California Health & Human Services Agency
Center for Data Insights and Innovation
Data Exchange Framework Implementation Advisory Committee
Meeting 3B Q&A Log (10:00AM – 2:00PM PT, January 10, 2023)

The following table shows comments that were entered into the Zoom Q&A by public attendees during the January 10th meeting:

Count	Name	Comment	Response
1	Steven Lane	How does the 2nd part of the 3rd meeting differ from the 4th meeting? ;-)	live answered
2	Steven Lane	This makes a lot of sense and aligns well with the federal effort to designate QHINs. We want to support a diverse community of QHIOs to support our diverse state.	
3	Steven Lane	Attending to data quality is important, but there are no standards by which this can be judged.	
4	Robby Franceschini	Regarding question 3 under organization (and in relation to functional capabilities), what consideration will be given to serving both health and social services organizations as a QHIO, and being able to share/receive all data types listed in P&P #8?	
5	Paul Matthews (He/Him/His)	Will Health Care Providers that wish to utilize their own technology or Intermediaries that will act on behalf of providers, such as those participating in a HCCN with a shared EHR, be required to meet the QHIO requirements on the Part A: Organizations slide? The cash on hand requirement is high and most would have 90 days COH.	No Participant or intermediary will be required to become a QHIO or meet QHIO organizational criteria to participate in DxF, and no Participant will be required to use a QHIO as long as it meets its obligations under the DSA and P&Ps.
6	Steven Lane	We should consider alignment with / adoption of the recent recommendations published by The Sequoia Project's Data Usability Workgroup. This is really one of the first "data quality standards" available and certainly one that we want to see adopted. Anoither opportunity for CA to be in the vanguard. https://sequoiaproject.org/interoperability-matters/data-usability-	

Count	Name	Comment	Response
		workgroup/data-usability-workgroup-implementation-guide/	
7	Dan Chavez	Are we trying to have parity between QHINs and QHIOs?	
8	John Helvey	John Helvey from SacValley MedShare, and I agree with Felix Su comment on QHIO	
9	Steven Lane	QHINs and QHIOs play very different roles in the specified national and statewide exchange initiatives. Nonetheless, california participants in information exchange will likely interact with both, so consistency or understandable and intentional differences should be identified and called out.	
9	Bill Barcellona	Will QHIOs be required to provide equity in access to all potential local providers? It is important to require that a QHIO serve all required and permitted purposes, data elements, and requirements to exchange HSSI. Providers need to choose a QHIO that doesn't limit data exchange. For example, payers and providers need QHIOs that support exchange of payment and operations data, not just clinical data. Physician groups need to access patient data, provide patient data, transact claims/encounters, payer-required administrative data, as well as clinical data like ADTs, in order to fulfill the requirements of CalAIM.	
10	Steven Lane	The specifics of what will be required of national QHINs under TEFCA are specified in the the QHIN Technical Framework (QTF): chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://rce.sequoiaproject.org/wp-content/uploads/2022/01/QTF_0122.pdf	
11	Dan Chavez	Targets should be communities	
12	L. Johns	'+1 David Ford re consumer being the target pop for a QHIO. Patient access is highest CMS priority (as payer) right now. Include subquestion in QUestion 3: what do you consider your primary	

Count	Name	Comment	Response
		market/target population/something like that.	
13	Dan Chavez	Agree Steven, understandable and itential differences should be identified and called out	
14	Dan Chavez	conflicts should include vendor agreements	
15	Steven Lane	We need to keep in mind that QHIOs are meant to facilitate connection to state and nationwide exchange and are not meant to be a required connection methodology. Recall that essentially all clinical providers across the state are already connected to the established networks and the existing data exchange framework. Our goal is to bring new participants into alignment with and in a position to benefit from all of the interoperability that is already happening.	
16	John Helvey	HIO's have spent a lot of time and money along with legal counsels of it's participants to establish our Participation Agreements. We do not have the resources to repeat that expense.	
17	Steven Lane	This is quite different than the federal architecture where all participants in TEFCA exchange will be required to route their data exchange through one or more QHINs.	
18	Dan Chavez	How many not-for-profits have 6 month cash on hand as a rule?	
19	Steven Lane	I hope that we design QHIO requirements so as to support a diversity of organizations, including smaller entities serving rural communities. 6 months cash may, intentionally or not, restrict this to large organizations with incomplete coverage of the state, perhaps inadvertently driving business from smaller to larger HIOs.	
20	Paul Matthews (He/Him/His)	Question 6: List of contractors. If contractors are facilitating support of vendor products, will they be required to be located in the US or be registered as US corporations and subject to US law.	Yes, that is the intent.

