California Health & Human Services Agency
Center for Data Insights and Innovation
Data Exchange Framework Implementation Advisory Committee
Data Sharing Agreement Policies and Procedures Subcommittee
Meeting 3 Chat Log (9:00AM – 11:30AM PT, December 15, 2022)

The following comments were made in the Zoom chat log by Subcommittee Members during the December 15th meeting:

09:16:33 From Steven Lane To Everyone:
Agree with Mark Savage that push messaging between participants is a critical component of functional interoperability, especially as relates to care coordination. Ad hoc push, in particular, is valuable for care team members to coordinate care.

09:18:03 From Deven McGraw, Invitae (she/her) To Everyone:
I have made a presumption that individual access will be taken care of in a separate policy - perhaps that's true of adding other push use cases

09:23:29 From Steven Lane To Everyone:
Most providers have the ability, through their certified EHR, to send a Direct secure message with appropriate attached documents, including a Continuity of Care Document, to other care team members with a Direct address available through the national directory. This is an inexpensive and readily available tool set to support the much needed coordination of care between medical and social/community service providers.

09:24:24 From Deven McGraw, Invitae (she/her) To Everyone:
Yes, if both endpoints are Direct-capable. Users of certified systems likely have lots of options not available to those who do not.

09:26:21 From Steven Lane To Everyone:
Yes, and plenty of Health Information Service Provider (HISP) vendors provide inexpensive access to Direct via web-based apps that could be utilized by those without already capable/enabled software systems.

09:29:28 From Belinda Waltman To Everyone:
On slide 18, 1.a.ii. states that participant delivering the electronic HSSI must ensure participant is authorized to receive the data. We discussed this in the earlier DSA meetings, but this bullet implies consent-driven management and potential data tagging of data elements that require consent (Part 2 data, LPS, HIV test results in

some cases, etc). Should language be added here to reference the "how" of consent-driven management?

09:32:23 From Steven Lane To Everyone:
https://www.healthit.gov/sites/default/files/page/2020-07/0720_Direct%20Secure%20Messaging%20Basics.pdf

09:34:44 From Steven Lane To Everyone:
That consent could be provided as part of providing consent for services and receiving the HIPAA Notice of Privacy Practices. If individuals need to opt in specifically to this exchange it will not scale.

09:35:08 From Deven McGraw, Invitae (she/her) To Everyone:
I think the intent on securely destroy is just to make sure that the information that wasn't supposed to be disclosed in the first place is disposed of in a way that doesn't increase risk - maybe take care of in security P&Ps?

09:35:28 From Deven McGraw, Invitae (she/her) To Everyone:
Fwiw, requiring secure destruction is consistent with the HIPAA security rule.

09:36:06 From Steven Lane To Everyone:


09:37:28 From Diana Kaempfer-Tong To Everyone:
For awareness around consent and authorization Not all participants use HIPAA notices of privacy practices. Most of CDPH is not HIPAA covered.

09:38:34 From Deven McGraw, Invitae (she/her) To Everyone:
Yes - but we reference HIPAA standards for all participants in other aspects of these policies, as I recall, in order to try to create more of a level playing field. But consistent with Shelley's comments, if you need to get consent before you share data, it would be your obligation to do so as the sender per the framework agreement (or if your particular legal obligations don't allow you to collect data without a patient's authorization/consent).

09:41:48 From Deven McGraw, Invitae (she/her) To Everyone:
I think it would be really helpful to map out a bunch of expected use cases, and the obligations on each end of those transactions.

09:42:09 From Deven McGraw, Invitae (she/her) To Everyone:
For different types of Participants

09:43:06 From Mark Savage To Everyone:
Agree that use cases with information flows would help tremendously to tweak the language in ways we've been discussing so far.

09:44:48 From Steven Lane To Everyone:
The standard for https://directtrust.org/standards/event-notifications-via-directsending ADT notifications via Direct:

09:45:17 From Steven Lane To Everyone:
Again, this is the standard for sending ADT notifications via Direct: https://directtrust.org/standards/event-notifications-via-direct

09:45:19 From Belinda Waltman To Everyone:
Minor thought for this ADT section - even though this is the technical req P&P, should it reference the real-time P&P here to let readers know that there are also timing expectations?

