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

The following table shows comments that were entered into the Zoom Q&A by public attendees during the January 25th virtual meeting:

Count	Name	Comment	Response
1	Jonathon Feit	Good morning ... can you please advise how the California Fire Chiefs Association can be added to the list of stakeholder organizations? Thank you.	
2	Jonathon Feit	If EMSA is not present, then it seems CalChiefs is the only representative of the Fire & EMS industry in California that is present here today.	
3	jessica.zheng	Good morning, Kevin Sutton and Jessica Zheng from California Correctional Health Care Services are present at the meeting on behalf of Dr. Diana Toche. Please confirm that you receive this message, thank you.	Thank you for joining, Kevin and Jessica.
4	Steven Lane	The Draft USCDI V3, https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#draft-uscdi-v3, open for public comment now, includes a number of new Patient Demographic data elements: Date of Death, Tribal Affiliation, Related Person's Name, Related Person's Relationship (to the individual), Occupation, and Occupation Industry.	
5	Steven Lane	The USCDI V2, which is formally approved and could be referenced by CA requirements includes all of the following data elements: First Name Last Name Middle Name (including middle initial) Suffix Previous Name Date of Birth Race Ethnicity	

CalHHS California Health & Human Services Agency

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

Count	Name	Comment	Response
		Sex (Assigned at Birth) Sexual Orientation Gender Identity Preferred Language Current Address Previous Address Phone Number Phone Number Type Email Address	
6	ljohns	Hope you will check out the Gravity recommended codes for several SDOH elements (food insecurity, housing, material insecurity, transportation, etc.). Some have been adoped by ICD-10 and LOINC.	
7	Steven Lane	As noted in Jonah's comments, the specification of data exchange standards for SDOH are limited. USCDI V2, https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi#uscdi-v2, includes: SDOH Assessment, SDOH Goals, SDOH Problems/Health Concerns, and SDOH Interventions. These are carried forward in the Draft USCDI V3 without modification. No assitional SDOH elements are proposed for inclusion in V3.	
8	Jonathon Feit	Seconding re: @LJohns above. Are the efforts being described here going to align with -- or contradict -- the efforts being percolated by HL7 Gravity?	
9	Steven Lane	Health Status is included a a new Data Class in USCDI Draft V3 including the following data elements: Functional Status • Disability Status • Mental Function • Pregnancy Status	
10	ljohns	If CA feels the Gravity terminology is adequate to its need, CA adoping - making requirement to report - would be exactly the “next step” many participating in the Gravity work would like to see happen. Thank you!	
11	ljohns	LJohns is Lucy Johns. Sorry can’t see how to put my full name in participant list! ;-)	

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12	"Heather Readhead , MD MPH "	Can you address how USCDI gets implemented and enforced through ONC and CMS via adoption/use of an ONC certified EHR? The questions in the chat suggest that folks are not familiar with how these EHR changes are made to meet federal expectations that are enforced via CMS $ essentially.	
13	Steven Lane	'+1 @LJohns	
14	Steven Lane	'@Heather - New USCDI versions, once published, are added to the ONC's Standards Version Advancement Process (SVAP) https://www.healthit.gov/topic/standards-version-advancement-process-svap, so HIT vendors can incorporate them into their certified products. HIT certification requirements can subsequently be upgraded to require the use of the new standard. In parallel, CMS or other local, state and/or federal agencies can point to any USCDI version in their requirements.	live answered
15	Jonathon Feit	Thanks Lucy. @LJohns :-)	
16	Steven Lane	Both of the co-chairs of the ONC Interoperability Standards Work Group are Californians and Mark Savage is a prominent member of this workgroup.	
17	ljohns	'@Bindman: Agree totally about need to lay tracks. Isn't it true though that when fed govt looks to specify fed standards, they look at state efforts? If that is true, then CA leading the way re SDOH data elements would help that, wouldn't it?	
18	Steven Lane	This is the workgroup that is advancing USCDI as well as the supporting Interoperability Standards Advisory ISA https://www.healthit.gov/isa/. Agree with the group that we should take full advantage of our opportunity to participate in and lead the national discussion of standards advancement.	
19	Steven Lane	CA, and UCSF in particular, has been helping to lead the advancement of SDOH data standards for a number of years now.	
20	Jeff Scarafia	If California chooses to move to USCDI v2 (or even v3) on timelines ahead of the federal gov't, what strategy will the state employ to ensure vendors complete v2 and v3 features on OUR timelines instead of the federal schedule?	