Count	Name	Comment	Response
21	Steven Lane	Nationally I predict that we will end up with roughly a dozen QHINs. The selection and designation process is designed to set a high bar while supporting a diverse community of network participants. I think we should have a similar goal in California, and not favor specific actors.	
22	Paul Matthews (He/Him/His)	On certification criteria, will certification be a requirement for those connecting to DxF or will this only apply to QHIO's. What about Intermediaries supporting provider groups?	live answered
23	Dan Chavez	Several large health systems in CA out HIOs through annual security assessments - will satisfaction of those assessments satisfy these requirements	
24	Wes Rishel	Could you consider matching the security assessment to the requirements that Sequoia requires on a national level?	
25	Steven Lane	Breaches happen through no fault of the organization. HIPAA breaches should not exclude participation. Worth evaluating, but should not be an absolute requirement.	
26	Paul Matthews (He/Him/His)	Will participants (providers) that exchange data internationally today under Treatment need to meet the no-exchange or storage of CA patient data outside of the US requirement?	This question may require some thought. I'd encourage you to submit it to CDII@chhs.ca.gov.
27	Steven Lane	If QHIOs go through merger/acquisition we may want to have them re-qualify in the following year, given how such changes can impact operations.	
28	JS	What is the target date to finalize this draft document?	Our goal is to finalize all of the sections of the QHIO application by early February and launch the application in March.
29	Paul Matthews (He/Him/His)	Breach notification should not be different to that currently required in regulatory language in regard to Public reporting.	
30	Dan Chavez	Is Health Gorilla acquiring?	

Count	Name	Comment	Response
31	Karen Ostrowski	We recommend reconsidering an annual audit or re-certification process…for comparison, Qualified Entities in NY are audited routinely and have to complete an abbreviated self-audit annually. The certification seems minimal at present but what additional requirements QHIOs will have to meet in order to maintain the certification and to what level will they be required to collaborate with one another for data sharing to be effective across the state?	
32	Paul Matthews (He/Him/His)	The HITRUST certification is valid for 24 months, with an interim review required to ensure standards continue being met. After 12 months, interim assessment testing is required. If HITRUST is required for QHIO's they should submit the interim and validation certificates as part of the attesting to maintaing their security.	
33	L. Johns	Is "Privacy by Design" a criterion for assessing the response to Part B Questionn 9? If not, how will you decide whether "privacy policy" is adequate/acceptable?	
34	Dan Chavez	Can a large CA based health system satisfy the SRA requirement?	
35	Yamin.Scardigli	2 or fewer breaches in three years seems like a really high standard.	
36	Paul Matthews (He/Him/His)	For provider organizations a clear FAQ on the requirements for their interfaces should be established to make it easier for the providers to work with their vendors and with QHIOS. It should claify the ADT HL7 Specification does not include balloted criteria to support SOGI/SDoH under v2.5.1, It should clarify that USCDIv2 support for FHIR in nascent in its development and not required for EHR in the national certification criteria (this is a vendor roadmap question), the same issue applies to CDA which is required to meet USCDIv1 in the certification requirements and USCDIv2 support is again governed	

