connections to falsifying information exchange intermediaries.
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And then on opportunity three expanding California alert notification requirements.

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We have expanded event notification requirements, described in the CMS patient access and interoperability final rule to require notifications to be sent to a beneficiaries health, health plan or payer.
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We would also establish a goal to expand alert notification requirements to additional entities to alert care team members to changes in clients incarceration housing or other statuses.
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We recognize this will be a big step for some health and human service organizations, which is why we envision this as a goal, rather than a immediate requirement.
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Please know all stakeholder requirements are sorry hold our comments and a red line version of the hit capacity grant gaps and opportunities are also available on our website.
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So with that, I'm going to pause and see if there's questions for the group.
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Okay.
02:11:40.000 --> 02:11:43.000
We're going to give up.
02:11:43.000 --> 02:11:48.000
a question. I just want to clarify.
02:11:48.000 --> 02:12:06.000
Are these statements your conclusions, so that if we don't agree with them we should comment again, or these statements, a summary of the comments that you may or may not agree with so I'm just wanting to know is what's on this page, what you plan to
02:12:06.000 --> 02:12:14.000
take forward in which case if we aren't in agreement we should send you additional comments.
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If you could clarify that'd be helpful.
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I'll turn to john and see how she would like to handle it.
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These are amendments based on feedback from this advisory group over the last 30 days. That would be incorporated into the opportunities we discussed.
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Sounds like if you have additional feedback please reach out, but we'd like to land here.
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Unless something isn't right.
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Okay, so if we don't agree with something on this on this page will send you additional.
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This is your proposed.

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Correct. recommendation. Okay, thank you.
02:12:55.000 --> 02:12:59.000
Thank you.
02:12:59.000 --> 02:13:02.000
Other questions or comments.
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Camilla, thank you john you just made a really important distinction between goal, and requirement wondering whether that will be equally as clear in the, in the final version of this.
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And when we started I realized the focus was on principles and the fact that Tesco had been released, do you envision taking another look at these in light of Stefka or not.
02:13:28.000 --> 02:13:45.000
Yes, and I think that's, That's why we kind of gave you guys also a chance between now and next Tuesday to come back to us with feedback but I believe that our team, initially reviewed the drafts, that, that was that were being put up over the last year
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if not more, and ensured alignment.
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JOHN any additional feedback on that.
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Yeah, I mean on the principles we did that was how we.
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One of the ways that we began to frame our principles we looked at Tech consumers Cal HHS.
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The trust exchange framework part of Tesco to develop those draft principles
02:14:11.000 --> 02:14:19.000
that fairly similar to what came out and final, but not 100%, there were some changes with a lot more, I think there was a few more emphasis on public health.
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But I think part of your question isn't just about the principles. What about these recommendations.
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if I'm not mistaken.
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Yes, and just, you know, at the beginning, you said you were going to ensure that our work is aligning with tough.
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You know, I think, to a to a degree but not to a large degree. What I mean by that is there. There's really more of a need to account for how our data sharing agreement needs to align with the common agreement that was released, that I think is a much
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bigger lift the trust exchange framework is really a set of principles. I mean that's as core that's what it is.