Count	Name	Comment	Response
21	tien@eff.org	I'm concerned that data collection/sharing will in fact be incentivized, but that using the data to address bias/equity/patient health problems will lag collection/sharing, and that patient data will be more widely shared w/o reducing bias or increasing equity.	
22	Jonathon Feit	'@Lucy / @Mark / @Steve / @Sandra -- might I point out, re: UCSF, that there are two separate and parallel groups working....arguably at odds...to create and implement datasets re: SDOH vs. Community Paramedicine, which is also based on SDOH principles but operates in a different sphere (EMS & Fire).	
23	Timi Leslie	CA is not alone solving for quality data collection. Example of data quality report card tied to incentives @Michigan: https://drive.google.com/file/d/1x_RRy8oQcUectz8j-_F6VMclgjHJVDSk/view	
24	"Heather Readhead, MD MPH "	Should CHHS perhaps REQUIRE its departments (ex. CDPH) to participate in the federal "open comment" periods for ONC/USCDI? This could perhaps ensure that our CA depts stay engaged with federal movement and modernization of health IT - and it would help CHHS understand what data folks in the various departments are thinking about, including what they still need or what is missing and what perhaps also concerns they have about the federal movements. I think this would help CDPH stay more uptodate.	Love this suggestion Heather, thank you! We'll make note and follow-up with CalHHS departments
25	John Helvey	'@David Ford - Thank you for that comment.	
26	ljohns	If CA would explore federated identity verification, the second bullet would become irrelevant. You could do it all at once, not impose artifical segmentation.	
27	Jeff Scarafia	For the cross-state agency data sharing, how can this data sharing enable us to analyze efficient use of services? For example, if a single client is engaged across 4 services to address 4 different needs, that can be a good thing. If a client is engaged across 4 services all working to address transportation barriers, that leads to a lot of repeated efforts and inefficent use of resources.	

Count	Name	Comment	Response
28	Allen Noriega	When discussing the practicality/use-case standardization of interagency interoperability, are there any learnings from the development of CalSAWS that may be applicable?	
29	Steven Lane	Encourage the CHHS team take a careful look at the recently published The Trusted Exchange Framework (TEF): Principles for Trusted Exchange https://www.healthit.gov/sites/default/files/page/2022-01/Trusted_Exchange_Framework_0122.pdf to see how much of this we might also embrace at the State level.	
30	tien@eff.org	has there been any thought about risks to or protection of data about providers or patients in the reproductive health space?	This is a really good point, currently some of these providers just dont participate as there is no trust of data sharing.
31	tien@eff.org	has there been any thought about risks to or protection of data about providers or patients in the reproductive health space?	Agree that it is important to address this issue, especially given national attention and emerging Supreme Court docket. Need consider risks/protections for reproductive

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			health for minors
32	Steven Lane	Digital identity credential and contact information should absolutely include Direct Addresses and FHIR API endpoints. THis would greatly facilitate the use of existing and evolving standards-based interoperability via EHRs, HIEs and federated solutions.	
33	John Helvey	My experience is that providers do not embrace Direct Secure Messaging as a norm even if it is in the EMR.	That is our experience in LA/Riverside county as well. The specialist side cannot receive it and often doesnt even know what we are talking about. Much better to go through an HIE.
34	"Heather Readhead , MD MPH "	To modernize the public health workforce to meet modern challenges - could CDPH have at least 1 staff member that is professionally trained in modern healthcare IT informatics, including system design and interoperability (example, UCSF's and Standford's medical informatics training programs), to help guide public health leadership in a very intentional way that would help CDPH better engage with the modernization of public health informatics and the landscape of modern health information exchange? That world is very distant from the current state of CDPH with systems like CalREDIE, although CalREDIE at least helps us not be fax-dependent for lab results.	
35	Steven Lane	Tracking data via individual provider and organizational NPIs is critically important. This does not, however, address the need to actually coordinate the care of the individuals involved. This will require accessibility of	