09:46:05 From Steven Lane To Everyone:
We should not assume that Event Notifications must go through a QHIO, unless that definition includes Direct as an appropriate method/HIO.

09:47:50 From Deven McGraw, Invitae (she/her) To Everyone:
I think the QHIO provisions are intended to govern when QHIOs are utilized - I could see these, and other, provisions also part of the criteria for which HIOs are judged on whether they can be QHIOs. But if we are going to promote Direct in these policies, do we also need to include those standards or vet providers of those services if we're going to recognize that methodology expressly in these policies.

09:48:40 From Deven McGraw, Invitae (she/her) To Everyone:
Again, I do not think this policy requires use of a QHIO - just making sure that if a participant uses an HIO, they are using one that meets the requirements. Potentially we need similar requirements for other technologies we are encouraging people to use....

09:48:46 From Jason Buckner To Everyone:
I believe that it should be A AND B are required, not one or the other.

09:49:33 From Mark Savage To Everyone:
To Bill's question, wouldn't the requirement to use one or the other means that if a.i.a. does not work (if one wants that), then must use a.i.b.

09:49:51 From Mark Savage To Everyone:
*mean

09:50:45 From Jonah Frohlich To Everyone:
If a hospital is able to meet requirements to notify participants in accordance with required standards, why must it be required that they use a QHIO if they can fulfill the requests through other means (Direct or otherwise)?

09:52:04 From John Helvey To Everyone:
Are the Hospitals required to notify the payers with ADT as well? They are players in this as well, not just providers.

09:53:04 From Jason Buckner To Everyone:
The issue is with a provider who wants to receive notifications, but does not want to comply with the burden of a hospitals preferred method of delivering notifications, which often entails paying a 3rd party vendor.

09:53:34 From William (Bill) Barcellona To Everyone:
It is unlikely that independent, small practices in larger networks like ACOs and IPAs will be able to accomplish direct exchange with hospitals. This has been a common problem. QHIOs are the most likely solution. But the goal of getting ADT information exchanged is a KEY priority for improving patient outcomes.

09:53:52 From Jason Buckner To Everyone:
Having the hospital provide that ADT to a QHIO provides a digital safety net for those providers to receive that ADT notification from a QHIO.

09:54:07 From John Helvey To Everyone:
How will all of this play in the Population Health Initiatives that are currently moving forward.

09:54:16 From John Helvey To Everyone:
agree with Jason Buckner

09:55:01 From Mark Savage To Everyone:
Agree about QHIO being a digital safety net for ADT notification!

09:55:08 From Steven Lane To Everyone:
In this exchange purpose, do we have a plan to support limiting responses to the Minimum Necessary data required/requested?

09:55:53 From Deven McGraw, Invitae (she/her) To Everyone:
Minimum necessary not required for treatment under HIPAA, fwiw. In general, we require senders to comply with applicable law in their responses, per Shelley's earlier comment.

09:55:58 From Steven Lane To Everyone:
Many times a Continuity of Care Document (CCD), the most common response to an IHE query, contains more information than necessary for some use cases.

09:56:50 From John Helvey To Everyone:
With these mandates for both hospitals and QHIO's is there funding to support this comprehensive model of ADT communications and appropriate management thereof

09:56:57 From Diana Kaempfer-Tong To Everyone:
Explanation on what would qualify as an “appropriate null response or error message” would increase clarity corresponding participants

09:57:27 From Diana Kaempfer-Tong To Everyone:
*responding participants

09:57:47 From Steven Lane To Everyone:
As community and social service providers will have access and ability to query, and we state that they must comply with HIPAA, does this imply that they need not request minimum necessary, or that data providers are excused from Min Necessary restrictions?

09:58:39 From Deven McGraw, Invitae (she/her) To Everyone:
Do you consider a community and social service provider to be acting as “treatment” for the patient? If so, minimum necessary won’t apply under HIPAA.