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I don't think we're misaligned and we will, because we just came out, we will make a final pass through them to make sure we are in alignment in terms of our principles and there's, I really think where the, the biggest lift here is going to be how does
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our data exchange data share data center work data sharing agreement, align with the common agreement and if you looked at the common agreement, it is not an easily digestible document.
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It is a big piece of work.
02:15:36.000 --> 02:15:37.000
Thanks.
02:15:37.000 --> 02:15:39.000
Thank you, Andrew.
02:15:39.000 --> 02:15:57.000
Yeah, hi, um, I guess I just want to maybe take us a slight step to the side related to what's come up throughout this meeting, including by myself and now just by Camilla, with, you know, you've highlighted that, you know, tough because now out, there's
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more to kind of align in our work.
02:16:02.000 --> 02:16:23.000
I'm wondering as an informational aspect of our work as a commission you envisioned an opportunity for us to hear directly from any leader at the federal agency of ONC so that we can really have a chance to get a very direct set of answers to the questions
02:16:23.000 --> 02:16:42.000
that come up there, this seems so fundamental to how we're trying to figure out where the right place for this state is to kind of either double down or to leverage and to enter basically aligned with the work of TEPCO and I just personally feel like
02:16:42.000 --> 02:16:58.000
I would benefit you've done a great job of trying to, you know, give us the cliff note version, if you will, of what's going on there but it sure would be nice to have some direct interaction and I just wonder, and I guess I would propose for consideration
02:16:58.000 --> 02:17:19.000
whether we could hear directly from leadership that ONC or who you think is appropriate related to the tough could process so that we can just be certain that we're being good stewards in trying to direct this activity on behalf of California.
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Thank you for that john. Yeah, go ahead. Yeah, I, I really liked that suggestion. So what I would will take that back.
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Andrew, and we've had one conversation, it wasn't with Nikki, with other members of on leadership team.
02:17:38.000 --> 02:17:57.000
But I would expect that given what we're undertaking here that leadership at on see would want to come speak to this group, and have a forum, the ability to discuss what we're doing and what it's been released and what's on the docket and give you all

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an opportunity to ask questions of them so we'll take that back.
02:18:01.000 --> 02:18:17.000
It may not be at the next session we might need to host a separate session, or just expand one of the sessions I know it's already a lot to get all this in, and to focus but I like that idea, we'll take it back and see what we can do.
02:18:17.000 --> 02:18:19.000
Thank you, Jonah.
02:18:19.000 --> 02:18:28.000
But I think your next
02:18:28.000 --> 02:18:34.000
party and Carmela sure a hand up from the last time we're
02:18:34.000 --> 02:18:37.000
okay and Claudia, So to dm.
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I actually had a job I'm sorry sorry. No worries, no worries.
02:18:40.000 --> 02:18:55.000
Sorry, sorry. No worries, no worries. Um, I just wanted to ask, why you concluded that ongoing funding for qualified Ha's is not needed.
02:18:55.000 --> 02:19:19.000
In our view, that is the thing we suffer slightly disagree with. And I'm just curious what was it that led you to conclude that if I'm reading this correctly.
02:19:19.000 --> 02:19:34.000
We, we believe we understand that there is a need for ongoing support of this work, it's not like it goes away. the proposal here is with the HIV onboarding program proposal.
02:19:34.000 --> 02:19:52.000
And that for the purposes of that onboarding program that it's the initial cost be afraid, and not ongoing costs, in part because there is a belief that there needs to be a holistic solution to how ongoing costs are afraid, and there needs to be more
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consideration about how that gets done. So for this onboarding program specifically, it would be limited to the onboarding process.
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I, it sounds like Claudia, you're suggesting we need another set of considerations about differing ongoing costs and what the state can do if I'm not mistaken your intent.
02:20:14.000 --> 02:20:34.000
Yes, and also that I think I believe the on the onboarding costs can be defrayed to enhance match, if that those costs are part of an ongoing MDS investment, they cannot be afraid if their traditional onboarding So, there are two issues.
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One is I do think there's a substantial need for ongoing funding and secondly, I want to be sure that California is taking advantage of enhanced match.
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And I think you could triple wire, without if you're not careful. If those are standalone costs so I will we will share comments separately but I just was very concerned that that ongoing piece, have been taken out.