Count	Name	Comment	Response
		individual provider and organizational Direct addresses and, increasingly, FHIR endpoints.	
36	ljohns	'@John Helvey: The DT Directory includes almost 1M providers, so a good chunk of providers use Direct, which includes IAL2 identity requirements for certificate issuance. FYI ;-)	
37	ljohns	'+1 to S Lane.	
38	Steven Lane	'@ John Helvey - Agree that many providers have not historically taken advantage of the full power of Direct messaging. With the recent finalization of the 360X standard for closed loop referral management via Direct and the potential to support cross organizational and cross discipline care coordination, I anticipate that we can and should expect additional uptake of this readily available channel for secure patient-centric communications.	
39	John Helvey	'@ljohns just because they are registered doesn't mean they use it. I am speaking from experience as a CIO. Providers from my experieince prefer using e-mail encryption from their organization e-mail platforms much more than they use Direct Secure Messaging.	
40	Steven Lane	Direct messaging is also increasingly used by providers to support Electronic Case Reporting (and the attendant BIdirectional data exchange with Public Health), which is now strongly incentivized by CMS through it Promoting Interoperability programs.	
41	John Helvey	'@Steven Lane - We can only hope. Typically they prefer everything through their private e-mails and how they are registered with CURES. They organizations want them to check and maintain their organizational e-mails, and now Direct Secure Messaging. Communication system overload is presenting a nightmare for providers to stay in the loop.	
42	ljohns	There is *no way* now for consumer to correct incorrect information in the EHR. If this could be a requirement somewhere somehow in CA, that's be a giant step. (Only the provider can correct the record, which is owned by the provider.)	
43	Steven Lane	'@ John Helvey - I AM one of those providers (a practicing PCP) and find patient-specific messaging incorporated into the EHR via DIrect	

Count	Name	Comment	Response
		mesagingWAY more convenient and secure than encrypted email with its attendant privacy and security risks.	
44	Michael Marchant	We need a system for cross organizational identity management - access is available but not coordinated across entity or industry	
45	John Helvey	integration in the EMR is key...having publication of these addresses is key to it's success	
46	Steven Lane	Re the federal requirement to populate NPPES, see CMS FAQ #25 at https://www.cms.gov/about-cms/health-informatics-and-interoperability-group/faqs/faqs#112	
47	ljohns	Re security of PHI in second bullets: be sure to check on the HHS XMS pilot now starting to be organized. Federated vs. centralized digital identities is a debate for the next decade.	
48	Steven Lane	Question. What is a digital contact? Where do providers find information on how to enter or update digital contact information associated with their National Provider Identifier (NPI) in the National Plan and Provider Enumeration System (NPPES) and what fields are required to complete their entry for digital contact? Response. Digital contact information, also known as endpoints, provide a secure way for health care entities, including providers and hospitals, to send authenticated, encrypted health information directly to known, trusted recipients over the internet.[18] Health care organizations seeking to engage in electronic health information exchange need accurate information about the electronic addresses (for example, Direct address, FHIR server URL, query endpoint, or other digital contact information) of potential exchange partners to facilitate this information exchange.	Thank you, this is a very helpful Q&A that helps answer the qusetion about what we need to solve for vis-a-vis provider identities
49	Steven Lane	NPPES can now capture information about a wide range of endpoints that providers can use to facilitate secure exchange of health information (85 FR 25581). Providers may find additional information on digital contact information in NPPES on the Health Information Exchange page of the NPPES website at: https://nppes.cms.hhs.gov/webhelp/nppeshelp/HEALTH%20INFORMATION	