09:58:59 From Deven McGraw, Invitae (she/her) To Everyone:
(And care coordination, when done in the context of “treatment,” is considered treatment and not operations)

09:59:54 From Steven Lane To Everyone:
https://www.healthit.gov/sites/default/files/page2/2020-08/Health_Care_Provider_Definitions_v3.pdf

10:01:24 From Steven Lane To Everyone:
It seems that only certain community/social service providers meet the definition of “Provider” under applicable law. Is is acceptable to say that (categories of) individuals are providing Treatment if they are not a Provider?

10:06:05 From Steven Lane To Everyone:
Project US@ is pronounced “Project USA”

10:07:04 From Steven Lane To Everyone:
https://www.healthit.gov/isa/uscdi-data-class/patient-demographicsinformation#uscdi-v2

10:07:22 From Deven McGraw, Invitae (she/her) To Everyone:
Maybe there is a requirement we should put in that requires those who query for data to ask for only what they need to meet the purpose, and the concomitant duty to respond is to provide the data requested, recognizing that in some cases it may be difficult from a technical standpoint to segment data not requested? And in push transactions, the obligation should be on the entity initiating the push to provide the data required in a way that is consistent with law.

10:07:50 From Deven McGraw, Invitae (she/her) To Everyone:
(Correction - respondent is to provide the data requested consistent with law)

10:08:20 From Steven Lane To Everyone:
Good approach, Deven. 👍

10:10:11 From Mark Savage To Everyone:
Here's HITAC's Interoperability Standards WG language: "Current and Previous Address should contain not only the components of address (number, street name, city, state, zip) in accordance with the Project US@ specification, but also must contain a value or values from the Patient Address Metadata Schema, which is able to represent homelessness or temporary addresses."

10:10:20 From Jason Buckner To Everyone:
Devon - so a requestor could ask for demographics, encounters, results and procedures. And the respondent should ONLY include those elements? Is that what you are proposing?

10:12:52 From Steven Lane To Everyone:
Good to see that this review will be completed at least annually.

10:12:52 From Deven McGraw, Invitae (she/her) To Everyone:
Jason, where technically feasible, yes. But where those elements requested are part of document that has other elements in it, like a CCD, and it's not possible to carve those out, then the CCD could be sent in order to meet the needs of the requestor. Just trying to think about how to address Steven's concerns about minimum necessary, including in the context of social services where it's not clear they would be exempt from minimum necessary under hIPAA's treatment exemption. Trying to balance fair

information practices with practical realities of document-centered exchange architectures.

10:14:25 From Jason Buckner To Everyone:
Got it and it makes a lot of sense when considering technical feasibility.

10:14:38 From Steven Lane To Everyone:
I anticipate that many providers will be reluctant to send a full CCD to community care organizations that are not clearly HIPAA covered entities even if we say, as part of the State DxF, that those individuals are bound by HIPAA.

10:16:48 From John Helvey To Everyone:
I agree with Steven...we need to align communications and common language with the Feds...Otherwise it is going to complicate and confuse. It is already confusing enough

10:18:10 From John Helvey To Everyone:
second Jason and Mark on no need to change the name

10:18:54 From John Helvey To Everyone:
thank you

10:19:43 From Diana Kaempfer-Tong To Everyone:
Referring to it as the California Information Blocking Rule would be clearer for those participants only subject to the rule through this policy

10:22:47 From Mark Savage To Everyone:
And the Early Exchange P&P states that these effective dates don't apply to early exchange.

10:22:59 From Steven Lane To Everyone:
Under the federal rules it is HHS OCR that determines whether an action constitutes Information Blocking.
https://inquiry.healthit.gov/support/plugins/servlet/desk/portal/6

10:24:04 From Deven McGraw, Invitae (she/her) To Everyone:
No, actually it's OIG (Office of the Inspector General). For state policy violations, there will need to be an enforcement body/entity to decide whether blocking has occurred.

10:24:25 From Steven Lane To Everyone:
Thanks!

10:25:26 From Steven Lane To Everyone:
Do we anticipate a parallel State process for adjudicating InfoBlocking complaints?

10:26:16 From Steven Lane To Everyone:
If so, could this, perhaps, apply only to actors in CA not covered by the federal InfoBlocking prohibitions?