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Yeah, that makes sense. We'd also appreciate what do we do from the other percent of the population that isn't served by medical added members or providers.
02:21:13.000 --> 02:21:23.000
So anything that may consider a solution for the entire state, including private to private and other means would be really, really helpful.
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Thank you.
02:21:27.000 --> 02:21:30.000
Thank you. Any other questions
02:21:30.000 --> 02:21:43.000
and comments about on sees annual virtual conference next week they do have two sessions on tough guy, so something folks find one for.
02:21:43.000 --> 02:21:45.000
Great.
02:21:45.000 --> 02:21:48.000
Thank you,
02:21:48.000 --> 02:21:51.000
David.
02:21:51.000 --> 02:22:11.000
Sure. Thank you This is sort of a big picture thought if we go back to the statute that governs this, the work of this committee in assembly about 133 point remember, it was a very carefully negotiated compromise between two competing visions that were
02:22:11.000 --> 02:22:31.000
running headlong into each other in the legislature incentive Bill 371 and Assembly Bill 1131, and what sort of resulted in it is the provider groups agreeing to accepting mandate on our providers to exchange data, a mandate that now it takes effect in
02:22:31.000 --> 02:22:33.000
two years in six days.
02:22:33.000 --> 02:22:42.000
For many of our providers in exchange for sort of this process that would build a data framework that would enable that exchange.
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And, you know that.
02:22:44.000 --> 02:22:57.000
I think what we were all sort of leading towards was an obsession about sort of like what networks are out there right now, how do we bring providers to that network and that big provider reading this piece that I feel like we're still missing.
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And then that all important question How are you going to pay for it.
02:23:01.000 --> 02:23:04.000
That just undergirds everything.
02:23:04.000 --> 02:23:15.000
And I feel like six months into this process unfortunately I'm not feeling like I have better answers those questions and I did at the beginning, and it feels like while we're talking about a lot of things that we're going a lot of different directions

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or some really big blocking and tackling pieces that we just continue to not discuss.
02:23:22.000 --> 02:23:35.000
And I think there's sort of we almost operate from this assumption that we're doing all this clinical exchange so we can build all this stuff on top of it and yet we aren't, there's still a lot of providers who are left out of this process, there's still
02:23:35.000 --> 02:23:38.000
a lot of a lot of gaps, we need to fill.
02:23:38.000 --> 02:23:44.000
And, you know, and we keep sort of raising this as those gaps, we're almost missing from this process.
02:23:44.000 --> 02:23:58.000
And I'm, you know and I know, talking to other organizations represented here. I'm not the only one feeling this so I guess I'm wondering if there is a roadmap that we're not seeing and how we're going to address those issues.
02:23:58.000 --> 02:24:11.000
It feels like we're kind of past time for someone to make that a parent. So, that's my, my comment and I would love any response.
02:24:11.000 --> 02:24:21.000
Okay. Um, I think a couple of things and I also ask and then I'll follow up to the LM comment Toronto and see.
02:24:21.000 --> 02:24:28.000
I thought we'd previously submitted and discuss recommendations around.
02:24:28.000 --> 02:24:45.000
You know, essentially a new EHR Incentive Program for those who are left behind, not funded under high tech that we had recommendations around technical assistance and some hub models that we might consider establishing and look to various sources of
02:24:45.000 --> 02:24:47.000
funding to get that done.
02:24:47.000 --> 02:24:59.000
So, I just I'm not really connecting what you think we're not addressing what we didn't address there around the gaps and who's left behind and technical assistance will be provided to providers.
02:24:59.000 --> 02:25:04.000
That wasn't covered in those recommendations.
02:25:04.000 --> 02:25:20.000
can be more specific. I think one part of it is that a lot of us I think were very surprised that there was nothing addressing the governor's budget around health information exchange even as a placeholder.
02:25:20.000 --> 02:25:29.000
You know, provider, if we do a provider onboarding program center program. That's one good that's going to require funding it's going to require support.
02:25:29.000 --> 02:25:39.000
And I think, you know the issue that we have at this point is that it's now the end of January and while it may not feel like it for budget that won't be done until June.
02:25:39.000 --> 02:25:43.000