Count	Name	Comment	Response
		%20EXCHANGE.html. In the CMS Interoperability and Patient Access final rule, CMS finalized the policy to publicly report the names and NPIs of those providers who do not have digital contact information included in the NPPES system beginning in the second half of 2020 (85 FR 25584). Instructions on how to update digital contact information in NPPES and what fields are required can be found in the instructional PowerPoint deck, beginning on slide 29, at: https://nppes.cms.hhs.gov/assets/How_to_apply_for_an_NPI_online.pdf. The required fields, shown on slide 30, are:	
50	Steven Lane	Endpoint; Endpoint Type; Endpoint Location; Endpoint Affiliation; and the Endpoint Use Terms and Conditions checkbox.	
51	John Helvey	'@Lori Hack's comment - contributing to HIE allows for a longitudinal record to be accessed as a resource in these situations..	
52	Timi Leslie	agree, utilize the qualified HIO proecess already in place ; and highlight emergency preparedness as a key use case	
53	tien@eff.org	I fully support patient access to their own data, it's critical for patient autonomy, but is not without costs to privacy, as patients who think their data is legally protected tend to overshare information (which is a variation of the wearables/not-HIPAA health data problem). So while access is really important, let's try to anticipate foreseeable consequences.	
54	Michael Marchant	Since access methods may differ by organization may need to create guidelines for 'approved' methods so consumer training can be effectively provided	
55	Steven Lane	Agree that patient's should be able to access all of the Electronic Health Information about them that is helpd by regional HIE/HIOs. This is required by the federal Information Sharing requirements but is not the reality today. Can our statewide effort address this gap? Patients should be able to download ALL their data from any HIO to combine as they see fit with dataa received from other sources.	live answered

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56	Steven Lane	Agree that patient's should be able to access all of the Electronic Health Information about them that is helpd by regional HIE/HIOs. This is required by the federal Information Sharing requirements but is not the reality today. Can our statewide effort address this gap? Patients should be able to download ALL their data from any HIO to combine as they see fit with dataa received from other sources.	I agree and think so Steven, we should include HIE/HIOs and reference federal requirements as part of this recommendation. Thank you!
57	ljohns	'@Tien: +1. Data exchange with, among non-HIPAA-covered entities is a trade off every single time. Who decides when the tradeoff is worth it?	Interesting idea. Maybe, but I think the cleaner approach is for OCR to provide guidance so the solution is cross cutting. This is a well known issue that has been raised repeatedly by us and other HIEs through public comment.
58	Steven Lane	'@ Claudia - Could the State require providers to agree to patient data sharing in their BAAs with HIE/HIOs?	live answered
59	Simon Vue	Public Comments: Simon Vue with the CA Council of Community Behavioral Health Agencies. We represent community nonprofit agencies that provide mental health and substance use disorder services to over 775,000	

Count	Name	Comment	Response
		Californians. We are thankful for the Governor and CalHHS's commitment to improving the health and wellbeing of all Californians through this important stakeholder advisory group. We are optimistic about this important initiative but do want to echo the comments from several members of the advisory group around accountability and prioritization of behavioral health county data. Data shows that the overwhelming majority of BIPOC and LGBTQ+ continue to turn to the county behavioral health safety net for their care, yet our behavioral health system still cannot answer how effective existing services are for these communities.	
60	Simon Vue	Much of the data collected is only reporting a partial picture of the true impact of these community-based interventions. This leads to incomplete or inaccurate reporting of data, which makes it difficult to improve the performance of these community-based interventions. Again, thank you to the department and stakeholders for their work on this important issue, and we look forward to working closely with the department on this initiative.	
61	Steven Lane	The TEFCA is setting the precedent of requiring participants to comply with HIPAA requirements even if they are not Covered Entities. CA should consider a similar requirement.	
62	ljohns	Pl be aware that an ANSI-approved standard for Notification is almost done. So recs concerning event notification should be aware of this, I would think.	
63	Steven Lane	Again, here is the link to the The Trusted Exchange Framework (TEF): Principles for Trusted Exchange https://www.healthit.gov/sites/default/files/page/2022-01/Trusted_Exchange_Framework_0122.pdf	

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64	Michael Marchant	I would suggest if there is a requirement for organizations to partciptate/onboard with an HIO/HIE - there should be an option to provide data but not 'join'.	

Total Count of Zoom Q&A comments: 64