Count	Name	Comment	Response
		by the vendor roadmaps but is much further ahead in the vendor roadmaps.	
37	Paul Matthews (He/Him/His)	Will Providers and Intermediaries be able to apply for grant if they will not be contracting with a QHIO and will instead be using their own technology under the DSA/Policy: OPP-8. How will the reporting criteria be met given the need to report grants through the QHIO.	
38	Darius Stelmach	How will QHIO be paid for assistance provided to DSA signatory which chose to seek QHIO assistance?	
39	Darius Stelmach	Does DSA signatory pay QHIO from the grant funds?	
40	Paul Matthews (He/Him/His)	If the QHIO programs is not implemented or QHIO lists are not avaliable that allow time for impleemntation by participants by the 1/31/2024 date (delayed in onboarding), will participants be in violation of the DSA? Will exception language in FAQs be supplied to mitigate concerns?	
41	Jennifer Martinez	Will the level of funding for a QHIO grant be set by a budget in the grant application, or in there an intended set amount for each approved grant?	
42	Paul Matthews (He/Him/His)	Will QHIO's be required to connect and exchange with other QHIO's. Networks may connect to multiple QHIO's because provider groups in the network will need to echange data in their community.	
43	Steven Lane	We have discussed before the idea that requiring that any QHIO to be able to provide ALL needed services to a signatory likely restricts us to a very small number of QHIOs and potentially only one or two for the state, intentionally or not.	
44	Darius Stelmach	What if signatory does not need an outside vendor for TA implementation?	
45	Ken Riomales	Is TA Grant funding opportunities prioritized for mandatory signatories similar to the HIO onboarding grants?	
46	Greg Stein	Will there be a directory (and possibly qualifications requirements) for vendor	

Count	Name	Comment	Response
		listing to assist Signatories in identifying and comparing solutions?	
47	Joe Prado	TA Grant Impermissible Uses - not allowed with other health and human services organizations. This significantly limits County public health exchanging information with Behavioral Health and Social Services.	
48	Steven Lane	Most clinical provider signatories won't require the services of a QHIO to conect to state and nationwide exchange. This means that the grants will largely support QHIOs in getting new customers from the social service organizations that need to connect to the existing interoperability framework. A nice financial benefit to any organization that meets the criteria to serve as a QHIO.	
49	Katy Weber# MPH	Has there been any thought around including social service organizations/community organizations that are contracted with medical providers under CalAIM in the earlier rounds of TA DxF funding to onboard to a QHIO?	
50	Greg Stein	Many EHR vendors charge ongoing maintenance and/or transaction fees once the initial integration is completed and live. It appears that the TA grant woud not cover these ongoing costs. Who bears this cost? The QHIO, the Signatory, or ?? I suggest this section be clarified and ongoing funding identified to address the need to maintain and update these integrations over time.	
51	Steven Lane	Again, hospitals and medical groups are already able to interoperate broadly. These are not the entities that need grant funding, unless we somehow squeeze in new DxF requirements specifically forcing them to unnecessisarily connect to an HIO, which is what certain political and business interests have been trying to force for some time.	

Count	Name	Comment	Response
52	Paul Matthews (He/Him/His)	If a provider group meet the technical criteria but chose not to connect a to QHIO or HIO, do they meet the requirements of DxF. Those outside this group are struggling to understanding who they must exchange with as endpoints. Example: If I am currently connected as a provider to eHealth Exchange/Carequality and respond to queries for CDA using USCDIv2 am I required to join or exchange with any 3rd party that is a signatory. Clarity is key the the discussion for small provider groups.	
53	Darius Stelmach	When will grant funding be available for County Public Health Labs? What will the grant maximum be for PHL?	
54	Margarita Bonaparte	This question is off topic, but this is my first time joining these meetings. I know this meeting is to discuss grants eligibility and criteria but can someone direct me to the specific person who can answer my question? I looked at the entities required to sign the DSA agreement before January 31, 2023, and I did not see my type of organization listed there. To be more specific, my organization is a county jail. I've looked at the different entitites that will be required to sign the agreement and detention facilities are not mentioned so I am assumming as of right now these type of organizations are not included. Thank you in advance for your time.	Please direct your question to CDII@chhs.ca.gov.
55	Paul Matthews (He/Him/His)	Will County Public Health providing clinical services to patients (SDT, TB, Primary Care etc) be treated differently.	
56	John Helvey	With regards to small -vs- large medical provider offices the costs is fairly the same...this is creating inequity given the size of the organization	
57	Paul Matthews (He/Him/His)	Will grant funding be made available in the future to small pratices that are not required to exchange until 2026?	

Count	Name	Comment	Response
58	John Helvey	Good Point Jonah...with reagrds to aligning language. Size should not matter if we are really trying to present an equitable situation	

Total Count of Zoom Q&A comments: 58