

Good morning,

As always CCLHO is pleased to continue being part of the discussion on AB 133 and improving data interchange between providers and government agencies to achieve better health for all Californians.

Thank you for the opportunity to review the draft documents of the framework policies and procedures, and the data sharing agreement. As discussed on Wednesday's call, there are a few concerns I would like to call the workgroup's attention to as the delegated CCLHO representative.

- Under the Draft Data Sharing Agreement, Definitions (section 3): The current definition of "Social Services Organization" indicates a "person or entity whose primary business purpose is to provide Social Services to individuals," defined immediately previously as "the delivery of items and/or services to address social determinants of health and social drivers of health, including but not limited to housing, nutrition, access to food, transportation, employment and other social needs." However, for those counties with an amalgamated health and human services agency, they may have multiple primary business purposes handled by individual component departments, including social services as defined in this section but also public health and direct care. It is our belief that the intention of this definition is not to exclude internal use by component departments within such agencies that may not necessarily provide social services as a primary aim (necessary for No Wrong Door entry and other efficiencies), so to make this plain, we recommend expanding the definition to "Social Services Organization' shall mean a person or entity whose primary business **purposes include** providing Social Services to individuals. Social Services Organizations can include but are not limited to government agencies (**including multi-department health and human services agencies**), community-based organizations, nonprofits, and private entities."
- Under "Permitted, Required and Prohibited Purposes," Definitions (article IV): "Public Health Activities excludes activities related to oversight or enforcement of laws, regulations or rules by Governmental Participants." As defined in Health and Safety Code section 101030, local health officers "shall enforce and observe ... a) orders and ordinances of the board of supervisors, pertaining to the public health and sanitary matters. b) orders, including quarantine and other regulations, prescribed by the department. c) statutes relating to public health." This statute clearly indicates that local health officers have law enforcement responsibilities, even though they are not sworn peace officers, and particularly for communicable diseases may use this information for the purposes of investigation, quarantine, isolation and contact evaluation. It is entirely possible and appropriate that in the process of such an investigation a local health officer may find that individuals will be or have been put at risk of a communicable disease in violation of other statutes or regulations, and require a legal remedy to prevent further exposure (example: HSC 121365). Similarly, medical records

obtained under this section may be used as part of a determination that an illegal discharge of a hazardous substance has occurred, which may also demand a legal remedy to protect the public from further harm (HSC 101080 and 101085, *et seq*). We recommend changing this wording to “Public Health Activities excludes activities related to oversight or enforcement of laws, regulations or rules by Governmental Participants, **except for those laws and regulations relating to the statutory powers of the state or local health officer.**”

- Related to this section and as also mentioned on the call, while “Research” is listed as a specific permissible purpose under “Permitted, Required and Prohibited Purposes,” it is likely and expected that many health departments, either as a funding requirement or for development of community health assessments, will have a need to obtain data sets (potentially deidentified, but with some level of demographic data) to evaluate community health disparities beyond that which current regulation already entitles the health department to receive. It is not clear if this would already constitute a “Public Health Activity,” as defined, although it is my belief that 45 CFR does not prohibit it *per se* and thus the DSA should not be construed to prohibit it either. One possibility is to augment the definition of “Research” with “designed to develop or contribute to generalizable knowledge, **and/or enhance services and outreach.**”

Finally, as commented upon by our colleague Ms Michelle Gibbons from CHEAC, for “Requirement to Exchange Health and Social Services Information,” Procedures (article III), section 2, paragraph f: “Participants that are not technologically ready and able shall not use such classification as a justification for failure to engage in the Meaningful Exchange of Health and Social Services Information under the Data Exchange Framework. Participants must engage in Meaningful Exchange of Health and Social Services Information.” Being technologically “unready” may well be the case for some local health jurisdictions who deal with limited local sources of funding and for whom this is a lower priority compared to higher need programs. It is our hope that, as part of making AB 133 maximally effective, California can continue to make further investments in its local public health infrastructure without requiring the \$300m in the current budget necessary for many other vital programs to be used for AB 133 purposes.

Particularly for smaller jurisdictions, a state turnkey solution may prove to be most useful where local IT and epidemiology resources are limited and departments may not be able to respond to other participant requests in a timely fashion. Existing systems like CalREDIE and CAIR may be shoehorned into this role and would need their own updates for similar reasons. This correlates with Gap #4 in your Gaps and Opportunities document, which documents related issues with county HIT in general (keeping in mind there are three city public health departments currently as well, and potentially a fourth in the near future, which you may wish to call out explicitly).

We look forward to continuing to participate in the future, including in the formation of future P&Ps should the advisory group’s mandate be extended or transformed. Similarly, given the importance of this initiative, CCLHO and its membership would like

to be represented in any future State & County Agency Advisory Group as envisioned in the Governance draft, in such form as determined by executive leadership at that time.

Attentively,

Cameron Kaiser, MD, MPH, FAAFP, Deputy Public Health Officer
Public Health Services
County of San Diego Health and Human Services Agency
C: 619-643-8256