We're, we're, we're burning time here.
02:25:43.000 --> 02:26:01.000
And we feel like it's, you know, we've got some principles, we've got some ideas we've got some concepts. And when do we get to the point of making those into, you know into hard recommendations that a lot of organizations here would be more than happy
02:26:01.000 --> 02:26:10.000
to advance our support in the legislature, that's where it's going to have to happen.
02:26:10.000 --> 02:26:14.000
JOHN you want to comment about budget etc.
02:26:14.000 --> 02:26:22.000
Oh, we are the plan is in to put dollars in, and a plan.
02:26:22.000 --> 02:26:32.000
In May, and we're working towards that right now so we are looking at what we're going to be needing to support this effort.
02:26:32.000 --> 02:26:34.000
Yeah.
02:26:34.000 --> 02:26:45.000
So I know that that's that. Not that far down the road, but it is part of our planning right now to have that understanding.
02:26:45.000 --> 02:26:50.000
Want me to expand on anything Jonah.
02:26:50.000 --> 02:26:52.000
I didn't ask the question.
02:26:52.000 --> 02:27:00.000
I'm fine with that.
02:27:00.000 --> 02:27:01.000
Well, and I guess.
02:27:01.000 --> 02:27:10.000
Yeah, I guess, john i guess i mean first of all that was an important piece for us to know. Right, so it wasn't in the January budget but we do expect something in the bay budget.
02:27:10.000 --> 02:27:29.000
That's a great piece. And I think a lot of us would be very interested in between sort of now and May, and how we structure that I know that Claudia and her folks have some ideas about federal funding we might be able to access, I know you know, a lot
02:27:29.000 --> 02:27:33.000
of our organizations are already putting stuff out there and putting stuff into the legislature.
02:27:33.000 --> 02:27:47.000
It would be really great if we sort of had that sort of big conversation and maybe we are and then we just haven't gotten to it yet, but that would be a piece I think we'd all want to know as well.
02:27:47.000 --> 02:27:52.000
Okay.
02:27:52.000 --> 02:28:11.000

Well, I think that the very least, we should be giving an update at the next meeting as to what thoughts we're putting into that, that type of a request to get reactions from this group and I think maybe in between then this group can share thoughts that
02:28:11.000 --> 02:28:20.000
they have I don't know, I'm trying to figure out the best for them to do it without creating another meeting.
02:28:20.000 --> 02:28:32.000
So I think that's if you have ideas and thoughts that you would be either irritated one way or another of things not being included or being included that you've heard about.
02:28:32.000 --> 02:28:37.000
I'd like to hear your feedback. Maybe you can send us your feedback.
02:28:37.000 --> 02:28:50.000
In that regard, or Jonah you have a way that maybe a little bit more eloquent or maybe a way to solicit input into this, so that others feel heard and listened to.
02:28:50.000 --> 02:28:52.000
Yeah.
02:28:52.000 --> 02:29:01.000
I certainly getting your feedback written comments, always appreciate it that's helpful I think john Why don't we take this back, and discuss with agency.
02:29:01.000 --> 02:29:06.000
Yeah, we can put some time on the spot. Awesome.
02:29:06.000 --> 02:29:06.000
Okay.
02:29:06.000 --> 02:29:24.000
I would ask Carmela Claudia, any others who noted sort of the ONC discussion, love to get your, your thoughts about what the agenda. What are the specific issues you want them to speak to, so we can prepare for that.
02:29:24.000 --> 02:29:32.000
And so welcome at anytime in the next week, that will start showing up that process.
02:29:32.000 --> 02:29:35.000
I think word closing.
02:29:35.000 --> 02:29:37.000
Thank you come out.
02:29:37.000 --> 02:29:48.000
I think we're closing, we are we're a couple minutes over but definitely good discussion very appropriate and needed so if you can go to the next slide.
02:29:48.000 --> 02:29:55.000
Just so everyone knows we're going to be sharing a summary of notes from this meeting as we always do but there may be new folks that around.
02:29:55.000 --> 02:30:09.000
We will be developing the pre read materials that you'll have to react to. In the meantime, please do reach out to any of us, Jonah Kevin myself. and our next meeting is March 3 at 10am.
02:30:09.000 --> 02:30:21.000

I want to thank you all for joining today thank you for the discussion thank finger, for your work of this important work that I know 10 years from now we can look back and say that we did something great for California, And thank you for all that you
02:30:21.000 --> 02:30:22.000
do.
02:30:22.000 --> 02:30:36.000
And we'll look forward to talking to you soon. Have a great day.