10:29:19 From Steven Lane To Everyone:
https://www.healthit.gov/sites/default/files/page2/2020-03/InformationBlockingExceptions.pdf

10:37:24 From Deven McGraw, Invitae (she/her) To Everyone:
Do we really want a health care provider being able to charge a fee to a social services agency for sending them data? The could if they rely on the info blocking fee exception in terms of the scope of that fee

10:39:28 From Steven Lane To Everyone:
Perhaps we could specifically prohibit that, Deven.

10:40:52 From Steven Lane To Everyone:
This does seem a reasonable approach to expanding the scope of this authority.

10:41:31 From Deven McGraw, Invitae (she/her) To Everyone:
That's what I was talking about in terms of making sure the fee and licensing exceptions wouldn't apply to that type of exchange, while making sure that entities/organizations providing the "interoperability elements" (mechanisms for exchange) could operate consistent with the federal fee and licensing exceptions.

10:42:15 From Steven Lane To Everyone:
Helpful FAQ: https://www.healthit.gov/sites/default/files/page2/2020-03/InformationBlockingExceptions.pdf

10:43:02 From Steven Lane To Everyone:
The FAQ above provides detail regarding Type of Harm and how this applies, under InfoBlocking and HIPAA, based on the requestor.

10:53:03 From Diana Kaempfer-Tong To Everyone:
Change to applicable law is appreciated.

11:01:58 From Deven McGraw, Invitae (she/her) To Everyone:

Apologies. Am going to log back on, as I am experiencing some technical difficulties.

11:02:22 From Jonah Frohlich To Everyone:
"California Information Blocking Prohibitions"?

11:02:29 From Steven Lane To Everyone:


11:02:30 From John Helvey To Everyone:
good with California Information Blocking P&P

11:03:25 From Jonah Frohlich To Everyone:
Good suggestion Diana and Steven, thank you!

11:05:51 From Steven Lane To Everyone:
It may be helpful to refer to the timeliness of making data available as opposed to the timeliness of exchange, as delays in the exchange itself may not be under the control of the data holder.

11:09:11 From Steven Lane To Everyone:
ONC InfoBlocking FAQ: When would a delay in fulfilling a request for access, exchange, or use of EHI be considered an interference under the information blocking regulation? https://www.healthit.gov/faq/when-would-delay-fulfilling-request-access-exchange-or-use-ehi-be-considered-interference-under

11:12:39 From Jason Buckner To Everyone:
I second that comment by John Helvey

11:13:14 From Steven Lane To Everyone:
I am also concerned that the introduction of “as soon as practicable” and “no more than 24 hours” add a loophole to our CA law that is NOT supported by federal requirements.

11:16:35 From Steven Lane To Everyone:
“It would likely be considered an interference for purposes of information blocking if a health care provider established an organizational policy that, for example, imposed delays on the release of lab results for any period of time in order to allow an ordering clinician to review the results or in order to personally inform the patient of the results before a patient can electronically access such results (see also 85 FR 25842 specifying that such a practice does not qualify for the “Preventing Harm” Exception).

To further illustrate, it also would likely be considered an interference: where a delay in providing access, exchange, or use occurs after a patient logs in to a patient portal to access EHI that a health care provider has (including, for example, lab results) and such EHI is not available—for any period of time—through the portal, where a delay occurs in providing a patient's EHI via an API to an app that the patient has authorized to receive their EHI."

11:19:52 From Steven Lane To Everyone:
Technology restrictions = "infeasibility"

11:20:02 From Steven Lane To Everyone:
Operational delays = information blocking

11:20:19 From Steven Lane To Everyone:
Or may

11:22:14 From Rim Cothren, CDII CalHHS To Everyone:
I believe that the CMS rule or FAQs may call out timing of ADT notification timelines we can reference.

11:25:32 From Steven Lane To Everyone:


11:27:23 From John Helvey To Everyone:
Early Exchange - as long as you clarify what you just stated in this policy it will help eliminate confusion

11:28:22 From Steven Lane To Everyone:
Good question, Deven.